Final report:
The Western Perinatal Support Group (WPSG) program in Western Adelaide
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inspiring achievement
Introduction

The evaluation of the programs provided by the Communities for Children initiative (CfC) is presented here. This report is divided into five sections. The first section presents the background information on the CfC initiative including an outline of the demographic and epidemiological outcomes for children in the area of focus for this evaluation. Additionally, the introduction outlines some of the theoretical basis for the models of care and the therapeutic models of care that are common in all the programs provided. Subsequent sections provide the therapeutic models of care specific to the particular program provided by the organisation or service. The report also provides a conclusion for each program and a final conclusion for the evaluation research project as a whole.
Section one:

Western Perinatal Support Group (WPSG)

Background

There are known linkages between child maltreatment and levels of economic and social stress that are generally prevalent in areas of relative disadvantage (Access Economics Pty Limited 2008, Maggi, Irwin et al. 2010, AIHW 2012). Accordingly, Communities for Children (CfC) was established in 2004 following a decision by the then Australian Government to establish the ‘Stronger Families and Communities Strategy’ (2004–08). Communities for Children was one of four streams of the Strategy, with the aim of addressing the risk factors for child abuse and neglect before they escalate, and to help parents of children at risk to provide a safe, happy and healthy life for their children and thus circumvent the deleterious health, education and welfare outcomes for children at risk.

Underpinned by the social determinants of health (Maggi, Irwin et al. 2010), the key feature of the CfC strategy sought to engage adults in activities with and for their children. These included home visiting, early learning and literacy programs, early development of social and communication skills, parenting and family support programs, and child nutrition (Allen 2011, AIHW 2012, Australia 2014). The CfC is a place based strategy aimed at improving an areas’ childhood disadvantage factors.

UnitingCare Wesley Port Adelaide is the Facilitating Partner of CfC and, as such, acts as a broker in engaging the community in the delivery of children’s and parent’s programs aimed at enhancing community outcomes (Muir, Katz et al. 2010). The CfC initiative aimed to improve the coordination of services for children 0-12 years and their families in order to minimise the impact of area-based disadvantage (Muir, Katz et al. 2010). Further, the
initiative aimed to build community capacity to provide appropriate, targeted and enhanced services delivery and improve the community context for children (Muir, Katz et al. 2010). The whole community approach to improving child development incorporated the needs of the community (Muir, Katz et al. 2010). This report presents the findings from the evaluation of the Western Perinatal Support Program.

The Western Perinatal Support programs are delivered on site at Seaton Central Community Centre which is an integrated Child and Family Centre. The centre provides an integrated service delivery approach supporting multiple service providers, and a resource for the parents accessing the programs, through individual support. The Seaton Central Community Centre staff provide valuable support to distressed parents when the WPSG program staff are not available. The majority of programs provided at Seaton Central are based on targeted relationship programs.

**Theoretical Basis for Program Models**

**Targeted relationship based programs**

Early human development impacts on health, learning, and behaviour throughout life (Mustard 2010). Programs targeting parents of children at risk aim to decrease the impact of the negative characteristics of some of the Social Determinants of Health (SDH) (Solar and Irwin 2010) and address the children’s potential level of complex vulnerabilities that accumulate to produce poorer adult health outcomes (Mackintosh, White et al. 2006, Noble-Carr 2007, DoCS 2009, Keys 2009, Dockery, Grath et al. 2010, Gibson and Johnstone 2010, Lynam, Loock et al. 2010, Solar and Irwin 2010, Marcynyszyn, Maher et al. 2011, Nelson and Mann 2011, Kilmer, Cook et al. 2012, McCartney 2012, McCoy-Roth, Mackintosh et al. 2012, Zlotnick, Tam et al. 2012, Coren, Hossain et al. 2013, Embleton, Mwangi et al. 2013, Roos, Mota et al. 2013, Kuehn 2014). Of note, the use of parenting programs have been effective in decreasing emotional and behavioural problems in children (Wyatt Kaminski, Valle et al. 2008). This includes children with behavioural conduct disorder, oppositional behaviour, attention-deficit hyperactivity disorder, and anxiety disorders (Wyatt Kaminski, Valle et al. 2008, DoCS 2009). In addition, there is evidence that investing economically in early childhood programming for children in disadvantaged circumstances has sustained benefits for the community and from a human resources perspective (Belfield, Nores et al. 2006, Mustard 2006, Noble, Norman et al. 2006, DoCS
Early Child Development (ECD) research has established that infants and children, who participate in well-conceived ECD programs tend to be more successful in kindergarten, primary and high school; are more competent socially and emotionally, and show higher verbal and intellectual development during early childhood, than children not enrolled in high quality programs (Mustard 2006, DoCS 2009, Dockery, Grath et al. 2010, Mustard 2010, Reynolds, Temple et al. 2011). Ensuring healthy child development, therefore, is an investment in a country’s future workforce and capacity to thrive economically and as a society (Reynolds, Temple et al. 2011). Figure 1.1 below illustrates the interconnections between health, welfare, and the community.

Figure 1.1 A child centred approach for social support (Sawyer, Gialamas et al. 2014).
Supporting children and parents through community-based programs is soundly theoretically based as figure 1.1 is based on the bio-ecological theory of development (Sawyer, Gialamas et al. 2014). The Communities for Children program offered through UnitingCare Wesley Port Adelaide, provides Early Childhood Care and Development and Parenting programs, to target the most vulnerable and disadvantaged members in society, with the goal of reducing risk factors, and improving family functioning and wellbeing. An evaluation of whether the programs efficacy is necessary in order to ensure funds have been well spent and to secure continued funding and expansion of such programs.

**Social determinants of health (SDH)**

The health of children is determined within the context of the environments in which they are born, grow, live, play, and learn (Krieger 2001, Marmot and Wilkinson 2006, Brandt and Gardner 2008, Solar and Irwin 2010). A range of determinants have been identified that shape the health of children and families. These education, housing, employment, health access, income, gender and social processes, such as social support and social exclusion and are coined the Social Determinants of Health (Krieger 2001, Marmot and Wilkinson 2006, Brandt and Gardner 2008, Solar and Irwin 2010). As such the SDH are the aspects of people lives in which they are born, grow, live, work, and age (Maggi, Irwin et al. 2010). This definition incorporates a variety of factors that impact on children and influence their adult health status. The SDH represent a broad array of characteristics that are not biological or genetic but result from the social, physical, and community environments(Maggi, Irwin et al. 2010).

The social determinants of health (SDH) are recognised as measures of individual and structural characteristics that can be addressed to assist families and communities to move away from vulnerability (Wilkinson and Pickett 2005, Wilkinson and Pickett 2009, Maggi, Irwin et al. 2010, Solar and Irwin 2010, Shonkoff and Garner 2011, Sinclair 2014). The concepts that define the SDH enable research into the structural and intermediary influences on health outcomes. Significantly, these concepts provide a means of understanding differences in health outcomes for different population groups (Hetzel, Page et al. 2004, Wilkinson and Pickett 2005, Wilkinson and Pickett 2009, Solar and Irwin 2010, Shonkoff and Garner 2011, Sinclair 2014).
Additionally, the Social Determinants of Health (SDH) provides a framework for exploring health inequities against services that provide supported, wrap around, models of care and intervention, which deliver individual support across a broad range of determinants of health through links with community health, education and welfare services. The development of models of care that address health inequities have been shown to deliver significant improvements (25%) in children’s development, behaviour, education, and health outcomes when combined with community based relationship partnerships to deliver targeted parenting programs (Lynam, Loock et al. 2010). As the programs provided by CfC promote the community based delivery ethos then using the SDH measurements could also highlight the impact of these programs on the community.

Communities for Children Programs and the Western Adelaide Region

Our clients

The Communities for Children Facilitating Partner programs are funded by the Australian Government Department of Social Services aimed at delivering strong outcomes for Australian families with a focus on early intervention and prevention to provide programs for children aged 0-12 years and their families (AIHW 2012, Stewart 2014). Research shows that children living in poverty are exposed to higher levels of stress and this interferes with their ability to learning and meet developmental milestones (Margolin and Gordis 2004, Suor, Sturge-Apple et al. 2015). Furthermore, the differences in cognitive ability are evident at aged four (Margolin and Gordis 2004, Suor, Sturge-Apple et al. 2015). The North West Adelaide Region has been recognised as an area where children experience high rates of developmental vulnerability (Australian Early Development Census 2015). There are five measures that outline domains of vulnerability for Australian children in the Australian Early Development Census (AEDC). The five domains are: physical health and wellbeing; social competency; emotional maturity; language and cognitive skills (school based), and, communication skills and general knowledge (Australian Early Development Census 2015). In Australia 6.8% of all children aged 0-12 years are assessed as being developmentally vulnerable in one or more domains (Australian Early Development Census 2015). In the Western Region of Adelaide 29.1% of children are assessed as developmentally vulnerable in one or more domains and a further 13.9% assessed as
developmentally vulnerable on two or more domains (Australian Early Development Census 2015). Of significance, is the decrease in the percentage of children assessed as vulnerable during the time the Communities for Children (CfC) programs have been implemented. In 2006, for example, 42.9% of children in the Western Region were assessed as developmentally vulnerable on one or more domains. This has decreased significantly to 29.1% in 2012, a change of -13.8% (Australian Early Development Census 2015). Furthermore, the percentage of children assessed as developmentally vulnerable on two or more domains in 2006 was 23.7%, and in 2012 this had decreased significantly to 13.9% a change of -8.7% (Australian Early Development Census 2015). While the Western Region of Adelaide is still behind the Australian average of 6.8% (Australian Early Development Census 2015) however, initiatives such as the CfC programs aim to address children’s vulnerability.

Significance of the research

Programs targeting parents of children who are at risk aim to decrease the impact of the SDH and address the children’s potential level of complex vulnerabilities that accumulate to produce poorer adult health outcomes (Keys 2009, Gibson and Johnstone 2010, Muir, Katz et al. 2010, Solar and Irwin 2010, Department for Education 2011, Nelson and Mann 2011, Kilmer, Cook et al. 2012, McCartney 2012, McCoy-Roth, Mackintosh et al. 2012). Importantly, the use of parenting programs has effectively decreased emotional and behavioural problems in children (Wyatt Kaminski, Valle et al. 2008, Sandler, Schoenfelder et al. 2011). This includes children with behavioural conduct disorder, oppositional behaviour, attention-deficit hyperactivity disorder, and anxiety disorders (Wyatt Kaminski, Valle et al. 2008, Sandler, Schoenfelder et al. 2011). In addition, there is evidence that investing economically in early childhood programming for children in disadvantaged circumstances has sustained benefits for the community and from a human resources perspective (Access Economics Pty Limited 2008, Wyatt Kaminski, Valle et al. 2008, Sandler, Schoenfelder et al. 2011).

The CfC program offered through UnitingCare Wesley Port Adelaide, provides early intervention and prevention programs, to target the most vulnerable and disadvantaged members in society, with the goal of reducing risk factors and improving family functioning and wellbeing. This report details research that aimed to explore the relationship between
CfC, Western Perinatal Support Group, the therapeutic interventions provided, and the social determinants of health for the children and families who have used the WPSG service. Whilst such programs appear sound from a theoretical perspective, unless there is evidence of the outcomes of the program, the work cannot be validated for continued funding or for wider application. This type of analysis and research provides the bridge between policy objectives and the practice applications of policy. This research provided the next keystone step in examining the broader impact of individually tailored programs.

**Overall aim and objectives**
The research evaluated the relationship based programs that were delivered to at risk children in Western Adelaide region (2014-2015). The Western Perinatal Support Program is a unique and targeted program to help ameliorate the deleterious health, welfare and educational impact of perinatal depression on infants, children and partners.

**AIM**
To explore the relationship between CfC programs delivered in Western Perinatal Support Program between 2014 to 2016 and the social determinants of health for the children and families who have used the service.

**OBJECTIVES**
1. To identify the SDH impacting on the children and families using the service
2. To assess the correlational relationships between the services provided and the extent to which these address the SDH.
3. To develop a set of recommendations that would enhance the programs’ capacity to improve the SDH for this population group.

These objectives represent the first step in determining the extent to which the CfC programs impact on the children broader social outcomes.

**Ethics**
Flinders University’s Social and Behavioural Human Research Ethics Committee approved the ethics protocol on the 6th of February 2015 and is valid for three years (SBREC 6719). Subsequent ethics and authorisation was also granted from the Queen Elizabeth Hospital,
Research Ethics & Governance Office to analyse previously collected de-identified pre and post Western Perinatal Support Group questionnaires. This was received on the 17th of March 2015 (HREC/14/TQEH/284).

**Approach to research**

This mixed methods research project was undertaken in two stages. The first stage involved:

**Stage one:**
1. Literature reviews to explore the theoretical and evidence bases for the programs provided.
2. Correlational analysis of local CfC program evaluations and comparison against the SDH identified for the populations using Western Adelaide regional services.
3. Analysis of quantitative data provided by UnitingCare Wesley Port Adelaide to inform the development of interview questions for the second qualitative stage.

**Stage two included:**
1. A combination of interviews and focus groups with providers, staff, parents and children.
2. Thematic analysis to provide an in-depth understanding of the impact of these programs on several SDH outcomes.

**Quantitative Methodology**

Data was only analysed quantitatively when data met adequate standards. For example, the quantitative data in the WPSG was of good quality and consistent with international standards on the use of the quantitative collection instrument provided to participants of the program. Further, the analysis performed on the data was consistent with approximate data analyses technique for the data provided (Foster, Diamond et al. 2015). Conversely, quantitative data may lack the depth in information regarding issues that influence choices on many aspects of family life that can be addressed through in-depth interviews or other qualitative approaches. This is addressed by the inclusion of narratives that allow families to express how these SDH impact on their children and families.
For example, aspects of the Edinburgh Postnatal Depression Scale (EDS), and anxiety scores and the information from the in-depth interviews, observation data, and focus groups methods of data collection each informed the use of different types of analysis. These characteristics where explored further in the qualitative data collection process. The qualitative data will inform future survey questions and evaluations. This circular process ensures triangulation and robustness of all data collection and the research process.

The predominant research methodology used in this evaluation is qualitative. However, quantitative data collected by Western Perinatal Support Group staff as part of their program performance analysis and quality improvement of their programs and was fundamentally in the analysis in the first instance as it informed the qualitative data collection. Using this mixed–method approach (Patton 2002, Parry and Willis 2013) ensures that this evaluation will be more robust. The inclusion of qualitative data is important as it bridges the current gap in evidence provided by quantitative data.

**Qualitative Methodology**

The qualitative component of the study was undertaken within a broad framework of critical social theory. This enabled the researchers to consider multiple positions, such as gender, race and poverty as they affect the SDH outcomes of children and families. Importantly, it situates the research as inquiry to inform change.

The subjective nature of qualitative enquiry has a number of relatively stable criticisms. The qualitative researcher selectively collects and analyses data that is not representative (Bogdan and Taylor 1975). Generalisations are consequently not appropriate. Qualitative enquiry is only appropriate as a research design where an in-depth understanding is required of a group of people who have been purposefully selected (Patton 1990). Here the data selected specifically explores the outcomes of the UnitingCare Wesley Port Adelaide programs on the mothers, infants and children’s outcomes.

While quantitative data provides a broad understanding of some influences on family circumstance, such as perinatal depression, qualitative data, stories and narratives provide a personal perspective on life and family circumstances. Both sources of information are useful and highlight the influences on how children and families cope with adverse life
circumstances and make decisions (Bogdan and Taylor 1975). Given this, this research employed a mixed method approach.

**Data Management and Analysis**
All copies of transcripts and any other pertinent qualitative and quantitative data sets are kept in a locked cabinet at Flinders University for seven years and then destroyed to comply with A.F.I. legislation.

Quantitative data analysis used correlations and regression analysis allowed for the relationships between for example, the Edinburgh Postnatal Depression scale data and the anxiety score data to be explored to provide an understanding of the interactions between the variables and explore for changes in these measures occurring during participation in UnitingCare Wesley Port Adelaide CfC programs. The researchers used databases, such as ABS to determine the SDH present in the areas targeted by the CfC programs and establish the SDH as measurable variables. The inclusion of qualitative data is important as it bridges the current gap in evidence provided by quantitative data.

Qualitative data management and analysis were completed in two separate but related steps in a procedure recommended by Patton (Patton 1990). The recordings were transcribed verbatim and pseudonyms assigned as the initial step to managing and analysing the data.

Qualitative data was analysed manually. Transcripts were disseminated into their component parts with reference to the original question categories. Respondent selections were separated and colour coded in a procedure outlined by Cavana et al (2001). Care was taken at this point as all data taken at the first instance as relevant and useful. There was a need to carefully identify statements that were made by the participants on issues that were not core to the focus of study, yet remained important, and those statements that were more clearly relevant.

The data was then inductively analysed. Patton (1980, p.306) describes inductive analysis as patterns, themes and categories of analysis come from the data; they emerge out of the data rather than being imposed on them prior to data collection and analysis. Themes that
emerged from the data were analysed in terms of the constant comparative method as described by Glaser and Strauss (1967). This method requires that themes be examined as they emerge directly from the raw data and compared to each other to ensure they are not different aspects of a previously designated theme (Glaser and Strauss 1967, Cavana, Delahaye et al. 2001).

Marshall and Rossman (1999) note that an alternate understanding will always exist and the job of the researcher is to argue and reason why the explanation associated with the data is a better explanation than the alternate understanding. Patton (1990) warns that researchers are always at risk of being accused of imposing an understanding that reflects the researcher’s world better than the world being studied. The search for alternate understandings was considered and one method that could be used was to counter this accusation.

**Selection of participants**
The use of multiple sources of information and informants enhances the validity and robustness of the findings (Parry and Willis 2013). Therefore, selecting the participants in the qualitative phase consisted of an evaluation of their provision or use of the programs which then resulted in their inclusion due to their key informant status. Furthermore, the managers of the programs provided important theoretical knowledge and background on program development and implementation.

**Interview questions**
Questions asked were open ended and simple in structure to elicit the participant’s in-depth responses and to obtain responses unconnected with the researcher’s experience or bias. The interview and focus groups covered several characteristics highlighted by the quantitative evaluation:

- The type of program;
- The usefulness of the program;
- The impact of the program[s] on other aspects of the participants lives (e.g. the SDH);
- Implications for changes;
- Impact on health (mental and physical);
The above considerations were used as a guide for the design of the questions. The initial data collection took place in the westerns region of metropolitan Adelaide South Australia.

**Community engagement strategies**

A research reference group was established from the various agencies delivering the CfC programs. This enabled the collaborative involvement of the service providers into the research process ensuring the final recommendations are usable. The research reference group verified the variables definitions for stage one and assist in the development of the qualitative questions for stage two interviews.

The researchers analysed the interview responses from staff, parents and children. The analysis was presented to the reference group for consideration and comment. The results of the first two phases informed the development of a set of recommendations for future service delivery of interventions of children at risk and their families. As well as provide a framework for future service evaluations and data collection. These could be used to ensure the effectiveness and viability of the CfC programs using an evidenced based perspective.

This report is divided into three sections with each section reporting on one aspect of the research evaluation. The first section reports on the literature review of the Western Perinatal Support Program. The second section reports on an evaluation of the WPSG delivered at Seaton Central. The third section provides the results of the research findings and a discussion of the findings and literature analysis.
Section two:

The Western Perinatal Support Group (WPSG) program

Introduction

This section reports on research with the Western Perinatal Support Group (WPSG); a program coordinated by Communities for Children (CfC). The research explored the relationship between Communities for Children (CfC) programs delivered in Western Adelaide and some of the Social Determinants of Health (SDH) for the children and families who have used the service (Lynam, Loock et al. 2010, Solar and Irwin 2010). Communities for Children (CfC) provide prevention and early intervention approaches to improve outcomes for children (0-12 years old) and families who are considered to be at risk. These programs are sound from a theoretical perspective. The WPSG Post Natal Depression program incorporates fundamental theoretical aspects of care, such as Cognitive Behavioural Therapy, Perinatal Depression and Anxiety therapy, Attachment Theory, the Circle of Security Parenting, along with addressing the broader constructs of the Social Determinants of Health (SDH) such as education, access to services and aspects of service delivery (Lynam, Loock et al. 2010). Further, the Social Determinants of Health (SDH) frameworks provide a means of exploring the impact of social phenomena, for example
limited: income, health access, community capacity, and family support, on individual aspects, such as health and wellbeing outcomes. The type of analysis and research undertaken for this evaluation provides the bridge between policy objectives and the practice applications of policy on SDH outcomes (Stewart 2014).

The WPSG perinatal depression program commenced in 2007 and provides an evidence based prevention and intervention program that uses the Edinburgh Postnatal Depression Scale (EPDS) as a perinatal depression assessment tool (Cox, Chapman et al. 1996, Bergink, Kooistra et al. 2011, Ji, Long et al. 2011, Bowen, Bowen et al. 2012, Matthey and Ross-Hamid 2012). The Edinburgh Postnatal Depression Scale (EPDS) enables quantitative analysis of the program due to the use of this world renowned pre and post participant assessment scores and its subsequent treatment and data (Cox, Chapman et al. 1996, Bergink, Kooistra et al. 2011, Ji, Long et al. 2011, Bowen, Bowen et al. 2012, Matthey and Ross-Hamid 2012). The positive impact of programs addressing perinatal depression on a mother, infant and child’s development is well documented (Cox, Chapman et al. 1996, Bowen, Duncan et al. 2013, Bowen, Baetz et al. 2014). The extent, to which the perinatal depression program meets the aims of reducing mother’s depression and anxiety, and the subsequent, child developmental issues, isolation, and negative community outcomes, is evaluated by this research project through analysis of the EPDS data, and focus group and interview data.

The Communities for Children WPSG perinatal depression and anxiety program is auspice by the Queen Elizabeth Hospital (QEH) is a unique and important program as it provides coordinated responses to the number of health challenges faced by mothers with perinatal depression and anxiety. The program responses to, and manages the multiple services required to circumvent the mental health impacts involved in perinatal depressions and anxiety (Ji, Long et al. 2011, Bowen, Duncan et al. 2013, Bowen, Baetz et al. 2014). The use of multiple local health, education and social support services is managed by the QEH and Seaton Central Community Centre staff. This program addresses the detrimental aspects of alternative walk-in episodic care provided by other services that are ineffective in the treatment of perinatal depression (Ji, Long et al. 2011, Bowen, Duncan et al. 2013, Bowen, Baetz et al. 2014).
Economic rationale / Social return on investment

The WPSG program provides intensive and comprehensive support for mothers diagnosed with perinatal depression and their children. The combination of the supportive care of the mothers and an intensive playgroup and crèche for their children is vitally important in providing a successful intervention to mitigate the profound negative impacts of perinatal anxiety and depression on parents and children (Allen 2011, Deloitte Access Economics and PANDA 2012, Bowen, Duncan et al. 2013, Bowen, Baetz et al. 2014). In Australia, perinatal depression affects over 100,000 new parents, and costs the Australian economy over $433.53 million per year in lost productivity (Allen 2011, Deloitte Access Economics and PANDA 2012). For every $1 spent in Australia on early intervention programs for perinatal depression there is a $15 saving (Allen 2011, Deloitte Access Economics and PANDA 2012). Research has shown that programs that directly address depression, anxiety and attachment for mothers with perinatal depression improve depression and anxiety by 50% (Bowen, Duncan et al. 2013, Bowen, Baetz et al. 2014). The use of early detection, prevention and intervention programs for parents and children has the potential to save public expenditure.

Theoretical Basis for the Program Model

Literature review

Edinburgh Postnatal Depression Scale (EPDS)

The Edinburgh Postnatal Depression Scale (EPDS) has been validated to use in pregnancy and postpartum to reliability measure depressive symptoms (Cox, Chapman et al. 1996, Bergink, Kooistra et al. 2011, Ji, Long et al. 2011, Bowen, Bowen et al. 2012, Matthey and Ross-Hamid 2012). The EPDS provides concurrent and predictive validity and high test-retest reliability (Bergink, Kooistra et al. 2011, Ji, Long et al. 2011). Further, the EPDS provides a tool that specifically and sensitively measures perinatal depression longitudinally (Bergink, Kooistra et al. 2011, Ji, Long et al. 2011). Thus the EPDS demonstrates reliable, valid and sensitive measure of perinatal depression over time.
The effect of Perinatal Depression on Parental Health and Wellbeing

The adverse impact of perinatal depression on mother, infant and child has been well documented and researched. Maternal physical complications of perinatal depression include: premature birth, surgically assisted births, impaired obstetric outcomes, and obstetric complications (Bergink, Kooistra et al. 2011, Bowen, Duncan et al. 2013). Along with the maternal psychological impacts including: self-harming thoughts, suicidal ideation, and psychosis (Bergink, Kooistra et al. 2011, Bowen, Duncan et al. 2013). Therefore, perinatal depression impacts on the interaction between the infant, mother and family both physically and psychologically. Attending to the needs of the infant is impacted by perinatal depression.

The effects of Perinatal Depression on Early Childhood Development

For infants the consequences of maternal depression include: premature birth, low birth weight, lower Apgar scores, poor weight gain, increased admissions to Neonatal Intensive Care Units, and prolonged irritability (Bergink, Kooistra et al. 2011, Bowen, Duncan et al. 2013). The outcomes for children of mothers with perinatal depression include ongoing physical, psychological, emotional, social, behavioural, cognitive, and developmental problems (Bergink, Kooistra et al. 2011, Bowen, Duncan et al. 2013). Additionally, the longitudinal consequences of untreated perinatal depression and its impacts compound accumulatively and exponentially for the mothers, infants, children, and families (Bergink, Kooistra et al. 2011, Ji, Long et al. 2011, Bowen, Duncan et al. 2013, Bowen, Baetz et al. 2014). The aforementioned research illustrates the pathophysiological links between perinatal depression, and maternal, infant, and child outcomes. Importantly universal and effective screening using tools, such as the EDS, identifies perinatal depression in a timely fashion (Bergink, Kooistra et al. 2011, Ji, Long et al. 2011). Further, programs that do not directly address perinatal depression have been shown to be ineffectual and detrimental to the families dealing with perinatal depression (Bowen, Baetz et al. 2014). Given the accumulative detrimental impact of perinatal depression on mothers, infants, children, and the family, programs that address perinatal depression have the ability to significantly change deleterious physical, psychological, behavioural and social outcomes for mothers, infants, and children.
**Targeted relationship based programs**


**Therapeutic Models of Care**

**Western Perinatal Support Group (WPSG)**

The Western Adelaide Region has been recognised as an area where the children experience high rates of developmental vulnerability (Australian Early Development Census 2015). The Western Perinatal Support Group (WPSG) specifically targets prevention and early intervention for perinatal depression. All pregnant women using the local medical and hospital services are routinely assessed using the Edinburgh Postnatal Depression Scale (EPDS). The EPDS score measures the level of perinatal depression in the presenting pregnant woman (Bergink, Kooistra et al. 2011, Ji, Long et al. 2011, Bowen, Duncan et al. 2013). Those assessed as having perinatal depression are referred to the WPSG. Mothers can also self-refer.

This program is delivery by speciality perinatal mental health professionals (psychologist and maternal/mental health nurses) and child development specialists (for the supported play group and crèche). This unique early intervention program provides an evidenced
based targeted program addressing and preventing the impact of perinatal anxiety and depression on families and children (Bergink, Kooistra et al. 2011, Ji, Long et al. 2011, Bowen, Duncan et al. 2013, Bowen, Baetz et al. 2014). The WPSG delivers a four part intervention program which consists of:

1. Part 1: The ‘Circle of Security Parenting’ program
2. Part 2: A Perinatal Depression Therapy Group
3. Part 3: An Intensive Supported Playgroup,
   a. Occurs during the parent’s attendance in part 1 and 2 of the program. It also involves instruction for parents on developmental activities and play.
4. Part 4: Home visiting
   a. assessment and follow up session.

Each of the components incorporate activities based on validated methods of engagement, group therapy and recovery that have developed over time in consultations with the families receiving the WPSG program. The WPSG uses Mindfulness Therapy, Cognitive Behaviour Therapy, Narrative Therapy, Systemic Therapy, and Solution Focused Brief Therapy. These strategies promote maternal infant attachment and support the reduction of depression and anxiety. Importantly, the program is free at point of use and includes inter-sectoral and inter-professional delivery. The liaison between health, education, and social support services delivered by mental health and child development experts is important to the outcomes of the intervention. The perinatal depression program also includes, community based, ‘in-kind’ inpatient and parent services, ensuring the safest management and delivery of mental health interventions. This ensures this program provides a cost effective service model. As it brings together long standing effective pre-established pathways of care, networks, and sponsored community supports in an evidence-based practice model of care to address the specific needs of families dealing with perinatal depression and anxiety.

In keeping with evaluative research methods this section of the research project sought to elicit both the quantitative and qualitative perspectives of the broad range of stakeholders impacted by perinatal depression program delivery. The stakeholders included: program managers, mothers, and community staff. This report discusses the findings of this evaluation.
Research Methods used in the WPSG evaluation

Mixed methods research processes are provided in the introductory section of this report. The use of mixed methods here provides a knowledge base that enables deeper understandings of complex factors involved in providing services to children (Australian Associated Press 2006, Parry and Willis 2013). Additionally, mixed methods research design have the potential to provide an evidence-informed understandings of public policy issues (Australian Associated Press 2006). Furthermore, the concurrent use of mixed methods enabled the quantitative data analysis to complementary collection of the qualitative data and the final use of the qualitative analysis to inform future quantitative data collection (Hesse-Biber 2010, Australian Early Development Census 2015). Other sections of this report do not contain the mixed methods evaluation process used here.

The WPSG evaluation used a concurrent mixed methods research project design to explore the use of targeted Mindfulness Therapy, Cognitive Behaviour Therapy, Narrative Therapy, Systemic Therapy, and Solution Focused Brief Therapy along with support and relationship based programs that aim to intervene with perinatal depression. Stage one involved the analysis's of the pre and post Edinburgh Postnatal Depression Scale (EPDS) scores and pre and post anxiety scores. This quantitative data source is from evaluation data already collected by Communities for Children. The quantitative data was analysed using correlational and multiple regression analysis to determine the impact of the EPDS program on the mother's levels of anxiety and depression. This analysis provided insight into the strength and direction of the relationship between variables rather than causal relations. The analysis of the quantitative data performed concomitantly with the qualitative data collection and analysis; interviews and focus groups. Qualitative data included interviews with providers (managers and staff) and focus groups with parents. Data were analysed thematically to provide in-depth understandings of the impact of these programs on the families. These two stages together will provide a broader and deeper understanding of whether the Communities for Children (CfC) program improved health, education and social outcomes for children and families. The therapies used to connect parents to providing appropriate and timely care are described below.
Attachment theory

Attachment theory was developed in the 1970s by John Bowlby to explain the carer/child connection in terms of biological and psychological functioning (van IJzendoorn 1995). The theory describes the sensitivity and responsiveness of the parent or caregiver to meet the child’s developmental needs as early attachment impacts on lifelong functioning (van IJzendoorn 1995, Van IJzendoorn, Schuengel et al. 1999, Centre for Parenting & Research 2006). Additionally, the measures used in the attachment assessments illustrate dysfunctional parent or caregiver responses to infants and children (van IJzendoorn 1995, Centre for Parenting & Research 2006). Responses from prolonged separations, either physically or psychologically impact on the child and their subsequent adult functioning and behaviour (van IJzendoorn 1995, Van IJzendoorn, Schuengel et al. 1999, Centre for Parenting & Research 2006). Longitudinal international research supports the use of attachment theory to predict infant, child and adult outcomes for appropriate parental responses to children’s needs and for the development of adults’ significant interpersonal relationships (van IJzendoorn 1995, Van IJzendoorn, Schuengel et al. 1999, Centre for Parenting & Research 2006). Further, attachment theory research explains the cognitive organisation and representations of interpersonal relationships and parenting behaviors (van IJzendoorn 1995, Centre for Parenting & Research 2006). The predicative capacity of the attachment theory measurements provides self-report and professional assessment items that consistently calculate levels of attachment and identify intervention pathways for program implementation (van IJzendoorn 1995, Van IJzendoorn, Schuengel et al. 1999, Centre for Parenting & Research 2006). Successful interruption of, reactive-attachment disorder, insecure-resistant, insecure-avoidant, or insecure-ambivalent attachment, through target programs is evidence-based and well documented (van IJzendoorn 1995, Centre for Parenting & Research 2006). The CfC programs offered through UnitingCare Wesley Port Adelaide directly address manifestations of interrupted attachment that subsequently decrease levels of vulnerability for children. Working with parents and children using evidenced-based parenting and child in supported play groups and crèche assists in the development of new positive relationships that have lifelong impacts for the children and their families’ (van IJzendoorn 1995, Centre for Parenting & Research 2006). Consequently, the UnitingCare Wesley Port Adelaide, Seaton Central organised programs delivered by the WPSG programs and, are collaborative, inter-disciplinary, and professional programs that
provide an environment that supply consistency, professional supervision, personal support, and commitment to the development of productive, positive and therapeutic relationships with the parents, caregivers and children using the programs.

**Circle of security**

The WPSG program delivers a program that includes the circle of security as a theoretical basis for evidence based practice and uses the practical activities provided by the circle of security training. The circle of security is an internationally based early intervention program based on attachment theory and relationship theory (Dolby 2007). The circle of security is one component of the many relationships based type programs used in the CfC programs as described in the introductory section at the beginning of this report. The circle of security theory explains the importance of secure attachment and relationships for early child development. Acknowledging that child development is ongoing, not linear and dependent on quality caregiver relationships (Dolby 2007, Dykas and Cassidy 2011). The theory is based on international academic research which confirms the key role of the use of increased empathy towards children and childhood as well as developing enhanced attachment between parent and child (Dolby 2007, Dykas and Cassidy 2011).

Figure 2.1 The circle of security: attending to children's need

The figure 2.1 above is used as a basis for the WPSG programs and explains the interactions between child and parent/care giver. The use of diagrams and easy to
understand language ensures that the programs are accessible for a variety of parents regardless of their cultural backgrounds and the stage of their depressive illness.

It should be noted that all staff engaged in providing the programs offered by the WPSG programs have received training the each of the theoretical areas. Along with the practical application of the theories into activities for children and parents. The structure of the programs provided are updated annually to ensure compliance with the latest research in the areas of attachment theory, circle of security and tuning in to kids. Further, the workers receive ongoing training in the theoretical and practical comments of their work.

**Therapeutic Models of Care**

*Models of service delivery (applying the theories)*

The WPSG programs use several models of service delivery. All families attending can assess the variety of programs designed to enhance children’s early development. The goal of the program is to use evidenced-based theories that develop early learning strategies in children, support and identify the assistance that is needed for the family to connect and build a stronger community. This is achieved using the following activities:

- Playgroup (Wednesday and Friday)
- Home visiting
- Family support
- Family play sessions

These activities are based on the theories outlined above and as such provide significant changes and improvements in parenting capacity, children’s behaviour and community engagement and participation. This provides services that are holistic and meet the needs of the program participants.

The programs address the needs of socially isolated parents and caregivers, due to the impact of perinatal depression and anxiety and this can also include: established migrant groups; new arrivals; and refugee families, fathers, mothers and children. The WPSG programs consist of:

- Early Childhood Learning program
• Children’s observational assessments
• Children’s transition from home to school program
• Enhancing children’s development programs
• Individual support
• Linking with the broader community services, such as housing, council services (i.e. public library), centre link and tertiary education providers

The programs are based on sound theoretical premises, for example, targeted relationship based programs, attachment theory, circle of security parenting programs, and tuning into kids. Targeted relationship based programs are described in the introduction. Attachment theory is discussed in the literature review above.
Section three: Results

Findings

General information

The methods used in the data collection inform the analysis used in the evaluation. Table 3.1 illustrates the types of participants involved in each stage and step of data collection. The table also highlights the method of data collection required for each participant group. The role of the participants indicates their basis for recruitment and where appropriate, their level of involvement in the WPSG program.

Table 3.1: the type of participants and method of data collection used

<table>
<thead>
<tr>
<th>Participant Type</th>
<th>Numbers</th>
<th>Basis for Recruitment</th>
<th>Component of Research Involved In (e.g. survey, interview, focus group, observations)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers (managers and staff)</td>
<td>5</td>
<td>Responsible for delivery of the CfC programs</td>
<td>Face-to-face interviews and observational information (on behavioural changes in mothers)</td>
</tr>
<tr>
<td>Participant Type</td>
<td>Numbers</td>
<td>Basis for Recruitment</td>
<td>Component of Research Involved In (e.g. survey, interview, focus group, observations)</td>
</tr>
<tr>
<td>------------------</td>
<td>---------</td>
<td>-----------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mothers</td>
<td>25</td>
<td>Participation in CfC program</td>
<td>Short surveys (pre and post Edinburgh Postnatal Depression Scale (EPDS) and Maternal Postnatal Attachment Scale and the Anxiety Scales). Focus group</td>
</tr>
</tbody>
</table>

The intensive support provided by the CfC WPSG assists families and their children to deal with perinatal depression by using proactive, complete, targeted and inclusive community based program delivery. The results of this research illustrate the importance of this program. The WPSG programs use reliable and validated internationally renowned practices and measurement instrument.

*Inclusion and exclusion criteria for the WPSG analysis*

In total 612 women had been referred to the WPSG. Of these, 454 mothers were eligible and have completed the WPSG program since 2007. However, of the 454 only 233 had completed both the EDS pre and post program questionnaires. Therefore, only the participants that had completed both questionnaires had their data included in the quantitative research analysis. Those participants completing one questionnaire, either the pre or post WPSG questionaries were not included in the data set.

It has established above that the use of multiple sources of information and informants enhances the validity and robustness of the findings (Parry and Willis 2013). The key informants in the WPSG program were the managers of the programs who provided the theoretical knowledge and background for the program development and implementation. Further, the managers and the staff provided insights via professional and clinical observations (e.g. use of EDS) and assessments of mother’s and children’s development, emotionally and socially, during the course of the WPSG program. The parents from the
WPSG were selected due to their status as participants and also as a source of critical evaluation for the WPSG program.

**Quantitative Results**

Across the duration of the WPSG program 454 mothers have participated in the WPSG. On average the participants attended 8.16 times. Of the 454, 233 (51%) participants have completed both the pre and post Edinburgh Postnatal Depression Scale (EPDS), questionnaires. The quantitative data collected by the WPSG staff provides the initial descriptive statistical information. The statistical means provide an average and an illustration of the changes that have occurred before and after participation in the WPSG program. The mean (average score) for the 233 participants levels of depression was $\bar{X} = 16.10$ on the pre-program score and the mean following (post) the intervention program was $\bar{X} = 10.95$ which is a change of more than two Standard Deviations (SD). This clearly demonstrates improvement in the level of depression experienced by the parents with the depression score on average 6 points lower following the WPSG. These results are consistent with the international research assessing programs that effectively address perinatal depression (Ji, Long et al. 2011, Bowen, Duncan et al. 2013, Bowen, Baetz et al. 2014).

The regression analysis found a positive correlation between attending the WPSG program and the post program depression score using the Edinburgh Postnatal Depression Scale (EPDS) showed a strong relationship between the two variables $r = 0.582$. Further, this relationship was statically significant with $p < 0.01$, and a $R^2 = 0.339$. Therefore, as the number of times the women attended the program increases, the levels of depression decrease. The relationship between the two variables accounts for 33% of the variance between attendance and depression.

The results found that when comparing the pre EDS intervention score and post EDS intervention score showed a strong relationship between the two variables $r = 0.533$, and a significant difference between the pre and post scores of $p < 0.001$, with a $R^2 = 0.280$. This indicates a strong positive correlation between the two variables with 28.0% of the variance explained by the relationship of these two variables. Therefore, the domains measured by the Edinburgh Postnatal Depression Scale (EPDS), score remain consistent over time and a
statistically significant change in the pre and post scores with the post score being lower than the pre WPSG program participation score.

The recent introduction in 2012 of the anxiety score and its accompanying program of intervention to the WPSG program resulted in 179 parents completing both the EDS and the anxiety questionnaires. Of the 179 participants also receiving the anxiety program and completing both sets of data, the pre-program mean score was $\bar{X} = 40.94$ and the post intervention program scores was $\bar{X} = 33.69$ and change is of more than one standard deviation (SD). Consequently, participation in the WPSG program is proven to address perinatal depression and anxiety and provides an effective intervention that diminishes depression and anxiety (Ji, Long et al. 2011, Bowen, Duncan et al. 2013, Bowen, Baetz et al. 2014).

Moreover, the Maternal Postnatal Attachment Scale questionnaire was introduced at the same time as the anxiety scoring questionnaire. The correlational analysis found a positive correlation between attending the WPSG and the Maternal Postnatal Attachment Scale, as the pre intervention score and post intervention scores indicated a strong relationship between the two variables $r =0.536$, and a significant difference between the pre and post scores of $p <0.001$, with a $R^2 = 0.339$. This indicates that there was a strong positive correlation between the two variables with 33.0% of the variance explained by the relationship of these two variables. Therefore 33% of the improvement in the Maternal Postnatal Attachment Scale score could be attributed to attending the WPSG program. However, 67% of the score change may be attributed to other factors.

**Qualitative Results**

Further, while method of data collection varied as the managers and staff participated in face-to-face interviews and the parents participated in a focus group the fundamental premise of questions regarding the WPSG program remained the same. The themes arising from the interviews and focus group are summarised below.

**Themes**

There were ten main themes found within the data. As there were a high number of members in the focus group and a small number of interviews, there was some data
saturation in certain areas. Interestingly, there did not appear to be much difference in comments between the program staff and managers, and the parents around the effectiveness of these programs in delivering support that addressed aspects of the SDH and changed the participants and their children lives for the better.

**Theme 1: Improved care of children**

The views presented in this theme have been derived from all participants. That is, the staff and managers, and the parent’s views are acknowledged here. In many instances, there were positive comments claiming that the WPSG program had driven changes in their lives that would not have been achievable without the program. Examples included being able to ‘attend to’ and ‘attach to’ their children in developmentally meaningful ways which did not happen prior to the parent attending the programs. The comment below reflects a number of staff, managers and parent’s responses to the WPSG program:

*The groups and programs are excellent… they teach you how to bond with your baby … and how to manage your depression … help with loads of community support… it’s made heaps of difference… the circle of security stuff is really important for children.*

*I bring my son and daughter too … the playgroup gives them activities they enjoy and they’re learning stuff… it’s good for them to interact with other children… with no extended family here children need to interact with other children its important.*

*We do things like story time… sing songs… make pancakes it helps me understand what children need… for a gold coin donation we couldn’t come otherwise. The crèche is absolutely fantastic for all of us… it’s the best thing they have here and it’s so beneficial for us to know your kids are cared for so well… with the same staff each week… it’s important for the kids and us.*

Most of the parents discussed their isolation from other families and services and the WPSG program had provided a means for them to connect to others with perinatal depression, supportive staff, other families with children and their community. This enhanced the support the parents and children received. The therapeutic interventions were constructed to alleviate the impacts of perinatal depression and anxiety, and enhance
maternal attachment. The playgroup and crèche activities undertaken were purposeful and constructed to meet the children’s developmental milestones such as fine and gross motor skills. For example, the use of play and songs increases infants and children’s language skills, linguistic development, and cognitive abilities. The playgroup and crèche staff modelled exemplary parenting and attachment behaviours and provided one on one support for parents having difficulties with parenting skills. Further, the interaction in the play group allowed the parents to explore the anxieties around childcare and social interaction, enabling them to successfully transition to work.

**Theme 2: Returning to Employment**

The views presented in this theme derive from all participants. Thereby, acknowledging the views of the managers, staff and parents. The participants had found the WPSG program provided the encouragement and support needed to return to work or to improve their qualifications to obtain better paying work. In many instances, there were positive comments claiming that the WPSG program ‘had driven changes in the mother for the better’. Examples included more confidence to pursue further education. However, there was variance around the benefits depending on who was commenting. For example, the majority of parents had very good working knowledge of the WPSG program and playgroup strategy. The parent’s knowledge varied from very little to a great deal, regarding the role of Communities for Children in facilitating the program. This comment reflects the positive changes to the mother’s capacity to engage productively in education and work:

- *We have women… after attending the program they are better … more confident and can return to do further study and get a better job or return to work… they couldn’t do that without the program.*
- *The groups have given me the confidence to reach out and join other groups and return to study and work.*

In this instance, the manager and the parent have highlighted not only the improvement in capacity of the parents to engage meaningfully in education but also confidence to participate in other programs such as tertiary education. Improvement in employment prospects can result in better participation of the mothers in the employment sector improving the family’s Social Determinants of Health outcomes.

**Theme 3: The Cost Effectiveness of the Program**
The views presented in this theme have been derived from the professional delivering the WPSG program. The comments reflect the professional observation that the program was delivered in a cost effective manner. The program provides for larger numbers of mothers than it would be possible to clinically assess and treat individually. Additionally, the method of therapeutic intervention allowed the women to receive support from one another in a purposeful and constructive manner. These aspects are illustrated in the quotation below:

*We feel it’s cost effective… we have 8-10 women per group and their children… its 2 hours in the group and 1 hour set up time and 1 hour debriefing… To provide that kind of support individually would be over 80 hours per week per staff member.*

The cost of untreated perinatal depression is just immense… there’s an overwhelming amount of research on the detrimental effects of untreated perinatal depression and anxiety on the mothers, fathers, and children…going on to late adolescents and adulthood and then the trans-generational effects… are enormous and costly to the community and society. This program helps, it saves money in the long term as all these problems caused by depression and anxiety can be addressed early on.

This comment captures that for families dealing with perinatal depression and anxiety the impacts of the maternal, infant and child physical, psychological and social problems are costly. Documented costs of perinatal depression and anxiety on the productive of a national, society and local community are well known. The comments above also illustrate the cost savings for the health system due to the programs effective and efficient use of staffing resources.

**Theme 4: Theoretically Based**

The views presented in this theme derive from the professionals delivering the WPSG program. The use of sound theories in the programs development is evident in the positive measurable outcomes (discussed in a later theme). The focus of the four key stone activities and interventions based on the Circle of Security, Perinatal Depression Therapy Group work, Supported Playgroup and Home Visiting based on Attachment theory, Cognitive Behavioural Therapy and Solution Based Brief Therapy. The use of theoretically verified interventions believed by the staff to add to the program’s success. As is evident in the comment below:
The program focuses on the mother’s mental health and attachment theory ... the focus is on the relationship with the child ... mother’s journaling ... and the professional staffed crèche. That’s why it works ... we work through the theories over the weeks and provide the mothers with strategies that work.

The theme above outline the main objective of the program is to improve the mothers and infants' mental health. Achieving this by the use of qualified staff across all areas of service delivery. For example, the use of the psychologist, maternal/mental health nurses, and the professionally trained crèche staff ensure the use of the WPSG theory based program remains sound. There is also a consistency of staff used to provide the programs (as mentioned in theme 1) and this assists with consistent delivery and in building trust with this vulnerable group of mothers, infants and children.

**Theme 5: Evidence Based Programs and Participant Change**

The use of standardised measurement tools to determine the extent to which there is any change has been outlined above and verified by the quantitative analysis above. The managers, staff and parent’s positive comments claimed that the WPSG program had precipitated the change in the participant’s mental health and improved their relationship and bonding with their infants and children. This is highlighted in the quotation below:

*We provide standardised assessments pre and post... we use psychosocial risk assessments and attachment measurements ... we’re improving their [parents] mental health.*

In many instances the parents spoke of profound changes and improvements in their ability to function as a parent, mother and spouse. The mothers recognised the importance of the program in changing their interpersonal relationships with their infants, children and families. The mothers identified the role the program had played in improving their attachment with their infant and children. The use of reliable and valid assessment tools has reaffirmed the improvement in the positive outcomes for the participants. This is also evident in the comments below.

**Theme 6: Substantial differences after the program**

The views presented in this theme have been derived from all participants. That is, the program managers, staff and parent’s views are acknowledged here. The comments
highlight the debilitating nature of perinatal depression and the positive results from participation in the WPSG program:

_We had an older mum 34 she was barely functioning... at the time she didn’t know if she would survive... she was suicidal... she came to our group and the other women were so supportive ... the group gave her hope that she would recover. This is a common situation with our families._

_I was in a bad way but coming here, the other mums, the staff, the crèche workers have all helped ... if it wasn’t for them ... it’s too frightening to think where I would be._

_They help me connect with my baby. I was barely functioning before I didn’t want to get up in the morning. Without this group I dread to think where I would be, I have learnt so much, you know, about caring for baby and me._

The managers, staff and parents clearly recognise the outcomes for the mothers, infants and children. In many instances the mothers believed that the WPSG CfC perinatal program had instilled the confidence and support required by the women to assist them not only with parenting but also in other aspects of their lives. As the Social Determinants of Health impact on a broad range of lived experiences and health outcomes, such as income and education, then this program may change aspects of the SDH impacts.

**Theme 7: Physical Space**

The views presented in this theme derive from all participants and reflect the importance of place. The venue is very important to vulnerable populations, such as women with perinatal depression. The mothers who attend WPSG, in the Seaton Central grounds, like the venue. The spaces for the mothers, infants and children are conducive to the types of therapy and activities that are associated with the program and its ultimate success. That is, using a different venue may not accommodate the needs of mothers who are anxious and depressed. The physical space allows the rooms to be used flexibly. Its close locality to a school provides an outside safe space for the children to play and its long distance from a hospital ensures it is viewed as a community setting. This is captured in the comment below:

_Yeah it works well being at Seaton Central... women don’t want to come here [hospital] with their babies... it’s a hospital it’s not an appropriate environment..._
Seaton Central is great there are toys and rooms for the toddlers ... so I tend to do my clinical work down there... there’s no stigma attached its part of the community

For the mothers with separation anxiety issues the flexibility of the space allowed them to manage their fears in a productive manner. The mothers also spoke of the stigma attached to having perinatal depression the feelings of being a ‘bad mother’ and the usefulness of attending Seaton Central in a setting that was community based. Many mothers noted that if the program were provided in a hospital that they would not attend due to the physical environment not being conductive for infants and children and the stigma involved in attending a hospital mental health unit.

Theme 8: Stigma

The views presented in this theme have been derived from all participants. The role of stigma in minimising the ability of mothers, infants, and children to receive the support they need was acknowledged by the managers, staff and parents. Mothers with perinatal depression and anxiety are socially isolated and stigma further excludes mothers from successfully managing their depression and anxiety issues. The participants related that the Communities for Children programs reduce stigma and provided supportive therapeutic interventions. This is evident in the quotation below:

So I tend to do my clinical work down there... there’s no stigma attached its part of the community... the parents can then hook into all the other community services.

You know coming here, you won’t be judged, and there are people here who have issues like you do, so you can talk about it, and someone can say hey, I’m feeling like this, and they totally get it. And that includes the workers. I found the facilitators and the child care workers so approachable, they’re interested in you and your kids, they love their job and it shows. It feels like a community.

According to the participants the WPSG CfC program provides safe, therapeutic programs that enhance feelings of social and community connections. The professional engagement of the staff with the mothers in a non-judgmental manner also enhances the strategies for overcoming perinatal depression and anxiety. The connections of the program to other community and health based services links the mothers and children into care in a timely fashion.

inspiring achievement
**Theme 9: No Alternative Service**

The participants were concerned with the possible cessation of the program. The uniqueness of the program whilst explaining its success is of concern if the program were to cease. The views presented in this theme derive from all participants and is captured in the comment below:

*I mean there are just no viable alternative services for these women. The mental health plan and individual sessions would not meet these women or their children’s needs. You need specialist trained staff [maternal mental health] in this area… with established links in the community … this program has that… we are dealing with directly improving health outcomes for the mums, family and children.*

*We have the program and the staff and we have CaFHNs here too so you know everyone is looking out for you and the baby... we have it all here ... its better ... and if you’re having a bad day, the staff notice, and they take you aside, and talk to you one-on-one, and it’s a great help. That doesn’t happen in other places like the hospital, or GP, they might be good but they just don’t get it.*

The participants were aware of possible changes to the programs provision and were concerned given the uniqueness and profound (they felt) benefits of this program. The program addresses the needs of this vulnerable population group in a positive and helpful manner that enhances the mothers, infants and children’s ability to link with their community in productive ways.

**Theme 10: Soft entry**

Two staff members from the crèche were also interviewed for the CfC evaluation. The programs provided are described as ‘soft entry’ programs that enable support to be given to families that do not traditionally use skill building programs. This is captured in the quotation below:

*An early childhood educator [crèche staff] and an early childhood assistant … with a social worker or of somebody with a similar discipline attached to provide the programs. So using playgroups as a ‘soft entry’ and getting ready for school and early childhood education type initiative, but also providing those wrap around services. So the family support worker would provide case management, therapeutic support but also those referrals to other agencies.*
It’s families with I guess high risk needs [WPGS]…the emphasis is on the child and that there may be some issues of the child being at risk or yeah that there’s some issues around parenting and helping with parenting to make it a safer more, better, functioning place … their own parenting or their own family histories or whether it’s circumstances or it’s poverty or current issues to do with employment or mental health, drug and alcohol. So a whole range of factors?

The programs use a range of professionals to provide inter-disciplinary, and holistic, family interventions. These types of ‘soft entry’ initiatives are important as it connects the programs with the isolated families and prepares the family and child for integrations into the schooling system. Also the family and child are prepared for recognising and providing learning opportunities. The programs provided to families are evidenced based. Additionally, the case study below illustrates a typical profile of the mothers using the WPSG and the outcomes of the WPSG program interventions.

**Case study**

Case scenario

- A 24 year old married mother of first baby referred at 3 weeks post natal by CYWHS nurse with increasing signs of anxiety and depression. Poor attachment to baby. Family history of suicide, referred to WPSG and attended the perinatal depression support group. Her infant now attends the play group. She has also attended Fatherhood evening with her husband he is now more supportive. Improved relationship with her mother since birth of baby. Edinburgh Postnatal Depression Scale score on initial visit was 26/30 (severe depression). Post group 6/30 (nil depression).

- Linked with Maternal and Mental Health Registered Nurse, to work through problems, made friends and now attachment with child clearly good loving, caring good eye contact, enjoying playing with him laughing. She has returned to work part time in 2015.

The case study illustrates one woman’s journey through perinatal depression. The staff and managers use a variety of processes and therapeutic practices, such as journaling, cognitive behaviour therapy, and attachment theory’s, circle of security, to bring about change and decrease the impact of perinatal depression.
Discussion

Indisputably, perinatal depression and anxiety is associated with negative outcomes for mothers, infant children and families. All of the managers, staff and parents have discussed the Communities for Children WPSG perinatal depression program with a great deal of positivity. Particularly when questioned on the notion that the mothers and fathers attending the program activities now had a set of strategies which assisted them in supporting their infants and children’s development and health. All the participants explained the strategies in detail and the stated how these strategies had improved outcomes for themselves and their families.

For the families dealing with perinatal depression and anxiety the impacts of the maternal, infant and child physical, psychological and social problems are costly. The cost of perinatal depression and anxiety on the productive of a national, society and local community are also well documented. Therefore, it is not inconceivable to suggest that the cost savings for the health system and society are effectively offset by the provision of the program.

The qualitative data explored also illustrates that the debilitating impact of the mother’s perinatal depression limited access to other services or programs. Therefore, in alignment with the international data, a reduction in the levels of perinatal depression is possible by attending a community base targeted program, such as the WPSG, Communities for Children perinatal depression programs (Ji, Long et al. 2011, Bowen, Duncan et al. 2013, Bowen, Baetz et al. 2014).

Additionally, all the participants had described how the WPSG perinatal program had improved the broader aspects of the Social Determinants of Health (SDH). The program had improved access to health services (a SDH). Often mothers on completion of the program pursued higher education (a SDH). Furthermore, mothers with the lower levels of depression and anxiety felt comfortable in returning to employment (a SDH). The families engaged with the local community thus decreasing social isolation (SDH). While the evaluation of the SDH has not been exhaustive in this report further research would explore the impact of the Communities for Children programs on the SDH outcomes.
The managers and staff highlighted the changes for the infants and children attending with the WPSG program with their mothers. Overall the infants and children had become calmer and the incidence of behavioural problems and anxiousness in the children had decreased as the mothers progressed through the program. The intensive supported playgroup and crèche provided the children with supportive learning environments and activities based on the Early Years Learning Framework, such as language development and enhancing motor and cognitive skills through play, drawing and reading. Additionally, the managers and staff modelled appropriate child engagement behaviours and strategies for the mother and fathers to use at home. Furthermore, the playgroup and crèche staff provided one-on-one sessions for parents who appeared to be distressed or struggling thereby circumventing future parenting problems and providing a strengths based approach to parental skill development.

There was a great deal of discussion on the need for the program to continue. Given the media reports of funding cuts the mothers were quite distressed by the possibility of the program folding. The mothers were very forthcoming in describing the level of disability and incapacity caused by perinatal depression and anxiety and the large levels of improvement they experienced by their participation in the WPSG program. The significant improvement in the decreased levels of perinatal depression and anxiety as an outcome is supported by the quantitative data analysis. The outcome is also maintained by the literature, in particular, the longitudinal studies of Ji et al (2011) and Bowen et al (2014). Both these studies found that the use of EDS effective measured changes in perinatal depression and the use of appropriate structured prevention and intervention programs, such as the WPSG significantly improve, depression and anxiety outcomes for mothers and their families. Furthermore, the research has outlined that only evidence based therapeutic prevention and intervention program circumvents the negative effects of perinatal depression and anxiety for mother, infants and children. The Communities for Children WPSG is one such program.

The CfC WPSG program illustrates the success of a whole community approach to a mental health problem. The use of this theoretically based prevention and intervention program along with the structured educational and developmentally based playgroup and crèche provides the broader family supported needed to address complex mental health problems such as perinatal depression. The use of one type of program or a program lacking in the
number of elements used in this program would arguably be unsuccessful. The inclusion of father’s sessions is also beneficial as it enhances spousal and family support for the mothers with perinatal depression.

The themes of: Improved Care of Children; Returning to Employment and Cost Effectiveness were also the main themes found within the data for the Hand in Hand evaluation. With the parents and staff outlining that this service provided links to other services including; health, welfare and education for the parents and children. Furthermore, the parents believed that without the service they would not be able to participate in tertiary education and employment. Additionally, the parents recognised the importance of the program in increasing their productivity and inclusion into Australian society. Therefore, the programs provide are cost effective on a number of fronts: the decrease in isolation, the increase in parenting skill to prevent accumulative harm in children.

**Conclusion**

The use of theoretical and therapeutic based protocols is paramount to the success of the WPSG perinatal depression program. The development of the program since 2007 has included the responsiveness of the professional staff required to change the program meet the needs of mothers experiencing perinatal depression. The inclusion of the strategies to address anxiety and the circle of security to address the attachment issues for this group is testament to the willingness of the staff to provide evinced based prevention and intervention for this unique needs group. The attitudes and responsiveness of the managers and staff promote and atmosphere of acceptance and support thereby promoting attendance of this vulnerable population to the WPSG perinatal depression program and ensuring the myriad of positive experiences. The ongoing success of this program relies on the ongoing funding of the CfC initiative.

The importance of prevention and intervention in perinatal depression and anxiety is paramount to the effective circumvention of the negative impacts on mothers, infants and children. Research outlines the importance of evidence based interventions and therapeutic group work and individual sessions. The Communities for Children WPSG program addresses the needs of this vulnerable group using the recommended interventions. The program is cost effective, theory based and therapy and treats mothers, fathers and
offspring. The program has been instrumental in alleviating the negative impacts of perinatal depression and anxiety for the mothers involved in this research.

The importance of children emotional competence, cognitive, language and psychological development is assisted by positive evidenced-based parenting, playgroup, and crèche programs. Children’s success in school is also based on children’s social adjustment. The CfC programs provide interventions that are successful and evidence-based in aiding children’s social, emotional, physical, psychological and educational development. Also the CfC programs assessed here build parental capacity to parent, parental confidence, and decrease parental mental health issues and parental isolation. These findings are supported by the literature, previous research and this research evaluation project.

Further, the extent to which programs succeed depends on the engagement of families with the programs offered. All of the programs provided by CfC delivered on this important aspect of service provision. All the programs made a difference and this has been evident in the comments from the participants evaluated here. Many of the research participants had come to use the CfC programs auspice by UnitingCare Wesley Port Adelaide as the programs made a difference. The provision of non-theoretical based playgroups made very little difference to the family functions and children’s behaviour. In contrast the parents and staff noted that the CfC UnitingCare Wesley Port Adelaide programs made a positive difference in the lives of their families. These factors have seen the expansion of the programs is evident through the longevity and increasing levels of participation in the programs offered. Further, the programs provided by UnitingCare Wesley Port Adelaide, CfC successfully engage with the difficult to reach populations. At risk children often come from families that refuse to engage with service provides yet the CfC programs successfully navigated family disadvantage and engaged successfully with at risk families.

The Child and Family Centre Seaton Central managed by the Facilitating Partner provides the physical setting and community based environment for many of the programs offered and seem to be an integral part of the program’s success. The staff of Seaton Central offers a welcoming and accepting atmosphere. They also offer extended support services and a liaison hub for families dealing with perinatal depression, social isolation, and children’s behavioural problems.
The theoretical basis of the programs provided and the use of evidence-based interventions based on world renown and well formulate interventions is also paramount to the success of the program evaluated in this report. The professional staff are trained in the programs offered.

The results of this research illustrates the importance of the programs in engaging with parents and changing the behaviour of parents, and children, that results in, a decrease in the level of risk for the children attending the programs. The information from the in-depth interviews, observation data, and focus groups supported the evidence that there had been sustained change in how the parents respond to their children, and an increased capacity in the parents’ ability to meet their children’s needs.

The methods used to collect the data have informed and enhanced the use of different types of analysis. This process has further validated the results and provided evidence that is substantiated and corroborated from many sources. The similarities in the themes, such as ‘improved care of the children’, and ‘returning to work’, is consistent across all programs. This is testament to the use of theoretically based, and evidence based interventions, and methods of working with at risk families and children. Additionally, the use of multiple informants and key stakeholders has provided a circular process that ensures triangulation and robustness of all data collection and the research process.

The predominant research methodology used in this evaluation is qualitative. However, quantitative data collected by WPSG staff as part of their program performance analysis and quality improvement of their programs and was fundamentally in the analysis in the first instance as it informed the qualitative data collection. Using this mixed–method approach (Patton 2002) ensures the robustness of the evaluation.

Therefore, the programs provided are cost effective on a number of fronts: the decrease in isolation, the increase in parenting skill to prevent accumulative harm in children. A note of caution is needed however, as the economic, social, and policy changes will impact on the community and families of this area. The consequence for the area and the families of the lessening of these interventions and therapeutic programs would place the at risk children in
higher risk of deleterious health, wellbeing, welfare and educational outcomes. Additionally, changes to the programs could diminish some positive outcomes for children and their families provided by these programs. Further, research and the development of robust measures of change are required to improve the collection of quantitative data in some of the programs.

Further, research into the findings of the Maternal Attachment Scale score and attendance in the WPSG program is warranted as there is a dearth of research exploring the relationship between depression and anxiety programs for mothers, and the impact of these on attachment levels. This said, research shows that improving maternal attachment can improve infants and children’s physical and psychological health, as well as, emotional, and social wellbeing.

**Facilitator Qualifications**

**Lead Clinician:** The current lead clinician in this program has a PhD in Psychology specialising in maternal mental health (or Bachelor/Degree in any of the following Nursing, Midwifery, Psychology, Social Work, Occupational Therapy, and Counselling). Additional training required - Circle of Security

**Clinician Support/Co facilitator:** The current co-facilitator is a Maternal and Mental Health qualified Registered Nurse.

Knowledge and skills for the roles of Lead Clinical and Clinician Support are essential for implementing the Therapy Group Home Visiting and Circle of Security components of the program, working with clients experiencing perinatal depression, collaborating with Early Childhood Educators for the Intensive Supported Play group and establishing and maintaining referral pathways.

Specific perinatal training can include but not be limited to workshops on a broad range of evidence based therapies including: Dialectical Behavioural Therapy, Acceptance and Commitment therapy, Mindfulness based Cognitive Behavioural therapy, Cognitive Behavioural Therapy.
Social Determinants of Health

The CfC programs provide some improvements of some aspects of the SDH for example: mental illness, low income, low parental educational attainment, and the impacts of these on children are addressed via the programs evaluated here. Further the programs used target children development including the: importance of children emotional competence, and their physical, emotional, social, cognitive, and educational development. By addressing these aspects of children’s lives early on the programs can go some way to prevent the deleterious impact of accumulative harm as the children grows.

The Social Determinants of Health (SDH) offer a way of explaining and understanding differentials in health across different population groups. The distribution of power and the socio-political features of health are the structural aspects of the health of a society and mediate access to health care (Solar and Irwin 2010). The consistency, timeliness and appropriateness of health, social, welfare and educational access for infants, children and their families form intermediary characteristics of the SDH that have influences on lifespan health outcomes both physically and psychologically, and are manipulated at a community and individual level (Solar and Irwin 2010). For example, research has found that the levels of education as determined by education policy and its availability, regardless of income, are key determinants of mental health outcomes (Maher, Marcynyszyn et al. 2011, Reynolds, Temple et al. 2011). The programs provided by CfC in the North West Adelaide region address the intermediary SDH directly.

Further, as the social determinants of health (SDH) are multi-causal and have lifespan consequences there is a need to define, explore and clarify their underpinnings and the causal pathways involved within the family of origin basis (Solar and Irwin 2010). Therefore, the CfC programs respond to at risk children by providing interprofessional, and multidisciplinary responses, that require higher level case management, individual and family therapeutic interventions, and strategic and well development referral networks and collaborations.
Limitations

This research project did not interview the fathers involved in the program and this is a limitation. Further research needs to explore the experiences of fathers in more depth. Also one-on-one interviews would provide a deeper level of understanding into the mother’s experiences.

References


McCoy-Roth, M., B. Mackintosh and D. Murphey (2012). "When the Bough Breaks: The Effects of Homelessness on Young Children."


APPENDIX A PROGRAM LOGIC
Western Perinatal Support Group

GROUP MANUAL

This manual is intended to be a guide and we have included from our experience what works well and our suggestions for questions to generate discussion. The groups work best if they are flexible and responsive to families’ needs and what comes up in discussion leads into the next topic. We mix the groups up according to clients current needs at times.

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Postnatal Depression (PND) Group Program Overview 5
Attendance sheet 6
PND Group Weekly Plans 7
**MOTHER'S DETAILS**

<table>
<thead>
<tr>
<th>SURNAME</th>
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<tbody>
<tr>
<td>GIVEN NAMES</td>
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<th>DATE OF BIRTH:</th>
<th>LANGUAGE SPOKEN:</th>
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**TELEPHONE CONTACTS:**

| HME: | MOB: |

**CHILD DETAILS**

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<th>Surname</th>
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**PARTNER DETAILS:**

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<th>SURNAME</th>
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**PND GROUP Assessment Form**

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56
REFERRED BY:
**MENTAL HEALTH HISTORY:**
How would you describe your mental health?

<table>
<thead>
<tr>
<th>Have you ever been diagnosed with a mental health illness?</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Are you taking any medication/herbal remedies at present?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you have any medical problems at the present time?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Do you drink Alcohol, smoke cigarettes, use any illicit substances</td>
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<tr>
<td>Have you had any stresses, changes or losses in the last 12 months?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Have you ever had a period of 2 weeks or more during which you felt more worried, depressed or miserable?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you suffer from anxiety in any form? Do you Gamble? How much?</td>
<td>Yes</td>
<td>No</td>
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</tbody>
</table>

How was your pregnancy? Was it planned? How long did you take to get pregnant? IVF conception? How is your relationship with partner? What was your labour and delivery like? How do you feel about your pregnancy? Your labour and delivery? How do you feel about your baby?

**SOCIAL**
Who are your immediate family /friends supports?
# MENTAL HEALTH ASSESSMENT

**Presentation:** Appearance, Behaviour, Conversation, Cognition

<table>
<thead>
<tr>
<th>Perceptual abnormalities</th>
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<td>Anxiety</td>
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<td>Mood</td>
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<td>Sleep</td>
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<td>Appetite</td>
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<td>Enjoyment from life</td>
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<td>Attachment</td>
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**Risks:** Suicidal thinking, plans, previous attempts, self harm, Infanticidal thoughts, Homicidal thinking

**Anxiety:**

Energy level: Libido, concentration, enjoyment from life

**Risk Issues:**
Postnatal Depression (PND) Group Program Overview

**Week 1**

**Week 2**
Mindfulness exercise. About Postnatal depression. Discussion about the signs and symptoms of postnatal depression. Treatment options and self help strategies. Where to get individual help in your local area; how to respond in a crisis – Acceptance Commitment Therapy.

**Week 3**

**Week 4**
Mindfulness exercise. Anxiety and stress management. CBT. Recognise those factors in your life that increase stress levels and learn some relaxation methods within the group that you can put into practice at home.

**Week 5**

**Week 6**
Meditation exercise. Attachment and bonding – Attachment theory. The importance of creating a sense of security within your children.

**Week 7**
Mindfulness exercise. Sleep what is normal? What to expect from your sleep and baby’s - Attachment theory.

**Week 8**

**Week 9**
<table>
<thead>
<tr>
<th>Client</th>
<th>Wk1</th>
<th>Wk2</th>
<th>W3</th>
<th>Wk4</th>
<th>WK5</th>
<th>Wk6</th>
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</table>
**PND group Weekly plan - Week 1**

**Aims**
- To create the forming of the group including dynamics, norms and relationships
- To set the routine for group facilitation
- To allow time for sharing of personal stories in a structured format
- To introduce mindfulness skills form week one
- To introduce participants to the facility and crèche

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Equipment</th>
<th>Person</th>
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</thead>
<tbody>
<tr>
<td>10-1020</td>
<td>Welcome, group program. EPDS, Condon and PASS baseline measures</td>
<td>Water, biscuits, Our 9 week program</td>
<td></td>
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<tr>
<td>1020-1040</td>
<td>Mindfulness of the body (Mindfulness)</td>
<td>Script Appendix1</td>
<td></td>
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<tr>
<td>1040-1100</td>
<td>Share 3 things with your neighbour and then share with the group</td>
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<tr>
<td></td>
<td>Group norms explanation and brain storm</td>
<td></td>
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<tr>
<td>1045-1100</td>
<td>What surprised you about motherhood? Goal setting as a group (Solution Focussed)</td>
<td>Handout and brain storm White board and textas Hand out</td>
<td></td>
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<tr>
<td>1115-1125</td>
<td>Over view of the program</td>
<td></td>
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<tr>
<td>1125-1145</td>
<td>Pleasant things I can do for myself this week (Solution Focussed)</td>
<td>White board and markers</td>
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<tr>
<td>1145-1200</td>
<td>Mums to pick children up from the crèche.</td>
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</tbody>
</table>

Team debrief & document
Review aims
## PND group Weekly plan Week 2 Aims

**Aims:**

1. To normalise the difficulties of transition to parenthood
2. to continue group development assist in the development of coping tool box skills
3. To keep your child in mind

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Equipment</th>
<th>Person</th>
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<tbody>
<tr>
<td>10-1020</td>
<td>Review pleasant thing from last week&lt;br&gt;Pear up with a different partner from last week, share something about your week and then feedback something that went better than expected.&lt;br&gt;Mindfulness of the breath (ACT Mindfulness)</td>
<td>Nil</td>
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<td></td>
<td></td>
<td>Script</td>
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<tr>
<td>1020-1040</td>
<td>Jessica Rowe Video (Beyond blue <em>Stories of Hope and Recovery</em>)</td>
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<td>1040-1100</td>
<td>Any surprises in the video?&lt;br&gt;Stigma perceptions&lt;br&gt;What in the video related to your experience or your perception of depression/anxiety in PND&lt;br&gt;How has/does depression/anxiety/distress effected your life?  &lt;br&gt;- Relationships with self and others,&lt;br&gt;- physically&lt;br&gt;- emotions,&lt;br&gt;- relationship with baby,&lt;br&gt;- other effects</td>
<td>White board and markers</td>
<td></td>
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<tr>
<td>11-1115</td>
<td>break</td>
<td></td>
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<tr>
<td>1115-30</td>
<td>Panda Handout or Beyond blue to cover anything that the women do not mention in the discussion</td>
<td>Panda and Beyond blue handouts</td>
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</tr>
<tr>
<td>1130-45</td>
<td>Where to get help in your local area&lt;br&gt;S.T.O.P. technique (Russ Harris – ACT)</td>
<td>handouts phone nos etc</td>
<td></td>
</tr>
<tr>
<td>1145-55</td>
<td>Homework: Pleasant things to do with someone special.&lt;br&gt;What is one thing you liked about today (SFBT)</td>
<td>White board and markers</td>
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<tr>
<td>Practice using S.T.O.P. technique</td>
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<tr>
<td>Mums to pick children up from the creche</td>
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</table>

Team debrief & document
Review aims
PND group Weekly plan – Week 3

Aims:

1. Introduction to Using CBT
2. Review of using ACT technique
3. Self Soothing to manage negative thinking.

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Equipment</th>
<th>Facilitator</th>
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</thead>
<tbody>
<tr>
<td>1000</td>
<td>Share one thing about your week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1010</td>
<td>How did you go with doing one pleasant activity with a someone important to you?</td>
<td>Share with each other</td>
<td>Script</td>
</tr>
<tr>
<td></td>
<td>mindfulness leaves on a stream</td>
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<td></td>
</tr>
<tr>
<td>1040</td>
<td>Depression and types of therapy where to get help &amp; “what works”</td>
<td>Beyond blue booklets</td>
<td>Whiteboard and marker</td>
</tr>
<tr>
<td></td>
<td>thoughts feelings behaviour cycle</td>
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<tr>
<td></td>
<td>Share a negative thought and show on the cycle - CBT</td>
<td></td>
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<td></td>
<td>Types of thinking distortions - CBT</td>
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<tr>
<td></td>
<td>Catch negative automatic thoughts (NAT's) on thought diary from Mind over mood CBT</td>
<td></td>
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<tr>
<td>1050</td>
<td>Break</td>
<td></td>
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</tr>
<tr>
<td>1100</td>
<td>Complete a thought diary on your own or in pairs</td>
<td>Handouts</td>
<td></td>
</tr>
<tr>
<td>1120</td>
<td>Review of S.T.O.P technique (Russ Harris, ACT)</td>
<td>Handouts</td>
<td></td>
</tr>
<tr>
<td>1145</td>
<td>What’s one thing you liked about today? And what did you like least or found least helpful in today’s group?</td>
<td>Whiteboard and markers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>What’s helping so far?</td>
<td></td>
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<tr>
<td></td>
<td>Home task – to ‘catch’ / write down hot thoughts - CBT</td>
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</tr>
<tr>
<td>1150-12</td>
<td>Mums to pick children up from the crèche</td>
<td></td>
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</tr>
</tbody>
</table>

Team debrief & document
Review aims
**PND group Weekly plan - Week 4**

**Aims:**
1. To continue development of mindfulness skills & CBT techniques
2. Understanding anxiety.

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Equipment</th>
<th>Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000-1020</td>
<td>Mindfulness exercise “Soften, Soothe and Allow”</td>
<td>Script</td>
<td></td>
</tr>
<tr>
<td></td>
<td>How did you go with doing any of the CBT &amp; ACT techniques?</td>
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<tr>
<td></td>
<td>Normalising thoughts</td>
<td></td>
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<tr>
<td></td>
<td>Leaves on a stream</td>
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<tr>
<td></td>
<td>Identifying hot thoughts</td>
<td></td>
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<tr>
<td></td>
<td>STOP</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Offer recap</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1020-1100</td>
<td>Psycho-education about anxiety psychology &amp; physiology</td>
<td>Beyond blue booklets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Understanding anxiety disorders</td>
<td>Clip boards, handouts</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CBT anxiety cycle- thoughts, feelings, behaviour interaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identifying NAT’s</td>
<td></td>
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<tr>
<td></td>
<td>CBT cycle- gain perspective, prioritise, connect with values to see beyond current situation</td>
<td></td>
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<tr>
<td></td>
<td>Mindfulness ‘let it go’ – detached mindfulness techniques</td>
<td></td>
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<tr>
<td></td>
<td>Break</td>
<td></td>
<td></td>
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<tr>
<td>1110-1120</td>
<td>What are your triggers for your hot thoughts - CBT</td>
<td>Brainstorm</td>
<td></td>
</tr>
<tr>
<td>1120</td>
<td>What can we do to modify? Should we modify? CBT</td>
<td>Brainstorm</td>
<td></td>
</tr>
<tr>
<td>1150</td>
<td>What’s one thing you liked about today? And what did you like least or found least helpful in today’s group?</td>
<td></td>
<td></td>
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<tr>
<td>1200</td>
<td>Home task:- Reflect on triggers</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Challenge / modify NAT’s</td>
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</tr>
</tbody>
</table>

Team debrief & document
Review aims
PND group Weekly plan - Week 5 creative writing
Aims
1. To creatively reflect on parenting through various journaling techniques
2. To acknowledge strengths and joy in the parenting experience

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Equipment</th>
<th>Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000-1020</td>
<td>Mindfulness technique – Mindfulness of your child’s hand (Russ Harris ACT)</td>
<td>Script</td>
<td></td>
</tr>
<tr>
<td>1020-1100</td>
<td>Journaling - Moon writing (Narrative approach)</td>
<td>Papers</td>
<td></td>
</tr>
<tr>
<td>1110-1120</td>
<td>Journailling Strength’s as a Mum St Lukes resources – strengths cards</td>
<td>Strength cards</td>
<td></td>
</tr>
<tr>
<td>1120</td>
<td>Poem about parenting experiences using 5 senses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1150</td>
<td>Feedback – what did you like / not like about todays session</td>
<td>Laminator</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facilitators laminating mum’s work for her to take home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1200</td>
<td>Home task – Try to use one of these journaling techniques this week</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Team debrief & document
Review aims
PND group Weekly plan - Week 6

Aims
1. To understand the importance of parent-infant attachment
2. Development of skills around building attachment and repair strategies with your child

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Equipment</th>
<th>Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-1010</td>
<td>The Magic Carpet meditation (Solution Focussed)</td>
<td>script</td>
<td></td>
</tr>
<tr>
<td>1010</td>
<td>Share one thing about your week and one about this group and how it has impacted on you?</td>
<td></td>
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<tr>
<td></td>
<td>Review of home task</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Which skills have you practiced?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1020-1100</td>
<td>Circle of security (COS-P ©) – Attachment theory</td>
<td>DVD/monitor</td>
<td></td>
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<tr>
<td></td>
<td>Handouts</td>
<td></td>
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<tr>
<td></td>
<td>• The difference that makes the difference</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Circle of Security with big hands</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Everything (almost) I need to know about being a parent</td>
<td></td>
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<tr>
<td></td>
<td>DVD excerpt from COS-P internet site</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Circle of Security:- Story of love and adventure so parents can assist children on how to be successful in the world</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1100-15</td>
<td>Break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1115-1130</td>
<td>Discussion from handouts and DVD</td>
<td>Baby strength cards</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Exercise using Baby strength cards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1130-1145</td>
<td>What’s one thing you liked about today? And what did you like least or found least helpful in todays group?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1145-1155</td>
<td>Homework notice your child coming and going on the circle of security</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1155-12</td>
<td>Mums to pick children up from the crèche</td>
<td></td>
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</tr>
</tbody>
</table>

Team debrief & document
Review aims
PND group Weekly plan- week 7

Aims
1. To continue development of mindfulness skills
2. Psycho-education re sleep
3. Discussion re babies sleep and mums sleep
4. To share personal experiences what works and what doesn’t
5. Development of skills around increasing mums reflective practice around babies sleep

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Equipment</th>
<th>Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-1020</td>
<td>Half Smile mindfulness exercise - DBT</td>
<td>Script</td>
<td></td>
</tr>
<tr>
<td>1020</td>
<td>Share one thing about your week and one about your child’s week. Review of home task</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1040</td>
<td>Adult sleep - psychoeducation Babies sleep using Helen Steven Safe Sleep Space DVD and Sensible sleep solutions book. Attachment theory</td>
<td>Handouts DVD</td>
<td></td>
</tr>
<tr>
<td>1100</td>
<td>break</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1120</td>
<td>Brainstorm what challenges have you had with your babies sleep &amp; suggestions to help</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1140</td>
<td>Discussion around what sleep problems you have had with your children and what worked and what didn’t</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1150</td>
<td>Where can I get professional support for my baby’s sleep problems Home task try something that was discussed for enhancing your childs sleep</td>
<td>Books and local resources</td>
<td></td>
</tr>
<tr>
<td>1200</td>
<td>Mums to pick children up from the crèche</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Team debrief & document
Review aims
**Review of home task - Week 8**

**Aims:**
1. Discussion re Assertiveness, self-esteem,
2. To share personal experiences of conflict and options for management
3. Development of skills around saying no, assertive language

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Equipment</th>
<th>Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000</td>
<td>Mindfulness “Loving Kindness meditation” - DBT</td>
<td>Script</td>
<td></td>
</tr>
<tr>
<td>1010</td>
<td>Review of home task. Share one thing about your week and one about your child’s week. How have you used any of the skills from the group over the last week?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1030</td>
<td>Psycho education on self-esteem and the impact Relationship with PND</td>
<td>White board</td>
<td></td>
</tr>
<tr>
<td>1050</td>
<td>Positive self attributes and supporting evidence – SFBT &amp; CBT</td>
<td></td>
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</tr>
<tr>
<td>1100</td>
<td>Bill of assertive rights – how do your feel about these statements? Assertive language examples Saying NO – how do you feel about saying no?</td>
<td>Handouts</td>
<td>White board</td>
</tr>
<tr>
<td>1115</td>
<td>Examples and practice from situations, how could you use “I” language</td>
<td>White board</td>
<td></td>
</tr>
<tr>
<td>1130</td>
<td>Home work: - choose something you would like to assert yourself with or say no without feeling guilty about. Practice what you would do to prepare for this using info from today. Asserting yourself-planning your approach</td>
<td>White board</td>
<td>Handout</td>
</tr>
<tr>
<td></td>
<td>Feedback What was one thing you liked about today? And what did you like least or found least helpful in today’s group?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1200</td>
<td>Mums to pick children up from the crèche</td>
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</tbody>
</table>

Team debrief & document
Review aims
Review of home task - Week 9

Aims
1. Pamper and celebrate
2. To give an overview of the past 9 weeks
3. What is next?
4. Emphasise the need to know warning signs what to do to manage them who your supports are in your community for you and your child

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Equipment</th>
<th>Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-1010</td>
<td>Clients choice of favourite mindfulness technique</td>
<td>Paper, clipboard, photocopier</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sharing of contact details</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1010</td>
<td>Share one thing about your week and one about your child’s week</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of home task.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>How are you going with assertiveness?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1020</td>
<td>Review of:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Overview of the program</td>
<td>1. Handout, next term COS P program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Therapeutic techniques used</td>
<td>2. Handout, clipboard, pens</td>
<td></td>
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<tr>
<td></td>
<td>3. Other groups playgroups etc</td>
<td>3. Forms, clipboard, pen.</td>
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<td></td>
<td>4. Relapse prevention plan for wellness</td>
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<td>5. Evaluations, EPDS, PASS and Condon scale</td>
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<tr>
<td></td>
<td>Talk with each mum individually break</td>
<td></td>
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</tr>
<tr>
<td>1120-1130</td>
<td>Hand massage, nail polish, hand moisturise</td>
<td>Bowls of warm water, towels and products.</td>
<td></td>
</tr>
<tr>
<td>1145</td>
<td>Snacks</td>
<td>Food</td>
<td></td>
</tr>
<tr>
<td>1200</td>
<td>Mums to pick children up from the crèche</td>
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</tbody>
</table>

Team debrief & document
Review scores and feedback