

Queensland Centre for Perinatal and Infant Mental Health

THE PERINATAL MENTAL HEALTH AND WELLNESS PROJECT:

Developing a collaborative model for mental health promotion, prevention and early intervention in the perinatal period

Final Report to the
Queensland Mental Health
Commission



The Perinatal Mental Health and Wellness Project:

Developing a Collaborative model for mental health promotion, prevention and early intervention in the perinatal period

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Project Funders

Queensland Mental Health Commission

Statewide Maternity and Neonatal Clinical Network, Clinical Excellence Division, Queensland Health

Project Partner Organisations

Redcliffe Hospital Maternity Service, Metro North Hospital and Health Service – government service
Queensland Centre for Perinatal and Infant Mental Health, Children’s Health Queensland HHS – government service

Women’s Health Queensland Wide – non-government service

Hope’s Room Limited – peer-led service

Metro North Perinatal Mental Health Service, Metro North Hospital and Health Service – government service

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Above all, we would like to acknowledge the families who participated in the Perinatal Mental Health and Wellness Project. Their engagement and feedback has been invaluable to the recommendations for further development of the program.

EXECUTIVE SUMMARY

The Perinatal Mental Health and Wellness Project, conducted from 2015 to 2017, aimed to develop and evaluate a collaborative model for mental health promotion, illness prevention and early intervention in the perinatal period. The model focused on promoting the emotional health and wellbeing of families in the perinatal period from approximately 12 weeks into pregnancy to approximately 8 weeks after birth.

Key innovations of the project included:

- parents with lived experience of perinatal mental health issues were involved in the delivery of antenatal and postnatal education, including the translation of clinical information into stories and examples of lived experience
- face-to-face group education sessions for expectant and new parents emphasised mental health and emotional wellbeing in the perinatal period
- a postnatal education session (Postnatal Connections) was offered in addition to an antenatal education session (Emotional Preparation for Parenthood) for the same cohort
- the sessions were delivered collaboratively by staff from clinical services, non-government services and peer-led services, who also worked to strengthen cross-department and cross-sectoral referral pathways among their services
- the mental health and emotional wellbeing of fathers and partners was valued alongside that of mothers, and sessions encouraged parents to support each other through the perinatal period
- infant mental health and emotional wellbeing were addressed in antenatal and postnatal education sessions

Components of the model included:

- antenatal education for expectant mothers, fathers, partners and support persons, with a focus on Emotional Preparation for Parenthood, delivered from approximately 28 weeks' gestation
- a postnatal education session for the same cohort, to reinforce a focus on emotional health and wellbeing for both parents and infants, offered approximately 6-8 weeks after birth
- active encouragement and empowerment of participants to form connections and continue supporting one another, for example through the formation of playgroups
- targeted peer support groups provided for parents experiencing symptoms of perinatal mental illness, conducted by peer support workers, who were supported by regular reflective supervision with a perinatal mental health clinician and mentorship by an experienced peer worker
- formalisation and documentation of referral pathways for expectant and new parents identified as experiencing symptoms of mental illness, among the organisations participating in the collaboration (maternity service, perinatal mental health service, child health service, peer-led organisation, non-government services)
- closer collaboration among public health services, non-government services and peer-led services, to provide information and resources to support the emotional health and wellbeing of expectant and new parents and their infants and families

- a focus on improving awareness of the importance of emotional health and wellbeing in the perinatal period, among staff of collaborating organisations and their networks

The project took a place-based action research approach, developing and trialing the model through Redcliffe Hospital Maternity Services in the Metro North Hospital and Health Service, with a view to producing reports, resources and recommendations to support a similar model being implemented in other sites across Queensland and potentially in other jurisdictions.

The project was jointly funded by the Statewide Maternity and Neonatal Clinical Network, Clinical Excellence Division, and the Queensland Mental Health Commission, with in-kind support from participating organisations including Children's Health Queensland Hospital and Health Service, Metro North Hospital and Health Service, Hope's Room Limited, and Women's Health Queensland Wide.

The model developed through the project sees joined-up, patient-centred services delivered through collaboration among public health services including maternity, mental health and child health services, and non-government services including peer-led organisations. The model encourages a holistic approach to the mental health and emotional wellbeing of expectant and new parents, their infants and families. While such an innovative project presented challenges at many levels, evaluation has been overwhelmingly positive and the model is seen as holding considerable promise for implementation in other areas.

This report provides a summary of project processes and outcomes, and a set of Recommendations for the implementation of similar initiatives in other sites. Greater detail is provided in the project outputs including manuals, resources and publications.

RECOMMENDATIONS – SUMMARY

Supporting the mental health and emotional wellbeing of expectant and new parents not only benefits the parents but has lifelong benefits for the infant, reducing demand for social and health services across the lifespan. The following Recommendations are based on an understanding that mental health promotion, prevention and early intervention should be part of the model of service for maternity services.

Key Recommendations

1. Project outcomes indicate that a collaborative cross-sector model for mental health promotion, prevention and early intervention in the perinatal period can be highly effective.
2. People with a lived experience of perinatal mental illness and recovery can provide a valuable contribution to the work of mental health promotion, prevention and early intervention in the perinatal period, both through contributing to universal psychoeducation for parents (antenatally and postnatally), and by conducting mental health peer support groups for parents wishing to access this form of support.

1. Governance

- 1.1 A Project Plan should be created, articulating all aspects of the proposed initiative.
- 1.2 It is vital that all levels of management understand what the initiative involves, and acknowledge the governance responsibilities that sit with the health service as the healthcare provider.
- 1.3 The maternity service holds clinical governance for the initiative and clinical responsibility for the participants. A midwife should be the lead educator for the Transition to Parenthood program.

2. Collaboration

- 2.1 The maternity service should identify a key staff member to take on the role of Co-ordinator, engaging non-government services in the initiative and co-ordinating the collaborative effort.
- 2.2 Where possible, face-to-face introductions should occur ahead of the initiative, among managers and service delivery staff of all partner organisations.
- 2.3 Contractual agreements should be signed with all organisations involved in delivering the initiative.
- 2.4 The roles and responsibilities, accountability and reporting lines for every staff member and partner organisation involved in the initiative must be clearly articulated and communicated.
- 2.5 Processes should be established to help managers and service delivery staff in each collaborating organisation to understand the role and scope of each organisation in supporting the mental health and wellbeing of expectant and new parents, their infants and families.
- 2.6 Public maternity services should seek the assistance of Primary Health Networks to engage local General Practitioners in the initiative.

3. Peer Work Components

3.1 All levels of staff responsible for implementing the initiative, from executive management to service delivery staff, should be appropriately oriented to mental health peer work and the specific model of peer work to be implemented. This orientation should be delivered by an experienced peer worker in partnership with the site coordinator.

3.2 The model for peer work within the initiative must be clearly articulated and understood by all parties. This includes clear roles, responsibilities and boundaries for peer workers.

3.3 Regardless of the model used for employing peer workers, the human resources processes pertaining to the position must be clearly documented and used (e.g. recruitment, training, remuneration, workplace health and safety, industrial relations, insurances, supervision and support).

3.4 An appropriate number of peer workers should be trained and oriented to participate in the program, to enable cover for sickness, absence or leave.

3.5 The skills required of peer workers co-delivering education and facilitating peer support groups should be considered in recruitment and supported through orientation, training, line management, reflective supervision and mentorship. These requirements are outlined in the Recommendations.

3.6 Peer workers should be supported through line management, reflective supervision with a mental health clinician, and mentorship by an experienced peer worker.

3.7 The model for peer support groups used in and recommended by the project is an open-ended, ongoing weekly group in which discussion topics week to week are determined by members.

4. Referral Pathways

4.1 Implementing sites need clearly documented referral pathways that are applicable to all individuals and their families during the perinatal period, irrespective of mental health status.

4.2 Peer support groups need clearly documented processes of referral to ensure individuals who need support for their emotional health and wellbeing can access services in a timely manner.

4.3 All relevant service delivery staff should be trained in how to use the referral pathways.

4.4 All relevant staff of the healthcare service should be familiar with the *Clinical Practice Guidelines for depression and related disorders – anxiety, bipolar disorder, puerperal psychosis – in the perinatal period* (update to be released late 2017), and application of these to local referral pathways and services.

4.5 A local process should be developed, documented and communicated to all relevant staff, for families identified as requiring support for their mental health or emotional wellbeing following a Transition to Parenthood session.

4.6 The discharge process from maternity services should include the provision of information on mental health and emotional wellbeing for all mothers.

5. Program/ Model Content and Delivery

5.1 Sites seeking to use the Transition to Parenthood program should implement the program in its entirety, including all topics and learning objectives from both Emotional Preparation for Parenthood and Postnatal Connections.

5.2 Where it is not possible for the appropriate service to attend Transition to Parenthood sessions to deliver a content area, these segments may be provided as video clips and accompanying slides/ print resources, with the content facilitated by the midwife educator.

5.3 Transition to Parenthood should be led by a midwife educator, preferably the same educator for both Emotional Preparation for Parenthood and Postnatal Connections for each cohort, and ideally the same educator throughout the program of birth and parenting education for each cohort.

5.4 Transition to Parenthood is ideally delivered by at least one clinical staff member in addition to a midwife educator, peer worker(s) and non-government partner(s). Clinical support should be available as required to ensure an environment of safe sharing for participants and educators.

5.5 Inclusion of lived experience as a field of professional expertise is considered a key element of the model. One to two stories of lived experience should be told in the Emotional Preparation for Parenthood session by lived experience practitioners.

5.6 Where no lived experience practitioner is available to present in the Emotional Preparation to Parenthood session, a video story may be used. The midwife educator should ensure the video is sensitively introduced, and allow time for discussion of the content afterwards.

5.7 Care should be taken to clearly introduce to the participants each member of the education team and their role. Each educator should take care that their contribution within the session conforms to the scope of their professional role.

5.8 Since the content of the Emotional Preparation to Parenthood session is emotionally sensitive and potentially triggering, the timing of this session within a program of antenatal education is important. The session should not be either the first or the last session within the program.

5.9 It is important to create space for participants to connect with one another in the Emotional Preparation for Parenthood session as well as in the Postnatal Connections session.

5.10 It is important to allocate an adequate budget for the ongoing production and dissemination of print resources.

6. Workforce Development

6.1 Midwives require adequate preparation time, including training, before beginning to lead a Transition to Parenthood program.

6.2 A model of reflective supervision, like the model that is mandatory for allied health staff, should be incorporated to provide sustainable reflective practice for midwives, particularly those involved in delivering Transition to Parenthood.

6.3 A formal debriefing time for the team delivering Transition to Parenthood sessions should be allocated immediately following each session. An appropriate staff member (e.g. Emergency Department social worker) should be present or on-call to support any member of the education team requiring further emotional support.

6.4 All midwives, members of the Transition to Parenthood education team, and other relevant staff, should receive training on responding to expectant or new parents who are emotionally distressed or concerned.

6.5 At a state-wide level it would be desirable to ensure that GPs and other healthcare providers are familiar with the *Clinical Practice Guidelines for depression and related disorders – anxiety, bipolar disorder, puerperal psychosis – in the perinatal period* (update to be released Oct 2017), including medication management.

6.6 Services should negotiate to have their referral forms embedded within GP referral software systems, for ease of referral.

7. Quality Management

7.1 Standardised reporting measures should be established to enable the measurement of change in quantitative indicators.

7.2 At a statewide level, it is desirable to evaluate the model developed through the Perinatal Mental Health and Wellbeing Project in other sites.

8. Communication

8.1 A formal Communication Strategy should be developed and endorsed prior to the initiative, including all stakeholders and channels.

8.2 It is particularly important to include administrative staff and medical staff in the Communication Strategy, to enable systems change.

8.3 Key messages from the Transition to Parenthood program at local and statewide levels should be disseminated as appropriate for the benefit of wider audiences through social, print and electronic media; conference presentations and journal articles; training programs and university curricula.

8.4 Maternity services should consider how the Birth and Parenting Program is marketed to families. The education sessions are not just for first-time parents and are still relevant for parents who already have children.

PROJECT OVERVIEW

The Perinatal Mental Health and Wellness Project, conducted from 2015 to 2017, aimed to develop and evaluate a collaborative model for mental health promotion, illness prevention and early intervention in the perinatal period. The model focused on promoting the emotional health and wellbeing of families in the perinatal period from approximately 12 weeks into pregnancy to approximately 8 weeks after birth.

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Components of the model included:

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- targeted peer support groups provided for parents experiencing symptoms of perinatal mental illness, conducted by peer support workers with the support of perinatal mental health clinicians
- formalisation and documentation of referral pathways for expectant and new parents identified as experiencing symptoms of mental illness, among the organisations participating in the collaboration (maternity service, perinatal mental health service, child health service, peer-led organisation, non-government services)
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The project was jointly funded by the Queensland Mental Health Commission and the Statewide Maternity and Neonatal Clinical Network, Clinical Excellence Division, Queensland Health, with in-kind support from participating organisations including Children's Health Queensland Hospital and Health Service, Metro North Hospital and Health Service, Hope's Room Limited, and Women's Health Queensland Wide.

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This report provides a summary of project processes and outcomes. Greater detail is provided in the project outputs including manuals, resources and publications.

BACKGROUND

The project was based on 'promising practice' identified at Redcliffe Hospital Maternity Services in relation to four areas of innovation:

- a focus on emotional health and wellbeing in the perinatal period, being provided through an antenatal education session called Emotional Preparation for Parenthood
- an emphasis on father-inclusive practice, acknowledging and acting upon the growing evidence-base that fathers as well as mothers are at higher risk for depression and anxiety in the perinatal period
- the involvement of parents with a lived experience of perinatal mental illness and recovery in both the delivery of the antenatal education session and the provision of community-based peer support groups for expectant and new parents experiencing perinatal mental health difficulties
- a willingness among staff from multiple disciplines, both within the public health service and in the non-government sector, to collaborate and provide co-ordinated patient-centred care, with these efforts being supported by hospital management

Both the Queensland Mental Health Commission and the Statewide Maternity and Neonatal Clinical Network recognised this promising practice at Redcliffe Hospital Maternity Services, and a level of service readiness to participate in formalising, evaluating and documenting a collaborative model for perinatal mental health promotion, prevention and early intervention. A project was formulated to undertake the development, implementation and evaluation of the collaborative model, to be managed by the Queensland Centre for Perinatal and Infant Mental Health (for the public health system) working closely with Women's Health Queensland Wide (for the non-government sector). Funding was provided by the Commission for a Project Officer hosted by Women's Health, and by the Network for a Project Co-ordinator hosted by QCPIMH. The diagram on page 15 provides a visual representation of the support provided by the funders for various components of the project. Deliverables funded by the Queensland Mental Health Commission are outlined in Appendix 8 (pages 95 to 98).

RATIONALE

The whole-of-government document *Early Action: Queensland Mental Health Promotion, Prevention and Early Intervention Action Plan 2015-17* (Queensland Mental Health Commission, 2015) outlines a commitment to:

- improve and maintain the mental health and wellbeing of all Queenslanders at all ages and stages in their lives
- prevent and intervene as early as possible where there is an identified risk of poor mental health or mental illness due to individual, social and or environmental circumstances
- improve the mental health and wellbeing of people living with mental illness by supporting their recovery and removing barriers to full participation in education, work and the community

A significant international body of evidence shows that detecting and treating mental health issues among parents in the perinatal period is vital for wellbeing of parents, infants and families.

Parents

- The perinatal period, which includes pregnancy and the first few years following the birth of a baby, is a time of great change in a woman's life. A woman is more at risk of developing an emotional or mental health disorder during this period than at any other time of life (Beyond Baby Blues, n.d.).
- Approximately 20 per cent of women experience a mental health issue within the first year after birth of their baby (WHO International, 2017).
- During pregnancy, approximately 15 per cent of Queensland mothers and five per cent of Queensland fathers are likely to experience clinically significant perinatal depression and/or anxiety (Buist et al., 2008).
- Australian Government and private direct healthcare costs for perinatal depression are estimated to be over \$78 million in a year (Deloitte Access Economics, 2012, p. 3). Additional costs to Australian workplaces of over \$310 million annually (Deloitte Access Economics, 2012, p. 9) are incurred due to lost productivity and over \$44 million from lost earnings and direct expenditure on services (Deloitte Access Economics, 2012, p. 5).

Infants and young children

- Mental health disorders in parents can restrict the parent's ability to provide responsive care, hampering the development of a secure attachment relationship between infant and parent (Stein et al., 2014).
- Children who experience insecure or disrupted attachment, poor parenting or adversity including abuse, neglect or trauma are particularly at risk of poor outcomes including mental health problems (Centre on the Developing Child, 2007).
- Studies show that difficult temperament, non-compliance and aggression in infancy and toddlerhood predict anxiety and behavioural disorders at age five years (Prior et al., 2000).

- According to recent Australian research, approximately 16.5 per cent of males and 12.8 per cent of females aged between four and eleven years were assessed as having mental disorders in the previous 12 months (Lawrence et al., 2015, p. 4).
- Left untreated, up to 50 per cent of these problems escalate throughout childhood and result in poorer outcomes emotionally, socially and educationally (Bayer et al., 2009, p. 1).

Families

- Family mental health problems and problematic drug and alcohol use can have significant negative impacts on family functioning and the child's development and care (Robinson, Rodgers and Butterworth, 2008).
- Early developmental delays or difficulties can set a pattern that is difficult to interrupt without intensive and targeted support and intervention (Burman, 2016).

Mental illness experienced by parents during the perinatal period is among the most preventable and treatable of all mental illness, but early detection and appropriate interventions are required. Evidence strongly suggests that early detection and intervention of mental health problems in the perinatal period is highly effective (Allison, 2006).

It remains the case that common conditions such as postnatal depression are widely misunderstood and may be confused with hormonal changes ('baby blues'), or considered to be a normal part of pregnancy and having a baby. A range of factors may deter parents and their support people, including family members, healthcare professionals and other service providers, from recognising and acknowledging early signs of perinatal mental health difficulties. If appropriate treatment is not accessed early, mental health is likely to deteriorate and problems are likely to become more severe.

Based on this evidence and the identified need for more effective models of promotion, prevention and early intervention in perinatal mental health, the Queensland Mental Health Commission committed under its Early Action Plan to 'trial and evaluate the Perinatal Mental Health Awareness Project' (Queensland Mental Health Commission, 2015), which in conjunction with the Statewide Maternity and Neonatal Clinical Network became the Perinatal Mental Health and Wellness Project. As originally conceived, the project had the following aims: 'to increase the provision of mental health and mental illness information across all points of the public maternity service system from initial contact through to delivery and aftercare including antenatal classes. The active role of parents with a lived experience of perinatal mental illness in the provision of mental health information and support will be investigated. The project also aims to embed actions to promote early access to clinical and non-clinical support and interventions. This includes enhanced linkages to peer led antenatal support and community based services' (Queensland Mental Health Commission, 2015, p. 11).

The project has been underpinned by the 'Dual Continua' model of mental illness and mental wellbeing (Westerhof and Keyes, 2009) and the 'Prevention First' Prevention and Promotion framework for Mental Health, both outlined in the *Early Action Plan*.

PROJECT GOVERNANCE

A Project Steering Committee was formed, representing:

- Queensland Mental Health Commission
- Statewide Maternity and Neonatal Clinical Network, Clinical Excellence Division
- Redcliffe Hospital Maternity Services (Metro North HHS)
- Metro North Perinatal Mental Health Service (Metro North HHS)
- Queensland Centre for Perinatal and Infant Mental Health (Children's Health Queensland HHS)
- Women's Health Queensland Wide
- Peer Support Supervisor (Metro South HHS) providing strategic advice regarding the mental health peer workforce and consumer participation in health services

The Project Working Group included:

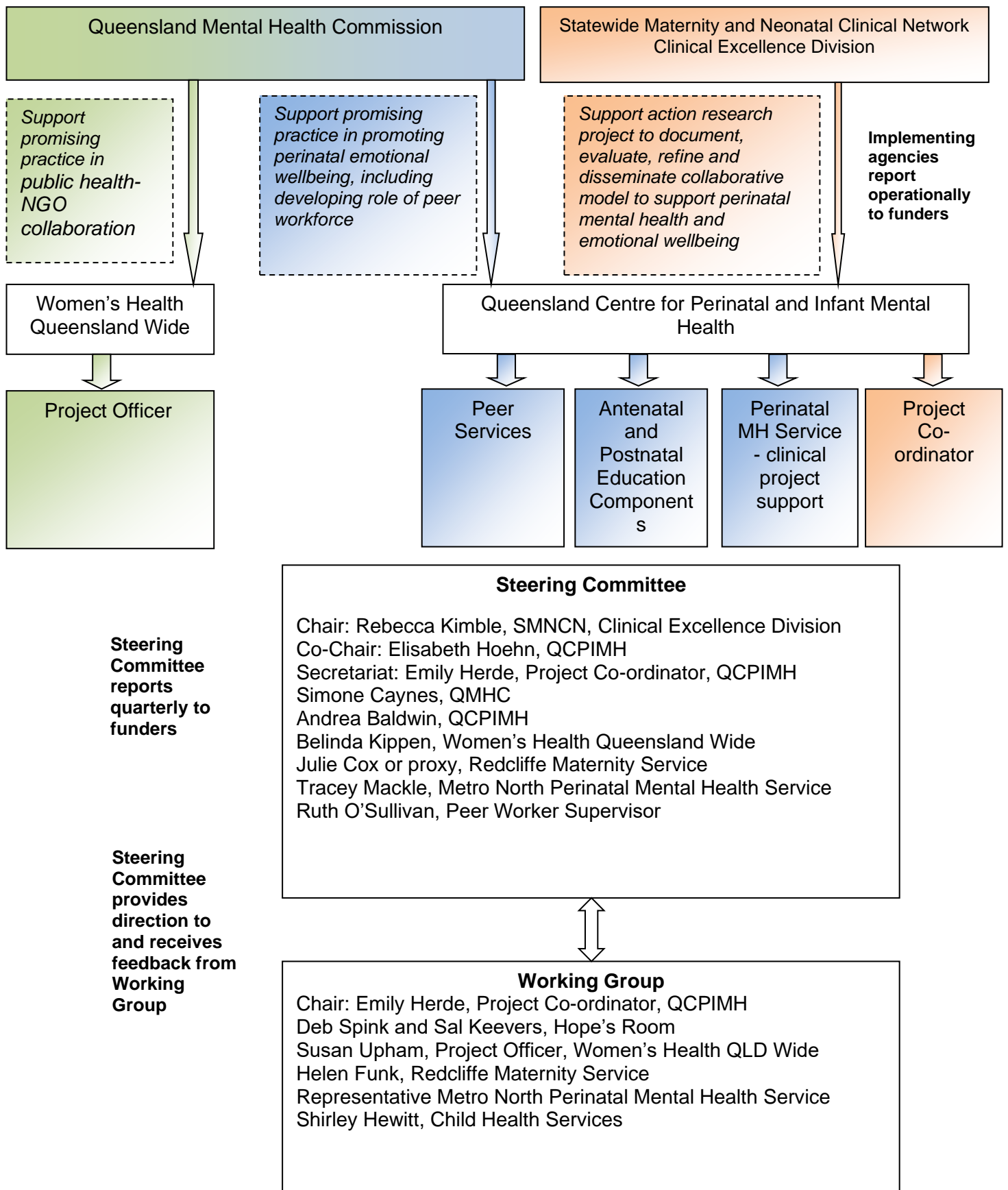
- Project Co-ordinator hosted by Queensland Centre for Perinatal and Infant Mental Health
- Project Officer hosted by Women's Health Queensland Wide
- Service Development Leader, Queensland Centre for Perinatal and Infant Mental Health
- Health Promotion Officer, Women's Health Queensland Wide
- Midwife Educator, Redcliffe Hospital Maternity Services
- Clinical Nurse, Child and Youth Community Health
- Directors of Hope's Room Ltd. (peer-led organisation)

Advice and input as required were provided to the Working Group by:

- Midwives, Redcliffe Hospital Maternity Services
- Allied Health staff, Redcliffe Hospital Maternity Services
- Peer workers, Hope's Room Ltd.
- Perinatal mental health nurses, Metro North Perinatal Mental Health Service
- Relevant non-government organisations
- Brisbane North Primary Health Network

Responsibilities and accountabilities of each of the organisations are outlined within Appendix 2

PERINATAL MENTAL HEALTH AND WELLNESS PROJECT



PROJECT PARTICIPANTS

Project participants were expectant mothers, fathers, partners and support people booked in to have a baby at Redcliffe Hospital Maternity Services between January 2016 and March 2017.

Recruitment commenced in October 2015 and the final participants completed their involvement in the project in May 2017. Over the life of the project, 391 mothers who were registered as clients of Redcliffe Hospital Maternity Services attended the EPP session. The majority of mothers who attended the session were accompanied by their baby's father/ their partner or another support person. Written feedback was received from:

- 299 mothers
- 238 fathers
- 20 support people

Women participating in the Transition to Parenthood Program were consumers of the public health service, which holds clinical responsibility for these consumers including provision of service, clinical quality and safety, documentation of service provision, keeping of consumer records etc. When partners and support people attended the education sessions they were also consumers of the public health service and the same conditions around clinical governance applied.

MODEL COMPONENTS

The model components as originally formulated were as follows:

Service Delivery

- antenatal education for expectant mothers, fathers, partners and support persons, with a focus on Emotional Preparation for Parenthood, delivered from approximately 28 weeks' gestation
- a postnatal education session for the same cohort, to reinforce a focus on emotional health and wellbeing for both parents and infants, offered approximately 6-8 weeks after birth
- active encouragement and empowerment of participants to form connections and continue supporting one another, for example through the formation of playgroups
- targeted peer support groups provided for parents experiencing symptoms of perinatal mental illness, conducted by peer support workers with the support of perinatal mental health clinicians

Intersectoral Collaboration

- formalisation and documentation of referral pathways for expectant and new parents identified as experiencing symptoms of mental illness, among the organisations participating in the collaboration (maternity service, perinatal mental health service, child health service, peer-led organisation, non-government services)
- closer collaboration among public health services, non-government services and peer-led services, to provide information and resources to support the emotional health and wellbeing of expectant and new parents and their infants and families
- a focus on improving awareness of the importance of emotional health and wellbeing in the perinatal period, among staff of collaborating organisations and their networks

Through the action research approach, the separate activities involved in delivering each component became more apparent. Project activities contributing to the model components are reported below under the following headings:

Service Delivery

1. Providing information on mental health and wellbeing at all points along the family's journey from booking-in to six to eight weeks after birth
2. Developing and distributing information resources to promote health and wellbeing of parents, infants and families, including emotional health and wellbeing
3. Antenatal education sessions incorporating perinatal mental health and emotional wellbeing, conducted collaboratively by educators with a range of expertise including lived experience of perinatal mental health recovery, and expertise in available supports for perinatal and infant mental health and wellbeing
4. Postnatal education sessions designed to reinforce key messages about mental health and wellness from the antenatal education, and foster connection and ongoing supports
5. Active encouragement and empowerment of participants to form connections and continue supporting one another, for example through the formation of playgroups
6. Peer support group(s) for women experiencing perinatal mental health challenges who choose to access this form of support

Intersectoral Collaboration

7. Establishment and strengthening of relationships between the public health service system and non-government services, to enable implementation of the project and embed the new collaborative model within the service environment of Redcliffe
8. In-service training for public health service staff to improve awareness of and referral to community services that support emotional wellbeing of parents, infants and families
9. Mapping of government, private and non-government services available in the Redcliffe catchment area to help support emotional health and wellbeing in the perinatal period
10. Formalisation and documentation of referral pathways for expectant and new parents identified as experiencing symptoms of mental illness, among the organisations participating in the collaboration (maternity service, perinatal mental health service, child health service, peer-led organisation, non-government services)
11. Local awareness-raising regarding emotional health and wellbeing in the perinatal period through professional networks, agency visits, partnerships and presentations
12. Dissemination of project learnings

ACTION RESEARCH APPROACH

The project involved the development, implementation, evaluation and documentation of a new model of service delivery, based on promising practice identified in the Redcliffe site. An action research approach was therefore considered appropriate, following a cycle of Plan, Act, Observe, Reflect.



Each component of the model was collaboratively planned and then implemented. Following implementation, a process of collaborative reflection and redesign involving the Working Group, Steering Committee, and other relevant parties, led to another cycle of implementation and reflection.

This process was particularly clear in the evolution of the EPP and PC education sessions, but was also at work through:

- the development of physical resources such as fliers and posters
- the delivery of peer support groups
- the formalisation of referral pathways
- processes for debriefing, reflective supervision and mentorship of facilitators
- processes by which participating organisations collaborated with one another to raise awareness and improve family-centred services
- provision of training sessions for staff
- processes by which project outcomes were communicated externally through presentations and publications

Project activities that were iteratively informed by formal written feedback collected from participants and facilitators included:

- Emotional Preparation for Parenthood sessions
- Postnatal Connections sessions
- peer support groups
- training sessions for midwives, allied health staff and administration staff at Redcliffe Hospital Maternity Services

At the end of the project, all stakeholders were interviewed; their reflections have contributed to the project evaluation and recommendations for implementation of a similar model in other sites.

PROJECT COMPONENTS – PROCESS AND OUTCOMES

SERVICE DELIVERY COMPONENTS

Component 1

Providing information on mental health and wellbeing at all points along the family's journey from booking-in to six to eight weeks after birth.

Overview of component

A key aim of the model is to help expectant and new parents, partners, support people and families gain knowledge, understanding, skills and confidence regarding about emotional health and wellbeing during pregnancy and early parenthood.

It is important that parents and others have strategies for maintaining emotional wellbeing in the perinatal period. Expectant and new parents need to be empowered to consider their individual risk and protective factors for perinatal mental illness, equipped to detect signs and symptoms of potential disruptions to mental health, empowered to offer and accept support, enabled to seek help appropriately and early, and supported to overcome stigma associated with perinatal mental health issues.

beyondblue's Matrix Framework of Perinatal Depression and Related Disorders (beyondblue.org.au, 2011) and the Queensland Centre for Perinatal and Infant Mental Health's *Workforce Development Framework* (2014) both emphasise the vital role played by maternity service staff in helping expectant and new parents to support their own emotional health and wellbeing.

Development of component

The Project Working Group mapped the patient journey through Redcliffe Hospital Maternity Services, identifying the points at which information about emotional health and wellbeing was already being delivered. The Working Group then proposed the following changes:

- A new resource, the Act Belong Commit (ABC) brochure, to be distributed at booking-in and referred to during antenatal and postnatal sessions
- Families to be encouraged to attend antenatal sessions earlier in the pregnancy (28 weeks versus the existing 30-32 weeks)
- An Emotional Preparation for Parenthood (EPP) session to be offered within the Birth and Parenting Program of antenatal education (see below)
- Families to be booked into antenatal sessions at booking-in, and sent automatic reminders ahead of the commencement of sessions
- A postnatal session to be offered 6-8 weeks post-birth, with involvement of non-government organisations
- Families to be booked into postnatal sessions at the booking-in visit and sent automatic reminders ahead of their scheduled session. By the end of the project, families were also receiving a printed reminder of their scheduled postnatal session when they attended their antenatal Emotional Preparation for Parenthood session.

Delivery of component

Figure 1 depicts engagement points for the provision of specific information about emotional health and wellbeing for families birthing at Redcliffe Maternity Services.

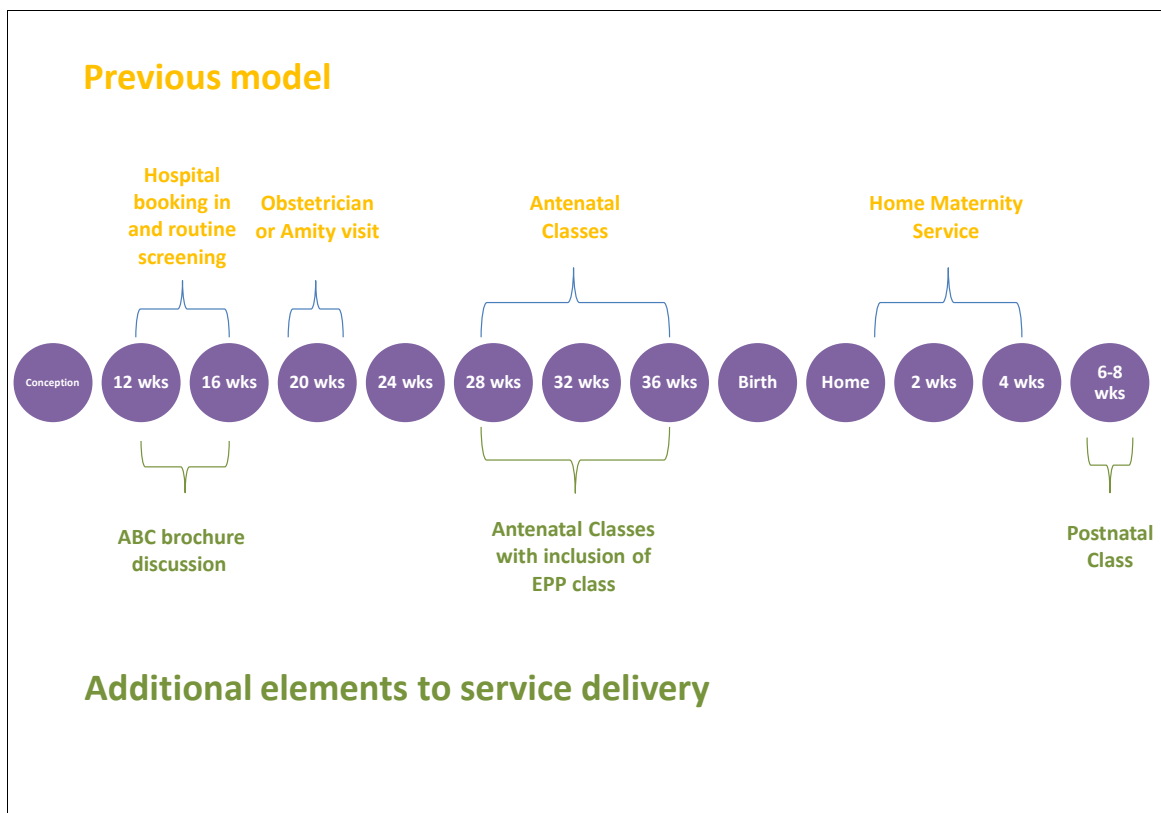


Figure 1: The family journey, before and after redesign

Challenges

- Challenges associated with implementing changes to the patient journey e.g. administration systems, communication breakdown in regard to systems changes
- Range of confidence levels among midwives, regarding discussing emotional health and wellbeing with expectant and new parents. Needs were identified for upskilling of midwives, and for access to clinical supervision for midwives to support their capacity to undertake potentially difficult/triggering conversations about emotional health

Outcomes

- Over the life of the project, components of the revised model were also adopted by other programs within Redcliffe Maternity Services such as the Young Parents Program.

Lasting Impact

- Changes to the patient journey at Redcliffe Hospital Maternity Services have maximised the opportunity for expecting parents to benefit from antenatal education, including the Emotional Preparation for Parenthood session, prior to the birth of their baby
- The addition of a postnatal session has had identifiable benefits (see below)

- Midwives report feeling more skilled and confident in discussing emotional health and wellbeing with expectant and new parents, and are therefore more likely to act appropriately on information about mental health disclosed by patients (e.g. high scores on the Edinburgh Postnatal Depression Scale)
- As a result of the project Redcliffe Maternity Services have adopted a more rigorous quality improvement process with a more detailed data collection for their Birth and Parenting Program.

Component 2

Developing and distributing information resources to promote health and wellbeing of parents, infants and families, including emotional health and wellbeing.

Overview of component

In order to provide information on mental health and wellbeing, it was necessary to develop or source a number of physical resources such as handouts, posters and fliers for distribution to families at various points along their journey of pregnancy and early parenthood. These were:

Antenatal Resources	Postnatal Resources
Antenatal and post-natal depression (WHQW) - blue	Nobody's perfect brochure
Beyond Blue Dads Handbook	ABC brochure (WHWQ)
Metro North Perinatal Mental Health Service brochure	Live in the moment (QCPIMH)
Dads card – How is Dad going?	Raising children cues sheet 0-18mths
Message to your baby (QCPIMH)	Healthy Minds (Zero to Three)
Child Health x 2 fact sheets	Looking after you (WHWQ) – pink
Midwife Check-in LD Cards	SMS 4 Dads 1 page handout
Hope's Room Business card	Hope's Room Business card

Development of component

The Perinatal Mental Health and Wellness Project Working Group reviewed and selected physical resources for distribution to families. Resources were selected to align with the following learning objectives:

- increased awareness of the importance of mental health and emotional wellbeing in the perinatal period
- greater knowledge of perinatal mental illness, including risk and protective factors for perinatal mental health disorders, signs and symptoms, and how to seek help
- increased awareness of risk and protective factors, including expectations of pregnancy and early parenting
- a greater capacity to mobilise resources and supports
- a basic understanding of the importance of early relationships for infant brain development and emotional wellbeing, and some specific ideas about how to nurture these relationships
- enhanced self-efficacy to connect with other parents for mutual social support
- greater awareness of the supports available in the community, clinical and non-clinical, and how to access these

The Act-Belong-Commit (ABC) brochure was adapted with permission from the Act-Belong-Commit Campaign, Mentally Healthy WA. The ABC community-based mental health promotion campaign was founded on Curtin University's research into people's perceptions of mental health and the behaviours that promote good mental health. For more details see <http://www.actbelongcommit.org.au/>

The version of the ABC brochure developed during this project encourages expectant and new parents to take action to support their own emotional wellbeing in the perinatal period.

Delivery of component

Print resources were used to reinforce the information provided to families along their journey. Laminated posters promoting the Act-Belong-Commit message were displayed in the antenatal clinic. Women received copies of the ABC brochure at the time of booking in to antenatal clinic (usually between 12 and 20 weeks). Women's Health Queensland Wide supplied 3,000 ABC brochures to Redcliffe Hospital Maternity Service for this purpose.

Laminated ABC brochures were provided to each of the antenatal midwives for use during consultations with expectant parents. The brochure provided a prompt for discussing emotional wellbeing, and a rationale for completing the Edinburgh Postnatal Depression Scale.

Parents attending the Birth and Parenting Program received another copy of the ABC brochure in their information pack, with the content discussed in Emotional Preparation for Parenthood and revisited in Postnatal Connections.

Other brochures included in the information packs were referred to at relevant points in the sessions.

Challenges

- A significant challenge was ensuring that the content of printed resources addressed all four quadrants of the Dual Continua model, in a way that all stakeholders considered appropriate for the target audience and project purpose. There was a perceived tension between 'wellness focus' and 'illness focus', which had to be thoughtfully negotiated.

Outcomes

- Midwives identified that the ABC brochure was particularly beneficial in assisting them to lead conversations about emotional health. Antenatally, the midwives felt more confident in exploring family and personal history of mental illness with expectant parents, and helping them identify any concerns. Postnatally, midwives were able to link conversations back to the ABC brochure, particularly during discharge.
- Participants were asked whether the print resources they had received in the Emotional Preparation for Parenthood and Postnatal Connections sessions were useful. Most participants said that they were. Some parents felt the content was covered so well in the sessions that it was not necessary to read the handouts. Some mothers suggested the printed resources were a useful way for their partners to revise content. Resources identified as particularly helpful included the sleep time sheets, Moments and Milestones information, and the brochure on feeding cues. One parent identified a preference for receiving such content via a phone app, so they could easily revisit the information.
- As part of the quality improvement process, a staff member from Playgroup Queensland provided observer feedback from a father's perspective on the Postnatal Connections session and the print resources given to participants. Overall he provided positive feedback regarding the usefulness of all the printed resources distributed in the session. He suggested that the Looking after You booklet from WHQW was somewhat wordy, and that the Deadly Mums Guide to Feeling Great might be used instead.

Lasting impact

- The physical resources produced or sourced as a result of the project are now available for use in other locations. Costs of printing and supply need to be factored into implementation budgets.
- Following review of the Postnatal Connections printed resources, the WHQW booklet *The Deadly Mums Guide to Feeling Great* (WHQW, 2016) has been co-produced and co-branded with Playgroup QLD.

Components 3 and 4

Antenatal education sessions incorporating perinatal mental health and emotional wellbeing, conducted collaboratively by educators with a range of expertise including lived experience of perinatal mental health recovery, and expertise in available supports for perinatal and infant mental health and wellbeing.

Postnatal education sessions designed to reinforce key messages about mental health and wellness from the antenatal education, and foster connection and ongoing supports.

Overview of component

The *Clinical Practice Guidelines Antenatal Care — Module II* (Australian Health Ministers' Advisory Council, 2014) recommends including psychological preparation for parenthood as part of antenatal care, as this has been found to have positive effects on women's mental health postnatally.

Since evidence shows that pregnancy and early parenting is a time of emotional challenge for fathers, partners and support people, as well as mothers, it is important to include and support all these participants in antenatal education. 'Involving members of a woman's support network in her care as early as practical provides opportunities for all involved to gain an understanding of the impact of pregnancy and early parenthood on emotional health and wellbeing. It also enables assessment of psychosocial factors affecting family members and family relationships' (Clinical practice guidelines for depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period. A guideline for primary care health professionals, 2011, p. 9).

The Transition to Parenthood (TtP) comprises an antenatal session, Emotional Preparation for Parenthood (EPP), which is delivered in the context of a Birth and Parenting education program based on traditional antenatal education; and a follow-up postnatal session, Postnatal Connections (PC), which is delivered approximately 6-8 weeks post-birth.

The TtP program has been designed to be delivered within a maternity service. The lead educator, a midwife from the maternity service, is supported by a team of educators drawn from the following disciplines:

- peer workers
- allied health staff
- perinatal mental health nurses
- child health nurses
- non-government workers

Peer workers, in this context, are parents who have a lived experience of perinatal mental illness and recovery. Allied health staff may include social workers, psychologists and other allied health staff who work with expectant and new parents. While not every region employs specialist perinatal mental health nurses, adult mental health staff may be involved in delivering TtP, at least in a consultative role. Child health nurses operate within the public health system and typically provide community-based care for mothers and infants following discharge from the maternity service. Non-government organisations which may usefully contribute to TtP include services that provide advice and support for expecting and new parents, such as Women's Health Queensland Wide, and those that support social connectedness for young families, such as First Five Forever and Playgroup Australia.

The TtP program was delivered in the following format:

- Emotional Preparation for Parenthood (EPP) session for expectant parents, partners and support people, offered in two formats (Monday evening or Saturday morning) and two settings (hospital or community health)
- Postnatal Connections (PC) offered approximately 6-8 weeks after birth, delivered on a Saturday in a community health setting

Development of component

The Emotional Preparation for Parenthood (EPP) session was redeveloped from a 3-hour stand-alone opt-in session, focused on emotional health and wellbeing in the perinatal period, which had previously been offered separately from the Birth and Parenting program at Redcliffe. The session had previously been facilitated by a perinatal mental health nurse, peer worker and midwife. The peer workers contributed concepts and strategies, including the Parenting Partner Concept, to help participants identify their own emotional challenges. Peer workers used personal storytelling, role-plays and illustrative examples as tools to support the education.

The project working group worked to integrate this EPP session into the Birth and Parenting program, which required attention to the following aspects:

- tailoring 3 hours of content into a 2-hour session, and distributing other content into the Postnatal Connections session and/or other sessions of the Birth and Parenting program
- ensuring messages about emotional health and wellbeing were also supported in other sessions of the Birth and Parenting program
- adapting the EPP session to fit both the Monday evening format and the Saturday format of Birth and Parenting program delivery
- training and supporting additional midwives to lead EPP sessions, as the new model involved the delivery of 23 sessions over the year rather than 4 sessions
- negotiating which categories of staff could most appropriately deliver which elements of program content, as there was no longer a perinatal mental health nurse available to assist with program delivery
- training and supporting additional staff (peer workers and perinatal mental health staff) to help deliver EPP sessions
- creating a standard manual and PowerPoint presentation for delivery of the EPP session
- creating tools for participants and educators to provide feedback on each EPP session

The Postnatal Connections (PC) session was developed by the Project Working Group, based on general principles of reinforcing the EPP session content, and providing additional information relevant to the postnatal development of infants and families. This session was designed to actively encourage families to connect with one another and with their community in an ongoing way.

Delivery of component

- 23 EPP sessions were delivered over the life of the project (10 Monday evenings and 13 Saturday mornings). 557 participants provided feedback.
- Each session was facilitated by at least 1 midwife, 1 peer support worker and 1 member of the QCPIMH Strategy and Service Development team (content experts on perinatal and infant mental health). The EPP facilitation roster included 5 midwives, 3 Peer Support Workers and 2 QCPIMH staff, with support from WHQW and Child Health with regard to content development.
- 12 PC sessions were delivered over the life of the project. 148 participants provided feedback.
- Each session was facilitated by at least 1 midwife, 1 peer support worker and 1 member of the QCPIMH Strategy and Service Development team (content experts on perinatal mental health), along with appropriate non-government staff (usually Women's Health Queensland Wide and First Five Forever). The PC facilitation roster was made up of 5 midwives, 3 Peer Support Workers, 3 QCPIMH staff, 2 Women's Health Queensland Wide staff, and 2 First Five Forever workers.
- A facilitator manual and supporting PowerPoint presentation were developed through an action learning approach, and professionally produced for the future use of Redcliffe and other sites.

Challenges

- Work required to ensure content addressed all four quadrants of the Dual Continua in a way all stakeholders considered appropriate for the target audience and project purpose (perceived tension between 'wellness focus' and 'illness focus')
- Clarity of roles and responsibilities among stakeholder organisations and among facilitators/ disciplines (e.g. what information should be delivered by midwives, mental health staff, peer workers, non-government staff)
- The action research approach meant that program content evolved over the life of the project, which challenged the ability of facilitators to prepare for sessions in a timely fashion
- Training needs of facilitators were somewhat underestimated at project commencement, resulting in a less systematic and more ad hoc approach to training than would have been ideal
- Organisations involved in delivering sessions need to be proactive in contingency planning for illness or unavailability of designated and trained facilitators
- The risk of vicarious trauma for facilitators was somewhat underestimated. Opportunities for facilitator debriefing and emotional support were created on a somewhat ad hoc basis. It is recommended that sites implementing TtP include routine post-session facilitator debriefing, and a mechanism by which facilitators can access additional emotional support if required
- While the project recognised and implemented mechanisms of reflective practice/ clinical supervision for peer workers and QCPIMH staff, it became clear that midwives also require regular reflective clinical supervision if they are to effectively support the mental health and wellbeing of expectant and new parents and families

Outcomes

Emotional Preparation for Parenthood Participant Feedback

In total, 561 attendees provided feedback on the Emotional Preparation to Parenthood session. Of these, 299 were expectant mothers, 241 were expectant fathers or partners, 17 were other family members or support persons, and 4 did not identify their role. For a detailed analysis of participant feedback on the EPP session, refer to Appendix 3.

Overall, 96% of mothers and 98% of fathers/partners said they had learnt at least 'a little bit' as a result of attending the EPP session: 68% of mothers and 74% of fathers/partners said they had learnt 'quite a lot' to 'a lot'. Mothers identified learnings relating to expectations of parenthood, mental health issues in the perinatal period, prevalence of perinatal mental illness, and signs and symptoms of mental health problems. Fathers and partners identified learnings relating to emotional wellbeing, risk factors for mental health problems, and signs and symptoms.

When asked whether the session had benefited them, 94% of mothers and 95% of fathers and partners said yes. Of the total sample, 62% of mothers and 63% of fathers/partners said they had experienced 'quite a lot' to 'a lot' of benefit. Participants said that the session had improved their knowledge of services available, as well as providing a safe space to open up and ask questions. They felt the session had improved their confidence in talking about emotional wellbeing with their partners.

Participants were asked whether the session had raised any concerns for them. Most said no (72% of both mothers and fathers). Only 4% of mothers and 3% of fathers said the session had raised 'a lot' of concerns for them. These concerns were mostly described as bringing up previous distressing experiences or negative thoughts, or concerns about their partner's wellbeing. These effects are considered appropriate and aligned with the purpose of the program, which is to help participants consciously reflect on and discuss possible challenges to their emotional wellbeing during pregnancy and early parenthood in order to be better prepared. All participants who identified concerns were followed up by the facilitators and referred for further support as required.

At the end of the session, 98% of both mothers and fathers/partners felt confident that they could identify any problems with their own emotional health and wellbeing, while 99% of both mothers and fathers/partners felt confident they could identify any problems with their partner's emotional health and wellbeing. In terms of being confident about seeking help, 95% of both mothers and fathers/partners felt they would be able to seek help for themselves if required, while 98% of mothers and 99% of fathers/partners felt confident they would be able to support their partner to seek help if required. These levels of confidence were maintained at post-program evaluation, at the end of the Postnatal Connections session.

At the Postnatal Connections session, participants were asked to reflect on their learnings from the antenatal Emotional Preparation to Parenthood session. Of the 88 mothers who completed questionnaires at this session, 92% remembered learning at least 'a little bit'. Of the 50 fathers and partners who completed questionnaires, 96% remembered learning at least 'a little bit'. Mothers remembered that the EPP session had highlighted the importance of connection and communication with their partner and support network, and with their baby. Fathers and partners remembered that the EPP session had explored strategies for communicating with their partner and providing support, and had also improved their knowledge of available services.

Interestingly, despite the participants' demographic (majority aged 19 to 35 years), 74% of mothers and 76% of fathers said they did not intend to discuss mental health and emotional wellbeing in pregnancy and early parenting on social media. Reasons for this reluctance warrant further investigation, since it is known that Australians in this age group increasingly consult social media for health information. Of those who said they would discuss perinatal mental health and emotional wellbeing on social media,

78% of mothers and 90% of fathers said they would use Facebook. This was significantly higher than the reported intended use of any other social media platform.

Postnatal Connections Participant Feedback

In total, 148 attendees at the Postnatal Connections Sessions provided feedback. For a detailed analysis of participant feedback on the PC session, refer to Appendix 3. Of the participants who attended the session, 92 were mothers, 51 were fathers or partners, 4 were other family members or support persons, and 1 did not identify their role.

Participants were asked if the Postnatal Connections session improved their awareness of ways to support their emotional health and wellbeing. Overall, 98% of mothers and 100% of fathers/partners said that it did: 42% of mothers and 49% of fathers said it improved their awareness 'quite a lot' to 'a lot'. These figures are appropriate, given that the session was designed to reiterate key messages from the EPP session rather than provide a significant amount of new information.

Participants highlighted the benefits of the session as an opportunity to connect with other parents through group activities. Some 30% of mothers and 41% of fathers/partners said they had remained in touch with other parents they had met through the antenatal education program. When asked whether they intended to stay in touch with other parents from the PC session, 34% of mothers and 36% of fathers/partners said 'yes', while 51% of mothers and 54% of fathers/partners said 'maybe'. At the end of most Postnatal Connections groups, participants spontaneously decided to establish a Facebook or email group to enable members who wanted to stay in touch to do so.

Twenty percent of mothers and 8% of fathers/ partners indicated that they had required additional support for their mental health and emotional wellbeing since participating in the EPP class. These figures are closely aligned with known prevalence data for perinatal mental illness, suggesting that the EPP class had helped participants to accurately identify their need for perinatal mental health support and actively seek this support through appropriate services. Of those who had accessed additional support, most had accessed done so through a GP (23% of mothers and 16% of fathers/partners), midwife (21% of mothers and 16% of fathers/partners), or Child Health service (20% of mothers and 12% of fathers). A significant number of parents had accessed the Perinatal Mental Health Service (7% of mothers and 2% of fathers/partners). A further 4% of mothers and 9% of fathers/partners had accessed support through a non-government or community service. Three percent of mothers and 2% of fathers/partners had accessed a social worker, while 3% of mothers and 2% of fathers had accessed support through a private psychologist, psychiatrist, counsellor or mental health professional. One percent of mothers had participated in a mental health peer support group. Since these categories were not exclusive, parents may have accessed more than one form of support.

At the PC session, 88% of mothers and 96% of fathers reported that they had not discussed perinatal mental health and emotional wellbeing on social media. Those who had done so had overwhelmingly used Facebook (10% of mothers and 4% of fathers). Social media may be an untapped avenue for disseminating accurate health information about perinatal mental health and emotional wellbeing, reducing stigma and engaging the community in more open, productive dialogue.

All participants reported finding the PC session helpful. There were no identifiable themes among the suggestions for improvement: most participants reiterated the aspects of the session that they had found helpful. One participant highlighted the importance of consistent staff across the EPP and PC sessions, and another requested that the session be offered earlier (closer to birth) so parents could benefit in a more timely fashion from the information on baby cues.

Facilitator Feedback

In line with the action research approach, feedback from facilitators was collected at the end of every EPP and PC session using a mixed-methods questionnaire (rating plus comments). Facilitators were asked about:

- overall impressions of the session (rating out of 10)
- positive outcomes experienced
- negative outcomes experienced
- how the session could be improved
- intention to make changes to facilitation of the session
- whether support would be required to make changes

Ten facilitators representing Redcliffe Hospital Maternity Services, Hope's Room Ltd, WHQW and QCPIMH provided feedback regarding the EPP sessions from January to December 2016. Much of the feedback from the initial implementation phase (Jan-June) centred on issues relating to manualisation of the content. Once the manual was formalised, feedback identified that ongoing training should be provided to facilitators to ensure all were up to date with session content, structure, and purpose. In the latter part of the implementation, feedback indicated that all facilitators felt the content was well-structured, appropriate and necessary.

Fifteen facilitators representing Redcliffe Hospital Maternity Services, Hope's Room Ltd, WHQW, QCPIMH, and non-government services, provided feedback regarding the PC sessions from May 2016 to March 2017. The feedback was overwhelmingly positive in relation to the core objective of 'connection'. All facilitators felt that participants had benefited from the session. Facilitators identified the marketing of the Postnatal Connections session as a key area for improvement, to increase uptake.

Facilitators stated that the session had provided a valuable opportunity for a range of organisations to connect with others involved in supporting families during the perinatal period. Facilitators stated that the work of developing and delivering the Postnatal Connections session had led to new intersectoral partnerships. For a more detailed summary of feedback see Appendix 4.

Midwives' Focus Group Feedback

A focus group was held with midwives who had facilitated Transition to Parenthood, to gauge their perceptions of the program's value. The following major themes emerged from the focus group:

- Antenatal and postnatal education sessions had positive effects for parents
- The project had positive impacts on midwifery practice at Redcliffe Hospital
- Collaborating with non-government services is valuable for the maternity service and beneficial for patients
- Regular training is required to help midwives and others implement similar initiatives in the future
- Reflective space and clinical supervision are necessary to enable midwives to effectively support the mental health and emotional wellbeing of expectant and new parents
- The contribution of peers with lived experience of perinatal mental health issues is highly valuable, to help destigmatise mental illness and help midwives improve their own practice
- A focus on infant mental health and emotional wellbeing is valuable
- Midwives reported positive experiences of participating in the program

For a more detailed analysis of the focus group feedback, see Appendix 4.

Research Study

Of the total participant group of 561, 302 participants agreed to enrol in a research study of outcomes of the Transition to Parenthood education program. The study aimed to investigate change in clinical measures of self-reported depression, anxiety, stress, parenting confidence and relationship quality from pre-program to post-program. Ethics approval was obtained through The Prince Charles Hospital Human Research Ethics Committee. For a more detailed summary of this research, refer to Appendix 5.

Lasting impact

- 'Transition to Parenthood' manual developed, professionally produced, and hosted by Queensland Centre for Perinatal Mental Health for download and use by other sites
- Generic PowerPoint template for the EPP and PC sessions hosted by Queensland Centre for Perinatal Mental Health for download and use by other sites
- Five training modules for Peer Support Workers hosted by Queensland Centre for Perinatal Mental Health for download and use by other sites

Component 5

Active encouragement and empowerment of participants to form connections and continue supporting one another, for example through the formation of playgroups

Overview of component

Postnatal sessions were scheduled to cater for cohorts of parents who had attended antenatal sessions together. At both antenatal and postnatal sessions, families were encouraged to connect with one another, as people who lived in the same area and would be raising children of similar age. There is evidence that social connectedness can help reduce isolation and provide social, emotional and practical support for new parents. This is all the more important where new parents are living away from extended family, where parents do not have cultural support, and/or where work commitments reduce a partner's ability to spend time supporting the new mother. All of these situations were identified by the project partners as common scenarios in the Redcliffe catchment.

Development of component

The design of the Emotional Preparation for Parenthood session included activities to help participants quickly become familiar and comfortable with each other. Postnatal Connections was explicitly designed to encourage parents to reconnect with one another.

Delivery of component

Antenatal session activities included group introductions and sharing of personal interests, small and large group discussions, participatory games and activities, and a mid-session break where parents were encouraged to mingle and chat.

The introductory section of the Postnatal Connections session focused on allowing parents to re-introduce themselves and to introduce their new babies. Messages about social connection were reinforced, information about Playgroup Australia and Child Health parent groups was provided, and parents were explicitly encouraged to make connections with one another. The education room was laid out in a 'market' format, displaying resources from the participating organisations. The final half-hour of the session was allocated to providing time for the participants to browse the 'market', share refreshments and discuss their experiences of parenting to date.

Challenges

- Facilitator skills required to assist parents to connect with others, particularly where social anxiety was a barrier

Outcomes

- These activities were observed to fulfil the purpose for which they were designed, encouraging lively discussion among participants, particularly at the end of the Postnatal Connections session. Facilitators consistently reported that it was difficult to get participants to leave when the session was over.
- Feedback from participants in the EPP session indicated a moderate degree of intention to remain in contact with other participants. While the majority (68.9%) expressed interest in maintaining contact with other participants, some identified that this was difficult as there was limited time during the sessions to interact with other participants (this feedback was more often received in relation to the 'two Saturdays' format than the 'five Mondays' format for the Birth and Parenting program). Of the participants who said they were not interested in maintaining contact, most stated this was because they already had a support network of family and friends, or already belonged to a parents' group.
- Feedback from participants in the PC session indicated a higher degree of intention to actively pursue social interaction with other parents, although some participants still identified lack of time to interact and establish relationships with other parents as a limitation of the sessions. Most Postnatal Connections sessions saw a participant spontaneously take responsibility for setting up a Facebook page or other opportunity for ongoing connection, for those who wished to participate. A number of couples exchanged contact details between themselves.

Lasting impact

Although it is beyond project scope to follow couples over time, to assess whether connections formed through the Transition to Parenthood program have lasted, it is reasonable to assume that at least some participating families have benefited from the social connections made or strengthened through participation in the program.

Component 6

Peer support groups for women experiencing mental health challenges who choose to access this form of support

Overview of component

Peer support groups are increasingly recognised as a component of the health service system, in such areas as cancer, epilepsy and heart disease, and notably in mental health. From the inception of the project, it was intended that peer support groups would be a project component, providing a referral option for expectant or new parents identified through the project as requiring additional support for their mental health and wellbeing.

Development of component

Peer support groups for parents experiencing symptoms of perinatal mental illness were already a service component available within the service system of the Redcliffe Hospital Maternity Services catchment area. However, changes had recently occurred in relation to the peer-led organisations providing these support groups. The Project Working Group resolved that the project would aim to avoid 'disrupting' existing peer support groups, and instead would establish a new group or groups as need was identified through the project.

The Project Working Group conducted a literature review and environmental scan to identify available models for the conduct of peer support groups for perinatal mental illness. Considerable consultation occurred with the peer-led organisation represented on the Working Group, Hope's Room, which held considerable knowledge about conducting perinatal mental health support groups both on an organisational level and through the experience of individual facilitators.

A full discussion of how the model for peer support groups was developed is provided in a paper that is an output of the project. In brief, the major dimensions along which peer support group models vary, and the choices made under the project, were identified as follows:

- Open versus closed groups. While an open group permits new members to join on an ongoing basis, a closed group does not. Under the model established for the project, new members could join with the group's agreement, although the total membership for each group was capped at 10 members.
- Open-ended versus time-limited groups. While an open-ended group has no defined end-point, a time-limited group runs for a set number of sessions agreed ahead of time. Under the model established for the project, groups were open-ended, with an understanding that the peer-led organisation would continue to facilitate groups beyond the life of the project.
- Spontaneous versus themed groups. A spontaneous group discusses whatever topics the group members wish to discuss on the day, while a themed group adopts a more structured approach to content (e.g. psychoeducation). Under the model established for the project, content was spontaneously generated by the group, with the option for content to be planned ahead (e.g. a guest speaker invited) should the group wish for this.
- Parent-only versus infant-inclusive groups. While some perinatal peer support groups may be established as parent-only, to enable members to concentrate on their own needs and their interactions with other adults, other groups welcome the infant also. Under the model established for the project, mothers were welcome to bring their infants to group.

These decisions were primarily made by the peer-led organisation, Hope's Room. Options were considered in the context of the Project Working Group, and with the support of reflective sessions provided by the Metro North Perinatal Mental Health Service, peer mentorship provided by an experienced consumer representative, and business and project management mentorship provided by QCPIMH. Decisions were made based on the peer workers' previous experiences of running peer support groups over a number of years, as well as consideration of the available literature and scoping of peer support group models within the health service environment.

Delivery of component

One peer support group was conducted in a community setting at Clontarf, in the Redcliffe Hospital catchment area. The total membership of the group was 8 and the group was on average attended by 3 to 6 participants per week. Groups were run weekly, with a total of 34 sessions conducted from 4th January 2016 to 31st March 2017.

The group was conducted by two peer workers, a lead facilitator and a co-facilitator. For all groups conducted under the auspices of the project, the lead facilitator was an experienced peer support group facilitator employed by Hope's Room with funding from the project. Some groups were co-facilitated by a volunteer being trained to work as a lead facilitator for future Hope's Room groups.

Throughout the project, three peer workers were involved in delivering education sessions and two of these workers were involved in facilitating peer support groups. Another 8 peer workers contracted by Hope's Room were involved in facilitating or co-facilitating peer support groups that were not part of the project. All peer workers were provided with access to reflective practice sessions with an experienced psychologist and allied health clinical supervisor, through the Metro North Perinatal Mental Health Service. These group sessions ran for two hours and were scheduled monthly. The sessions provided the peer workers with a safe, supportive and constructive space in which to reflect on their practice as group facilitators, educators and collaborators.

Challenges

Recruiting, training and supporting peer group facilitators, to ensure the sustainability of a safe and supportive group, presents challenges. The time-limited nature of the project, which required only one group to be facilitated, meant that the group could be facilitated within Hope's Room's resources. Issues involved in recruiting, training and supporting a peer workforce need to be addressed in any site considering implementation of a similar model in future.

Outcomes

Feedback was gathered from participants (n=6) and peer support group facilitators (n=6) to inform recommendations for future practice. Participant feedback focused on improvements to the facilities, such as room size (n=5). One participant commented on the need for a larger play space for the children of the attending parents, and one participant highlighted a need for a father-specific peer group.

Facilitator feedback from the targeted peer support groups highlighted the need for appropriate time to reflect on the session, and suggested additional opportunities to interact with other facilitators. Hope's Room had put supportive activities in place to assist the peer workers in their roles as facilitators, including initial phone calls and interviews, attending facilitated sessions with an experienced peer,

Mental Health First Aid training, clinical supervision, and additional lines of support. Some facilitators identified that they had not had the opportunity to participate in some of these supportive activities – but this was a concern identified by those who had been facilitating groups for less than 3 months (i.e. were fairly new staff members). Only half the facilitators who took part in the survey had completed Mental Health First Aid training and clinical supervision.

The facilitators who reported feeling ‘good, capable of dealing with all situations’, and ‘excellent, I know what to do no matter what occurs’ were those who had been facilitating sessions for more than six months. This suggests that confidence comes with experience, and a longer period of time in which to access the supports provided by the peer-led organisation.

Lasting Impact

Due to circumstances unrelated to the project, Hope’s Room Ltd ceased operating as an organisation following the project’s conclusion. However, a number of peer group facilitators who received opportunities for training, reflection and co-facilitation through the project have gone on to conduct peer support groups for other organisations.

INTERSECTORAL COLLABORATION COMPONENTS

Component 7

Establishment and strengthening of relationships between the public health service system and non-government services, to enable implementation of the project and embed the new collaborative model within the service environment of Redcliffe

Overview of component

The objective for undertaking the below strategies is supported by the concept of 'collaboration' that includes 'enhancing the health promotion capacity of other partners for mutual benefit and a common purpose' (Partnerships Analysis Tool, 2016, p. 4). Partnerships and collaborations have the benefit of bringing together varied skills and resources for more successful outcomes. Collaborative partnerships require a clear purpose, add value to the work of partners and have a bigger impact than if partners were working alone. It also requires the involvement of senior agency staff as there is a need to mobilise the agency resources required for collaboration. Our project was mindful of these factors in creating a successful project (The partnerships analysis tool, 2016, p. 3). The work is also based on the assumption that strengthened partnerships, collaboration and referral pathways lead to improved consumer experience and better perinatal mental health outcomes. This also involves identifying and removing systemic barriers to collaboration and referral across service providers (Queensland Mental Health Commission, 2014, p. 15) Better engagement and clear pathways for working together has been identified as one of the four pillars of reform to support improvements in mental health by the Queensland Mental Health Commission (Queensland Mental Health Commission, 2014, p. 14).

Development of component

The Project Officer hosted by WHQW established new relationships with the following organisations, which resulted in their collaborative contribution to the model of service:

- First 5 Forever
- Moreton Bay Regional Council
- Playgroup Queensland
- Brisbane North Primary Health Network (PHN)

Delivery of component

First 5 Forever

A relationship was established with the Moreton Bay Regional Council Library *First 5 Forever* Program, which conducts Baby Rhyme Time sessions in libraries. Staff of *First 5 Forever* presented during the Postnatal Connections session, encouraging parents to sing and play with their babies using two simple action songs and an action rhyme. *First 5 Forever* provided a 'stall' at the session, distributing early reading resources to families.

Moreton Bay Regional Council

Moreton Bay Regional Council supplied the Healthy and Active Moreton Directory/ iMove Directory for distribution to all participants at the Postnatal Connections session. This resource supports messages promoting emotional health and wellbeing through the concept of Act, Belong, Commit.

Playgroup Queensland

A relationship was established with Playgroup Queensland, which assists parents to set up playgroups, and provides support when required for special populations (e.g. playgroups for children with a disability). Playgroup Queensland provided a video for screening at the Postnatal Connections session and a selection of resources for distribution to parents, including the *Baby Play and Baby Playgroups* booklet, *Babies Love Playgroup* promotion card, *Playgroup Membership for Families of Newborns* and handout listing of playgroups in Redcliffe catchment area.

Brisbane North PHN

Six medical practices within the Brisbane North PHN area were visited by the Project Officer in conjunction with a PHN Liaison Officer. Referral pathways were explored with 17 General Practitioners. Awareness of and barriers to referring to government, NGO and private services were identified and documented in 'issues register' along with any barriers to GP service delivery to patients in the perinatal period. Issues raised were discussed at a Working Group meeting with input from PHN Liaison Officer to identify which issues required follow up and who would take responsibility.

Challenges

Cross-sectoral collaboration, especially the initial building of relationships, requires considerable time and effort. Such work may not be sustainable without either a dedicated co-ordinator, or staff members in each service for whom collaboration is a designated and valued component of their role.

Outcomes

First 5 Forever

The First 5 Forever Team Leader reports that the project has provided her team with a point of connection to the health sector and an opportunity to engage fathers: both have previously been limited.

Participating staff have taken back to the library information about perinatal and infant mental health, and the social and emotional needs of families. Library staff are reportedly now more aware of allowing time for parents to socialise at the end of Baby Rhyme time to enhance connectedness, a sense of belonging and social support among participating parents.

First 5 Forever have presented an in-service to Redcliffe Hospital Maternity Services on the services provided by libraries, in particular Baby Rhyme Time and the 'Discover and Learn' program for adults.

First 5 Forever connected with Redcliffe Hospital Young Parent Program and now participates on a regular basis in the antenatal education program for young parents.

Moreton Bay Regional Council

Moreton Bay Regional Council libraries organised use of a local library meeting room for peer support group meetings. This arrangement helped peer support group participants develop familiarity with the library as a community hub, helping participants transition into parent-child activities provided by library.

Moreton Bay Regional Council distributed resources promoting Women's Health Queensland Wide's Midwife Check-in to all 9 libraries in catchment area, increasing awareness of and access to this service.

Playgroup Queensland

A staff member from Playgroup Queensland provided observer feedback from a father's perspective on the Postnatal Connections session held 14th January 2017, as part of the quality improvement process.

The same Playgroup Queensland staff member attended a meeting of the Project Working Group to provide information on the Accessible Playgroup program that provides funding to set up playgroups for disadvantaged groups/ marginalised families.

Playgroup Queensland has connected with Redcliffe Hospital Young Parent Program and will provide Playgroup resources and explore opportunities for establishing a new playgroup to cater for clients of this program.

The Women's Health Queensland Wide booklet 'The Deadly Mums Guide to Feeling Great' has been co-produced and co-branded with Playgroup Queensland.

Brisbane North PHN

As a result of consultation with GPs from the region a collaborative initiative was established with Women's Health QLD Wide and Brisbane North PHN for the embedding of the Midwife Check-in referral template into GP electronic medical records software to facilitate easier referral processes. The installation of the software and the dissemination of promotional material were carried out by the Brisbane North PHN Primary Care Liaison staff. Midwife Check-in staff have reported an increase in referrals from GPs with up to two new referrals per month since installation of the software and promotion of the service with Practice Nurses in the Brisbane North region.

Lasting Impact

- At a local level, the activity has increased awareness of the importance of emotional health and wellbeing in the perinatal period across sectors, and has increased inter-agency awareness particularly across the public-NGO interface.
- Maintaining new links among organisations will require ongoing efforts on the part of these organisations, but will be facilitated by systemic changes, particularly the embedding of the Women's Health Queensland Wide referral form in the Medical Objects software.

Component 8

In-service training for public health service staff to improve awareness of and referral to community services that support emotional wellbeing of parents, infants and families

Overview of component

In-service education sessions have been conducted at various stages of the project, from early initiation and implementation through to later stages, following the mapping activity that identified gaps in service awareness and referral processes.

Other agencies with connections to the project have initiated their own contact with Redcliffe Hospital and have presented to midwives. Agencies are aware of the need to take part in in-service education events to enhance knowledge and interaction between services.

Development of component

The component developed organically as needs were identified through other components of the project. For example, the service mapping exercise revealed that managers and staff within Redcliffe Hospital Maternity Services were not aware of the Midwife Check-In Service provided by Women's Health Queensland Wide, and the services provided by Child and Youth Community Health. The desire for a closer working relationship between Encircle and the hospital Social Work Department was identified independently by both organisations during service mapping and agency visits.

Delivery of component

Services that have presented in-service sessions at Redcliffe Hospital include:

- Child and Youth Community Health
- Family and Child Connect (FACC) Mercy Services
- Women's Health Queensland Wide Midwife Check-in Program (2 nurses and Education Team Leader, 30/11/2016). The in-service was attended by approximately 14 midwives. Services offered by WHQW and specifically the Midwife Check-in telephone support service were outlined including referral criteria, how to refer, objectives and benefits of the service. Printed resource materials including booklets on *Looking After You* and *Antenatal and Postnatal Depression* were provided. See website for further information <http://womhealth.org.au/services/midwife-check-in>
- Encircle, Redcliffe Neighbourhood Centre. A Family Support Worker presented 20/12/2016. The session was attended by 12 midwives, 3 student midwives and 1 social worker. Services provided by Encircle that support families in the perinatal period were outlined including parent education courses e.g. Circle of Security and young parent support, counselling etc. See website for further information <http://www.encircle.org.au/redcliffe-neighbourhood-centre>.
- First5Forever (Moreton Regional Libraries) Team Leader and another staff member presented 20/12/2016. Attendance as per above as both speakers shared the session time. Lyndsay provided information on library programs including Baby Rhyme Time, playgroups, toy library and the adult 'Discover and Learn' program. The statewide First5Forever program is an early literacy program encouraging parents as first teachers of their child to spend time with their baby talking, playing and reading, so the child's growing brain can get what it needs at the right

time. First5Forever staff helped facilitate the Postnatal Connections session, therefore it was important for midwives to be aware of the program and its benefits for parents and for infants. See website for more information <https://www.moretonbay.qld.gov.au/f5f/>

- The Queensland Centre for Perinatal and Infant Mental Health presented four in-services on 14/12/2015, 17/12/2015, 23/09/2015, and 09/06/2016 for the maternity staff at Redcliffe Hospital. The sessions aimed to improve knowledge of emotional wellness, and confidence in engaging in conversations about emotional health and wellbeing with parents in the perinatal period. The in-services provided an overview of the project, an introduction to emotional health and wellbeing, a review of the current Birth and Parenting Program at Redcliffe, a review of the use of emotional health screening measures, and discussion of referral pathways for mothers requiring additional support.

Challenges

- Resources required to coordinate the in-services (time, staffing)
- Scheduling of in-services at the most appropriate times to access staff who work across teams and on a rotating roster (e.g. Home Maternity Service Midwives)

Outcomes

- WHQW midwives involved in delivering the Midwife Check-In in-service reported an increased understanding by Redcliffe Hospital Maternity Services midwives about what each service offers families. This led to the Midwife Check-In staff feeling more valued by the public maternity service.
- Referrals from Redcliffe Hospital Maternity Services and Metro North Perinatal Mental Health Service to the Midwife Check-In service increased significantly throughout and following the project, to the extent that WHWQ has sought funding to increase service capacity.
- First 5 Forever staff report increased family attendance at their library sessions in the Redcliffe catchment area.
- The in-services facilitated by QCPIMH were evaluated through questionnaires distributed before and after the in-service. Overall, participants indicated improvements in their level of knowledge about perinatal emotional wellness and mental health, their level of comfort in having conversations about emotional health and wellness, their understanding of risk and protective factors, and their understanding of available referral pathways, as a result of the in-service. Participants suggested that role-plays might be used in the sessions to help develop skills in talking with expectant and new parents about emotional health. They also expressed a wish for longer and more regular training sessions addressing this area.

Lasting Impact

- WHQW have delivered the same In-service to the Royal Brisbane and Women's Hospital (RBWH) Social Work Department. As a result, Midwife Check-in now receives 1-2 referrals per week from RBWH Social Workers.

Component 9

Mapping of government, private and non-government services available in the Redcliffe catchment area and beyond, to help support emotional health and wellbeing in the perinatal period

Overview of component

Women's Health Queensland Wide took responsibility for a service mapping activity that identified government, private and non-government services available in the Redcliffe catchment area and beyond, to help support emotional health and wellbeing in the perinatal period.

Development of component

The starting point was to map existing referral pathways for expectant and new parents who were consumers of Redcliffe Hospital Maternity Services, including those accessing usual care and those with identified risks or in need of targeted services. Consultation with service Team Leaders revealed no evidence that such a mapping exercise had been carried out previously. The mapping activity was conducted by WHQW's Project Officer with team leaders (face-to-face interviewing on site) who identified individuals or agencies that referred women and their families in and out from the service. It provided an understanding of how teams within the public health service, i.e. Redcliffe Maternity Service, communicate internally and externally and how their relationships with internal teams and organisations external function. Team leaders were asked to identify strong and weak connections to agencies and where further work could be directed to improve connection. Draft maps were subsequently circulated by email for comment and refined accordingly.

A similar process was used to map referral processes of key service providers in the community that had been identified from the hospital mapping activity that support parents that require early or targeted intervention in the perinatal period. The purpose of the mapping was to gain insight into service availability, accessibility, capacity and any barriers to appropriate referral and service provision.

The third activity was developing referral flow charts for key non-government agencies (Hopes Room and WHQW Midwife Check-in) for use by Redcliffe Maternity Hospital staff. Drafts were circulated for comment and revised (see Component 10).

The fourth activity was the collation of existing service directories. It includes websites, helplines and apps in addition to face-to-face services (See Appendix 6). The service/resource list is not intended to be comprehensive and has been compiled by firstly examining published resources of the partner organisations involved in the project including web links as well as resource lists distributed to their clients. The most frequently recommended resources and those of peak organisations have been included. Forums are only examples of some that are currently operating. The list can be modified for different geographical regions using the same category headings. The list exemplifies a conscious consideration of all four quadrants of the Dual Continua (Keyes, 2017) for supporting families in the perinatal period.

Delivery of component

Referral pathways were mapped and documented within Redcliffe Hospital for the Antenatal Clinic, Home Maternity Service, Amity Team, Ngarrama Team, Young Parents Group and Social Work Department. To assist this process, interviews were conducted by Project Officer with relevant Team Leaders.

Referral pathways were mapped and documented for other public health services including the Perinatal Mental Health Service, Child and Youth Community Health, and the Ellen Barron Family Centre. Interviews were conducted by the Project Officer with relevant managers and Team Leaders.

Draft referral flow charts were developed for use by Redcliffe Hospital maternity staff for Hopes Room and the Midwife Check-in Program. The aim of this activity was to clearly document the referral pathway and to increase the number of appropriate referrals.

Six General Practices were visited by the Project Officer in conjunction with the Brisbane North Primary Health Network (PHN) Liaison Officer. Referral pathways were explored with 17 General Practitioners. Awareness of and barriers to referring to government, NGO and private services were identified and documented in an Issues Register, along with any barriers to GP service delivery for families in the perinatal period. Issues raised were discussed at a Project Working Group meeting, with input from the PHN Liaison Officer to identify which issues required follow-up and who would take responsibility.

It was found that each organisation had either compiled a service directory or identified a service directory for use. It was acknowledged that keeping service directories comprehensive and up to date is extremely challenging.

Challenges

- In a rapidly-changing service environment, service maps and directories constantly become out of date. Web-based directories co-ordinated at a state or national level, such as One Place and the National Health Services Directory, in theory will help to address this issue as they attract greater participation over time. It is in the interests of services to ensure they are listed in these directories and to keep their details updated. However, influencing these processes is outside the scope of this project, beyond helping to spread awareness of the directories among participating services.

Outcomes

- Facilitators of the TtP program increased their awareness of services available in their community, appropriate referral processes, and the capacity of these agencies to provide support for families. This led to modification of the local supports section of the TtP PowerPoint Slide Presentations.
- The service mapping process allowed Team Leaders and managers time to reflect on their current processes and seek solutions to barriers identified. The following actions occurred:
 - PMHS is looking to roll out triaging meetings similar to those held at Redcliffe Hospital, to other hospitals within Metro North HHS.
 - Hopes Room changed its contact details to a generic phone and email address rather than an individual contact, and explored modes of accepting referrals other than phone (e.g. formal paper-based referral form).
 - Child Health held an in-service training session at Redcliffe Hospital Maternity Services to increase awareness of the services Child Health provides and the referral processes, as this relationship was identified as needing strengthening.

- Child Health scheduled a meeting with Family and Child Connect to improve understanding and collaboration for the support of families at risk of entering or re-entering the child protection system (Jan 2017).
- Child Health undertook to involve 8 community services in an upcoming quarterly cluster meetings of Child Health staff, to raise awareness and improve cross-sectoral collaboration.
- Redcliffe Hospital Young Parent Program (YPP) Team Leader reconnected with the Deception Bay Community Youth Program and arranged for a community social worker to participate in antenatal education sessions. The YPP Flowchart was provided to Redcliffe Hospital birthing suite staff, to raise awareness of what the YPP program offers and how to refer.
- WHQW presented at Redcliffe Hospital in-service training for midwives, to increase awareness of WHQW services including the Midwife Check-in program. Information on these services (video link, web page and information sheet) was emailed to all midwives.
- Additional visits by WHQW to GPs and other agencies resulted in an increase in requests for printed resources (Midwife Check- in cards, ABC brochures etc.).

Lasting Impact

- Local councils, neighbourhood centres and libraries exist in most communities and are an excellent source of information on community services. The directory of services and resources compiled through this project (Appendix 6) provides a template that other sites can use to reflect local community activities and support services.
- System change initiatives were implemented by WHQW to increase referrals to their Midwife Check-in Program from GPs in the Brisbane North region. WHQW partnered with Brisbane North PHN to have a referral template embedded in the GP medical record software, Medical Objects, to facilitate an easier and more secure referral process. PHN Liaison officers installed templates and provided information sheets and promotional sheets to all practices in the Brisbane North region. This demonstrated a low-cost system change that could be rolled out through other PHNs and could also be implemented by other services e.g. Child Health or Perinatal Mental Health Service.

Component 10

Formalisation and documentation of referral pathways for expectant and new parents identified as experiencing symptoms of mental illness, among the organisations participating in the collaboration (maternity service, perinatal mental health service, child health service, peer-led organisation, non-government services)

Overview of component

It is considered good practice in state health services to formalise and publicise a 'referral pathway'. This is typically a one-page flowchart that briefly describes the service, helping other services understand which client groups may benefit from this service, how referrals should be made, how decisions are made regarding the acceptance of referrals, and what options may be available should the referral not be accepted.

In the course of mapping government, private and non-government services available in the Redcliffe catchment area, the Project Officer was made aware of barriers and challenges each service encountered when attempting to work more collaboratively with other services. Services generally expressed a philosophical willingness to provide seamless, client-centred care, but found this difficult to do at a practical level for a variety of reasons. Referral pathways were identified as a potential tool to help services collaborate.

Development of component

The Project Officer undertook service mapping as outlined above under component 10. She then undertook to document referral pathways for the two key non-government services involved in the project. These pathways were designed to assist Redcliffe Hospital Maternity Service midwives in referring mothers to appropriate services to support their perinatal mental health and wellbeing.

It was intended that these flowcharts could then provide a template for other services seeking to strengthen cross-sectoral referral pathways. Since all services are different, the flowcharts provide templates or examples, and are not meant to be prescriptive.

Delivery of component

The Project Officer documented referral pathways that Redcliffe Hospital Maternity Service could use to refer mothers to the following services:

- Midwife Check-in program (Women's Health Queensland Wide)
- Hope's Room (peer support groups)

Metro North Perinatal Mental Health Service also used the Project Officer's work to help progress the referral pathway it was in the process of developing.

Challenges

- Each health service, even within a Hospital and Health Service, has its own referral processes, and these are often not well communicated to other services.

- Organisations typically have processes for the development and approval of documentation, including referral pathways. State health services may require many levels of document approval (e.g. team, service, Hospital and Health Service levels), which can pose a challenge to the development of new documents and the amendment of existing documents.
- Health organisations in particular may be reluctant to formalise referral pathways involving other organisations, with the acknowledgement of cross-sector service provision being viewed as somehow compromising or abrogating clinical governance responsibilities, and/or introducing risk.
- As service environments change quickly, particularly in the non-government sector, referral pathways can quickly become outdated. Keeping referral pathways up to date and staff trained in their use requires ongoing attention from a designated staff member in each service named in the pathway.

Outcomes

The referral pathways documented through the project can be found in Appendix 7. While Hope's Room has ceased to operate as an organisation, Redcliffe Hospital Maternity Service is using the referral pathway to access Women's Health Queensland Wide's Midwife Check-In Service, which has resulted in an increase in cross-sectoral referrals to this program.

Prior to formalisation of referral pathways, consumers identified as requiring support following assessments, such as the Edinburgh Postnatal Depression Scale, would be referred to the Perinatal Mental Health Service for specialist counselling. Women who were not identified as requiring support through this screening process were provided with a list of services (including Midwife Check-in) they could access should they choose to do so. Responsibility for finding appropriate support and accessing assistance was therefore on the consumer, potentially creating a barrier for seeking help.

Through the project, Women's Health Queensland Wide has been able to formalise the referral process to their Midwife Check-in service for consumers who did not meet the referral requirements for the Perinatal Mental Health Service, but would still benefit from receiving reassurance and guidance in adjusting to pregnancy/parenthood and to help reduce sense of isolation. As a result, up to three referrals a week are now made to the Midwife Check-in program from the Perinatal Mental Health Service.

Furthermore, as a result of the project, Women's Health Queensland Wide was invited to deliver an in-service to the Social Work Department at the Royal Brisbane and Women's Hospital. The department receive a number of perinatal referrals for women with complex needs including issues of domestic violence, isolation and anxiety/depression. Following the in-service, the social work team now make one to two referrals per week to the Midwife Check-in program and have established a clear referral pathway with the service.

Lasting Impact

It is a learning from the project that services seeking to provide more co-ordinated care for consumers should aim to document their referral pathways prior to commencing a new initiative like this one. It is very valuable to have a shared understanding across services of what each service offers and how referrals can/should be made.

Component 11

Local awareness-raising regarding emotional health and wellbeing in the perinatal period through professional networks, agency visits, partnerships and presentations

Overview of component

The Project Officer hosted by Women's Health Queensland Wide and the Project Co-ordinator hosted by Queensland Centre for Perinatal and Infant Mental Health undertook a systematic program of participation in professional networks, visits to agencies, partnership building and the delivery of presentations, with the aim of raising awareness about emotional health and wellbeing in the perinatal period, and strengthening interagency collaboration for supporting parents, infants and families.

Design of component

Consultation with the Redcliffe Hospital Social Work department identified a number of agencies which provide services to expectant and new parents birthing at Redcliffe Hospital. Further information about relevant networks and agencies was gathered in the process of undertaking the service mapping activity.

Decisions about participating in network meetings, visiting agencies and giving presentations were made through the Project Working Group and the management structures of the implementing agencies, Queensland Centre for Perinatal and Infant Mental Health and Women's Health Queensland Wide.

Delivery of component

Women's Health Queensland Wide and the Brisbane North PHN GP Liaison officer jointly visited 6 GP practices to raise awareness of perinatal mental health and the Midwife Check-In service. A referral form for this service has now been embedded in the Medical Objects software used by GP practices, which will greatly facilitate future referrals.

An article on perinatal mental health services was published in the September and October editions of Brisbane North PHN newsletter 'Network Link', distributed to approximately 290 practices and 1500 GPs in the Brisbane North catchment.

The following presentations were delivered:

- Women's Health Queensland Wide presented to the Deception Bay Child and Family Alliance meeting, 18/10/16, on emotional health in the perinatal period. Audience included 47 people from 30 organisations in the child and family sector from government and non-government, state and local government. This led to an invitation to present to a group of Caboolture Early Years Centre staff and Child Health nurses, with approximately 50 attendees.
- Women's Health Queensland Wide and QCPIMH presented on the Perinatal Mental Health and Wellness Project: Benefits for Families and the Community at the Show and Tell Conference hosted by the Moreton Bay Local Level Alliance, 29/11/16. Audience included approximately 90 attendees from organisations which support mental health and wellbeing of parents, infants and families.

- QCPIMH presented 'The Perinatal Mental Health and Wellness Project: A Cross-Sectoral Collaboration' at the Mental Health Professionals Network on 25/05/17. Audience included approximately 30 mental health professionals.
- QCPIMH and Redcliffe Hospital Maternity Services presented 'The Perinatal Mental Health and Wellness Project' to the Royal Brisbane and Women's Hospital Birth Working Group on 22/11/2016. Audience included five senior managers in the first instance. The presenters were then invited back on 12/12/2016 to present again to 9 staff including the psychiatry liaison nurse and Perinatal Mental Health Service Team Leader.
- QCPIMH and Hope's Room presented 'The Perinatal Mental Health and Wellness Project' at the Statewide Maternity and Neonatal Clinical Network 14th Annual Forum, 25/11/16.

Challenges

- Time involved in setting up agency visits and organising participation in networks

Outcomes

- Greater awareness among NGO sector agencies regarding the importance of emotional health and wellbeing in the perinatal period
- Increased awareness across sectors of agencies, services and resources available to support expectant and new parents
- Women's Health Queensland Wide has seen a sustained increase in referrals to the Midwife Check-In program and requests for resources
- Women's Health Queensland Wide has been invited to present regularly on sexuality and healthy relationships within the Glugor Young Parent Program
- Activity contributed to service mapping
- Activity enabled the dissemination of formalised referral pathways, to assist agencies to appropriately refer expectant and new parents experiencing or at risk of experiencing symptoms of perinatal mental health issues
- Activity resulted in stronger relationships among participating organisations, in particular Women's Health Queensland Wide, QCPIMH, First5Forever, Child and Youth Community Health, Brisbane North PHN, GPs, practice nurses, Neighbourhood Centres, and YourTown.

Lasting Impact

- At a local level, the activity has increased awareness of the importance of emotional health and wellbeing in the perinatal period across sectors, and has increased inter-agency awareness particularly across the public-NGO interface.
- Maintaining new links among organisations will require ongoing efforts on the part of these organisations, but will be facilitated by systemic changes, particularly the embedding of the Women's Health Queensland Wide referral form in the Medical Objects software.
- A project recommendation is to establish an annual Brisbane North Perinatal Mental Health Forum involving public health services, NGO organisations and GP practices, to deliver clinical education regarding screening for and management of perinatal mental illness.
- At a statewide level, this activity could be replicated in other sites seeking to implement a similar model collaborative model for mental health promotion, prevention and early intervention in the perinatal period.

Component 12

Dissemination of project learnings

Overview of component

From the inception of the project, it was planned to disseminate project learnings widely, for the benefit of other sites within Queensland and elsewhere. Channels for disseminating project learnings beyond local networks include journal publications and conference presentations.

Development of component

Project staff involved in delivering Transition to Parenthood and peer support groups collaborated on the preparation of journal articles and conference presentations. An approvals process was developed and endorsed by the Steering Committee, and this process will continue to be used until the completion of the project components funded by the Statewide Maternity and Neonatal Clinical Network, Clinical Excellence Division.

Abstracts proposed for submission to conferences are first submitted to the Steering Committee for approval. Once approved, the abstract is submitted to the conference. If the abstract is accepted by the conference organisers, the relevant staff members develop the presentation and submit it to the Steering Committee for approval. The Steering Committee receives a verbal report following the presentation, regarding audience numbers, reception, and whether any follow-up actions or opportunities have resulted from the presentation.

Papers proposed for submission to journals will similarly be submitted for Steering Committee approval prior to being submitted to journals.

Delivery of component

Within the timeframe of the project, it has not been possible to develop journal articles to the stage of submission and acceptance. However, project staff have delivered the following presentations to international conferences:

- 'Getting the Message Out There: Working in Partnership to Enhance Perinatal Mental Health and Wellness' and
- 'Getting the Message Out There: Midwives Shared Practice Experiences' 31st International Confederation of Midwives Congress, Toronto, Canada, 18-22 June 2017
- 'Many Doors, Many Rooms: A Partnership Approach to Perinatal Mental Health and Wellness' Recovered Futures: Asia Pacific International Mental Health Conference, Brisbane, Australia, 24-26 October 2016

Project staff have delivered the following presentation to a national conference:

- 'Emotional Preparation for Parenthood: Tools and Strategies for Dads' Childbirth and Parenting Educators of Australia Biennial National Conference, Adelaide, Australia, 12-14 October 2016

Project staff have submitted abstracts to the following conferences:

- 'The Perinatal Mental Health and Wellness Project: An Innovative Cross Sectoral Collaboration' Australian College of Midwives State Conference: Midwife Life, My Life, Brisbane, Australia, 09/09/17
- 'Symposium – The Perinatal Mental Health and Wellness Project: A Cross-Sectoral Collaboration' Australasian Marcé Society for Perinatal Mental Health 2017 Conference, Brisbane, Australia, 26-28 October 2017

Challenges

Participating in national and international conferences requires an investment of time and resources. This can be more challenging for non-government organisations including peer-led services, which tend to be smaller and have less access to funding for conference participation than government organisations.

Outcomes

Project learnings have been disseminated to a broad cross-sectoral and multi-disciplinary audience, at local, state-wide, national and international levels.

Lasting Impact

It is envisioned that the dissemination of project learnings through prestigious professional conferences and journals will help stimulate dialogue among professionals and organisations working with parents in the perinatal period, about the value of cross-sectoral collaboration, in particular the contribution of lived experience expertise. In the long term, it is hoped that these insights will help to strengthen cross-sectoral collaboration within service systems that support perinatal mental health and wellbeing.

RECOMMENDATIONS

Supporting and protecting the mental health and emotional wellbeing of expectant and new parents not only benefits the parents but has lifelong benefits for the infant, reducing demand for social and health services across the lifespan. The following Recommendations are predicated on the understanding that mental health promotion, prevention and early intervention should be part of the model of service for maternity services.

The following Recommendations are for public maternity services seeking to implement an initiative similar to the Perinatal Mental Health and Wellness Project, incorporating some or all aspects of:

- the Transition to Parenthood program (antenatal and postnatal education)
- peer support groups for expectant and new parents experiencing perinatal mental health challenges
- strengthened referral pathways and linkages between the maternity service and other government services, non-government services, and the mental health peer-led sector

The Recommendations have been formulated based on the evaluation of the Perinatal Mental Health and Wellness Project.

The Perinatal Mental Health and Wellness Project aimed to increase the focus on mental health and emotional wellbeing for parents and their infants in the perinatal period. This has not traditionally been a strongly acknowledged component of care in maternity services. Questions were raised throughout the project regarding the extent to which mental health professionals and mental health peer workers should play a role in the delivery of antenatal education for a 'universal' population.

The experience of the project has shown that creating a safe space where talking about emotional wellbeing is encouraged may raise many emotional issues for both participants and educators. Participants shared experiences of trauma, grief and loss, and mental illness, in the session and privately with educators. Educators also found the session content resonating with their own experience. Processing these experiences and accessing appropriate supports proved beneficial for participants and educators, which highlights the project's effectiveness in achieving its early intervention goals. Sites seeking to implement a similar initiative should be clear and open about clinical governance for the initiative, and about the pathways available routinely and on an ad hoc basis for participants and educators to access additional support when needed.

The project highlighted the importance of service readiness within the maternity service for deeper engagement with the emotional health and wellbeing of mothers and their partners and families. The project was innovative in the following respects:

- its emphasis on mental health and wellbeing in the context of the maternity service
- its strongly collaborative cross-sectoral approach
- the involvement of mental health peer workers in the delivery of a birth and parenting education program
- the addition of a postnatal education session to complement the antenatal program
- the active inclusion of fathers, partners and support people within the compass of the mother's and baby's wellbeing

Each of these elements may represent a significant shift of emphasis for a maternity service, and may require systematic change management to implement.

The project employed a collaborative cross-sector model for mental health promotion, prevention and early intervention in the perinatal period, which was shown to:

- enhance parents' experience of being emotionally and practically supported in pregnancy and early parenthood
- improve parents' social connectedness with other new parents and with community supports
- improve midwives' awareness and understanding of perinatal and infant mental health, and of father-inclusive practice
- help develop the skills and confidence of midwives and non-government staff to talk with expectant and new parents about mental health and emotional wellbeing
- increase understanding of health consumer participation in health service delivery, including peer work, among midwives and non-government partners
- improve cross-agency awareness and understanding of what each agency can offer expectant and new parents, including midwives' understanding of local non-government services and NGO staff's understanding of available clinical services
- potentially increase the rate of referral from maternity services to perinatal mental health services, child health services, peer-led services, and non-government services that support emotional wellbeing in the perinatal period; and from peer-led and non-government services to child health, perinatal mental health, peer support groups, and other non-government services

While establishing an initiative like this project is resource-intensive, it is likely that similar initiatives in other sites will yield similar benefits.

It is recognised that many maternity services are moving away from face-to-face delivery of birth and parenting education. The overwhelming feedback received from participants in the project is that face-to-face antenatal education is valued, particularly for the following aspects:

- it provides an opportunity for parents to attend as a couple, receiving the same information at the same time in a way that encourages them to discuss it together
- it supports parents to connect with others living in the same area who will have children the same age
- the availability of midwives, peer workers and other staff provides an opportunity to ask questions and feel more personally supported on the journey of pregnancy and early parenthood

Educators reflected that parents would be less likely to engage productively with the material on mental health and emotional wellbeing, in particular, if it were available only in a depersonalised context like print resources or an online presentation.

Key Recommendations

1. Public maternity services should consider implementing a collaborative cross-sector model for mental health promotion, prevention and early intervention in the perinatal period.
2. People with a lived experience of perinatal mental illness and recovery can provide a valuable contribution to the work of mental health promotion, prevention and early intervention in the perinatal period, both through contributing to universal psychoeducation for parents (antenatally and postnatally), and by conducting mental health peer support groups for parents wishing to access this form of support.

The following recommendations are intended to help services assess the benefits of implementing an initiative similar to this project; to evaluate the extent to which their service is ready to implement such an initiative; and to consider key factors that have been highlighted through the experience of the project.

1. Governance

1.1 A Project Plan should be created, articulating all aspects of the proposed initiative. This should be formally approved by all relevant levels of health service management prior to the implementation of the initiative.

1.2 It is vital that all levels of management understand what the initiative involves, including resource implications and the requirements of cross-sectoral collaboration, and acknowledge the governance responsibilities that sit with the health service as the healthcare provider.

1.3 The maternity service holds clinical governance for the initiative and clinical responsibility for the participants, and this should be made clear to participants, staff and collaborating organisations. A midwife should be the lead educator for the Transition to Parenthood program, with input from other health professionals, non-government organisations and peer workers.

2. Collaboration

2.1 The maternity service should identify a key staff member to take on the role of Co-ordinator, engaging non-government services in the initiative and co-ordinating the collaborative effort.

2.2 Where possible, face-to-face introductions should occur ahead of the initiative. It is beneficial for managers of the maternity service to meet managers of the non-government and peer-led services collaborating in the initiative, and for midwives and other maternity services staff (not just educators) to meet the non-government staff and peer workers who will be involved in the initiative. Joint training sessions may be of assistance in building relationships among front-line workers across sectors, including the clinicians of various disciplines, peer workers, and non-government staff.

2.3 Contractual agreements should be signed with all organisations involved in delivering the initiative. This may include other public health services, primary health networks, non-government services and peer-led services.

2.4 The roles and responsibilities, accountability and reporting lines for every staff member and partner organisation involved in the initiative must be clearly articulated and communicated. While the Perinatal Mental Health and Wellness Project has produced manuals and publications to assist this process, details will need to be negotiated and agreed at the local level.

2.5 Processes should be established to help managers and front-line staff in each collaborating organisation to understand the role and scope of each organisation in supporting the mental health and wellbeing of expectant and new parents, their infants and families. Roles within the initiative will be shaped by the aims, activities and capacities of the collaborating organisations.

2.6 Public maternity services should seek the assistance of PHNs to engage local GPs in the initiative, with a particular focus on communication with other local services and existing referral pathways for families.

3. Peer Work Components

3.1 All levels of staff responsible for implementing the initiative, from executive management to midwives and other frontline staff, should be appropriately oriented to mental health peer work and the specific model of peer work to be implemented. This orientation should be delivered by an experienced peer worker in partnership with the site coordinator. The Peer Work Hub provides tools to assist healthcare services assess their level of 'cultural readiness' for engaging mental health peer workers in service delivery (The Peer Work Hub, 2017). It is recommended that health services without prior experience of employing a mental health lived experience workforce access training in understanding and implementing mental health peer work. Four training manuals for peer workers produced by the project can also be used to provide a foundational understanding for health service managers and workers.

3.2 The model for peer work within the initiative must be clearly articulated and understood by all parties including health service management, clinicians, non-government partners, peer workers, supervisors and mentors involved in the project. This includes clear roles and responsibilities for peer workers, and with defined boundaries for what peer workers do and don't do.

3.3 At least three models for employing peer workers within public health services are current in Queensland:

- individual lived experience practitioner employed as a consultant
- paid role for a lived experience practitioner within the public health service
- peer-led organisation providing lived experience practitioner input on a contract basis

Regardless of the model used for employing peer workers, the human resources processes pertaining to the position must be clearly documented and used (e.g. recruitment, training, remuneration, workplace health and safety, industrial relations, insurances, supervision and support).

3.4 An appropriate number of peer workers should be trained and oriented to participate in the program, to enable cover for sickness, absence or leave. The project involved two peer workers in each Emotional Preparation for Parenthood session and one in each Postnatal Connections session, and peer support groups ran with a facilitator and co-facilitator. It is recommended that a pool of at least four peer workers and preferably six is required to sustain this level of involvement over the course of twelve months, if Transition to Parenthood is being run regularly and a single peer support group is ongoing.

3.5 Lived experience is not the only area of expertise required by peer workers within the model developed by the project. Skills required in the role of educator include:

- public speaking
- delivering education as a member of a team
- telling stories of lived experience
- responding appropriately to approaches by individual participants, including knowing when and how to link the participant with clinical support

Skills required in the role of peer support group facilitator include:

- group facilitation
- understanding and managing group dynamics

- negotiating the 'safe space', including the limits of confidentiality
- active listening, showing empathy and building trust
- knowing when and how to refer a participant for clinical services

It is recommended that, in addition to these foundational skills, peer workers:

- attain Mental Health First Aid certification
- work through the four training manuals produced by the project
- consider undertaking formal accredited training in peer work such as the Certificate IV in Mental Health Peer Work

3.6 Like clinicians, peer workers in the area of mental health and emotional wellbeing require regular reflective space in which to process their experiences with participants and other staff, in order to support and improve their practice for sustainability. It is recommended that peer workers are supported through three formal mechanisms:

- line management/ business processes support (depending on model of employment)
- reflective sessions with a mental health clinician (can be provided in the form of 'group supervision' for a team of peer workers)
- mentorship by an experienced peer worker with understanding of both the work and the broader mental health peer workforce

3.7 The model for peer support groups used in and recommended by the project is an open-ended, ongoing weekly group where members choose what to discuss from week to week rather than following a structured program. The group is open to new members, subject to a process of preparing the existing group for new members. More detail regarding the peer support group model can be found in the project's reports and outputs.

4. Referral Pathways

4.1 Implementing sites need clearly documented referral pathways that are applicable to all individuals and their families during the perinatal period, irrespective of mental health status. These referral pathways should be incorporated into a Communication Plan, and endorsed by all relevant levels of health service management and by all organisations included in the referral pathway.

4.2 Peer support groups need clearly documented processes of referral to ensure individuals who need support for their emotional health and wellbeing can access services in a timely manner.

4.3 All relevant frontline staff, including all midwives (not only those involved in delivering antenatal/postnatal education) should be trained in how to use the referral pathways, should an expectant or new parent, infant or family be identified as requiring additional mental health support.

4.4 All relevant staff of the healthcare service should be familiar with the Clinical practice guidelines for depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period. A guideline for primary care health professionals, (2011) (update to be released late 2017), and application of these to local referral pathways and services.

4.5 A local process should be developed, documented and communicated to all relevant staff, for families identified as requiring support for their mental health or emotional wellbeing following a Transition to Parenthood session. The process should incorporate different levels of urgency of referral, as assessed through the midwife educator's clinical judgement.

4.6 The discharge process from maternity services should include the provision of information on mental health and emotional wellbeing for all mothers, including a process for checking that the mother has understood the information and feels empowered to contact local mental health support services should the need arise.

5. Program/ Model Content and Delivery

5.1 Sites seeking to use the Transition to Parenthood program should ideally implement the program in its entirety, including all topics and learning objectives from both Emotional Preparation for Parenthood and Postnatal Connections.

5.2 Where it is not possible for the appropriate service to attend Transition to Parenthood sessions to deliver a content area, these segments may be provided as video clips and accompanying slides/ print resources, with the content facilitated by the midwife educator. Such segments may include lived experience stories and role-plays, child health information, and information from non-government partners.

5.3 Transition to Parenthood should be led by a midwife educator, preferably the same educator for both Emotional Preparation for Parenthood and Postnatal Connections, and ideally the same educator throughout the program of birth and parenting education for each cohort. This allows the participants to build trust and rapport with the midwife educator, so they are more likely to ask questions and seek support if required for their emotional wellbeing.

5.4 Transition to Parenthood is ideally delivered by at least one clinical staff member in addition to the midwife educator and available non-government partners. Appropriate clinicians may include another midwife, social worker or perinatal mental health staff member. This additional clinician can facilitate referral pathways during and after the session, and help support participants and other facilitators who might become triggered throughout the session. At the least, clinical support should be available to be called on (for example, through the hospital Social Work department) as required to ensure an environment of safe sharing for participants and educators.

5.5 Inclusion of lived experience as a field of professional expertise involved in presenting antenatal and postnatal education sessions was highly valued by participants and clinical staff, and is considered a key element of the model. One to two stories of lived experience should be told in the Emotional Preparation for Parenthood session by lived experience practitioners, complementing the clinical information provided by clinician-educators, as outlined in the program manual.

5.6 Where no lived experience practitioner is available to present in the Emotional Preparation to Parenthood session, a video story may be used. The midwife educator should ensure the video is sensitively introduced, and allow time for discussion of the content afterwards.

5.7 Care should be taken to clearly introduce to the participants each member of the education team and their role. It is important that participants understand the difference between clinical and non-clinical staff, which agency each educator represents, and what each agency offers. Each educator should take care that their contribution within the session conforms to the scope of their professional role.

5.8 Since the content of the Emotional Preparation to Parenthood session is emotionally sensitive and potentially triggering, the timing of this session within a program of antenatal education is important. The session should not be either the first or the last session within the program. Time should be allowed for participants to build a relationship with the midwife educator before the EPP content is covered, and time should be allowed following this content for the midwife to monitor participants' processing of the information and check in with them if indicated.

5.9 It is important to create space for participants to connect with one another in the EPP session as well as in the Postnatal Connections session. The use of introductory activities, group discussions and participatory exercises assists social connection, and staff should actively support participants to meet each other before the session and during the break. When possible, it may be beneficial to allow extra 'socialising' time following the session.

5.10 Print resources such as the Act Belong Commit brochure, posters and hand-outs play an important role in encouraging expectant and new parents to think about emotional wellbeing, retain their learnings from the Transition to Parenthood program, and discuss their needs and concerns with maternity services staff. It is important to allocate an adequate budget for the ongoing production and dissemination of these resources.

6. Workforce Development

6.1 Midwives require adequate preparation time, including training, before beginning to lead a Transition to Parenthood program. This training and preparation time must be factored into their rostering and remuneration.

6.2 A model of reflective supervision, such as is mandatory for allied health staff, should be incorporated to provide sustainable reflective practice for midwives, particularly those involved in delivering Transition to Parenthood.

6.3 A formal debriefing time for the team delivering Transition to Parenthood sessions should be allocated immediately following each session. An appropriate staff member (e.g. Emergency Department social worker) should be present or on-call to support any member of the education team requiring further emotional support.

6.4 All midwives, members of the Transition to Parenthood education team, and other relevant staff, should receive training on responding to expectant or new parents who are emotionally distressed or concerned. Training and resources can be accessed through universities, the Australian College of Midwives, *beyondblue*, PANDA and the Queensland Centre for Perinatal and Infant Mental Health, among others.

6.5 At a state-wide level it would be desirable to ensure that GPs and other healthcare providers are familiar with the Clinical Practice Guidelines for depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period. An updated version of the Guidelines, including medication management, is due for release in late October 2017.

6.6 Services should negotiate to have their referral forms embedded within GP referral software systems, for ease of referral.

7. Quality Management

7.1 Standardised reporting measures should be established to enable the measurement of change in quantitative indicators. Collection of baseline and post-program data provides a foundation for quality improvement processes and the building of an evidence base for program effectiveness. Data collection should include:

- the number of participants at each Emotional Preparation for Parenthood and Postnatal Connections session, including partners and support people
- the model of care the participant is engaged in within the Hospital and Health Service

- gestational age at which participants access the Emotional Preparation for Parenthood session, and age of baby when the Postnatal Connections session is accessed
- number of referrals from maternity service to perinatal mental health service (ongoing)
- number of referrals among services engaged in the initiative (ongoing)
- post-program feedback from participants for the purpose of local quality improvement and professional development of facilitators (ongoing)

7.2 At a state-wide level, it is desirable to evaluate the model developed through the Perinatal Mental Health and Wellbeing Project in other sites.

8. Communication

8.1 A formal Communication Strategy should be developed and endorsed prior to the initiative, including all stakeholders and channels. Stakeholders may include:

- Hospital and Health Service management
- maternity services management
- maternity services staff
- medical staff
- General Practitioners
- Primary Health Networks (PHNs)
- administrative staff
- non-government organisations
- peer-led services and peer workers
- Statewide Consumer and Carer Workforce Network
- expectant and new parents
- scholars and researchers
- health workers, non-government organisations and peer workers in other places
- general public

8.2 It is particularly important to include administrative staff and medical staff in the Communication Strategy, to enable systems change (e.g. encouraging families to book into birth and parenting sessions, discussing emotional health and wellbeing from the first visit to the antenatal clinic)

8.3 Key messages from the Transition to Parenthood program at local and statewide levels should be disseminated as appropriate for the benefit of wider audiences through social, print and electronic media; conference presentations and journal articles; training programs and university curricula.

8.4 Maternity services should consider how the Birth and Parenting Program is marketed to families. The education sessions are not just for first-time parents and are still relevant for parents who already have children.

REFERENCES

- Allison, L. (2006). *A national approach to mental health*. Canberra, A.C.T.: Select Committee on Mental Health. Available at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Former_Committees/mentalhealth/report/index.
- Australian Health Ministers' Advisory Council (2014). *Clinical Practice Guidelines Antenatal Care — Module II*. Canberra, ACT: Australian Government Department of Health.
- Bayer, J., Hiscock, H., Scalzo, K., Mathers, M., McDonald, M., Morris, A., Birdseye, J. and Wake, M. (2009). Systematic Review of Preventive Interventions for Children's Mental Health: What Would Work in Australian Contexts?. *Australian & New Zealand Journal of Psychiatry*, 43(8), pp.695-710.
- Beyond Baby Blues. (n.d.). [ebook] Hawthorne, VIC: Beyond Blue, pp.1 - 6. Available at: <https://www.bspg.com.au/dam/bsg/product?client=BEYONDBLUE&type=file&prodid=BL/0967> [Accessed 14 Jun. 2017].
- Beyondblue.org.au. (2011). *Matrix Framework of PERINATAL DEPRESSION and RELATED DISORDERS*. [online] Available at: <https://www.beyondblue.org.au/docs/default-source/8.-perinatal-documents/bw0118-training-matrix-for-perinatal-mental-health-skills-and-knowledge.pdf?sfvrsn=2> [Accessed 15 Jun. 2017].
- Buist, A., Austin, M., Hayes, B., Speelman, C., Bilszta, J., Gemmill, A., Brooks, J., Ellwood, D. and Milgrom, J. (2008). Postnatal Mental Health of Women Giving Birth in Australia 2002–2004: Findings from the Beyondblue National Postnatal Depression Program. *Australian & New Zealand Journal of Psychiatry*, 42(1), pp.66-73.
- Burman, E. (2016). *Deconstructing developmental psychology*. 3rd ed. London, UK: Taylor & Francis.
- Center on the Developing Child (2007). *The Impact of Early Adversity on Child Development* (InBrief). Retrieved from www.developingchild.harvard.edu.
- Child Family Community Australia. (2017). *Transition to parenthood - what works?*. [online] Available at: <https://aifs.gov.au/cfca/publications/supporting-couples-across-transition-parenthood/transition-parenthood-what-works> [Accessed 15 Jun. 2017].
- Clinical practice guidelines for depression and related disorders – anxiety, bipolar disorder and puerperal psychosis – in the perinatal period. A guideline for primary care health professionals. (2011). [ebook] Melbourne, VIC: beyondblue: the national depression initiative. Available at: <http://cope.org.au/health-professionals-3/clinical-practice-guidelines/> [Accessed 14 Jun. 2017].
- Deloitte Access Economics (2012). *The cost of perinatal depression in Australia*. [online] Post and Antenatal Depression Association. Available at: http://www.panda.org.au/images/stories/PDFs/PANDA_Exec_Summ_Deloitte_Web.pdf [Accessed 15 Jun. 2017].
- Hunter Institute of Mental Health (2015). *Prevention First: A Prevention and Promotion Framework for Mental Health*. [online] Newcastle NSW: Hunter Institute of Mental Health. Available at: http://www.himh.org.au/__data/assets/pdf_file/0013/11830/PreventionFirstFramework.pdf [Accessed 15 Jun. 2017].
- Keyes, C. (2017). Promoting and Protecting Positive Mental Health: Early and Often Throughout the Lifespan. In: C. Keyes, ed., *Mental Well-Being: International Contributions to the Study of Positive Mental Health*. Dordrecht: Springer, pp.3 - 28.

- Lawrence, D., Johnson, S., Hafekost, J., Boterhoven de Haan, K., Sawyer, M., Ainley, J. and Zubrick, S. (2015). *The mental health of children and adolescents*. Canberra: Department of Health.
- Prior, M., Sanson, A., Smart, D. and Oberklaid, F. (2000). *Pathways from infancy to adolescence: Australian Temperament Project 1983-2000*. Research Report No. 4. [online] Australian Institute of Family Studies. Available at: <https://aifs.gov.au/publications/pathways-infancy-adolescence> [Accessed 15 Jun. 2017].
- Queensland Mental Health Commission (2014). *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019*. [online] Brisbane QLD: Queensland Government. Available at: https://www.qmhc.qld.gov.au/wp-content/uploads/2014/10/QMHC-Mental-Health-Drug-and-Alcohol-Strategic-Plan-2014-2019_web.pdf [Accessed 15 Jun. 2017].
- Queensland Mental Health Commission (2015). *Early Action: Queensland Mental Health Promotion, Prevention and Early Intervention Action Plan 2015-17*. Brisbane, QLD: Queensland Mental Health Commission. Retrieved from: <https://cabinet.qld.gov.au/documents/2015/Sep/MentalHealthPlan/Attachments/Plan.PDF>
- Robinson, E., Rodgers, B. and Butterworth, P. (2008). Family relationships and mental illness : impacts and service responses. *AFRC issues*, [online] (4). Available at: <https://aifs.gov.au/cfca/sites/default/files/publication-documents/issues4.pdf>.
- Stein, A., Pearson, R., Goodman, S., Rapa, E., Rahman, A., McCallum, M., Howard, L. and Pariante, C. (2014). Effects of perinatal mental disorders on the fetus and child. *The Lancet*, 384(9956), pp.1800-1819.
- The partnerships analysis tool. (2016). 2nd ed. [ebook] Melbourne VIC: Victorian Government. Available at: https://www.vichealth.vic.gov.au/-/media/ResourceCentre/PublicationsandResources/General/VH_Partnerships-Analysis-Tool_web.pdf [Accessed 15 Jun. 2017].
- The Peer Work Hub. (2017). *Assess your readiness*. [online] Available at: <http://peerworkhub.com.au/starting-a-peer-workforce/assess-your-readiness/> [Accessed 15 Jun. 2017].
- Westerhof, G. and Keyes, C. (2009). Mental Illness and Mental Health: The Two Continua Model Across the Lifespan. *Journal of Adult Development*, 17(2), pp.110-119.
- WHO International Maternal mental health*. [online] Available at: http://www.who.int/mental_health/maternal-child/maternal_mental_health/en/ [Accessed 14 Jun. 2017].
- WHQW. (2016). *The deadly mum's guide to feeling great booklet | Women's Health Queensland Wide*. [online] Available at: <http://womhealth.org.au/pregnancy-and-parenting/the-deadly-mums-guide-to-feeling-great-booklet> [Accessed 15 Jun. 2017].

APPENDICES

Appendix 1: Financial Report

**Queensland Centre for Perinatal and Infant Mental Health
Perinatal Mental Health and Wellness Project
18th January 2015 to 31st March 2017
Funded by Queensland Mental Health Commission**

Income	Actuals
Queensland Mental Health Commission	\$82,153
TOTAL INCOME	\$82,153
Expenses	
Peer Support Work – Hope’s Room Limited/ WHQW Agreement	\$22,800
Peer Support Work – Hope’s Room Limited/ QCPIMH Contract	\$49,664
Peer Worker Management – Queensland Centre for Perinatal and Infant Mental Health	\$9,689
TOTAL EXPENSES	\$82,153
Profit/Loss	\$0

**Women’s Health Queensland Wide Collaborative Work
Perinatal Mental Health and Wellness Project
18th January 2015 to 31st March 2017
Funded by Queensland Mental Health Commission**

Income	Actuals
Queensland Mental Health Commission	\$82,910
TOTAL INCOME	\$82,910
Expenses	
Wages and on cost	\$71,905
Worker cost (recruitment and training)	\$1,600
Collaborative Service Delivery	\$5,355
Equipment Costs – Initial Setup	\$2,050
Operating Expenses	\$2,000
TOTAL EXPENSES	\$82,910
Profit/Loss	\$0

Appendix 2: Project Roles and Responsibilities	
Role	Responsibilities and Accountabilities
Statewide Maternity and Neonatal Clinical Network, Clinical Excellence Division, Department of Health	<ul style="list-style-type: none"> • Negotiate with the Department of Health to provide funding for 1 full-time Project Co-ordinator at HP5/NO7 for 2 years • Transfer funds to CHQ-HHS to enable hosting of the project • Retain intellectual property in reports and resources produced by the project • Oversee the project • Participate in the project Steering Committee
Children's Health Queensland Hospital and Health Service	<ul style="list-style-type: none"> • Establish/provide an HP5/NO7 position (1 FTE) for the Project Co-ordinator to occupy for the life of the project • Recruit and appoint an appropriately skilled person to the position • Facilitate transfer of funds by providing CARU (on behalf of the Statewide Maternity and Neonatal Clinical Network) with all required documentation • Assume financial responsibility for managing the budget associated with the Project Co-ordinator's employment • Provide logistical and specialist professional support to the Project Co-ordinator, including office accommodation, access to telecommunications and use of vehicles • Host project resources on the website of the Queensland Centre for Perinatal and Infant Mental Health, with appropriate access and links • Assist in promotion of the project and its outcomes through existing networks • Report to Statewide Maternity and Neonatal Clinical Network as required under funding agreement • Report as required to Queensland Mental Health Commission as required under funding schedule • Participate in the project Steering Committee • Assume financial responsibility for managing funds provided by the Queensland Mental Health Commission to deliver the following: <ul style="list-style-type: none"> - Co-ordination of peer support workers to participate in the delivery of antenatal and postnatal education in Metro North Hospital and Health service over a period of 15 months. Content of the antenatal and postnatal education, and delivery methods, will be determined by the project Working Group and approved by the project Steering Committee

Appendix 2: Project Roles and Responsibilities

Role	Responsibilities and Accountabilities
	<ul style="list-style-type: none"> - Co-ordination of peer support workers to deliver ‘targeted’ peer support groups (for parents experiencing symptoms of perinatal mental health issues) in the Metro North catchment over a period of 12 months - Co-ordination of reflective sessions for peer support workers, to be provided by Metro North Perinatal Mental Health Service. The Metro North Perinatal Mental Health Service will be reimbursed at the following agreed rate: \$60 per hour for provision of two-hour sessions, once a month, for a group of up to eight (8) peer workers, for a period of 12 months from project commencement - Develop and document a safe and effective model for the involvement of peers with a lived experience of perinatal mental health recovery in antenatal and postnatal care for women and their infants and families. - Develop, in conjunction with peer workers and Department of Health personnel involved in peer workforce development within the public health system, the roles of Peer Educator and Peer Support Facilitator, for perinatal mental health and wellness. - Identify, develop and document what is required of a management function to manage service delivery by peers within a public health setting. Based on environmental scanning of consumer workforce practice in Australia and internationally.
Queensland Mental Health Commission	<ul style="list-style-type: none"> • Provide funding to enable the project components involving peer support workers • Provide funding to enable the project components involving the non-government sector • Participate in the Project Steering Committee
Project Co-ordinator (QCPIMH)	<ul style="list-style-type: none"> • Coordinate and support the development, implementation and evaluation of the Perinatal Mental Health and Wellness Project • Coordinate and support the development, use and evaluation of associated resources including induction manuals and training packages • Take responsibility for project evaluation and the reporting of outcomes • Work with project sponsors and stakeholders, specifically the Statewide Maternity & Neonatal Clinical Network, Queensland Mental Health Commission, Queensland Centre for Perinatal and Infant Mental Health, Women’s Health Queensland Wide Inc., Redcliffe Hospital Maternity Services

Appendix 2: Project Roles and Responsibilities

Role	Responsibilities and Accountabilities
	<p>and Metro North Perinatal Mental Health Service</p> <ul style="list-style-type: none"> • Convene the project Working Group, which will consist of representatives of the sponsors and stakeholders, and provide the Secretariat function • Work with project sponsors and stakeholder/partners to achieve the project objectives • Chair the project Working Group • Provide secretariat function for the project Steering Committee • Ensure progress reports including reports from the Working Group are escalated for consideration/ endorsement as required by the project Steering Committee • Seek direction and clarity to achieve project deliverables • Adapt project elements according to Working Group and Steering Committee feedback • Facilitate standardisation of peer support education • Contribute positively and flexibly to QCPIMH team functioning and culture
<p>Women's Health Queensland Wide Incorporated</p>	<ul style="list-style-type: none"> • Assume financial responsibility for managing the funds provided by the Queensland Mental Health Commission for implementation of the project • Actively contribute to the project planning process and project governance • In collaboration with project partners, develop referral pathways between perinatal and infant mental health services (clinical and support services) and the project • Recruit and appoint an appropriately skilled person to the position of Project Officer (see Role Description attached) • Report as required by Queensland Mental Health Commission • Participate in project Steering Committee
<p>Project Officer (Women's Health)</p>	<ul style="list-style-type: none"> • Contribute to development and delivery of health promotion components of antenatal and postnatal education • Explore and document non-government services for expecting and new parents in the Redcliffe Hospital catchment • Strengthen collaborative relationships and referral pathways among the non-government sector, public health services and peer services in the Redcliffe Hospital catchment

Appendix 2: Project Roles and Responsibilities

Role	Responsibilities and Accountabilities
	<ul style="list-style-type: none"> • Explore and document resources, skills and expertise required of the non-government sector state wide, should similar initiatives be implemented in other Queensland sites • In collaboration with the Project Co-ordinator, report recommendations for sustainability and transferability of the model being explored at Redcliffe • Participate in the project Working Group
Peer Support Workers	<ul style="list-style-type: none"> • Participate in the development and delivery of antenatal and postnatal education sessions focused on emotional wellbeing in the perinatal period, at Redcliffe Hospital Maternity Services • Encourage the development of self-managing 'universal' peer support groups (parent groups) among participants in antenatal education • Facilitate at least one 'targeted' peer support group which is available to participants from the antenatal and postnatal education sessions • In collaboration with Redcliffe Hospital Maternity Services, Metro North Perinatal Mental Health Service, QCPIMH and Women's Health Queensland Wide, work to improve the experience of parents seeking to access clinical and support services across the public, private and non-government sectors in the Redcliffe Hospital catchment area by providing information about available services to both parents and organisations, and helping strengthen referral pathways • Recruit and develop additional peer support workers to assist in delivery of these activities • Work with the Project Co-ordinator, QCPIMH and Consumer Consultant/ Peer Worker Coordinator to maximise the benefits of the pilot project for participants, staff, sponsors and stakeholders • Contribute to data collection for the purposes of project evaluation • Participate in project Working Group
Project Working Group	<ul style="list-style-type: none"> • Collaboratively develop the content and format of antenatal and postnatal sessions and targeted peer support groups, including resources to assist delivery • Provide input into the evaluation framework and tools • Deliver the project according to roles outlined in the Project Plan • Participate in project documentation and evaluation as

Appendix 2: Project Roles and Responsibilities

Role	Responsibilities and Accountabilities
	<p>required under the evaluation framework</p> <ul style="list-style-type: none"> • Ensure information on project progress is delivered in a timely fashion, to enable monthly status reports to the Steering Committee.
Project Steering Committee	<ul style="list-style-type: none"> • Monitor the project plan to ensure deliverables meet agreed timelines • Engage with clinicians, education providers, non-government organisations and consumers to: <ul style="list-style-type: none"> ○ promote the project ○ disseminate information about the project to colleagues, consumers and workers from other services ○ elicit and report relevant feedback from these interested parties, for the purpose of continuous quality improvement in the project • Evaluate tools, resources and other documents within agreed timeframes and provide feedback
Redcliffe Hospital Maternity Services	<ul style="list-style-type: none"> • Work with the Project Co-ordinator to provide regular opportunities, venues and staff to implement the project • Provide clinical governance for the project • Assist in the promotion of the project with relevant staff and consumers who are potential participants • Participate in the project Working Group and Steering Committee
Metro North Perinatal Mental Health Services	<ul style="list-style-type: none"> • Provide input into the development of the antenatal and postnatal education sessions (content and format) • Provide reflective supervision sessions for peer support workers as outlined in the Project Agreement • Participate in the project Steering Committee
The Child and Youth Community Health Service	<ul style="list-style-type: none"> • Provide input into the development of the antenatal and postnatal education sessions (content and format) • Remain involved with the project Working Group to provide advice about referral pathways into Child Health services

Appendix 3:

Transition to Parenthood Participant Evaluation Report

Background

The evaluation of the Transition to Parenthood Program is part of a larger study being conducted by the Queensland Centre for Perinatal and Infant Mental Health at Redcliffe Hospital.

The TtP program was delivered in the following format:

- Emotional Preparation for Parenthood (EPP) session for expectant parents, partners and support people, offered in two formats (Monday evening or Saturday morning) and two settings (hospital or community health)
- Postnatal Connections (PC) offered approximately 6-8 weeks after birth, delivered on a Saturday in a community health setting

Aim

The purpose of this report is to assess the effectiveness of the antenatal education sessions delivered at Redcliffe in achieving the participant learning objectives.

Learning Objectives

After attending the EPP Session, participants should:

1. Increase understanding of emotional health and wellbeing, in general and in the perinatal period ('wellness is not just an absence of illness')
2. Explore expectations of pregnancy, birth, parenting and relationships, with a view to reducing the 'gap' between expectations and reality in the perinatal period
3. Improve understanding of the biological, psychological, and social protective factors that can help support mental health and wellbeing
4. Improve understanding of the biological, psychological, and social risk factors that can challenge wellbeing and contribute to mental health issues
5. Raise awareness of the high prevalence of antenatal and postnatal depression and anxiety, among both mothers and fathers, and the potential negative impacts of these disorders on mothers, fathers, infants and families
6. Raise awareness of the signs and symptoms of antenatal and postnatal depression and anxiety, and of less common perinatal mental health issues such as psychosis
7. Raise awareness of the signs and symptoms of antenatal and postnatal depression and anxiety, and of less common perinatal mental health issues such as psychosis
8. Reduce stigma and misinformation regarding perinatal mental health issues
9. Improve awareness of where and how to seek supports, including treatment for perinatal mental health issues, and raise the confidence/ self-efficacy of parents to be able to seek timely support as needed for themselves or their partner
10. Improve participants' confidence and competence to provide supportive listening for a person experiencing challenges to emotional wellbeing or mental health

11. Improve participants' confidence and competence to provide supportive listening for a person experiencing challenges to emotional wellbeing or mental health

By the end of the Postnatal Connections session, participants will have:

- ✓ a consolidated awareness of the importance of mental health and emotional wellbeing in the perinatal period for parents, infants and families
- ✓ a basic understanding of the importance of early relationships for infant brain development and emotional wellbeing, and some specific ideas about how to nurture these relationships
- ✓ enhanced self-efficacy to connect with other parents for mutual social support
- ✓ more awareness of the supports available in the community, clinical and non-clinical, and how to access these
- ✓ a greater capacity to mobilise their own resources and supports

Session Outlines

The content of the sessions was evaluated at various points throughout the study and was regularly altered as per feedback received from both participants and facilitators. Despite the content and its delivery being altered slightly between sessions, the following session outlines were followed throughout the duration of the project:

Emotional Preparation for Parenthood

Section 1	Overview and Introduction Welcome and introductions; Group guidelines; Housekeeping; initial session activity
Section 2	What is Emotional Wellbeing? Introduction to emotional health and wellbeing; Group activity; Transition to parenthood and expectations; Infant attachment and mental health
Section 3	The Dual Continua Explanation of the Dual Continua; Perinatal Mental Health; Introduction to the Baby Blues
Section 4	Mental Illness and Statistics Group Activity; Definition of Mental Illness; Mental Illness Statistics
Section 5	Signs and Symptoms Group Activity
Section 6	Risk and Protective Factors Group Activity; Risk and Protective Factors
Section 7	Personal Stories Peer Workers share stories of lived experience
Section 8	Seeking, Accepting, and Providing Help Parenting Partners; Peer Role Plays
Section 9	Available Supports and Resources Overview of services available
Section 10	Reflections and Farewell Key messages recap; Whole group questions; Evaluation

Postnatal Connections

Section 1	Overview
Section 2	Introduction activity
Section 3	Transition and expectations
Section 4	Nobody's perfect
Section 5	Connecting with supports
Section 6	Supporting wellness
Section 7	Relationships grow brains
Section 8	Take home messages and evaluation
Section 9	Time to connect

Data Collection – EPP

Feedback from participants was collected at the end of the EPP session using a mixed-methods questionnaire collecting information on:

- Participant demographics
- Learnings from the session
- Positive outcomes experienced
- Negative outcomes experienced
- Intentions to maintain contact with other participants
- Intentions to join or form parenting groups
- Intentions to access specific services
- How the session could be improved
- Intentions to mention EPP session on social media
- Ability to notice concerns in both their own and their partner's emotional health and wellbeing

Data Collection – PC

Feedback from participants was collected at the end of the PNC session using a mixed-methods questionnaire collecting information on:

- Participant Demographics
- Reflection on learnings from EPP class
- Learnings from the ONC class
- Positive and negative outcomes experienced
- Intention to maintain connections with other participants
- Services accessed throughout the perinatal period
- Feedback and Recommendations
- Confidence in noticing problems in both their own and their partners Emotional Health and Wellbeing

Participant demographics

	Emotional Preparation for Parenthood Participants (n = 561)		Postnatal Connections Participants (n = 148)	
	Count	%	Count	%
Role				
Mother	299	53%	92	62%
Father/ Partner	241	43%	51	34%
Other Support Person	17	3%	4	3%
No Answer	4	1%	1	1%
Age				
Under 18 years	1	0%	0	0%
19-25 years	128	23%	31	21%
26-35 years	330	59%	87	59%
36-45 years	81	14%	26	18%
46-55 years	12	2%	3	2%
55+ years	5	1%	1	1%
No Answer	4	1%	0	0%
Number of Other Children				
0	241	43%	-	-
1	243	43%	-	-
2	25	4%	-	-
3+	18	3%	-	-
No Answer	34	6%	-	-
Attended session				
Alone	27	5%	26	18%
With Support Person/ Identified as Support Person	30	5%	112	76%
With Partner	497	89%	10	7%
No Answer	7	1%	0	0%

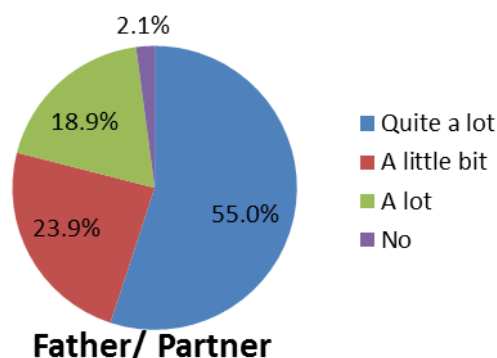
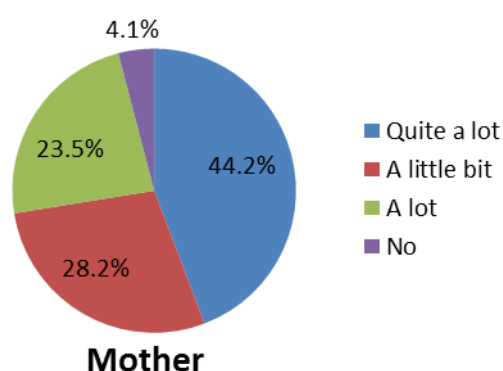
In total, 561 attendees provided feedback on the Emotional Preparation to Parenthood session. Of these, 299 were expectant mothers, 241 were expectant fathers or partners, 17 were other family members or support persons, and 4 did not identify their role. It became apparent in the analysis of the postnatal connections sessions that participants may have misinterpreted the survey question relating to how many children they have therefore it was difficult to determine results for this section postnatally.

Self-reported learning

Question:

Did you learn anything at today's Emotional Preparation for Parenthood session that you didn't know before?

	Mother		Father/ Partner		All Mothers and Fathers/Partners	
	Count	%	Count	%	Count	%
No	12	4.1	5	2.1	17	3.2
A little bit	83	28.2	57	23.9	140	26.3
Quite a lot	130	44.2	131	55.0	261	49.1
A lot	69	23.5	45	18.9	114	21.4
TOTAL	294	100	238	100	532	100.0



Overall, 96% of mothers and 98% of fathers/partners said they had learnt at least 'a little bit' as a result of attending the EPP session: 68% of mothers and 74% of fathers/partners said they had learnt 'quite a lot' to 'a lot'.

A number of themes were identifiable in participants' comments about what they had learnt through the EPP session.

- **Awareness of perinatal mental illness, understanding prevalence**

'I learnt a lot in relation to mental wellbeing, a lot of the time we aren't aware of these issues'

'I didn't know anything about it but now I am well informed'

'How common depression can be'

- **Signs and symptoms of perinatal mental illness**

'How to identify early signs of mental illness, and how to respond if necessary'

'How to identify anxiety and depression'

'Experiencing some signs/symptoms of anxiety and depression isn't a definite diagnosis you have a mental illness but recognising the signs means you can intervene'

- **Baby blues**

'Difference between baby blues and postnatal depression'

'The baby blues concept. Better understanding of mental illness and its link with pregnancy. How to be aware of it. How to help reduce the risk'

'Baby blues are normal, emotional wellness is important. Notice the signs'

- **Ways to support emotional wellbeing (e.g. diet, exercise, mindfulness)**

'How to identify anxiety/depression things to do to help prevent – exercise/ healthy eating etc.'

'Breathing and relaxation techniques'

'Emotional, physical health and wellbeing'

- **Importance of 'speaking up', seeking help if required**

'About depression/anxiety and how to deal with it and what support is out there (always ask for help if needed). Speak up'

'Communication and support is key and always out there. Don't blame yourself, you deserve the help to enjoy this journey'

'It's okay to ask for help and talk to someone even if you end up being alright'

'Not to be ashamed. It's okay to ask for help'

- **Where to seek help, reassurance that there is a great deal of support available**

'How much support is available'

'Where to get help. What is normal. Good to have my partner here so we are on the same page, there is an opportunity to get better'

'Where to go for support and ways to support others'

- **Monitoring and supporting partner's wellbeing**

'To watch and look after your partner'

'How to approach my wife if I am concerned'

'How to ask right questions if worried about partner'

'Differences between depression and anxiety, about mental illness and to actually observe and listen to my partner (or anyone) instead of saying "Everything will be okay" and just leaving it at that'

- **Normality of emotional challenges in perinatal period**

'It's okay not to feel 100% and to ask for help'

'That fears of birth and being a good mum is normal'

'It's okay to ask for help. Not to feel silly about feeling down'

'It's okay not to be perfect when parenting'

'yes it's okay to feel how you feel and talk about it'

'Normal emotions of becoming parents, and signs and symptoms that could become depression or anxiety'

- **You're not alone**

'You're not alone don't be afraid to speak'

'You're not the only mother/expectant mother going through it. Support – the importance of seeking/ talking to someone'

'You are not alone, and how things have changed by way of support to 30 years ago'

- **Infant mental health**

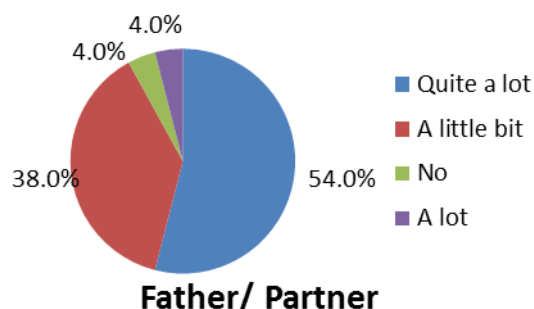
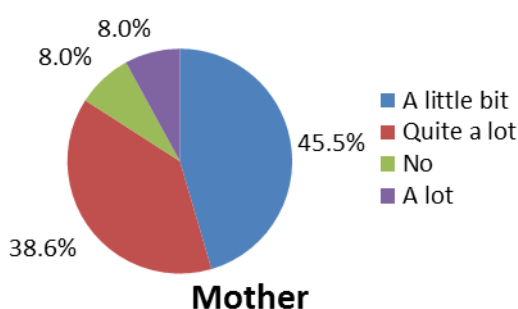
'I learnt that babies have infant wellbeing in the womb and when they are born'

'Infant depression'

Question:

Do you remember learning anything you didn't know before, at the EPP session you attended before your baby's birth?

	Mother		Father/ partner		All Mothers and Fathers/Partners	
	Count	%	Count	%	Count	%
No	7	8.0	2	4.0	9	6.5
A little bit	40	45.5	19	38.0	59	42.8
Quite a lot	34	38.6	27	54.0	61	44.2
A lot	7	8.0	2	4.0	9	6.5
TOTAL	88	100	50	100	138	100



At the Postnatal Connections session, participants were asked to reflect on their learnings from the antenatal Emotional Preparation to Parenthood session. Of the 88 mothers who completed questionnaires at this session, 92% remembered learning at least 'a little bit'. Of the 50 fathers and partners who completed questionnaires, 96% remembered learning at least 'a little bit'.

Participants were asked at the PC session how they had used their learnings from the EPP session. A number of themes emerged.

- **Awareness/preparation**

- 'Being aware of emotional preparation and contacts if needed'
- 'Expectations and reality – I remember this and don't let myself get disappointed'
- 'I was worried about my wife if she gets any emotional changes so the course was useful to see any possible change, fortunately nothing happened'
- 'It's amazing how much comes back when you need to call on it'

- **Communication with partner and other adults**

- 'Better communication with my husband and support friend, it's okay to say "I'm not fine"'
- 'Identifying emotional behaviours, being able to talk about everything'
- 'It was a great reminder to my husband and I to check in with each other regularly and also to take time for ourselves'
- 'Making sure I talk about how I'm feeling with my partner or mother'
- 'To give each other a break when needed and watch out for the other person's mental health'

- **Communication with baby**

'Engaging with my child even at such a young age'
'Keeping calm, calming baby'
'Baby cues, understanding what baby needs'

- **Normality of emotional challenges in perinatal period**

'By reading a lot of the info we were given at the antenatal classes it's been a great resource to go to when times get a little tough. It's normal!'
'Comparing people's examples with our circumstances helps to manage with the things and realise that everyone challenges the same problems and we will overcome them in the future'
'Emotions are normal and roller coasting feeling is okay'

- **Baby blues**

'Knowing that the baby blues were normal helped me through the feeling'

- **Connection**

'Connected with other mums'
'Ensuring we stayed in contact with friends and family'
'Join groups with other parents and library'

- **Mindfulness, self-care and emotional wellness**

'I've been less hard on myself'
'Taking time for me'
'Learnt to be more flexible'
'Think before I react. Chill out in stressful situations especially when tired'
'Enjoying the moment'

- **Reassurance/reduced anxiety**

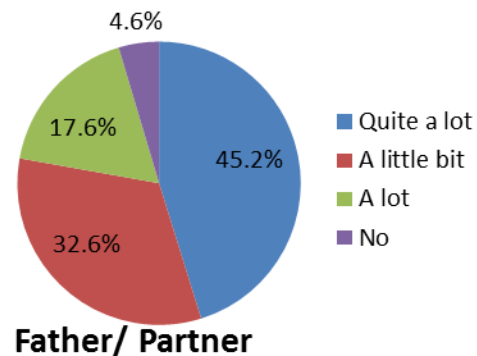
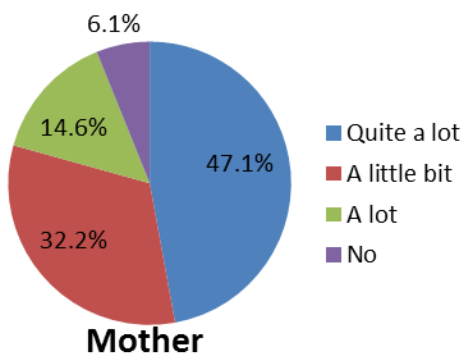
'Just having the knowledge of what I'm feeling and the process. Knowing it's okay to ask for help'
'It's good to know that the support is available'

Self-reported benefits

Question:

Did the session have any benefits for you?

	Mother		Father/ Partner		All Mothers and Fathers/Partners	
	Count	%	Count	%	Count	%
No	18	6.1	11	4.6	29	5.4
A little bit	95	32.2	78	32.6	173	32.4
Quite a lot	139	47.1	108	45.2	247	46.3
A lot	43	14.6	42	17.6	85	15.9
TOTAL	295	100	239	100	534	100



When asked whether the EPP session had benefited them, 94% of mothers and 95% of fathers and partners said yes. Of the total sample, 62% of mothers and 63% of fathers/partners said they had experienced 'quite a lot' to 'a lot' of benefit.

While many participants reiterated themes they had mentioned when asked about their learnings, some other themes also emerged as 'benefits' of the EPP session.

- **Awareness/ preparation**

'Caught my attention for potential issues'
 'Didn't know anything, now I know a lot'
 'Feeling more prepared for rollercoaster'
 'Feeling less overwhelmed'
 'Give me an insight to what to expect'
 'General awareness of emotional preparation'
 'Made me think about the type of concerns I have with pregnancy/birth'

- **Mental health literacy**

'I feel a lot more informed on mental health'
 'I feel more educated'
 'It helped me learn about stuff I didn't know or understand'
 'Knowing more about mental health'
 'Understanding some of my own issues with other children at home'

- **Insight**

'Shed light on my own struggles and thoughts during pregnancy'
'Supported thoughts and ideas I already have'
'Opened my eyes to reality'

- **Confidence**

'Being more confident to what to expect'
'Being prepared – expectation vs reality'
'Brought confidence'
'Gave me confidence in identifying issues and awareness through which we can ask for help'
'Gives the confidence to act on signs or symptoms, do the right thing'
'I feel like I know what to do'
'I feel confident that I know how to access support if challenges arise'
'Instilled confidence in myself'

- **Reduce fear and worry**

'I feel less worried about everything'
'I'm not scared of asking for help again'
'To remove worries regarding pregnancy'

- **Reduce stigma**

'It's okay if it happens to you'
'The ladies' [peer workers'] stories'
'That it is okay to feel anxious but to share these feelings'
'That it's okay to feel overwhelmed and know when and how to ask for help'

- **Empowerment**

'Empowering and knowledgeable, practical advice'
'I feel more empowered to notice changes in mood/behaviour'
'Validation'

- **Skills**

'Encouraging ways to start hard conversations if notice anything unusual'
'Gave me advice on how to help others also'
'How to help others with PND or mental illness'
'Ways to approach issues comfortably'

- **Hope and positivity**

'Good to see that there is hope even if diagnosed with a mental illness'
'I know no matter what it will be okay'
'Now I know there is someone who can help us'
'Made me look forward to parenthood more'
'We found it interesting and educational, just feel more positive'

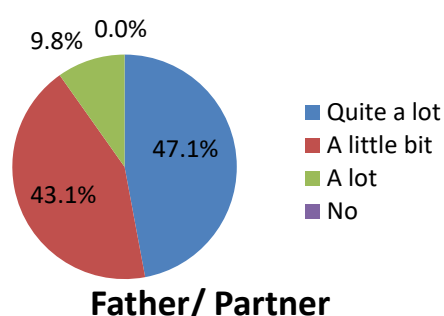
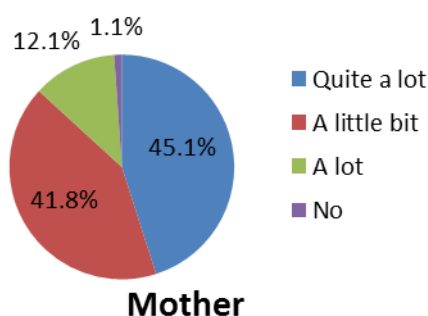
- **Partner communication**

'I feel like my partner and I can speak about this with the same frame of reference now'
'Now I know what my partner is going through'

Question:

Did TODAY's session have any benefits for you?

	Mother		Father/ Partner		All Mothers and Fathers/ Partners	
	Count	%	Count	%	Count	%
No	1	1.1	0	0.0	1	0.7
A little bit	38	41.8	22	43.1	60	42.3
Quite a lot	41	45.1	24	47.1	65	45.8
A lot	11	12.1	5	9.8	16	11.3
TOTAL	91	100	51	100	142	100



When asked whether the PC session had had any benefits for them, 99% of mothers and 100% of fathers said it had. A number of themes emerged through participants' feedback on 'benefits' of the PC session.

- **Baby cues, responsive care and child development**

'Baby cues'

'Cues, library groups, crying (not leaving)'

'Gave me a website about responsive care (for my partner)'

'How the newborn develops as time goes by'

'Know that I'm doing the right thing by picking her up when she cries'

'Knowing that it benefits the baby to be picked up when he is crying'

- **Connection**

'Connecting with other parents'

'Hearing from other parents. Learn about library and other support groups'

'Learning about social groups'

'Meeting other parents, knowing there's support'

'Joined a mums' group'

'Just to get out of the house and meet other parents and people is great'

'Understanding we're not alone'

'Taking the leap to go out there helped knowing there were other mums and bubs'

- **Shared stories**

'It was nice to hear that others are going through the same things'

'No-one is perfect and others are going through the same things'

'It was nice to hear others' thoughts and experiences'

- **Reassurance of support**

'Just to know there is help out there'

'Lots of parental support/contacts'

'Support services available, websites like Raising Children'

- **Self-care**

'Reminded me not to be too hard on myself'

'Reminder of coping strategies'

'Reminder to make time for myself'

- **Caring for others**

'Reminding me to make sure other parents are going okay'

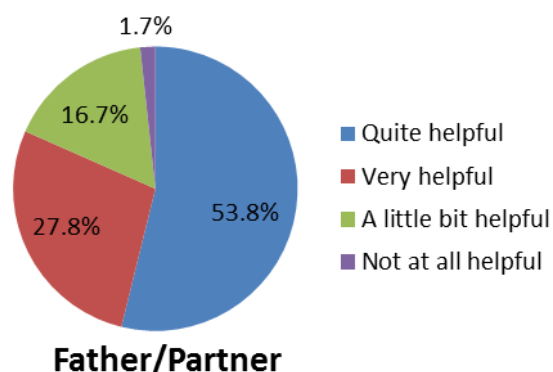
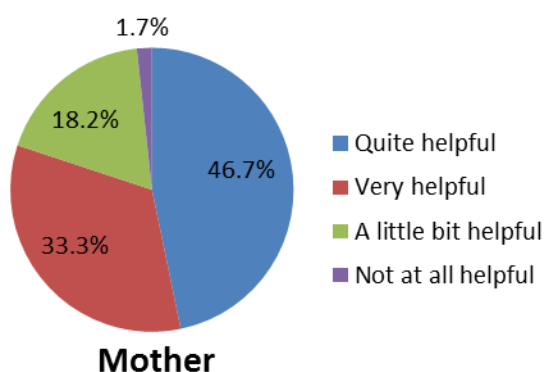
'What we can do to emotionally support each other'

Helpfulness

Question:

Overall, did you find the Emotional Preparation for Parenthood session:

	Mother		Father/Partner		All Mothers and Fathers/Partners	
	Count	%	Count	%	Count	%
Not at all helpful	5	1.7	4	1.7	9	1.7
A little bit helpful	53	18.2	39	16.7	92	17.5
Quite helpful	136	46.7	126	53.8	262	49.9
Very helpful	97	33.3	65	27.8	162	30.9
TOTAL	291	100	234	100	525	100



Ninety-eight percent of both mothers and fathers said they had found the EPP session helpful. Some of the helpful aspects identified were:

- **Education team**

‘Staff all were very open and easy to talk to’

- **Safe space, acceptance and lack of judgement**

‘Cover so much including things that so many parents would not want to disclose. Nothing was looked down on’

‘It was very helpful and had lots of opportunities for questions’

- **Sharing and connection**

‘I enjoyed when other people shared stories so maybe a little more group activities or getting to know each other in the groups’

- **Peer stories**

‘I think it was great. The real stories from Sal and Deb were good to hear about ot make you feel able to seek help (encouraging)’

‘Really like the real life experiences’

‘Love the session, personal experiences is a great touch’

‘I admire the courage and bravery of Deb and Sal in sharing their stories and obtaining their state of wellness. Very impressive and inspiring class and presenters’

‘Love the use of the recovery model. Deb and Sal’s stories normalise help-seeking and reduce stigma’

- **General positive feedback**

'All was perfect'
'As it stands the session is incredibly helpful'
'Awesome already'
'I loved it all!'
'I really enjoyed this session'
'I think the more this stuff is taught the better it will be'
'I think the session covered all bases'
'It was a lot better than I thought it would be'
'It was all very informative and helpful'
'Wow – very comprehensive, insightful, and enjoyable'
'You all did really well. No improvement needed'

The majority of participants stated that the session was excellent and that they could make no suggestions for improvement. Suggested improvements from the remainder of participants focused on the following themes:

- **Process issues**

'A run sheet for us to follow'
'Salt and vinegar chips'
'More chocolate'
'Better chairs'
'Bit more fun not so serious'
'Forms could be made digital to make it easier for you to collect this info'
'You can make them interesting by showing more videos'
'Make it shorter'
'A great session, possibly more time'

- **Additional information**

'Mention that GPs can issue a mental health plan that discounts psychologists etc. for X visits over 12 months'
'Talk about feelings of hating or resenting your baby and one topic not covered was how a couple's sex life can be affected by having a baby. Post baby sex may be different to pre – this can be depressing (especially for husbands)'
'Talk about stay at home dads'

- **More 'hands-on help'**

'A lot of focus on mental health I'm not sure such depth is necessary. More hands on help maybe?'
'I expected to learn practical skills, changing nappies, right holding positions (head support etc.)'

- **Peer stories**

'Have more people share their own stories/struggles'
'More real life stories examples of during pregnancy (not just after)'
'More group involvement it's different to be told from experts but to chat in a group with new parents is helpful'
'More personal stories and experiences'
'Relate it back to pregnancy more - more real life stories of mums and partners'
'Share more stories of recent parents – maybe a small interview video'

- **Sharing and connection**

‘More group interaction with other parents’

‘Maybe smaller classes so people are not afraid to join in’

‘Our own experiences section, ask if we want to share either private/to group’

- **More focus on fathers/ male partners**

‘Include a men’s health group with stories from other dads that had partners with mental illness or men that had their own issues. Could help dads notice issues with partners’

‘Maybe have a male share from his perspective’

‘Maybe some more focus on support methods for new fathers?’

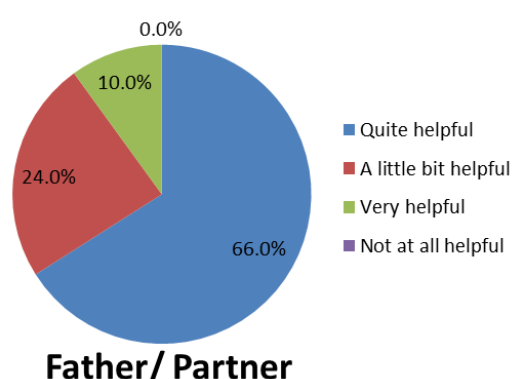
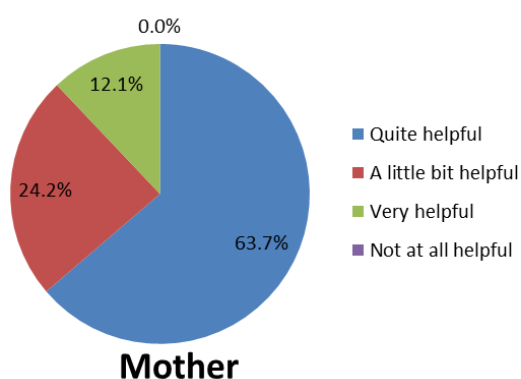
- **More acknowledgement of support people who are not fathers/ male partners**

‘Try not to focus on just mum and dad but mum and support partner’

Question:

Overall, did you find TODAY’s session:

	Mother		Father/ Partner		All Mothers and Fathers/ Partners	
	Count	%	Count	%	Count	%
Not at all helpful	0	0	0	0	0	0
A little bit helpful	22	24.2	12	24.0	34	24.1
Quite helpful	58	63.7	33	66.0	91	64.5
Very helpful	11	12.1	5	10.0	16	11.3
TOTAL	91	100	50	100	141	100



One hundred percent of both mothers and fathers said they had found the PC session helpful. There were very few suggestions on making the session more helpful, except for possibly providing information in more depth (e.g. baby cues) and making parts of the session more interactive.

‘A great project that should be accessible to all new parents’

‘It was good to see everyone else’s children’

‘It was great for me personally to talk about things with people other than my wife’

‘Keep up the great work’

‘Very appreciative of the service and the expertise of the session co-ordination’

‘Such a great service that we receive through the public system’

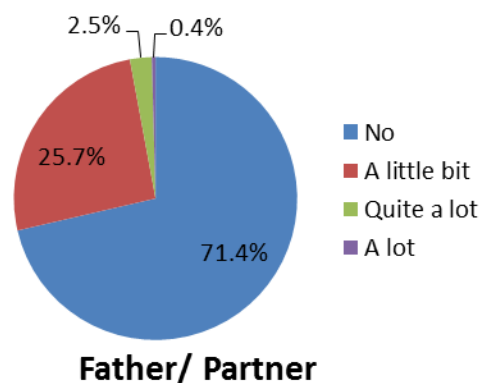
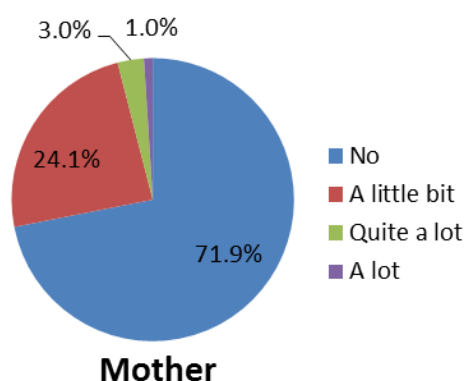
‘Thanks for everything – it’s been amazing’

Self-reported concerns

Question:

Did the session raise any concerns for you?

	Mother		Father/ Partner		All Mothers and Fathers/partners	
	Count	%	Count	%	Count	%
No	215	71.9	172	71.4	387	71.7
A little bit	72	24.1	62	25.7	134	24.8
Quite a lot	9	3.0	6	2.5	15	2.8
A lot	3	1.0	1	0.4	4	0.7
TOTAL	299	100	241	100	540	100



Participants were asked whether the EPP session had raised any concerns for them. Most said no (72% of both mothers and fathers). Only 4% of mothers and 3% of fathers said the session had raised 'a lot' of concerns for them.

The kinds of concerns participants identified that the session had brought up for them were appropriate and aligned with the session's aims. All participants were encouraged to approach the education team after the session or their midwife if they wished to discuss any concerns, and all who did so were referred for further support if required.

- **Pre-existing mental health issues**

'A few triggers that I will need to look out for'

'Anxiety (I worry too much)'

'Brings back memories of times my own anxiety and depression weren't under control (a little fear they will come back)'

'Had postnatal depression before'

'Having previous mental illness worries me'

- **Pre-existing issues with partner**

'Brought up issues already experienced with partner'

'Difficulties with partner (unhealthy relationship)'

'Was proven that my situation is lacking support'

- **Risk factors and vulnerabilities for mental health issues**

'Am a bit of an overachiever/perfectionist, need to adjust expectations'

'Lack of family support'

'Past childhood trauma'

- **Concerns for partner**

'Concerns about wife going through these emotional issues'

'Emotional wellbeing of my partner'

'Worry for my partner'

- **Anxieties about parenting and mental health**

'About the baby and how we are going to take care of him/her'

'I am worried I can't connect with my baby. Not very maternal person'

'I thought about the times I was so overwhelmed I was afraid I would hurt my baby. The aspect of feeling resentment or extreme frustration with the baby itself could be mentioned as part of PND'

'Reality is setting in. I really don't want my wife to get a mental illness'

A few participants identified, especially early on in the project, that the EPP session was 'a bit of a downer' or 'a tough way to start an antenatal class'. However, there was acknowledgement that the material was important and valuable:

'Bit of a downer but some things needs to be said'

'The stories and the role play were a bit distressing, however they were good in that they communicated the potential realities'

General comments on overall Transition to Parenthood Program

'A great project that should be accessible to all new parents'

'It was good to see everyone else's children'

'It was great for me personally to talk about things with people other than my wife'

'Keep up the great work'

'Very appreciative of the service and the expertise of the session co-ordination'

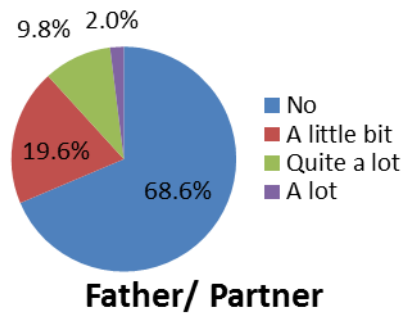
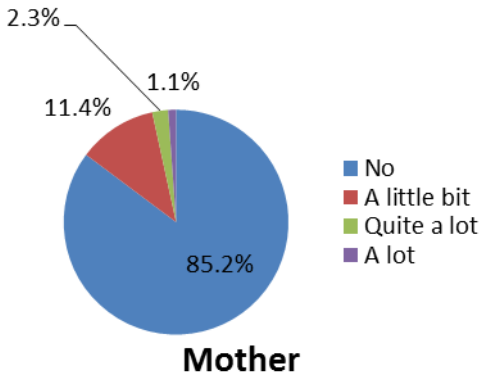
'Such a great service that we receive through the public system'

'Thanks for everything – it's been amazing'

Question:

Did TODAY’s session raise any concerns for you?

	Mother		Father/ Partner		All Mothers and Fathers/ Partners	
	Count	%	Count	%	Count	%
No	75	85.2	35	68.6	110	79.1
A little bit	10	11.4	10	19.6	20	14.4
Quite a lot	2	2.3	5	9.8	7	5.0
A lot	1	1.1	1	2.0	2	1.4
TOTAL	88	100	51	100	139	100



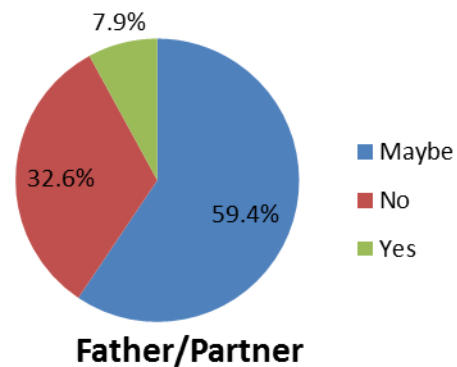
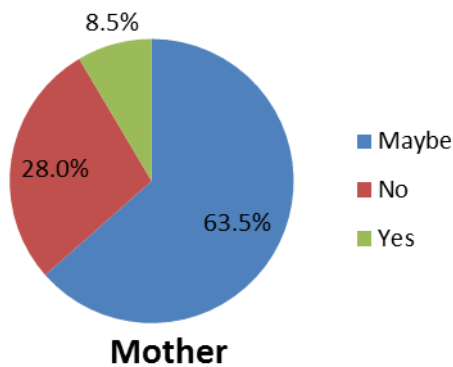
Participants were asked whether the PC session had raised any concerns for them. Most said no (85% of mothers and 67% of father/partners). Only 1% of mothers and 2% of fathers said the session had raised ‘a lot’ of concerns for them (in each case, this percentage represented one participant). No specific concerns were identified in the qualitative comments. All participants who identified concerns were followed up by the facilitators and referred for further support as required.

Social connectedness

Question:

Do you think you will stay in touch with other parents from this education session?

	Mother	Father/Partner		All Mothers and Fathers/Partners		
	Count	%	Count	%	Count	%
Yes	25	8.5	19	7.9	44	8.3
No	82	28.0	78	32.6	160	30.1
Maybe	186	63.5	142	59.4	328	61.7
TOTAL	293	100	239	100	532	100

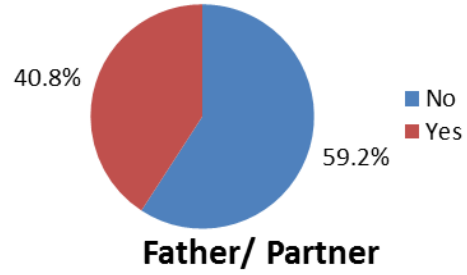
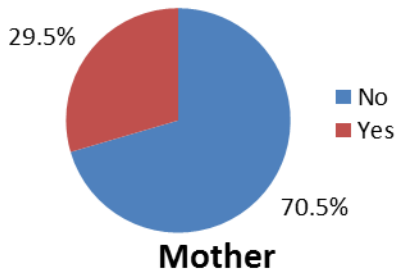


Participants were asked whether they thought they would stay in touch with other parents from the EPP session. Nine percent of mothers and 8% of fathers/partners said 'yes', 64% of mothers and 59% of fathers/partners said 'maybe', while 28% of mothers and 33% of fathers/partners said 'no'. Most participants who said 'maybe' or 'no' indicated that they already felt well-supported by family and friends, particularly friends who were also in the perinatal period.

Question:

Have you stayed in touch with other parents from the Birth and Parenting Program?

	Mother		Father/ Partner		All Mothers and Fathers/ Partners	
	Count	%	Count	%	Count	%
Yes	26	29.5	20	40.8	46	33.6
No	62	70.5	29	59.2	91	66.4
TOTAL	88	100	49	100	137	100

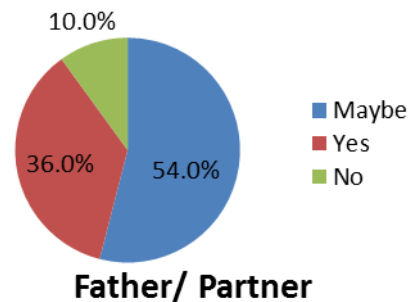
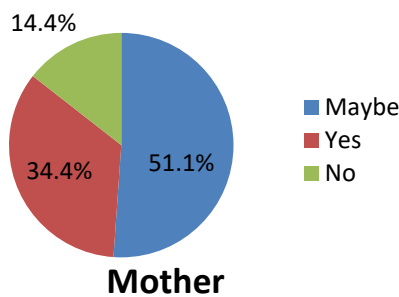


Some 30% of mothers and 41% of fathers/partners said they had remained in touch with other parents they had met through the antenatal education program. These figures were higher than the percentages who had originally said they intended to remain in touch with other group members; this may reflect that those who chose to return for the PC session were more engaged with the Transition to Parenthood program in general than those who did not return.

Question:

Do you think you will stay in touch with other parents from this education session?

	Mother		Father/ Partner		All Mothers and Fathers/ Partners	
	Count	%	Count	%	Count	%
Yes	31	34.4	18	36.0	49	35.0
No	13	14.4	5	10.0	18	12.9
Maybe	46	51.1	27	54.0	73	52.1
TOTAL	90	100	50	100	140	100

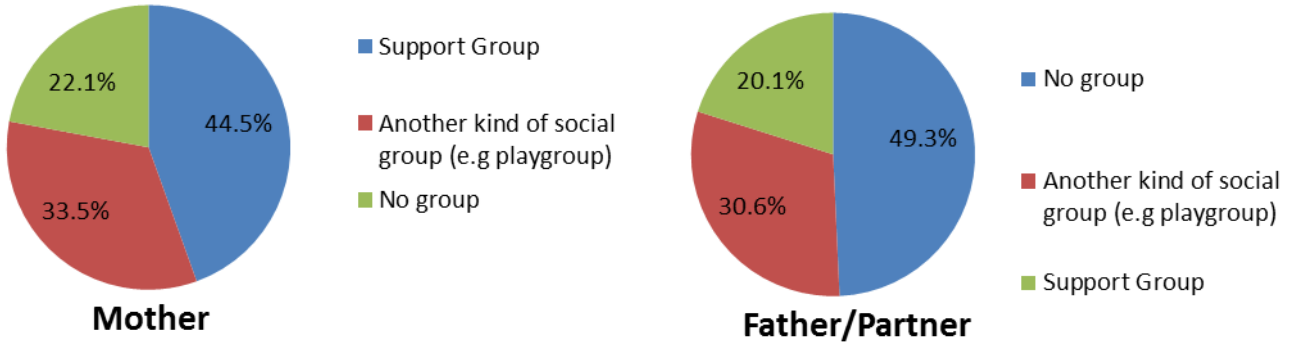


When asked whether they intended to stay in touch with other parents from the PC session, 34% of mothers and 36% of fathers/partners said 'yes', while 51% of mothers and 54% of fathers/partners said 'maybe'. At the end of most Postnatal Connections groups, participants spontaneously decided to establish a Facebook or email group to enable members who wanted to stay in touch to do so.

Question:

To support you through your pregnancy and early parenting, do you intend to join or form:

	Mother		Father/Partner		All Mothers and Fathers/Partners	
	Count	%	Count	%	Count	%
Support Group	125	44.5	42	20.1	167	34.1
Another kind of social group (e.g. playgroup)	94	33.5	64	30.6	158	32.2
No group	62	22.1	103	49.3	165	33.7
TOTAL	281	100	209	100	490	100

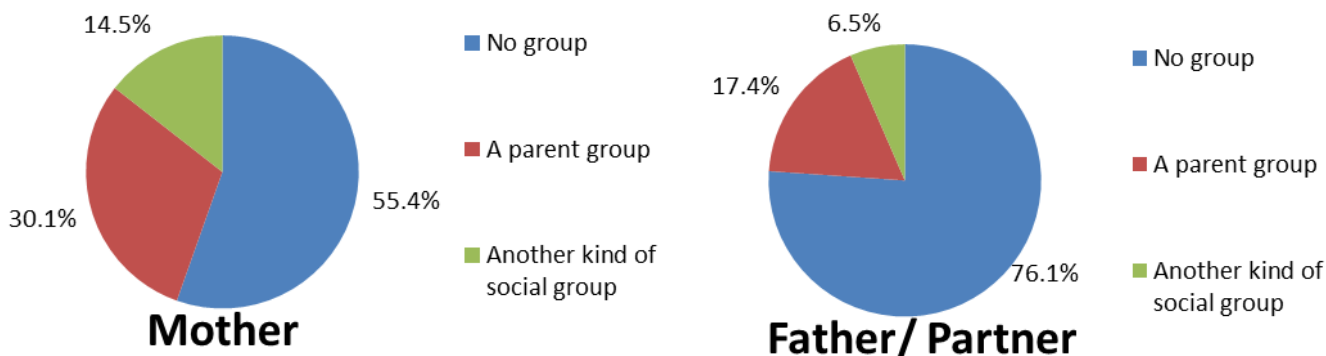


Seventy-eight percent of mothers and 50% of fathers/partners saw themselves as forming or joining some kind of parenting group to support them during pregnancy and early parenting. This included a number of participants who reported that they already belonged to a group of this nature.

Question:

To support you through your pregnancy and early parenting, did you join or form:

	Mother	Father/ Partner		All Mothers and Fathers/Partners		
	Count	%	Count	%	Count	%
A parent group	25	30.1	8	17.4	33	25.6
Another kind of social group	12	14.5	3	6.5	15	11.6
No group	46	55.4	35	76.1	81	62.8
TOTAL	83	100	46	100	129	100



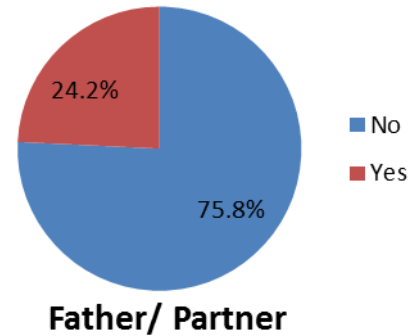
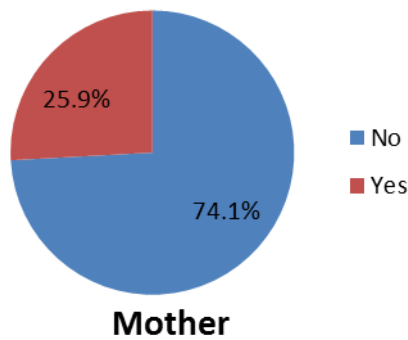
At the PC session, 45% of mothers and 24% of fathers/partners said that they had joined or formed a parenting group. It is worth noting that 55% of mothers and 76% of fathers/partners reported that they did not belong to such a group. Since social connectedness is recognised as a protective factor for perinatal mental health, a strategic focus on helping new parents to connect with others would be a worthwhile investment in perinatal mental health promotion and illness prevention.

Social Media

Question:

Do you intend to mention the Emotional Preparation for Parenthood session, or talk about mental health and emotional wellbeing in pregnancy and early parenting, on social media?

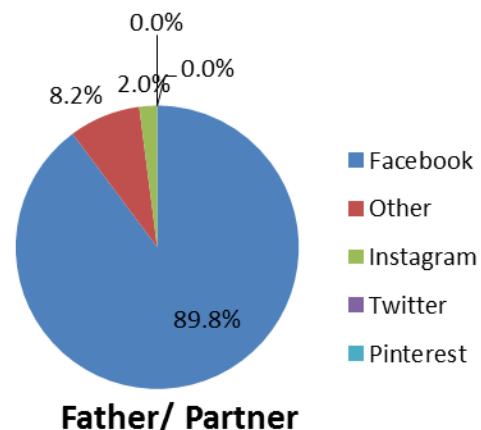
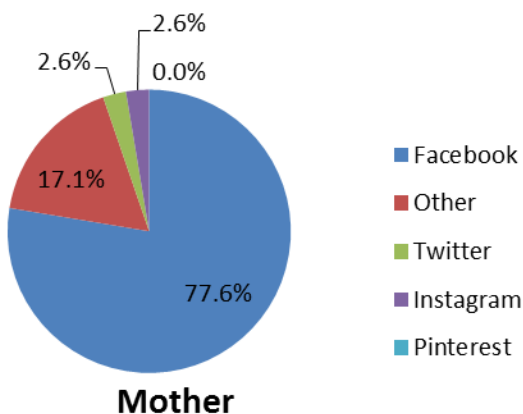
	Mother		Father/Partner		All Mothers and Fathers/Partners	
	Count	%	Count	%	Count	%
Yes	75	25.9	56	24.2	131	25.1
No	215	74.1	175	75.8	390	74.9
TOTAL	290	100	231	100	521	100



Question:

If yes, what social media platforms might you use to mention these issues?

	Mother		Father/Partner		All Mothers and Fathers/Partners	
	Count	%	Count	%	Count	%
Facebook	59	77.6	44	89.8	103	82.4
Twitter	2	2.6	0	0.0	2	1.6
Pinterest	0	0.0	0	0.0	0	0
Instagram	2	2.6	1	2.0	3	2.4
Other	13	17.1	4	8.2	17	13.6
TOTAL	76	100	49	100	125	100



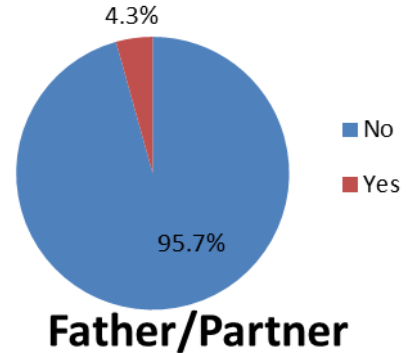
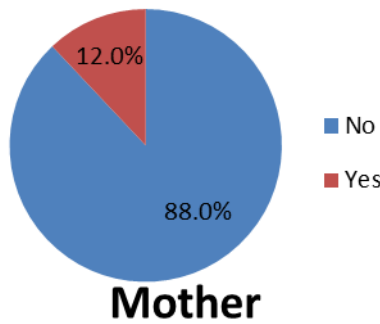
Interestingly, despite the participants' demographic (majority aged 19 to 35 years), 74% of mothers and 76% of fathers said they did not intend to discuss mental health and emotional wellbeing in pregnancy and early parenting on social media. Reasons for this reluctance warrant further investigation, since it is known that Australians in this age group increasingly consult social media for health information. The majority of participants who commented on this question said that they did not habitually use social media very much. Some stated that they would talk about perinatal mental health with family and friends, but did not feel confident 'explaining in' on social media.

Of those who said they would discuss perinatal mental health and emotional wellbeing on social media, 78% of mothers and 90% of fathers said they would use Facebook. This was significantly higher than the reported intended use of any other social media platform.

Question:

Did you mention the Emotional Preparation for Parenthood session, or talk about mental health and emotional wellbeing in pregnancy and early parenting, on social media?

	Mother		Father/ Partner		All Mothers and Fathers/ Partners	
	Count	%	Count	%	Count	%
Yes	10	12.0	2	4.3	12	9.3
No	73	88.0	44	95.7	117	90.7
TOTAL	83	100	46	100	129	100



Question:

If yes, what social media platforms did you use to mention these issues?

	Mother		Father/ Partner		All Mothers and Fathers/Partners	
	Count	%	Count	%	Count	%
Facebook	9	9.8	2	3.9	11	7.7
Twitter	0	0.0	0	0.0	0	0.0
Pinterest	0	0.0	0	0.0	0	0.0
Instagram	0	0.0	0	0.0	0	0.0
Other	0	0.0	0	0.0	0	0.0
No answer	10	10.9	5	9.8	15	10.5
Not applicable	73	79.3	44	86.3	117	81.8
TOTAL	92	100	51	100	143	100

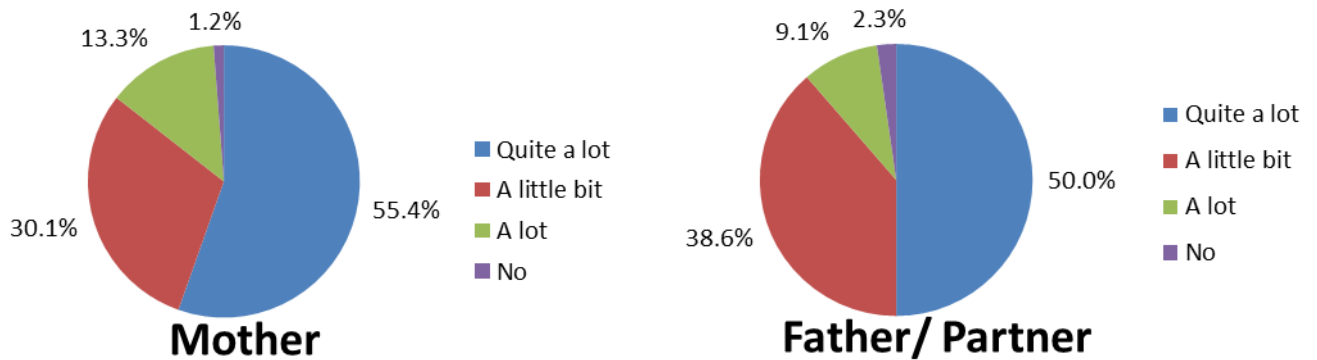
At the PC session, 88% of mothers and 96% of fathers reported that they had not discussed perinatal mental health and emotional wellbeing on social media. Those who had done so had overwhelmingly used Facebook (10% of mothers and 4% of fathers). Social media may be an untapped avenue for disseminating accurate health information about perinatal mental health and emotional wellbeing, reducing stigma and engaging the community in more open, productive dialogue.

Awareness

Question:

Did the Emotional Preparation for Parenthood session increase your awareness of ways to protect your emotional wellbeing?

	Mother		Father/Partner		All Mothers and Fathers/Partners	
	Count	%	Count	%	Count	%
No	1	1.2	1	2.3	2	1.6
A little bit	25	30.1	17	38.6	42	33.1
Quite a lot	46	55.4	22	50.0	68	53.5
A lot	11	13.3	4	9.1	15	11.8
TOTAL	83	100	44	100	127	100

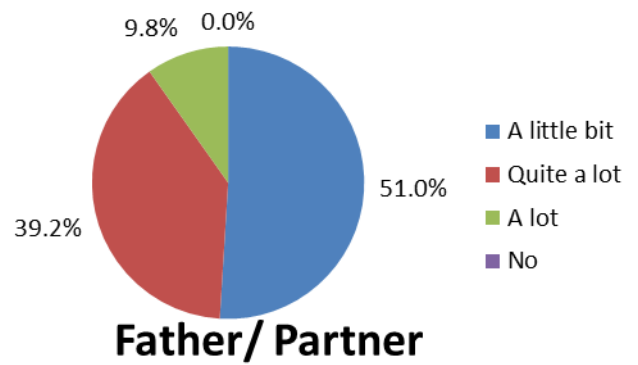
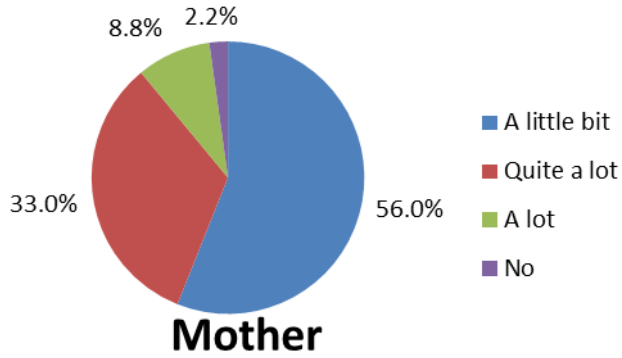


Ninety-nine percent of mothers and 98% of fathers/partners said the EPP session had increased their awareness of ways to protect their emotional wellbeing.

Question:

Did this POSTNATAL session increase your awareness of ways to protect your emotional wellbeing?

	Mother		Father/ Partner		All Mothers and Fathers/ Partners	
	Count	%	Count	%	Count	%
No	2	2.2	0	0.0	2	1.4
A little bit	51	56.0	26	51.0	77	54.2
Quite a lot	30	33.0	20	39.2	50	35.2
A lot	8	8.8	5	9.8	13	9.2
TOTAL	91	100	51	100	142	100

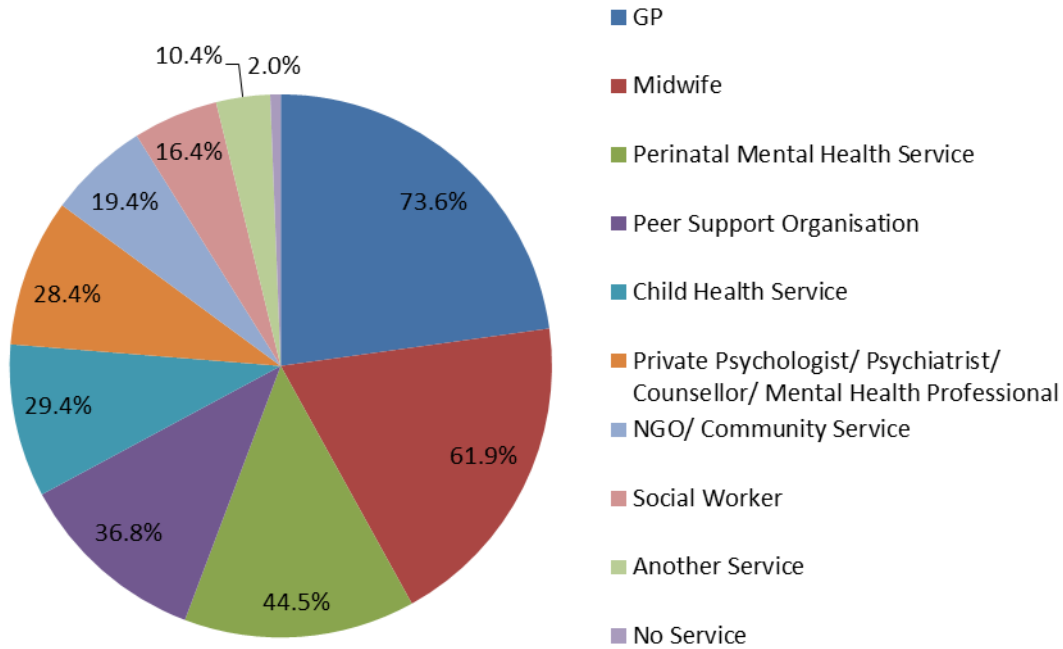


Ninety-eight percent of mothers and 100% of fathers/partners said that the PC session had increased their awareness of ways to protect their emotional wellbeing.

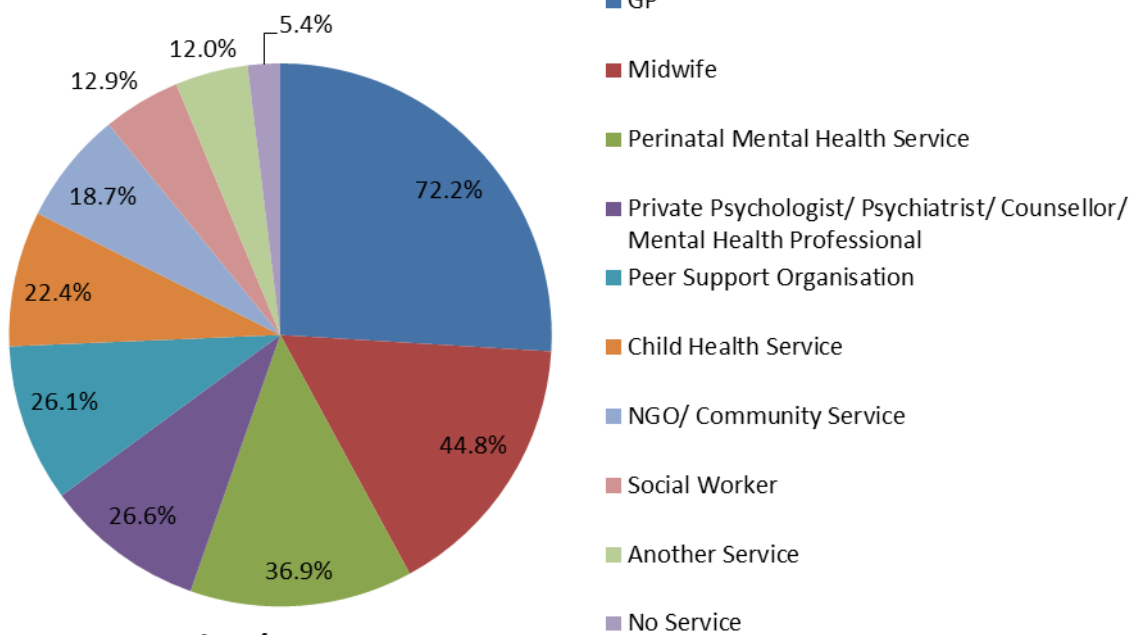
Seeking Support

Question:

If you need support for your mental health and emotional wellbeing during pregnancy or early parenting, are you most likely to seek help through:



Mother



Father/ Partner

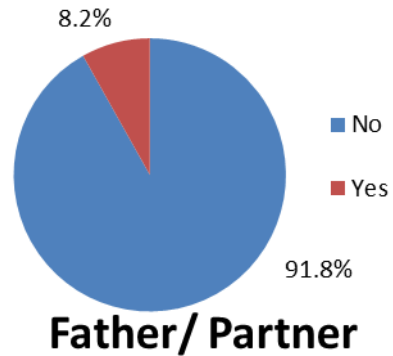
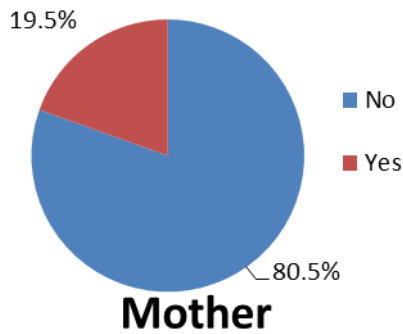
The majority of participants in the EPP session said that, if they required support for their mental health, they would consult a GP (74% of mothers and 72% of fathers/partners). Sixty-two percent of mothers and 45% of fathers/partners said they would consult a midwife, while 45% of mothers and 37% of fathers said they would seek support from the Perinatal Mental Health Service. Thirty-seven percent of mothers and 26% of fathers/partners thought they might seek support from a peer support organisations, while 29% of mothers and 22% of fathers/partners thought they might seek support from child Health. Twenty-eight percent of mothers and 27% of fathers thought they might seek support from a private psychologist, psychiatrist, counsellor or other mental health professional. Nineteen percent of both mothers and fathers thought they might seek support through the non-government/ community sector, while 16% of mothers and 13% of fathers/partners identified the hospital social work department as a potential source of support. Ten percent of mothers and 12% of father/partners suggested they would seek support through another service. Categories were not exclusive and participants were able to indicate more than one source of support.

Two percent of mothers and 5% of fathers/partners indicated that even if they required additional support for their mental health and emotional wellbeing, they would not seek this support through any service.

Question:

Have you needed any extra support for your mental health and emotional well-being during pregnancy or early parenting?

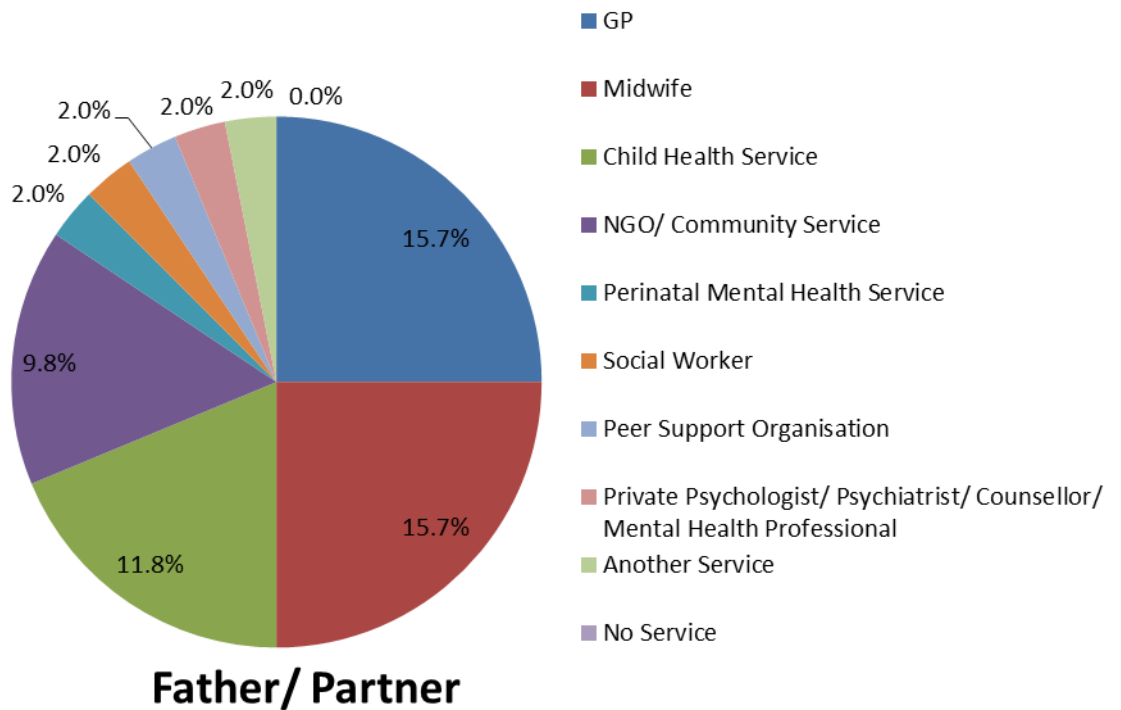
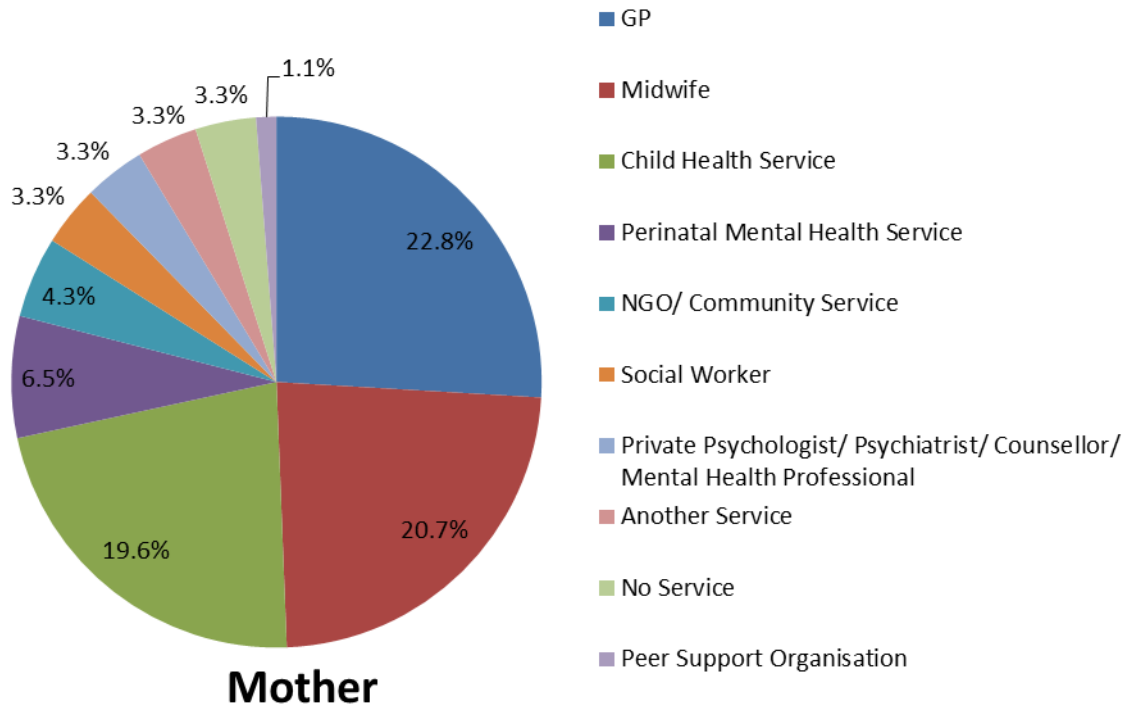
	Mother		Father/ Partner		All Mothers and Fathers/ Partners	
	Count	%	Count	%	Count	%
Yes	17	19.5	4	8.2	21	15.6
No	70	80.5	45	91.8	115	85.2
TOTAL	87	100	49	100	136	100



At the PC session, 20% of mothers and 8% of fathers/ partners indicated that they had required additional support for their mental health and emotional wellbeing since participating in the EPP class. These figures are closely aligned with known prevalence data for perinatal mental illness, suggesting that the EPP class had helped participants to accurately identify their need for perinatal mental health support and actively seek this support through appropriate services.

Question:

If yes, have you sought help or support through:



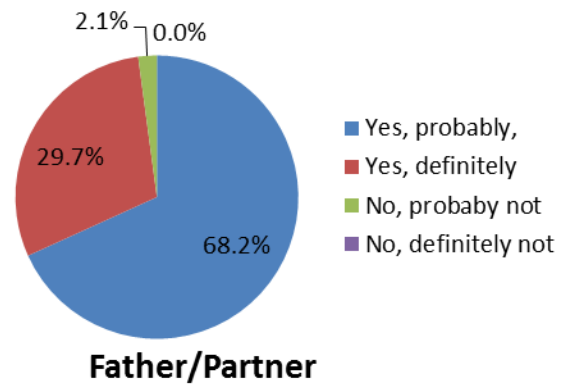
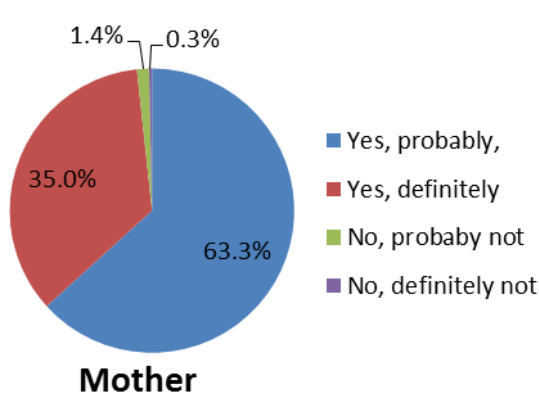
Of those who had accessed additional support, most had accessed done so through a GP (23% of mothers and 16% of fathers/partners), midwife (21% of mothers and 16% of fathers/partners), or Child Health service (20% of mothers and 12% of fathers). A significant number of parents had accessed the Perinatal Mental Health Service (7% of mothers and 2% of fathers/partners). A further 4% of mothers and 9% of fathers/partners had accessed support through a non-government or community service. Three percent of mothers and 2% of fathers/partners had accessed a social worker, while 3% of mothers and 2% of fathers had accessed support through a private psychologist, psychiatrist, counsellor or mental health professional. One percent of mothers had participated in a mental health peer support group. Since these categories were not exclusive, parents may have accessed more than one form of support.

Self-reported confidence

Question:

I feel confident I am able to notice any problems in my emotional health and wellbeing:

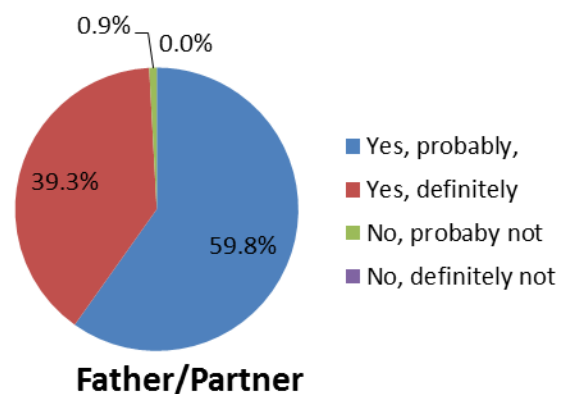
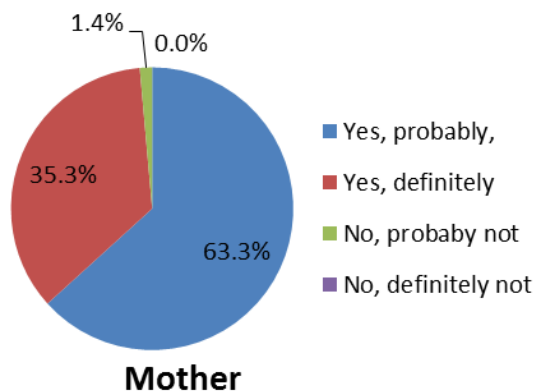
	Mother		Father		All Mothers and Fathers/Partners	
	Count	%	Count	%	Count	%
No, definitely not	1	0.3	0	0.0	1	0.2
No, probably not	4	1.4	5	2.1	9	1.7
Yes, probably,	186	63.3	161	68.2	347	65.5
Yes, definitely	103	35.0	70	29.7	173	32.6
TOTAL	294	100	236	100	530	100



Question:

I feel confident I am able to notice any problems in my partner's emotional health and wellbeing:

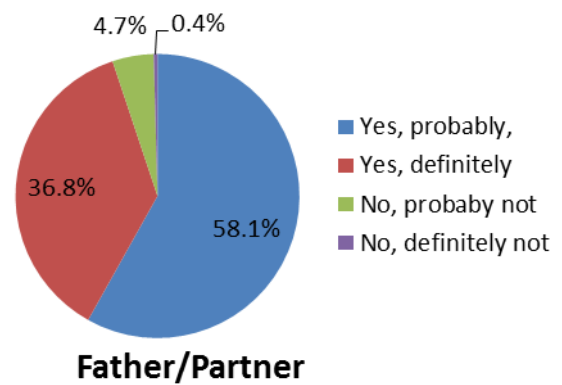
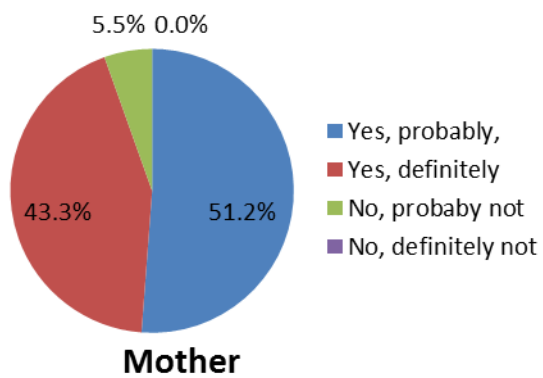
	Mother		Father		All Mothers and Fathers/Partners	
	Count	%	Count	%	Count	%
No, definitely not	0	0.0	0	0.0	0	0.0
No, probably not	4	1.4	2	0.9	6	1.2
Yes, probably,	181	63.3	140	59.8	321	61.7
Yes, definitely	101	35.3	92	39.3	193	37.1
TOTAL	286	100	234	100	520	100



Question:

I feel confident I can ask for any help I may need to stay emotionally well and healthy:

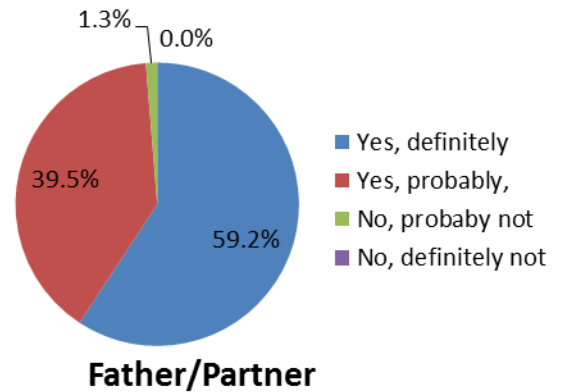
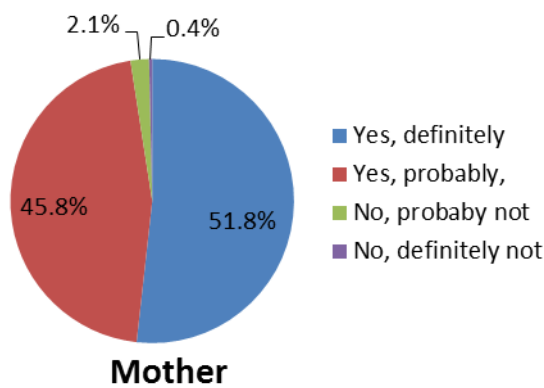
	Mother		Father		All Mothers and Fathers/Partners	
	Count	%	Count	%	Count	%
No, definitely not	0	0.0	1	0.4	1	0.2
No, probably not	16	5.5	11	4.7	27	5.1
Yes, probably,	150	51.2	136	58.1	286	54.3
Yes, definitely	127	43.3	86	36.8	213	40.4
TOTAL	293	100	234	100	527	100



Question:

I feel confident I can support my partner to ask for any help he/she may need to stay emotionally well and healthy:

	Mother/expectant Mother		Father/expectant Father		All Mothers and Fathers/Partners	
	Count	%	Count	%	Count	%
No, definitely not	1	0.4	0	0.0	1	0.2
No, probably not	6	2.1	3	1.3	9	1.7
Yes, probably,	130	45.8	92	39.5	222	42.9
Yes, definitely	147	51.8	138	59.2	285	55.1
TOTAL	284	100	233	100	517	100

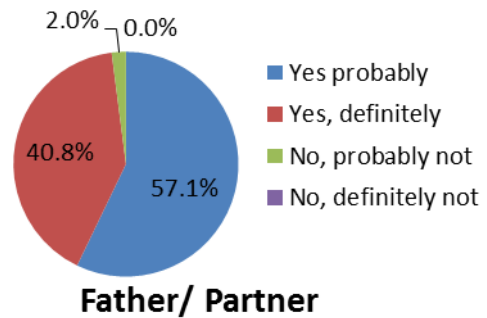
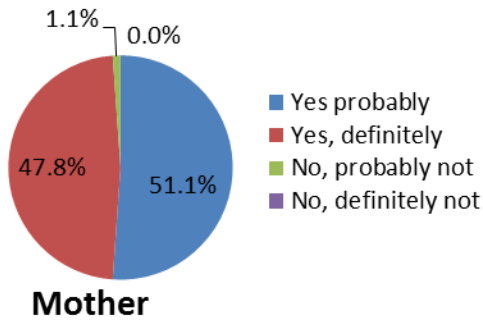


At the end of the EPP session, 98% of both mothers and fathers/partners felt confident that they could identify any problems with their own emotional health and wellbeing, while 99% of both mothers and fathers/partners felt confident they could identify any problems with their partner’s emotional health and wellbeing. In terms of being confident about seeking help, 95% of both mothers and fathers/partners felt they would be able to seek help for themselves if required, while 98% of mothers and 99% of fathers/partners felt confident they would be able to support their partner to seek help if required.

Question:

I feel confident I am able to notice any problems in my emotional health and wellbeing:

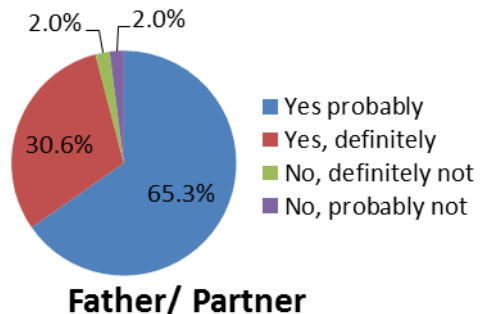
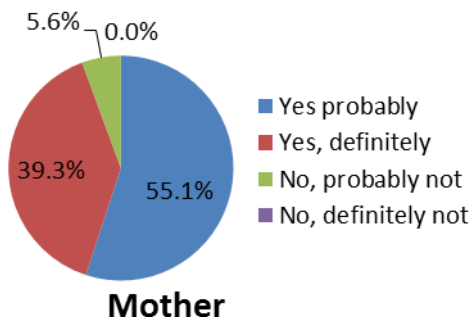
	Mother		Father/ Partner		All Mothers and Fathers/ Partners	
	Count	%	Count	%	Count	%
No, definitely not	0	0.0	0	0.0	0	0.0
No, probably not	1	1.1	1	2.0	2	1.4
Yes probably	46	51.1	28	57.1	74	53.2
Yes, definitely	43	47.8	20	40.8	63	45.3
TOTAL	90	100	49	100	139	100



Question:

I feel confident I am able to notice any problems in my partner's emotional health and wellbeing:

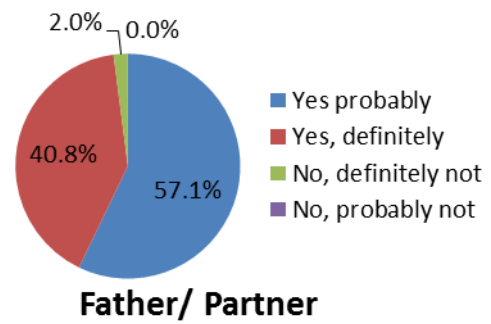
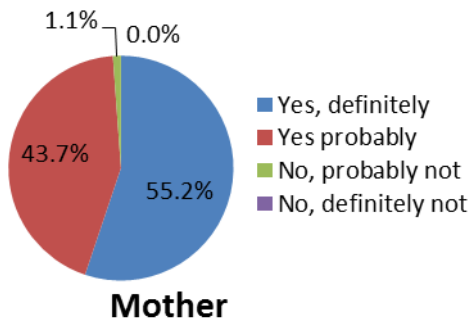
	Mother		Father/ Partner		All Mothers and Fathers/Partners	
	Count	%	Count	%	Count	%
No, definitely not	0	0.0	1	2.0	1	0.7
No, probably not	5	5.6	1	2.0	6	4.3
Yes probably	49	55.1	32	65.3	81	58.7
Yes, definitely	35	39.3	15	30.6	50	36.2
TOTAL	89	100	49	100	138	100



Question:

I feel confident I can ask for any help I may need to stay emotionally well and healthy:

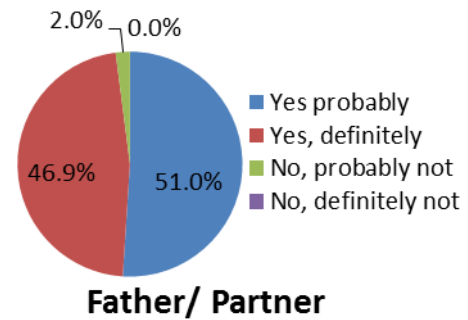
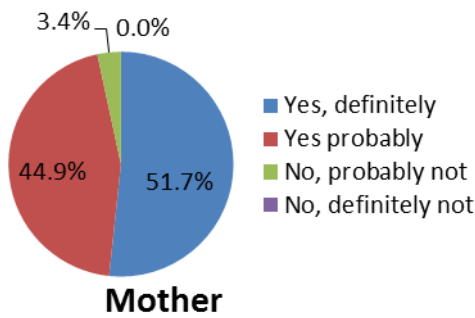
	Mother		Father/ Partner		All Mothers and Fathers/ Partners	
	Count	%	Count	%	Count	%
No, definitely not	0	0.0	1	2.0	1	0.7
No, probably not	1	1.1	0	0.0	1	0.7
Yes probably	38	43.7	28	57.1	66	48.5
Yes, definitely	48	55.2	20	40.8	68	50.0
TOTAL	87	100	49	100	136	100



Question:

I feel confident I can support my partner to ask for any help he/she may need to stay emotionally well and healthy:

	Mother		Father/ Partner		All Mothers and Fathers/ Partners	
	Count	%	Count	%	Count	%
No, definitely not	0	0.0	0	0.0	0	0.0
No, probably not	3	3.4	1	2.0	4	2.9
Yes probably	40	44.9	25	51.0	65	47.1
Yes, definitely	46	51.7	23	46.9	69	50.0
TOTAL	89	100	49	100	138	100



At the end of the PC session, 98% of mothers and 99% of fathers/partners felt confident that they could identify any problems with their own emotional health and wellbeing. Ninety-four percent of mothers and 96% of fathers/partners felt confident they could identify any problems with their partner's emotional health and wellbeing. In terms of being confident about seeking help, 99% of mothers and 98% of fathers/partners felt they would be able to seek help for themselves if required, while 97% of both mothers and fathers/partners felt confident they would be able to support their partner to seek help if required.

Appendix 4: Transition to Parenthood Facilitator Feedback Summary

Emotional Preparation for Parenthood

All participating midwives had delivered antenatal education sessions as part of their practice prior to the project. However, most had not previously delivered Emotional Preparation for Parenthood sessions, nor did they have experience co-facilitating with peer workers and non-government workers. Feedback suggested that it would be helpful to participate in training alongside these educators, to build relationships and reach shared understandings about co-facilitation (for example, the extent to which a facilitator may participate in class discussion being led by another facilitator). By the end of the project, facilitators were assessing inter-agency collaboration as one of the key strengths of the program.

Most of the challenges associated with delivering the EPP session within the project resulted from the action research approach, with content and processes being modified in response to participant and educator feedback over the first few months of the initiative. Time constraints were one challenge; the complexity of some content was another. As the session was manualised and facilitators became more comfortable with the content and the co-facilitation process, transitions between topics became smoother and the 'flow' of the session improved.

Over time, the peer workers refined their stories to highlight key messages in the session. Midwives reported that the peer stories provided great insight into mental health and illness, helped reduce stigma, encouraged sharing, and reinforced participants' understanding of the clinical content. QCPIMH staff also identified lived experience stories as playing a powerful role in engaging the participants and helping them relate to the information provided.

The timing of the EPP session within the Birth & Parenting Program was a subject of much debate and some experimentation. It was concluded that the EPP session worked best in Week Three of the five-week Monday evening course. Midwives felt that by this time they had established rapport with participants and a level of trust in the group, which empowered participants to contribute and ask questions about emotional wellbeing. For the Saturday classes, it was decided that the EPP session should be delivered at the beginning of the day and flow into the 'Looking forward to...' activity. Since the session is emotionally demanding, it works best while participants are still 'fresh', and they benefit from having the rest of the day to process the content and approach the midwife with any questions or concerns.

Careful consideration was given to the role of mental health information in a universal education program. Partner organisations debated the balance between a 'wellness focus' and an 'illness focus' within the program. By the time the program was manualised, all partners felt comfortable with the spectrum of emotional wellbeing and mental health explored through the program content. All facilitators felt that the content being delivered was well-structured, appropriate and necessary, and feedback from participants also supported this conclusion.

Early in the project, a concern was raised that repeatedly telling their story in the EPP session could be re-traumatising or emotionally draining for the peer facilitators. One potential solution was to replace the 'live' storytelling with video-recorded versions of the peers' stories. Unfortunately this could not be achieved for various reasons outside the control of the project. Over time, the peer facilitators changed the way they structured their personal stories, consciously adopting a more recovery-oriented approach. They reported that this helped to alleviate the distress of repeated storytelling.

Feedback identified that ongoing training should be provided to facilitators who deliver the Emotional Preparation for Parenthood session to ensure they are up to date with session content, structure, and purpose.

Postnatal Connections

Initially the Postnatal Connections session was not well attended. The maternity service undertook some investigation of barriers to attendance, and the session format was changed from two sessions to one in the middle of the day, which seemed to help improve take-up.

Facilitators enjoyed delivering the session content, stating that it fulfilled the aims of reinforcing content from the EPP session, providing additional information relevant to the family's stage of new parenthood, and helping families connect with one another. Facilitators also identified the value of involving community organisations in the session to help families link with services and opportunities in their local area.

Midwives' Focus Group Feedback

1. Benefits for participating expectant and new parents

- **Parents better prepared for emotional challenges of pregnancy, labour, birth and early parenthood**
 - 'They were more aware of the ups and downs and the transition to parenting when they got home'
 - It's like they're more prepared it's not going to go always to plan and they were able to process that'
 - 'They're excited to attend (postnatal sessions)'
 - 'And I know that postnatal class... I did... there was a couple there that the grandmother had had postnatal depression and she flew over from New Zealand specifically to be present during the time of transition so that she could be in the background doing some cooking and housework, and also helping with the baby. Specifically they planned for that because the grandmother had had a lived experience, and as they had done that class they had decided to plan that'.
- **Partners more attentive and aware of mothers' needs**
 - 'I found that the partners of the women who had just birthed appeared to be more attentive to her than the other people who... birthed at the same time who didn't attend classes'
 - 'As an observer in the postnatal ward I could see they were ready to get their hands dirty and get involved with being a parent. So for me I believe it was a big, big positive impact'
 - 'It gave the man a base to have a conversation with me about his concerns while his wife was in the toilet... then we could go on and have a conversation with her as well when she came back out and joined us'
 - 'The dads would come (to Postnatal Connections) and the conversations they had about the mother in labour and things weren't going right – "oh remember what they taught us in that emotional preparation class about expectations and reality"... They were able to process what had actually happened in the birth when it hadn't gone to plan'
 - 'For me in antenatal clinic... the most common feedback is from the partner that says "I had no idea about any of this before... I have really enjoyed the class because I wouldn't have known

any of that and I didn't know what postnatal depression was or that we should be considering emotional health".

- 'It provided... a basis for having a conversation with their partners on a topic they've never really talked about. One woman in particular driving home from the classes, they actually continued the conversation about... what their journey was actually like... She was really grateful for that... It was just not something they were used to doing as a couple and it gave them a basis for having a conversation about emotional health and how they think they'd go after they had their bub'.
- 'I'm just astounded by how much the dads like it. Some of them will joke with me at the class... they'll arrive really keen, and their wives will joke that "this is their favourite part of the week"... They think they have to be the man and look after this woman through this process but they don't know how to do that, so I think what we give them helps them do that'
- 'There's a gap with dads experience and being able to talk about their experience and they were able to in the class... They could actually talk about it'
- **Improved parents' mental health literacy**
 - 'You see a lot of people down the track and... they're talking to each other and you could hear them saying the same words we used in the class... they've taken it all on board'

2. Benefits for midwifery practice at Redcliffe Hospital Maternity Services

- **Midwives feel more comfortable discussing mental health and emotional wellbeing with expectant and new parents**
 - 'Everything has changed, I feel so much more confident and comfortable talking about it. I had no idea really how to talk about it before'.
 - 'We are able to look at a mother as a whole now'
 - 'It was a really easy way of having a conversation with the couples about that emotional journey because after they ask them if they've been to classes and when they had, you could re-explore some of the main things that happened in the class'
 - 'I would say that conversations with parents especially in the postnatal ward are a lot easier since we have done Transitions to Parenthood and I do know that it has changed some people's practice across the unit because I've heard feedback from some of the home maternity service staff'
 - 'I guess for me, myself personally, it certainly improved my knowledge and confidence about having conversations – I do the majority of my shifts in the clinic, I look at their history of mental health before I call anyone in and if there is anything written there I always have a conversation with them about their emotional health – where they're at now and so forth, to make sure someone's had a conversation with them about it. Whereas probably I wasn't doing it as diligently prior [to the project]'
 - 'I think the language that we use with them – "we care just as much about your emotional health as your physical health" – and we place a big emphasis on your emotional health, and I know I use those words all the time'.

- 'That's when the ABC brochure is useful, I know we talk about the brochure later on, but that brochure is really useful as a lead-in conversation'
- **More effective use of screening measures**
 - 'When we discharge, because of our clinical pathway guidelines, we have to have a set talk that we do with everyone who comes through the hospital, and part of that talk can be opened up... but for a lot of staff its exactly what's on the paper that we still follow – they still follow that exactly to the tee. Which means they may not be having the bigger conversation about emotional wellbeing... It identifies what their EPDS score was antenatally... it's a flag if you as a midwife detect that they had a score over say 11 or 12 or something, you would in theory unpack a little bit more information from them'. This midwife went on to say that midwives who've been involved in delivering Transition to Parenthood do this, but those who haven't limit the conversation to only what's on the form (ticking boxes)
 - 'I think we've always had a stigma attached to it by the fact that when we're doing the booking in and we're doing the depression tick list, "is there postnatal depression in the family?" the most common answer is "I don't know". Because their mothers or their grandmothers haven't told them that they had postnatal depression, and now the next generation will be able to answer that question yes/or no'.
- **More effective training of students**
 - 'Student midwives have given more feedback on what they've learned from sitting with myself and the other midwives, they felt that actually speaking about emotional health has helped their learning'
 - 'I guess because a lot of women are discharged form hospital early, the new student midwives aren't actually being exposed to going through baby blues because they don't see it. .. (The women) go home after the 48 hours and see ya later. There's a whole generation of midwives that is missing out on that'
 - 'It's given me greater insight into thinking about student training and what do they need. I like having conversations with the students about their training at uni and what they've found helpful like working with different midwives in the maternity unit and so forth'
 - 'A student said that to me the other day, she said, "I was interested in the conversation you had with that woman because I didn't pick up on that but you obviously you picked up on something and then you chose to actually explore that conversation with her". And I said "A particular comment she made about something I'll dig a little deeper, and then we end up having a much bigger conversation about emotional health"'
 - 'I ask the student midwives what's their own knowledge of or how comfortable do they feel about talking about perinatal mental health from their training from unis. And one of the areas that comes up is that they say that they feel like they haven't enough experience or time spent on actually literally how do you have a conversation with a woman. So that's why I guess they benefit from sitting in with those of us who have...the role playing is great for that'
- **Midwives make more effective referrals**
 - 'I feel confident putting (referrals) in... I feel confident telling the women why the referral will be really good for them. A lot of people think of those sorts of things as a little frightening... to go and see people like that. So it's been easier for me to tell them where these people are and how supportive they are and how it's going to help them'

3. Collaboration with non-government services is valuable for the maternity service and beneficial for patients

- 'I think it was really good, (First 5 Forever) and Women's Health Queensland Wide presenting what's in the community, so informing people about what's available in the community... that really engaged them and I think probably help encourage them to go and seek that out'
- 'I think we don't collaborate with these organisations – where do the women go once we've stopped seeing them with home maternity?... Unless you bring these organisations in for the women to meet and connect with, then when we finish with them in home maternity service where are they going to go? They wouldn't know... do they know they can then pick up the phone and call a midwife?'
- 'The postnatal class is very important... as it allows women to connect with these organisations and other services'

4. Regular training is required to help midwives and others implement similar initiatives in future

- 'We did an evening in-service where we basically ran through the actual program with midwives. It was reasonably well attended by midwives and student midwives. Maybe we could do that a couple of times a year. The midwives get to know what we're actually teaching the expectant parents...that was a fantastic training session'
- 'Certainly involving the peer workers in actually in-services helps ...cause we know how much it has helped our own experience and knowledge and understanding of perinatal mental health work. So having peer workers involved in education of other staff would also be of benefit. Because then they'll also...their knowledge will improve from hearing about other people's experiences'
- 'Definitely if it was implemented elsewhere the midwife who is going to be facilitating the class needs to actually observe a class at the very least. Or two so that they see how it flows... Because it's really so different, this class. The emotional prep class it's not something you can just watch once and do yourself because it has such a personal impact on you as well, discussing this sort of thing'

5. Reflective space and clinical supervision are necessary to enable midwives to effectively support the mental health and emotional wellbeing of expectant and new parents

- 'The other thing that comes to me for this is clinical supervision. It would have been good at times to actually have the opportunity to talk to a perinatal mental health nurse and just brainstorm or even a social worker at times to talk about things that have come up in classes... I'd probably recommend this for other facilities if there was an established regular opportunity'
- 'Debriefing yeah cause that's the way you learn'
- 'A debriefing too yet also an on-the-spot. After that class I wanted to stay back and for like 15-20 mins and just talk with everyone about what happened... Sometimes people react and I was thinking have they reacted positively or negatively and but that couldn't happen cause everyone had to go off... but that would have been really helpful. Yep on-the spot rather than later'
- 'Yep I actually think both.. on-the-spot for things that have just come up in that class and also the opportunity on a regular basis if you could touch base with someone... a perinatal mental health nurse or a social worker... and talk about some of the things that have come up or questions you want to ask'

- 'I think other facilities that are looking at putting it in do need support. We were lucky there was five of us doing it'

6. The contribution of peers with lived experience of perinatal mental health issues is highly valuable

- **Lived experience stories translate clinical information into relatable, real experience**

- 'Working with peer workers is incredible; we should do more of it. Even mums with new babies to come back to classes for breastfeeding or labour or anything like that. You can see by the looks on their faces when the peer workers were speaking, what an impact it was having on them – as it was straight from the horse's mouth'
- 'I find the peer workers sharing their own experience has helped mums and dads and sometimes grandmothers and so forth sitting in the room help identify with some of the particularly with the signs and symptoms that they're sharing. A number of families have said to me "That's the first time I appreciate" – I'm talking about grandmothers – "appreciate actually what was happening for myself 20years ago, 30yrs ago. I didn't realise at the time that I was experiencing postnatal depression but now listening to them tell stories I realise that's what was similar to my journey, that's what I experienced". I think that's amazing because those women then said that's actually helped them provide better support to their daughters or daughters-in-law'
- 'Having someone come in that's actually had the experience, than someone who hasn't. If you don't have them (peer workers), it's just not going to be as relatable'

- **Peer perspectives help to destigmatize mental illness**

- 'I think that's one of the huge benefits of this class as they all get to see each other and talk about these issues and raise their own concerns together which takes all of the stigma away. Peer workers talking about it taking the stigma away. I just think it's definitely had that benefit'
- 'I think the stories, the fact that you're tapping into humanity is really important because the groups have all met us as midwives, they've all seen us in our uniforms, they've seen us present but they're actually tapping into people that have stories that they may be able to align with and people who are doing it in a professional way, but also there are cues in their expression so that you can see that this is still raw for them, and occasionally questions might actually show the layers underneath that person, and I think it does give clients permission within themselves to open up with their own stories. I really think the peer workers are an integral part of any program where you're looking at perinatal wellbeing'

- **Peer perspectives help midwives improve their own practice**

- 'That's the biggest thing I've got out of this, is watching the peers be able to tell their story and interact with us in a real way that is both professional and showing humanity. Because if we lose our humanity this program is worthless'
- 'The peer members in the project has also helped immensely the fact that with the role plays that they've done from a professional point of view you're looking at information they're sharing that what didn't happen with their journey, and in their stories more so what didn't happen in their story, who missed the fact they were heading down hill emotionally, and why that was missed – and that was a big turnaround for me, because of those few stories I have now looking at the cues that someone might have a problem that they might trying to conceal a little bit, so using language that might be more open so that they can communicate back'
- 'Certainly involving the peer workers in actually in-services helps ... cause we know how much it has helped our own experience and knowledge and understanding of perinatal mental health

work. So having peer workers involved in education of other staff would also be of benefit. Because then they'll also...their knowledge will improve from hearing about other people's experiences'

7. A focus on infant mental health and emotional wellbeing is valuable

- 'I think it's great especially the stuff that the psychologist talked about you know the houses – you know where relationships grow brains... and I've incorporated that into my last evening. And not being a qualified person in child health I used to teach a hodge podge of things I'd found but now it feels really professional and focussed so I feel confident that I'm giving the right information about early parenting relationships'
- 'That Hello Dad/ Hey Dad DVD, if that was around 18 years ago it would have been great for my own knowledge in parenting'

8. Midwives reported positive experiences of participating in the project

- 'It was such a journey'
- 'I just found it a great experience. I'm having trouble thinking of things that I would change because I really enjoyed it'

Appendix 5: Research Summary

Of the total participant group of 561, 302 participants agreed to enrol in a research study of outcomes of the Transition to Parenthood education program. The study aimed to investigate change in clinical measures of self-reported depression, anxiety, stress, parenting confidence and relationship quality from pre-program to post-program. Ethics approval was obtained through The Prince Charles Hospital Human Research Ethics Committee.

Participants

Considerable difficulty was experienced in following up research participants to complete post-program measures. The 302 participants who completed the pre-program measures received a follow-up phone call at 6 weeks post-program. Those who did not complete the measures over the phone at this time were offered alternative interview times, and were followed up repeatedly via text and voice messages. If a participant had still not completed the measures after a further 6 weeks, contact attempts were discontinued. While 302 participants completed the pre-program measures, only 40 (13%) completed post-program measures. Of these, 35 were mothers and 5 were fathers/partners. While the researchers offered participants great flexibility in how and when to complete the post-program measures, it is likely that the pressures of new parenthood, family demands and in most cases the return to work of one or both partners meant that completing research measures was not a high priority for them. Future researchers should consider incentivising participation in order to improve post-program completion rates.

With small samples, generalisability and representativeness are important issues. An analysis was conducted to investigate any systematic differences between responders and non-responders on demographics and pre-program clinical measures. No significant differences were found. While caution must be exercised in interpreting analyses of small samples, this evidence suggests that the responders were representative of the larger sample and that results can, with caution, be generalised to the larger group.

Depression, Anxiety and Stress

Levels of depression, anxiety and stress were measured using the Depression Anxiety and Stress Scale 21-item version (DASS21). The DASS21 is a self-report measure, which asks respondents to rate how often each of 21 statements has applied to them in the past week. The rating scale ranges from 0 'did not apply to me at all' to 3 'applied to me very much, or most of the time'. Seven items assess each of the three constructs: depression, anxiety and stress. Clinical scores are as follows:

Clinical Scores DASS-21			
	Depression	Anxiety	Stress
Normal	0-4	0-3	0-7
Mild	5-6	4-5	8-9
Moderate	7-10	6-7	10-12
Severe	11-13	8-9	13-16
Extremely Severe	14+	10+	17+

The following tables record how many participants, pre-program, scored within each band of clinical severity on the DASS21 subscales: depression, anxiety and stress.

Pre-program DASS21 scores

Mothers						
	Depression		Anxiety		Stress	
	Number	%	Number	%	Number	%
Normal	144	66.6	149	68.9	87	40.3
Mild-Moderate	41	18.9	43	19.9	60	27.7
Severe-Extremely Severe	31	14.5	24	11.2	69	32
Total	216	100	216	100	216	100

Fathers/partners						
	Depression		Anxiety		Stress	
	Number	%	Number	%	Number	%
Normal	63	77.7	67	82.7	41	50.8
Mild-Moderate	9	11.1	11	13.6	21	25.8
Severe-Extremely Severe	9	11.2	3	3.7	19	23.4
Total	81	100	81	100	81	100

These data indicate that before the Transition to Parenthood program, when parents were approximately 28 weeks into pregnancy, prevalence rates for depression, anxiety and stress were in line with the literature for mothers, and slightly higher than predicted by the literature for fathers and partners. Considering only scores in the Severe to Extremely Severe range, approximately 15% of mothers and 11% of fathers/partners reported significant levels of depression, 11% of mothers and 4% of fathers/partners reported significant levels of anxiety, and 32% of mothers and 23% of fathers/partners reported significant levels of stress.

The following tables report the degree of change in self-reported depression, anxiety and stress from pre-program to post-program.

	MOTHERS (n=35)			
	Pre	Post	Z	Sig
DEP	4.51	1.49	2.64	p=.008 *
ANX	2.6	0.95	2.54	p=0.01*
STRESS	9.77	4.46	3.42	p=0.00*
CONF	51.63	56.97	-4.54	p=0.00*

	FATHERS/PARTNERS (n = 5)			
	Pre	Post	Z	Sig
DEP	3.2	1.6	0.55	p=0.59
ANX	1.4	0.6	0.71	p=0.08
STRESS	10.8	3.0	1.75	p=0.07
CONF	53.0	55.4	-1.91	p=0.06

For mothers, self-reported depression, anxiety and stress all improved to a statistically-significant degree from pre-program to post-program. Statistically-significant results were not attained in the fathers/partners group, however self-reported depression, anxiety and stress all trended towards improvement from pre-program to post-program. For anxiety and depression, the results approached statistical significance. It is likely that a larger sample size would have yielded statistically-significant results on all three subscales.

Caution is required in interpreting these results, as the Transition to Parenting program was only one component of the parents' experience during the period of study. Few participants who completed post-program measures had scored in the clinical range on depression, anxiety or stress on the pre-program measures. The most that can be said of the current results is that participants' self-reported mood appeared to improve between the time of the first clinical measurement and the time of the second.

It would be valuable to collect more data over time from participants in the Transition to Parenthood program, and investigate whether or not those with higher clinical scores pre-program appear to experience greater improvement in depression, anxiety and stress following the program than those whose scores are in the normal range. Such a study would require a higher rate of post-program data collection than the current study was able to achieve.

Parenting Self-Confidence

Parenting self-confidence or self-efficacy is a construct measured by the Karitane Parenting Self-Confidence Scale (KPSC). The existing KPSC has been normed for postnatal use only. The current study adapted the items of the KPSC for use antenatally and postnatally, in order to measure change over time.

	KARITANE PARENTING SELF CONFIDENCE SCALE				
	Number	Pre	Post	Z	Sig
Mothers	35	51.6	57.0	-4.54	p=0.00*
Fathers/partners	5	53.0	55.4	-1.91	P=0.06

Mothers reported a statistically significant improvement in their parenting confidence from pre-program to post-program. Fathers and partners also reported improvement: this trend did not attain statistical significance, most likely due to the small sample size.

Caution is required in interpreting these results, as the Transition to Parenting program was only one component of the parents' experience during the period of study. Intuitively, it seems likely that parenting confidence wanes and waxes over the perinatal period, probably in interaction with parental personality variables and experiences of pregnancy, birth and early parenthood. It would be of great value to invest in a normative study of parenting confidence, to establish typical trajectories for parenting confidence over the perinatal period, and identify more precisely the points at which targeted

intervention can increase confidence. Further research is also warranted into the relationship between parenting confidence and mental health.

Relationship Quality

The Relationship Quality Index (RQI) is a single index score that measures the respondent's overall perception of the quality of the relationship between them and their partner. This measure has demonstrated psychometrics equivalent to or better than tools that attempt to assess relationship satisfaction across multiple domains (Norton 1983). The question 'All things considered, what degree of happiness best describes your relationship with your partner?' is scored on a 10-point scale from 1 'unhappy' to 10 'perfectly happy'. A higher score indicates a higher degree of perceived relationship quality.

For the overall sample, the mean score on the RQI pre-program was 8.61, indicating a high degree of relationship satisfaction. For the 37 respondents who completed the RQI post-program, the mean score pre-program was 8.49, which did not differ significantly from the mean for the whole sample. The mean score post-program for the subsample was 8.27, which did not differ significantly from the mean score pre-program ($t = 1.1860$, $p = .88$).

This finding indicates that both the whole sample and the subsample had high self-perceived relationship quality, and that relationship quality did not change from pre-program to post-program.

Reference

Measuring marital quality: A look at the dependent variable," by R. Norton, 1983, *Journal of Marriage and the Family*, 45, p. 147. Copyright 1983 by the National Council on Family Relations, US. Adapted with permission.

Appendix 6: List of services and resources

Type of service	Organisation	Web address	Description of services
Online Information			
	Australian Childhood Foundation: Bringing up great kids	www.kidscount.com.au/en/	It is a resource for all parents with information that can help you to raise happy and confident children.
	Raising Children Network	http://raisingchildren.net.au/	Offers up-to-date, research-based material on more than 800 topics spanning child development, behaviour, health, nutrition and fitness, play, sleep and safety.
	QLD Government Health Dept, Parenting – the first 12 months	www.health.qld.gov.au/goldcoasthealth/html/services/smalltalk.asp	The Small Talk newsletter series provides evidenced-based information on feeding, settling, play and baby's development milestones. In the back of each edition is a comprehensive list of agencies families can contact for additional support.
	Queensland Government: Resources for Parents	https://www.qld.gov.au/families/babies/advice/pages/resources.html	This site is a guide to websites, books and DVDs that may answer some of your parenting questions. Advice on raising children, connecting with other parents, related links
	QLD Centre for Perinatal and Infant Mental Health	www.childrens.health.qld.gov.au/qcpimh	See Looking after yourself in the perinatal period.
	Circle of Security International	www.circleofsecurity.net/	Animated videos on emotional attachment and emotional well being
	Healthway WA: Act Belong Commit	www.actbelongcommit.org.au	Act-Belong-Commit is a comprehensive health promotion campaign that encourages individuals to take action to protect and promote their own mental wellbeing The A-B-C provide a simple approach to become more mentally healthy
	Beyond Blue: Pregnancy and new parents	https://healthyfamilies.beyondblue.org.au/pregnancy-and-new-parents	Information for new and expectant parents, covering everything from bonding with your baby to spotting the signs of anxiety and depression. Also includes maternal mental health and well-being and 'Dadvice' for new and expectant dads.
	PANDA: How is Dad	http://howisdadgoing.org.au/	See page on perinatal

	Going : for men as new dads		mental health for dads and stress busting for dads and Dadvice
	Black Dog Institute	www.blackdoginstitute.org.au/public/depression/inpregnancy/postnatal/babyblues.cfm	Psych-Education on diagnosis, treatment and prevention of mood disorders such as depression and bipolar disorder.
	Ellen Barron Family Centre	www.health.qld.gov.au/ellenbarronfamilycentre/html/vodcast.asp	Settling baby instructions and videos
	Australian Breastfeeding Association	www.breastfeeding.asn.au/bfinfo/index.html	Answers to most of breastfeeding questions. Information is general in nature.
	Babycenter	www.babycenter.com.au/e1023900/podcasts	Relaxation podcasts and other information about pregnancy and parenting babies
	Eat for Health	www.eatforhealth.gov.au	Advice about the amount and kinds of foods that we need to eat for health and wellbeing
	Healthy Food healthy Planet	www.healthyfoodhealthyplanet.org	'Healthy Food Healthy Planet' is all about helping you to make the food and lifestyle choices that will protect your health and the health of our planet
	Healthdirect: Healthy Lifestyle	https://www.healthdirect.gov.au/healthy-lifestyle	Articles on how to have healthy lifestyle
	COPE: Centre of Perinatal Excellence	http://cope.org.au/	Website with information dedicated to improving the emotional wellbeing of parents before and during pregnancy, and the year following the birth of a baby. All information on this site is based on the latest research and National Clinical Practice Guidelines.
Apps			
	What Were We Thinking!	www.whatwerewethinking.org.au/	WWWT is an innovative program for mothers and fathers and their first babies. Shows strategies to manage baby crying / settling difficulties. Second, it provides new language / ideas to help parents adjust to the changes in their relationship with each other after the birth of their first baby. Worksheets and app
	<i>Smiling Mind</i> and <i>beyondblue</i> : Mind the Bump	www.mindthebump.org.au/?gclid=CN6qh4fgttECFY4KKgodLGcDMA	Free mindfulness meditation app to help individuals and couples support their mental and emotional wellbeing in preparation for having a baby and becoming a new parent.

	Feed Safe	www.feedsafe.net/	Breastfeeding and alcohol information. Feed Safe is a collaboration between the Australian Breastfeeding Association, Reach Health Promotion Innovations and Curtin University
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Telephone support			
	Health Direct Australia: Pregnancy Birth & Baby Helpline	www.pregnancybirthbaby.org.au/pregnancy-birth-baby-helpline 1800 882 436	Telephone support from 7am to midnight 7 days a week. Maternal child health nurses will discuss with the caller their concerns providing guidance and reassurance on a range of topic areas. Also online information
	Women's Health QLD Wide	womhealth.org.au/services/midwife-check-in 32160376	Midwife Check-in program and health information line. Also online information
	Yourtown: Parentline	www.parentline.com.au/about-us/ 1300 30 1300 between 8am and 10pm, 7 days a week	Parentline supports and nurtures positive, caring relationships between parents, children, teenagers and the significant other people who are important to the well-being of families. Brisbane based. Also online information
	MensLine Australia	www.mensline.org.au/ 1300 78 99 78 (24/7)	Professional telephone and online support and information and referral service for Australian men. Focus on relationships and wellbeing.
	SMS4Dads	www.sms4dads.com/About/Project	SMS4dads provides new fathers with information and connections to online services through their mobile phones . The text messages with tips, information and links to other services help fathers understand and connect with their baby and support their partner.
	PANDA Support Helpline	1300 726 306 9am – 7:30pm (AEST) Monday to Friday	PANDA provides the only national perinatal specialist helpline. The <i>National Perinatal Anxiety and Depression Helpline</i> provides risk assessment, support, counselling and referral to mothers, fathers, family and

			friends, and secondary consultation to health professionals.
	Breastfeeding Helpline (Australian Breastfeeding Association)	1800 mum 2 mum (1800 686 268) available 24/7 www.breastfeeding.asn.au/bfinfo/index.html	Breastfeeding Helpline Members can also access email counselling. Also online information.
Parenting Support			
	Playgroup Queensland Association	http://www.playgroupqld.com.au/find-a-playgroup/	To find a Playgroup, use the search tool and browse through the <i>Find a Playgroup</i> directory. Playgroups are informal and relaxed weekly get togethers of mums, dads, grandparents, carers, children and babies. At playgroup families have the opportunity to connect with each other families in their local communities, to share parenting knowledge, seek advice and gain valuable support.
	Dragonfly Dads Playgroup	https://www.facebook.com/DragonflyDadsPlaygroup/	Dragonfly Dads Playgroup is a playgroup for dads in the Moreton Bay Region (meets Kallangur). To receive email newsletter - dragonflydads@gmail.com
	Moreton Bay Regional Libraries	https://www.moretonbay.qld.gov.au/libraries/find-us/	There 10 libraries in the Redcliffe Hospital catchment area. Libraries provide a range of services including First 5 Forever, Baby Rhyme Time , Storytime and Playtime, toy library.
Parenting and wellbeing support	Neighbourhood Centres		
	Bribie Island Neighbourhood Centre	https://www.mycommunitydirectory.com.au/Queensland/Moreton_Bay/Information_Counselling/General_Support_Services_Counselling/102261/Bribie_Island_And_District_Neighbourhood_Centre Phone: (07) 3408 8440 Email: neigh@hotmail.net.au	Parenting programs, information and referral service, personal development workshops, mums groups, Family support service, Men and family relationship counselling service
	Caboolture Neighbourhood Centre	www.caboolturenhc.com.au	Community and family support, counselling service parenting skills course, community garden, budgeting and money matters, meeting place for community groups eg playgroup, Men supporting Men,
	Deception Bay Neighbourhood	www.dbnc.org.au	Social inclusion and connection activities,

	Centre		Harmony Choir, Mens Shed, Grandparents group, In Side Out Parenting course, Anger management course. Pasifika Playgroup. Pasifika PoliKoffee is a Community Engagement activity for Pacific Islander families with young children.
	Pine Rivers (Lawnton / Strathpine) Encircle Neighbourhood Centre	www.prnc.org.au	Community Information, Family Support, Young Parent Program, Legal Service, Tax help, Housing assistance, Counselling and Family therapy
	Redcliffe Encircle Neighbourhood Centre	www.encircle.org.au	Family support, children's contact centre, family counselling, workshops on relationships and emotional wellbeing, Circle of Security. Access to Legal services, Centrelink
	Australian Breastfeeding Association	www.breastfeeding.asn.au/contacts/groups	A local group is looked after by trained, volunteer breastfeeding counsellors or educators who live in the area. Most groups get together once or twice a month for a variety of activities eg. discussions on breastfeeding and parenting topic, a guest speaker, play in the a park or visit to local attraction
	Parenting groups	https://www.qld.gov.au/health/children/babies/help/mothers/	Benefits and Tips on how to find a parent group and exercise classes for parents and babies
	Lady Gowrie: Early Years Centre	http://gowrieqld.com.au/	The Caboolture Early Years Centre is a place for all families with young children (0-8yrs) and expectant parents to learn new skills, meet new friends and can help you give your children the best start in life. Qualified, experienced and friendly staff offer free activities such as playgroups, advice on your child's health and development, parenting information and courses, child health clinics and advice on breastfeeding and post-natal care. Satellite services at Woodford, Deception Bay
	Brisbane Kids: Murrumba Downs & surrounding districts Mums	https://www.brisbanekids.com.au/murrumba-downs-surrounding-districts-mums-4/	We have regular meets, a facebook discussion group, Mums nights & much, much more!!
	Peachtree	http://peachtree.org.au/pepp-talks/	PEPP Talks ' Preparing

			Emotionally for the Perinatal period' These are designed to help prepare expecting parents emotionally (both as individuals and as a couple) for the transition to parenthood. Parents learn strategies to cope with the emotional realities and challenges that come with not only pregnancy and birth, but also the period of time after baby comes home.
	Queensland Government: Triple P parenting	https://www.qld.gov.au/about/newsroom/triple-p/	Triple P – Positive Parenting Program provides free tips, seminars, sessions and courses. They're now available free to all parents and carers of children from birth to 16 years throughout the state. There is a range of Triple P programs available to suit different ages, issues and needs.
	Yourtown: Glugor Young Parent Program	https://www.yourtown.com.au/what-we-do/young-parents-program	Parenting and early childhood development program in Deception Bay. The program offers parents up to age 25years opportunities to develop new skills through: - Parenting and child development workshops - Life skills workshops about things like healthy eating, budgeting and relationships - Personal Support - Playroom and outdoor play areas for children to explore and develop - Information about local services
	Relationships Australia	http://www.raq.org.au/courses/191	Relationship courses as well as family counselling and support
Online forums			
	Pandora Parent Group	https://pandoraparentgroup.org/ https://www.facebook.com/groups/pandorarentgroup	To create an online and face-to-face community of parents (including those expecting) who support one another in parenting by providing encouragement and advice, understanding and care whilst utilising the education and advice of experts in parenting-related fields. Also hold meetings at Reef Point Café Redcliffe
	Pasifika Families	https://www.facebook.com/PasifikaFamilies/	Pasifika Families began its roots in 2005 originally as a Samoan playgroup (Aute Samoa) which has now evolved and brought about

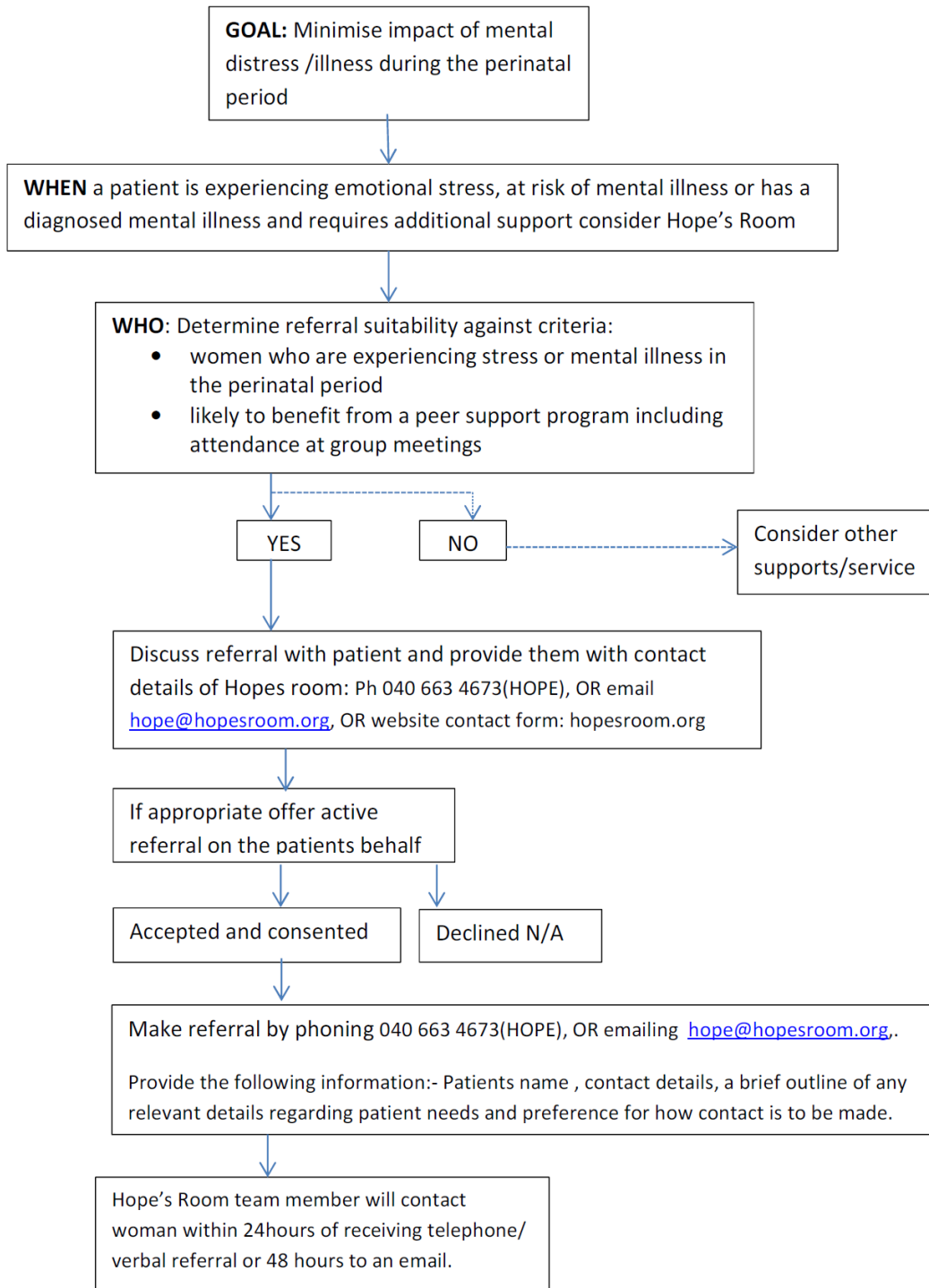
			projects such as Pasifika playgroup, Pasifika parenting program & POLIKOFFEE combined with various community events
	Babycenter: Mums and Bubs Northlakes	http://www.babycenter.com.au/thread/1914405/mums-and-bubs-north-lakes	Online chat group
	Murrumba Downs and Surrounding Districts Mums	https://www.facebook.com/MurrumbaDownsSurroundingDistrictsMums	Murrumba Downs & Surrounding Districts Mums is a place where mothers from suburbs on Brisbane's Northside (including, but not limited to Kallangur, Petrie, Narangba, Bray Park, Deception Bay, North Lakes and Caboolture) can come together; create connections with other mums whilst making lifelong friendships for themselves and their children. We have regular meets and a Facebook discussion group.
	North Brisbane Mums	https://www.facebook.com/NorthBrisbaneMums/	An open Community Page for families on the North side of Brisbane. Our community supports the Mummy's Wish Inc.
Physical, social and mental wellbeing			
	Moreton Bay Regional Council Healthy and Active Program (iMove Directory)	https://www.moretonbay.qld.gov.au/healthy-active/iMove/	The 2016/17 iMove directory offers more than 250 local activities to help keep you and your family active, healthy and connected with the community. Previously known as the Healthy and Active Moreton Guide. Prides information on mum and baby activities e.g. Mums and Bubs Yoga/Fitness, RnB music, Kanga training classes
	Brisbane Kids	https://www.brisbanekids.com.au/fitness/	Health and well-being classes for Brisbane Mums
	Moreton Regional Library Library Discover and Learn program	https://www.moretonbay.qld.gov.au/infotalks/	Discover & Learn through free special interest workshops and talks at libraries for adults eg. Infant Massage, Baby Yoga, Movement and massage, Fitness as the Fountain of Youth, Mindful Ageing.
	Deception Bay Community Youth Program	http://www.dbcyp.org.au/	Families program: Young parents morning tea, Pasifika Playgroup, Under 5s day. Healthy Activities: active kids

			playtime, Family Fun and Fitness.
Maternal and Child Health Services			
	Child Health Service	https://www.childrens.health.qld.gov.au/chg/our-services/community-health-services/child-health-service/	List of services and locations including Redcliffe, Kippa-Ring, Woodford, North Lakes, Pine Rivers, Bribie Island, Brighton, Burpengary, Caboolture, Deception Bay, Kallangur, Zillmere, Morayfield. Services include Early feeding support, early parenting support groups, parenting programs, immunisation services, self-weigh facilities.
	Institute for Urban and Indigenous health (IUIH) Family Partnership Program	http://www.iuih.org.au/Services/Child_and_Maternal_Health#bubsclub	This intensive home visiting program supports women who are pregnant with an Aboriginal or Torres Strait Islander child to improve their health and the health of their baby. The IUIH Family Partnership Program is based at Strathpine and available to women living in the North Brisbane/Caboolture region or who are planning to have their baby at the Royal Brisbane and Women's Hospital, Redcliffe Hospital or Caboolture Hospital.
	Moreton Aboriginal and Torres Strait Islander Community Health Service (ATSI CHS)	http://www.moretonatsichs.org.au/	Moreton ATSI CHS is committed to providing holistic health care to raise the health and well-being of Aboriginal and Torres Strait Islander people in the Moreton Bay area. Four clinics are located in Caboolture, Deception Bay, Strathpine and Morayfield
	General Practitioners	https://www.yellowpages.com.au/find/doctors-medical-practitioners/moreton-bay-council-qld/page-1?eventType=pagination Note : Moreton Bay North and Moreton Bay South have FTE rates that are significantly less than the Queensland average.	There are approximately 298 GP practices and 1200 GPs in the Brisbane North Primary Health Network > this is larger than the catchment area for Redcliffe Hospital. Moreton Bay north subregion has 74 GP practices. Preventative and primary care services including maternity shared care.
Redcliffe Hospital Services			
	Birth and Parenting		Weekly sessions over 5

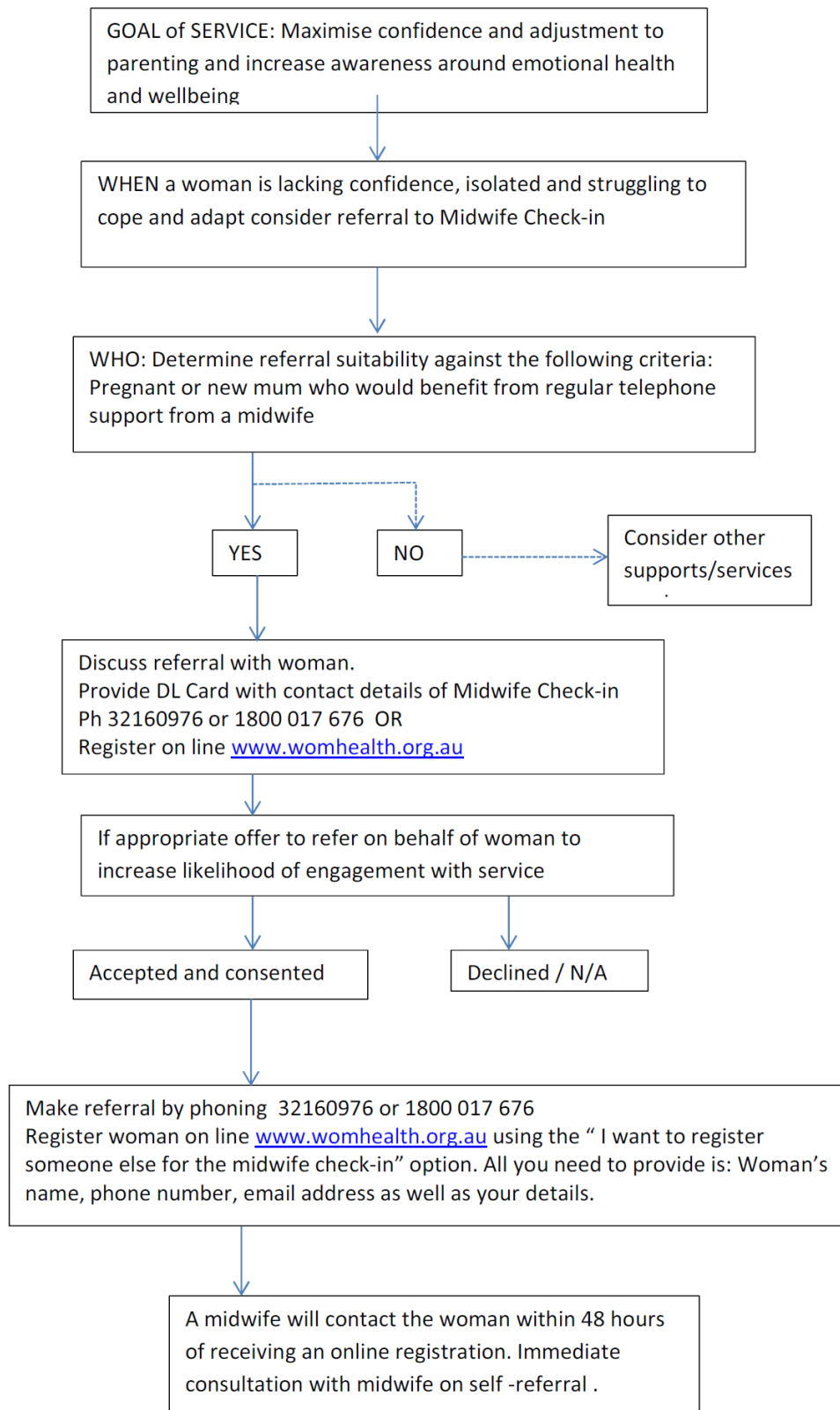
	Program		evenings or 2 Saturday Workshops, offered at 2 locations (Redcliffe and North Lakes). Best started around 28 weeks into pregnancy. Postnatal Connections session held approx 6 weeks after birth.
	Home Maternity Service	https://www.health.qld.gov.au/redcliffe/services/wns-maternity	Home visits by a hospital midwife following birth and discharge from hospital. Up to 3 visits depending on need. First visit 2-34 days after discharge.
	Ngarrama Antenatal and Birthing Service	http://www.childprotectioninquiry.qld.gov.au/_data/assets/pdf_file/0003/177222/Aboriginal-and-Torres-Strait-Islander-Health-Unit-Metro-North-Hospital.PDF	Antenatal care and education for women who identify as Aboriginal or Torres Strait Islander or have a partner who so identifies.
	Young Parent Program YPG	https://www.health.qld.gov.au/redcliffe/services/wns-maternity	Childbirth education, antenatal checkup and support group for young parents aged 21 years and under. There are 10 education sessions which parents can attend without booking. Located at the Community Health Service Redcliffe.
	Redcliffe Hospital Antenatal Social Work Services	https://www.healthdirect.gov.au/australian-health-services/service/30222623/redcliffe,4020/social-work/redcliffe-hospital-social-worker-services/?ref=%2Faustralian-health-services%2Fresults%2Fredcliffe,4020%2Ftights,aht-12757%2Fsocial-work Ph. 3883 7753	Support to women by providing information, counselling, support and advocacy in response to their current health and social needs.
Ethno Specific and multicultural support networks			
	Moreton Bay Regional Council	https://www.moretonbay.qld.gov.au/multicultural/	Council is committed to a multicultural Moreton Bay by providing services and initiatives for people from culturally and linguistically diverse backgrounds.

Appendix 7: Examples of Referral Pathways

Hope's Room Referral Pathway



Midwife Check in (Women's Health QLD Wide) Referral Pathway



Appendix 8: Summary of Deliverables Contracted Between Queensland Mental Health Commission and Queensland Centre for Perinatal and Infant Mental Health and Women’s Health Queensland Wide

Shared deliverables

Queensland Centre for Perinatal and Infant Mental Health

Women’s Health Queensland Wide

Stage 1: Preparation					
	Deliverables	Responsible Person/s	Start Date	Completion Date	Evidence
1	Comprehensive project plan developed and agreed by all stakeholders	QCPIMH and WHQW	1/5/15	11/10/16	Project Plan signed off by Steering Committee Co-chairs
2	Recommendations regarding training, supervision and support of peer workforce in mental health compiled from literature review and environmental scoping exercise	QCPIMH	1/5/15	12/7/16	Recommendations accepted and way forward endorsed by Steering Committee
3	Specialised resource developed and produced (ABC brochure), for use at all stages of family’s contact with Redcliffe Maternity Service, and potentially into future (sustainability and transferability)	WHQW	1/5/15	31/12/15	Brochure endorsed by Project Steering Committee. Other resources also sourced/ developed – see Report
4	New booking-in process devised for Redcliffe Maternity Service, to improve focus on emotional wellness in perinatal period	Redcliffe Maternity Service	1/5/15	31/10/15	New booking-in process embedded in practice
5	Content of antenatal and postnatal education sessions finalised	Project Working Group	1/5/15	13/12/16	Transition to Parenthood Manual Endorsed by Project Steering Committee
6	Model for peer support groups finalised	QCPIMH	1/5/15	31/3/16	Peer groups implemented using agreed model

7	Redcliffe Maternity Service senior staff engaged in new process and midwives and administration staff trained and engaged	Redcliffe Maternity Service	1/9/15	31/3/16	All midwives and administration staff using new booking-in and scheduling processes
8	Project Officer for NGO project components recruited	WHQW	31/10/15	30/04/16	Appointment of Susan Upham to Project Officer role

Stage 2: Implementation					
	Deliverables	Responsible Person/s	Start Date	Completion Date	Evidence
1	New process implemented at Redcliffe to improve focus on emotional wellness throughout perinatal period	Redcliffe Maternity Services	1/10/15	31/12/15	Booking in of families to revised model for Jan 2016 program
2	Antenatal education classes conducted at Redcliffe Hospital in 10 Monday night courses and 12 Saturday courses (approximately 330 couples)	QCPIMH/ Redcliffe Maternity Services	4/1/16	31/12/16	23 Antenatal sessions (Emotional Preparation for Parenthood) facilitated by Midwives, Peer Support Workers and QCPIMH with support from WHQW and Child Health
3	Follow-up postnatal classes conducted by Redcliffe Maternity Services for families who participated in antenatal classes	Project Working Group	14/5/16	31/3/17	12 Postnatal sessions (Postnatal Connections) facilitated by Midwives, Peer Support Workers, QCPIMH, WHQW and First5Forever with support from Child Health and Playgroup QLD
4	Facilitated Peer Support Groups conducted on ongoing basis for parents wishing to access this form of perinatal mental health support. One initial group and expand as necessary. Each group to have a lead and co-facilitator and support 5-8 parents and babies/infants as necessary	QCPIMH/ Hope's Room Limited	4/1/16	31/03/17	34 sessions conducted at Clontarf, supported by two peer group facilitators 8 mothers registered to attend these sessions On average 3 mothers attended sessions with 6

					mothers being the highest attendance
5	Reflective practice sessions provided by Perinatal Mental Health Service for Peer Educators and Peer Facilitators on group basis	QCPIMH	4/1/16	31/12/16	6 sessions conducted by Ann Moylan for 5 Hope's Room staff, average 2-4 attendees per session
6	Peer Educators, Peer Group Facilitators and Midwives provided with initial and ongoing training based on literature review and environmental scoping of available training materials	QCPIMH	4/1/16	31/12/16	All peer educators and peer group facilitators provided with Hope's Room orientation, and completed Mental Health First Aid training delivered by Hope's Room directors. Midwives provided with in-service training x 2, delivered by QCPIMH in collaboration with midwife educator and Hope's Room directors.
7	Resources required to deliver the program developed and hosted on appropriate platforms for optimal positive impact	QCPIMH/ WHQW		By 30/09/17	Resources hosted by QCPIMH
8	Services documented that promote emotional wellness in the perinatal period, support mental health and emotional wellness of mothers, fathers, infants and families in the Redcliffe Hospital catchment area	WHWQ	1/2/16	31/3/17	Service Mapping completed – Appendix 6
9	Collaborative relationships strengthened and 'active' referral pathways developed among the non-government sector, public health services and peer services in the Redcliffe catchment area	WHQW	1/2/16	31/3/17	2 Referral Pathways between state and NGO services completed as templates for other sites: Hope's Room and Midwife Check-In Program

Stage 3: Evaluation and Reporting					
Deliverables		Responsible Person/s	Start Date	Completion Date	Evidence
1	Training and HR processes required to implement the project evaluated and documented, resulting in the production and dissemination of manualised information on how non-government services and peer services can work safely and effectively in collaboration with public health services in the area of antenatal and postnatal education and care	QCPIMH	9/11/15	25/8/17	Manual hosted by QCPIMH
2	A suite of resources, including manuals, to enable services elsewhere to implement similar initiatives in future	QCPIMH	1/10/15	25/8/17	Resources hosted by QCPIMH
3	Review capacity of non-government sector to participate in perinatal mental health and wellness promotion, prevention, and early intervention, for future sustainability and transferability	WHQW	1/2/16	31/3/17	Capacity of NGO sector in Redcliffe is captured in service mapping. This provides a template to enable similar rapid mapping in other sites.
4	Greater awareness of emotional wellness in the perinatal period among expectant parents and public health service staff, as measured through project evaluation processes	QCPIMH	4/1/16	30/6/17	See Report
5	Parents feel the program has helped prepare them to meet the emotional changes and challenges of pregnancy and early parenthood, as measured through project evaluation processes	QCPIMH	31/3/17	30/6/17	See Report
6	Stakeholder organisations see the program as worthwhile, with benefits outweighing costs, as measured through project evaluation processes	QCPIMH	31/12/16	30/6/17	See Report



Developed by the Queensland Centre for Perinatal and Infant Mental Health (QCPIMH), Children's Health Queensland Hospital and Health Service, with the support of the National Perinatal Depression Initiative.
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