POST AND ANTENATAL
DEPRESSION
ASSOCIATION INC.

PANDA

Guide to Postnatal Depression Support Groups

2nd Edition

Second edition

Guide to Postnatal Depression Support Groups

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- All the staff and volunteers of PANDA throughout many years of dedication
- All the women who attend and grow through all types of support groups.

Male and female terms are used interchangeably. Postnatal depression used to encompass spectrum of mood disorders in perinatal period. Support groups is used to encompass spectrum of support groups.

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PANDA

Post and Antenatal Depression Association Inc.

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1. Introduction

Purpose of the Guide

PANDA has a long history of providing and promoting support groups for women with postnatal depression (PND). Its foundations and current funding are grounded in the principles that underpin PND support groups – mutual support self help. Until 2000, PANDA's volunteers, women who had recovered from antenatal and postnatal depression, ran support groups from their homes and in communities throughout Victoria.

Since 2000 PANDA has maintained its commitment to promoting the importance and benefits of support groups for women with PND by:

- building and maintaining the PND services database of support groups provided throughout Victoria
- promoting the benefits of attending a support group and providing referrals to women with PND who make contact with PANDA's helpline
- providing support and information to service providers and consumers establishing PND support groups
- establishing the PND Support Group Facilitators' Network (see Appendix 7) to connect group facilitators for peer support, ongoing professional development and to foster the establishment of PND support groups throughout Victoria.

The aim of this guide is to:

- present PANDA's resources and knowledge, amassed over a number of years, in a useful format
- promote the value of support groups in the recovery process for women with PND
- outline a structured approach to establishing and facilitating different PND support groups.

Much of this information has been developed by PANDA's staff and volunteers and some has been drawn from resources made available to PANDA by support groups from around Australia. Where possible the source has been identified.

The guide is for those interested in establishing and facilitating group based interventions for women with PND. This may be a:

- worker from agencies such as community health, counselling services, maternal and child health or local councils
- consumer who has recovered fully from her own experience of PND especially if she has additional group work or counselling skills.

Support groups should be established with the support of services or community agencies, ideally in partnership, to ensure resources and supports are available to the group.

There are many ways to facilitate a PND support group. It is hoped that service providers and consumers will use this guide to encourage and support the establishment of more support groups for women with PND. For more support and resources contact PANDA, the PND Group Facilitators' Network or other group facilitators who run PND support groups.

Belinda Horton
PANDA, CEO

About PANDA

PANDA is a community based not for profit organisation that provides telephone support, information and referrals to anyone affected by perinatal mood disorders including partners, extended family members and anyone who is seeking information about these conditions.

PANDA began in the early 1980's when two women with PND were introduced by their maternal and child health nurse. They found it helpful to meet regularly to share personal experiences. Over time they were joined by other women who also benefited from the mutual support and collectively the women established a support group. PANDA grew over the next few years with the establishment of more support groups around Victoria.

At this time, little was known about childbirth related mood disorders. PANDA's founders approached a psychiatrist with a special interest in this field to be available as a consultant and advisor for the women. The psychiatrist spoke at a PANDA information session about the treatment of PND. Personal experiences were shared by a woman who had recovered from PND and a man whose partner had experienced PND. Over two hundred women and their families attended the first information session, eager to learn more about PND and to meet others going through similar experiences.

In 1985 a Committee of Management was formed and in 1986 PANDA became an incorporated association. Regular newsletters and the growth of several support groups in various locations around Victoria were a highlight during this time. PANDA relied on hard working and dedicated women who had recovered from PND who facilitated support groups and provided 24 hour telephone support service from their homes and in their communities. PANDA also relied on funds raised by its volunteers.

PANDA was at the forefront of community discussions about antenatal and postnatal depression in building supports for women and their families during this time. However PANDA's reliance on volunteers to support unwell women and their families through support groups or telephone support became unsustainable. This also paralleled the reduction in volunteer resources within the community as there were more women in the paid workforce.

A review of PANDA in 2000 resulted in a more sustainable model of operation with recurrent funding from the Department of Human Services. The telephone support helpline became office based during business hours only, with answering machines providing information to support after hours callers. A database of support groups run throughout Victoria by other facilitators and the PND Group Facilitators' Network replaced PANDA's volunteer facilitated support groups.

PANDA has always relied on the enormous commitment of staff and volunteers to provide services to families and the mental health sector. PANDA has now consolidated its position in the mental health sector providing a critical service to Victoria.

Funding

PANDA's funding is primarily from the Victorian Department of Human Services, Mental Health Branch under the Psychiatric Disability Rehabilitation Support Services funding for Mutual Support Self Help services. It also receives project funds from the Department of Education and Early Childhood Development, Office for Children under the Supported Parents and Playgroups Initiative, Best Start. PANDA relies on a number of fundraising events, essential for it to grow.

PANDA staff, volunteers and operations are overseen by a Committee of Management, responsible for enhancing the functioning of PANDA and overseeing its adherence to its Constitution and funding accountabilities.

Services

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

- **telephone support, information, referral and advocacy**, staffed by counselling staff and trained volunteers, many of whom have recovered from antenatal or postnatal depression, in keeping with mutual support self help principles. Follow up calls are provided, in particular to high needs women where there is severe PND, suicide risk or at risk infants. Calls are received from partners and extended family members.
- **fact sheets** distributed to women, their families, friends, health professionals and general community members. Available on website.
- **state-wide resource and referral database** of professionals and services with a specific interest and expertise in working with women experiencing perinatal mood disorders and their families.
- **assistance setting up PND support groups** through information to prospective support group facilitators, ongoing secondary consultation and the PND Group Facilitator's Network.

- **website** - members of the community and health professionals access information about perinatal mood disorders, interventions, research and support.
- **information, education and training seminars** – customised for professionals and community groups according to specific requirements.
- staff and volunteers who appear as **guest speakers** to professional and community groups.

Service model

PANDA's model of service integrates a volunteer and paid workforce. The model is underpinned by principles of mutual support self help, the PDRSS Standards and National Mental Health Standards, duty of care, social justice and Continuous Quality Improvement.

PANDA views perinatal mood disorders and the process of recovery within a bio-psycho-social framework. This recognises individuals holistically, more broadly than the medical model alone. It recognises that perinatal mood disorders exist within family and social systems. This model is also based on the knowledge that treatment for depression is most effective when a combination of interventions is implemented.

PANDA's assessment, support, counselling and referral of women and their families who make contact with the helpline encompass the biological, psychological and social aspects of their lives. For all callers, PANDA offers to provide information and referral options that enable them to seek support from a range of services that will address their biological, psychological and social needs, for example a general practitioner, counsellor and PND support group.

For callers assessed to be high needs, PANDA takes on a short term intensive service coordination role involving contact with service providers and monitoring the caller until the services are established.

Helpline objectives

- Give new parents experiencing perinatal mood disorders a single contact point for information, referral, resources, follow up and support that is acceptable and accessible.
- Give women and their families access to intervention and support services within their local community that are important for recovery from perinatal mood disorders.
- Provide a follow up call program to ensure callers are supported while they link into good community supports and that they remain engaged with services or can seek alternatives
- Achieve significant and positive outcomes for the mental health of women, their relationships with their partners and families and the social and developmental health of their children.

PANDA's vision

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

PANDA's mission

- To support and inform woman and their families who are affected by post and antenatal mood disorders
- To educate health care professionals and the wider community about post and antenatal mood disorders

PANDA's governing principles

The mental health sector

The National Standards for Mental Health Services, introduced across Australia in 1997, have been used to develop a set of Standards for Psychiatric Disability Support Services (PDRSS Standards) in Victoria. The PDRSS Standards have been developed following consultation with the Psychiatric Disability Support Service sector and govern PANDA's operations. They are based on the following general principles for addressing mental health issues:

- promotion of optimal quality of life for people with mental health disorders and/or problems
- focus on consumers and a positive outcome for them
- an approach to consumers and their families that recognises their unique physical, emotional, social, cultural and spiritual dimensions
- recognition of the human rights of people with mental illness
- equitable access to appropriate services when and where they are needed
- community participation in service development
- informed decision-making by individual consumers
- continuity of care and support through clinical and community services
- a systematic approach which emphasises comprehensive, coordinated and individualised care and support

- accountability to consumers, their families, staff, funding bodies and the community
- equally valuing the various models and components of mental health care.

PANDA has developed it operations with regard to the above principles, to ensure the provision of consistent high quality services.

Mutual support self help

There are many services throughout Australia that could be categorized as mutual support self help. These services are based on a holistic view of mental health that recognises the importance of sharing knowledge gained by people who have experienced the impact of mental illness in their lives. PANDA was founded and continues to be governed by these principles.

The target group for these services is people who are affected by a mental illness – individuals, carers and family members.

The concept of mutual support refers to the positive effects of people with similar problems, solutions and experiences, working together to support each other. This involves identifying and sharing knowledge and experiences about the impact of mental illness in their lives. Put simply it is the sharing of the lived experience of perinatal mood disorders, vital to de-stigmatising these conditions.

The concept of self help refers to people's ability to take control over their own lives. People have access to information, referral and support to assist them to understand the effect of mental illness in their life and improve their quality of life.

Perinatal mood disorders

Having a new baby is usually a happy event but can be a stressful time during which many adjustments have to be made. Many new parents are not aware that mild to severe mood changes are common after childbirth. In the year after childbirth a woman is more likely to need psychiatric help than at any time in her life.

There are a range of recognised mood disorders in the perinatal period (from conception to the end of the first postnatal year).

Pregnancy is a time of immense physical and emotional change with some mood variation to be expected. For about 10% of pregnant women the emotional changes become a significant problem. **Antenatal depression** is not well understood but it requires early identification and treatment. Many women who are diagnosed with postnatal depression report their depression started during pregnancy.

Between the third and tenth day after birth about 80% of new mothers go through the '**baby blues**'. It is unlikely that the 'baby blues' are a mental illness as the prevalence would suggest that it is a normal process of release for the new mother, processing the pregnancy, labour and childbirth. Symptoms include exhaustion, tearfulness, anxiety, mood fluctuations and irritability. The 'blues' are transient and will pass with understanding and support.

The most severe perinatal mood disorder is puerperal or **postnatal psychosis**. This affects one in 1000 mothers, usually three to four weeks after delivery. The mother may be unaware she is ill as her grasp on reality is affected. Symptoms include severe mood disturbance (marked elation, depression or fluctuations from one to the other), disturbance in thought processes, bizarre thoughts, insomnia and inappropriate responses to the baby. There is risk to the life of both mother and baby if the problem is not recognised and treated. Postnatal psychosis requires hospital admission. Women usually fully recover with appropriate treatment.

Postnatal depression

Most new parents find adjusting to life with a new baby very challenging, but over 15% of women and 10% of new fathers develop PND. Many new parents do not know that PND can occur unexpectedly after delivery and typically blame themselves, their partners or their baby for the way they feel. Some try hard to 'snap out of it' without understanding they have little control over the way they feel. It is very important that women, their partners and families learn to recognise the signs and symptoms of PND so they can ask for help early.

The Diagnostic and Statistical Manual of Mental Disorders (DSM IV) diagnostic criteria

The DSM IV does not distinguish PND from Major Depression. With the addition of 'onset related to childbirth', it defines PND as a major depressive episode which has an onset within four weeks after baby's birth. At least five of the listed symptoms (see below) must be present for a diagnosis of PND to be made. One of the five symptoms must be depressed mood or diminished pleasure or interest in activities. Symptoms must be present most of the day nearly every day for two weeks. There must be an associated decline in social and/or occupational functioning.

DSM IV symptoms for PND

- Depressed mood; diminished pleasure or interest in activities
- Sleep disturbance (insomnia or hypersomnia);
- Weight loss or weight gain
- Psychomotor agitation or retardation
- Loss of energy
- Feelings of worthlessness or inappropriate guilt
- Diminished concentration, or indecisiveness
- Frequent thoughts of death or suicide

(Diagnostic and Statistical Manual of Mental Disorders. 1994.)

Bio-psycho-social model of PND and recovery

PND should be viewed within a bio-psycho-social framework inclusive of the woman's biological, psychological (spiritual) and social (cultural) wellbeing. Factors that contribute to PND come from all these areas and result in a variety of symptoms. A different combination of factors is responsible for each woman's unique experience of PND. Strategies for managing PND and the symptoms towards successful recovery must address all bio-psycho-social aspects of the woman's life. This usually requires a combination of interventions.

PND exists within family and social systems and does not belong to the woman alone. Factors that contribute to PND and its impact will relate to the broader family, community and social networks. Assessment and intervention services provided for women with PND need to consider the significant other people in her family.

Contributing factors for PND

Some women are more vulnerable to PND than others. Women experiencing some of the known contributory

factors should be encouraged to talk with their doctor and family. It is important to remember that it is the individual meaning and response to these factors that needs to be discussed and assessed.

Factors thought to contribute to PND

Biological

- Genetic predisposition to depression
- Sudden changes in pregnancy hormones following delivery
- Nutritional deficiencies
- Difficult or highly medicalised pregnancy or childbirth experiences
- History of pre-menstrual tension
- Previous experience of PND
- Family/personal history of mental health conditions such as depression, bipolar disorder or schizophrenia
- Sleep deprivation

Psychological

- Infertility and use of IVF for conception
- Difficult or traumatic birth (perhaps involving unexpected interventions such as an emergency caesarean)
- Traumatic or abusive childhood (particularly sexual abuse)
- Unrealistic expectations of motherhood and of herself
- Certain personality types (perfectionist or controlling)
- Limited social and emotional skills (difficulties in effective communication)
- Past unresolved issues of grief and loss such as previous miscarriage

Social

- Lack of family and community support
- Problematic or unresolved relationship issues with own mother
- Difficult couple relationship
- Partner who is removed emotionally, works long hours or travels
- Intrusive or difficult family relationships
- Social isolation
- Financial hardship
- Lack of close friends, particularly families with children
- Moving house
- Lack of access to transport
- Being a younger or older age
- Stressful life events such as a death in the family or job loss

PND Symptoms

PND symptoms can begin anywhere from 24 hours to several months after delivery. When onset is abrupt and symptoms severe, women are more likely to seek help early. When the symptoms are harder to separate from the normal adjustment to changes after having a baby treatment may be delayed, if it is ever sought and PND can linger beyond the first year.

The following descriptions of PND symptoms come from women who have spoken to PANDA or attended PND groups.

Sleep disturbance unrelated to baby's sleep needs

Most women with a young baby fall asleep as soon as they are able to. Women with PND can lie awake for hours feeling anxious while the baby sleeps. Some have trouble falling asleep or wake early in the morning. Others want to sleep all the time and have trouble getting up in the morning.

Appetite disturbance

Women may feel totally uninterested in food and say, "I force myself to eat because I am breastfeeding, but I don't taste anything". Some overeat in an attempt to control their anxiety. Some feel sick at the thought of food.

Crying

A woman may feel sad and cry without apparent reason. Tears come easily day and night. Some say, "I want to cry but can't. I am crying on the inside."

Inability to cope

Daily chores, caring for the baby and herself may seem insurmountable to a woman with PND. Small demands she previously coped with may make her feel completely overwhelmed. She may talk about feeling like running away, wishing it would all go away, feeling overwhelmingly exhausted and very heavy, physically and emotionally.

Irritability

She may snap at her partner or other children without cause. Partners often say, "I can't do anything right. If I fold nappies she complains I do it the wrong way. If I don't help, I'm being unsupportive".

Anxiety
She may feel a 'knot in the tummy' most of the time and panic without cause. Some experience heart palpitations so severe they fear they are having a heart attack. They may be anxious about their own or their baby's health even after being reassured that nothing is wrong. Many women describe anxiety as their most obvious symptom and reject the term postnatal depression. They deny being depressed. The term 'postnatal anxiety' might more accurately describe the way some women feel.

Negative obsessive thoughts
There can be little peace in the thinking processes of a woman with PND. Small worries can become consuming thought processes that interfere with her ability to listen, concentrate or remember. She may be afraid to let her partner go to work in case he has a car accident or be fixated on something bad happening to the baby. No amount of reassurance or distraction can hold her thinking at bay.

Fear of being alone
Many women go out a lot or need their partner (or someone) at home with them at all times because they are afraid of being alone at home. The fear of something going wrong with the baby or her own perceived inability to cope with the baby on her own is overwhelming. Some feel incredibly lonely and go out to feel connected with other people. This takes an enormous amount of effort. Others feel they cannot be with other people and withdraw from family and friends, not answering the door or telephone.

Memory difficulties and loss of concentration
A woman may forget what she wanted to say mid-sentence. She may not be able to concentrate on simple tasks or to take in new information. Organising herself and her family can become too difficult. Sometimes she doesn't know where to start or she starts everything at once. Her ability to think creatively about her problems and to find solutions disappear, including what will help her feel better and finding services to help her.

Feeling guilty and inadequate
Feeling guilty can be a common feeling for all mothers but more so for the mother with PND. Her thoughts and feelings constantly reinforce in her own mind that she is inadequate and a bad mother. She may be unable to take encouragement from the good things she has done or to feel affirmed by her relationship with her baby. Reassurance will not dissuade her thinking and can discourage her from talking about how inadequate and guilty she feels.

Loss of confidence and self-esteem
A woman who enjoyed her job may panic at the thought of returning to it; no longer sure she is able to do it. A woman who enjoyed having family and friends over may panic at the thought of visitors. She may feel unable to prepare a meal which she enjoyed doing before the baby was born. Most women with PND have very low self esteem regardless of how well they seem. Some describe their experience as a loss of sense of who they are, a loss of sense of self.

Some women sum it all up by saying "*There is no joy in anything any more*".

To be able to distinguish between normal struggles and emotions that come with adjusting to new parenthood and symptoms of PND it is important to gain an understanding of the:

- presence of known bio-psycho-social contributing factors
- pattern and number of bio-psycho-social symptoms
- intensity and degree of distress the symptoms cause for the woman and her family
- extent to which they interrupt her normal daily functioning
- length of time the woman has been experiencing symptoms
- effectiveness of her usual strategies for dealing with stress and whether these are not working.

Postnatal depression is difficult to identify

Society makes it difficult for a woman to acknowledge that she may be experiencing PND. She is constantly confronted by messages about joy and bliss that rarely include the challenges that come with motherhood. The media tends to reinforce the unrealistic expectations of motherhood, promoting celebrities who appear to be coping exceptionally well.

Added to this is the stigma of depression with PND often being portrayed negatively and sensationally. Women will put on a brave face and go to extraordinary lengths to hide how they feel. A woman who is not coping can feel very alone and can find it very hard to come to terms with the way she is feeling.

Reasons why women don't let people know or seek help:

- They don't know what PND is or how to recognise its signs.
- The stigma associated with depression prevents them asking for help. The need to be seen as normal and a good mother is very strong.

Symptoms can be masked with incredible effort, sometimes even from their partner.

- It is hard for a woman with PND to admit she is not coping and to ask for help - to acknowledge that she cannot manage her feelings and that something is seriously wrong. Denial is the enemy of recovery.
- Depression itself breaks down her ability to communicate, make decisions and help herself.
- It can be too difficult to find the words to talk about her painful and negative thoughts because she may feel that no one will understand or others will be horrified by her thoughts.
- In the early weeks after having a baby there are usually many other things happening that the woman uses to explain how she feels (baby's sleep, her sleep changes, impact on her partner). She assumes things will get better when everything settles down.
- She may have tried to communicate her feelings or to ask for help from family or services and her feelings were dismissed. This leads to an increased sense of failure, inadequacy and guilt, especially if she's told that she should be happy or that her own mother did it tough. She may not try again to access help until further along in the process.
- She might blame her partner for the way she feels resulting in significant conflict between the new parents.
- The woman does not trust workers in services with her dark secrets. She may deliberately put on a sunny, capable face when seeing her nurse or her doctor because she desperately doesn't want them to know the extent of her bad feelings.
- Fear that she will be put on antidepressants if she talks about her feelings and what this will mean if she is pregnant or breastfeeding.
- Fear that the authorities will take her baby away if aware that she has PND and is not coping, that she is therefore a bad mother. This is especially so if there is a conflictual partnership breakdown – her ex-partner will take the baby from her.
- Even the most skilled health professional can miss PND.
- Not knowing what services can help her or she feels that no one can help her anyway.

Effects of PND

With early identification and intervention most women fully recover from PND. However if PND is not identified or treated the toll it takes on the woman, her family and extended relationships increases.

Effects on the woman

- There can be significant impact on the woman's physical wellbeing – poor diet, lack of sleep, altered activity levels and exhaustion.
- Depression and anxiety may be expressed in physical symptoms such as pain, headaches, chest pain, difficulty breathing or feeling sick.
- Ongoing depression and high anxiety levels reduce the body's immunity and ability to fight infection.
- Unresolved or future episodes of depression or complicated mental health problems.
- Suicide is the leading cause of maternal mortality in the UK and probably also in northern Europe (Confidential enquiry into maternal and child health, 2001).

Effects on the mother-infant relationship

- PND can interfere with behavioural and emotional mother and infant interactions.
- A woman with PND may be less sensitive to her infant's needs and less appropriately responsive to his communications.
- There can be attachment difficulties between the mother and infant that effect her ability to parent.
- Severe PND has been claimed to contribute to child abuse and neglect. (Brockington, 1996).

Effects on the infant

- Difficulties in mother-infant interaction may lead to increased fussiness or withdrawal and have an impact on the development of the infant's brain pathways.
- PND can impact on the child's future cognitive and language development as well as social competence and mental health.
- The child may go into adulthood with behavioural and mental health problems and experience difficulties parenting their own children.

Effects on the partner relationship

- Living with a woman experiencing PND is difficult. Her partner can be the target for much of her frustration and distress, despite his best efforts to provide support.
- The couple's relationship may be threatened by the stress of PND. The woman's distress, her intense needs within the relationship and her partner's struggles to know how best to provide support can result in conflict.
- Partners often feel confused, lost and helpless and are at increased risk of developing depression and

anxiety. They may manage this with increased use of alcohol, drugs, withdrawal or extended hours at work.

- They benefit from counselling, support from their family and friends and from other people with similar experiences such as men at PND support groups.
- Partners benefit from understanding more about what is happening to the woman. It is important they are included by the health professionals who are treating women with PND. Partners tend to be more supportive if they understand what the problem is and what they can do to help.

Effects on family relationships

- Parent-child relationships may be damaged due to the woman's withdrawal or volatility with her children, parental conflicts and inconsistent parenting, often at a time when they need her most (toddlers and pre-schoolers).
- Extended family relationships may become strained due to a lack of understanding of PND or the family maybe unhelpful and provide only conditional support.
- Extended family members may worry about the new mother and become exhausted by providing practical and emotional support.

Research by Marian Radke-Yarrow (1999) into depressed mothers with children and found that depressed mothers:

- are more likely to back off when they meet resistance from children while trying to manage them
- are less able to compromise in disagreements with their children, responding with harsh enforcement or by avoiding confrontation
- personalise normal attempts at independence as breaking rules
- spoke less during routine activities like making and eating meals
- make more negative comments.

Summary

- PND can be mild, moderate or severe.
- Symptoms of depression and anxiety can begin:
  - during pregnancy (antenatal depression)
  - suddenly after birth
  - gradually in the first weeks or months after childbirth (mostly within 4 months).
- PND occurs in all cultures, religions, socioeconomic and age groups.
- PND is not a modern condition. Each generation calls it something different. It may have been called a 'nervous breakdown' fifty years ago.
- Some women are not identified with PND until well after the baby's first birthday.
- PND can happen after miscarriage, stillbirth, normal delivery, or caesarean delivery. Pregnancy is the common factor.
- PND is not something to be ashamed of; it should be seen as one of the many complications of pregnancy and delivery.
- Most PND occurs after a first baby. It can also occur after any or every pregnancy.
- A woman who has had PND has a 50% chance of recurrence with a subsequent pregnancy.
- If a woman becomes pregnant again before recovering from PND, it will continue through the pregnancy and may worsen. It is wise to wait at least a year after discontinuing medication before falling pregnant again.
- Early signs of PND are recognisable and with early identification and treatment most women make a full recovery.

Interventions

If a woman does not feel the way she expected to feel after having a baby it is very important that she talk to her partner, family, friends and her doctor or maternal and child health nurse. It could simply be that she is having trouble adjusting to changes in lifestyle that occur when a baby is born and to the demands of the new baby. With sensitive support and practical help her emotions and coping will improve dramatically.

If she is experiencing PND it is important that she receive appropriate help as soon as possible. See Bio-psycho-social Interventions flowchart for an outline of the combination of interventions and support.

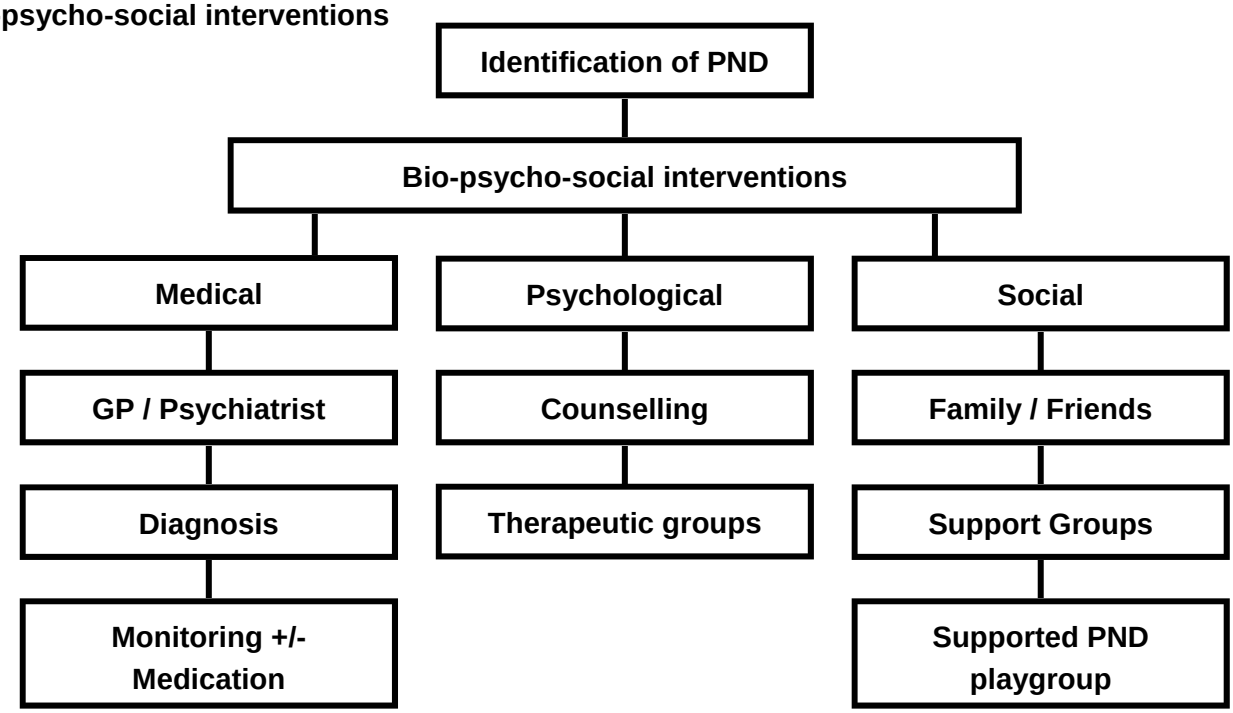
All women with PND need emotional support from their family and friends. Some women find psychological treatments in counselling and group work helpful especially if they have experienced traumatic events. Attending a PND Support Group can be a central part of the woman's recovery.

Antidepressant and other medications can be a vital form of treatment for many women with moderate to severe symptoms. There are many misconceptions about antidepressants and women who could benefit refuse to take them because they are afraid the medication is harmful. Women need support to commence and continue to take medication as there can be side effects initially and an initial increase in their symptoms needs to be monitored. Antidepressants are not addictive and some are safer than others while breastfeeding and pregnant. Important information can be gained from the doctor, pharmacist or an independent drug information line and should form the basis of the woman's decision regarding medication.

What helps?

- Early identification (antenatal carers, GP, MCHN)
- Emotional support (family, friends, PANDA)
- Monitoring and referral to services (MCHN, GP, PANDA)
- Practical help with housework and childcare (family, friends)
- Psychological help (GP, psychologist, counsellor)
  - counselling, support groups
  - range of psychological interventions such as cognitive behavioural therapy, emotion focussed therapy
- Medical help (GP, psychiatrist)
  - antidepressant medication
  - hospitalisation (ideally in a mother-baby unit)
- Time out from the baby to enjoy her own interests
- Exercise, meditation, relaxation, balanced diet

Bio-psycho-social interventions



Antenatal depression

Much of the information in this guide is applicable to women with antenatal depression (AND).

Many women with PND say that their feelings of stress, depression and anxiety began during pregnancy. It is an important time to support the mental health needs of pregnant women to provide early intervention and prevention, but it can be difficult to find services. Pregnant woman should be encouraged to access additional services to prevent ongoing depression after the baby is born.

Assessing the emotional and social status of women during pregnancy with routine screening should be accompanied by ongoing conversations about the pregnant woman's wellbeing, particularly if additional risk factors emerge during pregnancy such as domestic violence (Pollard, 2001) and mental illness. Once identified, it is ideal for women with AND to be able to access a range of support and intervention services.

Services that could be established to support women with AND include:

- The full range of support groups as outlined in Chapter 5. AND groups can be promoted through the same channels as PND groups with the addition of maternity clinics, hospitals, obstetricians, GPs and retail outlets.
- Educating antenatal carers and childbirth educators about the mental health needs of pregnant women to enhance their awareness and strategies for management as well the provision of psychosocial childbirth education.
- Expanded childbirth education programs like Ready, Set, Baby; Bringing Baby Home and Baby Makes 3, to identify women and couples who show symptoms of AND, and provide early intervention in a supportive psycho-educational group.

Antenatal education about AND and PND would significantly reduce the trauma these illness cause by:

- dispelling the myths and misconceptions and help to de-stigmatise AND/PND
- giving new mothers permission to ask for help if they do not feel the way they expect to feel
- informing expectant couples that the symptoms of AND/PND are recognisable and that help is available. Include partners, whenever possible, in discussions about AND/PND so the early signs are detected more quickly. The father is often best able to detect early symptoms
- differentiating AND/PND from the usual difficulties adjusting to pregnancy and having a baby that most couples experience.

Support groups established for women with AND might specifically focus on the following issues.

Set realistic expectations

Couples with high expectations may find adjusting to life with a baby more difficult. Couples should be given permission to find the early months difficult and encouraged to ask for help.

Acknowledge the grief that comes with the baby

Talk about some of the changes that can come with being a new mother and father. Having a baby can mean loss of time, freedom, control, couple time, skills, confidence and dreams. Discussing these in an AND support group can give permission for new parents to grieve and have the time, space and support they need. Unacknowledged grief can cause stress, anxiety and depression.

Plan for the baby's arrival

Encourage couples to think about a support network for when the baby is born and support them to establish it. This might include their doctor, maternal and child health nurse, friend who might help with older children, someone who can help with meals, and one of the many community support groups that deal with a variety of problems.

Explore the myths of motherhood

Acknowledge the pressure on new mothers to 'cope' by discussing the super mum image and the expectations that come with it. Help women with AND to think about how they want to approach being a mother, to make choices about their own priorities, reinforcing it is important to ask for help and to share the responsibilities. Reinforce that it will take time to get to know their baby and that things will be disorganized or feel out of control for a while.

2. PND support groups

Overview

- PND support groups are a valuable and constructive intervention for women with PND. They provide a group and peer to peer support experience for the participants.
- Women's learning about PND and themselves is enhanced within a group situation because they are learning from each other as peers.
- A PND support group should be offered as one aspect of a woman's recovery, complementing other interventions. It is advisable that women in a PND Support Group also be supported and managed by their health care providers and support services. Sometimes a PND group can be a safety net for women waiting to access other treatments such as counselling, or provide support after other treatments have been completed.
- Support groups do not suit all women with PND, as not everyone is comfortable in a group setting. Some women drawn to a PND support group may interact within the group in unconstructive ways. It is important to remember to keep the wellbeing of the group as a whole, a priority.
- There are many different types of PND support groups and each takes on a unique identity throughout its life span.
- There is no one way to establish and run a PND support group, but planning needs to occur to ensure that participants have a safe, beneficial experience (Chapter 5). Combined with the needs of the participants these structures help facilitators guide the group process.
- It can take perseverance for a support group to grow and mature. Facilitators need to be flexible and resourceful. If a strategy or approach does not work the first time it may work another time, during another session or with another group of participants.
- It is vitally important that facilitators are cared for in their roles in establishing and running a PND support group. It can be challenging personally and professionally to facilitate a group. There need to be opportunities for debriefing, supervision and ongoing training. Co-facilitation is very important for these reasons.
- PND support groups provide opportunities for women with PND to come together for mutual support. Women talk of their PND support group as the only place that they can come to where they do not have to explain or cover up how they feel and where they are not judged for their depression.
- Participants benefit from information about many aspects of PND, its assessment and treatment, motherhood transition, parenting and emotional skills. This information is provided by the facilitators with a degree of expert knowledge and by the participants who share their experiences with each other.
- Friendships established among participants can become lifelong relationships of mutual understanding and support. Saying goodbye to a support group can be an extremely difficult process that requires preparation and some ceremony. Participants may benefit from transition to an ongoing group such as a supported PND playgroup.
- PND support groups can provide opportunities for partners and family members to get support and information about living with PND. Men usually value an opportunity to gain support from other men in the same situation.

Following are some important aspects of PNS support groups.

Power of peers

Participating in a support group with other people facing the same challenges

"provides an opportunity for people with common needs and problems to draw upon and share the support, resources and knowledge of all for the benefit of all. By sharing experiences about the impact of mental illness in their lives, people are able to gain greater insight into, and understanding of, their difficulties and issues, and learn alternative and constructive approaches to dealing with the impact of the mental illness.

Outcomes for people who participate in mutual support and self-help programs include: abatement of feelings of guilt, shame and fear; greater knowledge about mental illness, effective treatments and self-help strategies; reduced social isolation and feelings of alienation; strengthening of hope, self-respect and self-reliance; and diminished distress and confusion for all affected by the mental illness".

(Department of Human Services, Standards for PDRSS)

Shared experiences

Even in the most structured therapeutic and educational groups participants benefit from the chance to share their experiences, to feel heard, validated, supported and understood by other people with similar experiences. They come to know they are not alone.

Recovery through connections

Some participants learn they can connect with others they have met in the group despite the depth of isolation and disconnectedness they may be feeling. PND cuts off relationships and having the opportunity to attend to and care for others in need can be powerful in the recovery process. Many facilitators have witnessed the wonderful empathy and support that women with PND can provide to each other.

Destigmatisation

Being with other people experiencing similar challenges and learning that having a mental illness does not make you inadequate is important to breaking down stigma about PND. Once participants experience telling their stories and being accepted and supported by the group they can be empowered to talk more openly with family and friends and seek help.

How has your week been?

This may be an obvious question to ask participants but sometimes overlooked. Starting each session with the sharing of how participants have been or any challenges/successes in the week between sessions is a powerful way to re-connect with the participants. It may be the only time they can share how they are managing PND, perhaps storing up the things they want to share with the group because they are not comfortable to confide in family or friends. Talking about these concerns with each other will help participants to clear their thinking before the group content, therefore maximising their receptiveness.

It will give facilitators an opportunity to hear how participant's learning in the group has been applied in their daily lives, as well as ensure that participants receive support and encouragement from the group. Participants report that this can be the most helpful part of the support group.

Laughter is the best medicine

Participants of support groups often find great pleasure in being able to have a good laugh in an environment where they feel relaxed, without the pressure of needing to appear well or happy. The use of humour and laughter about serious issues can help take some of the fear out of PND and to normalise many aspects of their otherwise stressed lives.

True acceptance

Not having to explain their feelings because of a shared understanding within the group can allow participants to explore the deeper issues they are facing. Many women feel protective of the concerns of their family and friends or feel pressure to perform or recover quickly. Being with peers removes this expectation enabling more significant issues to be dealt with.

Hope for recovery

It is usually beneficial to have women in the group at different stages of treatment and recovery. It encourages less well women to be hopeful and to draw on support from women further along in their recovery. Facilitators need to be mindful that the stories in the group do not have a dampening effect on the more well participants to avoid participation in the group causing relapse.

Building relationships

The key to establishing and facilitating any group is building strong relationships with all potential stakeholders.

Looking beyond the group, relationships need to be fostered with the community, with organisations, funding bodies and referring agencies. These external relationships are important to ensure that women with PND know about the group, will be referred and will come to the group. Those promoting the group need to clearly articulate the group's purpose to build the referrers' confidence and trust in its quality as an appropriate program for vulnerable women and their families. Mapping the key relationships begins in the early establishment stage. Decisions need to be made about how these relationships will be fostered through community consultations and communicating with stakeholders.

Group work theory maps how relationships develop within a group between participants and facilitators. One major benefit of attending PND support groups is the development of trust within new relationships, key to women continuing to attend. The first meeting of the group is crucial to the establishment of the trust that will underpin relationships. This is supported by the:

- setting of expectations in group rules (See Appendix 5)
- culture that develops within the group
- skills of facilitators to maintain the group and its members.

Good for babies/children

PND can have significant impacts on the participants' ability to connect with and be available to their babies and older children, impacting on the babies/children's wellbeing and development. There will be a vast range of quality in participants' relationships with their children and parenting but all women with PND require support.

Regardless of whether the babies/children are present in the group, support groups and supported playgroups have many benefits for the mothering and parenting skills of the participants by:

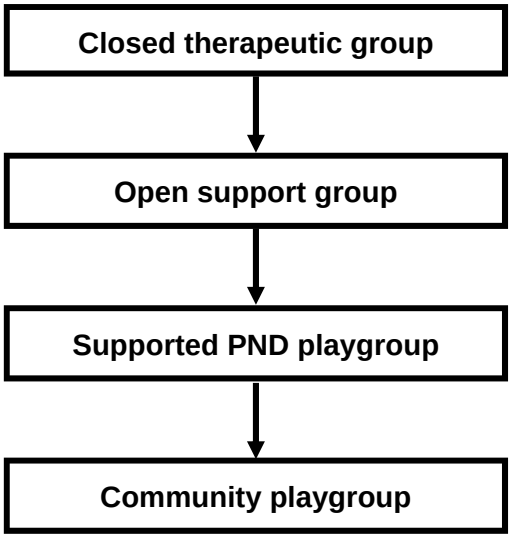
- supporting participants in their recovery, improving their capacity and resilience as parents
- raising participants' awareness of the importance and quality of their relationships with their babies/children
- educating participants about the developmental process and needs of their babies/children and providing activities that support their interactions including play, eye contact, imitation, noises and talking
- facilitators and participants providing role modeling of interactions and communication with babies/children and building/reinforcing the participant's skills in parenting and relationships
- providing strategies to manage parenting demands while experiencing PND and recovery.

Transition framework

The changing needs of the participants across the continuum of diagnosis and recovery from PND requires that a range of group options are available that are tailored to their increasing wellness and levels of independence. It is ideal in the planning stage to adopt a group transition approach and consider options available to participants once their involvement in the group ends. This may mean that the support group is established as one of a range of other groups or it fits into an existing continuum of programs. This is the benefit of the community consultations and partnerships in the planning stage to avoid the group being established in isolation or not at all if the organization is overwhelmed with the need across the continuum.

Strategies need to be considered that will support the transition of participants from one group to the next. For example, a woman may attend both a supported PND playgroup and community playgroup until she is ready to transition to the community playgroup. Having some continuity or at least handover with the facilitators will also support the transition.

An example of the transition along the continuum of care in group services:



Supported playgroups

"Supported playgroups are those that are initiated and facilitated by a paid coordinator and are available to families who might not normally attend a playgroup. They target culturally and linguistically diverse (CALD) families, Indigenous families, families with mental health and/or disability issues (either the parent or the child), teenage and young parent families, and families who are socially isolated and/or disadvantaged." (Playgroup Victoria, 2006).

Definitions of these groups vary across the sector. Supported playgroups may also be called facilitated playgroups and are different from intensive support or therapeutic playgroups where families are particularly disadvantaged and access ongoing professional support, counselling or therapy at the playgroup. (Playgroup Victoria, 2006).

Supported and intensive playgroups for women with PND, their babies and children are growing in number. They provide options in the continuum of group programs, following on from support or therapeutic groups. They are suitable for women who are further along in their recovery who require support to attend or ongoing therapeutic involvement. Supported playgroup programs shift the focus from participants to include their babies and children.

Benefits of supported PND playgroups are to:

- establish new or continue the support and friendships established through PND support groups
- provide opportunities for mothers and their children to play and have fun
- support and strengthen participants' parenting skills and knowledge of their children

- improve outcomes for children through stimulating activities and interactions with their mothers
- prepare participants for greater involvement in other community groups/resources.

While it is ideal for participants to transition from the supported playgroup to community playgroups or for the facilitator to slowly withdraw, the reality is that the playgroup usually requires ongoing support as new members are added.

The supported playgroup is registered with the state playgroup association to access the administrative and insurance benefits, and to join the database of supported playgroups. The local playgroup association will provide resources and training for those interested in establishing a supported PND playgroup.

The program for supported PND playgroups will be unique to each group. Some will focus on the developmental needs of children, others the parenting skills of participants. Furthering participants' recovery from PND will be common to all supported PND playgroups. Refer to the sample playgroup program in Chapter 6.

Sustainability

Once the group has been established within strong relationships and a continuum of group programs, consideration needs to be given to its sustainability. Successful groups have been de-funded or discontinued due to short sighted planning, limited evaluation and inadequate network relationships. The planning outlined in Chapter 5 will support the group's sustainability.

Barriers to groups

There are many obvious and subtle factors that will prevent the successful establishment and sustainability of the support group, and the engagement of the participants. Physical and transport barriers can prevent women attending the group as well as cultural and social barriers such as stigma and suspicion.

Identifying potential barriers and strategies to address them may lessen their impact on the group. The information in Chapter 5 is intended to support this process.

Engaging women in support groups

Support groups are usually established in response to an identified need but the attendance of women at support groups can be cyclical and unpredictable. Many facilitators have had the experience of setting up a support group and then struggling to attract and engage women in the group. At another time or for other groups there may be more referrals than they can accommodate and even a waiting list between groups. Even within one group's calendar year there can be adequate numbers for one program and not enough women to run the group later in the year.

There may be no obvious reason for inadequate numbers and may feel beyond the control of the facilitators. It may be fair to say that the women who are reluctant to attend the support group are the women that would benefit most from the group. It can be very disheartening that the work that has gone into setting up the support group has not been fruitful. Participants may feel disappointed that the numbers are low.

A significant factor in low numbers may be that the referrers are unfamiliar with the group or the facilitators. Building relationships with the referrers is important to ensure they understand and can promote the value of the support group to potential women.

On an individual level there are many reasons that may prevent a woman coming or staying in the support group, for example:

- not identifying herself as a group person, therefore uncomfortable in a group
- not well enough to manage the setting, program and relationships
- unable to commit to the program or get herself to the group program sessions (transport, childcare, costs)
- not confident being with other people feeling unattractive and unlikeable
- don't want to hear other people's sad stories that may make her feel worse
- don't understand how the group may be run or the benefits of staying in the group
- partner or family make her feel uncomfortable about going to the group
- going to the group acknowledges that something is wrong – that she is unwell, weak and needs help
- the woman's own stigma about being with other people with PND – will they all be crazy?

Strategies that can be used by facilitators to engage women in the PND support group.

1) **Planning** – this needs to be undertaken as outlined in Chapter 5 to make sure the recruitment

and engagement of the women into the group is defined and smooth.

2) **Engaging the referrers** – long running support groups which have a good reputation with referrers usually have consistent referrals. A newly established support group maybe viewed hesitantly by referrers as they are unsure of the quality and purpose of the group for the vulnerable women they are concerned about. Meeting with the referrers to inform them of the group, how it will run and how the referrers can identify potential group participants can help.

3) **Pre-group home visit** – meeting the woman after she has been referred to the group is a good opportunity for her to get to know the facilitator(s). Often the relationship with the facilitator(s) is the main reason a woman attends and keeps attending the group. The woman can tell her story to the facilitator which is an important part of assessing her suitability for the support group. She can also share her concerns about attending the support group. This contact can be an indepth telephone interview if a home visit is not feasible.

4) **Information about the support group** – providing the woman with information builds her trust and confidence in the group. An information brochure can cover things such as:

   - benefits of attending a support group
   - other people that will be attending the group
   - facilitators
   - what to expect from the group (program, safety and some inside stories)
   - supports in place to help her get to the group sessions (transport, child care and follow up).

5) **Help the woman understand how a support group fits into recovery** – discussing the following questions with her:

   - When do I know I am ready to attend a support group?
   - What can I gain from attending a support group that is different from the supports I already have?
   - What can I contribute to a group?
   - How can I explain the group to my partner, family and friends?
   - What might prevent my needs being met in the group or prevent me getting to the group? What to do if these things happen?

6) **Pre-group morning tea** – bringing women together for a brief morning tea in the week before the start of the group program can help ease anxieties. It provides the women with an opportunity to meet each other and the facilitators and to become comfortable with the group room and venue. Women can be encouraged to bring their partner, friend or family member for support, allowing the support person to learn about the group as well. Referrers could accompany the women they have referred. Women who have been through the group may be prepared to come along and chat to the new participants about their experiences.

7) **Follow up phone calls** – before the start of the support group making telephone contact with the woman can help keep her motivated to attend. Calling the woman who does not attend a session is very effective in establishing a support network for her and maintaining her links with the group.

8) **The first session** – once the pre-group preparation has occurred with the women the first session will determine their engagement. Acknowledging the nervousness of the women, greeting them warmly, orientation to the facilities, name tags and introducing them to each other is important. Burning oils and background music can add to the warmth and cosiness of the room.

9) **Setting expectations** – holding a brainstorm with the women in the first session to establish some group rules helps clarify behaviour, expectations and safety in the group. They can also explore why women with PND do not attend group sessions and how participants are expected to manage this. This may also include a discussion exploring how participants exit from the group, especially if related to behavior disruptions or group unsuitability. Being able to predict how things will be managed in the group may encourage the women to take the risks required to participate and stay in the group. See Appendix 5 for a sample of group expectations.

Being a PND support group facilitator

There is no doubt that facilitating a support group with women with PND can be an uplifting and fulfilling experience for facilitators. Some of the benefits and highlights facilitators experience includes:

- seeing relationships between isolated and unsupported women grow into genuine, supportive friendships

- seeing women who are unwell make gains in their recovery and learn new skills in communication and self care throughout the program
- supporting partners through the partners' session to understand what is happening to them and their wives/partners can effect real change in the couple's relationship and the life of the new family
- seeing a new mother fall in love with her baby and children.

Facilitating a PND support group can be demanding and draining. The engagement and maintenance of women with PND within the group can be difficult as they can be fragile and vulnerable. It can be disheartening for facilitators to continually hear of traumatic and chaotic developments in the lives of the women. Supporting women with their choices that are not always in their best interests takes endless patience and unconditional positive regard. To see women not getting better or drop out of the group can be disappointing.

Facilitators are often fitting the support group into an already overwhelming work load. Often there is limited time or space for the facilitator to prepare for the group sessions or to reflect on and process the sessions, their observations and experience of the group.

All facilitators will be personally affected by the group, women and discussions at some time. It is not possible to completely quarantine their own vulnerabilities and reactions from the content of the group. The stories of the women will tap into the facilitators' experiences which may be destabilizing and distressing. This needs acknowledgement and planning to ensure adequate support and supervision for facilitators as ultimately this will impact on women in the group.

Co-facilitation

PND support groups are best facilitated by two people who work well together and have shared visions for the group and its participants. There will be days when the energy level of one of the facilitators fluctuates and the back up of their co-facilitator is important to ensure the group runs smoothly. The relationship between the facilitators should be one of trust and good communication as there will be issues of difference that need to be addressed.

The co-facilitators' de-briefing and sharing of observations about the group, its participants and each other is vital to keep the group on track and for their own wellbeing.

Supervision

It is important that facilitators access external supervision and planning time. Reflecting personally and professionally on their skills, experience of the group and requirements of participants is in the best interests of group participants. Facilitators' organisations will need to support this supervision financially and with time allocations. If there is tension between the co-facilitator or within the group it is important that facilitators can access individual and external supervision.

Facilitators need to consider the following questions:

What is my motivation for facilitating a PND support group?
Being clear of the motivation to establish and facilitate the PND support group is important. Sometimes a worker may be directed to take on the group as a part of their workload due to the organization's focus on PND. Other reasons may include using their skills and experience in working with PND groups to meet an identified need. This question is particularly important for women who have personally experienced PND who want to establish a PND support group.

Do I have the time to commit to the group?
Planning for and establishing a support group is time consuming in the short and long term. Being available to make these time commitments will determine whether or not becoming a group facilitator is the right thing at this time.

Do I have knowledge of local services and networks?
Living or working in an area for a period of time is an asset to establishing a PND support group due to familiarity and awareness of local services and networks. Time will need to be spent building this local knowledge as part of the planning for the group and community consultations

What skills will I need to facilitate the group?
If one of the facilitators is less experienced or skilled in group work it is ideal for the other facilitator to provide this knowledge for the group and support to the co-facilitator. This guide outlines many of the skills required at different stages of the group's development (See Chapter 3). There are also a range of other training programs to develop skills in group work. Even with this knowledge and skill each group is unique and being a facilitator requires learning about each group and its dynamics. Often the greatest learning comes with experience, supervision and reflective practice.

How will I look after myself in the role of group facilitator?
Supervision and debriefing will support facilitators and the responsibility for their own well being lies with them. Being aware of their limitations and areas of expertise is important as well as their skills in self care and reflective practice.

Can I be clear of my role as group facilitator?
The group facilitators need to be able to set clear role boundaries for their involvement in the group to prevent becoming overly involved with the participants. Shared experiences within a support group can be intimate and tempt confusion in roles. Over stepping these boundaries runs the risk of loss of objectivity in the group which disadvantages the group as a whole and may create dependency in the participants. Co-facilitators can monitor each other for signs of role confusion and provide feedback.

To sum it all up……

The following came from a Brisbane PND support group and sums up the experience of facilitating a PND support group.

"Flexibility is the key. Some days women just want to talk and it may be difficult to be structured. (Remember that women with PND may not be able to concentrate for very long).

Flexibility should include the starting time of the group. Ill women may find it difficult on some days to meet deadlines at starting time. It is very important to let them know it is not set in concrete.

Be prepared for the women to become upset – crying can be very therapeutic, especially when there is an understanding environment. If it's obvious that someone is having a particularly bad day, if possible, take them aside and let them have one on one until the worst is over. You will be amazed how beneficial this is. The other women, who will already have picked up on this, will be able to be more supportive once the crisis is over.

Be prepared for the group to fluctuate quite dramatically. Some days you may have nine women and other days only two. Other days no one but you will be there. Don't get disheartened. Please remember that women with PND often find it hard to organise themselves and their children to go out. They may feel too tired or anxious to attempt this outing, even though they are feeling isolated. Often, when a woman attends a support group, she may not return for a while as the effort to organise such an outing leaves them exhausted and disorganized at home for days and she wonders if the effort was worth it, even though she enjoyed being at the group. This member will often stay at home until they feel they need to see other people and will again attend group. Ideally, when you have permission from the woman, give her a call and provide support.

NB: the aim of what we do, is that women get well and do not need us anymore. That is why we function. Don't feel badly because someone doesn't re-attend. They have what they need and pass on. It means we've done our job and done it well. PND is about recovery, not being ill."

3. Understanding group work

Aspects of group work include the:

- people who make up the membership of the group – the facilitators and the participants
- group dynamics or processes
- stages of group development and
- content and tasks of the group.

Participants and facilitators

Participants and facilitators are the two major roles that people play in groups. A group has an appointed facilitator to coordinate its activity, and this person's leadership ability is critical to how well the participants will work together. Participants need the ability to be part of a group in a way that is positive for the individual and supportive of other group members, for the overall wellbeing of the group.

Group facilitation and participation skills are also important because:

- most people are, at various times, both leaders and members of small groups, so they need both facilitation and participation skills
- the same issues of personal interaction arise for both facilitators and participants
- a group will not work well unless both facilitation and participation are handled competently.

There are many challenges to the role of facilitating a support group such as keeping the group focused on the task, coping with interpersonal conflicts and making decisions.

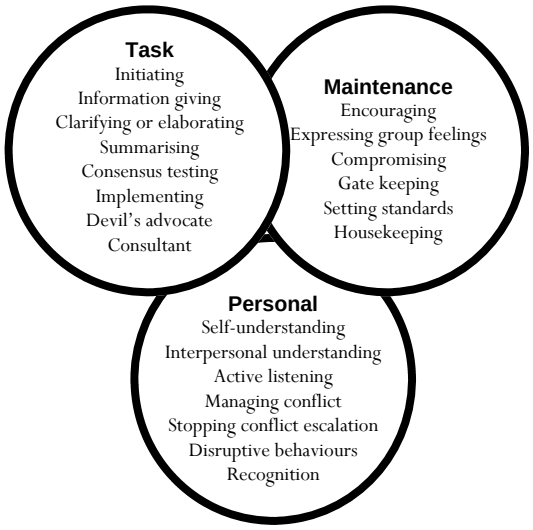
Task, maintenance and personal functions

It is possible to summarise many of the things which need to happen in order for any small group to be successful, and to give guidelines on how to approach or handle each of these. Small group success depends on three types of complementary functions being performed, which means they must all be performed if a group is to work well:

- **task functions** - help to keep the group focused and directed towards achieving its goals
- **maintenance functions** - help group participants stay involved and ensure that everyone can contribute to their maximum potential
- **personal functions** - address the personal needs of group participants to ensure the group functions with ways to handle conflicts and disruptive behaviours.

Responsibility for ensuring that these functions are performed rests, on the whole, with facilitators. Participants also have a responsibility to support the facilitators by improving their personal groupwork skills and helping the group achieve the best results possible.

The following illustration shows how the functions work together and the skills required to perform the functions. In the ideal situation group facilitators and participants are familiar with the functions and perform them whenever appropriate during the support group.



The tasks and skills important to working with small groups. (HCi)

See Appendix 2 for further information about skills required to perform each of these functions of group facilitation.

Group process

This can be the most difficult yet exciting part of group work. Emerging dynamics of the group process are created by a combination of individual personality styles of the group participants (including facilitators) and their:

- feelings about themselves and each other
- expectations of the group
- behaviour with each other
- unconscious needs.

Understanding the group process means being aware that:

- the group is more that the sum of its parts (participants and facilitators)
- there is a group unconscious or an unspoken life of the group
- group participants need to be seen from a systemic perspective rather than in isolation (influenced by family, friends, community, societal attitudes, cultural mores etc.).

Facilitation of a support group based on understanding the group process occurs if facilitators possess:

- an awareness of themselves as an individual and in the group
- unconditional positive regard for the support group participants
- an ability to listen to and observe participants and the group process
- an awareness of the needs of participants and the group
- curiosity about the participants' stories and the group process.

The facilitator's role is to harness the energy of the group process to move the group forward so it achieves its purpose of personal growth and mutual support. This is achieved when the facilitator:

- encourages feedback among participants
- ensures people feel heard and hear each other
- ensures there is equal participation
- ensures sessions are paced
- identifies and acknowledges feelings and interpersonal communication problems that are interfering with group work
- continually assesses and manages the emotional climate
- helps express and deal with conflict
- creates a climate where participants and facilitators feel accepted and valued.

(Katinka Pal-Zimny, Darebin Family Services)

Stages of group development

Theory of group dynamics states that groups move through certain stages in a more or less linear fashion, defined as:

1) **Forming**
   Participants seek guidance from facilitators and observe who the other participants are and whether they'll fit in. The issue at this stage is inclusion versus exclusion of the participants.

2) **Storming**
   Participants' individuality begins to be asserted during this stage. Hostility may emerge among participants, perhaps towards facilitators, (for not fulfilling possibly unrealistic expectations) or between participants as they establish their place in the group or settle their own internal conflicts.

3) **Norming**
   This stage sees a renewed energy and hope within the group. Differences among the participants are tolerated, norms established, harmony valued, and facilitators relied on less.

4) **Performing**
   Roles of participants within the group are chosen and fulfilled during this stage, seeing more emphasis on fulfilling the purpose of the group. There is a stronger balance between productivity and interpersonal skills. There may still be setbacks but they don't threaten the group's survival.

5) **Termination (mourning)**
   Evaluation of the group and goals, departure from the group and feelings of loss and sadness are expressed. There may be evidence of regression to patterns of exclusion/inclusion by some participants in denial that the group is about to end. Encouraging an ending ritual and celebration in acknowledgement of the life and importance of the group is important. Excitement about new skills and goals in the future may emerge for some.

Based on these recognised stages of the life of a group, the following descriptions outline the characteristics

and challenges that need to be managed by facilitators and participants. While it is usually possible to identify the stage that a particular group may be experiencing, the process through the stages will be different for each group. It is not necessarily a linear progression, one stage after the other. A group may move forwards and backwards through the stages.

Each stage is a potential exit point for participants to leave the support group as it requires that they adapt to the new functioning of the group. Without the skills or readiness to manage participants may feel uncomfortable in the group. Identifying and managing the stages and transition between them well will help to increase the retention of participants.

Group forming

This is a time for determining the structure of the group. During this stage:

- participants test the group's atmosphere
- participants learn what is expected, how the group functions and how to participate in the group
- participants display socially acceptable behaviour, risk taking is relatively low and exploration is tentative
- group cohesion and trust are gradually established if participants are willing to express how they are feeling
- participants are concerned with whether they are included or excluded and start defining their place in the group
- a central issue is trust versus mistrust - participants are deciding whom they can trust, how much they will disclose, how safe the group is, who they like and dislike and how much to get involved
- there are periods of awkwardness, participants look for direction and wonder what the group is about
- participants are learning the basics of respect, empathy, acceptance, caring and responding – all attitudes that facilitate trust building.

Functions of the facilitator

- Identify expectations and develop group rules with participants to ensure the group experience is safe and productive.
- Teach and model the basics of group processes and interpersonal skills such as listening and responding.
- Assist participants to express their fears and expectations about the group and to deal openly with their concerns and questions.
- Introduce the sensitive use of humour to break barriers and tensions and to model its potential use for problem solving.
- Help participants establish concrete personal goals.
- Assess the needs of the group participants and help those needs get met.
- Show participants they have a responsibility for the direction and outcome of the group.
- Deal with their own anxieties about the new group and their need to perform as facilitator.

Some problems that may arise:

- Participants may wait passively for something to happen.
- Participants may not disclose their feelings of distrust or fears about the group and entrench their own resistance.
- Participants may keep themselves vague and unknown, making meaningful interaction difficult.
- Participants may take on a problem solving and advice giving role with other participants.
- Participants may leave the group early because it is not well formed.

Group storming

This transitional stage of a group's development is marked by feelings of anxiety and defensiveness. Participants:

- wonder what other participants think of them
- test the facilitator and other participants to determine the safety of the group environment
- struggle with whether to remain on the periphery or to risk getting involved
- experience some struggle for control and power, and perhaps some conflict with other participants or facilitators
- learn how to work through conflict and confrontation
- feel reluctant to get fully involved in working on their personal concerns because they are unsure if others in the group will care about them
- observe the facilitator to determine if she is trustworthy and learn how to resolve conflict from this person
- learn how to express themselves so others will listen to them.

Functions of the facilitator

- Intervene in the group in a sensitive manner at the right time.
- Provide the encouragement and challenge necessary for participants to face and resolve conflicts that exist within the group and their own resistance and defences against anxiety.
- Deal successfully with this difficult phase of defensiveness and conflict for genuine cohesion that allows for productive work to develop.

Some problems that may arise:

- Participants can be categorised as a 'problem type', or they can limit themselves with a self-imposed label.
- Participants may refuse to express persistent negative feelings, thus contributing to a climate of distrust.
- If confrontations are poorly handled, participants may become defensive and hide issues, or they will withdraw from the group.
- Participants may collude by forming subgroups and cliques, expressing negative reactions outside the group but remaining silent in the group.

Group norming and performing

A more in depth exploration of significant issues occurs during these stages.

- The level of trust and cohesion is high.
- Communication within the group is open and involves an accurate expression of what is being experienced.
- Participants interact with each other freely and directly.
- Willingness to risk threatening material and make themselves known to each other, participants bring personal topics they want to discuss to the group.
- Conflict among participants is recognised and dealt with directly and effectively.
- Feedback is given freely, accepted and considered non-defensively.
- Confrontation occurs in a way in which those doing the challenging avoid judging or labelling others.
- Participants are willing to work outside the group to achieve behavioural changes.
- Participants feel supported in their attempts to change and are willing to risk new behaviour.
- Participants feel hopeful they can change if they are willing to take action.

Functions of the facilitator

- Allow participants to work freely in the group for maximum interaction and growth, providing containment as required.
- Provide ongoing challenges to the participants and the group as a whole to maximise learning.
- Reinforce the need for reflection and work between group sessions.
- Be on alert for complacency in the group.

Some problems that may arise:

- Participants may collude to relax and enjoy the comfort of familiar relationships and avoid challenging each other.
- Participants may gain insights in the sessions but not see the need for action outside the group to bring about change.
- Participants may withdraw because of anxiety over other's intensity.

Group termination

During the final stage of a group:

- There may be some sadness and anxiety over the loss of the haven the group has become for participants.
- Participants are likely to pull back and participate less intensely anticipating the end of the group.
- Participants are deciding what to do once the group ends.
- There may be some fears of separation and about being able to cope and implement what has been learnt in the group into daily life.
- Participants may express their fears, hopes and concerns for one another.
- There may be talk about follow-up meetings or some plan for accountability so participants will be encouraged to carry out their plans for change.

Functions of the facilitator

- Provide a structure that allows participants to clarify the meaning of their experiences in the group.
- Assist participants to generalise their learning from the group to everyday situations.
- Undertake evaluation of the group with the participants.

Some problems that may arise:

- Participants may avoid reviewing and integrating their experiences, limiting the generalisation of their learning.
- Participants may distance themselves due to separation anxiety.
- Participants may consider the group an end in itself and not a way of continuing to grow.

4. Establishing the need for a PND support group

Perceiving and then establishing that there is a need for a PND support group within the local community is a good place to start. A great deal of effort is required to set up a PND support group and seeking the input of the community will ensure that the efforts are well directed.

Health promotion principles, applied to the establishment of PND support groups, encourage a variety of strategies including:

- a cross section of sectors and agencies working together
- participation of community members in planning and ongoing evaluation to support health promoting behaviours.

A process of consultations will encourage this collaboration and community participation by talking with community agencies and community members about the establishment of a PND support group.

Community agency consultations

Sustainable groups are not usually operating in isolation and need to rely on strong service partnerships. Convening an initial meeting of local community agencies will help establish the need in the local community and to work collaboratively. A telephone invitation to the meeting or forum to the most appropriate person in the organization, followed by a reminder notice is the most effective method. Telephone consultations are also useful to support access to a wide range of agencies.

Interested parties might include maternal and child health service, counselling agencies, community health services, community mental health services, women's health services, general practitioners, psychiatrists, community nurses, hospital maternity staff and mother and baby unit staff, local councils – family and children's services, playgroup leaders, family support services, private psychologists, community/ neighbourhood houses, local churches or service groups such as Lions, Probus and Rotary.

The aims of this initial meeting/discussion are to:

- meet others in the local area with an interest in PND and an understanding of the needs of families
- determine which individuals or agencies could contribute to establishing a PND support group
- gain a commitment from these agencies and individuals to contribute.

Their contributions toward establishing the group may be to:

- establish need and potential transition framework
- suggest ideas for the group, e.g. purpose, structure
- provide a facilitator with time for planning, recording and evaluation;
- contribute information/resources to facilitators, e.g. developing evaluation tools
- provide meeting space, preferably with childcare
- promote the group in organisational newsletters
- produce or contribute towards production of promotional materials and/or distribution
- increase awareness of the group within their organisation e.g. developing an organisational process for referral to the group
- write submissions for funding
- be a contact person
- provide resources for group activities including guest speakers
- recruit and refer women with PND to the group.

Community member consultations

Consulting members of the community, particularly women who have experienced PND, can provide an opportunity for input into the establishment of a PND support group that meets the community's needs. Consultations with the community can ensure that existing resources are used and that community members are informed about the support group.

Discussions with community members could encompass the following issues:

- What would be the purpose of the support group?
- What would the group not be aiming to achieve?
- What might prevent women from attending the support group?
- How could the group be structured – venue, resources, duration, childcare?
- What might be the name of the group?
- Culture of the group – what is important for members to feel supported?
- Would there be topics of discussion, perhaps with guest speakers?
- Would partners be able to attend the group or specific sessions?

5. Planning PND support groups

The process of consultations with community agencies and members will have provided the foundations for decisions that need to be made. There will be someone within an agency or the community who takes responsibility for coordinating this planning process. They will need to maintain an overarching view of the process and enlist the support they require.

When planning the support group it is important to consider the:

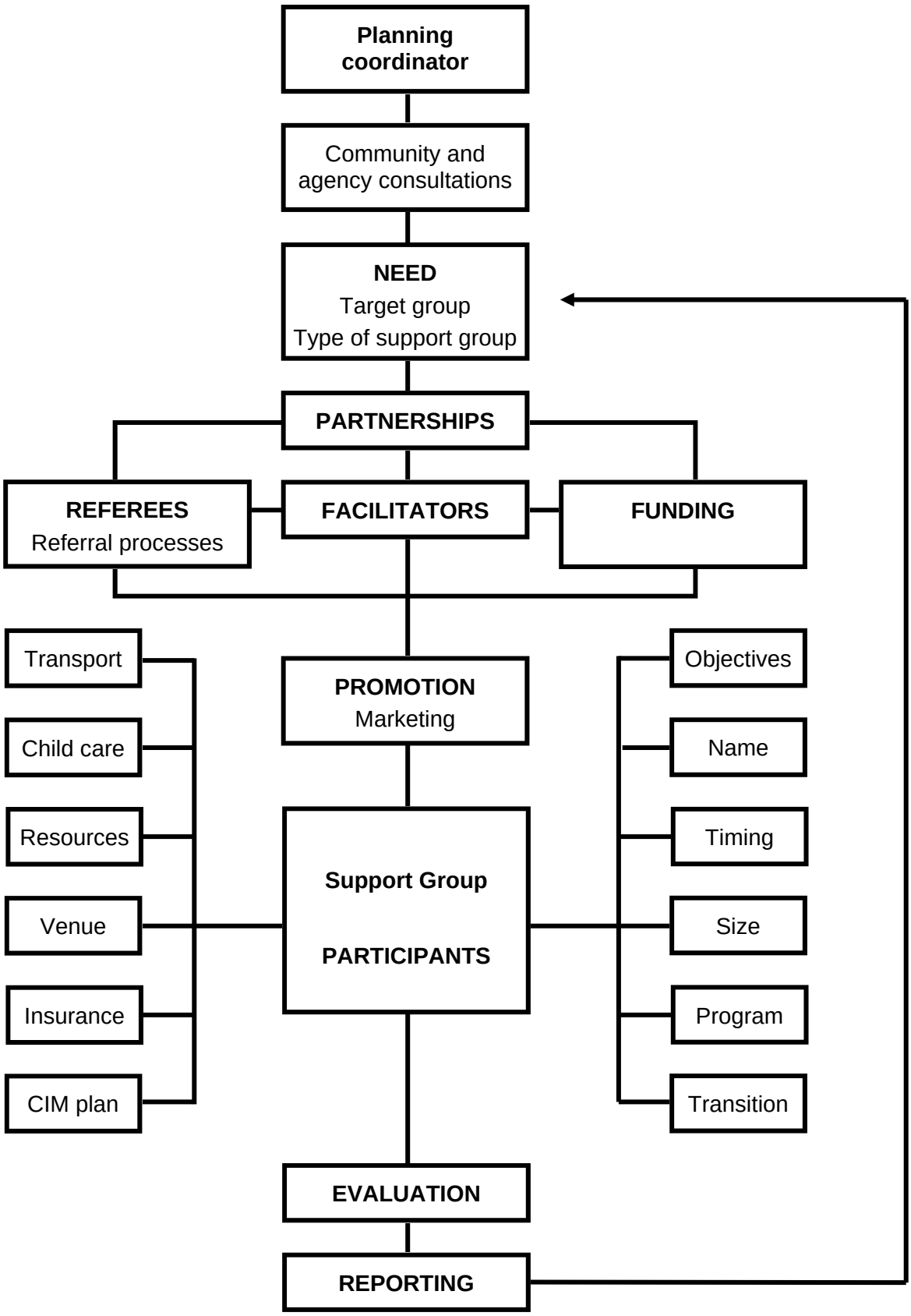
- needs of agencies and members of the community
- needs of the target group
- strengths and interests of facilitators
- partnerships that can be established that will help determine resources available for the group
- expectations and requirements of the agencies involved in the establishment and facilitation of the PND support group as well as referring agencies.

The smooth establishment of support groups occurs if all requirements are aligned. Stress can be high if the requirements of agencies conflict with those of the facilitators or participants, for example in evaluation, reporting, referral criteria or type of group. Once the needs for the community and target group are identified, consultations between facilitators and agencies must be ongoing throughout the planning and establishment processes. Some agencies manage these consultations by establishing a steering committee during the establishment phase or provide regular reporting to management.

Following is an outline of the PND support group components to assist the process of planning, implementation and consolidation of the group. It is ideal for the order of the process to be followed as approximately as possible. It is important to build strong foundations for the support group by identifying the need, its purpose and its target group.

The following flowchart demonstrates how the components fit together within the planning and implementation of the group. **Appendix 1** contains a checklist format of the planning process.

Support group planning flowchart



1. Types of support groups

There are several types of groups that make up the array of PND support groups. Each is unique and few hold rigidly to a type or focus throughout its life span. A support group is very fluid and takes on a life of its own, depending on the mix of participants and facilitators. The peer to peer support that grows through the support group will add enormous richness and value to the group participants and facilitators.

Some support groups focus primarily on the mother, her experience of PND and her needs, at the exclusion of the baby and older children from the group. Other groups focus on the needs of the baby for attachment and infant mental health by strengthening the mother's ability to interact and bond with her baby. Often there is a combination of the two where half the group session is focused on the mother alone and babies join the group for the other half. Supported PND playgroups are intended to keep mothers and their children up to school age together and interacting through play.

The following categories are descriptive and combine to identify the group. For example, a support group may be an open informal group, a closed therapeutic group or an open specific purpose group.

Open and closed groups

The decision for the group to be open or closed will be based on the requirements of agencies, facilitators, participants and the program.

Open group: This group is usually ongoing and welcomes new participants at any time during its life span. For example, if there are high numbers of referrals for the group an open group will be able to manage the intake of women as they are referred, avoiding a waiting list.

Closed group: This group usually has a defined life span and does not accept new participants after the first or second week. For example, if the group has a structured program with linear progression, a closed group is required as new participants are unlikely to catch up. Attendance at a closed group can be higher as participants have committed to the limited duration of the group program.

Focus of the support group

Therapeutic group: This group focuses on issues related to PND and recovery, such as emotions, experiences and strategies for managing and recovering from PND within group counselling. This group tends to be quite structured with a program of topics, possibly guest speakers or written material for participants. It may adopt a particular psychological tool as cognitive behavioural therapy or emotion focused therapy, and is usually facilitated by health professionals.

Support group: This group is less formal and structured. There is usually less weekly session planning involved in this group as therapeutic discussions spontaneously develop based on issues raised by participants during each session and are directed by facilitators to ensure group objectives are met. This flexible format lends itself well to an open group structure as the progressive addition of new members can be accommodated without interrupting a more structured program. This group type is also usually facilitated by health professionals.

Social group: This group meets to socialise and establish a network of support and friendships, such as a mother's group, drop in group, coffee morning, an afternoon chat group or a pram walking group. This group may be facilitated by a volunteer who may or may not have had PND, with the support of a health professional.

Specific purpose group: This group meets for a specific purpose and is usually quite structured. It could be a mother-baby interaction group, craft group with focus on learning a new craft as a form of creative expression, an exercise or relaxation group or music or art therapy group. This type of group is often established by a service with expertise and resources.

Educational group: The focus of this type of group is to impart knowledge to participants about a particular issue or skill, e.g. a parenting education, psychoeducational or first time parents' group.

Supported playgroup: This group has an official playgroup structure, ideally registered with the state playgroup association. It involves the same structures, costs, insurance and resources as a community playgroup but requires a playgroup leader in a support role to process referrals, liaise with the playgroup association and have a presence in the group. This is an ideal option for women with PND who have concluded their involvement in a therapeutic group for ongoing support or for those who are further in their recovery. The primary purpose of a supported playgroup is to provide opportunities for mothers and their children to share play activities and learning experiences that enhance their relationship and parenting skills. It can also be a stepping stone for the participants to join a community based playgroup or parent's groups.

2. PND support groups objectives

The objectives for every group program will be determined by facilitators, agencies and needs of participants. Objectives need to be clearly outlined, documented and circulated, for example to:

- create an opportunity for women with PND to meet in a non-judgmental and supportive environment to share experiences and skills and to feel heard and validated
- develop and extend participants' supportive social networks
- explore different ways of managing PND with the support and facilitation of a support worker that will enhance participant's wellbeing and ongoing recovery
- reduce the stigma associated with PND through regular contact with other parents experiencing PND
- empower women to open up to family, friends and community members to increase their supports and ongoing engagement with services
- improve participants' communication skills with their partners and supportive others
- create an opportunity for partners and supporters to access current PND thinking and information
- have some well needed time out from mothering and to experience some adult conversation,

(Based on Dianella Community Health Service – 'Post Natal Doldrums', PND support group objectives).

3. Target group

Through the process of community and agency consultations it is important to be able to identify who the support group is being established for. This may be based on existing gaps in the community or an identified need within an agency. The target group will also be determined by the skills and resources available to the facilitators. The characteristics of the target group will form the basis of the criteria for referral of participants to the support group. It is important for the referring agencies to be provided with clearly defined and documented criteria to ensure appropriate referrals and goodwill.

An example of the characteristics of target group for PND support group and the criteria for referral might include women who:

- have been diagnosed with PND or suspect the presence of PND, at the exclusion of other presenting mental health conditions
- live in a particular municipality or region
- are supported and monitored by their doctor, to ensure their treatment and recovery are ongoing
- have been assessed and referred by particular agencies such as maternal and child health
- express a desire to join a group and meet other women with PND
- have children under five years, one of whom is less than one year of age
- come from a particular social or cultural group.

The administration and completion of the Edinburgh Postnatal Depression Scale (EPDS) or other inventory may be preferred as an indication of the degree of PND and its symptoms. The EPDS is not a diagnostic tool but is useful as an indicator of the need for further assessment and discussion

Important considerations:

- **How strictly will the referral criteria be adhered to**? Diversity of the participants in the group includes variance in the levels of depression, social and cultural differences and other mental illnesses. Some groups may accept women with mental illnesses other than PND such as bipolar disorder, provided they are being cared for by a psychiatrist. Women with complex illnesses or situations may not

benefit from the group and may alter the focus of the support group.

- **How long should women participate in the group**? Is it for the term of the program or can she participate indefinitely? Some long term participants can become dependent on the group and this needs monitoring, especially if they are taking the place of a woman in more immediate need of the group.
- **How will referrals be assessed to ensure that they meet the target group criteria**? Is it feasible for an initial home visit to be conducted with all referrals to assess for suitability for the support group or is it more appropriate to conduct a telephone assessment? What tools or structures will be used for assessment of participants and how will results be used?
- **What steps will be taken if a woman is assessed to be unsuitable to start in or continue in the group**? Women who are too unwell or with other forms of mental illness will need to be referred on to a health professional or alternative support group. The exit process of participants needs to be defined, for example if a participant is disruptive or not integrating into the group after 1-2 sessions the wellbeing of the group as a whole needs to be protected and the participant moved on to a more appropriate service.
- **What is the process if a woman is assessed to be at risk or assessment/reassessment is required**? A risk assessment plan or referral on to a health professional, alternative support group or crisis intervention services (mental health or child protection) will need to be enacted with the woman.

4. Budget

The support group will be supported by or restricted by funds available to establish and run it. Using the suggested budget outlined in the checklist in Appendix 1, a cost per group program or term can be established. This will shape many aspects of the support group.

Decisions need to be made about whether the participants will be charged to attend the support group. It may be a minimal cost to attend each session, to cover child care (if this is provided), or a gold coin donation to cover refreshments. It is ideal to be flexible with any costs to ensure participants can attend regardless of their capacity to pay.

5. Funding

Using the developed budget, available funds need to be explored. Some costs could be met by facilitators' organizations, such as administration, venue or salaries. However donations, council or relevant grants bodies, service clubs or philanthropic sources may need to be explored. Partnerships between agencies can be helpful when trying to attract funding.

Generally funds tend to be granted to an established organisation with infrastructure for administering a grant such as an ABN (Australian Business Number) or a bank account.

6. Naming the group

It is important to determine whether the name of the group will reflect that it is a PND support group. Attracting and engaging women into the group will begin with the name of the group. Encouraging participants to name their group will help to establish how they view the group. A question that may indicate this is to ask the participants how they describe the group to their family or friends.

Some participants need to identify with the group as their place to come together with other women with PND to focus on their recovery. It lets their family know that they have acknowledged PND and that they are accessing help and support.

Others might prefer to identify with the group as a mother's support group and not acknowledge to family and friends they are attending a support group for women with PND. In this case the name of the group may not indicate the purpose of the group.

7. Co-facilitators

A PND support group should be facilitated by two workers unless it is a small group size. Some co-facilitators work best together if they have identified roles, others work in a very fluid way. The relationship between co-facilitators provides very effective modelling of cooperative behaviour, communication and problem solving for participants.

A particular set of professional, personal and group work skills is needed for a PND support group facilitator (Chapter 3). Not all facilitators will have all of these skills which is the benefit of co-

facilitation. When seeking a co-facilitator it is important to know which complementary skills are required. It is ideal that one of the facilitators has experience in facilitating groups and working with women with PND.

Between them group facilitators will require:

- knowledge of group work and ability to manage conflict and engage participants
- empathy, understanding and knowledge of women with young children with perinatal mental illness
- knowledge of the impact of perinatal mental illness and of a model of recovery and self help
- personal insight into their own life experiences, values, beliefs and capacity to manage their own stress and distress
- excellent communication and interpersonal skills - to be approachable and welcoming to participants, to role model positive interactions
- skills to manage potential alliances and divisions that can develop within participant and facilitator relationships
- sensitive use of humour to build rapport and model enjoyment and pleasure
- ability to genuinely and openly seek, accept and act on feedback from participants about the group's progress
- availability to take on the group and a commitment to working with a co-facilitator for planning and debriefing.

It can be a very complex process to facilitate a group that is fluid and dealing with vulnerable women who present certain challenges. It is important that the facilitators 'do no harm' and yet are able to orchestrate a rich and productive experience for the individual participants and the group as a whole. There will be significant relationships between each of the facilitators and individual participants in the group depending on natural rapport. This can be problematic if it is not managed well or openly as other participants may feel excluded and the group can become divided.

To ensure the wellbeing of facilitators and of participants it is important that facilitators have access to debriefing, supervision and training. Support will be gained from each other as they reflect on the session or the needs of the participants but it is important to provide for the impact that being in a PND support group may have on the emotional well being of the facilitators.

Coming from two different organisations can make it difficult to allocate time for joint planning and group review.

Co-facilitators can come from within an agency, from a partnership established between two agencies, between an agency and private practitioner or between an agency and a consumer. Some agencies use students as co-facilitators or assistants with support from experienced facilitators.

8. Venue

It is important that a venue has some of the following features:

- central location and accessible by public transport, with adequate parking
- presentation that is welcoming, engenders a sense of relaxation and comfort, and allows for privacy and quiet
- acceptable within the community, not stigmatised
- adequate size, seating and floor plan for participants to sit comfortably in a circle, to allow for prams, infants on the floor and comfortable seating for feeding mothers
- heating and cooling as required
- facilities for the needs of women and babies, e.g. kitchen, nappy changing facilities, toilets and a nearby room to take crying babies
- proximity to child care if required
- night or after hours access for partner sessions if required
- affordable cost
- within another facility with access to community resources or service providers that they may not otherwise use, e.g. community health, counselling services.

9. Support group size

To ensure participants are comfortable and have opportunities to share freely it is advisable for there to be a maximum number of participants. This will be determined by the type and purpose of the group, the size of the meeting space in the venue and resources. An ideal number to recruit for a therapeutic group would be 8-10 which allows for a number of non-attendances without the group session being disadvantaged. There will be fluctuating levels of attendance because of the nature of the target group, weather and ill health.

For a supported PND playgroup a maximum of 12–15 families is ideal. Other types of groups may benefit from larger numbers, especially social or informal groups.

Similarly, thought must be given to the minimum number of participants required for the group to run, such as 3-5 participants. Many women with PND see a support group as a great idea or agree to the referral to please their health care provider. Getting to the support group or taking the risk to attend may be too challenging, especially in light of the impact of PND on her self confidence.

10. Timing

Factors to consider when determining when the group will be held include:

- how often the group will run (e.g. weekly or fortnightly)
- the length of each session (e.g. 2 hours)
- whether the sessions will be in the morning or the afternoon
- the duration of the group program (e.g. ongoing, 8-10 weeks or a school term)
- whether the group will run during the school holidays.

These decisions will be determined by the venue, facilitators, participants and purpose of the group. Some of the challenges will come from sleep periods of children, morning slowness of unwell participants and availability of child care.

11. Child care

The women who meet the criteria for the support group will have children. While this may seem an obvious statement facilitators can sometimes underestimate the impact this fact can have on the support group. At the least, a woman with PND will have a baby. Other women will also have toddlers, preschoolers or school aged children. If there are eight women in the group there may be eight or more babies and children who will accompany the women.

It is preferable for women in the group to explore all alternatives available to them for child care such as family, friends or formal care. However, it is a feature of the target group that their child care options will be limited. Even if it is available, a woman may be reluctant to leave her baby due to her own separation anxiety or need to relate to the world through her baby. For these women providing opportunities to leave her baby for short periods in a room adjacent to the group room can be a positive way to reduce her separation anxiety and give her time to focus on her own needs and personal development.

The presence of babies and children is ideal for a social group, playgroup or specific purpose group as there can be wonderful opportunities to observe and foster the mother's interactions with her children. However, for a focused or structured therapeutic or support group the presence of babies and children can be very distracting for the mother, other participants and the facilitators. Babies aged under 12 months may be less disruptive in the meeting room, but once they are mobile and verbal the disruptions increase. This presents difficulties if a mother is faced with the choice between bringing her children and attending the group or not bringing them and not attending the group. It may be appropriate for participants to openly discuss the issue as part of setting group expectations. If options for child care are limited this will help determine the group's criteria, for example only women with babies under one year of age.

The ideal compromise is affordable formal child care at the same location as the support group, such as secured (paid for by the group budget) occasional care. All options near the venue will need to be explored for suitability, availability and cost and the conditions of this arrangement will need to be discussed with the participants.

Alternatively a volunteer may be recruited to provide onsite child minding. If this happens in an adjacent room participants will need to be made aware of the conditions for this child minding (Appendix 3.3). For example:

To ensure the child minding support operates according to government requirements participants are required to sign their agreement to the following conditions for child minding during the support group sessions:

- Child minding is provided for babies under 12 months of age only for the duration of each two hour session.
- Child minding is provided by volunteers recommended and recruited from local community organisations and have undergone a Police Check and Working with Children Check.

- Participants will continue to be responsible for their baby while in the care of the child minders.
- Child minding will be provided in the same room or an adjacent room to the group room in which participants will be located, ensuring they are accessible to their baby and child minders at all times.
- Participants are to provide for all the needs of their baby during the session, e.g. drinks, morning tea.
- Participants, their babies and child minders will be covered by the agency's public liability insurance while participating in the support group program.
- Participants are asked to refrain from bringing their baby to the session if they are unwell.

12. Transport

Another potential barrier important to consider is how participants will get to the venue. Some challenges they face in accessing transport include being a one car family, not feeling comfortable driving by themselves, not being able to afford the petrol, or finding public transport cumbersome or overwhelming with a baby, pram and children.

All available options need to be explored to give participants access to the group. For example:

- relying solely on the participant's capacity to access their own transport, e.g. car, partner, other participants or public transport
- transport provided by facilitators or volunteers in an agency vehicle
- local council community bus
- funding for taxi vouchers.

13. Resources

The venue needs to be equipped with resources required for setting up and running the PND support group. Some may need to be purchased or sourced to ensure the group is equipped to meet its stated purpose. They may include:

- literature and handouts for therapeutic or educational groups, materials for craft or social groups
- audiovisual equipment and DVDs for education and group discussions
- kitchen facilities and refreshments for group sessions
- chairs suitable for feeding a baby, change tables
- self care items such as aromatherapy burners, hand creams or strength cards.

14. Referrals

Aspects that need to be addressed to ensure the target group can access the support group include:

- who the support group is for. The defined target group and available resources will determine the criteria for referral.
- whether a referral form has been developed. This is a tool to collect basic background details about the participant, including the contact details for their caregivers and partner. The form should also clearly identify the criteria for participation in the support group (Appendix 3.2).

  To ensure that the participant has consented to communication between facilitators and their service providers the participant is also asked to sign a Release of Information (Appendix 3.2). If there is concern for the participant's wellbeing or ongoing non-attendance this gives the facilitators the consent of the participant to make contact with her caregivers.

- the referral sources, for example:
  - maternal and child health service
  - general practitioner
  - PND or community services providers
  - women who refer themselves who meet the criteria for participation
- the process for assessment of the referrals, for example:
  - where referrals will be sent to and securely kept, especially if received between agencies. Will a waiting list need to be established and managed?
  - process of responding to the referral, e.g. calling the woman, arranging an initial home visit or telephone interview, talking with her about her experience of PND and her needs for intervention and recovery, conditions and terms of the support group, outlining the expectations for attendance
  - providing information and encouragement to the woman to minimize her anxiety about attending the support group
  - process of informing the woman of the group's unsuitability for her and providing alternative options

- process of informing the referral source of the outcome of the referral and ongoing wellbeing of the mother.

15. Insurance

It is important to explore all the requirements for public liability and professional indemnity insurance before the start of the support group. It is important to know what existing insurance coverage includes. This will involve discussions with the facilitators' organisations and the venue's management.

16. Promotion

To ensure the community and referral sources know about the PND support group it is important to promote it.

- A flyer about the group, with contact details, can be distributed to referral sources and central community locations. The group's criteria, name and processes for information and referral will need to be included.
- Meeting with local referring agencies.
- Informing PANDA of the establishment of the support group or any changes to the group for its inclusion on the PND Services Database, to ensure referrals can come from PANDA. (Appendix 8).

17. Support group program

The type and purpose of the support group dictates how much planning and programming are required. Less content programming will be needed for an informal group than for a structured therapeutic or specific purpose group (Appendix 3.4). Seeking suggestions from participants for content and activities is a powerful way to increase their ownership of the program and ensure their requirements are met (Appendix 3.5).

Irrespective of the purpose of the group a number of aspects are important.

- **Group culture** – contributes to the group's atmosphere and expectations, e.g. use of group rules (Appendix 5), name tags, ice breakers, regular introductions and sharing morning/afternoon tea.
- **Group program** – outline of each weekly session can help to prepare facilitators for each group session. This may be simple and repetitive but planning and recording each session facilitates valuable discussions between facilitators and ensures the group continues to meet the needs of participants. External guest speakers, with preparation, can add content and program diversity.
- **Partners' sessions** – a great deal can be achieved for the woman, her partner and their relationship through facilitating a session for couples or partners in the evening or on the weekend. Partners benefit from hearing the stories and experiences of other men in similar situations and have an opportunity to learn more about PND and why their partner 'cannot just get better'. These sessions may be facilitated by a male worker accessed from another agency or group program.
- **Record keeping process** – Kept securely, the participant information form (Appendix 3.1), records observations from each session, valuable insights and the benefits of the support group, monitoring the well being of the participants and aiding planning.

18. Critical incident management plan

Despite the best planning, things go wrong during and between group sessions. Anticipating these incidents is important to minimize the impact on all involved. This may include:

- breakdown of a participant in the group (relapse or significant emotional distress)
- conflict between group participants or conflict between participant and facilitator
- participants expressing high risk behaviour, becoming suicidal or at risk of harming their baby within or between sessions
- intrusion into the group by a participant's partner/family member where there is conflict and risk for her safety and therefore the wellbeing of other participants
- intrusion into the group by a random person
- ill health, unavailability or lateness of both facilitators on the same day.

The critical incident management plan can be developed to address these and other potential critical incidents to map out the immediate management and action to minimize risk and ensure the wellbeing of facilitators and participants. The incident, and the critical incident management plan should be reviewed regularly to prevent recurrence.

19. Support group evaluation

Evaluation is the systematic investigation of the value, worth or significance of an object or effort. "Evaluation is a process of asking good questions, gathering information to answer those questions and making decisions based on those answers." (Horan-Smith, 2007) Evaluation should not be an episodic event, it should be ongoing in the day-to-day operation of any organization or program. In addition to regularly seeking feedback from participants establishing tools and processes for formal evaluation is valuable to demonstrating the effectiveness of the support group.

The purpose of evaluating PND groups is to:

- satisfy funding requirements and justify its continuation for the support group
- identify feedback about the positive gains in the group and areas for improvement
- provide an avenue for the views of participants that is respectful, safe and open
- build an evidence base to the group's program and interventions.

Evaluation plan

The objectives and measures for evaluation need to be identified and the evaluation plan built into the group process from the beginning of the planning for the group. An evaluation plan will:

- guide each step of the process of evaluation
- identify the information facilitators and stakeholders require
- avoid wasting time gathering information that isn't needed
- identify the best possible ways to get the information
- identify a reasonable and realistic timeline for evaluation
- support improvements to the group program.

Group evaluation requires a discussion about quantitative versus qualitative evaluation and the purpose for both. Evaluation beyond anecdotal or qualitative information may require the introduction of tools that measure outcome based improvement such as professional/self administered rating scales with pre and post tests administered several times, e.g. the Edinburgh Postnatal Depression Scale, Beck Depression Inventory or other inventories. The model of evaluation needs to be congruent with the type of group being evaluated and the requirements of the evaluation.

Qualitative evaluation is equally as powerful through questionnaires and feedback forms given to participants at the end of every session and the overall group program. An existing questionnaire or feedback form can be used or facilitators can develop tools specifically for the group and the purpose of the evaluation. Responses are collated to identify the main themes and outcomes from the group. This information can be measured against key indicators of the group's performance and long term outcomes such as:

- regular attendance of adequate numbers of participants as an indicator of their engagement in the group and an established social support network
- participants relating more positively with their children based on self reports and observations of facilitators, (e.g. play and initiating activities during the group and at home)
- participants demonstrating and self reporting improvements in parenting skills, including communication, problem solving and understanding of their children
- increased levels of access to services and support considered important for participants' recovery, e.g. regularly seeing their doctor or accessing counselling
- activities of facilitators that will enhance participants' access to the group e.g. providing support to travel to and from the group, phone calls as a reminder to attend and follow up of participants who may become more unwell
- discussions and activities/guest speakers during the group that focus on PND recovery strategies
- feedback from referral services/agencies about accessibility of the group and their observations of the impact of the group on participants
- participants willing to take on a mentoring/supportive role to other mothers with PND.

Asking present and past participants to write testimonials about their experiences in the group and changes they made to their lives is a powerful way to evaluate the long term benefits of the group.

See Appendix 6 for an example of a feedback form for participants.

20. Group transition

How the conclusion of the group impacts on participants requires consideration to avoid long term dependency on the group. Participants can react strongly to the cessation of the group, even with preparation, and this needs to be managed to prevent high levels of distress, relapse or participants dropping out of services altogether. While not all participants will require ongoing involvement in a group program or with services, being able to map possible access to services for the participants is important.

6. Sample programs

Planning for the group program and its individual sessions is vital. Planning needs to occur with the needs of the target group in mind and take into account any feedback facilitators have had about the success of previous sessions. The best made plans can go by the wayside depending on how participants are feeling and whether their more immediate issues take over. This requires facilitators to be flexible and prepared to negotiate with the group about issues that are priority. Missed content can always be rescheduled.

A comment on using guest facilitators: the use of guest facilitators for a particular topic or activity can be a great way to diversify participants' experiences and learning as well as support facilitators. However it is important to keep in mind that participants may feel they don't get enough time as a group to share because of an increase in content. It can be hard to develop a balance when developing the structure of the group.

If the group has been established for a while, participants may be resistant to any changes facilitators may want to make. This is an outcome of strong group ownership and it is important to let participants express how they feel as it models good communication and problem resolution. Group rules should support this process.

The following group programs are samples and can be modified.

Closed therapeutic group

Purpose
Education about PND with particular focus on how to monitor it and strategies for recovery

Target group
Women with postnatal depression who are on the road to recovery, receiving care from doctor

- 10 week program of weekly sessions for two hours, in the morning, within school terms
- Content is planned in advance with scheduled topics to give participants new information
- Scope for participants to direct content in the first half hour with their week in review, followed by morning tea
- Remaining group time is structured program content, last 15 minutes is a self care activity
- Two co-facilitators from different agencies
- Child care at the occasional care centre in the same street is pre-purchased for participants, so group focus is on participants
- Three sessions are held in the evening for couples
- New participants accepted only up to week two, group then closed.

Sample program

Week 1	Introductions, ground rules, pregnancy and birth experiences.
Week 2	Postnatal depression – what it is, recovery.
Week 3	Myths of motherhood – writing own stories of motherhood.
Week 4	Stigma and PND – what other people think of PND. Couples' session – partners' experience of PND.
Week 5	Family of origin – what we learn from families.
Week 6	Mood monitoring – how to track mood and manage it.
Week 7	Stress, anxiety and anger circle – what it is, how to manage it. Couples' session – supportive monitoring of partner's mood.
Week 8	Relapse prevention.
Week 9	Prepare for closure of the group and what comes after, evaluation of the group. Couples' session – being a dad and self care.
Week 10	Review participants' feedback, closure of the group.

Open semi-structured therapeutic group

Purpose
Personal reflections of PND, sharing of progress and peer support

Target group
Women early in the process of PND identification, still unwell and receiving care from doctor

- Runs within school terms, two hours a week in the afternoon

- Topics are identified for content and loosely allocated to sessions to support participants' interactions, more than providing information
- Resultant content is responsive to issues participants raise during the session, weaving in the allocated topic. Sessions start with week in review
- Child care for children at occasional care, babies under one year in the group if necessary
- Two co-facilitators each week with guest speakers planned twice a term to introduce different experiences for participants
- Focus of group is on participants and sometimes participants and their babies
- Two couple sessions planned during the term
- Participants are accepted into the group throughout the term

Sample program

Week 1	Introductions, ground rules, participant's suggestions for group content. Pregnancy and birth experiences.
Week 2	Week in review. Postnatal depression – what it is, recovery.
Week 3	Week in review. Myths of motherhood.
Week 4	Week in review. Stigma and PND – what other people think of PND. Couples' session – partners' experience of PND.
Week 5	Guest speaker – feeling better in mind, body and spirit, e.g. yoga, Pilates, relaxation, meditation.
Week 6	Week in review. Mood monitoring – how to track mood and manage it.
Week 7	Week in review. Family of origin – what we learn from families.
Week 8	Guest speaker – mother infant play and dance activities.
Week 9	Week in review. Prepare for break from group (school holidays). Couples' session – supportive monitoring of partner's mood.
Week 10	Week in review. Participants' feedback. Participants' catchup during holidays and look forward to coming back next term.

Consumer led support group

Purpose
Peer support, sharing of wisdom and social support network

Target group
Women who are progressing through recovery or experiencing transitional difficulties and distress

- Runs all year, two hours in the morning
- Established and facilitated by women who have experienced and recovered from PND who have been trained in additional counselling or group work skills. Ensuring the wellness of the consumer facilitators is important.
- Co-facilitators are supported by resources, supervision and referrals provided by an agency.
- Venue is neighbourhood house or community facility that provides resources for children.
- No established program – participants come together for support and socialisation. Activities and discussions are generated spontaneously within the group, e.g. craft, pram walking, experiences of recovery.
- Informal support networks are generated within the group, providing practical and emotional support between sessions.

Supported PND playgroup

Purpose
To provide playgroup structure for women recovering from PND and their children with support of playgroup leader to strengthen their interactions; to continue the support and friendships developed during participation in PND Support Group

Target group
Women who have been through a therapeutic or support group or who are well into their recovery, and their children.

- Supported PND playgroup registered with their state playgroup association.
- Runs within school terms for all children up to six years of age.
- Playgroup leader always present with the group to provide support and facilitation with the intention to slowly reduce direction of sessions and scope for participants to be rostered on for setting/packing up, morning tea or activities, depending on capacity.
- Program is identified and issued at the beginning of term for the two hour weekly morning sessions.

- More use of guest speakers and planned activities for participants and their children.
- Focus is on participants and their children with activities to enhance their interactions and parenting skills, allowing free discussions among participants and playgroup leader about how participants are.
- Sessions are structured - free play with set up toys and equipment for first half hour, scheduled activity related to the theme for up to one hour, morning tea for participants and children, story time, outdoor play and clean up.

Themes

Week 1	Introductions, ground rules, participants' suggestions for group activities
Week 2	Music activities with playgroup leader – making an instrument
Week 3	Guest activity: local library with children's books
Week 4	Dinosaurs
Week 5	Fairies
Week 6	Food and simple cooking activity
Week 7	The bush – native animals
Week 8	Guest speaker – mother infant play and dance activities
Week 9	Dress ups and making a mask
Week 10	Participants' feedback. Catchup during holidays and look forward to coming back next term

(Adapted from Ponder Playgroup, Darebin Family Services, 2007).

Partners' group

Purpose
To provide an opportunity for fathers to meet together to discuss their concerns about their partner's and their own wellbeing.

Target group
Partners of women with PND.

- Maybe one or two sessions within the overall PND group program
- Held in the evening or weekend
- Facilitated by a male counsellor or group worker.
- Discussions among the men may need to be initiated by the facilitator with structure but will usually continue spontaneously
- May be held over a barbecue or coffee, rather than group room in a circle.

Themes

Discussions may address:

- Expectations and lifestyle changes that have come with being a father
- Dad's bonding with babies/children
- Fathering versus mothering
- What is postnatal depression and what will recovery involve?
- Family of origin issues
- Anger management
- Balancing work and home pressures
- Their own self care and mental health issues
- "No matter what I do I am wrong"

Appendices

Appendix 1: Planning PND support group checklist

This checklist is intended to assist the establishment of a PND support group. It identifies some of the components of support groups that need to be addressed when planning the group. It can be used after community and agency consultations and may not cover all aspects of a support group that is unique to the local community. This checklist is available at www.panda.org.au.

Refer to Chapter 5 Planning PND support groups for further information.

Agency/consumer partnerships: Identify agencies and consumers available to support the group

NAME	AGENCY	CONTACT DETAILS

Requirements for the group outlined by the agency(s)

_____

_____

_____

1. Type of Support Groups

GROUP TYPES	DETAILS
Open group	
Closed group	
Therapeutic group	
Social group	
Specific purpose group	
Education group	
Supported playgroup	
Other	

2. Group objectives

* _____

* _____

* _____

* _____

3. Target group

What are the characteristics of the women and their families the support group is targeting?

_____

_____

_____

What are the criteria for referral of women to the group?

_____

_____

_____

How will the referrals be assessed for suitability for the group?

_____

_____

_____

Options for women assessed to be unsuitable for the group or at risk

_____

_____

_____

4. Budget

Will participants be charged for attending the support group? (gold coin for refreshments, minimal charge per week)

_____

What funds are required to establish and run the support group?

COSTS	AMOUNT
Rent (cost per session x number of sessions)	$
Child care (if funded or subsidised)	$
Facilitators (salaries, training, supervision)	$
Insurance (additional cover)	$
Transport costs (community bus, taxi vouchers, petrol reimbursement, agency vehicle)	$
Set up costs (set up resources, tea/coffee facilities)	$
Resources (related to purpose of the group)	$
Administration (phone calls, photocopying, stationery)	$
Promotion (logo, pamphlet, postage, phone calls)	$
Other needs	$
	$
TOTAL	$

5. Funding

What funds are available to establish and run support group? What options are available for applying for additional funds?

AVAILABLE FUNDS	OPTIONS FOR ADDITIONAL FUNDS

6. Naming the group

Will the name clearly define the purpose of the group? Refer back to the words used to describe the group purpose and target group and write the key words below.

_____

_____

Brainstorm some suggestions for names for the group:

_____

_____

_____

What will be the name of the group?

_____

_____

7. Co-facilitators

It is recommended that there are two facilitators. What skills are required to meet the needs of the target group?

_____

_____

_____

Who will be able (available and trained) and where will they come from to run the support group?

_____

_____

_____

What are the options for ongoing support and debriefing for facilitators?

_____

_____

_____

8. Venue

What are the criteria for the venue to meet the target group's needs?

What are the options for a venue for the support group?

VENUE OPTIONS	AVAILABILITY	BOOKING PROCESS

9. Support group size

Consider the purpose of the group, the venue and resources.

10. Timing of the group

TIMING	OPTIONS
Frequency of sessions	
Time of sessions (am/pm)	
Time of sessions (couples)	
Length of sessions	
Duration of the group	
Meet in school holidays	

11. Child care

Whether the participants will need to access child care during the sessions will depend on the purpose of the group and available options nearby.

Is the provision of child care for babies and toddlers important for the purpose of the support group? If so why?

Nearby child care options?

CHILD CARE OPTIONS	AVAILABILITY	COSTS

12. Transport

How will the participants get to the venue?

TRANSPORT OPTIONS	DETAILS
Participant's own vehicle	
Public transport	
Agency vehicle	
Council community bus	
Taxi vouchers	
Other	

13. Resources

What resources will be required to set up and run the support group? This will be determined by the purpose of the group and the available venue.

_____

_____

_____

_____

14. Referrals

REFERRALS	
Criteria for referral	
Developed referral form (including Release of Information consent)	
Sources of referrals	
Identified process for assessment of referrals	

15. Insurance

What requirements and options are there for insurance for the support group?

_____

_____

_____

16. Promotion of the support group

How will the community and referral sources be made aware of the establishment of the support group?

PROMOTION ACTIVITIES	TARGET
PANDA PND Services Database (See App 8)	

17. Group programming

The programming of the group sessions will be determined by the purpose, length and resources available to the group.

PROGRAMMING	DETAILS
Group culture (group rules, name tags, introductions, refreshments)	
Group program (weekly session outline, topics, material, guest speakers)	
Partners' sessions	
Record keeping processes (secure storage of client information forms, files and notes)	

18. Critical incident management plan

What actions will be taken if there is critical incident?

* _____
* _____
* _____
* _____

19. Evaluation plan

What are the objectives of the support group evaluation?

_____

_____

_____

_____

What measures and processes need to be developed for the support group evaluation?

_____

_____

_____

_____

How will the evaluation be reported?

_____

_____

_____

_____

20. Group transition

Options available to participants after the group ends?

_____

_____

_____

_____

Appendix 2: Group facilitation skills

Group work depends on three types of functions being performed – task, maintenance and personal functions. While participants are expected to be able to perform or at least support these functions it is dependent upon the skills of the group facilitators to ensure that they occur.

Task functions

SKILL	DESCRIPTION	AIMS AND DESIRED OUTCOMES
Initiating	Promote participation and introducing new directions in the group.	Prevent group floundering, to increase the pace of the group process.
Information seeking	Asking for facts, relevant information, suggestions or ideas about a group concern.	Elicit the experiences and knowledge among participants to enhance group discussions or resolutions.
Information giving	Offer information to the group in the form of facts, beliefs, opinions or ideas.	Add elements of education and knowledge enhancement to group discussions.
Restating	Paraphrase what a participant has said.	Determine if the facilitator has understood correctly the participant's statement, to provide support and clarification.
Clarifying	Grasp the essences of a message at both the feeling thinking and feeling levels, simplifying the participant's statements by focusing on the core of the message.	Help participants sort out conflicting and confused feelings and thoughts, to arrive at a meaningful understanding of what is being said.
Summarising	Pull together the important elements of an interaction or session.	Avoid fragmentation and give direction to a session, to provide for continuity and meaning.
Consensus seeking	Test whether the group is nearing a conclusion or decision.	Assess the extent to which the group is in agreement.
Questioning	Ask open ended questions that lead to self exploration of the 'what' and 'how' of behaviours.	Elicit further discussion, get information; to stimulate thinking, to increase clarity and focus, provide for further self exploration.
Interpreting	Offer possible explanations for certain thoughts, feelings and behaviours.	Encourage deeper self exploration, to provide a new perspective for the participant's considering and understanding their behaviour.
Confronting	Challenge participants to look at discrepancies between their words and actions, their bodily and verbal messages, pointing to conflicting information and messages.	Encourage honest self exploration, to promote full use of potentials, to bring about awareness of self contradictions.
Setting goals	Plan specific goals for the group process and helping participants define concrete and meaningful goals.	Give direction to the group's activities, to help participants select and clarify their goals.
Suggesting	Offer advice and information, direction and ideas for new behaviour.	Participants develop alternative courses of thinking and action.
Linking	Connect the work participants do to common themes in the group.	Promote participant to participant interactions, to encourage the development of cohesion.
Terminating	Prepare the group to close a session or end its existence.	Help participants assimilate, integrate and apply learning to everyday life.

Maintenance functions

SKILL	DESCRIPTION	AIMS AND DESIRED OUTCOMES
Encouraging	Provide encouragement and reinforcement.	Create an atmosphere that encourages participants to continue desired behaviours and provide help when participants are facing difficult struggles.
Reflecting feelings	Communicate understanding of the content of feelings.	Let participants know they are being heard and understood beyond words.
Expressing group feelings	Reading the mood of the group at appropriate times and disclosing your feelings or reactions to participants.	Encourage participants to disclose their emotional reactions to issues, problems, or discussion comments which accumulate but which most people normally keep to themselves.
Evaluating	Appraise ongoing group process and individual and group dynamics.	Promote better self awareness and understanding of group movement and direction.
Gate keeping	Keep communication channels open within the group at all times.	Restrain those who tend to talk at all times and draw out those who stay quiet and withdrawn, who find it difficult to enter a discussion or who are easily talked over by others.
Housekeeping	Make sure participants are kept aware of the group's decisions, progress and rules.	The wellbeing of the group and the comfort of participants.
Protecting	Safeguard participants from unnecessary psychological risks.	Inform participants of possible risks in group participation to reduce these risks.
Disclosing oneself	Reveal one's reactions to here and now events in the group.	Facilitate deeper levels of group interaction, to create trust and model ways of revealing oneself to others.
Modelling	Demonstrating desired behaviour through actions.	Give examples of desirable behaviour in the group to inspire participants to fully develop their potential.

Personal functions

SKILL	DESCRIPTION	AIMS AND DESIRED OUTCOMES
Self understanding	Facilitators' capacity to see their own behaviour, actions, and reactions in the group in an objective way.	Better self-understanding leads to better communication by reducing contradictions between your words and body language.
Active listening	Attending to verbal and nonverbal communication without judging or evaluating to understand their views.	Encourage trust and client self-disclosure and exploration.
Empathising	Identifying with participants by assuming their frames of reference.	Foster trust within therapeutic and group relationships. Communicate understanding. Encourage deeper levels of self exploration.
Facilitating	Opening up clear and direct communication within the group, helping participants assume increasing responsibility for the group's direction.	Promote effective communication among participants. Help them reach their own goals in the group.

Giving feedback	Expressing concrete and honest reactions based on observation of participant's behaviours.	Offer an external view of how the person appears to others. Increase the participant's self awareness.
Managing conflict	Preventing tensions and conflict escalating within the group by preventing the focusing on the conflictual issues and avoiding blaming.	Maintain the safety of the group and to protect the wellbeing of participants.
Blocking	Intervening to stop counterproductive group behaviour.	Protect participants to enhance the flow of group process.
Disruptive behaviours	Recognising, understanding and dealing with disruptive behaviours in the group tactfully and appropriately. E.g. blocking, diverting, power seeking, excessive talking, dominating, loud voice, clowning, silence, denying, seeking sympathy or attention seeking.	Manage disruptive behaviours which participants can engage in that hinder the group's progress or discourage other participants.

Appendix 3: Sample support group forms

Appendix 3.1 – Participant information form

INFORMATION FORM FOR POSTNATAL DEPRESSION SUPPORT GROUP

Name: _____ DOB: _____

Address: _____

Home hone: _____ Mobile: _____

Partner/spouse: _____Mobile: _____

Children (names and DOB): _____

_____

_____

Other family member: _____ Contact: _____

Current issues and difficulties: _____

_____

_____

_____

Other agencies you are involved with (e.g. doctor, psychiatrist, maternal and child health nurse, community supports)

_____

_____

_____

_____

Family supports: _____

_____

_____

What do you want from the support group? _____

_____

_____

Do you have any fears or concerns about coming to the group? If so please explain.

_____

_____

_____

What might prevent you from getting to a group session?

_____

Signature: _____ Date: _____

Appendix 3.2 – Referral and release of information form

Date: _____

Name: _____ Age: _____

Address: _____

Postcode: _____ Phone: home:_____ mobile:_____

Email: _____

Referred by: _____ From:_____ Phone: _____

EPDS Score (if known): _____ Date: _____

Marital status: _____Partner's name:_____

Children:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

What are reasons for referral being made?

_____

_____

_____

Support networks:

Maternal and child health nurse: Name:_____ Phone: _____

Doctor: Name:_____ Phone: _____

Other:

Name: _____ Phone: _____

Name: _____ Phone: _____

Release of information consent:

Under the Privacy Act I understand that all information recorded about me and my family for the purposes of (insert support group's name) will be held securely in the strictest confidentiality. It will not be used for any other purposes but to support me and ensure my wellbeing.

To assist this I give my consent for relevant information about me and my family to be released between my maternal and child health nurse/general practitioner _____ and the facilitator _____

Signed: _____ Name: _____

Please return Referral Form to:

Name: _____ Phone: _____ Fax: _____

Address: _____

Appendix 3.3 – Child minding consent form

Example

Dear Group Participant

As a part of the group program you are encouraged to explore leaving your baby or children with a child care service, friend or family member for the duration of the sessions. If you are unable to find alternative care volunteers will be on hand to help hold and distract babies under 12 months of age but there are no provisions for older children.

Child minding conditions
To ensure the child minding support operates according to government requirements, participants are required to sign their agreement to the following conditions for child minding during group sessions:

- Child minding will be provided for babies under 12 months of age only for each two hour session.
- Child minding will be provided by volunteers who have been recommended and recruited from local community organisations and have undergone a Police Check and Working with Children Check.
- Participants will continue to be responsible for their baby while in the care of the child minders.
- Child minding will be provided in the same room or a room adjacent to the room in which participants will be located, ensuring they are accessible to their baby and the child minders at all times.
- Participants are to provide for all the needs of their baby during the session, e.g. drinks and morning tea.
- Participants, their babies and child minders will be covered by public liability insurance while participating in the program.
- Participants are asked to refrain from bringing their baby to the session if they are unwell.

Child minding consent form
To ensure child minding support operates according to government requirements participants are required to agree to the following conditions for child minding during sessions from the date below:

I agree that my baby will remain my responsibility while in the care of the child minders in the adjacent room

I agree that I will continue to provide the supervision and care that my baby might require while in the care of the child minders

I agree to provide for all my baby needs during the sessions (drinks, morning tea)

I agree to refrain from bringing my baby to the session if he/she is unwell.

Parent's signature: _____

Print name: _____ Date:_____

Appendix 3.4 - Session planning and record keeping

Week 1

Date:_____ **Facilitators**: _____

Present: _____

DNA: _____

PLAN	NOTES
Welcome Introductions Icebreaker – pair up and chat with each other and then introduce your partner to the group. Discuss and establish rules for the group. Topic: tell your PND story Go around the group and give all participants (who are comfortable to) an opportunity to talk about their experiences of PND, their recovery etc. Refreshments Review the session with the group – how was it for you? Homework: what can you do during the week to take time for yourself? E.g. haircut, coffee, read, walk.	

Appendix 3.4.1 Sample session reports

Week 6

Date: 4 June **Facilitators**: Vicky and Mary

Present: Sarah, Jo, Annette, Lorraine, Michelle and Susie

DNA: Marie

PLAN	NOTES
Welcome and introductions • introduce new members	A big group today. One new member. The other members accepted Jo into group and she was able to participate in the group discussions.
TOPIC: Get on top of anger Brainstorm on paper • What is anger? • Relationship with depression? • What makes us angry? • What does anger do to us, others? • Use one example as an exercise – what happened? How did it feel? How did you handle the feelings? • How do we communicate anger: submissive, aggressive and assertive? • What are the consequences of the different ways of dealing with anger on self esteem and relationships? • Hand out on communication skills. • Role play using an example.	Group members were attentive during discussions and able to share their experiences of anger. Most felt it is a powerful state central to depression, primarily in response to anxiety and bottling up feelings. Overall members felt the little things make them feel angry, especially to do with their children. When the anger hits it can be very hard to avoid taking it out on those around them and this usually has detrimental effects on them and the person who is angry. Discussions about the styles of managing anger were well received, few concluding that they are able to deal with anger assertively. Most felt they were either aggressive or submissive and neither style was helpful. Gave examples about how to communicate assertively communication to deal with angry feelings. Encouragement was given to try to use this style of communication earlier in the anger process. It was acknowledged that it can be very difficult to be constructive in the middle of being angry. In reflecting on the session and what was useful, group members felt removing themselves as they feel the anger building and to try and communicate assertively was helpful. All felt OK to go home. Michelle was able to share her expectations for the group session – that she had hoped there would be more time for sharing personal stories and experiences. This was reinforced by other group members so it was suggested that next week's session could be spent sharing personally to help participants get to know those new to the group. Possible structure of the group - have an information focus one week followed by the group sharing session the next.
Refreshments Review the session with the group – how was it for you?	
Homework: what can you do during the week to avoid getting really angry?	Follow up next week: feelings about the session and what they had tried to do differently during the week, no mater how small.

Week 2

Date: 26 February **Facilitators**: Vicky and Mary

Present: Toni, Stella, Georgia

DNA: Lisa, Teresa, Julie, Louise

PLAN	NOTES
Welcome and introductions: • introduce new members • update on plans for couple's session. Hand out newsletter TOPIC: Family of origin – where have we come from? Draw picture of family of origin using choice of colour texta – share this with the group, introducing their family and explaining their picture and choice of colour. Brief input of theories of family development and family of origin. Open discussion as issues arise. Refreshments. Review the session with the group – how was it for you? Homework: reflect on the scripts taken from family of origin. Also self care task during the week. Evaluation	Small group again today but a very productive session. The new structure was well received by those present. Small group allowed for more in depth discussion. Participation in the drawing exercise was great with clear introductions and descriptions being shared. Consistent themes were evident of family breakdown, missing parent figures and the role of extended family. Other issues raised were the overall feelings being represented by the colours chosen – grey, black, yellow and blue. Provoking exercise for facilitators. The input of the family of origin theories was well received, using examples and simplified explanations. Covered the family as a system, family development theory and transition and transgenerational theory – myths, scripts and differentiation. As expected, this generated a lot of discussion. Consistent attempts to link experiences shared with the theory as explained. E.g. Toni was distressed over an issue in her family to do with her parents' separation and her tendency to get very emotionally involved. Linked this to limited emotional separation from her family of origin. Enabled Toni to reflect on her choice to try to become less involved with her family. Stella was distracted at times by the babies but talked and shared freely about her family of origin. Her lack of access to a car has limited her ability to get to the group. She shared that she has been very isolated. Her parents separated and she has grown up with a step father. She was able to reflect on aspects of this experience as part of the discussion. Georgia continued her family life reflection by incorporating the family of origin information, particularly the scripts she took on about the way families function to support each other and how this has not been fulfilled because she has moved away. Encouraged members to reflect on what scripts they might have taken from their family of origin and whether they are repeating or re-writing them.

Appendix 3.5 – Group input form

Thank you for coming along to the first week of the PND group – well done for getting here. We are keen to know what you would like from the group.

All PND groups are different. Some like to have a lot of structure and discussion topics, some are more casual and less structured, others are a combination of the two.

1) Are you interested in having a discussion topic during the group?

(Please tick) Yes _____ No _____

2) Please tick discussion topics that you might find interesting or helpful to cover in the group:

Our own story of pregnancy, birth and postnatal experience _____

Understanding PND and its treatment _____

Motherhood – did it meet our expectations? _____

Understanding our own families, how they affect our parenting _____

Anxiety – what it is and how to deal with it _____

Monitoring our progress and mood _____

Working and mothering _____

Helping our partners and families understand PND _____

Parenting and child development _____

3) Can you suggest any other discussion topics or anything you would like to see covered in the group?

_____

_____

_____

_____

Thanks for completing this form, please let us know if you have any other comments.

Appendix 4: Ideas for group discussions and activities

There are many ideas, topics and activities that a PND support group can focus on to help it meet its purpose. Some may be part of the planning for a particular session or group, or it may grow spontaneously from informal group discussions. Asking participants for their suggestions for what they would like to focus on can uncover a broad cross section of ideas, using form in Appendix 3.5.

Following is a list of different ideas for group discussions and activities, collated from various sources:

Postnatal depression

What is PND?
Antenatal depression
Community view of PND
Strategies to cope
Recovering from depression
Treatment
Medication
Week in review – how participants have been
Monitoring our progress and mood
Pregnancy and birthing experiences
Suicide and other risks
Relapse prevention
Factors that contribute to PND
Diet and depression
Partner's experiences of PND
Information session for partners and family
Past participant to share experiences with group
Sleep and mental health

Emotional wellbeing and skills

Self esteem
Spirituality
Managing feelings
Anxiety management
Stress management
Anger management
Feeling better in mind, body and spirit
How to achieve a balanced lifestyle

Cognitive skills

Dealing with obsessive thinking
Needs and wants
How to control worrying thoughts
Setting and achieving your goals
Cognitive approaches to treating PND

Mother/infant interaction

Mother infant play and dance activities
Mother infant video playback
Attachment
Baby massage
Baby's sleep pattern and settling
Importance of play
Child development
Communicating with your infant
Identifying your infant as an individual
Nursery rhymes, songs, books
Hand and foot prints
The good enough mother
Videos/DVDs
Child safety
Baby's photo gallery activity

Parenting

Myths of motherhood
Motherhood transition
Fatherhood transition
Expectations of parenthood
Change with a new baby
Role models
Parenting skills
Father's group
The parent's group
Balancing work and family
Working and mothering

Relationships and family

Building a support network
Effective communication
Changes with a new baby
Sex after birth
Conflict resolution
Understanding the family of origin
Family of creation

Personal growth

Assertiveness skills
Setting and achieving your goals
Realistic relaxation techniques
Foot and hand massage
Gentle yoga sessions
Bath bombs
Pampering group
Stretching and gentle exercises
Yoga
Aromatherapy
Outing to the park
Chocolate making
Dance therapy
Crafts – knitting, scrap booking, art
Where to from here

Appendix 4.1 Sample session plans

Foot and hand massage

Aim

To provide information about massage therapy as a stress management strategy and to provide a demonstration of either a foot or hand massage on willing participants.

Objectives

1) At the completion of the session participants will have a better understanding of:
   - basic massage and techniques of applying oils
   - massage as an emotional and physical stress management strategy.
2) At the completion of the session participants will have either received a foot or hand massage or watched the massage technique demonstration.
3) To provide willing participants with an opportunity to experience a safe form of physical intimacy and self care, shared with other participants or facilitators.

Method

Organise the group in the group room with relaxation music playing in the background. Encourage participants to sit comfortably on a chair or the floor. A warm foot/hand bath is provided to willing participants to begin each foot/hand massage, followed by a brief explanation of the massage techniques.

Note: each participant receiving a massage should be asked if she has sustained a past injury to her feet/hands or legs/arms or if there is any sore or tender areas at present. Care should be taken or the massage avoided if the answer is yes.

Discussion

Participants are encouraged to talk about their experience of the massage and options for alternative self care and stress management strategies. The experience of participants is used to provide stimulus for them to consider continuing or explore self care and stress management strategies.

Family of creation – families we have created

Aim

To gain a greater understanding of the processes involved with the creation of a new family.

Objectives

At the completion of the session participants will have a better understanding of:

1) Their family of origin and how it relates to their new families and that of their partners
2) How messages of the family of origin are transferred in scripts.
3) Their roles as mothers and how these relate to the relationship with their own mothers.

Method

Whiteboard discussion with the whole group

1) Use genogram (Goldrick et al, 1999) to show the bringing together of the new parent's family of origin in their family of creation – demonstrate how complex this can be and why it can be stressful
2) Use the genogram to identify and track scripts within each family of origin and whether these can be seen in the parenting of their children.
3) Participants to talk with person next to them – reflect on their roles as mothers in their family of creation, complete questionnaire about their relationship with their own mother.
4) Come back to larger group and share reflections.
5) Conclude with activity – write down 2-3 scripts participants would like to see in their family of creation – new or old. Identify one script they would like to let go of.

Communicating with your baby

Aim

To foster participants' relationship with their baby that acknowledges baby as an individual and is responsive to the baby's needs.

Objectives

At the completion of the session participants will have a better understanding of:

1) Their different ways of communicating with their baby and how this impacts on them
2) The importance of communicating with their baby to the child's development and wellbeing, acknowledging that sometimes this can be difficult for mother and baby to get right.
3) How babies communicate and why they cry.
4) The reciprocal nature of communicating with their baby. How they can communicate positively with their baby.

Method

1) Ask participants to brainstorm how they communicate with their babies – listening, looking, taste, smelling, feeling.
2) Ask participants to brainstorm how they think their babies communicate with them and how they learn to read their baby's cues. Discuss baby's crying as a means of communication – Why does a baby cry? What can be done with a crying baby?

   Use handouts of information or show DVD of child development 0-9 months to reinforce participants' observation skills.
3) Discuss other aspects of communication with baby at different stages of development, reinforced by DVD.
4) Ask each participant to identify a goal from information presented at the session that would help them communicate positively with baby and/or identify baby's communication with them.

Motherhood transition

Aim

To support mothers to manage the differences between their expectations of what motherhood was to be like and their actual experience of it.

Objectives

At the completion of the session participants will have a better understanding of:

1) Their experiences of becoming a mother and how it has impacted on their lives.
2) Ways new mothers can care for their own emotional and physical wellbeing.
3) Ways new mothers look beyond society's and their family's expectations of motherhood and to create their own realistic expectations of themselves as a mother.

Method

1) Warm up: Life before motherhood. Participants are asked to introduce themselves, how they are feeling and identify one or two things they enjoyed doing before they became a mother.
2) Introduce the story of a mother who has recovered from PND and her experience of transition to motherhood – maybe volunteer guest speaker.
3) Focus on how different cultures and societies mark the transition to motherhood and some of the myths, followed by a visualisation using visual aids and discussion.
4) Brainstorm myths of motherhood – what does society say new mothers should be like and able to do?
5) Focus on the dreams participants had of motherhood and the reality of motherhood. Then focus on identifying achievable goals from the dream, depending on their responses.
6) Discuss self care and taking time for themselves.
7) Participants are encouraged to take part in a hand massage as a form of relaxation and self care.
8) Review how participants are feeling and reflect on any new ways they might care for themselves to improve their emotional and physical wellbeing. Participants are asked to complete an evaluation form and stay for refreshments.

Appendix 5: Setting expectations

Early in the first session it is important to discuss with participants establishing a set of expectations for the group. Setting expectations as group rules is important to:

- ensure that the support group experience is safe and comfortable for participants and facilitators
- enable a transparent process of setting the expectations for the group that is consultative and ensures the group develops an ownership of the rules
- provide guidelines for managing conflict or disruptive behaviour within the support group.

It can be useful to give all participants a copy of the group rules once they are established, to display the list in the group room, to re-iterate the rules at the beginning of each session and to ensure that new participants are aware of the rules.

There are many different ways of wording the group rules, depending on the outcome of the consultation process. An example:

All discussions are confidential. What is talked about should remain in the room.

Respect each others' opinions and ideals. Value each others' differences.

Be attentive and willing to listen to each other when someone is talking. Only talk when you feel ready.

Be supportive of each other.

Be honest about our feelings about how the group is going.

Be as punctual to the group as you can. Ring if you can't come or are going to be late.

Tidy up the room and clean any dishes after the group is finished.

Appendix 6: Support group evaluation

At the conclusion of the support group it is important to assess the efficacy of the group and the outcomes of the group for participants. A great deal of time and energy goes into planning a support group so it is important to evaluate the planning and implementation process. Potentially all aspects of the support group need to be evaluated, from participants, the referral sources and facilitators.

Participants

Questionnaires tend to be the most commonly used form of evaluation completed by participants during the last session of the group program. Some of the questions it may include:

- What did participants gain from the support group?
- What expectations did they have of the support group that were not met?
- What has changed for them since participating in the support group?

Refer Appendix 6.1.

Referral sources

Interviews or questionnaires can be used to seek feedback from the referral sources about their use of the support group for their clients. It gives the referral sources an opportunity to reflect back on the consultation and planning process (of which they were part) and to feed back their observations of their clients' experiences of the support group.

Facilitators

Facilitators will need to reflect back on the consultation, planning and establishment phases of the support group when they evaluate the efficacy of the group. Drawing on the feedback from participants and the referral sources, some of the questions that can support this process may include:

- Did the support group reach its intended target group – how many people participated in the group, how many people did not engage or continue in the group?
- Was the support group implemented as it was planned – if not how did it differ from what was planned and why?
- Were the planning strategies and structures appropriate to meet the group's purpose?
- Were participants satisfied with the support group – information gained from the participants' evaluation form.
- Were the referral sources satisfied with the support group – accessibility for their clients, feedback from their clients.
- Were available resources (e.g. facilitators, timing, venue, materials) appropriate for the support group?
- Were there any unintended outcomes from the support group?
- What recommendations could be made for future support groups?

Appendix 6.1: Participant feedback form

Your feedback to us is very important. It will help us improve the services we can provide. Please assist us by completing the following short questionnaire. All information is strictly confidential.

What do you feel you have gained from coming to the PND group?

_____

_____

_____

_____

What else would you have liked to have gained from coming to the group, e.g. discussion topics?

_____

_____

_____

_____

Is there anything you are doing differently now as a result of coming to the PND group?

_____

_____

_____

_____

Did the structure of the group suit you and your needs?

_____

_____

_____

_____

Any other comments you would like to make, e.g. about the venue, duration of the group, facilities, facilitators?

_____

_____

_____

_____

Sample

Group interview proforma for assessing participant satisfaction

This is a quick way to get participant feedback for evaluating the group program without using questionnaires. Use a whiteboard or large sheet of paper. Discuss with the group which aspects of the program should be commented on and write these on the left.

COMPONENT OF PROGRAM	POSITIVE COMMENTS	NEGATIVE COMMENTS	RECOMMENDATIONS
Content (break down into specific components if possible)			
Facilitation			
Materials (pamphlets, handouts, DVDs)			
Group discussion			
Venue/facilities			
Other			

Adapted from Hawe et al (1990).

Sample Evaluation of Craft classes for women with PND

The evaluation of the experiences of the women with PND who participated in a knitting group demonstrates a cross section of positive benefits from their involvement.

Improvements in their experience of PND

Some the participants felt that their involvement in the knitting group had allowed them to be less tough on themselves, become more aware of their strengths and weaknesses and increased their knowledge of PND.

"About ¾ of the way through I felt the sudden uncontrollable 'rage' just lift and go. I still get angry but nowhere near the rage I experienced."

"I am speaking up more often when I don't feel like I'm coping very well."

Increased difficulties in their PND

One participant felt her PND was worse because her involvement in the knitting group had highlighted where her issues were.

Overall, most participants reported that their PND had improved.

Others reported that being with other women with PND in the group was the most beneficial aspect to their recovery from PND.

"The people I have met and experiences I have had have really given me the support I needed to build up my strength again."

"Finally meeting others who have shared my experience."

All participants expressed their enjoyment of being with each other, having a good laugh in an environment where they felt relaxed and more freedom to be themselves.

"I feel like I have made some very special friendships where I am not judged because of my depression."

"I cannot stress how comfortable I feel with these people!"

The effects that creative expression through craft may have had on the wellbeing of participants as part of their recovery from PND

Some of the benefits participants gained from learning to knit included:

- gaining a great deal of pleasure in learning to knit and being able to create a garment
- knitting as a means of relaxing and distracting them from anxious or depressed thinking and for time out
- learning she could complete a project if she set her mind to it.

"Remembering and obtaining that feeling of satisfaction when you complete something. I really gained some confidence and boost to my mental well being and self image."

The feedback from participants about their experiences of the knitting group, that may form the basis for planning future groups will benefit other women with PND.

All participants spoke positively about the venue, childminding and quality of the teaching. Positive comments were made about the staff. It was felt by everyone that the collaborative approach from all these parties was important to the group's success.

In summary, the following quotes describe participants' feelings about any future plans for the knitting group:

"It should be at all Spotlight stores."

"That it keeps going!! I would be willing to pay to attend other courses if they were made available."

"That it becomes a national event so all women (with PND) can gain from this project."

"I encourage a roll out throughout Australia, so many people will benefit."

"Thank god for the knitting course!"

"Thank you for giving me the opportunity to participate in the course. It really helped me as a person and a mum. I am not better yet but it certainly helped me take some big steps in the right direction."

Appendix 7: PND Group Facilitator's Network of Victoria

PANDA believes group work is a valuable treatment for women experiencing postnatal depression. It provides opportunities for sharing experiences with other women and learning strategies for managing their PND.

The Postnatal Depression (PND) Group Facilitator's Network of Victoria was established by PANDA in May 2003 to bring together health professional and self help facilitators who run a range of postnatal depression support and therapeutic groups. The Network is open to anyone who is interested in PND support groups.

Network objectives

- Provide a forum for PND support group facilitators to support each other and share experiences of what works and lessons learnt.
- Encourage the promotion of group work as a valuable and viable treatment and support model for both consumers and health professionals.
- Use the collective experience within the network to develop ways to sustain existing postnatal depression groups and establish new groups.
- Provide access to professional development with education component with guest speakers and involvement of the network in conference presentations and workshops.
- Promote more referrals to PND support groups by other health professionals and community members.

The network meets Monday morning every two months at PANDA, with a light lunch provided. All meetings encourage members of network to share their experiences and challenges. Every second meeting provide a guest speaker.

Enquiries to PANDA to attend the Network or join the email list.

Appendix 8: PANDA's PND Services Database Form

Please complete this form so we can maintain current information on practitioners with expertise in postnatal and antenatal depression for referral purposes. Information that you provide will be updated annually by PANDA.

A. CONTACT DETAILS	
Date	
Contact name:	
Practice/agency:	
Location:	
Postal address:	
Phone:	Fax:
Email (office use only)	
Hours/days of operation	
Is appointment required?	
Waiting list period?	

B. PRACTITIONER INFORMATION	
What is your experience and/or qualifications in working with women, their partners and/or families experiencing post and antenatal depression? Please include any professional development relating to post and antenatal depression you have had.	
Which categories of service do you provide for women and their families dealing with post and antenatal depression and wish to be entered into on the database?	
Counselling	
General practice	
Psychiatrist	
Support group (Reg fee exempt)	
Family support (Reg fee exempt)	

COST OF DATABASE REGISTRATION**: $33 (incl.GST) per year.**

Please forward cheque for the $33 Administrative Fee and completed form to 810 Nicholson St North Fitzroy VIC 3068 **or fax to (03) 9482 6210.**

Registration fee payment entitles you to receive listing on the PND Services Database, five free PANDA pamphlets and PANDA's quarterly newsletter.

What approaches or therapy do you use with women/partners/families?
Are there any other services provided at your clinic/office/service?
Are there are any other languages spoken in your service?

C. FEES AND CHARGES
Note: This information will only be used to give an idea of costs to assist in our referral process. All clients will be advised to contact and discuss fees directly with the practitioner.
Please provide a scale of your fees (i.e. individual, couples, family, concession).
Do you bulk bill?
Is there a rebate for your services for clients with Private Health Fund Cover?
Are you prepared to offer some clients referred by PANDA a nominated number of counselling sessions per client, on a pro bono basis or at a significantly reduced fee negotiated by you, according to an individual's financial circumstances? **Yes No (Please circle)**
Is the service registered under the Better Access to Mental Health Care Initiative? **Yes No (please circle)**
Your Privacy Information provided will be used solely for the purpose of referral. A full copy of PANDA's privacy policy is available on request or can be downloaded from the PANDA website.

Thank you for completing this form, your assistance is greatly appreciated.

Appendix 9: References and resources

References

American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*. 4th Edition. Washington. American Psychiatric Association. 1994.

Brockington, I. F. *Motherhood and mental illness.* Oxford University Press. 1996.

Confidential enquiry into maternal and child health. http://www.cemach.org.uk/ 1991.

Department of Human Services. *Standards for Psychiatric Disability Rehabilitation Support Service*. Victoria.

Goldrick et al. *Genograms Assessment and Intervention*. 2nd Edition. USA. 1999.

Hawe, P., Degeling, D. and Hall, J. *Evaluating health promotion, a health worker's guide.* Maclennan and Petty. Sydney. 1990.

HCi: http://www.hci.com.au/hcisite2/toolkit/smallgro.htm

Horan-Smith, Jacinta. *Evaluations and Outcome Measurement- A gentle exploration of the issues*. Ranges Community Health Service. 2007.

McConnell, Taylor. *Group Leadership and Self-Realization*. Leviathan House. 1974.

PANDA and Australian Breastfeeding Association. *Postnatal Depression and Breastfeeding*. Australia. 2006.

Pollard, Margaret. *To screen or not to screen that is the question? The case for opportunistic screening*. University of Melbourne. Joint Domestic Violence and Sexual Assault Conference. 2001.

Radke-Yarrow, Marian, and Pearce, John. *Children of depressed mothers: from early childhood to maturity*. Cambridge University Press. 1999.

Scholtes, Peter R. *The Team Handbook.* Joiner and Association. 1988.

Groupwork resources

Playgroup Victoria Inc. *Playgroup Manual.* 3rd Edition. 2002.

Playgroup Victoria Inc. *Supported Playgroup Manual.* Supplement to *Playgroup Manual* (3rd Edition). 2006

Milgrom, Jeanette, Martin, Paul R. and Negri, Lisa M. *Treating Postnatal Depression; A Psychological Approach for Health Care Practitioners*. John Wiley & Sons, Ltd. 1999.

Reconnexion (Formerly TRANX). *Communicating, Connecting and Caring Postnatal Depression Group Facilitation Manual*. 2006.

Postnatal depression resources

Behind the Smile – My Journey out of Postnatal Depression Marcia Wilkie & Dr Judith Moore. Harpers Collins Publishers. NSW. 2001.

Beginning Fatherhood – A guide for expectant fathers. Warwick Pudney & Judy Cottrell Finch. NSW. 1998.

Breaking the Patterns of Depression. Michael D. Yapko, PH.D. Double Day. New York. 1997.

Coping with Postnatal Depression Dr Bryanne Barnett. Lothian Books. Victoria. 1991.

Depression After Childbirth – How to recognize and treat postnatal illness. Katharina Dalton. Oxford. New York. 1996.

Don't Panic! – Overcoming Anxiety, Phobias & Tension Dr Andrew Page. Gore & Osment. NSW. 1993.

Down Came the Rain – A mother's story of depression and recovery Brooke Shields. Penguin. Australian. 2005.

Emotional health during pregnancy and early parenthood. beyondblue. 2007.

On Thin Ice- Experiences of Australian women with Pre and Post Natal Depression. Sharon Hauptberger. Affinity Publishing. NSW. 1997. (Out of print)

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Perinatal Psychiatry – Use and Misuse of the Edinburgh Postnatal Depression Scale. John Cox & Jeni Holden. Gaskell. London. 1994.

Postnatal Depression – A systematic review of published scientific literature to 1999. National Health and Medical Research Council. Commonwealth of Australia. 2000.

Postnatal Depression – families in turmoil Lara Bishop, Foreword by Dr Tom George. Halstead Press. NSW. 1999.

Postnatal Depression. Vivienne Welburn. Fontana Paperbacks. Great Britain. 1980.

Post Partum Depression and Anxiety. The Pacific Post Partum Support Society. 1987.

Robby Rose and Monkey. Andrea Louis. Helen Mayo House. SA. 1995.

Taming the Black Dog – A guide to overcoming depression Bev Aisbett. Harper Collins Publishers. NSW. 2000.

The New Mother Syndrome – Coping with postnatal stress and depression Carol Dix. Allen & Unwin. Great Britain. 1986.

Women's Experience of Postnatal Depression. Lisa Fettling and Belinda Tune. IP Communications. VIC. 2005.

Additional information

PANDA	Helpline 1300 726 306 (Vic) www.panda.org.au
Playgroup Victoria	(03) 9388 1599 www.playgroup.org.au
Playgroup Australia	www.playgroupaustralia.com.au
Better Health Channel	www.betterhealth.vic.gov.au
Beyond Blue	Information line 1300 224 636 beyondblue.org.au
Royal Women's Hospital	(03) 9344 2000 www.thewomens.org.au
Victorian Government Health Information	Victorian Mental Health Services Website www.health.vic.gov.au/mentalhealth/index.htm
Parentline	13 22 89
Early Childhood Intervention Line	1800 783 783
Maternal and Child Health Line	13 22 29 www.office-for-children.vic.gov.au/maternal-child-health
Child Protection Emergency Service	13 12 78
Raising Children Network	www.raisingchildren.net.au
Best Start	www.beststart.vic.gov.au