Postnatal Depression

A Handbook for General Practitioners

Perinatal Working Party Initiative
Postnatal Depression, A Handbook for General Practitioners was written by Maureen Miles, Perinatal Program Officer of Monash Division of General Practice (Moorabbin) Inc.

It is based on the work and experience of the Perinatal Working Party. Theories and explanations have been utilised and modified, and acknowledged in the Bibliography.

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“It was a huge relief to get a name for my feelings.”
Postnatal Distress and Depression

The Tip of an Iceberg?

Resources accessed by the Mental Health Foundation predict that by 2020, depression will be the greatest disease burden in the developing world. Consequently the new national health policy places greater emphasis on promotion and prevention of this condition.

Depressive disease in mothers has been recognised since the time of Hippocrates and current research suggests that between 10 and 30% of new mothers suffer from non-psychotic depressive illness of varying severity (as opposed to the rate of postpartum psychotic illness which is 0.2% of live births). Definition of these states is difficult – it usually refers to emotional problems and depression that occur around 2-8 weeks post-partum, and can last as long as 2 years. This problem occurs at a time when heavy demands are placed on a new mother’s resources. Because of this there is a vulnerability that leaves women highly sensitive to the considerable stresses of motherhood. Yet depression during pregnancy and postpartum remains under-recognised and under-treated. Even today when this emotional condition is identified, it is often wrongly presumed to be a normal and self-limiting side effect of pregnancy.

Authors of a recent study in Perth (WA) describe the consequences of this upheaval and vulnerability using circuit diagrams – those women who use a variety of support mechanisms (practical, financial, emotional, medical) move more quickly on to a more stable phase of motherhood, whereas those who do not have access (perceived or real) to support or who do not recognise the need for support and who therefore do not seek it take a longer circuit and endure a more protracted interval before resolution. The results show increased levels of stress, imposed isolation, low self-image and unrealistic expectations of self and others.

Recent research suggests that there are widespread under-reported health problems in the postpartum period that commonly persist beyond the first six months after childbirth. In fact, out of the 94% of women who had health problems between giving birth and 6 months post partum, only one in four sought medical attention. Less than 5% of those with urinary incontinence discussed this problem with their GP or Maternal and Child Health Nurse. The most common physical problems included chronic back pain (70%), sexual problems (26%), relationship difficulties (18%) and urinary incontinence (11%). The continued, unabating presence of such problems simply add more stresses to an already enormous load (Brown S, 1998).

Depression can cause cognitive distortions that lead to refusal of help from partners and friends, and sufferers are often trapped by a reluctance to admit mental illness. Mothers may hide emotional problems or fail to discuss them with their doctor in order to avoid indicating that they are not coping. Other reasons for not seeking help may be that women feel that to seek help indicates failure, or that the problem is not perceived as being severe enough to require
assistance or treatment. Some women only have a realisation of the extent of their depression after recovery. Consequently, clinicians must actively search for signs of distress and depression during the postnatal period. Failure to detect problems soon after they appear and to treat effectively can lead to health risks for mother and partner, problems with the viability of their relationship, and long term consequences for offspring, including siblings. Postnatal depression that remains untreated frequently causes more problems for the affected family than may be evident at the time, and the ramifications may persist long after the illness has resolved. Research suggests that boys in particular are more vulnerable to external influences, and one study found that 70% of boys whose mothers had postnatal depression go on to have behavioural problems at school (Cooper and Murray, 1998).

Social support is recognised as a protecting factor against depression. Those who have little social support are 13 times more likely to suffer from major depression. Unfortunately this is a self-perpetuating situation, as depression itself tends to lead to withdrawal and hence further isolation. Women have reported difficulty in talking about their distress. They may require considerable encouragement, real acknowledgment of their distress, and someone to listen. Studies by the Centre for the Study of Mothers’ and Children’s’ Health suggest that even evident distress remains unnoticed by health professionals.

The Postnatal Depression Handbook for General Practitioners has been developed especially for General Practitioners in the Monash Division of General Practice and their patients who are experiencing motherhood in the community.
Introduction

This handbook has been developed to help general practitioners in the prevention and early identification of postnatal depression. The handbook is not seen as prescriptive, rather as a range of options useful in a holistic approach to a complex disorder. Because of its long-term effects for the woman and her family, the general practitioner plays a crucial role in identifying postnatal distress and depression early and treating it aggressively and appropriately. They are well placed to be part of the support, monitoring and referral network for women experiencing PND.

Postnatal depression has many definitions and therein lies the problem for the clinician. The lack of consensus regarding the definition has led in the past to the disorder being undiagnosed or misdiagnosed and untreated or undertreated. The prevalence of the disorder has been reported as 14-16% of all postnatal mothers diagnosed, with a further reportedly 30-35% experiencing symptoms but no diagnosis. Even the rates of prevalence are reported differently in the range of studies available, and can be seen in the quoted studies in this handbook.

It has been demonstrated that the milder forms of postnatal depression have often been dismissed as a normal reaction to motherhood. Many women find that motherhood for them is not the joyful event as anticipated. These mothers present to their maternal and child health nurse or general practitioner on a regular basis with concerns for the baby, while never admitting to feeling unwell or experiencing unhappy feelings unless asked. The phrase ‘smiling depression’ captures the picture of a mother suffering and experiencing postnatal depression.

This handbook aims to inform care providers about the condition of postnatal distress/depression, so that care providers can not only recognise and correctly interpret the symptoms when help has been sought, but also, assess predictors so that appropriate initiation of preventative therapy can begin. It also encourages the active seeking for signs of postnatal distress/depression in those women who do not readily seek help for their emotional needs.

The layout of the management suggestions attempts to utilise the best possible referrals for women experiencing distress or depression postnatally.

- Source of reference about postnatal distress/ depression.
- Resource book for local services, both medical and non-medical that could be employed during the management phase.
- Information, to educate pregnant women and their partners about the manifestation, contributory factors and management of postnatal depression.

There are many services out in the community that can assist, offer support and give information to women and their families at this time. The question is where are they, how do you find them and which one should they choose? This handbook has been developed in order to give you, the health practitioner, the woman and her family a smorgasbord of referral choices.
Community Worker’s comments on:

♦ Maternal Expectations and Lifestyle Changes
♦ Maternal Feelings
♦ Environmental Factors

Kaye Paton
Founder of Midwives Supporting Mothers
Talks about maternal expectations and lifestyle changes:

The image of motherhood as an intensely satisfying, rich and fulfilling experience is one that is generally accepted by our society. But for many there is considerable disparity between the image, the expectation, and the reality.

Very few mothers are prepared for the awful side of motherhood, with the majority of women experiencing emotions that are foreign to them. Feelings of loneliness and the never ending demands leave the most loving mother frustrated and exhausted. The constant range of emotions from overwhelming love to frustrated rage is bewildering and often not acknowledged or recognised. While generally women love their children they do not necessarily love being mothers.

It is not uncommon today for new mothers to have had very little or no exposure to small babies. Knowledge no longer coming from the extended family, but from books and ‘experts’, leaving often an underdeveloped confidence to struggle alone at home with a totally dependant infant.

Barbara Minto
Mother and Baby Unit Manager, Mercy Hospital and Psychologist in Private Practice
Talks about maternal feelings:

The experience of childbirth and motherhood is unique to each individual woman. The woman’s feelings, thoughts and actions are dependent upon a multitude of factors. There are biological, psychological, sociological and spiritual factors that contribute to the woman’s sense of well being. There is no other developmental stage that involves so much change in every facet of a woman’s life. The woman’s feelings, the content of her thoughts and the actions that follow will be very variable.

Women can experience a wide range of feelings from euphoria to depression in the postnatal period. It is the duration (greater than three weeks) and intensity of the feelings (plus other symptoms) that indicate a diagnosis of postnatal depression.

Incorporating a new baby into the family creates enormous changes, not only for the woman but her partner as well. Research has shown that the two years after a baby is born is the most dissatisfying time in the marital life cycle (Sabini, 1992).

The mother needs to learn about the new baby, her new role and the new dynamics within the family. It is a vulnerable time and depending on her self esteem will depend on how she copes with these changes. A poor role model by her own mother, past history of abuse or psychiatric disorders, or other factors that could contribute to increase stress will make this woman extremely vulnerable to intense and a wide range of feelings. These feelings can be explored in variety of settings from mother and baby unit, to individual or group counselling.
Toni Lambourne,
Maternal and Child Health Nurse

**Talks about maternal environmental factors:**

Women have sometimes found that external environmental factors can be a major concern to them after childbirth. Change in their financial positions can bring feelings of anxiety and anger, as well as feelings of loss of control.

For some women it is a difficult time to return to work earlier than they would wish, leaving behind their baby and not fully recovered from the birth.

For others the isolation of staying at home is overwhelming, being away from socialising and working with adults, often living in neighbourhoods they used to only come home to after work.

Others are isolated from their families whether through their own parents’ work commitments or geographically.

Relationship difficulties can be accentuated at this time of great stress. Especially for women experiencing domestic violence.

Immediate and appropriate responses from health professionals can alleviate some of the pressure and isolation. Resources in the community are available to address some of the individual issues and some families may require a number of resources to bring balance and control back to the family.

“It never really came up with the Maternal Child Health Nurse - she seemed to be dwelling on other things more to do with the baby.”
“I felt totally overwhelmed, experienced uncontrollable crying and emotions.”
Postnatal Depression

Overview
What is postnatal depression?

In our community a broad range of conditions may be labelled as depression. These range from stress, to mild, moderate and severe postnatal depression (affecting 10–30% of mothers), including the rare condition of puerperal psychosis (affecting 0.2% of mothers). We must also include antenatal depression, as this condition often lingers on to become Postnatal Depression (PND) if left without intervention.

♦ Baby blues, Postpartum blues and postnatal stress
This disorder is common affecting 80% of all mothers. It appears as a transient mood disturbance occurring in the first week of the postnatal period through the dramatic drop in hormone levels after childbirth. Does not automatically lead to PND but for some women they do. The emotional liability should have settled by 14 days.

♦ Postpartum psychosis
This most severe disorder usually has an acute onset anywhere between the first and six weeks postpartum, the woman often presents with bizarre behaviour and requires urgent psychiatric assessment and hospitalisation.

♦ Postnatal depression
This disorder has no clear definition, but usually occurs over a period of time commencing within the first three postnatal months. It can often be described as an adjustment disorder in its mildest form. The severity of the disorder is often masked and may fluctuate.

<table>
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<tr>
<th>Signs and Symptoms of Postnatal Depression</th>
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<tbody>
<tr>
<td><strong>Disturbance of:</strong></td>
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<tr>
<td>• Mood (anxious, depressed, irritable)</td>
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<tr>
<td>• Sleep (unrelated to the baby’s needs)</td>
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<td>• Appetite</td>
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<td>• Gastrointestinal function</td>
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<tr>
<td>• Menstrual function (delayed resumption or severe pre-menstrual syndrome)</td>
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<td>• Increased sensitivity to noise (even familiar noises are found to be intrusive and stressful)</td>
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<th><strong>Loss of:</strong></th>
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<tr>
<td>• Energy</td>
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<tr>
<td>• Concentration</td>
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<tr>
<td>• Interests</td>
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<tr>
<td>• Confidence</td>
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<td>• Libido</td>
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<th><strong>Feelings of:</strong></th>
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<tbody>
<tr>
<td>• Anger</td>
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<tr>
<td>• Inadequacy (inability to cope)</td>
</tr>
<tr>
<td>• Helplessness</td>
</tr>
<tr>
<td>• Exhaustion</td>
</tr>
<tr>
<td>• Panic, fear</td>
</tr>
<tr>
<td>• Unworthiness, guilt</td>
</tr>
<tr>
<td>• Sadness, shame</td>
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</tbody>
</table>
Signs and Symptoms of Postnatal Depression

Some women may feel anxious and/or anxiety rather than depression which is often characterised by:

- Intense anxiety and/or fear
- Sense of doom
- Rapid breathing
- Hot or cold flushes
- Fast heart rate
- Chest pain
- Shaking
- Dizziness

Post partum distress/depression may also include obsessive compulsive features. Postnatal Obsessive Compulsive Disorders (OCD) can occur for the first time in women following childbirth. If a woman has a history of OCD, her symptoms may intensify.

Symptoms include:

- Intrusive, repetitive thoughts (including thoughts of harming the baby)
- Avoidance behaviour (avoiding the baby to alleviate intrusive thoughts)
- Anxiety
- Depression

These thoughts are often frightening and perceived as being out of character for the woman experiencing them. (Van der Kolk B, 1996)

Who is at higher risk of experiencing PND?

A woman who has given birth, has an increased risk of mental illness in the first two years, with a risk of 35 fold in the first month (Dennerstein L, 1989).

Women with a past psychiatric history, including depression (not PND) and/or family history of psychiatric illness have an increased risk.

Women with a past history of vulnerability, through events of trauma, loss and grief (Van der Kolk B, 1996) may increase their risk of PND.

Women with a past history of PND appear to have a significantly increased risk of recurrences with subsequent pregnancies.

The following list of common factors that may increase women’s risk of postnatal depression demonstrates that PND and the spectrum it encompasses is a multi-factorial issue with biological, psychological and social factors all playing some part. For each woman a different combination of factors is probably responsible (Holden J, 1991 and Beck C, 1996).

Common risk factors:

- Past History of Depression
- Unrealistic expectations of motherhood
- Physical problems
  - hormonal
  - thyroid hormone deficiency (thyroid dysfunction)
  - anaemia or iron deficiency
  - infection - uterine
    - breast
  - recovery from surgery
  - pain from perineum
Sleep deprivation
Lack of social supports
Relationship changes
• earnings
• division of labour
• loss of time together
• jealousy
• sexual changes, reduced sex drive and responsiveness
• pain on intercourse
• at risk of alcohol, drug abuse and/or domestic violence
Sense of failure
• birth experience or trauma
• breast feeding experience
• parenting, difficulties with baby, illness, crying, feeding
• partner, relationship changes
Ignorance about postnatal depression about the ups and downs of parenthood
Loss or Grief issues
• death of parents, siblings or baby
• childhood abuse
• if the woman herself has been adopted
• adoption of previous baby
• recent change in life circumstances

These postnatal predisposing factors can be grouped into economic, physical, psychological, marital and social categories. It can be demonstrated here that the stresses outstrip the woman's capabilities to manage as a new mother.

Predisposing sources of parental stress in the postnatal phase.
(Morse C A, 1993)

<table>
<thead>
<tr>
<th>Economic</th>
<th>Physical</th>
<th>Psychological</th>
<th>Marital</th>
<th>Societal</th>
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<tbody>
<tr>
<td>Extra financial demands</td>
<td>Sleep deprivation</td>
<td>New skills required</td>
<td>No partner</td>
<td>Myths of Motherhood as bliss</td>
</tr>
<tr>
<td>Loss of earnings</td>
<td>Excess work</td>
<td>Multiple demands on information</td>
<td>Long hours worked</td>
<td>“Good” mother expectations</td>
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<td></td>
<td>Demands overloads with</td>
<td>processing</td>
<td>Limited behavioural and emotional</td>
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<td></td>
<td>over-extension</td>
<td></td>
<td>support for female</td>
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<td></td>
<td>Boring, repetitive tasks</td>
<td>Feeling overwhelmed</td>
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<td></td>
<td>Increased responsibility</td>
<td>Feeling loss of control,</td>
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<td></td>
<td>Limited adult contact,</td>
<td>disempowered</td>
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<td></td>
<td>isolation social deprivation</td>
<td>Loneliness</td>
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<td></td>
<td>No or little experience in</td>
<td>No tangible rewards,</td>
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<tr>
<td></td>
<td>childcare</td>
<td>loss of identity</td>
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<tr>
<td></td>
<td>Unpredictability of tasks</td>
<td>Unrealistic</td>
<td></td>
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<td></td>
<td>No relief, breaks or personal space</td>
<td>expectations</td>
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<td></td>
<td>Adverse work conditions</td>
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‘Behaviour of Professionals’ - contribute to risk factors

The behaviour of the general practitioner and other health professionals can often contribute to the risk factors for women who are at risk of experiencing postnatal depression. They can include:

- Not involving the women in decision making during the birth or in their postnatal care
- Higher concern for the physical health, rather than the emotional health and not recognising the emotional trauma
- Not demonstrating understanding when the woman is not coping which can add to the feeling of guilt she has
- More concern shown about the baby than the mother
- Inconsistent advice
- Lack of respect for cultural or religious beliefs
- Failure to recognise and respond appropriately and adequately when a depressed woman presents
- Relying on medication alone to treat the problem

Why is PND missed?

- Failure of mothers and families to recognise the illness
- Failure of health workers to search for/or recognise possible signs and symptoms
- Failure to conclude that the observed symptoms justify a diagnosis

The woman with PND may feel depressed or distressed but not show it. PND is often known as the ‘smiling depression’, making it difficult for the health professional and family members to recognise anything is wrong, or make the assumption that it is normal adjustment to motherhood. Fear that she is not normal or not a good enough mother, prevent her telling the health professional. If and when she does present to the health professional, for some women this can be numerous, with either symptoms of her own or concerns for the baby. The health professional needs to be open to the possibility that this woman maybe suffering from depression or distress. This increased awareness will enhance the process of early recognition, identification, diagnosis and treatment.

“I told the GP I was weepy and very tired and he told me “all first time mothers are like that and you just have to cope.””
Postnatal Depression

What to do?
What to do?

As a general practitioner you may be wondering what can you do amongst this avalanche of risk factors and symptoms. The following is a guide:

♦ Prevention
♦ Identification
♦ Assessment
♦ Management
♦ Treatments
♦ Referral

Prevention

Some of the predictors of postnatal depression can be evident prior to the commencement of the pregnancy, some during pregnancy, during the birth process or during the postpartum period itself. Learning to recognise the predictors can be instrumental in identifying the symptoms early and prevent long-term affects of postnatal depression. Prevention begins with identification, (see page 4 common risk factors) assessment and then management.

Identification

The first key to assessment and future management is identification.

When to identify risk factors:

- **Preconceptual** - ideal but often missed as women present when already pregnant
- **First visit to confirm pregnancy** - opportunity to assess and identify PND risk. Also an ideal time to raise birth and mothering expectations including PND and what it is.
- **Six week postnatal check** - most common time that a woman is assessed, or shows signs of PND.
- **Acknowledgement** can bring relief. Debriefing can help to decrease negative emotion surrounding the birth experience.
- **Believe the woman**, it can bring comfort. Confusion and ‘joyless’ feelings can be explored
- **Talk to partners** and extended family. This is necessary to obtain a clear picture as well as support the new ‘father’ who may be just as confused. Remember the mother is not the only patient/client because her family is affected too.
Assessment

In assessing the woman with postnatal depression it is important to have a clear picture of this woman's pregnancy, labour and birth and postnatal period up to the point she has come to you. As well as a personal and social history. This can be very time consuming and may take a period of time to collect, the advantage however is demonstrated in planning appropriate future management.

Full History

- Family history and personal history of psychiatric disorders;
- Obstetric history including:
  - Previous pregnancies/deliveries/attitudes and physical wellbeing during the pregnancy; expectations and experience of delivery; post-partum health and breast feeding; postnatal depression; reproductive losses: abortion, miscarriage, stillbirth, and prior infertility;
- Hormonal factors such as premenstrual history and contraception;
- Societal factors, including emotional and practical supports by partner/family/social networks;
- Marital relationship; financial situation and accommodation and other life stresses;
- Infant factors, including the health, development and temperament of the child and other children;
- Personal adaptation to motherhood including issues such as parenting skills; emotional demands of the responsibility for the baby; lack of time to spend on her own needs (interests, exercise and time-out); loss of personal identity and independence; loss of a job and social isolation.
- Past or present violence of any kind: rape, childhood abuse, childhood sexual abuse, domestic violence
- Loss and grief issues, especially if unresolved: death of a sibling, death of a baby eg. SIDS, childhood abuse of any kind, adoption of the mother, adoption of other children, recent bereavement
- Social/Family; network of friends and/or family.

In the interview

- Ask specifically for symptoms of depression (see list of signs & symptoms of PND pg 3)
- Get the woman to complete Edinburgh postnatal Depression Scale (EPDS)
  (see resources pg 46)

Assess Symptoms of Depression

Severity determines need for medication and/or hospitalisation

Consider:
- Duration
- Depth of depression
- Suicidal thoughts
- Infanticidal thoughts

- Ask “What is the woman’s priority?” (what does she see as the most important issues she needs to be managed today?)
  - Interactive concerns
  - Maternal physical problems
  - Maternal feelings
  - Other

- Know that most women can be managed at home.
What you need to know and use for assessment.

- Edinburgh Postnatal Depression Scale
- Awareness of the signs of postnatal depression
- Awareness that early detection and treatment tends to reduce length and severity of postnatal depression
- An awareness of underlying ‘personal issues’ is generally also found helpful

Management

Giving the woman permission to talk openly about her relationships, disappointments and/or stresses that she may be experiencing in her new role as a mother is important. These may also include common feelings of ambivalence towards her baby, the resentment and frustrations that she may feel, when dealing with a demanding, vulnerable individual, without the skills to help her cope.

From these exchanges priorities may be identified and networking can begin. It may be simply that the GP can assist by referring her to agencies that can help her with childcare for timeout or update her mothercraft skills, or discuss ways she can recruit help from family and friends.

There may be specific physical treatment required, or emotional relationship problems requiring referral to individual counselling or group work. Other women may require medication and it may include a hospital stay in a Mother and Baby unit for psychiatric management or an early parenting centre for assistance with childcare issues e.g. crying baby, feeding problems, settling problems.

A woman needs to have a professional diagnosis and be encouraged to access as many forms of treatments, help and supports available that are appropriate for her given circumstance and degree of depression or anxiety.

Management includes:

- Empathic listening and validating the woman’s experience
- De-briefing the birth experience (Tell me about your pregnancy, birth: How was it?)
- Validating the work of mothering as a job: all parents require support at times
- Providing information on a woman’s postnatal depression: its severity, nature and likely duration
- Giving the woman (and family) a clear idea of their treatment options, what community services they may need to access, and also what help they may need to organise at home
- Refer to appropriate agencies
- Available time to talk about her experiences
- Referral to support organisations and/or individuals
- Skill development in parenting
- Encourage time or stress management
- Counselling – relationship, financial, sexual etc…
- Medication
- Support from GP
- Referral to a Mother and Baby Unit
- Referral to a Psychiatrist
- Help needs to be practical and supportive

(Clement, 1995)
Treatments

Because of the holistic approach of general practitioners, especially when dealing with a woman experiencing PND. The treatment approach of management needs to encompass this and may include:

- Medication – antidepressants, medical remedies for birth trauma etc.
- Psychotherapy – listening, counselling, psychiatrists, support groups.
- Natural Therapies – Bush Flower and Bach Flower remedies, Body work, massage, naturopathy etc.

Referral to Psychiatrist

In a recent seminar, Dr Jo FitzGerald made the comment that the location of treatment for postnatal depression can be in a variety of settings including home, home with CATT support or hospital (mother and baby unit). The choice is dependent on assessment of the safety of mother and infant and the severity of depression, both symptomatology and functioning.

Based on your assessment of the woman’s (patient’s) needs:

**Less severe:**

GP management may include:

- Working with Maternal Child and Health Nurse
- Use of antidepressants
- Involvement of agencies such as:
  - PaNDa
  - Groups working with PND women
  - (Local Womens Health/Community Health Centre)

**More severe:**

Referral to a psychiatrist when:

- Severe Post Delivery Depression with suicidal/infanticidal thoughts and psychotic symptomatology.
- Complicated psychiatric history currently and in the past.
- Identifiable major personal difficulties in past or current
- Predominant dysfunctional personality traits
- Major mother-infant relationship disturbance
- Disturbance in the infant
- Disturbance in the family unit
- Failure to respond to appropriate management

GP management may then include working with psychiatrist, woman and family at

- Home
- Home with CATT
- Mother and baby unit
Postnatal Depression

Interactive Concerns
Interactive Concerns

Interactive concerns include the crying and/or unsettled baby, breast feeding problems and sleep disturbances and/or deprivation. Here are some handy hints and resources that may be useful in the community.

Crying/ unsettled baby

Crying
- The average time that a baby cries at six weeks is 2-3 hours each day. This time will decrease as the baby learns to communicate in other ways.
- As the baby grows older parents learn to understand what many of its’ cries mean. Responding to a baby’s cries does not mean that parents are spoiling it.

Reasons for crying
A baby may cry for many reasons including:

Overstimulation/Relaxation Balance
- Babies have an immature nervous system.
- They do not have the “filters” which enable us as adults to be selective about what we respond to in our environment.
- They need us to help them to relax by providing periods of less stimulation.
- Often when a baby is unsettled the techniques that are used to settle and relax them actually stimulate them further.
- An unsettled period at the end of the day may occur. This is normal.
- Some professionals believe this is as a result of a build up of tension during the day as the baby’s immature nervous system is overloaded and that baby discharges this tension and reorganises the nervous system for the next 24 hours by:
  - Having shorter sleeping and feeding periods
  - Being very physically active, and crying (Brazelton, T. 1986)

Colic/ “wind” pain
Health professionals have never agreed on what colic is.
- It is said to affect 10 - 40% of infants; boys and girls equally.
- It can be used to describe what appears as wind or abdominal pain and often occurs in the evening when many babies have an unsettled period.
- The unsettled period or Colic usually disappears between 2 - 4 months.

Hunger, tiredness
- See breast feeding and sleep disturbances pg 16 – 18.

Management - History taking
Comprehensive maternal and baby history including:
- Patterns that occur over 24 hour period: sleeping, feeding, waking periods
- Feeding difficulties
- Urine/bowel movements
- Maternal mood/coping mechanisms

Coping with the unsettled period
Encourage parents to:
- Make a list of the techniques that work and try these one at a time. Different techniques may work at different times
- Prepare for that time of the day
  - Prepare evening meal early
  - Arrange for help, either with the baby, other children, or household tasks
  - Get some rest during the day
Breastfeeding issues

Some common breastfeeding difficulties include:

- Poor attachment
- Nipple or breast problems: thrush, nipple vasospasm, cracked nipples, engorgement, mastitis
- Reduced milk supply from: lack of stimulation, inadequate fluid intake and/or nutrition, maternal illness
- Baby won’t feed

Assistance

Do not reinforce mother’s perception that she may be unable to breastfeed!
Comprehensive maternal and child history including;
- Frequency and length of feeds during 24 hour period
- Adequate wet and/or dirty nappies

Attachment issues

Assist with attachment and include the following:

Engorgement:
- Ensure that baby is positioned and attached correctly
- Continue to breastfeed, do not restrict feeds
- May need to hand express a little milk prior to attachment
- Pain relief: paracetamol, ice packs, well supported breasts but not a too tight bra
- If engorgement continues for one or two days, drain the breast to comfort with an electric/hand breast pump after feeds

Enough milk?
- Reassure: this is not a common problem
- Milk supply will increase as breastfeeding continues
- Check that baby is feeding for long enough and often enough
- Check for 6-8 wet nappies every 24 hours
- Check baby hydration status
- Crying is not necessarily an indication of hunger, neither is putting fists in her mouth.
- Breasts will subside in size after a few weeks and this does not mean that there is no milk.
- Ensure healthy diet and adequate fluids and rest for the mother.

Baby won’t feed
- Baby may be unwell with a digestive, swallowing or breathing problem or oral thrush.
- Baby may be distracted because she is getting older and more alert (sometimes from about 10 weeks). Try feeding in a quiet room where there is reduced stimulation.
- Sometimes a new perfume will mean that the baby does not want to feed.
- A new medication, having a period or becoming pregnant can alter the taste of the milk.
- The mother may have a breast infection.
- It is important to talk to the mother about relaxation.
- If the baby will not suck at the breast, expressing the milk and giving it to the baby in a cup (or bottle) until the mother gets some professional support will ensure that the baby is fed.
Sore nipples

- Nipples may be sensitive with initial feeding but should not be really painful.
- It is important to check the feeding position and attachment to the breast.
- Sometimes the breasts are so full so that it is difficult for the baby to attach. It may be necessary to express a little milk so that the baby can attach.
- It is best to keep soaps and shampoos away from nipples as these can have a drying effect.
- Soothing the nipples with milk or colostrum after feeding may help if they are tender.
- Air dry the nipples after a feed.
- Replace damp nipple pads frequently.
- Pat, don’t rub nipples after a shower.
- Don’t use sprays, ointments or powders as they may irritate further.

Nipple Thrush

- Thrush (Candida) infection of the nipples can cause breast pain, sharp shooting nipple pain and/or an itchy pink or red rash.
- The pain may occur with and/or during feeds.
- The mother will need to be prescribed an anti fungal cream (oral mycostatin) and advised to boil dummies several times a day and replace item each week. Baby may require oral anti fungal (Nilstat drops or Daktarin Gel)

Blocked milk ducts

- This will make a part of the breast tender, hardened and reddish. It is important to clear the blockage to prevent mastitis. A blocked duct may be caused by: sudden engorgement, tight bra or clothes, pressure on one spot ie; always pushing in one spot during feeding
- Check positioning and attachment
- Vary feeding positions
- Feed frequently to drain breast
- Use a warm cloth to soothe breast before and during feeds
- Use cold packs after a feed and paracetamol for pain

“I was a victim of my own expectations - a fantasy - and saw myself as a failure.”
Sleep Disturbance/ Deprivation

Lack of sleep for:

1) **Mothers** can result in:
   - anxiety
   - depression
   - irritability
   - risk of relationship problems
   - risk to impaired maternal bonding
   - reduced parenting enjoyment

2) **Baby** can cause:
   - irritability
   - crying
   - feeding problems

Sleep is necessary for:

- Restoration of body and mind
- Normal daily functioning
- Maintenance of good health, growth and development

Sleep occurs in two states; Rapid Eye Movement (REM or light sleep) and Non REM (or deep sleep).

Babies, children and adults sleep in cycles of REM, Non REM, REM. These are 20-40 minutes long in babies and about 90 minutes long in adults.

**Average Sleep requirements** (Ferber, R. 1985)

<table>
<thead>
<tr>
<th>Age</th>
<th>Average Daytime hours sleep requirement</th>
<th>Average Night time hours sleep Requirement</th>
<th>Average total hours requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 week</td>
<td>8</td>
<td>8 1/2</td>
<td>16 1/2</td>
</tr>
<tr>
<td>4 weeks</td>
<td>6 3/4</td>
<td>8 3/4</td>
<td>15 1/2</td>
</tr>
<tr>
<td>3 months</td>
<td>5</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>6 months</td>
<td>4</td>
<td>10</td>
<td>14</td>
</tr>
</tbody>
</table>

- A newborn baby will sleep for a few hours at a time distributed over a 24 hour period.
- By 3-4 months sleep will usually happen in 4-5 sleep periods with about 2/3 of these occurring overnight. Many babies do not sleep through the night until at least 6 months of age.

Babies sometimes develop sleep associations which result in a difficulty with:

- initial settling or
- going back to sleep after not sleeping for long enough

A sleep association is something that enables sleep. eg breastfeed, rocking, dummy. It means that the association needs to be recreated as the baby cannot go to sleep by itself.

**Strategies**

- Teaching parents to recognise tired cues and put their baby to bed.
- Settle and relax baby without putting her to sleep
- Ensuring that Feed, Play, Sleep patterns are followed to ensure that baby is fed properly, has short periods of interaction and then adequate sleeps of one hour or longer.

**For Community Resources that may help see:**

Breastfeeding pg 32
Early Parenting Centre pg 36
Respite Care for Mothers & Babies pg 34 (Children’s Support Services)
Maternal & Child Health pg 37
Postnatal Depression

Medical & Physical Problems
Medical and Physical Problems

A woman's emotional state in the post partum period may be influenced by a number of physical and medical problems.

Some common problems which may be experienced (but may not be mentioned) by the woman, or recognised by the care giver are listed below.

Being aware of these problems and asking about them at the six week check or when a mother is seen may allow earlier treatment and relief of symptoms.

By starting with questions related to the physical status of the new mother, it is likely to be easier for the GP/health care provider to continue to explore the emotional well being of mothers.

<table>
<thead>
<tr>
<th>Medical</th>
<th>Physical</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infections:</strong></td>
<td><strong>Breast</strong></td>
</tr>
<tr>
<td><strong>Genital tract</strong></td>
<td>– engorgement</td>
</tr>
<tr>
<td>– endometriosis</td>
<td>– sore nipples</td>
</tr>
<tr>
<td>– salpingitis</td>
<td>– thrush</td>
</tr>
<tr>
<td>– pelvic peritonitis</td>
<td>– blocked duct</td>
</tr>
<tr>
<td>– sepsis</td>
<td></td>
</tr>
<tr>
<td><strong>Urinary tract</strong></td>
<td><strong>Bowels</strong></td>
</tr>
<tr>
<td>– cystitis</td>
<td>– constipation</td>
</tr>
<tr>
<td>– pyelonephritis</td>
<td>– haemorrhoids</td>
</tr>
<tr>
<td><strong>Breast</strong></td>
<td>– anal fissure</td>
</tr>
<tr>
<td>– mastitis</td>
<td></td>
</tr>
<tr>
<td>– breast abscess</td>
<td></td>
</tr>
<tr>
<td>–</td>
<td></td>
</tr>
<tr>
<td><strong>Anaemia</strong></td>
<td><strong>Bladder</strong></td>
</tr>
<tr>
<td>– especially if post partum haemorrhage</td>
<td>– infection</td>
</tr>
<tr>
<td>– complicated deliveries</td>
<td>– incontinence</td>
</tr>
<tr>
<td>–</td>
<td>– vesico vaginal fistula (rare but very important)</td>
</tr>
<tr>
<td><strong>Thyroid dysfunction</strong></td>
<td><strong>Perineum</strong></td>
</tr>
<tr>
<td>– consider checking Thyroid function tests</td>
<td>– pain</td>
</tr>
<tr>
<td>–</td>
<td>– infected tears/episiotomies</td>
</tr>
<tr>
<td>–</td>
<td>– dyspareunia</td>
</tr>
<tr>
<td>–</td>
<td><strong>Pelvic pain</strong></td>
</tr>
<tr>
<td>– “pelvic instability” (symphysiolysis)</td>
<td>– “pelvic instability” (symphysiolysis)</td>
</tr>
<tr>
<td>–</td>
<td>– backache</td>
</tr>
</tbody>
</table>
Sexual Relations

Be aware that in the Post Partum period libido may be affected by:

- Sleep disturbance
- Fatigue
- Depression
- Dyspareunia
- Hypo-oestrogenization of vagina (= poor lubrication)

For Community Resources that may help see:

Physiotherapists pg 39
Women's Health pg 42

“My doctor was just a businessman - he was not interested in me.”
Postnatal Depression
Medication
DRUG TREATMENT OF POSTNATAL DEPRESSION

The use of antidepressant medication in PND should be considered in all but mild cases. If a patient has symptoms fulfilling DSM IV criteria for Major Depression, medication is definitely indicated and is the most rapid and effective form of treatment. Even less severe forms of depression eg dysthymia, a chronic low grade form of depression, has been shown to respond to antidepressant medication, but the indications are less clear and patient preference should be taken into consideration.

Patients can expect to feel improvement of mood within 10 – 14 days, but it can take up to 6 weeks for full effect. Anxiety symptoms often respond more rapidly. It is wise to caution patients about side effects, but also to assure that some may be transient eg. sedation with Tricyclics, nausea with SSRIs. Sexual dysfunction with SSRIs is a troublesome side effect and may need a change of medication or specialist referral.

Medication should always be used in conjunction with psychosocial intervention.

Introduction of medication to women will enable them to accept medication as an appropriate, timely and useful addition to other overall treatment for PND.

- Appropriate, sensitive
- Right time
- Full explanation of why they might be used
- Expectation of effect/benefit, possible side effects
- Duration of treatment
- Explanation of what exactly depressants do to the brain chemistry etc.
- Reassurance from common myths
  - Antidepressants are addictive
  - Artificially make someone happier

All psychotropic medications including antidepressants are secreted in breast milk at varying concentrations. Data does not suggest that one antidepressant is safer than any other. Selection of an antidepressant should be based on prior response to antidepressants and side-effect profile.

OPTIONS

1. TRICYCLIC ANTIDEPRESSANTS

Dothiepin and Nortriptyline have been most widely used and monitored.

Dosage: up to 150 mgs per day.

ADVANTAGES
- Initial effect on sleep disturbance
- Initial effect on anxiety
- More experience with breastfeeding

DISADVANTAGES
- Dry mouth
- Excess sedation
- Postural hypotension
- Dangerous in overdose
2. **SSRI’S**

Sertraline has been seen as having the least side effects, Fluoxetine and Paroxetine have also been most extensively used over the last decade and no adverse effects reported. As with all therapy, benefits vary from patient to patient.

Dosage: minimum effective dose is advisable, once a day dose generally used.

**ADVANTAGES**
- generally well tolerated
- no sedation
- earlier onset of therapeutic benefit
- relatively safe in overdose

**DISADVANTAGES**
- agitation
- sleep disturbance
- sexual dysfunction
- limited knowledge and experience in breast feeding

3. **MOCLOBEMIDE**

Limited experience with this as it is not available in U.S.A.

Dosage: up to 900 mgs per day, morning and after lunch.

**ADVANTAGES**
- Well tolerated
- Minimal transfer to breast milk

**DISADVANTAGES**
- more appropriate for more mild presentations
- insomnia
- headaches

4. **LITHIUM**

Is generally considered contraindicated with breastfeeding. It is advisable to refer patients with bipolar disorder or resistant depression for management by a psychiatrist.

**DURATION OF TREATMENT:** should be at least 6 months, possibly longer if there is a past history of depression which has needed more lengthy treatment.
ANTIDEPRESSANTS AND BREAST FEEDING

• Controversial
• Divided opinions
• Paediatricians argue that the value of breast milk outweighs the risk of drug in the breast milk
• Many psychiatrists believe risks of untreated depression are greater than that of antidepressant exposure
• Benefit of breast feeding versus risk to infant from medication in breast milk
• Breast milk versus risk to infant from maternal depression
• Drugs generally pass into breastmilk at concentrations lower than maternal plasma
• Infant exposed to doses lower than maternal levels
• Drug passes to breast milk by passive diffusion
• % of drug free to be transported is small
• Drugs concentrate in the hind milk, which has higher fat content
• Infant liver metabolism is limited in the first few weeks of life
• Infant renal excretion of drug is initially limited and increases slowly over first 2 weeks of life

CONTRAINDICATIONS

• Premature infant
  • No drug exposure until normal hepatic and renal function
  • Seek paediatric opinion

• Congenital illness
  • Eg. cardiovascular malformation

• Postnatal medical complication in the infant
  • Neonatal jaundice.

“When he (GP) finally picked it up I felt ‘hallelujah’... The diagnosis from him was very positive because I mistrusted my own perceptions. He had faith in me and he neutralised the demon... It was as if I’d gone in there and said I’ve got a sore toe - can you fix it?”
“I did try to tell the doctor at three months that I was feeling terrible, but his response was that the baby was doing beautifully so I didn’t need to worry about anything.”
Postnatal Depression

Resources

Referral Base Resource Directory
Bibliography
Websites
Edinburgh Post-Natal Depression Scale
Postnatal Depression – a parents guide
Monash Division of General Practice Postnatal Depression Handbook
Referral Base:

Postnatal Depression Resources

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<th><strong>Breastfeeding</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Australian Lactation Consultants Association</strong></td>
<td><strong>Cabrini Lactation Clinic</strong></td>
</tr>
</tbody>
</table>
| Queen Victoria Women’s Centre  
210 Lonsdale Street, Melbourne 3001  
Tel. 9650 5391 | 183 Wattletree Road, Malvern  
Tel. 9508 1222 |
| Membership consists of International Board Certified Lactation consultants in private practice (some private health insurance companies offer minimal cover). Postnatal problems usually require 1-2 home visits. Costs are around $60-$90 which also covers follow-up care) | **O’Connell Family Centre** |
| **Lactation Resource Centre – Nursing Mothers’ Association of Australia** | 6 Mont Albert Road, Canterbury  
Tel. 9882 2326 |
| 1818-1822 Malvern Road, Malvern East 3144  
Tel. 9878 3304 (24 hour telephone counselling service) | **Offer advice on lactation problems** |
| A lactation and support program. Supports and educates mothers wishing to breastfeed their babies. Regular discussion group meetings and coffee mornings are held. Lending library available on all aspects of mothering and child care. | **City of Kingston Day Stay** |
| **Maternal & Child Health After Hours Service (State Govt. service)** | Tel. 9580 1943 |
| Tel. 9853 0844 | Is situated at Mordialloc currently but is about to move to the Old Mordialloc Hospital site. |
| Provides after-hours telephone consultation and advice from qualified maternal and child health nurses. | **South Eastern District Hospital** |
| **Mercy Hospital for Women – Breastfeeding Day Service** | Centre for Lactation Assessment Research & Education  
Princes Highway Cnr Heatherton Rd, Noble Park  
Tel. 9547 1000 |
| Clarendon Street, East Melbourne 3004  
Tel. 9270 2750 | **See also:**  
Physiotherapists (women’s health)  
Breast problems related to breastfeeding |
| Operates 8.30 am to 4.30 pm on Tuesdays, Wednesdays & Fridays. On Thursdays at 113 Waterdale Road, Ivanhoe. | **Queen Elizabeth Centre (Mothers & Babies)** |
| **Royal Women’s Hospital – Breastfeeding Day Assessment Service** | 53 Thomas Street, Noble Park  
Tel. 9549 2777 – 24 hour service |
| Grattan Street, Carlton 3053  
Tel. 9344 2000 | Early parenting centre which offers specialised support and education to families with children 0-3 years. Provide residential programs, day stay, home visiting, telephone advice. There is a waiting list period of between 4 – 8 weeks |
| Weekdays from 8am to 4.30pm (Except Wednesdays which is noon to 8 pm). Covered by Medicare. | **Lactation Clinic** |
| **Queen Elizabeth Centre (Mothers & Babies)** | Mitcham Private Hospital  
27 Doncaster East Road, Mitcham 3132  
Tel. 9210 3222 |
| 53 Thomas Street, Noble Park | **Masada Hospital** |
| Tel. 9549 2777 – 24 hour service | Centre for Lactation Assessment Research & Education  
26-28 Balaclava Road, East St Kilda  
Tel. 9526 5500 |
| **Lactation Clinic** | **Breastfeeding** |
**Child Care**

For information on local child care services and information on government services call:

**Child Care Access Information Line**

*Tel. 1800 670 305*

Local Government provide a wide range of services for children and families. This may include:

- **Child Care**
  (including day care, occasional care)

- **Family Support programs**
  Provide caring and practical support for families having problems coping during time of stress.

- **Integration program**
  To support parents and child care staff to integrate pre-school children with disabilities and/or special needs.

- **Maternal and Child Health Centres**
  (see page XX for listings)

- **Play Groups**

- **Toy Libraries**

**LOCAL GOVERNMENT CONTACTS:**

- **City of Glen Eira**
  Tel. 9524 3292

- **City of Greater Dandenong**
  Tel. 9239 5100

- **City of Kingston**
  Tel. 9556 4200

- **City of Monash Division**
  Tel. 9518 3549

---

**Child Protection**

**Community Policing Squads**

**Co-ordination Centre**

*Tel. 9247 6936*

Assistance, intervention, counselling and support for families in crisis, youth in trouble, victims of domestic violence, children at risk of abuse or who have been sexually assaulted.

Local Community Policing squads are:

- **Dandenong**
  Tel. 9767 7468

- **Moorabbin**
  Tel. 9556 6128

- **Prahran**
  Tel. 9520 5218

**Department of Human Services**

(State Government)

**Child Protective Services**

Southern Metropolitan  Tel. 9213 2111

Eastern Metropolitan  Tel. 9248 7102

**Gatehouse Centre for the Assessment and Treatment of Child Abuse**

Royal Children’s Hospital

Level 5, South Eastern Building

Gatehouse Street, Parkville 3052

Tel. 9345 6391

Provide 24 hour consultation to professionals, the community and concerned family members about children and young people who are victims of sexual abuse, physical injury and emotional abuse in the context of their family or other care givers. The Centre aims to work in close collaboration with other community agencies and is located in the Royal Children’s Hospital.

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**South East Centre Against Sexual Assault**

Moorabbin Campus, Monash Medical Centre

Centre Road, East Bentleigh 3165

Tel. 9575 7741 (Administration)

Provide counselling, medical assistance, information, legal advice and advocacy and referral. Provides 24 hour service for men, women and children. Counsellors from this service will provide assistance at hospital accident and emergency department when a person reports an incident of sexual assault.

**Child Protection Unit, Monash Medical Centre**

Monash Medical Centre (Children’s Division)

Sexual abuse

Tel. 9550 2289 (24 hours)  Tel. 9347 1212 (24 hours)
### Child Safety

**Royal Children's Hospital**  
Flemington Road, Parkville 3052  
Tel. 9345 6429  
*Information and referral centre on child health, parenting, childhood illnesses, disabilities, adolescence for the general public and health professionals.*

**Child Safety Centre**  
Level 1, Royal Children's Hospital  
Flemington Road, Parkville 3052  
Tel. 9345 5085  
*Hours: 10:00 am to 4:30 pm, Monday to Friday*  
An information, education and resource centre on child safety. Telephone advice; first aid courses; printed information; safety product consultancy; lecture programs; sale of safety products; library and professional training packages.

**Poisons Information Centre**  
Royal Children's Hospital, Parkville 3052  
Tel. 13 11 26 (24 hours)  
*Pharmacological and poisons information.*

**Pharmacy**  
Monash Medical Centre Clayton  
Tel. 9594 6666 * (business hours)*

### Children’s Support Services

#### Canterbury Family Centre

19 Canterbury Road, Camberwell 3124  
Tel. 9882 8336  
- Provide intensive services for families with young children who are in crisis.  
- Early parenting outreach – home-based services for families having significant problems with infants 0-18 months old (Eastern region only)  
- Family Admissions Unit: residential program for families having severe difficulties where child has been removed of abuse or neglect  
- Outreach program

#### Copelen Child and Family Services

69 Wellington Street, Windsor 3181  
Tel. 9510 2444  
*A range of intensive services for parents in crisis.*

#### Oz Child Family Support and Counselling Services

491 South Road, Moorabbin 3189  
Tel. 9553 4511  
*Offers respite care, parenting support groups and foster care for families where protective concerns exist.*

#### Oz Child Family & Children’s Services

1536 Heatherton Road, Dandenong 3175  
Tel. 9791 7066  
*Offers respite care, parenting support groups and foster care for families where protective concerns exist.*

### Community Groups

#### Birthing Wisdom

Contact: Thea Dempsey  
Tel. 9562 8592  
*Supportive environment for women to share experiences regarding adjustments to motherhood.*  
Fees: $10 - $12 per 2 hour session

#### Midwives Supporting Mothers

Contact: Kaye Paton  
Tel. 9885 4684  
*Supportive group environment for 6 week structured program to explore postnatal depression and motherhood. Childcare available.*

#### Counselling – General & Family

#### Bouverie Family Therapy Centre

50 Flemington Road, Flemington 3031  
Tel. 9376 9844  
*Family therapy for entire family unit. Do not refer clients who wish to discuss family problems on their own. This is a wide service and has specialised counselling eg sexual abuse, acquired brain damage, HIV and serious mental illness.*

#### Family Mediation Centre

367 Princes Highway, Noble Park 3174  
Tel. 9547 6466  
*Self-referral centre providing financial counselling and information, legal information and assistance in negotiating agreements between family members through mediation services. Available to any family member.*

#### Cabrini Centacare

1-3 Valetta Street, Malvern 3144  
Tel. 9576 2377  
*Psychologists and family therapists provide a wide range of services. Small fees apply.*

#### Cambodian Association

52 Queens Avenue, Springvale 3171  
Tel. 9546 3466  
*Counselling and support services for the Cambodian community.*

#### Catholic Family Welfare

96 Cleeland Street, Dandenong 3175  
Tel. 9793 2200  
*Provide marriage, family, personal, crisis, grief counselling. Religion is not a criteria and several languages are spoken.*
### Counselling – General & Family

**Eastleigh Family Services**

216 East Boundary Road, East Bentleigh 3165  
A program of the Eastleigh Community Church. Personal beliefs of individuals respected.

**Jewish Community Services**

25 Alma Road, St Kilda 3182  
Tel. 9525 4000  
Individual, couple and family counselling services geared to members of the Jewish community. Several languages spoken.

**Springvale Indo-Chinese Mutual Assistance Association**

9 Hillcrest Grove, Springvale 3171  
Tel. 9547 4922  
A wide range of support services for Vietnamese and Cambodian people.

**Family Court Counselling**

53-55 Robinson Street, Dandenong 3175  
Tel. 9767 6280  
Family court counsellors assist people who are having problems arising from separation and/or disagreements about children. People can be referred by anyone. Advice can be given over the phone by the duty counsellor who can make subsequent appointments.

**Lifeworks (formerly the Anglican Marriage Education & Counselling)**

Information, counselling and support service.  
Locations:  
CamCare, 19 Fairholm Grove, Camberwell 3124  
Tel. 9654 7360  
68 Playne Street, Frankston 3199  
Tel. 9769 6281

**Monash Link Community Health Service**

7 Dunscombe Avenue, Glen Waverley 3150  
Tel. 9886 3458

**Relationships Australia (formerly Marriage Guidance Council)**

46 Princess Street, Kew 3101  
Tel. 9261 8700  
Provide counselling at a small fee.

**Southern Family Life**

197 Bluff Road, Sandringham 3191  
Tel. 9598 2133  
Provide a wide range of counselling services including mediation for families. For people residing in Cities of Glen Eira, Bayside and Kingston.

### Domestic Violence Counselling – Important Phone Numbers

**Women’s Domestic Violence Crisis Service of Victoria**

Tel. 9329 8433 (24 hours 7 days)  
1800 015 188 (24 hours 7 days)  
Provides 24 hour support and information referral service specifically for victims of domestic violence and incest, etc. Referral to emergency accommodation services, legal information. Messages for women staying in refuges can be left on these numbers.

**Immigrant Women’s Domestic Violence Service of Victoria**

GPO Box 2905DD, Melbourne 3001  
Tel. 9898 3145 (Monday to Friday)  
Support services for women of migrant backgrounds who are the victims of any form of family violence. Services include counselling, accommodation and information. 21 languages available.

**Men’s Referral Service**

Tel. 9685 9814  
Phone advice, counselling and referral service for male perpetrators of domestic violence. Phone open between 3 pm and 9 pm Mondays to Fridays.

**Southern Family Life**

Tel. 9598 2133  
Peter Pinney, 197 Bluff Rd, Sandringham

### Domestic Violence Services

**Centre Against Sexual Assault**

South East Centre Against Sexual Assault  
Moorabbin Campus, Monash Medical Centre  
Centre Road, East Bentleigh 3165  
Tel. 9550 2289 (24 hours)  
Telephone counselling, support and advocacy for recent and past victims of sexual assault. Support and information to friends and families of victims. Consultation to workers and health care professionals.

**Community Policing Squads**

Provides assistance, intervention, counselling and support for families in crisis, young people in trouble, victims of crime, children at risk and victims of sexual assault.

**CO-ORDINATION CENTRE:**

Tel. 9247 6936

**BLACKBURN**

Tel. 9878 2742

**DANDENONG**

Tel. 9767 7468

**MOORABBIN**

Tel. 9556 6128

**FRANKSTON**

Tel. 9784 5605
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Postnatal Depression Handbook

Domestic Violence Services

Domestic Violence & Incest Resource Centre (DVIRC)
139 Sydney Road, Brunswick 3056
Tel. 9380 4343
Offers support, information, legal advice, community education workshops, support groups and referral to other services.

Immigrant Women’s Domestic Violence Service of Victoria
GPO Box 2905DD, Melbourne 3001
Tel. 9898 3145 (Monday to Friday)
Support services for women of migrant backgrounds who are the victims of any form of family violence. Services include counselling, accommodation and information. 21 languages available.

Men’s Responsibility Group
Monash Link Community Health Service
568 Nerim Road, Hughesdale 3166
Tel. 9568 2599
The program involves an education group for men who are violent to their partners/families, teaching non-violent behaviours, challenging patriarchal attitudes and learning respect for others. Resources are also available. Course is of twelve weeks duration, with one session per week. And an ongoing follow-up group.

Surviving Together – Women’s Group
Monash Link Community Health Service
568 Neerim Road, Hughesdale 3166
Tel. 9568 2599
Regular sessions are organised covering a range of topics and issues. Child minding available.

South East Women’s Domestic Violence Outreach Service
CENTRAL OFFICE: Tel 9781 4658
MENTONE OFFICE
For the cities of Bayside, Glen Eira and Kingston
Tel. 9585 2863
SPRINGVALE OFFICE
For women from non-English speaking backgrounds
Tel. 9548 3255
A service provided for women and children who have experienced domestic violence. The service provides support, information, advocacy, referral and casework.

Women’s Information Referral Exchange (WIRE)
247 Flinders Lane, Melbourne 3000
Tel 9654 6844 1800 136 570
Free confidential telephone service providing information, counselling and support. 9am to 7pm Monday to Friday.

Women’s Legal Resource Group
Level 3, 43 Hardware Street, Melbourne 3000
Tel. 9642 0343
Telephone advice and referral service on issues such as family violence, divorce and separation, custody and access, maintenance, child support, de facto rights, social security, rape, incest, sexual harassment, and court issues. Some languages spoken.

Early Parenting Centres

Masada Private Hospital
26 – 28 Balaclava Rd, East St Kilda
Tel. 9527 5145
Runs a sleep settling day stay program, 2 days per week.

O’Connell Family Centre (Grey Sisters)
6 Mont Albert Road, Canterbury 3126
Tel.9882 2326
Provides an early parenting program for mother and baby in the post-natal period. Focussing on feeding, settling, sleep and other behaviours. Cares for pre-school children when no family member is able to provide care, for example when the mother is hospitalised, or during a family crisis or emergency. Staff include Maternal and Child Health Nurses, Midwives, Child Care Workers and a Visiting Doctor and Counsellor.

The Queen Elizabeth Centre (Mothers & Babies)
53 Thomas Street, Noble Park 3174
Tel. 9549 2777 – 24 hour service
Early parenting centre which offers specialised support and education to families with children 0-3 years. Provide residential programs, day stay, home visiting, telephone advice.

Tweedle Child & Family Health Service
53 Adelaide Street, Footscray 3011
Tel. 9689 1577
Early parenting centres provide education to families with babies and young children. These centres offer extra help and support if needed than the local community can provide, ie information and practical help in ways to feed, settle and respond to a baby or a young child. All centres have facilities for a parent and child to stay for several days if required. Any parent with a child up to school age can use these services. The cost of services varies. Some of the cost may be covered by Medicare or private insurance. There is a waiting list period of between 4 – 8 weeks.

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### Emergency Financial Relief

These organisations provide community information and advice and provide a range of financial relief such as food vouchers, food parcels, Op-shop clothing vouchers, but not always money directly to people.

<table>
<thead>
<tr>
<th>Organisation Name</th>
<th>Address</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caulfield Citizens Advice Bureau</td>
<td>256 Hawthorn Road, Caulfield 3162</td>
<td>9524 3200 or 9524 3272</td>
</tr>
<tr>
<td>Moorabbin Citizens Advice Bureau</td>
<td>12 Katoomba Street, Moorabbin 3189</td>
<td>9555 6560</td>
</tr>
<tr>
<td>Monash-Oakleigh Citizens Advice Bureau</td>
<td>25 Downing Street, Oakleigh 3166</td>
<td>9568 4533</td>
</tr>
<tr>
<td>Springvale Citizens Aid &amp; Advice Bureau</td>
<td>5 Osborne Avenue, Springvale 3171</td>
<td>9546 5255</td>
</tr>
<tr>
<td>Dixon House</td>
<td>2 Dixon Street, Clayton 3168</td>
<td>9543 8911</td>
</tr>
<tr>
<td>St Vincent de Paul</td>
<td>16 Lightwood Road, Springvale 3171</td>
<td>9546 3715</td>
</tr>
<tr>
<td>St Vincent de Paul</td>
<td>20 Crewe Road, Oakleigh 3166</td>
<td>9568 1034</td>
</tr>
</tbody>
</table>

### Maternal & Child Health Centres

The cities of Glen Eira, Kingston, Greater Dandenong and Monash Maternal and Child Health Services are staffed by trained nurses who offer advice and support to parents and expectant parents in relation to the health and well-being of the mother, infant and family. These Centres also provide activities such as playgrounds, coffee mornings, baby massage, new mothers groups and parenting skills programs.

#### City of Glen Eira

- **BENTLEIGH**
  - 542 Centre Road
  - Tel. 9557 2359

- **CAULFIELD**
  - Town Hall
  - Corner Glen Eira & Hawthorn Roads
  - Tel. 9524 3403

  Elsternwick
  - 55 Orrong Road
  - Tel. 9528 1895

- **City of Greater Dandenong**

- **SANDOWN PARK**
  - 86 Grove Street
  - Tel. 9548 3336

- **SPRINGVALE**
  - 1 Lightwood Road
  - Tel. 9546 9495 and 9546 1648
  - (Nurse speaks Cantonese, Mandarin, Tieu Chieu)

  - 2A Olinda Avenue
    - Tel. 9546 5509

  - 3 Gillian Street
    - Tel. 9547 5197

- **NOBLE PARK**
  - 48-50 Ellendale Road
  - Tel. 9546 0551

  - 51 Buckley Street
    - Tel. 9546 9565

- **MURRUMBEENA**
  - 195 Murrumbeena Road
    - Tel. 9569 5700

- **KEYSBOROUGH**

  - 1632 Bloomfield Road
    - Tel. 9798 8719

- **HEATHERHILL**

  - 101 Noble Street
    - Tel. 9546 8812
Maternal & Child Health Centres

**City of Kingston**

CHELTENHAM
282 Warrigal Road
Tel. 9583 6875

HIGHETT
35 Turner Road
Tel. 9553 4981
*A multi nurse centre offering extended hours.*

CLAYTON SOUTH
Kale Street
Tel. 9543 3146

Jacobs Drive
Tel. 9551 1889

DINGLEY VILLAGE
Marcus Road
Tel. 9551 2668

WESTALL
Scott Avenue
Tel. 9540 3348

**City of Monash**

CHADSTONE
36 Burton Street
Tel. 9807 2501

CLAYTON
21 Mary Street
Tel. 9544 2241

OAKLEIGH
59 Greville Street
Tel. 9540 3073

OAKLEIGH SOUTH
Cnr North & Guest Roads
Tel. 9570 3982

Mother & Baby Units

**Masada Private Hospital Mother & Baby Unit**

Balaclava Road, East St Kilda 3183
Tel. 9527 5145
*For mothers with mild post-natal depression. More severe cases are referred or transferred to appropriate facility. GP or medical specialist referral required. Residential care ($500 per day). Father’s group. Day Programs. Waiting list 2 weeks.*

**Mercy Hospital - Mother & Baby Unit**

Clarendon Street, East Melbourne 3002
Tel. 9270 2501 (24 hour crisis line)
*This unit has 8 beds and is a care area specifically designed for women suffering from post natal depression. Care is provided by a multi-disciplinary team of psychiatric registrars, psychiatric nurses, psychologists and social workers. Referrals can be made by the women herself, a family member, GP or other health professional. An initially assessment is made over the phone and further assessment by psychiatric registrar is conducted on the day of admission. The waiting list is approximately 2-4 weeks from first contact. The admission includes children under 12 months of age and partners are encouraged to stay during the first weekend of treatment. The number also operates a 24 hour crisis line.*

**Postnatal Disorder Clinic**

Tel. 9270 2884
*This clinic operates in outpatients on Mondays, Tuesdays and Wednesdays A one hour appointment with a psychiatrist is covered under Medicare.*

**Mitcham Private Hospital**

27 Doncaster Road East, Mitcham 3132
Tel. 9210 3134
*General unit for postnatal problems for mothers with babies up to 12 months. Medical referral and private insurance required.*

**Monash Medical Centre Mother & Baby Inpatient Service**

246 Clayton Road, Clayton 3168
Tel. 9550 1418
Tel. 1300 369 012 (24 hours)
*The ward comprises six mother and baby beds providing services for mentally ill mothers. Comprehensive treatment of all postnatal disorders is provided and mother/baby interaction is assessed. Referral can be made by GP, psychiatrist or self-referral. Waiting interval may be up to 2 weeks, and urgent cases can be admitted to a general psychiatric bed.*

**Pinelodge Private Hospital**

1480 Heatherton Road, Dandenong 3175
Tel. 9794 5557
*GP referral to Private psychiatrist required. Can offer a program aimed at those women suffering from mild to moderate postnatal depression. Outpatient program consists of a 6 week program of one day per week. ($70 per week).*
**Mother & Baby Units**

Albert Road Clinic
Pathway Parent-Infant Unit
31 Albert Road, Melbourne 3004
Tel. 9256 8311
Offers inpatient, day patient and some outpatient services to families with PND. Has on-call Psychiatrist for after hours emergency admissions. Private health insurance required. Referral through Intake Worker. Waiting time depends on urgency, usually short.

Frances Perry House
Levels 10,11,12 Crn Cardigan and Gratton St Carlton
Tel. 9221 5000

The Melbourne Clinic
130 Church Street, Richmond 3121
Tel. 9429 4688 (ext 219 mother & baby program)
Private psychiatric clinic providing specialist programs. Referral via the Medical Admitting Officer, Monday to Friday 9.30am – 6.00pm, or the Nursing Supervisor after hours.

The South Eastern Private Hospital
Early Parenting Centre Service
Noble Park
Tel. 9549 6487
Provides In-patient program offering a 4 night stay, Monday to Friday. Day Stay program for patients with mild to moderate PND, irritable/unsettled babies, failure to thrive babies, feeding difficulties and colic/reflux. Private health insurance or self funding. Prior medical referral required. Staffed by Maternal & Child Health nurses, Midwives and pre-school Mothercraft nurses.

**Physiotherapists**

**Physiotherapists**

(Physiotherapists (Women's Health) specialising in Pelvic Floor rehabilitation, Continence management (including anorectal), Musculoskeletal treatment and breast problems related to breast feeding.

Angela Khera
44 Malane Street, Ormond 3163
Tel. 9576 9740
Pelvic floor rehabilitation, continence management (including anorectal), musculoskeletal treatment (pre/post natal)
Private.

Bentleigh Bayside Community Health Centre
Gardeners Road, East Bentleigh
Tel. 9579 2333

Brighton Beach Physiotherapy
24 The Esplanade, Brighton 3186
Tel. 9593 1977 contact Kirsten Larkworthy
Musculoskeletal treatment (pre/post natal)
Private.

**Brighton Physiotherapy Centre**

2-8 Church Street, Brighton 3186
Tel. 9592 5573 contact Fiona Dunham
Pelvic floor rehabilitation, continence management (including anorectal)
Private.

Central Bayside Community Health Centre
Parkdale
East Brighton Physiotherapy Centre
641 Hawthorn Road, Brighton East 3187
Tel. 9578 8657 contact Bronwyn McIlveen
Musculoskeletal treatment (pre/post natal), stress management.
Private.

Debbie Herz Physiotherapy
222 Kooyong Road, Caulfield 3162
Tel. 9528 5830
Pelvic floor rehabilitation, continence management (including anorectal), musculoskeletal treatment (pre/post natal), breast problems related to breast feeding, stress management.
Private.

Caulfield Continence Service
Caulfield General Medical Centre
260 Kooyong Road, Caulfield 3162
Tel. 9276 6124 contact Angela Khera
Pelvic floor rehabilitation, continence management (including anorectal)
Public.

Kingston Regional Continence Service
Warrigal Road, Cheltenham 3192
Tel. 9265 1401 contact Angela Khera, Janet Chase
Pelvic floor rehabilitation, continence management (including anorectal)
Public.

Kanooka Physiotherapy
246 Clayton Road, Clayton 3168
Tel. 9550 2250 contact Lindy Caldwell
Pelvic floor rehabilitation, continence management (including anorectal), musculoskeletal treatment (pre/post natal), breast problems related to breast feeding.
Private.

Monash Medical Centre
246 Clayton Road, Clayton 3168
Tel. 9550 2250 contact Janetta Webb
Pelvic floor rehabilitation, continence management (including anorectal), musculoskeletal treatment (pre/post natal), breast problems related to breast feeding.
Public.

Interhealth
110 Centre Dandenong Road, Dingley 3172
Tel. 9558 2155 contact Angela Khera
Continence management (including anorectal)
Private.
## Physiotherapists

**Hampton Physiotherapy & Rehabilitation Centre**

505 Hampton Street, Hampton 3188  
Tel. 9533 4313 contact Pauline McLeod  
Pelvic floor rehabilitation, continence management, musculoskeletal treatment (pre/postnatal), stress management, breast problems related to breast feeding. Private.

**Women’s Health and Continence Physiotherapy**

Linacre Private Hospital  
12 Linacre Road, Hampton  
Tel. 9599 5564 contact Helena Frawley  
Pelvic floor rehabilitation, Continence management (including anorectal), Musculoskeletal treatment (pre/postnatal), stress management, breast problems related to breast feeding. Private.

**Monash Medical Centre**

Moorabbin Campus  
Centre Road, East Bentleigh 3165  
Tel. 9575 7263 contact Lindy Caldwell  
Pelvic floor rehabilitation, continence management (including anorectal)  
Public.

**Sandringham Hospital**

Bluff Road, Sandringham 3191  
Tel. 9279 8000 contact Fiona Dunham  
Pelvic floor rehabilitation, continence management (including anorectal)  
Public.

**Bentleigh Bayside Community Health Centre**

Crn Centre Gardeners Road, East Bentleigh  
Tel. 9579 2333

## Postnatal Depression

**Post & Ante Natal Depression Association (PaNDA)**

Canterbury Family Centre  
18 Balwyn Road, Canterbury 3126  
Tel. 9836 7677 (support line)  
Tel. 9836 7382 (administration)  
PaNDA’s support network is run by volunteers and staff who have all recovered from PND or psychosis and are trained to provide support.  
- Provides telephone support to women and their families who may be experiencing antenatal or postnatal depression.  
- Provides monthly support groups for women and men.  
- Provides a range of information on postnatal mood disorders for families and health professionals.

## Psychiatrists

**Dr Bruce Batagol**

1087 Hoddle Street, East Melbourne 3002  
Tel. 9417 2705  
9.00am – 5.30pm Monday to Friday  
Provide out-patient private psychiatric management, prescriptions, psychotherapy. Referral from medical practitioner as needed for Medicare rebate.

**Michael Block**

Albert Road Centre for Health  
Level 2 60 Albert Road, South Melbourne 3205  
Tel. 9682 0380  
Mon 9 – 12 Tues & Wed 9am – 6 pm  
Assessment and management of perinatal psychiatric problems, depression, anxiety, psychosis, mother infant interaction problems, in-patient management (if privately insured). Emergency appointment available each week for new assessments.

**Dr Susan Brann**

3/17 Carrington Road, Box Hill 3128  
Tel. 9890 9668  
9.00am – 5.30 pm Monday to Friday  
Psychiatric Assessment and treatment (private psychiatrist). Referral from GP. Waiting time varies, can be 8 – 10 weeks.

**Professor Lorraine Dennerstein**

51 Napier Street, Fitzroy 3065  
Tel. 9416 0931  
Tues 8.45am – 7pm Some evenings 5.30pm – 7.30pm  
Experienced management of postnatal disorders. Referral letter from Doctor. Waiting period 1 to 2 weeks, unless urgent.

**Dr Astrid Dunsis**

1 Murray Street, Clayton 3168  
Tel. 9562 9695  
Tues 9am – 6.30pm Thurs 1 pm – 6.30pm  
Treatment of psychiatric disorder during pregnancy and postpartum, meditation and psychotherapy. GP referral.

**Dr Hanne Falkiner**

7 Foot Street, Frankston 3199  
Tel. 9781 3200  
8.30 – 3.30 Monday to Friday  
Consultant Psychiatrist. Referral from GP. Waiting time varies.

**Dr Andrew Firestone**

151 Wattletree Road, Malvern 3144  
Tel. 9822 1044  
Weekdays, including 1 evening. General psychiatry and psychotherapy, specialist in marital and family therapy. Referral by GP. Waiting period according to urgency, 1-3 weeks.

**Dr Jo Fitzgerald**

67 Erin St, Richmond  
Tel. 9427 1755  
Treatment of psychiatric disorder during pregnancy and postpartum.
Psychiatrists

Dr Judith Fleming
Kelvin Grove Clinic
40 Margaret Street, Moonee Ponds
Tel. 9375 7530
9am – 3pm Tuesday to Friday (occasional later aptts)
Psychiatrist with previous attachment to obstetric unit at
Sunshine Hospital. No in-patients. Referral from GP. Waiting
time varies.

Aileen Jones
Suite 4, 147 Wattletree Road, Malvern 3144
Tel. 9509 5065
9am – 5pm Monday to Friday
General adult psychiatric service. Referral from GP. Waiting
time 2 to 3 weeks.

Dr Trudy Kennedy
1/545 St Kilda Road
Tel. 9570 3446
8.30am – 6pm Mon and Wed
8.30am – 12noon Tues and Thurs
Support, counselling, medication. Referral required, waiting
time varies.

Dr John G King
1 Murray Street, Clayton 3168
Tel. 9562 9695
Consultant Psychiatrist, experienced with PND. Referral
required. Waiting time variable.

Dr Jack Kirszenblat
306 Warrigal Road, Burwood 3125
Tel. 9808 5552
8.30am – 5pm Monday
8.30am – 12noon Wed & Thurs
General adult psychiatry and psychotherapy. Waiting period
1 to 3 weeks.

Dr Diana Korzvar
140 Church Street, Richmond
Tel. 9420 1455
Private practice and works at Melbourne clinic.

Dr M. D. Lush
Vermont Specialist Centre
399-401 Burwood Highway, Vermont South 3133
Tel. 9803 0244
9am to 5.30pm Monday to Friday
General psychiatry with an interest in PND. Referral required.
Waiting time variable.

Dr Kerry Mack
North Park Hospital
Green Hills Road, Bundoora 3083
Tel. 9467 6022
Monday to Thursday
Private psychiatrist, out-patients and in-patients in specialist
mother and baby unit.
Referral required. Waiting time variable.

Dr Sue Mackersey
306 Warrigal Road, Burwood 3125
Tel. 9808 5552
Morning, afternoon and evening sessions.
Assessment of PND, mother and baby, complete family,
education, management of medication, psychotherapy.
Referral from GP. Waiting time variable.

Ross H Martin
1 Murray Street, Clayton 3168
21/140 Church Street, Richmond 3121
Tues pm, Wed all day, Thurs pm, Fri 10.30am - 6pm
Psychiatric outpatients, private treatment for general
psychiatry patients and PND. Referral required. Waiting time
2 weeks.

Dr Diane Neill
117 Milswyn Street, South Yarra
Tel. 9867 3500

Dr Liam O’Connor
Albert Road Consulting Suite, Albert Road Clinic
31 Albert Road, Melbourne 3004
Tel. 9256 8388
Outpatient psychiatric care, inpatient psychiatric care, parent
infant unit.

Dr Nicole Phillips
872 High Street, Armadale 3143
Tel. 0418 310 980
Monday to Thursday 9.15am – 3.30pm
Assessment and treatment of PND, holistic approach,
medication, various psychotherapies. Non psychotic illness.
Referral letter required. Waiting period 3 to 4 weeks, unless
urgent.

Dr Erin Redmond
Suite D, 31-33 Albert Road, Melbourne 3004
Tel. 9256 8344
Monday morning, Wednesday Thursday, Friday all day
Provide inpatient care through Parent Infant Unit plus
outpatient care for individuals, couples and mother baby.
Waiting time depends on urgency 1 to 2 weeks.

Dr Tony Sheehan
Lilydale Private Hospital, Anderson St Lilydale 3140
Tel. 9735 4288
Victorian Rehabilitation Centre, 499 Springvale Road
Glenwaverly 3150
Tel. 9566 2796
Mon, Tues, Thurs, Fri 9am – 6pm
General psychiatric services/assessment, interpersonal
psychotherapy. Referral by GP. Waiting period two to four
weeks.

Dr Karen Strungs
Albert Road Clinic, 31 Albert Rd, Melbourne
Tel. 9256 8311
**Psychiatrists**

**Dr Krys Syrota**  
Balwyn Rd Clinic, 497 Whitehorse Rd, Balwyn  
Tel. 9836 1088

**Dr Klara Szego**  
3/94 Kooyong Road, Caulfield  
Tel. 9509 2858  
Monday and Thursday 9am – 6pm  
Private psychiatric treatment, including psychotherapy, mother infant interaction. Referral required. Waiting time variable.

**Associate Professor Krishna Vaddadi**  
Delmont Private Hospital, 306 Warrigal Rd, Burwood  
Tel. 9808 5552  
Psychiatric assessment and ongoing treatment, CBT. Referral required. Waiting period variable.

**Private Practice – Enas Ghabrial**  
191 Lum Road, Wheeler’s Hill 3150  
Tel. 9561 6391  
Flexible hours.  
Mother/infant psychotherapy, supervision, mother’s support group. Refer by telephone.

**Psychotherapists**

**Dr Charlotte Laemille**  
Normandy Street, Brighton  
Tel. 9553 8177

Outpatients Mercy Mother & Baby Unit  
Clarendon Street, East Melbourne  3022  
Tel. 9270 2501 (24 hour crisis line)  
This unit has 8 beds and is a care area specifically designed for women suffering from post natal depression. Care is provided by a multi-disciplinary team of psychiatric registrars, psychiatric nurses, psychologists and social workers.  
Referrals can be made by the women herself, a family member, GP or other health professional. An initial assessment is made over the phone and further assessment by psychiatric registrar is conducted on the day of admission.  
The waiting list is approximately 2-4 weeks from first contact, The admission includes children under 12 months of age and partners are encouraged to stay during the first weekend of treatment. The number also operates a 24 hour crisis line.

**Resources**

**Specialist PND Services – Outpatient Clinics**

**Mercy Hospital for Women**  
Postnatal Disorder Clinic  
Clarendon Street, East Melbourne  3022  
Tel. 9270 2884 ask for outpatients  
Public, no referral required.

**Royal Women’s Hospital**  
Outpatients Special Clinics  
132 Gratton Street, Carlton  3053  
Tel. 9344 2055  
Public, no referral required.

**Women’s Health**

**WHISE – Women’s Health in the South East**  
15 O’Grady Avenue, Frankston  3199  
Tel. 9783 3211  
Website – www.vicnet.net.au/whise  
Provides accessible information on a wide range of issues such as health. Workshops and seminars.

**Women’s Health Information Centre**  
Royal Women’s Hospital  
133 Elgin Street, Carlton  3053  
Tel. 9344 2007 or 9344 2199  
Website – www.wellwomen.rwh.org.au

**Women’s Health Victoria**  
Queen Victoria Centre  
Level 2, 210 Lonsdale Street, Melbourne  3000  
Tel. 9662 3742  
Website – www.womenshealth.womenz.net.au  
Health information line and library open 1-9 pm Monday to Friday.

**Women’s Information and Referral Exchange (WIRE)**  
1st floor, 247 Flinders Lane, Melbourne  3000  
Tel. 9654 6844 (9am to 7pm)  
Free confidential service providing information, counselling and support. Referral to groups and practitioners from comprehensive database.

**Women’s Legal Resource Group**  
3rd Floor, 43 Hardware Street, Melbourne  
Tel: 9642 0334 or 9642 0343  
Free legal advice and referral service. For urgent legal advice call Victorian Legal Aid Commission.


Ferber, R. “Solve Your Child’s Sleep Problems” Penguin 1985


Miles, M and Eckhardt, J. Depression or Distress After Childbirth, Building blocks to a better recovery and understanding. Women’s Health East, 1993.


Tweddle Child and Family Health Service “Sleep Right, Sleep Tight. A practical guide to assist parents to resolve their young child’s sleep difficulties.” 1989


Internet Sites

Community Infoline – Post Nataal Depression support group (advertising)

info brochure online

North West Tasmania Post Nataal Disorders Network

PaNDa (Post and Antenatal Depression Association)
Email: www.panda@vicnet.net.au

Postnatal Depression for Men site (interactive)
http://freespace.virgin.net/ian.sands/pnd.htm

Twedde Child and Family Health Service
Email: twedde@co31.aone.net.au
Website: www.citysearch.com.au/mel/Twedde

“I do not remember about four months of my life, but now I am a happy and proud mother.”
The Edinburgh Post-Natal Depression Scale (EPDS) has been developed to assist Primary Care teams to detect such mothers with post-natal depression. It has proved a ‘useful screen that takes only minutes to complete/score. Implications can be discussed immediately and early identification of problems can occur’. GPs, Midwives and Maternal and Child Health Nurses are encouraged to implement the scale and to alert the mother’s doctor if she is shown to be depressed on the scale.

The EPDS consists of 10 statements which relate to symptoms of post-natal depression. The mother is asked to underline the reply which comes closest to how she has been feeling during the past week. The validation study showed that mothers who scored 13 or more on the EPDS had indications of depression but not its severity. Further discussions need to be made. (J. Cox, J. Holden, R. Sagousky 1987)

INSTRUCTIONS FOR USING THE EPDS

1. The EPDS relates to how the mother has been feeling during the previous week.

2. All 10 items must be completed.

3. The EPDS is best administered during the second or third month post partum; the baby’s six weeks’ check-up may well provide a suitable opportunity for its completion.

4. The EPDS is a self-report scale, so only in exceptional circumstances, as when a mother has poor understanding of English or difficulty reading, need the GP or Maternal and Child Health Nurse help with its completion.

5. The EPDS should be administered in such a way as to avoid the possibility of the mother discussing her answers with others, as this has been found to influence results. It may be filled in at the clinic, surgery or on a home visit, but it should always be handed back immediately on its completion to the doctor or maternal and child health nurse.

6. Scores for individual items range from 0-3 according to severity. The total score is calculated by adding the scores for each of the 10 PDS items. For most questions a positive answer for the first option scores 3. For items marked * the first option scores 0 and the fourth option 3.

7. A score of 13 or more indicates that the mother is probably depressed and therefore requires further assessment.
Edinburgh Post-Natal Depression Scale

Edinburgh Postnatal Depression Scale (EPDS)
J L Cox, J M Holdon, R Sagovsky 1987
Department of Psychiatry, University of Edinburgh

Name ____________________________________________________
Address  __________________________________________________

Baby’s Age (in weeks) ______________________________________

As you have recently had a baby we would like to know how you are feeling. Please underline the answer which comes closest to how you have felt in the past 7 days, not just how you feel today.

Here is an example already completed:

I have felt happy
Yes, all the time
Yes, most of the time
No, not very often
No, not at all

This would mean “I have felt happy most of the time during the past week”. Please complete the other questions in the same way.

**IN THE PAST 7 DAYS**

1. *I have been able to laugh and see the funny side of things:*
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all

2. *I have looked forward with enjoyment to things:*
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all

3. *I have blamed myself unnecessarily when things went wrong:*
   - Yes most of the time
   - Yes some of the time
   - Not very often
   - No never

4. *I have been anxious or worried for no good reason:*
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes very often

5. *I have felt scared or panicky for no very good reason:*
   - Yes, quite a lot
   - Yes, sometimes
   - No not much
   - No not at all

6. *Things have been getting on top of me:*
   - Yes most of the time
   - Yes sometimes I haven’t been coping as well as usual
   - No most of the time I have coped quite well
   - No I have been coping as well as ever

7. *I have been so unhappy that I have had difficulty sleeping:*
   - Yes most of the time
   - Yes sometimes
   - Not very often
   - No not at all

8. *I have felt sad or miserable:*
   - Yes most of the time
   - Yes some of the time
   - Yes quite often
   - Not very often

9. *I have been so unhappy that I have been crying:*
   - Yes most of the time
   - Yes quite often
   - Only occasionally
   - No never

10. *The thought of harming myself has occurred to me:*
    - Yes quite often
    - Sometimes
    - Hardly ever
    - Never
**Feedback on Postnatal Depression Handbook for General Practitioners**

Please feedback your comments to the Monash Division of General Practice, without these future developments cannot be made.

**What were the most useful aspects of the Handbook?** *(Please circle)*

<table>
<thead>
<tr>
<th>Section</th>
<th>Very Useful</th>
<th>Useful</th>
<th>Little use</th>
<th>No use</th>
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</thead>
<tbody>
<tr>
<td>Overview</td>
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<td>What to Do</td>
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<td>Interactive Concerns</td>
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<td>Medical &amp; Physical Problems</td>
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<tr>
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</table>

**Is the layout easy to read and are the resources easy to read and accessible?**

On a scale of 1 – 5 (1=poor, 5=excellent) *Please circle*

<table>
<thead>
<tr>
<th>Aspect</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<td>Layout</td>
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<td>Resources</td>
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What would you change?

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Would you tell other Practitioners about this resource?  Yes  No *(please circle)*

What other things, if any should be included?

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

Other comments:

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

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