Considerations for the implementation of e-health interventions using

MumMoodBooster

Guidelines for clinicians

The purpose

This manual provides education and guidance for clinicians when they are recommending the *MumMoodBooster* (*MMB*) program and other online interventions. It draws on findings from the project 'Supporting isolated new mothers in NSW using an e-health program for postnatal depression'.

The project—completed in 2020—was made possible with funding through the NSW Heath Translational Research Grant Scheme, and was undertaken to identify the barriers and facilitators to mums accessing online e-health interventions. It focused on new mums in rural and isolated locations who were referred to the *MMB* online cognitive behaviour therapy (CBT) program by child and family health nurses. The program and the clinicians involved are referred to throughout the manual.

This manual is also designed to help other clinicians (including GPs, midwives and mental health teams) in understanding the benefits of online treatments and to help them when referring individuals to *MMB* or other e-health programs.

How to use

Section 1-2

Provides an overview of *MMB*, how it was developed and what the program is about. Also highlights some key findings around the implementation of this program into practice.

Section 3-6

Discusses practical implementation and offers guidance to clinicians, as well as recommendations to aid the success of referring mums to online interventions.

More information

Includes resources and additional information.

Contents

A free, online, interactive cognitive behavioural therapy treatment program designed to help women recover from postnatal depression.

Section 1

The program and the research

What is *MMB*?

www.mummoodbooster.com

MMB is a cognitive behavioural therapy (CBT) treatment program designed to help women recover from postnatal depression. With funding from the Australian Government Department of Health, it is available free to the public.

MMB consists of six interactive sessions that include videos, interactive workbooks, easily accessible articles, a separate partner support website and telephone support from a personal coach.

Who was involved in developing *MMB*?

MMB was developed with funding from the US National Institutes of Health. The collaboration utilised expertise from:

- **Parent-Infant Research Institute** (PIRI) – developing and evaluating treatment to improve mental health for women and their partners in the perinatal period (Jeannette Milgrom, Jennie Ericksen, Charlene Holt, Alan Gemmill)
- **Oregon Research Institute** – delivering behaviour change programs using the internet (Brian Danaher, John Seely, Milagra Tyler) and expertise in using CBT to treat depression (Peter Lewinsohn)
- **University of Iowa** – delivering interpersonal psychotherapy for women with PND (Scott Stuart).

What is *MMB* based on?

MMB is based on the well-evaluated PIRI program **Getting Ahead of Postnatal Depression** (Milgrom et al., 1999; Milgrom et al., 2005).

It also includes content from other PIRI programs: **Towards Parenthood, Preparing for the Changes and Challenges of a New Baby** (Milgrom et al., 2009; 2010) and **Community HUGS Therapeutic Playgroup** (Ericksen et al., 2007).

Why should online treatment be considered?

The majority of women with postpartum depression or anxiety go undetected (Cox & Holden, 2003). Even when detected, fewer than half seek help (McGarry et al., 2009). **There are substantial barriers that limit new mothers' access to clinical treatment, such as:**

- Not coping and fear of failure
- Stigma and denial

UP TO

1 IN 5

WOMEN

EXPERIENCE DEPRESSION OR ANXIETY IN THE FIRST YEAR AFTER HAVING A BABY

- Being unsure of what postnatal depression looks like
- Help seeking experiences and relationships with health professionals
- Expectations of motherhood and baby management (Bilszta et al., 2010)
- Rural barriers, e.g. physical isolation, lack of practical supports, fear of exposure to health professionals they know, and availability of services (PANDA, 2019)
- With some women who are breast-feeding, hesitation to take medication (Gentile, 2007).

Web-based interventions may overcome many of these barriers for women, as they are:

- anonymous
- accessible (especially for rural based mums)
- affordable, and
- convenient.

Evidence that *MMB* is an effective treatment for postnatal depression

A pilot study was designed to test the feasibility, acceptability and potential efficacy of *MMB* (Danaher et al., 2013). The results provided initial support for the feasibility and acceptability of *MMB* to women with postnatal depression.

The feasibility study was followed up with a randomised controlled trial that tested the success of *MMB* in a sample of women with a clinical diagnosis of depression (Milgrom et al., 2016). The results suggested that *MMB* is an effective treatment option for those who were clinically diagnosed with postnatal depression, as they generally showed improvement equal to—or better than—the control group who were given face-to-face treatment.

Read more about these studies in **Appendix A**.

Section 2

Implementation into practice

Antenatal education

During pregnancy, it's important to raise awareness of the signs and symptoms of postnatal depression and anxiety—as well as the relapse of more severe mental illnesses.

Research identified that up to one third of postnatal depression and anxiety cases begin during pregnancy, and one in four have onset prior to pregnancy (Austin et al., 2017). **Women expressed that knowing the signs and symptoms earlier would've helped them to understand what was happening to them postnatally**, and prompt

'You're bombarded with so much information after birth and you're researching yourself, because there's no book—so Dr Google is your 'go to'. Maybe more information just before birth, I think that would have helped.'

–Mum, on antenatal education

them to seek help earlier than when they did. If women are not asked about their emotional and mental health, they're less likely to seek formal mental health care during pregnancy.

It's also important that the woman's partner/support people are educated about the signs and symptoms of postnatal depression that can occur during pregnancy—and know how to access help early.

Further, child and family health nurses felt mums would be more likely to accept the help they offer in postnatal care if mums-to-be knew more about postnatal depression.

'There's a whole lot of focus on the birth and breast-feeding. But nobody really sits down and says, "This is what's going to happen when you get home". They go, "Oh, you'll get the baby blues about day 3 or 4". And you go, "Yeah right, I'll expect it". But they don't sit down and just give it to you straight.'

–Mum, on antenatal education

'It'd be good to get that information to women in the antenatal period... So, then when we come to bring it up in the postnatal period, they go, "Oh that's right, my midwife talked to me about that", I think they'd be a bit more receptive.'

–A common sentiment reflected in a statement from one clinician

Postnatal education

Early identification and treatment of depression during pregnancy and in the postnatal period are extremely important. Contrary to what many believe, the depression won't 'just go away'. If left untreated, it will affect the quality of the woman's life, her relationships with her infant, her family and socially, and it could potentially re-emerge in months or years to come (Austin et al., 2017). **The earlier that effective treatment is sought, the faster the recovery time.**

Many women involved in the research either didn't know or didn't understand what postnatal depression looked like, particularly when their symptoms tended towards stress and anxiety. This highlighted the need for new mums to be well informed about the need for appropriate treatment for their symptoms.

Integrating the screening process and referral to *MMB* into your practice

Guided by NSW health policy, it is required practice for all maternity and child and family health nursing services to have in place a comprehensive assessment process to determine any risk factors and vulnerabilities of women and families with young children (NSW Department of Health, 2009; NSW Ministry of Health, 2019).

> ***'Sometimes I really want to, sort of... say, "Are you sure you're telling me the truth?"'***
>
> –Clinician on using clinical judgement

The Edinburgh Postnatal Depression Scale (EPDS) is one component of the comprehensive assessment offered to new mums that should be undertaken at identified key stages, to help health professionals identify and assist women who are experiencing current distress or depression (NSW Department of Health, 2009).

When discussing the EPDS in the study, clinicians highlighted the importance of clinical judgement—and that tools (such as the EPDS) shouldn't override professional judgement.

If you decide it's appropriate to refer a new mum to *MMB* or another online intervention, **Appendix B** provides resources to assist you.

What to do after screening with the EPDS

After using the EPDS to screen a woman for possible depressive disorder in the perinatal period, the following should be considered:

- For scores of 13 or more – it is strongly advised to arrange further assessment.
- For scores of 10-12 – monitor the woman and repeat the screening in 2-4 weeks.
- For a woman who scores positive to question 10 indicating thoughts of self-harm – undertake or arrange for further assessment (in consultation with your local protocols/policies).

Discussion with the woman regarding her scores and what they might mean, and the various options for help and support is important. **Appendix C** highlights some of the additional supports available.

'You're not just ticking a box. It is around so, how did you go at Christmas time? Did you look forward to meeting with family? Did you get out and have some engagements with friends? You've just got to unpack it. Because when you unpack it, they trust that they're not just doing a tool too.'

–Clinician on unpacking the EPDS

‘Some people just really don’t want to talk about it—which is such a shame. There’s still a stigma attached, maybe…’

–Clinician

Section 3

Considerations when referring and supporting a woman as she accesses *MMB*/online treatments

The importance of the clinician's engagement

Engagement with health professionals is key to the successful implementation of *MMB*/online treatments in the primary care setting.

PIRI have undertaken extensive consultation with psychologists, GPs, obstetricians and child and family health nurses. This has been fundamental to the awareness and successful uptake of *MMB*. More recently, a clinician portal has been made available, to assist in increasing clinician engagement (see **Clinician Portal** on page 17 for more information).

As primary health networks are engaged and start to integrate programs such as *MMB* into existing perinatal mental health care pathways, health professionals will need to become more aware of *MMB*/online treatments.

The need for feedback

In the research, many clinicians noted the importance of—and difficulty obtaining—feedback when the new mum was accessing other services within their local health district (LHD). Within LHDs, communication should be easier with clinicians now able to access the electronic medical record (eMR) system. This means staff are more informed now than they have ever been, and it's important that managers regularly remind frontline clinicians about accessing the eMR to review files.

However, communication outside the LHD can be tricky (e.g. with GPs, interstate border issues). Wherever possible, information should be relayed to close feedback loops. Clinicians should follow local policies in regards to exchange of information, and seek advice from their manager around any issues regarding this.

MMB additional features

Not all of the features of the *MMB* were used during the research project. Some of the additional features include:

1

Phone support

For women scoring 15 or above on the initial screening EPDS, there is an option to receive telephone calls (one per session) from a trained *MMB* coach. Women need to 'opt in' at the initial screening to receive these phone calls.

2

Text and e-mail reminders provided to all participants

Mums are sent automated supportive text messages as they progress through the program. E-mail reminders are also sent to prompt mums to complete follow-up symptom checklists. If their depression symptoms worsen (as measured by the symptom checklists), messages will also be sent encouraging them to engage with their GP or Access Line for additional support.

3

Clinician portal

In July 2020, the *MMB* clinician portal was made available. The portal allows health professionals (such as GPs and child and family health nurses) to directly refer new mums to the *MMB* treatment program, receive risk notifications, as well as track and support patient treatment and progress. This allows GPs and health professionals to integrate *MMB* treatment into their patients' care.

Consider resources needed

Many clinicians in the research project felt they didn't have the time and resources to learn about an e-health intervention such as *MMB*. However, it was acknowledged there needs to be an initial investment of time (by both

the clinician and health service) before an intervention like *MMB* can be more readily offered as a referral—otherwise it will remain a large barrier to the success of e-health treatments.

Findings from the research project suggested that:

1. The implementation of *MMB* was most effective when the clinician knew the program thoroughly, and was able to help the mum sign up during her appointment so she wouldn't forget. This highlights the importance of clinicians fully understanding—and being trained in—the program before they start to recommend it to new mums.

2. Staff need access to technology such as laptops and tablets (with data) that can be taken on home visits so they can demonstrate using the program to mothers.

3. It's important that clinicians discuss with their manager the technology required to provide this service, as well as the training and development they need to obtain the skills, knowledge and confidence to refer mums to online interventions.

'My job is to get them structurally set up so they work better. We ask all the time if they need any resources, tools, anything. With some, when we are discussing things like apps and online, I don't think they have an understanding of what it is... You have to step them through. We try hard to help them but we are reliant on them putting up their hands and saying, "I'm really willing, but at the moment I'm not able", and to help them through that.'

–Manager on providing resources and training

Section 4

The need for ongoing support for mums

Clinician support

A clinician can support the mum by checking that she:

- Is able to access and use the program
- Understands the material and how to use it day to day
- Continues with the program as long as possible.

To best support the mum, it's critical for the clinician to be aware of the program. This includes its content, how to access it and what is involved from a user perspective.

One barrier identified in the research was the need for the mum to have someone to remind her of the program, to discuss how she was going and to support her in the process. Many women identified their child and family health nurse as a person who did, or could, play this role. They also identified other clinicians such as GPs or psychologists.

MMB program coaches

The publicly available version of *MMB* offers up to six coach calls for women who score 15 or above on the EPDS. This generally consists of one call per week, with each call around 15 minutes duration. However, the six calls may be spread over a maximum of nine weeks, e.g. if the woman is going to be away. Appointments are made each week to phone the woman. If a phone call is missed, coaches try to talk about two sessions at the next call.

The role of a coach is to be a point of personal contact who can help to increase the woman's engagement with the program.

Coaches guide women through the features of the program and support them in what they are being asked to do. They provide encouragement to complete tasks, help to problem solve, and acknowledge the achievements and effort put in by mums.

While they offer support, they should not introduce additional processing of content or other therapeutic techniques. Coaches should not be too directive; that is, not be a 'therapist' but rather a 'coach'.

They should check that the mum:

- Understands how to use the program
- Comprehends the material she is learning
- Becomes/remains engaged with the program.

Coach phone support aims to facilitate completion of the program, as well as identify any personal barriers that might be interfering with using the program.

What if a woman needs additional help/support?

There is no issue with referring women to other services as needed while they are using *MMB*. If a woman is distressed during a coach call and needs further assistance, PANDA counselling may be offered. If a coach is concerned about the level of risk at any stage, they can complete a risk assessment proforma.

Family and friends

While some women enjoy the anonymity of completing treatment online, many benefit from enlisting the help of family and friends who provide the encouragement and support to start (and continue) using the program.

The research showed that many women found it very helpful talking to their partners, parents or another close person about the program and what they were doing. **Women commented that they would be more likely to complete the program if they were able to speak to someone who had found the program worked well for them.**

To encourage participation in the program, it's useful to have input from a consumer representative or through sharing of other success stories. Clinicians should ask about the mum's support network and, where appropriate, encourage her to discuss the program with them.

'It's that motivation. It's getting to that point where they go, "How hard is it going to be for me to do this, because if it's really easy for me to do it I will do it. If it's not I'm not going to do it."'

–Clinician on motivation and support

Section 5

Know what each session contains

Knowing the content of each session can assist in discussion with the mums, to help gain feedback on how they are engaging and progressing in the program as well as what they are finding useful.

Session 1

- Identifying reasons for wanting to feel better
- Postnatal depression causes
- Motherhood myths and facts and how these can create unrealistic expectations
- CBT approach – the connection between feelings, activities and thoughts
- Partner support website
- Mood spirals and their impact

Session 2

- Mood tracking – daily, rate your mood and its connection with activities
- Tension – recognising high tension situations and related anxiety
- Relaxation techniques to cope with high tension situations and anxiety
- Goals and personal contract to help motivate and keep track of progress

Session 3

- Balancing life to feel better and avoid downward mood spirals
- Increasing pleasant activities to help improve mood

Session 4

- Understanding negative thoughts
- Should thoughts always be positive?
- Extreme thoughts – all-or-nothing thinking, should and must statements, catastrophising
- Controlling negative thoughts to prevent a downward mood spiral

Session 5

- Positive thinking and the connection with feeling better
- Strategies for increasing positive thoughts
- Anticipating and looking forward to pleasant activities

Session 6

- Program concepts
- Review strategies chosen
- New routine and integrating strategies into daily routine
- Watch and respond to warning signs early, to begin strategies to get back on track
- Personal commitment contract

Section 6

Considerations for diverse needs

"The experience of pregnancy and parenthood differs for each woman and is influenced by the stability of her relationships and social network. Women who feel isolated either by distance, culture, or both, are more likely to develop distress or mental health conditions in the perinatal period" (Austin et al., 2015 as cited in Austin et al., 2017, p. 16).

When referring anyone from minority groups, clinicians should be aware that more time may be required as they may need to be flexible in the delivery process. It's also important to be aware of the different circumstances of each mum.

Literacy

Low health literacy is linked to poor mental health outcomes (Austin et al., 2017), so it's important that care provision is tailored to the individual needs of the woman and her family. In particular, this can be done by providing clear explanations and opportunities and making time for questions.

Literacy – Poor literacy may impact a woman's ability to understand the concepts in each session. It could mean that it takes her longer to engage with the program or work through the sessions, resulting in the need for support or additional explanation. It's important the woman gets support from her health professionals, tailored to her particular needs.

Technological literacy – Women will need access to technology that enables them to engage with the program and gives them the ability to use it. Technological support may be needed (at least initially) to ensure women feel confident with *MMB*/online intervention.

Culturally and linguistically diverse

Additional support may be needed for groups who do not speak English as a first language. Many clinicians receive information and strategies for addressing these barriers, to ensure women remain engaged in the health services they are accessing.

If you are unsure, you should discuss this with your manager.

Aboriginal and Torres Strait Islander

Clinicians need to be respectful and culturally sensitive when working with mums who identify as Aboriginal or Torres Strait Islander. The language used in the program may not be understood by all mums, so more support may be required to work through the program.

It could be helpful to explain that a support person is available to help guide the mums through the program—having someone they connect with may help with engagement.

Additional clinician support might be required in the areas of internet and data access, phone and credit etc.

‘Their reply to attend was,
“Are you going to be there?
If you’re going to be, I’ll be there”.
It’s like a familiar face
will be a guide.

So, if I’m there going through
it with the Indigenous mums,
they’re going to feel comfortable.’

–Clinician on supporting Aboriginal and Torres Islander mums

More information

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Appendix A: Evidence to support the use of *MMB*

Feasibility study

A feasibility study was conducted to test the acceptability of *MMB* as a concept worth validating. The following section from the research conducted by Danaher et al. (2013) provides this acceptance.

> 'A pilot study was designed to test the feasibility, acceptability and potential efficacy of *MMB*.
>
> A sample of 53 women were invited to participate because they satisfied the below eligibility criteria:
>
> - Less than nine months' postpartum
> - Over 18 years of age
> - Home internet access and use of personal e-mail
> - Edinburgh Postnatal Depression Scale score of 12–20 or Patient Health Questionnaire score from 10–19.
>
> A pre-test assessment occurred at screening and post-tests were conducted at three months following enrolment, and at six months' follow-up.
>
> **Results:** At the pre-test 55% (29/53) of participants met PHQ-9 criteria for minor or major depression. At the post-test, 90% (26/29) **did not** meet PHQ-9 criteria for minor or major depression.
>
> Significant improvement (p<.001) was also shown on these measures:
>
> - Automatic Thoughts Questionnaire
> - Behavioural Activation for Depression Scale
> - Self Efficacy.
>
> The feasibility study results provided initial support for the feasibility and acceptability of *MMB* to women with postnatal depression.'

Randomised controlled trial

The randomised controlled trial (RCT) is evidence that the program is effective. The following section from the research conducted by Milgrom et al. (2016) provides the evidence.

> 'In a randomised controlled trial we tested the efficacy of *MMB* in a sample of postnatal women with a clinical diagnosis of depression.
>
> **Methods:** A sample of 43 women participated, 21 completed the *MMB* treatment program and 22 were in the control group and received treatment as usual. At entry into the study and at 12 weeks after enrolment, women's diagnostic status was assessed by telephone with the Standardised Clinical Interview for the DSM-IV (SCID-IV) and symptom severity was assessed with the Beck Depression Inventory (BDI-II).
>
> **Results:** Adherence to the program was very good with 86% of users completing all sessions. Satisfaction with the program was rated 3.1 out of 4 on average. At the end of the study, 79% of the women who received *MMB* no longer met the diagnostic criteria for depression on the SCID-IV. This contrasted with only 18% remission in the treatment-as-usual (control) group.
>
> The randomised controlled trial results suggest that *MMB* is an effective treatment option for women clinically diagnosed with postnatal depression.'

Appendix B: Preamble to introduce *MMB* (can be altered for other online interventions)

Preamble to introduce the program and options

Within this health service we offer the Edinburgh with all new mums we see, as we have done with you. When women score 13 or above, it indicates possible postnatal depression or anxiety. It doesn't mean you have postnatal depression but people in that range often do. So I would like to tell you about some of the supports available to help you manage how you are feeling. Is that okay?

There are many support options available to you, but the really important thing is that we do something because this doesn't just go away on its own. We have heaps of options including working with your GP, accessing counselling or online interventions. One of the online options is called *MumMoodBooster* (*MMB*). You can do it in the comfort of your own home, and I think this could help you—even if we use other options as well.

With *MMB* you participate in the six online sessions—one a week, for six weeks. You can start and stop as you please and at your own pace. Here are what the sessions look like [refer to Section 5]. You can choose to stop at any stage and doing this doesn't mean you can't still talk to me, see your GP or counsellor. Does this sound like something you would like to do?

Action to be taken based on the mum's response to the preamble

If the mum says no – continue standard clinical care discussing other options that may suit the woman. Let her know she can still use *MMB* through the *MumSpace* website.

If the mum says yes – if possible open up www.mummoodbooster.com and sit with her while she signs up to the program. Once signed in point out some of the key navigations from the home page outlined in the image on the next page. If this is not possible, follow-up with a phone call or at the next visit to see how she is going with the program.

An important note

What was evident from mums who used this program was being reminded to partake in the program and how beneficial it was being able to share it. **We strongly recommend, where possible, that you follow up with the mums to ask what is working for them or if they have any questions regarding what they have read/seen in the program.** See below explanation of *MMB* homepage features.

1. Library tab for additional information on things such as time management, or communication
2. Tools tab for program tasks such as mood tracking and pleasant activities
3. Support tab for information on the partner site and other support options
4. My status page for information on how to use the program and complete tasks
5. Navigation to each session – will open up weekly when the one prior has been completed
6. Videos to explain key points
7. Navigation to the next page

Appendix C: Additional support services

MumSpace

MumSpace (https://www.mumspace.com.au/) offers a range of supports and online treatments.

For all new parents	
What Were We Thinking app	https://www.whatwerewethinking.org.au/
Baby Steps online program	https://www.babysteps.org.au/web/index

When you need extra help	
MindMum App	https://www.mumspace.com.au/when-you-need-extra-help/

Online treatments	
Mum2BMoodBooster	https://www.mum2bmoodbooster.com/public/
MumMoodBooster	https://www.mummoodbooster.com/public/

Other resources

Resource	Details
Access line	1800 800 944 (MLHD)
COPE	http://cope.org.au/readytocope/
Deadly tots	http://www.deadlytots.com.au/
Gidget Start Talking Telehealth	https://gidgetfoundation.org.au/get-support/start-talking-telehealth/
How is dad going	https://www.howisdadgoing.org.au/
Mental Health Line	1800 011 511
PANDA	1300 726 306 or https://www.panda.org.au/
Raising children network	https://raisingchildren.net.au/
Sms4dads info for dads on the go	https://www.sms4dads.com/
Tresillian Parent Helpline	1300 272 736 or https://www.tresillian.org.au

For further information about this research project
please contact MLHD-Research@health.nsw.gov.au

A partnership between

NSW GOVERNMENT

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Tresillian IN MURRUMBIDGEE
It's in our nature to nurture

BUILDING STRONG FOUNDATIONS FOR ABORIGINAL CHILDREN, FAMILIES AND COMMUNITIES