Supporting depressed mothers at home: their views on an innovative relationship-based intervention

Keywords: home visiting, qualitative research, postnatal mood disorders, satisfaction surveys, mothers, child and family health nursing,

Abstract

This study explored the responses of a group of 111 mothers who experienced distress and/or depression in the early months after childbirth and who received an innovative home visiting service until their child's first birthday. The current study reports a thematic content analysis of the qualitative questionnaire responses returned by the mothers after completing the intervention. The mothers valued the home visiting program for its capacity to increase their parenting confidence and to enhance their bond to their infants. They attributed this to the reassurance provided by the program and the skills and qualities of the home visitors. Their responses complement the benefits identified in quantitative analysis of the program and demonstrate its impact from participants' viewpoint.

Introduction

Home visiting has a long history in Australian child and family health services as an adjunct to centre-based care (O'Connor 1989). Yet, only during the past twenty years have these programs been acknowledged as effective in their own right for families with young children. This has coincided with a shift in focus from surveillance and imparting parenting skills to a more intensive and programmatic approach to supporting families with identified complex and multiple vulnerabilities (e.g. NSW Health 2009; Children Youth and Families Division 2010).

In 2001 an Australian early parenting organisation developed and implemented a home visiting program (HVP). The HVP aimed to provide innovative, non-institutional support to mothers with moderate to severe postnatal depression (PND). The program consisted of 10 home visits from a Child and Family Health (CFH) nurse to the mothers and their infants who were aged 4-6 months at admission. A key component of the intervention was the 'Seeing is Believing' technique from the University of Minnesota (Erickson, 1999), which involves a short video recording of a mother and infant interacting. The mother and nurse then review the interaction in a process of joint inquiry. They reflect together about how the infant and mother are experiencing the interaction. The nurse facilitates the mother identifying her own and her infant's strengths, and recognizing her infant's cues and attempts at communication. Using this knowledge they jointly consider how to enhance current mother/infant interactions and to equip the mother to anticipate and meet future parenting challenges. Additional components of the HVP intervention included supportive counseling, problem solving, identifying community supports, monitoring mood and anxiety, and supporting the development of infant development and behavior knowledge and parenting skills.

The current study examined the mothers' perspectives on the program, to understand how mothers experienced the intervention and which aspects they found particularly valuable. We were also eager to explore any aspects of the program that did not meet the...
mothers’ expectations. Some findings were as anticipated at the HVP’s establishment, given its aims to increase maternal confidence and the quality of their relationships with their infants.

By exploring mothers’ perspectives and experiences, we hoped to gain further insights into valued elements to help enhance the effectiveness and acceptability of future service delivery. This is vital given the long-term negative outcomes for children of mothers experiencing ongoing depression (e.g. Lectourneau, Salmani & Duffett-Leger 2010), and the need to provide support that is acceptable for participants and tailored to their needs, given considerable evidence of low treatment uptake in mothers with postnatal depression (McCarthy & McMahon, 2008).

This study is based on satisfaction questionnaire data from 111 mothers who were diagnosed as depressed and admitted to the HVP, over a seven-year period. It focuses on thematic analysis of the qualitative responses. We identified four major themes within these data.

**Background**

The difficulties caused by postnatal mood disorders have been well established, in terms of both the immediate distress for the parents and the longer-term consequences for child development and family functioning. Maternal depression, particularly when severe and persistent, has been associated with insecure attachment between mother and infant (McMahon et al 2006). Importantly, this study further showed that women with an insecure state of mind about their own childhood attachment experiences were significantly more likely to experience both the onset of PND and recurrent episodes during early parenthood.

Given considerable evidence indicating that treatment of maternal depression alone (either with antidepressant medication, counseling or psychotherapy) does not impact on infant outcomes (Murray, Cooper & Hipwell 2003), the HVP utilised a relationship focus at two levels. First, the nurse home visitor sought to provide the mother with a secure, predictable source of ongoing support. Secondly, from this base, the nurse worked in partnership to help the mother to explore her own parenting capacities and strengths, and to understand her baby’s perspective and needs. Many studies show that supportive interaction approaches promote more sensitive parental responding and more secure parent-child attachment (see Berlin, Zeanah & Lieberman 2008 for a recent review).

The HVP approach also responds to increased knowledge about the importance of early brain development and the significant impact of parenting behaviours (e.g. NSW Health 2009; Children Youth and Families Division 2010). Home visiting programs are used in many countries to provide supportive and therapeutic interventions for families with young children who are identified as having substantial risk factors (Nievar, Van Egeren & Pollard 2010). These risk factors often have a compromising effect on the ability to appropriately parent (Dixon, Browne & Hamilton-Giachritsis 2009).
The home visiting research literature usually focuses on measures of intervention success in terms of improved developmental and behavioural outcomes for children (Caldera et al 2007), mother child interaction (van Doesum et al 2008) and maternal outcomes (Zeanah, Larrieu & Boris 2006; Kitzman et al 2000). The reported outcomes of HVPs include: decreased risk of child abuse and neglect (Barlow et al 2007; Fraser et al 2000); reduced infant death (Donovan et al 2007); improved outcomes for infants of illicit drug using mothers (Bartu et al 2006); and increased spacing between subsequent pregnancies and improved maternal life course (Kitzman et al 2000).

Most published HVP research uses quantitative approaches with pre- and post-intervention measures to test the intervention’s efficacy (e.g. Donovan et al 2007; Duggan et al 2007; Kitzman et al 2000). Quantitative research findings play a significant role in demonstrating HVP outcomes objectively. However, findings are typically aggregated to the whole group of participants and do not portray the richness of the work nor its significance at an individual level.

Qualitative reporting of maternal satisfaction with HVPs has been minimal. Yet, measuring program satisfaction is identified as an essential evaluation strategy (Gerkensmeyer, Austin & Miller 2006). Examination of parental satisfaction is considered valuable in indicating quality of care and in informing policy and practice (Liptak et al 2006; Schaffer et al 2000). Satisfaction reviews are critical to identifying which aspects of a program participants value and which are therefore likely to enhance participation. These elements may assist in overcoming the barriers to care that reduce access to and uptake of suitable treatment interventions (McCarthy & McMahon 2008). Such elements can, in turn, be incorporated in future clinical programs and into nurse education and professional development.

**Method**

This study combines results from participants in a larger quantitative HVP evaluation study, who were recruited from an early parenting organisation. The HVP was conducted in four phases (Table 1), with a similar intervention; they differed only in the selection criteria (Phase 1 excluded multiparae). Women who received the intervention had previously attended the organisation’s services (in most cases a residential unit) and the HVP was an extension of the intervention. After gaining Ethics approval from the parenting organisation, nursing staff approached mothers with Edinburgh Postnatal Depression Scale scores in the range 15 to 23 (scores over 12 are suggestive of depression) (Cox, Holden, & Sagovsky, 1987) or <15 if they were already taking medication for previously-diagnosed PND. If willing, they were invited to take part in the HVP and the associated research. All mothers gave informed written consent to receive home visits and to complete psychosocial questionnaires and interviews.

Table 1 summarises participant numbers for the HVP and response rates for the satisfaction study. Attrition was generally related to mothers relocating or returning to paid work. Mothers who completed the HVP were mailed a confidential feedback survey and a pre-paid envelope. Over half (50.7%) returned these.

[Insert Table 1 here]
The current study analyses responses from the satisfaction questionnaire, consisting of 14 open-ended questions, developed specifically for the HVP. Questions addressed positive and negative aspects of participation, for clients and their partners (if applicable); the nurses’ approach; adequacy of information provided; reactions to the use of video-recorded material as a learning tool; perceived “closeness” to baby; and maternal confidence.

In the quantitative section of the satisfaction survey, 82.4% of those who responded reported that they were ‘extremely satisfied’ with the program; another 14.9% were ‘mostly satisfied’.

The data for the current study consisted of hand written responses to the 14 questions. The first author transcribed these and imported them into MAXqda qualitative data analysis software. The initial analysis was informed by the focus of the survey questions. We then conducted a further thematic content analysis, using a descriptive qualitative approach (Thorne 2008). Four major themes were identified: personal and professional qualities of the home visitors; the nature of the home visiting program; increased confidence in parenting; increased understanding between mothers and babies.

Findings

Analysis indicated that amongst those who responded to the questionnaire, the most valued elements of the program were:
- qualities of the home visitors, specifically their understanding manner and their professional knowledge;
- reassurance and consistency provided by the HVP;
- improved confidence of the participants;
- Mothers improved emotional responsiveness to their infants.

While these elements all related to intended outcomes of the program, the range of responses gives valuable insight into what aspects were significant and meaningful for the mothers and how the approach facilitated their engagement in the HVP, and consequent changes in their mood.

Several participants also reported their partners’ responses to the HVP. (The most common was either that it made little impact as fathers were not home during the visits or that fathers were pleased that their partners were well supported by the program.) However, the current study addresses only the mothers’ experiences. Pseudonyms are used in quoted excerpts.

Home Visitors

Many participants highlighted the personal qualities of the nurses, often in terms of their understanding, empathy and warmth, and their actions of support, friendship and encouragement. The mothers also emphasised the importance of interpersonal and listening skills. Several noted that they felt that their nurse genuinely cared for them and for their child/ren.
[The nurse] was someone I could rely on to be kind, understanding and constructive. Her visits made me feel like I was on the right track as a mother and that someone cared about me/my well-being. She brightened my days when she visited.

I feel that the interaction with a compassionate, qualified and knowledgeable nurse made all the difference. It was such a rewarding and wonderful journey.

She seemed to know me and my child very, very quickly. (Mother’s emphasis)

[The nurse] was a wonderful listener, very attentive and wonderfully kind and understanding.

Several participants specifically appreciated the nurses’ approach, which made them feel more relaxed and confident, at a vulnerable time in their own and their families’ lives.

The program … gives you the reinforcement and encouragement you need when you are doubting yourself in the first year of your child’s life. It is great to have support that is non-threatening and non-judgmental.

The non-critical attitude of [the nurse] and the acceptance of my efforts to care properly for my child.

The most fantastic non-judgmental home visitor, sensitive towards my needs and emotions. At no time condescending.

Many of these women had experienced feelings of guilt and inadequacy as mothers. Their comments signal the importance of the relationship with the nurses, through phrases such as: non-judgmental, sensitive and at no time condescending. This nursing approach was consistent with the program’s overall aims and the education provided to the nurses at its commencement.

As well as valuing their personal qualities, the mothers also acknowledged the nurses’ professional skills and knowledge. They valued having ready access to expertise about child development and behaviour, as well as the home visitors’ understanding and knowledge of postnatal mood states.

[I appreciated] the extreme comfort of a professional carer and the emotional rush of having a first baby and knowing they would know how to approach the problems I was having.

The ability to be able to talk to a professional, non-judgemental person on a regular basis about my child and the feelings and doubts surrounding the new experience I was going through. It was very reassuring.

Support from someone who knows what PND is and [has a] genuine interest in my well-being.
These comments underline the importance of selecting nurses suited to this mode of service provision as well as the need for training and ongoing support. Several qualities were highlighted including: empathy, being genuine, problem-solving capacity, consistency and professional knowledge.

**The Nature of the Home Visiting Program**

A frequent response was that mothers valued the consistency and continuity of the HVP, often resulting in strong bonds between the mothers and the nurses. They also welcomed the predictability of the program; anticipation of regular visits from the nurse reassured some mothers who were distressed or uncertain.

Knowing that every month [the nurse] would be visiting and that I would have a chance to talk and learn about my baby. I knew that I had a consistent support through some very sad and lonely times. Each visit helped me put things in perspective and look for positive outcomes.

Having the visit to look forward to each month and feeling very comfortable discussing any challenges.

Provided me with on-going reassurance and support during an extremely difficult year. The next appointment was always a ‘target’ date in my diary.

Continuity of home visit nurse because it meant the advice was consistent unlike early childhood centre.

Regular visits from the one person who would listen to your situation in the here and now, and suggest ways of dealing with the issues both practically and emotionally (Mother’s emphasis).

Respondents also valued the fact that the intervention took place in their home environment. This was important for depressed mothers who lacked confidence about venturing out with a young baby. Others reported that this made the advice more pertinent, being tailored to their own family situation. Strategies could take account of the circumstances and needs of individual families.

Having a qualified experienced nurse come to our home environment and see how my son behaved in it, as opposed to outside in an unfamiliar environment for him.

Having someone to come to my place and let me ask questions. With PND I found sometimes I was lazy or couldn’t be bothered to go out to mother’s group or ECHC to ask questions.

After our week stay at [the parenting organisation] it was all too overwhelming coming home trying to adopt all [we] learnt into the home environment. It was such a relief to have someone see how things actually are and help implement techniques/routine in your own surroundings.
Some mothers also indicated that they valued the independence of the nurse. This was a source of relief and support for those mothers who did not have family living close by - and for some of those who did.

[The nurse] was just like having your Mum come to visit, but a mum who doesn't tell you you should clean your house, sleep the baby on its tummy, stop breastfeeding blah, blah, blah. She was like a mum who totally supported you and your efforts as a mum, but also a mum who really did know what she was talking about.

By discussing the changes in my life and in myself, on a monthly basis with a caring, objective person with no personal involvement, I was able to gain a clearer perspective on what was happening and to see the changes as they were.

You don't often get told you're doing a good job as a mother and if family tell you you are, sometimes you think they're just saying it. When [the nurse] and other people that don't know us say it, you believe it more. I can't explain why. Maybe because it's coming from another mother or an experienced person.

Some elements of the HVP, including the on-going contact with a dedicated CFH nurse in the home environment, are not readily available through many CFH nursing services. However, other aspects such as the quality of care, predictable availability and the non-judgemental approach of staff are clearly relevant to all services. The comments highlight ways in which the mothers feel supported through positioning the nurse as having authority and authenticity.

**Increased Confidence in Parenting**

A major aim of the HVP was to enhance maternal confidence. Rather than ‘solving’ specific problems, the nurses discussed options and supports, and jointly developed feasible strategies with parents. By emphasising maternal strengths and their knowledge of their infants, the nurses encouraged them to feel confident in their ability to face a range of parenting issues.

Many respondents attributed their increased parenting confidence to participation in the HVP and to the skills of their nurse home visitor.

Talking to someone who did not have an immediate agenda to brush off your concerns – who listened and reassured you. It was nice to have that connection between you and your child illuminated for you. It made me feel more of a mother, more competent and confident re myself and my abilities.

I had never been around babies before and was very nervous with no clue in the beginning. The home visiting program really helped my confidence with my baby.

My emotional state was all over the place to begin. The visits provided ongoing support. [At] about 3 months I started answering questions in my mothers’ group as I had the confidence.
I really believe I’m the best carer for baby; before, I had no confidence.

Several mothers stated that they felt more confident as parents simply from reassurance that they were doing the ‘right thing’ and parenting their children well.

*It was wonderful to cross-check what I was doing with a health professional who was interested and intimately involved.*

*Somebody whom I had not met before, therefore being completely objective, saying that I was doing a good job and that my child was thriving because of how I was with him.*

*The extra support helped me to accept my baby’s/my behaviour as “normal” and go with my instincts.*

Many mothers found reassurance in having their questions answered by a health professional and knowing that their children were developing normally. Importantly, several mothers valued the fact that this health professional was a nurse able to span issues of child health, and maternal physical and emotional health.

*The opportunity to develop a trusting supporting relationship with [the nurse] who I could ask any questions without feeling inadequate, fearful or guilty in the comfort of my own house, so I didn’t have to rush to an appointment with two babies.* (Mother’s emphasis).

*Knowing I had someone (professional) to ask all those “silly” questions; having that same person who knew my history as a mum and [gave] consistent information.*

The HVP incorporated a strength-based approach, where nurses assisted parents to recognise the skills and knowledge that they already possessed. In jointly reviewing the video-taped interactions, the nurses encouraged mothers to see the many positive aspects of the relationship with their baby. In ‘wondering together’, nurses and mothers shared observations and ideas about what the infant was trying to communicate. This process increased maternal understanding of infant behaviour and communication, and boosted the mothers’ sense of how much they meant to their children and of their own expertise.

*Having someone listen to what was worrying me, having someone being positive (genuinely) about my mothering and about my child’s development.*

*[The nurse] always gave reassurance or offered supportive advice. I realised I was a good mum to both babies.*

*It was nice to have someone tell me I was doing OK when suffering a bad dose of mother guilt.*

*I can now see that I am a good mother who loves her baby and who responds to her baby’s needs.*
In using a partnership approach in their interaction with the clients, the nurses sought to avoid an ‘expert’ model. While they clearly shared their knowledge about infant development and health when required, they refrained from ‘jumping in’ with solutions, instead encouraging the mothers to recognise their own expertise and to collaborate in identifying appropriate strategies for parenting concerns.

[The nurse] was wonderful in that she’d only give feedback if I asked for it. An example was I was giving my very young baby full-strength juice and I commented that I hope this was OK. It was only after I’d said this that she ‘suggested’ I perhaps water it down a little. She must have witnessed many things she didn’t agree with but was very subtle and never once made me feel bad.

On the other hand some mothers indicated frustration with the partnership approach.

Sometimes I asked for advice and wanted a straight ‘yes’ or ‘no’ answer and could never get that. Often my question would be answered with a question e.g. ‘well what do you think your baby wants?’ … Everyone is different and some mothers may not necessarily like someone expressing a firm view but if the mother appears to want more direction, the nurse shouldn’t hesitate to give that.

Sometimes in the beginning I wanted more advice and I was asked what I thought in response – not given an answer by her.

Working in partnership with parents is now encouraged as a foundation practice for CFH nurses (NSW Health 2009). Many mothers do not expect to interact with a health professional as a facilitator of knowledge rather than as a provider of information that does not take account of the individual circumstances and context.

**Increased Understanding between Mothers and Babies**

The HVP aimed to increase the emotional connection and responsiveness between mothers and infants, by building the mothers’ knowledge about parenting and reinforcing their specific understanding of their own child. The nurses assisted mothers to identify infant cues and communication, which helped them to understand their infants and to appreciate their unique relationship with them. Several mothers describe feeling more connected to their infants.

[The nurse] highlighted those things such as eye contact I did not know. Reinforcing how much my son loves and values me even though he can’t communicate verbally.

The small things I learnt (baby cues) have helped me to be a better parent in so many ways. I can now listen and see what my baby is telling me.

Having twins … it was the support to show me and guide me to learn that my children, although born at the same time, are individuals.

She has given me the confidence and helped me accept my baby for who she is and taught me that all children are ALL different. (Mother’s emphasis)
Several mothers specifically mentioned the importance of observing the video-tape with the nurse in enhancing their understanding of their children. Some stated that they were grateful for the memento and the evidence of the infant's changes over time.

There were times my baby was trying to communicate with me through glances, gestures or smiles that I was totally oblivious to until I saw the video.

Made me realise how I interacted with both twins and how they responded to me and each other.

I was able to see myself responding to his needs. I was able to see him enjoying my company.

It highlighted the subtle but most beautiful bond.

It was nice to feel that connection and see it, rather that talk at me about it. (Mother’s emphasis)

I didn’t know I was calm until I saw the DVD of me feeding her! … Made me feel confident in my mothering skills.

Some mothers indicated that they felt much closer to their infants following the HVP. This was particularly important for depressed mothers who may experience a sense of distance from their infants. Others stated that they always felt close but that they had nonetheless learnt a great deal about their own children.

The bonded relationship I developed with Cassie, which was supported by the skills I learnt in play and communication with my daughter. [I learned] that I do not need to be superwoman or [to] mother by the book, to believe in my own judgment and go with what works best for our family.

[The nurse’s] support enabled me to become more confident in my mothering skills, and through her visits I have become closer to Lilly.

By helping me to gain greater confidence in myself as a mum and in trusting my instincts I definitely feel that I can watch my baby’s cues and thus respond better thereby feeling closer to him.

It taught me now to relax with my son.

The most positive aspect to the program was the outcome. I now have a fantastic mother-daughter relationship growing. We both feel confident and happy together.

Some mothers specifically mentioned that their increased knowledge and confidence would enable them to solve problems in future and to anticipate developments.

By 12 months, I felt I had the tools within myself to continue with sureness that I was a capable, confident mother.
It really married well with the development of my baby and consequently the many questions that came up as he changed and grew, from sleeping to feeding etc.

These outcomes reflect the components of the HV programmatic approach. The nurses encouraged independence in how the mothers parented, through using anticipatory guidance strategies and actively engaging in problem-solving.

Discussion

The range of responses indicates the elements of the HVP that participants valued the support and personal attention from skilled, caring and encouraging health professionals, and the growth in their confidence and understanding of their infants. These elements are important to all new parents and especially those suffering from depression and other mood disorders.

One area of practice requiring further investigation is the mismatch between a partnership approach and some mothers’ expectations of a more didactic approach to advice. Information provision can be a reasonable and useful strategy when used to respond immediately to a distressed mother. Unfortunately, if the follow-on actions that assist the mother to utilise the information are missing then the information remains impersonal; the mother may be unable or unwilling to implement the suggested strategies unless they have adequately addressed her circumstances and context. Facilitating the mother’s own problem-solving abilities, conversely, may be more likely to generalise to new challenges as the baby develops.

Further, additional research could explore the relationship between mothers’ responses and their reports of their partners’ views; and between reported experiences and the quantitative ratings on the questionnaire.

Limitations of this study include the 50.7% response rate. However, this is reasonable given the additional time pressure and consideration required to answer opened-ended questions, at a time when parents were keen to ‘move on with their lives’. Some mothers had returned to paid work; others were absorbed with another pregnancy or new infant.

The responses that were received provided a rich source of feedback data. A potential limitation of program satisfaction surveys is ‘courtesy bias’, leading respondents to over-estimate satisfaction levels, especially if an interview approach is used (Glick 2009). We attempted to overcome this bias by providing a de-identified questionnaire to the mother on the last visit, with a prepaid envelope addressed to the second author. However, this anonymous process meant that we were unable to remind those who had not responded, thereby limiting the overall response, and that we could not ascertain whether those who responded to the qualitative study fared differently on quantitative measures than those who did not.

Clearly some aspects of the HVP (e.g. home visits or continuity of personnel) cannot always be achieved by regular CFHN services. However, comments about the importance of this component demonstrate the importance of consistent information, predictable availability and of working with parents to identify solutions that suit their
personal needs and circumstances. This further highlights the importance of establishing a relationship as a vehicle for the intervention (Berlin et al 2008; Kilpatrick et al 2007; Erickson & Kurz-Riemer, 2002).

**Conclusions**

The favourable and thoughtful comments made by most respondents indicate that they felt the HVP succeeded in its objectives of enhancing parenting strengths, maternal bonding and connection with their infant. This is consistent with the significantly reduced depression and anxiety amongst participants at discharge from the program (Fowler et al 2004).

The satisfaction survey provided a detailed insight into participants' experience of the HVP, and which elements were meaningful and valuable to them in achieving the program's goals. Although the findings are largely in line with the intended outcomes of the program, especially increased maternal confidence and enhanced emotional connection and communication between mothers and infants, analysis of the mothers' words provides greater understanding of the aspects of the program which mothers feel contributed specifically to these outcomes.

These findings, particularly the emphasis on the interpersonal skills and empathy of the nurses, reinforce the importance of careful selection of staff and the essential professional and personal qualities required to work within a HVP. They also highlight elements that should be incorporated into future professional development for such programs. In particular, this mode of service delivery requires skills in listening and communication, working in partnership and strength-based approaches, as well as up-to-date and evidence-based knowledge of infant development, parent-infant relationship processes and attachment. It is essential that nurses working in HVPs, and indeed other services for mothers with mood disorders, have the flexibility to tailor support to be consistent with family contexts and circumstances.

In complementing the quantitative outcomes of the program, this qualitative study has elicited different data. Such results are rarely reported nor analysed for their implications for further development. Yet the clients’ satisfaction data have provided a deeper understanding of the program and valuable indicators as to how to adapt and enhance similar interventions in future in a way that is beneficial for participants, enhances their engagement, and overcomes some of the barriers to accessing support and early intervention.
References


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### TABLES

**Table 1: Numbers Participating in Home Visiting Program and Satisfaction Survey**

<table>
<thead>
<tr>
<th>Phase</th>
<th>Date</th>
<th>No commencing HVP</th>
<th>No completing HVP</th>
<th>Completion rate</th>
<th>No completing survey</th>
<th>Response rate</th>
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<td>July 2001 – Oct 2003</td>
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<td>84</td>
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<td>Two</td>
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