



Identifying depressed fathers during a home visit, why and how

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Identifying depressed fathers during a home visit, why and how**Abstract**

The knowledge and expertise required for Child and Family Health nursing practice has continued to evolve as a consequence of research based interventions and policy changes affecting families. The benefits of sustained home visiting on family health and wellbeing are now accepted and Australian trials have demonstrated improvements in maternal–infant attachment and mothers’ relationship with their child. At the level of clinical practice, best practice approaches for nurses visiting new mothers have moved away from delivering specific clinical procedures to focus on the particular needs and circumstances of the parent and family, emphasising psychological support and health promotion in partnership and collaboration with parents. A particular focus on detecting postnatal maternal depression has arisen due to the development of the National Perinatal Depression Initiative. Child and Family Health nurses now regularly screen mothers using the Edinburgh Postnatal Depression Scale. Recent evidence of the impact of fathers’ depression on children and mothers has drawn attention to fathers’ mental health in the perinatal period. Fathers’ postnatal depression has been shown to impact on children’s development at similar levels to mothers’ and while children are most affected by two depressed parents, the effect of fathers’ depression is independent of mood disorder in the mother. Nurses making home visits have an opportunity to engage with fathers and many do so when the father is available. In this paper we present the evidence and rationale for assessing fathers’ depression or anxiety at the postnatal home visit

Identifying depressed fathers during a home visit, why and how**Introduction**

Every Australian family with a child under five has access to a local accessible service providing individualised support, information, monitoring, screening, intervention and referral for a range of developmental, behavioural and health conditions. These publically funded programs play an essential role in primary health care provision to families. Each State and Territory administers and tailors their programs to meet local needs and challenges. The nurses delivering these services are known as Child and Family Health Nurses (CFHN¹) in NSW, Queensland, South Australia Tasmania, the Australian Capital Territory and the Northern Territory, Maternal and Child Health Nurses (MCH), in Victoria, and Child Health Nurses (CHN) in Western Australia,. The philosophy and practice of these nurses has changed in line with policy reforms and is reflected in the changing service names. Nurses' titles have evolved from Infant Health and Welfare Nurses to Maternal and Child Health Nurses to Child and Family Health Nurses, reflecting a shift in the focus from the infant alone to a recognition of the crucial roles of each family member for infant wellbeing.

Working with families

The knowledge and expertise required for child and family health nurses to effectively work with families has continued to evolve as a consequence of research evidence of effective interventions and policy changes affecting families (NSW Health 2010). The ability of early intervention to improve family functioning and reduce the burden of ill-health on individuals and the community is now widely recognised (Kendrick et al 2000). Since the way that parents care for and interact with their infants and children

¹ The acronym CFHN will be used for the remainder of this paper

has long term effects on children's development, intervening soon after the birth has been identified as a practical and cost effective way to avoid a range of maladaptive behaviours (Olds et al 2010).

Home visiting by qualified nurses after the birth is one area which has been extensively studied. Several randomised control trial have demonstrated the positive effects of sustained home visiting on family health and wellbeing (Kitzman et al 2010; Olds et al 2010) and Australian trials have demonstrated improvements in maternal–infant attachment and mothers' relationship with their child, (Armstrong et al 2000; Kemp et al 2011). Best practice approaches in home visiting have moved away from an expert model of advice giving and/or conducting specific clinical procedures and assessments to focus more closely on the particular needs and circumstances of the child and family, emphasising psychological support and health promotion in partnership and collaboration with parents.

The idea of partnership is now folded explicitly into policy directives such as *NSW's Supporting families early package* (NSW Health 2010) and into documents that guide CFHN professional practice (NSW Health 2011). Across Australia, the Family Partnership Model (FPM)(Davis & Day 2010) has been adopted as a framework to strengthen partnership practices and is based on a manualised training approach (eg Keatinge et al 2008). The 'F' in FPM clearly implies that support is framed around family units rather than individual family members: inclusion of fathers is therefore implied. FPM also guides professionals in how to conduct health assessment, not from a technical perspective, but in terms of how it is part of a joint, negotiated process of helping families, and in terms of how outcomes might be used. FPM sees interactions such as home visits as part of a linked services model, in which families' needs can be

met by professionals brokering access to different services, with relevant information being shared to ensure families' views and strengths remain respected throughout the process.

Reform in the scope of CFHN practice in relation to the social and emotional well-being of women has also been informed by policy developments targeting mental health. These include the *beyondblue* National Postnatal Depression Program (2001 – 2005), the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (2008) and the National Perinatal Depression Initiative (Department of Health 2009).

There are several principle elements of the NPDI. These are: routine, universal screening for perinatal depression, anxiety and psychosocial risk; workforce training and development for health professionals; agreed pathways of care, and follow-up support for women assessed as being at risk; research and data collection; national guidelines for screening for perinatal depression; and, community awareness.

As part of the NPDI, the development of National Clinical Practice Guidelines for Depression and Related Disorders in the Perinatal Period (CPG) were published (*beyondblue*, 2011). The guidelines had 8 recommendations for primary health care practice. One recommendation is the use of the Edinburgh Postnatal Depression Scale (Cox, Holden & Sagovsky, 1987) for screening of antenatal and postnatal maternal depression (cut off score 13 or above), together with specific additional questions to assess psychosocial risk factors known to be linked to mental health risk.

Child and Family Health nurses are the professional group in Australia who predominately undertake this role of offering routine psychosocial assessment and maternal depression screening to mothers in the postnatal period. Many jurisdictions have included this as part of the Universal Contact Visits and have updated health policy and practice manuals to be in line with the CPG recommendations and guidelines. In Victoria, for example, the format and questioning of this routine appointment with new mothers was re-modelled to align with the questions associated with the NPDI screening directives (State Government of Victoria 2013).

If Child and Family Health nurses were to extend this work to the inclusion of fathers several issues would need considered.

It could not be assumed that the questionnaires of choice would be similar. The use of the EPDS as a screening tool for mothers has been subject of much debate (eg NICE guidelines) and some reports have suggested that it is not appropriate for use as a screening instrument with fathers (Massoudi et al. 2013). It seems more appropriate, at least at this preliminary conceptual stage, to consider a screening tool in terms of a 'mental health or emotional well-being screening tool' (see Fletcher et al, 2008) rather than a specific standardised questionnaire or interview schedule. The particular tool of choice and method of delivery, if this was to be the direction, would require much more debate and review.

The availability of fathers in the postnatal period would also need to be considered since fathers frequently return to work soon after the birth (Bittman, Hoffman, & Thompson 2004) and they may not appreciate the importance of their involvement in early infant care (Wilson & Prior 2010). While a whole of family approach is gaining acceptance, the additional effort required for nurses to engage with fathers specifically

around their adjustment and mental health in the perinatal period will require workforce consultation and a strong rationale. Evidence of the short and long term impact of paternal perinatal depression will need to be brought to the attention of service managers and front-line staff to enlist their support of assessing fathers.

The impact of sad dads

We have known from research studies since the 1980's that the children of mothers suffering from depression in the perinatal period had increased risk of impaired cognitive and emotional development (Beck 1998). Over the last decade, a body of evidence has emerged showing that not only are fathers' mood disorders more common than previously believed (10.4% in a recent meta-analysis; Paulson & Blazemore 2010) they can also place children at risk independent of the mental health of the mother.

In a UK study of over 12,000 new parents, Ramchandani and colleagues (2005) measured fathers' and mothers' depression at eight weeks postpartum and then had teachers assess their children's development at three-and-a-half years of age. Children of fathers who had scores indicative of depression on the EPDS had twice the risk of behavioural and emotional problems compared to children from non-depressed fathers. This association remained after controlling for social class, degree of education, maternal depression and fathers' later depression. When the children were assessed at 7 years of age those children whose fathers had been depressed following their birth were almost twice as likely to have a psychiatric disorder, mainly oppositional defiant/conduct disorder, compared to other children. This relationship was found even after adjusting for maternal depression and paternal educational level

(Ramchandani et al. 2008). Analysis of an Australian cohort ($n = 2,620$), using the Kessler Psychological Distress Scale (K6) to indicate possible paternal depression also found highly elevated behaviour problems in preschool children whose fathers had shown depressive symptoms in their first year (Fletcher, Freeman, Garfield & Vimpani 2011). As in the UK study, this effect remained when allowing for maternal depression and socioeconomic position. Not surprisingly, when both fathers and mothers are depressed their children are at higher risk of behavioural impairment (Paulson, Dauben & Leiferman 2006).

Some indications of how paternal depression might impair infant development is now emerging. In a nationally representative, longitudinal birth cohort study of US children, Davis et al. (2011) examined 4 fathering behaviours: playing games, singing songs, reading and spanking. Of the 1746 fathers in the sample, 7% reported a major depressive episode in the previous year. These depressed fathers were only half as likely to read to their children but 4 times more likely to spank their 1-year-old as non-depressed dads. In a second large US study ($n=4,109$) following infants from birth to 2 years of age, reading to their 9 month old was also found to be reduced among depressed fathers and mothers. However, children of depressed fathers also had significantly lower vocabulary scores when tested at 2 years, compared to those whose fathers were not depressed, an effect not found for mothers' reduced reading (Paulson, Keefe, & Leiferman 2009). Investigators from the Netherlands have identified fathers' hostility as a key mediator between paternal postnatal depression and children's later behavioural problems (Velders et al. 2011), while Sethna and colleagues (2012) in the UK found more negative and critical utterances in depressed

fathers' speech to their 3 month old infants, compared with that of non-depressed fathers

A father's depression, expressed through hostility and negative comments, is also likely to impact on the relationship between the parents. Marital conflict and lack of partner support has been linked to maternal postnatal depression in several studies (McMahon, Barnett, Kowalenko, & Tennant 2005; Dennis & Ross 2006; Bilszta et al. 2008) and marital conflict has been shown to partially mediate the relationship between postnatal depression in both mothers and fathers and child outcomes (Hanington, Heron, Stein, & Ramchandani 2011).

Nurses' screening of fathers

As mentioned, community Child and Family Health nurses in Australia offer postnatal screening for depression and psychosocial well-being for new mothers as part of the first home visit during the early weeks postpartum (Rollans et al., 2013). Depending on concerns identified at this visit, for example, the mother experiencing issues with breastfeeding, further short term visiting may be provided (NSW Health, 2010). Parents are invited to contact their child and family health centre for follow-up appointments according to individual State and Territories schedules of infant surveillance and screening where nil or minimal issues are identified. In addition, primary health CFHN services generally invite new parents to attend a program of parenting support groups in the early weeks postpartum (Guest et al., 2009). Families who have been identified during the antenatal or postnatal psychosocial screening assessment that would benefit from active home visiting support from CFHNs over a

longer term may be offered specialist secondary services follow-up (NSW Health, 2010).

Child and family health nurses who make home visits may have an opportunity to engage with fathers. Many nurses do so now when the father is present and he is prepared to engage. Despite this effort, men may see themselves as marginalised (Bennett & Cooke 2012) and consider that “existing services might not make them feel welcome and assisted: ‘when you’re there it’s all got to do with the mum and the baby and it’s a mum friendly place’” (Rowe et al, 2012 :50). To address this, some CFHN services have implemented procedural guides related to engaging fathers at the first home visit. For example, the South Australian (SA) Universal Contact Visit Guidelines (SA Child and Family Health Service 2010) provide information regarding the significance of the father’s early and continued involvement in his new baby’s life and in supporting his partner. These guidelines (Child and Family Health Service 2010 :39) provide nurses with tips to engage fathers if present at the home visit as follows:

A friendly and interested approach will help the nurse engage with the father.

Use what you learned in the Family Partnership Training to guide you. The nurse may need to clarify that the visit includes any questions or issues the father has about parenting and, if you notice from his verbal or non-verbal communication that he has misgivings, try to address these e.g.: acknowledge his importance and that the visit is also ‘for him’.

There are also suggested ‘starter’ questions such as ‘how are you finding being a parent?’ (38).

Routine screening of fathers for depression is not undertaken in the SA Child and Family Health Service for families participating in the Family Home Visiting program (Personal communication, David Magor-Hampel, SA Health, 1 April 2014).

However, where fathers in families receiving services have been identified as potentially experiencing mental health concerns, screening for depression using the EPDS may be undertaken with referral to services within and external to Child and Family Health Service. A Fathering Support Worker is located within the Child and Family Health Service to provide support for fathers accessing specific programs (Personal communication, David Magor-Hampel, SA Health, 1 April 2014).

To date in Australia and internationally, there are no known, evidenced based, primary health protocols where nurses routinely screen fathers for depression. There are however, instances of routine paternal screening for depression in some Australian residential child and family parenting centres (Giallo et al. 2013; Personal communication with Nikki Zerman, Coordinator Tweddle Psychology Service, 28 March 2014). Approximately 280 fathers are admitted to the Tweddle Child and Family Health Service Residential Unit in Victoria, per year. These men often stay overnight with their partners and then leave in the morning for work or may attend part, or all, of the admission. While the EPDS is offered to mothers, staff find that the DASS-21 (Lovibond & Lovibond 1995) provides more relevant information for addressing fathers' needs. A single self-harm item is added to the screening tool (Personal communication, Nikki Zerman, 28 March 2014). In a study by Giallo et al. (2013), of 144 fathers admitted to a residential program at Tweddle during 2010-2011, distress was experienced in the clinical range for stress, anxiety and depression at 17%, 6% and 9% respectively. At Tweddle, psychology services are available and

offered to fathers where clinical concerns are identified; for scores in the moderate range or above on the DASS 21 and for any father that endorses the self-harm item regardless of their score on depression, anxiety or stress (Personal communication, Nikki Zerman, 28 March 2014).

The Ellen Barron Family Centre (EBFC) is a residential unit for families needing extra support in Queensland, Australia. The EBFC is one of the services delivered by Statewide and Specialised Services, Child and Youth Community Health Services, Children's Health Queensland Hospital and Health Service. EBFC provides for a whole family admission and request that the father be present for the whole or part of the duration of stay (including boarder admission where the father can stay overnight with the family and go to work during the day) in recognition of the crucial role of the father in the family unit and to the outcomes of the program (Personal communication, Karen Berry, Director of Nursing EBFC, 27 March 2014). Routine paternal screening for depression is not undertaken as the service requires a detailed professional referral, pre-admission questionnaires to be completed individually by both parents, and a detailed parent assessment tool completed by EBFC nursing staff separately with both parents. The EPDS however is used to screen both mother and/or father if clinical concerns are identified. Follow-up of fathers where indicated is undertaken by the EBFC psychologist or social worker who will administer the DASS-21. Referrals for paternal support are made to adult mental health services. The EBFC also has a 'Dad's Shed' that is run weekly on evenings by a male health professional.

Ngala in Western Australia (WA) is a state-wide early parenting service comprising a Residential, Day Stay Unit and home visiting service for parents with perinatal mental health issues with two or more children.(ref) Ngala has been screening both mothers and fathers using the EPDS on entry to the service. Approximately 30% of fathers are involved with their partner in these services although the rate of involvement with fathers on the evening home visit is extremely high. 4102 families attended Ngala Day Stay services during 2010-2013. Of 993 men screened using the EDPS, 44.7% were identified as having some level of distress. There is an interdisciplinary team including medical, social work and/or psychology services to support the Child Health Nurse with fatherhood related support and education, The universal child health service in WA, like elsewhere in Australia, does not screen fathers routinely for depression (Personal Communication, Elaine Bennett, 3rd April 2014)

Building CFHN capacity to screen fathers at home visits

. As part of the support for the NPDI (2008-2013), widespread education was delivered to up-skill nurses to include screening as part of their role. Given the routine NPDI screening which CFHN now offer across Australia to mothers, this professional group is equipped with significant skills and knowledge on the use of the EPDS and psychosocial questions around mental health screening. Furthermore, CFHN are aware of attachment theory and the importance of optimising the infant –parent relationship for the child’s life long mental health and well-being (NSW Health, 2011). This knowledge and skills set provide a good foundation for extending enquiry

about mental health conditions to include the father provided adequate time is allowed for this practice.

However, the NPDI was a time-limited project, therefore education of new staff and skills updating for existing staff is not guaranteed. Some States and Territories have adopted mental health training into induction packages for new staff and tertiary institutions in South Australia have recently introduced a perinatal mental health module into their undergraduate Midwifery courses and some postgraduate professional courses. Other options for ongoing, low cost and sustainable training may be found in the use of free to access e-learning resources (e.g., Adams, 2011; beyondblue 2011; SA Health 2011). These materials geared for mothers could be adapted to include addressing fathers' needs as has been done with the Perinatal and Infant Mental Health Program at the NSW Institute of Psychiatry.

In order to ensure effective and safe service delivery however, initial training must be accompanied by provision of ongoing support and supervision of staff, and referral pathways must be in place whereby identified services which offer follow up care are able to respond in a timely manner once one or both parents have been screened as high risk.

Recent studies investigating the sustainability of partnership approaches after implementation of the Family Partnership Model and associated training have shown, even the most committed and highly skilled professionals can struggle to achieve the high quality they desire in their work (Hopwood et al., 2013). CFH nurses, who often work autonomously out in the field, would benefit from a collaborative context to

effectively assess the mental health of both parents. Features of a supportive organizational structure would include: Clinical supervision, mentoring, and mechanisms to ensure information, practices and tools remain up to date and inclusive of fathers as well as mothers; appropriate training , organizational and inter-organisational structures to engage with other professionals , both to resource training for nurses, and as part of an integrated, collaborative service structure.

Conclusion

Nurses making a home visit in the period after the birth are uniquely placed to identify the signs of psychological distress in both mothers and fathers and to assist parents by linking them to the support that they need. The benefits of including fathers in the screening carried out by CFH nurses include improved outcomes for the fathers, their infants and their partners. However, while existing competencies of CFH nurses provide a suitable basis for engaging with fathers, those undertaking this role will need the capacity (skills and time) to act on screening outcomes. As well, they will need organizational support in terms of workload, aligned structures and mechanisms for ongoing development.

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