

Telephone-Based Peer Support Intervention for Postpartum Depression (PPD): Real World Implementation

coletourneau, PhD, RN, FCAHS¹, Loretta Secco, RN, PhD², Cindy-Lee Dennis, PhD³, Miriam Stewart, PhD⁴
Linda Duffett-Leger, RN, PhD¹ and Lubna Anis, MBBS¹

¹University of Calgary, Calgary AB, ² University of New Brunswick, Fredericton NB,
³University of Toronto, Toronto ON, ⁴ University of Alberta, Edmonton AB, Canada

Background

- Postpartum Depression (PPD) is a type of clinical depression that occurs after child birth (Dennis 2013).
- 10-15% of new mothers face this condition and it typically begins during the 1st 3 months postpartum (Gavin 20015).
- PPD is chronic rather than episodic, and chronicity is suggested by reports of continued symptoms during the 1st year for 30% to 60% of mothers and beyond the first year for 8%-63% (Letourneau, 2013; Reay 2011).
- PPD affects negatively on parenting quality, mother-infant interaction, infant emotions and personality, and longer-term child behavioural and cognitive outcomes (Dix 2014; Letourneau 2012; Lilja 2012).
- Women with PPD are less likely to adopt established treatments such as antidepressant medications, cognitive-behavioural and psychotherapy due to concern about transfer to the infant in breast milk and due to time and financial constraints (Davis 2012).
- Evidence grows on the positive effects, acceptability and accessibility of telephone-based peer support (TBPS) for women with PPD (Dennis 2009).
- Edinburgh Postnatal Depression Scale (EPDS) Scores ≥ 12 are consistent with physician diagnosis of major depressive disorder with postpartum onset (Cox 1997)

Research Questions

1. Do mothers with PPD (EPDS ≥ 12) who receive a three month peer telephone support mentorship intervention show lower symptoms and/or rates of depression?
2. How many telephone support calls are required to lower symptoms and/or rates of depression in mothers with PPD (EPDS ≥ 12)?

Methods

Telephone Peer Support Mentorship:

- Volunteer Mentors
 - A self-reported history of PPD
 - Motivated to help women with PPD
 - 19 to 45 years old
 - speak and understand English &/or French
 - not currently depressed (repeat scores EPDS <6)
- Mentor Training & Manual
 - Increase support skill
 - Refresher training & debriefing
- Weekly telephone support for 12 weeks:
 - Provided informational, emotional, affirmational, and practical support

Recruitment & Criteria:

- Screened by Tele-Care (811) and public health nurses with the EPDS
- Moms 15 – 45 years old with a child less than 24 months
- EPDS ≥ 12 <20 to enter study

Setting:

Atlantic Province of New Brunswick in Canada (North and Adjacent to Maine)

Results

Description of sample	Mothers N (%)	Mean	SD	Range
Mother Age (years)		26.25	6.74	17-43
Language:				
English	46 (74.2)			
French	9 (14.5)			
Prenatal Depression Symptoms	48 (77.4)			
Pregnancy Complications	35 (56.5)			
Infant Age (months)		7.58	5.44	1-23
Full Term Birth	53 (81.5)			
NICU Stay	25 (41)			
Infant Days in NICU		4.46	.50	0-24

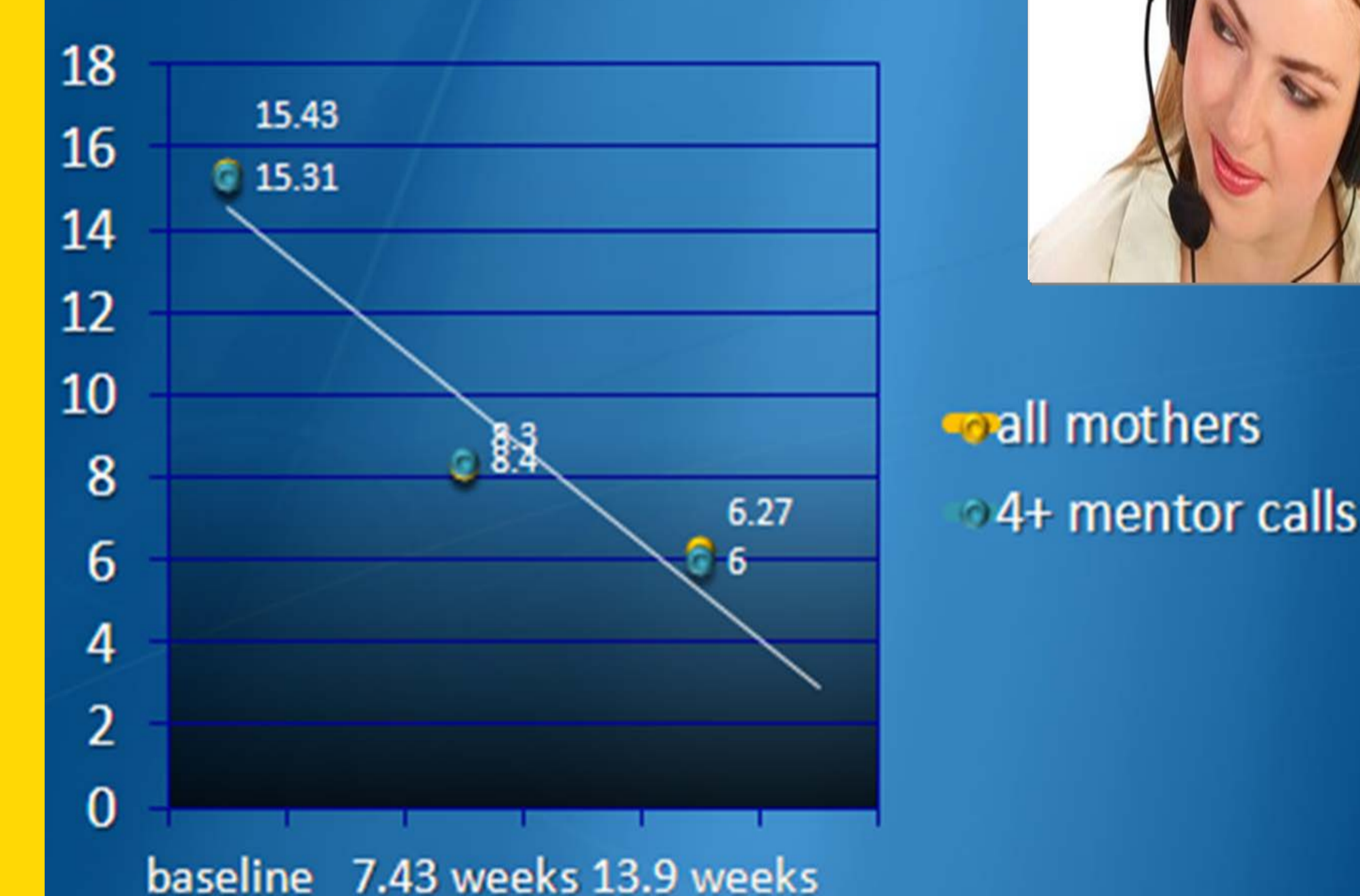
EPDS Depression Rates Outcome

	Depressed	Not Depressed	% depressed	total
baseline	64	0	100%	64
7.43 weeks	3	34	8.1	37
13.9 weeks	4	30	11.8	34
Intention to treat	23	30	44.23	52*

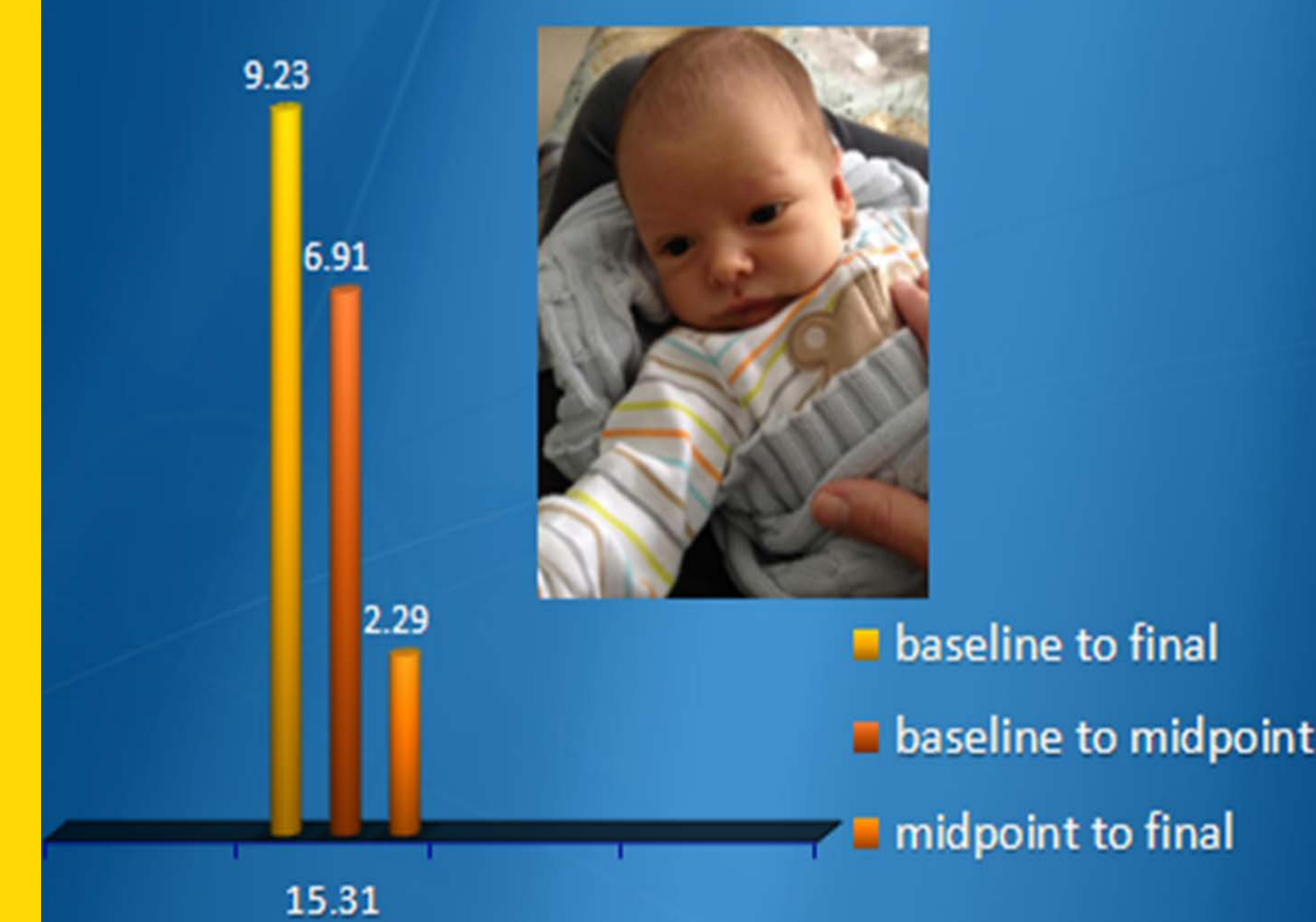
+ with EPDS ≥ 12 at baseline

* All assigned a mentor

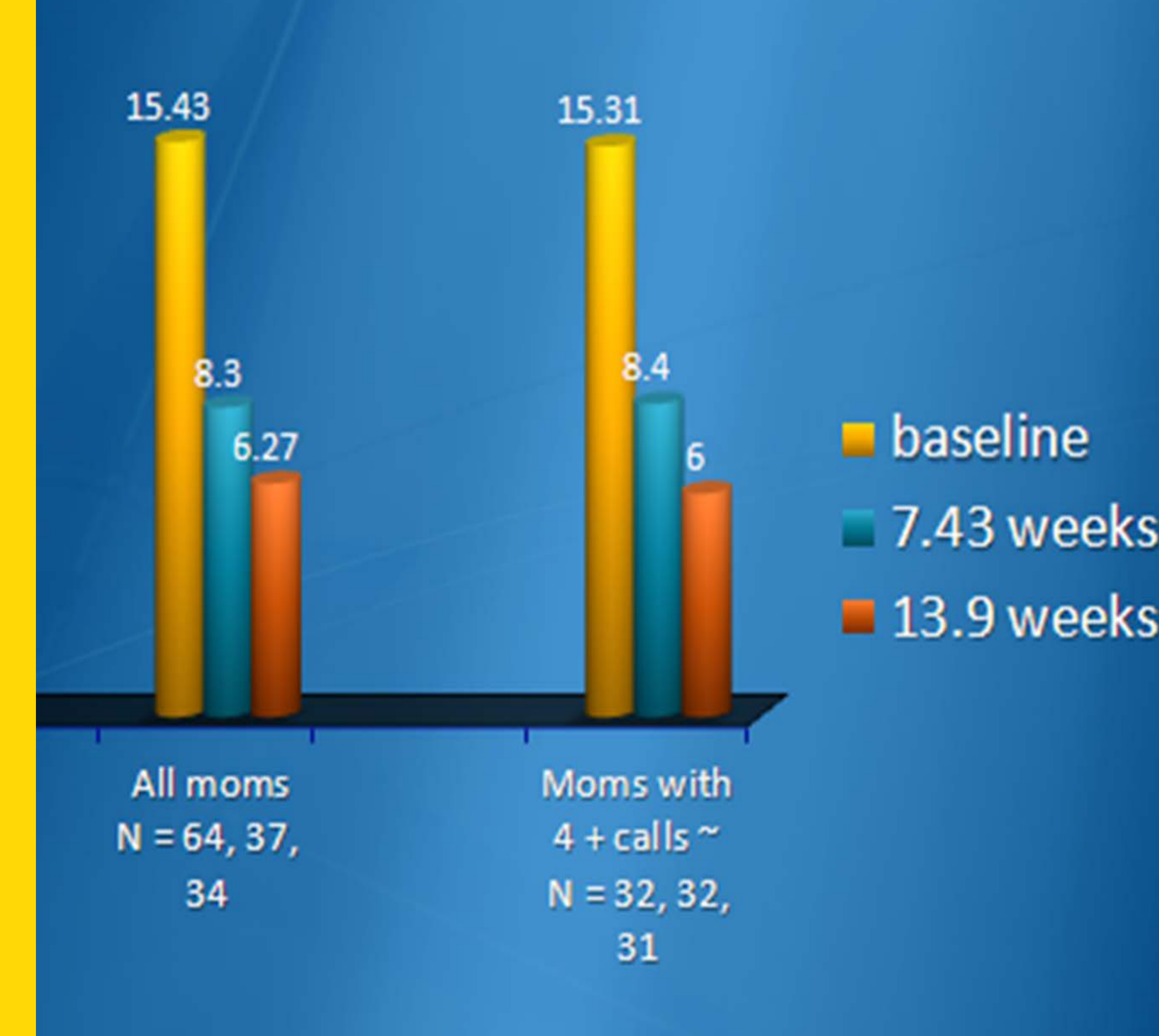
EPDS Change Over Time



EPDS Score 'Decreases' Over Time Periods (p values $<.009$)



EPDS Change Over Time



Conclusions

Main Findings:

- Tele-support intervention decreased PPD
- Findings validate previously reported benefits of TBPS for mothers with mild to moderate PPD (Dennis 2009), now in the real world setting
- Validated findings about satisfaction of mentors (Leger 2014)

Study Limitations:

- Small sample
- Attrition

Recommendations

Peer Tele-Support Intervention:

- Length of support responsive to EPDS score and mother's needs
- Closer monitoring of EPDS during intervention
- Use of EPDS 10 cut-off point to demonstrate effectiveness

Implement Systematic Screening for PPD:

- During the entire perinatal period
- Online or email EPDS monitoring
- Special attention to high risk groups

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