ABORIGINAL AND TORRES STRAIT ISLANDER PERINATAL MENTAL HEALTH MAPPING PROJECT

A scoping of current practice surrounding the screening, assessment and management of perinatal mental health across Australia's New Directions: Mothers and Baby Service Program.

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CONTENTS

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1. EXECUTIVE SUMMARY

A review of the social determinants of health for Aboriginal and Torres Strait Islander people highlights the high presence of risk factors that contribute to the increased likelihood of this population experiencing health and emotional and mental health conditions across the lifespan. This is also particularly with respect to the perinatal period, whereby Aboriginal and Torres Strait Islander women are perceived and known to be at much greater risk of developing emotional and mental health problems. In turn this has long term and widespread impacts on the women, their families, health services and the community.

It is in response to the acknowledged risk and impact of perinatal mental health in the population broadly that

Australia has become a world leader in this area, through taking a proactive prevention and intervention approach to perinatal mental health. Under Australia's National Perinatal Depression Initiative (NPDI, 2008-2013), clinical practice guidelines have been developed to inform practice, particularly with respect to the implementation of routine screening and provision of best practice care across the public sector.

Whilst there have been significant developments under the NPDI in the public sector of the *general population*, less is known about its application for the Aboriginal and Torres Strait Islander population *specifically*. In response, this Mapping Project sought to scope the degree to which screening and assessment is being undertaken across New Directions Mothers and Babies Services, and in particular

identify the barriers and enablers to the provision of screening, assessment and the provision of culturally appropriate care across New Directions Services nationally.

To achieve this, the Project undertook qualitative consultations to derive insight and understanding into health professionals' awareness, knowledge, attitudes and current practice with respect to screening, assessment and referral of Aboriginal and Torres Strait Islander women. Following, these results were quantified across all New Directions Services nationally, through an online survey.

Results derived from the qualitative (n=27 interviews) and quantitative (response rate 84%) stages of the Project, reveal that health professionals are *well aware* of the higher risk of perinatal mental health amongst Aboriginal and Torres Strait Islander women and place *high importance* on this issue. This is seen to *translate into practice* with the *majority* of healthcare workers currently assessing women to detect the presence of risk factors and mental health conditions as part of care *most of the time*. Although this could possibly be further improved with additional resources (time and staff), the majority of health professionals indicate that they are confident in their ability to undertake screening, assessment and referral practices with most employing a standardised approach.

This standardised approach also extends to the use of the Edinburgh Postnatal Depression Scale (EPDS) as recommended in the Clinical Practice Guidelines for the general population. Whilst the qualitative stage of the project highlighted some strong views surrounding the cultural inappropriateness of the scale, these views were more neutral across the broader sample. As a result, a significant proportion of health professionals indicated that they are currently using the EPDS in its original (57%) or adapted form (20%) some or most of the time. Furthermore, those health professionals currently using the EPDS (in original or adapted form) were more confident in their ability to identify perinatal mental health conditions when compared with health professionals using 'other' tools. Whilst some views surrounding the tool's perceived appropriateness may be limiting the tool's broader use, it is within the context of women being highly at risk, that its use (for most health professionals) is considered warranted. This provides valuable infrastructure on which to build upon.

When investigating the potential barriers and enablers to screening and assessment, interestingly the most frequently identified issues were *fear*, *trust* and *stigma*. In turn, these barriers are perceived by health professionals to be impacting on disclosure and ultimately the effectiveness of screening and assessment practices. These issues, together with the perceived *unavailability of culturally appropriate referral services* were also perceived by almost all health professionals to be preventing post-screening referrals being acted upon by women. This is being further impeded by current poor communication between services – another major barrier to effective referral practices. Further, in some cases more logistical issues such as transport were also commonly identified barriers to screening and referral practice.

When it comes to *reporting*, most services are employing procedures to collect and report screening and assessment data, however this involves a variety of approaches within and across settings. Further, whilst most services use the data for reporting purposes, the nature of the information being recorded is unlikely to be consistent, and could be streamlined and improved.

When exploring possible enablers to assessment, screening and referral practices, almost all health professionals indicated that the provision of culturally appropriate information resources for i) perinatal women and their families and ii) health professionals (e.g. assessment guides, guidelines) would be highly beneficial to increase their confidence. These enablers to practice rated even more highly than training. Whilst such materials have been developed under the National Perinatal Depression Initiative for the general population, the research and development of resources reflecting best practice for Aboriginal and Torres Strait Islander women is less established, hence further research and development in this area is required.

In response to these findings it is recommended that the Department build upon the *significant infrastructure* that already exists to further *increase the confidence* of health professionals to engage in screening practices and address the current divergence of views surrounding the most appropriate approaches to assessing and addressing perinatal mental health issues in this population. This could involve a number of strategies.

It is recommended that a qualitative approach is undertaken with Aboriginal and Torres Strait Islander women who are (or have recently been) in the perinatal period themselves. In particular this work should seek to understand Aboriginal and Torres Strait Islander women's *experience* of emotional health and wellbeing, including the *language* used to describe their *perceptions* and *symptoms* within their cultural context. A major focus of this work also needs to be on the issue of *stigma*, *shame* and *fear* – and how this impacts upon accessing maternity and postnatal care, screening and the observed reluctance to take up referrals. As with this Project, the sample would need to include women from across a range of settings to ensure recognition and inclusion of localised perspectives and experiences.

Gaining such insights would inform *what* and *how* resources could be appropriately developed in a culturally safe and sensitive way. The information could assist to educate and support these women, address their fears and concerns (that they may not express to health professionals) *provide assurance* and *increase their confidence* to engage and benefit from practices currently being provided through New Directions Services.

This work could also provide a valuable approach to further exploring and understanding Aboriginal and Torres Strait Islander women's *perceptions* and *experience of the EPDS* – including the scale's perceived acceptability (as found for non-Aboriginal women). This could include identifying the *specific concerns* surrounding disclosure and an understanding of how providing women with a rationale for completing the EPDS could alleviate concerns and encourage disclosure.

The way in which the EPDS is administered could also be explored. Currently most services ask questions directly to the women from the EPDS or a prompt sheet. Such an approach may in fact be confronting, and thus contribute to the reported fear and apprehension surrounding disclosure. Alternatively other approaches (such as completing the questionnaire electronically and in private) may be preferable for these women and should be explored with respect to optimising screening practices. Further, given the high proportion of young women in the perinatal period, the way in which information is provided to them (e.g. hard copy resources versus electronic) could also be investigated. Here for example, if screening was to be undertaken electronically, there is the potential to provide women with tailored specific information relative to their individual score, as opposed to generic information that may be overwhelming and not considered relevant to them.

The above information from consultations with women could also be used to *educate health professionals about the consumer perspectives* and *needs* (which they may not be truly aware of, due to current fears surrounding disclosure). Insights gained could also inform the development of culturally appropriate resources for health professionals – as desired by health professionals to increase their confidence.

As for perinatal women, the use of electronic screening approaches could also be of great benefit to the health professionals, by reducing their resource constraints (particularly time and staffing), as well as providing guided prompts to further increase their confidence surrounding management practices. This approach would also be highly beneficial in the recording of streamlined data, and assist to improve communication between services, which is essential given the poor uptake of referrals currently.

The current project also provides valuable baseline data together with a highly useful evaluation framework from which to monitor progress over time. The above quantitative methodology particularly could be replicated in time, to monitor and measure the impacts of any implemented recommendations or further research and development with respect to addressing perinatal emotional and mental health for Aboriginal and Torres Strait Islander women. Further, in the absence of any formal evaluation of the NPDI more broadly, the application of the approaches used to undertake this Mapping Project could also be replicated in the broader perinatal context. This would ultimately inform progress to date under the NPDI to date (which remains unestablished), identify barriers and enablers to the provision of best practice, whilst again providing baseline data from which progress could be measure over time. Ultimately this would also provide the Commonwealth with comprehensive, comparative measures across jurisdictions and funding streams.

In conclusion, the recommendations reflect the needs of health care workers to be more informed and better supported in the provision of culturally safe, sensitive and appropriate care. Ultimately, the implementation of the recommendations outlined in this report provide a mechanism to facilitate the further integration and evaluation of the NPDI Framework and clinical practice guidelines into standard practice for Aboriginal and Torres Strait Islander women. Taking this one step further, the inclusion of innovative approaches to screening, information provision, data collection and possible communication of referral information, stand to address many of the barriers identified in this Project – as well as address many of the gaps identified under the NPDI more broadly.

2. INTRODUCTION

The diversity and uniqueness of Aboriginal and Torres Strait Islander people's culture, knowledge and capabilities are acknowledged from the outset of this report. The Project team members are not Indigenous and have taken every effort to consider and analyse the information provided by healthcare workers relating to the Project objectives, in terms of the health and wellbeing needs, issues and contexts of Aboriginal and Torres Strait Islander women and their families.

Whilst literature abounds on the state of Aboriginal and Torres Strait Islander health overall, and a growing body of research around perinatal mental health exists, there is little that specifically addresses *Aboriginal women's perinatal mental health* and the care related to this specifically. This report contributes to the area and makes recommendations to improve perinatal mental health care and outcomes for Aboriginal and Torres Strait Islander women. The report also sheds light on the degree to which the National Perinatal Depression Guidelines[1] are currently being integrated into Aboriginal community controlled health organisations and primary care settings.

The dimensions of perinatal care reported as being presently delivered across New Directions Mothers and Babies Services, incorporate the context of Aboriginal and Torres Strait Islander culture and are described in some detail in the report. It follows, therefore, that the conclusions and recommendations outlined in this report aim to ensure that quality perinatal care for Aboriginal and Torres Strait Islander women needs to consider the range of dimensions reflective of the diversity and uniqueness of Aboriginal and Torres Strait Islander women, as this may vary between the women depending on age, location and specific circumstances.

A strong knowledge of local communities and relationships of respect and trust between care providers and women was identified as an essential element of provision of quality perinatal care by many clinicians. Equally important was that staff providing antenatal services possess an understanding of the cultural context, the concept of shame and its cultural complexity and its impact on young Aboriginal women.

There was a strong indication that the health services participating in the project were aiming to provide perinatal care to Aboriginal and Torres Strait Islander women within

frameworks incorporating philosophies for practice that emphasise partnership, respect and trust; consideration for cultural security, access and transport; child and family involvement; sensitive staff inclusive of sufficient appropriate Aboriginal health workers and continuity of care wherever possible. While the Project did not seek to directly assess these elements, it is worth noting that the commitment to provision of high quality care was evident, particularly in the qualitative consultations, and supported in the comments sections of the quantitative survey.

In making recommendations, we acknowledge that while a national standardised approach to perinatal care brings certain benefits, there are multiple issues and dynamics within and between Aboriginal women and their communities, which mean that what may work well in one area may not work well in another. In light of this, the recommendations highlight the need for a national approach to consult and consider the collective views across this population. Further, there is the opportunity to strengthen existing practice to ensure that perinatal mental health conditions are understood, appropriate screening is undertaken and referral pathways are accessible and culturally appropriate.

All recommendations in this report are premised on a commitment to cultural safety as an essential component of any mental health intervention with Aboriginal and Torres Strait Islander peoples.[2]

3. BACKGROUND

Health for Aboriginal and Torres Strait Islander people

An understanding of Aboriginal and Torres Strait Islander health and cultural contexts, and their inter-relationships with each other, is essential in any consideration of meeting the health needs of Aboriginal and Torres Strait Islander peoples. In the Aboriginal and Torres Strait Islander context, health is complex and multi-faceted, including the physical health of individuals, social and emotional health, and the well-being of whole communities. This holistic definition of health incorporates broader issues of social justice, well-being and equity as key attributes of health for Aboriginal peoples and is consistent with the World Health Organisation Alma Ata Declaration:[3]

Health... is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity... [it] is a fundamental human right.

It is also reflected locally in the definition of health contained within Australia's National Aboriginal Health Strategy (1989):[4]

"'Aboriginal health' means not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole Community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total wellbeing of their Community. It is a whole-of life view and includes the cyclical concept of life-death-life."

In undertaking this Project, it is acknowledged that Aboriginal health is determined by a complex interplay of historical, social, economic and political contexts. There is no denying the impact that poor socioeconomic conditions and colonisation have had on Indigenous peoples and the intergenerational effects of these factors which will continue to affect future generations.

The centrality of culture and wellbeing in the health of Aboriginal and Torres Strait Islander people

There is a wealth of evidence that supports the positive associations of health, education and employment outcomes as well as general wellbeing with language and culture.[5] Culture can influence Aboriginal and Torres Strait Islander people's decisions about when and why they should seek health services, their acceptance of treatment, likelihood of adherence to treatment and follow up, and the likely success of prevention and health promotion strategies. Ensuring that health services and providers are culturally competent will lead to more effective health service delivery and better health outcomes.[6]

Cultural safety

Cultural safety as a means of providing appropriate engagement with Indigenous people is an approach that respects, supports and empowers the cultural identity and well-being of individuals from differing cultural groups within society.[7][8] Qualitative methodologies that focus on psycho-socio-cultural factors with an openness and respect for the participants' perspective, are considered especially suitable for exploring issues associated with improving outcomes in Indigenous health[9][10] and are reflected in this Project methodology to provide opportunity for Aboriginal and Torres Strait Islander peoples' participation in a culturally sensitive way and to derive in-depth understanding of issues as identified by the population.

As mentioned in the Introduction, the emphasis on culturally safe practice with Aboriginal and Torres Strait Islander people is particularly important in the context of perceived deficiencies or shortcomings in medical practice in Aboriginal communities. This includes, of note, miscommunication that is considered pervasive. In contrast, positive experiences of people receiving health care are likely to translate into better engagement with services, and ultimately into better health outcomes for Aboriginal women and children.[11]

A further important note regarding culture in the Aboriginal and Torres Strait Islander context, relates to the need for it to be differentiated from the excessive risk behaviours present across the population, which can have a detrimental effect on the health and wellbeing of people, their families and communities.[6] These risk behaviours, Including excessive alcohol, substance abuse and family violence have no basis in Aboriginal and Torres Strait Islander cultures and relate to the history of colonisation and dispossession of land. Indeed it is the restoration and continuation of cultures that have been identified as providing both the reason for change, and the pathway for securing it.[6] Similarly, intergenerational trauma is likely to contribute to behavior and, in turn, health status, further reinforcing the importance of cultural regeneration and restoration.

Determinants of health

Many of the unique risks faced by Aboriginal and Torres Strait Islander people have persisted across generations. This reflects the fact that the health and wellbeing of Aboriginal people has been profoundly shaped by the circumstances of the past, and most particularly by the events and conditions in Australia since colonisation. The enduring legacy of colonisation on Aboriginal life has been pervasive and affected multiple generations and extends to all dimensions of the holistic notion of Aboriginal wellbeing, including psychological, social, spiritual and cultural aspects of life and connection to land. This has resulted in serious additional risks to wellbeing, including: unresolved grief and loss;

trauma and abuse; violence; removal from family; substance misuse; family breakdown; cultural dislocation; racism and discrimination; exclusion and segregation; loss of control of life; and social disadvantage.[12]

The origins of health behaviours are located in a complex range of environmental, social, economic, family and community factors leading to social determinants potentially affecting health outcomes both directly and indirectly. Avoidable health inequalities arise because of the circumstances in which people grow, live, work and age, as well as the systems put in place to deal with illness. Between one third and one half of the health gap may be explained by differences in the social determinants of health.[13] Similarly, up to one-third of the difference in life expectancy could be attributed to differences in income, school education, employment status and overcrowded housing.[14] [15] These factors affect the health of people and can also influence how a person interacts with health and other services.

Some researchers have attributed about two-thirds of the Indigenous–non-Indigenous health gap to chronic diseases such as cardiovascular disease, diabetes, mental disorders and chronic lung disease.[15] Indeed, half of the gap in health between Indigenous and non-Indigenous Australians is linked to eleven risk factors such as smoking, obesity, physical inactivity, high cholesterol and alcohol.[15] Risk factors are also closely linked to social and economic determinants of health as these determinants can also affect people's health by influencing their behaviours and decisions.

Many Aboriginal people face a set of interrelated risks to their social and emotional wellbeing.[16] While single risk factors—such as particular negative life events—might have a minimal effect on their own, when combined they can have a strong interactive effect, and exposure to multiple risk factors over time can have a cumulative effect.[17]

Grief, loss and trauma have perhaps had the most profound impact on the wellbeing of Aboriginal people and the implications of this in the perinatal context is discussed further in Chapter 9. National data illustrate that, in the twelve months to 2008, forty per cent of Aboriginal adults had lost a family member or friend (compared with 19 per cent in the non-Aboriginal population),[18] reflecting the substantially higher death rates among Aboriginal populations.[19]

In addition, high numbers of Aboriginal and Torres Strait Islander people have experienced some form of racism, which is not surprising given that a range of studies highlight the widespread nature of systemic racism in domains such as national politics, media, education, employment, the welfare system and in the criminal justice systems.[20] Such experiences of racism have profound effects on health, mental health and social and emotional wellbeing, for individuals, families and communities.[21]

Current State of Aboriginal and Torres Strait Islander Health

Given the prevalence of risk factors, not surprisingly, Indigenous Australians currently experience more illness, disability and injury than other Australians. They also have a shorter life expectancy than other Australians. The overall poorer health status of Aboriginal and Torres Strait Islander women is demonstrated by the estimated life expectancy at birth of an Aboriginal woman (73.7 years) being ten years less than that of a non-Aboriginal woman (83.1 years).[21] For males this gap is even greater at around 10.5 years.[22]

The heart attack rate for Indigenous people in 2011 was two and a half times higher than the rate for other Australians. Similarly, the rate for lung cancer was nearly double that of other Australians, and the rate of high or very high psychological distress, in 2011–13, was 2.7 times higher for Indigenous people than for non-Indigenous people.[22]

In addition, the Indigenous adult smoking rate in 2011–13 was 41.1%, which was more than double the non-Indigenous rate. In contrast, there was no significant difference between rates of adults at risk of long term harm from alcohol between Aboriginal and Torres Strait Islanders and the remainder of the population.[23]

Studies show that life expectancy and health are poorer in remote areas than in metropolitan or regional areas.[23] The relationship of remoteness to health is particularly important for Indigenous Australians, as they are more likely to live outside metropolitan areas than non-Indigenous Australians. In 2011, just over one third of Indigenous Australians lived in major cities (34.8%), compared with over 70% of non-Indigenous Australians. Only 1.7% of non-Indigenous Australians lived in 'remote' or 'very remote' areas, compared with about one-fifth of Indigenous Australians (7.7% in 'remote' and 13.7% in 'very remote' areas). Given the high proportion of Aboriginal and Torres Strait Islander people living remotely, this is a significant consideration due to the strong association between socioeconomic status and health – the lower someone's socioeconomic status, the worse their health is likely to be.[22]

Aboriginal and Torres Strait Islander women
Aboriginal and Torres Strait Islander women have considerably poorer general health, educational attainment and employment outcomes than other Australian women, continuing to endure widespread and disproportionate disadvantage compared to non-Indigenous Australians.[24] This remains true despite recent gains in Aboriginal women's health. Poor economic status is a central issue and influences access to quality education, appropriate health care and the many other services enjoyed by the majority of Australians.[25]

As discussed earlier, some of the contributing factors to the overall poor health status of Aboriginal women relate to non-health factors as in the social determinants. Educationally for example, the retention rate from Year 7-12 for Aboriginal girls is only 50.4% compared to 84.5% for non-Aboriginal girls.[26] Similarly, socioeconomic factors impact, with less than half (43%) of Aboriginal women being employed compared to over two-thirds (69%) of non-Aboriginal women.[27] This impacts on financial security, particularly given the fact that forty-two percent of Aboriginal children 0-14 years are raised in single-parent families (mostly mothers).[28]

There are a number of important stages in all of our lives, which are known to impact on health and wellbeing. So too, it is known that life events occurring in younger years often have a bearing on health over a lifetime. These life stages also provide significant and *strategic points of intersection* between health and mental health and social and emotional wellbeing.

Pregnancy and the start of life for a new child is one such stage. There is a significant body of evidence that shows that the experience of the child before, during and after birth, and into early childhood has a significant impact on health throughout life. The health and wellbeing of the mother during and after pregnancy is also important for the child's immediate and long-term outcomes. While the Indigenous infant mortality rate has improved significantly in the last 20 years, babies born to Indigenous mothers are more likely to be underweight than babies born to non-Indigenous mothers.[22] Low birth weight is linked to smoking during pregnancy and premature births, and is more likely to lead to illnesses throughout childhood and into adulthood, as well as lower achievement and other difficulties in school, and social problems.[29]

Not surprisingly, Indigenous women also have *poorer reproductive and maternal health* than other Australian women with consistent reporting of higher maternal and perinatal morbidity and mortality rates for Indigenous Australians: maternal mortality (5.3 times greater)[30]; low birth weight infants (12.3% vs. 5.9%); preterm births (13.3% vs. 8.0%); perinatal deaths (17.3 vs. 9.7 per 1,000)[31] and infant mortality rate (9.6 vs. 4.3 per 1,000).[32] Higher rates of chronic disease, poorer nutrition, and higher levels of genital and urinary tract infections can all complicate pregnancies.

Aboriginal and Torres Strait Islander women are also *less likely to access early antenatal care.* In the Northern Territory, for example, the proportion of Indigenous women who received antenatal care in the first trimester of their pregnancy was around half of that for non-Indigenous women.[33] An important contributor to population health is the availability and accessibility of health services. For example, high quality primary health care services are essential for preventive care and screening, managing acute and chronic illnesses, and providing a link to specialist services. A lack of access to primary health care services in areas with geographically dispersed populations (such as 'remote' and 'very remote' areas) may therefore affect the overall health and wellbeing of the populations living in those areas.[22]

Furthermore, they have *higher smoking rates* and, while it appears that proportionately fewer Aboriginal and Torres Strait Islander women than other non-Aboriginal women drink alcohol, the *hazardous use of alcohol* amongst Aboriginal women of child-bearing age is of great concern.[34] Nationally for Aboriginal and Torres Strait Islander children aged 0–3 years for whom data were collected in 2008, 42% of mothers reported that they had smoked tobacco during pregnancy.[35]

One of a number of factors that have been identified as contributing to poor outcomes for Aboriginal women in the perinatal period is the *quality of maternity care provided.*[31]

Aboriginal and Torres Strait Islander women and their families experience many of the same psychosocial risk factors as non-Aboriginal families. However, these risk factors are overrepresented in Aboriginal and Torres Strait Islander populations. For many Aboriginal and Torres Strait Islander women and families, multiple and complex life stressors exist that impact on their health and wellbeing.

Aboriginal and Torres Strait Islander mental health
Additionally, there are extensive *mental health problems* in Aboriginal and Torres Strait Islander communities than the broader population, with high rates of depression and anxiety, trauma and grief, self-harm and suicide and domestic violence.[36] [37]Despite these statistics, Aboriginal and Torres Strait Islander people are *less likely to engage* with mental health services, due in large part to the potential for culturally inappropriate services that fail to embrace Aboriginal concepts of health and wellbeing.[38]

Experts caution that any diagnosis of mental illness affecting an Aboriginal and Torres Strait Islander person should be conducted by expert clinicians within a culturally safe context wherever possible.[39] This allows for a more accurate assessment of the person being reviewed, with recognition of culturally relevant issues, in addition to the recognised availability of adjunctive therapeutic supports, such as social and emotional wellbeing counsellors, to assist the person, if appropriate.

Increasing complexity of defining mental illness in Aboriginal and Torres Strait Islander peoples has been noted by researchers.[40] Similarly, an increasing coincidence of mental disorders associated with harmful substance use and the problem that this leads to in diagnostic systems where the two entities are often separate has been observed. Changing patterns of mental health problems including

mental health disorders may not be surprising, given that Indigenous societies have undergone rapid social change and the social context in which these disorders arise has changed.[41]

In relation to this is the particular importance of an appropriate review of contextual data and the familiarity of the interview setting in engaging Aboriginal and Torres Strait Islander peoples in any assessment and therapeutic process for mental health issues.[41]

Similarly, the involvement of family, along with Aboriginal and Torres Strait Islander Mental Health professionals in assessments of Aboriginal and Torres Strait Islander clients, is an important component of culturally safe practice and the reliability of information thus obtained.[42]

Whilst admission to hospital of Aboriginal and Torres Strait Islander people with severe mood and neurotic disorders is only slightly higher than the non-Aboriginal population, recent community surveys have shown high levels of psychological distress (anxiety and depression) amongst Aboriginal and Torres Strait Islander peoples, with a rate of 50 per cent of respondents to the survey being three times higher (overall rates 20.2%–26.6%) compared with other Australians.[43] [44]

Forty-four percent of Aboriginal and Torres Strait Islander respondents surveyed by the Australian Bureau of Statistics reported at least three life stressors in the previous 12 months, and 12 per cent of respondents reported experiencing at least seven life stressors that included the death of a family member or close friend, serious illness or disability, inability to get work, overcrowding at home, and alcohol and drug-related problems.[45]

Social and Emotional Wellbeing

As mentioned previously, health for Aboriginal and Torres Strait Islander peoples is a very holistic concept and incorporates social and emotional wellbeing.[46] [47] The role of spirituality and the relationship with family, land and culture are intertwined and play a significant part in Aboriginal and Torres Strait Islander social and emotional wellbeing. Literature suggests that the development of social and emotional wellbeing is shaped by a small set of mechanisms. These mechanisms either prompt, facilitate or constrain the development of skills, capabilities and strengths in early life, and can have a lasting impact on all facets of life.

Given the high proportion of young women who are mothers, the development of social and emotional wellbeing in youth is of particular interest to the Project. The three major prompts of optimal social and emotional wellbeing are biology, expectations and opportunities.[48] The three major facilitators of optimal wellbeing in young people are intellectual flexibility coupled with an outgoing, easy temperament; good language development; and emotional support, especially in the face of challenge.[49]

The four main constraints on optimal wellbeing in young people are stress that accumulates and overwhelms, chaos, social exclusion (including racism), and social inequality.[49] While it is accepted that the underlying factors influencing development of social and emotional wellbeing are similar for Aboriginal and non-Aboriginal people, the scale of the problems (constraints) are generally much larger for Aboriginal peoples. In addition, many of the factors that support development in early life are either missing in the lives of Aboriginal children or are too limited to produce sustainable benefits and opportunities in later life.[49] As a result, too many young Aboriginal people find themselves in a situation where they are overwhelmed by the stresses of everyday life and unable to cope effectively – and this typically leads to high levels of mental health problems,[50] including psychological distress.[51]

Resilience

There are unique aspects of Aboriginal and Torres Strait Islander culture that can have a significant positive influence on Aboriginal and Torres Strait Islander health and wellbeing. Connection to land, spirituality and ancestry, kinship networks, and cultural continuity are commonly identified by Aboriginal people as important health protecting factors. These are said to serve as sources of resilience and as a unique reservoir of strength and recovery when faced with adversity, and can compensate for, and mitigate against, the impact of stressful circumstances on the social and emotional wellbeing of individuals, families and communities.[49] [52]

Additionally, the wellbeing of individuals, families and communities are shaped by their connections to body, mind and emotions, spirituality, ancestry and broader, inter-related notions of culture and cultural heritage.

While there is significant focus on the behaviour of the individual, initiatives to date have failed to fully consider the impact that social and emotional well-being has on perinatal outcomes. Indeed, there is little evidence in the literature about the role of social stressors and mental health among indigenous women.[53] There is a recognised need for an approach to both research and clinical practice that acknowledges the Aboriginal view of health that encompasses mental, physical, cultural and spiritual health.[54] With a greater understanding of *how* social and emotional well-being is experienced by Aboriginal women, it is likely that meaningful improvements will be seen, and thus is incorporated into the recommendations of this report.

Aboriginal and Torres Strait Islander mothers

Aboriginal and Torres Strait Islander women tend to have children at a younger age than the overall female population, with more than one in five Aboriginal and Torres Strait Islander mothers being aged under 20 years, compared with less than one in twenty-five for other mothers (22.6% of births, compared to 4.2% for 'other' mothers).[55]

In 2011, Aboriginal and Torres Strait Islander teenagers had one-fifth (19%) of the babies born to Indigenous women, compared with only 3.8% of those born to all mothers.[56] In Australia, Aboriginal and Torres Strait Islander women have 2.57 children per woman compared to 1.9 in the general population.[56]

Figure 3.1: Maternal age of Aboriginal & Torres Strait Islander & 'other' mothers (2001-2004)[67]
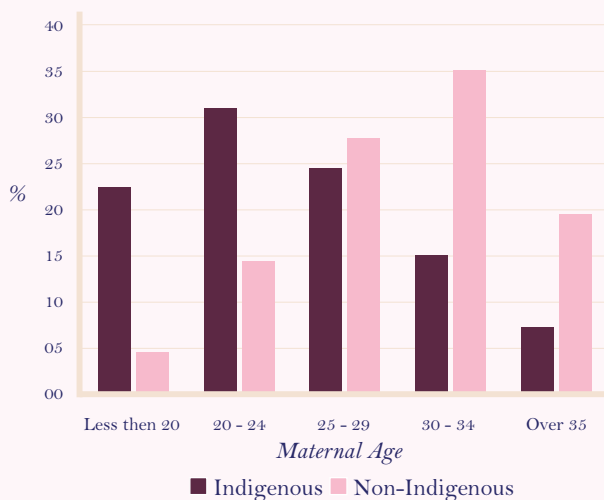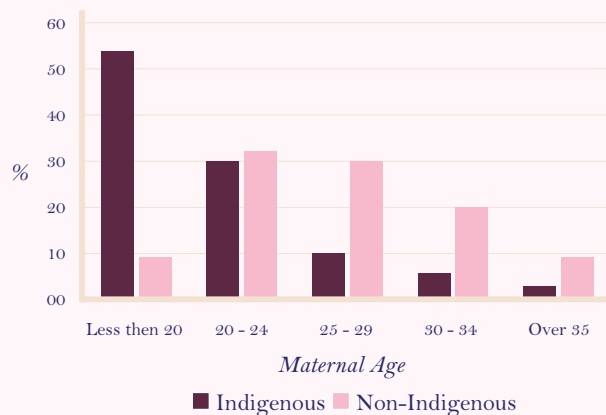

Source: AIHW NPSU National Perinatal Data Collection 2007.

The average age of first-time Aboriginal and Torres Strait Islander mothers was 21.5, which was markedly lower than for first-time non-Aboriginal and Torres Strait mothers (28.6).[32]

Significantly, over *half* of these mothers were aged *less than 20 years* (53%). Nine percent of multiparous Aboriginal and Torres Strait Islander mothers were also in this age group. This has major implications for service delivery and the implication of this will be considered in light of the outcomes of this Project.

Figure 3.2: Primiparous and multiparous Indigenous mothers by maternal age, 2001–2004 (%)[56]

Source: AIHW NPSU National Perinatal Data Collection 2007.

Challenges of youth

Having an understanding of the unique challenges of adolescence provides an opportunity to appreciate the potential for extra pressures and challenges faced by a young mother, her infant, partner and family. If a support system is not readily available, parental or child mental health and social and emotional wellbeing are a concern. For many young people, social opportunities for 'time out' or for 'time to be young' are scant, and there are added stressors imposed on a young family that may impact on perinatal mental health.[57]

Also noted in a qualitative study designed to explore what Aboriginal women in Central Australia perceived good antenatal care to be was the high incidence of shame described by young women regarding their pregnancy.[58] For these young women shame entailed becoming pregnant at

a young age; being disapproved of by family; being embarrassed by personal questions from members of the community about the father of the child and the pregnancy itself; feeling embarrassed at physical changes to their body; and fearing the anger or violence of the fathers or relatives. Participants considered that it was likely that other young women would feel similar feelings of shame regarding their pregnancy for similar reasons.[58]

Feeling shame was an explanation for not telling anyone about the pregnancy, not seeking assistance or help from family members and for not attending a health service early in the pregnancy.[58] It is known that around 97% of Aboriginal and Torres Strait Islander mothers' access antenatal services at least once during their pregnancy, but access is usually later and less frequent than other mothers.[58]

Box 3.1: Aboriginal and Torres Strait Islander women – pregnancy and birth

PREGNANCY & BIRTH FOR ABORIGINAL AND TORRES STRAIT ISLANDER WOMEN – WHAT WE KNOW

Aboriginal and Torres Strait Islander women:
- **Have a higher birth rate compared with all women in Australia (2.6 babies compared to 1.9);**
- **Are more likely to have children at a younger age (52 per cent of the Aboriginal women giving birth in 2010 were aged less than 25 years, and 20 per cent were less than 20 years, compared with 16 per cent and 3 per cent, respectively, for the broader community) [AIHW, 2012];**
- **Over 80% of first births to Aboriginal women are to mothers aged 24 years or younger**
- **Remain twice as likely to die in childbirth as non-Aboriginal mothers, and**
- **Are significantly more likely to experience pregnancy complications and stressful life events and social problems during pregnancy, such as the death of a family member, housing problems, and family violence [Brown, 2011];**
- **Are more likely to smoke during pregnancy (50% prevalence rate), which is almost four times the rate of other Australian mothers; and**
- **Are more likely to have babies of low birth weight.**

Perinatal mental health

The World Health Organisation predicts that by the year 2020, unipolar major depression will be the second greatest cause of disability; however, it is already the number one cause of disability in women of childbearing age worldwide.[59]

Given the high rates of social disadvantage affecting Aboriginal and Torres Strait Islander mothers, along with additional factors such as being a member of the Stolen Generation and having much higher numbers of children in out-of-home care,[60] it would be considered that the potential for postpartum depression in Aboriginal and Torres Strait Islander women would be greater. A recent survey of 25,455 women in South Western Sydney did not reveal a greater prevalence of postnatal depression in the very small component number (481) of Aboriginal and Torres Strait Islander women sampled. However, the survey did point to some significant health and social issues leading to an increased prevalence of postnatal depression that also commonly affect Aboriginal and Torres Strait Islander peoples. These included placement in public housing, difficult financial situation, single status, poor rating of own health and poor rating of their child's health.[61]

This is in contrast to the National Postnatal Depression Research Program[62] that involved the screening of over 40,000 women in Australia. Of these, 3.3% of the women were Aboriginal and Torres Strait Islander, representative of the national prevalence of 3.6% of Aboriginal and Torres Strait Islanders in the wider population. The study found that the strongest risk factor for depression was Indigenous ethnicity. Among the Indigenous women, 19% had antenatal depression versus 8.9% among non-Indigenous women, 12% had postnatal depression versus 7.6% in non-Indigenous women, and 6.3% had both antenatal and postpartum depression compared to 2.7% in non-Indigenous women.[62]

A study of 210 Aboriginal and Torres Strait Islander mothers in Queensland using an adapted, 'more culturally appropriate' form of the Edinburgh Postnatal Depression Rating Scale (EPDS) found higher rates of participants with 'at risk' issues (27.7 per cent) on the culturally adapted scale compared with 16.7 per cent identified with the normal scale.[63] The 'translations' of the EPDS demonstrated a high level of reliability, although there was a strong correlation between the 'translations' and the EPDS. This strong correlation suggests the potential applicability of the scale for the Aboriginal and Torres Strait Islander population, whilst the disparity could indicate the greater sensitivity and hence accuracy of the 'translated' version. As a result, the EPDS in its original form may be appropriate for this population, however the issues surrounding sensitivity may need to be addressed through consideration of lower cut-off schools than currently recommended for the general population.

Anxiety often co-occurs with depression. Anxiety often peaks in a person's mid-twenties, a time coincident with childbearing.[64] Women who experience prenatal anxiety are three times more likely to report severe postpartum depression symptoms compared to those without anxiety.[65]

Approximately ten per cent of pregnant women in the Australian population experience antenatal depression with at least one-in-six women experiencing postnatal depression,[66] yet despite this prevalence, postnatal anxiety and depression is frequently unrecognised and untreated in women in the general population.[67] [68]

Despite the known occurrence of perinatal depression and anxiety in the general Australian population, the extent of diagnosis and treatment in Aboriginal and Torres Strait Islander women remains unknown although it is increasingly described in Aboriginal women.[55] It is, however known that due to the cumulative cultural losses experienced by Australian indigenous women, there is a reduced buffer to psychosocial stressors during pregnancy.[69]

Additionally, there is increased risk of depression in young people, with young mothers (under the age of 20 years) reportedly up to three times more likely to experience postnatal depression than older mothers.[70]

Risk and protective factors

Findings of a recent study related to childbearing among Indigenous women with a focus on understanding the biological systems impinging people's lives, and the impact of existing inequities suggest that when women feel a sense of control over their lives, wellbeing is promoted and this is more effective than providing unsolicited advice about behaviours such as smoking, diet, and exercise.[71] The report states that reproductive risk, particularly among teenage mothers, reflects low socioeconomic status, inappropriate lifestyles and high levels of distress.

A range of parental risk factors, highlighting the different factors that impact on mothers and fathers in the first year after birth, has been identified as follows in Table 3.2.

Box 3.2: Psychosocial risk factors affecting parents of infants [57]

PSYCHOSOCIAL RISK FACTORS FOR PARENTS

- A lack of current practical or emotional supports;
- Poor quality of relationship with, or absence of, a partner;
- Domestic violence, past or present;
- Traumatic birth experience or unexpected birth outcome;
- Current major stressors or losses, such as bereavement, moving house or financial strain;

- Past history of depression and anxiety disorder or other psychiatric condition
- Depression in partner, either antenatally or in the early postnatal period;
- Difficult relationship with own parents;
- Poor social functioning;
- Unemployment; and
- Drug and/or alcohol misuse.

Conversely, protective factors for perinatal mental health and wellbeing and continuity of care for parents have also been identified and are as follows:[57]

Box 3.3: Psychosocial protective factors affecting parents of infants

PROTECTIVE FACTORS FOR PARENTS

- Cultural traditions, especially around the birthing process and perinatal period;
- Interconnectedness of cultural practices, spirituality, identity, family and community, connection to land/country;
- Strong family relationships and connections;
- Belief in traditional healing activities which assist the management of life stressors;

- Personal sense of wellbeing, satisfaction with life, and optimism;
- High degree of confidence in own parenting ability;
- Presence of social support systems;
- Access to appropriate support services;
- Economic security;
- Strong coping style, and problem-solving skills; and
- Adequate nutrition.

Cultural considerations

Consideration, from a cross-cultural perspective, that differences may exist in the experiences of mental disorders within Aboriginal and Torres Strait Islander contexts must be extended to perinatal stress and depression.[57] Similarly, consideration of the relevance of mainstream diagnostic criteria across cultures, where possible differences in symptom presentation exist (e.g. more physical symptoms), and causality (e.g. external forces arising from 'doing something wrong culturally'), are significant considerations when managing perinatal mental health.[72]

There have been questions raised about the suitability of the EPDS for Aboriginal and Torres Strait Islander women, partly due to the concern that the language used in the tool was easily misinterpreted by Aboriginal women, which reduced the usefulness of the measure.[63] Work on translation of the EPDS into Aboriginal languages has occurred in isolated instances, however more widespread application of adapted versions is yet to be reported.[63] Considering the diversity of Aboriginal and Torres Strait Islander languages and the small number of speakers, the translation of the EPDS into multiple languages is unrealistic.

Despite this, it is considered imperative that antenatal care services include screening for emotional wellbeing and psychosocial assessment during pregnancy for Aboriginal and Torres Strait Islander women and that appropriate follow up occurs when women are identified as being at risk of depression.[73] This is especially the case, given the higher rates of adverse pregnancy outcomes (i.e., low birth weight babies and maternal and perinatal mortality) and the higher risk of depression in the antenatal period among Aboriginal and Torres Strait Islander women.[74]

A range of ways that mental health clinicians, including Aboriginal mental health professionals can work with families has been identified. These include clarifying mutual goals; not forcing families to fit specific models to encompass the diversity of Aboriginal and Torres Strait Islander culture and social issues; acknowledging your own limitations as a therapist when working with Aboriginal and Torres Strait Islander families; working with the families as a team; pointing out family strengths; learning to respond to the family's intense feelings; encouraging family enrichment to fulfill their own needs in the context of care for the affected individual; providing information about the illness and therapies (including medications) required; providing practical advice (including information on community resources); encouraging family involvement in support and advocacy groups; acknowledging a diversity of beliefs; and making a personal commitment to the issues at hand.[75]

It therefore follows, that in reviewing the perceptions, screening practice, management and training issues for clinicians working with Aboriginal and Torres Strait Islander women in the perinatal period for this Project, it is important to note that any recommendations in this report are premised on the understanding that an appropriate clinical response to the large majority of Aboriginal and Torres Strait Islander peoples suffering from mental illness would involve a comprehensive appreciation of the cultural social and community context in which they live.[40 76]

Government's response to date

Government's response has been two-fold:

Response to the needs of Aboriginal and Torres Strait Islander Women

Improving mental health and social and emotional wellbeing are key goals of the National Indigenous Health Equality Targets.[77] In an effort to address some of the disparities noted above and reduce the gap in health outcomes between Indigenous and non-Indigenous Australians, the Council of Australian Governments has identified a number of strategic areas for action. Some that directly aim to improve

the mental health and social and emotional wellbeing of Aboriginal and Torres Strait Islander women include:[78]

- *Improved antenatal care provision,*
- *Reducing pregnancy-related alcohol and cigarette consumption,*
- *Reducing rates of low birth weight infants and*
- *Reducing teenage pregnancy and births, and*
- *Addressing the causes of maternal mortality and early childhood hospitalisations.*

In an attempt to improve poor pregnancy outcomes, health care providers have developed targeted antenatal programs that aim to address identified health behaviours that are known to contribute to poor health during pregnancy. While some areas of improvement have been noted in rates of engagement with health services, the rates of premature births and low birth weight babies continue to be significantly higher than in the non-Aboriginal population.[55]

National Perinatal Depression Initiative
Australia has become a world leader in perinatal mental health with significant advances made over the past decade (see Box 3.4), particularly with respect to the application of research into national mental health reform.

Identification of the high prevalence of depression in the perinatal period was followed by the development of a National Action Plan[79] and provided a blueprint for the translation of research into practice. This led to the development of the National Perinatal Depression Initiative (NPDI)[80] in 2008. The five-year Initiative represented a national approach to promotion, prevention, early intervention and treatment through the implementation of routine screening and services for those women at risk of, or experiencing perinatal mental health disorders. It is unclear, however, to what degree the NPDI has been integrated through Aboriginal community controlled health organisations and primary health care settings for Aboriginal and Torres Strait Islander women and their families.

Since Indigenous women overall experience a higher prevalence of depression as well as a higher birth rate, there is a need for better understanding of depression and other maternal mental health problems in this vulnerable population.[81]

Despite maternal and child health being identified as a priority area in key Aboriginal and Torres Strait Islander policy documents and previous recommendations that a national strategy is essential to help alleviate perinatal depression in Aboriginal and Torres Strait Islander women, there is little evidence to guide antenatal care planning for Aboriginal communities.[82] Indeed, national guidelines for Aboriginal women's maternity care informed by sound evidence-based practice in antenatal care have been reported as being much needed.[1]

The Project works toward addressing some of these identified gaps and aligns with the early childhood and family health themes of the National Aboriginal and Torres Strait Islander Health plan (NATSIHP) and the objectives of the National Perinatal Depression Initiative (NPDI). The Project will also contribute to maternal and child health outcomes for Aboriginal and Torres Strait Islander people by:

- Targeting a priority population group and supporting initiatives to address health inequities;
- Expanding the Department's understanding of the capacity of primary health care services to screen and support women experiencing perinatal depression (PND) in Aboriginal and Torres Strait Islander communities; and
- Increasing the Department's understanding of PND referral and care pathways for Indigenous women

In addition, the Project set out to determine the degree to which the National Perinatal Depression Guidelines are currently being integrated into Aboriginal community controlled health organisations and primary care settings.

Box 3.4: Reports of perinatal mental health and maternal and child health in Aboriginal women[57]

EXAMPLES OF REPORTS OF INITIATIVES, STRATEGIES AND PROGRAMS RELATED TO PERINATAL MENTAL HEALTH AND MATERNAL AND CHILD HEALTH IN ABORIGINAL AND TORRES STRAIT ISLANDER CONTEXTS:

- National Postnatal Depression Program, Prevention and Early Intervention 2001–2005, final report, June 2005 and the 2011 guidelines;
- State Perinatal Mental Health Initiative Report 2003–2007, State Perinatal Mental Health Reference Group and WA Perinatal Mental Health Unit, 2007;
- Western Australian Perinatal Mental Health Unit, Women and Newborn Health Service (2011). Aboriginal perinatal mental health service expansion: Final evaluation;
- Aboriginal Perinatal Mental Health Service Expansion: Final Evaluation. Western Australian Perinatal Mental Health Unit, Women and Newborn Health Service (2011);
- Lessons learnt about strengthening Indigenous families and communities: Stronger Families and Communities Strategy 2000–2004, Occasional Paper No. 19, 2008; and
- Australian Institute for Primary Care Evaluation of Child and Maternal Health Pilot Projects in Rural and Remote Australia (2004).

Chapter Summary

A review of the literature surrounding Aboriginal and Torres Strait Islander people highlights a number of sobering realities for this population. The complex interplay of historical factors including colonisation together with current environmental, social, economic and community factors, place Aboriginal and Torres Strait Islander people at significantly greater risk of health inequities, resulting in higher rates of social disadvantage and ultimately reduced life expectancy.

When reviewing the impact upon women in particular, Aboriginal women are more likely to smoke and have a higher incidence of hazardous alcohol and substance misuse when compared with non-Aboriginal women. This in turn has negative implications across their lifespan, including poorer reproductive and maternal health.

In addition to the effects on physical health, the impact on social, emotional and mental health is also significant. Here Aboriginal women are more likely to be exposed to risk factors for emotional and mental health when compared with non-Aboriginal women, which can culminate in higher prevalence of anxiety, depression, grief and self-harm.

The implications of this are even more significant when considering the perinatal period specifically, whereby all women are more likely to be at risk of experiencing perinatal mental health problems than at any other time of life. When considering the significantly lower maternal age of Aboriginal women, combined with the overall higher presence of risk factors present within this population, the emotional and mental health implications for these young mothers are further exacerbated. Despite this, Aboriginal women are less likely to receive maternal care.

The above context highlights the important role of prevention and early intervention approaches to identifying and addressing emotional and mental health, particularly amongst this population group and within the perinatal period. In response to the issue more broadly, Australia has invested significantly into the National Perinatal Depression Initiative (NPDI), which involves routine and universal screening all pregnant and postnatal women to assess possible risk and presence of perinatal mental health conditions. As part of the Initiative, this has led to the development of Clinical Practice Guidelines[1] for the general population (not specific to this population), which recommend the routine use of the Edinburgh Postnatal Depression Scale in the antenatal and postnatal periods, together with the assessment of possible risk factors.

The extent to which the Initiative has been extended into Aboriginal perinatal mental health care specifically is unknown. Further the approaches used (if any) to assess risk and the presence of common metal health conditions such as depression and anxiety also remains undetermined. Whilst the literature presents a range of perspectives regarding the appropriateness of the EPDS within this population, the implication of this on current practices across the country is yet to be established.

In response to this, the Project sought to undertake a mapping exercise, to determine the degree to which the National Perinatal Depression Guidelines are currently being integrated into Aboriginal community controlled health organisations and primary care settings under the New Directions Services. Further, the project sought to assess and identify the barriers and enablers to the assessment and the provision of culturally appropriate perinatal healthcare across these Services to provide recommendations that support the needs of healthcare providers and ultimately women and their families in the perinatal period.

Box 4.1 Project objectives
KEY OBJECTIVES OF THE SCOPING STUDY

4. PROJECT AIMS & OBJECTIVES

Project Aims

It is within this context that this project aims to examine perinatal mental health screening practices and referral pathways of primary health care service providers providing Commonwealth funded maternal and child health services for Aboriginal and Torres Strait Islander families with young children. The project will contribute to the Department's efforts to work towards Closing the Gap in life expectancy and child mortality rates for Indigenous Australians.

Project Objectives

Following on from these aims the project has four core objectives as summarized in Box 4.1.

Objective 1:
Determine current levels of awareness and understanding of perinatal mental health

The scoping Project sought to determine the context in which perinatal mental health sits for health professionals across settings. In particular, the Project will gain insight into the likely prioritization of perinatal mental health conditions relative to other aspects of maternal and child health care provided to Aboriginal and Torres Strait Islander women and their families through ACCHOs and primary healthcare services.

Objective 2:
Evaluate Current Perinatal Screening Practice

The perceived importance of screening for perinatal mental health will be evaluated together with a detailed scoping of current screening practices (if any). This will include a detailed scoping of what, when and how screening is undertaken, and also assess how screening data is currently managed and utilised.

Importantly the study will also identify the key drivers and barriers to screening. This includes obtaining very detailed information surrounding the use of the EPDS across communities, as well as approaches to evaluating psychosocial risk factors. These issues will be considered in light of the impact of dispossession, interruption of culture and intergenerational trauma which have significantly impacted on the health and wellbeing of Aboriginal and Torres Strait Islander people.

In reference to the National Perinatal Guidelines, the Project will provide the Department with information to inform future planning and possible approaches to increase perinatal mental health screening across primary health care settings for Aboriginal and Torres Strait Islander women and their families.

Objective 3:
Post screening referral

A specific focus will be given to examine current practice surrounding referral processes following screening. In particular the study will:

- Examine the current capacity of sites to refer women and their families, with identified risk factors, to referral services, if available;
- Explore reasons why families may not access referral support services, for example perceptions of racism, in order to gain a deeper understanding of factors underpinning access to referral services (if available), including current rates of utilization;
- Also assess the perceived confidence, or otherwise, of health professionals and their use of risk frameworks to inform decisions regarding referral of women to identified support services.

Through this activity, the Project will identify potential solutions or adapted approaches that can ultimately improve the identification of referral pathways and their effective implementation into current practice.

Objective 4:
Training and development for health professionals

Through gaining detailed information about current awareness, attitudes and practice, the study affords the opportunity to determine the education and training needs of health professionals. In particular the study will assess awareness of existing programs, assess the provision of training undertaken to date and identify specific areas of training need to increase confidence and competence to undertake screening and referral activity.

In turn this information can be used to inform the promotion and/or adaption of existing programs currently developed under the NPDI to better meet the needs of healthcare workers working specifically with Aboriginal and Torres Strait Islander women and their families.

5. METHODOLOGY

As the objectives of this study involved the collection and analysis of potentially sensitive, and detailed information surrounding cultural contexts and current practice across a number of sites, a mix of qualitative *and* quantitative *methodological approaches was implemented.*

Consistent with the Project Plan, below is an outline of the five stages undertaken in this report.

Stage 1: Planning and Preparation

Following the development of a full project plan and consultation with the Department, initial written communication (via electronic and postal) was made with each of the State/Territory Directors of New Directions Mothers and Babies Services via both email and post.

The letter to the Directors (Attachment 1) informed them of the purpose, objectives and timelines of the Project. This was considered important to emphasise the importance of the project, and provide an outline of the various stages of their project and seek their engagement across the various stages of the project. In addition, the cooperation of Directors was sought through the provision of service details and assistance in identifying the most appropriate key contact from each of the New Directions Service sites.

Telephone contact was then made with each of the State/Territory Directors to allow for any questions following receipt of the introductory letter describing the project. Directors from all States/Territories were enthusiastic about participating and provided contact details for each of their services.

In addition to contacting the Directors across the states and territories, peak bodies identified in consultation with the Department were also formally notified of the Project via written correspondence. This included the National Aboriginal Community Controlled Health Organisation (NACCHO) and Australian Indigenous Psychologists Association (AIPA) (Appendix 2).

Following this, initial written communication was made with each of the New Directions Mother and Babies Service's contacts provided by the State/Territory Directors. Again, this communication was made via both email and post, in order to emphasise the importance of the Project and increase the likelihood that the service contacts would recall receiving this correspondence at a later stage (stage 4). Once again the letter to the services (Attachment 3) informed them of the purpose, objectives and timelines of the Project, and invited their participation in the project. It also described the qualitative component of the project and indicated that a sample of services would be contacted in the coming weeks to be invited to participate in this stage of the project. to derive in-depth understanding of issues as identified by the population.

Stage 2: Qualitative Evaluation

Selection of services

This stage of the research involved undertaking in-depth qualitative research with a representative sample of selected services across most states and territories. The selected services comprised of a range of urban, rural and remote locations, and contained a mix of small, medium and large organisations. There was also representation of the different *types* of services, namely hospitals, Aboriginal community controlled health centres and Medicare locals.

In line with qualitative research methodology, the number of sites was determined by the level of consistency of obtained information across the range of settings. Initially whilst this was estimated to comprise of 20-23 sites, the nature of the information received and the high level of inconsistency in some areas necessitated further sites to be included in Stage 2 of the Project, resulting in twenty-seven services being involved in this qualitative stage (See Chapter 7).

Approach

Due to the sensitive nature of the information being sought to inform the study and to encourage open information sharing, it was necessary to conduct face-to-face interviews wherever possible. This was considered to be particularly important where the identified contact person was Aboriginal or Torres Strait Islander, in order to establish greater levels of trust in the Project and the interviewers.

Appropriate and respectful communication was employed at all times to engage and enlist the participation of Aboriginal and Torres Strait Islander people involved in the project. Further, a culturally sensitive approach to the collection of required information was undertaken. Here, in line with the Project objectives, a Moderator Guide was developed to guide the discussion as part of the consultations (Appendix 4). Comprising of open-ended questions together with some demographic information about those being interviewed, this enabled a broad range of detailed information to be obtained in a safe, culturally sensitive way.

All consultants engaged on the Project have either extensive experience working with Aboriginal and Torres Strait Islander people and/or the awareness and understanding to ensure that the approaches used are culturally safe and appropriate for the target population.

Stage 3: Analysis of Qualitative Data

Following the consultations, the qualitative results were analysed and key themes identified under each of the Project objectives. The key findings of this analysis were incorporated in the next stage of the Project, and have also provided extensive information, which is detailed in the following chapters of this report.

Stage 4:
Quantitative Evaluation across all sites

Survey Development

The rich data and invaluable insights yielded from Stage 3 of the Project were then used to inform the development of a quantitative survey. Here the survey items reflected the Project objectives and provided an opportunity to measure the extent to which the perceptions and practices identified in Stage 2 were reflected across Services nationally.

To allow for inclusion of views or practice that may not have arisen in stage 2, the survey was designed to enable respondents to include extensive additional information and commentary throughout the survey.

Following the development of the survey tool, it was then piloted across a small number of sites as well as the Department and non-New Directions Services (N=6). The survey could take anywhere from 20 minutes to one hour to complete, depending on the level of detail and additional commentary that was made by the respondents.

Survey dissemination

Following piloting, once again all State and Territory Directors were contacted and reminded of the Project, and informed of the next stage which involved all Services completing an online survey. The survey was then distributed via email with the online link to the identified person at each of the New Directions Services. Here the recipient was asked to have the survey completed by a staff member who had a good knowledge and understanding of current practices surrounding assessment and management of social and emotional health and wellbeing at their particular New Directions Service.

In order to encourage frank and open reporting, no identifying information about the respondent was obtained. Further, services were reminded that the information obtained would be used to inform the national picture surrounding New Directions Services, and that no specific information would be provided with respect to any particular site. The survey was positioned as an opportunity to inform what was happening currently and what (if anything) would assist services and health professionals in the delivery of best practice care.

Services were asked to complete the survey within ten working days from the date of release. This was considered an appropriate period of time to enable the survey completion to be scheduled internally, taking into account potentially urgent matters which may haven needed to be addressed, whilst simultaneously not allowing the survey to become completely 'lost' or 'forgotten'. This time frame also allowed for proactive follow-up by the Project team as needed.

Stage 5:
Consolidation of findings and reporting

Following proactive follow-up and achievement of a response rate that was considered reasonable, the survey was closed and the data from the qualitative stage (Stage 3) together with the quantitative data was analysed in line with the Project objectives.

The results from the data across both stages are detailed in the following chapters of this report.

6. OUTCOMES OF THE PROJECT

The outcomes of the project are detailed in the following chapters, the first of which describes the nature of the respondents involved in the two stages of the Project (Chapter 7, Sample Description). This information includes demographic as well as information about the professional backgrounds and states of the respondents. Where possible any notable differences between the respondents across the two stages of the project have been identified, to allow this to be considered in the context of the results and interpretation of outcomes.

Following, given the extensive, rich contextual information provided by health professionals and the impact of this across the Project, Chapter 8 (Cultural Context) has been dedicated to providing details of this. This information was initially derived throughout the qualitative consultations, and further explored in the quantitative stage. Hence this section is considered to provide an important context for the following sections of the Report, and therefore specifically addressed.

Chapters nine to twelve are specifically focused on addressing each of the Project Objectives as defined in the Project Plan and outlined in Chapter 4 (Rationale and Scope). For each of the objectives the data obtained from the qualitative and quantitative stages has been combined to inform the current status as described or defined by health professionals. As indicated, in most areas the findings from the qualitative consultations were substantiated in the larger survey, however in a few areas the results were not supported, and hence the reasons for this have been explored. Each chapter provides a summary of the key outcomes and recommendations relative to each of the Project objectives.

Where appropriate, direct quotes have been included throughout the relevant sections to depict the views and sentiments expressed by health professionals across both stages of the project. As assured, no identifying details of the health professionals have been provided in relation to the quotes (e.g. professional status, location) to assure anonymity.

7. SAMPLE DESCRIPTION

Qualitive Sample

As described in Chapter 6, qualitative interviews were conducted across a range of services representing different geographic locations *and different* service types.

Response to the Qualitative (Consultation) Stage

The number of services approached in the first instance was twenty-one, being approximately twenty-five percent of the New Directions Mother and Baby Services providers.

An overwhelmingly positive response was received in response to the initial invitation to participate in the qualitative stage from all services approached, and interviews were conducted across all of these sites that were initially selected.

Size of the qualitative sample

Due to the high *level of variability* in the discussions with health professionals in the qualitative phase, the sample size was increased until consistency in responses was obtained.

The resulting number of services thus engaged in these qualitative consultations was increased to twenty-seven. The increase in sample size ultimately provided a greater level of confidence that the information obtained was reflective across services, and did not result in a potentially skewed sample.

Approach to undertaking qualitative discussions

As described, *face-to-face interviews* were considered important, particularly as the project sought to include Aboriginal representatives in the sample and believed that this method would establish a greater level of rapport and trust to encourage openness in the interviews. As a result all but two of the interviews were conducted face-to-face (and included those health professionals with Aboriginal and Torres Strait Islander backgrounds), and the remaining two conducted over the phone (with non-Aboriginal health workers).

The *time taken* to undertake the interviews was on average 1.5 hours and in some cases extended to a two-hour period. When conducting interviews across the selected sites, in some locations there was more than one person involved in the discussions (often 2-3), hence representing the views of a range of healthcare workers in a team and/or setting (up to six).

Description of the resulting sample

As final sample of respondents in the qualitative phase comprised of a proportional representation with the majority of services being regional (41%), followed by remote services (33%) and then metropolitan services (26%).

Figure 7.1: Geographic distribution of participants in the qualitative consultation (Stage 2).

Site visits – Qualitative Stage

● Site visit

○ Phone consultation
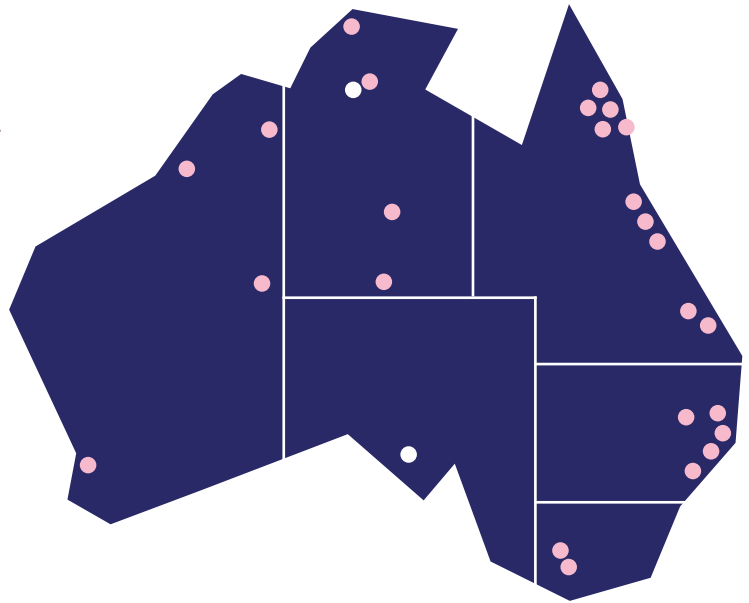
The size of the services in which the New Direction Service operated and the size of the New Directions teams varied with the number of babies born across Services ranging from approximately 20 to over 120.

The majority of services provided both *antenatal and postnatal care*, most of who indicated that they would see their clients early to middle of the perinatal period. There were, however, a number of health professionals who said that they also saw clients for the first time in the mid to late perinatal periods.

Demographics

Most of the health professionals interviewed were female (with exception to four), and a significant proportion of participants interviewed were Aboriginal and Torres Strait Islanders, representing just over a third (35%).

Professional background and status

Interviews were taken with health professionals from a range of different professional backgrounds including registered nurses, midwives, Aboriginal health workers, and maternal and child health nurses. The level of experience of these interviewed workers also varied considerably across the sample, ranging from one year to more than thirty years.

Hence when calculating the response rate across this sample size (N=82) the final response rate of the quantitative stage of the Project was 84%. This response rate therefore gives confidence that most of the services did participate in the survey stage of the Project, and hence are represented in the current report.

Quantitative Sample

Whilst initially it was thought that the total number of sites as provided on the by the Department was 85, closer review of the information and operation of sites revealed that the total number of sites represented was 82. This difference (n=3) is attributed to the following:
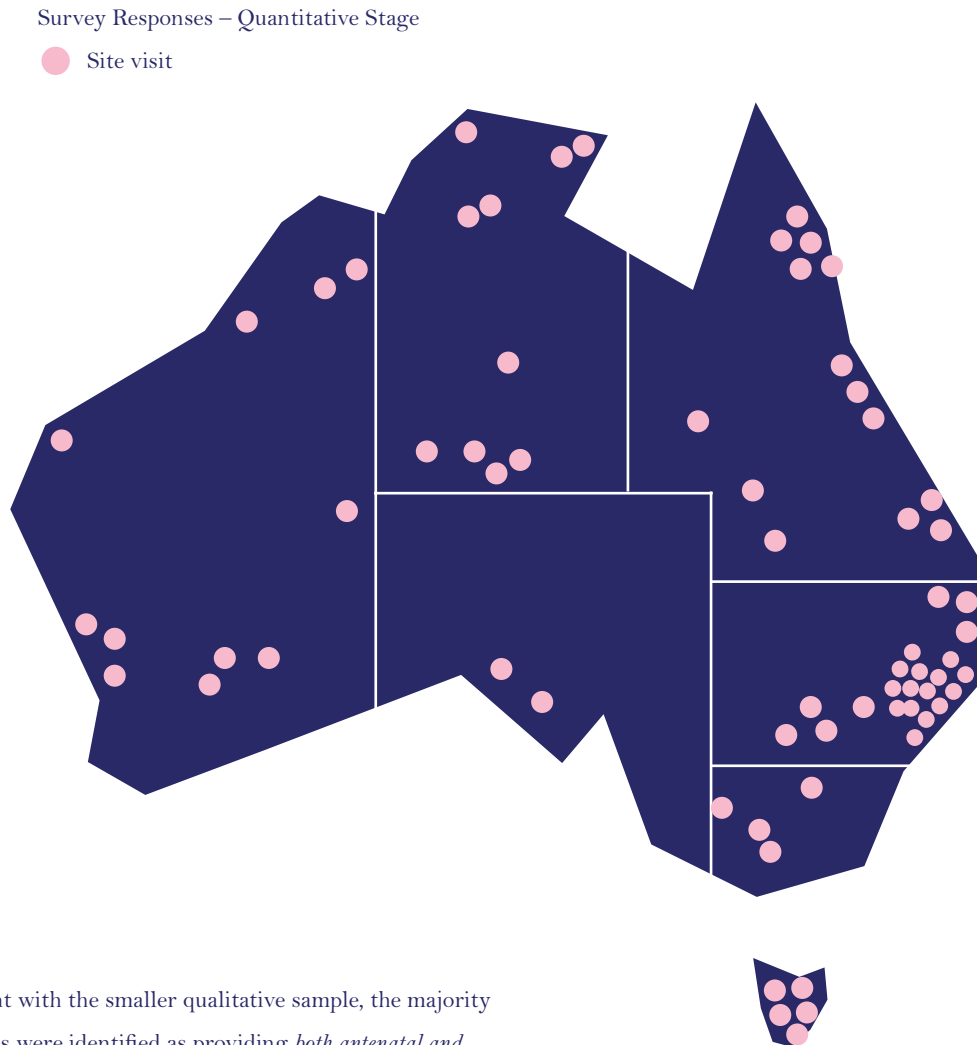
- One service was listed twice on the spread sheet;
- For each of two smaller services (one remote, NT and one regional, Tasmania) one survey was completed for two site locations (different postcodes), and hence responses were amalgamated into the one survey
- A response was deleted from the response set as on further investigation with the service directly there were no perinatal services being delivered, only a playgroup operating
- There were two responses received from a service in the ACT, so the response which appeared to have more detailed information about the service and perinatal practice was accepted. The other response was removed from the sample set so as not to duplicate the data.

Geographic distribution

This distribution of survey respondents is represented across the states and territories and also across the range of metropolitan (16%), regional (48%) and remote (36%) communities.

Figure 7.1: Geographic distribution of participants in the qualitative consultation (Stage 2).

Survey Responses – Quantitative Stage

● Site visit

Consistent with the smaller qualitative sample, the majority of services were identified as providing *both antenatal and postnatal care*, most of whom would see their clients early to middle of the perinatal period, but still a significant proportion of whom said that they often saw clients in the mid to late perinatal periods.

Demographics

The ages of the respondents who participated in both stages of the project were likely to be of similar age range, with most respondents again being female.

Twenty six percent (26%) of respondents undertaking the survey identified themselves as being from Aboriginal or Torres Strait Islander background [lower than the representation of Aboriginal and Torres Strait Islanders involved in the qualitative phase (35%)].

Professional background and status

As with the qualitative phase, the sample those completing the survey represented a range of different *professional backgrounds*. The breakdown of this is outlined in Figure 7.3.

As some respondents had more than one qualification, multiple responses were possible for this question. The highest proportion of respondents in the survey were nurses, including registered nurses, midwives and maternal and child health nurses.

Figure: 7.3: Professional Background of survey respondents
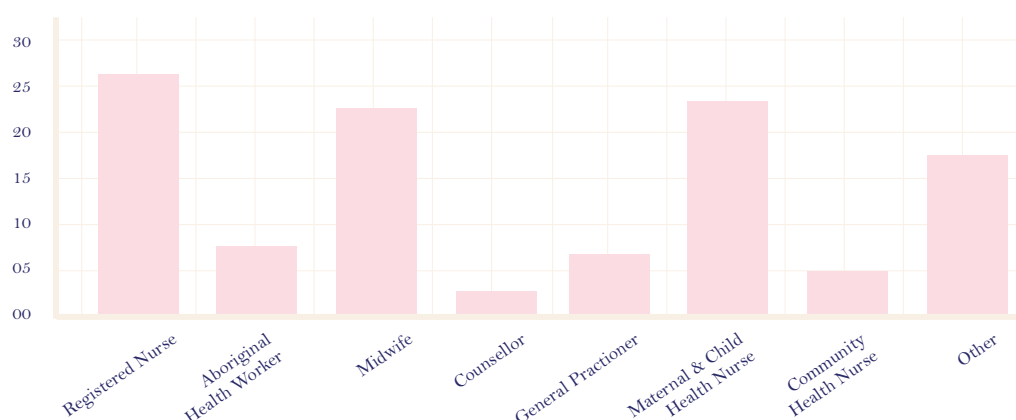
Overall seven survey respondents had Aboriginal health worker backgrounds and six were general practitioners. Two had counselling backgrounds and seventeen respondents noted 'other', indicating a range of backgrounds.

When asked to specify their position within the service, there was a fairly even split between those who identified themselves to be in managerial roles (40%) versus clinical roles (48%) or both (12%).
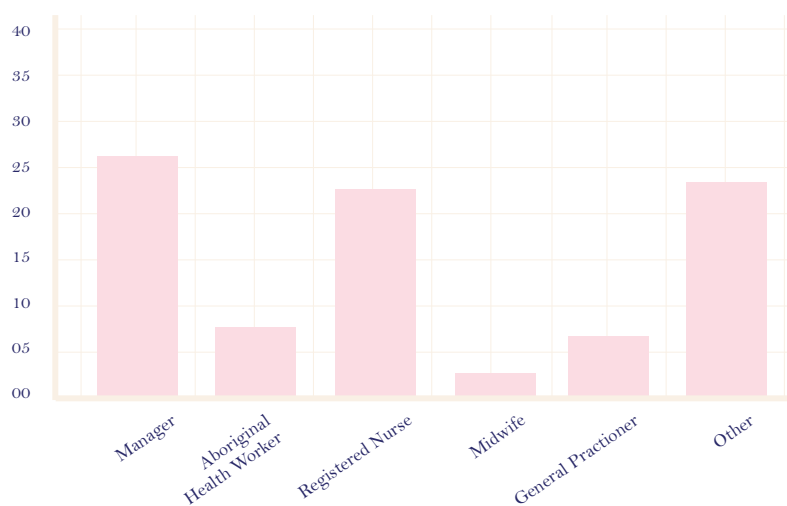
Figure: 7.4: Your current position within this service (%)

Those survey respondents in managerial roles included CEO's, together with program managers and coordinators. The remaining forty-eight percent of respondents identified themselves in a clinical/health service role.

Professional Experience

There was *range of experience* across the sample, with the number of years working in their profession ranging from 1 year to 49 years (with an average of nineteen years). Similarly the number of years' *experience working with Aboriginal and Torres Strait Islander populations* specifically was highly variable and ranged from less than 1 year to 42 years (average just under 14 years).

Years of experience with respect to working in the *perinatal* area specifically also varied considerably across the sample. Five respondents (7%) indicated that they had *no specific perinatal experience* (likely to be in managerial or executive roles) and 27 of them (40%) had five years or less experience in perinatal mental health. Of the remaining 60% who had *more than five years' experience*, sixteen respondents (29%) indicated that they had 20 years or more perinatal experience, with many having worked in the perinatal area for much or all of their working life.

Sample comparisons

When reviewing the final sample of respondents for the qualitative and quantitative stages of the project, there are a number of observations that are useful to be aware of and bear in mind when interpreting the findings.

Firstly, whilst the qualitative sample included respondents from all of the larger states and territories, the two smaller states and territories (Tasmania and the Australian Capital Territory) were not represented.

The *location of services* across metropolitan, rural and remote services were each represented across the two phases of the study, with the majority of respondents in each stage services in regional locations, followed by remote and a smaller proportion located in metropolitan areas. A review of these response rates however indicates that there is likely to be higher representation of remote services (and lower representation of metropolitan services) in the qualitative phase due to a slightly lower response rate from remote areas in the quantitative phase.

Table 7.1: Distribution of respondents across geographical locations across stages of the Project

Location	Stage 1 (Qualitive)	Stage 2 (Qualitive)
Remote	33%	16%
Regional	41%	48%
Metropolitan	26%	36%

Both samples were similar in their provision of predominantly antenatal and postnatal care. Most health professionals were female and both samples reflected a range of years' experience in working in their positions and with Aboriginal and Torres Strait Islander women.

When considering the cultural and professional backgrounds of the health professionals, some differences were noted across the two samples. First the qualitative stage involved a slightly higher proportion of healthcare workers from Aboriginal and Torres Strait Islander backgrounds (35%) when compared to the quantitative stage (26%), resulting in a higher representation of Aboriginal health workers in Stage 1.

These differences between the samples derived at each stage of the project will be considered when presenting and interpreting the outcomes. As the quantitative stage also provided opportunity for open-ended commentary, this information will also be assessed and incorporated into the analysis, providing opportunity for insights across potentially under represented areas.

8. CULTURAL CONTEXT

Throughout both the qualitative and quantitative stages of the project, there were a number of resounding themes that permeated throughout the subject areas. In response to this, and in order to ensure that we set the scene for the findings and discussions that follow, this chapter has been devoted to defining the cultural context as depicted by the respondents across both stages of the project.

In part these broader contextual issues related to many social and economic aspects that have an impact on the provision of antenatal care, including: cultural safety; communication; standards in care; cultural gaps between clients and staff (not Aboriginal or Torres Strait Islander); demography; community and the role of partners and families. In addition to the impact of these issues in terms of the broader cultural context, many of these were also seen to impact upon various project objectives, and these will be addressed specifically in the following chapters.

The following information provides the context in which the discussions occurred and in which the services are provided.

Cultural safety

The importance of culturally appropriate care that is responsive to the individual needs of the women was a consistent theme across services.

In particular, a number of clinicians commented on the importance of providing Indigenous–specific services, where Aboriginal women would be more likely to attend, and feel comfortable to disclose issues surrounding emotional and mental health and wellbeing.

Sixty-one percent of respondents agreed that one of the key reasons that women *don't* take up referrals is because the referral services are not *culturally appropriate*.

These comments were underpinned by the need to respect the women in their care as individuals and not assume that all Aboriginal and Torres Strait Islander women are the same or will have the same needs.

"You can't generalize about Aboriginal and Torres Strait Islander people and you can't expect that it will be the same for all of them. It's like saying that all short people or tall people or fat people or thin people will be the same just because of that characteristic. If someone speaking French or Italian or Chinese goes to hospital they will get an interpreter because the staff won't be able to understand them otherwise."

It was perceived to be important that at least some of the providers/health professionals were of Aboriginal origin, but in addition it was deemed essential that all clinicians had a cultural understanding of the community in which they worked. It was also noted as critical that the approach to consideration of cultural safety and respect was genuinely intended to acknowledge the cultural differences and needs of the community.

"Just putting a 'black person in a position because they're black is as useless as putting a screen door on a submarine. You need to make sure that the person has the right background and skills for the position that they will hold and that they are acceptable to the community (culturally) otherwise it's just ticking a box to make it look like you're respecting black people but in fact you're not because you're not recognizing that they're all different."

"The spirit and culture of Aboriginal people is not the same. Just because you might be Aboriginal doesn't mean that you will be able to understand the experience of another Aboriginal person from a cultural or spirit perspective so it is important that someone who can 'interpret' what the person is saying is available to assist. The land people come from, what language they speak, the cultural practices they grew up with, will all play a part in the persons experience and who they will be able to talk to."

Cultural Difference

A number of non-Indigenous clinicians commented on the cultural gaps between clients and staff, if non-Indigenous, and particularly if the clinicians were not sensitive to, or aware of, cultural differences.

"There's a massive cultural gap that doesn't get addressed when a white psych walks into see an Aboriginal woman after she's given birth."

The difference was also expressed in terms of Aboriginal and Torres Strait Islander people being more likely to tolerate lower levels or quality of service. Whether the difference originated from the woman's or the clinician's perspective varied and will be explored further in later chapters.

"What we pass over with Indigenous women would not be acceptable with a white woman because they (Aboriginal and Torres Strait Islander women) just tolerate so much and seem to accept it as normal but it isn't and shouldn't have to be accepted."

Demographics

Not surprisingly, given that over fifty percent of first births to Aboriginal women are to women under twenty years of age, youth was considered to be important to the cultural context in which New Directions Mothers and Babies Services provide perinatal care. For some clinicians, youth was seen to be a risk factor.

"The biggest concern we have for these girls would be depression. Some of them still live in a very male-dominated world."

For others it was seen as a protective factor.

"Younger women seem to cope better emotionally. Young women are generally well supported by family – cousins, aunties, etc."

"Young women are generally well supported by family – mums, cousins, etc."

The prevalence of young mothers and their lack of preparedness or knowledge of what to expect during birth and beyond, and the impact that this has on caring for self and child/ren was regularly raised. Some clinicians suggested that the challenges could be compounded postnatally when the young women were confronted with the realities of motherhood, lack of ability to socialise and/or lack of support from family, including the baby's father.

"There is a vulnerability of young mums. The traditional culturally relevant stuff around "preparation for birth is no longer there/available. If we could engage with young mums early enough we can prepare them better for what's about to occur and maintain contact".

In a number of locations, the social situation that resulted in young mothers residing with extended family was seen as both a protective factor against mental health conditions due to the level of support afforded the mother.

"In some ways it may be a godsend that there is overcrowding in so many of these communities – there are grannies and aunties around to help out with the bubs/little ones so even if the mum is experiencing PND there is support around her to assist with the care of the children."

In contrast, in other locations/services, clinicians noted that this could impose additional pressures on young mothers that may increase risk factors for postnatal depression and/or anxiety.

Social and emotional wellbeing

Social and emotional wellbeing and the differences in Aboriginal and Torres Strait Islander definition of health, including mental health was raised often. Eighty-three percent of respondents felt that Aboriginal and Torres Strait Islander women's view of health is different to that of non-Aboriginal and Torres Strait Islander women's definition of health, with only four percent disagreeing with this statement.

Many clinicians commented on the fact that Aboriginal and Torres Strait Islander cultures take a holistic view of life and health; therefore, cultural, spiritual and social wellbeing are integral to the health of Indigenous people.

Ninety-five percent of respondents agreed that all aspects of health are important, it being hard to separate the physical from the social and emotional wellbeing of Indigenous women and families. Ninety-six percent of respondents also agreed that social and emotional well-being and mental health was a very important area in their practice.

"Social and emotional wellbeing effects everything. There are a lot of issues in the community like domestic violence, alcohol abuse, etc."

Social and emotional wellbeing was certainly noted as a core part of New Directions Mother and Baby Services business. Many clinicians discussed the primary focus of their role as being the social and emotional wellbeing of the mothers.

Despite the obvious importance of a focus on social and emotional wellbeing, there were some locations where clinicians were constrained by time and therefore were not always able to provide this focus. This was notably more common in remote regions where travel consumed significant time.

"The pressing clinical needs take precedence over the SEW stuff due to time constraints. That's just the reality, the way it is. And when there aren't any appropriate referral options, what's the point in asking?"

Community

The natural extension to the discussion about the importance of social and emotional wellbeing was often the central role of family and community in wellbeing. Some clinicians felt that involving families as much as possible was important in promoting the social and emotional wellbeing of women in the perinatal period.

"Getting the families involved is really important (for the women) and being part of the pregnancy is a big part of it. There's a part of it that's women's business and we respect that, but babies are everybody's business so families need to be involved."

Clinicians also consistently indicated that postnatal depression is not well recognised – both amongst Aboriginal women themselves and within communities.

"What we pass over with Indigenous women would not be acceptable with a white woman because they (Aboriginal and Torres Strait Islander women) just tolerate so much and seem to accept it as normal but it isn't and shouldn't have to be accepted".

In fact, the lack of awareness and disregard for the higher prevalence rates amongst Aboriginal women in the perinatal period was also prevalent amongst clinicians in some areas who expressed the perception that perinatal mental health issues like depression and anxiety do not affect Aboriginal women.

"I have heard Aboriginal health workers say "That's a gardia disease, we don't get that (postnatal depression)."

"There's a strong sense of family here, which is protective."

Here examples were provided by both Indigenous and non-Indigenous clinicians with respect to clients and/or community members, stating that perinatal mental health disorders were effectively "white women's problems".

Some clinicians commented that lack of awareness of perinatal mental health conditions could contribute to mothers not seeking professional support.

"Sometimes they don't want to talk about it if they're not coping because they think they should be able to manage as their mothers/grandmothers did, they feel 'shame'."

It was felt to be possible that many Aboriginal mothers were not able to identify and seek help for symptoms of perinatal depression or anxiety because they were simply unaware that conditions such as postnatal depression and anxiety existed, and subsequently that support and treatments were available to them. Having culturally relevant information and education pertaining to perinatal mental health issues available to them was often raised as being an important gap.

The desire of many clinicians to provide more health promotion activities relevant to perinatal mental health, birth and parenting was raised regularly. The limited resources and/or time available for any health promotion activities and the lack of perinatal specific health promotion activities was identified as a problem. There was an expressed need and desire for such activities and a view that this would assist women in feeling more comfortable to seek professional support when needed.

Mental health, stigma and shame

Clinicians regularly commented on the stigma associated with mental health conditions, believing that many mothers hid their real feelings – from family, friends, services and even themselves. This is of course, not unique to Aboriginal and Torres Strait Islander communities and is prevalent across population demographics.

Some clinicians noted that alcohol and other substances are often used by mothers to cover up their feelings or 'self-medicate'. This was instead of seeking professional support, either due to the stigma, fear of what might happen to their baby or lack of awareness or understanding of the conditions and the fact that treatment was available.

_____

"I think that there is a lot of it (postnatal depression) out there that isn't recognized for a whole range of reasons. For example, a lot of people wouldn't be aware of it or recognize what the signs are and people might not realize that PMH disorders are a 'normal' part of pregnancy for 1 in 7 women that can be treated and outcomes can be improved for mum, bub and family."

Clinicians often noted the concept of "shame" to describe a woman's reluctance to disclose how she may be feeling.

_____

"Sometimes they don't want to talk about it if they're not coping because they think they should be able to manage as their mothers/grandmothers did, the feel 'shame'."

While shame was widely acknowledged as being a barrier to disclosure for women, it was also noted that this was not necessarily the same as stigma associated with mental health conditions in the non-Indigenous community.

Fear

Another potentially complicating factor relating to disclosure that was raised in locations nationally, in urban, regional and remote services, is the issue of fear about what might happen to the baby if the mother is experiencing a mental health condition.

While it was noted that it was not uncommon for women experiencing postnatal depression to fear disclosure for what might happen to their baby, health professionals felt that this was more pronounced and occurred more often for Aboriginal women.

Eighty percent of respondents agreed with the statement that 'Mothers might be worried about what will happen to their baby if they disclose any concerns (about how they are feeling).'

9. CURRENT LEVEL OF AWARENESS & UNDERSTANDING OF THE CONTEXT OF PERINATAL MENTAL HEALTH

OBJECTIVE ONE

The Mapping Project seeks to determine the context in which perinatal mental health sits for health professionals across settings. In particular, the Project will gain insight into the likely prioritization of perinatal mental health conditions relative to other aspects of maternal and child health care provided to Aboriginal and Torres Strait Islander women and their families through ACCHOs and primary healthcare services.

In particular, this section of the report addresses *healthcare worker perceptions and prioritisation* of health and wellbeing generally and with respect to *perinatal mental health specifically.* As informed by the Project objectives and initial qualitative findings, the areas covered included *social* and *emotional wellbeing*, *trauma stress and/or grief*, together with the perceived importance and relevance of risk factors for developing perinatal *mental health* conditions for this population group.

Key outcomes

Health professionals identified fundamental differences between working in Aboriginal and Torres Strait Islander health and the general population. This finding was consistent across both the qualitative and quantitative stages, and included issues particularly surrounding *communication* the need for *holistic* care.

Differences in working in Aboriginal and Torres Strait Islander health from general health

The first fundamental difference related to the way Aboriginal and Torres Strait Islander women communicate and express their symptomatology, as varying from that of non-Aboriginal and Torres Strait Islander women.

"There's a different way of communicating and expressing emotion for Aboriginal women."

"You can't separate it (mental health) from everything else but it's not the way that most Aboriginal people talk."

"We talk about social and emotional wellbeing – mind, body, place."

This finding was supported in the quantitative survey with seventy-seven percent of respondents agreed with the statement 'Aboriginal and Torres Strait Islander women communicate and express emotion in a different way to non-Aboriginal women'.

Another theme that emerged in the qualitative phase was the perceived high level of resilience amongst Aboriginal and Torres Strait Islander women. The commentary here related to different 'forms' or manifestations of resilience. For most health care workers, resilience was defined in a conventional way as in 'the ability to endure and recover from difficulties'.

"Many of these girls may be experiencing a level of depression but they don't see it that way. They are so resilient and cope with so much that a lot of other people wouldn't."

"The women are pretty tough and resilient. The men seem to reach the tipping point much more quickly/easily than the women from an emotional perspective."

This perception surrounding resilience was explored further in the quantitative phase and was supported by many, with over two-thirds of respondents agreeing with the statement that 'Aboriginal and Torres Strait Islander women are very resilient' while another forty-five percent agreed that 'Aboriginal and Torres Strait Islander women are *more* resilient' than non-Indigenous women'.

Further to this, a number of participants in the qualitative interviews went so far as to say that the resilience of Aboriginal and Torres Strait Islander women was a *protective factor against perinatal mental health conditions.* Again this perception was also tested in the survey, but not widely supported. Rather, high levels of resilience were not felt to protect Aboriginal and Torres Strait Islander women from perinatal mental health conditions in the most part, with only fourteen percent of respondents agreeing with the statement that 'the resilience of Aboriginal and Torres Strait Islander women protects them against post-natal depression.'

Figure 9.1: Clinicians level of agreement with the view that the resilience of Aboriginal and Torres Strait Islander women protects them against post-natal depression.

Legend:
- Stronly disagree
- Disagree
- Neither
- Agree
- Don't know
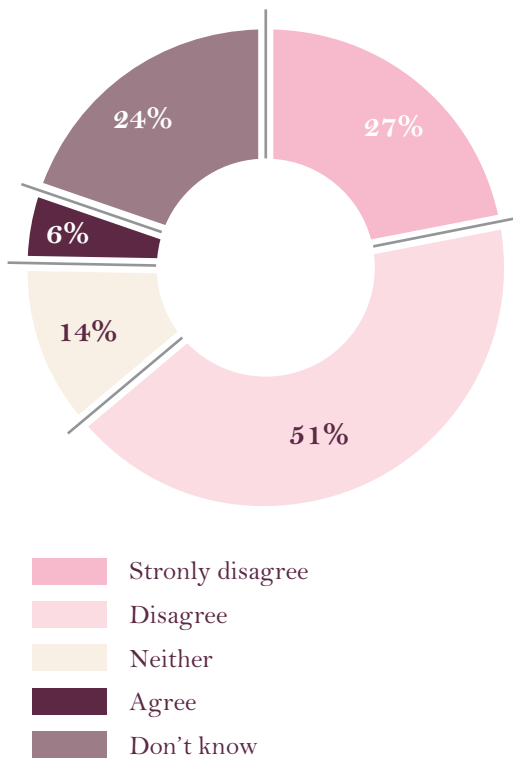
Holistic care

Perceived need for holistic care

Another key area raised regularly by health care workers in the qualitative consultations and supported by survey responses was the importance of providing holistic care.

"Equity, fairness and decency should see holistic perinatal care as a priority in communities."

"Holistic wellbeing is the beginning of women being physically well. Without holistic wellbeing its harder to reach optimal perinatal outcomes."

The importance of taking a holistic approach to the healthcare of women in the perinatal period, including social and emotional well-being was seen to be critical to providing appropriate and good perinatal care.

"Holistic care is most important because the main issues arising are housing, relationship and financial. These impact health and implementation of basic health care measures."

Similarly, the discussions highlighted the importance of recognising that Aboriginal and Torres Strait Islander women are likely to have a definition of health that may not translate directly to a medical model of health, as it is all-encompassing within the context of social and emotional wellbeing.

"Aboriginal women are likely to say, "It's not depression, I've just got humbug". The women are very resilient."

The project also sought to identify the key aspects of *healthcare* that were considered to be the most important in this community, within the context of overall health and well-being.

When asked to identify the *most important* perceived aspects of care, responses in both the qualitative and quantitative stages were seen to reflect the range of physical, social and emotional (mental health) aspects (and hence the holistic approach).

The most commonly identified aspects of care included:
- Culturally appropriate care
- Accessibility of the service
- Family
- Smoking
- Mental health

Consistent with the qualitative phase, the importance of taking a *holistic approach* to health care was emphasised with almost *all* respondents (97%) citing this as very *important*. The majority of services (84%) also indicated that they felt that they were 'able to currently provide holistic care' always (38%) or often (46%).

Perceptions of the *amount of time* spent on social and emotional wellbeing varied considerably across the sample, however on average most felt that *more time should be spent* on social and emotional care than *actually occurred*.

This difference between perceived need and actual practice was reflected in the survey findings also.

Figure 9.2: Time needed versus time actually spent on social and emotional wellbeing (%)

Time needed to address social and emotional wellbeing

Time actually spent on social and emotional wellbeing
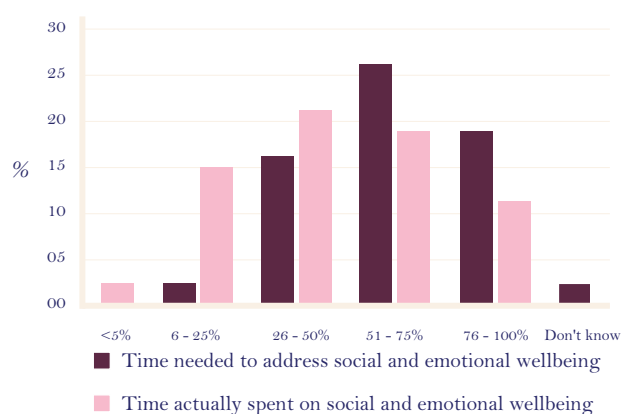
Barriers to providing holistic care

Qualitative consultations also revealed a number of perceived barriers to providing holistic care. Once identified in the initial consultations, respondents across all services were asked to indicate the perceived relevance of these barriers across their specific service.

Results reveal a high level of consistency across some identified barriers likely to impact on preventing holistic care being provided. In particular this included staffing (93%), time constraints (87%), financial resources (81%), travel (65%), lack of training (57%) and women having to relocate for birth (55%).

Particularly notable in some more remote locations, was the concerning reality that a focus on the social and emotional wellbeing and mental health of women in the perinatal period was simply not possible due to time, travel or resourcing constraints, or a combination of them. This suggests locational disadvantage being a real impediment to service provision.

"Time and travel constraints make it difficult to create the space to talk about social and emotional wellbeing issues or mental health."

Some practitioners noted that the realities of prioritising resources meant that the more holistic aspects of care were often not able to be delivered, due to the need to address more pressing medical issues.

"Given that a pregnant woman isn't considered sick, the priority has to be the acute injuries, chronic diseases and things like that which are likely to be filling the waiting room. Adult health checks, child health checks, chronic underlying conditions are often not addressed due to lack of time."

"For the RAN's it's more important to check the fundal height and fetal heartbeat than spend time on "how are you feeling"*

*Note: This statement was delivered in the context of having to prioritise care needs within the existing realities of geographic, funding, staffing and time constraints.

The range of barriers to providing holistic care to address the social and emotional wellbeing of women was further reinforced in the survey responses.

"The needs are significant and resources - both financial as well as human – are not quite sufficient to fully meet demand. For example, more specialised psychological services are in very heavy demand but more limited supply. Similarly, specialized skills in the area of perinatal mental health are not easily sourced."

"Possible factors that can contribute to less time allocated to the woman in the perinatal period is the workload of an already busy clinic running, thus keeping the woman waiting too long before she can be seen, then her having to rush home, or not even wait to be seen sometimes."

"Policies and structures to allow appropriate amounts of time to be spent with the clients, even if it doesn't garner extra income. Having an Aboriginal Health Worker specifically attached to our unit, so that they are available when needed (time critical), to explore these issues with the client in a culturally appropriate manner, and to allow more flexibility in providing services to these women (policies state home visits need 2 staff to attend, not always possible to find an extra staff member free to home visit, and often these women need to be followed up at home, due to their complex social/ emotional needs."

When asked about enablers to providing holistic care, survey respondents provided some comprehensive comments. Trust was a key theme. While many respondents saw knowledge of the client as a positive, it could also prevent barriers:

"These women need to be able to trust the health care worker, and know that what they say is confidential without the whole community knowing their business."

Other enablers noted often included accessibility, culturally appropriate care, multidisciplinary service provision and holistic care over the life course.

"The ND service provided through MATSICHS is integrated into a comprehensive primary health care model, with a multidisciplinary team available to support women and their families in the perinatal period. The team includes ND-funded staff such as the Indigenous social worker, as well as non-ND funded generalist (e.g. outreach AHWs and community engagement workers) and specialist on-site providers (psychologist, case manager, counsellor) – and visiting specialist and allied health providers including Paediatrician, paediatric speech and OT, addiction medicine specialist, etc.).

In this context, enabling factors include: (1) an accessible and responsive team, with a core focus on Aboriginal and Torres Strait Islander health; (2) a skilled generalist workforce with a clear model of care, able to provide a base level of general services and supports for all clients; (3) multidisciplinary team of providers located under one roof – an accessible one stop shop which integrates funding from a variety of sources to address key priorities including social health needs; and (4) care is provided for the whole family over a life course, not just an individual for a period of time."

"Understanding the needs of the Mothers and Babies, building a strong relationship around trust and respect, cultural understanding and being able to provide the client with enough information and resources to make informed decisions and having the commitment to follow up. Constantly check in with Mum to find out how they are going eg. Home visits to touch base regularly in a convenient location - also provides an insight as to what is happening at home and what the client may need."

Trauma and Grief

Perceived impact of trauma, stress and grief
Initial consultations with health professionals identified trauma, stress, grief and depression as important issues amongst the communities with which they worked.


"Recognising that a lot of Aboriginal people have endured a lot of trauma is important"

"I am still surprised by the amount of stress in communities and the amount of intergenerational trauma that you must deal with."

It was often within this context, that resilience was noted as a distinct feature of Aboriginal and Torres Strait Islander communities.

Consistent with the qualitative findings, trauma, stress and grief were perceived to be *highly important.* The high degree of significance of these issues was indicated by the 98% of respondents who rated this to be either *very significant* (71%) or significant (27%).

Figure 9.3: "Within your service, how significant do you consider the issues surrounding trauma, stress and grief are when working with Aboriginal and Torres Strait Islander women in the perinatal period?"

- Very significant
- Significant
- Neutral
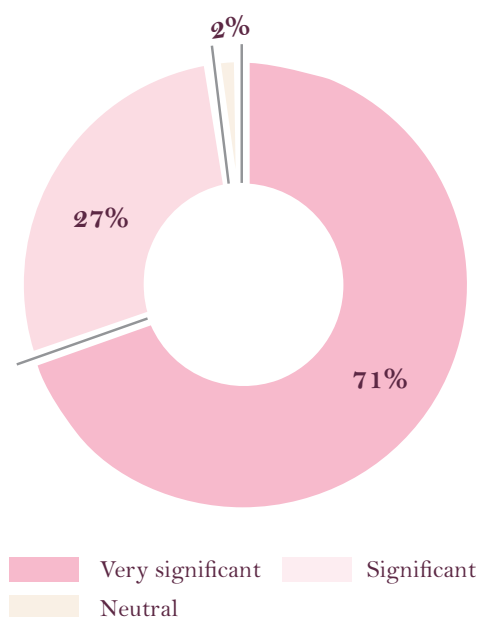
Perceived prevalence of trauma, stress and grief
Health care workers noted the high prevalence of these underlying issues and the potential for significant impact on all aspects of perinatal mental health.

"It's good to assume that there's a level of anxiety, depression and trauma in the community."

When investigating this view further in the quantitative survey, sixty-one percent of respondents agreed with the above statement, whilst the remaining responses varied with twenty-three percent (23%) of respondents 'neither agreeing nor disagreeing', and only sixteen percent (16%) disagreeing.

Managing trauma and grief
Further, when asked about their *perceived ability to identify and manage* issues surrounding trauma, stress and/or grief, most respondents (74%) indicated that they were 'currently satisfied' with their services ability to *identify* these issues (with only 10% being 'dissatisfied'). However just over half (57%) indicated that they were 'satisfied' with the *ability of their service to actually address these issues* (23% dissatisfied, 20% neutral). These results were also commented on in the larger survey when respondents were asked to comment on their ratings.

"In relation to the answers above, I've indicated neutral as I believe we have some capacity to be able to support and address these issues for women and their families during the perinatal period and I wouldn't say we are dissatisfied – but there is certainly room for improvement/enhancing our capacity to respond in a more timely manner and with greater preventative rather than such a reactive focus."

Other issues

In addition to the issue of trauma, stress or grief, services were also invited to identify other areas that were particularly important to be aware of when working with Aboriginal and Torres Strait Islander women in the perinatal period.

"Domestic violence is almost 'normalised' as part of life – may not always be physical, it might be emotional or verbal, but that's got to have an impact."

The most commonly identified issues included:

• Domestic violence
• Financial issues
• Housing
• Drug and alcohol issues

Perceptions of risk factors

Perceived presence of risk factors

Consistent with the high perceptions of trauma, grief and loss, there was a strong perception that Aboriginal and Torres Strait women were exposed to high levels of risk factors for perinatal mental health conditions expressed in the qualitative phase.

"There are multiple risk factors present in community and families."

Whilst the actual proportion of women perceived to possess risk factors for perinatal mental health across services varied across the quantitative sample, most respondents (93%) perceived Aboriginal women to be *'more likely'* to be at *risk of emotional and mental health problems* when compared with Non-Aboriginal women (and only 6% estimating the risk to be the same).

Survey responses provided further insight into the perceived major risk factors for ATSI women in the perinatal period in their health setting/community:

"Domestic violence, drug and alcohol use, past stress and trauma."

"In no particular order: (1) Poverty and socioeconomic disadvantage (2) Lack of access to education and supports – particularly for young/ teenage Aboriginal and Torres Strait Islander women but also an issue for many others (3) Social isolation, disruption of families (4) Institutional racism – adverse experiences for Aboriginal and Torres Strait Islander women attending hospitals and other service providers for care (5) Pre-existing health conditions including addictions such as smoking, heavy alcohol consumption, marijuana and other drug use; pre-existing mental health conditions including depression, anxiety, PTSD, and others."

"– Age – Financial Difficulties – Lack of transport – Health – Lack of support – Childhood trauma – Family history."

"The social determinates of health (e.g. housing, income). Trans-generational impacts of colonisation."

"Domestic violence and dysfunction in relationships. Childhood trauma (including abuse, experience of being in foster care). Substance abuse – either as a precipitating factor, or as a factor which increases/ augments other underlying risks."

"Young single mothers, substance abuse, family violence, poverty, overcrowded housing or no housing, chronic disease."

In turn, these factors culminate in the perception that Aboriginal women in the perinatal period are more likely to experience emotional and mental health problems when compared with non-Aboriginal women.

Figure 9.4: Do you consider that Aboriginal and Torres Strait Islander women are more or less likely to be at risk of emotional and mental health conditions in the perinatal period when compared with non-Aboriginal women?

Legend:
- Aboriginal women much less likely
- Aboriginal women less likely
- The same
- Aboriginal women more likely
- Aboriginal women much more likely
- Don't know
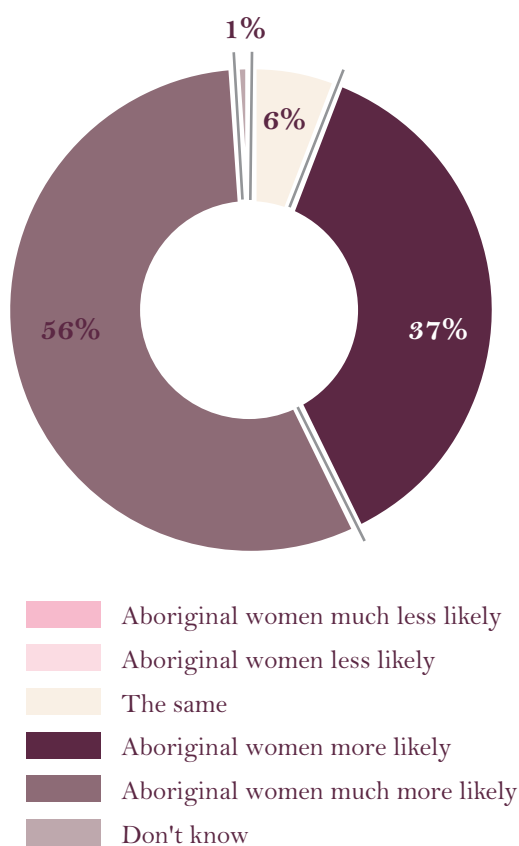
Thus *all* (100%) respondents in the survey indicated that it was important to assess for risk factors, with 94% stating this was *very important* and 6% stating that it was *important*.

Perceived confidence to assess and address risk factors

In terms of *confidence to assess and respond to risk* factors, most health professionals interviewed were very familiar with the potential risk factors that women were exposed to, demonstrating high levels of awareness of the communities, social challenges and the experiences of the women themselves.

The high levels of confidence in the assessment of risk factors was also reflected in the quantitative responses, with most services rating high levels of confidence to *assess* such risk factors amongst this population (82%). Only twelve percent indicated that they were '*not* confident', and 6% were 'neutral'.

Around two thirds of respondents (65%) were satisfied with the ability of their services to *respond* or address these risk factors (i.e. do something about), whilst 19% were neutral and 16% were *dissatisfied* with their ability to respond. When asking respondents to identify what may prevent risk factors from being identified and/or addressed, responses included staffing constraints (93%), time constraints (86%), financial constraints (79%) and travel (59%).

Perceptions of perinatal mental health conditions

Perceived prevalence of mental health conditions

Whilst the qualitative interviews revealed that most health professionals had high levels of awareness of the *range of risk factors* that women were exposed to, there were a variety of views as to their subsequent *impact upon mental health* in the qualitative phase.

In particular, whilst *some* health professionals in the qualitative consultations perceived that because Aboriginal and Torres Strait Islander women were *more likely* to possess risk factors, this in turn placed women at *greater risk of mental health conditions*.

Conversely, other health professionals interviewed perceived it to actually build resilience and make them at *lower risk of mental health problems*.

As a result, these health professionals in the qualitative phase were more likely to express the view that perinatal mental health is *not* as prevalent for Aboriginal and Torres Strait Islander women as it is for non-Indigenous women. In some instances this perception appeared to be related to the health professionals' observations,

"It's very rare to see it in Aboriginal women (postnatal depression)."

"I focus on it (perinatal mental health) and am very aware to pick up the signs, but don't see much postnatal depression."

"You can't take for granted that Aboriginal people experience PND like non-Aboriginal people."

In other instances these views appeared to be related to the health professionals strong perceptions of the differences between Indigenous and non-Indigenous women, inferring that conditions like postnatal depression were not relevant to Aboriginal and Torres Strait Islander women, but rather was a 'white-woman's' syndrome.
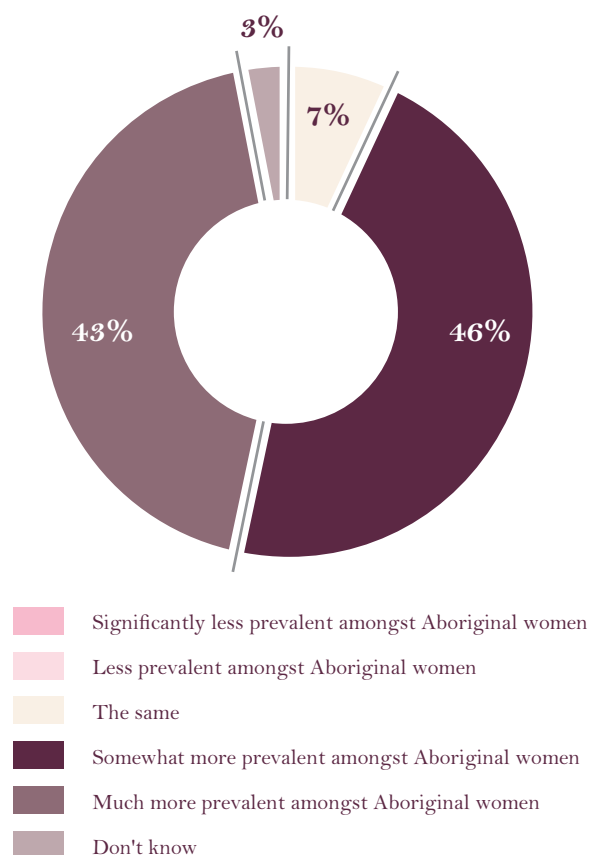
"It's the worrying well white woman."

"Perinatal / infant mental health has become very 'fashionable' in the white world."

"I have heard Aboriginal health workers say 'That's a white woman's disease, we don't get that (postnatal depression)'."

These contrasting perceptions regarding risk of developing perinatal mental health conditions and relative prevalence rates was further explored in detail in the quantitative survey.

When asking whether Aboriginal and Torres Strait Islander women were more or less likely than other women to experience perinatal mental health conditions, overall Aboriginal and Torres Strait Islander women were perceived to be *more likely experience mental health conditions such as depression and anxiety.*

Figure 9.5: How prevalent do you consider perinatal mental health conditions are amongst Aboriginal and Torres Strait Islander women compared to non-Aboriginal and Torres Strait Islander women?

- Significantly less prevalent amongst Aboriginal women
- Less prevalent amongst Aboriginal women
- The same
- Somewhat more prevalent amongst Aboriginal women
- Much more prevalent amongst Aboriginal women
- Don't know

In fact, *almost all* (90%) indicated these conditions were perceived to be *more prevalent* (either somewhat or significantly) for this population group, with only seven percent estimating the presence to be the same as non-Aboriginal women whilst three percent indicated that they 'did not know'.

Further, the survey also sought to quantify some of emerging views surrounding mental health conditions in Aboriginal and Torres Strait Islander women as opposed to other women in the population, as derived from the qualitative phase. This was considered important to ascertain the level to which these views may be held amongst health professionals and managers more broadly.

The majority of respondents refuted some such views, for example 83% of survey respondents disagreed with the statement that 'it is very rare to see such conditions like postnatal depression'. Further, only six percent of respondents agreed that 'postnatal depression was rare amongst Aboriginal and Torres Strait Islander women', and sixty-eight percent of respondents agreed with the statement that 'there is a lot of postnatal depression amongst Aboriginal and Torres Strait Islander women'.

Despite varying views in the qualitative phase, there was consistency across with respect to the perceived importance of *identifying and addressing perinatal mental health conditions* within this population. Here *almost all* respondents (97%) indicated that they perceived that it was *important for their service to identify the presence of perinatal mental health conditions* as part of standard care (with 87% indicating it was 'very important').

Perceived confidence to identify and address perinatal mental health conditions

Most respondents (89%) indicated that they were confident to *identify* perinatal mental health conditions amongst their clients, however again the *confidence to respond* to these issues was slightly lower. Here seventy-one percent of survey respondents were 'confident to respond' to such issues whilst nineteen percent were 'not confident', and ten percent indicated that they were 'neutral' on this issue.

Finally, when asking respondents' to identify the main barriers to assessing and/or addressing perinatal mental health problems, overall these were *less frequently identified* when compared with identifying risk factors with around half of responded indicating barriers such as the woman being anxious about attending a hospital setting (61%), lack of trust (55%), transport (46%), uncertainty of outcomes for the woman (46%), lack of staff (46%), lack of services to refer to (45%) followed by lack of time (38%) and least of all language (25%).

Chapter Summary

This chapter focuses on the *perceptions of health professionals* when working with Aboriginal women in the perinatal period and considering the specific needs of this population.

Health professionals highlight a number of fundamental differences when working with Aboriginal and Torres Strait Islander women. In particular this includes the *context of social and emotional wellbeing* (that incorporates mental health), and hence they emphasise the need for a *holistic approach* to healthcare. Healthcare workers also described how Aboriginal and Torres Strait Islander women *communicate and express their emotional and mental health concerns* in a different way to non-Aboriginal women.

Another key factor when working with this population particularly is the issues surrounding trauma, stress and grief, which are considered to be highly prevalent and fundamental aspects in the provision of care. Added to this are issues such as domestic violence, drugs and alcohol, financial and housing issues – all of which are considered highly prevalent within the context of working with this population group.

In turn, the presence of these social determinants lead healthcare professionals to perceive Aboriginal and Torres Strait Islander women to possess *more risk factors* (for perinatal mental health), and more likely to experience *perinatal mental health* conditions than non-Aboriginal women in the perinatal period. Whilst many healthcare workers spoke of *high levels of resilience* of this population, generally this did not translate into reduced rates of mental health conditions across the sample.

When providing care for this population, overall, healthcare workers indicate positive ratings of confidence to *identify and manage* issues surrounding trauma/stress, perinatal risk factors and mental health conditions. Whilst generally more time was perceived to be needed to address social and emotional wellbeing (than actually occurred), the majority were satisfied with the ability of their service to *respond to* (actually do something about) addressing trauma, stress and grief, risk factors and mental health issues, although a modest proportion were not satisfied (ranging from 16-23 %) or 'neutral' on this issue (ranging from 10 -20 %). The perceived barriers to assessing risk factors was higher overall when compared with assessment of perinatal mental health conditions, largely due to resource constraints (time, staff and financial) whereas barriers for assessing mental health problems largely involved concerns, trust for the women followed by resource constraints.

Recommendations:

This population is perceived to be at significantly greater risk of perinatal emotional and mental health problems, and hence recognition of this risk needs to be addressed in the provision and delivery of services.

The context of Aboriginal and Torres Strait Islander peoples and cultural safety should be central in the planning and delivery of perinatal services.

Resource constraints are perceived to be impacting on the ability of healthcare workers to address risk factors, and hence needs to be considered in context of the high risks within this population group.

As concerns held by the women themselves are likely to be identified as perceived barriers to addressing mental health issues, attention needs to be directed at understanding and addressing the needs of Aboriginal and Torres Strait Islander women specifically.

10. CURRENT PERINATAL SCREENING PRACTICE

OBJECTIVE TWO

The perceived importance of screening for perinatal mental health will be evaluated together with a detailed scoping of current screening practices (if any). This will include a detailed scoping of what, when and how screening is undertaken, and also assess how screening data is currently managed and utilised.

Importantly the study will also identify the key drivers and barriers to screening. This includes obtaining very detailed information surrounding the use of the EPDS across communities, as well as approaches to evaluating psychosocial risk factors. These issues will be considered in light of the impact of dispossession, interruption of culture and intergenerational trauma which have significantly impacted on the health and wellbeing of Aboriginal and Torres Strait Islander people.

In reference to the National Perinatal Guidelines, the Project will provide the Department with information to inform future planning and possible approaches to increase perinatal mental health screening across primary health care settings for Aboriginal and Torres Strait Islander women and their families.

The second key Project objective sought to assess what practices *actually* occur (as opposed to what may have been considered important) amongst health professionals across the New Directions Mothers and Babies Settings. Hence, this objective is focused on exploring and gaining insight into **current practice** used by individual healthcare workers. To achieve this, the questions in both the qualitative and quantitative stages, pertained to the processes used to undertake identify both *risk factors* as well as the presence of possible *perinatal mental health conditions* amongst Aboriginal and Torres Strait Islander women.

For each of the areas, information was obtained to determine the *extent to which assessment and screening practices* is occurring. In particular details were collated with respect to *what* is assessed and *when* this is likely to occur in the perinatal period. In addition questions were also asked to identify *which tools (if any) are used* in the assessment process and *how these tools are administered* across settings.

Given the existence of screening policies in certain states (i.e. Safe Start, NSW) and the longer history of screening in some states (e.g. WA), the impact of geographic locations was also assessed in relation to screening practice.

Finally, questions were also asked to ascertain *what happened with the data following screening*, namely *if* and *how* it was recorded and whether it is used for reporting purposes.

Key outcomes

Importance of assessing social and emotional wellbeing
While there was universal agreement regarding the *importance of assessing* aspects of social and emotional wellbeing and mental health (Objective 1), the qualitative interviews suggested that when it comes to *actual practice*, there was enormous variability as to *how* social and emotional wellbeing and mental health of Aboriginal and Torres Strait Islander women was actually assessed in the perinatal period.

Some health care workers were guided by various clinical practice guidelines, for example the national maternity assessment guidelines, while others considered that an opportunistic approach and knowledge of the woman and her circumstances were the best approach to exploring social and emotional wellbeing in women.

"The national maternity assessment guidelines are used. This may be done at home as part of an adult health check. Priority areas initially depend on geographic location."

Variability was also suggested in the approaches taken to assessing social and emotional wellbeing and mental health, from using a multidisciplinary team approach to a midwife's insistence that health professionals should play the key role in the social and emotional assessment of Aboriginal and Torres Strait Islander women.
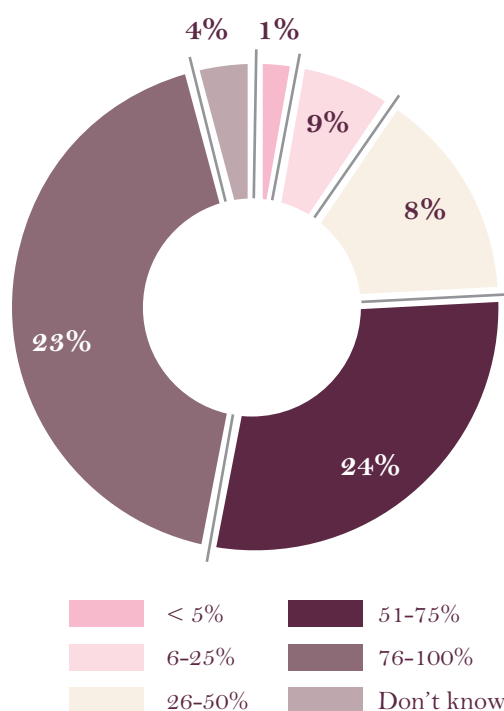
Assessment of risk factors

Practice surrounding the assessment of risk factors
As indicated in Chapter 9, the majority of health professionals (94%) held the broad *perception* that Aboriginal women were more likely to be at risk of emotional and mental health conditions. This perception is likely to be informed by their experience in their own services, as when asking health professionals to consider clients within *their service specifically*, a similarly high proportion of women were estimated to *possess risk factors*.

Here two-thirds of respondents in the quantitative survey indicated that over *fifty percent* of their clients possessed risk factors with one-third indicating that this likelihood is between 76-100%. Further analysis of the spread of these estimations across settings revealed that this did not vary across metropolitan, regional or remote areas.

Figure 10.1: Thinking about possible risk factors for perinatal mental health, what proportion of clients at your service would you estimate possess risk factors?

Legend:
- < 5%
- 6-25%
- 26-50%
- 51-75%
- 76-100%
- Don't know

The importance of risk factors for this population group was also substantiated by the fact that *all respondents* indicated that it was important to assess risk factors in Aboriginal and Torres Strait Islander women with ninety-four percent giving this the highest rating of 'very important'.

This could go some way to explaining why for many health practitioners interviewed in the qualitative phase, the focus seemed to be predominantly, or in some cases entirely, on risk factors and the structural issues surrounding social and emotional well-being.

"In the Aboriginal way it's very rare to see the flat face and if we do see it its more likely to be because of domestic violence."

Most of these health practitioners interviewed were very comfortable discussing the risk factors and structural issues surrounding social and emotional wellbeing with clients, which was supported in the survey (see Objective 1). From the qualitative discussions however, often it appeared that mental health conditions, like depression or anxiety, are not focused on.

"Assessment focuses on things like: stress, trauma, grief, family situation and support, housing situation, domestic violence, drugs and alcohol, financial situation."

In many instances it is likely assumed that if the risk factors are addressed then any mental health issues will be resolved. The predominant focus on risk factors in the qualitative stage in the qualitative (versus the quantitative) stage, may reflect the higher proportion of health professionals interviewed being of Torres Strait Islander background.

Proportion of women assessed for risk factors
To evaluate current practice surrounding the assessment of risk factors, respondents were asked to estimate the proportion of women who were likely to be assessed to detect possible risk factors within their service.

When reviewing current practice, the majority of services indicated that they do assess women to detect the presence of possible risk factors as part of standard practice, with sixty-five percent of practitioners reporting this to be done '76-100%' of the time.

Figure 10.2: As part of standard practice, what proportion of women would be assessed to detect the presence of risk factors in your service?

Legend:
- < 5%
- 6-25%
- 26-50%
- 51-75%
- 76-100%
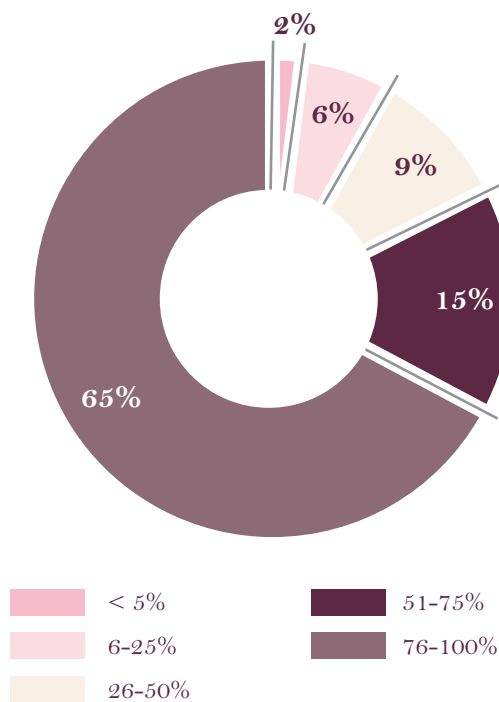
The proportion of women *being assessed* to detect the presence of risk factors did not vary across geographical areas, with similar proportions being assessed across the different states and territories and across metropolitan, regional and remote services.

Timing of risk factor assessment

Assessment of *when* risk factors were assessed revealed that most services undertook this *both antenatally and postnatally* (90% of respondents). In most cases this was undertaken routinely either always (65%) or often (20%), and these rates were consistent across geographic locations.

Approach to assessment of risk factors

When looking into *approaches* taken to assessing social and emotional wellbeing and mental health, here the qualitative consultations suggested variability in current practice (Objective 1). Similarly the tools that services used to assess risk factors also differed considerably.

Interestingly, when asking health professionals in the qualitative stage about what tools or questions (if any) were used to assess risk factors, often the EPDS or adapted versions of it was indicated to be used despite the fact that this is not actually a risk assessment tool (rather it is a tool to assess the presence of possible depression and/or anxiety). Hence, there seems to be some level of confusion regarding appropriate approaches to risk assessment.

"We use the EPDS (to assess risk factors), but modify it to suit the client. Changing the words around seems to work ok. It takes a lot longer to do it verbally and it's more confronting so we tend to just use the questions and weave them into conversation."

The qualitative research also revealed a range of approaches used to assess risk factors including using a standard list of questions or alternatively taking a more informal spontaneous approach.

"We tend to take a more informal approach, for example, will ask about how they're sleeping; anything that's worrying them; about 'dad' and family involvement and their support network."

When specifically asked and prompted about standard questions used to identify the presence of risk factors in the quantitative survey, most services (79%) indicated that this was undertaken using a *standard list of questions*. A further 21% of respondents indicated that questions were asked spontaneously as there was *no formal process*. Further comments were made about this in the survey:

"We use both questionnaire and spontaneous questions."

"Whatever is appropriate for the individual client."

"White fella ask questions."

These questions were either read out on a questionnaire/prompt sheet by the health worker (39%), were asked spontaneously by the health worker based on clinical judgment (20%) or asked by asking the woman to complete a questionnaire (16%). Twenty-two percent (23%) of people indicated that they used a mix of approaches.

Figure 10.3: How are questions around risk factors asked?

1%
23%
39%
16%
23%
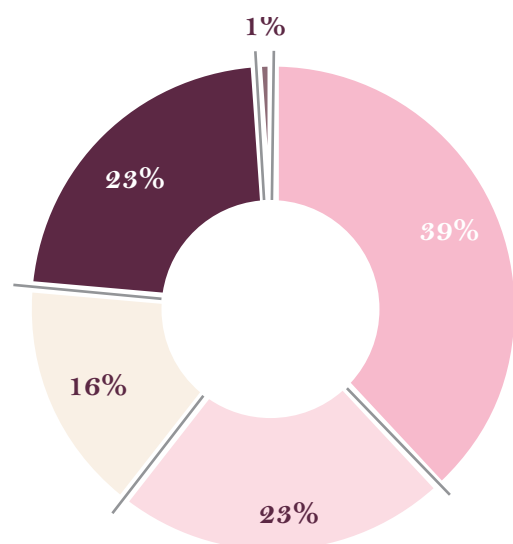
Questions read from questionnaire
Questions asked spontaneously
Questionnaire given to client
Mixed approach
Questions not asked

Secondary analysis of results showed that the way in which women were assessed to detect the presence of risk factors (namely the tools used and timing) did not vary across geographical areas.

Areas of assessment of risk factors
When exploring the specific *types of risk factors* that were enquired about, those most frequently noted in the qualitative stage were domestic violence, drug and alcohol misuse, trauma and social disadvantage (namely lack of transport, appropriate housing and education).

"Domestic violence is almost 'normalised' as part of life – may not always be physical, it might be emotional or verbal, but that's got to have an impact."

"There are multiple risk factors present in community and families. We're usually aware of family situations prior to pregnancy and can explore further as needed"

When investigated in the quantitative survey, the risk factors that were inquired about were derived from the Clinical Practice Guidelines with opportunity to add others. In response, the most common areas that were reported as being assessed are represented in Table 10.1.

Table 10.1: How likely is it that your service would enquire about each of the following risk factors?

Risk Factors	Very unlikely	Unlikely	Neutral	Likely	Very likely
Past or present mental health disorders	0%	6%	0%	25%	69%
Past or current physical, sexual or psychological abuse	0%	3%	4%	37%	56%
Current drug and/or alcohol use	0%	0%	0%	16%	84%
Recent life stressors	0%	3%	3%	22%	72%
Quality of the woman's attachment with her own mother	5%	21%	30%	28%	16%
Current practical and emotional Support	0%	0%	5%	24%	17%

Consistent with those identified in the qualitative stage, *drug and alcohol use* was consistently asked about across the sample together with *current life stressors*, *current or previous mental health problems* and *access to current practical/emotional support*.

Past or current *physical or sexual abuse* was reported to be 'very likely' to be enquired about by just over half of respondents (56%) and 'likely' to be enquired about by 37%. This lower result may reflect difficulty for some practitioners to enquire in this area. In addition, the most commonly noted 'other' risk factor in the quantitative survey was family and/or domestic violence. The assumption is made that this is reflected in the overall high response rate to likelihood of asking about past or current physical, sexual or psychological abuse.

The *quality of attachment with the woman's own mother* was less frequently asked about and this was reflected in both the qualitative and quantitative stages.

Barriers to assessing risk factors

When exploring possible barriers to screening for risk factors, the following were identified (% of respondents identifying this barrier):

- Woman anxious about attending hospital or health service (61%)
- Lack of trust (55%)

- Personal knowledge of woman by service workers (confidentiality concerns) (54%)
- Transport (46%)
- Don't have resources – staff (46%)
- Uncertainty about outcomes (46%)
- Lack of services to refer to (45%)
- Stigma (44%)

Documenting/recording risk factors

When assessing *how* information about risk factors was recorded, most (78%) indicated that this was 'entered onto a computer'. Further, 56% indicted that notes were 'written into patient file' and/or that the 'questionnaire prompt sheet was put in to the file' (39%).

Most people appear to be currently 'satisfied' with their current approach(es) to recording risk factors stating this to be 'useful' (42%), 'very useful' (38%) or 'neutral' (15%) with only 5% stating it to be 'not very useful'.

Just less than two-thirds of the sample indicated that this data was 'used for reporting purposes' (63%), whilst 19% were 'unsure' and an equal proportion indicated that it was 'not used for reporting purposes' (18%).

Assessment of perinatal mental health conditions

Following, the assessment of practices surrounding the detection of risk factors, respondents were also asked about their current practice surrounding the assessment of women to detect the possible presence of *perinatal mental health conditions* like depression and anxiety.

Extent to which perinatal screening for mental health conditions is undertaken

The survey revealed that almost two thirds of respondent's (66%) indicated that they assessed a high proportion of their clients (76-100%) to detect the presence of perinatal mental health conditions, with a further 12% undertaking this for 51-75% of their clients.

Proportion of women assessed using a formal screening tool (e.g. EPDS) to detect the possible presence of perinatal mental health conditions such as depression or anxiety

While the qualitative consultations suggested that many people also used formal assessment practices such as the Edinburgh Postnatal Depression Scale, an informal approach was also often described as an appropriate way to conduct assessments. This view around informal assessments was also supported in the quantitative survey whereby about two thirds of respondents (73%) agreed that *'women will open up more about symptoms when the assessment is less formal'*. Only ten percent disagreed with this statement and fifteen percent were neutral.

Despite this general perception, results from the quantitative survey reveal that over sixty percent (61%) of respondents indicate that most of their clients (76-100%) were assessed using a formal screening tool to detect possible depression and anxiety.

Figure 10.4: What proportion of women will be assessed using a formal screening tool (eg EPDS) to detect the presence of perinatal mental health conditions (such as depression or anxiety).

< 5%	51-75%
6-25%	76-100%
26-50%	Don't know
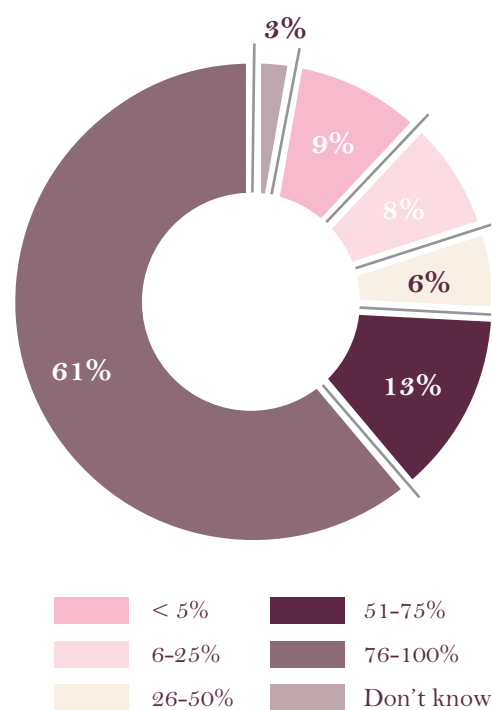
Timing and frequency of screening for perinatal mental health conditions

In most instances this assessment is conducted both *antenatally* and *postnatally* (75%), whilst a small proportion (10%) only screen when the opportunity presents or when issues arise.

Interestingly, only half of respondents said that screening was 'always' undertaken routinely (52%) with 29% indicating that this was done 'often'. A further 9% said this was done sometimes, rarely (7%) or never (2%).

Figure 10.5: Do you undertake this assessment for possible symptoms routinely (i.e. are all women asked questions)?

Never
Rarely
Sometimes
Often
Always
Don't know
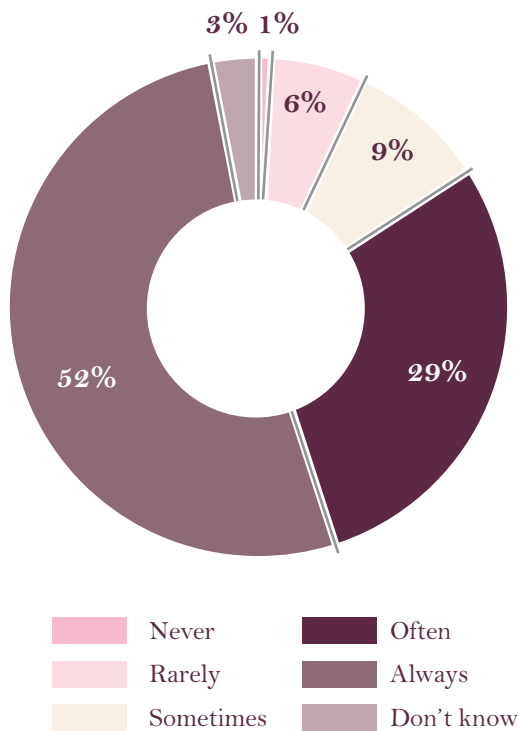
Both the timing and frequency of screening for perinatal mental health conditions was not seen to vary across geographic locations.

Tools used to assess for perinatal mental health conditions
There were a wide range of views expressed regarding the type of tools used to assess the presence of perinatal mental health conditions as well as their perceived appropriateness for the Aboriginal and Torres Strait Islander population.

Most health care workers interviewed in the qualitative stage had strong and contrasting views about the EPDS and its appropriateness for use with Aboriginal and Torres Strait Islander women. This was across the sample and did not reflect the professional background of the respondent or whether they were Aboriginal and Torres Strait Islanders. Some believed that the EPDS was a very useful tool and deemed appropriate to use with this population group.

"I use the EPDS in its original form and its fine with my Aboriginal clients."

In contrast, others had a less supportive view and did not consider the EPDS to be appropriate for their clients. Some expressed that the EPDS was not meaningful to use, and some even went as far as to say that the tool was insulting.

"I think it's a terrible, insulting tool, hate to use it but do as I'm a midwife so follow the primary care clinical manual."

"We don't use the formal assessment. I feel that women will open up more if it's less formal. We need to use simple language with our clients or they won't understand."

"The full assessment is really a bit too long and Indigenous women don't cope with that very well."

Still others were comfortable using adapted versions of the EPDS.

"The girls (Aboriginal Mums) found the adapted version much easier to understand and it has to be language that's at their level."

Interestingly, the responses in the quantitative survey did not reflect the strength of these views conveyed in the qualitative interviews.

"I have found that the women I work with are happy to undertake the EPDS screening, I think because they have come to trust us over the course of their pregnancy. We like to have a formal score recorded for reporting purposes, but the screening we do is much broader than that, and much of it takes place as informal questions, and there have been times where the woman has given answers which put her in the 'low risk' range, but due to suspicions that the answers have been 'sanitised', and other clues that there is real distress, we have still referred the woman on to services."

When assessing these views against current practice, a high proportion of people reported that they were using the EPDS in its *original* form (57%), whilst a further twenty percent were using it in an *adapted* form. Hence the EPDS was by far the most commonly used tool (in original or adapted form) as depicted in Figure 10.6. Other tools used to assess for perinatal depression and anxiety included the Mental State Exam (9%) or the services own 'other' tool, with 13% indicating that they did not use a standard tool.

The nature of the tool used to undertake screening to detect possible depression and anxiety was not seen to vary across geographical areas in terms of the state/territory, nor in terms of being a metropolitan, rural or remote service. Further, use of the EPDS (in its original or adapted form) was not affected by the background of the health professional, with Aboriginal and Torres Strait Islander health professionals using the EPDS as much as other health professionals.

Table 10.2: Below is a series of tools and approaches that health professionals indicate that they use to detect the presence of possible depression and/or anxiety. Which of the following (if any) are used within your service?
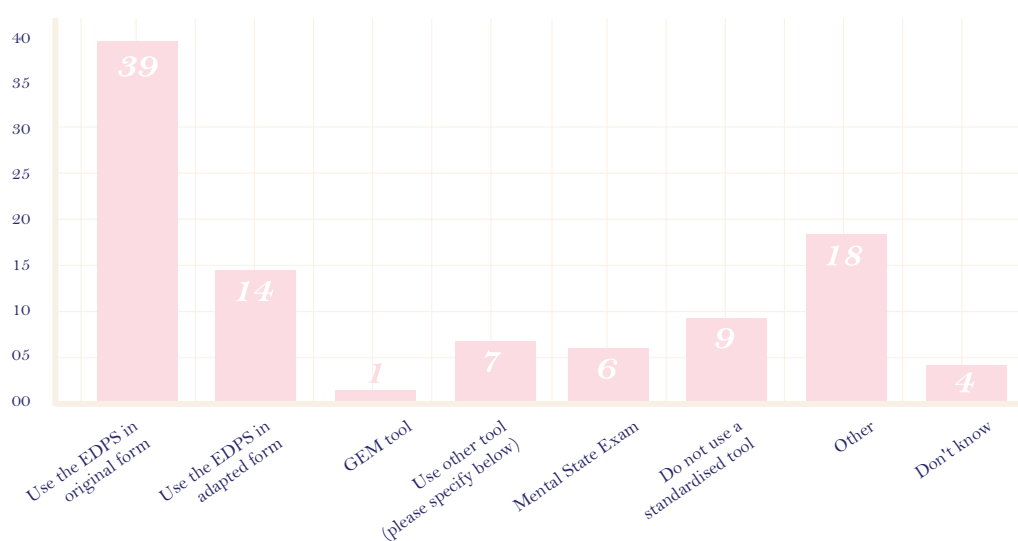
Specific views surrounding the EPDS

Further analysis of the qualitative findings showed that many health professionals using the EPDS did so because they were required to do so by their service. In particular, some said that they completed it as it was part of their professional practice, stating that they did it because they 'had to as a professional', not because they saw it as an appropriate tool for assessing their clients.

"I do it because I have to (the EPDS), but know it's not meaningful"

In order to gain further insight into the extent to which these varying views were held, particularly surrounding the EPDS, health professionals were presented with a series of statements made by their colleagues (derived from the qualitative phase) and asked to rate their level of agreement with these statements (see Table 10.3).

Table 10.3: Levels of agreement with health worker statements about the EPDS

Health Professionals Statements	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Don't know
If adapted the EPDS can be a useful tool	0	6	23	41	18	12
I think the EPDS is a terrible, insulting tool	13	30	40	7	0	9
You cannot use white women's scoring for Aboriginal women's mental health assessment	4	16	38	28	12	2
The EPDS is basically just not appropriate for our clientele	4	24	41	16	6	9
I use the EPDS in its original form and its fine with my Aboriginal clients	2	19	37	22	7	13
The EPDS is not language appropriate	4	15	31	31	10	9

The above results, in particular the high proportion of respondents indicating a 'neutral' response to each of these statements highlights the *lack of a firm or consistent viewpoint* with respect to the role of the EPDS in the Aboriginal and Torres Strait Islander population.

A secondary point of note in analysis of the responses was the higher proportions of respondents who agreed or disagreed with each of these statements, with very few people *strongly* agreeing or *strongly disagreeing*. This suggests therefore that the strong views expressed in the qualitative phase were not reflected across the sample but rather were likely to exist in isolation.

A review of the above statements also suggests that although many people (29%) are 'using the EPDS in its original form and deem it 'appropriate' for use with their Aboriginal clientele, others highlight the potential limitations of the scale, indicating for example that it is 'not language appropriate' (41%) nor appropriate to 'use a white woman's scale' for this population group (40%). Whilst recognizing these limitations, the potential value of the tool is likely to be reflected in the fact that a significant proportion of respondents believe that the EPDS 'can be useful if adapted '(59%).

To further explore the potential disparity of views surrounding the EPDS, further analysis was undertaken to assess whether these views differed according to the *position of the respondent* (clinician versus manager, or both) and the *location of the service* in terms of the state or territory that the service was located in, and whether it was located in a metropolitan, regional or remote area.

The position of the person completing the survey could not be attributed to any of the variance in views across each of the statements. Further, the responses to the statements did not differ on any of the items except for one response based on location of the service. Specifically, people in regional areas were significantly more likely to disagree with the statement that the EPDS is 'just not an appropriate tool for our clientele'. While this demonstrates the disparity of views about the scale it also highlights its potential value.

Approach to administering screening

As with the risk factor questions, in most cases the screening tool used to detect perinatal depression and anxiety were read out from a questionnaire or prompt sheet and completed by the health professional (40%) or completed by the woman herself (23%). An additional 17% of respondents indicated that the questions were asked spontaneously, 18% a mixed approach or not asked at all (2%). These patterns of screening approaches were similar across geographic locations.

Most respondents indicated that their current approach to assessing clinical symptoms amongst Aboriginal and Torres Strait islander women was very useful (24%) or useful (52%), whilst 19% indicated that it was not useful or were neutral/ didn't know (6%).

Barriers to screening

A number of barriers to effective screening were identified in the consultative stage. Some of the barriers that health care workers identified that may hamper mothers from attending antenatal sessions included structural barriers such as *inadequate finances, lack of transportation, or having no-one available to mind other children.*

Many health care workers were aware of major logistical challenges for rural Aboriginal people accessing care. Many believed that the poor transport arrangements restricted access and the patients' ability to attend appointments. In some areas, access to transport was critical and health care workers described examples of Aboriginal patients' negative outcomes resulting from poor access. Some services were able to provide assistance with transport, which was identified as an important enabler to screening.

"It's very difficult for the more isolated mums to do routine ante-natal care - due to transport issues usually – so that's why that first assessment is so important."

Trust was an enabler to effective screening that was often mentioned, the converse being that lack of trust could present barriers.

"There are a whole range of reasons why we might not be able to screen women. Maybe they (the women) don't feel comfortable talking to us because we're family or we know their family. It's a good thing that there are local people working here but sometimes that can be a barrier too because the women might think that everyone will know their business."

When seeking to quantify the *extent* to which these identified barriers were reflected across services, the figures below reflect the percentage of survey respondent who identified this to be an issue.

- Woman anxious about attending hospital or health service (61%)
- Lack of trust (48%)
- Uncertainty about outcomes (46%)
- Lack of services to refer to (42%)
- Personal knowledge of woman by service workers (confidentiality concerns) (41%)
- Transport (39%)
- Lack of appropriate screening tool (28%)

When further exploring the identified barriers to screening, these were validated across the sample. For example, when testing some of the statements made in the qualitative phase with the broader survey sample, most respondents (78%) agreed that '*Mothers might be worried about what will happen to their baby if they disclose any concerns (about how they are feeling).*' Conversely however, whilst forty-two percent of survey respondents indicated 'lack of services to refer to' was a barrier to screening, this did not appear to be preventing screening from occurring, as eighty-one percent of people disagreed with the statement that 'we don't screen because we don't have anywhere to refer women to'.

Enablers to screening

While there were multiple barriers to screening raised, enablers were almost universally agreed upon with ninety-six percent of respondents agreeing that 'trust and a good relationship with the woman is key to good assessment.'

Documenting/recording mental health screening outcomes

Following screening for possible symptoms of perinatal mental health problems most respondents indicated that data was 'entered into a computer' (68%), 'notes written into patient files' (46%) and/or 'questionnaires or prompt sheets placed into the patient file' (33%) or 'recorded in patient notes' (20%).

Current data recording processes were deemed by the majority to be 'useful' (57%) or 'very useful' (25%), and respondents reported that data was 'likely to be used for reporting purposes' by 79% of respondents.

Chapter Summary

The results surrounding current practice for assessing risk factors and screening for emotional and mental health conditions was seen to vary considerably in the qualitative phase, and much of this was substantiated in the survey results.

Health professionals perceive there to be a high prevalence of risk factors amongst women in their services, and attribute very high importance to this issue. *A high proportion of perinatal women are frequently assessed routinely* (65%) or often (15%) to identify possible risks in both the antenatal and postnatal periods, and in most settings this involves a formal process with most (79%) using a standard list of questions (usually read out by the health worker), whilst a smaller proportion ask spontaneously (21%). Consistent with the qualitative findings, the most commonly asked risk factors (likely to be enquired about in over 90% of cases) include drug and alcohol use, current life stressors, current or previous mental health problems and access to current practical/emotional support. Past or current physical or sexual abuse is likely to be asked about in just over half (56%) of the settings.

Screening to detect *emotional and mental health problems* such as depression and anxiety is also undertaken across the majority of services, with this appearing to be routine (occurring 75-100% of the time) in around half the services, and happening 'often' (50-75% of the time) in almost another third of settings. Despite the commonly held view that an informal approach to assessment is more optimal to encourage disclosure (73%), and the range of views expressed surrounding screening tools (qualitative phase), over half of services (57%) report to be using the EPDS in its original form, and a further 20% were using it in an adapted form.

Further enquiry into the perception of health professionals surrounding the EPDS specifically revealed fairly 'non-committal' views of the tool. For example, many health professionals remained neutral when presented with statements made by their colleagues regarding the appropriateness of the EPDS for Aboriginal and Torres Strait Islander women. Whilst highly critical statements (such as the EPDS is an insulting tool) were not supported, there was also some level of agreement that it was not ideal due to language for example, and hence many agreed it was useful if adapted (59%). In over half of the settings, screening involved a formal process of the health professional asking the questions (40%), or the woman completing the questionnaire herself (23%).

For each of these assessed domains, the location of the service was considered in further analysis, as it was possible that the State in which the service was located, and where state-wide screening policies exist or are more established, may impact on current screening practices. Similarly, it was thought possible that remoteness may impact on screening due to referral opportunities that may be limited in such areas. Overall the location of the service was *not* associated with screening practice, and hence current practice was not influenced by these factors. Use of the EPDS was also not effected by the cultural background of the health professional.

Interestingly, when exploring the *potential barriers* to screening and assessment of the above areas, the most frequently identified barriers pertained to issues surrounding confidence of the woman to disclose, trust and stigma, followed by more logistical issues such as services to refer to, transport and the lack of an appropriate screening tool. When it comes to the collection and reporting of screening and assessment data, a combination of approaches is likely to be used, with most (over two-thirds) entering data into a computer, writing case notes and/or placing record/prompt sheet into the patient file. This data was used by most services for reporting purposes, and approaches to data collection and the majority of services consider reporting processes to be useful.

Conclusion

In conclusion, there is significant screening and assessment practice currently occurring across most of the New Directions Mothers and Babies Services. Whilst approaches are not consistent, nonetheless there exists a significant infrastructure that could be built upon to improve practice and continuity across services.

In supporting the delivery of a more uniform, systematic approach to screening and assessment, there is clearly a lack of direction and clarity surrounding the appropriateness of the EPDS specifically amongst health professionals. Again there are currently a high proportion of services using the tool in its original or adapted form, yet a perception that it is not ideal and/or could be improved (for example, by making it more culturally appropriate) is likely to be limiting its uniform application.

Some of these issues surrounding the sensitivity of the tool could be assessed through a revision of the cut-off scores for this population specifically. Whilst the Guidelines[1] currently recommend cut-off scores for the tools used in the general population, a review and amendment of these scores could improve the sensitivity of the scale when used with Aboriginal and Torres Strait Islander women. This would go some way to potentially addressing the perceived barriers of the scale, whilst maintaining the benefits that the scale offers, including its current widespread use across Australia.

This does raise the question as to what the views of consumers may be, and in particular understanding their experience of the screening tools and processes, and whether this reflects the perspectives of health professionals and current practice. This *view of consumers* is also particularly important to understand when considering the potential *barriers to screening* – particularly as health professionals identified issues surrounding confidence of consumers to disclose, trust and stigma as potential barriers to screening and assessment.

These barriers may be currently enhanced and/or impeded by a range of factors such as the *screening context* (for example the communicated rationale or importance of screening) *the type of tools or questions used/asked*, and/or *how screening is undertaken* (for example, consumers may find direct questioning intimidating and fear disclosure and may prefer self-assessment or vice versa). Further exploration of this issue with consumers could ultimately provide important insights into optimising approaches to screening for the future, on which to build upon the infrastructure that is seen to currently exist. The impact of this could also be measured through reapplying the quantitative approaches used in the future.

Recommendations:

Further explore to gain insight and understanding of the *perspectives of consumers* with respect to i) using the EPDS and ii) barriers to screening in order to optimise current approaches to screening amongst Aboriginal and Torres Strait Islander women.

Consider how the perceived appropriateness and sensitivity issues surrounding the use of the EPDS could be improved. This could include, for example, undertaking research with this population to determine more culturally appropriate cut-off scores to heighten the scale's sensitivity to this population.

Build upon the significant infrastructure that currently exists to expand best practice across services. This may include for example, consideration of the role that technology could play to assist to undertake screening, and potentially alleviate some of the barriers by adopting an approach which may be less imposing/confrontational for the woman, alleviate identified resource constraints, and provide an infrastructure for recording and reporting of data.

Replication of this methodology (particularly the quantitative stage) over time could provide a mechanism to monitor screening and assessment practices over time and across New Directions Services nationally.

11. POST SCREENING REFERRAL

OBJECTIVE THREE

A specific focus will be given to examine current practice surrounding referral processes following screening. In particular the study will:

- **Examine the current capacity of sites to refer women and their families, with identified risk factors, to referral services, if available;**
- **Explore reasons why families may not access referral support services, for example perceptions of racism, in order to gain a deeper understanding of factors underpinning access to referral services (if available), including current rates of utilization;**
- **Assess the perceived confidence, or otherwise, of health professionals and their use of risk frameworks to inform decisions regarding referral of women to identified support services.**

Through this activity, the Project will identify potential solutions or adapted approaches that can ultimately improve the identification of referral pathways and their effective implementation into current practice.

In line with the objective beside, the results in the section below detail the scoping of current practice *post-screening*, with a specific focus on issues related to the referral of Aboriginal and Torres Strait Islander women.

Decision-making around referral

Like in the previous two sections, there was also enormous variability described in the qualitative interviews regarding practice around decision pathways and referral processes for women requiring support for mental health conditions in the perinatal period. In particular, the decision to refer a woman to specialist care, the nature of referral pathways and perceived referral options all varied.

Here a *range of different health professionals* were identified as being responsible for making the decision to refer a woman experiencing social and emotional or mental health conditions following screening. When specifically asked in the survey (multiple responses were possible), this could be seen to include the midwife (70%), GP/Doctor (68%), Aboriginal health worker (54%) or multidisciplinary team (48%).

Similarly, the interviews suggested that a *wide range of referral pathways* were utilized across services, both internal and external, which health care workers were familiar with.

"Referrals are made to the counsellor, GP or mental health team."

When assessing the proportion of referrals made internally and externally in the quantitative survey, the results indicated that the majority of referrals were *internal* (within organisations).

Ability to identify and refer to services
When required most respondents indicated that they were 'likely' (58%) or 'very likely' (28%) to be able to *identify appropriate referral pathways*.

In addition to being *identified*, positive responses were also obtained with respect to *service availability*. Here eighty-one percent of respondents (81%) in the survey perceived it 'likely' or 'very likely' that services would be *available*. It was perceived that it was *unlikely* that these services would be available in only thirteen percent of cases.

This was an interesting result, given that the qualitative interviews suggested that in some remote locations, it was considered pointless referring to certain services as access was limited.

"There's one mental health nurse for the region but services are inadequate and there is no appropriate referral options in the region."

"And when there aren't any appropriate referral options, what's the point in asking?"

In response to this, further analysis of the survey responses across locations was undertaken to assess whether these issues were more apparent in rural and/or remote locations or across jurisdictions. Results of this revealed that there was *no difference* between services located across states and territories, nor metropolitan, rural and remote locations in terms of ability to *identify a service*, or *service availability*.

Confidence to refer to available services
The perception that appropriate referral pathways were able to be identified and available, is likely to contribute to overall high levels of confidence to refer to such services, with eighty percent of respondents stating that they were either confident to refer [very confident (22%) or somewhat confident (58%)].

Figure 11.1: Overall how confident do you feel when referring to these services?

- 10%
- 10%
- 22%
- 58%

- Not very confident
- Neutral
- Somewhat confident
- Very confident
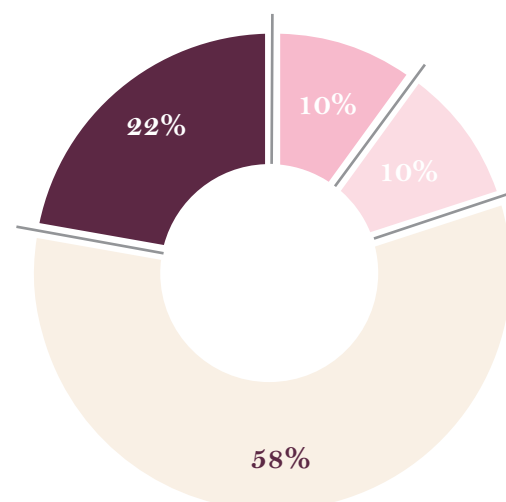
Likelihood of referrals being acted upon

Despite the high levels of confidence in *ability* to refer, there was slightly lower levels of confidence surrounding the *likelihood that these referrals would be acted* upon by the women overall.

Whilst thirty-nine percent of respondents said this would occur in '51-75%' of cases, only thirteen percent expected the referral to be acted upon in '76-100%' of cases. Of concern is the indication by forty-three percent of respondents that referrals were expected to be acted upon *less than half* of the time.

Figure 11.2: Following a referral, what do you perceive is the likelihood that women in your service actively act upon these referrals?

Legend:
- < 5%
- 6-25%
- 26-50%
- 51-75%
- 76-100%
- Don't know
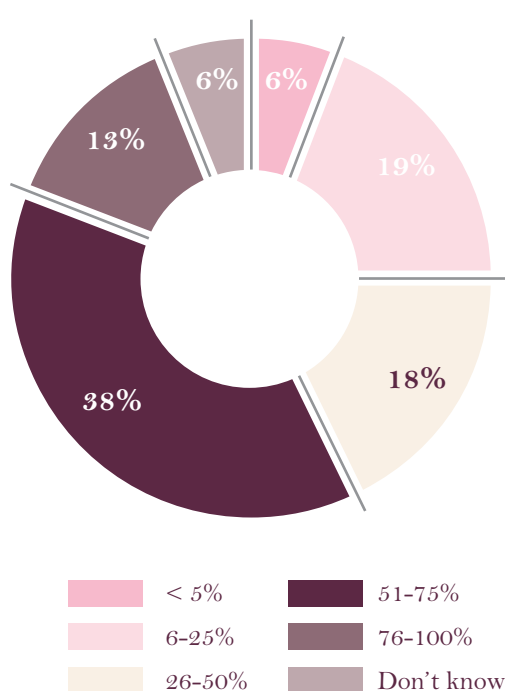
A number of factors were raised in the qualitative discussions as having a negative impact on the uptake of referrals, including lack of transport, stigma associated with the need to access mainstream or mental health services and communication between services.

When investigating the reasons for this potential lack of follow-up in the survey, a number of barriers preventing a woman from following up on a referral were indicated. Again, some of the reasons provided for this were likely to be the lack of availability of culturally appropriate services (identified by seventy-three percent of the sample) and/or poor communication with services (56%).

"The biggest barrier to assessment and follow-up is the lack of genuine communication between the Hospital and our service (ACCHO). There needs to be more integrated service delivery. It's the mindset of the medical staff that is the problem. They (the Hospital) say that they have a primary health care model but they don't."

"Transport is an issue for all of the communities, for example the DNA (did not attend) rate for hospital booking-in appointment is greater than 50%. Some women attend hospital for the first time at the time of birth."

Other issues raised pertained to issues of shame and stigma which were perceived as likely to have an impact on whether women would take up a referral.

"There is still a stigma to PND and mothers might be worried about what will happen to their baby or what people will think of them."

When comparing the range of potential barriers to uptake of referral across the quantitative sample in the survey, here those factors pertaining to shame and stigma were most likely to be identified as the key issues, and fear of outcome following referral was also rated by over three quarters of respondents to prevent a woman from taking up a referral.

- Shame and stigma about mental health (77%)
- Stigma associated with the need to access mainstream services (78%)
- Transport issues (76%)
- Fear of impact on their current situation (75%)
- Culturally inappropriate services (73%)
- Communication between services (55%)
- Racism (43%)

Improving uptake of referrals

Various strategies were suggested by health professionals as being likely to improve uptake of referrals. This included looking at the type of service that was available and offered as well as how it was made available.

Appropriateness of service for Aboriginal and Torres Strait Islander clients was considered to be a key factor, *with the provision of culturally appropriate social and emotional support* often raised as important in women taking up referrals.

This was validated in the survey with sixty-two percent of respondents agreeing that 'women didn't take up referrals because the referral services were not culturally appropriate'. Other more generalised suggestions to improve uptake of referral related to service provision overall, including improved health systems, improved communication between services and better utilisation of available funding. Again, these structural barriers however were not identified as frequently across services as other factors pertaining to shame and stigma about mental health and stigma associated with the need to access mainstream services.

Follow up of referrals

In terms of follow-up of referrals, one of the key themes was the *lack of information available* to health care workers about the process and whether referrals had actually been acted upon. This was most often related to the previous issue noted in Chapter 10 around poor communication between services.

"Our service doesn't receive any communication from the MH team regarding whether the client has accessed the service so we don't really know, other than what the woman tells us."

Chapter Summary

There were a range of practices surrounding *who* and *how* decisions were made about the referral of women across the services. Whilst the qualitative outcomes highlighted a number of concerns surrounding the availability of services to refer to (particularly in rural locations), this was not supported in the larger survey with most services indicating that they were likely to be able to *identify* services (80% of sites) and also perceived that these services were likely to be *available* (81%) with only thirteen percent indicating services to be unavailable. These findings were consistent across remote, rural and metropolitan services, and in turn likely to enhance health worker's confidence to refer, with most services (80%) indicating that they were confident to refer.

Whilst healthcare perceptions and confidence to refer was positive overall, this level of confidence reduced however when assessing the likelihood that a woman was likely to actually *act upon* a referral. Here issues surrounding stigma, fear and culturally inappropriate services were considered to be major barriers for the majority of the services (around three quarters) as was the more logistical issue surrounding transport.

In response to the issues surrounding stigma and shame, it would be interesting to explore these issues from the perspective of Aboriginal and Torres Strait Islander women in the perinatal period (the consumer), in order to gain insight and understanding as to what would make them more comfortable or likely to follow-through on a referral, and how this could be facilitated.

Another identified barrier to referral uptake was communication between services which was indicated to be a barrier by half of services, and hence also a significant issue. Further this issue of communication was also seen to impede follow-up on referrals once they had been made.

Conclusion

Whilst healthcare workers are generally confident in their ability to identify services to refer women to and perceived that these were generally available, issues surrounding stigma and shame, transport and the availability of culturally appropriate services is likely to prevent referrals being acted upon. Communication between services also needs to be improved to increase the uptake of referrals and facilitate follow-up once a referral has been made.
Recommendations

Recommendations:

Further exploration about Aboriginal and Torres Strait Islander women's perceptions of referral services, to gain insight into approaches to improve the uptake of referrals across services.

Improved communication systems between services to increase the uptake of referrals and follow-up women. This could include greater use of technological approaches to facilitate the transfer of screening data across services to improve poor communication that currently exists between services.

12. TRAINING & DEVELOPMENT FOR HEALTH PROFESSIONALS

OBJECTIVE FOUR

Through gaining detailed information about current awareness, attitudes and practice, the Project affords the opportunity to determine the education and training development needs of health professionals. In particular the Project will assess awareness of existing programs, the provision of training undertaken to date and identify specific areas of training need to increase confidence and competence and to inform clinicians' and Aboriginal health workers' decisions to undertake screening and referral activity.

This information can be used to inform the promotion and/or adaption of existing programs currently developed under Closing the Gap initiatives and the NPDI to better meet the needs of healthcare workers working with Aboriginal and Torres Strait Islander women and their families.

Awareness and access to training

Awareness and access to training around perinatal mental health and dealing with social and emotional wellbeing and mental health issues was divided across the sample.

While just over half of respondents (61%) were aware of specific training that existed, and half of the sample (51%) indicated that they had access to such training, the other half did not have access (41%) or were 'unsure' (7%) if they had access to such training.

Generally, health professionals indicated that training for perinatal mental health was important, with 93% of respondents stating that training should be mandatory for maternal and child health professionals. Meanwhile almost half of the sample (48%) indicated that they felt that they have opportunities for adequate training, 22% did not feel that they had opportunities for adequate training, whilst 27% of people were 'neutral' on this issue or did not know (3%).

The benefits of training were also highlighted in the qualitative research. Here where specific training around perinatal mental health and/or social and emotional wellbeing for women in the perinatal period had been received, there was considered to be definite benefit to staff.

In particular, respondents discussed the benefit that training has in terms of giving them added confidence to 'have the discussions' required, and likely to evolve out of both formal and informal screening practices.

Similarly some respondents in the survey similarly indicated that they would like to receive further training in this area.

"I'd like training on use of appropriate language and informal questions."

In addition to the request for training in screening, the use of appropriate tools, and aspects relating to perinatal mental health in Aboriginal and Torres Strait Islander women other mentioned areas mentioned included attachment and infant mental health, drug and alcohol, trauma and domestic violence

In addition to the need for training per se, participants in the qualitative research also highlighted the importance of *culturally appropriate* training for health care workers.

"Culturally appropriate training would be good."

When quantified in the survey, this need for training that was specifically relevant to this population group was highlighted. Here 97% of respondents indicated that 'there needs to be more training specifically around the issues of working with Aboriginal and Torres Strait Islander women', with 3% neutral.

Cultural appropriateness was referred to as not just the content of the training available, but also the *delivery model*, with many practitioners highlighting that face-to-face training was the preferred modality for Indigenous health care workers.

This preference for face-to-face training was also substantiated in the quantitative research with 85% of respondents agreeing that they 'prefer face-to-face training' (12% were 'neutral' and 3% disagreed).

Supervision
Separate to training, the issue of supervision was also explored.

Overall the issue of supervision to not feature highly as an issue in the qualitative research, and this was supported to some degree in the quantitative research. Here the issue of supervision was not indicated as highly as training to be as important a factor in increasing the confidence of health professionals to explore and manage emotional well-being and mental health issues (28% versus 57%).

Further, 59% of respondents agreed with the statement that they felt that they 'had appropriate access to supervision if required', with almost a fifth (19%) disagreeing with this statement and 21% remained neutral or did not know (1%).

Provision of culturally specific resources
Whilst probably not surprising that when asked to identify *what would make health professionals feel more confident* exploring and managing social and emotional wellbeing and mental health issues, over half of the respondents (57%) indicated that training would make them feel more confident in their work.

Of particular interest however, was the rel*ative importance of other factors* that were considered important for making them feel more confident in their perinatal work. Interestingly the results indicated there was **particularly high weightings of importance** attributed to the provision of culturally specific resources for both health professionals and women and their families in the perinatal period (see Table below).

Table 12.1: What would make you more confident to address social and emotional and mental health issues in Aboriginal and Torres Strait Islander women in the perinatal period?

Identified factors	Percent (%)
Resources for women and their families – culturally specific	83%
Clinical guidelines – indigenous specific	77%
Educational resources for health professionals	63%
Assessment guides for health professionals	60%
Training	59%
Resources for women and their families – general perinatal	45%
Supervision	29%
Clinical guidelines – generic	16%

The importance of this issue was also identified and discussed in the qualitative research. Here health professionals consistently highlighted the importance of '*having culturally appropriate resources* on hand and available' for both consumers and health professionals.

"Having a culturally appropriate referral booklet in the specific area would be useful."

This area was explored in further detail by asking respondents if they were aware of existing resources such as those developed by *beyondblue*, which were currently available for consumers, carers and health professionals. In response to this, whilst many health professionals indicated that they were aware of these resources, most indicated that they did not use them in practice as they were not culturally specific and hence not appropriate for Aboriginal and Torres Strait Islander women and their families.

The importance of having culturally specific resources available for health professionals and women and their families was further emphasised when asking survey respondents to provide ratings on a number of statements raised in the qualitative research.

Here, 98.5% indicated that 'there needs to be culturally specific resources made available for Aboriginal and Torres Strait Islander women and their families', with only 1.5% remaining neutral.

Figure 12.1: There is a need for culturally specific resources to be made available for women


Legend:
Strongly agree | Disagree
Agree | Strongly disagree
Neutral | Don't know

1.5%
47.1%
51.5%
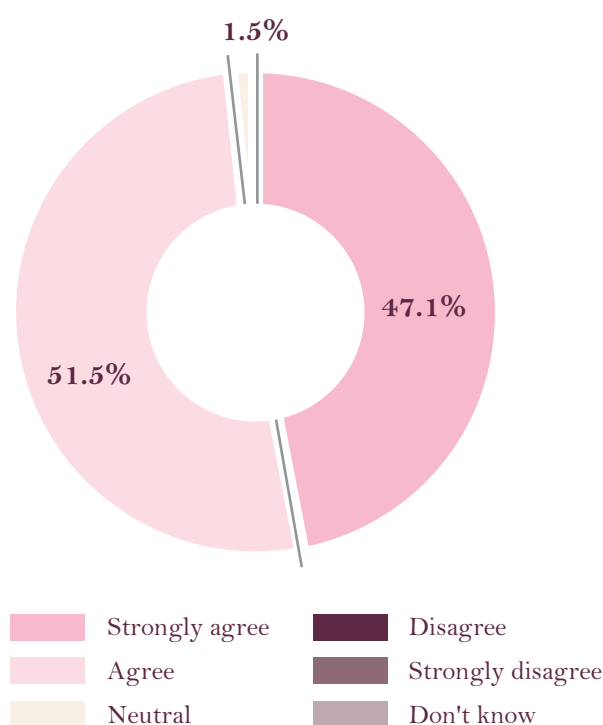
Further, commentary within the survey lead to additional comments about the importance of such resources for aboriginal women.

"It would be good to see any recent resources related to indigenous women and their families".

Furthermore, the importance of having culturally appropriate resources available for health professionals to guide them in their practice, was also considered to be useful by all respondents.

Figure 12.2: Culturally specific resources for **healthcare workers** *would be very useful*

- Agree
- Strongy agree
- Neutral
- Disagree
- Strongly disagree
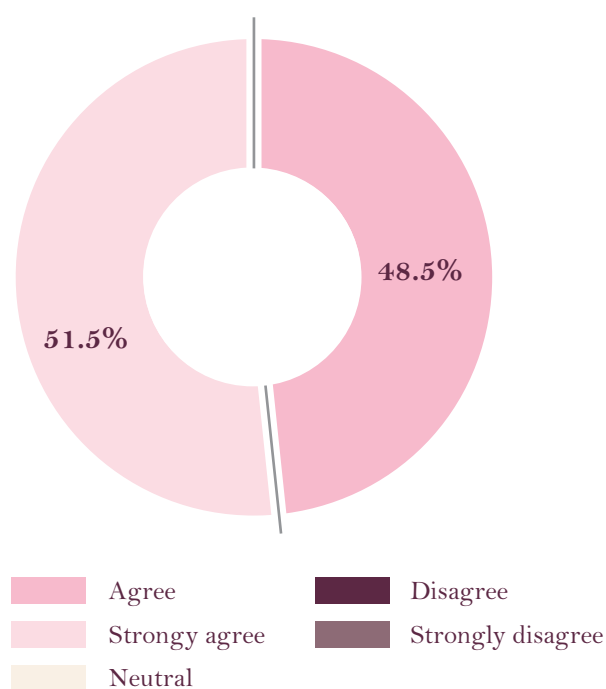
The National Perinatal Depression Initiative (NPDI)

Further to assessing current needs for training and development, the project also enquired about health professionals' awareness and knowledge and of the National Perinatal Depression Initiative (NPDI) and the Clinical Practice Guidelines and their *perceived relevance* to their practice.

Awareness of the NPDI and clinical guidelines was also divided across the sample. This finding was reflected in both the qualitative and quantitative stages of the project.

Awareness of the NPDI
Here whilst some were clearly aware of the initiative, a high proportion of health professionals were unsure of the NPDI or were not familiar with the initiative at all.

When asking respondent in the quantitative stage if they were aware of the Initiative, around half indicated that they were aware, whilst 38% were not aware and just over ten percent were unsure.
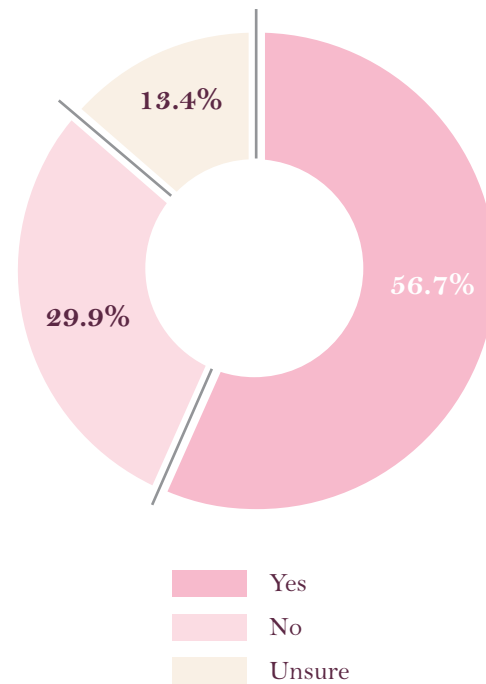
Perceived relevance of the NPDI
Despite the high proportion of people being unaware or unsure, generally people indicated that they thought that the NPDI was, or was likely to be, relevant to them.
Again this finding was replicated in the quantitative survey. Here almost two thirds of respondents either indicated or assumed that the NPDI was either very relevant (32%) or somewhat relevant (31%) to their service, whilst 18% remained neutral and 19% did not know.

Figure 12.3: How relevant do you consider the NPDI to be to your service?

Legend:
- Very relevant
- Somewhat relevant
- Neutral
- Not very relevant
- Not at all relevant
- Don't know
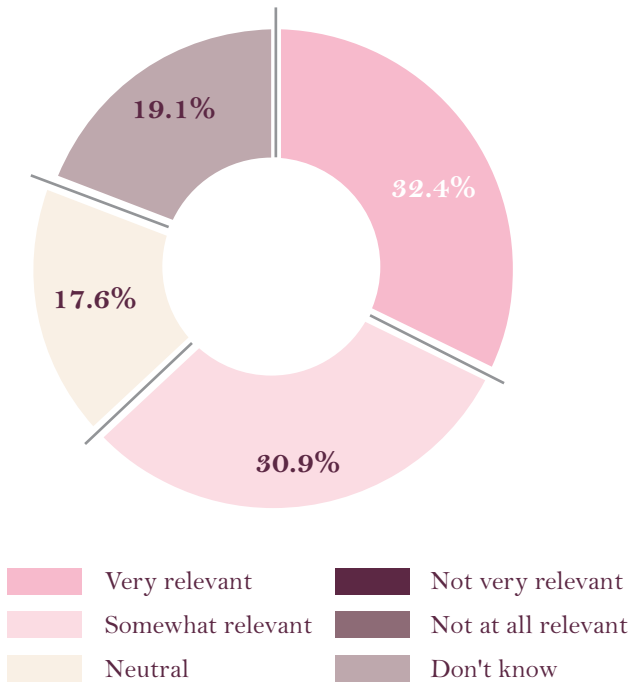
Figure 12.4: Are you familiar with the Clinical Practice Guidelines?'

Legend:
- Yes
- No
- Unsure

The Clinical Practice Guidelines

In addition to gaining insight into whether health worker viewed their work in the context of the NPDI, the project also sought to gain insight into the level of *awareness*, *perceived relevance* to their practice and *likelihood that people would use or refer* to them in their work with Aboriginal and Torres Strait Islander women.

### Awareness of the Clinical Practice Guidelines

As with the NPDI, there were variable levels of awareness of the perinatal clinical guidelines, both generally and with respect to their perceived relevance to practice with Aboriginal and Torres Strait Islander women. Some health professionals were not familiar with the guidelines at all, whilst others referred to them routinely as part of their practice. This variable response pattern was also evidenced in the quantitative survey. Here whilst just over half of respondents indicated that they were familiar with the perinatal clinical guidelines, almost a third were unsure and 13% unsure.

Perceived relevance with the Clinical Practice Guidelines

The levels of awareness of the guidelines also then translated to perceptions of relevance. Here in the qualitative stage whilst some indicated they were likely to be highly relevant, for others this there was less certainty, and the perceived relevance was more likely to be assumed. Others however, indicated that the guidelines were unlikely to be relevant, as they were not specific to Aboriginal and Torres Strait Islander women.

Again the varying results were replicated in the quantitative survey. Whilst most people indicated that these relevant (42%) or highly relevant (15%) to be relevant to their practice, whilst lower ratings were given by 7% who rated them as somewhat relevant. Just over a fifth (23%) of respondents were less clear of their relevance, with 16% indicating that they were neutral about their relevance or did not know (20%).

Figure 12.5: How relevant are the perinatal clinical guidelines to your service?

Legend:
- Not at all relevant
- Somwhat
- Neutral
- Relevant
- Highly relevant
- Don't know
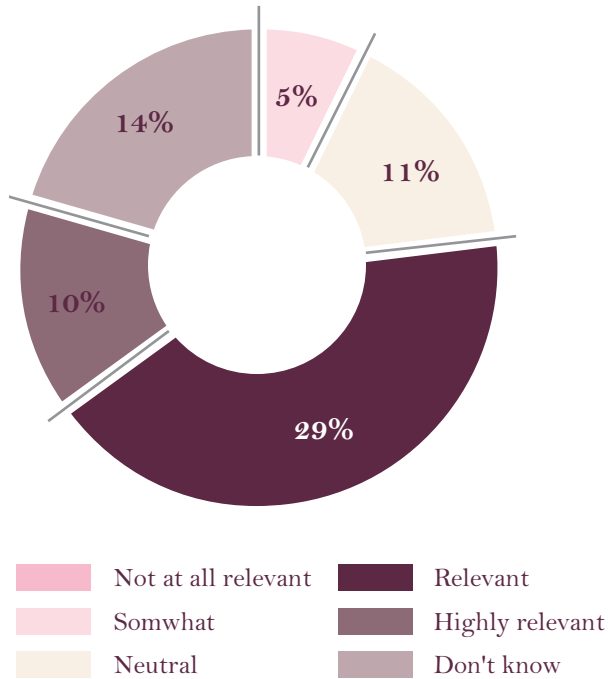
This neutrality and/or uncertainty may be partly due to the lack of awareness and/or familiarity of the guidelines (44%). Further, this finding may also reflect the perceived need for culturally specific guidelines. When considering these findings in the context of responses pertaining w*hat would assist health professionals in their practice*, the need for *culturally specific guidelines was indicated* by 77% of respondents, whereas generic perinatal guidelines (as these are likely to be perceived) were only thought to be useful by a much smaller proportion (16%). (Refer to table 12.1).

This perceived relevance in turn can be seen to reflect *actual practice*, with similar proportions of health professionals in the quantitative survey indicating that they actually referred to the Guidelines in their actual practice. Here just as around half of all respondents indicated that they were 'likely' (21%) or 'very likely' (18%) to refer to the guidelines, whilst 21% were 'unlikely' and a further 15% 'did not know'.

Figure 12.6: What is the likelihood that you would/have referred to the clinical practice guidelines to inform your practice?

Legend:
- Very unlikely
- Unlikely
- Neutral
- Likely
- Very likely
- Don't know
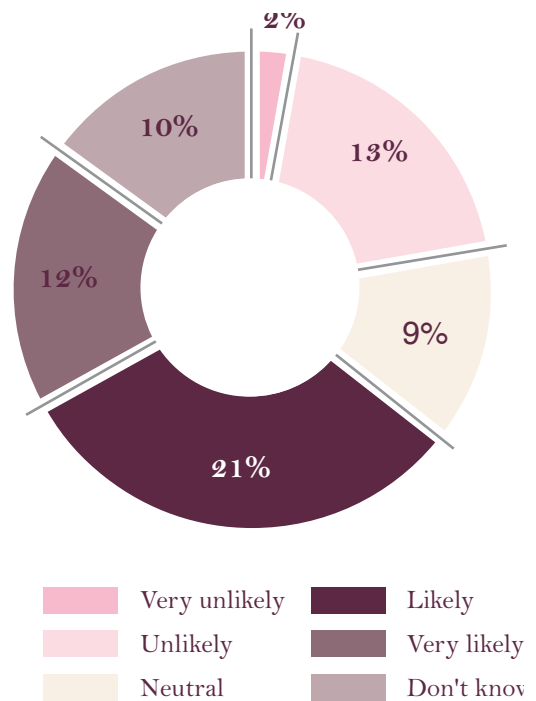
Summary

The National Perinatal Depression Initiative has been an important development in Australia, which has provided a framework for the implementation of best practice, as informed by the Clinical Practice Guidelines (developed under the Initiative). Whilst the Initiative has been in place for some time, *awareness* of the Initiative and Clinical Guidelines is variable with around half of health professionals across the services being unaware or unsure of both the Initiative and the Guidelines.

These mixed levels of awareness are also likely to have translated to mixed perceptions regarding the perceived *relevance* of the Initiative and Guidelines to Aboriginal and Torres Strait Islander women with around half considering them both to be relevant, the remaining half were unsure. This is also likely to translate into practice with around half of the work workers unlikely to ever refer to the Guidelines to inform their practice, or more broadly view their work in the perinatal area with the context of Australia's NPDI framework.

Similarly awareness and access to training was divided, and whilst almost all health professionals considered this to be very important and beneficial (when accessed), around half of health professionals were unaware or neutral about their access to training, and hence commonly identified the need for further *culturally specific* training particularly, (preferably face-to-face) with respect to processes surrounding screening and addressing risk factors (such as domestic violence, trauma).

Access to training was considered more important to increase health professionals *confidence* to explore and manage mental health problems than supervision, with more health professionals (59%) believing that they had appropriate access to supervision if required, although notably around one fifth of health professionals desired more supervision (19%) or did not know/were neutral (22%).

Interestingly however, when considering the role of training within the context of *other factors* perceived to be *most important to increase health worker confidence to address social and emotional and mental health issues in this population,* the highest ratings of importance were attributed to the provision of *culturally specific resources for women and their families.* Here almost all (99%) of workers identified this to be important to increase their confidence.

In addition to these resources for women and their families, the perceived need for *indigenous specific information for health professionals* (guidelines, education resources assessment guides) were also more likely to be rated as important when compared with training per se, the findings also suggest that the likely uptake of *generic resources* (guidelines and information for women and their families) is not likely to be successful with less than half of the sample indicating that these would be important for increasing health worker confidence when working in this area.

Given the significant investment to date under the NPDI in the development of Guidelines and resources for consumers, carers and health professionals, further investigation of this was assessed. Whilst most health professionals were aware of such resources, most perceived them not to be relevant, and hence unlikely to refer to them, or passed on to consumers.

Conclusion

Health professionals most commonly identified the development of *culturally specific resources for women and their families* as being of importance to increase their confidence to address social and emotional and mental health issues in this population. Secondary to this was the development of culturally specific guidelines or resources to health professionals – all of which was more likely to be identified over training or supervision.

Whilst the NPDI has invested heavily in these areas to date, the lack of awareness and perceived relevance to Aboriginal and Torres Strait Islander people by around half of the sample, means that the context of the NPDI and outputs are not understood by the significant proportion of health professionals working with Aboriginal and Torres Strait Islander women in the perinatal period.

Further to this, the role of technology to support and guide technicians in the screening, assessment and the referral process could further improve the knowledge and confidence of health professionals while simultaneously embedding the principles of best practice.[66] In particular, screening technology designed to guide screening and assessment by providing prompts for health professionals may be highly beneficial for those working with Aboriginal and Torres Strait Islander women (as well as for those working in the general population).

Recommendations:

> The development and provision of culturally specific resources for women and their families to assist health care workers in their role as well as inform consumers and carers. This needs to be informed by the needs and perspectives of Aboriginal women in the perinatal period.

> The provision of culturally specific resources for healthcare workers to guide practice to inform and promote the implementation of best practice across New Directions Services. Ideally these would be informed through the development of culturally specific clinical practice guidelines.

> When considering the above in the context of screening, there is an opportunity to consider the potential role of technology in the dissemination of tailored information to both Aboriginal and Torres Strait Islander women and health professionals at the point of screening. This could provide an enormously cost effective approach disseminating timely, best practice information to support the needs of women and health professionals.

14. SUMMARY & RECOMMENDATIONS

This project sought to gain insight and understanding into current perceptions and practices of health care workers in the delivery of perinatal health care across the New Direction Mothers and Babies Services. To achieve these project aims the project was undertaken in two stages.

Stage one involved undertaking in-depth (qualitative) interviews with a sample of twenty-eight healthcare workers across a range of settings and geographic locations. In particular this stage sought to gain insight into the *cultural context* in which perinatal care is provided, and derive an understanding of *current practice* surrounding *assessment*, *screening* and *referral*, together with issues surrounding *data collection*, *management* and *reporting*. The project also sought to identify *barriers* and *enablers* for healthcare workers in the delivery of perinatal care, as well as identify their perceived needs to enhance care for Aboriginal and Torres Strait Islander women.

Drawing on these insights, Stage two of the project quantified these findings (in line with the project objectives) through an online survey administered across all New Directions Mothers and Babies Services. In particular the survey enabled the *extent* to which the qualitative findings were *reflected across* Services to provide a detailed scoping of *current practices* across New Directions Services, together with *perceptions*, *attitudes*, *needs* and *perspectives* of healthcare workers across Sites nationally. These outcomes could then be considered within the context of the *National Perinatal Depression Initiative* (NPDI).

As supported in the extensive literature, the results derived across both stages of the project highlight the importance of the *cultural context* in the delivery of perinatal care to this population group. Aboriginal and Torres Strait Islander women were described as being unique in an array of aspects including their *cultural background*, *how they communicate* and the high levels of *stress and trauma* that they have been exposed to. In turn, and in line with national statistics, health professionals perceive this population to be significantly *more likely* to possess more *risk factors* for perinatal mental health[16] and ultimately more likely to experience *perinatal mental health conditions* when compared with non-Aboriginal women.[57] Whilst a number of healthcare professionals also spoke of the perceived higher levels of *resilience* amongst Aboriginal and Torres Strait Islander women, this was not seen to counteract the overall higher level of risk for this population.

It is in response to this cultural context and perceived risk for this population, that the identification and addressing of risk factors and perinatal mental health conditions is considered to be of *high importance*. This translates into practice with the majority of healthcare workers addressing these aspects as part of provided care. Whilst the approaches used to enquire about risk factors and screen for mental health conditions is variable across settings, screening and assessment procedures are reported to be undertaken in the majority New Directions Services. Further, a high proportion of health professionals are using a *standardised approach* to this screening and assessment, with most using a standard list of questions (to identify risk factors) or implementing screening tools (to detect possible mental health conditions).

The area where there are indistinct findings, relates to the use of the Edinburgh Postnatal Depression Scale (EPDS) specifically. Essentially whilst the tool is widely used, many perceive it to have limitations. In particular a number of healthcare workers perceive that the EPDS may not be *language appropriate or culturally appropriate* for this population, leading a smaller proportion of providers to use the EPDS in an *adapted* form. This divergence of views surrounding the EPDS is also reflected in the literature, whereby some studies indicate that adapted forms of the EPDS are more effective at detecting postnatal depression in an Aboriginal and Torres Strait Islander population[63] whilst other in a similar region have detected little difference between original and adapted forms of the scale, though note the potentially higher sensitivity of adapted forms.[62]

Despite these limitations, the EPDS currently by far the most widely used tool in its original form (by 57% of services) or adapted form (20%). Whilst greater use of the EPDS is likely to be inhibited by the perceptions surrounding its appropriateness, it is within the described context of women being highly at risk that its use is considered warranted. This provides valuable infrastructure on which to build upon.

Further to screening and assessment practices, most services are employing procedures surrounding collection and reporting of screening and assessment data. Again however a variety of approaches is being undertaken which are not consistent across settings, and could be streamlined and improved.

When investigating the healthcare workers' confidence surrounding undertaking screening, assessment and referral, on the whole most people indicate that they feel confident to identify and manage issues surrounding trauma and grief, risk factors and perinatal mental health conditions.

Whilst overall people indicated that they would like to have more time to devote to addressing social and emotional wellbeing issues (than they do currently), the overriding *barrier to screening* and assessment was not practical or structural factors so much as the issue of *trust*, *stigma* and *fear* amongst Aboriginal women themselves. This is likely to impact on disclosure and hence the effectiveness of screening and assessment practice. This finding also highlights the impact of the cultural context constantly described by health professionals, and the associated potential of adverse impact upon screening and assessment practices.

Similarly, when exploring issues surrounding post-screening *referral practices*, again most health professionals were generally *confident to refer* women to services, and most even indicating confidence that services would be *available*. Once again, a main barrier surrounding referral pertained to stigma. In particular, *fear*, *stigma*, *trust* and *culturally inappropriate services* were considered the main barriers that negatively impacted on the likelihood that a woman would *act upon* a referral. In addition transport was also identified as a major barrier to referral in some areas, as was the availability of culturally appropriate services.

Such barriers relating to referral highlighted the importance for health practitioners to follow-up women identified as requiring referral services. However, findings also suggest that for half of the New Directions Services, there is currently *poor communication between services,* and hence this was identified to be another barrier to effective referral practice.

The project also identified the *needs of healthcare workers,* in particular, what they perceived would increase their confidence to address social and emotional and mental health issues in this population. Almost all respondents indicated that the *provision of culturally appropriate information resources for perinatal women and their families* would be highly beneficial to increase their confidence. Whilst such materials have been developed under the National Perinatal Depression Initiative for the general population, the research and development of resources that reflect best practice for Aboriginal and Torres Strait Islander women is less established.

Second to this was the provision of *culturally specific information and education resources for the health professionals themselves,* including guidelines, education resources and assessment guides. Interestingly, more respondents indicated the importance of such culturally specific resources over training (which around half of respondents indicated that they had access to). Again this has been developed for the general population under the NPDI, however specific screening and assessment resources for this population group specifically are less extensive.

Further, this approach to education and support for both women *and* health care workers would also provide a mechanism for increasing consistency with the guidelines and alignment with practices under the Framework of NPDI, which currently around half of respondents across services are unaware of and uncertain as to their relevance to their practice.

SUMMARY OF CONCLUSIONS

This mapping of current practice and the needs of healthcare workers across New Directions Services reveal the following:

• The cultural context deems that Aboriginal and Torres Strait Islander women are at high risk, and hence assessment, screening and referral are a high priority amongst healthcare workers.

• Most services are currently undertaking screening and assessment procedures, and data is being recorded in most settings and reported in varying formats.

• The EPDS is the most widely used tool, despite perceptions by many that it is not ideal, due to not being culturally or language appropriate.

• In the main, most health professionals are confident in their ability to assess, screen and refer, however shame, stigma and trust currently inhibits the effectiveness of these practices, as women may be unlikely to disclose for fear of the impact, and unlikely to act upon referrals. In turn this highlights the importance of follow-up of women, which is currently impeded by poor communication between services.

• The provision of culturally appropriate education resources for women and their families and health professionals was most commonly identified to be useful in assisting health professionals in the delivery of care.

Recommendations

In considering future directions for addressing social and emotional wellbeing across the New Direction Services, the recommendations below can be considered in the context of providing holistic care and a commitment to cultural safety as an essential component of any mental health intervention with Aboriginal and Torres Strait Islander peoples.

In light of the recognised *importance* of emotional and mental health, the *confidence* amongst health professionals, and consequently the high proportion of services *currently engaged* in practices, importantly this provides an *established infrastructure* on which to undertake further possible development in this area.

Despite the widespread use of the EPDS and the absence of *uniform clarity* regarding the *perceived appropriateness* of the tool suggests the potential benefit of exploring the perceived appropriateness of the tool by Aboriginal and Torres Strait islander women *themselves*. In particular this could involve gaining in-depth insight and understanding of *their* experience of emotional health and wellbeing, the meaning of the scale items, and experience with completing the scale as opposed to other approaches.

Due to the views that there is great variability across Aboriginal and Torres Strait Islander communities, as with this national mapping project, this scoping study would need to be undertaken nationally to explore heterogeneity of views.

In addition to providing insights and understanding about *what* tool to use, *how* screening and assessment is currently undertaken could be explored simultaneously to further understand the issues surrounding fear and stigma that have been consistently identified in this project. For example, currently most services are directly asking questions to the women from the EPDS or a prompt sheet. Exploratory research with Aboriginal and Torres Strait Islander women could explore if this approach is acceptable to women or is confronting, and/or if such an approach contributes to the reported fear and apprehension surrounding disclosure. Alternatively other approaches such as completing the questionnaire electronically in private, may be preferable and should be explored with respect to optimising screening practices currently in place.

Further, the above described work with Aboriginal and Torres Strait Islander women could provide greater insight and understanding about frequently identified issues, namely stigma, fear and the reluctance to take up referrals following screening and assessment. Gaining such insights could inform *what* and *how* information could be developed in a culturally safe and sensitive way to educate and support these women, address their fears and concerns (that they may not express to health professionals) *provide assurance* and increase *their confidence* to engage and benefit from practices currently being provided through New Directions Services. Given the high proportion of young women in the perinatal period (AIHW), this may also impact upon how they best access such information (e.g. hard copy resources versus electronic), the extent and type of information they need, and the way the information is presented (language) and disseminated (for example, targeted versus generic).

When considering the outcomes of the project, not only would this be of benefit to the perinatal women themselves, but also to support health professionals who indicated this to be important to increase their confidence to address social and emotional and mental health issues in the population.

In addition to developing information resources for women and their families, information gained from this report together with insights from Aboriginal and Torres Strait Islander women could be used to inform and *educate health professionals about the consumer perspectives* and *needs* (which they may not be truly aware of due to current fears surrounding disclosure). It could similarly be incorporated into the development of culturally appropriate education and information resources for health professionals – as also indicated to be important to increase their confidence (second to resources for women and their families).

With the above issues surrounding stigma, trust and fear are perceived to currently preventing women taking up referrals, the findings also highlighted the need for improved communication systems between services to improve the uptake of referrals. Here through building upon the already existing processes surrounding data collection and reporting, this could be refined to increase the standardisation of data reporting and its transfer between services to improve communication.

These recommendations are aligned to those outlined in the National Aboriginal and Torres Strait Islander Health Plan (2013 – 2023) which identified the need to promote perinatal mental health among Aboriginal and Torres Strait islander mothers, as this is critical to address the negative impacts on their children families and the community.

The role of technology to assist in the facilitation of assessment, screening, referral and data collection/reporting has also been highlighted in response to many of the identified barriers in this Report, and indeed the NPDI more broadly.[84] Whilst the potential benefits of the described technological approaches also apply to the NPDI more broadly (Synopsis Report) their applicability to this population specifically is highly relevant and hence worthy of further exploration. This needs to be considered with respect to the needs of health professionals as identified in this report, as well as in relation to Aboriginal and Torres Strait Islander women (as the recommended area for future development).

Finally, the above mapping exercise provides valuable baseline data for the Department, which could be used to monitor and measure changes over time and across settings. This provides not only a valuable mechanism to monitor current practice screening and assessment practices across New Directions Services, but also the impact of implemented recommendations. Further, in the absence of any systematic, national evaluation of the NPDI more broadly,[84] the application of this methodology in the broader population could similarly provide a mechanism to assess the extent to which the NPDI is being implemented (retrospective evaluation), identify barriers and enablers across settings to inform future NPDI investment, as well as provide a much needed baseline to enable monitoring of progress in the future.

Conclusion

The findings from this project and the recommendations made provide a culturally appropriate strategy and approach to achieving this, and in doing so address the most commonly identified barriers, as identified by health professionals.

It is through the implementation of these recommendations (as informed by health care workers) that New Direction Services can be *more informed* and *better supported* in the provision of culturally safe, sensitive and appropriate care. Furthermore this provides a mechanism that ultimately facilitates the integration of the NPDI Framework and clinical practice guidelines into standard practice across New Directions Services nationally.

Summary of Recommendations for Project

Consider the cultural context together with the significant infrastructure that already exists to build upon current practices that are currently taking place across New Directions Services.

Undertake further work to explore and understand the perspectives of women themselves in the perinatal period, to gain insight into the perceived appropriateness of current screening tools and practices. This includes addressing issues around appropriateness of language and the scale's sensitivity for use within this population specifically

Through the above scoping with Aboriginal and Torres Strait Islander women to gain insight into their language, perceptions, attitudes and information needs, the development of education and information resources for women and their families can be informed. This work needs to be national to evaluate the possible divergence of views. Further it also needs to incorporate issues surrounding stigma, fear and shame, which are currently the major barriers to screening and uptake of referrals by women. In turn, this could be used to inform the development and dissemination of these resources that is culturally safe and appropriate to the needs of Aboriginal and Torres Strait Islander women and their families.

Together with the above areas, insights from Aboriginal and Torres Strait Islander women could be incorporated in to the development of information resources for health professionals, to provide guidance and support that is consistent with best practice and reflects the Clinical Practice Guidelines. This could also include the development of indigenous specific guidelines, however the absence of research in the area is likely to lead to adaption of the current Guidelines, including the need to consider a revision of cut-off scores to increase the sensitivity of the EPDS within this population group.

Consider the implementation of *standardised approaches* to reporting and data collection to facilitate screening processes that are currently impeded by lack of staff and time constraints. Further the use of more efficient electronic screening approaches could also facilitate the monitoring of screening and referral outcomes and could also support communication between referral agencies and improve follow-up of women post referral.

As informed by the above areas, consider the potential role and application of digital technology to improve the efficiencies and effectiveness of screening, assessment and referral practices specifically for this population group. This could serve to:

- Address many of the identified barriers to screening (resource constraints, stigma, shame),
- Provide a mechanism to provide relevant (targeted) information to women
- Support health professionals in the delivery of best practice
- Provide a platform to facilitate the consistent monitoring of screening and referral outcomes across Services
- Support communication between referral agencies and improve follow-up of women identified at risk.

Consider the reapplication of the above methodology across New Directions Services as well as the general population more broadly. This would serve to enable the monitoring of current practice, scope the extent to which the NPDI has been implemented nationally, identify barriers and enablers for future investment and importantly provide a benchmark to evaluate progress over time and settings.

14. APPENDICES

APPENDIX 1
Written communication with state and territory Directors

September 26, 2013

Name

Director

Department of Health

Address

City, Postcode

Email address

Dear Director,

RE: Aboriginal and Torres Strait Islander Perinatal Mental Health Mapping Project

I am writing to inform you of a new, national Perinatal Mapping Project being undertaken by the Centre of Perinatal Excellence (COPE). COPE is a national, independent, not for profit organisation dedicated to reducing the personal, social and economic impacts of antenatal and postnatal (collectively referred to as perinatal) mental health conditions for women and their families. As part of this project, we are contacting all New Directions Mothers and Babies Services sites nationally, and would like to invite your organisation to participate in this important Project.

This project has been commissioned by the Department of Health, and in order to undertake this important work, your contact details have been provided to COPE by the Department.

The purpose of this body of work is to undertake a mapping project to better understand a number of factors including the levels of *perinatal awareness* amongst service providers and current *screening practices*. In particular we are keen to understand any current *barriers* and *enablers* to screening and identify the *needs of health professionals* providing care to women in the perinatal period. The mapping project will also seek to ascertain the existence and use of *referral pathways* that exist for Aboriginal and Torres Strait Islander women and their families across Aboriginal Community Controlled Health Organisations and primary health care service providers.

Results from the will activity support staff in the delivery of best practice in the field and inform work under the National Perinatal Depression Initiative (NPDI) for Aboriginal and Torres Strait Islander women and their families specifically. Through informing policy, the Project will ultimately contribute towards closing the Gap in health care for Aboriginal and Torres Strait Islander people.

Commencing in October, in-depth consultations will occur with selected representatives across a number of urban, rural and remote services. This will include a mix of small, medium and large organisations, namely Hospitals, Aboriginal Community Controlled Health Organisations and Medicare Locals.

This information obtained from the initial consultations with a selection of services will then be used to inform the development of an online survey, which will be distributed across all 85 sites early in 2014. This survey will provide an opportunity *for* all services to provide input into the Project and assess the extent to which the insights and themes identified in the initial consultations are reflected across the range of Centres nationally. A detailed report of the results from the mapping project will be made available to all Centres once the project is completed in 2014.

In the upcoming weeks a member from our team will be contacting selected representative organisations, and inviting them to participate in the initial consultation stage of the Project. Following, in early 2014 *all* services will be contacted and invited to take part in the survey.

The team from COPE looks forward to working with your office on this exciting project which will provide invaluable insights to inform how we can collectively work to contribute towards closing the Gap in health care for Aboriginal and Torres Strait Islander people.

If you have any questions about the project, please feel free to contact me directly on 0438 810 235 or at nicole.highet@cope.org.au.

Yours sincerely,

Dr. Nicole Highet
Executive Director
COPE: Centre of Perinatal Excellence

APPENDIX 2
Written communication with Peak Bodies

Name

CEO

Address

City, Postcode

Email address

Dear

RE: Aboriginal and Torres Strait Islander Perinatal Mental Health Mapping Project

I am writing to inform you as the CEO of NACCHO of a new, national Perinatal Mapping Project being undertaken by the Centre of Perinatal Excellence (COPE).

COPE is a national, independent, not for profit organisation dedicated to reducing the personal, social and economic impacts of antenatal and postnatal (collectively referred to as perinatal) mental health conditions for women and their families. As part of this project, we will be contacting all New Directions Mothers and Babies Services sites nationally, and hence wanted to inform you and your organisation of this new program of work which has been commissioned by the Department of Health.

The purpose of this body of work is to undertake a mapping project to better understand a number of factors including the levels of perinatal awareness amongst service providers and current screening practices. In particular we are keen to understand any current barriers and enablers to screening and identify the needs of health professionals providing care to women in the perinatal period. The mapping project will also seek to ascertain the existence and use of referral pathways that exist for Aboriginal and Torres Strait Islander women and their families across Aboriginal Community Controlled Health Organisations and primary health care service providers.

Results from the activity will support staff in the delivery of best practice in the field and inform work under the National Perinatal Depression Initiative (NPDI) for Aboriginal and Torres Strait Islander women and their families specifically. Through informing policy, the Project will ultimately contribute towards Closing the Gap in health care for Aboriginal and Torres Strait Islander people.

Commencing in October, in-depth consultations will occur with selected representatives across a number of urban, rural and remote services. This will include a mix of small, medium and large organisations, namely Hospitals, Aboriginal Community Controlled Health Organisations and Medicare Locals.

The information obtained from the initial consultations with a selection of services will then be used to inform the development of an online survey, which will be distributed across all 85 sites early in 2014. This survey will provide an opportunity for all services to provide input into the Project and assess the extent to which the insights and themes identified in the initial consultations are reflected across the range of centres nationally. A detailed report of the results from the mapping project will be made available to all Centres and NACCHO once the project is completed in 2014.

As we progress with this exciting project we are keen to discuss any opportunities for collaboration as the project unfolds, and will keep you informed of the outcomes and learnings from the project. Further, we would be keen to discuss with NACCHO how we can support your work towards Closing the Gap in health care for Aboriginal and Torres Strait Islander people.

If you have any questions about the project, please feel free to contact me directly on 0438 810 235 or at nicole.highet@cope.org.au.

Yours sincerely,

Dr. Nicole Highet
Executive Director
COPE: Centre of Perinatal Excellence
cc:

October 7, 2013

Name

Chair

Australian Indigenous Psychologists Association

Email

Dear

RE: Aboriginal and Torres Strait Islander Perinatal Mental Health Mapping Project

I am writing to inform you of a new, national Perinatal Mapping Project being undertaken by the Centre of Perinatal Excellence (COPE). COPE is a national, independent, not for profit organisation dedicated to reducing the personal, social and economic impacts of antenatal and postnatal (collectively referred to as perinatal) mental health conditions for women and their families. As part of this project, we will be contacting all New Directions Mothers and Babies Services sites nationally, and hence wanted to inform you and your organisation of this new program of work which has been commissioned by the Department of Health.

The purpose of this body of work is to undertake a mapping project to better understand a number of factors including the levels of *perinatal awareness* amongst service providers and current *screening practices*. In particular we are keen to understand any current *barriers* and *enablers* to screening and identify the needs of *health professionals* providing care to women in the perinatal period. The mapping project will also seek to ascertain the existence and use of referral pathways that exist for Aboriginal and Torres Strait Islander women and their families across Aboriginal Community Controlled Health Organisations and primary health care service providers.

Results from the activity will support staff in the delivery of best practice in the field and inform work under the National Perinatal Depression Initiative (NPDI) for Aboriginal and Torres Strait Islander women and their families specifically. Through informing policy, the Project will ultimately contribute towards Closing the Gap in health care for Aboriginal and Torres Strait Islander people.

Commencing in October, in-depth consultations will occur with selected representatives across a number of urban, rural and remote services. This will include a mix of small, medium and large organisations, namely Hospitals, Aboriginal Community Controlled Health Organisations and Medicare Locals.

The information obtained from the initial consultations with a selection of services will then be used to inform the development of an online survey, which will be distributed across all 85 sites early in 2014. This survey will provide an opportunity for *all* services to provide input into the Project and assess the extent to which the insights and themes identified in the initial consultations are reflected across the range of centres nationally. A detailed report of the results from the mapping project will be made available to all Centres and NACCHO once the project is completed in 2014.

As we progress with this exciting project we are keen to discuss any opportunities for collaboration as the project unfolds, and will keep you informed of the outcomes and learnings from the project. Further, we would be keen to discuss with AIPA how we can support your work towards Closing the Gap in health care for Aboriginal and Torres Strait Islander people.

If you have any questions about the project, please feel free to contact me
directly on 0438 810 235 or at nicole.highet@cope.org.au.

Yours sincerely,

Dr. Nicole Highet
Executive Director
COPE: Centre of Perinatal Excellence

APPENDIX 3
Written communication with chief executive officers (CEO's) of New Directions Services

October 18, 2013

Name

Postion

Service

Address

Dear

RE: Aboriginal and Torres Strait Islander Perinatal Mental Health Mapping Project

I am writing to inform you of a new, national Perinatal Mapping Project being undertaken by the Centre of Perinatal Excellence (COPE). COPE is a national, independent, not for profit organisation dedicated to reducing the personal, social and economic impacts of antenatal and postnatal (collectively referred to as perinatal) mental health conditions for women and their families. As part of this project, we are contacting all New Directions Mothers and Babies Services sites nationally, and would like to invite your organisation to participate in this important Project.

This project has been commissioned by the Department of Health, and in order to undertake this important work, your contact details have been provided to COPE by the Department.

The purpose of this body of work is to undertake a mapping project to better understand a number of factors including the levels of *perinatal awareness* amongst service providers and current *screening practices*. In particular we are keen to understand any current *barriers* and *enablers* to screening and identify the *needs of health professionals* providing care to women in the perinatal period. The mapping project will also seek to ascertain the existence and use of *referral pathways* that exist for Aboriginal and Torres Strait Islander women and their families across Aboriginal Community Controlled Health Organisations and primary health care service providers.

Results from the activity will support staff in the delivery of best practice in the field and inform work under the National Perinatal Depression Initiative (NPDI) for Aboriginal and Torres Strait Islander women and their families specifically. Through informing policy, the Project will ultimately contribute towards closing the Gap in health care for Aboriginal and Torres Strait Islander people.

Commencing in October, in-depth consultations will occur with selected representatives across a number of urban, rural and remote services. This will include a mix of small, medium and large organisations, namely Hospitals, Aboriginal Community Controlled Health Organisations and Medicare Locals.

This information obtained from the initial consultations with a selection of services will then be used to inform the development of an online survey, which will be distributed across all 85 sites early in 2014. This survey will provide an opportunity for all services to provide input into the Project and assess the extent to which the insights and themes identified in the initial consultations are reflected across the range of Centres nationally. A detailed report of the results from the mapping project will be made available to all Centres once the project is completed in 2014.

In the upcoming weeks a member from our team will be contacting selected representative organisations, and inviting them to participate in the initial consultation stage of the Project. Following, in early 2014 *all* services will be contacted and invited to take part in the survey.

The team from COPE looks forward to working with your office on this exciting project which will provide invaluable insights to inform how we can collectively work to contribute towards closing the Gap in health care for Aboriginal and Torres Strait Islander people.

If you have any questions about the project, please feel free to contact me directly on 0438 810 235 or at nicole.highet@cope.org.au.

Yours sincerely,

Dr. Nicole Highet
Executive Director

APPENDIX 4
Moderator Guide for qualitative consultations

Consultation Stage of Mapping Project:

Moderator Guide

C O P E

Centre of
Perinatal Excellence

PURPOSE:

Mapping Project - Not an audit and not research

- To **see what is happening** around perinatal mental health screening practices and referral pathways in New Directions: Mothers and Babies Services.
- To **identify gaps** and **possible solutions** for women, health professionals and services and feed into broader Aboriginal and Torres Strait Islander health policy.
- This stage of project designed to **identify the specific issues and opportunities** – which will then inform a survey that will be then given to ALL services

---

Date: _____ Time: _____ Interviewer: *NH   AG*

Name of Service: _____

Location: _____

Type: *Remote   Regional   Urban*

Name of Person interviewed: _____

Professional Background (e.g. GP. Midwife): _____

Position in Service: _____

Personally see women versus Managerial role: _____

Today I'm now going to ask you a series of open-ended questions – of course there are no wrong or right answers to understand more about the delivery of perinatal care in your setting. To begin…

When providing pre and post-natal care for Aboriginal and Torres Strait Islander women, what are the *key areas* **that you focus on?**

> Further exploratory questions:
> - Are there any other priority areas? (e.g. health, social and emotional wellbeing,/mental health

- Of those that you have identified, what aspects of healthcare do *you* think is **most important**? Why?
  [NB: If social and emotional wellbeing/mental health NOT mentioned]
  What are your thoughts around social, emotional and mental health specifically?

- Do you think that this is an area that is important in *your practice*? Why?

- Do you have any *standard practice* around exploring social and emotional wellbeing and mental health with women?

1. ASSESSING PRESENT MENTAL HEALTH STATUS

- **Do you undertake any** *formal assessment* **to assess if a woman may be experiencing social and emotional or mental health symptoms? How is this done?** If not, why? Is it something that you keep in the back of your mind and what would prompt you or how would you bring it up with the woman?

- **Do you use the Edinburgh Postnatal Depression Scale (EPDS)/other tool? If EPDS is this modified in any way for Aboriginal and Torres Strait Islander women?**
  When – Is this asked antenatally/postnatally if at all? When?
  How – Is this done with the woman alone? Pen and paper or read out?
  Where – Is this completed alone/in waiting room/alongside health professional?
  Who – Are all women asked this routinely – or only if perceived at risk

  [If modified/different to EPDS – is it possible to have a copy of the Questions?
  If it's not the EPDS, why would you use this one rather than the EPDS?]

- **To your knowledge, is this reflective of this practice/setting?**

- **What happens with these scores data?** Is it kept in the file, recorded, referred to?

2. ASSESSING FOR RISK FACTORS (PSYCHOSOCIAL RISK FACTORS)

- **How does your practice define or identify if a woman may be at risk of social and emotional wellbeing and mental health issues?**

- **How are these psychosocial risk factors assessed?** Where these are not assessed please state the reasons why not? Is it something that you keep in the back of your mind and what would prompt you or how would you bring it up with the woman?

- **What are the key factors that you look for or assess to determine if a woman is at risk?** (e.g. domestic violence, housing situation, financial situation, family/partner support, other children, past trauma, racism, substance misuse, etc)

- **Do you use specific processes or tools or how do you do that?**
  When – Is this asked antenatally/postnatally if at all? When?
  How – Is this done with the woman alone? What if partner present? Pen and paper or read out?
  Where – Is this completed alone/in waiting room/alongside health professional
  Who – Are all women asked this routinely –or only if perceived at risk? Asked alone vs if partner is there?
  Is it possible to have a copy of the Questions?

- **To your knowledge, is this reflective of this practice/setting?**

- **What happens with these scores data?** Is it kept in the file, recorded, referred to?

- **Overall, *how do you find the process* of screening and assessment for social and emotional wellbeing and mental health?**

- **What are some of the *challenges* that you find around screening for social and emotional wellbeing and mental health?**

- **What *strategies* could help with this? (eg training, more services to refer to)**

- **Are there any particular things at the centre that help with screening?**

- **Are there any other comments or thoughts that you have about screening and assessment that we haven't talked about?**

- **What do you do with the outcome of all this, what happens next?**

3. REFERRAL
Thinking now about the referral process, if you identify that woman may be experiencing mental health needs or issues or is at risk of emotional or mental health problems…

- **How do you decide if a woman needs to be referred?**

- **Is there a formal referral process within your service?**

- **Do you have a list of referral pathways? If not, would this be helpful? How could that be provided?**

- **Thinking about referral, do you refer internally or externally?**

- **Where do you generally refer to?**

- **Do you know of services that you can identify? What circumstances?**

- **How confident do you feel referring to the services that are available? What would improve your levels of confidence?**

Of the referrals that you make:
- **Do you think they are generally acted on by women and their families? If not, why not?**

- **Does your service follow up? If not, Why not?**

- **Do you think that there is anything that needs to be done to increase the uptake of referrals? What could help?**

- **Is there anything else that could make the whole referral process easier, for both health professionals and for women? (eg referral pathways, etc**

4. TRAINING AROUND SCREENING AND ASSESSMENT
The final area that we wanted to talk about is your needs around training and development.

- **Have you had any specific training around mental health and dealing with social and emotional wellbeing and mental health issues for women in the perinatal period?** If so, please describe the type of training and indicate whether it was useful/relevant? Was there anything else you would like to have covered?

- **Given the range of issues that we've discussed today so far, what would make you feel more confident to be exploring social and emotional wellbeing and mental health issues?**

- **What about other people working in their service? What do you think they might find helpful?**

- **Are you aware of any training that is available?** Have you taken that up? Why or why not?

- **Are you aware of the National Perinatal Depression Initiative? Is this relevant to you?**

- **Are you familiar with the perinatal clinical guidelines?** Do you refer to them? Why or why not? Is it relevant to your practice with Aboriginal and Torres Strait Islander women?

WRAP–UP AND CLOSE

Just to finish off with, if I could ask you a few questions about your service here…

When women seen in the perinatal period in this service: Antenatal   Postnatal   Both

Proportion of clients are ATSI? _____

Size of population served by this service: _____

Number of babies born annually in Service (if known): _____

Number of staff in total: _____

Number of people in (perinatal) team (if applicable): _____

Stage of pregnancy/postnatal period when normally see women for the first time: _____

_____

Anything else specific about this service you think may be relevant/important? _____

_____

_____

_____

_____

- **Thank you so much for your time today.**
- **Outline next steps to inform the development of questionnaire.**
- **Leave card if think of anything like to add.**
- **Ask for their card and permission to contact if need to clarify anything.**

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