beyondblue

THE NATIONAL PERINATAL DEPRESSION INITIATIVE

A synopsis of progress to date and recommendations for beyond 2013

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1. Executive summary

Australia has become a world leader in perinatal mental health with significant advances made over the past decade. This is particularly with respect to the application of research into national mental health reform.

Identification of the high prevalence of depression in the perinatal period[1] was followed by the development of a National Action Plan[2] and provided a blueprint for the translation of research into practice. This led to the development of the National Perinatal Depression Initiative (NPDI) in 2008. The five-year Initiative (200813) represents 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.

As the Initiative enters the final year of initial funding, it is timely to evaluate progress undertaken to date and identify areas for future development. This report is designed to provide a synopsis of activity under the six objectives of the NPDI, review outcomes and provide recommendations for beyond 2013.

Figure 1 Overview of progress to date across the six objectives of the NPDI

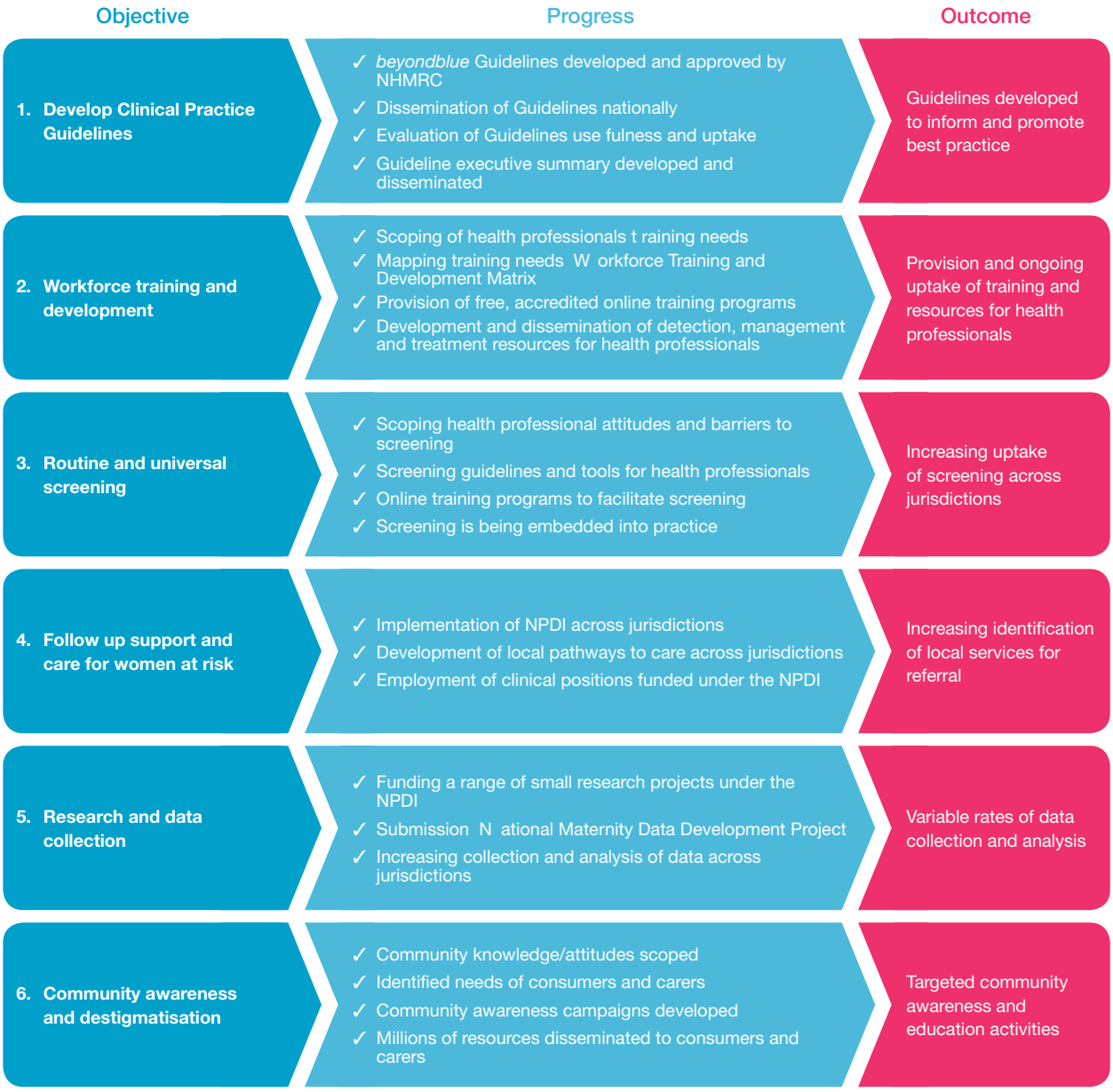


Figure 1 highlights that significant progress has been made to date under each of the NPDI objectives. However, as detailed in this report, there are a number of areas that require ongoing focused activity to consolidate the achievements to date, and extend the NPDI to achieve the implementation at a national level.

1.1 KEY RECOMMENDATIONS

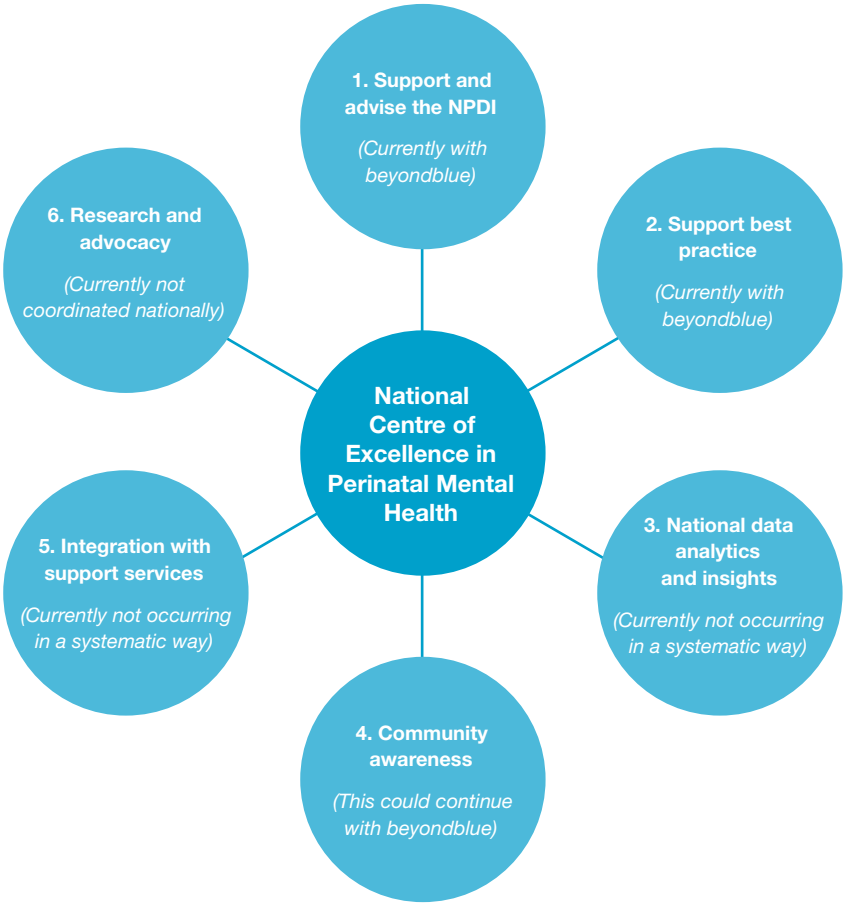
The current synopsis and review highlights the need to *maintain a national focus* as the Initiative continues to be implemented nationally across jurisdictions. This is paramount in order to ensure that evidence-based, best practice continues to be applied consistently, that national momentum is maintained, duplication is avoided, and consistent messaging is provided at a community level.

In response to this, *beyondblue* recommends the establishment of a National Centre of Excellence (or equivalent) in Perinatal Mental Health. The Centre will serve to continue providing national leadership, and support a nationally-consistent approach to implementation across Australia.

Key objectives of the Centre should include (but not be limited to):

1. ***Continued national leadership***, support and advice for all state and territory governments and partners in the implementation of screening and services for perinatal women. *beyondblue* currently provides this leadership under the NPDI and works closely with the Federal, state and territory governments.
2. ***Continued advocacy to embed best practice through the consistent implementation of the perinatal Clinical Practice Guidelines***. This includes the continued promotion and provision of the Guidelines (developed by *beyondblue* and approved by the National Health and Medical Research Council (NHMRC), 2011) and additional resources for health professionals. Consideration should also be given to the centralisation of research knowledge. The Centre would provide a central point for the maintenance of strategic partnerships with professional bodies, training institutions and service providers.
3. ***The development and management of national data systems*** to enable screening data to be collected and analysed in order to monitor and evaluate the impact of screening and inform service provision. This is currently a major gap in the NPDI, and is preventing the monitoring and evaluation of screening and referral outcomes on a national basis. *beyondblue* has partnered with NHMRC and is undertaking a Data Linkage Study (20122 014) that will provide some insights into the items for data collection, the impact of screening and inform future directions; however this is retrospective, and requires systems to be developed in order to provide ongoing evaluation.
4. ***Sustained community awareness, education, and destigmatisation activity.*** This includes the continued dissemination of national campaigns and the provision of high-quality, timely, evidence-based information about perinatal mental health disorders for consumers and carers. *beyondblue* currently provides this activity under the NPDI.
5. ***Integration with support services.*** In addition to primary care services, there is a range of independent support organisations that are well placed to provide information, education and support services to women at risk of, or experiencing, perinatal mental health disorders. Currently, these services work largely in isolation and could be more actively integrated into the NPDI through the support of the National Centre.
6. ***Research and advocacy.*** The Centre would continue to work with Australia s leading perinatal clinicians and researchers to ensure the integration and application of research outcomes into clinical practice. The Centre would also advocate for, and potentially commission, new areas of research (for example, addressing research gaps as identified in the Guidelines).

Proposed vision for a National Centre of Excellence in Perinatal Mental Health



Therefore, the aim of such a Centre is to sustain a national focus for perinatal mental health in Australia. This involves building upon the significant progress, established partnerships, research and momentum that has been achieved to date. The Centre would continue to work in close collaboration with *beyondblue*, health professional bodies, providers of clinical and support services, and Australia s leading researchers and clinicians from across the country.

2. Background and objectives

2.1 RATIONALE

The perinatal period, which includes pregnancy and the year following the birth of a baby, is a time of great change in a woman s life, placing her at significantly greater risk of developing depression[3] and other mental health disorders. There is extensive evidence to demonstrate that depression and anxiety can have a significant impact, not only on the mother[4], but also her partner[5]. Further, there is an ever-growing body of research which reveals the negative impact of depression and anxiety on the developing fetus[6,7,8], and the infant[9] which has been associated with developmental delays in the shorter[10] and longer term[11] (Refer to Appendix 1).

2.2 BACKGROUND

The *beyondblue* National Postnatal Depression Research Program (200105)

The high rate of psychiatric morbidity and corresponding impact in the immediate and longer term led to the *beyondblue* National Postnatal Depression Program being undertaken in 2001 05. This national research program identified that up to 10 per cent (one in 10) of women experience depression during pregnancy, and this increases to almost 16 per cent (one in seven) in the months following the birth of a baby[1]. This research also revealed the high levels of acceptability surrounding screening[12].

The *beyondblue* Perinatal Mental Health National Action Plan (2008)

This research substantiated the need for a targeted, national, early screening/detection and intervention program for women at risk of, and experiencing perinatal depression and anxiety. As a first step toward translating this knowledge into practice, *beyondblue* developed the Perinatal Mental Health National Action Plan. The National Action Plan provided a blueprint to increase awareness, improve assessment, training and workforce development, effective support and responses to the emotional and psychological wellbeing of women and their families[2].

The National Perinatal Depression Initiative (2008201 3)

In 2008, *beyondblue* attained government support for the National Action Plan, and at the Australian Health Ministers Advisory Council (AHMAC) meeting, Federal, state and territory governments agreed to collaborate on the development of a National Perinatal Depression Initiative (NPDI). The chief aim of the Initiative is to improve prevention and early detection of perinatal depression and provide better support and treatment for these expectant and new mothers.

In order to achieve this aim, funding under the Initiative has been distributed by the Federal Government to:

1) **State and territory government ($30M)** to contribute to the roll out of routine and universal screening, support and treatment services, and training for health professionals. State and territory governments also provided matched funding ($30M) with the Federal Government under the NPDI.
2) **Access to Allied Psychological Services (ATAPS) ($20M)** component of the Better Outcomes in Mental Health Care Program to build the capacity of Divisions of General Practice to improve support for women with perinatal depression.
3) ***beyondblue* ($5M)** to support and advise the Initiative and its implementation. This included the implementation of structures to facilitate and promote collaboration between the Federal, state and territory governments and *beyondblue*, as well as raising community awareness about perinatal depression. *beyondblue* is also responsible for developing information and training resources for health professionals who screen and treat new and expectant mothers for perinatal depression.

2.3 OBJECTIVES OF THE NPDI

There are six key objectives of the NPDI[13] outlined in Box 2.3.

Box 2.3 Objectives of the NPDI

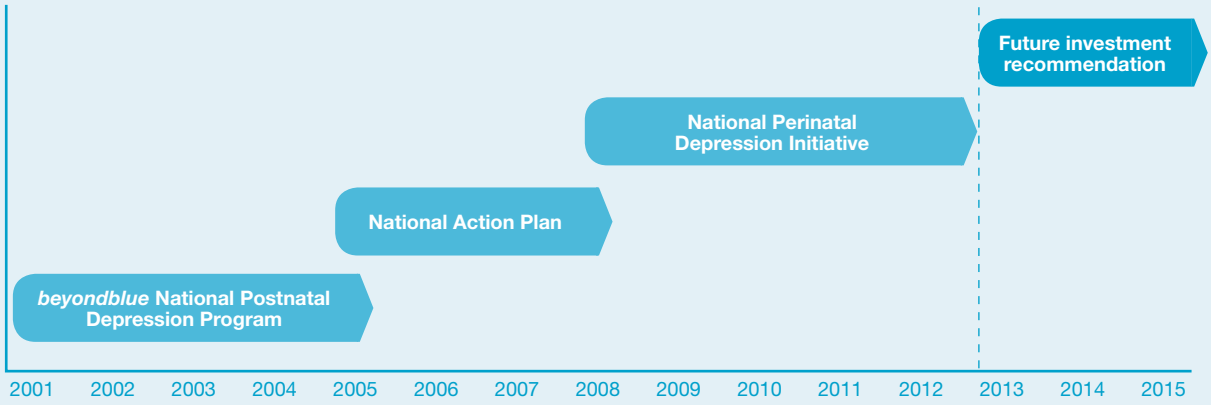
1. Develop national guidelines for screening and management of perinatal depression
2. Workforce training and development of health professionals
3. Routine and universal screening
4. Follow-up support and care for perinatal women assessed as being at risk of, or experiencing perinatal depression
5. Undertake research and data collection
6. Increase community awareness

The context in which these objectives of the NPDI are being implemented is broad and complex. Screening, assessment and treatment is required across the *public* and *private* sectors and involves a wide range of health professionals in the *antenatal* period (midwives, obstetricians, general practitioners, mental health practitioners, aboriginal health workers) and *postnatal* period (maternal and child family health nurses, general practitioners, mental health practitioners, aboriginal health workers).

2.4 AIMS OF THIS REPORT

In approaching the final year of the NPDI under the initial five-year funding agreement, the need to evaluate outcomes is paramount and becomes increasingly apparent.

Figure 2.4 *beyondblue* Perinatal Journey



While the initial Perinatal Framework for the NPDI indicated that an evaluation of the Initiative would be led by the Federal Government, in association with state and territory governments, to date this has not occurred.

In response to the need to assess progress under the Initiative, *beyondblue* has sought to provide a synopsis and highlight areas for future development.

The aims of this report are to:

i) provide a synopsis of progress to date under the Initiative
ii) identify gaps in the implementation of the NPDI to date
iii) make recommendations to inform future directions of the Initiative beyond 2013.

The current report provides an outline of each of these elements across the six objectives of the Initiative. Further, the key roles of state and territory governments and *beyondblue* are highlighted with respect to work undertaken to date, and recommendations are made for the future.

3. Progress to date and recommendations across the six objectives of the NPDI

3.1 THE DEVELOPMENT OF PERINATAL CLINICAL PRACTICE GUIDELINES

Objective

The development of national Clinical Practice Guidelines to *guide* and *inform* best practice among health professionals with respect to screening, treatment and management of postnatal depression.

The development of Clinical Practice Guidelines

Under the NPDI, *beyondblue* was responsible for the development of Clinical Practice Guidelines[14] to *guide* and *inform* primary health care professionals in the screening and management of depression in primary care settings. This was achieved through the formation of a Guideline Expert Advisory Committee (GEAC) comprising of experts representing all disciplines in maternity (midwives, maternal and child health nurses, obstetricians) and mental health (psychiatrists, psychologists) together with consumers and carers.

While *beyondblue* was required only to develop guidelines with respect to depression specifically, it was advised that it was unethical to focus solely on depression (as stipulated under the NPDI), as the screening process would potentially identify other mental health disorders. As a result, the Guidelines were more expansive and covered *four* mental health disordersd epression, anxiety and bipolar disorder in the antenatal and postnatal periods, as well as puerperal psychosis.

On completion, the Guidelines were approved by the NHMRC in February 2011. Since their release, *beyondblue* and state and territory partner and health professional bodies have promoted the Guidelines widely to health professionals and service providers. This has been achieved through guideline presentations and workshops at conferences, media interviews and editorial content, as well as articles published in scientific journals both nationally[15] and internationally[16].

Since their release, there has been ongoing high demand for the Guidelines from health professionals, resulting in the dissemination of ***16,853 hard copies and over 6,818 downloads of the Guidelines from the beyondblue website***, and reports that they have been among the most highly-accessed guidelines in Australia (National Institute of Clinical Studies, NICS). This is likely to reflect the growing momentum of the NPDI as the Guidelines are embedded into practice. Further, an independent evaluation of the Guidelines commissioned by *beyondblue* revealed them to be rated as highly-relevant and applicable to the range of health professionals involved in the delivery of maternity and primary care, as well as consumers and carers[17].

The development of companion documents H ealth professionals

beyondblue was also required to develop resources for health professionals. In response to this, a suite of resources has been developed in consultation with health professionals working across the range of maternity and primary care settings in order to support Guideline implementation. These resources are outlined in Box 3.1, and a more detailed description is provided in Appendix 2.

Since the official launch of these companion documents in April 2012, there has been significant uptake amongst health professionals with ***over 3,500 Health Professional Packs*** ordered and disseminated in the first two months.

Box 3.1 Perinatal Clinical Practice Guideline resources (companion documents): Clinical documents developed for health professionals

- Perinatal clinical practice guidelines E xecutive Summary: A guide for primary care health professionals
- Psychosocial assessment and management of perinatal mental health disorders: A guide for primary care health professionals
- Edinburgh Postnatal Depression Scale (EPDS) scoring pads
- Edinburgh Postnatal Depression Scale (EPDS) scoring wheel (to assist with interpretation of EPDS scores and follow-up action)
- Fact Sheet series to guide treatment and management of perinatal mental health disorders:
  - Identifying and managing depression and anxiety in the perinatal period
  - Managing bipolar disorder in the perinatal period A guide for primary care health professionals
  - Managing puerperal (postpartum) psychosis A guide for primary care health professionals
  - Information for health professionals regarding infant cognitive and emotional development.

The development of companion documents C onsumers and carers

beyondblue has also developed resources for consumers and carers to ensure they have access to appropriately-targeted, evidence-based information derived from the Guidelines. These resources cover the spectrum of four mental health disorders across the perinatal period.

In particular, two new booklets have been developed specifically for consumers and carers, focusing on:

- emotional health and wellbeing
- managing mental health conditions.

The second booklet, *Managing mental health conditions during pregnancy and early parenthood*, imparts information from the Guidelines. It contains detailed information about the signs of the different perinatal mental health disorders, an overview of treatments and where and how these treatments can be accessed. Issues surrounding the role and safety of medications are discussed, highlighting the importance of seeking specialist advice for the more severe disorders. Developed in consultation with consumers, carers, state and territory partners and health professionals representing all relevant disciplines, this 47-page booklet also provides tips, strategies and useful contacts for consumers and carers.

These new resources for consumers and carers (see also section 3.6) will be made available in the coming weeks.

FUTURE CONSIDERATIONS C LINICAL PRACTICE GUIDELINES

Since their release, awareness and demand for the Guidelines and companion documents continues to increase. In order to maintain momentum around screening and Guideline implementation, ***promotional activity needs to continue*** through collaboration with state and territory partners and health professional bodies. There is also potential to enhance this activity through the ongoing establishment of partnerships with universities, training colleges, professional bodies and Medicare Locals with the aim of ***embedding the Guideline recommendations into clinical practice***.

Secondly, as this demand is likely to continue with the implementation of screening, treatment and management under the NPDI, it is important to consider ***if and how these resources can continue to be made available at no cost to health professionals, consumers, carers and their families.*** This is considered important in order to continue to embed the Guideline recommendations into practice among health professionals and provide evidence-based healthcare information to consumers and carers.

As a requirement of NHMRC, the Guidelines will need to be ***formally revised in 2016***. Further, should there be any *significant developments* in the perinatal area, this will require a review of the Guidelines to ensure they remain current and continue to inform best practice.

Finally, there were a number of areas within the Guidelines where there was insufficient evidence to make recommendations and hence good practice points were devised. Therefore, it is recommended that ***further research is required to address these areas and inform best practice***. This could be achieved by commissioning targeted research with Australian experts across the relevant clinical areas.

3.2 WORKFORCE TRAINING AND DEVELOPMENT FOR HEALTH PROFESSIONALS

Objective

To equip health professionals with the knowledge and skills to increase their confidence and competence to detect and/or manage depression in primary and maternity care settings across Australia.

Scoping health professionals con fidence, competence and training needs

In 2010, *beyondblue* conducted qualitative research with health professionals (obstetricians, general practitioners, midwives, maternal and child health nurses) to assess their awareness and understanding of perinatal mental health disorders and to ascertain their confidence and competence to detect, treat and manage perinatal mental health disorders[18].

This research identified the *need for the Guidelines and training of maternal and child family health nurses and midwives* who are at the frontline of service delivery and ideally placed to provide screening and referral for women. The research also revealed *variable levels of knowledge and competence amongst general practitioners* and highlighted the need for *women to be proactive* in raising the issue within the general practice settings.

With respect to obstetricians, there was not only a *lack of awareness* of perinatal mental health disorders generally, but also a *perception that the incidence of mental health disorders was very low amongst their patients*. Paradoxically, this was in contrast to women who indicated that they would not disclose mental health problems to their obstetrician as they were ashamed or felt that they were in a position where depression/anxiety was unacceptable[19].

In addition to the reported *lack of knowledge and skills across the range of health professionals*, the research also highlighted a number of *barriers to screening and provision of care*, including a lack of time and uncertainty regarding appropriate referral and management practices. In turn, this research has informed the development of *beyondblue* education and training programs and resources.

Mapping training needs t he development of the Workforce Training and Development Matrix

In order to scope the education and training needs of health professionals who would be involved in the perinatal care of women, *beyondblue* formed a national Workforce Training and Development Committee under the NPDI. The committee was comprised of experts from a range of health, mental health, maternity and training/education disciplines, consumers, carers and representatives from the Federal Government and each state and territory government involved in the implementation of the NPDI, and *beyondblue.*

Under this committee, a training matrix was developed (see Appendix 3). Informed by the *beyondblue* perinatal Clinical Practice Guidelines, the Matrix guides health professionals to identify training needs/objectives for those delivering basic, intermediate and advanced levels of care, and provides those developing programs with a framework to assist with preparation of courses and curriculum. The Matrix also identifies key objectives in increasing Awareness and understanding of perinatal mental health disorders.

Since its development, the Workforce Training and Development Matrix has been placed on the *beyondblue* website and is used to inform the development of training programs and curricula across university and tertiary education settings, both nationally and internationally. In addition, *beyondblue* provides and maintains a directory of training programs and providers across the country, to assist in the alignment with the Matrix.

The development of online training programs

Under the NPDI, *beyondblue* has developed a free, fully-accredited, online training program to impart knowledge around screening, treatment and management of perinatal mental health disorders in primary and maternity care settings (www.thinkgp.com.au/beyondblue).

The *beyondblue* online training program *Beyond babyblues: Detecting and managing perinatal mental health disorders in primary care* is tailored to the Basic Skills section of the *beyondblue* Workforce Training and Development Matrix described in the previous section. As such, the program equips health professionals with the necessary tools to identify, screen, refer and treat perinatal depression and/or anxiety, and provide information and referral surrounding the more severe disorders. The uptake of the various training programs continues. ***To date, 3,144 people are participating in, or have completed (N=1,020) part of, or the entire entire beyondblue online training program.***

More details about the development of the *beyondblue* online training program, objectives and accreditation are detailed in Appendix 4.

Several online training programs have also been developed by various states including South Australia, New South Wales and Queensland. As with the *beyondblue* program, each of these has been designed for health professionals, is free, and each has a slightly different focus in terms of its learning objectives. All online training programs developed under the NPDI continue to be accessed by a range of health professionals.

In addition to the above online training, thousands of health professionals have received face-to-face training across various jurisdictions.

Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) position statement

As highlighted in *beyondblue s* research, there was a significant lack of awareness of perinatal mental health disorders particularly amongst obstetricians. Given the high proportion of women accessing private maternity care (30%), the need to collaborate with RANZCOG was deemed essential. This led to collaboration with key leaders and has resulted in the development of a position statement that reflects the *beyondblue* Clinical Practice Guidelines and plans are underway to launch and promote the statement with the College.

FUTURE CONSIDERATIONS WORKFORCE TRAINING AND DEVELOPMENT

Stakeholders have highlighted the ***need for a national agency or centre*** to continue to lead and inform national training opportunities and be identified as a repository of information about perinatal training programs nationally. In addition, the Agency could possibly become an accreditation body and be responsible for developing standards (reflecting the Guidelines and Matrix) and potentially endorsing perinatal training programs and resources.

Such an approach would be viable, given the ongoing need for training (both face-to-face and online) to support the uptake of screening under the NPDI. This is particularly necessary in those areas with a high staff turnover. A national approach would also ***ensure that all training programs are consistent, reflect the Clinical Practice Guidelines*** as well as ***reflect state and territory government policies*** and referral pathways.

There is also the need for the provision of ***intermediate and advanced training programs*** where online training is not suitable because face-to-face mentoring, supervision and/or peer support is required. Further, it is recommended that current training programs are expanded to cover issues surrounding the ***assessment of the infant***, and further dissemination of ***customised*** programs for those working with ***Indigenous and culturally and linguistically diverse (CALD) communities***. While some training programs have been established for people working with Indigenous and CALD communities specifically, the suitability of these programs for broader use needs to be scoped (for specific community groups), and if appropriate, made available nationally.

Finally, dissemination of training needs to build on partnerships with professional bodies, service providers (e.g. Medicare Locals) and training institutions, and to ***integrate core elements of established programs into curricula***. There needs to be greater uptake of training among ***general practitioners*** as well as those health professionals working within the ***private sector*** generally. It is also important to consider ways of targeting training to those practising in rural and remote areas.

3.3 ROUTINE AND UNIVERSAL SCREENING

Objective

To implement routine screening across antenatal and postnatal primary care and maternity settings to identify those women at risk of, or experiencing antenatal and/or postnatal depression.

Scoping health professionals at titudes and identifying barriers to screening

Under the NPDI, *beyondblue* research with a range of health professionals (general practitioners, obstetricians, midwives, maternal and child family health nurses) sought to explore awareness and understanding of perinatal mental health issues and competence and confidence to identify, treat and manage perinatal mental health disorders in primary care[18]. With respect to screening specifically, several barriers were identified. These included a lack of knowledge surrounding *perinatal mental health* generally, the lack of *skills and training* resulting in low levels of *confidence* and *competence* to undertake screening, insufficient *time* to implement the screening process itself and, insufficient time and skills to manage the *potential outcomes* of screening.

The development of screening guidelines, and resources for healthcare professionals

In order to increase the knowledge, skills and ability of health professionals to undertake screening, these issues were specifically addressed in the development of the Clinical Practice Guidelines. The Guidelines provide health professionals with specific guideline recommendations and good practice points pertaining to *when* and *how* to screen in the antenatal and postnatal periods. In addition to screening for possible depression and/or anxiety using the Edinburgh Postnatal Depression Scale (EPDS)[20], the Guidelines also include screening for risk factors which may identify women who may be *at risk* of developing a range of mental health disorders (psychosocial risk questionnaire) and prompt additional assessments and referrals as required.

This information surrounding the screening elements of the Guidelines is being widely disseminated through several specific companion documents developed to guide health professionals in the screening process. Information resources pertaining specifically to screening include the *Psychosocial assessment and management of perinatal mental health disorders: A guide for primary care health professionals*, the EPDS scoring wheel, and EPDS scoring pad (refer to Appendix 2).

The development of online training programs to facilitate screening

To increase the competency of health professionals who are well-positioned to undertake screening and referral, a number of the online training programs address screening specificallyin cluding the *beyondblue* online training program *Beyond babyblues: Detecting and managing perinatal mental health disorders in primary care*, which has dedicated accredited modules focusing specifically on screening and pathways to care. *To date, around* ***800 health professionals have completed, or are currently completing, the modules which specifically focus on screening***.

Embedding screening into practice

In addition to providing advocacy, training and resources at a national level, several policies and initiatives have been implemented at a state and territory level to promote screening across primary care and maternity settings. As a result of this activity and advocacy screening is being increasingly implemented routinely across all jurisdictions, although screening rates do vary.

One of the challenges when attempting to ascertain the level of screening currently underway under the NPDI, is the varying methods (or absence) of data collection, both *across* and *within* states and territories[21] and health professions. As a result, it is not possible to ascertain accurate rates of screening to date under the NPDI (refer to Section 3.5 of current report). While the *nature* and *rates* of screening vary considerably, there are however, some consistent themes which have emerged anecdotally.

Key observations pertaining to the implementation of routine screening

- ***Increasing overall rates of screening in the perinatal period:*** While in some areas it is unknown *where, how,* or *the extent* to which screening is underway, there are many indicators to suggest that screening rates are increasing over time across Australia.
- ***Wide variation in the implementation of screening:*** There is wide variability in the uptake of screening across and within states and territories. This is particularly due to historic factors including for example, the long-time focus on screening in metropolitan Western Australia and the introduction of state government policies such as the SAFE START model as outlined in the New South Wales Health/Families NSW Supporting Families Early Package (2009).
- ***Higher rates of screening in the public sector:*** In line with the NPDI, screening is more prevalent in the public sector, with screening routinely implemented across numerous health services and jurisdictions. Alternatively, screening in the private sector is in its infancy with several pilot studies currently underway.
- ***Various levels of screening and screening tools are being implemented:*** While the Clinical Practice Guidelines recommend that the EPDS is for the detection of depression and anxiety in the perinatal period, this scale is not universally implemented at this time. In addition, the Guidelines identify that it is good practice to use a *psychosocial assessment tool* to identify those women who *are at risk* of developing mental health problems in the perinatal period. To date, however, there is no standardised toolh ighlighting the need for further research and development in this area.
- ***Screening across Indigenous and CALD populations:*** Significant research and development work needs to be undertaken in order to adapt screening tools and processes for these population groups.
- ***Screening is more likely in maternity care settings (excluding private) than in general practice:*** While screening by midwives, and maternal and child family health nurses is increasing in a more standardised way across services, the uptake of screening in general practice can be described as more ad hoc.

Potential barriers to screening

While there has been no formal evaluation of the current barriers to screening under the NPDI, consultations with stakeholders who are implementing screening highlight a range of potential barriers (see Box 3.3). Many of these barriers reflect those identified in the initial research with health professionals detailed in the previous section.

Box 3.3 Potential barriers to screening

1. Need for health professionals to have a greater awareness of the importance of screening
2. Inadequate mandatory training among health professionals
3. Lack of a consistent approach to screening across health professions
4. Time restrictions (i.e. insufficient allocation of time)
5. Limited referral pathways to support women following screening, if required
6. Lack of attendance to routine health checks to enable screening to be undertaken (particularly among Indigenous people)
7. Need for further regulation (advocating for policy) and clinical leadership surrounding screening policy and practice.

FUTURE CONSIDERATIONS R OUTINE AND UNIVERSAL SCREENING

It is recommended that there is ***continued leadership and advocacy to promote the uptake of universal screening*** for perinatal women and promote a ***consistency of approach*** to screening (as stipulated in the Clinical Practice Guidelines). This includes the ***continued promotion and provision of the perinatal Guidelines, screening tools, information resources for health professionals*** and ***accredited training*** programs to embed screening into professional practice.

Identification of the potential barriers to screening highlights a number of areas that need to be addressed, including the need to scope and refine policies and practices to facilitate screening, and explore how provision of pathways to care can be facilitated. This could include the development of an online directory, which could be accessed by health professionals at the point of screening and referral (see Section 3.4).

3.4. FOLLOW-UP SUPPORT AND CARE FOR WOMEN ASSESSED AS BEING AT RISK FOR PERINATAL DEPRESSION

Objective

To provide timely follow-up support and care for women assessed as being at risk or experiencing perinatal depression.

Implementation of NPDI across jurisdictions

Since the commencement of the NPDI in 2008, there has been significant recruitment and activity across the states and territories to implement the Initiative. The number, type and nature of services vary across jurisdictions in order to accommodate local need (details of which would be reported in the state and territory government progress reports to the Federal government).

Pathways to care

All state and territory partners have dedicated time and resources to identify and/or establish pathways to care, to enable women to be referred to appropriate services. While in some jurisdictions this has occurred at a localised level, for others there appears to have been a scoping and mapping of pathways to care across the states and territories more broadly.

FUTURE CONSIDERATIONS F OLLOW-UP SUPPORT AND CARE

With the current commitments extending until June 2013, there is strong support for ***continued funding*** to state and territory governments to ***enable these clinical services to continue to be offered under the NPDI***. Further, there is likely to be a need to ***expand*** these services to meet the local needs ***as the rates of screening are increased*** across the country. In some areas, this needs to occur across both metropolitan and rural areas, whereas in other cases, the focus is required across rural areas, particularly where currently, there are no dedicated services or positions.

Future funding of services across states and territories also needs to take into account the need for dedicated staff and/or services to meet the specific needs of Indigenous and CALD consumers.

The provision of follow-up care and support for women in the private sector also remains an issue. As described in the previous section regarding screening, ***due to the current lack of screening*** undertaken in the ***private sector***, it is likely that perinatal mental health disorders remain ***undetected*** and hence, ***follow-up care and support is not provided*** to these women.

While scoping of referral pathways has occurred across jurisdictions (to varying degrees), to date this has resulted in health workers becoming aware of pathways in their own areas, however, services outside of these areas or specific regions are likely to remain unknown. This highlights the need for scoping and potential development of ***a national online Pathways to Care service*** *map/directory*, which could be populated by local areas to provide greater awareness of preventative, support and clinical services available across jurisdictions. If such a resource was to be developed it would require ongoing maintenance in order to ***provide health professionals with appropriate referral pathways to facilitate timely and appropriate referral. In addition*** providers could upload and update their details and those of their services.

State and territory representatives also highlight the need for ***clear communication*** for both health professionals, and consumers and carers, regarding ***how to access ATAPS funding*** or ***Medicare items for perinatal mental health***.

The requirement for services to be equipped to address the broader spectrum of mental health needs has also been identified. Under the NPDI, screening and psychosocial assessment is likely to reveal a range of perinatal mental health disorders (as covered in the Guidelines) and hence, services need to be equipped with the knowledge, skills and referral pathways to refer these women. This is particularly the case for those who may be experiencing severe mental health problems, including the need for mother and baby units which are currently not available or easily accessible to public patients in several states and territories.

Finally, while recognised as being ***out of scope*** of the current NPDI, many state and territory representatives highlighted the need for existing services to expand their remit to include issues surrounding the ***assessment and management of the infant***, in particular, by addressing issues pertaining to mother-infant attachment.

3.5 RESEARCH AND DATA COLLECTION

Objective

To undertake research and data collection to inform activity and progress under the NPDI.

Data collection cu rrent status

While a national approach to screening is currently being implemented across the country, to date, there has been *no national approach to data collection* across jurisdictions. As a result, data collection across states and territories is *variable* both *within* and *across* jurisdictions and in terms of the *type* of information that is being collected and the way in which it is being *recorded*. For example, in some areas, there is no collection/recording although in other areas, there are multiple (disconnected) databases or data systems. Further, many data collection systems are manual and/or inadequate. Some electronic data systems are being changed or modified to include more perinatal information. Despite these positive developments at local levels, however, there remains *no national, unified approach*.

As a result, the only way in which national information pertaining to screening outcomes and the impact of follow-up care can currently be assessed is retrospectively through the analysis of perinatal Medicare/ATAPS items. However, this presents an incomplete picture, as often, items cannot be aligned with respect to the perinatal period and information derived will be purely retrospective.

The absence of a national approach to data collection also prevents gathering of important information (such as screening rates, screening outcomes, service outcomes and cost effectiveness) from being captured and used to inform service provision at a local, state and national level.

Submission to the National Maternity Data Development Project

In response to the lack of consistency of the type of information recorded, *beyondblue* provided a detailed submission to the National Maternity Data Development Project being undertaken by the National Institute of Health and Welfare. The Submission advocated for the capture of data pertaining to the psychosocial risk assessment and EPDS (as recommended in the Clinical Practice Guidelines) to be consistently captured on a *national* basis (many maternity data items are currently collected only on a state and territory basis). The outcome of this is yet to be released.

NHMRC and *beyondblue* Linkage Grant

External to the NPDI, *beyondblue* has committed financial and in-kind support as a partner organisation in an NHMRC Linkage research grant (2012201 4) and is represented as a Chief Investigator on the Project. This research aims to evaluate the impact of perinatal mental health initiatives on *mental health outcomes*, which is critical for optimising the quality and uptake of services. In addition, this will assist in the identification of key data items to be embedded into the national minimum perinatal data set. This project is unique in that it will use very large *population health datasets* to examine the impact of the reforms on maternal health outcomes, service utilisation and the likely cost-effectiveness of these services. The specific aims and objectives of the Linkage Grant are detailed in Appendix 5.

FUTURE CONSIDERATIONS R ESEARCH AND DATA COLLECTION

With a range of research activities and evaluations being carried out under the NPDI, it is ***important to impart outcomes*** which may have ***applications across jurisdictions***. While this does occur currently at an informal level, this could be enhanced through the provision of a ***Centre of Excellence by a national organisation***.

It is recommended that consideration is given to ***establishing nationally-consistent items*** for ***collection and inclusion in the national minimum data set*** to enable screening and treatment outcome information to be captured, analysed and ultimately ***inform service provision and fiscal decision making***. The potential for agreement is now increased with the release of the Guidelines and uptake of routine psychosocial assessment.

Other issues currently pertain to ***data management systems***, which need to be aligned with the Federal Government s data management strategy. Currently, there are multiple data sets that are not integrated.

3.6 COMMUNITY AWARENESS

Objective

To raise awareness of the increased risk of depression, anxiety and other perinatal mental health disorders during pregnancy and the year following and reduce the stigma to promote help seeking.

Assessing community knowledge and attitudes (quantitative research)

In order to determine the Australian community s levels of awareness, knowledge, understanding and attitudes surrounding perinatal mental health disorders, a national survey of 1,200 people was initially conducted in 2009[22] and recently repeated in 2012. The results from this survey (the *beyondblue Perinatal Monitor)* revealed that there are high levels of confusion between the *baby blues* and postnatal depression, and the importance of family and friends as supports for those who may be experiencing postnatal depression. Postnatal depression is regarded as serious and requiring treatment across the community, and stigma among the broader community was not as concerning as that observed among older people in particular. The community was also seen to hold positive attitudes on screening for depression during pregnancy and in the postnatal period.

Identifying needs of consumers and carers (qualitative research)

Research undertaken with consumers and carers[23] with a personal experience of perinatal depression and/or anxiety revealed that, in most instances, early symptoms were missed as they were viewed as normal in the context of pregnancy or having a baby, and hence treatment was not sought until the condition had reached the point where the person was unable to cope from day to day[24]. While rates of stigma were not high across the broader community (as indicated in the perinatal monitor), there were very high levels of *self* stigma, which prevented women from seeking help, as well as disclosing their symptoms at the point of screening. This was largely because women feared this would reflect badly on them as individuals, indicate that they were b ad mot hers, or in some instances, result in their infant or child/ren being removed from their care[25].

National community awareness campaign Ju st Speak Up!

The observed high rates of stigma, particularly self stigma, ultimately informed the development of a national community awareness campaign Ju st Speak Up. Th e campaign, which featured high-profile and everyday people talking candidly about their experience of depression and anxiety, directs people to a dedicated website (www.justspeakup.com.au) where they are encouraged to read about other people s experiences and add their own story.

While the campaign has been developed for television, radio and print, limited funds have prevented the campaign from being disseminated more broadly. Despite this, *to date*, there have been ***43,934 visitors*** *to the website, and over* ***278 stories uploaded*** *since the launch of the campaign in November 2010.*

Education resources for consumers and carers

Developed by *beyondblue*, the *Emotional health and wellbeing during pregnancy and early parenthood* booklet is intended for *all* pregnant women, mothers (and their partners), and contains information about the importance of looking after the health and wellbeing of *both* parents. In a number of studies, such a resource has been used effectively as a tool to educate and encourage parents to employ a range of strategies that may ultimately prevent the development of mental health problems, and/or facilitate early detection and help seeking. In addition, this booklet briefly outlines the different types of mental health conditions that women are at greater risk of developing in the perinatal period. These conditions are addressed in more specific detail in the second companion booklet *Managing mental health conditions during pregnancy and early parenthood* (refer to section 3.1 for further information). Both booklets were developed in close consultation with consumers, carers and health professionals, and contain consumer and carer perspectives throughout.

In addition, *beyondblue* had also developed a flyer *Understanding perinatal depression and anxiety,* which provides an overview of the more common mental health conditions and references more detailed resources, information and support services available.

Information resources for Indigenous populations

Under the NPDI, several other campaigns and resources have been developed, including for example, the Queensland *Stay connected, stay strong b efore and after baby* mental health promotion DVD and a series of posters to promote awareness of health and wellbeing in Queensland. Western Australia has also developed radio advertisements in line with the *beyondblue Just Speak Up* Campaign specifically for Indigenous people, as well as resources for health professionals, consumers and carers. South Australia has developed and distributed specific resources for Aboriginal communities living in the EP Ylands.

Hey Dad booklet

This 16-page booklet is specifically designed for new fathers to provide some practical tips and advice on the transition to fatherhood. Initially developed by Ngala WA, the booklet has been expanded to incorporate information pertaining to mental health, and particularly recognising early signs of depression and anxiety, and information about help seeking. *beyondblue* is able to disseminate this booklet free of charge through funding received from the Movember Foundation.

FUTURE CONSIDERATIONS

The ***confusion surrounding perinatal mental health disorders*** in the community and high levels of ***self stigma*** highlight the need for ***ongoing community awareness activity*** to underpin the NPDI beyond 2013. This will ultimately encourage women (and partners) to speak up and seek help early, as well as ***maximise the potential for screening*** (which is being implemented) to detect these conditions promptly. While there has been capacity to develop the *Just Speak Up* campaign, there has been *limited funding available to disseminate the campaign broadly* and hence capitalise on this investment to date.

Under the NPDI, most state and territory governments and partners ***rely on beyondblue*** to develop and provide community awareness strategies including campaigns (e.g. *Just Speak Up*) and a range of resources, which are then disseminated throughout the states and territories. In order to build upon developments to date, it is important to ***continue to invest in community awareness*** activity to ensure the delivery of consistent messages across the country.

Several states governments have developed their own campaigns/community awareness resources (e.g. Queensland, Western Australia and South Australia) to ***target Indigenous communities specifically***. In turn, discussions have commenced regarding the potential ***adaptation and expansion of locally-developed campaigns and resources*** so that these can be tested and made available nationally.

4. Future directions

The current synopsis and review highlight the need to *maintain a national focus* as the Initiative continues to be implemented nationally across jurisdictions. This is vital in order to ensure that evidence-based, best practice continues to be applied consistently on a national scale, that duplication is avoided, and consistent messaging is maintained across the community.

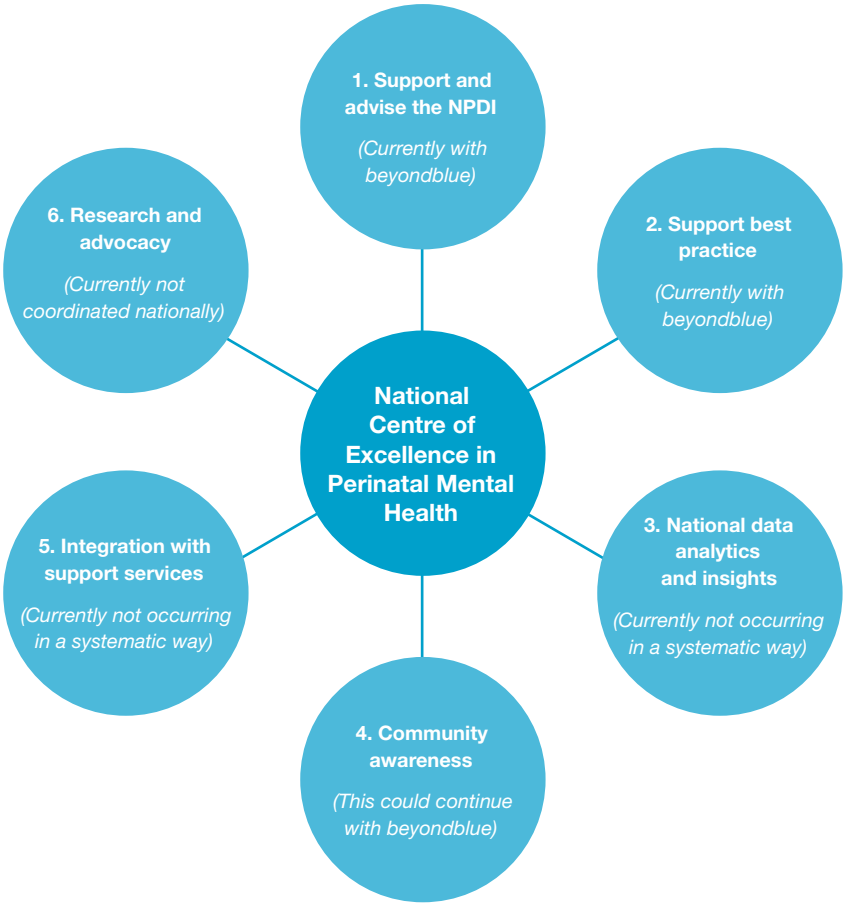
In order to build on the significant developments to date and address the considerations identified in the current report under each of the NPDI objectives, it is recommended that support be given to the establishment of a national perinatal entity, such as a National Centre of Excellence (or equivalent) in Perinatal Mental Health.

Key objectives of the Centre should include (but not be limited to):

1. ***Continued national leadership,*** support and advice for all state and territory governments in the implementation of screening and services for perinatal women. *beyondblue* currently provides this leadership under the NPDI and works closely with the Federal, state and territory governments.
2. ***Continued advocacy to embed best practice through the consistent implementation of the perinatal Clinical Practice Guidelines*** (developed by *beyondblue* and approved by NHMRC in 2011). This includes the continued promotion and provision of the Guidelines and additional resources for health professionals. Consideration should also be given to the centralisation of research knowledge and training programs. The Centre would provide a central point for the maintenance of strategic partnerships with professional bodies, training institutions, and service providers.
3. ***The development and management of data systems*** to enable screening data to be collected and analysed in order to monitor and evaluate the impact of screening and inform service provision. This is currently a major gap in the NPDI, and is preventing the monitoring and evaluation of screening and referral outcomes on a national basis. *beyondblue* has partnered with NHMRC and is undertaking a Data Linkage Study (20122014) that will provide some insights into the impact of screening, however, this will not inform current service utlisation or needs.
4. ***Sustained community awareness, education and destigmatisation activity*** This includes the continued provision of high-quality, timely, evidence-based information about perinatal mental health disorders for consumers and carers. *beyondblue* currently provides this activity under the NPDI.
5. ***Integration with support services*** I n addition to primary care services, there is a range of independent support organisations that are well placed to provide information, education and support services to women at risk of, or experiencing perinatal mental health disorders. Potentially, these services could be more actively integrated into the NPDI.
6. ***Research and advocacy*** Th e Centre would continue to work with Australia s leading perinatal clinicians and researchers to ensure the integration and application of research outcomes into clinical practice. The Centre would also advocate for, and potentially commission, new areas of research (for example, addressing research gaps as identified in the Guidelines).

The Centre would provide this leadership and integration across the components of the NPDI, by working in close collaboration with *beyondblue*, health professional bodies, providers of clinical and support services, and Australia s expert researchers and clinicians from across the country.

Figure 4 Proposed vision for a National Centre of Excellence in Perinatal Mental Health



Through the adoption of such a model, a national focus on perinatal mental health would ensure that the significant progress, partnerships, research and momentum achieved to date could be sustained and further developed and embedded across Australia.

5. Summary and recommendations

5.1 SUMMARY

In response to the high prevalence and debilitating impact of perinatal mental health disorders in Australia, the NPDI was established in an agreement between the Federal, state and territory governments and *beyondblue* in 2008. The aim of the Initiative, which was initially funded for a five-year period, is to improve prevention and early detection of perinatal depression and provide better support and treatment for expectant and new mothers.

A review of progress to date reveals that there have been significant advances in the development and implementation of Australia s NPDI since it s commencement in 2008. As the Initiative approaches the final year of its original five-year funding period, the current report sought to provide a synopsis of activity to date and recommendations for the future of perinatal mental health in Australia.

An outline of progress and recommendations across the six objectives of the Initiative are summarised below.

1. The development of Clinical Practice Guidelines

This has been an important and significant outcome to date, as the Guidelines (approved by NHMRC) provide health professionals with nationally-consistent, evidence-based recommendations to guide best practice. The Guidelines are comprehensive, as they address the screening, detection and management of mental health disorders in both the antenatal and postnatal periods. Further, the Guidelines also cover a range of mental health disorders namely depression, anxiety, bipolar disorder and puerperal psychosis. Following the Guidelines development, a range of resources (companion documents) has been developed for health professionals, to embed the Guidelines into routine care across primary and maternity settings, as well as to inform consumers and carers.

It is important that the Guidelines and resources continue to be promoted and made widely available in order to promote and implement best practice across the diverse range of perinatal settings and professional bodies. Also, consumers and carers need access to information pertaining to perinatal mental health disorders and treatments.

2. Workforce training and development for health professionals

Research undertaken with primary and maternity care health professionals highlighted the range of knowledge surrounding perinatal mental health disorders generally. Further, there was a lack of confidence and competence to identify, treat and manage perinatal mental health disorders. In response to this, *beyondblue* has scoped the education and training needs of health professionals through the development of a Workforce Training and Development Matrix, which in turn, has informed the development of various training programs and curricula. It is also vital that the Centre continues to work closely with professional bodies and institutions.

In order to meet the high demand for training among health professionals needed to facilitate screening, referral and provision of effective treatments, free, online training programs have been developed under the NPDI.

In order to ensure health professionals are equipped to implement the objectives of the NPDI within their clinical practice, it is important to ensure that training continues to be made widely available and reflects the Clinical Practice Guidelines. To achieve this, it is recommended that a national, centralised centre provides this function, to capitalise on work developed under the Initiative and to avoid duplication. This centre should also oversee the adaptation and expansion of existing programs to meet the needs of jurisdictions (e.g. to reflect local policies), population groups (e.g. Indigenous, CALD) and health professionals requiring more advanced levels of training.

3. Routine and universal screening

The rollout of the NPDI has seen an increase in the uptake of screening across Australia, and this has been facilitated through the release of the Clinical Practice Guidelines, resources for health professionals and online training programs. While it is not possible to assess the overall rates, location or impact of screening (due to the absence of universal data collection), current levels of screening are understood to vary considerably across states and territories, public and private sectors, and metropolitan and rural areas.

To continue the momentum surrounding screening, national leadership and advocacy is required to promote its uptake further. In addition, there have been a number of potential barriers to screening, which have been identified in this report, and which need to be scoped further and addressed through the review and refinement of policy, and the development of pathways to care.

4. Follow-up support and care for women assessed as being at risk

The process of screening aims to identify the risk of, and/or presence of perinatal mental health disorders to enable early intervention. In response to this, there needs to be adequate resourcing to provide evidence-based treatments in community and/or primary care settings. The level and types of services required need to take into consideration minority groups and people in rural areas who may have limited access to services. There is also a need for clear communication regarding how to access ATAPS funding or Medicare items for perinatal mental health for health professionals, as well as consumers and carers.

In order to identify and promote the range of services available at a community or primary care level, it is recommended that a National Pathways to Care Directory be scoped. This could include the identification and promotion of services at preventative, as well as treatment level. Further, research is required to evaluate the effectiveness and feasibility of high- and low-intensity interventions, including those that can be delivered online.

5. Research and data collection

There is no unified approach to data collection, which has resulted in disparate datasets across the countrya nd as a result, it is not possible to monitor or evaluate the rates or impact of screening and follow-up care for women.

Therefore, it is recommended that nationally-consistent items for collection and inclusion in the minimum data set are established to enable consistent information to be captured, embedded into the national minimum perinatal data set, and analysed to ultimately inform service provision and treatment efficacy. Also, there is a need to communicate the outcomes and learnings of local evaluations that are currently taking place in various jurisdictions to facilitate knowledge transfer. Again, these functions could be facilitated through a National Centre of Excellence.

6. Community awareness

Through the development and dissemination of community awareness campaigns *(Just Speak Up)*, resources, media liaison, work with high-profile ambassadors and expert media commentary; community awareness of perinatal mental health disorders has increased. *beyondblue* has played the lead role in this area, and relationships with state and territory partners, health professionals and service providers have facilitated the dissemination of consistent messages to the community. A smaller number of community awareness activities have also been initiated at a more local level, many of which target specific population groups.

In order to promote, prevent and improve early detection of perinatal mental health disorders, it is important that mental health promotion activity remains nationally consistent, is underpinned by research, is supported and sustained. This is particularly important when considering that the effectiveness of screening hinges upon open disclosurewh ich can be inhibited by the high levels of stigma that currently exist amongst women.

5.2 RECOMMENDATIONS

A review of progress to date, under each of these six objectives of the NPDI, highlights the significant developments and the need to maintain support to continue progress under the NPDI. As highlighted, this would be best achieved through maintaining a national focus to ensure that evidence-based, best practice continues to be consistently applied, that national momentum is maintained, duplication is avoided, and consistent messaging is provided at a community level.

In response to this, *beyondblue* recommends the establishment of a National Centre of Excellence in Perinatal Mental Health. The Centre will continue to provide national leadership and support a nationally-consistent approach to implementation across Australia. Initial thoughts about the role and function of such a Centre are outlined in Figure 5.2.

Figure 5.2 Proposed key objectives of a National Centre of Excellence in Perinatal Mental Health

1. Continued national leadership, support and advice for all state and territory partners in the implementation of screening and services for perinatal women. *beyondblue* currently provides this leadership under the NPDI.

2. Continued advocacy to embed best practice through the consistent implementation of the perinatal Clinical Practice Guidelines (developed by *beyondblue* and approved by NHMRC in 2011). This includes the continued promotion and provision of the Guidelines and additional resources (companion documents) for health professionals. Consideration should also be given to the centralisation of research knowledge and training programs. The Centre would provide a central point for the maintenance of strategic partnerships with professional bodies, training institutions, and service providers.

3. The development and management of national data systems to enable screening data to be collected and analysed in order to monitor and evaluate the impact of screening and to inform service provision. This is currently a major gap in the NPDI, and is preventing the monitoring and evaluation of screening and referral outcomes.

4. Sustained community education and awareness, and destigmatisation activity: This includes the continued provision of high-quality, timely, evidence-based information about perinatal mental health disorders for consumers and carers. *beyondblue* currently provides this activity under the NPDI.

5. In addition to the primary care services, there is a range of support organisations that are well placed to provide information, education and support services to women at risk of, or experiencing perinatal mental health disorders. Currently, these services work largely in isolation and could be more actively scoped and integrated into the NPDI.

6. The Centre would continue to work with Australia s leading perinatal clinicians and researchers to ensure the integration and application of research outcomes into clinical practice and could oversee the ongoing evaluation of the NPDI.

6. References

1 Buist A and Bilszta J (2006) The *beyondblue* National Postnatal Screening Program, Prevention and Early Intervention 20012005, F inal Report. Vol 1: National Screening Program. Melbourne: *beyondblue: the national depression initiative.*

2 *beyondblue* (2011) The *beyondblue National Action Plan for Perinatal Mental Health (NAP)*. Melbourne: *beyondblue: the national depression initiative.*

3 Gavin NI, Gaynes BN, Lohr KN et al (2005) Perinatal depression: a systematic review of prevalence and incidence. *Obstet & Gynecol* 106 (5-1).

4 Lewis G (ed) (2007) The Confidential Enquiry into Maternal and Child Health (CEMACH). Saving Mothers Lives: Reviewing Maternal Deaths to make Motherhood Safer 20032005. The Seventh Report on Confidential Enquiries into Maternal Dealths in the United Kingdom. London: CEMACH.

5 Paulson, JF and Bazemore, SD (2010) Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis. *Journal of the American Medical Association* 303 (19) 19611 969.

6 Glover V and OCon nor T (2002) Effects of antenatal stress and anxiety: implications for development and psychiatry. *Brit J Psychiatry* 180: 38991.

7 Grant K-A, McMahon C, Austin M-P et al (2009) Maternal prenatal anxiety, postnatal caregiving and infants cortisol responses to the still-face procedure. *Dev Psychobiol* 51(8): 6253 7.

8 OCon nor TG, Heron J, Glover V; Alspac Study Team (2002) Antenatal anxiety predicts child behavioural/emotional problems independently of postnatal depression. *J Am Acad Child Psychiatry* 41(12): 14707 7.

9 Murray L and Cooper P (1997a) Effects of postnatal depression on infant development. *Arch Disease in Childhood* 77(2): 99101.

10 Sinclair D and Murray L (1998) Effects of postnatal depression on children s adjustment to school. Teacher s reports. *Brit J Psychiatry* 172: 5863.

11 Verbeek T, Bockting CL, van Pampus MG, Ormel J, Meijer JL, Hartmen CA and Burger H (2012) Postpartum depression predicts offspring mental health problems in adolescence independently of parental lifetime psychopathology. *J Affective Disord*. 136 (3): 94854.

12 Buist, A, Condon, J, Brooks, J, Speelman, C, Milgrom, J, Hayes, Bet al (2006) Acceptability of routine screening for postnatal depression: An Australia-wide study. *J Affect Disorders*, 93: 2332 37.

13 Framework for the National Depression Initiative 2008/09 2012/ 13. Department of Health and Aging. March 2009, Australia.

14 *beyondblue* (2011) Clinical practice guidelines for depression and related disorders anxiety, bipolar disorder and puerperal psychosis in the perinatal period. A guideline for primary care health professionals. Melbourne: *beyondblue: the national depression initiative.*

15 Austin, MP, Middleton, P, Reilly, NM, and Highet NJ (2011) Australian mental health reform for perinatal care. *Med J Aust* 2011; 195 (3): 112113

16 Austin, MP, Middleton, P, Reilly, NM, and Highet NJ (2011) Detection and management of mood disorders in the maternity setting: the Australian Clinical Practice Guidelines. *Women Birth.*

17 Wallis Consulting Group (2012) The perinatal depression guideline post evaluation. Final Report. Wallis Consulting Group.

18 Highet NJ and Stevenson A (2011) A qualitative analysis of health professionals awareness, knowledge and perspectives of perinatal depression and anxiety. *beyondblue: the national depression initiative.*

19 Highet NJ and Stevenson A (2011) A qualitative analysis of consumer experiences with postnatal depression and accessing treatments. *beyondblue: the national depression initiative.*

20 Cox JL Holden JM and Sagovsky R (1987) Detection of postnatal depression: development of the 10 item Edinburgh postnatal depression scale. *Brit J Psychiatry* 150: 7828 6. EPDS

21 Hall P (2012) Current considerations of the effects of untreated maternal perinatal depression and the National Perinatal Depression Initiative. *Journal of Developmental Origins of Health and Disease (2012), 3(4): 293295.*

22 Highet, N, Gemmill, AW, Milgrom, J (2011). Depression in the Perinatal Period: Awareness, Attitudes and Knowledge in the Australian Population. *Aust NZ J Psychiatry.* Vol 45, No. 3: 223231.

23 Highet, NJ, Stevenson A L (2011) Living with perinatal depression and anxiety the partners experience. Melbourne: *beyondblue: the national depression initiative.*

24 Highet, NJ, Stevenson A L and Purtell CA (2012) Insights into women s personal experiences and perceptions of postnatal depression and anxiety and implications for information and service provision. Melbourne: *beyondblue: the national depression and anxiety initiative.*

25 Highet, NJ, Stevenson A L and Purtell CA (2012) Barriers to accessing support and help-seeking amongst perinatal women t he power of ignorance, self stigma and feelings of failure, shame, guilt and grief. Melbourne: *beyondblue: the national depression and anxiety initiative.*

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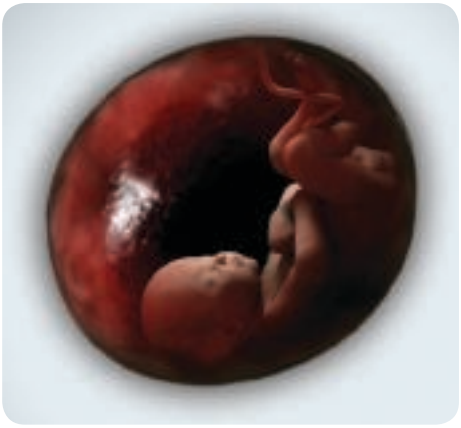
Appendix 1

THE IMPACT OF MENTAL HEALTH DISORDERS ON THE FETUS/INFANT

Maternal distress and anxiety during pregnancy can:

- increase the risk of complications during pregnancy and birth[1]
- negatively affect the developing fetal brain and infant behaviour[2]
- be associated with difficult infant temperament[3]
- increase cortisol (the hormone produced when stressed) in the infant[4]
- increase the likelihood of behavioural difficulties in childhood[5].



Postnatal mental health disorders in the first year following birth:

- negatively impacts on breastfeeding, infant nutrition and health/growth rates delaying infant physical development
- impairs bonding and attachment with the baby and can delay the child s cognitive[6], emotional and behavioural development[7]
- may lead to the development of adjustment problems in childhood[8], adolescence[9] and later in life.

1 Priest S and Barnett B (2008) Perinatal anxiety and depression: issues, outcomes and interventions. In: Sved-Williams A and Cowling V (eds) *Infants of Parents with Mental Illness: Developmental, Clinical, Cultural and Personal Perspectives*. Bowen Hills: Australian Academic Press.

2 Glover V and OCon nor T (2002) Effects of antenatal stress and anxiety: implications for development and psychiatry. *Brit J Psychiatry* 180: 38991.

3 Austin M-P, Hadzi-Pavlovic D, Leader L et al (2005a) Maternal trait anxiety, depression and life event stress in pregnancy: relationships with infant temperament. *Early Hum Dev* 81(2): 18390.

4 Grant K-A, McMahon C, Austin M-P et al (2009) Maternal prenatal anxiety, postnatal caregiving and infants cor tisol responses to the still-face procedure. *Dev Psychobiol* 51(8): 62537.

5 OCon nor TG, Heron J, Glover V; Alspac Study Team (2002) Antenatal anxiety predicts child behavioural/emotional problems independently of postnatal depression. *J Am Acad Child Psychiatry* 41(12):147077.

6 Milgrom J, Westley D, Gemmill AW (2004) The mediating role of maternal responsiveness in some longer-term effects of postnatal depression on infant development. *Infant Behavior & Devel* 27: 44354.

7 Murray L and Cooper P (1997a) Effects of postnatal depression on infant development. *Arch Disease in Childhood* 77(2): 99101.

8 Sinclair D and Murray L (1998) Effects of postnatal depression on children s adjustment to school. Teacher s reports. *Brit J Psychiatry* 172: 5863.

9 Verbeek T, Bockting CL, van Pampus MG, Ormel J, Meijer JL, Hartmen CA and Burger H (2012) Postpartum depression predicts offspring mental health problems in adolescence independently of parental lifetime psychopathology. *J Affective Disord.* 136 (3) 94854.

Appendix 2

PERINATAL GUIDELINE COMPANION DOCUMENTS FOR HEALTH PROFESSIONALS

1. **Executive summary of the perinatal Clinical Practice Guidelines**

   This is a 22-page Executive Summary of the perinatal Clinical Practice Guidelines. It provides health professionals with a synopsis of key recommendations and good practice points surrounding the detection (screening), treatment and management of perinatal mental health disorders in primary and maternity care settings.

2. **Edinburgh Postnatal Depression Scale (EPDS) scoring pads**

   To promote the implementation of screening using the EPDS, scoring pads have been developed and include instructions surrounding the administration, scoring and interpretation of the scores on the EPDS.

3. **Edinburgh Postnatal Depression Scale (EPDS) scoring wheel**

   EPDS and Psychosocial Questionnaire scoring wh eel t o assist health professionals in interpreting EPDS scores and provide recommended action.

4. **Booklet on psychosocial assessment and management of perinatal mental health disorders**

   This 8-page fl ip booklet p rovides health professionals with information to guide best practice in relation to screening and management of mental health disorders in the antenatal and postnatal periods.

   One side of the booklet focuses on screening and assessment specifically, outlining how to assess a woman s risk of developing perinatal mental health disorders and whether a woman may be experiencing depression and/or anxiety at the time of screening. The second side specifically focuses on the management of perinatal mental health disorders in primary care, including the role of psychological and pharmacological treatments.

5. **Information (fact) sheet on detecting and managing depression and anxiety disorders**

   This fact sheet provides summary information for health professionals pertaining to the most common perinatal mental health disorders, depression and anxiety as reflected in the perinatal Clinical Practice Guidelines.

6. **Information (fact) sheets on bipolar disorder in the perinatal period and puerperal (postpartum) psychosis**

   These two fact sheets are designed to provide health professionals with information and guidelines surrounding the detection and management of the more severe perinatal mental health disorders b ipolar disorder and puerperal (postpartum) psychosis. The information emphasises the importance of specialist consultation and addresses the safety issues surrounding medications.

7. **Information for health professionals regarding infant cognitive and emotional development**

   This 4-page information resource outlines the evidence relating to the impact of perinatal mental health disorders, namely depression and anxiety on the infant s cognitive and emotional development. The need for early identification, screening and support is emphasised, together with outlining how health professionals can assess and intervene to promote the best outcomes for the mother and developing baby/infant.

Appendix 3

THE *BEYONDBLUE* WORKFORCE TRAINING AND DEVELOPMENT MATRIX

The following pages contain the Training Matrix which was developed by the Workforce Training and Development Committee under the NPDI.

Matrix Framework of PERINATAL DEPRESSION and RELATED DISORDERS

Aim of the framework:

- Provide guidelines on the core skills required by health professionals predominantly involved in screening women for depression and related disorders in the perinatal period:

  Specifically skills in using the Edinburgh Postnatal Depression Scale (EPDS) and a psychosocial assessment, and, as appropriate, conducting or referring on for a comprehensive assessment and diagnosis for women and their families.
- Provide different levels of skills for the management of women and their families who are experiencing depression and related disorders in the perinatal period:

  Including awareness, understanding management from distress through to disorders and treatment options.
- Ensure uniform standards of comprehensive clinical care informed by Clinical Practice Guidelines.

  With a focus on:
  - prevention through early intervention and treatment
  - optimising the infant s environment.
- Inform organisations currently providing or developing professional development courses.
- Promote best practice across Australia for perinatal mental health training, informed by Clinical Practice Guidelines.
- The framework can be used to systemise existing training to see what is already available and where the gaps lie.

This matrix aims to define different levels of training, content areas to be covered, and which professionals could be the target of training.

SKILLS TRAINING					
	Awareness/Health Promotion/Prevention	Basic Skills	Basic Skills Plus	Intermediate Skills	Advanced Assessment and Intervention Modules
Who for	• General community • Parents • Significant others • Health professionals • All perinatal health professionals • Indigenous health professionals • General health workers • Childcare workers • NGOs • Health promotion/ Health Education Officers	• Midwives • Maternal and Child Health Care workers (M&CHC) • General practitioners (GPs) • Allied health professionals • All perinatal health professionals • Indigenous health professionals • General health workers • Childcare workers • Obstetricians/Paediatricians	This module is designed for health professionals who have completed the Ba sic Ski lls Online Training Package and are thus equipped to screen perinatal women for depression and anxiety. It is specifically targeted at health professionals who want to support women with mild levels of perinatal depression and/or anxiety; and is also helpful for those who will have some continued contact with the women across the perinatal period even if they are not the primary professional managing the depressive episode. Thus, they will need some basic understanding of how to effectively work and support a woman who is experiencing mild depressive and anxiety symptoms at the present time, or who has been referred to an appropriate health professional for further assessment and treatment. This may include: • Midwives • Child and Family Health Nurses/Maternal and Child Health Nurses (M&CHNs) • Social workers • GPs • Obstetricians	I ntermediate ski lls are relevant to health professionals who will be facilitating the treatment of mild to moderate anxiety and depression symptoms. For more severe or complex cases, specialist providers may be referred to and can be considered to have a dvanced ski lls. The skills below can be developed through didactic information, workshops as well as case presentations but importantly need to be consolidated through supervised practice. Below is an outline of skills considered to fall in the i ntermediate c ategory and are designed for various professional groups who have sufficient background (e.g. counselling skills) to manage mild and moderate mental health problems. This may include: • GPs • Child and Family Health Nurses, M&CHNs • Psychologists • Mental health nurses • Midwives (with sufficient background/ specialist training) • Social workers, occupational therapists and other allied health professionals with relevant mental health expertise • Health workers with mental health expertise e.g. Indigenous • Mental health clinicians	This level of training is designed for health professionals who already have extensive mental health training and are thus assumed to already have the knowledge covered in the Basic Skills Online Training Package, as well as the skills outlined in the Basic Skills Plus and Intermediate Skills modules. This section provides an overview of the essential skills that health professionals with a mental health background ought to have, specific to the perinatal field. It is specifically targeted at health professionals who will be actively treating perinatal depression and/or anxiety, while also managing other co-morbid mental health issues and psychosocial factors that may be present. This may include: • Psychiatrists • Psychologists • GPs • Mental health nurses • Mental health clinicians • Enhanced MCH workers • Appropriate professional staff in parenting centres • Appropriate professional staff in residential units • Social workers, occupational therapists and other allied health professionals with relevant mental health expertise

	SKILLS TRAINING				
	Awareness/Health Promotion/Prevention	**Basic Skills**	**Basic Skills Plus**	**Intermediate Skills**	**Advanced Assessment and Intervention Modules**
Learning Objectives	Overall Objective: To promote and educate women in the perinatal period, their families, other health professionals and the wider community on perinatal mental health, the issues and factors that contribute to both positive and negative outcomes; how to best support families during the perinatal period, and the importance of decreasing stigma associated with perinatal depression and/or anxiety. In summary, some of the key objectives include: • Raising community awareness of the high prevalence rates of antenatal and postnatal depression and anxiety in the perinatal period and the associated consequences. • Understanding: what perinatal mental health is, including the types and prevalence of perinatal mental health disorders, as well as the most common signs and symptoms the risk factors that contribute to perinatal mental health disorders the impact of untreated PND and anxiety on women, infants, partners and their family perinatal mental health in men the protective factors that can facilitate positive wellbeing during the perinatal period and/or improve recovery the importance of seeking help early. • Understanding the importance of screening and assessment of perinatal mental health disorders; and applying consistent screening and assessment practices. • Understanding where to access support and help for women and their families, including information on appropriate: information and support lines educational and support materials, including how to provide appropriate reassurance and information support groups treatment options providers. • Accessing and understanding the results of perinatal mental health research (including results from surveys and focus groups) and using the information to create and promote community awareness campaigns. • Recognising the importance of reducing stigma associated with mental health issues, both at the individual and community level and promoting positive practices regarding this issue (i.e. increasing community awareness campaigns, adapting assessment processes so that screening for perinatal depression and anxiety is seen as t he norm, rather than an unusua l p ractice).	• To be aware of the key features and prevalence rates of the most common perinatal mental health disorders, knowing how to differentiate between the various disorders, and understanding the impact on infant health and wellbeing. • Understand the background, purpose and importance of screening, its application and limitations. • Implement screening (using the EPDS). • Understand the importance of conducting a broader psychosocial assessment, including risk assessment, for comprehensive clinical care. • Interpret the EPDS scores and integrate with other assessment material as well as communicate these results to women using basic counselling skills and client centred communication. • Have awareness of evidence-based interventions for anxiety, depression and related disorders in the perinatal period. • Understand the importance of knowing where and how to refer to relevant referral pathways and existing treatments, interventions and support. • Have awareness of early intervention and management strategies of acute situations. • Ensure knowledge of relevant legislation. • Understand professional boundaries in relation to distress and disorders in the perinatal period. • Understand scope of practice. • Have knowledge of Clinical Practice Guidelines for mental health disorders in the perinatal period.	Knowledge and skills covered in the Basic Skills module are prerequisites. This module aims to provide: • knowledge on how to manage women with mild depressive and anxiety symptoms during routine care consultations who either do not require onward referral or are waiting for treatment, through the use of counselling skills that can promote a positive and supportive relationship with the woman (e.g. active listening, empathy, problem solving), with a particular focus on how to integrate these skills in discussions regarding the woman s mental health and overall wellbeing. • knowledge of perinatal mental health disorders and information particularly relevant to the subgroup of women who initially present with mild depression and anxiety, i.e. what are some key indicators that a woman may require some additional support or that her symptoms are escalating? • how to encourage women to follow-up with any referrals made to other mental health professionals and engage other services. • the importance of managing one s own emotions and reactions when addressing mental health issues and psychosocial risk factors with women.	Knowledge and skills described in the Basic Skills module of the matrix is a prerequisite. This module aims to provide: • knowledge of how to conduct indepth assessment of perinatal mental health difficulties and develop a detailed management plan • skills in management of mild-moderate perinatal mental health disorders • comprehensive knowledge of pathways to care • a basic knowledge of therapeutic interventions for mother, infant and father and significant other/partner • understanding the importance and role of supervision for health professionals.	Knowledge and core competencies covered in the Basic and Intermediate skills modules are assumed knowledge. This module aims to provide: • Further training in specialist management of moderate to severe perinatal mental health disorders • Comprehensive knowledge of: evidence based treatment options for moderate/ severe perinatal mental health disorders management of complex cases including infant and partner issues. **Advanced Assessment and Intervention Modules** Managing moderate to severe perinatal mental health disorders and indepth treatments. Choice of Modules (It is likely that health professionals from various backgrounds, will be more familiar with some of the following areas/ topics than others; thus rather than a c omplete package t he following overview can be used as a guide which clinicians can use to select the areas most relevant to their specific line of work and current gaps in knowledge base).

SKILLS TRAINING					
	Awareness/Health Promotion/ Prevention	Basic Skills	Basic Skills Plus	Intermediate Skills	Advanced Assessment and Intervention Modules
Content	• What is perinatal mental health? • The types of perinatal mental health disorders • The prevalence of perinatal mental health disorders • Signs and symptoms of perinatal mental health disorders • Normalisation of negative thoughts • Risk factors that contribute to perinatal mental health disorders • Awareness about screening and assessment of perinatal mental health disorders • Impact of untreated postnatal depression and anxiety on women, infants and their family • How to support/help, including providing information on appropriate: information lines educational and support materials support groups • Referrals to primary health care (e.g. to GPs) • Using results of surveys to create community awareness campaigns • Appropriate reassurance / info about consequences of disclosure • Psychoeducation	**1) Overview of pe rinatal m ental health** • Baby blues • Antenatal depression (symptoms and prevalence) • Postnatal depression • Antenatal and postnatal anxiety (the importance of anxiety as a target for support) • Related disorders: Psychoses, personality disorders • Understanding risk factors of depression and anxiety • Short and longer-term impact of perinatal disorders on mothers, fathers and infants (including attachment and effects on both short and long term development of the child). **2) Context and background to the National Perinatal Depression Initiative (NPDI)** • Prevalence of perinatal disorders and its impact • Difficulties in help-seeking beliefs and behaviours of women and their families • Why screen for depression? Purp ose of screening • Psychological and social assessment for comprehensive clinical care understanding the woman s current and past context including risk factors. • Brief historical milestones (National Postnatal Depression Program, NHMRC guidelines, national implementation). **3) How to talk to women about screening and further assessment** • Basic client centred communication skills and motivational interviewing skills to engage women • How to raise screening with the EPDS • Focusing on the whole woman and her life situation (broader psychosocial assessment) • Integrating assessment in routine consultations • Exploring women s responses to screening (include consumer perspective i.e. Wha t was it like being screened?) .	**Supportive care:** • Content covered under Basic Skills module is assumed screening, basic psychosocial assessment, understanding onward referral and Pathways to Care. **1) Basic management skills** • Counselling skills (active listening, empathy, reflecting, problem solving) to manage mild depression and anxiety and support women who may be waiting for treatment. **2) Co-morbid and differential diagnoses** • Knowledge of perinatal mental health disorders, with a particular focus on understanding signs and symptoms suggesting increasing severity of mood disorders, differential diagnoses, and the co-morbid issues that are often present (e.g. other mental health disorders, substance abuse, interpersonal and psychosocial difficulties). **3) How to encourage women to follow-up with any referrals made to other mental health professionals and engage other services** • Introduction to Motivational Interviewing Skills ho w can we encourage women to engage with services/health professionals if they are reluctant, particularly in the presence of a positive EPDS. **4) The importance of managing one s own emotions** • Dealing with one s own reactions when addressing mental health issues and psychosocial risk factors with women; seeking support when needed.	**1) Didactic content:** [to be supported by supervision] Managing mild to moderate perinatal mental health disorders. • Content covered under Basic Skills module is assumed screening, basic psychosocial assessment, understanding onward referral and Pathways to Care **2) Assessment** • Introduction to indepth psychosocial assessment for mothers, fathers, partners, infants, couples, families and significant others se e Attachment 1 example of some competencies expected to be achieved. **3) Diagnosis** • How to differentiate between different mental health problems such as adjustment disorder, depressive episodes and related disorders including co-morbidity. • How to identify aetiological factors important for management focus (formulation skills). **4) Treatment** • Introduction to treatment, including: motivational interviewing consolidating counselling skills psychological interventions (individual and group skills) managing family violence substance abuse and other psychosocial difficulties medication. • Introduction to treatment options for: women parent-infant relationship couples fathers/partners/significant others.	**1) Overview** [to be supported by supervision] • Content covered under Basic, Basic Plus and Intermediate Skills modules. **2) Assessment and Diagnosis** • Specialised assessment for mothers, fathers, infants, also covering: Parent-Infant relationships Asse ssing if the parent-infant relationship has been adversely affected by perinatal depression and/or anxiety. e.g. observing and assessing the interactions between parent and infant; how do you know if interaction difficulties are present? How do you assess a mother s responsiveness to her baby s cues and make a clinical judgement if appropriate or not? How do you assess whether issues such as abuse or neglect are present? Co-morbidity Ad vanced knowledge of the various co-morbid issues that may be present when a mother is severely depressed/anxious including other mental health disorders as well as psychosocial factors (e.g. drug and alcohol issues, relationship difficulties, domestic violence, financial/housing issues, infant sleep/settling/feeding difficulties, personality disorders, trauma, refugee, migration stress etc). • How to diagnose moderate to severe perinatal mental health disorders Knowledge of what needs to be covered in a diagnostic interview, including administration of standardised measures, in order for a formal diagnosis to be made. **3) Treatment/Referrals/Management** • Specialised treatment electives/units available for: Medication K nowledge of common medications prescribed, typical doses, side-effects etc. When is medication warranted and who is responsible for managing this side of treatment? What do you need to know either as a) the health professional prescribing the medication or b) as a non-medical health professional that is seeing a woman currently on medication?

	SKILLS TRAINING				
	Awareness/Health Promotion/ Prevention	Basic Skills	Basic Skills Plus	Intermediate Skills	Advanced Assessment and Intervention Modules
Content		**4) Depression screening using the Edinburgh Postnatal Depression Scale (EPDS)** • What is the EPDS? What does is measure? What doesn t it measure? (include a copy of EPDS) • Limitations • Acceptability • EPDS as current best practice tool (*beyondblue*/NHMRC guidelines and recommendations) • EPDS in other languages. **5) How to administer the EPDS and how to score it** • Recap how to introduce the EPDS to women and the importance of basic communication in regards to introducing screening tools • Instructions for completion • When to administer (single time versus repeated measures) • What do scores mean? • Key cut-off scores (threshold ≥13) • Thoughts of self harm e.g. Question 10 • Having a conversation with women about their responses on the EPDS • Importance of basic client centred communication/counselling skills in regards to feedback around screening and assessment results with women • *beyondblue* fact sheet for further information. **6) Further assessment (if needed)** • Risk assessment Safety plan Knowledge of appropriate referral pathway for crisis management (internal/external) • Psychosocial assessment Understanding the psychosocial context and tools that can be administered e.g. PRAM.			Specialised psychological treatments for antenatal and postnatal depression in women, including inpatient care. Detailed training in specialised psychological treatments for perinatal depression and anxiety (e.g. CBT, IPT). Understanding what the local inpatient care units are and when a referral to a residential/inpatient unit is warranted; and who is responsible for managing the mother once discharged, continuity of care and multidisciplinary care planning, working with area mental health services; non voluntary care. Fathers U nderstanding and recognising the occurrence of depression in new fathers; appropriate treatment options for fathers with depression and/or anxiety during the perinatal period. Partners U nderstanding the issues present for partners of women with perinatal depression and/or anxiety, and available support services. Couples K nowledge of and/or training in appropriate treatment options and services available for couples i .e. couples counselling with a focus on the perinatal period Significant others K nowledge of and/ or training in the issues; treatment options and support services relevant for significant others e.g. if a woman s mother has a significant role in providing practical/emotional support to her daughter who is experiencing postnatal depression/ anxiety, it is important to be aware of the issues and difficulties she may be experiencing herself and what support may be beneficial for her. Infants U nderstanding what Parent-Infant Therapy is, when it is indicated and who can provide this treatment effectively and appropriately. Knowledge of treatment options and support services available for vulnerable infants and families (e.g. Circle of Security; HUGS).

	SKILLS TRAINING				
	Awareness/Health Promotion/ Prevention	Basic Skills	Basic Skills Plus	Intermediate Skills	Advanced Assessment and Intervention Modules
Content		• Integrating EPDS scores and other assessment material and formulating a management plan Deciding on the need for diagnostic assessment Recap: Importance of basic client centred communication/counselling. **7) Awareness of appropriate evidence-based treatment options.** • Treatment options for women, couples, fathers, partners, significant others • Awareness of parent-infant interventions with evidence base and relevant theories (e.g. attachment, developmental) • Medication • Individual and group treatment models • Self-care strategies. **8) Pathways to Care: Collaborative practice** • Importance of multidisciplinary care/ collaboration between service providers • Knowledge of local referral pathways for mild, moderate and severe/complex mental health disorders (including mental health care plans) • Knowledge of local referral pathways for women and families at different levels of risk • Awareness of local community support including child care options. **9) Cultural and familial diversity: Adapting screening, assessment and referral pathways** • Special needs groups i.e. CALD and Indigenous community • EPDS translations • Using an interpreter.			Group treatments K nowledge and/or training in group treatment programs available and the associated benefits for severely depressed/anxious mothers. Knowledge about key factors that may be counter-productive in group treatment (i.e. if a women has recently been discharged from an inpatient mother-baby service and is still severely anxious, would a referral to a group program be appropriate? Should group therapy occur at the same time as other therapies? Motivational interviewing K nowledge about skills and strategies that can be useful in encouraging women to engage in treatment and access support services, especially when severely depressed. Co-morbidity M anaging co-morbid issues that may be present when a woman presents as severely depressed/anxious (e.g. drug and alcohol issues, domestic violence, financial/housing issues, infant sleep/ settling/feeding difficulties, refugee status etc). Providing low and high intensity care. Working with other agencies to provide a comprehensive management plan. Case management.

	Awareness/Health Promotion/Prevention	SKILLS TRAINING Basic Skills	Basic Skills Plus	Intermediate Skills	Advanced Assessment and Intervention Modules
Ethics, Duty of Care and Supervised Practice	Not applicable.	**Ethics, Duty of Care and Supervised Practice** • It is expected that all health professionals will conduct themselves in a manner that promotes and adheres to the professional code of ethics which is relevant to one s own service provider group, and will be accountable for decisions made. • It is also expected that issues regarding appropriate supervised practice, including access to ongoing support and supervision for health professionals across all skill levels will be an integral part of each health professionals clinical practice.			
		Duty of Care and Supervision: • Professional responsibilities and duty of care principles related to the screening and assessment process e .g. ensuring that there is adequate time to complete the screening and assessment process with women, recognising the importance of having and building upon relevant skills, knowledge of referral pathways both within the organisation [depending on context] as well as externally within the community). • Front line health professionals will need to have the opportunity to access professional support for issues associated with the screening process, including time to discuss challenging clients and additional supports that may be required.	**Duty of Care and Supervision:** • Knowing how, where and when to refer elsewhere (i.e. knowing what to do when a woman who initially presented with only mild depressive and anxiety symptoms now appears to be experiencing moderate/severe symptoms and/or other difficulties). • Knowing how, where and where to access support for one s self (i.e. recognising the importance and knowing how to manage your own emotions and se parate yo urself from your client and their presenting problems. Being aware of the issues you need to be mindful of and what to do if you notice yourself becoming affected by the woman s presentation and/or circumstances e.g. you too have previously experienced domestic violence, numerous miscarriages etc. • As health professionals will be engaging in some management or ho lding t here is likely to be a need for increased access to professional support.	**Duty of Care and Supervision:** • Knowing how and where to refer elsewhere when the scope of the clients issues are outside of one s skill range (this will vary depending on skill set of each health professional and the nature and severity of the diagnosed disorder and associated issues) e.g. knowing what to do if a woman s mental health has deteriorated even if she is already engaged in treatment with you kno wing what other referral pathways may be appropriate and necessary to refer to. • Health professionals who are actively involved in the management and treatment process, will once again require increased support for issues pertaining to the management of mental health issues, and ought to have access to appropriate supervision e .g. access to individual or peer supervision that allows the health professionals to discuss treatment and management issues of mild or moderate depression and anxiety and associated challenges.	**Duty of Care and Supervision:** • Knowing how, where and when to refer elsewhere when the scope of the clients i ssues are outside of one s skill range t his will once again vary depending on the skill set of each health professional and the nature and severity of the disorder being treated and other complicating factors that may be present, e.g. what do you do when a woman who initially presented with severe depression and anxiety but low risk of harming herself or others is now reporting increased suicidal ideation and/or has attempted to harm herself and/or her baby? • Health professionals treating severe and complex mental health issues will require increased access to ongoing and specialised supervision. It is critical that some form of appropriate supervision is always accessible, is there is an increased risk of working with escalating circumstances and issues relating to safety. • It is also essential that when learning specialised treatments, e.g. parent-infant specialist therapies, information and skills related to these are initially consolidated through regular supervision. Continued peer supervision is encouraged whenever specialist treatments are being implemented, regardless of experience.
How to deliver*	• Broad/specific campaigns *(beyondblue)* • Ambassadors • blueVoices • Website • Media • *beyondblue* Resources/fact sheets • Conferences/seminars • DVDs • Websites	• Specialised training packages • Online • Face to face • Accreditation • Curriculum (under development) • DVDs • Case presentations • Cross agency delivery/local network workshops		• Manualised treatments for face-to-face work • Online treatments • Self-help books	• Workshops/multi-disciplinary group

**Also Ot her methods as required*

Appendix 4

THE *BEYONDBLUE* ONLINE TRAINING PROGRAM FOR HEALTH PROFESSIONALS

Objectives of the *beyondblue* online training program

The *beyondblue* online training program *Beyond babyblues: Detecting and managing perinatal mental health disorders in primary care*, was developed with the Parent-Infant Research Institute (PIRI) in consultation with the *beyondblue* National Perinatal Depression Initiative (NPDI) Workforce Training and Development Committee, together with consumer and carer representatives, and other health professional experts.

All materials were produced by GenesisEd, an accredited provider with the Royal Australian College of General Practice (RACGP) and Royal College of Nursing Australia (RCNA), the Australian College of Rural and Remote Medicine (ACRRM) and the Australian College of Midwives (ACM). The program has been tailored to the Basic Skills section of the *beyondblue* Perinatal Workforce Training and Development Matrix (see Appendix 2).

Aims of the *beyondblue* online training program

1. Differentiate between and understand the range of perinatal mental health disorders.
2. Understand the background, purpose and importance of screening, its application and limitations, and how to implement screening using the Edinburgh Postnatal Depression Scale (EPDS).
3. Understand the importance of conducting a broader psychosocial assessment, including risk assessment, for comprehensive clinical care.
4. Interpret and integrate the EPDS scores and other assessment material, and communicate these results to women using basic counselling skills and client-centred communication.
5. Be aware of evidence-based interventions for anxiety, depression and related disorders in the perinatal period and integrating these in the development of care plans for patients.
6. Understand the importance of knowing where and how to refer to relevant pathways and existing treatments, interventions and support.

This program consists of six different learning activities, which can be completed as one Active Learning Module (ALM) or as six separate educational activities. Activities 5 and 6 of this program are aimed specifically at general practitioners; however all primary health professionals are encouraged to complete these activities also.

The ALM has successfully been accredited for RACGP (40 pt), ACRRM (6 pt) and endorsed by the RCNA (6 pt), ACM (6 pt) and each of the six individual educational activities has been fully accredited for RACGP (2 pt), ACRRM (2 pt) and endorsed by the RCNA (1 pt) and ACM (1 pt). This program has also been accredited by the General Practice Mental Health Standards Collaboration (GPMHSC) as a Mental Health Skills Training (MHST) activity.

Appendix 5

THE *BEYONDBLUE* AND NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL PARTNERSHIP LINKAGE GRANT RESEARCH AIMS

External to the NPDI, *beyondblue* has committed financial and in-kind support as a partner organisation in a National Health and Medical Research Council (NHMRC) Linkage Research Grant (commenced in 2012). This research aims to evaluate the impact of perinatal mental health initiatives on mental health outcomes, which is critical for optimising the quality and uptake of services. This project is unique in that it will use very large population health datasets to examine the impact of the reforms on maternal health outcomes, service utilisation and the likely cost-effectiveness of these services (see below).

Research aims of the *beyondblue*/NHMRC Linkage Grant Research

Aim 1

To examine mental health service utilisation and cost associated with introduction of key perinatal mental health initiatives, and likely cost-effectiveness of these reforms.

Objectives

1a. To measure i) hospital-related and ii) Medicare mental health service utilisation in women presenting with mental health morbidity in the perinatal period.

1b. To measure i) hospital-related service and ii) Medicare mental health item costs in women presenting with mental health morbidity in the perinatal period.

2. To assess the range of factors (e.g. socio-demographic, geographical, clinical) associated with mental health service utilisation by perinatal women.

3. To assess the impact of perinatal mental health initiatives on mental health service utilisation across time.

4. To determine the likely cost-effectiveness of key reforms in perinatal mental health.

Aim 2

To use the outcomes of Aim 1 to engage key stakeholders in a consideration of:

5. The further implementation and evaluation of the NPDI, with a particular focus on universal depression screening and psychosocial assessment (henceforth referred to as s creening)

6. The development of data elements (for inclusion in the Perinatal National Minimum Dataset), which can be used to evaluate the implementation of universal s creening.

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