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Perinatal and Infant Mental Health and Wellbeing

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OVERVIEW

This chapter considers factors influencing parental and infant mental health and social and emotional wellbeing. Perinatal depression and anxiety is a significant health problem affecting not only mothers but also their infants, other children, partners, extended families and communities generally. The significance of infant attachment in the perinatal period (from conception to the end of the first year after the baby is born) and the importance of culture and ways of working with families in this sensitive life stage are described.

Perinatal mental health is about the emotional wellbeing of pregnant women and their infants, partners and families during this time. This chapter discusses the risk and protective factors that impact on parental mental health and social and emotional wellbeing. It refers to processes of assessment and the issues related to culturally appropriate prevention, diagnosis, and treatment of perinatal depression and anxiety; and its potential impact on the infant, other children, parents, family and community. The key policies that impact on perinatal mental health and relevant preventative programs are briefly described.

INTRODUCTION

The available literature assures us that a strong family unit displays signs of being further strengthened during this transitional life stage, as adjustment followed by adaptation to the new situation of being a parent occurs. From a social and anthropological perspective, childbirth is a 'rite of passage', a transition where the relationship between the parents and wider family combines to trigger a secure environment for the developing infant.¹

However, perinatal mental health research has also identified that in this period women and their partners may have difficulties in adjusting to pregnancy and changing roles and relationships. They can experience social and emotional stress, psychological distress and anxiety and mood disorders. We also know that, physiologically, alterations in cerebral serotonin and noradrenalin metabolism and uptake, and hormonal changes —along with the interplay of psychosocial stressors such as stress of pregnancy, childbirth and constant caring for an infant, lack of support, concerns about the infant, sleep deprivation, and financial worries— may lead to syndromes of anxiety and depression² which can have long-lasting effects on the foetus, infant and family in the perinatal period.³

PERINATAL DEPRESSION AND ANXIETY

Depression accounts for the greatest burden of disease within all mental illness. Of particular concern and significance is the rate of depression among women and men during the perinatal period.

Maternal Depression

Between 50 to 80 per cent of women will experience baby 'blues' in the first few days after the birth.³ This stage is characterised by a depressed mood and negative thoughts that occur shortly after birth with symptoms that are not severe and resolve spontaneously within a few days or weeks in a supported environment.⁴ Reassurance and support by knowledgeable health professionals through this period assists mothers to strengthen their developing relationship with their new born child and to avoid misinterpreting risk factors or symptoms as representing a depressed state, or a state of illness.

There are questions as to whether perinatal distress is related to the psychological, sociological, environmental or biological phase of adjustment to parenthood, or if it is considered a mental health disorder. Media images of smiling, relaxed, in-control mothers and fathers continue to set expectations that are difficult to achieve—even in well-supported families. Buist² notes that nearly 30 per cent of women experience significant adjustment to parenthood difficulties, with the weight of the perceived role of motherhood creating levels of mental and emotional stress not previously seen.

Antenatal anxiety and depression frequently occur together and may lead to postnatal depression and anxiety.⁵ Approximately 10 per cent of women in the Australian population experience antenatal depression with one-half of those developing depression in the postnatal period.⁴ Yet, despite this prevalence, postnatal anxiety and depression is frequently unrecognised and untreated⁶ in women in the general population and is increasingly described in Aboriginal women.⁷ Despite the known occurrence of perinatal depression and anxiety in the general Australian population, there is reason to research the topic further, as the extent of diagnosis and treatment in Aboriginal and Torres Strait Islander women remains unknown.

While estimates of the prevalence of postnatal depression vary between 14–16 per cent,^{4,8} at least one-in-six women in Australia who birth will experience postnatal depression.

Additionally, there is increased risk of depression in young people, with Swann et al.⁹ reporting that young mothers (under the age of 20 years) are up to three times more likely to experience postnatal depression than older mothers.

Comorbid anxiety is reported in postnatal depression in 30–40 per cent of cases¹⁰; and suicide during the perinatal period is the equal (with haemorrhage) as the leading cause of maternal death in Australia.⁶ Also, a rare but alarming consequence of severe mental illness is infanticide.³ Co-occurring drug or alcohol use, with and without the added burden of domestic violence, increases the likelihood of affecting the mental health and wellbeing of a woman, her infant and other children, her partner, and others in the community.

Dysfunctional personality characteristics may become apparent in the perinatal period if negative emotions and memories of past experiences come to the surface. Fraiberg and colleagues refer to a mother's past experiences that continue to influence her ability to form a nurturing relationship with her child as 'ghosts in the nursery'.¹¹ These past experiences may be rekindled through retraumatisations in the perinatal period and it could follow that mental health disturbance, substance use and continuing inter or transgenerational patterns of abuse and neglect of children may occur.¹² See Chapter 17 (Atkinson and colleagues) for a discussion of transgenerational trauma.

Paternal Depression

A review by Goodman¹³ concluded that paternal depression ranges from 1.2 to 25.5 per cent the first year after the birth of an infant, and from 24 to 50 per cent among men whose partners were experiencing postnatal depression. In addition, fathers may experience increased rates of anxiety, restlessness or unhappiness (also known as dysphoria).¹⁴ Paternal depression ‘can seriously affect infant development.’^{15(p461)} The highest rates of depression in fathers occurred between 3 and 6 months of the infant’s first year of life—a critical time of development in the infant.¹⁶

There is a growing awareness across Australia of the need to support fathers in the perinatal period of transition to parenthood and there are programs and policy plans developed because it is recognised that:

- perinatal depression in fathers leads to poorer outcomes in children (just as maternal depression does);
- mothers experiencing perinatal depression will recover more effectively if the father is involved in the care of children;
- infants of mothers experiencing perinatal depression will be less affected if fathers (and extended family) are involved in their care.

The *New South Wales Men’s Health Action Plan 2009–2012* is an example of a Father-Inclusive Practice Framework that has been developed to align services with the needs of fathers.¹⁷

PERINATAL MENTAL HEALTH – A CULTURAL PERSPECTIVE

Differences may exist within Aboriginal and Torres Strait Islander contexts of the experience of mental health disorders. Westerman¹⁸ reflects on the relevance of applying mainstream diagnostic criteria across cultures where possible differences in symptom presentation exist (e.g. more physical symptoms), and causality (e.g. external forces arising from ‘doing something wrong culturally’), which are also significant considerations when managing perinatal mental health.

Vicary and Westerman¹⁹ contend that, because mental health problems may show themselves spiritually and culturally, resolution can only be achieved in the same manner. Many Aboriginal people ask that ‘workers in community agencies apply an ‘Aboriginal lens’ and consider additional factors and approaches’ when working with Aboriginal people.^{20(p2)} See also Chapter 25 (Dudgeon and colleagues). Social and emotional wellbeing (SEWB) workers and Aboriginal mental health workers (AMHWs) are well placed to assist their colleagues—see Chapter 13 (Schultz and Walker and colleagues) regarding interdisciplinary team care.

Traditional Cultural Beliefs and Practices Strengthen Wellbeing

In traditional Aboriginal cultures, birthing and child-rearing practices were strongly related to the land and plants that provided the necessary elements for rituals relevant to this life stage.²¹ Connection to country or ‘homeland’ was, and still is in most Aboriginal communities, an extremely significant feature in ensuring the wellbeing of the mother, infant, family and community in general.

In many rural and remote areas in Australia, pregnant women face removal from a partner, family, friends, community, country, and culture for the birth of their child/ren due to the emphasis on medical risks at the expense of cultural and family considerations. Such separation is highly likely to have a significant impact on the wellbeing of women and their families and is the heart of a report commissioned by the Maternity Services Interjurisdictional Committee for the Australian Health Ministers’ Advisory Council (AHMAC).²² Furthermore, excessive stress,

isolation from familiar and nurturing people, surroundings and cultural ways, may lead to fear, sadness and loneliness at this critical period.²² While many urban centres share a philosophy of family-friendly birthing environments and provide options for community midwifery services, many women living in remote settings experience displacement from their families and communities when birthing in unfamiliar settings²³ —both significant factors in creating high levels of stress for women.²⁴ Birthing away from country, and away from significant family members who would normally nurture, guide and assist the woman in the cultural practices associated with birthing, may well upset the normal process and rhythm of birth as well as subsequent mother–child interactions and child behaviour and development.²⁵ This can have potential negative impacts on the child’s health, especially the immune system.²⁴ There is evidence to show that an individual’s coping abilities are decreased when they have no control over what happens to them—and passive submission results.²⁴ This may occur when medical practitioners discount a woman’s cultural and spiritual values and women leave their family and country for birthing.

The women of Warmun community in the East Kimberley region of Western Australia (WA) have highlighted the importance of safeguarding both the physical and spiritual health of the mother through *‘Adherence to traditional women’s Law, ceremonies and rituals for a healthy mother and baby’* in recounting their traditional birth and child-rearing stories.^{26(p6)}

Werra Werra team members Peggy Patrick, Mona Ramsay and Shirley Purdie shared stories indicating the importance of cultural birthing practices:

“ When we were ready to have our babies the older women would take us away from the camp where men can’t see us. They would keep us there till the baby was born. They would pray over us and put warm paperbark on our back, belly and sides to help ease the pain... ”

“ When we smoke the girl we allow the strength of very strong spirits to give her strength and health. The water we use to sprinkle on the girl is water from the Dreamtime for us (mantha). This is done to welcome the new baby before it is born and that is why the baby is born healthy and stays strong. The baby feels welcome and wants to come to us even before it is born. The baby and mother won’t get sick easily either...Singing over the girl means the same as the water blessing.”^{26(p6-7)}

Connecting with Country and Relationships

The role of spirituality and the relationship with family, land and culture are intertwined and play a significant part in Aboriginal and Torres Strait Islander SEWB.^{21,27} See also Chapter 4 (Gee and colleagues) and Chapter 6 (Zubrick and colleagues) for discussion regarding the significance of country, cultural and family connectedness.

In respecting the importance of culture and birthing practices, it is important to minimise the impact of disconnectedness when birth occurs away from homelands. For example, offering Aboriginal and Torres Strait Islander women the opportunity to take the placenta (or part thereof) home for burial or special ceremonies may enable the creation of physical and symbolic links between mother, baby and the homeland.²⁸

PERINATAL MENTAL HEALTH RISK FACTORS

It is generally understood that the more risk factors present, the greater the chance that the mother, father and child/ren require extra mental health support or intervention in the perinatal period. An increase in couple mental illness throughout the first year after the birth of a child, with rates of distress being at the highest point for both partners at one year, has also been identified.²⁹ The range of risk factors for parents, highlighting the different factors that impact on mothers and fathers, follows.

Psychosocial risk factors have been shown to be associated with an increased risk of depression.³⁰ Essential considerations are listed below.

Parental Psychosocial Risk Factors

- a lack of current emotional or practical supports;
- poor quality of relationship with, or absence of, a partner;
- domestic violence (past or present);
- traumatic birth experience or unexpected birth outcome;
- current major stressors or losses such as bereavement, or moving house or financial strain³⁰;
- past history of depression and anxiety disorder or other psychiatric condition;
- depression in partner, either antenatally or during the early postnatal period;
- poor quality of relationship with partner;
- difficult relationship with own parents;
- poor social functioning;
- unemployment;
- current major stressors or losses; and
- drug and/or alcohol misuse.¹³

PERINATAL MENTAL HEALTH PROTECTIVE FACTORS

It is recognised that rather than trying to modify risk factors, a more effective way of promoting mental health and enhancing family wellbeing in the perinatal period is to increase a person's or family's, inner strength, level of resilience, or coping capacity, through the enhancement of protective factors relevant to the particular family. In population-based community health, strengthening or resilience-building concepts are often referred to as 'protective factors' because it is believed that these factors have a role in shielding a person from developing serious mental health problems resulting from stress or hard times.³¹ Protective factors for early child development and wellbeing are discussed in detail in Chapter 6 (Zubrick and colleagues). Preventive practices which acknowledge cultural and innate personal and community strengths should form the basis of all practice in primary health settings. Therapeutic modalities recommended and described by Aboriginal authors include narrative and demonstration, personal stories and anecdotes, open-ended discussion, yarning, and grief and loss therapies.³²

There are many protective factors that assist in the management of stressors over a life course and over many generations. Ypinazar et al. (2007) summarised protective factors for parents (and infants), with each defining, influencing and impacting on the other.²⁷ A list of protective factors for perinatal and antenatal mental health and wellbeing and continuity of care adapted from Ypinazar et al.²⁷ follows:

Protective Factors for Parents

- cultural traditions, especially around the birthing process and perinatal period;
- interconnectedness of cultural practices, spirituality, identity, family and community, connection to land/country;
- strong family relationships and connections;
- belief in traditional healing activities which assist the management of life stressors;
- personal sense of wellbeing, satisfaction with life, and optimism;
- high degree of confidence in own parenting ability;
- presence of social support systems;
- access to appropriate support services;
- economic security;
- strong coping style, and problem-solving skills; and
- adequate nutrition.

Protective Factors for the Infant/Child

- healthy infant;
- nurturing sensitive caregiving (i.e. sensitive interaction, age appropriate stimulation/ sleep habits, and physical care of the infant such as feeding);
- ‘easy’ temperament;
- safe and secure base with positive attention from a supportive, caring mother/family;
- strong mother–infant attachment;
- father–infant attachment;
- family harmony;
- sense of belonging, sense of connectedness; and
- strong cultural identity and pride.

INFANT MENTAL HEALTH

Understanding Secure Attachment in Infants

The first year of a child’s life is a critical period in the creation of secure parent–infant attachment. It is also the time when neuronal connections in the infant’s brain are being made, especially in the area of self-regulation of behaviour and emotions.³³ There is increasing emphasis on bonding and attachment and its importance on child wellbeing.

Further, insecure patterns of behaviour in the child may be a result of intergenerational transmission of insecure attachment.³⁴ Negative behavioural and emotional outcomes in childhood are associated with the presence of an insecure attachment, or insecure base, with primary caregivers in the stage of infancy.³⁵ Strained or inadequate mother–infant interactions may exacerbate a woman’s depressed mood, reinforcing her feelings of being a poor parent.¹³

Yeo contends that assessment of Aboriginal children in relation to attachment does not take into account the historical context or Aboriginal cultural values.³⁶ The challenge to health professionals when assessing infant attachment and maternal bonding with Aboriginal parents is to ensure they have developed a rapport with parents to include the context of Aboriginal values and culture in their clinical consideration, and to promote and support the protective factors identified above.

Impacts on the Development of Secure Attachment

Complex and diverse situations for many Aboriginal and Torres Strait Islander families have an impact on personal and family growth, role adjustment, and parenting knowledge and skills in the perinatal life stage.³⁵

It is important to recognise that fathers have a valuable role to play in their child’s development. However, research indicates that depression in fathers may lead to more negative interaction and less positive social interaction with their children, which correlates to anti-social and peer interactional problems for the child later.^{29,37} Aggressive behaviour in males may indicate depressive mood and hence possible risk to mother and baby. Given the importance of the early years in a child’s development and wellbeing, more research is needed on the rates of depression in fathers of toddler-aged children and the effects on relationship with the mother and child/ren.

Chronic psychosis in mothers may lead to a lessened ability to form secure attachments with their infants. The children of affected mothers are more prone to neglect, abuse and high rates of foster care, with a possible outcome of infanticide in extreme cases.⁴⁵ Thus the need for immediate and appropriate psychiatric care (e.g. admission to a Mother Baby Unit) in these rare cases is highlighted, increasing the possibility of positive outcomes for mother and baby.

According to various authors,^{17,38} ongoing psychological reactions to the policies and practices of the past are evident and include:

- inconsolable grief and loss
- post-traumatic stress disorders
- low self-esteem
- powerlessness
- anger
- depression
- anxiety
- alienation from kinship ties
- personality and adjustment disorders
- poor parenting skills
- lack of cultural identity
- substance misuse
- violence
- guilt, self-harm and suicidal behaviours.

For a detailed discussion of the issues surrounding transgenerational trauma, see Chapter 17 (Atkinson and colleagues).

Health professionals might consider applying the Circle of Security model to understand what it is that an infant or young child requires a parent or carer to do to support the development of secure attachment while at the same time allowing strong child self-esteem and confidence to develop.³⁵

Lee and colleagues (2010) used case studies to describe the development and evaluation of The Boomerangs Aboriginal Circle of Security Parenting Camp Program, an intervention based on an attachment framework using the Circle of Security and Marte Meo programs as a base and drawing on traditional Indigenous culture. Circle of Security is an early intervention group program based on attachment theory, which aims to improve parents' caregiving behaviours and prevent child mental health problems.³⁵

Possible Infant/Child Outcomes

Perinatal depression, as well as other mental illnesses can adversely affect the mother's care giving capacity, creating the potential for impairment of sensitive or attuned mother-infant interactions. Potential negative impacts on the infant include:

- spontaneous preterm birth;⁴⁰
- impaired mother–infant relationship;
- cognitive, emotional, behavioural and physical development;⁴¹
- crying and unsettledness;⁴² and
- diarrhoeal illness.⁴³

There is evidence that excessive maternal stress, anxiety and depression may result in increased infant irritability and poorer neurological scores at birth.⁴⁴ High maternal anxiety scores in the last trimester of pregnancy have also been shown to increase risk of hyperactivity in the child at four years of age.⁴⁵

PERINATAL MENTAL HEALTH IN YOUNG MOTHERS

Understanding the adolescent stage of life provides an opportunity to appreciate the potential for extra pressures and challenges faced by a young mother, her infant, partner and family. The energy and interest in new experiences and learning that young people enjoy usually ensures positive interactions with infants. However, if a support system is not readily available, parental or child mental health and social and emotional wellbeing are a concern. For many young people, social opportunities for 'time out' or for 'time to be young' are scant, and there are added stressors imposed on a young family which may impact on perinatal mental health.

One program that is proving highly successful is the Balga Teen Parent Program which support young mothers to achieve their education and career goals. The program is run through the Teen Family Centre to help to minimise the barriers to education and training for young parents. Education is seen as a way for a family to enhance their future prospects by providing economic independence as well as improving psychosocial, health and life skills outcomes.⁴⁶

A research project conducted by the Western Australian Perinatal Mental Health Unit in 2011⁴⁶ interviewed young women to find out how services are best adapted to meet the needs of young Aboriginal clients in particular. The project's baseline report provides examples of Aboriginal women's reflections about the challenges faced by young mothers when confronted with the realities of motherhood:

“ Young mums isolated socially, missing out. Difficult to get out—leads to depression. ”

“ Young mums frightened to seek help, worried about welfare and kids being taken away. Stigma is a big problem. ”

“ Mums don't know they're depressed, they just know they feel awful. ”

“ Many girls don't recognise symptoms. ”

“ We older women ask our daughters what's wrong but they are frightened to ask for help. They put on a brave front so we don't know they are in trouble. They are frightened and ashamed to go to a service. ”

“ Practical support really needed... ”

“ Families support mum, try to understand, but may not know anything about depression.^{47(p18-22)} ”

Multidisciplinary teams incorporating the knowledge and wisdom of Aboriginal Health Workers (AHWs) and Aboriginal Health Practitioners (AHPs) are essential in order to address the barriers to accessing services, and the ‘shame’ described and experienced by many young Aboriginal mothers when interacting with mainstream services.²³

Barriers to service access by young Aboriginal women must be understood in order to determine through collaborative processes ways to overcome them. *beyondblue* notes that understanding and overcoming barriers is the key to increasing early intervention, in association with routine screening.³

RELEVANT PERINATAL DEPRESSION SCREENING OPTIONS

The Edinburgh Postnatal Depression Scale (EPDS) is a screening tool to be used in conjunction with an individual's health history and self-report, and the health professional's observations and understanding of their client's family and community context. Currently, translation of the EPDS⁴⁸ into traditional Aboriginal languages or Aboriginal English is being explored in different Australian contexts. Different areas of Australia have begun to develop and evaluate adaptations to the EPDS for Aboriginal women. For example, an adapted EPDS trialled in Townsville and Mt Isa was found to be suitable for some women.⁴⁹ However, findings from the Victorian Antenatal Intervention Initiative indicate that Aboriginal women scored no differently on the language-specific EPDS than on the mainstream EPDS, or on the suicidal ideation question (Q10) in the population in their 2001–05 trial suggesting that⁸ the EPDS is generally acceptable, provided adequate explanation is given. Using the EPDS with an AHW/AHP present would ensure better understanding by the women.

Yelland et al. (2009) caution that not all women (or men) will agree with the correlation of their EPDS score to their mental health status.⁵⁰ Over or underestimation may occur either because of the misinterpretation of the questions, or intentionally. As consent for screening is required, it is important that health professionals concerned about their client's SEWB explain the value of using the tool, at the same time informing the client of the right to decline administration of the formal EPDS. See Chapter 16 (Adams, Drew and Walker) for further information on screening for perinatal depression.

Culturally Appropriate Perinatal Assessment

Research and education programs based on culturally appropriate service provision, including training in the use of the EPDS in diverse contexts, is undertaken by the WA Perinatal Mental Health Unit, funded by the State Government. The National Perinatal Depression Initiative (NPDI) key activity in the last five years has been on workforce training and development, and has been federally funded. A number of e-learning packages have been developed by *beyondblue* and in South Australia. All states and territories have undertaken face-to-face training, inclusive of AHW/AHPs. It is expected that these initiatives will further assist in the assessment and management of perinatal mental health problems in Aboriginal populations and communities.

Aboriginal Community Controlled Health Services (ACCHSs) provide culturally specific mental health services, and are initiating local adaptations to existing screening tools and developing culturally appropriate programs to address the issues. The *Kimberley Mums Mood Scale* (KMMS) a version of the EPDS, is currently being validated across the Kimberley in WA. While routine use of the EPDS is incorporated in all Kimberley health care provider perinatal protocols, its use is fraught with difficulties and inconsistencies.

An assessment of perinatal mental health screening trends and management practices among Kimberley maternal and child health nurses and midwives in late 2009 found 100 per cent of respondents reported poor screening practices for perinatal depression among Aboriginal women (personal comm, Jayne Kotz, 28th January, 2012). All respondents recognised that the language in the EPDS was complex and confusing for many Aboriginal women. Responding to this concern, the Kimberley Aboriginal Health Planning Forum, Maternal and Perinatal Mental Health subcommittee, decided to develop a culturally relevant universal screening tool, as well as protocols and accessible management pathways. Subsequently, the development of a Kimberley version of the EPDS, the KMMS, was commenced, with a collaboration of perinatal health care providers across the Kimberley and more than 114 local Aboriginal women from various language groups. This tool uses Kimberley English, locally developed graphics and a visual Likert scale to screen for depression and anxiety, and is based on the original items developed in the EPDS. The validation process is anticipated to be completed by mid-2014.

CHILD ASSESSMENT

The physical, social and emotional wellbeing of children is fundamental to communities experiencing optimal health in the future. There are many factors that impact on the parent-child relationship and compromise a child's growth and development. These include the use of certain medications, or smoking and alcohol-use by women during pregnancy and while breastfeeding, in addition to high levels of stress and perinatal mental illness.⁵¹

Child and community health practitioners play an important role in the ongoing assessment of infant and child health wellbeing. The recommended child and family visiting schedules provide an opportunity for assessments and support in the first weeks and months after birth and allow for the prevention or early detection and management of problems.

Infant assessment involves:

- observation of the two-way interaction (parent-to-child, and child-to-parent) and regular assessment of the child's growth, development and behaviours.
- asking about feeding patterns, sleep and settling patterns, interaction and responsiveness, attainment of development milestones, and general health and wellbeing status. Negative responses to any assessment require review, and if concerns persist, referral to paediatric services.

IMPLICATIONS FOR PRACTITIONERS

Working in Partnerships

It is important that, where perinatal depression has been diagnosed, community and child health nurses are able to work in partnership with families, their child/ren and the community, Aboriginal Medical Services, psychiatrists, and remote area mental health nurses to provide optimal care. Working with AHW/AHPs and Aboriginal Mental Health Workers (AMHWs) ensures that cultural advice is available. As well as AHW/AHPs, many communities have Strong Women workers or Community Care Workers who provide valuable understandings of cultural and contextual features of cases, as well as language interpretation.

Home visiting programs are currently in place or being trialled in different communities across Australia, including the Australian Nurse-Family Partnership program with Indigenous Family Partnership Workers. The program is supported by the Australian Government Department of Health and Ageing (now Department of Health) (DoHA). The Halls Creek Mothers Support Initiative is an example of an Aboriginal-led, home visiting program that focuses on culture and family to promote positive parenting and perinatal wellbeing.⁵²

Schultz, Walker and colleagues (Chapter 13) discuss the role of interdisciplinary teams adopting a bio-psycho-social-cultural-spiritual approach in providing culturally responsive care to support client's mental health and SEWB. Community health, women's health services, and local community centres can also provide community-based programs for women and families which focus on strengthening SEWB and mental health. These programs can lead to greater understanding for the health professional of the social, cultural and historical factors and associated social determinants impacting on families, and promote cultural information exchange.

The *'Making Two Worlds Work Project'* developed by Mungabareena Aboriginal Corporation and Women's Health Victoria, is a partnership addressing all aspects of women's and children's health care. The program provides an example of ways of working in community using stories and art to demonstrate communities and services working together through symbolic interaction.

A National Plan to Enhance Perinatal Mental Health and Wellbeing

There are numerous reports about initiatives, strategies and programs related to perinatal mental health and maternal and child health in Aboriginal and Torres Strait Islander contexts, including:

- *The beyondblue National Postnatal Depression Program, Prevention and Early Intervention 2001–2005, final report*, June 2005 and the 2011 guidelines;
- *State Perinatal Mental Health Initiative Report 2003–2007*, State Perinatal Mental Health Reference Group and WA Perinatal Mental Health Unit, 2007;
- Western Australian Perinatal Mental Health Unit, Women and Newborn Health Service (2011). *Aboriginal perinatal mental health service expansion: Final evaluation*;
- *Two years into the 'Healthy Parents, Healthy Minds' Service in Carnarvon*. Western Australian Perinatal Mental Health Unit, Women and Newborn Health Service (2011); and
- *Lessons learnt about strengthening Indigenous families and communities: Stronger Families and Communities Strategy 2000–2004*, Occasional Paper No. 19, 2008.

Many issues raised in these reports highlight the importance of effective and collaborative communication about perinatal mental health care. It is evident that misinterpretation, misunderstanding and miscommunication when diagnosing, treating and giving care, results in negative experiences for women and requires solutions that respect cultural sensitivity, demonstrate cultural competence, and adopt culturally appropriate methods and language related to the perinatal stage of life.⁵³ See also Chapter 12 (Walker and colleagues) on cultural competence; Chapter 13 (Schultz, Walker and colleagues) on interdisciplinary care; Chapter 14 (Adams and colleagues) on assessment; and Chapter 15 (Dudgeon and colleagues) on communication issues.

The Need for Integrated Care and Early Intervention

The need for integrated care and early intervention for mothers and infants in the perinatal period has been recognised and now includes screening and assessment to identify women currently experiencing, or at increased risk of, distress, depression or related functional impairment.^{3,54} Also, the awareness of potential difficulties for fathers is now recognised, with screening for postnatal depression in men becoming more frequent.²⁷

The *beyondblue* Clinical Practice Guidelines identify the importance of follow-up through:

a pathway or 'map' by which the woman and her family can access the most appropriate care and support during the perinatal period. The pathway to care will depend on the severity of the woman's risk or symptoms, together with her preferences and social context.^{4(pvi)}

Referral

Referral to a doctor is required if there is concern about mental health status in the perinatal period, if there is an EPDS score greater than 12, or a positive response to question 10 of the EPDS (which pertains to self-harm).

It is important that health professionals have an interdisciplinary perspective and where appropriate are proactive in referring a woman and her family on to the relevant health practitioners for assessment, monitoring, counselling, treatment such as medication, and hospital admission.

Medication

Decisions about the use of antidepressants or other psychiatric medications in the perinatal period, especially if the woman is breastfeeding, require particular consideration by medical practitioners, with review and ongoing attention by qualified health personnel.

Suitable medications and safety considerations, particularly during the perinatal period, is a continually evolving field of research with new information constantly emerging.

However, following appropriate referral and assessment, including consideration of potential side effects to the mother and her infant, any one of a number of medications may be decided upon after consultation with the patient, and her family as appropriate.

Appropriate Resources

The *beyondblue* National Postnatal Depression Research Program 2001–2005 was conducted Australia-wide (with the exception of the Northern Territory), providing information and resources about postnatal depression to health professionals as well as the wider community during that time.

Policy Initiatives

Several Australian Government initiatives for the implementation of a perinatal depression plan took place from 2008–09. The goal is to have:

- routine screening for depression during pregnancy and at two months following the birth;
- support and care for women determined to be at risk of, or experiencing, depression; and,
- training for health professionals in perinatal mental health screening and assessment.⁴⁹

In February 2011, the Chief Executive Officer of the National Health and Medical Research Council (NHMRC) approved the comprehensive *beyondblue Clinical Practice guidelines for depression and related disorders—anxiety, bipolar disorder and puerperal psychosis—in the perinatal period* for a period of 5 years (to early 2016).⁴ *beyondblue* produced the clinical guidelines as part of the NPDI requirements.

Research Directions

An urgent need for further research into the assessment and experiences associated with the perinatal mental health of Aboriginal and Torres Strait Islander women has been identified. Several authors claim that researchers have failed to consider the impact that SEWB has on health behaviours and pregnancy outcomes in Aboriginal women, and impacts on infants/ children.

Research to evaluate the impact of the planned expenditure of \$85 million is underway to identify outcomes and benefits transpiring; and whether there is translation into a reduction in the number of women affected by perinatal depression and anxiety.

The three year policy evaluation study (by UNSW, UWA, Deakin and *beyondblue*) is being funded by NMHRC and *beyondblue* and will conclude in March 2015. It will provide an indication of the utilisation and cost and whether there is translation into a reduction in the number of women affected by perinatal depression and anxiety.

CONCLUSION

This chapter has emphasised the promotion of perinatal maternal, paternal and infant mental health and wellbeing through prevention and management strategies and initiatives that are holistic in nature and encompass the special worldview of Aboriginal and Torres Strait Islander peoples. It has argued that, where there is a need for medical management of perinatal mental illness (through appropriate screening and assessment), collaboration with Aboriginal Maternal Health Workers and AMHWs who are recognised as experts in community-relevant knowledge, will allow the healing journey for the person affected to be greatly assisted.

At present there is still little known about the incidence and experience of perinatal mental illness in Aboriginal and Torres Strait Islander women and men. Nevertheless, the empirical evidence that is available has been presented, together with the valuable knowledge garnered from experienced AHW/AHPs in metropolitan, rural and remote settings, which support generalised psychosocial and wellbeing assessment and management strategies in the Aboriginal and Torres Strait Islander context. There is an urgent need for a culturally oriented and contextually sensitive yet comprehensive service model that includes high skill levels in prevention, recognition and management of perinatal mental health issues, collaborative practice, and the ability to be locally responsive to community needs in order to strengthen perinatal mental health and SEWB.

All practitioners working in the area of perinatal mental health have a key role to play in promoting maternal, paternal and infant SEWB, and in detecting and managing the risk factors that may impact negatively on a child's wellbeing throughout the perinatal period and in the long term.

Case Study **Zadalia, Brettan and Jonoky**

Following an induced labour and birth for maternal elevated blood pressure at 37 weeks gestation, Zadalia (aged 19) and her baby, Jonoky, are discharged from the regional hospital two weeks after the birth and arrive back in their community after eight hours of road travel. Zadalia had difficulty sleeping in hospital, and cried often during that time. Breastfeeding was well established, and a normal postpartum recovery period occurred.

During the following weeks Zadalia's husband, Brettan, frequently takes Jonoky to the community health clinic for a 'check-up' as he believes there is 'something wrong' with him. At each visit, Jonoky is reported to be growing well with no obvious signs of a problem and Brettan is reassured by clinic staff.

At six weeks postpartum, Zadalia is breastfeeding Jonoky who is gaining weight and progressing, but who is noted to be restless, irritable, and difficult to settle. It is noted that Zadalia is talking to Jonoky a lot but not actively attempting to settle him.

Zadalia's mother had passed away the previous year, she has limited family supports, but strong peer group support. The community has strong connection to cultural ways. Brettan has limited family support also and has a previous history of self-harm.

The family has come to the community health clinic at your request for a review at six weeks according to the recommended schedule of postnatal follow-up care.

As part of routine health services, an EPDS was administered with Zadalia in conjunction with an informal yarn about her wellbeing. The tool was used informally, as you asked questions from the EPDS and, at the request of Zadalia, was recorded by you and scored after explanation. The score recorded is 10 in total with 4 points noted in total to questions 3, 4, and 5, and 0 score on question 10.

Questions for Reflection

- Review the steps in the psychosocial assessment and the use of the EPDS for the mother and the father to determine findings related to this family's mental health and wellbeing status.
- What extra information do you require to best assess and support the family?
- What actions will you take following this assessment?

Make a list of possible actions you could take with the family to inform and support them at this time.

Wise Places

These are the places you might go in your head and in your heart for practice wisdom. What are your instincts telling you about the wellbeing of this family? Where might you go for further guidance and assistance in taking the most appropriate action for the mental health and wellbeing of this family?

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