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Promoting Perinatal Mental Health Wellness in Aboriginal and Torres Strait Islander Communities

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OVERVIEW

This chapter considers factors relating to perinatal mental health, culture, environmental context, and ways of working with families in this most sensitive of life stages. Perinatal mental health research has ascertained that in the perinatal period women experience increased susceptibility to social and emotional adjustment difficulties, psychological distress, anxiety and mood disorders. The issue of perinatal mental ill health is a major public health problem affecting not only mothers but also their infants, other children in the family, partners, and communities generally.

Protective and risk factors related to perinatal mental health are discussed from the perspective of mother, child and father, along with implications for the wider family and community. Ways of strengthening wellbeing and of recognising and managing perinatal distress and perinatal depression are explored. Cultural considerations in determining the presence of a perinatal disorder in Aboriginal and Torres Strait Islander contexts are highlighted throughout. Current practices and beliefs about recognising and managing signs of distress in a new family are considered, as well as existing strengths in Aboriginal and Torres Strait Islander community contexts which can lead the way in promoting perinatal mental health wellness. The chapter also briefly explores pathways and models of care, screening, and tools of assessment used in the perinatal period.

PERINATAL DEPRESSION

Depression accounts for the greatest burden of disease within all mental illness, and it has been predicted by the World Health Organization that it will be the second highest of all general health problems by the year 2020. Of particular concern and significance is the rate of depression among women (and men) during the perinatal period. Currently there is little information relating to depression and perinatal depression in Aboriginal and Torres Strait Islander communities, though numerous reports demonstrate the complexity of issues impacting on rates of depression in communities. There are indications that perinatal depression is also a significant health issue.

The perinatal period is a unique life stage for women (and men), bringing with it challenges and opportunities with more than one person directly affected if adaptation to the parenting role is impaired, or mental health is negatively affected.

There has been increasing recognition that perinatal mood and anxiety disorders alter a mother's physiological and emotional responses, possibly leading to long-lasting effects on the fetus during the pregnancy, and on the infant, family and community in the postnatal period (*beyondblue*,

2008). The need for comprehensive care provision for mothers and infants in the perinatal period has been identified and now includes screening and assessment to identify women currently experiencing or at increased risk of distress, depression or related functional impairment (beyondblue, 2008). In recent times, the awareness of potential difficulties for fathers has been recognised, with screening for postnatal depression in men becoming more frequent (Matthey, 2008).

A national plan to enhance perinatal mental health wellness

The Australian Government announced in the 2008/09 budget a health initiative for the implementation of a perinatal depression plan to be implemented across Australia over the next five years. The goal is to have available 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 (Yelland et al., 2009).

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 during that time. Actions arising from the research include the development of a national, integrated, coordinated approach to translate the research outcomes into evidence-based policy and practice (*beyondblue*, 2008).

Identifying perinatal issues in Aboriginal and Torres Strait Islander contexts

The development of perinatal screening initiatives in Aboriginal and Torres Strait Islander health contexts is in progress to prevent, detect and manage perinatal mental health problems. Centres such as Aboriginal-controlled Community Health Services and Aboriginal Medical Services provide culturally specific mental health services, and are initiating adaptations to existing screening tools and developing culturally appropriate programs to address the issues. The Western Australian State Perinatal Mental Health Unit is an example of a Department of Health state-based centre with initiatives such as research and education programs based on culturally appropriate service provision for health personnel, including training in the use of the Edinburgh Postnatal Depression Scale (EPDS) in diverse contexts.

Reporting on perinatal mental health

Numerous reports are available about initiatives, strategies, or programs related to perinatal mental health, and maternal and child health, in the Aboriginal and Torres Strait Islander context. Examples include:

- *The beyondblue National Postnatal Depression Program, Prevention and Early Intervention 2001–2005, final report*, June 2005
- *State Perinatal Mental Health Initiative Report 2003–2007*, State Perinatal Mental Health Reference Group and WA Perinatal Mental Health Unit, 2007
- *Aboriginal Perinatal Service Expansion Baseline Evaluation Report*, WA Perinatal Mental Health Unit, February 2008
- *Lessons learnt about strengthening Indigenous families and communities: Stronger Families and Communities Strategy 2000–2004*, Occasional Paper No. 19, 2008.

The reports raise many issues but also highlight the importance of effective communication about perinatal mental health care. Misinterpretation, misunderstanding and miscommunication that occurs when diagnosing, treating and giving care results in negative experiences for the recipients of care and the caregivers (Eley et al., 2006) and require solutions that respect cultural sensitivity, demonstrate cultural competence, and adopt culturally appropriate methods and language related to the perinatal stage of life. Chapters 13, 14 and 15 of this text discuss these issues further.

Scope of the problem

Beyondblue's national depression initiative outlines the scope of the problems arising when there are negative impacts on the wellbeing of families and communities in the perinatal period:

> It is now well recognised that vulnerability to psychological distress and disorder is accentuated in the perinatal period not only for the mother, but also her infant, partner and family. Poor maternal mental health can significantly affect the emotional, social, physical, and cognitive development of her child, and is associated with increased incidence of chronic disease. The perinatal phase is critical developmentally, both in terms of the attainment of parenting skills and secure infant attachment. (*beyondblue,* 2008, p. 1)

Role adjustment or mental health disorder?

According to the *beyondblue National Post Natal Depression Research Program*, which screened 40,000 women across Australia, one in seven women who give birth in Australia are affected by postnatal depression. However, questions arise as to whether distress during the perinatal period is related to psychosociology or biology—phase of adjustment to parenthood, or mental health disorder. Buist (2006) notes that nearly 30% of women experience significant adjustment to parenthood difficulties, with the weight of expectation on motherhood creating levels of mental and emotional stress not previously documented. Media images of smiling, relaxed, well-toned, in-control mothers and fathers set an expectation that is difficult to achieve even in well-supported families.

Mental ill health in the perinatal period is a serious public health problem for Australia, affecting mothers, fathers, infants and communities. While the extent of the problem is currently unknown in Aboriginal and Torres Strait Islander communities, the facts identified for the general population demonstrate reasons for concern. For example, approximately 10–13% of pregnant women experience *antenatal depression* and one half of these women will develop postnatal depression (Evans et al., 2001); antenatal anxiety and depression frequently occur together and may lead to postnatal depression and anxiety (WA Perinatal Mental Health Unit, 2007); approximately 50–80% of women will experience postnatal depression or baby 'blues' in the first few days after the birth (*beyondblue*, 2008); *postnatal depression* prevalence is estimated to be 14% in Australia (Milgrom et al., 2005); co-morbid anxiety is reported in postnatal depression in 30–40% of cases (Misri et al., 2000); during the perinatal period the potential consequence of suicide is the equal (with haemorrhage) leading cause of maternal death in Australia (Buist et al., 2005); infanticide is a rare but alarming consequence of severe mental illness (*beyondblue*, 2008).

Further, postnatal depression is frequently unrecognised and untreated (Buist et al., 2005); the incidence of paternal depression ranges from 1.2% to 25.5% in community samples, and from 24% to 50% among men whose partners were experiencing postnatal depression (Goodman, 2004); adolescent mothers are up to three times more likely to experience postnatal depression than older mothers (Swann et al., 2003).

Anxiety and depression are as common in women in the period of time *before* the birth of a baby as that seen postnatally (Buist, 2006). It is estimated that about a third of women will remain depressed over the months following birth, and sometimes for prolonged periods of time. If there is associated drug or alcohol use, domestic violence occurring, or pre-existing mental health problems, the mental health and wellbeing of the woman and her child or children, her partner, and others surrounding her in the community, may be affected.

Fathers may also experience increased rates of dysphoria and depression (Matthey et al., 2000). An integrative review concluded that during the first year after the birth of an infant, the incidence of paternal depression ranged from 1.2% to 25.5% in community samples, and from 24% to 50% among men whose partners were experiencing postnatal depression (Goodman, 2004). The *New South Wales Men's Health Action Plan 2009–2012* supports the *Father-Inclusive*

Practice Framework being developed to align services with the needs of fathers 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.

CONSIDERING PERINATAL STRESS AND DEPRESSION FROM A CROSS-CULTURAL PERSPECTIVE

Differences may exist in the experiences of mental disorders within Aboriginal and Torres Strait Islander contexts. Westerman (2004) reflects on the relevance of mainstream diagnostic criteria across cultures where possible differences in symptom presentation exist (e.g. more physical symptoms), and causality (e.g. external forces arising from 'doing something wrong culturally'), which are significant considerations when managing perinatal mental health. Vicary and Westerman (2004) contend that because mental health problems may show themselves spiritually and culturally, resolution can only be achieved in the same manner. It is to be noted that 'Aboriginal people ask that workers in community agencies apply an "Aboriginal lens" and consider additional factors and approaches' when working with Aboriginal people (Mungabareena Aboriginal Corporation and Women's Health, 2008, p. 2).

Traditional cultural beliefs and practices strengthen wellbeing in the perinatal period

In traditional Aboriginal cultures, birthing and child-rearing practices were strongly related to the land and the plants that provided the necessary elements for rituals relevant to this life stage (Dudgeon & Walker, 2009). Connection to country or 'homeland' was, and still is in most Aboriginal communities, an extremely significant feature in ensuring the wellbeing of the mother, the infant, the whole family and the community in general.

In many rural and remote areas in Australia, pregnant women face removal from a partner, family, friends and community, country, and culture for the birth of their children and this may have a significant impact on the wellbeing of Aboriginal and Torres Strait Islander women and their families. Excessive stress, isolation from familiar and nurturing people, surroundings and cultural ways, leads to fear, sadness and loneliness at a critical period. While many urban centres share a philosophy of family-friendly birth environments and provide options for community midwifery services, many women in remote settings face displacement from the familiar, and birthing in the presence of strangers (Hancock, 2007), both significant factors in the creation of high stress levels (Odent, 2002).

Optimal health supports women at the time of birth and, according to Hancock (2007, p. 79), the 'system of medicalisation and authority [that] has determined [on] removing the Aboriginal woman from her culture and tradition for birthing…' impacts on health and has not seen corresponding improvement in perinatal statistics to justify the action. Further, 'Aboriginal women's preferences, feelings and encounters with the health system as it impacts on them and their family and community lives during pregnancy and after, are poorly understood and appreciated' (Hancock, 2006, p. 4) with potential for long-lasting impacts on social and emotional wellbeing.

Birthing away from country, from significant family members who would normally nurture, guide and assist the woman, and from traditional and familiar ways of interaction through language and cultural practices may well upset the normal process and rhythm of birth as well as subsequent mother–child interactions and child behaviour and development (Hancock, 2006). Odent (2002) discusses current birth and primal period processes and the

potential for negative impacts on the child's primal health, especially immune system stimulation and the consequent state of wellness. According to Odent, results from scientific experiments about physiological changes and responses when placed under duress have been able to

> help us to understand just how much a person's entire capabilities are decreased when they have no control over what happens to them, and can only passively submit. They also help us to understand that the responses of the nervous system, the hormonal system and the immune system should never be dissociated. They form a whole. (2002, p. 7)

In recounting their traditional birth and child-rearing stories to Margaret Stewart (1999), the women of Warmun community in the East Kimberley region of Western Australia highlight 'the importance of safeguarding both the physical and spiritual health of the mother. Adherence to traditional women's Law, and with it the ceremonies and rituals for a healthy mother and baby, is critically important in the eyes of the older women' (p. 6). Werra Werra team members Peggy Patrick, Mona Ramsay and Shirley Purdie share 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. (pp. 6–7)

Life stage: The perinatal period

The available literature assures us that a strong family unit displays signs of being strengthened during this transitional life stage as adjustment followed by adaptation to the new situation of being a parent occurs. From a social-anthropological perspective childbirth is a 'rite of passage', a social transition with a different relationship ensuing between the parents and wider family as they combine to activate a secure environment for infant development and learning (Cox, 1996).

Families are described as a central point 'from which societies derive strength and forge the future' (Cox, 1996, p. 1), highlighting the importance of investment in services and programs to provide families with the supports and assistance required to meet challenges arising in the sensitive perinatal period.

PARENTAL MENTAL HEALTH

Understanding the secure base-safe haven concept, and secure attachment in infants

The first year of a child's life is a critical period in the creation of secure parent–infant attachment and also in the development of neuronal connections in the infant's brain, especially in the area of infant self-regulation of behaviour and emotions (Mustard, 2007). Further, insecure patterns of behaviour in the child may be demonstrated as intergenerational transmission of patterns of insecure attachment (Austin, 2003). 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 (Hoffman et al., 2006). Mother–infant attachment which is strained or lacking may result in a feedback mechanism that exacerbates the woman's depressed mood, reinforcing her feelings of being a poor parent (Goodman, 2004).

What impacts on the development of a secure base?

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. According to Swan and Raphael (1995) and Vicary and Westerman (2004), 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 and personality and adjustment disorders, poor parenting skills, lack of cultural identity, substance misuse, violence, guilt, self-harm and suicidal behaviours.

PROTECTIVE FACTORS PROMOTING PERINATAL MENTAL HEALTH WELLNESS

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 (Luthar, 2006). Protective factors are discussed in detail in Chapter 6. A more effective way of promoting mental health wellness, and enhancing family wellbeing in the perinatal period is to increase a person's, or family's, inner strength, or level of resilience, or coping capacity, through the enhancement of protective factors relevant to the particular family, rather than trying to modify risk factors.

There are many protective factors known to assist management of stressors over a life course and over many generations. The following list, adapted from Ypinazar et al. (2007), summarises examples of protective factors with each defining, influencing, being part of and impacting on, the other.

Protective factors

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
- adequate nutrition.

Infant/child

- healthy infant
- breast fed
- 'easy' temperament
- safe and secure base with positive attention from a supportive, caring mother/family
- strong mother–infant attachment and, where possible, father–infant attachment
- family harmony
- sense of belonging, sense of connectedness
- strong cultural identity and pride.

CAUSES OF PERINATAL MENTAL HEALTH DISORDER

The state of a person's wellbeing is affected by a complex interaction of internal and external factors and is sensitive to stressors mediated by a person's biology, neurochemistry, and psychosocial and environmental factors. Physiologically, alterations in cerebral seratonin and noradrenaline 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 depression (Buist, 2006).

Risk factors in maternal mental health

Dysfunctional personality styles of some women may become emphasised in the perinatal period as negative emotions and memories of past experiences may be brought to the surface. Memories and problematic behaviours arising from a history of neglect and abuse may be triggered, leading to further problems with mental health disturbance, substance use and, worse, to continuing transgenerational patterns of abuse and neglect of children (Buist, 1998).

Predisposing psychosocial risk factors shown in research studies to be associated with an increased risk of perinatal depression are essential assessment considerations and include 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 strain (Buist 2006).

However, care needs to be taken to avoid misinterpreting risk factors, or symptoms as representing a depressed state, or a state of illness. Many women experience depressed mood shortly after birth with symptoms that are not severe and that spontaneously resolve within a few days or weeks in a supported environment (Najman et al., 2000). Negative thoughts can be a normal experience after childbirth and reassuring new mothers about this fact may reduce associated feelings of guilt.

Risk factors in paternal mental health

An increase in *couple* mental health illness throughout the first year after the birth of a child is noted, with rates of distress being at the highest point for both partners at one year (Matthey et al., 2000).

Predisposing risk factors for depression in paternal mental health include 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 (Goodman, 2004).

The more risk factors found in the assessment, the greater the chance that the mother, father and family require extra mental health support or intervention in the perinatal period.

CHALLENGES FACED IN THE UNIQUE PERINATAL LIFE STAGE

There are many challenges apparent in the perinatal period including role and stage of life adjustment, personal family and environmental factors, service appropriateness and availability to name a few. Two examples are briefly presented here.

Adolescent parents and perinatal mental health

Understanding the adolescent stage of life provides an opportunity to appreciate the potential for extra pressures and challenges faced by an adolescent mother and her partner and family. The energy and interest in new experiences and learning that adolescents enjoy usually ensures positive interactions with infants. However, if a support system is not readily available, or

parental or child ill health is a concern, or social opportunities for 'time out' or for 'time to be an adolescent' are scant, there are added stressors imposed on a young family which may impact on perinatal mental health.

The recent Aboriginal Perinatal Service Expansion Baseline Evaluation report from the Western Australian Perinatal Mental Health Unit provides examples of Aboriginal women's reflections about challenges faced by adolescent 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.'
>
> 'Families support mum, try to understand, but may not know anything about depression.'
>
> 'Practical support really needed…' (Brooks, 2008, pp. 18–22)

Multidisciplinary services incorporating the knowledge and wisdom of Aboriginal Health Workers 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 (Hancock, 2007).

Barriers to service access must be understood in order to determine through collaborative processes ways to overcome them. *beyondblue* (2008) notes that understanding and overcoming barriers is the key to increasing early intervention, in association with routine screening.

DEFINING AND RECOGNISING PERINATAL DEPRESSION

In the first instance, other causes for symptoms that are similar to depression must be considered and ruled out. Anaemia, thyroid dysfunction, having experience of a recent bereavement, and sleep deprivation may present in the same way that depression presents. These may also coexist with depression (beyondblue, 2008).

Screening in the perinatal period

In the context of perinatal mental health, screening relates to the identification of anxiety and depressive illness through the use of a validated scale. The EPDS is the screening tool routinely used for predicting and detecting perinatal anxiety and depression and it assists in monitoring anxiety and depression in the perinatal period (Austin, 2003). It is used in conjunction with assessment strategies such as clinical observation, history-taking and physical assessment.

Assessment in the perinatal period

Different health service regions may have their own adapted or preferred tools, which may or may not be validated, in addition to standard assessment tools for determining psychological distress or depression. The Kessler Psychological Distress Scale (K10) is one example. The General Health Questionnaire, Personal Health Questionnaire and *Diagnostic and Statistical manual of mental disorders* (DSM 1V) are other tools used in assessment, alongside screening tools such as the EPDS.

Working with the Edinburgh Postnatal Depression Scale

The EPDS was initially developed to screen for postnatal depression in women in the primary care setting. It is a self-report questionnaire and although it appears simple to use, training in administering and scoring the scale is essential, as is giving women (and men) appropriate feedback, understanding its limitations, knowing when referral is required, and having a well-identified referral and care pathway. The EPDS questionnaire is usually administered in the primary care setting by child and family health nurses, midwives and psychologists.

According to Buist et al. (2002), the positive predictive value of the EPDS for clinical depression has a score threshold greater than 12 (i.e. 13 or higher). Like all screening methods, the EPDS does not identify all women with depression and some women with high scores will not be clinically depressed. Identification of women experiencing postnatal distress (i.e. EPDS > 10) may be useful as many may require practical assistance.

It is important that clarification of the EPDS as a screening tool that aids more extensive diagnostic testing for depression (if required) is given to those undertaking the EPDS. Diagnoses of depression should only be made based on a more rigorous psychiatric interview and never based on the EPDS or other such preliminary screening instruments alone (Buist, 2006). Murray et al. (2003) note that some psychologically vulnerable women (and men) who are at particular risk in the perinatal period may self-exclude from the health care system, and therefore miss opportunities for perinatal mental health screening, because of barriers to access, such as inappropriate or unaffordable services and unacceptable care options.

Guidelines for using the EPDS are provided by health services but there are some important points to note: the scale is completed by the person themselves, unless there is limited English or difficulty with reading; the EPDS should always be completed, scored and discussed during a consultation in order to assess the level of immediate support and supervision needed; the EPDS does not provide a diagnosis of postnatal depression, as a screening tool, but can only predict the risk that the person may be experiencing depressive symptoms; notice should be taken of any inconsistencies between the score and any apparent signs or symptoms; high scores on questions 3, 4 and 5 of the EPDS may need further assessment for anxiety; many people with clinical depression experience co-morbid anxiety; anyone who scores 1, 2 or 3 on question 10 (thoughts of self-harm) requires immediate attention and referral (WA Perinatal Mental Health Unit, 2009).

Table 16.1: EPDS scoring outcomes guideline

Women	EPDS score requiring follow-up (probable minor depression)	EPDS score requiring referral to a health professional (probable major depression)	EPDS subscale for anxiety—items 3, 4 and 5 combined score
Antenatal and Postnatal	10 or greater ANY score on question 10 (suicidal thoughts)	13 or greater ANY score on question 10 (suicidal thoughts)	4 or more considered high range **but** 6 or more shows probable anxiety
Men			
Postnatal	6 or greater ANY score on question 10 (suicidal thoughts)	10 or greater ANY score on question 10 (suicidal thoughts)	4 or more

Source: Adapted from WA Perinatal Mental Health Unit, 2009; Matthey, 2008

Self-harm scoring (Item 10 on the EPDS questionnaire)

If there is any score (i.e. 1, 2 or 3) on the EPDS for self-harm, *consultation with someone more experienced in the mental health area is strongly recommended*. It is also recommended that a suicide risk assessment is explored (see Appendix 16.2). A *suicide risk assessment is not everlasting and therefore reassessment throughout the period of risk is essential.*

Variations to the standard EPDS

Currently, translation of the EPDS into traditional Aboriginal and Torres Strait Islander languages or into Aboriginal English is being explored in different Australian contexts. Different areas of Australia have begun to develop variations to the EPDS for Aboriginal and Torres Strait Islander women and have undertaken research studies to test the adaptations. For example, an adapted EPDS has been trialled in Townsville and Mt Isa with Aboriginal and Torres Strait Islander women and noted to be suitable for some Australian Indigenous women (Campbell et al., 2008). However, Milgrom et al. (2005) report that findings from the Victorian Antenatal Intervention Initiative indicate that Aboriginal and Torres Strait Islander 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.

Cautions

Yelland et al. (2009) caution that not all women (or men) will agree with the correlation of their EPDS score to the reality of their mental health status. Over- or underestimation may occur either because of the interpretation of the questions, or on purpose. As previously pointed out, the EPDS is a guide to be used in conjunction with the history, observation and self-report. As consent for screening is required, the right to decline administration of the formal EPDS is acknowledged.

CHILD ASSESSMENT

The physical, social and emotional wellbeing of children is fundamental to communities experiencing optimal health in the future. It is important to understand that extraordinary stress and perinatal depression places the parent–child relationship at risk because it compromises a child's growth and development.

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

Possible infant/child outcomes

Perinatal depression adversely affects the mother's physiological responses, creating the potential for impairment of parenting and coping mechanisms. Potential negative impacts on the infant include spontaneous preterm birth (Dayan et al., 2006); impaired mother–infant relationship and cognitive, emotional and behavioural development of the infant (Murray et al., 1999); infant crying and unsettledness (Wurmser et al., 2006); and infant diarrhoeal morbidity (Rahman et al., 2007).

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 (Oates, 1997).

The literature on outcomes in infant and child behaviours where there has been excessive maternal stress, anxiety and depression shows there may be increased infant irritability and poorer neurological scores at birth (Lou et al., 1994), while high maternal anxiety scores in the last trimester of pregnancy may lead to hyperactivity in the child at 4 years of age (O'Connor et al., 2002). Fathers have an important role to play in their child's development; for example, through more frequent physical play. Therefore depression in fathers may lead to more negative interaction, and less interaction with their children, which correlates to pro-social and peer interactional problems for the child later (Dave et al., 2008).

PATHWAYS AND APPROACHES TO PROMOTING PERINATAL MENTAL HEALTH WELLNESS

This section specifically focuses on programs, strategies and initiatives addressing perinatal mental health and reflects observations and conversations with Aboriginal and Torres Strait Islander women over many years of working in community settings as well as recommendations from the literature arising from women's stories of the experience of PND. 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 (Bond 2009).

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 wellbeing (Vicary & Westerman, 2004; Ypinazar et al., 2007). Programs such as 'Strong Women, Strong Babies, Strong Culture' incorporate traditional cultural approaches to parenting and lifestyle, and support pregnant women and their babies throughout the perinatal period.

In respecting the importance of culture and birthing practices, a suggestion for minimising the impact of disconnectedness when birth occurs away from homelands includes offering Aboriginal and Torres Strait Islander women the chance to take the placenta (or part thereof) home for burial, enabling the creation of physical and symbolic links between mother, baby and the homeland (Middleton, 2006).

Programs promoting wellness and wellbeing

The Department of Health and Ageing (1995) point out that any program dealing with trauma (past or present) is beneficial and communities should be encouraged to develop models based on their own cultural context. Workshops such as 'Recreating the Circle' and the model 'We-Al-Li' using the concept of Dadirri—'inner depth listening and quiet still awareness'—and programs such as Rosemary Wanganeen's seven phases of self-healing are suggestions.

The community will determine the appropriateness, timeliness and acceptability of any programs or program content. Examples include traditional healing practices such as bush medicine, traditional ceremonies, song and dance, prayer, and holistic social, emotional, spiritual, and cultural wellbeing practices that are inclusive of all community members—and exercise. Exercise can be an effective way to relieve some forms of depression and is often a neglected strategy for treatment (Blackdog Institute, 2008).

Working in partnerships

The 'Making Two Worlds Work Project' developed by Mungabareena Aboriginal Corporation and Women's Health Victoria provides an example of ways of working in community using stories and art to demonstrate communities and services working together through symbolic interaction.

Working with Aboriginal Health Workers and Aboriginal Mental Health Workers ensures that cultural advice is available. As well as health workers, many communities have Strong Women workers, who provide valuable understandings of cultural and contextual features of cases, as well as language interpretation.

Where perinatal depression has been diagnosed, partnership work will be undertaken with families, child and family health nurses working with the community, community health services, Aboriginal medical services, psychiatrists, and remote area mental health nurses. Community Health and Women's Health services, and local community centres provide community-based programs for women and families which focus on strengthening wellbeing and mental health wellness. Outcomes demonstrate greater understanding of factors impacting on families, and of cultural information exchange.

Antidepressant medication

Decisions about the use of antidepressants in the perinatal period, especially if the woman is breastfeeding, require particular consideration, with review and attention by qualified health personnel. Referral to a doctor is required if there is concern about mental health status in the perinatal period, or, as noted previously, if there is an EPDS reading greater than 12, or any score on question 10 of the EPDS.

Suitable medications and safety considerations in antidepressants prescribed by medical practitioners is an evolving field of research with new information constantly being presented. However, following appropriate referral and assessment in the management of major perinatal depression, and consideration of potential side effects to the mother and her infant (especially if breastfeeding), one of the following examples of medications may be decided upon after consultation with the patient, and family of the person affected:

- selective serotonin reuptake inhibitors (SSRIs) such as Prozac, Zoloft, Cipramil, and Luvox.
- tricyclic antidepressants such as prothiaden.

Signs of withdrawal symptoms must be watched for in the infant (irritability, increased startle reflex, altered sleep) and are potential negative effects of antidepressants when taken by a breastfeeding mother.

CONCLUSION

The emphasis of this chapter has been on promotion of wellbeing and mental health wellness in the perinatal period through prevention and management strategies and initiatives which are holistic in nature and encompass the special worldview of Aboriginal and Torres Strait Islander peoples. Where there is determination of the need for medical management of perinatal mental health illness (through appropriate screening and assessment), collaboration with Aboriginal Health Workers and Aboriginal Mental Health Workers who are recognised as experts in community-relevant knowledge will allow the healing journey for the person affected to be greatly assisted.

Little is known about the incidence and experience of perinatal depression in Aboriginal and Torres Strait Islander women and men, in the perinatal period in particular. Empirical evidence has been presented from the perspective of experienced health workers in metropolitan, rural and remote settings which supports 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 ability to be locally responsive to community needs in order to strengthen perinatal mental health wellness.

Those working in the area of perinatal mental health have a key role to play in promoting wellness, and in detecting and managing threats to a child's secure base.

Reflective exercises

1 In considering challenges facing psychiatry, Austin (2003) notes that there are four key clinical questions to guide practice for those working with families in the perinatal period.

Four key clinical questions:

a. How does becoming a parent (the most challenging developmental phase of life for many people) impact on a new mother or father's mental health?

b. How does mental illness affect a person's ability to parent adequately?

c. How does parental mental illness influence parent–infant attachment and the growth and development of infants?

d. Are we able to minimise negative mental health outcomes for both parents and infants through early detection and appropriate and acceptable intervention for those affected in the perinatal period?

You are invited to reflect on the content of this chapter and answer the questions presented from the perspective of your particular work and geographical context.

2 **EPDS practice**

You are invited to turn to Appendix 16.1 and explore the EPDS as a tool of assessment by completing the EPDS based on your own feelings during the *past seven* days. Answer honestly and, when ready, score the answers.

Consider:

a. How did you feel about the invitation to complete the EPDS? If your response is negative, why did you feel that way?

b. What factors in your life affected the way you completed the EPDS today?

c. What was the total score? If greater than 10 it is recommended that you discuss your feelings with a health professional.

A focus of working as a mental health practitioner is providing self-care. If you marked any score on question 10, it is strongly recommended that you discuss this result with a health care provider.

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Appendix 16.1

BLACK DOG INSTITUTE

Self–testing for depression during pregnancy and the postnatal period

Fact Sheet

What this fact sheet covers:

- Self-test (Depression Scale)
- Scoring instructions and results
- Where to get more information.

This fact sheet provides a self-test that can guide you when thinking about any symptoms you may be experiencing.

Please note: While great care has been taken with the development of these self-assessment tools they are not designed to be a substitute for professional clinical advice. Users should always seek the advice of a qualified health care provider with questions regarding their health.

This self-test can also be completed online at: www.blackdoginstitute.org.au

If you want to talk to a health professional about any symptoms you are experiencing, contact your doctor (GP or obstetrician), your midwife, child and family health nurse, psychologist, counsellor, or psychiatrist.

DEPRESSION SCALE

(Also known as the Edinburgh Postnatal Depression Scale -EPDS)*

Instructions:
Please colour in one circle for each question that is the closest to how you have felt in the **PAST SEVEN DAYS**:

1. I have been able to laugh and see the funny side of things: ○ As much as I always could ○ Not quite as much now ○ Definitely not as much now ○ Not at all
2. I have looked forward with enjoyment to things: ○ As much as I ever did ○ Rather less than I used to ○ Definitely less than I used to ○ Hardly at all
3.I have blamed myself unnecessarily when things went wrong: ○ Yes, most of the time ○ Yes, some of the time ○ Not very often ○ No, never
4.I have been anxious or worried for no good reason: ○ No, not at all ○ Hardly ever ○ Yes, sometimes ○ Yes, very often

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Fact Sheet

5. I have felt scared or panicky for no very good reason:
- ○ Yes, quite a lot
- ○ Yes, sometimes
- ○ No, not much
- ○ No, not at all

6. Things have been getting on top of me:
- ○ Yes, most of the time I haven't been able to cope at all
- ○ Yes, sometimes I haven't been coping as well as usual
- ○ No, most of the time I have coped quite well
- ○ No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping:
- ○ Yes, most of the time
- ○ Yes, sometimes
- ○ Not very often
- ○ No, not at all

8. I have felt sad or miserable:
- ○ Yes, most of the time
- ○ Yes, quite often
- ○ Not very often
- ○ No, not at all

9. I have been so unhappy that I have been crying:
- ○ Yes, most of the time
- ○ Yes, quite often
- ○ Only occasionally
- ○ No, never

10. The thought of harming myself has occurred to me:
- ○ Yes, quite often
- ○ Sometimes
- ○ Hardly ever
- ○ Never

NB: If you have had ANY thoughts of harming yourself, please tell your GP or midwife today.

* Cox, Holden & Sagovsky 1987

NB: Please turn over for scoring instructions and results.

Self–testing for depression during pregnancy and the postnatal period

Fact Sheet

Scoring Instructions

To obtain your total score, add up the points for each circle you have filled in.

1. I have been able to laugh and see the funny side of things: ○ **0** As much as I always could ○ **1** Not quite as much now ○ **2** Definitely not as much now ○ **3** Not at all
2. I have looked forward with enjoyment to things: ○ **0** As much as I ever did ○ **1** Rather less than I used to ○ **2** Definitely less than I used to ○ **3** Hardly at all
3.I have blamed myself unnecessarily when things went wrong: ○ **3** Yes, most of the time ○ **2** Yes, some of the time ○ **1** Not very often ○ **0** No, never
4.I have been anxious or worried for no good reason: ○ **0** No, not at all ○ **1** Hardly ever ○ **2** Yes, sometimes ○ **3** Yes, very often
5. I have felt scared or panicky for no very good reason: ○ **3** Yes, quite a lot ○ **2** Yes, sometimes ○ **1** No, not much ○ **0** No, not at all
6. Things have been getting on top of me: ○ **3** Yes, most of the time I haven't been able to cope at all ○ **2** Yes, sometimes I haven't been coping as well as usual ○ **1** No, most of the time I have coped quite well ○ **0** No, I have been coping as well as ever
7. I have been so unhappy that I have had difficulty sleeping: ○ **3** Yes, most of the time ○ **2** Yes, sometimes ○ **1** Not very often ○ **0** No, not at all
8. I have felt sad or miserable: ○ **3** Yes, most of the time ○ **2** Yes, quite often ○ **1** Not very often ○ **0** No, not at all

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Self–testing for depression during pregnancy and the postnatal period

Fact Sheet

9. I have been so unhappy that I have been crying: ○ **3** Yes, most of the time ○ **2** Yes, quite often ○ **1** Only occasionally ○ **0** No, never
10. The thought of harming myself has occurred to me: ○ **3** Yes, quite often ○ **2** Sometimes ○ **1** Hardly ever ○ **0** Never NB: If you have had ANY thoughts of harming yourself, please tell your GP or midwife today.

Results

This information is offered as a guide only and not a substitute for seeking professional help. Please discuss your symptoms with your doctor, midwife or nurse if you have any concerns. Remember that the self-test scores apply to the ***last seven days***. Use the guide below in relation to your most recent self-test.

Range of Scores

0 - 9 When scores are in this range, this may indicate the presence of some symptoms of distress that may be short-lived and are not likely to interfere with day-to-day ability to function at home or at work. However, if these symptoms persist for more than a week or two, you may wish to discuss this with your doctor, midwife or child and family health nurse.

10 – 12 Scores within this range indicate presence of symptoms of distress that may be discomforting. You can discuss these with a health professional if you are concerned. We suggest that you repeat the self-test in 1-2 weeks time. If the scores are still within this level, seek further advice.

13+ Scores above 13 require further evaluation by a health professional. You may be asked to repeat the self-test and if your score is still within this range, you may be advised to review your results, with the assistance of a mental health professional. Your doctor will be able to advise you about this, and about whether further treatment is needed.

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Appendix 16.2: Current suicide risk evaluation

	Sample questions that might be used
Current mood state, or situation	How are you feeling at the moment? What is happening in your life that is causing you distress?
Frequency and intensity of suicidal thoughts	Have you had any thoughts of harming yourself? Of harming your baby? How often do these occur? How long do they last? What is usually happening just before you have these thoughts? Do you feel you can resist the thoughts?
Established plans to self-harm	Have you any plans at the moment to harm yourself? What have you thought about? Do you have the means available to harm yourself, e.g do you own, or have access to a gun? Are final arrangements being considered, e.g have you recently recorded a Will, or said a 'final' goodbye to friends or family?
Past history of suicide attempts	Have you harmed yourself in the past? Have you had thoughts of suicide in the past?
Thoughts, feelings and beliefs that stop the completion of a suicidal act	What stops you from harming yourself?
Openness to other solutions	Would you be willing to talk to someone about your problems? What other options do you see for yourself?
Supports	Who can you talk to about how you are feeling? Who is available to provide some practical assistance?
Substance use	Have you been drinking more alcohol, or taking more drugs lately? How much have you been drinking or using?
Coming events that may increase the suicidal risk	Is there anything coming up in the future that is going to be particularly difficult for you—such as anniversary dates, or family occasions—that will cause you extra stress?
Family history	Has anyone in your family been depressed or had mental health problems?