WA COUNTRY HEALTH SERVICE (WACHS) STAFFING NEEDS ANALYSIS

For positions to be funded by the National Perinatal Depression Initiative

WA Country Health Service and WA Perinatal Mental Health Unit
September 2010

NATIONAL PERINATAL DEPRESSION INITIATIVE
Funded by the Australian Government:
Department of Health and Ageing
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- WA Country Health Service – Mental Health
- WA Country Health Service - Population Health
- WA Perinatal Mental Health Unit (WAPMHU)

Acknowledgements

We acknowledge the following for generously contributing their time and expertise:

- Sue Ferguson-Hill, Senior Project Officer, Perinatal Depression Project, WA Country Health Service – Mental Health.
- WA Country Health Mental Health Service teams, WA Country Health Population and Public Health team members in the seven WA regional areas – Goldfields, Great Southern, Kimberley, Midwest, Pilbara, South West, and Wheatbelt.
- Aboriginal Medical Services in the regions.
- Non-Government organisations in each region.
- Non-Government organisation Ngala which provides a WA statewide service.
- Consumers – especially Midwest, Kimberley and Goldfields regions.
- From the Heart WA (formerly PNDSA Organisation, WA)
- Clinical Nurse Specialists from the North Metropolitan Integrated Service Model.
- Mother and Baby Unit – WNHS.

Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AHW</td>
<td>Aboriginal Health Worker</td>
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<tr>
<td>CHN</td>
<td>Child Health Nurse</td>
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<tr>
<td>DoHA</td>
<td>Department of Health and Aging</td>
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<tr>
<td>DMO</td>
<td>District Medical Officer</td>
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<tr>
<td>DSM-IV</td>
<td>Diagnostic and Statistical Manual for Mental Disorders – Version IV.</td>
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<tr>
<td>EPDS</td>
<td>Edinburgh Postnatal Depression Scale</td>
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<tr>
<td>FTE</td>
<td>Full Time Equivalent</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>KEMH</td>
<td>King Edward Memorial Hospital</td>
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<tr>
<td>MBU</td>
<td>Mother and Baby Unit, KEMH.</td>
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<tr>
<td>MHN</td>
<td>Mental Health Nurse</td>
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<tr>
<td>NHMRC</td>
<td>National Health and Medical Research Council (Australia).</td>
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<tr>
<td>NPDI</td>
<td>National Perinatal Depression Initiative</td>
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<tr>
<td>PAD</td>
<td>Perinatal Anxiety Disorders</td>
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<tr>
<td>WACHS</td>
<td>Western Australia Country Health Service</td>
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<tr>
<td>WNHS</td>
<td>Women’s and Newborn Health Service</td>
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<tr>
<td>WAPMHU</td>
<td>Western Australia Perinatal Mental Health Unit</td>
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Note: The term ‘Indigenous’ is used with respect throughout this document and refers to Australian Indigenous people i.e. of Aboriginal and/or Torres Strait Islander descent.
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EXECUTIVE SUMMARY

Across Australia, depression affects up to one in five women in the postnatal period and an estimated one in ten during pregnancy. Maternal depression during the perinatal period\(^1\), if left undiagnosed and untreated, impacts on the mother’s ability to bond with her baby, infant attachment and family relationships. The National Perinatal Depression Initiative (NPDI) Framework outlines a commitment by the Commonwealth, State and Territory Governments to improve outcomes for women and their families at risk of, or experiencing, perinatal depression. From this commitment Western Australia receives $3.6 million in Commonwealth funding staggered over 2008-2013 financial periods. The Commonwealth and jurisdictions agreed to address perinatal depression through the key activity areas of workforce development and training, universal and routine screening, treatment care and support, community awareness and data collection.

Under the key activity area of treatment care and support, the WA investment plan includes a funding allocation to employ specialist workers in perinatal depression in rural areas: 2.0 FTE commencing in the 2010/2011 period, with an extra 1.0 FTE allocation in 2011/2012. Through the WA Perinatal Mental Health Unit (WAPMHU) and WA Country Health Service (WACHS), a project officer was appointed from April to July 2010 to identify existing services, investigate regional needs and determine the best possible placement of NPDI positions in rural WA. This report outlines the findings from the scoping work undertaken by the project officer and provides recommendations for the placement of the NPDI positions in rural WA.

Method

The Project Officer used a number of strategies to obtain information from staff and consumers in WACHS regional areas. The scoping project included online surveys, face to face and phone interviews as well as focus groups with Mental Health, Population Health, Maternity Services, Aboriginal Medical Services, consumers, General Practice, and other Non-Government organisations. Major themes were extracted from qualitative data and descriptive statistics from quantitative data.

\(^1\) For the purpose of NPDI implementation, the perinatal period is from conception to 12 months after the birth of the baby. Depression is defined in accordance with DSM IV, noting that the term “perinatal” is not recognised.
Summary of findings

Demographics
A total of 196 people were interviewed and 174 people responded to a web-based purpose designed questionnaire. This included 30 responses from consumers. Questionnaire respondents included child health nurses (31% n=53), midwives (16% n=28), mental health nurses (13% n=22), community health nurses (10% n=18), health workers (4% n=7), social workers (4% n=6), clinical psychologists (2% n=4), GP Obstetricians (2% n=3), and others (19% n=33). Regional representation was reasonably well spread with a range from 19 to 20% of responses in the South West, Wheatbelt, Goldfields and Kimberley regions, and between 6 to 10% from Midwest, Great Southern and Pilbara.

According to the WA Planning Commission (2005), out of all WACHS regions the Goldfields, Midwest, Wheatbelt and South West demonstrate the highest projected population growth to 2016.

Service provision
Across rural WA, participants reported many activities and programs being conducted to address perinatal depression. Recent evaluation of some of these programs demonstrated positive outcomes for women and their families. Programs included:

- “Bouncing Back” in the Great Southern
- “Best Start” programs in Women’s Health Centres
- “New Directions Mother and Baby Services” in Aboriginal Health, and
- Better Outcomes in Mental Health Care through Access to Allied Psychological Services (ATAPS) schemes.

Despite the existence of highly valued programs, participants also identified service gaps across all regional areas, in particular inadequate and/or inaccessible perinatal mental health services for women diagnosed with, or at high risk of, depression. In areas with some access to services, there were perceived inequities with poor coordination, collaboration and integration between organisations. In some
instances, staff were unaware of perinatal mental health services provided in their local region or by statewide or national organisations.

Service enhancement
It was clear from the responses (78%, n=92) that the respondents felt the perinatal depression positions should be placed within a Population Health framework of service. Many of the participants perceived community health as family oriented, non-stigmatising and accessible to mothers and babies. In addition they felt community health was better placed to provide multi-disciplinary services.

To ensure the role of the allocated perinatal depression positions are well defined, participants were asked to provide suggestions on the model of care that best suited rural practice. Respondents viewed the positions as complementary to existing services with the aim of improving the experiences for women and their families as they adjusted to pregnancy and parenthood in the context of emotional health and wellbeing. It was also important that the positions are able to offer support for health care providers to increase confidence in identifying and dealing with perinatal depression. Many respondents believed midwives, in those regions that had maternity services, were an under-utilised resource particularly in the antenatal period.

The model of care needs to demonstrate a clear pathway to improving clinical outcomes through consultation, advice and liaison, enhancement of perinatal depression services, educational opportunities for health service providers, consumers and the general public.

Workforce Development and Education
Participants reported a varied level of expertise, knowledge and skill in respect to perinatal depression and infant mental health with most identifying the need for more up to date information. From the questionnaire, 52% (n=67) of respondents self-rated their knowledge of depression as above average, with 36% (n=46) requiring updating. The main areas the respondents felt they required updating in included but not limited to:

- perinatal depression risk factors
• screening
• management
• prevention, and referral systems.

Concerns were raised that access to educational opportunity was limited. Respondents reported difficulties in being released from the workplace and travel to the metropolitan area or major regional centres to attend workshops and seminars a barrier. Consumers also raised concerns that information about perinatal depression was not readily or easily available. Although infant mental health was out of scope for this project, it is a significant poor outcome of perinatal depression and deficits in health professional and consumer knowledge base need to be considered by health services.

Recommendations
From the scoping project, it is clear that all regional areas have high need for perinatal mental health specialist services. In order to allocate the perinatal mental health specialist positions the following principles were considered:
• strength of existing structures to support the program
• level of engagement with stakeholders
• application of limited funding as broadly as possible whilst not compromising the integrity of the proposed program
• greatest impact on the greatest number

The significant level of community engagement in the Great Southern, Pilbara and Kimberley regions is acknowledged however, given the universal nature of perinatal depression, it is recommended the positions in this initial funding round target the regions with the highest populations and birth numbers. The successful implementation of this initiative will support extending perinatal mental health services into these regions, either through the NPD1 process or other funding streams.

Based on the findings from the scoping report and the principles outlined above the following is recommended:
• That the specialist perinatal depression positions are based in Population Health and located in Wheatbelt (1 FTE), Midwest (0.5 FTE), Goldfields (0.5 FTE) servicing towns and surrounding districts. In 2011/2012, a further 1.0 FTE be situated in the South West Region.

• That the WA Perinatal Mental Health Unit provide educational support to the new positions; provide coordination and networking between incumbents, as well as support links with specialist perinatal mental health personnel in Women and Newborn Health Service.

• That the role of the specialist perinatal depression staff is primarily consultation and liaison and the provision of collegial support for regional health professionals. The role is also to include provision of workforce development for health staff particularly in perinatal depression screening and management, coordination of and linkages with other agencies, maternity units and GP practices as well as providing perinatal mental health leadership.
INTRODUCTION

The National Perinatal Depression Initiative (NPDI) has made funding available for specialist positions that will support women with perinatal depression in country Western Australia.

Through the WA Perinatal Mental Health Unit (WAPMHU) and WA Country Health Service (WACHS), a project officer was appointed from April to July 2010 to identify existing services, investigate regional needs and determine the best possible placement of NPDI positions in rural WA.

Aim

The aims of the staffing needs analysis were to:

1. Make contact with existing mental health and population health services across the state
2. Determine regional needs in relation to perinatal mental health, with consideration for population trends, level of isolation and current infrastructure
3. Develop a plan for the best placement of perinatal mental health specialist positions, to be funded by the NPDI.

Background

Beyondblue (2010) notes that the perinatal period is an exceptional time of life with constant and unpredictable change being a significant factor for the woman and her family. Emotional lability is common but usually resolves spontaneously with support from family and friends. For some women, pregnancy and early parenthood triggers symptoms of more serious mental health problems ranging from emotional distress to depression and anxiety.

Findings from the literature

Detecting and treating perinatal mental health disorders is vitally important as there is strong evidence for serious adverse consequences for mothers, infants, and families if left untreated (beyondblue: The national depression initiative, 2006).
• In the perinatal period, suicide and haemorrhage are the equal most common causes of maternal death in Australia (Buist et al., 2005)

• Postnatal depression is estimated to be prevalent in 10-15% of first time mothers in western populations generally, and 14% in Australia (Milgrom, Ericksen, Negri, & Gemmill, 2005). However, Buist et al (2008) state in their findings from the beyondblue National program (2007) that 16% is a more likely figure.

• Postnatal depression is frequently unrecognised and untreated (Buist, et al., 2005; Hendrick, 2003; Statewide Obstetric Support Unit, 2006)

• One quarter of those women identified as potentially depressed during the beyondblue National program did not seek or accept help (beyondblue: The national depression initiative, 2006)

• 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 (Buist, 2006)

• Significant antenatal or postnatal anxiety may increase the risk of developing postnatal depression (Heron, O'Connor, Evans, Golding, & Glover, 2004).

• Approximately 50 – 80% of women will experience postnatal or baby ‘blues’ in the first few days after the birth ((beyondblue: The national depression initiative, 2008; State Perinatal Reference Group & WA Perinatal Mental Health Unit, 2007).

• Severe ‘blues’ in the immediate postnatal period may be linked to later onset of postnatal depression (Glover & O'Connor, 2002)

• Co-morbid anxiety is reported in postnatal depression in 30 – 40% of cases (Misri, Kim, Riggs, & Kostaras, 2000).

• Disturbed maternal bonding leading to poor infant attachment may negatively influence cognitive, emotional, social and behavioural development of the infant both in the short and long term (Austin, Leader, & Reilly, 2005; O'Connor, Heron, Golding, & Glover, 2003)

• 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).
In 2008 the birth rate for Australian adolescent women was 17.3 per 1000 adolescents (Australian Bureau of Statistics, 2009). Adolescent mothers are up to three times more likely to experience postnatal depression than older mothers (Swann, Bowe, McCormick, & Kosmin, 2003).

**The National Perinatal Depression Initiative (NPDI)**

The National Perinatal Depression Initiative (NPDI) “aims to improve prevention and early detection of antenatal and postnatal depression and provide better support and treatment for expectant and new mothers experiencing depression” (Department of Health and Ageing, 2010).

The Australian Government has committed $30 million to the NPDI over five years (2008/2009 to 2012/2013), to be divided amongst States and Territories on a population basis. WA has been allocated $3.6 million, and the Government of WA has contributed an additional several million dollars (Australian Health Ministers' Advisory Council, 2009).

The NPDI covers several key activity areas:

- routine and universal screening for perinatal depression using the Edinburgh Postnatal Depression scale;
- follow up support and care for women assessed as being at risk of or experiencing perinatal depression;
- workforce training and development for health professionals; and
- community awareness.
METHODOLOGY

There were three stages to the Staffing Needs Analysis: planning, consultation and data collection and an analysis.

Planning

A Project Steering group was formed to help guide the project and consisted of representatives from WACHS Mental Health, WACHS Population Health and the WA Perinatal Mental Health Unit.

The project officer developed a questionnaire for service providers (see Appendix A). It was developed for use online (via SurveyMonkey.com) and in verbal exchanges (face-to-face interviews, focus groups and phone conversations).

Existing services around the state were identified (see Appendix B), and a schedule of visits/contacts was created. The Project Officer notified stakeholders in WACHS regions before visits, in order to organise focus groups. The Project Officer also planned a statewide case audit with the aim of calculating the number of women presenting to services with perinatal depression issues.

Consultation/data collection

Cargo and Mercer (2008) contend that participation in research activities encourages ownership of research outcomes and recommendations with enhanced likelihood of recommended changes being applied to practice, compliance with altered protocols and policies, and increased motivation. The value of participatory activities is demonstrated in this project by both the number of responses and the robust statements of respondents.

Participants in the consultation stage were advised that their responses would be de-identified and during collation in order to respect their privacy and also to promote honest responses.
Attempts at a statewide case audit were unsuccessful, as data collection procedures were not standardised across services or the different regions of WA.

The consultation and data collection stage produced information that was supplementary to this report and has been attached as Appendix C, for noting by WACHS, health services and Indigenous health services.

Analysis

Respondent comments are presented and discussed in the next section of this report, Summary of Findings. The discussion makes note of gaps in current service provision, provides suggestions for service enhancement, and identifies education and training needs for service providers. Population projection data and birth data are presented in the rationale section.

Limitations of the data

This data presents a ‘snapshot’ of services as at June 2010. Every effort was made within the time-frame to ensure that project-related information and invitations to participate were widely disseminated to all WA regional areas to ensure inclusivity and diversity of responses. Some stakeholders unfortunately were on leave at the time, or unavailable to respond due to work commitments, while others did not respond. Thus the responses presented in this report may not reflect the opinions of all health providers and consumers in rural and regional WA.

There is a possibility that participation in the data collection process may result in changes in practice, due to reflection and information exchange.
SUMMARY OF FINDINGS

This section of the Staffing Needs Analysis presents responses from health service providers across the state. Responses were collected through a variety of consultation methods. The responses are organised into three categories: those relating to service provision, those relating to service enhancement, and those relating to education needs.

Respondents

<table>
<thead>
<tr>
<th>Mode of consultation</th>
<th>Number of consultations</th>
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<tbody>
<tr>
<td>Online questionnaire, via SurveyMonkey.com (with WACHS staff)</td>
<td>174</td>
</tr>
<tr>
<td>Regional face-to-face or phone interviews (with staff from WACHS Mental Health, WACHS Population Health, Aboriginal Medical Services, hospitals and NGOs)</td>
<td>196</td>
</tr>
<tr>
<td>Consumer responses – hard copy or emailed questionnaire response (with participants from postnatal depression groups)</td>
<td>30</td>
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**Overview of online questionnaire respondents**

A variety of professionals responded to the online questionnaire. All WACHS regions were represented in the responses.
Figure 1: Online survey respondents by profession (N=174)

- Midwife (n=28, 16%)
- Child Health Nurse (n=53, 31%)
- Mental Health Nurse (n=22, 13%)
- Community Health Nurse (n=18, 10%)
- Social Worker (n=6, 4%)
- Other (n=33, 19%)
- Clinical Psychologist (n=4, 2%)
- Health Worker (n=7, 4%)
- GP Obstetrician (n=3, 2%)

Figure 2: Online survey respondents, by WACHS region (N=174)

- Wheatbelt - (35) 20%
- Goldfields - (32) 19%
- Sth West - (37) 21%
- Kimberley - (33) 19%
- Pilbara - (10) 6%
- Midwest - (16) 10%
- Gt Southern - (11) 6%
Service Provision

Two of the online questionnaire items asked respondents for their feedback on current service provision.

Knowledge of existing services

Respondents were asked, “What services are available in your community for women or men experiencing perinatal depression?” There were over 122 responses. These ranged from ‘None’ to a reasonably comprehensive list of regional health service providers including GP, mental health assessment and management team, Division of GP counselling services, Department of Child Protection parenting support, and Child Health.

Few references were made to community/peer support services, non-Government organisations, phone line services, self-help options, private services, tertiary or hospital services. This may indicate a lack of availability or a lack of awareness of these services.

Some responses are presented verbatim below.

None!

Limited!

Very, very few services are available in [large regional area]. If you have a severe mental illness, you will receive treatment. However, if you have anxiety or depression, there are few options open.

Very few that I am aware of.

For men I have no idea. For women we have one person to refer them to, mental health can at times be complicated especially after hours. GP.. A good flow chart of whom to contact for degrees of depression would be great and those people have to be easily available

Mental health service in another town 40 minutes drive away – They are generally good but have not been able to provide psychology service due to being unable to employ anyone – they have outsourced this service but still deficient. Counselling services are very limited and not easy to refer to, i.e. some only take GP referral. Some GPs not well versed in PND or mental health illness in general.

... Social and Emotional workers in AMS, Aboriginal Women’s group …
Several respondents noted limited capacity for services to provide early intervention for a number of reasons including but not limited to:

- time-limited visits
- a part-time workforce
- difficulties in providing outreach programs
- lack of community awareness of services, and lack of appropriately skilled personnel.

**Perceived adequacy of existing services**

Respondents were asked, “do you believe services are adequate?” There were 122 responses to this question online. 105 respondents (86%) believed services were inadequate, while 17 of the online respondents (14%) said they believed existing services were adequate.

**Service Enhancement**

Respondents identified several reasons why services were inadequate, and their comments highlight areas for improvement:

- coordination
- referral pathways
- service access
- service standards
**Reasons for perceiving services as inadequate**

Respondents were asked why they believed services were inadequate. This led many to identify problems with existing services and ways they could be improved.

Reponses of service providers are categorised below into two themes: lack of coordination and lack of referral systems.

**Lack of Coordination**

Respondents identified that there is limited coordination, collaboration, and integration of services in most communities.

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*Better coordination of services [is needed]. Lack of services to remote areas. Better education on (perinatal mental health) to men/partners. More practical assistance to mothers so they can engage fully in therapeutic programs e.g. counselling, groups, physical and social activities. Upskill mental health professionals in remote areas in perinatal mental health so services are more accessible and provide these professional with a network of support.*

Many women are in the community with no supports from family so any service that pulls together networks of service providers, and of consumers, will benefit the women.

[Someone] clearly identified as a resource person who is available to manage people suffering from PND. [There is] concern that people are left unsupported in the community due to unclear processes and lack of knowledge of availability of interventions required.

Parents worry that they may have their children removed from their care or be judged as ‘bad parents’ if they admit they are not coping. Services more specific in supporting mothers in early pregnancy and post delivery would help. Better community education. We tend to see the results of the lack of services in terms of behaviour in children with attachment issues often because of untreated PND.

As a MH service, I think we should be able to do more, including health promotion activities, however due to our own staffing issues, we are unable to provide this, and therefore often only reactive to enquiries and referrals.

There is plenty of choice [in this area] however there have been mix ups in the referral process and patients have been kept waiting overly long

*Improve by better detection - liaising with midwives + child health (poor communication at present).*
Mental health could be more helpful. When you refer it needs to go to an intake meeting, they really often only provide a diagnosis and then the women are sent elsewhere for treatment. Sometimes this takes a long time and becomes disjointed, and the women have to keep telling their story often, they don’t have the coping skills and miss appointments or just don’t get there. Need more home visiting services to support the families.

Many women are in the community with no supports from family so any service that pulls together networks of service providers, and of consumers, will benefit the women

Not coordinated enough. Lack of communication between agencies. Not enough resources dedicated to detection and prevention…

These positions will provide the opportunity for ‘drawing in’ a cohesive team attitude – a team focussed on perinatal mental health, open to ALL to input, and listening to the conversations, with an avoidance of ‘gate-keeping’. Include community based organisations such as child care centres. Knowing you’re working together, and not isolated is important.

The position could open the door for people getting effective service access. An ability to work across disparate organisations in order to get them together will be essential.

The mother, baby and family need an advocate to help navigate through the system.

The positions need to ensure advocacy within their own services for the value-adding to the national program as well.

Better systems to ensure that the PND screens are conducted. Better referral processes. Better monitoring of the outcome of those referral processes.

Respondents noted that the lack of coordination results in limited follow-up of women at risk and also affects the integrity of referral pathways.

Lack of referral pathways
The Framework for the National Perinatal Depression Initiative (Australian Health Ministers' Advisory Council, 2009) notes that ‘appropriate care pathways must be identified and developed that will enable sustainable services that address the needs of women experiencing mild, moderate or severe symptoms of perinatal depression’ (p.8). Respondents agreed, highlighting a lack of referral pathways as a major issue.
The comments included:

…there may be other problems such as for women who experience a miscarriage, or stillbirth, perinatal mental health services are not adequate – families are mainly left to their own devices. They may be referred on to Perth – but its up to the individual.

We need a specific PND referral point, we don’t have anywhere to refer women or men at risk to!

… More psychologist services, esp [sic] with a specialised service/clinic. Waiting times greater than 1-2 weeks seems ineffective as women lose momentum in attending. More public awareness to reduce shame.

GP services are often busy and not appropriate as an ongoing therapy for people experiencing depression.

Its hard to find out what exists, and how to access it. Little services for young mums or indigenous women. No coordination across services.

Service for women is great, maybe needs extending to include men.

Very high turn-over of staff in mental health area. Makes it difficult to maintain rapport. GPs have very long wait list here. Incentives for staff wanting to work in area are required. More staff creating a more supportive working environment less burnout!

I have received feedback from several clients who have been referred to Mental Health that they do not feel at ease talking with a male (mental health nurse), as their issues are largely resulting from abusive/problematic relationships with men/a male. These clients often then do not re-attend appointments and fail to receive the assistance required. We have female counsellors we can refer to, however, if the client has had any suicidal ideas, we can only refer to the Mental Health team, who are male.

I believe most child health nurses are very proficient in screening and assessing women and men for anxiety and PND but most of us have very few referral systems.

Appropriate referral systems for our area; latest research and management of perinatal depression; stress and anxiety disorders and appropriate treatment; PND and anxiety in men

Identifying appropriate referral pathways for women with EPDS (sic) for our region. Clearly identifying point at which referral [to a specialist service] is required

[Need to know]… what referral pathways we can use … other than the local GP.

We need a specific PND referral (sic) point. We don’t have anywhere to refer women or men at risk to!
Referral pathways will need to be localised and contextually appropriate. Key points raised in responses to the questionnaire included:

- Several regions have referral pathways in development
- EPDS trainers have undertaken the action of developing local referral pathways as a component of their training.
- There needs to be wide local consultation with all services accessed by women to ensure accurate information is included.
- Timeframes to responses by services in the pathway must be included.
- Regular review and update must be factored in to the process of referral pathways.

**Barriers to Service Access**

The summary of concerns expressed by many respondents centred around some aspects of GP service provision. The following points were categorised as barriers to access for care related to perinatal depression in regional areas:

- Cost of services – no bulk-billing other than health department services, and Aboriginal Medical Services.
- Debt accumulation in some service centres leading to inability to access that service.
- Limited time during visits for interaction and adequate assessment.
- Health professional deals with one condition per visit – even if a woman presents with perinatal depression it may not be reviewed or managed at the initial visit (GP may consider it isn’t the priority on the day).
- ‘Over-diagnosis’ – not taking the time to review all psychosocial (situational) factors impacting at the time.
- Over-use of medication (or no complementary options provided).
- Lack of collaborative or inclusive service provision.
- Limited feedback to other service providers – ‘not kept in the loop’.
A theme of many responses related to the reality of barriers arising due to service costs:

We can suggest referral for help but do the women then go? Many (we think) don’t because of the cost involved – there’s a money consideration in this region.

**Over-pathologising / medicalising normal life transitions**

Concerns were expressed by numerous respondents that there may be over-pathologising of perinatal distress or mild depression, and over-prescribing of medication by some regional GPs. Respondents suggested that services could be enhanced by including counselling and/or alternative modes of management.

Respondents felt that there was little discussion of some important issues, such as the consequences of a psychiatric diagnosis, or the side-effects of medication. Respondents stated this may have been due partly to time limited visits, suggesting that longer consults would benefit the patient and their family.

Concerns were raised over the lack of communication and feedback between local services and visiting GPs who prescribed medications. Increased social isolation may occur if the woman consults a GP outside the community as her situation may remain unknown to local service providers or possible community supports (*'it remains a problem well hidden').

Respondents note:

*Medication is frequently used as a quick fix and other options such as social supports in the community, or self-care management, are not discussed.*

*Medication side-effects (initially) may mean the woman [in this area – especially if living on a property] does not venture out, does not get the physical assistance she might actually get otherwise because she doesn’t talk about it, and may make her situation worse as she becomes even more tired/stressed.*

*The woman might be given medication outside the [remote] community but there is no follow-up in the community. We don’t know where the woman stores her medication, whether she takes it, if it is working for her …it’s worrying …*

*[We have] A visiting GP weekly who is generally not interested in mental health.*
Concerns were also expressed about perinatal mental health problems not being detected.

*Inconsistencies in service standards*

Responses indicated that some women and their families are being given inadequate and/or inaccurate information about perinatal emotional wellbeing.

Concerns were also raised about the risk of not detecting perinatal depression early if recommended practice guidelines were not followed.

*Education and Training Needs*

This section summarises the activity, findings and recommendations relating to the expressed educational needs of health service providers about perinatal depression prevention, detection, and management. The information is intended to assist the WAPMHU education team and interested health sector managers with professional development planning.

*Respondents’ self-rated level of perinatal mental health knowledge*

Respondents were asked, ‘How would you rate your knowledge of depression and anxiety that women and men can experience in the perinatal period?’ A total of 128 respondents answered the question. Their knowledge levels are presented in Figure 3.
Varied levels of expertise and up-to-date knowledge are noted in regional areas in relation to perinatal depression prevention and risk factor awareness, early detection, and management, especially in mild to moderate ranges of perinatal depression, and anxiety.

**Child Health Nurses (CHNs)**

Approximately 50% (n = approx. 38) of all CHNs (n = 75) who participated in the online questionnaire, focus groups and interviews determined that their knowledge base required updating. A further 15-20% (approximate) reported that their confidence level when using the EPDS was not good, while more than 2% noted that their knowledge level was ‘not good’ and a further 3% determined they were unsure.

Current practices relating to infant mental health and wellbeing when there are bonding and attachment problems were discussed as an identified educational need – e.g. Circle of Security principles and application.

It is of concern that statements included some Child Health Nurses in regional areas had not ‘had the opportunity for professional development / updates in PND’ in over 10 years.
Mental Health Nurses (MHNs)
Almost all MHN respondents acknowledged that their work with women and families was related only to the moderate to severe spectrum of perinatal mental disorders and that “the other end of the spectrum” was a distinct gap in knowledge, or required update. Consideration is to be given to educational activities related to ‘normal’ adjustment to parenthood, prevention (e.g. health promotion activities), early detection and early management, and infant mental health and wellbeing.

Midwives
Midwives felt they were ‘invaluable’ to the early identification of potential perinatal mental health problems for women and their families, and ‘a lost resource’, ‘don’t get a look in’. ‘Greater connection with other services is needed for midwives’.

However, midwives self-reported that they may not be taking opportunities presented to update or gain new knowledge when available, or do not have time to attend. Several stated that it is sometimes not seen as ‘core business’, especially if the midwife does not undertake antenatal clinic work as part of the role. The need for update of knowledge, or specific training in the area of perinatal depression was identified by almost all midwives who responded.

Psychiatrists
Several psychiatrists responded to questionnaires. One suggested that training in family focused care would enhance services.

Respondents’ self-identified education needs
Respondents were asked, “What areas of your knowledge of perinatal mental health (if any) do you believe would benefit from further education?” Over 100 respondents to the online questionnaire identified their educational needs.

Face-to-face and phone discussions allowed respondents to further elaborate on their educational requirements and concerns. Comments included:

We need information about detection, management, referral – all of it. Who is willing to see women/families experiencing PND? And some strategies that are helpful. Due to a variety of reason
[sic], some women are reluctant to access services so we all need to know how to begin helping with proven useful strategies.

I think it is beneficial to regularly update my skills in all areas mentioned – prevention, early detection, management, referral, medication, community supports.

Refreshing use of EPNS / and available referral processes – to ensure all up to date with current info.

...Education in ANC classes / for us, regarding perinatal depression in men. EPDS for men / partners. Update on management of PND. I haven’t been to an update for some time although I have been reading articles.

...further education is needed in screening men and discussing what referral pathways we can use … other than the local GP.

[Effects of perinatal depression] Clinical issues in parenting / attachment.

Appropriate referral systems for our area; latest research and management of perinatal depression; stress and anxiety disorders and appropriate treatment; PND and anxiety in men.

We have regular updates on use of EPNS [sic], referral systems and management of PND – these need to continue at least on an annual basis.

Clinical supervision with expert clinicians and ability to access advanced assessments …[would assist]

... I am sure that more local availability to professional development would be helpful. It is very difficult to attend pd in Perth due to time in travel, cost etc. Also time out of clinical area.

Community awareness on adjustment to parenting and relationship between PND and sleep deprivation for new parents; Parental high expectations; better relations with GP; coordinated local responses.

Given this [region] is classified as a difficult to staff area, any support to recruit and retain professionals in this area would be useful. i.e. access to relevant prof dev [sic], mentoring of existing staff to encourage development in the perinatal area would assist with future staff planning.

For the lay person in the community who have friends or family members with PND, they may not be aware of how they can support the person they know. More information needs to be available for the community as a whole.
Respondents reported varying levels of knowledge regarding infant mental health. Not all regions in WA have services with the capacity to address infant mental health issues. Relevant comments included:

At this time there is no provision to address the impact of depression on the infant itself and research has shown that addressing PND alone is not enough. Therefore I would like to see the service expanded to include infant mental health to reduce the likelihood of attachment disorders being seen later. …

We need to know more about applying the information from the ‘Circle of Security’ type work.

Respondents in many service centres noted that Aboriginal Health Workers (AHWs) also need education relating to perinatal depression, infant emotional health and wellbeing, and the impacts on the family. AHWs are well-recognised as a first point of contact for Indigenous women and their families.

The following table summarises the educational needs of respondents.
<table>
<thead>
<tr>
<th>Theme</th>
<th>Approx proportion of respondents who identified this need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management – current ‘recommended’ and ‘good’ practice</td>
<td>72%</td>
</tr>
<tr>
<td>EPDS – screening</td>
<td>62%</td>
</tr>
<tr>
<td>Medication + medication and breastfeeding</td>
<td>36%</td>
</tr>
<tr>
<td>Prevention, minimising risks, early detection</td>
<td>34%</td>
</tr>
<tr>
<td>Referral Systems</td>
<td>34%</td>
</tr>
<tr>
<td>Anxiety postnatally – detection and management</td>
<td>30%</td>
</tr>
<tr>
<td>Regular updates / Annual reviews / refresher</td>
<td>30%</td>
</tr>
<tr>
<td>Infant mental health, attachment issues, mother/infant psychotherapy</td>
<td>27%</td>
</tr>
<tr>
<td>Antenatal stress and anxiety</td>
<td>26%</td>
</tr>
<tr>
<td>Cultural considerations in mental health and wellbeing</td>
<td>26%</td>
</tr>
<tr>
<td>Pathways</td>
<td>23%</td>
</tr>
<tr>
<td>Screening vs assessment</td>
<td>22%</td>
</tr>
<tr>
<td>Perinatal depression and anxiety in men</td>
<td>18%</td>
</tr>
<tr>
<td>Perinatal mental health – what is ‘normal’?</td>
<td>18%</td>
</tr>
<tr>
<td>Perinatal mental health disorders</td>
<td>15%</td>
</tr>
<tr>
<td>Boosting health service provider confidence</td>
<td>15%</td>
</tr>
<tr>
<td>Management of acute episodes.</td>
<td>14%</td>
</tr>
<tr>
<td>Grief and loss/ PTSD/ Debriefing post birth</td>
<td>12%</td>
</tr>
<tr>
<td>Up to date research, and state-wide projects</td>
<td>11%</td>
</tr>
<tr>
<td>Management if client declines referral forward (continues with CHN though)</td>
<td>10%</td>
</tr>
<tr>
<td>Education to broader community</td>
<td>10%</td>
</tr>
<tr>
<td>Integrated services – how to facilitate this.</td>
<td>7%</td>
</tr>
<tr>
<td>Community services / programs available which best support women and families</td>
<td>7%</td>
</tr>
<tr>
<td>Making the most of limited resources.</td>
<td>6%</td>
</tr>
<tr>
<td>Understanding the ‘void’ – what happens AFTER referral?</td>
<td>6%</td>
</tr>
<tr>
<td>Interactive case studies (with answers)</td>
<td>6%</td>
</tr>
<tr>
<td>Data recording – understanding why and how it is used, correct coding</td>
<td>6%</td>
</tr>
<tr>
<td>Understanding issues for service providers in managing perinatal depression</td>
<td>5%</td>
</tr>
<tr>
<td>Roles and responsibilities – Who follows up? Legalities?</td>
<td>5%</td>
</tr>
<tr>
<td>Group facilitation training – when/where to move the client on from therapy group</td>
<td>5%</td>
</tr>
<tr>
<td>Diagnosis - when is it determined that the diagnosis has changed (better or worse). How is this recorded?</td>
<td>4%</td>
</tr>
<tr>
<td>eHealth – videoconferencing / telepsychiatry</td>
<td>3%</td>
</tr>
<tr>
<td>Appropriate resources/ brochures – availability</td>
<td>3%</td>
</tr>
<tr>
<td>What funding opportunities are there for relevant programs?</td>
<td>2%</td>
</tr>
<tr>
<td>How to access funding / grant writing.</td>
<td>2%</td>
</tr>
</tbody>
</table>
Some respondents identified the issue of self-responsibility for seeking professional education, and personal accountability for practice standards. Barriers to accessing education include distance and time constraints due to the demands of core business, especially in rural and remote areas. Respondents also felt Management should consider its responsibility to provide professional development opportunities for staff within their scope of practice. The development of eLearning modules by *beyondblue* and other agencies may assist in training staff, as long as they have adequate access to computing resources and the internet.

**Rationale For Placement Of NPDI Positions**

It is clear that all WACHS regions have a high need for perinatal mental health specialist services. It is vital to consider population projections and birth statistics to make informed recommendations for NPDI position placement.

**WA population projections**

<table>
<thead>
<tr>
<th></th>
<th>2004</th>
<th>2006</th>
<th>2011</th>
<th>2016</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goldfields</td>
<td>55,037</td>
<td>55,333</td>
<td>62,214</td>
<td>65,825</td>
<td>69,630</td>
</tr>
<tr>
<td>Great Southern</td>
<td>54,582</td>
<td>55,769</td>
<td>60,545</td>
<td>64,810</td>
<td>68,805</td>
</tr>
<tr>
<td>Kimberley</td>
<td>31,973</td>
<td>31,928</td>
<td>47,322</td>
<td>55,492</td>
<td>63,959</td>
</tr>
<tr>
<td>Midwest</td>
<td>60,222</td>
<td>61,364</td>
<td>68,266</td>
<td>72,138</td>
<td>75,925</td>
</tr>
<tr>
<td>North Metro</td>
<td>818,054</td>
<td>851,757</td>
<td>940,515</td>
<td>1,027,843</td>
<td>1,131,933</td>
</tr>
<tr>
<td>Pilbara</td>
<td>41,980</td>
<td>44,089</td>
<td>46,994</td>
<td>50,570</td>
<td>53,486</td>
</tr>
<tr>
<td>South Metro</td>
<td>712,620</td>
<td>742,552</td>
<td>861,022</td>
<td>961,815</td>
<td>1,050,024</td>
</tr>
<tr>
<td>South West</td>
<td>134,796</td>
<td>142,999</td>
<td>162,369</td>
<td>178,826</td>
<td>193,978</td>
</tr>
<tr>
<td>Wheatbelt</td>
<td>73,370</td>
<td>73,590</td>
<td>80,166</td>
<td>87,080</td>
<td>94,225</td>
</tr>
<tr>
<td><strong>WA</strong></td>
<td><strong>1,982,634</strong></td>
<td><strong>2,059,381</strong></td>
<td><strong>2,329,413</strong></td>
<td><strong>2,564,399</strong></td>
<td><strong>2,801,965</strong></td>
</tr>
</tbody>
</table>

By 2016, the South West, Wheatbelt, Goldfields and Midwest are expected to have the highest populations. By their nature, population projections cannot take into account the effects of unprecedented events such as war, major global economic shifts, and natural disasters.
WA birth data by region

Table 2: WA Health region of residence and Aboriginality of women who gave birth in 2007
(Source: Nguyen, Gee, & Le, 2008)

<table>
<thead>
<tr>
<th>Health region of residence</th>
<th>Total births</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan</td>
<td>22,352</td>
</tr>
<tr>
<td>Non-Metropolitan</td>
<td></td>
</tr>
<tr>
<td>Kimberley</td>
<td>723</td>
</tr>
<tr>
<td>Pilbara</td>
<td>793</td>
</tr>
<tr>
<td>Midwest</td>
<td>954</td>
</tr>
<tr>
<td>Wheatbelt</td>
<td>969</td>
</tr>
<tr>
<td>Goldfields</td>
<td>1027</td>
</tr>
<tr>
<td>Great Southern</td>
<td>719</td>
</tr>
<tr>
<td>South West</td>
<td>2028</td>
</tr>
<tr>
<td>Total Non-Metropolitan</td>
<td>7213</td>
</tr>
<tr>
<td>WA Non-resident</td>
<td>57</td>
</tr>
<tr>
<td>OVERALL STATE</td>
<td>29,622</td>
</tr>
</tbody>
</table>

The WACHS regions with the highest birth rates in 2007 were the Midwest, Wheatbelt, Goldfields and Southwest.

Respondent perspectives on placement of perinatal mental health positions

Respondents were asked, “Ideally, where would [the perinatal mental health] position be based, e.g. Community Health, or Mental Health? Why?” There were 118 responses to this question on the online questionnaire.
Table 3: online respondents’ preference for placement of perinatal mental health specialist positions

<table>
<thead>
<tr>
<th>Preference</th>
<th>% (n) of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health only</td>
<td>78% (92)</td>
</tr>
<tr>
<td>Community Health and/or Mental Health</td>
<td>9% (11)</td>
</tr>
<tr>
<td>Mental Health only</td>
<td>8% (9)</td>
</tr>
<tr>
<td>Hospital</td>
<td>2% (2)</td>
</tr>
<tr>
<td>Women’s Health</td>
<td>2% (2)</td>
</tr>
<tr>
<td>GP Centre</td>
<td>1% (1)</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2% (2)</td>
</tr>
</tbody>
</table>

Figure 1: online respondents’ preference for placement of perinatal mental health specialist positions

Comments from respondents included:

*Community Health* because often anxiety is relating to baby which the community health person could deal with as well, mother + baby need to be seen together as a unit.

*Community Health* as it can be incorporated into services provided for families.

*Community Health* because of the mythical stigma attached to mental health

*Coordinated out of community health* so differentiates between other mental health conditions

*Community Health*, clearly this is a community based need for easy access, especially in the early stages of primary prevention and short term interventions.

*Community Health*, stigma associated with Mental Health, and PND is about managing and ensuring positives of recovery, improving attachment to infant/children/partner, not ongoing negatives of other mental health issues.
Shared responsibility between mental health and pop health, but perhaps pop health is better placed in being the lead agency due to the whole pop health focus including Aboriginal Health.

Community - so that it is seen as a service that even people with low level perinatal health issues can access, as many mums with PND do not think they are serious enough to access mental health services.

Community Health as the most common point of contact is this area and it will take some of the stigma away from the issue if not in mental health - everyone has a poor understanding of this term.

I think it should be at Community Health - ideally where Child Health clinics are held because there will be better access to mothers & fathers and a multidisciplinary approach can be fostered.

Unsure about this one - for PND it would probably sit well in community or mental health. Maybe the person could work between the two sites?.

This is a difficult question but I think that I would have to go with Community Health because I believe to achieve optimum outcomes for families the people who work with these families are in the best position. If services are based in Community Health it also normalises seeking help a little more than parents attending Mental health services. I guess I am saying that I think parents would access services based in Community Health more.

During discussions, concerns were raised that if the positions were to be placed in mental health, the funding might be used to bolster clinical services for severe and persistent mental health disorders. This would detract from the NPDI deliverables of prevention, early detection and management of perinatal depression.

Most respondents preferred that the perinatal mental health specialist positions be placed in Community Health. Reasons for this included the reduction of stigma association with mental health and the opportunity to include infants in care. Some respondents suggested that the NPDI positions could ‘step between the two worlds of Mental Health and Community Health services’. However the ‘lack of coordination’ between the two services would limit the feasibility of such an approach.

Respondents also offered suggestions for the roles and responsibilities of the NPDI positions. Roles included consultation/liaison, education, coordination, monitoring,
advocacy and research. This information has been summarised and attached as Appendix D.
CONCLUSION AND RECOMMENDATIONS

The Perinatal Depression Project findings have affirmed the value of NPDI activities and the WA State Investment Plan as ways to improve and support perinatal depression services. Suggestions for service enhancement were based on identified needs of regional WA.

Respondents have presented a vision for an ‘ideal’ service and a potential position description (see Appendix D). They see the role would enhance existing services by facilitating change in prevention, earlier detection, and collaborative management processes related to perinatal depression. In addition the position responsibilities, when clearly defined, will align services provided in the regions with the national and state perinatal depression strategies.

Determining placement of positions from the available first round of funding and adjusting the roles of the new specialised positions to regional contexts is the next step, a process which has now been well informed by the perinatal depression project findings.

Recommendations

- That the specialist perinatal depression positions are based in Population Health and located in the Wheatbelt (1.0 FTE), Midwest (0.5 FTE), and Goldfields (0.5 FTE), servicing towns and surrounding districts. In 2011/2012, a further 1.0 FTE be situated in the South West Region.
- That the WA Perinatal Mental Health Unit provide educational support to the new positions, coordination and networking between incumbents, and links to specialist perinatal mental health personnel in Women and Newborn Health Service.
- That the position will focus primarily on consultation and liaison, and provide collegial support for regional health professionals. The responsibilities should include education, coordination and leadership in the field of perinatal mental health.
There is a significant level of community engagement in the Pilbara and Kimberley regions, however given the universal nature of perinatal depression, it is recommended that positions in this initial funding round be placed in the regions with the highest populations and birth numbers: namely the Goldfields, Wheatbelt, Southwest and Midwest. The successful implementation of this initiative will support extending perinatal mental health services into the Pilbara, Kimberley and Great Southern regions, either through the NPDI process or other funding streams.
REFERENCES


Hancock, H. (2006). *Aboriginal women's perinatal needs, experiences and maternity services: A literature review to enable considerations to be made about quality indicators*. Alice Springs, Northern Territory: Ngaanyatjarra Health Service.


APPENDICES

APPENDIX A: Questionnaire for Service Providers

APPENDIX B: Maps Showing Current Service Distribution

APPENDIX C: Supplementary Findings

APPENDIX D: Role Description
Appendix A: Questionnaire for Service Providers

Perinatal Depression Project
SurveyMonkey Questionnaire – April – June 2010

1. Welcome
   Welcome to our survey and thankyou for your participation. The survey will take about 10 minutes to complete. Results are de-identified from your name and email address.

   This survey is part of an information-gathering strategy about services in WACHS regional areas relating to Perinatal Depression. The Perinatal Depression Project is providing regional WA with an opportunity to input to the development of services related to perinatal depression.

   Your responses are important to us and are extremely valuable in providing contextual information when looking at the development of services in this field. Please complete and forward before Friday 25th June 2010.

   We acknowledge that your time is precious but your input is vital and is highly valued.

2. Demographic information
   * 1. Please indicate your occupation and WACHS region. [Use the dropdown menus]

3. Services for the management of perinatal depression in your region
   * 1. How would you rate your knowledge of depression and anxiety in the perinatal period that women and men can experience (during pregnancy and after childbirth)?
      Excellent / Above average / Needs updating / Not good / Unsure

      What areas of your knowledge of perinatal mental health (if any) do you believe would benefit from further education e.g. screening using the EPDS, referral systems, management of perinatal depression.

      * 2. What services are available in your community for women or men experiencing PND?

      * 3. Do you believe these services are adequate? Yes / No

      What do you believe could be done to improve the service provision?

      * 4. How accessible are these services in your area do you believe?
         Easily accessible / Somewhat accessible / Not accessible / Don’t know
Why did you select this response? What do you think could be done to improve service access by families in your area?

* 5. How would you go about referring someone you were concerned about for help?

* 6. In an ideal world, what do you believe a service catering for this period of time (the perinatal period) would look like?

* 7. What do you think should be in the Job Description for a position which is specifically working for women and men experiencing perinatal depression? Why?

* 8. Ideally, where would this position be based e.g. Community Health, or Mental Health? Why?

* 9. Do you have any other comments or suggestions?

Thankyou for your time. Please click on the 'Done' button to exit the survey.

You are welcome to contact us about the survey or the Perinatal Depression Project at any time up until 25th June 2010 when the project data collection will be finalised.

Sue Ferguson-Hill / Senior Project Officer / Perinatal Depression Project, WACHS
E: Sue.Ferguson-Hill@health.wa.gov.au
Phone: 0428 956 555
Appendix B: Maps Showing Service Distribution

Map 1: Distribution of Community Mental Health and Community Residential Accommodation (funded by WA Health)

(Source: The Centre for Social & Community Research, 2005)
<table>
<thead>
<tr>
<th>ID</th>
<th>Service Name</th>
<th>Service Location</th>
<th>Service Type</th>
<th>Stream</th>
<th>Service Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>South West Mental Health Service - Bridgetown Mental Health</td>
<td>Bridgetown</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
</tr>
<tr>
<td>29</td>
<td>Kimberley Mental Health and Drug Service - Broome Mental Health</td>
<td>Broome</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
</tr>
<tr>
<td>30</td>
<td>Richmond Fellowship of WA Inc.</td>
<td>South Bunbury</td>
<td>Community Residential Accommodation (CSRU)</td>
<td>General</td>
<td>NGO</td>
</tr>
<tr>
<td>31</td>
<td>South West Mental Health Service - Bunbury Living Skills Rehabilitation Centre</td>
<td>Bunbury</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
</tr>
<tr>
<td>32</td>
<td>South West Health Campus</td>
<td>Bunbury</td>
<td>Inpatient</td>
<td>General</td>
<td>Public</td>
</tr>
<tr>
<td>33</td>
<td>Richmond Fellowship of WA Inc.</td>
<td>Busselton</td>
<td>Community Residential Accommodation (CSRU)</td>
<td>General</td>
<td>NGO</td>
</tr>
<tr>
<td>34</td>
<td>South West Mental Health Service - Busselton Mental Health</td>
<td>Busselton</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
</tr>
<tr>
<td>35</td>
<td>Great Southern Mental Health - Katanning Community Mental Health</td>
<td>Katanning</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
</tr>
<tr>
<td>36</td>
<td>Pilbara Mental Health and Drug Service - Port Hedland Mental Health Unit</td>
<td>Port Hedland</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
</tr>
<tr>
<td>37</td>
<td>Pilbara Mental Health and Drug Service - Newman Mental Health Unit</td>
<td>Newman</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
</tr>
<tr>
<td>91</td>
<td>Baptiscare</td>
<td>Rangeway</td>
<td>Community Residential Accommodation (Transitional)</td>
<td>General</td>
<td>NGO</td>
</tr>
<tr>
<td>92</td>
<td>Fusion Australia (WA)</td>
<td>Geraldton</td>
<td>Community Residential Accommodation (CSRU)</td>
<td>General</td>
<td>NGO</td>
</tr>
<tr>
<td>93</td>
<td>Midwest Mental Health Service - Geraldton Mental Health</td>
<td>Geraldton</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
</tr>
<tr>
<td>105</td>
<td>Kimberley Mental Health and Drug Service - Derby Mental Health</td>
<td>Derby</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
</tr>
<tr>
<td>106</td>
<td>Kimberley Mental Health and Drug Service - Kununurra Mental Health</td>
<td>Kununurra</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
</tr>
<tr>
<td>107</td>
<td>South West Mental Health Service - Margaret River Mental Health</td>
<td>Margaret River</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
</tr>
<tr>
<td>108</td>
<td>Albany Halfway House Association</td>
<td>Albany</td>
<td>Community Residential Accommodation (CSRU)</td>
<td>General</td>
<td>NGO</td>
</tr>
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<td>109</td>
<td>Albany Halfway House Association</td>
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<td>Community Residential</td>
<td>General</td>
<td>NGO</td>
</tr>
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<td>110</td>
<td>Great Southern Mental Health - Albany Adult Community Mental Health</td>
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<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
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<tr>
<td>111</td>
<td>Albany Regional Hospital</td>
<td>Albany</td>
<td>Inpatient</td>
<td>General</td>
<td>Public</td>
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<tr>
<td>112</td>
<td>Midwest Mental Health Service - Meekatharra Mental Health</td>
<td>Meekatharra</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
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<td>113</td>
<td>Goldfields - Kalgoorlie Community Mental Health</td>
<td>Kalgoorlie</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
</tr>
<tr>
<td>114</td>
<td>Kalgoorlie Hospital</td>
<td>Kalgoorlie</td>
<td>Inpatient</td>
<td>General</td>
<td>Public</td>
</tr>
<tr>
<td>89</td>
<td>Midwest Mental Health Service - Carnarvon Mental Health</td>
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<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
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<td>90</td>
<td>Midwest Mental Health Service - Exmouth Mental Health</td>
<td>Exmouth</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
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<td>130</td>
<td>Goldfields - Esperance Community Mental Health</td>
<td>Esperance</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
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<td>157</td>
<td>Great Southern Mental Health Service - Narrogin Mental Health</td>
<td>Narrogin</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
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<tr>
<td>158</td>
<td>Pilbara Mental Health and Drug Service - Karratha Mental Health Unit</td>
<td>Karratha</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
</tr>
<tr>
<td>159</td>
<td>Pilbara Mental Health and Drug Service - Tom Price Mental Health Unit</td>
<td>Tom Price</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
</tr>
<tr>
<td>160</td>
<td>Wheatbelt Mental Health Service - Northam Mental Health</td>
<td>Northam</td>
<td>Community Mental Health</td>
<td>General</td>
<td>Public</td>
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</tbody>
</table>
Map 2: Distribution of mental health services in WA (including psychiatrists) in relation to the general population of children aged 0-3 years.

(Source: The Centre for Social & Community Research, 2005)
Map 3: Distribution of community health services in WA in relation to the general population of children aged 0-3 years.

(Source: The Centre for Social & Community Research, 2005)
Appendix C: Supplementary Findings

Inconsistency in data recording statewide

Attempts at a case audit were unsuccessful. There is a need for:

• Consistency and accuracy in terminology related to the perinatal period.
• Accurate diagnosis capture of any principal or additional diagnosis within this specific diagnostic group.
• Accurate data entry – coding and occasion of service.
• Accurate capture of data related to change in diagnosis.

This could be achieved through:

• review and improvement of data system linkage WA state and local databases (e.g. PSOLIS, HCARe, TOPAS).
• specifications for the type of data to be collected and by whom.
• education about data collection

Consumer perspectives

Consumers were invited to contribute to the Perinatal Depression Project to foster an updated understanding of the personal experience of perinatal depression and service provision, and consumer perspectives of what is considered necessary to improve early detection, early intervention, and management of perinatal depression.

A specific questionnaire designed for consumers was developed to be disseminated via consumer networks, and used as a framework for face-to-face discussions.

Respondents

There were 30 consumer respondents (all female), with 18 completing a formal questionnaire and 12 participating in informal discussions at different WA regional sites. The responses reflect both cultural and regional diversity with several Indigenous women participating in discussions and providing strong points about perinatal depression from their perspective.
Consumers were asked,

“what do you know about emotional or psychological problems that women and men can experience during pregnancy and following childbirth?

What impact do you think these problems have on women and their families?”

Responses included:

[I know] A lot! Emotional, physical and mental changes all bounce off each other pulling you in many different directions, you take on more than you should, you dig yourself deeper by trying to fix it. It can bring up past unresolved trauma. It changes who you are.

The impact to them and their families can be huge, with the mother feeling down and helpless most of the time, and the family feeling like there’s nothing that can help.

Could be draining, anxious, and could cause distance as you and your family are going through different experiences.

Severe! I myself, lost my home, partner and almost my son due to my ex-partner not understanding or choosing not to understand … couldn’t handle it, so kicked me out of my own home.

Consumers were invited to consider what would constitute an ‘ideal’ service for those women experiencing perinatal depression. Consumers were asked, “In an ideal world, what do you think a service catering for his period of time would look like?” Responses included:

Perhaps an all-in-one centre that could provide diagnosis as well as treatment …

Comprehensive screening by the maternity hospital in ante and postnatal period, to diagnose any concerns early.

Early intervention and screening at the beginning of pregnancy – start to get help as early as possible so that when baby comes you’ll be ready …

I think it’s important to educate women / men + families before, during and after the pregnancy. Putting strategies in place before or during pregnancy helps ensure support networks + services are there before they get to crisis point when the baby is born.

Prompt referral to appropriate counsellor … and also informed of other treatment options (e.g. exercise, relaxation, support groups …).
Less emphasis on the effects of PND on “the baby” and more emphasis on THE MOTHER! (or father)
– I found it infuriating that many professionals worry more about your child than about you!
Just because you have PND doesn’t mean you’re not meeting all of your child’s needs – more
often than not, the baby is fine as the mother is putting the child’s needs first, at the expense
of herself! Let’s focus on getting the mum well and stop going on about ‘the baby’ – this just
makes you feel worse and guilty that your condition is harming your baby ….

The opportunity to speak to other mums who have been through it and come out the other end (gives
you hope!).

A team of women and men with experience in PND that meet with pregnant women and new mothers
routinely (i.e. in hospital before discharge), and that are available to the community that
women can visit / ring when needed.

Breaking the stigma of PND and encouraging people to talk about depression will be made easier if
clinic nurses, GPs and midwives routinely talk to women (before and after they have a baby)
routinely, not just when they see warning signs. Women would be more inclined to talk about
PND etc if the subject was already open with a health professional – I know I would be more
comfortable to talk about it if someone started the subject – not just waiting for me to start
talking.

The notion of a safe and healing place for women to access and as the site for
service provision was raised numerous times in discussion with consumers, and was
also highlighted in written responses:

[The place should be] A SANCTUARY FOR NURTURE.

A friendly and open environment, somewhere women want to come.

More holistic care – women are nurturers and need to be nurtured and HONOURED and made to feel
SPECIAL.

Numerous responses indicate the need and desire for physical assistance
after the birth of a baby and reflect the isolation many women experience as they are
often away from family supports when living in rural and remote areas. Issues of
practical support raise points for consideration about the role of the new specialised
positions in communities (i.e. community development related activities) to assist
support services.

[An ideal service would provide] The help of a nanny type service for daytime to help with household
chores and help care of baby so mum can get some sleep.
[She] wished THE GOVERNMENT recognised that not only impoverished people need help, and she would just love some time from someone once a week, to help her with keeping her house slightly tidy and clean … One session a week would make her life manageable.

Country areas have limited services compared to Perth. Also to consider, many mums are home alone as their partners work away – mines / transport etc. I believe country women’s needs are different … and these should be addressed.

Guidance was sought as to where consumers considered specialised positions would be best situated. All consumer respondents indicated that the service should sit outside of mental health services. All respondents nominated Community Health with those in the positions able to mobilise and work between sites such as Aboriginal Health Services, women’s centres, community centres, the local hospital, or non-government community organisations.

Consumers were asked, “Ideally, where would this position be based?”

Responses included:

- Community Health – easily accessible and feel good going there.
- Community Health – Tired + stressed + lonely mums are not MENTAL and some mums might feel uncomfortable at mental health.
- Community Health – no one wants to think they have a mental health issue.

It is noteworthy that respondents recognised the therapeutic value of the psychosocial care given by health service providers with whom women stated they had a ‘good relationship’, and who they described as ‘trustworthy’, a ‘good listener’ and ‘respectful’. Simpson and Creehan (2008, cited in beyondblue: The national depression initiative, 2010) contend that attributes such as those described by the women are comforting, confidence building, and empowering for the woman and her significant other(s).

My GP listened to me, (I felt at ease), then I listened to her – she explained it all clearly …
If I feel really bad I know my Child Health Nurse is there – we talk and I feel much better. She always boosts me up – what does she do? – I don’t know – she’s just respectful and listens to me and we talk about what’s happening …

When I go to that Women’s Centre I feel safe, it’s a place to trust, and the people there I can trust, and they’re so understanding, and non-judgmental. Its good that they get other professional to come there to talk to us too …

Consumers also recommended ways to promote information to communities:

To get information to the community? – community forums / events, and [through] midwives clinics.

More media coverage of PND e.g. articles in newspapers, magazines, ads on TV – this would help remove the stigma still associated with mental health (& PND in particular); brochures in hospitals / CHN offices / GP surgeries etc. More dispelling of the ‘myths’ of motherhood that abound in society e.g. that motherhood is wonderful and fulfilling all of the time, that you will instantly fall in love with your baby etc. Any more experienced parent knows this is clichéd rubbish!! But it places a lot of expectations on a new mother.

…Information available at hospital - discussion in hospital after birth about health and wellbeing.

Best way to get information to people? – Word of mouth – it always works espically [sic] when you’ve been there and done whatever you needed.

**Indigenous perspectives**

The need for culturally sensitive care provision was identified by aware health service providers. Current pregnancy management of Indigenous women when birthing occurs away from community does not always support this philosophy. According to Hancock (2006), optimal physical and spiritual health supports Indigenous women at the time of birth and the “system of medicalisation and authority [that] has determined that removing the Aboriginal woman from her culture and tradition for birthing…” (p. 79) has not seen corresponding improvement in perinatal statistics to justify the action. Furthermore, “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” (p. 4). The potential for long-lasting impacts on social and emotional health and wellbeing of Indigenous women and their families is significant (Ferguson-Hill, 2009).
Extra protective factors identified for Indigenous women include:

- Cultural traditions, especially around the birthing process and perinatal period.
- Interconnectedness of cultural practices, spirituality, identity, family and community, connection to land/country (Ypinazar, Margolis, Haswell-Elkins, & Tsey, 2007)

There is a higher rate of teenage pregnancy in Indigenous Australia; 23% of Indigenous Australian mothers are under 20 years of age, compared to 5% of non-Indigenous mothers (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2005). Adolescent mothers are up to three times more likely to experience postnatal depression than older mothers (Swann, et al., 2003) but the incidence rate for Indigenous adolescent mothers remains unknown.

There were 10 Indigenous respondents who accessed the online questionnaire and provided insights. A further 19 Indigenous people including the Chief Executive Officer (CEO) of a regional Aboriginal Medical Service (AMS), and managers of AMSs, participated in meetings and discussions. Numerous other health care providers also contributed to the wealth of Indigenous information.

**Barriers to Indigenous women accessing perinatal mental health services**

- Fear of removal of the infant from the mother if she identifies as being distressed in the perinatal period.
- Fear of stigma associated with mental ill health.
- Language issues – not being able to understand the service provider (accent or language used), or what is being said (content).
- Negative experience of previous service attendance.
- Services not addressing the ‘real’ problem e.g. loss and grief

There is recognition by respondents of the need for improved processes and service structures to accommodate the needs of Indigenous women in the perinatal period:

For a woman with moderate to severe PND there is no [culturally appropriate] process or structure of care. Health professionals usually have no formal perinatal mental health qualifications. Aboriginal mothers are NOT getting service.

The services are easily accessible by the Caucasian population but not so accessible by Indigenous Populations for a range of reasons i.e. the pnd group is unlikely to appeal to young indigenous mums due to strict starting/finishing times, the 8 week commitment time frame., evening
Fear of services and service providers, and fear of stigma are real barriers that prevent many women from seeking help for stress, distress, and depression (Gjerdingen, Katon, & Rich, 2008) and remain a major issue for Indigenous women as was noted during numerous discussions. A group of young Indigenous women echoed the voices of others when they reported:

*Those places don’t treat us with respect – it’s hard to talk to them...*

*Our mothers won’t go to see a Social Worker – they’re worried they’ll take their babies. This is a big problem for us.*

*Some of my friends - us young women - don’t want to get pregnant and if they do they hide it – for shame – they stress – they don’t want to tell family or go to the medical people so behave as normal – go out, drink, and smoke, stress more, but they know they may be hurting the baby - so they stress more, so they drink more...*

*It’s shame to talk about it – to have it. People might think you’re mad...*

Of concern is the experience of postnatal depression described by an Indigenous participant.

*I didn’t know there was something wrong [after the birth] – my cousin saw I needed help. She took me to a GP but he said Aboriginal women don’t get postnatal depression and told me I’d be alright. I wasn’t and it took 2 years to get medication and help. That medication wasn’t right – I couldn’t function – 5 years wasted out of my life.*

Child Health Nurses repeated similar stories about Indigenous women’s experiences in their region. However, there were comments that this may have begun to change with education about perinatal depression being more available and accessed by service providers.

Responses reflecting other aspects of service provision include:

*I believe much depression and anxiety disorders specifically among the Indigenous population is a lot higher than accounted for and often goes undetected until it reaches a crisis situation. This often relates to stigma and lack of appropriate education. I feel the community could benefit by education to the broader community to pro actively engage a monitoring/referral system at key points of contact e.g. hospitals, Centrelink, prisons etc*
[Should be] Using the EPDS that is appropriate for Aboriginal people (English second to third language & potentially low literacy ability); who is available to take referrals for remote community members and how. Division of GP [sic] have a different method to WACHS / mental health/ local indigenous organisations that have some funding in this area; local referral sources not just state wide services; management of PND - particularly if referral to alternative management sources are not available - needs to be flexible for travelling service providers and [sic] well as be able to be provided (ideally) in union with local clinic nurse(s)/AHW for the respective community.

The Aboriginal Health Council of Western Australia (AHCWA) generously provided a brief summary from a recent review of perinatal mental health service considerations for Indigenous women (A-M. McHugh, personal communication, May 24, 2010):

*During the site visits and discussions with other service providers there were some common themes*

Loss and grief issues and their effects not only directly on perinatal mental health but also on the social capital available for support to women and families

It also appeared to be a fairly common view that depression due to overwhelming social issues was to be expected in pregnancy and therefore was not a pre-existing or developing illness. This may reflect lack of access to mental health professionals in the regions

*The use of the EPDS for Aboriginal women was often not felt to be useful – some services use this in conjunction with ‘Stay strong’ tools.*

**Other reported deterrents to service access**

The question arose numerous times about the influence of the cultural background and cultural experience of overseas trained doctors on their interpretation of perinatal depression perspectives, including signs and symptoms of perinatal depression, and the way it is managed through current Australian standards. Questions from Indigenous women included:

*How much information is misinterpreted by the Aboriginal woman because she is unable to understand the doctor’s language or accent?*

*Where do they obtain their training and updating about Australian standards of mental health care and Aboriginal cultural ways in the perinatal period?*

*The EPDS as a screening tool with Indigenous women*
Several regional services where Indigenous women attend noted that they will not use the existing EPDS as it is deemed ‘culturally inappropriate’. A common theme of the discussion during conversations with Aboriginal Medical Service (AMS) centres was the value of relationships, both in personal and work contexts - ‘you can’t replace “knowing” someone’ - and the need to look at the WHOLE person and their story at the time. The concern noted that this holistic review may not be done: 1) because of time; and 2) because of lack of cultural understanding if the current EPDS is used by non-aware staff members.

Respondents made several comments about the appropriateness of the EPDS for screening perinatal depression in Indigenous communities:

<table>
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<tr>
<th>Women laugh at it (and me) when I’ve attempted to use it – they ask “Why are you asking me that? You know me!”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Those questions just keep repeating – they’re the same. What do you really want to know?</td>
</tr>
<tr>
<td>An example of a response from an Aboriginal Health Worker (AHW) notes that [We need] an aboriginal tool for EPDS. Currently women are uncomfortable doing present tool. [We could be] using knowledge present tool by observation to assess. Cultural input from elder women to assist aboriginal women and families [is needed].</td>
</tr>
</tbody>
</table>

The comments raise the issue of appropriateness and interpretation of the existing EPDS tool in diverse contexts. Several respondents indicated there is an opportunity to re-frame an approach to the contextual understanding and usage of the EPDS as a screening tool through two-way education with communities and health professionals when it is used in Indigenous health contexts.

Indigenous women may present with other symptoms not addressed in the current standard EPDS and some noted the absence of physical symptoms in the current tool e.g. ‘gut’s ache’; ‘paining’ in the body or head. Concerns expressed about the EPDS as a screening tool included:

| It doesn’t ask the right questions – many Aboriginal women experience physical symptoms rather than emotional ones and these aren’t included. Many women would be missed. |

Enablers

Indigenous women consulted in different regions presented similar responses when asked about their perceptions of an ‘ideal’ service. A summary of the responses indicate the need for:
• Culturally appropriate services.
• A ‘safe place’ to come and just sit.
• A non-stressful, or ‘stress-reducing’, place.
• A ‘safe place’ to talk (or not, as the woman desires).
• A ‘companion’ (such as a health worker) to transport them to the service, sit with them, wait with them, explain / interpret the information.

The notion of a ‘stress-reducing’ place to be available within the community for women was frequently raised. Comments by Indigenous women included:

What did our mothers and grandmothers do?
In early days they’d just go bush until better – away from other stress. That’s not so easy for us now – too many responsibilities and expectations.

The need for a stress-reducing space was a common topic during discussions and the ‘Snoezelen room’ concept arose as a potentially positive way to influence a family’s emotional health. ‘Snoezelen’ or ‘controlled multisensory stimulation’ has a purpose of allaying distress, and involves exposure to a soothing and stimulating environment (Lancioni, Cuvo, & O’Reilly, 2002). The issue of funding and space led to discussion on the topic and about benefits to all FAMILY and COMMUNITY members if such a room was available.

Culturally and Linguistically Diverse (CALD) perspectives

Respondents presented similar issues for CALD women and their families as is experienced by Indigenous women and their families in relation to perinatal emotional health, especially perinatal depression. Incidence rates of perinatal depression are unknown at the present time, women of CALD backgrounds talk of cultural factors, shyness and language difficulties as key barriers to service access, and health service providers note that the increasing numbers of CALD families living in regional WA requires consideration of appropriate service provision.

The perspective of remote communities

Concern was expressed by many respondents that issues for women and families living in remote and isolated areas continue to be ineffectively addressed or
unrecognised. All issues raised are noted to reflect many previous health service reports relating to service provision to remote areas especially. Comments include:

<table>
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<th>Comments include:</th>
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<tr>
<td>Some families are more isolated geographically – very difficult for those who don’t have a car / financial problems.</td>
</tr>
<tr>
<td>[In this region] Women normally have to travel over 2000kms for many forms of specialised treatment. We need better partnerships between what services and resources are already available, or a women’s hospital established in the Northern region of Western Australia to cater for all aspects surrounding women’s health.</td>
</tr>
<tr>
<td>[We need] regional outreach programs with a structured course like … to those that find it difficult to travel the distances (physically and economically).</td>
</tr>
<tr>
<td>[For the service to be accessible we need] mobile mental health and counselling units for travel to remote communities.</td>
</tr>
<tr>
<td>Having to travel to a PND support group is too hard (possible lack of transport, no family support, so difficult to find care for other children, and partners working away makes it hard for a family to contemplate driving long distances)</td>
</tr>
<tr>
<td>Difficult in country areas. Distance to travel and issues for consumers regarding confidentiality...</td>
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APPENDIX D: Role Description

Findings relating to service ‘gaps’ and respondents ‘ideal’ service visions have led to a proposed draft of an emerging model of care with specialised positions for perinatal depression services initially in selected WA regional areas.

As noted in the report, 86% (n=105) of service provider respondents to the online questionnaire (n=122), determined that the existing services for perinatal depression detection and management in regional WA were inadequate. Linked with the service ‘gap’ findings, respondents were invited to consider and present their ideas about components of a job description which might enhance service activity.

Respondents were asked, “In an ideal world, what do you believe a service catering for this period of time (the perinatal period) would look like?”

“What do you think should be in the Job Description for a position which is specifically working for women and men experiencing perinatal depression?”

Many respondents indicated uncertainty about recommended practice in relation to the management of a woman (and her family) who is experiencing a mild to moderate state of distress (which may or may not be associated with depression); when to refer; to whom; and how to refer, in the perinatal period.

Concern was expressed that if a health professional was unsure, or felt there was no where to go for advice, community members would experience even more difficulty.

Examples of identified needs, and service enhancement opportunities include:

A perinatal depression consultancy and liaison role

[We need] … Specialist perinatal consultancy availability within region - which would also provide a support role / be a part of the perinatal workers network / meetings. …

An educator role

… I am sure that more local availability to professional development would be helpful. It is very difficult to attend pd in Perth due to time in travel, cost etc. Also time out of clinical area.

‘Go-between’ role

Someone to act as ‘go-between’ for client and services would help.
Someone with a ‘finger on the pulse’, ‘keeper of knowledge’ – local, regional, state, national

Someone who has organised access to, and knows the latest on funding for relevant programs – availability and sources. This person would be a ‘keeper of relevant knowledge’.

Someone with their finger on the pulse would know what’s going on in the region.

Coordination and advocacy role

This is also an opportunity for a care coordinator, especially to follow-up on referrals. Did the woman attend? Does she need anything else to assist her at this stage?

[An ideal service ensures that]… Any potential clients are referred to a source that will actively follow-up the referral in person and confirm or reassure referent that all is okay. Skilled manager of the PND that can work with all service providers / stakeholders to ensure a [sic] appropriate and consistent service is provided.

It’s hard to find out what exists, and how to access it. Little services for young mums or indigenous women. No coordination across services

Monitoring role

(Services are) ALMOST adequate - It would be good if we had resources to monitor ‘at risk’ mothers / expectant mothers, of having a perinatal MH problem. … does not always have capacity to follow asymptomatic / at risk of peri MH [sic] clients.

Research role

This position could assist with research activities in this region e.g. EPDS usage and translation with Aboriginal women.

Respondents identified several challenges to be addressed when establishing the new NPDI positions:

1. Regional site placement of a position
   - Clear geographic boundaries are required [until all regions have a dedicated position].
   - A current lack of systemic / organisational support may be an issue.
   - Addressing a broad range of regional issues at an operational level will be a big ask.
   - Time is required to engage all stakeholders and develop an action plan in line with regional strategic health plans.

2. Position Job Description
   Documented comments related to the job description include:
The relationship between the mother, or parent, and the child must be kept in mind at all times. This requires expertise in infant mental health as well, and support for the management of this must be available. Early intervention abilities are paramount. There must be a perceptive capacity to think that there is ‘more to her story’.

Must be able to support the [existing] clinicians to do what they do. This is really important [there is already terrific work being done].

The risk is greater [for the practitioner] when working in isolation – there may be a need to step beyond the scope of practice because of limited services and backup is required for next steps in the management [for example, if there is a crisis for the woman or her family].

To ensure overload doesn’t occur the role must be kept separate to existing roles and dedicated and recognised.

3. Incumbent

- Need for collegiate support – education for all relevant staff about the role.
- Clear role delineation (what the role DOES / DOES NOT do).
- Support network required for these professional people.
- Need for professional supervision / debrief opportunity.

Documented comments related to incumbent needs include:

There must be built into the framework SUPERVISION (for example, monthly), especially in relation to management of the whole family and preferably via a multidisciplinary team for input.

Other challenges were identified during discussions:

- Care pathway options are currently unclear / unavailable and could cause confusion for all service providers as to who does what.
- Regular case conferencing opportunities are required to enable review and quality improvement.