A national approach to perinatal mental health in Australia: exercising caution in the roll-out of a public health initiative

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ABSTRACT

- Perinatal depression is an important public health issue, with major consequences for the mother, child and family.
- Perinatal depression is often associated with anxiety and other mental health and psychosocial issues.
- The National Perinatal Depression Plan (NPDP) proposes routine screening during pregnancy and after birth, follow-up support for women assessed to be at risk of or experiencing depression, and training for health professionals.
- Identifying women at risk of or experiencing perinatal depression is difficult, and there is no standard tool used by all hospitals to assess women's emotional health and psychosocial comorbidities.
- The NPDP provides an opportunity to develop and evaluate new approaches to assessing perinatal depression and a range of psychosocial issues, and to test strategies for supporting women and their families before and after birth.

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A health initiative announced in the 2008–09 Australian federal government budget translates to over $80 million in state and federal funding for a perinatal depression plan to be implemented across Australia over the next 5 years. The National Perinatal Depression Plan (NPDP) has three goals:

- Routine screening for depression during pregnancy and a follow-up check at 2 months after birth;
- Follow-up support and care for women who are assessed to be at risk of or experiencing depression; and
- Training for health professionals to help them screen and assess expectant and new mothers for depression.[1]

This national focus on a major public health issue, together with designated funding, provides opportunities to develop and evaluate new approaches to assessing perinatal depression and the range of psychosocial issues that may underlie or contribute to this condition. It also provides opportunities to develop and test strategies for supporting women and their families during pregnancy and after birth.

We offer a cautionary note about the first goal of the national plan — routine screening of all women during pregnancy and postnatally — and consider the possibilities for building a stronger evidence base to inform the implementation of the perinatal depression initiative.

The screening debate

Screening women for psychosocial problems, including depression during pregnancy and postnatally, is advocated in a number of countries including the United Kingdom, where guidelines for clinical management of perinatal mental health include the use of routine screening.[2] To date, the situation in Australia has been somewhat different. Localised antenatal and postnatal depression screening programs have been undertaken for many years as part of routine clinical practice by some hospitals[3] and primary care services.[4] On a larger scale, the *beyondblue* perinatal depression program screened over 12 000 Australian women[5] using the Edinburgh Postnatal Depression Scale (EPDS)[6] to determine the prevalence of probable postnatal depression and acceptability of a screening program. Before the announcement of the NPDP, there was no national approach or guidelines for the assessment and management of perinatal depression in Australia.

There is no doubt that perinatal depression is an important public health problem. A meta-analysis of 59 studies yielded a mean prevalence of 13% in the first few weeks postpartum.[7] As a "hidden" form of maternal morbidity, depression has major consequences for the mother, child and family.[8]

The "to screen or not to screen" debate continues as we approach the roll-out of the NPDP. The evidence for effectiveness of universal antenatal and postnatal screening for depression is scarce.[9] Austin and Lumley urge health professionals to be cautious when using screening tools to select women for antenatal interventions, citing the high proportion of false positives among women identified as "at risk" and the high proportion of women identified as "low risk" who go on to develop depression after childbirth.[9]

This calls into question what screening is aiming to achieve. Is its purpose to identify "cases" or to identify women "at risk"? The aims are not always explicit, although the focus of antenatal studies has primarily been on determining the risk of developing depression, and the focus of most postnatal studies has been on identifying cases.

While the potential for harm associated with the high proportion of false positives and false negatives identified by risk-screening tools is clear, so too is the possibility of harm if women who are labelled as "at risk" or "depressed" do not perceive themselves in this way and do not wish to discuss their mental health status with health professionals. In a follow-up to the *beyondblue* perinatal depression screening initiative, 18% of women who screened positive for depression did not agree with the screening assessment. One in five of these women ignored the assessment and 40% were reported to be "a little upset" by it.[10] The stigma of being labelled as having a mental health condition or the belief that support and help are not available may lead women to deliberately under-report symptoms or risk factors.[11]

Increasingly, clinicians and researchers are suggesting that focusing on depression as a separate entity obscures the likelihood that there will be comorbidities such as anxiety and complex psychosocial factors. Several commentators have argued for screening for psychosocial risk, in recognition of the fact that anxiety and depression during pregnancy, psychiatric illness, stressful life events and perceived levels of social support are all predictors of postnatal depression.[12] Others have suggested that, in designing a tool with acceptable sensitivity and specificity to identify depression, a broader range of psychosocial risk factors needs to be considered.[8]

The poor sensitivity and specificity of available screening tools, women's reluctance to disclose sensitive issues to health professionals, and health professionals' reluctance to enquire about

psychosocial issues have led to calls for alternative approaches to psychosocial assessment. An evaluation of a Victorian health professional education program, the ANEW program, which is aimed at promoting practitioners' skills in active listening, has produced some promising results.[13,14] Other studies have also identified psychosocial assessment tools as a way of leading into a conversation about mood disorders or other psychosocial issues.[15] The third goal of the NPDP — training for health professionals — provides an opportunity to develop and evaluate models of health professional training in how to assess women's emotional and social health during pregnancy and after birth.

Current approaches to psychosocial assessment

Unlike the UK, which has guidelines for routine screening and management of perinatal depression,[2,16] Australia has taken a more "hands-off" approach, leaving the states with designated federal funding to determine the best approaches to screening and pathways for care. This is not to underestimate concern regarding this issue. Australian clinicians, researchers and state health departments have been calling for some time for the use of routine standardised screening and psychosocial risk assessment tools to identify women who may be at risk.[17,18]

Little is known about how primary care services approach psychosocial assessment and support for women experiencing psychosocial problems during and after pregnancy. A Victorian study found that, even when locally based efforts are made to introduce an integrated approach to screening women for postnatal depression in a primary care setting, implementation may be fragmented and ad hoc.[4] Striking findings of the study were that the well established program of universal screening was not effective in detecting probable depression and that there was no collaborative planning between maternal and child health services and general practitioners for affected women.[4] Another Victorian study — the Re-organising the Care of Depression and Related Disorders in the Australian Primary Health Care Setting (RE-ORDER) study — demonstrated how difficult it was for even highly motivated primary care services to implement systemic changes to improve care of people with depression.[19]

The Integrated Perinatal and Infant Care initiative in New South Wales uses a model of assessment, prevention and early intervention to identify the mental health and physical health needs of parents and their infants during pregnancy and after birth. Implementation has been widespread, although evaluation of the initiative appears to be confined to individual hospitals that have implemented routine psychosocial assessment in their antenatal clinics.[3,20]

Understanding the way that services have responded to calls for screening is an important first step in developing new approaches. A survey by our research group of all hospitals with maternity facilities in South Australia ($n = 35$) and Victoria ($n = 75$) sheds some light on how services currently approach psychosocial assessment. We conducted the study to inform the development of a population-based survey of women giving birth in both states in 2007.[21] Midwifery unit managers completed questionnaires on routine approaches to psychosocial assessment and the use of risk assessment tools. Among public hospitals, a third (9/30) in SA and a half (29/56) in Victoria reported using a psychosocial screening tool during pregnancy. The Edinburgh Depression Scale (EDS),[6] a well validated instrument for identifying probable clinical depression, was commonly used (Box 1). Most of the other psychosocial assessment tools in use contained a number of questions about women's emotional health. There was no consistency among the tools with regard to their format or the questions contained in them.

Fewer hospitals reported the routine use of a psychosocial risk assessment tool postnatally (Box 2): 3/35 hospitals in SA (all used the EPDS and 12/75 hospitals in Victoria (three used the EPDS). No private hospitals in SA and only one in Victoria routinely used a screening tool during the postnatal period.

Our survey of over 100 Australian hospitals in two states[21] revealed striking diversity in how hospitals interpret and respond to initiatives encouraging assessment of psychosocial issues during pregnancy and after birth. Few hospitals reported routinely using psychosocial assessment tools, and there was no standardised approach in either state. The focus was on emotional wellbeing, primarily on depression. Very few hospitals reported routine enquiry regarding intimate partner violence or psychosocial issues other than depression.

The challenge for health services and clinicians

Our findings pose a number of challenges for developing guidelines and policy and for implementing new approaches to service delivery. Change is difficult, particularly when there is uncertainty. For policymakers and clinicians there is uncertainty about how best to assess and support women, given the comorbidity factor of emotional wellbeing and complex psychosocial issues; the benefit or potential harm of standardised screening; and the availability and quality of support services for women identified as "cases" or "at risk".

Hospitals that have already implemented specific approaches to psychosocial assessment, such as screening with the EDS, may be resistant to change.[22] Equally, hospitals that have already introduced

1 Number of public maternity hospitals routinely using psychosocial assessment tools antenatally*

Psychosocial assessment tool	South Australia ($n = 30$)	Victoria ($n = 56$)
Edinburgh Depression Scale (EDS)[6]	5	14
Psychosocial issues checklist (various tools)	5	17
Total using a risk assessment tool	*9*†	*29*†

* Private hospitals are not included here, as most or all antenatal care was provided by private obstetricians in the private sector, with no hospital involvement during pregnancy. † One SA hospital and two Victorian hospitals used both the EDS and a psychosocial checklist. ◆

2 Number of public and private maternity hospitals routinely using psychosocial assessment tools postnatally

Psychosocial assessment tool	South Australia ($n = 35$)	Victoria ($n = 75$)
Edinburgh Postnatal Depression Scale (EPDS)[6]	3	4
Psychosocial issues checklist (various tools)	0	9
Total using a risk assessment tool	*3*	*12**

* One Victorian hospital used both the EPDS and a psychosocial checklist. ◆

an alternative approach to psychosocial assessment, such as the ANEW program in Victorian hospitals, may be reluctant to adopt the standardised screening approach recommended in the NPDP.

Primary care services are well placed to assess women's psychosocial health. There is a need for greater focus on integrated primary health care at the community level. Policymakers implementing the NPDP need to consider how to foster stronger links between primary and specialist services and a more cohesive approach to supporting women and their families in the longer term. A challenge for primary care services, particularly infant health services, is to focus on the health of the mother, when so much care during the postnatal period is oriented towards the child.

A recent Victorian longitudinal cohort study found that anxiety and depressive symptoms were associated with different patterns of help-seeking behaviour. Less than half of women experiencing anxiety symptoms postnatally had spoken to a health professional, compared with two-thirds of women experiencing depressive symptoms. Women experiencing emotional difficulties were significantly more likely to talk to a GP than to a maternal and child health nurse,[23] a finding that supports other studies suggesting that women may be reluctant to disclose such issues to staff of maternal and child health services.[24]

The National Perinatal Depression Plan: first steps

There is a danger that the current focus on maternal perinatal mental health and on the strategies most likely to be recommended to assist women (ie, cognitive behaviour therapy and pharmacotherapy) may shift the focus away from broader strategies to address known risk factors such as partner violence, comorbid physical health problems, housing, alcohol/drug problems or financial issues.

State governments currently considering the best way to spend their allocated funding need to tread carefully and consider innovative approaches to psychosocial assessment and support within an evaluation framework. Possibilities include developing a system model for changing the interface between primary care and the acute care sector, using perinatal psychosocial assessment as a pilot project. Fragmentation of care between the antenatal and postnatal periods is the norm in Australia. Although women may develop a relationship with their antenatal care practitioner during pregnancy through private obstetric care, GP care or the emerging midwifery group models, there is little likelihood that this relationship will continue in the 12 months after birth (except in the case of GP care). Thus, a creative model for enhanced continuity and communication between the acute and community-based health sectors is needed. Integration of maternal and child health services into antenatal clinics would be one possibility.

Trialling alternative approaches to screening and identification of psychosocial issues during pregnancy and after birth, in a variety of settings, is another possibility worthy of consideration. Hospitals and primary care services need implementation funding, guidance and support to develop and try new approaches. Given the large number of visits that women make to a GP in the 12 months after birth, taking an opportunistic approach to engaging women in discussion about their own health at these visits may be a viable option. Such an approach would require changes to the organisation of care (eg, offering longer consultation times), practitioner training and support, and the development of guidelines to enhance psychosocial enquiry and support.

New approaches to assessing and managing perinatal psychosocial issues will need to be developed, paying attention to workability and integration from the perspective of practitioners and women themselves.[22] Developing new service models and systems will take time and require a participatory approach involving clinicians (GPs, midwives, maternal and child health workers, practice nurses, obstetricians and psychologists), practice managers, hospital managers, funders and policymakers.

With so many questions about the effectiveness of screening, it is critical that new approaches to assessment and enquiry be evaluated before a universal population-based screening program is rolled out.

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Competing interests

None identified.

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