SAFE START Guidelines: Improving Mental Health Outcomes for Parents & Infants

Summary The SAFE START Guidelines: Improving Mental Health Outcomes for Parents and Infants, outlines the rationale for psychosocial assessment, risk prevention and early intervention. It proposes a spectrum of coordinated clinical responses to the various configurations of risk factors and mental health issues identified through psychosocial assessment in the perinatal period. It also examines the broader specialist role of Mental Health Services in addressing the needs of parents with, or at risk of, developing mental health problems.

Document type Guideline

Document number GL2010_004

Publication date 03 March 2010

Author branch Healthy Families and Communities

Branch contact 02 9391 9000

Review date 30 December 2020

Policy manual Patient Matters

File number 07/7324

Previous reference N/A

Status Active

Functional group Clinical/Patient Services - Mental Health, Baby and Child, Maternity, Nursing and Midwifery

Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations, Affiliated Health Organisations - Declared, Community Health Centres, Public Health Units, Public Hospitals

Distributed to Public Health System, Divisions of General Practice, Government Medical Officers, NSW Ambulance Service, Ministry of Health, Private Hospitals and Day Procedure Centres, Tertiary Education Institutes

Audience Maternity;child & family health;EDs;Aboriginal Health;mental health;drug & alcohol

Secretary, NSW Health

FAMILIES NSW SUPPORTING FAMILIES EARLY PACKAGE

Improving mental health outcomes for parents and infants

SAFE START guidelines

families NSW
supporting families to raise children

NSW GOVERNMENT

NSW HEALTH

NSW DEPARTMENT OF HEALTH
73 Miller Street
NORTH SYDNEY NSW 2060
Tel. (02) 9391 9000
Fax. (02) 9391 9101
TTY. (02) 9391 9900
www.health.nsw.gov.au

This work is copyright. It may be reproduced in whole or in part for study training purposes subject to the inclusion of an acknowledgement of the source. It may not be reproduced for commercial usage or sale. Reproduction for purposes other than those indicated above requires written permission from the NSW Department of Health.

Suggested reference: NSW Department of Health, 2009, *NSW Health/Families NSW Supporting Families Early Package – SAFE START Guidelines: Improving mental health outcomes for parents and infants*, NSW Department of Health

© NSW Department of Health 2009

SHPN (AIDB) 080166
ISBN 978 1 74187 291 2

Further copies of this document can be downloaded from the NSW Health website www.health.nsw.gov.au

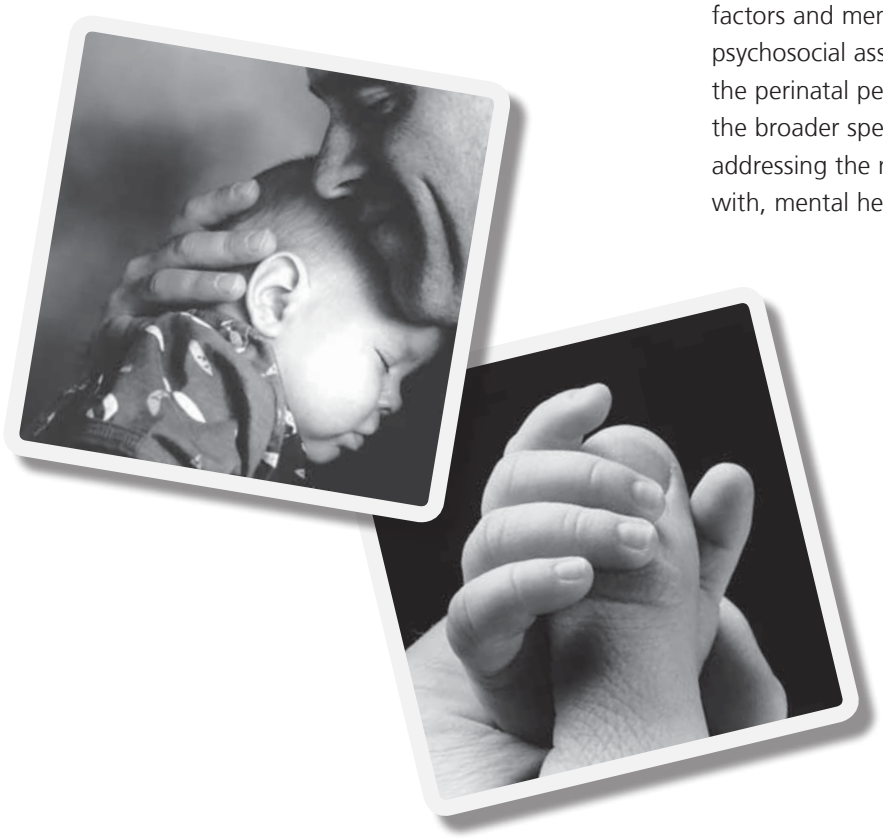
Revised June 2010

NSW Health / *Families NSW* Supporting Families Early package

The *NSW Health / Families NSW Supporting Families Early package* brings together initiatives from NSW Health's Primary Health and Community Partnerships Branch and Mental Health and Drug & Alcohol Office. It promotes an integrated approach to the care of women, their infants and families in the perinatal period. Three companion documents form the *Families NSW Supporting Families Early* package.

Supporting families early maternal and child health primary health care policy

The first part of the package is the *Supporting Families Early Maternal and Child Health Primary Health Care Policy.* It identifies a model for the provision of universal assessment, coordinated care, and home visiting, by NSW Health's maternity and community health services, for all parents expecting or caring for a new baby. This model is described within the context of current maternity and child & family health service systems.



SAFE START strategic policy

The second part of the package, the *SAFE START Strategic Policy*, provides direction for the provision of coordinated and planned mental health responses to primary health workers involved in the identification of families at risk of developing, or with, mental health problems, during the critical perinatal period. It outlines the core structure and components required by NSW mental health services to develop and implement the SAFE START model.

SAFE START guidelines: improving mental health outcomes for parents and infants

The third part of the package, the *SAFE START Guidelines: Improving Mental Health Outcomes for Parents and Infants*, outlines the rationale for psychosocial assessment, risk prevention and early intervention. It proposes a spectrum of coordinated clinical responses to the various configurations of risk factors and mental health issues identified through psychosocial assessment and depression screening in the perinatal period. It also outlines the importance of the broader specialist role of mental health services in addressing the needs of parents at risk of developing, or with, mental health problems.

Message from the Director-General

Pregnancy and becoming a parent is usually an exciting time, full of anticipation, joy and hope. It can also be a time of uncertainty or anxiety for parents and families. To support families fully during what can be a stressful period, it is important to address the range of physical, psychological and social issues affecting the infant and family. This range of issues and parents' understanding of the tasks and roles of parenthood are recognised as significant influences on the capacity of parents to provide a positive environment that encourages optimum development of the infant.

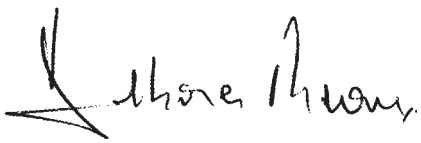
Providing support for infants, children and parents, beginning in pregnancy, including their physical and mental health, is a key priority of the NSW Government. This is clearly articulated in the NSW Action Plan for Early Childhood and Child Care which is part of the Council of Australian Government's National Reform Agenda, the NSW State Plan, and the NSW State Health Plan.

The NSW whole-of-government *Families NSW* initiative is an overarching strategy to enhance the health and wellbeing of children up to 8 years and their families. One way it does this is by improving the way agencies work together, so that parents get the services, support and information they need.

NSW Health is a key partner with other human service agencies in developing prevention and early intervention services that assist parents and communities to sustain children's health and wellbeing in the long term. Health services are the universal point of contact for these families entering the *Families NSW* service system.

NSW Health's vision is for a comprehensive and integrated health response for families. This response will encompass all stages of pregnancy and early childhood development and link hospital, community and specialist health services. The aim is to assist families in the transition to parenthood, build on their strengths, and ameliorate any identified risks that can contribute to the development of problems in infants and later on in life.

The *NSW Health / Families NSW Supporting Families Early* package integrates three NSW Health initiatives that are underpinned by a common understanding of the challenges that parenthood can involve, the importance of the early years of a child's development, and the benefits of appropriate early intervention programs. The initiatives contained within *Supporting Families Early* are an important contribution to the provision of services that enhance the health of parents and their infants, help to protect against child abuse and neglect, and enhance the wellbeing of the whole community.



Professor Debora Picone AM
Director-General
NSW Health

Contents

Families NSW Supporting Families Early package i

Message from the Director-General ii

SECTION 1. Key concepts in perinatal mental health 3

1.1 Fetal and early brain development 3

1.2 Attachment and parenting 3

1.3 Parental mental health problems and related disorders 4

1.3.1 Anxiety and depression 4

1.3.2 Post-partum psychosis 5

1.3.3 Parents with long-term mental illness and related disorders including substance use issues 5

1.3.4 Child abuse 6

1.3.5 Domestic violence 6

SECTION 2. Psychosocial assessment 8

2.1 Psychosocial questions 8

2.1.1 Issues in conducting perinatal psychosocial assessment 8

2.2 Edinburgh postnatal depression scale 9

SECTION 3. Clinical pathways for child problems 11

3.1 Introduction 11

3.2 Responses to psychosocial risk assessment 12

3.3 Immediate response to acute risk 12

3.4 No psychosocial risk identified 12

3.5 One or more psychosocial risk/s identified 12

3.5.1 Social issues and recent major stressors 12

3.5.2 Past history of adverse childhood experiences 13

3.5.3 Past or ongoing history of mental health problems (including partner's history) 14

3.6 Current symptoms of mental health problems 15

3.6.1 Mild symptoms 15

3.6.2 Acute symptoms 16

3.7 Families with complex needs 17

3.7.1 Prenatal and Postnatal Child Protection 18

3.7.2 Early antenatal identification of families with complex needs 19

3.7.3 Interventions 19

3.7.4 Care planning during the perinatal period 19

3.7.5 Caring for families with a substance use problem 19

3.8 Other important perinatal psychosocial issues 20

3.8.1 Traumatic and negative birth experiences 21

3.8.2 Loss of a baby 21

3.8.3 Prematurity and low birth weight 21

3.8.4 Excessive infant crying 22

3.8.5 Maternal physical disabilities 22

3.8.6 Partner with past or current mental illness 23

SECTION 4. Role of mental health services in SAFE START implementation 25

4.1 Introduction 25

4.2 Perinatal mental health expertise 25

4.3 Mental health services pathways of care 26

4.4 Consultation with no direct clinical intervention 27

4.5 Consultation with clinical assessment 28

4.6 Limited mental health intervention 28

4.7 Acute community-based mental health care 28

4.8 Mental health intake and assessment process 28

4.9 Clinical interventions 28

4.9.1 Home-based mental health care 28

4.9.2 Hospital-based mental health care 29

4.10 Care coordination for women with a long-term mental illness 30
4.11 Mental health act 2007 30
4.11.1 Stage one – 'Pure law' 31
4.11.2 Stage two – Duty of care to the patient and ethics 31

SECTION 5. Populations with particular needs 32
5.1 Working with specific populations 32
5.2 People from culturally and linguistically diverse backgrounds 32
5.3 Refugee populations 32
5.4 Aboriginal and torres strait islander populations 33

SECTION 6. Supervision 35

APPENDICES
1 SAFE START psychosocial assessment questions 36
2A The Edinburgh Depression Scale 37
2B The Edinburgh Postnatal Depression Scale marking guide 38
2C The Edinburgh Depression Scale (Antenatal) 39
3 Component of the Toronto Antenatal Psychosocial Health Assessment Questionnaire 40
4 Recommended issues for exploration in the postnatal period 41
5 Clinical effectiveness: definition and use in clinical practice 42
6A Example: pathways of care during the antenatal and birth periods 43
6B Example: pathways of care during the postnatal period 44
7 Information sheet sent to stakeholders when a planning meeting is organised 45
8 Assessment of parenting capacity when the parent has a mental illness – a guide for mental health staff 46
9 Terms and abbreviations – in the context of SAFE START 47

REFERENCES 49

Figures

1 Key responses for psychosocial risks identified in the pregnancy and postnatal periods 13
2 Three levels of intervention for women experiencing severe clinical symptoms during the perinatal period. 16
3 Mental health pathways of care during the acute period of perinatal mental health problems and disorders provided by public and private services 27
4 Opportunities and high-risk periods from conception until three months after the birth of the baby, for women with a long-term mental illness 30

Tables

1 Pathways to care for the intra-partum period (birth period) for women who have had traumatic and negative birth experiences, loss of a baby or have premature or low birth-weight babies 23
2 Pathway to care for pregnant women in inpatient mental health units 29

SECTION 1

Key concepts in perinatal mental health

The early years of a child's life are critical for the development of vital physical, cognitive and emotional competencies, including emotional self-regulation, habitual patterns of responding, binocular vision, language and literacy. Infants develop through a process of dynamic interaction with their environment. A range of bio-psychosocial factors can contribute to health problems and disorders for mothers and infants. Conversely, a range of factors including genetics, temperament, environment, access to resources and support can provide some protection against these risk factors. Prevention initiatives need to provide a range of support options, focused on working with parents, and building on personal and family strengths.

The following factors have a significant impact on the child's health, development and well-being.

1.1 Fetal and early brain development

Extensive scientific evidence demonstrates the powerful impact of the extra uterine world such as maternal nutrition, viral infections, trauma and exposure to drugs including nicotine and alcohol on the physical development of the fetus. Maternity services are cognisant of these factors and are vigilant at prevention and early intervention. Studies reveal that factors such as maternal anxiety and stress can also have a physical impact on the fetus. Research has identified a strong association between chronically elevated maternal cortisol levels and behavioural or emotional problems in children at age four (Glover & O'Conner 2002).

Recent research on bio-psycho-neurological brain development highlights that the process and context of neural pathway brain development during pregnancy and the first three years of life is more significant than previously thought (Perry & Pollard 1998, Schore, 1996). Contextual issues such as trauma or lack of stimulation associated with neglect or abuse impact on this neural pathway development. Lack of stimulation can result in the infant failing to internalise fundamental sensory experiences that are necessary for cognitive, language and social functions throughout the lifespan.

1.2 Attachment and parenting

While there is clearly an interaction between genetic vulnerability, biological processes, infant temperament and social or cultural factors, the significance of parenting capacities and styles on a child's social development are increasingly recognised. Modern families are very diverse in both structure and style. There are more single parents, blended families and divorced parents with shared custody arrangements. There is also a significant diversity of ethnic and cultural backgrounds. This means a greater variety in parenting attitudes and styles, and less of a consensus on what constitutes an optimal parenting model (Crockenberg & Leerkes, 2000).

The infant–caregiver relationship provides a fundamental experience for shaping of an infant's bio-psychosocial development. There is now a greater understanding of the importance of the first years of a child's life and how this affects their entire life course. The relational domain of influence on infant mental health is significant (Swain et al., 2007).

It has been established that the primary care-giving relationship during the first few years of life is the primary modulator and influence for infant development (Carlson et al., 2003; Crittenden, 2000; Crockenberg & Leerkes et al., 2000; Dolby, 1996; Schore, 2001; Sroufe, 1995). The social, local community and family network, including specifically transgenerational family patterns, impact on parent–infant relationships in the psychosocial domain.

Bowlby (1982) has described attachment as the interactive sensitivity that develops over time between an infant and the primary caregiver. Appropriate, sensitive and timely responses to the child's expressed needs and distress help the infant to develop adequate coping skills, responses to stress and emotional self-mastery, and an optimal inner working model of relational functioning. Secure attachment can serve as a protective factor against later emotional and behavioural problems, providing children with greater resilience, less anxiety and hostility and good interpersonal relatedness.

Inconsistent, insensitive or unresponsive patterns of parental interaction can be associated with later childhood depression, hostility, and externalising behaviour problems and reduced resilience (Fonagy, 2001; Rutter, 1995). McCain and Mustard (1999) also found that children receiving inadequate, inappropriate or disruptive stimulation will be more likely to develop learning, behavioural or emotional problems in the later stages of life. 'Disorganised attachment' in infants and children is generally found where mothers (or primary care-givers) have significant psychosocial problems, a history of mental illness, or childhood maltreatment or sexual abuse (Lyons-Ruth et al., 1987).

Attachment is increasingly conceptualised as a form of dyadic emotional regulation (Sroufe, 1995). Infants are not capable of regulating their own emotions and arousal states and require an 'external regulator' by means of a caregiver to do this for them. How an infant ultimately learns how to regulate their emotions will depend greatly on how the primary caregiver regulates their own emotions. Research demonstrates a very high correlation between the caregiver's attachment status and the attachment status of the infant. As children become more able to express their needs and emotions, they learn self-regulation skills. However, dyadic regulation never entirely disappears. There is a time for both types of regulation (self and dyadic) throughout a person's life.

Attachment relationships evolve over the first two years of life and beyond, but most importantly these attachment relationships overlap with a time of significant neurological development of the brain that has implications for bio-psychosocial functioning throughout life (Schore, 1996; 2001).

Canada's *National Longitudinal Survey of Children and Youth: Growing up in Canada* (Brannigan et al., 2002) confirmed that psychosocial factors are more significant for parental-infant relationship than health or medical factors. Importantly, the study found that socio-economic factors were linked only weakly to child outcomes and that a child's developmental prospects are at least as good with positive parenting in an 'at risk' family as with negative parenting in a more favourable, low-risk family.

1.3 Parental mental health problems and related disorders

A large and expanding body of research indicates that a link exists between parental mental health problems and disorders, parenting styles of interacting and child outcomes. The interplay between family coping patterns and factors such as genetic vulnerability, environmental resources and supports, and parenting styles is complex. While many parents who have a mental health problem are capable parents, the child–parent interaction can be compromised when the parent is acutely unwell and there may be times when the parent may need to be absent for treatment. In addition parents with a mental illness are more at risk of relationship difficulties, social isolation, poverty (including poor housing), and lack of transport (Australian Infant Child Adolescent and Family Mental Health Association, 2001). The higher risk associated with having a mentally ill parent needs to be addressed through appropriate supports and ongoing evidence based assessment and monitoring of parenting capacity.

1.3.1 Anxiety and depression

Even without significant external contextual difficulties, some parents will struggle with the transition to parenthood. Intra-personal and inter-personal vulnerabilities, lack of experience or understanding of the tasks of parenthood, memories of adverse parenting in their own infancy, or environmental restrictions may precipitate anxiety and vulnerability to depression. The extent and effect of conditions such as anxiety and depression are very dependent on the parent's own childhood experiences and current state of mind with respect to parenthood (McMahon et al., 2001).

For every 1000 live births, 100–150 (10–15%) of women will suffer a depressive illness (O'Hara & Swain, 1996) and one or two women will develop a puerperal psychosis (Kendell et al., 1987). Approximately one half of these women will have onset of depression during pregnancy (Gotlib et al., 1989). Infants of mothers with depression can display depressed interaction styles as young as three months. However, some mothers with depression who are able to make a conscious effort to interact positively with their infants, even when suffering impaired emotional capacity, have been observed to show similar infant responses as infants of mothers who were not depressed (Weinberg & Tronick, 1998).

Lack of practical and emotional support is identified as a correlate of postnatal depression (PND) and a partner's support and encouragement are important in the comprehensive management of maternal PND in order to enhance rapid recovery. Partners are not immune to emotional distress and mental health problems associated with early parenting and research findings indicate that as many as half of the partners of women with PND also suffered depression (Ballard, 1996). According to Areias, Kumar, & Figueiredo (1996), two variables implicated in the development of partner's PND are a past history of

depression and a maternal mental illness including depression in the first postnatal months. The strain of having a depressed partner is in any case a significant stressor likely to bring about feelings of isolation, resentment, disappointment and self-doubt. These findings suggest that ignoring fathers in the treatment process may result in delayed marital recovery and also aggravate the father's emotional distress.

It is important to consider that the loss of a baby, whether through termination, miscarriage, still birth, neo-natal death or Sudden Infant Death Syndrome (SIDS) can create a vulnerability for future mental health problems. Grief following the loss of a baby can last longer than a year and increase the risk for postnatal depression in a subsequent pregnancy (Murray & Murray, 1988). Parents who have lost a baby, either pre-term or at birth, require support services specifically designed to meet their needs.

1.3.2 Post-partum psychosis

Post-partum or puerperal psychosis is uncommon but serious. Symptoms usually appear within three weeks following the birth and prior history of mental illness is a predominant risk factor. Recovery is usually good. Recurrence with later pregnancies indicates a need for active management and intervention (Mares et al., 2005).

Puerperal psychosis and other severe mental illness in a parent or primary care-giver require ongoing risk assessment in regard to the nature of psychotic symptoms such as delusions and distorted attributions involving the infant. The nature of maternal mental illness has been associated with the quality of her infant care-taking and safety. Very little is known about the adequacy and safety of maternal parenting behaviour in the context of severe postpartum psychiatric illness, about specific difficulties in relation to different types of mental illness, or about the potential for improvement over the course of an episode of illness (Hipwell & Kumar, 1996). Frequent parent-infant risk assessment in hospital and community settings is important in the case of severe parental mental illness.

1.3.3 Parents with long-term mental illness and related disorders including substance use issues

The incidence of mental illnesses such as schizophrenia and bi-polar disorder in the population is approximately 3% (Commonwealth Department of Health and Aged Care, 1999). The prevalence of eating disorders is also relatively low. However, the impact of these mental illnesses on the lives of the person, their family and their capacity to parent positively is significant and profound.

Children of parents with a mental illness are at higher risk of developing mental illness or a psychological disorder during their childhood (Cowling, 1999). While there is a genetic component for mental disorders, most people with mental disorders have no family history, which indicates that there are other significant factors in the development of mental illness (Seifer & Dickstein, 2000).

In their 18-year longitudinal study in two counties in the state of New York, Johnson et al. (2001) followed 593 biological parents and their children to investigate the role of mental illness and maladaptive parental behaviour in the development of children's psychiatric disorders. The study results indicated that children of parents with mental illness were not at greater risk for mental health problems unless there was a history of maladaptive parental behaviour. Specific factors associated with chronic mental illness, acute symptoms and side-effects of psychotropic medications including cognitive impairment, lack of motivation and sedation have been noted for their negative effects on parent–infant attachment and parenting capacity (Snellen et al., 1999).

The family unit and extended family may provide much of the practical and emotional assistance needed to support parents with a mental illness. It can be helpful to identify individual roles within the support network. This can include planning for predictable events such as the possible need for respite care during times of mental illness. While there is often an emphasis on the mental health of the mother it is important to note that there are significant impacts on family stability and capacity to manage stress, with possible risks to children's safety when the father or partner has a mental illness or substance misuse problem. Whenever possible, the father (or partner) should be included in care planning, and the support expectations should be realistic and agreed.

One in six Australians aged 18–24 years had a substance use disorder in a 12-month survey period (Sawyer et al., 2000). Nearly one-half of women with identified substance use disorder also met the criteria for anxiety or affective disorder. Parental substance abuse is known to increase risks for infants during fetal development through health complications such as fetal alcohol syndrome or the diverse health consequences of cigarette smoking. Often, these babies can also suffer postnatal complications of their parents' addiction, such as neonatal abstinence syndrome. Later on, the children are at risk of neglect or abuse and exposure to the violence that frequently accompanies illegal substance misuse.

Parental substance abuse is also associated with parenting styles (coercive or inconsistent) that increase the risks of externalising problems, oppositional defiant disorder and conduct disorder (Merikangas et al., 1998). There is evidence of higher rates of alcohol and drug use amongst the children of substance-abusing parents, and a complex interplay among genetics, family coping styles and psychosocial difficulties.

Velleman (1996) identifies violence, including spouse-to-spouse abuse and child abuse, as one of the most concerning aspects associated with alcohol and drug consumption. Access to resources, including housing, transport and methadone maintenance programs, is an important protective factor in supporting parenting in this higher-risk population (Leif, 1985).

1.3.4 Child abuse

The Christchurch Longitudinal Study (Fergusson et al., 2001) showed that exposure to childhood sexual trauma, abuse or neglect is associated with higher risk of depression, anxiety, conduct disorders, substance-use disorders and suicidal behaviour in adolescence. Australian research indicates that one in three women had experienced some form of abuse in their childhood, with 10 per cent reporting severe beating and 28 per cent reporting child sexual assault involving physical contact (Mazza et al., 1996). Childhood sexual abuse can adversely affect women's experiences of pregnancy, birthing and parenting including ability to bond successfully (Stojadinovic, 2003).

Mothers who have experienced child abuse and who have ongoing relationship and personality issues are at risk of having difficulties in interaction with their infant (Newman, Stevenson, Bergman & Boyce, 2007).

NSW Health has a key role in the protection of children and young people through a comprehensive range of services that enhance the health and well-being of children, young people and their caregivers. Contact with families during pregnancy, at birth and through the postnatal period provides opportunities to address the psychosocial risks, engage with the family and facilitate access to support needs, as well as monitor for signs of potential child mistreatment (Olds et al., 1993). For families with complex or multiple needs, the option of assertive home interventions may provide an opportunity for prevention.

1.3.5 Domestic violence

Living with domestic violence seriously impacts the short-term and long-term psychological, emotional and physical health of women and children who are most often the victims of abuse in the home (Krug et al; 2002; VicHealth 2004).

Domestic violence is common, with approximately 1 in 10 women attending clinical practice currently experiencing persistent emotional, physical and sexual abuse by their partners (Roberts et al., 2006).

Victims of violence and abuse are at increased risk of mental health conditions such as depression, anxiety, post-traumatic stress disorder, and suicide attempts. They are at increased risk of chronic health conditions, physical injuries and elevated risk of homicide (Krug et al., 2002).

In addition, domestic violence is associated with health risk factors such as increased drug and alcohol use, lower level of physical activity, unhealthy eating habits, and exposure to sexually transmissible infections including a higher rate of Pap test abnormalities (Champion et al., 1998; VicHealth, 2004).

Violence during pregnancy has been associated with adverse outcomes including poor weight gain, anaemia, preterm labour, postnatal depression, reduced head circumference in infants, with teenage mothers at increased risk (Krug et al., 2002; Parker et al., 1994; Quinlivan & Evans, 1999). Young abused women are more likely to become pregnant, miscarry and seek terminations than young non-abused women (Taft & Watson, 2007).

Living in families where there is domestic violence affects the social, emotional and cognitive development of children, whether the violence is directly witnessed or not. Children and young people can rarely be protected from the knowledge that domestic violence is occurring. Australian research indicates that up to 61% of those who had experienced previous partner violence and 49% in current relationships had children in their care. One quarter of children reported witnessing the violence (Humphreys, 2007). Exposure to recurrent traumatic experience in early childhood, including domestic violence, places a child at much greater risk of long-term psychological, emotional and behavioural problems (Perry, 1994).

Physical abuse of children is 15 times more likely in families where domestic violence is occurring (McKay, 1994). Children can be at risk of serious harm where domestic violence and physical abuse and neglect of children co-exist. In the majority of cases of child death investigated by the NSW Child Death Review Team (2002), there was also a background of domestic violence (Laing, 2003).

The NSW Health domestic violence pilot project (NSW Health, 2001) identified a set of questions for the screening of women for domestic violence, which have been included in the SAFE START psychosocial assessment. It is now mandatory for antenatal and early childhood health services, together with mental health and drug & alcohol services to screen women for domestic violence in accordance with NSW Health Policy Directive 2006_084. The screening protocol requires staff training and identification of referral pathways, and screening is to be conducted in a safe and private place with no others present, including children over three years.

Screening of women in the perinatal period affords the opportunity for early intervention including the provision of information and support. Simply asking the questions tells the woman she is not alone, that domestic violence can affect her health and her children's health, and that she can get help.

Referrals may be made to appropriate services both within the health system and to other agencies or community organisations for accommodation, financial or legal needs. Where there are concerns that a child may be at risk of serious psychological harm due to the effects of living with domestic violence, a report to NSW Department of Community Services (DoCS) must be made in accordance with the *NSW Interagency Guidelines for Child Protection Intervention*, section 2.3 (2006).

SECTION 2

Psychosocial assessment

A range of bio-psychosocial factors that can contribute to health problems and disorders for mothers and infants is captured in the psychosocial assessment questions (Appendix 1) developed by NSW Health and recommended for universal use in NSW in antenatal and postnatal maternity and child & family health settings.

This section will guide the accurate use of the psychosocial questions and the Edinburgh Depression Scale (EDS/EPDS) (Appendix 2).

The psychosocial assessment process includes the use of two complementary questionnaires: A psychosocial assessment, which is part of comprehensive care undertaken for all women in early stages of pregnancy and the postnatal period. Psychosocial assessment includes depression screening using the EDS/EPDS, which enquires about the woman's level of emotional distress and anxiety in the past seven days. The EDS/EPDS is a screening tool to identify possible current depressive symptoms. Further assessment is required to confirm a diagnosis of depression.

2.1 Psychosocial questions

The SAFE START psychosocial questions cover seven key variables that have been identified as highly significant in contributing to poor maternal and child mental health outcomes:

- Lack of social or emotional support
- Recent stressors in the last year
- Low self-esteem (including self-confidence, high anxiety and perfectionistic traits)
- History of anxiety, depression and other mental health problems
- Couple relationship problems
- Adverse childhood experience
- Domestic violence.

Several other variables are acknowledged as contributing to poor mental health outcomes in children and families. However, these variables are already well covered in current obstetric and child & family assessment processes in NSW Health Services and, therefore, they are not duplicated in the SAFE START psychosocial assessment. Drug use is one of these variables potentially impacting significantly on the family's well-being, and this area is routinely explored by midwives and general practitioners during pregnancy. The development of a psychosocial assessment questionnaire to support the identification of psychosocial risk factors during the perinatal period was informed by research in Australia (Austin & Lumley, 2002; Austin et al., 2005; Matthey et al., 2004) and overseas (Reid et al., 1998). Appendix 3 outlines the antenatal psychosocial assessment questions evaluated in Canada.

It is intended that the psychosocial assessment should be incorporated as part of a comprehensive assessment for all women during pregnancy and again after the baby is born. See the *Maternal and Child Health Primary Health Care Policy*, section 3.1.1 (NSW Health, 2009).

The psychosocial assessment questions are intended as a frontline assessment, for identifying and flagging psychosocial problems. In some instances, referral to specialist health or related services will be required. To ensure effective and efficient intervention, it is essential that pathways to care linked to the psychosocial information have been clearly defined.

Appendix 4 contains specific issues for exploration pertinent to the postnatal period.

2.1.1 Issues in conducting perinatal psychosocial assessment

i. Introduction to the psychosocial questions

Some questions are particularly sensitive and some women may feel discomfort or even distress when asked about various psychosocial issues. For this reason, it is important for the midwife or child & family health nurse to explain the rationale for the assessment and the supportive benefits that may occur. It is recognised that the psychosocial assessment process requires particularly delicate and sensitive enquiry.

ii. Mode of asking the psychosocial questions

Psychosocial questions can be asked verbally as part of the initial antenatal/postnatal interview. The questions can also be self-reported in written form. Each approach has advantages and disadvantages. Administering psychosocial questions as part of the antenatal/postnatal assessment or review has the benefit of enhancing rapport between the clinician, the mother and the family. Administering the questions in the self-report format can take less time and ensure privacy for the respondent, particularly when other family members are present. However, self-administered questionnaires are unhelpful when there are literacy problems, where there is a lack of familiarity with the English language and/or if the health professional does not assess and discuss the report during the session.

Ideally, the questions should be included during pregnancy within a maternity antenatal booking-in database, which allows for standardisation of the assessment process. Matthey et al. (2004) evaluated the placement of psychosocial questions into the OBSTET database at Liverpool Hospital and Nepean Hospital. The project studied the placement of the questions in a 'block format' and an 'interspersed format'. Midwives preferred inclusion of the psychosocial questions in a 'block format'.

OBSTET provided NSW Health with most of the electronic maternity data in NSW. OBSTET no longer aligns with the Strategic Direction for Information Management & Technology (IM&T) in NSW Health and there was a redevelopment of OBSTET to ObstetriX in 2003. The ObstetriX system will be the interim state maternity clinical information system and is currently in place, or being implemented in most Area Health Services (AHSs) in NSW. The ObstetriX system provides point-of-care maternity data collection across the continuum of care. ObstetriX continues to collect all the psychosocial questions that were previously collected in OBSTET.

In AHSs where ObstetriX is implemented, the antenatal psychosocial questions will be asked as per the ObstetriX format only.

iii. Barriers to engagement

Engaging with the woman and family that is expecting or caring for an infant is a core component of any comprehensive assessment. Engagement is an ongoing process. It involves establishing rapport, conveying respect, promoting commitment, participating and building trust. Successful engagement necessitates creative, effective and proactive ways of communicating.

For many reasons some women may not engage as easily as others. Specific factors can contribute to this including: a traumatic past experience with health services; fear of information being shared with government agencies such as DoCS; a past experience of torture and trauma (where the experience of being questioned may trigger severe distress); and culturally appropriate behaviours (eg some women may find frank discussion and disclosure of personal details not culturally appropriate at a first meeting).

Cultural factors and privacy issues are important factors, which may influence the woman's ability to answer the questions.

The Family Partnerships Model (FPM) is a core practice principle underpinning the *Maternal and Child Health Primary Health Care Policy* (NSW Health, 2009, 1.4.2). The FPM is founded on yet goes beyond theory to explore the processes of support and the core skills of engagement and helping.

2.2 Edinburgh Postnatal Depression Scale

Early detection of maternal anxiety and depression may be difficult at a time when overwhelming physical and hormonal changes result in women experiencing some transient mood changes. It is common for women to ignore or deny these emotions and focus on their preparation for and adjustment to motherhood.

The Edinburgh Postnatal Depression Scale is a simple, reliable, valid and user-friendly tool used to check if a woman has been experiencing some emotional distress in the past seven days (Holden, 1994). It is a self-rating questionnaire available in several languages including Arabic, Chinese, Vietnamese and others. It can be administered relatively quickly in a multiplicity of settings (Cox, 1994).

When used to screen for depression in the antenatal period, beyond the immediate postnatal period, the scale is referred to as the Edinburgh Depression Scale (EDS) as a generic term for depression screening during the perinatal period (Cox, Chapman, Murray & Jones, 1996; Murray, Cox, Chapman & Jones, 1995; Murray & Cox, 1990). When administered during the antenatal period the antenatal version of the EDS/EPDS is recommended as this has an appropriate preamble acknowledging 'as you are about to have a baby' (Appendix 2C).

For English speaking women: the antenatal score for probable major depression is 15 or more, and at least probable minor depression is 13 or more. The postnatal

score for probable major depression is 13 or more, and is at least 10 or more for probable minor depression (Matthey, 2006, p.313). Matthey also recommends that for women from culturally and linguistically diverse backgrounds, reference should be made to studies using the EDS/EPDS from the particular culture/ethnic background for a cut-off score.

Research (Cox & Holden, 2003) has indicated that for many women immediate intervention may be unnecessary for women scoring 15 and above antenatally and 13 and above postnatally with the absolute exception being any woman who scores above zero on question 10 of the EDS/EPDS. It is therefore recommended for these women (ie those scoring 15 and above antenatally and 13 and above postnatally, and 0 (zero) on question 10) that a second EDS/EPDS be administered two weeks after the initial screen before any intervention is planned or agreed. There may be individual cases however where clinical judgement indicates that immediate intervention is required.

For any score above 0 (zero) on question 10 it is imperative that the clinician undertakes further sensitive questioning utilising Family Partnership skills (Davis et al., 2002) or a similar, supportive questioning style to commence a risk assessment. The safety of the mother, infant and family is a priority.

Prior to any clinician undertaking administration of an EDS/EPDS it is important that she/he receive training in administration and scoring of the EDS/EPDS and is familiar with AHS policy for assessment and response to consumers with possible suicidal behaviour (based on NSW Health's PD2005_121). Clinicians who administer the EDS/EPDS in NSW Health Services must have appropriate training in preliminary suicide risk assessment and management and understand the requirements of the Framework for Suicide Risk Assessment and Management protocols for General Community Health Services.

Assessment of people at risk of suicide is complex and demanding. Wherever possible, all assessments of possible suicidal ideation should be discussed with a colleague or senior clinician at some stage of the assessment process. The clinician can seek support from the Area Mental Health Service when risk of self-harm is identified, and response will be guided by local protocols. Consideration should also be given to making a report to DoCs in regard to risk of harm pertaining to the infant.

The EDS/EPDS complements the psychosocial assessment questions administered routinely at the first opportunity during pregnancy and repeated in the postnatal period.

While a score of 15 or more in the antenatal period and 13 or more in the postnatal period indicates depressive symptoms, the EDS/EPDS is a screening tool only. If a woman indicates depressive symptoms on two consecutive EDS/EPDS screens, and/or clinical judgement indicates, referral for further assessment should be arranged. A diagnosis of depression (major or minor) cannot be made based on the EDS/EPDS score alone.

SECTION 3

Care pathways

3.1 Introduction

The perinatal psychosocial risk assessment, which includes the psychosocial risk questions and the Edinburgh Depression Scale (EDS/EPDS), allows identification of key issues that may impact on the development of emotional and behavioural problems in infants, children and families.

This section describes a spectrum of mental health and other interventions, which will guide clinicians in choosing specific clinical pathways to care during both pregnancy and the postnatal period, as a response to perinatal psychosocial risk assessment. These interventions include prevention, early intervention, through to treatment and continuing care to maximise the mental health outcomes for women, children and their families (Raphael, 2002). The proposed framework for best service delivery includes:

- Universal support for all families.
- Prevention and early intervention initiatives for families that are vulnerable during the transition to parenthood.
- Specialist or continuing intervention and support for families with complex needs, including mental health needs.

The proposed intervention framework covers the following areas identified during psychosocial risk assessment and depression screen during pregnancy or in the postnatal period:

- Immediate response to risk of harm (either to oneself or others).
- No psychosocial risk factors identified.
- One or more psychosocial risk/s in the pregnancy period:
  - social issues and recent major stressors
  - low self-esteem and history of adverse childhood events
  - past or ongoing history of mental illness (not currently acute).
- Mental health symptoms present (mild or acute).
- Complex psychosocial risks.
- Woman's partner (baby's father) with mental health or substance use problems.
- Some vulnerabilities specific to the postnatal period that are worth exploring include:
  - Traumatic or negative birthing experience
  - Loss of a baby
  - Prematurity and low birth-weight
  - Excessive irritability in infancy
  - Maternal physical disability
  - Past or current experiences of violence

Support for families with psychosocial needs:

- Family support (professional and non-professional support).
- Effective programs beginning near the time of the child's birth and continuing for at least three months.
- More intensive interventions may be more effective and reduce health intervention costs over time than less intensive interventions.
- Relationship with caring, trustworthy adults over time facilitates optimal child development especially in the domain of social-emotional development.
- Parenting behaviours that promote healthy development of infants and toddlers (talking to babies, encouraging exploration, supporting mastery opportunities) need to be encouraged.
- Gaps in parenting knowledge, or negative beliefs and attitudes towards their infants or towards themselves need to be addressed.

The selection of mental health and related interventions outlined is based on the evidence available. It should be acknowledged, however, that at present the existing published research concerning the effectiveness of available interventions for women and their families during the perinatal period is nominal, yet mounting. Findings are likely to be inconsistent at this stage where research foci are varied and the body of evidence is in an early developmental stage. Many local programs and interventions have demonstrated effectiveness anecdotally, yet rigorous evaluation is required, especially in regard to long-term effectiveness. Moreover, the current evidence base reports on predominantly small sample sizes (below 20) resulting in low statistical power. These issues reinforce the importance of scrupulous development and

evaluation of interventions using the principles of clinical effectiveness. Further information about clinical effectiveness is provided in Appendix 5.

It is important to recognise that clinical pathways to care vary according to the specificity of the population, the availability of existing resources, the service configuration and the diversity between city, metropolitan and rural areas. Appendices 6A and 6B provide an overview of the pathways to care during pregnancy and the postnatal period.

3.2 Responses to psychosocial risk assessment

Appropriate clinical responses to psychosocial risk assessment should be decided through a multidisciplinary case discussion process and team management approach as outlined in the *Maternal and Child Health Primary Health Care Policy* (NSW Health, 2009), section 3.3, see also Figure 1, section 3.

The composition of the intake team will vary according to local resources and should represent the key services (Government and non-government) involved in the comprehensive physical and emotional care of the woman, the infant and the family during pregnancy and the postnatal period. The stakeholders most likely to be involved include: midwifery, discharge planning, child & family health, alcohol and other drugs, social work (most Areas employ a social worker for maternity services), mental health, specialist services according to local needs (e.g. Aboriginal, youth, multicultural). A holistic approach to decision-making will consider the physical and emotional needs of the mother, infant and family and respond in an integrated manner, avoiding duplication, referral fragmentation, and breach of privacy policy.

The main role of the multidisciplinary case discussion process is to review the initial assessment and decision-making about appropriate referral pathways. A management plan is developed, a key worker identified and appropriate documentation and updates are included in the relevant notes (medical record). Over time, the multidisciplinary case discussion process should become a source of knowledge and expertise for others in the service. The advantages of clinical representation of various services involved in SAFE START include wider dissemination of information through effective networking, enhanced access to clinical teams, and a culture of sharing, involvement and cooperation, leading to the promotion of good practice.

3.3 Immediate response to acute risk

A review of responses to the psychosocial risk assessment and depression screen should occur prior to the woman leaving the premises, to identify any immediate action that is required. Any of the following would indicate the need for immediate action:

- Obvious emotional distress displayed by the woman.
- Evidence of severe depressive symptoms with feelings of worthlessness.
- Possible suicidal ideation (as shown by any score above 0 (zero) in question 10 of the EDS/EPDS).
- Manifest psychotic symptoms likely to affect the woman's ability to care safely for herself, her infant or her family (eg delusional thoughts and/or auditory hallucinations).
- Disclosure of current domestic violence or unsafe home situation.

Actions

Local protocols to guide a service response to acute risk are essential to ensure safety for the client. The assessment and care pathways must include access to acute mental health assessment and interventions including admission to hospital in situations where non-containable risk to self or others, including the child, is present. Child protection measures become a priority and should be addressed accordingly.

3.4 No psychosocial risk identified

No specific action indicated

For many women, psychosocial risks may not be present and therefore not identified during the assessment process. Several initiatives are underway at State and local levels aiming to enhance the health and well-being of mothers and their families. These initiatives embrace a diversity of health promotion and related activities, such as classes for pregnant women and their partners and support groups for new fathers, and are widely available and accessible.

3.5 One or more psychosocial risk/s identified

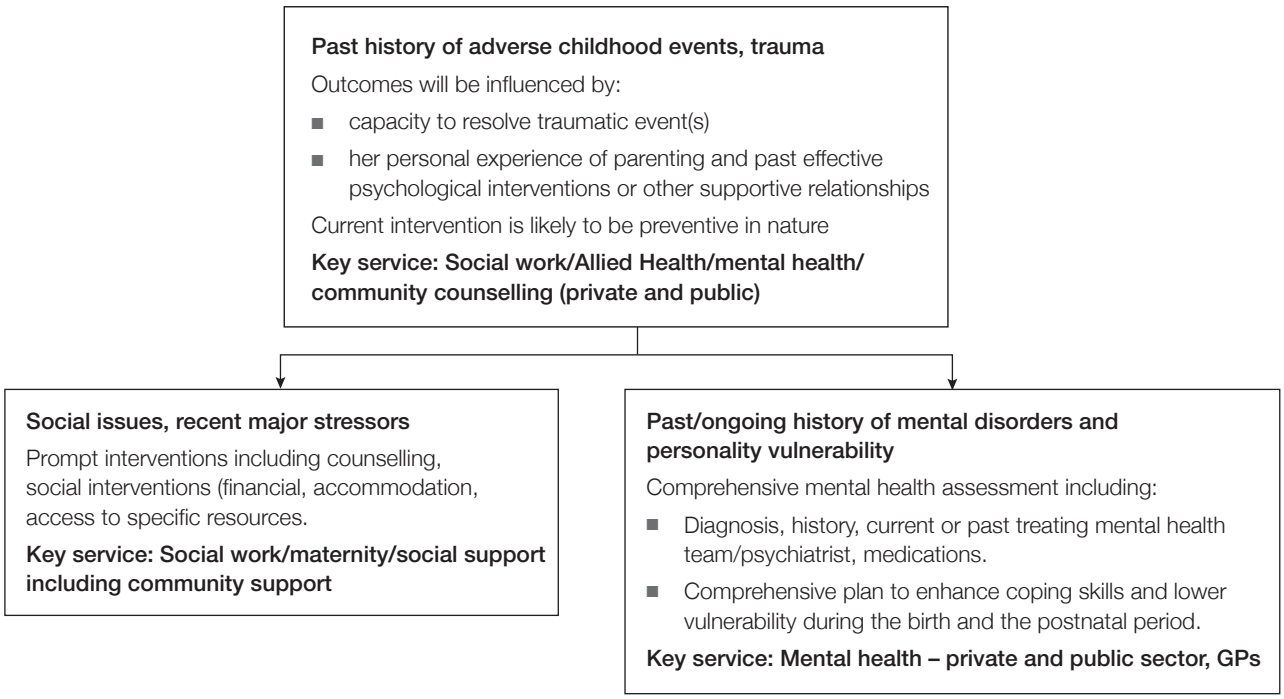
Psychosocial risk factors for mental health problems in women and infants during pregnancy and the postnatal period have been classified into three categories:

- Social issues and recent major stressors.
- Past history of adverse childhood events.
- Past and/or ongoing history of mental illness (no acute symptoms and including partner's history).

Figure 1 summarises the key responses for psychosocial risks identified in the ante and postnatal periods.

3.5.1 Social issues and recent major stressors

Figure 1. Key responses for psychosocial risks identified in the pregnancy and postnatal periods



This category refers to women who respond positively to the psychosocial risk concerning social issues and recent major stressors. This relates to questions 1, 2 (lack of support), 3 (recent major stressors), 8, 9 (partner relationship problems), 11, 12, 13, 14 15, 16, 17 and 18

Example 1. Selective prevention intervention — Schools as Community Centres Program (SaCC). New Focus on 0–3

The aim of this interagency community development program (Departments of Health, Education and Training, Community Services, and Housing and Ageing Disability and Home Care) is to reduce the impact of disadvantage for children entering school by providing integrated services for families in severely disadvantages communities. The program, funded through *Families NSW* emphasises the importance of the early years for learning and development and the role of parents as their child's first teacher. In some Areas (eg the Springfield Family Centre, Central Coast AHS) this program traditionally targeting preschoolers, now has a new focus on families 0–3 years, strengthened by a strong partnership with the child and family nurse.

Interventions may need to continue postnatally. It is important to keep in mind that specialist services do not automatically overlap between the pregnancy and postnatal period. For example, a generic community health worker may continue postnatal counselling provided antenatally by the hospital social worker.

Actions

If a positive response is noted, a further assessment will establish the complexity of the issues arising for the woman during pregnancy or after birth. This assessment can also inform the need for referral to specialist services. This could include agencies or organisations outside of health. Pro-active intervention and advocacy may be indicated in cases where the woman may be too overwhelmed to initiate the contact. This may include organising the appointment, transport to the appointment, writing supportive letters, eg to the Department of Housing.

Monitoring throughout the pregnancy of the efficacy of the intervention provided is essential. Distinguishing between reactive sadness and emergence of clinical depression is important, especially if a past history of depression has been flagged. The regular use of the EDS/ EPDS and, if there is doubt, consultation with mental health services, may be indicated.

3.5.2 Past history of adverse childhood experiences

This category refers to women who respond positively to the psychosocial risk associated with a past history of adverse childhood experiences. This relates to questions 4, 5 (low self-esteem) and 10 (adverse childhood experiences) on the psychosocial risk questionnaire.

Rationale

A past history of adverse childhood events, including physical, emotional or sexual abuse, early neglect and deprivation, may result in serious disruption of the woman's own parenting abilities. Most women will cope well with the experience of motherhood. For some women, however, the experience may raise fears of failing as a parent, reactivate memories of a traumatic childhood or a reoccurrence of mental health problems such as anxiety, low self-esteem and depression, with an impact on their capacity for a sensitive and empathic relationship with their infants.

Actions

The level of distress experienced by the woman whilst talking about her past experiences and her acceptance of the proposed interventions will influence the timing and nature of the service response. A mental health assessment may be indicated to inform the selection of interventions.

When women have received prior effective treatment for disorders associated with adverse childhood events (eg anxiety management or psychotherapy for childhood abuse), a comprehensive mental health assessment will facilitate the development of a management plan formulated with the woman to enhance her mental well-being. This activity is likely to promote a more confident approach to parenting. Short, early interventions such as revisiting anxiety management techniques, self-esteem groups or short-term individual counselling are often sufficient.

Close monitoring by a child & family health nurse (repeat the EDS/EPDS) and health home visiting during the early postnatal period (up to 3 months following the birth) is recommended as the risk for postnatal depression for this group of women is high. Example 2 illustrates the management of a woman with a past history of adverse childhood experiences commencing in the antenatal period.

Women who have a history of sexual abuse can present with significant mental health issues, including depression, alcohol and other drugs misuse, domestic violence, failed relationships, unstable housing and other complex problems. This group of women may be at increased risk of replicating parenting disturbances and may present with complex issues complicated by parenting difficulties and recurrent crisis situations. The pathways of care and management principles will be discussed later in this section.

3.5.3 Past or ongoing history of mental health problems

This category refers to women who respond positively to the psychosocial risk concerning past or ongoing history of mental health problems, but are **currently well and not experiencing symptoms**.

This relates to questions 6, 7 (history of mental health problems) and 8 - 9,(relationship problems that might be related to history of mental health problems). This group of women is distinct from the next category where women are experiencing active symptoms of a mental illness. This is an important distinction relating to the episodic nature of mental illness.

Pregnancy and having a new baby can significantly increase the level of stress experienced in a family. High stress levels have been identified as a strong contributor to relapse or exacerbation of mental health problems or

Example 2. Adverse childhood events

Jennifer is 25-year-old teacher. She has been happily married for the past four years and recently became pregnant. At her antenatal interview, Jennifer told the midwife that she was ambivalent about the pregnancy as she was worried about her ability to be a competent parent. Jennifer reported a two-year history of sexual abuse by her uncle when she was 10 years old. She attempted to kill herself when she was 16 years old and, consequently, was treated for depression and anxiety disorder by a private psychiatrist. She admitted to becoming too easily distressed and feared small changes in her daily routine.

Plan

Jennifer was referred to the antenatal Cognitive Behaviour Counselling group at the local antenatal clinic, conducted over an eight-week period. As Jennifer had never discussed her past with her husband, two counselling sessions were provided to the couple, by the hospital sexual assault counsellor. An EDS/EPDS was administered at 36 weeks antenatally and prior to discharge when she also met the Child & family health nurse. She was home visited twice weekly for three weeks to enhance her parenting skills. Increasing sadness, EDS/EPDS anxiety and EDS/EPDS score of 14 led to a joint home visit with the local Mental Health Acute Care team. A comprehensive management plan was developed with Jennifer and her husband, the community mental health team and the child and family team. The plan was reviewed weekly until all symptoms subsided and the couple felt comfortable coping on their own.

Prevention of depression was not achieved but early intervention resulted in prompt treatment and a limited period of ill-health.

illness. Ideally, the mental well-being of the woman and her close family, strong collaborative partnerships need to be established early in the pregnancy between women's, children's and mental health services.

A mental health worker should complete the comprehensive assessment, which should have a prevention focus targeting long-term risk factors and should include early warning signs as identified by the woman, past effective treatments and source of treatment. Ideally, a key worker should be identified and a comprehensive management plan, which includes a range of preventive interventions, should be develop in consultation with the woman and the family. All case planning must involve the family and should provide activities acceptable to the family. Written information is crucial to ensure positive outcomes and an up-to-date care plan should always be held by the family and key professionals including the family GP (if applicable).

Close monitoring of this group of women throughout the perinatal period is indicated. Collaborative partnership between child & family health, adult mental health, maternity services, the family GP, the woman and her family is crucial to ensure successful health outcomes. Example 4 outlines a comprehensive management plan for a woman with a history of mental illness during the antenatal, birth and postnatal periods.

3.6 Current symptoms of mental health problems

Symptoms of mental illness including psychotic phenomena are usually recognised through clinical observation, at the time of the booked antenatal visit, during delivery or child's family healthcare. Although symptoms of depression and/or anxiety may be identified through depression screening using EDS/EPDS, a thorough assessment is required to reach a diagnosis of depression, anxiety disorder, or any other mental illness or disorder.

Mental health problems can commence during, or be exacerbated by pregnancy. The symptoms may be:

- Mild and the woman is able to function normally.
- Acute, causing significant distress, disturbing daily activities, impairing the woman's cognitive functioning and limiting her parenting skills.

Actions

Mental health problems do not always resolve spontaneously and symptoms can increase in severity after birth. Sometimes families may be reluctant to acknowledge this or seek out treatment. For this reason, non-threatening, assertive, home-based, follow-up care is recommended.

Example 3. Past or ongoing history of mental illness – Case study

Jane 28, is expecting her second child. At the birth of her first child, now five years old, Jane became psychotic and spent two months in a psychiatric in-patient unit. Two further psychotic episodes led to a diagnosis of schizophrenia. Jane has a supportive family, she occasionally contacts her psychiatrist at the local health centre, and she stopped taking her medications when she found out she was pregnant.

The following plan was formulated with Jane and her husband:

- Appointment with the psychiatrist to discuss issues of medication, pregnancy and breastfeeding, stress management to prevent relapse, warning signs and access to acute mental health services.

As relapse of mental health problems can be expected in the first few days/weeks after delivery (due to higher stress levels), a management plan for the inpatient delivery period was formulated including:

- Single room to promote low-stimuli environment, extra rest and sleep.
- Husband allowed to stay at night to provide emotional comfort and help care for the infant.
- Encouragement to stay in hospital for four days after delivery.
- Review by the Consultation Liaison team, which also informed the community psychiatrist.

As Jane chose to recommence medication following delivery, treatment was initiated in hospital and monitored by the midwives. Home visits were provided jointly by the Child & Family Health nurse and the Mental Health nurse (who met Jane while she was in hospital) for three months, to monitor and enhance the family's well being. Monitoring included the relationship between the mother and infant, specifically parenting skills. Extra support from the local volunteer service was offered.

3.6.1 Mild symptoms

Mild symptoms of anxiety and depression are often unrecognised or not addressed, because the woman may appear to be functioning adequately. These symptoms often continue from pregnancy through to the postnatal period (Evans et al., 2001). Management may be more complex because the woman has little available time to adhere to regular therapy or attend groups. The universal use of the EDS/EPDS in association with the psychosocial assessment questionnaire is an efficient way of identifying emerging issues and to monitor for potential escalation of illness.

3.6.2 Acute symptoms

Acute symptoms can be manifested by severe changes in affect (depression–mania) and/or psychotic phenomena. In each case, urgent assessment and interventions are necessary to reduce the woman's distress and also to make the decision about the person's capacity to parent at that time. This is a time when the family context is crucial and the best outcomes for the woman and the infant are often related to supportive and understanding relatives and friends.

Timely comprehensive assessment should be followed by appropriate bio-psychosocial interventions. Information and education should be offered to the woman and her family. Impact of medications on the fetus or the breast-fed infant and side effects, especially sedation, need to be balanced against the potential serious consequences of untreated psychiatric illness. The safety of the mother and the infant is paramount in selecting the type and level of intervention.

Several treatment options are available for women who are acutely mentally ill. Figure 2 illustrates three possible modes of treatment for women in this category including referral to a private psychiatrist or general practitioner, referral to community-based adult mental health services or inpatient care.

The woman and her family should be presented with the range of options available and actively participate in the decision-making process. Decision-making regarding treatment options will be influenced by several factors including the:

- Severity of symptoms and the level of cognitive impairment resulting from the illness.
- Level of support, especially in the domains of caring for the infant, performing household chores and other daily activities usually undertaken by the woman.
- Presence of co-morbidity (use of alcohol and other drugs, physical complications).
- Level of risk to the woman and others (including suicide risk and risk of harm to the infant) if home treatment is selected.
- Ability of the family to cope with the woman's symptoms (this will be influenced by the number of people available to help and the length of time between the onset of symptoms and the actual intervention).
- Availability of local comprehensive acute mental health services to provide home-based intensive care.

Inpatient care

If hospitalisation is inevitable, admission of the mother and infant is the best option but it may not always be available, particularly in rural areas.

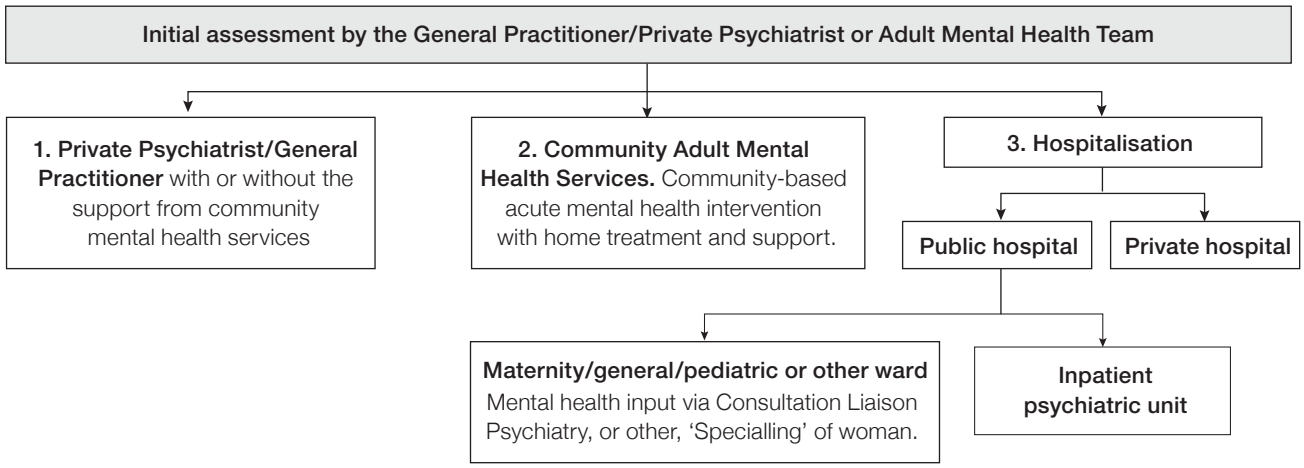
Clear protocols, collaborative partnerships with midwives and child & family health nurses to support the mental health staff, need to be in place to support perinatal psychiatric admissions. Some identified issues include the level of acuity and staffing in the unit, the access to local Women's and Children's Health Services and the location in the unit. The mother and infant should be located in close proximity of the nurses' supervision and monitoring.

Admission to a ward in the local hospital may be possible. This may be the maternity ward where the woman delivered her baby or a general ward. The success of this practice is based on collaborative partnerships between the services involved. It demands clear protocols and clinical pathways. It also requires ongoing clinical input from mental health staff (including after hours) that, depending on the service model, would generally be the Consultation Liaison Psychiatry team or another identified mental health team.

Non-Government organisations

Some mothers with a history of mental illness, socio-economic problems and a long-term risk of parenting problems may benefit from long-term residential care

Figure 2. Three levels of intervention for women experiencing severe clinical symptoms during the perinatal period



that will address the woman's on-going mental health issues, her social difficulties (eg accommodation) enhance her parental skills and strengthen the mother–child relationship. These services are Statewide, often run by NGOs and work closely with child protection agencies. They are limited in numbers and the best outcomes are achieved with extensive planning occurring during the antenatal period when multiple risk factors are identified.

3.7 Families with complex needs

This category refers to women who respond positively to multiple questions on the psychosocial risk questionnaire. The EDS/EPDS score is not necessarily reliable for placing women into this category.

The multiple characteristics that could be identified in this group of women include:

- Parental mental health related disorders including alcohol and other drugs issues and/or personality disorder.
- Maternal history of child abuse with involvement of child protection agencies.
- Involvement of child protection agencies for other children in the family.
- Unstable, non-supportive social context including homelessness, extreme poverty, domestic violence.
- Any of the above complicated by severe, chronic medical problems and or parental intellectual disability.

Families with complex needs can be defined as families that, because of current circumstances and or life history and personality vulnerabilities, are likely to require specialist and intensive response from a number of services and, or, agencies, to achieve best health outcomes in the postnatal period. It may be noted that the intensity of intervention may be variable over time depending on needs. These families may experience ongoing disruption and distress but can also cope relatively well for long periods of time.

Excerpt from the electronic brochure re Charmian Clift Cottages (circulated via email, 2008)

The Richmond Fellowship of NSW (RFNSW) understands that women experiencing mental health issues can benefit from assistance with routine planning, living skills and parenting. This is especially important if they are homeless or at risk of becoming homeless. Serving clients from across NSW, Charmian Clift Cottages offers stable, supported accommodation for up to 3 months for women living with a mental illness and their dependent children.

Charmian Clift Cottages also provides mental health information and referrals for mothers and children. Ongoing support may be provided for families on their return home. Accommodation is provided in six furnished self-contained 2-bedroom villas. Disabled access is available. There is a shared laundry and outdoor BBQ facilities.

Charmian Clift Cottages aims

- Provide accommodation in a safe and secure environment.
- Enable women with mental health issues to become more independent.
- Help them become more aware of their illness and to help prevent relapses.
- Help them develop living and parenting skills.
- Provide access to mainstream support for women with mental health issues and their children.
- Promote a safe and stable home life.
- Advocate on behalf of women with mental health issues and their children.
- Strengthen relationships between mothers and children.
- Enhance children's development by providing activities that meet their developmental needs.
- Provide opportunities for mothers to gain greater understanding of their children's communication and developmental needs.
- Provide age appropriate activities that enhance the development of children.
- Instil a sense of hope, self-confidence and self-esteem.

RFNSW believes that with appropriate support a parent with mental illness can be an effective parent. The support offered at Charmian Clift Cottages aims to ensure that women with mental health issues and their children have greater opportunities to live independently, secure and free from the worry of becoming homeless. A team of support workers with specialist knowledge and skills will provide a broad range of educational, vocational and disability support to meet the women's needs. They will provide opportunities for mothers to discover their strengths as parents and how they can optimise the development of their children. Individual support planning will include a variety of resources to ensure that clients (women and children) have access to the full range of services they require, using psychosocial programs focused on developing living skills, parenting skills and the maintenance of good health. Referrals to Charmian Clift Cottages can be made by health professionals, case workers, social workers or family members. Self-referral is also possible using the referral form downloadable from the RFNSW website.

They can also relapse rapidly and unexpectedly if unanticipated trauma affects their life. For this reason, it is critical that strategies to address safety issues and ongoing vigilance by involved health professionals be in place to support parenting and child development until school entry. Communication between families and the various agencies involved is required to ensure positive health outcomes.

> 'Disturbed parents and disturbed families have a tendency to involve a whole range of professionals, commonly referred to as multi-agency families. The more problems the disturbed family presents, the more professionals get recruited to provide "help". Frequently such "help" further enhances the parents' sense of failure, thus requiring more help which, in turn, leads to an even more helpless posture of the parents.' (Schuff & Asen, 1996).

Action

Early identification of families with complex needs can be delayed because of late presentation to antenatal services, poor attendance at appointments and incomplete or inconsistent history provided. Families may deliberately avoid contact with health services if past experiences with the services have been negative or traumatic.

Families can be so absorbed with their multiple problems that they have difficulty mastering the complexity of interventions proposed to them by professionals. This can be interpreted as non-compliance, when in fact it may relate to a multiplicity of problems confronting the family. For example, culturally and linguistically diverse families may be fearful of losing their children to welfare agencies, or of being perceived as incompetent parents because of their own childhood experience, because of media reporting or simply because of lack of knowledge. Some families may have special issues such as literacy problems, extreme poverty, or geographical isolation, which they may not want to discuss.

Families already engaged with multiple agencies and services can become confused by the 'seemingly uncoordinated actions' of various professionals. It is especially important, in working with families that have complex needs, to have clearly articulated roles for the services and professionals involved.

Child protection is a key issue for consideration in working with families that have complex needs. Reference to the *NSW Interagency Guidelines for Child Protection Intervention* (2006) is essential, appropriate protocols must be in place and staff must be trained to implement the guidelines.

3.7.1 Prenatal and postnatal child protection

Child protection is a key issue for consideration in working with families that have complex needs. The relevant child protection legislation in NSW is the *Children and Young Persons (Care and Protection) Act 1998*. This legislation is operationalised through the *NSW Interagency Guidelines for Child Protection Intervention* (2006). It is essential that appropriate local policy and protocols are in place and that all staff are trained to implement the guidelines.

Subsequent to the issue of the *NSW Interagency Guidelines for Child Protection Intervention* (2006) the NSW Ombudsman released a *Report of Reviewable Deaths* in 2005 *Volume 2: Child Deaths* which contained a recommendation (30) that NSW Health and DoCS should jointly develop a state-wide policy by which hospitals can alert DoCS about the birth of a baby, and through which a coordinated response to any concerns about risk to the baby can be initiated. In March 2007 the *Children and Young Persons (Care and Protection) Miscellaneous Amendments Act 2006* was passed to help facilitate information sharing and reporting requirements for a prenatal reporting system. NSW Health policy directive PD2007_023, which was developed in consultation with DoCS, was circulated to ensure NSW Health staff understand their obligations in relation to prenatal reports and the legislative changes.

NSW Health and DoCS are seeking to implement a system for responding to prenatal reports in order to standardise response procedures. It is proposed that the AHS section 248 Central Contact Points will be involved in liaison between DoCS and relevant health services as part of the system. A two tier system is proposed for responding to prenatal reports:

1. After receiving a prenatal report DoCS will issue a section 248 direction for information relating to the safety, welfare and well-being of an unborn child. This direction will be issued via the Area Health Service Section 248 Central Contact Point and will act as notification of a prenatal report to the specific health service to which it is directed.

2. In high risk cases DoCS will issue an Unborn Child High Risk Birth Alert form to section 248 Central Contact Points. The CCP will distribute the form to relevant health services within their auspices and this will act as notification of a prenatal report to those services.

A health service notified that a prenatal report has been made will be required to make a further risk of harm report to DoCS if deemed appropriate once the child has been born.

3.7.2 Early identification of families with complex needs

Early identification of families with complex needs who may have difficulties providing a safe and nurturing environment for their children is imperative. Early intervention can support, strengthen and empower the family to reach their greatest potential as parents.

There are three important areas to include in the assessment process for these families:

- parental understanding of children's basic developmental needs (Ivaniec, 1995)
- parental capacities including strengths that promote positive parenting and the ability to provide:
  - physical care and protection
  - affection and approval
  - stimulation and teaching
  - structure, routine and protection from danger consistent and appropriate to the child's age and stage of development
- parental negative attributions about the infant, or any child.

3.7.3 Interventions

Advocating a broad ecological perspective for the promotion of child welfare in working with families with complex needs is important. This includes recommending that the responsibility for children's well-being lies not only with parents and families but also with the community at large (Dubowitz, 1993). This view supports the importance of collaborative partnerships with families at risk and is reflected in the *Children and Young Persons (Care and Protection) Act 1998* (NSW) and the *NSW Interagency Guidelines for Child Protection Intervention* (2006).

> 'The Act has a number of provisions that allow children and young people, as well as parents and any other persons in some restricted circumstances, to ask for assistance from the Department of Community Services before a problem becomes more serious… a parent of a child or young person may ask the Department of Community Services for assistance to obtain services that will enable the child or young person to remain in or return to the care of their family.' (*NSW Interagency Guidelines for Child Protection Intervention* 2006).

Early intervention is initiated, if practical, at the first contact with health services. This enables:

- Short- and long-term goal setting, advocacy activities and monopolising of resources (such as safe housing, baby's equipment, extra support, care of other children during the birth period).
- A coordinated, collaborative, efficient approach to care that ensures synchronised appointments, appropriate sharing of information, maintaining privacy and confidentiality within reason and streamlining of interventions to avoid duplication or conflicting information.
- Identification of bio-psychosocial needs by the woman and the health professionals. It is important to note that the woman may have a perception of her needs as different from the health professionals' perception; hence, the importance of ensuring clear communication, accurate information sharing and negotiation of common goals.
- Identification of services and/ or agencies involved currently and in the past (eg the support of local volunteers with other children in the family).
- Organisation, in collaboration with the family, of initial and subsequent care planning meetings involving all relevant stakeholders, ideally commencing in the antenatal period and continuing through after birth. An example of invitation to a stakeholder meeting is provided in Appendix 7.
- A team management approach to case discussion and care planning underpins intervention for families with complex needs. This approach is described in the *Maternal and Child Health Primary Health Care Policy* (NSW Health 2009, 3.3).

3.7.4 Care planning during the perinatal period

Care planning has been identified throughout the *NSW Health/Families NSW Supporting Families Early Package* as a key intervention for families with complex needs, commencing in the antenatal period and continuing through to after the birth of baby. The woman and her family should always be included in the process of planning, except when the welfare or safety of the woman and/or, the infant would be compromised. Regular review of the care plan and multi-disciplinary peer review (or supervision) for health workers involved with faimiles who have complex needs is important.

3.7.5 Caring for families with a substance use problem

Women who misuse drugs (sometimes complicated by mental health problems) may have complex psychosocial needs and specific issues require attention:

- Special consideration needs to be given to the current drug use. This includes drug management, reduction or cessation, and access to appropriate drug treatment, if requested. Most women using drugs in pregnancy or when caring for an infant feel guilty and may attempt to self-withdraw (by going cold turkey or by

substituting another drug).
This can lead to negative outcomes for the fetus (intrauterine death as in the case of heroin withdrawal) or for the woman (seizures in the case of benzodiazepine cessation), or for the infant (decreased maternal attunement capacity).

- Identification of specific health problems that are likely to affect the well-being of the fetus and/or the breast-fed infant, including poor nutrition and blood- born viral infections.
- Neonatal withdrawal from drugs such as heroin and benzodiazepine. Most NSW maternity hospitals have local protocols for nursery care of these children. These protocols are based on PD2005_494).

The *National Clinical Guidelines for the Management of Drug Use during Pregnancy, Birth and the Early Development Years of the Newborn* (2006) will guide clinicians to provide evidence-based care to parents with a substance use problem during the perinatal period.

Some specialised services for women who misuse substances during pregnancy provide a comprehensive range of interventions to this high-risk group.

The 'Substance Use in Pregnancy and Parenting Service' (SUPPS) program provides a case management model that facilitates continuity of care, which includes assessment, planning, implementation, monitoring and review. SUPPS liaise with other service providers such as mental health, housing, counselling and correctional services to provide optimal access to services (Hudoba 2005).

3.8 Other important perinatal psychosocial issues

There are a range of issues that may increase risk for adverse psychosocial outcomes for families during the perinatal period, such as:

- Traumatic birth experiences
- Loss of the baby
- Prematurity, low birth weight, illness or disability
- Excessive infant crying
- Maternal physical disabilities
- Partner that has past or current mental illness

These issues are generally identified as part of routine assessment processes conducted by relevant health professionals. The EDS/EPDS is an important aspect of this assessment process.

Some families may experience increased risk of adverse psychosocial outcome as a direct consequence of the pregnancy and/or the birth experience. We all cope and recover from trauma and/or loss in various ways and at different paces according to past experiences, individual resources and current levels of physical and mental health, and support (emotional, practical and social). Trauma and/or loss for families who are expecting or caring for a baby can create significant complexities and challenges to coping and recovery capacity for individuals, and the family as a whole.

The evidence linking factors such as prematurity, low birth weight, excessive infant crying and maternal physical disability are discussed. The field of perinatal and infant mental health is dynamic. It is important for health workers to continually update assessment and intervention knowledge through keeping abreast with current clinical evidence; and to review assessment perspectives and intervention decisions with peers.

Actions

3.8.1 Traumatic and negative birth experiences

Women's perceived negative birth experiences have been implicated in the development of mental health issues in the postnatal period. For example, for a small proportion of women, pregnancy and birth complications including caesarean section, forceps delivery and vacuum extraction, were linked to postpartum depression (Campbell & Cohn, 1991). Most women recover quickly and spontaneously but a small proportion of women continue to experience significant distress (Laurence, 1997).

Traumatic and negative birth experiences can lead to:

- Impaired ability to breastfeed and bond with the infant.
- Persistent vague pains.
- Unexplained anger.
- Nightmares of re-experiencing the birth (or other traumatic event).
- Inability to resume sexual activities.
- Avoidance of future pregnancies.
- Request for planned caesarean section in future pregnancies.
- Maternal depression and/or other mental heath problems.

Laurence (1997) identifies extreme pain and a sense of loss of control as two common features of childbirth that can potentially lead to traumatic birth experiences. To promote prevention and early identification, Laurence suggests the following:

- High quality communication and adequate pain relief according to the woman's wishes during the birth, which allows the woman to feel in control.

- Postpartum recognition of the traumatic birth experience which can enhance early intervention.
- Careful and sensitive questioning about past pregnancies during the antenatal psychosocial assessment will support the formulation of an appropriate management plan for the coming birth.

3.8.2 Loss of a baby

Families that have lost a baby through miscarriage, abortion, stillbirth, neonatal death or sudden infant death syndrome experience severe psychological distress, sometimes under-estimated by relatives, friends, and health professionals. Parents work through their grief in different ways but the death of an infant is particularly traumatic and various health problems in the mother can be expected. They include general ill-health, tiredness, high levels of anxiety, panic attacks, insomnia, social adjustment problems and relationships disturbances (Nicol et al., 1986).

In a cohort study of 60 women who had experienced stillbirth, Hughes et al. (1999) found that rates of anxiety and depression in a subsequent pregnancy were significantly higher for women who conceived within one year of the stillbirth. The decision to have another child following stillbirth is a personal one but the need for sufficient grieving time is recommended, especially when psychological distress is severe and persistent.

3.8.3 Prematurity and low birth weight

Prematurity and low birth weight resulting in admission of the infant to a neonatal intensive care unit has also been linked with family maladjustment and poor outcomes. These infants are likely to have more difficult temperaments and behavioural problems including feeding and sleeping, than full-term infants. They are also more vulnerable to neonatal medical complications, long hospitalisations and delayed or abnormal cognitive development (Affleck et al., 1991). As a consequence, mothers are more likely to experience greater stress, psychological distress, anxiety and depression, and early parenting behaviours and attachment can be affected adversely (Taylor et al., 2001). The key characteristics leading to positive outcomes include the parents' ability to set appropriate expectations, to view the child's quality of life as high (even in the presence of significant disabilities) and to adapt to, and compensate for, the child's needs (Taylor et al., 2001).

Recognition of the special needs of vulnerable families is crucial and should occur as soon as possible, and the pathways to care should be identified to ensure appropriate interventions that promote adjustment and adaptation.

Example 4: Neonatal Intensive Care (NIC) Graduate Playgroup, Westmead Hospital, Sydney West Area Health Service

This open group aims to provide support for parents of premature and low-birth weight children. The objective of the group is to help parents to deal appropriately with the intense trauma they have faced, enhance their parenting skills to meet the specific needs of their infant and to promote sharing of information and experiences between the parents. The hospital-based group is run by social workers; it targets families of in-patient infants. No formal evaluation of the program has taken place.

Example 5: Case study

Jasmine and Joe have four children under the age of three. They have a son each from prior relationships. The new pregnancy was unexpected and a car accident led to the premature caesarian section delivery of twins at 31 weeks gestation.

The infants were discharged seven weeks later; appointments to the early childhood health clinic and at the paediatric outpatient clinic were made. Jasmine and Joe did not keep their appointments. The local GP referred Jasmine for assessment of depressive symptoms four months later. She had an EDS/EPDS score of 19 and a thorough mental health assessment led to a diagnosis of major depressive illness.

The following issues were identified. Jasmine had difficulty managing the four children, her stepson became emotionally distressed. His behaviour became difficult to manage. Joe stopped work to help, and because of the financial hardship, the couple moved in with Joe's elderly parents in their three-bedroom cottage. Lacking transport, the couple could not attend their appointments. Due to the limited attention and stimulation of the infants, they had progressed poorly.

Optimal, more effective intervention prior to discharge from the hospital after the birth of the twins would include:

1. A multi-disciplinary case-planning meeting with key stakeholders including the local child & family health nurse, the social worker, the paediatrician and the family GP (using teleconferencing if attendance was problematic).
2. Assertive health home visiting by child & family health nurse.
3. Identification of problems beforehand or as they arose, and early intervention (Centrelink, Mental Health, Child and Adolescent Mental Health Services for older son, administration of EDS/EPDS in early stages, physiotherapy for the twins, volunteer support, and preschool attendance for the older sons).

Example 4 describes a neonatal intensive care intervention that was delivered for parents of premature and low-birth weight babies at Westmead Hospital, Sydney West AHS.

Example 5 (page 26) illustrates how multiple births complicated by prematurity can impact on a young family and trigger a chain reaction leading to vulnerability of the whole family.

Table 1 (page 27) lists the interventions available in the intra-partum period (birth period) for women who have had traumatic and negative birth experiences or the loss of a baby, or have premature or low birth-weight babies.

3.8.4 Excessive infant crying

Infant crying usually leads to a rapid response and intervention by the mother or other caregiver. Unmanaged, excessive crying and irritability can have a major impact on the family, resulting in disturbed sleep patterns for all family members, maternal irritability and depression, marital breakdown, and, in extreme cases, child abuse (Armstrong, 2000). Armstrong's research indicates that infants' excessive crying is often misdiagnosed and organic, infant-based diagnosis can lead to over-prescription of medication, and the identification of a 'special' child with long-term behavioural concerns. Armstrong also comments on the recurrent high EDS/EPDS scores of mothers of irritable infants. He identifies a multiplicity of factors needing attention, including parental experiences with children, parental mood and psychological status, parental cognitive state and the infant's temperament, all of which will influence the perception of their infant.

The long-term impact of excessively unsettled, crying babies can be addressed by a multi-disciplinary approach to the problem, including:

- A comprehensive bio-psychosocial assessment (including EDS/EPDS) in order to understand the factors leading to the presentation;
- The greater use of day-stay facilities (such as Tresillian, Karitane, Family Care Cottages); or, if possible;
- Management of the infant and the family in a residential setting (such as Tresillian, Karitane or a Paediatric unit) where social work and mental health input are available.

An excessively quiet baby that is also flat/floppy and/or has limited appropriate responsive interaction (for age) requires prompt attention. A multidisciplinary approach to this problem can be followed as per the three points above.

3.8.5 Maternal physical disabilities

Physical disabilities generally are no obstacle to competent parenting; they simply bring about ingenious adaptations by mothers to care fully for their infants. For example, mothers with disabilities successfully teach their infants co-operation techniques very early in life (Kirshbaum, 1988). There is a potential to address community attitudes towards mothers with physical

Table 1. Pathways to care for the intra-partum period (birth period) for women who have had traumatic and negative birth experiences, loss of a baby or have premature or low birth-weight babies

Timing	Interventions
Birth (Trauma: infant/mother)	■ Identify the extent of the problem. ■ Initiate immediate physical and psychological interventions, including midwives/social worker/ consultation liaison (CL psychiatry) team, as appropriate. ■ Record and monitor signs of increasing emotional distress, depression, anxiety, anger. ■ Validate distress.
Postnatal (Maternity ward/ intensive care nursery)	■ Address current physical complications. ■ Initiate interventions to enhance bonding and limit family's distress. ■ Identify possible concurrent existing problems not always identified in the antenatal period (eg inadequate housing, low income). ■ Offer counselling (via social work department or CL team). ■ If counselling is indicated post-discharge, community counselling will need to be organised promptly. ■ Plan discharge by identifying anticipated long-term needs. ■ Organise a pre-discharge care planning meeting involving all appropriate stakeholders, including family and community support and professionals. ■ Promote mental well-being by providing education and coping strategies to the family. ■ Support parenting skills. ■ Administer EDS/EPDS to screen for current anxiety and/or depressive symptoms if clinically indicated.
Immediate post-discharge (home-based)	■ Home-based intervention, frequency and duration according to needs initiated as soon as possible. ■ Propose/provide range of interventions to support family adaptation including referral to specialist services (eg Mental health) if appropriate. ■ Repeat EDS/EPDS. ■ Monitor the well-being of family members especially partner (consider using EDS/EPDS). ■ Review effectiveness of the care plan and formulate new intervention with family, if indicated.

disabilities to overcome the commonly held belief that women with physical disabilities should not become mothers (Westbrook & Chinnery, 1995). Westbrook and Chinnery suggest that negative community attitudes are an additional problem for mothers with physical disabilities as they can undermine the woman's confidence and provoke feelings of guilt. Their study indicated that women with physical disabilities received significantly less support from their relatives (especially their own mothers), and they also were more likely than able-bodied women to use services in the home that directly or indirectly assisted with childcare.

Women with physical disabilities need to have opportunities to determine for themselves the specific and appropriate support required to achieve the optimum potential as a parent. Access to Health Home Visiting can facilitate this.

3.8.6 Partner with past or current mental illness

Many people are affected by mental health problems and mental disorders at some stage of their lives and require appropriate assessment, treatment and support services provided and/or organised by a mental health professional. Early detection and early intervention may minimise an episode of mental illness and enable an early return to optimal wellbeing and functioning. When the partner of a woman who is expecting or caring for a baby has a mental illness, or has had an episode in the past there are important issues to consider.

Stress can and does affect the mental state of any of us, particularly during pregnancy, birth and care of a baby. In this context, a partner may be a husband, defacto, same sex partner and/or key support person (such as mother, best friend or other confidante who provides key emotional and practical support). If the partner has had a mental illness in the past, or is currently experiencing a mental illness, it is crucial to embrace a relapse prevention approach to promote mental health for the family.

Prevention of relapse and promotion of recovery are priorities for the partner of a woman who is expecting or caring for a baby. Ideally, the partner would be encouraged to see a mental health professional (or appropriate supportive counsellor) who can provide ongoing supportive assessment, monitoring and relapse prevention counselling in a setting of the partner's choice. In situations where the partner has a current episode of mental illness, a comprehensive care plan should be developed collaboratively with the partner and other people nominated by him/her; including strategies for relapse prevention and links with a general practitioner; and other health and welfare services as appropriate. In some cases, when required, the partner may be referred to specialist rehabilitation and support services, which may include housing, vocational, recreational or leisure services.

Relapse prevention for the perinatal partner

In the course of illness, relapse is a return of symptoms after a period of time when no symptoms are present. Any strategies or treatments applied in advance to prevent future symptoms are known as relapse prevention. Reminding the partner that a stressful life event such as expecting or caring for a baby can sometimes contribute to triggering an episode of mental illness and it would be important to be aware of how stress may affect them so they can be prepared to deal it. Consistent and regular self-monitoring and early intervention are the keys to preventing relapse and episode recurrence.

Self-monitoring – signs and symptoms of mental illness are unique to each person. In order to detect an oncoming episode, it is essential that the partner is aware of their own early warning signs and symptoms of their illness. Awareness of early warning signs will only be of use if they are monitored regularly.

Regular self monitoring of mood, symptoms and early warning signs will be important to ensure that the partner can get early intervention to prevent relapse during the time that the mother and baby will need support.

Early intervention plan – it is important that the partner is provided with support to develop an early intervention plan that details their most significant early warning signs, what they would do if these signs appeared; what they would ask their family and friends to do if early warning signs appeared, and what they could be asked to say or do if the partner became unwell.

SECTION 4

Role of mental health services in SAFE START implementation

4.1 Introduction

Mental health services provide a range of consultation, education, liaison and clinical interventions (community- and hospital-based) for families experiencing mental health problems or disorders. This is a small but important role and involves the direct and indirect provision of mental health care. The policy and planning context in section 1.3 of the *SAFE START Strategic Policy* outlines the range of services, agencies and service providers that comprise 'mental health services' in NSW.

The roles of the Adult Mental Health Service and Child and Adolescent Mental Health Service in supporting women and families during the perinatal period should be complementary. A proportion of women in the antenatal and postnatal periods will be identified with psychosocial risks from the psychosocial assessment. However, not all of these women will need to be seen by mental health services.

Whilst mental health issues, such as anxiety and depression, are common throughout the life span, with a greater vulnerability during the perinatal period, most are time-limited and dealt with by the various primary health care services available within the public and private health system, and the NGO sector. In some areas, Health Services and general practitioners are the main service providers (through the Antenatal Shared Care Program). Mental Health services may be consulted or included in care planning but usually do not become involved clinically with the family.

Some women will require specialist mental health service intervention. Some women, because of specific vulnerability or circumstances, will be unable to resolve the current emotional crisis without specialist mental health intervention, eg women who experience severe anxiety or suicidal ideation. This intervention is likely to be short-term and intensive—it may require a brief hospitalisation or regular home visits by the local Acute Community Care team—with referral back to primary health care services once the acute situation has been stabilized.

A second but significant group of women and/or partners have had an on-going mental illness prior to the current pregnancy. This may have involved contact with mental health services in the past or the person may be an active client of the service.

For mental health services to respond appropriately and adequately to the needs of families with mental illness during the perinatal period, consideration needs to be given to the service configuration that best addresses the mental illness in the mother or partner in a family context, including the relationship with the new infant and other family members. This could be provided through the adult mental health services, child and adolescent mental health services, or a perinatal mental health service. Collaborative partnerships with general practitioners and maternity, child & family health services are essential.

4.2 Perinatal and infant mental health expertise

Perinatal mental health expertise includes a comprehensive knowledge and understanding of perinatal mental health assessment and treatment of parental psychopathology, mothercraft skills, child development stages, attachment theory and parenting skills.

Within the 'perinatal mental health service' (however, configured), access to the expertise of perinatal and infant psychiatry is important. Some strategies to enhance this include the following:

- Inclusion of perinatal and infant mental health in regular in-service and supervision activities for psychiatric registrars provided at Area level.
- Development of perinatal and infant mental health clinical practice guidelines for psychiatrists and registrars.
- Identification of psychiatrists, child and adolescent psychiatrists and psychiatric registrars with a particular interest in perinatal and infant mental health.
- Use of teleconferencing, on-line supervision, regular training packages or workshops to support rural perinatal and infant mental health service provision.

Example 6. Providing perinatal and infant mental health services through collaboration

Joanne is mother of a healthy six-month-old boy. Following multiple complications including a six-month hospitalisation during pregnancy due to relapse of a brain tumor, severe eclampsia, and the death of four close family members, including the stillbirth of her nephew, Joanne experiences severe depression, has occasional suicidal ideation and has difficulty leaving the house. The relationship with her husband has deteriorated and he admits to having thought about leaving the marriage. He works shifts and is the main carer for the child. Joanne admits that she does not feel that her son belongs to her and cares for him out of guilt and duty. The couple has financial difficulties but good family support. They are very protective of their privacy and identify the recent medical interventions delivered by multiple teams and professionals as very stressful.

Issues:

- Clinical depression requiring regular risk assessment and monitoring of symptomatology and effectiveness of medications.
- Impact of maternal depression on interaction with baby.
- Relationship difficulties.
- Husband's emotional distress.
- Parental sense of grief and loss.
- After hours/home-based and potential crisis intervention required.

Actions suggested:

- Collaborative, comprehensive intervention.
- Limited number of clinicians working together rather than independently – ideally this may include a designated member of the mental health acute care team (rather than 'a team approach'), a child & family health nurse (with expertise in attachment difficulties and grief counseling skills) and a psychiatrist with perinatal mental health expertise (may be from adult or child and adolescent mental health background).
- An alternative would be referal to a local GP and psychologist or other mental health professional through GP referral.
- A primary clinician to coordinate interventions with a longer-term role depending on specific residual needs.

Example 6 demonstrates the potential adaptation of existing mental health and related systems of care, tailored to the individual family needs in the perinatal period. The following criteria contributed to the optimal outcomes for the whole family:

- Tailored individual and family care.
- Recognition that all needs are interrelated and improvement in one is likely to effect a chain of improvement.
- Identification of key clinicians by their individual skills and expertise rather than job description or team allocation.
- Potential for joint intervention, eg the child & family health nurse may home visit jointly with a mental health worker.

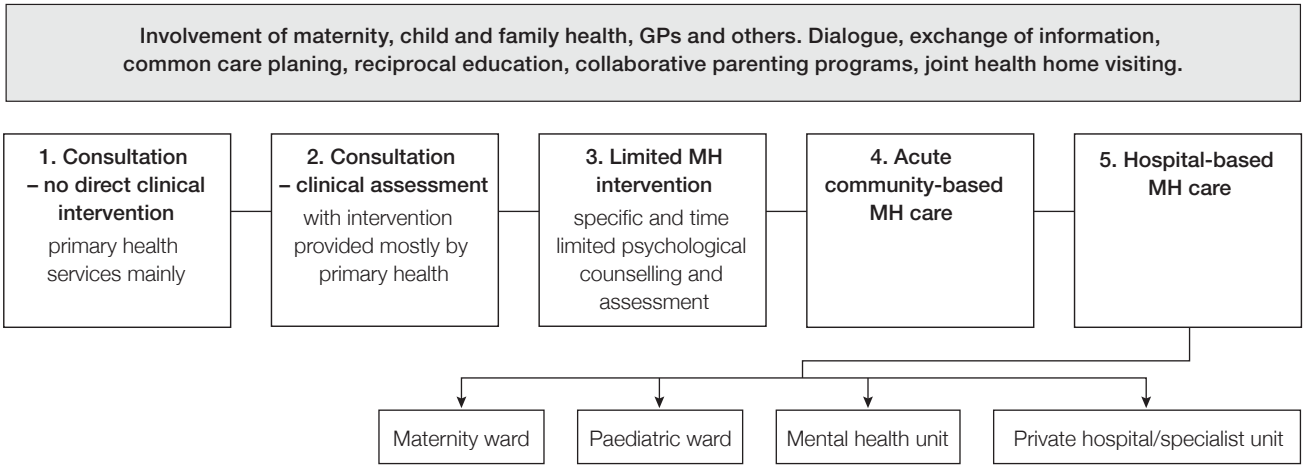
4.3 Mental Health Services pathways of care

Successful implementation of SAFE START relies on active partnerships, collaboration, healthy dialogues and good communication between the numerous services, departments, organisations, and agencies involved in supporting families at risk of developing mental health problems. Mental health services are an essential component of this implementation because their role extends beyond the acute management of mothers with mental illness. Mental health services need to integrate a consultative and an educational role to their secondary and tertiary service level and clinical capacity.

Figure 3 outlines a range of possible roles for mental health services in providing mental health care in the perinatal period:

- Consultation with no direct clinical intervention.
- Consultation with clinical assessment.
- Limited mental health intervention.
- Acute community based mental health care.
- Hospital-based mental health care.

Figure 3. Mental health pathways of care during the acute period of perinatal mental health problems and disorders provided by public and private services



4.4 Consultation with no direct clinical intervention

This category is for women or men in the perinatal period who present to primary health care professionals with unclear or undefined evidence of mental health problems or symptoms but not yet reaching a clinical threshold for mental disorder. This will often involve distress and changed behaviour in the person.

Examples of presenting concerns for women or men in the perinatal period can include:

- Ongoing physical exhaustion and pain sometimes accompanied by sleep disturbance (not related to the infant's demands).
- Over-anxious in the face of new roles and responsibilities or body changes.
- Unpredictable emotional outbursts or behaviour.
- Lingering sadness.
- Unexplained concerns often relating to the infant.
- Abnormal ideas, beliefs or sensations.

Actions

The role of the mental health professional for this group of people is to guide the primary health care worker by providing information, recommending further assessment or treatment or confirming treatment regimes. For example, general practitioners may feel unsure about prescribing antidepressant medications during pregnancy or lactation and will seek advice about types of medication, dosage and available literature on the illness, treatment, interpretation of EDS/EPDS scores and information about other services.

The consultancy role also covers indirect mental health care for families who would benefit from mental health care but are reluctant to access mental health services. This can often relate to the trust that a family feels with maternity or child & family health nurses.

The availability of a direct contact number to access a mental health professional well versed in perinatal mental health will support prompt, user friendly, reliable access. This will also enhance collaborative partnerships. The model effectively developed in some emergency departments (EDs), in which general practitioners are connected directly to a designated ED specialist who will triage, advise, or organise appropriate intervention, could be used for GPs seeking perinatal mental health expertise.

This service level also includes perinatal mental health education for primary health care professionals to enhance the understanding of mental health problems and disorders and pathways to mental health care. The benefits include early identification of mental health problems during the perinatal period and demystifying the nature of mental illness.

Education can include formal in-service training and workshops on perinatal mental health. It can also include sharing information on clinical activities to increase exposure to mental health assessments, counseling techniques and other mental health interventions. These interactions can promote a mental health-mentoring role to midwives, child & family health nurses and other primary health care professionals. A specific example includes providing information on good mental health and the recognition of post natal depression for clients in antenatal classes and postnatal groups.

4.5 Consultation with clinical assessment

This category is similar to the category above; however, the primary health care professional remains concerned about mental health issues and care and requests a specialist mental health assessment.

Action

When a referral is received from the primary health care worker, mental health services would conduct an initial comprehensive mental health assessment of the person. Primary health care workers generally resume the care of the person affected in the perinatal period, after the specialist mental health assessment. The condition of discharge to the primary health care professional should accommodate a direct re-entry into the service if the condition worsens. Moreover, it should also include the provision for the mental health clinician providing support for the primary health care worker in an on-going partnership.

4.6 Limited mental health intervention

This category refers to women who respond positively on questions 5 and 6 (perfectionist traits and high anxiety and history of mental health problems) on the psychosocial risk questionnaire. The EDS/EPDS score is not necessarily reliable for placing women into this category. It generally includes women who have experienced, or are experiencing, heightened levels of anxiety.

Actions

In many cases mental health service intervention is not required, however intervention by the mental health service for this group of women may be quite specific and short-term in nature. It usually involves psychological interventions, such as cognitive behavioural therapy and stress management. Close links with the woman's general practitioner during and after intervention are essential for ensuring close monitoring of progress.

4.7 Acute community-based mental health care

This category includes women and men in the perinatal period who display obvious or extreme distress or significant behavioural disturbances. The EDS/EPDS score from the psychosocial assessment is likely to be 13 or above.

Actions

For further information see section 3.6.2, which refers to the response to acute mental health symptoms in the woman and the partner.

4.8 Mental health intake and assessment process

The perinatal period is unique in terms of potential for impact on mental health. Women who have never had a mental health problem in the past can become overwhelmed and extremely distressed by the experience of acute anxiety, depression or psychosis. Symptoms are often sudden and unexpected, eg following a period of sleep deprivation.

Prompt access to a mental health assessment is important. Streamlined access to mental health assessment can be assisted by:

- Ensuring that a senior Mental Health clinician attends the perinatal intake/multidisciplinary case discussion.
- Building the capacity of centralised intake services by introducing specific knowledge and skills about perinatal mental health (including familiarisation with the EDS/EPDS) and identifying key clinicians who are able to respond expeditiously.
- Defining specific clinical pathways to care.
- Developing perinatal mental health protocols and procedures that support the use of clinical pathways.

4.9 Clinical interventions

4.9.1 Home-based mental health care

Home-based mental health interventions can be beneficial to women and their families in the perinatal period. Home-based mental health intervention facilitates comprehensive psychosocial assessment created by the ability to:

- Observe the home environment, including access to shops, bus routes, school, and home comfort.
- Assess the woman's ability to cope in her own environment, including assessing safety issues, particularly child protection.
- Assess parenting capacity (Appendix 8 contains an assessment proforma).
- Identify social support/s and family strengths.
- Develop a comprehensive health care plan.

Another benefit of home-based mental health intervention includes promoting access to care. This is important given the anxieties experienced by mothers or pregnant women, including fear of travelling to the clinic and the prospect of getting the baby ready for departure to the clinic at a time when he should be sleeping; particularly when the woman is depressed, anxious, confused and tired.

Joint service delivery, involving a mental health clinician and other clinicians, is an important aspect of the acute clinical intervention during the perinatal period.
The woman receiving mental health care also needs to see the child & family health nurse, the GP, and others as indicated. Joint service delivery is not a duplication of services but reflects the complexity of the problem. Furthermore, it can enhance health outcomes for the family. Joint home visits support the message given to the family that professionals work collaboratively to achieve a recovery. This process also assists cross-fertilisation of knowledge and problem-solving skills between mental health and related professionals.

4.9.2 Hospital-based mental health care

The criteria for determining hospital based mental health care include the:

- Severity of symptoms and the level of cognitive impairment resulting from the illness.
- Level of support especially in the domains of caring for the infant, performing household chores and other daily activities usually undertaken by the woman.
- Presence of co-morbidity – use of alcohol and other drugs, physical complications.
- Level of risk to the woman and others if home treatment is selected.
- Ability of the family to cope with the woman's symptoms – this will be influenced by the number of people available to help and the length of time between the onset of symptoms and the actual intervention.
- Availability of local, comprehensive acute mental health services to provide home-based intensive care.

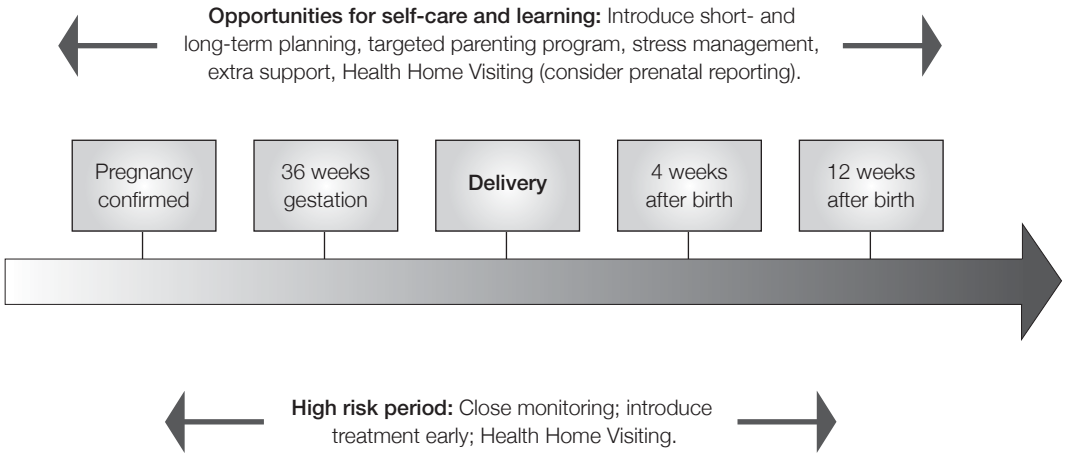
Actions

The following pathway (Table 2) is suggested for the care of women who may be pregnant whilst in inpatient mental health units. The pathway can be adapted for women who are cared for in the community.

Table 2. Pathway to care for pregnant women in inpatient mental health units

Steps	Actions
The pregnancy is not confirmed	■ Organise test with the woman's medical officer. ■ Consider effect of current medication on fetal development, review accordingly. ■ If there is ambivalence about continuation of the pregnancy organise counselling.
The pregnancy is confirmed	■ If appropriate (the woman is emotionally stable) and the woman lives in the local Area, discuss and encourage a midwife assessment with her.
The woman is not yet booked in a maternity hospital	■ Discuss and organise booking as early as possible if the woman is agreeable. ■ Escort the woman on the first antenatal visit or arrange a confidante to be with her. ■ Initiate a collaborative process to ensure the woman is not lost to follow-up once discharge from hospital. ■ The first antenatal visit is complex, lengthy and involves multiple tests. Extra support may be required from the social worker and the midwife .
Record of information	Record key information outlined below as per local protocol and provide a written copy to the woman prior to discharge: ■ Expected date of birth. ■ Date of next antenatal appointment. ■ Name of primary midwife/obstetrician. Ensure that the woman is assisted to attend obstetric appointments, antenatal classes and medical investigations as required
Discharge planning	Organise discharge planning from the time of admission including: ■ Care coordinator identified. ■ Care planning with all relevant stakeholders and family. ■ Special birth care plan including role of consultation liaison psychiatry if appropriate. ■ Written care plan with copies to the woman and her family, the patient's notes and the antenatal notes.

Figure 4. Opportunities and high-risk periods from conception until three months after the birth of the baby, for women with a long-term mental illness



The following issues need consideration:

- Vulnerability of a pregnant woman in an acute psychiatric unit.
- Indications for prenatal reporting to Department of Community Services.
- Impact of psychotropic medications on the fetus.
- Ethical issues associated with compulsory treatment involving medications.
- Women cared for in the private sector or living out of Area.

4.10 Care coordination for women with a long-term mental illness

Traditionally, care coordination has targeted individuals who are chronically unwell and require significant specialist care and support from a mental health professional. The person is usually discharged from the service when the rate of relapse diminishes. Perinatal mental health is different in that it requires care coordination at a time when the woman feels and manages well and brings a sense of false security about the likelihood of relapse.

Women with a diagnosed mental illness are most vulnerable when they are exposed to the trauma of birth and the demanding care of the newborn child. Mental health deterioration is often rapid and unexpected, especially when the woman has been stable for a long period of time prior to the birth.

The preventive aspect of caring for a woman who is well can be a challenge for mental health services but provides a window of opportunity for the introduction of contingency planning, parenting programs, stress management and psycho-education for family and friends. Prenatal reporting for the purpose of advocacy should be considered.

Care coordination for women with co-existing mental health and substance use disorders requires the sharing of expertise in joint assessment and co-management to ensure integrated service provision and the delivery of comprehensive perinatal health care at a time when the woman is most at risk (NSW Health, 2000).

Figure 4 outlines opportunities and high-risk periods from conception until three months after the birth of the baby, for women with a long-term mental illness.

4.11 Mental Health Act 2007

The *Mental Health Act Guide Book* can provide further information about the processes described in this section.

In the course of treating a woman with acute mental health problems during the perinatal period, acute risks to the woman or to the child's safety or recurrent relapse due to poor adherence to a treatment regime may become so critical that compulsory treatment becomes necessary. The decision to use a coercive mode of intervention should be carefully considered, and used only in extreme cases, as part of a comprehensive management plan for the woman and her family; ethical considerations should support the decision-making.

4.11.1 Stage one – 'Pure law'

Three options are available under the *NSW Mental Health Act 2007* to provide involuntary treatment.

The woman can be scheduled under the Act for two distinct reasons:

- she has a mental illness and because of this illness treatment or control is necessary for her own protection from serious harm or for the protection of the fetus or child from serious harm; and/or
- she is 'mentally disordered' meaning that her behaviour is so irrational that there are reasonable grounds for deciding that the temporary care, treatment or control is necessary to protect her or the fetus or child from serious physical harm.

'Transfer of patients to or from mental health facilities' (*Mental Health Act 2007*–Sect 80) refers to the legislative process for transferring a woman under involuntary care to a non-mental health facility for medical treatment. Admission in a declared mental health facility may impact on the obstetric treatment that the woman needs while pregnant or following the birth of her baby. The woman can be transferred to a health facility (maternity, pediatric or other) in accordance with an arrangement between medical officers of each facility or an order in writing by the Director-General of Health.

Under the Act, a woman can be placed under a Community Treatment Order (CTO)—a legal order that sets out the terms under which a person must accept medication/s, therapy, rehabilitation or other determined intervention.

4.11.2 Stage two – Duty of care to the patient and ethics

Ethics serve to identify good, desirable or acceptable conduct and provide reasons for those conclusions. (National Health and Medical Research Council, 2007).

Ethics do not override the law but allows for better decision-making. As the woman has lost her autonomy by virtue of the decision to treat her as an involuntary patient, health care professionals have a greater obligation to make decisions that are in the best interests of both the mother and the child (unborn or born). Decisions such as to administer psychotropic medication during pregnancy, especially during the first trimester or when the woman wishes to continue breastfeeding, need to be considered with extreme caution.

Health professionals have separate obligations to the mother and to the child. Where there is a conflict of interest between the mother and the child (eg teratogenic effect of the medication on the fetus, impact of discontinuing breast feeding), good practice provides that separate practitioners should act for the mother and for the child. Multidisciplinary planning meetings involving professionals caring for the mother and the child (eg mental health and paediatric professionals) are recommended.

SECTION 5

Populations with particular needs

Several groups within the general population have particular mental health needs requiring specific, sensitive and responsive modes of interventions appropriate to their needs. These groups include families with greater risks for mental health problems because of specific problems during the intra-partum period or because of the presence of multiple complex psychosocial needs throughout the perinatal period. Some other groups require specific pathways of care because of their geographical isolation or because of their cultural and linguistic diversity. In the first instance, comprehensive psychosocial assessment and liaison with postnatal services is vital to ensure adequate early intervention.

5.1 Working with specific populations

Specific population groups may experience additional issues that can impact on their mental health and that of their children. In particular, this applies to working with people from culturally and linguistically diverse backgrounds and Aboriginal and Torres Strait Islander populations. This has implications for the psychosocial assessment questions asked of these groups antenatally and postnatally. The issues that affect these populations, with specific reference to the antenatal and postnatal periods, are discussed in this section.

5.2 People from culturally and linguistically diverse backgrounds

People in NSW come from a range of cultural and linguistic backgrounds. These backgrounds include a diversity of religions, cultural beliefs and values, social structures and mores, history and political backgrounds. It should be noted that even within the same language group or shared home country, there are variants in terms of socio-economic background, educational background, religious and political beliefs among other issues. Furthermore, the spectrum of pre-migration and settlement experiences may either contribute to the risk of developing psychological and other problems or act protectively.

Within the context of this diversity, there are some shared factors across cultural and linguistically diverse populations for consideration that may impact on the mental health of families and their children, and need to be considered in the context of working with families antenatally and postnatally. This includes: the length of time that the person has been in Australia and their level of adaptation or acculturation; language and communication barriers; settlement difficulties, such as finding employment, social isolation and lack of family or social support networks; anxiety about giving birth in an unfamiliar environment; racism or discrimination experienced; expectations about perinatal health care and related services in Australia; life in general in the new country; ability to return to the home country; and feelings of loss and grief.

Refugees are at greater risk of developing psychological problems. In addition to the factors mentioned above, the following are also acknowledged: experience of trauma or possibly torture, physical and, or, sexual abuse; feelings of guilt or acute anxiety about family members left behind; poverty; chronic physical health problems such as dental and nutrition issues, and effects of female circumcision.

5.3 Refugee populations

The experiences of refugees may vary considerably from other newly-arrived migrant groups in that, for refugees, migration was involuntary – primarily forced upon them as a result of economic, political and social unrest within their home country. This may place them in a higher risk group for developing physical and, or, psychosocial problems. Additional factors relevant to refugees that need to be considered and understood are:their possible experience of torture and, or, physical and, or, sexual abuse, including domestic abuse; grief and loss; chronic physical health problems such as dental, nutritional issues; insomnia and nightmares; feelings of guilt or acute anxiety about family members left behind; unemployment; and lack of family and social support networks.

For many families 'traditional' parenting practices may be disrupted. Issues that refugee parents may experience include:

- Financial difficulties
- Unemployment
- Uncertainty of status
- Inadequate or appropriate housing
- Lack of emotional and practical support
- Isolation
- Language difficulties
- Cultural adjustment
- Racism
- Lack of awareness of services and the Australian system, including health, school and child protection issues.

Refugees who are survivors of torture and trauma may be suspicious and distrustful of others and may be hesitant to respond to questions, especially by strangers. The use of language-specific resources and bilingual workers is important in the intervention process in order to facilitate communication and the building of trust. This population would generally be considered 'vulnerable' and would benefit from early engagement strategies.

Example 7. Midwives' management of severe antenatal anxiety in the context of adverse refugee experience

Jill is five months pregnant and scored 13 on the EDS/EPDS at her first antenatal visit. Jill and her husband John came to Australia from Bosnia 12 months ago. The couple's first child died in utero as a result of severe trauma during the Bosnian war. Jill's anxiety escalated and she presented on a daily basis to the emergency department fearing that her baby had died. The local acute care team assessed Jill. She was referred to STARTTS (Service for Torture and Trauma Survivors, Fairfield, NSW) for urgent assessment and counselling.

Jill's day-to-day crisis intervention consisted of the option of attending the antenatal clinic where she would be reassured by listening to the fetal heart and the midwives commenced brief anxiety management techniques. John was also taught anxiety management in order to support his wife. The incidence of anxiety attacks decreased dramatically within six weeks. Appropriate long-term counselling through STARTTS was commenced six months postnatally.

5.4 Aboriginal and Torres Strait Islander populations

Aboriginal and Torres Strait Islander populations are seriously disadvantaged in comparison with the NSW population in general. Overall, Aboriginal and Torres Strait Islander populations experience markedly poorer health, poorer nutrition, greater poverty, poorer housing and facilities, lower levels of education and higher levels of violence including sexual assault, childhood sexual assault and domestic and family violence, unemployment, imprisonment, racism and discrimination (ABS, 1996; NSW Health, 2002; Swan & Raphael, 1995).

People from Aboriginal and Torres Strait Islander backgrounds also experience higher rates of mental health problems (Wronski et al., 1994).

Recognising the impact on mental health of historical events related to invasion and colonisation is essential. This includes trauma and loss, premature death, racism and social disadvantage, family breakdown and separation of children from their families. Understanding this social and emotional context of presenting problems for Aboriginal and Torres Strait Islander populations is essential in working with these groups.

Aboriginal families frequently report that there may be a loss of attachment and early maternal skills in relation to the 'stolen generation'. The taking away and institutionalisation of rearing may lessen the capacity to internalise maternal roles. The trauma of early separation from the mother results in insecure relationship patterns that may then be transmitted to the next generation. This may impact adversely in the perinatal period and beyond. Culturally appropriate birthing practices and support from other Aboriginal women and communities may be important.

Furthermore, many Aboriginal women do not access mainstream services. In 1999, over 29 per cent of Aboriginal women presented after 20 weeks gestation for their first antenatal visits (NSW Health, 2002). The under-utilisation of antenatal and postnatal services by Aboriginal women is associated with several factors, including inappropriate and inaccessible maternal health services, lack of long-term targeted Aboriginal maternal health programs and the itinerancy of many Aboriginal women. Previous negative experiences with mainstream services have also contributed to the mistrust and fear of these services that are experienced by Aboriginal and Torres Strait Islander populations.

The *NSW Aboriginal Perinatal Health Report* (NSW Health, 2002) identifies the preventable risk factors associated with Aboriginal perinatal mortality and morbidity and proposes strategies to improve Aboriginal perinatal health. Numerous examples are given of successful Australian and international programs especially in relation to serious issues such as under-utilisation of antenatal and postnatal services, disempowerment of Aboriginal women and high adolescent birth rates. Reference to this report is recommended for managers and clinicians caring for Aboriginal families during the perinatal period.

Example 8. A successful early intervention program for vulnerable families

Based in Casino (Northern NSW), Malanee Bugilmah – meaning 'families together' – provides an intensive, family-based early intervention service to vulnerable Aboriginal families with children of all ages, including infants and toddlers, at risk of their children taken into care. The service aims at supporting families to help prevent child abuse and neglect. The strength of the program is its connectedness with the general community. Pro-active interventions that are tailored to individual needs, and focused on parenting skills and practical support, have resulted in a high profile, highly successful program.

SECTION 6

Supervision

Supervision for clinical staff supports learning and skill enhancement in the workplace. It is important for all staff. Working with families with complex psychosocial issues and complex needs is often challenging and demanding.

The aims of supervision are to:

- Support staff to implement their skills appropriately and to the best of their knowledge and abilities.
- Encourage self-evaluation of performance.
- Provide an opportunity for the development of additional skills and ideas.
- Provide a forum to explore complex or challenging situations.
- Allow debriefing and reflection following traumatic experiences.

Supervision is necessary on a regular basis and should be negotiated according to the clinician's level of needs at a specific time. Level of personal expertise, familiarity with a specific population, level of peer support (including clinicians working in isolation) are some of the factors influencing the frequency of supervision.

Individual or group supervision, face-to-face or teleconferencing are some options currently available that often depend on affordability (cost), availability of skilled supervisors and geographical constraints. Ideally options for individual supervision should be explored as some clinicians may not feel comfortable sharing their own experience with a group, or may require intensive support not possible in the presence of peers.

Supervision has been identified as vital to ensure the successful implementation of the Supporting Families Early Package.

APPENDIX 1

SAFE START psychosocial assessment questions

Variables (Risk Factors)	Suggested format for psychosocial assessment questions
I. Lack of support	1. Will you be able to get practical support with your baby? 2. Do you have someone you are able to talk to about your feelings or worries?
II. Recent major stressors in the last 12 months	3. Have you had any major stressors, changes or losses recently (ie in the last 12 months) such as, financial problems, someone close to you dying, or any other serious worries?
III. Low self-esteem (including lack of self-confidence, high anxiety and perfectionistic traits)	4. Generally, do you consider yourself a confident person? 5. Does it worry you a lot if things get messy or out of place?
IV. History of anxiety, depression or other mental health problems	6 a) Have you ever felt anxious, miserable, worried or depressed for more than a couple of weeks? 6 b) If so, did it seriously interfere with your work and your relationships with friends and family? 7. Are you currently receiving, or have you in the past received, treatment for any emotional problems?
V. Couple's relationship problems or dysfunction (if applicable)	8. How would you describe your relationship with your partner? 9. a) Antenatal: What do you think your relationship will be like after the birth OR b) Postnatal (in Community Health Setting): Has your relationship changed since having the baby?
VI. Adverse childhood experiences	10. Now that you are having a child of your own, you may think more about your own childhood and what it was like. As a child were you hurt or abused in any way (physically, emotionally, sexually)?
VII. Domestic violence Questions must be asked only when the woman can be interviewed away from partner or family member over the age of 3 years. Staff must undergo training in screening for domestic violence before administering questions	11. Within the last year have you been hit, slapped, or hurt in other ways by your partner or ex-partner? 12. Are you frightened of your partner or ex-partner? (If the response to questions 11 and 12 is "No" then offer the DV information card and omit questions 13–18) 13. Are you safe here at home?/to go home when you leave here? 14. Has your child/children been hurt or witnessed violence? 15. Who is/are your children with now? 16. Are they safe? 17. Are you worried about your child/children's safety? 18. Would you like assistance with this?
Opportunity to disclose further	19. Are there any other issues or worries you would like to mention?

APPENDIX 2A

Edinburgh Post Natal Depression Scale

(Cox JL, Holden JM, Sagovsky R. 1987)

As you have recently had a baby we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today. Here is an example, already completed.

I have felt happy:

Yes, all the time

Yes, most of the time

No, not very often

No, not at all

This would mean: "I have felt happy most of the time" during the past week. Complete the other questions in the same way.

---

1. I have been able to laugh and see the funny side of things:

   As much as I always could
   Not quite so much now
   Definitely not so much now
   Not at all

2. I have looked forward with enjoyment to things:

   As much as I ever did
   Rather less than I used to
   Definitely less than I used to
   Hardly at all

3. I have blamed myself unnecessarily when things went wrong:

   Yes, most of the time
   Yes, some of the time
   Not very often
   No, never

4. I have been anxious or worried for no good reason:

   No, not at all
   Hardly ever
   Yes, sometimes
   Yes, very often

5. I have felt scared or panicky for no very good reason:

   Yes, quite a lot
   Yes, sometimes
   No, not much
   No, not at all

6. Things have been getting on top of me:

   Yes, most of the time I haven't been able to cope at all
   Yes, sometimes I haven't been coping as well as usual
   No, most of the time I have coped quite well
   No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping:

   Yes, most of the time
   Yes, sometimes
   Not very often
   No, not at all

8. I have felt sad or miserable:

   Yes, most of the time
   Yes, quite often
   Not very often
   No, not at all

9. I have been so unhappy that I have been crying:

   Yes, most of the time
   Yes, quite often
   Only occasionally
   No, never

10. The thought of harming myself has occurred to me:

    Yes, quite often
    Sometimes
    Hardly ever
    Never

APPENDIX 2B

Edinburgh Post Natal Depression Scale (Antenatal)

(Cox JL, Holden JM, Sagovsky R. 1987)

As you are about to have a baby we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today. Here is an example, already completed.

I have felt happy:

Yes, all the time
Yes, most of the time
No, not very often
No, not at all

This would mean: "I have felt happy most of the time" during the past week. Complete the other questions in the same way.

---

1. I have been able to laugh and see the funny side of things:

   As much as I always could
   Not quite so much now
   Definitely not so much now
   Not at all

2. I have looked forward with enjoyment to things:

   As much as I ever did
   Rather less than I used to
   Definitely less than I used to
   Hardly at all

3. I have blamed myself unnecessarily when things went wrong:

   Yes, most of the time
   Yes, some of the time
   Not very often
   No, never

4. I have been anxious or worried for no good reason:

   No, not at all
   Hardly ever
   Yes, sometimes
   Yes, very often

5. I have felt scared or panicky for no very good reason:

   Yes, quite a lot
   Yes, sometimes
   No, not much
   No, not at all

6. Things have been getting on top of me:

   Yes, most of the time I haven't been able to cope at all
   Yes, sometimes I haven't been coping as well as usual
   No, most of the time I have coped quite well
   No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping:

   Yes, most of the time
   Yes, sometimes
   Not very often
   No, not at all

8. I have felt sad or miserable:

   Yes, most of the time
   Yes, quite often
   Not very often
   No, not at all

9. I have been so unhappy that I have been crying:

   Yes, most of the time
   Yes, quite often
   Only occasionally
   No, never

10. The thought of harming myself has occurred to me:

    Yes, quite often
    Sometimes
    Hardly ever
    Never

APPENDIX 2C

Edinburgh Postnatal Depression Scale Scoring Guide

Score for each question has been inserted on the left-hand side of each possible response.
Add the scores for each question to calculate a total score out of a possible 30.

1. I have been able to laugh and see the funny side of things:
   - 0 As much as I always could
   - 1 Not quite so much now
   - 2 Definitely not so much now
   - 3 Not at all

2. I have looked forward with enjoyment to things:
   - 0 As much as I ever did
   - 1 Rather less than I used to
   - 2 Definitely less than I used to
   - 3 Hardly at all

3. I have blamed myself unnecessarily when things went wrong:
   - 3 Yes, most of the time
   - 2 Yes, some of the time
   - 1 Not very often
   - 0 No, never

4. I have been anxious or worried for no good reason:
   - 0 No, not at all
   - 1 Hardly ever
   - 2 Yes, sometimes
   - 3 Yes, very often

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

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

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

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

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

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

APPENDIX 3

Antenatal psychosocial health assessment: domains used in the ALPHA model, Canada

(Reid et. al., 1998)

Categories	Antenatal risk factors	Associated postpartum outcomes
Family factors	■ Social support	**CA**, **WA**, PD
	■ Recent stressful life events	**CA**, **WA**, **PD**, PI
	■ Couple's relationship	**CD**, **PD**, WA, CA
Maternal factors	■ Prenatal care (late onset)	**WA**
	■ Prenatal education (refusal or quit)	**CA**
	■ Feeling towards pregnancy after 20 weeks	**CA**, **WA**
	■ Relationship with parents in childhood	**CA**
	■ Self-esteem	**CA**, WA
	■ History of psychiatric/emotional problems	**CA**, **WA**, PD
	■ Depression in this pregnancy	**PD**
Substance use	■ Alcohol/drug abuse	**WA**, CA
Family violence	■ **Woman or partner experienced orwitnessed abuse (physical, emotional, sexual)**	**CA**, WA
	■ Current or past woman abuse	**WA,** CA, PD
	■ **Previous child abuse by woman or partne**r	**CA**
	■ **Child discipline**	**CA**

The antenatal risk factors in the left column have been shown to be associated with one or more of the following postpartum outcomes:

CA—child abuse

CD—couple dysfunction

PI—physical illness

PD—postpartum depression

WA—woman abuse

Bold indicates that there is good evidence of an association

APPENDIX 4

Recommended issues for exploration in the postnatal period

	Issue
Infant	■ Health problem. ■ Prematurity–low birth weight. ■ Disability. ■ Feeding difficulties. ■ Unsettled behaviour. ■ Multiple births. ■ Others.
Mother	■ Traumatic birth experience (surgery, forceps etc). ■ Postnatal complications. ■ Feelings about and responsiveness to the infant.
Others	■ Support at home: – Physical. – Emotional. – Respite from infant.
Subsequent assessments	
Infant	■ As for Initial postnatal assessment. ■ Initial problems managed, improved or resolved. ■ Temperament.
Mother	■ As for Initial postnatal assessment. ■ Initial problems managed, improved or resolved. ■ Relationship with partner. ■ Sexual activities. ■ Contraception. ■ Re-establishment of sleep pattern. ■ Social activities.
Others	■ Support systems as perceived by the: – woman – couple – health professional – partner's emotional state. ■ Levels, modes, patterns of communication in the household (conflicts, arguments, violence, increased use of alcohol or other drugs including nicotine). ■ Family adjustment to the baby (siblings and others sharing the household). ■ Financial situation.

APPENDIX 5

Clinical effectiveness: definition and use in clinical practice

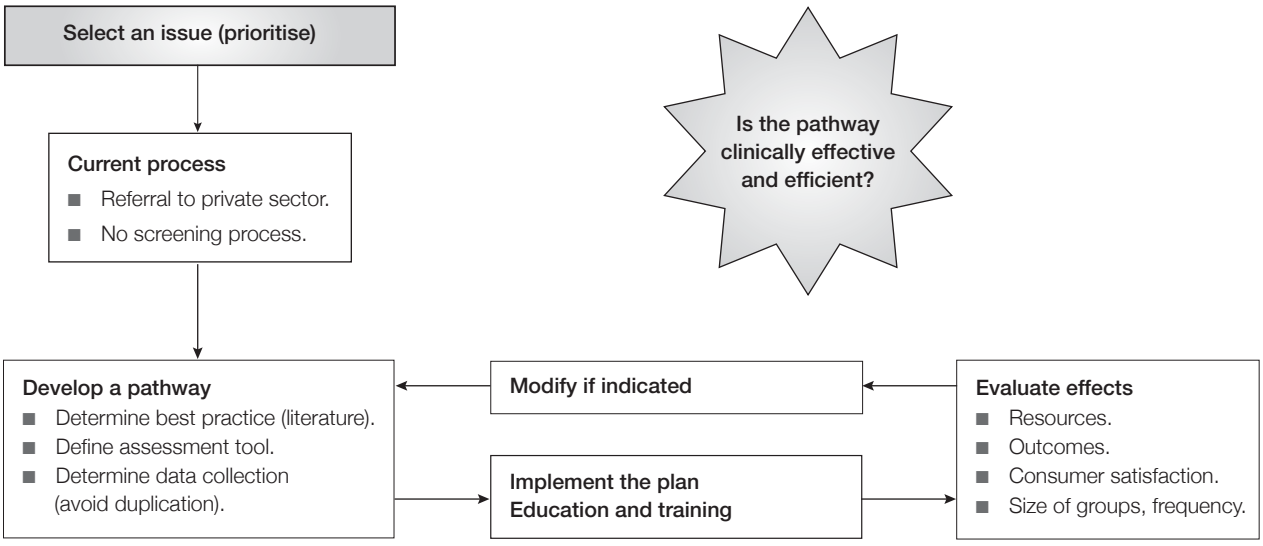
Clinical effectiveness is important in determining which interventions to implement in clinical care pathways. Clinical effectiveness has been defined as:

The extent to which specific clinical interventions, when deployed for a particular patient or population, do what they are intended to do. That is, maintain or improve health and secure the greatest possible health gain from the resources available (Benton, 1999).

Clinical effectiveness is assisted by an explicit statement of goals relating to the intervention, followed by regular audits against clinical outcomes following implementation. It allows for the monitoring and quantifying of unmet needs and resource deficits indicating a demand for reallocation of resources. Caution is required in identifying programs or types of interventions appropriate for population needs. Some relevant questions include:

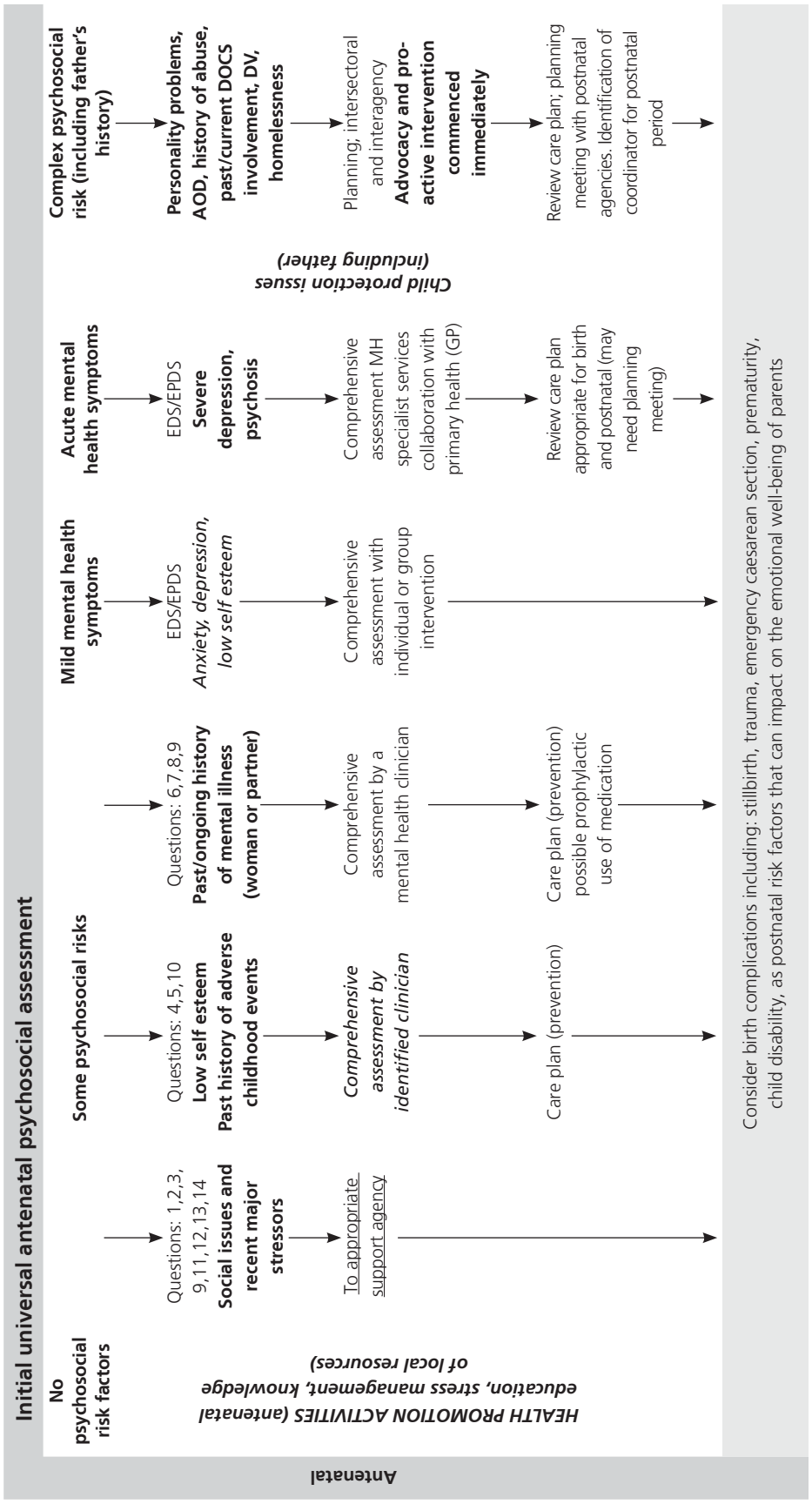
- How transferable is a program (metropolitan to rural, general population to culturally and linguistically diverse populations)?
- How affordable is the intervention?
- Can it be modified for delivery to groups rather than individually?

Care pathway-development and evaluation of clinical effectiveness



APPENDIX 6A

Example: pathways of care during the antenatal and birth periods



See Appendix 6B for example of pathways to care during the postnatal period.

APPENDIX 6B

Example: pathways of care during the postnatal period

Postnatal psychosocial assessment and universal health home visiting (as figure)

No Risk	Some Risk Factors			Mild Symptoms	Acute Symptoms	Child protection issues	Multiple RF, Complex needs
Encourage attendance to: ECHC and/or GP. Inform about local resources (playgroups and others). Follow up psychosocial assessment and EDS/ EPDS, 6-8 weeks postnatally.	**Social issues, recent major stressors** **Vulnerability to PND.** Support as indicated. Educate about warning signs **Risks Identified during pregnancy** Continue antenatal intervention with transfer to postnatal services if indicated. **Risks identified postnatally** Refer to appropriate services. Liaise with family GP.	**Past history of adverse childhood events** **Vulnerability to PND.** Educate about warning signs of depression. Promote and support parenting.	**Past/ongoing history of mental illness (including partner)** **Birth-6 months: vulnerable period with high risk of relapse in early stages** Educate about warning signs. Comprehensive care plan including prompt access to identified emergency services and access to sustained HHV if indicated. Liaison with MH Services at discharge time. Joint intervention with CFH nurse to enhance coping skills and mental wellness, and monitor effectiveness of treatment. Access to specific parenting program if indicated. Home-based intervention (CFHS&MHS) recommended in first 12 weeks. Exchange of clinical information between relevant services/ organisations.	Symptoms persisting from antenatal period Review of current management prior to discharge from hospital. Liaise with primary MH worker, GP, CFH nurse and relevant community agencies and support network. Monitor progress/ deterioration (MH & CFH services) Identify access to emergency MHS Weekly review, evaluate intervention. **If symptoms are new** Comprehensive assessment by appropriate MHS. Education of woman and her close support. Assertive follow-up (may involve time limited home visiting MH/CFHS). Identify primary mental health worker. Liaise with GP. Others as above.	Symptoms persisting from antenatal period or new Assessment by relevant MH staff may require inpatient care or referral to acute MHS for assertive home follow-up. Involvement of support services (volunteer, case management etc) will depend on the nature of the symptoms, the level of support available in the home and the progress of the infant. *Should be in place:* Tailored parenting program. MH Crisis intervention plan within and after hours (who, what and how). Complementary role of MH, AOD and CFH services health home visiting with exchange of clinical information between relevant services. DoCS involvement: If child protection issues or for advocacy purposes Care Planning meeting as indicated Monitoring of clinical outcomes		Discharge to Early Intervention Program as available and indicated (residential or community) Mother/infant leave hospital with comprehensive, written plan emerging from PM or PPM. (partnership model) *Should be in place:* Tailored parenting program (parenting capacity). MH urgent intervention within and after hours (who, what and how). Complementary role of MHS, AOD and CAMHS, in conjunction with other relevant services. Ongoing exchange of clinical information between service and organisations. Social support (volunteer agencies, local programs). DoCS involvement: If child protection issues or for advocacy purposes. Regular care planning meetings. Monitoring of clinical outcomes.

Abbreviations: CFH Child & Family Health; ECHC Early Childhood Health Centre; GP General Practitioner; SW Social Workers; RF Risk Factor; DV Domestic Violence; DoCS Department of Community Services; AOD Alcohol & Other Drugs; PM Planning Meeting; PPM Protective Planning Meeting; MH Mental Health; EDS/EPDS Edinburgh Depression Scale; PND Postnatal Depression

APPENDIX 7

Information sheet sent to stakeholders when a planning meeting is organised

Welcome to stakeholders planning meeting

In order to achieve best possible outcomes with families with high needs it is sometimes necessary for many different professionals and agencies to become involved. To help provide best antenatal and postnatal care we call all the different people, families, friends and professionals who are important to the pregnant woman and her family. In order to ensure stakeholders are working together in partnership we organise 'Stakeholders Planning Meetings'.

At such a meeting a number of things take place.
Each stakeholder is asked to discuss:

- Their past and present involvement with the family.
- Their role in the specific perinatal period.
- Ideas on how they might be able to help with specific needs throughout the perinatal period in order to enhance outcomes for the baby and the family.

Sometimes it may be necessary for the professionals to meet first to discuss concerns. But in all situations the family should be expected to take an active role in determining the outcomes of the meeting and ensuring that the action plan is agreeable to them.

At the end of the meeting a written summary is developed which outlines the plan made in the meeting. A copy of this summary is sent to all stakeholders (and anyone else the family tell us is important).

We appreciate the crucial role of primary health carers especially the family GP in contributing to the meeting. As attendance may be difficult, teleconferencing tools may be used to facilitate phone participation. We look forward to meeting with you and hope this information sheet has helped you to understand why we value your input in this most important process.

Source: St George Hospital and Community South Eastern Sydney Illawarra AHS, 2004.

APPENDIX 8

Assessment of parenting capacity when the parent has a mental illness. A guide for mental health staff

Focus on parenting

- Ability to provide a safe and nurturing environment (secure base)
- Ability and motivation to meet the child's needs (physical and emotional)
- Understanding of the child's age-appropriate behaviours and demands.

Focus on the parent with a mental illness

- Behaviour and psychiatric symptoms directly affecting capacity and ability
- Alcohol and drug misuse
- Attitude to social norms
- Ability to form trusting relationships
- Sense of responsibility
- Ability to assess/recognise risk to the child (when well and when unwell)
- Quality of functioning (when well versus when acute exacerbation of symptoms occurs)
- Response to treatment.

Focus on the 'well' parent

- Attitude towards the illness of the partner
- Relationship to the child
- Commitment to the family unit
- Capacity to support, to be available and to intervene on the child's behalf if indicated (when partner is unwell).

Focus on the relationship between parents or partners (as relevant)

- Strength of relationship.
- Conflict resolution skills (intensity, frequency of conflict)
- History of violence
- Capacity to work together as parents.

Focus on the child

- General health
- Feeding, sleep pattern
- Developmental progress
- Responsiveness.

Focus on the socio-cultural context including significant others

- Degree and pattern of support from extended family and others
- How available are social supports when the parent cannot function properly (eg if hospitalisation is necessary)
- Access to specialist intervention (eg case worker, psychiatrist) if required
- Housing and, or, income.

Source: Adapted from Gopfert et al., 1996

Specific considerations when parent has a personality disorder

Parental attachment history

- Unresolved early trauma
- Mental state with respect to relationships
- Interaction with and attitude to infant.

Infant mental state

- Somatic regulation in young infant
- Emotional regulation in older infant
- Behavioural regulation and patterns of relating/ interacting (attachment)
- Assess for signs of abuse, neglect, and/or trauma.

Source: Mares et al., 2005 (pp 244-245).

APPENDIX 9

Terms and abbreviations – in the context of SAFE START

Care pathways
Formally articulated mapping of services provided within and across sectors and with agreed streamlined entry/exit procedures that support continuity of care by ensuring that families are able to negotiate the system in a seamless and timely manner.

COPMI
Children of Parents with a Mental Illness. For the purpose of the SAFE START documents and to match with *Families NSW*'s target age group, the term 'children' includes unborn children and children aged 0–8.

Early childhood health service
Services offered predominantly by the child & family health nursing service but may also offer staff from other disciplines as members of that team. The role of this service is to provide support to families with children 0–5 years.

Early intervention
Timely interventions that target people displaying the early signs and symptoms of a mental health problem or a mental disorder. In the context of perinatal mental health, early intervention can target families who because of specific risk factors (identified in the psychosocial assessment) may develop mental health problems that can impact negatively on the infant's physical and mental well-being.

Evidence-based practice
Holistic approach to the improvement of mental health and well-being using the best available evidence integrated with clinical expertise.

Family partnership training
Training introduced in NSW in 2002 to underpin the *NSW Health/Families NSW Supporting Families Early* initiative.

Focussed psychological strategies
One of the *Better Outcomes in Mental Health Care* initiatives. Since November 2002, a new Medicare Benefit Schedule item for 'Focussed Psychological Strategies' has been available for appropriately trained General Practitioners to provide psychological interventions that facilitate better access to specialist mental healthcare providers.

Mental health consultation liaison team
Consultation Liaison Mental Health often called Consultation Liaison Psychiatry provides assessment, consultation and referral regarding patients of the general hospital including Emergency Departments and Maternity Wards.

MH-OAT
Mental Health Outcomes and Assessment Tool. Statewide project to strengthen the mental health assessment skills of clinicians, insure accurate data collection and documentation, promote continuity of care and collect outcome measure data, in a standardised way.

MOU
Memorandum of Understanding- Its purpose is to outline roles and responsibilities to facilitate effective interaction between 2 or more organisations by setting forth principles and guidelines under which parties work together towards common goals.

NGO
Non-Government Organisation which in the context of SAFE START is involved with families during the perinatal period.

Outcomes
A measurable change in the health of an individual or group of people or population, which is attributable to an intervention or series of interventions.

PANOC
Physical Abuse and Neglect of Children Services. PANOC Services provide services to children and their families where physical abuse, neglect or exposure to domestic violence has been confirmed by DoCS or a Joint Investigation Response Team (JIRT).

Patient specialling
One to one observation and care of a patient with high and complex needs.

Perinatal and infancy period
The SAFE START model defines the perinatal and infancy period as the dynamic developmental phase from conception to two years for the child, and the associated critical early parenting tasks for families.

Population-based interventions
Target populations rather than individuals. They include activities targeting the whole population as well as activities targeting specific population groups such as parents with mental illness.

Primary healthcare
In the health sector generally, 'primary healthcare' services are provided by generalist providers who are not specialists in a particular area of health intervention. Generalists involved with the care of families include GPs, child and family health nurses.

Protective factors
Those factors that mediate risk factors.

Risk factors
Characteristics, variables or hazards that, if present for a given person, make it more likely that this individual, rather than someone selected at random from the general population, will develop a disorder.

Resilience
Capacity within a person that promotes positive outcomes such as mental health outcomes and well-being and provide protection from factors that might otherwise place that person at risk of adverse outcomes.

Stakeholders
Different groups affected by decisions, consultations and policies.

References

Affleck, G., Roll, J., Tennen, H., 1991, *Infants in Crisis*, Springer-Verlag, New York.

Areias, M., Kumar, R., Barros, H. Figueiredo, E., 1996, 'Correlates of postnatal depression in mothers and fathers', *British Journal of Psychiatry*, Vol. 169, No. 1, pp. 36–41.

Armstrong, K., 2000, Medicalizing normality? Management of irritable babies, *Journal of Pediatrics and Child Health*, Vol. 36, pp. 301–305.

Austin, M–P., Lumley, J., 2002, Antenatal screening for women at risk of postnatal depression, *Acta Psychiatrica Scandinavia*, Vol. 106, pp. 1–8.

Austin, M.-P., Hadzi-Pavlovic, D., Leader, L., Saint, K., Parker, G., 2005, Antenatal screening for the prediction of postnatal depression: validation of a psychosocial pregnancy risk questionnaire, *Acta Psychiatrica Scandinavica*.

Australian Bureau of Statistics, 1996, *Women's Safety Australia* 4128.0.

Australian Infant, Child, Adolescent and Family Mental Health Association, 2001, *Children of Parents Affected by a Mental Illness Scoping Project Report,* Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care.

Benton, D., 1999, *Clinical Effectiveness, in Evidence-based Practice*, S. Hamer & G. Collinson, eds., Balliere Tindall, Edinburgh, pp. 87–109.

Brannigan A., Gemmell W., Pevalin D., Wade T. 2002, Self-control and social control in childhood misconduct and aggression: the role of family structure, hyperactivity and hostile parenting, *Canadian Journal of Criminology*, Vol. 44, pp. 119–137.

Bowlby J., 1982, The making and breaking of affectional bonds, *British Journal of Psychiatry*, Vol. 130, pp. 201–210.

Campbell, S., Cohn, J., 1991, Prevalence and correlates of postpartum in first-time mothers, *Journal of Abnormal Psychology*, Vol. 100, pp. 594–599.

Carlson, E. A., Sampson, M. C., Sroufe, L. A., 2003, Implications of attachment theory and research for developmental-behavioural paediatrics, *Journal of Developmental and Behavioural Paediatrics,* Vol. 24, No. 5.

Champion J.D., Piper J., Holden A., Korte J., Shain R.N. 1998, The context of sexually transmitted disease: life histories of woman abuse. *Issues in Mental Health Nursing*, Vol. 19, pp. 463–480.

Children and Young Persons (Care and Protection) Act 1998 (NSW).

Commonwealth Department of Health and Aged Care. 1999, *National survey of mental health and well-being report 4: people living with psychotic illness: an Australian study 1997–98*, Mental Health Branch, Canberra.

Cox, J., 1994, The origin and development of the 10-items Edinburgh Postnatal Depression Scale, in: *Use and misuse of the Edinburgh Postnatal Depression Scale*, Cox, J. & Holden, J. (eds.),Gaskell, London.

Cowling, V. (Ed). 1999, *Children of Parents with Mental Illness.* Australian Council for Education Research, Melbourne.

Cox, J., Holden, J., Sagovsky, R. 1987, Detection of postnatal depression: development of the 10 item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, Vol. 163, pp. 27–31.

Cox, J. and Holden, J., 2003, *Perinatal Mental Health: A Guide to the Edinburgh Postnatal Depression Scale (EPDS)*. London: Gaskell

Cox, J., Chapman, G., Murray, D., Jones, P. 1996, Validation of the Edinburgh Postnatal Depression Scale in non-postnatal women. *Journal of Affective Disorders*, Vol. 39, No. 3., pp. 185 – 189.

Crittenden, P.M. 2000, A dynamic-maturational exploration of the meaning of security and adaptation: Empirical, cultural, and theoretical considerations. In: P.M. Crittenden and A.H. Claussen (Eds). *The organisation of attachment relationships: maturation, culture, and context* pp. 358–384, Cambridge University Press, New York.

Crockenberg, S., and Leerkes, E. 2000, Infant Social and Emotional Development in Family Context, in: *Handbook of Infant Mental Health,* pp. 60–90,

Guilford Press, New York.

Davis H., Day C., Bidmead C. 2002, *Working in partnership with parents: the parent advisor model*, The Psychological Corporation, London.

Dolby, R., 1996, Overview of attachment theory and consequences for emotional development: a report on the seminar presented by the New South Wales Child Protection Council, Sydney, 24 October 1996, NSW Child Protection Council, *Seminar Series,* Seminar 15.

Dubowitz, A. 1993, A conceptual definition of child neglect, *Journal of Criminal Justice and Behavior*, Vol. 20, No. 1, pp. 8–26.

Evans, J., Heron, J., Francom, H., Oke, S., Golding, J. 2001, Cohort study of depressed mood during pregnancy and after childbirth. *British Medical Journal*, Vol. 323, No. 1, pp. 257–269.

Evins, G., Chescheir, N., 1996, Prevalence of domestic violence among women seeking abortion services. *Women's Health Issues*, Vol. 6, pp. 204–210.

Fergusson, D., Horwood, J., 2001, The Christchurch health and development study: review of findings on child and adolescent mental health. *Australian and New Zealand Journal of Psychiatry*, Vol. 35, pp. 287–296.

Fonagy, P. 2001, *Early intervention and prevention: the implication of secure and insecure attachment.* Paper presented at the Attachment and Development – Implications for Clinical Practice Conference, August, 2001.

Glover, V., O'Connor, T. 2002, Effects of antenatal stress and anxiety Implications for development and psychiatry. *British Journal of Psychiatry*, Vol. 180, pp. 389–391.

Gopfert, M., Webster, J., Pollard, J., Nelki, J., 1996, The assessment and prediction of parenting capacity: a community-oriented approach, in: *Parental Psychiatric Disorder,* Gopfert, M., Webster, J., Seeman, M. (eds) Cambridge University Press, Cambridge.

Gotlib, L., Whiffen, V., Mount, K., & Cordy, N. 1989, Prevalence rates and demographic characteristics associated with depression in pregnancy and the postpartum. *Journal of Consulting and Clinical Psychology,* Vol. 57, pp. 269–274.

Hipwell, A. and Kumar, R. 1996, Maternal psychopathology and prediction of outcome based on mother- infant interaction ratings, *The British Journal of Psychiatry*, Vol.169, pp.655-661

Holden, J. 1994, Using the Edinburgh Postnatal Depression Scale in clinical practice, in: *Use and misuse of the Edinburgh Postnatal Depression Scale,* Cox, J. & Holden, J. (eds.), Gaskell, London.

Hudoba, M. 2005, *Substance use in pregnancy and parenting service (SUPPS) evaluation (Part 2)*, Wollongong, NSW: University of Wollongong, Illawarra Institute for Mental Health, pp. 271–310.

Hughes, P., Turton, P., Evans, C. 1999, Stillbirth as risk factor for depression and anxiety in the subsequent pregnancy: cohort study. *British Medical Journal,* Vol. 318, pp. 1721–1729.

Humphreys C. 2007, Domestic violence and child protection: challenging directions for practice, *Issues Paper 13*, Australian Domestic and Family Violence Clearinghouse, University of NSW.

Iwaniec, D. 1995, Emotional abuse and neglect, in: *The emotionally abused and neglected child, identification, assessment and intervention*, John Wiley and Sons, Chichester, p. 9.

Johnson, J., Cohen, P., Kasen, S., Smailes, E., Brooks, J. 2001, Association of maladaptive parental behaviour with psychiatric disorder among parents and their offsprings, *Archives of General Psychiatry,* Vol. 58, pp. 453–469.

Kendell, R.E., Chalmers, J.C., Platz, C. 1987, Epidemiology of puerperal psychoses, *British Journal of Psychiatry,* Vol. 150, pp. 662–73.

Kirshbaum, M. 1988, Parents with physical disabilities and their babies, *Zero to Three*, Vol. 23, pp. 509–512.

Krug E.G., Dahlberg L.L., Mercy J.A., Zwi A.B., Lozano R. (eds). 2002, *World report on violence and health,* World Health Organization, Geneva.

Kumar, R. and Hipwell, A., 1994, Implications for the infant of maternal puerperal psychiatric disorders. In Rutter, M., et al., (Eds) *Child and Adolescent Psychiatry.* Third edition. Oxford, Blackwell

Laing L. 2003, *Domestic violence in the context of child abuse and neglect,* Australian Domestic and Family Violence Clearinghouse, Topic paper, Sydney.

Laurence, R. 1997, Post-traumatic stress disorder after childbirth: the phenomenon of traumatic birth. *Journal of Canadian Medical Association*, Vol. 156, pp. 831–835.

Lief, N., 1985, The drug user as a parent. *International Journal of Addictions*, Vol. 20, pp. 63–97.

Lyons-Ruth C., Connell D., Zool, D., Stahl J. 1987, Infants at social risk: relations among infant maltreatment, maternal behaviour and infant attachment behaviour. *Journal of Developmental Psychology,* Vol. 40, pp. 1367–1374.

Mares, S., Newman, L., Warren, B., Cornish, K. 2005, *Clinical skills in infant mental health*, Skillbeck, W. (ed), NSW Institute of Psychiatry, ACER Press, Camberwell, Victoria.

Marshall, J., Watt, P. 1999, Child Behaviour Problems. *A literature review of the size and nature of the problem and prevention interventions in childhood*. Interagency Committee on Children's Futures, Perth, Western Australia.

Matthey S., Henshaw C., Elliot S., Barnett B., 2006, Variability in use of cut off scores and formats on the Edinburgh Postnatal Depression Scale – implications for clinical and research practice. *Archives of Women's Mental Health*, Vol. 9, pp. 309–315.

Matthey S., Karatas J., Junod S., Cooke H., Holley S., Barnett B. 2004, Evaluation of the placement of psychosocial questions on the OBSTET Database, ICAMHS Research Unit, South Western Sydney AHS, Sydney, Australia (unpublished).

Mazza D., Dennerstein L., Ryan V. 1996, Physical, sexual and emotional violence against women: A general practice-based prevalence study. *Medical Journal of Australia*, Vol. 164, pp. 14–17.

McCain M., Mustard J. 1999, *Reversing the real brain drain: early years study final report*. The Canadian Institute of Advanced Research, Toronto, Ontario.

McKay, M. 1994, The link between domestic violence and child abuse: Assessment and treatment considerations, *Child Welfare*, Vol. 73, pp. 29–39.

McMahon, C., Barnett, B., Kowalenko, N., Tennant, C., Don, N. 2001, Postnatal depression, anxiety and unsettled infant behaviour, *Australian New Zealand Journal of Psychiatry*, Vol. 35, pp. 581–588.

Merikangas K., Dierker L., Szatmari, P. 1998, Psychopathology among offspring of parents with substance abuse and/or anxiety disorders: a high-risk study. *Journal of Child Psychology and Psychiatry,* Vol. 39, pp. 711–720.

Mental Health Act 2007, NSW.

Mental Health Act Guide Book, 1998, NSW Institute of Psychiatry. Sydney Australia

Murray, D., Cox, J. 1990, Screening for depression during pregnancy with the Edinburgh Depression Scale. *Journal of Reproductive and Infant Psychology*, Vol. 8, No. 2, pp. 99–107.

Murray, D., Cox, J., Chapman, G., Jones, P. 1995, Childbirth: Life event of start of a long-term difficulty? further data from the Stoke-on-Trent controlled study of postnatal depression. *British Journal of Psychiatry*, Vol. 166, No. 5, pp. 595–600.

Murray J., Murray M. 1998, *When the dream is shattered: coping with childbearing difficulties*. Lutheran Publishing House. Adelaide

National Health and Medical Research Council, Australian Research Council and Australian Vice-Chancellors' Committee, 2007, *National Statement on Ethical Conduct in Human Research*, Australian Government, Canberra

Newman L. K., Stevenson, C., Bergman, l. and Boyce, P. 2007, Mothers with borderline personality disorder: mother-infant interactions and parenting perceptions; preliminary findings. *Australian and New Zealand Journal of Psychiatry*, Vol. 41, No. 7, pp. 598–605.

NSW Child Death Review Team, 2002, *2001–2002 Report*, NSW Commission for Children and Young People, Sydney.

NSW Department of Community Services, 2006, *NSW Interagency Guidelines for Child Protection Intervention*, NSW Government, Sydney.

NSW Department of Health. 2001, *Routine screening for domestic violence in NSW Health: an implementation package, Education Centre Against Violence*. NSW Department of Health, North Sydney.

NSW Health. 2003 (revised 2006), *Policy and procedures for identifying and responding to domestic violence*, NSW Department of Health, North Sydney.

NSW Health. 2000, *The management of people with a co-existing mental health and substance use disorder-service delivery guidelines.* NSW Department of Health, North Sydney.

NSW Health. 2001, *Unless they are asked – routine screening for domestic violence in NSW Health: an evaluation report of the pilot project*. NSW Department of Health, North Sydney.

NSW Health. 2002, *The NSW Aboriginal perinatal health report – a report into the preventable risks factors associated with Aboriginal perinatal mortality and morbidity and strategies to improve Aboriginal perinatal health*. NSW Department of Health, North Sydney.

NSW Health. 2004, *Routine screening for domestic violence program: snapshot report 1*. North Sydney

NSW Health. 2004, *Framework for Suicide Risk Assessment and Management for NSW Health Staff* (and CDROM training modules). NSW Department of Health, North Sydney.

NSW Health, 2005, PD 2005_494, *NSW Neonatal Abstinence Guidelines*, NSW Department of Health, North Sydney.

NSW Health, 2006, *National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn*, NSW Department of Health, North Sydney.

NSW Health. 2007, PD2007_023, *Prenatal Reports*, NSW Department of Health, North Sydney.

NSW Health. 2005, PD2005_121, *Policy guidelines for the management of patients with possible suicidal behaviour for NSW health staff and staff in private hospital facilities.* NSW Department of Health, North Sydney.

NSW Ombudsmen, 2005, *Report of Reviewable Deaths in 2005 Volume 2: Child Deaths*, NSW Ombudsman, Sydney.

Nicol, M., Tompkins, J., Campbell, N., Syme, G. 1986, Maternal grieving responses after perinatal death. *Medical Journal of Australia*, Vol. 144, pp. 287–289.

O'Hara, M.W., Swain, A.M. 1996, Rates and risks of postnatal depression – a meta-analysis. *International Review of Psychiatry*, Vol. 8, pp. 37–54.

Olds D., Kraemer H., Kazadin A., Jensen P., Harrington R., Gardiner J. 1993, Lowering the burden of suffering – monitoring the benefits of clinical targeted and universal approaches. *The Ecology of Child Development,* pp. 293–310.

Parker, B., Soeken, K. 1994, Abuse during pregnancy: effect on maternal complications and birth weight in adult and teenage women. *Obstetrics and Gynecology,* Vol. 84, pp. 323–328.

Perry, B. 1994, *Catechochalamine function in post-traumatic stress-disorder: emerging concepts*, American Psychiatric Press, Washington.

Perry B.D. 1994, Neurobiological sequelae of childhood trauma: Post-traumatic stress disorders in children, in *Catecholamine function in post-traumatic stress disorder: emerging concepts,* Murburg M (ed.) American Psychiatric Press, Washington.

Perry, B., Pollard, R. 1998, Homeostasis, stress, trauma, and adaptation: a neuro developmental view of childhood trauma. *Child and Adolescent Psychiatric Clinics of North America*, Vol. 7, pp. 33–51.

Queensland Department Family Services. 1988, *Beyond these walls: report to the Queensland Domestic Violence Task Force*.

Quinlivan, J., Evans, S. 1999, *Detecting domestic violence in adolescent pregnancy.* 7th Australasian Conference on Child Abuse and Neglect, Perth, WA.

Raphael, B. 2000, *A population health model for the provision of mental health care,* Commonwealth of Australia, Canberra.

Reid, A., Biringer, A., Carroll, J., Midmer, D., Wilson, L., Chalmers, B., Stewart, D. 1998, Using the ALPHA form in practice to assess antenatal psychosocial health. *Canadian Medical Association Journal,* Vol. 159, pp. 677–684.

Roberts, G., Hegarty, K., Feder, G. 2006, *Intimate partner abuse and health professionals new approaches to domestic violence*. Elsevier, United Kingdom

Rutter, M.1995, Relationships between mental disorders in childhood and adulthood. *Acta Psychiatrica Scandinavia*, Vol. 91, pp. 73–85.

Sawyer, M., Arney, F., Clark, J., Graetz, B., Kosky, R., Nurcome, B., Patton, G., Prior, M., Raphael, B., Rey, J., Whaites, L., Zubrick, S., Baghurst, P. 2000, *Mental health of young people in Australia, child and adolescent component of the national survey of mental health and well-being.* Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.

Schore, A., N. 1996, The experience-dependent maturation of a regulatory system in the orbital prefrontal cortex and the origin of developmental psychopathology. *Development and Psychopathology,* Vol. 8, 59–87.

Schore, A., N. 2001, Effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal,* Vol. 22, No. 1–2, pp. 7–66

Schuff, H., Asen, E., 1996. in: *Parental Psychiatric Disorder,* 1st edn, M. Gopfer, J. Webster, & M. Seeman, (eds.), Cambridge University Press, Cambridge, pp. 135–151.

Seifer, R., Dickstein, S. 2000, Parental mental illness and infant development, in: *Handbook of Infant Mental Health*, 2nd edn., C. Zeanah, (ed.), The Guilford Press, London, pp. 145–160.

Snellen M., Mack K., Trauer T. 1999, Schizophrenia, mental state, and mother-infant interaction: examining the relationship. *Australian and New Zealand Journal of Psychiatry,* Vol. 33, pp 902–911.

Sroufe, A., L. 1995, *Emotional development: The organisation of emotional life in the early years,* (pp. 151–191), Cambridge University Press.

Stewart, D., Cecutti, A. 1993, Physical abuse in pregnancy. *Canadian Medical Association Journal,* Vol. 149, pp. 1257–1263.

Stojadinovic, T. 2003, *For the first time somebody wants to hear: the effects of childhood sexual abuse on women's experiences of pregnancy, birth and mothering; a research report for health professionals*, Women's Health Statewide, North Adelaide.

Swain, J., Lorberbaum, J., Kose, S. and Strathearn, L. 2007, Brain basis of early parent-infant interactions: psychology, physiology, and in vivo functional neuroimaging studies, *Journal of Child Psychology and Psychiatry*, Vol. 48, No. 3/4 , pp. 262 – 287

Swan, P., Raphael, B. 1995, *Ways forward: national consultancy report on Aboriginal and Torres Strait Islander mental health.* Australian Government Publishing Service, Canberra.

Taft A., Watson L.F. 2007, Termination of pregnancy: associations with partner violence and other factors in a national cohort of young Australian women. *Australian and New Zealand Journal of Public Health,* Vol. 31, No. 2, pp. 135–142.

Taylor, G., Klein, N., Minich, N., Hack, M. 2001, Long-term family outcomes for children with very low birth weight. *Archives of Pediatrics and Adolescent Medicine,* Vol. 155, pp. 155–166.

Velleman, R. 1996, Alcohol and drug problems in parents: an overview of the impact on children and the implication for practice, in: *Parental psychiatric disorders distressed parents and their families,* Gopfert, M., Webster, J., & Seeman, M. (eds.). Cambridge University Press, Cambridge, pp. 233–243.

VicHealth, 2004, *The health costs of violence, measuring the burden of disease caused by intimate partner violence,* VicHealth, Melbourne.

Weinburg M., Tronick E. 1998, Emotional characteristics of infants associated with maternal depression and anxiety. *Journal of Pediatrics,* Vol. 102, pp. 1298–1304.

Westbrook, W., Chinnery, D. 1995, The effect of physical disability on women's childbearing and early childrearing. *Australian Disability Review,* Vol. 3, pp. 3–17.

Wronski, I., McKenna, P., Stanley, J. 1994, *Report on the questionnaire survey and follow up structure interviews on community Aboriginal health services.* Report for the National Aboriginal Health Strategy Evaluation Committee, Canberra.