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Factors affecting implementation of perinatal mental health screening in women of refugee background

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Background: Perinatal mental health disorders present a major public health challenge given the impacts on women, children, families and the economy. Up to 40% of postpartum depression begins antenatally. A high proportion of resettled refugees experience depression, anxiety and/or post-traumatic stress disorder (PTSD). Australian clinical practice guidelines recommend routine antenatal screening for depression and anxiety symptoms using the Edinburgh Postnatal Depression Scale (EPDS). However, screening is not routinely done at many hospitals. Little is known about how best to apply screening for and management of mental health for women of refugee background.

Aims: (i) Define barriers and enablers to implementing nationally recommended mental health screening in pregnancy care and (ii) inform sustainable introduction of a perinatal mental health screening and management program for women of refugee background.

Methodology: Semi-structured interviews with 28 health professionals (HPs) (e.g. midwives, obstetricians, perinatal mental health and refugee health experts, interpreters) and 9 community representatives (CRs) from diverse ethnic backgrounds.

Results: Almost all participants thought perinatal mental health screening was necessary and most recognised the importance of PTSD screening. Staff training needs were identified as well as inter-professional roles to support referral. CRs prioritised continuity of care, female interpreters and HPs, social support and appropriate follow-up care (including provision of practical strategies). Key resource considerations were availability of accurate, in-person interpreters, translated versions of the EPDS, time constraints, and capacity of mental health services. Success factors for referral included clear and well communicated referral pathways, feedback mechanisms to confirm receipt of referrals, and communication channels between services.

Discussion: Results highlight the need for an inter-disciplinary approach, coordinating care within and between services, and facilitating effective communication with women.

Recommendations derived by mapping themes to behaviour change techniques that address barriers and enhance enablers identified by participants

Theme	Examples to support HPs and women of refugee background
Knowledge	Provide information for HPs regarding rationale for screening, clinical guidelines and evidence-practice gap, appropriate EPDS administration, scoring and actions, and PTSD screening. Provide appropriate information to women at earlier appointments about perinatal mental illness, routine screening, and mental health services.
Skills	Provide training for HPs in identification of refugee or asylum seeker background, identification and prioritisation of refugee and mental health needs, appropriate EPDS use and follow-up actions, and cultural competence.
Professional role and identity	Involve refugee health nurses, bicultural workers and perinatal mental health nurses to support referral. Provide clarity around roles of different HPs and services. Ensure clear communication between antenatal and postnatal services and identify women already receiving mental health care (to avoid referral duplication).
Beliefs about capabilities	Provide training for HPs about sensitively administering PTSD screening and management of acutely unwell women. Engage staff by communicating the reasons for screening and the benefits for women.
Beliefs about consequences	HPs to normalise screening, manage expectations regarding referrals, and communicate professionalism of interpreters and usefulness of follow-up care. Provide culturally appropriate follow-up mental health care (e.g. practical advice about managing symptoms).
Environmental context and resources	Incorporate translated and validated screening tools into routine maternity care. Provide onsite, female interpreters and standardised instructions for EPDS translation. Administer EPDS at the 2nd antenatal visit and again in 3rd trimester, while allowing HPs discretion to screen earlier or later, or to abstain from screening if directed by mental health services already involved in care. Allow appropriate appointment length and flexibility to manage disclosures or make immediate referrals. Map local mental health services and confirm their capacity to absorb referrals in the long-term. Provide privacy for women to complete screening and permit women to bring children to appointments.
Social influences	Ensure a 'go-to' person (e.g. refugee health nurse, psychiatry liaison) and debrief opportunities for HPs. Ensure continuity of care and include referral pathways to social work, women's groups or language services. HPs to explain to family members what screening and potential follow-up involves; however screening to be undertaken privately.
Behavioural regulation	Establish robust referral pathways, feedback mechanisms to confirm receipt of referrals and clear documentation. Clearly communicate pathways and contact numbers to HPs. Develop pathways for different needs while minimising referral points or using on-site services (e.g. social worker).

This information will be used to improve clinical care for women of refugee background.