Aboriginal Perinatal Mental Health Service Expansion: Final Evaluation

Two years into the ‘Healthy Parents, Healthy Minds’ Service in Carnarvon

WA Perinatal Mental Health Unit
August 2011
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- The staff of St John of God’s Strong Family Strong Culture program;

- The staff of the Central West Mental Health Service; and

- The staff of all other government and non-government agencies that assisted in the evaluation process.
### ACRONYMS

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<th>Acronym</th>
<th>Description</th>
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<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>AMS</td>
<td>Aboriginal Medical Service</td>
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<td></td>
<td>(i.e. Carnarvon Medical Service Aboriginal Corporation)</td>
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<td>CHPQ</td>
<td>Carnarvon Health Professionals’ Questionnaire</td>
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<td>CWMHS</td>
<td>Central West Mental Health Service, Carnarvon</td>
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<td>DCP</td>
<td>Department for Child Protection</td>
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<td>DFC</td>
<td>Department for Communities</td>
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<td>EOD</td>
<td>Expected output deliverable</td>
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<td>EPDS</td>
<td>Edinburgh Postnatal Depression Scale</td>
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<td>(Cox, Holden, &amp; Sagovsky, 1987)</td>
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<td>FTE</td>
<td>Full-Time Equivalent</td>
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<td>GDHR</td>
<td>Growing and Developing Healthy Relationships training</td>
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<td>HPHM</td>
<td>Healthy Parents Healthy Minds</td>
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<td></td>
<td>(Carnarvon Indigenous Perinatal Mental Health Service)</td>
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<td>IPMHW</td>
<td>Indigenous Perinatal Mental Health Worker</td>
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<td>(Healthy Parents Healthy Minds staff member)</td>
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<td>KEMH</td>
<td>King Edward Memorial Hospital, Subiaco</td>
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<td></td>
<td>(Western Australia’s major tertiary maternity hospital, Perth metropolitan area)</td>
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<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
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<tr>
<td>NAIDOC</td>
<td>National Aborigines and Islanders Day Observance Committee</td>
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<td>PAD</td>
<td>Perinatal Anxiety Disorders training</td>
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<td>PC</td>
<td>Project Coordinator</td>
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<td>PSOLIS</td>
<td>Psychiatric Services Online Information System</td>
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<td>Postnatal Women’s Questionnaire</td>
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<td>(Indigenous Midwifery program, Carnarvon Hospital)</td>
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<td>WAPMHU</td>
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EXECUTIVE SUMMARY

In 2006 a review of the literature revealed a need for culturally specific perinatal mental health services for Western Australian (WA) Aboriginal women and their families. Moreover, it was acknowledged that mental health services to date had found it difficult to engage Aboriginal clients. Subsequently, a proposal to fund a perinatal mental health service expansion initiative, designed to specifically meet the needs of a WA rural Aboriginal community, was prepared and presented to the State Perinatal Mental Health Reference Group (SPMHRG). The service expansion proposal was endorsed by the SPMHRG at the November 2006 meeting.

Carnarvon was subsequently selected as the pilot site for this project, and based upon evaluation results over a 32-month period, future funding allocation to this site would be decided as well as the possible proposal for expansion of similar services to other WA rural/regional communities. The current Evaluation Report is the final in a series of three Reports. It integrates earlier findings with more recent data to reflect the 32 months of the pilot/evaluation period.

With the intention of gathering data from a wide variety of stakeholders that could be used to build a unique service, an evaluation framework was developed in 2006 and then continuously refined. The methods of data collection, analysis and reporting had to meet the requirements of the Department of Health (i.e. measure outcomes against Key Performance Indicators and assess whether Expected Outputs were delivered) whilst being flexible, intuitive and culturally sensitive. Not an easy task, but critical if the evaluation was going to successfully capture the strengths of the Service and uncover the weaknesses, so that strategies could be put in place to address them. So, a mixed-method design was used to collect evaluation data: a combination of qualitative and quantitative methods. Several questionnaires have been used, along with interviews, focus groups and service data.

The Carnarvon Indigenous Perinatal Mental Health Service was named Healthy Parents, Healthy Minds (HPHM) following consultation with the local community. There are two paid positions within the Service; the Project Coordinator who commenced in August 2008 (initially at 0.5 FTE, increasing to 0.7 in 2010), and the Indigenous Perinatal Mental Health Worker (1.0 FTE) who started in May 2009. The HPHM Service aims to raise awareness of perinatal mental health issues within...
the local Aboriginal community, assist existing services and establish support networks for Aboriginal women living in Carnarvon during the perinatal period.

Over the duration of the Service pilot, HPHM has developed strong collaborative relationships with many agencies in the Carnarvon area. Along with HPHM, there are two other core perinatal services: the True Culture True Care program (TCTC) operated by Carnarvon Hospital and the Strong Family Strong Culture program (SFSC) coordinated by St John of God Health Care. HPHM is also involved in a range of collaborative health promotion and support activities with various agencies.

Overall, the results of the evaluation show that despite its initial challenges, the HPHM Service has achieved a great deal during the 32 month pilot period, with four of the five Key Performance Indicators (KPIs) reached. The HPHM Service appears to have successfully built a solid foundation of trust within the local community, and in particular young Aboriginal mothers, over the pilot period. This is due to the hard work and dedication of the two HPHM Service staff and the flexible, needs-oriented approach taken. Direct support is provided to an average of seven women each month, in some cases with intensive support necessary (up to 25 occasions of service per client over one month). Results from the Postnatal Women’s Questionnaire suggest that this has increased the level of support perceived by Aboriginal mothers in Carnarvon. This finding is strengthened by the qualitative data collected in focus groups and interviews.

The establishment of the ‘Ninny Jinas’ (Little Feet) playgroup by HPHM in collaboration with SFSC, the Department for Communities and the Department for Child Protection has been particularly successful. Attendance levels and feedback from participants and other service providers suggest the playgroup is providing a valuable supportive and engaging environment for mothers in Carnarvon.

The HPHM Service has also taken a long-term approach, educating and building relationships with high school students (as suggested by Aboriginal community members at baseline) – in part to increase the likelihood these teenage girls will engage with services if or when they become pregnant. The difficulty of engaging young mothers in Carnarvon was discussed by family members and professionals alike, and it is hoped that this innovative approach of building connections prior to pregnancy will help to alleviate this problem.
Another area of strength has been the health promotion activities undertaken by HPHM. Between November 2008 and December 2010, eleven interactive community awareness stalls have been held. Over 1100 attendances have been recorded at events and activities run with (or by) HPHM.

The main area of weakness identified throughout the evaluation process is in regards to the amount of education and training provided for local service providers. Subsequently, one of the KPIs has not been fully met, reflecting a need for HPHM staff to provide further training sessions to local health professionals. There appears to have been an improvement in some areas of health professionals' knowledge since the progress evaluation, however there is potential for further improvement in this area. Numerous strategies have been suggested for ways in which to address the difficulties experienced and improve outcomes.

Overall, HPHM has provided a responsive client-focussed Service, unique to the local community, and achieved a great deal in the 32 month pilot period. The Service utilises a multi-faceted approach to improving perinatal mental health, developed in response to the needs of the local Aboriginal mothers and their families. The approach includes one-on-one case management, playgroups, community level health promotion, as well as training and education of health professionals. As a result, they have had many successes, which have been captured and reported in this final evaluation, Based on these findings it was recommended that funding for the HPHM Service should be continued, and if possible increased to enable an increase in staff hours and additional infrastructure requirements to be considered.

Over the 32-month pilot period, the HPHM Service has established a solid foundation, strengthening its community and service partnerships and cementing itself as a core health service for the Carnarvon Aboriginal community. This final evaluation of the Service has provided a valuable forum for the HPHM staff, other service providers and community members to reflect on issues that relate to building and developing a perinatal mental health service with an Aboriginal community. However, it is hoped that the Service will continue to be shaped by ongoing consultation and collaboration with the local community, and keep responding to the unique and changing needs of Aboriginal families in Carnarvon.
INTRODUCTION

In 2006 a review of the literature revealed a need for culturally specific perinatal mental health services for Western Australian (WA) Aboriginal women and their families. Moreover, it was acknowledged that mental health services to date had found it difficult to engage Aboriginal clients. Subsequently, a proposal to fund a perinatal mental health service expansion initiative, designed to specifically meet the needs of a WA rural Aboriginal community, was prepared and presented to the State Perinatal Mental Health Reference Group (SPMHRG). The service expansion proposal was endorsed by the SPMHRG at the November 2006 meeting. Carnarvon was subsequently selected as the pilot site for this project, and based upon evaluation results over a 32-month period, future funding allocation to this site would be decided as well as the possible proposal for expansion of similar services to other WA rural communities.

Figure 1: Map of Western Australia showing pilot site (Carnarvon)
A comprehensive baseline evaluation was conducted in 2007 to provide a forum for the local community to be involved in the on-going development of the service and provide a comparison point for follow-up data collection once the service commenced. Outcome measures for the evaluation were developed and selected to gather required data from local Aboriginal women, as well as obstetric, medical and mental health service providers. For example, 34 local Aboriginal women attended one of three focus groups providing a rich and valuable source of information. The resulting ‘data’ clearly revealed a high level of community support and a genuine need for the service. It also provided invaluable strategies and directions for service implementation. For further details of the baseline evaluation and the development of the Service please see the Aboriginal Perinatal Service Expansion Baseline Evaluation Report (Western Australian Perinatal Mental Health Unit, 2008).

The Aboriginal Perinatal Mental Health Service Expansion Progress Evaluation Report was the second produced, presenting ‘data’ collected 12 months into the pilot period (Western Australian Perinatal Mental Health Unit, 2010). Despite considerable delays with recruiting suitable staff, the progress evaluation indicated that the Healthy Parents Healthy Minds (HPHM) Service, as it became known, had achieved a great deal in 12 months. Two of the five Key Performance Indicators (KPIs) had been achieved and substantial progress made towards the remaining three.

The current document is the third evaluation and titled the Aboriginal Perinatal Mental Health Service Expansion: Final Evaluation. It integrates earlier findings with more recent data to reflect the 32 months of the pilot period.

**Background**

Improving Aboriginal health is a priority at both the state and national level (Cant, Penter, Henry, & Archibald, 2010). Between the baseline and final evaluation, former Prime Minister of Australia Kevin Rudd made a formal apology to the Stolen Generation. The speech on February 13th, 2008 was a significant event for all Australians, and in particular the Aboriginal people of this country. For many Aboriginal Australians the apology allowed the healing of deep trauma; others greeted it with suspicion, their mistrust of government deeply ingrained (Garvey, 2008). In his speech, then-Prime Minister Rudd spoke of Aboriginal and non-Aboriginal Australians working together to ‘close the gap’ in economic, academic and
health outcomes. The gap is apparent not only in physical health outcomes, but in mental health outcomes.

**Social and emotional wellbeing**

Rather than talking about ‘mental illness’ or ‘mental health’, Aboriginal people often prefer the term ‘social and emotional wellbeing’ as it implies a more positive approach, and avoids the stigma and shame associated with the former (Garvey, 2008). The use of this term reflects a more holistic view in which the physical, social, emotional and cultural wellbeing of individuals and their communities are interdependent (Purdie, Dudgeon, & Walker, 2010). Social and emotional wellbeing can refer to illnesses such as depression, as well as behaviours such as alcohol or drug use. It also encompasses spirituality and culture, which are integral to Aboriginal health. The strength of connections between people, spiritual entities and the land contribute greatly to Aboriginal social and emotional wellbeing. The term relates to individual wellbeing as well as the wellbeing of the group, and the two are connected: in an Aboriginal context, the “social, emotional, spiritual and cultural wellbeing of the whole community is paramount and essential for the health and wellbeing of the individuals that comprise it” (Garvey, 2008).

The social and emotional wellbeing of Aboriginal people today is intimately connected to their past. Aboriginal people have suffered and endured deep trauma due to “separation from land, family and cultural identity” (Milroy, from the preface of Zubrick et al., 2005, p. xvi). Traumas from the past are transmitted from generation to generation through insecure attachment relationships, impaired parenting and family functioning, diseases of the body and mind, and “alienation from extended family, culture and society” (p. xxi).

The cycle of grief and trauma is not easily broken. Despite acknowledgement of the wide gap between the health outcomes of Aboriginal and non-Aboriginal Australians, there have been only minor improvements in recent years (Australian Government, 2011; National Aboriginal Community Controlled Health Organisation & Oxfam Australia, 2007). To close the gap, Australia will require “long-term, sustained efforts across multiple sectors of the community [and] collaborative inter-sectoral partnerships” (Garvey, 2008) to remove the structural inequalities that limit Aboriginal social and emotional wellbeing, the need for long-term investment and effort was

Research into Aboriginal social and emotional wellbeing

Recent national reports highlight a number of poor outcomes relating to Aboriginal social and emotional wellbeing (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2008). Aboriginal Australians are more likely to report significant stressors in their lives such as mental illness, alcohol or drug-related problems, abuse, violent crime, or the death of a close friend or family member. Surveying conducted in 2004-05 showed 27% of Aboriginal adults were experiencing high or very high levels of psychological distress - twice the proportion of non-Aboriginal adults (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2008). In 2008, the figure had risen to 32%, more than twice the rate for non-Aboriginal people (around 13%) (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2010).

Aboriginal women were more likely than Aboriginal men to report high levels of psychological distress: 34% compared to 27% (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2008). The health of Aboriginal women can be improved by “holistic approaches that encompass spirituality and connections to family, community and country, and the sharing of Aboriginal women’s knowledge, skills and networks” (Australian Bureau of Statistics, 2007).

Aboriginal Australians are more likely to be hospitalised for intentional self-harm or for mental and behavioural disorders resulting from psychoactive substance use (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2008). However the report also notes that in a survey of positive wellbeing, 71% of Aboriginal respondents said they felt happy, 56% said they felt calm or peaceful and 55% said they felt full of life all or most of the time (ABS & AIHW, 2008). This may reflect the strong resilience among Aboriginal Australian communities. In the words of Ken Wyatt, a past Director of Aboriginal Health in Western Australia and New South Wales:

“Aboriginal people are a traumatised people. But they are also a resilient people, otherwise we would all be dead”

(cited in Tracey et al., 2007, p. 13).
Teenage pregnancy rates

A recent report on Aboriginal mental health noted that adolescent pregnancy can create additional challenges for the woman, her partner and family (Ferguson-Hill, 2010). In Western Australia in 2008, the birth rate for Aboriginal teenage mothers was six times the rate for non-Aboriginal teenage mothers (104.2 per 1000 mothers, compared to 16.6 per 1000 mothers respectively; Le & Tran, 2010).

Between 2007 and 2009, the Mid-west region of Western Australia (in which Carnarvon is situated) saw an increase in the number of girls aged 16 or less giving birth (Strutt, 2010). Health Department statistics showed there were 7 births to girls aged 16 or less in 2007, 9 births in 2008 and 11 births in 2009. Between 2008 and 2009, most other regions of Western Australia showed a decrease in the number of births to girls aged 16 and under; for example, the number of births in the north metropolitan and south metropolitan regions dropped from 22 to 14 and 38 to 20 respectively. There were also decreases in the number of births in the Kimberley, Pilbara and Goldfields regions (Strutt, 2010). Unfortunately, the statistics did not specify the cultural background of the young mothers, but it does show a concerning trend within Carnarvon and the surrounding Mid-West region.

Pregnancy and neonatal outcomes

A recent meta-analysis of Aboriginal communities worldwide found an increased (unadjusted) risk of many negative birth outcomes including low birth weight, preterm birth, still-birth, and perinatal/neonatal mortality. Analysis of subgroups by country found that infants born to Australian Aboriginal women were at heightened (unadjusted) risk for all these factors, while infants born to Canadian Aboriginals, American Indians and Alaskan Native women were at risk of some (but not all) of these outcomes (Shah, Zao, Al-Wassia, & Shah, 2011).

The proportion of low birth weight babies born to Aboriginal mothers in 2008 (16%) was more than two and a half times that of non-Aboriginal mothers (6.1%). The proportion of Aboriginal mothers having babies with low birth weight has not improved in the last 15 years (Le & Tran, 2010). Low birth weight is associated with chronic disease in adulthood (Gracey & King, 2009; O'Dea, 2005) and perinatal mortality (Johnston & Coory, 2005).
Perinatal comorbidities

In 2008, researchers investigated the cigarette and alcohol use of mothers in Australia with children aged 0–3 years. One in five (20%) birth mothers of Aboriginal children reported they had consumed alcohol during pregnancy and 42% had smoked tobacco (although 24% reported they smoked less while pregnant). Those who sought advice during pregnancy were less likely to smoke during pregnancy than those who did not seek advice (53% compared with 64%; Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2010).

In Western Australia in 2008, Aboriginal mothers smoked during pregnancy at around four times the rate of non-Aboriginal mothers (51% and 13% respectively) (Le & Tran, 2010). This is a particularly concerning statistic, given the results of a recent review outlining the health effects of smoking in pregnancy: increased ectopic pregnancies, spontaneous abortions, still births, premature birth, intra-uterine growth retardation and lower birth weight (Thomas & Glover, 2010). Following birth, exposure to second-hand smoke increases the risk of sudden infant death, lower respiratory tract infections and otitis media, and also exacerbates asthma (Thomas & Glover, 2010).

The negative health effects of alcohol consumption in pregnancy include miscarriage, premature birth, stillbirth, low birth weight and Foetal Alcohol Spectrum Disorders, such as foetal alcohol syndrome (FAS). Children with FAS may suffer prenatal and/or postnatal growth retardation, as well as abnormalities of the central nervous system (Peadon et al., 2010). A recent report based on consultation with community members and service providers in the Murchison-Gascoyne region of Western Australia (in which Carnarvon is located) noted that foetal alcohol syndrome was considered a large and unresolved issue by many of the people they spoke to (Cant, et al., 2010).

Not only is alcohol consumption associated with poor birth outcomes, it is also associated with mental health problems, psychological distress, injury, self-harm and exposure to violence. In 2003, excessive alcohol consumption accounted for the second highest proportion of the burden of disease and injury for Aboriginal young women, after intimate partner violence (Australian Bureau of Statistics & Australian Institute of Health and Welfare, 2010).
Difficulties in providing Aboriginal mental health services

Mental health services have generally found it difficult to engage Aboriginal people, for many reasons: “…geographic isolation, a lack of culturally appropriate services, a lack of Indigenous staff within available services, limited training of mental health service staff regarding Indigenous issues, and stigma and stereotyping all contribute to the limited use of current mental health services by Indigenous people. These factors may be accompanied by a fear of being admitted to hospital or confined in unfamiliar surroundings…. compounded by an historical legacy of miscommunication and, at times, mistrust to the intent of mental health initiatives” (Garvey, 2008, p. 19).

One could also add here the fear of having children removed by authorities, particularly when looking at social and emotional wellbeing in the perinatal period; the experiences of Aboriginal people in Australia include a “long history of mistreatment by mainstream health and welfare services” leading to mistrust and wariness of such services (Rickwood, Dudgeon, & Gridley, 2010, p. 18).

Culturally safe and culturally appropriate services

The professions involved in mental health service provision, including psychology and psychiatry, have historically failed to meet the needs of Aboriginal people due to an ethnocentric approach (Rickwood, et al., 2010). However, through collaboration between Aboriginal and non-Aboriginal people, and the application of culturally informed approaches to mental health, significant changes are being made in the way services are provided (Rickwood, et al., 2010). A service is ‘culturally safe’ when the client feels their cultural needs are respected and met. The aim of cultural safety is for health practitioners to develop an open-minded and non-judgemental attitude when observing the differences between cultures (Kruske, Kildea, & Barclay, 2006). It is more than learning about the ‘other’ culture as a token gesture or as a professional development requirement; it requires the practitioner to “explore their own cultural makeup” (p. 74) so that they can better understand and respect the differences between cultures. They are then in a position to provide a more culturally safe service that will likely enhance the social and emotional wellbeing of Aboriginal clients.

Strategies to improve Aboriginal access to health services include employment of Aboriginal staff (such as community liaison workers), cross cultural
training for non-Aboriginal staff (including ongoing two-way learning with Aboriginal colleagues and clients), cultural liaison (having Aboriginal mentors who can help non-Aboriginal staff understand the roles and responsibilities in the Aboriginal community), and working with key community members such as elders and Aboriginal health workers. In the case of women’s health, aunts and grandmothers are also key community members (Read, 2006).

Culturally safe maternity services for Aboriginal women

Culturally safe practices are vital when providing maternity services for Aboriginal women. Pregnancy and birth have profound spiritual and cultural meaning for Aboriginal Australians; they are “among the most sacred and precious of events” (Tracey, et al., 2007, p. 7). Failure to observe the rituals and laws associated with pregnancy and childbirth can result in feelings of shame and guilt. This failure could also threaten the health of the mother and baby, as well as the group (Kruske, et al., 2006).

For Aboriginal Australians, “being born ‘on country’ is pivotal to their identity and also to their holistic sense of being... to be born ‘off country’ potentially disengages and disconnects the person from the privileges of belonging and responsibility to care for their country, the culture, traditions, law and people belonging to that country… birthing in large maternity units, away from country and isolated from kin, deprives Aboriginal women of their cultural security” (Dietsch et al., 2011, p. 59).

Researchers suggest that to be culturally safe, maternity care should be offered by known female practitioners (Kruske, et al., 2006), as being attended by a male practitioner would cause shame. Services should ideally be community-based and run through an Aboriginal-controlled organisation. Birthing should occur “as close to the woman’s home as possible” (p. 76) to observe beliefs about relationship to the land; however if women must travel to give birth, they should have the option of taking their young children with them, and be allowed an ‘escort’ to keep them company while they are in town.

Perinatal emotional wellbeing

Research supports a holistic, multidisciplinary approach for improving Aboriginal health outcomes. The Mothers and Babies Program, a shared antenatal care intervention for pregnant Aboriginal women in Townsville, helped to increase
access to antenatal care and was associated with less preterm deliveries (Panaretto et al., 2005). The program brought together staff from several Townsville organisations, ensuring that Aboriginal women were seen by Aboriginal health workers, midwives, child health nurses, female doctors, the obstetric team and an Aboriginal outreach health worker.

**Measurement of perinatal mental health (emotional wellbeing)**

The Edinburgh Postnatal Depression Scale (EPDS; Cox, et al., 1987), a 10-item questionnaire used to screen for symptoms of depression, is used internationally and is becoming increasingly common in Australian perinatal health services. Campbell, Hayes and Buckby (2008) note that Aboriginal populations tend to score higher on the English version of the EPDS; however there have been no Aboriginal translations of the EPDS until recently.

Campbell, Hayes and Buckby (2008) worked on translations of the EPDS with Aboriginal communities in Townsville and Mt Isa, which, while still in English, substituted words and phrases to make them more appropriate to local people and to reduce misunderstanding. The translations had a high level of reliability for people within the respective communities (Campbell et al., 2008). A third translation was developed with the Palm Island community, but not reported in the 2008 published article.

As Aboriginal communities are diverse in their languages and beliefs, it would be culturally unsafe to use these EPDS translations with other communities in other locations. However, a translation is being developed in Kununurra, Western Australia, which will be acceptable to five local language groups (personal communication, J Kotz, 2010). Unfortunately, to the authors’ knowledge, no EPDS translations have yet been developed for the language groups of Carnarvon. Subsequently, the English version of the EPDS is currently being used by local health professionals.

**Evaluation Framework**

With the intention of gathering data from a wide variety of stakeholders that could be used to build a unique service and then keep strengthening that service, an evaluation framework was developed at baseline (2006) and then continuously
refined. It was evident from the baseline research and on-going consultation that
to assess the program
against *Key Performance Indicators* and *Expected Output Deliverables* (as required
by the Health Department), the data collection, methods of analysis and reporting
would also need to be flexible and responsive to the cultural context.

Data collection proved to be a challenge. With sampling techniques and sizes
inadequate for conclusive results (i.e. validity, reliability, transferability) and service
provider data being initially scarce, finding alternative ways of measuring and
reporting outcomes of the HPHM Service became crucial. The researchers had to
think outside the confines of their empiricist training and employ methods that were
culturally sensitive and flexible.

Building trust with the local Aboriginal community so that they were willing to
engage with a new service and participate in the evaluation was a major challenge,
though in no way unique. However, it was believed that building a solid foundation of
trust was crucial for this service, if we were to provide a quality service that will truly
meet the needs of the local Aboriginal families. If we were not willing to invest the
necessary time, and unable to make the honest effort to *listen* to the local community
and utilise their input in the on-going evaluation and development of the Service, this
was going to be another service that, despite its good intentions, failed to make any
real difference.

The researchers initially planned to collect a second round of evaluation data
6 months after service implementation, and then a third at the end of the 18-month
pilot period. These evaluations would assess progress of the Service, recommend
strategies for improvement, and advise whether funding should be continued beyond
the pilot period. However, there were unexpected delays in filling the two paid
positions in the Healthy Parents Health Minds Service, which significantly lengthened
the periods between data collection points. The Project Coordinator position was
filled in August 2008, marking the official beginning of the pilot project. However, the
Indigenous Perinatal Mental Health Worker position was not filled until May 2009,
which limited the degree to which the project could fulfil its mandate, at least initially.
It was thus decided that the research team would begin collecting Progress
evaluation data in August 2009 (12 months after official service commencement), to
give the staff time to orient themselves and begin work.
The data for the Final evaluation was collected between October 2010 and April 2011. The interviews and focus groups were planned for late 2010/early 2011, but were postponed due to record-level flooding in Carnarvon in December 2010. Data collection was therefore completed in April 2011 (32 months after official service commencement and 23 months after the program was fully staffed).

**Key Performance Indicators (KPIs)**

KPI-1- Increase in level of perceived social support by Aboriginal mothers living in the Carnarvon region of WA

KPI-2- Increased perinatal specific knowledge by local service providers and health professionals

KPI-3- Provision of perinatal specific health promotion strategies in the target area

KPI-4- Documented increase in engagement with obstetric/medical services during pregnancy and postpartum by local Aboriginal women

KPI-5- Documented increase in engagement with mental health services during pregnancy and postpartum by local Aboriginal women

**Expected Output Deliverables (EODs)**

EOD-1- Number of occasions of service

EOD-2- Number of referrals for perinatal mental health concerns to mental health services

EOD-3- Number of groups held and types of activities

EOD-4- Description of perinatal mental health promotion strategies

EOD-5- Number of education and training sessions conducted for local service providers

Each KPI and EOD relates to a data set collected in this evaluation (see Table 1). At the beginning of each section of this report, KPIs and EODs are highlighted where relevant.
Table 1: Evaluation Framework for the ‘Healthy Parents, Healthy Minds’ Service

<table>
<thead>
<tr>
<th></th>
<th>Feb 2008</th>
<th>Aug 2009</th>
<th>April 2011</th>
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<td>Final</td>
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<td>Focus groups/interviews</td>
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<tr>
<td>Health Professionals Questionnaire</td>
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<td>Service Mapping</td>
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<td>Interviews</td>
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<td><strong>Service Provider Data/Records</strong></td>
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<tr>
<td>HPHM referrals to mental health services</td>
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<tr>
<td>Local Aboriginal women engaging with Carnarvon Hospital and/or Carnarvon Medical Service Aboriginal Corporation (CMSAC) during antenatal &amp; postnatal period (i.e. through the True Culture True Care Program)</td>
<td>*</td>
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<tr>
<td>HPHM PSOLIS Database data</td>
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<tr>
<td>HPHM event reports</td>
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</table>
MAPPING OF THE ‘HEALTHY PARENTS, HEALTHY MINDS’ SERVICE

The Indigenous Perinatal Mental Health Service, named the ‘Healthy Parents, Healthy Minds’ Service (HPHM) following consultation with stakeholders and local community members, commenced in August 2008. The framework for the Service was based on a community liaison model. The following key parties have collaborated on the coordination and support of the Service to date:

- WA Perinatal Mental Health Unit
- State Aboriginal Mental Health Service
- Central West Mental Health Service – Gascoyne
- Carnarvon Medical Service Aboriginal Corporation (commonly referred to as the Aboriginal Medical Service or AMS)
- Carnarvon Hospital
- Gascoyne Primary & Community Health

The HPHM Service aims to raise awareness of perinatal mental health issues amongst Aboriginal communities, provide support to existing service infrastructure and establish support networks for Aboriginal women during the perinatal period. Line management has been provided by the Clinical Nurse Manager of the Central West Mental Health Service (CWMHS) with the staff based at Mental Health as well as at Carnarvon Hospital.

Two staff members make up the Service: the Project Coordinator (PC) who commenced in August 2008 (initially at 0.5 FTE, increased to 0.7 FTE in 2010), and the Indigenous Perinatal Mental Health Worker (IPMHW) who began in May 2009 (1 FTE). Considerable delays were experienced in recruiting a suitable candidate for the IPMHW role, hence the time difference between the commencement of roles within HPHM. The memorandum of understanding for the Service provides an outline of key activities for both staff members.

The following key activities were noted for the IPMHW:

- Provision of health promotion within the community
- Development and implementation of activities promoting positive emotional wellbeing
• Advocacy for perinatal mental health client group
• Provision of support groups for targeted women
• Consultation/liaison with community and local services
• Collect data as required

The following key activities were noted for the PC:

• Consultation/liaison with community and local services
• Provision of education and training for local service providers
• Case management of small number of high risk mothers
• Advocacy for perinatal mental health client group
• Provide local supervision and support to Indigenous Perinatal Mental Health Worker
• Collect data as required
Client Support Activities

Relevant Expected Output Deliverables:

<table>
<thead>
<tr>
<th>EOD-1</th>
<th>Number of occasions of service</th>
</tr>
</thead>
<tbody>
<tr>
<td>EOD-2</td>
<td>Number of referrals for perinatal mental health concerns to mental health services</td>
</tr>
<tr>
<td>EOD-3</td>
<td>Number of groups held and types of activities</td>
</tr>
</tbody>
</table>

Capturing data on the number of service events and referrals has been an ongoing challenge since HPHM began. This is partly due to time constraints, with the PC not being full time, and also to the varied and sometimes informal nature of service events. As mentioned in the Progress Report (Western Australian Perinatal Mental Health Unit, 2010), the HPHM Service does not lend itself easily to a formal reporting process. While a clinical service could easily measure its service by the number of appointments in a month, the HPHM Service has such a breadth of roles that measurement becomes problematic. An instance of service could be a formal mental health assessment at Central West Mental Health Service; assisting a client at a medical appointment; transporting a client to the Women’s Refuge and stopping at the supermarket on the way to buy nappies; attending a playgroup; or running a community stall during Children’s Week. Each client might require a range of advocacy and support activities. Some activities are undertaken one-on-one, however as noted in the Progress Report, clients sometimes feel more comfortable in groups.

As recommended, HPHM staff members have fulfilled the required data provision by using the Psychiatric Services Online Information System (PSOLIS) database, as used by all mental health agencies within the WA Department of Health. PSOLIS allows each instance of service, however small or complex, to be recorded and categorised. Table 2 shows the recorded occasions of service from May 2009 to December 2010, fulfilling EOD-1, number of occasions of service. Direct service provision refers to the caseload component of HPHM work. There is an average caseload of seven women per month. At times, intensive support is provided to a client, with up to 25 occasions within a month. Other activities cover a wide variety of tasks involved in the Service, ranging from health promotion activities to meetings and professional development.
Table 2: HPHM Occasions of Service

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of Clients</th>
<th>Number of Occasions</th>
<th>Max. Occasions per Client</th>
<th>Number of Occasions</th>
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<tbody>
<tr>
<td>May-09</td>
<td>6</td>
<td>20</td>
<td>10</td>
<td>37</td>
</tr>
<tr>
<td>Jun-09</td>
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<td>40</td>
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<td>Jul-09</td>
<td>9</td>
<td>26</td>
<td>13</td>
<td>48</td>
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<td>Aug-09</td>
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<td>57</td>
<td>17</td>
<td>49</td>
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<tr>
<td>Sep-09</td>
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<td>10</td>
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<td>Feb-10</td>
<td>12</td>
<td>38</td>
<td>6</td>
<td>64</td>
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<tr>
<td>Mar-10</td>
<td>12</td>
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<td>Dec-10</td>
<td>7</td>
<td>22</td>
<td>10</td>
<td>20</td>
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</table>

Types of client contact

Direct client contact provided thus far by the HPHM Service has involved the following, depending on the individual needs and circumstances of the client:

Practical Support

- Assisting clients to gain food vouchers or financial support from appropriate agencies
- Providing transport to pharmacy, doctor, specialists
• Providing transport and support to attend community events, e.g. Best Start playgroup at Mungullah Aboriginal Community (10min drive out of Carnarvon)
• Providing transport for clients to allow them to gain support from other agencies
• Assisting clients to access practical support from family
• Assisting clients to initiate and access day care including completing day care forms
• Assisting clients with practical support in the home and household tasks such as: laundry; cleaning; shopping for groceries, clothes and household goods; transporting household goods; moving house

Client advocacy

• Liaising with other agencies such as the Carnarvon Women’s Refuge, Homeswest, the Department for Child Protection, Centrelink and the Aboriginal Legal Service
• Assisting clients with financial matters by helping them to complete and lodge forms
• Supporting clients to interact with other agencies
• Attending appointments with clients at other agencies
• Discussing Durack Institute (TAFE) courses with clients and assisting them with enrolments

Emotional Support

• Home visits to monitor client’s mood, level of functioning and need for medication reviews
• Being available via the phone when a client is distressed or in need of assistance
• Visiting clients on the ward at Carnarvon Hospital
• Providing direct support to clients and their extended families via mediation and family meetings
• Providing clients with emotional support and relevant information, to allow them to make important decisions regarding their relationships, children and health care
• Addressing risk, e.g. when clients are having thoughts of harming self, partner or baby

Health Promotion / Prevention

• Many of the health promotion activities are conducted with groups and described more in a later section of the report. However occasionally direct service provision includes a health promotion component (e.g. attending antenatal clinics at the AMS and building relationships with clients)
Referrals

One of the aims of the HPHM Service is to increase engagement with mental health, medical and obstetric services by Aboriginal women in the perinatal period. AS HPHM is co-located with CWMHS, many ‘referrals’ for mental health services are informal, occurring in-house; HPHM staff members seek the guidance and assistance of Central West Mental Health Service (CWMHS) clinicians when required.

From June 2009 to April 2011, the HPHM has referred clients to the following:

- Psychologist – 4
- Beyond Blue – 1
- Mother and Baby Unit (KEMH) – 1
- General Practitioner – 11
- Drug and Alcohol – 3
- Aboriginal Legal Service – 3
- Homeswest – 9
- Department for Child Protection – 9
- SIDS and Kids – 1
- Day care – 5
- Playgroup – 12
- MIRAC Housing – 1
- Carnarvon Women’s Refuge – 3
- Strong Family Strong Culture (St John of God) – 6
- Child Health Nurse – 5
- Burringurrah Nurse – 2
- Police – 2
- Family Support Service – 1
- Carer Respite – 1
- Population Health – 1
- Durack Institute (TAFE) – 1

This information provides the number of referrals for perinatal mental health concerns to mental health services (EOD-2), as well as a range of holistic concerns in clients’ lives.
Groups

Expected Output Deliverable 3 (EOD-3; number of groups held and types of activities), has been provided for this final evaluation. Until 2011, the HPHM Service had not run any support groups of its own. In Carnarvon there were already two playgroups which reportedly met this need: the Best Start Playgroup at the Mungullah Aboriginal Community, and the Bridge Playgroup, which was attended by Aboriginal and non-Aboriginal mothers. At the time of the Progress Report (Western Australian Perinatal Mental Health Unit, 2010) a third playgroup (also Best Start) was planned to open in the middle of town. Given the population of Carnarvon and the cross-over in ‘target population’ of these groups (i.e., postnatal women) it was decided by the HPHM staff that it was not necessary for HPHM to run an additional group. Instead the HPHM Service attended the existing groups at regular intervals to ensure that (i) maternal emotional health and wellbeing content was included in discussion topics and activities and (ii) that the HPHM staff became familiar and trusted faces to the women attending.

However, in late 2010 – early 2011, the Best Start playgroup coordinator position became vacant and flooding affected access to the Bridge Playgroup, so the need arose for a playgroup in town. HPHM established the ‘Ninny Jinas’ playgroup, in conjunction with the St John of God Strong Family Strong Culture program (SFSC), the Department for Communities (DFC) and the Department for Child Protection (DCP). The playgroup has been held weekly since February 11th, with nine sessions undertaken prior to the final evaluation data collection.

The playgroup has been well promoted, including an article in the local paper and flyers at numerous locations in Carnarvon. Several special days have been held, such as a ‘Teddy Bears Picnic’ open day, a ‘Harmony Day’ event celebrating different cultures, and guest speaker sessions (e.g. an educational talk on child brain development).

Participation in the playgroup has been very good, typically around 8 –15 children and similar numbers of parents. On special occasions as many as 17 children, 17 parents and 5 volunteers attended. The playgroup provides many opportunities for health promotion, however it also provides direct social support. Research has shown that social support is an important factor associated with postnatal depression- a lack of social support presents a risk, but sufficient social support is protective (Nielsen, Videbech, Hedegaard, Dalby, & Secher, 2000; O’Hara
Staff reflections on client support provision

The PC and IPMHW note that the HPHM Service plays many roles in Carnarvon. Each role provides support in some way, either to clients or service providers. Being linked in with many agencies means that the HPHM staff can provide support not only for Aboriginal mothers to access these services, but also provide support to the agencies in terms of advice or practical assistance. For example, advice on how they might best approach an Aboriginal mother in the community, or assistance in locating a client and proving transport to help them get to an appointment.

Case management and direct client support are the most important roles of the HPHM Service, and these can be complex. Clients of the HPHM Service typically face a number of stressors in their lives, from making sure there is enough formula for the baby, to chronic problems such as lack of transport, sub-adequate housing, or domestic violence. The HPHM Service provides holistic support to meet their clients’ varied needs. For some clients, support is out of the ordinary, as they may not have experienced it in the past.

PC And sometimes I’ve had people say - that same girl said to me, ‘no-one’s ever helped me before. No-one’s ever just helped me. And youse helped me’.

Another major role is that of client advocate. The PC and IPMHW will sometimes need to speak to agencies on the client’s behalf, as the client may not feel comfortable talking to the agency on their own. Staff may also attend appointments with their clients to provide emotional or practical support, at agencies such as the Family Violence Prevention Service, the AMS and the Department for Child Protection (DCP).

Sometimes clients also want a HPHM staff member in attendance because they feel their reading and writing skills may be lacking.

IPMHW they feel a lot more comfortable because they know that I’m there and that as soon as that form is slid across the table they know that I’m going to take it and fill it in for them.
The issue of literacy can be especially important when it comes to financial matters. Clients of the HPHM Service are often eligible for small loans for household items through the No Interest Loan Scheme (NILS), operated by the Carnarvon Family Support Service. However, NILS applications involve many pages of paperwork, and as the PC pointed out, “someone illiterate won’t go and do that themselves”. One of the planned activities for the playgroup is to include literacy activities. Although overtly targeted at the children, the activities will be run in a way that allows mothers with literacy problems to learn as well and not feel uncomfortable.

The PC and IPMHW cite their biggest challenge as engaging mothers on an ongoing, individual basis. Mothers will reportedly often seek support only when they are in crisis; it is only with experience that the mothers learn the long-term benefits of regular support.

**PC** Every now and then when they’re in distress they come to us and we can help them.

**IPMHW** But when they’re going alright, too busy.

**PC** It’s not that they don’t want the help other times, it’s just that they get busy doing other things.

**IPMHW** Some of them have a lot of children.

**PC** But I think for them to stay well they need to see us more regularly. And some of them that have been through that process a couple of times now recognise that…

The HPHM staff sometimes find it challenging to engage with young mothers. Even making initial contact can be difficult:

**PC** The younger mums are harder to track down and keep to appointments… appointment times don’t really mean much to the young mums. Sometimes you have to catch them on the hop when you can catch them. Chase them up. Try and get other family without breaking confidentiality.

**IPMHW** Go to more than one spot.

The HPHM staff indicated that perseverance is often needed, to build relationships and trust so that young mothers will access the Service when they feel they need it.

**PC** A lot of it’s just hard slog isn’t it.
Continually going back they know that you’re there. There will come a time when they need you… and they know that you’re there and that you’re not just going to go away then, they know that you’re available.

As challenging as it can be to engage and provide support to some of the young mothers with very difficult circumstances, there have been a number of ‘successes’. These include a long-term client who was able to leave a violent partner:

We can’t tell them to do that, we just gave her the strength and view of the rest of the world that she wanted to do that herself in the end for herself and the kids.

Other reported successes include a client who had her first baby at a young age, who is now completing tertiary education. Sometimes the successes are less tangible, such as a teenaged client who was fearful of having her children taken away and reluctant to acknowledge any problems or engage with agencies. With support from a range of agencies she has developed more insight about parenting and will now actively seek help when she has concerns.
Service Partnerships

Two other Carnarvon services were established at around the same time as HPHM, with the same target group of Aboriginal mothers. One is the True Culture True Care program (TCTC) operated by Carnarvon Hospital, and the other is SFSC (see Figure 2).

Preparations for the TCTC program began in early 2009 with the aim of providing antenatal care to Aboriginal women in the area; the Service commenced when a Community Midwife was employed in July 2009. The Community Midwife’s role is to see every pregnant Aboriginal woman in town, and screen them with the Edinburgh Postnatal Depression Scale (EPDS; Cox, et al., 1987). She may refer women to the HPHM Service if they score high on the EPDS (>12), or if she feels that they could benefit from the specialised support of the Service; however referral numbers have fluctuated with different staff members in the role (four midwives have been in the role since the TCTC service began).

The Community Midwife role is responsible for running antenatal clinics, which have previously been held at the Best Start playgroup in Mungullah, and the AMS buildings in both Mungullah and Carnarvon. The antenatal clinic is currently held at Carnarvon Hospital on a Thursday, on-and-off all day. An Aboriginal worker started with TCTC this year, supporting the Community Midwife by locating Aboriginal mothers and transporting them to the clinic. This is reported to have increased attendance.

The SFSC program runs in towns across Western Australia, in the Midwest, Gascoyne, Pilbara and Kimberley regions. A Coordinator is employed to oversee the program in each site. The program aims to improve the health and wellbeing of Aboriginal women and their babies in the area, with particular attention placed upon increasing the birth weights of babies. The program also aims to recognise and encourage cultural parenting practices, strengthen families, and reduce lifestyle diseases through prevention, early intervention and education. No two programs are the same, as each site has its own needs. The SFSC program began in Carnarvon in June 2008.

Two other agencies provide the HPHM Service with a way of making contact with Aboriginal mothers- the child health centre, and the Best Start program run by
DFC. When the PC first started in her role, she shadowed the Child Health Nurse at the clinic and on home visits, in order to meet Aboriginal mothers. She also developed a partnership with the Best Start Coordinator, as they see a lot of the mothers from the Mungullah community who may not come into town for antenatal care.

This ‘web’ of perinatal services – comprising primarily the HPHM, TCTC and SFSC, but also including the Best Start program and child health centre – work together to provide a greater probability of seeing each Aboriginal woman in the community throughout her pregnancy. The TCTC Community Midwife and the SFSC Coordinator are usually the first to see pregnant Aboriginal women, and they refer to the HPHM Service where needed, however referrals can occur in all directions between the three services (both formally and informally). Collaborative activities with perinatal service partners have greatly strengthened service provision to Aboriginal women in Carnarvon.

Figure 2: Services for Carnarvon Aboriginal women during the perinatal period
In addition to the on-going collaborative relationships described above, HPHM staff members have had the following regular meetings and commitments over the life of the Service so far:

- Gascoyne Early Years Learning Network: monthly meetings, to apply for funding and organise events.
- At-Risk Children meetings (Child Health Centre). Dissolved in early 2011.
- Bridge Playgroup: attended the group each Friday, transported clients to the group, and followed up on mutual clients (the playgroup operated until the end of 2010)
- Best Start playgroups: Mungullah (Thursdays during school terms, still operating at time of evaluation) and in town (Wednesdays during school term, operated until at end of 2010)
- Ninny Jinas playgroup: collaboration between HPHM, SFSC and Department for Communities; Fridays (February – April 2011), Wednesdays (April 2011 to time of evaluation)
- Mungullah antenatal clinic: Thursdays at CMSAC building (until early 2011; clinic now operating in Carnarvon only)
- TCTC antenatal clinics: Opportunity to follow up on mutual clients, and meet new clients. (Level of attendance has varied depending on scheduling and arrangements with midwives. Currently not attending on a regular basis at time of evaluation)
- Carnarvon Senior High School: in 2009, weekly/fortnightly visits talking to and developing relationships with students; in late 2010, regular ‘Growing and Developing Healthy Relationships’ education sessions with female year 8 students
- Planning meetings for high school education sessions, Children’s Week activities, NAIDOC week activities, Ninny Jinas playgroup
- WA Perinatal Mental Health Unit trainers meetings, by video-conference, three times per year

It is noted by Cant and colleagues (2010) that to achieve population-based results, successful strategies involving multiple agencies each addressing certain target issues is likely to be necessary. Given the complex needs of a number of HPHM clients, this is certainly likely to be the case. HPHM staff members refer clients to a number of additional programs, agencies and services in Carnarvon, reflecting the strength of networks developed in the relatively short period of service provision (i.e., 32 months). Services referred to and liaised with include the:

- Aboriginal Legal Service
- ARAFMI (Mental Health Carers and Friends Association) - Family and Community Support Officer
- Best Start Playgroup, Mungullah
- Bridge Playgroup
- Burringurrah Nurse
- Carer Respite
- Carnarvon Family Support Service- includes Paralegal Service, Community Counsellor, No Interest Loan Scheme (NILS)
- Carnarvon Furniture Pool
- Carnarvon Hospital
- Carnarvon Medical Centre (General Practitioner)
- Carnarvon Senior High School
- Carnarvon Women’s Refuge
- Centacare
- Central West Mental Health Team, Carnarvon
- Centrelink
- Child Health Centre
- Child Support Agency
- Closing The Gap
- Denham High School (Shark Bay)
- Department for Child Protection
- Department for Communities- includes Best Start Program, Parenting Officer
- Drug and Alcohol Service
- Durack Institute (TAFE)
- Family Violence Protection Legal Service
- FOCUS (local charity group)
- Gascoyne Arts Council
- Granny Glasgow Day Care Centre
- Homeswest
- MIRAC Housing
- Mother and Baby Unit (KEMH)
- Police
- Population Health
- SIDS and Kids
- Visiting Psychologist
- Women’s Refuge
Incoming referrals to HPHM are streamlined using a referral form developed in collaboration with midwives and doctors from Carnarvon Hospital. The form was approved by the Midwest Clinical Governance Committee (see Appendix A).

The HPHM Service is co-located with the Central West Mental Health Service (CWMHS), providing many opportunities for partnership. Being part of the team has allowed the HPHM Service to draw on the expertise, local knowledge and support of experienced clinicians. The PC and IPMHW attend daily in-take meetings at CWMHS, and liaise with clinicians often in their work. They debrief with clinicians when required, and have recently started monthly case supervision sessions with a Clinical Nurse Specialist (CNS) based at the Mother and Baby Unit at King Edward Memorial Hospital in Perth. Supervision is conducted via video-conference.

**Staff reflections on service partnerships**

The IPMHW is “proud of the connections that [the Service has] made in the community, with both the clients and the service providers”. The PC adds that she thinks the Service has now proved its credibility to the other agencies in Carnarvon.

Both HPHM staff members note that the services in Carnarvon rely on each other for support. One way this can happen is when HPHM locates Aboriginal mothers and transports them to appointments at other agencies.

*IPMHW* … there’s been times you know when I’ve gone to a meeting at DCP and that and the persons not there, they’ve been around and tried to get ‘em to come, but they won’t come, and then I’ve said, ‘I’m going to go get ‘em’. And I’ve just gone over and said, ‘Come on, get in the car, we’re going now’.

*PC* And say, ‘I’ll stay with you, I’ll give you some support’.

*IPMHW* ‘We’ll be there’, and they’ll go.

*PC* Mental Health do that a lot with DCP.

*IPMHW* So we help a lot of the other agencies as well.

*PC* And they help us generally as well, they’re very good.

*IPMHW* They’re lovely, we get on well with them all.

Being co-located with CWMHS also comes with the benefit of having skilled mental health practitioners on hand to provide support and advice to HPHM staff members. HPHM staff can also support CWMHS staff. On rare occasions, the PC who is a registered nurse is called on to provide assistance or administer medication.
to adult mental health clients. If the clinicians are busy or out of the office, she may be the only person in the building who is able to assist the client at that time. Working alongside the mental health team has also provided opportunities for HPHM staff members to build skills relevant to their tertiary case management role (e.g. conducting assessments).
Education and Training Activities

**Relevant Expected Output Deliverable:**

EOD-5  Number of education and training sessions conducted for local service providers

This section covers training that the staff of Healthy Parents Healthy Minds (HPHM) have received, as well as training they have facilitated.

**Training received**

When the HPHM Service began, the Project Coordinator (PC) and Indigenous Perinatal Mental Health Worker (IPMHW) did not have prior experience in perinatal mental health. However they have sought out many professional development opportunities to increase their knowledge base and skill set.

The PC visited Perth in October 2008 to meet with WA Perinatal Mental Health Unit (WAPMHU) staff and visit relevant agencies. When visiting the Mother and Baby Unit (MBU) at King Edward Memorial Hospital, the PC toured the facility, attended a patient consult meeting and patient handover, discussed roles with individual workers and attended home visits with the community nurse. She also visited Northbridge Women’s Health Service (now called Women’s Health and Family Service), where she had the opportunity to network with staff and learn about the services available.

Both HPHM staff members completed the Aboriginal Maternal Mental Health training, presented by the WAPMHU; both have also attended Mental Health First Aid training, presented by the Carnarvon Medical Service Aboriginal Corporation (CMSAC) and the Central West Mental Health Service.

HPHM staff members have attended numerous other training opportunities relevant to their work: these have included ‘Interviewing Techniques’, ‘Signs of Safety’, ‘Child Abuse’, ‘Mandatory Reporting of Child Sexual Abuse’ and ‘the Impact of Trauma on Children’ (all hosted by the Department for Child Protection); as well as ‘Overview of the Mental Health Act’, ‘Mental Health State Examination’, ‘Assessment of Risk in Mothers with Serious Mental Illness’, ‘Indigenous Health Promotion’, ‘PSOLIS training’ (mental health computer database), ‘Gatekeeper Suicide
Prevention’, the 2009 Rural and Remote Mental Health Conference and the 2010 Perinatal Mental Health Symposium (hosted by the WAPMHU).

Some sessions are attended via video-conference; these included presentations by the MBU, the Drug and Alcohol Office, and an ongoing series on Indigenous health organised by the Heart Foundation.

HPHM staff members have also attended training sessions useful for holistic client support, including healthy meal preparation, community re-entry for incarcerated women, the Australian Early Development Index, Sudden Infant Death Syndrome (SIDS), and alcohol and substance misuse during pregnancy.

Training facilitated

To begin with, HPHM staff members provided only short-form information sessions to service providers in Carnarvon. They offered a brief information session to Carnarvon Hospital staff in January 2009. This presentation also gave the PC an opportunity to consult with health professionals to develop a perinatal mental health referral form that is still being used.

A further two sessions were aimed primarily at consumers, but some local service providers also attended; these sessions took place at the Bridge Playgroup Centre in March 2009, and at an AMS antenatal group in September 2009. The next month, HPHM staff spoke with nursing staff at Shark Bay about perinatal mental health to increase their awareness.

The PC has facilitated formal training only recently, with Edinburgh Postnatal Depression Scale (EPDS; Cox, et al., 1987) training and Perinatal Anxiety Disorders (PAD) training being offered for the first time in Carnarvon in 2011.

The PC participated in EPDS training in December 2008, and completed the Train-the-Trainer program in May 2009 through the WAPMHU, enabling her to facilitate EPDS training in Carnarvon.

The researchers note that there was one EPDS-related presentation in Carnarvon between the Baseline evaluation and the Progress evaluation, though not conducted by HPHM staff; in September 2008, Professor Barbara Hayes travelled to Carnarvon with WAPMHU staff and discussed the Aboriginal EPDS translations she developed with communities in Queensland. However the session did not involve training per se. The lack of EPDS training in Carnarvon up to that point in time was
reflected in the low levels of EPDS-related knowledge displayed by health professionals in the Progress evaluation; the recommendation was made that the PC present EPDS training in Carnarvon.

Since the Progress evaluation, the PC has conducted one EPDS training session in Carnarvon, on March 3\textsuperscript{rd} 2011. Two service providers attended: a mental health worker and the St John of God Strong Families Strong Culture (SFSC) Coordinator.

In May 2010 the PC completed the PAD Train-the-Trainer program through the WAPMHU. On April 14\textsuperscript{th} 2011, she co-facilitated PAD training with the Education and Research Project Officer from the WAPMHU. Only one local service provider was in attendance, the SFSC coordinator. The low turnout was unexpected, as several local service providers had expressed an interest in coming. However it was advertised only a week or two in advance, possibly making it difficult for local staff to become aware of the training, to make time to attend or to arrange backfill. Nevertheless, it was worthwhile holding the training as the PC co-facilitated, which raised her confidence; thus she will be better placed to facilitate sessions on her own in future.

The results of the health professionals’ questionnaire in the final evaluation show a general increase in the number of respondents able to identify both anxiety and depression in an antenatal case study, and an increase in recognition that professional help was needed (100\% of respondents). However, as only limited EPDS and PAD training has been offered in Carnarvon, it is unlikely that this is the reason for the improvements seen. It may be that HPHM involvement in health promotion activities, interagency collaborations and referral-related interactions, has enabled HPHM staff to pass on practical aspects of perinatal mental health knowledge to service providers.

There is still a need for more EPDS and PAD training to increase clarity and differentiation between different perinatal mental health problems. It is recommended that more EPDS and PAD training sessions take place in Carnarvon, but that one-hour versions be used. Several sessions a year should be booked in advance and also advertised in advance, so that local service providers have the most chance of being able to attend. One-hour sessions would also limit the amount of time that the PC has to take away from her clinical duties in her already limited hours. An annual training calendar would be a useful strategy for booking and advertising
training sessions; this would also ensure that the PC is able to quarantine time for the training in her schedule.

Both the PC and IPMHW have completed the ‘Nuts and Bolts of Sexual Health’ Train-the-Trainer program; and the ‘Growing and Developing Healthy Relationships’ Train-the-Trainer program. These programs have been presented to high school students in Carnarvon and Shark Bay; more information can be found in the Health Promotion section that follows.

**Staff reflections on education and training**

The PC notes that many Carnarvon services seem to have a problem with understaffing. She has found it very difficult to “get midwives out of the hospital” to attend training, as they are too busy. The PC would like to offer a short one-hour version of the EPDS training at the hospital, held over an extended lunch break, to make it as easy as possible for midwives to attend.
Health Promotion Activities

Health Promotion – Indigenous Perinatal Mental Health Service

Health promotion is essentially the process of enabling people to increase control over, and to improve, their health (World Health Organisation (WHO), 1986). It can focus on individuals, groups or whole populations. Effective health promotion interventions encompass a combination of educational, motivational, organisational, economic and political actions, which may include individual or group change and social-influence techniques (Egger, Spark, Lawson, & Donovan, 2002; Howat et al., 2003). As such, the Indigenous Perinatal Mental Health Service – “Healthy Parents, Healthy Minds” (HPHM) – has adopted a number of coordinated approaches in Carnarvon, which are described below, in line with the Ottawa Charter principles for health promotion (WHO, 1986).

Table 3: Health promotion strategies

<table>
<thead>
<tr>
<th>Ottawa Charter Principle</th>
<th>What this means for Healthy Parents Healthy Minds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop personal skills &amp; knowledge</td>
<td>Educate Aboriginal community about perinatal mental health</td>
</tr>
<tr>
<td>Create supportive environments</td>
<td>Address the cultural, social, geographic and interpersonal landscapes impacting on perinatal mental health</td>
</tr>
<tr>
<td>Support community action</td>
<td>Empower communities to enhance self-help, social support and community participation</td>
</tr>
<tr>
<td>Re-orient health services</td>
<td>Encourage multi-sectoral support and action, increasingly using health promotion concepts</td>
</tr>
<tr>
<td>Build healthy public policy</td>
<td>Putting perinatal mental health on the agenda</td>
</tr>
</tbody>
</table>
Developing personal skills and knowledge

The HPHM Service has worked directly with the community in three main ways to develop personal skills and knowledge that would promote good perinatal mental health:

- Organising and running community awareness stalls;
- Visiting local high schools to engage students; and
- Conducting regular playgroup sessions and special days.

Between November 2008 and December 2010, eleven interactive community awareness stalls have been held, enabling HPHM to distribute resources (e.g. brochures, information bags, magnets), display posters, show PowerPoint presentations and videos, and have staff from numerous local health and social services available to talk directly with the community. Service providers can discuss relevant issues such as settling babies, postnatal depression, breastfeeding, baby massage, financial support and the type of support they can offer (see Appendix B for more detail).

HPHM staff facilitated stalls at the 2009 and 2010 NAIDOC week celebrations in Carnarvon; at both these events, staff distributed a community awareness survey to attendees. This was not a requirement of their reporting for the evaluation reports, but an initiative of the staff members themselves. The survey covered several aspects of perinatal mental health awareness, asking attendees: how common they believed perinatal mental health problems (including depression) to be; where they knew they could access help; and the warning signs that might show someone needed support. A copy of the questionnaire is included as Appendix C.

Forty-five questionnaires were completed in 2009, and 74 in 2010. Responses were received from men and women. Results for 2009 and 2010 were similar, however they have not been merged or contrasted as it was unclear which respondents filled out questionnaires both years. The 2010 results are reported below.

The first question was multiple choice, asking community members how common they believed depression or mental health problems were amongst women during pregnancy and after birth. Respondents had the choice of 2%, 5%, 10% or
15%; the majority of respondents (90%, n=66) believed the prevalence rates were 10% or 15%, which is in the correct range.

The second question asked, “if someone you know (or yourself) appears to be having problems, do you know where to access help to assist them to become well? Please list where you may contact”. Respondents were free to list as many services as they could think of. Eighty-four percent (n=62) were able to mention at least one service; 15% (n=11) did not list a service. Most respondents listed between one and three services. The most commonly mentioned services are presented in Table 4 below.

Table 4: Sources of help identified by community members at NAIDOC Week (2010)

<table>
<thead>
<tr>
<th>Contacts / services</th>
<th>Number of mentions (N=74)</th>
<th>Contacts / services</th>
<th>Number of mentions (N=74)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health/services/unit /clinic</td>
<td>27</td>
<td>Family/Friend</td>
<td>8</td>
</tr>
<tr>
<td>Hospital/Carnarvon Regional Hospital/Health Dept</td>
<td>27</td>
<td>Nurse/child health nurse/clinic sister</td>
<td>8</td>
</tr>
<tr>
<td>Doctor/local GP/medical practitioner</td>
<td>18</td>
<td>Helplines/Crisis Care Lines</td>
<td>4</td>
</tr>
<tr>
<td>AMS/Aboriginal health centre</td>
<td>15</td>
<td>Health centre</td>
<td>3</td>
</tr>
<tr>
<td>Perinatal Mental Health/Parental Mental Health/Indigenous Perinatal Mental Health</td>
<td>10</td>
<td>Lotteries House</td>
<td>4</td>
</tr>
<tr>
<td>Family support services/counselling service/counsellors/youth counselling service</td>
<td>9</td>
<td>Other</td>
<td>23</td>
</tr>
</tbody>
</table>

The third and final question asked community members to pick from a list of six signs and symptoms those they thought would show someone needed support. The choices were lack of sleep, feeling angry or frustrated, not bonding with baby, change in eating habits, feeling sad or tearful, and a lack of energy or being unable to attend to daily needs. All six choices are risk factors or signs/symptoms for perinatal mental health issues; 45% (n=33) of respondents selected all six. Sixty-three percent (n=48) of respondents selected between 4 and 6 of the choices given. Almost 20% of respondents (n=14) only selected one choice, perhaps indicating that they didn’t read the question closely and assumed that they could only pick one.
Each option was selected by between 62% and 73% of respondents, indicating that for any of the particular signs/symptoms listed, somewhere between 27% and 38% of respondents did not see it as a useful indicator of need. HPHM staff may need to further educate the community on common signs and symptoms displayed by people at risk of (or experiencing) perinatal mental health issues. Posters and/or flyers, posted in highly visible areas often frequented by Aboriginal mothers and their families, may be one way of addressing this issue.

Overall, the results are positive, indicating that among those who attended the NAIDOC event in 2010, there is a generally high awareness of perinatal mental health issues (or perhaps the HPHM stall at the event helped to raise their awareness level on the day). As the respondents were a convenience sample, they are not necessarily representative of the entire Carnarvon community.

Despite this, the questionnaire provides a useful baseline measure for community awareness of perinatal mental health issues. It is recommended that the questionnaire continue to be used in the Carnarvon community once a year, ideally during NAIDOC week. It is also recommended that when the questionnaire is used in future, that a fourth question be added: “have you filled in the questionnaire previously?” (giving three options: ‘yes’, ‘no’ and ‘don’t know’). This will enable more accurate comparisons to be made year to year.

Alongside the public awareness-raising events, HPHM has invested time in engaging students at high school – particularly teenage girls – in an effort to establish relationships and build knowledge about social and emotional wellbeing before the girls become pregnant. This approach was originally suggested by local Aboriginal women during focus groups conducted as part of the Baseline evaluation. A strong theme throughout the Baseline data was that without trust, the young mothers – who in all likelihood were those that most needed the support – would be extremely reluctant to engage the HPHM Service.

To this end, the Project Coordinator (PC) and Indigenous Perinatal Mental Health Worker (IPMHW) began attending Carnarvon Senior High School once a week to collaborate with the School Health Nurse and provide information to students. Simple actions such as visiting the student common area at the high school (the ‘Cottage’) and yarning with the students enabled the development of rapport and trusting relationships with the teenage girls.
Following this, both the PC and IPMHW completed the ‘Nuts and Bolts of Sexual Health’ Train-the-Trainer program in October 2009. The training was developed by Family Planning Western Australia, and is suitable to present to primary and secondary students; it includes explanations of anatomy, sexually transmitted infections and contraception to address deficits in basic sexual health knowledge of students (an issue identified in the Baseline evaluation). HPHM staff presented the training to all students (years 8-12, male and female) at Shark Bay in April 2010. Carnarvon Senior High School has also requested the training for all its students, beginning with year 12s and working down to year 8s. Both male and female students will participate in these sessions also.

In May 2010 both HPHM staff members completed a second Train-the-Trainer program concerning sexual health, called ‘Growing and Developing Healthy Relationships’ (GDHR). The training, developed by the WA Departments of Education and Health, contains learning activities for Kindergarten through to year 10. In the second half of 2010 HPHM staff co-facilitated several GDHR sessions with the School Health Nurse and teachers at Carnarvon High School, speaking with female year 8 students. The students would break up into small groups to discuss contraception, pregnancy, intimacy, self-esteem and life skills with a facilitator; being in small groups allowed the girls to ask questions amongst their friends rather than before the whole class, and permitted more frank and open discussion. Although these sessions were not directly evaluated, the HPHM staff (and School Health Nurse) reported greater levels of communication and trust with the girls following the sessions.

From February 2011, the HPHM Service also began facilitating the Ninny Jinas playgroup along with partner agencies SFSC, DCP and DFC. Ninny Jinas provides knowledge and skills-development opportunities for parents by role-modelling a broad range of healthy practices including: nutrition and cooking, parenting, understanding of different cultures and parenting styles, safety, and hygiene. In addition, parents have the opportunity to discuss and share information on subjects such as child development, self-esteem, and local health and social services information.

Children who attend the playgroups also benefit, by participating in activities that promote school readiness. These have included opportunities to practice fine
motor skills; identify colours; and develop language, literacy and social skills through play.

As such, the HPHM Service is addressing a range of basic skills in the community across the life-span (i.e., from early childhood, through school, to parenthood), which has the potential to contribute to a long-term improvement of outcomes in the community. While not every piece of knowledge or skill acquired relates directly to perinatal mental health, it is important to acknowledge the vulnerable psychosocial context in which perinatal mental illness exists in this community, thus creating the need to implement strategies for change in a broader sense.

For example, improved knowledge about hygiene and nutrition may lead to less physical illness in children, which subsequently reduces the potential stress experienced by parents who would have to care for their sick child, attend health services, etc. As another example, a child who is well prepared for school is in a better position to participate fully at school, get a good education, develop self-esteem, and make well-informed choices (which may include delayed sexual activity and parenthood down the line). Interventions that teach parenting skills in infancy and toddlerhood can increase parents’ sense of competence and positive affect, and reduce the likelihood of adverse outcomes for children in the long-term (Sandler, Schoenfelder, Wolchik, & MacKinnon, 2011).

Creating supportive environments

In recognising the importance of a ‘supportive environment’ to promoting good mental health, HPHM has addressed a number of cultural, social, geographic and interpersonal landscapes impacting on perinatal mental health.

In order for the Service to be more culturally appropriate and easily identifiable within the community, the Service was renamed early on from “Indigenous Perinatal Mental Health Service” to “Healthy Parents, Healthy Minds”.

Community awareness stalls have also been held in locations that are easily accessible, receive regular ‘traffic’ and are regularly attended by the target audience. These locations have included shopping centres, cultural centres, the town oval, the PCYC, the town pool and the skate park.

Other strategies the Service has used to create supportive environments include:
Offering raffle tickets, certificates, gift bags and prizes as incentives for participation in activities and completing questionnaires;

Setting up stalls outside of school hours to encourage participation of as many children as possible;

Supporting the presence of children at events by providing craft and other activities to engage families (e.g., painting of mural at Ninny Jinas);

Providing positive feedback to parents about their children and parenting while participating in activities;

Sharing food (e.g., scones, fruit, cupcakes, damper, kangaroo, emu) with visitors to stalls and group participants;

Including traditional cooking practices in activities in recognition of cultural histories and values;

Encouraging support of the local media (e.g., radio, newspaper);

Establishing a community playgroup and inviting the community to attend an “open day”;

Participating in events such as NAIDOC Week, Children’s Week, Multicultural Day (Harmony Day) and National Youth Week;

Creating opportunities for social interaction at events (e.g., Gwoonwardu Mia Antenatal Workshop Day) and groups (e.g., Ninny Jinas), such as women sitting together and talking over a cup of tea;

Arranging for transport to improve access to Ninny Jinas playgroup;

Displaying banners and posters at events and in the community; and

Slowly building positive relationships with school students.

In addition to work currently undertaken, the HPHM Service has identified several areas where additional changes could be made to create more supportive environments in the future, including:

- Amending survey wording to make completion easier and more user friendly;
- Making public toilet access and shade available at events;
- Running events at more appropriate times for target audience; and
- Providing safety equipment at events for youth.

As with the strategies for developing skills and knowledge in the community, the above strategies for creating supportive environments are varied and far-reaching. The work undertaken has clearly been effective as more than 1100 attendances have been recorded at events and activities run with (or by) HPHM from 2008 to early 2011 (this may equate to less than 1100 people as some people may have attended
Supporting community action

Wherever possible, HPHM has encouraged participation from the Aboriginal community in events that promote good perinatal mental health. These often include activities to engage children (e.g., bubble blowing, fingernail painting, craft), as well as adults (e.g., belly casting, questionnaire completion, interactive discussions) and students/youth (e.g., sport, dance, circus activities, film). With attendance rates of 56 people per event on average, they appear to be effective ways of reaching the local community.

Of particular note is the Service’s engagement with volunteers. Since 2008, there have been 96 occasions of volunteering in the activities of HPHM, e.g. by helping to set up, take down and man community stalls. This demonstrates that the Service is embedded within, and valued by, the community it is serving. By utilising volunteers, the community is being encouraged to take ownership and invest in the goals of the Service.

In addition, participants at the Ninny Jinas playgroup are actively involved in the planning of special events, such as Harmony Day and Easter, as well as general directions for the playgroup (e.g., topics to discuss, presentations to hear). Some events have also included participation of mental health consumers in setting up and manning the stall. Involving participants and consumers in this way is a great example of “working with”, rather than “working for” the community, creating opportunities for empowerment and self-determination.

Reorienting health services

Much has been done by HPHM to ensure health services are reoriented toward better addressing perinatal mental health. This has included planning and organising community awareness activities and establishing the Ninny Jinas playgroup alongside other community services – the full list of which is included under the Service Partnerships section.
The HPHM Service staff members note that through partnering on initiatives they have increased rapport and strengthened inter-agency relationships. Not only has HPHM cemented itself as a key service within the community, but it has done so with support from and in collaboration with existing community services.

In the same way that the Ninny Jinas playgroup has sought input from the participants, HPHM has also facilitated consumer input into other services. For example, Population Health attended the playgroup to survey the parents and carers attending, allowing them to make adjustments to service provision to better meet the needs of the Carnarvon community.

Building healthy public policy

Building a healthy public policy to support good perinatal mental health into the future will involve multi-sectoral approaches and changes to existing policies and practices. A local Perinatal Mental Health Steering Committee was established in the initial service implementation phase to contribute to governance structures and processes that regulate and affect provision of health care. The HPHM Service has therefore enabled a solid foundation for the development of healthy public policy.

Steering Committee meetings were held on four occasions from the start of the HPHM Service: 09/10/08, 12/02/09, 11/06/09 & 13/08/09. Once the service was established these meetings were no longer required and dissolved. However, input to the Service is still sourced from community on an informal basis, and particularly from the clients of HPHM as well as the mothers who attend Ninny Jinas playgroup.

The HPHM Service has fully provided EOD-4 (description of perinatal mental health promotion strategies) and achieved KPI-1 (provision of perinatal specific health promotion strategies in the target area). The HPHM has undertaken an impressive amount of health promotion activities, with high levels of community involvement over the duration of the Service trial.

Staff reflections on health promotion activities

The PC and IPMHW are both “proud of the community links” formed through the Ninny Jinas playgroup. The playgroup forms a supportive environment, conducive to health promotion; as the participants are from a variety of cultural backgrounds, there is an inclusive atmosphere. The IPMHW notes, “it’s about everybody together, the Indigenous and the non-Indigenous people”.

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PC I think keeping Indigenous women in isolation from everybody else isn’t really helping them. They’re a part of the whole community and they need to be part of that whole community to move forward. To learn and grow... the community events, the playgroups, the other programs in the town, helps them, because they are a part of the community and they learn more.

Ideas for community action are often drawn from the playgroup community itself:

PC When we’ve said, ‘what do you want’, or, ‘what do you want to happen’, – simple things – what rules should we have at playgroup, and mums who you think aren’t going to say anything start coming out with all this stuff... we’re making library bags at playgroup – [they] wanted to learn how to sew. That’s quite an easy one.

The added bonus of library bags is that their regular use by mothers and children promotes literacy, which is a protective factor of social and emotional wellbeing (World Health Organisation, 2004).

Mothers at the playgroup get the chance to develop their personal knowledge by sharing ideas and information with other mothers in a trusting, supportive environment. Their different cultural backgrounds make for some interesting exchanges, particularly around sensitive issues such as the sexual health of their older children.

IPMHW ‘Cause a lot of the women also have older children. And its often brought up sexual health for the older children... you know, like the different cultural beliefs about when a child should be spoken to about sexual health.

PC And they talk about these things, and its really good because its all open too...

At the time of the progress evaluation, the PC was attending Carnarvon High School each Friday morning to work alongside the School Nurse and Aboriginal Education Workers and engage with teenage girls. Consideration was given to providing information about pregnancy and perinatal mental health, based on concerns by community members about the number of teenage pregnancies and how unprepared for parenthood many of these young parents were. However, high school staff strongly recommended that an evidence-based approach focussed on
prevention of pregnancies would result in better outcomes. Contrary to community concerns, the research suggests that information on motherhood would be better given if and when pregnancy occurred. The HPHM staff therefore assisted with the ‘Growing and Developing Healthy Relationships’ (GDHR) program and obtained training in the ‘Nuts and Bolts of Sexual Health’ focussing on relationships and sexuality. This provided an opportunity for the HPHM staff to build trust with students.

The GDHR education sessions covered a number of topics related to sex and relationships, including contraception, behaviour and consequence, drug and alcohol use during pregnancy, and perinatal mental health issues. The PC and IPMHW were grateful also for the opportunity to develop trusting relationships with the girls. Again, the PC will “see those girls down the street and they say hello. Any of the girls in that class. So we’ve got that relationship with them now”.

The girls broke up into small groups during the GDHR sessions. The PC noted that girls would often ask “really intimate questions… they wouldn’t have asked those questions unless they felt comfortable with what the responses would be”. Some even asked subtly about the situations of family members, “you could tell from the tone of voice… especially in relation to PND and parenting of new babies. You could kind of tell, and you’re able to give them input and information”. The PC and IPMHW noted that many girls wanted to protect themselves from becoming pregnant, but were worried about the side-effects of a contraceptive implant, particularly weight gain.

**IPMHW**  It’s often asked – the young ones too, they go, ‘If I go and get contraceptive, an implanon or a depot, I’ll get fat then, won’t I?’, and I say, ‘you’ll get a lot fatter if you get pregnant love!’

**PC**  That’s the big question.

The girls participating in the GDHR sessions engage in scenario-based learning activities; the students are asked to think about real life situations they may find themselves in. One activity, a sequencing game, helps the participants think about the decisions they need to make if they are planning to become sexually active:

**PC**  There’s about 20 cards. And it’s the whole act right from when you’re talking through to what you do to fix everything up afterwards… everything - checking the use by date.

**IPMHW**  Purchasing the condom. Do you purchase the condom before you’ve decided to have sex or after?
After he’s asked you, do you then run to the chemist? And it gets them thinking. Or ‘do I have that and be ready’, you know.

Aside from information on sexual activity, the sessions also covered the emotional side of sex and relationships. HPHM staff members were surprised to find that the boys in Shark Bay were better at “tuning into the emotional side” than the girls. The girls were empowered through finding they had a choice (i.e. they didn’t have to have sex just because a boy asked them).

It’s not just he asks you and that’s what you do… it needs to be nice for you and it needs to be done in a nice way and you need to be nice to each other… it’s basically saying to the girls, you’re worthwhile, there’s more to you than just ‘having the sex’ part… you don’t have to, and I think the girls do need to be told that, don’t they… you can say no.

The PC and IPMHW note that, despite a high number of teenage pregnancies in Carnarvon, none of the girls who attended the GDHR education sessions in 2010 have become pregnant since, a positive result.

Carnarvon and Shark Bay high schools were interested in more formal education for their students. In Shark Bay, for instance, teachers had discovered that many students were becoming sexually active at a young age, and engaging in unsafe sex (e.g. using improvised contraception in place of condoms). The school requested that the PC and IPMHW present the ‘Nuts and Bolts of Sexual Health’ to the students. The session was well received and HPHM staff members were asked to go back and present again later that year, however they were unable to do so due to time constraints. They would like to go back this year, but the HPHM Service and the school had not yet made any plans at the time of the evaluation.
Aboriginal Obstetric Data for Carnarvon and King Edward Memorial Hospital

Relevant Key Performance Indicator:

KPI-4  Documented increase in engagement with obstetric/medical services during pregnancy and postpartum by local Aboriginal women

The purpose of this section is to give background statistics on the number of Aboriginal women giving birth every year in Carnarvon Hospital and at Western Australia’s only tertiary maternity hospital, King Edward Memorial Hospital for Women (KEMH). Aboriginal women in Carnarvon with ‘high-risk’ pregnancies (as determined by obstetric staff at Carnarvon Hospital) are referred to KEMH for their antenatal care and/or the delivery of their baby. The data presented below provides a context for the potential population for Aboriginal perinatal mental health services in WA, and more specifically Carnarvon.

Data were sought from three sources: the Stork Clinical Application Specialist at Health Information Network (HIN), the Manager of Maternal and Child Health Information Management & Reporting (also at HIN), and the Community Midwife at Carnarvon Hospital.

Aboriginal births in Carnarvon have remained relatively steady between 2002 - 2009, with the proportion of spontaneous vaginal deliveries stable also (see Table 5).

Table 5: Deliveries at Carnarvon Hospital for Aboriginal women, 2002 – 2009

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
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<th>2006</th>
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<tbody>
<tr>
<td>Elective caesarean section</td>
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<td>***</td>
</tr>
<tr>
<td>Spontaneous vaginal delivery</td>
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<td>20</td>
<td>21</td>
<td>26</td>
<td>20</td>
<td>29</td>
<td>27</td>
<td>24</td>
</tr>
<tr>
<td>Assisted delivery (forceps or vacuum)</td>
<td>***</td>
<td>***</td>
<td>***</td>
<td>***</td>
<td>***</td>
<td>***</td>
<td>***</td>
<td>***</td>
</tr>
<tr>
<td>TOTAL</td>
<td>43</td>
<td>31</td>
<td>29</td>
<td>39</td>
<td>34</td>
<td>36</td>
<td>36</td>
<td>28</td>
</tr>
</tbody>
</table>

*** indicates values 5 or less. These are suppressed because of confidentiality.
A number of Carnarvon Aboriginal women travel to KEMH to deliver each year (see Table 6); specific reasons are unavailable to the researchers, but, as with the Baseline and Progress Reports, it is safe to assume that obstetric risk factors were present for these women (Western Australian Perinatal Mental Health Unit, 2008, 2010). The importance of being born “on-country” with the supportive presence of kin was noted in the Background section (Dietsch, et al., 2011).

<table>
<thead>
<tr>
<th>Table 6: Deliveries at KEMH for Aboriginal women, 2004 – 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Caesarean section</td>
</tr>
<tr>
<td>Vaginal delivery</td>
</tr>
<tr>
<td>TOTAL DELIVERIES</td>
</tr>
<tr>
<td>Number of mothers from Carnarvon</td>
</tr>
<tr>
<td>Liveborn infants admitted to SCN: n (% of livebirths)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Mother had at least 1 antenatal EPDS ≥10: n (% of deliveries)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Mother referred to, and/or reviewed by Psychological Medicine: n (% of deliveries)</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Table 7 presents the number of Aboriginal births per month, as well as the number of women travelling to KEMH to deliver. For the relatively small number of pregnant Aboriginal women in Carnarvon, a significant proportion (26%) experience high-risk births (i.e. are transferred to KEMH for obstetric care). The table also presents the number of referrals to the HPHM Service.
### Table 7: Statistics from Aboriginal True Culture True Care Program, Carnarvon Hospital, 2009-2010.

<table>
<thead>
<tr>
<th>ANTENATAL STATISTICS</th>
<th>JUL '09</th>
<th>AUG</th>
<th>SEP</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
<th>JAN '10</th>
<th>FEB</th>
<th>MAR</th>
<th>APR</th>
<th>MAY</th>
<th>JUN</th>
<th>JUL</th>
<th>AUG</th>
<th>SEPT</th>
<th>OCT</th>
<th>NOV</th>
<th>DEC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of antenatal women on TCTC Program</td>
<td>23</td>
<td>25</td>
<td>21</td>
<td>26</td>
<td>27</td>
<td>34</td>
<td>33</td>
<td>33</td>
<td>25</td>
<td>24</td>
<td>20</td>
<td>22</td>
<td>31</td>
<td>28</td>
<td>24</td>
<td>28</td>
<td>31</td>
<td>34*</td>
</tr>
<tr>
<td>Total number of new referrals</td>
<td>5</td>
<td>4</td>
<td>7</td>
<td>6</td>
<td>4</td>
<td>8</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>8</td>
<td>3</td>
<td>0</td>
<td>5</td>
<td>6</td>
<td>5*</td>
</tr>
<tr>
<td>Number of Aboriginal woman seen in clinic</td>
<td>8</td>
<td>6</td>
<td>18</td>
<td>17</td>
<td>12</td>
<td>24</td>
<td>23</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Aboriginal clinics held at the Aboriginal Medical Service (Carnarvon Medical Service Aboriginal Corporation)</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Number of antenatal home visits</td>
<td>10</td>
<td>10</td>
<td>9</td>
<td>16</td>
<td>22</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4*</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Number of antenatal clinics at Mungullah</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of antenatal clinics at Burringurrah</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Antenatal transfers to KEMH</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1†</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Total number deliveries</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>8</td>
<td>5</td>
<td>0</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Total number deliveries KEMH</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total Referrals to HPHM</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Monthly records not available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Referrals to Clinical Psychologist</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Monthly records not available</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* approximate figure  † did not attend
Two recent case audits highlight the rates of Aboriginal antenatal attendance in Carnarvon, before and after the implementation of the TCTC program (Carnarvon Hospital Midwifery Department & Carnarvon Medical Service Aboriginal Corporation, 2008, 2010). The 2008 audit reviewed the records of 30 Aboriginal mothers and 30 non-Aboriginal mothers from 2007-2008. The 2010 audit was conducted similarly, reviewing the records of 25 Aboriginal and 25 non-Aboriginal women. Records were selected at random. Results revealed that in 2008, Aboriginal women had an average of 6.3 antenatal visits (with the first at 16 weeks gestation); however in 2010 this had increased to 8.4 (with the first at 13.8 weeks gestation).

Comparison of the 2008 and 2010 audits shows a significant improvement in the time of ‘presentation’ (i.e. the first antenatal visit) by Aboriginal women in Carnarvon. In 2008, only 23.3% of Aboriginal women presented for antenatal care in the first trimester. This increased almost three-fold to 64% of Aboriginal women presenting for antenatal care in the first trimester in 2010. Moreover, 23% of Aboriginal women presented for antenatal care in the third/last trimester in 2008, and this was reduced to 8% in 2010, showing an important increase in engagement with obstetric services over that time.

Poor attendance for antenatal care is considered a likely indication of inadequate antenatal care (Chan, Scott, Nguyen, & Sage, 2006) as there is much less opportunity for interventions to be employed to increase the chance of positive outcomes for mother and infant. Unfortunately, it is common for Aboriginal women to access care late in pregnancy and to attend irregularly not just in Carnarvon but across Australia (New South Wales Department of Health, 2003).

Although there is a lack of consensus regarding the appropriate schedule and frequency of visits for optimal care in pregnancy (Eades, 2004; Hunt, 2002), where poor perinatal outcomes exist (e.g. Aboriginal women), the evidence suggests that providing targeted and responsive antenatal care, which can screen for and treat specific conditions of concern, improves outcomes (Lee & Panaretto, 2004).

In light of this evidence, the documented increase in engagement with obstetric/medical services during pregnancy and postpartum by local Aboriginal women (KPI-4) is to be celebrated. However, it is difficult to determine the cause of this increase. It is likely that the combined efforts of all perinatal agencies in Carnarvon, including TCTC, SFSC and the HPHM Service, have contributed. The
results of the postnatal women’s questionnaire, presented later in this report, also contribute some evidence towards a documented increased in engagement with mental health, obstetric and medical services.
**POSTNATAL WOMEN’S QUESTIONNAIRE**

*Relevant Key Performance Indicators:*

KPI-1  Increase in level of perceived social support by Aboriginal mothers living in the Carnarvon region of WA

KPI-4  Documented increase in engagement with obstetric/medical services during pregnancy and postpartum by local Aboriginal women

KPI-5  Documented increase in engagement with mental health services during pregnancy and postpartum by local Aboriginal women

**Method**

**Participants**

Aboriginal women living in Carnarvon who have had a baby in the past 3 years were eligible to participate in this component of the evaluation. In the 2011 data collection, the distribution of the questionnaire led to completion by several non-Aboriginal women, and non-Aboriginal mothers or grandmothers of Aboriginal children. The results are reported for only the Aboriginal participants, however some comparisons are made. Women were selected as a convenience sample: they had either been seen at Carnarvon Hospital by the midwife, or they had been supported by the HPHM Service.

**Materials**

Women who met the eligibility criteria were invited to complete a ‘Postnatal Women’s Questionnaire’ (PWQ), with 12 multiple choice questions and 3 written response questions. The PWQ was designed especially for the evaluation of this service as the researchers needed an easy-to-read and culturally relevant survey tool. The tool was designed to assess the level and type of perinatal mental health issues present, as well as determine help seeking behaviour in local mothers. More information on the development of the PWQ can be found in the Aboriginal Perinatal Service Expansion Baseline Evaluation Report (Western Australian Perinatal Mental Health Unit, 2008). A copy of the PWQ is included as Appendix D.
Procedure

Questionnaires were distributed by the Project Coordinator of the HPHM Service on behalf of the WAPMHU research staff. Questionnaires were completed over a period of 3 months, from February to April 2011. Finished questionnaires were returned by mail to the research office at the WAPMHU for analysis and storage.

Results

A total of five Aboriginal mothers completed and returned a questionnaire in 2011. In addition, two non-Aboriginal women caring for Aboriginal children, and three non-Aboriginal women with non-Aboriginal children completed the questionnaire. Results provided in this Report refer to the Aboriginal mothers only, unless otherwise specified. Substantial statistical analysis was not possible with such a small sample. Respondents ranged in age from 22 to 39, with an average of 31 years. This is a somewhat older sample than in the Progress Report, where the average age was 23.6 years (Western Australian Perinatal Mental Health Unit, 2010). Four of the five women were in de facto relationships, and one was separated. Most of the respondents had only one child; one had more than four children. All women birthed at Carnarvon Hospital, except for one who delivered at King Edward Memorial Hospital. All of the respondents were born in Western Australia; three were born in Carnarvon. Two of the mothers (38%) reported pregnancy complications.

Adequate social support was reported by 100% of the Aboriginal mothers (five women) who completed the questionnaire. Although the convenience sample is likely to be representative of women linked in with the HPHM, and the sample is small, this is a positive result. By comparison, only 20% (one of the five) non-Aboriginal women who complete the questionnaire answered “yes”, with the rest reporting they received enough support only “sometimes” or “occasionally”. This is likely to be partially a result of the migratory population within Carnarvon, with a number of new mothers separated from their relatives and previous social support networks.

Three of the five Aboriginal respondents indicated they had asked for help, and all three felt they had received help. There was some variation in help-seeking, with two women specifying they received help from family alone (one of these may not have considered this ‘help-seeking’, as she had previously indicated “no” to having asked for help). Two women specified one or more services, both including the HPHM Service or staff.
The most common reason for seeking help was lack of sleep. Other reasons included ‘feelings of depression/not coping’, ‘baby’s feeding problems’, ‘someone else asked/told me to’ and issues related to the baby’s father/the partner. One of the women reported feeling depressed and anxious for more than 2 weeks from the time she became pregnant to completing the questionnaire. She had received treatment or help from HPHM and other appropriate services and indicated this had been “very helpful”.

Comparison with Baseline

A total of 5 Aboriginal mothers completed the questionnaire for this final evaluation, 13 had completed it for the progress evaluation and 6 for the baseline evaluation. Table 8 presents a comparison of demographic data from the three evaluations.

Table 8: Comparison of demographic responses to Postnatal Women’s Questionnaire, baseline evaluation (2008), progress evaluation (2010) and final evaluation (2011)

<table>
<thead>
<tr>
<th></th>
<th>Baseline (N=6)</th>
<th>Progress (N=13)</th>
<th>Final (N=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average age of women</td>
<td>26.5 yrs</td>
<td>23.6 yrs</td>
<td>31.0 yrs</td>
</tr>
<tr>
<td>Age range of women</td>
<td>20-37 yrs</td>
<td>17-33 yrs</td>
<td>22-39 yrs</td>
</tr>
<tr>
<td># born in Western Australia</td>
<td>6 (100%)</td>
<td>12 (92%)</td>
<td>5 (100%)</td>
</tr>
<tr>
<td># born in Carnarvon</td>
<td>3 (50%)</td>
<td>8 (62%)</td>
<td>3 (60%)</td>
</tr>
<tr>
<td># speaking English at home</td>
<td>6 (100%)</td>
<td>13 (100%)</td>
<td>5 (100%)</td>
</tr>
<tr>
<td># unmarried (i.e. single or de facto)</td>
<td>5 (83%)</td>
<td>12 (92%)</td>
<td>5 (100%)</td>
</tr>
<tr>
<td># married</td>
<td>1 (17%)</td>
<td>1 (8%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Average number of children</td>
<td>2.6</td>
<td>2</td>
<td>1.8</td>
</tr>
<tr>
<td>Range of number of children</td>
<td>From 1 to 5</td>
<td>From 1 to &gt; 6</td>
<td>From 1 to &gt; 4</td>
</tr>
<tr>
<td># who delivered at Carnarvon Hospital</td>
<td>5 (83%)</td>
<td>12 (92%)</td>
<td>4 (80%)</td>
</tr>
<tr>
<td># who delivered at KEMH Subiaco</td>
<td>3 (50%)</td>
<td>1 (8%)</td>
<td>1 (20%)</td>
</tr>
</tbody>
</table>

Pregnancy complications were reported by 2 of the 5 women in the current cohort (40%), 5 of the 13 mothers in the progress evaluation (38%), and 3 of the 6
women at baseline (50%). The type of pregnancy complications experienced by the women are shown in Table 9.

Table 9: Comparison of pregnancy complications reported in Postnatal Women’s Questionnaire, baseline evaluation (2008) and progress evaluation (2010)

<table>
<thead>
<tr>
<th></th>
<th>Baseline (N=6)</th>
<th>Progress (N=13)</th>
<th>Final (N=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td># who had pregnancy complications</td>
<td>3 (50%)</td>
<td>5 (38%)</td>
<td>2 (40%)</td>
</tr>
</tbody>
</table>

Type of complication:

- Pre-eclampsia: 0 2 0
- Threatened miscarriage: 1 1 0
- Caesarean section: 1 0 1
- Prematurity: 1 0 0
- Rheumatic fever: 0 1 0
- Urinary tract infection: 0 1 0
- Gestational diabetes: 0 0 0
- Ante-partum haemorrhage: 0 0 0
- Other: 0 0 1

Adequate social support was reported by 100% (n=5) of the mothers in the current sample, an increase from 77% (n=10) in the progress evaluation and 67% (n=4) in the baseline (see Table 10). Over two-thirds (72%) of the women who took part in the progress or final evaluations (13 out of 18 women) indicated that they had asked for help since becoming a mum, an increase from 50% (3 of 6 women) in the baseline. It is surprising that no mothers at baseline reported ‘not sleeping well’ as a reason for asking help, as it is usually a common complaint of new mothers, and 7 of 18 mothers reported it as a stressor in subsequent data collections.
### Table 10: Comparison of help and support-related responses to Postnatal Women’s Questionnaire, baseline evaluation (2008) and progress evaluation (2010)

<table>
<thead>
<tr>
<th></th>
<th>Baseline (N=6)</th>
<th>Progress (N=13)</th>
<th>Final (N=5)</th>
<th>Total Post-Baseline (N=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td># who had enough people to support them</td>
<td>4</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td># who had enough support most of the time</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td># who had enough support sometimes/ occasionally</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td># who didn’t have enough people to support them</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td># who asked for help</td>
<td>3</td>
<td>10</td>
<td>3</td>
<td>13</td>
</tr>
</tbody>
</table>

Reasons for asking for help:

- Feelings of depression/ not coping: 2 3 1 4
- I wasn’t sleeping well: 0 5 2 7
- Problems with baby’s father/ their partner: 2 3 1 4
- Feeling alone/ overwhelmed by baby’s needs: 1 3 0 3
- Baby’s crying problems: 1 1 0 1
- Baby’s feeding problems: 1 1 1 2
- Babysitting: 0 2 0 2
- Baby’s sleeping problems: 0 1 0 1
- General help: 0 1 0 1
- Someone else asked/ told me to: 0 1 1 2
**Table 11: Comparison of sources of help noted in to Postnatal Women’s Questionnaire, baseline evaluation (2008) and progress evaluation (2010)**

<table>
<thead>
<tr>
<th>Who they asked for help:</th>
<th>Baseline (N=6)</th>
<th>Progress (N=13)</th>
<th>Final (N=5)</th>
<th>Total Post-Baseline (N=18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family</td>
<td>3</td>
<td>7</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>Hospital staff</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Healthy Parents Healthy Minds Service</td>
<td>-</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>AMS/GP</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Friends</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Aboriginal Health Worker</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Child Health Nurse</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Community Nurse</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Drug and Alcohol Service</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Family Support Service</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Homeswest</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Husband/boyfriend</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Strong Families Strong Culture Service</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Women’s Refuge</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Counsellor</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Social Worker</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mental Health</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Police</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td># who felt supported/ helped</td>
<td>2 of 3 who asked</td>
<td>10 of 10 who asked</td>
<td>3 of 3 who asked</td>
<td>13 of 13 who asked</td>
</tr>
</tbody>
</table>

Mothers most commonly turned to family for help, followed by HPHM and hospital staff. In the current sample, the HPHM Service was approached by two women; in the Progress evaluation they were approached by four women (see Table 11). As the HPHM Service was not available at baseline, it can only be hypothesised that these six women may not have sought and thus received help without the Service being established in the interim period.
In the post-baseline evaluations, all 13 women who asked for help felt they received it; in comparison, 3 women asked for help at baseline and 1 of these felt she didn’t receive it, despite approaching numerous sources.

Across the two post-baseline samples, only one woman experienced depressive symptoms alone, while six women reported comorbid depression and anxiety (see Table 12). Of the five women in the post-baseline evaluations who had felt anxious and/or depressed, four reported receiving treatment or help from health professionals. The results at baseline were poorer; neither of the two women who had felt anxious and/or depressed reported receiving professional treatment or help for their symptoms. Both had asked hospital staff as well as family for assistance.


<table>
<thead>
<tr>
<th></th>
<th>Baseline (N=6)</th>
<th>Progress (N=13)</th>
<th>Final (N=5)</th>
<th>Total Post-Baseline (N=18)</th>
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<tbody>
<tr>
<td># who felt depressed only</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
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<tr>
<td># who felt anxious only</td>
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<td>0</td>
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<tr>
<td># who felt anxious and depressed</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>4</td>
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<tr>
<td># who had treatment/help for their symptoms</td>
<td>0 of 2</td>
<td>3 of 4</td>
<td>1 of 1</td>
<td>4 of 5</td>
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Who they asked for help:

- Healthy Parents Healthy Minds Service
- Aboriginal Medical Service
- Community Health Service
- Family Support Service
- Mental Health Service
- Women’s Refuge

Treatments they received:

- Counselling
- Herbal/natural remedies
- Medication (antidepressants)
- Hospital admission
- None

Helpfulness of the treatment

Helpful/ Very Helpful/
The earlier literature review featured a few methods of improving Aboriginal access to health services: including the employment of Aboriginal staff, and working with key community members such as elders, aunts and grandmothers (Read, 2006). It appears that these strategies have been applied successfully in Carnarvon, as HPHM staff members have been able to develop trusting relationships with mothers as well as with aunties and grandmothers. Working with the older women enables the staff to gain information and to meet more women in the town and surrounding area. The HPHM Indigenous Perinatal Mental Health Worker is Aboriginal, and while the Project Coordinator is non-Aboriginal she has lived in Carnarvon her entire life, is well accepted by the community and has a great deal of experience working with Aboriginal people in the town.

The HPHM staff members have focussed on developing trust within the community by providing a service that is flexible and responsive to the needs of clients. In addition, by holding a number of ‘universal’ community events and an inclusive playgroup, women within the community can get to know and trust the staff. This makes it easier for staff to be able to identify where there is a need for extra support, and is likely to make it easier for women to approach the staff for one-on-one help with mental health issues.

It could be argued that women who have accessed services and felt comfortable doing so are probably also more likely to feel comfortable completing the Questionnaire when asked. The high level of support among respondents should not therefore be taken to indicate that all postnatal Aboriginal women in Carnarvon currently feel supported. A more accurate interpretation of the results is more likely to be that a number of women within Carnarvon now have access to more support, and that this support is making a positive difference to those women who have engaged with the services available. However, when considered in combination with the qualitative results, there is still a need to continue to reach out to pregnant and postnatal women within the community who are not currently accessing support.
Conclusions

Whilst statistical significance could not be reached (due to small sample size), the current results indicate an improvement on the results from the baseline evaluation: a greater proportion of women reported feeling supported, as well as asking for help. At baseline there were only two women who felt anxious or depressed and neither received treatment/help for their symptoms. However, in the post-baseline evaluations, there were five women who felt depressed or anxious, and four of these reported receiving professional treatment (such as counselling or medication), as well as support from the HPHM Service and other sources. This evidence supports **KPI-1**: an *increase in the level of perceived support by Aboriginal mothers living in the Carnarvon region of WA*.

Women who responded to this Questionnaire reported going to the Aboriginal Medical Service, Community Health Service and the HPHM Service; three women received counselling, and two women specifically mentioned going to the Mental Health Service for treatment or help with symptoms of anxiety or depression. This Questionnaire showed an increase in the level of help-seeking and engagement with services from the baseline, thus providing some evidence for an *increase in engagement with obstetric/medical services during pregnancy and postpartum (KPI-4)*, and an *increase in engagement with mental health services during pregnancy and postpartum (KPI-5)*.
FOCUS GROUP AND INTERVIEWS: QUALITATIVE DATA

Relevant Key Performance Indicators:

| KPI-1 | Increase in level of perceived social support by Aboriginal mothers living in the Carnarvon region of WA |

Interviews and focus groups were conducted in September 2009 for the progress evaluation, and in April 2011 for the final evaluation. These qualitative data collections provided a wealth of insight into the community context, the Healthy Parents Healthy Minds (HPHM) Service and factors impacting on service provision in Carnarvon and the Gascoyne region. For a number of reasons (including availability during the data collection period, and turnover among health professionals), it was not possible to re-interview all of the 2009 participants. Many of the themes were similar across the two data collection points. Consequently, information from both years has been analysed together. The qualitative data that follows describes the HPHM Service from different points of view, providing a context for how the Service interacts with clients and other agencies. The interviews also highlight an increased level of perceived social support amongst Aboriginal women living in Carnarvon (KPI-1).

Overview of Interviews and Focus Groups

The following provides background to the interviews and focus groups held in 2009 and 2011. The schedules of interview questions are included in Appendices E - H.

Interview with HPHM Project Coordinator, 2009

WAPMHU research staff met with the HPHM Project Coordinator (PC) to discuss the successes and challenges of the Service so far. A schedule of questions was developed prior to the interview.

Interview with Aboriginal mother, 2009

WAPMHU research staff interviewed a young, pregnant Aboriginal woman with a young daughter. The PC also attended the interview. WAPMHU staff had
developed a schedule of questions to use with a focus group during the progress evaluation; the questions were used as a guide during this interview.

**Interview with Indigenous Mental Health Worker, 2009**

The HPHM staff work closely with a male Indigenous Mental Health Worker from the Central West Mental Health Service (CWMHS). Before beginning his current job, the Indigenous Mental Health Worker was employed at the Aboriginal Medical Service (AMS) in Carnarvon for 13 years. His views were sought on his experiences supporting the HPHM staff members, and in particular, his work with local Aboriginal men in the context of perinatal mental health.

**Interview with ‘True Care, True Culture’ Community Midwife and ‘Strong Family, Strong Culture’ Coordinator, 2009**

The HPHM Service has benefited greatly from the support of the Community Midwife in the ‘True Culture True Care’ (TCTC) program and the Coordinator of the ‘Strong Family Strong Culture’ (SFSC) program. The two health professionals shared their experiences in working alongside the HPHM Service and the challenges of supporting local Aboriginal women during the perinatal period.

**Focus group with Health Professionals and consumers, 2009**

A focus group was held with Aboriginal mothers and health professionals at the AMS in September 2009. Five Aboriginal mothers attended. Two were sisters; one had three children and the other had seven. The second sister was the more vocal of the mothers who attended; she is referred to as the ‘older Aboriginal mother’ throughout the following section in order to differentiate her from the Aboriginal mother previously mentioned. The older Aboriginal mother gave much insight into the difficulties of engaging with young mothers, as her daughter (aged 15) recently had her first child. The other three mothers who attended were younger and left early; they did not sign consent, respond to questions or join in the discussion, instead sitting in the background for moral support.

Three key health professionals attended: the PC, the TCTC Community Midwife and the SFSC Coordinator. As previously mentioned, a schedule of questions was developed and used as a guide during the focus group (see
Interview with HPHM Project Coordinator and Indigenous Perinatal Mental Health Worker, 2011

WAPMHU research staff met with the PC and Indigenous Perinatal Mental Health Worker (IPMHW) to discuss the successes and challenges of the Service as it has developed. WAPMHU staff employed the same schedule of questions used in the 2009 interview.

Focus group with health professionals, consumers and community members, 2011

A two-hour session was used to run interviews/focus groups with a range of women from the community, including mums and grandmothers, as well as Aboriginal women who were also health/social service professionals. In order to make the session accessible to women with other time commitments, invitees were informed that they could arrive and leave at any point during this session. As a result, the group ran as a ‘rolling’ focus group, with varying numbers of women present and varying composition from community members to health professionals. However, it should be noted that the distinction between ‘professional’ and ‘community member’ is not clear-cut in a small town, and perhaps even less so for Aboriginal health professionals given the cultural importance of family and community connections. All of the health professionals at this session also had personal experiences of being an Aboriginal mum, aunty or grandma, and were not immune to the challenges faced by other members of the community. The women interviewed included mothers of school-aged and adult children, and grandmothers with grandchildren from babies through to teenagers (in some cases the children were in full-time or intermittent care of the grandmothers). Unfortunately no mothers in the perinatal period attended. HPHM staff were present for part of the session. WAPMHU staff developed a new question schedule for this focus group, based upon the schedule used in the 2009 focus groups.

Interviews with Aboriginal mother and mother/grandmother, 2011

Two brief (maximum ten-minute) interviews were conducted with an Aboriginal mother with two pre-school aged children and with a mother who has children from the age of 6 through to mid-20s (and also has infant and toddler grandchildren).
**Interviews with Health, Education & Social Services Professionals, 2011**

Staff from the following services participated in face-to-face or telephone interviews or provided input (i.e. attendance at focus groups, emailed feedback):

- AMS
- Carnarvon Medical Centre, GP (who services the town and Burringurrah)
- Carnarvon Senior High School
- Centrelink
- Child Health Centre
- Closing The Gap
- Department for Child Protection
- Department for Communities, including their Best Start program
- SFSC, St John Of God
- TCTC, Carnarvon Hospital

**Brief Playgroup Evaluation Questionnaire, 2011**

Due to availability of flights, the research team were unable to attend the Ninny Jinas playgroup to observe or speak to the attendees. In order to obtain feedback from playgroup attendees, a brief, two-question qualitative questionnaire was distributed by staff at one playgroup meeting. The questions were, ‘what do you like best about Ninny Jinas’ and, ‘what would you change, if anything, about Ninny Jinas’. Five women completed the questionnaire as well as a consent form. Results are included in the section ‘Building Trust and Providing Support’.

**Data collection and preparation**

Informed consent was obtained prior to the interviews and focus groups, with both written and verbal consent options available to meet the needs of participants with lower levels of literacy (see Appendix I for copies of consent forms). WAPMHU research staff made introductions to explain the purpose of each interview/focus group; these included a Welcome To Country where appropriate, as advised by the IPMHW. In most cases the face-to-face interviews were audio-taped, however when permission was sought to tape the interview, respondents were offered the option of having notes taken instead and encouraged to take up this option if they appeared
uncomfortable about being taped. Telephone interviews were recorded in written notes. The tape recordings were transcribed by the interviewers.

The PC and/or IPMHW were present at some of the interviews and focus groups, in order to create a more comfortable environment for the participants. Although this had the potential to bias results (i.e. participants providing more positive responses about the Service), on balance it was considered preferable in order to recruit participants and increase their comfort levels. Comparison of the comments from interviews with and without HPHM staff present showed no positive bias occurring; if anything, there was more praise when they were not present. In addition, younger women appeared more comfortable talking when a known and trusted person was present.

Analysis and Findings

The findings of the interviews and focus groups are presented in three parts.

Firstly, findings from the interviews with the HPHM staff have, for the most part, been included in the earlier ‘Service Mapping’ section of this report. Quotes from staff members have been included as ‘Staff reflections’ relating to relevant aspects of the Service (i.e. client support, service partnerships, health promotion and education and training).

Secondly, findings from the bulk of the interviews and focus groups conducted in both the progress and final evaluations were combined and analysed as a whole. The findings are presented under a set of thematic headings, which describe delivery of service within HPHM. Feedback from clients and other agencies in Carnarvon also provide qualitative evidence for KPIs, particularly KPI-1.

A further set of findings drawn from stakeholder interviews and focus groups provide information on the establishment and maintenance of the Service. HPHM staff, other health/social service providers, and community members spoke about various issues such as staffing, funding, defining the target group and service location. As these findings are lengthy and could be of use to those considering the development of a similar service in future, they are presented after this analysis, in their own section titled ‘Organisational/Service Issues’.

Finally, one interview from the progress evaluation – with the young Aboriginal mother who was a client of the Service – is analysed on its own, and presented
below. This was considered important as it provides a detailed account of how HPHM supports a client.

**Interview with Aboriginal mother**

At the time of the interview the mother had a young daughter and was pregnant with her second child. She was in a de facto relationship with the father of her children. A WAPMHU research team member conducted the interview, and the HPHM PC also attended.

The session was originally intended to be a focus group; several younger mothers indicated they would attend, however only one was able to be there on the day. The headings below represent themes that came up in the interview. Key quotes are grouped under these headings.

**Making Connections, Providing Support**

The young Aboriginal mother first met the HPHM staff members when they visited her at home, not long after the birth of her daughter. She had few social supports in the town; she passed on the details of the Service to one other young mother she knew.

Project Coordinator - Do you think other mums know about the Service?

Aboriginal mother - Yeah, I talked to my cousin. She knows. I don't know about the others.

The young mother was supported by all three of the perinatal services in Carnarvon: the HPHM Service, the SFSC program and the TCTC program. As discussed previously, the three services are well-linked with each other. The following exchange regarding two of those services illustrates the way they dovetail together to provide timely and efficient service for Aboriginal mothers.

Research Officer - Did you also see [the TCTC Community Midwife] in hospital?

Aboriginal mother - Yeah.

Research Officer - Was she good as well?

Aboriginal mother - Yeah. I went there. I had a dizzy spell. Me aunty took me down, and she explained it, I had to eat and that, 'cause I never ate.
Research Officer: So when you were pregnant you never ate proper?
Aboriginal mother: Nah, I was rushing around.
Project Coordinator: This was only a couple of weeks ago.
Research Officer: Ah okay.
Project Coordinator: And what was really good for me was [the Aboriginal mother] came to see us at the clinic and she said, ‘I’m really worried, I don’t feel well, I’ve been dizzy’, so we were able to ring [the TCTC Community Midwife] and within about five or 10 minutes, she said, ‘bring her straight to the hospital and I'll meet you there’. But you could never do that before, you’d be told to go and wait to see a doctor, or there’s a midwife clinic on Thursday. It was no-one’s fault, it was just how it was set up before. But [the Community Midwife] said ‘I don’t want [her] to be worried, I want to make sure she’s okay, bring her to the hospital now and I’ll check her out’. But I didn’t think it was gonna happen that quick, did you?
Aboriginal mother: Yeah me too.
Project Coordinator: It was really good and it was sorted out like that. It really highlighted how good it can be now.

The Aboriginal mother pointed out how the support of the HPHM staff members had helped her.

Research Officer: So do you feel like you’ve been supported by [the HPHM staff members], it’s been really good for you?
Aboriginal mother: Yep.
Research Officer: So it’s made a difference to you being a mum?
Aboriginal mother: My stress would going down from talk to them.
Research Officer: Your stress has gone down.
Aboriginal mother: I know what to do.
Research Officer: You know what to do, where to go for help and that sort of stuff yeah?
Aboriginal mother- Yep.

The HPHM PC and the Aboriginal mother had several moments of conversation throughout the interview, unrelated to the questions prepared by the researchers. These informal exchanges yielded much useful information, revealing the level of support provided by the HPHM Service (extending even to such seemingly minor matters as where to get cheap storage boxes for toys).

Aboriginal mother- All of [my daughter’s] toys somehow went scattered, I can’t find them anywhere. I’ve been moving things a lot, and I forgot where they are.

Project Coordinator- Do other kids come up to them, sometimes other kids walk off with things and you don’t know, I used to find that.

Aboriginal mother- Next pay day I’m thinking of buying a big set of boxes for toys. I don’t know where that is.

Project Coordinator- Get those ones in [the supermarket] when they go down to half price with the clip-on lids, then you can put it all away when other kids come over. (To the daughter) You’ve got some nice toys haven’t you. Your mum reads you books doesn’t she.

The following exchange shows the degree of friendship involved in supporting the Aboriginal mother. Without knowledge of the context, the conversation could sound simply like two friends talking at home.

Aboriginal mother- Yeah. We took the net out, and it took us 10 minutes, there was round about 25 fishies.

Project Coordinator- Was it mullets?

Aboriginal mother- Yeah, mullets.

Project Coordinator- You like mullets don’t you.

Aboriginal mother- Yeah.

Project Coordinator- You’ll have to show me how to cook it properly, doesn’t work out for me.

**Building Trust**

The Aboriginal mother indicated that she trusted the HPHM staff members. She agreed that trust builds slowly, and that the women talk with each other about whether someone can be trusted or not.
It’s a lot of talking amongst you girls isn’t it, to find out they’re okay, you can go and talk to them- is it like that, that you hear about services and what’s good and who you can trust?

Yeah, I trust them.

Do you think the other girls do, do you think it’s building up, getting more trust as time goes on?

Yep.

Yeah. I suppose that if you tell other girls ‘you can trust them’, does that mean a lot to the other girls to hear it say from you, or a friend or a cousin or whatever?

A friend, yeah.

Further proof of the Aboriginal mother’s trust in the HPHM staff members is shown in the story mentioned earlier: when she was feeling dizzy and worried about her health, she went to the HPHM staff members for assistance.

Social Support

Support from family was very important for the Aboriginal mother. She had few friends or relatives in Carnarvon.

I hardly have friends in this town, there’s only my sister, and [the HPHM staff members].

And even though [she’s] got a family here, she didn’t grow up here... It’s a bit isolating when you don’t know many people.

The Aboriginal mother’s in-laws had been very helpful; when she was feeling dizzy due to stress and lack of food, they cooked for her and pushed her to eat.

My partner came with kangaroos and that, we ate it. Cooked it up and ate it, barbecue with his family, and they’re telling me ‘eat more, eat more’.

We get on your back don’t we.

Yeah.

*laughter*

That dizzy spell, they’re telling me, ‘you’ll be dizzy, eat more eat more’.
Her mother-in-law had even offered to look after the Aboriginal mother’s daughter for a short time, to give her an opportunity to rest.

Aboriginal mother- I was talking to [my mother in law], and she said, ‘if you need help for the baby, let me know’, and I said yeah. When she turn one, she’ll take her.

Project Coordinator- She’s gonna come and give you a little break.

Aboriginal mother- Yeah.

Research Officer- Right, that’d be good.

Aboriginal mother- Yeah. She’ll be going to [a nearby town] with her.

Project Coordinator- Oh she’s gonna take her [there]? Do you want her to do that?

Aboriginal mother- Yeah.

Project Coordinator- Okay. Oh, I’ll be sad. *laughter*

Research Officer- So how long would she take her up there for?

Aboriginal mother- For a week.

At the time, her mother-in-law was hoping to move to Carnarvon soon to be closer to her son, daughter-in-law and granddaughter. This would have been likely to make life easier for the Aboriginal mother, providing her with much needed social and practical support.

Self-Care

In the meantime, the Aboriginal mother is using simple ways to support and care for herself when she is feeling stressed. She also talks to the HPHM staff members for advice.

Research Officer- So what are you trying to do when you get stressed?

Aboriginal mother- I got a puzzle book at home, I just do a bit of that.

Research Officer- Sort of switch off, zone out?

Aboriginal mother- Yep.

Research Officer- Do you go for a walk or something like that?

Aboriginal mother- Nah, just sit outside, sit out there and look around.

Research Officer- What about when you get sad or down, what do you do then, you talk to someone?
Aboriginal mother- Nah I just go to sleep, if no-one’s around I just go sleep.
Research Officer- Do you find that helps?
Aboriginal mother- Make me relax, sometimes I make tea.
Research Officer- Yep a cup of tea. I think when you’re sad it’s good to talk to people. When you’re stressed it’s good to have a cup of tea, have a lie down, the sort of things you’re doing by the sound of it, but I think if you get sad or down it’s good to talk to people, so you know, [the HPHM staff members], it helps to share your problems, to talk it out.
Aboriginal mother- Yeah.
Project Coordinator- We talk a lot, don’t we.
Aboriginal mother- Yeah.

Drugs and Alcohol
The Aboriginal mother made the decision early on to avoid alcohol and drugs as a means of coping with stress, as she had seen their harmful effects firsthand.

Project Coordinator- It’s amazing, just stopped didn’t you?
Aboriginal mother- I gave it up, smoking.
Research Officer- Yep.
Aboriginal mother- No more, nup.
Research Officer- So you gave up smoking, drinking…
Aboriginal mother- Yep.
Project Coordinator- I wish that she could pass that on to other girls, give them your little bit of magic that you used.
Research Officer- Did you find it hard to stop?
Aboriginal mother- Nah I just think about the baby.
Research Officer- Yep. It’s a good reason isn’t it.
Project Coordinator- And that’s why you’ve got such a healthy little girl.
Research Officer- It is, such a beautiful girl. So when you’ve had this one, do you reckon you’d go back to drinking and smoking or is that it?
Aboriginal mother- Nah that’s it.
Project Coordinator- She’s never been back to it.
The interview reveals the difficulties facing a young, socially isolated Aboriginal mother in Carnarvon. Although it was originally intended to be a focus group with several women in attendance, the interview allowed different types of information to surface. It was useful to see the rapport and trust between a client and HPHM staff member firsthand, and also to elicit more personal responses from an individual woman. Clearly the HPHM Service was of great benefit to this Aboriginal mother, helping her to stay healthy and happy as she looked after one child and prepared for the arrival of a second.

Findings from interviews with Health and Social Services Providers and community members

The transcripts from the 2011 interviews and focus groups were analysed and a number of key themes were identified. These were then compared and integrated with the 2009 themes. These ‘second tier’ or ‘secondary’ themes have been further grouped under ‘primary’ themes: ‘Challenging Context’, ‘Interagency Relationships’, ‘Developing Relationships and Providing Support’ and ‘Areas of Need’. The primary and secondary themes are listed below.

- Challenging Context
  - Domestic violence and relationship problems
  - Alcohol and drugs
  - Education, illiteracy and unemployment
Challenging Context

Perinatal mental health problems are common across Australia, with postnatal depression (PND) alone affecting approximately one in six women (beyondblue: the national depression initiative, 2011). These problems are not limited to any one ethnic, demographic or socio-economic group. For example, a Victorian study found no statistically significant difference in the PND prevalence of an urban and a rural sample, despite differences in socioeconomic status (SES), age and marital status (Bilszta, Gu, Meyer, & Buist, 2008). Studies have found multiple psychosocial risk factors for experiencing perinatal mental difficulties (Boyce & Hickey, 2005; Leigh & Milgrom, 2008). For example, a study of women attending public hospitals found their PND rates were higher among those with lower SES and education levels (Buist et al., 2008). Subsequently, there is a need for services to provide support that addresses a client’s social context as well as the disorder.

The Carnarvon community has a number of strengths including existing infrastructure, such as established health services, and a supportive working environment. Collegiate support for the HPHM staff has been provided by health
professionals within the mental health service, hospital and non-Government sector. Furthermore the local Aboriginal community has been willing to not only give ‘another new Government Service a fair go’ but to work with the WAPMHU staff to develop a program to meet community needs.

However, it is also a region of WA where many families and individuals are experiencing or are at high risk of poor perinatal mental health outcomes amongst a range of other negative outcomes. As outlined in the introduction, Carnarvon was selected for this pilot project partly because there are numerous health and social issues present, as well as a clear need for effective services to address these issues. As one social services provider stated when asked about issues affecting pregnant women and mothers of small children in the region, “there’s a whole lot of issues, a whole lot… it can make your head spin when you think of them all”.

Some of the common issues are outlined below.

**Domestic Violence and Relationship Problems**

Domestic violence was raised as an issue by a number of health professionals and community members:

“So that could be a part of their depression too, getting flogged like a little lamb, just gotta do whatever the man tell ‘em to do”
(Grandmother of very young children)

“Some are pregnant, come up with marks on their face or eyes or something, from the dads… I took one yesterday down the clinic, and she had a black eye… that’s why I never go without my work phone, to contact police straight away, ‘cause sometimes you can see ‘em hitting ‘em in the street”
(Health/Social Services professional)

Other relationship difficulties mentioned by interviewees included jealousy, and absence via incarceration:

“And you know what another thing, is all the jealousy. They’re that jealous of each other”
(Grandmother of very young children)

“A lot of partners seem to be in jail”
(Health/Social Services professional)

“Some [of the partners] end up in jail”
(Health/Social Services professional)
However, many of the interviewees indicated that there are fewer services available for fathers/men and that it was even harder to engage them in service provision than female clients.

**Alcohol and Drugs**

This theme was quite pervasive. It became quite evident that mothers in Carnarvon can have problems with alcohol and drug use during pregnancy and the postnatal period, that affect their health and potentially the health of their baby.

“A lot of the mothers too, because they’re starting their relationships early, and they’re with young blokes, before they fall pregnant they’re all into drugs and all the different things. And see after the newborn they get straight back into it. And so you don’t know whether their mood swings… you don’t know whether it’s the drugs or the postnatal [depression]”

(Health/Social Services professional)

“My little granny [grandchild] was bloody 2 and a half weeks old, and I had him for two nights while the mother and father was pissed, partying around, fighting, ‘killing’ each other, and you know…”

(Grandmother of very young children)

“Not all, but some [mothers drink or use drugs]. She might drink for a day, and then be sober the next”.

(Mother of very young children)

Financial and relationship issues often appear to be interwoven with drug and alcohol misuse. These complex issues are best explained by the ‘older’ Aboriginal mother and the HPHM PC, SFSC Coordinator and TCTC Community Midwife in a 2009 interview:

SFSC Coordinator- … a lot of these young girls, they have a baby, they’re being supported by mum, and they don’t have their own money and then all of a sudden they have a baby and they’re getting all this money every fortnight but they don’t really know what to do with it. They go from having nothing to having 8 or 9 hundred dollars a fortnight, which is a lot of money for 15-16 year old girls. But they don’t really know what to do with it, they don’t understand that you need to make that last so you’ve got nappies for your baby ‘til the next pay day.
Older Aboriginal mother: That’s what I tell my daughter but she doesn’t listen.
TCTC Midwife: So what does she spend her money on instead?
Older Aboriginal mother: She’ll get the baby stuff, and then she’ll go and do whatever.
TCTC Midwife: Is she drinking and smoking?
Older Aboriginal mother: Drinking… and I told youse before about how she lost a lot of weight… she just doesn’t eat.
Project Coordinator: Is she stressed about the man all the time too I think.
TCTC Midwife: And she’s still feeding the baby too isn’t she.
Older Aboriginal mother: Mmm [agreement]… I’m really worrying a lot about her. They do get a lot of money from Centrelink and...
Project Coordinator: Not going in the right places.
Older Aboriginal mother: There’s a lot of mothers out there [in similar circumstances].

This issue was also discussed by several of the grandmothers interviewed in 2011. One grandmother suggested a need for fathers of young children to learn how to budget and prioritise spending:

“they need to learn how to budget week to week, and help out mothers. Bills first, then shopping, then what they need. And to shop for cheap stuff”.

Education, Illiteracy, Unemployment

Lack of education, illiteracy and unemployment were also identified by interviewees as common problems for Aboriginal mothers in Carnarvon. These factors can compound leading to financial difficulties and lack of transport, thus creating many difficulties for mothers of young children and potentially impacting upon their ability to care for themselves and to parent effectively.

Accommodation

Lack of suitable accommodation was noted as an issue by several of the interviewees. Problems include overcrowding, which can place strain on families and impact on health. In addition, some of the housing available was reported to be unsatisfactory. For example, one of the health professionals interviewed described a pest infestation affecting the home of one of her clients:
“One mum, and she was very neat, had clean habits, and looked after her house - but not great housing. When she put the purple baby book down on the counter [at my workplace], cockroaches scurried out of it”.

**Early Parenthood**

Carnarvon has a comparatively high rate of teenaged girls and young women becoming pregnant, and this was raised as a concern by many interviewees:

“A lot of them are too young. Just coming straight from school, nine months after leaving school they’re having a baby… they need to be more educated and not having babies when they’re so young. They don’t realise the work involved in having babies”
(Grandmother of very young children)

“I’m a bit concerned about the younger mums, the ones that are falling pregnant. We find that a lot of the younger mums, once they have their first baby, they’re pregnant straight after, and they’re only like kids themselves”
(Health/Social Services professional)

“There’s a big population of young mums, who need support not only as parents but also in life. Lack of education impacts on the whole family as well as the Mum’s wellbeing”
(Health/Social Services professional)

Two of the grandmothers interviewed had taken on full-time or intermittent care of their grandchildren, and indicated that when young women became pregnant without understanding the amount of work involved in parenting, it was not uncommon for them to leave the grandchildren with the grandmothers. In such cases, grandmothers tended to assume a great deal of extra responsibility for the children, which could put further demands on their financial and emotional wellbeing.

It appears that the health professionals can find it difficult to get across the importance of avoiding alcohol and drugs in the perinatal period without driving the young mothers away, and while still letting them take responsibility for their own decisions. This is illustrated in the following quote from the progress evaluation:

*TCTC Midwife-* …one of the things that I find, particularly for the young girls, and I’m talking 15 and 16, I find it amazing, a lot of these girls when they find out they’re having a baby they can stop their drinking and they can stop smoking,
which is marvellous. The younger girls don’t tend to as much. They’re not stupid, they know what’s happening, so I don’t want to keep going on and on about it, because that’ll just annoy them. It’s about trying to explain about, just making sure they’re alright, that they’re alright and their baby’s alright, really… I just want the girls to understand what’s happening. But they’re not stupid, they know what they’re putting in their mouth or up their arm or whatever, that’s their decision, it’s a bit like what you [the older Aboriginal mother] were saying about your girl. She’s not stupid, and yet she’s making her own decisions… but you can only advise her or help her and you can’t live their lives for them.

Older Aboriginal mother- Mmm that’s right…

The older Aboriginal mother and health professionals talked at length over the best way to get information across to young mothers, when they are sometimes reluctant to listen.

SFSC Coordinator- Like you said to me, when she first had the baby, and remember it was hot and all she wanted to do was go to the pool, and she wanted to take the baby and it was only 3 weeks old? But she won’t listen to mum.

Older Aboriginal mother- She still doesn’t.

SFSC Coordinator- So how do you reckon…

Older Aboriginal mother- I don’t know.

SFSC Coordinator- If we just spend more time with them, do more stuff with them?

Older Aboriginal mother- Yeah.

SFSC Coordinator- Just getting to know them more?

Older Aboriginal mother- But I can’t even keep her at home too, she just takes off.

TCTC Midwife- She’s your girl, with a baby?

Project Coordinator- And he’s nearly one.

Research Officer- And how old’s your girl?
Older Aboriginal mother- She’s only 15. When I do want to talk to her she just sits there, shy and smiles at me.
SFSC Coordinator- Do you think it’s better when one of us tell her?
Older Aboriginal mother- Yeah I reckon.
SFSC Coordinator- If we pick her up to take her to more activities, do more stuff with her?
Older Aboriginal mother- Yeah.
Project Coordinator- Just plain stuff with them maybe, just do easy stuff with them. Building up that friendship.
TCTC Midwife- One of the things that [the HPHM Indigenous Perinatal Mental Health Worker] talked to me about was cooking for the girls, and shopping, knowing how to cook some basic things, not hard stuff- what do you think of that?
*agreement from mothers*
Project Coordinator- So before we start trying to talk to them about drinking alcohol when they’re pregnant or…
SFSC Coordinator- Just basic life skills stuff.
Project Coordinator- …yeah or violence or whatever it is else that we want to talk to them about, start with a bit more plain stuff.
Older Aboriginal mother- …when I do talk to her and that, she thinks that I’m growling at her, and then she starts taking off then… I’ve tried sitting down with my daughter and talking to her…
TCTC Midwife- Ears aren’t working at the moment.
Older Aboriginal mother- Yeah.

The theme of trust is again evident here. Being a young mother, and knowing that alcohol or drugs are harmful for you and your baby, most likely leads to feelings of shame. Young mothers may be sensitive to perceived ‘growling’ from their elders or from health professionals, or perhaps a fear of having their baby taken away. It was noted in the Progress Report (Western Australian Perinatal Mental Health Unit, 2010) that in order to promote healthy behaviour and support mothers, health professionals must start by developing trust – a recurrent theme in the evaluations since baseline. This has therefore been a central focus of the HPHM Service.
Shame, Stigma and Reluctance to Seek Help

As is often the case for services addressing clients with multiple risk factors and complex needs, the clients who are most in need of support or treatment are often the hardest to reach. In the Aboriginal community, shame can make it more difficult for health promotion messages and services to reach potential client groups.

“They get shame if they get a letter to say from the court you know, you go to court you get a letter saying you gotta go drug and alcohol, they get shame. I tell ‘em, ‘it’s not shame to go there, it’s only helping you. It’s not helping anyone else’”
(Health/Social Services professional)

“You know a lot of Aboriginal people they shamed to use a condom? ‘Cause I know they always say, ‘nah, that’s shame using a condom’”
(Grandmother of very young children)

Many service providers and members of the community identified hard-to-reach mums and dads (often young parents, with high-risk circumstances) as a major challenge for families and service providers. Older Aboriginal women had varied opinions on why young or hard-to-reach mothers did not often access the available services. Some expressed frustration that younger women who were struggling or involved in high-risk behaviours were not always accessing the support available, while others described emotional barriers to accessing services:

“A lot of them are shy”
(Grandmother of older children)

“There’s so much for them, but if they turn up they turn up, if they don’t want to come they don’t come, you know. I mean a lot of them don’t really I think understand how much is out there, and that they can come and access this. And I think a lot of the young girls when they come pregnant they get a bit shamed. Yeah, they don’t want to come along. Maybe they’re frightened they might get judged”
(Grandmother of older children)

Overcoming the reluctance, particularly of high-risk clients, to engage with services is a necessary starting point for services in Carnarvon. Readiness to change unhealthy behaviours and readiness to engage with services is often low in the high-risk, hard-to-reach groups as reported by the staff of numerous programs. Various service providers related experiences of apparently well-designed workshops and
activities with disappointing attendance. In the 2009 interviews, the male Indigenous Mental Health Worker said that he had organised a Mental Health First Aid workshop at the Mungullah Aboriginal community, promoted it two months in advance, and no-one came. Another service provider in 2011 spoke of an event where only one woman turned up. However, positive changes can be made with persistent and dedicated efforts, as evidenced by the significant increases in attendance at antenatal clinics by Aboriginal women in Carnarvon (see section on the ‘Mapping of the HPHM Service).

It is generally recognised by the service providers interviewed that services need to continually reach out to clients and develop trust. Relying on individuals to access services on their own is likely to mean that the poor Aboriginal health outcomes continue. It takes time to develop the trust and relationships in which services can have a positive impact on high-risk families enabling steps to be taken towards reducing the inequality in health outcomes.

Perhaps the greatest of all challenges when working with Aboriginal communities is trying to improve health outcomes despite the array of risk factors they experience. In the words of the Community Midwife, “Indigenous health didn’t get this bad overnight, and it won’t improve overnight”, but it is possible to make improvements as shown by HPHM and the associated services discussed in this report.

**Interagency Relationships**

*The Web* – Perinatal Services

A key element of successful service provision in the Carnarvon area appears to be the development of strong interagency relationships. In the Progress Report it was noted that the three perinatal-focussed services HPHM, TCTC and SFSC provide a ‘web of support’ for women during the perinatal period (Western Australian Perinatal Mental Health Unit, 2010). Interviewees from these services agreed that the connections between their programs and the HPHM Service are integral to their combined success with the Carnarvon community. Staff members from the three services shared notes informally, and had at least weekly phone contact to follow up regarding their common clients. With staff turnover in other agencies, the strength of the connections have fluctuated, but it is clear that close collaboration has many benefits when it is possible.
At the time of the 2009 evaluation, the Community Midwife would take a HPHM staff member with her when visiting mothers with obstetric and mental health issues, to ensure women are linked in with both services. The Community Midwife role has experienced substantial turnover, with four different people filling the role since the progress evaluation was undertaken. Different procedures have been implemented by various staff members. At the time of the 2011 data collection, the Community Midwife no longer undertakes home visits and instead an Aboriginal staff member has been hired who transports women to the antenatal clinic. As service procedures change, opportunities for collaboration also evolve and change.

The referral process among the three perinatal-focussed services was outlined in the Progress Report. Referrals between the three services don’t usually happen “A then B then C”: the TCTC Community Midwife and the SFSC Coordinator are usually the first to identify pregnant women, then referring to HPHM staff members. Fortunately distance is not a challenge within town, as the three services are a short walk from each other (Western Australian Perinatal Mental Health Unit, 2010).

The EPDS is completed with all patients seen by the TCTC Community Midwife; if the mother scores >10 in total, or answers positively to question 10 she will be offered a referral to the General Practitioner and the HPHM Service. EPDS scores are kept with the Pregnancy Health Record for comparison to future results.

The Community Midwife at the time of the progress evaluation noted that she had been “blown away” by the generally high EPDS scores from Aboriginal women in Carnarvon. She validates these by reflecting back to the women what they have indicated, and it appears the high scores are genuine responses.

A Broader Net

In talking to a range of service providers in the 2011 interviews, it became clear that the ‘web of support’ is now broader than when reported on for the progress evaluation, including not only the core perinatal-focussed services, but a range of health and social services that work with Aboriginal families (in part or exclusively). Each service has a different focus, but by working together they increase the support available to Aboriginal mothers, and make it easier to navigate the services available.

The most common source of referrals to HPHM is hospital staff (including TCTC, midwives, and doctors). Referrals also come from AMS, Child Health,
A great deal of collaboration takes place between the services, and not just in terms of referrals. The Ninny Jinas playgroup that HPHM run on Friday mornings is a collaborative initiative with involvement from a range of services. Many activities such as events held in Children’s Week and NAIDOC Week are also team efforts with other services involved. Agencies described collaborative efforts as essential to reaching clients, building trust, providing more integrated support and reducing the likelihood that vulnerable mothers and children would fall through the cracks. There is also a risk, as pointed out by one Health/Social services provider, of overwhelming a client with support. If more than one service is involved with a client, “there can be too many agencies all going to a client’s home, telling them what to do”, thus coordination between agencies is important.

Health and social service providers made the following comments relating to collaboration:

“The HPHM Service is involved with a number of DCP’s families, there’s a lot of overlap as both work with high-risk families. We’re pleased to hear when they’re involved. Families need the services”.

“Very important for agencies to work together. You can be more successful, get more done”.

“[Collaboration is] so critical to stop families slipping through the cracks”.

“Collaboration – we are all looking after the same families… Someone from DCP or someone in community might see a mum who’s struggling and let us know”

“You can’t work on your own. Or I find you can’t work on your own. You wouldn’t probably be as successful in your role if you didn’t link in with all the other services around town. All the different…AMS and these guys [HPHM], child health and True Culture True Care”…”If any of us have an idea we want to do something, we always like consult each other – what do you think about this, shall we do this, shall we do that?”

Many of the health and social services professionals interviewed made positive comments about successful referrals, interactions and activities they had been involved in with HPHM. When asked what were the best things about the
HPHM Service, several mentioned not only the support for mothers but also the professional and collegial support provided by HPHM:

“Open communication, friendship, knowing you can contact them for advice and not feel stupid, learning off each other”
(Health/social services provider)

“Definitely more support. For mums, and for us in terms of referral pathways. Knowing that a mum will go to a dedicated team.”
(Health/social services provider)

Developing relationships and providing support

Knowing the Community

Having an Aboriginal health worker in the Service and both staff members having strong community connections were considered valuable assets when making connections with clients:

“Things are working well at the [HPHM] service. Having the ‘in’ through the indigenous worker is important”
(Health/Social Services professional)

“Indigenous workers [at HPHM and the other perinatal services] are worth their weight in gold”
(Health/Social Services professional)

“The [HPHM] program works because the right people are in the job. They know the community. [HPHM Project Coordinator] and [HPHM Indigenous Perinatal Mental Health Worker] help us access clients too”
(Health/Social Services professional)

Using the ‘Grapevine’

In the Progress Report, perinatal service partners TCTC and SFSC noted that they utilised their informal networks (i.e. the ‘grapevine’) to identify pregnancies in the community. It was then via this informal network that they were able to access the necessary information to engage clients as they have made connections and built trust with local Aboriginal women (particularly elder women). The informal networks are useful as many Aboriginal women will not present for antenatal care unless approached. The Community Midwife remarked, “if you didn’t use social connections you couldn’t do your job”. There have been cases in the past of Aboriginal women making their first pregnancy-related visit to hospital when they are in labour (Western Australian Perinatal Mental Health Unit, 2010).
The health professionals and the Aboriginal mother gave several examples of the usefulness of the ‘grapevine’ during the 2009 focus group discussion. The following series of exchanges explains the informal process that occurs:

**SFSC Coordinator** - It’s good with the young girls, they will tell us if they know someone who might be having a baby, so it’s all word of mouth, they’ll tell us and we’ll contact them.

**Older Aboriginal mother** - See those two [women] sitting in the seat, they’ll tell you who’s having a baby…

**TCTC Midwife** - It’s amazing what [the SFSC Coordinator]’s saying… [she’ll] say ‘this one’s having a baby’ so I write it down, so then I go to these girls ‘oh you know this one?’ ‘Oh yep’. Then [another woman]’s going ‘no I don’t know this name, I’ll go looking’. She goes to me, and then she comes back and goes, ‘nah, she’s gone to Meeka[tharra]’. It’s amazing.

**SFSC Coordinator** - You get all that information.

**Project Coordinator** - We’re just small enough. And even if you don’t know that person, you can ask usually by their parents, you can figure out where they fit even if you don’t know them. Doesn’t take long to catch on does it.

The older Aboriginal mother was also able to provide up-to-date information about other women, their histories and their children during the focus group. For example:

**SFSC Coordinator** - [Another mother had her baby] on the same day.

**PC** - He’s the cutest little thing.

**Older Aboriginal mother** - There’s talk already saying she’s expecting again.

**Project Coordinator** - She had twins! Were the twins the last ones she had? They were weren’t they, how old are they, about three?

**Older Aboriginal mother** - Three.

And another example:

**TCTC Midwife** - … I don’t think there’s any pregnant girls out [at Mungullah] at the moment.
Local women were sometimes active participants in this networking process. In the example below a young mother pointed out that she knew other women who were pregnant and could benefit from attending the clinic.

TCTC Midwife- A couple of weeks ago when we had a big clinic here, it was so funny, the girls, and one’s going, ‘you should have brought this one’. And I go, ‘where does she live?’, and she goes, ‘with me’, and I go, ‘yeah you should have brought her’. And anyway, we found out about two or three. Then blow me down, I’m doing the clinic up at the hospital, and the cousin’s in labour and hello, all of them are here. So I’ve got them all. And then when they’re together it’s better too.

Project Coordinator- It’s very hard to see someone on their own sometimes.

Research Officer- You feel safer don’t you when you’re with someone else.

SFSC Coordinator- And that’s what I found when I first started on picking the girls up for their appointments, they’d bring a friend or two with them, and if that’s what they wanted well, just jump in, come along.

**Building Connections**

One of the greatest challenges when attempting to provide a mental health service for Aboriginal women in a rural/regional area of WA is building trust and thus establishing and maintaining a connection with the local community. For a range of reasons, perinatal health services for Aboriginal women in Carnarvon have to be particularly proactive in building and maintaining connections with clients. For
instance, they often need to provide practical support such as transport in order for clients to attend appointments and activities. The Community Midwife (in 2009) pointed out that “you’ve got to work the way your people work; catch them when you can, and work with the client’s needs”. She found it important to be flexible with appointment times and allow for last-minute changes in plans.

Several health professionals suggested that the HPHM staff’s commitment to connecting with clients is a key to the Service’s success:

“There is absolutely no question that they understand the need to get out of the office and get to clients”
(Health/Social Service Professional)

“Following up high-risk families is so important, not letting them slip through the gaps. [The PC] and [IPMH/W] do a lot to keep following up clients. And they have a bloody good turnout on Fridays [Ninny Jinas playgroup day], which indicates they’re getting through to clients”
(Health/Social Service Professional)

The SFSC Coordinator in 2009 acknowledged that sometimes it can be frustrating for health professionals to chase up their clients, but by putting effort in over time, you develop trusting relationships and the process becomes easier:

“…when you go to get someone and they’re not there, and then you have to go to another house, and it does make you wild, but you just go with the flow and eventually you build up that relationship with them too, that you know they trust you and they think, ‘oh she’s not that bad after all, maybe I will just hang around here until she comes and gets me and takes me to my appointment or whatever’…”

In addition to building ‘targeted’ connections through following up individual clients, HPHM is building its profile within the community. HPHM facilitate the development of trusting relationships between clients and other agencies by inviting service providers to present information to the playgroup. Active involvement in community events such as NAIDOC week, Children’s Week, and Harmony Day help to make the Service and its staff more visible, which may help to break down barriers to accessing support when needed. Involvement in high school education sessions is hoped to not only provide immediate educational benefits, but also develop familiarity and trust with the staff so that if the teenage girls become pregnant they may be more likely to feel comfortable approaching the Service.
Building Trust and Providing Support

The 2009 focus group discussed the importance of building trust with local women, to promote engagement with services. The group of mothers in attendance agreed that trust builds up slowly over time, and also gets passed around by word of mouth: another reason why the informal communication network is so important. By way of example: the Aboriginal mother agreed that there was more support for mothers in Carnarvon now that the HPHM Service was running; she believed it had made a difference. She also indicated that she trusted the HPHM Project Coordinator, and had recommended the Service to her daughter.

Similar discussions occurred in the 2011 focus groups. One grandmother whose daughter had been supported by the HPHM felt the Service was doing many of the right things to build trust among young mothers:

“Just continue the way they’re doing and I think all the girls will trust them, the young girls”.

As noted by the group of mothers in 2009, it takes time for trust to develop. It is important to create stability within services to allow staff to develop relationships and trust over time:

“In services for Aboriginal women, it is absolutely crucial to have people with personal relationships and personal trust with the clients… twelve months is the minimum to get the trust and relationships”.

(Health/Social services professional)

Another health/social services provider commented on the impact of the HPHM on clients:

“I’ve seen the relationships with some of the clients they’ve brought along. The support gives them more confidence in themselves as parents, particularly where there are mental health issues”.

The Ninny Jinas playgroup serves a number of purposes: it provides social support, which protects against postnatal depression (Nielsen, et al., 2000; O’Hara & Swain, 1996; Robertson, et al., 2004; Warren, 2005); it is a forum for promoting social and emotional well-being and mental health awareness via education; and it allows staff to identify additional support needs and link women with services as required. The inclusiveness of the playgroup is considered one of its strengths. One health/social services provider commented, contrary to her personal experience as a
mother, there was greater cohesiveness within this playgroup. The high participation rate also suggests that it is providing support that women find valuable.

A brief questionnaire was distributed at one of the playgroups in order to obtain some feedback directly from the participants. Feedback from the five respondents was very positive. The women appreciated the friendliness of the staff and other attendees, and the opportunity to talk and share ideas. They also valued the learning and social opportunities for their children, the relaxed environment and the well-organised activities. One mother of several children commented, “it’s great as it is… it would be the best one that I’ve been to”.

**Areas of Need**

During the interviews and focus groups, several current or potential client groups were identified as either lacking support or requiring continued efforts. Which of these groups should be targeted by HPHM will depend on funding, scope/mandate decisions and the practicalities of which service is most appropriate to meet the needs of a particular group. However, they are outlined here in order to highlight areas for continued prioritisation or for potential service expansion by HPHM or other services in the area.

**Young and Hard-to-Reach Mothers**

As noted in the ‘Challenging Context’ section, there was a great deal of concern by family members, community members and service providers about young mothers who are often unprepared for the challenges of parenting. Early parenthood can interrupt education, and may occur at a life stage when people are more likely to be involved in a ‘partying’ lifestyle involving alcohol and drugs. Young mothers were also considered less likely to seek help even if they were struggling, for fear of being judged. The interviews suggested that HPHM is on the right track in developing trust and engaging young and hard-to-reach mothers, but that it is a difficult task requiring ongoing effort, creativity, patience and commitment. This is seen as a service priority for HPHM.

Theories of behaviour change that are commonly used in health research suggest that there can be a number of stages or precursors before more healthy behaviours are implemented. For example Diclemente and Prochaska’s stages of change model suggests that people may go through a series of stages as they become increasingly ready for change (Prochaska, Redding, & Evers, 2008). Azjen’s
theory of planned behaviour suggests that attitudes, beliefs, social norms and sense of personal control are all important factors in choosing healthy behaviours (Montano & Kasprzyk, 2008). As such, service providers working with these hard-to-reach mums not only have to engage and build trusting relationships with this group, they may also have to address attitudes and beliefs, and build young women’s confidence before behaviour change is likely.

**Including Partners**

There is increasing recognition within the field of perinatal mental health of the importance of considering fathers as well as mothers, for men also experience depression and other mental health problems in the perinatal period (Condon, 2006; Matthey, Barnett, Howie, & Kavanagh, 2003). In addition, fathers play a very important role in supporting mothers and parenting children (Dennis & Letourneau, 2007; Figueiredo et al., 2008; Vandell, Hyde, Plant, & Essex, 1997). Conversely, relationships featuring conflict or abuse (physical and emotional) have a negative impact on women’s mental health (Dennis & Ross, 2006; Ludermir, Lewis, Valongueiro, de Araújo, & Araya, 2010; Tiwari et al., 2008).

A number of interviewees indicated that it would be useful to be able to provide more services for fathers, but also felt they were a much harder group to engage in services than the mothers. In the progress evaluation, WAPMHU research staff interviewed a male Indigenous Mental Health Worker from the CWMHS who works closely with HPHM.

He believed that men, whether they were Aboriginal or non-Aboriginal, were not likely to say if something was wrong; women were more likely to speak up. He suggested having workshops for couples, to give information on perinatal mental health and the services available for both men and women. He suggested HPHM staff members could reach the partners via their clients (i.e. by asking the mothers to encourage their partners to attend). As perinatal mental health can involve both partners, he considered it important to bring the two people together to learn. He mentioned that in Aboriginal communities further north where traditional culture is stronger, men’s and women’s business is kept more separate. However, in Carnarvon where the culture is not as strong, men are more involved in pregnancy and postnatal care, so they should know about perinatal mental health issues. He remarked that if men knew more about perinatal mental health, they would understand what the HPHM staff members were trying to do and why it’s important;
without that understanding, men could become resentful in seeing the HPHM staff members supporting and empowering their female partners.

One notable success involved the partner of a female client of the HPHM Service. There were issues of domestic violence, alcohol and drug use, and financial problems. The Indigenous Mental Health Worker said that although the partner still had changes to make regarding drugs, he had come a long way since the Service began providing support to the couple.

In the progress evaluation, a questionnaire was developed and used with fathers and other men in Carnarvon, asking for their opinions on the level of awareness and trust in the community regarding the HPHM Service (see Appendix J). A focus group was not conducted with fathers as there was limited time to collect information whilst in Carnarvon, and also because it was advised that few men, if any, were likely to attend. Six men completed the questionnaire. Unfortunately, many of the responses were brief ‘yes/no’ type answers. Nevertheless, four of the six indicated they thought community members trusted the HPHM staff enough to talk to them if they were struggling. One man said only some people trusted them. One man said yes, “but as of most communities, trust takes time”. Several gave recommendations for promoting awareness of the Service and how to help families and these were incorporated into the recommendations from the Progress Report (Western Australian Perinatal Mental Health Unit, 2010).

It is noted that there appear to be more services in Carnarvon targeting women, and while there is certainly a need for these, there may be gaps in what is available for fathers particularly given the difficulty in engaging men. A shortage of services for Aboriginal men was also identified in a recent report that mapped services in the Murchison-Gascoyne region (Cant, et al., 2010). Anecdotal evidence suggests that when services are effective in supporting the social and emotional well-being of young Aboriginal men, together with promoting healthy relationships, there is a positive impact on their partners.

Comprehensively addressing the needs of fathers is beyond the scope of the HPHM Service. Partners are likely to be better served by male service providers. However, perinatal services should be aware of the value of including fathers (or couples together) should opportunities arise.
Outreach Services

There is also the challenge of providing support to people in remote communities, which can at times be inaccessible. At the time of the Progress Report, the Indigenous Mental Health Worker, along with a male Mental Health Nurse, has been providing support to the partner of a mother experiencing drug and alcohol-related psychosis. Despite the high risk nature of this case, care could not be provided on a daily basis as the family lived in a remote community (Western Australian Perinatal Mental Health Unit, 2010).

A potential area of service expansion that has been considered since early in the trial is for the HPHM Service to begin visiting areas such as Burringurrah community (approximately 500 km east of Carnarvon). The value of increasing services to remote areas is generally recognised.

“More budget to allow them to travel to Burringurrah would be great. This would allow them to maintain contact with clients. The Remote Area Nurse is fantastic, a trained midwife, but it would be great if [HPHM PC & IPMHW] could get there for a new referral at Burringurrah before they come into town. (Most women there come to town for the delivery, with care shared between Remote Area Nurse and several others).”
(Health/social services provider)

There is little doubt that provision of HPHM Services in Burringurrah would be beneficial. However, there have been several obstacles to beginning this outreach service, including time constraints and funding. With the pilot stage and associated contracts nearing an end, the HPHM staff have also been mindful of not starting a service that they may not be able to continue. Making contact and then terminating outreach could create expectations that can not be followed through on, damaging trust in the community.

Grandmothers Raising Children

Several of the grandmothers that participated in the evaluation process over the pilot period have been primary caregivers for their grandchildren. As perinatal services tend to focus on the mother, there can be a lack of support for grandmothers who find themselves raising infants and toddlers. However, as one of the major reasons for supporting mothers is to improve child development outcomes, there is a strong argument for ensuring grandmothers who are primary caregivers also receive the support required to provide the positive environments that optimise outcomes for
children. If the HPHM Service has the capacity to provide support to grandmothers acting as primary carers for infants/toddlers without adversely affecting service delivery to the core target group (mothers in the perinatal period), this would be beneficial.

**Summary**

The focus group and interviews presented in this document provide a detailed picture of the HPHM Service in Carnarvon: from the day-to-day activities of its staff members as they work with clients and collaborate with other core services, to the everyday difficulties facing clients.

Key themes emerged in each interview: the slow process of building trust, so vital in promoting Aboriginal engagement with any service; capitalising on the informal communication networks to help build trust, but also to find information and locate clients; the challenges of being a young parent, such as shame, relationship problems, and alcohol and drugs; and the difficulties involved in providing a perinatal mental health service. Over time, HPHM has built relationships with clients and other agencies, and developed a strong and sustainable service. Each interview also highlighted several successes; the Service has achieved a great deal in its 32 months.

Women in the focus groups agreed that they felt supported by the HPHM Service, thus meeting KPI-1, an *increase in level of perceived social support by Aboriginal mothers living in the Carnarvon region of WA*.

**Organisational/Service Issues**

This final evaluation of the Service has provided a valuable forum for the HPHM staff, other services providers and community members to reflect on issues that relate to building and developing a perinatal mental health service with an Aboriginal community. However, the Service is still being shaped by ongoing consultation and collaboration with the local community, with both formal methods (such as recommendations at each of the three stages of evaluation) and informal methods (such as HPHM staff seeking input from clients, community members and service providers about service direction) being used.
It takes time - The need for stability in staffing and funding

There was widespread agreement that it takes time for a service to develop trust within the community. Furthermore, this trust is based on authentic relationships between staff members and clients. One health/social service provider noted that,

“one of the striking things about the [HPHM] team is that the original people are still in place now. In services for Aboriginal women, it is absolutely crucial to have people with personal relationships and personal trust with the clients. Services with too much turnover can’t get the outcomes. Twelve months is the minimum to get the trust and relationships.”

This has important implications for staffing and funding. In a broader mapping of services in the Murchison-Gascoyne region, Cant et al (2010) note that Aboriginal people are frustrated by high turnover within services and the impact on service provision. They also note that short-term funding arrangements are disruptive for service provision, creating a ‘stop-start’ mentality and impacting on recruitment, retention and capacity for long-term planning. At the time of this final evaluation, these issues were causing concern.

The uncertainty of not knowing whether funding and individual contracts will be continued has caused stress for the HPHM staff as the end of the pilot stage approaches. This situation does not leave the staff with much time to consider alternative employment should the need arise. The thought of possibly leaving the Service, when they have worked so hard to establish it, is unappealing to the HPHM staff, as it would have a negative impact on the continuation of the Service.

PC  …very stressful. [The Service] would have to be rebuilt, someone [would] have to rebuild it. Learn.

IPMHW  We only just felt like we were getting on top of it.

PC  Yeah, last year really. Especially the second half of [2010], everything just really gelled together. It might seem ridiculous that it took so long, but it has.

Thus there is a high need for effective succession planning within HPHM, for if a staff member was to leave their position in future, there would need to be a smooth transition to ensure that the Service continues at full capacity.

HPHM staff members expressed wariness about starting longer-term projects (such as outreach to Burringurrah) in case they could not be continued/completed due to work pressures. Unfortunately, the nature of Government funding may make
limited-term funding unavoidable; however, strategies should be put into place to limit the disruption caused towards the end of funding cycles and to support longer-term planning.

In addition to the time needed to develop trust with clients, it also took time for the HPHM staff to establish their role, and gain a sense of direction. Such pilot services often have to develop processes and networks as they create the Service ‘from the ground up’. As the Service has developed, HPHM is increasingly being asked for input in the planning of other services. Although care should be taken not to overburden staff members who have successfully developed a new service, such staff could play a valuable mentoring role in supporting new service ‘pioneers’.

**Being part-time**

The PC in particular has found that part-time hours have been a limitation affecting all areas of the Service. She expressed a desire to be full-time in her role as she feels that it would make it easier for her to keep records, coordinate with the IPMHW, support her clients, and would make outreach activities more feasible.

**PC** …not being full time is a huge challenge… It’s too disjointed. I mean, I don’t work Mondays, and I don’t work Friday afternoons. It’s only in the last few months that I’ve picked up Wednesday afternoons which is a lot better than what it was, but it could still be better. Doing the playgroup, the playgroup takes up about a day a week. ‘Cause you’ve got the planning beforehand, the organising, then you’ve got the pick ups, the drop offs…

**IPMHW** …activities, food…

**PC** So roughly a day, a bit less than a day maybe. And then if you get a new referral, you make an appointment, you go out and do the assessment, and then you say to them – especially if they’re quite unwell, you might want to go back and see them the next day – I usually can’t do that. It gets a little bit disjointed with the Mums. Plus I don’t think…

**IPMHW** We never seem to…

**PC** No we don’t – we have trouble gelling over things.

**IPMHW** Just having time to sit down and knowing what you’re doing and I’m doing.

**PC** We run.

**IPMHW** We do.
When asked how often they see each other during the week, HPHM staff replied:

PC Fridays we always see each.
IPMHW Fridays we see each other.
PC But then, that’s a really hectic day…

A number of other service providers interviewed also indicated it would be beneficial for the Service if the PC’s hours were increased.

Who fits into the target group?

One of the interesting dilemmas in developing the Service is identifying who fits into the Service’s target group. This would be clearer in a mainstream perinatal mental health service; target groups would be limited to antenatal and/or postnatal women, possibly with or at risk of a mental health problem, and might include a specific demographic (age, ethnicity, place of residence). However, focus group participants at baseline made it clear that developing trust within the Aboriginal community involves an investment of time that goes beyond a standard structured model of ‘occasions of service’ provided to clients meeting a diagnostic criteria.

Their suggestions indicate that the Service needs to take a holistic and flexible approach to gain trust. For example, this holistic approach may require taking the time getting to know clients in a relaxed environment before they are willing to discuss personal social and emotional health issues (e.g. “there has to be enough trust that they will open up – they need to sit and have a cup of tea”). In addition, building trust may require being flexible in broadening the range of people that the staff work with beyond women currently in the perinatal period. For example, investing time in teenage girls before they get pregnant may increase the likelihood that they will be willing to ask for help and engage with services if they do become pregnant: “If you’ve got someone who will visit the girls before they get pregnant, and keep in contact during the pregnancy, they will open up more”. The need to involve extended families was also emphasised, again broadening the target group beyond the core group of women currently in the perinatal period.

These suggestions can be seen as a reflection of the more holistic approach to social and emotional health within Aboriginal culture. The HPHM staff have used the information from the baseline evaluation and thus provide a flexible and
responsive service. Through their activities with the high school, they are building trust in a cohort of future parents before they get pregnant.

However, the issue of who falls within the target group can provide challenges, particularly related to mothers who are non-Aboriginal, or may not fit a strict definition of ‘Aboriginal’. One reason that this issue has arisen is the high level of need for support for women of all cultural backgrounds living in Carnarvon; there are few perinatal-specific services in town aimed at mothers in general. The hospital will on occasion refer a non-Aboriginal mother to the HPHM Service, and sometimes non-Aboriginal people will make contact looking for advice.

HPHM staff members have encountered many other challenging situations regarding their target group criteria. For example: when a non-Aboriginal woman is married to an Aboriginal man, and has Aboriginal children; or when an overwhelmed Aboriginal aunty or grandmother is the main caregiver for her young nieces, nephews and grandchildren; or if a non-Aboriginal mother and an Aboriginal mother are best friends, and both are in need of support. HPHM staff members have expressed concern that turning people away could reduce the trust they have developed within the community.

Further challenges can arise when HPHM collaborates with other agencies, whose target groups may not solely be Aboriginal mothers; sometimes HPHM must rely on these agencies to contribute funding for events such as playgroups (e.g. DCP, DFC and SFSC). In these cases, the HPHM Service has needed to include a broader clientele. However, the staff and playgroup participants perceive that the inclusion of non-Aboriginal women has had a positive impact on Aboriginal participants (and vice-versa), creating a friendly, inclusive environment with opportunities to expand social networks and learn from one another. In establishing new services, it is worth considering the potential complexities of this issue, and the potential advantages and disadvantages of any decision made – particularly in regard to community trust.

**Selection of staff**

Feedback from the baseline evaluation focus groups suggested that Aboriginal mothers, particularly young mothers, would benefit from a choice of whether they received support from an Aboriginal worker or a non-Aboriginal worker. Sometimes within community there is a hesitation by an Aboriginal client to see a non-Aboriginal
service provider due to lack of trust; sometimes there is also the opposite situation, where an Aboriginal client may not want to see an Aboriginal service provider, over fears that information might get back to their family. It follows then that in the case of the HPHM Service, where there is one Aboriginal and one non-Aboriginal staff member, the situation could arise where a client preferred to see a particular staff member over the other. However, HPHM staff members have not encountered this situation. All clients are reportedly happy to see either the PC or the IPMHW, and while the PC is non-Aboriginal, she is a Carnarvon local and is trusted by the Aboriginal community.

IPMHW: [The PC has] got Aboriginal children, she’s accepted by the Aboriginal community.

PC: No-one’s ever said to me, ‘can I see someone else’.

IPMHW: And because you’ve been here forever. I mean you know, you went to school with everybody.

PC: And no-one’s ever said to me that they don’t want to see [IPMHW], but people sometimes think – not for [IPMHW], but I know when I was at DCP sometimes an Aboriginal person doesn’t want to see an Aboriginal person to speak about something privately ‘cause they think that …its never come up for us… everybody’s been quite happy to see either of us. Or both of us.

As the PC is part-time in her role, and because she and the IPMHW are often in-and-out of the office attending to their numerous duties, clients might not have a choice as to the staff member they get to speak to. Thus it is fortunate that the Aboriginal mothers have been happy to liaise with either staff member; as the PC put it, “especially if I’m not there every day, I can say, you could get [IPMHW] or you could get me”.

It would seem from the staff members’ positive interactions with Aboriginal clients that it is not so important whether staff are Aboriginal or not; what is important is whether staff can earn the trust of the Aboriginal community or not. However, the value of having an Aboriginal staff member within the Service was commented on by other service providers.

**Stigma and service location**

Some challenges relate to the stigma of mental health. Stigma can be a strong barrier to providing support. When asked about stigma during interviews, some staff
members of other services suggested that it was possible the HPHM Service may suffer from the stigma of being co-located with the Central West Mental Health Service (i.e. that some clients may not wish to visit the building to receive their support due to stigma). However, opinions were mixed. The placement of perinatal mental health services can be contentious, with advantages and disadvantages to being positioned within mental health services, hospitals, or other women’s health services. The HPHM staff members have found many advantages in being located within the mental health building:

…it doesn’t really make sense for us not to be part of mental health. Which I think’s probably important for the pilot evaluation because it would be too isolating [being located] at the hospital. In the office you’re pulled in with everybody else… I think because of the work that we’ve done in the community we haven’t had any mums that don’t want to come in here… No one’s said, ‘oh I don’t want to go there, that’s Mental Health’, and I think that’s what they were worried about… and in some ways I think it would be detrimental to have it separate, ‘cause we’d be buying into the same stigma. Being here – so what, we’re just another health service and we’re part of mental health. I think its better. Rather than you know, helping people to keep it stigmatised.

However, staff were sensitive to the potential issues of stigma. They will remove their ID cards when meeting clients away from the office or providing support in the community, or give clients the choice of whether they want staff to accompany them in public.

**Other challenges in service operation**

**Funding Related Issues: Service Budget & Client Transport**

As previously mentioned, the short-term nature of funding for the Service creates many challenges. In addition, because funding is limited, there has been no extra budget available to put towards the Ninny Jinas playgroup, or stalls at community events. For example, the playgroup requires use of a suitable building, toys, and provision of morning tea. A bus is also borrowed to transport clients. HPHM relies on other services to provide facilities, materials and vehicles. The staff members have on occasion used personal donations to provide items, and find it difficult “having to rely on somebody else to always provide the funding”.


Being reliant on other agencies to provide all facilities, vehicles, equipment and food vouchers creates a risk for the Service, because if these external contributions are withdrawn, an alternative source would have to be located quickly or service provision would be severely disrupted. As an example, the building which was initially used for the Ninny Jinas playgroup (provided by DCP) became unavailable, but the playgroup was able to continue without interruption because, luckily, another suitable building was immediately available in the town.

Another funding-related challenge is accessing sufficient vehicles to provide transport for clients. Many HPHM clients are unable to attend appointments or playgroup as they don’t have their own transport, so the PC and IPMHW are often called upon to provide this. They currently borrow one of the cars owned by the CWMHS, when it is available, but they expressed a need for a large van to meet their client’s needs.

PC  …there’s not enough cars for the clinicians, let alone them having us front up at the Service as well. And there’s going to be two more.

IPMHW  Two more people.

PC  And we really need a people mover, not a little car.

IPMHW  When we started the playgroups, I’d stay there and [PC]’d go out to do the pickups. And we wouldn’t pick them all up in time. We’d have to ring up at the end saying we can’t come and pick you up.

PC  Because it wouldn’t be worthwhile coming to playgroup just for half an hour, because then we’d have to start taking everybody home again.

Child car seats are also an issue here, as only one of the CWMHS cars has a child seat installed. Even if the car is available, one child seat may not be sufficient for the size of the client’s family.

PC  … we’re not allowed to remove [the child seat]. They’ve got to be put in by an accredited person. So the man at the Shire put them in, and we can’t take them out again. And they stay in that one car, so we need that car… and every child, until the day they turn 8 needs to be in a [child] seat. But we need to have really a people mover. Some of our mums have 5 kids.

IPMHW  We can’t go and say, ‘can you just leave the other kids at home? Can you bring the little one?’
If additional funding were to become available, consideration should be given to providing a service budget and/or a suitable vehicle for transporting groups of clients accompanied by children and infants. If additional funding is not available, it is important that strategies are put in place to reduce the risk of disruption should current support from other agencies become unavailable.

**Staff Debriefing Support**

Developing a trusting relationship with each client carries a risk. Many of the clients are traumatised from domestic violence, and staff members are at risk of suffering vicarious trauma when supporting these clients:

> PC And it can be hard… when you’ve been really working with someone and you do have that relationship – so when they do get beaten up or put back in the refuge that can be really hard.

These situations can take a toll on staff member’s own well-being. Adequate support is important. HPHM staff members obtain debriefing support from each other and from CWMHS staff. Their newly begun clinical case supervision sessions will also provide a buffer to ensure that they can continue providing support to their clients.

**Summary**

The organisational/service issues outlined above highlight some of the complexities and challenges in developing an Indigenous perinatal mental health service. Issues that might appear simple can be surprisingly complex; and staff providing healthcare in a regional Aboriginal community often have to be innovative and flexible. Given that services cannot be effective without trust, and that the Aboriginal community and those who work with them know that trust takes time, an important aim is to create service and workforce stability. Thus trusting relationships can develop without the disruptions that can be caused by high turnover of staff or services.
HEALTH PROFESSIONALS QUESTIONNAIRE

Relevant Key Performance Indicator:

KPI-2 Increased perinatal specific knowledge by local service providers and health professionals

Method

Participants

Health professionals currently providing a local service to Aboriginal women living in Carnarvon during the perinatal period were eligible to participate in this final evaluation; that is, to complete a Questionnaire. A convenience sample was used.

Materials

The Carnarvon Health Professionals’ Questionnaire (CHPQ; Appendix K) was purpose-designed for the baseline evaluation, and used again for the progress evaluation. The CHPQ is based on the knowledge assessment questionnaires completed nationally by health professionals as part of the beyondblue National Postnatal Depression Program (2001-2005). More information on the development of the CHPQ can be found in the Aboriginal Perinatal Service Expansion Baseline Evaluation Report (Western Australian Perinatal Mental Health Unit, 2008).

The Questionnaire is designed to assess perinatal-specific knowledge and is divided into 2 sections. Section 1 includes 10 multi-choice items about depression prevalence and treatment, baby blues prevalence and management, and the use of the Edinburgh Postnatal Depression Scale (EPDS; Cox, et al., 1987). Section 2 presents an antenatal and a postnatal vignette, then several sets of Likert scale responses, to assess the health professional’s ability to diagnose, treat and/or refer women presenting with symptoms of depression/anxiety.
The vignettes for Section 2 are as follows:

Antenatal vignette

“Mary is 19 years old and is 29 weeks pregnant with her first child. For the past three weeks, Mary has been feeling sad and miserable, which is not like her. She is unable to sleep and has lost interest in her work and hobbies. She is very anxious and concerned about how she is going to cope with the new baby and whether she will be a good mother. She is also worrying about the health of her boyfriend Jim, who has been out of work for a long time. Jim, despite being unemployed, has tried to be supportive and has noticed that Mary is not her normal self. There is no real reason for her to be so worried – why isn’t she excited about her expected baby?”

Postnatal vignette

“Six weeks after having her son, Tom, Mary is crying most days and is unable to sleep even when Tom sleeps through. She is worrying constantly about Tom and thinks there is something wrong with him. She believes she is a bad mother and shouldn’t have had him. Most days when she wakes she wishes she were dead. Jim, her boyfriend finds there is nothing he can say to Mary that makes her feel better.”

Although the Questionnaire provides useful information regarding health professional knowledge, there are a number of limitations; these relate primarily to scoring some of the questions accurately. The original Questionnaire was used for all three data collections to maintain consistency; however, questions where scoring issues adversely affect data quality have been excluded from this report. For example, Question 10 of Section 1 is not reported, as there are three correct answers, however respondents were not prompted to select multiple responses. The question asked ‘which of the following statements is false’, rather than ‘which of the following statements are false’, which implies a single correct answer. In this scenario, to mark a single correct answer as incorrect (as only one of the 3 correct answers were selected) would unfairly lower scores, however to mark such a
response as correct would mean that a guessed answer had a 75% chance of being correct, which cannot be considered an accurate measure of knowledge.

**Procedure**

Copies of the Questionnaire were sent to the HPHM PC, who agreed to coordinate distribution and collection on behalf of the WAPMHU researchers. Questionnaires were completed over a period of 3 months, from February to April 2011. Finished Questionnaires were returned by mail to the WAPMHU for analysis and storage.

**Results**

A total of nine health professionals completed and returned a Questionnaire. The sample comprised a diverse range of professionals: two Mental Health Nurses, two Alcohol and Drug Counsellors, one Child Health Nurse, one Community Nurse, one Midwife and one Therapy Assistant. One participant did not provide information about their occupation. Professional experience ranged from 6 to 35 years, with an average of 17 years.

Table 13 presents a summary of the number of correct and incorrect responses to each of the nine multiple choice items contained in Section 1 of the Questionnaire.

<table>
<thead>
<tr>
<th>Question Description</th>
<th>Correct</th>
<th>Incorrect</th>
<th>No response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Antenatal depression</td>
<td>7</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>2 Baby blues prevalence</td>
<td>4</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>3 Baby blues management</td>
<td>7</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>4 Postnatal depression symptoms</td>
<td>8</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>5 Postnatal depression onset</td>
<td>8</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>6 Postnatal depression prevalence</td>
<td>3</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>7 Postnatal depression treatment</td>
<td>3</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>8 Postnatal depression treatment</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>9 Edinburgh Postnatal Depression Scale</td>
<td>2</td>
<td>6</td>
<td>1</td>
</tr>
</tbody>
</table>

Of note are the high number of correct responses to question 1 (antenatal depression), question 3 (recommended management of the baby blues), question 8
(recommended treatment for moderate-severe postnatal depression), and questions 4 and 5 (onset and symptoms of postnatal depression).

Question 4, regarding the symptoms of postnatal depression, prompted respondents to select all that apply. While eight out of nine respondents correctly identified low mood, many also selected symptoms that are more indicative of other perinatal mental health disorders. When considered in conjunction with some of the answers for section 2 of the questionnaire regarding useful medications, it appears there may be a lack of differentiation between the range of perinatal mental health disorders. A tendency to use the now widely recognised term postnatal depression (PND) as an ‘umbrella’ term to cover all perinatal mental health related issues has been noted elsewhere (Miller, Pallant, & Negri, 2006).

Question 3 (baby blues management) had two possible correct answers; however, no respondent identified more than one answer. All correctly-answering respondents chose ‘understanding, information and support’ as a baby blues management strategy, but no-one picked the second correct answer, ‘mothercrafting assistance’. The wording of question 3 implied that there was only one correct answer, and this may account for why respondents only picked one answer: question 3 asked “which of the following is the recommended management for the ‘baby blues’”, rather than ‘which of the following are the recommended management for the ‘baby blues’”.

It is concerning to see the high proportion of respondents who answered question 9, about the EPDS, incorrectly. Four of eight respondents thought the EPDS diagnosed depression, when it is only a screening tool that indicates risk of depression. This was also a common misunderstanding noted in the Progress Report (Western Australian Perinatal Mental Health Unit, 2010). Two answered this question correctly.

There was also confusion about the prevalence rate of PND. Only three respondents correctly identified the prevalence rate as 15%; five respondents answered 30%, and one said 5%. This shows the need for EPDS training in Carnarvon.

Section 2 presented two vignettes of a fictional patient/client called Mary, as described previously. Six of the nine respondents indicated they had seen a patient/client like ‘Mary’ (or a patient with symptoms of depression and anxiety
outside of the perinatal period), five respondents had treated a patient/client like Mary, and six respondents had referred a patient/client like Mary to a specialised mental health service. Respondents were asked if anything was wrong with Mary, based on the antenatal vignette. Four of the nine respondents correctly identified that Mary was exhibiting symptoms of anxiety and depression. Two respondents identified symptoms of depression only, and one respondent identified symptoms of anxiety only. The remaining two respondents gave no response. Subsequently, all of the nine respondents believed that Mary needed professional help.

There were a further six questions in Section 2, aimed at checking the respondents’ understanding of the management of a patient/client like Mary. Each question used a Likert scale, with the respondent having to rate the appropriateness of certain actions, treatments and referral options for Mary in both the antenatal and postnatal periods. The questions were quite difficult to score as there were varying degrees of ‘correctness’. A grading system was thus employed: “A” indicating a high level of understanding (80% or more correct), “B” indicating a good level of understanding (65-80% correct), “C” indicating an acceptable level of understanding (50-65% correct), and “F” a very limited understanding (less than 50% correct). Responses were marked correct if they fell on or to either side of the recommended point on the Likert scale.

On the whole, respondents displayed a satisfactory level of knowledge, with most questions averaging an A or B score. Most participants correctly identified Mary was suffering from antenatal (and later postnatal) depression and anxiety, however many respondents incorrectly suggested certain medications as useful for ‘Mary’. Antipsychotics were incorrectly identified as useful in this scenario by four of nine respondents. Although there are scenarios when psychotic and depressive symptoms co-occur, there was no suggestion in the scenario or the respondents’ identification of what was wrong with Mary to indicate that this was the case¹.

¹ With pharmaceutical developments continuously occurring, there are cases where medications developed for one use are found to be useful in others. However, a more likely explanation for the high number of responses supporting the use of anti-psychotics to treat a client with anxiety/depression is that perinatal mental health disorders are not being differentiated.
Comparison with Baseline and Progress Evaluations

The baseline, progress and final evaluations involved a range of health professionals, with varying levels of experience and knowledge. Table 14 lists the number of respondents by profession.

Table 14: Comparison of respondents, baseline evaluation (2008), progress evaluation (2010) and final evaluation (2011)

<table>
<thead>
<tr>
<th>Respondents by profession:</th>
<th>Baseline evaluation (N=14)</th>
<th>Progress evaluation (N=8)</th>
<th>Final evaluation (N=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Health Worker</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Medical Practitioner</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mental Health Nurse</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Child Health Nurse</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Community Nurse</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Counsellor</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Manager/Allied Health</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Midwife</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Occupational Therapist</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Psychologist</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Student Nurse</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>AOD Counsellor</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Therapy Assistant</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>No response</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Years professional experience, range</td>
<td>0.3 – 30 yrs</td>
<td>4 – 39 yrs</td>
<td>6 – 35 yrs</td>
</tr>
<tr>
<td>Years professional experience, average</td>
<td>19.3 yrs</td>
<td>20 yrs</td>
<td>17.4 yrs</td>
</tr>
</tbody>
</table>

The responses to the Section 1 multiple choice from the baseline, progress and final evaluations did not show a clear pattern of improvement. This is not surprising as fewer training sessions were undertaken than had been anticipated. The HPHM Service had given only one brief presentation to local service providers on the topic of perinatal mental health services between the baseline and current evaluations; this was to Carnarvon Hospital staff in January 2009. Subsequent
training sessions were delayed for various reasons, and only conducted shortly before, and during the week of the final evaluation visit, with small attendance levels. Now that the HPHM PC has successfully run both the EPDS and Perinatal Anxiety Disorders training courses on a small scale, it is recommended that the training sessions be repeated with the aim of increasing health professionals’ knowledge regarding perinatal mental health.

There does appear to be an improvement in responses to the vignette questions. Respondents were asked to read the antenatal vignette, then identify what (if anything) was wrong with Mary. As can be seen in Table 15, similar rates of response were found in both evaluations: 3 out of 14 Baseline respondents (21%) and 2 out of 8 Progress evaluation respondents (25%) identified that Mary showed signs of both anxiety and depression; several respondents identified anxiety or depression in isolation. In this final evaluation this proportion had increased, with 4 out of the 9 (44%) respondents identifying that Mary showed signs of both anxiety and depression. There was also an increase in recognition that Mary needs professional help (100% in the Final evaluation). Although the reason for the improvement in these more informal, practice-focussed questions cannot be deduced from the Questionnaire, it may be that through health promotion activities, interagency collaborations and referral-related interactions, HPHM has been able to increase practical aspects of perinatal mental health knowledge among service providers.
Table 15: Comparison of responses to section 2 questions regarding ‘Mary’, baseline evaluation (2008) and progress evaluation (2010)

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Responses</th>
<th>Baseline Evaluation (N=14)</th>
<th>Progress Evaluation (N=8)</th>
<th>Final Evaluation (N=9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mary was depressed</td>
<td>6 (43)</td>
<td>3 (38)</td>
<td>2 (22)</td>
</tr>
<tr>
<td></td>
<td>Mary was anxious</td>
<td>3 (21)</td>
<td>2 (25)</td>
<td>2 (22)</td>
</tr>
<tr>
<td></td>
<td>Mary was depressed and anxious</td>
<td>3 (21)</td>
<td>2 (25)</td>
<td>4 (44)</td>
</tr>
<tr>
<td></td>
<td>Mary had other problems only (social, financial)</td>
<td>2 (14)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td></td>
<td>did not respond</td>
<td>0 (0)</td>
<td>1 (13)</td>
<td>2 (22)</td>
</tr>
<tr>
<td>2</td>
<td>Mary needed help</td>
<td>9 (64)</td>
<td>5 (63)</td>
<td>9 (100)</td>
</tr>
<tr>
<td></td>
<td>Mary might need help</td>
<td>4 (29)</td>
<td>2 (25)</td>
<td>0 (0)</td>
</tr>
<tr>
<td></td>
<td>Mary didn’t need help</td>
<td>1 (7)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td></td>
<td>did not respond</td>
<td>0 (0)</td>
<td>1 (13)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>10</td>
<td>had seen a patient/client like Mary</td>
<td>10 (71)</td>
<td>7 (88)</td>
<td>6 (67)</td>
</tr>
<tr>
<td>11</td>
<td>had treated a patient/client like Mary</td>
<td>9 (64)</td>
<td>5 (63)</td>
<td>5 (56)</td>
</tr>
<tr>
<td>12</td>
<td>had referred a patient/client like Mary</td>
<td>7 (50)</td>
<td>7 (88)</td>
<td>6 (67)</td>
</tr>
</tbody>
</table>

Conclusions

There is evidence that some aspects of health professionals’ knowledge have improved, particularly around identifying and responding to perinatal depression and anxiety. However, there is still a need for more training sessions around the EPDS and specific aspects of postnatal depression. Training to increase clarity and differentiation between different perinatal mental health problems is also recommended. This would likely help the project fully meet KPI-2, increased perinatal-specific knowledge by local service providers and health professionals.
 FINAL CONCLUSIONS AND RECOMMENDATIONS

This report describes and evaluates the pilot Healthy Parents, Healthy Minds service (HPHM), 32 months after service commencement. A mixed-method design was used to collect data: a combination of qualitative and quantitative methods. The focus group and interviews conducted in September 2009 and April 2011 as part of evaluation provide useful insights into the way the Service works with the local community.

The evaluation has revealed that the Service has achieved a great deal in supporting Aboriginal women in Carnarvon in the perinatal period. Table 16 shows the achievements that have been made in the HPHM Service’s Key Performance Indicators (KPIs) and Expected Output Deliverables (EODs).

Table 16: Summary of Key Performance Indicators and Expected Output Deliverables

<table>
<thead>
<tr>
<th>Key Performance Indicators</th>
<th>Achieved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>KPI-1 Increase in level of perceived social support by Aboriginal mothers living in the Carnarvon region of WA</td>
<td>✓</td>
</tr>
<tr>
<td>KPI-2 Increased perinatal specific knowledge by local service providers and health professionals</td>
<td>Partially achieved. More EPDS and PAD training needed</td>
</tr>
<tr>
<td>KPI-3 Provision of perinatal specific health promotion strategies in the target area</td>
<td>✓</td>
</tr>
<tr>
<td>KPI-4 Documented increase in engagement with obstetric/medical services during pregnancy and postpartum by local Aboriginal women</td>
<td>✓ achieved directly or indirectly</td>
</tr>
<tr>
<td>KPI-5 Documented increase in engagement with mental health services during pregnancy and postpartum by local Aboriginal women</td>
<td>✓ achieved directly or indirectly</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expected Output Deliverables</th>
<th>Delivered?</th>
</tr>
</thead>
<tbody>
<tr>
<td>EOD-1 Number of occasions of service</td>
<td>✓</td>
</tr>
<tr>
<td>EOD-2 Number of referrals for perinatal mental health concerns to mental health services</td>
<td>✓</td>
</tr>
<tr>
<td>EOD-3 Number of groups held and types of activities</td>
<td>✓</td>
</tr>
<tr>
<td>EOD-4 Description of perinatal mental health promotion strategies</td>
<td>✓</td>
</tr>
<tr>
<td>EOD-5 Number of education and training sessions conducted for local service providers</td>
<td>Partially achieved. More EPDS and PAD training needed</td>
</tr>
</tbody>
</table>
Number of occasions of service, number of groups and increase in perceived support

Capturing data on the number of service events (EOD-1) has been an ongoing challenge since HPHM began, due to the often informal, flexible, and multi-component nature of the service offered. However, Progress Report recommendations led to implementation of a system to capture this data via PSOLIS (Western Australian Perinatal Mental Health Unit, 2010). Direct support has been provided to an average of seven women within any month. At times intensive support is required, with up to 25 occasions of service recorded for a client over a one month period. The HPHM Service has also been involved in establishing and facilitating the Ninny Jinas playgroup since the need arose in February 2011. At the time of the final data collection (April 2011) nine groups had been held (EOD-3), with attendance rates typically around 8-15 children and similar numbers of parents. Attendance has been even higher at special event days, with as many as 17 children, 17 parents and 5 volunteers attending. The playgroup provides many opportunities for health promotion, however it is also provides direct social support. A brief survey of playgroup attendees showed that the friendly environment and learning opportunities for the children were valued by participants.

A Postnatal Women’s Questionnaire was used at baseline (N=6), for the progress evaluation (N=13), and for the final evaluation (N=5), results of which indicated an increase in the level of perceived social support by Aboriginal women in Carnarvon (KPI-1). The result was strengthened by data collected during the focus groups and interviews, conducted with local Aboriginal mothers, as well as health and social service professionals.

Number of education and training sessions and increased perinatal-specific knowledge by health professionals and service providers

The HPHM Service provided a brief information session on perinatal mental health to Carnarvon Hospital staff in January 2009 (EOD-5); a further two information sessions that year were aimed primarily at consumers (i.e. mothers at the Bridge Playgroup Centre and women at an Aboriginal Medical Service antenatal group). Recommendations from the Progress Report included the provision of more training sessions (Western Australian Perinatal Mental Health Unit, 2010). Close to the time
of the final evaluation, the PC conducted two training sessions, including Edinburgh Postnatal Depression Scale (EPDS; Cox, et al., 1987) training and Perinatal Anxiety Disorders (PAD) training. Both had a small attendance, and it is recommended that further training is conducted to increase the number of health professionals in Carnarvon that have attended the training. As it can be difficult for staff involved in direct service provision in rural/regional areas to attend lengthy sessions, a condensed version of each training is recommended.

A Health Professionals’ Questionnaire was used at baseline (N=14), for the progress evaluation (N=8) and for this final evaluation (N=9). Comparisons indicated a limited increase in the perinatal mental health knowledge of health professionals and service providers in Carnarvon (KPI-2), with improvements primarily in recognising not only perinatal mental health disorders but the need to offer professional help.

Health promotion strategies

The HPHM Service has conducted numerous health promotion activities aimed at raising awareness and improving social and emotional wellbeing in the perinatal period (KPI-3). Event reports have been provided, describing health promotion activities undertaken (EOD-4). Between November 2008 and December 2010, eleven interactive community awareness stalls were held, enabling HPHM to distribute resources (e.g. brochures, information bags, magnets), display posters, show PowerPoint presentations and videos, and have staff from a range of local health and social services available to talk directly with the community. Over 1100 attendances have been recorded at events and activities run with (or by) HPHM. Over 700 of these were classified as “active participants” (i.e., completed a survey, participated in craft activities, discussions, etc).

The HPHM Service has also been working alongside staff at Carnarvon Senior High School to provide sexual health information to students, and build rapport and trust with teenage girls (prior to pregnancy); they have provided similar education to all students at Shark Bay High School. A range of health-promoting activities and special days (e.g. ‘teddy bears’ picnic’, Harmony Day) occur through the Ninny Jinas playgroup.
Referrals and increased engagement with mental health and obstetric/medical services

The HPHM Service works closely and collaboratively with a range of other agencies that have clients in common. Numbers of referrals to other agencies are noted in this report (EOD-2), with clients referred to psychologists, and the WA Mother and Baby Unit (a specialist psychiatric in-patient facility in Perth), along with a range of other services. Given the importance of building trust with clients, a friendly, informal approach often supplements formal referral procedures. Health and social service providers may bridge relationships between their clients and other services. For example, HPHM may drive clients and/or accompany them when they attend other agencies. Other services attend or give talks at playgroups, allowing them to develop relationships with the clients in an informal environment.

It was somewhat difficult to document significant increases in engagement with obstetric, medical or mental health services by Aboriginal women in the perinatal period (KPI-4 and KPI-5) due to insufficient data collection practices within services. However, case audits conducted by the True Culture True Care program (TCTC) operated by Carnarvon Hospital provide data on increased engagement in antenatal services. The Carnarvon Hospital Midwifery Department performed a case audit on 30 Aboriginal women who were seen in 2007-2008, and subsequently repeated on 25 Aboriginal women in 2010. The audit showed evidence of increased antenatal clinic attendance including:

- a higher number of antenatal visits: 6.3 in 2008 vs. 8.4 in 2010;
- more women first seen in the first trimester: 23.3% in 2008 vs. 64% in 2010; and
- less women only seen in third trimester: 23% in 2008 vs. 8% in 2010.

As services work closely together, it can be difficult to determine the extent of each agency’s role in improving outcomes. However, this evidence suggests that there has been an increased engagement with medical/obstetric services by Aboriginal women in Carnarvon.

Some evidence is also provided from the Postnatal Women’s Questionnaire data. A greater proportion of women in the progress and final evaluations reported help-seeking and engagement with obstetric/medical services and mental health services than at baseline. Of the five women in the current evaluation who had felt anxious and/or depressed, four reported receiving treatment or help from health
professionals. The results at baseline were poorer, with neither of the two women who had felt anxious and/or depressed reportedly receiving professional treatment or help for their symptoms.

**Qualitative themes**

A number of focus groups and interviews were conducted over the course of the evaluation/pilot period. These qualitative methods of data collection enabled the research team to capture and present a substantial description of the HPHM Service for readers/stakeholders, as seen from various perspectives that would have otherwise been lost.

Key themes surfaced in each interview: the slow process of building trust to promote Aboriginal engagement; making good use of the informal communication networks to spread trust throughout the community and to gain information; the difficulties faced by young parents and their family members; and the challenges involved in providing an Aboriginal mental health service. It became evident through these interviews that the HPHM has achieved a great deal in a relatively short amount of time and had a significant positive impact on the lives of some of the Aboriginal women living in Carnarvon.

It also became clear via the interview process that health and social service providers in Carnarvon co-operate and support each other in their work. Collaboration is extremely important in being able to provide effective services. The three core perinatal services in Carnarvon – the HPHM Service, the True Culture True Care program (TCTC) operated by Carnarvon Hospital, and the Strong Family, Strong Culture program (SFSC) coordinated by St John of God Health Care – all have important roles to play in meeting the needs of Aboriginal mothers, and have often worked together very closely in order to optimise service provision. Since the progress evaluation, HPHM’s networks with other agencies have continued to grow. Many service providers commented that collaborative efforts and collegial support were vital in order for services to be effective.
Recommendations

1. There is an ongoing need for perinatal mental health service provision for Aboriginal women in the Carnarvon area. It is recommended that funding for the HPHM Service is continued so the Service can further build on the strong foundations it has established. Young mothers, particularly those with multiple psychosocial risk factors, continue to be a vulnerable and hard-to-reach client group. Some successes have been achieved with such clients, but engaging and building trust with this group will require ongoing commitment and remains a priority.

2. Strategic planning needs to consider the disruption caused by Government funding cycles leading to potential disruption to service provision and the initiation of new projects, as well as reducing job security and the capacity for long term service planning. It is recommended that strategies are developed to reduce the disruption that can be caused by limited-term funding.

3. It is recommended that consideration be given to increasing the Project Coordinators hours. Although the Service has achieved a great deal with 1.5 (and more recently 1.7) FTE, the Project Coordinator’s part-time hours have created a number of pressures and limitations. If funding is available, increasing the staffing level would increase service capacity (e.g. to undertake training activities, and/or develop an outreach service to the remote Aboriginal community of Burringurrah).

4. The Service currently relies on support from a number of other agencies in providing materials, and use of facilities and vehicles that are necessary for central service provision activities. It is recommended that strategies be explored to reduce risks to service provision should this support be withdrawn. If additional funding is available to provide a budget for health promotion and service activities and/or a suitable vehicle for transporting clients (often with large families), this would be beneficial.

5. It is recommended that the HPHM Service conduct further perinatal mental health training sessions for health professionals and service providers in order to more fully meet KPI-2. Development of short (1-hour) training sessions and facilitation of training at the workplace of target participants are recommended to make it easier for professionals to attend. A training calendar may also be a useful strategy to facilitate higher attendance.
Conclusion

Collecting quantitative data has been a challenge, as service provider data was initially scarce, and sampling techniques and sizes were inadequate for conclusive results (i.e. validity, reliability, transferability). Over time this has become easier, as data sources have been found or developed. However, finding alternative, flexible and culturally sensitive ways of measuring and reporting upon outcomes has been crucial. Building trust with the local Aboriginal community so that they are willing to engage with a new Service and then also participate in the evaluation of that Service has been a major challenge. However, it is challenge that has had to be overcome in order to provide a quality Service that will meet the community’s needs.

This final evaluation indicates that the HPHM Service has achieved a great deal in two years, with four KPIs achieved and some progress made towards the fifth. Vital to the Service’s success is the collaborative relationships established with a broad range of other agencies. The three primary perinatal services in Carnarvon – the HPHM Service, the TCTC program and the SFSC program – have collaborated to provide a holistic range of supports for Aboriginal childbearing women. Also vital to the Service’s success has been the ability and commitment by the HPHM staff to undertake the slow process of building connections, trust, and ongoing supportive relationships within the community. Continued funding beyond the pilot phase is recommended so that the Service can continue to build on the strong foundations it has established.
REFERENCES


Carnarvon Hospital Midwifery Department, & Carnarvon Medical Service Aboriginal Corporation. (2008). *Antenatal audit September October 2008: Aboriginal and non-Aboriginal patients*. Carnarvon, Western Australia: Authors.

Carnarvon Hospital Midwifery Department, & Carnarvon Medical Service Aboriginal Corporation. (2010). *Antenatal audit September August 2010: Aboriginal and non-Aboriginal patients*. Carnarvon, Western Australia: Authors.


## APPENDICES

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendix A-</td>
<td>Healthy Parents, Healthy Minds Service (HPHM) incoming referral form</td>
</tr>
<tr>
<td>Appendix B-</td>
<td>Health Promotion activities data</td>
</tr>
<tr>
<td>Appendix C-</td>
<td>Perinatal Questionnaire (community awareness)</td>
</tr>
<tr>
<td>Appendix D-</td>
<td>Postnatal Women’s Questionnaire</td>
</tr>
<tr>
<td>Appendix E-</td>
<td>Interview questions for HPHM staff members</td>
</tr>
<tr>
<td>Appendix F-</td>
<td>Focus Group questions</td>
</tr>
<tr>
<td></td>
<td>(Progress Evaluation, 2009)</td>
</tr>
<tr>
<td>Appendix G-</td>
<td>Focus Group questions</td>
</tr>
<tr>
<td></td>
<td>(Final Evaluation, 2011)</td>
</tr>
<tr>
<td>Appendix H-</td>
<td>Health/ Social Service Provider questions</td>
</tr>
<tr>
<td></td>
<td>(Final Evaluation, 2011)</td>
</tr>
<tr>
<td>Appendix I-</td>
<td>Consent form proformas- verbal version, written version</td>
</tr>
<tr>
<td></td>
<td>(wording was adapted for use in interviews/ focus groups/ questionnaires)</td>
</tr>
<tr>
<td>Appendix J-</td>
<td>Father's Questionnaire</td>
</tr>
<tr>
<td></td>
<td>(Progress Evaluation, 2009)</td>
</tr>
<tr>
<td>Appendix K-</td>
<td>Carnarvon Health Professionals' Questionnaire</td>
</tr>
</tbody>
</table>
INDIGENOUS PERINATAL MENTAL HEALTH
REFERRAL FOR SUPPORT/INFORMATION/ASSESSMENT

Referring agency: _____________________________
Contact name: ______________________________ Contact number: __________________
Client family name: ________________________ Client first name: ________________
Date of birth: ______________________________
Address: ____________________________________
Phone no/s: __________________________________
Partner’s name & contact details (if applicable): ________________________________

Names & dates of birth of dependants:
________________________________________________
________________________________________________
________________________________________________

Gestation in weeks (if applicable): ____________________________
Relevant medical history: _______________________________________
____________________________________________________________
____________________________________________________________

Current treating doctor or medical service: _________________________
Family history / current situation: ___________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

Alcohol / substance use: Yes No
If yes, please provide details _______________________________________

Family violence: Yes No
If yes, please provide details _______________________________________

Edinburgh Postnatal Depression Scale score & date completed
(if applicable): ____________________________________________
Other agency / service involvement: _____________________________
____________________________________________________________
____________________________________________________________

Reason for referral: _________________________________________
____________________________________________________________
____________________________________________________________
____________________________________________________________

Signature: ___________________________ Signature: ___________________________
(client) Date (officer representing agency) Date

Indigenous Perinatal Mental Health Project Coordinator
Central West Mental Health, Carnarvon
Carnarvon Regional Hospital
REFERRAL INDICATORS:

Indigenous women, or Non-Indigenous women who are pregnant with an indigenous child, who meet any of the following indicators during the perinatal period (before, during and after pregnancy until the child reaches 3 years of age):

- Up to and including the age of 21 years (automatic referral)
- Score 9 or above on the Edinburgh Postnatal Depression Scale
- At risk of becoming depressed and/or needing emotional support
- Involved in relationships where there is violence or family breakdown
- Have a diagnosed mental illness prior to, or during the perinatal period
- Experiencing difficulties bonding with their infant or in relation to becoming a parent
- Score 25 or above on the Kessler 10 Self Reporting Depression Scale
### APPENDIX B - HEALTH PROMOTION ACTIVITIES DATA

<table>
<thead>
<tr>
<th>Event Title</th>
<th>Date</th>
<th>Venue</th>
<th>Description</th>
<th>Attendees</th>
<th>Active Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postnatal Depression Awareness Week</td>
<td>24-Nov-08</td>
<td>Boulevard Shopping Centre Carnarvon</td>
<td>An interactive, interagency stall displaying brochures and posters highlighting postnatal depression was set up in the middle of the shopping centre. Indigenous Perinatal Mental Health, along with two other new services for Carnarvon, ARAFMI and Strong Family Strong Culture combined to make the stall interesting and informative.</td>
<td>Between 50 - 60 children, other members of the public also enquired about the activities and services represented</td>
<td>31 questionnaires were completed</td>
</tr>
<tr>
<td>Family Week</td>
<td>27-May-09</td>
<td>Carnarvon Central Shopping Centre</td>
<td>Interagency activities for children to complete with the assistance of their parents and staff, activities included: making pet rocks, colouring in, building block activities, balloon designs, bubble blowing, fingernail painting, fruit and vegetable face making. Brochures and information about each agency was on display, staff were available to speak to parents, or the general public, about what their service has to offer the community.</td>
<td>48 and their parents/carers/grandparents children, other members of the public also enquired about the activities and services represented</td>
<td>48 children</td>
</tr>
<tr>
<td>NAI DOC Week Indigenous Services Expo</td>
<td>9-Jul-09</td>
<td>Pilaryli Yardi Cultural Centre</td>
<td>A number of agencies in Carnarvon, who provide services to indigenous people or groups, showcased their organisation and what they have available to the community. Strong Family Strong Culture organised a baby show with support from the IPMHS. The baby show was made available to indigenous children aged from 0 to 5 years old. Each child received a certificate, balloon and lolly bag with numerous trophies, medals and prizes (toys, clothing, books) awarded.</td>
<td>Throughout the day the expo was attended by most of the indigenous families, individuals and groups in the Carnarvon area. Many non-indigenous people and agencies also attended.</td>
<td>Number of questionnaires completed at the Indigenous Perinatal Mental Health stall - 45 , with many more people asking questions and taking brochures.</td>
</tr>
<tr>
<td>NAI DOC Week Baby Show</td>
<td>10-Jul-09</td>
<td>Pilaryli Yardi Cultural Centre</td>
<td></td>
<td>Extended family members of all children entered</td>
<td>56 babies/children entered</td>
</tr>
<tr>
<td>Breast Feeding Week</td>
<td>5-Aug-09</td>
<td>Carnarvon Central Shopping Centre</td>
<td></td>
<td></td>
<td>60</td>
</tr>
</tbody>
</table>
## APPENDIX B- HEALTH PROMOTION ACTIVITIES DATA

| Volunteers | 3 | 12 | 7 (2 x indigenous perinatal mental health workers, 1 x mental health consumer, 5 x mental health clinicians) all took part in setting/packing up the stall and manning the stall. | 5 (2 x perinatal mental health workers, 1 x strong family strong family worker, 1 x sport & rec worker, 1 x AMS health worker) and numerous parents | 1 |
| Health Promotion Methods | Eye-catching posters and brochures were on display, scones and fruit were available for stall visitors, and a staff member was always available to provide information. | An interesting and colourful interactive stall was set up in the middle of the shopping centre for 2½ hours after commencing just before school finishing times to capture as many children and their families as possible. | At all times a staff member was available to speak directly with visitors to the stall. Scones and balloons in the NAIDOC week colours were provided to stall visitors. Service information and a number of brochures relating to perinatal mental health were available. Service information and a number of brochures relating to perinatal mental health were available. A power point display of the service ran continuously throughout the day. The stall was very colourful with many posters etc to interest the public. A questionnaire to provide useful information to the service was made available for stall visitors to complete and enabled them to enter the free draw for a set of earthenware mugs. | The parents of all children entered were given positive feedback about their children and parenting, along with service information if requested. | Coffee Coupons, Display board, Flyers, Localised Posters and brochures |
| Media Exposure | N/A | The local paper came and took photographs and conducted an interview, but unfortunately the article did not make it to the newspaper! | The expo was advertised, showing a list of participating agencies, including the Perinatal Mental Health service, on posters and flyers throughout Carnarvon. | The local newspaper was present and took numerous photographs, an article was published in the next week’s paper. | Radio and Newspaper |
**APPENDIX B- HEALTH PROMOTION ACTIVITIES DATA**

| Positive Outcomes | The Indigenous Perinatal Mental Health Service was introduced to the Carnarvon community. | All of the agencies involved strengthened their inter-agency working relationships. Perinatal mental health found it particularly useful to make strong links with the Carnarvon Women’s refuge with whom we share mutual clients. | The community and other local agencies/organisations were made aware of the services provided by the Perinatal Mental Health service and personal links were established with both agencies and individuals. | Positive relationships were reinforced or initiated with indigenous mothers and their families. | Informing young mothers about the positives of breast feeding. |

| Improvements to Make | A banner would be beneficial for future stalls. | Even after careful planning and a number of meetings, the event did not actually take place during family week, which was earlier in May. This could mostly be attributed to the late recognition of this event and the difficulties in collaborating with other agencies due to availability. Planning would need to commence earlier for this event in 2010. | The power point was difficult to establish due to a lack of ports and power points, which was eventually resolved, more practical planning would be of benefit for the next expo. We will have to come up with something eye-catching again, as our stall was very popular! | Direct promotional information about the Indigenous Perinatal Mental Health Service would be made available at future events. | Display a little more eye catching |
## APPENDIX B- HEALTH PROMOTION ACTIVITIES DATA

<table>
<thead>
<tr>
<th>Event Title</th>
<th>Date</th>
<th>Venue</th>
<th>Description</th>
<th>Attendees</th>
<th>Active Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gwoonwardu Mia Ante Natal Workshop Day</td>
<td>24-Feb-10</td>
<td>Gwoonwardu Mia Cultural Centre</td>
<td>A workshop was arranged at the cultural centre focussed on women's health, including before, during and after pregnancy, women’s mental health wellbeing, healthy pregnancies, art therapy, baby massage techniques, service provider information and support, early parenting and Centrelink support for women and new mothers and their families. Activities included, one on one information, group discussions, plaster belly cast interactive session, and presentations by sexual health, True Culture True Care, Indigenous Perinatal Mental Health, Strong Family Strong Culture, Centrelink, parenting officer and child health.</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>National Youth Week Nuts &amp; Bolts of Sexual Health</td>
<td>12-16 April 2010</td>
<td>Town Oval, PCYC, Town Pool, Skate Park, Civic Centre</td>
<td>Engage 12 – 18 year olds to participate in a range of activities including sport, art, dance, circus, swimming and film. Sexual health presentation, including explanation of anatomy, STIs, contraception.</td>
<td>200</td>
<td>156</td>
</tr>
<tr>
<td>Story Time NAIDOC Week “Growing and Developing Healthy Relationships” training</td>
<td>29-30 April 2010</td>
<td>Denham High School (Shark Bay)</td>
<td>Focus on 0-5 yr olds to promote literacy</td>
<td>300</td>
<td>74</td>
</tr>
<tr>
<td></td>
<td>1-Jul-10</td>
<td>Gascoyne Early Years Learning network</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>5 &amp; 6 July 2010</td>
<td>Goonwardu Cultural Centre</td>
<td>Agencies and service providers to indigenous people or groups showcased their organisation and services that are available to the community. Fun activities for the children provided (bouncy castle, making clapping sticks, painting etc. Damper Kangaroo, Emu and buffalo meals served.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>21-Sep-10</td>
<td>Carnarvon Senior High School</td>
<td>discussed perinatal mental health, anxiety and service</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX B- HEALTH PROMOTION ACTIVITIES DATA

<p>| Volunteers | 5 | 16 | 20 |<br />
|------------|---|----|----|---|
| Health Promotion Methods | Brochures, stickers, banners, posters. | Information presentation. | Staff members spoke directly to visitors, Cupcakes and balloons in indigenous colours provided, promotional bags, Brochures and pamphlets relating to perinatal mental health available, Videos on perinatal mental health issues screened, Stall made appealing with posters, banners and live goldfish, Questionnaires (75) filled out by visitors and enabled them to enter a free draw for a set of earthenware mugs. | Discussion, supportive environment |
| Media Exposure | nil |<br />
|               | The expo was advertised, showing a list of participating agencies, including the Perinatal Mental Health service, on posters and flyers throughout Carnarvon. |  |  |</p>
<table>
<thead>
<tr>
<th>Positive Outcomes</th>
<th>Improvements to Make</th>
<th>Improvements to Make</th>
<th>Improvements to Make</th>
</tr>
</thead>
<tbody>
<tr>
<td>To inform pregnant women of the different services available to them in Carnarvon. To give the ladies a better understanding of factors that impact on pregnancies and unborn babies. Providing informative sessions on the importance of mental health during pregnancies and the impact related to depression and anxiety on the foetus. Art and Massage therapy provided breaks between deliveries. 100% (n=12) of survey respondents said they enjoyed the day, would come again if another event was held and would tell their friends about the day. 5 people liked everything, 4 people liked the belly casting most. Another response included: sitting around with the other mothers enjoying a cuppa and the kids playing and talking about different things.</td>
<td>Workshop commenced at 9.00am and ceased at 3.00pm, some of the participants became tired and felt that the day may have been a bit too long, although they all stayed until the end. Discussion afterwards by service providers resulted in the next workshop being planned for a shorter period of time, possibly from 10.00am until 2.00pm</td>
<td>Public toilet access at Skate park required. Concerns in regards to lack of safety gear at skate park workshop. Young people riding to events without helmets. Lower attendance to Pool Disco maybe too cold this time of year.</td>
<td></td>
</tr>
<tr>
<td>The program provided may opportunities for youth to socialise and interact positively while building skills and celebrating achievements through activities available. It also enabled the community to partner in accessing skills and resources to contribute to the wellbeing youth. Promote interagency rapport.</td>
<td></td>
<td>The community and other local agencies/organisations were made aware of the services provided by the Perinatal Mental Health services and personal links were established with both agencies and individuals.</td>
<td>Increase personal knowledge. Received direction for future sessions. Trust and relationship building. Co-facilitated with School Health Nurse and female teacher.</td>
</tr>
</tbody>
</table>
**APPENDIX B- HEALTH PROMOTION ACTIVITIES DATA**

<table>
<thead>
<tr>
<th>Event Title</th>
<th>Date</th>
<th>Venue</th>
<th>Description</th>
<th>Attendees</th>
<th>Active Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Growing and Developing Healthy Relationships&quot; training</td>
<td>12-Oct-10</td>
<td>Carnarvon Senior High School</td>
<td>attended girls health class at carnarvon senior high school, discussed pregnancy, wellbeing, kids helpline, smoking, alcohol and what the girls would like information about.</td>
<td>150</td>
<td>150</td>
</tr>
<tr>
<td>Children's week celebrations - &quot;Little foot steps to a big day out&quot;</td>
<td>26-Oct-10</td>
<td>Gwoonwardu Mia Cultural Centre</td>
<td>The celebration of children with interactive activities, food, prizes, drinks and gift bags with service providers information.</td>
<td>36 girls</td>
<td></td>
</tr>
<tr>
<td>&quot;Growing and Developing Healthy Relationships&quot; training</td>
<td>9-Nov-10</td>
<td>Carnarvon Senior High School</td>
<td>Discussed and role played contraception workshop on sexual health and contraception</td>
<td>33 girls</td>
<td></td>
</tr>
<tr>
<td>&quot;Growing and Developing Healthy Relationships&quot; training</td>
<td>16-Nov-10</td>
<td>Carnarvon Senior High School</td>
<td>discussed 'social consequences and risk factors for behaviour' with the girls health class at carnarvon senior high school in an interactive environment, with 10 girls (years 8/9).</td>
<td>10 girls</td>
<td></td>
</tr>
<tr>
<td>&quot;Growing and Developing Healthy Relationships&quot; training</td>
<td>30-Nov-10</td>
<td>Carnarvon Senior High School</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX B - HEALTH PROMOTION ACTIVITIES DATA

<table>
<thead>
<tr>
<th>Volunteers</th>
<th>Health Promotion Methods</th>
<th>Media Exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>27</td>
<td>Discussion, supportive environment</td>
<td>Radio and community gazette</td>
</tr>
<tr>
<td>Volunteers</td>
<td>Magnets, pencils, balloons, wrist bands, pamphlets, brochures, bags and stickers. 88 gift bags containing service info given away.</td>
<td></td>
</tr>
<tr>
<td>Health Promotion Methods</td>
<td>discussion, role play/case scenarios, games, supportive environment</td>
<td></td>
</tr>
<tr>
<td>Media Exposure</td>
<td>discussion, role play/case scenarios, games, supportive environment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>discussion, role play/case scenarios, games, supportive environment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>discussion, role play/case scenarios, games, supportive environment</td>
<td></td>
</tr>
</tbody>
</table>
## Positive Outcomes

| Increase personal knowledge. Received direction for future sessions. Trust and relationship building. Co-facilitated with School Health Nurse and female teacher. |
| Strengthening of inter-agency relationships. Promotion of services provided by Indigenous Perinatal Mental Health and other agencies. Agencies included: DCP – Sausage sizzle/Fairy Floss; Indigenous PMH – Face Painting/Bubbles; CAMHS – Balloons; Granny Glasgows Child Care – Playdough; Population Health – Fruit cups / Water / Parachute tent; Centrelink - Free Raffles / Door Prize; Department for Communities – Pancakes / Face painting; St John of God – Gift bags / Celebration cake; Best Start – Face painting / floater; Emu Services – Transport; St John’s Ambulance – Vehicle / Service display; Gascoyne Arts council – Circus play area; Family Violence Prevention Legal Service – Mural; Carnarvon Family Support Service – Bouncy Castle; Carnarvon Women’s Refuge - Colouring in Competition; PCYC – Bouncy Castle |
| Increase personal knowledge. Trust and relationship building. Co-facilitated with School Health Nurse and female teacher |

## Improvements to Make

| Provide shade over BBQ area. Ensure that stall holders are there an hour and a half prior to the event. Maybe extend by and hour. |
| Increase personal knowledge. Trust and relationship building. Co-facilitated with School Health Nurse and female teacher |
| Increase personal knowledge. Trust and relationship building. Co-facilitated with School Health Nurse and female teacher |

## APPENDIX B- HEALTH PROMOTION ACTIVITIES DATA
<table>
<thead>
<tr>
<th>Event Title</th>
<th>Gender violence and homelessness surveys</th>
<th>Best Start playgroups, Bridge playgroup</th>
<th>Ninny Jinas</th>
<th>Ninny Jinas</th>
<th>Ninny Jinas</th>
<th>Ninny Jinas</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date</strong></td>
<td>8-Dec-10</td>
<td>throughout 2009-11</td>
<td>11-Feb-11</td>
<td>18-Feb-11</td>
<td>25-Feb-11</td>
<td>4-Mar-11</td>
</tr>
<tr>
<td><strong>Venue</strong></td>
<td>Carnarvon Boulevard Shopping Centre</td>
<td>Mungullah/ in Carnarvon</td>
<td>DCP house</td>
<td>DCP house</td>
<td>DCP house</td>
<td>DCP house</td>
</tr>
<tr>
<td><strong>Description</strong></td>
<td>Display in shopping centre</td>
<td>Promote social interaction for mothers and babies, motor skills, colours, shapes, literacy, numeracy and school readiness. Opportunities to discuss perinatal mental health issues and promote HPHM service. Opportunities for mothers to develop social support networks.</td>
<td>Playgroup</td>
<td>Playgroup</td>
<td>Playgroup Teddy bears picnic open day</td>
<td>A playgroup was held to enhance positive and educational interaction between parents/carers and preschool aged children. During the playgroup, the children played with toys available at the community house, which included them being aware of safe play, sharing, interactive play and packing away. Parents/carers were encouraged to join in their children’s play and to take responsibility in supervising their children to remain safe.</td>
</tr>
<tr>
<td><strong>Attendees</strong></td>
<td>300</td>
<td>14</td>
<td>14</td>
<td>28</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td><strong>Active Participants</strong></td>
<td>152</td>
<td>14</td>
<td>14</td>
<td>28</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX B- HEALTH PROMOTION ACTIVITIES DATA

<table>
<thead>
<tr>
<th>Volunteers</th>
<th>nil</th>
<th>nil</th>
<th>6</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Promotion Methods</td>
<td>Pamphlets, brochures, 152 surveys, awareness</td>
<td>Service Providers Presentation</td>
<td>Sharing of cultures in the form of traditional cooking practices. Group discussion on cultural histories and cultural values. Painting activities to develop fine motor skills.</td>
<td>Social and emotional wellbeing through group discussions. Positive parenting through agency modelling. Mothers and children made bear bags. This activity encouraged cutting, sorting and gluing.</td>
</tr>
<tr>
<td>Media Exposure</td>
<td>nil</td>
<td>nil</td>
<td>Newspaper</td>
<td>nil</td>
</tr>
</tbody>
</table>
## APPENDIX B- HEALTH PROMOTION ACTIVITIES DATA

<p>| Positive Outcomes | Survey wording should be altered to make user friendly. There were a lot of people that needed the document simplified. | Increase numbers of participants. Provide interactive activities with a focus on health. | The playgroup provided a social outing for families in the Carnarvon area, reducing the isolation some parents/carers feel whilst they are caring for young children. Opportunities for information sharing were also made available and the children were able to be involved in positive play and relaxed interaction with their parents/carers. Agencies involved in organising playgroup activities and transport: Strong Culture Strong Families, Indigenous Perinatal Mental Health, DCP, Dept for Communities. |</p>
<table>
<thead>
<tr>
<th>Event Title</th>
<th>Date</th>
<th>Venue</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ninny Jinas</td>
<td>11-Mar-11</td>
<td>DCP house</td>
<td>playgroup held to enhance positive &amp; educational interaction between parents/carers and preschool aged children. During the playgroup, the children played with toys available at the community house, which included them being aware of safe play, sharing, interactive play and packing away. Parents/carers encouraged to join in children's play and take responsibility in supervising their children to remain safe. The children, with assistance of their parents/carers painted pictures to take home, using a variety of colours and paint vessels. Coordinator from Granny Glasgow Daycare attended the playgroup with 2 staff from Meerilinga parenting services, Perth. Overview of early brain development was provided along with information about the services provided by Meerilinga and GGDC. Future information sessions about topics relevant to parents/carers were outlined- possible a workshop in May 2011</td>
</tr>
<tr>
<td>Ninny Jinas</td>
<td>18-Mar-11</td>
<td>DCP house</td>
<td>Multicultural Day (Harmony Day)</td>
</tr>
<tr>
<td>Ninny Jinas</td>
<td>8-Apr-11</td>
<td>DCP house</td>
<td>A playgroup was held to enhance positive and educational interaction between parents/carers and preschool aged children. During the playgroup, the children played with toys available at the community house, which included them being aware of safe play, sharing, interactive play and packing away. Parents/carers were encouraged to join in their children's play and to take responsibility in supervising their children to remain safe. The children with assistance of their parents made shapes and creatures out of playdough.</td>
</tr>
<tr>
<td>Attendees</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Active Participants</td>
<td>34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attendees</td>
<td>21</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## APPENDIX B- HEALTH PROMOTION ACTIVITIES DATA

| Volunteers | 3 | 5 |  
|------------|---|---|---
| Health Promotion Methods | children given healthy morning tea- fruit & vegies, cheese & crackers. children also encouraged to wash hands and sit down to eat, cold water also provided. Parents/carers made quiche, shared amongst everyone; encouraged at all times to engage with their children & discuss issues or parenting information with the agency staff and each other; actively involved in discussion about what they would like to achieve as a playgroup, & info they want | Population health presentation by Natalie Dook and Pat Smith. Survey on needs of families in Carnarvon Community. Sharing of cultures and cultural dishes eg Kangaroo, damper, curry, coconut rice with jackfruit, spring rolls, Indonesian custard slice, lamingtons, hot dogs and Greek salad. Cooking healthy food zucchini slice. Painting of mural children did little feet (ninny jinas) prints. | children given healthy morning tea- fruit & vegies, cheese & crackers. children also encouraged to wash hands and sit down to eat, cold water also provided. Parents/carers made pumpkin scones, shared amongst everyone; encouraged at all times to engage with their children & discuss issues or parenting information with the agency staff and each other; actively involved in discussion about what they would like to achieve as a playgroup, & info they want |
| Media Exposure | nil | nil | nil |
## Positive Outcomes

The playgroup provided a social outing for families in the Carnarvon area, reducing the isolation some parents/carers feel whilst they are caring for young children. Opportunities for information sharing were also made available and the children were able to be involved in positive play and relaxed interaction with their parents/carers. Agencies involved in organising playgroup activities and transport: Strong Culture Strong Families, Indigenous Perinatal Mental Health, DCP, Dept for Communities.

Better understanding of services offered by population health. Population health took away information on what the parents need in the carnavon area. Understanding of different cultures and parenting strategies. Development of fine motor skills and colour recognition. Social interaction with children of different cultures.

The playgroup provided a social outing for families in the Carnarvon area, reducing the isolation some parents/carers feel whilst they are caring for young children. Opportunities for information sharing were also made available and the children were able to be involved in positive play and relaxed interaction with their parents/carers. Agencies involved in organising playgroup activities and transport: Strong Culture Strong Families, Indigenous Perinatal Mental Health, DCP, Dept for Communities.

## Improvements to Make

Some housekeeping rules need to be discussed as a group, with the parents/carers and agency staff to ensure the smooth running of the playgroup and safety standards for anyone attending.

The possibility of locating another venue was discussed due to the current building eventually being unavailable.
PERINATAL QUESTIONNAIRE

1. How common do you think depression or mental health problems are for women during pregnancy and after the birth of a baby?

   2%  5%  10%  15%

2. If someone you know (or yourself) appears to be having problems, do you know where to access help to assist them to become well? Please list where you may contact:

3. What do you think may be some signs that someone (or yourself) is in need of support?

   Lack of Sleep               Change in eating habits
   Angry/frustrated            Sad/Tearful
   Not bonding with baby      Lack of energy/unable to attend
t                              to daily needs

If you have any questions or you would like the Indigenous Perinatal Mental Health Service to contact you please speak to staff at the expo or phone: 99416600.

NAME:

CONTACT PHONE NO.

THANK YOU FOR COMPLETING OUR QUESTIONNAIRE
Carnarvon Postnatal Women’s Questionnaire

If you have had a baby in the past 3 years we would really like you to answer these questions for us. Your answers will help us to support Aboriginal women having babies in Carnarvon. It won't take you long and your answers will be kept confidential (we do not need your name so no-one else will know your answers).

Please fill in the blank spaces for the questions asked below:

1. What is your age? ……

2. Where were you born? ........................................

3. Language spoken at home: .................................

Please colour in the circle to show your answer to the following questions:

4. Are you:  O Married   O Defacto   O Single
O Divorced   O Separated   O Widow

5. Number of children:  1  2  3  4  5  6 or more
O O O O O O

6. Were there any problems with your pregnancy?
   O None
   O Gestational diabetes
   O Ante-partum haemorrhage (bleeding during pregnancy)
   O Pre-eclampsia (high blood pressure)
   O Threatened miscarriage
   O Other (please specify): .................................

7. Name of hospital where you delivered your baby:
   O Carnarvon Hospital   O King Edward Hospital (Perth)
   O Other..........................
Please answer these questions about your experiences as a mum:

8. Do you think you have enough people around you who support you?
   - No
   - Occasionally
   - Sometimes
   - Most of the time
   - Yes

   O O O O O

9. Have you asked anyone to help you since you became a mum?
   - Yes
   - No

10. If you have asked for help, what made you ask?
    - Feelings of depression / not coping
    - I wasn’t sleeping well
    - Problems with the baby’s father/my partner
    - Someone else asked/told me to
    - Feeling alone / overwhelmed by needs of the baby
    - Not coping with housework
    - Baby’s feeding problems
    - Baby’s sleeping problems
    - Baby’s crying
    - Other (please explain) ……………………………….

11. If you asked for help for any of the things in Question 10, who did you ask for help from?
    - AMS / GP
    - Child Health Nurse
    - Community Nurse
    - Hospital staff
    - Women’s Refuge
    - Counsellor
    - Social Worker
    - Aboriginal Health Worker
    - Husband / Boyfriend
    - Family
    - Friends
    - Family Support
    - Healthy Parents, Healthy Minds (Nicole or Naomi)
    - Other (please specify): ………………………………. and did you feel supported / helped?
    - Yes
    - No

12. From the time you became pregnant to now, have you felt depressed for more than two weeks? (feeling sad, hopeless, or crying)
    - Yes
    - No

13. From the time you became pregnant to now, have you felt anxious for more than two weeks? (feeling on-edge, restless, panicky or had problems sleeping)
    - Yes
    - No
14. If you’ve been depressed or anxious, have you had treatment / help for it?
   ○ Yes    ○ No
   If Yes, where did you get treatment / help from:
   ○ Aboriginal Medical Service
   ○ Healthy Parents, Healthy Minds Service
   ○ Mental Health Service
   ○ Women’s Refuge
   ○ Family Support Service
   ○ Community Health Service
   ○ Other (please specify)………………………

   and which of the following have you had:
   ○ Medication (please say what type)…………………………
   ○ Herbal or natural remedies
   ○ Been admitted to hospital (please say where): …………………
   ○ Counselling
   ○ None

15. How helpful was the treatment / help you have gotten?

<table>
<thead>
<tr>
<th>Very helpful</th>
<th>Helpful</th>
<th>OK</th>
<th>Helped a little</th>
<th>Did not help at all</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Thankyou very much for completing this questionnaire
APPENDIX E- INTERVIEW QUESTIONS FOR
HEALTHY PARENTS HEALTHY MINDS STAFF MEMBERS

Healthy Parents, Healthy Minds Indigenous Perinatal Mental Health Service - Carnarvon

12-MONTH PROCESS EVALUATION
Service Mapping Interview

21st September, 2009

Interview questions:

Type of support
1. Can you tell us about the successes and challenges of providing support for new mums?

2. Do you currently have any future plans for expanding or changing what type of support you provide?

Trust
3. What have been some of the successes and challenges of building trust with the local community

4. Do you have any ideas for how to improve or build trust further?

Young mums
5. We understand that teenage mums are one of the most at need groups but are also one of the most difficult to engage - can you tell us about some of the successes and then some of the challenges of providing support for teenage mums?

6. We understand that you have begun to work on some ways to target kids whilst they are at school – do you have any success stories yet?

7. Do you have any other strategies for how to target young mums?

Referral pathways
APPENDIX E- INTERVIEW QUESTIONS FOR
HEALTHY PARENTS HEARTY MINDS STAFF MEMBERS

8. We have put together a bit of a mud-map of what we understand to be the referral pathways (connections between services) but can you give us some idea from your perspective of what the pathways/connections are between the Service and everyone else? (e.g. MHS, AMS, Midwives, CHN’s, GP)

9. What parts of the current referral system are working well?

10. What need to be changed/improved to support the Service and your clients better?

Outreach service
11. One of the recommendations from the community at baseline was that an outreach service would be an important component of the Service, in order to build trust and reach those in most need – do you agree and have you been able to provide any outreach services so far?

12. What have been the barriers to providing an outreach service?

13. What could be done to overcome those barriers?

Including family
14. Have dad’s been involved much with the Service? Have they asked for help/support for themselves or their partner?

15. Do you believe that dad’s need to be targeted/included more by this Service?

16. Dad’s can be really difficult to engage (stereotypically don’t like to talk about feelings) - so have you thought about any ways to engage them more?

THE END.
Healthy Parents, Healthy Minds Indigenous Perinatal Mental Health Service - Carnarvon

12-MONTH PROCESS EVALUATION
Focus Groups

Acknowledgement:
“We acknowledge and respect the traditional custodians whose ancestral lands we are meeting upon here today. We acknowledge the deep feelings of attachment and relationship of Aboriginal and Torres Strait people to country. We also pay respect to Aboriginal and Islander people visiting/attending from other areas present here.”

Introduction:
Thank you for coming to this group today to have a talk/yarn about the Healthy Parents, Healthy Minds Service for Aboriginal mums and bubs living in Carnarvon. I’m Janette, I’m from Perth and my job is to collect information about the Service, and then write a report describing the Service, what is going really well and what can be done to make it better. This is X, she lives in Carnarvon and is the Coordinator of the service, she will be taking notes today so that we can remember what has been said. (We are also tape recording it but don’t know how well that will turn out!)

So that we can make this Service as good as possible, and help as many families as we can, we need to find out what you think about it – what works, what doesn’t, and what we can do to make it better.

We have 6 questions we are going to ask you but if you want to talk about anything else as well please do – the more information we can get the better.
At the end we will also ask if you have any questions for us.

Ask participants to sign the form of consent before beginning.
Focus Group Questions:

1. Do you think the local Aboriginal community knows the SERVICE is here to support new mums and their family?  
   How did you find out about the SERVICE?

2. Do you feel that there is more support for new Aboriginal mums now the SERVICE is available in Carnarvon?

3. Is the SERVICE providing the type of support you think is helpful for new mums…and dads?  
   If not, what type of support do you think is needed?

4. Do you think the community trust Nikki and Naomi enough to talk to them if they are struggling?  
   If not, why, and what can they do to build trust?

5. How can the SERVICE provide better support to family members?

6. Do you think teenage mums know about the SERVICE?  
   Do you have any ideas for ways we can reach and support young mums more?
Healthy Parents, Healthy Minds Indigenous Perinatal Mental Health Service - Carnarvon

32-MONTH FINAL EVALUATION
Interviews/Focus Groups

Acknowledgement:
“We acknowledge and respect the traditional custodians whose lands we are meeting upon here today. We acknowledge the deep feelings of attachment and relationship of Aboriginal and Torres Strait people to country. We also pay respect to Aboriginal and Islander people visiting/attending from other areas present here.”

Introduction:

Thank you for coming to this group today to have a talk/yarn about what its like being a Mum in Carnarvon, and the Healthy Parents, Healthy Minds Service for Aboriginal mums and bubs living here. I’m Miriam, I’m from Perth and my job is to collect information about the Service, and then write a report describing the Service, what is going really well and what can be done to make it better. This is Naomi, she lives in Carnarvon and is the Coordinator of the service, she will be taking notes today so that we can remember what has been said. (We are also tape recording it but don’t know how well that will turn out!)

So that we can make this Service as good as possible, and help as many families as we can, we need to find out what you think about it – what works, what doesn’t, and what we can do to make it better. I was a Kiwi before I moved to Perth and this is my first time in Carnarvon, so anything you can tell me about what its like being a Mum here, what’s good, what’s bad, and how services can help Mums is going to help give me a good picture of what its like. There’s no right or wrong answers, we just want to know what you think.

We have about 12 questions we are going to ask you but if you want to talk about anything else as well please do – the more information we can get the better. At the end we will also ask if you have any questions for us.

Ask participants to sign the form of consent before beginning.
Focus Group Questions:

1. What are the most important issues for Aboriginal women during pregnancy and becoming a mum that workers need to know about?

2. Do you think mums need help and support during pregnancy and when they have little ones?
   
   *If yes, what do they need?*

3. How about very young Mums, is it the same for them?
   
   *What kind of help and support do they need?*

4. What kind of things does the Healthy Parents Healthy Minds SERVICE that Naomi and Nikki work at do that are helpful for new mums?

5. Did any of you here have a baby more than 3 years ago? Or have sisters or cousins or friends that did? Do you feel that there is more support for new Aboriginal mums now the SERVICE is available in Carnarvon?

6. (For everyone) Is there anything else that the service could be doing to help support pregnant women and new mums and dads here?
   
   *If so, What would help?*

7. And how about for teenage Mums? Is there anything else the service could be doing to reach and support teenage Mums?

8. Do you think most of the local Aboriginal community knows the Healthy Parents Healthy Minds SERVICE is here to support new mums and their family?

9. How did you find out about the SERVICE?

10. a)When the SERVICE was first being set up, there were some focus groups (like these ones) to get ideas from the community about how to make the service work well. One of the important things was trust. It can be hard for people to go to a service if they don’t trust that they will get good help, or if they feel that their business will be talked about with other people in the community, or even if you just don’t know much about the service. It can take time to build trust too. Is there anything more the service needs to do to build trust in the community? If yes, what could they do?

11. Do you know of any pregnant women or new mums who don’t want to go to the HPHM service? *If yes, Why is that?* Do you think there is
there still any stigma or shame about accessing services?

12. In the focus groups that were done before, some of the older women who’s daughters are having babies talked about how hard it can be as a grandma trying to help their daughters to look after themselves and the kids. Sometimes the grandmas, or the dads need help too to help the Mums. How can the SERVICE support family members?

13. Is there anything else that you’d like to add about SERVICES for pregnant women and new mums in Carnarvon?

Thanks for talking with us. Do you have any questions?
Carnarvon Final Evaluation

Service Provider questions

How long have you been working alongside HPHM? (Did you start before them?)

In what capacity do you work together?

How frequent are you in contact? (Daily? Weekly? Monthly?)

Strength of connection (??)

What issues do you see affecting the social and emotional wellbeing of Indigenous parents in Carnarvon?

Are the issues the same for teenage parents? Different?
Have you seen an increase in Indigenous mothers’ engagement with obstetric or medical services?

Have you seen an increase in Indigenous mothers’ engagement with mental health services?

What’s the best thing about HPHM?

Are there any weaknesses, areas for possible improvement?
APPENDIX I- VERBAL CONSENT FORM

VERBAL FORM OF CONSENT

I ………………………………………………………………………………………,  

Given Names   Surname

have explained to the participant what this questionnaire/interview is for and what the information will be used for. The participant understands the information I gave, and I have answered any questions the participant asked.

The participant is aware that she is able to contact me to ask any more questions she may have.

The participant understands that the information collected during this questionnaire/interview will be kept confidential (her name or any personal details that can identify her will not be shared). The participant gave verbal consent that the results of this questionnaire/interview may be published (written about) or presented (talked about), as long as confidentiality is maintained.

The participant understands that she may decide not to take part in the questionnaire/interview at any stage and her decision will not interfere with services she may receive from anyone.

Interviewer’s signature…………………………………………………………

Dated…………………………day of………………………………20………………......

Month                              Year

Interviewer’s contact details:

Phone number/s……………………………………………………………………

Postal address……………………………………………………………………


Thank you.
CONSENT FORM

I ………………………………………………………………………………………….,

Given Names                     Surname

have been told what this questionnaire is for and what the information will be used for. I understand the information given to me and any questions I have asked have been answered.

I am aware that I am able to contact the women running the group to ask any more questions I may have.

I understand that the information collected in this questionnaire will be kept confidential (my name or any personal details that can identify me will not be shared). I agree that the results of this questionnaire may be published (written about) or presented (talked about), as long as confidentiality is maintained.

I understand that I may decide not to take part in the questionnaire at any stage and this decision will not interfere with services I may receive from anyone.

Participant's Signature………………………………………………………………

Date……………………………………………………………………………………

Facilitator:

I, ____________________, have explained the above to the signatory who stated that she understood the same.

Facilitator's Signature………………………………………………………………

Thank you.
1. Do you think the local Aboriginal community knows the Indigenous Perinatal Mental Health Service is here to support new mums and dads?

__________________________________________________________

__________________________________________________________

__________________________________________________________

How did you find out about the Service?

__________________________________________________________

__________________________________________________________

2. Do you feel that there is more support for new Aboriginal mums and dads now that the Service is available in Carnarvon?

__________________________________________________________

__________________________________________________________

__________________________________________________________

3. Is the Service providing the type of support you think is helpful for new mums and dads?

__________________________________________________________

__________________________________________________________

__________________________________________________________

If not, what type of support do you think is needed?

__________________________________________________________

__________________________________________________________

__________________________________________________________
4. Do you think the community trust the Perinatal Workers enough to talk to them if they are struggling?

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

If not, why, and what can they do to build trust?

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

5. How can the Service provide better support to family members?

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

6. Do you think teenage mums and dads know about the Service?

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Do you have any ideas for ways we can reach and support young mums and dads more?

_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

Thank you for taking the time to answer these questions.
Dear Service Provider,

Based on a well-documented need for culturally specific mental health services for Aboriginal women and their families, the WA Perinatal Mental Health Unit, Department of Health, allocated funding to develop and trial a social and emotional well-being service in Carnarvon. It was proposed that this service would extend and support the existing services delivering support to Aboriginal women and their families during the perinatal period (that is, during pregnancy and after giving birth).

The Healthy Parents, Healthy Minds Indigenous Perinatal Mental Health Service has now been operational for 12-months and is subsequently being evaluated to ensure the needs of the community are being met. The attached questionnaire is part of this evaluation, and is really important as it will help us keep refining the service, as we strive to meet the needs of local service providers as well as Aboriginal women and their families.

There are two sections to the attached questionnaire, the first contains 10 multiple choice questions, the second section contains 12 multiple choice questions. It will only take about 10 minutes to complete the entire questionnaire.

A baseline evaluation was completed in February 2008, the results of which have been integral to the development of the Service thus far. It does not matter if you completed the baseline version of this questionnaire previously; your input on the attached questionnaire is valuable either way.

Although the results of the evaluation will be presented in reports and presentations no personal/identifying details are required on questionnaires, so confidentiality can be maintained. The baseline report is available in full or an executive summary can be downloaded from our website: www.wnhs.health.wa.gov.au/emotionalhealth.php

Your input on the Carnarvon Health Professionals Questionnaire would be greatly appreciated and valued.

Please return your completed questionnaire within 7 days.
APPENDIX K – HEALTH PROFESSIONALS’ QUESTIONNAIRE

Carnarvon Health Professionals Questionnaire

Profession:
- O Aboriginal Health Worker
- O Midwife
- O Social Worker
- O Mental Health Nurse
- O Psychologist
- O Medical Practitioner
- O Childcare Worker
- O Psychiatrist
- O Child Health Nurse
- O Other (please specify): ……………………………….

Years of Professional Experience: …….years

SECTION 1 (of 2)

Please complete the following 10 questions - Colour in the circle to indicate your response.

1. Which of the following statements is true?
   - O Antenatal depression always continues into the postnatal period
   - O Antenatal depression may be as prevalent as postnatal depression
   - O Women who are depressed antenatally do not require specific treatment
   - O Antenatal depression will resolve with birth of the baby

2. The proportion of mothers who experience the “baby blues” is approximately:
   - O 1 – 2%
   - O 10 – 20%
   - O 20 – 30%
   - O 30 – 80%

3. Which of the following is the recommended management for the “baby blues”?
   - O Understanding, information and support
   - O Mothercrafting assistance
   - O Information, debriefing and counselling
   - O Postnatal support group

4. Which of the following is a symptom of postnatal depression? (indicate all that apply)
   - O Grandiose/Unrealistic future plans
   - O Frequent mood swings
   - O Preoccupation with cleanliness
   - O Persistent low mood
5. The period for greatest onset of postnatal depression cases occurs after the birth within:
   - O 2 - 5 days
   - O 10 - 14 days
   - O The first month
   - O The first 3 months

6. The proportion of mothers who experience postnatal depression is approximately:
   - O 5%
   - O 15%
   - O 30%
   - O 50%

7. What is the recommended treatment for mild postnatal depression?
   - O Understanding, information, mothercrafting assistance
   - O Psycho-education, supportive counselling, treatment groups
   - O Psychotherapy, anti-depressant medication, respite care
   - O Hospitalisation, debriefing, medication

8. Which is the recommended treatment for moderate – severe postnatal depression?
   - O Understanding, information, mothercrafting assistance
   - O Community groups, information, supportive counselling
   - O Psychological therapy, support of parenting, antidepressant medication
   - O Hospitalisation, debriefing, medication

9. Which of the following statements is true about the Edinburgh Postnatal Depression Scale?
   - O It distinguishes between moderate and severe depression
   - O It measures depressive symptoms to give a diagnosis of depression
   - O It does not detect phobic or psychotic symptoms
   - O It does not detect antenatal depressive symptoms

10. Which of the following statements is false?
    - O Mothers should not breastfeed while taking antidepressants
    - O Few long-term trials of antidepressants in breast milk have been reported
    - O Antidepressants are habit-forming
    - O Antenatal depression can be treated with tricyclic medication
THANK-YOU FOR COMPLETING SECTION 1
SECTION 2 (of 2)

Please read the following vignette and complete the 12 questions below - Colour in the circle to indicate your response.

Mary is 19 years old and is 29 weeks pregnant with her first child. For the past three weeks, Mary has been feeling sad and miserable, which is not like her. She is unable to sleep and has lost interest in her work and hobbies. She is very anxious and concerned about how she is going to cope with the new baby and whether she will be a good mother. She is also worrying about the health of her boyfriend Jim, who has been out of work for a long time. Jim, despite being unemployed, has tried to be supportive and has noticed that Mary is not her normal self. There is no real reason for her to be so worried – why isn't she excited about her expected baby?

1. From the information given, what, if anything is wrong with Mary?

2. Do you think Mary needs professional help?
   ○ Yes    ○ No    ○ Maybe, more information needed
3. Please rate how useful any of the following actions might be for Mary in dealing with her feelings.

**Please choose one response for each line in the following questions**

<table>
<thead>
<tr>
<th>Action</th>
<th>Not useful at all</th>
<th>Unsure</th>
<th>Very useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase physical activity</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Improve knowledge about the problems by reading</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Attend self-help group with other women</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Arrange more outings and social contacts</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Practice relaxation (e.g., walks or meditation)</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Attend individual or couple counselling</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Engage in specialised mother-infant treatment</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Admission to a psychiatric unit</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Electroconvulsive (&quot;shock&quot;) Therapy (ECT)</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Using alcohol responsibly</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Abstaining from alcohol</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Commencing a special diet</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Seek support from family or friends</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Talk to her husband / partner</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
4. Please indicate how useful you think it would be for Mary to seek help from…

<table>
<thead>
<tr>
<th>Professional</th>
<th>Not useful at all</th>
<th>Unsure</th>
<th>Very useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP/ family doctor</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Chemist or pharmacist</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Aboriginal Health Worker</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Counsellor</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Child health nurse/ mother-infant nurse</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Obstetrician</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Social worker</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Family or friends</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Partner</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Naturopath or homeopath</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Clergy, minister or priest</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Try to deal with her problems on her own</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

5. Please rate how useful any of the following might be for Mary.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Not useful at all</th>
<th>Unsure</th>
<th>Very useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitamins and minerals</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>St John’s Wort</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Pain relievers</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>O</td>
<td>O</td>
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</tr>
<tr>
<td>Antibiotics</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Sleeping pills</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Anti-psychotics</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Tranquilisers</td>
<td>O</td>
<td>O</td>
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</tbody>
</table>
Six weeks after having her son, Tom, Mary is crying most days and is unable to sleep even when Tom sleeps through. She is worrying constantly about Tom and thinks there is something wrong with him. She believes she is a bad mother and shouldn’t have had him. Most days when she wakes she wishes she were dead. Jim, her boyfriend, finds there is nothing he can say to Mary that makes her feel better.

6. Please indicate how useful you think it would be for Mary to seek help from the following people now; remembering that it is now 6 weeks after Mary has given birth to her son.

<table>
<thead>
<tr>
<th>Health Professional</th>
<th>Not useful at all</th>
<th>Unsure</th>
<th>Very useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP/ family doctor</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Chemist or pharmacist</td>
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<td>Psychiatrist</td>
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<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Family or friends</td>
<td>O</td>
<td>O</td>
<td>O</td>
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<td>Try to deal with her problems on her own</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
7. Please rate how useful any of the following preparations and / or medications might now be for Mary.

<table>
<thead>
<tr>
<th>Preparation</th>
<th>Not useful at all</th>
<th>Unsure</th>
<th>Very useful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitamins and minerals</td>
<td>O</td>
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</tr>
<tr>
<td>Anti-psychotics</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Tranquillisers</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

8. Please rate how useful the following actions might be for Mary.

<table>
<thead>
<tr>
<th>Action</th>
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<td>O</td>
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</tbody>
</table>

*This table is continued on next page*...
APPENDIX K – HEALTH PROFESSIONALS’ QUESTIONNAIRE

10. Have you ever had a patient/client with a problem similar to Mary?  
   Yes  No  o  o

11. Have you ever treated a patient/client with a similar problem to Mary?  
   Yes  No  o  o

12. Have you ever referred a patient/client with similar problems to Mary to a specialised mental health service?  
   Yes  No  o  o

Thank-you very much for completing this questionnaire