“If you don’t ask it; you don’t tell”
Perinatal mental health screening for women of refugee background

Suzanne Willey[A], Rebecca Blackmore[A], Melanie Gibson-Helm[A], Razia Ali[B], Lee Boyd[C], Jacqueline McBride[B] & Jacqueline A Boyle[A,I]

[A]Monash Centre for Health Research and Implementation, School of Public Health and Preventive Medicine, Monash University, Melbourne, Australia.
[B]Refugee Health & Wellbeing Service, Monash Health, Melbourne, Australia
[C]Executive Director, Nursing and the Cabrini Institute, Melbourne, Australia.
[D]Department of Obstetrics and Gynaecology, Monash Health, Melbourne, Australia.

contact: jacqueline.boyle@monash.edu

MCHRI Monash Centre for Health Research and Implementation

Background

- The perinatal period is a time of increased vulnerability for the recurrence or development of mental health disorders such as anxiety and depression.
- Routine, standarised screening in pregnancy for mental health disorders is recommended in Australia’s Clinical Practice Guidelines[1].
- In 2016, we established a perinatal mental health screening program at a dedicated refugee antenatal clinic with a high migrant population, in Melbourne, Australia.
- The Edinburgh Postnatal Depression Scale (EPDS) and a psychosocial assessment were administered in common refugee languages using the digital platform iCOPE.

Why focus on women of refugee background?

Women who are refugees

- have experienced one or more acts of violence related to war, persecution, gender based violence, protracted situations of uncertainty for the future and discrimination[2]
- higher rates of psychological disorders are evident and exacerbated by resettlement stressors such as language barriers, separation from or loss of family, cultural barriers, and marginalization[3]
- a recent systematic review of perinatal mental health and migrant women from low-and middle-income countries reported a pooled prevalence of 31% for any depressive disorder and 17% for major depressive disorder[4]
- epidemiological research at Monash Health reported very low rates of anxiety and depression diagnosis (less than 5%) in refugee women, and no recording of PTSD, suggesting a major gap in perinatal mental health diagnosis and management[5].

Data specifically on mental health disorders in pregnancy for women of refugee background is lacking and screening is often not offered in routine care, likely due to

- screening for mental health disorders not being available;
- screening not being accurate or appropriately administered;
- lack of validated screening tools in languages other than English;
- lack of interpreters; and
- lack of health professional skills and knowledge[1]

What we did:

Collaborations

A steering committee with relevant stakeholders met fortnightly during implementation and planning for sustainability. A Community Advisory Group representing a number of cultural groups met bimonthly.

Translated resources

- The EPDS and a psycho-social assessment were translated into common refugee languages: Arabic, Burmese, Dari, Hazaraghi, Farsi, Pashto, Tamil. Vietnamese and Dinka were also available
- Audio versions are in development for women who are illiterate

EPDS cut-off scores

- Recommended Edinburgh Postnatal Depression Scale (EPDS) cut-off score in women of culturally and linguistically diverse populations is 9/10[6]
- A score equal to or above 9/10 requires a clinical assessment[6]
- **Question 10:** a positive score indicates possible risk of harming self or others[1]

Anxiety sub-score

- Increasing evidence that the EPDS is sensitive to anxiety symptoms[3]
- Questions 3, 4 and 5 are anxiety specific
- Optimal anxiety sub-score cut-off is ≥4[7]

Post screening

Score-based, language appropriate information for women and online management guides for midwives were generated immediately.

Referral Pathways

Co-designed, refugee-appropriate referral pathways were developed in collaboration with MH Maternity services and MH Refugee Health and Wellbeing.

Aim

We aimed to assess the feasibility and acceptability of the perinatal mental health screening program from the perspective of women of refugee background.

Method

One focus group (5 participants) and semi-structured interviews (n=17) were held from April to July 2018 with refugee (Afghan and Burmese) and non-refugee (Vietnamese and Indian) women.

Audio-recorded narratives were transcribed verbatim, prior to thematic analysis.

Table 1: Characteristics of all women screened at booking visit (n=275)

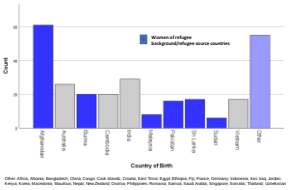
		All women of refugee background				Non-refugee women	All women
		Asylum Seeker (n=10)	Refugee-like (n=54)	Refugees (n=58)	Total (n=122) (%)	(n=155) (%)	Total (n=276) (%)
Year of Arrival	≤ 2006	6	4	11	15 (13)	32 (20)	47 (17)
	2007-2012	2	15	23	40 (33)	54 (35)	94 (34)
	2013-2017	7	35	23	65 (54)	43 (28)	108 (39)
	N/A					26 (17)	26 (9)
EPDS score	≤8	5	38	29	72 (60)	93 (60)	165 (60)
	9-12	3	5	12	20 (17)	43 (28)	63 (23)
	≥13	2	11	15	28 (23)	19 (12)	36 (17)
Anxiety sub-score	0-3	6	31	25	61 (51)	82 (53)	143 (52)
Both	≥4	5	23	31	59 (49)	73 (47)	132 (48)
Positive Q10	Anxiety ≥4 (total)	2	15	24	43 (36)	50 (32)	93 (34)
		2	8	12	22 (18)	13 (8)	35 (13)
	Score 1	1	5	5	11 (9)	7 (4)	18 (7)
	Score 2	1	2	6	9 (8)	4 (2)	13 (5)
	Score 3	0	1	1	2 (1)	2 (1)	4 (1)

There is no association between both high EPDS/anxiety score and year of arrival in women of refugee background: $X^2(3, N=135) = 0.436$, $p = 0.514$

There is no association between both high EPDS/anxiety score and year of arrival in all migrant (refugee and non-refugee) women: $X^2(3, N=249) = 0.089$, $p = 0.843$

Photos: Courtesy of Lindy Marlow

Figure 1: Country of Birth (n=275)



Other: Africa; Albania; Bangladesh; China; Congo; Cook Islands; Croatia; East Timor; Egypt; Ethiopia; Fiji; France; Germany; Indonesia; Iran; Iraq; Jordan; Kenya; Korea; Macedonia; Mauritius; Nepal; New Zealand; Oceania; Philippines; Romania; Samoa; Saudi Arabia; Singapore; Somalia; Thailand; Uzbekistan

Interesting facts

- 36% of women from a refugee background self-report symptoms of both depression and anxiety at the first antenatal visit (Table 1)
- 51% of women of refugee background in our study were born in Afghanistan (Fig 1)

Centre of Perinatal Excellence: COPE

http://cope.org.au/

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Results

1. Acceptability of screening

- Overwhelmingly, women felt the screening was acceptable. Women indicated they felt cared for, the screening was helpful and felt supported. Screening initiated discussion to express feelings that would not have otherwise been discussed with health professionals.

> ***“if you don’t ask it, you don’t tell, … you don’t open it up … You … keep it inside and, build it up, like a solid something inside your body. And when you open it up maybe you might need help with something, …, when you have the chance to express people know what your needs are and then they might be able to help you and guide you and advice you. And I think it’s really good”*** [Int 6]

- Lack of continuity of carer models was seen as a key barrier to women being able to open up and talk about sensitive issues

2. Self-reliance and empowerment for women

- All women respond positively to the idea of an audio format. It would provide independence and privacy, and questions would be answered more truthfully:

> ***“people who can’t read, … with the listening audio tape … much better … we can answer it on our own …answer … truly … express their true feelings”*** [Int 6]

> ***“some women didn’t even want to tell the interpreter … or maybe they not answer it properly or they don’t say the right answer”*** [FG]

3. Language & communication

- The presence of an interpreter was seen by many to reduce privacy and a barrier to answering truthfully.
- Some women expressed they did not understand all questions. Midwives were supportive and helpful when clarifying questions and answer to questions.

> ***“And that time she [midwife] told me are you sure? I said, … actually I didn’t understand the meaning of that word. And she explained it to me and after that I did it correct”*** [Int 7]

4. Referrals: improving access and reducing barriers

- Improving access: women felt if referral was needed, it was important to attend. Many indicated the family doctor is a good referral option. Many however, suggested more continuity of care/carer models and being able to access a mental health professional at the antenatal clinic. This was seen as more convenient and likely to improve access to ongoing mental health care.

> ***“It’s good if someone has a difficulty or a problem; it’s very good to refer to somewhere, to specific places, to look after them”*** [Int 2]

> ***“Every time I go I am seeing different person; different midwife … Changing all the time … with the same person you becoming more closer and you feel like, … more comfortable to talk to”*** [Int 11]

- Barriers to referral: there were a number of reason for women not accessing referral options to include being busy, confused, for cultural reasons, reluctant to talk/disclose, stigma, transport and language

In summary

Perinatal mental health screening in pregnancy is feasible and acceptable to women of refugee and migrant background. Screening enables discussion of sensitive issues, allowing women to ‘*open up and release*’ their feelings in a supportive environment. Women value privacy and independence when completing the screening questions. The audio format will provide greater self-reliance and likely to result in more truthful answers. Access to more continuity of carer models and locating mental health professionals in antenatal clinics are recommended improvements.

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