

ORIGINAL ARTICLE

Barriers and enablers to postpartum depression and anxiety screening: A qualitative study of Victorian maternal and child health nurses' practices

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Abstract

In Victoria, Australia, Maternal and Child Health nurses (MCHNs) play a key role in facilitating the timely identification of Postnatal Depression and Anxiety (PNDA). Understanding MCHNs' screening practices, and the factors which impact them, is central to ensuring that future screening policy agendas are evidence-based and able to support MCHNs in carrying out this critical work. Yet, little is known about this subject. The purpose of this study was to gain an in-depth understanding of MCHNs' screening practices, and the factors which impact them. Qualitative descriptive design with semi-structured interviews were used. Participants were MCHNs who had been practicing for a minimum of 6 months and regularly saw new mothers. Purposeful sampling was used to facilitate diversity across participant characteristics. Twelve MCHNs were interviewed between March and May 2021. Thematic analysis was conducted to identify patterns across our data. Qualitative content analysis was then used to identify issues which were most emphasised by MCHNs. Two themes were identified. Theme one, 'variations in screening practices', pertained to MCHNs' various screening practices (i.e., who, when, how) and the factors which influence them. Theme two, 'systemic barriers hinder equitable screening', pertained to factors which hindered equitable screening practices. Results indicate that systemic barriers contribute to inconsistent and inequitable screening practices, with women from culturally and linguistically diverse backgrounds less likely to be screened in line with best practice. Our findings emphasise an urgent need for MCHNs to be allocated with the resources required to screen all women equally, regardless of their cultural background.

KEYWORDS

anxiety, midwifery, postnatal depression, public health nursing, qualitative analysis, screening

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1 | INTRODUCTION

Postnatal depression and/or anxiety (PNDA) affects between 10 and 21% of all mothers in the immediate postpartum period up until 12 months (Fawcett et al., 2019; Woody et al., 2017) and if untreated, can adversely impact the long-term well-being of mother and child (Slomian et al., 2019). Routine screening for PNDA using a validated tool facilitates a standardised approach to screening, which is central to fostering a reliable and consistent method of PNDA identification (and management) for all women, regardless of their socio-economic status. Moreover, use of a validated tool improves detection as well as referral and service utilisation by women (Reilly et al., 2020; Waqas et al., 2022; van der Zee-van den Berg et al., 2017), and is associated with improved maternal mental health outcomes (O'Connor et al., 2016; Reilly et al., 2020). In a recent systematic review of randomised controlled trials involving postpartum or pregnant women, O'Connor et al. (2016) found as much as 9% absolute risk reduction in depression prevalence at 3–5 months follow-up among women who were screened, compared to those not screened routinely.

The Edinburgh Postnatal Depression Scale (EPDS) (Cox et al., 1987) is the most commonly utilised screening instrument for postnatal depression (Levis et al., 2020) and its efficacy (characterised as having a positive effect on depressive symptoms, services referred to or utilised and impact on women's mental health) is supported by a substantial body of evidence (Austin et al., 2019). Although it was initially developed to screen for symptoms of depression (Cox & Holden, 2003), there is accumulating evidence that the EPDS can also identify symptoms of anxiety (Smith-Nielsen et al., 2021). This, along with established evidence that screening with the EPDS is overall acceptable to women and healthcare workers (El-Den et al., 2015), has led the World Health Organisation (2022), as well as countries such as Australia, to recommend use of the EPDS to screen for both postnatal depression and anxiety (Austin et al., 2019).

In Victoria, the important task of screening for PNDA is assigned to Maternal and Child Health Nurses (MCHNs), whose role is comparable to that of Health Visitors in the United Kingdom and public health nurses in Canada (Premji et al., 2019). MCHNs offer free universal services to all Victorian families with children (from birth to school age), through the provision of 10 Key Ages and Stages (KAS) visits intended to support optimal maternal and child health. Victorian MCH practice guidelines (Department of Health and Human Services, 2019b) recommend that MCHNs screen all mothers, by conducting a psychosocial assessment and administering the EPDS during the four-week KAS visit (attended by 97% of all Victorian mothers) (Department of Health and Human Services, 2019a).

Data pertaining to the PNDA screening practices of MCHNs are not routinely collected (Productivity Commission, 2020). However, findings from a 2018 inquiry into perinatal services by the Family and Community Development Committee (Family and Community Development Committee, 2018) indicated that Victorian PNDA screening is not universal and that MCHNs (and other healthcare

What is known about this topic

- Maternal and child health nurses play a critical role in reducing the global burden of postnatal depression/anxiety by facilitating its timely identification.
- Systemic barriers can hinder screening practices in line with recommended practice guidelines.

What this paper adds

- Our results indicate the absence of a systematic approach and an overall lack of uniformity in screening practices between maternal and child health nurses.
- Nurses were largely reluctant to administer the Edinburgh Postnatal Depression Scale to women from culturally and linguistically diverse backgrounds, particularly those with limited English proficiency.
- Nurses relied predominantly on their professional judgement to identify postnatal depression/anxiety among non-English speaking mothers, resulting in screening practices which were potentially inequitable.

providers) face concurrent systemic barriers to universal screening, including a lack of time, insufficient workforce screening competency and limited referral pathways. To our knowledge, no prior studies have examined Victorian MCHNs' PNDA screening practices and/or the factors which impact them, leading to a considerable gap in our understanding regarding this critical issue. Early identification of PNDA necessitates detection in universal services, including the MCH service. Understanding the screening practices of MCHNs, as well as the factors which influence them, is an imperative first step toward facilitating the conditions and supports MCHNs require to effectively identify and support women experiencing PNDA. This evidence is also essential for the development of service delivery models that are evidence-based and tailored to facilitate optimal outcomes for women and their families.

This study is the second phase of a two-phased mixed methods study (phase one was a cross-sectional survey of all MCHNs practicing in Victoria) into MCHNs' knowledge, attitudes and practices relating to the screening (and management) of PNDA in Victoria, Australia (2019–2020). The goal of this study was to gain a comprehensive understanding of PNDA screening practices among Victorian MCHNs, and the factors which influence them.

2 | METHODS

2.1 | Design

A qualitative descriptive design was used. Qualitative descriptive studies examine events and experiences in their natural state and allow a comprehensive presentation of a phenomenon in the

language of participants (Sandelowski, 2000). To that end, the intent of this approach is to convey facts, and the meanings attributed to these facts, as defined by participants. The study is reported in compliance with the Standards for Reporting Qualitative Research (SRQR) (O'Brien et al., 2014).

2.2 | Participants and recruitment

Eligible participants were MCHNs who: (1) undertook KAS visits with new mothers as a primary component of their role, and (2) had been practicing in Victoria as an MCHN for a minimum of 6 months and (3) had agreed to be re-contacted following participation in phase one. The final survey question in phase one asked if MCHNs would be willing to participate in a follow-up interview. Those who said 'yes' were invited to provide their best contact information. A total of $n = 62$ MCHNs agreed to be interviewed, of which purposive sampling was used to ensure variability in participants' attitudes toward screening, age, years of professional experience, geographical area (metropolitan versus regional) and concentration of socio-economic disadvantage in the Local Government Area (LGA) in which they practiced. Data from the Australian Bureau of Statistics' (ABS) Socio-Economic Indexes for Areas (SEIFA) (Australian Bureau of Statistics, 2016) used as an indicator of each LGAs' relative socio-economic disadvantage (low vs. high), compared to other LGAs in Victoria. The ABS determine socio-economic disadvantage by drawing on variables including income, education, employment, occupation and housing characteristics.

Twelve MCHNs were initially invited to participate via email. Of these, one no longer worked as an MCH, and three were uncontactable, at which point (using the same recruitment method) four more MCHNs were invited to participate. The sample size was determined by the principle of saturation (Saunders et al., 2018). Saturation is widely acknowledged as the 'gold standard' for defining sample size in qualitative research, signifying that (based on the already collected and/or analysed data) additional data collection is largely redundant (Saunders et al., 2018). Based on this definition, the research team agreed that data saturation was reached after 10 interviews; however, two additional interviews were conducted for confirmation.

2.3 | Data collection

Between March and May 2021, interviews with semi-structured questions were held via Zoom videoconferencing (Inc, 2016). The first author emailed all participants a participant information statement (detailing the study's purpose, eligibility conditions, data storage and how anonymity would be maintained) 2 weeks prior to each interview, and again 48h before each interview. Prior to all interviews, participants were requested to acknowledge that they had read the participant information statement and were given the opportunity to ask any questions or express any concerns regarding

TABLE 1 Interview guide

Can you tell me about how you identify new mums who may be experiencing PNDA?

What has been your experience with hospitals sharing relevant information with the MCH service about women's mental health (e.g., upon discharge, antenatally or any known history of mental ill health)?

In your experience, is identifying postnatal anxiety different in any way to identifying postnatal depression? (e.g., is the process of identification any different? Is it easier or more challenging to identify?)

What is your approach to screening women from non-English speaking or culturally diverse backgrounds? (e.g. do you apply the same process of identification? Is it more/less challenging?)

What is your approach to screening ATSI women?

Is there anything we have not discussed today regarding this issue that you think is important and would like to share?

their involvement in the study (none had any questions or concerns). Following this, verbal consent to participate, and for the interview to be audio-recorded on a recording device were obtained prior to the commencement of all interviews. An interview schedule (Table 1) was prepared based on preliminary findings from the survey results from phase one. Prior to the study, pilot interviews were held with three MCHNs (not included in the study sample) which resulted in minor changes to the wording of some questions. All interviews were conducted by the first author and lasted between 30 and 45 min.

2.4 | Analysis

All interviews were transcribed verbatim and anonymised. Data were analysed using thematic and qualitative content analysis. Commonly employed in qualitative descriptive studies, thematic and content analysis were selected for this study because of their suitability for undertaking exploratory research in an area where relatively little is known (Vaismoradi et al., 2013). A decision to use theme methods of analysis together was made because while Braun and Clarke's (2006) approach allowed us to apply a systematic and replicable approach to identifying, organising and reporting patterns across our data, content analysis provided an opportunity to confirm these patterns and better understand their significance by counting the number of times each response was identified (Vaismoradi et al., 2013). Counting the number of repetitions allowed us to identify which issues were most emphasised by MCHNs.

First, thematic analysis, using Braun and Clarke's (2006) six-step process, was conducted. This involved coding the data in an iterative process where two members of the research team initially coded three interviews separately and discussed any variations until consensus were reached. The remaining nine transcripts were then coded by the first author who engaged in regular discussions with the co-authors during this process to ensure methodological rigour. Similar codes were grouped together, and themes were identified and defined in a joint process by all authors. Qualitative content

analysis (Sandelowski, 2000) was then used to confirm and better understand each theme by counting the number of times each response (code) was identified (Figures 1 and 2). Counting the number of repetitions allowed us to identify which issues were most emphasised by MCHNs. Data are presented in themes and frequency.

Thematic and content analysis are commonly used in nursing research and were chosen for this study due to their unique suitability for conducting exploratory research in an area where little is known (Vaismoradi et al., 2013). Furthermore, thematic analysis has the added benefit of being a versatile and effective research method that can facilitate the nuanced understanding of rich and complex data (Braun & Clarke, 2006).

2.5 | Ethics considerations

This study was approved by the La Trobe University Low Risk Human Ethics Committee (reference HEC18512) and the Department of Health and Human Services, Centre for Evaluation and Research.

3 | RESULTS

3.1 | Participant demographic characteristics

Our sample consisted of 12 MCHNs, working across 11 Local Government Areas (LGAs) in regional ($n = 4$) and metropolitan ($n = 8$) Victoria. Participants were all female and predominantly worked part-time (Table 2). Most participants were between 45 and 54 years old and had between 10 and 20 years of experience as an MCHN. Seven MCHNs worked in communities with low socio-economic status, and half had indicated (in study one) that they were able to identify PNDA without screening for it (i.e., without use of a tool such as the EPDS).

3.2 | Themes

Two overarching themes were identified. Theme one, 'variations in screening practices', included three subthemes relating to MCHNs' various screening practices (i.e., who, when, how and how often) and the co-occurring factors which influence them (Figure 1). Theme two, 'systemic barriers hinder equitable screening', included two subthemes pertaining to the factors which impact equitable screening practices (Figure 2). Representative quotes from a range of MCHNs have been included, along with brackets containing each MCHNs' unique deidentified code and the geographical area in which they work—MCHNs working in a regional area are identified with 'R' and those working in metropolitan areas are identified with 'M' (e.g., MCHN 1, M).

3.2.1 | Theme one. Variations in screening practices

Screening: Who, when, how often and why

Overall, screening for PNDA was focussed on mothers (rather than all parents), however three MCHNs made attempts to also screen fathers by offering them the EPDS tool. They specified that screening fathers was not a workplace requirement, but a personal preference.

MCHNs all said that they screened mothers (in some capacity) during the 4-week KAS visit (as per Victorian practice guidelines). Three MCHNs said that this timing posed a possible threat to accurately identifying PNDA, given that most new mothers were still adjusting to motherhood at 4-week postpartum. Despite their view, all said that they continued to screen at the 4-week visit because, of the 10 KAS appointments they provided, this was the only appointment where there was additional time allotted specifically for PNDA screening.

"It's common knowledge that that's probably too early... I don't think you get an accurate, what's going on, because they're still recovering from the birth and everything at four weeks." (MCHN 6, R).

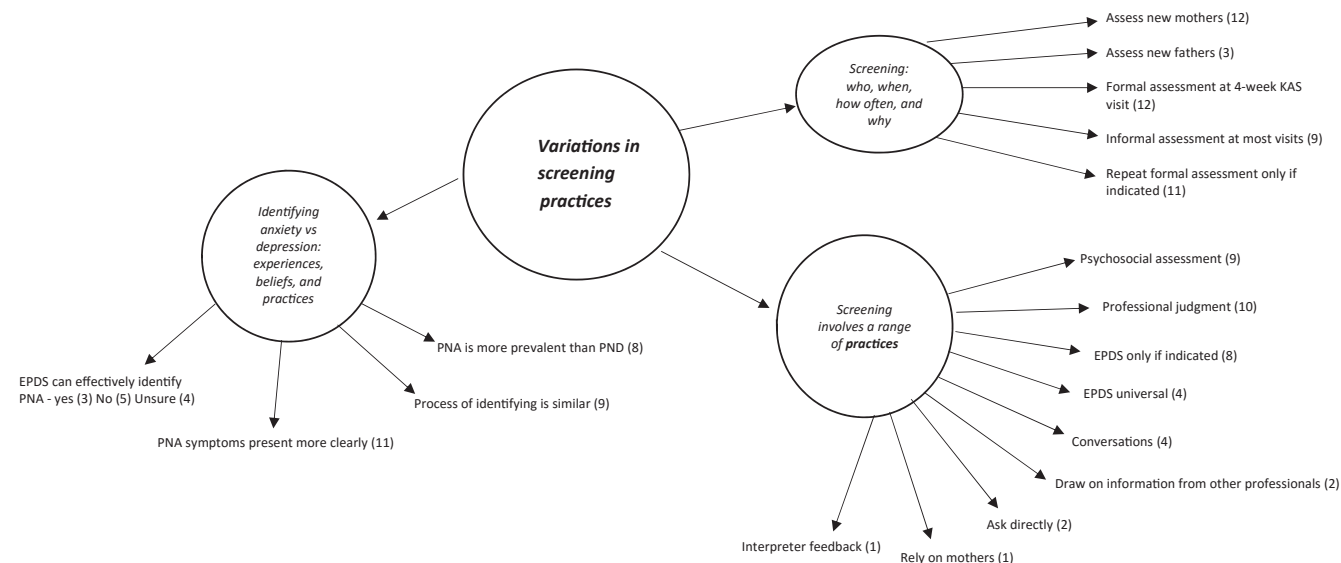


FIGURE 1 Variations in screening practices.

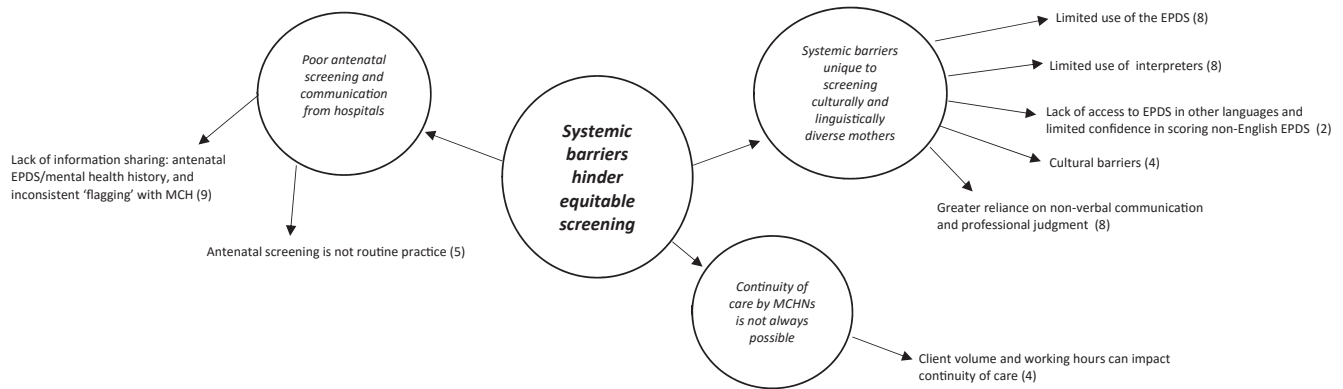


FIGURE 2 Systemic barriers hinder equitable screening.

TABLE 2 Demographic information of participants ($n = 12$)

Age	n (%)
45–54	6 (50)
55–64	4 (33)
≥ 65	2 (17)
Years of experience as an MCHN	
3–9	2 (17)
10–20	7 (58)
> 20	3 (25)
Role	
Universal MCHN only	6 (50)
Enhanced & Universal MCHN	5 (42)
Enhanced MCHN only	1 (8)
Employment hours	
Part-time	9 (75)
Full-time	2 (17)
Casual / Relief	1 (8)
Gender	
Female	12 (100)
Remoteness area	
Metro	8 (67)
Regional	4 (33)
Level of disadvantage in LGA	
High Disadvantage (1–5)	7 (58)
Low Disadvantage (6–10)	5 (42)

Following the formal 4-week assessment, most MCHNs ($n = 9$) said that they typically conducted an informal 'check-in' with mothers at each visit thereafter, to enquire about how they were feeling.

"I do it at every appointment pretty much... just ask how they're going emotionally." (MCHN 1, M).

"I always just ask general questions like, how are you travelling at the moment?" (MCHN 10, R).

However, nearly all ($n = 11$) said that repeated administration of the EPDS (after the 4-week visit) took place only if indicated. This was typical if a mother presented with poor affect (e.g., she was

tearful), verbalised that she was not coping, scored high on the initial EPDS and/or responded 'yes' to EPDS item-10 (i.e., thoughts of self-harm), did not appear to bond with her baby, and if the MCHN felt that she had not responded truthfully to the initial EPDS. Reasons for not repeating the EPDS (unless indicated) were: the belief that they were not required to do so ($n = 4$); lack of time ($n = 3$) and competing workplace priorities, particularly family violence screening ($n = 2$). The only MCHN who said she screened all mothers twice, said that her workplace provided additional time (at 3-month post-partum) to do so.

"There is no workplace policy (to repeat EPDS). It's just at our discretion." (MCHN 11, R).

"(PNDA) was top of the list of figures we were all talking about... But now, family violence is. And I think with my clients, family violence is probably more of a problem." (MCHN 3, M).

Screening involves using a range of practices

Most MCHNs ($n = 9$) said that they typically began their screening process by conducting some form of psychosocial assessment. However, there were notable practice variations between MCHNs regarding what this entailed. Four MCHNs used the 'parents and carers psychosocial assessment' questionnaire—a set of standard questions recommended by the Victorian Department of Health and Human Services (Department of Health and Human Services, 2019c). However, most took a less structured approach and used certain questions they had 'come up' with over their years of practice and/or looked for other indicators, such as reviewing hospital discharge notes regarding delivery complications, gestation at birth and medical history ($n = 5$). Some also enquired about current or past family/domestic violence ($n = 4$), and the level of family or social support available to mothers ($n = 2$).

"...questions I've come up with over the years (like): have you ever experienced depression in the past, or anxiety – or anyone in the family?" And that's pretty much all we say about it." (MCHN 12, M).

"If they've had the delivery from hell, or they've got a really prem baby...then I put a flag on their system." (MCHN 4, M).

Findings from the psychosocial assessment were often used to partially inform what most MCHNs ($n = 10$) felt was their most

reliable screening tool: their own experience and professional judgement. Sometimes referred to as 'experience and common sense' or a 'gut feeling', these MCHNs believed that while the EPDS was a useful screening asset, it was not as reliable in identifying PNDA as their professional judgement.

"Oh, look, it's experience and common sense." (MCHN 2, M).

"The Edinburgh just usually ends up confirming what you were thinking about with that mum." (MCHN 9, M).

In addition to the psychosocial assessment, most ($n = 8$) looked for the presence or absence of certain conditions or factors, to inform their professional intuition. These included: issues relating to infant sleep and settling, changes in mother's physical or emotional presentation, greater frequency of appointments initiated by mothers, and infant's presentation.

"You can see it in their body. If they ring you frequently ... or if the baby's not sleeping well, you think hang on a minute what's going on here?" (MCHN 1, M).

Personal views regarding what anxiety 'looked like' could also influence professional judgements:

"You feel they're not doing well. She's very anxious and it's not her first baby... that's what concerns me most." (MCHN 5, M).

"If I do a home visit, and the house is spotless, I think 'righto, I'm going to keep an eye on this lady. She's putting a lot of pressure on herself.'" (MCHN 11, R).

While all MCHNs said that they used the EPDS, most ($n = 8$) did not do so with every mother. MCHNs were less likely to administer the EPDS when: mothers did not read or speak fluent English ($n = 8$); mother's affect was 'normal' and/or she said she was feeling okay ($n = 4$); they believed that administering the EPDS to all mothers was not a workplace requirement ($n = 3$); they faced additional work and time pressures resulting from the COVID-19 pandemic ($n = 1$); or they had concerns regarding the likelihood of family violence and the mother's partner was present ($n = 1$).

"It's not something we have to do, it's only if we feel it's needed, if she (mother) said she wasn't managing." (MCHN 6, R).

"We have to clean the rooms before and after each appointment (due to COVID) and we still only have 45 minutes for those appointments. You tend to take shortcuts to keep your time management in place." (MCHN 12, M).

Despite not using the EPDS with all mothers, three MCHNs said that they always asked or talked about EPDS item-10 (relating to thoughts of self-harm) with all mothers. In fact, attaining an honest response to item-10 was very important to most MCHNs ($n = 8$).

"Number 10 is the big one, red flag and I tell them I'm really worried about them...I don't muck around with a "yes" to number 10." (MCH 8, M).

Moreover, overall EPDS scores offered most MCHNs ($n = 8$) important indicators, provided red flags, prompted urgent action, as well as plans for referral and follow-up.

"...if you get a score of 0 or 1, to explore that, and to actually ask if there's any reason that they wouldn't have filled it out honestly." (MCHN 5, M).

"...if she scores 12,13 or 14... we'd refer her." (MCHN 8, M).

Other ways of screening, in conjunction with those already described, included: conversations to 'check in' and explore ($n = 4$); asking mothers directly if they felt they were experiencing PNDA ($n = 2$); relying on mothers to be forthcoming about experiencing PNDA ($n = 1$); or drawing on feedback from interpreters ($n = 1$).

"I always preface it: 'I'm going to ask you the hard questions now. [Will you accept that]?... and then ask, are you aware of postnatal depression? Do you think that's you at the moment?'" (MCHN 7, R).

"It's not uncommon for an interpreter to talk to us after the consultation and say, 'I don't think she's telling us the whole story.'" (MCHN 5, M).

Identifying anxiety vs depression: Experiences, beliefs and practices

Five MCHNs expressed the view that depression and anxiety were often comorbid. However, most ($n = 8$) felt that anxiety was significantly more prevalent (than depression) and experienced by most mothers.

"Anxiety would be one of the most common referral criteria for my role, more so than depression. Everyone's saying, Anxiety, anxiety, anxiety." (MCHN 10, R).

"...in my experience, most women have anxiety. It's the age of anxiety." (MCHN 2, M).

MCHNs shared different views regarding why anxiety was so prevalent, including: anxiety was more socially acceptable and less 'taboo', making it easier to talk about ($n = 3$), mothers (particularly educated mothers) had unrealistic expectations of motherhood ($n = 2$) and mothers were choosing to have children later in life ($n = 1$).

"Maybe because everyone is talking about it, it's okay to be anxious". (MCHN 10, R).

"Upper middle-class people, well educated, with very high expectations of themselves." (MCHN 8, M).

Most MCHNs ($n = 9$) said that identifying PNA involved a similar process to that of identifying PND (i.e., combined use of psychosocial assessment, EPDS and professional judgement). However, all but one MCHN (who felt that she did not have a clear understanding of PNA) expressed that professional judgement was their most reliable tool for identifying PNA. Reasons for why professional judgement was so greatly relied upon were two-fold: first, MCHNs felt that symptoms of anxiety presented a lot more clearly than those of depression, making it easier to identify. MCHNs viewed obvious signs of anxiety as: increased frequency of contact by mothers, distressed demeanour and asking a lot of questions. Second, MCHNs ($n = 3$) had perceived mothers to be more forthcoming about their anxiety than depression.

"Just by observation, without even screening them. The anxiety displays itself very evidently by frequency of appointments; the questions asked..." (MCHN 5, M).

"You can tell with anxiety...mother's demeanour, pattern of speech, long list of questions they have." (MCHN 12, M).

Views regarding how effectively the EPDS could identify PNA varied: three MCHNs said that the EPDS effectively identified PNA, four were not sure either way and five said that it was not an effective tool for identifying anxiety. The most cited ($n = 5$) reason for

why the EPDS could not reliably identify PNA was that most of its questions related to depression, and that the anxiety specific questions were worded poorly, making it difficult for mothers to respond accurately ($n = 2$).

"It says, 'do you worry excessively for no apparent reason'... and it's like well, yeah, they worry but there's a reason for it." (MCHN 1, M).

3.2.2 | Theme two. Systemic barriers hinder equitable screening

Poor antenatal screening and communication from hospitals

Most MCHNs ($n = 9$) said that poor and inconsistent communication from hospitals was a common problem. This included inadequate information in the mothers' discharge summary regarding her mental health antenatally, and/or mental health history, lack of information regarding whether an EPDS was administered and/or an EPDS score, inconsistent efforts to communicate a need for urgent/priority contact by MCHNs following discharge.

"Never get a record of it, so in their discharge summary they would never put EPDS, which would be helpful." (MCHN 1, M).

"I can say that in the last 6–12 months, never (received information from hospital regarding mothers' mental health). Absolutely hopeless." (MCHN 2, M).

Some MCHNs ($n = 5$) believed that antenatal PNDA screening was not standard practice among most hospital healthcare workers, even in instances where mothers had a known history of depression and/or anxiety. Two MCHNs said that in their experience, mothers who gave birth at private hospitals were less likely to be asked about their mental health, while one MCHN said that physicians were less likely (than midwives) to conduct routine antenatal PNDA screening.

"(screening) depends on what hospital they've birthed at...private hospitals are shocking." (MCHN 10, R).

The combined impact of these challenges (lack of routine screening and poor communication from hospitals) meant that mothers who should have been flagged upon referral to MCH as 'at risk' or requiring more urgent attention were not always identified.

"I've just seen two babies that the private hospital should have flagged us, were quite urgent to see and they didn't. And I'm looking at them thinking they've been sitting there for a while." (MCHN 6, R).

Systemic barriers unique to screening culturally and linguistically diverse mothers

MCHNs identified a number of challenges which they felt made the identification of PNDA among Culturally and Linguistically Diverse (CALD) mothers (particularly those with limited English), significantly more difficult. These pertained to use of interpreters, administration of the EPDS, poor access to the EPDS in other languages, uncertainty around correctly scoring a translated EPDS and certain cultural barriers.

Most MCHNs (8) said that they did not routinely use an interpreter with Non-English-Speaking (NES) mothers due to: a lack of trust in how accurately things were being translated ($n = 8$), the additional burden of time it added to their already demanding workload ($n = 4$), and some mothers' reluctance to use an interpreter because they are known to them in the community ($n = 1$).

"I would never do it with an interpreter because I don't think the interpreter could interpret that and translate that well enough for us." (MCHN 10, R).

"...it takes forever (to use an interpreter), and we're really under the pump in time pressure." (MCHN 2, M).

Most MCHNs ($n = 8$) said that they seldom offered the EPDS to mothers who did not speak and read English well, unless she presented with obvious symptoms. The most common ($n = 8$) reason for not using the EPDS with every NES mother was reluctance to use an interpreter (due to the reasons outlined above). Other reasons included, a greater likelihood of illiteracy among NES mothers ($n = 3$), which made administering the EPDS in a mother's own language challenging.

Poor access to the EPDS in other languages and lack of confidence in adequately scoring a non-English EPDS ($n = 2$), and the belief that the EPDS just 'does not translate' ($n = 1$) were also identified barriers to its use among NES mothers.

"I have to find them first, which is never as easy as it should be ... then you'd have to work out which questions you score which way." (MCHN 3, M).

"The words that are in the actual questions don't translate properly into their own language. They tell me that, interpreters tell me the same." (MCHN 9, M).

While language barriers were predominantly unique to NES mothers, cultural barriers impacted NES and CALD mothers (who were proficient in English) equally. Specifically, MCHNs ($n = 4$) said that mental health was often viewed as a foreign and poorly understood concept within some CALD communities, that mental health (particularly poor mental health) was less likely to be openly discussed or acknowledged, and that there was a greater sense of distrust in institutions and services among some CALD communities.

"Usually it's something very foreign (mental health) they (CALD mothers) say no, that's right we don't talk about it". (MCHN 1, M).

"...I feel a lot like mental health in non-English backgrounds is a bit hidden. Not often spoke about." (MCHN 3, M).

"They (CALD mothers) are more likely to say everything's okay because they have got a fear of services... they (worry) if they say they're not managing that we might then come in and take their kids." (MCHN 6, R).

As a result of these challenges, most MCHNs ($n = 8$) said that in lieu of the EPDS and a thorough psychosocial assessment, they relied on other things to identify PNDA among CALD/NES mothers. These included asking more direct questions (e.g., 'are you feeling sad?' or 'are you crying a lot?'), relying more on hand gestures and facial expressions, taking more notice of mothers' body language and demeanour, and looking for other signs (e.g., poor infant sleep).

"I ask them, 'Do you cry?' Well, I show them with my fingers what crying means, they say, 'No, no.' Or 'Yes, yes'. You can use your hands a lot." (MCHN 2, M).

"Their body language tells you something and then they talk about how bad baby's sleeping and he's a naughty boy and you go, hang on a minute." (MCHN 1, M).

4 | DISCUSSION

To our knowledge, no previous studies have undertaken a detailed investigation of the screening practices of Victorian MCHNs. This study offers new evidence which addresses this knowledge gap and has relevance for other similar systems in Australia and internationally.

Consistent with findings from comparable international studies, (Borglin et al., 2015; Kang et al., 2019; Noonan et al., 2017) we found that MCHNs were committed to identifying and supporting women experiencing PNDA. However, our results indicate the absence of a systematic approach to the identification of PNDA, and an overall lack of uniformity in screening practices between MCHNs. Although all said that they conducted some form of mental health assessment during the 4-week KAS visit, how this manifested in practice largely varied between MCHNs. While some conducted routine (and comprehensive) psychosocial assessments, most took a less structured approach, with obvious variations between MCHNs regarding which psychosocial risk factors were assessed. Similar findings have been reported in qualitative Australian studies by Rollans et al. (2013) and Sims and Fowler (2018) who found that MCHNs undertook psychosocial assessments in various ways, with Rollans et al. (2013) reporting that assessments were not always conducted in line with recommended guidelines. Although evidence regarding the use of structured psychosocial questionnaires versus a less structured approach is mixed (Austin, 2014), there is little debate that risk factors for PNDA are complex (e.g., domestic violence, substance misuse and history of abuse) (Ramakrishna et al., 2019; Zhao & Zhang, 2020). Gaining a comprehensive understanding of the number and nature of existing risk factors is critical to the provision of appropriate care pathways and is endorsed by Australian and other relevant international expert committees (Austin, 2014; Austin et al., 2017). Moreover, a comprehensive psychosocial assessment can facilitate important conversations and information sharing between MCHNs and the women they support (American College of Obstetricians and Gynecologists Committee, 2018; Austin et al., 2017).

Similarly, we found that while administration of the EPDs was largely at MCHNs' discretion, there was no systematic process in place to support MCHNs in making this important decision. To that end, MCHNs predominantly relied on their professional judgement to identify PNDA, with most deciding to administer the EPDS only if they believed PNDA symptoms were apparent. Our findings are consistent with existing evidence (Arefadib et al., 2021; Goldin Evans et al., 2015; Puspitasari et al., 2021) that highlight heterogeneous PNDA screening practices among healthcare workers, including

midwives. In a cross-sectional study of 118 healthcare workers, Puspitasari et al. (2021) found that nearly 40% used a validated screening tool only when women expressed PNDA symptoms.

Evidence suggests that screening with a validated tool (such as the EPDS) improves PNDA detection (Reilly et al., 2020) as well as professional responsiveness and screening frequency (Clevesy et al., 2019). Conversely, failure to screen with a validated tool, and relying predominantly on professional judgement, can result in approximately half of women with PNDA remaining undetected (Anding et al., 2015; Puspitasari et al., 2021). In a quasi-experimental study involving 104 community-based midwives, Anding et al. (2015) found that midwives who relied only on their professional judgement, failed to identify 50% of mothers experiencing severe postnatal depression. Previous research has shown that perceived lack of time and expressed negativity toward the EPDS tool reduces the likelihood of its use among MCHNs (Arefadib et al., 2021; Higgins et al., 2018), particularly when assessing CALD and NES mothers (Prady et al., 2021). Our results support this finding, demonstrating a clear pattern in MCHNs' reluctance to administer the EPDS to mothers from CALD backgrounds, particularly those with limited English proficiency.

A growing body of evidence indicates that immigrant women experience significantly higher rates of PNDA (Falah-Hassani et al., 2015; Giscombe et al., 2020; Ogbo et al., 2019) than their native-born counterparts. In a systematic review, Falah-Hassani et al. (2015) found that compared with non-immigrant women, the prevalence of PND among immigrant women was 1.5 to 2 times greater. Moreover, those with limited local language ability experienced a greater prevalence of PND than immigrant women proficient in the language of the host country. Considering this evidence, we were concerned to find that poor English proficiency was the most frequently cited barrier to MCHNs administering the EPDS. This was mostly due to MCHNs reluctance to utilise an interpreter, given the additional burden of time associated with communicating through an interpreter, and the belief that interpreters were unable to effectively translate what was being said. Similar findings were reported in a systematic review by Prady et al. (2021) who found that midwives evaded use of interpreters because it was time consuming. We found that in the absence of interpreters and the EPDS tool, MCHNs relied solely on their professional judgement and even resorted to hand gestures to ask women important questions about their mental health. There is evidence to suggest that such screening discrepancies contribute to inequitable PNDA identification among CALD mothers universally (Arefadib et al., 2021; Prady et al., 2021; Redshaw & Henderson, 2016).

4.1 | Strengths and limitations

This is the first study to explore in detail, Victorian MCHNs' PNDA screening practices and highlights opportunities for a more systematic and equitable approach to PNDA screening.

Our purposeful sampling facilitated diversity across a range of participant personal and professional characteristics. We also

adhered to recommended strategies to ensure validity, reliability and rigour (Korstjens & Moser, 2018). Our study also has several limitations. It is possible that our results are influenced by self-selection bias given that those who participated in the study may have a special interest in perinatal mental health, and as such their views and practices do not accurately reflect those of all MCHNs.

Finally, because all 12 participants were aged 45 or older, and most had over 10 years of professional experience, we cannot be certain that our findings are reflective of the experiences of MCHNs with less clinical experience. However, while the Victorian government does not publicly share the demographic profile of MCHNs, existing evidence suggests that, like our sample, the majority of Victorian MCHNs are over the age of 45 and have more than 10 years of experience as an MCHN (Family and Community Development Committee, 2018; Hooker et al., 2021). This offers some encouragement that our sample is largely representative of Victorian MCHNs.

5 | CONCLUSION

Our findings have significant implications for future policy, research and practice. While best-practice guidelines support a uniform approach to PNDA screening, our findings reveal systemic barriers which impede equitable PNDA screening, irrespective of women's cultural background, language and literacy skills and the setting in which they give birth. MCHNs can be better supported to carry out their important work by having access to continued education, training and mentorship regarding PNDA, as well as the EPDS, particularly its application among mothers from non-English speaking backgrounds. Additionally, there is an urgent need to improve antenatal PNDA screening and the way in which hospitals (both private and public) communicate and share information with the MCH service. Such efforts are likely to promote a multidisciplinary approach to supporting better health and well-being outcomes for women and their families.

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CONFLICT OF INTEREST

The authors declare that they have no known conflict of interest, including any competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available upon reasonable request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS STATEMENT

This study was approved by the La Trobe University, Science Health & Engineering College Low Risk Human Ethics Committee (reference HEC18512) and the Department of Health and Human Services (DHHS), Centre for Evaluation and Research.

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