'Baby Coming You Ready' an innovative screening and assessment tool for perinatal mental health with Aboriginal families: a protocol for pilot evaluation

Keywords Aboriginal perinatal mental health, evaluation protocol, screening and assessment

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Note: Within Western Australia, the term Aboriginal is generally used in preference to Aboriginal and Torres Strait Islander in recognition that Aboriginal people are the original inhabitants of Western Australia. Therefore, in this paper, the term Aboriginal will be used to respectfully encompass the Aboriginal and Torres Strait Islander peoples and their unique ways of 'knowing, being and doing' that are culturally specific to their 'country' affiliation. No disrespect is intended to Torres Strait Islander peoples or communities.

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What is known about the topic

- Standard screening tools for mental health and social and emotional wellbeing (SEWB) developed for mainstream populations are not suitable or effective with Aboriginal women.
- Perinatal depression and anxiety among Aboriginal mothers and fathers need to be understood, identified and supported.
- Aboriginal people experience complex trauma that is rarely considered in mainstream services.

What this paper adds

- The Baby Coming You Ready (BCYR) program is a culturally secure, innovative approach to the identification of perinatal distress in Aboriginal women and their families.
- The pilot evaluation will use a robust mixed methodology.
- Aboriginal Elders and stakeholders are involved with the planning, analysis and interpretation of data.

Abstract

Introduction The Baby Coming You Ready (BCYR) program emerged from the Kalyakool Moort PhD research which explored barriers and enablers to effective mental health screening. Current practice using the Edinburgh Postnatal Depression Scale (EPDS) has not been validated for use with Aboriginal women. Our aim is to pilot a clinically and culturally effective alternative for practitioners to assess and support Aboriginal women's social and emotional wellbeing (SEWB) and health outcomes during pregnancy and early parenting.

Methods and analysis Diverse pilot sites have been selected in metropolitan Perth and regional perinatal health settings. This

study will use a mixed method approach to data collection and analysis. The aim is to improve service quality and implementation science (IS) is the best way to promote the uptake of evidence-informed practices into 'business as usual'. This methodological approach specifies context mechanisms to explain what works, for whom, under which circumstances, and how. Additionally, the most significant change (MSC) technique will be drawn on to illuminate similarities and differences in what the different groups and individuals value. Qualitative data will be obtained from interviews and focus groups with clients, practitioners and managers, and analysed using thematic analysis. De-identified quantitative data will be obtained from i) the WA Health (STORK) midwifery data set and ii) the digitised BCYR rubric.

The Lead Research Group and Aboriginal Research Reference Group will maintain research governance oversight via regular review cycles over an 18-month period. Members will guide the synthesis and interpretation of evidence, and recommendation development and dissemination will be based on the evaluation findings. The pilot study will collect the clinical evidence needed to support a future state-wide and national rollout.

Background

Routine perinatal maternity care includes clinical measures and risk screening for mental health, smoking and alcohol use, and family and domestic violence (FDV) exposure. Risk screening is intended as a means of understanding a woman's needs to provide supportive interventions during pregnancy and beyond. Standard screening tools, developed for mainstream populations, are neither suitable nor effective with Aboriginal women (Marley et al. 2017; Chan et al. 2018, 2021; Kotz et al. 2021).

There has been little improvement in Aboriginal maternal and infant outcomes since the Council of Australian Governments announced "closing the gap" in 2007. Many of these outcomes are linked with poor maternal mental health and wellbeing. Despite the intention of universal perinatal mental health screening, the mental health of Aboriginal women continues to decline (Lima et al. 2019).

The impacts of colonisation, dispossession and long-term social and economic consequences have had unique influences on the mental health of Aboriginal Australians. These include intergenerational and complex trauma, cultural disruption, and social inequities such as poverty, racism, housing pressures, illness and suicide (AIHW 2020). Aboriginal women experience significant risks to their mental health including high rates of family violence, premature births, infant death and child removal (Adane et al. 2021; AIHW 2021; AIHW 2020; Mah et al. 2019; O'Donnell et al. 2008).

Culturally unsafe maternity services, fragmented service delivery and inadequate consultation with Indigenous women about service design has resulted in their disengagement from mainstream maternity care (Marriott R et al. 2020, 2021). Aboriginal mothers experience alarmingly high rates of mental health problems (Lima et al. 2019; AIHW 2020), yet remain under-screened and poorly managed (Gausia et al. 2013). Inadequate antenatal care and maternal distress contribute to unacceptable disparity in Aboriginal maternal/infant outcomes (AIHW 2020; Mah et al. 2019).

Perinatal clinical care focuses on risks, health behaviours, physical outcomes and routine mental health screening using the Edinburgh Postnatal Depression Scale (EPDS). Identifying and enhancing strengths is ignored. Improving health and wellbeing is likely to continue to fail to improve significantly for Aboriginal mothers and infants unless social and emotional wellbeing (SEWB) and influencing factors are prioritised in perinatal care (Steering Committee for the Review of Government Service Provision [SCRGSP] 2020).

Overall, a growing recognition of the contextual importance in identifying perinatal mental health concerns led to the development of broader psychosocial assessments such as the Antenatal Risk Questionnaire (ANRQ) (Austin et al. 2013) and the two-Part Kimberley Mums Mood Scale (KMMS) (Marley et al. 2017). While these tools shift towards including SEWB influences, there are notable limitations for widespread use with Aboriginal women. The need for a comprehensive, holistic, culturally safe and strengths-based approach to understanding Aboriginal women's SEWB is warranted.

The Baby Coming You Ready (BCYR) pilot project emerged from the Kalyakool Moort PhD study (Kotz 2021) with a view to developing a culturally safe perinatal mental health assessment process. BCYR is a co-designed culturally safe model for perinatal mental health and SEWB screening for Aboriginal parents. This strength-based, trauma-informed approach to perinatal assessment and follow-up supportive care has been designed to:

- Enhance maternal agency.
- Support trusting therapeutic relationship and engagement.
- Improve fidelity and accuracy of perinatal SEWB screen/assessments.
- Enhance cultural safety.

The co-design process included Aboriginal and non-Aboriginal professionals, managers and researchers from multiple sectors working with and for Aboriginal families. BCYR has emerged to effectively replace culturally unsafe and positively biased approaches to perinatal mental health screening practices including the EPDS, tobacco, alcohol and other drugs (AOD) and FDV screening.

BCYR validity

Each separate component/element embedded within BCYR: supports practitioners in the use of evidence-based strategies i.e. narrative therapy (Simmons & Mozo-Dutton 2018) using "clinical yarning" (Lin et al. 2016); uses the Kessler 5 (McNamara et al. 2014) plus two additional questions; and incorporates motivational interviewing within identified stages of change (Holt et al. 2017; Levounis & Marienfeld 2017) and brief intervention strategies (Saitz et al. 2014). This was followed by beta-testing (proof of concept of a digital application) the digitised BCYR rubrics with 12 Aboriginal new mothers, five new Aboriginal fathers and 12 midwives/child health nurses (CHN). The subsequent focus groups and workshops added strength to the cultural, face and content

validity. Suggested amendments were made and approved by the Kalyakool Moort Elders Cultural Safety Group, the Lead Research Group and the Aboriginal Working Party.

BCYR overview

The BCYR program centres around touchscreen digitised rubrics (one for each parent). The wrap-around program includes the BCYR website hosting (i) identified gaps in knowledge for Aboriginal parents in the perinatal years and (ii) access to interactive professional resources/referral sources and the BCYR Professionals Training (eLearning). BCYR supports Aboriginal women to retain control over their perinatal care whilst building practitioner capacity to sensitively collect highly relevant psychosocial information that supports individualised effective and relevant care planning.

Using smart technology on iPads and a suite of culturally safe relevant touchscreen images depicting common real-life events and scenarios, Aboriginal voice-overs guide the users through self-reflection and self-assessment of social determinants. The focus is on strengths and protective factors. The parent selects images she relates to, prioritises her strengths for enhancing and any concerns/worries she has, then a self-directed way forward (management plan) is jointly developed. The selected images generate an automated clinical event summary that links to each service's electronic patient health records and the national My Health Record.

Aims and objectives of the pilot

Aims

The BCYR pilot will demonstrate a culturally responsive care approach to perinatal mental health screening and assessment with Aboriginal women and their families. The pilot will determine the readiness (useability, acceptability and fidelity) of the BCYR assets for widespread application.

Objectives

The objectives of the pilot are to evaluate whether BCYR supports:

- Patient safety: does the BCYR rubric provide a culturally safe process for Aboriginal women to discuss their individual circumstances relevant to their SEWB and pregnancy care (qualitative data on patient acceptability/quality of care experience).
- Practice effectiveness: does the BCYR rubric promote effective woman/practitioner engagement and support practitioners to have meaningful, respectful clinical discussions with Aboriginal women related to their SEWB (qualitative data on practitioner acceptability).
- Professional capacity building and training effectiveness.
- Health record integration: is the BCYR rubric able to seamlessly integrate with existing information systems and produce appropriate clinical reports (clinical documentation integrity).
- Improved clinical maternal and infant outcomes for women who engage with BCYR.

Methods

Design

The pilot study evaluation design will use a mixed method approach. Research governance will have oversight through the Lead Research Group and Aboriginal Research Reference Group with identified review cycles over an 18-month period. These groups are comprised of researchers and service users, community organisations and Aboriginal women previously involved in the development phase of BCYR. The team members will guide the evidence synthesis and interpretation, and the development and dissemination of recommendations based on review findings. The overarching frameworks are implementation science (IS) and the most significant change (MSC) technique.

Implementation science (IS)

IS is the study of methods and strategies to promote the uptake of evidence-informed practices into 'business as usual', with the aim of improving service quality (Eccles & Mittman 2006). Evidence-informed programs and practices are incorporated into 'business as usual' at very different speeds and there is often a gap between what we know works and what's being done in practice. There are many reasons for this. Sometimes the research is difficult to access and translate into a real-world environment; sometimes the evidence-informed program or practice is not a good fit for the local context; sometimes the service provider or staff are not interested in making changes to how they work; and sometimes there are barriers relating to the broader operating context such as funding models. The field of IS aims to close this gap between research and practice.

Drawn from realist evaluation (Chakravartty 2007), the pilot will be utilising IS, described by Hateley-Browne et al. (2019) as the best theoretical approach to evaluate the active process of integrating evidence-informed programs (in this case BCYR) into real-world clinical settings. This approach focuses on 'how' a program or practice fits into and improves a service. It is ideal for evaluating evidence-based programs in clinical practice settings. We will progressively explore and move toward outcomes (for mother, infant, clinician and service) that are explicitly valued, and away from less valued directions.

There are four operational strategies to this progressive exploration (Figure 1). There are four main stages of IS. Having completed the first two stages – (i) engagement/exploration and (ii) planning/preparation – we will be undertaking (iii) initiation/refinement and then (iv) maintenance/expansion. We will investigate what works (or doesn't work) for whom and under what circumstances from the perspectives of all users – client, clinician, manager and service (Figure 2).

IS will be the umbrella approach which safeguards sustainability, with other evaluation methods addressing aspects of the overall evaluation strategy. These include MSC, process, and impact evaluation methods.

Most significant change (MSC)

MSC (Davies & Dart 2005) explores the impact and most significant change occurring as a result of engaging with BCYR. This will be

measured at specified time points as well as longitudinally across time intervals. It focuses on changes in behavioural, physical, relational and attitudinal changes through engagement with BCYR. Exploration of the MSC between using BCYR compared with other screening tools (e.g. EPDS) will also be undertaken when applicable. It will involve collection and participatory interpretation of stories of significant change according to the following domains:

- Quality of experience from perspectives of both users (trust, safety, acceptability).
- Nature of participation in screening process (engagement, worth, value, benefit).
- Usability of the BCYR process.

The benefits of using MSC include structured in-depth development in thinking, changes in thinking among staff, learning through the process rather than just measuring, and working together with all the key stakeholders (community, workers, management and researchers).

The implementation of MSC involves:

- Establishing:
  - Champions at each site.
  - Domains of change.
- Collecting stories.
- Reviewing (de-identified) stories with:
  - BCYR Research Reference Groups.
  - Participating services.
  - Practitioners (midwives, Aboriginal Liaison Officers and managers) soliciting perceptions of the MSC within specified domains.
- Continuing analysis of MSC stories with service providers and Lead Research Group, e.g. does story priority vary according to different stakeholders?
- BCYR research team determining quantification and setting MSC priorities with stories.

Pilot sites

The pilot sites are in selected metropolitan Perth and regional health settings, across nine organisations, with 12 sites included. The implementation phase is staged over 2 months. Training, both eLearning and face-to-face delivery, is undertaken prior to an information session and the dissemination of tablet devices and the BCYR program package.

Participants

The total number of practitioners/service providers who have completed the training is 45. The number at each site depends on the size of the service or team. Metropolitan teams are larger in size and some rural sites may have only one or two practitioners.

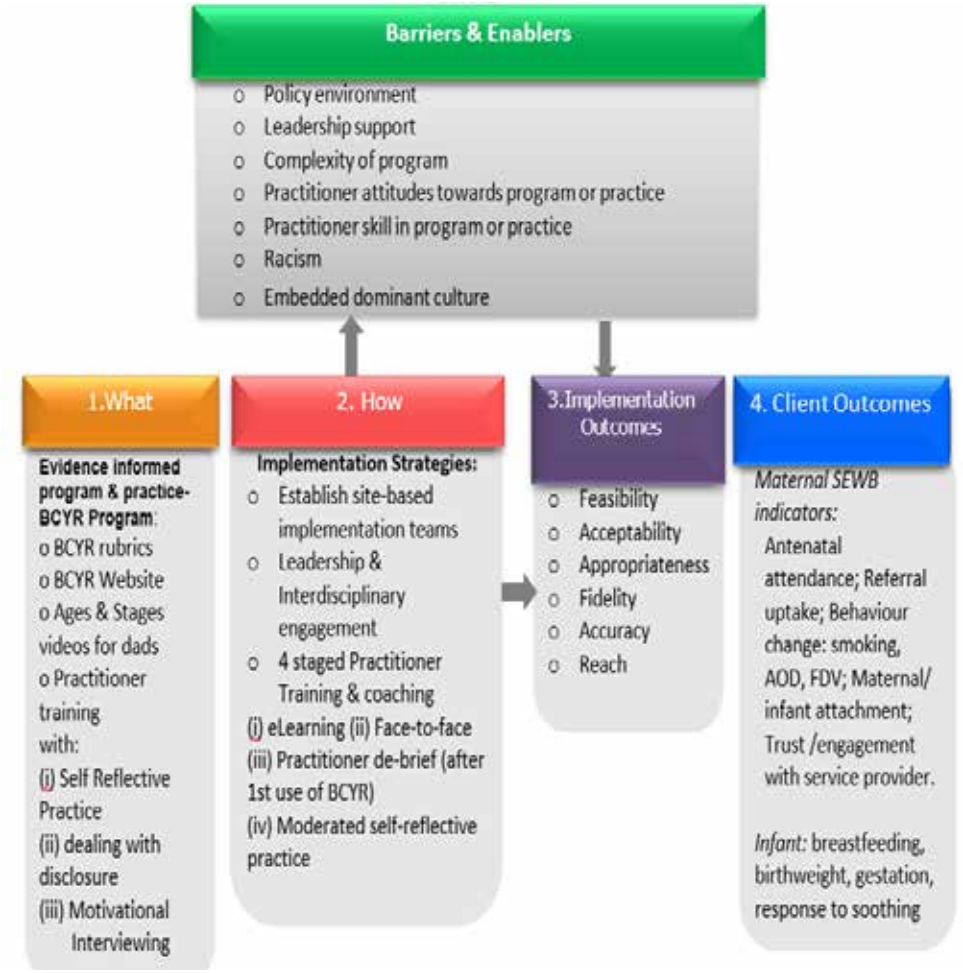

Figure 1. IS stages (realist evaluation) (Hateley-Browne et al. 2019)

The BCYR assessment is administered by either the midwife or CHN.

All practitioners using BCYR will be interviewed individually after initially using the rubric for the first time. This interview supports de-briefing and self-reflective practice and will begin to explore IS parameters (Figure 2). Later, small groups in moderated sessions after four to five implementation sessions using BCYR will explore the same parameters. Service managers will be interviewed quarterly. Consenting clients will be interviewed at three time points – directly after the initial BCYR assessment (within 7 days), at approximately 20 weeks and again at approximately 8 weeks post-birth. We anticipate enrolling approximately 30 women in an initial interview and up to 10 in all three interview sessions.

Data collection

PROCESS evaluation

This will assess how well the BCYR program functions, its usability, and its relevance in a variety of perinatal healthcare contexts using varied health management systems. The following sections will be assessed (Table 1):

- Acceptability criteria: for BCYR's capacity to support:
  a. Replacement of current screening for:
     i EPDS
     ii FDV
     iii AOD
  b. Psychosocial assessment.
  c. The clinical event summary.
  d. Referrals.
  e. Increased collaborations, e.g. Aboriginal parents and families.
  f. Practitioner's confidence in responding to disclosure.
  g. Development of relevant management plans.
- Usability and experience using the BCYR:
  a. Website.
  b. Resources and referral pathways.
  c. Ages & Stages short films.

IMPACT evaluation

This will use multi-methods evaluation criteria; short-term impacts for the target groups and examination of whether the BCYR pilot met its stated aims will be evaluated. The BCYR pilot is expected to demonstrate measurable short- and medium-term benefits and impacts for the:

- Parent.
- Infant.
- Clinician.
- Manager and service.

Inter-rater reliability / implementation

Healthcare providers from selected organisations will undergo specific training in implementing the BCYR process, and information regarding their role in the research, including clarification of the role as a midwife versus the role as a researcher (i.e., data recording and collection and paperwork). Aboriginal research assistants (ARAs) will receive inter-rater reliability training in the use of 'yarning' as a data collection strategy and the MSC technique.

Table 1. PROCESS evaluation in the BCYR

	Evaluation sections				
Evaluation elements	**Women's rubric**	**Men's rubric**	**Website**	**Referral pathways**	**Training**
	Images	Images	Women's content	Functionality	eLearning
	Voice-overs	Voice-overs	Men's content	Usability	Face-to-face
	Skip logic	Skip logic	Ages & Stages films for dads	Applicability	Self-reflection
	Practitioner guidelines prompts feature				Motivational interviewing
	Free text feature				Dealing with disclosure
	CES				Self-care
	Follow-up usability	Follow-up usability			Time / structure
	Support	Support			

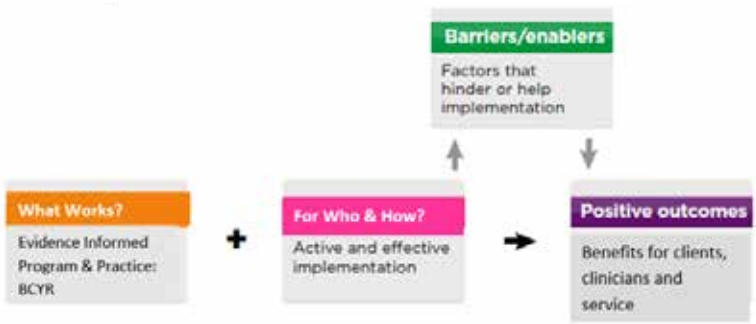

Figure 2. IS: realist evaluation considerations

Data collection methods

The BCYR assessment/screen is being offered to *all* women at pilot sites as part of their routine perinatal care in an additional 30-minute standalone appointment even if they decline or are unsuitable to participate in the research interviews. It was considered ethical to not offer BCYR to clients as a replacement to current mental health, FDV and AOD screening which are considered positively biased and culturally unsafe.

The BCYR de-identified data will be part of the pilot evaluation. The BCYR appointment is scheduled as close as possible, preferably within 7 days of the initial intake assessment. At the conclusion of their first intake appointment, clients will be invited to their next BCYR assessment appointment and offered an opportunity to participate in the research interview. If they are interested, they will be given the BCYR pamphlet and the more detailed BCYR information sheet to take home for consideration. At the conclusion of their next appointment, the BCYR assessment/screen, they will be asked if they still wish to participate in the research interviews. If they consent, they will be given the BCYR consent form and followed up by the trained ARA for the semi-structured interview (yarn) at a convenient time.

Qualitative data collection

Yarning as a credible and rigorous form of research (Bessarab & Ng'andu 2010) will be drawn on as the principal data gathering tool among Aboriginal mothers and fathers. Information will be gathered through relaxed discussion in a manner that is familiar and culturally safe. Semi-structured 'yarning style' interviews, focus groups and questionnaires will be employed with practitioners:

- Mothers: semi-structured narrative approach to yarning sessions will be facilitated at three key points for antenatal entry mothers as previously mentioned.
- Fathers: one yarning session will be facilitated within 48 hours of administration of BCYR.
- Practitioners (midwives, CHNs, Aboriginal Liaison/Health Officer (ALO): three semi-structured reflective interview sessions will be facilitated with each midwife, CHN and ALO:
  - A de-brief session over the phone within 48 hours of first administering BCYR. Self-reflective practice will be encouraged, drawing on trauma-informed culturally competent care (Varghese et al. 2018).
  - Small focus group sessions facilitated after administering BCYR a number (3–4) of times (ZOOM or Microsoft Teams).
  - Finally, subject matter expert focus group sessions will be facilitated with practitioners and, if feasible, mothers, exploring identified domains of inquiry drawing on i) the MSC technique (Davies & Dart 2005) and ii) the realist evaluation technique (Chakravartty 2007).

Quantitative data collection

We expect to demonstrate measurable short-term impacts (including trust and engagement, self-disclosure, self-assessment regarding distress, AOD etc.) and medium-term impacts. These data will be collected according to automated de-identified data from BCYR and the midwives reporting data:

- At discharge (midwives reporting data):
  - Appointment attendance rates.
  - Referrals.
  - Birth details: APGARs, breast feeding.
- At 8 weeks post-partum: CHN/home visiting midwife assessment.
- BCYR de-identified: data rates of:
  - FDV, AOD, smoking, negative life events.
  - Stages of change over time.
  - Kessler 5 + two results.

The following techniques will be employed by participants:

- Mothers: Maternal data collection: data collected through: (i) yarning sessions; (ii) midwives reporting data; (iii) BCYR rubric de-identified data; and (iv) CHN/midwife home visit assessment.
- Baby: Infant data collection will be gathered through: (i) semi-structured interview with CHN; (ii) midwives mandatory reporting data; and (iii) CHN questionnaire.
- Practitioners: a pre- and post-questionnaire is sent to all staff participating in the BCYR training via an online survey for the eLearning and face-to-face training. The 63 questions require a reflective approach to how the training was received, and strengths and weaknesses. The survey asks the practitioner to rate their pre- and post-knowledge and the perceived impact on their practice. A 6-month follow-up survey will assess their confidence in using the BCYR and further training requirements.

Analysis

The data from all sources will be brought together and analysed by the research team with qualitative and quantitative researchers and practitioners, and preliminary analysis will be undertaken in readiness to workshop outcomes in review meetings. There will be three meetings held every 3–4 months once data has been collected from all sites. The review meetings will present the findings to the Lead Research Group and the Aboriginal Advisory Group who will analyse and interpret the findings for discussion and agreement according to the criteria in Figure 3.

Cultural considerations

The evaluation will be conducted according to Aboriginal values and principles (National Health and Medical Research Council

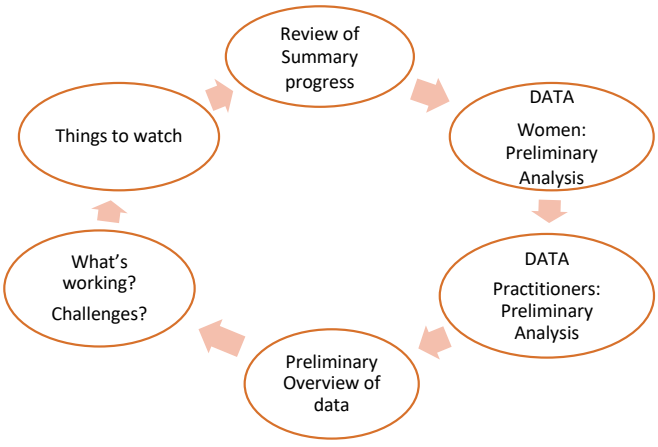

Figure 3. Review meeting process

[NHMRC] 2018). Aboriginal voices are paramount in directing the interpretation of implementation and findings. There may be cultural differences between rural and metropolitan communities which will impact on service delivery. Given the challenges of the different contexts and emerging issues it will be critical for reflection by Aboriginal researchers, colleagues and Elders to analyse what works and what lessons are learnt. This will be important for the final part of the evaluation when reviewing the rubric, the implementation process, the acceptability by women, and the impact of the training with practitioners.

Ethics, generation of recommendations and dissemination of findings

Ethics and dissemination approval was obtained from the Human Research Ethics Committee of Murdoch University (2021/101); Western Australian Aboriginal Health Ethics Committee (WAAHEC) (HREC553); the Research Governance Service (RGS) (RGS002649); and St John of God Health Care HREC (#1162). Pilot sites have individually approved site-specific agreements through RGS. Interim reports on the progress of the pilot evaluation will be provided through the website https://babycomingyouready.org.au/ and through various reports to funders and sites participating. Findings of this study will be submitted for publication/s in peer reviewed journals.

Phase 2 of the pilot (2023)

The pilot study design will be expanded to incorporate other areas in Western Australia to collect the clinical evidence needed to support a future national rollout.

Significance and conclusion

The significance of a study like BCYR will have far-reaching effects in the longer-term to identify and support Aboriginal women and their families with their pregnancy and follow-on support into parenting. Currently, Aboriginal maternal mental health requires urgent attention as women are not being screened and followed up through mainstream services. The BCYR digital application will provide a strengths-based and culturally secure approach to engaging and working with women on the issues of most significance to them. Practitioners will be more informed on culturally acceptable approaches which involve women as partners in their pregnancy care, wellbeing and pathway to parenting.

Contributorship

The authors are members of the Ngangk Yira research team and have contributed to the conception and design of the pilot evaluation framework and protocol. All authors contributed to the writing and revision of the manuscript.

Conflict of interest

The authors declare no conflicts of interest.

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