SUPPORTING YOUNG PARENTS

ADDRESSING PERINATAL AND YOUTH MENTAL HEALTH NEEDS

PANDA
Perinatal Anxiety & Depression Australia

orygen

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The final report reflects Orygen's analysis and independent conclusions. It may not necessarily reflect all the opinions or conclusions of key contributors.

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GLOSSARY AND TERM LIST

Antenatal the time period before birth and during pregnancy

AOD Alcohol and other drugs

COPE Centre of Perinatal Excellence

CBT Cognitive behaviour therapy

DBT Dialectical behaviour therapy

EPDS Edinburgh Postnatal Depression Scale

IPS Individual Placement and Support

Neonatal relating to newborns

PANDA Perinatal Anxiety & Depression Australia

Perinatal relating to the time before and after birth

Postnatal relating to the time period after birth

Postpartum relating to the time period after birth

PTSD Post-traumatic stress disorder

QALY Quality-adjusted life years

Note The current report predominately uses the term 'mothers' to refer to the pregnant parent and the term 'fathers' and 'non-birth parent' to refer to the partner of the pregnant parent as this reflects the research and data that has been referenced. To date, research and data collection has taken a limited and heteronormative view on pregnancy and parenting. While some of the available research into the mental health of fathers may be relevant to non-birth parents, we have recommended that an LGBTIQ+ research agenda is developed to better understand the unique experiences of LGBTIQ+ parents.

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Orygen acknowledges the Traditional Owners of the lands we are on and pays respect to their Elders past and present. Orygen recognises and respects their cultural heritage, beliefs and relationships to Country, which continue to be important to the First Nations people living today.

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EXECUTIVE SUMMARY

Parenthood can be both a joyful and challenging time. While many young parents are well equipped and well supported, young parents are disproportionately impacted by mental ill-health and mental health risk factors during the perinatal period. Young mothers are at higher risk of a wide range of mental ill-health experiences, and young fathers or non-birth parents disproportionately experience a number of mental health risk factors. Unintended pregnancy, sole parenting, family violence and experiences of stigma can all increase mental ill-health or distress, and may be more pertinent to young parents than other age groups.

Both mental ill-health in the perinatal period and young parenthood are associated with significant social, vocational and economic impacts, highlighting unmet support needs for young parents and parents with mental ill-health. Despite the need to focus on supporting young parents, the specific mental health and wellbeing needs of young parents are often overlooked in existing services, guidelines and frameworks. Young parents require focused attention to ensure that they receive adequate and appropriate perinatal mental health support.

SEEKING AND ACCESSING SUPPORT

Parents experience a number of known barriers to accessing mental health support during the perinatal period. One reason for low help-seeking rates may include concerns about child protection notifications, particularly given that intrusive thoughts are common during the perinatal period. Additionally, despite an increased focus on mental health screening for women, barriers to universal screening for all parents remain.

PERINATAL MENTAL HEALTHCARE

Parents have access to a broad range of health professionals, peer workers, hospitals, perinatal organisations, early parenting centres, digital supports and helplines. Young parents identified that the perinatal mental health system is the most appropriate system to address their needs. However, perinatal mental health services reported an absence of focus on vocational supports, few referral pathways between youth mental health supports, and that youth-specific supports may benefit some young parents.

INTEGRATING CARE

A number of opportunities exist for perinatal and youth mental health services to collaborate to support young parents. Partnership between these sectors could result in appropriate training for health professionals and other staff to support young people with perinatal mental ill-health, developing stronger awareness of service options and referral pathways between sectors, provide collaborative care, co-facilitate young parent groups and provide pathways to appropriate vocational support.

SOLUTIONS

1. Develop a perinatal mental health research agenda that addresses key gaps in the experiences of young mothers, fathers and non-birth parents; LGBTIQ+ parents; and parents with complex or low prevalence mental ill-health.
2. Develop a national perinatal mental health strategy, which should include a dedicated focus on young parents.
3. Establish a joint agency taskforce to implement the national perinatal strategy.

4. The current review and update of the national perinatal mental health clinical practice guidelines should include a unique focus on young parents, developed in partnership with young parents. Guidelines should include:
    a. best-practice models for mother-baby units that include partner engagement and considerations for siblings;
    b. addressing fear of child protection notifications as a barrier to help-seeking; and
    c. screening, services and referral pathways for people experiencing family violence.
5. Expand the Perinatal National Minimum Data Set to include mental health and vocational indicators, and perinatal mental health screening data. Data and reporting should allow for young parents to be separately analysed.
6. Collect and publish national data for mother-baby units. Reporting should allow for separate analysis of young parent data.
7. Assess the service need for mother-baby units in each state and territory and ensure adequate resourcing to enable coverage.
8. Assess the youth-friendliness of mother-baby units and develop and trial youth-specific supports in partnership with young people and youth mental health services. The trial should be conducted for two years across different states and territories, prioritising sites providing care to a greater number of young parents.
9. Fund a trial that augments PANDA's national perinatal mental health helpline with webchat support, designed in partnership with young parents. The two-year trial and evaluation should include all parents and assess age differences in efficacy, preference and support.
10. Fund existing online perinatal mental health websites to augment their website with specific content aimed at young parents. This should include:
    a. resourcing for a co-design process with young parents;
    b. information in multiple languages;
    c. information for the health workforce that enables referrals between perinatal and youth mental health services; and
    d. unique information for schools and employers supporting young parents.
11. Perinatal and youth mental health services should work with young parents to:
    a. audit and map available training;
    b. co-develop augmented training with youth-specific information, referral pathways and experiences; and
    c. produce and distribute a national resource that can be adapted to both perinatal and youth mental health services.
12. Develop nationally consistent, best-practice guidance for inclusion of pregnant young people and young parents in education. Guidance should include systemic policies and a number of supports and interventions that schools can provide, based on co-design with young parents and evidence-based solutions.
13. Expand the Additional Child Care Subsidy eligibility to include young people engaging in education.
14. Develop, trial and evaluate pathways between perinatal mental health services and youth mental health International Placement and Support (IPS) services to support young parents with mental ill-health who are not currently engaged in education or employment. Commission a two-year trial of IPS service access for young parents. Priority should be given to sites in the Northern Territory, Queensland and Tasmania.

INTRODUCTION

Pregnancy and parenthood can be both a joyful and challenging time for new and expectant parents. Experiences of mental ill-health are common during the perinatal period, which includes both the antenatal (before birth) and postnatal or postpartum period (commonly defined as up to 12 months after birth). In Australia, perinatal depression and anxiety impacts one in five mothers or one in ten fathers or non-birth parents.(1)

Young parents are disproportionately impacted by mental ill-health during the perinatal period. Evidence suggests that mothers under 25 years of age in Australia experience perinatal depression at a higher rate than mothers of other ages.(2) The mental health impacts may be increasing, as a UK study reported that a quarter of young pregnant women showed signs of depression or anxiety, an increase from 17 per cent in the 1990s.(3) Research also indicates that young fathers are more likely to report experiencing stress than older fathers.(4) However, non-birth parents are not necessarily men, and the lack of academic literature and programs to support LGBTIQ+ parents is a significant gap.

Perinatal and youth mental health services and experts were consulted for this report, along with a group of young mothers in Australia. Perinatal Depression & Anxiety Australia (PANDA) assisted with the identification of key stakeholders, provided advice on key issues, assisted with the design and recruitment of consultations with young parents, and provided their expertise in reviewing this report. Notably, young mothers reported that the perinatal mental health sector was best placed to address most of their needs. However, perinatal mental health services acknowledged a service gap in education and employment support, which is a core pillar of youth mental health services. Some young parents also reported that youth-specific supports can be isolating and further stigmatising, as they are already at risk of feeling labelled or defined by their age and disconnected from other people accessing perinatal mental health supports.

For this reason, many of the policy solutions developed herein focus on opportunities for the perinatal sector more broadly. Where youth-specific opportunities are identified, it is recognised that young parents are not a homogenous group and these initiatives will allow young parents to choose supports aligned to their preferences. There are opportunities for perinatal mental health services and youth mental health services to work together in developing training on young parents for the health workforce, providing young parents groups, and developing stronger referral pathways. Youth mental health services have particular expertise in supporting young people with mental ill-health to reach their vocational goals. The identified opportunities provide a comprehensive and cohesive approach to supporting all parents, while supporting the specific needs and preferences of young parents.

YOUNG PARENTS

Young parents are not a homogenous group. Consultations with stakeholders for this report acknowledged vast differences in experiences of the perinatal period for parents aged 25 or under. Parenthood experiences can include: young parents with adolescent or young adult pregnancies; young parents living with their parents, with partners, alone or in insecure housing; planned or unplanned pregnancies; and partnered or sole parenthood. The predominant focus on the traditional child and adult dichotomy in perinatal care has led to differences in perinatal supports between adolescents and young adults. Some young adults may benefit from youth-focused (12 to 25 years) supports during the perinatal period.

Depending on their needs, a range of mental health services are available for young parents. Young parents have access to both perinatal mental health services and youth mental health services. Young parents may find one or both systems to be more beneficial depending on their needs, which may change over the perinatal period. For example, young parents whose main concerns involve parenting and bonding will likely receive the most appropriate support from perinatal services, as well as young parents who no longer feel developmentally aligned with youth-specific supports.

Consultations with perinatal mental health services indicated that young parents might feel uncomfortable discussing breastfeeding and pregnancy issues in youth mental health services and that service providers outside of the perinatal mental health system are unlikely to have the relevant knowledge or skills to support parents with these issues. Additionally, consulted young parents identified that they preferred to receive the same care and support as parents of other ages and felt that youth supports can be 'othering'. However, for young parents who find youth-friendly environments more appropriate or who are looking for age-appropriate support to reach education and employment goals, youth-focused mental health services may be more appropriate. Additionally, youth mental health services have a focus on promoting early help-seeking and engaging young people from diverse backgrounds, which will be essential in engaging some young parents.

Consultations with perinatal mental health services noted very few relationships and referral pathways to youth mental health services. They also noted that some young parents were less interested in engaging in perinatal mental health services, and that care was sometimes more complex than other age groups requiring responses to issues relating to childhood trauma, family violence and drug and alcohol use. While each service stream has specific expertise, both sectors require stronger referral pathways in both directions to enable collaboration in care provision and knowledge sharing.

YOUNG MOTHERS

Many young mothers experience both joyful and challenging times during pregnancy and parenthood. While young mothers in Australia have reported experiencing positive feelings such as an added depth of meaning when becoming a parent, many experience similar challenges to all new mothers, such as difficulties with routine and feeling overwhelmed.(5) However, some challenges are more pertinent for younger mothers. International evidence indicates that adolescent and young adult mothers are more likely to rate their infant's health as suboptimal, have lower healthy prenatal care behaviours, and experience physical abuse, stressful life events and depressive symptoms.(6) A study of Australian adolescent parents (between 13 and 19 years old) reported that 20.5 per cent had experienced sexual or physical abuse, which was associated with postnatal depression and anxiety.(7) Children born to mothers aged under 25 are at a higher risk for perinatal mortality and children to parents under 20 are at a higher risk of being born pre-term.(8) These risks disproportionately expose young mothers to significant adverse life events. While young parents often face a range of challenges, consulted services indicated that young parents were also sometimes more flexible, resilient and less rigid in their approaches than other parents. Young mothers disproportionately experience mental ill-health and adverse life events which require comprehensive care.

Mothers aged 25 or under represent almost 17 out of every 100 births in Australia (Table 1).(9) In 2019, there were 51,551 births to mothers between 15 and 25 years old in Australia, which includes 6,358 births to mothers between 15 and 19 years old.(9) Notably, these statistics do not include fostered, adopted or step-children, nor does it necessarily include young people who gave birth in previous years. Births to young mothers aged 25 years or under are at a historic low, and the average age of new parents

TABLE 1: NUMBER OF BIRTHS TO YOUNG WOMEN IN 2019 (PERCENTAGE OF TOTAL BIRTHS)(9)

MATERNAL AGE	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUSTRALIA
15-19 years old	1,969 (2.0%)	920 (1.2%)	1,907 (3.1%)	736 (2.2%)	356 (1.8%)	178 (3.1%)	79 (1.4%)	213 (5.8%)	**6,358 (2.07%)**
20-25 years old	14,238 (14.4%)	8,771 (11.4%)	11,887 (19.3%)	4,861 (14.5%)	2,964 (15.2%)	1,106 (19.3%)	552 (10.0%)	813 (22.2%)	**45,193 (14.8%)**
Total	**16,207 (16.4%)**	**9,691 (12.5%)**	**13,794 (22.3%)**	**5,597 (16.7%)**	**3,320 (17.0%)**	**1,284 (22.4%)**	**631 (11.4%)**	**1,026 (28.0%)**	**51,551 (16.9%)**

continues to rise. While births to mothers aged 25 or under account for 16.9 per cent of all births, a decrease from 23.0 per cent in 2009, births from mothers aged 15 to 19 fell from 4.2 per cent to 2.1 per cent of all births over the same period. Data for young mothers varies across state and territories. While mothers under 25 years old account for 28.0 per cent of all births in the Northern Territory in 2019, the account for 11.4 per cent of births in the ACT. Similarly, births to mothers between 15 to 19 years old represent 5.8 per cent of all births in the Northern Territory and 1.2 per cent of all births in Victoria.

Some groups are overrepresented in Australian adolescent pregnancy data. In 2017, rates for births to mothers aged 15 to 19 were higher in rural and remote areas than major cities (21 births per 1,000 compared to 3.2 births per 1,000), in areas of greater socio-economic disadvantage than in higher socio-economic areas (21 births per 1,000 compared to 1.7 births per 1,000).(10) Aboriginal and Torres Strait Islander women under 25 years old account for 43.4 per cent of births, compared to 11.8 per cent of births to non-Indigenous women in 2018.(11) In 2018, births to women under 20 account for 11.9 per cent of all births to Aboriginal and Torres Strait Islander women (compared to 1.5 per cent of all births for non-Indigenous women), and births to women between 20 to 24 years old account for 31.5 per cent of births to Aboriginal and Torres Strait Islander women (compared to 10.3 per cent of births to non-Indigenous women). Initiatives for young parents must be appropriate and acceptable to young people in regional areas, areas of greater socio-economic disadvantage and Aboriginal and Torres Strait Islander young people.

MENTAL HEALTH

While perinatal mental health research has seen inconsistent age-related outcomes, there is some evidence to suggest that young mothers are disproportionately impacted by mental ill-health. In a longitudinal analysis of 4,262 Australian women, mothers aged under 25 were found to be at higher risk of mental ill-health in later life, particularly if they were adolescent mothers.(12) In Canada, nearly two in three young mothers report at least one mental health concern, and almost 40 per cent reported more than one mental health issue.(13) Mental health impacts to young mothers are likely disproportionate and places them at risk for experiences of mental ill-health later in life.

DEPRESSION

Perinatal depression is the most prevalent perinatal mental health concern, impacting one in five mothers.(1) Risk factors for maternal depression during pregnancy include maternal anxiety, stress and a history of mental ill-health; demographic factors, such as lower income and lower education levels; relationship factors, such as being unpartnered and poor relationship quality; a lack of social support; unintended pregnancy; domestic violence; and smoking.(14) There is evidence to indicate that young mothers are more likely to experience one or more of these risk factors.

Younger maternal age is a common risk factor of perinatal depression.(15) International evidence finds adolescent mothers to be approximately twice as likely to experience maternal depression than mothers of other ages.(16) Adolescent mothers are more likely to experience risk factors for depression than older mothers, such as high levels of isolation from peers, being single, higher levels of family conflict, lower self-esteem, greater body dissatisfaction, being more likely to be having their first child, lower socio-economic status and limited social support.(16) Other risk factors more relevant for young mothers include negative perceptions about their own pregnancy and high levels of family criticism.(17) In adolescents, maternal depression is highest from the child's first to fourth year,(16) and being under 25 at the time of first birth is associated with maternal depression at four years postpartum.(18) Despite young parents requiring perinatal mental health support years after birth, many perinatal mental health services are only able to provide services to parents within one-to-two years following the birth of their child. The extended period of time in which young parents can experience perinatal depression indicates that services should be available to flexibly provide parents up to starting school age.

ANXIETY

Mothers of all ages experience anxiety during the perinatal period. The reported prevalence for any anxiety disorder ranges widely across different measures and communities, with one review finding anxiety prevalence to be between 2.6–36.9 per cent during the antenatal period and 3.7–20.0 per cent during the postnatal period.(19) The review also found that maternal anxiety in the perinatal period was associated with younger maternal age, and associations between maternal anxiety and other demographic factors, such as being unpartnered, completing lower levels of education, unemployment and housing or financial difficulties; health and lifestyle factors, such as smoking, being overweight and genetic/biological factors; social and relational factors, such as a lack of support within family or partner relationships and domestic violence; psychological factors, such as previous experiences of mental ill-health, negative self-perception or low self-esteem; prior perinatal loss; and infant-related concerns, such as health issues or issues with breastfeeding. Young mothers experience many of these risk factors at a higher rate than older mothers. Broad health and social supports appear to therefore be pertinent to reducing the risks and severity of anxiety among young mothers during the perinatal period.

COMPLEX OR LOW PREVALENCE MENTAL HEALTH ISSUES

Low prevalence mental ill-health concerns (i.e. complex and severe mental ill-health that affect fewer people) can arise during pregnancy. More than one presenting issue, complex mental health refers to the interplay between the individual, workforce, and service system.(20) Postpartum psychosis occurs in 1–2 per cent of pregnancies and usually requires the support of mother-baby units or inpatient care.(21, 22) There is some evidence to indicate that young parents may be at an increased risk of experiencing postpartum psychosis.(23) While there is a paucity of research on postpartum psychosis, bipolar disorder is a known major risk factor.(24) Additionally, one to two per cent of women experience postnatal post-traumatic stress disorder (PTSD), with subjective distress and obstetric emergencies being the top risk factors, followed by infant complications, low support during labour and delivery, previous experiences of trauma and mental ill-health during pregnancy.(25) Studies have also found that there is a strong association between antenatal depression and anxiety and disordered eating during pregnancy, as well as some evidence for a correlation between disordered eating and obsessive compulsive symptoms during pregnancy, and between depressive symptoms and disordered eating during the perinatal period.(26)

For some young parents, complex and low prevalence mental ill-health is pre-existing. Borderline personality disorder has been associated with adolescent pregnancies and unplanned pregnancies.(27) A study of adolescent females with bipolar disorder found that five per cent had experienced pregnancy.(28) Parents with pre-existing mental ill-health concerns can experience relapse or recurrence during the perinatal period. In an Australian study, one in five (22.5 per cent) pregnant women with severe mental ill-health were admitted for psychiatric care during the antenatal period.(29) Another study reported that mothers under 30 years old had twice the risk of postpartum bipolar relapse (60 per cent risk) as mothers over 30 years old (30 per cent risk).(30)

Medication use is an important consideration for mothers with complex or low prevalence mental ill-health. For example, people with bipolar disorder require preconception guidance as some medications are not suitable for pregnant women, but medication should be withdrawn gradually.(31) Due to the high risk of relapse in the postnatal period, medication use is often encouraged after delivery, impacting breastfeeding.(31)

Young parents with complex or lower prevalence mental health concerns require complex service responses. Very little is known about the experiences of young parents with low prevalence mental health concerns, despite evidence that transitions to parenthood may be particularly difficult for young people with pre-existing mental ill-health and that young parenthood may be associated with some mental health concerns. A strong research agenda is required to better understand the support needs of young mothers with complex or low prevalence mental ill-health.

SELF-HARM AND SUICIDE

Suicide and self-harm can be a risk for some mothers during the perinatal period. The Australian Institute of Health and Welfare (AIHW) lists suicide as the leading cause of maternal death in Australia, with Aboriginal and Torres Strait Islander mothers disproportionately impacted.(32) While this data indicates that suicide may be more pertinent for mothers aged 35 years or older, increases to suicide-related behaviours and thoughts have been reported during the postnatal period for adolescent mothers.(16) Maternal suicidal ideation may have long-term impacts on mother and infant bonding.(33) Researchers have previously noted that perinatal self-harm has been overlooked as the perinatal period is considered a protective factor for self-harm for the general population, but self-harm is still prevalent in this period for people with mental ill-heath.(33) To adequately support young mothers, research is needed to better understand perinatal self-harm and suicide prevalence and risk factors.

ALCOHOL AND OTHER DRUG USE

Alcohol and other drug (AOD) use is associated with perinatal depression and anxiety. It is estimated to cost the Australian health system and economy $77 million in the first year after birth and $155 million in years two to three.(1) Australian mothers with complex mental health concerns have high AOD use during pregnancy,(29) and AOD use in the perinatal period is more likely to occur for younger mothers than mothers of other ages.(34) Services must be able to competently support new or expecting parents with AOD concerns, and may benefit from preventive interventions for people with complex mental health concerns.

SUMMARY

Mothers aged 25 or under represent almost 17 of every 100 births in Australia.

While many young mothers share experiences that are similar to all new mothers, they are more likely to experience mental ill-health and mental health risk factors during the perinatal period.

Experiences of perinatal depression are more likely to be extended across years for young mothers, often requiring services for longer than they are currently available.

A strong research agenda is needed to better understand the prevalence and service needs of young mothers during the perinatal period, particularly for parents with complex and low prevalence mental ill-health.

> “Mental health impacts to young mothers are likely disproportionate and places them at risk for experiences of mental ill-health later in life.”

YOUNG FATHERS AND NON-BIRTH PARENTS

Orygen acknowledges that families are diverse, and that more research addressing the needs of LGBTIQ+ parents is required. The over-use of the term 'father' or 'fathers' in this report is not because it is considered synonymous with 'non-birth parent', but used when it is the most accurate term to reflect the referenced research.

As with young motherhood, young parenthood can be a joyful time for fathers and non-birth parents. Young fathers have reported feeling accomplished and proud, experiencing strong emotional connections to their children and benefits to being a father at a young age.(35) However, some experiences associated with adolescent fatherhood such as lower levels of academic completion, lower socio-economic status, greater likelihood of engaging in offending behaviours, and having peers who are engaged in anti-social behaviour, suggest that some young fathers may need additional supports.(36)

In 2019, there were 29,475 births to fathers between 15 to 25 years old in Australia, including 2,505 births to fathers between 15 to 19 years old (Table 2).(9) Births to fathers aged 25 or under account for 10.0 per cent of all births, a decrease from 13.1 per cent in 2009. Births to fathers aged 15 to 19 fell from 1.5 per cent to 0.9. This varies across state and territories, with fathers under 25 years old accounting for 16.6 per cent of all births in the Northern Territory, and 6.3 per cent of births in the ACT.

Although fathers and non-birth parents have traditionally had less involvement in perinatal care compared to mothers, there is evidence to suggest that expectant parents want fathers to have more involvement in healthcare during the pregnancy.(37) Evidence from the United Kingdom suggests that over half of all fathers were present at pregnancy checks and for one or more antenatal tests, and almost all were present for ultrasound examinations and labour.(38)

Additionally, the same study suggests that male partners of younger women were more likely to attend antenatal checks, obtain information, be present for labour and were less likely to have a negative reaction to pregnancy. Given that many young fathers and non-birth parents are engaging with perinatal healthcare, there are available opportunities for services to provide mental health screening and early intervention, and to build rapport.

LGBTIQ+ PARENTS

There is a paucity of research and data that describe the experiences of LGBTIQ+ parents, both nationally and internationally. As most perinatal mental health research utilises heteronormative assumptions, binary gender identities and predominately examines heterosexual relationships, experiences of LGBTIQ+ parenthood and their perinatal service needs are not adequately understood.(39) A better understanding is needed to address the significant barriers that the LGBTIQ+ community experience in accessing mental health supports.(40) Existing research and service data not been designed to adequately capture the experiences of LGBTIQ+ parents.

Non-birth mothers experience issues that are not experienced by male non-birth parents, such as having few role models to help them navigate their parenting role and not being adequately recognised as a parent by others.(41) Despite structural barriers, such as limited representation in resources or in the language used by some services, non-birth mothers report positive and inclusive experiences with maternity healthcare staff.(42) However, consultations with perinatal mental health organisations have reported negative experiences with staff and services.

Many trans and non-binary people who were assigned female or intersex at birth experience pregnancy and engage in family-building.(43) Trans and non-binary people may experience dysphoria, isolation, exclusion, anticipated or experienced poor care, and may need to discontinue testosterone therapy, which may increase the likelihood of perinatal mental ill-health.(44) An Australian study of pregnant and parenting trans men identified issues

TABLE 2: NUMBER OF BIRTHS TO YOUNG MEN IN 2019 (PERCENTAGE OF TOTAL BIRTHS)(9)

PATERNAL AGE	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	AUSTRALIA
15-19 years old	686 (0.7%)	416 (0.5%)	774 (1.3%)	320 (1.0%)	145 (0.8%)	78 (1.4%)	28 (0.5%)	58 (1.9%)	**2,505 (0.9%)**
20-25 years old	7,925 (8.4%)	5,225 (6.9%)	7,551 (13.0%)	2,922 (9.1%)	1,787 (9.5%)	789 (14.2%)	310 (5.8%)	459 (14.7%)	**26,970 (9.2%)**
Total	**8,611 (9.1%)**	**5,641 (7.4%)**	**8,325 (14.3%)**	**3,242 (10.1%)**	**1,932 (10.2%)**	**867 (15.6%)**	**338 (6.3%)**	**517 (16.6%)**	**29,475 (10.0%)**

with exclusion in formal fertility services and experiences of isolation and loneliness, and reported that healthcare workers in reproductive health settings require more training to ensure inclusive experiences for the trans community.(45) Change is needed to support LGBTIQ+ families to have inclusive, safe and supportive healthcare during the perinatal period.

Perinatal mental health services consulted for this report confirmed the paucity of research available, but some highlighted that they felt equipped to support LGBTIQ+ parents. Other consulted perinatal mental health organisations noted that there is a need for more training, and that services feeling equipped does not always translate to LGBTIQ+ parents feeling safe to access services or access support. In 2013, the Bouverie Centre developed *Guidelines for Healthcare Providers Working with Same-Sex Parented Families*.(46) These could be updated and expanded to reflect the current needs of other LGBTIQ+ parents, include training for the workforce and be more directly aimed at ensuring that services adhere to removing structural and service-related barriers.

MENTAL HEALTH

While perinatal mental health services have traditionally focused on the mental health of mothers, there is a growing acknowledgement that the mental health of fathers and non-birth parents needs to be supported by services and guidelines. Fathers with previous experiences of mental ill-health, low family income or poor relationships are at a greater risk of mental ill-health during the perinatal period.(47) This may be more pertinent for younger non-birth parents, as fathers between 18 and 35 years of age are more likely to report feeling that their stress levels had increased a lot in the first 12 months of fatherhood (29 per cent compared with 17 per cent for older fathers).(4) Despite the known mental health impacts on fathers and non-birth parents during the perinatal period, almost half of new Australian fathers are not aware that both parents can be affected by perinatal depression or anxiety, and almost a third view postnatal depression or anxiety as a sign of weakness.(48)

In addition to benefits for their own mental health, addressing the mental health of fathers and non-birth parents supports maternal mental health. Supportive partners can be a protective factor for maternal mental health and a major influence in recovery.(47, 49) However, experiences of mental ill-health in fathers and non-birth parents may impair their ability to support their partner. There is strong evidence that paternal depression has a positive correlation with maternal depression and is associated with a worsening or continuation of maternal depression.(50, 51) Fathers can also be a barrier to help-seeking for mothers during the perinatal period.(6) Supporting the mental health of fathers and non-birth parents is essential in providing perinatal mental health care for mothers.

Support for a wide range of challenges during the perinatal period are sought by fathers and non-birth parents, as evidenced by common themes identified in a study of 462 male callers to PANDA's national helpline in 2014.(47) Counsellors recorded an emotional issue for 83.5 per cent of callers, in which callers were overwhelmed (50.9 per cent) or anxious (50 per cent), followed by irritable (40.6 per cent), angry (35.8 per cent), depressed (30.2 per cent), crying (25.5 per cent), feeling hopeless (24.5 per cent), feeling guilty (23.6 per cent) or feeling unable to cope (23.6 per cent). Of the 62.2 per cent of all calls that recorded relationship-based issues, most reported relationship strain (83.5 per cent), followed by relationship breakdown (31.6 per cent) and poor attachment to the baby (8.9 per cent). Half of all male callers identified physical issues, predominately related to low energy, poor sleep, exhaustion and fatigue. In addition to calling perinatal mental health hotlines for their individual mental health needs, fathers also called to receive support, advice and information about their partner's mental health, including mood instability, suicide attempts and psychosis. There may be missed opportunities for preventive supports or early intervention as 43.3 per cent sought information for postnatal depression compared to 4.7 per cent for antenatal depression. Supports for fathers and non-birth parents must address a wide range of common issues, and should focus on both their individual mental health needs and the needs of their family.

DEPRESSION

Perinatal depression is the most prevalent perinatal mental health concern, impacting one in 10 fathers or non-birth parents.(1) A meta-analysis reported that paternal prenatal depression had a similar prevalence to paternal postpartum depression (9.8 per cent and 8.8 per cent, respectively).(52) Notably, as this analysis included studies published before 2014 and identified that these studies were associated with a lower prevalence of postpartum depression, the reported data may underestimate current prevalence. A number of risk factors have been associated with paternal depression, such as poor sleep quality, poor couple adjustment or declines in couple adjustment, partners with antenatal depressive symptoms, elevated parental stress, financial stress, history of mental ill-health, lower levels of education and unplanned pregnancy.(53, 54) More research is needed to better understand the current prevalence and risk factors of depression in the perinatal period for all non-birth parents.

Adolescent fathers are more likely to experience financial disadvantage, low parental socio-economic status, challenging and antisocial behaviour, and lower academic results.(36) This may disproportionately expose younger fathers to risk factors for mental ill-health, such as financial stressors, insecure employment and insecure housing. However, studies have been inconsistent on the impact of age on paternal depression. One meta-analysis identified that fathers over 18 years of age are more likely to experience postpartum depression, possibly due to more independent responsibilities and lower support than adolescent fathers, yet the prevalence of postnatal depression also decreases with age.(52) Research suggests that depressive symptoms for young resident fathers increased by an average of 68 per cent five years after becoming a father,(55) and that young fatherhood was associated with third-year paternal depression.(56) This suggests that perinatal services must extend their current inclusion criteria to provide services medium-term services and ensure that young parents are adequately supported.

ANXIETY

Many fathers or non-birth parents experience anxiety during the perinatal period. A systematic review of 43 studies found that the prevalence of anxiety disorders in fathers ranged from 4.1–16.0 per cent during the antenatal period and 2.4–18.0 per cent during the postnatal period.(57) These wide ranges are partially explained by differences across cultural settings, such as fathers in countries with better paternity leave experiencing lower anxiety prevalence. Paternal anxiety during the antenatal period impacts their mental health, physical health, social relationships and parenting skills.(58) Risk factors for anxiety in fathers during the antenatal period include previous experiences of mental ill-health, stress, low levels of prenatal attachment, anxiety surrounding the birth, presence at birth of during a past delivery, having twins, lower education and income levels, intolerance of uncertainty, low self-esteem, work-family conflict, frequent alcohol use, smoking, a partner with mental ill-health, low co-parenting support, low social support and a lack of practical support.(58) Younger fathers are at a greater risk of anxiety during the perinatal period,(58-61) which may be partially explained by the number of overlapping risk factors between paternal anxiety in the perinatal period and young fatherhood.

COMPLEX OR LOW PREVALENCE MENTAL HEALTH ISSUES

Currently, there is a significant paucity of research on complex or low prevalence mental health issues in fathers or non-birth parents, particularly young parents. Complex mental health can refer to the interplay between the individual, workforce, and service system.(20) Without adequate research, associations between complex mental ill-health and the perinatal period for fathers and non-birth parents are unclear. Given the available evidence that complex mental ill-health can emerge in the perinatal period for mothers, and that transitions to parenthood can be a difficult time for the mental health of fathers or non-birth parents, further research needs to determine the prevalence and support needs of fathers and non-birth parents with mental ill-health.

SELF-HARM AND SUICIDE

There has been limited research into the self-harm and suicide of fathers and non-birth parents during the perinatal period. However, a study of 650 men in Brazil found that 4.8 per cent of fathers were at suicide risk in the postnatal period, and that fathers with depression were 21.0 times more likely to be at risk of suicide than fathers without a mood disorder.(62) No significant age-related differences were found. Research is needed to understand the prevalence and risk factors of self-harm and suicide-related behaviours in fathers and non-birth parents during the perinatal period, and should examine for differences by age.

ALCOHOL AND OTHER DRUG USE

AOD use during the perinatal period can have wide-ranging impacts. Previous research has reported that the strongest predictor of maternal smoking during pregnancy was their partner's smoking status, and high levels of alcohol consumption in fathers was associated with an impaired mother-infant relationship.(49) For young fathers, marijuana use has been associated with almost double the risk of elevated depressive symptoms during the perinatal period.(63) Given the known barriers to connecting young people with AOD services,(64) the perinatal mental health sector will need to carefully assess how to best support and refer young parents.

PERINATAL MENTAL HEALTH RESEARCH

With the exception of research on depression and anxiety in mothers, major gaps exist in perinatal mental health research. The available research leaves several questions unaddressed, including:

- the prevalence, risk factors and effective supports for the mental ill-health of young parents, including low prevalence or complex mental ill-health, self-harm and suicide;
- the experiences of young mothers, young fathers and non-birth parents;
- the service needs of young parents;
- effective supports to reducing or supporting mental ill-health recurrence for parents with pre-existing complex or low prevalence mental ill-health diagnoses;
- the prevalence and effective interventions for supporting complex or low prevalence mental ill-health in fathers and non-birth parents;
- the prevalence and service needs for LGBTIQ+ parents with mental ill-health, including young parents;
- the experience of young parents in mother-baby units;
- impacts of perinatal mental ill-health to friends and family;
- a comprehensive economic analysis of the cost of perinatal mental ill-health in Australia, including a wide range of impacts and mental health concerns; and
- effective interventions that support education and employment participation for young parents.

A perinatal mental health research agenda should be developed to address these gaps and other gaps identified by young parents, LGBTIQ+ parents, parents with complex and low prevalence mental ill-health, the perinatal mental health sector and perinatal mental health researchers.

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
ADDRESS KEY GAPS IN PERINATAL MENTAL HEALTH RESEARCH			
Develop a perinatal mental health research agenda that addresses key gaps in the experiences of young mothers, fathers and non-birth parents; LGBTIQ+ parents; and parents with complex or low prevalence mental ill-health.	To date, perinatal mental health research has focused on depression and anxiety, and research on young parents has focused on adolescent pregnancies. A perinatal mental health research agenda should include a focus on young parents and be designed in partnership with perinatal and youth mental health services, and young parents.	Policymakers and perinatal and youth mental health services have a better understanding of the unique needs of young parents, LGBTIQ+ parents and parents with complex or low prevalence mental ill-health.	National Health and Medical Research Council, Medical Research Future Fund.

SUMMARY

Young fathers and non-birth parents may need more wide-ranging health and social supports than older parents.

There is a paucity of research on fathers and non-birth parents, particularly for young parents.

More research is needed on the prevalence, experiences and service needs of young parents, LGBTIQ+ parents, and parents with complex or low prevalence mental ill-health.

> “Given that many young fathers and non-birth parents are engaging with perinatal healthcare, there are available opportunities for services to provide mental health screening and early intervention, and to build rapport.”

CONSIDERATIONS

Experiences of parenthood can look significantly different between young parents. Some of these experiences can be risk factors for mental ill-health, and many are more pertinent to young parents than parents of other ages. For example, some young parents consulted for this report identified experiences of social stigma and stigma in healthcare due to their age, and described the difficulty of being a parent in the modern era. These factors should be well-understood by health workforces supporting young parents in the perinatal period.

UNINTENDED, MISTIMED OR UNEXPECTED PREGNANCY

There is an association between unintended pregnancy and mental ill-health. There is strong evidence to suggest that the risk of perinatal depression is twice as high for women who report an unintended pregnancy,(65) which most often occurs despite the use of contraception. (66) Young parents may be disproportionately impacted by this risk factor as young people are more likely than other age groups to have unintended, mistimed or unexpected pregnancies. In a study of people with previous experiences of pregnancy, people aged 18 to 32 years old were almost twice as likely to have had an unintended first pregnancy (40.8 per cent) than people aged 43 to 51 years old (22.0 per cent).(67) One in five (21.1 per cent) Australian women aged between 18 and 23 years reported ever being pregnant, and the majority of those pregnancies were unintended (84.6 per cent). (66) A longitudinal study found that young women with stress and depressive symptoms were twice as likely to have experienced an unintended pregnancy than young women without symptoms.(68) Young people may benefit from additional support that allows them to plan their families and time significant life transitions, which may include ensuring high levels of sexual health education and healthcare, including supports that increase best-practice use of contraception. This exemplifies the need for public health and health promotion initiatives that support young people and include sexual health as a core pillar. Consulted perinatal mental health services identified that the health needs of young people with a dual disability require unique, focused supports to prevent unintended pregnancy. Additionally, as consulted perinatal mental health services reported that reproductive coercion and sexual assault are common themes when talking to parents with unintended pregnancies, services that work with parents require the skills and confidence to appropriately support and refer people with experiences of coercion or assault.

RELATIONSHIP QUALITY

There is consistent evidence identifying low partner support and poor relationship quality as common risk factors for mental ill-health in the perinatal period for both partners.(14, 53, 54, 58) Conversely, a systematic review of modifiable partner factors during the perinatal period found that emotional closeness and global support (i.e. broad partner support) were protective against depression and anxiety, and communication, lack of conflict, emotional and instrumental support, and relationship satisfaction were protective against depression.(69) The review also identified emerging evidence that a partner's AOD use, control, division of household labour, sexual relationship or relationship withdrawal may impact mental health during the perinatal period. Similarly, lower rates of depression are seen in adolescent mothers with high rates of partner involvement.(16) Comprehensive supports for perinatal mental health need to include relationship supports, as well as identifying alternative sources of support for young parents without a partner.

FAMILY VIOLENCE

There are strong associations between mental ill-health in the perinatal period and experiences of family violence. A study of 1,305 Australian women within 12 months of birth reported that 16 per cent experienced depressive symptoms postnatally, and approximately 40 per cent of women experiencing depressive symptoms reported intimate partner violence.(70) The same study found that the youngest and oldest age categories were at a greater risk of intimate partner violence. Thirty-eight per cent of financially insecure adolescent parents experienced intimate partner violence in a US study, with experiences of bilateral violence associated with a four-fold increase in odds of depression and a five-fold increase in odds of anxiety.(71) Perinatal mental health training, services and strategies must consider early identification, risk factors and supports for intimate partner violence.

SINGLE OR SOLE PARENTING

Being unpartnered is a risk factor for maternal anxiety and depression during the perinatal period.(14, 19) This risk factor may be particularly relevant for young parents, as nine in ten adult mothers report having a partner during their pregnancy compared to five in ten adolescent mothers.(72) Consulted perinatal mental health services also identified that there is a growing group of people who are sole parents by choice, who face risk factors for mental ill-health such as stigma. In addition to supporting relationships and partner involvement, services need appropriate and targeted supports for single and sole parents. A system that supports single or sole parents may require more specialised, holistic support. For example, one in six people aged 15 to 24 years presenting alone to specialist homelessness services in New South Wales are single parents.(73) Services working with young parents must ensure holistic approaches and strong referral pathways to health and social support services.

SOCIAL SUPPORT AND CONNECTION

Despite the association between low levels of social support and mental ill-health in the perinatal period for both partners,(22) submissions to a Victorian inquiry into perinatal services reported a historically low level of social support from family, friends and the community.(22) This may be more pertinent for young people, with 40 per cent of fathers between 18 to 35 feeling isolated when they first become a father, compared to 23 per cent of all fathers.(4) There are serious impacts from social isolation, with one study of 6,421 mothers in Canada finding that adolescent mothers were five times more likely to experience depression in the postnatal period if they received no or minimal support.(72) Consultations with young parents identified that becoming a parent earlier than their peers can be isolating and lead to a loss of social connection. Adequate perinatal mental health support for young parents requires a focus on providing or increasing social support and reducing social isolation, which may include connecting young parents to other young parents or new parents of any age.

Young parents may have unique social support circumstances, as the parents of young parents often play a central and sometimes complicated role that attempts a balance between support and interference.(35) The parents of young parents can be central to practical, emotional and financial support. These relationships can be protective or risk factors for mental ill-health, as a good relationship between young fathers and their child's grandparents can increase a young father's participation in care, while a negative relationship can be detrimental.(35) While most perinatal services are focused on partners as a main support, consulted services identified that broader supports are involved for young parents, with family members or friends often a primary support. A better understanding of how broad supports can best support the mental health and wellbeing of young parents is needed.

STIGMA

Parents experiencing perinatal mental ill-health report that stigma is a barrier for seeking support. Consulted perinatal mental health services noted that many parents felt an expectation to be experiencing joy during pregnancy and parenthood, which could add stress for those experiencing mental ill-health. In addition, adolescent parents report negative experiences of stigmatisation in mothers groups, public transport, schools, medical services, government services, and with family and friends.(74) Australian adolescent parents have indicated that the stigma of being a young parent can have a serious impact on their mental health, as they feel stereotyped by others and excluded from activities with friends.(74)

Consulted perinatal mental health organisations identified that young parents are often unwilling to seek support due to stigma and fear of judgement from health professionals due to their young age. In consultation for this report, some young parents said that stigma, stereotypes and disapproval added additional pressure to prove that they are a 'good parent'. This perceived pressure to prove that they are a 'good parent' may reduce or prevent help-seeking behaviour when support is needed. A better understanding of the stigma associated with perinatal mental health and young parenting is required across the health sector, and the Australian Government Department of Health should ensure that community awareness and stigma-reduction initiatives are embedded in national perinatal mental health strategies.

HEALTHCARE EXPERIENCES

Consultations with young parents revealed that some healthcare experiences during the perinatal period had caused distress. Young parents reported that their pregnancy-related experiences and concerns were sometimes ignored by clinicians. Some believed that clinicians were more likely to dismiss their reports of abnormal pain because of an assumption that they are unable to identify typical pregnancy pain or discomfort due to their age. Additionally, they reported feeling that their pregnancy and parenting preferences or decisions were more likely to be questioned or dismissed due to their age. Some reported feeling more comfortable to advocate for themselves during later pregnancies. The healthcare experiences of young parents should be addressed in training for health professionals to increase awareness and minimise distressing experiences.

MODERN LIFESTYLES

Young parents today may be experiencing a number of additional risk factors that were not shared by previous generations. Differences in eating habits, technology use, sedentary lifestyles, sleep and chronic stress may contribute to higher levels of perinatal mental ill-health.(75) Some young parents consulted for this report identified that social media has added pressure to their role as a parent, as they may compare their parenting with another parent's 'highlight reel'. Training and perinatal mental health strategies should include a focus on the impact of modern lifestyles and technology during the perinatal period.

SUMMARY

A number of factors impact mental health in the perinatal period, and some are more likely to occur to young parents, such as unintended pregnancy, intimate partner violence and sole parenting.

Young parents experience stigma for both their age and their mental health experience.

Some consulted young parents describe negative healthcare experiences such as feeling dismissed and a lack of autonomy during the perinatal period due to their age.

> “Experiences of parenthood can look significantly different between young parents.”

IMPACTS

Perinatal mental health has a direct impact on the parent or parents involved. However, perinatal mental health can also have broad implications for families, education and employment outcomes, and the economy. These impacts may be more pertinent to young parenthood. Supporting perinatal mental health and young parents has tangible and significant benefits for partners, families and friends; education and career trajectories; and the economy.

FAMILY IMPACTS

PARTNERS, FRIENDS AND FAMILY

In addition to the potential impact that parenthood can have on their own mental ill-health, parents can provide a supporting role for a partner with mental ill-health. Significant economic costs have been attributed to family breakdown (divorce has been associated with a reduction in household income) and carer roles (associated with reduced earning potential).(1) A systematic review and thematic synthesis of fathers with partners experiencing postnatal mental ill-health identified that it can have impacts on their role as a father and a partner.(76) The review noted that people partnered to a parent with mental ill-health may experience distress or solitude during periods when they may have to parent alone, have concerns about not being able to provide their child with enough attention, experience relationship breakdown, and feel helpless, uncertain, shocked or confused. However, the review also identified opportunities for bonding with their child to provide distraction, a deepening understanding and communication within the relationship, and a growth in confidence in their role as a partner and parent. Perinatal mental health strategies should include partners as a critical support and identify opportunities to effectively support them in their role.

Consultation with perinatal mental health services identified that friends and family of young parents may be particularly impacted by perinatal mental ill-health, as young parents are more likely to be unpartnered or living at home. While we can assume that some of the impacts to family and friends of a parent with mental ill-health may be similar to some of the impacts experienced by partners, most perinatal mental health research to date has not included the experiences of friends and family. More research is also needed to identify opportunities for friends and family to effectively support pregnant and parenting young people.

CHILDREN

Some people experiencing perinatal mental health require support to get through the challenges of parenting. Perinatal mental health support for parents is also a preventive measure for poor mental and physical health of their child or children. Almost three-quarters of economic costs associated with perinatal mental health are attributable to impacts on the child, such as low birth weight, reduced immune systems, respiratory conditions and mental ill-health.(1) The cost of lifelong impacts to children is one reason that perinatal mental health was considered a priority reform in the Productivity Commission's Mental Health Inquiry.(77)

It is well-established that perinatal mental ill-health is associated with a child's mental and physical wellbeing. The research provided in this section is not to add stigma to perinatal mental health issues or condemn parenting during difficult periods, but highlights the impacts that can occur when parents with perinatal mental ill-health are not supported. A meta-analysis found an association between maternal antenatal mental ill-health and a moderate increase in the risk of stillbirth and infant mortality, likely due to mechanisms that include direct effects, behavioural factors and increased risk of pregnancy complications.(78) Another meta-analysis reported an increased risk of infant hospitalisation for people with maternal depression in the perinatal period.(79) Cohort studies that examine outcomes for children whose parents required the support of inpatient units found an increased risk of homicide during childhood by five-to-ten times, and a two-to-three-fold increase in risk of suicide in early adulthood.(80) A meta-analysis of 15,584 people found that the odds of youth and adult depression was were 1.7 times higher for people whose mothers experienced perinatal depression.(81) In Australia, postnatal paternal depression has been associated with behavioural difficulties, low social and emotional development, and low wellbeing scores in children at the point of school entry.(82) These well-established impacts to children highlight the importance of providing parents with timely, adequate support.

While many children born to young parents have positive experiences of childhood, they may

also be more likely to experience some poor mental and physical outcomes. A systematic review found that children to adolescent fathers were more likely to be born preterm or with a low birthweight.(36) Children born to young parents are also at a greater risk for AOD issues and intellectual disability.(83) A meta-analysis of 133,585 people found a small association between young maternal age and increased externalising behaviour issues in their children, such as hyperactive, disruptive or aggressive behaviour.(84) Increased risk of suicide during the lifespan of a child has also been associated with prenatal and perinatal factors, such as young maternal age.(85) The same review found that being born to an adolescent mother increased suicide risk by 1.8 times. Children with young parents who are also experiencing mental ill-health may be disproportionately exposed to risk factors that impact their mental and physical health across the lifespan, possibly highlighting a need for more comprehensive support for young parents and their families. Perinatal mental health supports and strategies must be well connected to children's mental health supports and promote the early identification and help-seeking of children's mental and physical health concerns.

EDUCATION AND EMPLOYMENT IMPACTS

EDUCATION

For young parents, lower levels of school engagement occurs before, during and after pregnancy. Education may be a mental health protective factor, as lower educational attainment is associated with perinatal mental ill-health.(14, 19, 58) One survey found that 64 per cent of Australian adolescent mothers were not regularly attending school when they became pregnant,(74) and very few adolescent mothers in Australia continue secondary education after becoming a mother.(86) The National Children's Commissioner identified that adolescent mothers had lower levels of educational attainment than mothers of other ages, partially due to a high portion of adolescent mothers leaving school before becoming pregnant, which is also where sex education is delivered.(87) The National Children's Commissioner also noted that some pregnant students feel discriminated against by the secondary education system, which may also contribute to disengagement or exit from education. Low education engagement needs to be addressed to increase potential protective factors of perinatal mental ill-health.

EMPLOYMENT

Parenthood can be disruptive to all career trajectories, but young parents experience this disruption during a period of significant vocational development. The Australian Department of Education has identified that parents without employment are at a high risk of mental ill-health, poverty and financial stress.(88) These outcomes require a particular focus on young parents, who are at an important transitional period in their vocational development, and barriers to employment may have long-term effects over their lifespan.

ECONOMIC IMPACTS

In 2019, PwC Australia estimated the cost of perinatal depression and anxiety to be $877 million for the first year of an annual birth cohort, with 25.9 per cent attributable to health costs (e.g. increased use of health services and increased risk of health conditions), 73.3 per cent attributable to economic costs (e.g. productivity losses due to workforce exit, absenteeism, presenteeism and carer requirements), and 0.8 per cent attributable to wellbeing costs.(1) In years two to three of this birth cohort, these total costs increase to $1.2 billion due to chronic disease, AOD use, health costs for children, ongoing workforce exit and productivity costs, and costs related to relationship separation. The lifetime impacts are estimated to be $7.3 billion for each yearly cohort of births, with 72.6 per cent attributable to the impact on children. Importantly, this modelling did not cost postnatal psychosis, or neurodevelopmental issues and cognitive concerns associated with perinatal mental ill-health.

An analysis in the UK identified that 72 per cent of the total cost relates to adverse impacts on the child, which includes costs relating to neonatal care and mental healthcare for the child, special education costs, criminal justice costs, quality-of-life losses and productivity loss.(89) Despite the high costs associated with perinatal mental health in the model, it had not included costs related to stress, complex or low prevalence disorders (eating disorders, PTSD, obsessive compulsive disorder and personality disorders), costs related to breastfeeding and mother-infant attachment, child temperament, impacts to partners, children being placed in care, unemployment and decisions relating to having future children. Future economic evaluations need to be more comprehensive to adequately understand the economic issue of perinatal mental health.

While perinatal mental health is associated with a significant cost to the individual and governments, cost-effective perinatal mental health supports exist. The Productivity Commission's Mental Health Inquiry estimated that supporting the mental health of new parents would result in a net economic benefit of $25–65 million.(77)

SUMMARY

Perinatal mental ill-health and young parenthood can have an impact on families, education and employment, and the economy.

Perinatal mental health services should include family and relationship support and refer to services that can support children's mental health and education and employment involvement.

Investment in perinatal mental health results in net economic benefit.

> "Supporting perinatal mental health and young parents has tangible and significant benefits for partners, families and friends; education and career trajectories; and the economy."

POLICY CONTEXT

Most key mental health reports refer to the importance of perinatal supports. In the national review of mental health programs and services, the National Mental Health Commission recommended a long-term target of building resilience and targeted interventions for families with children, increasing the proportion of young children and new parents receiving mental health support, and increasing resilience at home, in the community and through the education and care system.(90) The Productivity Commission's Mental Health Inquiry recognised perinatal mental health as a key area of reform due to its economic benefits, ease of implementation and potential for impact.(77) The Productivity Commission identified the impact that perinatal mental health had on children and recommended universal screening for all new parents. The draft National Children's Mental Health and Wellbeing Strategy also included a key focus on supporting families in the perinatal period, highlighting the long-term impacts of unaddressed risk factors in this period.(91) While perinatal mental health concerns were considered in these guiding documents for the mental health sector, they did not address the unique needs of young parents.

Perinatal mental health has received an increased policy focus over the last two decades. The Beyond Blue Postnatal Depression Research Program (2001–2005) informed a 2008 Beyond Blue National Action Plan (2008), focusing on perinatal depression and anxiety.(2) Between 2008–2013, the federal government funded the National Perinatal Depression Initiative, aiming to improve prevention and early intervention of maternal perinatal depression through funding to state and territory governments, the Access to Allied Psychological Services program, and Beyond Blue.(2) The initiative developed perinatal clinical practice guidelines, training, screening guidelines, care pathways, research and awareness.(2) Since 2013, the Centre of Perinatal Excellence (COPE) was established to continue this work, which involved the development and release of the National Mental Health Care in the Perinatal Period Australian Clinical Practice Guideline in 2017.(21) The 2019–20 Australian Government budget saw a $43.9 million investment in the Perinatal Mental Health and Wellbeing Program to support new and expecting parents from 2018–25, aiming to deliver screening, support and increased community awareness.(92) In 2020–21, the Australian Government budget included a $47.4 million investment to work with states and territories to achieve universal perinatal mental health screening, extended funding to COPE to support digital screening and funding to PANDA's national helpline.(93)

State and territory governments have an important role to play in perinatal mental health. They have developed perinatal models of care, specialised perinatal mental health clinics and early parenting centres; manage mother-baby units; and work with the Australian Government towards universal perinatal mental health screening.(77) In 2018, the Parliament of Victoria held an inquiry into perinatal services(22) and the Legislative Assembly of New South Wales' Committee on Community Services released a report on new parents and babies.(73) Both identified that young parents require additional support, with the Legislative Assembly of New South Wales recommending specialised and integrated support services for young parents. Consulted perinatal mental health services highlighted that state and territory governments should be actively engaged and working with the federal government in developing policy solutions for young parents. A national perinatal mental health strategy should clearly delineate the roles and responsibilities for state and territory governments in perinatal mental health.

While an increased policy focus exists, consultations with the perinatal mental health sector identified a need for a more coherent, collaborative and coordinated perinatal mental health system, as service offerings differ vastly across the country and are fragmented in some areas. A national perinatal mental health strategy would allow a coordinated and consistent approach to supporting new parents, and should be designed in partnership with parents. The strategy should focus on mothers, fathers and non-birth parents, as well as recognise their friends and family, social supports, relationship supports, supports for sole parents and support for parent-infant bonding. The strategy should map current services, identify roles and responsibilities, develop strong referral pathways between and external to perinatal services, highlight gaps in the perinatal mental health system, and identify and leverage best-practice initiatives and models of care. The strategy should align current services to accreditation and national standards in mental health services. It should also develop a plan to integrate with the wider health and social support systems, and education and employment support. Initiatives for awareness and stigma reduction should also be addressed by the strategy. Consulted perinatal mental health organisations have identified that this should include a focus on young parents, Aboriginal and Torres Strait Islander parents, LGBTIQ+ parents, culturally and linguistically diverse parents, rural and regional parents, refugee and asylum seeker parents and parents with a disability. Co-design and engagement with parents, including dedicated processes with young parents who have diverse experiences, should be embedded throughout the strategy. Led by the Australian Government Department of Health, this strategy should be designed and implemented by a number of relevant government departments on federal, state and territory levels. The strategy should also include youth-specific consultations and considerations.

Australia has seen progress in perinatal mental health policy and support. However, current policies and guidelines primarily focus on mothers and do not include dedicated or specialised insight into the unique needs of young people. While there has been an increased focus on perinatal mental health for mothers of all ages, few guidelines and resources focus on the unique supports needed for young parents and their partners. In 2021, COPE were funded to review and update the national perinatal mental health clinical practice guidelines.(94) Given that young parents are disproportionately impacted by mental ill-health, likely require support from a broader range of health and social services, and are more likely requiring educational and employment supports, young parents need to be authentically engaged in co-design processes to ensure that guidelines, strategies and frameworks and expanded to address their needs.

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
DEVELOP A NATIONAL PERINATAL MENTAL HEALTH STRATEGY			
Develop a national perinatal mental health strategy, which should include a dedicated focus on young parents.	Consulted perinatal mental health organisations identified that the sector would benefit from a coordinated approach to perinatal mental health. This would enable consistent, best-practice care for new and expecting parents. This work would integrate and leverage the work of current services. Young parents should be engaged in co-design process.	Services and programs are not duplicative, leverage expertise, and all new or expecting parents receive consistent, best-practice care.	Australian Government Department of Health, perinatal mental health sector, state and territory health departments.

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
ESTABLISH A JOINT AGENCY TASKFORCE			
Establish a joint agency taskforce to implement the national perinatal strategy.	Reform in perinatal care will require holistic supports that cover mental health, education, employment and social services. Implementation requires partnership between relevant state and territory government departments.	Broad supports for new and expecting parents are better implemented across relevant departments.	National Cabinet Reform Committee responsible for delivering the National Mental Health and Suicide Prevention Agreement.

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
SUPPORT FOR ALL YOUNG PARENTS IN UPDATED GUIDELINES			
The current review and update of the national perinatal mental health clinical practice guidelines should include a unique focus on young parents, developed in partnership with young parents. Guidelines should include: • best-practice models for mother-baby units that include partner engagement and considerations for siblings; • addressing fear of child protection notifications as a barrier to help-seeking; and • screening, services and referral pathways for people experiencing family violence.	Current policies and guidelines do not adequately cover the experiences of young people, who have unique risk factors for perinatal mental health and unique experiences of care.	The experiences of young parents are uniquely considered and addressed.	Centre of Perinatal Excellence.

SEEKING AND ACCESSING SUPPORT

Despite the prevalence of mental ill-health among parents, levels of help-seeking are low. One Australian study reported that 65.5 per cent of mothers experiencing symptoms of depression and 44.4 per cent of mothers with anxiety had spoken to a health professional about their mental health by nine months postnatal.(95) In an Australian study of 1,531 fathers, 35.0 per cent sought professional help to cope with the stress of being an expectant or new father, but this includes fathers whose youngest child is under five.(48) Of fathers who sought professional support, 65.7 per cent found it helpful and 34.3 per cent accessed support and did not find it helpful. However, fathers were less likely to seek professional support than to talk to their partner (91.0 per cent) and family members (76.0 per cent), or engaged in avoidant strategies such as focusing on work (56 per cent) or drinking (39 per cent) to cope with stress. Data provided by PANDA reported that approximately only one in three people using PANDA's Mental Health Checklist and one in two people using the PANDA helpline had spoken with their GP about their perinatal mental health concerns or experiences in 2020, and one in 20 had told nobody prior to speaking with PANDA.

A number of barriers to help-seeking exist for parents experiencing perinatal mental ill-health. A review of the experiences of mothers with perinatal mental ill-health in the UK identified the following barriers:(96)

- Individual-level barriers
  - poor mental health awareness among healthcare professionals and mothers, and a low awareness of early signs of perinatal mental ill-health, which may be misattributed to common symptoms of pregnancy and parenting;
  - insufficient knowledge about care pathways; and
  - negative and stigmatised attitudes towards mental ill-health and related medications.
- Organisational-level factors
  - inadequate resources, such as limited staff time to build rapport or limited childcare facilities;
  - fragmented services, impacting continuity of care; and
  - long waitlists for specialist services.
- Sociocultural factors such as language barriers and differences in cultural values.
- Structural-level factors such as unclear policies relating to assessment tools and dissatisfaction of healthcare providers with assessment tools, resulting in issues such as poor implementation.

Additionally, stakeholder consultations for this report identified barriers such as a lack of inclusive and culturally responsive services for culturally and linguistically diverse parents, Aboriginal and Torres Strait Islander parents, LGBTIQ+ parents and parents with a disability; ineffective screening due a lack of training or confidence needed to build rapport and assess risk; a lack of services in regional and remote communities; financial barriers; and a lack of affordable services, particularly in low socio-economic families. Consultations identified that young parents may be disproportionately impacted by practical barriers such as cost, childcare or transport-related issues, which are all concerns previously reported by young Australian parents.(87) Stakeholders also reported that telehealth has been helpful for parents as it reduces transport-related barriers, provides care without the need to interrupt the child's routine and sleep schedule, provides care for parents who cannot drive after a caesarean, and allows parents to receive support from the comfort of their home. A wide-ranging system design approach is needed to enhance perinatal mental health services and remove barriers to care.

CONCERNS ABOUT CHILD PROTECTION INVOLVEMENT

In consultations for this report, stakeholders spoke to the challenge of parents avoiding healthcare and support for perinatal mental health issues due to a concern that it will impact their role as a parent. Australian mothers have previously indicated that fear of adverse repercussions, such as removal of their child into care, is a barrier to honestly answering questions from health professionals about emotional wellbeing.(97) This issue is more pertinent for young parents, who may have more concerns about disclosing and are more likely to be experiencing intimate partner violence.(98)

A systematic review and meta-analysis of international data reported that maternal and paternal perinatal mental health was associated

with an increased risk of child maltreatment.(99) Australian data indicates that maternal mental ill-health is an important risk factor for child protection involvement, with a history of mental health contact associated with double the risk of notifications to child protection, and a higher substantiation of notifications.(100) Young parents are particularly impacted, as the risk of having a child taken into care is 2.75 times greater for adolescent mothers.(101) Child protection involvement and experiences of mental ill-health require careful consideration, with Canadian research identifying an association between children taken into care and increased suicide and suicide-related behaviours in mothers.(102)

A fear of notifications to the child protection system due to intrusive thoughts are one reason for a hesitancy to access mental health services. Intrusive thoughts can be unwanted and distressing, which may include thoughts about accidental or intentional harm to their child.(103) Consulted perinatal mental health services indicated that intrusive thoughts are a distressing and common experience for parents. Most new mothers (70–100 per cent) experience unwanted and intrusive thoughts, with approximately 32.6–46 per cent relating to intentional harm, and intrusive thoughts may predispose or exacerbate mental ill-health.(103) Parents require support to understand that intrusive thoughts are common, that health professionals can assist, and that unwanted intrusive thoughts are unlikely to lead to a child protection notification. Consulted perinatal mental health services indicated that health professionals in other areas, such as the general health workforce and the youth mental health workforce, may need training and resources to understand the prevalence of intrusive thoughts in this cohort, to normalise these experiences for parents, and to feel more confident to begin these conversations without increasing concerns about child protection notifications.

The majority of parents engaging with health professionals for perinatal mental ill-health do not require child protection involvement. Given that there are known effective interventions to reduce mental ill-health and increase parenting skills and confidence, there is a role for mental health services in reducing child protection risk and increasing family safety. For those who need higher levels of support, the perinatal mental health system offers intensive home-based family interventions that may support family preservation and unification in Australia.(104) Perinatal mental health services are likely better placed than youth mental health services to be acutely aware of the complex issues relating to risk and child protection notifications, and are well-placed to refer young parents to high-intensity parenting supports when it is most appropriate. Consulted perinatal mental health services indicated that lived experience workers could further reduce barriers and stigma related to clinical services and child protection involvement.

Consulted perinatal mental health services identified that the current child protection system is confusing for perinatal mental health services and the workforce, particularly for national organisations attempting to navigate differences across state and territory systems. Relatedly, there was an identified need to develop reporting pathways across states and territories. A best-practice, nationally consistent child protection system is needed to support perinatal mental health services and the workforce. To reduce barriers that may disproportionately impact young people, this system should actively work with the perinatal mental health sector and parents to reduce the concerns that parents with mental ill-health may have in relation to child protection involvement.

SCREENING

Screening can be used to identify parents who are experiencing mental ill-health, and provides health professionals with the opportunity to provide support or refer people to appropriate services. In perinatal mental ill-health, screening is predominately undertaken by general practitioners (GPs), maternity services and maternal and child health nurses. Internationally, approximately 40 per cent of maternal perinatal depression is clinically identified, and only 60 per cent of those recognised (or 24 per cent of overall cases) are provided treatment.(105) This may be higher in Australia, as Australian perinatal clinical practice guidelines recommend that all women are screened in the perinatal period, and that the first antenatal screening begins as early as practical, that screening occurs at least once again during pregnancy, that postnatal screening occurs six–12 weeks after birth and is repeated at least one other time in the first year, and that people with high scores receive repeated screening two to four weeks later.(21) Additionally, the guidelines recommend that women with high scores require monitoring and repeated screening after two to four weeks, or any time when clinically indicated.

Australian guidelines recommend that the Edinburgh Postnatal Depression Scale (EPDS) is used to screen mothers for depression. As the scale can also be useful in screening for anxiety and suicide risk and has been validated for men by using a lower cut-off score to signal psychological distress, there is a clear need to ensure that future guidelines discuss the appropriate use of the scale for all non-birth parents. A systematic review and meta-analysis of the accuracy of EPDS to screen for major depression found the tool to be appropriate for women under 25 years old.(106) COPE have developed a digital, web-based mental health

screening tool, iCOPE, that contains the EPDS, an antenatal/postnatal risk questionnaire and an assessment of both drug and alcohol use and family violence.(107) iCOPE is currently available in 13 languages, provides SMS or email reports to parents, and is currently assessing whether the tool can be adapted to better screen Aboriginal and Torres Strait Islander people. The Australian Government funded the implementation of iCOPE in every public maternity hospital in Australia, and made changes to an MBS item in 2017 to ensure that obstetrician or GP appointments between four-to-eight weeks postnatally involve a compulsory mental health assessment, which includes drug and alcohol use, and family violence.(108)

Growing attention and changes to guidelines have led to changes in screening patterns. A longitudinal study of 7,566 Australian mothers identified that the number of women not being screened reduced from 40.6 per cent in 2000 to 1.7 per cent in 2017, and the number of women screened both antenatally and postnatally increased from 31.8 per cent to 79.3 per cent over the same period.(109) While this increase is positive, current figures fall short of clinical guidelines. Issues related to screening rates may be less applicable to young mothers, as older mothers were 35 per cent less likely than younger mothers to be screened both before and after birth.

Screening does not ensure that people will receive the support they require. In one Australian study of mothers who had been told that they might have perinatal depression, 23 per cent felt relieved, 27 per cent felt unsure, 29 per cent felt upset and 16 per cent ignored the assessment.(110) Parents experiencing perinatal mental ill-health will have a range of help-seeking requirements, even once diagnosed. More than a referral, parents require continued education and considerable outreach from health providers. (97) Consulted perinatal mental health services reported a need for health providers to provide follow up after screening and warm referrals to perinatal mental health services. They also noted that investment in screening needs to be followed by investment in perinatal mental health services and the development of effective referral pathways to meet the demand created by screening.

There is some evidence to suggest that barriers and enablers to receptive engagement in mental health screening during the perinatal period were personal and not system-related. The most common barrier to receptively engaging in perinatal mental health screening was that their significant other normalised their symptoms, followed by a desire to handle their mental health on their own.(6) The primary facilitator for screening related to the quality of the relationship with the health provider, followed by the health provider normalising perinatal mental health issues, knowing that help is available and having access to many treatment options. Health professionals must take adequate time during the screening process to build rapport, normalise concerns and provide an array of possible service options.

Parents have mixed views on screening acceptability. Mothers have previously identified the acceptability of perinatal mental health screening, describing it as simple and reassuring.(97) However, one in five (20.7 per cent) Australian mothers have reported that they did not always respond honestly to health professionals during the perinatal period when asked about depression, anxiety, stress, AOD use, and domestic violence.(111) Concerningly, as mothers who felt uncomfortable during these questions were four times more likely to report perinatal depression and were nearly two times more likely to perinatal anxiety than other mothers, screening questions and health professionals may be missing opportunities to identify and support parents experiencing mental ill-health. The same study found that normalising symptoms, negative perceptions from themselves or others, fear of repercussions, and not wanting health service involvement were barriers to answering these questions honestly. There is a need for health professionals to not solely rely on answers to screening questions, to focus on rapport, to increase mental health literacy and reduce help-seeking barriers for all parents, and to assess broad signs of perinatal mental ill-health. Given the perinatal mental health risk factors experienced by young parents, health professionals should also be able to build rapport with young parents and provide youth-friendly care.

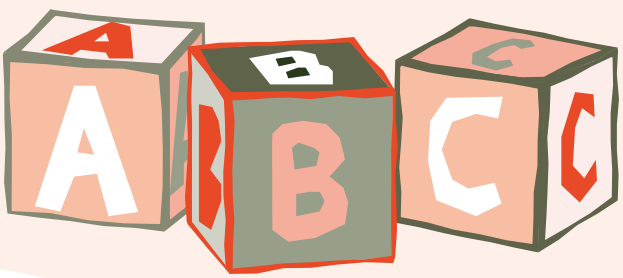
FATHERS AND NON-BIRTH PARENTS

Fathers and non-birth parents are not supported by nationally consistent and comprehensive approaches to screening. Barriers to screening fathers in early parenting services include the perception that a service has an incomplete understanding about fatherhood, a lack of male-screening specific tools, the prevalence of female staff and men feeling as though they are attending as a support person to their partner. (112) As many perinatal mental health services and guidelines place a strong focus on mothers, many of these barriers are likely transferable to other settings. Given the benefits of early intervention and the association between maternal mental health and the mental health of their partner, improved screening rates and acceptability for fathers and non-birth parents is required.

IMPROVEMENTS TO SCREENING

A number of significant mental health reports have identified recommendations for perinatal mental health screening. The Productivity Commission noted that there is no consistent data being collected on the number of parents who are screened for perinatal mental ill-health, and that estimates vary from 50–75 per cent for mothers and far less for fathers or non-birth parents.(77) It also noted that the AIHW Perinatal National Minimum Data Set does not include perinatal mental health indicators and recommended that it is expanded to include screening data. The Productivity Commission reported that state and territory governments should report screening data to the National Mental Health Commission as part of their role in child and maternal health visits. The Royal Commission into Victoria's Mental Health System has recommended a review of screening practices to improve effectiveness and take-up of screening, considering issues such as a fear to disclose, cultural appropriateness and suitability for non-birth parents; support clinicians and services to use screening tools effectively; and to align policies with COPE's clinical practice guideline.(21) Young parents should be uniquely considered in this review, and the Australian Government should use findings from this review to improve screening outcomes nationally.

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
EXPAND THE PERINATAL NATIONAL MINIMUM DATA SET			
Expand the Perinatal National Minimum Data Set to include mental health and vocational indicators, and perinatal mental health screening data. Data and reporting should allow for young parents to be separately analysed.	The Productivity Commission recommended expanding the Perinatal National Minimum Data Set to enable greater understanding of population-level changes and screening rate rollout. Additionally, the National Children's Commissioner noted a need to understand the number of pregnant and parenting students in Australia.	Improved resource allocation through a better understanding of population-level perinatal mental health outcomes and screening rates.	Australian Institute of Health and Welfare.



SUMMARY

A number of known mental health help-seeking barriers exist for young parents.

Unaddressed concerns about the child protection system may reduce help-seeking for young parents with mental ill-health.

Increased and accurate screening is required, particularly for fathers and non-birth parents.

> “Despite the prevalence of mental ill-health among parents, levels of help-seeking are low.”

PERINATAL MENTAL HEALTHCARE

Perinatal mental health services deliver a broad range of services to parents. Consultations with stakeholders identified that perinatal mental health services benefited from focusing on parenthood and normalising parenthood stressors, rather than a strictly clinical focus on individual mental health. Services spoke of a cohort of parents who were unaware that they were experiencing mental ill-health in the perinatal period, but knew that they were experiencing stress related to child or parenting-related issues and would more comfortably seek support for these concerns. Services reported that conversations about stress and emotional wellbeing were also more culturally appropriate for Aboriginal and Torres Strait Islander parents and culturally and linguistically diverse parents, and some stakeholders also felt that this approach was particularly appreciated by young parents. Paternal perinatal depression experts have also previously highlighted the importance of broad supports that include a focus on physical health and social connection, and that interventions for paternal perinatal mental ill-health should take a strengths-based approach to highlight the role of fatherhood, focus on relationship changes, education about infant development and highlighting the importance of social support.(113) Parents benefit from services delivering a broad focus on parenthood stressors, social activities and emotional wellbeing, allowing services to build rapport and identify early signs of mental ill-health and facilitate access or referral to appropriate services if needed.

Some young parents require unique support during the perinatal period. Programs such as the Young Women's Health Program at the Royal Women's Hospital ensure that women 19 years old or under receive specialised pregnancy support, including access to social workers, psychologists and workshops.(114) However, similar programs are not widespread nationally and often include strict age criteria. Stakeholder consultations with perinatal mental health services identified that young parents are more likely than other parents to be cautious when accessing services, can sometimes seem guarded and services often need to work harder to build a relationship. Perinatal mental health services will benefit from understanding some of the common principles, models and approaches utilised in youth mental health care.

WORKFORCE

The perinatal system is composed of workforces such as midwives, nurses, maternal and child health nurses, obstetricians, gynaecologists, GPs, perinatal psychologists, perinatal psychiatrists and Aboriginal and Torres Strait Islander health workers. These workforces provide physical and mental healthcare to new and expecting parents, and each would benefit from being able to support young parents to access a range of perinatal and youth mental health supports.

MIDWIVES

Midwives provide care to mothers, families and children. Midwifery continuity of care refers to care that involves the same health professional throughout the perinatal period, and is considered by the perinatal clinical practice guidelines to be an underlying principle of effective perinatal mental healthcare.(21) While interviews with young Australian mothers from out-of-home care indicated that midwives provide non-judgemental communication and acceptance, particularly in youth-specific hospital clinics,(115) consulted perinatal mental health services indicated that parents often have mixed experiences of being supported during experiences of mental ill-health. In a submission to the Productivity Commission, the Australian College of Mental Health Nurses recommended a training needs analysis of Australian nursing and midwifes, which may include assessing whether midwives working in perinatal services require more support with perinatal mental health assessment and communicating with people experiencing mental ill-health.(116) Australian midwives have identified that part of their role is to assess mental health status, but many also identified that they feel ill-equipped to do so.(117) Similarly, although 77.9 per cent of midwives identified that engaging with fathers was a large part of their role, 83.0 per cent reported not receiving any formal training about working with fathers, and all identified a lack of training as one barrier to engaging fathers.(118) Midwives should be supported with training to provide consistent mental health support for both parents.

CHILD AND FAMILY HEALTH NURSES

Child and family health nurses, or maternal and child health nurses, are registered nurses with additional qualifications in midwifery or maternal and child health. They provide information about a broad range of topics, including parenting, child development, immunisation and the physical and mental health of parents. While states like Victoria provide funding for ten visits at key time points for all families between birth and school, other state and territories provide fewer sessions or do not offer a regular schedule.(119) In Tasmania, young first-time mothers are provided with home visits from child and family health nurses from the antenatal period to the child's second birthday to improve child development, support parents, and set employment and educational goals. (120) Consulted perinatal mental health services identified that parents report mixed experiences of the child and family health nurse workforce and identified a need for perinatal mental health training content before they are registered. A need for additional training and support was also identified for remote area nurses, who cover this role in rural and remote communities. Consulted perinatal mental health services also described an opportunity for this workforce to better engage fathers and non-birth parents.

GENERAL PRACTITIONERS

GPs are well-placed to provide mental health screening and refer parents to appropriate mental health services. However, very little is currently understood about GP's awareness and management of mental health in the perinatal period.(121) Australian researchers have previously provided practice recommendations for GPs supporting young parents.(34) The recommendations described the role of a GP in establishing trusting relationships with young people, reducing the risk of unintended pregnancy, and providing non-judgemental support, care and education during the perinatal period. There is a need to better understand the roles that GPs play in supporting young parents with perinatal mental health.

PSYCHIATRISTS

Perinatal psychiatrists provide specialist psychiatry care during the perinatal period. Their expertise is particularly needed for people requiring medication, as acceptance of mental health medication is low with mothers, particularly if they are breastfeeding.(97) In their submission to the Productivity Commission, the Australian Medical Association suggested expanded services for perinatal psychiatry, co-located with existing GP and general private psychiatry.(122)

PEER WORKERS

Peer work has been increasingly recognised as an essential workforce in the mental health system, and peer workers have been successfully embedded into many perinatal mental health services. Peer support is provided by peer-led perinatal services in some jurisdictions, or through peer workers in perinatal mental health services. They may be particularly appropriate for young parents, as the Mental Health Foundation identified peer support as one of five primary support needs for young mothers. (123) Young mothers have volunteered as peer workers to assist in the facilitation, recruitment and retention of a young mothers group in the UK.(124) Consultations with perinatal mental health services identified that role models are particularly important to young parents, and that peer workers are able to provide parents with hope that they can get through difficult times. There may be some benefits to ensuring that peer workers employed in perinatal mental health services have varied pregnancy and parenting experiences, including experiences of being a young parent.

AWARENESS

While perinatal mental health awareness has improved, there is still a need for greater knowledge among new parents and the general community about perinatal mental ill-health. Mothers who receive adequate information about postnatal depression are less likely to experience it, particularly if they receive information during hospitalisation after delivery.(72) Fathers have previously recommended that perinatal mental health information could be provided during antenatal classes.(125) A core component of PANDA is to raise awareness of perinatal mental health through community education, fact sheets and resources, which are provided in a number of languages and include resources aimed at health professionals.(126) A focus on increased awareness, particularly during key points of pregnancy and parenting, may reduce distress for young parents and encourage help-seeking. Youth mental health services and general health services would benefit from being aware of and distributing existing perinatal mental health resources Alongside young parents, youth mental health services should be involved in the design and dissemination of youth-specific perinatal resources.

PREVENTION AND TREATMENT

A number of effective prevention and treatment interventions exist in perinatal mental health. The perinatal mental health clinical practice guidelines highlight a number of strong evidence-based recommendations for treatment, including structured psychoeducation, cognitive behavioural therapy (CBT) and interpersonal psychotherapy for women with depression, and selective serotonin reuptake inhibitors (SSRIs) for moderate-to-severe depression for women postnatally.(21) An assessment of 20 perinatal mental health interventions, including universal preventive preventions (e.g. education and infant sleep interventions), selective preventive interventions (e.g. CBT to prevent risks), interventions for mild or subthreshold symptoms (e.g. peer support), interventions for moderate to major symptoms (e.g. CBT at home and multidisciplinary care) and interventions for major symptoms (e.g. mother and baby inpatient units).(127) In each category, the study found evidence for interventions that prevented mental ill-health or assisted in recovery. For all five of the interventions identified for universal prevention or selective prevention, the study determined a positive net benefit in health and social care, largely due to the low cost of the interventions. In interventions that require more intensive investment, and may not achieve net benefits to health and social care costs, net benefits were seen in a societal perspective as they still substantially supported women and children. A systematic review of perinatal depression interventions for adolescent mothers reported that motivational interviewing and an interpersonal group were effective in treating depression, and there was evidence that maternal massage, infant massage, interpersonal group therapy, and multi-component treatments that include day-care, massage and relaxation, can prevent depression during the perinatal period.(128) There is good evidence for efficacious and cost-effective initiatives to support perinatal mental health.

PARENT-INFANT AND FAMILY-FOCUSED CARE

In addition to benefits to the child and their families, a focus on parenting and parent-infant bonding provides a pathway to perinatal mental health services without the barriers that can come with a focus on individual mental health. The Australian perinatal mental health clinical practice guidelines highlight that mother-infant interaction is an integral part of postnatal care.(21) Focusing on parent-infant interaction has wider benefits, as some evidence suggests that focusing on maternal depression may not necessarily change outcomes for their child.(97) Perinatal mental health services identified that providing initiatives focused on general social activities for infants or parents, such as playgroups and baby yoga, were pivotal at identifying people at risk for perinatal mental health issues. These initiatives also assist in building stigma-free relationships with parents and providing an entry point to more direct mental health supports when needed. A focus on parenting and parent-infant bonding is seen in early parenting services and child and family health services, which can provide broad supports for sleeping, nutrition and mental health. Consultations with services reported that addressing some of these issues can improve wellbeing and decrease distress for parents. Services also reported that parents appreciate broad parenting supports, which can improve their wellbeing, provide a soft entry point to care, and connect parents to mental health services when needed.

Perinatal mental health services also deliver family-focused support. There is a growing recognition that fathers and non-birth parents require a greater focus in perinatal mental health services. In one systematic review, three of five paternal mental health interventions that had significant positive effects were focused on massage techniques (e.g. partner pregnancy massage or infant massage training).(129) While none of the couples-based interventions were found to be effective in reducing paternal mental ill-health, there was some evidence to indicate that they increase co-parenting support and infant regulation, and the review noted that these evaluations had limitations. A strong perinatal mental health system provides services that effectively support relationships and family.

HOME SUPPORT AND TELEHEALTH

Parents experience several barriers to accessing mental health services, such as the need to arrange childcare and transport, the extensive travel that can be required to access specialist perinatal mental health care, the inability to drive after a caesarean section, and difficulties discussing issues relating to their mental health while looking after a newborn. Some services provide home-based support, such as child and family health nurses, or services who offer intensive home-based family interventions to support family preservation or people needing greater levels of support. Following increased access to telehealth in response to the COVID-19 pandemic, perinatal mental health services have reported reduced barriers to care, increased coverage of support and high levels of acceptability for the parents that they are working with. As parents experience disproportionate barriers to accessing face-to-face mental health care, the continuation of perinatal mental health telehealth services is vital.

MOTHER-BABY UNITS

For mothers experiencing severe mental ill-health that requires inpatient support, mother-baby units are considered best-practice for avoiding separation between mothers and their child where possible.(21) Mother-baby units provide effective mental health support(130, 131) and improve parenting outcomes.(131, 132) Australian mother-baby units have been found to improve clinical symptoms, parenting confidence, attachment to their infant and overall functioning,(132) and a client evaluation of an Australian mother-baby unit identified that mothers were largely satisfied with the quality of care provided.(133) Systematic reviews have identified that the most common diagnoses are depression, schizophrenia and experiences of psychosis.(131) An audit of one Victorian mother-baby unit found that the average length of stay was 4.4 weeks and the mean age of children was 3.3 months.(130)

There is little national and international consistency about the structure, provided interventions and admission requirements of mother-baby units. In the UK, mother-baby units offer psycho-education, mindfulness, CBT and DBT-based skills, peer support and parent-specific interventions, mostly through regular group sessions.(134) Australian mothers have recommended that mother-baby units include greater involvement of primary and community healthcare professionals and clients/carers in discharge planning, a greater focus on the relationship between mother-baby, and greater use of technology for communication post-discharge.(133) There is a need to develop and define best-practice models for mother-baby units to ensure consistent care across Australia, which should be co-designed with parents who have accessed mother-baby units.

Fathers and non-birth parents have a unique experience of mother-baby units, and may be separated from their partner and child during this period, despite mothers previously stating that the inclusion of families and their partners helped to alleviate their distress.(135). Interviews with fathers highlighted concerns about bonding, strained relationships with their partner, anxiety about their partner's mental ill-health, relief when admitted, uncertainty about the prognosis and identified a need for better communication with health professionals.(136) Regular one-to-one meetings between partners and health professionals may provide a better understanding for both parties while allowing staff to regularly screen partners and understand their support needs.(137) Mother-baby units have identified that lack of childcare for other siblings, unwillingness to engage, work and childcare commitments, and ability to travel have all been barriers in engaging partners in mother-baby units.(138) Fathers have previously recommended that their involvement could be improved by providing mental health information in antenatal classes, involving partners in admission, increased involvement in care, information on how to support their partner, information about recovery from health professionals and mothers with lived experience, specific supports for partners, increased family-centred activities and advice, involvement in discharge and information on how to continue supporting their partner post-discharge.(125) Fathers and non-birth parents could be better supported by mother-baby units through admission packs, telephone support, support groups, couple's therapy, couple's mindfulness activities and individual therapy.(138) A number of opportunities exist in improving father and non-birth parent involvement in mother-baby units, and best-practice models should include their involvement where beneficial.

YOUNG PARENTS

Mother-baby units may need to be adjusted to best support young parents. A study of 191 Australian mothers who accessed a mother-baby unit found that reductions in mental health symptoms and increased parenting confidence were associated with increasing maternal age.(132) This finding suggests that young parents require additional or adjusted supports in these settings. Young people using inpatient care often require specialised, purpose-built supports to ensure the active involvement of family and friends, increased staff-to-patient ratios, and integrated AOD use services.(139) There is a need to develop and trial innovative, youth-specific supports in mother-baby units, which could be extended to best-practice models for all parents.

Access to mother-baby units are limited and need expanding.(21) Consulted young parents identified that many parents in Australia are not provided timely access to mother-baby units when needed. The Productivity Commission's Mental Health Inquiry highlighted the importance of ensuring adequate numbers of beds in mother-baby units,(77) which are still not publicly available in some states. As the current alternative involves staying in an inpatient unit separated from family, states and territories should increase the timely access to mother-baby units where they are needed.

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
NATIONAL DATA REPORTING FOR MOTHER-BABY UNITS			
Collect and publish national data for mother-baby units. Reporting should allow for separate analysis of young parent data.	More information is needed about the experiences and outcomes of people accessing mother-baby units. Data should include information that assesses service need.	An understanding of the experiences, outcomes and need of mother-baby units across Australia.	Australian Institute of Health and Welfare, state and territory health departments.

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
INCREASE ACCESS TO MOTHER-BABY UNITS			
Assess the service need for mother-baby units in each state and territory and ensure adequate resourcing to enable coverage.	Despite good clinical and parenting outcomes, there is limited access to mother-baby units across Australia. Considerations for assessing service need can be incorporated with the recommended national data collection for mother-baby units.	Young parents receive timely inpatient care alongside their child.	State and territory health departments.

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
TRIAL YOUTH-SPECIFIC SUPPORTS IN MOTHER-BABY UNITS			
Assess the youth-friendliness of mother-baby units and develop and trial youth-specific supports in partnership with young people and youth mental health services. The trial should be conducted for two years across different states and territories, prioritising sites providing care to a greater number of young parents.	Tertiary care for young people often involves additional, youth-specific support to deliver appropriate care. Innovative youth-specific supports should be trialled for young people accessing mother-baby units, and could be expanded to all age groups if effective and acceptable.	Young parents receive appropriate, youth-friendly care in mother-baby units.	Australian Government Department of Health, state and territory health departments, youth mental health services.

PERINATAL HELPLINES

Helplines allow parents to access perinatal mental health support without time and transport-related barriers. PANDA have provided data for this report, including an analysis of 6,183 calls to the PANDA helpline in 2020. Approximately 90 per cent of all helpline callers were women and seven per cent were under 25 years old. The helpline identified significant risks, with parents experiencing significant mental health decline (60 per cent), suicidal ideation (16 per cent), harm to infant (16 per cent), family or partner violence (eight per cent), self-harm (five per cent), and alcohol and/or drug misuse (three per cent).

The most frequent symptoms recorded for all ages were somatic issues of anxiety and depression (60 per cent), adapting to changes in the perinatal period (60 per cent), lowered mood (58 per cent), obsessive or negative thinking (41 per cent), and grief and loss (39 per cent). The PANDA helpline predominately provides support, followed by information, self-help suggestions and lifestyle strategies and care navigation to local services. Most callers receive at least one referral, predominately to a counsellor, GP or medical information service. The PANDA helpline also supports fathers, non-birth parents, partners and carers. The need for the PANDA helpline grew during the pandemic, as evidenced by a 63 per cent increase in calls (19,481 in 2019 compared to 31,754 in 2020). There is an opportunity to ensure that counsellors (peer and clinical) feel prepared to provide youth-specific support and referral pathways.

There is evidence to suggest that online text-based mental health services are acceptable for young people, and possibly more preferable as a source of support than telephone helplines. In consultation for this report, stakeholders identified that webchat is more preferable than telephone support in youth mental health services. Kids Helpline has reported a 204 per cent increase to their webchat services over five years, with email and web services accounting for approximately half of all contacts.(140) Consultation with youth mental health services indicated that the vast majority of young people using eheadspace choose to use webchat instead of the telephone line. There is a clear indication that young people prefer webchat and online text-based supports over telephone lines. Trialling an augmentation of the perinatal mental health helpline with webchat functionality will provide young parents with a support that is likely more aligned to their preferences, helping more young parents to access help when and where they need it.

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
TRIAL ONLINE SUPPORT			
Fund a trial that augments PANDA's national perinatal mental health helpline with webchat support, designed in partnership with young parents. The two-year trial and evaluation should include all parents and assess age differences in efficacy, preference and support.	Where online and telephone services are available, young people have reported a strong preference for online support. While a perinatal helpline is currently available, webchat may be a more acceptable method of help-seeking for young parents. A trial is needed to understand efficacy, acceptability, and preferences for parents across demographics.	Young parents have access to appropriate help-seeking options and receive information and support aligned to their preferences.	PANDA.

DIGITAL SUPPORTS

It is well-established that young people find digital mental health interventions to be acceptable, with more than half of young Australians with moderate to high levels of distress using the internet to seek information about mental health or AOD use and 80 per cent identifying that the internet had helped them with their problems.(141) An Australian study of young parents who access welfare and social services found that many turn to the internet to receive parenting advice and information.(142) Augmenting existing digital perinatal supports with youth-specific content may allow perinatal and youth mental health services to work together to best support young parents.

WEB-BASED INTERVENTIONS

Digital interventions are available to provide evidence-based support to parents. The Parent-Infant Research Institute (PIRI) developed MumMoodBooster and Mum2BMoodBooster to be online treatment programs that improve cognitive and behavioural skills and decrease antenatal and postnatal depression through six interactive sessions that are supported by a weekly phone call with a psychologist or phone coach.(143) PIRI's BabyHUGS is an online intervention designed to improve the mother-infant bond. PIRI's Beating the Blues Before Birth is an eight-week cognitive behavioural therapy program for women experiencing depression during the antenatal period. Many of these interventions provide parents with new cognitive skills and behaviours.(143)

SMS AND EMAIL

SMS4Dads was developed to send regular clinician, researcher and parent-developed text messages to new fathers to address father-infant care, father-partner support and self-care.(144) SMS4Dads uses an interactive mood tracker every three weeks, with highly distressed fathers then managed by the PANDA helpline. Fathers reported that the messages helped them to transition to fatherhood (92.8 per cent), in their relationship to their partner (79.0 per cent) and to develop a strong connection to their child (54.9 per cent).(145) There is some evidence to suggest that a similar program for partners of mothers with severe mental ill-health may increase the effectiveness of the support they deliver to their partner, increase knowledge and relationship with their child, and provide reassurance.(146) In partnership with Aboriginal and Torres Strait Islander people, a similar program has been developed for young fathers and was found to be viable and acceptable.(147)

COPE's Ready to COPE newsletters provide regular updates to expecting or new mothers.(148) It has been adapted for expecting or new fathers and Aboriginal and Torres Strait Islander parents. These emails are underpinned by the national perinatal mental health clinical practice guidelines and provide emotion and wellbeing information to parents that is specific to their pregnancy or parenting timeline, up to 12 months post-birth. The information aims to set realistic expectations of parenthood, provide strategies to cope with situations and emotions, increase mental health literacy and the identification of early signs of distress, and information about when, why and how to seek help. Consultations with COPE identified that it may be possible to enhance these emails with youth-specific content, stories and resources for young parents.

WEBSITES

A number of states, territories and national perinatal mental health organisations have developed websites that provide mental health information, self-guided exercises and resources for parents. PANDA provide a range of information about perinatal mental health issues, stories of recovery, information about the perinatal mental health system and screening tools. COPE's website includes information about planning a family, preparing for births, adjusting to parenthood, as well as a directory of perinatal mental health professionals and resources for health professionals who work with parents. Monash University's WhatWereWeThinking website and app provides information about common experiences in the postnatal period. Beyond Blue's Healthy Families website provides perinatal mental health information, screening tools and links to online forums. Beyond Blue and Movember's Dadvice website provides a web series, a self-directed screening tool, an emotional health and wellbeing guide, information about partners and parenthood, and links to resources such as SMS4Dads. PANDA's How is Dad Going? website provides lived experience stories, links to resources, and advice on preparing for a baby, identifying mental health risk factors, supporting partners, balancing parenthood and work. While all of these resources are likely relevant and useful to all parents, there is very little youth-specific information available to young parents, including information on particularly pertinent topics such as education and employment supports for parents with mental ill-health.

ONLINE PEER SUPPORT

Young Australian mothers who access welfare and social supports have previously noted that online peer groups are potentially beneficial.(142). Online groups allow parents from across Australia to connect and provide mutual support through their shared experience. Online groups may be particularly useful for young people in regional areas, who are more likely to be pregnant or parenting at an earlier age and have reduced access to services. While young parent groups are currently only available in limited locations, online groups remove geographical limitations. Consulted perinatal mental health organisations noted that social media groups have been essential in supporting many parents, but noted that they likely require more professional support to identify risk, connect parents to services and provide the best possible support for parents. A national perinatal mental health strategy should leverage and support existing online communities of young parents.

YOUTH-FRIENDLY DIGITAL SUPPORTS

Digital supports can provide acceptable interventions to parents, but rarely include youth-specific content or referral pathways. Digital supports enable support for parents who prefer anonymity and would not seek support openly, for parents is rural and regional areas who have reduced access to perinatal mental health professionals and for parents who would otherwise need to arrange childcare to seek support. While many young parents are well-supported by an abundance of available digital content and programs, some young parents may benefit from receiving information that is focused youth-specific risk factors or parenting supports, such as information to support education and employment goals.

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
AUDIT AND AUGMENT ONLINE PERINATAL MENTAL HEALTH SUPPORTS			
Fund existing online perinatal mental health websites to augment their website with specific content aimed at young parents. This should include: • resourcing for a co-design process with young parents; • information in multiple languages; • information for the health workforce that enables referrals between perinatal and youth mental health services; and • unique information for schools and employers supporting young parents.	Currently, there is little information available that focuses on the unique needs of young parents, such as effective employment and education adjustments. Additionally, both perinatal services and youth mental health services are not provided with dedicated resources that explain the broad range of service delivery options and considerations for young parents. An existing platform should be audited and augmented with youth-specific content, developed in partnership with young parents and youth mental health services. This content should then be connected to the Head to Health platform.	Young parents and their supports are provided with youth-specific information about pregnancy, birth and parenting and associated mental health resources.	Australian Government Department of Health, perinatal and youth mental health organisations.

SUMMARY

The perinatal mental health system is composed of a number of workforces that provide support for parents and families; increase awareness; and deliver care in homes, communities, hospitals, over the phone and online.

There are opportunities to collect and report data on mother-baby units, increase access and trial youth-specific supports in these settings.

Young parents are likely to find online supports and interventions acceptable, and there are opportunities to increase online support and youth-specific perinatal mental health content.

> “There is good evidence for efficacious and cost-effective initiatives to support perinatal mental health.”

INTEGRATING CARE

Consultations with perinatal mental health organisations found that the perinatal sector largely utilise a traditional adolescent and adult dichotomy, which differs from youth mental health services that specialise in age-appropriate supports for people aged 12 to 25 years old. Consultations with young parents identified that they feel supported by the perinatal mental health sector and that they are not seeking or requiring youth-specific services. However, youth mental health services may be appropriate for young parents who prefer youth-friendly settings or for young parents who require support for common, age-appropriate concerns, such as peer-related issues or education and employment goals.

Young people are at a crucial age for employment and education trajectories, and parenting can alter these pathways. In addition to benefits to career trajectories and financial security, consulted perinatal mental health services noted that education and employment engagement can provide much-needed social contact for parents. In an Australian study, almost all young mothers identified personal aspirations for the future, such as returning to education and employment, but were unsure how to reach them.(5) A study of 31 young fathers in the UK identified that financially supporting their family was perceived as a key role in fatherhood, regardless of relationship with the mother or whether they reside with their child, and that many young men experienced a triple burden of engaging in employment, education and caring. (149) Despite the need to support young parents to set and reach their personal education and employment goals, perinatal mental health services indicated that vocational supports were not often a focus of their service offerings. There is an opportunity to improve integration and collaboration between youth mental health and perinatal mental health services to meet the service need of young parents.

Perinatal mental health and youth mental health services should collaborate to create training, with a focus on developing stronger awareness of service options and referral pathways between sectors. Perinatal mental health services are well-placed to provide information to the youth mental health workforce about intrusive thoughts during pregnancy and the range of services available, and youth mental health services are able to describe the principles of youth-friendly care, service options, and vocational supports that may be appropriate to young parents.

Opportunities exist for perinatal and youth mental health services to provide collaborative care, co-develop youth-specific perinatal mental health training, co-facilitate young parent groups and provide pathways to appropriate vocational support.

COLLABORATION AND CROSS-REFERRALS

Young parents require better collaboration between perinatal and youth mental health services. Perinatal mental health services have reported that referrals to youth mental health services are infrequent, including pathways to the youth-specific vocational supports that youth mental health services offer, but noted that these pathways would be beneficial. A strong mental health system would ensure that young parents can access collaborative care and cross-referrals between perinatal and youth mental health services, ensuring that young parents can access elements of care from each system. A perinatal national mental health strategy should highlight opportunities to increase collaborative care and partnerships across systems, as well as highlighting key roles for each sector. Training and associated resources for both workforces should increase an understanding of the services provided by each sector and promote the benefits of collaborative care, with an aim to develop strong referral pathways that benefit young parents. Young parents should be able to access services in either sector and expect to be referred to the most appropriate supports for any presenting issue.

TRAINING

Both the perinatal and youth mental health workforce would benefit from a better understanding of young parents and their unique needs. While referral pathways will allow young people to receive appropriate, specialised support, stakeholder consultations identified that workforces within both sectors wold benefit from training on young parents. In consultation for this report, young parents identified a number of experiences that they want health professionals to better understand, such as autonomy and respect for decisions, eliminating stereotypes that young parents cope or adjust better due to their age, and ensuring that their concerns are not dismissed due to their age. Embedding the experiences of young people into training

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
AUDIT AND DEVELOP TRAINING AND RESOURCES			
Perinatal and youth mental health services should work with young parents to: • audit and map available training; • co-develop augmented training with youth-specific information, referral pathways and experiences; and • produce and distribute a national resource that can be adapted to both perinatal and youth mental health services.	Both perinatal and youth mental health workforces identified gaps in their knowledge that the other workforce could provide. Training should be provided in modules to ensure that workforces can access the most relevant content and should be provided to a broad range of workforces. Training should be co-designed with young parents.	A workforce enabled to support young parents and refer them to the most appropriate supports.	Perinatal and youth mental health organisations.

should help to ensure that these experiences are reduced. Training and resources should provide a broad understanding of the lives of young Australian parents. This should include their experiences of age-related and mental health stigma, risk and protective factors of mental ill-health, the broad supports needed and the resources available, vocational needs and appropriate adjustments, relevant perinatal guidelines and screening information, and perinatal medication considerations.

Both the youth and perinatal mental health sector should collaborate to audit training across sectors, develop cross-sector training on young parents, and to produce a national resource that can be adapted for each jurisdiction. This resource should include youth-specific perinatal information and provide information that encourages collaborative care and referral pathways, Young parents should be engaged in co-design processes to ensure that the training addresses their preferences and meets their needs. Training modules should be applicable to a broad workforce from both sectors, such as peer workers, IPS workers, telephone and online counsellors, administration and support staff, employers and educators.

YOUNG PARENT GROUPS

Young parent groups can support parents to connect with peers and remain engaged with services. In consultation for this report, perinatal mental health services identified that young parents often do not remain engaged in parent groups over long periods of time and suggested that this may due to young parents feeling disconnected from other parents. Services also noted a particular need to keep young parents engaged with these groups, as they are often disconnected from social opportunities due to leaving work or study. The need to connect with other young parents is addressed by some perinatal and youth mental health services through young parent groups. Conversely, while these groups work for some young people, consulted young parents reported a preference for non-youth-specific groups, as they considered youth-specific groups to be 'othering' and appreciated the support from parents of all ages. It is likely that both youth-specific and all-ages parent groups are needed to meet the diverse preferences of young parents.

The Mental Health Foundation in the UK facilitates groups for mothers aged 25 and under, running weekly drop-in sessions with creative activities and opportunities to play.(150) In their guide to supporting young mothers, the Mental Health Foundation recommends facilitating fluid, informal and uncensored discussions with guest speakers such as counsellors, baby yoga instructors, psychologists, careers advisors, sexual health clinicians and advisors who provide information on government support payments. (123) Consultations with perinatal mental health stakeholders identified that similar groups could benefit from being co-facilitated by a peer worker.

Young parent groups face a number of barriers. Consulted youth mental health services identified that they have been developing their group curriculum independently and may

be supported by resources and information about the coordination of young parent groups. Services also identified that young parent group attendance can be low and inconsistent in youth mental health settings. However, as it is likely that some young parents will prefer to meet other young parents, providing the option of youth-specific parent groups will be beneficial for some young people. Attendance may be increased by promoting and supporting the group to larger geographic areas, connecting with PHNs and hosting online young parent groups. For young parents wanting a youth-specific group, local perinatal and youth mental health services could work in partnership. Guides are available to support such groups, including PANDA's support group guide and the Mental Health Foundation's young parent group guide with content based on their expertise and deliver young parent groups across their services, co-facilitated by peer workers.(123, 151)

VOCATIONAL SUPPORT

EDUCATION

Young parents have reported social and practical barriers to participation in education. Young Australian parents have previously reported high levels of bullying and perceived judgement from their peers.(74) They also reported practical barriers, such as fatigue, feeling unwell while trying to study and an inability to concentrate. Parenthood can be a significant practical barrier to education, and requires considered support to ensure that young parents can continue to reach their personal educational goals.

A number of available strategies to support young parents' education. Those attending school report feeling supported through strategies such as flexible schedules, out-of-school supports such as home visits, onsite creche or allowing children in classrooms, assistance accessing external childcare, supplying larger uniforms while pregnant and providing access to lifts and other accessible options. Young parents in Australia also identified potentially useful strategies that were not made available to them, such as providing information about distance education options, proactively addressing bullying of pregnant students, flexibility for child-minding and breastfeeding, helping young people handle dual pressures, and allowing home education when unwell.

Social interventions can also improve educational outcomes for young parents. Interventions include service information and support from case managers, providing childcare, parenting and life education, and welfare incentives, such as bonuses or reductions based on school attendance.(152) One review found that interventions were effective at achieving educational outcomes, that adolescent parents were more likely to achieve vocational or alternative high school equivalent qualifications, that peer support is often instrumental to success, that early intervention to address multiple risk factors is effective, that childcare facilities in the school improve educational outcomes and that housing stability should be addressed.(152) The review recommended flexible and inclusive vocational training and providing childcare to allow young parents to return or reconnect with schooling.

An Australian Department of Education trial, Helping Young Parents, aimed to increase the education participation of adolescent parents, with a focus on attaining a Year 12 qualification or equivalent.(88) Young parents developed a participation plan that included a minimum of one vocational activity and one early childhood or parenting activity, and access to parent income support was dependent on the completion of these activities. Young parents were supported through greater access to childcare during the trial period. The 1,167 parents in the trial had a 30 percentage point higher chance of participating in education and a 14 percentage point higher chance of attaining a Year 12 qualification or equivalent compared to similar young parents who were not in the trial. They were also more likely to access childcare, which they were provided greater access to, which may partially explain positive outcomes. Supporting education participation through increased access to childcare should be explored.

Currently, some state and territories provide guidance on supporting young parents in schools through specific policies or references to pregnant and parenting students in their education legislation.(87, 153, 154) These programs include such features as allowing part-time attendance, flexible timetables and assessments, and increased childcare availability. (87, 153, 154)

While most state and territory laws ensure that all students receive an education, they do not necessarily require schools to make the adjustments necessary to support continued education.(74) The National Children's Commissioner has previously recommended that the Commonwealth work with state and territory governments to develop specific programs and systemic policies to support expecting and new parents in education, and that state and territory education departments collect data on pregnant and parenting students.(87) Schools should be supported with a better understanding of the number of options available to them, and should then be required to demonstrate that they are making adjustments where appropriate.

Some universities have developed strategies to support pregnant and parenting students. These supports include committing to discrimination-free environments and flexible arrangements, and offering parenting rooms and subsidised childcare services. There is some evidence to indicate a need for accessible and flexible childcare services that meets the demand of university students, financial assistance, transport and housing support, and flexible or prioritised class scheduling.(155)

Young parents require better support for defining and achieving their education goals. Youth mental health services such as headspace are well-placed to provide advice on setting and obtaining educational goals, and identifying opportunities for schools and universities to work flexibly to support pregnant and parenting students. Referral pathways from perinatal mental health services to youth mental health services will facilitate vocational support, and all health professionals need training and resources that address school inclusion for young parents.

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
NATIONAL GUIDANCE FOR EDUCATION PARTICIPATION			
Develop nationally consistent, best-practice guidance for inclusion of pregnant young people and young parents in education. Guidance should include systemic policies and a number of supports and interventions that schools can provide, based on co-design with young parents and evidence-based solutions.	The National Children's Commissioner has recommended the Commonwealth work with states and territories to develop consistent best-practice advice. State and territory departments should be required to regularly publish adjustments made to support young parents in education, as well as systemic policies and programs provided for pregnant and parenting students.	Pregnant or parenting young people are well-supported to continue their education.	Education Ministers Meeting.

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
ADDITIONAL CHILD CARE SUBSIDY FOR YOUNG PARENTS			
Expand the Additional Child Care Subsidy eligibility to include young people engaging in education.	There is evidence to suggest that reducing childcare-related issues may improve engagement in education. Financial barriers to childcare can result in some parents leaving education who would otherwise continue or complete their education.	Young people are better supported to continue or complete their education.	Services Australia.

EMPLOYMENT

Employment supports may reduce the impact of perinatal mental ill-health on young parents. As unemployment and financial difficulties are associated with mental ill-health in parents,(19, 58) engagement in the workforce may be protective for mental ill-health during the perinatal period. Adolescent parents in Australia have previously noted that young mothers are more likely focused on caring responsibilities and were unlikely to have full or part-time work, while many young fathers were engaged in employment.(74) Young parents with vocational goals will require personalised supports, and both young parents and employers will need to be supported to understand effective workplace adjustments.

Parenting Payments are the main income support for parents, including for parents seeking employment. Parents receiving a Parenting Payment for the last six months, caring for a child between nine months and six years old, and have not reported paid work to Centrelink in a six-month period may be required to participate in ParentsNext to receive their Parenting Payment. ParentsNext providers work with parents to develop a plan to achieve education and employment goals. Parents who do not meet the plan's requirements have their Parenting Payment temporarily suspended. Internationally, similar policies in pre-employment programs for single parents identified that benefits for employment and income were likely small, and that while there were some increases in self-worth, the requirements conflicted with job responsibilities, available jobs were low paid and insecure, and requirements increased stress, fatigue and depression.(156). Despite broad support and need for pre-employment programs, a 2019 Senate committee recommended that ParentsNext should not continue in its current form as it does not have a clear goal and may be causing distress.(157) Additionally, it recommends that participants with specific needs are referred to alternative pre-employment programs. Vocational initiatives will require unique, personalised and specialised approaches to support young parents with mental ill-health, who will likely have greater difficulties with ParentsNext than other participants.

Young parents with mental ill-health require focused and specialised employment supports, and conditional income support may increase distress. Individual Placement and Support (IPS) is an effective and cost-effective model of vocational support for young people with mental ill-health.(158) The Productivity Commission's Mental Health Inquiry suggested that a youth-focused IPS model will need to account for limited employment experience and the training and education needs of young people. From 2021, 50 headspace centres will deliver IPS.(159) Youth and perinatal mental health services should support the program design and training of an IPS referral pathway that supports young parents with mental ill-health.

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
TRIAL IPS PATHWAYS FOR YOUNG PARENTS WITH MENTAL ILL-HEALTH			
Develop, trial and evaluate pathways between perinatal mental health services and youth mental health IPS services to support young parents with mental ill-health who are not currently engaged in education or employment. Commission a two-year trial of IPS service access for young parents. Priority should be given to sites in the Northern Territory, Queensland and Tasmania.	IPS is an evidence-based vocational support that may support young parents with mental ill-health to create and achieve their vocational goals. IPS workers will require training on best-practice supports for the inclusion of young parents in the workforce. The Northern Territory, Queensland and Tasmania have been selected as births to young parents constitute a higher percentage of total births in these states and territories.	Increased access to vocational supports for young parents with mental ill-health.	Department of Social Services.

SUMMARY

Youth mental health services have expertise in supporting the vocational goals of young people, which is a service element likely valued and required by young parents.

Stronger collaborative care and referral pathways are needed across perinatal and youth mental health systems.

Opportunities for partnership include training development, parent groups and vocational support trials.

> “Young people are at a crucial age for employment and education trajectories, and parenting can alter these pathways.”

POLICY SOLUTIONS

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
ADDRESS KEY GAPS IN PERINATAL MENTAL HEALTH RESEARCH			
Develop a perinatal mental health research agenda that addresses key gaps in the experiences of young mothers, fathers and non-birth parents; LGBTIQ+ parents; and parents with complex or low prevalence mental ill-health.	To date, perinatal mental health research has focused on depression and anxiety, and research on young parents has focused on adolescent pregnancies. A perinatal mental health research agenda should include a focus on young parents and be designed in partnership with perinatal and youth mental health services, and young parents.	Policymakers and perinatal and youth mental health services have a better understanding of the unique needs of young parents, LGBTIQ+ parents and parents with complex or low prevalence mental ill-health.	National Health and Medical Research Council, Medical Research Future Fund.
DEVELOP A NATIONAL PERINATAL MENTAL HEALTH STRATEGY			
Develop a national perinatal mental health strategy, which should include a dedicated focus on young parents.	Consulted perinatal mental health organisations identified that the sector would benefit from a coordinated approach to perinatal mental health. This would enable consistent, best-practice care for new and expecting parents. This work would integrate and leverage the work of current services. Young parents should be engaged in co-design process.	Services and programs are not duplicative, leverage expertise, and all new or expecting parents receive consistent, best-practice care.	Australian Government Department of Health, perinatal mental health sector, state and territory health departments.

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
ESTABLISH A JOINT AGENCY TASKFORCE			
Establish a joint agency taskforce to implement the national perinatal strategy.	Reform in perinatal care will require holistic supports that cover mental health, education, employment and social services. Implementation requires partnership between relevant state and territory government departments.	Broad supports for new and expecting parents are better implemented across relevant departments.	National Cabinet Reform Committee responsible for delivering the National Mental Health and Suicide Prevention Agreement.
SUPPORT FOR ALL YOUNG PARENTS IN UPDATED GUIDELINES			
The current review and update of the national perinatal mental health clinical practice guidelines should include a unique focus on young parents, developed in partnership with young parents. Guidelines should include: • best-practice models for mother-baby units that include partner engagement and considerations for siblings; • addressing fear of child protection notifications as a barrier to help-seeking; and • screening, services and referral pathways for people experiencing family violence.	Current policies and guidelines do not adequately cover the experiences of young people, who have unique risk factors for perinatal mental health and unique experiences of care.	The experiences of young parents are uniquely considered and addressed.	Centre of Perinatal Excellence.

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
EXPAND THE PERINATAL NATIONAL MINIMUM DATA SET			
Expand the Perinatal National Minimum Data Set to include mental health and vocational indicators, and perinatal mental health screening data. Data and reporting should allow for young parents to be separately analysed.	The Productivity Commission recommended expanding the Perinatal National Minimum Data Set to enable greater understanding of population-level changes and screening rate rollout. Additionally, the National Children's Commissioner noted a need to understand the number of pregnant and parenting students in Australia.	Improved resource allocation through a better understanding of population-level perinatal mental health outcomes and screening rates.	Australian Institute of Health and Welfare.
NATIONAL DATA REPORTING FOR MOTHER-BABY UNITS			
Collect and publish national data for mother-baby units. Reporting should allow for separate analysis of young parent data.	More information is needed about the experiences and outcomes of people accessing mother-baby units. Data should include information that assesses service need.	An understanding of the experiences, outcomes and need of mother-baby units across Australia.	Australian Institute of Health and Welfare, state and territory health departments.
INCREASE ACCESS TO MOTHER-BABY UNITS			
Assess the service need for mother-baby units in each state and territory and ensure adequate resourcing to enable coverage.	Despite good clinical and parenting outcomes, there is limited access to mother-baby units across Australia. Considerations for assessing service need can be incorporated with the recommended national data collection for mother-baby units.	Young parents receive timely inpatient care alongside their child.	State and territory health departments.

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
TRIAL YOUTH-SPECIFIC SUPPORTS IN MOTHER-BABY UNITS			
Assess the youth-friendliness of mother-baby units and develop and trial youth-specific supports in partnership with young people and youth mental health services. The trial should be conducted for two years across different states and territories, prioritising sites providing care to a greater number of young parents.	Tertiary care for young people often involves additional, youth-specific support to deliver appropriate care. Innovative youth-specific supports should be trialled for young people accessing mother-baby units, and could be expanded to all age groups if effective and acceptable.	Young parents receive appropriate, youth-friendly care in mother-baby units.	Australian Government Department of Health, state and territory health departments, youth mental health services.
TRIAL ONLINE SUPPORT			
Fund a trial that augments PANDA's national perinatal mental health helpline with webchat support, designed in partnership with young parents. The two-year trial and evaluation should include all parents and assess age differences in efficacy, preference and support.	Where online and telephone services are available, young people have reported a strong preference for online support. While a perinatal helpline is currently available, webchat may be a more acceptable method of help-seeking for young parents. A trial is needed to understand efficacy, acceptability, and preferences for parents across demographics.	Young parents have access to appropriate help-seeking options and receive information and support aligned to their preferences.	PANDA.

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
AUDIT AND AUGMENT ONLINE PERINATAL MENTAL HEALTH SUPPORTS			
Fund existing online perinatal mental health websites to augment their website with specific content aimed at young parents. This should include: • resourcing for a co-design process with young parents; • information in multiple languages; • information for the health workforce that enables referrals between perinatal and youth mental health services; and • unique information for schools and employers supporting young parents.	Currently, there is little information available that focuses on the unique needs of young parents, such as effective employment and education adjustments. Additionally, both perinatal services and youth mental health services are not provided with dedicated resources that explain the broad range of service delivery options and considerations for young parents. An existing platform should be audited and augmented with youth-specific content, developed in partnership with young parents and youth mental health services. This content should then be connected to the Head to Health platform.	Young parents and their supports are provided with youth-specific information about pregnancy, birth and parenting and associated mental health resources.	Australian Government Department of Health, perinatal and youth mental health organisations
AUDIT AND DEVELOP TRAINING AND RESOURCES			
Perinatal and youth mental health services should work with young parents to: • audit and map available training; • co-develop augmented training with youth-specific information, referral pathways and experiences; and • produce and distribute a national resource that can be adapted to both perinatal and youth mental health services.	Both perinatal and youth mental health workforces identified gaps in their knowledge that the other workforce could provide. Training should be provided in modules to ensure that workforces can access the most relevant content and should be provided to a broad range of workforces. Training should be co-designed with young parents.	A workforce enabled to support young parents and refer them to the most appropriate supports.	Perinatal and youth mental health organisations.

POLICY SOLUTION	EVIDENCE BASE AND RATIONALE	OUTCOME	MECHANISM
NATIONAL GUIDANCE FOR EDUCATION PARTICIPATION			
Develop nationally consistent, best-practice guidance for inclusion of pregnant young people and young parents in education. Guidance should include systemic policies and a number of supports and interventions that schools can provide, based on co-design with young parents and evidence-based solutions.	The National Children's Commissioner has recommended the Commonwealth work with states and territories to develop consistent best-practice advice. State and territory departments should be required to regularly publish adjustments made to support young parents in education, as well as systemic policies and programs provided for pregnant and parenting students.	Pregnant or parenting young people are well-supported to continue their education.	Education Ministers Meeting.
ADDITIONAL CHILD CARE SUBSIDY FOR YOUNG PARENTS			
Expand the Additional Child Care Subsidy eligibility to include young people engaging in education.	There is evidence to suggest that reducing childcare-related issues may improve engagement in education. Financial barriers to childcare can result in some parents leaving education who would otherwise continue or complete their education.	Young people are better supported to continue or complete their education.	Services Australia.
TRIAL IPS PATHWAYS FOR YOUNG PARENTS WITH MENTAL ILL-HEALTH			
Develop, trial and evaluate pathways between perinatal mental health services and youth mental health IPS services to support young parents with mental ill-health who are not currently engaged in education or employment. Commission a two-year trial of IPS service access for young parents. Priority should be given to sites in the Northern Territory, Queensland and Tasmania.	IPS is an evidence-based vocational support that may support young parents with mental ill-health to create and achieve their vocational goals. IPS workers will require training on best-practice supports for the inclusion of young parents in the workforce. The Northern Territory, Queensland and Tasmania have been selected as births to young parents constitute a higher percentage of total births in these states and territories.	Increased access to vocational supports for young parents with mental ill-health.	Department of Social Services.

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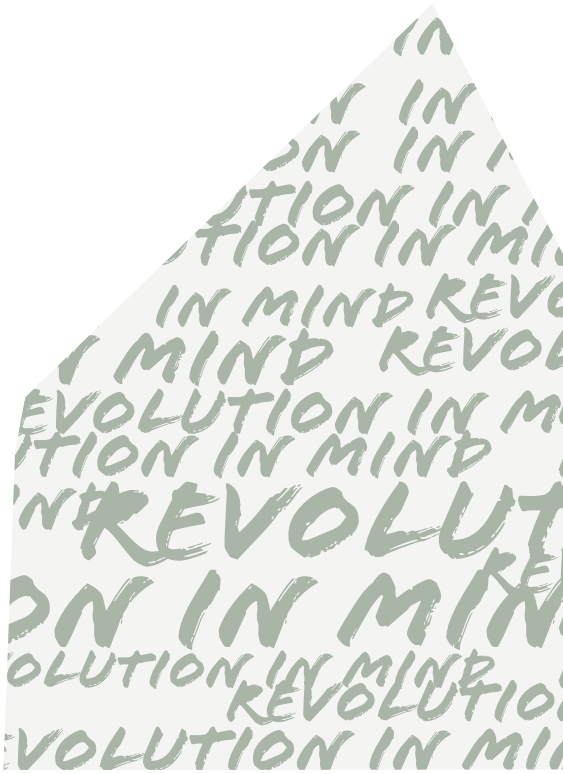

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