GUIDELINE

Perinatal and infant mental health

Scope (Staff): Child Health
Scope (Area): CACH/WACHS

This document should be read in conjunction with this DISCLAIMER

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Aim
To support nurses working in community child health settings to identify, assess, and offer additional support services and/or referral to specialist services where available, to mothers and/or family members who are experiencing a perinatal or infant mental health issue.

Risk
Unresolved mental health issues in the perinatal period can impose a great burden on women, their infants and families and the health system.¹

Background
Evidence around the importance of maternal perinatal mental health has been well documented; however the impact of the perinatal period on fathers and co-parents remains an emerging area of research.¹ The majority of presentations at child health centres are by mothers and their babies, but it is recognised that nurses working in community health settings may engage with diverse family structures where the primary caregiver may not be the birth-mother or female and not all partners may be male.

Research suggests that parents who identify as Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) may be at a greater risk of developing perinatal anxiety and depression than other population groups. This is due to the additional conception complications, discrimination and potential relationship difficulties with their families of
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origin experienced by LGBTIQ families. Understanding the family context will support nurses to a fuller understanding of the individual situation. This document will use the terms mother and father where gender issues are relevant to the mental health concern, and partner and caregiver at other times.

Mental health issues can significantly impact parents, caregivers and infants during the perinatal period, which for the purpose of this guideline has been defined as conception to thirty-six months postpartum. The transition to parenthood and the addition of a child to an existing family structure can be a complex and stressful time for all family members. Parents with perinatal mental health issues may experience difficulties in their relationships with other family members and the potential disruption of mother-infant attachment may lead to poor infant mental health.

Maternal mental health

The maternal mental health conditions experienced most frequently in the perinatal period are perinatal depression and anxiety. Perinatal depression is a term used to describe a sustained depressive disorder which can present in both the antenatal and postnatal periods. Perinatal anxiety can be defined as problematic anxiety experienced by parents during the period from conception through pregnancy and up to three years postpartum, affecting the development of secure relationships and a person’s ability to complete daily tasks.

Approximately 13% of women experience depression in the antenatal period, 13% experience anxiety, and comorbidity with anxiety and depression is high. As many as 15-20% of women experience depression and/or anxiety in the first 12 months postpartum. Depression and or anxiety can lead to disinterest in regular activities, feelings of being overwhelmed, sleep and appetite disturbances, and may result in thoughts of suicide or self-harm.

Perinatal anxiety disorders are characterised by levels of fear or worry that are out of proportion to the object of the worry. The presence of anxiety disorders is also a risk factor for the development of perinatal depression. Perinatal anxiety has been associated with reduced duration of breastfeeding, increased use of health services in the first six months, and perceived infant temperament problems. Women with a history of untreated or unstable anxiety and depression may find their symptoms are exacerbated in the perinatal period.

Anxiety disorders may include generalised anxiety disorder (GAD), panic attack disorder, social anxiety, adjustment disorders with anxiety, post-traumatic stress disorder (PTSD), obsessive compulsive disorder (OCD), comorbid depression and anxiety and phobias, such as blood, needle, or tokophobia (fear of pregnancy).

Postnatal psychosis, also known as puerperal psychosis, is a severe psychotic illness associated with the perinatal period. It is relatively rare at a rate of 0.2 percent but due to the potential safety concerns for the affected woman and her infant, psychosis is a psychiatric emergency. Nurses must seek immediate assistance from a mental health service, emergency department, or a general practitioner (GP) depending on the availability of services if psychotic symptoms are present.

Existing serious mental illness, such as schizophrenia and bipolar disorder will require ongoing support of specialist services throughout the perinatal period as these conditions are risk factors for developing postnatal psychosis. This guideline does not address the management of pre-existing conditions; rather will deal with the impact of mental health issues that develop or recur as a direct result of pregnancy and parenting.
Mothers with a previous mental health issue, of low socioeconomic status, limited social support; or those experiencing adverse life events such as bereavement, poverty, unemployment, family and domestic violence or history of abuse or migration are at increased risk of developing perinatal mental health issues. Mental health issues may lead to inadequate self-care and nutrition; suicidal thoughts or harm to self and/or baby; drug and alcohol misuse; or relationship disruption or breakdown.

The hormonal changes experienced as a result of pregnancy and birth can increase a mother’s susceptibility to mental illness. Unrealistic expectations of motherhood may result in stress, anxiety, or depression if the mother feels she is not coping, needs assistance, or finds the task of parenting more challenging than expected.

Complications with conception, pregnancy, unplanned pregnancy, an adverse birthing experience, difficulties with parenting such as infant feeding, sleeping, and infant temperament may increase the risk of developing mental health issues in the perinatal period. It is important to note that while risk factors can be present, mental health issues in the perinatal period frequently occur in the absence of any identifiable risk.

**Paternal mental health**

Fathers may experience mental health issues in the perinatal period, and evidence suggests that men’s mental health issues are currently under reported and under-screened. Reviews on mood disorders within fathers during the perinatal period have identified a prevalence of one in ten for paternal depression, one in six for anxiety during the prenatal period and up to one in five during the postnatal period. While these estimates are for fathers irrespective of their partner’s mental health status, the incidence of paternal depression is 24-50% for men whose partners have perinatal depression.

There are differences between the way men and women present with perinatal mental health issues. Men are more likely to express anger, irritability, and have lower impulse control, and may mask their depression using drugs, alcohol or interpersonal conflict.

Fathers can experience a number of barriers to seeking help because the focus is often on the woman’s health and they may have less access to a health professional postnatally than their partner. It is important that nurses provide a welcoming environment to fathers and screen for mental illness whenever possible. Using screening to open up communication will assist fathers to access information, reduce barriers, and be proactive in identifying and addressing their needs.

Mental health issues for fathers may lead to relationship concerns, reduced desire for sexual intimacy and difficulty bonding with the infant. Infants whose father experienced perinatal depression are more likely to exhibit behavioural problems at age three and at school entry. Risk factors predisposing fathers to a mental health issue may include: experiencing excessive stress surrounding the pregnancy or birth and fear for their partner; perceived lack of information, support, and inclusion in the pregnancy and birth process; a lack of acknowledgement of their role and needs; childhood trauma; alcohol and other drug use; and changes in their financial situation and intimate relationship with their partner.

**Infant mental health**

Infant mental health refers to the capacity of children from birth to five years of age to:

- develop secure relationships with parents/caregivers, other adults and their peers
- experience, manage and express a range of emotions
Infant mental health is influenced by a range of factors including the infant’s own physical health and temperament, carer availability, capacity and responsiveness and the quality of the relationship between infant and carer. A struggle in this relationship can affect the infant’s growth, development, play and learning; their behaviour and ability to regulate their emotions; and their sleep and feeding patterns.

Attachment theory helps us understand the patterns of behaviour which develop in response to the parent’s caregiving style. A secure attachment develops when a child learns to trust that their parent/caregiver will respond appropriately when given the signal that they need something, for example, food or to be cuddled and soothed.

Consistently responding to the infant’s signals (e.g. smiles, eye contact, crying) builds two-way communication between the infant and parent/caregiver which helps the infant feel safe and secure, allowing them to explore and learn from their surroundings. This is the cornerstone of the infant’s biological, cognitive, social, and emotional development for their future adulthood.

If an infant is unable to form a secure attachment with the mother, encouraging a secure attachment with another caregiver, such as the father, partner or a grandparent, may protect the infant and help them to optimise their growth and development within these circumstances.

The Mental health care in the perinatal period: Australian clinical practice guideline provides a list of prompts to support the assessment of the mother-infant relationship. These should not be used as a checklist or formal assessment tool, but observation of the following can indicate protective factors and potential difficulties in the mother-infant attachment.

- Is the mother thoughtful about her baby?
- Can the mother describe the baby’s daily routine?
- Is the mother able to reflect on the baby’s needs?
- Does the mother express empathy for the baby?
- Does the mother play/talk appropriately with the baby?
- Does the baby ever make her feel uncomfortable, unhappy or enraged?
- Is the mother excessively worried about the baby?
- Does the mother cope with the baby’s distress?
- Are her responses consistent?

In the long term poor attachment may negatively impact language acquisition, school performance, cognitive and social development, and emotional regulation. These factors lead to further problems which can put the child at a higher risk of developing a mental health issue later in life.

The arrival of a new baby may be difficult for young children or toddlers, who may express jealousy, exhibit oppositional, attention-seeking, or defiant behaviour. Parents/caregivers may feel guilty about not having as much time and connection with their older child and may need support to deal with their own feelings, as well as the behaviours of their older child.
Mental health impact

When a parent/caregiver is experiencing a mental illness, the family may benefit from additional support. People with a mental illness might be faced with a stigma that labels them as emotionally and psychologically less capable and unable to cope with ‘normal’ life. They might also feel shame, humiliation or embarrassment, or might view themselves as being weak for developing a mental illness. Additionally, parents/caregivers may fear that their children will be removed from their care if they have a mental health issue. As a result, parents/caregivers experiencing a mental health issue may limit their contact with health professionals or choose not to disclose their true feelings and thoughts.

For some parents/caregivers, the perceived dangers faced by a new baby may cause heightened awareness and worry, and lead to repetitive or irrational behaviours or thoughts. For others, such worry may lead to intrusive thoughts or images, which may be distressing and overwhelming. These thoughts and images are often not shared with others as parents/caregivers may feel guilty or ashamed. When these intrusive thoughts are acknowledged it is important that parents/caregivers are reassured that these are relatively common, and only problematic if they are causing them to be afraid. Exploring these thoughts usually provides reassurance that they can be recognised as being unusual and can be easily discounted. Referral for further mental health assessment is required if these thoughts are distressing or overwhelming.

Nurses are encouraged to adopt a family partnership approach to develop an open and non-judgemental environment to generate communication about emotional issues and mental health and normalise the parents'/caregivers' experiences. A recent Canadian study reported that mental health screening is broadly acceptable to parents and caregivers, therefore screening should be offered universally, both at scheduled visits, and where there is parental or professional concern. The use of the Edinburgh Postnatal Depression Scale (EPDS) to screen for depression and the Perinatal Anxiety Screening Scale (PASS) to screen for anxiety will be discussed further in Appendices A and B. All caregivers should be invited to participate in mental health screening and it is important to recognise that there are gender issues in mental health presentations and different risk cut-off scores for women and men.

Key points

Nurses will:

- Work within their scope of practice.
- Have a well-developed understanding of perinatal and infant mental health issues.
- Provide non-judgemental care to support parents/caregivers and promote sensitive parenting and secure attachment.
- Implement a process to identify parents/caregivers with mental health issues which, at minimum, includes:
  - Exploring family circumstances as per the per Indicators of Need (ION)
  - Offering screening with the Edinburgh Postnatal Depression Scale (EPDS) as described in Appendix A
  - Offering screening with the Perinatal Anxiety Screening Scale (PASS) where indicated as described in Appendix B
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- Assessing the attachment between the infant and mother/caregiver as demonstrated by their interaction.

- Follow the *Universal Contacts* Guidelines in regard to care-planning and future contacts.

- Be aware of their emotional health and to undertake clinical supervision where available.
Appendix A: Edinburgh Postnatal Depression Scale (EPDS)

Aim

To identify parents and caregivers at risk of depression and/or anxiety in the perinatal period, by using the Edinburgh Postnatal Depression Scale (EPDS).

Risk

Untreated perinatal depression and/or anxiety may cause distress, impaired functioning and impact the parent/caregivers relationship with their partner and/or family members. Infant health and emotional wellbeing can also be affected, due to the potential disruption in the development of a safe and secure parent-infant attachment.

Background

The Edinburgh Postnatal Depression Scale (EPDS) was developed in 1987 as a self-report questionnaire and is used in many countries to screen for the risk of developing perinatal depression. An anxiety subscale with cut-off scores for anxiety is also included. The EPDS is an easy to administer 10-item first stage screening questionnaire has been translated into 36 different languages with 18 being validated. Each language version has a unique recommended cut-off score. The EPDS can be used with both men and women, though the cut-off scores are different (see Appendix C).

The EPDS should be offered in an environment where the nurse and parent/caregiver have privacy. It should not be used in an open clinic setting, over the telephone, or posted to parents/caregivers. Where the EPDS is administered to both parents attending the appointment, care should be taken for each parent to answer independently without the influence of the other.

Nurses should be aware of a client’s life events and recent stressors, such as job loss or bereavement, because these stressful events might produce a high EPDS score indicating emotional distress rather than depression.

Key points

- The EPDS should only be used by nurses who have been trained in its use and have a clear referral pathway. Training should include suicide risk assessment and management.
- The EPDS is an indicator of the risk of depression and anxiety NOT a diagnostic tool. It should be used in conjunction with a holistic consultation and professional judgement to identify those who need follow-up or referral.
- The scale provides an indication of the parent’s/carer’s perception of their mood in the preceding 7 days. It does not predict on-going mood.
- Where the offer of the EPDS is refused, the refusal should be documented according to local processes, and nurses should use their clinical judgment to determine follow-up actions. The EPDS should be offered again at subsequent visits.
- The EPDS provides a universal language between health care professionals that facilitates referrals.
- Nurses should ensure correct use of a professional interpreter as required.
## Process

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<td><strong>1. Administer EPDS</strong>&lt;br&gt;• The EPDS must be offered to all parents or caregivers at:&lt;br&gt; 8 weeks&lt;br&gt;4 months&lt;br&gt;12 months&lt;br&gt;Any other time where there is parental or professional concern&lt;br&gt;• All ten items must be completed.&lt;br&gt;• Any mismatch between the EPDS score and the clinical presentation should be explored further.</td>
<td>• The child health centre or a home visit may provide suitable opportunities for the completion of the EPDS.&lt;br&gt;• The parent/caregiver is asked to <strong>underline</strong> the response which comes closest to how he or she has been feeling in the <strong>previous 7 days</strong>.&lt;br&gt;• The link to the English version of the EPDS form is available on the CACH Intranet forms page or Womens and Newborns Health Service.&lt;br&gt;• The scale should be completed by the parent/caregiver personally unless they have limited English (and a relevant translation is not available) or have difficulty with reading.&lt;br&gt;• If English is the parent/caregivers second language, the use of a <strong>translated EPDS</strong> should be considered.</td>
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| **2. Calculate score**<br>• Questions 1, 2, & 4 are scored 0, 1, 2, or 3 with the top response scored as 0 and the bottom response scored as 3.<br>• Questions 3 and 5-10 are scored in reverse, with the top response scored as a 3 and the bottom response scored as 0. | • The maximum score on the EPDS is 30.<br>Table 1: EPDS Question Scores<br><br>Table 1: EPDS Question Scores<br><br>| Q 1-2 | Q 3 | Q 4 | Q 5-10 |
|-------|-----|-----|--------|
| 0     | 3   | 0   | 3      |
| 1     | 2   | 1   | 2      |
| 2     | 1   | 2   | 1      |
| 3     | 0   | 3   | 0      |

| **3. Interpret score**<br>Nurses should score the EPDS on completion and discuss the parent’s/carer’s responses.<br>The screening tool is used in conjunction with good clinical judgement, clinical observation of the client’s interaction with the infant and the staff member, and a psychosocial assessment. | • A score of 0 is considered unusual, may indicate masking or literacy issues and requires further discussion with the client.<br>• Explore any individual question with a high score. This helps to clarify and explore the answer with the parent, in the context of what is happening for them. Cut-off scores for the English version for |
### Steps

- The following are postnatal cut-off scores for English speaking men and women.
- Note: the scores in the table apply to the English version. If a translated version of the EPDS has been used, refer to the additional notes for that specific language version to determine the appropriate cut-off scores.

### Additional information

men and women, according to the EPDS.
- **Low risk** of perinatal depression
  - Women: 0-9  Men: 0-5
- **Moderate** risk of perinatal depression
  - Women: 10-12  Men: no moderate measure refer to high risk.
- **High risk of perinatal depression**
  - Women 13 – 30  Men 6 or more

The antenatal cut-off score for women is 13 or above.\(^\text{12}\)  

**Cut-off scores for Anxiety** using the English version for men and women, according to the EPDS:
- Subscale on questions 3, 4, & 5
- Total possible anxiety score of 9
  - Women: 6 or more  Men: 4 or more
  - Irrespective of the overall EPDS score, a score over 6 for women and over 4 for men may indicate the presence of anxiety, and further clinical assessment is required.
  - See Appendix B for guidance on administering and scoring the *Perinatal Anxiety Screening Scale (PASS)*.

### 4. Assess suicide risk

- Question 10 on the EPDS assesses the suicidal ideation of the respondent

A score of 1, 2 or 3 requires a more detailed assessment regarding current risk of suicide or self-harm (including: intent, plan, method, impulsivity, recent events, etc.)
  - Recheck that these feelings occurred in the last 7 days.
  - Use clinical judgement to assess risk to parent/caregiver and child.
  - Discuss support network with the parent/caregiver.
  - Where nurse has concerns about the risk to parent/caregiver or child, the family or support network should be contacted.
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| **5. Discuss results**  
a) **Low risk of perinatal depression**  
   o Women 0-9  Men 0-5  
   • Some symptoms of distress may be present but they are less likely to interfere with day to day functioning.  
| • Check the anxiety sub scale as the parent/caregiver may have scored 9 out of 9 on the anxiety score  
• Discussion of feelings, experiences, role change, changes in relationship, and losses and gains.  
• Provide support to ensure continued wellbeing. |
| b) **Moderate risk of perinatal depression (Women only)**  
   o Women: 10-12  Men: no moderate measure refer to high risk.  
   • Scores in this range indicate that the presence of symptoms are distressing and discomforting, and may impact functioning.  
   Use active listening techniques  
   • Encourage enlisting support from GP, partner, family, and friends. Encourage participation in new parent groups.  
   • Provide links to online resources and apps on perinatal mental health.  
| • Encourage parents to have regular time devoted to positive interactions with the infant.  
• Encourage regular weekly time-out e.g. with child care services or partner or friends looking after child  
• Offer follow-up *Universal plus* appointment to offer to repeat EPDS in 2 to 4 weeks, using clinical judgement to determine the most appropriate time for this to occur.  
• *Head to Health* provides a list of endorsed mental health web pages and apps. See Useful resources section. |
| c) **High risk of perinatal depression**  
   o Women 13 – 30 Men: 6 or more  
   • Scores in this range require further assessment as the likelihood of depression is high.  
   • Assess thoughts of harm to self or baby.  
   • Refer to GP, if indicated and consent has been provided.  
   • Discuss the range of options that may be offered by the GP, including counselling and anti-depressants.  
| • Consider urgent referral for a mental health assessment to GP, local hospital, or mental health service using the Clinical Handover/Referral Form (CHS 663), especially where a positive score for Question 10 has been returned.  
• Ensure the parent/caregiver is in the company of a partner, family member or friend to ensure their safety prior to leaving the child health centre.  
• Provide and discuss relevant local mental health services, information, and contact details to parent/caregiver and support networks.  
   o Encourage participation in perinatal depression support groups. |
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<td></td>
<td>o Encourage parents to have regular time-in devoted to positive interactions with the infant.</td>
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<td></td>
<td>o Ensure frequent time out e.g. with child care services or partner or friends looking after child.</td>
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<td></td>
<td>o Encourage the client to take medication if it has been prescribed and to return to the GP if they have concerns or questions.</td>
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<td>- Repeat EPDS in 2 to 4 weeks, using clinical judgement to determine the most appropriate time for this to occur.</td>
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<td>6. Refer</td>
<td>- Use the Clinical Handover/Referral Form (CHS663) for referrals to GP or other health services.</td>
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<td>- The local Family Support Network may be able to offer support for identified psychosocial concerns. See Useful resources section.</td>
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<td>- Nurses should be aware of, and consider their own appropriate local services and referral options.</td>
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<td>- Nurses should inquire about the parent/caregivers support network, the safety of the parent/caregiver and the safety of the child, to decide whether it is appropriate to contact mental health services or the Child Protection and Family Services (CPFS).</td>
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<td>- If signs of harm are evident, mental health services and/or CPFS should be contacted.</td>
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<td>7. Follow-up</td>
<td>Nurses will ensure that culturally appropriate services are provided to parents/carers where they are available e.g. provision for CalD parents/carers, Aboriginal and Torres Strait Islander parents/caregivers, single parents/caregivers, young parents, and</td>
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<td>- Use professional judgement to determine if phone follow-up is necessary within one week if possible. If the nurse is unable to contact the parent/caregiver, they may discuss this with their line manager to ensure the</td>
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- The Perinatal Mental Health Clinical Referral Pathway indicates the types of services that might be helpful to parents/caregivers.

- If the parent/caregiver does not consent for referral, the nurse should document the offer and the refusal according to local processes.
### Steps

- Follow up should occur even if EPDS hasn’t been administered and nurse has concerns about a parent or caregiver’s mental health.
- Offer a Universal plus appointment within next 2-4 weeks as per clinical judgement and family need/ willingness to attend.

### Additional information

- men.

### 8. Document

- All EPDS scores, notes on clinical presentation, and the psychosocial assessment, along with any other relevant findings, are to be recorded in the appropriate electronic or paper based records.

| Nurses must record all findings in relevant electronic data systems according to local protocols. |
| Retain a copy of the parent completed EPDS in the client record, for the purpose of a future comparison of results and to meet legal requirements regarding the medical record. |
Appendix B: Perinatal Anxiety Screening Scale (PASS)

Aim
To identify women at risk of problematic anxiety in the perinatal period, by using the Perinatal Anxiety Screening Scale (PASS) as a secondary screening tool where indicated following an Edinburgh Postnatal Depression Scale (EPDS).

Risk
Untreated perinatal anxiety may cause distress, impaired functioning and impacts the mother’s relationship with her partner and family members. Infant health and emotional wellbeing can also be affected, due to the potential disruption in the development of a secure mother-infant attachment.

Background
In 2014 King Edward Memorial Hospital developed the PASS to screen for problematic anxiety symptoms in women in the perinatal period up until twelve months postpartum. It has been validated for use for women who are English-speaking, literate and aged 18 years and older. The PASS should be offered to gain a greater understanding of the severity and nature of anxiety symptoms when a score over 6 is identified on the anxiety subscale questions of the EPDS. As PASS does not have a specific suicide risk question, it should not be used without the EPDS or a discussion around risk.

When determining appropriate management and referrals, additional clinical information such as risk of suicide or self-harm, recent stressors for the woman, observations of body language, verbal responses, physical health, personal and familial mental health risk factors, and observing the mother baby relationship should be considered.

Key points
- The PASS should only be used by nurses who have been trained in its use, have a clear referral pathway and knowledge of local resources.
- The PASS is an indicator of the risk of anxiety and NOT a diagnostic scale. It should be used in conjunction with a holistic consultation and professional judgement to identify those who need follow-up or referral.
- The PASS can be used:
  - With women aged 18 years or older, English speaking, and literate
  - During pregnancy and up until 12 months postpartum
  - After a EPDS anxiety subscale score of 6 or above has been identified (Questions 3, 4, and 5)
  - When anxiety symptoms are present, even when an EPDS anxiety subscale score less than 6 has been identified; and
  - Where a nurses’ professional judgement warrants further screening.
- Where the offer of the PASS is refused, the refusal should be documented according to local processes and nurses should use their clinical judgment to determine follow-up actions. The PASS should be offered again at subsequent visits if indicated.
### Steps

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<tr>
<td><strong>1. Discuss</strong></td>
<td>- When clinically appropriate, a Universal Plus contact may be scheduled to complete the PASS if other issues need to take priority within a contact.</td>
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<td>- The nurse will explain the reason for offering the secondary screening is to gain a greater understanding of the anxiety symptoms which were identified on the EPDS; and to provide assistance if the symptoms are impacting on everyday life.</td>
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<tr>
<td><strong>2. Administer PASS</strong></td>
<td>- Women must self-rate all of the thirty one (31) PASS questions, indicating the frequency of the symptoms over the previous month.</td>
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<td>- Access PASS forms. These are available on the CACH Child Health intranet forms page.</td>
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<td><strong>3. Calculate score</strong></td>
<td>- The items are on a scale ranging from 0 (“not at all”) to 3 (“almost always”). A total PASS score is obtained by adding all of the items on the PASS.</td>
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<tr>
<td><strong>4. Interpret results</strong></td>
<td>- Cut-off scores are somewhat arbitrary. Individuals who fall just short of a clinical cut-off should be recognised as experiencing considerable symptoms and at risk of developing more severe symptoms</td>
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<td>- Nurses can discuss therapeutic lifestyle changes with the woman such as eating a nutritious diet, developing good sleep habits, participating in enjoyable activities, and maintaining positive relationships. Exercise, muscle relaxation techniques and mindfulness based therapies have been shown to be effective in treating anxiety.35</td>
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<td>- Women requiring referral may engage in behavioural therapy, self-directed learning, facilitated and computer aided psychological therapy, acupuncture, yoga, mindfulness practice and meditation.36</td>
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**Minimal 0 – 20**

Some symptoms of anxiety may be present but they may be short-lived and less likely to interfere with day to day functioning.

- Where required, offer additional contacts to meet individual client needs.
- Provision of perinatal mental health information and resources may be of benefit.
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| **Mild to Moderate** 21 – 41  
Scores may indicate presence of symptoms of anxiety that may be discomforting and possibly starting to impact on daily life. | A cut-off score of 26 is recommended to differentiate between high and low risk for presenting with an anxiety disorder  
- If the score is < 26 referral is not necessary, unless clinically indicated through further inquiry.  
- Provide information on perinatal anxiety and depression (see the list of resources at the end of this document).  
- Offer to repeat the PASS in 2 weeks.  
- **If the score is > 26**  
  - As above.  
  - Assess further and consider referral for further mental health assessment to GP or the local Women’s Health Clinic as needed using the Clinical Handover/Referral Form (CHS 663).  
  - If possible, offer another appointment (or phone contact) in 1-2 weeks for support and to monitor anxiety.  
  - With the woman’s consent include the woman’s support person in discussions. |
| **Severe** 42 – 93  
Anxiety symptoms are likely to be problematic and interfering with functioning |  
- Seek the woman’s consent to set up emergency supports in consultation with her support person and family if possible.  
- Consider urgent referral for further mental health assessment to GP, local hospital, or mental health service using the Clinical Handover/Referral Form (CHS 663).  
- Consider the safety of mother and baby.  
  - Referral pathways:  
    - Mental Health Emergency Response Line – Metro: 1300 555 788; Peel: 1800 676 288  
    - Rurallink - 1800 552 002  
    - Suicide Call Back Service, Lifeline |
| **5. Document**  
Nurses will exchange information between health professionals and agencies according to local protocols and by adhering to the Clinical handover referral form |  
- Nurses must record all relevant findings in relevant electronic data systems according to local protocols.  
- Retain a copy of the parent completed PASS in the client record, for the |
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<td>(CHS663).</td>
<td>purpose of a future comparison of results and to meet legal requirements regarding the medical record.</td>
</tr>
</tbody>
</table>
Appendix C: Clinical referral pathway

The scores identified in this pathway are for ENGLISH speaking men and women. Refer to each translated EPDS for the cut off scores associated with that language.

**EPDS Overall score 1-30**
- **Low risk**
  - Women: 0-9
  - Men: 0-5
- **Moderate risk**
  - Women: 10-12
  - Men: No moderate risk score identified for men
- **High risk**
  - Women: 13-30
  - Men: 6-30

**Actions**
- Discuss score
  - Provide relevant information and support services
  - Provide basic therapeutic lifestyle information – nutrition, sleep, exercise self-care
  - Offer additional contacts to meet individual needs where clinical judgement warrants

**EPDS anxiety subscale Q3, 4 & 5**
Irrespective of the overall score, if response is:
- 6 and above for women
- 4 and above for men
- Problematic anxiety may be present consider administering PASS

**PASS overall score 1-31**
- **Minimal risk**
  - 0-20
- **Mild-moderate risk**
  - 21-41
  - Score of 26 or more differentiates between high & low risk of anxiety

**EPDS suicide risk Q10**
Irrespective of overall EPDS score:
If response is a 1, 2, or 3, further assessment is required

**Actions**
- Requires a more detailed assessment regarding current risk of suicide or self-harm including:
  - Intent
  - Plan
  - Method
  - Recent events
  - Determine that these findings have occurred within the last 7 days
  - Explore any thoughts of harm to the baby

**Actions**
- Discuss and agree on safety plan
- Share information re suicide call back service

**Actions are the same as for moderate risk, and:**
- Conduct further assessment
- Discuss referral options as per moderate risk
- Consider urgent referral for high scores and where clinical judgement warrants
- Ambulance
- Local emergency department
- Mental health services
- Mother and baby unit
- Ensure families have emergency telephone numbers
- Offer follow-up phone call in one week and universal + appointment in 2-4 weeks to review and repeat EPDS/PASS
<table>
<thead>
<tr>
<th>Related internal policies, procedures and guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following documents can be accessed in the Community Health Manual via the HealthPoint link or the Internet link</td>
</tr>
<tr>
<td>Family and domestic violence</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Related internal resources and forms</th>
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</thead>
<tbody>
<tr>
<td>The following resources and forms can be accessed from the HealthPoint CACH Intranet link under Child Health</td>
</tr>
<tr>
<td>Clinical handover referral form (CHS663)</td>
</tr>
<tr>
<td>Edinburgh Postnatal Depression Scale</td>
</tr>
<tr>
<td>Perinatal Anxiety Screening Scale (PASS)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Department of Health, Government of Western Australia resources or policies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical and Clinical Event Debrief</td>
</tr>
<tr>
<td>Guidelines for Protecting Children 2015 Department of Health, Government of Western Australia</td>
</tr>
<tr>
<td>Language services policy</td>
</tr>
<tr>
<td>Translated EPDS resources</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Useful resources</th>
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</thead>
<tbody>
<tr>
<td>COPE (Centre of Perinatal Excellence) provides perinatal and postnatal advice</td>
</tr>
<tr>
<td>COPMI resource centre for children of parents with mental illness</td>
</tr>
<tr>
<td>Head to Health- Digital mental health gateway is a repository of endorsed mental health websites and apps, including many suitable for the perinatal period</td>
</tr>
<tr>
<td>Western Australian Family Support Networks</td>
</tr>
<tr>
<td>Mental Health Commission WA</td>
</tr>
<tr>
<td>General facts, causes, and personal stories on mental health issues</td>
</tr>
<tr>
<td>Mental Health in Multicultural Australia</td>
</tr>
<tr>
<td>Assists providers and government agencies in providing services to culturally and</td>
</tr>
</tbody>
</table>
linguistically diverse (CaLD) groups with mental health issues

| **NHMRC Mental Health Care in the Perinatal Period Australian Clinical Practice Guideline**  
| October 2017 |
| **PANDA**: Perinatal Anxiety and Depression Australia, a not-for-profit organisation that provides information and support on maternal mental health. National helpline number: 1300 726 306 |
| **Perinatal and infant mental health toolbox** |
| **Raising children network** provides parenting information from pregnancy to adolescence, as well as information on relationships |
| **WA Perinatal Mental Health Unit** is a government agency that provides resources, training, and research on perinatal mental health issues |
| **What were we thinking?** is an online parenting program which can be used by individuals or in small groups. |

### Useful resources – Services

**Lifeline**

Lifeline provides access to crisis support, suicide prevention, and mental health support services. Phone: 13 11 14

**Suicide Call Back Service**

The Suicide Call Back Service provides crisis counselling to people at risk of suicide, carers for someone who is suicidal, and those bereaved by suicide, 24 hours per day 7 days a week across Australia. Phone: 1300 659 467

**Mother and Baby Unit**

State-wide inpatient treatment centre at King Edward Memorial Hospital (KEMH) and at Fiona Stanley Hospital (FSH) for acute perinatal psychiatric conditions

Free call **KEMH**: 1800 422 588
Call **FSH**: 6152 2222

**Mental Health Emergency Response Line (MHERL)**

The mental health call centre provides expert and accurate telephone response to acute mental health issues. All callers will be triaged and referred to the most appropriate acute response team according to the level of clinical priority.

Perth Metro Residents: 1300 555 788
Peel Residents: 1800 676 822
TTY: 1800 720 101
**Rurallink**: Phone 1800 552 002
References


Perinatal and infant mental health


31. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. Development of the 10-


