



## GUIDELINE

### Perinatal and infant mental health

<b>Scope (Staff):</b>	Community health staff
<b>Scope (Area):</b>	CAHS-CH, WACHS

#### Child Safe Organisation Statement of Commitment

CAHS commits to being a child safe organisation by applying the National Principles for Child Safe Organisations. This is a commitment to a strong culture supported by robust policies and procedures to reduce the likelihood of harm to children and young people.

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.<sup>1</sup>

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

## 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.<sup>1</sup> The majority of presentations to 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 origin experienced by LGBTIQ families.<sup>2</sup> 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.<sup>3</sup> 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.<sup>4, 5</sup>

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.<sup>1</sup> 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.

## Protective and risk factors

Protective factors strengthen a person's mental health and improve their ability to cope during difficult times. Protective factors include resilience, self-esteem, physical activity, positive parent and family relationship, social supports, employment, and a sense of belonging.<sup>6</sup>

Risk factors adversely impact a person's mental health. Parents experiencing adverse life events or with a previous mental health issue, low socioeconomic status<sup>7</sup> or limited social support<sup>1,12</sup>; are at increased risk of developing perinatal mental health issues. Adverse life events include bereavement, poverty, unemployment, family and domestic violence or history of abuse<sup>1</sup>, substance misuse<sup>1</sup> or migration.<sup>1</sup> Mental health issues may lead to inadequate self-care and nutrition, suicidal thoughts or harm to self and/or infant, drug and alcohol misuse, or relationship disruption or breakdown.<sup>8</sup>

The hormonal changes experienced as a result of pregnancy and birth can increase a mother's susceptibility to mental illness.<sup>9</sup> 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.<sup>10</sup>

Complications with conception and pregnancy, unwanted pregnancy, an adverse birthing experience, or difficulties with parenting such as infant feeding and sleeping, issues or a mismatch with infant's temperament may increase the risk of developing mental health issues in the perinatal period.<sup>11</sup> 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.

When working with clients who are at high risk of mental health condition, staff can seek the support of, or refer clients to relevant support agencies. For example, consult with the Aboriginal Health Team when working with Aboriginal clients or the use of a translator when clients only speak a language other than English.

## Maternal mental health

The 12-week period after birth is sometimes referred to as the 'fourth trimester'. It is a time of significant physical and emotional change as both mother and infant adjust to their new life.

During this perinatal period, it is common for new parents to experience adjustment difficulties. A large amount of energy is required to deal with the many changes to daily

life and sleepless nights and it commonly takes some time for new parents to feel comfortable and confident with their new roles.

The Centre of Perinatal Excellence (2021) reports that the greatest challenges experienced in the first weeks of parenthood include recovering from birth, breastfeeding, sleep deprivation, heightened emotions, coping with an unsettled infant, bonding with infant, managing priorities and changes in relationship dynamics.<sup>12</sup>

For most people, this time of adjustment is temporary, but for others it can take a long time and cause a lot of distress. Admission to a Mother Baby Unit (MBU) for inpatient mental health services is sometimes required.

The maternal mental health conditions experienced most frequently in the perinatal period are perinatal depression and anxiety.

### Perinatal depression

Perinatal depression is a term used to describe a sustained depressive disorder which can present in both the antenatal and postnatal periods.<sup>1</sup> Perinatal depression is common, 1 in 7 women experiencing depression in the year following birth.<sup>12</sup> Common symptoms include a loss of interest in everyday life, lethargy, negative thinking, withdrawal from regular activities and feeling tearful. It is identified as a person experiencing these symptoms over a period of two weeks or more. It can affect a woman's capacity to cope with day to day issues but in more severe cases, it can affect her ability to care for her infant.<sup>12</sup>

### Perinatal anxiety

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.<sup>13</sup>

Perinatal anxiety disorders are characterised by levels of fear or worry that are out of proportion to the object of the worry.<sup>7</sup> The presence of anxiety disorders is also a risk factor for the development of perinatal depression.<sup>1</sup> 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.<sup>7</sup> Women with a history of untreated or unstable anxiety (or 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),<sup>7</sup> obsessive compulsive disorder (OCD),<sup>7</sup> comorbid depression and anxiety and phobias such as blood, needle, or tokophobia (fear of pregnancy).<sup>14, 15</sup>

Approximately 13% of women experience depression in the antenatal period, 13% experience anxiety, and coexistence of anxiety and depression is high.<sup>1,16</sup> As many as 15-20% of women experience depression and/or anxiety in the first 12 months postpartum.<sup>16</sup> 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.<sup>17</sup>

### Intrusive thoughts

For some parents, the potential dangers experienced by a new baby may cause heightened awareness and worry, and lead to repetitive or irrational behaviours or intrusive thoughts or images. These may be distressing and overwhelming.<sup>18</sup> These thoughts and images are often not shared with others as parents may feel guilty or ashamed.<sup>18</sup> When intrusive thoughts are acknowledged it is important that parents are reassured that worries about possible dangers are common, however when these thoughts affect everyday function, further support is required.<sup>18</sup> The nurse can 'dig deeper' to investigate if these intrusive thoughts require referral for mental health assessment, particularly if these thoughts are worsening, becoming more frequent, distressing or overwhelming. These intrusive thoughts also occur frequently in fathers.<sup>18</sup>

### Postnatal psychosis

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<sup>19</sup> but due to the potential safety concerns for the affected woman and her infant, psychosis is a psychiatric emergency. If psychotic symptoms are present, nurses must seek immediate assistance from a mental health service, emergency department, or a general practitioner (GP), depending on the availability of services.<sup>19</sup> Symptoms relate to a loss of sense of reality, and may include hallucinations, paranoia, and powerful delusions as well as extreme mood swings, aggression, and agitation.<sup>20</sup>

### Paternal mental health

Fathers may experience mental health issues in the perinatal period<sup>21</sup>, and evidence suggests that men's mental health issues are currently under-reported and under-screened.<sup>22</sup> Reviews on mood disorders experienced by 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.<sup>1</sup> 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.<sup>22</sup>

There are differences between the way men and women present with perinatal mental health issues.<sup>23</sup> Men are more likely to express anger, irritability, and have lower impulse control. Both men and women may mask their depression with drugs or alcohol use, or interpersonal conflict.<sup>23</sup>

Fathers can experience a number of barriers to seeking help. The focus is often on the woman's health and they may access health professionals less frequently postnatally than their partner.<sup>21</sup> It is important that nurses provide a welcoming environment to fathers and screen for mental illness whenever possible.<sup>21</sup> Utilising screening to open up communication will assist fathers to access information, reduce barriers, and be pro-active 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.<sup>21</sup> Infants whose father

experienced perinatal depression are more likely to exhibit behavioural problems at age three<sup>21</sup> and at school entry.<sup>24</sup> Risk factors predisposing fathers to a mental health issue may include: experiencing excessive stress surrounding the pregnancy or birth and fear for their partner<sup>21</sup>, perceived lack of information, support, and inclusion in the pregnancy and birth process<sup>21</sup>, a lack of acknowledgement of their role and needs<sup>3, 25</sup>, childhood trauma<sup>26</sup>, alcohol and other drug use<sup>26</sup>, changes in their financial situation and intimate relationship with their partner.<sup>24, 25</sup>

## Mental health impact

When a parent is experiencing a mental illness, the family may benefit from additional support.<sup>27</sup> 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.<sup>27</sup> They might also feel shame, humiliation or embarrassment, or might view themselves as being weak for developing a mental illness.<sup>27</sup> Additionally, parents may fear that their children will be removed from their care if they have a mental health issue.<sup>1</sup> As a result, parents experiencing a mental health issue may limit their contact with health professionals or choose not to disclose their true feelings and thoughts.

## Screening

A recent Canadian study reported that mental health screening is broadly acceptable to parents and caregivers.<sup>10</sup> 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 will be discussed further below, and the screening process outlined in Table 1. All caregivers should be invited to participate in mental health screening. It is important to recognise that there are gender issues in mental health presentations, and different risk cut-off scores for women and men.

### *Edinburgh Postnatal Depression Scale (EPDS)*

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.<sup>28</sup> 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<sup>29</sup>

The EPDS has been translated into 36 different languages with 18 being validated.<sup>29</sup> Each language version has a unique recommended cut-off score.<sup>29</sup> Challenges in administering the EPDS may relate to the fact that not all dialects are available in translated versions. There is a need to ensure the interpreter understands the question before translating it.

The EPDS should be offered in an environment where the nurse and client have privacy. It should not be used in an open clinic setting or posted to clients. 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. These stressful events might produce a high EPDS score reflecting situational emotional distress rather than depression.

Note: Nurses in the Kimberley and other designated WACHS regions who have received the appropriate training to use the Kimberley Mum's Mood Scale (KMMS), will follow endorsed local protocols and where agreed with the client, use the KMMS instead of the EPDS. The KMMS is an adapted version of the EPDS and enables an approach for communicating with Aboriginal women, prioritising time, trust and rapport that is more acceptable to Aboriginal families.

## Infant mental health

The foundations for lifelong mental health and wellbeing are built during infancy and childhood.

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

- develop secure relationships with parents, other adults and their peers
- experience, manage and express a range of emotions
- explore their environment and learn.<sup>30</sup>

It is relatively common for children to experience or be at risk of experiencing poor mental health. Estimates indicate that 8% of infants (0–1 years) have 5 or more risk factors for developing adult mental illness, increasing to 20% of 10-11-year-olds.<sup>31</sup>

## Influencing factors

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. All of these affect an infant's developmental trajectory, but the most significant is the quality of the relationship with their primary caregiver.<sup>32</sup> 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.

Whilst mental illness can have a genetic component, there are also strong links between adverse childhood experiences (ACEs) and development of mental illness.<sup>33</sup> Such experiences typically include physical, emotional or sexual abuse, physical or emotional neglect and household dysfunction including mental illness, incarcerated relative, mother treated violently, substance abuse or separation/divorce.<sup>34</sup>

## Attachment theory

Attachment theory helps us understand the patterns of behaviour which develop in response to the parent's caregiving style.<sup>17</sup> Secure attachment develops when a child learns to trust that their parent will respond appropriately to their signals of need, for example, food or to be cuddled and soothed.<sup>35, 36</sup> Consistently responding to the infant's signals (e.g. smiles, eye contact, crying) builds two-way communication between the infant and parent which helps the infant feel safe and secure. This allows the infant to explore and learn from their surroundings and this is the cornerstone of

the infant's biological, cognitive, social, and emotional development for their future adulthood.<sup>35</sup>

If an infant is unable to form a secure attachment with the mother, a secure attachment with another caregiver, such as the father, partner or a grandparent can be encouraged. This may protect the infant and help them to optimise their growth and development within these circumstances.<sup>1</sup>

In the long term, poor attachment may negatively impact language acquisition, school performance, cognitive and social development, and emotional regulation.<sup>1, 35, 37</sup> These factors lead to further problems which can put the child at a higher risk of developing a mental health issue later in life.<sup>17</sup>

### Infant assessment

The *Mental health care in the perinatal period: Australian clinical practice guideline*<sup>1</sup> provides a list of prompts to support the assessment of the mother-infant relationship. (Refer to table 2, step 1 below).

Infants may experience mental health issues irrespective of their mother's mental health or parent-infant attachment.<sup>38</sup> The infant may display behaviours indicating that they have a mental health issue and the nurse can observe the infant's behaviour and interaction with their primary care giver. (Refer to table 2, step 2 below).

## Principles

- Nurses are encouraged to adopt a **child and family centred care** approach to develop an open and non-judgemental environment to generate communication about emotional issues and mental health and normalise parent experiences.<sup>39</sup> Both the child and their family should be active participants in health care journey. Clients are treated as partners in their care planning.
- **Trauma-informed care** is one in which all components of the system have been recognised and evaluated in the light of a basic understanding of the role that violence and trauma play in the lives of people seeking mental health services.

## Key points

Nurses will:

- Provide non-judgemental care to support parents and promote sensitive parenting and secure attachment.
- Reassure families that some mental health issues such as perinatal anxiety and depression, are most often transient rather than permanent.
  - Refer to the [Nursing and Midwifery Board AHPRA Decision-making framework](#) in relation to scope of practice and delegation of care to ensure that decision-making is consistent, safe, child and family-centred and evidence-based.
- Discuss the case with the line manager if clinical judgement indicates the need for Department of Communities involvement.



- Be aware of their emotional health and to undertake clinical supervision where available.
- Implement a process to identify parents and infants with mental health issues as outlined below.

## Process

Nurses will conduct a holistic assessment, including each of the following

1. Parental mental health. Refer to [Table 1](#).
2. Parent-infant attachment and infant mental health. Refer to [Table 2](#).

Refer to [Appendix A: Perinatal and infant mental health concerns: process flowchart](#)

Refer to the following flowcharts for information about Community health processes when a baby is admitted to and discharged from an MBU.

[Mother and Baby Unit - Admission and discharge flowchart - FSH](#)

[Mother and Baby Unit - Admission and discharge flowchart - WNHS](#)

**Table 1: Parental mental health and EPDS**

Steps	Additional information
<b>1. Explore family protective and risk factors</b>	<ul style="list-style-type: none"> <li>• Refer to the <a href="#">Indicators of Need</a></li> </ul>
<ul style="list-style-type: none"> <li>• <b>Introduce the tool and offer to the client</b></li> <li>• Where the offer of the EPDS is declined, this should be documented in the child health record 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.</li> <li>• Whilst face to face delivery of EPDS is the preferred method, given the alternative ways of providing services (appointments via telehealth, phone calls or VC) it is important to ensure that these questions are asked via these methods if it is safe and appropriate to do so. Develop a</li> </ul>	<ul style="list-style-type: none"> <li>• The EPDS should only be used by nurses who have been trained in its use and where there is a clear referral pathway. EPDS training should include suicide risk assessment and management.</li> <li>• The EPDS is an indicator of the risk of depression and anxiety. It is a screening tool and 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.</li> <li>• The EPDS can be used with both men and women, though the cut-off scores are different (see below).</li> <li>• Ensure clients understand that they can visit their Community health nurse or GP at any point if they feel overwhelmed or unable to cope.</li> </ul>

Steps	Additional information
<p>care plan in partnership with parent/carer to ensure a shared understanding of concerns and plan.</p> <ul style="list-style-type: none"> <li>• Staff in designated WACHS regions who have received the appropriate training to use the Kimberley Mum's Mood Scale (KMMS), will follow endorsed local protocols and where agreed with the client, will use the KMMS instead of the EPDS for screening Aboriginal women.</li> </ul>	<ul style="list-style-type: none"> <li>• The scale provides an indication of the client's perception of their mood in the preceding 7 days. It does not predict on-going mood. <sup>28</sup></li> <li>• The EPDS provides a universal language between health care professionals that facilitates referrals.</li> <li>• Nurses should ensure correct use of a professional interpreter as required.</li> </ul>
<p><b>2. Administer EPDS</b></p> <ul style="list-style-type: none"> <li>• The EPDS must be offered to all clients at: <ul style="list-style-type: none"> <li>○ 8 weeks</li> <li>○ 4 months</li> <li>○ 12 months</li> <li>○ Any other time where there is parental or professional concern</li> </ul> </li> <li>• All ten items must be completed.</li> <li>• Any mismatch between the EPDS score and the clinical presentation should be explored further.</li> </ul>	<ul style="list-style-type: none"> <li>• The child health centre or a home visit may provide suitable opportunities for the completion of the EPDS. EPDS should be completed when offering appointments via telehealth, phone or VC</li> <li>• The client is asked to <b>underline</b> the response which comes closest to how he or she has been feeling in <b>the previous 7 days</b>.</li> <li>• The link to the English version of the EPDS form is available on the community health <a href="#">CACH Intranet</a> forms page or <a href="#">Women and Newborn Health Service</a>.</li> <li>• The form should be completed by the client personally unless they have limited English (and a relevant translation is not available) or have difficulty with reading.</li> <li>• If English is the client's second language, the use of a <a href="#">translated EDPS</a> should be considered.</li> </ul>

Steps	Additional information																									
<p><b>3. Calculate score</b></p> <ul style="list-style-type: none"> <li>Questions 1, 2, &amp; 4 are scored 0, 1, 2, or 3 with the top response scored as 0 and the bottom response scored as 3.</li> <li>Questions 3 and 5-10 are scored in reverse, with the top response scored as a 3 and the bottom response scored as 0.</li> <li>On completion, add all scores to obtain a total</li> </ul>	<ul style="list-style-type: none"> <li>The maximum score on the EPDS is 30.</li> </ul> <p>Table 1: EPDS Question Scores</p> <table border="1" data-bbox="727 499 1353 763"> <thead> <tr> <th></th> <th>Q 1- 2</th> <th>Q 3</th> <th>Q 4</th> <th>Q 5-10</th> </tr> </thead> <tbody> <tr> <td>Top response</td> <td>0</td> <td>3</td> <td>0</td> <td>3</td> </tr> <tr> <td></td> <td>1</td> <td>2</td> <td>1</td> <td>2</td> </tr> <tr> <td>Bottom response</td> <td>2</td> <td>1</td> <td>2</td> <td>1</td> </tr> <tr> <td></td> <td>3</td> <td>0</td> <td>3</td> <td>0</td> </tr> </tbody> </table>		Q 1- 2	Q 3	Q 4	Q 5-10	Top response	0	3	0	3		1	2	1	2	Bottom response	2	1	2	1		3	0	3	0
	Q 1- 2	Q 3	Q 4	Q 5-10																						
Top response	0	3	0	3																						
	1	2	1	2																						
Bottom response	2	1	2	1																						
	3	0	3	0																						
<p><b>5. Interpret score</b></p> <ul style="list-style-type: none"> <li>Analyse the score in context of client presentation.</li> <li>Discuss the responses with the client.</li> <li>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.</li> </ul>	<ul style="list-style-type: none"> <li>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.</li> <li>Low scores still warrant discussion in the context of prevention and self-care.</li> <li>A score of 0 is considered unusual, may indicate masking or literacy issues and requires further discussion with the client.</li> </ul> <p>The following are postnatal cut-off scores for English speaking men and women.</p> <p>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.</p> <p><b>Cut-off scores for the English version for men and women</b>, according to the EPDS:</p> <p><u>Low risk of perinatal depression</u></p> <p>Women: 0-9</p>																									

Steps	Additional information
	<p>Men: 0-5</p> <p><u>Moderate risk of perinatal depression</u></p> <p>Women: 10-12</p> <p>Men: no moderate score identified, refer to high risk.</p> <p><u>High risk of perinatal depression</u></p> <p>Women: 13–30</p> <p>Men: 6 or more</p> <p><b>Antenatal cut-off scores</b></p> <p>According to the Women’s Health Strategy and Programs - WA Perinatal Mental Health Referral Pathway, the antenatal cut-off score for women is 14 or more, and for men is 6 or more.</p> <p><b>Cut-off scores for Anxiety</b> using the English version for men and women, according to the EPDS:</p> <p>Subscale on questions 3, 4, &amp; 5</p> <p>Total possible anxiety score of 9</p> <p>Women: 6 or more</p> <p>Men: 4 or more</p> <p>NB: Do not deduct anxiety score from total score</p> <p>Irrespective of the overall EPDS score, a score over 6 for women and over 4 for men may indicate the presence of anxiety that requires further clinical assessment.</p>
<p><b>6. Results and actions</b></p> <p><b>a) Low risk of perinatal depression</b></p> <ul style="list-style-type: none"> <li>• Check the anxiety sub scale as the client may have a high anxiety score</li> <li>• Discussion of feelings,</li> </ul>	<p>Scores indicating low risk:</p> <ul style="list-style-type: none"> <li>• Women 0-9</li> <li>• Men 0-5</li> </ul> <p>Some symptoms of distress may be present, but they are less likely to interfere with day to day functioning.</p>

Steps	Additional information
<p>experiences, role change, changes in relationship, and losses and gains.</p> <ul style="list-style-type: none"> <li>• Provide general lifestyle information regarding nutrition, sleep, exercise and self-care.</li> <li>• Provide support to ensure continued wellbeing. Offer additional contacts to meet individual needs where clinical judgement warrants.</li> </ul>	
<p><b>b) Moderate risk of perinatal depression (Women only)</b></p> <ul style="list-style-type: none"> <li>• Use active listening techniques.</li> <li>• Explore past history of mental health issues, social support and current life stressors.</li> <li>• Ask mum what she thinks is wrong, and what she needs</li> <li>• Encourage clients to have regular time devoted to positive interactions with the infant.</li> <li>• Encourage regular weekly time-out if possible (partner, extended family or friends looking after the infant).</li> <li>• Discuss the benefits of eating healthy foods, regular exercise, social networks.</li> <li>• Discuss safety plans if client feels they are not coping on any day (including support networks)</li> <li>• Encourage enlisting support from GP, local women's health centre, partner, family and friends.</li> <li>• Encourage participation in parent</li> </ul>	<p>Scores indicating moderate risk:</p> <ul style="list-style-type: none"> <li>• Women: 10-12</li> <li>• Men: no moderate score identified, refer to high risk.</li> </ul> <p>Scores in this range indicate that the presence of symptoms are distressing and discomforting and may impact functioning.</p> <ul style="list-style-type: none"> <li>• <i>Head to Health</i> provides a list of endorsed mental health web pages and apps.</li> <li>• Refer to Useful Resources for additional resources.</li> </ul>

Steps	Additional information
<p>groups.</p> <ul style="list-style-type: none"> <li>• Provide links to online resources and apps supporting perinatal mental health.</li> <li>• Offer follow up <i>Universal plus</i> appointments to review client progress against outcomes in client's care plan</li> <li>• Use clinical judgement to determine if a repeat EPDS is required at the follow up appointment.</li> <li>• Use clinical judgement to determine if consultation with the Partnership services (CAHS-CH) or ECHS (WACHS) is required.</li> <li>• Complete the Clinical Handover/Referral Form (CHS 663) for relevant referrals.</li> </ul>	
<p><b>c) High risk of perinatal depression</b></p> <ul style="list-style-type: none"> <li>• Assess thoughts of harm to self or infant.</li> <li>• Consider urgent referral to GP, local hospital or mental health service for a mental health assessment, especially where the client has verbalised intent and/or plans of harm to self or infant.</li> <li>• Consult with <a href="#">Mother Baby Unit</a> for complex cases if required.</li> <li>• Discuss the range of options that may be offered by the GP, including counselling and possible medication.</li> <li>• Refer to GP, if indicated and</li> </ul>	<p>Scores indicating high risk:</p> <ul style="list-style-type: none"> <li>• Women: 13 – 30</li> <li>• Men: 6 or more</li> </ul> <p>Scores in this range require further assessment as the likelihood of depression is high.</p> <p>See <a href="#">Appendix B</a> for MBU contact details.</p>

Steps	Additional information
<p>consent has been provided.</p> <ul style="list-style-type: none"> <li>• Use clinical judgement to determine if consultation with the Partnership services (CAHS-CH) or ECHS (WACHS) is required.</li> <li>• Complete the Clinical Handover/Referral Form (CHS 663) for relevant referrals.</li> <li>• Discuss relevant local mental health services, information, and contact details to clients and support networks.</li> <li>• Encourage participation in perinatal depression support groups.</li> <li>• Encourage clients to have regular time devoted to positive interactions with the infant.</li> <li>• Ensure frequent time out, (partner, extended family or friends looking after the infant).</li> <li>• Encourage the client to take medication if it has been prescribed and discuss this with the GP if they have concerns or questions.</li> <li>• Offer follow up phone call within one week and a <i>Universal plus</i> appointment to review client progress against outcomes in the client's care plan.</li> <li>• Ensure client is in the company of a partner, family member or friend to ensure client's safety prior to leaving the child health centre.</li> <li>• Use clinical judgement to determine if a repeat EPDS is required at the follow up</li> </ul>	

Steps	Additional information
appointment.	
<p><b>d) Assess immediate risk</b></p> <ul style="list-style-type: none"> <li>• If client scores 1, 2 or 3 on question 10, recheck that these feelings occurred in the last 7 days.</li> <li>• Determine if the client and/or infant are at risk. Ask the client if they have any thoughts of harming their infant.</li> <li>• Aim to keep the client and infant safe.</li> <li>• Use clinical judgement to assess the situation and arrange immediate specialist assessment, as required.</li> <li>• Where the nurse has concerns about risks to the client or infant, seek permission to contact their support person to discuss the situation.</li> <li>• Consider urgent referral to GP, local hospital, or mental health service for a mental health assessment, especially where the client has verbalised intent and/or plans of harm to self or infant.</li> <li>• Consult with Mother Baby Unit for complex cases if required.</li> <li>• Use clinical judgement to determine if consultation with the CAHS-CH Partnership services is required.</li> <li>• Complete the Clinical Handover/Referral Form (CHS 663)</li> <li>• Discuss client's available support</li> </ul>	<ul style="list-style-type: none"> <li>• 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 asking about intent, plan, method, impulsivity and recent events.</li> </ul> <p>See <a href="#">Appendix B</a> for the contact details of Emergency Mental Health services.</p>



Steps	Additional information
<p>networks, and protective factors.</p> <ul style="list-style-type: none"> <li>• Discuss possible referral options, as required.</li> <li>• Undertake a follow up phone call within one week, to determine further care planning.</li> <li>• Nurse to discuss client's care plan with their line manager.</li> </ul>	<p>See <a href="#">Appendix B</a> for MBU contact details.</p>
<p><b>7. Develop a care plan</b></p> <ul style="list-style-type: none"> <li>• Develop a care plan (which includes completing <i>My Care Plan</i> for the client), in partnership with parent/carer to ensure a shared understanding of concerns and plan. <ul style="list-style-type: none"> <li>○ Give one copy to client and retain a copy in client record.</li> </ul> </li> </ul>	<p><i>My care plan</i> will outline (where relevant):</p> <ul style="list-style-type: none"> <li>• A summary of the concern</li> <li>• Strategies/plan of the parents/carers to implement</li> <li>• Review appointments</li> <li>• Referral point/s</li> <li>• When to escalate care, if required.</li> </ul>
<p><b>8. Refer</b></p> <ul style="list-style-type: none"> <li>• The <a href="#">WA Perinatal Mental Health Referral Pathway</a> indicates the types of services that might be helpful to clients. Refer to this pathway for actions according to risk level.</li> <li>• If the client does not consent to referral, the nurse should document the offer and the refusal in the client's health record.</li> <li>• Nurse should inquire about the client's support network, the safety of the client and the safety of the infant; to decide whether it is appropriate to contact mental health services</li> <li>• If signs of harm are evident, discuss with line manager, and contact mental health services.</li> </ul>	<ul style="list-style-type: none"> <li>• Use the Clinical Handover/Referral Form (CHS663) for referrals to GP or other health services.</li> <li>• The local Family Support Network may be able to offer support for identified psychosocial concerns. See Useful Resources section.</li> <li>• Availability of appropriate parent groups may vary between sites - nurses should be aware of and consider appropriate local services and referral options.</li> <li>• Nurses will ensure that culturally appropriate services are provided to clients where they are available. This may include services for parents requiring a translator, Aboriginal parents, single parents and young parents.</li> </ul>

Steps	Additional information
<p><b>9. Follow-up</b></p> <ul style="list-style-type: none"> <li>• Universal plus appointment can be offered according to client need/willingness to attend. The purpose of this would be to follow up on the progress of specific actions from the previously agreed care plan.</li> <li>• If progress towards agreed actions has not improved at the follow-up appointment, discuss the client's care plan with the Line Manager and/or Clinical Nurse Specialist (CNS) and WACHS staff consider offering ECHS</li> <li>• Use professional judgement to determine if phone follow-up within one week, is necessary for clients at high risk of perinatal depression. If the nurse is unable to contact the client, they may discuss this with their line manager to ensure the client continues to receive care.</li> </ul>	<ul style="list-style-type: none"> <li>• Nurse to follow up clients where EPDS has not been administered and nurse has concerns about a client's mental health.</li> </ul>
<p><b>10. Document</b></p> <ul style="list-style-type: none"> <li>• All EPDS scores, notes on clinical presentation, and the psychosocial assessment, along with any other relevant findings, are to be recorded in electronic health information systems, according to local processes.</li> <li>• Document care planning including follow up and referral details.</li> </ul>	

**Table 2: Parent-infant attachment and infant mental health**

Steps	Additional Information
<p><b>1. Observe the attachment between the infant and mother/caregiver</b> as demonstrated by their interaction.</p> <p>Nurse can observe:</p> <ul style="list-style-type: none"> <li>• How thoughtful the mother appears to be about her baby</li> <li>• If the mother can describe the baby's daily routine</li> <li>• If the mother can reflect on the baby's needs</li> <li>• If the mother is appearing to express empathy for the baby</li> <li>• If the mother can play/talk appropriately with the baby</li> <li>• If the baby appears to make the</li> </ul>	<p>These prompts should not be used as a checklist or formal assessment tool. However, observation of the following can indicate protective factors and potential difficulties in the mother-infant attachment.</p> <p>Parent resources relating to attachment (offer electronic link or printed handout) available at:</p> <ul style="list-style-type: none"> <li>• <a href="#">Circle of Security</a></li> <li>• <a href="#">Raising Children Network</a> (newborn/connecting and communicating)</li> <li>• Related external resources at end of this document.</li> </ul>

Steps	Additional Information
<p>mother feel uncomfortable, unhappy or enraged</p> <ul style="list-style-type: none"> <li>• If the mother seems to be excessively worried about the baby</li> <li>• If the mother appears to be able to cope with the baby's distress</li> <li>• The mother is responding consistently towards her baby<sup>1</sup></li> </ul>	
<p><b>2. Observe infant behaviours</b></p> <p>Nurse can observe the infant, specifically:</p> <ul style="list-style-type: none"> <li>• Eye contact or gaze avoidance - is the mother looking at her baby and is the baby looking back at her or looking away?</li> <li>• Flat/no or minimal facial expression, emotionally under-responsive</li> <li>• Lack of crying, or irritable with constant crying</li> <li>• Limited vocalising<sup>40</sup></li> <li>• Reciprocity – are mother and baby 'tuned in' to each other's cues? For example, when mum holds her baby, baby may show physical signs of not wanting to be in her arms (arched back, stiff, seems anxious).</li> </ul>	<p>These prompts should not be used as a checklist or formal assessment tool. However, observation of the following can indicate concerns regarding the infant's mental health</p>
<p><b>3. Develop a care plan</b></p> <ul style="list-style-type: none"> <li>• Develop a care plan (which includes completing <i>My Care Plan</i> for the client), in partnership with parent/carer to ensure a shared understanding of concerns and plan. <ul style="list-style-type: none"> <li>○ Give one copy to client and retain a copy in client record.</li> </ul> </li> </ul>	<p><i>My care plan</i> will outline (where relevant):</p> <ul style="list-style-type: none"> <li>• A summary of the concern</li> <li>• Strategies/plan of the parents/carers to implement</li> <li>• Review appointments</li> <li>• Referral point/s</li> <li>• When to escalate care, if required</li> </ul>

Steps	Additional Information
<p><b>4. Refer</b></p> <p>If any concerns are present, refer client to more specific parenting support:</p> <ul style="list-style-type: none"> <li>• Nurse to offer brief intervention based on the attachment theory (Circle of Security) in a one to one setting. This may include offering both information for the parent and referral to local parenting group (depending on local availability).</li> <li>• Nurse to discuss Circle of Security concepts in one to one setting or refer to group (pending local availability)</li> <li>• An externally provided, relevant parenting group may also be considered.</li> </ul> <p>If there are serious concerns that the Mother's mental health is impacting on the wellbeing of the infant, a referral to a GP or Mother-Baby Unit may be warranted. Follow local protocols to refer to services according to client need.</p>	<p>Nurse to be aware of local services/groups in their community, as availability of appropriate parent groups may vary between sites.</p> <p>Family may already be connected with mental health support services.</p>
<p><b>5. Follow-up</b></p> <p>If progress towards agreed actions has not improved at the follow-up appointment, discuss the client's care plan with the Line Manager and/or Clinical Nurse Specialist (CNS) and WACHS staff consider offering ECHS.</p>	<p>Universal plus appointment can be offered according to client need. The purpose of this would be to follow up on the progress of specific actions from the previously agreed care plan.</p>

## Documentation

Nurses must record all findings in relevant electronic data systems according to local protocols.

## Training

Nurses are required to complete training specific to their role as per the CAHS-CH Nurses working in Child Health Nursing Practice Framework or the WACHS Nursing and Midwifery Practice Framework and Guidelines and associated individual global learning plans.

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**Related CAHS internal policies, procedures and guidelines**

The following documents can be accessed in the **Clinical Nursing Manual** via the [HealthPoint](#) link or the [Internet](#) link or for WACHS staff in the [WACHS Policy](#) link

Clients of concern management

Clinical handover - nursing

Factors impacting child health and development

Family and domestic violence

Partnership – child health service

Universal contacts

The following documents can be accessed in the [CAHS Policy Manual](#)

Language Services

The following documents can be accessed in the [Department of Health Policy Frameworks](#)

Clinical Handover Policy ([MP0095](#))

**Related CAHS-CH forms**

The following resources and forms can be accessed from the [CAHS-Community Health Forms](#) page on HealthPoint

Clinical handover referral form (CHS663)

Edinburgh Postnatal Depression Scale – English and Translated versions

**Related CAHS-CH resources**



The following resources and forms can be accessed from the <a href="#">CAHS-Community Health Resources</a> page on HealthPoint
Early Parenting Group (Topic: Getting to know your baby)
Indicators of Need

Related external resources
<a href="#">Beyond Blue</a>
<a href="#">Circle of Security</a>
<a href="#">COPE (Centre of Perinatal Excellence)</a> provides perinatal and postnatal advice and resources
<a href="#">COPMI</a> resource centre for children of parents with mental illness
<a href="#">EPDS translated versions</a>
<a href="#">embrace multicultural mental health</a> National platform for Australian mental health services and multicultural communities to access resources, services and information
<a href="#">Emerging minds</a> <a href="#">What is infant mental health, why is it important, and how can it be supported?</a>
<a href="#">Finding help before and after baby arrives</a> provides a list of resources for new parents (including specific Father's resources) and their families, developed by the Women and Newborn Health Service
<a href="#">Guidelines for Protecting Children 2020</a>
<a href="#">Head to Health</a> is a repository of endorsed mental health websites and apps, including many suitable for the perinatal period
<a href="#">Lifeline</a> Provides access to crisis support, suicide prevention, and mental health support services. Phone: 13 11 14
<a href="#">Mental Health Commission WA</a> General facts, causes, and personal stories on mental health issues
<a href="#">Mental Health Care in the Perinatal Period Australian Clinical Practice Guideline</a> COPE

<p><a href="#">PANDA</a>: 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</p>
<p><a href="#">Raising children network</a> provides parenting information from pregnancy to adolescence, as well as information on relationships</p>
<p><a href="#">Statewide Perinatal and Infant Mental Health Program (SPIMHP)</a> Information for health professionals and consumers across WA about health promotion, education and training, and research.</p>
<p><a href="#">Statewide Perinatal and Infant Mental Health Program (SPIMHP)</a> - staff resources</p>
<p><a href="#">Still face experiment</a> by Dr Edward Tronik (YouTube)</p>
<p><a href="#">Suicide Call Back Service</a></p> <p>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</p>
<p><a href="#">WA Perinatal Mental Health Referral Pathway</a> Women's Health Strategy and Programs. EPDS scoring and risk categories, actions and possible referrals.</p>
<p><a href="#">Western Australian Family Support Networks</a></p>
<p><b>Mother and Baby Unit</b></p> <p>State-wide inpatient treatment centre at King Edward Memorial Hospital (KEMH) and at Fiona Stanley Hospital (FSH) for acute perinatal psychiatric conditions up to 12 months.</p> <p>Free call <b>KEMH</b>: 1800 422 588</p> <p>Call <b>FSH</b>: 6152 2222</p> <p><b>Mental Health Emergency Response Line (MHERL)</b></p> <p>The mental health call centre provides expert telephone response to acute mental health issues. All callers are triaged and referred to the most appropriate acute response team according to the level of clinical priority.</p> <p>Perth Metro Residents: 1300 555 788</p> <p>Peel Residents: 1800 676 822</p> <p>TTY: 1800 720 101</p> <p>Rurallink: Phone 1800 552 002</p>

This document can be made available in alternative formats on request.

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## Healthy kids, healthy communities

Compassion
Excellence
Collaboration
Accountability
Equity
Respect

Neonatology | Community Health | Mental Health | Perth Children's Hospital

**Appendix A: Process flowchart - Perinatal and infant mental health concerns**





