South Australian Perinatal Practice Guidelines

Screening for perinatal anxiety and depression

Literature review

- Antenatal anxiety and depression often occur together. Postnatal depression and / or anxiety often follow[1,2]
- Prevalence of antenatal depression is reported as 7.4 % in the 1st Trimester, 12.8 % in the 2nd Trimester, 12.0 % in the 3rd Trimester[3]
- Maternal distress during pregnancy influences obstetric and birth outcomes[4]
- Effects of maternal anxiety in pregnancy can adversely affect the developing fetal brain[5]
- Maternal anxiety / depression has been associated with difficult infant temperament[6], increased infant cortisol levels[7] and behavioural difficulties in childhood[1]
- As perinatal depression begins before birth and extends beyond 6 weeks postpartum – (by definition at any time until 12 months postpartum):
    - Depression surveillance is warranted during antenatal visits, at the postnatal check up, and at paediatric visits during the initial 12 months of the first postnatal year[8]
    - All professionals working with antenatal and postnatal women should routinely inquire about mood, anxiety and coping abilities
- Many women with perinatal mental health disorders are not diagnosed or treated[9]. Screening has been shown to improve detection and referral for treatment[10]
- Antenatal screening of depression using the EPDS[11] is generally associated with adequate sensitivity and specificity to detect possible depression using a score of 13 or more[12,13,14,15,16]
- Psychosocial risk factors can be screened using the AnteNatal Risk Questionnaire[17]
- Early identification with intensive postnatal follow up is a valuable psychosocial intervention for postnatal depression[18]

Risk factors

Psychological

- Antenatal anxiety, depression or mood swings
- Previous history of anxiety, depression, or mood swings, especially if occurred perinatally
- Family history of anxiety, depression or alcohol abuse, especially in first degree relatives
- Severe baby blues
- Personal characteristics like guilt-prone, perfectionistic, feeling unable to achieve, low self-esteem
- Edinburgh (postnatal) depression score ≥ 13 (See Appendix I)[20]

Social

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- Lack of emotional and practical support from partner and / or others
- Domestic violence, history of trauma or abuse (including childhood sexual abuse)
- Many recent stressful life events
- Low socioeconomic status, unemployment
- Unplanned or unwanted pregnancy
- Expecting first child or has many children already
- Child care stress[20]

Biological / medical

- Ceased psychotropic medications recently
- Medical history of serious pregnancy or birth complications, neonatal loss, poor physical health, chronic pain or disability, or premenstrual syndrome
- Perinatal sleep deprivation
- Neonatal medical problems or difficult temperament[20]

Where risks are identified, document details about the nature and degree of risk in the case notes

Antenatal care

- Complete the personal history section of the South Australian Pregnancy Record, including mental health history
- Establish who is responsible for the woman's mental health care throughout pregnancy and postpartum
    - Document details of any existing mental health or community supports e.g. general practitioner, psychiatrist, psychologist, social worker, mental health case worker, Anglicare, Kids and You, local community centres

- **Screening for depression**
- The Australian 'National Perinatal Depression Initiative' (NPDI) recommends routine screening of all women in the antepartum and postpartum periods using the Edinburgh Postnatal Depression Scale (EPDS) and psychosocial risk questions[21]
- Questionnaires should only be used by appropriately trained staff
- Questionnaires are only intended as an adjunct to clinical history taking and are not meant to replace clinical judgement
- Complete EPDS (Appendix I); see Appendix II for further information on symptoms and management according to EPDS score.
- In addition to the EPDS, complete the Psychosocial risk questionnaire (ANRQ, Appendix III) with the woman at booking-in triage visit. If this visit is missed or not a point of contact for any individual women, administer EPDS and ANRQ at the first appropriate appointment in pregnancy
- The screening process should also include the routine provision to all women antenatally of information on perinatal emotional health and where to get help, currently available in a booklet form and fact sheets by beyondblue
- Assess the need for referral to any other services e.g. Social Worker, Mental Health liaison, Case discussion meeting, Obstetric Consultant, GP
- If possible, repeat EPDS in the late 2nd or early 3rd trimester (Appendix I)

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The Edinburgh Postnatal Depression Scale

- The EPDS (Appendix I) screens for current symptoms of depression
- Symptoms and management according to EPDS score are described in appendix II
- It was developed as a screening tool for postnatal depression and has also been used successfully antenatally[11]. It does not diagnose depression but raises awareness of mood problems which need further exploration and care
- Question 10 is about thoughts of self harm. Positive answers to question 10 need to be explored further by conducting a risk assessment looking at current plans, frequency of thoughts, intent, reasons for / against etc. See chapter 141 suicidal ideation and self harm
- For women who score 10, 11 or 12; administration of the EPDS should be repeated within one month and existing support services reviewed and increased if necessary. A score of 13 or higher requires offer of follow-up support or referral. Women with high scores (e.g. 15 or more) should have access to timely mental health assessment and management, current safety and care of other children should be considered (Appendix II)
- The scale should be completed at least once antenatally and at least once postnatally
- Antenatal scores should be communicated on referral to Child and Family Health Service

Instructions:

- Ask the mother to underline or tick the response which comes the closest to how she has felt over the past 7 days
- All 10 questions must be completed
- The woman should fill it out without help from others. However, if needed she may have the questions read out to her by the clinician or an interpreter
- The EPDS is available in many different languages however and may be used as a self report scale in the woman's own language and scored in the standard way

Psychosocial Questionnaire

- Psychosocial risk factors can be identified using the Antenatal Risk Questionnaire (ANRQ) [17]. See Appendix III
- The ANRQ is a self-report psychosocial assessment tool which is highly acceptable to both women and staff. In combination with the EPDS and routine questions relating to drug and alcohol use and domestic violence, the ANRQ is most useful as a key element of a "screening intervention" aimed at the early identification of mental health risk and morbidity across the perinatal period
- See Appendix IV for a guide to scoring of the ANRQ. A score of over 24 or endorsement of critical questions (item no's 2 AND 2a or 2b, Q 8 or 9) requires further assessment and / or appropriate referral (e.g. to social work)

Postpartum care

- The average postpartum stay before discharge home is 2 to 3 days
- The EPDS may be completed by 'at risk' women at any stage after birth though may not be reliable during the first 3 postpartum weeks[22]

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- The EPDS should be completed by all women at their Universal Contact Visit with a Child and Family Health nurse. If this appointment is missed the EPDS should be competed at their 6 week check up (usually with GP)
- Psychosocial risk factors can be identified using the PostNatal Risk Questionnaire (PNRQ) [17]. See Appendix V
- The PNRQ is a self-report psychosocial assessment tool which is highly acceptable to both women and staff. In combination with the EPDS and routine questions relating to drug and alcohol use and domestic violence, the PNRQ is most useful as a key element of a "screening intervention" aimed at the early identification of mental health risk and morbidity across the perinatal period
- See Appendix VI for a guide to scoring of the PNRQ. A score of over 24 or endorsement of critical questions (item no's 2 AND 2a or 2b, Q 8 or 9) requires further assessment and / or appropriate referral (e.g. to social work)

Referral Pathways

Generic referral pathways provide a guideline for management of antenatal and postnatal women. See appendices VII-IX

Appendix VII – Metropolitan pathway

Appendix VIII – Country pathway

Appendix IX – CaFHS postnatal pathway

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Appendix I:

The Edinburgh Postnatal Depression Scale - (Cox et al. 1987)

To complete this set of questions, mothers/mothers to be should circle the number next to the response which comes closest to how they have felt IN THE PAST 7 DAYS.

1. I have been able to laugh and see the funny side of things:
- 0 As much as I always could
- 1 Not quite so much now
- 2 Definitely not so much now
- 3 Not at all

2. I have looked forward with enjoyment to things:
- 0 As much as I ever did
- 1 Rather less than I used to
- 2 Definitely less than I used to
- 3 Hardly at all

3. I have blamed myself unnecessarily when things went wrong:
- 3 Yes, most of the time
- 2 Yes, some of the time
- 1 Not very often
- 0 No, never

4. I have been anxious or worried for no good reason:
- 0 No, not at all
- 1 Hardly ever
- 2 Yes, sometimes
- 3 Yes, very often

5. I have felt scared or panicky for no very good reason:
- 3 Yes, quite a lot
- 2 Yes, sometimes
- 1 No, not much
- 0 No, not at all

6. Things have been getting on top of me:
- 3 Yes, most of the time I haven't been able to cope at all
- 2 Yes, sometimes I haven't been coping as well as usual
- 1 No, most of the time I have coped quite well
- 0 No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping:
- 3 Yes, most of the time
- 2 Yes, sometimes
- 1 Not very often
- 0 No, not at all

8. I have felt sad or miserable:
- 3 Yes, most of the time
- 2 Yes, quite often
- 1 Not very often
- 0 No, not at all

9. I have been so unhappy that I have been crying:
- 3 Yes, most of the time
- 2 Yes, quite often
- 1 Only occasionally
- 0 No, never

10. The thought of harming myself has occurred to me:
- 3 Yes, quite often
- 2 Sometimes
- 1 Hardly ever
- 0 Never

The total score is calculated by adding together the numbers you circled for each of the 10 items. The higher the score, the more likely it is that the person completing the questionnaire is distressed and may be depressed.

Scoring: Questions 1, 2 and 4 score 0-3 questions 3, 5 – 10 score 3-0

This is a screening tool only, and should not be used to diagnose depression.

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Appendix II: Management according to EPDS score

EPDS score	0-9	10-12	≥ 13
Likelihood of depression	Considered low	Considered moderate	Considered high Very high scores can be suggestive of a woman in crisis or with a personality disorder. It warrants further investigation.
Referral – (Tertiary & Rural)	Mothers group for support Parenting groups Consumer led support groups Community supports NGO family support services CaFHS for help with baby issues. Help involve family and friends support.	Refer to General Practitioner for mental health treatment plan Referral to ATAPS or Better Access practitioner via GP Referral on as needed e.g. specialist MH services, community services, groups Perinatal Mental Health Team Postnatal Depression Group Parenting groups NGO family support services Where relevant refer to DV, drug & alcohol service (DASSA or NGO)	Refer for psychiatric assessment ACIS - 131465 Emergency Department Referral on as needed e.g. specialist MH services, Perinatal Mental Health Team, Helen Mayo House, Postnatal Depression Group Refer to General Practitioner for mental health treatment plan Referral to ATAPS or Better Access practitioner via GP Consider risk to child/ren Parenting groups NGO family support services Where relevant refer to DV, drug & alcohol service (DASSA or NGO)
Referral - Time frame	As needed	As soon as able	Immediate – especially if risk of suicide or infanticide
Symptoms	Anxiety, particularly about baby and mothering, overwhelmed, lowered mood but some fluctuation and 'good days'	Anxiety, particularly about baby and mothering, overwhelmed, lowered mood, panic attacks, hopelessness and helplessness, life not worth living, lowered mood most of the time	Anxiety – vague and not necessarily directed, overwhelmed, labile, low or elevated mood, preoccupied, vague and distracted, psychotic symptoms (delusions and hallucinations), suicidal
Risk assessment	Any risks more related to personality and any concomitant substance use	Risk of suicide but baby often protective. Neglect of baby and/or poor parenting secondary to the depression or underlying risk factors (e.g. childhood abuse and subsequent personality issues)	May be significant to self and baby due to poor judgement, severe depression, suicidal ideation, command hallucinations or delusional beliefs-needs hospitalisation.
Differential diagnosis	Consider other causes for symptoms such as anaemia, poor sleep, & lack of energy. Thyroid dysfunction, anaemia or bereavement should be excluded before diagnosing a depression.		

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Appendix III: AnteNatal Risk Questionnaire (ANRQ)

Name: _____ **Today's Date:** ____/____/_____

Weeks Pregnant: _____ **Due date:** ____/____/_____

Phone (h) _____ **(w)** _____ **(m)**_____

This is part of your Antenatal Booking Evaluation and will guide us as to what services we can offer you during your pregnancy. It is confidential information and will remain in your file. PLEASE COMPLETE ALL ITEMS

TOTAL ☐

1. When you were growing up, did you feel your mother was emotionally supportive of you? *(If you had no mother circle 6).*
   1 2 3 4 5 [6
   very much somewhat not at all [☐

2. a) Have you ever had 2 weeks or more when you felt particularly worried, miserable or depressed? **Yes** ☐ **No** ☐
   b) Do you have <u>any other history of mental health problems</u>? **Yes** ☐ **No** ☐
   e.g. eating disorders,psychosis,bipolar disorder,schizophrenia. Please specify: _____

   <u>If Yes to 2a or 2b</u>, did this:
   c) Seriously interfere with your work and your relationships with friends and family?
   1 2 3 4 5
   not at all somewhat very much ☐

   d) Lead you to seek professional help? **Yes** ☐ **No** ☐
   Did you see a: Psychiatrist ☐ Psychologist / Counsellor ☐ GP ☐
   _____ (Name of professional) ☐

   e) Did you take tablets/herbal medicine? No ☐ Yes ☐ Please specify: _____

3. Is your relationship with your partner an emotionally supportive one? *(If you have no partner circle 6)*
   1 2 3 4 5 [6
   very much somewhat not at all [☐

4. a) Have you had any stresses, changes or losses in the last 12 months (e.g separation, domestic violence, unemployment, bereavement ?) **Yes** ☐ **No** ☐
   Please list: _____
   b) How distressed were you by these stresses, changes or losses?
   1 2 3 4 5
   not at all somewhat very much ☐

5. Would you generally consider yourself a worrier?
   1 2 3 4 5
   not at all somewhat very much ☐

6. In general, do you become upset if you do not have order in your life (e.g. regular time table, a tidy house)?
   1 2 3 4 5
   not at all somewhat very much ☐

7. Do you feel you have people you can depend on for support with your baby?
   1 2 3 4 5 [6
   very much somewhat not at all [☐

8. Were you emotionally abused when you were growing up? **Yes** ☐ **No** ☐

9. Have you <u>ever</u> been sexually ☐ or physically ☐ abused? **Yes** ☐ **No** ☐

If you would like to seek some help with any of these issues please discuss this with your midwife or doctor.

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Appendix IV: AnteNatal Risk Questionnaire scoring system

ANTENATAL RISK QUESTIONNAIRE (ANRQ)

The Antenatal Risk Questionnaire (ANRQ) is designed to consider specific key risk factors thought to increase the risk of women developing perinatal mental health morbidity (e.g. postnatal depression or anxiety disorder) and sub-optimal mother-infant attachment. It is copyrighted to Prof Marie-Paule Austin, Royal Hospital for Women, Sydney.

ANRQ Questionnaire components include:

- Past mental health history
- Past history of physical (including domestic violence), sexual or emotional abuse
- Current level of supports
- Relationship with mother and partner
- Anxiety and obsessionality levels
- Stressors in the last year (including bereavement, separation etc.).

1. Requirements for the ANRQ

It is essential that the following requirements be adhered to when administering the ANRQ (used in isolation or in combination with the Edinburgh Depression Scale):

- The ANRQ is only intended as an **adjunct to clinical history** taking and is not meant to replace good clinical practice.
- The ANRQ should only be used by appropriately trained staff;
- The ANRQ should be completed toward the end of the interview with the woman in the office at the time, so that any endorsed risk factors can be determined before they leave the Clinic;
- Scores shown below are meant to serve as an indicator of need for support and to aid in the formulation of an appropriate mental health plan.

2. Scoring Instructions for the ANRQ

i. For items 2a, 2b, 2d, 4, 8, 9:

a. **Score Yes=5, No=0** and place the scores in the boxes along the right hand side.
b. If answer is "No" do not give a score for the following section (e.g., Q2a, 2b, 4a: If answer is No" there will be no score for item 2c-e, 4b)

ii. For items 1, 2c, 3, 4b, 5, 6, 7:

c. **Score the number circled** and place the scores in the boxes along the right hand side.

iii. Sum all scores (yes/no and circled answers) and **place total in the box at the top of the questionnaire.**

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IMPORTANT

Questionnaires with a "YES" response on any or all of the following:

- **Q2a** – 'YES' to past history of depression AND causing *significant* impairment in social/occupational function (i.e. *scoring 3 or more on Q2c*) OR necessitating professional contact (Q2d).
- **Q2b** – 'YES' to past history of any other mental health problems (e.g., eating disorder psychosis, bipolar disorder, schizophrenia)
- **Q8** – relating to emotional abuse
- **Q9 –** relating to physical or sexual abuse

Must be considered high risk *irrespective* of the total ANRQ score

iv. Minimum score is 5; Maximum score is 67

v. There is no absolute cut-off score for the ANRQ, but a score of 24 or more suggests presence of significant psychosocial risk factors, and consideration of the woman as at significant risk of perinatal mental health problems. Further enquiry is indicated to establish psychosocial care needs and treatment planning.

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Appendix V: PostNatal Risk Questionnaire (PNRQ)

Name: _____ **Today's Date:** ____/____/_____

Phone (h) _____ **(w)** _____ **(m)** _____

This questionnaire is confidential information and will remain in your file.
PLEASE COMPLETE ALL ITEMS - *circle numbers 1-6 or tick YES/NO*

Total ☐

1. When you were growing up, did you feel your mother was emotionally supportive of you? *(If you had no mother circle 6).*
   1 very much 2 3 4 5 somewhat 6 not at all ☐
2. a) Have you ever had 2 weeks or more when you felt particularly worried, miserable or depressed?
   Yes ☐ **No** ☐ ☐
   b) Do you have any other history of mental health problems? e.g. eating disorders,psychosis,bipolar disorder,schizophrenia.
   Yes ☐ **No** ☐ ☐
   Please specify _____

   If Yes to 2a or 2b, did this:
   c) Seriously interfere with your work and your relationships with friends and family?
   1 not at all 2 3 4 somewhat 5 very much ☐
   d) Lead you to seek professional help?
   Yes ☐ **No** ☐ ☐
   Did you see a: Psychiatrist ☐ Psychologist / Counsellor ☐ GP ☐
   _____ (Name of professional)
   e) Did you take tablets/herbal medicine? No ☐ Yes ☐ Please specify: _____
3. Is your relationship with your partner an emotionally supportive one? *(If you have no partner circle 6)*
   1 very much 2 3 4 5 somewhat 6 not at all ☐
4. a) Have you had any stresses, changes or losses in the last 12 months (e.g separation, domestic violence, unemployment, bereavement ?)
   Yes ☐ **No** ☐ ☐
   Please list: _____
   b) How distressed were you by these stresses, changes or losses?
   1 not at all 2 3 4 somewhat 5 very much ☐
5. Would you generally consider yourself a worrier?
   1 not at all 2 3 4 somewhat 5 very much ☐
6. In general, do you become upset if you do not have order in your life (e.g. regular time table, a tidy house)?
   1 not at all 2 3 4 somewhat 5 very much ☐
7. Do you feel you have people you can depend on for support with your baby?
   1 very much 2 3 4 somewhat 5 not at all ☐
8. Were you emotionally abused when you were growing up?
   Yes ☐ **No** ☐ ☐
9. Have you ever been sexually ☐ or physically ☐ abused?
   Yes ☐ **No** ☐ ☐
10. Was your experience of giving birth to this baby disappointing or frightening?
    1 not at all 2 3 4 somewhat 5 very much ☐
11. Has your experience of parenting this baby been a positive one?
    1 very much 2 3 4 somewhat 5 not at all ☐
12. Overall, has your baby been unsettled or feeding poorly?
    1 not at all 2 3 4 somewhat 5 very much ☐

How comfortable did you feel in completing this questionnaire?
1 very comfortable 2 3 somewhat 4 not at all 5 comfortable

If you would like to seek some help with any of these issues please discuss this with your nurse or doctor.

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Appendix VI: PostNatal Risk Questionnaire scoring system

POSTNATAL RISK QUESTIONNAIRE (PNRQ)

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PNRQ Questionnaire components include:

- Past mental health history
- Past history of physical (including domestic violence), sexual or emotional abuse
- Current level of supports
- Relationship with mother and partner
- Anxiety and obsesionality levels
- Stressors in the last year (including bereavement, separation etc.)
- Experience of giving birth and parenting

1. Requirements for the PNRQ

It is essential that the following requirements be adhered to when administering the PNRQ (used in isolation or in combination with the Edinburgh Depression Scale):

- The PNRQ is only intended as an *adjunct to clinical history* taking and is not meant to replace good clinical practice.
- The PNRQ should only be used by appropriately trained staff;
- The PNRQ should be completed toward the end of the postnatal visit in the presence of the health professional, so that any endorsed risk factors can be determined before the conclusion of the visit;
- Scores shown below are meant to serve as an indicator of need for support and to aid in the formulation of an appropriate mental health plan.

2. Scoring Instructions for the PNRQ

i. **For items 2a, 2b, 2d, 4, 8, 9:**
   a. **Score Yes=5, No=0** and place the scores in the boxes along the right hand side.
   b. If answer is "No" do not give a score for the following section (e.g., Q2a, 2b, 4a: If answer is "No" there will be no score for item 2c-e, 4b)

ii. **For items 1, 2c, 3, 4b, 5, 6, 7, 10, 11, 12:**

   c. **Score the number circled** and place the scores in the boxes along the right hand side.

iii. **Sum all scores** (yes/no and circled answers) and **place total in the box at the top of the questionnaire.**

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IMPORTANT

Questionnaires with a "YES" response on any or all of the following:

- **Q2a** – 'YES' to past history of depression AND causing *significant* impairment in social/occupational function (ie *scoring 3 or more on Q2c*) OR necessitating professional contact (Q2d).
- **Q2b** – 'YES' to past history of any other mental health problems (e.g., eating disorder psychosis, bipolar disorder, schizophrenia)
- **Q8** – relating to emotional abuse
- **Q9 –** relating to physical or sexual abuse

Must be considered high risk *irrespective* of the total PNRQ score

iv. Minimum score is 8; Maximum score is 82

v. There is *no absolute cut-off score* for the PNRQ, but a score of **24 or more** suggests presence of significant psychosocial risk factors, and consideration of the woman as at significant risk of perinatal mental health problems. Further enquiry is indicated to establish psychosocial care needs and treatment planning.

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Appendix VII: Antenatal Screening Pathways (Generic – Metropolitan)

RISK	No Risk	Low Risk	Moderate Risk	Moderate Symptoms	High Risk/Complex Needs	High Risk/Mental Health	High Risk Social
SCORE	EPDS 10 or below ANRQ/PNRQ below 24 • MH symptoms low • Social risk factors low • No history of abuse • No psychiatric history	EPDS equals 11 or 12 ANRQ/PNRQ any item above 3 • Past psychiatric history - not current	EPDS below 13 ANRQ/PNRQ above 24 • MH symptoms low • Social risk factors high • Psychiatric history - current • Early attachment issues • Domestic Violence • History of abuse	EPDS equals 13 ANRQ/PNRQ below 24 • MH symptoms high • Social risk factors low	EPDS above 13 ANRQ/PNRQ 24 or above • MH symptoms high • Social risk factors high	Positive score for Q 10 of the EPDS • Yes, quite often • Sometimes	• Acute emotional distress • Current domestic violence
ACTION	• No referral required • Offer contact details of PMHT • Offer Beyond Blue "Emotional health" booklet	• Monitor for distress at each visit – repeat EPDS • Referral not required • Offer contact details of social work or PMHT • Offer Beyond Blue "Emotional health" booklet	• Refer to Social Work or PMHT • Offer CSA, DV booklets if appropriate • Offer *Beyond Blue* "Emotional health"	• Refer to PMHT • Offer *Beyond Blue* "Emotional health" CSA, DV booklets if appropriate	• Immediate referral to PMHT by phone or within 24 hours • Advise re: emergency services	• Gently explore if the question is understood • Urgent/ Immediate referral to PMHT, ACIS or Emergency Dept.	• Urgent/ Immediate referral to Social Work Services, Domestic violence services, Families SA, Police • Check safety
DOCUMENTATION	• Document score in progress notes, handheld record, database	• Document score in progress notes, handheld record, database	• Document score in progress notes, handheld record, database	• Document score in progress notes, handheld record, database	• Document score in progress notes, handheld record, database	• Document score in progress notes, handheld record, database	• Document score in progress notes, handheld record, database
DECLINES SERVICE	Score indicates referral required to social work service or PMHT, BUT woman declines referral • Send letter to GP (with client consent) • Document in progress notes • Offer *Beyond Blue* information: "Emotional health during pregnancy and early parenthood booklet". • Offer contact details of PMHT team, to allow the woman to self-refer in the future.						

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PATHWAYS OF CARE	No Risk	Low Risk	Moderate Risk	Moderate Symptoms	High Risk/Complex Needs	High Risk/Mental Health	High Risk/Social
	• N/A unless circumstances change	• N/A unless circumstances change	• Social work will undertake an assessment, and refer on as appropriate	• PMHT will undertake a comprehensive mental health & risk assessment • PMHT develop care plan and provide follow up • Referral on as needed e.g. specialist PMH services, community services, groups • GP for ATAPS - psychologist	• PMHT will undertake a comprehensive mental health & risk assessment • PMHT develop care plan and provide follow up • Referral on as needed e.g. specialist PMH services, community services, groups • GP for ATAPS - psychologist	• PMHT/Emergency Dept or ACIS to undertake a comprehensive mental health & risk assessment • Referral for hospital admission as necessary • PMHT develop care plan and provide follow up	• Social worker to undertake family risk assessment, coordinate follow up • Referral to PMHT as required

Legend
ACIS Assessment & Crisis Intervention Service (only Metro)
ANRQ Antenatal Risk Assessment Questionnaire
Access to Allied Health Professionals Scheme (Via Divisions of General Practice)
ATAPS
CPS Clinical Practice Support
EPDS Edinburgh Depression Scale
MH Mental Health
PMHT Perinatal Mental Health Team
PS Psychosocial
SAPR South Australian Pregnancy Record
SW Social Worker

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Screening for perinatal anxiety and depression

Appendix VIII: Antenatal Screening Pathways (Generic – Country)

RISK	No Risk	Low Risk	Moderate Risk	Moderate Symptoms	High Risk/Complex Needs	High Risk/Mental Health	High Risk Social
SCORE	EPDS 10 or below ANRQ below 24 • MH Symptoms Low • PS Risk factors low • No history of Abuse • No psychiatric history	EPDS equals 11 or 12 ANRQ any item above 3 • Past psychiatric history - not current	EPDS below 13 ANRQ above 24 • MH Symptoms low • Social Risk Factors high • Current Psychiatric Hx • Early attachment issues • Domestic Violence • History of abuse	EPDS equals 13 ANRQ below 24 • MH Symptoms high • Social Risk Factors low	EPDS above 13 ANRQ 24 or above • MH Symptoms high • Social Risk Factors high	Positive score for Q 10 of the EPDS • Yes, quite often • Sometimes	• Acute emotional distress • Current domestic violence
REFERRAL	• No referral required	• Referral not required • Social work &/ or referral to appropriate local services if indicated or requested • Monitor for distress at each visit	• Referral to PMHT or Social Work and counselling services • Referral to appropriate local services • Offer CSA, DV booklets if appropriate • Offer *Beyond Blue* 'Emotional health	• Referral to PMHT • Referral to appropriate local services • Offer *Beyond Blue* 'Emotional health' CSA, DV booklets if appropriate	• Immediate referral to PNMHT / ETLS by phone or within 24 hours • Advise re emergency services • Referral to appropriate local services	• Gently explore if the question is understood • Urgent/ Immediate referral to PMHT, ETLS or Emergency Dept.	• Urgent/Immediate referral to Social Work Services, appropriate local services, Domestic violence services, Families SA, Police
DOCUMENTATION	Document score in: • Progress notes • SA Pregnancy record • CPS & or other database	Document score in: • Progress notes • SA Pregnancy handheld record • CPS & or other database	Document score in: • Progress notes • SA Pregnancy record • CPS & or other database	Document score in: • Progress notes • SA Pregnancy record • Complete referral & send with questionnaires	Document score in: • Progress notes • SA Pregnancy record • Complete referral by phone & send handcopy and questionnaires • CPS & or other database	Document score in: • Progress notes • SA Pregnancy record • Complete referral by phone & send handcopy and questionnaires • CPS & or other database	Document score in: • Progress notes • SA Pregnancy record • Complete referral by phone & send handcopy and questionnaires • CPS & or other database
DECLINES SERVICE	Score indicates referral required to social work service or PMHT, BUT woman declines referral • Send letter to GP (with client consent) • Document in progress notes • Offer *Beyond Blue* information, "Emotional health during pregnancy and early parenthood booklet". • Offer contact details of PMHT team, to allow the woman to self-refer in the future.						

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	No Risk	Low Risk	Moderate Risk	Moderate Symptoms	High Risk/Complex Needs	High Risk/Mental Health	High Risk/Social
PATHWAYS OF CARE	• Offer contact details of PMH-T team • Offer *Beyond Blue* information: "Emotional health during pregnancy and early parenthood" booklet	• Offer contact details of PMH-T team • Offer *Beyond Blue* information: "Emotional health during pregnancy and early parenthood" booklet	• Offer Social Work Services, Childhood sexual abuse services, Domestic violence services, other appropriate local services • Offer contact details of PMH-T team • Referral to local GP • Offer *Beyond Blue* information: "Emotional health during pregnancy" booklet	• PMH-T will undertake a comprehensive mental health assessment & risk assessment • Treatment and referral for specialist services as required • Referral to GP and ATAPS - psychologist • Support group referral • Offer *Beyond Blue* info: "Emotional health during pregnancy" booklet	• PMH-T will undertake a comprehensive mental health assessment & risk assessment • Treatment and referral for specialist services as required • GP and ATAPS - psychologist • Support group referral • Offer *Beyond Blue* info: "Emotional health during pregnancy" booklet	• PMH-T/Emergency Dept or ETLS to undertake a comprehensive mental health assessment & risk assessment • Refer for Hospital admission as necessary	• Social worker to undertake family risk assessment, coordinate follow up • Referral to PMH-T as required
FOLLOW UP	• N/A unless circumstances change	• Midwife/Doctor to repeat EPDS if clinical concerns	• PMH-T/ social work develop care plan and provide follow up	• PMH-T develop care plan and provide follow up	• PMH-T develop care plan and provide follow up • Ongoing high level of support	• PMH-T develop care plan and provide follow up • Ongoing high level of support	• Social work/ other appropriate local services to provide ongoing high level of support. • Referral to PMH-T as required

Legend
Hx History
ANRQ Antenatal Risk Assessment Questionnaire
Access to Allied Health Professionals Scheme (Via Divisions of General Practice)
ATAPS Clinical Practice Support
CPS Edinburgh Postnatal Depression Scale (also used antenatally)
EPDS Emergency Triage Liaison Team
ETLS Mental Health
MH Perinatal Mental Health Team
PMHT South Australian Pregnancy Record
SAPR Social Worker
SW General Practitioner
GP

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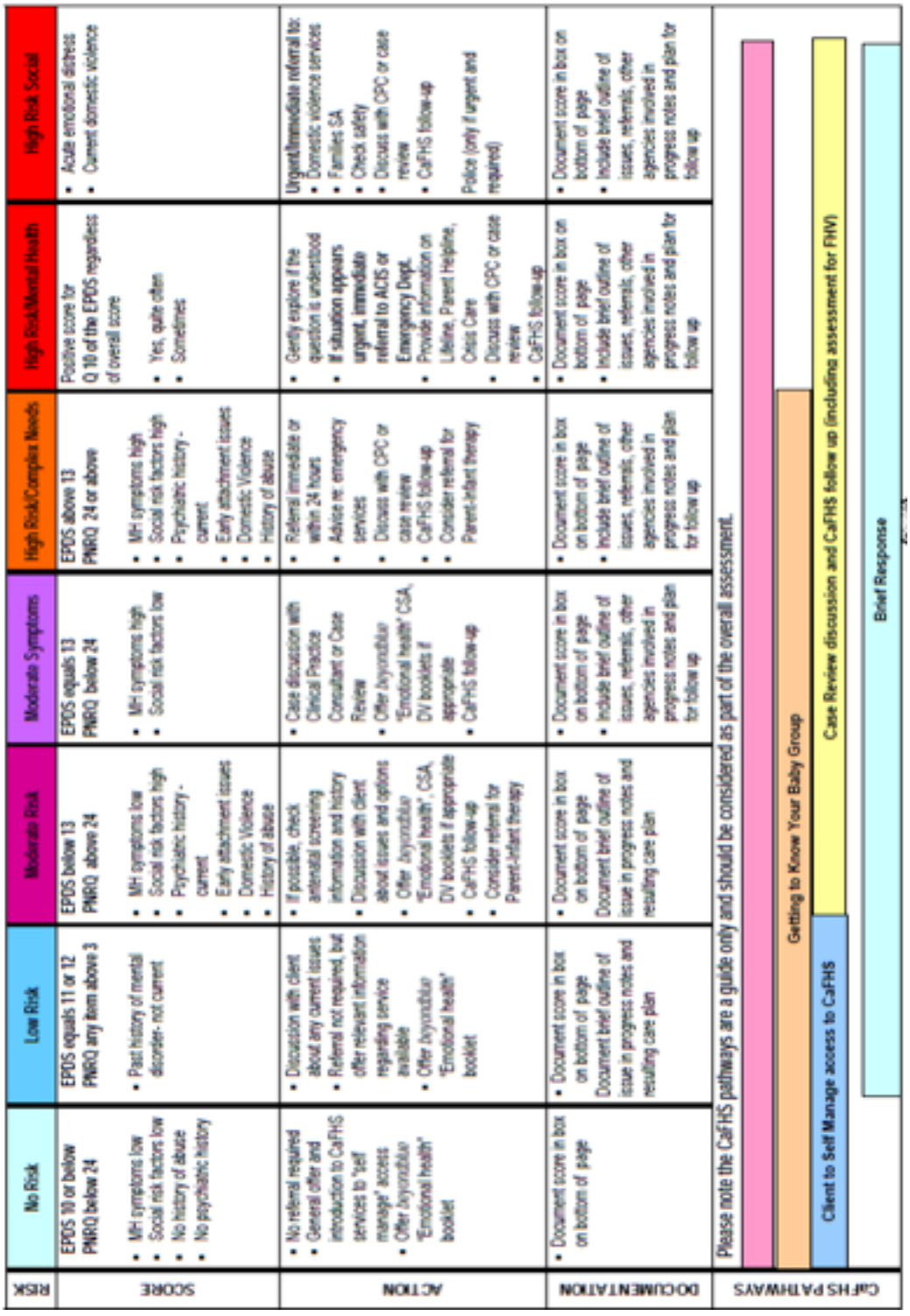
Appendix IX: Postnatal Screening Pathways (CaFHS)



RISK	No Risk	Low Risk	Moderate Risk	Moderate Symptoms	High Risk/Complex Needs	High Risk Mental Health	High Risk Social
SCORE	EPDS 10 or below PNRQ below 24 • MH symptoms low • Social risk factors low • No history of abuse • No psychiatric history	EPDS equals 11 or 12 PNRQ any item above 3 • Past history of mental disorder- not current	EPDS below 13 PNRQ above 24 • MH symptoms low • Social risk factors high • Psychiatric history - current • Early attachment issues • Domestic Violence • History of abuse	EPDS equals 13 PNRQ below 24 • MH symptoms high • Social risk factors low	EPDS above 13 PNRQ 24 or above • MH symptoms high • Social risk factors high • Psychiatric history - current • Early attachment issues • Domestic Violence • History of abuse	Positive score for Q 10 of the EPDS regardless of overall score • Yes, quite often • Sometimes	• Acute emotional distress • Current domestic violence
ACTION	• No referral required • General offer and introduction to CaFHS services to 'self manage' access • Offer Joyoundulu "Emotional health" booklet	• Discussion with client about any current issues • Referral not required, but offer relevant information regarding service available • Offer Joyoundulu "Emotional health" booklet	• If possible, check antenatal screening information and history • Discussion with client about issues and options • Offer Joyoundulu "Emotional health", CSA, DV booklets if appropriate • CaFHS follow-up • Consider referral for Parent-Infant therapy	• Case discussion with Clinical Practice Consultant or Case Review • Offer Joyoundulu "Emotional health" CSA, DV booklets if appropriate • CaFHS follow-up	• Referral immediate or within 24 hours • Advise re: emergency services • Discuss with CPC or case review • CaFHS follow-up • Consider referral for Parent-Infant therapy	• Gently explore if the question is understood • If situation appears urgent, immediate referral to ACIS or Emergency Dept. • Provide information on Lifeline, Parent Helpline, Crisis Care • Discuss with CPC or case review • CaFHS follow-up	Urgent/Immediate referral to: • Domestic violence services • Families SA • Check safety • Discuss with CPC or case review • CaFHS follow-up Police (only if urgent and required)
DOCUMENTATION	• Document score in box on bottom of page	• Document score in box on bottom of page Document brief outline of issue in progress notes and resulting care plan	• Document score in box on bottom of page Document brief outline of issue in progress notes and resulting care plan	• Document score in box on bottom of page • Include brief outline of issues, referrals, other agencies involved in progress notes and plan for follow up	• Document score in box on bottom of page • Include brief outline of issues, referrals, other agencies involved in progress notes and plan for follow up	• Document score in box on bottom of page • Include brief outline of issues, referrals, other agencies involved in progress notes and plan for follow up	• Document score in box on bottom of page • Include brief outline of issues, referrals, other agencies involved in progress notes and plan for follow up
CaFHS PATHWAYS	Please note the CaFHS pathways are a guide only and should be considered as part of the overall assessment. Getting to Know Your Baby Group Case Review discussion and CaFHS follow up (including assessment for FHV) Client to Self Manage access to CaFHS Brief Response						

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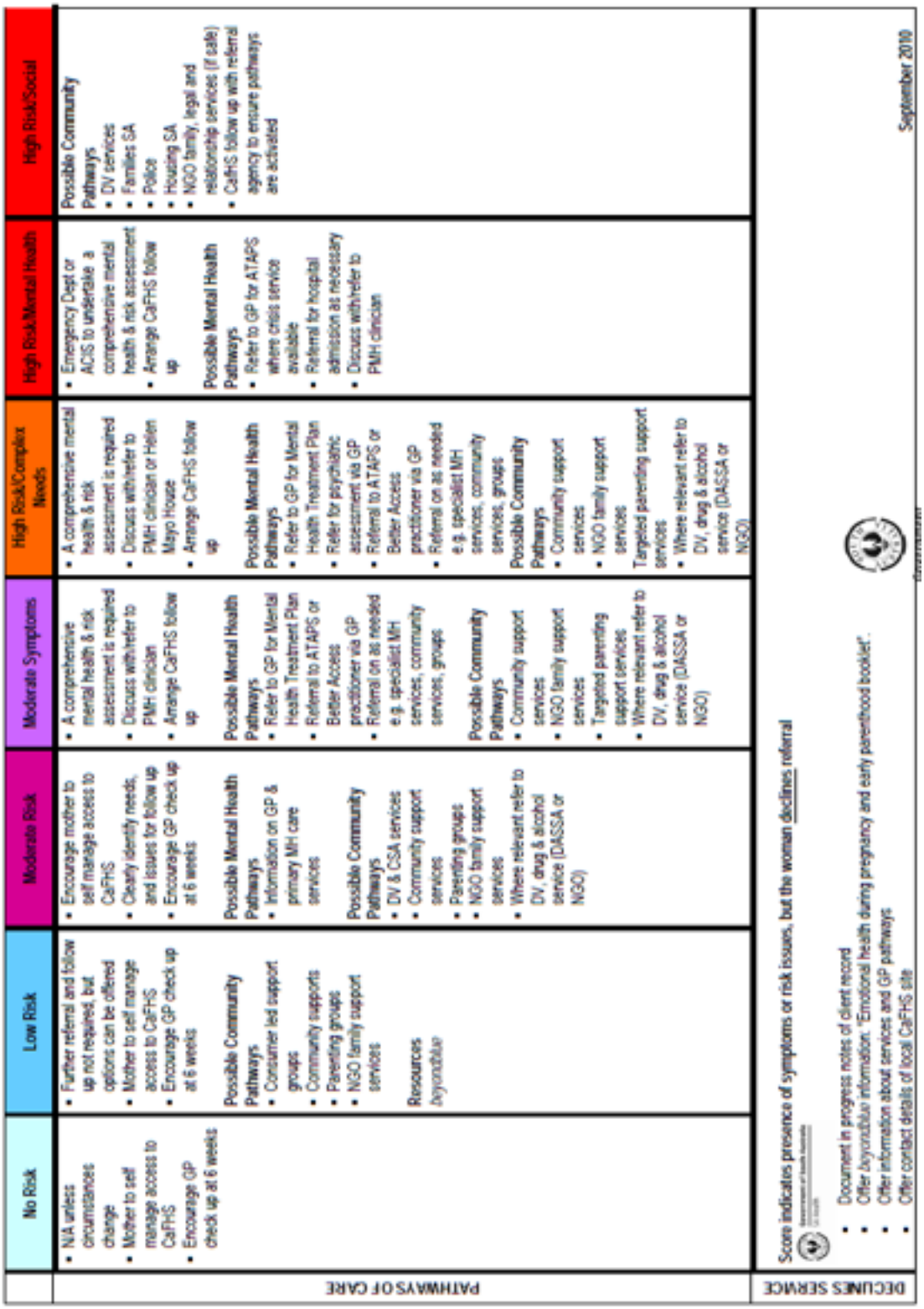

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Useful web sites

Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
http://www.ranzcog.edu.au/publications/o-g_pdfs/OG_Summer-2005/Postnatal-or-perinatal-depression_ABuist.pdf

Royal Australian College of General Practitioners (RACGP)
Perinatal depression – assessment and management
http://www.racgp.org.au/afp/200609/20060906buist.pdf

Beyond blue
Link to page with translated versions of the booklet 'Emotional health during pregnancy and early parenthood'
http://www.beyondblue.org.au/index.aspx?link_id=7.980

Beyond blue.
Draft Clinical guideline on depression and related disorders. Available from URL: http://www.beyondblue.org.au/index.aspx?

PANDA
Information leaflets, telephone counselling and service information
http://www.panda.org.au/

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Abbreviations

et al.	And others
KEMH	King Edward Memorial Hospital
EPDS	Edinburgh Postnatal Depression Scale
e.g.	For example
ANRQ	Antenatal Risk Questionnaire
PNRQ	Postnatal Risk Questionnaire
NPDI	National Perinatal Depression Initiative
GP	General Practitioner
ATAPS	Access To Allied Psychological Services
MH	Mental Health
PMH	Perinatal Mental Health
PMHT	Perinatal Mental Health Team
ETLS	Emergency Triage Liaison Team
NGO	Non Government Organisation(s)
CaFHS	Child and Family Health Service
DASSA	Drug and Alcohol Services South Australia
ACIS	Assessment and Crisis Intervention
DV	Domestic violence
CSA	Childhood sexual abuse
N/A	Not applicable
CPS	Clinical practice support
SW	Social worker
Hx	History

Version control and change history

PDS reference: OCE use only

Version	Date from	Date to	Amendment
1.0	21 Sept 10	current	Original version

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