

# Perinatal mental health and psychosocial assessment

Practice resource manual for Victorian maternal and child health nurses



# Statement

Due to machinery of government changes, this document was reissued in 2019 without revision to meet accessibility requirements. While the content is still relevant, some references to departments, agencies and other publications are out of date.

For further information email [Maternal and Child Health and Parenting](mailto:mch@dhhs.vic.gov.au) <mch@dhhs.vic.gov.au>.

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In this document, 'Aboriginal' refers to both Aboriginal and Torres Strait Islander people. 'Indigenous' or 'Koori/Koorie' is retained when part of the title of a report, program or quotation.

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# Background and executive summary

The perinatal period is a time of huge change and adjustment. For most new parents life settles after a few months but for some pregnancy and early parenthood can trigger symptoms of more serious mental health conditions that need active management. A consistent, early and effective response by trained health professionals to families during the childbearing years is being implemented nationally.

The National Perinatal Depression Initiative (NPDI) is a collaboration between State and Territory Governments together with the Commonwealth Government. The Victorian Government has committed \$14.03 million over 5 years to improve the prevention and early detection of antenatal and postnatal depression, and to provide better care and treatment for expectant and new mothers experiencing perinatal depression. The key components of the NPDI are:

1. Routine and universal screening for perinatal depression and anxiety in both antenatal and postnatal settings
2. Follow up support and care for women assessed as being at risk of or experiencing perinatal depression
3. Workforce training and development for health professionals
4. Research and data collection
5. National Clinical Guidelines on perinatal mental health
6. Community awareness

Training for Victorian Maternal and Child Health Nurses (part of the NPDI and involving the Departments of Health and Education and Early Childhood Development)

Clinical Practice Guidelines for Depression and Related Disorders- anxiety, bipolar disorder and puerperal psychosis- in the perinatal period provide recommendations on the delivery of universal screening and support. The Guidelines have been developed by beyondblue, the Guidelines Expert Advisory Committee and approved by The National Health and Medical Research Council (2011). These Guidelines (available from [www.beyondbabyblues.org.au](http://www.beyondbabyblues.org.au)) summarise published literature and also include recommendations and good practice points on key areas of perinatal mental health care. These Guidelines form the basis of practice and training to be provided to Victorian Midwives and Maternal and Child Health Nurses (MCHN), as part of the roll out of women centred care for perinatal depression, anxiety and psychosocial assessment.

Recommendations in the Guidelines for best practice postnatal care that are relevant to Maternal and Child Health Practice include:

- As a minimum, all health professionals providing care in the perinatal period should receive training in woman centred communication skills and psychosocial assessment.
- The Edinburgh Postnatal Depression Scale (EPDS) should be used by health professionals as a component of the assessment of all women in the postnatal period for symptoms of depression and anxiety.
- A score of 13 on the EPDS or more can be used for detecting symptoms of depression in the postnatal period.

## Timing and components of assessment

While the Clinical Practice Guidelines suggests that psychosocial assessment be conducted between 6–12 weeks after delivery, the Key Ages and Stages (KAS) framework includes the maternal emotional health and wellbeing check at the 4 week consultation and encourages MCHN's to monitor maternal

health and wellbeing throughout all the KAS visits. The 4 week consultation involves asking questions about the mother's mental and physical health. It also includes the family violence assessment which is part of the broader psychosocial assessment.

**The maternal health and wellbeing check will now include:**

- initial 'Case finding' questions
- administration of the EPDS where indicated, and
- asking psychosocial questions aiming to understand a woman's risk for mental health difficulties and useful pathways to care

The maternal health and wellbeing check should be undertaken at the 4 week KAS consultation but not later than the 8 week consultation. With regard to family violence assessment, it should be noted that the MCH Service Practice Guidelines state that 'although the family violence assessment is noted to be done at the four-week KAS consultation, these questions can be asked at any MCH consultation if professional judgement warrants'. A similar approach should be used with regards to the psychosocial questions.

## **Professional development and resources for maternal and child health nurses**

### **Practice resource manual for Victorian maternal and child health nurses on perinatal mental health and psychosocial assessment**

This resource manual has been developed by expert staff at the Parent-Infant Research Institute (PIRI), Mercy Women's Hospital and Austin Health perinatal, who have an extensive background in the area of perinatal mental health as well as health professional training.

This practice resource manual is divided into six resources. It covers recognition of perinatal mental health disorders (Resource 1), the rationale for screening and properties of the EPDS (Resource 2) the depression screening protocol (Resource 3), psychosocial assessment (Resource 4) and decision making about the pathways to care in (Resource 5). Women centred care and advanced communication skills to undertake these activities are also covered (Resource 6). The manual will be published and distributed to MCHN's by the Department of Education and Early Childhood Development.

The manual takes advantage of a range of existing resources including the aNEW fact sheets and a number of beyondblue resources. It is designed to be a companion document to an innovative, engaging and time efficient workshop for MCHN's designed to build capacity to undertake depression and anxiety screening as part of a fuller psychosocial assessment. This training will provide the opportunity to develop and practice the skills necessary to conduct effective depression screening and psychosocial assessment.

### **Delivery of face-to-face workshop to Victorian Maternal and Child Health nurses through 14 metropolitan and 6 regional training sessions**

This manual is designed to complement the training workshops that will be conducted across metropolitan and regional centres during 2013. The 6-hour workshops will be skills based and focus on how psychosocial assessment and depression screening may be implemented in MCH practice as part of routine practice.

As part of the training process, MCHN's will be asked to:

- read this practice resource manual
- attend the skills workshop and participate in the discussions and interactive exercises
- undertake all workshop activities (individual and group)
- participate in discussion and role plays

- complete a before and after evaluation form
- follow up the workshop by familiarising themselves with the Beyond babyblues online training and other materials.

Overall, the manual is designed to support the key processes for assessment of perinatal depression as outlined in the following summary figures:

**Figure 1: Executive summary – overview of depression screening and psychosocial assessment**

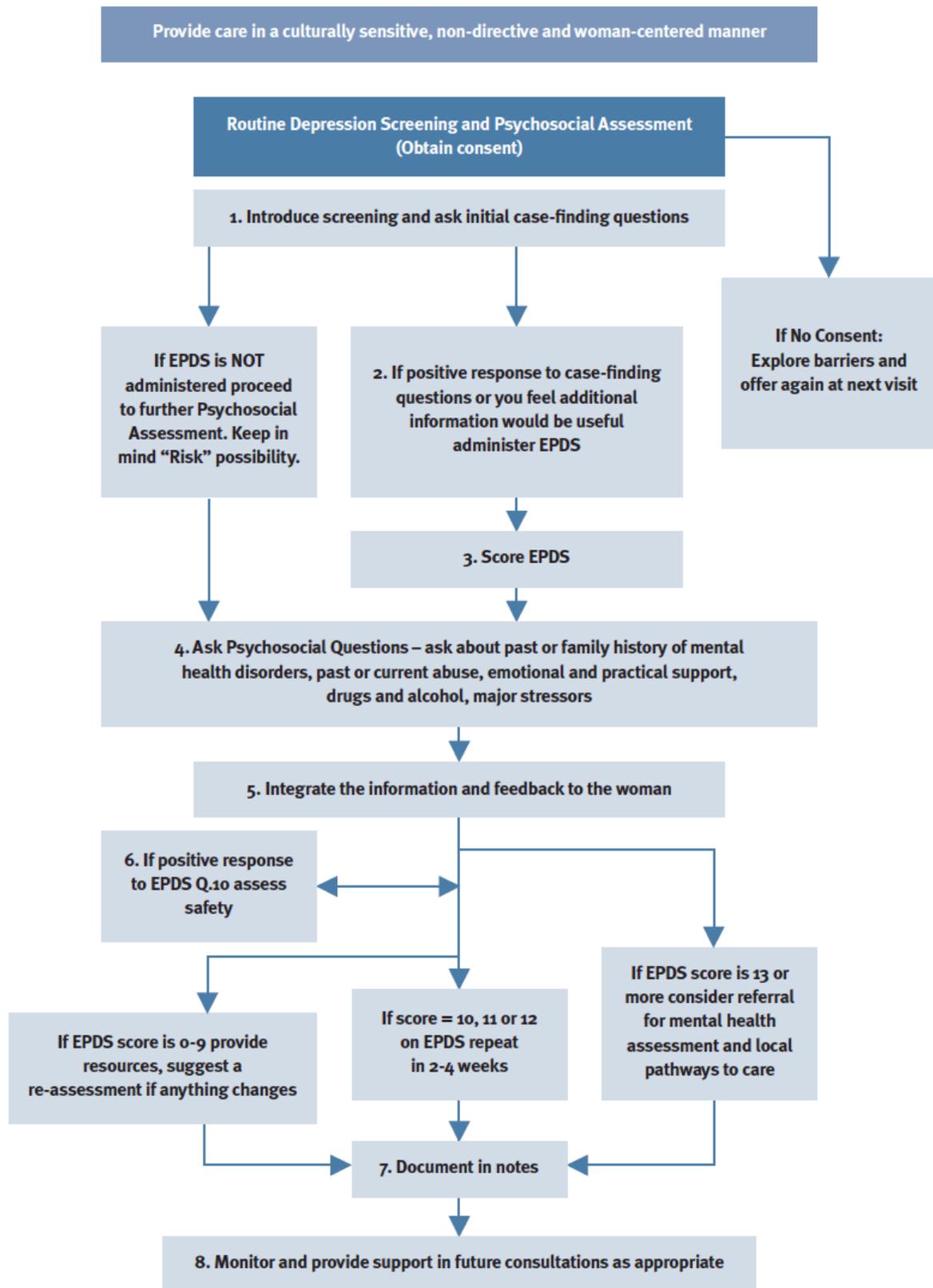


Figure 2: Risk assessment protocol summary



**Table 1: Determining level of risk and suggested actions (modified from PIRI risk protocol)**

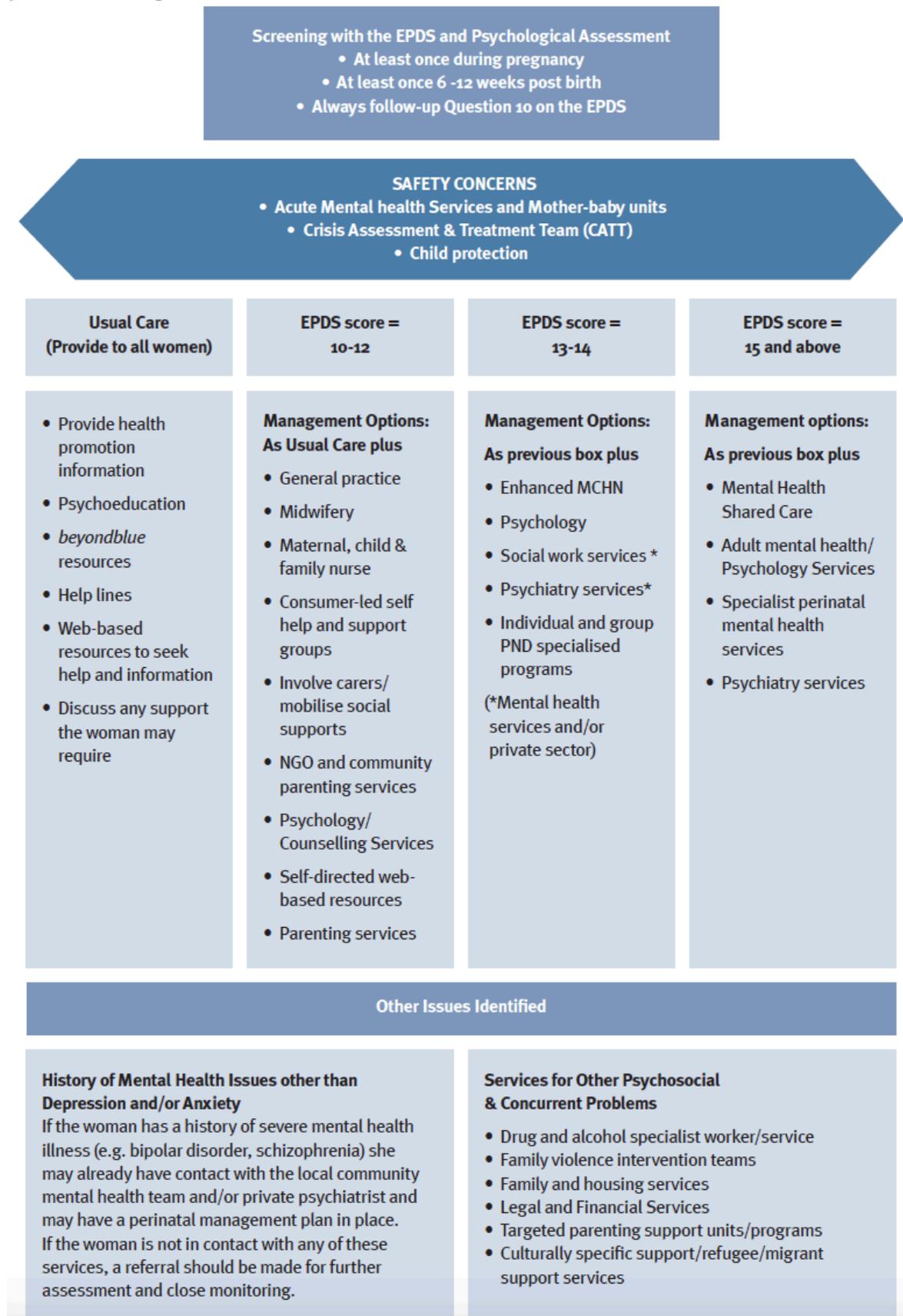
**Risk factors**

Low risk	Medium risk	High risk
<ul style="list-style-type: none"> <li>• Some vague suicidal thoughts or thoughts about death</li> <li>• Denies suicidal intention No plan. No recent attempts Quite connected</li> <li>• Mild depression</li> <li>• No psychotic symptoms Feels hopeful</li> <li>• Mild anger/Hostility</li> </ul>	<ul style="list-style-type: none"> <li>• Frequent suicidal thoughts Some intention</li> <li>• Rough plan and potential access to means</li> <li>• Some connectedness Moderate depression Some psychotic symptoms</li> <li>• Some feelings of hopelessness Moderate anger/hostility</li> </ul>	<ul style="list-style-type: none"> <li>• Continual/specific thoughts Clear intention</li> <li>• Specific plan and access to means. Can't guarantee safety</li> <li>• Severe depression</li> <li>• Preoccupied with despair, hopelessness</li> <li>• Psychotic symptoms command hallucinations or delusions</li> <li>• Severe anger/hostility</li> </ul>

**Actions**

Low risk	Medium risk	High risk
<ul style="list-style-type: none"> <li>• Develop a safety and management plan including GP and partner.</li> <li>• Provide numbers for: Lifeline – 131114</li> <li>• Suicide Helpline – 1300 651 251</li> <li>• Maternal and Child Health Line – 132229</li> <li>• Parentline (8am – 12am Mon-Fri &amp; 10am-10pm on weekends) – 132289</li> <li>• Panda – 1300 726 306</li> </ul>	<ul style="list-style-type: none"> <li>• Consult with senior colleague if possible</li> <li>• If in doubt telephone Crisis Assessment &amp; Treatment Team and discuss client</li> <li>• Develop a safety contract and management plan including GP and partner</li> <li>• Arrange for support person to pick up client from appointment and discuss a safety plan with support person. If necessary request permission to develop safety plan with additional support people</li> <li>• Ensure client and support person has numbers for: <ul style="list-style-type: none"> <li>– Crisis Assessment &amp; Treatment Team (CATT) - 9450 9090</li> <li>– Lifeline – 131114</li> <li>– Suicide Helpline – 1300 651 251</li> <li>– Mental Health Advice Line – 1300 280 737</li> <li>– Parentline (8am – 12am Mon-Fri &amp; 10am-10pm on weekends) – 132289</li> <li>– Panda – 1300 726 306</li> <li>– Permission to contact other health professionals involved</li> <li>– Regular risk assessment</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Consult with senior colleague if possible</li> <li>• Telephone Crisis Assessment &amp; Treatment Team (CATT)</li> <li>• Telephone Community Mental Health Service</li> <li>• If CATT &amp; CMHS are unable to attend:</li> <li>• Arrange to take the client to Emergency Department (ED)</li> <li>• Telephone significant other and ask them to attend ED</li> <li>• Arrange follow-up and request permission to inform GP, psychiatrist and other health professionals involved. If you are to continue seeing client develop a safety and management plan and request permission to discuss this with other health practitioners involved.</li> <li>• Regular risk assessment</li> </ul>

**Figure 3: Pathways to care – a sample guide for the management of depression (adapted from PIRI protocols and beyond babyblues online training)**



# Edinburgh Postnatal Depression Scale<sup>1</sup>

## Instructions

We would like to know how you have been feeling in the past week. Please indicate which of the following comes closest to how you have felt in the past week, not just how you feel today. Please choose only one response for each question, which is the closest to how you have felt in the past seven days. Mark the question with an X.

### I have been able to laugh and see the funny side of things

Response	Mark with an X
As much as I always could	
Not quite so much now	
Definitely not so much now	
Not at all	

### I have looked forward with enjoyment to things

Response	Mark with an X
As much as I ever did	
Rather less than I used to	
Definitely less than I used to	
Hardly at all	

### I have blamed myself unnecessarily when things went wrong

Response	Mark with an X
Yes, most of the time	
Yes, some of the time	
Not very often	
No, never	

### I have been anxious or worried for no good reason

Response	Mark with an X
No, not at all	
Hardly ever	
Yes, sometimes	
Yes, very often	

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<sup>1</sup> Cox et al., 1987

**I have felt scared or panicky for no very good reason**

<b>Response</b>	<b>Mark with an X</b>
Yes, quite a lot	
Yes, sometimes	
No, not much	
No, not at all	

**Things have been getting on top of me**

<b>Response</b>	<b>Mark with an X</b>
Yes, most of the time I haven't been able to cope at all	
Yes, sometimes I haven't been coping as well as usual	
No, most of the time I have coped quite well	
No, I have been coping as well as before	

**I have been so unhappy that I have had difficulty sleeping**

<b>Response</b>	<b>Mark with an X</b>
Yes, most of the time	
Yes, sometimes	
Not very often	
No, not at all	

**I have been so unhappy that I have been crying**

<b>Response</b>	<b>Mark with an X</b>
Yes, most of the time	
Yes, quite often	
Only occasionally	
No, never	

**The thought of harming myself has occurred to me**

<b>Response</b>	<b>Mark with an X</b>
Yes, quite often	
Sometimes	
Hardly ever	
Never	

# Summary of 'case finding' and psychosocial questions and notes

## Domain 1: Past and present mental health disorders

### Questioning about current depressive symptoms:

'During the past month, have you often been bothered by feeling down, depressed or hopeless?'

'During the past month, have you often been bothered by little interest or pleasure in doing things?'

### Questioning about current anxiety symptoms:

'Do you sometimes worry so much that it affects your day-to-day life?'

If the woman answers yes to either of these questions, proceed by asking if she has previously received treatment for these feelings.

### Questioning about past mental health (self and family):

'Have you ever experienced or needed treatment for a mental health condition such as depression or anxiety disorders, bipolar disorder or psychosis?'

**If the woman answers yes, ask how long ago this occurred and what type of treatment she received. (i.e., medication, individual counselling etc.)**

'Has anyone in your immediate family (i.e., grandparents, parents, siblings) experienced or received treatment for a mental health problem?'

**If the woman answers yes, ask whether this family history includes any significant depression, bipolar disorder, psychoses, self-harm and/or suicide attempts; or significant drug and alcohol use.**

## Domain 2: Past and/or current physical, sexual or psychological abuse (incorporating the family violence questions from the MCH Practice guidelines)

'When you were growing up, did you always feel cared for and protected?'

**Before the question is asked, it is important that the health professional has a plan about how to respond to a negative response, including appropriate referral options.**

'Has anyone in your household ever pushed, hit, punched or otherwise hurt you?' 'Are you in anyway worried about the safety of yourself or your children?'

'Are you afraid of someone in your family?'

## Domain 3: Current drug and/or alcohol use

'Do you or others think that you (or your partner) may have a problem with drugs or alcohol?'

## Domain 4: Recent life stressors

'Have you had any major stressors, changes or losses in the last 12 months - for example, financial strain, relationship problems, loss of someone close to you or have you moved house?'

**If the woman answers yes, ask some questions regarding when the event/s occurred, the impact that the event/s had on her life and how she coped at the time.**

## **Domain 5: Current emotional and practical support**

'If you found yourself struggling, what practical support do you feel would be available to you? Who could help provide that?'

'If you found yourself struggling, what emotional support do you feel would be available to you? Who could help provide that?'

'When you were growing up, was your mother emotionally supportive of you?'

**It is important to note that women may interpret terms such as 'struggling' and/or 'support' differently, and thus you should use your own clinical judgement and what you know about the woman and her background to modify the way in which the question is asked and phrased. At this point in the assessment, if the woman has not mentioned her partner, or indicated that she does have a partner, it may be a good idea to ask what support she feels that she gets from people around her.**

# Resource 1: Overview of mental health problems in the perinatal period

This section will cover:

- a brief background on perinatal mental health difficulties and disorders (high and low prevalence)
- the risk factors and symptoms of postnatal depression and anxiety
- the impact of maternal mental health on attachment and infant development
- the other factors that can impact on maternal mental health

## High-prevalence disorders (depression, anxiety and adjustment disorders)

High prevalence disorders refer to those presentations that are most common and therefore most likely to be seen in routine practice. These include adjustment difficulties, depression and anxiety. While screening and psychosocial assessment is not aimed at diagnosing a definite disorder, it is important to understand the symptoms associated with these conditions to enhance your ability for early identification and to decide who needs further assessment.

### Adjustment difficulties

Women can experience a range of symptoms of varying severity and duration as they make the transition to parenthood. Many symptoms resolve themselves over time as the woman adjusts to her new situation, however for some women the distress experienced is more severe than one would expect and disrupts her functioning. In these cases, occurring in approximately 29% of postnatal women, criteria for an adjustment disorder are met (Diagnostic and Statistical Manual IV/V).

Symptoms typically experienced are those of depression and/or anxiety. By definition, the symptoms are transient (begin within three months of the stressor and end within 6 months), and an adjustment disorder is diagnosed when the symptoms do not meet the criteria for any other mental disorder. A diagnosis of adjustment disorder with depressed mood (for example, symptoms of low mood, tearfulness and feelings of hopelessness), or with anxious mood (for example, symptoms of nervousness, worry and jitteriness) can be made.

### Depression

Current research indicates that the prevalence of a diagnosed depressive disorder is around 13% at three months post-birth. For up to 40% of these women, symptoms begin during their pregnancy. Women who experience postnatal depression are also more likely to relapse, with 20-40% of women likely to have a subsequent depressive episode with further births.

### Diagnostic criteria for perinatal depression

For a diagnosis of major depression according to the Diagnostic and Statistical Manual IV (DSM-IV) criteria a woman should have at least five symptoms from the list below, of which one must be symptom 1 or symptom 2, occurring on most days in the previous two weeks (the ICD-10, World Health Organization 2010, provides a widely used and similar list of clinical criteria).

1. Depressed mood/irritability
2. Diminished interest in activities

3. Significant weight or appetite change
4. Sleeping problems, for example insomnia or hypersomnia
5. Fatigue
6. Feelings of worthlessness/guilt
7. Inability to think clearly or concentrate
8. Recurrent thoughts of death and/or suicide
9. Psychomotor agitation and/or retardation

For a DSM-IV diagnosis of minor depression fewer symptoms are needed to meet the diagnostic criteria. It should be noted that minor depression can develop into a major depressive episode, and both can be present with anxiety.

While the symptoms of a major or minor depressive disorder in the perinatal period are the same as those at any other time of life, the presence of an infant or unborn baby can make depression at this time harder to deal with and also to identify as some of the physical changes associated with motherhood overlap with the symptoms of depression, for examples changes in sleeping, changes in appetite.

Early identification is important as ongoing depression can leave women, their infants and their families vulnerable to a wide range of negative and lasting consequences.

## **Anxiety**

Anxiety symptoms may be as common as depression in the perinatal period. A number of anxiety disorders may be diagnosed and include generalised anxiety disorder, phobias, obsessive compulsive disorder, panic disorder, agoraphobia and post-traumatic stress disorder.

The rate of generalised anxiety disorder (GAD) has been estimated at 8.5% in pregnancy and up to 8.2% after birth – in both cases higher than in non-perinatal populations. However, estimates of prevalence are variable, depending on which anxiety disorders are examined, and whether sub-clinical levels of anxiety symptoms are included in the estimate.

## **Diagnostic criteria for perinatal anxiety**

Anxiety disorders involve excessive worry and anxiety that the woman finds difficult to control, occurring on most days.

The symptoms of Generalised Anxiety Disorder include anxiety and worry over most

days over a number of events/activities that is difficult to control plus three of the following six symptoms:

- restlessness or feeling keyed up or on edge
- being fatigued easily
- difficulty concentrating
- irritability
- muscle tension
- sleep disturbance.

The symptoms of panic disorder: defined as recurrent panic attacks that have the following characteristics:

- palpitations, pounding heart, accelerated heart rate
- trembling, numbness or tingling sensations
- sensations of shortness of breath

- chills or hot flushes
- feeling dizzy, lightheaded or faint
- fear of losing control
- fear of dying.

Panic disorder is also commonly associated with agoraphobia: a fear and avoidance of being in public or unfamiliar places where escape is not possible or is embarrassing.

Other types of anxiety disorders that may be present during the perinatal period and affect the mother's capacity to cope and care for herself and her baby include obsessive compulsive disorder (OCD) and post-traumatic stress disorder (PTSD). PTSD in particular, may be of particular interest in the context of the perinatal period, given that some women may experience the birth, or other pregnancy-specific events (i.e., severe complications) as traumatic events in themselves. It can be persistently re-experienced in thoughts, dreams and flashbacks which are accompanied by intense distress. Women persistently avoid thoughts, feelings and situations that are associated with the traumatic event and can feel detached from others and have a restricted range of affect.

The woman may feel persistently aroused as indicated by at least two of the following: difficulties falling or staying asleep, irritability or outbursts of anger, difficulties concentrating, hyper vigilance, exaggerated startle response and physiologic reactivity to exposure to events that resemble the traumatic event. Women would need to experience these symptoms for at least a month to warrant a diagnosis.

Some women who do not meet diagnostic criteria for an anxiety disorder will still have severe levels of anxiety which can have a significant impact on daily functioning.

## **Major risk factors for depression**

Like depression and anxiety at any other time, there is no single, definite cause. It is important to consider the combination of risk factors that increase a woman's chances of experiencing postnatal depression.

In the case of postnatal depression the most established and strong risk factors are:

- a past history of depression and/or anxiety
- antenatal depression and/or anxiety
- lack of support from partner or marital problems
- a family history of depression or other mental health difficulties
- a lack of practical, financial, social and/or emotional support.

Major life events and stresses (for example, death of a relative, relationship break up, unemployment, moving house, miscarriage, illness and pregnancy and birth for some etc.)

Some of these same factors also make antenatal depression more likely. In addition, it seems that low self-esteem and being a past victim of abuse can increase the chances of antenatal depression.

For some perinatal women, other things might play a role in depression and/or anxiety. Moderate risk factors include maternal personality factors (shy, self-conscious or 'worrier') and marital relationship difficulties. Smaller risk factors include obstetric factors and complications, low income and unemployment (Robertson, Grace, Stewart 2004)

## **Low prevalence disorders (schizophrenia, puerperal psychosis and bipolar affective disorder)**

More severe mental health disorders are far more disabling for the woman and her family but are less common and therefore less likely to be seen in routine practice. For this reason they are often described as the low prevalence disorders and include psychosis and bipolar affective disorder.

Puerperal psychosis affects 0.1–0.2% or one or two in 1,000 women. It is a psychotic episode that arises following childbirth and is regarded as a psychiatric emergency. It is associated with risk of suicide and infanticide and requires hospitalisation for treatment. It can be related to an underlying bipolar disorder, schizophrenia or in some cases only occurs in the context of childbirth. It may be the first presentation of symptoms and usually occurs with a sudden onset within the first four weeks of birth. Symptoms can cover the entire psychotic range including:

- delusional beliefs
- disorganised thinking and confusion
- mood lability, irritability or elevated/depressed mood
- false sensory perceptions (hallucinations).

These symptoms require immediate assessment due to the high risk of harm to the infant and the woman herself.

See beyondblue fact sheet 'Puerperal psychosis. A guide for primary care health professionals'

## **Bipolar affective disorder**

Bipolar affective disorder affects 1.6% of the general population and typically develops during late adolescence and early adulthood, however it can arise for the first time during the perinatal period or re-occur. Women with bipolar disorder who cease their medication in pregnancy have more than twice the risk of relapse than those who maintain their medication (Viguera et al., 2007).

Bipolar Affective disorder is characterised by mood cycling between depressive episodes and manic episodes and includes symptoms of:

- elevated mood
- grandiosity
- increased energy
- racing thoughts
- rapid pressured speech
- impaired judgement and impulsive behaviour
- decreased need for sleep
- increase libido
- psychotic symptoms

A mixed episode presents with features of both mania/hypomania and depression.

See the beyondblue fact sheet 'Bipolar Disorder during pregnancy and early parenthood: A guide for primary health professionals.'

## **Schizophrenia**

Schizophrenia is a psychotic disorder with a prevalence rate of approximately 1% in the general population. It is important to note that there is an increased risk of relapse (24%) in the first 3 months after birth.

The positive symptoms include:

- hallucinations (seeing or hearing things that don't exist)
- delusions (strange fixed beliefs that are not true)

The negative symptoms include

- lack of motivation
- emotional blunting (lacks verbal or non-verbal expression of feelings)

- poverty of thinking (reduction in the quantity of thoughts expressed)
- limited speech
- inability to enjoy any activities
- poor self care.

Further information about these disorders can be accessed at [Orygen Youth Health](http://www.oyh.org.au) <<http://www.oyh.org.au>>, [SANE Australia](https://www.sane.org/) <<https://www.sane.org/>>, [Mental Illness Fellowship Australia](https://www.mifa.org.au/en/) <<https://www.mifa.org.au/en/>> and [Black Dog Institute](https://www.blackdoginstitute.org.au/) <<https://www.blackdoginstitute.org.au/>>.

## Working with culturally and linguistically diverse (CALD) and indigenous families – mental health considerations

When working with CALD and Indigenous families it is important to acknowledge that differences may exist between parenting practices, as well as a general understanding of mental health ‘illness’ and how it can be treated. Depression and anxiety for example may be experienced differently in some cultures and there may not be an ‘equivalent’ word for terms such as ‘depressed’ or ‘anxious’. Care should always be taken when discussing symptoms of mental health disorders to ensure that your assessment of their mental state is accurate. The idea of speaking to someone about ‘how they are feeling’ may also be completely foreign and so care should be taken once again to accurately explain to the individual why you are asking about their emotional wellbeing (i.e., that it is routine practice and not because there seems to be ‘something wrong with them’). Further information on important issues to be aware of when providing care to CALD families is covered in Resource 3.

## Impact of maternal mental health in the perinatal period on infant and attachment relationships

A woman’s mental health difficulties can impact on her relationships with her partner and can interfere with the developing attachment relationship with her baby.

### Postnatal impact

Depression and anxiety can both affect the mother–infant relationship. The symptoms of depression and anxiety and associated difficulties may lead to sub-optimal interactions. Infants are very sensitive to the quality of care they receive early in life. The symptoms of postnatal depression such as lowered mood make it difficult to engage in joyful mother–infant interaction. A depressed woman may be more withdrawn, less available or more irritable.

Some of the risk factors for postnatal depression may also impact on a mother’s capacity to care for her infant. Examples of these include; poor social and partner support, low self- esteem and stresses, such as lack of finances and insecure housing. When mothers and babies engage in positive interaction, there is eye contact and sensitive responsiveness by the mother. Infants thrive on warm responsive experiences that create an expectation that their physical and emotional needs will be met.

Negative influences of postnatal depression in the first year of life have shown longer- term effects on infants’ emotional and cognitive development which may persist into later childhood.

For the evidence relating to this see beyondblue fact sheet: ‘Perinatal depression and anxiety. evidence relating to infant cognitive and emotional development.’

## Impact of maternal anxiety in the perinatal period on infant development and attachment

### Antenatal Influences

Recognising and treating antenatal anxiety is important as it is now established that there is an independent association between maternal anxiety in pregnancy and negative effects on the fetus in utero, risk of adverse obstetric outcomes as well as some potential later problems in child cognitive, behavioural and emotional development. Antenatal anxiety and depression are important predictors of postnatal depression which can further compound the effects on infant development. Hyperactivity, lower school grades, elevated baseline cortisol levels and a generally higher vulnerability to psychopathology in children have all been reported in connection with severe or prolonged antenatal anxiety and stress (beyondblue Clinical Practice Guidelines).

### Impact of maternal psychotic disorder in the perinatal period on infant and attachment relationships

Psychotic disorders can impact on parenting in the following ways and may require mandatory reporting to child protection and subsequent court and custody considerations (alternate care)

- inconsistent care and neglect of the infant's needs
- disruption in the mother-infant relationship which results in failure to bond and insecure or disorganised attachment with the infant
- the infant may be at risk of harm through being incorporated into the mother's delusions
- the infant has double the risk of death through pregnancy and early childhood up to middle age compared to infants of non-psychotic mothers ( see aNEW fact sheet).

### What to look for when thinking about mother-infant interaction

It is helpful to be aware of 'good enough' interactions that include interactions which give the infant a consistent experience of positive interaction most of the time, for instance:

- mother is physically attentive and responsive to the infant
- some eye contact between mother and infant
- empathy for and ability to reflect infant's feelings
- sensitivity to infant through immediate and appropriate responses
- mother's response is paced to infant's cues
- emotional engagement with the infant and enjoyment
- environment that creates the expectancy of interaction
- infant is interactive, engaging, cries when distressed and settles when comforted.

Concerning interactions include:

- mothers who are unable to soothe or comfort their infants
- infants who are difficult to settle or are irritable most of the time or almost always
- infants and mothers who avoid looking at each other
- mothers who state they do not know what their infant wants or needs and cannot understand their infant's experience
- mothers who are intrusive with their infants - poking, too close, too loud, frightening, too rough
- infants who struggle or arch their backs when held or comforted
- infants who are experiencing serious and continued feeding problems or are failing to thrive
- relationships where there is no joy or mutual reciprocity

- mothers who have difficulty keeping their baby's needs at the forefront of their mind.

For further information see beyondblue fact sheet 'Perinatal depression and anxiety: evidence relating to infant cognitive and emotional development.'

## The impact of depression and anxiety on the partner relationship

Over one million Australians live with depression each year. Studies show that living with a depressed partner is itself a risk factor for depression. In the perinatal period there is evidence that around 5% of new and expectant fathers will experience depression, anxiety and other forms of emotional distress (Condon et al., 2004). In a more recent analysis, it was reported that 3.6% of fathers experience postnatal depression (PwC, 2012). Depression in partners may influence and/or contribute to maternal distress, just as maternal depression can affect their partners' mental health. Thus, given the reciprocal relationship between maternal and paternal depression/distress, it is important to also assess whether the partner's mental health is an issue that needs to be addressed, either in the context of the mother's presentation or independently. Useful questions to elicit an indication of the impact on the relationship with a partner include:

- 'How has your partner been coping since the birth of your baby?'
- 'How is your partner adjusting to parenthood?'
- 'How is your relationship with your partner?'

## Economic impact of untreated postnatal depression

Perinatal depression and anxiety resulting from births in 2012 have been estimated in a recent Price Waterhouse Coopers (PwC 2012) report (*Valuing perinatal health*) to cost Australia up to \$500 million by the time the children turn two. This includes loss of productivity for mother and father as well as health care costs. Considering not only the significant personal impact of perinatal mental health on mothers but also the broader social and economic costs, it is clear that early identification and treatment is imperative.

## Summary of Resource 1

- Anxiety and depression occur in the perinatal period in around 13% of women.
- Previous depression and anxiety, especially antenatally, is the best predictor of postnatal depression.
- Other risk factors include past and family history of depression, current or past history of abuse and violence, available support and current major life stressors.
- Infant, partner and extended support network are also affected.
- Psychotic illnesses such as puerperal psychosis, bipolar disorder and schizophrenia occur much less often and require referral to specialist services.

# Resource 2: Rationale for depression and anxiety screening

This section will cover:

- Why mental health screening is important and the best methods of raising the issue with women.
- The screening process: asking case finding questions about symptoms of depression and following up with the EPDS.
- Information on the Edinburgh Postnatal Depression Scale (EPDS), the recommended screening tool for depression in the perinatal period.
- The Clinical Practice Guideline key recommendations.
- How women feel about screening and guidelines for effective screening.

## Rationale for depression and anxiety screening

Key reasons to undertake screening include:

### 1. Depression and anxiety is prevalent

Perinatal depression and anxiety is common with over 100 pregnant women or new mothers becoming depressed every day in Australia. Consequences can be serious and long lasting, for the women and her family, particularly if left untreated. It is important to remember that women with depression and anxiety can be treated successfully. Early identification, management and monitoring improve positive outcomes.

### 2. Women do not seek help

Most women will not spontaneously seek help when they experience symptoms of depression and anxiety, and thus the health system needs to be proactive in reaching women who may be in need of additional support and assistance. In the universal service, this involves asking women about their mental health (further details on the barriers to care for women are outlined in Resource 5). Women and families from CALD backgrounds may find it particularly difficult to seek help as there may not only be a language barrier present, but their understanding of 'health' or 'illness' may also differ significantly. It is likely that they will also be unfamiliar with the Victorian health system, and hence the range of support options available.

## The use of screening tools to identify perinatal depression and anxiety

The only way to be sure whether any woman is depressed is by conducting a full mental health assessment (this is often by referral to a professional such as a psychologist, psychiatrist or doctor). However, with almost 300,000 births each year in Australia, it is not practical to do this for every woman, every year. This is where the concept of screening for the likelihood of depression has become best practice. Screening may involve asking certain questions to elicit symptoms of depression and anxiety and/or using a screening tool.

### 'Case finding' questions

Currently Maternal and Child Health nurses routinely ask women questions regarding a woman's emotional health at the four week Key Ages and Stages consultation. Recent research has indicated that asking two particular 'case finding' questions can be a quick and useful 'screener' as they can narrow

down the number of individuals needing a longer assessment (Mann & Gilbody 2011), given that it is unlikely that depression is present if a negative response is obtained to both of the above questions. The two questions are:

- 'During the past month, have you often been bothered by feeling down, depressed or hopeless?'
- 'During the past month, have you often been bothered by little interest or pleasure in doing things?'

It is important to note however that women experiencing depressive symptoms may initially minimise or hide their symptoms if they feel that they have to preserve a certain image of themselves as a competent and capable mother, e.g.:

- Believing that a good mother should be able to cope on her own.
- Stigma/shame.
- Guilt.
- Denial ('I'm just having a bad day').

The beyondblue Clinical Practice Guidelines have reviewed the literature and have made a number of recommendations about delivery of mental health care in the Perinatal period. The Guidelines suggest as a Good Practice Point that the EPDS should be given at least once in pregnancy and at least once again at 6 to 12 weeks postpartum or as indicated by clinical judgement.

It is important to consider all tools available as components of an overall effective screening process.

## **The Edinburgh Postnatal Depression Scale (**

The Edinburgh Postnatal Depression Scale (EPDS) is a simple and short 10 item self-report screening questionnaire initially developed for use in postnatal women to improve detection of postnatal depression (Cox, Holden & Sagovsky 1987). The EPDS allows health professionals screening women to identify most of the women who might need help and require a referral for a full diagnostic assessment. See the 'Edinburgh Postnatal Depression Scale' of this publication for a copy of the tool.

In practical terms, six out of 10 women who score positive on the EPDS will meet the diagnostic criteria for major depression and others will meet the criteria for minor depression, adjustment disorder and postnatal distress

Internationally, the EPDS is the most widely applied depression screening instrument in the perinatal period and can be used by midwives, maternal and child health nurses, psychologists, general practitioners and researchers. In addition, it has been validated as a screening tool for antenatal women, and is recommended nationally for use in the antenatal population in Australia (beyondblue Clinical Practice Guidelines).

The EPDS purposely excludes three symptoms of depression that are also commonly experienced by most women in the perinatal period (tiredness, sleep disturbance, irritability); and includes three questions (questions 3, 4 and 5) that may tap into symptoms of anxiety as well as depression. Currently there is no strong evidence that any one tool (including the EPDS) is reliable enough for screening for anxiety in perinatal women.

Well-coordinated and resourced screening can increase the detection of depression (Milgrom et al., 2011) and other postnatal mood disorders and distress. Figures of missing up to 60% of case have been reported if screening is not universally undertaken (Holden & Cox, 2003).

### **Limitations of the EPDS**

It is important to remember that the EPDS cannot diagnose depression, but is very useful as a rapid screening tool that will allow informed clinical judgements about the emotional health and wellbeing of the women being cared for. The EPDS is purely a screening tool, so those who score positive are best thought of simply as a sub-group of women among whom there is a higher likelihood of depression

compared to the general perinatal population: that is, it is not true that everyone in this 'positive' sub-group is clinically depressed. However, those that score high may have other difficulties and be going through a difficult patch that may require some support.

Always be aware that a low score may not mean a woman is not depressed. That is, some depressed women will score below the threshold (a false 'negative' result) so you must always follow your own clinical judgement and discuss the results with her. The EPDS result must not replace your clinical judgment.

The EPDS does not predict who will become depressed later on. That is, it is not a measure of the risk of becoming depressed. There is no tool currently available, including the EPDS that can reliably forecast the development of future depression in advance.

## Beyondblue clinical practice guidelines recommendations

There are eight recommendations and 44 good practice points included in the Clinical Practice Guidelines. While the eight recommendations are summarised in the table below, please see the full document and the very useful Executive Summary for further details (available from the [beyondblue website](https://www.beyondblue.org.au/) <<https://www.beyondblue.org.au/>>).

No.	Recommendations	Grade
1.	As a minimum, all health professionals providing care in the perinatal period should receive training in woman-centred communication skills and psychosocial assessment.	C
2.	The EPDS should be used by health professionals as a component of the assessment of all women for symptoms of depression in the antenatal period.	B
3.	The EPDS should be used by health professionals as a component of the assessment of all women in the postnatal period for symptoms of depression or co-occurring depression and anxiety.	B
4.	A score of 13 or more can be used for detecting symptoms of major depression in the postnatal period.	C
5.	Non-directive counselling in the context of home visits can be considered as part of the management of mild to moderate depression for women in the postnatal period.	C
6.	Cognitive behavioural therapy should be considered for treating women with diagnosed mild to moderate depression in the postnatal period.	B
7.	Interpersonal psychotherapy can be considered for treating women with diagnosed mild to moderate depression in the postnatal period.	C
8.	Psychodynamic therapy can be considered for treating women with diagnosed mild to moderate depression in the postnatal period.	D

Note:

A = Body of evidence can be trusted to guide practice

B = Body of evidence can be trusted to guide practice in most situations

C = Body of evidence provides some support for recommendations but care should be taken in its application

D = Body of evidence is weak and recommendation must be applied with caution

Routine screening with the EPDS is recommended as it provides a structured approach to depression screening, while also being an effective tool that can help open up the conversation between the mother and her MCHN (or other health professional) about how she has been feeling and is coping.

The EPDS when combined with further psychological questions gives a fuller picture and understanding of emotional health and existing stressors which can then guide management.

## How do women feel about screening?

Screening is generally acceptable to women. In an Australian sample of 860 women, as part of the National Postnatal Depression Program, women's comments about being screened with the EPDS by their MCHN were documented (Buist et al., 2006). Most women involved in routine perinatal screening found the EPDS easy to complete (93%) and experienced no discomfort (85%).

These results are in keeping with the 90% of women who thought that the EPDS questions were reasonable ones to be asked (Matthey et al., 2005). Another Australian study, based on an in-depth telephone survey of 403 pregnant women reported 100% acceptability of being screened (Leigh & Milgrom, 2007). Here, no women reported feeling upset, labelled, stigmatised or distressed by the screening process recommended in Australian settings. Research conducted by Highett et al. (2011) with over 1200 Australians revealed that 78% and 83% of adult Australians agree with a universal screening policy for ante and postnatal depression respectively.

Although acceptability appears positive, it cannot be assumed for everyone and seems to depend on the way screening is carried out. In at least one small UK study (Shakespeare et al., 2003, n = 39) about half of the women did raise some of these issues, but the UK screening processes differs from the commended Australian one.

Screening is acceptable to perinatal women, both depressed and non-depressed (Gemmill et al., 2006; Leigh & Milgrom, 2007) and the vast majority of women believe universal screening is a good thing (Gemmill et al., 2006).

## Guidelines for effective screening and screening acceptability

- Screening should only be undertaken by trained health professional as part of a routine interview allowing sufficient time to discuss the process and results
- Privacy for the woman and support for her to manage her baby during the screening needs to be arranged
- Literacy, language and cultural issues need to be considered
- Using the initial 'case finding' questions to elicit lower mood or loss of interest is a way to begin the conversation and to introduce the EPDS if indicated
- High scores do not necessarily mean a woman is depressed: other factors may be influencing her response. Similarly low scores may reflect no symptomatology or may mean the woman was not ready to share her feelings at this time. A cut off of 13 is recommended in the Guidelines to trigger further assessment of a woman's wellbeing. For scores of 10, 11 and 12, the EPDS should be repeated within 2 to 4 weeks
- Discuss items one by one, exploring high scores and inconsistencies. The interview can continue to explore the symptoms of depression and anxiety and other psychosocial factors that might be contributing to the woman's current situation
- If a woman declines the screening process, screening with the EPDS can be offered again at the next visit.
- Screening is most effective when it is part of an enhanced pathway of care, treatment and support
- Screening is only recommended and feasible when there is ongoing training for staff and when time is allocated for the process and adequate facilities and treatment options are available (Scottish Intercollegiate Guidelines Network, 2002)
- Screening should be conducted within a woman-centred model of care

## Summary of Resource 2

- Screening for depression and anxiety is important given its prevalence and the fact that most women will not spontaneously seek help
- A variety of tools can be very useful when undertaking screening, such as the use of case finding questions which can assist in opening up the conversation about women's emotional health
- Currently the EPDS is the recommended screening tool and should be used as a component of the assessment for all women in the postnatal period
- Universal screening picks up most women who need further assessment. By using the EPDS 60% of those scoring 13 or above will have a major depressive episode and others will have minor depression, anxiety or adjustment disorders
- Screening is acceptable to women
- Screening using women-centred model of care is recommended

# Resource 3: How to use screening tools for depression and anxiety

This section will cover:

- How to ask the initial 'case finding' questions
- How to introduce, administer, score and interpret the EPDS
- How to provide feedback on women's responses
- How to conduct a risk assessment
- How to be aware of the meaning of various EPDS scores
- Issues to be aware of and sensitive to when providing care to CALD and indigenous women
- How to improve women's safety by responding appropriately to the results of the screening

## Introducing screening and gaining consent

Current recommended practice for Victorian MCHN is to conduct universal screening for depression and anxiety and a psychosocial assessment (covered in Resource 4) at the four-week KAS visit, as part of the Maternal Health and Wellbeing Check. It is suggested that this is introduced as a conversation about how the woman is coping. It is also a good idea to provide women with an explanation regarding the purpose of the assessment and some psycho-education about early parenthood being a challenging time and that some women may need some extra support:

'Your emotional health is as important to me as your physical health. Routine MCH care here at...(Council) involves asking you some questions that will help me to understand a bit more about you and your situation and if necessary, assist me to help you and your baby. All the information we discuss today will remain confidential and you will not have to follow up anything you don't want to.'

Obtaining consent should be relatively easy to integrate with consent processes for existing routine care procedures:

'I would like to talk to you about any past or present issues you might have and to ask you a few questions about how you are feeling and fill out this short form and then we can discuss it, is that all right with you?'

If a woman does not consent to undertaking the assessment, this should be documented and an assessment offered at subsequent consultations. It may also be prudent to enquire as to why consent has been declined. This needs to be documented and offered at a later visit.

'Would you feel more comfortable filling this out privately or maybe next time?'

## Asking the initial 'case finding' questions

As a first step, ask about current symptoms of depression and symptoms of anxiety and follow up any positive responses with the EPDS.

### Questioning about current depressive symptoms

'During the past month, have you often been bothered by feeling down, depressed or hopeless?'

'During the past month, have you often been bothered by little interest or pleasure in doing things?'

## Questioning about current anxiety symptoms

'Do you sometimes worry so much that it affects your day-to-day life?'

If the woman answers 'yes' to any of these questions follow up with the EPDS. If the EPDS is not used, then keep in mind the possibility of risk being present. As always, clinical judgement should be used.

## Introducing the EPDS

'I'm interested to know some more about how you have been feeling. I wonder if you would have a look at this screening tool and fill it out? It asks you how you have been feeling in the last week,' or

'I would like to ask you some more questions about how you have been feeling. One way to do this is to use this screening questionnaire. Would you mind reading the instructions and filling it out? Then we can talk about it,' or

'I know that English is not your first language. If you would prefer, I can give you the EPDS in your own language and then we can discuss it.'

## Becoming familiar with the EPDS

The 'Edinburgh postnatal depression scale' section contains a copy of the EPDS. Beyondblue has produced an Edinburgh Postnatal Depression Scale and psychosocial Questionnaire scoring wheel for health professionals which you might find convenient.

The Instructions for the EPDS are:

We would like to know how you have been feeling in the past week. Please indicate which of the following comes closest to how you have felt in the past week, not just how you feel today. Please choose only one response for each question, which is the closest to how you have felt in the past seven days. Mark the question with an X.

## How to calculate a screening result – EPDS scoring instructions

1. Once completed, each item is scored on a scale from 0–3 or from 3–0.
2. These scores do not appear on the copy that a woman fills out.
3. Instead you will use a scoring template to score each answer.
4. The total EPDS score is calculated simply by adding the scores of each answer. The highest possible total EPDS score is 30.

## What does the EPDS measure?

- The EPDS measures the presence of symptoms that can indicate current depression or possible symptoms of anxiety.
- Currently a score greater than or equal to a threshold of 13 is considered a positive screen, indicating that follow-up assessment is required
- Any score greater than zero on Item 10 also requires exploration as it reflects thoughts of self-harm.

Scores of 10, 11 or 12 need a follow up re-administration in 2–4 weeks

It is important to remember that some women's scores can be considered to be 'false positives' on the EPDS (that is, scores are above 13, but on further assessment women will not be found to be depressed). However, they may have other stressors in their lives causing distress or have mental health disorders other than depression (for example, anxiety). This is an additional reason for always offering diagnostic assessment to every woman who scores positive.

Some women may not feel ready to fill out the EPDS honestly and will mark all answers as if they are coping well. So scores of zero need to be followed up with some additional questioning. You may wish to use the questions of the EPDS to enquire further about how she is coping. 'Are you enjoying life as much as you used to?'

It takes some professional judgment to make up your mind if you think the score is an honest indication of how the woman is feeling versus what she may be trying to portray. In this instance, encouragement may be given, for example:

'It looks like things are going well for you at present, remember you can always come and talk to me or another health professional if you feel that you need to. Sometimes it is hard to admit even to yourself that things are not right for you.'

## Explaining Screening Results to Women

Here are some ways that others have expressed the meaning of a positive screening result on the EPDS:

'Over half the women I see who answer like you have, found after a more full assessment of their situation, that they do need professional help with depression. Would you like me to line up an assessment to discuss further your current situation and to see if any additional support might be needed?'

'This screening form isn't perfect, and sometimes gets it wrong. You might just be having a bad day, but from looking at your answers, I'd suggest you have a further assessment to look at how you are feeling and to see if you have the symptoms of depression. We can line that up for you now and make sure you have all the help you need.'

Here are some ways that others have expressed the meaning of a negative screening result:

'From your answers, you seem to be doing pretty well. Is that how you feel too? Remember that I am happy to put you in touch with any further support you think you might need at any stage. We can talk again, at our next visit, about how you are feeling.'

## Positive responses to individual items

### Question 10: 'The thought of harming myself has occurred to me'

An advantage of the EPDS is that it allows for rapid identification of women who are experiencing suicidal ideation. This is often a scary area for the health professional, especially those with minimal mental health training and experience.

It should be remembered that the majority of new mothers are unlikely to act on such suicidal feelings and that asking about these thoughts will not exacerbate them or induce an act of self-harm.

Every woman needs to be asked some more questions about a score greater than 0 on question 10 and be taken seriously.

'I notice you have marked that you have sometimes thought about harming yourself. Can you tell me a bit more about these feelings?'

On the basis of her answer, you will be able to know what the next step is. Careful exploration to discriminate between accidental misinterpretation of the question, self-harm and true suicidal intent will need to be undertaken. Each organisation undertaking screening will need to develop some clear guidelines for managing women who are experiencing thoughts of self-harm or suicidal ideation.

## Risk assessment protocol

If a woman has a score of more than zero on Question 10 of the EPDS the next step is to conduct a risk assessment by asking further questions to understand more about the likelihood of harm to herself or her infant and to determine the level and immediacy of the risk.

'I see you have indicated on question 10 that you..... can you tell me a bit more about what you mean?'

'Have you had thoughts that life isn't worth living?'

'Have you thought of harming yourself?'

'Have you thought about suicide?'

The additional points to ask about to determine risk are outlined below (adapted from clinical guidelines and PIRI protocols).

### Ask about the current thoughts/risk

#### Suicidal thoughts

'What exactly have you been thinking? How often? How compelling or powerful are these thoughts? Is it worse than previously? What triggers these thoughts?'

#### Planning

'What have you been thinking you might do?' Press for plan details

#### Lethality

Is the specific method likely to be lethal?

#### Means

'Have you been thinking about how you might do it? Do you have the means to carry out your plan using this method?'

#### Intention

'How likely do you think you are to follow through and act on your thoughts or plan? What stops you?'

#### Protective factors

'What are the factors that prevent you from acting on these thoughts?'

### Consider the current situation and if these factors are present

- Hopelessness/perceived lack of control over life
- Stressors in last 6 months
- Current suicide attempt

'Have you ever acted on similar thoughts?' "What did you hope would happen as a result of your attempt?' (Did they want to die or end their suffering?)

'Do you still have access to the method used?'

'Did you use alcohol or drugs before the attempt? What did you use?'

'Do you have access to a weapon?'

- Distress/anger/hostility
- Isolation
- Impulsivity

- Psychotic symptoms, hallucinations, delusions

### **Consider the static factors that influence risk**

- History of suicide attempts
- Family history of suicides
- Recent peer suicide
- History of sexual abuse
- Aboriginal/Torres strait islander

### **Consider baby safety**

Also ask about thoughts of harm towards the baby:

- ‘Have you had thoughts of harming your baby?’
- ‘Have you felt irritated by your baby?’
- ‘Have you had significant regrets about having this baby?’
- ‘Does the baby feel like it’s not yours at times?’
- ‘Have you wanted to shake or slap your baby?’
- ‘Have you ever harmed your baby?’

Document the results of this assessment and the actions you have taken. Refer to an appropriate health professional, document, and most importantly follow up to make sure referral is acted on and review progress at subsequent visits.

- ‘Thank you for being so honest today about your concerns and about your thoughts of hurting yourself/your baby. This will allow me to put you in touch with an agency that can support you to keep yourself and your baby safe.’

Table 1 contains a tool for determining level of risk and suggested action.

### **Indications of Possible Anxiety Q3, Q4 & Q5**

It is worth considering the following Questions on the EPDS individually:

- ‘I have blamed myself unnecessarily when things went wrong.’
- ‘I have been anxious or worried for no good reason’
- ‘I have felt scared or panicky for no very good reason.’

These three items in the EPDS are known to have a correlation with clinical anxiety although this was not the intention of the authors of the EPDS.

It is worth noting a woman’s response on these questions, and the primary question about anxiety for all women including those who score below the overall threshold of 13 for the EPDS. However, note that the validity of these items for screening for anxiety has not been formally established.

### **Documenting your assessment with the woman in the clinical notes**

The clinical notes should contain the EPDS score and the score to question 10, any psychosocial issues identified and information about what was discussed with the woman about her management.

Where a risk assessment has been undertaken, this should be well documented as well as any management plan or referral made. Referrals should be made according to your organisation’s policy.

Notes about follow up should also be clearly made. This allows other health professionals to be involved in the woman's care.

## **Adapting screening for women from culturally and linguistically diverse backgrounds**

All health professionals need to ensure that their services are delivered in a culturally sensitive manner. When working with perinatal populations, it is important to remember that 1 in 4 women who give birth in Australia were born overseas. These women may have higher rates of mental health problems because of their background, the circumstances that surrounded their migration and possible history of trauma and loss. Refugee, asylum-seeking and immigrant women may have postnatal depression rates of 24-42% compared to native born women with an incidence of 10-15% found in a recent review found (Collins et al 2011).

Challenges for these women in accessing quality perinatal care can include:

1. Language and cultural barriers
2. Lack of literacy
3. Inaccessibility of health services
4. Cultural issues regarding male health professionals
5. Cultural stigma regarding mental health problems
6. Absence of female family and peer support
7. Traditional expectations around birth and motherhood
8. History of grief and trauma
9. Migration
10. Lack of suitable interpreter services

Although perinatal depression and anxiety is experienced by women from all backgrounds, there may be differences in the understanding and attitudes of mental health among women, their families and their communities. Sensitivity to possible differences in cultural norms and a family-centred approach are therefore essential. Thus a "one-size-fits-all" approach to perinatal mental health is impractical.

Some key challenges (Henshaw & Elliott, 2005) for health professionals working with CALD families may include:

1. Language barriers
2. Understanding the diversity of cultural norms
3. Considering health professional's own prejudices, preconception and attitudes
4. Understanding women's concepts of 'health' or 'illness'
5. Appropriate modes of communication – for example the use of interpreters and link workers
6. Arranging suitable access

The EPDS has been translated into numerous languages. Table 2 lists 36 non-English versions, 18 of which have been validated (however there may still be difficulties in translating the meaning of a particular question). It is important to note that some women may not be literate in their own language and so will still need an interpreter.

**Table 2: EPDS translations**

Validated translations	Non-validated
1. Arabic	1. Afaan Oromo – Ethiopia
2. Chinese	2. Amharic
3. Dutch	3. Czech
4. French	4. Farsi/Persian
5. German	5. Filipino/Tagalog
6. Igbo	6. Greek
7. Italian	7. Hebrew
8. Japanese	8. Hindi
9. Malay	9. Indonesian
10. Maltese	10. Khmer/Cambodian
11. Norwegian	11. Korean
12. Portuguese	12. Macedonian
13. Punjabi	13. Myanmar/Burmese
14. South African - English	14. Serbian
15. Spanish	15. Slovenian
16. Swedish	16. Somali
17. Turkish	17. Thai
18. Vietnamese	18. Urdu

Source: Using the EPDS Translated into languages other than English. Government of Western Australia, Department of Health from the beyond babyblues online training

The basic guidelines for using EPDS translations are similar to those for the English language version:

1. The EPDS should only be used by health professionals who are appropriately trained.
2. In completing the EPDS, women's privacy should be ensured.
3. The idea of completing a questionnaire may be alien to some cultural groups and thus a discussion introducing this process may first need to occur.
4. Depression may be expressed differently in some cultures and the lack of an equivalent word for 'depression' or an expression of depressed mood through somatic rather than emotional symptoms needs to be considered.

5. Literacy level and language difficulties (e.g. even if there is an existing translation, there may be variations in dialect among speakers of the same language).
6. If an interpreter is required they should not be a family member and will require some understanding of using the screening tool, but should not influence the woman's responses.

## Adapting screening and assessment for Indigenous women

Aboriginal or Torres Strait Islander women represent 3.8% of all new mothers in Australia (39.5% of mothers in the Northern Territory). In general, Aboriginal and Torres Strait Islander people have disproportionately higher rates of mental health problems. There are a variety of reasons for this including higher rates of maternal and infant morbidity and mortality and higher social stressors in general.

Aboriginal and Torres Strait Islander women are thus at higher risk of mental health problems in the perinatal period, than other Australian women, and distress may also be caused by lack of access to antenatal care in remote areas, or if traditional birthing practices cannot be followed.

The Clinical Practice Guidelines offer the following advice:

Factors that may assist in improving maternal mental health outcomes among women from Aboriginal and Torres Strait Islander communities include:

- Involving an Aboriginal and Torres Strait Islander health worker, liaison officer or interpreter in the maternal health care team (the role taken will depend on knowledge and experience but may include administering assessments, home visits and assisting women to access follow-up) — consulting the woman about who she would like to be involved in her care may help to ensure that internal roles within the community are not compromised (eg family members are not appropriate interpreters).
- Acknowledging the importance of involving extended family and kin (community) in decision-making.
- Cultural competence of health professionals.
- Providing culturally appropriate educational materials (including local adaptation of materials).
- Specific birth, parenting and young mother programs.
- Where possible, providing services in a setting that is comfortable for the woman (e.g., Aboriginal and Torres Strait Islander staff are employed in a range of roles and there is evidence that Aboriginal and Torres Strait Islander people are welcome)
- Acknowledging the role of traditional healers.

For further information see beyondblue fact sheets:

- Perinatal mental health of women from culturally and linguistically diverse (CALD) backgrounds: A guide for primary health professionals
- Aboriginal and Torres Strait Islander perinatal mental health: A guide for primary care health professionals.

## Summary of Resource 3

- The purpose of screening should be discussed with women and consent obtained. Screening should include some initial case finding questions followed by the EPDS if indicated.
- The EPDS is scored out of 30 with 0, 1, 2 or 3 scored for each of the 10 questions.
- The EPDS should be scored with particular attention to Question 10. Risk assessment needs to be conducted if a score above zero is obtained on Q. 10.
- The EPDS is scored with particular attention to Questions 3, 4 and 5 as possible indicators of anxiety.
- All questions can be followed up by a discussion.
- Screening results need to be documented including the total score, Question 10 score and the pathways to care discussed.
- Particular care is needed for culturally or linguistically diverse and indigenous women.

# Resource 4: Psychosocial assessment and interpreting responses to EPDS

This section will cover:

- The need for further assessment following the key questions and EPDS administration
- How to ask relevant questions to further assess the woman for symptoms of depression and anxiety in the perinatal period.
- How to ask relevant questions to further assess psychosocial risk factors commonly associated with postnatal depression and anxiety.
- Other factors that ought to be considered that can impact on maternal mental health (e.g., partner violence, eating disorder, substance use, partner's mental health, personality factors and lifestyle)
- How to integrate and consider all the information gained from the assessment and formulate a management plan.
- How to discuss possible referral and management needs with the woman.

## Psychosocial Assessment

One of the primary aims of conducting a routine psychosocial assessment is to gain a better understanding of the woman in the context of her family and life circumstances, including her past and current social, emotional and psychological status. It provides a holistic integrated approach to emotional health that encompasses other psychological and social factors.

Current practice includes routine questions at the 4 week KAS visit as part of the Maternal Health and Wellbeing Check, and ought to be followed up at all subsequent visits as required. Having asked the woman the 'case finding' questions and possibly to complete the EPDS, a comprehensive understanding of her situation ideally involves discussing her EPDS responses with her and exploring psychosocial factors known to be associated with a greater likelihood of mental health issues in the perinatal period. This allows for potential identification of 'increased risk' of depression and other mental health disorders, while also allowing suitable pathways to care to be put in place. The psychosocial assessment should be conducted with all women.

Asking about the major risk factors for mental health disorders can occur by using the following sample questions, or your own questions about:

## **Past and family history of mental health disorders**

Have you ever experienced or needed treatment for a mental health condition e.g. depression, anxiety, bipolar disorder, psychosis?’

‘Has any member of your immediate family (grandparent, parent, brother or sister) needed treatment for a mental health problem?’

## **Past and/or current abuse/family violence (incorporate the family violence questions from the MCHN practice guidelines)**

‘When you were growing up did you always feel cared for and protected?’

‘Has anyone in your household ever pushed, hit, punched or otherwise hurt you?’

‘Are you in anyway worried about the safety of yourself or your children?’

‘Are you afraid of someone in your family?’

## **Emotional and practical support**

‘Do you feel safe and well supported by your current partner?’

‘When you were growing up did you feel like your mother provided the emotional support you needed?’

‘If you need practical support do you have someone who could help you?’ or

‘Do you have people you can rely on to provide practical support if you need it?’

‘If you needed emotional support do you have someone who could help you?’ or

‘Do you have someone who you can rely on to provide emotional support to you if you need it?’

## **Drug and/or alcohol abuse**

‘Do you or others think that you or your partner may have a problem with drugs or alcohol abuse?’

## **Major life stressors**

‘In the last twelve months have you experienced stress, change or loss of someone close, relationship problems, illness, pregnancy complications or loss, financial worries or moving house or interstate?’

## **Other factors impacting on maternal mental health**

There are other factors that can impact on maternal mental health and how a woman is functioning which include eating disorders, personality disorders, insecure housing, partner’s mental health status, general lifestyle, cultural differences in birthing practices and refugee background.

Physical conditions such as diabetes and physical disability can also impact as do previous reproductive loss and pregnancy complications. If time is available or the need arises, it may also be helpful to discuss the presence and impact of these factors with the mother.

Further information about some of these factors can be accessed at:

- aNEW fact sheet: Eating Disorders
- aNEW sheet: Patients with Personality Disorders
- aNEW fact sheet: Domestic Violence

- beyondblue Aboriginal and Torres Strait Islander Perinatal Mental Health: A Guide for Health Professionals
- beyondblue Psychosocial assessment and management of perinatal mental health disorders

## **Integrating all the information and formulating a management plan**

Developing a management and/or a referral plan involves integrating all the information you have about the woman from the case finding questions, the EPDS and the psychosocial assessment, together with the discussions you have had with her since her baby was born. Understanding her and her context will be helpful in leading you towards making a realistic management plan with her.

What is included in the management plan will depend on the main issues for the woman and her willingness and ability to participate in treatment. Use of the advanced communication skills and Motivational Interviewing strategies (see Resource 5) can assist in discussing these issues with her and her willingness to take up a referral. Future care is likely to include ongoing support from yourself as a MCHN for the woman and her child, as well as possible assistance from other agencies.

## **Providing feedback from the overall assessment with the woman**

Discussing the results of the depression screening and psychosocial assessment with a woman (and her partner if she wishes and is appropriate) is an important step in finding out what management plan they would prefer, and what treatment options they are willing to consider at this point in time.

It can often be useful both for yourself and the woman to try and understand, or formulate, what is 'going on' for the woman and contributing to her current situation. A coherent way of doing this is to organise the information you have gathered by answering the following questions.

### **What are the predisposing factors?**

- historical factors such as family history of mental health problems, history of depression or alcohol or drug taking or childhood experiences including the mother's own attachment status

### **What are the precipitating factors?**

- recent stressors or triggers such as a difficult pregnancy complicated birth, breastfeeding problems, parent dying, partner loses job

### **What are the maintaining factors?**

- what keeps the situation as it is e.g. lack of social support, a mother's reluctance to ask for help could be a maintaining factor and increase her social isolation, poor coping/ stress management, difficulties in relationship with her own mother

### **What are the woman's strengths?**

- strengths may include family supports, mother's previously adaptive functioning or skills, financial resources to pay for babysitting, presence of a baby, motivation to feel better, past success in treatment etc.

Sharing your provisional formulation with the woman, and her partner, is often a therapeutic process as it lets the woman know you have understood all she has told you and that you are providing her with a rationale for why she might be feeling the way she is at present. This is the beginning of clarifying and understanding her situation and can help her to think about some changes she can make to feel better. A discussion can then occur about whether additional support and/or referral is needed depending on the severity of symptoms and presence of other psychosocial risk factors (referral and pathways to care discussed in Resource 5).

'From all that you have told me in our discussions it seems to me that there are some things that have predisposed you to experiencing symptoms at this time e.g. ...

There are some recent stressors too like ... (precipitating factors) ... that have put some extra pressure on you just now.

Some things that are happening are also helping to maintain things the way that they are. When you this can make you feel even worse.

I can see from what you have done in the past and what you tell me that you have a lot of strengths ...

These will help you in overcoming your (depression, anxiety etc.)

How does this all sound to you?'

Feedback in this manner provides you with an opportunity to check that you have interpreted the information accurately and that the woman agrees with how you see her situation. It is also a good opportunity for the woman to clarify or add any further information.

It is also important to remember that mobilising partners/carers to support a woman's treatment is vital to recovery. Partners have a number of key roles to play in maximising support around treatment. Lack of support from a partner is a key risk factor for depression in the perinatal period. Sessions with the partner to inform them of the diagnosis and start collaborative problem solving can mobilise the support within their family and community network. Partners can provide effective support by helping with tasks such as scheduling and transport to appointments, taking over some household chores, making sure they share in the care of the baby and other children etc. Partners also have a prime role in simply listening to and acknowledging the woman's feelings. As one of the main carers involved in a woman's recovery, it should be noted that partners, too, may have emotional issues which need support.

### **Discussing the psychosocial assessment and determining the woman's preferences**

'On the basis of what we have discussed today, I think it would be worthwhile to find some more support for you with these issues.'

'What do you think would be most helpful for you?'

'I have some information about things that have been helpful for others. Would it be ok if I shared it with you?'

'Help can come from a number of places, your GP, a counsellor, psychologist, psychiatrist or community support groups etc.'

or

'Considering the issues we have discussed today it seems like you are having some difficulties with ...

(list the issues e.g. lowered mood and lack of social support)

do you think you would benefit from some support with these or a referral to a specialist who can ...

(list the prospects e.g. give you some strategies to cope with your mood)?'

## Summary of Resource 4

- Psychosocial Assessment should be conducted with everyone who gives consent
- The psychosocial questions play a key role in obtaining information about known risk factors for mental health disorders and also inform which pathways to care may be helpful and appropriate
- When combined, the case finding questions, the EPDS and the psychosocial questions allow for a more comprehensive understanding of the woman's circumstances and needs
- Integrating the information obtained and the factors present for the woman (predisposing, precipitating, maintaining and strengths) into a coherent formulation can be very useful in demonstrating that you have really listened to the woman and sets the scene for an appropriate management plan

# Resource 5: Pathways to care: management plan and referral

This section will cover:

- The need to follow up depression screening and psychosocial assessment with effective pathways to care.
- Pathways to care need to be appropriate to the woman's circumstances and respect her health beliefs and attitudes.
- The range of treatment options that may be included in a depression management plan
- Collaborative multidisciplinary care is important for good outcomes
- The need for specialist agency referrals for certain psychosocial issues
- An overview of the Victorian mental health system and how it can be accessed through the GP
- Child Protection Services
- An overview of community agencies that can offer family support

## Overview of mental health care in the perinatal period

A multidisciplinary approach to supportive care and treatment, where available, and collaboration between service providers is always important. Knowledge of the Victorian mental health system and local referral pathways to care for different levels of risk, severity and complexity of mental health disorders is imperative.

## Knowing your local pathways

It is essential that all health professionals working with families during the perinatal period are aware of the various referral pathways available in their local area. This includes knowledge about services within your organisation as well as referral pathways to external services and other health professionals.

It is particularly important to be aware of the different referral pathways needed, based on the severity and complexity of the mental health issues present, the level of risk to the mother and/or her infant, as well as any other family and environmental issues that may be present.

Following the initial depression screening and psychosocial assessment, some decisions need to be made about what is a suitable and available management plan for the woman and her family.

## Management planning for the range of depressive symptoms and psychosocial risk

Although an individually tailored management plan is always ideal, the beyondblue Clinical Guidelines have made some general recommendations about the pathways to care for degrees of depression severity and psychosocial risk. Pages 1, 7 and 8 of the Executive Summary also outline suitable pathways to care depending on symptom severity and risk status.

For women with no symptoms of depression or psychosocial risk factors you provide psychosocial support and make sure they feel they can discuss their emotional wellbeing at any time with you.

'You seem to be doing well at present; however you know that you can always discuss this at another appointment and that there is a lot of information and support available should you need it.'

### **For women with mild symptoms of depression and some psychosocial risk factors**

- Provide psychosocial support including lifestyle advice and early postnatal care, non-directive counselling and possibly peer support

### **For women with mild to moderate symptoms**

- Consider mental health further assessment
- Provide psychosocial support including lifestyle advice and early postnatal care, non-directive counselling and possibly peer support
- Psychological therapies including Cognitive Behavioural Therapy, Interpersonal Psychotherapy, Psychodynamic therapy are recommended and possibly mother infant psychotherapy
- Pharmacological treatment. Consider potential risks and benefits to the woman and infant of treatment vs non-treatment

### **Severe symptoms**

- Mental Health assessment is recommended
- Psychological therapies including Cognitive Behavioural Therapy, Interpersonal Psychotherapy, Psychodynamic therapy are recommended and possibly mother infant psychotherapy
- Pharmacological treatment. Consider potential risks and benefits to the woman and infant of treatment V's non-treatment

### **Community pathways to care, procedures and protocols**

Women with an EPDS score of 13 or above can be referred to their GP for further assessment of their mental health and management. GPs can manage the women themselves or arrange referral to a variety of programs according to availability and the woman's wishes.

- Medicare Better Access to Mental Health Care program (referral to eligible Clinical psychologists for Psychological Therapy or registered psychologists, social workers and occupational therapists for Focussed Psychological strategies (Up to 10 sessions per year)
- Access to Allied Psychological Services program (referral to ATAPS mental health professionals( psychologists, social workers, mental health nurses etc) who deliver focussed psychological strategies (12 -18 sessions per year)
- Health Insurance coverage for psychological/allied health sessions.

A multidisciplinary approach to treatment is recommended using the support and interventions available to provide treatment and prevent relapse. Communication between service providers is crucial so that a 'safety net' is provided for the woman and her family. Without this communication there is a risk that women may 'fall between the cracks' of services by not following up on referrals and not accessing treatment as recommended by the referrer. This leaves the woman vulnerable as she may not be engaged with any support agencies when people think she is.

There is a need for continuity of care for women between agencies especially maternity and postnatal community care. Antenatal care involving mental health and psychosocial assessment together with any interventions undertaken is best communicated to community services such as MCHN who take on the ongoing care of the woman and her baby. Collaboration and communication between health professionals is imperative so that each knows their area of responsibility and that progress or changes in their involvement are communicated to others involved. Lapses in communication can lead to break down in the 'safety net'.

## **Making an effective referral considering health beliefs**

Women can feel overwhelmed, unmotivated and unable to make a decision about effective help (Bilstza et al., 2010) when they are depressed. Furthermore, they can often be unaware of what help is available. A positive relationship with their relevant health professionals has been shown to facilitate treatment uptake by perinatal women as it facilitates the match between each woman and an acceptable treatment option. The attributes perinatal women perceive as “ideal” in a health professional are: empathy, kindness, knowledge of available help, availability, active, timely assistance and continuity of care (Bilstza et al., 2010).

Studies show that perinatal women often feel unable to disclose emotional health difficulties to family, friends or health professionals (Dennis and Chung-Lee, 2006) and some can have strong aversions to particular types of treatment. All of this means that it is imperative to make sure that women who do need treatment have as much information as possible about available options and are matched to an option that suits their preferences.

For perinatal women in particular, studies have found that antidepressants are unpopular among pregnant and breastfeeding women (Boath et al., 2004) and that, in general, “talking” options are preferred (Dennis and Chung-Lee, 2006). Many are concerned about potentially harmful effects of medication on their unborn or breast-feeding children. Fear of ‘addiction’ to medication and a perceived stigma of having to take medication are also shared by some women. Having the ‘permission’ to talk openly about difficult feelings and emotions, with a non-judgmental listener has shown to be particularly important to perinatal women in many different countries (Dennis and Chung-Lee, 2006). However, it is worth remembering that a smaller fraction of perinatal women actively prefer medication as their first choice for treatment and may not wish to engage in counselling or similar “talking’ options (Turner et al., 2008). It is also worth remembering that natural and complimentary therapies are seen as attractive options for some women. While evidence is limited as

to their effectiveness it is important to be responsive to these beliefs. A woman’s health beliefs and preferences are central, so it is always important to discuss and consider what she wants and expects from treatment and what referral options she is willing to accept.

## **Integrating the information to formulate a management plan**

A management plan will look different for everyone, but may include:

- Urgent assessment for crisis intervention.
- Supportive Approaches
  - Peer support/Self-help groups – support from others who have or are currently experiencing depression and/or anxiety
  - Psychoeducation.
  - Non-directive counselling listening, debriefing, discussing problems and developing goals.
- Focused Psychological Strategies
  - Relaxation Strategies.
  - Skills Training:
    - Problem solving.
    - Anger management.
    - Improving social skills.
    - Improving communication.
    - Stress management.
    - Parenting skills and strategies.

- Psychological Therapies
  - Cognitive Behaviour Therapy (CBT): CBT focuses on educating people about how their thinking and behaviour affects their mood.
  - Interpersonal Therapy (IPT): IPT focuses mainly on improving interpersonal relationships.
  - Psychodynamic therapy: Psychodynamic therapy focuses on unconscious processes as they are manifested in a person's present behaviour.
- Couple counselling if problems exist within the relationship - make certain the woman's partner is informed and included in any plan. This may include Couple/Relationship Counselling or joint participation in group programs.
- Medication from GP/psychiatrist - particularly when depression is very severe and when biological symptoms (poor appetite and sleep), psychotic symptoms or suicidal ideation are present - Care must be taken regarding use of psychotropics during pregnancy and lactation. Where there is an acute need for diagnosis, consider admission to hospital or mother-baby unit.
- Specialised agency referral, if the woman has a specific problem she wants assistance with e.g. Substance use, domestic violence refer to appropriate treatment services.
- GP Mental Health Care Plan enabling a woman to receive subsidised psychological treatment through either the Better Access to mental Health Program or ATAPS.
- Assess partner's ability to support – check mental health, substance use and “adjustment to parenthood”. If a woman's partner is experiencing depression and/or anxiety, some form of formal assistance/therapy (i.e., CBT, IPT) is likely to be helpful, if accepted.
- Attending to mother-infant relationship. Depression may affect the woman's ability to respond to her partner and her child/ren. In the context of the KAS consultations mother- infant interactions can begin to be observed by paying attention for example to how the mother looks, talks and settles her infant and how she places her infant on the scales (MCHN can encourage the mother to do this themselves). Mother and Infant Psychotherapy is a specialised treatment approach where the mother and infant are seen together, with the treatment focus predominantly being the quality of the mother-infant relationship. A number of approaches are available and include:
  - Wait, Watch and Wonder – Muir (1992)
  - Circle of Security – Marvin et al. (2002)
  - Baby & Community HUGS – Ericksen, Milgrom, & Loughlin (2007)

The above programs all have a limited evidence base, but suggest that targeted interventions are beneficial to improve the mother-infant interaction.
- Support mother's parenting – she may need reassurance and/or ongoing practical help or respite. Enlist other parenting services including specific baby management/settling programs.
- In severe cases, notification to Family & Children's Services may be needed if the baby or other children are considered to be “at-risk”. This allows access to assessment of risk and specific programs in the home.

Having formulated a management plan with a woman you will then need to decide what management and issues you feel you can manage and which need to be referred onwards to a another health professional or program. It is important to remember that the 'first assessment' may be brief and may require further assessment in more detail at another time.

## **The importance of social support and the role of carers in recovery**

Management plans also need to focus on mobilising family and or social support. The Clinical Practice Guidelines list, “involving members of a woman's support network in her care as early as possible” as part of a best-practice approach to effective care of mental health in the perinatal period. Depressed women often find it difficult to communicate to those around them their need for support and, in many cases, reduce their social contact as their depression deepens. Accepting help offered is also less likely

as it reinforces their view that they are not coping. Helping depressed women to communicate to those around them and setting in place strategies to help, is an important part of a management plan.

A supportive social network is an especially important aspect of perinatal mental health care since a lack of support (and in particular lack of support from a partner) is frequently found to be associated with an elevated risk of postnatal depression. Social support can involve several aspects e.g. practical support, emotional support, information provision and peer-support (Honikman, 2008).

Some evidence suggests that programs that increase peer-support for women can have a preventative effect against depression. Similarly, for women affected by postnatal depression, some intervention studies have found that increased social support can reduce the severity of depression (Leahy-Warren & McCarthy, 2007).

## **The importance of considering individual differences and cultural factors**

The Clinical Practice Guidelines also list factors that have been identified as important to improving perinatal mental health care for women from culturally and linguistically diverse backgrounds, including women from refugee backgrounds, which include:

Social support, for example through ethnic-specific cultural liaison officers and women's groups, to maintain cultural connections with the traditions, birthing ceremonies and rituals of women's countries of origin

Cultural awareness among health professionals, including knowledge of cultural traditions and practices, relevant to the perinatal period and associated expectations of the woman

Perinatal education, including provision of linguistically appropriate information, parenting education workshops, and education for significant others on perinatal issues

Culturally appropriate resources, including resources in spoken format for women who lack literacy in their own languages and access to interpreter services during appointments or important events

## **The Victorian mental health system**

The Victorian health care system includes a number of options for referral.

### **Public health options**

- GP's can triage and manage woman and refer under Medicare to:
  - Psychiatrists (partial rebate or bulk billing options)
  - Medicare Mental Health Care Plan under gives limited access to Psychology Rebate/ bulk bill individual and group sessions
  - ATAPs limited access to Psychology
  - ATAPS access to psychiatric nurse visits
- Free services through Area mental Health services (AMHS) including Crisis Assessment and Treatment Teams (CATT). Primary Mental Health Teams (PMHT), for acutely unwell
- Community Mental Health Services providing a range of free services depending on location
- Child and Adolescent Mental Health Services (CAMHS) providing psychological and psychiatric treatment for children up to 25 years of age located at public hospitals.
- Public hospital ED for emergency psychiatric evaluation.
- Mother Baby Inpatient Psychiatric Units at Monash, Austin and Werribee Mercy Hospitals providing treatment of acute serious mental illness admitting mother and baby.
- Psychiatric inpatient units provides acute admission of mother without baby.
- PIMHI community support and education to AMHS case workers working with women with serious mental illness who are parents delivered through each of these MBU

- Parent Infant Research Institute, Austin Health. Research, training and treatment options.
- Austin Health Women's Perinatal Depression Clinic Assessment and treatment/referral for perinatal depression and anxiety
- Victorian Parenting Centres, Tweddle, O'Connell Family Centre, Queen Elizabeth Centre, Support assessment and management of sleeping, settling and referral of mental health issues
- Panda peer support telephone, information and referral service

### Private health options

- Psychiatrist
- Allied health /psychologist
- Private health fund
  - Ancillaries access to Psychological treatment
  - Parenting support programs: Parent and Baby Wellbeing Program (BUPA), Parent & Infant Program (Teacher's Health Fund), Baby and Me (Australian Unity) etc
- Private hospital inpatient parent support/MBU psychiatric programs, North Park Private, Mitcham Private, Masada, Albert Road Clinic, Melbourne Clinic, St John Of God Raphael Centres etc.
- Private hospital psychiatric units provide acute admission of mother without baby.

### Community agencies (availability varies in different regions – may at times follow Child FIRST and/or Department of Health and Human Services involvement)

- Non-Government Organisations provide family support o Berry Street
  - Anglicare
  - Uniting Care Connections
  - Brotherhood of St Lawrence
  - Salvation Army etc

### Child protection concerns

If there is concern about the safety and wellbeing of a child then reporting is mandated in Victoria. A step by step guide to making a report to Child Protection or Child First, along with the relevant contact numbers is available on the [Department of Education and Training website](https://www.education.vic.gov.au/Documents/childhood/parents/health/mandreportsep10.pdf)  
<<https://www.education.vic.gov.au/Documents/childhood/parents/health/mandreportsep10.pdf>>

A report to Child FIRST is the best way of connecting a family to the services they need and a report to Child First should be made where there are concerns about the child's wellbeing but they are not in need of protection.

In cases where you believe that a child has experienced or is at-risk of significant harm, or if you have a doubt about the child's safety and the parent's ability to protect the child then a report to Child Protection should be made. Further information about this is available in the current MCH Manual (pages 40-50) and can also be accessed on the [Department of Education and Training website](https://www.education.vic.gov.au/Documents/childhood/professionals/health/mchsguidelines.pdf)  
<[http://www.education.vic.gov.au/Documents/childhood/professionals/health/mchsguidelines.pdf](https://www.education.vic.gov.au/Documents/childhood/professionals/health/mchsguidelines.pdf)>.

### Designing your own pathway

As part of setting up routine screening, assessment and referral in each location a detailed referral pathway needs to be documented. In designing your own pathway the name of local agencies need to be included, together with the contact names and details, hours

of operation and support that is provided. Many services find that this sort of service mapping exercise is best done by having a local service forum that shares information and produces a document for all to use

at the end of the forum. Face to face contact helps to introduce health professionals to each other, which assists with the collaborative management plan necessary for many families. This kind of regional health professional forum also can highlight the service gaps that need to be addressed through agencies and lead to service development in the area. The data from screening can help to support submissions to management about service gaps.

## Summary Resource 5

- Depression screening and psychosocial assessment need to be followed by effective pathways to care
- Pathways to care need to respect the woman's health beliefs
- There is a range of treatment or support options that may be included in a depression management plan
- Collaborative multidisciplinary care is encouraged and has good outcomes
- Some psychosocial risk factors need specialist agency referral
- There is a complex mental health system in place in Victoria which can be accessed through the GP
- Child Protection Concerns – what to do and who to call
- An up-to-date and comprehensive local pathways to care plan is critical

# Resource 6: Interpersonal skills that help with psychosocial assessment

This section will cover:

- The key components and strategies used in delivering women centred care
- The key principles of motivational interviewing
- The key barriers to care for women - Collaborative multidisciplinary care is important for good outcomes
- The need for confidentiality and reassurance when discussing mental health issues with women
- The key skills that are often useful in managing women's distress and moving them towards taking action and accepting help
- The importance of managing job stress as a health professional and knowing when to seek secondary consultation and assistance

## Strategies for providing sensitive woman-centred care

Depression screening and a psychosocial assessment involves discussing information that can be potentially sensitive for women. Thus it is important to have a solid understanding of the communication strategies that can be particularly useful during these discussions, as well as an understanding of how to manage some of the difficulties that may arise during the consultations.

If a woman is experiencing antenatal or postnatal depression or anxiety, or simply finding the transition to motherhood more challenging than expected, an open and trusting relationship between the woman and her midwife, nurse /general practitioner / obstetrician becomes even more important. These are often the key professionals that can assist the woman to better understand the challenges she is experiencing, and the range of support services available to her. A trusting relationship can also help and support the woman to identify her own strengths which may assist her in coping with any difficulties she may be experiencing.

## Woman-centred care

Woman-centred care is a model of perinatal service delivery that seeks to embrace the concept of providing holistic care (for more information see the aNEW fact sheet on Women-Centred Care). The key characteristics of the model are:

- treating the woman as an individual
- understanding her context
- honouring her preferences and individual needs
- involving her in making decisions about her care.

Screening can be conducted within the woman-centred model of care by introducing the process with a full explanation and gaining consent. Using effective communication skills to ask the psychosocial questions, gaining an understanding about her context, and then involving the woman in discussions about her preferences for support and intervention are all steps in providing woman-centred care.

It should be noted that although reference is made to 'women-centred' care and to mothers as the primary carer throughout this manual, the same issues and principles apply to fathers and other primary cares (e.g., grand-parents, foster parents etc). As always, practice needs to be modified and delivered in a way that is appropriate to the individual and acknowledges the various family constellations and primary care arrangements.

## Advanced communication skills

Good communication skills can facilitate a woman's exploration of her situation. Listening and Empathy are two of the key communication skills which form part of what is referred to as 'Woman Centred Communication Skills'. These skills are essential when it comes to engaging women in various discussions concerning their physical and emotional well-being, as well as how they have been coping during the course of their pregnancy/since giving birth. These skills are important whether or not a woman is depressed.

Core skills for effective communication include:

### Attention giving

- Good eye contact
- Open relaxed posture
- Friendly interested facial expression
- An environment that has comfortable seating /room and privacy
- Low distractions/help with baby. e.g., limit interruptions, a practice staff member to care for the baby while the mother is with the GP

### Active listening

Communicate empathy/facial expression

- Acceptance/confirmation of the accuracy of your understanding with the woman
- Paraphrasing content
- Reflecting thoughts and feelings
- Summarising

### Focusing

- Probing/helping mother to be specific
- Clarification
- Confirmation
- Moving the conversation on.
- Summarising.
- Problem solving.
- Conclusion.

Empathy is the ability to identify with and understand another's situation, feelings, and motives and communicating your understanding verbally to the woman using paraphrasing and summarising.

## Understanding why women don't seek help, attitudes, beliefs and help seeking

Many women will not seek help for their mental health concerns. There are a number of barriers that have been identified. Some women believe that the symptoms of distress they are experiencing are a 'normal' part of motherhood. They are unable to distinguish between what are 'normal' levels of distress versus distress that requires some form of assistance. They are unable to recognise symptoms indicative of depression. Even if they may think they should seek help they do not know where or whom to approach.

Some women's attitudes to seeking help may hold them back. They may be reluctant to disclose emotional problems to health professionals (this is particularly important when working with women and

families who believe that they should be able to cope on their own). Even the symptoms of depression themselves like lack of motivation, confused thinking and decision making reduce help seeking.

Some women fear that they will be stigmatised if they disclose 'having an emotional problem' (i.e., What will others think?) Others may fear that they may lose the baby and/or their other children if they were to be 'labelled' (i.e., diagnosed) as having a mental health disorder.

There are also concerns about the service they might receive, such as wasting people's time or an unhelpful response from the health professional or having her experience and feelings dismissed, trivialised or normalised. Prior negative experience with a health professional and concerns about privacy and confidentiality also are barriers to care.

For some there is a lack of awareness of available resources and an unwillingness to take antidepressant medication and a fear that this is the 'treatment' that will be suggested. ('What can they do for me anyway?')

Logistical barriers are also very real and include:

- Lack of time (especially for working mums)
- Difficulty arranging childcare for other children
- Transport problems and long waiting times for appointments
- Cost of treatment
- Distance and availability of treatment options.

Additional barriers for Indigenous women and women from culturally and linguistically diverse backgrounds can include:

- Lack of fluency in English
- Lack of familiarity with using an interpreter
- Lack of confidence and difficulty accessing health care
- Fear of unfamiliar health services
- Cultural perceptions that depression is not a medical problem
- Family disapproval of help-seeking
- Lack of social networks.

## **Managing barriers to care, distress, denial, confidentiality**

Having an understanding of the range of attitudes and barriers to care is important in being able to speak with women to ascertain what their views are about their mental health and what they would like to do about it, if anything. Using the advanced communication skills and the women centred approach should help to understand better what the specific issues are for each woman.

Dealing with distress can be difficult for the woman who may be embarrassed to have shown someone else her level of distress and also for the MCHN who then needs to deal with it. Usually listening and saying some calming and empathic words and allowing some time for her to regain her composure will be appropriate actions, the woman will feel unburdened and have the experience of her nurse being there for her.

Confidentiality needs to be maintained and explained to the woman so she can feel free to truly let you know how she is feeling in an environment that is safe and not judgemental. Using the advanced communication skills will convey your readiness to hear what she wants to say.

'Everything we talk about today is confidential and cannot be disclosed to others unless I am worried about your safety or the safety of someone else including your baby. Then I would need to let others know so we can support you.'

Providing an opportunity to hear about how a woman is feeling is a good start but does not mean she is ready to take the next step and seek further help. She may still be ambivalent or unsure about what she wants, in too much distress or denial about her situation.

Making such a decision is a process and may take some time. There are some additional strategies that can help her clarify and work through her ambivalence and move her towards taking action.

## **Motivational interviewing (MI): Moving women towards taking action about their mental health**

Motivational Interviewing is a collaborative, woman-centered form of guiding to elicit and strengthen motivation for change and a way of helping people find their own motivation for change. It focuses on listening carefully with a goal of understanding the individual's dilemma, while refraining from giving advice.

Many women with postnatal depression and/or other mental health issues don't seek help

– Motivational Interviewing has been found to be helpful in other areas of health in terms of increasing help-seeking, and thus may be useful with perinatal women as well.

### **Brief Overview of Motivational Interviewing Framework (Miller and Rollnick 2002)**

The spirit of MI:

- Collaborative Approach
  - Partnership with client – working together
  - We structure the discussion, client provides the content
- Evocative
  - Draw out the client's own good reasons to change and ideas for how to go about it
  - We tend to believe what we hear ourselves say
- Honouring client autonomy
  - Acceptance that choice of whether to make a change lies with the client
  - Help the client see change as possible, while leaving decision up to her

Principles of MI:

- Express empathy
  - Acceptance and understanding of the client's perspective and decisions
  - Expressed through core skills, particularly accurate reflections
- Develop discrepancy
  - Discrepancy between the status quo and the client's goals/values
  - Leads to strengthening of internal motivation
- Support self-efficacy
  - Clients need to feel that they will be successful in making a change before they will attempt to change
  - Support and promote the client's perception of her own ability
  - We communicate our confidence in clients when we let them do the work of making a change
- Roll with resistance
  - Resistance is a temporary state, not a stable trait, so it can change for each target behaviour, in each session

## Core skills used in MI

- Open questions
  - Closed questions can be answered with a simple word or short phrase
  - Open questions allow the client to provide information about what they think is important
- Affirming
  - Reinforce strengths and resources that you hear from the client that might be helpful for her to make a change
  - May include personal qualities, effort, abilities, confidence and change
- Reflecting
  - A reflection is a statement that captures what you heard the client tell you without judgement, opinion or reaction
  - Aims to capture the meaning of what was said and lets the client know you have understood her meaning
  - Shows the client that you are really listening
  - Provides the client with an opportunity to elaborate and clarify misunderstandings
  - Shorter reflections are better
  - Goal: At least two reflections for every question
  - Simple vs. Complex reflections:
    - Simple reflections do not go far beyond the client's original meaning or intent
    - Complex reflections add meaning or emphasis to what the client has said
  - A good reflection is a statement
  - The inflection of the last word goes down (not asking a question)
  - It may initially feel strange (presumptuous) to make a statement instead of asking a question
  - No stem words are needed to form a reflective statement, but some that can be used (be careful of overuse) are:
    - “So you feel...”
    - “It sounds like you...”
    - “You’re wondering if...”
  - The common element is the word “you”
- Summarising
  - Shows the client that you are listening
  - Allows you to draw together key points
  - Can be used to move the discussion in a new direction

A distinct feature of MI is focusing on the woman's 'change talk'

- Change talk is speech that favours movement towards change
- Talk of the possibility of change
- The more one talks about change, the more likely they are to make a change
- Encourage women to talk about:
  - benefits of change
  - disadvantages of the status quo
  - confidence/ability to change
  - intention to change
- What comes from the woman is more important than what you say

Types of 'change talk':

- D – Desire: Statements about preferences for change o “I want to...”
  - “I would like to...”
  - “I wish I could...”
- A – Ability: Statements about capacity to change
  - “I could...”
  - “I might be able to...”
- R – Reasons: Specific arguments for change (“if...then” statements)
  - “I might feel better if I...”
- N – Need: Statements about feeling obliged to change
  - “I should...”
  - “I need to...”
  - “I’ve got to...”
- When we hear change talk from the client, we can be confident we are on the right track

Your role in change and commitment and talk:

- Listen for it
- Elicit it
- Recognise it
- Reinforce it through reflections
- Pull it together in a summary
- As change talk is voiced, commitment gradually strengthens

Ways of sharing information and concerns within the MI framework:

- E – Elicit the client’s thoughts/ideas first
  - “What ideas have you had about...?”
- P – Obtain permission to provide information
  - “I have some information about things that have been helpful for others. Would it be ok if I shared it with you?”
- E – Elicit the client’s thoughts about the information provided
  - “What are your thoughts about that?”

Eliciting Change Talk:

- Assess the woman’s rating of importance and confidence in change
- To increase importance
  - ask about concerns with the status quo
- To increase confidence o Elicit strengths
  - Encourage her that change is possible
  - Help her generate ideas about how to do it

Providing Information:

- Obtain permission from the woman
- Provide information
- Check what the woman’s thoughts are about the information

Eliciting commitment talk from the woman:

- Key questions – What next?
  - Assess level of commitment

- Ask what she will do rather than what she can do
- Low commitment
  - Explore why commitment is low
  - Use hypothetical language – less threatening
- Moderate to high commitment
  - Obtain more specific details to increase commitment
- Summary
  - Summarise key points, drawing together the woman's change/commitment talk

Some key questions and tips to help women think about change:

- Why would you want to make this change (e.g. attend counselling)? How might you go about it, in order to succeed?
- What are the 3 best reasons to do it?
- On a scale from 1 – 10, how important is it for you to make this change?
- And why are you at a \_\_\_ and not \_\_\_ (a lower number)?
- Give a short summary/reflection of the speaker's motivations for change Then ask: "So what do you think you'll do?" and just listen

If your consultation time is limited you are better off asking patients why they would want to make a change and how they might do it rather than telling them that they should"

## **Looking after yourself: Consulting with others in management, support, mentoring and reflective practice**

It is important to remember that you do not work in isolation and that there are times when you will need an opportunity to discuss your work and to reflect on your practice. Reflective practice has had wide application in the health setting and can be an important tool for practitioners who want to promote learning from their own ongoing professional experiences, rather than from formal teaching.

Reflective activities need not be complicated or intrusive and can help develop skills in self- awareness, analysis and evaluation. Journals, diaries (video, written, photo), logs, critical incident interviews; observation; metaphors; action learning sets; mentoring; coaching; visits to other organisations and on-line discussion groups all can facilitate reflection.

Self and/or group processes can support deeper understanding and improvement of practice. Some agencies have in place a program to support nurse's practice and may include reflection, coaching and mentoring. Coaching tends to focus on technical skill and knowledge acquisition and implementation. Mentoring is likely to involve some of the skills of coaching, but is focused on the growth and development of the professional.

In every workplace there is a practice protocol that needs to be followed. There will be times when consultation needs to be undertaken with management to ensure you feel supported and that the optimal care is provided to the woman and her family.

In undertaking depression screening and psychosocial assessment clear lines of responsibility and support need to be in place to protect the nurse, the women she works with and the organisation she works for. When in doubt consult with your manager about what action is best to be taken.

Looking after yourself involves setting some limits on your work and aiming for a healthy work, leisure balance.

Some strategies for avoiding burn out and manage job stress include:

- Identify your symptoms of stress
- Identify your sources of stress

- Analyse how you respond to specific stressors
- Set goals to respond more effectively
- Motivate yourself
- Change your thinking
- Deal with expectations of you
- When in conflict, negotiate
- Pace and balance yourself
- Know when to quit

## **Summary Resource 6**

- Women centred care is a holistic way to see each woman as an individual
- Advance communication skills help to form a relationship in which a woman feels understood
- Many women experience barriers to seeking and accepting help
- Understanding the barriers helps us help them to work through them
- Motivational interviewing communication strategies move women towards making change
- Looking after your own wellbeing is important

# Appendix 1: Useful links and references

This resource provides some links to other useful information and training programs in addition to those covered in this manual to extend the knowledge base of those MCHN wanting to continue their learning in this area.

## Links, books and other resources

'Write from the Heart' is an A5 booklet featuring women's personal stories of overcoming perinatal depression and anxiety. It is written in everyday language for women and their families. Email <info@fromtheheartwa.org.au> to order.

### Hey Dad: Fatherhood – First 12 Months

The long-awaited and much needed resource just for dads is now available free of charge thanks to Hey Dad WA at Ngala and beyondblue. Copies are available by calling 1300 224 636 or by visiting the website <www.beyondblue.org.au>.

### Twins, triplets or more?

'Emotional health during pregnancy and early parenthood: An information booklet for parents of multiple birth children' is a booklet produced by beyondblue. Copies are available by calling 1300 224 636 or by visiting the website <www.beyondblue.org.au>.

### The Best for Me and My Baby

This booklet was developed with and for women with a mental health problem and their partners. It encourages health professionals and parents to work together to manage mental health during pregnancy and early parenthood and provides tips for parents and for supporting family and friends. To order, visit the COPMI website: <www.copmi.net.au>

### Support for Mum when Dad works away

With such a large mining sector in WA, many families face the prospect of having one parent working away from the family home for long periods of time. Recognising this parenting challenge, the WA Department for Communities has developed this handy booklet. To order, call (08) 6217 8700 or visit <www.communities.wa.gov.au>

Towards Parenthood. Preparation for the changes and challenges of a new baby Well evaluated and effective step by step work book covering many of the key areas that facilitates the transition to parenthood. Written and evaluated as beneficial by psychologists from the Parent Infant Research Institute 2010. To order call 03 9496 4496 or <www.towardsparenthood.org.au>

Rekindling is a book written for new parents who are keen to rekindle their relationship after childbirth. Written by Dr Martein Snellen Psychiatrist.

Dad Factor Richard Fletcher's book about the importance of the father and attachment in the development of the infant.

Clinical Skills in Infant Mental Health. The first three years. Sarah Mares, Louise Newman and Beulah Warren 2nd edition ACER Press 2011

Infants of Parents with Mental Illness. Developmental, Clinical, Cultural and Personal Perspectives. Ed Anne Sved Williams and Vicki Cowling Australian Academic Press 2008

## Useful sites for MCHNs (perinatal mental health fact sheets and resources)

[beyondblue](http://www.beyondblue.org.au) <www.beyondblue.org.au>

[Black Dog Institute](http://www.blackdoginstitute.org.au) <www.blackdoginstitute.org.au>

[Motherisk](http://www.motherisk.org) <www.motherisk.org>

[Sane](http://www.sane.org) <www.sane.org>

[Post and antenatal depression association \(PANDA\)](http://www.panda.org.au) <www.panda.org.au>

[Organization of Teratology Information Specialists](http://www.otispregnancy.org) <www.otispregnancy.org>

[Drugs and lactation database \(LactMed\)](http://toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT) <toxnet.nlm.nih.gov/cgi-bin/sis/htmlgen?LACT>

[Massachusetts General Hospital Centre for Women's Mental Health, Harvard University](http://www.womensmentalhealth.org/)  
<www.womensmentalhealth.org/>

GP psych support phone 1800 200 588 fax: 1800 012 422

The [website](http://www.psychsupport.com.au) <http://www.psychsupport.com.au> is a secure and password protected website. Log in and submit questions online. For username and password, call 1800 200 588.

[Parent-Infant Research Institute](http://www.piri.org.au) <www.piri.org.au>

## Useful sites for women and their families

[beyondblue](http://www.beyondblue.org.au) <www.beyondblue.org.au>

[Black Dog Institute](http://www.blackdoginstitute.org.au) <www.blackdoginstitute.org.au>

[Motherisk](http://www.motherisk.org) <www.motherisk.org>

[Post and antenatal depression association \(PANDA\)](http://www.panda.org.au) <www.panda.org.au>

[Gidget Foundation](http://www.gidgetfoundation.com.au) <www.gidgetfoundation.com.au>

[Tresillian](http://www.tresillian.net) <www.tresillian.net>

[Mood gym](http://moodgym.anu.edu.au/welcome) <moodgym.anu.edu.au/welcome>

[Australian Government site](http://www.pregnancybirthbaby.org.au) <www.pregnancybirthbaby.org.au>

## Phone numbers

beyondblue 1300 22 4636 crisis 24 hour support for women and men.

pregnancy, birth & baby helpline 1800 882 436

Lifeline 13 11 14

Lifeline Suicide Helpline 1300 651 251

Suicide helpline (Victoria only) 1300 651 251

PANDA 1300 726 306

Maternal and Child health Line (Victoria only) 132 229

Parentline 132 289

Mensline 1300 789 978

## Reference materials for this manual

A Step by Step Guide to making a report to Child Protection or Child First. Protecting the safety and wellbeing of children and young people- A joint protocol of the Department of Human Services Child Protection, Department of Education and Early Childhood Development, Licensed Children's Services and Victorian Schools.

aNEW Perinatal Mental Health Fact Sheets (Mercy Hospital for Women 2010)

- Perinatal depression
- Anxiety disorders
- Eating disorders
- Psychosis and bipolar affective disorder in pregnancy
- The Management of Difficult Patients
- Patients with personality disorders
- Psychotropic medication and also
- Women centred care
- Domestic violence
- Child sexual abuse

Beyondblue [Fact Sheets](http://www.beyondblue.org.au/resources) <[www.beyondblue.org.au/resources](http://www.beyondblue.org.au/resources)>

- Perinatal Depression and Anxiety: Evidence relation to infant cognitive and emotional development
- Perinatal mental health of women from culturally and linguistically diverse (CALD) backgrounds: A guide for primary health professionals.
- Aboriginal and Torres Strait Islander perinatal mental health: A guide for primary care health professionals
- Psychosocial assessment in the Perinatal period A guide for primary care health professionals
- Management of Perinatal mental health disorders. A guide for primary care health professionals
- Interpreting Edinburgh Postnatal Depression Scale (EPDS) in the antenatal and postnatal period
- Puerperal (postpartum) psychosis. A guide for primary care health professionals
- Bipolar disorder during pregnancy and early parenthood. A guide for primary care health professionals

Bilszta J, Ericksen J, Buist A, & Milgrom J. (2010). Women's experience of postnatal depression-beliefs and attitudes as barriers to care. *Australian Journal of Advanced Nursing* Vol.2(3), 44-54.

Buist A, & Bilszta J (2006). The beyondblue National Postnatal Screening Program, Prevention and Early Intervention 2001-2005 Final Report Vol 1. National Screening Program. Melbourne Beyondblue: the national depression initiative

Clinical Practice Guidelines for Depression and related disorders- anxiety, bipolar disorder and puerperal psychosis- in the perinatal period. A guide for primary care health professionals. Melbourne: beyondblue: the national depression initiative. Beyondblue (2011) <[www.beyondblue.org.au](http://www.beyondblue.org.au)>

Collins CH, Zimmerman C, & Howard LM. (2011). Refugee, asylum seeker, immigrant women and postnatal depression: rates and risk factors. *Archives*

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Condon JT, Boyce P, & Corkingdale CJ. (2004). The First Time Fathers Study: a prospective study of the mental health and wellbeing of men during the transition to parenthood. *Australian and New Zealand Journal of Psychiatry*,

38 (1-2): 56-64

Detecting and Managing Perinatal Mental Health Disorders in Primary Care: online training Beyond babyblues: <[www.thinkgp.com.au/beyondblue](http://www.thinkgp.com.au/beyondblue)>

Diagnostic and Statistical Manual of Mental Disorders DSM-IV-TR (2000). American Psychiatric Association Fourth Edition Text Revision.

Edinburgh Postnatal Depression Scale. Cox JL, Holden JM, & Sagovsky R (1987). Detection of postnatal depression. *Brit.J.Psychiatry* 150, 782-786

- Gemmill AW, Leigh B, Ericksen J, & Milgrom J. (2006). A survey of the acceptability of screening for postnatal depression in depressed and non depressed women. *BMC public Health* 6, 211.
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- Highett NJ, Gemmill AW, & Milgrom J. (2011). Depression in the Perinatal period: awareness, attitudes and knowledge in the Australian Population. *Australian and New Zealand Journal Of Psychiatry*, 45:223-231
- Holden JM, & Cox JL. (2003). *A Guide to The Edinburgh Postnatal depression Scale*. Royal College of Psychiatrists.
- International Statistical Classification of Diseases and Related Problems (2010). *ISD-10 10th Revision* World Health Organisation
- Leigh B & Milgrom J. (2007). Acceptability of antenatal screening for depression in routine antenatal care. *Australian Journal of Advanced Nursing* 24: 14-18
- Perinatal Clinical Practice Guidelines- Executive Summary A guide for primary care health professionals. *Beyond babyblues* Melbourne 2012
- PwC 2013 Valuing Perinatal health. The consequences of not treating perinatal depression and anxiety. *PrincewaterhouseCoopers Australia for Beyondblue*
- Mann R, & Gilbody S. (2011). Validity of two case finding questions to detect postnatal depression: A review of diagnostic test accuracy. *Journal of Affective Disorders*, 133, 388-397.
- Maternal and Child Health Service Practice Guidelines (2009). Department of Education and Early Childhood Development
- Matthey S, White T, Phillips J, Taouk R, Chee T & Barnett B. (2005). Acceptability of routine antenatal psychosocial assessment to women from English and non English speaking backgrounds. *Archives of Women's Mental Health* 8, 171-180.
- Milgrom J, Holt CJ, Ericksen JM, Leigh B, Buist A, & Schembri C. (2011). Treating postnatal depressive symptoms in primary care: a randomised controlled trial of GP management, with and without adjunctive counselling. *BMC Psychiatry*, 11:95
- Miller, W.R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing people to change*. 2nd Edition NY Guilford
- Perinatal Depression and Anxiety: Evidence related to infant cognitive and emotional development. Information for Health Professionals (2010). *beyondblue: the national depression initiative*
- Emotional health during pregnancy and early parenthood. Copies are available by calling 1300 224 636 or by visiting the [website](http://www.beyondblue.org.au) <[www.beyondblue.org.au](http://www.beyondblue.org.au)>
- Perinatal depression and anxiety: Evidence relating to infant cognitive and emotional development. Copies are available by calling 1300 224 636 or by visiting the website [www.beyondblue.org.au](http://www.beyondblue.org.au)
- Robertson, E. Grace, S. Stewart, T. (2004). Antenatal risk factors for postpartum depression the recent literature. *General Hospital Psychiatry*, 26, 289-295.
- Scottish Intercollegiate Guidelines Network SIGN (2002) *Management of Perinatal mood disorders*.
- Shakespeare J, Balke F, Garcia J. (2003). A qualitative study of the acceptability of routine screening of postnatal women using the Edinburgh Postnatal Depression Scale. *British Journal General Practice* 53: 614-19
- Stockl, H. Hertlein, L. Himsl, I et al (2013). Acceptance of routine or case-based inquiry for intimate partner violence: a mixed method study. *BMC Pregnancy and Childbirth*, 13:77

Valuing perinatal health. The consequences of not treating perinatal depression and anxiety  
PrincewaterhouseCoopers report (2012). Commissioned by beyondblue.

Viguera AC, Nonacs R, Cohen LS et al. (2007). Risk of recurrence in women of bipolar disorder during pregnancy. Prospective study of mood stabiliser discontinuation. *Am J Psychiatry* 164:1817-24

# Appendix 2: Text-equivalent descriptions of figures

## **Figure 1: Executive summary – overview of depression screening and psychosocial assessment**

The figure shows a flowchart of depression screening and psychosocial assessment.

At the top of the figure is a box labelled 'Provide care in a culturally sensitive, non-directive and woman-centred manner'.

The first step in the flow chart is 'Routine depression screening and psychosocial assessment: obtain consent'. If no consent, explore barriers and offer again at next visit.

If yes, go to step 1. 'Introduce screening and ask initial case-finding questions'. There are two arrows.

The first leads to step 2. 'If positive response to case-finding questions or you feel additional information would be useful administer EPDS.'

Then proceed to step 3. 'Score EPDS'. An arrow proceeds to step 4. Returning to step 1, the second arrow points to 'If EPDS is not administered, proceed to further Psychosocial Assessment. Keep in mind 'Risk' possibility'. From here, an arrow points to step 4.

Step 4 is 'Ask Psychosocial Questions – ask about past or family history of mental health disorders, past or current abuse, emotional and practical support, drugs and alcohol, major stressors'.

An arrow points to step 5 'Integrate the information and feedback to the woman.'

If EPDS score is 13 or more, consider referral for mental health assessment and local pathways to care. Proceed to step 7.

If score = 10, 11 or 12 on EPDS repeat in two to four weeks. Proceed to step 7.

If positive response to EPDS question 10, assess safety. If EPDS score is 0–9 provide resources, suggest a re-assessment if anything changes. Proceed to step 7.

Step 7 is 'Document in notes'. Step 8 is 'Monitor and provide support in future consultations as appropriate'.

## **Figure 2: Risk assessment protocol summary**

Score 0 on question 10 of EPDS or any disclosure re: self-harm or suicidal ideation.

Ask about suicidal thought, planning, lethality and means.

- Suicidal thoughts – 'What exactly have you been thinking? How often? How compelling or powerful are these thoughts? Is it worse than previously? What triggers these thoughts?'
- Planning – 'What have you been thinking you might do?' Press for plan details.
- Lethality – Is the specific method likely to be lethal?
- Means – 'Have you been thinking about how you might do it? Do you have the means to carry out your plan using this method?'

Consider other factors that may increase risk as well as protective factors (refer to Resource 3 for further information).

Consider baby safety and ask about thoughts of harm towards the baby

Based on the information obtained and your clinical judgement assess the level of risk and monitor or refer as appropriate.

Document in notes.

Monitor and provide support in future consultations as appropriate.

**Figure 3: Pathway to care – a sample guide for the management of depression**

Screening with the EPDS and psychosocial assessment:

- at least once during pregnancy
- at least once 6–12 weeks post birth
- always follow-up question 10 on the EPDS

Safety concerns:

- acute mental health services and mother–baby units
- crisis assessment and treatment team (CATT)
- child protection

**Usual care (provide to all women):**

- Provide health promotion information
- Psychoeducation
- beyondblue
- resources
- Help lines
- Web-based resources to seek help and information
- Discuss any support the woman may require

**EPDS score = 10–12:**

Management Options: As Usual Care plus

- General practice
- Midwifery
- Maternal, child & family nurse
- Consumer-led self help and support groups
- Involve carers/ mobilise social supports
- NGO and community parenting services
- Psychology/ Counselling Services
- Self-directed web- based resources
- Parenting services

**EPDS score = 13–14:**

Management Options: As previous box plus

- Enhanced MCHN
- Psychology
- Social work services (mental health services and/or private sector)
- Psychiatry services (mental health services and/or private sector)
- Individual and group PND specialised programs

EPDS score = 15 and above:

- Management options: As previous box plus
- Mental Health Shared Care
- Adult mental health/ Psychology Services

- Specialist perinatal mental health services
- Psychiatry services

Other issues identified:

History of mental health issues other than depression and/or anxiety

- If the woman has a history of severe mental health illness (e.g. bipolar disorder, schizophrenia) she may already have contact with the local community mental health team and/or private psychiatrist and may have a perinatal management plan in place.
- If the woman is not in contact with any of these services, a referral should be made for further assessment and close monitoring.

Services for other psychosocial and concurrent problems

- Drug and alcohol specialist worker/service
- Family violence intervention teams
- Family and housing services
- Legal and Financial Services
- Targeted parenting support units/programs
- Culturally specific support/refugee/migrant support services