PROCEDURE

Infant and perinatal mental health

Scope (Staff):	Community health
Scope (Area):	CACH, WACHS

Child Safe Organisation Statement of Commitment

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

This document should be read in conjunction with this disclaimer

Contents

NOTE: Appendix A: Infant and perinatal mental health: Supporting information resource is **required reading** in order to implement this procedure.

Aim

To support community health nurses working in child health settings to:

- provide parents/carers with anticipatory guidance and resources highlighting the critical role of infant and parent mental health and wellbeing for healthy growth and development.
- screen, identify and assess infants and parents/carers who may be experiencing a relational difficulty or mental health issue, and offer them additional support and/or referral to available specialist services.

Risk

Failure to identify clients at risk of infant or perinatal mental health issues can negatively affect immediate and lifelong health and wellbeing, and may also impact the relationships between the infant, parent, partner and/or other family members.

Definitions

- **Anxiety disorder:** Excessive feelings of apprehension, worry, nervousness and stress out of proportion to the object of the worry, and affecting a person's ability to complete daily tasks and develop secure relationships[1]. Feelings of anxiousness or fear that are often accompanied by physical symptoms, and can cause significant distress and impairment of function. Anxiety is commonly associated with depression and substance use disorders. Anxiety disorders include generalised anxiety disorder (GAD), panic disorder, social anxiety disorder (social phobia), agoraphobia, and specific phobias.
- **Attachment:** The unique, instinctive emotional bond between an infant and its caregiver that has evolved to protect the infant from threat or fear, and is the basis of an infant's social and emotional development[2, 3]. Attachment can be secure, insecure, or disorganised.
- **Depression:** Feelings of sadness, lethargy, negative thinking, and/or a loss of interest in everyday life and and withdrawal from regular activities which can lead to a variety of emotional and physical problems and decrease a person's ability to function at work and at home. Depression symptoms vary from mild to severe[4].
- **Early Relational Health:** describes the positive, stimulating and nurturing relationships between infants and their primary caregivers. These relationships ensure the emotional security and connection that provide the foundational capacities for lifelong learning, development and overall wellbeing[5].
- **Infant:** The definition for Infant Mental Health (IMH) definition used throughout this document is an overarching term referring to any infant or young child aged 0 – 4 years[6, 7].

- **Parent**: Parent/Carer refers to anyone with caregiving responsibility for the infant. This is often but not always the birth mother. In this guideline, caregivers will be referred to as parents. The terms mother and father will be used where gender issues are relevant to the mental health concern.
- **Parent-infant relationship:** The connection or bond created between the parent and infant through the exchange of behaviours and emotion between them both[8].
- **Perinatal**: The period from conception to 12 months after the birth of the baby[7].

Principles

- All nurses will refer to the Nursing and Midwifery Board AHPRA Decision-making framework in relation to scope of practice and delegation of care to ensure that decision-making is consistent, safe, person-centred, and evidence-based.
- Nurses need to provide a culturally safe service delivery which demonstrates a welcoming environment that recognises the importance of the cultural beliefs and practices of all clients[9].
- Nurses need to be sensitive and client-focused, and consider trauma and its associated effects on physical health, development, and social and emotional wellbeing. These factors are considered holistically rather than in isolation.

Key points

- Consider the emotional health of the infant through observations and clinical judgment in addition to parent's self reports.
- Use active listening techniques to thoroughly explore strengths as well as possible risks for infant and perinatal mental health (IPMH) issues. Work in partnership with parents to identify their inner strengths, outer supports and resources, and things they enjoy about their infant, as well as discussing any identified concerns.
- Recognise and praise parents for what is going well, and role-model positive interactions with both the parent and the infant.
- Provide unbiased care and promote sensitive parenting and secure attachment to all families.
- Discuss realistic expectations of both parenting and infant development, encourage parents to ask for help from family, friends and professionals, and provide information about self-care activities and support services.
- When discussing identified infant and parent mental health issues, use language that promotes positive early relational experiences and avoids shaming parents and increasing their distress.
- Reassure families that mental health issues such as perinatal anxiety and depression are most often transient rather than permanent, and that effective treatments are available.

- Consider and assess risk and discuss client care with line manager if unsure of review and referral options or if clinical judgement indicates the need for Department of Communities involvement.
- Use the interactive ASQ-3 and ASQ:SE-2 assessment tools for developmental–behavioural screening while concurrently teaching parents and partners how to be more responsive to their infants' communication cues.
- Use Indicators of Need resource as needed to prompt review of psychosocial supportive and risk factors. Use clinical judgment when interpreting these factors and considering care pathways and ongoing care.
- Consider your own emotional health and undertake clinical reflective practice where available.
- Debrief as required with Line Manager/ Clinical Nurse Specialist (CNS) or seek assistance directly from an Employee Assistance Program provider.
- Use an interpreter for parents who are not fluent in English, as per WA Health and CAHS Language Services policies.

Infant assessment

Infant mental health assessments can help to identify and understand the strengths, issues and challenges facing a family, and can assist families to build their parenting capacity and confidence. Assessments should be holistic and culturally responsive, covering emotional, behavioural, social, and environmental factors and attachment, as well as child development. The aim is to understand the nature of the relationship between the infant, parents, and any other family members, the capacities for change, and the infant's developmental strengths.

Community health assessments are currently observation-based in clinic and home settings. During the assessment, parents should be encouraged to have an active voice and be given time and space to reflect and to express their needs and feelings in a safe way[9].

Infants may experience mental health issues irrespective of their mother's mental health or parent-infant attachment. However, an infant's failure to connect securely with a consistent parent during early developmental stages often gives rise to recognisable signs[8]. The nurse can observe the infant's behaviour and interactions with their primary care giver for indications of attachment concerns or a mental health issue (see Process Table 1 – Step 4).

Screening questions are used most effectively when they prompt a conversation and ongoing dialogue with the parent. This helps to target interventions and strengthen existing protective factors[8]. The Centre of Perinatal Excellence (COPE) *Mental Health Practice Guideline* provides a list of prompts to support the assessment of infant behaviours and the parent-infant relationship[4]. These prompts have been adapted and included in Process Table 1 – Step 3.

Process Table 1: Parent-infant interactions and infant attachment

1. Preparation
Review client record, including: • Progress notes, WACHS WebPAS Child at Risk Alert (CAR alert) or CACH flags, Special Child Health Referral information, areas of concern identified, previous referrals, areas for follow-up, Clients of Concern list, resources provided, and services offered previously.
2. Engagement and consent
Aim to promote trust and a warm and responsive relationship to encourage open communication, and engagement. • Ensure verbal consent, and awareness of the limits to confidentiality within CACH and WACHS services. Services are confidential unless parent says they are thinking of hurting themselves, their infant or someone else, or that someone is hurting their child. Refer to the following policies as needed (CACH - CACH Family and domestic violence procedure and CAHS Child Safeguarding and Protection) and (WACHS - Child Safety and Wellbeing Policy and Family and Domestic Violence Procedure).   ○ For mental health emergencies, contact Mental Health Emergency Response Line (MHERL).
3. Discuss wellbeing and initial concerns
Discuss infant's development and wellbeing, and any concerns parent has for themselves or their infant. • Obtain a current history from the parent. Consider family protective and risk factors. Refer to Infant and perinatal mental health: Supporting information, and Indicators of Need. • Ask if already accessing mental health or other specialist services for themselves or infant. • Allow sufficient time for discussion of concerns.
4. Observe caregiving behaviours[4, 10, 11]
Home and clinic visits provide many opportunities to observe caregiving as the infant's stress may go up a little during weighing, changing, feeding, and managing competing demands[10]. Consider the parent's sensitivity, acceptance, accessibility, and cooperation when helping the infant with their emotional state. All relationships have some periods where interaction is not finely attuned, and this is perfectly normal. What is important is the ability for repair or re-attunement[10]. Nurse can also sensitively ask questions such as:

- Does your infant make you feel sad, angry, resentful?
- Are you enjoying your time with your infant?
- What have you been doing together this week?
- What kind of activities are you doing at home?

Note: These prompts should not be used as a checklist or formal assessment tool. However, observation of the parent's interactions with their infant can indicate protective factors and potential difficulties in attachment.

- Curious, respectful conversations about the qualities of the parent-infant relationship can sensitively highlight challenges and foster responsive care and the ability to reflect on the potential meaning of their infant's reactions and behaviours.
- Observations should be considered within both cultural and infant health and development contexts.
- When assessing parent-infant interactions in Aboriginal, migrant, refugee and culturally and linguistically diverse (CaLD) families, use a family-centred approach and consider cultural parenting practices to ensure that assessment and clinical judgment is culturally appropriate and not informed by personal bias[4]. Be aware of local regional demographics and any local cultural practices.
- Consider the potential additional needs of young mothers to ensure assessment of their parent-infant interactions is situation and age-appropriate.

Observations suggesting more sensitive caregiving reflection and responsiveness[10]	**Observations suggesting less sensitive caregiving reflection and responsiveness[10]**
• Communicates with their infant with warm language and an affectionate tone of voice. • Speaks directly to the infant with sensitivity, responsiveness, and turn-taking. • Interacts in sync with infant's behaviour and emotional state. • Responds to the infant's cues, even when talking with clinician or another adult.	• Scowls, criticises or otherwise behaves harshly towards the infant. • Responds inconsistently to their infant. • Mistimed, mistuned responses. • Misses the 'slow down' or 'back off' signals the infant is giving. • Displays emotion that doesn't match the infant's display of affection.
• Describes the infant's needs and daily patterns.	• Seems unaware or uninterested in infant's needs and daily patterns.
• Expresses empathy for the infant.	• Rejects or minimises infant's needs.

MP 0097/18 - Within Western Australia, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.

• Accepts infant behaviour that is not what they hoped for.	• Tunes out or mislabels infant's bids for attention. • May see negative motives in the infant.
• Plays and talks with the infant and engages in enjoyable activities with them.	• Overstimulates and intrudes on the infant. • Understimulates and neglects infant.
• Handles the infant in a safe and gentle manner.	• Physically manipulates, intrudes, or impinges on the infant.
• Copes with the infant's distress. • Is usually able to calm the infant.	• Feels anxious or helpless when infant shows needs. • Seems distressed by the infant's needs or demands.
• Smiles and shows delight in their infant.	• Appears to feel uncomfortable, unhappy, or enraged by the infant.
• Shows protectiveness about infant. • Helps infant to interact with clinician.	• Appears to have either excessive worry or lack of interest in the infant.

5. Observe infant behaviours[4, 10]

Observe the infant for behaviours that may indicate concerns with IMH or attachment.

Note: The following prompts should not be used as a checklist or formal assessment tool.

Observations suggesting no issues with infant mental health and wellbeing and more secure attachment	**Observations suggesting issues with infant mental health and wellbeing or less secure attachment**
• Mutual gaze - the infant looks back when the parent looks at them. • Developmentally appropriate shared attention.	• Gaze avoidance or no eye contact – infant looking away when parent looks at them. • Little interaction or interest in parent. • Appears flat, withdrawn, sleepy.

• Smiling, sharing delight. • Able to express a wide range of emotions.	• Flat, minimal, or absent facial expression, emotionally under-responsive.
• Calling, vocalising and crying to seek proximity.	• Lack of crying or limited vocalising.
• Generally settled and able to observe, explore, and play. • Seeks parent for comfort and accepts the support being offered.	• Irritable and restless, with constant crying. • Amplified attention-seeking behaviours. • Difficulty being consoled when distressed. • Approaching and avoiding the parent at the same time.
• Reciprocity – parent and infant seem 'tuned in' to each other's cues.	• Physical signs of not wanting to be in parent's arms when being held (arched back, stiff, seems anxious). • Freezes, stills, or shows fear of parent. • Seems dazed or confused when parent comes to help.
• Reaches or goes to parent, maintains proximity, and resists release.	• An unusual level of separation anxiety, or of attention-seeking behaviour and engagement with the nurse. • Older infants with mental health concerns may have separation anxiety from parent or interact and seek attention unusually easily with strangers.
• Unsettled sleep and difficulty feeding[4, 12] may be normal behaviours for infants at certain developmental stages. However, these behaviours and also growth faltering may sometimes be indicators of infant mental health concerns if associated with other listed behaviours of concern. • It can be challenging to determine if infant behaviours are signs of mental health struggles, a phase of development, or due to a physical health issue[12].	

6. Discussion and anticipatory guidance

Work in partnership with the parent to identify their inner strengths and outer supports and resources, as well as things they enjoy about their infant.

- Discuss and offer relevant anticipatory guidance, brief intervention and related resources as needed. Areas supporting IMH may include:
    - Sensitive parenting and attachment information
    - Awareness of signs of infant mental health issues
    - Child development, communication, and early literacy
    - Nutrition and feeding, including breastfeeding promotion and support
    - Sleep and settling
    - Play, movement, and screen time
- Suggest local parenting groups, Rhyme Time, and playgroups (as available)
- Offer printed resources about attachment and development (or electronic link):
    - ASQ-3 and ASQ:SE-2 parent activity sheets (as needed), highlighting relevant activities
    - Your child magazines
    - Circle of Security
    - Raising Children Network (newborn/connecting and communicating)
    - Other related external resources – See External Resources

7. Care planning and review

If concerned about an infant's wellbeing, it is important to have transparent conversations with the parent about the observations.

- Use an empathetic, family-centred approach to discuss care planning and to collaboratively explore whether additional supports or assessments are needed. This helps to ensure a shared understanding of concerns and care planning.
- Consider need for Universal Plus or ECHS (WACHS) appointment for follow-up. Use clinical judgment or consult with CNS or Line Manager about follow-up timeframes.
- Consider the potential impact of identified mental health problems on parent-infant interactions and discuss possible need for Partnership (CACH) referral with CNS or CNM.

- Work with the parent to complete a CHS825 *My Care Plan* when Universal Plus follow-up is required, and as needed. Give one copy to parent and retain a copy in client record. CHS825 *My Care Plan* will outline (where relevant):
    - Sensitively worded overview of the concern
    - Strategies/plan for the parents to implement
    - Review appointments – date and location
    - Resources - including services and groups for additional support and/or further information
    - Referral services – include contact details
    - When and how to escalate care, if required.

8. Refer

- If IMH concerns are present, refer client as needed to General Practitioner (GP), Child Development services, or more specific parenting support services. GP referral may be required to services such as perinatal and infant mental health specialist services or paediatrician. Follow local protocols to refer to services.
- Nurse may refer client to CACH/WACHS or community services providing attachment-based individual services or groups (for example, Circle of Security), depending on local availability.
- Externally provided, relevant parenting groups may also be considered. Nurse to be aware of local services and groups in their community. Availability of appropriate parent groups may vary between sites.
- If there are significant difficulties with interactions between mother and an infant up to 12 months, a referral from a GP to a Mother and Baby Unit (MBU) may be warranted.
- If psychotic symptoms are present, seek immediate assistance from a mental health service such as MHERL, an Emergency Department, or a GP, depending on the availability of services[13].
- After discussion with CNS or Line Manager, offer Partnership referral (CACH) to the family.

The family may already be connected with mental health support services. However, clinical judgment may indicate need for earlier specialist review.

Note: Recognise possible indicators of child abuse or neglect. See Guidelines for Protecting Children 2020, CAHS Child Safeguarding and Protection, and WACHS Child Safety and Wellbeing Policy.

Staff can use the TEN-4-FACESp tool to improve recognition of potentially abused children with bruising who require further evaluation.

If possible indicators of abuse or neglect are noted, take the following actions:

- Identify any immediate safety concerns.

- Discuss concerns with parent if safe to do so.
- If a belief is formed that the child has been harmed or is likely to be harmed, a formal report to the Department of Communities is required as soon as possible.
- Document discussion, actions, referrals and plans in CDIS/CHIS, including discussions with relevant Line Manager or CNS.
- Add to Clients of Concern list.
- Add CAR alert (WACHS) or flag (CACH) in electronic record.
- Discuss possible child protection concerns with Line Manager or CNS.

9. Follow-up

Discuss progress against agreed actions and strategies with parent.

- If an identified concern has not improved at the follow-up appointment, contact Line Manager or CNS to:
    - Discuss client's care plan
    - Consider offering ECHS (WACHS) or Partnership referral (CACH).

10. Document

Ensure timely completion of documentation of notes and referrals, and storage in CHIS (WACHS) or CDIS (CAHS) according to local processes.

- Documentation to include protective and risk factors, clinical presentation, ASQ-3 and ASQ:SE-2 scores as relevant, action taken, health education and resources provided, care planning including follow up and referral details, consultation with colleague/other agencies, and discussion of safety if indicated.
- Consider adding client to the Clients of Concern group.
- Consider adding CAR alert (WACHS) or flag (CACH) in electronic record.

Parental mental health and EPDS screening[4]

Nurses must use the EPDS form to screen parents' mental health[4, 14].

- EPDS screening is offered at **8 week, 4 month and 12 month** Universal contacts, and at any other time where there is parental or nurse concern.
- EPDS screening is an indicator of the risk of depression and anxiety. It should be used in conjunction with a holistic consultation and professional judgement to identify those who need follow-up or referral. Enquire about the parent's general health and wellbeing before offering the EPDS screen.
- The EPDS can be used with both men and women, though the cut-off scores are different (see Process Table 2 below).

- The EPDS should be offered in a private environment. It should not be used in an open clinic setting or emailed to parents. Face to face delivery of EPDS screening is recommended, but telehealth or phone delivery may occasionally be required depending on appointment location or if parent has difficulty accessing services in person.
- Where the EPDS is administered to both parents attending the appointment, care should be taken for each parent to answer independently, without the influence of the other parent[14].
- The EPDS should only be used by nurses who have been trained in its use and where there is a clear referral pathway. EPDS training should include suicide risk assessment and management[14].
- The EPDS provides a universal language between health care professionals that facilitates referrals.
    - Refer to Appendix B: Infant and perinatal mental health concerns: process flowchart
    - Refer to Appendix C: Edinburgh Postnatal Depression Scale (EPDS) referral pathway – WA
    - Refer to the following flowcharts for information about Community health processes when a baby is admitted to and discharged from an MBU

      Mother and Baby Unit - Admission and discharge flowchart - FSH

      Mother and Baby Unit - Admission and discharge flowchart - WNHS

EPDS considerations for Aboriginal and CaLD parents[14]

- Translated EPDS screening forms are available for parents.
- For Aboriginal women, the score may be influenced by the woman's understanding of the language used, mistrust of mainstream services, or fear of consequences such as removal of her baby if depression is identified[15, 16].
- Translations of the EPDS developed in consultation with women from Aboriginal communities identify a slightly higher number of women experiencing symptoms of depression[4]. The Kimberley Mum's Mood Scale (KMMS) is an adapted EPDS version that is more acceptable to Aboriginal families and faciltates communication with Aboriginal women by prioritising time, trust and rapport[15, 16].
- Cultural practices such as attending the consultation with a family member, differences in emotional reserve, and the perceived degree of stigma associated with depression may influence EPDS responses in women from culturally and linguistically diverse backgrounds[1].
- When working with parents who are at high risk of a mental health condition, staff can get advice from or refer parents to relevant support agencies. For example, seek advice as needed from Aboriginal health or bicultural health staff in CACH/WACHS Community Health when assessing perinatal mental health in

Aboriginal, migrant, refugee and CaLD families, to ensure that assessment and clinical judgment is culturally appropriate and not informed by personal bias[4].

Process Table 2: Parental mental health and EPDS screening

1. Preparation
Review client record, including: ○ Progress notes, flags/CAR alert, Special child health referral, areas of concern identified, previous referrals, areas for follow-up, Clients of Concern list, and resources/ services offered previously.
2. Engagement and consent
Aim to promote trust and a warm and responsive relationship to encourage open communication, and engagement. • Before offering EPDS ensure verbal consent, and awareness of the limits to confidentiality within CACH and WACHS services. Services are confidential unless parent says they are thinking of hurting themselves, their infant or someone else, or that someone is hurting their child. Refer to the following policies as needed (CACH - CACH Family and domestic violence procedure and CAHS Child Safeguarding and Protection) and (WACHS - Child Safety and Wellbeing Policy and Family and Domestic Violence Procedure). ○ For mental health emergencies, contact Mental Health Emergency Response Line (MHERL).
3. Discuss wellbeing and initial concerns
Discuss parent wellbeing and any current concerns. Enquire about family, past and present history of mental health conditions as part of the first child health assessment. • Obtain a current history from the parent. Consider family protective and risk factors. Refer to the Indicators of Need. • Explain that the EPDS is a routine screen for the risk of developing perinatal depression or anxiety that is offered to all parents at this time of increased vulnerability. The scale provides an indication of the parent's perception of their mood in the preceding 7 days. It does not predict on-going mood[17], but supports nurses to understand how to support parents better. • If a parent attends the appointment alone, enquire about their partner's wellbeing. Explain that perinatal mental health concerns can affect both parents, and offer relevant resources and information about supports and services for their partner as needed. • Allow sufficient time for discussion of concerns, and consider the timing of the EPDS offer in the appointment. Aim to establish trust and open communication by

addressing less sensitive topics initially, but avoid leaving the EPDS screening until late in the appointment in case concerns are identified.

- EPDS screening is offered prior to FDV screening.

4. Offer EPDS screening

- Ensure privacy.
- Staff in designated WACHS regions who have received the appropriate training to use the Kimberley Mum's Mood Scale (KMMS) will follow endorsed local protocols and where agreed with the parent, will use the KMMS instead of the EPDS when screening Aboriginal women.
- Document in the client record if the offer of EPDS screening is declined, and use clinical judgment to determine follow-up actions. The nurse should still have a conversation about parental mental health and wellbeing, and ensure that the parent understands they can visit their Community health nurse or GP at any point if they are feeling overwhelmed or unable to cope. The EPDS should be offered again at subsequent visits.
- See CACH Intranet forms page or Women and Newborn Health Service for the English version of the EPDS form.
- The form should be completed by the parent personally unless they have limited English (and a relevant translation is not available), or literacy issues.
- If English is the parent's second language, consider use of a translated EDPS.

5. Administer EPDS

- The parent is asked to **underline** the response which comes closest to how he or she has been feeling in **the previous 7 days**. The process of underlining responses helps parents to acknowledge any mental health concerns they are feeling.
    - Advise the parent to tick their answer if completing an electronic EPDS form.
- All ten items must be completed.

6. Calculate score

- Questions 1, 2, & 4 are scored 0, 1, 2, or 3 with the top response scored as 0 and the bottom response scored as 3.
- Questions 3 and 5-10 are scored in reverse, with the top response scored as a 3 and the bottom response scored as 0.
- On completion, add all scores to obtain a total.
- The maximum score on the EPDS is 30.

EPDS Question Scores[18]

	Q 1- 2	Q 3	Q 4	Q 5-10
Top response	0	3	0	3
	1	2	1	2
	2	1	2	1
Bottom response	3	0	3	0

7. Interpret score

- Clinical judgement is integral to interpreting EPDS scores, as in some cases the score may not accurately represent a parent's mental health. Consider mismatch between the EPDS score and the clinical presentation. For example, a woman may have a low score but clinician has reason to believe that she is experiencing depressive symptoms. Ask the parent if the score reflects how they feel. Consider also the parent's level of literacy and insight.
- A score of 0 is considered unusual. It may indicate masking or literacy issues and requires further discussion with the parent.
- A very high EPDS score could suggest situational emotional distress from a crisis, other mental health issues, or unresolved trauma[14]. Explore with the parent what may be happening for them.
- Scores may be influenced by several factors, including the client's understanding of the language used, their fear of the consequences if depression is identified, differences in emotional reserve, and perceived degree of stigma that is associated with depression[14].
- Scores used to identify possible depression for parents of Aboriginal or CaLD backgrounds are generally lower than those used in the general population.

The following postnatal cut-off scores are for English speaking men and women.

  - Note: If a translated version of the EPDS has been used, refer to the additional notes in that specific language version to determine the appropriate cut-off scores.

Postnatal cut-off scores for women and men for the English version of EPDS[19].

Low risk of perinatal depression

Women: 0-9

Men: 0-9

Moderate risk of perinatal depression

Women: 10-12

Note: Men have **No moderate score.** Refer to high risk for scores 10 or more.

High risk of perinatal depression

Women: 13–30

Men: 10 or more

Cut-off scores for Anxiety

- The anxiety subscale questions are Questions 3, 4, & 5.
- The total possible anxiety score is 9.
- **Do not** deduct the anxiety score from the total score.

Cut-off scores for Anxiety for women and men for the English version of EPDS:

Women: 6 or more

Men: 4 or more

NB: Irrespective of the overall EPDS score, a score over 6 for women and over 4 for men may indicate the presence of anxiety that requires further clinical assessment.

Antenatal cut-off scores for women and men for perinatal depression

The antenatal cut-off score is:

Women: 13 or more

Men: 10 or more

8. Actions – for EPDS levels of risk with or without identified concerns

Low risk EPDS score and NO concerns identified **EPDS 0 – 9**

If EPDS score is low risk and no concerns are identified, some symptoms of distress may be present but they are less likely to interfere with day to day functioning.

- Discuss feelings, experiences, role change, changes in relationship, protective factors, and sense of losses and gains.
- Offer anticipatory guidance, including information and support about general lifestyle, support networks, nutrition, sleep, relaxation, exercise, and self-care.

Provide general information about emotional wellbeing, healthy relationships and available helplines. See External resources.

- Provide support to ensure continued wellbeing. Advise parent to visit their Community health nurse or GP if they feel overwhelmed or unable to cope.
- Offer additional contacts to meet individual needs where clinical judgement warrants.
- Give details of community support groups, early parenting centres
- Consider offering *Finding help before and after baby arrives* booklet and child health magazine for local resources to support the family.
- Re-screen EPDS at subsequent universal contacts.

Low risk EPDS score WITH concerns identified or anxiety score above cut-off
EPDS 0 – 9 and may have Anxiety score 6 and over

If EPDS is low risk but concerns including **intrusive thoughts** are identified or **anxiety score** above cut-off, some distressing and discomforting symptoms may be present and may impact functioning.

- Discuss and explore any high-scoring items.
- Explore whether intrusive thoughts are present. If disclosed, reassure parent that intrusive thoughts and worries are common. Check if these are becoming more frequent, overwhelming, or affecting everyday function. In particular, ask if the parent is acting on their intrusive thoughts or having thoughts of harming themselves or their infant. Referral for further mental health assessment is required when intrusive thoughts are affecting everyday function or parent and/or infant safety[20].
- Provide discussion, anticipatory guidance, information and resources/supports as for parents above with Low EPDS score and no concerns identified.
- Suggest supports to address concerns in individual parent circumstances, including general and mental health support and resources.See External resources.
- Offer the *Finding help before and after baby arrives* booklet and child health magazine for local resources to support the family.
- Use professional judgement to:
    - consider offering a Universal Plus or Enhanced Child Health Schedule (WACHS) appointment to the parent to review EPDS.
    - consider referral to GP.
- Complete a CHS825 *My Care Plan* if Universal Plus appointment is accepted by parent (see Step 9, Develop a care plan in this Process Table 2).
- Complete the Clinical Handover/Referral Form (CHS 663) for relevant referrals.

Moderate risk of perinatal depression (NB. This category applies to women only)
EPDS 10-12

Scores in this range indicate that the presence of symptoms are distressing and discomforting and may impact functioning.

- Discuss and explore any high-scoring items and intrusive thoughts.
- Explore past history of mental health issues, social supports, and current life stressors.
- Check what parent thinks is contributing to how they are feeling and what they need to improve this.
- Encourage parent to have regular time for positive interactions with infant.
- Encourage regular time-out if possible and culturally appropriate, with partner, extended family, or friends caring for the infant.
- Discuss the benefits of eating healthy foods, regular exercise, social networks.
- Discuss support networks, including partner, family, and friends.
- Encourage to seek support from a GP, counsellor, psychologist, or women's health centre.
- Encourage participation in parent group.
- Provide links to online resources and apps. See External resources.
- Offer Universal Plus or ECHS appointment in a few weeks to review parent's progress against their agreed care plan.
- Use clinical judgement to determine if CNS/Line Manager consultation is required for Partnership services (CACH) or ECHS (WACHS).
- Complete a CHS825 *My Care Plan* if Universal Plus appointment is accepted by parent. (see Step 9. Develop a care plan in this Process Table 2)
- Complete Clinical Handover/Referral Form (CHS663) for relevant referrals.
- Consider need to add to Clients of Concern list and/or need for CAR alert (WACHS) or flag (CACH) in electronic record.

High risk of perinatal depression without identified immediate risk to parent and/or infant **EPDS 13–30**

Scores in this range require external assessment as the likelihood of depression and possibly anxiety is high.

- Assess thoughts of harm to self or infant.
- It is important to have transparent conversations with the parent about identified concerns for the parent's or infant's wellbeing.
- Nurse should inquire about the parent's support network and the safety of both the parent and the infant to decide whether contact with mental health services is appropriate.
- Consider need for urgent referral to GP, local hospital or mental health service for a mental health assessment, especially where the parent has 18erbalized intent and/or plans of harm to self or infant.

- Consult with Mother Baby Unit for complex cases if required.
- Discuss the range of options that may be offered by GP, including counselling and possible medication.
- Refer to GP, if indicated and consent has been provided.
- Encourage the parent to take medication as prescribed, and to discuss any concerns or questions they may have with their GP.
- Discuss relevant local mental health services, information, and contact details to parents and support networks.
- Encourage participation in perinatal depression support groups.
- Encourage parent to have regular time for positive interactions with their infant.
- Ensure regular time out if possible and culturally appropriate, with partner, extended family, or friends caring for the infant.
- Offer Universal Plus follow-up phone call within one week and/or a Universal Plus appointment to review progress against the parent's agreed care plan.
- Complete a CHS825 *My Care Plan* if Universal Plus appointment is accepted by parent (see Step 9. Develop a care plan in this Process Table 2).
- Use clinical judgement to determine if CNS/CNM consultation is required about Partnership level of service (CACH) or ECHS appointments (WACHS).
- If parent agrees, provide information to and involve their partner/significant other(s) in discussions about their emotional wellbeing and care[4]. To ensure parent's safety, arrange for them to be in the company of a partner, family member, or friend prior to leaving the child health centre.
- Complete the Clinical Handover/Referral Form (CHS663) for relevant referrals.
- Consider need to add to Clients of Concern list and/or need for CAR alert (WACHS) or Risk flag (CACH) in electronic record.

High risk of perinatal depression WITH identified immediate risk to parent and/or infant **EPDS 13–30**

Nurse needs to determine if there are immediate safety concerns. This is determined using a combination of clinical judgement, consideration of risk indicators, and the parent's own assessment of their level of risk.

- Question 10 on the EPDS assesses the suicidal ideation of the respondent. A score of 1, 2 or 3 requires a more detailed assessment regarding current risk of suicide or self-harm, including asking about intent, plan, method, impulsivity and recent events.
- If parent scores 1, 2 or 3 on question 10, recheck whether these feelings occurred in the last 7 days.

- Use direct questioning without judgement to determine if the parent and/or infant are at risk. Ask about parent's capacity to care for their infant and if they have any thoughts of harming their infant. Discuss openly with the parent any identified concerns for parent or infant wellbeing.
- Use clinical judgement to assess the situation and arrange immediate specialist assessment, as required. Discuss parent's available support networks and protetive factors as well as concerns, and discuss possible referral options.
- Refer urgently to GP, local hospital, or mental health service for a mental health assessment, especially where the parent has 20erbalized intent and/or plans of harm to self or infant.
- Where the nurse has concerns about risks to the parent or infant, seek permission to contact their support person to discuss the situation.
- Consult with Mother Baby Unit for complex cases if required.
- Use clinical judgement to determine if consultation with CNS/CNM about Partnership services (CACH) is required.
- Undertake a follow up phone call within one week to determine further care planning.
- Nurse to discuss parent's care plan with their line manager.
- Complete the Clinical Handover/Referral Form (CHS663).
- Document all discussions and care given.

Note: If concerned about a parent's wellbeing or infant's safety speak with line manager or CNS, ideally **before** parent leaves the clinic.

- If a parent (or their infant, or another person) is in immediate danger and parent is NOT willing to provide consent, information may legally be disclosed to the Department of Communities or Police. While parents have a right to privacy and confidentiality, information may be shared without consent to protect the safety of children.
    - WACHS: Regional managers and staff are to identify the local positions that are at Tier 6 or higher and that can authorise disclosure.
- Advise parent of the nurse's obligation to report concerns to Department of Communities when it is unsafe for children to be at home or if there is reasonable belief that the child has been (or is at risk of) emotional or physical abuse or neglect.
- Outline the options available and obtain consent for referrals to ensure ongoing safety and protection.
- Consult with the line manager and/or CNS or social worker (WACHS) to discuss further parent care planning. Also arrange work cover with line manager/CNS for other clinic appointments if urgent action is required.
- Use professional judgement to determine if CNS/CNM consultation is required about Partnership level of service (CACH) or ECHS appointments (WACHS).

- Add to Clients of Concern list.
- Add CAR alert (WACHS) or flag (CACH) in electronic record

Note: If parent refuses help and leaves and nurse has **fears for immediate parent and/or infant safety**, ring Police and inform Line Manager and consider Department of Communities involvement.

In case of emergencies, call 000.

9. Care planning

Care planning occurring in all contacts should be developed in partnership with the parent, and must be documented fully in the client record. This may include a plan to make a follow-up phone call with the parent to check if they have called their GP or a recommended Community service, suggested ASQ parent activities and an appointment time for review of ASQ-3 and ASQ:SE-2, or planning suggestions for review or referral.

If concerns are identified, a CHS825 *My Care Plan* form is completed together with parent. This helps to ensure a shared understanding of concerns and planning, and is reviewed at a Universal Plus contact.

- A CHS825 *My Care Plan* will outline (where relevant):
    - Sensitively worded summary of the concern
    - Strategies/plan for the parent/family and nurse to implement
    - Review appointments – date and location
    - Option to visit Community health nurse or GP at any point if they feel overwhelmed or unable to cope
    - Resources (including services and groups) for additional support and/or further information
    - Referral services – include contact details
    - When to seek further care or escalate concern, if required.
- Give one copy of CHS825 *My Care Plan* to parent and retain a copy in client record.

10. Referral

The WA Perinatal Mental Health EPDS Referral Pathway indicates the types of services that might be helpful to parents. Refer to this pathway for suggested actions for each EPDS risk level.

- If the parent does not consent to referral, the nurse should document the offer and the refusal in the client health record.
- Discuss concerns with CNS/Line manager and contact mental health services or Department of Communities.

- ForWhen perinatal mental health support line may be able to offer support for identified psychosocial concerns. See External resources.
- Availability of appropriate parent groups may vary between sites. Nurses should be aware of and consider appropriate local services and referral options.
- If family is already connected with mental health support services, use clinical judgment about need for an earlier specialist review for raised EPDS score and/or increased level of concern about parent's mental health.

11. Follow-up

Follow-up occurs at a Universal Plus appointment that has been offered according to clinical judgment and the parent's need and willingness to attend and to review progress from previously agreed actions in their CHS825 *My Care Plan*.

- If the identified concern has not improved at the follow-up appointment, discuss the parent's care planning with Line Manager or CNS. WACHS staff may consider offering ECHS.
- Use clinical judgement to determine if a repeat EPDS is required at the follow up appointment.
- If the nurse is unable to contact a parent for their planned follow-up phone call, discuss this with their line manager to ensure the parent continues to receive care.
- Nurse to follow up parents where EPDS was not administered but nurse has concerns about the parent's mental health.

12. Documentation

Nurses maintain accurate, comprehensive and contemporaneous documentation of assessments, planning, decision making, and evaluations according to CACH and WACHS processes.

- Ensure timely completion of documentation of notes and referrals, and storage in CHIS (WACHS) or CDIS (CAHS) according to local processes.
- Documentation to include protective and risk factors, clinical presentation, psychosocial assessment, EPDS scores, FDV screening when offered, ASQ-3 and ASQ:SE-2 scores as relevant, action taken, health education and resources provided, care planning including follow up and referral details, consultation with colleague/other agencies, and discussion of safety.
- (CACH-only) – Paper EPDS form completed by parent to be scanned into CDIS and also saved in client record.
- Use Clinical Handover/Referral Form (CHS663) for referrals to GP or other health services.
- Consider adding infant to the Clients of Concern list.
- Consider adding a WebPAS Child at Risk Alert (WACHS) or flag (CACH) in electronic record.

Training

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

Compliance monitoring

Failure to comply with this policy document may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the *Integrity Policy Framework* *issued pursuant to section 26 the Health Services Act 2016 (WA) and is binding on all CAHS and WACHS staff as per section 27 of the same act.*

Compliance monitoring methods may include observation of clinical practice, clinical incident review, client health record documentation audit, including monitoring of an offer of EPDS and/or attendance at identified training sessions.

Related internal policies, procedures and guidelines
The following documents can be accessed in the CACH Clinical Nursing Policy Manual HealthPoint link or CACH Clinical Nursing Policy Internet link
Ages and Stages Questionnaire
Clients of concern management
Clinical handover - nursing
Factors impacting child health and development
Family and domestic violence
Partnership – child health service
Suicide Risk Response
Universal contacts
The following documents can be accessed in the WACHS Policy Manual
Child Safety and Wellbeing Policy
Engagement Procedure
Enhanced Child Health Schedule Guideline
Family and Domestic Violence Procedure

WebPAS Child At Risk Alert procedure
The following documents can be accessed in the CAHS Policy Manual
Child and Family Centred Care
Language Services
The following documents can be accessed in the CACH Operational Policy Manual
Consent for services
Consent for Release of Client Information

Related external legislation, statewide mandatory policies, and guidelines
Clinical Handover Policy (MP0095)
Language Services Policy (MP0051/17)
Related internal resources (including related forms)
Clinical handover referral form (CHS663)
Early Parenting Group (Topic: Getting to know your baby)
Indicators of Need
Infant and perinatal mental health: Supporting information

External resources and related forms

Urgent referral information

Mother and Baby Unit: State-wide inpatient specialist treatment centres for women with significant mental health problems and their babies, from late pregnancy up until baby is walking. An MBU is **not** an emergency or crisis service.

KEMH: Free call 1800 422 588, or 64581799

FSH: 6152 1583 (MBU CNS)

Mental Health Emergency Response Line (MHERL): expert triaged telephone response for acute mental health issues, with referral to most appropriate acute response team.

Perth Metro Residents: 1300 555 788 (local call)

Peel Residents: 1800 676 822 (free call)

TTY: 1800 720 101 Rurallink: Phone 1800 552 002
13YARN National Aboriginal andTorres Strait Islander Crisis Support line 24 hours/day. Australian government funded and supported by Lifeline.
ASQ3 and ASQ :SE-2 assessment tools and activities
Beyond Blue
Bright Tomorrows Start Today
Circle of Security
Connected Parenting Attachment-based resources and eLearning health professionals to undertake early intervention and promote safe, secure relationships for Aboriginal families.
COPE (Centre of Perinatal Excellence) provides perinatal and postnatal advice and resources and free online education modules. Ready to COPE is a free app for pregnancy, birth and the first year of parenthood.
COPMI resource centre for children of parents with mental illness.
EPDS English and translated versions
embrace multicultural mental health Australian National platform for mental health services & multicultural communities to access resources, services and information.
Emerging Minds offers resources and free online training courses for parents and professionals to support children's mental health and wellbeing. Includes What is infant mental health, why is it important, and how can it be supported?
Finding help before and after baby arrives provides a list of general and mental health resources for individuals and families during pregnancy and after the birth.
ForWhen National PIMH support for expecting and new parents.
Gidget Foundation Offers Mums Matter Psychology, a bulk billing telehealth psychological support to pregnant and new parents (children 0-4), Start Talking telehealth program, and face to face services at Gidget House in Harrisdale. A mental health care plan from GP is required. Contact service for information about how to book an appointment.
Guidelines for Protecting Children 2020
Head to Health National service providing access to digital mental health services, information and support, including many suitable for the perinatal period.

Ishar Multicultural Women's Health Service providing refugee and migrant women with affordable and culturally sensitive care.
Lifeline Provides 24 hour access to crisis support, suicide prevention, and mental health support services. Phone: 13 11 14
National Perinatal Mental Health Guideline 2023 – COPE Includes assessment of perinatal mental health disorders, screening and psychosocial assessment for fathers and non-birthing partners, and management of psychological birth trauma.
Ngala offers Parenting helpline, ForWhen PIMH helpline, and some free community programs such as Attachment and Biobehavioural Catch-Up (ABC) and Mother Baby Nurture.
Mental Health Commission WA Mental health resources, services and information for community members and the mental health workforce.
Mother Baby Nurture A 10-week group to support mothers and infants (0-6 months)
PANDA: Perinatal Anxiety and Depression Australia, a not-for-profit organisation providing information and support for parents. National helpline no: 1300 726 306
Perinatal and infant mental health toolbox Statewide Perinatal and Infant Mental Health Program.
Pregnancy, Birth and Baby National Australian Government service. Telephone support from maternal child health nurse 7 days a week from 7am to 12MN (AEST), on 1800 882 436. Free from landline.
Raising Children Network provides parenting information from pregnancy to adolescence, as well as information on relationships, RCN - The First 1000 Days.
RUAH Community Services Supports vulnerable and disadvantaged people navigate homelessness, domestic violence and chronic mental health challenges.
Statewide Perinatal and Infant Mental Health Program Support WA health professionals and consumers (health promotion, education, training, & research)
Still face experiment by Dr Edward Tronik (YouTube)
Suicide Call Back Service provides crisis counselling to people at risk of suicide, carers for someone who is suicidal, and those bereaved by suicide, 24 hours per day 7 days a week across Australia. Phone: 1300 659 467
WA Perinatal Mental Health Referral Pathway Women's Health Strategy and Programs. EPDS scoring and risk categories, actions and possible referrals.
Western Australian Family Support Networks

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

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Appendix A: Infant and perinatal mental health: Supporting information

Note: This Appendix is **required reading** in order to implement the Infant and perinatal mental health procedure.

Mental health and wellbeing overview

General health and wellbeing is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. Like the other aspects of health, mental health can be affected by a range of socioeconomic factors such as poverty, chronic health conditions, conflict, discrimination, unemployment, homelessness, family and domestic violence, conflict, and natural disasters[21].

A state of mental well-being enables people to cope with the stresses of life, realise their abilities, learn and work well, and contribute to their community. It is an integral component of health and underpins our individual and collective abilities to make decisions, build relationships, and shape the world we live in[22].

Infant Mental Health

Infant mental health (IMH) may also be called emotional wellbeing, social and emotional health, or early relational health. Although referred to as IMH throughout this document, terms such as attachment and social and emotional health and wellbeing may be preferred in discussions with parents.

IMH refers to the capacity of infants to:

- form close and secure relationships
- experience, cope with, and express a range of emotions
- explore their environment and learn[9, 12, 23, 24].

IMH care is distinguished from child and youth sub-specialties through its emphasis on parent-infant relationships and the integral role of parents in assessment and treatment. For example, infants are developmentally unable to self-regulate their emotions. They only gradually develop this skill as children and young adults with support (known as co-regulation) from a parent who can regulate their own emotions and help the infant to organise its feelings[3].

IMH is dynamic and may change over time on a continuum between healthy and unwell. Deviations from normal mental health and the presence of developmental trauma can be identified in infancy[12] and are key predictors of an infant's risk for developing mental disorders later in life[9]. Strong evidence shows that infant mental health problems are not transitory, and without intervention may persist or worsen[12]. The prevalence of mental health disorders in infants and young children aged 1–5 years is 16–18%, with approximately half of these children being severely impacted[25].

A Western Australian study found that by age five, 20% of the children studied had clinically significant behavioural problems. Difficulties in early infancy include

regulatory disturbances such as sleeping or feeding difficulties, excessive crying, and attachment difficulties, while early childhood mental health concerns include externalising problems such as aggression and oppositional defiance, and internalising problems such as anxiety and depression[25, 26].

Community nurses have the opportunity to build and strengthen parenting capacity and confidence, and the ability to provide timely, predictable and 'good enough' care to their infant[10]. Parents may need information and support to understand that infants experience mental health as well as physical health, and that IMH needs nurturing and protecting by the parent. Recognising and accepting that their infant may be struggling emotionally promotes earlier support seeking. However, understanding that infants may be mentally unwell can be difficult due to stigma and misunderstandings that surround mental health[27].

Factors affecting infant mental health

Optimal child development requires good health, adequate nutrition, safety and security, responsive caregiving, and opportunities for learning[23, 28].

Experiences in infancy and childhood lay the foundations for lifelong mental health and wellbeing[29]. The infant is at its most adaptable but also its most vulnerable during the earliest stages of development from conception to the end of the second year. The foetus actively responds to changes in the environment, using cues provided by the mother's physical and mental state to 'predict' the kind of world they will be born into and alter their bodily structures accordingly. This powerful capacity of the foetus and infant enables adaption to adverse experiences in the short term, but may impact negatively on physical and mental health in the long-term.

Individual protective and risk factors impacting IMH include temperament, genetics, neurodevelopmental conditions, and general health. Family, parenting, and social determinants include parent availability, capacity and responsiveness, parental mental health, family and domestic violence, social supports, and physical environment[7, 12, 28, 30]. (See Factors impacting child health and development guideline and Supporting information resources) Around 8% of infants aged 0–1 year have 5 or more risk factors for developing later adult mental illness and this increases to 20% of 10-11 year-olds[31].

Consistent, sensitive and responsive parenting promotes relational trust and positive social, emotional and cognitive outcomes. It also buffers children from the negative effects of IMH risk factors[8, 28]. Unresolved disruptions in the development of safe and secure infant attachment can affect the infant's growth, development, play and learning, and their sleep and feeding patterns. It can also significantly impact their behaviour, infant mental health, and the gradual development of their ability to regulate their emotions[9, 23].

Early relational health is influenced by the way a parent or family member relates to an infant during the daily caregiving routines of feeding, changing nappies, bathing, and playing. This can be role-modelled by how a nurse attends to the infant and listens to the worries of new parents, affirming all the things they are already doing well, explaining appropriate developmental expectations, and helping them to recognise

what their infant is trying to communicate through their sometimes difficult and challenging behaviours.

While developmental trauma and mental illness can have a genetic component, they are also strongly linked to adverse childhood experiences (ACEs)[32, 33]. Such experiences may include physical, emotional or sexual abuse, physical or emotional neglect, and being in out-of-home care, and household dysfunction including mental illness, incarcerated relative, mother treated violently, substance abuse or separation/divorce[34].

Evidence also shows that positive childhood experiences (PCEs) protect later adult mental health, general health, and life outcomes, even in the face of ACEs[35]. Community health screening and interventions can help parents and families to identify PCEs such as supportive relationships for the infant with adults other than the parents, a safe, equitable, stable and culturally secure home and community environment, the family's social and community connections, and opportunities for play and interaction[36].

PIMH research recognises that relatives, teachers, faith leaders, neighbours, elected officials and all members of society share responsibility for supporting parents to optimise the quality of child development, eliminate ACEs, and to developing PCEs[32].

Attachment theory

Attachment is the unique bond between the infant and caregiver, and has evolved to protect the infant from threat or fear, when in real or perceived need of protection and soothing[10]. The infant adapts their attachment behaviours in response to the parent's caregiving[12, 37]. Parents can bond with their baby, but babies attach to their parents. Attachment is not strong or weak - it can only be secure/organised, insecure, or disorganised[10].

Infant signals indicate their attachment needs for coming closer to the parent and for maintaining proximity. These signals include smiling, reaching out, eye contact, calling out or crying, and resisting release. The parent's sensitivity and responses to these cues builds a two-way communication between the infant and parent. Secure attachment develops when a child learns to trust that their parent will respond consistently and sensitively to their signals[10, 38, 39]. Feeling secure then enables the infant to explore and learn from their surroundings, gaining the biological, cognitive, social, and emotional development required for their future adulthood[12].

Avoidant attachment is an organised but insecure attachment strategy. The infant appears disinterested in contact and avoids getting close to the caregiver with their eyes, body and face, even when they would normally need to approach for comfort[10].

Ambivalent or anxious attachment is also an organised but insecure attachment strategy. The infant shows low confidence in exploring and playing, and seeks but resists closeness and comforting from a parent, even when they need to be soothed[10].

Disorganised attachment is typified by conflict in the infant between the two attachment strategies of seeking proximity and maintaining contact. If the parent who is the source of protection for the infant is at the same time a source of uncertainty,

fear or threat, the infant's attachment system becomes disorganised. Disorganised attachment is a chief indicator of trauma within the relationship[10].

There are various factors that may interfere with the development of relational trust and secure attachment. The parent may find it difficult to be fully responsive to the infant, either because of mental health issues (e.g., postnatal depression, post-traumatic stress disorder) or their own developmental trauma. They may be preoccupied by stressful family circumstances (e.g., housing or financial insecurity, family violence). The infant may also be harder to engage with due to a more challenging temperament or social/communication difficulties related to developmental issues[28].

When the attachment process is disrupted, infant brain growth prioritises the development of neural pathways associated with survival over those required for future learning and growth. This can negatively impact language acquisition, cognitive and social development, and emotional regulation[4, 40], and may lead to problems with behaviour and school performance, and a higher risk of developing a mental health issue later in life[29, 41].

If an infant is unable to form a secure attachment with the primary carer they may still develop a secure attachment with another caregiver, such as the other parent or a grandparent. This supports the infant and helps them to optimise their growth and development[4].

Early relationships are important for the parent as well as the infant. For parents, these intimate caregiving experiences enrich maternal-infant bonding, decrease symptoms of maternal anxiety and depression, and improve physical health and emotional resilience[42].

Although research on parenting often focuses on the role of mothers or families in general, growing evidence indicates that fathers play a distinct, different role to mothers in supporting children's socialisation. For example, evidence supports that fathers typically play a more prominent role in facilitating play exploration which fosters emotional and behavioural self-regulation, while mothers are more likely to provide comfort in times of distress. Fathers who model positive behaviours such as accessibility, engagement and responsibility contribute to better psychosocial adjustment, better social competence and maturity, more positive child/adolescent-father relationships, and a significantly increased likelihood of secure attachment style. Moreover, poor quality early father-child relationships have been associated with an increased likelihood of mental health disorders such as depression, bipolar, anxiety disorders and phobias in later life, regardless of socioeconomic status and perceived quality of childhood maternal relationship[42, 43].

Perinatal mental health

Perinatal mental health and wellbeing of a parent is assessed during the period from conception to 12 months after the birth of the baby[7]. However, parental mental health needs to be considered in the community health setting beyond this timeframe[4].

A parent's capacity to consistently and sensitively meet the infant's needs and nurture healthy attachment is dependent on the parent's own mental health and wellbeing.

Therefore, any intervention to improve the infant's mental health or development must include at least a two-generational approach that also supports the physical, emotional, and psychological needs of the parent(s)[34].

Protective and risk factors for perinatal mental health

Individual protective factors that strengthen mental health and improve the ability to cope during difficult times include resilience and insight, self-esteem, good health, physical activity, and positive social supports. Wider influences include social supports, employment, education, and a sense of belonging [44].

Risk factors that can adversely impact perinatal mental health include previous and current mental health issues or experience of adverse life events, low socioeconomic status[45], or limited social support[4]. Adverse life events include bereavement, poverty, unemployment, family and domestic violence or history of abuse, substance misuse, or migration[4].

Early challenges

The transition to parenthood and the addition of a child to an existing family structure can be a complex and stressful time for all family members. It is common for new parents to experience adjustment difficulties until they become comfortable and confident in their new role[34, 46]. While this adjustment time can be brief for some, for others it can be long and distressing as they adjust to the many changes to their daily life and night-time sleep.

The 12-week period after birth is sometimes called the 'fourth trimester' and is a time of significant physical and emotional change as both mother and infant adjust to their new life. Significant challenges during this time include getting to know their new baby, recovery from the birth, heightened emotions, breastfeeding, coping with an unsettled infant and sleep deprivation, managing priorities, and changes in relationship dynamics[4]. Unrealistic expectations of motherhood and of infant development may result in stress, anxiety, or depression if the mother feels she is not coping, needs assistance, or finds the task of parenting more challenging than expected[47].

Hormonal changes during pregnancy, birth and postnatally can also increase a mother's susceptibility to mental illness[48]. Complications with conception or pregnancy, an unwanted pregnancy or an adverse birthing experience, difficulties with parenting such as infant feeding or sleeping issues, or a mismatch with an infant's temperament may increase the risk of developing mental health issues in the perinatal period[49]. However, perinatal mental health issues frequently occur in the absence of any identifiable risk[4].

Paternal mental health

Fathers have similar rates of mental health issues to mothers in the perinatal period[13]. However, the incidence of paternal depression rises to 24-50 % for men whose partners have perinatal depression[50].

Men differ from women by being more likely to express their perinatal mental health issues with anger, irritability, and lower impulse control[51]. Both men and women may mask depression with drug or alcohol use, or interpersonal conflict[4, 51].

Mental health issues for fathers may lead to relationship concerns, reduced desire for sexual intimacy, and difficulty bonding with the infant[52]. Infants whose father experienced perinatal depression are more likely to exhibit behavioural problems at age three[52] and at school entry[53]. Risk factors predisposing fathers to a mental health issue may include experiencing excessive stress surrounding the pregnancy or birth and fear for their partner[52], perceived lack of information, support, and inclusion in the pregnancy and birth process[52], a lack of acknowledgement of their role and needs[46, 54], childhood trauma[55], alcohol and other drug use [55], changes in their financial situation, and changes to their intimate relationship with their partner[53, 54].

Fathers can experience a number of barriers to seeking help. The focus is often on the mother's health, and men may access health professionals less frequently postnatally than their partner[52]. It is important that nurses provide an inclusive service for fathers, and screen for mental illness whenever possible[52]. Offering EPDS screening can promote communication, and assist fathers to access information and be pro-active in identifying and addressing their needs[4].

Mental health, family, and gender

Evidence around the importance of maternal perinatal mental health has been well documented. However, the impact of the perinatal period on fathers and co-parents remains an emerging area of research[4, 32, 34]. Although most parents seen with their babies in community health settings are still mothers, the increasing diversity of family structures and of work and infant care arrangements mean the primary caregiver may not be the birth-mother or female, many parents are single, and not all partners may be male.

Research suggests that parents who identify as Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) may be at a greater risk of developing perinatal anxiety and depression than other population groups. This is due to possible additional conception complications, discrimination, and potential relationship difficulties with their families of origin[56]. Understanding each family's context will support better understanding of their individual situation[1].

Additional impacts of perinatal mental health concerns

Perinatal mental health issues may contribute to:

- difficulties in relationships with partner or other family members[57]
- potential disruption to the caregiving behaviours that support relational trust and infant mental health[58, 59]
- inadequate self-care and nutrition
- drug and alcohol misuse
- social isolation
- suicidal thoughts or harm to themselves and/or infant.

Existing serious mental illness such as schizophrenia and bipolar disorder will require ongoing support of specialist services throughout the perinatal period as these conditions are risk factors for developing postnatal psychosis[4, 13]. This document and

the Infant and perinatal mental health procedure do not address the management of pre-existing conditions, but deal with the impact of mental health issues that develop or recur as a direct result of pregnancy and parenting. The maternal mental health conditions experienced most frequently in the perinatal period are perinatal depression and anxiety[13].

Perinatal depression

Perinatal depression is a term used to describe a sustained depressive disorder which can present in the antenatal and/or postnatal periods[4]. Perinatal depression is common, with up to 10% of women experience depression antenatally and up to 16% postnatally[13]. Common symptoms include a loss of interest in everyday life, lethargy, negative thinking and tearfulness, and withdrawal from regular activities. Depression is identified if these symptoms are experienced over a period of two weeks or more. It can affect a women's capacity to cope with day to day issues but in more severe cases, it can affect her ability to care for her infant and may lead to thoughts of suicide or self-harm[60].

Death by suicide was one of the leading causes of maternal death in Australia, accounting for 10% of maternal deaths (20 women) between 2012 and 2021 (AIHW 2024). Maternal death is defined as the death of a woman while pregnant or within 42 days of the end of pregnancy, irrespective of the duration and outcome of the pregnancy. Research indicates the risk of death by suicide may be even higher between 43 and 365 days after the end of pregnancy. In Queensland between 2014 and 2019, 31 of the 130 deaths during pregnancy and up to one year postpartum (24%) were by suicide, of which 27 (87%) occurred after 42 days postpartum[1].

Mental health screening is a critical tool for the early identification of women at risk of suicide, and can reduce the risk of perinatal suicide if supported by strong referral pathways that connect at-risk mothers to accessible mental health care and support[1].

Perinatal anxiety

Perinatal anxiety can be defined as excessive feelings of apprehension, worry, nervousness and stress out of proportion to the object of the worry, and affecting a parent's ability to complete daily tasks and develop secure relationships[1]. Approximately 20% of women experience perinatal anxiety, and the presence of anxiety disorders is a risk factor for the development of perinatal depression[4,13, 61]. Both depression and anxiety can lead to disinterest in regular activities, difficulty concentrating, sleep and appetite disturbances, and feelings of being overwhelmed[60].

Perinatal anxiety has been associated with reduced duration of breastfeeding, increased use of health services in the first six months, and perceived infant temperament problems[45]. Women with a history of untreated or unstable anxiety or depression may find their symptoms are exacerbated in the perinatal period.

Perinatal anxiety disorders may include generalised anxiety disorder (GAD), panic attack disorder, social anxiety, adjustment disorders with anxiety, post-traumatic stress disorder (PTSD)[45], obsessive compulsive disorder (OCD)[45], comorbid depression, and anxiety and phobias such as blood, needle, or tokophobia (fear of pregnancy)[4, 62, 63].

Intrusive thoughts

Intrusive thoughts are unwanted thoughts or images that are strange or disturbing. Nearly everyone experiences these thoughts, but they can become more frequent and disruptive when there are underlying problems such as anxiety, stress and sleeplessness. For some parents the possibility of dangers threatening their new baby may cause heightened vigilance and worry, and lead to repetitive or irrational behaviours or intrusive thoughts or images. This may be distressing, but is often not shared with others due to feelings of guilt or shame[20].

Postnatal psychosis

Postnatal psychosis, also known as puerperal psychosis, is a severe psychotic illness that occurs relatively rarely in 0.2% of postnatal women[13,64]. Symptoms relate to a loss of sense of reality, and may include hallucinations, paranoia and powerful delusions, as well as extreme mood swings, aggression, and agitation[65]. Psychosis is a psychiatric emergency due to the potential safety concerns for the affected woman and her infant[13].

Perinatal mental health screening

Perinatal mental health concerns can be identified through observation and/or disclosure, but may not be identified without screening. A holistic assessment of infant and parent wellbeing includes identifying parental strengths and risk factors as soon as possible. The nurse should discuss or yarn about the client's general health and wellbeing before offering screening. This optimises the assessment of emotional health and wellbeing and the psychosocial factors associated with mental health issues, and supports the discussion of the screening responses. As well as considering responses to questions, nurses must be familiar with signs of depression and anxiety including emotional state, body language, loss of touch with reality or the consequences of behaviour, and decreased ability to perform daily activities.

Standardised screening tools such as the Edinburgh Postnatal Depression Scale (EPDS) assist clinical judgement about parental mental health and status. Routine clinical screening is a simple and effective way to engage clients in discussing and managing their mental health.

Barriers to the parent engaging with a nurse about mental health issues may include fear of child removal, stigmatisation of mental illness, and concerns regarding breaches to their confidentiality[12, 16].

Studies show that mental health screening is broadly acceptable to parents[4, 47]. Therefore screening should be offered universally, both at scheduled visits and when there is parental or professional concern.

Edinburgh Postnatal Depression Scale (EPDS)[14]

The EPDS was developed in 1987 as a self-report questionnaire, and is used in many countries to screen for the risk of developing perinatal depression[17]. An anxiety subscale with cut-off scores for anxiety is also included. The EPDS is an easy to administer 10-item first stage screening questionnaire[66].

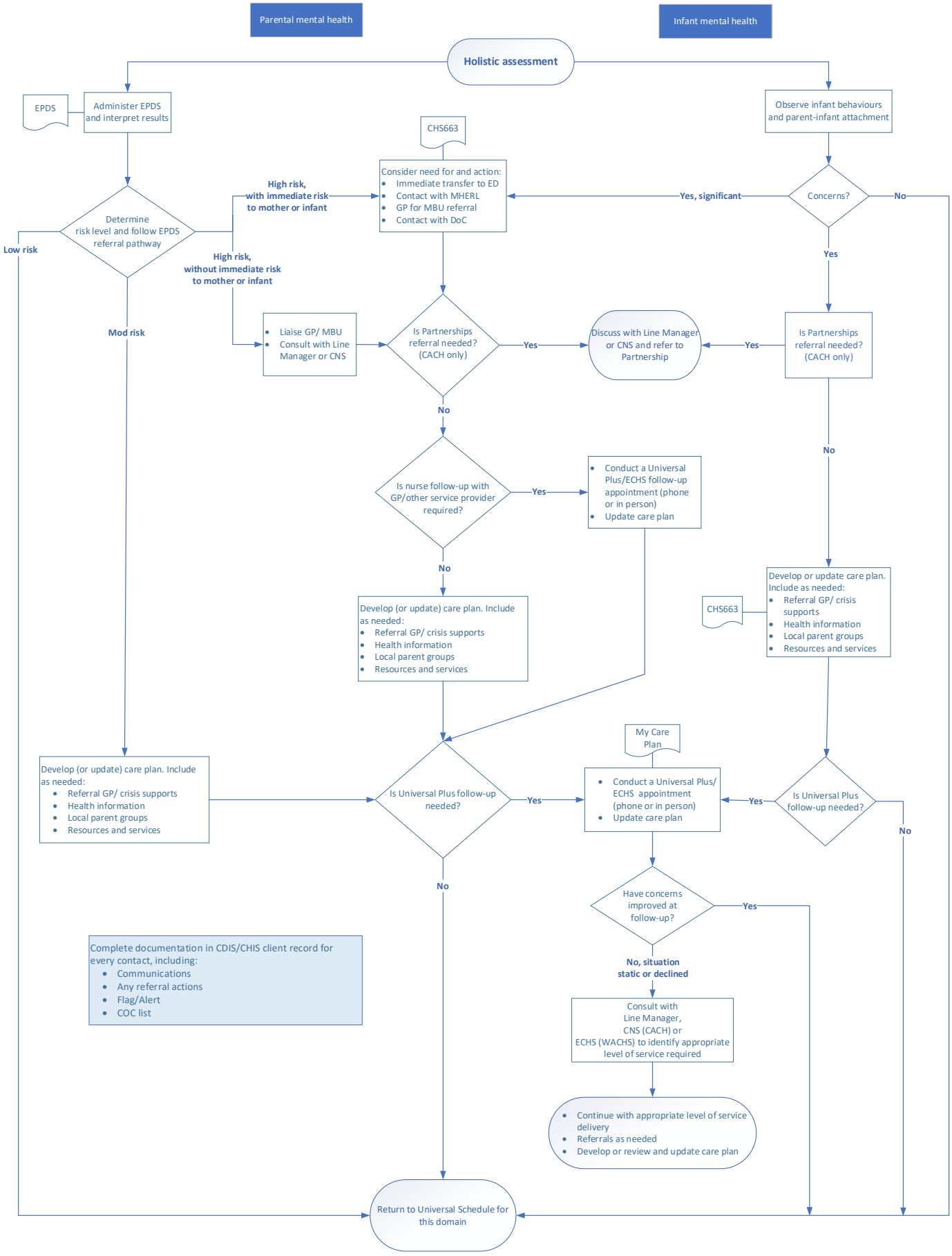
The EPDS is an indicator of the risk of depression and anxiety. It is a screening tool and NOT a diagnostic tool, and should be used in conjunction with a holistic assessment and professional judgement to identify parents who may benefit from follow-up or referral for mental health assessment and care.

The EPDS has been translated into 36 different languages with 18 being validated.[66] Each language version has a unique recommended cut-off score[66]. Challenges in administering the EPDS may relate to the fact that not all dialects are available in translated versions[67].

It is important to recognise that there are gender issues in mental health presentations, and different risk cut-off scores for women and men. The EPDS does not capture possible differences in signs of men's mental health issues, such as irritability, aggression and risk-taking behaviours. The EPDS has been used to screen fathers using a lower cut-off score, but evidence for which cut-off score is mixed[67]. The COPE Practice Guideline states that no evidence was identified on the performance or acceptability of mental health screening tools in co-mothers, step-parents or other partners including non-binary parents. Across the studies there was no consensus on the appropriate EPDS cut-off for screening fathers for mental health problems[1, 4].

Evidence shows a significant increase of prevalence of mental health diagnosis in the transgender population, and EPDS scoring should be considered with care for these parents[4, 14].

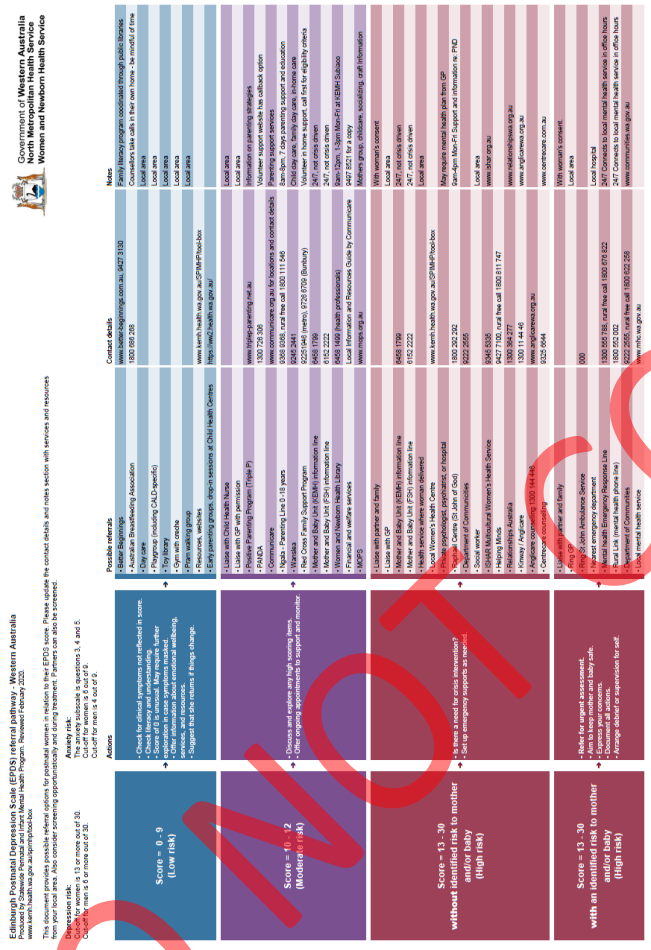
Appendix B: Process Flowchart – Infant and perinatal mental health concerns



Appendix C: Edinburgh Postnatal Depression Scale (EPDS) referral pathway – WA

NB: Always click on link to see the most up to date referral information.

The sample document below is for **illustration purposes only**. A copy of the most recent EPDS referral pathway can be found at the Statewide Perinatal and Infant Mental Health Program (resource tool box)



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