Clinical Guideline
Screening for Perinatal Anxiety and Depression Clinical Guideline

Policy developed by: SA Maternal & Neonatal Clinical Network
Approved SA Health Safety & Quality Strategic Governance Committee on:
07 September 2015
Next review due: 30 September 2018

Summary
Clinical practice guideline on screening women for perinatal anxiety and depression

Keywords
Anxiety, depression, Perinatal depression, mood swings, EPDS, Edinburgh Postnatal depression scale, psychosocial questionnaire, antenatal risk questionnaire, ANRQ, screening for perinatal anxiety and depression, clinical guideline

Policy history
Is this a new policy? N
Does this policy amend or update an existing policy? Y v1.0
Does this policy replace an existing policy? N

Applies to
All SA Health Portfolio
All Department for Health and Ageing Divisions
All Health Networks
CALHN, SALHN, NALHN, CHSALHN, WCHN, SAAS

Staff impact
All Staff, Management, Admin, Students, Volunteers
All Clinical, Medical, Nursing, Allied Health, Emergency, Dental, Mental Health, Pathology

PDS reference CG224

Version control and change history

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<th>Date to</th>
<th>Amendment</th>
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<td>1.0</td>
<td>21 Sept 2010</td>
<td>07 Sept 2015</td>
<td>Original version</td>
</tr>
<tr>
<td>2.0</td>
<td>07 Sept 2015</td>
<td>Current</td>
<td>Reviewed</td>
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South Australian Perinatal Practice Guidelines
screening for perinatal anxiety and depression

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Note

This guideline provides advice of a general nature. This statewide guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. The guideline is based on a review of published evidence and expert opinion.

Information in this statewide guideline is current at the time of publication.

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Health practitioners in the South Australian public health sector are expected to review specific details of each patient and professionally assess the applicability of the relevant guideline to that clinical situation.

If for good clinical reasons, a decision is made to depart from the guideline, the responsible clinician must document in the patient’s medical record, the decision made, by whom, and detailed reasons for the departure from the guideline.

This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing care with consumers in an environment that is culturally appropriate and which enables respectful confidential discussion. This includes:

• The use of interpreter services where necessary,
• Advising consumers of their choice and ensuring informed consent is obtained,
• Providing care within scope of practice, meeting all legislative requirements and maintaining standards of professional conduct, and
• Documenting all care in accordance with mandatory and local requirements

Explanation of the aboriginal artwork:
The aboriginal artwork used symbolises the connection to country and the circle shape shows the strong relationships amongst families and the aboriginal culture. The horse shoe shape design shown in front of the generic statement symbolises a woman and those enclosing a smaller horse shoe shape depicts a pregnant women. The smaller horse shoe shape in this instance represents the unborn child. The artwork shown before the specific statements within the document symbolises a footprint and demonstrates the need to move forward together in unison.

Australian Aboriginal Culture is the oldest living culture in the world yet Aboriginal people continue to experience the poorest health outcomes when compared to non-Aboriginal Australians. In South Australia, Aboriginal women are 2-5 times more likely to die in childbirth and their babies are 2-3 times more likely to be of low birth weight. The accumulative effects of stress, low socioeconomic status, exposure to violence, historical trauma, culturally unsafe and discriminatory health services and health systems are all major contributors to the disparities in Aboriginal maternal and birthing outcomes. Despite these unacceptable statistics the birth of an Aboriginal baby is a celebration of life and an important cultural event bringing family together in celebration, obligation and responsibility. The diversity between Aboriginal cultures, language and practices differ greatly and so it is imperative that perinatal services prepare to respectively manage Aboriginal protocol and provide a culturally positive health care experience for Aboriginal people to ensure the best maternal, neonatal and child health outcomes.
Literature review

> Antenatal anxiety and depression often occur together. Postnatal depression and / or anxiety often follow.\(^1,2\)
> Prevalence of antenatal depression is reported as 7.4 % in the 1st Trimester, 12.8 % in the 2nd Trimester, 12.0 % in the 3rd Trimester\(^3\)
> Maternal distress during pregnancy influences obstetric and birth outcomes\(^4\)
> Effects of maternal anxiety in pregnancy can adversely affect the developing fetal brain\(^5\)
> Maternal anxiety / depression has been associated with difficult infant temperament\(^6\), increased infant cortisol levels\(^7\), cognitive, emotional and behavioural difficulties in childhood\(^1,8\)
> As perinatal depression can begin before birth and extends beyond 6 weeks postpartum – (by definition at any time until 12 months postpartum):
  > Depression surveillance is warranted during antenatal visits, at the postnatal check-up, and at paediatric visits during the first postnatal year\(^9\)
  > All professionals working with antenatal and postnatal women should routinely inquire about mood, anxiety and coping abilities
> Many women with perinatal mental health disorders are not diagnosed or treated\(^10\). Screening has been shown to improve detection and referral for treatment\(^11\). It is the first step towards reducing the impact of perinatal depression\(^12\).
> Antenatal screening of depression using the EPDS\(^13\) is generally associated with adequate sensitivity and specificity to detect possible depression using a score of 13 or more\(^13-18\)
> Psychosocial risk factors can be screened using the AnteNatal Risk Questionnaire (ANRQ)\(^19\)
> Early identification with intensive postnatal follow up is a valuable psychosocial intervention for postnatal depression\(^20\)

Risk factors

Psychological

> Antenatal anxiety, depression or mood swings
> Previous history of anxiety, depression, or mood swings, especially if occurred perinatally
> Family history of anxiety, depression or alcohol abuse, especially in first degree relatives
> Severe baby blues
> Personal characteristics like guilt-prone, perfectionistic, feeling unable to achieve, low self-esteem
> Edinburgh Postnatal Depression Scale score ≥ 13 (See Appendix I)\(^21\)

Social

> Lack of emotional and practical support from partner and / or others
> Domestic violence, history of trauma or abuse (including childhood sexual abuse)
> Many recent stressful life events
> Low socioeconomic status, unemployment
> Unplanned or unwanted pregnancy
> Expecting first child or has many children already
> Child care stress\(^21\)

Biological / medical

> Ceased psychotropic medications recently
> Medical history of serious pregnancy or birth complications, neonatal loss, poor physical health, chronic pain or disability, or premenstrual syndrome
> Perinatal sleep deprivation
Neonatal medical problems or difficult temperament
Where risks are identified, document details about the nature and degree of risk in the case notes

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

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

The Edinburgh Postnatal Depression Scale
> The EPDS (Appendix I) screens for current symptoms of depression
> Symptoms and management according to EPDS score are described in Appendix II
> It was developed as a screening tool for postnatal depression and has also been used successfully antenatally. It does not diagnose depression but raises awareness of mood problems which need further exploration and follow up.
> Question 10 is about thoughts of self harm. Positive answers to question 10 need to be explored further by conducting a risk assessment, looking at current plans, frequency of thoughts, intent, reasons for / against etc. For further information, see suicidal ideation and self harm at www.sahealth.sa.gov.au/perinatal in the A to Z index
> For women who score 10, 11 or 12; administration of the EPDS should be repeated within one month and existing support services reviewed and increased if necessary. A score of 13 or higher requires offer of follow-up support or referral. Women with high scores (e.g. 15 or more) should have access to timely mental health assessment and management, current safety and care of other children should be considered (Appendix II)
> The scale should be completed at least once antenatally and at least once postnatally
> Antenatal scores should be communicated on referral to Child and Family Health Service
Instructions:
> Ask the mother to underline or tick the response which comes the closest to how she has felt over the past 7 days
> All 10 questions must be completed
> The woman should fill it out without help from others. However, if needed she may have the questions read out to her by the clinician or an interpreter
> The EPDS is available in many different languages however and may be used as a self-report scale in the woman’s own language and scored in the standard way

Psychosocial Questionnaire
> Psychosocial risk factors can be identified using the Antenatal Risk Questionnaire (ANRQ)\(^1\). See Appendix III
> The ANRQ is a self-report psychosocial assessment tool which is highly acceptable to both women and staff. In combination with the EPDS and routine questions relating to drug and alcohol use and domestic violence, the ANRQ is most useful as a key element of a “screening intervention” aimed at the early identification of mental health risk and morbidity across the perinatal period
> See Appendix IV for a guide to scoring of the ANRQ. A score of over 23 or endorsement of critical questions (item no’s 2 AND 2a or 2b, OR Q 8 or 9) requires further assessment and / or appropriate referral (e.g. to social work)

Conducting a mental health conversation
> Understand your own responses to stress: be alert to your attempts to withdraw or try to control and take over the situation
> Recognise anxiety in the client. Acknowledge the issue and the client’s feelings and delve deeper to develop a plan
> Remember compassion and kindness; an empathic response is more likely to get the client to open up
> Listening more than talking, to enable following the clients cues in facilitating the conversation
> Ensure you have regular clinical supervision
> Be reassured that asking a client directly about suicide and self harm does not increase the risk of it happening

Postpartum care
> Screening 2 months after delivery detects most mothers who become depressed during the first 6 postpartum months\(^2\)\(^4\)
> The EPDS should be completed by all women at their Universal Contact Visit with a Child and Family Health nurse. If this appointment is missed the EPDS should be competed at their 6 week check-up (usually with GP)
> Psychosocial risk factors can be identified using the PostNatal Risk Questionnaire (PNRQ)\(^1\). See Appendix V
> The PNRQ is a self-report psychosocial assessment tool which is highly acceptable to both women and staff. In combination with the EPDS and routine questions relating to drug and alcohol use and domestic violence, the PNRQ is most useful as a key element of a “screening intervention” aimed at the early identification of mental health risk and morbidity across the perinatal period
> See Appendix VI for a guide to scoring of the PNRQ. A score of over 24 or endorsement of critical questions (item no’s 2 AND 2a or 2b, OR Q 8 or 9) requires further assessment and / or appropriate referral (e.g. to social work)
Referral Pathways

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

Appendix VII – Metropolitan pathway
Appendix VIII – Country pathway
Appendix IX – CaFHS postnatal pathway
South Australian Perinatal Practice Guidelines
screening for perinatal anxiety and depression

References


Useful web sites

Royal Australian College of General Practitioners (RACGP)
Perinatal depression – assessment and management

Beyond blue
Link to page with translated versions of the booklet ‘Emotional health during pregnancy and early parenthood’

Post & Ante Natal Depression Association (PANDA)
Information leaflets, telephone counselling and service information
Appendix I:
The Edinburgh Postnatal Depression Scale - (Cox et al. 1987)

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
</table>
| 1. I have been able to laugh and see the funny side of things:           | > 0 As much as I always could  
> 1 Not quite so much now  
> 2 Definitely not so much now  
> 3 Not at all                                                             |
| 6. Things have been getting on top of me:                                | > 3 Yes, most of the time  
> 2 Yes, sometimes  
> 1 Not very often  
> 0 No, not at all                                                        |
| 2. I have looked forward with enjoyment to things:                        | > 0 As much as I ever did  
> 1 Rather less than I used to  
> 2 Definitely less than I used to  
> 3 Hardly at all                                                          |
| 7. I have been so unhappy that I have had difficulty sleeping:           | > 3 Yes, most of the time  
> 2 Yes, sometimes  
> 1 Not very often  
> 0 No, not at all                                                         |
| 3. I have blamed myself unnecessarily when things went wrong:            | > 3 Yes, most of the time  
> 2 Yes, some of the time  
> 1 Not very often  
> 0 No, never                                                               |
| 8. I have felt sad or miserable:                                        | > 3 Yes, most of the time  
> 2 Yes, quite often  
> 1 Not very often  
> 0 No, not at all                                                         |
| 4. I have been anxious or worried for no good reason:                   | > 0 No, not at all  
> 1 Hardly ever  
> 2 Yes, sometimes  
> 3 Yes, very often                                                        |
| 9. I have been so unhappy that I have been crying:                      | > 3 Yes, most of the time  
> 2 Yes, quite often  
> 1 Only occasionally  
> 0 No, never                                                               |
| 5. I have felt scared or panicky for no very good reason:               | > 3 Yes, quite a lot  
> 2 Yes, sometimes  
> 1 No, not much  
> 0 No, not at all                                                          |
| 10. The thought of harming myself has occurred to me:                   | > 3 Yes, quite often  
> 2 Sometimes  
> 1 Hardly ever  
> 0 Never                                                                   |

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

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

This is a screening tool only, and should not be used to diagnose depression.
### Appendix II: Management according to EPDS score

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

Name: ____________________________________________  Today’s Date: _____/_____/______

Weeks Pregnant: ________  Due date:  ____/_____/______

Phone (h) ___________________ (w) ___________________ (m)_____________________

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

<table>
<thead>
<tr>
<th>TOTAL</th>
</tr>
</thead>
</table>

1. When you were growing up, did you feel your mother was emotionally supportive of you?  
(If you had no mother circle 6).

2. a) Have you ever had 2 weeks or more when you felt particularly worried, miserable or depressed?  
Yes ☐ No ☐

b) Do you have any other history of mental health problems?  
Yes ☐ No ☐  
e.g. eating disorders, psychosis, bipolar disorder, schizophrenia. Please specify: ____________________________

If Yes to 2a or 2b, did this:

c) Seriously interfere with your work and your relationships with friends and family?  
Yes ☐ No ☐

d) Lead you to seek professional help?  
Yes ☐ No ☐

Did you see a: Psychiatrist ☐ Psychologist / Counsellor ☐ GP ☐

(Name of professional)

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

3. Is your relationship with your partner an emotionally supportive one?  
(If you have no partner circle 6)

4. a) Have you had any stresses, changes or losses in the last 12 months  
(e.g. separation, domestic violence, unemployment, bereavement ?)  
Yes ☐ No ☐  
Please list:________________________________________

b) How distressed were you by these stresses, changes or losses?

5. Would you generally consider yourself a worrier?

6. In general, do you become upset if you do not have order in your life (e.g. regular time table, a tidy house)?

7. Do you feel you have people you can depend on for support with your baby?

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

9. Have you ever been sexually ☐ or physically ☐ abused?

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

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Appendix IV: AnteNatal Risk Questionnaire scoring system

ANTENATAL RISK QUESTIONNAIRE (ANRQ)

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

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

1. Requirements for the ANRQ

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

2. Scoring Instructions for the ANRQ

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

ii. For items 1, 2c, 3, 4b, 5, 6, 7:
   c. **Score the number circled** and place the scores in the boxes along the right hand side.

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

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

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

Must be considered high risk irrespective of the total ANRQ score

iv. Minimum score is 5; Maximum score is 67

v. There is no absolute cut-off score for the ANRQ, but a score of 23 or more suggests presence of significant psychosocial risk factors, and consideration of the woman as at significant risk of perinatal mental health problems. Further enquiry is indicated to establish psychosocial care needs and treatment planning.
Appendix V: PostNatal Risk Questionnaire (PNRQ)

Name: ___________________________________________  Today's Date: ______/_____/_____

Phone (h) ____________________ (w) ____________________ (m) ____________________

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

1. When you were growing up, did you feel your mother was emotionally supportive of you? (If you had no mother circle 6).

2. a) Have you ever had 2 weeks or more when you felt particularly worried, miserable or depressed?  
Yes □ No □

b) Do you have any other history of mental health problems? e.g. eating disorders, psychosis, bipolar disorder, schizophrenia. 
Yes □ No □ Please specify ______________________

If Yes to 2a or 2b, did this:

c) Seriously interfere with your work and your relationships with friends and family?  
Yes □ No □

Did you see a: Psychiatrist □ Psychologist / Counsellor □ GP □ 
(Name of professional) ____________________________

3. Is your relationship with your partner an emotionally supportive one? (If you have no partner circle 6)

4. a) Have you had any stresses, changes or losses in the last 12 months (e.g. separation, domestic violence, unemployment, bereavement?)
Yes □ No □ Please list: _______________________________________

b) How distressed were you by these stresses, changes or losses?

5. Would you generally consider yourself a worrier?

6. In general, do you become upset if you do not have order in your life (e.g. regular time table, a tidy house)?

7. Do you feel you have people you can depend on for support with your baby?

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

9. Have you ever been sexually □ or physically □ abused?  
Yes □ No □

10. Was your experience of giving birth to this baby disappointing or frightening?  
Yes □ No □

11. Has your experience of parenting this baby been a positive one?

12. Overall, has your baby been unsettled or feeding poorly?

How comfortable did you feel in completing this questionnaire?

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

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Appendix VI: PostNatal Risk Questionnaire scoring system

POSTNATAL RISK QUESTIONNAIRE (PNRQ)

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

PNRQ Questionnaire components include:

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

1. Requirements for the PNRQ

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

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

2. Scoring Instructions for the PNRQ

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

ii. For items 1, 2c, 3, 4b, 5, 6, 7, 10, 11, 12:
   c. Score the number circled and place the scores in the boxes along the right hand side.

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

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

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

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

iv. Minimum score is 8; Maximum score is 82

v. There is no absolute cut-off score for the PNRQ, but a score of 24 or more suggests presence of significant psychosocial risk factors, and consideration of the woman as at significant risk of perinatal mental health problems. Further enquiry is indicated to establish psychosocial care needs and treatment planning.
## Appendix VII: Antenatal Screening Pathways (Generic – Metropolitan)

<table>
<thead>
<tr>
<th>RISK</th>
<th>SCORE</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No Risk</strong></td>
<td><strong>EPDS 10 or below ANRQ/PNRQ below 24</strong></td>
<td><strong>No referral required</strong></td>
</tr>
<tr>
<td></td>
<td>▪ MH symptoms low</td>
<td>▪ Offer contact details of PMHT</td>
</tr>
<tr>
<td></td>
<td>▪ Social risk factors low</td>
<td>▪ Offer Beyond Blue “Emotional health” booklet</td>
</tr>
<tr>
<td></td>
<td>▪ No history of abuse</td>
<td>▪ Offer Beyond Blue “Emotional health” booklet</td>
</tr>
<tr>
<td></td>
<td>▪ No psychiatric history</td>
<td>▪ Monitor for distress at each visit – repeat EPDS</td>
</tr>
<tr>
<td><strong>Low Risk</strong></td>
<td><strong>EPDS equals 11 or 12 ANRQ/PNRQ any item above 3</strong></td>
<td><strong>Refer to Social Work or PMHT</strong></td>
</tr>
<tr>
<td></td>
<td>▪ Past psychiatric history - not current</td>
<td>▪ Offer CSA, DV booklets if appropriate</td>
</tr>
<tr>
<td></td>
<td>▪ Monitor for distress at each visit</td>
<td>▪ Offer Beyond Blue “Emotional health”</td>
</tr>
<tr>
<td><strong>Moderate Risk</strong></td>
<td><strong>EPDS below 13 ANRQ/PNRQ above 24</strong></td>
<td><strong>Refer to PMHT</strong></td>
</tr>
<tr>
<td></td>
<td>▪ MH symptoms low</td>
<td>▪ Offer Beyond Blue “Emotional health”</td>
</tr>
<tr>
<td></td>
<td>▪ Social risk factors high</td>
<td>▪ Offer CSA, DV booklets if appropriate</td>
</tr>
<tr>
<td></td>
<td>▪ Psychiatric history - current</td>
<td>▪ Offer Beyond Blue “Emotional health”</td>
</tr>
<tr>
<td></td>
<td>▪ Early attachment issues</td>
<td>▪ Offer Beyond Blue “Emotional health”</td>
</tr>
<tr>
<td></td>
<td>▪ Domestic Violence</td>
<td>▪ Offer Beyond Blue “Emotional health”</td>
</tr>
<tr>
<td></td>
<td>▪ History of abuse</td>
<td>▪ Offer Beyond Blue “Emotional health”</td>
</tr>
<tr>
<td><strong>Moderate Symptoms</strong></td>
<td><strong>EPDS equals 13 ANRQ/PNRQ below 24</strong></td>
<td><strong>Immediate referral to PMHT by phone or within 24 hours</strong></td>
</tr>
<tr>
<td></td>
<td>▪ MH symptoms high</td>
<td>▪ Advise re: emergency services</td>
</tr>
<tr>
<td></td>
<td>▪ Social risk factors low</td>
<td>▪ Gently explore if the question is understood</td>
</tr>
<tr>
<td></td>
<td>▪ Early attachment issues</td>
<td>▪ Urgent/ Immediate referral to PMHT, ACIS or Emergency Dept.</td>
</tr>
<tr>
<td></td>
<td>▪ Domestic Violence</td>
<td>▪ Urgent/ Immediate referral to Social Work Services, Domestic violence services, Families SA, Police</td>
</tr>
<tr>
<td></td>
<td>▪ History of abuse</td>
<td>▪ Check safety</td>
</tr>
<tr>
<td><strong>High Risk/Complex Needs</strong></td>
<td><strong>EPDS above 13 ANRQ/PNRQ 24 or above</strong></td>
<td><strong>Positive score for Q 10 of the EPDS</strong></td>
</tr>
<tr>
<td></td>
<td>▪ MH symptoms high</td>
<td>▪ Yes, quite often</td>
</tr>
<tr>
<td></td>
<td>▪ Social risk factors high</td>
<td>▪ Sometimes</td>
</tr>
<tr>
<td></td>
<td>▪ Current domestic violence</td>
<td>▪ Acute emotional distress</td>
</tr>
<tr>
<td><strong>High Risk/Mental Health</strong></td>
<td><strong>EPDS equals 13 ANRQ/PNRQ below 24</strong></td>
<td>▪ Current domestic violence</td>
</tr>
<tr>
<td></td>
<td>▪ MH symptoms high</td>
<td>▪ Acute emotional distress</td>
</tr>
<tr>
<td></td>
<td>▪ Social risk factors high</td>
<td>▪ Current domestic violence</td>
</tr>
<tr>
<td><strong>High Risk Social</strong></td>
<td><strong>EPDS above 13 ANRQ/PNRQ above 24</strong></td>
<td>▪ Current domestic violence</td>
</tr>
<tr>
<td></td>
<td>▪ MH symptoms high</td>
<td>▪ Acute emotional distress</td>
</tr>
<tr>
<td></td>
<td>▪ Social risk factors high</td>
<td>▪ Current domestic violence</td>
</tr>
<tr>
<td></td>
<td>▪ Early attachment issues</td>
<td>▪ Acute emotional distress</td>
</tr>
<tr>
<td></td>
<td>▪ Domestic Violence</td>
<td>▪ Current domestic violence</td>
</tr>
<tr>
<td></td>
<td>▪ History of abuse</td>
<td>▪ Acute emotional distress</td>
</tr>
</tbody>
</table>

- EPDS: Edinburgh Postnatal Depression Scale
- ANRQ: Antenatal Risk Questionnaire
- PNRQ: Postnatal Risk Questionnaire
- PMHT: Perinatal Mental Health Team
- CSA: Centre for Stepping Stones
- DV: Domestic Violence
- ACIS: Australian Centre for Developing Inclusionary Services
- SA: South Australia
- SA Health: Government of South Australia
### No Risk
- N/A unless circumstances change

### Low Risk
- N/A unless circumstances change

### Moderate Risk
- Social work will undertake an assessment, and refer on as appropriate

### Moderate Symptoms
- PMHT will undertake a comprehensive mental health & risk assessment
- PMHT develop care plan and provide follow up
- Referral on as needed e.g. specialist PMH services, community services, groups
- GP for ATAPS - psychologist

### High Risk/Complex Needs
- PMHT will undertake a comprehensive mental health & risk assessment
- PMHT develop care plan and provide follow up
- Referral on as needed e.g. specialist PMH services, community services, groups
- GP for ATAPS - psychologist

### High Risk/Mental Health
- PMHT/Emergency Dept or ACIS to undertake a comprehensive mental health & risk assessment
- Referral for hospital admission as necessary
- PMHT develop care plan and provide follow up

### High Risk/Social
- Social worker to undertake family risk assessment, coordinate follow up
- Referral to PMHT as required

Score indicates referral required to social work service or PMHT, BUT woman declines referral
- Send letter to GP (with client consent)
- Document in progress notes
- Offer Beyond Blue information: "Emotional health during pregnancy and early parenthood booklet”.
- Offer contact details of PMHT team, to allow the woman to self-refer in the future.

<table>
<thead>
<tr>
<th>DOCUMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Document score in progress notes, handheld record, database</td>
</tr>
<tr>
<td>• Document score in progress notes, handheld record, database</td>
</tr>
<tr>
<td>• Document score in progress notes, handheld record, database</td>
</tr>
<tr>
<td>• Document score in progress notes, handheld record, database</td>
</tr>
<tr>
<td>• Document score in progress notes, handheld record, database</td>
</tr>
<tr>
<td>• Document score in progress notes, handheld record, database</td>
</tr>
<tr>
<td>• Document score in progress notes, handheld record, database</td>
</tr>
</tbody>
</table>

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**South Australian Perinatal Practice Guidelines**

**screening for perinatal anxiety and depression**

ISBN number: 978-1-74243-051-5

Endorsed by: South Australian Maternal & Neonatal Clinical Network

Last Revised: 07/09/15

Contact: South Australian Perinatal Practice Guidelines workgroup at: HealthCYWHSPerinatalProtocol@sa.gov.au
screening for perinatal anxiety and depression

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

Contact:  South Australian Perinatal Practice Guidelines workgroup at: HealthCYWSPerinatalProtocol@sa.gov.au
### Appendix VIII: Antenatal Screening Pathways (Generic – Country)

<table>
<thead>
<tr>
<th>Risk</th>
<th>No Risk</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>Moderate Symptoms</th>
<th>High Risk/Complex Needs</th>
<th>High Risk/Mental Health</th>
<th>High Risk Social</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Score</strong></td>
<td>EPDS 10 or below ANRQ below 24</td>
<td>EPDS equals 11 or 12 ANRQ above 24</td>
<td>EPDS below 13 ANRQ above 24</td>
<td>EPDS equals 13 ANRQ below 24</td>
<td>EPDS above 13 ANRQ 24 or above</td>
<td>Positive score for Q 10 of the EPDS</td>
<td></td>
</tr>
<tr>
<td><strong>Referral</strong></td>
<td>No referral required</td>
<td>Referral not required</td>
<td>Referral to PMHT or Social Work and counselling services</td>
<td>Referral to PMHT</td>
<td>Immediate referral to PNHNT / ETLS by phone or within 24 hours</td>
<td>Gently explore if the question is understood</td>
<td>Urgent/Immediate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Referral to appropriate local services</td>
<td>Referral to appropriate local services</td>
<td>Advise re emergency services</td>
<td>Urgent/Immediate referral to PMHT, ETLS or Emergency Dept.</td>
<td>referral to Social</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Offer CSA, DV booklets if appropriate</td>
<td>Offer Beyond Blue “Emotional health” CSA, DV booklets if appropriate</td>
<td>Referral to appropriate local services</td>
<td></td>
<td>Work Services,</td>
</tr>
<tr>
<td></td>
<td>- Progress notes</td>
<td>- Progress notes</td>
<td>- Progress notes</td>
<td>- Progress notes</td>
<td>- Progress notes</td>
<td>- Progress notes</td>
<td>- Progress notes</td>
</tr>
<tr>
<td></td>
<td>- CPS &amp; or other database</td>
<td>- CPS &amp; or other database</td>
<td>- CPS &amp; or other database</td>
<td>- CPS &amp; or other database</td>
<td>- CPS &amp; or other database</td>
<td>- CPS &amp; or other database</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### RISK
- No Risk
- Low Risk
- Moderate Risk
- Moderate Symptoms
- High Risk/Complex Needs
- High Risk/Mental Health
- High Risk Social

#### SCORE
- EPDS 10 or below
- ANRQ below 24

#### Referral
- No referral required
- Social work &/or referral to appropriate local services if indicated or requested
- Monitor for distress at each visit
- Referral to PMHT or Social Work and counselling services
- Referral to appropriate local services
- Offer CSA, DV booklets if appropriate
- Offer Beyond Blue “Emotional health” CSA, DV booklets if appropriate
- Immediate referral to PNHNT / ETLS by phone or within 24 hours
- Advise re emergency services
- Referral to appropriate local services

#### Documentation
- Progress notes
- SA Pregnancy record
- CPS & other database

- Progress notes
- SA Pregnancy record
- CPS & other database

- Progress notes
- SA Pregnancy record
- Complete referral & send with questionnaires

- Progress notes
- SA Pregnancy record
- Complete referral by phone & send hardcopy and questionnaires
- CPS & other database

- Progress notes
- SA Pregnancy record
- Complete referral by phone & send hardcopy and questionnaires
- CPS & other database

- Progress notes
- SA Pregnancy record
- Complete referral by phone & send hardcopy and questionnaires
- CPS & other database
### Score indicates referral required to social work service or PMHT, BUT woman declines referral
- Send letter to GP (with client consent)
- Document in progress notes
- Offer Beyond Blue information: “Emotional health during pregnancy and early parenthood booklet”.
- Offer contact details of PMHT team, to allow the woman to self-refer in the future.

<table>
<thead>
<tr>
<th>PATHWAYS OF CARE</th>
<th>NO RISK</th>
<th>LOW RISK</th>
<th>MODERATE RISK</th>
<th>MODERATE SYMPTOMS</th>
<th>HIGH RISK/COMPLEX NEEDS</th>
<th>HIGH RISK/MENTAL HEALTH</th>
<th>HIGH RISK/SOCIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offer contact details of PMHT team</td>
<td>Offer contact details of PMHT team</td>
<td>Offer Social Work Services, Childhood sexual abuse services, Domestic violence services, other appropriate local services</td>
<td>PMHT will undertake a comprehensive mental health assessment &amp; risk assessment</td>
<td>PMHT will undertake a comprehensive mental health assessment &amp; risk assessment</td>
<td>PMHT/Emergency Dept or ETLS to undertake a comprehensive mental health assessment &amp; risk assessment</td>
<td>PMHT/Emergency Dept or ETLS to undertake a comprehensive mental health assessment &amp; risk assessment</td>
<td></td>
</tr>
<tr>
<td>Offer Beyond Blue information: “Emotional health during pregnancy and early parenthood” booklet</td>
<td>Offer Beyond Blue information: “Emotional health during pregnancy and early parenthood” booklet</td>
<td>Offer contact details of PMHT team</td>
<td>Treatment and referral for specialist services as required</td>
<td>Treatment and referral for specialist services as required</td>
<td>Treatment and referral for specialist services as required</td>
<td>Treatment and referral for specialist services as required</td>
<td></td>
</tr>
<tr>
<td>Midwife/Doctor to repeat EPDS if clinical concerns</td>
<td>PMHT/ social work develop care plan and provide follow up</td>
<td>PMHT/ social work develop care plan and provide follow up</td>
<td>PMHT develop care plan and provide follow up</td>
<td>PMHT develop care plan and provide follow up</td>
<td>PMHT develop care plan and provide follow up</td>
<td>PMHT develop care plan and provide follow up</td>
<td></td>
</tr>
<tr>
<td>FOLLW UP</td>
<td>PMHT will undertake a comprehensive mental health assessment &amp; risk assessment</td>
<td>PMHT develop care plan and provide follow up</td>
<td>Ongoing high level of support</td>
<td>Ongoing high level of support</td>
<td>Ongoing high level of support</td>
<td>Ongoing high level of support</td>
<td></td>
</tr>
</tbody>
</table>

**Legend**

- N/A unless circumstances change
- No Risk
- Low Risk
- Moderate Risk
- Moderate Symptoms
- High Risk/Complex Needs
- High Risk/Mental Health
- High Risk/Social

**Contact:**
South Australian Perinatal Practice Guidelines workgroup at: HealthCYWHSPerinatalProtocol@sa.gov.au

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### Appendix IX: Postnatal Screening Pathways (CaFHS)

<table>
<thead>
<tr>
<th>Risk</th>
<th>No Risk</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>Moderate Symptoms</th>
<th>High Risk/Complex Needs</th>
<th>High Risk/Mental Health</th>
<th>High Risk Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hx</td>
<td>History</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>ANRQ</td>
<td>Antenatal Risk Assessment Questionnaire</td>
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<td></td>
<td></td>
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<td></td>
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<tr>
<td>ATAPS</td>
<td>Access to Allied Health Professionals Scheme (Via Divisions of General Practice)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPS</td>
<td>Clinical Practice Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EPDS</td>
<td>Edinburgh Postnatal Depression Scale (also used antenatally)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ETLS</td>
<td>Emergency Triage Liaison Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMHT</td>
<td>Perinatal Mental Health Team</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAPR</td>
<td>South Australian Pregnancy Record</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>SW</td>
<td>Social Worker</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Contact:** South Australian Perinatal Practice Guidelines workgroup at: [HealthCYWHSPerinatalProtocol@sa.gov.au](mailto:HealthCYWHSPerinatalProtocol@sa.gov.au)
<table>
<thead>
<tr>
<th>SCORE</th>
<th>EPDS 10 or below PNRQ below 24</th>
<th>EPDS equals 11 or 12 PNRQ any item above 3</th>
<th>EPDS below 13 PNRQ above 24</th>
<th>EPDS equals 13 PNRQ below 24</th>
<th>EPDS above 13 PNRQ 24 or above</th>
<th>Positive score for Q 10 of the EPDS regardless of overall score</th>
<th>Urgent/Immediate referral to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MH symptoms low</td>
<td>MH symptoms low</td>
<td>MH symptoms high</td>
<td>MH symptoms high</td>
<td>MH symptoms high</td>
<td>Yes, quite often</td>
<td>Domestic violence services</td>
</tr>
<tr>
<td></td>
<td>Social risk factors low</td>
<td>Social risk factors high</td>
<td>Social risk factors high</td>
<td>Social risk factors high</td>
<td>Social risk factors high</td>
<td>Sometimes</td>
<td>Families SA</td>
</tr>
<tr>
<td></td>
<td>No history of abuse</td>
<td>Psychiatric history - current</td>
<td>Psychiatric history - current</td>
<td>Early attachment issues</td>
<td>Early attachment issues</td>
<td></td>
<td>Check safety</td>
</tr>
<tr>
<td></td>
<td>No psychiatric history</td>
<td>History of abuse</td>
<td>History of abuse</td>
<td>Domestic Violence</td>
<td>Domestic Violence</td>
<td></td>
<td>Discuss with CPC or case review</td>
</tr>
<tr>
<td>ACTION</td>
<td>No referral required</td>
<td>Discussion with client about any current issues</td>
<td>Referral immediate or within 24 hours</td>
<td>Referral for Parent-Infant therapy</td>
<td>Gently explore if the question is understood</td>
<td>If situation appears urgent, immediate referral to ACIS or Emergency Dept.</td>
<td>Domestic violence services</td>
</tr>
<tr>
<td></td>
<td>General offer and introduction to CaFHS services to “self manage” access</td>
<td>Referral not required, but offer relevant information regarding service available</td>
<td>Advise re: emergency services</td>
<td>CaFHS follow-up</td>
<td>If situation appears urgent, immediate referral to ACIS or Emergency Dept.</td>
<td>Provide information on Lifeline, Parent Helpline, Crisis Care</td>
<td>Families SA</td>
</tr>
<tr>
<td></td>
<td>Offer beyondblue ”Emotional health” booklet</td>
<td>Offer beyondblue “Emotional health” booklet</td>
<td>Offer beyondblue “Emotional health” booklet</td>
<td>CaFHS follow-up</td>
<td>CaFHS follow-up</td>
<td>Discuss with CPC or case review</td>
<td>Check safety</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Case discussion with Clinical Practice Consultant or Case Review</td>
<td>Consider referral for Parent-Infant therapy</td>
<td>CaFHS follow-up</td>
<td>CaFHS follow-up</td>
<td>Discuss with CPC or case review</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Offer beyondblue “Emotional health”, CSA, DV booklets if appropriate</td>
<td>CaFHS follow-up</td>
<td>CaFHS follow-up</td>
<td>CaFHS follow-up</td>
<td>CaFHS follow-up</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CaFHS follow-up</td>
<td>CaFHS follow-up</td>
<td>CaFHS follow-up</td>
<td>CaFHS follow-up</td>
<td>CaFHS follow-up</td>
</tr>
</tbody>
</table>

**DOCUMENTATION**

- Document score in box on bottom of page
- Document brief outline of issue in progress notes and resulting care plan
- Document score in box on bottom of page
- Document brief outline of issue in progress notes and resulting care plan
- Document score in box on bottom of page
- Include brief outline of issues, referrals, other agencies involved in progress notes and plan for follow up
- Document score in box on bottom of page
- Include brief outline of issues, referrals, other agencies involved in progress notes and plan for follow up
- Document score in box on bottom of page
- Include brief outline of issues, referrals, other agencies involved in progress notes and plan for follow up
- Document score in box on bottom of page
- Include brief outline of issues, referrals, other agencies involved in progress notes and plan for follow up

<table>
<thead>
<tr>
<th>URGENT/IMMEDIATE REFERRAL</th>
<th>ACTION</th>
<th>DOCUMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic violence services</td>
<td>No referral required</td>
<td>Document score in box on bottom of page</td>
</tr>
<tr>
<td>Families SA</td>
<td>General offer and introduction to CaFHS services to “self manage” access</td>
<td>Document score in box on bottom of page</td>
</tr>
<tr>
<td>Check safety</td>
<td>Offer beyondblue “Emotional health” booklet</td>
<td>Document brief outline of issue in progress notes and resulting care plan</td>
</tr>
<tr>
<td>Discuss with CPC or case review</td>
<td>Case discussion with Clinical Practice Consultant or Case Review</td>
<td>Document score in box on bottom of page</td>
</tr>
<tr>
<td>Provide information on Lifeline, Parent Helpline, Crisis Care</td>
<td>Offer beyondblue “Emotional health”, CSA, DV booklets if appropriate</td>
<td>Include brief outline of issues, referrals, other agencies involved in progress notes and plan for follow up</td>
</tr>
<tr>
<td>CaFHS follow-up</td>
<td>CaFHS follow-up</td>
<td>Include brief outline of issues, referrals, other agencies involved in progress notes and plan for follow up</td>
</tr>
<tr>
<td>Police (only if urgent and required)</td>
<td>CaFHS follow-up</td>
<td>Include brief outline of issues, referrals, other agencies involved in progress notes and plan for follow up</td>
</tr>
</tbody>
</table>
Please note the CaFHS pathways are a guide only and should be considered as part of the overall assessment.

<table>
<thead>
<tr>
<th>CaFHS PATHWAYS</th>
<th>Parent Helpline PANDA and websites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting to Know Your Baby Group</td>
<td></td>
</tr>
<tr>
<td>Client to Self Manage access to CaFHS</td>
<td>Case Review discussion and CaFHS follow up (including assessment for FHV)</td>
</tr>
<tr>
<td></td>
<td>Brief response</td>
</tr>
</tbody>
</table>
### PATHWAYS OF CARE

<table>
<thead>
<tr>
<th>No Risk</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>Moderate Symptoms</th>
<th>High Risk/Complex Needs</th>
<th>High Risk/Mental Health</th>
<th>High Risk/Social Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A unless circumstances change</td>
<td>Further referral and follow up not required, but options can be offered</td>
<td>Encourage mother to self manage access to CaFHS</td>
<td>A comprehensive mental health &amp; risk assessment is required</td>
<td>Emergency Dept or ACIS to undertake a comprehensive mental health &amp; risk assessment</td>
<td>Emergency Dept or ACIS to undertake a comprehensive mental health &amp; risk assessment</td>
<td></td>
</tr>
<tr>
<td>Mother to self manage access to CaFHS</td>
<td>Mother to self manage access to CaFHS</td>
<td>Clearly identify needs, and issues for follow up</td>
<td>Discuss with/refer to PMH clinician</td>
<td>Discuss with/refer to PMH clinician or Helen Mayo House</td>
<td>Discuss with/refer to PMH clinician or Helen Mayo House</td>
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<td>Encourage GP check up at 6 weeks</td>
<td>Encourage GP check up at 6 weeks</td>
<td>Encourage GP check up at 6 weeks</td>
<td>Arrange CaFHS follow up</td>
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#### Possible Community Pathways
- Consumer led support groups
- Community supports
- Parenting groups
- NGO family support services

**Resources**
- beyondblue

#### Possible Mental Health Pathways
- Information on GP & primary MH care services

**Possible Community Pathways**
- DV & CSA services
- Community support services
- Parenting groups
- NGO family support services
Where relevant refer to DV, drug & alcohol service (DASSA or NGO)

**Possible Mental Health Pathways**
- Refer to GP for Mental Health Treatment Plan
- Refer to ATAPS or Better Access practitioner via GP
- Referral on as needed e.g. specialist MH services, community services, groups

**Possible Community Pathways**
- Community support services
- NGO family support services
- Targeted parenting support services
Where relevant refer to DV, drug & alcohol service (DASSA or NGO)

**Possible Mental Health Pathways**
- Refer to GP for Mental Health Treatment Plan
- Refer for psychiatric assessment via GP
- Referral to ATAPS or Better Access practitioner via GP
- Referral on as needed e.g. specialist MH services, community services, groups

**Possible Community Pathways**
- Community support services
- NGO family support services
- Targeted parenting support services
Where relevant refer to DV, drug & alcohol service (DASSA or NGO)

**Possible Mental Health Pathways**
- Refer to GP for ATAPS where crisis service available
- Referral for hospital admission as necessary
Discuss with/refer to PMH clinician

**Possible Community Pathways**
- DV services
- Families SA
- Police
- Housing SA
- NGO family, legal and relationship services (if safe)
CaFHS follow up with referral agency to ensure pathways are activated

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**Contact:**
South Australian Perinatal Practice Guidelines workgroup at: HealthCYWHSPerinatalProtocol@sa.gov.au

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**Endorsed by:**
South Australian Maternal & Neonatal Clinical Network

**Last Revised:**
07/09/15

**ISBN number:**
978-1-74243-051-5

**Government of South Australia**
SA Health
Score indicates presence of symptoms or risk issues, but the woman declines referral

- Document in progress notes of client record
- Offer beyondblue information: “Emotional health during pregnancy and early parentood booklet”.
- Offer information about services and GP pathways
- Offer contact details of local CaFHS site

September 2010
Abbreviations

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<tr>
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<tr>
<td>ACIS</td>
<td>Assessment and Crisis Intervention</td>
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<tr>
<td>ANRQ</td>
<td>Antenatal Risk Questionnaire</td>
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<td>ATAPS</td>
<td>Access To Allied Psychological Services</td>
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<td>CaFHS</td>
<td>Child and Family Health Service</td>
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<td>CPS</td>
<td>Clinical practice support</td>
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<td>CSA</td>
<td>Childhood sexual abuse</td>
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<td>DASSA</td>
<td>Drug and Alcohol Services South Australia</td>
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<td>DV</td>
<td>Domestic violence</td>
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<td>EPDS</td>
<td>Edinburgh Postnatal Depression Scale</td>
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<td>et al.</td>
<td>And others</td>
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<td>ETLS</td>
<td>Emergency Triage Liaison Team</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>Hx</td>
<td>History</td>
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<td>KEMH</td>
<td>King Edward Memorial Hospital</td>
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<td>MH</td>
<td>Mental Health</td>
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<td>NGO</td>
<td>Non Government Organisation(s)</td>
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<td>NPDI</td>
<td>National Perinatal Depression Initiative</td>
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<td>PMHT</td>
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<td>PNRQ</td>
<td>Postnatal Risk Questionnaire</td>
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Version control and change history

**PDS reference:** OCE use only

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