GUIDELINE	
Perinatal and infant mental health	
Scope (Staff):	Community health staff
Scope (Area):	CAHS-CH, WACHS

This document should be read in conjunction with this DISCLAIMER

Aim

To support nurses working in community child health settings to identify, assess, and offer additional support services and/or referral to specialist services where available, to mothers and/or family members who are experiencing a perinatal or infant mental health issue.

Risk

Unresolved mental health issues in the perinatal period can impose a great burden on women, their infants and families and the health system.[1]

Background

Evidence around the importance of maternal perinatal mental health has been well documented; however the impact of the perinatal period on fathers and co-parents remains an emerging area of research.[1] The majority of presentations at child health centres are by mothers and their babies, but it is recognised that nurses working in community health settings may engage with diverse family structures where the primary caregiver may not be the birth-mother or female and not all partners may be male.

Research suggests that parents who identify as Lesbian, Gay, Bisexual, Transgender, Intersex and Queer (LGBTIQ) may be at a greater risk of developing perinatal anxiety and depression than other population groups. This is due to the additional conception complications, discrimination and potential relationship difficulties with their families of origin experienced by LGBTIQ families.[2] Understanding the family context will support nurses to a fuller understanding of the individual situation. This document will use the terms mother and father where gender issues are relevant to the mental health concern, and partner and caregiver at other times.

Mental health issues can significantly impact parents, caregivers and infants during the perinatal period, which for the purpose of this guideline has been defined as conception to thirty-six months postpartum. The transition to parenthood and the addition of a child to an existing family structure can be a complex and stressful time for all family members.[3] Parents with perinatal mental health issues may experience difficulties in their relationships with other family members and the potential disruption of mother-infant attachment may lead to poor infant mental health.[4, 5]

Maternal mental health

The maternal mental health conditions experienced most frequently in the perinatal period are perinatal depression and anxiety. Perinatal depression is a term used to describe a sustained depressive disorder which can present in both the antenatal and postnatal periods.[1] Perinatal anxiety can be defined as problematic anxiety experienced by parents during the period from conception through pregnancy and up to three years postpartum, affecting the development of secure relationships and a person's ability to complete daily tasks.[6]

Approximately 13% of women experience depression in the antenatal period, 13% experience anxiety, and comorbidity with anxiety and depression is high.[1,7] As many as 15-20% of women experience depression and/or anxiety in the first 12 months post-partum.[7] Depression and or anxiety can lead to disinterest in regular activities, feelings of being overwhelmed, sleep and appetite disturbances, and may result in thoughts of suicide or self-harm.[8]

Perinatal anxiety disorders are characterised by levels of fear or worry that are out of proportion to the object of the worry.[9] The presence of anxiety disorders is also a risk factor for the development of perinatal depression.[1] 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.[9] Women with a history of untreated or unstable anxiety and depression may find their symptoms are exacerbated in the perinatal period.

Anxiety disorders may include generalised anxiety disorder (GAD), panic attack disorder, social anxiety, adjustment disorders with anxiety, post-traumatic stress disorder (PTSD),[9] obsessive compulsive disorder (OCD),[9] comorbid depression and anxiety and phobias, such as blood, needle, or tokophobia (fear of pregnancy). [10, 11]

Postnatal psychosis, also known as puerperal psychosis, is a severe psychotic illness associated with the perinatal period. It is relatively rare at a rate of 0.2 percent[12] but due to the potential safety concerns for the affected woman and her infant, psychosis is a psychiatric emergency. Nurses must seek immediate assistance from a mental health service, emergency department, or a general practitioner (GP) depending on the availability of services if psychotic symptoms are present.[12]

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. [1] This guideline does not address the management of pre-existing conditions; rather will deal with the impact of mental health issues that develop or recur as a direct result of pregnancy and parenting.

Mothers with a previous mental health issue, of low socioeconomic status [9]; limited social support [1,12]; or those experiencing adverse life events such as bereavement, poverty, unemployment, family and domestic violence or history of abuse[1],substance misuse[1] or migration[1] are at increased risk of developing perinatal mental health issues. Mental health issues may lead to inadequate self-care and nutrition; suicidal thoughts or harm to self and/or baby; drug and alcohol misuse; or relationship disruption or breakdown.[13]

The hormonal changes experienced as a result of pregnancy and birth can increase a mother's susceptibility to mental illness.[14] Unrealistic expectations of motherhood may result in stress, anxiety, or depression if the mother feels she is not coping, needs assistance, or finds the task of parenting more challenging than expected.[15]

Complications with conception, pregnancy, unplanned pregnancy, an adverse birthing experience, difficulties with parenting such as infant feeding, sleeping, and infant temperament may increase the risk of developing mental health issues in the perinatal period.[16] It is important to note that while risk factors can be present, mental health issues in the perinatal period frequently occur in the absence of any identifiable risk.

Paternal mental health

Fathers may experience mental health issues in the perinatal period[17], and evidence suggests that men's mental health issues are currently under reported and under-screened.[18] Reviews on mood disorders within fathers during the perinatal period have identified a prevalence of one in ten for paternal depression, one in six for anxiety during the prenatal period and up to one in five during the postnatal period.[1] While these estimates are for fathers irrespective of their partner's mental health status, the incidence of paternal depression is 24-50 % for men whose partners have perinatal depression.[18]

There are differences between the way men and women present with perinatal mental health issues.[19] Men are more likely to express anger, irritability, and have lower impulse control, and may mask their depression using drugs, alcohol or interpersonal conflict.[19]

Fathers can experience a number of barriers to seeking help because the focus is often on the woman's health and they may have less access to a health professional postnatally than their partner.[17] It is important that nurses provide a welcoming environment to fathers and screen for mental illness whenever possible.[17] Utilising screening to open up communication will assist fathers to access information, reduce barriers, and be pro-active in identifying and addressing their needs.

Mental health issues for fathers may lead to relationship concerns, reduced desire for sexual intimacy and difficulty bonding with the infant.[17] Infants whose father experienced perinatal depression are more likely to exhibit behavioural problems at age three[17] and at school entry.[20] Risk factors predisposing fathers to a mental health issue may include: experiencing excessive stress surrounding the pregnancy or birth and fear for their partner [17]; perceived lack of information, support, and inclusion in the pregnancy and birth process[17]; a lack of acknowledgement of their role and needs [3, 21]; childhood trauma [22]; alcohol and other drug use [22]; and changes in their financial situation and intimate relationship with their partner. [20, 21]

Infant mental health

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

- develop secure relationships with parents, other adults and their peers
- experience, manage and express a range of emotions
- explore their environment and learn.[23]

Infant mental health is influenced by a range of factors including the infant's own physical health and temperament, carer availability, capacity and responsiveness and the quality of the relationship between infant and carer. A struggle in this relationship can affect the infant's growth, development, play and learning; their behaviour and ability to regulate their emotions; and their sleep and feeding patterns.

Attachment theory helps us understand the patterns of behaviour which develop in response to the parent's caregiving style.[8] A secure attachment develops when a child learns to trust that their parent will respond appropriately when given the signal that they need something, for example, food or to be cuddled and soothed. [24, 25] Consistently

responding to the infant's signals (e.g. smiles, eye contact, crying) builds two-way communication between the infant and parent which helps the infant feel safe and secure, allowing them to explore and learn from their surroundings. This is the cornerstone of the infant's biological, cognitive, social, and emotional development for their future adulthood.[24]

If an infant is unable to form a secure attachment with the mother, encouraging a secure attachment with another caregiver, such as the father, partner or a grandparent, may protect the infant and help them to optimise their growth and development within these circumstances.[1]

The *Mental health care in the perinatal period: Australian clinical practice guideline*[1] provides a list of prompts to support the assessment of the mother-infant relationship. These should not be used as a checklist or formal assessment tool, but observation of the following can indicate protective factors and potential difficulties in the mother-infant attachment.

- Is the mother thoughtful about her baby?
- Can the mother describe the baby's daily routine?
- Is the mother able to reflect on the baby's needs?
- Does the mother express empathy for the baby?
- Does the mother play/talk appropriately with the baby?
- Does the baby ever make her feel uncomfortable, unhappy or enraged?
- Is the mother excessively worried about the baby?
- Does the mother cope with the baby's distress?
- Are her responses consistent?[1]

In the long term poor attachment may negatively impact language acquisition, school performance, cognitive and social development, and emotional regulation. [1, 24, 26] These factors lead to further problems which can put the child at a higher risk of developing a mental health issue later in life.[17]

The arrival of a new baby may be difficult for young children or toddlers, who may express jealousy, exhibit oppositional, attention-seeking, or defiant behaviour.[27] Parents may feel guilty about not having as much time and connection with their older child and may need support to deal with their own feelings, as well as the behaviours of their older child.

Mental health impact

When a parent is experiencing a mental illness, the family may benefit from additional support. [28] People with a mental illness might be faced with a stigma that labels them as emotionally and psychologically less capable and unable to cope with 'normal' life. [28] They might also feel shame, humiliation or embarrassment, or might view themselves as being weak for developing a mental illness. [28] Additionally, parents may fear that their children will be removed from their care if they have a mental health issue.[1] As a result, parents experiencing a mental health issue may limit their contact with health professionals or choose not to disclose their true feelings and thoughts.

For some parents, the perceived dangers faced by a new baby may cause heightened awareness and worry, and lead to repetitive or irrational behaviours or thoughts. For

others, such worry may lead to intrusive thoughts or images, which may be distressing and overwhelming.[29] These thoughts and images are often not shared with others as parents may feel guilty or ashamed.[29] When these intrusive thoughts are acknowledged it is important that parents are reassured that these are relatively common, and only problematic if they are causing them to be afraid.[29] Exploring these thoughts usually provides reassurance that they can be recognised as being unusual and can be easily discounted. Referral for further mental health assessment is required if these thoughts are distressing or overwhelming.

Nurses are encouraged to adopt a family partnership approach to develop an open and non-judgemental environment to generate communication about emotional issues and mental health and normalise parent experiences. [30] A recent Canadian study reported that mental health screening is broadly acceptable to parents and caregivers[15], therefore screening should be offered universally, both at scheduled visits, and where there is parental or professional concern. The use of the Edinburgh Postnatal Depression Scale (EPDS) to screen for depression will be discussed further in Appendix A.[1] All caregivers should be invited to participate in mental health screening and it is important to recognise that there are gender issues in mental health presentations and different risk cut-off scores for women and men.

Note: WACHS nurses in the Kimberley will follow Kimberley protocols and use the Kimberley Mum's Mood Scale instead of the EPDS.

Key points

Nurses will:

- Work within their scope of practice.
- Have a well-developed understanding of perinatal and infant mental health issues.
- Provide non-judgemental care to support parents and promote sensitive parenting and secure attachment.
- Implement a process to identify parents with mental health issues which, at minimum, includes:
    - Exploring family circumstances as per the per Indicators of Need (ION)
    - Offering screening with the Edinburgh Postnatal Depression Scale (EPDS) as described in Appendix A
    - Assessing the attachment between the infant and mother/caregiver as demonstrated by their interaction.
- Follow the *Universal Contacts* Guidelines in regard to care planning and future contacts.

  Be aware of their emotional health and to undertake clinical supervision where available.

Related policies, procedures and guidelines
The following documents can be accessed in the **Clinical Nursing Manual** via the HealthPoint link or the Internet link or for WACHS staff in the WACHS Policy link
Clients of concern management
Clinical Handover
Family and domestic violence
Partnership – child health service
Universal contacts
Vulnerable populations
The following documents can be accessed in the CAHS Policy Manual
Language Services
The following documents can be accessed in the Department of Health Policy Frameworks
Clinical Handover Policy (MP0095)

Related CAHS-CH forms
The following resources and forms can be accessed from the CAHS-Community Health Forms page on HealthPoint
Clinical handover referral form (CHS663)
Edinburgh Postnatal Depression Scale – English and Translated versions

Related CAHS-CH resources
The following resources and forms can be accessed from the CAHS-Community Health Resources page on HealthPoint
Indicators of Need

Related external resources
Beyond Blue
COPE (Centre of Perinatal Excellence) provides perinatal and postnatal advice
COPMI resource centre for children of parents with mental illness

EPDS translated versions
Guidelines for Protecting Children 2015 (revised May 2017)
Head to Health is a repository of endorsed mental health websites and apps, including many suitable for the perinatal period
Mental Health Commission WA General facts, causes, and personal stories on mental health issues
Mental Health Care in the Perinatal Period Australian Clinical Practice Guideline COPE
Mental Health in Multicultural Australia Assists providers and government agencies in providing services to culturally and linguistically diverse (CaLD) groups with mental health issues
PANDA: Perinatal Anxiety and Depression Australia, a not-for-profit organisation that provides information and support on maternal mental health. National helpline number : 1300 726 306
Perinatal and infant mental health toolbox Statewide Perinatal and infant Mental Health Program
Raising children network provides parenting information from pregnancy to adolescence, as well as information on relationships
Statewide Perinatal and Infant Mental Health Program Support health professionals and consumers across WA, including health promotion, education and training, and research
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
Lifeline Lifeline provides access to crisis support, suicide prevention, and mental health support services. Phone: 13 11 14
Suicide Call Back Service The Suicide Call Back Service provides crisis counselling to people at risk of suicide, carers for someone who is suicidal, and those bereaved by suicide, 24 hours per day 7 days a week across Australia. Phone: 1300 659 467
Mother and Baby Unit State-wide inpatient treatment centre at King Edward Memorial Hospital (KEMH) and at Fiona Stanley Hospital (FSH) for acute perinatal psychiatric conditions Free call **KEMH**: 1800 422 588 Call **FSH**: 6152 2222 **Mental Health Emergency Response Line (MHERL)** The mental health call centre provides expert and accurate telephone response to acute

mental health issues. All callers will be triaged and referred to the most appropriate acute response team according to the level of clinical priority.

Perth Metro Residents:	1300 555 788
Peel Residents:	1800 676 822
TTY:	1800 720 101
Rurallink:	Phone 1800 552 002

Appendix A: Edinburgh Postnatal Depression Scale (EPDS)

Aim

To identify clients at risk of depression and/or anxiety in the perinatal period, by using the Edinburgh Postnatal Depression Scale (EPDS).

Risk

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

Background

The Edinburgh Postnatal Depression Scale (EPDS) was developed in 1987 as a self-report questionnaire and is used in many countries to screen for the risk of developing perinatal depression.[31] 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 [32] has been translated into 36 different languages with 18 being validated.[32] Each language version has a unique recommended cut-off score.[32] The EPDS can be used with both men and women, though the cut-off scores are different (see Appendix B).

The EPDS should be offered in an environment where the nurse and client have privacy. It should not be used in an open clinic setting, over the telephone, or posted to clients. Where the EPDS is administered to both parents attending the appointment, care should be taken for each parent to answer independently without the influence of the other.

Nurses should be aware of a client's life events and recent stressors, such as job loss or bereavement, because these stressful events might produce a high EPDS score indicating emotional distress rather than depression.

Key points

- The EPDS should only be used by nurses who have been trained in its use and have a clear referral pathway. Training should include suicide risk assessment and management.
- The EPDS is an indicator of the risk of depression and anxiety, NOT a diagnostic tool. It should be used in conjunction with a holistic consultation and professional judgement to identify those who need follow-up or referral.
- The scale provides an indication of the client's perception of their mood in the preceding 7 days. It does not predict on-going mood. [31]
- Where the offer of the EPDS is refused, the refusal should be documented according to local processes, and nurses should use their clinical judgment to determine follow-up actions. The EPDS should be offered again at subsequent visits.
- The EPDS provides a universal language between health care professionals that facilitates referrals.
- Nurses should ensure correct use of a professional interpreter as required.

Process

<table>
<tr><th>Steps</th><th>Additional information</th></tr>
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1. Administer EPDS

- The EPDS must be offered to all clients at:
  - 8 weeks
  - 4 months
  - 12 months
  - Any other time where there is parental or professional concern
- All ten items must be completed.
- Any mismatch between the EPDS score and the clinical presentation should be explored further.

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The child health centre or a home visit may provide suitable opportunities for the completion of the EPDS.

The client is asked to **underline** the response which comes closest to how he or she has been feeling in **the previous 7 days**.

- The link to the English version of the EPDS form is available on the community health CACH Intranet forms page or Womens and Newborns Health Service.

The scale should be completed by the clients personally unless they have limited English (and a relevant translation is not available) or have difficulty with reading.

If English is the client's second language, the use of a translated EDPS should be considered.

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2. 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.

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- The maximum score on the EPDS is 30.

Table 1: EPDS Question Scores

Q 1- 2	Q 3	Q 4	Q 5-10
0	3	0	3
1	2	1	2
2	1	2	1
3	0	3	0

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3. Interpret score

Nurses should score the EPDS on completion and discuss the client's responses.

The screening tool is used in conjunction with good clinical judgement, clinical observation of the client's interaction with the infant and the staff member, and a psychosocial assessment.

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

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A score of 0 is considered unusual, may indicate masking or literacy issues and requires further discussion with the client.

Explore any individual question with a high score. This helps to clarify and explore the answer with the parent, in the context of what is happening for them.

Cut-off scores for the English version for men and women, according to the EPDS.

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Steps	Additional information
women. • Note: the scores in the table apply to the English version. If a translated version of the EPDS has been used, refer to the additional notes for that specific language version to determine the appropriate cut-off scores.	**Low risk** of perinatal depression Women: 0-9 Men: 0-5 **Moderate risk** of perinatal depression Women: 10-12 Men: no moderate score identified, refer to high risk. **High risk** of perinatal depression Women: 13–30 Men 6 or more According to the Women's Health Strategy and Programs - WA Perinatal Mental Health Referral Pathway, the antenatal cut-off score for women is 14 or more, and for men is 6 or more. **Cut-off scores for Anxiety** using the English version for men and women, according to the EPDS: Subscale on questions 3, 4, & 5 Total possible anxiety score of 9 Women: 6 or more Men: 4 or more Irrespective of the overall EPDS score, a score over 6 for women and over 4 for men may indicate the presence of anxiety, and further clinical assessment is required.
4. Results and actions a) **Low risk of perinatal depression** ○ Women 0-9 Men 0-5 Some symptoms of distress may be present but they are less likely to interfere with day to day functioning.	Check the anxiety sub scale as the client may have scored 9 out of 9 on the anxiety score Discussion of feelings, experiences, role change, changes in relationship, and losses and gains. Provide general therapeutic lifestyle information regarding nutrition, sleep, exercise and self-care. Provide support to ensure continued wellbeing. Offer additional contacts to meet individual needs where clinical judgement warrants.
b) Moderate risk of perinatal depression (Women only) ○ Women: 10-12 Men: no moderate	Explore past history of mental health issues, social support and current life stressors.

Steps	Additional information
score identified, refer to high risk. Scores in this range indicate that the presence of symptoms are distressing and discomforting, and may impact functioning. Use active listening techniques. Encourage enlisting support from GP, local women's health centre, partner, family and friends. Encourage participation in parent groups. Provide links to online resources and apps on perinatal mental health.	Encourage clients to have regular time devoted to positive interactions with the infant. Encourage regular weekly time-out, with child care services, partner or friends looking after the infant. Offer follow up *Universal plus* appointments in 2 to 4 weeks to review client progress. Use clinical judgement to determine if a repeat EPDS is required at the follow up appointment. *Head to Health* provides a list of endorsed mental health web pages and apps. See Useful resources for additional resources. Complete the Clinical Handover/Referral Form (CHS 663) for relevant referrals.
c) High risk of perinatal depression ○ Women 13 – 30 Men: 6 or more Scores in this range require further assessment as the likelihood of depression is high. Assess thoughts of harm to self or baby. Refer to GP, if indicated and consent has been provided. Discuss the range of options that may be offered by the GP, including counselling and anti-depressants.	Consider urgent referral for a mental health assessment to GP, local hospital or mental health service, especially where the client has verbalised intent and/or plans of harm to self or infant. Complete the Clinical Handover/Referral Form (CHS 663) for relevant referrals. Ensure the clients are in the company of a partner, family member or friend to ensure their safety prior to leaving the child health centre. Provide and discuss relevant local mental health services, information, and contact details to clients and support networks. ○ Encourage participation in perinatal depression support groups. ○ Encourage clients to have regular time-in devoted to positive interactions with the infant. ○ Ensure frequent time out, with

Steps	Additional information
	child care services, partner or friends looking after infant. ○ Encourage the client to take medication if it has been prescribed and to return to the GP if they have concerns or questions. Offer follow up phone call within one week and a *Universal plus* appointment in 2 to 4 weeks, to review client progress. Use clinical judgement and to determine if a repeat EPDS is required at the follow up appointment.
d) Assess immediate risk • Question 10 on the EPDS assesses the suicidal ideation of the respondent. • Determine if the client and/or infant are at risk. • Aim to keep the client and infant safe. • Use clinical judgement to assess the situation and arrange immediate assessment, as required. • Document all actions and record the risk level in electronic health information systems, according to local processes.	• 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. ○ Recheck that these feelings occurred in the last 7 days. Discuss with client if they have any thoughts of harming their infant. Discuss with client available support networks. Where the nurse has concerns about risks to the client or infant, seek permission to contact their support person to discuss the situation. Discuss possible referral options, as required. Consider urgent referral for a mental health assessment to GP, local hospital, or mental health service, especially where the client has verbalised intent and/or plans of harm to self or infant. Complete the Clinical Handover/Referral Form (CHS 663) Undertake a follow up phone call within one week, to determine further care planning.
5. Refer	Use the Clinical Handover/Referral Form (CHS663) for referrals to GP or other

Steps	Additional information
• The WA Perinatal Mental Health Referral Pathway indicates the types of services that might be helpful to clients. If the client does not consent for referral, the nurse should document the offer and the refusal according to local processes.	health services. The local Family Support Network may be able to offer support for identified psychosocial concerns. See Useful resources section. Nurses should be aware of, and consider their own appropriate local services and referral options. Nurses should inquire about the clients support network, the safety of the client and the safety of the infant; to decide whether it is appropriate to contact mental health services or the Department of Communities Child Protection and Family Services (CPFS). If signs of harm are evident, mental health services and/or CPFS should be contacted.
6. Follow-up Use professional judgement to determine if phone follow-up within one week, is necessary for clients at high risk of perinatal depression. If the nurse is unable to contact the client, they may discuss this with their line manager to ensure the client continues to receive care. Follow up should occur even if EPDS hasn't been administered and nurse has concerns about a client's mental health. Offer a Universal plus appointment within next 2-4 weeks as per clinical judgement and family need/ willingness to attend.	Nurses will ensure that culturally appropriate services are provided to clients where they are available. This may include providing service for CaLD parents, Aboriginal and Torres Strait Islander parents, single parents, young parents, and men.
7. Document • All EPDS scores, notes on clinical presentation, and the psychosocial assessment, along with any other relevant findings, are to be recorded in the appropriate electronic or paper based records. • Document care planning including	Nurses must record all findings in relevant electronic data systems according to local protocols. Retain hard copies as per local protocols in the client record, for the purpose of a future comparison of results and to meet legal requirements regarding the medical record.

Steps	Additional information
follow up and referral details.	

Appendix B: EPDS clinical pathway

Adapted from the Women's Health Strategy and Programs - WA Perinatal Mental Health Referral Pathway – Western Australia

Antenatal cut-off for high risk:
Women - 14 or more
Men - 6 or more

	Actions
Low risk Women 0-9 Men 0-5	Check for clinical symptoms not reflected in score. Provide relevant information and support services. Provide therapeutic lifestyle information. Offer additional contact to meet individual needs.
Moderate risk Women 10-12 *No score identified for Men*	Discuss relevant actions for low risk. Explore past history of mental health issues, social support and current life stressors. Refer to GP, local women's health centre, counselling – if not already accessing. Offer Universal + appointment in 2 to4 weeks for review of client and repeat EPDS.
High risk Women 13-30 Men 6-30 ***Without** identified risk to client and/or infant*	Discuss relevant actions for low/moderate risk. Undertake further assessments. Determine risks to parent/caregiver and infant/child. Consider urgent referral, as required. Offer follow-up phone call within one week. Offer Universal plus appointment within 2 to 4 weeks for review of client and repeat EPDS.
Immediate risk Women 13-30 Men 6-30 *Question 10: response of 1, 2 or 3* ***With** identified risk to client and/or infant*	Discuss relevant actions for low/moderate/high risk. Aim to keep parent and infant/child safe. Arrange immediate assessments, as required. Express concerns and seek permission to contact support person. Consider possible referral, as required. Consider urgent referral where intent and plans of harm to self or infant/child. Undertake a follow up phone call to determine further care planning.

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