COPE

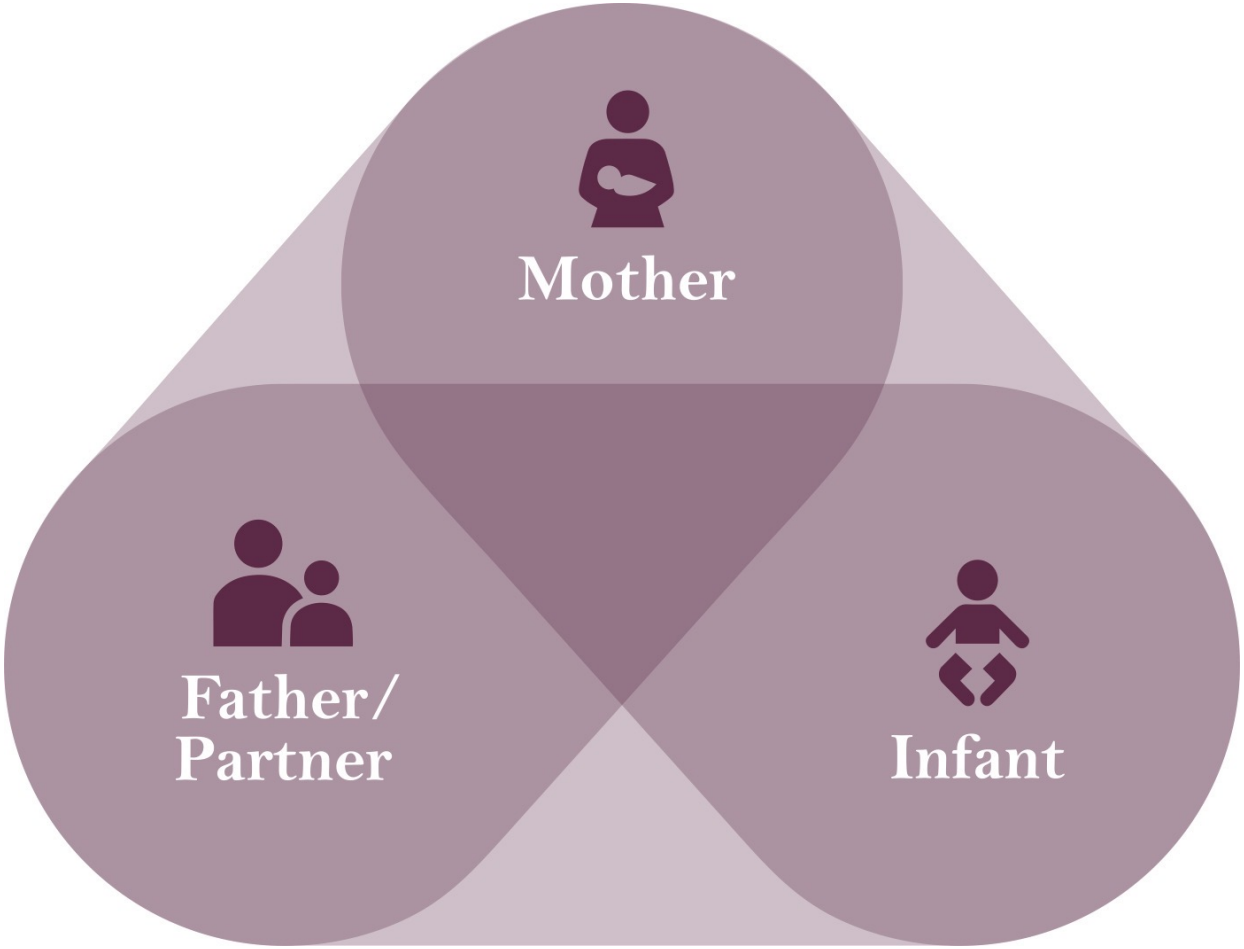
Centre of Perinatal Excellence

Applied Skills in Perinatal Mental Health Assessment and Care

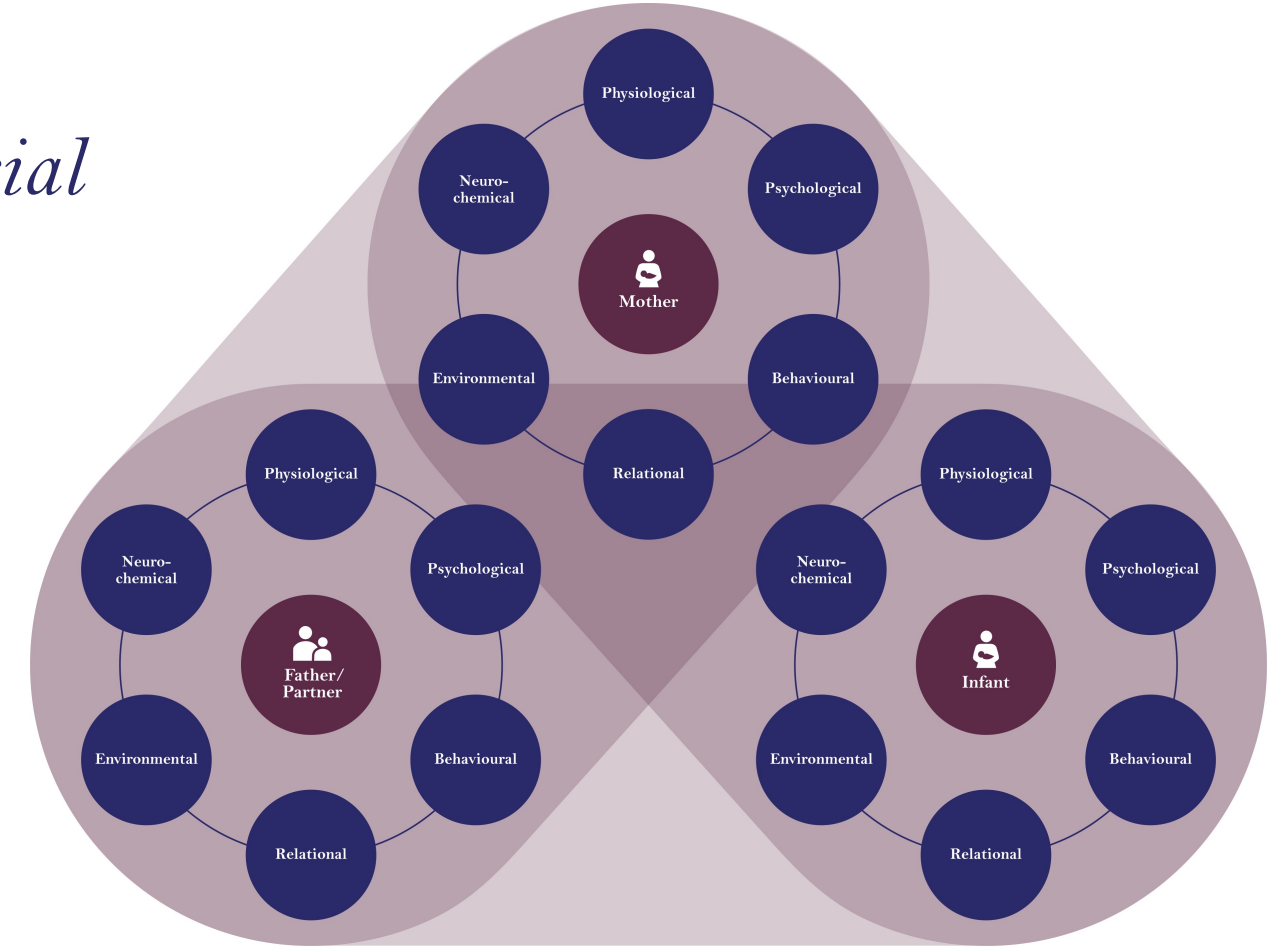
PRACTICE GUIDE

COPE Accredited Program

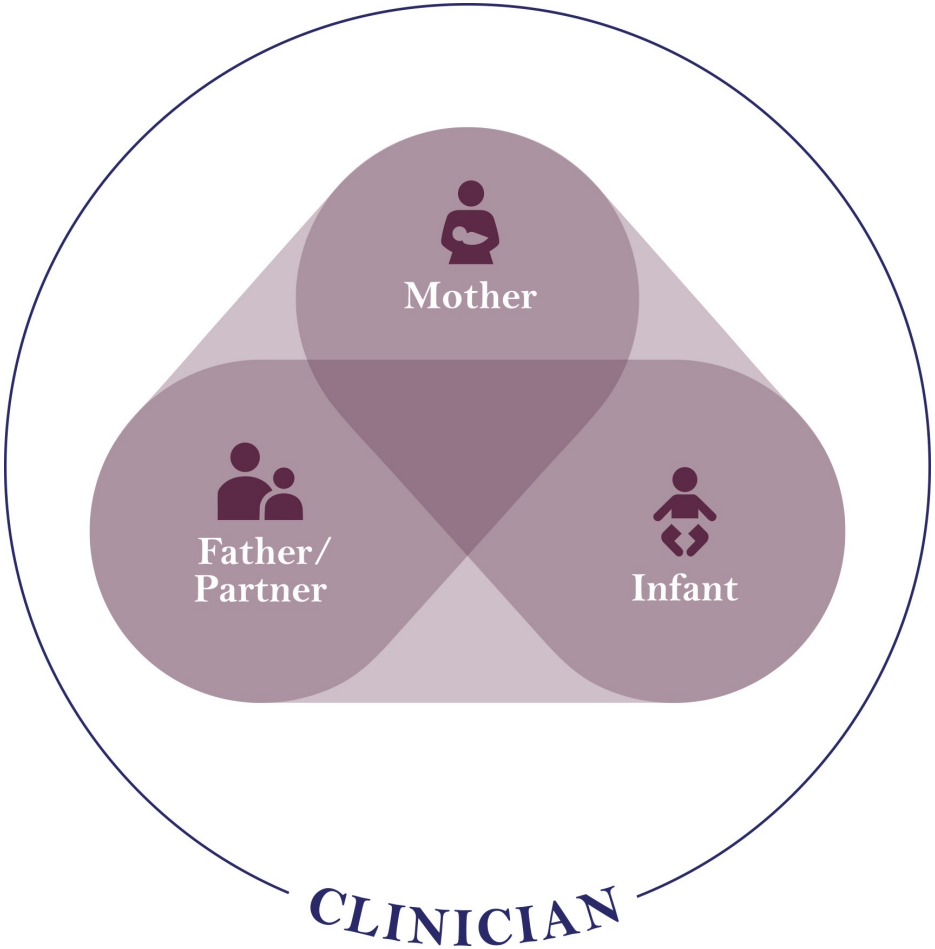
The Perinatal Context



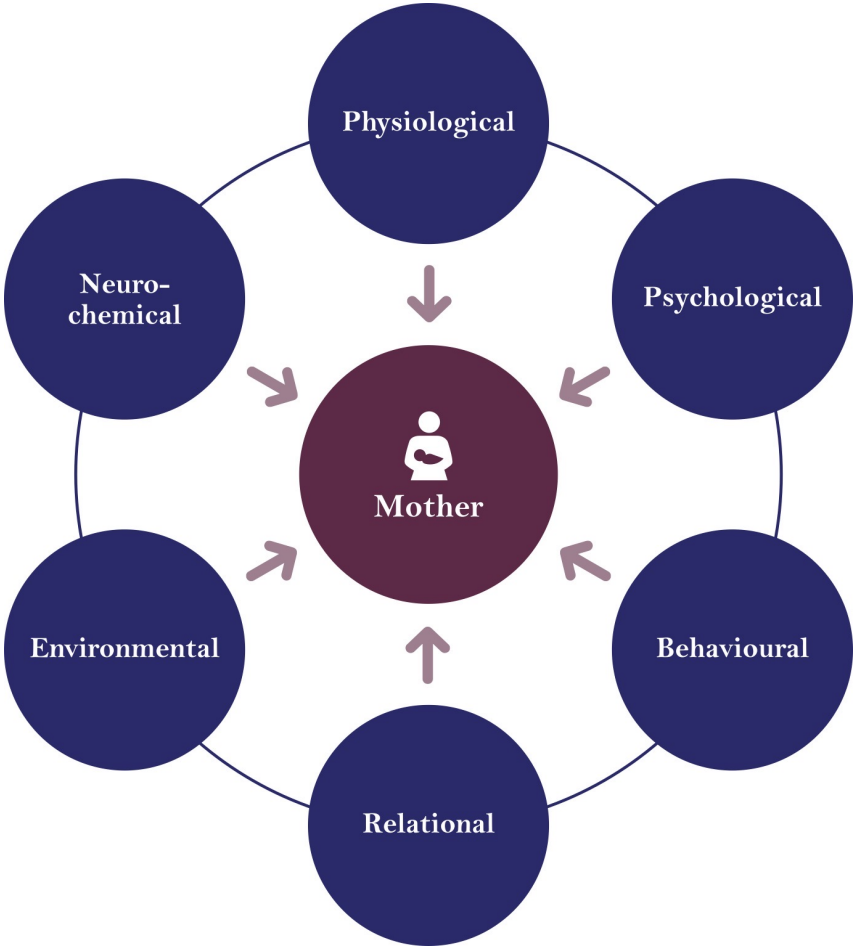
The *Biopsychosocial Model* in the Perinatal Context



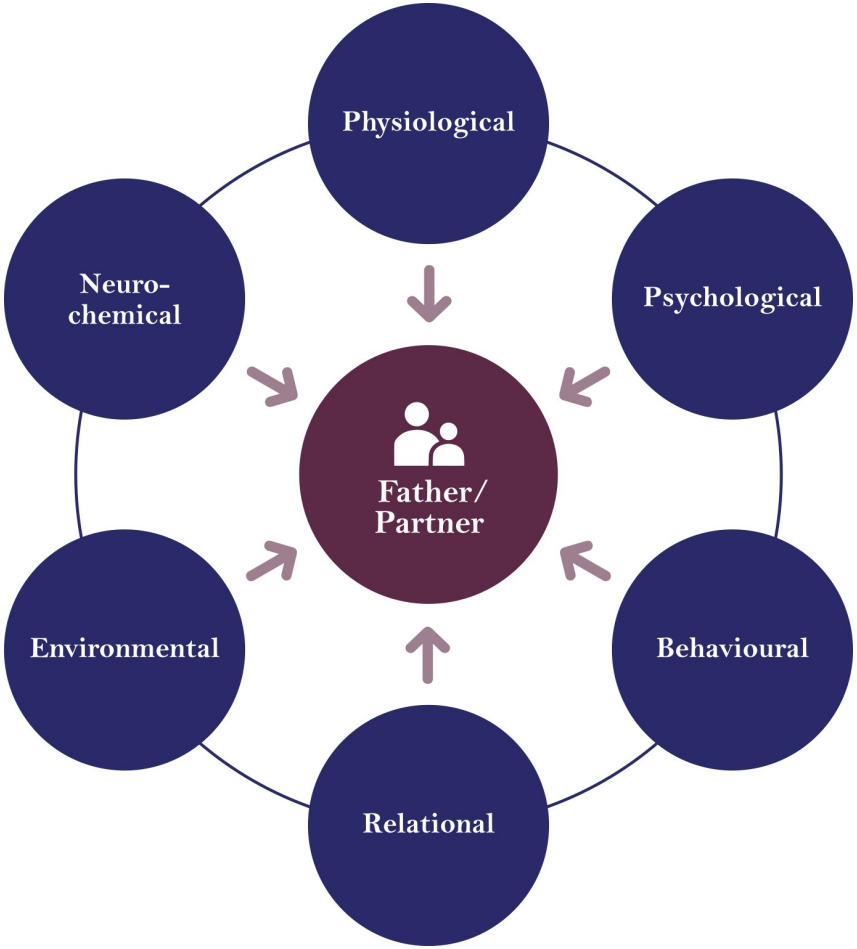
The *Therapeutic Relationship* in the Perinatal Context



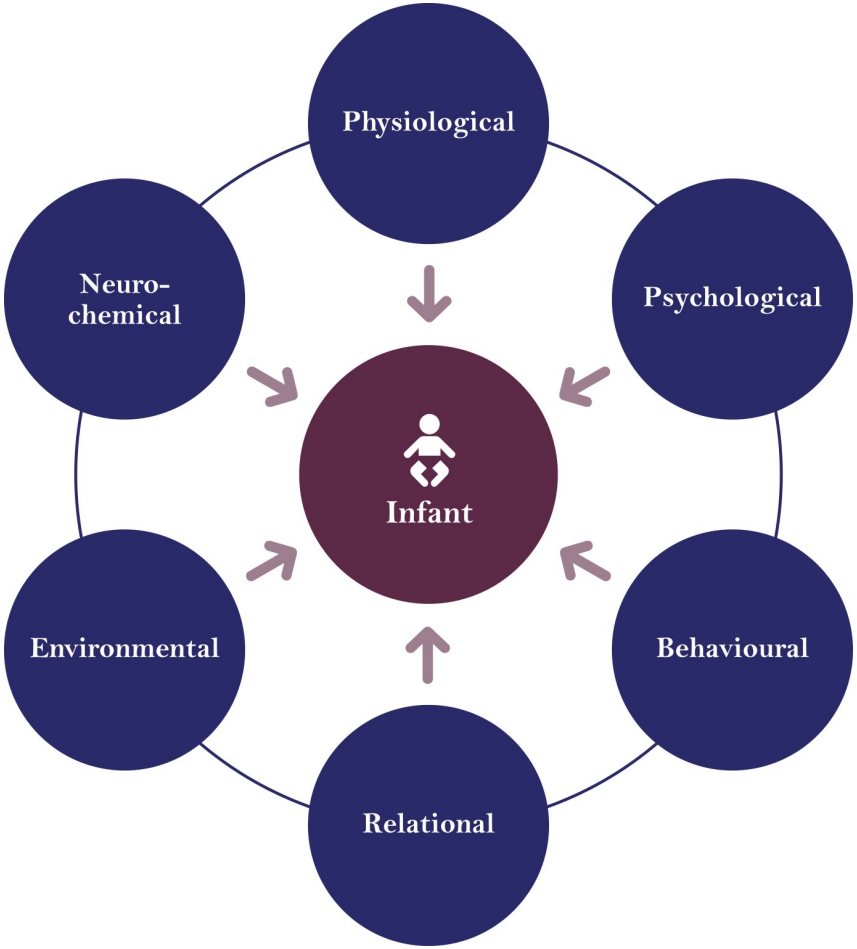
The COPE *Maternal* Perinatal Context Model

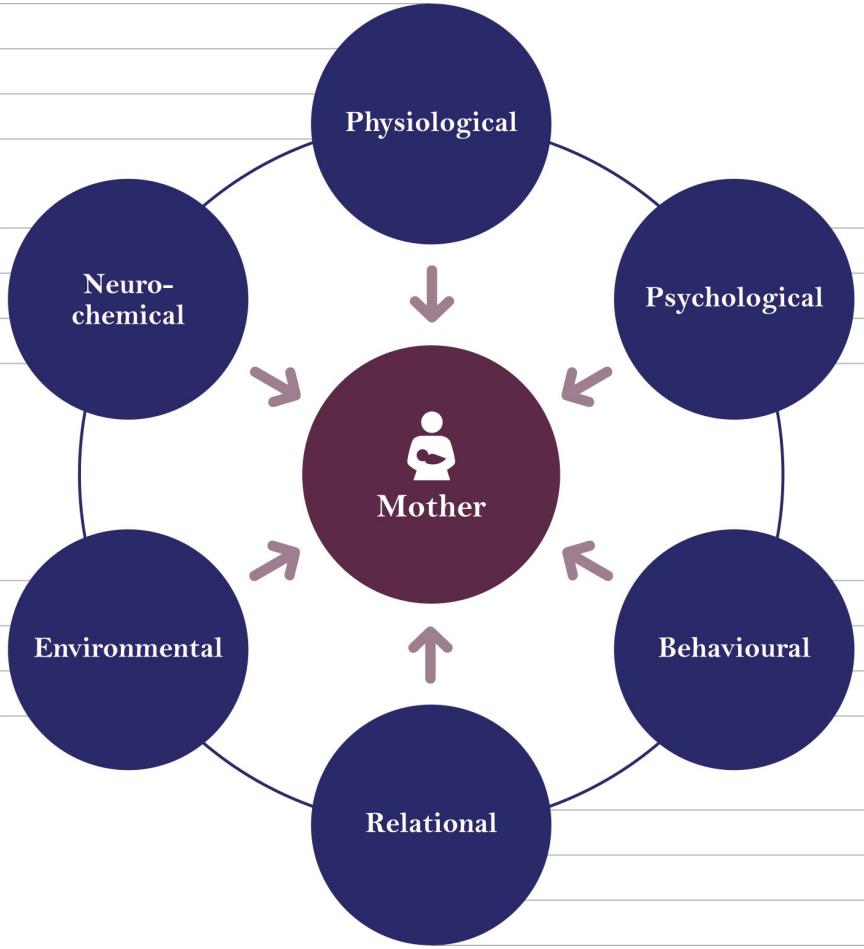


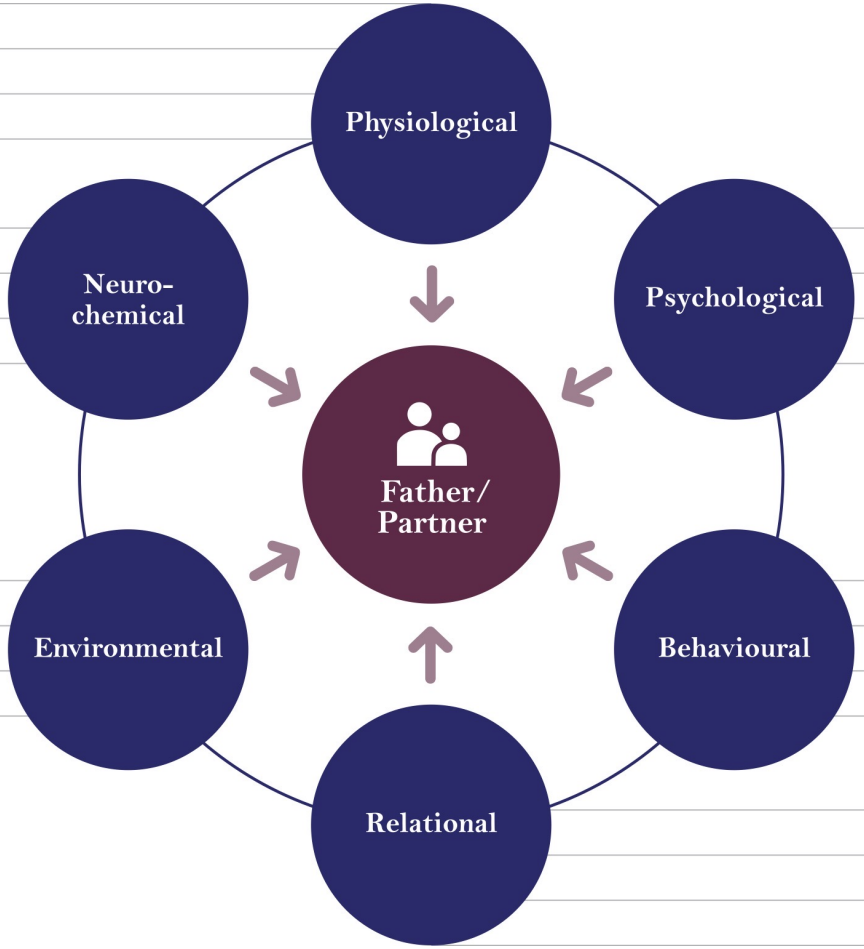
The COPE *Father/Partner* Perinatal Context Model

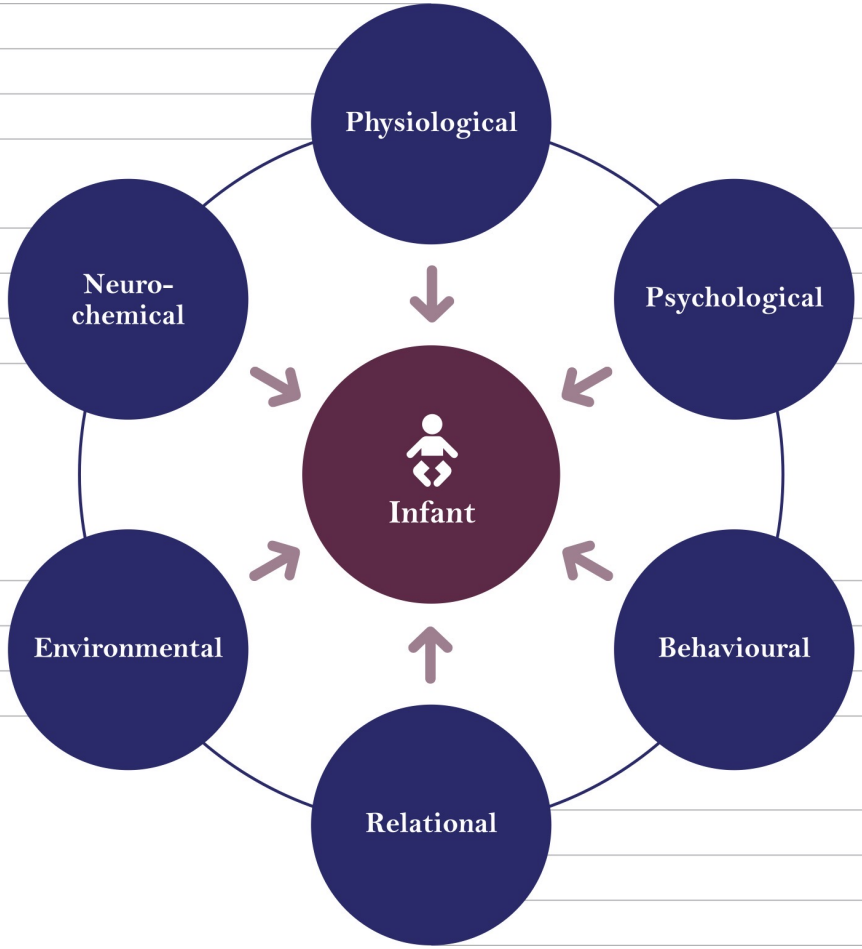


The COPE *Infant* Perinatal Context Model









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Perinatal Mental Health Assessment Template

Name: _____ **Date:** ____/____/____

Address: _____

_____

Date of Birth: ____/____/____

Perinatal Status: ☐ Antenatal | EDD: ____/____/____ ☐ Postnatal | Baby's DOB: ____/____/____

Clinician:

_____

Referral Source:

_____

Screening Results: EPDS: _____ ☐ ANRQ: _____ ☐ PNRQ: _____

Other Screening/Assessment Results *(please specify)*:

Medication *(current and previous use of medication)*:

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Perinatal Mental Health Assessment Template

Mental State Exam (MSE)

Appearance:

Behaviour/Speech:

Affect:

Cognition:

Mood:

Thoughts and Perception:

Judgement and Insight:

Assessment Considerations

Main Presenting Issues:

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Perinatal Mental Health Assessment Template

Current Symptoms

Physical:

- ☐ Easily fatigued, tiredness
- ☐ Sleep disturbance
- ☐ Significant weight or appetite change
- ☐ Insomnia, even though exhausted
- ☐ Other: _____

Cognitive:

- ☐ Intrusive thoughts
- ☐ Having trouble making easy decisions or thinking clearly
- ☐ Difficulty concentrating
- ☐ Worrying or feeling anxious about baby's health and safety
- ☐ Worried about things not being in control
- ☐ Recurrent thoughts of death or suicide, or both
- ☐ Other: _____

Affective:

- ☐ Fearful
- ☐ Muscle tension
- ☐ Feeling weepy or crying over seemingly minor things
- ☐ Mood swings
- ☐ Feelings and/or outbursts of rage
- ☐ Depressed mood or irritability
- ☐ Feeling restless, keyed up, on edge, panicky
- ☐ Feelings of worthlessness or guilt
- ☐ Feeling unattached or unbonded to fetus/baby
- ☐ Other: _____

Behavioural:

- ☐ Panic attacks
- ☐ Missing parts of old life *eg. the freedom to go out with friends*
- ☐ Avoidance behaviours *eg. towards baby or social interactions*
- ☐ Diminished interest or enjoyment in activities
- ☐ Other: _____

Other Symptoms:

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Perinatal Mental Health Assessment Template

Patient Information

1. **History of Mental Illness**
   Previous diagnoses | Substance misuse | Childhood experiences/adverse childhood experiences | Intimate partner violence | Abuse | Relationships

2. **Current Physical and Mental Health**
   Eating | Lifestyle factors | Other personal or family history of health conditions | Exercise

3. **Children and Families**
   Other siblings | Extended family dynamics

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Perinatal Mental Health Assessment Template

4. Relationships

Woman's relationship with partner | Cultural differences | Relationships with wider family | Expectations of family life and parenthood (own and partner) | Relationship strengths and satisfaction | Communication | Intimacy

5. Journey to Parenthood

Planned or unplanned | Reactions to pregnancy (same or different) | Fertility treatment | Donor conception | First or subsequent pregnancy or child | History perinatal loss | Birth experience(s) and aftercare

6. Transition to Parenthood

Adjustment to role change | Adjustment to identity shift | Sense of loss | Restrictions and lifestyle change | Parenting confidence | Isolation | Partner's perspectives

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Perinatal Mental Health Assessment Template

7. Support Network

Perception of support | Availability of support | Communication

8. Drug and Alcohol Use

Quantity and Frequency | Triggers/antecedents

9. PIMH Risk Assessment *(use COPE Risk Template)*

Woman:

- ☐ Risk of harm to self - Direct Self Harm (DSH) or Suicide Intent (SI)
- ☐ Risk of harm to others/Family violence

Details:

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Perinatal Mental Health Assessment Template

Risk to infant:

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

Further Comments:

10. Protective Factors

Edinburgh Postnatal Depression Scale (EPDS)

Cox JL, Holden JM Sagovsky R (1987) Detection of postnatal depression: development of the 10-item Edinburgh postnatal depression scale. Brit J Psychiatry 150 782-86. Reproduced with permission.

Name: _____ **Date:** _____

We would like to know how you have been feeling in the past week. Please indicate which of the following comes closest to how you have been feeling over the past seven days, not just how you feel today. Please tick one circle for each question that comes closest to how you have felt in the **last seven days.**

Here is an example already completed.

I have felt happy:

- ☐ Yes, all of the time
- ■ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: 'I have felt happy most of the time during the past week'.

Please complete the other questions in the same way.

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

- ☐ As much as I always could
- ☐ Not quite so much now
- ☐ Definitely not so much now
- ☐ Not at all

2. I have looked forward with enjoyment to things

- ☐ As much as I ever did
- ☐ Rather less than I used to
- ☐ Definitely less than I used to
- ☐ Hardly at all

3. I have blamed myself unnecessarily when things went wrong

- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ Not very often
- ☐ No, never

4. I have been anxious or worried for no good reason

- ☐ No, not at all
- ☐ Hardly ever
- ☐ Yes, sometimes
- ☐ Yes, very often

5. I have felt scared or panicky for no very good reason

- ☐ Yes, quite a lot
- ☐ Yes, sometimes
- ☐ No, not much
- ☐ No, not at all

6. Things have been getting on top of me

- ☐ Yes, most of the time I haven't been able to cope at all
- ☐ Yes, sometimes I haven't been coping as well as usual
- ☐ No, most of the time I have coped quite well
- ☐ No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping

- ☐ Yes, most of the time
- ☐ Yes, sometimes
- ☐ Not very often
- ☐ No, not at all

8. I have felt sad or miserable

- ☐ Yes, most of the time
- ☐ Yes, quite often
- ☐ Not very often
- ☐ No, not at all

9. I have been so unhappy that I have been crying

- ☐ Yes, most of the time
- ☐ Yes, quite often
- ☐ Only occasionally
- ☐ No, never

10. The thought of harming myself has occurred to me

- ☐ Yes, quite often
- ☐ Sometimes
- ☐ Hardly ever
- ☐ Never

Edinburgh Postnatal Depression Scale (EPDS)

Cox JL, Holden JM Sagovsky R (1987) Detection of postnatal depression: development of the 10-item Edinburgh postnatal depression scale. Brit J Psychiatry 150 782-86. Reproduced with permission.

Name: _____ **Date:** _____

We would like to know how you have been feeling in the past week. Please indicate which of the following comes closest to how you have been feeling over the past seven days, not just how you feel today. Please tick one circle for each question that comes closest to how you have felt in the **last seven days.**

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- ■ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: 'I have felt happy most of the time during the past week'.

Please complete the other questions in the same way.

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

0 As much as I always could
1 Not quite so much now
2 Definitely not so much now
3 Not at all

2. I have looked forward with enjoyment to things

0 As much as I ever did
1 Rather less than I used to
2 Definitely less than I used to
3 Hardly at all

3. I have blamed myself unnecessarily when things went wrong

3 Yes, most of the time
2 Yes, some of the time
1 Not very often
0 No, never

4. I have been anxious or worried for no good reason

0 No, not at all
1 Hardly ever
2 Yes, sometimes
3 Yes, very often

5. I have felt scared or panicky for no very good reason

3 Yes, quite a lot
2 Yes, sometimes
1 No, not much
0 No, not at all

6. Things have been getting on top of me

3 Yes, most of the time I haven't been able to cope at all
2 Yes, sometimes I haven't been coping as well as usual
1 No, most of the time I have coped quite well
0 No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping

3 Yes, most of the time
2 Yes, sometimes
1 Not very often
0 No, not at all

8. I have felt sad or miserable

3 Yes, most of the time
2 Yes, quite often
1 Not very often
0 No, not at all

9. I have been so unhappy that I have been crying

3 Yes, most of the time
2 Yes, quite often
1 Only occasionally
0 No, never

10. The thought of harming myself has occurred to me

3 Yes, quite often
2 Sometimes
1 Hardly ever
0 Never

Antenatal (Psychosocial) Risk Questionnaire (ANRQ) – Client

Name: _____ Date: _____

The questions below are designed to help you and your clinician understand whether you may benefit from some extra support during this time of change. You may find some questions challenging, but please choose the answers that best apply to you. There are no right or wrong answers.

Please complete all questions, unless instructed to SKIP a question. Once you have completed the questions, your clinician will discuss your responses with you. If you have any concerns about any of the questions, please let your clinician know.

Total

Q1. Have you ever had a period of 2 weeks or more when you felt particularly worried, miserable or depressed?

☐ No — **If No**, skip to **Q1.c.**

☐ Yes — **If Yes**, please answer **Q1.a., Q1.b. and Q1.c.,**

If Yes, did this:

Q1.a. Seriously interfere with your work or your relationships with friends and family?

☐ Not at all ☐ A little ☐ Somewhat ☐ Quite a lot ☐ Very much

Q1.b. Lead you to seek professional help?

☐ No ☐ Yes

Did you see a:

☐ psychiatrist ☐ psychologist/counsellor ☐ GP

If yes, name of professional: _____

Did you take tablets/herbal medicine? ☐ No ☐ Yes

If yes, list medication(s): _____

Q1.c. Do you have **any other history of mental health problems?** (*e.g. eating disorders, psychosis, bipolar, schizophrenia)* ☐ No ☐ Yes

If yes, list other mental health problems: _____

_____

Q2. Is your relationship with your partner an emotionally supportive one?

☐ Very much ☐ Quite a lot ☐ Somewhat ☐ A little ☐ Not at all ☐ No partner

Q3. Have you had any stresses, changes or losses *in the last 12 months? (e.g. only: separation, domestic violence, job loss, bereavement etc.)*

☐ No — **If No**, skip to **Q4.**

☐ Yes — **If Yes**, please answer **Q3.a.,**

If yes, please specify: _____

If Yes:

Q3.a. How distressed were you by these stresses, changes or losses?

☐ Not at all ☐ A little ☐ Somewhat ☐ Quite a lot ☐ Very much

Q4. Would you generally consider yourself a worrier?

☐ Not at all ☐ A little ☐ Somewhat ☐ Quite a lot ☐ Very much

Antenatal (Psychosocial) Risk Questionnaire (ANRQ) – Client

Q5. In general, do you become upset if you do not have order in your life? *(e.g. regular timetable, tidy house)*

Not at all ☐ | A little ☐ | Somewhat ☐ | Quite a lot ☐ | Very much ☐

Q6. Do you feel you will have people you can depend on for support with your baby?

Very much ☐ | Quite a lot ☐ | Somewhat ☐ | A little ☐ | Not at all ☐

Now you are having a baby, you may be starting to think about your own childhood and what it was like:

Q7. Were you emotionally abused *when you were growing up?*

No ☐ | Yes ☐

Q8. Have you **ever** been sexually ☐ or physically ☐ abused?

No ☐ | Yes ☐

Q9. *When you were growing up,* did you feel your mother was emotionally supportive of you?

Very much ☐ | Quite a lot ☐ | Somewhat ☐ | A little ☐ | Not at all ☐ | No Mother ☐

And finally...

Do you feel safe with your current partner?

Not at all ☐ | A little ☐ | Somewhat ☐ | Quite a lot ☐ | Very much ☐ | No partner ☐

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

Not at all ☐ | A little ☐ | Somewhat ☐ | Quite a lot ☐ | Very much ☐

Do you have any other concerns that you would like to talk about today? _____

_____

_____

Antenatal (Psychosocial) Risk Questionnaire (ANRQ) – Client with postnatal items

Name: _____ Date: _____

The questions below are designed to help you and your clinician understand whether you may benefit from some extra support during this time of change. You may find some questions challenging, but please choose the answers that best apply to you. There are no right or wrong answers.

Please complete all questions, unless instructed to SKIP a question. Once you have completed the questions, your clinician will discuss your responses with you. If you have any concerns about any of the questions, please let your clinician know.

Total

Q1. Have you ever had a period of 2 weeks or more when you felt particularly worried, miserable or depressed?

☐ No — **If No**, skip to **Q1.c.**

☐ Yes — **If Yes**, please answer **Q1.a., Q1.b. and Q1.c.,**

If Yes, did this:

Q1.a. Seriously interfere with your work or your relationships with friends and family?

☐ Not at all ☐ A little ☐ Somewhat ☐ Quite a lot ☐ Very much

Q1.b. Lead you to seek professional help?

☐ No ☐ Yes

Did you see a:

☐ psychiatrist ☐ psychologist/counsellor ☐ GP

If yes, name of professional: _____

Did you take tablets/herbal medicine? ☐ No ☐ Yes

If yes, list medication(s): _____

Q1.c. Do you have **any other history of mental health problems?** (*e.g. eating disorders, psychosis, bipolar, schizophrenia)* ☐ No ☐ Yes

If yes, list other mental health problems: _____

_____

Q2. Is your relationship with your partner an emotionally supportive one?

☐ Very much ☐ Quite a lot ☐ Somewhat ☐ A little ☐ Not at all ☐ No partner

Q3. Have you had any stresses, changes or losses *in the last 12 months? (e.g. only: separation, domestic violence, job loss, bereavement etc.)*

☐ No — **If No**, skip to **Q4.**

☐ Yes — **If Yes**, please answer **Q3.a.,**

If yes, please specify: _____

If Yes:

Q3.a. How distressed were you by these stresses, changes or losses?

☐ Not at all ☐ A little ☐ Somewhat ☐ Quite a lot ☐ Very much

Q4. Would you generally consider yourself a worrier?

☐ Not at all ☐ A little ☐ Somewhat ☐ Quite a lot ☐ Very much

Antenatal (Psychosocial) Risk Questionnaire (ANRQ) – Client with postnatal items

Q5. In general, do you become upset if you do not have order in your life? *(e.g. regular timetable, tidy house)*	Not at all ☐	A little ☐	Somewhat ☐	Quite a lot ☐	Very much ☐	☐
Q6. Do you feel you will have people you can depend on for support with your baby?	Very much ☐	Quite a lot ☐	Somewhat ☐	A little ☐	Not at all ☐	☐

Now you are having a baby, you may be starting to think about your own childhood and what it was like.

Q7. Were you emotionally abused *when you were growing up?*	No ☐	Yes ☐					☐
Q8. Have you **ever** been sexually ☐ or physically ☐ abused?	No ☐	Yes ☐					☐
Q9. *When you were growing up,* did you feel your mother was emotionally supportive of you?	Very much ☐	Quite a lot ☐	Somewhat ☐	A little ☐	Not at all ☐	No Mother ☐	☐

If you have already had your baby, please complete the following questions about your experiences.

Was your experience of giving birth to this baby disappointing or frightening?	Not at all ☐	A little ☐	Somewhat ☐	Quite a lot ☐	Very much ☐	
Has your experience of parenting this baby been a positive one?	Not at all ☐	A little ☐	Somewhat ☐	Quite a lot ☐	Very much ☐	
Overall, has your baby been unsettled or feeding poorly?	Not at all ☐	A little ☐	Somewhat ☐	Quite a lot ☐	Very much ☐	

And finally...

Do you feel safe with your current partner?	Not at all ☐	A little ☐	Somewhat ☐	Quite a lot ☐	Very much ☐	No partner ☐
Do you think that you (or your partner) may have a problem with drugs or alcohol?	Not at all ☐	A little ☐	Somewhat ☐	Quite a lot ☐	Very much ☐	

Do you have any other concerns that you would like to talk about today? _____

_____

_____

 Reference: Austin, M. P., Colton, J., Priest, S., Reilly, N., & Hadzi-Pavlovic, D. (2013) The Antenatal Risk Questionnaire (ANRQ): Acceptability and use for psychosocial risk assessment in the maternity setting. Women & Birth, 26, 17-25.

Antenatal (Psychosocial) Risk Questionnaire (ANRQ) – Client

The questions below are designed to help you and your clinician understand whether you may benefit from some extra support during this time of change. You may find some questions challenging, but please choose the answers that best apply to you. There are no right or wrong answers.

Please complete all questions, unless instructed to SKIP a question. Once you have completed the questions, your clinician will discuss your responses with you. If you have any concerns about any of the questions, please let your clinician know.

Total ☐

Q1. Have you ever had a period of 2 weeks or more when you felt particularly worried, miserable or depressed?

☐ No — **If No**, skip to **Q1.c.**

☐ Yes — **If Yes**, please answer **Q1.a., Q1.b. and Q1.c.,**

If Yes, did this:

Q1.a. Seriously interfere with your work or your relationships with friends and family?

Not at all ☐ | A little ☐ | Somewhat ☐ | Quite a lot ☐ | Very much ☐

Q1.b. Lead you to seek professional help?

☐ No ☐ Yes

Did you see a:
☐ psychiatrist ☐ psychologist/counsellor ☐ GP

If yes, name of professional: _____

Did you take tablets/herbal medicine? ☐ No ☐ Yes

If yes, list medication(s): _____

Q1.c. Do you have **any other history of mental health problems?** (*e.g. eating disorders, psychosis, bipolar, schizophrenia)* ☐ No ☐ Yes

If yes, list other mental health problems: _____

_____

Q2. Is your relationship with your partner an emotionally supportive one?

Very much ☐ | Quite a lot ☐ | Somewhat ☐ | A little ☐ | Not at all ☐ | No partner ☐

Q3. Have you had any stresses, changes or losses *in the last 12 months? (e.g. only: separation, domestic violence, job loss, bereavement etc.)*

☐ No — **If No**, skip to **Q4.**

☐ Yes — **If Yes**, please answer **Q3.a.,**

If yes, please specify: _____

If Yes:

Q3.a. How distressed were you by these stresses, changes or losses?

Not at all ☐ | A little ☐ | Somewhat ☐ | Quite a lot ☐ | Very much ☐

Q4. Would you generally consider yourself a worrier?

Not at all ☐ | A little ☐ | Somewhat ☐ | Quite a lot ☐ | Very much ☐

Q5. In general, do you become upset if you do not have order in your life? *(e.g. regular timetable, tidy house)*

Not at all ☐ | A little ☐ | Somewhat ☐ | Quite a lot ☐ | Very much ☐

Antenatal (Psychosocial) Risk Questionnaire (ANRQ) – Client

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Q6. Do you feel you will have people you can depend on for support with your baby?

Very much ☐ | Quite a lot ☐ | Somewhat ☐ | A little ☐ | Not at all ☐

Now you are having a baby, you may be starting to think about your own childhood and what it was like:

Q7. Were you emotionally abused *when you were growing up?*

No ☐ | Yes ☐

Q8. Have you **ever** been sexually ☐ or physically ☐ abused?

No ☐ | Yes ☐

Q9. *When you were growing up,* did you feel your mother was emotionally supportive of you?

Very much ☐ | Quite a lot ☐ | Somewhat ☐ | A little ☐ | Not at all ☐ | No Mother ☐

Do you have any other concerns that you would like to talk about today? _____

_____

_____

Antenatal Risk Questionnaire (ANRQ) Clinician Information and Scoring Template

Background

The Antenatal Risk Questionnaire (ANRQ) addresses key domains of psychosocial health that have been shown to be associated with increased risk of perinatal mental health morbidity (e.g., depressive or anxiety disorder) and less optimal mother-infant attachment. The ANRQ can be **self-completed or administered** by the clinician and can be used during pregnancy or postnatally[1]. The ANRQ has **12 scored items** relating to the following risk domains:

- Mental health history
- Level of practical support and emotional support from partner
- Stressors/losses in the last year (e.g. bereavement, separation etc.).
- History of physical, sexual or emotional abuse or neglect
- Anxiety and perfectionism levels

Scoring the ANRQ

- There are **12 scored items**
- **Use the scoring template provided:**
  - **Q1, Q1b, Q3, Q7, Q8:** No = 0, Yes = 5
  - **Q1.a, Q2, Q3.a, Q4, Q5, Q6, Q9:** Scores range from 1 to 5
  - **Notes**:
    - *If Q1 = No, Q1a and Q1b should not be answered or scored;*
    - *Q1.c should not be scored;*
    - *If Q3 = No, Q3.a should not be answered or scored.*
- Based on these scoring instructions, place individual questions scores **in the score box on the right hand side**.
- Add up the maximum 12 scored items and place the **Total Score in the box at the top of the questionnaire**.
- The range of scores is 5-60. **A higher score indicates greater psychosocial risk**.

Rules for clinical use of the ANRQ

It is recommended that the following rules be followed when administering the ANRQ:

- The ANRQ should only be used by appropriately **trained** staff with ongoing clinical supervision;
- Ideally, the ANRQ should be administered toward the end of a visit;
- ANRQ responses should be **discussed** with the woman, and **a psychosocial care plan** developed as appropriate (see box);
- The ANRQ should be administered with a depression screening measure (e.g., Edinburgh Depression Scale) to assess for possible current depression;
- The ANRQ is only intended as an **adjunct to clinical history** taking. **ANRQ items and the ANRQ cut-off scores** have been developed to aid the identification woman at increased psychosocial risk but are not a substitute for clinical judgement. If you feel a woman is experiencing distress or is at risk of such, you should discuss your concerns with her, explore these issues further and develop a psychosocial care plan as appropriate.

Summary of ANRQ results and clinical interpretation

- **Cut-off scores:** There is no absolute cut-off score, however an ANRQ **cut-off score of 23 or more is recommended,**[2]
- **A significant mental health history** (i.e., causing functional impairment or requiring professional help) **or** a **history of abuse** places the woman at increased risk of poor psychosocial outcome, **irrespective** of the total ANRQ score (see Box below).

Actions arising from responses to the ANRQ

Results should be discussed with the woman, responses further explored, and a psychosocial care plan developed as appropriate, for women who meet any of the following criteria:

- **Total ANRQ score of 23 or more;**
- **Significant mental health history: If Q1 = 5 (Yes) AND [Q1.a ≥ 4 (Quite A Lot/Very Much) OR Q1b = 5 (Yes)];**
- **History of abuse: If Q7 = 5 (Yes) OR Q8 = 5 (Yes).**
- **If clinical judgement indicates a woman is experiencing distress, or is at risk of such.**

1. The ANRQ has been validated for use during pregnancy, but is yet to be validated in the postnatal period.
2. Austin et al (2013). The Antenatal Risk Questionnaire (ANRQ): Acceptability and use for psychosocial risk assessment in the maternity setting. Women & Birth, 26, 17-25

Antenatal (Psychosocial) Risk Questionnaire (ANRQ) Clinician Information and Scoring Template

Brief Scoring instructions & Interpretation of Results

- There are a maximum of **12 scored items.** Based on the scoring instructions, place individual questions scores **in the score box on the right hand side.**
- Add up the maximum 12 scored items and place the Total Score **in the box at the top of the questionnaire.**
- **Total scores range from 5-60. A higher score indicates greater psychosocial risk.**

Women are at increased psychosocial risk if ANY of the following criteria are met:

> **Total ANRQ score of 23 or more;**
> **Significant mental health history:** If Q1 = 5 (Yes **AND** [Q1.a ≥ 4 (Quite A Lot/Very Much) **OR** Q1.b = 5 (Yes)];
> **History of abuse:** If Q7 = 5 (Yes) **OR** Q8 = 5 (Yes).

Instructions for women identified as at 'increased risk' (as per above):

- **Explore** psychosocial risk further as needed;
- **Discuss** the ANRQ and depression screening[1] results with the woman and establish a **care plan** with her as appropriate.

1. NOTE: The ANRQ should be administered with a depression screening measure (e.g., Edinburgh Depression Scale) to assess for possible current depression.

TOTAL SCORE (5-60)

Total

Q1. Have you ever had a period of 2 weeks or more when you felt particularly worried, miserable or depressed?

No **0** — **If No**, skip to **Q1.c.**

Yes **5** — **If Yes**, please answer **Q1.a., Q1.b. and Q1.c.,**

***SCORE Q1.A AND Q1.B ONLY IF Q1 = 5 (YES)**

If Yes, did this:

Q1.a. Seriously interfere with your work and your relationships with friends or family?

Not at all	A little	Somewhat	Quite a lot	Very much
1	**2**	**3**	**4**	**5**

Q1.b. Lead you to seek professional help?

No **0** Yes **5**

Did you see a:
☐ psychiatrist ☐ psychologist/counsellor ☐ GP

Did you take tablets/herbal medicine? ☐ No ☐ Yes

If yes, name of professional: _____

If yes, list medication(s): _____

Q1.c. Do you have **any other history of mental health problems?** (*e.g. eating disorders, psychosis, bipolar, schizophrenia)* ☐ No ☐ Yes

If yes, list other mental health problems: _____

_____

UNSCORED

Q2. Is your relationship with your partner an emotionally supportive one?

Very much	Quite a lot	Somewhat	A little	Not at all	No partner
1	**2**	**3**	**4**	**5**	**5**

Antenatal (Psychosocial) Risk Questionnaire (ANRQ) Clinician Information and Scoring Template

Q3. Have you had any stresses, changes or losses *in the last 12 months? (e.g. only: separation, domestic violence, job loss, bereavement etc.)*

No **0** — **If No**, skip to **Q4.**

Yes **5** — **If Yes**, please answer **Q3.a.,**

If yes, please specify: _____

***SCORE Q3.A ONLY IF Q3 = 5 (YES)**

If Yes:

Q3.a. How distressed were you by these stresses, changes or losses?

Not at all	A little	Somewhat	Quite a lot	Very much
1	**2**	**3**	**4**	**5**

Q4. Would you generally consider yourself a worrier?

Not at all	A little	Somewhat	Quite a lot	Very much
1	**2**	**3**	**4**	**5**

Q5. In general, do you become upset if you do not have order in your life? *(e.g. regular timetable, tidy house)*

Not at all	A little	Somewhat	Quite a lot	Very much
1	**2**	**3**	**4**	**5**

Q6. Do you feel you will have people you can depend on for support with your baby?

Very much	Quite a lot	Somewhat	A little	Not at all
1	**2**	**3**	**4**	**5**

Now you are having a baby, you may be starting to think about your own childhood and what it was like:

Q7. Were you emotionally abused *when you were growing up?*

No **0** — Yes **5**

Q8. Have you **ever** been sexually ☐ or physically ☐ abused?

No **0** — Yes **5**

Q9. *When you were growing up,* did you feel your mother was emotionally supportive of you?

Very much	Quite a lot	Somewhat	A little	Not at all	No Mother
1	**2**	**3**	**4**	**5**	**5**

Do you have any other concerns that you would like to talk about today? _____

_____

_____

COPE Safety Plan

Warning signs:

What are some of the warning signs that you may be at risk of harming yourself (e.g. feeling trapped, worthless or hopeless) and what can you do to protect yourself and your infant?

Warning signs:

Protective action:

Coping strategies:

What are some of coping strategies that you help you and decrease the level of risk?

Support networks:

Who can you turn to people to assist you in times of need?

Professional help:

Which health professionals and agencies can be contacted for help?

This resource is developed by COPE: Centre of Perinatal Excellence and is derived from *Effective Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*. 2017. Centre of Perinatal Excellence.
Funded by the Australian Government

Assessing Suicide Risk

Ask

• Suicidal thoughts • Plan • Lethality • Means

Consider risk to the infant at all times

Fleeting thoughts of self-harm or suicide but no current plan or means

Low risk

- Discuss availability of support and treatment options
- Arrange follow-up consultation (timing of this will be based on clinical judgement)
- Identify relevant community resources and provide contact details

Suicidal thoughts and intent but no current plan or immediate means

Medium risk

- Discuss availability of support and treatment options
- Organise re-assessment within one week
- Have contingency plan in place for rapid re-assessment if distress or symptoms escalate
- Develop a safety plan with the woman

Continual/specific suicidal thoughts, intent, plan and means

High risk

- Ensure that the woman is in an appropriately safe and secure environment
- Organise re-assessment within 24 hours and monitoring for this period
- Follow-up outcome of assessment
- Monitor risk to infant

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Pathways to Care

A Guide to the Management of Depression and Anxiety

Screening with the EPDS and Psychosocial Assessment (ANRQ)

- As early as practical in pregnancy and repeat screening later in pregnancy
- Always follow-up Q10 on the EPDS
- At 6–12 weeks after birth and repeat screening at least once in the postnatal year

Safety Concerns

Acute Mental Health Services | Crisis Assessment and Treatment Teams (CATT) | Child Protection

Usual Care
Provide to all woman

- Provide health promotion information
- Psycho-education
- Sign-up to Ready to COPE
- Help lines
- Web-based resources to seek help and information
- Discuss any support the woman may require.

EPDS score = 10–12
(Monitor and Repeat EPDS 2-4 weeks)

Management Options:
As Usual Care *plus*

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

EPDS score = 13–14

Management Options:
As previous box *plus*

- *Enhanced midwifery/MCHN*
- Psychology
- Social work services*
- Psychiatry services*
- Individual and group PND specialised programs

*(*MCH and/or private sector)*

EPDS score = 15 and above

Management Options:
As previous box *plus*

- Mental Health Shared Care
- Adult mental health/Psychology services
- Specialist perinatal mental health services
- Psychiatry services

History of Mental Health Issues other than Depression and/or Anxiety

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

Services for Other Psychosocial and Concurrent Problems

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

Adapted and updated from Beyondbabyblues online training program to reflect the 2017 Guideline

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Assessing mother-infant interaction and safety of the woman and infant

A guide for health professionals

The following table provides a list of prompts to assess difficulties in the mother-infant relationship[1]. The list is not exhaustive and is not intended to be used as a checklist or formal assessment tool. Rather, it indicates areas of functioning that are important to the mother-infant relationship. If any concerns arise, consulting with and/or referring to the appropriate specialist service is a consideration.

Psychosocial risk factors

- Unresolved family of origin issues
- History of physical/sexual abuse, family violence, childhood neglect
- Past pregnancy loss or excess pregnancy concern
- Unplanned or unwanted pregnancy
- Was the mother able to touch the baby on the day of birth?
- Did the mother have responsibility for infant care during the first week of life?
- Who is involved in the baby's care?
- Availability of emotional/social/practical support
- How much time does the mother spend away from the baby?
- Is the mother excessively worried about the baby?

Infant factors

- Is baby achieving normal developmental milestones?
- Is the baby growing adequately?
- Are there feeding difficulties, reflux, gastric distress, sleep difficulties?

Infant behaviour of concern (observed or reported)

- Gaze avoidance
- Flat affect
- Lack of crying
- Limited vocalising
- Emotionally under-responsive
- Interacts too easily with strangers (age-dependent)
- Unsettled sleep or feeding
- Difficult to console when distressed
- Irritable, constant crying
- Difficulty separating from parent (age-dependent)

Relationship factors (observed or reported)

- 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 engage in enjoyable activities with the baby?
- Does the mother play/talk appropriately with the baby?
- Does she delight in her 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?
- Does she respond and attend appropriately to the baby's cues?
- Are her responses consistent?
- Is she protective of the baby?

Maternal factors

- Current maternal psychopathy
- Antenatal or postnatal mood disorder
- Psychosis
- Diagnosed personality disorder
- Suicidal or homicidal ideation
- Negative symptoms (low motivation, anhedonia, blunted affect, poverty of thought/speech)
- Medication side-effects
- Substance abuse
- Engaging in dangerous or risk-taking behaviours (e.g. alcohol or drug misuse)

Protective factors

- Mother is sensitive to the baby
- Mother is able to monitor the baby's well-being adequately
- Mother is responsive to the baby
- Mother is able to cope with flexibility in her routine
- Mother has a close relationship with at least one other adult
- Mother is thoughtful about what might be going on in the baby's mind

Adapted from Stefan et al (2009).

Assessing mother-infant interaction and safety of the woman and infant

A guide for health professionals

Risk to the infant

If difficulties with the mother-infant interaction as outlined above are observed and/or if the woman has a significant mental health condition, further assessment will be required. Risk of harm to the infant can be related to suicide risk in the mother but can also be a separate issue. Although expressions of fear of harming the baby may be a sign of anxiety rather than intent, these should always be further assessed.

The way in which risk to the fetus or infant is assessed depends on the setting and the extent of the therapeutic relationship. The following are examples of questions that could be asked, taken from the Postpartum Bonding Questionnaire (Brockington et al 2006) and adapted to the perinatal context.

- Have you felt irritated by being pregnant or by your baby?
- Have you had significant regrets about becoming pregnant or having the baby?
- Does the baby feel like it's not yours at times?
- Have you wanted to harm your unborn child or shake or slap your baby?
- Have you ever harmed your baby?

Action will depend on the answers to these questions. It is preferable that the mother and infant remain together but, if there is a perceived risk of harm to the infant, involvement of others (e.g. father or co-parent) in caring for the infant or alternative arrangements are advisable.

Notification to the relevant child protection agency may be necessary. All health professionals should be familiar with the legislation concerning reporting of concerns about children at risk of harm from abuse or neglect in their State or Territory. Health services and child and maternal agencies will generally have internal policies setting out these requirements.

Risk of suicide[2]

Suicide risk assessment requires clinical judgement, a sense of the woman in context, understanding of the baby/infant as both a protective factor and a risk factor, and awareness of how mental health symptoms might affect impulsivity.

Assessing the risk of suicide

Assessment of risk involves asking about the extent of suicidal thoughts and planning, including:

- *suicidal thoughts* – if a woman has suicidal thoughts, how frequent and persistent are they?
- *plan* – if the woman has a plan, how detailed and realistic is it?
- *lethality* – if the woman has a planned method, how lethal is it?
- *means* – does the woman have the means to carry out the method?

Consideration should also be given to:

- risk and protective factors
- mental state – hopelessness, despair, psychosis, agitation, shame, anger, guilt, impulsivity
- history of suicidal behaviour
- family history of suicidal behaviour
- substance use – current misuse of alcohol or other drugs
- strengths and supports – availability, willingness and capacity of supports.

Whenever a woman is assessed as at risk of suicide, her capacity to care for the infant and any thoughts of harm to the infant should be assessed.

1. Stefan J, Hauck Y, Faulkner D et al (2009) *Healthy Mother-infant Relationship: Assessment of Risk in Mothers with Serious Mental Illness*. North Metropolitan Area Health Service, Mental Health, WA Department of Health.
2. Australian National Suicide Prevention Strategy (NSPS) website — www.livingisforeveryone.com.au

Centre of Perinatal Excellence

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