Perinatal mental health

Clinical Guideline Presentation v1.0

45 minutes

Towards CPD Hours

Clinical Excellence Queensland

Queensland Government

References:

Queensland Clinical Guideline: *Perinatal mental health* is the primary reference for this package.

Recommended citation:

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Disclaimer:

This presentation is an implementation tool and should be used in conjunction with the published guideline. This information does not supersede or replace the guideline. Consult the guideline for further information and references.

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Objectives

Identify:

- Risk factors for perinatal mental health conditions
- Screening recommendations and appropriate responses to identified risk
- Treatment principles for perinatal mental health conditions
- Principles about the use of psychotropic medication in the perinatal period
- Principles to reduce risk of, and respond to birth trauma
- Screening recommendations of the parent-infant relationship
- Mental health considerations for infants
- Perinatal mental health considerations for partners

Abbreviations

Abbreviation	Meaning
ANRQ	Antenatal Risk Questionnaire
CALD	Culturally and linguistically diverse
DFV	Domestic and family violence
ED	Eating disorder
EPDS	Edinburgh Postnatal Depression Score
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, queer, plus
PNRQ	Postnatal Risk Questionnaire

Overview

- The perinatal period is a high-risk time for new and relapse of existing mental health issues
- Approximately 16% of women and 10% of men will develop a significant perinatal mental health condition in this period
- Suicide is a leading cause of maternal death in Queensland

Risk factors

- Previous mental illness is the most significant risk factor for developing a perinatal mental health condition
- Family history of mental illness
- Pregnancy and birth related factors (e.g. hyperemesis, adverse birth experience, perinatal loss, complications during perinatal period)
- Vulnerable populations including First Nations peoples, CALD families, LGBTIQ+ parents, migrants including refugees and asylum seekers, adolescent parents, parents with a disability

Risk factors continued…

Psychosocial risk factors:

- Domestic and family violence (DFV)
- Low levels of support
- Isolation (cultural, distance, social)
- Substance use (previous or current)
- Unstable relationships
- History of adversity, trauma or adverse childhood experiences
- Housing stressors
- Current or recent stressful life events
- Natural disasters or pandemics
- Low socioeconomic status

Psychosocial screening

- Screens for psychosocial risk factors (both past and present) and history of mental illness
- Informs care for woman and family
- Is conducted in addition to screening for symptoms of depression and anxiety
- Some tools incorporate screening for DFV and substance use
- The ANRQ/PNRQ is the recommended psychosocial screening tool in Australia

Psychosocial screening

Recommendations

- Use the **ANRQ/PNRQ** to screen for psychosocial risk factors
  - As early as practical in pregnancy
  - After birth
- Complete when woman is alone
- Use in conjunction with **EPDS**
- Review responses to facilitate appropriate support/referrals as indicated

Screening for depression and anxiety

- The EPDS is the recommended tool for screening for depression in Australia
- Items 3, 4 and 5 screen for anxiety symptoms
- Screen using the EPDS:
  - As early as practical in pregnancy
  - At least once later in pregnancy
  - In the first 6 to 12 weeks following birth
  - Repeat at least once in first postnatal year
  - Repeat at any time in pregnancy or the first postnatal year if indicated

EPDS

- Screening tool only, it is not diagnostic
- Consider full context and apply clinical judgement regardless of score
- Further assessment indicated if
  - Score of 13 or more
  - Positive response to item 10
  - Current thoughts and/or plans of harm towards self or infant
  - EPDS anxiety questions (Q3 to Q5) score 6 or more

Screening summary

Enquire about emotional wellbeing at every antenatal and postnatal visit

As early as practical in pregnancy

- Enquire about history of and/or current mental health conditions
- Complete EPDS, ANRQ and DFV screening

Throughout pregnancy

- Complete EPDS at least once later in pregnancy or at any time if concerned

After birth

- EPDS and PNRQ 6 to 12 weeks after birth
- Repeat EPDS at least once in first postnatal year or at any time if concerned

First Nations peoples

- At increased risk of mental health conditions
- Fear of institutional racism or past trauma can deter or prevent from accessing services
- Social and emotional wellbeing is foundational for physical and mental health
- Prioritise cultural safety and wherever possible, provide continuity of care and offer connection with First Nations workforce
- For screening, consider cultural appropriateness of tools
  - Consider use of Kimberley Mums Mood Scale
  - If using EPDS, use adapted cut-off score of equal to or greater than 9

Multidisciplinary care and referral pathways

- Multidisciplinary care from multiple providers or services is often required
- Provide a coordinated and multidisciplinary approach appropriate to clinical circumstances
- Work collaboratively and communicate effectively to decrease fragmentation of care
- Wherever possible, recommend and facilitate continuity of care/carer models
- Co-design locally applicable referral and care pathways
- Establish clear and explicit pathways into and out of perinatal mental health services
- Eliminate gaps in services
- Consider telehealth and electronic care formats

Treatment principles

- Continuity of care/carer wherever possible
- Collaborate with women, partners and other family or support persons to support management and recovery
- Provide supportive management to address psychosocial adversities
- Emphasise importance of nutrition, adequate rest, self-care and stress management
- Assess for contributing organic factors (e.g. iron deficiency and thyroid status)
- Adopt a trauma-informed, non-judgmental, empathetic, strength-based approach
- Consider and discuss risks and benefits of treatment options for woman and fetus/infant
- Include planning for relapse prevention
- Refer woman and partner to quality information and support resources including peer support
- In severe cases, hospital care may be indicated, preferably in a mother-baby unit wherever possible

Psychotropic medication

Considerations and principles include:

- Select medications with an established pregnancy safety profile for all women of reproductive age wherever possible
- Combine pharmacological treatment with psychological therapies and psychosocial interventions wherever possible
- Discuss risks and benefits of medication versus no treatment for the woman and fetus/breastfeeding infant
- Consider woman's past or current response to treatment

Stopping medication

- Sudden cessation of medication may contribute to relapse, especially during the perinatal period
- If medication cessation or changes are required before conception, advise about reducing gradually under professional guidance
- Discuss the risks of relapse associated with stopping medication with woman, partner and support persons

Case study – Laura

Laura is 30 years old and pregnant with her first baby. She presents for her first antenatal appointment at 16 weeks gestation.

What screening is indicated for Laura?

- Enquire about emotional wellbeing
- Enquire about history of and/or current mental health conditions and fear of birth
- Screen for depression and anxiety using the EPDS
- Complete the ANRQ, plus DFV and substance use screening

Screening

Laura scores 5 on the EPDS, and less than 23 on the ANRQ. There is no identified personal or family history of mental illness. There is no identified substance use or DFV.

What action is recommended for Laura?

- Provide universal education and resources about emotional health and wellbeing in the peripartum
- Provide key messages about perinatal mental health including that:
  - Mental health conditions are common in the perinatal period
  - It's OK to ask for help
  - Support is available
  - The sooner conditions are assessed and treated, the sooner recovery is possible

Case study - Zhang

Zhang is 32 years old. She had her first baby six weeks ago and presents to her local child health clinic for the baby's scheduled vaccinations.

What screening is indicated for Zhang?

- Enquire about emotional wellbeing
- Screen for depression and anxiety using the EPDS
- Complete the PNRQ

Assessment and response

Zhang's EPDS score is 15. She has responded to Q10 (about thoughts of self-harm) positively. Her response is "hardly ever". The PNRQ identifies that Zhang has a history of depression. Her family and friends live overseas and she feels very isolated. Her partner is very supportive and they have a good relationship.

What perinatal mental health risk factors are identified for Zhang?

- EPDS score 15
- Positive response to Q10 on EPDS
- History of depression
- Isolation from family and friends

Assessment

You have a conversation with Zhang about her mental health and discuss her positive response to Q10.

What questions are important when assessing the risk of suicide and self-harm or harm to others?

- Suicidal thoughts—if suicidal thoughts are present, how frequent, and persistent are they?
- Suicidal history—is there a history of previous suicide attempts?
- Plan—if the woman has a plan, how detailed is it?
- Lethality—what method has the woman chosen; how lethal is it?
- Means—does the woman have the means to carry out the method?
- Intent—does the woman intend on carrying out her plan?
- Risk of harm to infant—any thoughts of harm towards infant?

Assessment

What other factors are important to assess?

- Assess for high-risk indicators (e.g. recent significant change in mental state, severe difficulties with sleeping, intrusive worry, psychotic symptoms, difficulty caring for self or infant)
- Collateral information from family members or support persons
- Substance use or DFV concerns
- Relationship and attachment with infant
- Safety of infant
- Strengths and protective factors

Response

You have a thorough discussion with Zhang and liaise with a senior colleague. You have established the Zhang does not have any active plans to harm herself or her infant. She is open and receptive to receiving help. Zhang has a good relationship with her GP and makes an appointment for the next day.

What are your next steps?

- Develop a safety plan to identify
  - Warning signs
  - Protective actions
  - Coping strategies
  - Support networks
  - Professional help
- Consider appropriate referrals and locally accessible supports
- Arrange follow up and repeat EPDS in 2 weeks

Crisis support

Two weeks later, Zhang attends her follow up appointment. Her partner Mike is with her. Mike is extremely worried about Zhang. He reports Zhang is not sleeping, is extremely paranoid and is expressing thoughts of suicide.

What are you next steps?

- Conduct a comprehensive assessment of Zhang's symptoms and explore her suicidal thoughts (see previous slide)
- Repeat EPDS—can provide guide for review and further questioning
- Liaise with senior colleagues
- Sensitively enquire about thoughts of harm to her baby
- If immediate risk to self or baby is identified, options include:
  - Calling 000 for Queensland Ambulance Service or Queensland Police Service
  - Phone 1300 MH CALL (1300 642 255)
  - Arrange for assessment at nearest emergency department

Severe mental illness

- **Includes**
  - Bipolar disorder
  - Schizophrenia
  - Postpartum psychosis
- **When identified, it is important to facilitate**
  - Continuity of care/carers
  - Ongoing care and management from a perinatal psychiatrist (or psychiatrist with access to perinatal psychiatry advice)
  - Relapse prevention plans
  - Close monitoring
  - Multidisciplinary care
  - Trauma-informed care

Borderline personality disorder (BPD)

Important principles include:

- Trauma-informed care and developing a trusting relationship
- Facilitate continuity of carer/s and a ‘wrap around’ approach
- Management of co-occurring mental health conditions, substance use and psychosocial stressors
- Assess and support the mother-infant relationship
  - May experience challenges in early parenting related to sleep, physical changes and own experience of being parented
  - Consider therapies to support healthy attachment and infant mental health

Eating disorders (ED)

Risk factors

- Personal or family history of ED
- History of infertility, menstrual disturbances, or polycystic ovary syndrome
- Body mass index (BMI) at booking in of less than 18 or more than 30 (but do not assume presence or absence of an ED based on weight)
- Perfectionistic and obsessional personality traits
- Adopting and aspiring to cultural ideals of thinness, muscularity and leanness
- History of belonging to high-risk groups such as competitive sports, modelling and performing arts

Eating disorder screening

- Wherever possible, screen for and support the treatment of an ED prior to pregnancy
- Screen for symptoms at booking in visit, and opportunistically throughout the perinatal period
- Enquire about current or past history of ED
- Monitor for risk factors and signs and symptoms
- Maintain a low threshold for referral to an ED service
- Facilitate continuity of care/carer and multidisciplinary involvement as appropriate (e.g. eating disorder specialists, perinatal mental health team, dietitian and obstetric medicine physicians)

Mental health in partners

- Partners and non-birthing parents can also experience perinatal mental health conditions
- Symptoms present differently in men compared to women
- Estimated prevalence in partners is 1 in 10 for depression and 1 in 5–6 for anxiety

Recommendations

- Facilitate a welcoming and inclusive environment for partners
- Enquire about partner's emotional wellbeing when providing perinatal care
- If using a screening tool, consider use of EPDS or K10 (Kessler Psychological Distress Scale) or other tools if available and competent in use
- Encourage partners to access community programs and digital supports

Infant mental health

- Refers to capacity of developing infant to
  - Form close and secure relationships
  - Explore, manage and experience emotions
  - Explore their environment

- Foundations of lifelong mental health and emotional wellbeing are developed in utero, and across infancy and childhood

Infant mental health

- Social and emotional development of the infant occurs in context of the parent-infant relationship
- A secure, warm, responsive and predictable relationship with at least one caregiver influences positive infant wellbeing
- Attachment between an infant and their parent/caregiver is critical for healthy development
- Poor parental mental health can have negative impacts on the infant
- Recommendation
  - Be mindful of the parent-infant relationship and screen for positive indicators and indicators of concern
  - If infant mental health concerns are identified, refer for appropriate care and support (e.g. infant mental health services, and early intervention parenting support)