Perinatal Depression and Anxiety

Introduction

'Perinatal' is the term used to collectively describe the ante and post-natal period. During this time women are more at risk of experiencing mood disorders or low social and emotional wellbeing (SEWB). Caring for women during the perinatal period includes engaging with women about their mental health and broader SEWB.

Perinatal depression and/or anxiety is thought to affect one in ten women across Australia. Research suggests this figure is likely to be higher for Aboriginal and Torres Strait Islander women.

Engaging perinatal women in a conversation around their mood and/or SEWB should occur at each antenatal and postnatal appointment. This should involve a strengths-based yarn with the woman about her current risks and protective factors and/or formal screening via a validated screening tool.

Validated screening tools include the Kimberley Mum's Mood Scale (KMMS) and the Edinburgh Postnatal Depression Scale (EPDS). All Aboriginal and Torres Strait Islander women should be offered the KMMS.

The KMMS is not a low literacy tool. It is a locally designed and validated tool that incorporates psychosocial yarning alongside a regionally adapted symptomology assessment. The KMMS offers a more culturally sensitive approach to perinatal mental health screening.

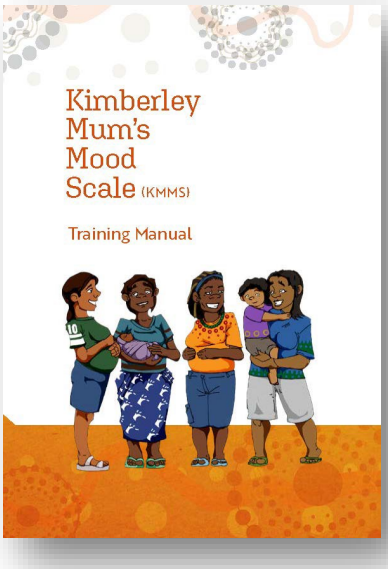
Formal screening using the KMMS (or the EPDS) should be offered according to the following schedule:

Antenatal

- First booking visit or soon after
- 28- or 36-week's visit

Postnatal

- 8 weeks, 4 months, and 12 months



Case Definitions (as per DSM-IV)

Depression

Depression is a clinical diagnosis defined as five or more of the following symptoms for at least two weeks (must have one of the first two):

- Persistent depressed mood
- Loss of interest or pleasure in activities
- Significant change in weight (loss or gain)
- Disturbed appetite
- Markedly increased or decreased sleep or disturbed sleep
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feeling worthless or guilty
- Loss of concentration, indecisiveness
- Recurrent thoughts of death, self-harm or suicide
- Loss of sex drive

Additional symptoms of perinatal depression may include: poor attachment, lack of interest and / or ability to care for the infant. This is a symptom of the illness and does not mean the woman is a 'bad' mother.

Anxiety

Anxiety disorders are common in the perinatal period. These symptoms may be in addition to depressive symptoms or alone:

- Excessive anxiety and worries that are difficult to control
- Restlessness
- Fatigue
- Difficulty concentrating
- Irritability
- Muscle Tension
- Sleep problems

Panic attacks may or may not be present.

Presentation also commonly includes physical symptoms such as headaches, nausea, chest pain, shortness of breath. The presence of these with no physical causes on medical review should trigger screening with KMMS/EPDS.

Both anxiety and depression can result in behavioural changes such as avoidance e.g., missed appointments or self-medication with substance misuse. If these behaviours are present, consider screening with KMMS/EPDS.

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Perinatal Depression and Anxiety

Risk Factors

- Previous history of anxiety or depression, particularly during perinatal period
- History of abuse and/or trauma
- Unhappy about pregnancy/unplanned pregnancy
- Stressors such as those relating to relationships, finances, housing, alcohol, substance use
- Difficult/traumatic/premature birth
- Birth/infant health concerns
- Difficulties breast feeding
- Lack of supports, such as social, emotional, family supports

The risks of untreated perinatal depression and anxiety include:

1. *For the mother*: greater risk of complications in labour/ delivery; risk of self-harm, inability to perform daily functions, reduced ability to care for the child.
2. *For the child*: low birth weight, feeding problems, attachment issues, developmental and behavioral issues.

Perinatal depression and anxiety are not the same as:

- *Baby Blues* – a common response that develops within 3-10 days after birth. It affects 80% of postnatal women. Women feel emotional and teary, anxious, tense and exhausted. They may have difficulty sleeping. It is a self-limiting condition that resolves within 1-2 weeks. Requires recognition, support, empathy, and education.
- *Postnatal (Puerperal) Psychosis* – manifests as hallucinations, thought disturbances, paranoia, and delusions, and affects 1 in 1,000 postnatal women within the first month but may develop up to 12 weeks after childbirth. Postnatal psychosis is more common in women who have a personal or family history of mental illness. If you suspect a mother has puerperal psychosis immediate emergency care is required.

Screening

Perinatal depression and/or anxiety are serious conditions which can pose a threat to the health, safety and wellbeing of the mother, the baby, and her broader family.

Routine clinical screening is a simple and effective way to engage patients in discussing and managing their mental health. Barriers to a woman engaging with her clinician about her mental health may include fear of child removal, stigmatisation, and concerns regarding breaches to her confidentiality.

It is important to address these by emphasising the routine nature of mental health screening for all women, the confidential nature of the discussion and the limits of confidentiality.

Screening Aboriginal women via the KMMS includes:

- An assessment of risk factors based on the commonly recognised diagnostic criteria of depression and anxiety.
- A yarn – talking and listening to women about their current situation (psychosocial domains of support, current stressors, relationships, childhood experiences, alcohol and substance use, SEWB) while assessing for risk and protective factors.
- Determining risk of perinatal depression and/or anxiety and working with women to develop a management plan.

Understanding a woman's current situation (risks and protective factors) and her psychosocial care needs is essential in adequately determining risk and ensuring appropriate follow up support and treatment. It is for this reason that the KMMS is recommended as the primary screening tool for Aboriginal women. The KMMS must be completed as a two-part tool.

It is recommended that all staff are trained in the administration of the KMMS.

Further assessment

Symptoms of depression and/or anxiety are associated with, or exacerbated by, physical issues and the social determinants of health.

If not discussed during the screening process, enquire about a woman's eating, exercise, and sleep and for other issues including substance misuse, nutrition, breastfeeding concerns, infant medical status, birth experiences/fear of childbirth and family and domestic violence. Refer to the KMMS psychosocial question guide to help with this exploration. For exploration around family and domestic violence, refer to the Kimberley Family and Domestic Violence Clinical Guideline.

Assess when the last time baseline bloods where taken. If full blood count, urea and electrolytes, liver function test, thyroid function test, iron studies, B12, folate were not taken within the last month, discuss with general practitioner (GP) about follow up blood tests.

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Principles of Management

Care pathways

Screening will determine if a woman is at low, moderate, or high risk of depression and/or anxiety.

Risk assessment	Low	Moderate	High
Follow up action	Self-care recommended	Clinical assessment within 7 days	Clinical assessment within 72 hours

Health professionals should refer to the Kimberley Deliberate Self Harm and Suicidal Behaviour Clinical Guideline, if during screening the patient discloses a positive response to:

- Thoughts of self-harm or suicide
- Thoughts of harm to baby/family

A Clinical judgement is crucial in determining risk of perinatal depression/anxiety- if you are concerned about a patient speak to a senior clinician in your clinic or telephone KMHDS triage via 9194 2222, prior to the patient leaving the clinic.

Providing psychosocial support

- Assess the woman's current supports including partner, family, and other social/service-based supports. Discuss support options with the woman. To identify appropriate support services visit online directories, such as healthdirect, Mappa, and the Kimberley Mental Health and Other Drug Service Map
- Encourage active self-care through:
  - De-stigmatisation of depression/anxiety. Reassure the woman that she is not a 'bad' mother.
  - Physical activity, being on Country, good nutrition, and rest.
  - Participating in social or recreational activities (such as fishing) with supportive family and/or friends
  - Daily planned activities for self with baby and social supports.
- Provide meaningful education to the woman (and where appropriate, partner and/or family) about perinatal depression and/or anxiety.
- Encourage the woman to engage with supports/primary health care clinic if her situation changes.
- If the woman has been assessed at moderate or high risk explain that as per standard clinical care, she will be referred for further clinical assessment.
- Summarise the woman's protective factors and speak with her about the importance of keeping herself strong.

Findings from the development and implementation of the KMMS have demonstrated how important it is to yarn with women about their protective factors. Women identified that yarning about their resilience enabled their health care provider to see all of them, not just their risks and challenges. Being seen and heard was identified as critical in developing an engaging and trusted woman-clinician care partnership.

GP role in management

1. Assess and formally diagnose if the patient has a mental health disorder.
2. Continue to offer support and if necessary, refer to specialist mental health/psychosocial support services.
3. Consider role of medication in antenatal/perinatal depression and/or anxiety.

In formal diagnosis, consider other concomitant diagnosis such as post-traumatic stress disorder, obsessive-compulsive disorder OCD and bipolar disorder. Consider the significant trauma history experienced by many people in the Kimberley region.

Selective serotonin reuptake inhibitors (SSRIs) are an appropriate choice of medication for antenatal and/or postnatal depression

- Escitalopram or Sertraline (on the Kimberley Standard Drug List (KSDL)) are an appropriate first choice.
- **Avoid** Paroxetine. This is not on the KSDL and has been associated with heart defects when given in the first trimester.
- Preconception planning is recommended for women with pre-existing depression who are already controlled on antidepressant medication. Consider the risks and benefits of medication. Refer to the Pre-conception protocol.

Resources

- Kimberley Mental Health and other Drug Service Map
- Kimberley Mum's Mood Scale
- KMMS Training (free)

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