Mental health care in the perinatal period: Australian clinical practice guideline.

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Overview

Guideline Objective

To guide best practice in the identification, prevention, and treatment/management of the more common mental health disorders (depression and anxiety) that may occur during pregnancy or in the first year following the birth of a baby (i.e., the perinatal period)

Note: While obsessive compulsive disorder is not included as specific review of the evidence was not undertaken, the general principles for treatment align with those for anxiety disorders.

Patient Population

- All pregnant or postnatal women and non-birthing partners
- Pregnant or postnatal women who have an existing mental health disorder, or are considered to be at risk of developing a mental health disorder

Note:

- The postnatal period is defined as the 12 months following birth.
- As the guideline also provides an assessment of the harms associated with interventions used for the treatment or prevention of perinatal mental health issues, the population also encompasses the offspring of these women (i.e., the fetus, infant, or child).
- Attention is also given to women with a history of mental health issues who might be planning a pregnancy.
- The guideline uses the terms "woman" or "mother" and "breastfeeding" throughout. These should be taken to include people who do not identify as women but are pregnant or have given birth.

Recommendations

Recommendation Statements

Screening and Assessment

Considerations Before Screening and Psychosocial Assessment

Consensus-based Recommendation (CBR). All health professionals providing care in the perinatal period should receive training in parent-centred communication skills, psychosocial assessment and culturally safe care.

CBR. The administration of a screening tool is part of a multicomponent approach that must involve clinical judgement, clear protocols for further assessment of women who screen positive and appropriate care pathways.

Screening for Depressive Disorders

Evidence-based Recommendation (EBR). Administer the Edinburgh Postnatal Depression Scale (EPDS) to screen women for a possible depressive disorder in the perinatal period. (**Strong**)

EBR. Arrange further assessment of perinatal women with an EPDS score of 13 or more. (**Strong**)

CBR. For a woman with a positive score on Question 10 on the EPDS undertake or arrange immediate further mental health assessment and, if there is any disclosure of suicidal ideation, take urgent action in accordance with local protocol/policy.

CBR. Complete the first antenatal screening as early as practical in pregnancy and repeat screening at least once later in pregnancy.

CBR. Complete the first postnatal screening 6–12 weeks after birth and repeat screening at least once in the first postnatal year.

CBR. For a woman with an EPDS score between 10 and 12, monitor and repeat the EPDS in 2–4 weeks as her score may change subsequently. Use clinical judgement in planning monitoring and further care.

CBR. Repeat the EPDS at any time in pregnancy and in the first postnatal year if clinically indicated.

CBR. When screening Aboriginal and/or Torres Strait Islander women, consider language and cultural appropriateness of the tool.

Practice Point (PP). Where possible, seek guidance/support from an Aboriginal and/or Torres Strait Islander worker or professional when conducting psychosocial assessment on an Aboriginal and/or Torres Strait Islander woman.

CBR. Use appropriately translated versions of the EPDS with culturally relevant cut-off scores. Consider language and cultural appropriateness of the tool.

Screening for Anxiety Disorders

CBR. Be aware that anxiety disorders are very common in the perinatal period and should be considered in the broader clinical assessment.

CBR. As part of the clinical assessment, use anxiety items from the EPDS or other validated tools that include anxiety items and relevant items in structured psychosocial assessment tools (e.g., the Antenatal Risk Questionnaire (ANRQ)).

Assessing Psychosocial Factors that Affect Mental Health

PP. Assess psychosocial risk factors as early as practical in pregnancy and again after the birth.

EBR. Administer the ANRQ to assess a woman's psychosocial risk. (**Strong**)

CBR. Undertake psychosocial assessment in conjunction with a tool that screens for current symptoms of depression/anxiety (i.e., the EPDS) as early as possible in pregnancy and 6-12 weeks after the birth.

PP. Ensure that health professionals receive training in the importance of psychosocial assessment and use of a psychosocial assessment tool.

PP. Ensure that there are clear guidelines around the use and interpretation of the psychosocial tool/interview in terms of threshold for referral for psychosocial care and/or ongoing monitoring.

PP. Discuss with the woman the possible impact of psychosocial risk factors (she has endorsed) on her mental health and provide information about available assistance.

CBR. Use appropriately translated versions of the ANRQ. Consider language and cultural appropriateness of any tool used to assess psychosocial risk.

Assessing Perinatal Mental Health in Non-Birthing Parents

CBR. Offer non-birthing parents mental health screening in the perinatal period.

CBR. Given the absence of support for one specific screening tool it is not currently possible to universally recommend one screening tool over another.

CBR. Select screening tools in accordance with availability and competencies of health professionals to use a specific tool within specific settings.

CBR. Consider use of the EPDS (with a lower cut-off score) and the K10 due to the brevity of these tools and their current use in maternity and postnatal settings (EPDS), and in primary care settings (K10) in the Australian context.

CBR. When administering the EPDS to male parents, use a lower cut-off score (10 or more), noting responses to individual items.

CBR. Offer non-birthing parents mental health screening as early as practicable in pregnancy and from 3–6 months after the birth. Offer repeat screening when clinically indicated.

CBR. Offer non-birthing parents psychosocial screening in the perinatal period.

CBR. Use the amended ANRQ/Postnatal Risk Questionnaire (PNRQ) screening tool for male non-birthing parents.

CBR. Use the ANRQ/PNRQ in its current form for psychosocial screening of female non-birthing parents.

CBR. For parents who do not identify as male or female, offer the ANRQ/PNRQ in its current form to the birthing parent, and the amended version to the non-birthing parent.

CBR. Offer psychosocial assessment as early as practicable in pregnancy and the postnatal period (in combination with mental health screening).

Assessing Mother-Infant Interaction and Safety of the Infant

PP. Assess the mother-infant interaction as an integral part of perinatal care and refer to a parent-infant therapist as available and appropriate.

PP. Seek guidance/support from Aboriginal and/or Torres Strait Islander health professionals when assessing mother-infant interaction in Aboriginal and/or Torres Strait Islander women, to ensure that assessment is culturally appropriate and not informed by unconscious bias.

PP. Seek guidance/support from bicultural health workers when assessing mother-infant interaction in migrant, refugee and culturally and linguistically diverse women, to ensure that assessment is person and culturally appropriate, and not informed by unconscious bias.

PP. Consider the potential additional needs of young mothers when assessing mother-infant interactions to ensure that assessment is person and age appropriate, and not informed by unconscious bias.

PP. When a woman is identified as at risk of suicide, manage immediate risk, arrange for urgent mental health assessment and consider support and treatment options, including ensuring safety/appropriate care for the baby.

PP. Assess the risk of harm to the infant if significant difficulties are observed with the mother-infant interaction, the woman discloses that she is having thoughts of harming her infant and/or there is concern about the mother's mental health.

Supporting Emotional Health and Well-Being

PP. At every antenatal or postnatal visit, enquire about a woman's emotional and physical well-being, and the well-being of her partner if appropriate.

PP. Provide parents in the perinatal period with support for integrating healthy behaviours in their daily lives, and where appropriate referral to evidence-based physical activity, healthy eating and/or sleep programs.

Prevention and Treatment

Providing Information and Advice

CBR. Provide all women with information about the importance of enquiring about, and attending to, any mental health problems that might arise across the perinatal period.

PP. If a woman agrees, provide information to and involve her significant other(s) in discussions about her emotional well-being and care throughout the perinatal period.

Planning Care for Women with Mental Health Conditions

PP. Provide advice about the risk of relapse during pregnancy and especially in the first few postpartum months to women who have a new, existing or past mental health condition and are planning a pregnancy.

PP. For women with schizophrenia, bipolar disorder or borderline personality disorder, a multidisciplinary team approach to care in the perinatal period is essential, with clear communication, a documented care plan and continuity of care across different clinical settings.

PP. Wherever possible, assessment, care and treatment of the mother should include the infant.

PP. Where possible, health professionals providing care in the perinatal period should access training to improve their understanding of care for women with schizophrenia, bipolar disorder and borderline personality disorder.

Use of Pharmacological Treatments

PP. Discuss the potential risks and benefits of pharmacological treatment in each individual case with the woman and, where possible, her significant other(s). Document the discussion.

PP. Ensure that women are aware of the risks of relapse associated with stopping or changing medication and that, if a medication is ceased, this needs to be done gradually and with advice from the treating health professional.

PP. Discuss treatment (medication and psychological) options that would enable a woman to breastfeed if she wishes and support women who choose not to breastfeed.

PP. Ideally, treatment with psychoactive medications during pregnancy would involve close liaison between the prescribing health professional and a woman's maternity care provider(s). In more complex cases, it is advisable to seek a second opinion from a perinatal psychiatrist.

PP. When exposure to psychoactive medications has occurred in the first trimester–especially with anticonvulsant exposures–pay particular attention to the 13 or 18-20 week ultrasound due to the increased risk of major malformation.

PP. Plan for pharmacological review in the early postpartum period for women who cease psychotropic medications during pregnancy.

Postnatal Care and Support

CBR. Arrange observation of infants exposed to psychoactive medications in pregnancy for the first 3 days after the birth.

PP. In planning postnatal care for women with schizophrenia, bipolar disorder, severe depression or borderline personality disorder, take a coordinated team approach to parent and infant mental health care and pre-arrange access to intensive maternal child health care.

PP. When caring for mothers with severe mental illness, including borderline personality disorder, it is important to ensure that child protection risks are understood and addressed, if necessary.

CBR. Where possible, if a mother with a severe postnatal episode requires hospital admission, avoid separation from her infant with co-admission to a specialist mother-baby unit where facilities are available and appropriate.

Women with Depressive and Anxiety Disorders

Psychosocial and Psychological Interventions

EBR. Provide structured psychoeducation to women with symptoms of depression in the perinatal period. (**Strong**)

EBR. Advise women with symptoms of depression in the postnatal period of the potential benefits of a social support group. (**Conditional**)

EBR. Recommend individual structured psychological interventions (cognitive behavioural therapy or interpersonal psychotherapy) to women with symptoms of depression in the perinatal period. (**Strong**)

CBR. Consider online approaches for delivery of cognitive behavioural therapy.

EBR. Advise women with depression or anxiety disorder in the postnatal period of the possible benefits of directive counselling. (**Conditional**)

CBR. For women who have or are recovering from postnatal depression and are experiencing mother–infant relationship difficulties, consider provision of or referral for individual mother–infant relationship interventions.

Complementary Therapies

EBR. Advise women that omega-3 fatty acid supplementation does not appear to improve depression symptoms but is not harmful to the fetus or infant when taken during pregnancy or while breastfeeding. (**Conditional**)

CBR. Advise pregnant women that the evidence on potential harms to the fetus from St John's Wort is limited and uncertain and its use during pregnancy is not recommended.

CBR. Advise pregnant women that potential harms to the fetus from Ginkgo biloba have not been researched and its use during pregnancy is not recommended.

Pharmacological Treatments

PP. Be aware that failure to use medication where indicated for moderate-to-severe depression and/or anxiety in pregnancy or postnatally may affect mother-infant interaction, parenting, maternal health and well-being and infant outcomes.

EBR. When prescribing antidepressants to pregnant women, consider selective serotonin reuptake inhibitors (SSRIs) as first-line pharmacological treatment for depression and/or anxiety. (**Conditional**)

PP. Before choosing a particular antidepressant for pregnant women, consider the woman's past response to antidepressant treatment, obstetric history (e.g., other risk factors for miscarriage, preterm birth or postpartum haemorrhage) and any factors that may increase risk of adverse effects.

EBR. When prescribing antidepressants to women in the postnatal period, use SSRIs as first-line pharmacological treatment for depression. (**Strong**)

PP. Before prescribing antidepressants to women who are breastfeeding, consider the infant's health and gestational age at birth.

CBR. Consider the short-term use of benzodiazepines for treating symptoms of anxiety while awaiting onset of action of an antidepressant in pregnant or postnatal women.

PP. Use caution in repeated prescription of long-acting benzodiazepines around the time of the birth.

PP. Use caution in prescribing non-benzodiazepine hypnotics (z-drugs) to pregnant women for insomnia.

PP. Use caution in prescribing benzodiazepines in the perinatal period due to the risk of dependence, withdrawal in the neonate and sedation with breastfeeding.

PP. Doxylamine, a Category A drug in pregnancy, may be considered for use as a first-line hypnotic in pregnant women who are experiencing moderate-to-severe insomnia.

Women with Severe Mental Illness

Antipsychotics

EBR. Use antipsychotics to treat psychotic symptoms in pregnant women. (**Conditional**)

CBR. Use caution when prescribing antipsychotics with metabolic effects to pregnant women, due to the increased risk of gestational diabetes.

CBR. If women commence or continue use of antipsychotics with metabolic effects during pregnancy, consider earlier screening and monitoring for gestational diabetes.

CBR. If considering use of clozapine in pregnant women, seek specialist psychiatric consultation.

PP. Seek specialist psychiatric consultation if considering use of clozapine in women who are breastfeeding and monitor the infant's white blood cell count weekly for the first 6 months of life.

Anticonvulsants

PP. Given their teratogenicity, only consider prescribing anticonvulsants (especially valproate) to women of child-bearing age if other options are ineffective or not tolerated and effective contraception is in place.

PP. Once the decision to conceive is made, if the woman is on valproate wean her off this over 2–4 weeks, while adding in high-dose folic acid (5 mg/day) which should continue for the first trimester.

EBR. Do not prescribe sodium valproate to pregnant women. (**Strong**)

CBR. Use great caution in prescribing anticonvulsants as mood stabilizers for pregnant women and seek specialist psychiatric consultation when doing so.

CBR. If prescribing lamotrigine to a woman who is breastfeeding, arrange close monitoring of the infant and specialist neonatologist consultation where possible.

Lithium

CBR. If lithium is prescribed to pregnant women, ensure that maternal blood levels are closely monitored and that there is specialist psychiatric consultation.

PP. If lithium is prescribed to a pregnant woman, monitor lithium levels carefully and adjust individual dose prior to and after delivery.

CBR. Where possible, avoid the use of lithium in women who are breastfeeding.

Women with Borderline Personality Disorder

PP. Provide trauma-informed care for women with borderline personality disorder.

PP. Specific support for health professionals in dealing with challenging behaviours associated with borderline personality disorder should be prioritised.

PP. Advise women with borderline personality disorder who are planning a pregnancy, of the additional challenges of parenting associated with their emotional dysregulation, and the importance of ongoing support during and after pregnancy.

CBR. Where possible and appropriate, for women with borderline personality disorder, arrange structured psychological therapies that are specifically designed for this condition and conducted by adequately trained and supervised health professionals.

PP. Encourage pregnant or postnatal women with borderline personality disorder to undertake mindfulness and/or relaxation training to assist in managing their emotional dysregulation.

CBR. As far as possible, do not use pharmacological treatments as the primary therapy for borderline personality disorder, especially in pregnant women.

PP. Consider pharmacological treatment for comorbidities in women with borderline personality disorder.

Women Who Experience Psychological Birth Trauma

CBR. Use routine psychosocial screening (e.g., PNRQ) to gain knowledge about a woman's risk of experiencing birth as traumatic.

CBR. If post-traumatic symptoms persist beyond 3 months, consider referral to appropriate mental health professionals for further assessment and/or care.

CBR. Offer women who have post-traumatic stress disorder resulting from a traumatic birth a high-intensity psychological intervention (trauma-focused cognitive behavioural therapy (CBT) or eye movement desensitisation and reprocessing).

CBR. Do not offer single-session high-intensity psychological interventions with an explicit focus on 're-living' the trauma to women who experience a traumatic birth.

CBR. Depending upon the woman's post-traumatic stress symptoms, consider the use of pharmacological treatments.

Women Who Do Not Respond to Pharmacological Treatment

Electroconvulsive Therapy (ECT)

CBR. Consider ECT when a postnatal woman with severe depression has not responded to one or more trials of antidepressants of adequate dose and duration.

CBR. Consider ECT as first-line treatment for postnatal women with severe depression especially where there is a high risk of suicide or high level of distress; when food or fluid intake is poor; and in the presence of psychotic or melancholic symptoms.

PP. In pregnant women, ECT should only be undertaken in conjunction with close fetal monitoring (using cardiotocography to monitor fetal heart rate), specialist pregnancy anesthetic care and access to specialist maternal-fetal medical support.

Evidence Rating Scheme

Scheme not provided.

Recommendation Rating Scheme

Four types of guidance are included:

- **Evidence-based Recommendation (EBR)**: A recommendation formulated after a systematic review of the evidence, with a clear linkage from the evidence base to the recommendation using Grading of Recommendations, Assessment, Development and Evaluations (GRADE) methods and graded either:
    - "**Strong**" implies that most/all individuals will be best served by the recommended course of action; used when confident that desirable effects clearly outweigh undesirable effects or, conversely, when confident that undesirable effects clearly outweigh desirable effects; or
    - "**Conditional**" implies that not all individuals will be best served by the recommended course of action; used when desirable effects probably outweigh undesirable effects; used when undesirable effects probably outweigh desirable effects.
- **Consensus-based Recommendation (CBR)**: A recommendation formulated in the absence of quality evidence, after a systematic review of the evidence was conducted and failed to identify sufficient admissible evidence on the clinical question.
- **Practice Point (PP)**: Advice on a subject that is outside the scope of the search strategy for the systematic evidence review, based on expert opinion and formulated by a consensus process.

Related Content

Supporting Documents

- Administrative Report; 2023.
- Technical Report:
    - Part A: Overall Approach for Developing the Australian Perinatal Mental Health Guideline; 2023 Feb 13.

- Part B: Psychosocial Assessment and Screening for Depression or Anxiety in the Perinatal Period; 2023 Feb 13.
- Part C: Effectiveness of Treatment and Prevention Interventions for Depression and Anxiety in the Perinatal Period; 2023 Feb 13.
- Part D: Harms Associated with Treatment and Prevention Interventions for Mental Health Disorders in the Perinatal Period; 2023 Feb 13.
- Part E: Treatment and Prevention of Mental Health Problems Arising from Traumatic Birth Experience; 2023 Feb 13.
- Part F: Perinatal Mental Health Assessment of Fathers and Non-Birthing Partners; 2023 Feb 13.

Implementation Tools

- Perinatal Mental Health Fact Sheets for Health Professionals:
  - Perinatal Anxiety.
  - Perinatal Depression.
  - Schizophrenia in the Perinatal Period.
  - Assessing Mother-Infant Interaction & Safety of the Woman and Infant.
  - Postpartum Psychosis.
  - Borderline Personality Disorder in the Perinatal Period.
  - Bipolar Disorder in the Perinatal Period.
  - Ready to COPE.
- Edinburgh Postnatal Depression Scale (EPDS) Scoring Guide.
- Antenatal (Psychosocial) and Risk Questionnaire (ANRQ) Clinician Information and Scoring Template.
- Online Training and Education Programs.

Patient Education

- Antenatal Fact Sheets for Women and Their Families:
    - Antenatal Anxiety.
    - Depression During Pregnancy.
    - Schizophrenia in Pregnancy.
    - Bipolar Disorder in Pregnancy.
    - Borderline Personality Disorder in Pregnancy and the Postnatal Period.
- Postnatal Fact Sheets for Women and Their Families:
    - Postnatal Anxiety.
    - Postnatal Depression.
    - Postpartum Psychosis.
    - Schizophrenia in the Postnatal Period.
    - Bipolar Disorder in the Postnatal Period.
    - Borderline Personality Disorder in Pregnancy and the Postnatal Period.

Note: This patient information is intended to help patients better understand their health and their diagnosed disorders. Patients and their representatives should still consult with a licensed health care professional for evaluation of treatment options as well as answers to their personal medical questions.

Disclaimer

these Guideline Profiles is responsible for evaluating the appropriateness of applying them in a clinical setting.

TRUST Scorecard

Composition of Guideline Development Group (GDG)

Multidisciplinary GDG Members	Yes
Methodologist Involvement	Yes
Incorporation of Patient and Public Perspective	

Systematic Review of Evidence

Literature Search	
Study Selection	
Evidence Synthesis	

Foundations for Recommendations

Strength of Evidence Grade	
Description of Benefits and Harms of Recommendations	
Summary of Evidence Supporting Recommendations	
Strength of Recommendations Rating	
Clear Articulation of Recommendations	

Funding Source	Yes
Disclosure and Management of Financial Conflicts of Interests	
External Review	
Updating