Perinatal mental health

Presented by: Dr Anastasia BRAUN Consultant Perinatal Mental Health  Liz Bennett Team Leader
Maternal and perinatal mortality and morbidity in Qld

- Maternal death
- During 2012 and 2013 there were eight (8) maternal deaths due to causes directly or indirectly related to the pregnancy. The maternal mortality ratio in Queensland for 2012 and 2013 was 6.4 per 100,000 births. The most recently published national maternal mortality ratio was 7.1 per 100,000 births for the five years 2008 to 2012 and the Queensland maternal mortality ratio for this same period (8.5 per 100,000 births) was not statistically significantly different.
- There were also four (4) maternal deaths due to incidental causes and 28 late maternal deaths. Five (5) of the 40 women who died were of Aboriginal and/or Torres Strait Islander origin; all of these deaths were late maternal deaths with causation incidental to the pregnancy. Suicide was the leading cause of death in women during pregnancy and within 365 days of the end of pregnancy.
- 40 deaths that occurred during pregnancy or within 365 days of the end of a pregnancy. Suicide (8), malignancy (8) and motor vehicle trauma (6) were the most prominent causes of death.

Mental illness in perinatal women

- Pregnancy not protective against mood disorders
- About 13% of women meet DSM 5 criteria for a depressive disorder in antenatal/postnatal period
- 3-5% incidence of moderate or severe major depression
- 75% relapse rate in first trimester if discontinue antidepressants
- Suicide is now foremost cause of perinatal deaths 60-75% cases maternal suicide antenatally
- Infant’s exposure to maternal PND associated with higher cortisol levels and thus mental health difficulties
- Effects on mother-infant interaction
- Can affect infant temperament and attachment
- Motor, cognitive, social development
- Severity and chronicity of maternal illness predictive
- Impact on relationship
Service snap shot

- Perinatal Mental Health services for MNHHS are based at Nundah Community Health Centre. The perinatal mental health team provide services to mothers and their partners from conception up to the first year following delivery.
- Service covers the Metro North catchment area
- We run ante natal clinics in all the birthing hospitals within Metro North
- We see on average 3 clients per clinic for an hour interview
- The perinatal mental health team hold a multi-disciplinary meeting at each clinic to discuss complex cases. Attendees include child health workers, alcohol and drugs workers and social work. The psychiatrist attends the RBWH clinic team meetings
- Perinatal psychiatrist runs BB clinics at Nundah RBWH mental health and maternity
- Psych Reg has one clinic per week
- We also see postnatal women in their home
- Women can self refer. Referrals via GPs child health, midwives a variety of NGOs
- We also see men
- Women can be seen by psychiatrist for pre conception work up
- Shades clinics' at the RBWH manages woman with complex mental health issues and polysubstance use. Redcliffe also has complex acse clinic meetings and we are rolling out the same at Caboolture
What we do

• Community based short term non acute referral service.
• Ante and post natal women and their partners. Specialist Perinatal mental health assessment and brief intervention model in a non acute setting
• Mental health assessment with emphasis of mother baby attachment and bonding.
• Increase awareness and use of the Edinburgh Depression Scale (EDS) for screening
• Perinatal consultation liaison service to primary care and other specialist mental health providers
• Improve support and access for primary health providers to specialist mental health
• Develop pathways of care to support women and their families in the Perinatal period to identify and seek treatment early
• To continue to map and collate a resource of services within Brisbane Metro North area
Vulnerable groups

- Hyperemesis Gravidarum
- Body Image & Obesity
- Birth trauma
- Previous intrauterine fetal death
- LGBTIQ
- Advanced maternal age
- IVF
- Drug and alcohol
- Previous child safety
- Sexual trauma of both partners
- Previous and existing major mental health disorders
- Previous post partum psychosis
Untreated antenatal anxiety and depression on developing foetus

- Effects on foetus’s developing (transplacental passage of stress hormones)
- Decreased serotonin and dopamine
- Increased cortisol and noradrenaline
- Foetal neurological development (neural tube defects/ birth weight/head circumference)
- Newborns – decreased motor tone/increased irritability/decreased alertness
- Relationship between antenatal anxiety and “difficult” or “negative” infant behaviours in first few months of life controlling for postnatal mood, SES etc
Antenatal distress and infant development

• Association between antenatal distress and infant development (attentional tasks)

• High maternal anxiety in T3 associated with increased risk hyperactivity

• Persistent antenatal depression associated with 50% increased risk of developmental delay at 18 months

• Long term HPA dysregulation confers increased risk of mental health difficulties
COPE

• October 2107 the new mental health care in the perinatal Period: clinical practice perinatal guidelines was launched
• These guidelines included
  • supporting emotional health and wellbeing of women
  • screening for symptoms of depression and anxiety and assessment for psychosocial factors that affect mental health
  • assessing mother-infant interaction and the safety of the woman and infant
  • referral and care pathways for women who require further assessment or care
  • care planning for women with diagnosed mental health conditions
  • psychological approaches to prevention and treatment of depressive and anxiety disorders
  • prescribing in pregnant and breastfeeding women, in terms of potential risks (harm to fetus/infant) and benefits
  • potential areas for future development to support the sustainable and measurable implementation of best practice.
COPE recommendations

- Recommendation of SSRi’s as a first line treatment for moderate to severe post natal depression which considering previous responses
- Consideration of short-term use of benzodiazepines for treating moderate to severe symptoms of anxiety while awaiting onset of action of an SSRI or tricyclic antidepressants (TCA) in pregnant or postnatal women. Using caution with repeated prescription of long acting benzodiazepines around the time of birth
- do not prescribe Sodium valporate ( women should be weaned over2 to 4 weeks with high dose folic acid
- Do not initiate clozapine in pregnant women use with extreme caution with breastfeeding women
- Use caution with prescription of anti psychotics
- If lithium is used reduce dose prior to onset of labour. Lithium should be avoided when breast feeding
- Lamotrigine should be discontinued prior to pregnancy but can be resumed post partum but not breast feeding. If maintained past first trimester refer for specialist perinatal psychiatry advice and in depth morphology
- Recommended use of psychological interventions with consideration of CBT and EMDR
- If exposure to psychoactive medications in the first trimester must have in depth morphology scan at 18 to 20 weeks
Interpreting EPDS scores

• Clinical judgement is integral to interpreting EPDS scores, as in some cases the score may not accurately represent a woman’s mental health. For example, a woman may have a low score, even though there is good reason to believe that she is experiencing depressive symptoms. A very high EPDS score could suggest a crisis, other mental health issues or unresolved trauma.

• Scores may be influenced by several factors, including the patients understanding of the language used, their fear of the consequences if depression is identified, and differences in emotional reserve and perceived degree of stigma that is associated with depression.
Cultural considerations

• Scores used to identify possible depression in Aboriginal and Torres Strait Islander and culturally and linguistically diverse populations are generally lower than those used in the general population.

• For Aboriginal and Torres Strait Islander women, the score may be influenced by the woman’s understanding of the language used, mistrust of mainstream services or fear of consequences of depression being identified.

• Translations of the EPDS developed in consultation with women from Aboriginal communities have been found to identify a slightly higher number of women experiencing symptoms of depression.

• Cultural practices (such as attending the consultation with a family member) and differences in emotional reserve and the perceived degree of stigma associated with depression may also influence the performance of the EPDS in women from culturally and linguistically diverse backgrounds.
Antidepressants and pregnancy

- Up to 35% of women use psychotropics in pregnancy
- SSRI/SNRI most commonly used
- TGA alert Sept 2005 reported association 2 fold risk of VSD and Paroxetine in pregnancy
- Alert based on unpublished, retrospective, noncontrolled GSK drug company study, plus conference abstracts from 2 studies
- Fluoxetine associated with increased risk of cleft lip palate and neonatal toxicity
- Otherwise no clear evidence increased risk of major malformations or foetal death
Valporate and pregnancy

- Risk congenital malformations 10-15% (Victorian anticonvulsant register)

- 7-10x increase in neural tube defects with 1st T exposure
- ?dose dependent; Increased risk at doses over 1000mg
- *Retrospective* study of *epileptic* mothers (N=249) identified reduced verbal IQ in school aged children exposed to Valproate vs non exposure (Vinten 2005)
How to refer

- All referrals go to our generic email box
  - **Perinatal-Mental-Health@health.qld.gov.au**
- They will be triaged promptly and taken to the triage team meetings on Mondays
- GP referrals are a priority and recent Edinburgh's are appreciated
- Referral to Dr Anastasia Braun can be faxed to 3646 1821. Patients can be seen at Nundah community health centre, E floor mental health or ANC RBWH
Supports for women

- White cloud foundation [http://whitecloudfoundation.org/](http://whitecloudfoundation.org/)
- Beyond blue
• YPP https://encircle.org.au/young-parents-program/
• QPAST http://qpastt.org.au/
• Amend http://betterrelationships.org.au/services/counselling/amend/
Supports

- Perinatal Mental Health Service
- General Practitioner (GP). Private Psychologist or Psychiatrist through Mental Health Care Plan (MHCP).
- Child Health
- Allied Psychological Services (ATAPS)
- Pregnancy and Counselling Link (PCL)
- Social worker
- Lavender Mother and Baby Mental Health Unit (Gold Coast)
- MH CALL
- Acute Care Mental Health Team
- Department of Emergency Medicine – Please note there can be extended wait times and this must be taken into consideration.
- Consult Liaison – For inpatients in public hospitals
- Department of Child Safety (DOCS)
- Culturally Appropriate services e.g. CALD, ATSI
ACT versus PNMH

- An Acute care team (ACT) functions as the first point of contact to public mental health services, 24 hours, 7 days a week. Following triage, they facilitate the most appropriate type of care (e.g. inpatient, community, crisis interventions) for acute and non-acute referrals.

- Examples:
  - If a mother or father requires further mental health triage
  - If a mother or father requires assertive follow up
  - When Perinatal Service has limited capacity to follow up with client in an appropriate time frame due to workload or other clinical reasons. This can be discussed with the PNMH team.

- Acute referrals, for example:
  - In cases of suspected postpartum psychosis (urgent assessment is required).
  - Suicidal and self harm ideation, plan and intent.
  - Acute risk to mother and/or others, including baby.

  - For ACT referrals please contact MHCALL: 1300642255
  - Or if imminent risk to send the client to Department of Emergency medicine.
Sites of interest