

25 January 2024

The Secretary,
House of Assembly Select Committee
on Reproductive, Maternal and
Paediatric Health Services in Tasmania,
House of Assembly,
Parliament House, Hobart, TAS, 7000

Dear Committee Chair,

Public Submission into Reproductive, Maternal and Paediatric health services in Tasmania

The Centre of Perinatal Excellence (COPE) welcomes the opportunity to provide a submission to the Select Committee on reproductive, maternal and paediatric health services in Tasmania, with a focus on perinatal mental health.

Up to one in ten women experience depression during pregnancy and one in seven women in the year following birth. Anxiety disorders are also common and, like perinatal depression, often go undetected. Suicide is one of the leading causes of maternal death in Australia.

COPE is Australia's peak body in perinatal mental health. COPE is funded by the Commonwealth Government to undertake a range of activities to inform and facilitate the implementation of best practice in Mental Health across Australia.

Activities include the development of Australia's National Clinical Practice Perinatal Mental Health Guideline (2023), to guide best practice in the detection, management, and treatment of perinatal mental health. The Guideline underpins the implementation of COPEs innovative approaches to train health professionals, support early identification of mental health disorders and provide appropriate referral pathways. Our work also extends to educating expectant and new parents to support prevention and early intervention of perinatal mental health disorders.

The attached submission draws on this work, which is fully funded by the Commonwealth Government. The submission outlines how perinatal mental health services can capitalise on Commonwealth investment to prevent and reduce the negative impacts of perinatal mental health disorders for Tasmanian parents, families, and infants. The submission also highlights current statistics and any disparities with other States and Territories.

Please do not hesitate to contact us if we can provide any further assistance.

Yours sincerely,

Dr Nicole Highet
Founder & Executive Director
Chairperson, 2023 Perinatal Mental Health Guideline

About COPE

COPE is Australia's peak body in perinatal mental health and devoted to reducing the impacts of mental health conditions in the pre and postnatal periods. COPE is a world leader in best practice innovative solutions to delivering best practice in perinatal mental health. This includes engaging and interactive approaches to psychoeducation, digital screening, online training, and e-referral pathways to care.

COPE's philosophy is that all women, men and families should have access to timely and effective screening, management, treatment and care.

Our programs and opportunities for Tasmania

Revision of Perinatal Mental Health Guideline

COPE released the latest revision of the *Australian Perinatal Mental Health Guidelines* that was funded by the Commonwealth Government and approved by the National Health and Medical Research Council (NHMRC) in 2023.

The Guideline provides vital information to the broad range of health professionals delivering antenatal and postnatal care (including midwives, GPs, maternal child and family health nurses) to guide them in the identification, prevention and treatment of mental health conditions in the perinatal period.

Opportunities for Tasmania

COPE welcomes the opportunity to work with the Tasmanian Government to increase awareness of, and support the uptake of, the national Guideline across the State, to ensure practice is in line with the latest evidence and clinical recommendations surrounding training, screening, assessment, and treatment.

Training for Health Professionals

COPE provides a range of online training programs for health professionals to support the implementation of best practice in accordance with the National Guideline. Training is designed for frontline health professionals providing antenatal and postnatal care, and is free of charge for all professionals, namely midwives, GPs, maternal and child health nurses.

In addition, COPE has responded to the need to increase the capacity of the *perinatal mental health workforce* through the development of an Applied Skills Program. This program is currently being offered through some States and Territories wishing to increase skills amongst mental health providers in the treatment of perinatal mental health disorders.

Opportunities for Tasmania

Feedback and scoping of perinatal mental health services across the State of Tasmania highlights a need for greater mental health services to support early intervention and care in Tasmanian community.

COPE has responded to the need to increase the capacity of the perinatal mental health workforce in other States and Territories through the provision of the Applied Skills Program. Here COPE offers discounts for Governments wishing to make this available to appropriately trained mental health workers within their State/Territory.

iCOPE Digital Screening

Funded by the Commonwealth Government, a digital screening tool, iCOPE, facilitates efficient and effective mental health screening across all public maternity hospitals and all maternal and child health services in Australia. iCOPE allow screening to be undertaken prior to or at the maternity postnatal appointment via the client's own mobile phone, saving time, ensuring 100% accuracy and offering screening in 25 languages.

The iCOPE system produces instant clinical reports for health professionals, which guide the assessment process. Patients also can access their screening results (via email or sms) at the point of screening.

Further, the automated collection of data in real time informs screening rates and outcomes across sites and services, whilst also meeting compliance for the collection and storage of patient data and claiming of Medicare Item numbers.

Opportunities for Tasmania

iCOPE is currently being rolled out across the States of Victoria, Queensland and South Australia. With over 150,000 screens having been undertaken to date, iCOPE serves to support efficient and inclusive screening of parents, whilst simultaneously allowing the monitoring and evaluation of screening outcomes across jurisdictions.

Funding for the national rollout of iCOPE also includes integration with hospital and maternal and child health patient record systems across the States and Territories.

COPE and our partner diginostic have already been in discussions with the Perinatal Mental Health Project Lead and Project Officers regarding the implementation of iCOPE in 2024 across Tasmania.

eCOPE Directory

To support the identification of timely and appropriate referral pathways at, or beyond the point of screening, COPE developed the eCOPE Directory.

This is a national online directory of perinatal mental health and community support services. The eCOPE directory supports the identification of local and telehealth services. All listings are maintained by the services, to ensure that they maintain currency, and reviewed by our clinical team prior to listing to ensure services are appropriately accredited.

Opportunities for Tasmania

COPE frequently receives requests for assistance around referral pathways in Tasmania for perinatal mental health treatment and community support – particularly in rural and regional areas as well as across the State broadly.

We know from our work populating the eCOPE Directory of perinatal mental health services, that building the current workforce and ensuring clinicians have appropriate perinatal expertise is a key priority area in all areas of the state of Tasmania, with very few services currently identified and listed on the Directory.

While the continuation of telehealth options means services are more accessible for those in rural and regional areas and from the mainland, upskilling the current workforce is required to meet the demands of those needing face-to-face treatment and overall service accessibility.

We welcome the opportunity to work closely with Tasmanian representatives to scope the perinatal mental health workforce for inclusion on the Directory. In addition, if there is a need to further upskill the workforce, this can be supported through the provision of our Applied Skills program.

Ready to COPE app

In line with the Guideline recommendations highlighting the importance of universal, psychoeducation for all expectant and new parents, COPE has developed the free, Ready to COPE app.

The app provides timely, relevant emotional and mental health information weekly, throughout pregnancy and first year of parenthood. Now available for men, women and adapted for Aboriginal and Torres Strait Islander men and women (and translated into ten languages), Ready to COPE is an effective, sustainable education and early intervention resource.

Again, this activity is fully funded by the Commonwealth Government.

Opportunities for Tasmania

COPE welcomes the opportunity to promote the uptake of this valuable resource to all expectant and new parents in Tasmania through our digital screening and health promotion posters across key maternity settings.

Installation of Ready to COPE posters will be completed across three Hobart Hospitals in 2024.

- The Royal Hobart Hospital – public
- Calvary Lenah Valley Hospital – private
- Hobart Private Hospital – private

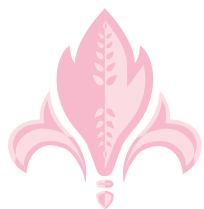
Comment on Perinatal Mental Health Inpatient service

As a peak body, COPE is not a provider of clinical services. However, we do advocate for service provision in accordance with National Guideline recommendations.

Following the closure of Healthscope's St Helen's Private Hospital in Hobart, and its eight-bed Mother and Baby Unit, COPE has been contacted by several consumers and clinicians concerned about the impact on those seeking care for serious perinatal mental illness.

We commend the Tasmanian government for their swift action to establish three public beds at Royal Hobart Hospital. However more beds are likely to be needed around to the state to ensure mothers with serious mental illness (such as postpartum psychosis and severe postnatal depression) can be safely treated as inpatients without being separated from their babies.

There are currently no services available for private referrals, and public places are very limited with only three beds available for the state.



COPE

Centre of Perinatal Excellence

Mental Health Care in the Perinatal Period

Australian Clinical Practice Guideline

2023 REVISION



The Centre of Perinatal Excellence (COPE) is an independent, not-for-profit organisation. Since COPE's establishment in June 2013, it has been the policy of the COPE Board not to accept funding from, nor partner with pharmaceutical companies. None of COPE's activities are funded by pharmaceutical companies. This allows COPE to retain independence and impartiality and promote evidence-based approaches to perinatal mental health.

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Disclaimer

This is a general guide to appropriate practice, to be followed subject to the relevant clinician's judgement in each individual case.

COPE has taken all reasonable steps to ensure that the Guidelines is based on, and accurately represent, the best available published evidence on key areas of antenatal care.

However, COPE does not accept any legal liability for any loss, damage, costs or expenses that may result from reliance on the information and recommendations contained in the Guideline.

Systematic literature review

The systematic literature review that provides the evidence base for the Guideline was conducted by Hereco.

Technical writing

Ampersand Health Science Writing was responsible for drafting and editing the Guideline in consultation with the EWG.

Expiry of the Guideline

The Guideline was submitted to the National Health and Medical Research Council (NHMRC) in March 2023 and approved in April 2023.

Approval for the Guideline by the NHMRC is granted for a period not exceeding 5 years, at which date the approval expires. The NHMRC expects that all guidelines will be reviewed no less than once every 5 years. Readers should check with COPE for any reviews or updates of the Guideline.

Suggested citation

Hight, NJ and the Expert Working Group and Expert Subcommittees (2023) *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*. Melbourne: Centre of Perinatal Excellence (COPE).

Funding

COPE acknowledges the funding provided by the Australian Government Department of Health and Aged Care for the development of the Guideline.

Publication approval



Australian Government

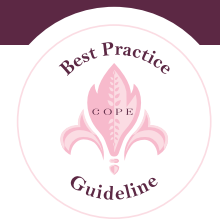
National Health and Medical Research Council

The guideline recommendations on pages vii–xv of this document were approved by the Chief Executive Officer of the National Health and Medical Research Council (NHMRC) on 14 April 2023 under section 14A of the *National Health and Medical Research Council Act 1992*. In approving the Guideline recommendations, NHMRC considers that they meet the NHMRC standard for clinical practice guidelines. This approval is valid for a period of five years.

NHMRC is satisfied that the Guideline recommendations are systematically derived, based on the identification and synthesis of the best available scientific evidence, and developed for health professionals practising in an Australian health care setting.

This publication reflects the views of the authors and not necessarily the views of the Australian Government.

Foreward



On behalf of the Centre of Perinatal Excellence (COPE) and the Expert Working Group, I am pleased to issue **Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline**. The purpose of the Guideline is to support health professionals in providing evidence-based care and inform and support the provision of quality emotional and mental health information to those in their care.

In this 2023 revision, the Guideline covers the important areas of screening and psychosocial assessment not only for women, but for the first time, this has been extended to include expectant and new fathers and partners. This work was supported by the development of a newly-formed Fathers and Partners expert advisory committee.

The Guideline also provides guidance on care for women with depressive and anxiety disorders, severe mental illnesses (schizophrenia, bipolar disorder and postpartum psychosis) and borderline personality disorder at this time. This includes examination of the role of psychosocial and psychological interventions, complementary therapies and pharmacological treatments, the latter supported by the work of the harms and safety expert advisory committee. Also new to this edition is guidance for women who experience psychological birth trauma.

The Guideline includes discussion of:

- Supporting emotional health and well-being of women and their families
- Screening for symptoms of depression and anxiety and assessment for psychosocial factors that affect mental health in expectant and new mothers, fathers and non-birthing partners
- 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
- Care planning for those who have experienced psychological birth trauma
- 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.

The Guideline does not cover:

- The diagnosis or specifics of managing mental health conditions in the perinatal period
- Routine assessment of specific social and lifestyle factors that affect perinatal outcomes and may also be associated with mental health.

The Guideline revision comes at an important time as Australia continues to expand its focus and investment into the prevention, early identification and treatment of perinatal mental health. The Centre of Perinatal Excellence will continue to support the implementation of this Guideline through the development of summary resources, companion documents, training and innovative approaches to screening and referral. Further, COPE will monitor the uptake and impact of the Guideline on the delivery of best practice and assess its contribution to changes in practice and potentially to health outcomes.

A handwritten signature in black ink that reads "Nicole Highet".

Dr Nicole Highet

Chair, Expert Working Group
Founder and Executive Director

Centre of Perinatal Excellence

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Summary



Studies in Australia and around the world have found that up to one in ten women experience depression during pregnancy and one in seven women in the year following birth. Anxiety disorders are also prevalent (around one in five women in both the antenatal and postnatal periods) and comorbidity with depression is high. Severe mental illnesses – schizophrenia, bipolar disorder and borderline personality disorder – are much less common than depression and anxiety disorders. All of these conditions have the potential to have a negative impact on outcomes for the mother and infant and for the family more broadly. This is more likely to occur when a mental health condition is combined with serious or multiple adverse psychosocial circumstances.

The importance of a woman's physical and mental health should be central to every aspect of maternity and postnatal care. As well as affecting a woman's emotional welfare and happiness, mental health conditions affect her experience of pregnancy and parenting, are associated with a degree of increased risk of obstetric and neonatal complications and can profoundly affect a woman's ability to bond with her baby and the infant's psychological adaptation in the immediate and longer term.

Mental health conditions in the perinatal period (pregnancy and 12 months after the birth) often go undetected and untreated, imposing a significant burden on women, their families, the health system and society more broadly. This Guideline therefore recommends assessment of psychosocial risk and screening for symptoms of depressive and anxiety disorders for all women in the perinatal period. This approach is critical to identifying and providing women with access to support and/or early intervention if needed. While referral and care pathways vary with setting (e.g. general practice, maternity services) and location (e.g. metropolitan, rural and remote), it is important that women are provided with access to timely, appropriate services post-assessment, ongoing psychosocial support and appropriate treatments.

While women with pre-existing severe mental illness may already be under the care of a GP and/or psychiatrist, specific consideration must be given to planning their care due to the complexity of these conditions and the substantial challenges for primary care professionals involved in their management.

Care planning for a woman with a mental health condition ideally begins preconception; requires close multidisciplinary collaboration; and a particular focus on continuity of care across the different health and other government sectors and the private sector, as appropriate.

Interventions to support women with mental health conditions in the perinatal period range from psychosocial support, through structured and systematic psychological interventions to pharmacological treatment (or a combination of these), depending on the severity of a woman's symptoms or condition. Interventions are decided with the woman and her significant other(s)¹ based on risk-benefit analysis, which takes into account the benefit to the woman, and the fetus or newborn, versus the potential for harm.

The way in which different health professionals use this Guideline will vary depending on their knowledge, skills and role, as well as the setting in which care is provided. Whatever the setting and circumstances, perinatal mental health care should be culturally responsive and family-centred. It should involve collaborative decision-making with the woman and her significant other(s) if the woman agrees, which includes full discussion of the potential risks and benefits of any treatments offered. Health professionals providing care should have appropriate training and skills and should work together to provide continuity of care for women and their families.

This Guideline provides a reliable and standard reference for health professionals providing care to women in the perinatal period. By providing a summary of the currently available evidence on effective approaches to mental health care at this time, it aims to improve a woman's experience of pregnancy and early parenthood, her emotional well-being, her safety and outcomes for all families.

¹ In this Guideline, 'significant other(s)' includes individuals in a woman's support network and may include partner, co-parent, members of her immediate or extended family and/or close friends.

Summary of recommendations and practice points

The table below lists the recommendations and practice points included in this Guideline. This information will also be provided as a separate document and be available on the COPE website.

Four types of guidance are included:

- **evidence-based recommendations (EBR)** - a recommendation formulated after a systematic review of the evidence, with a clear linkage from the evidence base to the recommendation using 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 (shaded in dark pink) 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 (shaded in light pink)
- **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 (shaded in blue)
- **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 (shaded in burgundy).

Table 1 Recommendations and practice points

SCREENING AND ASSESSMENT

Considerations before screening and psychosocial assessment

| | | |
|----|-----|--|
| i | CBR | All health professionals providing care in the perinatal period should receive training in parent-centred communication skills, psychosocial assessment and culturally safe care. |
| ii | 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

| | | | |
|-----|-----|---|--------|
| 1 | EBR | Administer the Edinburgh Postnatal Depression Scale (EPDS) to screen women for a possible depressive disorder in the perinatal period. | Strong |
| 2 | EBR | Arrange further assessment of perinatal women with an EPDS score of 13 or more. | Strong |
| iii | 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. | |
| iv | CBR | Complete the first antenatal screening as early as practical in pregnancy and repeat screening at least once later in pregnancy. | |
| v | CBR | Complete the first postnatal screening 6–12 weeks after birth and repeat screening at least once in the first postnatal year. | |

| | | |
|------|-----|---|
| vi | 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. |
| vii | CBR | Repeat the EPDS at any time in pregnancy and in the first postnatal year if clinically indicated. |
| viii | CBR | When screening Aboriginal and/or Torres Strait Islander women, consider language and cultural appropriateness of the tool. |
| a | 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. |
| ix | 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

| | | |
|----|-----|---|
| x | CBR | Be aware that anxiety disorders are very common in the perinatal period and should be considered in the broader clinical assessment. |
| xi | 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. ANRQ). |

Assessing psychosocial factors that affect mental health

| | | | |
|------|-----|--|--------|
| b | PP | Assess psychosocial risk factors as early as practical in pregnancy and again after the birth. | |
| 3 | EBR | Administer the Antenatal Risk Questionnaire (ANRQ) to assess a woman's psychosocial risk. | Strong |
| xii | 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. | |
| c | PP | Ensure that health professionals receive training in the importance of psychosocial assessment and use of a psychosocial assessment tool. | |
| d | 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. | |
| e | 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. | |
| xiii | 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

| | | |
|-------|-----|---|
| xiv | CBR | Offer non-birthing parents mental health screening in the perinatal period. |
| xv | CBR | Given the absence of support for one specific screening tool it is not currently possible to universally recommend one screening tool over another. |
| xvi | CBR | Select screening tools in accordance with availability and competencies of health professionals to use a specific tool within specific settings. |
| xvii | 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. |
| xviii | CBR | When administering the EPDS to male parents, use a lower cut-off score (10 or more), noting responses to individual items. |
| xix | 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. |
| xx | CBR | Offer non-birthing parents psychosocial screening in the perinatal period. |
| xxi | CBR | Use the amended ANRQ/Postnatal Risk Questionnaire (PNRQ) screening tool for male non-birthing parents. |
| xxii | CBR | Use the ANRQ/PNRQ in its current form for psychosocial screening of female non-birthing parents. |
| xxiii | 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. |
| xxiv | 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

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

| | | |
|---|----|--|
| j | 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. |
| k | 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

| | | |
|---|----|---|
| l | 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. |
| m | 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

| | | |
|-----|-----|--|
| xxv | 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. |
| n | 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

| | | |
|---|----|--|
| o | 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. |
| p | 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. |
| q | PP | Wherever possible, assessment, care and treatment of the mother should include the infant. |
| r | 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

| | | |
|---|----|---|
| s | 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. |
| t | 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. |

| | | |
|---|----|--|
| u | 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. |
| v | 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. |
| w | 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. |
| x | PP | Plan for pharmacological review in the early postpartum period for women who cease psychotropic medications during pregnancy. |

Postnatal care and support

| | | |
|-------|-----|---|
| xxvi | CBR | Arrange observation of infants exposed to psychoactive medications in pregnancy for the first 3 days after the birth. |
| y | 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. |
| z | 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. |
| xxvii | 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

| | | | |
|--------|-----|---|-------------|
| 4 | EBR | Provide structured psychoeducation to women with symptoms of depression in the perinatal period. | Strong |
| 5 | EBR | Advise women with symptoms of depression in the postnatal period of the potential benefits of a social support group. | Conditional |
| 6 | EBR | Recommend individual structured psychological interventions (cognitive behavioural therapy or interpersonal psychotherapy) to women with symptoms of depression in the perinatal period. | Strong |
| xxviii | CBR | Consider online approaches for delivery of cognitive behavioural therapy. | |
| 7 | EBR | Advise women with depression or anxiety disorder in the postnatal period of the possible benefits of directive counselling. | Conditional |
| xxix | 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

| | | | |
|------|-----|---|-------------|
| 8 | 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 |
| xxx | 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. | |
| xxxi | 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

| | | | |
|-------|-----|---|-------------|
| aa | 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. | |
| 9 | EBR | When prescribing antidepressants to pregnant women, consider selective serotonin reuptake inhibitors (SSRIs) as first-line pharmacological treatment for depression and/or anxiety. | Conditional |
| bb | 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. | |
| 10 | EBR | When prescribing antidepressants to women in the postnatal period, use SSRIs as first-line pharmacological treatment for depression. | Strong |
| cc | PP | Before prescribing antidepressants to women who are breastfeeding, consider the infant's health and gestational age at birth. | |
| xxxii | 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. | |
| dd | PP | Use caution in repeated prescription of long-acting benzodiazepines around the time of the birth. | |
| ee | PP | Use caution in prescribing non-benzodiazepine hypnotics (z-drugs) to pregnant women for insomnia. | |
| ff | PP | Use caution in prescribing benzodiazepines in the perinatal period due to the risk of dependence, withdrawal in the neonate and sedation with breastfeeding. | |
| gg | 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

| | | | |
|--------|-----|--|-------------|
| 11 | EBR | Use antipsychotics to treat psychotic symptoms in pregnant women. | Conditional |
| xxxiii | CBR | Use caution when prescribing antipsychotics with metabolic effects to pregnant women, due to the increased risk of gestational diabetes. | |
| xxxiv | CBR | If women commence or continue use of antipsychotics with metabolic effects during pregnancy, consider earlier screening and monitoring for gestational diabetes. | |
| xxxv | CBR | If considering use of clozapine in pregnant women, seek specialist psychiatric consultation. | |
| hh | 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

| | | | |
|--------|-----|---|--------|
| ii | 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. | |
| jj | 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. | |
| 12 | EBR | Do not prescribe sodium valproate to pregnant women. | Strong |
| xxxvi | CBR | Use great caution in prescribing anticonvulsants as mood stabilisers for pregnant women and seek specialist psychiatric consultation when doing so. | |
| xxxvii | CBR | If prescribing lamotrigine to a woman who is breastfeeding, arrange close monitoring of the infant and specialist neonatologist consultation where possible. | |

Lithium

| | | | |
|---------|-----|--|--|
| xxxviii | CBR | If lithium is prescribed to pregnant women, ensure that maternal blood levels are closely monitored and that there is specialist psychiatric consultation. | |
| kk | PP | If lithium is prescribed to a pregnant woman, monitor lithium levels carefully and adjust individual dose prior to and after delivery. | |
| xxxix | CBR | Where possible, avoid the use of lithium in women who are breastfeeding. | |

WOMEN WITH BORDERLINE PERSONALITY DISORDER

| | | |
|-----|-----|---|
| II | PP | Provide trauma-informed care for women with borderline personality disorder. |
| mm | PP | Specific support for health professionals in dealing with challenging behaviours associated with borderline personality disorder should be prioritised. |
| nn | 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. |
| xl | 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. |
| oo | PP | Encourage pregnant or postnatal women with borderline personality disorder to undertake mindfulness and/or relaxation training to assist in managing their emotional dysregulation. |
| xli | CBR | As far as possible, do not use pharmacological treatments as the primary therapy for borderline personality disorder, especially in pregnant women. |
| pp | PP | Consider pharmacological treatment for comorbidities in women with borderline personality disorder. |

WOMEN WHO EXPERIENCE PSYCHOLOGICAL BIRTH TRAUMA

| | | |
|-------|-----|---|
| xlii | CBR | Use routine psychosocial screening (e.g. Postnatal Risk Questionnaire) to gain knowledge about a woman's risk of experiencing birth as traumatic. |
| xlili | CBR | If post-traumatic symptoms persist beyond 3 months, consider referral to appropriate mental health professionals for further assessment and/or care. |
| xliv | CBR | Offer women who have post-traumatic stress disorder resulting from a traumatic birth a high-intensity psychological intervention (trauma-focused CBT or eye movement desensitisation and reprocessing). |
| xliv | 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. |
| xlvi | 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

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

Introduction



The perinatal period (considered here as the period from conception to the end of the first postnatal year) is a time of great change in a woman's life. For most women and their families, pregnancy, childbirth and parenting are a time of great joy and happiness. However, this period is associated with a significantly increased risk for onset and relapse of mental health conditions – higher than at many other times in a woman's life.

This Guideline therefore has a primary focus on early identification of women experiencing psychosocial problems and mental health conditions in the perinatal period, so that they receive the timely support and care they need. This approach aims to improve a woman's experience of pregnancy and early parenthood, her emotional well-being and her safety.

This approach is also beneficial to the well-being of families. Most women who experience mental health conditions are able to parent effectively and the majority of infants are not specifically disadvantaged. However, mental health conditions in their more severe form are often associated with reduced quality of life, impaired functioning, especially in relation to a woman's ability to care for her infant and the formation of secure infant attachment, which may in turn be associated with poorer social, cognitive, and behavioural outcomes in the child (*1st 1001 Days APPG 2015*). Moderate to severe mental disorders are more likely to adversely impact outcomes for women and children. As such, specialist services and care are of paramount importance to improving mental health outcomes for communities now and into the future.

Development of the Guideline

This is the third version of Australian Perinatal Mental Health Guidelines, with the foundation laid by the first version developed by *beyondblue* in 2011 (*beyondblue 2011*) and the scope broadened to include schizophrenia and borderline personality disorder as well as depressive and anxiety disorders, bipolar disorder and postpartum psychosis in the Guideline developed by the Centre of Perinatal Excellence (COPE) in 2017 (*Austin et al 2017*).

The development of this version was also undertaken by COPE, with funding from the Australian Government Department of Health and Aged Care and a broadening of scope to include psychological birth trauma. The Guideline has been developed in accordance with National Health and Medical Research Council (NHMRC) Guideline development processes (see Administrative report). This involved convening an Expert Working Group comprising members nominated by their professional college, with specific expertise in mental health care, as well as representatives of maternity care (including general practice, obstetrics, midwifery and maternal and child health), consumer and carer organisations and Aboriginal and/or Torres Strait Islander health care (see Appendix A). An expert subcommittee was also convened to provide specific advice on harms associated with pharmacological treatments (see Appendix A). A systematic literature review, which identified and critically appraised the recent evidence on screening, prevention and treatment of mental health among women in the perinatal period, provided the basis for the Guideline (see Administrative report). In addition, a systematic review appraised the evidence on assessing perinatal mental health among non-birthing parents as part of a separate process using funding for iCOPE. Both reviews used the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) approach. The clinical questions underpinning the reviews of are outlined in Appendix C.

Recommendations were formulated through a process in which the 2017 Guideline recommendations were reviewed in the context of available new evidence. For screening and psychological intervention questions, the Expert Working Group reviewed the recommendations. For other intervention questions, the Expert Medical Subcommittee (Harms Subcommittee) conducted an initial review of the recommendations and their suggested changes were then reviewed by the Expert Working Group. No major debates arose within or between committees.

Formal consultation with a wide range of experts, stakeholders and consumer representatives was undertaken through the public consultation process and the Guideline was revised to incorporate comments received. COPE member organisations comprising of the peak bodies in maternity, postnatal, primary care and mental health care will be invited to endorse the Guideline.

Aim and Scope of the Guideline

To support health professionals in providing evidence-based care, the Guideline summarises current evidence on approaches to the assessment of psychosocial risk factors (associated with or exacerbating mental health conditions) and screening for common mental health symptoms among women in the perinatal period. It also covers the perinatal-specific aspects of prevention and treatment of mental health conditions in women, including depressive and anxiety disorders, severe mental illnesses (schizophrenia, bipolar disorder, postpartum psychosis), borderline personality disorder and psychological birth trauma. 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.

While the focus of the Guideline is on the mental health of women in the perinatal period, the impact of the transition to parenthood on fathers/non-birthing parents is also an important consideration. A brief section on assessment of perinatal mental health is therefore included based on the limited evidence available.

The following are beyond the scope of the Guideline:

- the process of diagnosis or specifics of managing mental health conditions in the perinatal period – appropriate guidelines for the general population should be used
- topics for which the evidence has been reviewed in the development of the **Pregnancy Care Guidelines** (*Department of Health 2020*)
 - assessment for smoking and substance use
 - assessment and first-line response for family violence (noting that the same process applies beyond the antenatal period)
 - other aspects of maternity care.

It was planned that the Guideline revision include review of the evidence around eating disorders in the perinatal period and the impact of congenital anomalies on maternal mental health but funding for these topics was not available.

Terminology used in the Guideline

The Guideline recognises that individuals have diverse gender identities. 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. The Guideline developers understand that individual parents and families may use different words and we respect their preferred terminology.

Intended Audience

The Guideline is intended for all health professionals caring for women and families during the perinatal period (the period covering pregnancy and the first year following birth). This includes but is not limited to midwives, general practitioners (GPs), obstetricians, neonatologists, paediatricians, maternal and child health nurses², paediatric nurses, Aboriginal and/or Torres Strait Islander health workers, allied health professionals, lactation consultants; mental health practitioners (psychologists, psychiatrists, mental health nurses, perinatal and infant mental health professionals); and consumers and carers and those working with families in the community (e.g. social workers, child protection agencies), hospital and legal systems.

The way in which different professionals use this Guideline will vary depending on their knowledge, skills and role, as well as the setting in which care is provided. It is anticipated that Part B on screening and assessment will be of greatest relevance to health professionals in the primary care setting³, while Part C on prevention and treatment will provide guidance to health professionals involved in both primary and specialist mental health care. Practical guidance for specific health professional groups and information for consumers and carers will be derived from this Guideline, and will be available from the COPE website.

Implementation and Review

As Australia's peak body in perinatal mental health, COPE will facilitate implementation of the Guideline through its membership, online channels and innovative approaches to dissemination. This will include training programs and summary documents for health professionals (which will be available from the COPE website), and a mobile app (Ready to COPE) and website containing supporting information for consumers. It is anticipated that the Guideline will be updated periodically to include higher-level evidence as it becomes available, ideally with a major review of the evidence within 5 years.

² Also referred to as child and family health nurses in some jurisdictions.

³ Primary care is generally the first point of contact people have with the health system. It relates to the treatment of non-admitted patients in the community.

Structure of the Guideline

Part A: Background Information is a concise review that includes discussion of an individual woman's context, the prevalence and impact of mental health conditions in the perinatal period (Chapter 1), and factors relevant to enabling effective mental health care in the perinatal period (Chapter 2).

Part B: Screening and Psychosocial Assessment discusses considerations before psychosocial assessment and screening (Chapter 3), the process of screening for symptoms of depressive and anxiety disorders (Chapter 4), assessing psychosocial factors that affect mental health (Chapter 5), assessing perinatal mental health in fathers and non-birthing parents (Chapter 6) and of assessing mother-infant interaction and the safety of the woman and infant (Chapter 7). Considerations for implementing psychosocial assessment and screening in practice are also outlined (Chapter 8).

Part C: Prevention and Treatment discusses general principles in prevention and treatment (Chapter 10), the evidence for interventions for women with depressive and anxiety disorders (Chapter 11), women with severe mental illnesses (schizophrenia, bipolar disorder and postpartum psychosis; Chapter 12), women with borderline personality disorder (Chapter 13), women who experience psychological birth trauma (Chapter 14) and women who do not respond to psychological or pharmacological treatment (Chapter 15).

Part D: Areas for Future Research identifies current gaps in the literature.

Appendices list membership of the Expert Working Group and the Harms Expert Subcommittee (Appendix A), provide further information about the development of the Guideline, including the processes used and the evidence-to-decision deliberations of the Expert Working Group that were informed by the systematic literature review (Appendix B) and provide copies of the tools used for psychosocial assessment and screening (Appendix C).

Practice Summaries are included in Parts B and C (Chapter 9 and Chapter 16).

Part A

Background Information



1 Mental health conditions in the perinatal period

1.1 Understanding the woman's context

Every person has a right to health care that takes into consideration their individual social and emotional situation (*UN General Assembly 1948; UN General Assembly 2007*). From childhood to old age, women and gender diverse people experience health, illness, and healthcare differently to men (*AWHN 2022*). These differences begin from birth and progress into gendered childhoods, gendered work lives, sexism and violence, sexual and reproductive health, economic insecurity, and the disproportionate demands of women including care giving and motherhood (*AWHN 2022*). Women have higher levels of chronic disease, poorer mental health linked to sexism, violence and chronically poor incomes; they experience gender discrimination in healthcare which can result in delayed access to care, misdiagnosis, and neglect (*AWHN 2022*).

The experience of pregnancy and parenthood differs for each woman and is influenced by the stability of her relationships and social network. While the biggest risk factor for developing perinatal mental health conditions is a prior history of mental illness, the presence of psychosocial risk factors may be associated with greater risk of onset, relapse or exacerbation of mental health conditions. Women who feel isolated either by distance, culture, or both, are more likely to develop distress or mental health conditions in the perinatal period (*Austin et al 2015*). The likelihood is also greater for women who have experienced life stressors (e.g. family problems, family violence or loss, disability) or multiple trauma (*Austin et al 2015*). Assessment for specific psychosocial risk factors is discussed in Chapter 5.

Some groups of women potentially have greater exposure to life stressors, trauma or lack of support.

- **Aboriginal and/or Torres Strait Islander peoples** - Aboriginal and/or Torres Strait Islander women are strong and resilient, and many individual women experience good social and emotional well-being throughout the perinatal period (*Carlin et al 2020a*). At the population level however, Aboriginal and Torres Strait Islander women face an increased risk of experiencing perinatal depression and/or anxiety due to their collective and individual experiences of colonisation, trauma, racism, and other social determinants of ill health. Studies show that Aboriginal and/or Torres Strait Islander women are more than twice as likely to experience perinatal depression and/or anxiety than their non-Indigenous counterparts (*Buist & Bilszta 2005*).
- **Migrant women (including refugees, asylum seekers)** - These women may experience higher rates of perinatal depression than their non-migrant counterparts in the destination country, with previous depression and poor social support strongly increasing risk. Social isolation faced by migrant communities may be exacerbated by language and cultural barriers and can pose a significant hardship for new mothers (*Fellmeth et al 2017*). Refugee women are at heightened risk of psychological morbidity (*Yelland et al 2014*).
- **Women living in rural and remote areas** - Rural and remote communities have their own risk and protective factors. Some women may have limited access and consistency of care, alongside additional life stressors associated with living in small communities or remote circumstances.
- **Women experiencing pregnancy in adolescence** - Young women at greater risk of mental health problems during the perinatal period include those lacking social support, isolated from their usual social structures, in complex family situations and/or experiencing economic insecurity.
- **Women experiencing intimate partner violence** - In an Australian study (*Dahlen et al 2018*), women who reported intimate partner violence at the first antenatal visit were more likely to report a raised Edinburgh Postnatal Depression Scale (EPDS) >13 (7.63%), thoughts of self-harm (2.4%) and anxiety and depression (34.2%). In another study, two in five women reporting depressive symptoms in the first year postnatally were experiencing intimate partner violence (*Woolhouse et al 2012*). Among a cohort of Aboriginal women, one in two women who reported violence during pregnancy reported 'high' to 'very high' psychological distress postnatally (*Weetra et al 2016*).
- **Lesbian, gay, bisexual, trans, intersex and/or queer (LGBTQI+) parents** - There has been very little research on LGBTQI+ couples and their experiences with perinatal depression and anxiety (*PwC Consulting Australia 2019*). Evidence suggests that many LGBTQI+ people, especially transgender people, avoid or delay healthcare or do not disclose to avoid discrimination, resulting in poorer health outcomes (*Seelman et al 2017; Kcomt et al 2020; Saxby et al 2020*).

Many of these factors are beyond the scope of this Guideline but taking them into account (including in psychosocial assessment) is important and will lead to a fuller understanding of the individual woman's situation. Consultation with relevant organisations (e.g. local Aboriginal and/or Torres Strait Islander Health Services or Migrant Health Centres) is advisable.

1.2 Prevalence and impact of maternal mental health conditions in the perinatal period

Perinatal mental health conditions include all adult mental health conditions in addition to perinatal period-specific disorders such as postpartum psychosis.

1.2.1 Depressive and anxiety disorders

- **Depressive disorders** in the perinatal period are symptomatically the same as those at other times and range from mild to severe.
- **Anxiety disorders** at this time include generalised anxiety disorder, panic disorder, social phobia, specific phobia and post-traumatic stress disorder and are often reported as equally prevalent as depressive disorder in the perinatal period (*Fairbrother et al 2016*).
- In Australia, perinatal depression and anxiety affects one in five mothers (*PwC Consulting Australia 2019*). This means that around 60,000 mothers will experience perinatal depression and anxiety annually (*PwC Consulting Australia 2019*).
- Primary perinatal anxiety disorders are prevalent and their comorbidity with depression is very high (*Wisner et al 2013*) – for example the three month postnatal period prevalence for any anxiety disorder was reported as one in six in one study (*Fairbrother et al 2016*), while another (*Giardinelli et al 2012*) reported a point prevalence of anxiety disorder of one in five in the third trimester of pregnancy. Women who experience moderate or high-risk maternal and fetal complications are at five to seven times greater risk of developing prenatal onset anxiety disorders (*Fairbrother et al 2016*).
- Depression may arise in pregnancy or pre-date the perinatal period. In a subset of women in a large US study of women assessed at 6 weeks postnatally, two in five episodes of depression began postnatally, one in three during pregnancy and one in four before pregnancy (*Wisner et al 2013*). An Australian study found that, for most mothers with postnatal depression, onset occurred after 12 weeks postpartum (*Woolhouse et al 2012*).
- Australian studies have reported persistence of maternal depressive symptoms beyond the first year postpartum, with more mothers reporting depressive symptoms at 4 years follow-up than in the first 12 months postpartum (*Woolhouse et al 2015*), symptoms persisting from pregnancy to 4 years postpartum in one in eleven women (*Giallo et al 2017*) and symptoms persisting from the first year to 6–7 years postpartum in one in six women (*Giallo et al 2014*).
- Maternal mental disorders affect the mother, infant, and surrounding community. Without adequate management of maternal mental disorders, symptoms and impairment of functioning can persist for years (*RANZCP 2016*).
- Both depression and anxiety disorders may be associated with secondary conditions which affect health in pregnancy including nicotine and alcohol and substance use and poorer engagement in antenatal care.
- Severe depression in the perinatal period is associated with maternal suicide (*PwC Consulting Australia 2019*).
- Obstetric complications in women with depression (independent of antidepressant use) are slightly increased, including risk of preterm birth, low birth weight, gestational hypertension and perinatal death (*Grigoriadis et al 2013*).
- Anxiety disorders during pregnancy may have a negative influence on obstetric, fetal and perinatal outcomes, including more pregnancy symptoms (nausea and vomiting); more medical visits; increased alcohol or tobacco consumption or unhealthy eating habits; pre-eclampsia and preterm birth; and postnatal depression and mood disorders (*Marc et al 2011*). High levels of maternal anxiety during pregnancy is associated with increased exposure of the fetus to maternal cortisol and risk of adverse neurodevelopmental outcomes (*O'Donnell et al 2012*).
- In Australia in 2019, the total disability adjusted life years (DALYs) attributable to parental perinatal depression and anxiety was 35,670 for each annual cohort of parents (*PwC Consulting Australia 2019*). The estimated impacts of perinatal depression and anxiety totalled \$877 million, comprised of (*PwC Consulting Australia 2019*):
 - health costs attributable to perinatal depression and anxiety equalling \$227 million, comprising increased use of primary and community health services and hospital health care services and increased risk of certain conditions for both the parent and child
 - economic costs of \$643 million are attributable to productivity losses associated with increased workforce exit, absenteeism, presenteeism and carer requirements
 - monetised social and well-being impacts include increased likelihood of developmental issues, depression, anxiety and child attention deficit/hyperactivity disorder diagnoses, totalling \$7 million.

- Beyond this are estimated lifetime impacts of \$5.2 billion attributable to the increased risk of depression, anxiety and attention deficit hyperactivity disorder in the children of parents with perinatal depression and anxiety, affecting well-being, productivity and health system use (*PwC Consulting Australia 2019*).
- Untreated or undertreated mental illness in the perinatal period is associated with significant economic and social costs to Australia, in addition to increased morbidity and mortality for women and poorer outcomes for children and families (*Deloitte Access Economics 2012*).

1.2.2 Severe mental illness

- Severe mental illness includes psychotic disorders (schizophrenia and postpartum psychosis) and bipolar disorder. These are much less common than depressive and anxiety disorders, with a prevalence of around 1 in 100 in the general population for schizophrenia and bipolar disorder (*Mitchell et al 2013; Galletly et al 2016*) and 1 in 1,000 pregnancies for postpartum psychosis.
- People with schizophrenia or bipolar disorder (in the general population) suffer from high rates of other mental health conditions, including depression and anxiety disorders (*Merikangas et al 2011; Galletly et al 2016*).
- Population studies demonstrate an increased risk of new onset psychiatric episodes, especially psychoses, in the first few months postpartum (*Munk-Olsen et al 2006*), while risk of relapse of pre-existing mood disorder (often following the cessation of medication in pregnancy increases significantly across the perinatal period (*Viguera et al 2000; Cohen et al 2006; Viguera et al 2007*), especially for bipolar disorder (*Munk-Olsen et al 2009*).
- Women with bipolar disorder are more likely than women with no history of a mental health condition to experience some adverse pregnancy outcomes, including gestational hypertension, antepartum haemorrhage, severe fetal growth restriction (<2nd–3rd percentile) (although this may be related to smoking) and neonatal morbidity (*Rusner et al 2016*).
- Women with diagnosed schizophrenia or bipolar disorder are more likely than women in the general pregnant population to have obstetric complications (pre-eclampsia, gestational diabetes) (*Nguyen et al 2013*). Relapse of these conditions during pregnancy is common, with 22.5% of diagnosed women in one study being admitted to a psychiatric hospital during pregnancy (38.6% with schizophrenia and 10.7% with bipolar disorder) (*Nguyen et al 2013*). Women with schizophrenia had a high rate of involvement of statutory child welfare services (50%).

1.2.3 Borderline personality disorder (and emotional dysregulation)

- **Borderline personality disorder** is characterised by a pervasive pattern of instability of emotions, relationships, sense of identity and poor impulse control and is consistently associated with severe functional impairment.
- Estimates of the prevalence of borderline personality disorder range from 1% among all Australian adults and 3.5% among Australians aged 24–25 years (*NHMRC 2012*). A more recent study (*Quirk et al 2016*) estimated prevalence among women aged ≥25 years to be 2.7% (95%CI: 1.4–4.0).
- **Emotional dysregulation** refers to poorly modulated emotional responses and is also referred to as mood or affective instability. It has been measured by a number of well-validated scales, including the Difficulties in Emotional Regulation Scale (*Gratz & Roemer 2004*). While it is associated with depressive and anxiety disorders, it is considered a core feature of borderline personality disorder (*Glenn & Klonsky 2009; Kroger et al 2011*).
- Emotional dysregulation and borderline personality disorder are associated with a history of childhood trauma (including sexual abuse), and/or experience of dysfunctional parenting in a substantial proportion of cases (*Fossati et al 2016*).
- Women with borderline personality disorder in the perinatal period experience considerable psychosocial impairment – they may anticipate birth as traumatic and frequently request early delivery, comorbidity with substance abuse is common and rates of referral to child protective services high (*Blankley et al 2015*).
- Women with borderline personality disorder during pregnancy have been found to be at increased risk of gestational diabetes, premature rupture of the membranes, chorioamnionitis, venous thromboembolism, caesarian section and preterm birth (*Pare-Miron et al 2016*).
- Mothers with borderline personality disorder are often parenting in the context of significant additional risk factors, such as depression, substance use and low support (*Petfield et al 2015*). Levels of parenting stress are high, and self-reported competence and satisfaction are low (*Petfield et al 2015*).

- Mothers with borderline personality disorder symptoms – including emotional dysregulation – are more likely than women without symptoms to engage in maladaptive interactions with their children characterised by insensitive, overprotective, and hostile parenting (*Eyden et al 2016*). Adverse outcomes among children included borderline personality disorder symptoms, internalising (including depression) and externalising problems, insecure attachment patterns and emotional dysregulation (*Eyden et al 2016*).

1.2.4 Experience of psychological birth trauma

The level of intervention during childbirth and the perception of inadequate intrapartum care are associated with the development of acute trauma symptoms, with one in three women in an Australian cohort study reporting the presence of at least three trauma symptoms at 4–6 weeks postpartum (*Creedy et al 2000*). Physical birth injury also affects mental health – among a self-selected sample of women who experienced birth injury, 85.5% reported that their mental health was affected (*Dawes et al 2022*). Of the women with a self-reported mental health diagnosis, 40% experienced depression or anxiety and 30% post-traumatic stress disorder, with some respondents experiencing more than one condition. Another study suggested that post-traumatic stress disorder (PTSD) can result from a traumatic birth experience (1.2% of women met PTSD criteria at 4–6 weeks, 3.1% at 12 weeks and 3.1% at 24 weeks postpartum), though this is not the normative experience (*Alcorn et al 2010*). Both birthing and non-birthing parents may experience significant levels of psychological trauma following birth (*Heyne et al 2022*).

1.2.5 Perinatal mental health in non-birthing parents

Mood disorders among non-birthing parents (male or female) have not been well studied but the emerging evidence suggests that the individual and social costs of perinatal depression and anxiety in this group are significant. Studies have indicated that depression, anxiety and stress are more prevalent among fathers in the perinatal period than among men in the general population (*Cameron et al 2016; Leach et al 2016; Philpott et al 2017*):

- up to one in ten fathers experience depression between the first trimester and 1 year postpartum (*Paulson & Bazemore 2010*)
- one in six experience anxiety during the prenatal period and up to one in five during the postnatal period, although there was wide variation between studies (*Leach et al 2016*)
- fathers may also experience post-traumatic stress symptoms following the birth (*Leach et al 2016; Etheridge & Slade 2017; Daniels et al 2020*).

Non-birthing parents who observe adverse maternal, fetal or neonatal outcomes may experience a higher prevalence of depression and traumatic stress, inclusive of non-birthing parents whose partners experience a termination for medical reasons (*Kothari et al 2022*). Specifically, 83% of male non-birthing parents experienced a prenatal diagnosis of a fetal anomaly as a traumatic event (*Aite et al 2011*).

Studies have shown that 50 per cent of fathers are unaware that they can also experience perinatal depression and anxiety (*beyondblue 2022*). This lack of awareness means that this group is less likely to reach out to the appropriate support networks or be diagnosed. Other risk factors for non-birthing parents can include financial stress, particularly as they may be the main income earner following the birth of a child, as well as attitudes towards perinatal depression and anxiety and fear of being seen as a ‘failure’ if they are not coping with parenting as they expected (*beyondblue 2022*).

Paternal depression may influence a fathers’ parenting and therefore the well-being of his infant into the future. Depressed fathers in the USA, for example, were four times more likely to spank their one-year-old infants and less than half as likely to read to them as non-depressed fathers (*Davis et al 2011*). Studies following infants whose fathers showed signs of postnatal depression through to childhood show that these children are three times more likely to exhibit behaviour problems as a preschooler and twice as likely to receive a psychiatric diagnosis by 7 years of age (*Ramchandani & Psychogiou 2009; Fletcher et al 2011*). Severe mental illness among fathers has been shown to pose a risk to infant’s physical and emotional well-being (*Fletcher et al 2013*).

Non-birthing parents’ mental health will affect, and be affected by, the mental health of their partner. Among couples recruited during pregnancy, antenatal depression in the non-birthing parent predicted significant worsening in mothers’ overall symptom severity during the first 6 months postnatally (*Paulson et al 2016*). Australian studies have found that fathers’ postnatal depression is particularly affected by the couple relationship and the mother’s mental health problems (*Matthey et al 2000; Dudley et al 2001*). Not surprisingly, when both parents are depressed their children are at higher risk of behavioural impairment (*Paulson et al 2006*).

2 Enabling best-practice mental health care in the perinatal period

The principles underlying best-practice provision of mental health care in the perinatal period include:

- establishing a therapeutic relationship
- providing care that is recovery-oriented and trauma-informed
- providing culturally safe support and information
- ensuring continuity of care, where possible.

Mental health care in the perinatal period should be clinically and emotionally safe and based on the best available evidence.

2.1 Therapeutic relationship

Providing psychosocial care during the perinatal period involves establishing and maintaining a therapeutic relationship between the health professional and the woman and her significant other(s) (where applicable). Continuity of carer is likely to improve and facilitate the therapeutic relationship. Key aspects of the therapeutic relationship include development of trust, confidence, mutuality, active listening and empowerment.

It is important for health professionals to:

- understand the normal range of emotions common to various stages during the perinatal period so they can better identify anxiety and depressive symptoms if they occur
- allow adequate time to assess, listen and build rapport
- ascertain and address any misconceptions or need for information, encourage women to express their feelings about pregnancy and motherhood, validate any concerns and support their emotional state
- maintain a non-judgemental attitude and address any feelings of stigma (very common)
- assess women's support systems, including the attitudes and availability of her significant other(s) and support network.

Where mental health treatment is required, the collaborative process continues, with the setting of mutually agreed goals and tasks and regular support to help the woman to achieve those goals. If mental health referral is necessary, the process should be managed in an empowering, supportive way. For women with severe mental health conditions and complex social challenges, mental health support may be integrated into case management models of antenatal care.

Engaging women in mental health care

Factors that improve a woman's experience of accessing and engaging with mental health care in the perinatal period include being given the opportunity to develop trusting relationships with health care professionals who acknowledge and reinforce the woman's role in caring for her baby in a non-judgmental and compassionate manner, and foster hope and optimism about treatment (*Megnin-Viggars et al 2015*).

High quality information for women, their families and healthcare professionals, and the provision of individualised care and treatment, are also crucial (*Megnin-Viggars et al 2015*).

Cultural safety

Cultural safety identifies that health consumers are safest when health professionals have considered power relations, cultural differences and people's rights (*AHMAC 2016*). Part of this process requires health professionals to examine their own realities, beliefs and attitudes. Cultural safety is not defined by the health professional, but is defined by the health consumer's experience - the individual's experience of care they are given, ability to access services and to raise concerns. It is important that services work in partnership with Indigenous and culturally and linguistically diverse populations to ensure that the services provided are culturally safe (*RANZCP 2021*).

Aboriginal and/or Torres Strait Islander women

Health professionals working with Aboriginal and/or Torres Strait Islander peoples need to be cognisant of the social determinants of ill-health which are disproportionately experienced by this population. These include mental health problems, cultural disconnection and multiple stressors in the form of poverty or poor housing, child removal, as well as trauma, abuse and loss (*AIHW 2014*).

This level of complexity requires:

- different models of engagement and new approaches and ways of thinking about mental health – trauma-informed care (see below) is particularly important when working with this population
- greater understanding about the determinants of mental health and well-being
- recognition of factors consistently identified by Aboriginal and/or Torres Strait Islander people as critical to the design and delivery of services and programs aimed at improving their mental health and social and emotional well-being – these include Indigenous definitions of health and well-being as holistic, underscored by connections to culture, family, community and country
- respectful consultation to ascertain individual cultural preferences, with every effort taken to incorporate these by the health service and/or health professional where it is safe to do so
- changes in the cultural safety of mental health systems, services, professions, disciplines and individual professionals.

The **Pregnancy Care Guidelines** include a chapter on optimising care for Aboriginal and/or Torres Strait Islander women, which is applicable to both the antenatal and postnatal periods (*Department of Health 2020*).

2.2 Care provision

This section outlines the principles of trauma-informed care, which may inform practice of all health professionals involved in perinatal care, and recovery-oriented mental health care, which is likely to be more appropriate to the care provided by mental health professionals.

2.2.1 Trauma-informed care

Adverse childhood experiences, including various forms of child maltreatment, together with their mental health sequelae (e.g. posttraumatic stress disorder, depression, dissociation) contribute to adverse pregnancy outcomes (e.g. preterm birth, low birth weight), poor postpartum mental health, and impaired or delayed bonding (*Sperlich et al 2017*). Intergenerational patterns of maltreatment and mental health disorders have been reported that could be addressed in the childbearing year. Trauma-informed care is increasingly used in health care organisations and has the potential to assist in improving maternal and infant health (*Sperlich et al 2017*).

Principles of trauma-informed care for use across service sectors include (*Law et al 2008; Kezelman & Stavropoulos 2012; Sperlich et al 2017*):

- physical and emotional safety
- trustworthiness and transparency
- peer support and mutual self help
- empowerment, voice and choice
- collaboration and mutuality
- attention to cultural, historical, and gender issues.

Key concepts that underpin trauma-informed care include (*Sperlich et al 2017*):

- the '3 Es' conceptualisation of trauma – individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being
- the '4 Rs' for interacting and responding – care that is trauma-informed:
 - **realises** the widespread impact of trauma and understands potential paths for recovery
 - **recognises** the signs and symptoms of trauma in clients, families, staff and others
 - **responds** by fully integrating knowledge about trauma into policies, procedures and practices
 - seeks to actively **resist retraumatisation**
- relationship-based themes – attachment, dyadic regulation and a holding environment (*Rowe et al 2015*).

2.2.2 Recovery-oriented mental health care

The principles of recovery-oriented mental health care are:

- **Individual uniqueness** - recovery is about having opportunities, living a meaningful, satisfying and purposeful life and being a valued community member; outcomes are personal and unique with an emphasis on social inclusion and quality of life; individuals are central to the care they receive.
- **Real choices** - individuals make choices about how they want to lead their lives; are supported to build on their strengths and take as much responsibility for their lives as they can; duty of care is balanced with support for individuals to take positive risks and make the most of new opportunities.
- **Attitudes and rights** - involves listening to, learning from and acting upon communications from individuals; promotes and protects their rights; supports individuals to maintain social, recreational, occupational and vocational activities; instils hope in an individual about his or her future.
- **Dignity and respect** - involves courtesy, respect and honesty in all interactions; having sensitivity and respect for the values, beliefs and culture of each individual; and challenging discrimination.
- **Partnership and communication** - involves working in partnership with individuals and their carers; valuing the importance of sharing information and communicating clearly; and working together in positive and realistic ways to help individuals realise their own hopes, goals and aspirations.
- **Evaluating recovery** - involves individuals and their carers tracking their own progress and services using the individual's experiences of care to inform quality improvement activities.

2.3 Support and information⁴

Key points to discuss with women are that mental health conditions are not uncommon and that treatments are available.

In any health interaction, a woman has the right to:

- determine what treatment she accepts or chooses not to accept
- be given easy to understand verbal explanation and written or audiovisual information in the woman's preferred language of the details of her specific health problem, any proposed treatments or procedures and the results of any tests performed
- have access to all health information about herself and her baby
- be treated with respect and dignity and know that, except where there is a significant risk of harm or where required by law, her health information will be kept confidential.

Health professionals and women need to communicate and collaborate in a team approach. The woman's input - and that of her significant other(s) when she chooses - is an important part of this process. Consistency of information, especially if this is provided by different professionals, is very important.

Making a choice or consenting should be an ongoing process of discussion between a woman and the health professionals involved in her care.

2.3.1 Implications of low health literacy for maternal mental health surveillance and support

Health literacy refers to the degree to which an individual can obtain, communicate, process and understand basic health information and health services to make appropriate decisions. Low health literacy is inextricably linked to poor mental health outcomes.

Several studies have identified that people with lower educational attainment generally have poorer health literacy (*Hill 2014; Jayasinghe et al 2016*). Consequently, highly educated individuals tend to find it easier to find and appraise health information, as well as being better able to navigate the Australian health system (*Beauchamp et al 2015*).

⁴ This section is adapted from Department of Health (2020) Clinical Practice Guidelines: Pregnancy Care. Canberra: Australian Government.

In Australia, health literacy levels also tend to be lower in people who speak English as a second language or come from a culturally and linguistically diverse background (*ABS 2018*). Although there is a dearth of research on health literacy levels among Aboriginal and/or Torres Strait Islander Australians, existing disadvantage in areas of education and general literacy means that health literacy is likely poorer among these communities than among non-Indigenous Australians (*ACSQHC 2014*). Other characteristics that have been associated with poor health literacy include being unemployed (*Jayasinghe et al 2016*), having a disability (*ABS 2018*), and having a lower socioeconomic status (*AMSA 2019*).

It is important that health services tailor care to populations likely to have low health literacy, for example by involving bicultural or Aboriginal and/or Torres Strait Islander workers in facilitating conversations and in brokering trusting relationships with health professionals involved in their care. Health literacy is a consideration in all forms of communication, including publications and direct conversations

2.4 Continuity of care

Continuity of care involves a shared understanding of care pathways by all professionals involved, with the aim of reducing fragmentation and conflicting advice. Continuity of carer is when a named professional, who is known by the woman, provides all her care as appropriate, thus enabling the development of a relationship. Factors that may improve continuity of care include sharing of information (e.g. through documenting of all assessments), collaborative development of management plans, developing linkages and networks and adapting successful approaches to care (e.g. case conferencing, shared care approaches). The benefits of midwifery continuity of care and carer when providing maternity services are well-documented (*Sandall et al 2016; WHO 2016*).

In the context of mental health care, continuity of care is supported by strong links between primary care, adult mental health care services, services with expertise in infant and child mental health and services for infant health and development. A system to flag previously identified at-risk families that could be readily shared with other health professionals could also improve continuity of care.

Some pregnancy experiences and complications, such as the prenatal diagnosis of a fetal anomaly, may disrupt continuity of care. Women with complicated pregnancies are at risk of falling through the gaps between different health providers, models of care and maternity services (*Naughton et al 2021*).

Part B

Screening and Psychosocial Assessment

This section describes screening - which aims to detect signs and symptoms of depressive and anxiety disorders and psychosocial assessment - which aims to identify the presence of psychosocial factors that are known to be associated with an elevated likelihood of mental health conditions in the perinatal period.



3 Considerations before screening and psychosocial assessment

Key considerations for service provision are outlined below:

- **Acceptability** - Studies have shown that acceptability of routine assessment using the Edinburgh Postnatal Depression Scale (see Chapter 4) and the Antenatal Risk Questionnaire (see Chapter 5) is high (*Kalra et al 2018*) and that mental health e-screening is feasible and acceptable to pregnant women (*Kingston et al 2017*).
- **Systems for follow-up and support** - Before screening and assessment is carried out, systems need to be in place to ensure that appropriate health professionals are locally available to provide follow-up care if required and to assist if there are concerns for the safety of the woman, the fetus or infant or other children in the woman's care. Identifying appropriate health professionals to provide follow-up care may be supported through electronic referral pathways or directories. Health professionals may benefit from identifying other professionals from whom they can seek advice, clinical supervision or support regarding mental health care in the perinatal period (e.g. senior health professionals).
- **Who attends assessment** - Women need to feel safe during screening and assessment, so consideration should be given to other people who may be present. While the presence of significant others is often helpful, sensitivity is required about whether it is appropriate to continue with psychosocial assessment while they are in the room. Screening for family violence (see the **Pregnancy Care Guidelines**) should only be conducted when alone with the woman. Postnatal assessments with baby and partner present, provide an opportunity to view the mother-infant relationship and partner relationship (see Section 7.1).
- **Informed consent** - An explanation of the purpose of screening and assessment should be given before they take place and it is important to stress that this is part of routine care and results will generally remain confidential. Consent can be readily integrated with consent processes for existing routine antenatal and postnatal care procedures. If a woman does not consent to assessment and/or screening, this should be explored and documented and assessment and screening offered at subsequent consultations.
- **Confidentiality** - It should also be explained that confidentiality may not be kept if there is a perceived risk of harm to the woman or her baby as there is a duty of care for this to be communicated to key others. However, in this situation, only information relevant to the risk will be shared.
- **Follow-up to screening** - Decision-making about the need for and type of follow-up mental health care is based on a woman's clinical presentation, responses at interview and/or structured assessment, and the woman's preferences. The initial assessment in the primary care setting is not diagnostic, rather, its aim is to ensure that women who may benefit from help with their distress or symptoms, or who need further assessment for a possible mental health condition, will be offered the care (including diagnostic assessment) they need.
- **Ongoing care and support** - Most women will not need further monitoring or mental health assessment, while many of those who need it will not accept it, at least initially. Providing ongoing exploration of their symptoms and information and encouraging continuing contact with an appropriate health professional may support women in seeking further assistance. The process of screening and assessment is likely to be facilitated when a woman has a relationship with her care provider. Ideally, ongoing mental health care in the perinatal period is provided by a woman's regular GP. However, it is acknowledged that not all women have access to this type of care or choose it when it is available. Women should be assisted in identifying a health professional with the skills and knowledge to provide appropriate and culturally safe ongoing care.

Consensus-based recommendations

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

4 Screening for depressive and anxiety disorders

'Screening' involves the application of a validated test (or questionnaire) or, where appropriate, clinical interview to identify people who may be experiencing a particular disorder. Screening tools are not diagnostic. Rather, accurately identifying women experiencing symptoms of depression and anxiety enables referral for more formal mental health assessment and suitable follow-up, with a view to improving outcomes for women. The screening process is informed by the considerations outlined in Chapter 3.

4.1 Screening for depression

4.1.1 Summary of the evidence

In Australia, the Edinburgh Postnatal Depression Scale (EPDS) has been recommended for screening for depression in the antenatal and postnatal periods since 2011, based on evidence from systematic reviews conducted in 2010 and 2017 to support previous iterations of the Guideline (*beyondblue 2011; Austin et al 2017*). The evidence identified in the 2022 systematic review was of very low to low certainty and lacked the power to change the strength or direction of the previous recommendation.

The systematic review assessed the appropriateness of screening tools based on their performance (defined as sensitivity, specificity, positive likelihood ratio, negative likelihood ratio), non-technical characteristics (defined as number of items, time to administer, perinatal/postnatal timing, complexity of scoring, training requirements, and available languages), acceptability (to the birthing parent, health professionals, and the general public), effectiveness (defined as positive impact on depressive symptoms, services referred to or utilised and impact on a woman's mental health) and implications for implementation (see Table 4; page 58).

The performance of the EPDS was acceptable (high certainty), while there was uncertainty about the performance of the PHQ (low certainty), 'Whooley questions' (very low to low certainty) or Kessler 10 (K10) (very low to low certainty) (*NICE 2014; updated 2020*) (see Table 8; page 75). Ease of administration and implementability were high for all of the tools but the EPDS was superior in terms of language availability and cultural sensitivity; acceptability; and effectiveness (see Table 9; page 76).

When reviewing the evidence, the outcomes that the EWG considered important were the identification of women experiencing mental distress or symptoms of depression. In addition, it was noted that screening has broader aims and other desirable effects (see Table 10; page 77).

Evidence-based recommendation

1 Administer the EPDS to screen women for a possible depressive disorder in the perinatal period.

Strong

A cut-off score of 13 or more is associated with the highest sensitivity, specificity and positive likelihood ratio and the lowest negative likelihood ratio for detecting possible major depression in the antenatal or postnatal period compared to other cut-off scores (high certainty) in studies of women in high-income countries. A score of 10 or more has moderate sensitivity and specificity (moderate certainty). See Table 8; page 75.

Evidence-based recommendation

2 Arrange further assessment of perinatal women with an EPDS score of 13 or more.

Strong

Appendix C includes the EPDS and information on calculating a woman's score.

4.1.2 Other considerations in screening for depression

Risk of harm

Regardless of the total EPDS score, women who score positive on Question 10 may be at risk of harming themselves and/or their children and further assessment is necessary. See Section 7.2.1 for further guidance on assessing the risk of self-harm or suicide.

Consensus-based recommendation

- iii 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.

Timing of screening

The timing of screening should reflect available resources and existing contacts between the woman and the health professionals caring for her:

- an obvious contact point is the first antenatal visit, however, it is acknowledged that the time available at this visit and the number of other assessments undertaken may limit opportunities for assessment of mental health. The second screening should take place later in their pregnancy at or around thirty weeks gestation.
- postnatal assessment may be integrated into routine maternal and infant checks after six weeks postnatal and later in the first postnatal year (6–8 months) when symptoms are often likely to develop.

Timing of repeat screening following the initial screen at each recommended interval is based on results of the initial screen and clinical judgement.

Consensus-based recommendations

- iv Complete the first antenatal screening as early as practical in pregnancy and repeat screening at least once later in pregnancy.
- v Complete the first postnatal screening 6–12 weeks after birth and repeat screening at least once in the first postnatal year.
- vi 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.
- vii Repeat the EPDS at any time in pregnancy and in the first postnatal year if clinically indicated.

Mode of assessment

The EPDS is a self-report tool and is usually completed by the woman, preferably without consultation with others. It may at times be appropriate for the health professional to verbally administer the questionnaire whether face to face or by phone.

Women who decline screening

Some women may not accept the offer of screening for a range of reasons, for example to protect their privacy (*Highet et al 2018; Willey et al 2020a; Willey et al 2020b; Blackmore et al 2022*). In such situations, some woman may prefer to complete the EPDS electronically and receive advice on whether further assessment is recommended. As the therapeutic relationship develops, subsequent offers of the EPDS may be accepted.

4.2 Culturally appropriate screening for depression

4.2.1 Aboriginal and/or Torres Strait Islander women

Screening for perinatal depression and anxiety among Aboriginal and/or Torres Strait Islander women can be hampered by poor rapport between the health professional and the woman, language barriers, mistrust of mainstream services and/or fear of the consequences of depression being identified (i.e. involvement of child protection services (Carlin *et al* 2019). In addition, the EPDS 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 (i.e. involvement of child protections services).

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 (Hayes *et al* 2006; Campbell *et al* 2008). A recent adaptation of the EPDS developed in the Kimberley by Aboriginal women and health professionals (the Kimberley Mum's Mood Scale; KMMS) includes an additional component of psychosocial assessment (using a semi-structured 'yarn'), acknowledging the contribution that stressful events and social health issues play in maternal mental health (Marley *et al* 2017a). Many elements of the approach taken to adapting this instrument (i.e. the way in which questions are asked, implementation by Aboriginal health workers) are likely to have broader relevance to urban as well as remote and regional Aboriginal and Torres Strait Islander communities. The tool has been implemented in the Kimberley region (Carlin *et al* 2022) and is being tested for acceptability and phrasing of questions in the Pilbara (Carlin *et al* 2019), Arnhem Land and Far North Queensland. However, it is not clear whether the tool is appropriate for use in other groups of Aboriginal women.

If use of the EPDS is considered inappropriate, involvement of an Aboriginal and/or Torres Strait Islander health worker may facilitate assessment of symptoms of depressive or anxiety disorders.

Consensus-based recommendation

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

Practice point

- a Where possible, seek guidance/support from an Aboriginal and/or Torres Strait Islander worker or professional when screening Aboriginal and/or Torres Strait Islander woman for depression and anxiety.

4.2.2 Women from culturally diverse backgrounds, including migrant and refugee women

The EPDS has been translated into more than 50 languages and validated for depression screening in more than 20 languages. Scores used to identify possible depression in migrant and refugee women are generally lower than those used in the general Australian population. Specific scores are given in translated versions of the tool.

Cultural practices (such as attending the consultation with a family member) and the perceived degree of stigma associated with depression may also influence the performance of the EPDS. Pressure to under-report symptoms may be an issue for women awaiting outcomes on visa and residency applications.

The use of interpreters may be a consideration even when a validated translation is used as some women may not have sufficient literacy skills to understand the questionnaire even in translation.

Consensus-based recommendation

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

4.3 Screening for anxiety

In Australia, the anxiety items from the EPDS or other tools (e.g. the Depression, Anxiety and Stress Scale [DASS] or Kessler Psychological Distress Scale [K10]) have been recommended for screening for anxiety in the antenatal and postnatal periods since 2017.

As the overall certainty of the evidence for all screening tests is very low to low, firm conclusions on the optimal tool cannot be drawn.

In the absence of a practical screening tool for anxiety disorders with adequate evidence in the perinatal period, clinical judgment must be used. This may include consideration of items 3, 4 and 5 of the EPDS (*Matthey et al 2013a; Matthey et al 2013b*).

| Consensus-based recommendations | |
|---------------------------------|---|
| x | Be aware that anxiety disorders are very common in the perinatal period and should be considered in the broader clinical assessment. |
| v | 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. ANRQ). |

5 Assessing psychosocial factors that affect mental health

Psychosocial assessment allows identification of circumstances (past and present) that affect a woman's mental health and is conducted in addition to screening for symptoms of depression and/or anxiety. The number and type of psychosocial factors identified influences the care pathway, with more approaches or interventions needed to support women who are experiencing multiple psychosocial factors. The presence of complex risk factors will require a coordinated multidisciplinary approach to the woman's care plan.

Psychosocial assessment can be undertaken as part of the clinical interview and/or using a structured psychosocial assessment tool. Different approaches can be taken to suit the setting, health professional confidence and skill set, as well as time constraints. Structured questionnaires are useful in providing a comprehensive, time-efficient overview of the woman's circumstances, especially when the health professional is not experienced in undertaking a detailed psychosocial assessment as part of the broader clinical evaluation. Whatever the approach taken, psychosocial assessment should take place in a safe and non-judgemental space.

Practice point

- b** Assess psychosocial risk factors as early as practical in pregnancy and again after the birth.

5.1 Psychosocial assessment tools

5.1.1 Summary of the evidence

The Antenatal Risk Questionnaire (ANRQ) has been the recommended psychosocial screening tool in Australia since 2017, based on evidence from a systematic review conducted in 2017. The evidence identified in the 2022 systematic review was consistent with the previous recommendation (see Table 12; page 78).

The ANRQ (*Austin et al 2013; Reilly et al 2015*) is a 13-item structured questionnaire with categorical (yes/no) and dimensional (1 to 5) responses, which generates a total psychosocial risk score (cumulative risk) as well as identifying specific risk factors that independently put the woman at greater psychosocial risk (past history of trauma or significant mental health condition). The ANRQ covers relationship with partner, social support, recent stressful life events, anxiety or perfectionism, past history of depression or other mental health conditions (and treatment for same), having experienced abuse as a child or as an adult, and quality of relationship with mother in childhood. Assessment of a revised version of the tool, the ANRQ-R, is in progress (*Reilly et al 2022*) but there is currently insufficient evidence from which to draw conclusions about the tool's validity. The ANRQ has acceptable technical performance in identifying women at greater risk of postnatal depression and anxiety disorder (moderate certainty). It is rated high for ease of administration, acceptability among women and health professionals and has a positive impact on rates of referral for further mental health assessment.

A cut-off score of 23 or more is recommended but women with a significant mental health history or history of abuse are at increased risk of poor psychosocial outcome irrespective of the total ANRQ score. As the items on the ANRQ are applicable to both pregnancy and postnatal women, it can be used postnatally using the same cut-off score.

Appendix C includes the ANRQ and guidance on its use in clinical practice, scoring and interpretation of results.

Evidence-based recommendation

- 3** Administer the ANRQ to assess a woman's psychosocial risk.

Strong

Consensus-based recommendation

- xiii** 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.

5.2 Other considerations in psychosocial screening

As a clinically useful psychosocial assessment tool needs to be brief and to cover the key risk domains, it cannot be fully comprehensive and should be used to “start the conversation” such that particular domains can then be explored further as needed.

5.2.1 Further exploration and interpretation of psychosocial assessment

Psychosocial risk items endorsed by the woman need to be further explored and documented. The results of the evaluation need to be explained to the woman and then (in consultation with the woman) be translated into a practical approach to further care (e.g. referral or monitoring). This will be reliant on the availability of adequate referral pathways.

Practice points

- c** Ensure that health professionals receive training in the importance of psychosocial assessment and the use of a psychosocial assessment tool.
- d** 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.

5.2.2 Education about psychosocial risk factors

Given the potential impact that psychosocial risk factors may have on a woman's mental health and the well-being of her baby/other children, it is important that all women are provided with information about the nature of the different risk factors that may increase her likelihood of experiencing a mental health condition in the perinatal period. In turn this provides an opportunity to identify supports (protective factors) to assist in the prevention of mental health conditions, and/or raise awareness of the importance of early symptom recognition to facilitate early detection and intervention.

Practice point

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

5.2.3 Culturally appropriate assessment of psychosocial risk

Aboriginal and/or Torres Strait Islander women

The ANRQ was not developed and validated with Aboriginal and/or Torres Strait Islander representation and therefore may not represent an Aboriginal and/or Torres Strait Islander world view.

A more conversational approach to psychosocial assessment may be needed in these groups, with a focus on developing rapport and trust.

- A South Australian study (among Aboriginal women) found that women were happy to be asked about social health issues, including family and community violence, when questions were asked by Aboriginal community women in an interview or when women were given the option to self-complete a questionnaire (*Weetra et al 2016*).
- Analysis of assessments undertaken using the KMMS suggests that it may provide an acceptable and effective framework for undertaking a culturally nuanced approach to assessment (*Marley et al 2017b; Carlin et al 2019; Carlin et al 2020b; Carlin et al 2022*).
- A digital perinatal mental health screening platform, Baby Coming - You Ready?, has been developed in consultation with Aboriginal communities in Perth. However, there is currently insufficient evidence from which to draw conclusions about the tool's validity.

Migrant and refugee women

The ANRQ is available digitally in over 25 languages, with more becoming available. However, no published evidence has been identified describing its use in migrant and refugee women.

A study into migrant and refugee women's perspectives found that mental health screening is an acceptable and feasible option (*Willey et al 2020a*). The implementation of screening via a digital platform provided privacy and contributed to more truthful responses from women, when using this function on their own.

Consideration should also be given to psychosocial risk and protective factors that are not covered in the tools but may be relevant to specific groups (see Section 1.1).

Consensus-based recommendation

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

5.2.4 Assessment of specific social factors and health behaviours

It is recommended that enquiry about personal and partner use of drugs and alcohol and family violence is included as part of psychosocial assessment of factors influencing mental health (see Chapter 5).

Routine assessment of specific social and health behaviours that affect perinatal outcomes and may also be associated with mental health is described in the **Pregnancy Care Guidelines** (*Department of Health 2020*). This includes:

- family violence
- health behaviours including, nutrition, physical activity, substance use and smoking.

6 Assessing perinatal mental health in non-birthing partners

The systematic literature review underpinning this Guideline was specific to screening, prevention and treatment of mental health among women in the perinatal period. This chapter is informed by a systematic review that appraised the evidence on assessing perinatal mental health among non-birthing partners as part of a separate process (*hereco unpublished*).

6.1 Screening for depression and anxiety

Evidence on the use of mental health screening tools in non-birthing partners is limited. All studies reporting diagnostic test accuracy included male partners only; no evidence was identified on the performance or acceptability of mental health screening tools in co-mothers, step-parents or other partners.

Although a small number of studies suggest that mental health screening tools may be accurate and acceptable in male parents in the postnatal period, overall there is insufficient evidence that using a specific tool (on a universal basis or targeted to high-risk groups) would be accurate or acceptable in identifying mental health problems or improving outcomes.

All studies that assessed diagnostic performance of mental health screening tools in the target population reported on the EPDS, which is likely a reflection of the wide use of this tool in perinatal clinical and research settings rather than it being the most appropriate tool for use in non-birthing partners. The included studies (n=7) were all of low or very low quality and only one study, published in 2001, was conducted in Australia. Across the studies there was no consensus on the appropriate EPDS cut-off for screening for mental health problems.

While the EPDS is currently used in maternity and postnatal settings in Australia, other tools, such as the Kessler Psychological Distress Scale (K10) may be more commonly used in other settings.

The literature on mental health screening in fathers points toward the need for male-specific measures that are not limited to “traditional” symptoms of distress, but instead incorporate different signs and behaviours. For example, men may be more likely to acknowledge fatigue and irritability, to withdraw socially, use avoidant/escapist activities (e.g. sports, overworking, excessive time on internet/TV, gambling, alcohol use, reckless behaviour) and to display hostility and anger.

The mode/setting of delivery of mental health screening may be an important consideration as non-birthing partners tend not to be in regular contact with the health system throughout the perinatal period.

Implementation of mental health assessment for non-birthing partners into clinical practice depends on acceptability to both health professionals and parents. Evidence regarding the acceptability of specific measures is limited but resonates with literature on acceptability in women, with timing of administration, time required to complete the assessment and clarity of wording being important considerations (*Darwin et al 2020*).

Consensus-based recommendations

- xiv** Offer non-birthing parents mental health screening in the perinatal period.
- xv** Given the absence of support for one specific screening tool it is not currently possible to universally recommend one screening tool over another.
- xvi** Select screening tools in accordance with availability and competencies of health professionals to use a specific tool within specific settings.
- xvii** 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.
- xviii** When administering the EPDS to male parents, use a lower cut-off score (10 or more), noting responses to individual items.

- xix** 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.

6.2 Psychosocial screening

There is insufficient evidence to draw conclusions on the most appropriate tools for perinatal psychosocial assessment of non-birthing partners. Although the ANRQ/PNRQ appears to be appropriate, with high ease of administration and implementability, the language and domains covered in the tool may not be appropriate for non-birthing parents. A version of the ANRQ has been developed to include additional items and revised language (see Appendix C).

Assessment of the ALPHA and PRQ found ease of administration to be moderate and implementability to be limited.

The mode/setting of delivery may be an important consideration as mothers tend to be in contact with health services throughout the perinatal period, whereas non-birthing parents may have more sporadic contact.

Consensus-based recommendations

- xx** Offer non-birthing parents psychosocial screening in the perinatal period.
- xxi** Use the amended ANRQ/PNRQ screening tool for male non-birthing parents.
- xxii** Use the ANRQ/PNRQ in its current form for psychosocial screening of female non-birthing parents⁵.
- xxiii** 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.
- xxiv** Offer psychosocial assessment as early as practicable in pregnancy and the postnatal period (in combination with mental health screening).

⁵ In this context, the first postnatal question could be reworded as 'Was your experience of the birth of this baby disappointing or frightening?'

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

7.1 Mother-infant interaction⁶

The table below provides a list of prompts to assess difficulties in the mother-infant relationship. 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.

Table 2 Indications of potential difficulties in the mother-infant interaction

| PSYCHOSOCIAL RISK FACTORS | RELATIONSHIP FACTORS (OBSERVED OR REPORTED) |
|---|---|
| <ul style="list-style-type: none"> Unresolved family of origin issues | <ul style="list-style-type: none"> Is the mother thoughtful about her baby? |
| <ul style="list-style-type: none"> History of emotional/physical/sexual abuse, family violence, childhood neglect | <ul style="list-style-type: none"> Can the mother describe the baby's daily routine? |
| <ul style="list-style-type: none"> Past pregnancy loss or excess pregnancy concern | <ul style="list-style-type: none"> Is the mother able to reflect on the baby's needs? |
| <ul style="list-style-type: none"> Unplanned or unwanted pregnancy | <ul style="list-style-type: none"> Does the mother express empathy for the baby? |
| <ul style="list-style-type: none"> Did the mother receive a prenatal diagnosis of fetal anomaly? | <ul style="list-style-type: none"> Does the mother engage in enjoyable activities with the baby? |
| <ul style="list-style-type: none"> Fertility issues or assisted reproduction | <ul style="list-style-type: none"> Does the mother play/talk appropriately to the baby? |
| <ul style="list-style-type: none"> Did the women experience birth trauma? | <ul style="list-style-type: none"> Does she delight in her baby? |
| <ul style="list-style-type: none"> Was the mother able to touch the baby on the day of birth? | <ul style="list-style-type: none"> Does the baby ever make her feel uncomfortable, unhappy or enraged? |
| <ul style="list-style-type: none"> Did the mother have responsibility for infant care during the first week of life? | <ul style="list-style-type: none"> Is the mother excessively worried about the baby? |
| <ul style="list-style-type: none"> Who is involved in the baby's care? | <ul style="list-style-type: none"> Does the mother cope with the baby's distress? |
| <ul style="list-style-type: none"> Availability of emotional/social/practical support | <ul style="list-style-type: none"> Does she respond and attend appropriately to the baby's cues? |
| <ul style="list-style-type: none"> How much time does the mother spend away from the baby? | <ul style="list-style-type: none"> Are her responses consistent? |
| | <ul style="list-style-type: none"> Is she protective of the baby? |
| | <ul style="list-style-type: none"> How does she refer to the baby? |
| | <ul style="list-style-type: none"> Does she show/share photos of the baby? |
| | <ul style="list-style-type: none"> Has she set up a room for the baby? |
| | <ul style="list-style-type: none"> Does she buy baby clothes? |

⁶ This section is adapted from 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. http://www.nmahsmh.health.wa.gov.au/projects/docs/healthy_mothers_clinicians_manual.pdf.

| INFANT FACTORS | MATERNAL FACTORS |
|--|--|
| <ul style="list-style-type: none"> Is the baby achieving normal developmental milestones? | <ul style="list-style-type: none"> Current maternal personality disorder |
| <ul style="list-style-type: none"> Is the baby growing adequately? | <ul style="list-style-type: none"> Antenatal or postnatal mood disorder |
| <ul style="list-style-type: none"> Are there feeding difficulties, reflux, gastric distress, sleep difficulties? | <ul style="list-style-type: none"> Psychosis |
| <ul style="list-style-type: none"> Does the infant have other health concerns (e.g. eczema, allergies, congenital anomalies)? | <ul style="list-style-type: none"> Diagnosed personality disorder |
| INFANT BEHAVIOUR OF CONCERN (OBSERVED OR REPORTED) | <ul style="list-style-type: none"> Suicidal or homicidal ideation |
| <ul style="list-style-type: none"> Gaze avoidance | <ul style="list-style-type: none"> Negative symptoms (low motivation, anhedonia, blunted affect, poverty of thought/speech) |
| <ul style="list-style-type: none"> Flat affect | <ul style="list-style-type: none"> Medication side-effects (e.g. causing sedation) |
| <ul style="list-style-type: none"> Lack of crying | <ul style="list-style-type: none"> Substance abuse |
| <ul style="list-style-type: none"> Limited vocalising | <ul style="list-style-type: none"> Engaging in dangerous or risk-taking behaviours (e.g. alcohol or drug misuse) |
| <ul style="list-style-type: none"> Emotionally under-responsive | |
| <ul style="list-style-type: none"> Interacts too easily with strangers (age dependent) | |
| <ul style="list-style-type: none"> Unsettled sleep or feeding | |
| <ul style="list-style-type: none"> Difficult to console when distressed | |
| <ul style="list-style-type: none"> Irritable, constant crying | |
| <ul style="list-style-type: none"> Difficulty separating from parent (age dependent) | |

Table 3 Protective factors in the mother-infant interaction

| | |
|---|--|
| <ul style="list-style-type: none"> Mother is sensitive to the baby | <ul style="list-style-type: none"> Mother is able to monitor the baby's well-being adequately |
| <ul style="list-style-type: none"> Mother is responsive to the baby | <ul style="list-style-type: none"> Mother is able to cope with flexibility in her routine |
| <ul style="list-style-type: none"> Mother has a close relationship with at least one other adult | <ul style="list-style-type: none"> Mother is thoughtful about what might be going on in the baby's mind |

Practice points

- f** Assess the mother-infant interaction as an integral part of perinatal care and refer to a parent-infant therapist as available and appropriate.
- g** 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.
- h** 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.
- i** 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.

7.2 Safety of the woman and infant

7.2.1 Risk of suicide⁷

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 making enquiry into the extent of suicidal thoughts and intent, including:

- **Suicidal thoughts** - if suicidal thoughts are present, how frequent and persistent are they?
- **Plan** - if the woman has a plan, how detailed and feasible 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?

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.

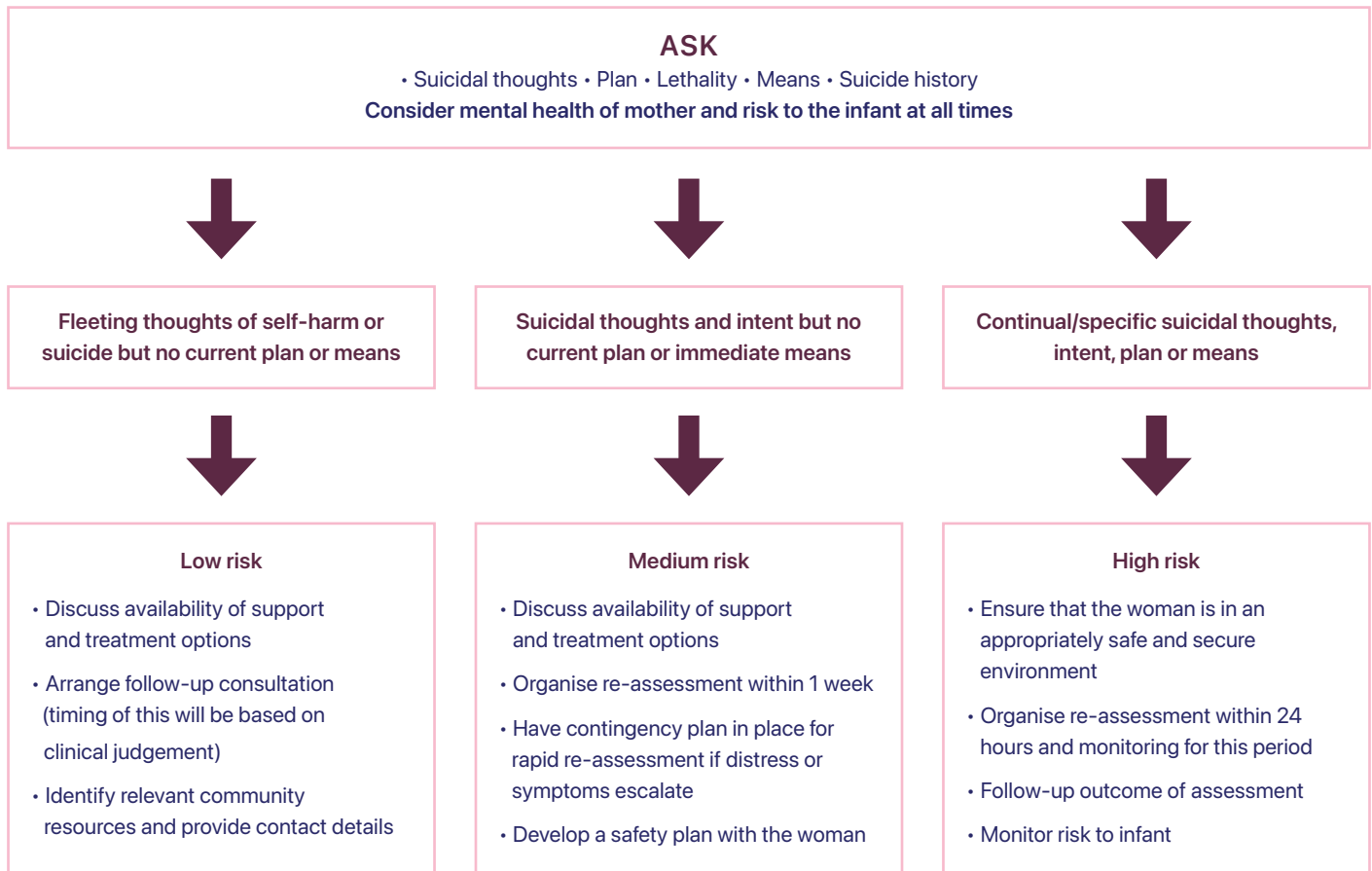
Whenever assessing a woman for risk of suicide, enquiry should be made about her capacity to care for the infant and any thoughts of harm to the infant.

Managing immediate risk

The following diagram represents some general principles for responding to suicide risk. Care and referral pathways will need to be adapted to individual circumstances and local resources and will be informed by clinical judgement, including assessment of impulsivity. The safety of the baby must also be considered as there may also be a risk of abandonment or infanticide.

⁷ This section has been developed based on resources available through the Australian National Suicide Prevention Strategy (NSPS) website - www.livingisforeveryone.com.au

Figure 7.1 General responses to identified risk of suicide



Additional considerations in managing identified risk of suicide

- **Low risk** - Seek to understand what precipitates the fleeting thoughts. If triggers are core to the woman's current perinatal experience (e.g. sense of maternal failure; shame about negative thoughts towards infant; interpersonal conflict), ensure a safety plan is specific to the issues.
- **Medium risk** - Assess context of current suicidal thoughts (e.g. previous suicide ideation or behaviours and outcomes). Establish factors that might contribute to escalation of risk (e.g. unsettled baby; conflict with partner). If triggers relate to the woman's current perinatal experience (and cannot be immediately resolved), carers for infant/children and mother need to be located.
- **High risk** - Locate a support person to care for infants/children. A mother can deny intent yet be at high risk. A woman with significant perinatal mental health decline, inability to sleep, distorted thinking, inability to care for self or infant with fleeting thoughts her family would be better off without her can be just as at risk as a woman with intent.

Developing a safety plan

A safety plan is a prioritised list of coping strategies and sources of support that women can use when they experience suicidal thoughts.

Developing a safety plan involves assisting the woman to identify:

- warning signs that she may be at risk of imminent suicide (e.g. feeling trapped, worthless or hopeless) and actions to protect herself and the infant
- internal coping strategies that decrease the level of risk

- people within the woman's network who can assist in times of need
- health professionals and agencies that can be contacted for help.

Safety plans should be frequently revisited and modified as needed.

Practice point

- j** 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.

7.2.2 Risk to the infant

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

Assessment of risk to the infant needs to be conducted with sensitivity to avoid implicitly blaming or stigmatising the mother for having negative thoughts about her infant which could impact the therapeutic relationship and reduce open/honest discussions.

The nature of the enquiry will depend on a range of factors, including 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. 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.

Practice point

- k** 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.

8 Implementing psychosocial assessment and screening

Routine assessment of all women in the perinatal period is critical to providing them with access to early intervention and improving outcomes for women and their families. While referral and care pathways vary with setting (e.g. general practice, maternity services) and the location (e.g. metropolitan, rural and remote), it is important that women are provided with access to timely, appropriate services post-assessment and ongoing psychosocial support.

8.1 Incorporating psychosocial assessment and screening into routine practice

Recommended psychosocial assessment and depression screening can be conducted by a variety of health professionals depending on where a woman seeks antenatal and postnatal care.

- **General practice** - In the general practice setting, screening and psychosocial assessment may be conducted by the general practitioner or a practice nurse.
- **Midwifery and maternal and child health care** - Midwives in public or private practice and maternal and child health nurses⁸ are well-placed to conduct screening and psychosocial assessment in the antenatal and postnatal periods.
- **Obstetric practice** - Obstetricians in public or private practice are responsible for ensuring that screening with the EPDS and psychosocial assessment take place. Regardless of who conducts the assessments (e.g. the obstetrician or a practice midwife), the woman's GP and the hospital at which the woman will give birth need to be notified if there are any concerns and relevant information included in the woman's discharge summary.

8.2 General approaches post-assessment

Screening and psychosocial assessment provide an indication of a woman's general mental health status and the presence of psychosocial risk factors but do not provide a diagnosis. Initial steps following these assessments include determining whether comprehensive mental health assessment is required (which may lead to a psychiatric diagnosis) and identifying supports and services tailored to the woman's needs.

The following points illustrate a range of situations and the types of approaches that may be appropriate:

- **Women with moderate-to-severe symptoms** will require comprehensive mental health assessment - subsequent management will most likely involve pharmacological treatment and/or psychological treatment and ongoing psychosocial support
- **Women with a past history of a severe mental health condition** will require comprehensive mental health assessment before conception or in the antenatal period and additional support (particularly in the early postnatal period)
- **Women with mild-to-moderate symptoms** may require comprehensive mental health assessment and may also benefit from some form of psychological treatment in addition to psychosocial support; additional support such as apps or on-line programs may be helpful
- **Women experiencing mild depressive or anxiety symptoms in the early postnatal period** may benefit from emotional and social support (e.g. advice on parenting, unsettled infants, sleep deprivation, support groups) and monitoring
- **Women without current symptoms but experiencing significant psychosocial risk** (e.g. a recent separation, experiencing prenatal diagnosis of a chromosomal anomaly) may benefit from ongoing psychosocial support.

Women with a pre-existing mental health condition may already be under the care of a GP, psychologist and/or psychiatrist (depending on the nature and severity of their condition). However, comprehensive mental health assessment is required if the woman has, or is suspected to have, a recurrence or new onset of severe mental health condition, suicidal thoughts or thoughts of harm to herself or infant, or if other children in her care may be at risk of harm.

⁸ Also referred to as child and family health nurses in some jurisdictions.

8.3 Referral and care pathways

The general principles for referral are the same in all settings. However, referral pathways will depend on the setting and the access to services available in the area. Telehealth is increasingly providing a broader access to services. Whatever pathway is chosen, there is a need for documentation, coordinated care and inter-professional communication as well as clear communication with the woman and her significant other.

Consideration needs to be given to the urgency of the referral, particularly when women have severe symptoms or suicidal thinking. Women with severe mental health conditions may need to be referred directly to the local mental health team for urgent assessment or may even require involuntary treatment at a local psychiatric facility.

In rural and remote settings, mental health services may not be locally available and waiting times can be long. In such cases, advice may need to be sought from a GP, visiting psychiatrist, telehealth or mental health support line (e.g. those provided by non-government organisations).

For Aboriginal and/or Torres Strait Islander women, involvement of a culturally appropriate worker (e.g. Aboriginal and/or Torres Strait Islander health worker) is advisable.

For migrant and refugee women, the involvement of a cultural liaison officer and/or interpreter is advisable.

- **General practice** - Where possible a GP will diagnose and develop a management plan for depressive and anxiety disorders. Women with symptoms suggestive of more serious low prevalence conditions should be referred directly to a psychiatrist. Once a psychiatric diagnosis is established, and where psychological intervention is deemed the best treatment approach, a GP may develop a mental health treatment plan to allow the woman to access the relevant Medicare items for psychological treatment. GPs and psychiatrists can provide a mental health care plan to access psychological care.
- **Midwifery** - For midwives, referral pathways will differ depending on whether they are in the private or public sector, independent, involved in a group midwifery practice, working through an Aboriginal and/or Torres Strait Islander Medical Service or hospital-based. Midwives in a hospital-based setting may provide ongoing care and support to the family, seeking the advice of an in-house, psychiatrist, psychologist and/or allied health professional (e.g. mental health nurse) and/or social worker as required. Midwives in other settings may refer women to a GP or private mental health service providers.
- **Obstetrics** - For obstetricians in the public sector, referral pathways will usually be established with in-house social workers and allied mental health professionals. Women may be referred back to their GP if there is shared care. For obstetricians in private practice, referral is likely to be to the woman's GP or directly to a psychologist or a psychiatrist, depending on the individual situation and availability.
- **Postnatal care** - Most women will see a GP or midwife in the first 6 weeks postnatally and then transition to maternal and child health nurse care. In this setting, referral will likely be to a GP for further referral for counselling or psychological assessment. A maternal and child health nurse may provide ongoing care and support to the family, seeking the advice of a GP and/or allied mental health professional as required.

Addressing individual psychosocial risk factors is beyond the scope of this Guideline. In some situations, referral to or liaison with other agencies (e.g. child protection, alcohol and drug, family violence and other support services) may be necessary.

8.4 Supporting emotional health and well-being

8.4.1 Ongoing psychosocial support

Whether or not referral is required, primary and maternity care professionals have an ongoing role in the psychosocial care of women in the perinatal period. Regular enquiry about emotional well-being provides a woman with opportunities for discussion about how she is managing and allows health professionals to determine whether repeat depression screening or other assessments are indicated. Enquiry about physical well-being enables referral to relevant support services or allied health professionals (e.g. for women suffering ongoing pain, discomfort or incontinence issues).

Enquiry about the outcome of previous discussions or referrals may also be a consideration.

Practice point

- I 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.

8.4.2 Advice on health behaviours

All women in the perinatal period will benefit from advice on healthy eating in accordance with the Australian Dietary Guidelines (NHMRC 2013), physical activity in accordance with **Australian Physical Activity Guidelines** (DoH 2014, updated 2017) and sleep patterns. During pregnancy or following the birth of a baby, these aspects of a woman's life may be disrupted and can contribute to impaired mental health. Advice on health behaviours for the general population will need to be adapted to suit the woman's particular circumstances, taking into consideration the demands of the pregnancy or baby and other family needs. For example, regardless of whether women follow healthy sleep habits, their nights will be disrupted during the early postnatal period and they should be encouraged to take opportunities to rest during the day (e.g. when the baby is asleep). When specific advice on nutrition is required (e.g. if there is excessive or inadequate gestational weight gain), referral to an accredited practising dietitian may be a consideration. Referral for physical activity support may also be a consideration.

Practice point

m 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.

8.4.3 Electronic perinatal mental health support

There is emerging evidence of the efficacy of using e-mental health support in both prevention and treatment of perinatal mental health difficulties (Danaher et al 2012; Danaher et al 2013; Milgrom et al 2016). There is a range of options, including apps to support mental health and emotional well-being for individuals and couples during the perinatal period or for individuals who are experiencing suicidal thoughts, feelings, distress or crisis. There are also moderated online forums where people can connect with others with similar experiences and receive and provide advice and support. Many of these are provided by non-government organisations. Details of the different perinatal mental health support services can be found on the **eCOPE Directory** or the **HeadtoHealth** website.

8.4.4 Psychological preparation for parenthood

Including psychological preparation for parenthood as a routine part of antenatal care has a positive effect on women's mental health postnatally (Department of Health 2020). This type of education focuses on coping, problem-solving and decision-making skills; recognising distress and seeking help; cognitive restructuring and psychosocial issues associated with parenthood.

8.5 Women with complex presentations

When a woman has comorbidities – such as more than one mental health condition, a significant maternal-fetal or medical condition, challenging personality traits, major psychosocial stressors (e.g. adolescent pregnancy, poverty, family violence or substance use) – referral to a psychologist and/or psychiatrist for treatment is needed and inter-professional collaboration is strongly recommended.

There are several options for how this might take place, depending on the setting. In the public sector, multidisciplinary case-planning meetings may be the most efficient approach. In the private sector, collaboration may take the form of a mental health treatment plan, a chronic disease management plan, case conferencing and/or regular contact between health professionals. In all cases, informed consent is a prerequisite for case conferencing/ case discussion, with exceptions for risk of harm to self or others, or as provided for by state legislation.

Processes for monitoring outcomes and the continuing safety of the infant or family should be put in place, particularly when women are at risk of loss to follow-up or there is a concern about risk to the infant or mother.

9 Practice summary - Screening and assessment

| BEFORE ASSESSMENT | COMMENTS |
|-----------------------------|--|
| Establish referral pathways | Identify appropriate health professionals available to provide follow-up care and to assist if there are concerns for the safety of the woman, fetus or infant. Identify other professionals from whom you can seek advice, clinical supervision or support regarding mental health care in the perinatal period. |
| Seek informed consent | Explain the purpose of the assessment and screening - emphasise that this is part of routine care and results will generally remain confidential. |

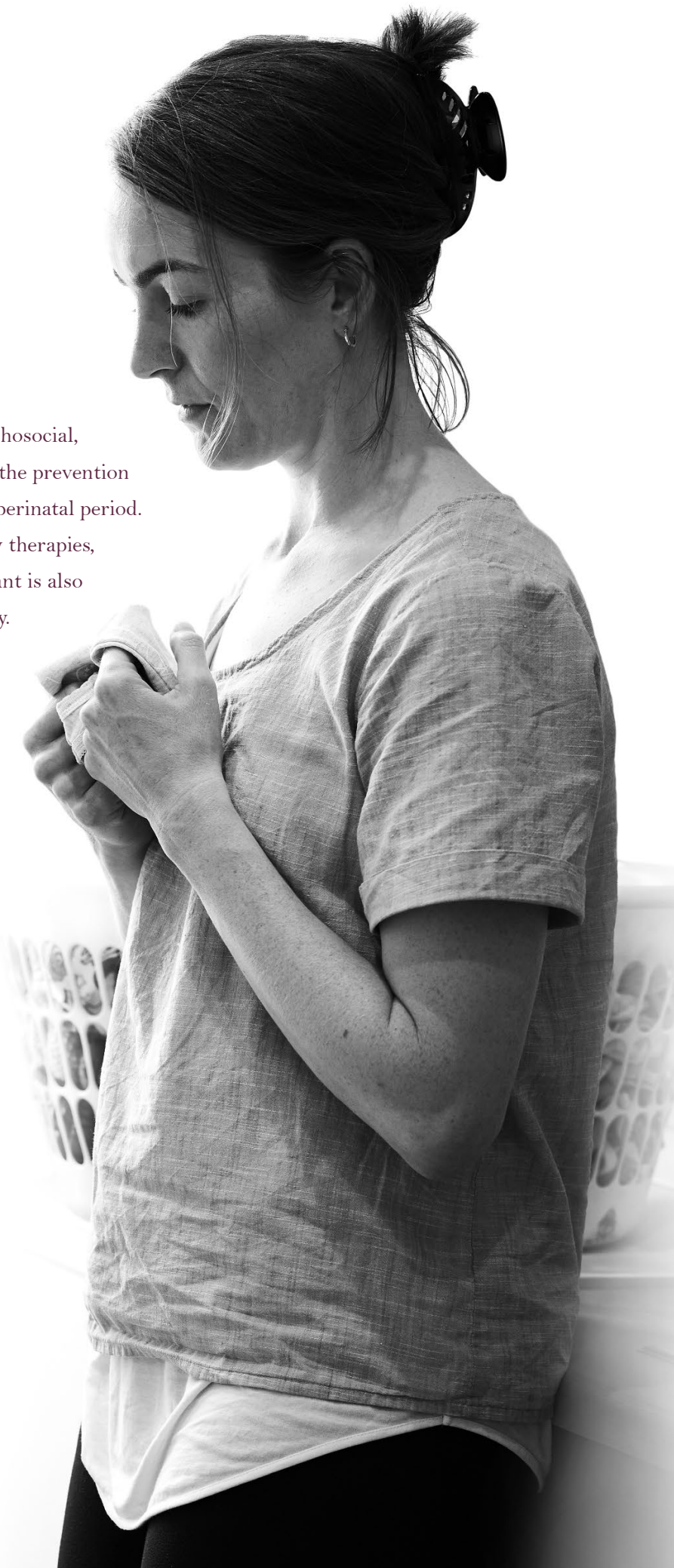
| ANTENATAL PERIOD | WHEN | ACTIONS |
|---|--|--|
| Assess for depressive symptoms (EPDS) | As early as practical in pregnancy | Arrange further assessment for women with a score of 13 or more Repeat at least once in pregnancy and whenever clinically indicated |
| Assess for anxiety symptoms | When conducting EPDS | Refer to anxiety items of the EPDS or other tool |
| Assess psychosocial risk factors | As early as practical in pregnancy | Further explore psychosocial risk as needed |
| Assess mental health of non-birthing partners | As early as practical in pregnancy | Select screening tools according to availability and competencies of health professionals - use the original or amended ANRQ/PNRQ as appropriate |
| Assess maternal safety | Based on EPDS Q10 and clinical judgement | Manage immediate risk and arrange specific assessment |
| Enquire about emotional well-being | Every antenatal visit | Determine whether repeat assessments are required |
| Provide advice on healthy behaviours | At least once during pregnancy | Focus on healthy eating, physical activity and sleep hygiene |
| Psychological preparation for parenthood | At least once during pregnancy | Focus on coping, problem-solving and decision-making skills and psychosocial issues |

| POSTNATAL PERIOD | WHEN | ACTIONS |
|---|---|---|
| Assess for depressive symptoms (EPDS) among women | 6-12 weeks after birth | Arrange further assessment for women with a score of 13 or more Repeat at least once in the first postnatal year and whenever clinically indicated |
| Assess for anxiety symptoms among women | When conducting EPDS | Refer to relevant items of the EPDS |
| Assess psychosocial risk factors among women | 6-12 weeks after birth | Further explore psychosocial risk as needed |
| Assess mental health among non-birthing parents | Psychosocial risk as early as practical; mental health screening 3-6 months after birth | Select screening tools according to availability and competencies of health professionals - use the original or amended ANRQ/PNRQ as appropriate |
| Assess maternal safety | Based on EPDS Q10 and clinical judgement | Manage immediate risk and arrange specific assessment |
| Assess mother–infant interaction | At postnatal contacts | If there are concerns, consult with or refer to appropriate specialist service |
| Assess infant safety | Difficulties with mother–infant interaction observed | Manage immediate risk and refer for mother–infant intervention |
| Enquire about emotional and physical well-being | Every antenatal and postnatal visit | Determine whether repeat assessments are required |
| Provide advice on healthy behaviours to parents | Early postnatal period | Focus on healthy eating, physical activity and sleep hygiene |

Part C

Prevention and Treatment

This section outlines the current evidence on psychosocial, pharmacological and complementary therapies in the prevention and treatment of mental health conditions in the perinatal period. For pharmacological, physical and complementary therapies, information on potential harms to the fetus or infant is also included. Interventions are defined in the Glossary.



10 General principles

Approaches to prevention and treatment of specific mental health conditions are discussed in detail in Chapters 11 to 13. This chapter outlines general principles in promoting emotional well-being.

10.1 Providing information and advice

All women should be given culturally appropriate information on mental health problems in pregnancy and the postnatal period, including their prevalence, risk factors and symptoms (*NICE 2014; updated 2020*).

Consensus-based recommendation

xxv 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.

Additional information provided to women with mental health conditions and their significant other(s) (with the woman's consent) should include (*NICE 2014; updated 2020*):

- the potential benefits of psychological interventions and pharmacological treatment
- the possible consequences of no treatment
- the possible harms associated with treatment
- what might happen if treatment is changed or stopped, particularly if pharmacological treatments are stopped abruptly (e.g. increased nausea when antidepressants are stopped in the first trimester).

Practice point

n 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.

10.2 Planning care for women with mental health conditions

Planning care for a woman with a mental health condition in the perinatal period should be based on the woman's preferences and include consideration of (*NICE 2014; updated 2020*):

- the care and treatment for the mental health condition
- the roles of all healthcare professionals, including who is responsible for:
 - coordinating the integrated care plan
 - the schedule of monitoring
 - providing the interventions and agreeing on the outcomes with the woman.

The healthcare professional responsible for coordinating the care plan should ensure that (*NICE 2014; updated 2020*):

- everyone involved in a woman's care is aware of their responsibilities
- there is collaboration and sharing of information with all services involved and with the woman herself
- mental health (including mental well-being) is taken into account as part of all care plans
- all interventions for mental health conditions are delivered in a timely manner, taking into account the stage of the pregnancy or age of the infant.

10.2.1 Preconception planning

Discussion with all women of childbearing potential who have a new, existing or past mental health condition should cover (*NICE 2014; updated 2020*):

- the use of effective contraception and any plans for a pregnancy
- how pregnancy and childbirth might affect a mental health condition, including the risk of relapse
- how a mental health condition and its treatment might affect the woman, the fetus and infant
- how a mental health condition and its treatment might affect parenting.

Practice point

- o 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.

10.2.2 Planning care for women with severe mental illness

There are specific considerations in planning care for women with severe mental illness, with priority being given to ensuring that mental health professionals involved in their care take into account the complexity of these conditions and the challenges of living with severe mental illness. Where available, involvement of specialist perinatal mental health services is advisable.

Practice points

- p 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.
- q Wherever possible, assessment, care and treatment of the mother should include the infant.
- r 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.

10.3 Use of pharmacological treatments

While approaches to the pharmacological prophylaxis and treatment of mental health conditions during the perinatal period are not likely to differ from approaches at other times, the potential for harm to the fetus and the breastfed infant must be carefully balanced with the potential harm to mother and fetus or infant if the mother remains untreated. In view of this, medications should only be prescribed after careful deliberation with the woman (and her significant other[s]). Ongoing monitoring and evaluation will be required.

10.3.1 Discussing risks and benefits

Whenever pharmacological treatment is proposed for women who are planning a pregnancy, pregnant or breastfeeding, a risk/benefit analysis needs to be performed with consideration given to the risks for the mother as well as the risks to the fetus, and the risks to either of non-treatment.

Practice point

- s 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.

Discussion about the possible risks of mental health conditions or the benefits and harms of treatment in pregnancy and the postnatal period should include the following, depending on individual circumstances (*NICE 2014; updated 2020*):

- the likely benefits of each treatment, taking into account the severity of the mental health condition
- the woman's response to any previous treatment
- the background risk of harm to the woman and the fetus or baby associated with maternal mental health conditions and the risk to mental health and parenting associated with no treatment
- the possibility of the sudden onset or relapse of symptoms of mental health conditions in pregnancy and the postnatal period, particularly in the first few weeks after childbirth (e.g. in women with bipolar disorder)
- the risks or harms to the woman and the fetus or baby associated with each treatment option
- the need for prompt instigation of treatment and monitoring for treatment response because of the potential effect of an untreated mental health condition on the fetus or baby and woman's ability to transition optimally to the parenting role
- the risk of harm to the woman and the fetus or baby associated with stopping or changing a treatment
- the side effects of any medication taken by the woman (especially those that increase the risk of gestational diabetes due to weight gain).

Practice point

- t** 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.

When discussing the benefits and risks of treatment with a woman and her significant other(s) (*NICE 2014; updated 2020*):

- acknowledge the woman's central role in reaching a decision about her treatment and that the role of the professional is to inform that decision with balanced and up-to-date information and advice
- use **absolute risk** values based on a common denominator (that is, numbers out of 100 or 1,000) rather than **relative risk** values to more accurately reflect risk to the woman
- acknowledge and describe, if possible, the uncertainty around any estimate of risk, harm or benefit
- use high-quality decision aids in a variety of numerical and pictorial formats that focus on a personalised view of the risks and benefits
- consider providing records of the consultation, in a variety of visual, verbal or audio formats, to the woman, her significant other(s) and other health professionals involved in her care.

Other considerations include the adherence to medications and the benefits of increased non-pharmacological treatment for women who cease or change medications during pregnancy. Discussion may also cover barriers, cultural aspects and stigma attached to medication and encouraging women to speak to a trusted health professional about commencing, ceasing or changing medication or dosage.

10.3.2 Planning for breastfeeding

Breastfeeding should be discussed with women who may need pharmacological treatment in pregnancy or in the postnatal period (*NICE 2014; updated 2020*). This may include the benefits of breastfeeding, the potential risks associated with taking medication when breastfeeding and with stopping some medications in order to breastfeed.

Practice point

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

10.3.3 Pharmacological treatment during pregnancy

Information about specific mental health conditions and their pharmacological treatments is included in Chapters 11 to 13. This section provides guidance on specific considerations in the use and monitoring of effects of pharmacological treatments in pregnancy.

When pharmacological treatment is started in the perinatal period, considerations include (*NICE 2014; updated 2020*):

- seeking advice, preferably from a specialist in perinatal mental health
- choosing the medication with the lowest risk profile for the woman, fetus and baby, taking into account a woman's previous response to medication and changes in pharmacodynamics in pregnancy, which may necessitate dose adjustment
- using the lowest effective dose (this is particularly important when the risks of adverse effects to the woman, fetus and baby may be dose related), but note that sub-therapeutic doses may lead to ineffective treatment of the mental health episode
- use a single drug, if possible, in preference to two or more drugs
- take into account that dosages may need to be adjusted in pregnancy.

Practice point

- v** 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.

As there is a risk of major malformation associated with the use of some antipsychotics, anticonvulsants and mood stabilisers in the first trimester (see Chapter 12), it is important that the 13 week and 18-20 week ultrasound assessments are conducted so that major malformations may be identified. A finding of a fetal anomaly enables women and their significant other(s) to consider their options (e.g. receive counselling regarding the option of termination) and plan for additional care if the pregnancy continues (e.g. specialist management of the pregnancy and the infant). Psychosocial support should also be provided due to the potential for significant distress.

Practice points

- w** 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.
- x** Plan for pharmacological review in the early postpartum period for woman who cease psychotropic medications during pregnancy.

10.4 Postnatal care and support

10.4.1 Observation of the newborn

Due to the risk of poor neonatal adaptation syndrome associated with the use of some pharmacological treatments in pregnancy, monitoring of exposed newborns is required.

Consensus-based recommendation

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

10.4.2 Support in the early postnatal period

The early postnatal period is a time of emotional change for most women. Some women may experience distress or symptoms of depression and/or anxiety if they feel overwhelmed and unable to manage. They may also experience disappointment and grief if something has gone wrong or their expectations of the pregnancy and birth are not realised. Early intervention, in the form of support or specific care, can help women to adjust and prevent more serious mental health conditions from developing. The early postnatal period is also the time when symptoms of postpartum psychosis emerge.

Women with severe mental illness may find the early postnatal period particularly distressing for many reasons, particularly as their bond with the infant may be compromised. Ensuring partner, family or paid (e.g. nanny) support is important, particularly overnight so the woman can sleep. Sleep deprivation is a common trigger for relapse so prevention is worthwhile.

Women with borderline personality disorder are especially likely to have difficulties in the emotional care of the infant and will benefit from programs from early infancy to promote attachment, improve parenting sensitivity and reduce the risk of poor child outcome (*Newman 2015*).

Practice points

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

10.4.3 Women requiring hospital care in the postnatal period

The early postnatal period is a time when relapse of severe mental health conditions is common and when some women who have not previously had symptoms experience postpartum psychosis. When symptoms are severe enough to warrant hospital admission, co-admission with the infant will assist with the development of mothercraft skills and a positive relationship with the infant. This approach may not be appropriate for women who are severely unwell and incapable of caring for the infant and/or the safety of the infant may be compromised.

As the number of specialised mother-baby units in Australia is limited, governments and health services should prioritise their funding and establishment.

Consensus-based recommendation

- xxvii** 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.

11 Women with depressive and anxiety disorders

A range of psychosocial, psychological and pharmacological therapies have been evaluated for their effect in preventing and treating depressive and anxiety disorders in the perinatal period.

11.1 Psychosocial and psychological interventions

This section summarises the current evidence on psychosocial and psychological interventions that have been found to have a positive effect on symptoms.

11.1.1 Psychosocial support

Psychoeducation

Structured psychoeducation improves depression symptoms among women in the perinatal period (high certainty) (*NICE 2014; updated 2020*).

| Evidence-based recommendation | | |
|-------------------------------|--|--------|
| 4 | Provide structured psychoeducation to women with symptoms of depression in the perinatal period. | Strong |

Social support

Involvement in a social support group may improve depression symptoms among women in the postnatal period (low certainty) (*NICE 2014; updated 2020*).

| Evidence-based recommendation | | |
|-------------------------------|---|-------------|
| 5 | Advise women with symptoms of depression in the postnatal period of the potential benefits of a social support group. | Conditional |

Home visits

There is emerging evidence from Australia that women experiencing adversity may benefit from a program of nurse home visits (*Goldfeld et al 2021*).

Physical activity

The **Pregnancy Care Guidelines** recommend that women be advised that usual physical activity during pregnancy has health benefits and is safe (*Department of Health 2020*).

In addition, there is emerging evidence that:

- yoga has a positive effect on emotional well-being among women with symptoms of depression or anxiety (*Davis et al 2015*).
- exercise interventions may have a protective effect on perceived stress among women at risk of postpartum depression (*Lewis et al 2021*).

11.1.2 Psychological approaches

Individual structured psychological interventions

Individual structured psychological interventions (CBT or IPT) in the perinatal period reduce depression diagnosis (high certainty) and depression mean scores (moderate certainty) and may improve depression symptoms (low certainty) among women with symptoms or a diagnosis of depression (*NICE 2014; updated 2020*).

| Evidence-based recommendation | | |
|-------------------------------|--|--------|
| 6 | Recommend individual structured psychological interventions (cognitive behavioural therapy or interpersonal psychotherapy) to women with symptoms of depression in the perinatal period. | Strong |

Online interventions

CBT is available as an internet-based or app-based intervention (not telephone-based) and can be self-directed or clinician-guided. The demand for and accessibility of online interventions has increased post-COVID.

The available evidence is limited but shows that online CBT may have some benefits compared to face-to-face interventions, although level of benefit is likely to vary with levels of motivation.

Consensus-based recommendation

xxviii Consider online approaches for delivery of CBT.

Directive counselling

Among women in the postnatal period with a diagnosis of depression, directive counselling – which includes supportive listening, problem-solving and goal setting – may improve depression and anxiety symptoms (low certainty) (*NICE 2014; updated 2020*).

Evidence-based recommendation

7 Advise women with with depression or anxiety disorder in the postnatal period of the possible benefits of directive counselling.

Conditional

Mother–infant relationship interventions

Among women with depression, individual mother–infant interventions may improve mother–infant attachment problems (very low quality) and mother–infant behavior management problems (low certainty) (*NICE 2014; updated 2020*).

Consensus-based recommendation

xxix 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.

Mindfulness

There is emerging evidence of benefit from mindfulness-based cognitive therapy (*Dimidjian et al 2016*) and a mindfulness-based childbirth and parenting program (*Lonnberg et al 2020*) among women at risk of depression. However there is insufficient evidence for conclusions to be drawn.

11.2 Complementary therapies

11.2.1 Omega-3 fatty acids

There is insufficient evidence to determine the effects of omega-3 fatty acid supplements on postnatal depression symptoms (low certainty) (*Middleton et al 2018*). However, there is a reduction in risk of early preterm birth (<34 weeks), preterm birth (<37 weeks) (high certainty) and low birthweight (high certainty) and a possible reduction in risk of perinatal death (moderate certainty) and neonatal care admission (moderate certainty). There was a possible small increase in large for gestational age (moderate certainty) and mean gestational length (moderate certainty).

The Australian **Pregnancy Care Guidelines** recommend a dose of 800 mg docosahexaenoic acid (DHA) and 100 mg eicosapentaenoic acid (EPA) per day for women with low omega-3 levels (*Department of Health 2020*).

Evidence-based recommendation

8 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

11.2.2 Herbal products

St John's Wort

No evidence was identified on the effectiveness of St John's Wort in treating depression in the perinatal period or on potential harms to the fetus. St John's Wort is known to interact with SSRIs (increased serotonergic effects) and anticonvulsants (reduced blood levels) (*TGA 2001*).

Consensus-based recommendation

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

Ginkgo biloba

No evidence was identified on either the effectiveness of Ginkgo biloba in treating depression in the perinatal period or on potential harms to the fetus.

Consensus-based recommendation

xxxi Advise pregnant women that potential harms to the fetus from Ginkgo biloba have not been researched, and that use of this treatment during pregnancy is not recommended.

Cannabidiol

There is a lack of evidence on the use of cannabidiol in the perinatal period.

11.2.3 Quality of dietary supplements

Caution should be used when taking dietary supplements in pregnancy as some unlicensed products may be adulterated and may not contain what they say they contain (*FDA 2022*). Only TGA dietary supplements that are approved for use during pregnancy should be considered.

11.3 Pharmacological treatments

The information in this section is based on the best available evidence, up to March 2022. The evidence base is limited – few studies on the benefits of pharmacotherapy in the perinatal period have been conducted and, while many studies report on harms, they are of low quality. Decision-making regarding pharmacotherapy is a collaborative process and is based on a woman's level of distress, the impact of her symptoms on her social, occupational and relationship functioning and her ability to engage with structured psychological therapy.

11.3.1 Antidepressants during pregnancy

There is high certainty evidence for efficacy of antidepressants in the general population (*NICE 2022*). While there is a lack of RCT evidence of benefits of antidepressants in the perinatal period (for ethical reasons), there is observational evidence of benefit (e.g. improved mother-infant interaction), and evidence of harms associated with abrupt cessation of treatment due to pregnancy (e.g., suicide, adverse effects on physical activity and nutrition).

Practice point

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

During pregnancy, exposure to several antidepressants may be associated with a higher risk of postpartum haemorrhage (low certainty) (Viswanathan *et al* 2021). However, the causal link between exposure and adverse events is unclear and may be attributable to confounds (Viswanathan *et al* 2021). The evidence on other potential harms is too uncertain for conclusions to be drawn.

Evidence-based recommendation

| | | |
|---|---|-------------|
| 9 | When prescribing antidepressants to pregnant women, consider SSRIs as first-line pharmacological treatment for depression and/or anxiety. | Conditional |
|---|---|-------------|

If SSRIs are prescribed, consider the woman's past response to SSRI treatment and whether she has risk factors for miscarriage (e.g. thyroid dysfunction) or preterm birth (e.g. previous preterm birth, active smoking during pregnancy), factors that may increase risk of postpartum haemorrhage (e.g. uterine trauma) and the half-life of the treatment (e.g. risk of poor neonatal adaptation syndrome is increased with SSRIs with a short half-life such as paroxetine).

Practice point

| | |
|----|---|
| bb | 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. |
|----|---|

11.3.2 Antidepressants in the postnatal period

There is high certainty evidence for efficacy of antidepressants in the general population (NICE 2022). While there are few data on the efficacy of antidepressants in perinatal samples, the available evidence suggests that SSRI use may improve response and remission rate at 6–8 weeks (very low to low certainty) (Brown *et al* 2021).

Compared to fetal exposure during pregnancy, exposure to antidepressants through breast milk is very low and there is an even greater need to treat depression postnatally (given its effect on the woman's ability to care for the infant and on mother-infant attachment).

Evidence-based recommendation

| | | |
|----|--|--------|
| 10 | When prescribing antidepressants to women in the postnatal period, use SSRIs as first-line pharmacological treatment for depression. | Strong |
|----|--|--------|

The effects of exposure to SSRIs may be increased in preterm or otherwise unwell infants.

Practice point

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

11.3.3 Benzodiazepines and non-benzodiazepine hypnotics

Benzodiazepines are an accepted treatment for anxiety symptoms and panic attacks in the general population. The evidence on their use in pregnancy is uncertain (*Viswanathan et al 2021*).

Consensus-based recommendation

xxxii 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.

Practice points

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

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

There is a lack of evidence regarding potential harms to the fetus associated with the use of non-benzodiazepine hypnotics (z-drugs) in pregnant women.

Practice point

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

11.3.4 Antihistamines

Practice point

gg 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.

11.3.5 Emerging pharmacological interventions

Pharmacological interventions that are emerging as treatments for depression include ketamine, ADHD medications and zuranolone. However, there is currently insufficient evidence on their use in the perinatal period for conclusions to be drawn.

12 Women with severe mental illnesses: schizophrenia, bipolar disorder and postpartum psychosis

This chapter provides guidance specific to schizophrenia, bipolar disorder and postpartum psychosis. It should be read in conjunction with the advice in Chapter 10, which includes general principles on prevention and treatment.

12.1 Preconception planning

Preconception planning should start at diagnosis of a severe mental illness among women of childbearing age. Many of these women will have poor health literacy and will need clear explanations of the importance of contraception if the woman is not planning a pregnancy, the effects of some medications on fertility, the risk of relapse in pregnancy or after the birth (particularly if medications are stopped) and the complexities of raising a child in the context of severe mental illness. These comments are particularly applicable to women with schizophrenia and more severe bipolar disorder.

Preconception planning should include discussion of pharmacological treatments to be used after the birth, which will involve decision-making by the woman about whether she will breastfeed (e.g. if it is planned that lithium be used postnatally).

Women with a history of postpartum psychosis are at significant risk of relapse with subsequent pregnancies and require psychoeducation, care planning and psychiatric input from preconception.

12.2 Considerations in providing antenatal and postnatal care

12.2.1 Antenatal care

In addition to the general principles outlined in Chapter 10, key considerations in providing antenatal care to women with severe mental illness include:

- monitoring for early signs of relapse, particularly as medication is often ceased (by the woman and/or her doctor) before or during pregnancy
- education about nutrition and ceasing smoking, illicit substance use and alcohol intake in pregnancy
- monitoring for gestational diabetes in women taking antipsychotics, with consideration given to referral to an appropriate health professional if excessive weight gain is identified
- referral for multi-dimensional care planning early enough in the pregnancy (particularly if the pregnancy is unplanned) to build trusting relationships and develop a safety net for mother, infant and significant others
- case conferences may be required depending on the complexity of the presentation and number of services involved with family.

12.2.2 Postnatal care

Postpartum psychosis can be the first episode of a mental health condition for many women, with family history of severe mental illness, including bipolar disorder or psychosis, a risk factor.

Careful monitoring is required in the first month after birth for women with severe mental illness or a history of postpartum psychosis, especially those with bipolar disorder, with regular review in the following months. Sleep preservation is an important consideration. Collaboration between health professionals involved in a woman's care and, with her consent, a partner or support person is also important.

If relapse of severe mental illness or postpartum psychosis occur, co-admission to a mother-baby unit is recommended. In some instances, it may be necessary for women to cease breastfeeding if they are too unwell, require night-time sedation, or sleep disruption (to feed the infant) would have an adverse effect on their mental state.

Access to specialist intervention to support parenting skills, including the role of partners and significant others, and attend to the mother-infant attachment is a consideration for women with severe mental illness and their families. Such an approach can best be taken in specialist mother-baby units, however, availability of publicly funded mother-baby units that cater to both the woman and her infant is variable across Australian jurisdictions.

12.3 Psychosocial and psychological intervention

Psychoeducation and supportive therapy that includes family and significant others is most important for women with severe mental illness. CBT and other psychological interventions can also be beneficial in managing secondary depression or anxiety, which are frequently associated with severe mental illness.

12.4 Pharmacological treatment

12.4.1 Antipsychotics

Antenatal period

There is insufficient evidence on benefits and harms of antipsychotic use in the antenatal period for conclusions to be drawn. However, while there is no specific RCT evidence around efficacy in pregnancy, evidence from the general population supports the use of antipsychotics to treat psychosis (Goulding *et al* 2022) as untreated psychosis is associated with relapse and adverse effects on pregnancy (stillbirth, poor antenatal attendance).

Evidence-based recommendation

11 Use antipsychotics to treat psychotic symptoms in pregnant women.

Conditional

Cohort studies show that some antipsychotics (specifically clozapine, olanzapine and quetiapine) have metabolic-inducing effects and increase the risk of gestational diabetes and large-for-gestational age (Heinonen *et al* 2022).

Consensus-based recommendations

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

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

Clozapine crosses the placenta, which may increase the risk of agranulocytosis in the newborn (Mehta & Van Lieshout 2017). However, its use may be a consideration in pregnant women who do not respond to other antipsychotics.

Consensus-based recommendation

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

Postnatal period

The evidence on the safety of clozapine in breastfeeding women is limited.

Practice point

hh 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.

12.4.2 Anticonvulsants

While anticonvulsants are used in the treatment of bipolar disorder in the general population (*Malhi et al 2021*), most of the information on their safety profile in pregnancy is in epileptic women.

Preconception

There is insufficient evidence for overall estimation of risk of anticonvulsant medication use for all outcomes in the perinatal period (*Viswanathan et al 2021*). Several of these medications are folate antagonists.

Practice points

- ii 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 place⁹.
- jj 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.

Antenatal period

There is evidence of substantial increases in absolute risk of major malformation and cardiac malformation in the newborn (*Weston et al 2016*) and adverse cognitive outcomes in the child (e.g. increased risk of below average intelligence quotient [IQ]) (*Bromley et al 2014*) (very low to low certainty) associated with the use of sodium valproate in pregnancy. There is insufficient evidence to determine the effect on other outcomes (*Viswanathan et al 2021*).

Evidence-based recommendation

- 12 Do not prescribe sodium valproate to pregnant women.

Strong

There is evidence that use of carbamazepine during pregnancy may be associated with an increased risk of major malformation in the newborn (very low certainty) (*Weston et al 2016*). Lamotrigine may carry a lower risk of cardiac and major malformations than lithium (low certainty) (*Viswanathan et al 2021*).

Consensus-based recommendation

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

Postnatal period

Due to the need to treat symptoms in the postnatal period (i.e. due to their potential effect on the woman's ability to care for the infant and on mother-infant attachment), consideration may be given to prescribing anticonvulsants for bipolar disorder. There is uncertainty about the passage into breastmilk of some anticonvulsants (e.g. lamotrigine) and adverse effects in the infant.

Consensus-based recommendation

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

⁹ Guidance on ensuring effective contraception is in place is provided in Shakespeare J & Sisodiya SM (2019) Guidance document on valproate use in women and girls of childbearing years. London: UK Royal College of General Practitioners and Association of British Neurologists and Royal College of Physicians. <http://www.rcog.org.uk/media/uqofkcl/valproate-guidance-march-2019.pdf>.

12.4.3 Lithium

Antenatal period

There is evidence that first trimester use of lithium in pregnancy may be associated with a greater risk of cardiac and major malformation in the newborn than lamotrigine (low certainty) (*Viswanathan et al 2021*). Maternal lithium requirements increase as pregnancy progresses, so monitoring of levels is advised and dose adjustment may be required.

Consensus-based recommendation

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

There is a sudden increase in lithium level at parturition as the woman's fluid balance shifts and returns to pre-pregnancy levels.

Practice point

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

Postnatal period

There is potential for high passage of lithium into colostrum and breastmilk. Among women taking lithium who will not be able to breastfeed, the benefits of colostrum for the infant need to be balanced against the risk of infant toxicity. Testing of cord or infant blood could inform decision-making although exposure across the placenta would already have occurred.

Consensus-based recommendation

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

13 Women with borderline personality disorder

Borderline personality disorder is a long-term, complex condition that waxes and wanes, has broad impact on socio-occupational function (especially parenting) and has substantial treatment and prognostic implications (*NHMRC 2012*). Borderline personality disorder often co-exists with depression, anxiety and substance use disorders. It can also be very difficult to differentiate borderline personality disorder from bipolar and post-traumatic stress disorders (*NHMRC 2012*). There is significant overlap between borderline personality disorder and bipolar disorder type 2 in terms of affective instability and impulsivity; however they remain distinct disorders (*Henry et al 2001*).

Borderline personality disorder is associated with high levels of morbidity and mortality (lifetime rates of approximately 70% for acts of self-injury, 80% for suicide attempts and 10% for suicide) (*Kroger et al 2011*). There is growing consensus that emotional dysregulation (also referred to as affective instability; see Section 1.2.3) is a core feature of borderline personality disorder, and was found to be the one DSM-III-R criterion distinguishing individuals with borderline personality disorder from those without (*Clifton & Pilkonis 2007*). Women with emotional dysregulation will find parenting very challenging (see Section 13.1.3). It is also clear that there are significant risks for children of women with borderline personality disorder of the inadvertent intergenerational transfer of mental health problems from mother to child (*Eyden et al 2016*).

The label 'borderline personality disorder' should be used with caution as it often has negative connotations (especially for health professionals) and may be associated with substantial stigma. Conversely, it is important to identify women with such a condition, as they, their family and treating health professionals will need additional resources and support over the perinatal period and beyond.

13.1 Considerations in providing antenatal and postnatal care

Women who have borderline personality disorder have often experienced sexual, physical or emotional abuse or neglect in childhood. In addition to emotional dysregulation, their behaviour is characterised by efforts to overcome their fear of abandonment; intense and unstable relationships; engaging in impulsive activities (e.g. substance use); talking about or engaging in self-harm and/or suicidal behaviours; inappropriate, intense anger or difficulty controlling anger; and transient, stress-related paranoid ideation or severe dissociative symptoms. These symptoms are particularly difficult to manage in the primary health care setting and the behaviours targeted at staff may make it difficult for health professionals to work optimally with them. Continuity of carer (the same person or small group of people) is likely to be helpful for women with this condition.

Practice points

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

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

13.1.1 Preconception planning

While in Australia borderline personality disorder is becoming better recognised, formally diagnosed and discussed with women, many women with emotional dysregulation and/or their treating health professionals may not be aware that the diagnosis makes preconception planning challenging. A first step may be a diagnostic discussion when there is clarity that this approach is likely to be therapeutic.

Multidisciplinary care

As borderline personality disorder is associated with several adverse obstetric and neonatal outcomes (see Section 1.2.3), women with the disorder should be monitored closely by a multidisciplinary health care team before and during their pregnancies (*Pare-Miron et al 2016*). This approach would aim to optimise management of challenging symptoms and behaviours and address the frequency of comorbid substance misuse and other conditions.

Planning for support during and after pregnancy

Considerations in preconception planning include the woman's capacity for parenting, her support network and other support available in the antenatal period, the need for additional support and parenting interventions in the postnatal period (see Section 13.1.3) and treatment to assist in managing emotional dysregulation and preparing for pregnancy and parenting (see Section 13.2).

Practice point

nn 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.

13.1.2 Antenatal care

Health professionals involved in the antenatal care of women with borderline personality disorder should be aware that women who have experienced physical or sexual abuse or complex traumas may experience distress when touched (e.g. when vaginal examination is conducted), bonding with the baby during pregnancy may be challenging, that birth may be anticipated as traumatic and that early or caesarean delivery is frequently requested. The woman's emotional dysregulation may cause distress for herself, her family and treating health professionals. A team approach for all health professionals involved in a woman's care, with good open regular communication, is likely to be beneficial to her care.

13.1.3 Postnatal care

The early postnatal period can be particularly distressing for women with borderline personality disorder as they may find normal infant crying intrusive and unsettling and may be experiencing isolation and poor support due to interpersonal difficulties. Issues arising for women with borderline personality disorder in the perinatal period reflect possible unresolved early trauma (*Newman 2015*).

Women with borderline personality disorder are more likely to have difficulties in the emotional care of the infant and in promoting secure attachment (*Newman 2015*). These mothers are also more likely than others to have experienced sexual trauma and exploitation in relationships and to be experiencing domestic violence (*Newman 2015*).

Intensive maternal and child health care (i.e. maternal and child health care for families requiring additional support) is advisable and targeted mother-infant therapy (individual or with a group of women with similar requirements for help with their emotional dysregulation) may be considered after other more acute symptoms are controlled. It is important to ensure that child protection risks are understood and addressed, if necessary.

13.2 Psychosocial support and psychological intervention

Psychological and psychosocial therapies are the preferred treatment for borderline personality disorder.

13.2.1 Psychological therapies

A range of structured psychological therapies have been evaluated in the treatment of borderline personality disorder in the general population (*NHMRC 2012; Cristea et al 2017*). These include CBT, IPT, dialectical behaviour therapy (DBT), mentalisation-based therapy (MBT), schema-focused psychotherapy (SFT), systems training for emotional predictability and problem solving (STEPPS) and transference-focused psychotherapy (TFP).

DBT is effective in treatment of borderline personality disorder, with effects including a decrease in inappropriate anger, a reduction in self-harm and an improvement in general functioning (*Stoffers et al 2012*). A group-based adaptation of mother-infant DBT showed promising improvements in maternal symptoms and caregiver-infant relationships (*Sved Williams et al 2018*). While other treatments have been less evaluated, overall findings support a substantial role for psychotherapy in treating borderline personality disorder.

In clinical trials, the duration of treatment for borderline personality disorder ranged from 13 weeks to several years (*NHMRC 2012*). In clinical practice, some therapies (e.g. DBT) are usually continued for substantially longer periods.

Consensus-based recommendation

- xl** 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.

13.2.2 Psychosocial support

While specialist psychological treatments are the preferred treatment for borderline personality disorder, these take time to have an effect and other more generic psychological approaches are also required so that women are assisted in managing their emotional dysregulation and are better prepared for pregnancy and early parenthood.

Practice point

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

13.3 Pharmacological treatment

Overall, pharmacological treatments do not appear to alter the nature and course of borderline personality disorder (*NHMRC 2012*). However, they may be useful in the short-term in controlling more acute symptoms.

Consensus-based recommendation

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

Practice point

- pp** Consider pharmacological treatment for comorbidities in women with borderline personality disorder.

The risks associated with the use of pharmacological treatments in the perinatal period is discussed in Sections 10.3 (general principles), 11.3 (antidepressants and benzodiazepines) and 12.3 (mood stabilisers and antipsychotics). In addition to these risks, if a pharmacological treatment is prescribed to a woman with borderline personality disorder, consideration should be given to avoiding medications that may be lethal in overdose (because of the high risk of suicide) or are associated with substance dependence.

14 Women who experience psychological birth trauma

14.1 Considerations in providing antenatal and postnatal care

While the concept of physical birth trauma (or birth injury) is well-accepted, less research has been conducted into psychological birth trauma. With the potential for both birthing and non-birthing parents to experience significant levels of post-traumatic stress following birth (*Heyne et al 2022*), key considerations include that:

- post-traumatic symptoms occur on a continuum - ranging from acute distress, to post-traumatic stress symptoms or post-traumatic stress disorder (PTSD) meeting DSM-V or other diagnostic criteria; birth trauma can occur with or without PTSD and still cause associated distress
- psychological birth trauma may also be associated with anxiety or depressive symptoms or disorder
- births may be experienced as traumatic even when they are perceived as obstetrically straightforward (*NICE 2014; updated 2020*)
- an event that is traumatic for one person may not be for another (*MHFAA 2008*)
- the term 'PTSD' is commonly, and often inaccurately, used by women and health professionals, to describe distress following birth trauma, where it should only be used when it refers to a psychiatric diagnosis - this popularisation of the term has led to its widespread use across various forms of media
- many parents don't seek help after their first birth which may have been traumatic or distressing, but may seek help once they are planning to have a second child.

14.1.1 Factors that contribute to experience of birth as traumatic

Factors that contribute to birth being experienced as traumatic include:

- previous experience of trauma, including childhood abuse (*Seng et al 2008*), domestic violence, rape and migrant trauma (*SA Dept Health and Wellbeing 2018*)
- unplanned intervention (including emergency caesarean section or instrumental birth)
- giving birth to an unwell (e.g. preterm) or stillborn baby (*SA Dept Health and Wellbeing 2018*)
- child removal
- birth, social and cultural expectations
- fear of birth or a pregnancy requiring increased monitoring
- a history of vaginismus
- physical injury and subsequent poor postpartum pain management
- having a strong desire to adhere to a birth plan
- co-occurring or history of a mental health condition
- other predisposing factors to experiencing birth as traumatic include (*SA Dept Health and Wellbeing 2018*):
 - lack of social support
 - poor coping strategies
 - feelings of powerlessness
 - extreme pain
 - perception of hostile or uncaring staff
 - loss of control
 - medical interventions
 - lack of information
 - past traumatic birth.

¹⁰ PTSD is a form of anxiety with diagnostic criteria that include direct or indirect exposure to death or threatened death, actual or threatened serious injury or sexual assault.

Some of these risk factors are covered in the PNRQ and could be used to identify risk of experiencing birth as traumatic.

Consensus-based recommendation

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

14.1.2 Preventative care before and during the birth

Fundamental aspects of antenatal care that may reduce the risk of birth being experienced as traumatic include:

- continuity of care(r), which reduces the risk of intervention
- trauma-informed care, which is an integral part of quality maternity care (see Section 2.2.2)
- screening for key vulnerability factors during pregnancy and adapting care to prevent the risk of post-traumatic stress/PTSD from occurring (*Ayers & Ford 2016; Heyne et al 2022*)
- involvement of a supportive non-birthing partner or significant other in antenatal care and planning for the birth, if the women gives consent
- appropriate referral pathways, which ensure that parents experiencing psychosocial risk factors (including a history of childhood sexual abuse, domestic violence, high trait anxiety, perfectionism or need for control), previous traumatic birth, depression, anxiety or other co-occurring mental health conditions, are linked with appropriate assessment and treatment services (see Chapter 3).

It is particularly important that health professionals are aware, where possible, of past sexual abuse history or complex trauma, as this is likely to be associated with a more severe reaction to traumatic birth.

Fundamental aspects of intrapartum care that may reduce the risk of birth being experienced as traumatic include (*SA Dept Health and Wellbeing 2018*):

- maximising the woman's control in labour
- providing information about any proposed procedure, involving the woman in the decision-making, and gaining consent before proceeding
- stopping a procedure at the woman's request
- providing pain control as requested by the woman.

A positive birth experience subsequent to a traumatic one can have a therapeutic effect (*Reynolds 1997*).

14.1.3 Responses to traumatic birth

Following a psychologically traumatic birth, women may experience symptoms of distress (acute stress) or adjustment disorder. This is a normal response and will likely resolve without treatment. However, standard care should include ongoing monitoring, support and the provision of information to support help-seeking. Providing parent-centred, trauma-informed opportunities for review of what happened during the birth shortly afterwards and again at 6 weeks is an important aspect of postnatal care. Symptoms extending beyond 3 months may be indicative of more serious disorder.

Symptoms occur across a continuum and include (*SA Dept Health and Wellbeing 2018*):

- appearing dazed, agitated, overactive and/or withdrawn
- reduced conscious state
- autonomic anxiety symptoms – increased heart rate, palpitations, sweating, jelly legs, "butterflies in stomach" and dry mouth
- some amnesia-blocked memories
- disorientation
- depression
- flashbacks, depersonalisation, hypervigilance

- nightmares
- emotional numbness
- intrusive memories
- anxiety
- bonding difficulties
- fear of sexual intimacy
- avoidance of normal vaginal birth or future pregnancy
- increased psychological arousal
- avoidance of infant.

Diagnostic scales are available to assess PTSD symptoms and clinical disorder in women or their partners who have experienced trauma in childbirth (e.g. the City Birth Trauma Scale; BiTS). The BiTS has recently been validated as a reliable measure of childbirth-related post-traumatic stress symptoms in Australian women (Fameli *et al* 2022).

Consensus-based recommendation

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

14.2 Psychosocial and psychological interventions

Trauma-focused CBT interventions aim to improve birth-related PTSD symptoms as well as other important outcomes and these improvements can be maintained up to a year later (NICE 2014; updated 2020). Trauma-focused cognitive behaviour therapy should be the first-line psychological treatment for birth-related post-traumatic stress disorder (NICE 2014; updated 2020). While there is less evidence on eye movement desensitisation and reprocessing (EMDR), it has also shown benefit when delivered between 1 and 3 months after trauma (NICE 2014; updated 2020). Single-session high-intensity psychological interventions with an explicit focus on 're-living' the trauma do not appear to be of benefit and could cause further psychological distress (NICE 2014; updated 2020). Peer support may also be of benefit.

Consensus-based recommendations

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

14.3 Pharmacological treatment

Post-traumatic stress disorder is a severe anxiety disorder and treatment may include antidepressants. A combination of trauma-informed cognitive behavioural therapy and pharmacotherapy outperforms either alone; depending upon the patient's symptoms, a stepped approach including pharmacological therapies may be needed. Section 11.3 outlines considerations in the use of pharmacological therapies in the treatment of anxiety.

Consensus-based recommendation

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

15 Women who do not respond to psychological or pharmacological treatment

15.1 Electroconvulsive therapy

Electroconvulsive therapy (ECT) is a safe and effective treatment for the more severe forms of depression¹¹. In practice, it is usually reserved for people who have not responded to several trials of medication. ECT is recommended as first-line treatment in severe melancholic depression, particularly when the patient refuses to eat or drink and/or there is a high suicide risk, when the patient has very high levels of distress, has psychotic depression, catatonia or has previously responded to ECT (*Malhi et al 2021*). It may also be considered in the treatment of mania, severe mixed episodes of bipolar disorder and psychosis (including postpartum psychosis).

Consensus-based recommendations

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

xlvi 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.

ECT may be prescribed by a perinatal psychiatrist for pregnant women who meet the criteria above. Screening and selection of appropriate patients for ECT is essential and should be conducted by a psychiatrist experienced in ECT, in consultation with both a psychiatrist with appropriate training and expertise in perinatal psychiatry, and an obstetrician (*Weiss et al 2019*). Specific considerations include the risk of induction of premature labour associated with ECT and the risk of reduced fetal heart rate associated with maternal anaesthesia (*Lakshmana et al 2014*).

Close monitoring of mother and baby is essential before, during and after ECT including consideration of fetal heart rate monitoring with Doppler or cardiotocography. ECT after 20 weeks gestation should only be administered in hospitals where obstetric support is available.

In all situations, it is essential to have care plans and clear communication about ECT between obstetric care providers and the woman's psychiatrist.

Practice point

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

A decision to prescribe ECT must involve obtaining informed consent from the woman and her significant carer(s) where possible (*Lakshmana et al 2014*). Involving carers and families is critical in situations where the woman is clinically unable to provide informed consent due to her psychiatric condition. This decision must weigh up risks associated with ECT (e.g. short-term memory loss), the risks of not undertaking ECT and maintaining status quo and the risks of alternative treatments for the woman and, if ECT is conducted during pregnancy, the fetus and pregnancy. This process needs to be documented as per consent guidelines of the hospital/health service.

15.2 Repetitive transcranial magnetic stimulation

Repetitive transcranial magnetic stimulation (rTMS) is a form of neurostimulation therapy for people who do not respond to pharmacological interventions, which is considered as lower risk than ECT and for which a Medicare item is now available. It involves the focal application of a localised, pulsed magnetic field to the cerebral cortex, inducing small electrical currents which stimulate nerve cells (*RANZCP 2018*). rTMS does not require sedation with anaesthesia.

¹¹ The use of ECT is regulated through the Mental Health Act in each jurisdiction.

While Australian guidelines exist for its use in the general population (*RANZCP 2018*), there is insufficient evidence to recommend for or against its use in the perinatal period. Although the theoretical risk of rTMS is thought to be low due to the rapidly dissipating magnetic field from the stimulation coil and the distance of the fetus from the coil (*Taylor et al 2018*), the guidelines recommend careful assessment of the woman's situation and detailed informed consent. Discussion of known and potential risks of rTMS compared to alternative modalities of treatment is warranted (*RANZCP 2018*). It is advisable for these discussions to include other family members and support people as appropriate (*RANZCP 2018*). Outcomes in pregnant women should be closely monitored and where possible, employed to inform an empirical evidence base.

16 Practice summary - Prevention and treatment

General principles in prevention and treatment of mental health conditions in the perinatal period

| ACTION | FOR WHOM | COMMENTS |
|---|---|---|
| Provide psychoeducation | All women | Mental health problems are common in the perinatal period and can be treated. |
| Involve significant other(s) | All women | Provide information and involve in discussions about the woman's emotional well-being and care. |
| Preconception planning | Women of childbearing age at risk of or with new, existing or past severe mental health condition | Risk of relapse is substantial in pregnancy and especially in the early postnatal period. |
| Liaise with other health professionals involved in a woman's care | Women who would benefit from treatment for mental health conditions during pregnancy | This involves clear communication between professionals providing antenatal and maternity care and treating psychiatrists and psychologists. In more complex cases, seek advice from a perinatal psychiatrist. |
| Discuss risks and benefits of medications | Women being prescribed/ considering medications in the perinatal period | Where possible, involve significant other(s). Describe absolute risk (i.e. X in 1,000) when discussing risk of birth defects above the risk in the general population. |
| Discuss risk of relapse | Women on regular medication who fall pregnant and then consider medication cessation | Risk is high if medications are ceased and this needs to be done slowly and with advice from a psychiatrist or GP. |
| Plan for breastfeeding where feasible | Women who will need pharmacological treatment during the postnatal period | Examine the best treatment options for a woman who wishes to breastfeed. |
| Offer and facilitate the 13 or 18-20 week ultrasound | Women exposed to lithium, anticonvulsants and antipsychotics | Identifies malformations and enables women and significant other(s) to consider options and plan for additional care. |
| Arrange appropriate observation of the newborn | Mothers of infants exposed to any psychotropic medication in pregnancy | Poor neonatal adaptation syndrome is associated with the use of some psychotropic treatments in pregnancy. |
| Arrange co-admission of mother and baby to a mother-baby unit, where possible | Women with a severe postnatal episode | Assists with monitoring safety of the infant, the development of mothercraft skills and a positive relationship with the infant. |
| Take a team approach | Health professionals involved in care of women with severe mental illness | Clear communication and continuity of care and carer across clinical settings is needed. |
| Undertake training | Perinatal health professionals involved in care of women with severe mental illness | Improves understanding of care for women with severe mental illness. |

Psychosocial and psychological therapies

| HEALTH BEHAVIOURS & PSYCHOSOCIAL SUPPORT | FOR WHOM | COMMENTS |
|--|--|--|
| Healthy diet and regular, suitable physical activity | All women | Good nutrition and physical activity are associated with emotional well-being. |
| Psychologically informed psychoeducation | Women with symptoms of depression and/or anxiety | Structured education (often in groups) on preparation for childbirth, practical aspects of childcare and mental health . |
| Social support group | Women with symptoms of depression and/or anxiety | Enables mutual support by bringing women into contact with other women who are having similar experiences. |
| Mindfulness or relaxation training | Women with borderline personality disorder | Assists in managing emotional dysregulation. |
| Intensive maternal and child health care | Women with borderline personality disorder | The early postnatal period can be particularly distressing, with difficulties in care and emotional parenting of the infant. |

| PSYCHOLOGICAL TREATMENT | FOR WHOM | COMMENTS |
|--|---|---|
| Structured psychological interventions | Women with mild to moderate depression | CBT or IPT provided to individuals by a trained health professional. |
| | Women with moderate to severe depression | As an adjunct once medications have taken effect. |
| | Women with severe mental illness | CBT can be beneficial in managing secondary depression or anxiety. |
| | Women with borderline personality disorder | Interventions specifically designed for borderline personality disorder. |
| Directive counselling | Women with mild to moderate depression or anxiety disorder | Structured education (often in groups) on preparation for childbirth, practical aspects of childcare and mental health. |
| Post-traumatic birth counselling | Women who experience traumatic birth and have depression symptoms or PTSD | Enables mutual support by bringing women into contact with other women who are having similar experiences. |
| Mother-infant interventions | Women experiencing mother-infant difficulties | Involves observation of mother-infant interactions, feedback, modelling and cognitive restructuring. |
| | Women with severe mental illness, borderline personality disorder | Provided individually or to groups of women with similar requirements. |

| COMPLEMENTARY THERAPIES | FOR WHOM | COMMENTS |
|--|---|---|
| Complementary therapies (e.g. omega-3 fatty acids, St John's Wort) | Women who enquire about complementary therapies | Omega-3 fatty acids may be used in pregnancy but not as sole treatment for depression. St John's Wort and Gingko biloba are not recommended. |

Part D

Areas for Future Research



Areas for future research

Since the 2017 Australian Guideline, there have been considerable advances in research and innovation, in particular in the area of screening and assessment. This includes:

- exploration of digital approaches to screening – these include a standalone digital platform for screening and automated reporting across primary, maternity and postnatal settings, which facilitates reporting at national, state and local levels; an electronic model of assessment integrated into existing maternity sector databases; and web-based applications for self-assessment of psychosocial risk and possible depression
- development of electronic information for consumers and carers by a range of organisations, with many of these linked to the Australian government Head to Health platform
- internet-based interventions specific to mental health in the perinatal period
- electronic referral pathways, which benefit consumers through better coordinated care and health professionals through improved two-way communication, resulting in fewer errors and greater administrative efficiency.

The following section highlights potential areas for future development to support the sustainable and measurable implementation of best practice.

Understanding the woman's context

- Further research into migrant and refugee and minority groups is important to further understand the intersectionality and complexities of diverse community access and equity to women's health care outcomes.

Models of care

- Models of maternity care to determine the most effective ways to prevent and manage perinatal mental health conditions
- Models of perinatal care that are responsive to the dynamic and individual needs of women and families who receive a prenatal diagnosis of a fetal anomaly.

Screening programs

- Effectiveness and cost-effectiveness of screening programs (including **e-screening**)
- Effectiveness of screening and service models for **women experiencing intimate partner violence**/family violence
- Integrated approaches to screening/inquiry regarding women's mental health, experience of intimate partner violence and other social health issues
- Effective screening tools, interventions and support for perinatal mental health problems among **non-birthing parents**, including consideration of changing gender roles
- Effective means of screening for and managing **eating disorders** in the perinatal period
- Tailoring of screening/inquiry and first line responses for **Aboriginal and/or Torres Strait Islander women** to ensure that approaches are culturally safe, relevant and effective for these communities, and most importantly, to ensure that programs do not contribute to further trauma or harm for women and children
- Tailoring of screening/inquiry and first line responses for **migrant and refugee women** to ensure that approaches are culturally safe, relevant and effective for these communities, and most importantly, to ensure that programs do not contribute to further trauma or harm for women and children
- Follow up outcomes from universal screening for perinatal mental health
- The benefits of more frequent and staged maternal mental health surveillance in the **early years of parenting** (e.g. at 3, 6, 12 and 18 months and again at 4 years postpartum).

Health behaviours

- The effectiveness and cost-effectiveness of perinatal health behaviour (e.g. physical activity, healthy diet, sleep) programs on perinatal mental health.

Birth trauma

- The impact of birth trauma and recommended interventions; and research focused on specifically vulnerable cohorts e.g., **members of the LGBTQI+ community**
- The psychological impacts of birth-related trauma on women, birthing people and parents in the **migrant and refugee** community
- Investment in population-level research into **birth-related injuries** to better understand the prevalence, impacts, and treatment options.

Interventions

- Pharmacological treatment of mental disorders
- Couple and family-based interventions for perinatal mental health problems
- Parent-infant therapy.

Patient-reported outcomes

- Also essential is a Patient-Reported Outcome Measurement (PROM) Study to be developed to identify a woman/birthing person's mental well-being in conjunction with physical well-being beyond six weeks.

Cost-effectiveness

- Impact of including child outcomes on cost-effectiveness models.

Appendices



A Membership of the expert working groups and subcommittees

Membership of the Expert Working Group

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| Ms Julie Borninkhof | Consumer/Carer representative, CEO PANDA helpline with expertise in consumer needs, experiences and advocacy. | Consumer representative Perinatal Anxiety and Depression Association (PANDA) | Perinatal Anxiety and Depression Association (PANDA) | Fitzroy, VIC |
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| Dr Jan Taylor | Researcher and educator in midwifery with expertise in perinatal mental health. Former member of the COPE 2017 Guideline EWG. | Australian College of Midwives (ACM) | University of Canberra | Canberra, ACT |
| Professor Rhonda Marriott | Professor in Indigenous perinatal mental health, Murdoch University. AIHW perinatal data collection committee, CATSINaM Representative. | Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) | Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) | Murdoch, WA |

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Membership of the Fathers and Partners Expert Advisory Committee

| NAME | ORGANISATION |
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| Mr Dominic Alford | Program Leader, Primary Prevention, Relationships Australia (Victoria) |
| Mr Thomas Docking | CEO, Dads Group |
| A/Prof Richard Fletcher | Assoc Prof, Fathers and Families Research Program, University of Newcastle, SMS4dads |
| A/Prof Rebecca Giallo | Senior Research Fellow, Intergenerational Health Group, MCRI |
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| Dr Nicole Reilly | Research Fellow, University of Wollongong |
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Guideline development team

| GUIDELINE DEVELOPER - COPE |
|---|
| Dr Nicole Highet - Founder & Executive Director |

| SYSTEMATIC LITERATURE REVIEW - HERECO | |
|---------------------------------------|--------------------|
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B Administrative report

B1 Scope and purpose

Objectives

The objective of the Australian Clinical Practice Guideline on mental health care in the perinatal period is to guide best practice in the identification, prevention and treatment/management of mental health disorders that may occur during pregnancy or in the first year following the birth of a baby (the perinatal period).

Health intents

The Guideline aims to guide health professionals in the identification of the more common mental health conditions (depression and anxiety) and the prevention and treatment of these conditions through a range of treatment approaches that includes psychosocial and psychological therapies, pharmacological, complementary and physical therapies.

In addition, the Guideline addresses the management of low prevalence, more severe mental illnesses – namely schizophrenia, bipolar disorder, postpartum psychosis, borderline personality disorder and psychological birth trauma. For each of these conditions the Guideline provides guidance in the provision of psychosocial and psychological therapies, pharmacological and physical therapies.

The review of evidence to support the current update of the Guideline recommendations and practice points replicated the review of evidence conducted in support of the 2017 version of the Guideline and covers the following aspects in the birthing parent:

- screening for depressive and anxiety disorders in the perinatal period
- assessing psychosocial factors that affect mental health in the perinatal period
- prevention and treatment of mental health conditions during the perinatal period
- care of those with depressive and anxiety disorders
- care of those with severe mental illnesses such as severe depression, schizophrenia, bipolar disorder and postpartum psychosis
- care of those with borderline personality disorder
- harms to the fetus or breastfeeding infant associated with interventions used for the treatment or prevention of maternal perinatal mental health conditions
- the efficacy and safety of interventions for the prevention and treatment of mental health problems as a result of birth trauma (new topic).

In addition, a separate review covered perinatal mental health assessment in non-birthing partners.

Expected benefits or outcomes

The Guideline aims to:

- improve a women's emotional well-being, experience of pregnancy and early motherhood
- identify current and effective tools for the detection of women most at risk of perinatal mental health conditions (psychosocial assessment) as well as those experiencing symptoms of the more common conditions (screening tools)
- provide advice on perinatal mental health assessment in non-birthing partners
- assess the evidence for interventions used in managing mental health disorders, with a focus on the impact of exposure of the fetus to systemically active treatments (i.e., medications, complementary therapies and some physical therapies).

It is intended that this Guideline will inform local, state and national policy surrounding the timely implementation of appropriate tools to ensure early identification of women's needs and timely, safe (for mother and baby) and effective intervention. Early detection and management of perinatal mental health conditions will have significant health and economic benefits for the woman, her family and the broader community.

Target population

The population to whom the Guideline applies includes pregnant or postnatal women, with the postnatal period being defined as the 12 months following birth. Specifically, the investigations/interventions of interest are assessed in the following populations:

- **Psychosocial assessment** - all pregnant or postnatal women
- **Screening** - all pregnant or postnatal women
- **Perinatal mental health assessment** - non-birthing partners
- **Interventions** - pregnant or postnatal women who have an existing mental health disorder, or are considered to be at risk of developing a mental health disorder.

As this 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.

Questions

The topics under investigation for this evidence review mirror the three main topics that were addressed in the 2017 version of the Australian Perinatal Mental Health Guideline, with the addition of the new topic birth trauma. The broad topics in the updated Guideline are as follows:

- Maternal psychosocial assessment and screening for mental health problems in the perinatal period
- Treatment and prevention of maternal mental health problems in the perinatal period
- Harms to the fetus or breastfeeding infant from treatments administered to the birthing parent during the perinatal period
- Treatment and prevention of mental health problems in the perinatal period in parents who have experienced birth trauma.

The clinical research questions to focus the Guideline include:

- What are the most appropriate methods for psychosocial assessment of birthing parents at risk of mental health problems in the perinatal period?
- What are the most appropriate methods for screening birthing parents for depression and anxiety in the perinatal period?
- What is the efficacy and safety of interventions for the treatment of mental health problems in birthing parents in the antenatal or postnatal period?
- What is the efficacy and safety of interventions for the prevention of mental health problems in birthing parents identified as being at risk of developing a mental health problem in the antenatal or postnatal period?
- What are the harms to the fetus or breastfeeding infant that occur as a result of perinatal exposure to pharmacological interventions, complementary interventions or physical interventions used for the treatment or prevention of mental health problems?
- What is the efficacy and safety of interventions in the perinatal period for the prevention of mental health problems for parents who have experienced birth trauma?
- What is the efficacy and safety of interventions for the treatment of mental health problems in the perinatal period for parents who have experienced birth trauma?

The clinical research questions are summarised in Table 4. Detailed Population Intervention Comparison Outcome (PICO) criteria are included in Table 5.

Table 4 Clinical research questions

| PSYCHOSOCIAL ASSESSMENT IN WOMEN | |
|----------------------------------|---|
| Main question | What are the most appropriate methods for psychosocial assessment of the birthing parent at risk of mental health problems in the perinatal period? |
| Sub-questions | What is the performance (defined as reliability, validity, and accuracy) of validated multidimensional tools for perinatal psychosocial assessment? |
| | What are the non-technical characteristics (defined as number of items, time to administer, perinatal/postnatal timing, complexity of scoring, training requirements, and available languages) of validated multidimensional tools for perinatal psychosocial assessment? |
| | What is the acceptability to the birthing parent, health professionals, and the general public of validated multidimensional tools for perinatal psychosocial assessment? |
| | What is the effectiveness (defined as impact on detection, care sought or received, and mental health outcomes) of perinatal psychosocial assessment with validated multidimensional tools? |
| | What are the implications (for resourcing, workforce, and models of care) of implementing perinatal psychosocial assessment (via different modes of delivery) with a validated multidimensional tool? |
| DEPRESSION SCREENING IN WOMEN | |
| Main question | What are the most appropriate methods for screening the birthing parent for depression in the perinatal period? |
| Sub-questions | What is the performance (defined as reliability, sensitivity, specificity, positive likelihood ratio, and negative likelihood ratio) of validated tools for perinatal depression screening? |
| | What are the non-technical characteristics (defined as number of items, time to administer, perinatal/postnatal timing, complexity of scoring, training requirements, and available languages) of validated tools for perinatal depression screening? |
| | What is the acceptability to the birthing parent, health professionals, and the general public of screening for perinatal depression? |
| | What is the effectiveness (defined as impact on detection, care sought or received, and mental health outcomes) of screening for perinatal depression? |
| | What are the implications (for resourcing, workforce, and models of care) of implementing perinatal depression screening (via different modes of delivery) with a validated tool? |
| ANXIETY SCREENING IN WOMEN | |
| Main question | What are the most appropriate methods for screening the birthing parent for anxiety in the perinatal period? |
| Sub-questions | What is the performance (defined as reliability, sensitivity, specificity, positive likelihood ratio, and negative likelihood ratio) of validated tools for perinatal anxiety screening? |
| | What are the non-technical characteristics (defined as number of items, time to administer, perinatal/postnatal timing, complexity of scoring, training requirements, and available languages) of validated tools for perinatal anxiety screening? |
| | What is the acceptability to the birthing parent, health professionals, and the general public of screening for perinatal anxiety? |
| | What is the effectiveness (defined as impact on detection, care sought or received, and mental health outcomes) of screening for perinatal anxiety? |
| | What are the implications (for resourcing, workforce, and models of care) of implementing perinatal anxiety screening (via different modes of delivery) with a validated tool? |

PERINATAL MENTAL HEALTH ASSESSMENT IN NON-BIRTHING PARTNERS

| | |
|------------|---|
| Q1 | What are the most appropriate methods for psychosocial assessment of fathers or non-birthing partners at risk of mental health problems in the perinatal period? |
| Q1a | What is the performance (defined as reliability, validity and accuracy) of multidimensional tools for perinatal psychosocial assessment? |
| Q1b | What are the non-technical characteristics (defined as number of items, time to administer, perinatal/postnatal timing, mode of delivery, validation, complexity of scoring, training requirements, and available languages) of multidimensional tools for perinatal psychosocial assessment? |
| Q1c | What is the acceptability to fathers/non-birthing partners, health professionals, and the general public of multidimensional tools for perinatal psychosocial assessment? |
| Q1d | What are the implications (for resourcing, workforce, and models of care) of implementing perinatal psychosocial assessment (via different modes of delivery) with a multidimensional tool? |
| Q2 | What are the most appropriate methods for screening fathers or non-birthing partners for mental health problems in the perinatal period? |
| Q2a | What is the performance (defined as reliability, sensitivity, specificity, positive likelihood ratio, and negative likelihood ratio) of tools for perinatal mental health screening? |
| Q2b | What are the non-technical characteristics (defined as number of items, time to administer, perinatal/postnatal timing, mode of delivery, validation, complexity of scoring, training requirements, and available languages) of tools for perinatal mental health screening? |
| Q2c | What is the acceptability to fathers/non-birthing partners, health professionals, and the general public of screening for perinatal mental health screening? |
| Q2d | What is the effectiveness (defined as impact on detection, care sought or received, and mental health outcomes) of screening for perinatal mental health screening? |
| Q2e | What are the implications (for resourcing, workforce, and models of care) of implementing perinatal mental health screening (via different modes of delivery) with a tool? |

MENTAL HEALTH - TREATMENT INTERVENTIONS FOR WOMEN

| | |
|----------------------|---|
| Main question | What is the efficacy and safety of interventions for the treatment of mental health problems in the birthing parent in the antenatal or postnatal period? |
| Sub-questions | What is the efficacy and safety of psychosocial interventions for the treatment of mental health problems in the birthing parent in the antenatal or postnatal period? |
| | What is the efficacy and safety of psychological interventions for the treatment of mental health problems in the birthing parent in the antenatal or postnatal period? |
| | What is the efficacy and safety of online interventions for the treatment of mental health problems in the birthing parent in the antenatal or postnatal period? |
| | What is the efficacy and safety of pharmacological interventions for the treatment of mental health problems in the birthing parent in the antenatal or postnatal period? |
| | What is the efficacy and safety of complementary interventions for the treatment of mental health problems in the birthing parent in the antenatal or postnatal period? |
| | What is the efficacy and safety of physical interventions for the treatment of mental health problems in the birthing parent in the antenatal or postnatal period? |

MENTAL HEALTH PREVENTION INTERVENTIONS AMONG WOMEN

| | |
|----------------------|--|
| Main question | What is the efficacy and safety of interventions for the prevention of mental health problems in the birthing parent identified as being at risk of developing a mental health problem in the antenatal or postnatal period? |
| Sub-questions | <p>What is the efficacy and safety of psychosocial interventions for the prevention of mental health problems in the birthing parent identified as being at risk of developing a mental health problem in the antenatal or postnatal period?</p> <p>What is the efficacy and safety of psychological interventions for the prevention of mental health problems in the birthing parent identified as being at risk of developing a mental health problem in the antenatal or postnatal period?</p> <p>What is the efficacy and safety of online interventions for the prevention of mental health problems in the birthing parent identified as being at risk of developing a mental health problem in the antenatal or postnatal period?</p> <p>What is the efficacy and safety of pharmacological interventions for the prevention of mental health problems in the birthing parent identified as being at risk of developing a mental health problem in the antenatal or postnatal period?</p> <p>What is the efficacy and safety of complementary interventions for the prevention of mental health problems in the birthing parent identified as being at risk of developing a mental health problem in the antenatal or postnatal period?</p> <p>What is the efficacy and safety of physical interventions for the prevention of mental health problems in the birthing parent identified as being at risk of developing a mental health problem in the antenatal or postnatal period?</p> |

HARMS

| | |
|----------------------|--|
| Main question | What are the harms to the fetus or breastfeeding infant that occur as a result of perinatal exposure to pharmacological interventions, complementary interventions and physical interventions used for the treatment or prevention of mental health problems? |
| Sub-questions | <p>What are the harms that occur to the fetus (defined as malformations) as a result of perinatal exposure to pharmacological, complementary and physical interventions used for the treatment or prevention of mental health problems?</p> <p>What are the harms that occur to the infant (defined as pregnancy and birth outcomes) as a result of perinatal exposure to pharmacological, complementary and physical interventions used for the treatment or prevention of mental health problems?</p> <p>What are the harms that occur to the child (defined as neurodevelopmental outcomes) as a result of perinatal exposure to pharmacological, complementary and physical interventions used for the treatment or prevention of mental health problems?</p> <p>What are the harms that occur to the mother (defined as postpartum haemorrhage) as a result of perinatal exposure to pharmacological, complementary and physical interventions used for the treatment or prevention of mental health problems?</p> <p>What is the efficacy and safety of complementary interventions for the treatment of mental health problems in the birthing parent in the antenatal or postnatal period?</p> <p>What is the efficacy and safety of physical interventions for the treatment of mental health problems in the birthing parent in the antenatal or postnatal period?</p> |

BIRTH TRAUMA - PREVENTION INTERVENTIONS

| | |
|----------------------|---|
| Main question | What is the efficacy and safety of interventions ¹ in the perinatal period for the prevention of mental health problems for parents who have experienced birth trauma (associated with the current or a previous pregnancy)? |
| Sub-questions | What is the efficacy and safety of interventions for the prevention of mental health problems in the birthing parent or non-birthing partners who have experienced birth trauma associated with the current or a previous pregnancy? |
| | What is the acceptability to birthing parents, health professionals, and the general public about interventions used to prevent mental health problems related to birth trauma? |
| | What are the implications (for resourcing, workforce, and models of care) of implementing prevention interventions for parents who have experienced birth trauma? |

BIRTH TRAUMA - TREATMENT INTERVENTIONS

| | |
|----------------------|--|
| Main question | What is the efficacy and safety of interventions ² for the treatment of mental health problems in the perinatal period for parents who have experienced birth trauma (associated with the current or a previous pregnancy)? |
| Sub-questions | What is the efficacy and safety of interventions for the treatment of mental health problems in the perinatal period for parents who have experienced birth trauma? |
| | What is the acceptability to parents, health professionals, and the general public about interventions used to treat mental health problems related to birth trauma? |
| | What are the implications (for resourcing, workforce, and models of care) of implementing treatment interventions for parents who have experienced birth trauma? |

Footnotes:

¹ Interventions and approaches might include but not be limited to psychosocial interventions, psychological interventions (e.g., trauma focused cognitive behavioural therapy), pharmacological interventions (anti-depressant medication such as selective serotonin reuptake inhibitors [SSRIs]).

² Interventions and approaches might include but not be limited to psychosocial interventions, psychological interventions (e.g., counselling; trauma-focused cognitive behavioural therapy [CBT]; eye movement desensitisation and reprocessing [EMDR]), pharmacological interventions (anti-depressant medication such as SSRIs), complementary interventions or physical interventions.

Table 5 Detailed PICO criteria

| QUESTIONS PERTAINING TO WOMEN | |
|-------------------------------|---|
| Question 1 | What are the most appropriate methods for psychosocial assessment of birthing parents at risk of mental health problems in the perinatal period? |
| Population | <p>Pregnant or postnatal women (birthing parent)</p> <p>Subgroups of interest:</p> <ul style="list-style-type: none"> • Aboriginal and/or Torres Strait Islander pregnant or postnatal women • Refugee and asylum seeker pregnant or postnatal women • Pregnant or postnatal women from migrant or CALD background • LGBTQI+ birthing parents and non-birthing partners with or without a previous history of abuse |
| Intervention | <p>Validated psychosocial assessment tools to identify people at risk of mental health problems in the perinatal period</p> <ul style="list-style-type: none"> • Limited to tools investigated in the 2017 Australian Guideline (ALPHA, ANRQ, ARPA, CAME^A, CAN-M^B, PNRQ, PRQ and the revised versions of the ANRQ and PNRQ (ANRQ-R and PNRQ-R), and the KMMS |
| Comparator | <ul style="list-style-type: none"> • Subsequent manifestation of mental health issues or any standard clinical/diagnostic interview as a reference standard |
| Outcomes | <p>Tool performance:</p> <p><u>Critical outcomes</u></p> <ul style="list-style-type: none"> • Validity • Reliability • Predictive accuracy (OR odds of identifying a factor of concern) <p>Clinical usefulness:</p> <p><u>Critical outcomes</u></p> <ul style="list-style-type: none"> • Validity • Reliability • Acceptability to pregnant or postnatal women, to healthcare providers, to the general public <p><u>Critical outcomes</u></p> <ul style="list-style-type: none"> • Sensitivity • Specificity |

Abbreviations: ALPHA, Antenatal Psychosocial Health Assessment; ANRQ, Antenatal Risk Questionnaire; ANRQ-R, Antenatal Risk Questionnaire – Revised; ARPA, Antenatal Routine Psychosocial Assessment; CALD, culturally and linguistically diverse; CAME, Contextual Assessment of Maternity Experience; CAN-M, Camberwell Assessment of Need–Mothers; KMMS, Kimberly Mum’s Mood Scale; LGBTQI+, lesbian, gay, bisexual, transgender, queer/questioning, intersex; PNRQ, Postnatal Risk Questionnaire; PNRQ-R, Postnatal Risk Questionnaire – Revised; PRQ, Pregnancy Risk Questionnaire.

Footnotes:

^A The CAME has been developed and tested in women known to be at high risk, namely women with past or current major depressive disorder, and women living in poverty. Women with a history of MDD and women living in poverty comprise a subset of the target population.

^B The CAN-M has been designed for use in pregnant women and mothers with current severe mental illness who are already receiving mental health care, which is very different to the target population for the current Guideline (women under routine antenatal care with unknown past or current mental health status) behavioural therapy [CBT]; eye movement desensitisation and reprocessing [EMDR]), pharmacological interventions (anti-depressant medication such as SSRIs), complementary interventions or physical interventions.

| | | |
|---------------------|---|--|
| Question 2 | What are the most appropriate methods for screening the birthing parent for depression in the perinatal period? | |
| Population | Pregnant or postnatal women (birthing parent) Subgroups of interest: <ul style="list-style-type: none"> • Aboriginal and/or Torres Strait Islander pregnant or postnatal women • Refugee and asylum seeker pregnant or postnatal women • Pregnant or postnatal women from migrant or CALD background • LGBTQI+ birthing parents and non-birthing partners with or without a previous history of abuse | |
| Intervention | Validated screening tools to identify people with depression in the perinatal period <ul style="list-style-type: none"> • Limited to tools investigated in the Australian Guideline (EPDS, PHQ [PHQ-2 or PHQ-9], K10, Whooley questions) and the HADS | |
| Comparator | <ul style="list-style-type: none"> • Any type of standardised diagnostic interview, defined as a structured interview (such as the SCID, CIDI or MINI) delivered by trained staff, or an ICD mental health diagnosis by a psychiatrist or clinical psychologist • A different screening tool (from the list above) | |
| Outcomes | Tool performance: <u>Critical outcomes</u> <ul style="list-style-type: none"> • Positive Likelihood Ratio (LR+) • Negative Likelihood Ratio (LR-) • AUROC Clinical usefulness: <u>Critical outcomes</u> <ul style="list-style-type: none"> • Acceptability to women, to healthcare providers, to the general public • Mental health outcomes | <u>Critical outcomes</u> <ul style="list-style-type: none"> • Sensitivity • Specificity • Youden's index <u>Important outcomes</u> <ul style="list-style-type: none"> • Impact on help-seeking behaviour (services sought or utilised) • Impact of detection (e.g., referral rates if screen positive) |

Abbreviations: AUROC, area under the receiver-operating characteristics curve; CIDI, Composite International Diagnostic Interview; DASS-21, Depression Anxiety Stress Scales; DSM, Diagnostic and Statistical Manual of Mental Disorders; EPDS, Edinburgh Postnatal Depression Scale; HADS, Hospital Anxiety and Depression Scale; ICD, International Statistical Classification of Diseases and Related Health Problems; K10, Kessler Psychological Distress Scale (10 item); LGBTQI+, lesbian, gay, bisexual, transgender, queer/questioning, intersex; MINI, Mini-International Neuropsychiatric Interview; PHQ-2, first 2 items of the PHQ-9; PHQ-9, Patient Health Questionnaire-9; SCID, Structured Clinical Interview for DSM Disorders.

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|---------------------|---|--|
| Question 3 | What are the most appropriate methods for screening the birthing parent for anxiety in the perinatal period? | |
| Population | Pregnant or postnatal women (birthing parent) Subgroups of interest: <ul style="list-style-type: none"> • Aboriginal and/or Torres Strait Islander pregnant or postnatal women • Refugee and asylum seeker pregnant or postnatal women • Pregnant or postnatal women from migrant or CALD background • LGBTQI+ birthing parents and non-birthing partners with or without a previous history of abuse | |
| Intervention | Validated screening tools to identify people with anxiety in the perinatal period <ul style="list-style-type: none"> • Limited to tools investigated in the 2017 Australian Guideline (EPDS, DASS-21, GAD-2/GAD-7, GHQ, HADS, HADS-A, K10, STAI) or the ANRQ-2A | |
| Comparator | <ul style="list-style-type: none"> • Any type of standardised diagnostic interview, defined as a structured interview (such as the SCID, CIDI or MINI delivered by trained staff, or an ICD mental health diagnosis by a psychiatrist or clinical psychologist • A different screening tool (from the list above) | |
| Outcomes | Tool performance: <u>Critical outcomes</u> <ul style="list-style-type: none"> • Positive Likelihood Ratio (LR+) • Negative Likelihood Ratio (LR-) • AUROC Clinical usefulness: <u>Critical outcomes</u> <ul style="list-style-type: none"> • Acceptability to women, to healthcare providers, to the general public • Mental health outcomes | <u>Critical outcomes</u> <ul style="list-style-type: none"> • Sensitivity • Specificity <u>Important outcomes</u> <ul style="list-style-type: none"> • Impact on help-seeking behaviour (services sought or utilised) • Impact of detection (e.g., referral rates if screen positive) |

Abbreviations:

ANRQ-2A, 2 'anxiety' items from the Antenatal Risk Questionnaire; AUROC, area under the receiver-operating characteristics curve; CIDI, Composite International Diagnostic Interview; DASS-21, Depression Anxiety Stress Scales; DSM, Diagnostic and Statistical Manual of Mental Disorders; EPDS, Edinburgh Postnatal Depression Scale; GAD-2, Generalized Anxiety Disorder 2-item scale; GAD-7, Generalized Anxiety Disorder 7-item scale; GHQ, General Health Questionnaire; HADS, Hospital Anxiety and Depression Scale; HADS-A, Hospital Anxiety and Depression Scale - Anxiety subscale; ICD, International Statistical Classification of Diseases and Related Health Problems; K10, Kessler Psychological Distress Scale (10 item); LGBTQI+, lesbian, gay, bisexual, transgender, queer/questioning, intersex; MINI, Mini-International Neuropsychiatric Interview; STAI, State-Trait Anxiety Inventory; SCID, Structured Clinical Interview for DSM Disorders.

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| Question 4 | What is the efficacy and safety of interventions for the treatment of mental health problems in birthing parents in the antenatal or postnatal period? | |
| Question 5 | What is the efficacy and safety of interventions for the prevention of mental health problems in birthing parents identified as being at risk of developing a mental health problem in the antenatal or postnatal period? | |
| Population | Pregnant or postnatal women who: <ul style="list-style-type: none"> • have an existing mental health problem (Q4 treatment) • are considered to be at risk of developing a health problem (Q5 prevention) | |
| Intervention | <ul style="list-style-type: none"> • Psychosocial interventions • Psychological interventions • Online interventions • Pharmacological interventions • Complementary interventions • Physical interventions | |
| Comparator | <ul style="list-style-type: none"> • Treatment as usual • Enhanced treatment as usual • No treatment/placebo or waitlist control • Other active interventions | |
| Outcomes | <u>Maternal mental health symptomatology or diagnosis</u> <ul style="list-style-type: none"> • Depression/anxiety/PTSD diagnosis • Depression/anxiety/PTSD symptomatology • Negative thoughts/mood <u>Safety</u> <ul style="list-style-type: none"> • Side effects | <u>Mother-infant interactions</u> <ul style="list-style-type: none"> • Mother-infant attachment problems • Positive mother-infant interaction • Maternal sensitivity |

Abbreviations:

PTSD, post-traumatic stress disorder.

Notes:

Specific psychosocial, psychological, online, pharmacological, complementary and physical interventions are listed in Table 3.

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| Question 6 | What are the harms to the fetus or breastfeeding infant that occur as a result of perinatal exposure to pharmacological interventions, complementary interventions and physical interventions used for the treatment or prevention of mental health problems? | |
| Population | <ul style="list-style-type: none"> • Pregnant or postpartum/postnatal women (birthing parent) • Infants or children exposed during pregnancy or postnatally | |
| Intervention | <p>Pharmacological</p> <ul style="list-style-type: none"> • antidepressants, antipsychotics, mood stabilisers (including anticonvulsants, benzodiazepines and z-drugs), lithium <p>Complementary</p> <ul style="list-style-type: none"> • Omega-3 fatty acids, St John's Wort, Ginkgo biloba <p>Physical</p> <ul style="list-style-type: none"> • ECT, TMS | |
| Comparator | <ul style="list-style-type: none"> • No exposure • Exposure to an active comparator | |
| Outcomes | <p>Fetal, infant or child harms:</p> <p><u>Malformations</u></p> <ul style="list-style-type: none"> • Major malformations • Cardiac malformations • Septal malformations <p><u>Pregnancy and birth outcomes</u></p> <ul style="list-style-type: none"> • Neonatal mortality • Stillbirth • Miscarriage • Preterm birth • SFGA/IUGR • PNAS • Persistent pulmonary hypertension • Respiratory distress • Tremors • Convulsions <p><u>Neurodevelopmental outcomes</u></p> <ul style="list-style-type: none"> • Autism spectrum disorder • ADHD • Other disorders measured with validated instruments • Intelligence quotient • Behavioural problems • Depression • Anxiety | <p>Maternal harms:</p> <ul style="list-style-type: none"> • Postpartum haemorrhage |

Abbreviations:

ADHD, attention deficit hyperactivity disorder; ECT, electroconvulsive therapy; IUGR, intrauterine growth restriction; PNAS, poor neonatal adaptation syndrome; SFGA, small for gestational age; TMS, transcranial magnetic stimulation.

QUESTIONS PERTAINING TO FATHERS AND NON-BIRTHING PARTNERS

| Question 1 | What is the most appropriate method for psychosocial assessment of fathers or non-birthing partners at risk of mental health problems in the perinatal period? | |
|--|---|--|
| Population | <p>Expectant or new non-birthing partners, regardless of relationship status, gender, and relationship to the child</p> <p>Includes:</p> <ul style="list-style-type: none"> fathers co-parents step-parents or other non-birthing partners of gestational parents | <p>Subgroups of interest:</p> <ul style="list-style-type: none"> Previous mental health problems and/or a history of trauma Aboriginal and/or Torres Strait Islander peoples Refugee and asylum seekers Migrant or CALD backgrounds |
| Intervention | <p>Relevant multidimensional psychosocial assessment tools to identify people at risk of mental health problems in the perinatal period</p> <ul style="list-style-type: none"> Limited to ALPHA, ANRQ, BRO, PAT, PAT-2, PRQ | |
| Comparator | <ul style="list-style-type: none"> Any type of standardised diagnostic interview, defined as a structured interview (such as the SCID, CIDI or MINI) delivered by trained staff, or an ICD mental health diagnosis by a psychiatrist or clinical psychologist A different psychosocial assessment or symptom-based tool (from the list above) | |
| Outcomes | <p>Tool performance:</p> <p><u>Critical outcomes</u></p> <ul style="list-style-type: none"> Predictive accuracy (OR odds of identifying a factor of concern) Positive Predictive Value (PPV) Negative Predictive Value (NPV) Positive Likelihood Ratio (LR+) Negative Likelihood Ratio (LR-) <p>Clinical usefulness:</p> <p><u>Critical outcomes</u></p> <ul style="list-style-type: none"> Acceptability to fathers & non-birthing partners, to healthcare providers, to the general public | <p><u>Critical outcomes</u></p> <ul style="list-style-type: none"> Sensitivity Specificity AUROC |
| Additional information & data extraction | <ul style="list-style-type: none"> Evaluation of applicability (country, setting and availability of normative data) <p><u>Inclusion of non-technical characteristics</u></p> <ul style="list-style-type: none"> Number of items Time to administer Perinatal/postnatal timing Mode of delivery Validation Complexity of scoring Training requirements Available languages <p><u>Information on practice implications</u></p> <ul style="list-style-type: none"> Resourcing (e.g., who funds the delivery of psychosocial assessment) Workforce (e.g., who delivers the psychosocial assessment) Models of care (e.g., systems for referral/pathways to care) | |

Abbreviations:

ALPHA, Antenatal Psychosocial Health Assessment; ANRQ, Antenatal Risk Questionnaire; AUROC, Area Under the Receiver Operator Characteristic; BRO, Brief Risk Overview; CALD, culturally and linguistically diverse; CIDI, Composite International Diagnostic Interview; DSM, Diagnostic and Statistical Manual of Mental Disorders; ICD, International Classification of Diseases; MINI, Mini-International Neuropsychiatric Interview; OR, odds ratio; PAT/PAT-2, Psychosocial Assessment Tool; PRQ, Pregnancy Risk Questionnaire; SCID, Structured Clinical Interview for DSM.

| Question 2 | What are the most appropriate methods for screening fathers or non-birthing partners for mental health problems in the perinatal period? | |
|--|---|--|
| Population | <p>Expectant or new non-birthing partners, regardless of relationship status, gender, and relationship to the child</p> <p>Includes:</p> <ul style="list-style-type: none"> • fathers • co-parents • step-parents or other non-birthing partners of gestational parents | <p>Subgroups of interest:</p> <ul style="list-style-type: none"> • Previous mental health problems and/or a history of trauma • Aboriginal and/or Torres Strait Islander peoples • Refugee and asylum seekers • Migrant or CALD backgrounds |
| Intervention | <p>Relevant screening tools to identify people with current mental health problems in the perinatal period</p> <ul style="list-style-type: none"> • Limited to BDI, DASS-21, EPDS, GAD-7, GMDS, K-6, K10, MGMQ, PHQ-2 (Whooley questions), PHQ-9, STAI | |
| Comparator | <ul style="list-style-type: none"> • Any type of standardised diagnostic interview, defined as a structured interview (such as the SCID, CIDI or MINI delivered by trained staff, or an ICD mental health diagnosis by a psychiatrist or clinical psychologist • A different screening tool (from the list above) | |
| Outcomes | <p>Tool performance:</p> <p><u>Critical outcomes</u></p> <ul style="list-style-type: none"> • Sensitivity • Specificity • Positive likelihood ratio (LR+) • Negative likelihood ratio (LR-) | <p><u>Critical outcomes</u></p> <ul style="list-style-type: none"> • AUROC |
| | <p>Clinical usefulness:</p> <p><u>Critical outcomes</u></p> <ul style="list-style-type: none"> • Mental health outcomes • Acceptability to fathers & non-birthing partners, to healthcare providers, to the general public | <p><u>Important outcomes</u></p> <ul style="list-style-type: none"> • Impact on help-seeking behaviour (services sought or utilised) • Impact of detection (e.g., referral rates if screen positive) |
| Additional information & data extraction | <ul style="list-style-type: none"> • Evaluation of applicability (country, setting and availability of normative data) <p><u>Inclusion of non-technical characteristics</u></p> <ul style="list-style-type: none"> • Number of items • Time to administer • Perinatal/postnatal timing • Mode of delivery • Complexity of scoring • Training requirements • Available languages <p><u>Information on practice implications</u></p> <ul style="list-style-type: none"> • Resourcing (e.g., who funds the delivery of screening) • Workforce (e.g., who delivers the screening) • Models of care (e.g., systems for referral/pathways to care) | |

Abbreviations:

AUROC, Area Under the Receiver Operating Characteristic; BDI, Beck Depression Inventory; CALD, culturally and linguistically diverse; CIDI, Composite International Diagnostic Interview; DASS-21, Depression Anxiety Stress Scales; DSM, Diagnostic and Statistical Manual of Mental Disorders; EPDS, Edinburgh Postnatal Depression Scale; GAD-7, General Anxiety Disorder-7; GMDS, Gotland Male Depression Scale; ICD, International Classification of Diseases; K10/K-6, Kessler Psychological Distress Scale (10 item/6-item); MGMQ, Matthey Generic Mood Question; MINI, Mini-International Neuropsychiatric Interview; PHQ, Patient Health Questionnaire; STAI, State-Trait Anxiety Inventory; SCID, Structured Clinical Interview for DSM.

Table 6 **Eligible psychosocial, psychological, online, pharmacological, complementary and physical interventions**

| PSYCHOSOCIAL | PSYCHOLOGICAL | ONLINE |
|---|--|---|
| Psychoeducation | Structured psychological interventions (cognitive behavioural therapy and interpersonal psychotherapy) | Web-based and computer-based online programs <ul style="list-style-type: none"> • Guided • Self-guided/unguided |
| Psychoeducational booklet | Directive counselling | |
| Social/peer support | Non-directive counselling | |
| Online peer-to-peer support | Case management/individualised treatment | |
| Home visits | Self-help or facilitated self-help | |
| Non-mental health-focused education and support | Post-traumatic birth counselling | |
| Pre-delivery discussion | Post-miscarriage counselling | |
| Post-delivery discussion | Mother-infant relationship interventions | |
| Post-miscarriage self-help | Eye movement desensitisation and reprocessing | |
| Seeing and/or holding stillborn infant | Acceptance and commitment therapy | |
| Co-parenting interventions | Mindfulness | |
| PHARMACOLOGICAL | COMPLEMENTARY | PHYSICAL |
| Antidepressants | Omega-3 fatty acids | Exercise |
| Antipsychotics | St John's Wort | Yoga |
| Mood stabilisers | Ginkgo biloba | Acupuncture |
| Anticonvulsants | | Electroconvulsive therapy |
| Benzodiazepines and z-drugs | | Transcranial magnetic stimulation |
| Lithium | | Meditation |
| Dexamphetamine | | |

Population

Please see Table 3.

B2 Stakeholder involvement

This is the third version of the Australian Perinatal Mental Health Guidelines, with the foundation laid by the first version developed by beyondblue in 2011 and the scope broadened to include schizophrenia and borderline personality disorder as well as depressive and anxiety disorders, bipolar disorder and postpartum psychosis in the Guideline developed by the Centre of Perinatal Excellence (COPE) in 2017.

The development of this version was also undertaken by COPE, with funding from the Australian Government Department of Health and Aged Care and developed in accordance with National Health and Medical Research Council (NHMRC) Guideline development processes. This involved convening an Expert Working Group comprising members nominated by their professional college, with specific expertise in mental health care, as well as representatives of maternity care (including general practice, obstetrics, midwifery and maternal and child health), consumer and carer organisations and Aboriginal and Torres Strait Islander health care. An expert subcommittee was also convened to provide specific advice on harms associated with pharmacological treatments.

Formal consultation with a wide range of experts, stakeholders and consumer representatives was undertaken through the public consultation process and the Guideline was revised to incorporate comments received.

Group membership

Please see Appendix A.

Target population preferences and views

Capturing consumer perspectives

The establishment of the EWG with dedicated consumer and carer representation was considered fundamental to the inclusion of consumer and carer perspectives in the development of this Guideline. In particular the appointment of representatives from Australia's peak perinatal consumer body (PANDA) ensured that the perspectives of many consumers were included at the EWG level. It is also noted that a number of representatives brought to the table expertise and insights from the lived experience of perinatal mental health.

In addition, the perspectives of consumers and carers were actively sought through the consultation process.

Capturing perspectives of specific groups

Aboriginal and/or Torres Strait Islander perspectives were captured through the inclusion of an EWG representative from Aboriginal and/or Torres Strait Islander background, who was also a health professional with a specialist background in perinatal mental health. As with all other members of the EWG, the representative was nominated on behalf of a specific organisation (Congress of Aboriginal and Torres Strait Islander Nurses and Midwives; CATSINaM).

Target users

The Guideline is intended for all health professionals caring for women and families during the perinatal period. This includes but is not limited to midwives, general practitioners (GPs), obstetricians, neonatologists, paediatricians, maternal and child health nurses, paediatric nurses, Aboriginal and/or Torres Strait Islander health workers, allied health professionals, mental health practitioners (psychologists, psychiatrists, mental health nurses, perinatal and infant mental health professionals), consumers and carers and those working with families in the community (e.g. social workers, child protection agencies), hospital and legal systems.

The Guideline will be used by each of the professional groups in accordance with their role in the management of perinatal health. For example, those involved at the front-end of maternity and postnatal care provision (GPs, midwives and obstetricians, maternal and family health nurses) will be informed about best practice screening and assessment tools to identify and respond to identified mental health problems in pregnancy. Professionals involved in the provision of treatment for mental health conditions (psychiatrists, psychologists, GPs, mental health nurses) will likely refer to the information surrounding safe and effective treatments for perinatal mental health conditions. Consumers and carers will also refer to the Guideline to obtain information about the assessment of risk and symptom detection, as well as recommended safe and effective treatments for perinatal mental health conditions.

B3 Rigour of development

This section provides a brief outline of the process for reviewing the evidence. Full details on the process are available in the Technical Reports, which will be available on the COPE website.

Search methods

Screening, psychosocial assessment and intervention (effectiveness and harms)

The evidence review conducted to support the 2017 version of the Australian Perinatal Mental Health Guideline was updated for the Guideline update. Literature searches were performed to identify relevant new evidence relating to the pre-specified research questions for psychosocial assessment, depression and anxiety screening, and treatment and prevention interventions for mental health problems seen during the perinatal period (depression, anxiety, schizophrenia, and bipolar disorder). The searches were conducted in February and March 2022 according to three main topics: psychosocial assessment, depression screening and anxiety screening; treatment and prevention interventions; and harms. Further details regarding the search strategy and literature search dates are available in the Technical Reports.

Articles recommended by the EWG were considered for inclusion if they met the pre-specified eligibility criteria, or they could be used for reference in the background or narrative sections of the Guideline.

Birth trauma

A review was undertaken to identify and evaluate national and international birth trauma or PTSD clinical practice guidelines to support the development of recommendations on the prevention and management of mental health problems (including PTSD) following birth trauma.

A variety of guideline-related electronic databases and websites were searched for potentially relevant national or international guidelines published and/or endorsed by reputable organisations since 1 January 2006, with the aim of covering all the topics in scope (birth trauma and PTSD).

The search was restricted to English-language clinical practice guidelines. The guideline databases searched included the National Health and Medical Research (NHMRC) Australian Clinical Practice Guidelines Portal (now decommissioned), the **Trip database** and the Guidelines International Network (GIN) **International Guidelines Library**. A Google search was also carried out to identify any birth trauma or PTSD guidelines developed by Australian medical colleges or State health departments. Further to electronic searches, EWG members were consulted to identify any other current clinical practice guidelines or appropriate sources to search for such guidelines, such as Australian peak health body websites.

The aim of the guideline assessment process was to identify the highest quality, most relevant guidelines on birth trauma or PTSD that had relevant recommendations that could be adopted or adapted for these Guidelines. There was a preference for Australian guidelines over international guidelines as they are more likely to be relevant to the Australian health care context.

Evidence selection criteria

The main inclusion/exclusion criteria for each of the research question types were as follows:

Psychosocial assessment and screening

- **Target population** - pregnant or postnatal women
- **Comparisons** - subsequent manifestation of mental health issues, or any standard clinical/diagnostic interview as a reference standard (psychosocial assessment); any standardised diagnostic interview by trained staff or ICD mental health diagnosis by psychiatrist or clinical psychologist, or a different screening tool (from the pre-specified intervention list) (screening)
- **Language** - limited to English

Effectiveness of interventions

- **Target population** - pregnant or postnatal women diagnosed with a mental health problem, or considered to be at risk of developing a mental health problem
- **Study design** - RCTs
- **Interventions** - Psychosocial, psychological, pharmacological, complementary, online or physical interventions used to treat or prevent mental health problems in pregnant or postnatal women
- **Comparisons** - no exposure or exposure to an active comparator
- **Language** - limited to English

Harms of intervention

- **Target population** - pregnant or postnatal women diagnosed with a mental health problem, or considered to be at risk of developing a mental health problem, or a fetus, infant or child of a mother exposed to a pharmacological, complementary or physical therapy
- **Study design** - SRs of RCTs (if available), SRs of observational studies, or individual observational studies if no SR or SR out of date or unsuitable
- **Comparisons** - no exposure or exposure to an active comparator
- **Language** - limited to English

Strengths and limitations of the evidence

The strengths and limitations of the evidence have been considered from the perspective of the individual studies and the body of evidence aggregated across all the studies. Wherever possible validated methods have been used to assess:

- study design(s)
- study methodology limitations (sampling, blinding, allocation concealment, analytical methods)
- appropriateness/relevance of primary and secondary outcomes
- consistency of results across studies
- direction of results across studies
- magnitude of benefit versus magnitude of harm
- applicability to practice context.

The GRADE methodology was used to determine the quality of the evidence available for each intervention/outcome.

Consistent with the 2017 Guideline, a hybrid method was developed for quality appraisal of psychosocial assessment instruments, and is described in detail in Part B of the Technical Report.

Formulation of recommendations

The recommendations in the Guideline are derived from those in the 2017 Australian Guideline, some of which were revised in the light of new evidence or to improve clarity. In reviewing the recommendations, committee members considered benefits and harms, certainty of the evidence, preferences and values, resources, equity, acceptability and feasibility. Any proposed changes to the wording of evidence-based or consensus-based recommendations were agreed through a process by which:

- the guideline methodologists advised on aspects of a recommendation that could be changed to better reflect the evidence or improve clarity
- committee members proposed wording changes, these were discussed and refined until there was general agreement among attending committee members
- wording changes were noted and circulated (in the form of meeting minutes) by email to ensure members not in attendance could contribute to the wording.

Recommendations on screening and psychosocial risk assessment

The Expert Working Group met on 12 September 2022 and reviewed the 2017 Australian Guideline recommendations on screening for depressive and anxiety disorders and on psychosocial assessment. The EWG acknowledged that the new evidence available for technical performance of depression and anxiety screening tools was of very low to low certainty. The importance of using clinical judgement was highlighted by the EWG, which informed changes to CBR vi. Other minor amendments to recommendations and the rationale for the changes are outlined in Tables 7, 10, 11 and 13.

Recommendations on perinatal mental health assessment non-birthing partners

A set of draft consensus-based recommendations was developed by the Fathers and Partners Expert Advisory Committee (FPEAC) based on a mixed-method review. The approach included the use of systematic reviews of quantitative evidence (e.g., screening test performance), descriptions of non-technical characteristics of the tests (e.g., time to administer, complexity of scoring), and narrative reviews of acceptability, effectiveness and implementation issues associated with perinatal mental health assessment in non-birthing partners. The draft consensus-based recommendations were subsequently revised for consistency with the approach used in this Guideline and reviewed and agreed by the EWG. The process of the review and the development of consensus-based recommendations is described in Tables 14 and 15.

Recommendation on postnatal care and support

The EWG met on 29 August 2022 and reviewed the 2017 Australian Guideline recommendations and practice points on assessing mother-infant interaction, assessing risk of suicide, supporting emotional health and well-being and postnatal care and support. The EWG agreed that the wording of the existing recommendations was appropriate, with a minor change to CBR xxvii (see Table 21).

Recommendations on interventions for prevention and treatment

The Expert Working Group met on 29 August 2022 and reviewed the 2017 Australian Guideline recommendations on psychosocial and psychological interventions, general principles in prevention and treatment and general principles in the use of pharmacological treatments. The EWG agreed that, based on analysis of the new evidence, there were no grounds to change the existing strong recommendation on structured psychological interventions.

The Harms Expert Subcommittee met on the 12 August 2022 and reviewed the 2017 Australian Guideline recommendations in the context of new evidence relating to harms of pharmacological, complementary and physical interventions. The Harms Expert Subcommittee suggested changes to some of the existing recommendations, which were reviewed and accepted without alteration by the EWG at their meeting on 29 August 2022, following consideration of the evidence relating to both benefits and harms of the relevant interventions. These changes are described in Tables 22 to 30.

Recommendations on screening and preventive strategies for birth trauma

The Expert Working Group met on 1 April 2022 and reviewed the findings of a review undertaken to identify and evaluate national and international birth trauma or PTSD clinical practice guidelines to support the development of recommendations on the management and prevention of mental health problems (including PTSD) following birth trauma.

Where existing high-quality guidance was available, the Expert Working Group assessed the suitability of the recommendations within existing guidelines being sensibly applied as recommendations in this updated Guideline, with or without modification. This approach avoided duplicating existing syntheses of the research literature and avoided the need to critically appraise primary research that had already been assessed using reliable processes and tailored to the Australian setting. Australian Guidelines took precedence because they were likely to be the most relevant to Australian clinical practice. If appropriate high-quality Australian birth trauma or PTSD guidelines were not identified as source guidelines, international birth trauma or PTSD guidelines were considered for inclusion.

The deliberations of the EWG are described in Tables 32 and 33.

Consideration of harms and benefits

While recommendations on the use of psychosocial and psychological interventions were based primarily on evidence of effectiveness because they do not cause direct harm to the fetus, infant or child, recommendations on the use of pharmacological, complementary and selected physical interventions were to be based on a trade-off between effectiveness and harm. However, there was very little evidence of effectiveness for these interventions in the perinatal population. The only effectiveness evidence available was for antidepressants (suggesting it may improve postnatal depression) and omega-3 fatty acids (where it appeared to have no effect on depression).

Antidepressants

The review found low confidence evidence for increased risk of postpartum haemorrhage, persistent pulmonary hypertension and depression in the child with SSRI exposure, and moderate confidence evidence for increased risk of autism spectrum disorder, compared with no exposure. There was insufficient evidence on comparisons between agents to make judgements on the direction of effect.

The Harms Expert Subcommittee noted that:

- there is a lack of RCT evidence for ethical reasons but there is evidence from observational studies of benefits of antidepressants (e.g. improved mother–infant interaction) and harms associated with abrupt cessation of treatment due to pregnancy (e.g. suicide, adverse effects on physical activity and nutrition)
- links between exposure and adverse events are unclear and may be attributable to confounding
- the evidence on harms other than postpartum haemorrhage is too uncertain to inform discussion in the Guideline.

Benzodiazepines

The evidence on harms associated with benzodiazepines was of low confidence or uncertain.

Antipsychotics

The review found insufficient evidence for overall estimation of risk for all outcomes. The Harms Expert Subcommittee noted that:

- untreated psychosis is associated with relapse and adverse effects on pregnancy (stillbirth, poor antenatal attendance)
- while there is no specific RCT evidence around efficacy in pregnancy, evidence from the general population supports the use of antipsychotics to treat psychosis based on relapse if untreated and effects of untreated psychosis in pregnant women (e.g. stillbirth, poor antenatal attendance)
- not all antipsychotics are associated with metabolic effects
- clozapine may be a consideration in women who do not respond to other antipsychotics and specialist input would be required.

Anticonvulsants

The review found insufficient evidence for overall estimation of risk for all outcomes. The Harms Expert Subcommittee agreed that:

- the evidence-based recommendation on sodium valproate should refer to pregnant women rather than women of childbearing age and that reference to recommendations on ensuring effective contraception need to be included
- harms associated with anticonvulsants when breastfeeding are variable and this should be reflected in the consensus-based recommendation
- consensus-based recommendations be revised to specify metabolic-inducing antipsychotics and reflect the associated increased risk of gestational diabetes
- the consensus-based recommendation on clozapine use in pregnancy be revised to reflect that it may be used in unique circumstances and specialist input is required.

Lithium

The review found insufficient evidence for overall estimation of risk associated with use of lithium for all outcomes.

Complementary interventions

Of the three identified systematic reviews into omega-3 fatty acids, one found a decreased risk of preterm birth, an increased risk of prolonged pregnancy and no other harms. The other reviews found no harms.

No new evidence was identified on harms associated with St John’s Wort or Ginkgo biloba.

Transcranial magnetic stimulation

A single small RCT (n=26) was considered underpowered.

Members agreed to note in the Guideline that there is insufficient evidence to recommend for or against TMS.

Electroconvulsive therapy

No new evidence on harms associated with electroconvulsive therapy was identified.

Links between evidence and recommendations - evidence-to-decision frameworks

The recommendations in the Guideline are derived from those in the 2017 Australian Guideline, some of which were revised in the light of new evidence or to improve clarity. Recommendations from the 2017 Guideline that remain unchanged are not included in this discussion.

Screening and psychosocial assessment

The evidence-to-decision deliberations of the EWG for updated recommendations relating to psychosocial assessment and mental health screening are provided below:

Training for screening and psychosocial assessment

Table 7 GRADE Evidence-to-decision process for considering training for screening and psychosocial assessment (by the EWG)

| | | |
|-------------------------------|-----|---|
| i | CBR | <p>2017 recommendation: All health professionals providing care in the perinatal period should receive training in woman-centred communication skills, psychosocial assessment and culturally safe care.</p> <p>Revised recommendation: All health professionals providing care in the perinatal period should receive training in parent-centred communication skills, psychosocial assessment and culturally safe care.</p> |
| EVIDENCE-TO-DECISION-CRITERIA | | |
| Rationale for changes | | The EWG agreed to change the wording of CBR i from ‘woman-centred’ to ‘parent-centred’. This change was made to improve inclusiveness by expanding the recommendation to encompass all parents, not just the birthing parent. |

Abbreviations: CBR, consensus-based recommendation; EWG, Expert Working Group; GRADE, Grading of Recommendations, Assessment, Development and Evaluation.

Table 8 Summary of performance of depression screening tools in the antenatal period (2017 systematic review)

| TOOL | CONDITION | CUT-OFF | SENSITIVITY | SPECIFICITY | CERTAINTY |
|------------------------------|---------------------------|---------|--|--|-----------|
| Antenatal period | | | | | |
| EPDS | Major depression | ≥10 | 0.88 (0.89 to 0.94) | 0.88 (0.86 to 0.90) | High |
| | | ≥13 | 0.83 (0.76 to 0.88) | 0.90 (0.88 to 0.92) | |
| | Minor or major depression | ≥10 | 0.74 (0.65 to 0.82) | 0.86 (0.83 to 0.89) | Moderate |
| | | ≥13 | 0.61 (0.5 to 0.72) | 0.94 (0.92 to 0.96) | |
| K10 | Major depression | 6 | 0.75 (0.48 to 0.93) to 1.00 (0.88 to 1.00) | 0.54 (0.44 to 0.63) to 0.81 (0.74 to 0.86) | Low |
| PHQ-9 | Major depression | 9/10 | 0.74 (0.61 to 0.85) to 0.85 (0.66 to 0.96) | 0.73 (0.38 to 0.94) to 0.84 (0.81 to 0.87) | Low |
| | Minor or major depression | 9/10 | 0.75 (0.64 to 0.84) | 0.88 (0.85 to 0.90) | Very low |
| Whooley questions | Minor or major depression | - | 1.00 (0.80 to 1.00) | 0.68 (0.58 to 0.77) | Low |
| Whooley plus 'help' question | | | 0.59 (0.33 to 0.82) | 0.91 (0.77 to 0.98) | |
| Postnatal period | | | | | |
| EPDS | Major depression | ≥10 | 0.95 (0.92 to 0.97) | 0.82 (0.80 to 0.84) | High |
| | | ≥13 | 0.80 (0.77 to 0.83) | 0.93 (0.92 to 0.94) | |
| | Minor or major depression | ≥10 | 0.83 (0.81 to 0.86) | 0.85 (0.84 to 0.86) | High |
| | | ≥13 | 0.68 (0.66 to 0.71) | 0.92 (0.92 to 0.93) | |
| K10 | Minor or major depression | 6 | 0.85 (0.66 to 0.96) | 0.41 (0.25 to 0.59) | Low |
| PHQ-2 | Major depression | 2 or 3 | 0.77 (0.46 to 0.95) to 0.84 (0.71 to 0.94) | 0.59 (0.53 to 0.66) to 0.79 (0.75 to 0.83) | Low |
| | | 3 or 4 | 0.63 (0.32 to 0.86) | 0.79 (0.73 to 0.84) | |
| PHQ-9 | Major depression | simple | 0.82 (0.68 to 0.92) to 0.89 (0.80 to 0.95) | 0.65 (0.43 to 0.84) to 0.84 (0.80 to 0.87) | Very low |
| | | complex | 0.67 (0.51 to 0.80) | 0.92 (0.89 to 0.94) | |
| Whooley questions | Minor or major depression | - | 1.00 (0.81 to 1.00) | 0.64 (0.53 to 0.75) | Very low |
| | Major depression | | 1.00 (0.92 to 1.00) | 0.44 (0.39 to 0.49) | |
| Whooley plus 'help' question | Minor or major depression | - | 0.39 (0.17 to 0.64) | 1.00 (0.87 to 1.00) | - |

Source: (NICE 2014; updated 2020).

Table 9 Summary of findings related to the use of perinatal depression screening tools (2017 systematic review)

| TOOL(S) | TECHNICAL CHARACTERISTICS | | NON-TECHNICAL CHARACTERISTICS | | CLINICAL USEFULNESS | | |
|-------------------|---------------------------|------------------------|-------------------------------------|--|----------------------------------|----------------------------|-------------------------------|
| | Performance ¹ | Certainty ² | Ease of administration ³ | Language availability ⁴ & cultural sensitivity ⁵ | Acceptability ⁶ | Effectiveness ⁷ | Implementability ⁸ |
| EPDS | Antenatal: Acceptable | ●●●● High | High | Multiple languages Multiple populations | High | Good | High |
| | Postnatal: Acceptable | ●●●● High | | | | | |
| PHQ-9 | Antenatal: Uncertain | ●●○○ Low | High | English Western populations | Unknown but likely to be Good | Unknown | High |
| | Postnatal: Uncertain | ●●○○ Low | | | | | |
| Whooley questions | Antenatal: Uncertain | ●●○○ Low | High | English Western populations | Unknown but likely to be Good | Limited | High |
| | Postnatal: Uncertain | ●○○○ Very Low | | | | | |
| K10 | Antenatal: Uncertain | ●●○○ Low | High | English Western populations | Unknown but likely to be Good | Unknown | High |
| | Postnatal: Uncertain | ●○○○ Very Low | | | | | |

Footnotes:

- ¹ Performance defined as sensitivity, specificity, positive likelihood ratio, negative likelihood ratio (defined as Acceptable, Limited, or Uncertain).
- ² Certainty assessed according to GRADE and QUADAS-2 criteria (defined as High, Moderate, Low or Very Low).
- ³ Ease of administration was based on judgement regarding the number of items, and the time and complexity of administering and scoring the tool (rated as High, Moderate, or Low).
- ⁴ Language availability based on information from the included literature and the awareness of the EWG.
- ⁵ Cultural sensitivity was based on information from the included literature of any use in culturally and linguistically diverse populations.
- ⁶ Acceptability was based on the overall judgement of the EWG of the acceptability of each tool to women, health care professionals and/or the general public (rated as High, Moderate, Low or Unknown).
- ⁷ Effectiveness was defined as positive impact on depressive symptoms, services referred to or utilised, and impact on a woman's mental health (rated as High, Good, Limited, or Unknown).
- ⁸ Implementability was based on the overall judgement of the EWG based on available information regarding the training requirements for use of the tool and implications for current models of care and staff and service availability.

Table 10 **GRADE Evidence-to-decision process for considering screening for depression (by the EWG)**

| | | | |
|-----|-----|--|--------|
| 1 | EBR | <p>2017 recommendation: Use the EPDS to screen women for a possible depressive disorder in the perinatal period.</p> <p>Revised recommendation: Administer the EPDS to screen women for a possible depressive disorder in the perinatal period.</p> | Strong |
| 2 | EBR | <p>2017 recommendation: Arrange further assessment of perinatal woman with an EPDS score of 13 or more.</p> <p>Revised recommendation: Arrange further assessment of perinatal women with an EPDS score of 13 or more.</p> | Strong |
| iii | CBR | <p>2017 recommendation: For a woman with a positive score on Question 10 on the EPDS undertake or arrange immediate further assessment and, if there is any disclosure of suicidal ideation, take urgent action in accordance with local protocol/policy.</p> <p>Revised recommendation: 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.</p> | |
| vi | CBR | <p>2017 recommendation: For a woman with an EPDS score between 10 and 12, monitor and repeat the EPDS in 2–4 weeks as her score may increase subsequently.</p> <p>Revised recommendation: 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.</p> | |

EVIDENCE-TO-DECISION-CRITERIA

| | |
|---|--|
| <p>Benefits and harms</p> <p>Certainty of evidence</p> <p>Preferences and values, Resources, Equity, Acceptability and Feasibility</p> | <p>The 2017 recommendations were graded as strong based on evidence that:</p> <ul style="list-style-type: none"> the EPDS in the antenatal or postnatal period has moderate sensitivity and moderate-to-high specificity for identifying possible depression (moderate to high certainty) and that there is uncertainty about the adequacy of sensitivity or specificity of the PHQ (very low to low certainty), 'Whooley questions (very low quality) or K10 (low quality) a cut-off score of 13 or more is associated with the highest sensitivity, specificity and positive likelihood ratio and the lowest negative likelihood ratio for detecting possible major depression in the antenatal or postnatal period compared to other cut-off scores (high certainty evidence). <p>The EWG considered the new evidence presented in Section B4 of the technical report with regard to the technical performance, non-technical characteristics, and clinical usefulness (acceptability, effectiveness and implementability) of depression screening tools. The EWG acknowledged that the new evidence available for technical performance of depression screening tools was of very low to low certainty and did not have the power to change the strength or direction of the recommendation. The importance of using clinical judgement was highlighted by the EWG, which informed the changes to CBR vi. With the exception of the changes listed in this table, the EWG agreed that no further changes to the 2017 Guideline recommendations for depression screening were justified.</p> <p>When reviewing the evidence, the outcomes that the EWG considered important were the identification of women at greater risk of experiencing mental health issues or struggling with their emotional well-being (noting that outcomes such as reduced risk of postpartum depression at 6 months reflect availability of services rather than outcomes of screening per se). The grading of recommendations for screening as Strong reflects that the EWG is confident that the desirable effects of screening outweigh the undesirable effects. A strong recommendation implies that most people will be best served by being screened (with the underlying assumption that there are further services available). In addition, it was noted that the process of screening is invitational. Screening has broader aims than solely reducing the incidence of depression, with desirable effects in that it provides opportunities for people to be offered additional support and to discuss mental health and may generate data to support ideal service delivery.</p> |
|---|--|

| | |
|----------------------------------|--|
| Rationale for changes | <p>Grammatical changes were made to EBR 1 and EBR 2:</p> <ul style="list-style-type: none"> The EWG felt the word 'administer' was more appropriate to 'use' in the context of EBR 1 EBR 2 was amended to correct a spelling error (from woman to women) <p>Minor editorial changes to CBR iii were made in response to comments received through public consultation.</p> <p>Two changes were made to CBR vi. The word 'increase' was amended to 'change' to acknowledge that EPDS scores may increase or decrease over time. The second sentence was added by the EWG to reinforce the necessity of applying clinical judgement when implementing this recommendation.</p> |
| Implications for practice | <p>The use of the EPDS in the antenatal and postnatal period was recommended in the previous Perinatal Mental Health Guideline. It is hoped that this recommendation will continue to increase rates of screening, which may have implications for services providing further assessment or treatment in primary care settings, while potentially reducing the severity of disorders (through early identification) and hence need for medical/specialist care. The EPDS is a free tool for use in clinical and research settings, available in multiple languages, and the Guideline developer has incorporated it into digital screening, with permission from the authors.</p> |

Abbreviations: CBR, consensus-based recommendation; EBR, evidence-based recommendation; EPDS, Edinburgh Postnatal Depression Scale; EWG, Expert Working Group; GRADE, Grading of Recommendations, Assessment, Development and Evaluation.

Screening for anxiety

Table 11 GRADE Evidence-to-decision process for considering screening for anxiety (by the EWG)

| | | |
|-----------|------------|---|
| x | CBR | <p>2017 recommendation: Be aware that anxiety disorder is very common in the perinatal period and should be considered in the broader clinical assessment.</p> <p>Revised recommendation: Be aware that anxiety disorders are very common in the perinatal period and should be considered in the broader clinical assessment.</p> |
| xi | CBR | <p>2017 recommendation: As part of the clinical assessment, use anxiety items from screening tools (e.g. EPDS items 3, 4 and 5, Depression, Anxiety and Stress Scale (DASS) anxiety items and Kessler Psychological Distress Scale (K10) items 2, 3, 5 and 6) and relevant items in structured psychosocial assessment tools (e.g. Antenatal Risk Questionnaire (ANRQ)).</p> <p>Revised recommendation: As part of 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. ANRQ).</p> |

EVIDENCE-TO-DECISION-CRITERIA

| | |
|--|---|
| Benefits and harms Certainty of evidence Preferences and values, Resources, Equity, Acceptability and Feasibility | <p>The EWG considered the new evidence presented in Section B5 of the technical report with regard to the technical performance, non-technical characteristics, and clinical usefulness (acceptability and effectiveness) of anxiety screening tools. It was highlighted that the new evidence available for technical performance of anxiety screening tools was of very low to low certainty.</p> <p>One study of the ANRQ-R (<i>Austin, 2021</i>) was identified but was excluded due to the reference standard (SAGE-SR) not meeting the criteria outlined in the PICO.</p> <p>With the exception of the change to CBR xi, the EWG agreed that no further changes to the 2017 Guideline recommendations for anxiety screening were justified.</p> |
| Rationale for changes | <p>Minor editorial changes to CBR x were made in response to comments received through public consultation.</p> <p>Changes to CBR xi were made to simplify the recommendation, which the EWG acknowledged was more complex than necessary.</p> |

Abbreviations: ANRQ-R, Antenatal Risk Questionnaire - Revised; CBR, consensus-based recommendation; EBR, evidence-based recommendation; EPDS, Edinburgh Postnatal Depression Scale; EWG, Expert Working Group; GRADE, Grading of Recommendations, Assessment, Development and Evaluation; PICO, population-intervention-comparator-outcome; SAGE-SR, Series of Assessments for Guiding Evaluation - Self-Report.

Table 12 Summary of findings related to the use of perinatal psychosocial assessment tools

| TOOL(S) | TECHNICAL CHARACTERISTICS | | NON-TECHNICAL CHARACTERISTICS | | CLINICAL USEFULNESS | |
|---------|---------------------------|------------------------|-------------------------------------|---|----------------------------|-------------------------------|
| | Performance ¹ | Certainty ² | Ease of administration ³ | Language availability ⁴ & cultural sensitivity ⁵ | Acceptability ⁶ | Implementability ⁷ |
| ALPHA | Limited | ●●●○ Moderate | Moderate | English; Cultural sensitivity unknown | Moderate | Limited |
| ANRQ | Acceptable | ●●●○ Moderate | High | Translated and available digitally in >25 languages (including English) Cultural sensitivity unknown | High | High |
| PRQ | Acceptable | ●●●○ Moderate | Moderate | English; Cultural sensitivity unknown | Unknown | Limited |
| KMMS | Acceptable | ●●●● High | Low | English only; initially developed for Aboriginal women in the Kimberley region in Western Australia. Developed to be culturally specific to Kimberley Indigenous women. Being trialled in other Aboriginal and Torres Strait Islander population groups. | High | Context specific |

Footnotes:

- ¹ Performance defined as predictive accuracy, sensitivity, specificity, positive predictive value and/or negative predictive value (defined as Acceptable, Limited, or Unknown).
- ² Certainty assessed on the basis of study design and evidence of validity, reliability and applicability (defined as High, Moderate, Low or Very Low).
- ³ Ease of administration was based on judgement regarding the number of items, and the time and complexity of administering and scoring the tool (rated as High, Moderate, or Low).
- ⁴ Language availability based on information from the included literature and the awareness of the EWG.
- ⁵ Cultural sensitivity was based on information from the included literature of any use in culturally and linguistically diverse populations.
- ⁶ Acceptability was based on the overall judgement of the EWG of the acceptability of each tool to women, health care professionals and/or the general public (rated as High, Moderate, Low or Unknown).
- ⁷ Implementability was based on the overall judgement of the EWG based on available information regarding the training requirements for use of the tool and implications for current models of care and staff and service availability.

Table 13 **GRADE Evidence-to-decision process for considering the assessment of psychosocial risk (by the EWG)**

| | | | |
|------|-----|---|--------|
| 3 | EBR | <p>2017 recommendation: If using a tool to assess psychosocial risk, administer the ANRQ.</p> <p>Revised recommendation: Administer the ANRQ to assess a woman's psychosocial risk.</p> | Strong |
| xii | CBR | <p>2017 recommendation: Undertake psychosocial assessment in conjunction with a tool that screens for current symptoms of depression/anxiety (i.e. the EPDS).</p> <p>Revised recommendation: 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.</p> | |
| xiii | CBR | <p>2017 recommendation: Consider language and cultural appropriateness of any tool used to assess psychosocial risk.</p> <p>Revised recommendation: Use appropriately translated versions of the ANRQ. Consider language and cultural appropriateness of any tool used to assess psychosocial risk.</p> | |
| e | PP | <p>New: 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.</p> | |

EVIDENCE-TO-DECISION-CRITERIA

| | |
|---|---|
| <p>Benefits and harms</p> <p>Certainty of evidence</p> <p>Preferences and values, Resources, Equity, Acceptability and Feasibility</p> | <p>The 2017 recommendation was graded as strong based on evidence that the ANRQ has acceptable technical performance in identifying women at increased risk of depression or anxiety disorder (OR 6.3 [95% CI 3.5 to 11.5]), is acceptable among pregnant women (92-97%) and midwives (98%) and has a positive effect on the rates of referral for mental health assessment (moderate certainty evidence). In contrast, the ALPHA has limited psychometric properties, is moderately acceptable to users and is effective in identifying family violence (OR 2.7; 95%CI 1.1 to 6.9) and 'high level of psychosocial concern' on the health professional's part (OR 2.8; 95%CI 0.7 to 11.7) but does not have adequate capacity to identify women at increased risk of postnatal depression (moderate certainty evidence).</p> <p>The EWG considered the new evidence presented in Section B3 of the technical report with regard to the technical performance, non-technical characteristics, and clinical usefulness (acceptability and implementability) of psychosocial assessment tools. EWG members with a conflict of interest (such as authorship of an included study) were required to exit the videoconference during the discussions and voting.</p> <p>The EWG extensively discussed the reference standard criteria as defined in the PICO. This was specifically discussed in relation to a new study by Reilly (2022) evaluating the ANRQ-R, using SAGE-SR as a reference standard. It was noted that the requirement for a clinical/diagnostic interview to be used as a reference standard may result in larger, appropriately powered studies being excluded due to the practical limitations of conducting clinical/diagnostic interviews with a large sample size. Nevertheless, the EWG agreed that the study by Reilly (2022) should be excluded from the Evidence Review Update as the SAGE-SR did not meet the pre-specified PICO criteria for the reference standard. The EWG agreed that this important emerging evidence on the ANRQ-R would be noted in the Guideline narrative.</p> <p>The EWG reviewed new evidence on the Kimberley Mum's Mood Scale (KMMS), the acceptability and feasibility of web-based mental health screening (compared with paper-based screening), and the acceptability of the ANRQ and EPDS as part of routine psychosocial assessment. The EWG agreed that references to this evidence would be included in the Guideline narrative but did not specifically result in edits to existing recommendations from the 2017 Australian Guideline.</p> <p>The availability of language translations of the ANRQ was discussed by the EWG.</p> |
|---|---|

| | |
|----------------------------------|--|
| Rationale for changes | <p>The EWG agreed to change EBR 3 from 'If using a tool to assess psychosocial risk, administer the ANRQ' to 'Administer the ANRQ to assess a woman's psychosocial risk.' This change is consistent with the current psychosocial assessment program implemented in the Australian context. The change also aligns with cumulative moderate quality evidence that the ANRQ has acceptable technical performance, that it is easy to administer in practice, that it has high acceptability among pregnant women and midwives, and that it has a positive impact on the rates of referral for further mental health assessment.</p> <p>Changes to CBR xii were made in response to comments received through public consultation.</p> <p>The EWG agreed to change CBR xiii to include the additional wording 'Use appropriately translated versions of the ANRQ'. This change was made to align with changes to EBR 3, and in the context of increased availability of translated versions of the ANRQ since the 2017 Australian Guidelines were published. The addition of wording to recommend using an appropriately translated questionnaire is consistent with the findings of Nithianandan (2016), who identified the use of translated EPDS versions (for mental health screening) as an important environmental factor affecting the implementation of perinatal mental health screening in women of refugee background in Australia.</p> <p>Practice point e was added in response to comments received through public consultation.</p> |
| Implications for practice | <p>The ANRQ is a free tool for use in clinical and research settings and the Guideline developer has incorporated it into digital screening, with permission of the authors. The ANRQ has also been translated into multiple languages for use in the digital screening.</p> |

Abbreviations: ANRQ, Antenatal Risk Questionnaire; ANRQ-R, Antenatal Risk Questionnaire - Revised; CBR, consensus-based recommendation; EBR, evidence-based recommendation; EPDS, Edinburgh Postnatal Depression Scale; EWG, Expert Working Group; GRADE, Grading of Recommendations, Assessment, Development and Evaluation; PICO, population-intervention-comparator-outcome; SAGE-SR, Series of Assessments for Guiding Evaluation - Self-Report.

Assessing perinatal mental health in non-birthing partners

In addition to the systematic recent evidence on screening, prevention and treatment of mental health among women in the perinatal period, a separate review appraised the evidence on assessing perinatal mental health among fathers and non-birthing partners. A mixed-methods approach was used for the assessment of psychosocial assessment and screening tools for the detection of mental health problems. The approach included the use of systematic reviews of quantitative evidence (e.g., screening test performance), descriptions of non-technical characteristics of the tests (e.g., time to administer, complexity of scoring), and narrative reviews of acceptability, effectiveness and implementation issues associated with perinatal mental health assessment in non-birthing partners. A set of draft consensus-based recommendations was developed by the Fathers and Partners Expert Advisory Committee (FPEAC). These were subsequently revised for consistency with the approach used in the Guideline and reviewed and agreed by the EWG.

Mental health screening of fathers and partners

Table 14 GRADE Evidence-to-decision process for considering mental health screening in non-birthing partners (by the FPEAC)

| GRADE CATEGORY | |
|-----------------------------------|---|
| Benefits and harms | It is expected that screening for mental health problems will provide benefits in that potential issues that may require additional support will be highlighted. Screening should be undertaken within the context of having training and referral pathways in place. |
| Certainty of evidence | <p>A limited body of evidence was identified on the use of the mental health screening tools of interest to the FPEAC in fathers and non-birthing partners. All studies reporting diagnostic test accuracy included male partners only; no evidence was identified on the performance or acceptability of mental health screening tools in co-mothers, step-parents or other partners including non-binary parents.</p> <p>Although a small number of studies were identified suggesting the accuracy and acceptability of mental health screening tools in fathers in the postnatal period, overall there is insufficient published evidence to support whether any one specific tool (on a universal basis or targeted to high-risk groups) would be accurate, acceptable or effective at identifying mental health problems or improving outcomes. There was no evidence regarding screening tools for fathers/partners in the antenatal period.</p> <p>All studies that assessed diagnostic performance of mental health screening tools in the target population reported on the EPDS, which is likely a reflection of the wide use of this tool in perinatal clinical and research settings rather than it being the most appropriate tool for use in fathers and non-birthing partners. The included studies (7 in total) were all of low or very low quality and only one study, published in 2001, was conducted in Australia. Across the studies there was no consensus on the appropriate EPDS cut-off for screening fathers for mental health problems.</p> |
| Preferences and values, Resources | We have no systematically collected information regarding patients' preferences and values, or resources regarding mental health screening of fathers and non-birthing partners in the perinatal period. No concerns were raised regarding preferences and values or resources by the FPEAC during deliberations. |
| Equity | <p>We have no systematically collected evidence regarding impact on equity of mental health screening of fathers and non-birthing partners in the perinatal period.</p> <p>Further research is needed in a range of practice settings and with a range of stakeholders, including minority groups (minority ethnic parents, non-resident parents, step-parents, LGBTQI+ parents). The literature to date is largely focused on postnatal depression but anxiety and distress will also be important to address in the perinatal period.</p> |

| | |
|----------------------|---|
| Acceptability | <p>Implementation of mental health assessment for fathers and non-birthing partners into clinical practice depends on acceptability to both health professionals and parents.</p> <p>The Darwin review (the foundation review) noted that evidence regarding the acceptability of specific measures is limited but resonated with literature on acceptability in women, with timing of administration, time required to complete the assessment and clarity of wording being important considerations. However, there are also fundamental challenges to overcome if effective mental health screening is to be implemented in fathers and non-birthing parents.</p> <p>Further research is required to determine acceptability. Acceptability among health professionals is likely to be dependent on the availability of systems to support screening in fathers and partners. This is currently lacking in traditional maternity settings where the birthing mother/person is the registered client/patient.</p> |
| Feasibility | <p>The timing of screening using the EPDS was postnatal in all except two studies, which presented pooled data for antenatal and postnatal timepoints. The accuracy of screening fathers during pregnancy therefore remains unknown.</p> <p>There were a number of mental health screening tools that were considered however were deemed inappropriate due to their length and the time required for administration, additional training requirements and implementability across different settings.</p> |
| Rationale | <p>In formulating the recommendation, the FPEAC considered the context of mental health screening, existing training in mental health assessment tools, the timing of implementation and the need for training and support structures to support mental health screening.</p> |

| NO. | CONSENSUS-BASED RECOMMENDATIONS |
|---------------------------------------|--|
| Draft (developed by FPEAC) | Fathers and partners should be offered mental health screening in the perinatal period. |
| xiv | Offer non-birthing parents mental health screening in the perinatal period. |
| Draft (developed by FPEAC) | Given the absence of support for one specific screening tool it is not currently possible to universally recommend one screening tool over another. |
| xv | Given the absence of support for one specific screening tool it is not currently possible to universally recommend one screening tool over another. |
| Draft (developed by FPEAC) | Selection of screening tools should be in accordance with availability and competencies of clinicians to use a specific tool within specific settings. |
| xvi | Select screening tools in accordance with availability and competencies of health professionals to use a specific tool within specific settings. |
| Draft (developed by FPEAC) | The EPDS (with a lower cut-off score) and the K10 should be considered 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. |
| xvii | 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. |
| Draft (developed by FPEAC) | If using the EPDS, a lower cut-off score (ten or more) is recommended for men compared to women, noting responses to individual items. |
| xviii | When administering the EPDS to male parents, use a lower cut-off score (10 or more), noting responses to individual items. |
| Draft (developed by FPEAC) | The timing of mental health screening should be as early as practicable in pregnancy and from three to six months following the birth for fathers and partners. Repeat screening should be offered when clinically indicated. |
| xix | 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. |

Table 15 GRADE Evidence-to-decision process for considering the assessment of psychosocial risk among fathers and partners (by the FPEAC)

| GRADE CATEGORY | |
|---|--|
| Benefits and harms | No evidence-based conclusions can be drawn on the benefits and harms of using tools for perinatal psychosocial assessment of fathers and non-birthing partners. It is expected that screening for psychosocial risk factors (if supported by the setting) will provide benefits in that potential issues that may require additional support will be highlighted. The potential harms of screening are that it should not take place if there is no skilled workforce and there are no services available to assist should issues be identified. |
| Certainty of evidence | No evidence-based conclusions can be drawn on the most appropriate tools for perinatal psychosocial assessment of fathers and non-birthing partners due to the absence of specific tools developed. Overall, the existing evidence regarding the most appropriate methods for psychosocial assessment of (a) fathers or (b) non-birthing partners at risk of mental health problems in the perinatal period is insufficient and more research is needed. |
| Preferences and values, Resources, Equity | We have no systematically collected information regarding patients' preferences and values, resources or equity. Use of psychosocial assessment is expected to be affordable with no negative impact expected. |
| Acceptability | No studies were identified in the literature search that specifically reported on acceptability of psychosocial assessment tools in fathers or non-birthing partners in the perinatal period... Although the ANRQ appears to be attractive in terms of ease of administration and implementability, the language and domains covered in the tool may not be appropriate for fathers in its current form. |
| Feasibility | The use of psychosocial screening is likely to be feasible if there is extension of service infrastructure to support screening for fathers and partners. Although it is already widely used for mothers in the maternal child health setting, the mode/setting of delivery may be an important consideration as mothers tend to be in contact with health services throughout the perinatal period, whereas fathers and partners have sporadic contact. |
| Rationale | In formulating the recommendation, the FPEAC considered the suitability and need for adaption of existing psychosocial assessment tools, the timing of implementation and the need for training and support structures to support psychosocial assessment. |

| NO. | CONSENSUS-BASED RECOMMENDATIONS |
|-------------------------------|--|
| Draft (developed by FPEAC) | Fathers and partners should be offered psychosocial screening in the perinatal period. |
| xx | Offer non-birthing parents psychosocial screening in the perinatal period. |
| Draft (developed by FPEAC) | Fathers and partners identifying as male should be offered screening using the amended ANRQ/PNRQ screening tool. |
| xxi | Use the amended ANRQ/PNRQ screening tool for male non-birthing parents. |
| Draft (developed by FPEAC) | The ANRQ/PNRQ in its current form can be used for psychosocial screening of female non-birthing parents. |
| xxii | Use the ANRQ/PNRQ in its current form for psychosocial screening of non-birthing mothers. |

| | |
|---------------------------------------|---|
| Draft (developed by FPEAC) | For those not identifying as male or female, the existing version (for mothers) should be offered to the birthing parent, and the revised male version for non-birthing parent. |
| xxiii | 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. |
| Draft (developed by FPEAC) | The timing of psychosocial assessment should be as early as practicable in pregnancy and the postnatal period (in combination with mental health screening). |
| xxiv | Offer psychosocial assessment as early as practicable in pregnancy and the postnatal period (in combination with mental health screening). |

Assessing mother-infant interaction and the safety of the woman and infant and general principles in prevention and treatment

The EWG reviewed the recommendations from the 2017 Australian Guideline on assessing mother-infant interaction, assessing risk of suicide, supporting emotional health and well-being, general principles in prevention and treatment, general principles in the use of pharmacological treatments and postnatal care and support.

Assessing mother-infant interaction and safety of the infant

Table 16 Changes to practice point on women identified as at risk of suicide

| | | |
|----------|-----------|--|
| j | PP | <p>2017 wording: 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.</p> <p><i>(in response to comments received through public consultation)</i></p> <p>Revised wording: 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.</p> |
|----------|-----------|--|

Supporting emotional health and well-being

Table 17 Changes to practice point on healthy behaviours

| | | |
|----------|-----------|--|
| i | PP | <p>2017 wording: Provide parents in the perinatal period with advice on lifestyle issues and sleep, as well as assistance in planning how this advice can be incorporated into their daily activities during this time.</p> <p><i>(in response to comments received through public consultation)</i></p> <p>Revised wording: 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.</p> |
|----------|-----------|--|

Providing information and advice

Table 18 Changes to practice point on involving significant others

| | | |
|----------|-----------|---|
| n | PP | <p>2017 wording: 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.</p> <p><i>(in response to comments received through public consultation)</i></p> <p>Revised wording: If a woman gives informed consent, provide information to and involve her significant other(s) in discussions about her emotional well-being and care throughout the perinatal period.</p> |
|----------|-----------|---|

Planning care for women with mental health conditions

Table 19 Changes to practice point on planning care for women with mental health conditions

| | | |
|---|----|---|
| o | PP | <p>2017 wording: Provide advice about the risk of relapse during pregnancy and especially in the early postpartum period to women who have a new, existing or past mental health condition and are planning a pregnancy.</p> <p><i>(on advice from Prof Marie-Paule Austin)</i></p> <p>Revised wording: 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.</p> |
|---|----|---|

Use of pharmacological treatments

Table 20 Changes to practice points on use of pharmacological treatments

| | | |
|---|----|---|
| t | PP | <p>2017 wording: Ensure that women are aware of the risks of relapse associated with stopping medication and that, if a medication is ceased, this needs to be done gradually and with advice from the treating clinician.</p> <p><i>(on advice from Dr Tamara Cavenett)</i></p> <p>Revised wording: 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.</p> |
| v | PP | <p>2017 wording: Ideally, treatment with psychoactive medications during pregnancy would involve close liaison between a treating psychiatrist or where appropriate the woman's GP and her maternity care provider(s). In more complex cases, it is advisable to seek a second opinion from a perinatal psychiatrist.</p> <p><i>(in response to comments received through public consultation)</i></p> <p>Revised wording: 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.</p> |

Postnatal care and support

The EWG agreed with the deliberations of the Harms Expert Subcommittee detailed in the table below and therefore the following table represents the decisions of both the Harms Expert Subcommittee and the EWG.

Table 21 GRADE Evidence-to-decision process for postnatal care and support (by the EWG)

| | | |
|--|--|---|
| xxvii | CBR | 2017 recommendation: 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. Revised recommendation: 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. |
| EVIDENCE-TO-DECISION-CRITERIA | | |
| Benefits and harms | | |
| Certainty of evidence | | |
| Preferences and values, Resources, Equity, Acceptability and Feasibility | In amending this recommendation to include the wording ‘where possible’, the EWG acknowledged that it will not always be possible to implement this recommendation, and factors such as preferences, resources, acceptability and feasibility may impact on this decision. | |
| Rationale for recommendation | The EWG agreed to change EBR 3 from ‘If using a tool to assess psychosocial risk, administer the ANRQ’ to ‘The EWG agreed to the addition of the wording ‘where possible’ at the beginning of this CBR to acknowledge that implementing this recommendation will not be possible in all scenarios. | |

Abbreviations: CBR, consensus-based recommendation; EBR, evidence-based recommendation; EWG, Expert Working Group; GRADE, Grading of Recommendations, Assessment, Development and Evaluation.

Treatment and prevention interventions for depression and anxiety in the perinatal period

The following section describes the evidence-to-decision deliberations of the EWG and the Harms Expert Subcommittee in relation to treatment and prevention interventions for anxiety and depression in the perinatal period.

Psychosocial and psychological interventions

The EWG met on the 29 August 2022 and reviewed the 2017 Australian Guideline recommendations in the context of new evidence relating to the effectiveness of interventions for anxiety and depression in the perinatal period. For treatment interventions, the only evidence identified as suitable for full GRADE appraisal from the Evidence Review Update were in the categories of structured psychological interventions (8 RCTs on CBT, none on IPT) and online interventions (4 RCTs). There were no RCTs suitable to proceed to full GRADE appraisal for preventive interventions.

No new evidence relevant to structured psychoeducation or social support was identified. The heterogeneity of the studies of structured psychological interventions was discussed at the EWG meeting, as was the resulting inability to perform a meta-analysis of the studies. Based on analysis of the new evidence, the EWG agreed that there are no grounds to change the existing strong recommendation (EBR 6) for structured psychological interventions and agreed that the existing wording of the recommendation remains appropriate.

The EWG noted the importance of online interventions in the current Australian context, with increasing demand for and access to online interventions since the COVID-19 pandemic. The heterogeneity of the evidence for online interventions, and therefore unsuitability for meta-analysis was discussed. Following review of the evidence for online interventions, the EWG agreed that an evidence-based recommendation could not be made, however noted that reference to online interventions in the Guideline was necessary, and consideration would be made to including a new practice point or consensus-based recommendation on online interventions.

Table 22 Recommendations on psychosocial and psychological interventions - implications for practice

| | | | |
|---------------------------|-----|--|-------------|
| 4 | EBR | No change: Provide structured psychoeducation to women with symptoms of depression in the perinatal period. | Strong |
| Implications for practice | | The provision of structured psychoeducation was recommended in the previous version of this Guideline. The need for quality psychoeducational material for pregnant women, new mothers and their families available across maternity and healthcare settings remains. This has previously taken the form of education booklets and electronic information for consumers and family members, and more recently this has involved the development of the Ready to COPE App to deliver timely, relevant information throughout the perinatal period. The provision of such psychoeducation resources needs to be sustained, taking into account the needs of women from non-English speaking backgrounds. | |
| 5 | EBR | No change: Advise women with symptoms of depression in the postnatal period of the potential benefits of a social support group. | Conditional |
| Implications for practice | | Social support groups were recommended in the previous version of this Guideline. As these groups can play an important role in the prevention and/or adjunct to interventions, the need for continued provision of support groups (e.g. mothers' group) and the promotion of other quality support networks within community settings remains. | |
| 6 | EBR | <p>2017 wording: Recommend individual structured psychological interventions (cognitive behavioural therapy or interpersonal psychotherapy) to women with mild-to-moderate depression in the perinatal period.</p> <p>Revised wording: Recommend individual structured psychological interventions (cognitive behavioural therapy or interpersonal psychotherapy) to women with symptoms of depression in the perinatal period.</p> | Strong |
| Implications for practice | | Individual structured psychological interventions were recommended in the previous version of this Guideline. Continued provision of these interventions requires clear referral pathways for health professionals to refer women to suitably qualified health professionals and/or online treatments for the provision of timely recommended psychological treatments; and continued Medicare rebatable item numbers to ensure the continued provision of psychological services to women within the perinatal period. | |
| Rationale for changes | | <p>Submissions received through the public consultation process raised concerns about a lack of definition for 'mild-to-moderate' and the perception that women with more severe symptoms would not be offered psychological interventions. The evidence supporting the recommendation refers to 'women with symptoms or a diagnosis of depression' (<i>NICE 2014; updated 2020</i>). The recommendation has been revised to reflect this evidence base and address submission concerns regarding:</p> <ul style="list-style-type: none"> • definitions of mild, moderate and severe depression • the recommendation appearing to preclude psychological interventions for women with more severe depression • the need to include women's preferences. | |

| | | | |
|---------------------------|-----|--|-------------|
| 7 | EBR | No change: Advise women with depression or anxiety disorder in the postnatal period of the possible benefits of directive counselling. | Conditional |
| Implications for practice | | Directive counselling was recommended in the previous version of this Guideline. Continued provision of this intervention requires clear referral pathways for health professionals to refer women to suitably qualified health professionals and/or online treatments for the provision of timely recommended psychological treatments; and continued Medicare rebatable item numbers to ensure the continued provision of psychological services to women within the perinatal period. | |

Complementary therapies for depressive and anxiety disorders

The EWG agreed with the deliberations of the Harms Expert Subcommittee detailed in the table below and therefore the following table represents the decisions of both the Harms Expert Subcommittee and the EWG.

Table 23 GRADE Evidence-to-decision process for considering the harms from complementary therapies (by the Harms Expert Subcommittee)

| | | | |
|------|-----|--|-------------|
| 8 | EBR | No change: 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 |
| xxx | CBR | No change: Advise pregnant women that the evidence on potential harms to the fetus from St John's Wort is limited and uncertain and that use of this treatment during pregnancy is not recommended. | |
| xxxi | CBR | <p>2017 recommendation: Advise pregnant women that potential harms to the fetus from Ginkgo biloba have not been researched, and that use of this treatment during pregnancy is not recommended.</p> <p><i>(spelling correction)</i></p> <p>Revised recommendation: Advise pregnant women that potential harms to the fetus from Ginkgo biloba have not been researched, and that use of this treatment during pregnancy is not recommended.</p> | |

EVIDENCE-TO-DECISION-CRITERIA

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| Benefits and harms | The Harms Expert Subcommittee considered the information presented in Technical Report Part D for complementary therapies. Of the three identified reviews into omega-3 fatty acids, the Middleton Cochrane review (2018) found a decreased risk of preterm birth, an increased risk of prolonged pregnancy and no other harms. Middleton 2018 concluded that omega-3 supplementation during pregnancy is effective at reducing incidence of preterm birth, but probably increases the incidence of post-term pregnancies. No harms of omega-3 supplementation were reported in the other reviews (<i>Nevins et al. 2021 and Firouzabadi et al. 2022</i>). No new evidence was identified on harms associated with St John's Wort or Ginkgo biloba. |
| Certainty of evidence | The Harms Expert Subcommittee considered the information presented in Technical Report Part D for complementary therapies. Of the three identified reviews into omega-3 fatty acids, using AMSTAR 2, the overall confidence in the results of the reviews was high for Middleton 2018, moderate for Nevins 2021 and low for Firouzabadi 2022. No new evidence was identified on harms associated with St John's Wort or Ginkgo biloba. |

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| Preferences and values, Resources, Equity, Acceptability and Feasibility | We did not systematically collect evidence regarding patients' preferences and values, resources, equity, acceptability, and feasibility of using complementary therapies by pregnant or postnatal women, or women who are breastfeeding. No concerns were raised regarding preferences and values, resources, equity, acceptability, and feasibility by the Harms Expert Subcommittee. |
| Rationale for recommendation | The Harms Expert Subcommittee members agreed that the current wording of the recommendations is appropriate (other than an edit to the spelling of ginkgo biloba in Consensus Based Recommendation xxxi). |
| Implications for practice | This recommendation is unchanged since the previous version of the Guideline. It supports the need for quality information provision to women and families about the role of omega-3 fatty acid supplementation as part of psychoeducation (outlined above). |

Abbreviations: AMSTAR, A Measurement Tool to Assess systematic Reviews; CBR, consensus-based recommendation; EBR, evidence-based recommendation; GRADE, Grading of Recommendations, Assessment, Development and Evaluation.

Pharmacological treatments for depressive and anxiety disorders

The EWG agreed with the deliberations of the Harms Expert Subcommittee detailed in the tables below and therefore the following tables represent the decisions of both the Harms Expert Subcommittee and the EWG.

Table 24 GRADE Evidence-to-decision process for considering the harms from antidepressants (by the Harms Expert Subcommittee)

| | | | |
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| aa | PP | New: 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. | |
| 9 | EBR | 2017 wording: Consider the use of selective serotonin reuptake inhibitors (SSRIs) as first-line treatment for moderate-to-severe depression and/or anxiety in pregnant women. Revised wording: When prescribing antidepressants to pregnant women, consider SSRIs as first-line pharmacological treatment for depression and/or anxiety. | Conditional |
| bb | PP | 2017 wording: Before choosing a particular SSRI for pregnant women, consider the woman's past response to SSRI treatment, obstetric history (e.g., other risk factors for miscarriage or preterm birth) and any factors that may increase risk of adverse effects. Revised wording: 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. | |
| 10 | EBR | 2017 wording: Use SSRIs as first-line treatment for moderate-to-severe depression in postnatal women. Revised wording: When prescribing antidepressants to women in the postnatal period, use SSRIs as first-line pharmacological treatment for depression. | Strong |
| cc | PP | 2017 wording: Before prescribing SSRIs to women who are breastfeeding, consider the infant's health and gestational age at birth. Revised wording: Before prescribing antidepressants to women who are breastfeeding, consider the infant's health and gestational age at birth. | |

EVIDENCE-TO-DECISION-CRITERIA

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| Benefits and harms | <p>The grading of the 2017 recommendation on SSRIs in the postnatal period was based on high quality RCT evidence of efficacy in the general population; while there are few data on the efficacy of antidepressants in perinatal samples, the available evidence suggests that SSRI use may improve response and remission rate at 6–8 weeks. Although the perinatal-specific evidence is of very low quality, this recommendation was graded as ‘strong’ due to the minute exposure to these antidepressants through breast milk and the greater need to treat depression postnatally (given its effect on the woman’s ability to care for the infant and on mother–infant attachment).</p> <p>The Harms Expert Subcommittee considered the information presented in Technical Report Part D for antidepressants. They specifically noted that there is a lack of RCT evidence of benefits of antidepressants (for ethical reasons) but there is evidence from observational studies (e.g., improved mother–infant interaction), and evidence of harms associated with abrupt cessation of treatment due to pregnancy (e.g., suicide, and adverse effects on physical activity and nutrition). The Harms Expert Subcommittee agreed that the potential harms of the 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.</p> |
| Certainty of evidence | <p>The Harms Expert Subcommittee found that overall confounding was an issue across the studies included in the AHRQ review¹² because primary studies looking at harms of exposure to pharmacological agents during pregnancy are most likely to be observational studies (case-control studies, pregnancy registry studies, observational cohort studies, and secondary analyses of administrative databases). The AHRQ review¹³ found low confidence evidence for increased risk of postpartum haemorrhage, persistent pulmonary hypertension, and depression in the child with SSRI exposure, and moderate confidence evidence for increased risk of autism spectrum disorder (ASD), compared with no exposure. The Harms Expert Subcommittee noted serious issues regarding residual confounding around risk of ASD and depression in the child. There was insufficient evidence on comparisons between agents to make judgements on the direction of effect. The Harms Expert Subcommittee members noted that links between exposure and harms are unclear and may be attributable to confounding.</p> |
| Preferences and values, Resources, Equity, Acceptability and Feasibility | <p>We did not systematically collect evidence regarding patients’ preferences and values, resources, equity, acceptability, and feasibility of using antidepressants in pregnant or postnatal women, or those who are breastfeeding. The Harms Expert Subcommittee did not raise any concerns regarding patients’ preferences and values, resources, equity, acceptability, and feasibility of using antidepressants to treat depression or anxiety in women who are pregnant, postnatal or breastfeeding.</p> |
| Rationale for recommendation/s | <p>In formulating and editing the recommendations on antidepressants in pregnancy, the postnatal period, and in women who are breastfeeding, the Harms Expert Subcommittee acknowledged:</p> <ul style="list-style-type: none"> • There is a lack of RCT evidence for ethical reasons but there is evidence from observational studies of benefits of antidepressants (e.g. improved mother–infant interaction) and harms associated with abrupt cessation of treatment due to pregnancy (e.g. suicide, and adverse effects on physical activity and nutrition) • Links between exposure and adverse events are unclear and may be attributable to confounding • A practice point on the harms of failing to treat moderate-to-severe depression and/or anxiety should be included • The risk of postpartum haemorrhage should be included in practice point aa • Consensus-based recommendations and practice points should refer to antidepressants generally rather than SSRIs specifically • The new evidence on harms other than postpartum haemorrhage is too uncertain to be included in the Guideline. |

^{12, 13} Viswanathan, M., Middleton, J. C., Stuebe, A. M., Berkman, N. D., Goulding, A. N., McLaurin–Jiang, S., Dotson, A. B., Coker–Schwimmer, M., Baker, C., Voisin, C. E., Bann, C., Gaynes, B. N. (2021). Maternal, Fetal, and Child Outcomes of Mental Health Treatments in Women: A Meta-Analysis of Pharmacotherapy. *Psychiatric Research and Clinical Practice*, 3(3), 123–140.

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| Rationale for changes to EBRs 9 and 10 following public consultation | <p>Concerns raised through the public consultation process included:</p> <ul style="list-style-type: none"> the use of the classifications of symptoms as mild, moderate or severe, without these being defined the perception that treatment would be based on classification of symptoms (i.e. women with mild symptoms would only be offered psychological treatment and women with moderate-to-severe symptoms would only be offered pharmacological treatment) the need for treatment decisions to reflect women's preferences. <p>The inclusion of 'moderate-to-severe' in the recommendations was based on consensus not evidence, so has been taken out. First-line treatment has been qualified as first-line pharmacological treatment to remove the perception that psychological treatment is not a consideration. An additional clause has been added to the beginning of the recommendation to acknowledge that an agreement between treating health professional and woman is needed before a treatment decision is made.</p> |
| Implications for practice | The intent of these recommendations is unchanged since the previous version of the Guideline. They support the need for quality information provision to women and families about the safe and effective use of SSRIs in the perinatal period. |

Abbreviations: AHRQ, Agency for Healthcare Research and Quality; CBR, consensus-based recommendation; EBR, evidence-based recommendation; GRADE, Grading of Recommendations, Assessment, Development and Evaluation; RCT, randomized controlled trial; SSRI, selective serotonin reuptake inhibitor.

Table 25 **GRADE Evidence-to-decision process for considering the harms from benzodiazepines or z-drugs (by the Harms Expert Subcommittee)**

| | | |
|-------|-----|--|
| xxxii | CBR | <p>2017 recommendation: Consider the short-term use of benzodiazepines for treating moderate to severe symptoms of anxiety while awaiting onset of action of an SSRI or tricyclic antidepressant (TCA) in pregnant or postnatal women.</p> <p>Revised recommendation: Consider the short-term use of benzodiazepines for treating moderate-to-severe symptoms of anxiety while awaiting onset of action of an antidepressant in pregnant or postnatal women.</p> |
| ff | PP | <p><i>(in response to comments received through public consultation)</i></p> <p>New: Use caution in prescribing benzodiazepines in the perinatal period due to the risk of dependence, withdrawal in the neonate and sedation with breastfeeding.</p> |

EVIDENCE-TO-DECISION-CRITERIA

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| Benefits and harms | The Harms Expert Subcommittee considered the information presented in Technical Report Part D. The subcommittee agreed that the potential harms of the failure to use medication where indicated for moderate-to-severe depression and/or anxiety in pregnancy or postnatally, or those who are breastfeeding may affect mother-infant interaction, parenting, maternal health and well-being, and infant outcomes. |
| Certainty of evidence | The Harms Expert Subcommittee found that overall confounding was an issue across the studies included in the AHRQ review ¹⁴ as primary studies looking at harms of exposure to pharmacological agents during pregnancy are most likely to be observational studies (case-control studies, pregnancy registry studies, observational cohort studies, and secondary analyses of administrative databases). The AHRQ review ¹⁵ found the evidence on benzodiazepines was of low confidence or uncertain compared with no exposure. The AHRQ review found no eligible studies of the harms of benzodiazepines or z-drugs versus an active comparator. |

^{14, 15} Viswanathan, M., Middleton, J. C., Stuebe, A. M., Berkman, N. D., Goulding, A. N., McLaurin-Jiang, S., Dotson, A. B., Coker-Schwimmer, M., Baker, C., Voisin, C. E., Bann, C., Gaynes, B. N. (2021). Maternal, Fetal, and Child Outcomes of Mental Health Treatments in Women: A Meta-Analysis of Pharmacotherapy. *Psychiatric Research and Clinical Practice*, 3(3), 123-140.

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| Preferences and values, Resources, Equity, Acceptability and Feasibility | We did not systematically collect evidence regarding patients' preferences and values, resources, equity, acceptability, and feasibility of using benzodiazepines or z-drugs in pregnant or postnatal women, or those who are breastfeeding. The Harms Expert Subcommittee did not raise any concerns regarding patients' preferences and values, resources, equity, acceptability, and feasibility of using benzodiazepines or z-drugs in pregnant or postnatal women, or those who are breastfeeding. |
| Rationale for recommendation/s | The Harms Expert Subcommittee members agreed that the current wording of the practice points is appropriate, and no changes were suggested to practice points cc, dd or ee. The Harms Expert Subcommittee members noted that consensus-based recommendation xxxii should refer to antidepressants generally rather than SSRIs specifically. |

Abbreviations: AHRQ, Agency for Healthcare Research and Quality; CBR, consensus-based recommendation; EBR, evidence-based recommendation; GRADE, Grading of Recommendations, Assessment, Development and Evaluation; SSRI, selective serotonin reuptake inhibitor.

Pharmacological treatments for severe mental illness

The EWG agreed with the deliberations of the Harms Expert Subcommittee detailed in the tables below and therefore the following tables represent the decisions of both the Harms Expert Subcommittee and the EWG.

Table 26 GRADE Evidence-to-decision process for considering the harms from antipsychotic medications (by the Harms Expert Subcommittee)

| | | | |
|-------|-----|--|-------------|
| 11 | EBR | <p>2017 recommendation: Consider the use of antipsychotics for treating psychotic symptoms in pregnant women.</p> <p>Revised recommendation: Use antipsychotics to treat psychotic symptoms in pregnant women.</p> | Conditional |
| xxxiv | CBR | <p>2017 recommendation: Use caution when prescribing any antipsychotic to pregnant women, particularly for women with a propensity for weight gain and metabolic syndrome.</p> <p>Revised recommendation: Use caution when prescribing metabolic-inducing antipsychotics to pregnant women, due to the increased risk of gestational diabetes.</p> | |
| xxxv | CBR | <p>2017 recommendation: If women commence or continue antipsychotic treatment during pregnancy, monitor them for excessive weight gain and the development of gestational diabetes and refer them for advice on weight management as required.</p> <p>Revised recommendation: If women commence or continue metabolic-inducing antipsychotic treatment during pregnancy, consider earlier screening and monitoring for gestational diabetes.</p> | |
| xxxvi | CBR | <p>2017 recommendation: Do not initiate use of clozapine in pregnant women.</p> <p>Revised recommendation: If considering use of clozapine in pregnant women, seek specialist psychiatric consultation.</p> | |

EVIDENCE-TO-DECISION-CRITERIA

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| Benefits and harms | <p>The Harms Expert Subcommittee considered the information presented in Technical Report Part D for antipsychotic medications. The AHRQ review¹⁶ found insufficient evidence of the harms of antipsychotic use by pregnant or postnatal women, or women who are breastfeeding when compared to no exposure. The Harms Expert Subcommittee members noted that:</p> <ul style="list-style-type: none"> • Untreated psychosis is associated with relapse and adverse effects on pregnancy (e.g., stillbirth, poor antenatal attendance). • While there is no specific RCT evidence around efficacy in pregnancy, evidence from the general population supports the use of antipsychotics to treat psychosis (<i>Goulding 2022¹⁷ commentary</i>). This is based on relapse if untreated and the impacts of untreated psychosis in pregnant women (e.g., stillbirth, poor antenatal attendance). • Not all antipsychotics are associated with metabolic effects. • Clozapine may be considered for use in women who do not respond to other antipsychotics and specialist input would be required when considering its use. |
| Certainty of evidence | <p>The Harms Expert Subcommittee found that overall confounding was an issue across the studies included in the AHRQ review¹⁸ as primary studies looking at harms of exposure to pharmacological agents during pregnancy are most likely to be observational studies (case-control studies, pregnancy registry studies, observational cohort studies, and secondary analyses of administrative databases). The AHRQ review¹⁹ found insufficient evidence for overall estimation of risk for all outcomes when considering antipsychotics versus no exposure. The AHRQ review²⁰ found low confidence evidence of a lower risk of cardiac and major malformations for lamotrigine when compared with lithium.</p> |
| Preferences and values, Resources, Equity, Acceptability and Feasibility | <p>We did not systematically collect evidence regarding patients' preferences and values, resources, equity, acceptability, and feasibility of using antipsychotics by pregnant or postnatal women, or women who are breastfeeding. No concerns were raised regarding preferences and values, resources, equity, acceptability, and feasibility by the Harms Expert Subcommittee.</p> |
| Rationale for recommendation | <p>In editing the recommendations on the use of antipsychotics by pregnant, postnatal, or breastfeeding women, the Harms Expert Subcommittee members agreed that:</p> <ul style="list-style-type: none"> • Consensus-based recommendations xxiii and xxiv should be revised to specify metabolic-inducing antipsychotics and reflect the associated increased risk of gestational diabetes. • The consensus-based recommendation on clozapine use in pregnancy should be revised to reflect that it may be used in unique circumstances (where other treatments have failed) and that specialist psychiatric input is required. |
| Implications for practice | <p>This recommendation has been modified since the previous Guideline on the basis of adverse effects on pregnancy associated with relapse. This requires education of health professionals and women and their families and may lead to changes in practice amongst prescribing specialists.</p> |

Abbreviations: AHRQ, Agency for Healthcare Research and Quality; CBR, consensus-based recommendation; EBR, evidence-based recommendation; GRADE, Grading of Recommendations, Assessment, Development and Evaluation; RCT, randomized controlled trial.

^{16, 18, 19, 20} Viswanathan, M., Middleton, J. C., Stuebe, A. M., Berkman, N. D., Goulding, A. N., McLaurin-Jiang, S., Dotson, A. B., Coker-Schwimmer, M., Baker, C., Voisin, C. E., Bann, C., Gaynes, B. N. (2021). Maternal, Fetal, and Child Outcomes of Mental Health Treatments in Women: A Meta-Analysis of Pharmacotherapy. *Psychiatric Research and Clinical Practice*, 3(3), 123-140.

¹⁷ Goulding, A. N., Metz, T. D., Middleton, J. C., Hoffman, M. C., Miller, E. S., Simas, T. A. M., ... & Gaynes, B. N. (2022). Pharmacologic Treatment for Perinatal Mental Health Disorders. *Obstetrics & Gynecology*, 139(2), 297-303.

Table 27 **GRADE Evidence-to-decision process for considering the harms from anticonvulsant medications (by the Harms Expert Subcommittee)**

| | | | |
|------|-----|---|--------|
| gg | PP | <p>2017 recommendation: Use caution when prescribing any antipsychotic to pregnant women, particularly for women with a propensity for weight gain and metabolic syndrome.</p> <p><i>(on advice of Prof Megan Galbally)</i></p> <p>Revised recommendation: Use caution when prescribing metabolic-inducing antipsychotics to pregnant women, due to the increased risk of gestational diabetes.</p> | |
| 12 | EBR | <p>2017 recommendation: Do not prescribe sodium valproate to women of childbearing age.</p> <p>Revised recommendation: Do not prescribe sodium valproate to pregnant women.</p> | Strong |
| xxxi | CBR | <p>2017 recommendation: If anticonvulsants are prescribed to a woman who is breastfeeding, arrange close monitoring of the infant and specialist neonatologist consultation where possible.</p> <p>Revised recommendation: If prescribing lamotrigine to a woman who is breastfeeding, arrange close monitoring of the infant and specialist neonatologist consultation where possible.</p> | |

EVIDENCE-TO-DECISION-CRITERIA

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| Benefits and harms | The Harms Expert Subcommittee considered the information presented in Technical Report Part D for anticonvulsant medications. The AHRQ review ²¹ found insufficient evidence for overall estimation of risk of anticonvulsant medication use for all outcomes by pregnant or postnatal women, or women who are breastfeeding. |
| Certainty of evidence | The Harms Expert Subcommittee found that overall confounding was an issue across the studies included in the AHRQ review ²² as primary studies looking at harms of exposure to pharmacological agents during pregnancy are most likely to be observational studies (case-control studies, pregnancy registry studies, observational cohort studies, and secondary analyses of administrative databases). The AHRQ review ²³ found insufficient evidence for overall estimation of risk for all outcomes. |
| Preferences and values, Resources, Equity, Acceptability and Feasibility | We did not systematically collect evidence regarding patients' preferences and values, resources, equity, acceptability, and feasibility of using anticonvulsant medications by pregnant or postnatal women, or women who are breastfeeding. The Harms Expert Subcommittee did not raise any concerns regarding patients' preferences and values, resources, equity, acceptability, and feasibility of using anticonvulsant medication in pregnant or postnatal women, or women who are breastfeeding. |
| Rationale for recommendation | <p>In editing the recommendations on the use of antipsychotics by pregnant, postnatal, or breastfeeding women, the Harms Expert Subcommittee members agreed that:</p> <ul style="list-style-type: none"> • Consensus-based recommendations xxiii and xxiv should be revised to specify metabolic-inducing antipsychotics and reflect the associated increased risk of gestational diabetes. • The consensus-based recommendation on clozapine use in pregnancy should be revised to reflect that it may be used in unique circumstances (where other treatments have failed) and that specialist psychiatric input is required. |
| Implications for practice | This supports the need for education and training for health professionals about the danger of use of sodium valproate among women of childbearing age and provision of clear information to women. |

Abbreviations: AHRQ, Agency for Healthcare Research and Quality; CBR, consensus-based recommendation; EBR, evidence-based recommendation; GRADE, Grading of Recommendations, Assessment, Development and Evaluation.

^{21, 22, 23} Viswanathan, M., Middleton, J. C., Stuebe, A. M., Berkman, N. D., Goulding, A. N., McLaurin-Jiang, S., Dotson, A. B., Coker-Schwimmer, M., Baker, C., Voisin, C. E., Bann, C., Gaynes, B. N. (2021). Maternal, Fetal, and Child Outcomes of Mental Health Treatments in Women: A Meta-Analysis of Pharmacotherapy. *Psychiatric Research and Clinical Practice*, 3(3), 123-140.

Table 28 **GRADE Evidence-to-decision process for considering the harms from lithium
(by the Harms Expert Subcommittee)**

| | | |
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| xxxix | CBR | No change: If lithium is prescribed to pregnant women, ensure that maternal blood levels are closely monitored and that there is specialist psychiatric consultation. |
| kk | PP | 2017 wording: If lithium is prescribed to a pregnant woman, reduce the dose just prior to the onset of labour and aim to recommence treatment immediately after the birth at a pre-pregnancy dose. <i>(on advice of Prof Megan Galbally)</i> Revised recommendation: If lithium is prescribed to a pregnant woman, monitor lithium levels carefully and adjust individual dose prior to and after delivery. |
| xl | CBR | No change: Where possible, avoid the use of lithium in women who are breastfeeding. |

EVIDENCE-TO-DECISION-CRITERIA

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| Benefits and harms | The Harms Expert Subcommittee considered the information presented in Technical Report Part D for lithium. The AHRQ review ²⁴ found insufficient evidence for overall estimation of risk of lithium use for all outcomes compared with no exposure by pregnant or postnatal women, or women who are breastfeeding. The AHRQ review ²⁵ found low confidence evidence of a greater risk of cardiac and major malformations for lithium when compared with lamotrigine when used by pregnant or postnatal women, or women who are breastfeeding. |
| Certainty of evidence | The Harms Expert Subcommittee found that overall confounding was an issue across the studies included in the AHRQ review ²⁶ as primary studies looking at harms of exposure to pharmacological agents during pregnancy are most likely to be observational studies (case-control studies, pregnancy registry studies, observational cohort studies, and secondary analyses of administrative databases). The AHRQ review ²⁷ found that the evidence was insufficient for overall estimation of risk for all outcomes for lithium versus no exposure. |
| Preferences and values, Resources, Equity, Acceptability and Feasibility | We did not systematically collect evidence regarding patients' preferences and values, resources, equity, acceptability, and feasibility of using lithium by pregnant or postnatal women, or women who are breastfeeding. No concerns were raised regarding preferences and values, resources, equity, acceptability, and feasibility by the Harms Expert Subcommittee. |
| Rationale for recommendation | The Harms Expert Subcommittee members agreed that the current wording of the lithium recommendations is appropriate. |

^{24, 25, 26, 27} Viswanathan, M., Middleton, J. C., Stuebe, A. M., Berkman, N. D., Goulding, A. N., McLaurin-Jiang, S., Dotson, A. B., Coker-Schwimmer, M., Baker, C., Voisin, C. E., Bann, C., Gaynes, B. N. (2021). Maternal, Fetal, and Child Outcomes of Mental Health Treatments in Women: A Meta-Analysis of Pharmacotherapy. *Psychiatric Research and Clinical Practice*, 3(3), 123-140.

Physical interventions

Transcranial magnetic stimulation (TMS)

The EWG agreed with the deliberations of the Harms Expert Subcommittee detailed in the table below and therefore the following table represents the decisions of both the Harms Expert Subcommittee and the EWG.

Table 29 GRADE Evidence-to-decision process for considering the harms from TMS (by the Harms Expert Subcommittee)

| | |
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| Proposed Recommendations | None |
| Proposed Practice Points | None |
| EVIDENCE-TO-DECISION-CRITERIA | |
| Benefits and harms | The Harms Expert Subcommittee considered the information presented in Technical Report Part D for transcranial magnetic stimulation. One new primary study was identified in the literature search for the current evidence review update, but this study was not sufficiently powered to allow the sub-committee to make any judgements about the benefits and harms of transcranial magnetic stimulation. |
| Certainty of evidence | The Harms Expert Subcommittee considered the results of the evidence review update on transcranial magnetic stimulation and found that the one study identified was a single small RCT (n=26) that was underpowered. |
| Rationale for recommendation | Members agreed to note in the Guideline that there is insufficient evidence to recommend for or against the use of transcranial magnetic stimulation in pregnant or postnatal women, or women who are breastfeeding. |

Abbreviations: GRADE, Grading of Recommendations, Assessment, Development and Evaluation; RCT, randomized controlled trial.

Electroconvulsive therapy (ECT)

The EWG agreed with the deliberations of the Harms Expert Subcommittee detailed in the table below and therefore the following table represents the decisions of both the Harms Expert Subcommittee and the EWG.

Table 30 GRADE Evidence-to-decision process for considering the harms from ECT (by the Harms Expert Subcommittee)

| | | |
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| qq | PP | <p>2017 wording: In pregnant women, ECT should only be undertaken in conjunction with close fetal monitoring (using cardiotocography to monitor fetal heart rate) and access to specialist maternal-fetal medical support.</p> <p><i>(on advice of Prof Megan Galbally)</i></p> <p>Revised recommendation: In pregnant women, ECT should only be undertaken in conjunction with close fetal monitoring (using cardiotocography to monitor fetal heart rate), specialist pregnancy anaesthetic care and access to specialist maternal-fetal medical support.</p> |
| EVIDENCE-TO-DECISION-CRITERIA | | |
| Benefits and harms | The Harms Expert Subcommittee considered the information presented in Technical Report Part D for electroconvulsive therapy. No new primary studies on electroconvulsive therapy with concurrent controls were identified in the literature search for the current evidence review update. | |

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| Certainty of evidence | No new evidence was identified. |
| Rationale for recommendation | We did not systematically collect evidence regarding patients' preferences and values, resources, equity, acceptability, The Harms Expert Subcommittee members agreed that the current wording of the recommendations and practice point is appropriate, with further review by Prof Galbally requested. |

Abbreviations: CBR, consensus-based recommendation; ECT, electroconvulsive therapy; EBR, evidence-based recommendation; GRADE, Grading of Recommendations, Assessment, Development and Evaluation.

Screening and preventive strategies for birth trauma

The deliberations of the EWG in considering recommendations on prevention and treatment are outlined below.

Table 31 GRADE Evidence-to-decision process for birth trauma preventative strategies

| | | |
|---|--|--|
| xliii | CBR | Use routine psychosocial screening (e.g. Postnatal Risk Questionnaire) to gain knowledge about a woman's risk of experiencing birth as traumatic. |
| xliv | CBR | If post-traumatic symptoms persist beyond 3 months, consider referral to appropriate mental health professionals for further assessment and/or care. |
| EVIDENCE-TO-DECISION-CRITERIA | | |
| Benefits and harms | No evidence-based conclusions could be drawn on the benefits and harms of preventative strategies that protect against the development of postnatal post-traumatic stress disorder following a traumatic birth. The EWG agreed that the preventative methods proposed in the SA Health Guideline could benefit most or all women as they promote clear communication and informed decision making by the woman (if supported by the setting). The potential harms of the preventative strategies proposed in the SA Health Guideline are that they should not take place if no services are available to assist (e.g. if referral is identified). | |
| Certainty of evidence | No evidence-based conclusions could be drawn on the certainty of evidence on preventative strategies that protect against the development of postnatal post-traumatic stress disorder following a traumatic birth as a de novo evidence review was not undertaken to develop this chapter (rather, existing guideline recommendations were considered for use). The EWG noted evidence contained within source guidelines showed that good evidence is available regarding continuity of care (specifically that it can reduce intervention rates which may be important for preventing PTSD). | |
| Preferences and values, Resources, Equity, Acceptability and Feasibility | We did not systematically collect evidence regarding patients' preferences and values, resources, equity, acceptability, and feasibility of preventative strategies that protect against the development of postnatal post-traumatic stress disorder following a traumatic birth. The EWG commented that if supported by setting, preventative strategies are likely to be acceptable to women and health professionals. The EWG did not raise any concerns regarding feasibility of screening and prevention for PTSD following traumatic birth. The EWG noted that trauma-focused treatment needs to be delivered by specially trained health professionals, which raises issues of equity for women in rural and remote areas and Aboriginal and/or Torres Strait Islander women. | |

| | |
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| Rationale for recommendation | <p>In formulating the consensus recommendations on screening and referral, the EWG acknowledged the following:</p> <ul style="list-style-type: none"> • Births may be experienced as traumatic even when obstetrically straightforward and an event that is traumatic for one person may not be for another • Birth trauma can occur with or without PTSD and still cause associated distress • The term PTSD is commonly used by women to describe distress following birth trauma (noting that the distress is not PTSD) • The importance of psychosocial screening to identify those who might be at risk of developing PTSD • There are diagnostic tools available (e.g., The City Birth Trauma Scale is a questionnaire developed to measure birth-related post-traumatic stress disorder [PTSD]) • Trauma-informed care is an integral part of quality maternity care, and the importance of trauma-informed care should be noted in the narrative section of the birth trauma chapter • Preventative strategies should involve appropriate referral (rather than 'counselling' as stated in some source guidelines) • Unplanned intervention (including emergency caesarean section or instrumental birth) is associated with fear of subsequent birth and post-traumatic stress • There is evidence that continuity of care reduces intervention rates and is important for prevention of PTSD • Existing expectations of women about the birth play a role in the potential development of PTSD (e.g., if the birth itself didn't go as planned, if they were unable to adjust to being a parent) • Birth, social and cultural expectations can contribute to the perception of birth as traumatic. |
|-------------------------------------|---|

Psychosocial and psychological treatments following traumatic birth

Table 32 **GRADE Evidence-to-decision process for developing birth trauma treatment recommendations (psychosocial and psychological treatments)**

| | | |
|------|------------|---|
| xliv | CBR | Offer women who have post-traumatic stress disorder, which has resulted from a traumatic birth, a high-intensity psychological intervention (trauma-focused CBT or eye movement desensitisation and reprocessing [EMDR]). |
| xlvi | 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. |

EVIDENCE-TO-DECISION-CRITERIA

| | |
|---------------------------|---|
| Benefits and harms | <p>Only one source recommendation was evidence-based (Offer women with persistent post-traumatic stress disorder (PTSD) symptoms at 1 month referral to skilled professionals as per the NICE guidance on PTSD). Beyond this recommendation, no evidence-based conclusions could be drawn on the benefits and harms of general treatment strategies for postnatal post-traumatic stress disorder following a traumatic birth. The EWG concluded that most or all women will benefit from the general treatment strategies noted in the 2018 SA Health Guideline "Managing distress after traumatic birth" as they promote clear communication and informed decision making by the woman (if supported by the setting).</p> <p>The potential harms of the strategies proposed are that they should not take place if there are no services available to assist (e.g., if referral is identified).</p> <p>It is likely that the harms of single session, high-intensity psychological interventions with an explicit focus on 'reliving' the trauma outweighed the benefits (strong, do not do recommendation by NICE).</p> |
|---------------------------|---|

| | |
|---|--|
| Certainty of evidence | Not applicable. No evidence-based conclusions could be drawn on the certainty of evidence of treatment strategies for post-traumatic stress disorder following a traumatic birth as a de novo evidence review was not undertaken to develop this chapter (rather, existing guideline recommendations were considered for use). |
| Preferences and values, Resources, Equity, Acceptability and Feasibility | We did not systematically collected evidence regarding patients' preferences and values, resources, equity, acceptability, and feasibility of psychosocial and psychological treatments for PTSD following traumatic birth. The EWG commented that if supported by setting, psychosocial and psychological treatment strategies are likely to be acceptable to women and health professionals. The EWG did not raise any concerns regarding feasibility of psychosocial and psychological treatment strategies for PTSD following traumatic birth. The EWG noted that EMDR requires trained health professionals which raises issues of equity for women in rural and remote areas and Aboriginal and/or Torres Strait Islander women. |
| Rationale for recommendation | <p>In formulating the consensus recommendations on psychosocial and psychological interventions for PTSD following traumatic birth, the EWG acknowledged that EMDR may be contraindicated in complex PTSD, and that most psychologists are not trained in EMDR.</p> <p>Members recommended that the NICE 2014 recommendation on EMDR be used as a source recommendation but to keep text general (i.e., don't specify the number of EMDR sessions).</p> <p>Both recommendations were adopted with minor changes from the NICE 2014 Guideline Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance (recommendation 1.9.5 and 1.9.6).</p> |

Pharmacological treatments following traumatic birth

Table 33 **GRADE Evidence-to-decision process for developing birth trauma treatment recommendations (pharmacological treatments)**

| | | |
|---|---|--|
| xlvi | CBR | Depending upon the woman's post-traumatic stress symptoms, consider the use of pharmacological treatments. |
| EVIDENCE-TO-DECISION-CRITERIA | | |
| Benefits and harms | | |
| Certainty of evidence | | |
| Preferences and values, Resources, Equity, Acceptability and Feasibility | Members noted that pharmacological treatment options for PTSD are the same as those available for anxiety and to refer to that section of the Guideline. | |
| Rationale for recommendation | <p>In formulating the consensus recommendations on pharmacological treatment interventions for PTSD following traumatic birth, the EWG acknowledged:</p> <ul style="list-style-type: none"> • PTSD is a severe anxiety disorder and treatment involves use of selective serotonin reuptake inhibitors (SSRIs) or tricyclic antidepressant (TCAs), with TCAs used less commonly as SSRIs have a better side effect profile • Depending upon the patient's symptomology, consider using pharmacological treatments • A combination of behavioural therapy and pharmacotherapy outperforms either therapy alone; a stepped approach may be needed (e.g., psychological or combined therapy [psychological and pharmacological]) • Refer to the interventions for anxiety section as these interventions will be the same for PTSD. | |

External review

External review, including methodological review, independent AGREE appraisal and independent peer review, was conducted in parallel with public consultation. No substantive changes that had not arisen through public consultation were suggested through this process.

Updating procedures

The developer is aware of the current requirement of the NHMRC for Guidelines to be updated at an interval no greater than 5 years. The developer commits to this timeframe, subject to appropriate funding. However, given the rapid emergence of relevant evidence in recent years, the developer is exploring ways in which the Guideline might be updated within a shorter timeframe, ideally in response to the publication of evidence that has the potential to change current recommendations or inform the development of new recommendations. The developer plans to update the current Guideline with methodology consistent with the principles and standards of the NHMRC current at the time of update.

B4 Clarity of presentation

Specific and unambiguous recommendations

The evidence-based and consensus-based recommendations were worded based on the following principles:

- recommendations are succinct and action-oriented
- the action recommended is clearly articulated and matches the strength of the body of evidence
- women to whom the recommendation relates are identified
- where relevant, timing of the action is included.

Where there is uncertainty about the best care options, this is outlined in the text.

Management options

The Guideline addresses multiple management options and these are clearly articulated via the structure of the Guideline and the wording of the recommendations and practice points.

Identifiable key recommendations

The evidence-based recommendations, consensus-based recommendations and practice points are clearly identified by colour coding and use of separate numbering systems. The strength of the evidence is also clearly identified. A summary of recommendations is included.

B5 Applicability

Facilitators and barriers

Facilitators

There are a number of facilitators to Guideline application which include the following:

- **Engagement of key stakeholders in the Guideline development** - Peak bodies that provide aspects of perinatal health and mental health care have been involved in the development of the Guideline from the outset.
- **The infrastructure of peak bodies** - Each of the Colleges will play a key role in communicating the Guideline to their members and advocating for its implementation through communication with College members in newsletters, academic publications in journals and presentation at conferences.
- **The infrastructure of the health system** - The framework of maternity, postnatal and primary care provision provides a vehicle for all aspects of Guideline implementation from consumer education through to screening and assessment and treatment provision. The health and community care landscape has been taken into account when considering the Guideline application across maternity, postnatal, general practice, public and private healthcare settings as well as the range of services available across jurisdictions.
- **The history of the National Perinatal Depression Initiative (NPDI)** - The Commonwealth Government's investment into the NPDI with States and Territories (2008-13) has provided some valuable history and infrastructure to implementation of the Guideline. Current investment is variable across States and Territories. Awareness of the state of play across each jurisdiction and ongoing relationships and collaboration with key Commonwealth and State Government and policy stakeholders provides an opportunity to continue to advocate and seek support for national Guideline implementation.

- **The development of a perinatal mental health website to house all information for consumers, carers and health professions** - COPE (Guideline developer) has been established to provide a dedicated focus on perinatal mental health. As part of this work, an extensive **website** has been developed to provide best practice information for consumers, carers and health professionals. The website will be updated to reflect the latest evidence for depression, anxiety, bipolar disorder and postpartum psychosis, and be expanded to include the additional mental health conditions that have been addressed in the current Guideline. In addition, this website will include all factsheets and screening aids (companion documents) and house the online training program (see below).
- **The development of a free, online, accredited training program for health professionals** - To support implementation, a free online training program will accompany the release of the Guideline by the Guideline developer (COPE). This will facilitate education for front-line health professionals and include coverage of all Guideline recommendations and practice points. In addition, all companion documents that have been developed for health professionals and consumers/carers will be embedded into the online program to direct people to specific information on each topic.
- **Innovative support for consumers and carers** - As much of the Guideline focus is on the need for education and information provision for consumers, emotional and mental health information relative to each stage in the perinatal period, as well as information and links to further information and factsheets derived from the Guideline are available **online** and as a free mobile application (The Ready to COPE App).
- **Innovative technology to facilitate screening in accordance with the Guideline** - As one of the greatest barriers to screening is time taken to do screening within tight maternity and postnatal appointments, the Guideline developer has developed a **digital screening platform** that allows screening to be undertaken electronically. Screening can be done privately by the patient on their mobile phone prior to, or at the appointment (in the waiting room or consultation). The feasibility trials and subsequent implementation across a range of primary, maternity and postnatal healthcare settings demonstrate the ability of the platform (iCOPE) to save time, reduce language barriers, improve screening rates and encourage disclosure. Programming of any additional tools recommended in the Guideline onto the iCOPE Platform will also facilitate their application. Furthermore, the automated production of instant clinical reports at the time of screening serves to guide health professionals in best practice with respect to screening outcomes and referral pathways. Consumers also can also access a tailored report (via email or SMS) detailing outcomes and referring to more information on the COPE website. At the time of writing the Guideline, the iCOPE tools and patient reports are available in 25 different languages.

Barriers

Barriers to application include the following:

- **Low screening in the private sector** - The greatest barriers to implementation are likely to be found in the private system, as many specialist obstetricians do not prioritise perinatal mental health and focus on physical health. Medicare item numbers aim to increase rates of screening and early detection of mental health problems and women at risk.
- **Lack of time to undertake screening and assessment** - As detailed above, time is a barrier and hence this is addressed through the selection of brief assessment tools and the digitisation of screening to improve screening rates, times, accuracy and inclusiveness.
- **Barriers among women** - Barriers among women include stigma, significant others normalising their emotional difficulties, desiring to manage mental health problems on their own, preferring to discuss feelings with significant others, not knowing what emotions are 'normal' and perceiving that the health professional is disinterested or lacks time. This may be improved by the provision of timely, relevant information and education about emotional and mental health in the perinatal period through the Ready to COPE App. Digital screening via the patient's phone also increases privacy and encourages disclosure at the point of screening.
- **Lack of validated screening tools for women of non-English-speaking backgrounds** - Screening is often not available, accurate or appropriately administered for women of non-English speaking backgrounds due to the lack of validated screening tools in other languages, and/or the accuracies and costs associated with interpreter services. This is improved through the provision and constant expansion of the iCOPE Digital screening platform in multiple languages.
- **Limited uptake of referral** - Research suggests that only half of women who screen positive follow up with a subsequent mental health assessment and 30-85% do not engage in treatment. This may be improved by consumers as well as health professionals having access to timely and appropriate referral pathways, including the provision of bulk-billing and telehealth services.

- **Workforce shortages** – There is continued demand for services across the healthcare and mental healthcare sector. There is a need to ensure the provision of specialist workforce training and service provision to build the capacity of the workforce to ensure access to timely and identification and appropriate referral.

Implementation advice/tools

In addition to deploying a range of approaches to raise awareness and ensure easy access to the Guideline, a range of engaging and innovative tools and mediums will be used to disseminate the contents of the Guideline across health professional groups, consumers and carers.

Health professionals

- Currently all Guideline information for health professionals is hosted under a specific tab on the **COPE website** as well as being housed on the Commonwealth Department of Health and Aged Care website. This will be updated and expanded to reflect changes to the Guideline.
- A range of companion documents for health professionals will be developed to enable easy access and reference to particular elements of the Guideline, as relevant to the respective professional bodies. This is likely to include a range of fact sheets to summarise key recommendations and practice points. These resources will be promoted widely across all College memberships and made available through COPE and College websites.
- The development of an online (accredited) training program to inform and educate health professionals about the Guideline recommendations and practice points. This **online training program** will be promoted widely across all College memberships.

Consumers and carers

- All information currently contained on the **COPE website** is underpinned by the previous Clinical Practice Guideline. As such, all website content will be reviewed to ensure it accurately reflects the new Guideline and directs people to access the Guideline and companion documents.
- The development, promotion and dissemination of companion documents for consumers and carers will facilitate the dissemination of Guideline information in a succinct and digestible format for consumers and carers.
- Ready to COPE, an innovative e-guide for consumers to receive relevant information throughout pregnancy and the postnatal period has been developed and widely disseminated. All information pertaining to mental health in the app is underpinned by the Clinical Practice Guideline, and provides an engaging and innovative approach to information dissemination for consumers and carers. The Ready to COPE guide can be accessed free of charge in Australia **online** or downloaded from the App Store or Google Play (Ready to COPE) for expectant and new mothers, fathers and non-birthing mothers.

Resource implications

The recommendations are considered to have a low requirement for additional resourcing. This is because the recommendations encompass psychometric tools or treatments that are already in use in clinical care in Australia. If anything, it is possible that the systematic use of psychosocial assessment and screening for depression and anxiety in the perinatal period will result in cost-savings from a whole of health system or societal perspective.

Monitoring/auditing criteria

As the peak body for perinatal mental health in Australia, COPE will continue to consult with service providers nationally to ensure the dissemination and application of the Clinical Guideline across the country. For those utilising digital screening, this will enable the monitoring of screening rates and outcomes across sites and settings in real time. It is noted that the ability to measure uptake of screening across and within jurisdictions will be crucial for designing and applying implementation strategies.

Further the integration of clinical advice into the clinical reporting facilitated by the iCOPE platform will serve to inform and guide best practice by the health professionals.

COPE will continue to liaise with representatives of all states and territories involved in the implementation of perinatal mental health initiatives.

B6 Editorial independence

Funding body

Financial support

COPE acknowledges that the total amount of financial support of \$750,000 plus GST for the development of this Guideline was received from the Commonwealth Department of Health and Aged Care.

Separate funding of \$50,000 plus GST was received from the Commonwealth Department of Health and Aged Care for work on perinatal mental health assessment of fathers and non-birthing partners. As the two projects were concurrent, the same process was followed.

Editorial independence from funders – The commissioning of the Guideline development to COPE as the national peak body in perinatal mental health ensures editorial independence from the Commonwealth as the funding body.

Competing interests

Processes used for declaration and management of competing interests

At the outset of the Guideline development process, all representatives were informed of the importance of managing competing interests and ensuring that any potential conflicts of interest were identified in advance of any meeting (as evidenced in meeting minutes). Processes put in place to manage any potential conflicts of interest were as follows:

- All EWG members and proxies involved in the Guideline development process were required to complete a Declaration of Interest Form (as per the NHMRC requirements). These signed and scanned forms were reviewed by the Co-Chairs of the EWG and are held by the Guideline developer.
- On sending out agenda papers, EWG members were informed of the arising agenda items and asked to notify the Chairperson in advance of the meeting of any potential conflicts of interest that had arisen since the most recent meeting.
- Any arising conflicts of interest were adjudicated by the Chair or a nominated Co-Chair. When a conflict of interest was declared by a EWG member, he or she was invited to take part and contribute to discussions but was asked to exit the videoconference during discussion and when recommendations were being formed. A conflict of interest held by the Chair was managed by the Co-Chair and the area of conflict clearly stated. The same provisions as for other members were applied.
- If a conflict of interest was deemed to be material prior to a meeting, the member was asked to continue to contribute to the committee, with the above measures taken to limit the introduction of bias.

There was only one instance of a possible competing interest – the review of a clinical psychometric instrument (the ANRQ), which was developed by two of the expert working group members. This was made known to all members of the EWG at the outset of discussions. To address this issue, these members of the group were involved in the initial discussion of all available psychometric instruments but not in further discussion or the decision-making process.

Table 34 **Competing interests of EWG members**

| REPRESENTATIVE | COMPETING INTEREST |
|---------------------------|---|
| Dr Nicole Highet | Developer of online screening tool and consumer education resources (Ready to COPE) |
| Prof Marie-Paule Austin | Has published in the area of screening and psychosocial assessment Developed the Antenatal Risk Questionnaire (ANRQ) |
| Dr Nicole Hall | Nil |
| Dr Suzanne Higgins | Nil |
| Ms Tamara Cavenett | Nil |
| Denise McDonald | Nil |
| Julie Borninkhof | Nil |
| Dr Rachael Hickinbotham | Nil |
| Dr Jan Taylor | Nil |
| Professor Rhonda Marriott | Nil |
| Dr Nicole Reilly | Has published in the area of screening and psychosocial assessment Developed the Antenatal Risk Questionnaire (ANRQ) |
| Sam Moses | Nil |
| Ariane Beeston | Nil |

Public consultation

The NHMRC Act, 1992 (as amended), requires that the draft Guideline be released for a 30-day public consultation, so that the final Guideline can be submitted for approval by the CEO of the NHMRC, under Item 14A Approval by CEO of Guidelines for third parties, under the Act.

The draft Guideline was released for a 60-day public consultation. While a 30-day consultation is required in Section 14A of the NHMRC Act 1992 and accompanying regulations, it was agreed to hold a longer consultation period due to the consultation period coinciding with the summer break, which may affect the ability of some individuals to provide a submission. The public consultation began on 7 November 2022 and formally ended on 7 January 2023. Some additional submissions were accepted after this date, with the final submission accepted on 23 January 2023.

The consultation draft was disseminated through COPE company members:

- Australian College of Mental Health Nurses (ACMHN)
- Australian College of Midwives (ACM)
- Australian Psychological Society (APS)
- Maternal Child and Family Health Nursing Association (MCaFNA)
- Perinatal Anxiety and Depression Australia (PANDA)
- Royal Australian College of General Practitioners (RACGP)
- Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG)
- Royal Australian and New Zealand College of Psychiatrists (RANZCP)
- The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM).

These key stakeholders were contacted via email and directed to the COPE website where papers could be accessed. Stakeholders were also asked to forward the information to other contacts who may be interested. In addition COPE promoted the public consultation process via their Facebook posts.

Representatives of state and territory health departments were also contacted and advised of the public consultation.

Of the 27 submissions received, 12 were from health professionals, 3 were from divisions of state/territory/Commonwealth health departments, 3 were from professional colleges/associations, 2 were from research groups, 6 were from non-government organisations and one was withdrawn.

The submissions provided useful feedback that enabled the EWG to expand on some areas in the background sections of the Guideline, including further understanding of the experiences of women from Aboriginal and/or Torres Strait Islander communities, rural and remote areas, women experiencing pregnancy in adolescence and LGBTQI+ people. Additional information on the prevalence and experience of psychological birth trauma was also received.

Feedback on other areas of the Guideline (concerning screening, prevention and treatment) allowed a more nuanced discussion around the evidence, including:

The consultation draft was disseminated through COPE company members:

- enhanced understanding of depression screening and psychosocial assessment in Aboriginal and/or Torres Strait Islander women and migrant and refugee women
- greater emphasis on enquiry about personal and partner use of drugs and alcohol and family violence
- revision of language around health behaviours
- additional indicators of potential difficulties in the mother-infant interaction
- greater emphasis on postpartum psychosis
- expanded discussion on psychological birth trauma.

Key concerns regarding the recommendations were:

- the use of the classifications of symptoms as mild, moderate or severe, without these being defined
- the perception that treatment would be based on classification of symptoms (i.e. women with mild symptoms would only be offered psychological treatment and women with moderate-to-severe symptoms would only be offered pharmacological treatment)
- the need for treatment decisions to reflect women's preferences
- the strength of the evidence underlying recommendations on screening for depression using the EPDS, psychosocial assessment using the ANRQ and SSRI use in the postnatal period.

The inclusion of 'moderate-to-severe' in the recommendations was based on consensus not evidence, so the recommendations have been modified to reflect this. First-line treatment has been qualified as first-line pharmacological treatment to remove the perception that psychological treatment is not a consideration. As reflecting women's preferences is not part of the evidence base, additional text has been included in the narrative to acknowledge that an agreement between treating health professional and the woman is needed before a treatment decision is made.

| | | | |
|----|-----|--|-------------|
| 9 | EBR | <p>2017 wording: Consider the use of selective serotonin reuptake inhibitors (SSRIs) as first-line treatment for moderate-to-severe depression and/or anxiety in pregnant women.</p> <p>Revised wording: When prescribing antidepressants to pregnant women, consider SSRIs as first-line pharmacological treatment for depression and/or anxiety.</p> | Conditional |
| 10 | EBR | <p>2017 wording: Use SSRIs as first-line treatment for moderate-to-severe depression in postnatal women.</p> <p>Revised wording: When prescribing antidepressants to women in the postnatal period, use SSRIs as first-line pharmacological treatment for depression.</p> | Strong |

In response to comments on the strength of the evidence, additional information has been included in the relevant sections and Appendix B3:

- to clarify that the foundation for the evidence base is the 2017 technical report, with the new evidence lacking the certainty to change the strength or direction of the recommendation
- to provide further details on the links between 2017 evidence and recommendations.

For EPDS screening, comment has also been included on the outcomes considered important by the EWG in reviewing the evidence.

Dissemination and implementation

As Australia's peak body in Perinatal Mental Health, the Centre of Perinatal Excellence will provide leadership and collaborate with its membership to support and promote the implementation of the updated Guideline.

The final complete Guideline, together with a series of companion documents and resources (see above), will be disseminated broadly through the implementation of the following strategies:

Overarching

- Production of Guideline and companion documents for health professionals and consumers, which will be available from the COPE website.
- Placement of Guideline on key websites (COPE, Colleges, PANDA and the Commonwealth Government).
- E-dissemination of the Guideline through all professional bodies.
- National and targeted Media releases to announce the release of the new Perinatal Guideline.

Health Professionals (targeted)

- Writing of newsletters and articles to be disseminated across all professional bodies (COPE Membership) to inform respective college members of the new Guideline and where and how to access them.
- Presentation of key recommendations at key meetings/conferences.
- Publication of journal articles for journals commonly referred to by health practitioners.

Consumers and carers (targeted)

- Promotion of key recommendations of interest for consumers across broad and targeted media (including broad-span and social media channels).
- Education of all staff at the PANDA Helpline regarding the key recommendations and the implications for advice to consumers who may be calling the helpline.
- The development of targeted social media to promote key messages and direct consumers to the Guideline and companion documents.
- Placement and links to Guideline and companion documents on partner organisation websites (e.g. beyondblue; PANDA; Pregnancy, Birth and Baby; Healthshare; Gidget Foundation Australia).

C Psychosocial assessment and screening tools

The following pages include tools for use in psychosocial assessment and screening for depression. These are followed by guides to scoring the tools.

Edinburgh Postnatal Depression Scale (EPDS)

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

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Edinburgh Postnatal Depression Scale Scoring Template

Edinburgh Postnatal Depression Scale (EPDS)

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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

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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

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Antenatal (Psychosocial) Risk Questionnaire Instructions

Antenatal Risk Questionnaire (ANRQ) Clinician Information and Scoring Template



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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 postnatally¹. 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.

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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

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Antenatal (Psychosocial) Risk Questionnaire for Antenatal Assessment

Antenatal (Psychosocial) Risk Questionnaire (ANRQ) – Client

V.2004 (Updated 2017) © M-P Austin



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

Yes

☐ If No, skip to Q1.c.

☐ 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

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: _____

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
☐

Yes
☐

☐ If No, skip to Q4.

☐ 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

V.2004 (Updated 2017) © M-P Austin



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 | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

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 | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

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 | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | |

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

| | | |
|--------------------------|--------------------------|--------------------------|
| No | Yes | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | |

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 | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

And finally...

Do you feel safe with your current partner?

| | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Not at all | A little | Somewhat | Quite a lot | Very much | No partner |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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 |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

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Antenatal (Psychosocial) Risk Questionnaire for Postnatal Assessment

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

V.2004 (Updated 2017) © M-P Austin



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 ☐ Yes ☐

If No, skip to Q1.c.

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

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: _____

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 ☐ Yes ☐

If No, skip to Q4.

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 ☐

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

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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 | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

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 | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

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 | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | |

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

| | | |
|--------------------------|--------------------------|--------------------------|
| No | Yes | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | |

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 | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

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 | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

Has your experience of parenting this baby been a positive one?

| | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Not at all | A little | Somewhat | Quite a lot | Very much | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

Overall, has your baby been unsettled or feeding poorly?

| | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Not at all | A little | Somewhat | Quite a lot | Very much | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

And finally...

Do you feel safe with your current partner?

| | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Not at all | A little | Somewhat | Quite a lot | Very much | No partner | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

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 | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

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

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

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

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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 screening¹ 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

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

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.,

If Yes, did this:

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

Not at all
1

A little
2

Somewhat
3

Quite a lot
4

Very much
5

Q1.b. Lead you to seek professional help?

Did you see a:

☐ psychiatrist ☐ psychologist/counsellor ☐ GP

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

No
0

Yes
5

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
1

Quite a lot
2

Somewhat
3

A little
4

Not at all
5

No partner
5

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

V.2004 (Updated 2017) © M-P Austin



| | | | | | | | |
|--|------------------------|--|----------------------|-------------------------|------------------------|--------------------------|--------------------------|
| Q3. Have you had any stresses, changes or losses <i>in the last 12 months?</i> (e.g. only: separation, domestic violence, job loss, bereavement etc.) | No 0 | Yes 5 | | | | | <input type="checkbox"/> |
| If No, skip to Q4. | | If Yes, please answer Q3.a., | | | | | |
| If yes, please specify: _____ | | | | | | | |
| *SCORE Q3.A ONLY IF Q3 = 5 (YES) | | | | | | | |
| If Yes: | Not at all 1 | A little 2 | Somewhat 3 | Quite a lot 4 | Very much 5 | <input type="checkbox"/> | |
| Q3.a. How distressed were you by these stresses, changes or losses? | | | | | | | |
| Q4. Would you generally consider yourself a worrier? | Not at all 1 | A little 2 | Somewhat 3 | Quite a lot 4 | Very much 5 | <input type="checkbox"/> | |
| 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 1 | A little 2 | Somewhat 3 | Quite a lot 4 | Very much 5 | <input type="checkbox"/> | |
| Q6. Do you feel you will have people you can depend on for support with your baby? | Very much 1 | Quite a lot 2 | Somewhat 3 | A little 4 | Not at all 5 | <input type="checkbox"/> | |
| 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 <i>when you were growing up?</i> | No 0 | Yes 5 | | | | | <input type="checkbox"/> |
| Q8. Have you ever been sexually <input type="checkbox"/> or physically <input type="checkbox"/> abused? | No 0 | Yes 5 | | | | | <input type="checkbox"/> |
| Q9. <i>When you were growing up,</i> did you feel your mother was emotionally supportive of you? | Very much 1 | Quite a lot 2 | Somewhat 3 | A little 4 | Not at all 5 | No Mother 5 | <input type="checkbox"/> |
| Do you have any other concerns that you would like to talk about today? _____ | | | | | | | |
| _____ | | | | | | | |
| _____ | | | | | | | |

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Antenatal (Psychosocial) Risk Questionnaire with Postnatal Items for Fathers

Antenatal (Psychosocial) Risk Questionnaire (ANRQ) - Client with postnatal items for Fathers



Adapted from: V.2004 (Updated 2017) © M-P Austin

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 where you have felt particularly worried, miserable, angry 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

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: _____

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: unwanted pregnancy, financial pressures, work-related stress, relationship conflict, job loss, bereavement)

No

☐

Yes

☐

If No, skip to Q4.

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

☐

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Antenatal (Psychosocial) Risk Questionnaire (ANRQ) - Client with postnatal items for Fathers



Adapted from: V.2004 (Updated 2017) © M-P Austin

| | | | | | | |
|---|---------------------------------------|---|--------------------------------------|--------------------------------------|--|--------------------------|
| Q6. Do you feel you will have people you can depend on for support with your baby? | Very much <input type="checkbox"/> | Quite a lot <input type="checkbox"/> | Somewhat <input type="checkbox"/> | A little <input type="checkbox"/> | Not at all <input type="checkbox"/> | <input type="checkbox"/> |
|---|---------------------------------------|---|--------------------------------------|--------------------------------------|--|--------------------------|

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 <i>when you were growing up</i> ? | No <input type="checkbox"/> | Yes <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------------|---------------------------------|--------------------------|

| | | | |
|---|--------------------------------|---------------------------------|--------------------------|
| Q8. Have you ever been sexually <input type="checkbox"/> or physically <input type="checkbox"/> abused? | No <input type="checkbox"/> | Yes <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------------|---------------------------------|--------------------------|

| | | | | | | | |
|--|---------------------------------------|---|--------------------------------------|--------------------------------------|--|---------------------------------------|--------------------------|
| Q9. <i>When you were growing up</i> , did you feel your mother was emotionally supportive of you? | Very much <input type="checkbox"/> | Quite a lot <input type="checkbox"/> | Somewhat <input type="checkbox"/> | A little <input type="checkbox"/> | Not at all <input type="checkbox"/> | No Mother <input type="checkbox"/> | <input type="checkbox"/> |
|--|---------------------------------------|---|--------------------------------------|--------------------------------------|--|---------------------------------------|--------------------------|

| | | | | | | | |
|---|---------------------------------------|---|--------------------------------------|--------------------------------------|--|---------------------------------------|--------------------------|
| Q10. <i>When you were growing up</i> , did you feel your father was emotionally supportive of you? | Very much <input type="checkbox"/> | Quite a lot <input type="checkbox"/> | Somewhat <input type="checkbox"/> | A little <input type="checkbox"/> | Not at all <input type="checkbox"/> | No Mother <input type="checkbox"/> | <input type="checkbox"/> |
|---|---------------------------------------|---|--------------------------------------|--------------------------------------|--|---------------------------------------|--------------------------|

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

| | | | | | |
|---|--|--------------------------------------|--------------------------------------|---|---------------------------------------|
| Was your experience of the birth of this baby disappointing or frightening? | Not at all <input type="checkbox"/> | A little <input type="checkbox"/> | Somewhat <input type="checkbox"/> | Quite a lot <input type="checkbox"/> | Very much <input type="checkbox"/> |
|---|--|--------------------------------------|--------------------------------------|---|---------------------------------------|

| | | | | | |
|---|--|--------------------------------------|--------------------------------------|---|---------------------------------------|
| Has your experience of parenting this baby been a positive one? | Not at all <input type="checkbox"/> | A little <input type="checkbox"/> | Somewhat <input type="checkbox"/> | Quite a lot <input type="checkbox"/> | Very much <input type="checkbox"/> |
|---|--|--------------------------------------|--------------------------------------|---|---------------------------------------|

| | | | | | |
|--|--|--------------------------------------|--------------------------------------|---|---------------------------------------|
| Overall, has your baby been unsettled or feeding poorly? | Not at all <input type="checkbox"/> | A little <input type="checkbox"/> | Somewhat <input type="checkbox"/> | Quite a lot <input type="checkbox"/> | Very much <input type="checkbox"/> |
|--|--|--------------------------------------|--------------------------------------|---|---------------------------------------|

And finally...

| | | | | | |
|---------------------------------|--|--------------------------------------|--------------------------------------|---|---------------------------------------|
| Are you scared of your partner? | Not at all <input type="checkbox"/> | A little <input type="checkbox"/> | Somewhat <input type="checkbox"/> | Quite a lot <input type="checkbox"/> | Very much <input type="checkbox"/> |
|---------------------------------|--|--------------------------------------|--------------------------------------|---|---------------------------------------|

| | | | | | |
|---|--|--------------------------------------|--------------------------------------|---|---------------------------------------|
| Do you think your partner is scared of you? | Not at all <input type="checkbox"/> | A little <input type="checkbox"/> | Somewhat <input type="checkbox"/> | Quite a lot <input type="checkbox"/> | Very much <input type="checkbox"/> |
|---|--|--------------------------------------|--------------------------------------|---|---------------------------------------|

| | | | | | |
|---|--|--------------------------------------|--------------------------------------|---|---------------------------------------|
| Do you think that you (or your partner) may have a problem with drugs or alcohol? | Not at all <input type="checkbox"/> | A little <input type="checkbox"/> | Somewhat <input type="checkbox"/> | Quite a lot <input type="checkbox"/> | Very much <input type="checkbox"/> |
|---|--|--------------------------------------|--------------------------------------|---|---------------------------------------|

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

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Glossary



For the purposes of this Guideline, the following terms are defined as outlined below:

Aboriginal and/or Torres Strait Islander peoples: It is recognised that there is no single Aboriginal or Torres Strait Islander culture or group, but numerous groupings, languages, kinships, and tribes, as well as ways of living. Furthermore, Aboriginal and Torres Strait Islander peoples may currently live in urban, rural or remote settings, in urbanised, traditional or other lifestyles, and frequently move between these ways of living.

Agranulocytosis: An acute condition involving a severely lowered white blood cell count, most commonly of neutrophils. Also known as agranulosis or granulopenia.

Anticonvulsant: Medications used in the treatment of epileptic seizures. Anticonvulsants are also used in the treatment of bipolar disorder, as many also act as mood stabilisers.

Antidepressants: Medications used to treat moderate to severe depression and dysthymia. Antidepressants include selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), monoamine oxidase inhibitors (MAOIs) and tricyclic antidepressants (TCAs).

Antihistamines: Medications that oppose the activity of histamine receptors and are used in the treatment of, among other things, insomnia.

Antipsychotics: Medications most commonly, but not exclusively, used to treat psychosis.

Bipolar disorder: A condition characterised by intense and sustained mood shifts usually between episodes of depression and mania.

Borderline personality disorder: A condition characterised by a pervasive pattern of instability of emotions, relationships, sense of identity and poor impulse control that is consistently associated with severe functional impairment.

Catatonia: An abnormality of movement and behaviour arising from a disturbed mental state (typically schizophrenia).

Cognitive-behavioural therapy: Psychological treatment based on the assumption that faulty thinking patterns, maladaptive behaviours and "negative" emotions are all inter-related. Treatment focuses on changing an individual's thoughts (cognitive patterns) or maladaptive behaviours in order to change emotional states. Cognitive-behavioural therapy integrates the cognitive restructuring approach of cognitive therapy with the behavioural modification techniques of behavioural therapy.

Continuity of care: Continuity of care involves a shared understanding of care pathways by all professionals involved, with the aim of reducing fragmentation and conflicting advice.

Continuity of carer: Continuity of carer is when a named professional, who is known by the woman, provides all her care as appropriate, thus enabling the development of a relationship.

Depression: Feelings of sadness and/or a loss of interest in activities once enjoyed, which can lead to a variety of emotional and physical problems and decrease a person's ability to function at work and at home. Depression symptoms vary from mild to severe.

Dialectical behaviour therapy: A cognitive behavioural treatment that was originally developed to treat chronically suicidal individuals diagnosed with borderline personality disorder, which is now an accepted psychological treatment for this population.

Directive counselling: An intervention incorporating elements of supportive listening and history taking and techniques of problem clarification, goal formation, problem solving and partner sessions, delivered individually or in a group format.

Electroconvulsive therapy: A procedure used to treat certain psychiatric conditions. It involves passing a carefully controlled electric current through the brain, which affects the brain's activity and aims to relieve severe depressive and psychotic symptoms.

Emotional dysregulation: A term used by health professionals to refer to an emotional response that is poorly modulated, and does not fall within the conventionally accepted range of emotive response. Emotional dysregulation may be referred to as labile mood (marked fluctuation of mood), mood swings, or mood or affective instability.

Generalised anxiety disorder: Feeling anxious about a wide variety of things on most days over a long period of time (e.g. 6 months).

Interpersonal psychotherapy: A short-term supportive psychotherapy that focuses on the connection between interactions between people and the development of psychological disorder symptoms.

Mental health (or psychiatric) condition: Condition fulfilling diagnostic criteria (depression, anxiety disorder, bipolar disorder, postpartum psychosis), which may be mild, moderate or severe.

Mental health symptoms: Signs of mental health problems that do not in themselves constitute a clinical diagnosis.

Mentalisation-based therapy: An integrative form of psychotherapy, bringing together aspects of psychodynamic, cognitive-behavioural, systemic and ecological approaches designed for the treatment of borderline personality disorder.

Mindfulness training: Mindfulness-based cognitive therapy is intended to enable people to learn to become more aware of the bodily sensations, thoughts and feelings associated with depressive relapse, and to relate constructively to these experiences. It is based on theoretical and empirical work demonstrating that depressive relapse is associated with the reinstatement of automatic modes of thinking, feeling and behaving that are counterproductive in contributing to and maintaining depressive relapse and recurrence (for example, self-critical thinking and avoidance) (*NICE 2014; updated 2020*).

Mood stabilisers: Medications used to treat bipolar disorder.

Mother-infant relationship interventions: Interventions that aim to improve the relationship between the mother and infant (*NICE 2014; updated 2020*). These interventions are based on a psychological theory about the nature of attachment between the mother and infant and typically involve observations of mother-infant interactions, feedback (often video-based), modelling and cognitive restructuring. The primary goal is to enhance maternal sensitivity to child behavioural cues and awareness of the child's developing skills and needs.

Negative predictive value: The probability that a person who tests negative using a test does not have the condition.

Panic disorder: Frequent attacks and intense feelings of anxiety that seem like they cannot be brought under control; this may go on to be associated with avoidance of certain situations (e.g. going into crowded places).

Perinatal period: The period covering pregnancy and the first year following birth.

Positive predictive value: The probability that a person who tests positive using a test has the condition.

Post-traumatic stress disorder: A form of anxiety with diagnostic criteria that include direct or indirect exposure to death or threatened death, actual or threatened serious injury or sexual assault.

Postnatal depression: Depression experienced in the postnatal period.

Postpartum psychosis: Acute psychotic episode arising in the early postnatal period.

Psychoeducation: A structured educational treatment (often offered in groups), which may focus on preparation for childbirth (antenatal) or practical aspects of childcare (postnatal) but also includes a specific mental health component with information about common mental health conditions in the antenatal and/or postnatal period (*NICE 2014; updated 2020*). These interventions are often informed by psychological principles and use techniques such as cognitive restructuring, pleasant event scheduling, role play, guided relaxation, and homework exercises.

Psychosis and psychotic episode/disorder: An acute mental health episode defined by abnormality of thinking, perception and behaviour in which the patient loses touch with reality and lacks insight into being ill.

Psychosocial: Various psychological and social factors that may have an impact on health and well-being in the perinatal period.

Psychotherapy: A general term for a process of treating mental and emotional conditions through an intentional interpersonal relationship used by trained psychotherapists to aid the person in overcoming the problems of living.

Relative risk: The ratio of the risk (rate) of an outcome in an exposed group (e.g. to a specific medication) to the risk (rate) of the outcome in an unexposed group in a specified time period.

Schema-focused psychotherapy: An integrative psychotherapy combining theory and techniques from previously existing therapies, including cognitive behavioural therapy, psychoanalytic object relations theory, attachment theory, and Gestalt therapy.

Schizophrenia: A complex condition of brain function with wide variation in symptoms and signs, and in the course of the illness. The experiential 'core' of schizophrenia has been described as a disturbance involving the most basic functions that give the person a feeling of individuality, uniqueness and self-direction (*Galletly et al 2016*).

Sensitivity: The proportion of people with the condition who have a positive test result.

Significant other(s): Individuals who are significant to the woman and considered by the woman to be important to her care. This may include her partner or members of her immediate or extended family. In some cases, the father of the infant may be estranged from the mother but remain significant to the infant.

Social phobia: Intense fear of criticism, being embarrassed or humiliated, even in everyday situations (e.g. eating in public or making small talk).

Social support group: A system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful and is primarily in one direction with a clearly defined peer supporter and recipient of support (*NICE 2014; updated 2020*). Peer volunteers who are mothers themselves and also have a history of antenatal or postnatal mental health problems are recruited and trained to deliver interventions. These interventions can include befriending and mentoring. Support groups also provide an opportunity for peer support but are usually facilitated by a healthcare professional and discussions are usually structured around a series of pre-defined topic areas (for instance, transition to motherhood, postnatal stress management, co-parenting challenges). However, the primary goal of these interventions is to enable mutual support by bringing women into contact with other women who are having similar experiences and providing opportunities for sharing problems and solutions.

Specific phobia: Fearful feelings about a particular object or situation (e.g. going near an animal, flying on a plane or receiving an injection).

Specificity: The proportion of people without the condition who have a negative test result.

Transference-focused psychotherapy: An evidence-based psychodynamic therapy designed for patients with personality disorders.

Trauma-informed care: Trauma-informed care and practice is a strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma, that emphasises physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment (*Kezelman & Stavropoulos 2012*).

Yoga: A system of gentle exercises, with the aim of attaining bodily or mental control and well-being (*Marc et al 2011*).

Abbreviations and acronyms

| | |
|----------------|--|
| ACM | Australian College of Midwives |
| ACMHN | Australian College of Mental Health Nurses |
| AIHW | Australian Institute of Health and Welfare |
| ANRQ | Antenatal Risk Questionnaire |
| APS | Australian Psychological Society |
| AWHN | Australian Women's Health Network |
| CBR | Consensus-based recommendation |
| CBT | Cognitive behavioural therapy |
| CHF | Consumers Health Forum |
| CI | Confidence interval |
| COPE | Centre of Perinatal Excellence |
| DALY | Disability-adjusted life year |
| DBT | Dialectical behaviour therapy |
| DHA | Docosahexaenoic acid |
| DSM | Diagnostic and Statistical Manual of Mental Disorders |
| EBR | Evidence-based recommendation |
| ECT | Electroconvulsive therapy |
| EPA | Eicosapentaenoic acid |
| EPDS | Edinburgh Postnatal Depression Scale |
| EWG | Expert Working Group |
| GP | General practitioner |
| IPT | Interpersonal psychotherapy |
| IQ | Intelligence quotient |
| K10 | Kessler Psychological Distress Scale |
| LGBTQI+ | Lesbian, gay, bisexual, transgender, queer/questioning, intersex |
| MAOIs | Monoamine oxidase inhibitors |
| MBT | Mentalisation-based therapy |
| MCaFNA | Maternal Child and Family Health Nursing Association |
| NHMRC | National Health and Medical Research Council |
| NICE | National Institute for Health and Clinical Excellence (UK) |
| OR | Odds ratio |
| PANDA | Perinatal Anxiety and Depression Australia |
| PHQ | Patient Health Questionnaire |
| PP | Practice point |
| PTSD | Post-traumatic stress disorder |
| RACGP | Royal Australian College of General Practitioners |
| RANZCOG | Royal Australian and New Zealand College of Obstetricians and Gynaecologists |
| RANZCP | Royal Australian and New Zealand College of Psychiatrists |
| RCT | Randomised clinical trial |
| SFT | Schema-focused psychotherapy |
| SLR | Systematic literature review |
| SNRI | Serotonin-norepinephrine reuptake inhibitor |
| SSRI | Selective serotonin reuptake inhibitor |
| STEPPS | Systems training for emotional predictability and problem solving |
| TCA | Tricyclic antidepressants |
| TFP | Transference-focused psychotherapy |
| TGA | Therapeutic Goods Administration |

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