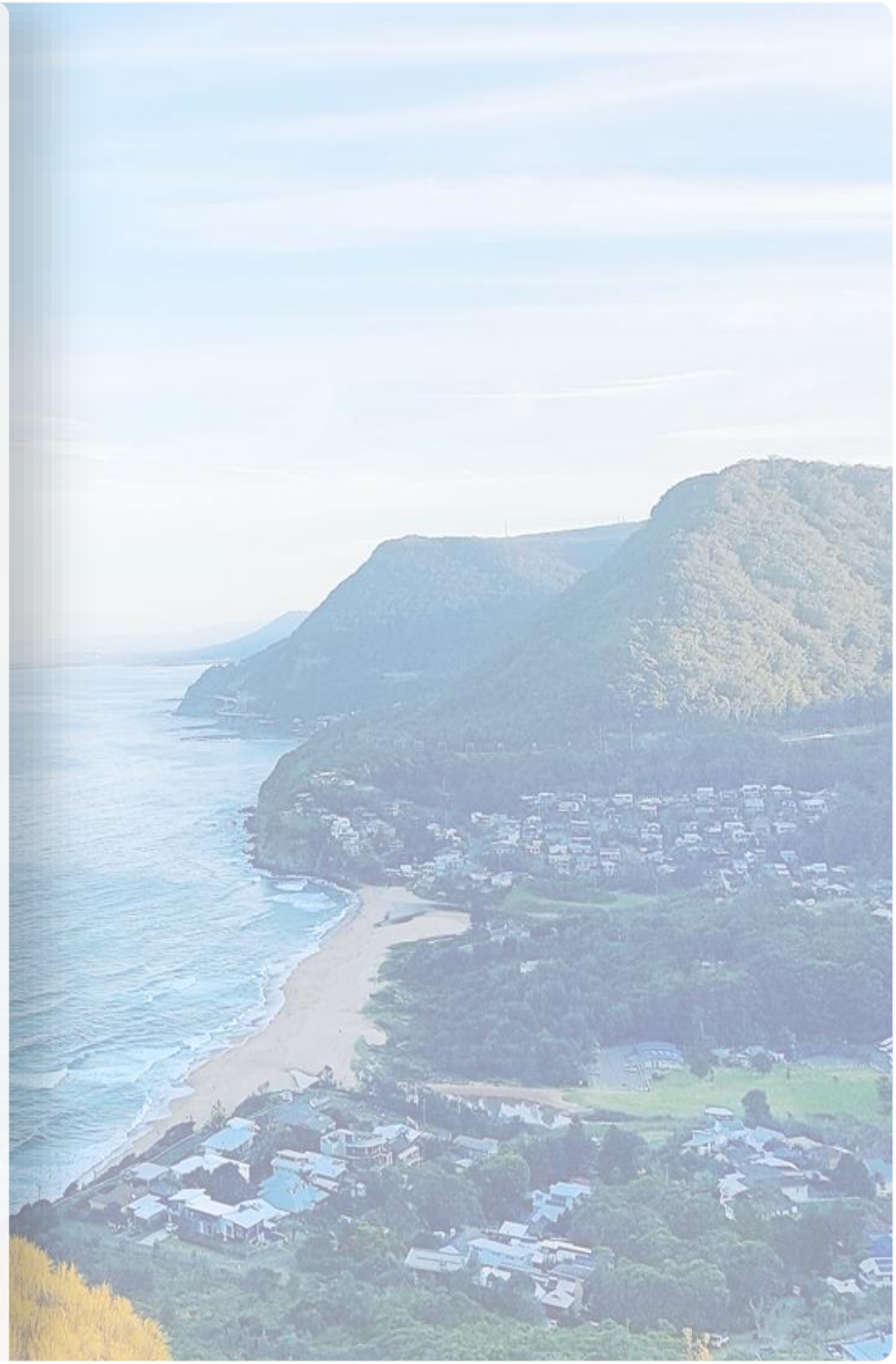
Perinatal Mental Health

A resource guide for mental health practitioners

Who is this guide for?
The following guide is designed for mental health practitioners working in remote, rural or regional NSW who have not completed specialty training in working with people living with a perinatal mental illness but are treatment providers for individuals with a perinatal mental illness, and their family.

What does this guide include?
This is an introductory guide to working with individuals experiencing perinatal mental illness and is not exhaustive nor designed as a treatment manual. We encourage all practitioners who are working with individuals with a perinatal mental illness to seek specialised training in evidence-based treatments and engage in supervision.

A note on language.
The Peregrine Centre recognises and values the diversity of families. For simplicity, 'mother', 'Mum' and 'women' are used to refer to the birthing parent and/or primary caregiver. In practice, listen and reflect the language of the person. If in doubt, ask.



THE PEREGRINE CENTRE

This resource was developed for the Rural Mental Health Partnership by Dr Dayle Raftery (Psychologist) at The Peregrine Centre. We thank Brendan Cook (Perinatal and Infant Mental Health Coordinator, Southern NSW Local Health District) and Gabrielle Micallef (Perinatal Mental Health Lived Experience Advocate) for their valuable contributions to this resource.

How Likely Is It?

Around 15% to 20% of Australian mothers will experience some form of mental health condition related to their pregnancy or birth. Women living rurally are more likely to experience perinatal mental health condition than those in cities. Globally, First Nations women have an increased risk of perinatal mental illness compared to non-Indigenous women.

Depression and anxiety can occur at all stages of pregnancy and post partum and often co-occur.
Around 1 in 6 women experience anxiety and/or depression in the first year post birth.

Postpartum psychosis affects 1-2 in 1,000 women. A pre-existing history of psychosis increases risk of a psychotic episode in the first few months postpartum. There is also a strong link between pre-existing bipolar disorder and postpartum psychosis.

Not only does perinatal distress have a negative impact on the mother, it also affects the infant's physical and emotional development, including having a direct effect on brain architecture.

When and how should I ask about mental health?

Mental health should be included in regular screening throughout pregnancy, and into the postnatal period. Framing mental health questions as a normal part of perinatal care can help with engagement.
Building a good relationship with warmth and empathy is important. There is a handy list of six approaches for your practice toolbox to keep in mind, including example statements that will help to build rapport.

Consider who is in the room when these questions are being asked. Dads, other support people, or other children may attend the appointments and it may not be appropriate or comfortable for Mum to be asked and answer questions about her mental health. However, it may also be helpful for Mum to have a support person.

What tools should I use?

Standard screening tools such as the PHQ-9 and K-10 are appropriate. It is also worth considering a perinatal specific measure.

The Edinburgh Postnatal Depression Scale (EPDS; Boyce et al., 1993; Cox et al., 1987) is a 10-item self-report measure assessing symptoms of depression and anxiety specific to the postnatal period. It is relatively quick and may facilitate a conversation about the mother's experiences.
The Antenatal Risk Questionnaire (ANRQ; Austin, 2017) assesses a number of psychosocial risk factors including childhood experiences, domestic violence history, mental health history, and current supports.

The Kimberly Mum's Mood Scale (KMMS; Marley et al., 2017) is a two part tool developed in collaboration with Aboriginal women of the Kimberley (WA) region. The first part is a culturally sensitive adaption of the EPDS. The second part is a structured psychosocial yarn format, with open ended questions exploring both risk and protective factors. At this time, it has only been culturally validated with Aboriginal women from the Pilbara area meaning it may require careful consideration if used with other cultural groups.
Baby Coming, You Ready? is a web-based, culturally sensitive interactive screening program for collaborative use between clinician and client. Use requires practitioner training, available through the website.

What might stop Mum saying something?

Talking about perinatal issues is not easy, and some mums might be reluctant to open up. Here are a few factors that may be behind Mum's reluctance.

Health literacy. Having a new baby comes with a number of challenges and new mothers may not think their mood is abnormal. Psychoeducation and resources about perinatal mental illness can help mothers to understand when to ask for help.

Stigma and fear of judgement: When everyone tends to know everyone, this can add an extra barrier to accessing mental healthcare and is closely related to stigma. Creating a non-judgemental space, and normalising or validating the difficulty of new motherhood may help. Discussing confidentiality and, if possible, providing flexible treatment options (e.g., can mental health support be accessed at a general clinic?) may help mothers feel more secure.

Fear of repercussions: Mothers may be fearful of what will happen if they disclose poor mental health. Fear of child protection involvement, specifically removal of children, is commonly reported by mums. Discussing openly the purpose of conducting screening and treatment may help mothers engage in the process. DCJ also has information for families on what might happen if DCJ gets involved.

Safety: Consider the supports of the woman. She may be worried about who in her support network this information may be shared with, which may pose a threat to her or the child's safety. Consider any custody or children's court issues that may be ongoing.

Cultural Considerations: Women from non-English speaking backgrounds may perceive their experiences differently, due to either cultural or language differences. Therefore, screening should not solely rely on closed questions. Use of interpreters may be beneficial.

How do I know it's not just the baby blues?

Poor mental health in the Perinatal period can get overlooked as being a 'normal' part of new motherhood. Whilst some women may experience mood changes after birth, these should resolve after a few days. If the mood changes last for longer than this you should explore the possibility of a perinatal mental health condition. As changes in sleep and appetite are common following pregnancy, it is advisable to avoid using depression screening tools that have a focus on physical symptoms as this may be misleading. Exploring mental health history, and considering current social supports, mood state, and feelings towards the baby will help to assess the mental health of the mother.

Mental Health Risk Factors in mothers	Postnatal Depression	Psychosis	Suicidality	Anxiety
Past history	X	X	X	X
Family history		X	X	
Poor social support	X	X	X	X
Low/no partner support	X		X	X
Lack of parental support	X		X	
Stressful life events	X	X	X	X
Unwanted Pregnancy	X		X	X
First baby		X		X
Young age	X		X	X

Adapted from Orsolini, L., et al. (2016). Suicide during Perinatal Period: Epidemiology, Risk Factors, and Clinical Correlates. *Frontiers in Psychiatry*, *7*.
Leach, L. S., Poyser, C., & Fairweather-Schmidt, K. (2017). Maternal perinatal anxiety: A review of prevalence and correlates. Clinical Psychologist, 21(1), 4–19.

Help! I'm it.. How do I treat Mum?

First, you are not alone! PANDA offer a free secondary consultation service for health professionals via phone or email. They also have a learning hub for health professionals and community.

Creating a non-judgemental, listening environment where parents feel they are able to talk can be very therapeutic. Using active listening skills, open questions, and validation helps people to feel they are being heard.

Cognitive Behavioural Therapy has been found to be effective for mothers with depressive and anxious symptoms. You don't need to be a CBT expert! Basic skills in thought challenging, problem solving, and goal setting are enough.

Common stuck points present in mothers:
- Mismatch of expectation of motherhood versus reality
- Health anxiety (own and baby)
- Grief regarding loss of past life/identity
- Grief related to past miscarriages
- Being a burden on partner/impact on relationship

Throughout treatment, **there is a balance to be held with ensuring baby's needs continue to be met**. While it may be okay that Mum doesn't shower every day, baby will still need regular nappy changes.

Behavioural activation has been shown to be effective in treating perinatal mental illness. Experiences during pregnancy and the postpartum period can make usual activities difficult to engage in and mothers often express frustration at their inability to do the things they once could. Work together to shift unhelpful expectations of self, problem solve adjustments to usual enjoyable activities, and help Mum to identify ways she can take care of herself and get out and about. This may include finding local mothers' groups, or identifying supports who can care for baby and allow Mum some personal time.

It Takes a Village

The non birthing parent/caregivers can get overlooked in conversations about perinatal mental health, however it is important that they too are forming a bond with the infant, as well as having an appropriate understanding of their own and mum's mental health and how to support them.
Other caregivers can be a protective factor in supporting Mum's recovery, and ensuring baby's needs are met. Identifying a network of caregivers is beneficial, as it allows for sharing of the load, and encourages good development for baby.

If safe to do so**, involve the other parent/caregivers from the beginning.** Mums can carry guilt about asking partners to take care of the baby. Make an explicit collaborative agreement with all parents/caregivers that treatment is important for everyone, and working out who will do what. For example, can partner hold responsibility for night time bath and bed routine, allowing Mum a period of uninterrupted sleep or downtime?

The partner's mental health may also need to be assessed. It is a time of transition for them as well. Research with new fathers indicates that **depression occurs in around 10% of men** in the period between first trimester and 12 months after birth. Up to **18% of men will experience an anxiety disorder** in the perinatal period.

Offering support in the form of information, and referrals for mental health support in the area may be helpful. To help engagement, consider reaching out via telephone or letters addressed and mailed to the partner/caregivers (rather than passed on via the mother).

Don't put baby in the corner

As mentioned at the start, maternal mental health impacts the infant's mental health and development. Infant mental health is an area that is increasingly being recognised as important.

Perinatal distress is a primary risk factor for child development issues. **Improving Mum's mental health is not necessarily enough to also address the baby's development.** Experience of perinatal distress can disrupt the developing relationship between mum and baby, and there may need to be intervention to help Mum connect with her baby appropriately.

This can start during pregnancy. There is some evidence that suggests that mums who can think about their baby's experiences or imagine who their baby might become also feel more connected to the baby.

How is Mum interacting with her baby? How well is she able to understand or take on her baby's perspective? **Ask questions that encourage caregivers to consider what their baby might be thinking.** The table opposite has examples of interactions, though this is not an exhaustive list nor should it be used as a checklist.

Parents who are able to reflect on the internal world of their infant (what they are thinking and feeling) are more likely to be able to recognize and respond to their infants needs in a sensitive way. This can be prompted by reflecting on what parents think baby is thinking, or looking at. It can be helpful to observe how parents interact with baby and respond to baby's signals. Serve and Return is a strategy that promotes engaging with baby-led signals and builds relationship.

Raising Children contains videos and descriptions of how babies communicate. Watching these with parents and reflecting on what they notice in their baby is one way to help build communication between parents and baby.
This Zero to Three resource has tips for parents on appropriate activities to build relationships with young children.

Positive interactions include:	Concerning interactions include:
Mother is physically attentive and responsive to the infant.	Infants who are difficult to settle or are irritable most of the time
Empathy for and ability to reflect infant's feelings.	Mothers who state they do not know what their infant wants or needs and cannot understand their infant's experience.
Emotional engagement with the infant and enjoyment.	Infants who struggle or arch their backs when held or comforted.
Infant is interactive, engaging, cries when distressed and settles when comforted.	Relationships where there is no joy or mutual reciprocity.
Some eye contact between mother and infant.	Mothers who are unable to soothe or comfort their infants.
Sensitivity to infant through immediate and appropriate responses.	Infants and mothers who avoid looking at each other.
Mother's response is paced to infant's cues.	Mothers who are intrusive with their infants - poking, too close, too loud, frightening, too rough.
Environment that creates the expectancy of interaction.	Infants who are experiencing serious and continued feeding problems or are failing to thrive.
	Mothers who have difficulty keeping their baby's needs at the forefront of their mind.

Adapted from Department of Health and Human Services. (2013). *Perinatal Mental Health and Psychosocial Assessment: Practice Resource Manual for Victorian Maternal and Child Health Nurses*. Department of Education and Early Childhood Development. https://www.health.vic.gov.au/publications/perinatal-mental-health-and-psychosocial-assessment-practice-resource-manual-for

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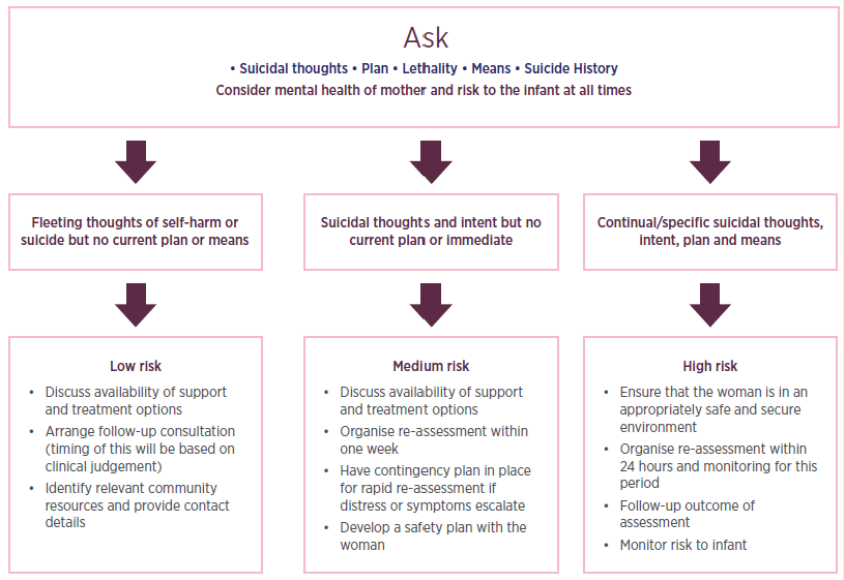
Asking the tricky questions

Screening for mental health also needs to consider the risk of harm to the mother or other family members. Introducing these questions as a standard part of the assessment that get asked to everyone can help with engagement.

Keep in mind that risk is dynamic and evolving, and it is increasingly being recognized that risk categories are too static. Reassess risk and revisit safety plans routinely to ensure they remain relevant and useful.



Austin, M-P, Highet, N., & the Expert Working Group. (2017). *Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline*. Centre of Perinatal Excellence. https://www.cope.org.au/health-professionals/health-professionals-3/review-of-new-perinatal-mental-health-guidelines/

Risk to self. Suicide is lower in perinatal women compared to the general population, however **suicide is one of the leading causes of maternal mortality** in the 12 months following birth. Asking about thoughts of suicide, or dying, is an important part of assessment. If using the EPDS for screening, check Question 10.

Risk to infant/other children. Ask if Mum has ever thought about hurting her baby. Keep in mind a mother expressing thoughts of harming her baby can be coming from a place of anxiety, such as feeling underprepared and fearing inadvertently harming her baby. Also consider Mum's capacity to meet the needs of the infant (or other child/ren). Being curious and empathetic will help Mum feel comfortable speaking about this tricky topic.

Substance Use. Screen for any substance use, including misuse of prescribed substances. Keep in mind the barriers of shame and guilt, and it may take some time and relationship building before disclosure. A guide and further resources here.

Family and Domestic Violence. Always ask about family and domestic violence with Mum alone. Consider risk from other people in Mum's network (e.g. other family members, housemates, etc.). Keep in mind that domestic violence extends beyond physical abuse. Does Mum have access to her own money? Is she allowed to see friends and family? Did you have difficulty convincing the partner/support person that you needed to speak with Mum alone?

Risk of worsening illness/escalation. People with a history of mental health disorders may be at higher risk in the perinatal period, even if they are not currently experiencing symptoms. Taking a good history and talking through proactive ways to maintain good mental health can be helpful, as well as ongoing check ins.

There are risk issues. What now??

Working collaboratively to create a safety plan can help identify warning signs and extra supports. It is important to continually revisit the safety plan, as it should be a dynamic document. Provide a copy for Mum, and any support people Mum nominates.
Risk is evolving and should be considered through a dynamic lens. Reassessment should occur frequently.

Assess current supports, pervasiveness of thoughts of harm to self or others, presence of plan and/or means to harm, and history of actual harm.
Consider the threshold for mandatory reports, particularly around infant safety. Consider who is in the mother's support network and may be able to be involved in care, including other health professionals and informal supports.

Medication
Women often are concerned about the impact of their mental health medication on fetal development or breastfeeding. Having an open discussion about the benefits versus consequences of medication, and providing written information (such as these) can be helpful for the mother to feel like she has agency in her own treatment.

Health providers and the public can also contact MotherSafe at The Royal Hospital for Women for further information and advice about medication or other exposures (including substances, radiation, infections) during the perinatal period.

Are there other support options out there?

The next page has a list of resources for health professionals and for families.

It is important to know what is available in your area, or online, to support the mother and her infant. Perinatal Anxiety & Depression Australia (PANDA) is a national service that is a good place to start and can be helpful to direct parents to as well. COPE has an interactive directory of perinatal specific services, including a list of online services as well as local. ForWhen is a national support line connecting people to the right service.

It can be difficult to find an appropriate service in a rural area. There are a range of online and telephone options for mothers (resources at the end of this pack). Consider safety before using this as a primary service. If a mum is presenting with significant risk factors, she may need a more intensive service than phone or online options alone can offer.

Inpatient options are limited, especially in rural areas. The services below accept referrals from across NSW.
Naamuru Parent Baby Unit is based at Royal Prince Alfred, Camperdown and is a publicly funded unit for parents and babies. Referral is via NSW Health Mental Health or specialist perinatal services only.
Mother and Baby Unit is a 21-day inpatient program located at St John of God, Burwood. Requires private health insurance or ability to self-fund.
Tresillian runs 5-day inpatient programs in Canterbury, Nepean, Willoughby and Macksville, as well as Canberra. They also have day programs in some regional centres around NSW.

Additional Resources

For Health Professionals:
COPE Fact Sheets for Health Professionals
Directory of Perinatal specific services. Includes online and f2f services.
NSW Health Perinatal and Infant Mental Health Service Website
Free webinar for health professionals for recognising and responding to risk in the perinatal period (PANDA)
Gidget Foundation Resources for new parents and health professionals
NSW Health guidelines for working with substance use in the perinatal period

For Mums:
Mothersafe a free telephone counselling service for women and healthcare providers concerned about exposures during pregnancy and breastfeeding
MumMoodBooster an online six-session treatment for postnatal depression, with additional resources.
MumSpace contains a range of resources to help with adjustment to motherhood through to online programs and supports for perinatal mental illness.
PANDA national helpline on **1300 726 306** is free and available 9am-7.30pm Mon-Fri.

For non-birthing parent:
SMS4Dads free SMS service providing advice, support and resources to new parents.
Dadvice BeyondBlue curated collection of support and resources for Dads, partners and other carers.

For parents:
ParentLine NSW 1300 1300 52 A free telephone counselling line for parents. Available 9am-9pm Mon-Fri and 4pm-9pm Sat-Sun.
Karitane has a number of resources on their website, including videos of infant communication, mental health resources, and support for dads. They also offer free Parent Child Interaction Therapy for families in NSW via telehealth (for children 15 months – 4 years of age)
Deadly Tots A website for Aboriginal and Torres Strait Islander parents with parenting support, play ideas, and additional apps.