



**The Royal Australian and New Zealand College of Obstetricians and Gynaecologists**  
*Excellence in Women's Health*

# Mental Health Care in the Perinatal Period

This statement has been developed and reviewed by the Women's Health Committee and approved by the RANZCOG Board and Council.

A list of Women's Health Committee Members can be found in Appendix A.

Disclosure statements have been received from all members of this committee.

**Disclaimer** This information is intended to provide general advice to practitioners. This information should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient. This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The document has been prepared having regard to general circumstances.

**First endorsed by RANZCOG: March 2012**

**Current: July 2018**

**Review due: July 2021**

**Objectives:** To provide advice on perinatal anxiety and depression, serious mental illness and bipolar disorder.

**Target audience:** All health professionals providing maternity and mental health care, and patients.

**Values:** This statement is consistent with the evidence review undertaken as part of the development of the evidence-based 2017 Australian National guideline *Mental Health Care in the Perinatal Period*, and was also reviewed by the Women's Health Committee (RANZCOG), and applied to local factors relating to Australia and New Zealand.

**Background:** This statement was first developed by Women's Health Committee in March 2012 and reviewed in July 2018 to incorporate the 2017 guidance from the national evidence-based guideline *Mental Health Care In The Perinatal Period 1*

**Funding:** The development and review of this statement was funded by RANZCOG.

## 1. Patient summary

Mental health problems are common during pregnancy and after birth. Recognised risk factors do exist but mental health disorders can arise for the first time in the perinatal period. Mental health problems can be difficult to identify, and have the potential to cause harm to both mother and baby. In line with 2017 Australian evidence-based guideline recommendations<sup>1</sup>, those providing maternity and postnatal care should consider using recommended screening tools to help identify women who would benefit from specialised care.

## 2. Summary of recommendations

| Recommendation 1   | Grade and Reference                       |
|--|---|
| <p>Screening for Anxiety and Depression and Psychosocial Assessment</p> <p>Health professionals providing care in the perinatal period should receive training in woman-centred communication skills, screening and psychosocial assessment and culturally safe care</p> | <p>Consensus-based recommendation [1]</p> |
| Recommendation 2   | Grade and Reference                       |
| <p>Mental health problems during the perinatal period are common. Routine screening should lead to identification, referral and treatment. There is evidence that early intervention produces the best outcomes for mothers and their families</p>                       | <p>Consensus-based recommendation [2]</p> |
| Recommendation 3   | Grade and Reference                       |
| <p>Perinatal mental health care should be culturally responsive and familycentred. Obstetricians are in a unique position to develop a long term trusting relationship with their pregnant patients</p>  | <p>Consensus-based recommendation</p>     |

| <b>Recommendation 4</b>  | <b>Grade and Reference</b>            |
|--|---------------------------------------|
| In line with the recognition by the College of the importance of reciprocal trust between practitioner and the patients and those who support them (cultural competency), it is imperative that an awareness of systemic inadequacies (such as poor communication, or lack of continuity of care, or non-collaborative models of care) remains a high priority in order to avoid these pitfalls  | Consensus-based recommendation        |
| <b>Recommendation 5</b>  | <b>Grade and Reference</b>            |
| The mental wellbeing of patients should be seen as important as physical health. Maternal anxiety and depression can have detrimental effects on fetal and infant development and on mother infant attachment  | Consensus-based recommendation        |
| <b>Recommendation 6</b>  | <b>Grade and Reference</b>            |
| All pregnant women should be routinely screened for depression and anxiety symptoms. Use the Edinburgh Postnatal Depression Scale (EPDS) to screen women for a possible depressive disorder in the perinatal period. All pregnant women should also be screened for psychosocial risk factors. Screening for perinatal mood disorders, in the form of a psychosocial assessment or administration of a validated tool, such as the ANRQ3. Screening for psychosocial risk factors can be undertaken at the same time as screening for depression and anxiety and should be considered part of routine antenatal and postpartum care. Screening can be undertaken using written or digital approaches | Consensus-based recommendation [1, 3] |
| <b>Recommendation 7</b>  | <b>Grade and Reference</b>            |
| In line with the Department of Health Pregnancy Care guidelines [4], all pregnant women should be routinely screened for Drug and Alcohol and Family Violence. It is also important to state that questions surrounding family violence should be asked when the woman is alone  | Consensus-based recommendation [4]    |
| <b>Recommendation 8</b>  | <b>Grade and Reference</b>            |
| Any treatment offered should involve collaborative decision-making with the woman and her partner including a full discussion of the potential risks and benefits  | Consensus-based recommendation        |
| <b>Recommendation 9</b>  | <b>Grade and Reference</b>            |
| The safety of mothers and infants needs to be considered at all times; as we well as the safety of families  | Consensus-based recommendation        |
| <b>Recommendation 10</b>   | <b>Grade and Reference</b>            |
| When a woman is identified as at risk of suicide (through clinical assessment and/or the EPDS), manage immediate risk, arrange for urgent mental health assessment and consider support and treatment options  | Consensus-based recommendation        |
| <b>Recommendation 11</b>   | <b>Grade and Reference</b>            |
| At every antenatal or postnatal visit, enquire about women's emotional wellbeing   | Consensus-based recommendation        |
| <b>Recommendation 12</b>   | <b>Grade and Reference</b>            |
| Provide women 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  | Consensus-based recommendation        |
| <b>Recommendation 13</b>   | <b>Grade and Reference</b>            |
| 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  | Consensus-based recommendation [1]    |

### 3. Introduction

The perinatal period – in the mental health setting-includes the time from conception to one year postpartum. Perinatal anxiety and depression is the result of biological, sociological and psychological factors occurring at this time and can affect mothers and fathers. It can be new in onset or the recurrence of a pre-existing illness.

The perinatal period is a time of great adjustment for women and their partners. While many couples resolve issues that may arise, for many parents this time can lead to the development of mental health problems. Risk factors can include a history of mental health problems, lack of support, previous trauma including physical, emotional or sexual abuse, isolation (physical, mental, cultural), stressful life events, and a history of drug or alcohol abuse.

Suicide is one of the leading causes of maternal deaths in Australia [5–7]. The presence of maternal mental health conditions can also have an adverse impact on the growth and development of the fetus/infant, and the wellbeing of other family members. The psychological wellbeing of pregnant women and new mothers should therefore be considered as important as their physical health and considered as part of routine antenatal and postnatal care.

## 4. Discussion

### 4.1 How common is perinatal anxiety and depression?

Up to 80% of mothers experience the 'baby blues' 3–5 days after giving birth. This period of emotional lability is transient and self-limiting usually dissipating within 10 days.

Australian research suggests that up to 10% of women experience antenatal anxiety and/ or depression, increasing to 16% of women experiencing postnatal anxiety and / or depression. 10% of fathers are also affected [8]. Rates of anxiety are even higher affecting up to 20% of women in pregnancy and in the postnatal period [1]. Puerperal psychosis, which is considered a psychiatric emergency, affects around 1 in 1000 women. Bipolar disorder is at greater risk of reoccurring and bipolar women are at particularly high risk of suicide in the first postnatal year. Post-traumatic stress disorder is reported to occur in 2–3% of women after childbirth. Those who are particularly at risk are those who have suffered previous trauma (domestic violence, rape or childhood sexual abuse), those with risk factors for perinatal mood disorder, and those who perceived that their birth experience was traumatic.

Mental health problems affect the wellbeing of the woman, her baby, her partner and family, during a time that is critical to the future health and wellbeing of children. Early detection and intervention can improve outcomes for all and are the responsibility of all maternity care providers. Health professionals providing care should have appropriate training and skills and should work together to provide continuity of care for women and their families [1].

### 4.2 Why is identification and treatment important?

Of women identified with antenatal or postnatal depression, 50–70% of those untreated remain depressed 6 months later. 25% of women will develop a chronic illness and 25% of women will develop recurrent depression. Perinatal anxiety and depression has adverse consequences for mothers, fathers and children especially in respect to the critical parent-infant attachment that potentially influences the mental health of the next generation [9].

### 4.3 Identification of depressive and anxiety disorders

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV TR, 2000) diagnostic criteria suggest that women must exhibit five or more symptoms for at least two weeks with at least one symptom from the first two symptoms listed below:

- Depressed mood
- AND/ OR
- Anhedonia (no interest or pleasure or enjoyment)
  - Significant change in weight or appetite
  - Markedly increased or decreased sleep
  - Psychomotor agitation or retardation
  - Fatigue or loss of energy
  - Feelings of worthlessness or guilt
  - Reduced concentration
  - Recurrent thoughts of death or suicide

In addition, these symptoms must be accompanied by significant *impairment in capacity to engage and function in usual activities* e.g. parenting, occupational, social and other roles.

As some of these symptoms overlap with common feelings during the perinatal period [10] a diagnosis can be difficult. Problems sleeping [11, 12] should be investigated and anxiety disorders should also be considered [13]. More specific symptoms to perinatal depression are listed below.

Symptoms more specific for perinatal anxiety and depression can include:

- Inability to enjoy activities which were enjoyed prior to pregnancy or birth
- Can't concentrate, make decisions or get things done
- Physical symptoms such as heart palpitations, constant headaches, sweaty hands
- Feeling overwhelmed and constantly exhausted
- Feel numb and remote from family and friends
- Feel out of control, or 'crazy', even hyperactive
- Can't rest even when the baby is sleeping

- Have thoughts of harming themselves or the baby (infanticide)
- Have constant feelings of guilt, shame, or repetitive thoughts
- Feel trapped or in a dark hole or tunnel with no escape
- Experience feelings of anger, grief, loss, tearfulness
- Changes in appetite
- Persistent negative thoughts
- Feeling very irritable or sensitive

| Recommendation 1  | Grade and Reference                |
|---|------------------------------------|
| Screening for Depression and Anxiety and Psychosocial Assessment<br><br>Health professionals providing care in the perinatal period should receive training in woman-centred communication skills, screening and psychosocial assessment and culturally safe care   | Consensus-based recommendation [1] |
| Recommendation 2  | Grade and Reference                |
| Mental health problems during the perinatal period are common. Routine screening should lead to identification, referral and treatment. There is evidence that early intervention produces the best outcomes for mothers and their families   | Consensus-based recommendation [2] |
| Recommendation 3  | Grade                              |
| Perinatal mental health care should be culturally responsive and familycentred. Obstetricians are in a unique position to develop a long term trusting relationship with their pregnant patients  | Consensus-based recommendation     |
| Recommendation 4  | Grade                              |
| In line with the recognition by the College of the importance of reciprocal trust between practitioner and the patients and those who support them (cultural competency), it is imperative that an awareness of systemic inadequacies (such as poor communication, or lack of continuity of care, or non-collaborative models of care) remains a high priority in order to avoid these pitfalls | Consensus-based recommendation     |
| Recommendation 5  | Grade                              |
| The mental wellbeing of patients should be seen as important as physical health. Maternal anxiety and depression can have detrimental effects on fetal and infant development and on mother infant attachment   |                                    |

#### 4.4 2017 Perinatal Mental Health Care in the Perinatal Period – Evidence-based National Guidance

RANZCOG supports the *2017 Australian Clinical Practice Guideline Mental Health Care in the Perinatal Period*, which was developed by the Centre of Perinatal Excellence (COPE) and approved by the National Health and Medical Research Council (NHMRC). The Guideline recommends routine, universal antenatal and postnatal mental health screening [1].

Screening for possible symptoms of depression and anxiety is recommended using the EPDS. Psychosocial assessment to identify the presence of risk factors is also recommended, and if using a screening tool the Antenatal Risk Questionnaire (ANRQ) [3] is recommended.

Screening in pregnancy for perinatal mental health disorders is now a mandatory requirement. Local maternity health care facilities should negotiate ways to implement this. Private obstetricians should be aware of their MBS obligations and introduce screening into their routine antenatal care or facilitation through their private maternity unit and the requirements surrounding documentation for auditing purposes. For further details visit: <http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-ObstetricsServices>

Care should be taken to consider physical health issues as well as broader psychosocial issues (as identified by the psychosocial risk questions) such as intimate partner violence, drug and alcohol misuse, other stressors and comorbid health problems.

| Recommendation 6  | Grade and Reference                   |
|---|---------------------------------------|
| All pregnant women should be routinely screened for depression and anxiety symptoms. Use the Edinburgh Postnatal Depression Scale (EPDS) to screen women for a possible depressive disorder in the perinatal period<br>All pregnant women should also be screened for psychosocial risk factors. Screening for perinatal mood disorders, in the form of a psychosocial assessment or administration of a validated tool, such as the ANRQ [3]. Screening for psychosocial risk factors can be undertaken at the same time as screening for depression and anxiety and should be considered part of routine antenatal and postpartum care<br>Screening can be undertaken using written or digital approaches | Consensus-based recommendation [1, 3] |

| Recommendation 7   | Grade and Reference                |
|--|------------------------------------|
| In line with the Department of Health Pregnancy Care guidelines [4], all pregnant women should be routinely screened for Drug and Alcohol and Family Violence — It is also important to state that questions surrounding family violence should be asked when the woman is alone | Consensus-based recommendation [4] |
| Recommendation 8   | Grade                              |
| Any treatment offered should involve collaborative decision-making with the woman and her partner including a full discussion of the potential risks and benefits  | Consensus-based recommendation     |
| Recommendation 9   | Grade                              |
| The safety of mothers and infants needs to be considered at all times; as well as the safety of families   | Consensus-based recommendation     |

Refer to Appendix A for detailed recommendations from the *2017 Australian Mental Health Care in the Perinatal Period guideline* [1] which is available at:

[http://cope.org.au/wp-content/uploads/2018/05/Mental-health-care-in-the-perinatal-period\\_COPE-Guideline.pdf](http://cope.org.au/wp-content/uploads/2018/05/Mental-health-care-in-the-perinatal-period_COPE-Guideline.pdf)

#### 4.5 What are the diagnosis and safety issues?

For women with an EPDS score between 10–12, monitor and repeat 2–4 weeks later. Arrange further assessment of perinatal woman with an EPDS score of 13 or more 1 as it may suggest a crisis. Clinicians need to consider the safety of the infant at all times.

Appropriate guidelines for the general population and accepted diagnostic criteria (DSM-IV-TR or ICD-10) should be used when diagnosing depression, anxiety, bipolar disorder, psychosis or other mental health disorders. A diagnosis should not be made before considering physical conditions (e.g. thyroid dysfunction), sleep deprivation or recent events that might be relevant. A diagnosis of adjustment disorder or minor depression should also be considered.

#### 4.6 Assessing risk of suicide

| Recommendation 10*  | Grade                          |
|---|--------------------------------|
| When a woman is identified as at risk of suicide (through clinical assessment and/or the EPDS), manage immediate risk, arrange for urgent mental health assessment and consider support and treatment options | Consensus-based recommendation |

\*Taken directly from the 2017 Australian Mental Health Care in the Perinatal Period guideline which is available at: [http://cope.org.au/wp-content/uploads/2018/05/Mental-health-care-in-the-perinatalperiod\\_COPE-Guideline.pdf](http://cope.org.au/wp-content/uploads/2018/05/Mental-health-care-in-the-perinatalperiod_COPE-Guideline.pdf)

#### 4.7 What are the referral pathways?

Managing a mental health problem should be collaborative. Referral requires consent from the mother and referral options and/ or treatment plan should take into account the mother's preferences. In most cases, referral will be to the woman's usual GP or to a health professional with mental health training and expertise. Obstetricians should make themselves aware of referral options to mental health trained general practitioners, psychologists, psychiatrists, social workers and/or culturally appropriate services in their local area.

#### 4.8 Supporting emotional health and well-being

| Recommendation 11*  | Grade                          |
|---|--------------------------------|
| At every antenatal or postnatal visit, enquire about women's emotional wellbeing  | Consensus-based recommendation |
| Recommendation 12*  | Grade                          |
| Provide women 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 | Consensus-based recommendation |

\*Taken directly from the 2017 Australian Mental Health Care in the Perinatal Period guideline which is available at: [http://cope.org.au/wp-content/uploads/2018/05/Mental-health-care-in-the-perinatalperiod\\_COPE-Guideline.pdf](http://cope.org.au/wp-content/uploads/2018/05/Mental-health-care-in-the-perinatalperiod_COPE-Guideline.pdf)

#### 4.9 What are the management considerations?

Both psychological and pharmacological treatments have been shown to be effective in treating perinatal anxiety and depression.<sup>1</sup> Women with more severe depression or with bipolar disorder will need medication.

Psychological therapies specifically cognitive behavioural therapy (CBT), interpersonal psychotherapy (IPT) and psychodynamic therapy have been shown to improve depressive symptoms in the postnatal period.

Pharmacological treatment of depression and related disorders during the perinatal period is not likely to differ from approaches at other times. SSRIs are generally considered to be relatively low risk and safe to prescribe during pregnancy and while breastfeeding. Medications should only be prescribed after careful discussion with the mother. When symptoms are severe, involving a psychiatrist is advisable [15].

Reference should be made to the most recent TGA *Therapeutic Guidelines and Medications Handbook* for current advice for use of medication in the general population.

|   |                                    |
|---|------------------------------------|
| <b>Recommendation 13</b>  |                                    |
| 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 | Consensus-based recommendation [1] |

#### 4.10 Severe mental illness and borderline personality disorder in the perinatal period

RANZCOG supports the recommendations on severe mental illness and borderline personality disorder contained within the 2017 Australian Clinical Practice Guideline Mental Health Care in the Perinatal Period [1].

#### 4.11 Perinatal mental health in men

Perinatal mental health disorders affect up to 1 in 10 men. Maternity caregivers should be alert to this possibility and have referral pathways in place for men/partners who are affected. Further information regarding perinatal mental health in men is contained within the *2017 Australian Clinical Practice Guideline Mental Health Care in the Perinatal Period* [1].

### 5. References

1. Austin M-P, Highet N. and the Expert Working Group. Mental Health Care in the Perinatal Period: Australian Clinical Practice Guideline. Centre of Perinatal Excellence. Melbourne: 2017.
2. Austin MP, Priest S. New developments in perinatal mental health. *Acta Psychiatr Scand.* 2004; 110(5): 321–2.
3. Austin MP, Colton J, Priest S, Reilly N, Hadzi-Pavlovic D. The antenatal risk questionnaire (ANRQ): acceptability and use for psychosocial risk assessment in the maternity setting. *Women and birth: journal of the Australian College of Midwives.* 2013; 26(1): 17–25.
4. Department of Health. Clinical Practice Guidelines: Pregnancy Care, . Canberra: 2018.
5. Austin MP, Kildea S, Sullivan E. Maternal mortality and psychiatric morbidity in the perinatal period: challenges and opportunities for prevention in the Australian setting. *The Medical journal of Australia.* 2007; 186(7): 364–7.
6. Bielawska-Batorowicz EK-P, K. Depressive mood in men after the birth of their offspring in relation to a partner's depression, social support, fathers' personality and prenatal expectations. *Journal of Reproductive and Infant Psychology.* 2006; 24(1): 21–9.
7. Australian Institute of Health and Welfare (AIHW). Maternal deaths in Australia 2012–2014. Canberra: AIHW, 2017.
8. Bielawska-Batorowicz E, Kossakowska-Petrycka K. Depressive mood in men after the birth of their offspring in relation to a partner's depression, social support, fathers' personality and prenatal expectations. *Journal of Reproductive and Infant Psychology.* 2006; 24(1): 21–9.
9. Petrillo L, Nonacs, R, Viguera, AC, & Cohen, L. Course of psychiatric illness during pregnancy and the postpartum period. Cohen, L. & Nonacs, R, editors. *Review of psychiatry: Mood and anxiety disorders during pregnancy and postpartum.* 2005.
10. Smith M. Perinatal Depression – Assessment, Diagnosis & Management Strategies. Central Sydney GP Network Perinatal Meeting, 2010.
11. Born L, Zinga D, Steiner M. Challenges in identifying and diagnosing postpartum disorders. *Primary Psychiatry.* 2004; 11(3): 29–36.

12. Rapkin AL, Mikacich JA, Moatakef-Imani B. Reproductive Mood Disorders. *Primary Psychiatry*. 2003; 10(11): 31–40.
13. Wenzel A, Haugen EN, Jackson LC, Robinson K. Prevalence of generalized anxiety at eight weeks postpartum. *Arch Womens Ment Health*. 2003; 6(1): 43–9.
14. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *The British journal of psychiatry: the journal of mental science*. 1987; 150: 782–6.
15. Austin MP. Antenatal screening and early intervention for «perinatal» distress, depression and anxiety: where to from here? *Arch Womens Ment Health*. 2004; 7(1): 1–6.
16. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Canberra: 2009.

## 6. Screening and Assessment Tools for Health Professionals

2017 National Guideline Screening and Assessment Tools:

Screening for Anxiety and depression

EPDS Screening tool

EPDS Scoring Guide

Psychosocial Assessment – to detect the presence of risk factors

ANRQ Instructions

ANRQ questionnaire (with added family violence and drug and alcohol questions)

ANRQ Scoring Guide

Further information on the Psychosocial Assessment

## 7. Information and Training for Health Professionals

2017 National Guideline Factsheets for Health Professionals

Perinatal Depression

Perinatal Anxiety

Bipolar Disorder in the perinatal period

Schizophrenia in the perinatal period

Postpartum Psychosis

Borderline personality disorder in the perinatal period

Online training for Health Professionals

Basic Skills in Perinatal Mental Health – This is free online training program to equip health professionals with a background on emotional and mental health conditions, and provides guidance surrounding implementing screening, assessment, management and referral of women identified with perinatal mental health conditions.

Accessible at: [training.cope.org.au](http://training.cope.org.au)

## 8. Information for Women and their Families

A range of RANZCOG Patient Information Pamphlets can be ordered via:

<https://www.ranzcog.edu.au/Womens-Health/Patient-Information-Guides/Patient-Information-Pamphlets>

A range of patient information developed as part of the *2017 Australian Clinical Practice Guideline Mental Health Care in the Perinatal Period* includes:

Antenatal depression – consumer fact sheet

Antenatal anxiety – consumer fact sheet

Bipolar disorder in the pregnancy – consumer fact sheet

Postnatal Depression – consumer fact sheet

Postnatal Anxiety – consumer fact sheet

Bipolar disorder in the postnatal period – consumer fact sheet

Postpartum Psychosis – consumer fact sheet

Borderline Personality Disorder in the perinatal period – consumer fact sheet

Schizophrenia in the postnatal period – consumer fact sheet

### 9. Helplines

Perinatal Anxiety and Depression (PANDA) National Helpline 1300 726 306 (Monday to Friday 9am-7pm AEST).

The Gidget Foundation: starttalking@gidgetfoundation.org.au or call us on 1300 851 758.

### 10. Websites

| Organisation                                      | Specialisation   | Weblink   |
|---|--|---|
| Beyond Blue                                       | General consumer support for mental health conditions  | <a href="http://www.beyondblue.org.au">http://www.beyondblue.org.au</a>                   |
| Centre of Perinatal Excellence (COPE)             | Developer of the Australian Perinatal Mental Health Guideline, online training and resources for health professionals including digital screening platforms. Guideline resources also available for consumers                            | <a href="http://cope.org.au/">http://cope.org.au/</a>                                     |
| Gidget Foundation                                 | A not for profit organisation supporting the emotional wellbeing of expectant and new parents to ensure that those in need receive timely, appropriate and supportive care   | <a href="http://www.gidgetfoundation.com.au">http://www.gidgetfoundation.com.au</a>       |
| Good Beginnings                                   | An organisation dedicated to achieving more for children and their families in Australia's most disadvantaged communities through early childhood development programs   | <a href="http://www.goodbeginnings.org.au">http://www.goodbeginnings.org.au</a>           |
| Karitane  | We provide education and support on the unique challenges of parenting to mums and dads with children from birth to 5 years of age   | <a href="http://www.karitane.com.au">http://www.karitane.com.au</a>                       |
| Moodgym   | Moodgym is an interactive self-help book which helps you to learn and practise skills which can help to prevent and manage symptoms of depression and anxiety  | <a href="http://www.moodgym.anu.edu.au">http://www.moodgym.anu.edu.au</a>                 |
| Mental Health in Multicultural Australia          | Provides a national focus for advice and support to providers and governments on mental health and suicide prevention for people from culturally and linguistically diverse (CALD) backgrounds   | <a href="http://www.mhima.org.au">http://www.mhima.org.au</a>                             |
| Post and Antenatal Depression Association (PANDA) | Perinatal Anxiety & Depression Australia supports women, men and families across Australia affected by anxiety and depression during pregnancy and early parenthood  | <a href="http://www.panda.org.au/">http://www.panda.org.au/</a>                           |
| Parent-Infant Research Institute (PIRI)           | PIRI provides a unique contribution to early intervention in Australia by combining basic research and clinical expertise to address perinatal depression and other difficulties facing parents and infants                              | <a href="http://www.piri.org.au">http://www.piri.org.au</a>                               |
| Tresillian  | Tresillian is an early parenting service offering families guidance in the early years of their child's life. We support new parents around breastfeeding and settling baby, as well as dealing with post-natal depression and nutrition | <a href="http://www.tresillian.net">http://www.tresillian.net</a>                         |
| What were we thinking?                            | This website contains information about common experiences in the early months of parenthood and some effective ways of thinking about and managing them   | <a href="http://www.whatwerewethinking.org.au/">http://www.whatwerewethinking.org.au/</a> |

### 11. Further information regarding perinatal MBS items

Further information regarding the 2017 Changes to MBS Items for Obstetrics Services can be found here:

<http://www.mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/Factsheet-ObstetricsServices>

### 12. Other suggested reading

Depression

Lam RW, Kennedy SH, Grigoriadis S et al. Clinical guidelines for the management of major depressive disorder in adults: III. Pharmacotherapy. Canadian Network for Mood and Anxiety Treatments (-CANMAT). J Affective Disorders 2009; 117: S26-S43.

NICE (2009) Depression: the Treatment and Management of Depression in Adults: National Clinical Practice Guideline 90 (Full Guidance). National Institute for Health and Clinical Excellence.



Parikh SV, Segal ZV, Grigoriadis S et al. Clinical guidelines for the management of major depressive disorder in adults: II. Psychotherapy alone or in combination with antidepressant medication. Canadian Network for Mood and Anxiety Treatments (CANMAT). *J Affective Disorders* 2009; 117: S15-S25.

Patten SB, Kennedy SH, Lam RW et al. Clinical Guidelines for the Management of Major Depressive Disorder in Adults: I. Classification, Burden and Principles of Management. Canadian Network for Mood and Anxiety Treatments (CANMAT). *J Affective Disorders* 2009; 117: S5-S14.

RANZCP. Australian and New Zealand clinical practice guidelines for the treatment of depression. *Aust NZ J Psychiatry* 2004; 38: 389–407.

RANZCP (2009) Position Statement 57 Mothers, Babies and Psychiatric Inpatient Treatment. Royal Australian and New Zealand College of Psychiatrists.

SIGN (2010) Non-pharmaceutical Management of Depression in Adults: A National Clinical Guideline. Edinburgh: Scottish Intercollegiate Guidelines Network.

#### Anxiety disorders

NICE (2004; amended 2007) Anxiety: Management of Anxiety (Panic Disorder, with or without Agoraphobia, and Generalised Anxiety Disorder) in Adults in Primary, Secondary and Community Care. National Institute for Health and Clinical Excellence.

#### Bipolar disorder

NICE (2006) The Management of Bipolar Disorder in Adults, Children and Adolescents, in Primary and Secondary Care. National Institute for Health and Clinical Excellence.

RANZCP. Australian and New Zealand clinical practice guidelines for the treatment of bipolar disorder. *Aust NZ J Psychiatry* 2004; 38: 280–305.

Yatham LN, Kennedy SH, Schaffer A et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) collaborative update of CANMAT guidelines for the management of patients with bipolar disorder: update. *Bipolar Disord* 2009; 11(3): 225–55.

### 13. Links to other College statements

#### Cultural Competency (WPI 20)

[https://www.ranzcog.edu.au/RANZCOG\\_SITE/media/RANZCOGMEDIA/Women%27s%20Health/Statement%20and%20guidelines/Workforce%20and%20Practice%20Issues/Cultural-Competency-\(WPI-20\)-Review-November-2014.pdf?ext=.pdf](https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOGMEDIA/Women%27s%20Health/Statement%20and%20guidelines/Workforce%20and%20Practice%20Issues/Cultural-Competency-(WPI-20)-Review-November-2014.pdf?ext=.pdf)

#### Evidence-based Medicine, Obstetrics and Gynaecology (C-Gen 15)

[https://www.ranzcog.edu.au/RANZCOG\\_SITE/media/RANZCOGMEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20%20General/Evidence-based-medicine,-Obstetrics-and-Gynaecology-\(C-Gen-15\)-Review-March-2016.pdf?ext=.pdf](https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOGMEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical%20%20General/Evidence-based-medicine,-Obstetrics-and-Gynaecology-(C-Gen-15)-Review-March-2016.pdf?ext=.pdf)

## Appendices

### Appendix A

#### Summary of recommendations from the 2017 Australian Mental Health Care in the Perinatal Period guideline

The following recommendations are taken directly from the 2017 Australian Mental Health Care in the Perinatal Period guideline which is available in full at:

[http://cope.org.au/wpcontent/uploads/2018/05/Mental-health-care-in-the-perinatal-period\\_COPE-Guideline.pdf](http://cope.org.au/wpcontent/uploads/2018/05/Mental-health-care-in-the-perinatal-period_COPE-Guideline.pdf)

For information, these recommendations are graded using the GRADE process. 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 or

– 'conditional' – implies that not all individuals will be best served by the recommended course of action; used when desirable effects probably outweigh undesirable effects; used when undesirable effects probably outweigh desirable effects

- consensus-based recommendation (CBR) – a recommendation formulated in the absence of quality evidence, after a systematic review of the evidence was conducted and failed to identify sufficient admissible evidence on the clinical question.
- practice point (PP) – advice on a subject that is outside the scope of the search strategy for the systematic evidence review, based on expert opinion and formulated by a consensus process.

### Training for screening and psychosocial assessment

|   |                                |   |
|---|--------------------------------|---|
| I | Consensus Based Recommendation | All health professionals providing care in the perinatal period should receive training in woman-centred communication skills, psychosocial assessment and culturally safe care |
|---|--------------------------------|---|

### Screening for depression

|      |                                |  |        |
|------|--------------------------------|--|--------|
| 1    | Evidence Based Recommendation  | Use the Edinburgh Postnatal Depression Scale (EPDS) to screen women for a possible depressive disorder in the perinatal period   | Strong |
| 2    | Evidence Based Recommendation  | Arrange further assessment of perinatal woman with an EPDS score of 13 or more   | Strong |
| II   | Consensus Based Recommendation | Complete the first antenatal screening as early as practical in pregnancy and repeat screening at least once later in pregnancy  |        |
| III  | Consensus Based Recommendation | Complete the first postnatal screening 6–12 weeks after birth and repeat screening at least once in the first postnatal year   |        |
| IV   | Consensus Based Recommendation | For a woman with an EPDS score between 10 and 12, monitor and repeat the EPDS 2–4 weeks later as her score may increase subsequently   |        |
| V    | Consensus Based Recommendation | Repeat the EPDS at any time in pregnancy and in the first postnatal year if clinically indicated   |        |
| VI   | Consensus Based 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 |        |
| VII  | Consensus Based Recommendation | When screening Aboriginal and Torres Strait Islander women, consider language and cultural appropriateness of the tool   |        |
| VIII | Consensus Based Recommendation | Use appropriately translated versions of the EPDS with culturally relevant cut-off scores. Consider language and cultural appropriateness of the tool  |        |

### Screening for anxiety

|    |                                |   |
|----|--------------------------------|---|
| IX | Consensus Based Recommendation | Be aware that anxiety disorder is very common in the perinatal period and should be considered in the broader clinical assessment   |
| X  | Consensus Based Recommendation | As part of the clinical assessment, use anxiety items from screening tools (e.g. EPDS items 3, 4 and 5, DASS anxiety items and K-10 items 2, 3, 5 and 6) and relevant items in structured psychosocial assessment tools (e.g. ANRQ) |

### Assessing psychosocial risk

|    |                                |  |        |
|----|--------------------------------|--|--------|
| a  | Practice Point                 | Assess psychosocial risk factors as early as practical in pregnancy and again after the birth  |        |
| 3  | Evidence Based Recommendation  | If using a tool to assess psychosocial risk, administer the Antenatal Risk Questionnaire (ANRQ)  | Strong |
| XI | Consensus Based Recommendation | Undertake psychosocial assessment in conjunction with a tool that screens for current symptoms of depression/anxiety (i.e. the EPDS)     |        |
| b  | Practice Point                 | Ensure that health professionals receive training in the importance of psychosocial assessment and use of a psychosocial assessment tool |        |

|     |                                |  |
|-----|--------------------------------|--|
| c   | Practice Point                 | 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 |
| d   | Practice Point                 | Discuss with the woman the possible impact of psychosocial risk factors (she has endorsed) on her mental health and provide information about available assistance                             |
| XII | Consensus Based Recommendation | Consider language and cultural appropriateness of any tool used to assess psychosocial risk  |

### Assessing mother-infant interaction and safety of the infant

|   |                |  |
|---|----------------|--|
| e | Practice Point | Assess the mother-infant interaction as an integral part of postnatal care and refer to a parent-infant therapist as available and appropriate   |
| f | Practice Point | Seek guidance/support from Aboriginal and Torres Strait Islander health professionals or bicultural health workers when assessing mother-infant interaction in Aboriginal and Torres Strait Islander or migrant and refugee women, to ensure that assessment is not informed by unconscious bias |
| g | Practice Point | 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  |

## Appendix D

### RANZCOG Women's Health Committee Membership

| Name                              | Position on Committee     |
|-----------------------------------|---------------------------|
| Professor Yee Leung               | Chair                     |
| Dr Joseph Sgroi                   | Deputy Chair, Gynaecology |
| Associate Professor Lisa Hui      | Member                    |
| Associate Professor Ian Pettigrew | EAC Representative        |
| Dr Tal Jacobson                   | Member                    |
| Dr Ian Page                       | Member                    |
| Dr John Regan                     | Member                    |
| Dr Craig Skidmore                 | Member                    |
| Associate Professor Janet Vaughan | Member                    |
| Dr Bernadette White               | Member                    |
| Dr Scott White                    | Member                    |
| Associate Professor Kirsten Black | Member                    |
| Dr Greg Fox                       | College Medical Officer   |
| Dr Marilyn Clarke                 | Chair of the ATSI WHC     |
| Dr Martin Byrne                   | GPOAC Representative      |
| Ms Catherine Whitby               | Community Representative  |
| Ms Sherryn Elworthy               | Midwifery Representative  |
| Dr Amelia Ryan                    | Trainee Representative    |

## Appendix E

### Overview of the development and review process for this statement

#### I. Steps in developing and updating this statement

This statement was originally developed in March 2012 and was most recently reviewed in June 2018. The Women's Health Committee carried out the following steps in reviewing this statement:

- Declarations of interest were sought from all members prior to reviewing this statement.
- The review group assessed the statement in relation to the 2017 Clinical Practice Guideline Mental Health Care in the Perinatal Period. The existing consensus-based recommendations were reviewed and updated (where appropriate) based on the available body of evidence and clinical expertise. Recommendations were graded as set out below in Appendix E part III)

II. *Declaration of interest process and management*

Declaring interests is essential in order to prevent any potential conflict between the private interests of members, and their duties as part of the Women's Health Committee.

A declaration of interest form specific to guidelines and statements was developed by RANZCOG and approved by the RANZCOG Board in September 2012. The Women's Health Committee members were required to declare their relevant interests in writing on this form prior to participating in the review of this statement.

Members were required to update their information as soon as they become aware of any changes to their interests and there was also a standing agenda item at each meeting where declarations of interest were called for and recorded as part of the meeting minutes.

There were no significant real or perceived conflicts of interest that required management during the process of updating this statement.

III. *Grading of recommendations*

Each recommendation in this College statement is given an overall grade as per the table below, based on the National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines [16] Where no robust evidence was available but there was sufficient consensus within the Women's Health Committee, consensusbased recommendations were developed or existing ones updated and are identifiable as such. Consensus-based recommendations were agreed to by the entire committee. Good Practice Notes are highlighted throughout and provide practical guidance to facilitate implementation. These were also developed through consensus of the entire committee.

| Recommendation category |   | Description  |
|-------------------------|---|--|
| Evidence-based          | A | Body of evidence can be trusted to guide practice  |
|                         | B | Body of evidence can be trusted to guide practice in most situations                                     |
|                         | C | Body of evidence provides some support for recommendation(s) but care should be taken in its application |
|                         | D | The body of evidence is weak and the recommendation must be applied with caution                         |
| Consensus-based         |   | Recommendation based on clinical opinion and expertise as insufficient evidence available                |
| Good Practice Note      |   | Practical advice and information based on clinical opinion and expertise                                 |

The recommendations contained within the 2017 Australian Clinical Practice Guideline Mental Health Care in the Perinatal Period 1 were graded using the GRADE process. 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 or

– 'conditional' – implies that not all individuals will be best served by the recommended course of action; used when desirable effects probably outweigh undesirable effects; used when undesirable effects probably outweigh desirable effects

- consensus-based recommendation (CBR) – a recommendation formulated in the absence of quality evidence, after a systematic review of the evidence was conducted and failed to identify sufficient admissible evidence on the clinical question
- practice point (PP) – advice on a subject that is outside the scope of the search strategy for the systematic evidence review, based on expert opinion and formulated by a consensus process.

## Full Disclaimer

This information is intended to provide general advice to practitioners, and should not be relied on as a substitute for proper assessment with respect to the particular circumstances of each case and the needs of any patient.

This information has been prepared having regard to general circumstances. It is the responsibility of each practitioner to have regard to the particular circumstances of each case. Clinical management should be responsive to the needs of the individual patient and the particular circumstances of each case.

This information has been prepared having regard to the information available at the time of its preparation, and each practitioner should have regard to relevant information, research or material which may have been published or become available subsequently.

Whilst the College endeavours to ensure that information is accurate and current at the time of preparation, it takes no responsibility for matters arising from changed circumstances or information or material that may have become subsequently available.

## ДО УВАГИ АВТОРІВ!

## АЛГОРИТМ РЕЄСТРАЦІЇ ORCID

**Open Researcher and Contributor ID (ORCID) — міжнародний ідентифікатор науковця**

Створення єдиного реєстру науковців та дослідників на міжнародному рівні є найбільш прогресивною та своєчасною ініціативою світового наукового товариства. Ця ініціатива була реалізована через створення в 2012 році проекту Open Researcher and Contributor ID (ORCID). ORCID — це реєстр унікальних ідентифікаторів вчених та дослідників, авторів наукових праць та наукових організацій, який забезпечує ефективний зв'язок між науковцями та результатами їх дослідницької діяльності, вирішуючи при цьому проблему отримання повної і достовірної інформації про особу вченого в науковій комунікації.

Для того щоб зареєструватися в ORCID через посилання <https://orcid.org/> необхідно зайти у розділ «For researchers» і там натиснути на посилання «Register for an ORCID iD».

В реєстраційній формі послідовно заповнюються обов'язкові поля: «First name», «Last name», «E-mail», «Re-enter E-mail», «Password» (Пароль), «Confirm password»

В перше поле вводиться ім'я, яке надане при народженні, по-батькові не вводиться. Персональна електронна адреса вводиться двічі для підтвердження. Вона буде використовуватися як Login або ім'я користувача. Якщо раніше вже була використана електронна адреса, яка пропонується для реєстрації, з'явиться попередження червоного кольору. **Неможливе створення нового профілю з тією ж самою електронною адресою.** Пароль повинен мати не менше 8 знаків, при цьому містити як цифри, так і літери або символи. Пароль, який визначається словами «Good» або «Strong» приймається системою.

Нижче визначається «Default privacy for new works», тобто налаштування конфіденційності або доступності ідентифікатора, серед яких «Public», «Limited», «Private».

Далі визначається частота повідомлень, які надсилає ORCID на персональну електронну адресу, а саме, новини або події, які можуть представляти інтерес, зміни в обліковому записі, тощо: «Daily summery», «Weekly summery», «Quarterly summery», «Never». Необхідно поставити позначку в полі «I'm not a robot» (Я не робот).

Останньою дією процесу реєстрації є узгодження з політикою конфіденційності та умовами користування. Для реєстрації необхідно прийняти умови використання, натиснувши на позначку «I consent to the privacy policy and conditions of use, including public access and use of all my data that are marked Public».

Заповнивши поля реєстраційної форми, необхідно натиснути кнопку «Register», після цього відкривається сторінка профілю учасника в ORCID з особистим ідентифікатором ORCID ID. Номер ORCID ідентифікатора знаходиться в лівій панелі під ім'ям учасника ORCID.

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Наприклад: <http://orcid.org/0000-0001-7855-1679>.

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