Category: Best Practice Statement

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: November 2021
Review due: November 2026

Objectives: To provide advice on identifying 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 Australian national evidence-based guideline *Mental Health Care In The Perinatal Period* [1]. It was most recently reviewed by the Women's Health Committee in September 2021, when the Committee approved the document with a provision for final edits to be added to the statement in agreement with the authors.

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

Contents

1. Plain language summary 3

2. Summary of recommendations 3

3. Introduction 5

4. Discussion 5

4.1 How common is perinatal anxiety and depression? 5

4.2 Why is identification and treatment important? 6

4.3 Identification of depressive and anxiety disorders 6

4.4 2017 Perinatal Mental Health Care in the Perinatal Period - Evidence-based National Guidance 7

4.5 What are the diagnosis and safety issues? 9

4.6 Assessing risk of suicide 9

4.7 What are the referral pathways? 9

4.8 Supporting emotional health and well-being 10

4.9 What are the management considerations? 10

4.10 Severe mental illness and borderline personality disorder in the perinatal period 10

4.11 Perinatal mental health in men/partners 11

5. References 11

6. Information for Women and their Families 12

7. National Helplines: 12

8. Websites 12

10. Medical Benefits Scheme (MBS): Information on perinatal MBS items 14

11. Other suggested reading 14

12. Links to other College statements 15

Appendices 16

Appendix A Women's Health Committee Membership (2021) (11th Council) 16

Appendix B: Contributing authors 16

Appendix C: Summary of recommendations from the 2017 Australian Mental Health Care in the Perinatal Period guideline 17

Appendix D: Overview of the development and review process for this statement 20

Steps in developing and updating this statement 20

Declaration of interest process and management 20

Grading of recommendations 20

Appendix E Full Disclaimer 21

1. Plain language summary

Mental health problems are common during pregnancy and after birth. There has been increased focus on the early detection and treatment of depression and anxiety during pregnancy and after the birth due to the recognition of the impact that emotional wellbeing can have on a women, partner and family. 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 mother, partner and baby. Assessment of the mental wellbeing of women should be seen as important as their physical health. Maternal anxiety and depression can have detrimental effects on fetal and infant development, on mother infant attachment and on family relationships.

This statement emphasises the importance of timely detection, and referral for early intervention if needed, of mental health conditions during the perinatal period. In line with Australian clinical practice guideline: Mental Health Care in the Perinatal Period (2017) [1], those providing maternity and postnatal care should consider using recommended screening tools to help identify women and their partners who would benefit from specialised care.

2. Summary of recommendations

Recommendation 1	Grade
Health professionals providing care in the perinatal period should be trained in woman-centred communication skills, psychosocial assessment and cultural safety to screen for Anxiety and Depression and perform Psychosocial Assessment.	Consensus-based recommendation [1]
Recommendation 2	**Grade**
Conduct routine screening for depression and anxiety symptoms and psychosocial risk factors as early as practical in pregnancy and repeat at least once later in the pregnancy. Conduct the first postnatal screening from 6–12 weeks after birth and repeat screening at least once in the first postnatal year. Repeat screening at any time, if clinically indicated.	Consensus-based recommendation [1-3]
Recommendation 3	**Grade**
Obstetricians delivering perinatal mental health care should promote culturally sensitive communications that are inclusive, collaborative and ongoing.	Consensus-based recommendation
Recommendation 4	**Grade**
All women in the perinatal period should be routinely screened for depression and anxiety symptoms using a validated scale (the Edinburgh Postnatal Depression Scale (EPDS)[4] is recommended). For perinatal women with EPDS scores: • between 10-12: repeat testing 2-4 weeks later; • 13 or higher - arrange further assessment.	Evidence based recommendation - Strong [1, 5]

Recommendation 5	Grade
All women in the perinatal period should be screened for psychosocial risk factors using validated screening tools (such as the ANRQ[5]) as early as practical in pregnancy.	Evidence based recommendation - Strong [1, 5]
Recommendation 6	**Grade**
Early in pregnancy, assess a woman's use of tobacco, alcohol and any illicit substances and misuse of pharmaceuticals, and provide advice about the associated harms.	Consensus-based recommendation [3]
Recommendation 7	**Grade**
All pregnant women should be asked about their exposure to Family Violence, using validated assessment tools. (Asking questions surrounding Family Violence should be asked when the woman is alone, using validated tools as recommended by jurisdiction.[3] Medical practitioners should use clear referral pathways for those recognised as at risk.)	Consensus-based recommendation [3]
Recommendation 8	**Grade**
Medical practitioners offering treatment should involve collaborative decision-making with the woman (and significant other(s), if the woman agrees) including a full discussion of the potential risks and benefits.	Consensus-based recommendation
Good practice point	
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.[1]	
Good practice point	
At every antenatal or postnatal visit, enquire about women's emotional wellbeing.[1]	
Good practice point	
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.[1]	
Recommendation 9	**Grade**
Medications should only be prescribed after careful discussion with the woman (and her significant other(s), if agreed) about the risks and benefits of pharmacological treatment with ongoing monitoring and evaluation.	Consensus-based recommendation [1]

Recommendation 10	Grade
Provide women with timely referral to appropriate services for ongoing psychosocial support and appropriate treatment according to jurisdictional referral and care pathways (e.g. general practice, maternity services) and location (e.g. metropolitan, rural, regional and remote).	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 are 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. Obstetricians are in a unique position to develop a long-term trusting relationship with women and their families.

The perinatal period is a time of great adjustment for women and their partners. While many couples resolve issues that may arise, for other 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, domestic 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 and New Zealand.[6-8] 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 government data suggests that anxiety and/ or depression is experienced by up to 10% of women during pregnancy, and one in seven in the year after birth.[9] 10% of partners are also affected.[10] Puerperal psychosis, which is considered a psychiatric emergency, affects around 1 in 1000 women. Bipolar disorder is at greater risk of reoccurring and women with bipolar disorder 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. Maternal anxiety and depression can have detrimental effects on fetal and infant development, on mother infant attachment and on family relationships. Early detection and intervention and referral pathways to appropriate care 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, partners and children especially in respect to the critical parent-infant attachment that potentially influences the mental health of the next generation.[11]

4.3 Identification of depressive and anxiety disorders

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM 5, 2013) diagnostic criteria suggest that women during the perinatal period 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[11] a diagnosis can be difficult. Problems sleeping[12, 13] should be investigated and anxiety disorders should also be considered.[14]

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

Health professionals providing care in the perinatal period should be trained in woman-centred communication skills, psychosocial assessment and cultural safety to screen for Anxiety and Depression and perform Psychosocial Assessment.	Consensus-based recommendation [1]

Recommendation 2	Grade
Conduct routine screening for depression and anxiety symptoms and psychosocial risk factors as early as practical in pregnancy and repeat at least once later in the pregnancy. Conduct the first postnatal screening from 6–12 weeks after birth and repeat screening at least once in the first postnatal year. Repeat screening at any time, if clinically indicated	Consensus-based recommendation [1-3]

Recommendation 3	Grade
Obstetricians delivering perinatal mental health care should promote culturally sensitive communications that are inclusive, collaborative and ongoing.	Consensus-based recommendation

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] (digital questionnaires are available).

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 a full discussion of the potential risks and benefits of any treatments offered. [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)[5] and Postnatal Risk Questionnaire (PNRQ) are recommended.

When screening Aboriginal and Torres Strait Islander women, the guideline recommends that language and cultural appropriateness (of the tools) are considered. [1]

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 (in Australia) should be aware of their MBS obligations and introduce screening into their routine antenatal care or

* Within the 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".

facilitation through their private maternity unit and the requirements surrounding documentation for auditing purposes. Under the MBS a complex birth (MBS item 16522) includes:

> (m) mental health disorder (whether arising prior to pregnancy, during pregnancy or postpartum) that is demonstrated by:
> (i) the woman requiring hospitalisation; or
> (ii) the patient receiving ongoing care by a psychologist or psychiatrist to treat the symptoms of a mental health disorder; or
> (iii) the patient having a GP mental health treatment plan; or
> (iv) the patient having a management plan prepared in accordance with item 291;
> (n) disclosure or evidence of domestic violence;

Extract from: Medicare Benefits Schedule: Changes to MBS Items for Obstetrics Services, effective from 2017

The MBS item (16590) will also include: a mental health assessment, including screening for drug and alcohol use and domestic violence. The mental health service will be offered to every woman however, if the woman chooses not to undertake the assessment they will not be disadvantaged. 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 co-morbid health problems. The safety of mothers and infants needs to be considered at all times; as well as the safety of families.

Recommendation 4	Grade
All women in the perinatal period should be routinely screened for depression and anxiety symptoms using a validated scale (the Edinburgh Postnatal Depression Scale (EPDS)[4] is recommended). For perinatal women with EPDS scores: • between 10-12: repeat testing 2-4 weeks later; • 13 or higher - arrange further assessment.	Evidence based recommendation - Strong [1, 5]
Recommendation 5	**Grade**
All women in the perinatal period should be screened for psychosocial risk factors using validated screening tools (such as the ANRQ[5]) as early as practical in pregnancy.	Evidence based recommendation - Strong
Recommendation 6	**Grade**
Early in pregnancy, assess a woman's use of tobacco, alcohol and any illicit substances and misuse of pharmaceuticals, and provide advice about the associated harms.	Consensus-based recommendation [3]
Recommendation 7	**Grade**
All pregnant women should be asked about their exposure to Family Violence, using validated assessment tools. (Asking questions surrounding Family Violence should be asked when the woman is alone, using validated tools as recommended by jurisdiction.[3]	Consensus-based recommendation [3]

Medical practitioners should use clear referral pathways for those recognised as at risk.)	
Recommendation 8	**Grade**
Medical practitioners offering treatment should involve collaborative decision-making with the woman (and significant other(s), if the woman agrees) including a full discussion of the potential risks and benefits.	Consensus-based recommendation

Refer to Appendix B for detailed recommendations from the 2017 Australian Mental Health Care in the Perinatal Period guideline (2017). [1]

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. Medical practitioners need to consider the safety of mothers and infants at all times.

Appropriate guidelines for the general population and accepted diagnostic criteria (DSM-5 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

Good practice point	
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.[1]	

4.7 What are the referral pathways?

Care planning for a woman with a mental health condition requires close multidisciplinary collaboration; and a particular focus on continuity of care across the different health and other government sectors. [1]

Referral requires consent from the mother and referral options and/ or treatment plan should be women centred and guided by 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, domestic violence services and/or culturally appropriate services in their local area.

4.8 Supporting emotional health and well-being

Recommendation 9	Grade
Medications should only be prescribed after careful discussion with the woman (and her significant other(s), if agreed) about the risks and benefits of pharmacological treatment with ongoing monitoring and evaluation.	Consensus-based recommendation [1]
Recommendation 10	**Grade**
Provide women with timely referral to appropriate services for ongoing psychosocial support and appropriate treatment according to jurisdictional referral and care pathways (e.g. general practice, maternity services) and location (e.g. metropolitan, rural, regional and remote).	Consensus-based recommendation [1]
Good practice point	
At every antenatal or postnatal visit, enquire about women's emotional wellbeing.[1]	
Good practice point	
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.[1]	

4.9 What are the management considerations?

Both psychological and pharmacological treatments have been shown to be effective in treating perinatal anxiety and depression.[1] 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. [1] 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.

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 section 1.2 of the Australian clinical practice guideline for Mental Health Care in the Perinatal Period (2017).[1]

4.11 Perinatal mental health in men/partners

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 in section 1.3 of the Australian clinical practice guideline for Mental Health Care in the Perinatal Period (2017).[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. Department of Health. Clinical Practice Guidelines: Pregnancy Care, . Canberra: 2018.
4. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. Br J Psychiatry. 1987;150:782-6.
5. 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 Birth. 2013;26(1):17-25.
6. Austin MP, Kildea S, Sullivan E. Maternal mortality and psychiatric morbidity in the perinatal period: challenges and opportunities for prevention in the Australian setting. Med J Aust. 2007;186(7):364-7.
7. Australian Institute of Health and Welfare (AIHW). Maternal deaths in Australia 2012–2014. Canberra: AIHW, 2017.
8. Health Quality & Safety Commission New Zealand. Maternal mortality (Te mate o ngā whaea). Extract of Fourteenth Annual Report of the Perinatal and maternal Mortality Review Committee.: HQSC; 2020. Available from: https://www.hqsc.govt.nz/assets/PMMRC/Publications/14thPMMRCreport/Maternal_mortality.pdf.
9. Australian Government. Perinatal Mental Health and Wellbeing Program media release [press release]. Department of Health.2020.
10. Paulson JF, Bazemore SD. Prenatal and postpartum depression in fathers and its association with maternal depression: a meta-analysis. JAMA. 2010;303(19):1961-9.
11. Petrillo L N, 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.
12. Born L, Zinga D, Steiner M. Challenges in identifying and diagnosing postpartum disorders. Primary Psychiatry. 2004;11(3):29-36.
13. Rapkin AL, Mikacich JA, Moatakef-Imani B. Reproductive Mood Disorders. Primary Psychiatry. 2003;10(11):31-40.
14. Wenzel A, Haugen EN, Jackson LC, Robinson K. Prevalence of generalized anxiety at eight weeks postpartum. Archives of women's mental health. 2003;6(1):43-9.
15. Austin MP. Antenatal screening and early intervention for "perinatal" distress, depression and anxiety: where to from here? Archives of women's mental health. 2004;7(1):1-6.
16. Balshem H, Helfand M, Schünemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011;64(4):401-6.

6. 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

Further, information for consumers 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

7. National Helplines:

Perinatal Anxiety and Depression Australia (PANDA) National Helpline +61 1300 726 306 (Monday to Friday 9am-7pm AEST).

Perinatal Anxiety and Depression Aotearoa Phone (+64) 04 461 6318. PADA, formerly the Perinatal Mental Health New Zealand Trust (PMHNZ), aims to champion awareness and facilitate best practice in perinatal mental health and wellbeing to ensure all families have access to appropriate information and support.

8. Websites

Organisation	Specialisation	Weblink
Beyond Blue	General consumer support for mental health conditions	http://www.beyondblue.org.au
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.	http://cope.org.au/
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	http://www.gidgetfoundation.com.au
Good Beginnings	An organisation dedicated to achieving more for children and their families in	http://www.goodbeginnings.org.au

Organisation	Specialisation	Weblink
	Australia's most disadvantaged communities through early childhood development programs	
Health Navigator New Zealand Perinatal depression resources	A non-profit community initiative providing New Zealanders with reliable and trustworthy health information and self-care resources, including information on antenatal and postnatal depression and anxiety.	https://www.healthnavigator.org.nz/health-a-z/d/depression-perinatal/
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.	http://www.karitane.com.au
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	http://www.moodgym.anu.edu.au
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.	http://www.mhima.org.au
Perinatal Anxiety and Depression Australia (PANDA)	Perinatal Anxiety & Depression Australia supports women, men and families across Australia affected by anxiety and depression during pregnancy and early parenthood	http://www.panda.org.au/
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	http://www.piri.org.au
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.	http://www.tresillian.net
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.	http://www.whatwerewethinking.org.au/

9.

Organisation	Specialisation	Weblink
Perinatal Wellbeing Centre	Primarily funded by ACT Health, it is staffed by experienced, non-clinical support workers	https://www.perinatalwellbeingcentre.org.au/

10. Medical Benefits Scheme (MBS): Information on 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

11. 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.
- 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;^{2}4(1):21-9.
- 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

- National Institute for Health and Clinical Excellence.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.
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Bipolar disorder

- National Institute for Health and Clinical Excellence.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.

Family violence

- WHO (2014) Health care for women subjected to intimate partner violence or sexual violence. A Clinical Handbook.
- Aotearoa New Zealand Pregnancy and Reproductive Health - mental health guide (2019), published by BPAC.
- Royal Australian College of General Practice (RACGP) Family Abuse and Violence Professional Development Program

12. Links to other College statements

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

Substance use in pregnancy (C-Obs 55)
https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Substance-use-in-pregnancy-(C-Obs-55)-March-2018.pdf?ext=.pdf

Appendices

Appendix A Women's Health Committee Membership (2021) (11th Council)

Name	Position on Committee
Professor Yee Leung	Chair and Board Member
Dr Gillian Gibson	Deputy Chair, Gynaecology
Dr Scott White	Deputy Chair, Obstetrics and Subspecialties Representative
Dr Jared Watts	Member and EAC Representative
Dr Kristy Milward	Member and Councillor
Dr Will Milford	Member and Councillor
Dr Frank O'Keeffe	Member and Councillor
Professor Sue Walker	Member
Prof Steve Robson	Member
Dr Roy Watson	Member and Councillor
Dr Susan Fleming	Member and Councillor
Dr Sue Belgrave	Member and Councillor
Dr Marilyn Clarke	ATSI Representative
Associate Professor Kirsten Black	Member
Dr Thangeswaran Rudra	Member
Dr Nisha Khot	Member and SIMG Representative
Dr Judith Gardiner	Diplomate Representative
Dr Angela Brown	Midwifery Representative, Australia
Ms Adrienne Priday	Midwifery Representative, New Zealand
Ms Ann Jorgensen	Community Representative
Dr Ashleigh Seiler	Trainee Representative
Dr Leigh Duncan	Maori Representative
Prof Caroline De Costa	Co-opted member (ANZJOG member)
Dr Christine Sammartino	Observer

Appendix B: Contributing authors

RANZCOG Women's Health Committee would like to acknowledge the significant contribution of Ms Catherine Knox to the 2021 update of this statement.

Appendix C: Summary of recommendations from the 2017 Australian Mental Health Care in the Perinatal Period guideline

The following recommendations are taken directly from the Australian clinical practice guideline Mental Health Care in the Perinatal Period (2017). [1]

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: Overview of the development and review process for this statement

Steps in developing and updating this statement

This statement was developed in November 2021. 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.

Structured clinical questions were developed and agreed upon.

An updated literature search to answer the clinical questions was undertaken.

At the September 2021 Committee meeting, the 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 B part iii)

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.

Grading of recommendations

For information, each recommendation in this College statement is given an overall grade using the GRADE[16] process, based on:

- the Evidence-based recommendation (EBR) – a recommendation formulated after a systematic review of the evidence, with a clear linkage from the evidence base to the recommendation using 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.
- Good practice point/Practice Point – 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.

The National Health and Medical Research Council (NHMRC) Levels of Evidence and Grades of Recommendations for Developers of Guidelines has been replaced with GRADE.

Appendix E Full Disclaimer

Purpose

This Statement has been developed to provide general advice to practitioners about women's health issues concerning mental health care in the perinatal period 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 person with need for mental health care. 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 person and the particular circumstances of each case.

Quality of information

The information available in Mental health care in the perinatal period (C-Obs 48) is intended as a guide and provided for information purposes only. The information is based on the Australian/New Zealand context using the best available evidence and information at the time of preparation. While the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) had endeavoured 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. The use of this information is entirely at your own risk and responsibility.

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Exclusion of liability

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Version	Date of Version	Pages revised / Brief Explanation of Revision
v1.1	Mar / 2012	WHC
v2.1	Mar/2015	WHC
v3.1	Mar/2018	WHC (renamed)

Policy Version:	Version 4.1
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Policy Approved by:	RANZCOG Council/Board
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