



Antenatal and Postnatal Depression

A GUIDE TO MANAGEMENT



www.beyondblue.org.au

- ◆ **Diagnose depression early, discuss it with the woman and her partner and actively treat it.**
- ◆ **Develop a management plan. Discussion with the woman's local Child Health Nurses (CHN) and contact with organisations listed (see Resources) should provide the support your patient needs in conjunction with your ongoing involvement.**

DIAGNOSIS

The Edinburgh Postnatal Depression Scale (EPDS; Cox et al., Brit J Psychiatry 1987; 150: 782-86) is an efficient means of giving an indication of depressive illness both antenatally and postnatally.

- ◆ Women with scores consistently 13 or more have a high probability of meeting diagnostic criteria for major depression.
- ◆ If symptoms are less severe or present for a period shorter than 2 weeks, it may be worth considering an alternative diagnosis such as adjustment disorder, minor depression and/or co-morbid anxiety disorder.
- ◆ Other causes for symptoms such as anaemia, sleep deprivation, thyroid dysfunction or bereavement should be considered before diagnosing depression.
- ◆ Anxiety needs equally assertive treatment – consider psychological treatment to avoid the development of chronic problems.
- ◆ Very high EPDS scores may suggest a crisis and/or a personality disorder that warrant further evaluation.

MANAGEMENT PLAN

A management plan might include some of the following:

- ◆ Supportive counselling - listening, debriefing, discussing problems and developing problem solving skills.
- ◆ Treatment from a psychologist (individual or group) such as CBT especially where there are features of anxiety.
- ◆ Couple counselling if problem exists within the relationship. Make certain partner is informed and included in any plan.
- ◆ Medication from GP/psychiatrist - best when biological symptoms present (poor appetite & sleep, anxiety). Severe depression may require anti-psychotic drugs as well. Care must be taken regarding use of psychotropics in pregnancy and lactation.
- ◆ Psychosis (delusions, odd ideas/hallucinations) & suicidal ideation needs prompt treatment. Where there is an acute need for assessment, consider admission to hospital or mother-baby unit.
- ◆ Assess partner's ability to support - check mental health, substance abuse and "adjustment to parenthood".
- ◆ Support mother's parenting - she may need reassurance and/or ongoing practical help or respite. Enlist CHN services.
- ◆ Specific baby management/settling programs and attend to mother-infant relationship.
- ◆ Depression may affect the woman's ability to respond to her partner and her child/ren. Observe how the mother picks up signals from her baby and how she speaks about her child. In severe cases notification to Dept of Community Services (DoCS) may be needed if the child/ren are "at-risk". This allows access to assessment of risk and specific programs in the home.
- ◆ Self-help groups - support from others who are experiencing depression or who have done so.
- ◆ If the woman has a substance abuse problem, refer to appropriate support services.

For a diagnosis of major depression, a person should have at least five symptom from the list below, of which one is symptoms A or B, most days for two weeks*:

- A** depressed mood/irritability
- B** diminished interest in activities
- C** significant weight or appetite change
- D** sleeping problems eg insomnia or hypersomnia
- E** fatigue
- F** feelings of worthlessness/guilt
- G** inability to think clearly or concentrate
- H** recurrent thoughts of death and/or suicide
- I** psychomotor agitation and retardation.

* DSM-IV diagnostic criteria

Risk factors that predispose women to postnatal depression:

- ◆ past history of depression, especially postnatal depression
- ◆ strong family history of depression
- ◆ past history of abuse/dysfunctional family
- ◆ little social support
- ◆ preterm/sick baby
- ◆ long term difficulties with partner
- ◆ traumatic birth experience
- ◆ adverse life events
- ◆ changes in work or financial circumstances.

Referral to a psychiatrist should be considered if (see Resources):

- ◆ the woman has severe or complex depression
- ◆ there is a continued inability to cope at home despite mobilisation of supports
- ◆ there is significant suicide/infanticide risk
- ◆ the situation is not improving after the standard treatments have been tried (ie antidepressants and/or psychological support)
- ◆ there are issues requiring ongoing therapy (eg trauma, grief & loss)
- ◆ there are frequent relapses
- ◆ there is an accompanying biological condition requiring medical treatment
- ◆ a second opinion is required.

The text "A Manual of Mental Health Care in General Practice" by John Davies contains further information and is available through the State divisions of general practice.

NOTES ON ANTIDEPRESSANT MEDICATION IN PREGNANCY AND LACTATION

PREGNANCY

When prescribing psychoactive medication during pregnancy, it is important to balance the potential risk to the foetus posed by medication against the risk that mental illness may pose for both the mother and foetus.

The newer SSRI antidepressants are the most commonly prescribed. All SSRIs cross the placenta and enter the foetal system. Studies have reported no increased risk of major malformation or miscarriage with SSRI usage in pregnancy. However, data is limited and caution should be taken. Similarly, there is little evidence that exposure to tricyclic antidepressants or Efexor (venlafaxine), even in first trimester, carries any significantly increased risk of malformation to the foetus. If unsure about prescribing, contact the information services listed.

LACTATION

The benefits of breastfeeding are sufficiently well known to recommend that it is important to balance the potential risk to the infant caused by medication in breast milk against the loss of benefits of breastfeeding. Although psychoactive medication is present in breast milk, infant levels of active drug are usually found to be low. Women and their partners must be given this information and a case-by-case decision made regarding risk-benefit. In most cases, the dosage to which the infant is ultimately exposed to is very low.

When medication is prescribed, it should be:

- ◆ at the lowest effective dose
- ◆ for the shortest duration
- ◆ avoiding, if possible, the first trimester
- ◆ avoiding polypharmacy
- ◆ at a reduced dose prior to delivery
- ◆ as single repeats (ie do not over-prescribe).

During lactation the following is observed:

- ◆ few drugs are totally contraindicated
- ◆ in most cases, drugs cross the placenta more efficiently than they pass into breast milk
- ◆ caution is required in cases of premature infants or infants whose ability to metabolise and/or excrete drugs may be impaired.

MORE INFORMATION

- ◆ Therapeutic Guidelines
www.etg.hcn.net.au
- ◆ Therapeutic Goods Administration
1800 020 653 or www.tga.gov.au
- ◆ The Australian Breastfeeding Association
8853 4999 or www.breastfeeding.asn.au
- ◆ Therapeutic Advisory & Information Service
1300 138 677 or tais@nps.org.au
- ◆ National Prescribing Service
www.nps.org.au
- ◆ Motherisk
www.motherisk.org

RESOURCES (Details are correct at time of publication. Services subject to change without notice. For an up-to-date list of resources, please visit www.beyondblue.org.au/postnataldepression)

GENERAL

- ◆ Karitane Help Line: (02) 9794 1852/1800 677 961
- ◆ Tresillian Parent-Help Line: (02) 9787 0855 / 1800 637 357
- ◆ Australian Psychological Society Referral Service: 1800 333 497
- ◆ Parent Line: 13 20 55
- ◆ Home Start Program: (02) 9310 5885
- ◆ Relationships Australia: 1300 364 277
- ◆ Domestic Violence: 1800 656 463

DRUG ADVICE

- ◆ MotherSafe: (02) 9382 6539

MOTHERCRAFT ADVICE

- ◆ Karitane Cottages: (02) 9399 6999/(02) 9821 4555
- ◆ Karitane Residential Unit: (02) 9794 1800
- ◆ Tresillian Family Care Centre:
Canterbury: (02) 9787 0800, Wentworth: (02) 4734 2124
Willoughby: (02) 8962 8300, Wollstonecraft: (02) 9436 4086

INTERNET

Dept of Health (<http://www3.health.new.gov.au/services>):

A comprehensive listing of Child Health centres by address, suburb or municipality.

PRIVATE MOTHER-BABY UNITS

- ◆ St John of God Hospital (Burwood):
(02) 9747 5611

PERINATAL MENTAL HEALTH SERVICES IN NSW

- ◆ Royal Hospital for Women (Outpatient Psychiatric Unit): (02) 9382 6665
- ◆ King George V: (02) 9515 7101
- ◆ Sydney South West Area Health Service (PIMHS): (02) 9827 8011
- ◆ Nepean: (02) 4734 2585
- ◆ St George (Mental Health Unit): (02) 9350 2432
- ◆ Manly Hospital (MAMS): (02) 9976 9727
- ◆ John Hunter Hospital (ACE Service):
(02) 4921 3575

Depressionet (www.depressionet.com.au):

An Australian-based organisation that provides information on depression, anxiety & other mental health issues.

beyondblue (www.beyondblue.org.au):

A national, independent body established to address issues related to depression in Australia. Their website includes links to information about psychiatrists specialising in pregnancy-related depression (Vic only), the EPDS and its use and interpretation and an education/information booklet for parents.