Purpose and introduction

The purpose of this journal is to examine the assessment and management of depression in women during the antenatal and postnatal periods. It is the second of three follow-up publications which supplement the Best Practice Journal, Special Edition: "Adult Depression", published in June 2009.

The Evidence Based Practice Guideline for the Identification of Common Mental Disorders and Management of Depression in Primary Care,[1] published in July 2008 by the New Zealand Guidelines group, has formed the basis of this publication. It is intended as a resource for all primary care practitioners – including general practitioners, midwives and practice nurses.

This publication focuses on the management of depression, however any mental health disorder can occur during the antenatal and postnatal periods, including anxiety, bipolar disorder, substance use disorder and affective psychoses. The characteristics and presentation of mental health disorders in the antenatal and postnatal periods are similar to that in other adult women. However, there are some differences to consider and the treatment of mental health disorders during this period often poses challenges, especially regarding the use of antidepressants, antipsychotics and mood stabilisers during pregnancy or breastfeeding.

This publication is also a supporting information resource for the *bestpractice* Decision Support Module which is freely available to all New Zealand general practices.

Recommendations and key practice points

(Adapted from NZGG, 2008[1])

- **History**
  As part of routine antenatal care, the practitioner should enquire whether a woman has any history of mental health disorder or any family history of mental illness including in the antenatal or postnatal periods.

- **Contact and screening questions**
  On first contact with primary care, and subsequent postnatal checks, the practitioner should consider the use of the verbal two to three question screening tool for depression as part of routine assessment. Screening questions for anxiety and substance abuse should also be considered.

- **Further assessment**
  If a woman's response to a verbal two to three question screening tool arouses concern about a possible mental disorder (or if other issues do so) she should normally be referred promptly for further

clinical assessment by her GP. This should include a check for suicidal ideation or intent. It is important to differentiate postnatal depression from milder "baby blues" or more severe bipolar disorder or psychosis (see page 8).

- **Information – Risks and benefits of treatment**
  A woman with depression in the antenatal or postnatal period should be informed of the risks and benefits of treatment options including the risks of untreated depression.

- **Collaboration**
  There should be close collaboration and sharing of information between the midwife, general practitioner and other practitioners involved in the care of a woman with antenatal or postnatal depression. All relevant information should be available to the Lead Maternity Carer.

- **Empowerment, communication and the wider family/whānau environment**
  Involve women in decisions about their care. If possible, family/whānau should also be involved. Good communication is important; patients, relatives and carers should be given information that is easy to understand. Consider the needs of other children and the impact of the illness on relationships.

- **Active support and management**
  This includes education, activities and the involvement of family/whānau and appropriate support people and groups. This should be combined with, and maintained during, all other treatment strategies. A woman with depression in the postnatal period should be encouraged to attend a mother and infant support group.

- **Consider non-pharmacological interventions**
  Non-pharmacological interventions such as enhanced social support and/or a psychological therapy should be considered before prescribing medication for depression during pregnancy or postnatal depression,

Mental health disorders in the antenatal and postnatal period

10–15% of women experience depression after having a baby

10% of pregnant women experience depression

20 – 30% of women experience anxiety during and after pregnancy

2 – 3% of women experience bipolar disorder during and after pregnancy

0.5% of women experience postpartum psychosis

Adapted from: Postnatal Depression Family/Whānau New Zealand Trust. Mothers Matter. Available from: **www.mothersmatter.co.nz**

Caution with use of the term "postnatal depression"

A spectrum of depressive symptoms can occur in the postnatal period ranging in severity from "baby blues" to severe depression or bipolar disorder. Caution has been advised in using the term postnatal depression as it can be misused as an inclusive "catch-all" term to describe any mental illness occurring in the postnatal period. This may result in misdiagnosis and failure to recognise more serious mental illness. The term postnatal depression has been used in this publication on the understanding that it is essential that practitioners differentiate this from the spectrum of mental health disorders that can occur in the postnatal period.

Complications and consequences of depression in the antenatal or postnatal period[2,3]

Severe depression in these periods is associated with:

- Poorer long-term outcomes for the child, including cognitive, emotional and behavioural difficulties
- Adverse effects in other children, the woman's partner and the family's socioeconomic situation
- Relationship difficulties - the woman's partner may also become depressed
- Suicidal behaviour - in the developed world, suicide is the major cause of maternal death in the first year postpartum, mainly due to relapse of severe mental illness. However, the suicide rate in age-matched, non-postpartum women is higher.[2]

especially for a woman with mild symptoms, or in early pregnancy (first trimester).

- **Mild to moderate depression**
  A brief psychological intervention, e.g. six to eight weeks of non-directive counseling, interpersonal therapy (IPT) or cognitive behavioural therapy (CBT), should be considered as a first line intervention in the management of a woman with mild to moderate depression in the antenatal or postnatal period. If there is no response to initial treatment, a more structured psychological therapy, e.g. longer courses of CBT or IPT, could be considered, in consultation with maternal mental health services.

- **Moderate to severe depression**
  An antidepressant may be considered as first-line treatment for a woman with moderate to severe depression in the antenatal or postnatal period, after discussion of the likely benefits, risks of untreated depression and possible risks of treatment. A woman with severe depression should be managed in consultation with maternal mental health services or other appropriate psychiatric services.

- **Antidepressants in pregnancy and breastfeeding**
  If any woman who is pregnant or planning pregnancy is being treated with an antidepressant, her treatment preference, previous history and risk should be reviewed. If appropriate, attempts should be made to withdraw the antidepressant and substitute an alternative treatment and/or ensure that the antidepressant with the lowest risk profile is used. Most commonly used antidepressants are considered to be compatible with breastfeeding.

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