A GUIDE TO MANAGEMENT FOR HEALTH PROFESSIONALS

- 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 & Maternal Health Nurses (C&MHN) 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 and 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) and 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 C&MHN 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 Family & Children’s Services 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.
- Prepare a GP mental Health Care Plan enabling a woman to receive subsidised psychological treatment through either the Better Access Program or ATAPS.

For a diagnosis of major depression, a person should have at least five symptoms from the list below, of which one is symptom 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 and 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 Australian General Practice Network.

1 For the purposes of this guide, the terms antenatal and postnatal include the time from conception to one year of age.
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.

There are a number of studies examining several thousand infants, reporting no increased risk of overall birth defects or malformations above the general population risk (which is 2-3 per cent, a third being heart defects) with early pregnancy exposure to the SSRI and Tricyclic antidepressants. After much controversy, Aropax, (previously associated with Ventricular Septal Defect or VSD) has not been found to be associated with heart defects. Were a causal association to be found between Aropax and VSD, it is important to keep in mind that most VSDs will resolve spontaneously as the baby grows.

There have also been reports of ‘withdrawal’ syndromes in babies exposed to the SSRI and Tricyclic antidepressants, in the last few weeks of pregnancy. Withdrawal symptoms are reported in around 20 per cent newborns but are usually mild, mostly begin between day 1 and day 4 of birth and usually last for 2-3 days. Withdrawal symptoms include mild breathing problems, irritability, difficulty in settling and feeding and very occasionally the baby may have a seizure. No babies have died from late pregnancy SSRI exposure. It is recommended that newborns be monitored in hospital for the first 3 days for such symptoms.

Two recent small retrospective reports suggest an increased, but minimal, chance of more severe breathing problems with SSRI exposure in pregnancy; this is referred to as the Pulmonary Hypertension of the Newborn. These findings remain to be confirmed in future studies and no deaths are reported.

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 (i.e. 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 Goods Administration 1800 020 653 or www.tga.gov.au
- The Australian Breastfeeding Association 1800 686 2 686 or www.breastfeeding.asn.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

TELEPHONE AND SUPPORT SERVICES

- beyondblue info line 1300 22 4636
- Karitane Help Line 1800 677 961
- Tresillian Parent’s Helpline (02) 9787 0855 or Country 1800 637 357
- Australian Psychological Society Referral Service 1800 333 497
- Parent Line 1300 130 052
- Women’s Information and Referral Service (WIRS) 1800 817 227
- Lifeline 131 114
- Volunteer Home Visiting (02) 9310 5885
- Relationships Australia 1300 364 277
- SANE Australia 1800 18 7263
- Domestic Violence Line 1800 566 463
- GROW support groups 1800 558 268
- PANDA (Post and Antenatal Depression Association Inc) (Mon-Fri 9.00am-7pm) help line 1300 726 306

INTERNET

beyondblue (www.beyondblue.org.au)
A national, independent body established to address issues related to depression in Australia. This website includes links to medical and allied health practitioners who have completed post graduate mental health training and information on perinatal depression/anxiety support services.

Department of Health (www2.health.nsw.gov.au/services)
A comprehensive listing of Child Health centres by address, suburb or municipality.

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