Queensland Clinical Guidelines

Translating evidence into best clinical practice

Maternity and Neonatal **Clinical Guideline**

Perinatal mental health

Queensland Government

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The Department of Health acknowledges the Traditional Custodians of the lands, waters and seas across the State of Queensland on which we work and live. We also acknowledge First Nations peoples in Queensland are both Aboriginal Peoples and Torres Strait Islander Peoples and pay respect to the Aboriginal and Torres Strait Islander Elders past, present and emerging.

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- Advising consumers of their choices in an environment that is culturally appropriate and which enables comfortable and confidential discussion. This includes the use of interpreter services where necessary
- Ensuring informed consent is obtained prior to delivering care
- Meeting all legislative requirements and professional standards
- Applying standard precautions, and additional precautions as necessary, when delivering care
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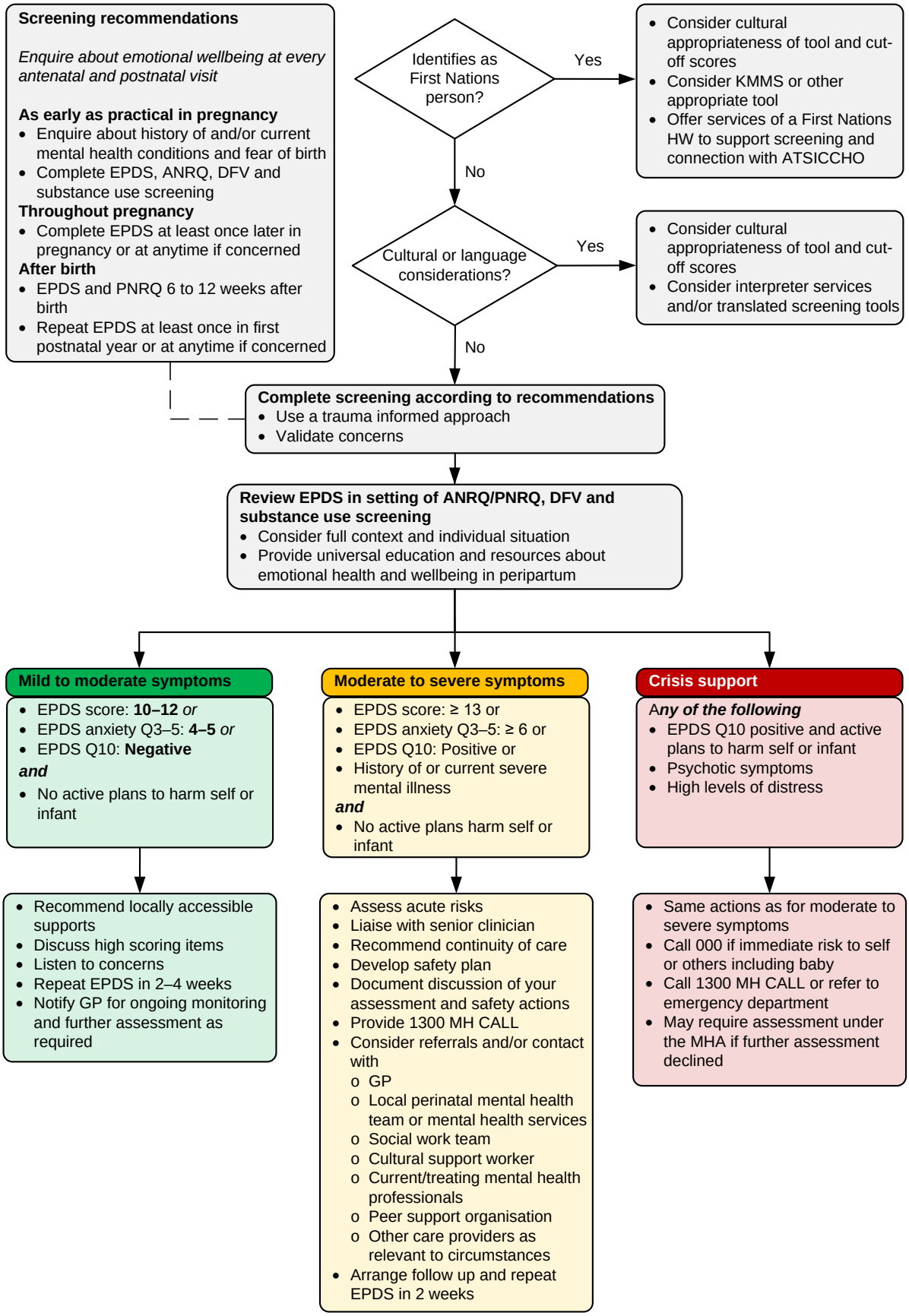
Flowchart: Screening recommendations for women in the perinatal period



Flowchart: F24.76-1-V1-R29

1300 MH CALL: 1300 642 255 (Queensland mental health access line); **ANRQ:** Antenatal Risk Questionnaire; **ATSICCHO:** Aboriginal and Torres Strait Islander community controlled health organisation; **DFV:** domestic and family violence; **EPDS:** Edinburgh Postnatal Depression Scale; **GP:** general practitioner; **HW:** health worker; **KMMS:** Kimberley Mum's Mood Scale; **MHA:** Mental Health Act; **PNRQ:** Postnatal Risk Questionnaire; **Q:** question

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Abbreviations

ANRQ	Antenatal Risk Questionnaire
ATSICCHO	Aboriginal and Torres Strait Islander Community Controlled Health Organisation
BPD	Borderline personality disorder
CALD	Culturally and linguistically diverse
CBT	Cognitive behavioural therapy
DASS	Depression, Anxiety and Stress Scale
DFV	Domestic and family violence
ED	Eating disorder
EPDS	Edinburgh Postnatal Depression Scale
GP	General practitioner
HHS	Hospital and Health Service
K10	Kessler Psychological Distress Scale
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, queer, plus. The '+' reflects all other variations and is not intended to be limiting or exclusive of certain groups.[1]
MBU	Mother-baby unit
PNRQ	Postnatal Risk Questionnaire
PTSD	Post-traumatic stress disorder
SSRI	Selective serotonin reuptake inhibitor
TCA	Tricyclic antidepressant

Definitions

1300 MH CALL	Confidential mental health telephone triage service that provides the first point of contact to public mental health services to Queenslanders. Available 24 hours a day, 7 days a week and links to caller's nearest Queensland Public Mental Health service. pH: 1300 642 255.
Anxiety disorders	Characterised by persistent feelings of excessive worry, anxiety or fear that interfere with daily functioning. Examples of anxiety disorders include generalised anxiety disorder, specific phobias, obsessive-compulsive disorder, health anxiety disorders and panic disorder.[2]
Birth trauma	A woman's experience of interactions and/or events related to childbirth that caused overwhelming distressing emotions and reactions; leading to short and/or long-term negative impacts on a woman's health and wellbeing.[3]
Bipolar disorder	Characterised by unusual shifts in a person's mood, energy, activity levels, and concentration.[4]
Blind weighing	Weighing without person seeing the measurement.
Borderline personality disorder	Characterised by a pervasive pattern of instability of emotions, relationships, sense of identity, poor impulse control and consistently associated with severe functional impairment.[5] Also referred to as emotionally unstable personality disorder.
Cognitive behavioural therapy	Psychological treatment based on the assumption that faulty thinking patterns, maladaptive behaviours and 'negative' emotions are inter-related. Focuses on changing unhelpful thoughts and behaviours in order to change emotional states.[5]
Depression	Characterised by a persistent feeling of sadness and a loss of pleasure or interest in everyday life that interferes with functioning.
Dialectical behaviour therapy	A structured program of psychotherapy with a strong educational component designed to provide skills for managing intense emotions and negotiating social relationships.[6] Most commonly used in people with borderline personality disorder.[7]
Eating disorders	Characterised by persistent disturbance of eating behaviour that impairs health or psychosocial functioning. Eating disorder types include: binge eating disorder; anorexia nervosa; bulimia nervosa; avoidant/restrictive food intake disorder and other specified feeding and eating disorders.

Eye movement desensitisation and reprocessing	A psychotherapy treatment that aims to reduce distressing emotions associated with traumatic memories.
Fear of birth	A spectrum of anxious thoughts and feelings relating to a woman's appraisal of labour and birth[8]
e-PIMH	Telehealth service for perinatal and infant mental health. e-PIMH can provide direct or de-identified clinical consultations with consumers and health referrers, or health referrers alone. Clinical governance of the consumer remains with the referrer. Aims to support local health workforce to build capacity to support perinatal and infant mental health needs in regional, rural and remote areas.
First Nations peoples	A collective name to describe Aboriginal and/or Torres Strait Islander peoples. Commonly used in reference to the distinct and diverse nations and peoples of the First Australians.[9]
Mania	Elevated mood characterised by high energy, excitement and euphoria over a sustained period.
Motivational interviewing	Counselling method that involves enhancing a person's motivation to change and improve their mental health and wellbeing.[10]
Partner	In QCG documents, the term *partner* includes fathers, non-birthing parents, spouses and significant others.
Perinatal period	Conception to two years postpartum.
Personality disorder	Personality traits that are inflexible and maladaptive across a wide range of situations, and cause significant distress and impairment of social, occupational and role functioning.[11]
Psychoeducation	An intervention that educates patients and their families about their illness with a view to improving long term outcomes.[12]
Psychosis/ Psychotic episode	An acute mental health episode defined by an abnormality of thinking, perception and behaviour in which the person loses touch with reality and loses insight into being unwell.[5]
Postpartum psychosis	Psychosis occurring in the early postnatal period.
Post-traumatic stress disorder (PTSD)	Can occur in people who have experienced trauma. Characterised by intrusive thoughts, nightmares, flashbacks, avoidance of reminders of trauma, hypervigilance and sleep disturbance, all of which lead to considerable social, occupational and interpersonal dysfunction.[13]
Complex PTSD	Can occur after prolonged, intense or repeated trauma. Symptoms are similar to PTSD, but also include difficulties with managing emotions, self-esteem, and relationships.[14]
Schizophrenia	A mental illness characterised by chronic or recurrent psychosis. It is commonly associated with impaired social, emotional, cognitive and occupational functioning.[15,16]
Severe mental illness	Includes psychotic disorders (schizophrenia and postpartum psychosis) and bipolar disorder.[5]
Trauma-informed care	An approach to care based on the understanding of trauma and its far reaching implications.[17,18]
Woman/women	QCG recognise that individuals have diverse gender identities. In QCG documents, although the terms *woman* and *women* are used, these guidelines are inclusive of people who are pregnant or give birth and who do not identify as female.[19-21]

1 Introduction

For the purposes of this guideline, perinatal mental health refers to the psychological and emotional wellbeing of parents, from conception to two years after the end of pregnancy. For most women, partners and families, this period is a time of much joy and happiness. However, pregnancy, birth, and the transition to parenthood can be a stressful time of adjustment for all family members, and substantial biological changes for the woman.[22] The perinatal period is associated with a significantly increased risk of mental health conditions compared to other times in life.[5] This risk is especially increased for individuals who are vulnerable to mental illness.[23]

The focus of this guideline is on the early identification, assessment and intervention across the continuum of care for women and partners experiencing mental health conditions during the perinatal period. Early identification through standardised and universal screening and assessment maximises the opportunity for effective treatment, improving emotional wellbeing and safety, and minimising the impact on the fetus, infant and wider family.

1.1 Context

Table 1. Context

Aspect	Consideration
Perinatal period	• A period of increased mental health vulnerability for various reasons including: o Significant physical, biological and hormonal changes for the woman[24,25] o Sleep deprivation associated with pregnancy, labour, birth, and postpartum period o Significant psychological and social change o Substantial changes and shifts in identity and relationships[25]
Prevalence	• Estimated that 16% of women, and 10% of men will develop a significant perinatal mental health condition in the perinatal period[26] • In Australia, perinatal depression and anxiety affects one in five mothers[5,27] and one in 10 partners[27] • In Queensland, suicide is a leading cause of maternal death* [28] o In 2018–2019, there were 12 maternal suicides in Queensland
Importance	• Perinatal mental health conditions are associated with an increased risk of: o Adverse pregnancy and fetal developmental outcomes [29,30] o Engaging in high-risk activities including substance use[31] o Limited engagement in antenatal care[32] o Suboptimal nutrition[31,32] o Disrupted development of a safe and secure parent-infant attachment[22] ▪ Associated with long term negative impacts on the infant's health, development, and emotional wellbeing if not appropriately addressed o A wide range of negative outcomes for the infant which can have long term impact[30,33,34] • During the perinatal period, women with existing mental health conditions may have increased motivation to[35]: o Engage with health services o Change behaviour o Engage in treatment

**Maternal deaths defined as deaths occurring during pregnancy or within one year after the end of pregnancy*

2 Clinical standards

2.1 Universal recommendations for all families

Table 2. Universal recommendations for all families

Aspect	Consideration
Universal care	• Provide trauma-informed care to all women and families[17,18] • Keep the fetus/infant in mind during all assessments, interactions and care provision[36] • Inform women and partners of the importance of disclosing and accepting support for any mental health concerns that may arise across the perinatal period[5] • Provide continuity of care and carer wherever possible[5,37,38] • Refer to appropriate care providers for management of medical conditions and maximisation of physical health (e.g. referral to or consultation with obstetric medicine physician to manage treatment of hyperemesis) • Refer to Queensland Clinical Guideline *Standard care*[39] for care considered 'usual' or 'standard' o Includes for example: privacy, consent, woman-centred care, informed decision making, communication for safety, culturally safe care
Trauma-informed care	• Care and service delivery based on an understanding of the impact of trauma and the possibility of underlying trauma in all people[17,40,41] • Strengths based approach that aims to minimise risk of trauma related distress during care[40] • Core principles include safety, trust, choice, collaboration and empowerment[17,41]
Information and resources	• Provide appropriate education and resources, including digital resources, on emotional health and wellbeing in the peripartum period • Provide information about[5]: o Risk and protective factors o Prevalence and risk of mental health conditions in the perinatal period o Symptoms of perinatal mental health conditions o Lifestyle factors that contribute to mental health and wellbeing o Infant and child mental health and wellbeing (refer to Section 15 Infant mental health)
Antenatal education	• Within antenatal education classes for expectant parents and support persons, include content on[42,43]: o Emotional preparation for, and transition to parenthood o Emotional mental health and emotional wellbeing for the infant and family unit o Parent-infant attachment and its importance o Child health services and supports
Key messages	• Provide families with key messages about perinatal mental health including[5]: o Mental health conditions are common in the perinatal period o It's OK to ask for help o Support is available, and the sooner conditions are assessed and treated, the sooner recovery is possible
Training	• Support training of healthcare providers in: o Mental health and illness in the perinatal period o Trauma-informed care o Culturally safe care o Importance and purpose of mental health screening and assessment[28,44] o Risk assessment and safety planning o Use of validated screening tools and screening platforms (e.g. iCOPE) o Motivational interviewing [refer to Definitions] o Appropriate responses to identified concerns o Local and statewide service referral pathways

2.2 Care for First Nations peoples

Table 3. Care for First Nations peoples

Aspect	Consideration
Context	• First Nations peoples are at an increased risk of mental health conditions, particularly depression, anxiety and substance use disorders[45,46] • Mental illness is the leading burden of disease experienced by First Nations peoples in Queensland[47] • First Nations women are over-represented in maternal suicides[48] o From 2004 to 2017, First Nations women accounted for 17% of all maternal suicides, but only represented 6% of those giving birth in Queensland • The majority of Queensland women who give birth to First Nations babies live in regional areas (54% regional, 31% major cities and 14% remote)[49] • Fear of underlying institutional racism or past trauma can prevent First Nations peoples from accessing services, and affects trust in government services and healthcare systems[40] • Fear of child removal is of particular concern for First Nations families, given the significant over-representation of First Nations children in the child protection system in Queensland[50] o May lead to reluctance to seek help or disclose concerns about perinatal mental health
Social and emotional wellbeing	• Foundational for the physical and mental health of First Nations people[46] • Contains overlapping domains of connection to body, mind and emotions, family and kin, community, culture, country, and spirituality and ancestors • Enhanced through multi-dimensional care that builds on a person's existing community, family and individual strengths[46] • Lack of access to culturally appropriate perinatal care can increase risk of mental illness for
Trauma	• Rates of intergenerational and complex trauma are high in First Nations peoples[40,46,48,49] o Stems from historical injustices such as the separation of families, forced removal of children (known as the Stolen Generations), dispossession of land and cultural suppression • Remain cognisant of the historical trauma experienced over generations by First Nations peoples and its potential impact on their perinatal mental health[46] • Provide trauma-informed care o Support training needs of service providers for upskilling in First Nations specific trauma-informed care[40]
Partnerships	• Strive for culturally safe and community driven perinatal mental health services and resources through co-design with local First Nations peoples[49] • Strengthen partnerships between Hospital and Health Services (HHS) and Aboriginal and Torres Strait Islander Community Controlled Health Organisations (ATSICCHO)[49] • Offer First Nations families connection with ATSICCHO
Recommendation	• Prioritise cultural safety and respect the unique cultural identities and traditions of First Nations peoples[47] • Recognise the importance of traditional practices, connection to Country and spirituality in promoting emotional health and wellbeing in the perinatal period[47] • Recognise and support the significance of extended families and kinship networks for First Nations peoples[46] • Wherever possible, provide continuity of carer and offer connection with the First Nations workforce[49] • Access and utilise services and resources designed with, and for First Nations peoples (e.g. midwifery group practices and child health services for First Nations peoples, parenting courses such as Connected Parenting[51,52])

2.3 Multidisciplinary care and referral pathways

Perinatal mental health conditions are complex, and encompass interactions of biological, psychological and social factors. Multidisciplinary care from multiple providers or services is often required for holistic and thorough management.[53,54]

Table 4. Referral pathways

Aspect	Consideration
Care providers	• Refer to Appendix A: Potential care providers
Reducing fragmentation of care	• Work collaboratively, flexibly, and communicate effectively[55] • Wherever possible, recommend and facilitate continuity of care/carer models for women with a mental health condition[5,37,38,55] • Options for continuity of care include, but are not limited to: o Continuity of midwifery care (e.g. midwifery group practice) o Care co-ordinated by a nurse/midwife navigator, nurse practitioner or case manager o Private midwifery or obstetric care o General practitioner (GP) shared care o Child health service continuity models
Importance	• The most appropriate referral and setting for care depends on: o The preferences of the woman o Safety and level of risk for the woman and infant o Severity of mental health concerns o Services available in local setting (face-to-face or telehealth) • A coordinated and multidisciplinary approach to avoid unnecessary delay in care provision[56] • Timely and appropriate referral to perinatal mental health services is critical to minimising impact on the family unit[57] o Recommend lower thresholds for access to care compared to access thresholds at other stages of life[35]
Co-design	• Co-design locally applicable referral and care pathways and services with: o Local consumer representatives, and people and carers with a lived experience of perinatal mental illness[38] o Local ATSICCHOs and First Nations peoples (consumers, families, and communities) o Culturally and linguistically diverse (CALD) consumers, families and communities o Care providers across the continuum of care from outpatient consultation liaison to inpatient care, and from primary to tertiary levels of care[28]
Recommendation	• Establish clear and explicit pathways and transitions into and out of perinatal mental health services[58] • Develop, disseminate, promote and maximise access to local referral pathways for perinatal mental health care across the continuum of care • Prioritise development or enhancement of digital solutions that allow for timely data and information sharing between all care providers[28] • Establish mechanisms to: o Maintain currency of referral pathways o Facilitate timely sharing of assessments and information • Eliminate gaps in referral pathways and services (e.g. between child and youth mental health services and perinatal mental health services) • Educate care providers and referrers about local and statewide services, including digital and telehealth services • Inform families about services in their local area and facilitate access to services • Consider telehealth and electronic care formats such as e-PIMH (refer to Definitions) and patient travel subsidy scheme as required

2.4 Peer support

Table 5. Peer support

Aspect	Consideration
Context	• A form of social and emotional support provided by individuals who have a lived experience of perinatal mental illness and/or parenting challenges[59] • Involves an exchange of resources between individuals of equal status, similar adverse experiences, and founded on principles of respect and shared responsibility[60] • Can be delivered in various forms including face-to-face meetings, online forums, text messaging and phone support lines[59,60]
Benefits and drawbacks	• Potential benefits include: o Emotional validation through the provision of a safe and non-judgmental environment for women to share honestly about their thoughts, feelings and concerns[59-61] o Flexible approach to support compared to formal, more rigid supports[61] o Reduced power imbalance enabling genuine connection and empowerment o Reduced feelings of isolation and stigma through a sense of belonging, hope, shared experience and community[60-62] o Cost effective[63] o Well received by women in the perinatal period[63] o Improved confidence in parenting through reassurance and practical support[59,60] • Potential drawbacks include: o Potential for incompatibility between peer support worker and woman[59] o Varied quality of peer support depending on level of training, experience and suitability[59]
Recommendation	• Peer support is a worthwhile, complementary intervention to professional treatment and support[59] • Discuss peer support options with women

3 Risk and protective factors

3.1 Protective factors

Protective factors may reduce the risk of developing a mental health condition.

Table 6. Protective factors

Aspect	Consideration
Psychosocial	• Positive self-esteem (prior to conception)[33] • Access to practical and emotional support[22,33] • Safe and stable living environment[33] • Financial stability • Meaningful connections to family, culture and community[33] • Support network (e.g. partner, family and friends) • Stable childhood and positive experience of being parented[33] • Access to, and engagement with cultural support • Social and emotional wellbeing • Planned pregnancy
Health	• Positive history of well managed mental health condition/s • Good physical health[33] or well managed physical health conditions • High levels of health literacy
Service	• Access to healthcare and support services[33] • Continuity of care/carer models[5,37]

3.2 Risk factors

Risk factors are associated with an increased risk of onset, relapse, or exacerbation of mental health conditions.

Table 7. Risk factors

Aspect	Consideration
Mental illness	• Previous mental illness o The most significant risk factor for developing a perinatal mental health condition[5,25] • Family history of mental illness, particularly bipolar or postpartum psychosis[38,58]
Psychosocial factors	• Adverse childhood experiences (e.g. sexual/emotional/physical abuse, neglect, exposure to domestic and family violence (DFV))[28] o Childhood maltreatment is associated with a significantly increased risk of mental health disorders[64] • History of adversity including trauma (e.g. intergenerational trauma, DFV, complex trauma) • Poor relationship with own mother in childhood • DFV[5,28] • Unsupportive or unstable relationships[5] • Low levels of social support[28] • Isolation (cultural, distance, social)[5] • Substance use (previous, recent or current) • Current or recent stressful life events such as bereavement, relationship breakdown, unemployment or migration[22] • Personality traits (e.g. perfectionist or anxious traits) • Adjustment difficulties in transition to parenthood including mismatch between expectations and reality • Housing stressors or homelessness[28] • Low socioeconomic status[65] • Natural disasters and pandemics[66] • History of feeling invalidated by healthcare providers • Department of Child Safety involvement
Physical factors	• Poor physical health or medical conditions[67]
Perinatal factors	• Complications during conception, pregnancy, birth and postnatal period[22,68] • Unwanted and/or unexpected pregnancy[22] • Hyperemesis gravidarum[69,70] • Fear of birth[8] • Previous experience of birth trauma or adverse birth experience[22] • Perinatal loss (current or previous)[58] o Refer to Queensland Clinical Guidelines: *Early pregnancy loss*[71]; *Termination of pregnancy*[72]; *Stillbirth care*[73] • Conception from sexual assault • Infant requiring neonatal unit/hospital admission or other infant health concerns[74] • Unmet expectations about pregnancy, birth and parenting[22] • Difficulty with infant feeding and sleeping[22]
People groups	• Some population groups have greater social and emotional vulnerabilities, and are at increased risk of perinatal mental health conditions[5] o First Nations peoples o Migrants (including refugees and asylum seekers) o CALD families o Parents who identify as lesbian, gay, bisexual, transgender, intersex, queer plus (LGBTIQ+)[22] [refer to Abbreviations] o People who are neurodivergent o Parents with intellectual and/or physical disability o Adolescent parents

4 Pre-conception care

Table 8. Pre-conception care

Aspect	Consideration
Overall guidance	• Screen for current or previous mental health conditions including eating disorders, psychosis, schizophrenia and bipolar disorder • If current mental health condition, recommend stabilisation of mental health prior to considering pregnancy, especially for eating disorders and severe mental illness [refer to Definitions] • If current or previous mental health condition and planning pregnancy, encourage and support to seek discussion and advice from: o GP o Current treating mental health team (or re-engage with team if previous history) o Perinatal psychiatrist when indicated (e.g. severe mental illness) • Important discussion points for all women of childbearing age with a current or previous mental health condition include[5,75]: o Importance of continuing with mental health management and treatment, and avoiding sudden cessation of medication or treatment o Contraception and planning for pregnancy o Potential impact of pregnancy on mental health condition[35] o If changes to medication are indicated in pregnancy (seek perinatal psychiatrist advice when required)[5] o Individual risk of relapse during perinatal period[5,75] o Individualised counselling and a prospective plan for management of pregnancy[76] o Social and emotional wellbeing o Management and support plan including early warning signs, internal and external coping strategies, and support persons
Screening	• Screen for substance use and if identified, advise on the importance of seeking help and management prior to pregnancy • Screen for psychosocial risk factors, adverse childhood experiences or history of trauma o If psychosocial risk factors are identified, arrange relevant psychosocial support and interventions
Medication	• Refer to Section 7 Psychotropic medication
Severe mental illness	• Refer to Definitions • Facilitate preconception counselling from a perinatal psychiatrist wherever possible[75] • A comprehensive, co-ordinated, and collaborative multidisciplinary approach is required[5,75] • Obtain history regarding: o Course of illness and prior treatment including hospitalisation, response to medication and psychosocial interventions o Co-occurring physical and mental health conditions o Substance use • Involve partners, family and other support people if possible and appropriate • Promote awareness of early warning signs and provide structured psychoeducation about their condition[12,75,77] o Associated with positive outcomes such as: ▪ Enhanced understanding of condition ▪ Increased capacity to identify early warning signs ▪ Improved treatment adherence

5 Screening

Table 9. Overview of screening

Aspect	Consideration
Context	• Screening involves administering a validated tool to identify: o Current or previous mental illness o People who may be at risk of experiencing a particular mental illness[5,78] o Psychosocial risk factors • There are established, validated screening tools for perinatal depression and psychosocial risk factors recommended for use in Australia[5,57]
Australia and Queensland	• In Australia, there is a move to have a consistent national approach to psychosocial and mental health screening during the perinatal period • Queensland Health public services have historically demonstrated some consistency in antenatal perinatal mental health screening, but postnatal mental health screening is fragmented and inconsistent[56,66]
Settings	• Screening occurs across a range of systems and settings in Queensland including[66]: o HHS o Private practice of various healthcare professionals o Child health settings o Primary health care services o Community organisations
Methods	• Screening may be: o Conducted in person or remotely o Completed using pen and paper forms, or via an electronic format o Completed independently or by a healthcare provider asking questions directly • Completed with the support of a cultural health worker or interpreter, or using translated screening tools
Benefits of screening	• Supports awareness, early identification and treatment of mental health concerns which may prevent escalation of symptoms • Provides opportunity to identify psychosocial support needs • Supports conversations about emotional wellbeing • High levels of acceptability amongst women and healthcare providers[79,80]
Screening for previous or current mental illness	• Sensitively ask women if they have a personal or family history of, or are currently experiencing mental illness • Options to facilitate identification include: o Verbal inquiry at appointments o Pregnancy health record history (mental health history section) o Medical records, including electronic and digital records o Correspondence from other healthcare providers (e.g. GP referral) o Antenatal Risk Questionnaire (ANRQ) and Postnatal Risk Questionnaire (PNRQ) responses o Clinical judgement o Woman's previous maternity care experience • Consider women with a history of psychotic disorders and/or bipolar disorder as being at high risk, and arrange for individualised assessment from specialised perinatal mental health service wherever possible[58] • Closely monitor women with a family history of bipolar disorder or postpartum psychosis, and refer if any change in mental state[58]
Domestic and family violence	• Risk increased during pregnancy[44] • Associated with an increased risk of perinatal mental health conditions[44] • Screen for current or previous DFV according to local HHS policy, and refer to appropriate care providers and resources as indicated
Substance use	• Associated with an increased risk of perinatal mental health conditions[44] • Refer to Queensland Clinical Guideline: *Perinatal substance use—maternal*[81]

5.1 Facilitating screening

Table 10. Facilitating screening

Aspect	Consideration
Digital screening	• Advantages include: o Elimination of scorer error o Facilitation of remote and mobile screening o Adaptability to support culturally appropriate screening suitable for women who are First Nations people or CALD o Translation and delivery into multiple languages o Streamlined and consistent collection of data o Women may feel more comfortable completing the screening on their own device, in their own environment and at their own pace, potentially allowing them to be more honest with their responses o Capacity to set alerts for escalation o Potential time saving for clinician (screening can be done outside of consultation) o Capacity to generate customised reports and recommendations for both woman and clinician o May act as a clinical decision support tool for less experienced care providers • Disadvantages include: o Requirement for technology (by woman and/or healthcare provider) o Internet connectivity barriers o Requires a level of health literacy and understanding of the questions o Inability to clarify or explain questions
Recommendation	• Undertake screening within a system that is supported by established referral pathways to care o Refer to Table 4. Referral pathways • Enquire about woman's emotional wellbeing at every antenatal and postnatal visit and use the screening process to initiate conversation with woman about emotional health and wellbeing in the perinatal period[5,57] • Maintain awareness that women may be reluctant to disclose mental health difficulties for various complex reasons (e.g. shame, fear of stigma, or fear of their baby being removed) • Sensitively introduce screening to the woman and explain purpose • Explain that perinatal mental health and psychosocial screening are a part of routine care for everyone • Undertake screening and discussions in a safe, comfortable and private environment to support honest responses • Adopt an open and honest approach, and address any concerns the woman has about screening • If digital screening is used, establish local protocols and procedures for: o Alerts and notifications about high-risk screening results o Timely review and follow up
Cultural and linguistic considerations	• Use validated translated versions of screening tools, or provide interpreters for CALD women[82] o Translated versions may provide adapted cut-off scores[5] • Use lower cut-off scores to identify the possibility of depression in refugees and women from CALD backgrounds[5] • Refer to Queensland Clinical Guideline: *Standard care*[39] for further guidance and resources on culturally safe care • Refer to Section 5.2 for First Nations screening considerations

5.2 First Nations screening considerations

Table 11. First Nations considerations

Aspect	Consideration
Context	• Culturally appropriate screening is an essential part of care • Screening that is not completed with a culturally safe and sensitive approach may be misinterpreted[66] • Screening may be influenced by[5,83]: o Woman's understanding of language used o Mistrust of mainstream services o Fear of consequences of screening results o Concern for privacy
Screening tools	• The Kimberley Mum's Mood Scale (KMMS) is a screening tool developed and validated for Aboriginal women in the Kimberley region of Western Australia[5,78,84] o Further validation across other areas of Australia is in progress and may provide further applicability[84,85] • KMMS includes two parts[5,78]: o Part 1: an adaptation of Edinburgh Postnatal Depression Scale (EPDS) using co-designed language and graphics o Part 2: uses conversational approach of yarning to explore psychosocial risks and protective factors[86]
Recommendation	• Refer to Queensland Clinical Guideline: *Standard care*[39] for further guidance and resources on culturally safe care • When screening people who identify as a First Nations person, consider language, localisation and appropriateness of the tool[5] o Consider use of KMMS if appropriate to local context o Consider referral to First Nations healthcare worker, or inclusion of First Nations healthcare worker or support person in screening process[5] o Consider referral to ATSICCHO • If using EPDS, use an adapted cut-off score of equal to or greater than 9[66] • Support professional learning and development in the use of culturally appropriate tools

5.3 Psychosocial screening

Table 12. Psychosocial screening

Aspect	Consideration
Context	• Screens for psychosocial risk factors (both past and present), emotional vulnerability and history of mental illness • Informs care for woman and her family[5] • Enables identification of circumstances (current or historical) that impact a woman's mental health[5] • Is conducted in addition to screening for symptoms of depression and anxiety[5] • Enables individualised care and referral pathways[5]
Screening tools	• The ANRQ/PNRQ is the recommended psychosocial screening tool in Australia[5] o Can be used in both antenatal (ANRQ) and postnatal (PNRQ) periods o A structured questionnaire consisting of scored and unscored items[5] o Found to have high levels of acceptability among women[87] o No absolute cut-off score—score of 23 or more indicative of significantly higher risk o Identification of abuse significantly increases risk irrespective of total score • For First Nations women, an alternative tool may be more appropriate o Refer to Section 5.2 First Nations screening considerations

5.3.1 Psychosocial screening recommendations

Table 13. Psychosocial screening recommendations

Aspect	Consideration
Administration	• Use the ANRQ/PNRQ to screen for psychosocial risk factors as early as practical in pregnancy[57], and again after birth[5,44] • Administer screening tool when woman is alone (without partner present), or via the digital platform to support open and honest responses • Use in conjunction with EPDS or other culturally appropriate depression screening tool[44] Review individual item responses to facilitate appropriate support and/or referrals as indicated
Explanation and exploration	• Sensitively explain screening results and explore responses • Discuss responses with the woman to further assess risk, and better understand underlying factors and reasons for responses • Not discussing responses may leave woman feeling as though responses, feelings or challenges are unacknowledged, dismissed or ignored • Apply clinical judgement when interpreting screening results[33] o Symptoms can be missed or under-reported o High scores may be related to general life difficulties rather than an underlying mental health condition • Low scores do not exclude an underlying mental health condition
Response	• If any of the following identified, further assessment or follow up is recommended [5]: o History of, or current mental health condition o Current or recent DFV o Substance use o History of adverse childhood experiences o Score of 23 or more on ANRQ o Other concerns raised by clinical judgement • If risk factors or concerns are identified, the most appropriate response depends on[5]: o Type, number and severity of identified risk factors o The woman's unique context and current mental state o Any identified safety risks to woman or infant o Availability and capacity of support • If complex risk factors are identified, a cohesive and coordinated multidisciplinary approach is recommended[33]

6 Treatment principles

Table 14. Treatment principles for all mental health conditions

Aspect	Consideration
Holistic care	• Work in collaboration with women, partners and other family members to help support management and recovery • Provide supportive management to address psychosocial adversities • Support the mother-infant relationship and include the fetus/infant in assessment, care and treatment[5,35] • Emphasise the importance of nutrition, adequate sleep, rest, and self-care stress management • Assess for contributing organic factors such as iron deficiency, thyroid status, vitamin or mineral deficiencies (e.g. iron studies, vitamin B12, folate, magnesium and vitamin D) • Consider mental health needs of partners and offer support and referral when indicated (refer to Section 14 Mental health in partners)
Overarching principles	• Encourage discussions about emotional wellbeing and reassure woman that perinatal mental health conditions can be treated and managed[5] • Be flexible in terms of duration of treatment, and if indicated refer to appropriate clinician • Adopt a trauma-informed, non-judgmental, empathetic and strengths based approach[46,88] o Recognise the resilience of individuals and communities o Focus on knowledge, abilities, capacities and available supports • Consider and discuss with woman and partner/support persons[5,31,57,89]: o Potential benefits and harms of management options (both psychological and pharmacological) for woman and fetus/infant o Possible consequences of no treatment for the woman, fetus/infant, partner and other family members o Potential issues if treatment is changed or stopped • Refer woman and partner to quality information and support resources including peer support networks[5] • Encourage to[5]: o Consult with GP or other qualified healthcare provider o Identify and draw on all supports available, including local, state and national services, as well as support from family and friends o If at risk of self-harm and/or harming infant or others to ring 000 (for emergency services), or present to GP or local hospital[5] • Provide 1300 MH CALL number [Refer to Definitions]
Relapse prevention	• During pregnancy, liaise with the multidisciplinary team to develop an individualised mental health action plan to reduce risk of relapse • Consider personal and familial history and patterns of occurrence[58] • Include plans for: o Medication management across perinatal period o Timing and mode of birth o Infant feeding o Minimisation of sleep disturbance o Availability of support persons and provision of practical support • Length of recommended inpatient stay following birth o Where possible, encourage an extended hospital stay postpartum for assessment and support of early parenting o Consideration for support person to be in hospital overnight to preserve woman's sleep and care for infant
Hospital care	• In severe cases where symptoms cannot be managed effectively or safely in the home environment, hospital care may be indicated • If inpatient treatment for mental health is required during late pregnancy or within the first year after birth, admit the mother and baby together to a mother-baby unit (MBU) wherever possible[35] • MBUs avoid separation of mothers and babies, encourage breastfeeding, enhance attachment, provide support for partners and caregivers, and offer opportunities for education about illness and prevention of future episodes[75]

7 Psychotropic medication

Table 15. Psychotropic medication considerations

Aspect	Consideration
Context	• Medication considerations may arise: o Pre-conception for women with pre-existing mental health conditions o At any stage throughout the perinatal period for new or pre-existing mental health conditions • Psychotropic medication, and untreated or poorly treated mental health conditions may affect the developing fetus or breastfeeding infant
Medication safety	• Wherever possible, select medications with an established pregnancy safety profile for all women of reproductive age[23] o Seek advice from perinatal psychiatrist when required • Refer to pharmacopoeia and other medication resources (e.g. Pregnancy and Breastfeeding Medicines Guide[90], Choice and Medication[91], LactMed[92], Medications and Mothers' Milk[93], Australian Medicines Handbook[94]) • Refer to Queensland Clinical Guideline: *Perinatal substance use: maternal*[95]
Discuss risks and benefits	• Options for treatment[75] • Safety profile for pregnancy and breastfeeding, and infant feeding plans • Risks and benefits to woman, fetus and breastfeeding infant associated with[5] o Each treatment option o No treatment o Stopping or changing treatment • Woman's past or current response to treatment[75,89] • The possibility of onset or relapse of symptoms in the perinatal period, particularly in the first few weeks after birth[5] • Options for restarting medication later in pregnancy or postpartum • Expected time for treatment to take effect • Known and potential side effects in general, and with relevance to pregnancy, postpartum and breastfeeding[89]
Stopping medication	• Sudden cessation of medication may contribute to discontinuation symptoms and/or potential relapse of mental illness or worsening of symptoms[31] • If medication change or cessation is required before conception, advise about reducing gradually under guidance from a mental health professional[5]
General principles	• Wherever possible: o Combine pharmacological treatment with psychological therapies and psychosocial interventions o Limit the number of medication exposures to the fetus or infant by maximising one medication at an effective dose rather than using multiple medications (polypharmacy) at lower doses[23] • Monitor symptoms regularly and make medication adjustments as necessary to sustain efficacy, particularly in the later stages of pregnancy[31] • Do not omit psychotropic medications during labour and postpartum period unless there is an agreed plan to do so
Newborn Observation	• If the fetus or infant has been exposed to pharmacological treatment (or other substances) during pregnancy, monitoring for neonatal abstinence syndrome may be required o Refer to Queensland Clinical Guidelines: *Perinatal substance use: neonatal*[81]

7.1 Specific psychotropic medications

Information below is general in nature—seek expert advice and refer pharmacopoeia and other medication resources for up-to-date information as appropriate.

Table 16. Specific psychotropic mediations

Medication type	Consideration
Antidepressants	• For moderate to severe depression[5] • When choosing an antidepressant[5] o Consider the woman's past response to antidepressant treatment, obstetric history and any factors that may increase the risk of adverse effects o Consider serotonin reuptake inhibitors (SSRIs) as first-line pharmacological treatment for depression and/or anxiety in the perinatal period
Benzodiazepines	• Often used for symptoms of anxiety[96] • If symptoms of anxiety are moderate to severe, benzodiazepines may be considered while waiting for antidepressants to take effect • Recommend short-term use only due to risk of dependence and impacts for the fetus and breastfeeding infant—lowest effective dose for the shortest duration possible • Exercise caution in repeated prescription of long-acting benzodiazepine hypnotics around time of birth[5] • Short acting benzodiazepines are preferred for breastfeeding women
Antipsychotics	• For psychosis and some mood disorders[5] • If antipsychotic medication prescribed, recommend early screening for gestational diabetes mellitus and monitoring of fetal growth[5,89,97] ▪ Refer to Queensland Clinical Guideline: *Gestational diabetes mellitus*[98] • If considering clozapine for pregnant woman, seek perinatal psychiatrist advice[5] • There is limited evidence on the safety of clozapine while breastfeeding[5] o Recommend women avoid breastfeeding while on clozapine o Seek perinatal psychiatrist and neonatologist advice
Anticonvulsants	• For bipolar disorder as many anticonvulsants also act as mood stabilisers[5] • Do not prescribe sodium valproate to women of childbearing age unless all other agents are ineffective or not tolerated, and effective contraception is in use[5,94] • Do not prescribe sodium valproate to pregnant women[5,75] o If conception occurs while receiving valproate, wean over 2–4 weeks while adding high dose folic acid (5 mg/day)[5] o Continue high dose folic acid for the first trimester • Use caution in prescribing anticonvulsants as mood stabilisers for pregnant women[5] o Seek perinatal psychiatrist advice • If prescribing lamotrigine to women who are breastfeeding, close monitoring of infant is required and consultation with neonatologist where possible[5]
Lithium	• Used as a mood stabiliser • If prescribed lithium[5] during pregnancy, monitor maternal lithium blood levels closely[99] and consult with a perinatal psychiatrist[75,100] o Suggest monthly during pregnancy serum lithium measurements and renal and thyroid function[101] increasing to weekly after 36 weeks gestation o Recommend fetal echocardiography at 16 weeks gestation[101] • Dose increases are likely required during pregnancy to maintain a therapeutic level[75] • Monitor lithium levels and adjust individual dose prior to and after birth[100] • Establish a plan for adequate hydration during birth[102] • If breastfeeding, avoid prescribing lithium (where possible)[5,99]

8 Depression and anxiety

8.1 Overview of depression and anxiety

Table 17. Overview of depression and anxiety

Aspect	Consideration
Perinatal depression and anxiety	• Most common mental health conditions experienced in the perinatal period • Can range from mild to severe[5] • Commonly co-occurring • Experienced by 1 in 5 mothers across the perinatal period[27]
Baby blues versus depression	• The postpartum is a period of significant physical and emotional adjustment[22], and up to 80% of women experience temporary and transient emotional distress in the days after birth[5,38,57] o This distress (often referred to as 'baby blues') generally resolves in a week or so without treatment or intervention o May include being teary, sensitive, moody, overwhelmed or irritable[5] • If symptoms are frequent and persist beyond the first two weeks after birth, assessment of depression is recommended
Depression in perinatal period	• Severe depression in perinatal period is associated with maternal suicide[27] • Symptoms may be falsely attributed to challenges and adjustments of pregnancy and parenting • Depressive disorders in the peripartum range from adjustment disorders, to mild to moderate or severe depression • Moderate to severe depression may have significant consequences for pregnancy, fetal and infant wellbeing, parent-child interactions and bonding • Severe depression may have psychotic features
Anxiety in the perinatal period	• Co-occurrence with depression is very common • Women may experience a relapse or new onset of the following anxiety disorders: generalised anxiety disorders, panic disorders, obsessive-compulsive disorder, health anxiety disorders, and post-traumatic stress disorders • Symptoms may be falsely attributed to context of pregnancy or parenthood (e.g. hormones or sleep deprivation) • Exacerbated in pregnancies following perinatal loss, previous birth trauma, and in pregnancies where there are medical concerns • May experience obsessional thoughts of harm occurring to fetus or infant • High levels of maternal anxiety during pregnancy are associated with increased fetal exposure to maternal cortisol and risk of adverse neurodevelopmental outcomes[103]

8.2 Screening for depression and anxiety

Table 18. Screening for depression and anxiety

Aspect	Consideration
Depression screening tools	• The EPDS is the recommended tool for screening for perinatal depression in Australia[5] o Supported by high-quality evidence as an effective screening tool for depression in both antenatal and postnatal period[89] o Contains 10 items that screen for possible symptoms of depression and anxiety in the previous 7 days o Can be used antenatally and postnatally • Question 10 on EPDS enquires about self-harm o A positive response is anything other than "never" (score of 1, 2 or 3)
Anxiety screening tools	• Overall certainty of evidence for screening tools specifically for anxiety in the perinatal period is low[5] • Tools recommended for use in Australia are: ▪ EPDS items 3, 4 and 5 ▪ Anxiety items from the Depression, Anxiety and Stress Scale (DASS) ▪ Kessler Psychological Distress Scale (K10) • For First Nations women, an alternative tool may be more appropriate o Refer to Section 5.2 First Nations screening considerations
Minimum screening recommendation	• Screen for perinatal depression using EPDS[5] o As early as practical in pregnancy (e.g. at booking appointment) o Repeat at least once later in pregnancy o In the first 6–12 weeks following birth o Repeat at least once in first postnatal year o Repeat at any time in pregnancy or first postnatal year if indicated • Maintain awareness that anxiety disorders are common in the perinatal period and consider within a broader clinical assessment[104] o Use anxiety items (3, 4 and 5) from EPDS to screen for anxiety
Interpretation of EPDS	• The EPDS is a screening tool only, it is not diagnostic • Apply clinical judgment regardless of score • If any of the following are identified, further assessment is required[5]: o EPDS score of 13 or more, or positive response to item 10 o Current thoughts and/or plans for self-harm and/or suicide o Current thoughts and/or plans of harm towards infant o EPDS anxiety questions (Q3–Q5) score greater than or equal to 6 • Interpret the EPDS within the full context of the woman's situation including[5]: o Psychosocial risk factors and screening (Refer to Section 5.3 Psychosocial screening) o Substance use and DFV screening o Current mental state and level of distress of woman (e.g. agitation, despair, impulsivity) o Strengths and supports o Personal and family history of mental illness o Personal and family history of suicidal behaviour o Cultural factors • Refer to Section 9 Risk assessment and response

8.3 Treatment of depression and anxiety

Table 19. Management of depression and anxiety

Aspect	Consideration
Principles	• Refer to: o Section 2 Clinical standards o Section 6 Treatment principles
Psychosocial support	• Advise of the potential benefits of: o Social and peer support groups[89] o Parenting and parent support programs (e.g. parent aide programs) • Promote and offer structured psychoeducation wherever possible[98] o Demonstrated to improve depressive symptoms[89]
Psychological therapies	• Recommended for mild to moderate perinatal depression and anxiety[5] • Recommend individual structured psychological interventions including cognitive behavioural therapy (CBT)[96], interpersonal therapy[5,89], mindfulness, compassion-focused therapy and acceptance and commitment therapy • Online approaches may also be helpful (e.g. online courses, text and software applications)
Medication[5]	• May be indicated for moderate to severe symptoms • Refer to Section 7 Psychotropic medication • If symptoms are severe, recommend involvement of perinatal psychiatrist
Neurostimulation treatment[5]	• May be considered for severe depression in pregnancy and the postpartum • Electroconvulsive therapy (ECT)—a safe and effective treatment for severe forms of depression or when other treatments have not been effective[5] • Repetitive transcranial magnetic stimulation (rTMS)—a recognised treatment for depression • Seek perinatal psychiatrist advice regarding use of rTMS or ECT in the perinatal period[5]

9 Risk assessment and response

9.1 Risk assessment and safety plans

Table 20. Assessment and safety plans

Aspect	Consideration
Risk of suicide[5]	• A positive response to item 10 on EPDS, or disclosure of thoughts of self-harm or suicide, requires further assessment including asking the following questions: o Suicidal thoughts—if suicidal thoughts are present, how frequent, and persistent are they? o Suicidal history—is there a history of previous suicide attempts? o Plan—if the woman has a plan, how detailed is it? o Lethality—what method has the woman chosen; how lethal is it? o Means—does the woman have the means to carry out the method? o Intent—does the woman intend on carrying out her plan? • Risk of harm to infant—any thoughts of harm towards infant? o Refer to Table 36. Reducing risk to the infant • Obtain collateral information and history from family members or support persons • Refer to Section 9.2 Response to risk
Risk indicators	• The following are high risk indicators and require escalation of care[38,55,58,105]: o Recent significant change in mental state or emergence of new symptoms o New thoughts or acts of violent self-harm (e.g. thoughts or attempts of hanging) o New and persistent expressions of incompetency as a mother or estrangement from the infant o Severe difficulties with sleeping o Intrusive worry and/or obsessional thoughts o Consistent and pervasive symptoms of depression and/or anxiety o Psychotic symptoms or behavioural disturbances ▪ Disordered thinking, unusual behaviour, paranoia, significant sleep disturbance, agitation o Co-occurring substance use disorder o Difficulty caring for self or infant o Deterioration in physical health o Concerns raised by close family and friends • Refer to Section 9.2 Response to risk
Safety plan[5]	• A prioritised list of coping strategies and sources of support a woman can access if they experience thoughts of harm to self or infant o Completed with woman and unique to individual situation • Recommended for women at risk of suicide[38] • Include partner or other appropriate support person with consent of woman and identify[5,38]: o Warning signs that they may be at risk of imminent suicide o Actions to protect themselves and their infant o Internal coping strategies that reduce the level of risk o People within support network who can assist in times of need o Healthcare providers and agencies that can be contacted • Refer to Appendix B: Example safety plan

9.2 Response to risk

When interpreting screening results and responding to identified risks and concerns:

- Maintain awareness that the EPDS is a screening tool only, it is not diagnostic
- Review EPDS in setting of psychosocial, DFV and substance use screening
- Apply clinical judgment regardless of score
- Use adapted cut-off scores for First Nations women, and women from CALD backgrounds (refer to Section 5 Screening)

Table 21. Response to risk

Risk category	Indicators	Recommended actions
Mild to moderate	• EPDS: o Score of 10–12 or o Anxiety Q3–Q5: 4–5 o Q10: Negative ***and*** • No active plans to harm self or infant	• Recommend locally accessible supports • Discuss high scoring items • Listen to concerns • Repeat EPDS 2–4 weeks later • Notify GP for ongoing monitoring and further assessment as required
Moderate to severe	• EPDS: o Score of 13 or more o Anxiety items score 6 or more o Any positive response Q10 • History of or current severe mental illness ***and*** • No active plans to harm self or infant	• Assess acute risks • Liaise with senior clinician as appropriate to local clinical environment • Recommend continuity of care/carer[5,37] • Develop an initial safety plan • Document discussion of assessment and safety actions • Provide 1300 MH CALL (1300 642 255) details (refer to Definitions) o Refer to and/or contact most appropriate care provider/s for circumstances • Arrange follow up and repeat EPDS in 2 weeks
Crisis support	***Any of the following*** • EPDS Q10 positive and active plans to harm self or infant • Psychotic symptoms • High levels of distress	• Same actions as for moderate to severe symptoms • If immediate risk to self or others including baby call 000 for Queensland Ambulance Service and or Queensland Police Service • Call 1300 MH CALL (1300 642 255) or refer to emergency department • May require assessment under the Mental Health Act[106] if further assessment is declined

10 Eating disorders

10.1 Overview of eating disorders

Table 22. Overview of eating disorders

Aspect	Consideration
Eating disorders (ED)	• Mental health conditions with severe physical and psychological impacts[107] • Subtypes of ED include binge eating disorder, anorexia nervosa, bulimia nervosa, avoidant/restrictive food intake disorder and other specified feeding and eating disorders • Mortality rate of ED is the highest of all mental health conditions—over 12 times the mortality rate for people without eating disorders[107] • Women with ED are at an increased risk of co-occurring mental health conditions such as depression and anxiety[53,108]
Eating disorders in the perinatal period	• Vulnerable period for the onset or relapse of an ED[109] • Can occur at any stage throughout the perinatal period and on a continuum from disordered eating through to ED[107] • May exist prior to pregnancy and be exacerbated during the perinatal period, or may develop during the perinatal period • Associated with a heightened risk of adverse outcomes such as maternal anaemia, miscarriage, fetal growth restriction, preterm birth, low infant birthweight and infant feeding difficulties[53,107] • Symptoms may persist or worsen after birth, especially if woman's expectations about returning to pre-pregnancy size and shape are unrealistic[107] • May experience feelings of guilt and shame around how the ED is affecting their baby and may not disclose their history[107] • May present with rigid expectations and thoughts associated with the growth and feeding routines of their infant • Common among women seeking fertility treatment, yet often not considered by clinicians as potential underlying cause of infertility[53] • Pregnancy related symptoms may mask eating disorder symptoms[107,109], examples include: o Cravings may mask binge eating o Recommendations of avoidance of certain foods may mask restriction o Nausea may mask restriction and purging • Societal beliefs and phrases about pregnancy may contribute to ED symptoms (e.g. "eating for two", "you are looking big")
Prevalence	• Approximately 4% of Australians are living with an ED in any given year[110] o Many more experience disordered eating (eating behaviours consistent with an ED that do not meet criteria for a clinical diagnosis)[111] • EDs are common among women of reproductive age[53] and disproportionately affect this cohort[112,113] • In Australia, it is estimated around 15% of women will experience an ED at some stage during their lives[107] • Approximately 5–7% of women have an ED in the perinatal period[35,53,114] • The prevalence of EDs during pregnancy is: 0.5% anorexia nervosa, 0.1% bulimia nervosa, 1.8% binge eating disorder, 5% other specified eating disorders and 0.1% used purging[114]
Risk factors	• Personal or family history of an ED[53] • Body mass index (BMI) at booking appointment less than 18 or more than 30 • History of infertility[53], menstrual disturbances, or polycystic ovary syndrome[53,107] • Perfectionistic and obsessional personality traits • History of bariatric surgery • Adopting and aspiring to cultural ideals of thinness, muscularity and leanness • History of belonging to high-risk groups such as competitive sports, modelling and performing arts

10.2 Signs and symptoms of eating disorders

Table 23. Signs and symptoms

Aspect	Consideration
Psychological and behavioural signs and symptoms	• Concern about weight and body image[107] • Preoccupation regarding change in weight and shape in pregnancy[107] • Vomiting or using laxatives, enemas, appetite suppressants or diuretics o Explore reasons for vomiting (e.g. hyperemesis versus means of weight control) • Negative or unusual attitude towards food and eating[107] • Negative attitude towards unborn baby or infant[107] • Depression and/or anxiety about pregnancy and/or caring for infant[53,107] • Restriction of certain foods not advised by a clinician[107] • Secretive behaviour around food, avoidance of meals, or changes in eating behaviours (e.g. refusing to eat with others) • Excessive or distorted exercise patterns, or signs of distress when exercise is not possible
Physical and medical signs and symptoms	• Signs and symptoms of electrolyte disturbances (thirst, dizziness, fluid retention, swelling, weakness/lethargy, muscle twitches)[107] • Signs of damage due to vomiting including swelling around the cheeks or jaw, calluses on knuckles, damage to teeth and bad breath[107] • Inadequate or excessive weight gain in pregnancy[107] • Deep irregular sighing (sign of ketoacidosis)[107] • Poor peripheral circulation[107] • Postural hypotension and postural tachycardia[115] • Bradycardia or tachycardia[115] • Low body temperature[115] • Fetal growth concerns[107] • Fainting, dizziness, headaches, shortness of breath, fatigue[107] • Gastrointestinal problems and low bone density[107]

10.3 Screening for eating disorders

Table 24. Screening

Aspect	Consideration
Screening overview	• Wherever possible, screen for and support the treatment of ED prior to pregnancy • The perinatal period provides an ideal opportunity for screening for EDs, as women are engaged with healthcare providers during this time[107] • Screen for ED symptoms at booking in, and opportunistically at other times during pregnancy • Routinely and sensitively enquire if the woman has a current or past history of ED and be aware of potential barriers for disclosure[108] • Remain cognisant that EDs are serious mental health conditions associated with significant risks • If information provided by woman does not align with clinical presentation, gather collateral information
Screening tools	• There are currently no validated ED screening tools specifically designed for use in the perinatal period[109,113] • Insufficient evidence to recommend a particular tool • The Eating Disorder Screen for Primary Care (ESP) is used in the general population and has not been validated in the perinatal population, but may be useful for initiating conversations and may be considered for use o Refer to Appendix C: Eating disorder screen for primary care • Monitor for risk factors and signs and symptoms • Maintain a low threshold for referral to an ED service for assessment and/or treatment[53] • Collateral history can be helpful due to the secretive nature of EDs, this is particularly important for adolescents

10.4 Treatment of eating disorders

Table 25. Treatment of eating disorders

Aspect	Consideration
Principles	• Refer to: o Section 2 Clinical standards o Section 6 Treatment principles o Appendix D: Eating disorder indicators for escalation of care and/or admission • If current ED, refer for high risk maternity care and obstetric medicine (where available) and provide continuity of care[5,37,38,108] • If pre-existing ED, and is currently well, provide information about risks of relapse, and establish a relapse prevention plan[35]
Care options	• Refer early to eating disorder/perinatal mental health services o If not available in local area, seek expert advice through Queensland eating disorder service/e-PIMH telepsychiatry service o Refer to Section 2.3 Multidisciplinary care and referral pathways • Treatment options include o GP management o Specialist outpatient management, including: ▪ Psychological interventions (e.g. enhanced CBT, specialist supportive clinical management) ▪ Specialised dietetic input ▪ Day programs o Courses and day programs from public, private, peer support and not-for-profit providers o Private psychiatrist o Peer support o Inpatient care
Weight	• Weighing, weight change, and talking about weight can perpetuate weight stigma and trigger past difficulties with weight • Do not rely on weight as indicator of ED • Consider clinical necessity of weighing, and if weighing is required: o Seek permission before weighing o Consider blind weighing if distressing for the woman (refer to Definitions) • Weight gain associated with pregnancy may contribute to further restriction and other behaviours
Monitoring and assessment	• Signs or symptoms of relapse or worsening condition[53] [refer to Table 23.] • Compensatory behaviours (e.g. purging, overexercise, laxative use) • Refer to Appendix D: Eating disorder indicators for escalation of care and/or admission • Fetal growth and wellbeing • Co-occurring mental health conditions[35,53] • Impact of ED on experience of pregnancy, changing body and relationship with and care of infant[35] • Infant growth and development and weight gain • Align assessment and monitoring schedule with the severity of the ED and treatment model being implemented
Support and information	• Offer information about o Body changes in pregnancy and postpartum o Importance of nutrition o Impact of starvation o Bowel health and appropriate use of stool softeners if necessary o Cravings, nausea and hyperemesis when indicated • Refer to, or consult with dietitian for nutrition advice during the perinatal period, support the establishment of regular eating, and manage nutritional deficiencies as indicated • Provide support for early parenting, infant feeding, settling and emotional attachment with their infant[53]

11 Severe mental illness

In this guideline, the term severe mental illnesses encompass psychotic disorders (schizophrenia and postpartum psychosis) and bipolar disorder[5,75]

Table 26. Severe mental illnesses

Aspect	Consideration
Bipolar disorder	• Prevalence in general population is about 1 in 100[116] • There is strong and consistent evidence of an association between bipolar disorder and postpartum psychosis[75,117] o Commonly associated with new onset psychotic episodes in first few months after birth[5] • Relapse across the perinatal period is common[57], particularly in the setting of medication cessation[75] • Birth may trigger first episode or presentation of bipolar disorder
Postpartum psychosis	• Also referred to as postnatal or puerperal psychosis[5] • Usually occurs within first few days or weeks following birth[75], but can occur at other times and may last for many months[5] o Can occur regardless of pregnancy outcome (e.g. live birth or stillbirth) • Incidence is rare, occurring in around 1 to 2 per 1,000 births[57,117,118] • Risk factors include[75,117]: o Previous history of postpartum psychosis (meta-analysis found a 31% relapse rate)[119] o Bipolar disorder o Family history of bipolar disorder or postpartum psychosis[58] o Primiparity o Sleep deprivation during labour and postpartum period • May occur as: o An isolated episode that does not progress to a subsequent diagnosis, or further psychotic episodes outside the postpartum period[117] o An initial event or first presentation of bipolar disorder, or another mental health condition with psychotic features[5] o A continuation or relapse of a chronic psychotic condition that began before or during pregnancy[75] • Clinical picture commonly includes rapid onset of psychotic symptoms, confusion and disorganisation[75,117] • Symptoms may fluctuate over time o Avoid management decisions based on a single review o Obtain information and history from family members o Consider cultural factors • Symptoms may resemble delirium o Consider physical examination and investigation to exclude organic causes such as infection and thyroid conditions
Schizophrenia	• Prevalence in general population is around 1 per 100 people[5,120] • Episodes of schizophrenia can vary in frequency and severity and over time[44] • Frequently associated with secondary depression and/or anxiety[5] • Relapse in peripartum may be associated with cessation of medication, or other contributors including stress related to pregnancy and parenting • Associated with higher rates of unplanned pregnancy, late booking in, co-occurring chronic medical conditions, obstetric complications, co-occurring mental health conditions, substance use and psychosocial adversity[75]

11.1 Treatment of severe mental illness

Table 27. Treatment of severe mental illness

Aspect	Consideration
Principles	• Refer to: o Section 2 Clinical standards o Section 6 Treatment principles • Recommend and facilitate: o Ongoing care and management from perinatal psychiatrist, or psychiatrist with access to perinatal psychiatry advice o Coordinated care from a multidisciplinary team o Psychoeducation for woman and partner/support persons
Monitoring	• Closely monitor woman in first month after birth, and review regularly in the subsequent months[5] o Be alert to possible symptoms of postpartum psychosis or relapse[89] • The risk of relapse is increased if: o Medications have been ceased or altered before or during pregnancy[5] o Protracted labour or extended period of sleep deprivation o Psychosocial stressors and lack of support • If relapse occurs and management in the community is not safe, recommend admission to a MBU wherever possible[5]
Postpartum psychosis	• In most cases, postpartum psychosis constitutes a medical emergency and generally requires rapid intervention and hospitalisation[117] • Associated with risk of suicide and infanticide • Hospitalisation with appropriate specialist care and supervision is recommended[121] • If safe, co-admission of the woman and infant to a MBU is recommended o Dependent on the acuity of the woman's illness and associated risks to both the woman and infant • If woman presents to an acute mental health service, seek specialist advice from perinatal mental health and MBU
Medication	• Refer to Section 7 Psychotropic medication
Electroconvulsive therapy	• Electroconvulsive therapy (ECT) is a safe and effective treatment for postpartum psychosis and bipolar disorder[75] • Provide education to woman and family about ECT
Indicators for escalation of care	• Psychotic symptoms • Risk of self-harm • Risk of harm to infant or others • Acute distress • Refer to Section 9 Risk assessment and response

12 Borderline personality disorder

Table 28. Borderline personality disorder

Aspect	Consideration
Context	• In Australia, prevalence estimates range from 1–3.5%[122] • Sometimes referred to as emotionally unstable personality disorder[38,123] • Often associated with adverse childhood experiences, trauma, or a lack of emotional validation and support from caregivers[5] • May overlap or co-occur with complex post-traumatic stress disorder (PTSD) • Behaviour is characterised by: o Impulsivity and emotional dysregulation including self-harm[38,123] o Efforts to overcome fear of abandonment o Intense and unstable relationships which tend to be short lived o Risk taking behaviour (co-occurrence with substance use is common) o Chronic feeling of emptiness o Anxiety and insecurity (may manifest as hostile and angry behaviour)
Stigma	• BPD diagnosis often carries a heavy and negative stigma which can be pervasive and damaging[38] • Misconceptions and stereotypes are prevalent (e.g. labelling individuals with BPD as manipulative or attention seeking) • Judgmental approaches can hinder individuals accessing and receiving the help they required
Perinatal context	• Increased risk of unplanned pregnancy • High co-occurrence with depression and anxiety • May experience challenges in early parenting related to sleep, physical changes and impact of past trauma of own experience of being parented • Inconsistent engagement with healthcare providers is common[16,38] • Increased risk of adverse maternal and fetal outcomes[5] • Parenting often occurs in an environment of poor support, high stress and anxiety, and co-occurring substance use[38] • Parents with BPD are more likely to experience difficulties with attachment and bonding[38]

12.1 Treatment of borderline personality disorder

Table 29. Treatment and management of bipolar personality disorder

Aspect	Consideration
Principles	• Refer to: o Section 2 Clinical standards o Section 6 Treatment principles • Trauma-informed care and developing a trusting relationship is especially important for women with BPD[124] • Recommend and facilitate a multidisciplinary team, 'wrap around' case management approach to address complex psychosocial risk factors[35,89] • Facilitate continuity of carers to facilitate trusting relationships wherever possible[37,124] • Assess and support the mother-infant relationship • Assess for and consider possibility of overlapping and co-occurring mental health conditions and/or substance use[35]
Therapies	• Individual and group sessions designed to build health supports and develop resilience, emotional regulation skills, and functional coping patterns[35] o Includes dialectical behaviour therapy, emotional regulation groups and couple therapy • Offer psychoeducation about therapies and facilitate referrals • Consider therapies to support healthy attachment and infant mental health o Refer to Section 15 Infant mental health • If identified, manage and treat co-occurring mental health conditions and/or substance use as appropriate

13 Birth trauma and fear of birth

Table 30. Overview of birth trauma

Aspect	Consideration
Fear of birth	• May occur before experiencing birth, or after a traumatic birth experience[125] • Also referred to as tocophobia[125] • Experienced by around 1 in 5 birthing women[126] • Severe fear of birth is an intense fear affecting woman's daily functioning and is estimated to occur in around 3% of birthing women[8] • Often associated with anxiety and depression[8] and may impact relationship with infant
Birth trauma	• Women and partners can experience distress and/or post-traumatic stress symptoms following birth[5,127] • Associated with post-traumatic stress symptoms, post-traumatic stress disorder and postnatal depression • Around 1 in 3 women feel traumatised to some degree by their birthing experience[128-130] • May be accompanied with anxiety or depressive symptoms[5] • Birth may be experienced as traumatic even when viewed as medically straightforward by care providers[89] • May impact the parent-infant relationship • Can have physical and psychological sequalae • Many parents do not seek help following a traumatic or distressing birth, but may seek help when planning next pregnancy or birth[5]
Risk factors	• History of trauma, including childhood and adult sexual trauma[5] • History of vaginismus[5] • Co-occurring or pre-existing mental health condition[5,131] • Poor social support[5] • Experience of extreme pain including during pregnancy[5] • Having a strong desire to adhere strictly to a birth plan[5,131] • Labour and birth events varying from expectations[131] • Feelings of powerlessness and lack of control and information[5] • Feeling uncared for, invalidated or dismissed by healthcare professionals[5,131] • Unplanned intervention (e.g. instrumental or emergency caesarean birth)[5] • Significant birth injury to woman (e.g. obstetric anal sphincter injury) • Giving birth to an unwell or injured baby[5] • Fear for self or infant[131] • Early separation of parent and infant for maternal or infant care needs[5]
Perinatal loss	• Birth in the setting of perinatal loss may be experienced as traumatic o Refer to Queensland Clinical Guidelines: ▪ *Early pregnancy loss*[71] ▪ *Termination of pregnancy*[72] ▪ *Stillbirth care*[73]
Trauma response[5,128]	• Appearing dazed, distressed, overactive and/or withdrawn • Autonomic arousal symptoms (e.g. increased heart rate, tightness in chest, restlessness, sweating) • Flashbacks and nightmares[131] • Feeling of disconnect and/or numbness • Intrusive memories • Avoidance of external reminders (e.g. infant, health appointments, future pregnancy or future vaginal birth)
Other signs and symptoms	• Bonding and attachment difficulties[131] • Fear of sexual intimacy[131] • Anger and/or mistrust towards healthcare providers

13.1 Risk reduction and response to birth trauma and fear of birth

Table 31. Response to birth trauma

Aspect	Consideration
General principles	• Provide trauma-informed care • Recommend continuity of care/carer and consistency of information[5,37]
Antenatal care	• Enquire about woman's feelings towards birth and where applicable, explore concerns about previous birth/s • Refer to appropriate providers when mental illness, psychosocial risk factors or previous traumatic birth are identified o Refer to Section 2.3 Multidisciplinary care and referral pathways, and Appendix A: Potential care providers • Discuss strategies and support that may mitigate distress including identification of potential triggers • Prepare women, partners and support persons for possibility of unexpected events in labour, birth and postnatal period[42]
Intrapartum care	• A positive birthing experience subsequent to a traumatic birth can be therapeutic[5] • Maximise woman's sense of control in labour by communicating respectfully, and empowering woman to make informed choices about care[128] • Provide information about any proposed procedure and seeking informed consent o Refer to Queensland Clinical Guideline: *Standard care*[39] • Provide pain management as desired by woman o Refer to Queensland Clinical Guideline: *Intrapartum pain management*[132]
Debriefing	• Debriefing provides women an opportunity to discuss the events and experience of their birth[133] • Women with symptoms of post-traumatic stress are more likely to view their birth negatively, and to desire the opportunity to talk about their birth[129] • There is no evidence that debriefing reduces morbidity[133], however, evidence indicates that overall, women review debriefing opportunities positively and value talking and being listened to by care providers following birth[134]
Recommendation	• Psychological interventions delivered within 72 hours of a traumatic birth are more effective than usual care in reducing symptoms of PTSD at 4–6 weeks[135] • Offer women the opportunity to discuss their birth experience and listen with empathy[128] • Arrange debriefing at a time suitable to the woman and wherever possible with desired support person present • Avoid high intensity psychological interventions that focus on 're-living' a traumatic birth experience[5,89] • If desired by the woman, facilitate postnatal review appointment 4–6 weeks following birth[128] • If post-traumatic symptoms persist, consider referral to appropriate mental health professionals for further assessment and care[5,128] • Consider: o Psychological interventions such as trauma focused CBT and eye movement desensitisation and reprocessing (EMDR)[5] • Adjunctive pharmacological treatments[5]
Subsequent pregnancies following birth trauma	• Provide preconception planning and support (or as early as possible antenatally) • Recommend continuity models of care[5,37] • Facilitate planning for birth including mode of birth and pain management options • Assist with identification of potential triggers and a plan for management • Recommend peer support and facilitate connection and referral

14 Mental health in partners

Table 32. Mental health in partners

Aspect	Consideration
Context	• Partners and non-birthing parents can also experience perinatal mental health conditions[57,136] • Evidence suggests mental health conditions in men are under-reported and under-screened[137,138] • Symptoms of mental health conditions present differently in men compared with women[138] o Men are more likely than women to have symptoms such as anger, irritability, reduced impulse control[139], social withdrawal, substance use, escapist activities (e.g. overworking, gaming, gambling), avoidance and hostility[138] • Estimated prevalence in partners[5]: o 1 in 10 for depression o 1 in 5–6 for anxiety
Impact	• Mental health conditions in partners may lead to[136] o Relationship concerns with partner o Reduced desire for sexual intimacy o Difficulty bonding with infant and resultant impacts on infant mental health o Feelings of resentment • There is growing evidence that the mental health of fathers and non-birthing parents is also connected to childhood development[30] • Depression in fathers during an infant's first year of life is related to poorer outcomes for social and emotional development, and behavioural difficulties at age of school entry[140]
Risk factors	• Current or past mental health condition • Excessive stress during pregnancy and birth ,and fear for their partner and/or baby[136] • Perceived lack of information, knowledge and inclusion in pregnancy and birth process[136] • Lack of acknowledgement of their needs and role[141] • Childhood trauma[142] • Substance use[142] • Change in financial situation[140] • Change in intimate relationship with partner[140] • Especially vulnerable to mental illness if their partner is experiencing a perinatal mental illness[138] o Prevalence of mental health conditions in partners of women receiving inpatient treatment for perinatal mental health conditions is estimated to be 42–50% o Depression in one partner is correlated with depression in the other partner

14.1 Screening in partners

Table 33. Screening in partners

Aspect	Consideration
Context	• There is limited evidence on: o Screening and assessment of mental health and psychosocial risk factors in partners during the perinatal period, particularly in non-male partners[5,138] o Partners' acceptability of receptiveness to screening • Currently in Queensland, partners are not routinely screened for mental health conditions in the perinatal period o When partners are screened, documentation is inconsistent, and data is reported[66]
Barriers	• Barriers for screening partners include: o Lack of contact with health services[136] o Focus on the woman and infant during routine perinatal care[138] o Stigma and societal expectations o Lack of culturally appropriate services o Lack of validated screening tools
Screening tools	• Evidence for diagnostic accuracy for use of screening tools in partners is limited, and results are varied[138] o Insufficient evidence to recommend one screening tool over another[5,138] • EPDS is the most widely assessed screening tool in literature for accuracy and acceptability[138] • EPDS performs similarly to or better than other screening tools however, there are divergent recommendations in literature about[138] o Sensitivity and validity of EPDS for use in partners[138] o Recommendations for targeted versus routine screening o Recommended cut-off score for use in partners with EPDS[138]
Recommendation	• When providing care to families in the perinatal period, facilitate a welcoming and inclusive environment for partners[137] • If safe to do so and where agreed by the woman, encourage partner attendance at antenatal and postnatal appointments • Enquire about partner's emotional wellbeing when providing perinatal care • If using a screening tool[5]: o Consider use of EPDS or K10 o If using EPDS for male partners, a cut-off score for further assessment of 10 is recommended o Select tool in accordance with availability of tool and competence of healthcare professional to administer tool within setting • Establish and promote locally adapted referral pathways for partners to access mental health support when concerns are identified[57] • Encourage partners to access community programs and digital supports • Encourage First Nations peoples to access ATSICCHO • Promote benefits of establishing relationship with regular GP and supports designed for partners (e.g. SMS for Dads)

15 Infant mental health

Table 34. Overview of infant mental health and attachment

Aspect	Consideration
Context	• The foundations of lifelong mental health and emotional wellbeing are developed in utero, and across infancy and childhood[22,143,144] • Infants' brains are extremely malleable to environmental stress, and respond differently to external stress than older children[145]
Definition and incidence	• Infant mental health refers to the developing capacity of the infant to[22]: o Form close and secure relationships o Experience, manage and express a full range of emotions o Explore their environment and learn within the context of family, community and culture[145] • It is estimated that 6–18% of infants experience mental health disorders globally[146]
Influencing factors	• Infant mental health is impacted by[22]: o The intrauterine environment including exposure to stress and/or substances o Infant's physical health and unique temperament o Carer availability, capacity and responsiveness o Quality of relationship between carer and infant o The physical, social and political environment the infant is living in
Parental mental health	• Social and emotional development of an infant occurs primarily within the context of the parent-infant relationship[26,144] • A secure, warm, responsive and predictable relationship with at least one caregiver influences the formation of neural structures in the brain that lead to positive infant wellbeing[144,145] • There is growing evidence of the negative impacts of poor parental mental health on outcomes for the infant[26,34,144,147,148], however, negative impacts are not inevitable[30] o If maternal mental health condition is not chronic and there are no other significant hardships, the effect size of negative impacts on development, are generally small or moderate[30]
Attachment	• Attachment between an infant and their parent or caregiver(s) is critical for healthy development[144,145] • Begins during pregnancy (maternal-fetal attachment)[149] • Formed when an infant learns to trust that their parent or caregiver will reliably and consistently respond to their signals of need[22,30,150] o Enables infant to explore and learn from their environment, laying the foundation for their biological, cognitive, social and emotional development[22,144,150] • Poor attachment can negatively impact on longer term outcomes for infant including language acquisition, school performance, cognitive and social development, emotional regulation and an increased risk of mental health conditions later in life[22,144,145,149,150] • If an infant is unable to form a secure attachment with a parent, a secure attachment with another caregiver may protect the infant and help to optimise their growth and development
Risk factors for poor attachment	• Perinatal mental health condition, particularly severe mental illness[5,26] • Psychosocial risk factors [refer to Section 3.2 Risk factors] • DFV • Unresolved family of origin issues[5] such as poor attachment relationship with their own caregivers • Previous perinatal loss[5] • Unplanned or unwanted pregnancy[5] • Fertility issues or assisted reproduction • Separation of parent and infant[5] • Health complications for parent or infant • Significant amounts of time spent away from infant[5] • Current parental substance use[5] • Birth trauma[131]

15.1 Screening of parent-infant relationship

The aim of screening the parent-infant relationship is to identify the strengths and challenges within the family unit, in order to maximise parenting capacity, and to maximise the development and mental health of the infant.[143] Table 35 below is not a formal assessment tool or checklist, however, observation of the following may provide reassurance, or indicate difficulties in the parent-infant relationship.

Table 35. Positive and problem indicators of parent-infant relationship[5,145,151,152]

Positive indicators	Indicators of concern
Parent • Responsive to the infant's communication cues and needs • Maintains eye contact with the infant when culturally appropriate • Communicates in a kind, loving, empathetic manner most of the time • Engages with infant appropriately (e.g., welcomes infant, encourages infant to explore, comforts infant when needed, plays with infant) • Appears to enjoy being with the infant • Provides practical support and comfort to the infant as needed • Provides sensitive and appropriate guidance when needed by the infant • Provides a developmentally appropriate and simulating environment for infant • Able to consider the infant's perspective • Prioritises infant's needs over own or others?	**Parent** • Inability to identify and respond consistently and appropriately to the infant's cues and needs • Lack of sensitivity, warmth or thoughtfulness towards the infant • Unable to delight in the infant or enjoy activities with the infant • Difficulty coping with the infant's distress • Infant's behaviour results in parent's discomfort, panic, unhappiness or rage • Does not ensure the infant is safe, or is overprotective and/or excessively worried and hypervigilant about the infant • Uses hostile, rejecting language towards the infant • Handles the infant roughly, including shaking of the infant • Has thoughts of harm towards the infant • Inappropriate interpretation of the infant's behaviours, (e.g., manipulative, rejecting or vindictive) • Inability to describe infant's routine • Lack of empathy towards the infant • Inflexible approach to routine • Disengaged, inattentive or distracted from infant • Limited communication with infant (verbal or non-verbal) • Does not provide a safe or stimulating environment for infant • Misinterpretation of infant cues • Extreme guilt about relationship with infant
Infant • Alert, yet relaxed demeanour • Maintains eye contact • Engages with caregivers appropriately, (e.g. engages, disengages to explore and re-engages) • Seeks and responds to comfort from caregiver • Enjoys being cuddled, sitting on parent's lap • Generally predictable with needs, (e.g. eating, sleeping, interaction cycles appropriate to age stage) • Mimics parental behaviours, (e.g. infant smiles and babbles)	**Infant** • Overly friendly and/or overly fearful with strangers • Difficulty with feeding or sleeping patterns • Avoids looking at and/or towards the parent • Does not seek out the parent for comfort • Does not explore environment • Flat affect or emotionally under-responsive • Lack of crying, limited vocalising • Irritable, constant crying • Difficulty settling • Difficulty separating from parent (age dependent) • Interacting too easily with strangers (age dependent) • Under-responsive emotions • Failure to thrive • Delay in meeting developmental milestones

15.2 Reducing risk to the infant

Table 36. Reducing risk to the infant

Aspect	Consideration
Assessment	• The infant may be at risk of harm if the woman is at risk of suicide or has thoughts of harming the infant, • If problem indicators are observed, further specialist assessment may be required with the family • If the parent and/or infant are displaying a combination of risk factors, specialist assessment is recommended to determine support needs • Use sensitivity when discussing infant mental health concerns with parents
Safety	• It is preferable for parent and infant to remain together, but if there is perceived risk of harm to the infant, it may be necessary to make alternative arrangements for care of the infant (e.g. co-parent)[5] • Maintain awareness of obligation to report reasonable suspicions of child abuse or neglect to Department of Child Safety (within Department of Child Safety, Seniors and Disability Services) {reference] • Collaborate with local child protection unit and social work teams as required
Parenting	• Parental mental health conditions can have a detrimental impact on parenting[144] o May interfere with sensitive parenting and disrupt the formation of healthy and secure attachment o If adequate supports are provided, risks to infant may be mitigated • Parents experiencing a mental health condition may be less likely to participate in parenting programs or interventions, because of their mental health difficulties and perceived stigma[26] • Adequate treatment and management of parental mental health will have a positive impact on the infant • Reassure parents that bonding and attachment can take time and practice
Cultural considerations	• Different cultures display different styles of parenting and have different ways of interacting with their infants • When assessing parent-infant interactions in First Nations families, seek guidance and support from First Nations professionals to reduce risk of unconscious bias, and ensure assessment is culturally appropriate[5] • When assessing parent-infant interactions in migrant, refugee and CALD women, seek guidance and support from bicultural health workers to reduce risk of unconscious bias, and ensure assessment is culturally appropriate[5]
Referral	• If infant mental health concerns are identified, consider referral to: o Infant mental health services and resources (e.g. e-PIMH) o Community and peer support services o Early intervention parenting clinician support o Day program or parenting courses (e.g. Circle of Security, Together in Mind) o Specialist MBU if required o ATSICCHO for First Nations families • Early intervention in infant's mental health and wellbeing is the best prevention for lifelong illness

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Appendix A: Potential care providers

Women with perinatal mental illness often have complex needs that require care and support from multiple providers across a multidisciplinary team. Potential providers for referral include but are not limited to the categories described in the table below.

Category	Providers
Medical, nursing and midwifery	• Nurses (including nurse practitioners, mental health nurses, nurse navigators and child health nurses) • Midwives and midwife navigators • Consultant and perinatal psychiatrists • Obstetricians • Medical specialists (e.g. obstetric medicine physicians, maternal fetal medicine, endocrinologists)
Allied health	• Social workers • Psychologists • Dietitians • Pharmacists • Occupational therapists • Physiotherapists • Counsellors • Infant mental health clinicians
Primary care providers	• General practitioners • Child health services • Primary health networks • Aboriginal and Torres Strait Islander Community Controlled Health Organisations
Support workers or groups	• Peer support and lived experience support groups • First Nations health workers • Cultural support or health workers • Maternity support workers (e.g. doulas) • Family support workers
Services	• Specialist multidisciplinary services (e.g. alcohol and other drugs services and eating disorder services) • Family support services • Perinatal and parent helpline services • Child safety units and child protection services • Translation services
Organisations	• Community, non-government, peer support and not-for-profit organisations for: o Substance use o Addictions o Perinatal loss o Physical and/or intellectual disability o Specific mental health conditions o Domestic and family violence o Cultural supports o Relationship counselling o Housing o Young parents o Gender differences and those who identify as lesbian, gay, bisexual, trans, intersex and/or queer plus (LGBTIQ+)

Appendix B: Example safety plan

Safety plans help people reduce their immediate risk of suicidal behaviour by providing a structured approach to managing distress and suicidal thoughts. The below table provides some examples of what may be included in a safety plan[1]. This is an example only—safety plans require clinical judgment according to individual circumstances. Use local safety plan template wherever available.

Aspect	Points to consider
Warning signs	• Warning signs that you may be at risk of harming yourself • Examples o Feeling trapped, helpless or irritable o Thoughts about harming yourself or your baby o Behaviours such as avoiding others, arguing more often with loved ones, increasing alcohol consumption
Protective action	• Things you can do to protect yourself and your baby • Examples o Making the environment safe by: ▪ Asking someone else to manage your medication access ▪ Reducing access to firearms or improving safety procedures ▪ Removing glass or blades that might be used to cause harm o Staying close to people that care about you and that help keep you safe (e.g. partner, parents, close friends) o Being honest with others about how you are feeling and telling others when you notice warning signs o Asking for help when you need it
Coping strategies	• Coping strategies that help you and decrease the level of risk • Examples o Remembering reasons to live, things you enjoy, and things you have to look forward to such as family, friends, pets, spiritual beliefs o Doing activities that you enjoy (e.g. enjoying nature, cuddling a pet, watching a movie) o Breathing or relaxation exercises o Being active (e.g. going for a walk, doing exercise)
Support networks	• People you can turn to for assistance in times of need • Examples: o Partner o Family o Friends o A coffee shop or park o Church or place or worship o Community group or sports club
Professional help	• Health professionals and agencies that can be contacted for help • Examples o GP o Psychiatrist o Nurse or midwife o Psychologist or social worker o Acute mental health team (can be accessed by ringing 1300 MH CALL) o Organisations such as Lifeline, PANDA, Gidget Foundation and ForWhen o Queensland Ambulance Service (accessed by ringing 000)

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Appendix C: Eating disorder screen for primary care

The Eating disorder screen for primary care (ESP) has not been validated in the perinatal population but may be considered for use if concerned about possibility of an eating disorder.

ESP questions[1]:

1. Are you satisfied with your eating patterns?
2. Do you ever eat in secret?
3. Does your weight affect the way you feel about yourself?
4. Have any members of your family suffered with an eating disorder?
5. Do you currently suffer with, or have you ever suffered in the past with an eating disorder?

A 'no' to question 1 is classified as an abnormal response. A 'yes' to questions 2–5 is classified as an abnormal response. Any abnormal response warrants further assessment.

Appendix D: Eating disorder indicators for escalation of care and/or admission

Indicators for escalation of care in the perinatal period include[2,3]:

- Inadequate nutritional or fluid intake
- Unmanageable compensatory behaviours (vomiting, exercise, laxatives)
- Weight loss or lack of weight gain in pregnancy
- Concerns about fetal growth and wellbeing
- Not responding to outpatient treatment
- Co-occurring mental illness or concerns based on clinical judgement
- Low systolic blood pressure
- Postural* hypotension
- Bradycardia or tachycardia
- Postural* tachycardia
- Arrythmia on electrocardiogram (ECG)
- Hypoglycaemia
- Hypothermia
- Abnormal electrolyte levels (e.g. sodium, potassium, magnesium and phosphate)
- Poor or rapidly declining kidney function
- Abnormal liver function tests
- Neutropenia

Maintain a low threshold for escalation and treatment in the perinatal period.

Expert advice can be obtained from:

- Local eating disorder specialist services
- Eating disorder specialists
- Perinatal mental health and/or perinatal psychiatrists
- Obstetric medicine physicians
- Queensland Eating Disorder Service (QuEDS)

***** *Postural blood pressure and heart rate are measured from lying to standing with a two minute break*

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