3.5 Guidelines, Monitoring and Surveillance of At Risk Groups

3.5.3 Perinatal and Infant Mental Health

Background

Mental health issues are an important health concern for mothers, fathers, and other non-parental primary caregivers during the perinatal period, which covers conception to thirty-six months postpartum. The mental health issues that a parent or carer may suffer from during this time include:

- Perinatal depression
- Anxiety disorders, including: generalised anxiety disorder (GAD), panic attacks, social anxiety, adjustment disorders, Post traumatic stress disorder (PTSD), obsessive compulsive disorder (OCD), and phobias (e.g. blood, needle, tokophobia)
- Puerperal psychosis.

Estimates of the prevalence of mental health issues in the perinatal period vary widely depending on study parameters.\(^1\) The two most common perinatal mental health issues are depression and anxiety. Perinatal depression is a term used to describe a sustained depressive disorder which can present in both the antenatal and postnatal periods. The point prevalence of perinatal depression for women is currently estimated to be 7-12 percent in the antenatal period, and approximately 13 percent in the postnatal period.\(^2\)\(^3\) For fathers, the point prevalence of depression during the perinatal period is estimated at one in ten.\(^4\)\(^5\) Depression can leave parents/carers feeling disinterested in their regular activities, unable to cope, experiencing a loss of appetite, and with thoughts of suicide or self harm.\(^6\)

Anxiety disorders are more common than perinatal depression, may be just as detrimental, and are characterised by levels of fear or worry that are out of proportion to the object of the worry. The presence of anxiety disorders is also a risk factor for the development of perinatal depression.\(^7\)

Puerperal psychosis is relatively rare at a rate of 0.2% but is a severe psychotic illness.\(^8\) Due to the potential safety concerns for the affected woman and her infant, it represents a medical emergency. Community Child Health Nurses (CCHNs) must seek immediate assistance from a mental health service, emergency department, or a general practitioner (GP) depending on the availability of services if psychotic symptoms are noted.\(^9\)

Co-morbidity of all mental health issues is high. Thirty to 50% of depressed women experience co-morbid depression and anxiety, increasing the negative outcomes for the parents/carers and the infant.\(^10\)\(^11\)
As well as pregnancy specific issues, there are a range of other pre-existing mental health issues that can impact families during the perinatal period which require specialist services, including schizophrenia and bipolar disorder. CCHNs should be aware of the signs of these disorders and have access to appropriate services for referral. However, this policy will deal specifically with the impact of mental health issues that can develop as a direct result of pregnancy and parenting.

The transition to parenthood and the addition of a child to an existing family structure can be a complex and stressful time for all parents/carers. Every pregnancy is different and the life events surrounding each new pregnancy are different, therefore it is important that CCHNs assess parents/carers with two or more children as rigorously as they would new parents/carers.

Risk factors that lead to the development of mental health issues during the perinatal period include:

- Lack of social support or social isolation\(^1\,\,12\)
- Adverse life events such as bereavement, unemployment, poverty, migration\(^1\)
- Relationship dissatisfaction\(^12\)
- Complications with the conception, pregnancy, and/or birth (conception method/timing/type of delivery)\(^13\)
- Difficulties with parenting such as infant feeding, sleeping, and temperament\(^1\)
- Family and domestic violence or history of abuse\(^1\)
- Substance abuse\(^1\)
- Dysfunctional coping styles and low self esteem or parenting self efficacy\(^14\)
- Past or pre-existing mental health issues or family history of mental illness\(^1\)
- The assumption that parenthood is always joyous.\(^15\)

Mental health issues impact the individual, their outlook on life, and their relationships with other family members, in particular the infant and other children. When one or both parents are experiencing mental health issues, there can be significant negative consequences including:

- Delays in the infant’s biological, cognitive, social, and emotional development due to the development of an insecure attachment\(^16\)
- Increased risk of the child developing a mental health issue later in life\(^17\)
- Inadequate parental self care and nutrition\(^18\)
- Parental suicidal thoughts or harm to self and/or baby\(^18\)
- Drug and alcohol abuse\(^18\)
- Relationship disruption or breakdown.

When a parent/carer is affected by mental illness, the family is more likely to be vulnerable to social hardship and require additional support. There are many social issues that may affect the family including relationship difficulties, family disruption, financial concerns, and housing problems. Often these factors lead to
Parents/carers might not seek help for mental health issues due to factors such as access to services, lack of trust of medical professionals, decreased ability to recognise their symptoms as problematic, and fear of being labelled as a ‘bad parent’. People with a mental illness might be faced with a stigma that labels them as less capable, emotionally and psychologically unstable, and unable to cope with and participate in ‘normal’ life. They might also feel shame, humiliation or embarrassment, or might view themselves as being weak for developing a mental illness. Additionally, parents/carers may fear that their children will be removed from their care if they have a mental health issue. As a result, parents/carers suffering from a mental health issue may experience social exclusion.

Due to the many barriers to seeking help, CCHNs should utilise tools such as the Edinburgh Postnatal Depression Scale (EPDS) and a psychosocial assessment within an open and non-judgemental environment as ways to open communication about emotional issues and mental health and normalise the parents’/carers’ experiences.

**Mothers**

As previously stated, current depression rates in mothers range from 7-12 percent during the antenatal period and around 13 percent in the postnatal period. In addition to the risk factors listed previously, mothers also experience hormonal changes as a result of pregnancy and birth that can increase their susceptibility to mental illness. Given that many women also stop work after the birth of their child, they may experience a unique type of social isolation that the woman, her partner, and other family members are not aware of and may not be able to anticipate.

Additionally, mothers may feel the need to be the ‘perfect’ mother, due to an assumption that mothering is joyous and innate. This has the potential for women to suffer from stress, anxiety, or depression if they feel they are not coping, need assistance, or if they do not find the task of parenting joyous all the time.

**Fathers and Other Partners**

One in ten men will experience a mental health issue in the perinatal period, irrespective of their partner’s mental health status. The incidence of paternal depression is 24 to 50% for men whose partners have PND. The greater the severity of the mother’s PND, the greater the risk of the partner developing PND.
Father’s may also experience vicarious trauma from witnessing a difficult birthing situation that may lead to PTSD. This may lead to marital issues, reduced desire for sexual intimacy, and issues bonding with the infant. Additionally, as many as 4.8% of men who did not show depressive symptoms antenatally may have suicidal thoughts postnatally. This demonstrates that fathers and other partners represent a significant at-risk group during the perinatal period and should be assessed and offered appropriate support as well as mothers.

Risk factors that may lead to fathers/other partners suffering from a mental health issue, particularly increased stress and anxiety, may include:

- A partner with a mental health illness
- Excessive stress surrounding the pregnancy or birth and fear for their partner
- Perceived lack of information, support, and inclusion in the pregnancy and birth process
- Feeling a lack of acknowledgement of their role, needs, and mental health
- Changes in their financial situation and intimate relationship with their partner
- The assumption that parenthood is always joyous.

These may lead to feelings of isolation and helplessness, which can in turn increase stress, potentially leading to mental health issues such as depression and anxiety.

Fathers/other partners can experience a number of barriers to seeking help because the focus is often on the woman’s health and ability to safely birth and nurture the baby. They may not feel able to talk about their feelings for fear of being seen by friends and family as weak, being ignored by medical staff, feeling too overwhelmed to seek help, or not knowing where they can get help. As a result, fathers’/other partners’ relationship with the mother and attachment to their baby could be significantly compromised.

It is important that CCHNs provide a welcoming environment to fathers/other partners and screen for mental illness whenever possible. Utilising screening to open up communication will assist fathers/other partners to access information, reduce barriers, and be pro-active in identifying and addressing their needs.

Infant Mental Health

Infant mental health refers to the impact parent/carer mental health and the social context of the family have on the biological, cognitive, social, and emotional development of the child, both short and long term. It has been estimated that at least 70,000 children in Western Australia have a parent/carer with a mental illness.

Foetal exposure to chronic anxiety can lead to prematurity, hyperactivity, as well as cognitive, social, and behavioural delays in the infant. Postnatal
parental mental health issues can impact infant mental health by impeding the development of a secure attachment, reducing the parent’s/carer’s perception of their parenting skills and increasing the vulnerability of the family to social adversity.

Attachment is the cornerstone of successful, lifelong development for the infant. It is the ability of the child to trust that their parent/carer will respond appropriately when the infant gives them a signal that they need something, e.g. food or to be cuddled or soothed. Consistently responding to the baby’s signals (e.g. smiles, eye contact, crying) builds two-way communication between the infant and parent/carer which helps the infant feel safe and secure, allowing them to explore and learn from their surroundings. Developing a secure attachment with an individual is essential for good biological, cognitive, social, and emotional development for the infant and future adult.

Parents/carers with a perinatal mental health issue may be less emotionally available to their infants and young children, may feel they lack the skills to parent, or view their child’s temperament more negatively. This may limit the parent’s/carer’s ability to respond appropriately to the infant’s signals, which can lead to an insecure attachment. Without a sense of safety and trust with the parent/carer, the infant is less likely to explore their surroundings, limiting their opportunities to learn from their environment. In the long term this may negatively impact language acquisition, school performance, cognitive and social development, and emotional regulation. If an infant is unable to attach with the primary caregiver, encouraging a secure attachment with another caregiver, such as the father or a grandparent, may protect the infant and help them to optimise their growth and development within these circumstances.

To assist attachment, parents/carers who suffer from a severe and persistent mental illness may need help and support with their parenting skills. They may also need to be taught how to effectively reflect on their parenting ability and the reasons for their child’s behaviour to assist their problem solving skills. While not all parents who have mental illness experience parenting difficulty, the parents/carers competence seems to be related to severity of the illness.

General Principles

There are a number of strategies that can help all parents/carers and infants maximise their potential. It is clear however, that some families are more likely to experience poor outcomes than others. It is important that the risk factors for social vulnerability, insecure attachment, and parenting difficulty are identified and reduced and the protective factors within the family are enhanced. With appropriate support and management of the mental illness, the majority of parents/carers can reduce the negative impacts of their mental illness and become self-sufficient in providing a nurturing and positive environment for their child’s development.

Parents/carers may seek support for specific issues surrounding their ability to care for their infant/child or they may just need additional support for a defined
period during a crisis e.g. hospitalisation. CCHNs need to have the capacity to identify, assess, and offer additional support services and/or refer to other specialist services, where they are available, to those families who have a parent/carer with a perinatal depressive and/or anxiety disorder.

Families experiencing a perinatal mental health issue can be supported in the community child health environment by services that:

- Have a skilled and safe workforce that provide non-judgemental, open forums for parents/carers to feel comfortable expressing their emotions

- Implement a process to identify parents/carers with mental health issues which, at minimum, includes:
  - Screening through the Edinburgh Postnatal Depression Scale (EPDS)
  - Psychosocial Assessment
  - Assessment of the attachment between the parents and the infant e.g. looking for eye contact, response to baby’s cries etc. (refer to Department of Health Attachment pamphlet in “Resources for Professionals”).

- Develop partnerships with other service providers to enable families with extra needs to be linked into appropriate services e.g. perinatal depression support services, general mental health support, men’s health services, and social services such as respite care and financial or legal aid

- Have Aboriginal and Culturally and Linguistically Diverse (CaLD) workers who have appropriate training and support to work with families from Aboriginal and CaLD backgrounds who have perinatal depressive or anxiety disorders

- Provide service delivery that:
  - is responsive to the needs of families, as well as individual needs of the mother, father, carer and the infant, including outreach services and parenting groups
  - recognises the importance of viewing and treating the family as a unit
  - understands the importance to overall health and wellbeing of the relationships between family members (including the relationship between the parents, as well as their individual relationships with the infant)
  - understands the significant long term behavioural, cognitive, emotional, and social impacts of parental/carer mental health issues on the infant
  - normalises their experiences, explaining that all parents/carers need assistance at some point.

- CCHNs should debrief with colleagues to ensure the maintenance of their own mental health and to ensure the continued provision of quality care of difficult cases.
Role of the Community Child Health Nurse

CCHNs are ideally placed to support parents/carers who have perinatal mental health issues and provide basic therapeutic lifestyle advice (such as nutrition and exercise), relevant mental health information, parenting support, intervention, and referral where indicated. CCHNs are acceptable to parents/carers, non-stigmatising, and use a family partnership approach which allows them to develop genuine relationships with families.

Follow-up and Monitoring

The CCHN, together with the parents, will develop a plan outlining frequency of visits and referral needs. Additional contacts or a more intensive home visiting service should be offered where appropriate and where resources allow.

Follow up and monitoring should include the following aspects:

- Monitoring the emotional health and wellbeing of the parent and their family and referral to specialist mental health agencies as indicated

- Completion of the EPDS at recommended intervals and at other times if indicated (see 3.3 - Universal Contact Schedule and 3.8.4 - EPDS-Guidelines for Use)

- Monitoring the health, development, and attachment of children and identifying key early interventions or referral for those families who face difficulty

- Utilise referral pathways for families with additional needs within health and other agencies

- Assisting parents with young children to overcome barriers to accessing health services.

The CCHN will also follow the Guidelines outlined in the Universal Contact Schedule (guideline 3.3) in regard to contacts and documentation.

Useful Resources

Information Sites

- WA Perinatal Mental Health Unit
  A government agency that provides resources, training, and research on perinatal mental health issues

- Department of Health
  A list of services, information, and resources under the ‘pregnancy’ listing in the A-Z of health topics
- **Department of Health**
  Attachment (pamphlet)

- **Beyond BabyBlues**
  Information on mental illnesses such as depression, anxiety, schizophrenia, and bipolar disorder that can develop or reoccur during pregnancy and parenthood

- **COPMI**
  A Resource Centre for Children of Parents with Mental Illness

- **Mental Health Commission WA**
  General facts, causes, and personal stories on mental health issues

- **From the Heart WA**
  A volunteer run consumer organisation providing support and information to families who are affected by stress and depression related to pregnancy, childbirth, and parenting

- **Men’s Advisory Network**
  MAN links men and boys into organisations, services, and information targeted at improving their health, wellbeing, and connection with health services

- **Meerilinga Dads in the Early Years**
  A father focussed set of resources and services to assist men with parenting issues in the early years

- **Mental Health in Multicultural Australia**
  Assists providers and government agencies in providing services to Culturally and Linguistically Diverse (CaLD) groups with mental health issues

**Services**

- **Mental Health Commission WA: Mental Health Services Directory**
  A directory of WA mental health services: Metropolitan, regional and rural

- **Mental Health Emergency Response Line (MHERL)**
  24-hour hotline, providing emergency help for people who have mental illness and are in a crisis. Phone: 1300-555-788

- **Lifeline**
  Lifeline provides access to crisis support, suicide prevention, and mental health support services. Ph: 13 11 14
• **Suicide Call Back Service**
The Suicide Call Back Service provides crisis counselling to people at risk of suicide, carers for someone who is suicidal, and those bereaved by suicide, 24 hours per day 7 days a week across Australia. Ph: 1300 659 467

• Parenting WA Helpline
Provides telephone information and support to parents. Ph: 1800-654 432

• **Mensline Australia**
A professional telephone and online support service helping men to deal with family and relationship issues

• Mother and Baby Unit
State-wide inpatient treatment centre at King Edward Memorial Hospital for acute perinatal psychiatric conditions. Free call: 1800 422 588

**Supporting and/or Related Policies**

• 3.3 Guidelines for Birth to School Entry Universal Contact Schedule
• 3.8.4 Edinburgh Perinatal Depression Scale - Guidelines for use
• Guidelines for Responding to Family and Domestic Violence (2007)
• Guidelines for Protecting Children (2009)

**References**


