Mental health morbidity associated with the perinatal period— from conception to the end of the first postnatal year—is now recognised as a major public health issue, with depression affecting up to 15% of women during this period. It has been reported that 45% of postnatal depression begins in pregnancy, and about 38% of women with postnatal depression have a comorbid anxiety disorder. About 3% of women experience moderate to severe depression during the perinatal period and 0.2% experience a puerperal psychosis, and maternal suicide continues to be identified as one of the leading causes of indirect maternal mortality. There is growing evidence of the negative impact of poor mental health outcomes not only for the mother, but also for her child and family.

The existence of well established maternal and infant health care systems across Australia has provided a unique opportunity for integrating mental health care into mainstream services. Increasingly, the maternal and infant health care sectors are introducing routine, universal psychosocial assessment aimed at detecting women who are at risk of, or suffering from, mental health morbidity. This approach, underpinned by a philosophy of prevention and early intervention, has been developed in the Australian perinatal setting over the past decade through the work and advocacy of leading clinicians and researchers, policymakers and beyondblue: the national depression initiative. Feasibility of widespread screening for depression in the perinatal period was evaluated in the National Postnatal Depression Research Program (2001–2005). It was concluded that screening for depression was feasible in routine clinical settings and acceptable to women and their health care providers (including general practitioners).
addition, maternal mental health morbidity often went undetected and untreated if routine screening was not used. The National Action Plan for Perinatal Mental Health (2008) went on to recommend implementing universal psychosocial assessment, training primary health care staff who administer the assessments, and establishing structures that optimise coordination of, and access to, appropriate services. This was followed by the establishment, by the Department of Health and Ageing, of the National Perinatal Depression Initiative (2008–2013), which enabled the introduction of a specific perinatal mental health Medicare stream (under the Access to Allied Psychological Services initiative) and the development of national clinical practice guidelines for depression and related disorders in the perinatal period.

The clinical practice guidelines are aimed at all clinicians who have a “primary health care” role in detecting possible mental health morbidity in the perinatal period — including midwives, GPs, child and family health nurses, obstetricians and paediatricians. They are underpinned by a systematic literature review that points to a paucity of quality evidence, especially on routine psychosocial assessment and the safety of psychotropic medication in pregnancy. The guidelines recommend routine, universal screening for depression (antenatal and postnatal) using the Edinburgh Postnatal Depression Scale (EPDS) and treatment of mild to moderate postnatal depression with evidence-based psychological interventions (eg, cognitive behaviour therapy). Where there is insufficient evidence for recommendations, good practice points (based on lower-quality evidence and/or expert consensus) have been formulated. These include using comprehensive, universal psychosocial assessment (eg, the Antenatal Risk Questionnaire) in addition to the EPDS, considering mother–infant interaction and risk to infant as integral parts of the assessment, monitoring women with an existing mood disorder closely to reduce risk of relapse, and providing specific advice about the safety of psychotropic medication during pregnancy and breastfeeding.

While the guidelines recommend routine use of the EPDS in the perinatal period, they emphasise that it should only be used as an adjunct to clinical assessment in the primary care setting. They also highlight that universal psychosocial assessment is an area of debate, has significant resource implications (including training, service organisation and workload requirements), and needs to be closely integrated with access to mental health services.

The clinical effectiveness of routine psychosocial assessment remains to be evaluated. A recent randomised controlled trial of early postnatal screening using the EPDS (including supportive counselling where indicated) demonstrated improved maternal mental health outcomes at 6 months postpartum for women receiving the intervention compared with those receiving usual care. In a meta-analysis of screening interventions for general depression, screening was found to be beneficial as long as it was integrated with clear pathways to care. This is in line with the National Action Plan for Perinatal Mental Health and the clinical practice guidelines — the first steps in translating evidence into practice and developing a broader evidence base. There is now a need to evaluate the effectiveness of combining psychosocial assessment with integrated pathways to care. In addition, an evaluation of the impact of the National Perinatal Depression Initiative on mental health outcomes for mothers is critical if we are to optimise the quality and uptake of services for this vulnerable, yet highly accessible, population.

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