Perinatal Depression Protocol (PND)

At each antenatal visit, screen for depression by asking the following questions:

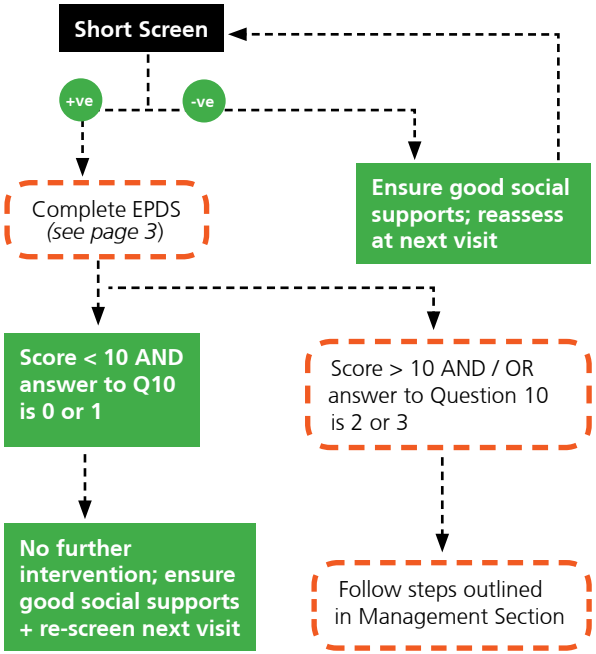
During the past month have you often been bothered by feeling down, depressed or hopeless?

During the past month have you often been bothered by having little interest or pleasure in doing things?

If the patient answers "yes" to either question, use the EPDS (see p.3) for formal screening for antenatal depression (AND) and postnatal depression (PND).

In addition, all women should be offered more detailed screening for depression and anxiety using the Edinburgh Postnatal Depression Scale (EPDS) at

- first visit
- 28 week visit
- 6 week post-natal check



Case Definition

Depression a clinical diagnosis defined as 5 or more of the following symptoms for at least 2 weeks (must have one of the first two):

- Persistent depressed mood
- Loss of interest or pleasure in activities
- Significant change in weight or appetite
- Markedly increased or decreased sleep
- Psychomotor agitation or retardation
- Fatigue or loss of energy
- Feeling worthless or guilty
- Loss of concentration
- Recurrent thoughts of death, self-harm or suicide

Antenatal depression is depression experienced during pregnancy

Postnatal Depression is depression which develops any time within the first year after delivery

Additional symptoms of PND may include: poor attachment, lack of interest and / or ability to care for infant. This is a symptom of the illness and does not mean the woman is a "bad" mother.

Risk Factors for PND

- Previous history of anxiety or depression, particularly previous PND.
- History of abuse
- Unhappy about pregnancy
- Relationship / financial / housing problems, etc
- Difficult / prolonged / traumatic birth, preterm/ ill child, difficulties breast feeding
- Substance abuse
- Lack of social / emotional / family supports

Antenatal and postnatal depression are not the same as:

Postnatal Psychosis manifests as hallucinations, thought disturbances, paranoia and delusions, and affects 1 in 500 postnatal women within the first week of childbirth. It is a medical emergency.

Baby Blues: develops within 3-10 days after birth. It affects 80% of postnatal women. Women feel emotional and teary, anxious, tense and exhausted. They may have difficulty sleeping. It is a self-limiting condition that resolves within 1-2 weeks.(see box 1 below)

Box 1: Managing Baby Blues

- Accept help from others
- Talk with sympathetic friends/family
- Find time/ways to rest

Principles of Management

Antenatal and postnatal depression are serious conditions which can pose a threat to the safety and well-being of both the mother and her family

It is critical to distinguish baby blues / "normal" response to pregnancy, childbirth and new parenthood from the more serious forms of antenatal and postnatal depression, as this will guide initial action and ongoing care – see flow chart under "screening".

Consistent care is essential - coordinated by a nominated care coordinator preferably from the local primary health care team, in conjunction with specialist, allied health, and community support agencies as required

BASELINE ASSESSMENT

Assess client's mental state, including assessment of red flags:

Thoughts of self-harm or suicide

Thoughts of harm to baby/family

If there are any "red flags" discuss immediately with the GP.

If there are no red flags identified, complete usual antenatal or post-natal check, including assessment of well-being of foetus or infant

Discuss with GP before proceeding to management

Baseline bloods:

FBC, UEC, LFTs, TFTs, iron studies, B12, folate - if not done within last month

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PERINATAL DEPRESSION

Perinatal Depression Protocol (PND)

PERINATAL DEPRESSION

Management

For GPs:

If depression is severe/ there are any red flags present (see "Baseline Assessment") may need admission to hospital. Discuss with psychiatrist – admission to local hospital may be appropriate, or admission to KEMH mother/baby unit may be needed.

Role of medication in antenatal / perinatal depression

The risks of untreated depression during pregnancy and in the postnatal period include:

1. For the mother: greater risk of complications in labour / delivery; risk of self-harm, inability to perform daily functions including provision of adequate care for the child
2. For the child: low birth weight, feeding problems, developmental and behavioural issues

For women with moderate to severe depression, discuss medication, using the following as a guide. If unsure, discuss with regional psychiatrist.

SSRIs are an appropriate choice of medication for antenatal and / or postnatal depression

- AVOID Paroxetine – not on KSDL and has been associated with heart defects when given in the first trimester
- Citalopram (on KSDL) is an appropriate first choice – start with 20mg daily, aiming to control symptoms with the lowest effective dose, increasing dose 4 weekly to a maximum of 60mg daily

For women with pre-existing depression who are already controlled on antidepressant medication:

- Continue if already on Citalopram.
- If already on another antidepressant: in many instances, benefits of continuing will outweigh risks. A decision which involves patient, GP, obstetrician and / or psychiatrist is recommended.

Psychological Management

1. Assess partner/family support/coping and enlist support services if required. This may include relative (mother, aunty, other), Aboriginal Health Worker, other trusted service provider, community agencies (see "referrals" section)
2. Assess mother-baby interaction. If available, access parenting support, with client consent, through Maternal/ Child Health Nurse (MCHN). Ensure MCHN is notified that woman has PND
3. Ensure client and where appropriate, partner / family, have a sound understanding about AND / PND, with education provided in a meaningful way over a period of time
4. Encourage Client care of self through:

   Physical activity

   Good nutrition

   Participating in social activities

   Spending time doing what you enjoy e.g. fishing, reading

   Ensuring quality time with partner / family

   Relaxation time

Consider referral to appropriate community resources – see referrals section below

Referrals

For patients with severe depression +/- red flags that need hospital admission, (after contacting the on call GP), contact the regional psychiatrist via Kimberley Mental Heatlh and Drug Service (see numbers below) +_ contact DMO at receiving hospital.

Emergency referrals

Kimberley Mental Health and Drug Service:

Broome 9194 2640
Derby 9193 1633
Kununurra 9166 4350

Hospitals

Broome 9194 2222
Derby 9193 3333
Fitzroy Crossing 9166 1777
Halls Creek 9168 6003
Kununurra 9168 4222
Wyndham 9161 0222
Graylands Psychiatric Hospital Perth 9347 6600

Non-Emergency Referrals

Counseling/support for moderate to severe Depression:

Kimberley Mental Health and Drug Service (see above numbers).

Counseling/support for mild to moderate Depression:

Kimberley Division of General Practice Mental Health Unit
Broome 9192 7888
Derby/Fitzroy 9193 6222

Kinway

Broome 9194 2400
Derby 9191 2274
Halls Creek 9166 5080
Kununurra 9166 5000

Social and Emotional Well Being Unit,
OVAHS, Kununurra 9168 1288

Counseling/support for Drug and Alcohol Addiction:

Kimberley Mental Health and Drug Service (see above numbers)

Assistance with Mothercrafting:

Community Health

Broome 9194 2340
Derby 9191 1308
Fitzroy Crossing 9166 1727
Halls Creek 9168 9201
Kununurra 9168 2280
Wyndham 9161 0262

Other Support Services

Postnatal Depression Support Association PNDSA
..... 08 9340 1622

Post and Antenatal Depression Association Inc PaNDa
www.panda.org.au

Beyondblue info line 1300 22 4636
Parent Helpline 1800 654 432
Lifeline 13 11 14

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Perinatal Depression Protocol (PND)

Below is an adaptation of the EPDS that has been translated for use in Aboriginal populations and demonstrated a high level of reliability[1]; the original EPDS is in italics[2].

Please check the answer that comes closest to what has been going on IN THE PAST 7 DAYS, not just how things are today. Circle the number next to the answer given, then add up the numbers to get the overall EPDS score. See the green box below: "How to use the EPDS Score"

1. I can sit down and have a good laugh
I have been able to laugh and see the funny side of things

As much as I always could	0
Not quite so much	1
Definitely not so much now	2
Not at all	3

2. I look forward for good things to happen
I have looked forward with enjoyment to things

AS much as I ever did	0
Rather less than I used to	1
Definitely less than I used to	2
Hardly at all	3

3. I blame myself all the time when things go wrong

I have blamed myself unnecessarily when things went wrong

Yes, most of the time	3
Yes, some of the time	2
Not very often	1
No, never	0

4. I worry too much and don't know why

I have been anxious or worried for no good reason

No, not at all	0
Hardly ever	1
Yes, sometimes	2
Yes, very often	3

5. I feel frightened and shaky all the time

I have felt scared or panicky for no good reason

Yes, quite a lot	3
Yes, sometimes	2
No, not much	1
No, never	0

6. I feel things are getting me down, I need a rest

Things have been getting on top of me

Yes, most of the time I haven't been able to cope at all	3
Yes, sometimes I haven't been coping as well as usual	2
No, most of the time I have coped quite well	1
No, I have been coping as well as ever	0

7. I can't sleep because I am sad

I have been so unhappy that I have had difficulty sleeping

Yes, most of the time	3
Yes, some of the time	2
Not very often	1
No, not at all	0

8. I feel really no good
I have felt sad or miserable

Yes, most of the time	3
Yes, some of the time	2
Not very often	1
No, not at all	0

9. I am so sad I've been crying
I have been so unhappy that I have been crying

Yes, most of the time	3
Yes, quite often	2
Only sometimes	1
No, never	0

10. Sometimes I want to harm myself
The thought of harming myself has occurred to me

Yes, quite often	3
Yes, sometimes	2
Hardly ever	1
No, never	0

How to use the EPDS score:

Question 10: anyone who answers "yes, quite often" or "yes, sometimes" needs immediate referral / discussion with GP

If the answer to Q 10 was "hardly ever" or "never", the following provides a guide to the significance of the overall EPDS score:

- 0-9 :likelihood of depression low
- 10-12: likelihood of depression is considered moderate
- 13 or more: likelihood of depression is high

Refer / discuss with GP before person leaves clinic if:

- Score is 10 or more, and / or:
- Answer to Q10 is "yes, quite often" or "yes, sometimes"
- You have any other concerns that the woman is at risk of harming herself or her baby

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1 Campbell A, Hayes B, Buckby B. Aboriginal and Torres Strait Islander women's experience when interacting with the Edinburgh Postnatal Depression Scale: A Brief Note. Aust J Rural Health 2008: 16: 124-1312 Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry 1987: 150:782-786

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