WORLD PSYCHIATRIC ASSOCIATION
Advance Psychiatry and Mental Health Across the World

Document Title:	Perinatal Mental Health
Document Type:	Position Statement
Date Last Reviewed:	February 2023
Author/s:	

Approved at the General Assembly in Vienna on 30 September 2023

WPA Position Statement on Perinatal Mental Health GA23.10.7

Foreword

Mental health conditions are among the most common health problems of the perinatal period (pregnancy and the year after birth). Prevalence rates of perinatal depression are >10% of women in high income settings with higher prevalence in many low and middle income countries (LMICs). While most of the attention in services, public and provider education and research has been towards postpartum depression, there is growing evidence on the impact of other disorders including anxiety disorders (post-traumatic stress, obsessive-compulsive, panic and generalized anxiety disorders) which are common, and less common disorders including bipolar disorder, psychosis, eating disorders and personality disorder all of which can occur in both the antenatal and postnatal period (Howard et al 2014; Jones et al, 2014; Wisner et al, 2013).

The perinatal period is a time when there is an increased risk of most psychiatric disorders. The impact of psychological morbidity includes adverse impacts on pregnancy outcomes (e.g. low birthweight, prematurity) (Stein et al 2014;); deficits in mother-infant interactions which are associated with an increased risk of child behaviour, cognitive and emotional problems; impaired growth in children from LMICs (Stein et al 2014; Weobong et al 2015); infant mortality (Stein et al Lancet 2014); and maternal mortality resulting from suicide, substance misuse, domestic violence homicides and comorbid physical

health problems (including HIV) (Langer et al 2015).

The development of perinatal mental health services and training of psychiatrists in perinatal mental health has not been uniform across the world. While several countries like the UK, Australia and New Zealand have seen policy driven changes in accessible services, there are many HIC countries where services are not uniformly available. The situation in LMICs is even more concerning with most countries not having any screening or case identification protocols for perinatal mental health problems and inadequate specialized services or training. Psychiatrists and other mental health professionals need to be actively involved in training of primary care and maternity practitioners and developing protocols for identifying perinatal mental health problems and providing appropriate interventions.

Psychiatrists should also ensure that services are developed for women with perinatal mental illness - in the clinic, within hospitals and in the community. The Marcé International Society for Perinatal Mental Health has several important resources including a Position Statement on screening and assessment (Austin et al, 2014; https://marcesociety.com/). The COVID 19 pandemic exposed many deficiencies in the mental health care and support for women in the perinatal with mental health problems and the WHO guide for integration of perinatal mental health in maternal and child health services (https://www.who.int/publications/i/item/9789240057142), is a welcome step for many countries to integrate maternal mental health into routine antenatal and postnatal care (WHO, 2022).

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Introduction

Psychiatrists frequently come across perinatal mental health problems in their day to day practice. Perinatal anxiety and depression are the most common conditions; however there are several other psychiatric conditions that are relatively common in secondary care but have received less attention. These include PTSD, OCD and personality disorders. Women may present with postpartum bipolar disorders and postpartum psychosis. Many women with severe mental illness such as schizophrenia will also need attention during pregnancy and after birth. . In addition, preconception support and medication as well as

health related counselling does not occur routinely or uniformly in most countries.

Perinatal depression and anxiety have been linked to risk factors including a personal and/or family history of psychopathology, poverty, young age, gender based violence and abuse, unwanted pregnancy, traumatic life events, poor social support, medical conditions (notably HIV in Sub-Saharan Africa) and other stressors including living in a conflict zone, giving birth to a daughter in cultures with a strong male preference, and being a refugee or asylum seeker (Howard et al, Lancet 2014). Specific situations that may have mental health impact include the experience of infertility and treatments with assisted reproductive technologies (Cesta et al 2016; Seibaek et al 2015). Obstetric violence (disrespect and abuse during childbirth; Bohren et al 2015) and severe obstetric complications increase the risk of mental health problems (Fillipi et al 2007; Mannava et al 2015), while having a severe mental illness increases the risk of life threatening obstetric complications (Easter et al 2022). The COVID 19 pandemic led to increase in rates of anxiety and depression among pregnant and postpartum women due to lack of services, poor access and concerns about infection. Suicide is a leading cause of mortality in the perinatal period with data from Confidential Enquiries the world over highlighting this.Nill However, Low levels of reporting and poor audit systems in LMIC mean that the extent of suicides in the perinatal period is grossly underestimated in these settings (Fuhr et al, 2014)

High rates of morbidity and mortality are also related to substance abuse in the perinatal period that needs addressing. A growing global literature supports the efficacy of psychosocial and psychological interventions for mild to moderate disorders (e.g. Nillni et al, 2018; Howard and Khalifeh, 2020;Rahman et al 2013) and for pharmacological interventions for moderate to severe disorders (Jones et al 2014).
Regarding the use of psychotropic medication during the perinatal period The data on the long term impact of antidepressants and atypical antipsuchotics on children exposed in utero and during lactation are generally reassuring (Jones et al, 2014; Kimmel at al, 2018; Staub et al, 2022). The risks of perinatal mental disorders, which are associated with adverse maternal and child outcomes, need to be considered when considering the type of treatment needed. In addition, partners or other significant people in the woman's social network may also need their own mental health support.

Services vary internationally (Baron et al, 2016; Howard and Khalifeh, 2020) and while specialized services are not uniformly available, at the primary care level at least. interventions in LMICs may be cost- effective when integrated with maternity and postnatal healthcare/primary care based on data from the USAID MOMENTUM Landscape Analysis (McNab et al 2021). Interventions should also address risk factors (e.g. poor nutrition, smoking, partner violence) and associated problems in addition to the mental disorder, and need to be culturally appropriate and acceptable.

Care planning is essential for women with severe mental illness such as schizophrenia and bipolar disorder, which ideally should take place pre-conception so that risk- benefit decision making for medication and other risk factors (poor nutrition, smoking, substance misuse, intimate partner violence, social support) can

be considered before the crucial first weeks of embryo development. In some countries women with severe postnatal disorders are admitted to psychiatric mother and baby units to avoid separation from the baby at a critical time for mother-infant bonding, but availability is inequitable (Glangeaud-Freudenthal et al 2014). There are low cost models available such as the Mother Baby inpatient in India where family caregivers stay with the woman in the inpatient unit and a family approach to intervention is provided (Chandra et al, 2015). Finally, there is global emphasis on using gender transformative approaches to perinatal mental health care addressing the role of the father during pregnancy and infant care, the importance of gender equity and addressing gender based violence (Raghavan et al, 2022).

What the Position Statement aims to achieve

The position statement aims to

1. Describe the relevance and importance of perinatal mental health conditions
2. Discuss what psychiatrists need to know about assessment of different mental health conditions and the risk factors in pregnancy and the postpartum
3. Emphasise the need for active liaison with maternal health services and pediatricians and community-based services
4. Discuss system level changes to ensure integration of mental health into maternal health services
5. Advocate for the need to develop services for women with severe mental health problems including collaborative care planning
6. Focus on the role of the family, including the partner in prevention and treatment

Main Text

Competency in perinatal mental health is crucial for practitioners and patients, due to several reasons:

1. Good quality research has repeatedly demonstrated that anxiety and depression are highly prevalent during pregnancy and the puerperium, especially in LMIC's
2. The impact of untreated mental health problems in pregnancy on birth weight, gestational age and future mental and physical health of the fetus:
    a. The evidence that exposure to antenatal depression is associated with childhood cognitive and behaviour problems, attention-deficit/hyperactivity disorder (ADHD) and autism.
    b. Postnatal depression is associated with increased mortality and hospitalization among children in the first year of life. In LMIC settings, an association was found between postnatal depression and poor infant health as well as lower rates of breastfeeding.
    c. The high rates of maternal mortality because of suicide in the first year after childbirth related to untreated mental health problems
    d. The association between maternal mental health problems and obstetric complications, including pre-eclampsia
3. The existence of well-defined risk and protection factors
    a. The fact that having a personal and familial history of depression is a powerful risk factor allows for identification of a vulnerable group
    b. Other risk factors such as exposure to intimate partner violence, sexual violence in childhood and lack of social support that are amenable to reduction or eradication
    c. Pregnancy during adolescence, whether related to violence or to cultural pressures has serious negative consequences for the young women, their offspring and the community. It perpetuates poverty and hinders the integral development of girls. There is a need for dedicated services that provide a friendly, empowering environment
4. The availability of effective psychosocial and pharmacological interventions

a. The existence of clinical guidelines for the management of mood and other psychiatric disorders in the perinatal period, that are periodically updated and allow for safe use of pharmacotherapy and other interventions.
b. There is evidence that psychological interventions are effective for postpartum depression. Some of these may be peer led or delivered by community mental health workers.
c. The importance of community mental teams to ensure the continuity of care
d. The availability of effective pharmacotherapy, although there is the need to have better quality data to inform the user and the prescriber; there is also clarity about the adverse outcomes of the exposure to specific medications, such as valproate, which is not to be used in pregnant women and that has prompted specific guidelines about its use in women of reproductive age
e. The rich clinical experience from various countries that support joint admission of mother infant dyads when a mother has postpartum mental health problems and needs inpatient care
f. The need to involve partners, family and older children in the planning and delivery of care
g. The special need to involve service users as experts by experience in the planning of service

5. The abundant qualitative literature that informs about the expectations of women: non judgmental care, access to information about adverse effects on mental and physical development as well as information on the effects of stopping treatment and clear information on the genetic risk for their children

Recommendations for Action

WPA urges all health care professionals and policy makers to improve pregnancy outcomes, reduce maternal and infant mental and physical morbidity, and mortality, improve care of the infant and enhance the mother infant relationship:

a. Recommendations for Health Systems

1. WPA recommends that mental health data include information on whether women are pregnant, have recently experienced any obstetric problems (e.g. pregnancy loss, fertility treatment, surgery) or have recently given birth. Psychiatrists should also be advocates for mental health indicators to be included in routine maternity data and enable maternal and child health systems to carry out appropriate screening and case identification.

2. WPA calls for all care providers in contact with women in the perinatal period to be trained to be equipped with knowledge and skills to identify and treat, or refer for treatment, women with perinatal mental disorders. These providers should also receive appropriate remuneration, personal mental health support and receive regular supportive supervision in order to be sustained in the work they do and to ensure quality of care. These include mental health professionals, nurses, midwives, obstetric care providers and pediatricians.

3. WPA calls for integration of mental health assessments as well as assessment of demographic, educational and social resources and vulnerabilities and core packages of mental health services into routine antenatal and postnatal care (including infant care such as baby clinics) including establishing of effective referral mechanisms. Tools that have been validated for a target population and interventions that are culturally appropriate and culturally sensitive for the local context should be used.

b. Recommendations for Clinical Care

4. WPA calls for all health professionals and other care providers to focus on symptoms of anxiety, PTSD, somatic symptoms (as potential indicators for depression) and psychotic disorders in addition to perinatal depression.

5. Women with severe mental illnesses need to be recognised as a high risk group requiring coordinated obstetric, paediatric, primary care and mental health care including community based

services, in order to reduce mental illness and suicide as an important cause of maternal mortality and morbidity.

6. WPA calls for all care providers to provide, or refer appropriately for, pre-pregnancy consultation including contraceptive services for childbearing aged women with a past, current or new mental illness.

7. Many women with severe mental illness (and in the general population) have unplanned pregnancies, so it is unrealistic to expect more than a small proportion of women to access preconception care even where it is available. WPA recommends that generic adult psychiatric services include routine preconception discussions within usual care for women. These give an opportunity to discuss medication use but also provide a window to discuss physical and mental preconception health, including pregnancy planning, relationships, nutrition, physical exercise, weight management, smoking, substance misuse, and folic acid supplementation.

8. WPA recommends offering mental health support to the partner and family in perinatal mental health services. There is evidence that depression among fathers on the perinatal period is common and needs addressing.

9. WPA emphasizes the need to assess the quality of mother infant interactions and the care of the infant while providing interventions as needed. Simple methods such as video based interaction feedback and education to enhance maternal sensitivity maybe provided to all dyads when the mother has a mental health problem.

10. WPA calls for all health professionals caring for women with, or at risk of, perinatal mental Illnesses to develop an integrated care plan in collaboration with women, their partners and their families

c. Recommendations for Information and Guidance

11. WPA urges mental health, maternity and primary care services to provide universal accurate and accessible information about emotional and physical health, to de-stigmatise mental illnesses, in addition to providing a range of specific information related to the perinatal period.

12. WPA recommends specific guidance for providing care to pregnant and postpartum women for situations such as pandemics, natural and other humanitarian crises'

13. WPA urges all relevant stakeholders to address stigma related to mental illness and to recognise the 'embedding opportunities' in the maternal mental health field – including maternity, public health, child health, early childhood development and HIV – to facilitate integration of mental health into maternity and child programmes.

d. Recommendations for Policy and Governance

14. WPA recommends each national society to develop a user-friendly directory of resources, which should be updated regularly and provide as much detail as possible. The resources need not only be medical personnel or institutions. Community groups and associations, effective peer educators and other informal sources of support are all important resources.

15. WPA urges mental health policy makers to develop evidence-based policy for prevention, early intervention and treatment for women in the perinatal period, and develop leadership and clinical governance structures to ensure that services are implemented and audited. These must be carried out in the local cultural contexts, customs and adequate resources provided.

16. WPA urges policy makers to work with National associations where appropriate, to ensure that there are relevant and affordable medication options available on the essential drug list suitable

for women of reproductive age in LMICs.

17. WPA urges research funders to provide support for research on the effectiveness and cost-effectiveness of pharmacological and psychosocial interventions, including low cost technological solutions such as mHealth, and care pathways and protocols for perinatal mental disorders across the diagnostic spectrum, including the impact on the child. Research must be translated into clinical practice and communicated as meaningful and engaging communication for policy makers, budgeters, implementers and evaluators. Equity of resources between physical and mental health needs of mothers must be a priority in terms of investment into research, training, treatment, and prevention.

18. WPA recommends developing, evaluating and implementing interventions for health promotion and enhancement of maternal wellbeing, including the use of culturally appropriate care and supportive customs and interventions designed to reduce known risk factors; these include violence against women, particularly intimate partner violence and unintended or unwanted pregnancy including reproductive coercion.

19. WPA recommends that interventions for PMH are also gender transformative especially in countries where women have no agency related to childbirth

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