Diagnosing and managing perinatal depression in primary care

The following questions can be used as discussion points for primary care peer groups or self-reflection of practice.

It is strongly recommended that the following article is read before considering the questions.

"Diagnosing and managing perinatal depression in primary care" **www.bpac.org.nz/2019/perinatal-depression.aspx**

Depression and anxiety are the most common mental health issues women experience in the perinatal period. It is important that these conditions are effectively managed as the potential consequences can be severe. Suicide is the leading cause of maternal mortality in New Zealand with rates* seven times higher than in the United Kingdom; over half of these deaths (57%) occur in Māori.

* The rate of maternal suicide in New Zealand is 4.06 per 100,000 maternities, i.e. all live births and all fetal deaths at 20 weeks or beyond or weighing at least 400g if gestation is unknown

To identify potential mental health issues early, primary healthcare professionals should consider the presence of risk factors for women who are trying to conceive or once their pregnancy has been confirmed. When a woman is identified as needing additional mental health and wellbeing support, there needs to be a clear understanding between the patient, the LMC and the general practice about who is taking overall clinical responsibility for this. It is important that general practices continue to be involved during the perinatal period and to communicate with other healthcare providers, where appropriate.

Some of the symptoms associated with perinatal depression, e.g. tiredness, sleep disturbance, changes in weight and loss of libido, can be difficult to distinguish from pregnancy-related changes and the demands of caring for an infant. It is therefore important to distinguish the persistent symptoms of depression from the transitory feelings of distress, sometimes referred to as the "baby blues", that are experienced by up to 80% of new mothers, typically beginning three days after birth and resolving in 10–14 days. If symptoms persist for more than two weeks, postnatal depression is more likely.

Screening questions are used to identify women who may benefit from a more structured assessment of their mental health. Active follow-up is recommended.

The management of perinatal depression follows a similar approach to depression at other stages in life, but with the additional considerations of the pregnancy, fetus or infant and the mother-infant relationship:

- Mild depression is treated with behavioural and psychological interventions, reassurance and support
- Moderate to severe depression or persistent depression usually requires the addition of an antidepressant; generally a selective serotonin reuptake inhibitor (SSRI)

Management is also guided by the relative success of any treatments for previous episodes of depression and the patient's preference for treatment. Referral to secondary care is appropriate for women with severe mental illness, including post-partum psychosis which is a medical emergency most likely to occur three to ten days after birth.

Non-pharmacological interventions are the first-line treatment for depression or anxiety, e.g. behavioural activation (connecting with family/whānau and friends), exercise, relaxation techniques, cognitive behavioural therapy (CBT) and avoiding alcohol and drugs . These interventions focus on developing coping strategies, building resilience against relapses and establishing social supports. Social media may exacerbate unrealistic expectations of motherhood and it may be appropriate to recommend that some patients minimise their contact with these platforms.

When considering pharmacological treatments for perinatal depression, explain to patients that the benefits of antidepressants prescribed appropriately generally outweigh the risks. Sertraline, citalopram and escitalopram are often the preferred SSRIs due to their relative safety and efficacy. The differences in the safety of antidepressants does not, however, outweigh the potential risks of switching antidepressants in women who are already receiving effective treatment. Breast feeding is encouraged regardless of the antidepressant that is being taken.

Questions for discussion

1. What factors do you think might contribute to the high rate of maternal suicide in New Zealand in comparison with other countries such as the United Kingdom? What can health professionals in primary care due to help to reduce this burden, especially among Māori?
2. What strategies, if any, does your practice have to increase opportunities to assess the mental health of new and expectant mothers and their families/whānau?
3. What do you think are the risk factors to identify women who are more likely to experience perinatal depression? Or do you not think that it is possible to predict this?
4. It can be challenging to distinguish women with transient stress and anxiety in the perinatal period from those with persistent depression. Are there certain clinical features that help you to make this distinction?
5. What non-pharmacological treatments do you think are most useful for women with perinatal depression? Do you recommend online CBT? If so, are there particular courses that you choose and why?
6. If pharmacological treatment is indicated, what are the main factors that you consider when selecting an antidepressant for a woman who is pregnant or who is breastfeeding? How long do you usually continue treatment for?