THE ELIZABETH CLINIC

CARING FOR YOU AND YOUR FAMILY

Perinatal and Infant Mental Health

Some Helpful Things to Know

Dr Julia Feutrill, 21st September 2019

Why Perinatal and Infant Mental Health

- It is different
- High risk of relapse
- Rapid deterioration
- High impact of disorder
- Treatment complicated by pregnancy and breastfeeding
- Complex psychological adjustments
- Relationship Changes

It takes a village to raise a child……

The loss of the village….

Sleep School .com.au
FOR BABIES & TODDLERS

The rise of ‘Science’, ’Experts’ and Snake Oil Salesmen

Give your child the gift of sleep

Sleep is the corner stone of your whole families health and well-being. You're not alone in the sleep issues you're currently facing. We've already helped over 60,000 families and with your trust we know that we can help you too.

How does the Glow Dreaming actually help us sleep?

MSS Archangel

One size does not fit all. MSS Archangel adapts to your needs and personality; it is at the heart of how we bring you sleep success.

Red Light Therapy

NASA technology used to stimulate the body's Melatonin production, so your body knows it's time for sleep.

Aromatherapy

A medical grade organic essential oil designed especially for children to calm the body and relax the muscles.

Humidifier

Cool mist technology to help ease breathing, prevent snoring, stop the spread of airborne viruses and maintain a more even room temperature.

Pink Noise

Enhances brain activity associated with the deep phases of sleep as well as improving memory retention and focus.

Mental Health is about being cognitively, emotionally and socially healthy – the way we think, feel and develop relationships – and not merely the absence of a mental health disorder.

The Perinatal Period is the highest risk time in any woman's life for a mental health disorder

- 10-14% depression, 40% in antenatal period – 45 000 cases per year – less than half get help
- 10-16% women have anxiety disorders antenatally and postnatally – 26 000 cases per year
- 1/10 women is the rate of background depression
- 1:6 FDV since age 15 from a partner ,1:5 sexual violence since the age of 15
- 1:6 physically or sexually abused before the age of 15
- 1 woman dies every 9 days from FDV……FDV is more likely to occur when a woman is pregnant…..
- What has happened to you?

And don't forget the men…..

- 1:20 men experience antenatal depression or anxiety
- 1:10 men experience postnatal depression or anxiety
- Only a handful get help.
- Fathering Project, SMS4DADS

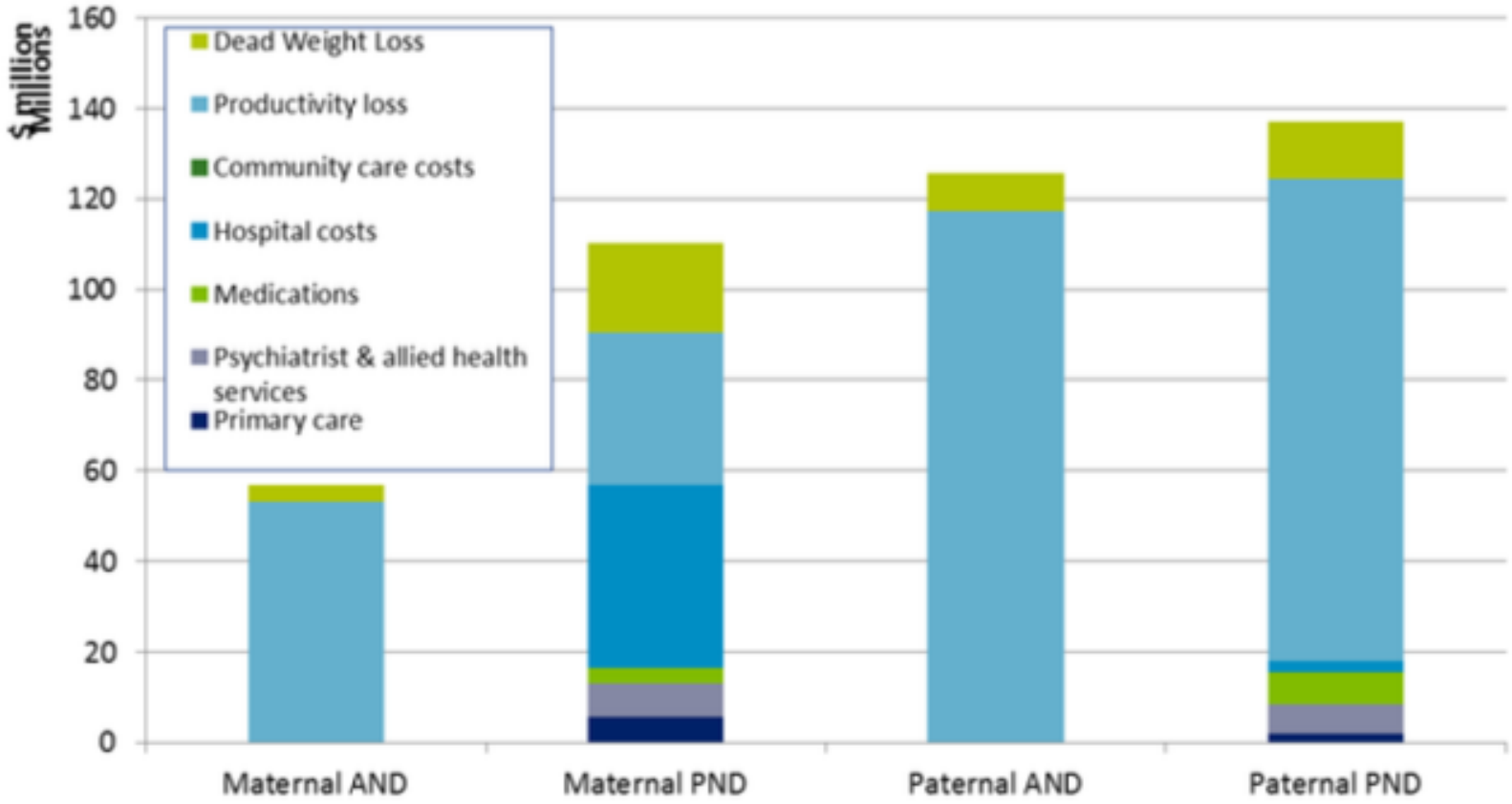
When to call in reinforcements?

- BPAD – 40-90% risk of relapse, 10-21 days postpartum
- Psychosis – PPP 1-2/1000, psychiatric emergency
- Severe PD – impact on attachment relationship
- D&A abuse
- OCD
- Active ED
- Risk.

Why should we worry about Perinatal and Infant Mental Health?

- Impact on Mother
- Impact on Fetus
- Impact on Pregnancy
- Impact on Delivery
- Impact on Infant
- Impact on Family

Chart i: Total estimated economic costs of perinatal depression in Australia in 2012



Source: Deloitte Access Economics calculations.

Untreated Symptoms in Mother

- Fertility – spontaneous abortion, success of ART
- Pregnancy – premature delivery, SGA
- Delivery – increase intervention
- Breastfeeding – shorter duration, less success

Developmental Origins of Health and Disease

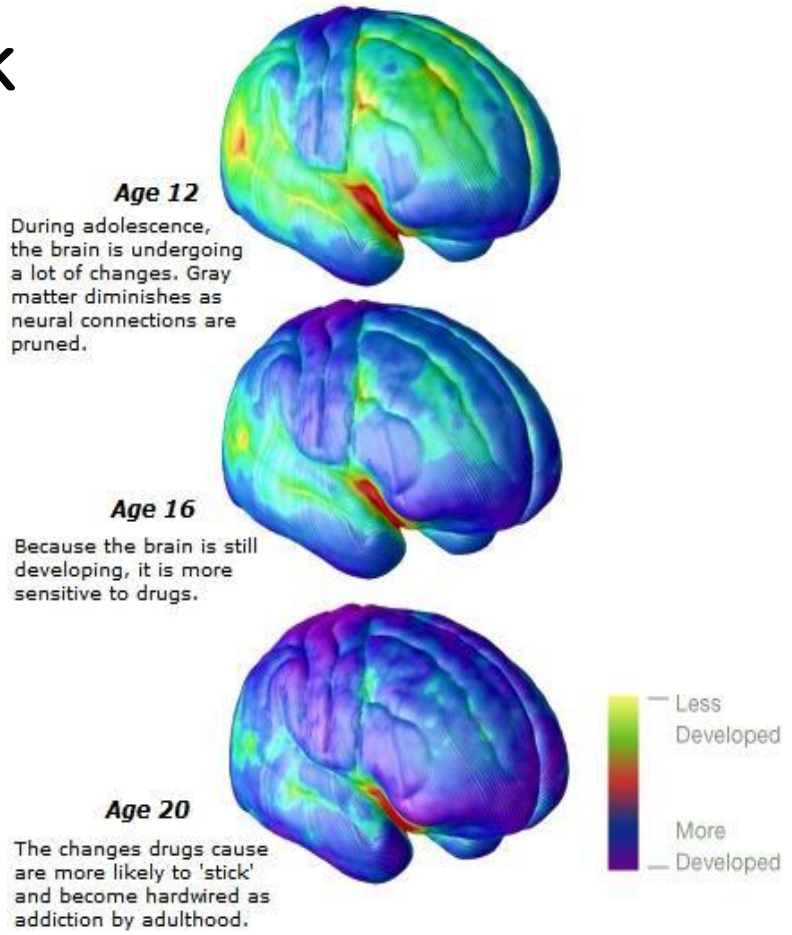
- 63% deaths non-communicable
- Genes probably account for only 5% of risk
- Epigenetics
- Attachment relationship is preventative and curative

The Infant Brain At Risk

Most of neurogenesis is genetically determined but environment can alter this.

Wiring is an ongoing process

Use it or lose it – lack of activation or over-activation alters wiring.



Parenting is about organising a brain

- poor wiring leads to problems with cognitive, social and emotional functioning
- Disorganised or Insecure attachment
- Treating PND does not seem to impact on attachment status.
- Need to treat parental MHD **AND** relationship

The vexed issue - Medication

- Consider if mod-severe symptoms, dysfunction, past history, long duration, lack of progress with good therapy, OCD
- Need to know diagnosis, efficacy and stage of pregnancy before any discussion of risk
- Find out their perception of risk
- Need to balance risk of medication against risk of untreated illness
- Risk varies across time – T1, T3, delivery

Odds ratios, associations and clinical relevance…

Prenatal SSRI Exposure and Speech/Language Disorders: Many Headlines, Little Risk 22/10/2016 8:41 am

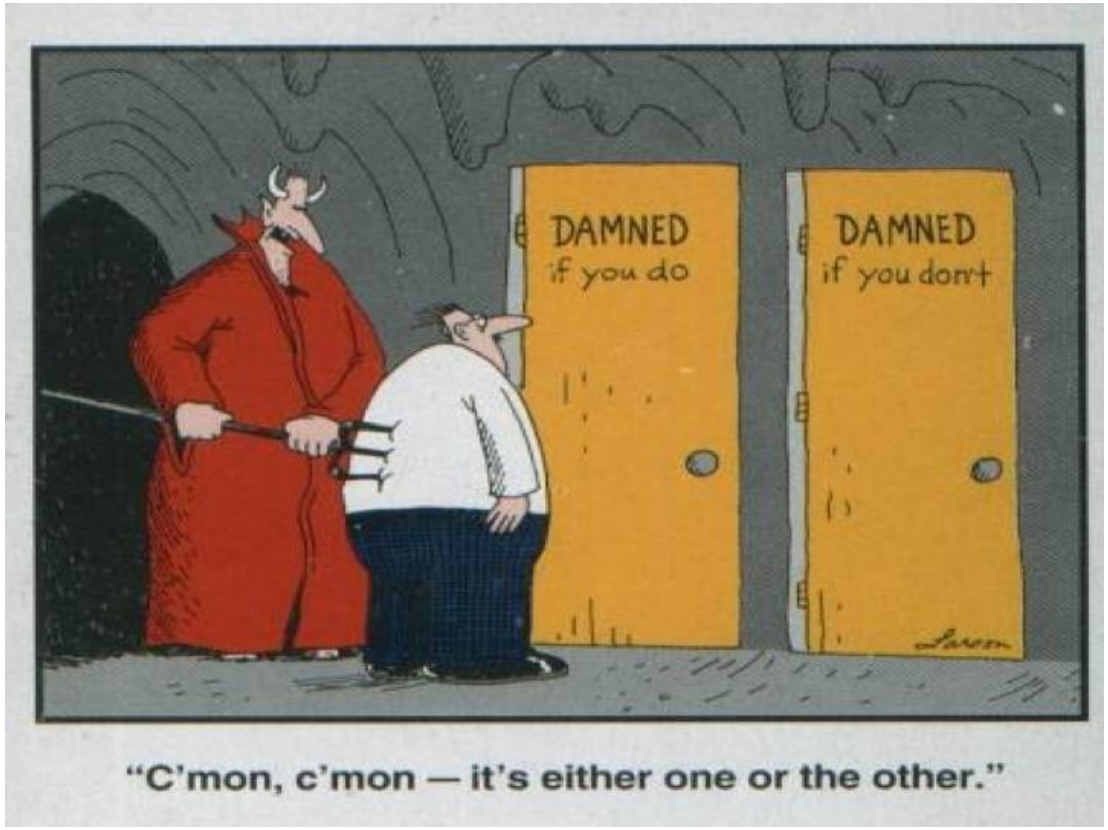
Prenatal SSRI Exposure and Speech/Language Disorders: Many Headlines, Little Risk


womensmentalhealth.org/posts/prenatal-ssri-exposure-speechlanguage-disorders-many-headlines-little-risk/

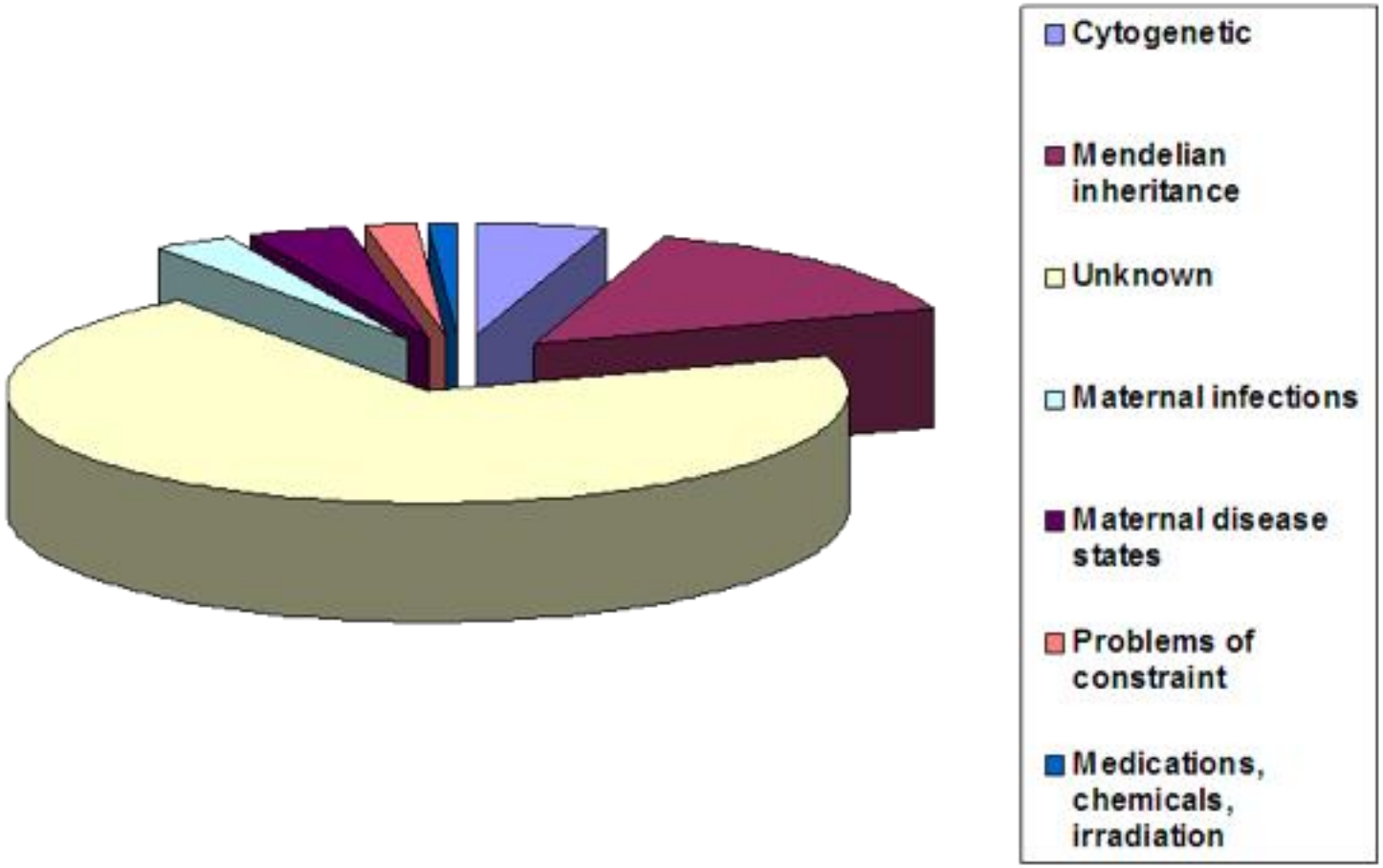
MGH Center for Women's Mental Health 10/21/2016

Last week, an article looking at the cognitive and motor development of children with prenatal exposure to antidepressants was published in *JAMA Psychiatry*. Since that time, we have received a lot of questions regarding the article and the clinical implications of its findings. When I did a quick Google search, I found 36 articles reviewing this study published within the last week. It is unfortunate, however, that none of the headlines seem to accurately reflect the results of the study and may be misleading and unnecessarily alarming.

Perceived risk, stigma and the Double Whammy….



Congenital Malformations



ADEC

A	Safe
C	Have caused or may be suspected of causing harmful effects on the human fetus or neonate…without malformations….may be reversible
B	Limited number of human pregnancies…no increase in malformations
B1	Animal Studies safe
B2	Animal Studies inadequate data
B3	Animal Studies increased fetal damage
D	Fetal Malformations/irreversible damage
X	High risk should not be used in pregnancy or when a possibility of pregnancy

Commonly Prescribed Medications and ADEC

A	
C	Cipramil, Lexapro, Luvox, Prozac, TCA, Zoloft, Seroquel, Risperidone, Olanzapine, Promethazine, Benzodiazepines
B1	Edronax, Ondansetron, valdoxen
B2	Effexor, Mianserin, Parnate, Pristiq
B3	Aurorix, Avanza, Nardil, Cymbalta, Melatonin
D	Aropax, NaV, Lamotrigine, Lithium
X	

But Will It Make Me Put on Weight?

Weight Gain	Paroxetine (2.73), Mirtazapine (2.59), Doxepin (2.73), Clomipramine (1), Duloxetine (0.71)
Minimal Effect	Lexapro (-0.65), Venlafaxine (-0.5), Fluoxetine (-0.3), sertraline (-0.12), Pristiq (-0.8)
Weight Loss	Bupropion

So what do we worry about in T1?

- Sodium Valproate should not be prescribed to any woman of child bearing age (NICE)
- Paroxetine – positive signal for cardiac defects
- Lamotrigine – limited risk with doses under 300mg, folate 5mg recommended
- Benzodiazepines – week 7-9, low dose is ok
- Lithium – Ebsteins, initially 1/5000, now more like 1/10000 (double baseline risk)

What about the rest of pregnancy and beyond?

- Mostly no concern for any meds in T2
- Lithium needs monitoring throughout due to changes to GFR
- Increased risk of GDM with antipsychotics
- PPHN, NAS
- Long term impact

Breastfeeding

- Few contraindications
- % of maternal dose on assumption of 150ml/kg/day
- < 10% safe (<3% in preterm)
- NN and Preterm slower metabolism
- Low bioavailability, high protein binding, high molecular weight, short half life, high clearance better

Medication	Weight Adjusted Exposure
Pristiq	6.8 %
Efexor	6.4 %
Lexapro	6.2%
Prothiadin	4.4%
Cipramil	3.6%
Clomipramine	2.8%
Edronax	2.5%
Zoloft	2.2%
Avanza	1.9%
Luvox	1.3%
Duloxetine	0.14%

- 35 year old professional, married two boys aged 4 and 2
- Referred by GP Obs, regional centre
- Previous admission to MBU with BPAD, D/C olanzapine
- Preconception
- Appt via telehealth with husband present
- Discussed medications in pregnancy, risk of relapse, relapse signature, immediate management of relapse
- They were not convinced of diagnosis

- Returned at 6 weeks pregnant, had ceased olanzapine
- Wanted to trial without medication
- Restated EWS, early intervention and identified support team
- Contact monthly, GP liaison
- Remained well until 24 weeks – hypomania
- Settled within three days with reinstatement of olanzapine
- Decided to continue olanzapine

- Remained well in rest of pregnancy
- Managed sleep rigorously
- Highest risk 10 days then 21 days
- Planned for delivery – no period of 24 hours without 4 hours sleep, not exclusive feeding in initial three weeks to sleep overnight, support in hospital and at home
- Day 9 slight increase in energy and difficulty with sleeping. Increase dose olanzapine, add in lorazepam.

- Exclusive breastfeeding by 12 weeks
- Continued to breastfeed for 12 months
- Ceased medication at 24 months
- Adjustment Disorder at 30 months
- Sleep is the key

Screening

- High false positives or false negatives
- Denial of care to those of low risk and inappropriate intervention to those of high risk
- Undermine the patients sense of self determination and competency
- No consistent evidence to show that risk assessment reduces harm
- EPDS and ANRQ

So what do we use at the Elizabeth Clinic?

- EPDS
- Growing Together Questionnaire
- Coming Together Questionnaire
- My Baby/My Child

Growing Together

- I think my birth experience will be good
- When I think about feeding my baby, I feel worried
- When I think about getting my baby to sleep enough, I feel worried
- During the pregnancy, the professional care has been good
- Thinking about my baby makes me feel happy
- In the last few weeks, I have felt tense
- Lately, I have been thinking a lot about past losses
- I can laugh and have fun easily
- When my baby is crying, I will be able to help my baby feel better
- When I think about being alone at home with my baby, I feel stressed
- When I think about my partners current wellbeing
- The right help is there when I need it.

Coming Together

- I remember my birth experience as:
- Feeding my baby has been:
- I get anxious settling my baby to sleep:
- In the last 2-3 weeks, I have felt very tense
- I really enjoy cuddling my baby
- I worry about my baby's health and development
- In the last 2-3 weeks I have felt panicky
- In the last two months I have received good professional care
- When my baby is crying, I find it hard to cope
- I worry about my partners' current wellbeing
- I have the right support at home

Mothers Object Relations Scale

- My baby always smiles at me
- My baby annoys me
- My baby likes doing things with me
- My baby talks to me
- My baby irritates me
- My baby wants too much attention
- My baby gets moody
- My baby likes to dominate me
- My baby likes to please me
- My baby cries for no obvious reason

Relationship in action…..

- Crucial to assessment of risk to infant
- How the parent positions self and child?
- Do they reference/attend to the child?
- Do they make eye contact/talk to/ how do they hold the baby?
- Are they aware of the impact their distress has on the child?
- How does the baby use the parent to manage their emotions?

- 30 year old mum to 3.5 year old and 8/12 old, married
- Referred GP in local hospital
- Anxious, depressed, physiological symptoms and brief suicidal ideation
- Two previous episodes ?BPAD (not likely though)
- FOO issues, conflict in couple relationship
- Medication and MHCP to psychologist

- Over next 6 months regular sessions
- Husband referred to psychiatrist with undiagnosed OCD
- Couples therapy with his MHCP
- Recovered
- Continued to notice hormonal sensitivity with anxiety and low mood preceeding menstruation
- Discussed management of this – OCP, sleep, exercise, SSRI dose

Elizabeth Clinic Model of Care

- No wrong door - Limit Barriers to care
- Whole family
- Relationship focus to all interventions
- Financial considerations – medicare safety net, non-directive counselling, MHCP
- Acuity must be managed appropriately
- Support Primary Care to detect and respond to PIMH concerns
- Prevention……..
- Psychiatry, psychology and even groups via telehealth

PAEDIATRICIAN

OBSTETRICIAN

CHILD HEALTH NURSE

GP

LACTATION CONSULTANT

FERTILITY SERVICE

PHARMACIST

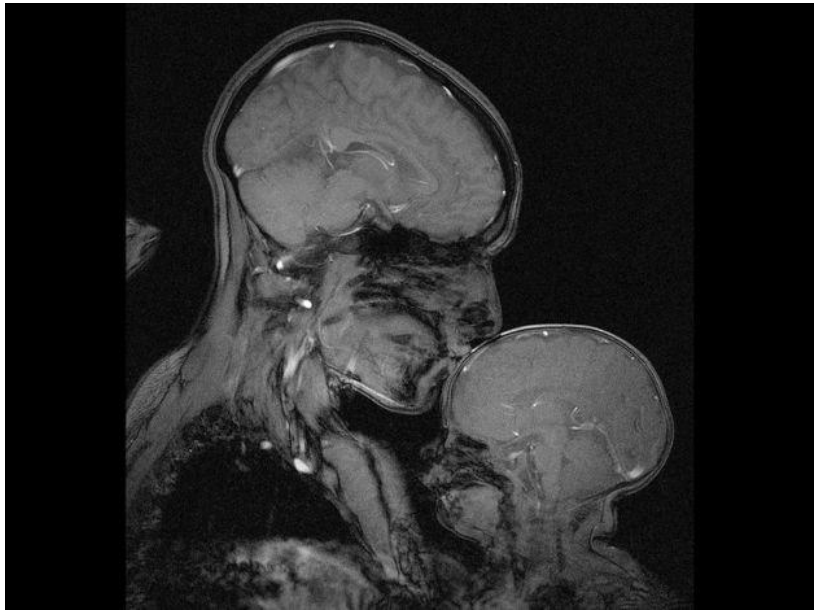
MIDWIFE

DIETITIAN

PHYSIO

Potential Referral/Support Pathways

- CAMI KEMH/pharmacy/registrar/preconception counselling
- MBU KEMH FSH/telehealth FU?
- Glengarry EPU/Ngala
- Enhanced CHN
- CMHS – New Beginnings
- Womens' Health Organisations
- ECU Pregnancy to Parenting
- Mother Nuture – Playgroups
- Raphael Services
- Gidget Foundation
- COPE



Elizabeth Clinic

222 Stirling Highway

Claremont 6010

9384 4565

enquiries@elizabethclinic.com.au

jfelizabethclinic@iinet.net.au