phn NORTH WESTERN MELBOURNE

An Australian Government Initiative

Perinatal mental health and psychotropic medicines in pregnancy

Tuesday 1 October 2024

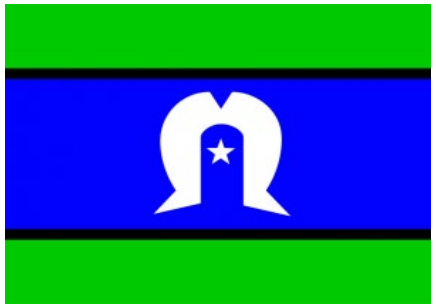
Email: gp.liaison@thewomens.org.au

The content in this session is valid at date of presentation

Acknowledgement of Country

Royal Women's Hospital, North Western Melbourne Primary Health Network, PANDA and the Parent-Infant Research Institute acknowledge the Traditional Custodians of the land on which our work takes place, The Wurundjeri Woi Wurrung People, The Boon Wurrung People and The Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.



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Parent-Infant Research Institute

Housekeeping – Zoom Webinar

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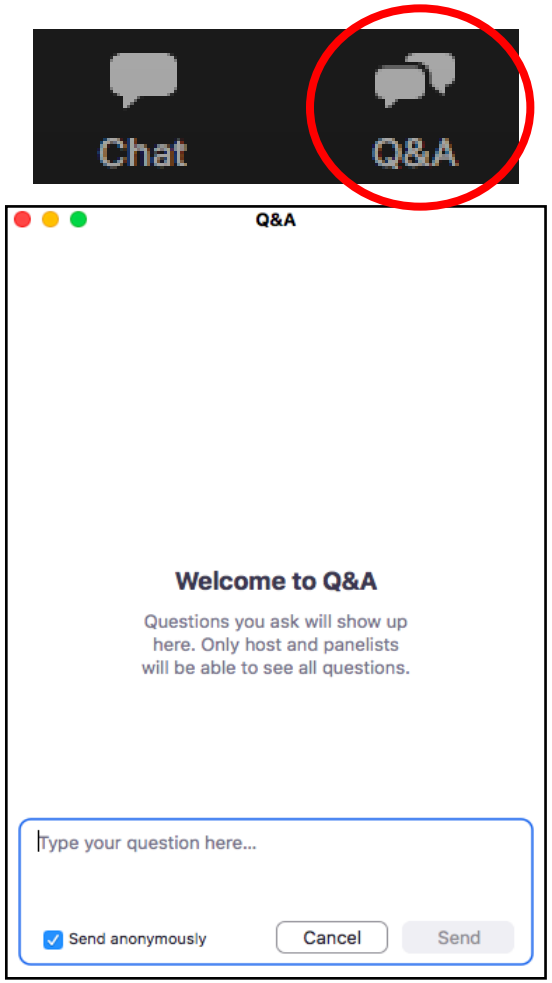
Please ask questions via the Q&A box only

Q&A will be at the end of the presentation

This session is being recorded

Questions will be asked anonymously to protect your privacy



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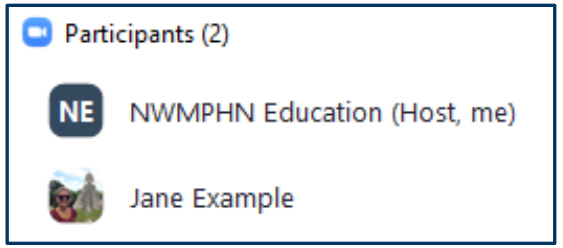

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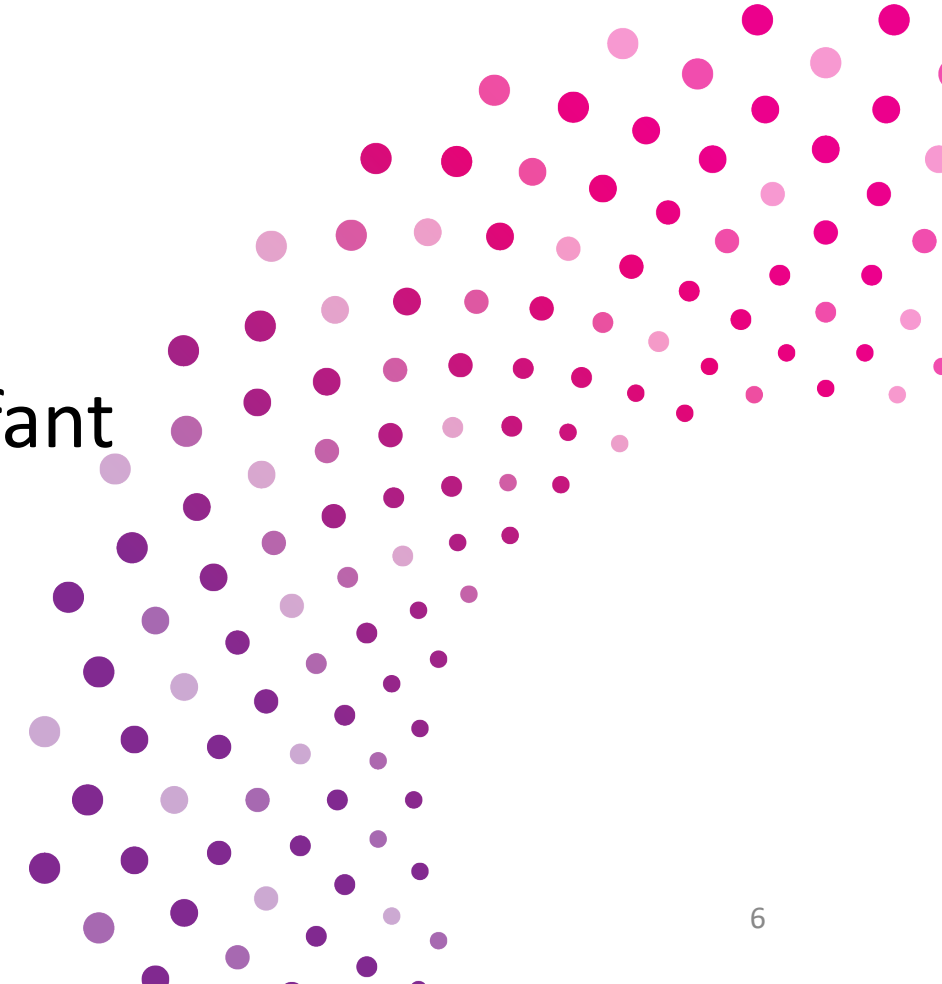
HealthPathways Melbourne

Perinatal mental health and psychotropic medicines in pregnancy

1 October 2024

1. Supporting new parents, their babies & families: PANDA
2. Perinatal Mental Health/Psychotropic Prescribing in Perinatal Period: RWH
3. Online Resources and Support: Parent Infant Research Institute (PIRI)



Speakers

Perinatal Anxiety & Depression Australia (PANDA)

Kirsty Oldridge is the National Helpline Manager for PANDA. She has over 20 years' experience working within the public, private and NFP sectors, at senior operational and strategic levels. Kirsty has successfully managed national programs and overseen significant digital transformation projects, with a focus on improving community outcomes through service delivery improvement initiatives.

Bonnie Jephcott is the Practice Liaison Lead at PANDA, and has over 15 years' experience in counselling, training and health writing. Bonnie has worked at PANDA since 2017 in several roles including the Helpline, Community Education and Training, and Communications and Engagement teams.

How PANDA can support your work with expecting and new parents, their babies and families

Kirsty Oldridge, PANDA National Helpline Manager
Bonnie Jephcott, PANDA Practice Liaison Lead

PANDA

Acknowledgement of Lived Experience

It's not your fault.

You are not alone.

You are not broken.

It’s not only okay,

but *incredibly* brave to ask for help.

– Lauren, PANDA Community Champion

‘I was completely incapacitated and in my own head. I was too scared to tell anyone exactly what thoughts I was having, in case they took my baby away and put me in jail.’

- Monique, PANDA Community Champion

Learning objectives

- Perinatal mental health: Brief overview
- Screening: Best practice, future directions
- PANDA Helpline programs and services
- PANDA's Model of care
- What can callers to PANDA expect?
- Helpline data: Insights and emerging trends
- Common Helpline themes
- Spotlight: Peer support, Intensive Care
- Case study
- Referring to PANDA
- PANDA digital resources

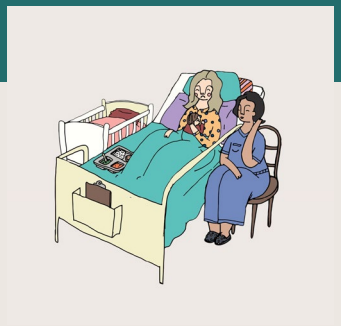
Perinatal mental health in Australia: An overview

Perinatal depression and/or anxiety

Up to 1 in 5 mums and birthing parents.

Up to 10% of dads and non-birthing parents.

Partner diagnosed with PND/A: up to 50% more likely to experience anxiety/depression themselves.



Birth-related trauma

Up to 1 in 3 mums and birthing parents.

Dads/non-birth partners Healthcare providers.

Up to 1 in 4 experience post-traumatic stress.

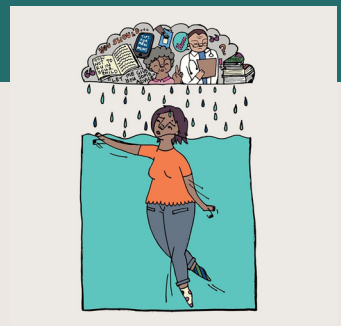
Up to 4% of mums and 1% of partners meet criteria for Post-Traumatic Stress Disorder (PTSD).

Obsessive-compulsive disorder with perinatal onset (p-OCD)

90-100% of parents experience intrusive thoughts.

Perinatal OCD: 2.9% of women in pregnancy, and 2.2% - 16.9% of women postnatally.

Dads and other caregivers can also experience p-OCD



Perinatal psychosis

Rare but serious mental health emergency: 1-2 in every 1000 parents who give birth.

Early intervention can be life-saving for parents and their infants.

Many parents make a full recovery with support from family and healthcare providers.

Mental health and psychosocial screening

Perinatal screeners recommended in COPE Australian Clinical Practice Guideline:

- Edinburgh Postnatal Depression Scale
- Antenatal Risk Questionnaire

Use clinical judgement, further assessment and safety planning, appropriate follow-up and referral/s.

Emerging evidence:

- Kimberley Mum's Mood Scale (KMMS)
- City Birth Trauma Scale

PANDA National Perinatal Mental Health Helpline: Programs and services

PANDA National Helpline: Counselling and peer support

Intensive Care and Counselling (funded in Victoria and QLD)

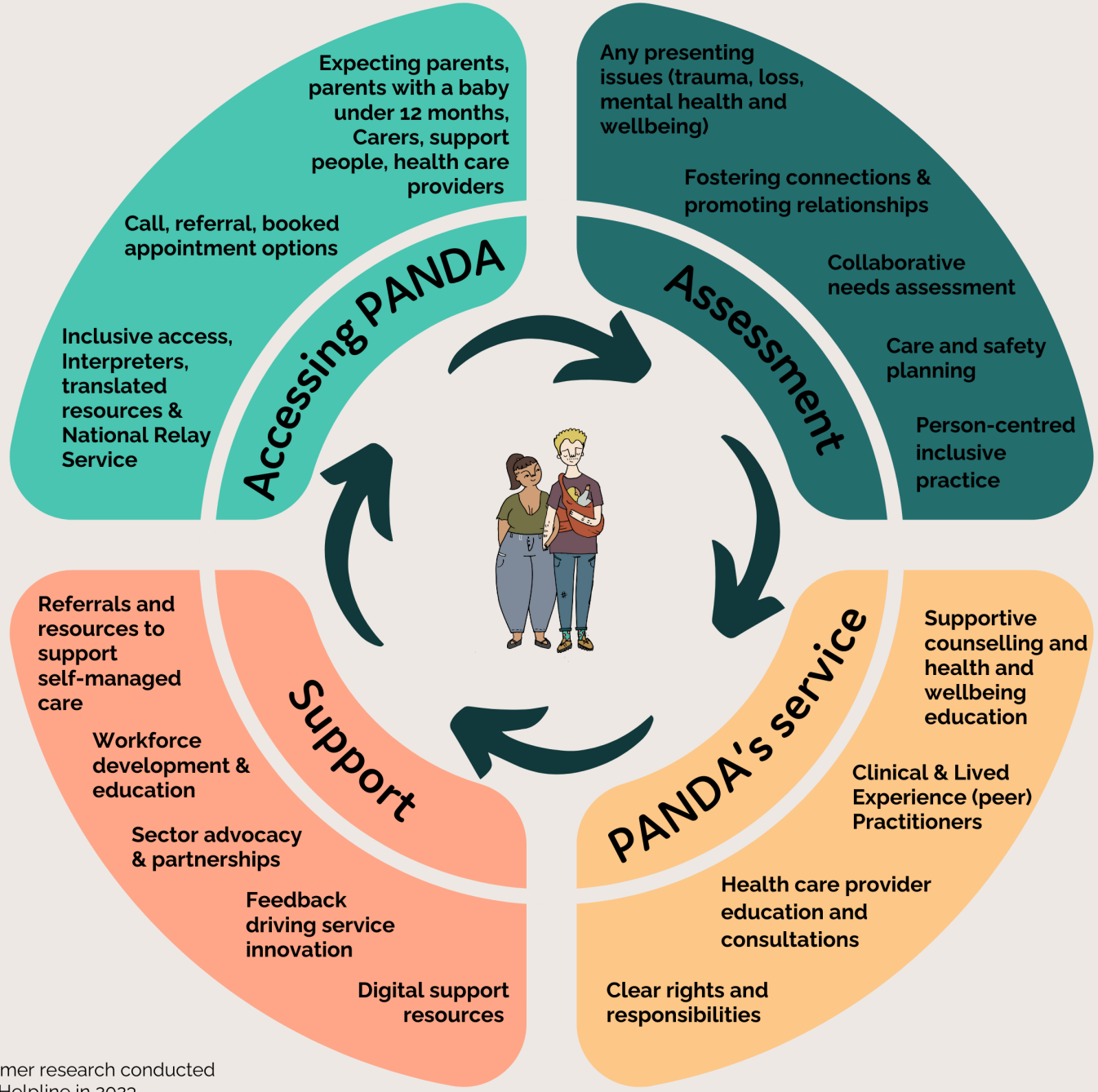
Secondary Consultation service (national)

Specialist programs:

- Pregnant in Prison (funded by NSW Justice Health)
- Mum2B/MumMoodBooster (partnership with Parent-Infant Research Institute)
- SMS4Dads (partnership with University of Newcastle)

PANDA
Perinatal Anxiety & Depression Australia

PANDA Model of Care



PANDA's model of care is informed by extensive consumer research conducted during the independent review of the PANDA National Helpline in 2023.
Last updated July 2024. Next review July 2025.

What can callers expect?

Non-judgmental, inclusive and trauma-informed **counselling and peer support**.

Person-centred, compassionate, collaborative care.

Initial call: 20-60 minutes counselling or peer support call.

Opportunity to share their story; explore concerns and support options; care and safety planning; referrals for local healthcare providers, specialist services and support groups.

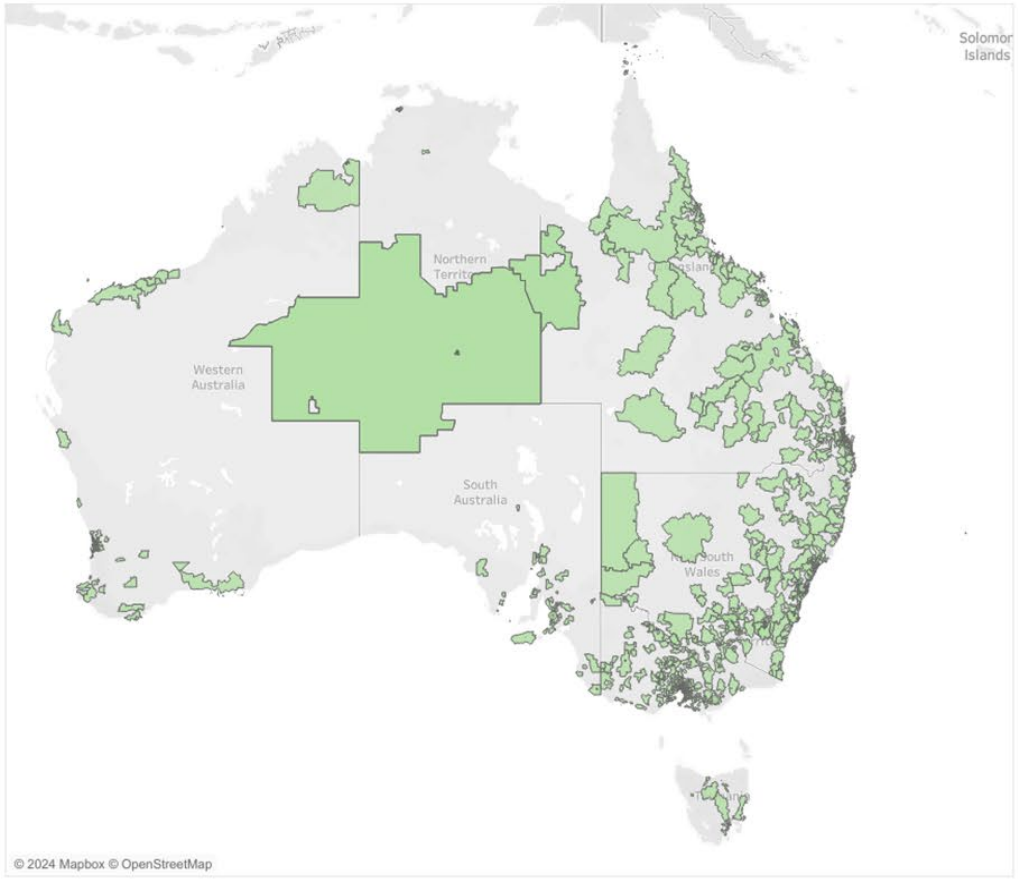
Follow-up calls may be offered, some callers opt to call in.

Helpline Data Insights July 2023 – June 2024

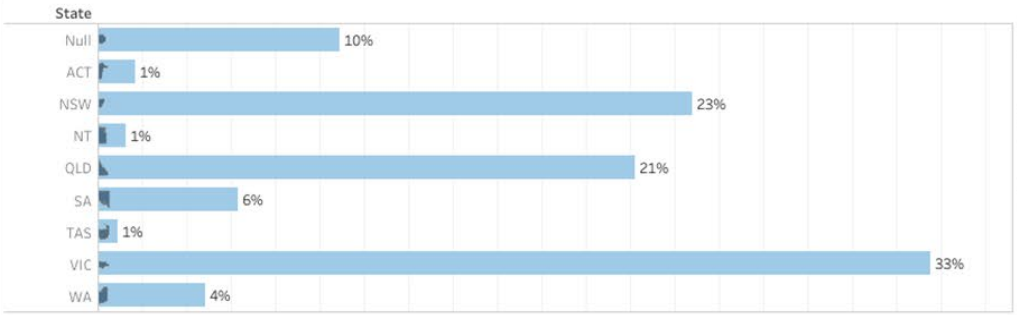
Locations

All programs, All states, July 2023 - June 2024

Postcode



State



Program
All

Report Start
July 2023

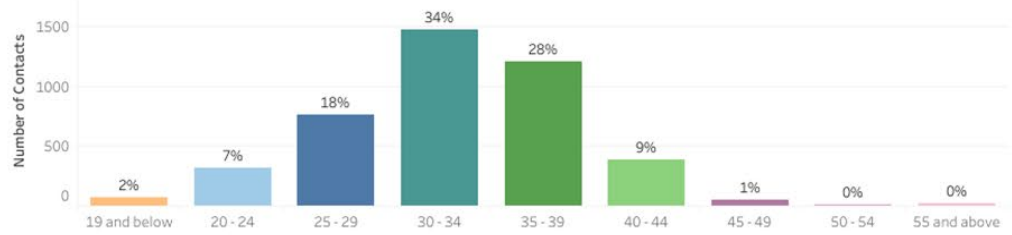
Report Period
Annual

Demographic
Age Group

Remoteness Area

Major Cities of Australia	77%
Inner Regional Australia	15%
Outer Regional Australia	6%
Remote Australia	1%
Very Remote Australia	1%

Age Group

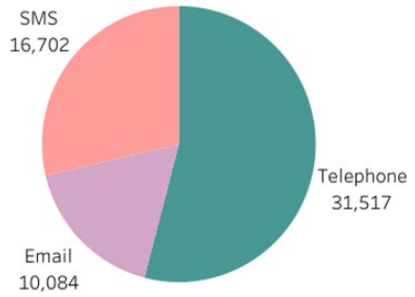


Helpline Data Insights July 2023 – June 2024

Number of Activities

63,490

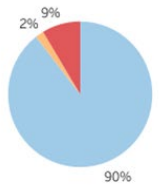
Number of Activities by Modality



Risk Assessments & Presenting Issues

All programs, All states, July 2023 - June 2024

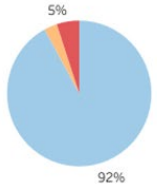
Suicide



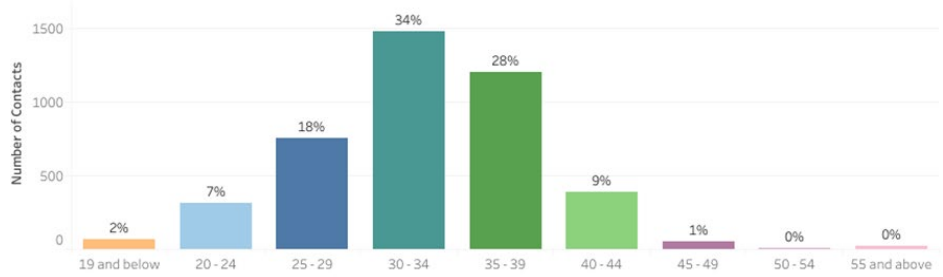
Self Harm

Family Violence

Harm to Infant



Age Group



Presenting concerns: Common themes on the PANDA Helpline

- Anxiety/depression
- Bonding/attachment
- Birth-related trauma
- Chronic pain/health issues
- Complex trauma/PTSD
- Dads and non-birthing parents
- Expectations vs ‘reality’
- Family violence
- Grief and loss
- Intrusive thoughts
- Managing strong emotions
- Harsh inner critic
- Parenting concerns (self/partner)
- Pregnancy decision-making
- Relationship conflicts
- Self-harm and suicide
- Self-care challenges
- Social issues
- Strong emotions
- Young parents (16-25)

Spotlight on: Peer support

Paid and volunteer peer support practitioners work alongside clinical counselling staff on PANDA's Helpline.

- Effective support during pregnancy and early parenthood.
- Peer practitioners are highly trained and actively supported.
- Committed to helping callers feel less alone and more confident in managing mental health and parenthood challenges.
- Parent-to-parent peer support as someone who has 'been there', survived and thrived.

Intensive Care and Counselling program: Victoria and Queensland

Provides quality, specialist perinatal support for families experiencing complex mental health and wellbeing challenges during pregnancy and early parenthood.

- Free service, referral required.
- Intensive medium-term support.
- Staffed by clinical counselling and peer support practitioners.
- Collaborative care coordination and service navigation.
- Comprehensive risk assessment and safety planning.
- Supports people with complex barriers to accessing care.
- Secondary consultation service for healthcare providers.

Case Study: ‘Sarah’

Referral: Perinatal Mental Health team social worker

Service user: 22-year-old sole parent with 4-month-old son

Presentation: Low mood, bonding/attachment concerns

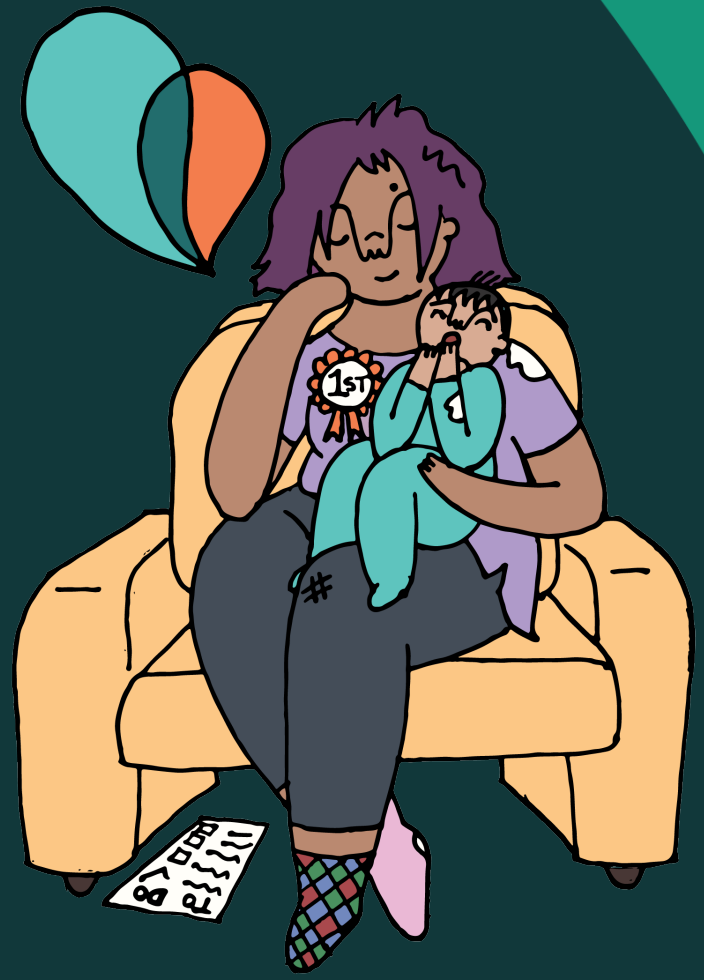
Assessment: Mental health, parenting and social support

Intervention: Fortnightly calls, counselling and peer

Outcome: Linked with community services, discharge

PANDA services and resources

Supporting you and the parents, babies, and families in your care



Referring to PANDA

Tips for making a great referral to PANDA

- Encourage parents in your care to self-refer and call PANDA.
- Obtain consent if submitting referral.
- Clients’ contact details and location.

- Include if partnered, older children, family dynamics.
- If bereaved, include their infant's name.
- Person’s gender and/or pronouns.

- Language preferences.
- If they require referral/are engaged with other support services.
- History including mental/physical health and/or psychosocial challenges

- Your own contact details.
- Preferences re: counselling/peer, gender of Helpline practitioner.
- Any court orders or child safety/care arrangements, include safest time for calls

PANDA digital resources

PANDA website

Stories, information, self-support resources, mental health checklists, videos, free PANDA Learning Hub courses, podcasts.

Healthcare provider hub

PANDA.org.au

PANDA
Perinatal Anxiety & Depression Australia

Download/order

Posters, postcards and brochures, download factsheets, share helpful links and resources with families in your care

Translated resources in **over 40 community languages**

Brochures for First Nations families

Download or order free hardcopies.

New! PANDA video - Support for Aboriginal and Torres Strait Islander parents

Survive & Thrive podcast (2 seasons)

Videos for expecting and new parents

PANDA's YouTube channel includes a 'guided grounding exercise' available in over 40 languages

We welcome your questions (during Q&A later in this session)

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Kotz, J., Marriott, R., & Reid, C. (2021). The EPDS and Australian Indigenous women: A systematic review of the literature. *Women and Birth*, *34*(2), e128-e134.

Marley, J. V., Kotz, J., Engelke, C., Williams, M., Stephen, D., Coutinho, S., & Trust, S. K. (2017). Validity and acceptability of Kimberley Mum's Mood Scale to screen for perinatal anxiety and depression in remote Aboriginal health care settings. *PloS one*, *12*(1), e0168969.

Thank you

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PANDA

Speaker

Royal Women's Hospital

Dr Charles Su is a Consultant Psychiatrist with a keen interest in psychotherapy, perinatal psychiatry and adolescent mental health. After graduating from the University of New South Wales MD program, he completed a Master of Psychiatry. Working across hospitals in Sydney and Melbourne, he has had rich exposure to complex psychiatric presentations and dedicated perinatal psychiatry training. Charles's clinical practice focuses on providing holistic and evidence-based treatments for parents affected by mental illnesses during pregnancy and in the postpartum period.

Psychotropic Prescribing in Perinatal Period

Dr Charles Su

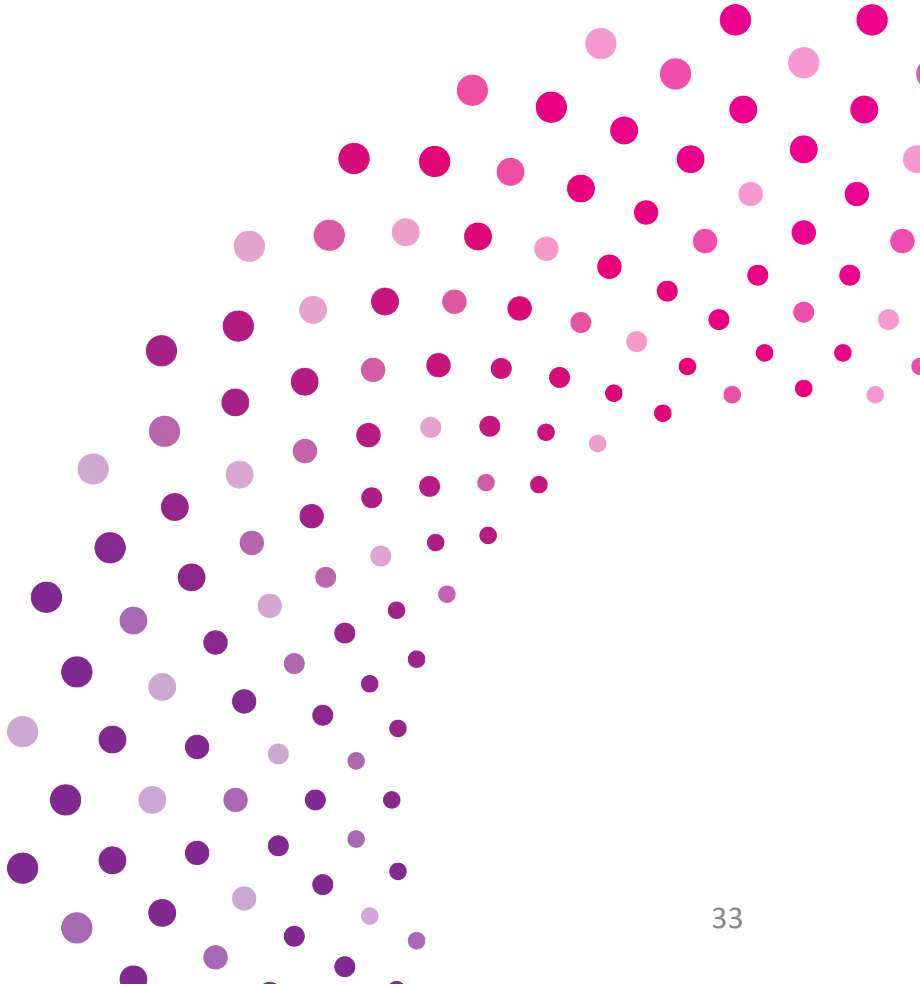
CL Consultant Psychiatrist

Charles.su@thewomens.org.au

Overview

- Perinatal depression
  - Antenatal depression
  - Postnatal Depression
- Treatment in pregnancy
  - Principles of prescribing
  - SSRI / SNRI Medication
  - Mirtazapine
  - Antipsychotics
- Questions!

Perinatal Depression



Antenatal Depression

- Over 50% women cease antidepressants without consultation when they find out they are pregnant
- Onset is often insidious, and it is often not reported
- High risk relapse with cessation of treatment
  - Relapse rate 26% those who continued medication vs 68% of those who discontinued medication[1]
  - Relapse more severe in those who ceased medication c/w those who continued
- Antenatal depression is a significant risk factor for postnatal depression

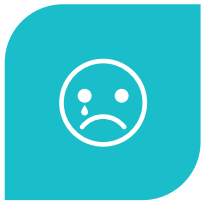
1. Cohen LS, Altshuler LL, Harlow BL, Nonacs R, Newport DJ, Viguera AC, Suri R, Burt VK, Hendrick V, Reminick AM, Loughead A, Vitonis AF, Stowe ZN. Relapse of major depression during pregnancy in women who maintain or discontinue antidepressant treatment. JAMA. 2006 Feb 1;295(5):499-507. doi: 10.1001/jama.295.5.499. Erratum in: JAMA. 2006 Jul 12;296(2):170. PMID: 16449615.

Postnatal Depression

SERIOUS AND COMMON

PREVALENCE RANGES FROM 1/8 TO 1/10 IN AUSTRALIA ANNUALLY

1/5 OF ANTENATAL DEPRESSION PERSISTED THROUGHOUT POSTNATAL PERIOD. 1/10 OF THEM EVENTUATED TO A MAJOR DEPRESSIVE EPISODE



MANY WERE UNAWARE OF/COMPLETELY BLINDSIDED BY THE ONSET OF DEPRESSION

THERE IS A SHIFT FROM POSTNATAL DEPRESSION TO ANXIETY AND DEPRESSION IN PERINATAL PERIOD

PERINATAL IS DEFINED AS PREGNANCY AND ONE YEAR POST-PARTUM

How does PND present?

Mood: Depression, irritable, anxious	Panic attacks	Sleep (reduced in spite of baby sleeping)	Appetite changes	Hopelessness/failure
Lack of pleasure in usual activities	Poor "bonding“	Social withdrawal	Marital problems	Undue concern for baby's health
“Unworthy" mother	Obsessional features	Suicidal ideation	Thoughts harming baby.	

Difference between Baby Blues and PPD

Baby Blues

- Normal emotional adjustment to having a baby
- Occurs in most women (≤ 80%)
- Transient symptoms
- Mild mood lability
- No more than mild dysfunction
- Resolves within 10 to 14 days

PPD

- Meets DSM-5 criteria for major depressive episode
- Persistent symptoms
- Impairs function for at least 2 weeks
- Warrants treatment

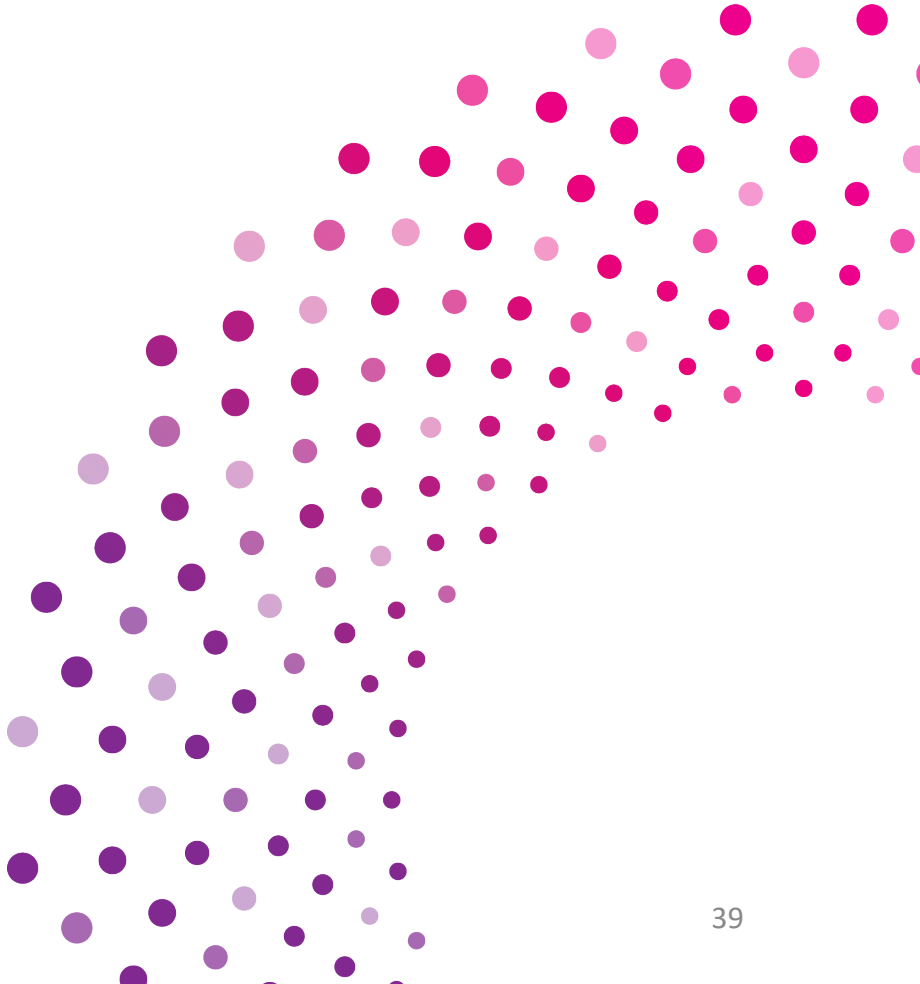
Risk with PPD

8 fold ↑ risk suicide for women with severe illness in first postnatal year.

Use more violent means

the leading cause of maternal death in the UK (Oates 2004) cf. cardiac or other causes; 3rd leading cause in Australian study

Principles of Treatment



Principles of Treatment

- There are no risk free options
- Optimize non-pharmacological treatments
- Addressing substance misuse, unhealthy lifestyle and physical illness as important as minimising medication effects for infant outcome
- Treatment decisions are highly individual – there is no right answer for everyone!
- **When choosing medication with the patient take into account:**

  Past response to treatment

  Side effect profile

  Individual preferences
- Include partner / significant other in discussion (with patient consent)

Transfer of psychotropic medication to the foetus

- All psychotropic drugs pass through placenta and are present in the amniotic fluid
- The degree varies between drugs but little as yet known
- Surveys estimate psychotropic medications taken in 21 – 33 percent of established pregnancies[1]

- [1]ACOG Practice Bulletin: Clinical management guidelines for obstetrician-gynecologists number 92, April 2008 (replaces practice bulletin number 87, November 2007). Use of psychiatric medications during pregnancy and lactation.

Timing of exposure and potential adverse outcomes

Early pregnancy	Major structural defects
Later pregnancy	Minor structural defects Functional defects (e.g. Valproate linked to developmental delay / Autism Spectrum Disorder Preterm delivery
	Abnormal foetal growth
At delivery	Poor neonatal adaptation syndrome
Postnatal	Cognitive and behavioural effects

Investigating whether a drug is harmful to the developing child

- Randomised, double-blind controlled trials not ethical
- Next best levels of evidence:

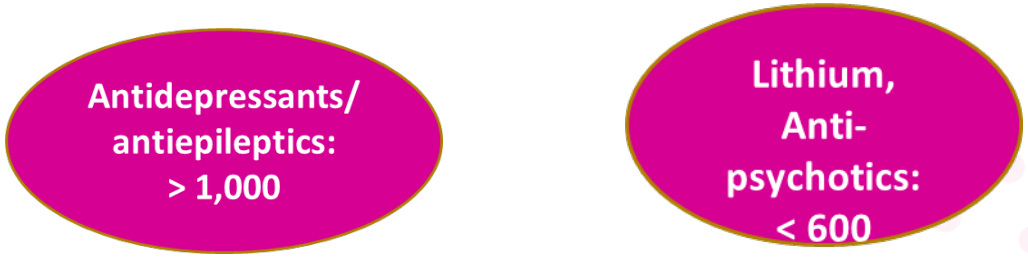
  pregnancy registers, population studies, cohort studies,

  case series and control studies
- There are a lack of well designed prospective comparative studies for psychotropic use in pregnancy[1]

- [1]Einarson A1, Boskovic R. (2009). *Use and safety of antipsychotic drugs during pregnancy.* J Psychiatr Pract. 15(3):183-92.

Large sample sizes needed to test for congenital anomalies

- Major congenital malformation rate 3% in general population
  - 1,000 exposed cases needed to test for doubling of risk[1]
- Specific malformation with a 0.1% occurrence in general population (e.g. cleft palate)
  - Even when including 4 controls for each exposure, almost 11,000 exposed cases to test for a doubling effect[2]
- Sample sizes in studies of first trimester exposure to *individual* psychotropic agents



- Sample sizes for studies of later pregnancy exposure are also often inadequate

[1]European Medicines Agency (2008) http://www.ema.europa.eu/docs/en_GB/document_library/Scientific_guideline/2009/09/WC500003307.pdf
[2]Dellicour S, ter Kuile FO, Stergachis A (2008). PLoS Med 5(9): e187. doi:10.1371/journal.pmed.0050187

Quality of evidence

- Many other factors confound pregnancy and infant outcomes
- Little as yet known about untreated maternal mental illness, but preliminary insights point to an adverse effect (stress, life style, physical health, sleep, illness itself)
- Conversely women with SMI (serious mental illness) are more likely to smoke, drink alcohol or use illicit substances in pregnancy[1]
- Studies control for different confounding factors – hampers comparison between studies
- Epidemiological studies have the advantage of large numbers but lack accuracy of infant diagnoses and diagnostic bias
- Research difficult to do!

[1]McAllister-Williams et al (2017). British Association for Psychopharmacology consensus guidance on the use of psychotropic medication preconception, in pregnancy and postpartum 2017. *Journal of Psychopharmacology*, 31(5), pp.519-552.

Risk : Benefit Analysis

- Risk/Benefit to the unborn
- Risk/Benefit to mother (including benefit of treatments
- Risk/Benefit in the neonatal period
- Risk/Benefit in breast-feeding

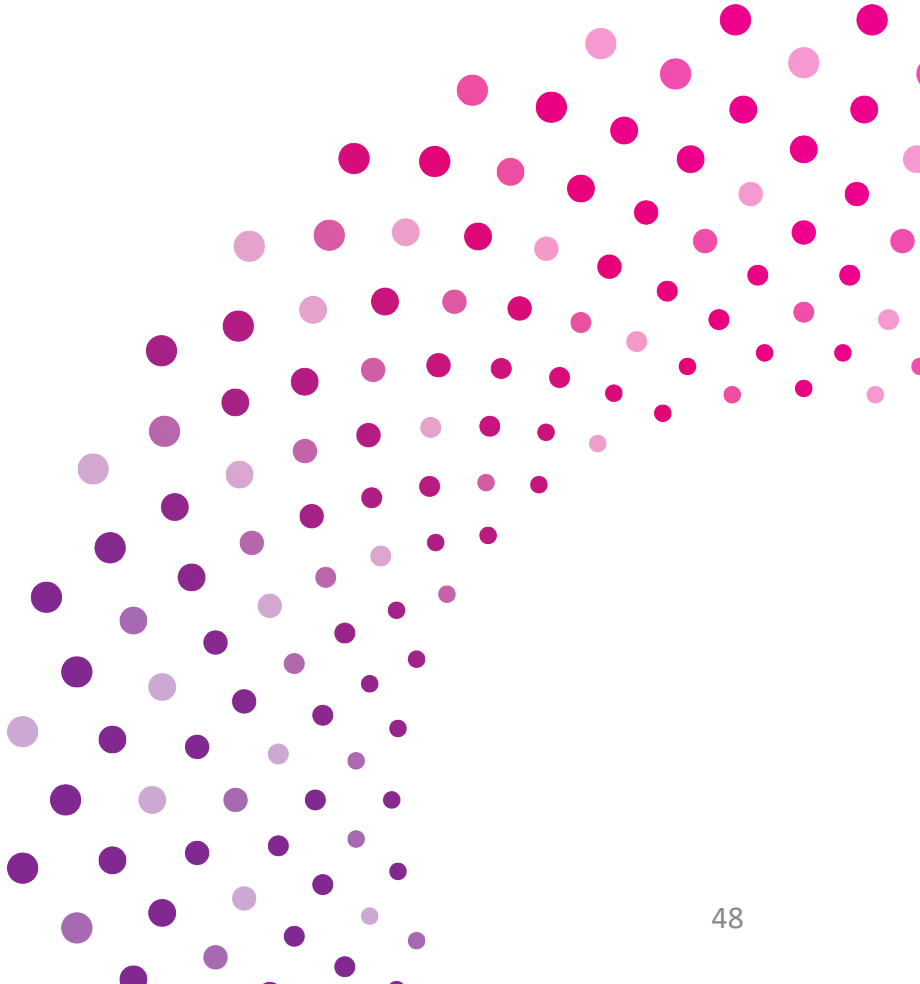
A risk : benefit analysis applies to a specific patient within a particular mental health scenario

The comparison point is not the well, un-medicated woman next door.

Psychotropics in Pregnancy

- Risk of malformation,
- Obstetric complication,
- Neonatal adaption risk,
- Longer term risk (including relapse risk)
- Breast feeding consideration

Principles of Prescribing



Principles of Prescribing

- Avoid drugs with higher teratogenic risk
- Avoid drugs with the least safety data
- Avoid abrupt discontinuation on confirmation of pregnancy (unless it is **valproate**)
- Avoid polypharmacy, if possible
- Use lowest but still effective dose
- Women who are obese or have poor diet should take folic acid (folate) at a high dose (5 mg)

  Folic acid, ***at best***, provides only **partial** protection re Valproate effects[1]

- [1]Wieck, A. and Jones, S. (2018). Dangers of valproate in pregnancy. *BMJ*, p.k1609.

Principles of Prescribing: Teratogenic Risk

Estimated risk of major congenital malformations (greatest to least teratogenic)

- Valproate
- Carbamazepine
- ***Lithium***
- Lamotrigine
- Antipsychotics
- Antidepressants

SSRIs

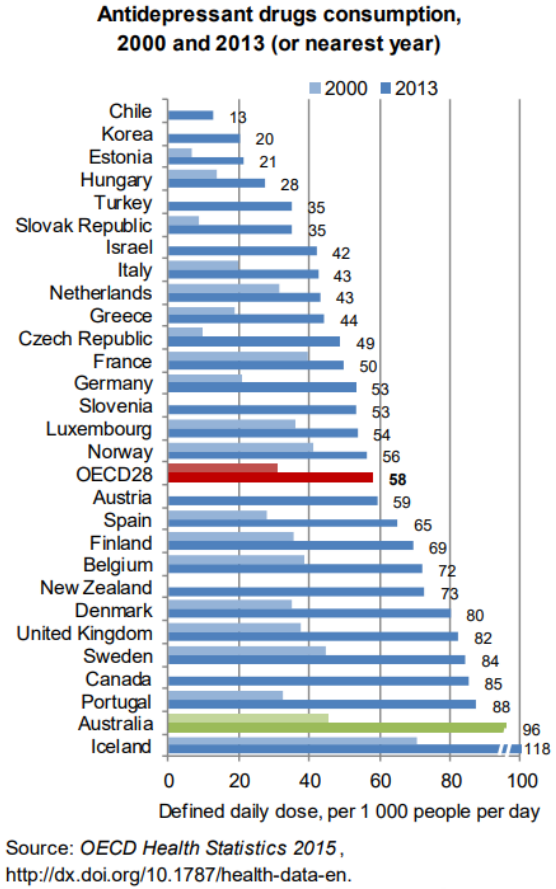
- Specific Serotonin Reuptake Inhibitors
  - SSRIs block the reabsorption (reuptake) of serotonin
  - Little effect on other neurotransmitters

Timing of exposure and potential adverse outcomes

Early pregnancy	Major structural defects
Later pregnancy	Minor structural defects Functional defects (e.g. Valproate linked to developmental delay / Autism Spectrum Disorder Preterm delivery
	Abnormal foetal growth
At delivery	Poor neonatal adaptation syndrome
Postnatal	Cognitive and behavioural effects

SSRI / SNRI Medication

- Very high rates antidepressant prescribing in the community
  - 2nd highest user of antidepressants per capita (around one in 10 adults) among Organisation for Economic Co-operation and Development (OECD) countries excluding the USA.[1]



1. OECD iLibrary. Antidepressant drugs consumption, 2000 and 2015 (or nearest year). Paris, FR: OECD Publishing, 2017. Available at dx.doi.org/10.1787/health_glance-2017-graph181-en

SSRI / SNRI Medication

- No known negative impact on **fertility**
- Not known to increase risk of **miscarriage** above background rate of 10-15%
- Late pregnancy use of SSRIs, SNRIs associated with small increased risk of **post-partum haemorrhage**
- SNRIs and TCAS may be associated with increased risk of **pre-eclampsia**

SSRI / SNRI Medication

- **Birth defects**, no clear evidence for increase in *heart or other birth defects* beyond the 2-3% general population risk
- Increased risk **Persistent Pulmonary Hypertension of the Newborn**
  - From 1:1000 general population rate to 3:1000
  - Sertraline *may be least* likely association
- **Poor neonatal adaptation syndrome**
  - Irritability, jitteriness, temperature instability, feeding difficulties, sleep disturbance, respiratory distress
  - In most cases, onset is 1-2 days postpartum, symptoms are mild and spontaneously resolve within 2-6 days.
  - Severe PNAS requiring treatment uncommon (~3%[1])

1 - Forsberg L, Naver L, Gustafsson LL, Wide K. Neonatal adaptation in infants prenatally exposed to antidepressants--clinical monitoring using Neonatal Abstinence Score. PLoS One. 2014; 9:e111327.

SSRI / SNRI Medication

- **Cognitive deficits / neurodevelopmental disorders** – no consistent data to suggest antidepressant use increases risk[1]
  - Some studies show increased risk
  - Adjusted results this is not maintained
  - Possible results explained by confounding factors – parental mental health, genetics, environmental factors
- **Breastfeeding** - small amount passes into breast milk (usually <5% of maternal dose)
  - No problems reported but extremely limited evidence

1 Suarez EA, Bateman BT, Hernández-Díaz S, Straub L, Wisner KL, Gray KJ, Pennell PB, Lester B, McDougle CJ, Zhu Y, Mogun H, Huybrechts KF. Association of Antidepressant Use During Pregnancy With Risk of Neurodevelopmental Disorders in Children. JAMA Intern Med. 2022 Oct 3;182(11):1149–60. doi: 10.1001/jamainternmed.2022.4268. Epub ahead of print. PMID: 36190722; PMCID: PMC9531086.

Mirtazapine

- Limited information available
  - Case reports have shown healthy outcomes[1]
  - Used for management hyperemesis
- **Birth defects**, no clear evidence for increase in *heart or other birth defects* beyond the 2-3% general population risk
- **Poor neonatal adaptation syndrome**
- **Breastfeeding** - small amounts excreted into milk
  - No serious adverse effects noted
  - Monitor for adverse effects such as drowsiness, poor feeding

1 Uguz F. Low-dose mirtazapine in treatment of major depression developed following severe nausea and vomiting during pregnancy: two cases. Gen Hosp Psychiatry. 2014;36(1):125 e5-6.

Antipsychotics

Typical Antipsychotics

- Risk of prolactinemia: harder to fall pregnant
- Several larger studies which have **not** shown an increased risk of birth defects.
- Babies exposed to haloperidol and chlorpromazine in utero may show extrapyramidal abnormalities for weeks after birth.
- Other suspected withdrawal symptoms following intrauterine exposure to chlorpromazine: paralytic ileus, necrotising enterocolitis, fever, cyanotic spells and transient heart block
- No good long term impacts studies
- No clear lactation limitation studies

Atypical Antipsychotic

- One large scale study which follow exposure of atypical antipsychotic (risperidone, quetiapine, olanzapine and clozapine) did not demonstrate differences in complication other than lower birth weights
- No clear lactation concern

Neurodevelopmental concern

- Two large scale studies (2013/2015): possible cognitive, motor, socio-emotional developmental delay at 2 months of age. But no longer present at 12 months
- Recent smaller scale observational studies suggested concerns with ADHD but poor quality studies

First Generational Antipsychotics

- Haloperidol: First trimester use has been associated with potential limb defects. Potential cardiac abnormalities in third trimester. Other abnormalities in recent larger scale studies were not higher than non-exposure population
- CPZ: fetal hypotonia (dose dependent), EPSE and withdrawal symptoms in neonates. Associated with increased preterm delivery
- Zuclopenthixol: VSD, congenital heart block, and potential congenital cataract

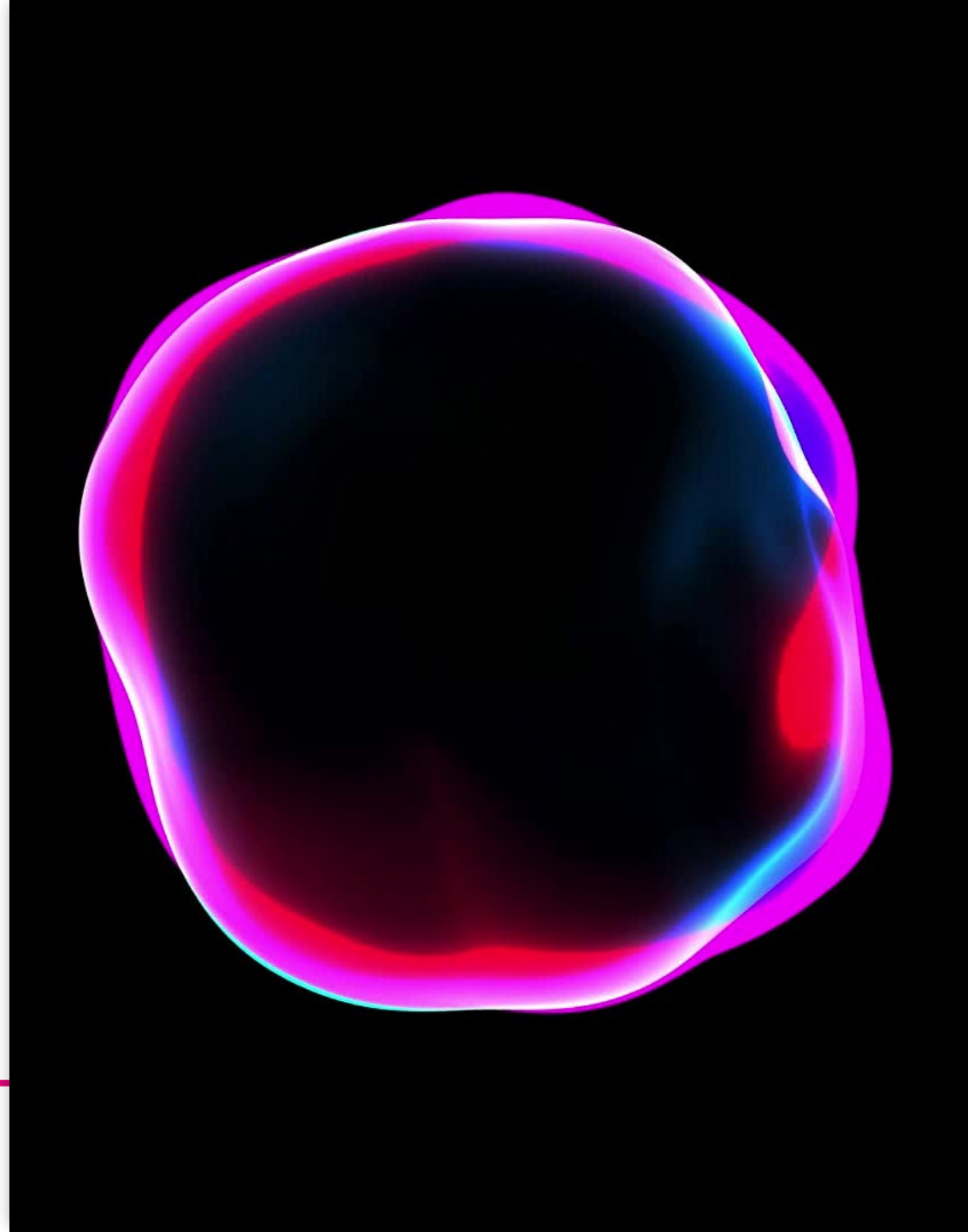
Clozapine

- No increased risk of malformation
- Main observed risk are: floppy baby syndrome, gestational diabetes, risk of neonatal seizures, agranulocytosis in baby (theoretical risk)
- Ideally not to be initiated during pregnancy
- At risk of metabolic impacts in pregnancy
- On the balance of risk, patients on clozapine should be continued if pregnant

Risks to foetus

- Clozapine and norclozapine small enough to cross placental barrier theoretically, but highly protein-bound in non-pregnant populations with a reduction of 20-30% in concentration of protein binding the metabolite in 3rd trimester.
  - Only case series and case reports on neonate concentrations of clozapine

- Neonatal withdrawal/ adaptation syndrome
- Risk of NICU and early paediatric involvement
- Clozapine secretion in breastmilk, and risk of agranulocytosis, seizures, sedation
- No clear evidence of longer term developmental impacts



Olanzapine

- Risk of large for gestation age
- Gestational diabetes
- No clear association with congenital malformation

Quetiapine

- One of the most researched SGAs, likely the lowest placental passage (less variability, most studies average 23.8%)
- Associated with atrial septal defect and cleft lip/palate

Paliperidone

- TGA class C
- Very limited evidence
- European birth monitoring in French and Germany did not note major congenital malformations
- Concerns around hypotonia and potential EPSE. Concerns of preterm delivery and theoretical increased risk of SIDS especially in the first 4 days (based on animal studies)

Depot IMI

- Very limited studies
- Overall risk/benefit analysis apply and current advice is to continue treatment esp with risk of non-compliance
- Given lack of clear evidence against or for, some studies have concluded with avoiding using IMI depo

Lithium

- First trimester exposure associated with Ebstein Anomaly (baseline incidence rate 1/20,000 births in Australia)
- Conflicting and evolving evidence: 2017 large scale cohort studies found adjust prevalence 0.6% vs 0.18% in non-exposed population
- Multiple follow up studies (most up until the age of 6) found no other physical or neurodevelopmental complications

Maternity Psychotropic Assessment Service

- Women in early pregnancy or pre-pregnancy who are taking or have been prescribed psychotropic medications
- Assessment and advice on medication management in pregnancy, including risks and benefits for mother, fetus/baby and lactation
- Single session only consultation service
- Provides written assessment and recommendations

https://www.thewomens.org.au/health-professionals/maternity/maternity-psychotropic-assessment-service

Medicines Information Service

Pharmacist-led service to assist patients and healthcare professionals use medicines safely and effectively

- the safety of prescription and over-the-counter medicines (including complementary and alternative medicines), diagnostic agents and everyday exposures during pregnancy and while breastfeeding
- medicines use in women's health and neonates

Website: https://www.thewomens.org.au/health-professionals/support-services-professionals/medicines-information-service

Phone: (03) 8345 3190

Email: drug.information@thewomens.org.au

Other resources

- https://www.choiceandmedication.org/sahealth/printable-leaflets/
- https://thewomenspbmg.org.au/medicines
- https://mothertobaby.org/fact-sheets/

Questions?

Thank you

For more information, contact:
Dr Charles Su
Ph: 03 8345 2070
Email: charles.su@thewomens.org.au

the women's
the royal women's hospital

Speakers

Parent-Infant Research Institute (PIRI), Heidelberg Repatriation Hospital, Austin Health

Dr Michele Burn is a clinical psychologist with a special interest in perinatal, infant and child psychology.

Brydie Garner is a research officer with a strong background in psychology, focusing on parenting and child mental health outcomes.

MumMoodBooster Program

Dr Michele Burn (Clinical Psychologist) &

Brydie Garner (Research Officer/Program Manager)

Parent-Infant Research Institute (PIRI), Austin Health

MUM space

Supporting your mental and emotional wellbeing during and beyond pregnancy

Presented by Brydie Garner and Michele Burn

www.mumspace.com.au

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Perinatal Depression & Consortium

Parent-Infant Research Institute

Austin Health

PANDA Perinatal Anxiety & Depression Australia

QUT Queensland University of Technology

MONASH University

Jean Hailes for Women's Health

Australian Government Department of Health

Perinatal Mental Health and Wellbeing Program - Continuing Support

We acknowledge the traditional owners of the land on which we join today, the Wurundjeri people of the Kulin Nation, and pay our respects to their Elders, past, present and emerging. We pay our respects to other Elders, and to all Aboriginal and Torres Strait Islander peoples.

We commit to creating a safe and welcoming environment for all Aboriginal people.

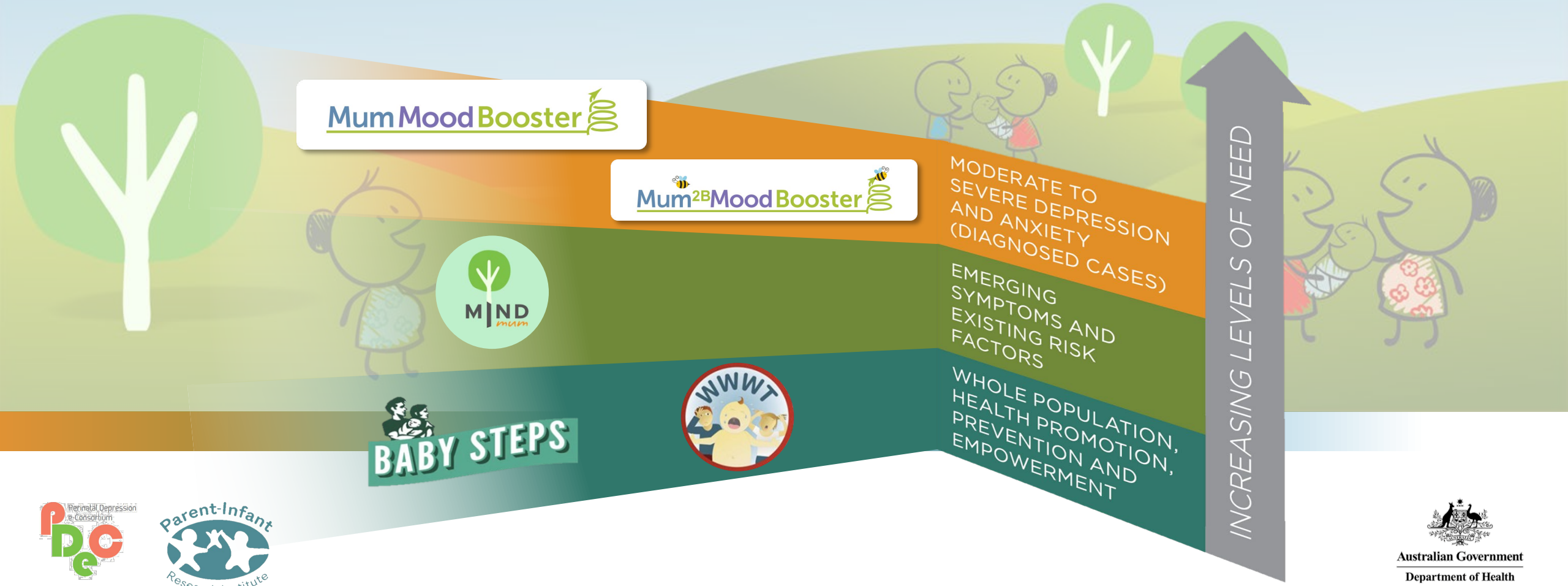
Perinatal Depression & Consortium

Parent-Infant Research Institute

Australian Government
Department of Health

MUM space

MumSpace provides a digital stepped-care approach which includes the **MumMoodBooster** (MMB) treatment programs, **MindMum** smartphone application, and universal supports.



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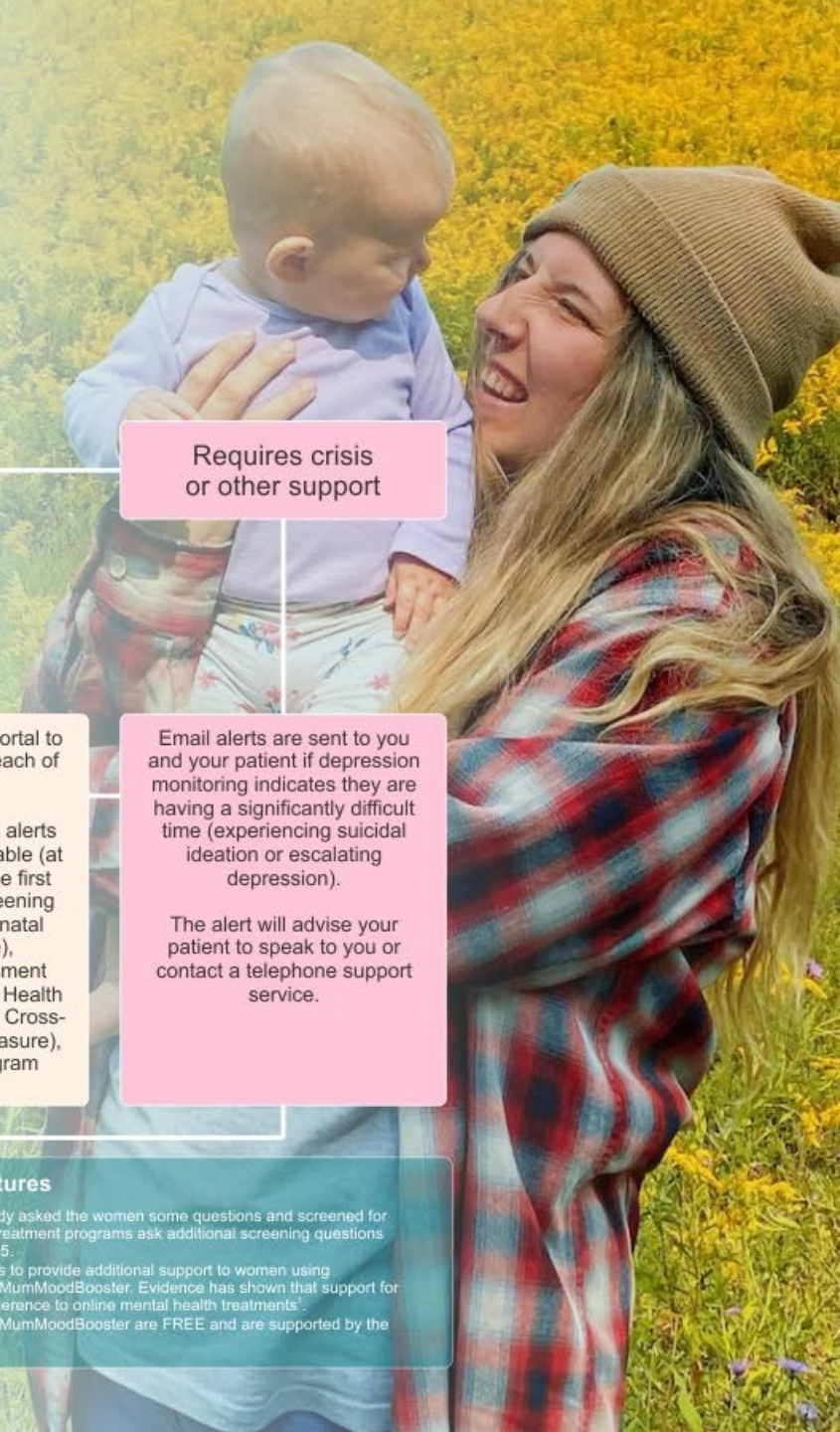
Australian Government
Department of Health

Referring to MumMoodBooster - a guide for Health Professionals



Usual emotional health assessment (routine visits)

Diagnosis of depression or anxiety

Requires crisis or other support

Suggest Self Referral

Supported Referral

Antenatal

Mum2BMood Booster

www.mum2bmoodbooster.com

Free evidence-based online program designed to help women recover from **antenatal depression**.
Six online and personalised CBT sessions.

Postnatal

Mum Mood Booster

www.mummoodbooster.com

Free evidence-based online program designed to help women recover from **postnatal depression**.
Six online and personalised CBT sessions.

Access Clinician Portals

Mum2BMood Booster

admin.mum2bmoodbooster.com

Mum Mood Booster

admin.mummoodbooster.com

Refer your patients to Mum2BMoodBooster or MumMoodBooster using the referral form, which contains your unique referral code.

Once a patient registers for the treatment program using your unique code, she can start using the program.

Your unique referral code can be given to any of your patients.

Access your clinician portal to monitor the mood for each of your patients.

You will receive e-mail alerts when reports are available (at 1, 4 and 8 weeks). The first report will contain screening (The Edinburgh Postnatal Depression Scale), psychological assessment results (PHQ-9 Patient Health Questionnaire), DSM-5 Cross-sectional symptom measure), and her level of program usage.

Email alerts are sent to you and your patient if depression monitoring indicates they are having a significantly difficult time (experiencing suicidal ideation or escalating depression).

The alert will advise your patient to speak to you or contact a telephone support service.

Clinician Portal Features

- While you may have already asked the women some questions and screened for perinatal depression, the treatment programs ask additional screening questions including EPDS and DSM-5.
- Allows health professionals to provide additional support to women using Mum2BMoodBooster and MumMoodBooster. Evidence has shown that support for users will increase the adherence to online mental health treatments[1].
- Mum2BMoodBooster and MumMoodBooster are FREE and are supported by the Australian Government.

Your suite of evidence-based parent-infant programs.
www.piri.org.au

[1]Mohr, D. C., Cuijpers, P., & Lehman, K. (2011). Supportive accountability: a model for providing human support to enhance adherence to eHealth interventions. *Journal of medical Internet research*, *13*(1), e30.

MUM space

MumMoodBooster is our central CBT treatment designed to ***innovatively deliver the benefits of a face-to-face CBT treatment*** for women who are experiencing antenatal or postnatal depression. Includes Phone Coach Support for High-Risk Users and email alerts with links to help.

Perinatal Depression & Consortium

Parent-Infant Research Institute

Mum Mood Booster

Mum2B Mood Booster

Australian Government
Department of Health

Research Evidence for MumMoodBooster

2012 International Collaboration. **Formative Research, Consumer Co-Design & Testing (Focus Groups)**

2013 International Multi-Site Feasibility Trial on MMB. revealed excellent adherence and acceptability (87% completed all 6 sessions). **90% Remission**

2016 Australian Randomised Controlled Trial on MMB. found program to be highly effective
4 x as effective as standard care, even for severe symptoms. **2-Group RCT (N = 48): Excellent Adherence; 4-Fold increase in Remission vs Standard Care**

2021 Australian NHMRC funded Randomised Controlled Trial on MMB. **RCT with DSM-diagnosed Depressive Disorders 3-Group RCT** found program to be highly effective. MMB as effective as face to face, even for severe symptoms. **Efficacy in Superior to TAU in terms of symptom reduction for both depression and anxiety (p<.05) ; At least as good as FTF CBT in producing Remission from Depressive Episode; Superior to FTF CBT in terms of symptom reduction for depression (p<.05)**

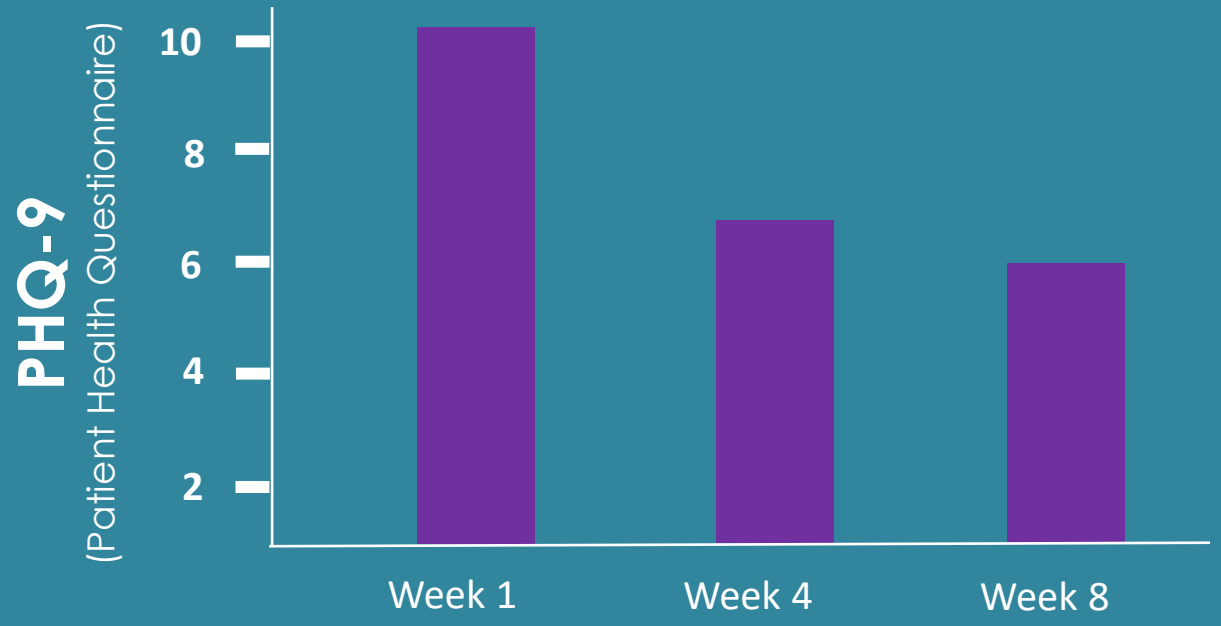
2022 Australian Antenatal version M2B Feasibility Trial. **74% Adherence, 50% symptom reduction.**

2023 United States MMB2. **Feasibility trial At pretest, 55% (29/53) of participants met PHQ-9 criteria for minor or major depression. At posttest, 90% (26/29) no longer met criteria.**

Benefits in the real world

MumMoodBooster (MMB) is one of the first online CBT evidence-based program shown to be effective for perinatal women with diagnosed depression.

The program has shown benefits in the real world, with rapid symptom reduction as measured by the PHQ-9.



Each **year** in Australia…

3o0,000 Births

60,000 depressed mums

48,150 MumSpace Visits

Many women have used MMB programs to overcome PND

~2,000 program Registrations per annum

MumMoodBooster Benefits

Increased access to care: MMB can be accessed online from anywhere in Australia, making it easier for women to receive the care they need.

Effective treatment: MMB has been shown to be as effective as face-to-face CBT for women with diagnosed depressive disorders.

Flexible delivery: MMB can be used as standalone treatment, to manage waitlists, or as a tool for therapists to shorten treatment times.

Easy to use: The dedicated clinician portal makes it easy for health professionals to use MMB with their patients.

Danaher, B. G., Milgrom, J., Seeley, J. R., Stuart, S., Schembri, C., Tyler, M. S., ... & Lewinsohn, P. (2012). Web-based intervention for postpartum depression: Formative research and design of the MomMoodBooster program. *JMIR research protocols*, *1*(2), e18.

Danaher, B. G., Milgrom, J., Seeley, J. R., Stuart, S., Schembri, C., Tyler, M. S., ... & Lewinsohn, P. (2013). MomMoodBooster web-based intervention for postpartum depression: feasibility trial results. *Journal of medical Internet research*, *15*(11), e242.

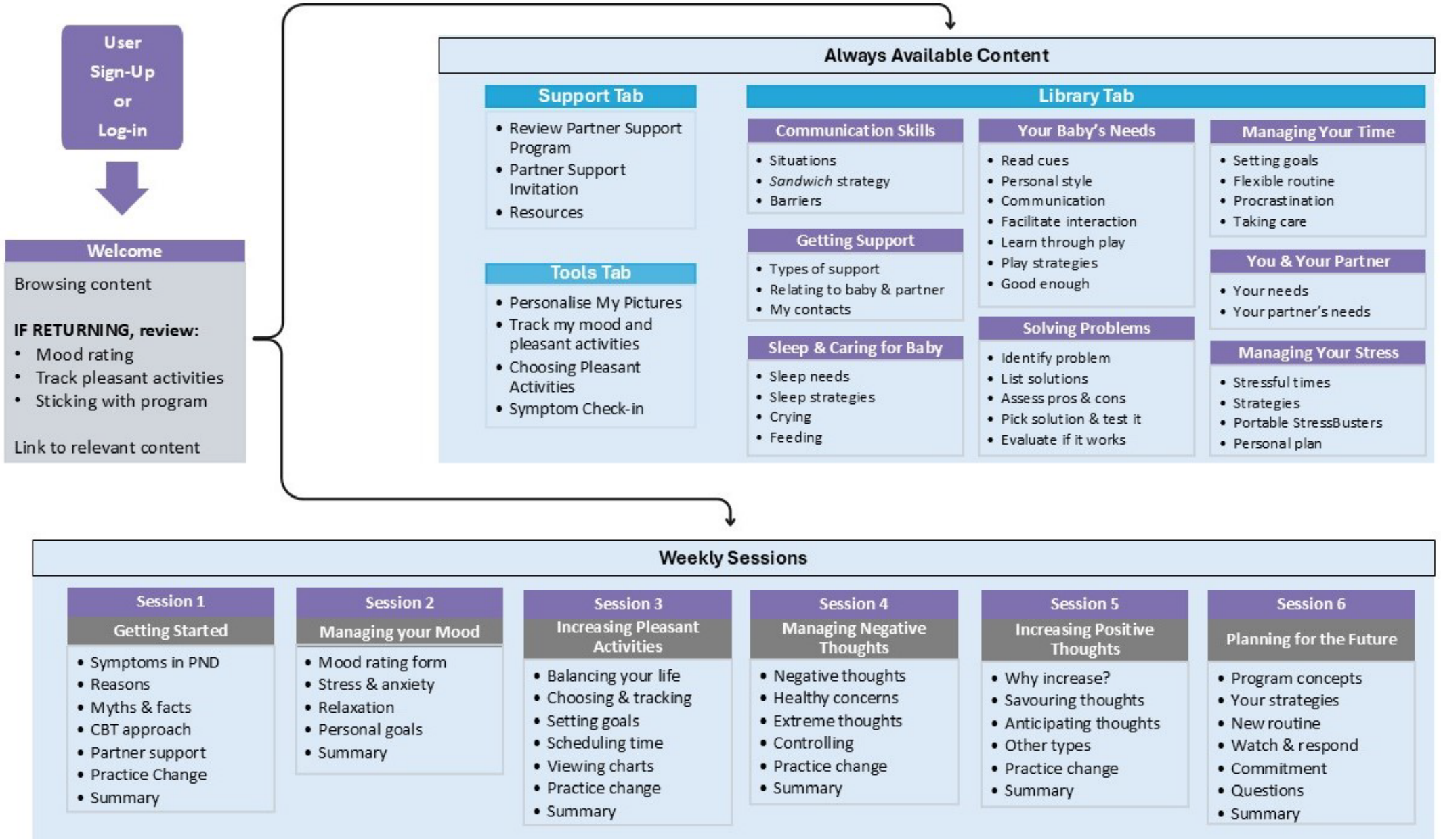
Milgrom, J., Danaher, B. G., Gemmill, A. W., Holt, C., Holt, C. J., Seeley, J. R., ... & Ericksen, J. (2016). Internet cognitive behavioral therapy for women with postnatal depression: a randomized controlled trial of MumMoodBooster. *Journal of Medical Internet Research*, *18*(3), e54.

Adding motivational SMS and ‘coaching’ to online interventions

Low intensity adjunctive phone or email coaching for higher risk users (EPDS greater than 15) has been shown to:

- Improve effect sizes
- Treatment adherence
- Provides a secondary “**safety net**” for those who experience symptom worsening
- SMS motivational messages also increases engagement

What is inside MumMoodBooster?



Mum2BMoodBooster

What about depression in pregnancy?

Mum2BMoodBooster has been adapted from the MumMoodBooster program for women who are depressed during pregnancy.

The structure of the program and content is similar to MumMoodBooster and is tailored to the specific needs of women during pregnancy.

Led by the Parent-Infant Research Institute

Perinatal Depression e-Consortium

MUM space

Parent-Infant Research Institute

Australian Government
Department of Health

Perinatal Depression Consortium

MumMoodBooster

Mum2BMoodBooster

New Development: Clinician Portal

Integrate MumMoodBooster and Mum2BMoodBooster seamlessly and securely into your practice through our Clinician Portals.

1.Register an account and access your unique code for mothers to access the program.

2. Self-assessment on registration (EPDS and DSM-5).

3.Monitor mother's engagement and symptom improvement.

4. Mother receives a risk alert if her symptoms escalate (copy to clinician).

REGISTER HERE

www.mumspace.com.au

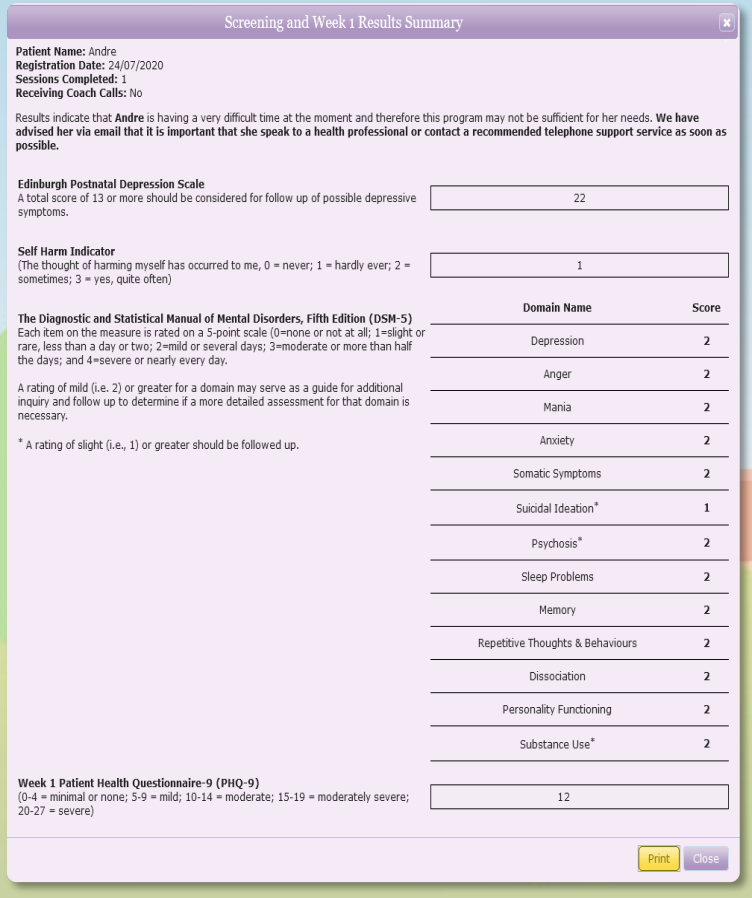
SCAN ME

DOWNLOAD BROCHURE

SCAN ME

Clinician Portal

Screening and Activity Summary



Screening and Week 1 Results Summary

Patient Name: Andre
Registration Date: 24/07/2020
Sessions Completed: 1
Receiving Coach Calls: No

Results indicate that **Andre** is having a very difficult time at the moment and therefore this program may not be sufficient for her needs. **We have advised her via email that it is important that she speak to a health professional or contact a recommended telephone support service as soon as possible.**

Edinburgh Postnatal Depression Scale
A total score of 13 or more should be considered for follow up of possible depressive symptoms. 22

Self Harm Indicator
(The thought of harming myself has occurred to me, 0 = never; 1 = hardly ever; 2 = sometimes; 3 = yes, quite often) 1

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)
Each item on the measure is rated on a 5-point scale (0=none or not at all; 1=slight or rare, less than a day or two; 2=mild or several days; 3=moderate or more than half the days; and 4=severe or nearly every day.

A rating of mild (i.e. 2) or greater for a domain may serve as a guide for additional inquiry and follow up to determine if a more detailed assessment for that domain is necessary.

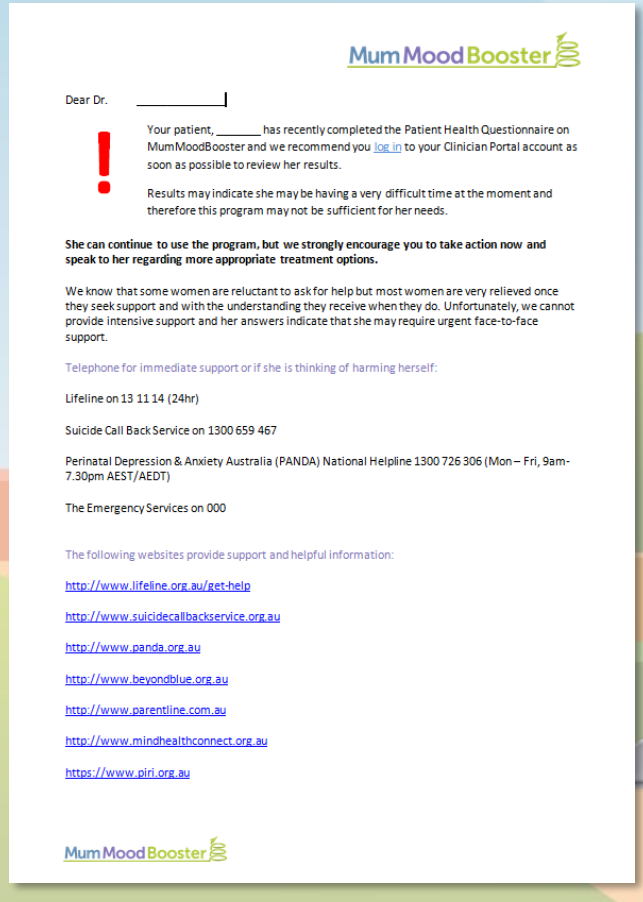
* A rating of slight (i.e., 1) or greater should be followed up.

Domain Name	Score
Depression	2
Anger	2
Mania	2
Anxiety	2
Somatic Symptoms	2
Suicidal Ideation*	1
Psychosis*	2
Sleep Problems	2
Memory	2
Repetitive Thoughts & Behaviours	2
Dissociation	2
Personality Functioning	2
Substance Use*	2

Week 1 Patient Health Questionnaire-9 (PHQ-9)
(0-4 = minimal or none; 5-9 = mild; 10-14 = moderate; 15-19 = moderately severe; 20-27 = severe) 12

Print Close

Notification of risk alerts sent to patients



Mum Mood Booster

Dear Dr. _____

Your patient, _____ has recently completed the Patient Health Questionnaire on MumMoodBooster and we recommend you log in to your Clinician Portal account as soon as possible to review her results.

Results may indicate she may be having a very difficult time at the moment and therefore this program may not be sufficient for her needs.

She can continue to use the program, but we strongly encourage you to take action now and speak to her regarding more appropriate treatment options.

We know that some women are reluctant to ask for help but most women are very relieved once they seek support and with the understanding they receive when they do. Unfortunately, we cannot provide intensive support and her answers indicate that she may require urgent face-to-face support.

Telephone for immediate support or if she is thinking of harming herself:

Lifeline on 13 11 14 (24hr)

Suicide Call Back Service on 1300 659 467

Perinatal Depression & Anxiety Australia (PANDA) National Helpline 1300 726 306 (Mon – Fri, 9am-7.30pm AEST/AEDT)

The Emergency Services on 000

The following websites provide support and helpful information:

http://www.lifeline.org.au/get-help

http://www.suicidecallbackservice.org.au

http://www.panda.org.au

http://www.beyondblue.org.au

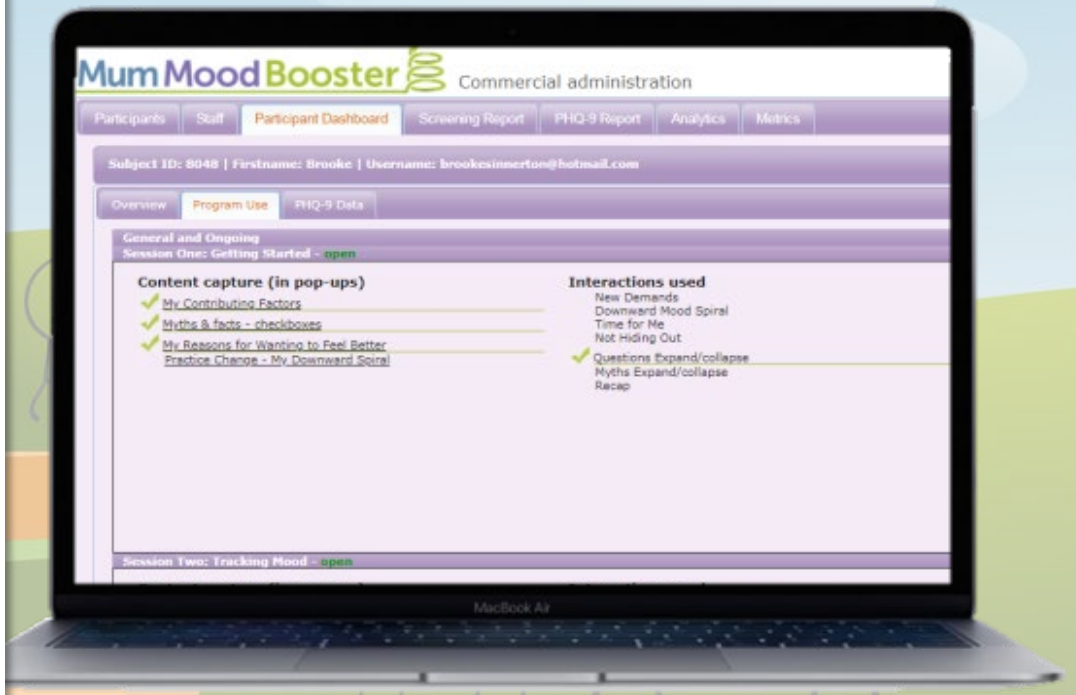
http://www.parentline.com.au

http://www.mindhealthconnect.org.au

https://www.piri.org.au

Mum Mood Booster

Clinicians can integrate MumMoodBooster Programs into their practice via the portal



New Responsive Design

Mum Mood Booster

Mum2B Mood Booster

Feedback

Thank you for listening, and we hope you find the clinician portal helpful as part of your practice. It would be great to get your feedback about the clinician portal as you use it to help us improve it.

Specifically:

- What is working?
- How easy was the portal to navigate?
- What did you like about the portal?
- What isn't working?
- What else would be beneficial to have on the clinician portal?
- Any other feedback?

REGISTER HERE
www.mumspace.com.au

SCAN ME

MumMoodBooster Clinician Portal

Refer to MumMoodBooster for additional screening and to monitor your your patients symptoms and risk.

MumMoodBooster is a great complement to face-to-face services and is available 24/7 when and where support is needed.

Parent-Infant Research Institute

Investing in the earliest years to build a brighter future.

https://www.mumspace.com.au/

Contact us via email at piri@austin.org.au or

brydie.garner@austin.org.au

Australian Government
Department of Health

Perinatal Depression e-Consortium

MUM space

Increasing access to abortion health care in north east Melbourne

- A joint initiative to increase access to early medical abortion (EMA) in primary care settings in north east metro Melbourne
- Identified need for improved access in Hume, Whittlesea and Yarra Ranges LGAs
- Healthcare providers are encouraged to consider becoming a publicly list EMA provider, and/or providing patients with information other local services

To discuss becoming a listed EMA provider, or for further information, use the contact request form here

Project partners:

North Eastern Public Health Unit (NEPHU)
North Western Melbourne Primary Health Network
Women's Health in the North
Women's Health East
1800 My Options

Further information:

https://nephu.org.au/news-and-events/ema-access

https://www.1800myoptions.org.au/for-professionals/become-an-mtop-provider/

NEPHU NORTH EASTERN PUBLIC HEALTH UNIT

Save the date!

Shared Maternity Care Workshops

Tuesdays 8 & 15 October, 7-9pm online

Hosted by the Shared Maternity Care Collaborative (The Women's, Mercy Health, Northern Health & Western Health)

Register via NWMPHN website:

https://nwmphn.org.au/resources-events/events/

Thankyou

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or visit thewomens.org.au/health-professionals/for-gps/

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the royal women's hospital

Session Conclusion

We value your feedback, let us know your thoughts.

Scan this QR code

You will receive a post session email within a week which will include slides and resources discussed during this session.

Attendance certificate will be received within 4-6 weeks.

To attend further education sessions, visit,

https://nwmphn.org.au/resources-events/events/

https://nwmphn.org.au/resources-events/resources/