

WPA Perinatal mental health position statement

Mental disorders are among the most common health problems of pregnancy and the year after birth (the perinatal period), with >10% of women in high income settings experiencing a disorder, and >25% in many low and middle income countries (LMICs) (Fisher et al 2012; Howard et al 2014). Until recently, research and healthcare services have focused on depression, particularly postnatal depression, but a growing evidence base has accrued on the importance of other primary and comorbid disorders, particularly bipolar disorder, anxiety disorders (post-traumatic stress, obsessive-compulsive, panic and generalized anxiety disorders), psychosis, eating disorders and personality disorder in both the antenatal and postnatal period (Howard et al 2014; Jones et al, 2014; Wisner et al, 2013). Far from being protective, the perinatal period is a time when there is an increased risk of psychiatric episodes such as postpartum psychosis, with bipolar disorder being a significant risk factor. 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 behavioural, cognitive and emotional problems internationally; 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).

Risk factors include 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).

A growing global literature supports the efficacy of psychosocial and psychological interventions for mild to moderate disorders (Rahman et al 2013) and for pharmacological interventions for moderate to severe disorders (Jones et al 2014). There are limited data on the long term impact of medication on children exposed in utero and during lactation (Howard et al 2014; Jones et al 2014), but the risks of disorders, which are associated with adverse maternal and child outcomes, need to be considered

when considering the type of treatment needed. Services vary internationally (Baron et al 2016), and are rare in LICs but interventions may be cost-effective when integrated with maternity and postnatal healthcare/primary care (Rahman et al 2013). Especially for mild disorders, these can be delivered effectively by trained lay health workers and community workers (Clarke et al 2013; Rahman et al 2013; 2015) and are available to access (e.g. http://apps.who.int/iris/bitstream/10665/152936/1/WHO_MSD_MER_15.1_eng.pdf?ua=1&ua=1). Interventions should address risk factors and associated problems (e.g. poor nutrition, smoking, partner violence) 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 cessation, 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).

Recommendations:

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

1. WPA recommends that mental health data include information on whether women are pregnant, have recently experienced any obstetric issues (pregnancy loss, fertility treatment, surgery) or have recently given birth.
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.
3. WPA calls for integration of psychosocial assessments and core packages of mental health services into routine antenatal and postnatal care and 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. Healthcare professionals should receive appropriate training.
4. WPA calls for all health professionals and other care providers to look beyond depression and also focus on other symptoms of anxiety, PTSD, somatic symptoms (as potential indicators for

depression) and psychotic disorders. Women with severe mental illnesses need to be recognised as a high risk group requiring co-ordinated obstetric, paediatric and mental health care.

5. 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.

6. WPA urges 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.

7. 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.

8. WPA urges 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.

9. 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.

10. 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.

11. 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.

12. WPA recommends developing, evaluating and implementing interventions for health promotion and enhancement of maternal well-being, 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.

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