Public Health Association AUSTRALIA

Perinatal and Infant Mental Health and Wellbeing

Policy Position Statement

Key messages: New parents and their infants must be supported to achieve their optimum mental health and wellbeing. This involves initiatives to promote and protect their mental wellbeing, the implementation of culturally appropriate, routine universal antenatal and postnatal screening programs and treatment of mood and relational difficulties.

Key policy positions:

1. Promote access to the protective factors that holistically support the mental health and wellbeing for new and expectant parents and their infants.
2. Advocate for infant-led practices within healthcare systems and community service organisations.
3. Advocate for policy and legislation which results in equitable and inclusive community environments in which parents and infants can achieve optimal mental health during the antenatal and postnatal periods.
4. Support the development/adaptation of perinatal mental health care guidelines for Aboriginal and Torres Strait Islander communities, families from CALD, migrant and refugee-like backgrounds, gender diverse families, those in rural/remote areas, secondary caregivers, and partners.
5. Encourage further research on evidence-based strategies to prevent, detect and manage perinatal and infant mental health issues.
6. Advocate for increased allocation of resources (e.g., funding and workforce development) in perinatal and infant mental health services.

PHAA is committed to inclusion and respect for our members and the wider community. PHAA acknowledges that some individuals who undergo perinatal mental health issues do not identify as women.

Audience: Federal, State and Territory Governments, policymakers and program managers, PHAA members, media.

Responsibility: PHAA Mental Health Special Interest Group

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Perinatal and infant mental health and wellbeing

Policy position statement

PHAA affirms the following principles:

1. Good perinatal mental health is an asset to the mother, father, infant and surrounding community. Pregnancy, childbirth, the postpartum period and early parenthood are life-altering moments and can be stressful for some women and their partners.[1, 2] Supporting parents during this time is important.
2. Some populations face unique challenges during this period. Aboriginal and Torres Strait Islander people, people with culturally and linguistically diverse (CALD), migrant and refugee backgrounds, women experiencing intimate partner violence, and LGBTIQ+ people often face additional challenges to their mental health in the perinatally. [3] They may require additional and/or tailored supports.
3. Good perinatal and infant mental health literacy (knowledge) can enable parents to care for their mental health and recognise emerging difficulties. It should be improved through provision of resources by health professionals and non-government perinatal mental health agencies and mental health organisations (https://panda.org.au/, blackdoginstitute.org.au, https://www.aaimh.org.au/).
4. Prevention involves reducing risk factors and promoting protective factors. More initiatives need to be developed to increase the availability of preventive mental health care for new and expectant parents.
5. Early detection and intervention to address perinatal depression and anxiety can significantly benefit new parents and their infants.
6. Timely, affordable access to national and local level programs for parental health surveillance and a range of culturally appropriate and non-stigmatising perinatal mental health services are needed.

PHAA notes the following evidence:

7. Several factors are associated with mental ill health during the perinatal period such as low socioeconomic status, a lack of social support, sleep problems, a difficult partner relationship, intimate partner violence, multiple or unintended pregnancies, alcohol and other drug use, history of mental ill health, and unequal distribution of household responsibilities and chores. [4-9]
8. Perinatal mental illness is a common and major public health issue in Australia. Any mental illness present during pregnancy and/or the first 12 months after birth is considered a 'perinatal mental illness'. [10, p.4] With anxiety and depression being the most common during the perinatal period.[11]
9. At least 20% of new mothers and 10% of new fathers or partners are likely to experience perinatal anxiety and/or depression (PNDA). With about 600,000 people becoming parents in Australia yearly, it can be estimated that roughly 60,000 mothers and 30,000 fathers or partners will suffer from PNDA.[10]
10. During the perinatal period women may also experience other less frequent but still significant disorders such as posttraumatic stress disorder (PTSD), bipolar disorder, and schizophrenia.[10] Approximately one to two new mothers in every 1,000 may develop postnatal psychosis. [10, 11]

11. In 2018, suicide was one of the leading causes of maternal deaths in Australia, making up approximately 20% of postpartum deaths.[12]

12. While there is less research on the mental health of fathers during the perinatal period, [10] a recent review, found the prevalence of anxiety in men during the antenatal period ranged between 3.4% and 25%, while during the postnatal period it ranged from 2.4% to 51%.[13] Having a partner with a mental illness is a risk factor for paternal perinatal mental illness.[10]

13. In Australia, suicides are not officially recorded for fathers. However, the age range (25-34 years) when most men become fathers also coincides with the highest rate of male suicide.[14]

14. Fathers with mental ill-health may not be able to support their pregnant partner or care for their infant. Fathers' lack of support is associated with PNDA in mothers[15], and a father's depressive symptoms during a child's infancy can cause behaviour problems in the child at preschool age.[16, 17]

15. Infant mental health usually refers to the first three years of life and is defined as 'the young child's capacity to experience, regulate, and express emotions, form close and secure relationships, and explore the environment and learn'.[18, p.4] Behaviours outside the normal developmental pattern may indicate mental health struggles among infants.[19]

16. In Australia, the cost of poor infant mental health is unknown. Infants and children (aged 0-12 years) experiencing mental health issues have limited access to and utilisation of specialised mental health services.[20] Prevention and early intervention are cost-effective and can help avoid extensive use of mental health services in later stages of childhood.[19]

17. Certain communities face higher risks of PNDA, as well as obstacles to obtaining appropriate services and timely detection and support, discrimination, increased emotional stress, physical health problems, economic hardship, isolation, and conflict related to traditional parenting roles which can further discourage them from seeking help during a crisis period.[10, 21-24] At-risk communities include:

    - LGBTIQ+ parents
    - Parents in rural areas
    - Parents with Aboriginal and Torres Strait Islander backgrounds
    - Parents with CALD, migrant and refugee-like backgrounds
    - Parents of children with developmental disability (e.g. autism, cerebral palsy)
    - Parents with intellectual disabilities

18. In 2019, the economic burden of PNDA amounted to $877 million due to health costs, productivity losses (e.g. increased workforce exit, absenteeism and caregiving requirements) and social and wellbeing impacts of PNDA (e.g. increased likelihood of developmental issues).[25]

19. In Australia, there has been significant improvements in perinatal mental health screening rates.[26] However, despite these improvements, antenatal and postnatal mental health screening is still not universal, and some women are not screened in accordance with clinical practice guidelines.[3, 27, 28]

20. Research suggests that older mothers, who are considered higher-risk, are 35% less likely to be screened during and after pregnancy compared to younger mothers.[26]

21. Barriers to implementation of antenatal mental health screening include a lack of time, funding, follow-up infrastructure, and inadequate training among healthcare providers.[3, 29] Healthcare professionals often find the identification and management of PNDA challenging, with limited knowledge on how to effectively integrate mental health screening into antenatal care.[30, 31]

22. Mobile technology can effectively provide timely and relevant information to new fathers during the antenatal and postnatal period.[32] Internet-based screening programs are well-received and can identify at-risk pregnant individuals for improving mental health during pregnancy.[27]

23. Cognitive-behavioural therapy, interpersonal therapy, social and peer support, improving sleep hygiene, self-help and physical activity programs (e.g. integrated yoga and pram walking exercise) have been shown to improve perinatal mental health outcomes for women with symptoms of perinatal depression.[3]

24. Family-centred interventions can help improve service delivery for parents with intellectual disabilities.[33]

25. Effective perinatal mental health interventions for parents and infants require a comprehensive and multi-faceted approach. This should be informed by an understanding of various factors, including the secure infant-caregiver attachment framework, cultural context, parental histories (like adverse childhood experiences), and socioeconomic factors such as housing, education and employment.[1]

26. This policy would help to advance UN Sustainable Development Goal 3-Good Health and Wellbeing.

PHAA seeks the following actions:

27. Increase funding for the development and implementation of initiatives that focus on promoting mental wellbeing and preventing mental health difficulties during the perinatal period.

28. Increase public awareness of perinatal mental health, reduce stigma and promote help-seeking behaviours.

29. Advocate for evidence-based and culturally appropriate interventions for Aboriginal and Torres Strait Islander communities, parents with CALD, migrant and refugee-like backgrounds, and LGBTQI+ families.

30. Implement a national screening program for perinatal mental health issues to identify at-risk parents and infants. This would involve perinatal mental health re-training of relevant health professionals (e.g., midwives, obstetricians).

31. National service standards for perinatal mental health assessment, treatment, and service delivery.

32. Encourage perinatal mental health research and programme development and delivery be co-designed with at-risk communities and individuals with lived experience.

33. Evaluate and enhance perinatal mental health services within sexual and reproductive healthcare, ensuring inclusion of infants in delivering care. As well as considering the impact of experiences such as fertility treatments, miscarriage, abortion and sexual abuse or domestic violence on mental health.

34. Encourage health departments to develop and implement targeted services and programs for new fathers and parents of children with disabilities. As well as foster local partnerships among health services, community organisations and peer support groups.

PHAA resolves to:

35. Advocate for the above steps to be taken based on the principles in this position statement.

ADOPTED September 2023

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