UPPSALA HEALTH SUMMIT POST-CONFERENCE BRIEF

Pathways to Lifelong Mental Wellbeing
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Addressing Peripartum Depression

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Background

Depression is one of the world's most common psychiatric conditions, and depressive disorders rank among the leading causes of years lived with disability worldwide. Perinatal depression is considered a major depressive non-psychotic episode with onset either during pregnancy or within 4 weeks after delivery. Depression during pregnancy, namely antepartum depression, has a global estimated prevalence that ranges from 15% to 65%. In fact, antepartum depression is more prevalent in low-income countries, with an estimated prevalence of 34.1%. Postpartum depression is similarly more frequent in low-income countries, where the estimated prevalence is around 20%, while globally it is about 17%. Mood disorder episodes during pregnancy and in the postpartum period are associated with suffering for the whole family. Untreated depression during pregnancy is associated with higher risks of both preterm birth and low birth weight. In addition, peripartum depression may have long-term effects on maternal bonding, child development and the mother's future mental and even somatic health. Every year in Sweden, approximately four women take their lives around the time of childbirth, highlighting the importance of early detection.

Risk factors that we need to consider when trying to detect peripartum depression include a history of depressive episodes, low socioeconomic status, and inadequate partner support. Further, some biological risk factors have been established, including substantial changes in the hormonal milieu, such as the abrupt fall of oestrogen and progesterone levels after childbirth.

Validated questionnaires for depression (e.g., the Edinburgh Postnatal Depression Scale [EPDS]) are used to improve detection rates. However, it has been reported that only a small proportion of women with symptoms (as small as 6% in some cases) are identified and adequately treated in routine healthcare. Our current ability to predict the development of peri-partum depression, especially among first-time mothers, is deficient. To achieve good prediction, high-quality data from representative samples of the population, collected using modern methodologies, are needed.

Apart from the practical difficulties of identifying depression due to the overlap of cardinal symptoms of depression and normal experiences of the early postpartum period, there is generally poor knowledge about mental illness among expectant and new parents, and there is still a taboo surrounding the problem. This causes many to suffer in secret.

For those identified, new drug preparations based on allopregnanolone actions and transcranial magnetic stimulation treatment, for which there are promising preliminary results, are emerging as more effective treatment options for women with peripartum depression. However, because prevention should always be considered superior to treatment, efforts in the field of prevention are strongly encouraged. There are efficient psychological and psychosocial methods for preventing PPD, i.e., cognitive behavioural therapy (CBT), interpersonal psychotherapy (IPT) and peer support. However, such preventions are cost effective only among high-risk women. Therefore, better prediction models could enable us to design adequate prevention interventions.

Approach

The objective of the workshop was to address depression around the time of childbirth, focusing on what underlies the continued stigma associated with peripartum depression and what concrete actions should we take to fight it. There are several questions we might pose: Do women become sick of becoming mothers, why it is important to start addressing depression around childbirth and its consequences, and how we can improve early identification of women at risk so that we can offer preventive interventions?

The workshop was attended by 15 participants. Because we aimed to take an interdisciplinary approach, experts from obstetrics, psychology, psychiatry, information technology, epidemiology and economics were invited. Besides these experts, the panel and audience consisted of users' organizations from Sweden and Norway, participants from the Philippines, Ghana and Kenya, and PhD students from Uppsala University and the WOMHER centre.

The workshop opened with an inspirational speech by Professor John Cox. The question of childbirth as a life event was brought to light, and biological, sociocultural and psychodynamic aspects of perinatal depression were problematized around it.

The speech was followed by shorter presentations from Professor Alkistis Skalkidou, who discussed the gap in depression rates between men and women, the challenge of diagnosing mental ill health during pregnancy due to symptom similarities to the period after childbirth, and the relatively stable rates of maternal suicide. Lastly, the importance of prevention, and how it can be achieved using user-friendly methods, was discussed.

The next presentation by Associate Professor Emma Fransson focused on how the Swedish healthcare system functions for women in the perinatal period. Problems in the system that have led to 1 out of 3 mothers not being offered screening for mental ill health after pregnancy were discussed. Fransson stressed that the mothers who are missed are mainly those with known risk factors for perinatal depression as well as that Sweden lacks perinatal mental health teams and mother-baby units.

Malin Henriksson and Karin Lindholm, representatives of the Swedish user organization "Mamma till Mamma" (mother to mother), introduced their organization as one focusing on peer support, information distribution via, among other methods, interviews and videos online on social media, and efforts to positively influence decisions affecting the care of these patients.

Lastly, Associate Professor Erica Lindahl presented the major gap in both income and sick leave between men and women and how this gap greatly increases after the birth of the first child. Further, the lack of further improvement by making a generous parental leave system even more generous was presented.

The participants were then divided into two break-out rooms to engage in more in-depth discussion.

The break-out rooms focused on **stigma and possible prediction possibilities.** Discussions concerned how using the term "mental health problems" vs. "mental disorders" might be helping to lift the stigma. Additionally, awareness needs to be raised among all pregnant women, healthcare staff, authorities, and the press. All women need to hear about the possibility of mental ill health around the time of childbirth during their visits to maternal healthcare centres, in exactly the same way as they hear about the risk for diabetes, anaemia or high blood pressure.

One important point considered was that women who suffer from PPD do not form a cohesive group. Instead, due to their different characteristics, they tend to create different subgroups that make treatment choice and effect challenging. Screening during pregnancy may also need to become a routine process in Sweden, where user-friendly and culturally adapted assessments should be offered to all. Of note was the comment regarding the research on the tools doctors could utilize to screen and immediately refer to other mental health professionals. Moreover, the cost effectiveness of some ongoing screening interventions during pregnancy should be evaluated. Screening data are not included in quality and national registers in Sweden at this time. This should be encouraged, as it would allow us to closely monitor whether guidelines are followed as well as to study interventions and identify areas in need of improvement.

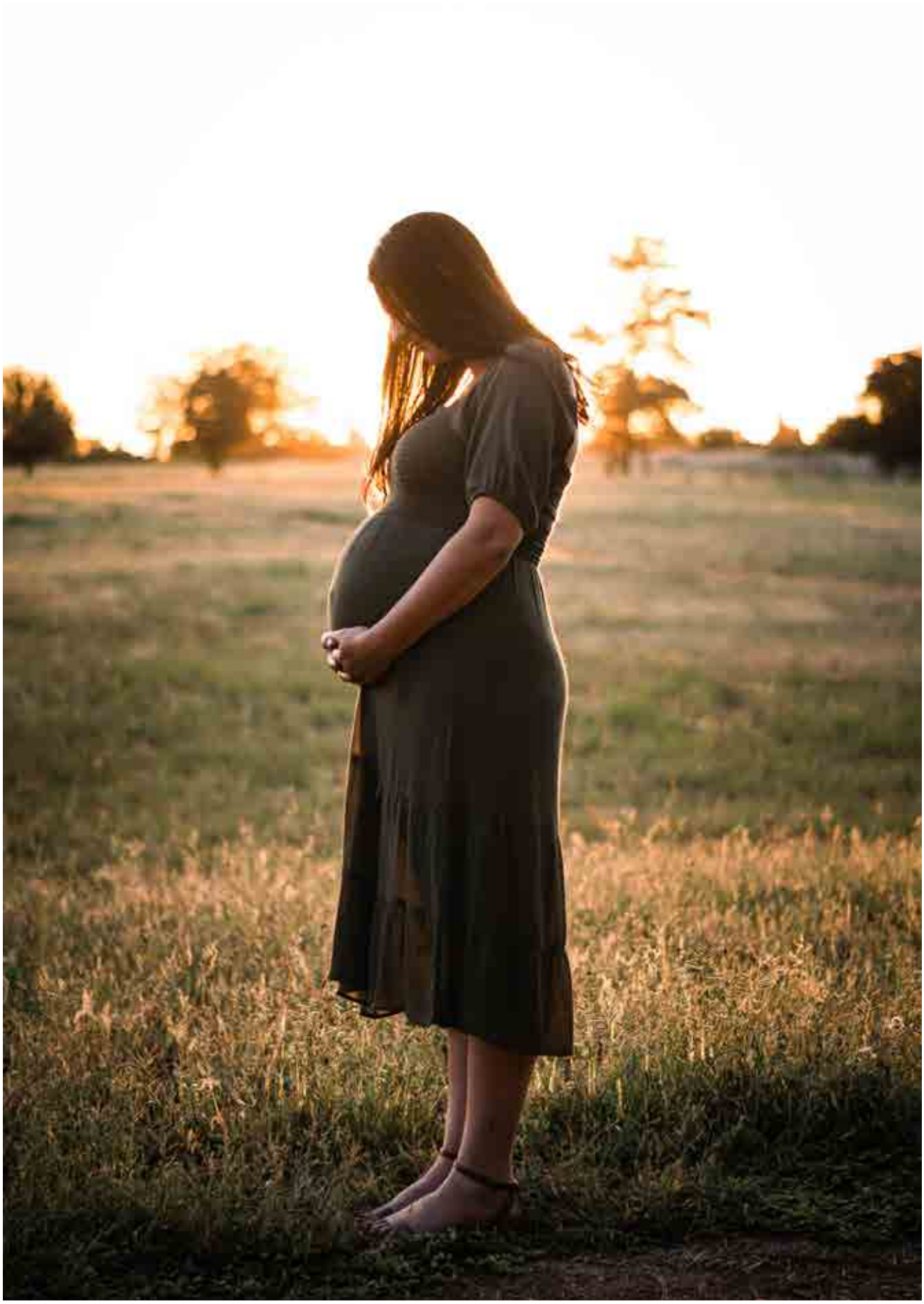
Work in this area can be further facilitated by multidisciplinary teams that work diligently to increase efficacy in screening and offer different treatment options, as well as by taking advantage of all contemporary resource-effective solutions, like telepsychiatry and robotics solutions, once these have been evaluated for effectiveness and safety. Specialized education programmes for perinatal mental health among psychiatrists, psychologists, general practitioners and midwives – which are available in some countries — should be encouraged. The aforementioned suggestions will lead us towards a rather personalized healthcare model, focused on prevention and respect for the culture, needs and values of each woman.

There was a discussion on the important data presented on women's earnings, which tend to decrease or stay stable around the childbirth years, while men's earnings increase. Policies concerning parental and sick leave need to be implemented in an effort to minimize their impact on the pay gap and mental health.

Recommendations

Based on our inspirational talks and discussions in the workshop, we put forward the following recommendations, which require collaboration between state agencies, organizations related to maternal health and healthcare professionals.

- Evaluate and implement methods to reduce the stigma surrounding perinatal mental ill health
- Focus on early risk identification and preventive interventions
- Adopt more personalized approaches and user-friendly assessments with respect to each woman's culture, needs, and values
- Train sub-specialists in perinatal mental health and promote effective care pathways using



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multidisciplinary teams
- Raise awareness among all pregnant women, healthcare staff, authorities, and the press
- Promote user organizations and social media awareness campaigns
- Use resource-effective solutions such as telepsychiatry and robotics
- Evaluate screening in pregnancy and among partners
- Evaluate the potential benefits of shared parental leave and remote work

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