Supporting Perinatal Mental Health After Loss or a History of Eating Disorders

Dr Nicole Highet (00:00:02):

Well, good evening everyone, and welcome to tonight's webinar, Supporting Perinatal Mental Health After Loss or a History of Eating Disorders. On behalf of MHPN, I would like to start with an acknowledgement of country. MHPN would like to acknowledge the traditional custodians of the land, seas and waterways across Australia, upon which our webinar presenters and participants are located tonight. We wish to pay our respect to the elders past, present, and acknowledge that memories, traditions, culture, and hopes of Aboriginal and Torres Strait Islander people. So welcome everyone who has joined us tonight's live event and also those viewers who will be watching the recording. I'm Dr. Nicole Highet, and I'll be moderating the session tonight. And I'm a doctor of psychology by background, and I'm the founder and executive director of COPE, the Centre of Perinatal Excellence, which is Australia's peak body in perinatal mental health and developed with the national guidelines.

(00:01:05):

And we're very excited to be partnering with the MHPN to really bring you this interesting and invigorating panel tonight. So tonight I'm joined by an esteemed panel of contributors. I'd just like you to introduce you to, starting with Dr. Nicole Hall. Nicole is a general practitioner with RACGP and a representative for general practitioners for COPE. We also have Dr. Susan Roberts, who's a perinatal psychiatrist, and she's the clinical lead of the Lavender Mother and Baby Unit in Queensland. Aleshia Ellis is a senior dietitian working in child, youth and young eating disorders, specialty services, and in the lavender mother and baby unit inpatient service as well. We have Frances Bilbao, who is the director and clinical psychologist of the wonderful bulk billing organisation, Mom's Matter Psychology. And Robyn Stanislavski from PANDA, who also is a performance and improvement analyst and peer practitioner. And we'll hear lots about the very important work of PANDA and peer support in tonight's presentation as well.

(00:02:22):

So tonight's presentation gives us a wonderful opportunity to really address the aims of the webinar and really show us a lot of the complexity. The aim of tonight's webinar is to really promote and support the multidisciplinary care in mental health space, and we certainly can see that with our panel tonight. This activity really aims to showcase the how-to of integrated multidisciplinary care, and we'll be discussing things like the hurdles and enablers to multiple disciplinary care. We'll be looking at good practise, processes, approaches and procedures to support different disciplines and the needs and wants when people participate in multidisciplinary care. We'll also be looking at successful models of multidisciplinary and integrated care. So tonight we're going to be looking at a case study, which is Nadia. And I just thought I'd start by reflecting on the fact that whilst Nadia is hypothetical, it's not by accident that her clinical profile is the way it is, because it really is based and informed by the research evidence which shows us how common a lot of these conditions are and might present in a clinical or a maternity or postnatal or general practise care setting.

(00:03:42):

So it really gives us an opportunity to look at what is quite common in different presentations and often can be very complex. Just by way of example, looking at the iCOPE screening data for over 200,000 people that have been screened across Australia today, we know that 23% of pregnant women like Nadia have experienced a history of mental health problems. The most common of those is anxiety, which is experienced by 85% of expectant mothers. 65% have experienced depression, and eating disorders is actually the third most common mental health condition that women report in pregnancy or in the postnatal period having that history of an eating disorder. And this brings with it lots of challenges and complexities when our bodies are changing in pregnancy, and we're going to be hearing a lot about those different challenges and how this impacts on multidisciplinary care and the importance of trauma-informed care at the same time.

(00:04:46):

Another feature of tonight's presentation is the history of perinatal loss. And this is also very common. We know that we hear the statistic that one in three people will experience miscarriage prior to a pregnancy. And in fact, the data from the iCOPE survey has shown that 23% of people identified major life stressors in the last 12 months, and of those, 40% reported bereavement and loss as a major life stressor. So again, this is going to be very common in our clinical presentations. So whilst Nadia is hypothetical, she does reflect a lot of issues that are coming up in practise, and we really hope that this case study will bring a lot of these things to your attention as you're likely to see them in your clinical care settings. So tonight's activity will take the form of this hypothetical, and the panel are going to be thinking on their feet, being sharp, troubleshooting, shooting, and we're going to be negotiating each other's roles.

(00:05:51):

There'll be compromises as we deal with the complexities, particularly with Nadia in a rural area. We're going to have to be flexible and entrepreneurial and solution focused. So as part of that, of course, we'll be looking at the different roles of the interdisciplinary care model. So I'll start just by briefly introducing Nadia. So Nadia, as per your notes that you have which can be found in the supporting resources tab, Nadia is a 34-year-old woman who lives in regional South Australia. Just as a note, South Australia is one of the states with the least number of perinatal mental health services. So we've got that additional challenge to being in a regional area. She's 22 weeks pregnant with her first child. Nadia experiences persistent worry about the health of her baby and difficulty concentrating. She has muscle tension and frequently seeks reassurance from others. Nadia describes feeling constantly on edge and unable to relax.

(00:06:57):

Her sleep is disturbed by worry about the baby's wellbeing and repeated checking behaviours. She monitors foetal movement closely and feels distressed when she perceives changes. These checking behaviours temporarily reduce her anxiety, but the relief is short-lived and the anxiety returns quickly. Nadia lives with her partner, Ryan. He works full-time and she often feels alone during the day. Ryan wants to support her, but often feels unsure about what will help when she becomes distressed and Nadia hesitates to ask him for support. She worries about being a burden to Ryan. So I'm going to open the discussion by perhaps coming to Nicole, Nicole Hall. As a managing GP, working with women in the perinatal period, Nicole, how common is Nadia's presentation?

Dr Nicole Hall (00:07:53):

Yeah, it's pretty common. I work in high-risk obstetrics too, so I guess I see it from both perspectives. I think my first thought as a GP, if I saw this would to be feeling overwhelmed myself because I would be rationally going, "Oh my goodness, I have 15 minutes. I have five patients in the waiting room. This is a lot. I really want to help Nadia, but I'm feeling overwhelmed right now just by this situation." So I think from a GP perspective, feeling that it's okay to say to a patient, "I'm not going to be able to fix all of this today, but I'm here for you. I really want to help you. " Making sure we book in follow-up appointments and make them longer appointments so that both I and Nadia feel like we've got time to talk about it. And I know that a lot of patients get really overwhelmed by having to see lots of doctors and lots of nurses, and we're saying to them, "You've got this, you're higher risk because of this, you're high risk because of this.

(00:08:50):

" And they often just feel so overwhelmed. So I'll often say to my patients, "I'm your debrief base. Please come back and talk to me. If you've seen lots of people at the hospital or you've spoken to lots of doctors and you just feel really overwhelmed by this. " So really as a GP, generally we have the privilege of knowing our patients for a very long time. We haven't met them for the first time, and that means we're really well placed to act as a sounding board to deconstruct everything else that's going on, as well as being the person in the multidisciplinary team that can reach out to everybody else when required.

Dr Nicole Highet (00:09:30):

Great, thanks. And I think there's some great advice there about just taking one step at a time, and given this is a complex case. Okay. I'm going to then just reveal a little bit more about Nadia. So she often feels isolated during the day and has become increasingly reliant on contact with health professionals for reassurance. As her anxiety and low confidence and fear of judgement have become more challenging to manage, she has gradually withdrawed from antenatal classes and social activities. Alongside this, she has noticed her mood and has seemed lower with less enjoyment in things that she previously looked forward to. Robyn, as a peer support worker for PANDA, how common is this feeling of isolation amongst people who might contact PANDA or the PANDA Helpline, and how much of a contributing factor is this to mental health?

Robyn Stanislavski (00:10:27):

Thanks, Nicole. Isolation is a massive topic that we talk about on the helpline, and it's not just from people who are living in those rural and remote communities. It's actually across the board. We find that the perinatal period, especially it can feel so isolating because perhaps you are maybe the first in your friend group that has had a pregnancy and you are navigating all of this newness, but even for those with subsequent children and pregnancies, again, your networks change over time. And so for Nadia, it's about understanding who is in her support network and what are those connections there. The rural aspect, it really does add another layer because that can impact access to services as well with lots of travel required and time to get to appointments. For us at PANDA, we are supporting people over the phone. So as long as people have access to our phone, then they have access to PANDA, which is wonderful.

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So we can really help to reduce those wait times in terms of actually speaking to someone. Yeah.

Dr Nicole Highet (00:11:50):

Great. Thank you. I'm now going to move into some additional information about Nadia. Just in relation to her history of pregnancy loss, two years ago, Nadia experienced a late miscarriage at 19 weeks following fertility treatment. She experienced the loss as frightening and overwhelming and involving emergency and hospital care. Grief is not present every day for her, but memories of hospital care and fear of loss return frequently and easily. She describes taking the pregnancy one day at a time and avoids thinking too far ahead. She feels torn between hope and fear and worries that allowing herself to feel either might make things worse. Frances, we know that perinatal loss is common and that the impact of miscarriage, as this was less than 20 weeks, it was a miscarriage can significantly impact on people's experience of stress and particularly anxiety in a subsequent pregnancy. How commonly do you see this in your clinical presentations and how does it impact on your approach when working with these expectant parents?

Frances Bilbao (00:13:03):

Yeah, great. Thanks, Nicole. Yeah, certainly is extremely common to have elevated anxiety in a subsequent pregnancy after a loss, especially around things like anniversary dates or significant milestones in a pregnancy where perhaps the loss occurred previously. So there's a significant monitoring, I suppose, of the body that continues on after that previous loss. We know that anxiety is generally heightened in pregnancy anyway because our brain is starting to turn towards being hypervigilant about a baby. But of course, having a prior loss, which really, I guess for the brain, it sort of cements the idea that this is a real threat, that I need to be hypervigilant about the pregnancy. So we do see that really increased frequency in monitoring what's happening, often asking for more scans, more professional involvement in the pregnancy. The brain's trying to mitigate some of that risk that it thinks is real.

(00:14:14):

So even though there may not be any actual increased risk of another loss, this pregnancy, the brain is definitely primed to be looking for any sign that that traumatic event may happen again. So yes, extremely common.

Dr Nicole Highet (00:14:32):

So hypervigilance, particularly around any indications of loss or possible loss.

Frances Bilbao (00:14:36):

Absolutely.

Dr Nicole Highet (00:14:38):

Which explains the high levels of anxiety statistics we often see. I've got a question here for Susan. It sounds like Nadia may have needed to have a DSC previously, and now that she might be birthing at the same hospital, what impact might this have on Nadia and might there be a risk of PTSD in this situation?

Dr Susan Roberts (00:15:04):

Certainly, Nicole. And I think some of the aspects mentioned in the case study talked about her becoming more withdrawn, avoiding antenatal appointments. So that avoidance is her way of coping with the surge of anxiety that she might experience when going back into the same hospital setting that she went to when she lost the baby, when she had to have the DNC. And we know that maybe to health professionals and obstetricians, that procedure might be fairly regular, that really trauma is in the eye of the beholder, the person who experienced that. So being able to understand what her experience is now, we talked about hypervigilance, anxiety, but is she also being troubled by intrusive ruminations, nightmares? That might mean that she does reach the threshold for a diagnosis of post-traumatic stress disorder. Well, certainly she sounds like she's got post-traumatic stress symptoms. And I think being able to talk to her about that to help her with engaging with her antenatal care, because the risk is that she will disengage and try and manage all that anxiety herself, but then not be monitored for her pregnancy care.

Dr Nicole Highet (00:16:19):

Yeah, no, that's great advice. All right, we're going to move a little bit more now into some more information about Nadia's history, and the next piece of information really pertains to her history of eating disorders. So Nadia lived with an eating disorder since her teenage years. She received support for anorexia nervosa in her late teens and felt particularly physically and emotionally well for many years before her current pregnancy. During pregnancy, she's found changes in her body appetite and daily routines unsettling, which has increased her distress. Nadia has noticed old patterns around food returning, including strict food rules, skipped meals, and feeling guilty after eating. These urges feel stronger when her anxiety is high. So Susan, as a perinatal psychiatrist specialising in eating disorders, how common are relapses in pregnancy and the postnatal period?

Dr Susan Roberts (00:17:20):

Well, the pernatal period can be a trigger for both the development of a new eating disorder or for a relapse of existing eating disorders. And the changes in a woman's body shape and weight can certainly trigger relapses. And then there are aspects of pregnancy that are quite normal that can be rationalised, such as cravings might be ... Binges might be rationalised as craving, being told what foods are safe to eat, might mask restriction of a dietary intake, and what are the safe foods, and hyperemesis might also be masking purging behaviours. So it is important to try and gently tease these out because there are significant barriers to detection of eating disorders in pregnancy, both on the side of health professionals and disclosure when it comes to the women because of shame and stigma, or their concern about previous treatment that they've had that they're not ready to go down that path again.

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And health professionals don't have the time or know where to send women or know how to ask those questions. So that can hinder conversations as well.

Dr Nicole Highet (00:18:33):

Can pregnancy sometimes be a protective factor for eating disorders?

Dr Susan Roberts (00:18:39):

Absolutely. Absolutely. Women who see the pregnancy as a motivating factor and can focus on the health of the growing baby can moderate their eating disorder symptoms. What we often see in this situation is that they may develop higher level symptoms of anxiety and low mood because that's what the eating disorder symptoms we're managing, managing in terms of modulating their emotions previously. So they then struggle with higher levels of anxiety and depression. But with the higher levels of support from health professionals and from family, that can be quite supportive, which then leads us to be thoughtful and concerned about the risk of relapse in the postpartum period when they're very keen to get back to their pre-pregnancy weight, they no longer have to think about baby on board in terms of protecting their nutritional needs. So that's another thing to consider.

Dr Nicole Highet (00:19:36):

And Aleshia, as a dietitian with a focus on eating disorders, what are the key considerations for supporting people with an eating disorder?

Aleshia Ellis (00:19:46):

Yeah. And I think ... Thanks, Nicole. In relation to Nadia, I guess the thing that strikes me is that how many times am I going to get the opportunity to see her and what is the balance of information I need to gather and also provide to give her, I guess, a nutritional platform to be suitable for her pregnancy. We always, I think, start with food first and we try and take the approach of what food driven by or negotiated or collaborated with Nadia around what she can eat, what does that look like, why she might need to eat, what are the reasons that the nutritional needs have increased or that the appetite has increased? So try and give the why and then work practically with the how.

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So if we take those three sort of avenues, we're hopefully finding some common ground. It's definitely a collaborative approach. And in my experience, someone that's had an eating disorder in the past, reengaging with a dietitian in pregnancy can be tricky and there might be experiences or adverse experiences with dietitians in the past. We're absolutely focusing on the one thing that is creating the high level anxiety and fear, but we look to balance the education with the practical strategies. And I think it does come down to meeting the person where they're at. I think also we have a role to advocate for safe conversations and the women's preferences throughout pregnancy. And because our assessment sort of looks at eating behaviours, weight, body shape, things like that, we can elicit information around what do they feel comfortable with. And we can, I guess, support the sharing of information with other professionals whilst we might not get the opportunity to see them as regularly as the GP or the midwives.

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We can be a source of, I guess, education or support around what the woman's preference may be around weighing nutrition, how often we're checking in on those things. And I guess we also work to understand what worked in the past. It's really important to bring to Nadia's attention that she reports being well for many years prior to the pregnancy. So what were the key things in her life, both practically support-wise, nutritionally that supported her to be well before pregnancy? And that's really

what we want to tap into. And we really want to highlight that there has been that positive time in her life that she did manage this whilst acknowledging and validating the concerns, but really I guess empowering her that she did this before and how can we bring that to the forefront again in this really tricky time.

Dr Nicole Highet (00:22:45):

Yeah. No, that's great advice. There's something certainly very positive to build on there. Can I just ask as well, quite topical at the moment, I think is that the whole question about what is the current view around weighing clients in pregnancy? Is this still recommended or can it be potentially triggering for expectant patients?

Aleshia Ellis (00:23:08):

Yeah, I think we can probably accept that actually it's triggering for many people to have this focus on weight. And I think what we encourage is to get professionals, whether it be the GP, the obstetrician, the midwife, to go back to that why, why are we doing it and what are we hoping to gain from that information? Whilst acknowledging in Nadia's case, this refocus on her weight and this real, I guess, objective number and what does that mean? And that's been quite difficult in the past. What would be our reasoning? And I guess we also encourage everyone in the team to think about the other parameters to measure, the other things to look at that are supporting a safe pregnancy. And whilst weight might be part of that, really seeking the pregnant person's preferences about weighing, what do they feel comfortable with? Do they want to know their weight?

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Do they want to know trends? I think it comes back to that collaborative care and approach. What is the person's preference around it? Because I think if any of us in the room have had children, we've all been told to jump on the scales, the number gets written down, we see it or we don't, and we don't really know why. Also, we know that using BMI in pregnancy is not a valid form, but I guess we have to balance with knowing that not nourishing your body and not gaining weight or is it risk for yourself and the baby? So there's a balance between, again, the education and the practicalities of the why. But look, my biggest advice is to ask and to seek permission and also to seek a collaborative understanding as to how that information is to be shared and fed back and to what level it needs to be fed back.

Dr Nicole Highet (00:25:03):

Yeah, certainly the asking the why. I think so. We always have to do no harm as part of our care, but sometimes doing things that we've always done when there is no logical why can actually be doing more harm. So I think that's ... And the potential to potentially obsess on the number and things like that. And we do see obsessive some OCD types of behaviours here. So Frances, can this history of eating disorder lead to OCD type symptoms and particularly for the checking and reassurance due to her anxiety, do you think?

Frances Bilbao (00:25:38):

Yeah, for sure. There is usually some overlap between eating disorder and OCD, but I think if you're looking at this case as a whole, there's this history of eating disorder, she's currently pregnant, which that in itself means there's a heavy focus on the body, of course. And she is engaging in some of these

disordered eating activities, but she may also be suppressing a lot of what she might normally do. So she's feeling completely out of control at the moment. She's entering a phase where she's hyper focused on the idea that this loss could occur again. So she's probably ... And OCD is essentially trying to manage intrusive thoughts and trying to manage high levels of anxiety by undertaking behaviours or compulsions that help reduce that anxiety. So she may be engaging in whatever control mechanism she has at the moment. So reassurance seeking, trying to ... Well, she's not actually seeking help from her partner, but she seems to be latching onto health professionals as these experts who will be able to provide her some security and some safety and thinking that this is going to help mitigate any risk about the loss.

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So I think all these things go together. And the common overarching theme is control, how she's trying to control things in her environment to minimise her anxiety. The unfortunate thing is that actually a lot of these compulsions or readurance seeking behaviours actually increase anxiety. So when they relieve that anxiety for a very short amount of time, that feels good. And our brain says, oh, great, this is a good tactic to reduce anxiety, but actually it just reinforces that those behaviours. And so they tend to get worse and increase, and actually the anxiety continues to increase as well.

Dr Nicole Highet (00:27:46):

So already we've seen with the eating disorder, how this involves such a multidisciplinary care team. Nicole, this is often coordinated by the GP. What are the special considerations for the GP when coordinating care for such a disorder which has such physical and psychological and other implications?

Dr Nicole Hall (00:28:10):

Yeah. So I think as a GP, again, it's sort of helpful for GPs to think of the person that the patient keeps coming back to you. So we're kind of, I don't want to say the centre of the circle, but we kind of are.

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And also we don't need to have all the answers. So as a GP, it's really important to know what your local network is. Who am I going to call? Who am I going to talk to? Who's up the road? Who's down the road? And also as a GP, I think it's really important to not be afraid to have to call people and put the feelers out there. And it goes the other way as well. I'm always really happy to hear from people that are involved in the care of my patients as well, because otherwise if I'm not getting any feedback from them, I don't know what's happening outside of my little circle. So I'm always really happy to take emails, letters, phone calls about my patients, particularly for someone like this because if we're all working together, we're going to give the patient a much better outcome than if we're all giving her different advice.

(00:29:14):

And I guess working in the high-risk obstetric space as well, I see so many patients who are told so many different rules by so many people, it just gets so overwhelming for them. So picking up the phone and calling the psychologist that's seeing the patient or calling the dietitian or even calling the obstetrician

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Just to see where things are up to or emailing or letters or whatever it looks like for each individual GP so that we're not completely bombarding someone like Nadia with a million different messages. But

also, as I said earlier, as a GP, often we're the sounding board. A patient will go and they'll see the dietitian and the psychologist and the diabetes educator and the endocrinologist and the obstetrician and the foetal maternal unit, and they'll just come back and go, "Whoa." And So if we have the information from other people, it helps us to debrief with the patient about what's happening as well. And I just wanted to come back to the weighing thing. I certainly do not weigh my patients in pregnancy. I think it is really triggering for a lot of people whether they have an eating disorder or not. And certainly the evidence is not there to do that anymore and it has been removed from a lot of our pregnancy care guidelines.

Dr Nicole Highet (00:30:23):

Great. Okay. That's great to know. Okay. We'll just go back to our case study because it's complex and we've got a bit to get the brief still. So as the pregnancy progresses, Nadia notices that her anxiety is beginning to affect her relationships. Her mother has become more involved, checking in frequently about Nadia's eating, sleep, and appointments. While this is meant to be supportive, Nadia experiences this as intrusive and feels judged. She notices feelings of shame increasing and finds herself withdrawing further. Comments about food and her body are hard for Nadia to hear because of her past eating challenges. And she notices that after these conversations, she becomes more rigid around eating. Robyn, as a peer worker, what role can peer support play, especially at times when people may begin to withdraw from those close to them or from other health professionals?

Robyn Stanislavski (00:31:18):

Yeah, I'm loving hearing this conversation. And Aleshia, I really enjoyed hearing you talk about the empowerment of the person and considering how the elements, whether those elements need to actually happen during your processes. And for you, Nicole, being that central person in the person's care, but also noting the time limitations for you. So I think that that's really something where peer support can actually really just hold a lot of space for the person in terms of a safe, non-judgmental space where we can connect and we can actually allow that person space to talk through their experience with less time restrictions. We can find out what are the elements that are most important to them and where would they like their focus to be? And then for us at Panda, our focus is perinatal, but of course people are whole people and they're coming with full stories and all of our stories don't always overlap in the same way as peer practitioners, but the ability to connect with someone with an element of their story is so powerful.

(00:32:39):

And we speak to people so frequently that maybe haven't spoken to anyone who's experienced a part of their story. And so to use peer support in that way is just very, very powerful. And offering them that space to talk through their experience is just unbelievable. And then when they know that you've also had an experience in your journey, the hope of recovery, the empowerment, and potentially the exchange of strategies, not saying that what we are using will work for them, but just saying that this helped us, this is how we implemented. And what are your care professionals? What are they mentioning to you? And is that something you'd like to try and can we help you to work through what that might be like for you? So in that real supportive space of another sort of interconnector, I guess, of other services and helping Nadia to navigate her care of how she would like to navigate it and what's most important for her.

Dr Nicole Highet (00:33:48):

So really can be very important in empowering her. And what about, are there any special considerations, Robyn, when delivering peer support, given that Nadia is living in a rural area?

Robyn Stanislavski (00:34:02):

In terms of peer support in a rural area, I think Panda has an advantage because of that phone connection, but that's just not always the case. And I think it would take Nadia potentially a little bit of investigation to see where she might also be able to seek support and where it's important for her. So accessing those telehealth options, the online chat rooms, seeking out professional organisations in the areas that you'd like support. So if we're thinking about Nadia in terms of her pregnancy loss, we could think about an organisation such as Pink Elephant or in terms of the eating disorders, we could think about the butterfly, and they have online chats as well. So really navigating different services and thinking about how Nadia would like her care picture to look and engaging in those online groups. A little less formal, I guess, but still equally as valuable can be depending on where you are, social media spaces, you can find some good groups.

(00:35:15):

And I think that the connecting piece in those groups are that someone's who has been through something that I've been through and that's where back to that lived experience, right?

Dr Nicole Highet (00:35:26):

Yeah.

Robyn Stanislavski (00:35:26):

People want to connect with some part of their story and they want to speak to someone who has experienced part of their story.

Dr Nicole Highet (00:35:35):

Yeah, for sure. So just a question, I suppose then for the panel, given that Nadia is now beginning to withdraw and become highly sensitised around her reading, what suggestions would you have from your multidisciplinary perspectives? Are there indications potentially? I'll go to Nicole as a GP, would you be starting to be concerned about possible depression at this point?

Dr Nicole Hall (00:36:05):

Yeah, absolutely. And I think I wouldn't dive into it and go, "Do you feel like you're depressed?" I'd be more wanting an open conversation and often using some empathetic lines like, "Pregnancy can be really tough. You can feel like there's so much pressure on you. There's so many things to think about. " That can really be a bit overwhelming for people. Do you ever feel like that? Or have you ever had those thoughts? Or sometimes I'll even use a bit of lived experience myself and say, "Geez, I found pregnancy in the postpartum period really tough. How are you going with things?" And often that, I guess, combination of obviously professionalism, but also I'm a mom and I can empathise to some degree, is

more likely to get the dialogue going, but also appreciating that it might take multiple visits with multiple prompts for the information to come out in dribs and drabs.

Dr Nicole Highet (00:36:59):

Yeah, for sure.

Dr Nicole Hall (00:37:00):

And certainly not pushing, just asking the right questions, but giving Nadia time to open up the way she wants. And I think the other thing, sometimes as health professionals, we're all in a rush. Sometimes I think we all say too much and sometimes as hard as it is, it's better to almost open the floor for discussion and then accept the silence because that might be Nadia building herself up to telling you things. So sometimes I think silence, even though sometimes it's hard for some of us to sit with in a consult can actually be really powerful.

Dr Nicole Highet (00:37:35):

Yeah. Yeah. As my husband likes to say, silence and listen have the same letters. All right. Let's just then go on to the fact that Nadia is currently receiving care from her obstetric team through a private obstetrician and has been referred for additional support through her pregnancy. She has chosen not to share her past eating disorder with her obstetric team. She worries this might lead to increased monitoring or a loss of control over decisions about her care. Naty wants support for her mental health, but feels conflicted. She feels being judged or seen as unsafe or incapable as a future parent. So it seems that as more people are getting involved in this case and we're going to have to be managing information sharing between practitioners. Nicole, maybe you're the GP at the centre. How do we manage this when there's so many people involved in the care and how do we approach this with Nadia?

Dr Nicole Hall (00:38:41):

Yeah. So again, I guess from a GP perspective, I like to let people know that I'm the person that you can come back to and debrief about everything that's happened, that if you've had an experience at the hospital or someone's given you some information you're not sure about, come and chat to me about it. If I can help you out with the answer, I will. And if I can't, I will make a call or I will send a letter or I will speak to the person I need to to get Nadia the right information. And that can be really important because when you're seeing so many different people in a structured obstetric space, it can almost feel ... People often feel scared to ask questions. And people will often come in and say to me, "Well, I really wanted to ask this of the endocrinologist or the psychologist or the diabetes educator, but I didn't want to sound silly, so I just didn't ask at all.

(00:39:27):

" I think really nominating myself as the safe place where you can say whatever you need to say and ask whatever you need to say and there's no judgement can be really helpful. And yeah, as the GP, sometimes you just have to pick up the phone and call someone and ask a question.

Dr Nicole Highet (00:39:44):

And I suppose, Robyn, that's where peer support can be really important as well, encouraging, giving people the confidence and support to take those first steps and talk to their professional.

Robyn Stanislavski (00:39:55):

Absolutely. Yes. And also navigating with them those barriers that they might be having to having those conversations or to opening out the information to different providers and really working through that with them in terms of talk me through what do you think could happen if you share or things like that. And also sharing our experience of maybe when we have acted in a way that we thought at the time was very safe and helpful and that we're not passing on specific information. But if we have had an experience of sharing, then perhaps we did that and we may using modelling in our experience to support somebody else with their decision making.

Dr Nicole Highet (00:40:49):

Yeah, fantastic. Okay. So Ryan feels, let's talk about Ryan, focus on Ryan a little bit. So he feels unsure about how involved he should be. He worries about Nadia's mental health, but he often feels uncertain about his place in appointments and conversations. Nadia notices his concern and occasionally experiences this as being watched rather than supported. Over time, this creates tension with Ryan feeling helpless and Nadia feeling more closely monitored. So it seems like Ryan's in a little bit of a no-win situation here. What does the panel think might be helpful for Ryan? Are there any supports given that they're in this rural community that might help Frances? Do you have any thoughts about that? What might be helpful for Ryan?

Frances Bilbao (00:41:37):

Yeah. Well, I mean, if anyone is thinking that their partner is struggling and they're not quite sure how to broach it with their partner, it is a good idea to call Panda. Partners can call Panda as well and talk through their concerns and might be able to get some more specific advice on maybe what might be appropriate in the situation. And Ryan may also need his own support in terms of he might need psychological help as well, so it might be good for him to engage in his own work as well. And I think same, I was just thinking while you're all talking before and reflecting on, I'm not even sure if Nadia has told anybody about this, she's just withdrawing into herself and she's seeking a lot of reassurance about the baby, but she's not really letting anyone know actually that she's feeling like this.

(00:42:32):

So I think if we're all coming at it with that sort of trauma-informed approach, we have to assume that people struggling in a way. We assume that people have some kind of trauma in their history. And so just letting them know lots of people struggle. It would be really normal if you wanted to seek out some extra psychological support around this because it's very common and there's nothing wrong with getting that extra help. So just really making it kind of a normal thing that, hey, there is support out there, lots of people get it, here's the options if you do want to seek that support. Because if she's not coming to the table with sharing this information, we just need to make it really safe and non-judgmental about, "Hey, there is support out there if you do need it. " And I'm hoping someone like Panda would give that same advice to Ryan just for him to continue to let her know that he loves her, that he's here for her, whatever she needs, he's there to look after her essentially, and he'll advocate for her in the ways that she wants him to.

Dr Nicole Highet (00:43:44):

Now, if Ryan happened to be also a patient of the same GP, given we're in a rural area, should the GP ask Nadia about how she feels about sharing information with Ryan, what are some of the sensitivities here, Nicole?

Dr Nicole Hall (00:43:59):

Yeah, it's a bit delicate, isn't it? Because obviously patient confidentiality is paramount and any breach of that confidentiality would, of course, the therapeutic relationship that you have with Nadia or with Ryan. So I will often say to, for example, Nadia on her own, would it be okay if maybe next time you bought Ryan with you and maybe then we could have a chat all of us together to see how he's going as well? Or I might say the same thing to Ryan, "Hey, Ryan, obviously I know Nydia's pregnant, presuming I'm sure I can share that information. How are you feeling about all of that? Do you think maybe it'll be okay if maybe the two of you came in together at some point and we could have a chat all together so we can figure out how we can support both of you during this time?" So it's really about seeking permission from the patient before you say something you shouldn't say essentially, but it can be hard, particularly in a small practise if you are the only person looking after everybody, figuring out which bits you can say and which bits you can't.

(00:45:02):

Yeah, for

Dr Nicole Highet (00:45:02):

Sure. Yeah,

Dr Nicole Hall (00:45:03):

Asking permission. Asking permission is really important.

Dr Nicole Highet (00:45:06):

Excellent. And Susan and Robyn, are there any particular ways that Ryan might be able to help support Nadia in relation to her eating disorder, do you think?

Dr Susan Roberts (00:45:15):

Well, I think going back one step, and some of the research that we've done on peripartum eating disorders, getting opinions from women with lived experience of peripartum eating disorders. And what they told us is that nobody asks them. And if they were asked, they would share that information. And similarly, that it's become very common to do the Edinburgh Postnatal Depression Scale, and we ask about anxiety and depression. Similarly, I think asking regularly about a history of any trouble with disordered eating, body weight, shape concerns, and normalising that can help open that sort of conversation. And I think what's happening at the moment is that Nadia's experiencing what she experienced as a teen. We know that eating disorders that develop in teenagers are often contributed to by family dynamics that need for control, and there's that potentially it's happening all again, that her mother's looking over her shoulder, she feels that Ryan's looking over her shoulder.

(00:46:26):

So how to diffuse all that to help. And sometimes in these situations that the women I speak with say that the partner doesn't know that they've struggled with eating, and sometimes they don't, but sometimes they do have an inkling. So even just talking about who does the cooking at home, do you sit down to eat? Do you sit down and have dinner together? How does that work? So having those sort of normative conversations about how he can support through social eating can sometimes be really helpful.

Dr Nicole Highet (00:47:02):

Yeah, fantastic. Okay. I'll move on with the case study. So a very important issue coming up now around medication. So Nadia has been offered medication to support her anxiety. She feels conflicted about using medication during pregnancy and worries about the possible harm to the baby. Information that she finds online only adds to her uncertainty. She seeks reassurance from several professionals and feels distressed when the advice differs even in small ways. Her fear of making the wrong choice is intensified by her past loss and she wants clear, constant guidance. So here, now that it's really important that we have good quality information and we know that people are getting multiple sources of information of varying qualities from various people, and this obviously can contribute to the overwhelm. One of the big questions we often get asked at COPE is about the safety of medications in pregnancy and postnatally when breastfeeding.

(00:48:09):

So whilst the national guidelines do recommend SSRIs for the treatment of moderate to severe anxiety or depression, as is for the case with eating disorders, as a GP, Nicole, how common is it for people to want to avoid taking medication in pregnancy and when breastfeeding?

Dr Nicole Hall (00:48:29):

I have to say over the years, I feel like the approach has changed a little bit. People do seem to be more open to it these days than previous. I think particularly if you have a good relationship with a patient, they will often trust your judgement if you do make that recommendation. It might be a little bit harder for someone like Susan if she hasn't known the patient for as long. So sometimes as a GP, that can work in our favour. The other thing I really like to do is not necessarily say to someone, "I think you need medication. Here's why. Let's do it today." But it's more of a, let's talk about medication. It's a possibility. Here's how it works. Here's the science behind it. I'll usually give them some written information from, say, the Royal Hospital for Women. And in New South Wales where I work, we have, and I presume everyone else does too, we have an excellent resource called MotherSafe.

(00:49:20):

And I will often get patients to ring MotherSafe because MotherSafe will give them a huge amount of information about safety of medications in pregnancy. And a lot of my patients will come back to me and say, "Yeah, I rang MotherSafe. Now that I've spoken to them and they've given me all the information, I actually feel fine about being on medication."

Dr Nicole Highet (00:49:38):

Yeah, fantastic. And Susan, when would you as a psychiatrist consider recommending antidepressants in pregnancy?

Dr Susan Roberts (00:49:48):

Well, I think you've always got to talk about the risks versus the benefits of taking medication in pregnancy, the risks of taking medication versus the risks of not taking medications. I think Nadia's case, you also have to think about her history of perinatal loss, and that's going to be really upper in her mind. And we can't give a cast iron guarantee that medications are a hundred percent safe, so it's her weighing these risks versus the benefits. But I think you also have to take the history of what other factors are playing into it, particularly with Nadia whereby her nutritional status, food is medicine, and if she's not meeting her nutritional needs, then that might implicate how successful antidepressant medications are going to be. So when you're prescribing antidepressants, you need to have a fair degree of confidence that they are going to be treating what you want them to treat.

(00:50:49):

Because if they're not going to be doing that, then you're exposing a woman both to the symptomatology and to the medication. If you have made a decision, however, and the woman's in agreement to taking medication, it's really important that you do try to treat to remission because if you're trying to play it safe and use low doses of antidepressants, particularly if they've had a good response to antidepressants in the past, then if they're still experiencing high levels of symptoms of anxiety and depression and they're on low dose of antidepressants, they're exposed to the risks of the medication and the risks of their anxiety and depression. So you've got to be thoughtful about that as well. And I think being open and transparent with women in having these conversations and doing that collaborative sort of decision-making. And sometimes women who've had previous perinatal losses do not want to jeopardise at all their pregnancies.

(00:51:44):

And you just have to say, well, okay, what else can you do? Can you engage in psychological care? How about getting all the basics right, food, nutrition, exercise, relationship support? And what if these symptoms persist in the postpartum period? Would you consider taking medication at that stage? So I thinking about what needs to happen in the short-term, but long-term as well, and getting on board and building that therapeutic relationship.

Dr Nicole Highet (00:52:12):

Yeah. Great. Okay. Well, let's bring in another little aspect here with, at 28 weeks into the pregnancy, Nadia has told that she has gestational diabetes. She finds the diagnosis upsetting and notices her anxiety increasing quickly. Blood glucose monitoring and dietary advice feel overwhelming, and at times she experiences them as harsh and controlling. She notices old thoughts returning and she finds it harder to eat flexibly. She sometimes avoids appointments or holds back information because she feels anxious about being judged. I'm interested to hear from Elise and Nicole, what are people's reactions when they find out when they have diabetes, gestational diabetes? Is that seen as a failure?

Aleshia Ellis (00:53:03):

A body failure, which obviously with someone with the eating disorder can be quite reinforcing that there's something wrong, there's wrong with me. But I think sometimes it's the reaction of the health professionals as well to the diagnosis because there's a real assumption that the cause of gestational diabetes, how could someone with anorexia nervosa or of a certain body weight present and get gestational diabetes? So there's a lot of myth debusting to be done around, I guess, how and why gestational diabetes occurs. And then from the person, from Nadia, just this is hormonal changes, all the contributing factors so that I guess we can rationalise that this happens out in the community. And the reason I guess we're doing the testing for it is to find out if they're experiencing that. Nutritionally, it's tricky because we can buy into the fact that we're asking someone to be rigid, count carbohydrates, be restrictive in some ways, reduce certain foods.

(00:54:09):

And in my experience, people that have already built that in or experiencing that or have a reemergence of those symptoms, we're actually finding that we're cutting their eating by giving them more advice around the way in which they should eat. My approach to Nadia in this instance would be to work really closely with the GP, the diabetes educator, onto, again, that same theme that I talked about before is what actually needs to be done to ensure safety, why that needs to be done, and then how do we do it? So I think over time we've accepted that traditional gestational diabetes advice and approach is not appropriate for someone with an eating disorder, but I guess that we can work together with the multidisciplinary team to work out what is the bare minimum or the levels of things that need to be done around the blood glucose monitoring to ensure her safety.

(00:55:04):

But whilst we have to be careful that dietary advice can be more restrictive, and that's what we want to avoid restricting someone's intake who's already bringing back food rules and restrictive behaviours. It's a real tricky balance. And I might not necessarily get the opportunity to see someone depending when it's diagnosed. I might not get the chance to see someone after this, but I think traditional GDM care isn't really set up to support someone that's struggling with an eating disorder.

Dr Nicole Hall (00:55:37):

Yeah, I would 100% agree. It's not set up. So I actually work in the gestational diabetes clinic, preeclampsia clinic of a big tertiary hospital. And I actually had a patient say to me once, "I come in to see you doctors and you circle all the sugars in my book that are out of range in a big red pen and I feel terrible and you make me feel like I'm horrible and I can't do anything right." And it made me really stop and think, wow, that is ...

(00:56:05):

We wouldn't even be thinking about that. We're just going, "Yep, this many high sugars, see the dietitian, see the diabetes educator." But yeah, it's a delicate balance. And I agree, I don't think traditional GDM care takes into account eating disorders at all. A red flag for me is always women that don't record their sugars. Now, sometimes that's just because they haven't checked or whatever, but I always find that to be a red flag. I always also really look for the women whose babies are not growing quiet in the way that I would like. And that's also a red flag that perhaps we are making things so rigid that we are completely undermining her underlying nutritional value. And I think that can be really hard to pick up when you are seeing lots of women and there's a lot going on. But yeah, I agree. I think our

care for GDM women with eating disorder is suboptimal and just trying to look for patterns where maybe sugars aren't making sense with baby's growth or with what a patient's actually reporting and accepting that it doesn't have to be perfect all the time.

(00:57:19):

She still needs to eat. We need to make sure that she still feels like she can eat.

Aleshia Ellis (00:57:25):

And this can add to the overwhelm of the presentation, but also I guess the anxiety within the care team. But I think if we can bring it back to what is needed for safe baby growth, healthy mom medically, physically, emotionally, and what do we need to do to nurture that? Because obviously we want the blood tests done and the pre-meals and post-meals and things like that. But I guess if we can do person-centered care, collaborative care that really focuses on what do we need to do and know to ensure that we are seeing that safe trajectory of the pregnancy, I think is really important. And I think it's important to be open and honest too, that what can happen postpartum if you have GDM in pregnancy, what that might mean for the postpartum. And the nutritional advice also, we look at it as a journey.

(00:58:22):

So this is not something that stops and starts with pregnancy. This is something that starts in pregnancy we build on and that we really want to create and continue in the postpartum so that emotionally, physically, functionally, you have the necessary nutrition to do what you need to do to be a parent and to manage that as well. And I think it's important to be quite open and honest about that as well.

Dr Nicole Highet (00:58:47):

Yeah. So making sure that we're not involving so many people and making it so overwhelming. In the case of Nadia, as she attends more appointments and meets practitioners, she does not know. She finds herself having to explain her story repeatedly, becoming more tense at the appointments. She reports feeling watched rather than supported. And in their lead up to appointments, her anxiety builds and sometimes she experiences panic attacks. So I think we've just had a really good explanation about why we need to be mindful of what goals we're setting and involving to keep things as person-centered and realistic in the context of where the person is at. So it can obviously be particularly the case in the private sector where there might not be the access to the multidisciplinary teams and it comes down to the individual. You can see how in the case of Nadia, it might be easy to start, easier to disengaged.

(00:59:44):

So living regionally, Nadia also experiences challenges in accessing the support she needs. Appointments are spaced out and she must travel to attend some appointments and she feels worn down by the process and wonders whether staying engaged is really worth it. At times she It feels more like problems. It's more like a problem to be managed than a person being supported. Just a question to wrap this up for the panel is really what role can telehealth play here to ensure that supports are accessible? We've talked a little bit earlier about the great role of peer support things that are online for eating disorders, for loss and for perinatal anxiety and depression. But what other roles might telehealth pay in other aspects of her care to ensure that treatment remains accessible? Frances, your organisation provides Medicare funded support for people. And does that include telehealth, for example?

Frances Bilbao (01:00:46):

Absolutely. Yeah. Most of our consults are telehealth mainly because obviously in rural areas, there is usually not specialist services available. So that makes our specialist perinatal psychology service available there. But actually for people in the perinatal period in general, they don't really want to go out of their house more than they have to. So it actually makes our care accessible to everybody going through this sort of challenging time. And we do find quite a lot of clients also actually prefer telephone even because they are anxious. They actually don't want to show their face and they prefer to be behind that telephone. So we find people who would not otherwise get any support are willing to get it if they can be on the telephone.

Dr Nicole Highet (01:01:36):

And so who is coordinating the care here? Are we back to you, Nicole, coordinating the care?

Dr Nicole Hall (01:01:44):

Yes, probably. I guess the other thing, and I know not all hospitals have this and I have no idea what South Australia has, but in New South Wales, there's more and more teams of something called MAPS or MSP being set up. And that's where you'll often have a midwife that will coordinate everything for you and be your support person and go to appointments with you and be there on text if you need. And I know not everywhere has that, but we're certainly doing a lot more of that in New South Wales. And I think for someone like Nadia, that would be perfect because it's just a constant person, particularly if she doesn't have easy access to her GP, which can be hard in rural communities. But just someone that is a text messageer away or a phone call away that she can just call on at any time.

(01:02:29):

But yeah, I think sometimes in the private system, as much as I hate to say it, it's easier to get isolated.

(01:02:37):

Sometimes in the public system, we're all there. We're all hanging out together. We can grab each other in the corridor. I can ring Susan. Susan's in the corridor, she's in the room down the corridor or the diabetes educator's next door. But yes, obviously rurally, it's a little bit more challenging. Thankfully, telehealth, one of the blessings that came out of COVID, it is so much easier now for all of us across all disciplines to do things over the phone. And it might be that the GP or midwife schedules a phone call with Nadia every Friday at two o'clock just to touch base, say, "Hey, how are things going? How are you feeling?" Any questions, any concerns just for that low pressure weekly check-in session.

Dr Nicole Highet (01:03:25):

All right. So look, I'm just going to wrap up. We're at time now. I think it's been a really fascinating case study. We've highlighted a lot of the challenges, the barriers and the needs for multidisciplinary care. I'd just like to ask each of the panel to take a minute or so to sum up really what you consider to be the most important takeaway message for you in terms of managing Nadia from your discipline of care. So Susan, I might start with you.

Dr Susan Roberts (01:03:57):

Well, I think what's important is to understand the person as a whole and for maternity care providers to be curious at all times and at all points. And to think about perinatal mental health as not just about PNDA, depression and anxiety, to think about other factors such as perinatal loss, such as eating disorders, and to really validate a woman's journey, but being person-centered, meeting them with where they're at. But that doesn't mean that you don't ask them again next time you see them, how they're going, what's happening within the family. We've got these resources if you want, and utilising, particularly in a regional, remote areas, telehealth options, whether that's telehealth psychology or there's a number of perinatal mental health psychiatry sort of options that are available via telehealth to outreach into regional and remote areas. These days, it can provide a one-off consultation to provide feedback to the obstetrician, to GPs.

(01:04:58):

So I think that's really important. And you've got to work really, really hard at the collaboration with the woman, but also with everybody involved in her care. So communication is key.

Dr Nicole Highet (01:05:10):

Fabulous. Thank you. Aleshia?

Aleshia Ellis (01:05:14):

Yeah, probably echo what Susan has said, but it got me thinking about actually how do we set up these wonderful MDTs like the people that are on the panel tonight that people have access to in the one spot? Because whilst obviously communicating with everyone in the team and emailing and things like that is great, it's quite time-consuming, isn't it? And you're missing people and catching people. And so I think for me with Nadia, and I guess in my practise, really early seeking consent to share on her behalf and be that option to provide the information potentially to other practitioners and providers that maybe she doesn't want to. And I think that the complexity of the case has also just reinforced how, I guess, find the balances between ensuring safety, being client-centered and collaborative, and how you navigate that whilst being, I think, honest and transparent.

(01:06:17):

And I think in my experience, people really respond when you're honest about the potential trajectories and how we can intervene. Yeah. So I think getting in early in that way, and this is what I can offer, this is what the rest of the MDT can offer, and I guess we can curate the journey by all of those different engagements, but also holding in your mind that there is a risk and they are risky patients and there is risk to mom and baby both in pregnancy and in the postpartum that we need to be conscious of and have in the forefront of our mind with our care.

Dr Nicole Highet (01:06:56):

Yeah. Great. Thank you, Aleshia. Frances.

Frances Bilbao (01:07:00):

Hello. Yeah, there's a few thoughts. I think people have summed it up very well so far, but this case in particular, there is a lot of complexity, as we've said. And sometimes from a psychologist point of view, we're working on two levels. We're working on the here and now. So what do we need just to keep this

person safe and navigate them through this pregnancy and get through the pregnancy safely? And then we're also probably thinking in that longer term way around what might Nadia need longer term. She's absolutely high risk for decompensation in the postnatal period. So we'd be thinking about planning ahead for that as well. So yeah, I think from a psychologist perspective, we'd just be thinking about what can we do right now to help Nadia with her immediate anxiety, but also what do we need to think about longer term and what is that care team going forward so that we can make sure that her and Ryan are both set up as best as possible entering into that sort of postnatal period.

(01:08:10):

And yeah, I just hope that it is exactly lovely. She was saying it's very hard sometimes working in private settings to actually work in that multidisciplinary way. But I think as long as we do make that effort to communicate and we all know that each other's services are available and we're advocating for this with the patient to be able to reach out to all the wonderful supports that are there, then we will bring a team together around this person.

Dr Nicole Highet (01:08:40):

Yeah. Thank you, Frances. Robyn.

Robyn Stanislavski (01:08:43):

For myself, it's really bringing Nadia to the forefront as a person, as a human going through this experience. And from the peer perspective, it's connecting with that and working with Nadia to understand how it is that she would like to navigate this period and how can we support her to do that, whether it's finding resources or engaging with other services and making connections, referrals, those sorts of things. But it's really just remembering that there's a person here and they are the most important thing. To

Dr Nicole Highet (01:09:21):

Awesome. Thank you, Robyn. Thank you. And at the centre of the care, Nicole, final thoughts. Yeah,

Dr Nicole Hall (01:09:28):

Thank you, Robyn, for an excellent summary. I think that's really true. Nadia is the centre person here. And I think as a GP, we're really privileged to be able to have a relationship with a patient and offer them support. And maybe the first time you see her, you don't know what that support is yet, and that's okay. And I think not feeling like you need to solve everything in the first consult's really important and putting aside time for you and for Nadia together to work out what is going to help her, even if it's just debriefing on the information that everybody else is giving her and not necessarily adding extra to- do tasks to her list.

Dr Nicole Highet (01:10:13):

Great. Thank you so much. Thank you so much to the panel. Look, I think it's been a really fascinating, interesting webinar. We've seen a lot of complexity. We've seen a lot of challenges. We've seen the opportunity to really look at the importance of holistic, integrated, multidisciplinary care with a sensitivity around being trauma-informed at all points in the care process. We hope that this

presentation has really given us a really good insight into how common these issues are in the perinatal period, the importance of asking and detecting them. As mentioned by Susan, we often focus on anxiety and depression, but we really need to go further than that to understand the complexities that come with different presentations in people's perinatal journey. We've also been had the opportunity with Nadia to look at how past grief and her eating disorder has influenced her perinatal mental health and the importance of person-centered and trauma-informed care throughout her care planning and care provision.

(01:11:17):

Hopefully also we've talked about a number of very practical strategies, keeping it real, keeping it measured and what's really possible, and making sure we don't overwhelm Nadia and dealing with the here and now and what we can at the time. And of course, as mental health professionals and clinicians working in the area, also taking the time for self-care as these conditions can take their toll, not only on those we are caring for, but also for clinicians as well. So that brings us to the end of tonight's webinar. We'd really love to hear your feedback by the button below the video. And just to let us know if we've achieved what you expected and any feedback that you might have. Statements of attendance will be available in your MHPN portal and a link to the recording and webinar resources will be posted out within a week.

(01:12:13):

If you'd like more information or content from the Mental Health Professionals Network, please check out the links in the chat and keep an eye out for the upcoming podcast episode with Robyn from tonight's webinar who'll be talking about her peer work in the perinatal space. And also in the chat, if you haven't got a copy of the National Perinatal Mental Health Guidelines, there's a link there where you can access that, which covers all of the best practise, including the latest resources around medication and safe and effective treatments. So thanks for coming along to this activity tonight on behalf of MHPN. We've enjoyed being able to present to you tonight and we wish you all well. Thank you. Thank you.