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Special Feature Article

The Role of Psychiatrists in the Prevention of Child Abuse: The Practice of Perinatal Mental Care Clinic

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Abstract

During the perinatal period, women experience physical, mental, and social changes and are prone to mental health problems such as depression and anxiety. Continuous support throughout pregnancy is essential for women with psychosocial risk factors such as unexpected pregnancy, young age, unmarried, financial problems, and mental illness. The perinatal mental care clinic established since 2008 in the Department of Psychiatry, Tohoku University Hospital has been working for the treatment of pregnant women with mental illnesses and multidisciplinary collaboration both inside and outside the hospital. In particular, the problems of childcare are insufficient childcare skills due to severe mental illness or intellectual problems, agitation, and strong impulsivity, and the isolation of mothers due to lack of childcare support. It is important not only to stabilize mental illness throughout the perinatal period, but also to evaluate feelings of mother towards children, bonding, childcare, existence of childcare support and interpersonal relationship, and to share information with public health nurses and children welfare centers. While sharing information, it is desirable to get the consent of subjects, however, in the case of "Specified Expectant Mothers" who are deemed to be particularly requiring support before childbirth, the provision of sharing of information from the hospital to the administrative agency through the regional council for Children Requiring Aid is not

considered a breach of confidentiality. The role of a psychiatrist is to collaborate actively with multiple institutions while understanding the roles and functions of multiple occupations, to provide a psychiatric evaluation of pregnant women, to share their diagnosis, and to advise on future involvement.

Keywords : child abuse prevention, perinatal mental health, multidisciplinary collaboration

Introduction

The perinatal period is a time of significant physical, mental, and social change for women, and mental health problems such as depression and anxiety are likely to occur, which often affect the care of the child. In particular, continuous support from pregnancy onward is essential for expectant mothers with psychosocial risk factors such as unexpected pregnancy, young age, unmarried status, economic problems, and mental illness. This paper reviews perinatal mental health and abuse prevention, and discusses what psychiatrists can do to prevent abuse based on the practice of outpatient perinatal mental health care that the authors are engaged in.

I. Perinatal Mental Health and Abuse Prevention

1. Risk Factors for Abuse

According to the Ministry of Health, Labour and Welfare's "Guidance for Responding to Child Abuse (August 2013 revised edition)" 8), the risk factors on the part of guardians for the occurrence of abuse are listed in the table, and factors related to mental health including mental health problems specific to the perinatal period such as maternity blues and postpartum depression, history of other mental disorders, intellectual disabilities, alcoholism, drug addiction, and anxiety about child rearing are considered risk factors for the occurrence of abuse. Although mental illness is one of the risk factors for abuse, it is necessary to consider not only the presence of mental illness but also the influence of psychosocial factors related to the child-rearing environment, such as marital relationships and child-rearing supporters, as well as personality traits and coping abilities. For example, in a meta-analytic review of 155 studies, Stith, S.M. et al. 18) identified anger/hyper-reactivity, family conflict, and family cohesion as risk factors with significant influence on

physical abuse. Other factors include parental perception of the child as a problem, unexpected pregnancy, parent-child relationship, anxiety, mental illness, depression, and social competence. Ayers, S. et al. 1), in a systematic review and meta-analysis of 17 studies on perinatal mental health and child maltreatment, stated that perinatal mental health problems are associated with the risk of child maltreatment, but it is important to examine how the severity of mental health problems interacts with other factors. Although mental illness is one of the risk factors for maltreatment, it is desirable to assess the risk of maltreatment based on a comprehensive view of the psychosocial circumstances of pregnant women and their families.

2. Trends in Perinatal Mental Health Measures in Japan

In Japan, the newborn visitation program was established in 1961, and has been implemented mainly for the purpose of newborn development and health guidance. Subsequently, nationwide studies on perinatal mental health were conducted 13), and in 1996, a Japanese version of the Edinburgh Postnatal Depression Scale (EPDS), which is now widely used as a screening tool for postpartum depression, was developed 16). Subsequently, a survey was conducted on specific support methods, such as whether midwives, who are close to expectant mothers, can assess postpartum depression and provide support 14). According to the 2002 Report on the Actual Conditions of Postpartum Depression 15), the percentage of women with an EPDS score of 9 or higher and suspected of having postpartum depression was 13.9%, and this figure served as a baseline reference value for the incidence of postpartum depression in the "Healthy Parents and Children 21" 10). The importance of early detection and intervention for postpartum mothers' mental health has been emphasized since the goal of reducing the incidence of postpartum depression was set. The "Healthy Parents and Children 21" is a national campaign plan that promotes various initiatives to improve the health of mothers and children.

According to a report by the Ministry of Health, Labour and Welfare, "Results of Verification of Child Abuse Deaths, etc.," 6) about half of abuse-related deaths, other than mother and child suicides, occurred at the age of 0, and unwanted pregnancy and child-rearing anxiety were cited as background factors. This has led to recognition of the need to enhance support systems from the pregnancy stage and strengthen cooperation between medical

institutions and local health and welfare institutions. In 2007, the "Project for Visiting All Families with a Baby" was launched to visit all families with infants up to four months of age, listen to their various concerns and worries, and provide information on child-rearing support 11). As this project developed nationwide, efforts for postpartum mental health became active for early detection and intervention for postpartum depression, but the following issues attracted attention: collaboration with psychiatry and the need for screening and support from the pregnancy period rather than after birth. In the "Healthy Parents and Children 21 (Second)" from 2015, the issues raised in the previous "Healthy Parents and Children 21" were reviewed, and based on the current situation surrounding maternal and child health, the three basic issues of: "health measures for expectant mothers and infants without interruption," "health measures from school age and adolescence to adulthood," and "community development to watch over and nurture the healthy growth of children", were identified. In particular, "support for parents who feel difficulty in raising children" and "measures to prevent child abuse from pregnancy" were identified as priority issues (Figure 1) 9). The revision of medical fees in April 2016 made it possible to calculate the "additional fee for high-risk pregnancy and birth management" for pregnant women with mental illness. In April 2017, the Maternal Health Examination Project was implemented, and the cost of two postpartum health examinations at obstetric medical institutions became publicly subsidized for the purpose of early detection of postpartum depression and prevention of abuse. In particular, the project includes the understanding of the mother's psychological state and feelings toward the child and providing care as needed, and collaboration with comprehensive childcare support centers, postpartum care services, psychiatry, and pediatrics as necessary. In the April 2018 revision of medical fees, the "high-risk expectant and nursing mother cooperation guidance fee" was newly established and can be calculated when several requirements are met, such as when obstetrics, psychiatry, psychosomatic medicine, and municipalities collaborate and a multidisciplinary conference is held to discuss medical treatment policies.

Thus, it can be said that medical health and welfare cooperation in the maternal and child health field is being actively promoted in a wide range of areas, including the sound upbringing of the child through seamless support from the pregnancy period, identification of difficult-to-nurture

families, and prevention of abuse.

II. Outpatient Perinatal Mental Health Care Clinic and Multidisciplinary Collaboration

1. Outpatient perinatal mental health care clinic

We are a university hospital with more than 40 departments, located in the center of Sendai City. The Department of Obstetrics has a Comprehensive Perinatal Maternal Center, which handles approximately 900 deliveries per year. Almost all of them are high-risk pregnancies and deliveries with serious complications and pre-existing conditions. The Department of Psychiatry has 40 closed beds and an outpatient perinatal mental care clinic for expectant and nursing mothers. In Miyagi Prefecture, there are only three hospitals including our hospital that have outpatient obstetrics and psychiatry departments and psychiatric beds, and expectant and nursing mothers with psychiatric disorders often deliver at one of these hospitals.

In the Obstetrics Department of this hospital, an outpatient psychological support clinic staffed by midwives was established in 2005, and has played a role in listening to the anxieties of pregnant women with complex psychosocial factors such as young age, mental illness, economic problems, and lack of childcare support, as well as in providing health guidance and bridges to other professions. In 2008, a special outpatient clinic for women who are pregnant or within one year postpartum (including perinatal loss) was established in the outpatient psychiatry department in conjunction with an outpatient psychological support clinic staffed by midwives. The specialized outpatient clinic is staffed twice a week by two psychiatrists who are board-certified in psychiatry. The psychiatrists in charge of the specialized outpatient clinic collaborate with obstetric staff (physicians, midwives, nurses, and licensed psychologists), pediatric staff, medical social workers (MSW), pharmacists, and other professionals to treat pregnant women with a history of psychiatric disorders and perinatal psychiatric disorders. In addition, since the psychiatrists in charge of general new patients, liaison, and returning patients are also in charge of treating expectant and nursing mothers, the department has a system in place for consultation regarding perinatal pharmacotherapy and collaboration with other fields.

In our perinatal mental health care flow, midwives identify psychiatric history and psychosocial factors during the prenatal checkup, and refer pregnant women who need psychological support and adjustment of

the childcare support system to the outpatient psychological support clinic run by midwives. If a midwife determines that more specialized counseling is needed, the patient is referred to a licensed psychologist in obstetrics, and if psychiatric care is deemed necessary, the patient is referred to this specialized outpatient clinic. If referral to social resources or collaboration with other organizations is necessary, the patient is referred to MSW. Pregnant women taking psychotropic drugs are given a "Lactation and Medication Plan Sheet" at the obstetrician's outpatient clinic in late pregnancy, where they write down their wishes regarding lactation and the drugs they are taking. The pharmacist collects drug information, which is reviewed by the midwife, obstetrician, pediatrician, and psychiatrist to make a comprehensive decision. When a plan sheet is implemented, a postpartum neonatal withdrawal symptom checklist is used to evaluate the effects of the drugs (Figure 2) 5).

A monthly multidisciplinary meeting is held to share information within the hospital. Participants mainly include obstetricians, psychiatrists, midwives, nurses (obstetricians, pediatricians, and psychiatrists), licensed psychologists, and MSW. Information is shared and psychiatrists provide advice to expectant and nursing mothers who are using the outpatient psychological support clinic and with whom licensed psychologists and MSW are involved. Information is also shared regarding pregnant and nursing mothers consulting psychiatrists. Information on cases that will be referred to a psychiatrist may also be shared in advance.

2. Multidisciplinary collaboration in cases requiring childcare support

When social foster care is required due to the patient's medical condition or lack of support system, or when it is necessary to introduce social resources before and after childbirth and coordinate a childcare support system including the family, a care conference is held for each case to connect the expectant mother and family with community supporters such as public health nurses, visiting psychiatric nurses, and helpers, and information is shared 5). For psychiatric problems that began before pregnancy or newly emerged during the perinatal period, such as postpartum depression, psychiatric symptoms are evaluated, psychiatric medication is administered as needed, and feelings toward the child and the caregiving status are assessed. We often have difficulty dealing with cases in which the patient refuses treatment because of concerns about the effects of medication on the fetus, or

cases in which the psychiatric illness is severe and a comprehensive childcare support system is needed, but the expectant mother and family do not feel the need for such a system. The reality is that we have to work collaboratively with multiple disciplines, and adopt the best possible measures in each case.

Cases in which child-rearing problems are a concern from the time of pregnancy include: (1) cases in which child-rearing skills are considered insufficient due to serious mental illness or intellectual problems, (2) cases in which child-rearing skills themselves are not a problem but the mother has psychiatric symptoms of agitation or strong impulsivity, (3) cases in which there is no child-rearing support person or the relationship with a child-rearing support person is poor, and as a result there is concern about the mother's isolation. During pregnancy, in addition to the provision of support in the typical hospital multidisciplinary collaboration system, the child-care support system is adjusted on an individual basis as needed. The relationship with the family members who will be the supporters is evaluated to ensure that the supporters the pregnant woman is considering can actually be supporters. As social resources in the community, introduce visiting nurses and helpers, and hold a care meeting including the person in charge of maternal and child health in the community, and possibly the person in charge of the child guidance center. During the period from delivery to one month postpartum, assessments of childcare skills during hospitalization, mental status before and after delivery, and marital relationships are conducted, and mental health (EPDS) and bonding (questionnaire on feelings toward baby) are assessed at the pre-discharge, 2-week, and 1-month checkups, and community contact is made. Telephone consultation is provided for concerns about childcare after discharge, and information is shared among obstetrics, pediatrics, and psychiatry so that families at high risk of abuse who call or visit the hospital for consultations other than medical checkups will be handled with caution.

If a family is considered to be at high risk of abuse, we refer the family to a child guidance center or a short-stay family. In such cases, be very careful about who, when, and how to communicate. Provide information so that the child care provider can make good use of the information and send out an SOS when he/she has problems with child rearing. Sendai City has a child-care support short-stay program, under which children up to the sixth grade who have a residential address in the city can be taken care of at a child

welfare facility when it becomes temporarily difficult to care for them at home, for up to seven days per visit, for a fee 17).

Although it may be difficult to maintain a therapeutic relationship when the expectant mother herself feels that psychiatric intervention is not necessary, even if she has a mental illness, we try to be involved so that she will continue to visit the hospital to stabilize her mental illness and the child-rearing environment. In addition, we try to discern childcare anxiety that may be behind the abuse and encourage them to connect with supporters while empathizing with them. It is important for the medical staff and supporters to share information and prevent burnout by working together.

III. What Psychiatrists Can Do To Prevent Abuse

In clinical work with pregnant and nursing mothers with mental illness, psychiatrists can play a role in abuse prevention by stabilizing psychiatric symptoms throughout the perinatal period and assessing other factors that may lead to abuse (e.g., emotional evaluation toward the child and family relationships). Considering that the young age of the child is itself a risk factor for maltreatment, and considering the significant impact of the experience of abuse on the child's brain neurodevelopment before the age of one year, it is especially important to stabilize psychiatric symptoms during pregnancy and the first year postpartum.

1. Stabilization of psychiatric symptoms throughout the perinatal period

Appropriate pharmacotherapy and psychological intervention are necessary to stabilize psychiatric symptoms in mothers with psychiatric disorders. It has been reported that schizophrenia, bipolar disorder, and depression might recur after the discontinuation of medication 2)12)19)20). The risks and benefits of psychotropic medications to the fetus and breast milk should be fully explained to patients and their families to help them make decisions (shared decision-making). In addition to pharmacotherapy, psychotherapeutic intervention should be provided whenever possible, paying attention to pregnancy acceptance, psychosocial changes associated with pregnancy, and bonding.

2. Assessing the severity and urgency of mental illness

Next, the severity and urgency of psychiatric disorders should be assessed. In order to prevent mother and child suicides, it is necessary to understand the severity and urgency of psychiatric

disorders and, depending on the situation, they may constitute a psychiatric emergency. This is especially true in cases of severe mental illness such as post-partum psychosis, schizophrenia, bipolar disorder, and severe depression. The NICE Guidelines 2014 recommend "linking to mental health within 4 hours" when postpartum psychosis is suspected 3).

3. Assessment of feelings toward the child and bonding and parenting functions

It is also important to assess feelings toward the child and bonding and child-rearing functions. During pregnancy, we focus on feelings toward the child and carefully ask about the background of poor pregnancy acceptance and negative feelings toward the child. The following factors may be discussed: role changes associated with pregnancy, the mother's growth history (e.g., being an abused child herself), the relationship with the current family, and marital relationship. Postnatal bonding is assessed for the presence of negative feelings, anger, and alienation toward the child, and attention should be paid to secondary bonding disorders (bonding disorders that occur with worsening mental illness). In addition to the sense of difficulty in child-rearing, the degree to which the patient actually takes charge of child rearing and the extent to which family members and supporters help with child rearing should be assessed.

4. Multidisciplinary collaboration

Many institutions and staff are involved in abuse prevention. In particular, perinatal mental health screening and abuse prevention efforts have recently been implemented in obstetrics and community maternal and child health care. The Child Welfare Law defines a "Specified Expectant Mothers" as "a pregnant mother who is particularly identified as one in need of extra support after giving birth". "The Guide for Responding to Child Abuse (revised edition of August 2013)" 8) describes "pregnant women with mental problems, intellectual challenges, alcohol dependence, drug dependence, etc." Psychiatrists are sometimes requested by municipalities and child guidance centers to provide information regarding psychiatric visits. Although it is desirable to provide such information with the consent of the person concerned, according to a 2012 Ministry of Health, Labour and Welfare notice 7), provision of information from a medical care provider to a government agency via a Regional Council of Countermeasures for Children Requiring Aid (hereinafter referred to as a "Council") is a legitimate act under the law based on Article 25-2,

paragraph 2 of the Child Welfare Law, and is not considered a violation of the duty of confidentiality. In addition, provision of information from a medical care provider to an administrative agency without the involvement of a council is also considered a legitimate act as long as it is necessary and within the scope of socially accepted norms, and does not basically constitute a violation of the confidentiality obligation 4)7). It is an important role of psychiatrists to actively collaborate with these other organizations while fully understanding the roles and functions of multiple professions, share information on the psychiatric evaluation and diagnosis of pregnant and nursing mothers, and provide advice on future involvement.

Conclusion

We have summarized the role of psychiatrists in abuse prevention based on the practice of outpatient perinatal mental health care clinic. The involvement of multiple fields of medicine, health, and welfare in measures against abuse, and the involvement of psychiatrists at each stage of life, such as the perinatal period, infancy, childhood, adolescence, and adulthood, to counteract the medium-to-long-term effects of abuse, will be required to a greater extent in the future.

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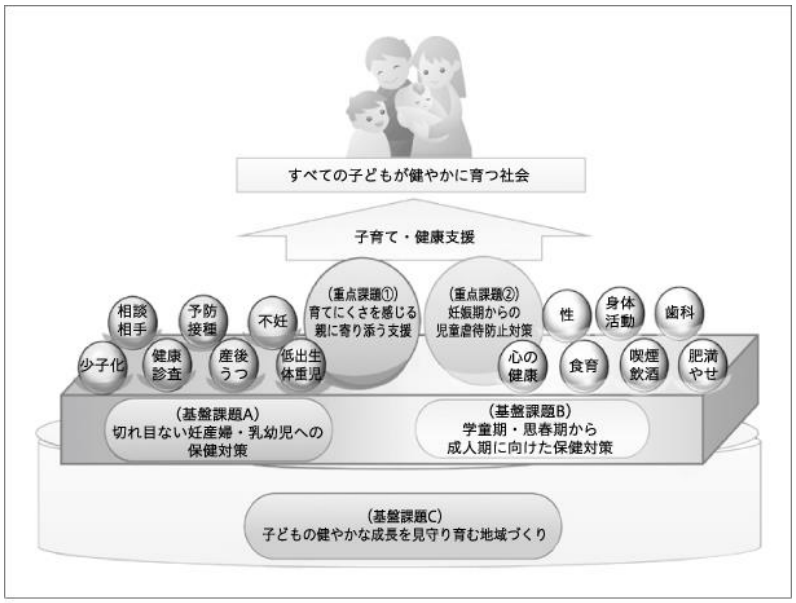

図1　健やか親子21（第2次）イメージ図
（文献9より引用）

Figure 1: Image of Healthy Parents and Children 21 (Second)
(Adapted from Reference 9)

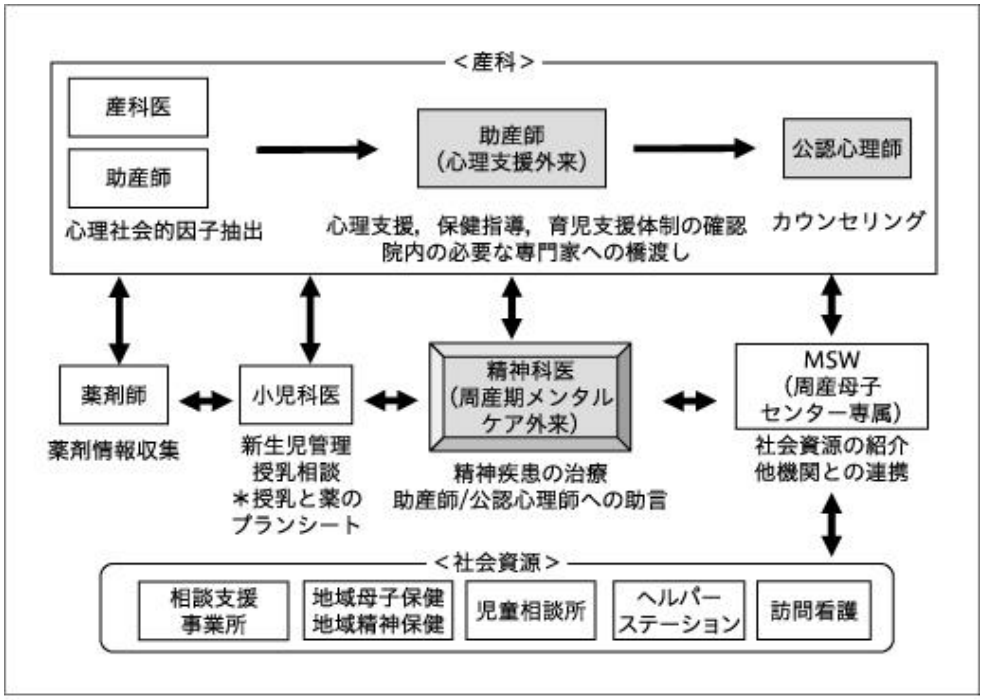

図 2　東北大学病院の周産期メンタルケア外来と多職種連携イメージ図

Figure 2: Image of outpatient perinatal mental care and multidisciplinary collaboration at Tohoku University Hospital

表　虐待に至るおそれのある要因・虐待のリスクとして留意すべき点

保護者側のリスク要因
・妊娠そのものを受容することが困難（望まない妊娠）
・若年の妊娠
・子どもへの愛着形成が十分に行われていない（妊娠中に早産など何らかの問題が発生したことで胎児への受容に影響がある，子どもの長期入院など）
・マタニティブルーズや産後うつ病など精神的に不安定な状況
・性格が攻撃的・衝動的，あるいはパーソナリティの障害
・精神障害，知的障害，慢性疾患，アルコール依存，薬物依存など
・保護者の被虐待経験
・育児に対する不安（保護者が未熟など），育児の知識や技術の不足
・体罰容認などの暴力への親和性
・特異な育児観，強迫的な育児，子どもの発達を無視した過度な要求など

（文献 8 より改変して引用）

Table: Factors that may lead to abuse and points to keep in mind as risks of abuse

Risk factors on the guardian's side:
・Difficulty in accepting the pregnancy itself (unwanted pregnancy)
・Young pregnancy
・Insufficient attachment formation with the child (e.g., preterm birth or other problems during pregnancy that affect acceptance of the fetus, prolonged hospitalization of the child, etc.)
・Maternity blues, postpartum depression, or other mental instability.
・Aggressive or impulsive personality or personality disorder
・Mental disorder, intellectual disability, chronic illness, alcoholism, drug addiction, etc.
・Parental experience of abuse
・Anxiety about child rearing (e.g., inexperienced parents); lack of knowledge and skills in child rearing
・Affinity for violence, such as acceptance of corporal punishment
・Peculiar views on child rearing, obsessive-compulsive child rearing, excessive demands that ignore the child's development, etc.
(Adapted with modifications from Reference 8)