Worcestershire Acute Hospitals NHS Trust

Management of mental health issues in pregnancy

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Key Amendments

Date	Amendments	Approved by

Introduction and Principles of Care

Introduction

Although pregnancy has typically been considered a time of emotional well being, recent studies suggest that up to 20% of women suffer from mood or anxiety disorders during pregnancy. Particularly vulnerable are those women with histories of psychiatric illness who discontinue psychotropic medications during pregnancy.

Mental illness is one of the primary indirect leading cause of maternal mortality (MBRRACE, 2015). Women who have had an episode of mental illness following a previous delivery have a one in two to three chance of recurrence.

Mental Health Issues may also develop in the postnatal period, where there has been no identified history. Mental disorders during pregnancy and the postnatal period can have serious consequences for the health and wellbeing of a mother and her baby, as well as for her partner and other family members.
The purpose of this guideline is to provide a clear pathway for women with mental health needs whilst they are receiving maternity care.

Principles of Care

Relevant to	All maternity service staff
Purpose	To ensure effective and equitable care for women with perinatal mental health issues

Women with an existing mental disorder who are pregnant or planning a pregnancy, who develop a mental disorder during pregnancy or the postnatal period should be given information at each stage of assessment, diagnosis, and treatment about the impact of the disorder on their health and the health of their baby. This information should cover the use and side effects of medication.

All staff should work to develop a trusting relationship with the woman, and with consent involve her partner and family members. In particular, they should:

1. Explore and listen to the woman's ideas, concerns and expectations and regularly check her understanding of the issues.
2. Discuss the level of involvement of the woman's partner, family members and carers, and their role in supporting the woman.
3. Be sensitive to the issues of stigma and shame in relation to mental illness.

Continuity of care and effective transfer of information will reduce the need for multiple disclosures and assessments.

The care of the patient will be provided by a Multi-agency Team which may consist of following groups:

- General practitioner
- Consultant Obstetrician
- Consultant Psychiatrist
- Midwife
- Community psychiatric nurse
- Health visitor
- Social / children's services
- Voluntary services.
- Psychotherapist
- Psychologist
- Family support Worker

Pre-Conceptual Counselling

Pre-conception counselling and support should be both opportunistic and planned. It should be provided for women of childbearing age with pre-existing serious mental health conditions that may be aggravated by pregnancy. Preconception counselling will be primarily provided by consultant Psychiatrist if currently receiving mental health services.

First Antenatal booking appointment

Early detection of mental health problems in pregnancy is essential however not exclusive to a given timeframe in pregnancy. For this reason repeated screening is essential. The handheld antenatal records provide the tool for this information to be gathered and recorded a minimum of three times during the pregnancy, once in each trimester. This is essential in all cases regardless of lead care provider or place of care.

Identification of mental health problems

The health care professional (Midwife, Obstetrician, GP, Health visitor) completing the patient hand held records at booking should ask all women about their past or psychiatric history. This should be done in a sensitive manner, and this may be postponed if the woman has a partner with her and does not want him/her to know.

Suggested questions to identify possible current depression that the health care professional can ask during the first contact with the woman at the primary care / booking appointment are:

1. During the past month, have you felt low, hopeless or depressed?
2. During the past month, have you been bothered by having little interest or pleasure in doing things?

A third question should be considered if the woman answers 'yes' to both of the initial questions:

"Is this something you feel you need or want help with?"

General practitioners should ensure that all relevant information concerning a woman's current or previous psychiatric history is included in referral letters to the booking clinic.

Information regarding the current or previous psychiatric history should be documented with consent, in the patient hand held notes, details should include:

- Nature and severity of illness
- Treatment
- Health Professional involved

Completion of the risk assessment form (MD20) and the flow chart (appendix 1) for referral and assessment to mental health services should be completed by the community midwife and both should be attached to the women's hand held notes.

Action to take if the woman answers 'Yes' to the screening questions but does not have a history of mental health treatment or family history of severe mental illness

- Woman to contact GP for mental health assessment
- If required, the GP will treat and manage the issues with the woman or will refer the woman to the Mental Health team where appropriate.

Action to be taken if woman has a previous history of inpatient or outpatient psychiatric treatment

- Refer to the obstetric Consultant clinic
- With consent, contact Community Mental Health key worker if women is currently in contact with Mental Health Services
- Refer to Perinatal Mental Health Team for assessment if not currently under their care.
- Perinatal Mental Health Services for their area for assessment if not currently in contact with mental health services, using referral flow chart (appendix 1).

The health professional completing this assessment should write a clear plan on page 11 of the patient hand held records and record in all versions of her notes (handheld, maternity hospital, primary care and mental health). This plan should be agreed with the woman, and should usually be completed in the first trimester. If not already aware of the assessment and referral the G.P should be informed and or updated of any current plan.

Criteria for referral for Consultant Obstetrician led care

If the woman has a significant history of any of the following (either currently or in the past):

1. Depression where out-patient or in-patient care was required.
2. Anxiety / panic attacks
3. Current or recent Eating disorders
4. Puerperal psychosis
5. Bi-polar disorder
6. Schizophrenia
7. Self harm / overdose / suicide attempts
8. Other psychiatric conditions / mental health problems
9. Previous treatment by psychiatrist or mental health team
10. Significant Family history of perinatal mental illness (first degree relative only)

Action required following assessment by obstetrician and specialist mental health service

All correspondence relating to mental health assessment or individual care plans should be filed in a pink alert envelope in the hospital records.

The woman and her family should be informed of how to access services promptly if a crisis situation arises.

Women with a past or current history of serious psychiatric disorder should receive the most intensive level of care. If a woman is non-compliant or fails to attend appointments this must be clearly documented and an action plan made and promptly followed up by the health care professional involved. In all cases ensure good liaison between all professionals involved.

Ongoing Care for all Women during the Antenatal period
Antenatal advice for all women should include recognition of antenatal and postnatal depression and the importance of seeking help if necessary.

Mild to Moderate Depression or Anxiety

For pregnant women who have symptoms of depression and / anxieties that do not meet diagnostic criteria but that significantly interfere with personal and social functioning:

1. Liaise with GP and Health Visitor, and other local support services (e.g. Childrens Centre Services) as appropriate

If previous history of Postnatal Depression, but "currently well", the health care professional providing care should:

- Discuss/counsel re risk of reoccurrence
- Ensure the women are aware of the importance of seeking help in pregnancy and post delivery.
- Ensure the women are aware of who to contact if assessment or further advice is required.
- This should be documented in the women's records.

Specialist midwives for vulnerable women and link midwives
The specialist midwives can provide continuity of care for those women who have complex problems and significant mental health problems. Advice and referral can be made to them directly. Link midwives at Worcester and Alexander Hospital are available in the antenatal clinic for advice and support.

	Kidderminster	07786963414
	Droitwich - Evesham	07919598304
	Worcester - Malvern	07786431798
	Redditch	07717530360
	Worcester Antenatal Clinic	01905 760573
	Redditch Antenatal Clinic	01527 512004

Further considerations

Home birth/ Birth Centre
Those women who wish to undergo home birth should have a plan documented in their notes after discussion with their consultant obstetrician. A **multidisciplinary team** meeting may be considered this should include Obstetrician, Paediatrician, Psychiatrist, and Community Midwife, Supervisor of Midwives and the women and her partner.

History of Substance Misuse
Consider liaison with community drug team (CDT). Psychiatric referral may not be necessary. See guidelines on the management of substance misuse. If dual diagnosis (i.e. mental illness and substance misuse) joint working is required.

Child Protection / Confidentiality Issues
Confidentiality is an important principle of service delivery especially in cases of mental health services. Parents and carers should be made aware of the limits of confidentiality early in the pregnancy before it becomes an issue. The Department of Health has set out a framework for information exchange and maintenance of confidentiality. Personal information about children and families should not be disclosed without the consent of the person involved. However the law permits the disclosure of confidential information necessary to safeguard the child or children. Disclosure should be justified in the written record of each case.

Domestic violence
Maternity care providers should be vigilant in identifying and communicating any possible risk factors including domestic violence to specialist services and the named midwife for domestic violence. (See guidelines on Domestic Violence)

Medication during pregnancy or when breastfeeding

- Refer to Obstetrician in pregnancy.
- If woman taking drugs with known teratogenic risk (lithium, valproate, carbamazepine, lamotrigine, paroxetine) offer appropriate screening and counselling about the continuation of the pregnancy. If the pregnancy continues additional monitoring may be required.
- Prescribing psychotropic medication during pregnancy and while breastfeeding, should be undertaken on specialist expert advice.
- Obstetricians are not expected to prescribe medication for mental illness, however they should be aware of the following factors:

1. Discussion should take place with the woman about absolute and relative risks associated with treating and not treating mental disorder.

2. If considering stopping drugs in pregnancy the following should be taken into consideration:
   - NICE guidance on specific disorder
   - Risk to fetus or infant during withdrawal period
   - Risk from not treating the disorder.

3. Further advice regarding risk of teratology can be obtained from:
   - Wolfson Unit - Neonatal Teratology Centre in Newcastle 0191 232 1525

- Worcestershire Royal Hospital Pharmacy 01905 760611 or internal extension 30435

  Specialist information on drugs in psychiatry can be obtained from the specialist mental health pharmacist on call. Liaise with Paediatricians in preterm deliveries.

4. Preterm delivery, paediatricians should be made aware if the mother is taking medication for mental health disorders. This is especially important if the mother is breast feeding as a preterm baby may not be able to efficiently eliminate any small amount of drugs it receives in the milk.

For further information in relation to specific considerations for the use of psychotropic drugs during pregnancy and the postnatal period, please refer to NICE Guidelines on Antenatal and Postnatal Mental Health. NICE CG045 Antenatal & Postnatal Mental Health

Action

- All medication should be clearly documented in hand held records and hospital notes this should include dosage and frequency of medication.
- Discussion of the risks and benefits of medication should be recorded in PHHR/ hospital records.
- Paediatric antenatal referral should be considered if more than one medication is prescribed and any plan of care for the neonate placed in the pink alert envelope in the mother's notes. Copies of this plan should be sent to the neonatal unit and delivery suite. (See Antenatal Paediatric Referral Guideline.)

Care for all women in postnatal ward

The onset of a serious mental illness following childbirth tends to have an early and rapid onset, with the illness often developing very quickly over a period of 24-48 hours. Such illnesses may be life threatening

50% of these illnesses have presented by day 7 and 90% by 3 months postpartum. NICE guideline for Antenatal and Postnatal Mental Health recommends women who require admission to specialised hospitals, should be admitted together with their infant to a specialised mother-and-baby unit.

All women should have their mental wellbeing monitored at each postnatal contact and documented in the mother's purple postnatal notes. Women should be asked about their emotional well-being, what family and social support they have and their usual coping strategies for dealing with day-to-day matters. Women and their families/partners should be encouraged to tell their healthcare professional about any changes in mood, emotional state and behaviour that are outside of the woman's normal pattern.

Health care professional should have access to local social support networks, contact details and ensure these are up to date and relevant.

Formal debriefing of the birth experience is not recommended

Disorder	Baby Blues	Depression	Psychosis

Incidence	50%	15-20%	1:1000
Onset	2-5 days	Early onset possible - 6months	1-2 weeks
Duration	A few days	May last for an extended period of time.	Weeks –months.

The full range of Psychiatric illnesses can be found on www.rcpsych.ac.uk
All healthcare professionals should be aware of signs and symptoms of maternal mental health problems that may be experienced in the weeks and months after the birth.
Here is a list of common signs, this list is not exclusive:

- Less able to cope with the demands of the baby and of the home
- A feeling of despondency
- Overwhelming feeling of sadness
- Crying frequently fearful and anxious about your own health or the baby's
- Panic attacks
- Overwhelming tiredness or hyper activity and restlessness energy
- Totally exhausted
- Poor appetite or overeating
- Suicidal thinking
- Thoughts of harming the baby.

On discharge from hospital
Women with existing mental health problems are at increased risk of postnatal depression and exacerbation of their mental illness. To help reduce these risks:

- Ensure health visitor and GP are aware of discharge by fax or phone by the midwife responsible for discharge.
- Ensure woman is aware of support services and phone numbers. (These may need to be arranged before discharge and should be clearly documented in the postnatal records.)

Screening for postnatal depression using Edinburgh Postnatal Depression Scale is routinely undertaken by Health Visitors. Extreme cases may need to be discussed in a case conference with multidisciplinary professionals.

At 10–14 days after birth, women should be asked about resolution of symptoms of baby blues (for example, tearfulness, feelings of anxiety and emotional liability.) If symptoms have not resolved, the woman should be assessed for postnatal depression, and if symptoms persist, evaluated further.

Seeking help in urgent/emergency situations

Acute Psychosis

Puerperal psychosis is a severe condition and there may be no previous psychiatric history.

- The condition is unpredictable and requires admission to a specialist unit.

- Remain calm; the vast majority of violence and aggression does not arise from psychosis.
- The woman should not be left alone with the baby or other children.
- If the psychosis is identified whilst in hospital, the perinatal mental health team or the Psychiatric Rapid Response Team must be contacted to assess the woman.
- If this occurs out of hours/weekend then the Perinatal team should be telephoned and made aware as soon as possible.
- The woman should not be left unattended, and if possible should be moved to a single room ensuring any equipment that could cause harm is removed.
- Should the woman show any signs of psychosis, refer to duty psychiatrist, obstetrician and senior midwifery manager.
- If the psychosis occurs in the community, the GP should be notified and admission arranged.
- Health visitors, social services and safeguarding children team may be involved.

Referral pathways for acute mental health problems and Emergency contacts

		Alexandra Hospital	**Kidderminster Hospital**	**WRH**
In patient	0900-1700	Liaise with Psychiatric team 01905 734573	Not applicable	Liaise with Psychiatric team 01905 734573
In patient	After 1700 & weekends	Bleep on call psychiatrist via switchboard	Not applicable	Bleep on call psychiatrist via switchboard
Out patient	0900-1700	Contact perinatal team for advice 01905 734573	Contact perinatal team for advice 01905 734573	Contact perinatal team for advice 01905 734573
Out patient	After 1700 & weekends	North PES team 01527 488400	North PES team 01527 488400	Crisis and home treatment team 01905 768030

✹PES team - Psychiatric Emergency Services (Crisis Team)

Further Advice on Specific Disorders

Refer to NICE guidelines on Antenatal and Postnatal Mental Health for further advice on the following specific disorders: NICE CG045 Antenatal & Postnatal Mental Health

1. Depression
2. Generalised anxiety disorder

3. Panic disorder
4. Obsessive – compulsive disorder
5. Post traumatic stress disorder
6. Eating disorders
7. Bi polar disorder
8. Schizophrenia

Documentation

- Any plan of care from the psychiatric team must be documented in the woman's pregnancy notes.
- All plans of care and actions taken must be documented clearly in the woman's records and communicated to her GP and community midwife directly by the perinatal mental health team or the consultant obstetrician
- If advice is obtained from pharmacy or the paediatric team regarding medication and breastfeeding, this should be documented in the hospital notes and in PHHR and any plan of care placed in the pink envelope.

Appendix 1 - Management algorithm

Please attach patient sticker here or record:

Name:.....

Unit No.

D.O.B: ...../...../.....

Male ☐ *Female* ☐

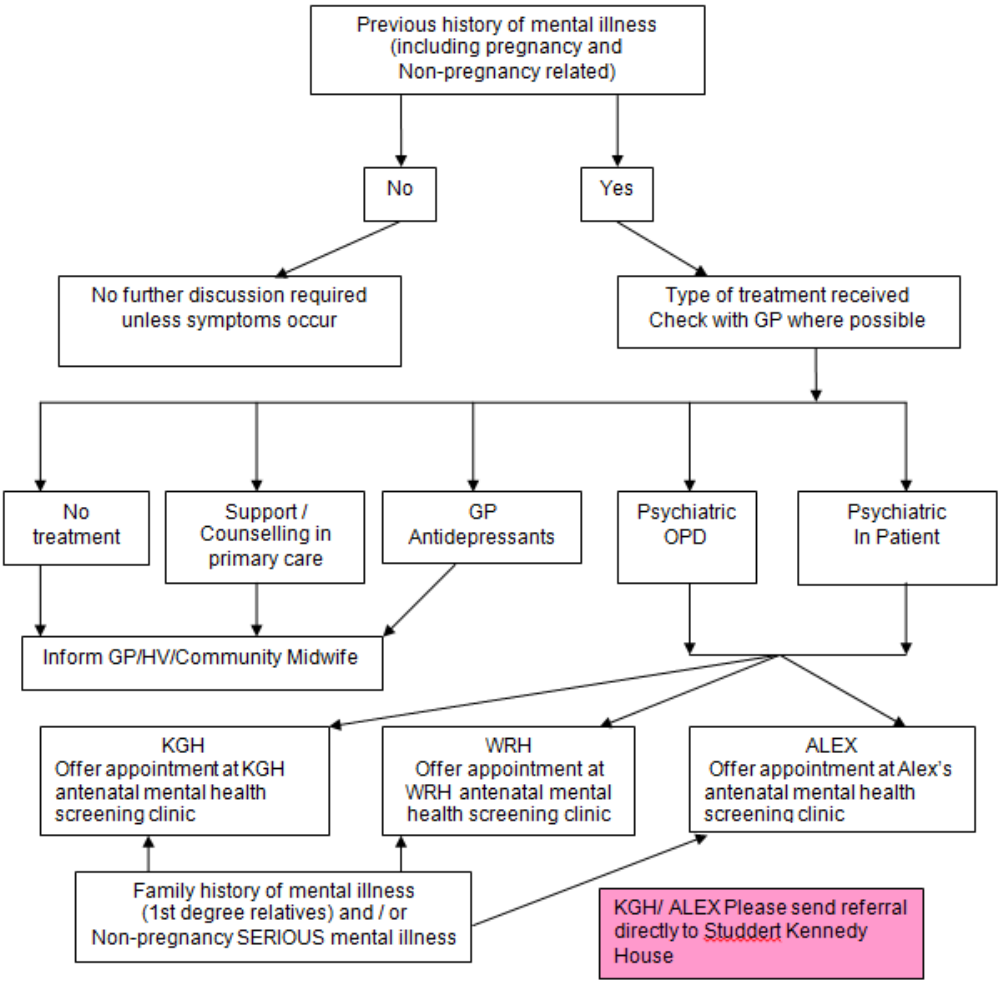
Consultant:..... Ward: .....

Assessment completed by:

Name:.....

Designation: .....

Date:...../...../.....



Appendix 2 - Worcestershire Mental Health Partnership NHS Trust Perinatal Mental health recommendations for drugs in pregnancy and lactation September 2006

Healthcare Professionals should discuss contraception and the risks of pregnancy (including relapse, risk to the foetus and risks associated with stopping or changing medication) with all women of child-bearing potential who have an existing mental disorder and/or who are taking psychotropic medication. Such women should be encouraged to discuss pregnancy plans with their doctor. (*NICE Clinical Guideline 45: April 2007*)

Before starting therapy → If possible, avoid all drugs especially in the first trimester. Balance the risk of not prescribing medication with untreated mental health symptoms

Before stopping therapy → Balance the high risk of relapse of major psychiatric illness with continuation of medication Consider safer alternatives

Antidepressants → Amitriptyline, Imipramine; SSRIs - sertraline / fluoxetine
SSRIs may be associated with an increased risk of miscarriage

Increased risk after 20 weeks gestation regarding persistent pulmonary hypertension of Newborn (PPHN). A *six* fold increase in relative risk with first line SSRIs – absolute risk of PPHN remains low at around 1%

→ **Avoid** MAOIs Paroxetine, Citalopram
Do not Switch SSRIs

Antipsychotics (Neuroleptics Major Tranquillisers) → Trifluoperazine Haloperidol Traditional depot Quetiapine → Anticholinergics Procyclidine but observe for any neonatal withdrawal

Sedatives → Promethazine

Mood stabilisers → No ideal choice - must be discussed with perinatal psychiatry team.
Lithium, Carbamazepine, Lamotrigine best avoided during first trimester. In utero exposure to Valproate poses the highest risk and should be avoided in all females of child-bearing potential.
Folic acid 5mg to be given to patients on Carbamazepine or Valproate preconception and during first trimester.

Anxiolytics → Diazepam, lorazepam and chlordiazepoxide are used but facial cleft abnormalities may occur if used in the first trimester: respiratory depression and hypothermia may occur if high doses are used too close to delivery

Hypnotics → Zopiclone in preference to zolpidem (safety not established)
Temazepam

General Information

- There is generally more information available for older drugs.
- Select smallest effective dose.
- Use drugs with shorter half lives wherever possible.
- Neonatal withdrawal from psychotropic medication may occur post partum because infant exposure will be reduced compared with that before birth.
- Consider discussing with paediatrician via antenatal referral form
- Advice on drug effects on infant can be sought antenatally from Paediatric Pharmacist or Medicines Information via Worcester Royal Hospital switchboard.

Further Information

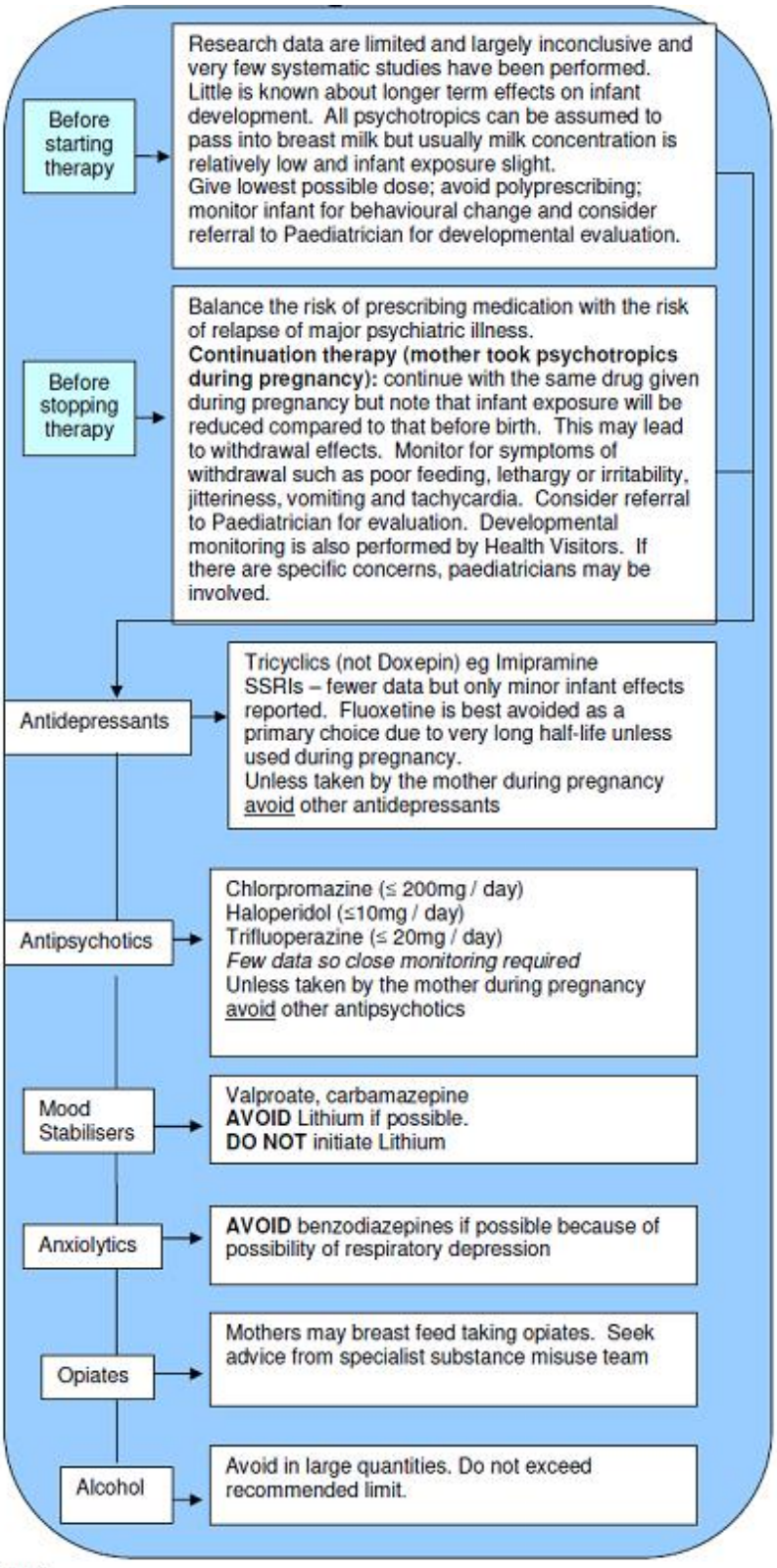
Perinatal Psychiatric Team –
Tel: 01905 734572

National Teratology Information Service
Tel: 0844 892 0909
Mon-Fri : 8.30am-5.00pm
http://www.uktis.org/

Useful website
http://www.motherisk.org/women/index.jsp

Mental Health Specialist Pharmacy Team
Tel: 01905 354180

Revised July 2010



General Information

- Avoid breast feeding if
  1. mother is taking MAOIs, lithium or clozapine. For all other drugs discuss with paediatricians during pregnancy.
  2. Infant has evidence of renal impairment, hepatic impairment, cardiac problems or neurological problems.
- Prematurity is not an absolute contraindication.
- If breast feeding while taking psychotropics, **avoid** feeding infant **within an hour of peak levels.** Time to peak after mother's ingestion is known for the following:-

Haloperidol:	2-6 hours
Quetiapine	1- 3 hours
Imipramine:	1-2 hours
Amitriptyline:	2-4 hours
Sertraline:	8 hours
Fluoxetine:	1.5 -12 hrs
Venlafaxine	2-4 hours

- For other drugs, suggest giving drug as a single daily dose before the infant's longest sleep period (feeding should take place immediately before this dose is given). May be discussed with paediatrician.
- Monitoring of the infant may include biochemical and behavioural indices.
- Psychiatric care plans may be available out of hours via the Crisis and Resolution team

Further Information
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Tel: 01905 354180

July 2010

Appendix 3 - Useful contact numbers

Depression Alliance ..... 0845 123 2320.

Focus Line ……..….. 0800 027 2127 (24hr helpline)

MDF. The Bipolar organisation ……. 0845 434 9970

Meet-a-Mum Association ……0845 120 3746

Anxiety UK …… 08444 775 774

NSPCC ……...0808 800 5000 (24 hrs, safeguarding children)

Parent line Plus ……. 0808 800 2222 (Support for parents)

The Association for Postnatal Illness ….. 020 7386 0868.

Triumph Over Phobia ……... 0845 600 9601

WEB SITES

www.resourcedirectory.co.uk (Mental Health Directory).

www.freefromfear.org (Domestic Violence).

www.parentlineplus.org.uk (Parent support).

www.nspcc.org.uk (Safeguarding Children).

www.rcpsych.ac.uk (royal college of Psychiatrists)

www.mentalhealth.org.uk (Mental health information)