# Perinatal Mental Health

## Introduction

About one in 5 women suffer from a mental health problem in the perinatal period and these may be either pre-existing or new conditions. The management of childbearing women differs from other times because of the nature of this life stage and the potential impact of any difficulties and treatments on the woman and the baby. There are risks associated with taking psychotropic medication in pregnancy, during breastfeeding and risks of stopping medication for an existing mental health problem (NICE, 2014). There is also an increased risk of postpartum psychosis (NICE, 2014).

NICE (2014) emphasises recognition of mental health problems by all healthcare professionals not just at booking but during every contact a health care professional has during the entire antenatal and postnatal period. It emphasises the need to include anxiety disorders as well as depression, and to promptly identify severe mental disorders as well as understanding their nature. It also emphasises that postpartum psychosis is an emergency in the postpartum period and needs to be managed promptly and efficiently.

This abbreviated version of our clinical guideline at Saint Mary's will give GP's more information about prescribing for perinatal mental health in pregnancy, referral to specialist support services and about relevant support networks that may benefit the women in your care.

## Recognising mental health problems in pregnancy, the postnatal period and at booking (NICE 2014)

At all contacts during pregnancy and the first year after birth, the health visitor and other healthcare professionals who have regular contact with the woman should ask the two depression questions and using GAD-2 as well as the EPDS or the PHQ-9 as part of monitoring (NICE 2014)

- During the past month have you often been bothered by feeling down, depressed or hopeless?
- During the past month have you often been bothered by having little interest or pleasure in doing things?

GAD-2: (NICE 2014)

- During the last month have you been feeling nervous, anxious or on edge?
- During the past month have you been not able to stop or control worrying?

## Signposting to relevant support networks

When a mental health problem has been identified women should be signposted to the relevant support networks as appropriate. These include:

- www.selfhelpservices.org.uk
- Sure Start children's centres: www.gov.uk/find-sure-start-childrens-

centre

- The association for postnatal illness: www.apni.org   Tel 020 7386 0868
- www.pandasfoundation.org.uk ( antenatal and postnatal advice and support)
- www.bipolaruk.org.uk - 020 7931 6480
- The Sanctuary - 0300 003 7029 (24 hour phone line or face to face 8pm-6am 7 days a week)
- Crisispoint – 0161 225 9500 ( 6am -12 midnight ,7 days a week)
- Samaritans: www. samaritans.org  Tel 116 123
- Family action: www.family-action.org.uk
- Relate: www.relate.org.uk 0300 100 1234
- Home Start www.home-start.org.uk
- Mind: www.mind.org.uk : Tel 0300 123 3393.
- Cry-sis www.cry-sis.org.uk  Tel 08451 228669
- Greater Manchester  domestic abuse helpline 0161 636 7525 (www.endthefear.co.uk)
- 24/7 National Helpline Number for Domestic abuse: 0808 2000 247
- Sexual assault referral centre (Saint Mary's Centre): http://www.stmaryscentre.org/ 0161 276 6515
- Action on post-partum psychosis www.app-network.org
- Best Beginnings: Out of the Blue Campaign to improve awareness and access to help for perinatal mental health problems, including informative videos and the baby buddy app www.bestbeginnings.org.uk/out-of-the-blue
- RCGP perinatal mental health toolkit http://www.rcgp.org.uk/clinical-and-research/toolkits/perinatal-mental-health-toolkit.aspx

**Psychotropic medication in pregnancy and lactation**

If a woman is taking psychotropic in pregnancy or whilst breastfeeding, and you are unsure about prescribing, you can contact the Specialist Midwife on 0161 701 3522 for advice on stopping or changing medication.

Please note that no psychotropic medication has UK marketing authorisation specifically for women who are pregnant or breastfeeding. The prescriber should therefore follow relevant professional guidance and have a full discussion of risks and benefits of medication in pregnancy with a pregnant women regarding the decision to start or continue medication..

Please note, if a woman who is pregnant is taking valproate for a mental disorder, please contact the perinatal mental health team immediately. Valproate can cause harm to up to 50% of unborn children and should only be prescribed to women with mental disorders in  exceptional circumstances. The perinatal mental health team will contact the prescriber and ensure that the woman receives a psychiatric review within 48 hours.

**Other psychotropic medication and breastfeeding:**

If a woman is taking antipsychotic, lithium or anti-epileptic (taken for mental health disorders) medication she would have normally been seen in the perinatal mental

health clinic before delivery and will have a perinatal care plan with breastfeeding advice. In all women who have been seen by the team, the plan discussed with the patient should not be changed without checking it with the Specialist Midwives for drugs alcohol and mental health or an obstetrician who has a special interest in perinatal mental health.

## Antidepressant medication in pregnancy and lactation

### Women taking antidepressants at booking/beginning of pregnancy:

Depression is common, particularly in inner city populations, and as such a significant proportion of women who book at Saint Mary's Hospital (central site) are likely to be prescribed antidepressant medication at the time they discover they are pregnant. This often causes concerns to the woman, her family and at times healthcare providers. This is often due to links that have been made to fetal effects in both lay and medical press which have been the source of controversy.

Women on antidepressant medication should be offered a referral to the perinatal mental health team where an in-depth discussion on risks and benefits can take place, but in the interim, the following points can be discussed:

- Not treating mental health problem carries risks in pregnancy. Harm can arise from untreated illness in the form of poor self-care, missed antenatal appointments, poor nutrition, bonding and attachment problems in the postnatal period, long term emotional and behavioural disorders in children raised by those with untreated illness and in severe circumstances self-harm/suicide.
- Explain that there is more reassuring data about the safety in pregnancy of commonly prescribed drugs, like selective serotonin reuptake inhibitor (SSRIs), compared to drugs such as lithium. For SSRIs the magnitude of the risk to the baby is exceptionally small, except for neonatal withdrawal syndrome which can affect 1 in 3 babies. This syndrome is usually mild and transient.
- Antidepressant medication should not be discontinued without discussion with the perinatal mental health team or the GP. If a woman wishes to discontinue her antidepressants she should discuss reducing her regime with their GP rather than suddenly stopping it in order to avoid withdrawal symptoms.

**Antidepressants and teratogenicity**:-
The volume of evidence has steadily increased for SSRIs in the last few years and the concerns have decreased. Current evidence suggests that, if there is an effect on cardiovascular anomalies, it is very small and the involved conditions may not have clinical significance (Grigoriadis et al, 2013). There is an exception and that is paroxetine which has more consistently been associated with a small risk of cardiovascular defects. Less is known about other antidepressants and contact should be made with the perinatal mental health team or the patient should discuss the medication with her GP.

**Antidepressants and autism:-**
To date, there are no compelling data to suggest that antidepressant use in pregnancy significantly contributes as a causal factor in the development of autistic spectrum disorder (Raj et al, 2013).

**Antidepressants and Pulmonary Hypertension of the newborn:-**
One study suggested small increased risk of persistent pulmonary hypertension with SSRIs used after 20 weeks. However, subsequent large scale studies have failed to reproduce this finding. Overall the risk is thought to be very low.

**Antidepressants and Neonatal Abstinence Syndrome**
All antidepressants have the potential to cause withdrawal symptoms in 1 in 3 babies (compared to the same symptoms occurring in 1 in 10 babies in unexposed infants) but it is usually mild and self-limiting. Symptoms include sleeping problems, tremors, constant crying, poor feeding. It is rare that symptomatic treatment is required but an observation period is recommended **only if** symptoms of Neonatal Abstinence Syndrome are displayed **or** there is a care plan specifying that observations are required.

Babies showing no signs of neonatal abstinence syndrome, who don't have care plans, do not need to routinely remain in hospital for an extended stay. However, signs of withdrawal should be discussed with the mother as part of the discharge plan and she should be advised to contact the community midwife if the baby is displaying mild symptoms or Children's A&E if the baby is displaying significant symptoms, such as seizures.

**Antidepressants and breastfeeding:**
A very small quantity of commonly used antidepressants such as SSRI's are transferred to breast milk and no major adverse events have been reported. For other antidepressants contact the Perinatal Mental Health Team or Consult the Drugs and Lactation database for up to date information:
https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm

## Treating pregnant and breastfeeding women: balancing risks and benefits

To minimise the risk of harm to the fetus or child, drugs should be prescribed cautiously for women who are planning a pregnancy, pregnant or breastfeeding.

As a result, the thresholds for non-drug treatments, particularly psychological treatments, are likely to be lower than those set in NICE clinical guidelines on specific mental disorders, and prompt and timely access to treatments should be ensured if they are to be of benefit. National targets state that pregnant women should access primary care talking therapy within two weeks of referral. Treatments include psychological treatments such as interpersonal psychotherapy or cognitive behavioural therapy, counselling and self-help strategies.

**Discussions about treatment options with a woman with a mental disorder who is planning a pregnancy, pregnant or breastfeeding should cover:**

- The risk of relapse or deterioration in symptoms and the woman's ability to cope with untreated or sub-threshold symptoms
- Severity of previous episodes, response to treatment and the woman's preference
- The possibility that stopping a drug with a known teratogenic risk after pregnancy is confirmed, may not remove the risk of malformations
- The risks from stopping medication abruptly (i.e. the increased risk of mental illness relapse and withdrawal symptoms such as vomiting, nausea, headaches, trouble sleeping, muscle spasms, flu like symptoms and fatigue).
- The need for prompt treatment in order to avoid the potential impact of an untreated mental disorder on the fetus or infant
- The reproductive safety of drug treatments during pregnancy and the postnatal period, including the risk of overdose
- Treatment options that would enable the woman to breastfeed if she wishes – women must not be discouraged from breastfeeding if this is their wish.

**Postnatal period**

Should a possible mental illness be identified by the midwife or health visitor for the first time in the post-natal period; a further assessment must be considered and discussed with the woman and her family. The midwife or health visitor will contact the woman’s GP and arrange an urgent appointment. The midwife must also inform the health visitor of the concerns. All communication must be documented in the woman’s postnatal notes.

If significant concerns are identified it may be necessary to also contact the following for advice:

- Gateway 0161 882 2400 (for women not already under mental health services)
- Manchester Royal Infirmary A&E department – 0161 901 0313
- Salford Royal Hospital A&E department – 0161 789 7373
- North Manchester General Hospital A&E department 0161 795 4567
- Wythenshaw Hospital A&E department – 0161 291 6047
- In case of inpatients refer to the mental health ward liaison team refer via MFTs ICE ordering system or contact the team on ext 65391 or 65355 for advise (Mon-Fri - 09.00 hrs til 17.00hrs ) or if out of hours contact A & E mental health liaison service on ext 10310

**Acute Emergency Concerns**

If there is any suspicion that a woman is developing a postpartum psychosis for the first time or a recurrence of a postpartum psychosis, this must be regarded as a

psychiatric emergency. This is because the illness can rapidly progress to a very severe state and requires urgent intervention.

**Perinatal Mental Health and Safeguarding**

If there is any suggestion that the level of mental ill health will affect the ability to parent safely, a referral must be made to the appropriate Children's Social Care service.

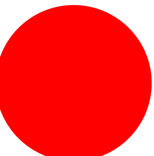
**Specialist services at Saint Mary's**

There are specialist perinatal mental health services available at Saint Mary's, however, due to the number of women affected by mental health concerns a traffic light system is used to prioritise women requiring referral. See the next page for the criteria used.

# Criteria for referral to Perinatal Mental Health Clinic

Referrals are only accepted for women who are booked for care at SMH

**Telephone: - 0161 701 3522 email: substancemh.specialistmw@mft.nhs.uk**

<table>
<tr>
<td>Refer when:<br>Current/previous history of:<br>Schizophrenia<br>Psychosis/psychotic episodes<br>Bi-Polar Disorder<br>Severe depression<br>Any common mental disorder (anxiety disorders, PTSD, OCD, depression, eating disorder) , with severe impairment of day-to-day functioning<br>Previous/current psychiatric in-patient<br>Under care of psychiatrist/Mental Health Services<br>PND requiring contact with M.H. services<br>Several co-existing psychiatric diagnoses<br>Any other M.H. problem causing severe limitation of function (i.e. inability to leave the house/go to work/engage in routine activities of daily life)<br>Fulfilling amber with previous children removed from maternal care<br>Any of the above combined with substance misuse requiring treatment services</td>
<td>Specialist Midwives will refer to: Perinatal Consultant Psychiatrist<br></td>
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<td colspan="2">A referral will be made to the Perinatal Consultant Psychiatrist. Information should include EDD, parity, reason for referral, diagnosis, any crisis issues, and interpreting requirements. Please ensure that women are informed that a referral is being made. A copy of the referral should be sent to the Safeguarding Midwife. The care plan will be co-ordinated by the Specialist Midwife and filed in the hospital notes.</td>
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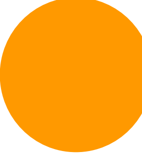
<td>Refer when:<br>Current/previous history of:<br>Eating disorders<br>Tokophobia<br>Moderate to severe anxiety with marked impact on day-to-day functioning<br>Depression moderate.<br>Self-harm (on-going)<br>PTSD (with impact on day to day functioning)<br>Personality disorders<br>Suicide attempt<br>OCD</td>
<td>Specialist Midwives will refer to: Obstetric Consultant with specialist interest<br></td>
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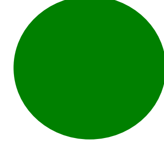
<tr>
<td>Current/previous history of:<br>Mild anxiety disorders<br>Mild depression<br>Currently on medication/or ceased without medical advice<br>Relationship/family/ bereavement problems<br>Social problems<br>Sexual abuse/assault/rape<br>Distressed by unwanted pregnancy/too late for TOP</td>
<td>For Normal midwifery care and on-going monitoring.<br>Inform Health Visitor & liaise with GP<br><br>Women should not be informed that contact will be made by Specialist Midwife<br></td>
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<td colspan="2">Promote positive mental health/well-being e.g. diet/mood foods/ exercise. Give self-help leaflets/telephone numbers Refer on to: SureStart, HomeStart, National Phobics /Self-Help Services (Zion Community Resource Centre), Miscarriage Association, Psychological Services, CAPS, Counselling Services (Kath Locke Centre) CRUISE, RELATE, SANDS, SARC (Sexual Assault Centre), Domestic Abuse Services, IDVA Team<br>For women who do not meet referral criteria for Specialist Midwifery, the documentation of concerns, care plans and attending safeguarding meetings/ Child Protection conferences is the responsibility of core maternity staff. If necessary advice can be sought from the Matron for Safeguarding.</td>
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## References

National Institute for Health and Clinical Excellence (2014) *Antenatal and postnatal mental health* London: NICE.

Howard L, Megnin-Viggars O, Symington I & Pilling S (2014) *Antenatal and postnatal mental health: summary of updated NICE guidance* (BMJ 2014;349:g7394 doi: 10.1136/bmj.g7394). On behalf of the Guideline Development Group

Grigoriadis S, VonderPorten EH, Mamisashhvili L, Roerecke M, Rehm J, Dennis CL et al (2013), *Antidepressant exposure during pregnancy and congenital malformations: is there an association? A systematic review and meta-analysis of the best evidence*, Journal of Clinical Psychiatry, 2013, 74(4), 293-308

Raj D, Lee BK, Dalman C, Golding J, Lewis G and Magnusson C (2013), *Parental depression, maternal antidepressant use during pregnancy, and risk of autism spectrum disorders: population based case-control study*, British Medical Journal 2013;346:f2059

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