University Hospital of North Staffordshire NHS
NHS Trust

**Achieving Sustainable Quality in Maternity Services**

# ASQUAM

# Perinatal Mental Health Guideline

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| **Ratified by:** | Labour Ward Forum Sub-Group<br>Obstetric Guideline Group |
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## Contents

# 1. INTRODUCTION

Perinatal Psychiatry is now the internationally recognised term for mental health disorders which complicate pregnancy and the first postnatal year. These include continuation and relapses of pre-existing conditions and new onset conditions such as antenatal depression, postnatal depression and puerperal psychosis (Henshaw *et al,* 2009). The high incidence of maternal mortality due to suicide as reported in the Confidential Enquiry into Maternal Death (CEMD) has had a significant influence on most of the national perinatal mental health policies (Lewis & Drife, 2001, 2004; Lewis, 2007).

# 2. PURPOSE AND SCOPE

## Prevalence

The World Health Organisation (WHO) predicts that by the year 2020, depression will be the second major cause of disability and premature death worldwide. For every 1000 births, 100-150 of the women will develop a depressive illness (O'Hara & Swain, 1996), as many as half of which will be severe (Lewis & Drife, 2004). For a Trust the size of the University Hospital of North Staffordshire, this equates approximately to 600-900 women every year developing a depressive illness of which 300-450 will be severe.

## Mortality and Morbidity

Mental illness is a significant factor in the maternal mortality rate, suicide being the second highest cause of maternal death (Lewis, 2007). However, mortality is recognised as the *tip of the iceberg* in perinatal psychiatry, with maternal morbidity also seen as a significant problem (Henshaw *et al,* (2009). Diagnosis of disorders can be hampered by the individual's fear of being stigmatised.

Service user issues: - Stewart (2004) identified, that women with serious mental health problems failed to disclose symptoms during pregnancy for fear of being stigmatised. Society categorises people according to their individual attributes and a psychiatric disorder can be seen as a negative attribute or *blemish of character* (Goffman, 1963). However the stigmatising of an individual will depend greatly on its visibility (Goffman, 1963; Mason *et al,* 2001; Page, 1984; Sayce, 2000). The dilemma then becomes one of disclosure (Goffman, 1963). The potential for this label predisposes some women and their families to withhold vital information about previous and family histories of psychiatric disorders (Lewis & Drife, 2004; Stewart, 2004). Shakespeare (2003) highlighted in a qualitative study that mothers were prepared to lie during routine screening to avoid being detected. Consultation with local service users confirmed these findings (Aiken, 2007).

The morbidity, which exists, has been seen to affect the extended family. An association between a mother's depression and its subsequent development in a partner has been reported (Ballard *et al,* 1994). Also, untreated depression in the pueperium is associated with negative effects on the infant's social, cognitive, emotional and behavioural development (Murray & Cooper, 1997; Cooper & Murray, 1997; Field *et al,* 1988; Cogil *et al,* 1986; Sharp *et al* 1995; Murray *et al* 1993; Murray *et al* 1999).

## 3. COMMUNICATION CHANNELS BETWEEN THE MATERNITY SERVICES AND MENTAL HEALTH SERVICES AND THE PROCESS FOR DOCUMENTING PATIENT CONTACTS.

The most recent CEMD report continues to highlight the problem of poor communication between disciplines as a factor for increasing risk to mothers suffering from severe mental health disorders (Lewis, 2007). Appleby *et al* (1997) suggest that delay in delivering treatment to these high-risk women is particularly unfortunate as research shows that response to treatment is good. Co-ordination of a wide range of primary and secondary care services is required for the effective detection and management of perinatal psychiatric disorders. Service providers should include midwives, health visitors, GPs, obstetricians, psychiatrists, community psychiatric services, clinical psychologists and pharmacists, with the support of other agencies, such as, social services and voluntary organisations.

The Health Professional will record in the health record the assessment and advice given at each antenatal appointment. Where a referral is made to another service whether this is in writing or by telephone, this will also be recorded in the health record.

Following delivery, the health professional that discharges the woman will ensure that a summary of the antenatal/intrapartum assessment, advice and care is recorded on the Discharge Summary.

## 4. PROCESS FOR PROVIDING INFORMATION FOR WOMEN WHO NEED COMMUNICATION OR LANGUAGE SUPPORT

Where women need communication or language support in the community setting, the Community Midwife will access the language support facilities provided by the GP Service. The GP codes will be needed for Language Line and within the trust Applied Languages can be used.

Where women are referred to the antenatal clinic and have communication or language support needs identified, the Community Midwife must ensure that this is included in the referral letter to the clinic. The Antenatal Clerk will notifying the clinic midwife, who will then arrange for an appropriate interpreter to be present

at the woman's Antenatal appointment by making a booking with Applied Languages (approved provider for the UHNS Trust)

The Trust Maternity Service also has access to Language Line and some limited in house interpretation and communication support facilities as additional support to women with communication/language support needs.

Language line may be used when an interpreter is not available.

Any member of the team can access language line by first obtaining approval of the budget holder and obtaining a budget code number and then accessing the service by telephone number 08453109900.

Confirmation that Language Line or the trust interpretation services has been accessed will be documented in the mother's health record

## 5. VARIATION AND PRACTICE

Considerable geographical variation in the management of perinatal psychiatric disorders exists across the UK, but the North Staffordshire area has benefited from the advances made by the Parent and Baby Day Service (PBDS) for 20 years. However, as this service focuses on the more severe day cases and covers a wide catchment area, gaps still exist in facilitating access to care provided by local community services for less severe cases and for those unable to access the day facility.

Historically, health visitors locally have been trained to a high standard in screening for postnatal depression and performing listening visits. Services available via the community and GP surgeries can be accessed via Single Point of Access in both Newcastle-under-Lyme and Stoke-on-Trent areas. All practitioners can refer to the PBDS after 20 weeks gestation and the Mother and Baby unit at Stafford can be accessed for inpatient care if required. Access to Liaison Psychiatry and the Crisis Intervention Team is available for maternity staff in an emergency for maternity inpatients via the Harplands Hospital.

Research has shown that midwives continue to lack confidence and knowledge about dealing with mental health disorders once identified (Stewart & Henshaw, 2002; Keng, 2005; Ross-Davie *et al,* 2006) and consultation locally with service providers confirmed this concern (Aiken, 2007). Further consultation with service users and providers determined that this problem could only be achieved with a suitable training and education programme for service providers (Aiken, 2007).

Since November 2007, the service of a Mental Health Link Midwife has been available in the Trust. The post includes a clinic session within a Consultant led antenatal clinic and minimal client review around the maternity department as time allows. The clinic has been named the Parent Emotional Antenatal Clinic for Health (PEACH) in an attempt to reduce stigma. The main aim of the post is to help with sign-posting clients to the most appropriate care available. This post

requires further development to allow closer links and networking with primary care services, perinatal psychiatrists and community psychiatric services. This development would enhance communication between all disciplines responsible for the care of these clients following a period of education and training.

## 6. IDENTIFICATION AND DIAGNOSIS OF WOMEN ANTE-NATAL PERIOD WHO HAVE A CURRENT MENTAL HEALTH PROBLEM, WHO ARE AT RISK OF DEVELOPING A MENTAL HEALTH PROBLEM OR EXACERBATING A PRE-EXISTING MENTAL ILLNESS AS A RESULT OF THEIR PREGNANCY

As previously stated, perinatal psychiatry includes pre-existing and new-onset mental health disorders during the perinatal period. Ideally, pre-existing disorders will have been properly diagnosed by psychiatric services and this information should have been provided at the booking visit by the client herself and/or by the GP/CMW. This is also an ideal opportunity for the lead psychiatrist to liaise with the obstetric team once pregnancy is identified. Identification of new-onset disorders will require vigilance by maternity workers, which once suspected should be referred to perinatal psychiatric services for full assessment and diagnosis.

As a minimum the initial assessment of the woman should be completed on page 3 (Mental Health) of the WMPI antenatal notes.

Potential psychiatric conditions affecting pregnancy:-
Agoraphobia
Anxiety disorders
Antenatal depression
Bi-polar disorder: - labile mood
Claustrophobia
Clinical depression
Deliberate self-harm (DSH)
Eating disorders: - anorexia nervosa, bulimia nervosa, binge eating
Obsessive compulsive disorder (OCD)
Negative ideation: - DSH, Para-suicidal
Neurosis
Panic disorders
Para-suicide
Personality disorders
Postnatal depression
Post traumatic stress disorder
Psychosis: - including auditory/visual hallucinations
Puerperal psychosis
Schizo-affective disorders
Tocophobia (often as a result of previous sexual abuse/rape/or traumatic delivery)

## 7. RISK FACTORS

Risk factors for psychiatric disorders can be identified by screening to aid optimal targeting of effective interventions. Evidence suggests that the following risk factors as having moderate to strong associations to developing in particular postnatal illness.

- Past history of psychopathology
- Past history of psychological disturbance during pregnancy
- Family history of psychopathology
- Low social support
- Poor marital relationship
- Recent life events
- Prolonged or severe 'baby blues'

## 8. SCREENING

Antenatal- community midwives locally have developed good skills in enquiring about past and family history of psychiatric disorders at the booking visit. Good communication skills are also essential for the CMW to pick up adverse mood during subsequent antenatal checks. Once a potential problem is identified, the individual if consenting is referred to the PEACH midwife and/or consultant obstetrician (Appendix 1). Following further assessment, the client has the option of being referred for counselling via community psychiatric services. However, further education and training is required for medical and midwifery staff to pick up and accurately assess/refer these potential problems. Specific antenatal screening for postnatal depression has not found to be effective with no particular tool giving a clear indication of manifestation (Appleby *et al,* 1994; SIGN, 2002; Henshaw *et al,* 2009). All pregnant women should be screened for previous puerperal psychosis, history of other psychopathology particularly affective psychoses and a similar family history (SIGN, 2002).

## 9. PROCESS FOR IDENTIFYING WOMEN WHO ARE AT RISK OF DEVELOPING A MENTAL HEALTH PROBLEM OR EXACERBATING A PRE-EXISTING MENTAL ILLNESS DURING THE POSTNATAL PERIOD

Postnatal- health visitors in the North Staffordshire area have screened effectively for postnatal depression since the introduction of the Edinburgh Postnatal Depression Scale (EPDS). However, identification of puerperal psychosis or similar florid symptoms is often up to the family, CMW, GP and HV. Here again it is vital to introduce suitable teaching packages/workshops to aid in the diagnosis and management of this extremely debilitating illness.

Health care professionals involved in antenatal and postnatal care should be aware that NICE Antenatal and Postnatal Mental Health Guideline (2007) states that:

- At a woman's first contact with primary care, at her booking visit and postnatally (usually at 4 to 6 weeks and 3 to 4 months), healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask two questions to identify possible depression.

- 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?

- A third question should be considered if the woman answers 'yes' to either of the initial questions[1].

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

As a minimum the initial assessment of the woman should be completed on page 16 (Mental Health) of the WMPI postnatal notes.

## 10. PREVENTION

The evidence of effectiveness of intervention to prevent postnatal depression is conflicting. The findings of the few good randomised controlled trials (RCT), which have been published, have been inconclusive. The current research base for preventative measures in low risk women is very limited, but in high risk women may suggest some effectiveness. The evidence relating to prevention of puerperal psychosis is not of adequate quality to provide a recommendation other than to support the need to receive specialist psychiatric review (SIGN, 2002). There is an argument however for prompt, accurate diagnosis to minimise the extent of potential morbidity.

[1] In this reissued guideline, this recommendation has been corrected by changing 'both of the initial questions'to 'either of the initial questions'.

# 11. MANAGEMENT

Untreated mental health conditions can prolong the morbidity and have serious consequences for the whole family. Studies have shown significant negative effects on the relationship of the parents, the relationship of the mother and child and the emotional and cognitive development of the child (Murray & Cooper, 1997; Cooper & Murray, 1997; Boath *et al,* 1998; Field *et al,* 1988; Cogil *et al,* 1986; Sharp *et al* 1995; Murray *et al* 1993; Murray *et al* 1999).

However, although some studies have shown that only one third of women with depression during pregnancy are treated (Flynn *et al,* 2006), other studies suggest that response to psychosocial and pharmacological treatment is good (Appleby *et al,* 1997). Although rare, risk of suicide, infanticide and ideation of each are possibilities and the potential that this risk may be significantly increased must be considered if conditions go untreated.

## 11.1 THE DEVELOPMENT AND DOCUMENTATION OF AN INDIVIDUAL MANAGEMENT PLAN WHICH WILL INCLUDE THE PHARMACOLOGICAL AND PHYSICAL MANAGEMENT

Given the risk of substantial psychiatric morbidity during pregnancy, many women will require pharmacological or other physical treatments, either because non-drug interventions have not worked or because there is no alternative. A number of factors need to be taken into consideration when weighing up the benefit-risk ratio (Henshaw *et al,* 2009). Not least the potential effect of the untreated disorder on the foetus and family as a whole. Bonari et al, (2004) reviewed the risks associated with untreated depression, highlighting maternal morbidity including suicidal ideation and attempts and adverse neonatal outcomes.

## 11.2 ALL WOMEN MUST HAVE AN INDIVIDUAL MANAGEMENT PLAN IN PLACE WHICH SHOULD BE DOCUMENTED IN THE HEALTH RECORD

The following principles should be considered:

- Each individual should be risk/benefit assessed considering all aspect of maternal and foetal/baby wellbeing
- If possible, where the disorder is mild to moderate in severity, use a non-pharmacological treatment
- Establish a clear indication for drug treatment
- Avoid first-trimester exposure if at all possible
- Use treatments in the lowest effective dose for the shortest period possible
- Where possible the more established drugs are preferable
- Avoid polypharmacy wherever possible, either sequentially or concurrently

- The risks of stopping TCI or SSRI antidepressants should be assessed carefully in relation to the mother's mental state and previous history. Routine withdrawal in early pregnancy is not in indicated

## 12. ANTI-DEPRESSANTS

**Background:**

The evidence suggests that there is no increased risk of spontaneous abortion or major malformation in the newborn from exposure to tricyclic antidepressants (TCAs) and most selective serotonin re-uptake inhibitors (SSRIs) in pregnancy (SIGN, 2002). Altshuler *et al* (1996) concluded that first trimester exposure to TCA was relatively safe, whilst McElhatton *et al* (1996) concluded that the incidence of spontaneous abortion, late foetal deaths and congenital malformations was within normal range for the general population. These findings were mirrored by Ericson *et al* (1999) and Simon *et al* (2002). However, a Swedish study suggested an increased risk of cardiac defects with the use of clomipramine (Kallen & Otterblad Olausson, 2006). NICE (2007) suggest that the TCAs with a lower known risk during pregnancy are: - **Amitriptyline Impiramine** and **Nortriptyline**. Meta-analysis of the evidence suggest the SSRIs, **fluoxetine, citalopram, fluoxamine**, **paroxetine** and **sertraline** are relatively safe in pregnancy (S.I.G.N. (2002), however Henshaw *et al* (2009) conclude that paroxetine carries a small increased risk of congenital malformation and withdrawal symptoms.

In view of the current variation in literature, in PEACH we try to base pharmacological management on individual circumstances taking into account, past medical history, gestational age and the severity of the perinatal mental health illness. Hence, please consult with the PEACH team if you feel necessary. However, whenever feasible we abide by current NICE guidance (2007) which recommends the following:

When choosing an antidepressant for pregnant or breastfeeding women, prescribers should, while bearing in mind that the safety of these drugs is not well understood, take into account that:

- tricyclic antidepressants, such as amitriptyline, imipramine and nortriptyline, have lower known risks during pregnancy than other antidepressants
- most tricyclic antidepressants have a higher fatal toxicity index than selective serotonin reuptake inhibitors (SSRIs)
- fluoxetine is the SSRI with the lowest known risk during pregnancy
- imipramine, nortriptyline and sertraline are present in breast milk at relatively low levels
- citalopram and fluoxetine are present in breast milk at relatively high levels
- SSRIs taken after 20 weeks' gestation may be associated with an increased risk of persistent pulmonary hypertension in the neonate

  - paroxetine taken in the first trimester may be associated with fetal heart defects
  - venlafaxine may be associated with increased risk of high blood pressure at high doses, higher toxicity in overdose than SSRIs and some tricyclic antidepressants, and increased difficulty in withdrawal
  - all antidepressants carry the risk of withdrawal or toxicity in neonates; in most cases the effects are mild and self-limiting.

- For a woman who develops mild or moderate depression during pregnancy or the postnatal period, the following should be considered:

  - self-help strategies (guided self-help, computerised cognitive behavioural therapy or exercise)
  - non-directive counselling delivered at home (listening visits)
  - brief cognitive behavioural therapy or interpersonal psychotherapy.

**Benzodiazepines and mood stabilisers (NICE, 2007)**

**Benzodiazepines**

Benzodiazepines should not be routinely prescribed for pregnant women, except for the short-term treatment of extreme anxiety and agitation. This is because of the risks to the fetus (for example, cleft palate) and the neonate (for example, floppy baby syndrome). Consider gradually stopping benzodiazepines in women who are pregnant.

**Antipsychotics**

Women taking antipsychotics who are planning a pregnancy should be told that the raised prolactin levels associated with some antipsychotics (notably amisulpride, risperidone and sulpiride) reduce the chances of conception. If prolactin levels are raised, an alternative drug should be considered.

If a pregnant woman is taking clozapine, switching to another drug and careful monitoring should be considered. Clozapine should not be routinely prescribed for women who are pregnant (because there is a theoretical risk of agranulocytosis in the fetus) or for women who are breastfeeding (because it reaches high levels in breast milk and there is a risk of agranulocytosis in the infant).

When deciding whether to prescribe olanzapine to a woman who is pregnant, risk factors for gestational diabetes and weight gain, including family history, existing weight and ethnicity, should be taken into account.

Depot antipsychotics should not be routinely prescribed to pregnant women because there is relatively little information on their safety, and their infants may show extrapyramidal symptoms several months after administration of the depot. These are usually self-limiting.

Anticholinergic drugs should not be prescribed for the extrapyramidal side effects of antipsychotic drugs except for acute short-term use. Instead, the dose and timing of the antipsychotic drug should be adjusted, or the drug changed.

**Valproate**

Valproate increases the risk of neural tube defects (mainly spina bifida and anencephaly) from around 6 in 10,000 pregnancies in the general population to around 100 to 200 in 10,000. It also has effects on the child's intellectual development. Many pregnancies are unintended and/or not confirmed until after the 28th day (when the neural tube closes) so care is needed when prescribing the drug.

Valproate should not be routinely prescribed to women of child-bearing potential. If there is no effective alternative, the risks of taking valproate during pregnancy, and the importance of using adequate contraception, should be explained.

Valproate should not be prescribed to women younger than 18 years because of the risk of polycystic ovary syndrome and increased risk of unplanned pregnancy in this age group.

If a woman who is taking valproate is planning a pregnancy, or is pregnant, she should be advised to stop taking the drug. Where appropriate in the treatment of bipolar disorder, an alternative drug (usually an antipsychotic) should be considered.

If there is no alternative to valproate, doses should be limited to a maximum of 1 gram per day, administered in divided doses and in the slow release form, with 5 mg/day folic acid. However, it is not clear how the serum level of valproate affects the risk of abnormalities.

**Lithium**

Lithium increases the rate of fetal heart defects to around 60 in 1000, compared with the risk of 8 in 1000 in the general population. It is estimated that lithium increases the risk of Ebstein's anomaly (a major cardiac malformation) from 1 in 20,000 to 10 in 20,000.

Lithium should not be routinely prescribed for women, particularly in the first trimester of pregnancy (because of the risk of cardiac malformations in the fetus) or during breastfeeding (because of the high levels in breast milk).

If a woman taking lithium is planning a pregnancy, and is well and not at high risk of relapse, she should be advised to stop taking the drug because of the risk of cardiac malformations in the fetus.

If a woman who is taking lithium becomes pregnant:

- if the pregnancy is confirmed in the first trimester, and the woman is well and not at high risk of relapse, lithium should be stopped gradually over 4

weeks; it should be explained that this may not remove the risk of cardiac defects in the fetus

- if the woman is not well or is at high risk of relapse, the following should be considered:
  - switching gradually to an antipsychotic, or
  - stopping lithium and restarting it in the second trimester if the woman is not planning to breastfeed and her symptoms have responded better to lithium than to other drugs in the past, or
  - continuing with lithium if she is at high risk of relapse.

If a woman continues taking lithium during pregnancy, serum lithium levels should be checked every 4 weeks, then weekly from the 36th week, and less than 24 hours after childbirth; the dose should be adjusted to keep serum levels towards the lower end of the therapeutic range, and the woman should maintain adequate fluid intake.

Women taking lithium should deliver in hospital, and be monitored during labour by the obstetric team. Monitoring should include fluid balance, because of the risk of dehydration and lithium toxicity (in prolonged labour, it may be appropriate to check serum lithium level.

**Carbamazepine and lamotrigine**

Carbamazepine is estimated to increase the risk of neural tube defects from 6 in 10,000 to around 20 to 50 in 10,000, and carries a risk of other major fetal malformations including gastrointestinal tract problems and cardiac abnormalities. Lamotrigine carries the risk of oral cleft (estimated at nearly 9 in 1000 exposed fetuses).

If a woman who is taking carbamazepine or lamotrigine is planning a pregnancy or has an unplanned pregnancy, healthcare professionals should advise her to stop taking these drugs because of the risk of neural tube defects and other malformations in the fetus. If appropriate an alternative drug (such as an antipsychotic) should be considered.

Carbamazepine or lamotrigine should not be routinely prescribed for women who are pregnant because of the lack of evidence of efficacy and the risk of neural tube defects in the fetus.

Lamotrigine should not be routinely prescribed for women who are breastfeeding because of the risk of dermatological problems in the infant, such as Stevens–Johnson syndrome.

## 13. SPECIAL CONSIDERATIONS ARISING FROM THE USE OF PSYCHOTROPIC DRUGS DURING EARLY PREGNANCY OR WHILE BREASTFEEDING

If a pregnant woman was taking drugs with known teratogenic risk (lithium, valproate, carbamazepine, lamotrigine and paroxetine) at the time of conception and/or in the first trimester, healthcare professionals should:

- confirm the pregnancy as quickly as possible
- offer appropriate screening and counselling about the continuation of the pregnancy, the need for additional monitoring and the risks to the fetus if the woman continues to take medication
- undertake a full paediatric assessment of the newborn infant
- monitor the infant in the first few weeks after delivery for adverse drug effects, drug toxicity or withdrawal (for example, floppy baby syndrome, irritability, constant crying, shivering, tremor, restlessness, increased tone, feeding and sleeping difficulties and, rarely, seizures); if the mother was prescribed antidepressants in the last trimester, these may result from serotonergic toxicity syndrome rather than withdrawal.

Infants of mothers who are breastfeeding while taking psychotropic medication should be monitored for adverse reactions.

For any additional information please contact the PEACH team or the Drug information service provided by Pharmacy at UHNS.

## 14. NON-DRUG INTERVENTIONS

Electroconvulsive therapy (ECT) may be an effective treatment for depression and mania during pregnancy. If the pregnant woman has severe depression or psychosis it can minimise the use of medication by avoiding polypharmacy (Henshaw *et al,* 2009). Miller (1994) reviewed 300 cases and concluded it to be safe in pregnancy provided full consent is obtained and precautions are taken.

Transcranial magnetic stimulation has been reported to have been used on pregnant women during pregnancy with no adverse effect (Nahas *et al,* 1999; Klirova *et al,* 2008; Henshaw *et al,* 2009).

Vagus nerve stimulation is gaining interest as a method of treatment for treatment-resistant depression (Hussain *et al,* 2005; Henshaw *et al,* 2009).

## 15. PSYCHOSOCIAL MANAGEMENT

*Birth Afterthoughts*- Unanswered questions and negative feelings about birth experiences may contribute to or exacerbate mental health problems. Referral to Birth Afterthoughts service in the North Staffordshire area may then be appropriate.

*Counselling/listening visits*- Health visitors in some areas of the UK including North Staffordshire have had training to deliver Rogerian-based non-directive counselling as an effective intervention for mild to moderate non-psychotic unipolar postnatal depression (Henshaw *et al,* 2009).

*Interpersonal psychotherapy* (IPT) has been shown to significantly reduce symptoms of postnatal depression by focusing on the mother's past and present relationships, including the relationship with her own mother (SIGN, 2002).

*Cognitive behavioural therapy* (CBT) is a structured therapy, which seeks to reduce symptoms and solve problems by changing unhelpful beliefs, thoughts and behaviours (SIGN, 2002). CBT is useful in addressing depressive symptoms, OCD, general anxiety disorders, panic disorders, PTSD and bipolar disorders (NICE, 2007).

## 16. TREATMENT BASE

### Inpatient

NICE (2002) suggest that each perinatal mental health network should have access to a mother and baby facility which should be staffed to provide specific care appropriate to both mothers and infants. The **Mother and Baby Unit** (The Brockington) at Stafford provides such care, including offering a full range of therapeutic services and effective liaison with general, mental health and community-based services.

### Outpatient

The **Parent and Baby Day Service** based at Bucknall Hospital offers a similar range of facilities and services to the mother and baby unit but on an outpatient basis to accommodate the mothers' needs. This service has recently been extended to offer service nearer home to those based in the Newcastle and Silverdale areas via children's centres, but is dependent on postcode.

### Community

Care in the community is accessible via Single Point of Access in both Stoke and Newcastle areas. Referrals can be made by any health professional including GP, HV, CMW and hospital based professionals. However, care will often be passed to the Parent and Baby Day Service after 20 weeks gestation by these services.

### Prescribing Issues

Concerns are raised around prescribing drugs during pregnancy and breastfeeding due to the perceived risks to the fetus and infant. Teratogenesis is the main concern in early pregnancy and withdrawal or neonatal toxicity in later pregnancy and the potential impact on neurodevelopment (SIGN, 2002). Many drugs taken by the breastfeeding mother are excreted in the milk and ingested

by the infant. Much of the evidence base for risk is based on case reports. The hospital drug information service will access these cases when advising and making recommendations about exposure.

## 17. PRESCRIBING IN BREASTFEEDING

The Trust Infant feeding policy recommends that breastfeeding should be taken into account during pregnancy when considering prescribing. This would help with most appropriate medication being offered and reduce delay in treatment or feeding in the postnatal period (Garrington, (2008). When considering prescribing in breastfeeding, the maternity service has access to the Breastfeeding co-ordinators and Drug information services at the pharmacy department (telephone ext: 2905) for advice. Advice can be sought from UK Medicines Information (UKMi) pharmacists for NHS healthcare professionals (UKMi, 2009) and from Medication and Mothers' Milk (Hale, 2008). If in doubt, decisions should always be backed up by the Drug Information services before changing or commencing medication.

Selective serotonin reuptake inhibitors (SSRIs) are considered the antidepressant drug type of choice for depression, panic disorders, general anxiety disorder, OCD, bulimia nervosa, social anxiety and PTSD, due to it being better tolerated and safer in overdose than other classes of antidepressants such as tricyclic antidepressants (TCIs).

When considering an antidepressant for a breastfeeding woman, prescribers should take into account:

- all antidepressants carry the risk of withdrawal or toxicity in the neonate; in most cases, effects are mild and self-limiting
- sertraline, imipramine and nortriptyline are present in breast milk at relatively low levels
- citalopram and fluoxetine are present in breast milk in relatively high levels (NICE, 2007)

KMi (2009) suggest that it can be difficult to determine withdrawal between *in utero* and breast milk exposure and include the following recommendations:

- limited data on effects of SSRI exposure via breast milk on weight gain and infant development are encouraging
- SSRIs should be used at the lowest effective dose and for the shortest possible time
- if a woman has been successfully treated with an SSRI in pregnancy and needs to continue therapy after delivery, there is no need to change the drug, provided the infant is full term, healthy and can be adequately monitored
- infants exposed to SSRIs via breast milk should be monitored for sedation, poor feeding and behavioural effects
- co-therapy with other sedating agents is best avoided (UKMi, 2009)

## 18. PRE-CONCEPTUAL CARE

Pre-conceptual counselling is available in a limited capacity via Peach and consultant obstetrician antenatal clinic session. GPs and Mental Health professionals of women with on-going or previous mental health problems can refer clients or notify maternity services of impending pregnancies. Clients can then be seen to discuss pregnancy plans and discuss medication implications.

## 19. RESOURCE IMPLICATIONS

Education of maternity practitioners in the skill of questioning clients about perinatal psychiatric disorders and the subsequent referral and management of these service users, have resource implications. The close monitoring of this group of vulnerable women creates potential funding issues if adequate communication between disciplines is to be maintained. However, if these educational needs are not met, CEMD recommendations will not be achieved.

## 20. INTEGRATED CARE PATHWAYS

Integrated Care Pathways (ICPs) are structured care plans which define the essential steps to be taken in the management of patients with specific problems. These are based on the premise that, despite the need for holistic individualised care planning, to secure the best possible outcome, a serious of steps must be undertaken for a particular illness or condition (SIGN, 2002). Therefore they can offer the service provider a clear indication of the services which should be available to a client and thereby prevent any omission of care. The ICP should include a comprehensive flow chart with an easy to follow format.

## 21. FOLLOW UP OF ANY TESTS THAT HAVE BEEN CARRIED OUT

Any member of the multidisciplinary team requesting a test has a responsibility to access and action any results. All tests carried out must be recorded in a test book and the results accessed and actioned in a timely manor. In the case of a non attending pregnant woman, results to be actioned should be forwarded to the GP and Community Midwife which may necessitate a home visit.

## 22. TRAINING

The process for the maternity services expectations in relation to staff training is identified in the 'Maternity Services Training Needs Analysis.

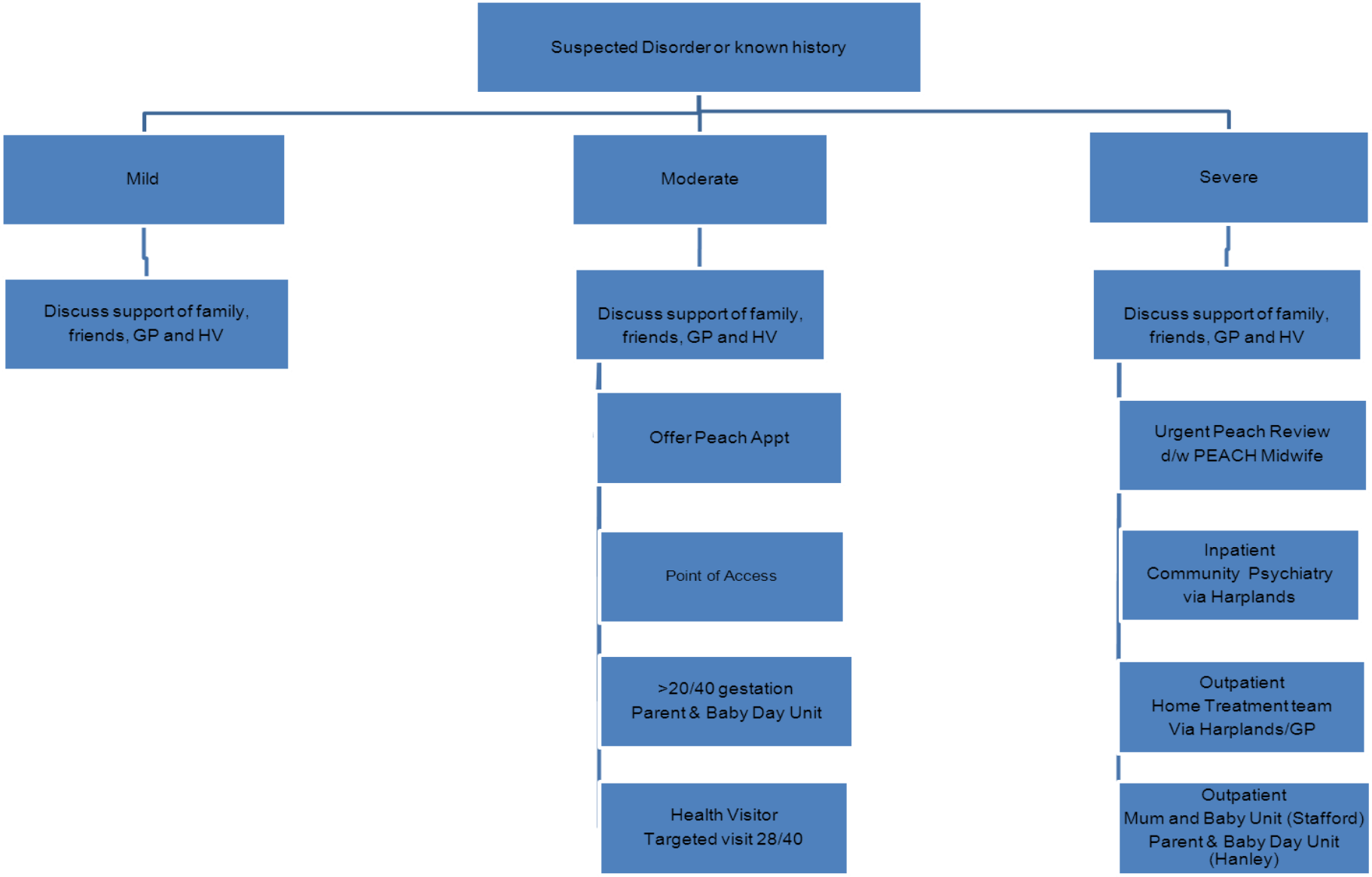
## 23. MONITORING AND AUDIT

The need to monitor/audit the standards set out below will be considered alongside other Directorate requirements and prioritised accordingly. The Directorate Clinical Audit programme is drafted by the Directorate Clinical auditor, in liaison with clinical staff, and approved by the Directorate.

| Element to be monitored | Lead | Tool | Frequency | Reporting arrangements | Acting on recommendations and lead(s) | Change in practice and lessons to be shared |
|---|---|---|---|---|---|---|
| **process for identifying women during the antenatal period who have a current mental health problem, or who are at risk of developing a mental health problem** | Directorate Clinical Auditor | On-going CNST Data Collection | Audit of ≥ CNST compliant sample size (e.g. 1% or 1 sets) reported annually | Directorate Business, Performance and Clinical Governance Meeting **(DBP&CG Meeting)** | Required actions will be identified and completed in a specified timeframe as per the audit action plan. These will be monitored and approved by the DBP&CG Meeting | Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan. |
| process for identifying women who are at risk of developing a mental health problem or exacerbating a pre-existing mental illness during the postnatal period | Directorate Clinical Auditor | Rolling Audit Programme | Every three years | DBP&CG Meeting | Required actions will be identified and completed in a specified timeframe as per the audit action plan. These will be monitored and approved by the DBP&CG Meeting | Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan. |
| **documentation of an individual management plan where appropriate** | Directorate Clinical Auditor | On-going CNST Data Collection | Audit of ≥ CNST compliant sample size (e.g. 1% or 1 sets) reported annually | DBP&CG Meeting | Required actions will be identified and completed in a specified timeframe as per the audit action plan. These will be monitored and approved by the DBP&CG Meeting | Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan. |
| process for the documentation of clear lines of communication between the maternity service and the following: | | | | | | |
| mental health services | Directorate Clinical Auditor | Rolling Audit Programme | Every three years | DBP&CG Meeting | Required actions will be identified and completed in a specified timeframe as per the audit action plan. These will be monitored and approved by the DBP&CG Meeting | Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan. |

| Element to be monitored | Lead | Tool | Frequency | Reporting arrangements | Acting on recommendations and lead(s) | Change in practice and lessons to be shared |
|---|---|---|---|---|---|---|
| general practitioners | Directorate Clinical Auditor | Rolling Audit Programme | Every three years | DBP&CG Meeting | Required actions will be identified and completed in a specified timeframe as per the audit action plan. These will be monitored and approved by the DBP&CG Meeting | Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan. |
| health visitor services | Directorate Clinical Auditor | Rolling Audit Programme | Every three years | DBP&CG Meeting | Required actions will be identified and completed in a specified timeframe as per the audit action plan. These will be monitored and approved by the DBP&CG Meeting | Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan. |
| interpretation services | Directorate Clinical Auditor | Rolling Audit Programme | Every three years | DBP&CG Meeting | Required actions will be identified and completed in a specified timeframe as per the audit action plan. These will be monitored and approved by the DBP&CG Meeting | Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan. |
| process for the maternity service's expectations in relation to staff training, as identified in the training needs analysis | Lead Midwife for Development and Education | Review of Training Needs Analysis | Reported bi-annually | DBP&CG Meeting | Required actions will be identified and completed in a specified timeframe as per the audit action plan. These will be monitored and approved by the DBP&CG Meeting | Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per action plan. |

**Appendix 1 - Management of Women at Risk of Perinatal Psychiatric Disorders**



University Hospital of North Staffordshire NHS

NHS Trust

**UNIVERSITY HOSPITAL OF NORTH STAFFORDSHIRE NHS TRUST**
**SURGICAL DIVISION**
**OBSTETRICS AND GYNAECOLOGY DIRECTORATE**

# PEACH REFERRAL FORM

**(For completion by Community Midwives when booking women with mental health issues)**

| PATIENT'S DETAILS | MIDWIFE DETAILS |
|---|---|
| NAME: | NAMED MIDWIFE: |
| ADDRESS:<br><br>POST CODE: | TELEPHONE NUMBER: |
| D.O.B. | |
| UNIT NUMBER: | |
| TELEPHONE NUMBER: | |
| DATE OF REFERRAL: | E.D.D.<br><br>GESTATION AT TIME OF REFERRAL: |

**Previous Mental Health Problem**

| DATE | DIAGNOSIS | MANAGEMENT |
|---|---|---|
| | | |

**Current Mental State**

**Level of Concern**

**MILD [ ]** **MODERATE [ ]**
**SEVERE/URGENT [ ]**

| |
|---|
| Referred by: |
| Designation: |
| Date: |

**Please send with Referral form and booking history to:**

**Sister in Charge**
**Antenatal Clinic**
**Maternity Department**
**University Hospital of North Staffordshire NHS Trust**
**Newcastle Road**
**Stoke-on-Trent**
**Staffs ST4 6QG**
**Telephone No: 01782 672113**
**Fax No: 01782 672136**

University Hospital of North Staffordshire NHS
NHS Trust

# Perinatal Mental Health Contact List

**PEACH:-** **Mobile- 07595245088**
**Appointments- 01782-(6)72113**
**Midwives office ANC- 01782-(6)72126**
**Midwives office (fax)- 01782-(6)72136**

**PARENT & BABY DAY UNIT:- Referrals- 03001231769**
**>20/40 Fax- 01782-275174**

**MUM & BABY UNIT: 01785-221560**
**The Brockington (Stafford) 01785-221554 (Dr Hofberg sec: Sheila)**
**(Community referrals to inpatient services/emergency advice)**

**ACCESS POINT:- Stoke-on-Trent/Newcastle/Moorlands - 03001230907**
**Fax – 01782-276435**

**HOME TREATMENT TEAM:- Harplands switchboard- 01782-441600**

**HARPLANDS:- 441600**
**(speed-dial): 15031**

**COMMUNITY PSYCHIATRY (in-patient emergency A&E/Maternity)**
**:-bleep via UHNS switch/Harpland's switch**

**ST GEORGE'S EATING DISORDER UNIT:- 01785-257888**
**(Stafford)**

**RAPE CRISIS (Savana Centre):- self referrals: 01782-221000**
**Professionals only: 01782-221005**

**FAMILY SUPPORT SERVICES: 01782- 287902 / 280245**
**(Domestic violence-Pregnancy-General support-CBT-Anger Management)**

**RELATE:- 01782-683050**
**(Relationship guidance)**

**DOVE CENTRE:- 01782-683153**
**(Bereavement & Major Life Crisis)**

**SUTHERLAND CENTRE:- 03001231162**

**GREENFIELDS:- 03007900236**

**HEALTHY MINDS (CBT):- 01782-828041**

| University Hospital of North Staffordshire NHS NHS Trust | **Patient Details** |
|---|---|
| **Patient Information**<br>**P.E.A.C.H.** | |

### What does PEACH stand for?
Parent Emotion Antenatal Clinic for Health

### What is the Peach clinic?
The Peach clinic is a midwife led service which runs on a Thursday morning in the Antenatal Clinic alongside a consultant led clinic.

### What does the service provide?
It is a short (approx fifteen minutes) confidential session, which attempts to address what outside services are available to a pregnant woman who has concerns about her mental well-being.

It is not a counselling session, but is there to help support women through their pregnancy when they might need some extra care and encouragement. You might simply be reassured to know what services are available if you should need them.

### Can I bring someone with me for support?
As with any clinic appointment, you can bring a support person with you that you are happy sharing confidential information with.

### What sort of problems can it help with?
You may be worried about the return of postnatal depression or if someone in your family has had a serious mental health problem.

Any on-going condition that affects your mental health, such as anxiety, depression, OCD, schizophrenia and bi-polar disorder.

You might find that your mood changes during the pregnancy, or that you are struggling with the change in your shape as your baby grows causing you problems with eating.

### Who can refer you to the Peach service?
Your community midwife (CMW), GP, the ward staff, or any of the doctors that you might see while seeking other treatment can refer you to the service. You can even refer yourself.

### Where can you be referred by Peach?
Care is always taken to tailor the support to each individual's needs. Help may be accessed through the community or hospital services. However our most common source of support is The Parent and Baby Unit (PBDU) based in Broad Street in Hanley. This unit is run by a group of Specialist Nurses overseen by a Specialist Consultant Psychiatrist. Care can be provided after 20 weeks of pregnancy right up to one year after your baby is born.

### Who can refer you to the PBDU?
You need to be referred by a professional. This can be at the Peach clinic or through your CMW, GP, Health Visitor or maternity hospital staff.

### Contact details for Peach
You can make or alter your own appointment with the clinic by ringing the antenatal clinic reception on:
01782-672113