

What does excellence in Perinatal Mental Health look like? Meeting the NICE Guideline for Postnatal Mental Health

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Brief evidence reviews:

<http://www.thelancet.com/series/perinatal-mental-health>

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Broad range of mental disorders to consider, including depression, anxiety disorders, eating disorders, drug and alcohol-use disorders, personality disorder and severe mental illness (psychosis, bipolar disorder, schizophrenia)

NICE focuses on aspects of their identification, presentation & management in perinatal context and in women of childbearing potential – evidence review (mainly depression) >900 pages!



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CLINICAL REVIEW



Depression in pregnancy

Simone N Vigod *assistant professor, psychiatrist, and Shirley Brown clinician scientist*¹, Claire A Wilson *academic clinical fellow*², Louise M Howard *NIHR research professor*² *professor in women's mental health, and consultant perinatal psychiatrist*²

Series

Non-psychotic mental disorders in the perinatal period

Louise M Howard, Emma Molyneaux, Cindy-Lee Dennis, Tamsen Rochat, Alan Stein, Jeannette Milgrom

[Full Text](#) | [PDF](#)

Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the post-partum period

Ian Jones, Prabha S Chandra, Paola Dazzan, Louise M Howard

[Full Text](#) | [PDF](#)

Effects of perinatal mental disorders on the fetus and child

Alan Stein, Rebecca M Pearson, Sherryl H Goodman, Elizabeth Rapa, Atif Rahman, Meaghan McCallum, Louise M Howard, Carmine M Pariante

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Background

Although response to treatment for mental health problems is good, problems frequently go unrecognised and untreated in pregnancy and the postnatal period.

If untreated, women can continue to have symptoms, sometimes for many years

Symptoms may also affect their babies and family

APMH guideline should be read in conjunction with other NICE guidelines on the treatment and management of specific mental health problems.

APMH guideline indicates where modifications to treatment and management are needed in pregnancy and the postnatal period

The guideline draws on the **best available** evidence. However, there are significant limitations to the evidence base, including limited data on the risks of psychotropic medication in pregnancy and during breastfeeding

Relevant to **all** healthcare professionals recognising, assessing and referring for or providing interventions for mental health problems in pregnancy and the postnatal period. Professionals need to understand variations in presentation and course, how this affects treatment, and the context in which they are assessed and treated eg maternity, health visiting

How does childbearing affect vulnerability to, development and expression of mental illness?

Depression and anxiety (incl GAD, PTSD, OCD) common in pregnancy and postpartum— up to 40% in mothers on NICU

Associated with small increase in adverse fetal outcomes

Eating disorders associated with nutritional deficiencies

Vesga-Lopez et al Arch Gen Psychiatry 2008

Table 2. Twelve-Month Prevalence and ORs of DSM-IV Axis I Psychiatric Disorders by Pregnancy Status

Disorder	% (SE)		OR (95% CI)	AOR ^b (95% CI)	Postpartum Women, ^c % (SE)	OR (95% CI)	AOR ^b (95% CI)
	Nonpregnant Women (n=13 025)	Past-Year Pregnant Women ^a (n=1524)					
Any psychiatric disorder	30.1 (0.8)	25.3 (1.3)	0.78 (0.69-0.90)	0.75 (0.62-0.90)	25.7 (1.8)	0.80 (0.68-0.95)	0.81 (0.65-1.02)
Any new-onset psychiatric disorder (current but not before past 12 mo)	7.0 (0.3)	8.0 (0.8)	1.16 (0.92-1.46)	0.97 (0.75-1.25)	8.3 (1.1)	1.20 (0.89-1.61)	0.96 (0.69-1.33)
Any substance use disorder	19.9 (0.7)	14.6 (1.2)	0.68 (0.57-0.82)	0.56 (0.44-0.71)	12.0 (1.3)	0.55 (0.43-0.69)	0.44 (0.33-0.59)
Any alcohol use disorder	7.6 (0.4)	3.6 (0.5)	0.45 (0.34-0.60)	0.49 (0.36-0.67)	2.9 (0.6)	0.36 (0.23-0.54)	0.41 (0.27-0.64)
Any drug use disorder	2.0 (0.2)	1.6 (0.4)	0.82 (0.49-1.37)	0.52 (0.29-0.94)	1.3 (0.5)	0.63 (0.30-1.34)	0.50 (0.23-1.08)
Nicotine dependence	14.6 (0.6)	12.5 (1.1)	0.84 (0.68-1.02)	0.79 (0.64-0.97)	10.7 (1.2)	0.70 (0.55-0.89)	0.60 (0.47-0.76)
Any mood disorder	13.7 (0.5)	13.3 (1.1)	0.96 (0.80-1.16)	1.04 (0.83-1.32)	15.2 (1.5)	1.13 (0.90-1.40)	1.28 (0.97-1.69)
MDD	8.1 (0.9)	8.4 (0.4)	0.95 (0.75-1.20)	1.24 (0.94-1.64)	9.3 (1.1)	1.11 (0.84-1.46)	1.52 (1.07-2.15)
Dysthymia	2.0 (0.2)	0.9 (0.4)	0.46 (0.21-1.00)	0.51 (0.22-1.18)	1.0 (0.5)	0.49 (0.18-1.33)	0.74 (0.26-2.07)
Bipolar disorder	2.3 (0.2)	2.8 (0.5)	1.26 (0.86-1.84)	1.09 (0.70-1.70)	2.9 (0.6)	1.31 (0.86-2.00)	1.08 (0.66-1.78)
Any anxiety disorder	14.9 (0.6)	13.0 (1.1)	0.85 (0.70-1.03)	0.99 (0.68-1.43)	12.3 (1.3)	0.81 (0.65-1.00)	0.89 (0.57-1.38)
Panic disorder	3.0 (0.2)	2.2 (0.5)	0.73 (0.46-1.15)	0.91 (0.53-1.56)	2.5 (0.6)	0.83 (0.50-1.39)	0.92 (0.48-1.73)
Social anxiety disorder	2.8 (0.2)	1.8 (0.4)	0.65 (0.41-1.02)	0.66 (0.33-1.31)	1.0 (0.4)	0.34 (0.15-0.75)	0.36 (0.14-0.92)
Specific phobia	10.2 (0.5)	9.2 (0.9)	0.89 (0.72-1.11)	0.93 (0.53-1.61)	8.7 (1.0)	0.84 (0.66-1.08)	0.97 (0.49-1.91)
Generalized anxiety	1.8 (0.2)	1.3 (0.4)	0.73 (0.42-1.29)	1.57 (0.82-3.02)	1.5 (0.5)	0.81 (0.41-1.60)	1.78 (0.81-3.94)
Any psychotic disorder	0.3 (0.1)	0.4 (0.2)	1.14 (0.44-2.94)	1.50 (0.54-4.18)	0.5 (0.2)	1.60 (0.58-4.45)	1.98 (0.61-6.46)
Any substance use	73.8 (1.0)	63.0 (1.8)	0.60 (0.53-0.69)	0.66 (0.57-0.77)	62.1 (2.1)	0.58 (0.49-0.69)	0.63 (0.52-0.77)
Any alcohol use	68.5 (0.9)	59.0 (1.7)	0.66 (0.58-0.75)	0.71 (0.61-0.81)	58.1 (2.1)	0.64 (0.54-0.75)	0.69 (0.57-0.83)
Any tobacco use	26.6 (0.8)	21.9 (1.5)	0.77 (0.66-0.91)	0.76 (0.64-0.89)	21.5 (1.8)	0.75 (0.62-0.92)	0.69 (0.56-0.83)
Any illicit drug use	6.8 (0.3)	6.2 (0.7)	0.91 (0.72-1.17)	0.87 (0.66-1.15)	6.1 (0.8)	0.89 (0.66-1.20)	0.93 (0.67-1.28)
Mean No. of cigarettes a day in past 12 mo (only among smokers)	15.9 (0.3)	16.6 (1.4)	$t=0.52$ $P=.60$	$\beta=0.05$ $SE=0.04$ $P=.29^d$	16.3 (1.6)	$t=0.23$ $P=.82$	$\beta=0.04$ $SE=0.04$ $P=.28^d$

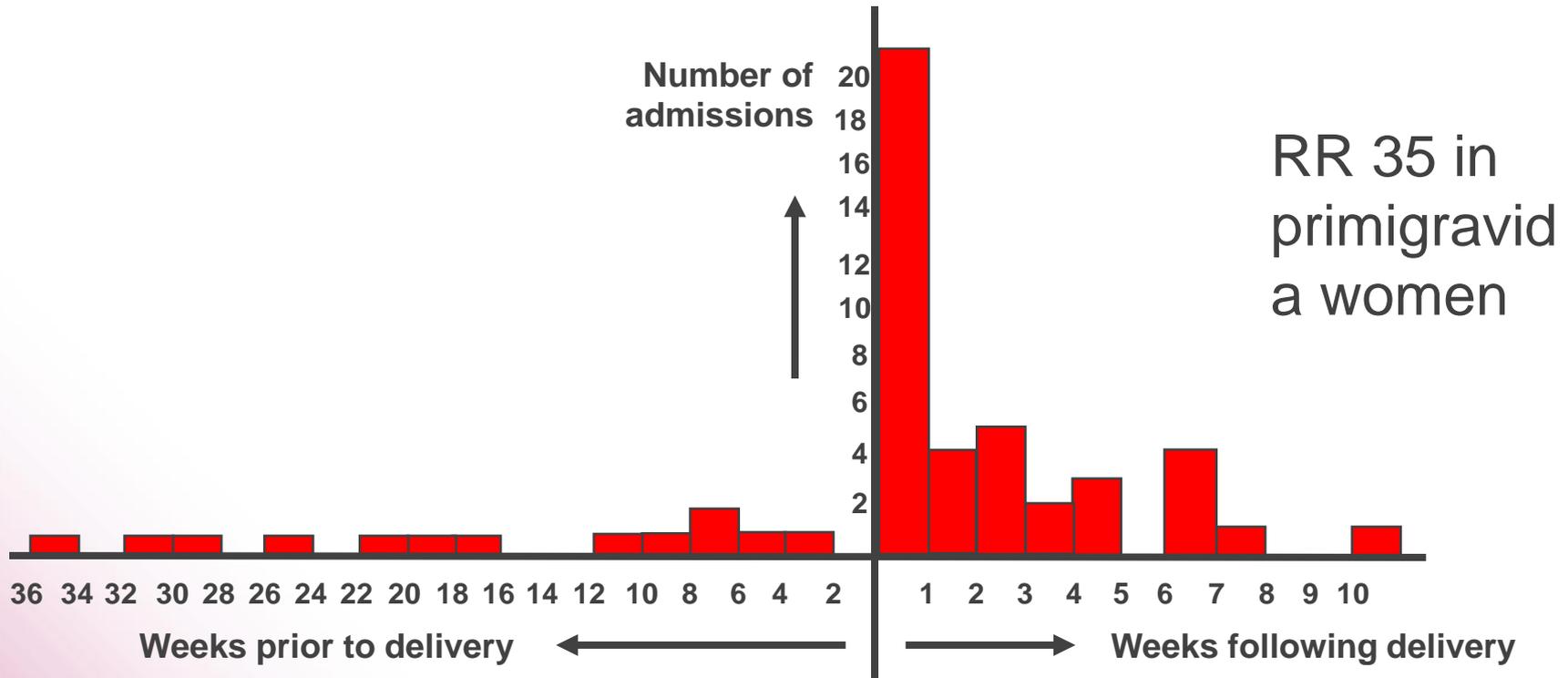
Psychotic disorders

Schizophrenia <1%- chronic functional impairment in many; parenting difficulties (10-50% lose custody)

Bipolar disorder (0.4% with manic psychoses) – less functional impairment

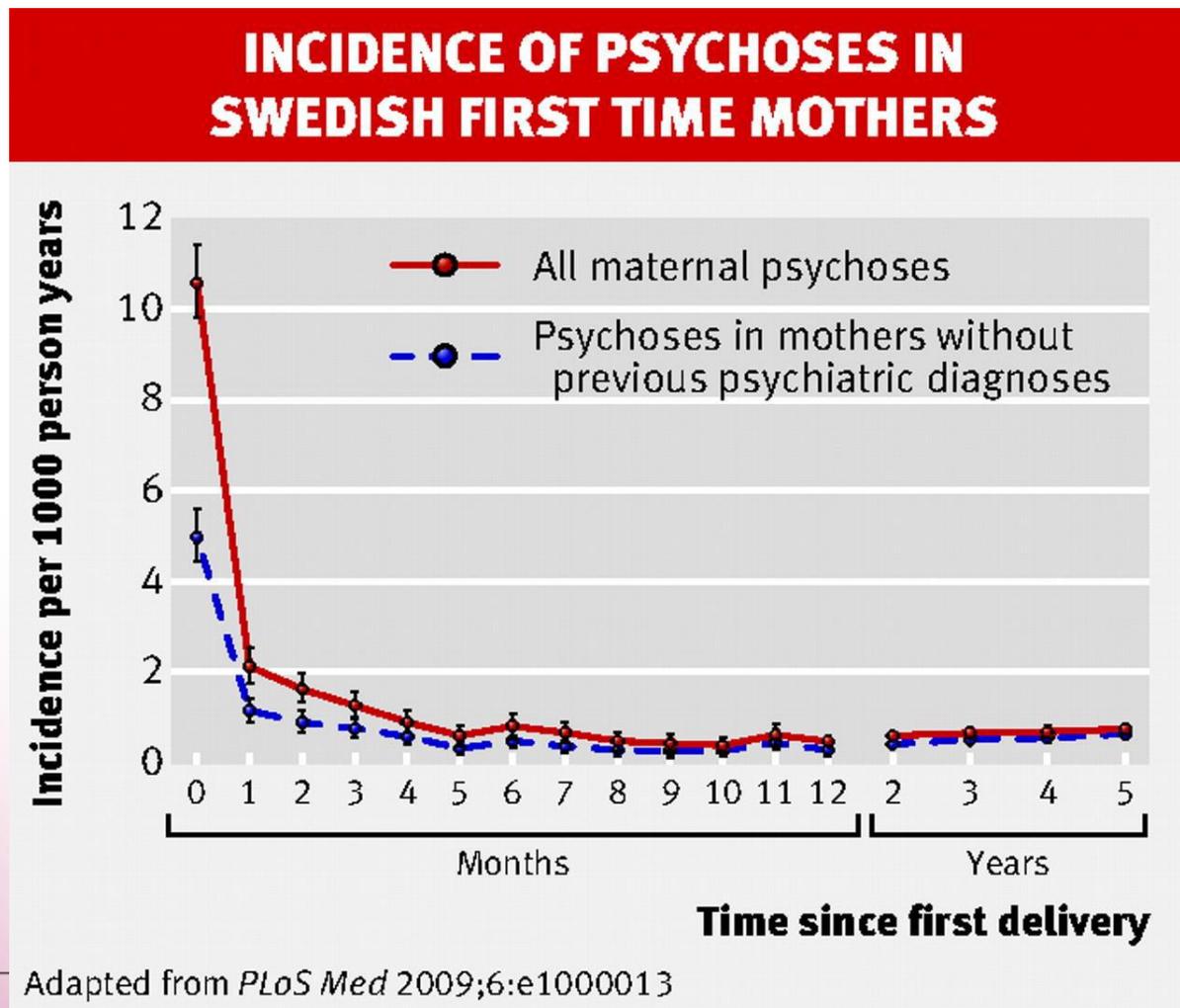
Both associated with adverse obstetric outcomes often associated with modifiable risk factors eg smoking

Is childbirth associated with increased risk?

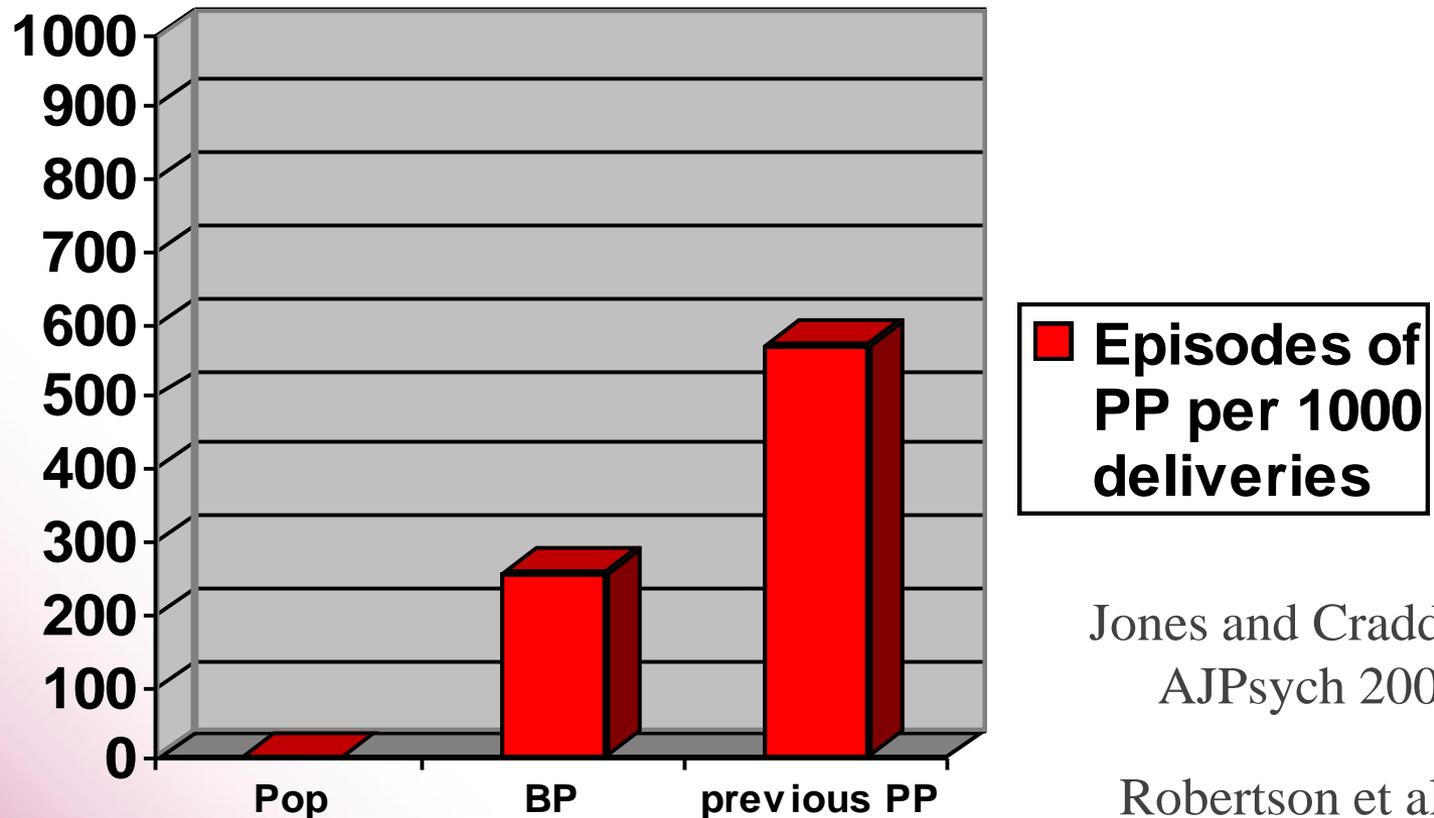


Onset of major functional disorders in the puerperium

What women are particularly at risk?



What women are particularly at risk?



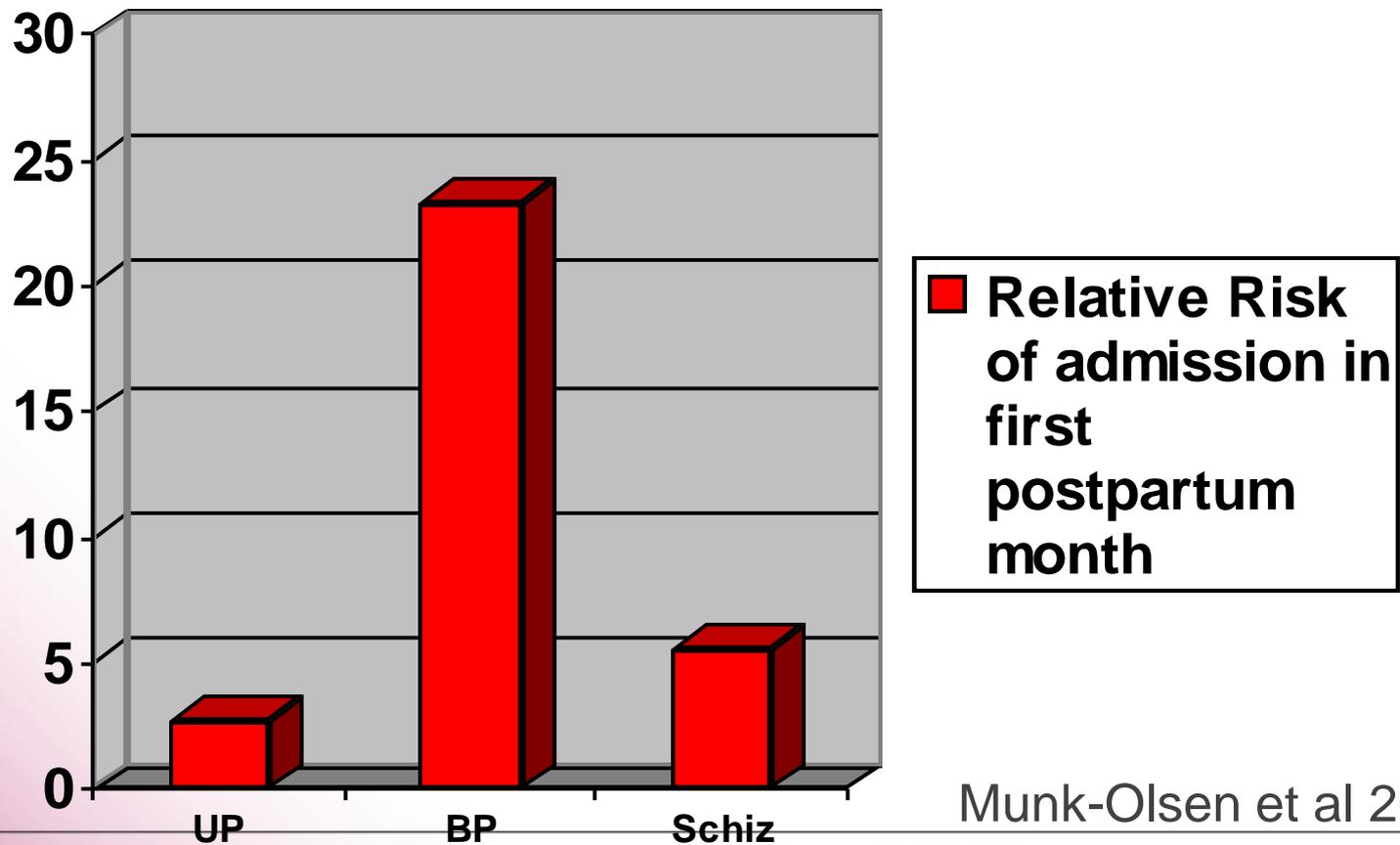
■ Episodes of PP per 1000 deliveries

Jones and Craddock,
AJP_{psych} 2001

Robertson et al,

BIP_{psych} 2005

Is the risk across the psychosis spectrum?



Munk-Olsen et al 2006

What women are particularly at risk?

Risk associated with:

Recency of hospitalisation

Number of previous admissions

Length of most recent admission

20-30% rate of PP in women with BPD

>70% in women with FHx PP

>55% in women with previous PP

Puerperal psychosis

clinical features – early symptoms

Rapidly changing, undifferentiated psychotic state

Perplexity, fear, restless agitation, insomnia

Other signs include:

Hallucinations (incl. visual, tactile, olfactory) and delusions

Purposeless activity

Uncharacteristic behaviour

Disinhibition

Irritation and fleeting anger

Puerperal psychosis - clinical features

Condition deteriorates, symptoms usually become more clearly those of an acute affective psychosis.

Most women have symptoms and signs suggestive of a depressive psychosis, a significant minority have a manic psychosis

Very commonly women have a mixed affective psychosis

Delusions including first rank symptoms (delusional mood and delusional perception) & delusions re: infant ill-health or changed identity

Confusion and disorientation

Grandiosity, elation alternating with guilt, tearfulness

Restlessness and agitation

Disorganised and distractable  inability to care for infant

How does mental illness affect the experience of childbearing? Preconception to motherhood: a qualitative meta-synthesis

Guilt

“Not able to be the mother I really wanted to be”
“I felt a failure”

Importance of motherhood

“I wouldn’t be alive without my child”
“My child is the only good thing that ever happened to me”

Stigma

“I was really paranoid about what people would think...I didn’t want people to know I had a mental illness”

Fear of custody loss

There was a pervasive fear of losing their child: “Every mother’s fear is that her children will be taken into care”



Coping with Dual Identities

“I had this vision of - picture of - how I would be as a mother and I didn’t live up to that expectation, so it made me feel quite bad”

Impact on the Child

3 sub-themes:

Genetic: one woman with bipolar disorder said she did not want to have children: “you know, inflict whatever illness I have on an innocent child”

Environmental: possible damage from poor childrearing and psychological impact

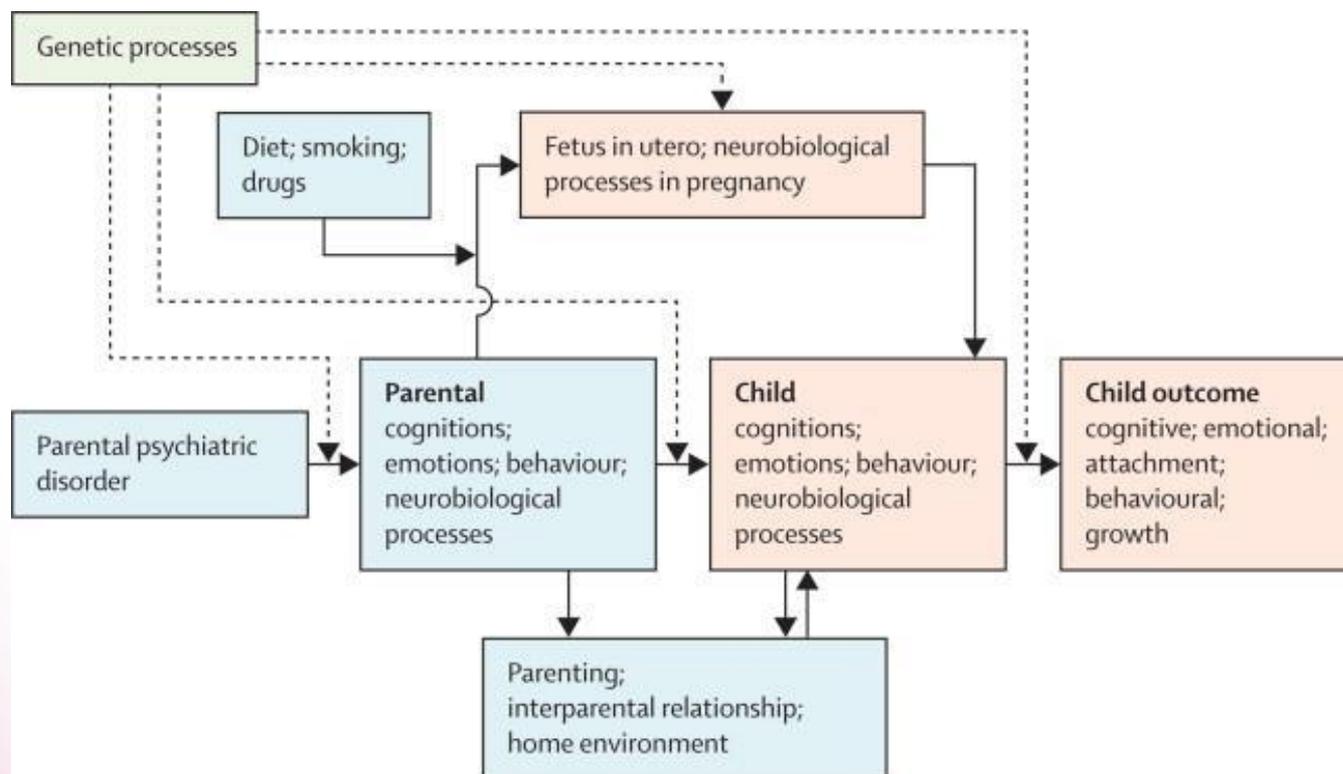
Secondary Stigma: by child’s association with a ‘mad mother’

Conflicting information re medication

Isolation

“I was lonely. . . . I felt like a reject”

Stein et al. Effects of perinatal mental disorders on the fetus and child. The Lancet, 2014



SMALL-MODERATE IMPACTS ON FETAL OUTCOMES, MODERATED BY SES and CHRONICITY

MOTHER-INFANT INTERACTION DEFICITS PARTLY MEDIATE CHILD ADVERSE OUTCOMES

The mother–baby relationship

Recognise that some women with a mental health problem may experience on-going difficulties with the mother–baby relationship.

Assess verbal interaction, emotional sensitivity and physical care

3 primary mechanisms through which depression disrupts early parenting:

- 1. Emotional disturbance associated with lack of maternal warmth, difficulties in regulating an infant’s distress and intrusiveness during stressful situations.**
- 2. Depressive rumination interferes with vital cognitive processes such as maternal attention and responsiveness to infant cues.**
- 3. Depressed mothers show reduced motivation and withdrawal from parenting tasks.**

Infants/children experience higher rates of emotional and behavioural difficulties, compromised social functioning, insecure attachment, and cognitive and language delays – compounded by social adversity

Discuss any concerns that the woman has about her relationship with her baby and provide information and treatment for the mental health problem.

Consider further intervention

Wording of recommendations

Interventions that should (or should not) be used – a ‘strong’ recommendation

We use ‘offer’ (and similar words such as ‘refer’ or ‘advise’) when we are confident that, for the vast majority of patients, an intervention will do more good than harm, and be cost effective. We use similar forms of words (for example, ‘Do not offer...’) when we are confident that an intervention will not be of benefit for most patients.

Interventions that could be used

We use ‘consider’ when we are confident that an intervention will do more good than harm for most patients, and be cost effective, but other options may be similarly cost effective. The choice of intervention, and whether or not to have the intervention at all, is more likely to depend on the patient’s values and preferences than for a strong recommendation, and so the healthcare professional should spend more time considering and discussing the options with the patient.

Information and advice for women who are planning a pregnancy, pregnant or in the postnatal period

Mental health professionals providing detailed advice about possible risks of mental health problems or the benefits and harms of treatment should include discussion of the following, depending on individual circumstances:

- the uncertainty about the benefits, risks and harms of treatments
- the likely benefits of each treatment, taking into account severity of the problem
- the woman's response to any previous treatment
- the background risk of harm to the woman and the fetus or baby and the risk to mental health and parenting associated with no treatment
- the possibility of sudden onset of symptoms, particularly in the first few weeks after childbirth (for example, in bipolar disorder)
- the risks or harms to the woman and the fetus or baby associated with treatment options
- the need for prompt treatment
- the risk or harms to the woman and the fetus or baby associated with stopping or changing a treatment

Discuss breastfeeding with all women who may need to take psychotropic medication in pregnancy or in the postnatal period.

Explain the benefits of breastfeeding, the potential risks associated with taking psychotropic medication when breastfeeding and with stopping some medications in order to breastfeed.

Discuss treatment options that would enable a woman to breastfeed if she wishes and support women who choose not to breastfeed.

If needed, seek more detailed advice about the possible risks of mental health problems or the benefits and harms of treatment in pregnancy and the postnatal period from a secondary mental health service (preferably a specialist perinatal mental health service). This might include advice on the risks and possible harms of taking psychotropic medication while breastfeeding and how medication might affect a woman's ability to care for her baby (for example, sedation).

Principles of care for women with mental health problems in pregnancy and the postnatal period

- Acknowledge the woman's role in caring for her baby and support her to do this in a non-judgmental and compassionate way.
- Involve the woman and, if she agrees, her partner, family or carer, in all decisions about her care and the care of her baby.
- Assess and address the needs of partners, families and carers
- Instil hope
- Mental health taken into account as part of all care plans
- Provide culturally relevant information
- Be aware of the recommendations in the guideline on pregnancy and complex social factors (CG110)
- When working with girls and young women with a mental health problem in pregnancy or the postnatal period be familiar with local and national guidelines on confidentiality and the rights of the child
- Ensure continuity of care for the mental health problem if care is transferred from adolescent to adult services

Principles of care for women with mental health problems in pregnancy and the postnatal period

Monitoring and increased contact

Develop an integrated care plan that sets out:

- The care and treatment for the mental health problem
- The roles of all healthcare professionals, including details of who is responsible for:
 - Coordinating the integrated care plan
 - The schedule of monitoring
 - Providing the interventions and agreeing the outcomes

The care plan should be recorded in all versions of the woman's notes (her own records and maternity, primary care and mental health notes) and a copy given to the woman and all involved professionals

Principles of care for women with mental health problems in pregnancy and the postnatal period

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- Use relevant NICE guideline eg psychological interventions for ED; monitor weight in line with weight management before, during and after pregnancy guideline;
- Practitioners should be “perinatally competent”; know when to refer
- Threshold for pharmacological interventions higher arising from the changing risk–benefit ratio for psychotropic medication at this time (use of low intensity and high intensity interventions)
- Discuss risks associated with stopping psychotropic medication
- Choose the drug with the lowest risk profile for the woman, fetus and baby, taking into account a woman’s previous response to medication
- Avoid polypharmacy
- Take into account that dosages may need to be adjusted in pregnancy

Identification

All health professionals should consider asking the following depression identification questions as part of a *general discussion about mental health and wellbeing at each contact*.

During the past month have you often been bothered by :

- feeling down, depressed, or hopeless?
- having little interest or pleasure in doing things?

Also consider asking about anxiety using the GAD-2:

During the past month have you been:

- feeling nervous, anxious, or on edge?
- unable to stop or control worrying?

If the woman answers yes to any of the above questions, or where there is clinical concern, further assessment is needed.

Consider using formal measures such as the patient health questionnaire (PHQ-9), the Edinburgh Postnatal Depression Scale (EPDS) or GAD-7 and referral to a general practitioner or mental health professional, depending on the severity of the presenting problem.

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

At a pregnant woman's first contact with services, ask about any past or present severe mental illness, previous or current treatment, and any severe postpartum mental illness in a first degree relative

If alcohol misuse is suspected, use the alcohol use disorders identification test (AUDIT) as an identification tool in line with the guideline on alcohol use disorders.

If drug misuse is suspected, follow the recommendations on identification and assessment in the guideline on drug misuse—psychosocial interventions.

Assessment and diagnosis of a suspected mental health problem should include:

- A history or family history of any mental health problem
- Physical wellbeing and history of any physical health problem
- Alcohol and drug misuse
- The woman's attitude to and experience of the pregnancy
- The mother-baby relationship
- Any current or past treatment for a mental health problem and response to any treatment
- Social networks, living conditions, and social isolation
- Domestic violence and abuse, sexual abuse, trauma, or childhood maltreatment
- Housing, employment, economic and immigration status
- Responsibilities as a carer for other children and young people or other adults

Take account of learning disabilities or acquired cognitive impairments; consult

Risk assessment e.g. self-neglect, self-harm, risks to others (incl baby), domestic abuse

Follow local safeguarding protocols where safeguarding concerns

Assessment and referral

Assess all women with a known or suspected mental health problem who are referred in pregnancy or the postnatal period for psychological treatment *within two weeks of referral* and provide psychological interventions *within one month of initial assessment*.

Refer all women who have, are suspected to have, or have a history of severe mental illness to a secondary mental health service (preferably a specialist perinatal mental health service) for assessment and treatment, and ensure that the woman's GP knows about the referral.

If a woman has sudden onset of symptoms suggesting postpartum psychosis, refer her to a secondary mental health service (preferably a specialist perinatal mental health service) for immediate assessment (within four hours)

When discussing likely benefits and risks of treatment with the woman and, if she agrees, her partner, family or carer:

- acknowledge the woman's central role in reaching a decision about her treatment and that the role of the professional is to inform that decision with balanced and up-to-date information and advice
- use absolute values based on a common denominator (that is, numbers out of 100 or 1000)
- acknowledge and describe, if possible, the uncertainty around any estimate of risk, harm or benefit
- consider providing records of the consultation, in a variety of visual, verbal or audio formats.

Case discussion

At booking midwife is told by 23 year old woman that she is feeling low and emotional. Partner with her says this has only been for the last few days and women agrees. What do you do?

Treatment of mental disorders in perinatal period

Psychological interventions preferred - interventions probably need to be tailored and should be seen quickly during perinatal period (NICE recs)

Large evidence base on postnatal psychological interventions – but treatment of mental disorder will not always improve parenting so may need referral for this

Evidence base on medication based mainly on observational studies with emerging evidence from meta-analyses

- Quality of evidence base is improving
- Problem of residual confounding including co indication
- Challenge of data on rare disorders

(use of scandinavian registers, GP databases)



From: Antidepressant Treatment for Postnatal Depression

JAMA. 2015;313(19):1965-1966. doi:10.1001/jama.2015.2276

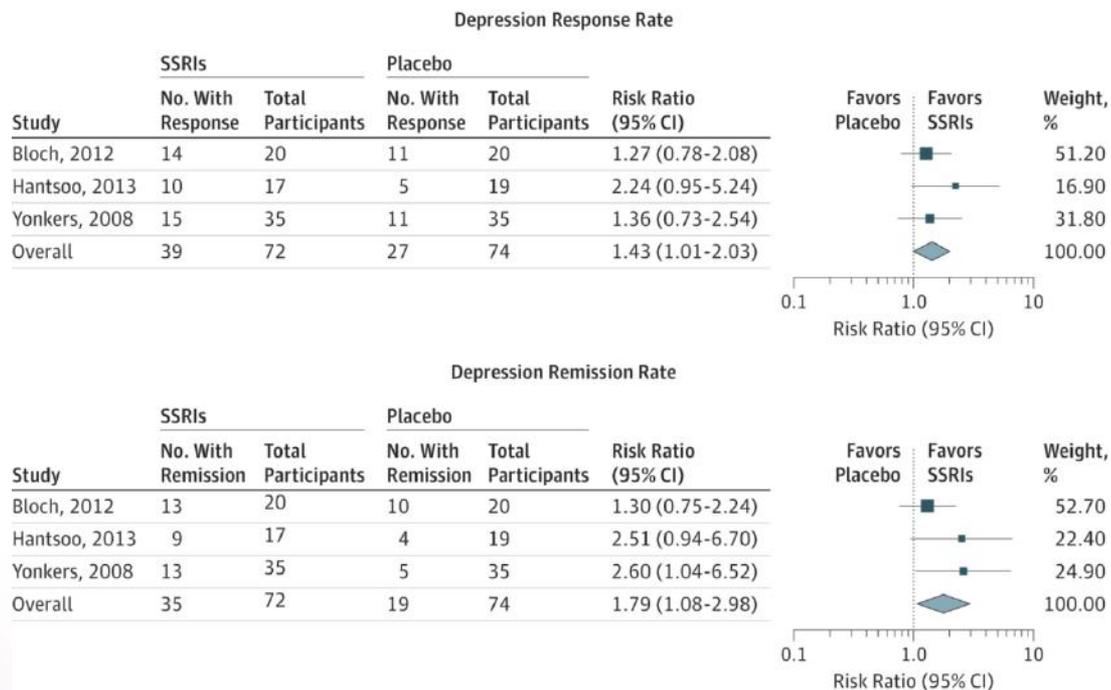


Figure Legend:

Pooled Response and Remission Rates for Selective Serotonin Reuptake Inhibitors vs Placebo Treatment for Postnatal Depression. Source: Data have been adapted with permission from Wiley. The size of the data markers indicates the relative weight of each study in the meta-analysis. Response indicates scoring as at least "much improved" on the Clinical Global Impression scale or more than 50% symptom reduction; remission indicates no longer meeting validated criteria for depression.

If a pregnant woman is stable on an antipsychotic and likely to relapse without medication, advise her to continue the antipsychotic.

Advise pregnant women taking antipsychotic medication about diet and monitor for excessive weight gain, in line with the guideline on weight management before, during and after pregnancy.

When assessing the risks and benefits of antipsychotic medication for a pregnant woman, take into account risk factors for gestational diabetes and excessive weight gain

Monitor for gestational diabetes in pregnant women taking antipsychotic medication in line with the guideline on diabetes in pregnancy (NICE guideline CG63) and offer an oral glucose tolerance test.

Do not offer depot antipsychotics to a woman who is planning a pregnancy, pregnant or considering breastfeeding, unless she is responding well to a depot and has a previous history of non-adherence with oral medication.

When a woman with severe mental illness decides to stop psychotropic medication in pregnancy and the postnatal period, discuss with her:

- her reasons for doing so
- the possibility of:
 - restarting the medication
 - switching to other medication
 - having a psychological intervention
 - increasing the level of monitoring and support.

Ensure she knows about any risks to herself, the fetus or baby

European medicines agency (EMA) review

- Up to 40% of pre-school children exposed to valproate in utero experienced some form of developmental delay, incl delayed walking and talking, memory problems, difficulty with speech and language and a lower intellectual ability (periconception folate ass with improved IQ)
- congenital malformations in 11%
- increased risk of autistic spectrum disorder (x 3), autism (x 5), ?symptoms of attention deficit hyperactivity disorder (ADHD)

Coordination Group for Mutual Recognition and Decentralised Procedures – Human (CMDh - a regulatory body representing EU Member States)

Doctors in the EU now advised not to prescribe valproate for epilepsy or bipolar disorder in pregnant women, in women who can become pregnant or in girls unless other treatments are ineffective or not tolerated. Those for whom valproate is the only option should be advised on the use of effective contraception and treatment should be started and supervised by a doctor experienced in treating these conditions (see also NICE CG192; 185)

http://www.ema.europa.eu/ema/index.jsp?curl=pages/medicines/human/referrals/Valproate_and_related_substances/human_referral_prac_000032.jsp&mid=WC0b01ac05805c516f

Other concerns

NOTE: Carbamazepine may also be associated with behavioural effects

Lamotrigine – estradiol up-regulates the expression of UGT1A4, which increases lamotrigine clearance associated with rising estrogen levels during pregnancy; returns to pre-preg levels within 3-4 weeks so:

- check levels every 4 weeks;
- decrease the dosage immediately after delivery by 20%–25% to prevent lamotrigine toxicity from the rapid increase in concentration that may occur within the first 2 weeks after delivery and as early as 3 days after delivery
- Otherwise, check the lamotrigine serum level every 1–2 weeks and reduce the dosage by 20%–25% until the serum level returns to the pre-pregnancy level

Recorded risk factors in pregnant women with SMI under SLAM care 2007-11

	Whole sample N = 456	Non-affective group, N=236	Affective group, N=220	P*
Deprivation score, median(range) ¹	34.9 (3.8-77.2)	35.4 (3.8-77.2)	33.6 (6.8-9.7)	0.226
Maternal age at 1 st index delivery, mean(SD),	31.8 (6.2)	30.9 (6.4)	32.9 (5.8)	<0.001
Partner during 1 st index pregnancy				
Yes	294 (71.5)	143 (68.1)	151 (75.1)	0.114
No	117 (28.5)	67 (31.9)	50 (24.9)	
History of domestic abuse before pregnancy	159 (34.9)	83 (35.2)	76 (34.6)	0.889
Domestic abuse in pregnancy	86 (18.9)	45 (19.1)	41 (18.6)	0.906
Smoking in pregnancy	79 (17.3)	51 (21.6)	28 (12.7)	0.012
Alcohol use in pregnancy	77 (16.9)	40 (17.0)	37 (16.8)	0.970
Substance use in pregnancy	61 (13.4)	39 (16.5)	22 (10.0)	0.041
Time since last admission (years)				
1 year	104 (53.6)	65 (56.5)	39 (49.4)	0.326
2 years	90 (46.4)	50 (43.5)	40 (50.6)	
Highest HoNOS total (range)	12 (0-36)	12 (0-36)	12 (0-28)	0.768

Some specifics in addition to valproate... Page 35

- Do not offer carbamazepine to treat a mental health problem in women who are planning a pregnancy, pregnant or considering breastfeeding
- Do not offer depot antipsychotics to a woman who is planning a pregnancy, pregnant or considering breastfeeding, unless she is responding well to a depot and has a previous history of non-adherence with oral medication
- If a pregnant woman develops mania or psychosis and is not taking psychotropic medication, offer an antipsychotic
- Monitor for gestational diabetes in pregnant women taking antipsychotic medication in line with the guideline on diabetes in pregnancy (NICE guideline CG63) and offer an oral glucose tolerance test
- If a woman is taking lamotrigine during pregnancy, check lamotrigine levels frequently during pregnancy and into the postnatal period because they vary substantially
- Encourage women with a mental health problem to breastfeed, unless they are taking carbamazepine, clozapine or lithium. However, support each woman in the choice of feeding method that best suits her and her family.

GP sees a 28 year old administrator on fluoxetine; seen today at practice as has discovered she is pregnant (now approx 8 weeks) –GP suggests continuing but switching to sertraline for breastfeeding.

35 year old, bipolar disorder, no episodes for 5 years, on risperidone, wants to conceive

Considerations for women who experience traumatic birth, stillbirth, or miscarriage:

Discuss with a woman whose baby is stillborn or dies soon after birth, and her partner and family, the options of seeing a photograph of the baby, having momentos of the baby, seeing the baby, or holding the baby. This should be facilitated by an experienced healthcare professional and the woman and her partner and family should be offered a follow-up appointment in primary or secondary care. If the baby is known to be dead in utero, this discussion should take place before the delivery.

Do not offer single-session high-intensity psychological interventions with an explicit focus on 're-living' the trauma to women who have a traumatic birth.

For a woman with tokophobia: (extreme fear of childbirth), offer an opportunity to discuss her fears with a healthcare professional with expertise in providing perinatal mental health support in line with CG132

For anxiety disorder in pregnancy or the postnatal period:

Offer a low-intensity psychological intervention (for example, facilitated self-help) or a high-intensity psychological intervention (for example, CBT) as initial treatment in line with the NICE guideline for the specific mental health problem; be aware that:

- high-intensity psychological interventions are recommended for PTSD, social anxiety disorder

For a woman with an eating disorder in pregnancy or the postnatal period:

- offer a psychological intervention in line with the guideline on eating disorders (NICE guideline CG9)
- monitor the woman's condition carefully throughout pregnancy and the postnatal period
- assess the need for fetal growth scans
- discuss the importance of healthy eating during pregnancy and the postnatal period in line with the guideline on maternal and child nutrition (NICE guideline PH11)
- advise her about feeding the baby in line with the guideline on maternal and child nutrition (NICE guideline PH11) and support her with this

Interventions for alcohol and drug misuse

If hazardous drug or alcohol misuse is identified, refer or offer brief interventions in line with section 1.3.1 of the guideline on drug misuse - psychosocial interventions (NICE guideline CG51) or the guideline on alcohol-use disorders: preventing harmful drinking (NICE guideline PH24)

If harmful or dependent drug or alcohol misuse is identified in pregnancy or the postnatal period, refer to a specialist substance misuse service for advice & treatment

Offer assisted alcohol withdrawal in collaboration with specialist mental health and alcohol services (preferably in an inpatient setting) to pregnant women who are dependent on alcohol. Work with a woman who does not want assisted alcohol withdrawal to help her reduce her alcohol intake

Offer detoxification in collaboration with specialist mental health and substance misuse services to pregnant women who are dependent on opioids.

Monitor closely after completion of detoxification.

Work with a woman who does not want detoxification to help her reduce opioid intake.

Recognise the risk of accidental overdose in women who stop or reduce drug misuse in pregnancy but start misusing again after childbirth.

Organisation of services

Women who need inpatient care within 12 months of childbirth should normally be admitted to a specialist mother & baby unit, unless there are specific reasons not to

Managers and senior healthcare professionals responsible for perinatal mental health services (incl maternity and primary care (IAPT) services) should ensure that:

- there are clearly specified care pathways so that all primary and secondary healthcare professionals know how to access assessment and treatment
- staff have supervision and training, covering mental health problems, assessment methods and referral routes, to allow them to follow the care pathways

Clinical networks should be established for perinatal mental health services, managed by a coordinating board of healthcare professionals, commissioners, managers, and service users and carers. These networks should provide:

- a specialist multidisciplinary perinatal service in each locality, which provides direct services, consultation and advice (incls psychiatrist, psychologist, nurses)
- access to specialist expert advice on psychotropic medication
- clear referral and management protocols for all relevant services

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- pathways of care for service users, with defined roles and competencies for all professional groups involved.

The guideline emphasises **recognition of all types of mental health problems** by *all* healthcare professionals during both the antenatal and postnatal periods.

Improved recognition will come from:

- ***staff training to address lack of knowledge and skills (work in progress..)***
- ***revision of routine care pathways*** to provide
 - *prompt access to further assessment, including that by specialist perinatal mental health services*
 - *prompt access to psychological therapies*
 - *Services to meet needs of women including when they have young babies*
- information for the public (eg NICE IFP)

References

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