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CONTENTS

1. Purpose

The purpose of this document is to detail the process for responding to women presenting to Maternity with a current or historic mental health problem

The policy applies to all Maternity staff.

Implementation of this policy will ensure that:

- Women receive effective maternity care which considers and responds to their psychological wellbeing alongside their physical health
- Maternity staff will be supported to deliver consistent, individualised and evidence based care which considers the role of other departments and agencies in meeting women's care needs.

2. Definitions

PHQ-9 – Patient hospital questionnaire (screening tool for depression)

GAD-2 – Generalised anxiety disorder questionnaire (modified screening tool for use in pregnancy)

PMHT- perinatal mental health team

CMHT- Community Mental Health Team

CCO- Care coordinator (allocated member of CMHT- community psychiatric nurse, social worker or occupational therapist)

PLT- Psychiatric Liaison Team (inpatient psychiatric service)

SMI-Severe Mental Illness- this refers to

- Severe depressive illness or psychosis
- Bipolar mood disorder
- Schizophrenia
- Has required hospitalisation for mental illness whether related to childbirth or not

3. Responsibilities

It is the responsibility of all staff working within the Maternity Service to follow this guideline unless there is a clear indication to divert from its recommendations, clear documentation must be made to provide clinical rationale in this case

The Complex Care Midwife is responsible for:

- Ensuring that this guideline is effective and fit for purpose
- Ensuring that this guideline remains up to date and relevant in light of new research, service availability, and key stakeholder recommendations
- Supporting staff in its delivery

4. Introduction

Mental illness in the perinatal period has a significant and detrimental effect on the wellbeing of women, their children and families, as well as constituting a considerable financial and social cost on health and social care services, as well as society itself (Bauer et al 2014) It is vital that a robust, multi-disciplinary approach is developed and maintained in order to address reduce the risk of adverse outcomes for women and their families (Cantwell and Mahmood 2011, NICE 2014, National Maternity Review 2016).

Depression and anxiety are the most common mental health complications of the postnatal period (Oates and Cantwell 2011) estimates of prevalence of postnatal depression are around 13% (Leahy–Warren and McCarthy 2007) however less-common disorders including puerperal psychosis should not be overlooked, and require careful management. Suicide remains one of the leading causes of maternal death (Nair and Knight 2017). Furthermore, poor maternal mental health impacts not just the woman, but also increases the likelihood of emotional and behavioural problems in her children (Avan et al 2010, Della Vedova 2014, Pawlby et al 2009).

There is a tendency by clinicians to use the term postpartum, postnatal depression to describe several psychiatric disorders, including puerperal psychosis (Chaudron 2003). Severe depressive illness, psychosis and other psychiatric disorders should be clearly distinguished. It is vital that risk factors and potential vulnerability are recognised and women at risk of mental illness are accurately identified. Early detection should trigger referral to the appropriate agency and systems should be in place for good communication pathways between all agencies - Maternity, GP, Health Visiting, and, where necessary, CMHT, PMHT, and Children's Services.

Midwives play a pivotal role in early identification of women at risk and in recognising signs and symptoms of a relapse or development of a mental illness. The postnatal period is a higher risk time, with the risk of developing a serious mental illness markedly elevated following birth, in comparison to other times in a woman's life (Oates and Cantwell 2011, Kendell et al 1987). Sudden onset and rapid deterioration are characteristic of puerperal psychosis, but the significance of this has been known to have been catastrophically underestimated by professionals, including psychiatric team members (Cantwell et al 2015).

5. Risk factors and potential vulnerability:

The midwife, at booking, should carry out a thorough risk assessment to identify any of the following which may increase a woman's likelihood of developing a mental illness, and care plan accordingly (see appendix 1: Mental health needs identified at booking: A guide for midwives)

- Any past history of mental illness or mood disorder
- A past episode of severe mental illness (severe depressive illness or psychosis) have a significant risk of recurrence or relapse following delivery. Those with a history of bipolar mood disorder, schizophrenia or who had their first episode of puerperal psychosis in the previous 24 months are particularly at risk (Sichel 1995).
- Family history- women who have a close family history of puerperal psychosis or bipolar disorder are at increased risk of experiencing severe mental illness postnatally than those without such a family history (Nair and Knight 2017).
- Social disadvantage, isolation, and poverty
- Minority ethnic groups, asylum seekers, and refugees
- Late bookers and non-attenders
- Current domestic violence/abuse
- Substance or alcohol misuse
- Involvement with children's social care
- Physical ill health (note association of diabetes with depression)
- Adverse life events/lack of support and low levels of emotional resilience (Jomeen 2017)
- Women with no history of mental illness but identified as having risk factors should have regular antenatal visits, ideally with a named midwife and their attendance monitored. Continuity of midwifery carer makes an important contribution to a mental health assessment. **All women should be asked about their mental health at every contact.**

6. Antenatal

At a woman's booking appointment, when completing the antenatal notes, midwives should ask women two questions ("Whooley Questions") (Whooley et al 1997) to screen for depression:

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

If the answer to either/both of these questions is “yes” then ask:

- Is this something you want or need help with?

Anxiety should be screened for by using the (modified) GAD-2 questions:

Over the last two weeks, have you often been bothered by feeling anxious, nervous or on edge?

Over the last two weeks, have you often been bothered by not being able to stop or control worrying?

Positive Screening for Current Mental Illness:

Answering yes to any of the screening questions should prompt further assessment and management. If depression, anxiety or any other mental health problems are suspected, the woman should be encouraged to see her GP for a review.

Encourage self-referral to Talkworks – this service offers individualised assessment and delivery of psychological therapies such as CBT. This approach is recommended by NICE to treat mild-moderate depression as well as anxiety

The midwife should suggest self-help strategies- such as good diet, rich in Omega 3, exercise (particularly yoga); guided meditation/mindfulness; as well as online resources such as www.mind.org.uk; www.getselfhelp.co.uk and Living Life to the Full (online CBT designed for pregnancy: www.llttf.com). Identify and explore what support the woman already has at home

If a developing mental health problem is identified at 16 weeks or later, offer referral to the children’s centre, who can provide antenatal preparation that focuses on emotional changes in pregnancy including some work on bonding and attachment. This work can continue into the postnatal period and engagement with the sessions may help to improve a woman’s symptoms. If a severe mental health problem is emerging, this work may complement that of the perinatal mental health team

The effectiveness of any suggested interventions should be reviewed in a timely manner with an individualized approach – for example: arranging to contact the woman 2 weeks after booking to review her mood (as opposed to waiting till the next routine appointment which may not be for several weeks)

If it is felt this supportive intervention is not effective and the woman's mental state is deteriorating, affecting her quality of life or ability to care for herself or dependents, then advice should be sought from the GP, complex care midwife, team leaders or PMHT, and a CANI (Complex or Additional Needs Identified) form should be completed to evidence the ongoing plan

Women with a history of mental illness:

Women with a history of any mental illness, including postnatal depression, should be advised at booking that they may experience a relapse or recurrence of their illness in pregnancy or after delivery. Reassurance should be provided that safe, effective treatments are available and widely used.

Any woman assessed as at increased risk of mental illness, including postnatal depression, in the postnatal period, should be given the opportunity to discuss this risk and develop an individualised birth and postnatal plan, outlining current concerns, past history, plan and follow up for the postnatal period. This should include the offer of extended postnatal care, with regular contact, for a minimum of 14 days after delivery (Dennis and Dowswell 2017)

Continuity of carer should be achieved; caregivers familiar to the woman are better able to accurately assess her mental state. A CANI form should be completed to share the information with the complex care midwife and evidence steps taken

Women with a history of severe mental illness:

When it is known that a woman has a history of severe mental illness (whether linked to pregnancy or not), the woman's GP should be contacted for further information on their history, as well as liaison with mental health and health visiting services in order that information is shared, and a comprehensive history is documented. This enables a full and thorough risk assessment and will inform the care plan

Women with a history of SMI (see definitions) should have a documented plan of care which addresses their increased risk of relapse in the perinatal period. A CANI (complex and additional needs identification form) should be shared with the Complex Care midwife, and a referral sent (with the woman's consent) to the PMHT, sharing

- Diagnoses (previous and current)
- Dates and location of admissions due to mental health reasons
- Treatments past and present, including the efficacy of these treatments

For women at high risk of severe mental illness in the perinatal period, this care plan should be completed with input from the perinatal mental health team, who will liaise with professionals involved in the woman's care. A copy should be given to the woman, with another to be placed in the front of the woman's hospital (buff) notes.

The safety and wellbeing of any other children in the household should be considered and appropriate support offered, for example through Early Help services. Mental illness alone should not be seen as a reason to refer to children's social care, however if a woman's symptoms are considered to be likely to impact on her ability to care effectively for her child/children, then Early Help services must be offered. If risks of harm are considered to be significant, a MASH enquiry must be submitted- this may be done with support from safeguarding leads. Any assessment/referral must be done sensitively, with an awareness that women's fear of social services involvement may exacerbate feelings of depression and anxiety (Oates and Cantwell 2011). Requests for additional services' support should evidence steps taken to support the woman and her family in caring for her child/children

7. Medication and pregnancy

Around 10% of adult women report a longstanding mental health condition (Moody 2019) - it is reasonable to assume from this that around 1 in 10 women booking for maternity care will be taking, or have taken in the past, medication for a mental health problem

Any medication taken either at the start of the pregnancy or commenced during pregnancy must be documented clearly in the handheld notes. This must be made available for review by the obstetric consultant

Women must be counselled at the first available opportunity regarding the benefits and risks of treating their mental health problem- at booking if they have not already had a review of their medication by their prescriber (usually their GP)

Use appropriate resources to ensure women are fully informed about their decision to continue or discontinue psychiatric medication, and **seek advice from a specialist** if there is any uncertainty about the risks associated with specific drugs (NICE 2014). **Complex prescribing should always be referred to the PMHT**

Suggested resources:

- BUMPS website (www.medicationsinpregnancy.org) – summarises the research for individual medications, easy to use patient information leaflets
- UKTIS- uk teratology information service- summarises info in pregnancy for professionals
- BNF- www.bnf.nice.org.uk
- Consultant perinatal psychiatrist (via PMHT)
- Maternity pharmacist
- Neonatal consultant

The majority of commonly-used medications are not considered to pose any significant risk to fetal development or adaptation once born, but research findings have not always been consistent; and as a result there are no UK national guidelines for the management of antidepressant-exposed newborns, and many neonatal units have no formal policy (Thomas et al 2017)

Risk to developing babies may be balanced by risk of continuing depression or relapse of severe mental illness

The most common medications used for the most common disorders (depression and anxiety) are **Sertraline, Citalopram and Fluoxetine**. Significant withdrawal symptoms after in-utero exposure to commonly used SSRIs is rare, if the baby is full term and not SGA, and especially if the baby is breastfed. Women should be offered 48 hours of observations on their babies after birth (as per Neonatal Abstinence Syndrome Guidelines) however they may choose to return home before the observation period is complete. Principles of informed consent apply in this case and the woman's choice should be respected, in the absence of any other clinical concerns which would pose a risk to the baby if discharged. Liaison with the neonatal team must be evidenced.

The risk of persistent pulmonary hypertension is also low (2.9:1000; Masarwa et al 2019) but slightly higher than background population. We do not carry out formal investigations for this but parents should be advised (as routine) to seek urgent review if any concerns around a baby's breathing

less commonly used psychiatric medications (but still seen frequently) include: **pregabalin, amitriptyline, trazodone, quetiapine, duloxetine, venlafaxine, mirtazapine**- offer routine observations for babies exposed to these medications as there is still a small risk of poor adaptation (withdrawal or toxicity), or PPHN, a risk theoretically increased if a baby is exposed to more than one of these medications. Clinical judgement (seek specialist advice in pregnancy), awareness of additional risks (eg prematurity, weight) and a woman's personal preference and circumstances should guide the care planning in these cases

Women taking benzodiazepines (eg **diazepam, clonazepam, lorazepam**) must be advised that their baby is likely to experience withdrawal symptoms/poor adaptation if taken regularly during pregnancy. The prescriber should be made aware that the woman is pregnant and efforts made to reduce, replace or discontinue the medication if safe to do so- seek specialist advice

Antipsychotics such as **quetiapine, olanzapine and risperidone** have a theoretical risk of metabolic effects including gestational diabetes; consider GTT if prescribed these medications

8. Inpatient and intrapartum care

Ensure that any medications are prescribed and administered whilst in hospital (or documented each time they are self-administered)

Reference must be made to any individualised plans regarding care in labour and around birth, as this will take into account the woman's mental health history, including the impact of any previous birth experience

9. Postnatal care

At every opportunity, women should be asked about their mood and mental health, with prompt review and referral to specialist services if significant concerns (see Red Flag Symptoms in section 7). Observing a woman's interaction with her baby can be useful in assessing her mental state- this should be documented as part of a more thorough assessment if any concerns

If a woman has a mental health birth plan, this should continue to be followed and all relevant professionals informed of the birth

If a woman is taking medication to treat or manage her mental illness, she should be asked about compliance with this medication, with urgent review considered if she discontinues her medication, or changes the dose (without clinical supervision)

Women at risk of postnatal depression should not be discharged from midwifery care until at least 14 days postnatal, up to a maximum of 28 days. A formal handover to the Health Visitor is recommended.

10. Infant feeding and mental health

There is a complex relationship between breastfeeding and the mental health of both mother and baby. When successful, breastfeeding can benefit and protect mothers' mental health and positively impact on children's cognitive and emotional development by reducing toxic stress and supporting bonding and secure attachment (Kendell-Tackett 2010) However, there is evidence that breastfeeding difficulties and negative breastfeeding support experiences can increase the risk of postnatal depression, as can stopping breastfeeding earlier than intended. (Borra et a 2014)

Women with mental health problems are more likely to experience difficulties with feeding, and these difficulties can also be a trigger for developing or re-experiencing mental ill-health (Dennis and McQueen 2015)

Having access to timely, effective infant feeding support may help mitigate the escalation of symptoms of anxiety and depression in the postnatal period.

For additional infant feeding support in the antenatal and postnatal period, please contact the Infant Feeding Coordinator and email ndht.infantfeedingteam@nhs.net for support with preparation in pregnancy and/ or refer to the Infant Feeding Team using the e-form on BOB for postnatal support.

The evidence shows that stopping anti-depressant / anti- anxiety medication is often unnecessary in many cases, and there should be careful consideration of the impact that stopping breastfeeding before the woman is ready might have on the woman's mental health (Brown 2018). For information on drugs in breastmilk, please refer to Breastfeeding Network for evidence based, up to date support https://www.breastfeedingnetwork.org.uk/

11. Response to urgent mental health concerns whilst under maternity care

The following are 'red flag' signs for severe maternal mental illness and require urgent senior psychiatric assessment:

- **Recent change in mental state or emergence of new symptoms**
- **New thoughts or acts of violent self-harm**
- **New and persistent expressions of incompetency as a mother or estrangement from the infant. (Cantwell et al 2015).**
- **For suicidal ideation, see urgent referral guidance in Associated Documentation below**

A practitioner familiar to the woman (eg her named midwife) may be best placed to identify any changes in behaviour, as well as providing reassurance and support if the woman is distressed

If a woman is an inpatient- the psychiatric liaison team should be contacted for urgent review (01271 443244; bleep 291)

If the woman is an outpatient- contact the woman's GP in the first instance, if urgent review is not available then the Crisis Resolution and Home Treatment Team (CRHTT) should be contacted on 01271 443200

Out of hours, if the woman is an outpatient and requires urgent or emergency review, referral should be made through the Single Point of Access on 0300 555 5000. The Single Point of Access triage emergency, urgent and routine referrals with onward referral to the appropriate team for assessment

If the woman is assessed as being likely to require admission ("admission vulnerable") she should be referred to the Mother and Baby Outreach Service for assessment. The Mother and Baby Outreach Service are contactable via the MBU - 01392 539 100 and operates Monday to Friday between 9am and 5pm. Outside of these hours referrals for admission can be made directly to the Mother and Baby Unit following completion of the national MBU referral form

The PMHT do not fall within the emergency (response within 4 hours) or urgent care (response within 24 hours) but should still be contacted for advice and to inform of concerns as soon as possible (available during office hours)- 01271 443177

The woman and her baby's (and other children's) safety must be considered, with the safeguarding of children taking priority. Involve site management and children's services if immediate safety is at risk whilst in hospital. If at home, appropriate risk assessment should consider the ongoing presence and support of the woman's partner and other family members. Discuss with senior midwives or safeguarding leads whether readmission to the maternity unit is appropriate

Admission to a mother and baby unit should always be considered where a woman has any of the following:

- rapidly changing mental state,
- suicidal ideation (particularly of a violent nature),
- pervasive guilt or hopelessness,
- significant estrangement from the infant,
- beliefs of inadequacy as a mother,
- evidence of psychosis (Cantwell et al 2015)

If the woman requires psychiatric inpatient services every effort should be made, if appropriate, to arrange a mother and baby placement. This aim should be escalated by either, the psychiatric liaison team, PMHT, CMHT or the Mother and Baby Unit Outreach team.

If the woman is transferred to local mental health services, her named midwife should visit to continue her maternity care

The psychiatric liaison team is responsible for leading the process if a woman requires detention under the Mental Health Act (1983) while inpatient at NDDH.

12. Monitoring Compliance with and the Effectiveness of the Guideline

Monitoring and implementation, effectiveness and compliance with this guideline will be the responsibility of the Complex Care Midwife. Its effectiveness will be discussed within the annual clinical update Mandatory study day to raise awareness and compliance

Standards/ Key Performance Indicators

Key performance indicators comprise:

Appropriate advice, support and follow-up offered to women reporting concerns relating to their mental health

Women are asked about their mental health at each appointment

Appropriate referrals to the PMHT

Process for Implementation and Monitoring Compliance and Effectiveness

This newly developed guideline will be disseminated to staff via email, with a summary of most relevant changes outlined in the "IQ" newsletter

Its contents will be shared at the annual clinical updates training day

Compliance will be monitored through review of CANI forms, clinical discussion, and audit (complex care audit)

The Complex Care midwife will discuss any matters arising with relevant staff including the PMHT at the weekly meeting

Any non-compliance that is identified through eg clinical incidents, claims or complaints will be reviewed as per relevant Trust policies, and may result in further audit and/or amendment to this guideline

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14. Associated Documentation

- PMHT referral form
  \\Nds.internal\public\MIDWIFERY RESOURCES\FORMS and REFERRALS\SPECIALIST REFERRAL FORMS\Perinatal Mental Health Team Antenatal Referral Form.docx
- PNMHT Urgent Referral Guidance
  G:\MIDWIFERY RESOURCES\FORMS and REFERRALS\SPECIALIST REFERRAL FORMS\PMHT Urgent Referral Guidance.pdf
- Tommy's wellbeing plan
  Tommys Wellbeing Plan

APPENDIX 1: Mental health needs identified at booking- a guide for midwives:

Need Identified:		Required response:
1:	Well woman with history of mental illness	• Detailed history – **use accurate terminology and diagnostic language*** • Advice re emotional changes in pregnancy, risk of recurrence of condition and safe treatment options and support available** • Liaise with GP and HV • Confirm history with GP – request copy of GP record • Regular CMW contacts*** • Vigilance for mood changes and encouragement to report concerns • Offer individualised wellbeing plan later in pregnancy
2:	Well woman currently treated for mental illness	• Advice as **1** plus: • Ensure medication name and dose is clearly documented in notes • Ensure prescriber is aware of pregnancy • Direct to BUMPS website for advice on medications in pregnancy https://www.medicinesinpregnancy.org • Refer to Antenatal Clinic for consultant review
3:	Well woman with previous care by secondary mental health services/community mental health team (CMHT)	• Advice as **1** and **2** • Prompt referral back to relevant team in the event of MH deterioration or relapse • Seek advice from PMHT or Complex Care midwife
4:	Well woman with history of **Serious mental illness** (schizophrenia, Bipolar disorder, psychosis, severe postnatal depression requiring admission)	• Advice as **1** and **2** • Refer to Perinatal Mental Health Team as soon as possible • Complete MH birth plan with woman, her partner, PMHT and HV (around 32 weeks of pregnancy) and ensure this is easily accessible in her hospital and handheld notes
5:	Currently has a care co-ordinator, MH worker or psychiatric input	• Liaise with care co-ordinator • Ask what their care plan is and that this is taking the pregnancy into consideration • Discuss whether PMHT referral is required- consider their referral criteria, contact PMHT for advice if necessary • Invite care co-ordinator to complete a wellbeing plan with the woman around 32 weeks of pregnancy with PMHT input if required
6:	Previous birth trauma **affecting current pregnancy or ability to access care**	• Refer to Talkworks for review +/- psychological therapy

7:	Positive to Whooley or GAD-2 *and wishes help with this*	• Explore current situation and woman's own support network • Suggest self help strategies*****- encourage the woman to identify what has worked for her in the past • Encourage self referral to Talkworks • Encourage self referral to GP for further assessment and treatment options (emphasise that SSRIs are considered overall safe in pregnancy, use BUMPS website) • Document advice given and plan in notes • Follow up via phone within 2 weeks, reiterate plan and document

Notes:

*****Please avoid using vague language eg "mental health history", aim to provide specific diagnoses such as "depression" "anxiety" "OCD"- this makes it easier to assess risk and care plan

****** This must be done to meet NICE quality standards which are assessed quarterly

******* Women at risk of mental illness benefit from continuity of carer and a familiar caregiver will be more likely to identify mood changes or deterioration (or, conversely, that distinctive behaviour, which is typical of an individual woman, is *not* suggestive of developing mental illness). Women should be offered **all** NICE recommended appointments with their community midwife- 16/40, 25/40, 28/40, 31/40, 34/40, 36/40, 38/40, 40/40+ *even if* she has an appointment at the antenatal clinic that week

******** PMHT referral criteria:

1. Women who have an established diagnosis of Bipolar Affective Disorder, previous Post-Partum Psychosis, or schizophrenia
2. Women with complex mental health prescribing- this may be a single consultation with a medic or pharmacist
3. Women in the perinatal period with active symptoms of psychosis.
4. Women with current serious eating disorder ante-natally.
5. Women with active thoughts of ending their life and/or their child's life in context of current episode of mental illness.
6. Women who have a serious mental illness who have recently become estranged from their infant.
7. Women who have worsening depression, who have previously been detained under the Mental Health Act, had inpatient admissions for depression and/or had ECT
8. Women living in farming communities with current perinatal mental illness/risk. (This cohort of women who are from a farming community may be less likely to ask for help early, are more likely to understate their distress and have high lethality means at their disposal).

***** The midwife should suggest self-help strategies- such as good diet, rich in Omega 3, exercise (particularly yoga); guided meditation/mindfulness; as well as online resources such as www.mind.org.uk ; www.getselfhelp.co.uk , and Living Life to the Full (online CBT designed for pregnancy: www.llttf.com)