



**Healthy London
Partnership**



Pan-London Perinatal Mental Health Networks

**Pre-conception advice: Best Practice Toolkit for
Perinatal Mental Health Services**

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Foreword

This toolkit is part of a series commissioned by the London Perinatal Mental Health Network to address areas of perinatal mental health care where there is a need for specific and tailored guidance. It is written by practitioners with experience of working with women and families who have experienced perinatal mental illness, with reference to research and national guidance.

Every woman should think about her physical and mental health when planning a pregnancy, to support her health and the health of her future baby. This toolkit aims to provide practitioners supporting women with mental illness with information and resources to help answer the many questions that women and their partners have in relation to this very important decision, such as:

- Do I have to stop taking my psychiatric medication while pregnant?
- If so, will I be able to function without it?
- If I keep taking the medication, what are the risks to my baby?
- What is the chance of my mental health getting worse?
- How might my condition and its treatment affect parenting?
- What are the chances of my mental health affecting my child's mental health?
- Are there any risks associated with not treating my condition?
- What mental health services are available for pregnant women in my area?
- What kind of support is available after my baby is born?

Ensuring women and their partners are equipped with information and specialist advice when needed, will help them make the choice that is best for them and their family and to avoid rushed decisions that can result in tragic outcomes.

We would like to thank all the individuals that contributed to this much needed resource for their hard work and thoughtfulness. We hope it proves useful to practitioners and helps improve outcomes for women and their families.

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Executive summary

This toolkit is designed to offer advice to doctors and informs the multi-disciplinary team of best practice in providing preconception/family planning advice to women with a mental illness. The document contains not only information and resources, but also recommendations that shift the clinical approach towards a collaborative model of care, using a strengths-based formulation.

Although this toolkit focusses on preconception advice for women with a mental illness who are planning a pregnancy, its use can be extended to guide family planning and contraception advice when women are at the point of discharge from generic and specialist (including perinatal) mental health services.

This toolkit should be used in conjunction with the relevant updates and guidelines on prescribing in pregnancy and breastfeeding; therefore, it will not detail the available evidence on the association between the exposure to psychotropic medication in pregnancy with adverse outcomes.

In addition, the toolkit should be used in conjunction with the pre-birth planning meeting (PBPM) toolkit <https://www.healthylondon.org/wp-content/uploads/2019/01/Pre-birth-planning-guidance-for-Perinatal-Mental-Health-Networks.pdf>

Untreated mental illness in the perinatal period places the woman and her baby at increased risk of adverse outcomes, both in terms of their physical and mental health. This has to be carefully weighed against any potential risks associated with prescribing medication in pregnancy and when breast feeding. The use of medication during pregnancy is indicated when risk to the baby from exposure to this medication is outweighed by the risks of untreated mental illness in the mother (Guze and Guze 1989; Cohen 1998; Austin and Mitchell 1998; Allison 2008; Trixler et al. 2005; Galbally et al. 2011). However, there is noted uncertainty amongst health professionals about prescribing during pregnancy, possibly related to lack of training in this area and the focus of concern on teratogenic harm (Watanabe 2014; Stevenson et al. 2016). This toolkit aims to support this decision-making process.

Providing advice and support, not only to mother and their partner, but also to the wider context of health professionals, regarding the potential risks to the mother and baby's physical and mental health, is an important part of care planning in perinatal mental health. All the professionals involved in the woman's care should be aware of any identified risks and there should be plans in place to mitigate them.

The Perinatal Quality Network for perinatal mental health services recommends contraception advice to be included as part of the discharge planning process from both inpatient and community specialist services (Royal College of Psychiatrists Care and Quality Commissioning 2015a, b).

This Toolkit will provide guidance on the following:

- How to structure the consultation
- What specific areas to address in the consultation with a focus on identifying protective as well as risk factors

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- How to formulate and communicate the outcome of the consultation in a meaningful way to women and their partner so that they feel empowered and reassured
 - Who to involve in the consultation process and in supporting the ensuing plan

The following resources are included:

- A template letter for professionals
- Web-links on prescribing medication in pregnancy and lactation and self-help guidance
- A case vignette

The Toolkit is based on recommendations from the following Guidelines and Standards:

- *NICE CG62 Antenatal Care (2008)*
- *Management of women with mental health issues during pregnancy and the postnatal period. Royal College of Obstetricians and Gynaecologists: Good practice No.14 (2011)*
- *NICE CG192 Antenatal and Postnatal Mental Health: Clinical management and service guidance (2014)*
- *Pan-London Perinatal Mental Health Network – Perinatal Mental Health Care Pathway (2015)*
- *Perinatal quality network for perinatal mental health services. Service standards 3rd edition: perinatal community mental health services. Royal College of Psychiatrists (2016)*
- *British Association for Psychopharmacology consensus guidance on the use of psychotropic medication preconception, in pregnancy and postpartum 2017 (BAP 2017)*
- *Guidance for Newborn Assessment The Pan-London Perinatal Mental Health Network and the London Neonatal Operational Delivery Network 2017*
- *Knight M, Bunch K, Tuffnell D, Jayakody H, Shakespeare J, Kotnis R, Kenyon S, Kurinczuk JJ (Eds.) on behalf of MBRRACE-UK. Saving Lives, Improving Mothers' Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-16. Oxford: National Perinatal Epidemiology Unit, University of Oxford 2018*
- *The Perinatal Mental Health Care Pathways NHS England, NHS Improvement, National Collaborating Centre for Mental Health 2018*

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1 Focus and structure of the preconception consultation

The research on family planning and contraception use for those with perinatal mental health difficulties is sparse (Faisal-Cury et al. 2013). The same applies for the effectiveness of preconception advice on maternal mental health and pregnancy outcome. Thus there is no current guideline about what preconception advice should be offered to women of childbearing age with a mental illness.

It is important to determine what preconception advice should be given to women with a mental illness in order to help them to make positive changes and hopefully improve their reproductive choices and the chances of having a healthy pregnancy outcome.

Setting the tone of the consultation

Many women and couples affected by a mental illness often face the prospect of a pregnancy with profound apprehension. They are concerned about the intra-uterine exposure to psychotropic medication, the risk of a relapse precipitated by the physical adaptation to pregnancy and parenthood and the impact of psychiatric symptoms on their ability to care for their baby. Many women with a psychiatric diagnosis harbor fears and beliefs that they will never be able to have children.

A thoughtful and well-informed preconception consultation can empower women and their partners to make informed choices and plan for a pregnancy knowing that their mental health will receive the same consideration of their physical health.

Doctors should be mindful of the language used to explore sensitive areas during the consultation and formulate the relevant recommendations. Women and their families may feel overwhelmed by the notion that maternal mental illness is associated with an increased risk of adverse pregnancy outcomes and child psychopathology. The toolkit explores areas related to teratogenic risk (risk associated with drugs or substances that may produce physical or functional defects in the embryo), parenting and intergenerational transmission of disturbances (this relates to the potential impact of the persons own experiences of being parented on their ability to understand the baby's needs) however there is an expectation that the consultation is conducted in a way that makes feel the woman or the couple empowered and confident that they will be supported in their decisions, whatever these may be.

Looking After The Womens ' Physical Health

The chance of having a healthy, live birth may be impacted upon by a number of factors such as weight, diet, smoking, substance abuse, environmental pollutants, infections, medical conditions, medications and family medical history. The womens physical health may not be the primary focus from a specialist perinatal mental health perspective, however the preconception consultation could be the only chance women or couple may have to be informed on vitamin, supplements (e.g. folic acid) and nutrition in pregnancy, to discuss smoking cessation, alcohol consumption, weight optimization as well as screening test (e.g. rubella).

Integrating Physical and Mental Health

Physical adaptation to pregnancy leads to changes in drugs pharmacokinetics i.e. absorption, distribution, metabolism and elimination, with implications for prescribing. Therefore the approach to preconception advice cannot preclude from the integration of reproductive health and perinatal mental health

The susceptibility to factors affecting fetal development varies throughout the different stages of pregnancy. Teratogens (substances or drugs that may produce physical or functional defects in the embryo) are especially damaging in the first twelve weeks of gestation because it is a critical period in perinatal development. The timely recognition and management of obstetric complications e.g. intrauterine growth restriction (IUGR), can be instrumental in minimizing the risk of adverse outcomes. The evidence suggests that untreated (or sub-optimally treated) maternal mental illness is associated with an increased risk of adverse obstetric outcomes (Jablensky et.al 2005), although it is unclear if this is secondary to health behavior or is a direct effect of maternal mental illness. This knowledge can assist decisions concerning the reinstatement of medication during pregnancy when this is necessary and motivate mothers to implement life style changes in preparation for motherhood.

Interface between mental illness and parenting

Exploring the interface between mental illness and parenting is extremely anxiety provoking for women or couples with lived experiences.

A number of longitudinal studies indicate that children of parents suffering from a mental illness are at increased risk of developing psychological and psychiatric conditions later in life, however it is not possible to infer a causal relationship.

The ability to meet the baby's needs adequately can be affected by a number of factors; identifying factors that the women recognise as potentially impacting on their ability to meet the needs and ways to minimize the impact is an integral part of empowering women or couple to plan for parenthood. The mechanisms underlying the intergenerational transmission of disturbance are complex. Some of the identified mediating variables (i.e. links between parent psychopathology and offspring) and moderators (i.e. which change the strength of the association) are potentially modifiable e.g. social (including partner or significant other) and material support, duration of the parental disorder and the quality of parenting (Stein, 2014).

There is ample evidence that the quality of the parenting – sensitive, unresponsive or controlling – shapes the organizational attachment (Attachment is the strong emotional bond that an infant forms with a caregiver) patterns, and these in turn are predictive of future functioning. Sensitive parenting promotes the development of secure attachment, resilience and emotional wellbeing.

The research on parent sensitivity identified two main correlates of sensitive parenting:

- Attunement (or contingency) between parent and infant (*Beebe et al. 2010*)
- Mind-mindedness or reflective function. The parent's capacity to understand the infant behaviour in terms of internal feeling states (*Meins et al. 2001; Slade et al.*

2005)

It is important to reiterate that having a mental illness does not equate to “bad parenting” and many women and couples with lived experience are perfectly capable of caring for their children. Women and couples should be reassured that if they experience difficulties in bonding and parenting, they will be able to receive appropriate help. There is increasing evidence supporting the effectiveness of interventions based on video interactive guidance to improve the quality of parenting and increase sensitivity of the parent infant relationship.

Many women and couples are deeply apprehensive at the prospect of being referred to social care on account of maternal mental illness. Often the fear that social services “will take the baby away” discourage women from being open about their diagnosis and from seeking help. The consultation offers the opportunity to explain the referral criteria and remit of social care and clarify that their primary role is to support parenting and empower families.

Risk factors for the intergenerational transmission of psychopathology are not routinely considered in mental health assessments but this aspect can no longer be overlooked and should be an integral component not only of preconception advice but also of all generic mental health assessment of childbearing (female and male) population.

Summary of key points of consideration during consultation

Focus of the consultation: (*think laterally & longitudinally*)

- a. Providing a safe environment to explore fears, expectations and empower the woman or the couple to make an informed decision about pregnancy and parenthood.
- b. Physical and mental health risks deriving from adaptation to pregnancy and parenthood
- c. Associated impact on the baby throughout her developmental trajectory
- d. Risk of intergenerational transmission of dysfunctional parenting

Structure of the consultation – two steps

1. *Initial appointment – one hour – with the woman*
 - Discuss formulation, risks, *protective factors*, wellbeing recommendations
 - Discuss pharmacological options:
 - a. Continue medication throughout conception and pregnancy
 - b. Continue medication but switch to a different psychotropic medication with a better teratogenic profile; this however may well increase the risk of relapse and there is always the uncertainty related to the response to medication.
 - c. Discontinue prior to conceiving, be mindful that the time scale for conceiving cannot be fully controlled and:
 - Reinstate medication after 12 weeks of gestation even if there is no evidence of symptoms breakthrough
 - Reinstate medication after delivery or at any stage of the pregnancy if there is evidence of a relapse/recurrence
 - Discuss the evidence for non-pharmacological interventions e.g. psychological therapies and agree at what stage they need to be supplemented by pharmacological ones
 - Establish who is going to provide mental health support while the woman is trying to conceive and share the plan with the woman's consent.
 - Explore woman's preferences and choices of maternity care and clarify her entitlement to perinatal mental health care provided locally.
2. *Follow up appointment with partner/significant others to revisit the plan and provide psycho-education*

2 Preconception advice: The basics – Elicit a comprehensive History

Taking a thorough mental and physical health history is the fundamental pre-requisite for formulating an appropriate pre-conception advice consultation plan and establishing the basis for a meaningful therapeutic relationship.

- **Past Psychiatric History.** *Focus: prognostic factors and health behaviour.*
 - Age of onset, characteristics of episodes, frequency and duration of relapses, number and modalities of admissions to hospital, factors precipitating relapses (e.g. sleep deprivation), compliance with treatment, response to interventions (pharmacological and non), insight and ability to take responsibility for health.
 - Impact of the symptoms on level of functioning and cognitive processing
 - Does the current diagnosis need revisiting?
- **Family & Personal History.** *Focus: risk of intergenerational transmission of parenting style.*
 - Exposure to developmental stressors, experience of being parented “I want to give my baby what I have never had”
 - Neurobiological evidence on intergenerational transmission of parenting
- **Pre-morbid personality.** *Focus: coping styles at times of stress*
 - Consider screening tool for personality disorders SAS-PD (Olajide et al., 2017) as personality traits influence adaptation to parenthood. E.g. are the usual coping strategies – e.g. smoking, alcohol, substances use, over-reliance on fitness, comfort eating, compatible with physical adaptation to pregnancy and motherhood?
- **Relationships and Social Circumstances.** *Focus: protective factors*
 - Quality of the relationship with the father of the future baby (domestic violence, “parents as partners”, partner’s understanding and acceptance of mental illness).
 - Outsourcing household management, childcare. Be specific about “support”, clarify that material and social support is not substitutive of interventions; one should be realistic about what statutory and non-statutory agencies can offer.
 - Entitlement to maternity pay. Harassment in the workplace
- **Reproductive history and attitude toward conception.** *Focus: ability to prioritise the baby’s need.*
 - TOPs, miscarriages, sexual health and behavior – this is also helpful in assessing the risk of vulnerability.
 - Try to get a sense of the “role of the baby” e.g. replacement baby, the desire to have a baby can be driven by unmet emotional needs or the wish to consolidate an unstable relationship.
- **Medical History.** *Focus: risk factors for pregnancy.*
 - Existing health condition
 - High blood pressure (uncontrolled)
 - Polycystic Ovarian Syndrome is associated with a reduction in fertility and an increased risk of obstetric complications
 - Diabetes
 - Kidney disease
 - Auto-immune diseases (e.g. Lupus, Multiple Sclerosis)
 - Thyroid disease
 - Infertility [in 8–12% of couples (WHO, 2014)] fertility treatment is associated with increased risk of obstetric complications and multiple gestation)
 - Obesity (52% of UK female population is overweight)
 - Age (early or advanced maternal age is associated with increased risk of adverse obstetric and neonatal outcomes)
- **Lifestyle factors: alcohol, tobacco, recreational drugs, physical exercise**
- **Current Medication** Prescribed and over the counter (OTC)

Summary of key points for consideration

The main focus of women's (and their families) anxiety is commonly related to the prescribing of psychotropic medication in pregnancy and lactation. The pre-conception consultation is an opportunity to look at reproductive choices in a holistic manner and should include a tactful discussion on the importance of the quality of parenting and other factors mediating and moderating the risk of intergenerational transmission of psychological disturbances and psychopathology.

3 Prescribing strategies and medication dosage - pregnancy

- Prescribing in pregnancy is common; there is evidence that the mean number of medications taken in pregnancy has almost doubled over the past five years.
- The average pregnant patient in the US and Canada uses more than two drugs during the course of their pregnancy (Mitchell et al., 2001). 95.8% of participants of a longitudinal study took prescription medications, 92.6% self-medicated with OTC medication, and 45.2% used herbal medications (Glover et al. 2003).

Physiological adaptation to pregnancy results in changes to various systems:

Pharmaco-kinetic changes secondary to physiological adaptation to pregnancy:

- Reduced gastric motility, increased gastric PH, reduced gastric secretion, reduced intestinal motility
 - Increased cardiac output, increased plasma volume and increased volume of distribution (50%)
 - Increased body fat
 - Decrease plasma protein binding
 - Increased glomerular filtration and drug elimination.
 - Increased activity of P450 CYP enzyme family.
 - The placental MAO and COMT can accelerate the metabolism of some drugs.
 - Increased Insulin resistance
-
- Treatment and dosing strategies are based on data from healthy male volunteers and non-pregnant women. Pregnant women are actively excluded from phase 3 clinical trials, which establish the safety and efficacy of a drug. The evidence from observational studies must be interpreted with caution also because the individual variability.
 - Therefore there is very limited data to guide clinicians in dosing strategies in pregnancy and clinicians must rely upon:
 - What is known about pharmacokinetic in pregnancy
 - The critical stages of fetal development. The rate of major birth defects in the general population is 3% (Cunningham et al 2010)
 - Basic principles:
 - Use the lowest beneficial dose
 - Monitor closely mental state and response
 - Avoid poly-pharmacy
 - The discussion of the risk *versus* benefit for specific classes of medication should be based on relevant guidelines e.g. BAP, NICE, the recommendation of UK Teratology Information Service and when relevant should incorporate pharmacovigilance alerts (e.g. Pharmacovigilance Risk Assessment Committee of the European Medicine Agency recommendations on Valproate use in pregnancy).

4 Breastfeeding: pharmacological and non-pharmacological considerations

On average, nursing mothers produce 600 to 1,000 ml of milk daily (Burt, 2001).

- All psychotropic medications are transferred in the breast milk by simple diffusion processes. Maternal drug concentration (controlled by maternal pharmacokinetics) and milk plasma ratio are major determinants of infant dose via breast milk (Rampono et al, 2006).
- Lipophilic compounds tend to have concentration higher in the hind milk because of its high lipids content. Therefore hind milk has a higher concentration of maternal (lipophilic) medication than fore milk (Burt, 2001).
- Relative Infant Dose (RID), i.e. the ratio between the infant dose/Kg Body Weight (BW) and the maternal dose/Kg BW is considered the best index of safety for medication in lactation
 - RID < 10% is regarded as relatively safe (Bennett et al, 1996)
 - Most psychotropic drugs have a RID < 10%

“Breast is best” (Victoria, et. al 2016)¹

Advice on breastfeeding to women with a mental illness should consider additional aspects not routinely considered in the discussion on breastfeeding choices. The WHO recommends exclusively breastfeeding for at least six months and continuing breastfeeding for at least two years. Breastfeeding also reduces the risk of gastrointestinal and respiratory tract infections and atopic eczema.

The PROBIT study (Kramer et al. 2001), a randomised controlled trial of an effective breastfeeding support intervention in 17,000 women in Belarus, followed the children to early adulthood; the clearest long-term effect was an increase in IQ in the breastfed group (mean 6 points increase at age 6.5 years).

Lactation may be influenced by level of stress, maternal nutritional state, maternal medication and prematurity. Difficulties in establishing breastfeeding lead to significant sleep deprivation, which is one of the identified risk factors for postnatal relapse. If the woman chooses to do so, breastfeeding should be encouraged. Mixed feeding, either with expressed milk or formula should be suggested to help reduce sleep deprivation, or to minimize baby’s exposure to medication by avoiding feeds when the medication reaches the plasmatic peak. Women should not be made to feel guilty if they wish to stop breastfeeding and should prioritise their mental health.

¹ The UK has one of the lowest rates of breastfeeding at 1 year in the world. Worldwide it is estimated that one third of

5 Preconception advice – risk benefit analysis

As clinicians we need to support women to make informed choices and we must present information in an unbiased way. The final decision of whether to prescribe or not relies upon the balance between risks *versus* benefits. Women should also be asked routinely about over the counter medication and this information should be incorporated to guide the final choice. The discussion on prescribing should be formulated not in the restrictive context of the teratogenic risk but in the wider context of the cost of untreated maternal mental illness.

The choice of the language and the general tone of the discussion are important to establish a non-judgmental environment allowing women or couples to make an informed choice. Words such as “risk”, “teratogenic”, “psychopathology” and “adverse outcomes” can be deeply anxiety provoking therefore require further explanation and checking that they are understood by the woman. Psychiatric illnesses and the associated risks should not be downplayed but a transparent risk benefit analysis balanced by the inclusion of protective factors as well as information on accessing specialist professional help is likely to empower women and couples to make the best choice.

List of associated risks related to prescribing

<i>Risk of prescribing</i>	<i>Risk of not prescribing</i>
Teratogenicity	Increased risk of maternal relapse (worsening of long-term prognosis)
Obstetric complications	Increased risk of maternal hospitalisation
Neonatal toxicity and withdrawal symptoms	Increased risk of adverse obstetric outcomes
Neonatal complications (newborn Persistent Pulmonary Hypertension)	Increased risk of bonding and attachment disorders (when the ability to parent is compromised as a result of maternal mental illness)
Neuro-developmental disorders (autism) and child psychopathology	Increased risk of child of child psychological and psychiatric problems

6 Outcome of the consultation – management plan

- The outcome of the consultation should be summarised with a view of generating a formulation guiding the management plan. Using “chance” or “likelihood” rather than “risk” may be less anxiety provoking; a clear explanation of relative versus absolute risk can empower women and couples to make a better-informed decision.
- Irrespective of the decision made in regard of medication, it is prudent to monitor the woman’s mental state. This should be done by the professionals responsible for her mental health care i.e. the GP or adult community mental health services.
- It is helpful to repeat self-administered disorder specific rating scales (e.g. PHQ, GAD) at regular intervals to track changes indicative of relapse/recurrence while trying to conceive.
- Non pharmacological interventions do not substitute pharmacological treatment but have a role in containing the risk of relapse for some mental illness; there is evidence supporting the effectiveness of modified psychological interventions in relapse prevention e.g. cognitive behavioural therapy for the relapse prevention of bipolar affective disorder (BAD) (Geddes, et al.2013) (Mansell et al 2007)
- The management plan should include information on access to mental health services with a recommendation to refer to specialist Perinatal Mental Health Services (should these be available) at pregnancy recognition.
- The Perinatal Package of Care should include:
 1. Monitoring the mental state for early signs and symptoms of relapse or recurrence
 2. Monitoring the response to medication and adjusting the dosage accordingly
 3. Assessment of suitability and referral for psychological interventions
 4. Working in partnership with the maternity services, ensuring that the woman receives enhanced obstetric care and additional obstetric monitoring where indicated and that her birth choice is carefully discussed.
 5. Arranging a pre-birth multidisciplinary planning meeting at 32 weeks to ensure the woman and her family have the care and support they need during the remainder of the pregnancy, her maternity admission for the birth of her baby and for the early postnatal period. (6-8 weeks). This can include discussions regarding the mode of delivery, care during labour and post-delivery, as well as discharge planning e.g. a prophylactic admission to a specialist Mother & Baby Unit where indicated or involvement with the home treatment team.
 6. Arranging a visit to the nearest Mother & Baby Unit (when possible). Meeting the team and visiting the premises can reduce the anxiety and assist families to make a better-informed decision on in-patient treatment, should this be necessary at any point.
 7. Working in partnership with health visiting services to deliver infant mental health psycho-education and implement screening of bonding and attachment

difficulties.

8. The Perinatal Package of Care should be ideally coordinated by a specialist Perinatal Mental Health team. When this is not possible another healthcare professional (either from adult mental health services or maternity services or social care) should take the lead in coordinating the care and ensuring effective communication and sharing of information (e.g. creating a distribution list of all the professionals and significant others involved in the care of the woman). This is extremely important when clinical and other relevant information is held on separate, not-interfaced database and therefore not universally accessible.

APPENDICES

APPENDIX 1 – Resources (last updated December 2018)

UK Teratology Information Service <http://www.uktis.org/>
<http://www.medicinesinpregnancy.org/>

Drugs & Lactation Database <https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm>

Royal College of Psychiatrists - Planning a pregnancy - Information Leaflet
<https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/planning-a-pregnancy>

Royal College of Obstetricians and Gynaecologists Patients Information Leaflets
<https://www.rcog.org.uk/en/patients/patient-leaflets/>

Royal College of General Practitioners Mental Health Toolkit
<https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/perinatal-mental-health-toolkit.aspx>

Eating Disorders and Pregnancy <http://www.eatingdisordersandpregnancy.co.uk/>

Infant Mental Health Resources

- Prof. Brazelton: <http://www.brazelton-institute.com/intro.html>
- Prof. Murray <http://www.amazon.co.uk/The-Social-Baby-Understanding-Communication/dp/1903275423>
- Prof Tronick http://www.umb.edu/academics/cla/faculty/edward_tronick
<https://www.youtube.com/watch?v=apzXGEbZht0>

Programs Facilitating Parenting

- Family Action <http://www.family-action.org.uk/parentsaspartners>
- The Circle of Security <http://circleofsecurity.net/>
- Squiggle <http://www.squiggle-foundation.org/>

APPS

- Baby Buddy (for iOS and Android) “The New App for Parents and Parents to be) created by Best Beginnings <http://www.bestbeginnings.org.uk/>
- LactMed @NIH <http://toxnet.nlm.nih.gov/help/lactmedapp.htm>

Mindfulness (Best ones as reviewed by the Guardian, Digital Trends)

- Headspace
- Calm
- Buddhify
- Smiling mind – adults and children
- Insight Timer

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- Stop, Breathe & Think
 - Timeless
 - Aura – 3 minute meditations
 - www.bemindfulonline.com - 4-week online course

Others

- CBT-I
- CBT based app for sleep
- NHS Couch 2 5k
- Pacifica – track mood and health behaviours
- Catch It – CBT based app for mild to moderate depression
- PTSD coach
- Recovery Record – CBT based app for Eating Disorders
- Drink Aware – set goals + make changes around alcohol

APPENDIX 2 – Example of template letter

PRIVATE AND CONFIDENTIAL

Many thanks for referring _____ for preconception advice. I saw her at the Hospital on _____ with her partner/family/friend.

The woman is planning to conceive and wanted to discuss their options regarding medication in pregnancy. I reiterated that the remit of the preconception advice goes beyond the discussion on the risks deriving from intrauterine exposure to medication and includes assessment of protective factors, family dynamics and access to general supportive measures as well as expectations about parenthood.

The focus of the consultation was therefore:

- a. Physical and mental health risks deriving from adaptation to pregnancy and parenthood
- b. Associated impact on the baby throughout her developmental trajectory
- c. Risk of intergenerational transmission of dysfunctional parenting

Past Psychiatric History

Family & Personal History

Medical History, Reproductive History and Attitude toward conception & lifestyle

Pre-morbid Personality

Relationships and Social Circumstances

Current Medication

Name of Woman _____ is currently maintained on _____.

The hypothetical increased risk of birth defects deriving from the intrauterine exposure to _____ should be weighed against the risks of untreated maternal mental illness. The risk of relapse following discontinuation of medication is elevated and may lead to hospitalisation and polypharmacy.

The teratogenic risk of medication is contingent upon the time of exposure; reinstating medication at the end of the first trimester should reduce the risk of birth defects attributable to psychiatric medication, bearing in mind that the rate of spontaneous congenital malformations is in the range of 2-3%.

With this in mind the medication regimen options are:

1. Continue with medication throughout conception and pregnancy.
2. Discontinue prior to conceiving, being mindful that the time scale for conceiving cannot be fully controlled and:
 - a. Reinstate after 12 weeks if there is gestation, even if there is no evidence of symptoms breakthrough
 - b. Reinstate after delivery or at any stage of the pregnancy if there is evidence of a relapse
3. Continue medication but switch to a different psychotropic medication with a better teratogenic profile; this however may well increase the risk of relapse and there is always the uncertainty related to the response to medication.

The option of continuing medication while conceiving is probably the safest from the maternal mental health perspective however it is understandably anxiety provoking.

We also discussed management during the pregnancy and in the post delivery period and this protocol is recommended by the NICE guidelines and the members of Pan London Perinatal Mental Health Network.

Management Plan

The following management plan was agreed and she had capacity to make an informed decision:

1. Discontinue medication whilst being prepared to reinstate it at the early signs and symptoms of a relapse/continue medication.
2. Start to implement lifestyle changes to increase protective factors, minimise stress deriving from family dynamics and work management (if any).
3. Referral to psychology to increase her resilience and focus on relapse prevention.
4. At pregnancy recognition she should be immediately referred to a specialist in Perinatal Mental Health.

APPENDIX 3

Case vignette

A woman with a history of Bipolar Affective Disorder dating back her twenties with four hospital admissions, one of which compulsory under the MHA, was referred for preconception advice. At the time of the assessment she was managed in primary care; she had been stable on a low dose of antipsychotic medication for five years.

She attended the consultation with her partner; he was aware of the diagnosis but who had never seen his partner unwell. The couple was given unbiased information on the risk of discontinuing medication and the risk of adverse pregnancy outcomes deriving from in utero exposure to medication and a management plan for each option was discussed. Protective factors including managing the workload, increasing peer support, changes in lifestyle, outsourcing home help and attitude towards parenthood were discussed. The partner was made aware of early signs and symptoms indicative of a relapse and given information on accessing emergency mental health services.

The woman opted to continue with medication and was referred for psychological intervention. At pregnancy recognition she was referred to the perinatal mental health service, re-assessed and offered follow up. The pregnancy progressed uneventfully.

At the 32 weeks pre-birth planning meeting, attended by her partner and all the professionals involved in her care, she presented her written version of the birth plan indicating her preferences to deliver at the Birth Centre. Normally the birth plan is discussed with the Midwife at 32-34 weeks, but the discussion is guided by a form devised by the hospital. The policy of the Birth Centre at the time stated the current use of antipsychotic medication as one of the exclusion criteria.

The Perinatal Mental Health Team with the Lead Consultant Midwife of the Birth Centre to advocate for the patient's preferences to be respected. Following a discussion with the lead consultant neonatologist informed by the Pan London PMHN New-born Guidance, she was accepted by the Birth Centre. The birth plan was incorporated in the psychiatric pre-birth plan, uploaded onto the maternity database and the patient kept a copy in the hand-held maternity notes. She delivered a healthy baby by uncomplicated vaginal delivery; her partner was with her at all times; the woman was offered an elective admission to the local MBU but opted to be discharged home under the care of the Home Treatment Team. The couple reported they had a positive experience of the birth and the woman felt that she had been listened to.

Mother and baby were discharged home with enhanced midwifery and health visiting care and involvement of the HTT, who worked jointly with the community perinatal mental health service; the medication was increased at the early signs and symptoms of a relapse. The health visitor helped the new parents to mix feed the baby to minimize sleep deprivation. At the six weeks postnatal check, the woman remained well and she was discharged to the perinatal mental health service.

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