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Royal College of  
Obstetricians and Gynaecologists

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# **Management of Women with Mental Health Issues during Pregnancy and the Postnatal Period**

# Management of Women with Mental Health Issues during Pregnancy and the Postnatal Period

## 1. Purpose

Mental illness makes a significant contribution to maternal deaths. This document highlights the role of maternity services in the early identification of high-risk women and assessment of current illness, and describes principles of service organisation for health providers to meet these needs.

## 2. Background

Over the past decade, the Confidential Enquiries into Maternal Deaths in the United Kingdom<sup>1,2</sup> have highlighted that suicide in pregnancy and during the first postnatal year remains a leading cause of maternal death. Lack of recognition of high-risk factors, or failure to develop appropriate management plans even when high risk has been identified, emerges as a major contributory factor in deaths from suicide. In a further group of women, misattribution of underlying physical illness as psychological in origin contributed to delayed diagnosis and inappropriate management. The reports on Confidential Enquiries into Maternal Deaths in the United Kingdom<sup>1,2</sup> recommend that assessment of risk should begin pre-pregnancy and continue throughout the pregnancy and the early postpartum period.

Mental disorders are no less common in pregnancy than at other times in a woman's life. Anxiety and depression are common, and women with pre-existing major mental disorders, such as schizophrenia, are at greater risk of compromised maternity care, delivery complications and relapse in pregnancy and the postpartum period. Pre-existing bipolar disorder (also known as manic-depressive disorder), other serious affective disorder and personal history of puerperal psychosis predicts a 50% risk of early postpartum major mental illness. Raising awareness is therefore necessary among service providers as well as service users.

Women and, with their consent, their partners and families should be active participants in plans for management of risk and current mental disorders in pregnancy and the postpartum period. Effective care can best be delivered when there is good communication, information sharing and joint working between all professionals involved in caring for childbearing women.

## 3. Standards

The recommendations in this Good Practice guidance are supported by standards set out in the National Institute for Health and Clinical Excellence (NICE) guideline *Antenatal and Postnatal Mental Health: The NICE Guideline on Clinical Management and Service Guidance*,<sup>3</sup> the Confidential Enquiry into Maternal and Child Health (CEMACH) reports *Why Mothers Die*<sup>1</sup> and *Saving Mothers' Lives*<sup>2</sup> and the RCOG multiprofessional report *Standards for Maternity Care*.<sup>4</sup>

## 4. The patient journey

### 4.1 Prepregnancy

- Women should be asked about their past history of major mental disorders, particularly bipolar disorder, other serious affective disorder (both following previous childbirth and at other times) or schizophrenia.
- Women should be asked about their current psychotropic medication intake as some psychotropic drugs may have inherent risks for early fetal development (for information about specific drugs, visit the British National Formulary at [www.bnf.org](http://www.bnf.org) or the Medicines and Healthcare products Regulatory Agency at [www.mhra.gov.uk](http://www.mhra.gov.uk)). The details about current care providers should be recorded along with their past history.

- Women identified as having serious mental disorders should be referred for pre-pregnancy advice to specialised perinatal mental health services where available, or to general psychiatric services.
- Advice should also be sought from specialised perinatal mental health services (or, in their absence, general psychiatric services), in line with local pathways and service provision, where women are taking psychotropic medication, particularly mood-stabilising anticonvulsants and lithium, where there is clear teratogenic risk.
- Care is needed when prescribing to all women of childbearing potential. Women should understand the risks associated with becoming pregnant while taking psychotropic drugs and the risks from an untreated mental disorder and from stopping medication abruptly without discussion with their doctor.
- All communication between maternity and mental health services should include primary care (this applies to all stages of the patient journey).

#### 4.2 Antenatal booking visit

All services should ensure that women are seen for their antenatal booking visit before 12 completed weeks of pregnancy to identify women with, or at high risk of, major mental illness (target: over 90%).

- Women should be asked about previous or current major mental illness, particularly schizophrenia, bipolar disorder, other serious affective disorder, previous psychotic illness in the postnatal period or severe depression in the postnatal period.
- Women should be asked about previous treatment by mental health services, including periods of inpatient care.
- Women should be asked about family history of bipolar disorder and of early postpartum major mental illness (puerperal psychosis).
- Women should be asked about current treatment with psychotropic medication.
- Women should be sensitively asked about any history of intimate partner violence, sexual abuse or assault, use of illegal drugs, self-harm and lack of social support, as this group of women are at risk of depressive illness and suicide during pregnancy.<sup>5,6</sup>
- Women identified as at high risk of postpartum major mental disorders should be referred to specialised perinatal mental health services where available, or otherwise to general psychiatric services.

#### 4.3 Antenatal care throughout pregnancy

Every obstetric unit should have in place a clearly defined care pathway for referring women to local specialised perinatal mental health services (or, in their absence, to general psychiatric services) led by a named consultant psychiatrist.<sup>3</sup>

- Each obstetric unit should have in place local protocols for antenatal care, risk identification during pregnancy, ultrasound scanning for fetal abnormalities, tests for fetal wellbeing and access to anaesthetic services to discuss methods of pain relief during labour.
- At each antenatal clinic visit, women should be asked about their current mental health. Questions which may be used to detect depression include:
  - During the past month, have you often been bothered by feeling down, depressed or hopeless?
  - During the past month, have you often been bothered by having little interest or pleasure in doing things?

If yes to either question, further enquiry may be made: Is this something you feel you need or want help with?

- Women identified as suffering from current mild to moderate illness, and those with previous depressive/anxiety disorders treated only in primary care, should be referred to their GP in the first instance.
- To minimise the risk of harm to the fetus or child, drugs should be prescribed cautiously. As a result, the thresholds for non-drug treatments, particularly psychological treatments, are likely to be lower than those set in NICE clinical guidelines on specific mental disorders.
- For women who develop mild/moderate depression or anxiety during pregnancy, self-help strategies (guided self-help, computerised cognitive behavioural therapy or exercise) should be considered. Local protocols should be in place to assist maternity services to refer such women to their GP for further assessment.
- Women and health professionals should understand the risks of taking psychotropic drugs and the risks from an untreated mental disorder and from stopping medication abruptly.
- Referral should be made to specialised perinatal mental health services where available, otherwise general psychiatric services, for women suffering from serious illness with symptoms of psychosis, suicidal ideation, self-neglect, evidence of harm to others or significant interference with daily functioning. Such illnesses may include psychotic disorders, severe anxiety or depression, obsessive-compulsive disorder and eating disorders.
- Women with alcohol or drug misuse should be referred to addiction services in accordance with local protocols.
- Special consideration should be given to referring women who present with new symptoms in late pregnancy.

#### 4.4 *Care during labour*

- There should be an agreed care plan in place describing the roles of different care workers, midwives (one-to-one care), obstetrician, anaesthetist and neonatologist/paediatrician.
- There should be clearly stated advice on whether women can continue to take their prescribed psychotropic medicines during labour and the anaesthetist and neonatologist should be made aware of it.
- The RCOG Clinical Governance Advice *Obtaining Valid Consent*<sup>7</sup> should be used for obtaining consent for various procedures during labour.

#### 4.5 *Early postpartum period*

- Women identified as being at high risk of early postpartum mental illness (puerperal psychosis) should be managed according to the detailed plan for late pregnancy and the early postpartum period, which should have been devised in collaboration with specialised perinatal mental health services (or, in their absence, general psychiatric services).
- Infants of mothers who have taken psychotropic medication in pregnancy should be observed for signs of neonatal adaptation syndrome. While usually mild and self-limiting, if they occur the infant should receive neonatal assessment.
- Information on high risk should be shared with community midwives, health visitors and the GP.
- Any change in mental state should result in urgent discussion with specialised perinatal mental health services (or, in their absence, general psychiatric services).

## 5. Indications for referral to specialised perinatal mental health services where available, otherwise general psychiatry services

- Woman with current illness where there are symptoms of psychosis, severe anxiety, severe depression, suicidality, self-neglect, harm to others or significant interference with daily functioning. Such illnesses may include psychotic disorders, severe anxiety or depression, obsessive-compulsive disorder and eating disorders.
- Woman with a history of bipolar disorder or schizophrenia.
- Woman with previous serious postpartum mental illness (puerperal psychosis).
- Women on complex psychotropic medication regimens.
- Referral should be considered for women with illness of moderate severity if developing in late pregnancy or the early postpartum period.
- Referral should be considered for women with current illness of mild or moderate severity where there is a first-degree relative with bipolar disorder or puerperal psychosis. In the absence of current illness, such a family history indicates a raised, but low absolute, risk of early postpartum serious mental illness. Where identified, information should be shared with primary care and any evidence of mood disturbance during pregnancy or in the postpartum period should lead to referral.
- Women with previous periods of inpatient mental health care should be screened by mental health services (either by assessing case records or seeing the woman).
- Maternity services need to ensure that appropriate communication with primary care, and social services where necessary, takes place for women who decline referral to specialised mental health services.

## 6. Service organisation

### 6.1 Care pathway during pregnancy

- Locally agreed arrangements should be in place between maternity, specialised perinatal mental health services (or, in their absence, general psychiatric services) and primary care on the management of pregnant women on antidepressant medication. These may include written guidance to indicate risks associated with specific drugs during and after the pregnancy, availability of telephone advice or, where indicated, assessment by specialised perinatal mental health services.
- Locally agreed arrangements should be in place between maternity, specialised perinatal mental health services (or, in their absence, general psychiatric services) and primary care on the psychological management of women with mild to moderate anxiety or depression in pregnancy, including patient information on self-help strategies and access to local primary care mental health/psychology services.
- Referral pathways should be in place for care by the local specialised perinatal mental health service, or the general psychiatry service where a specialised service does not exist. In addition, maternity services should be able to discuss cases where the need for referral is uncertain. Contact details for the specialised perinatal mental health service or, in its absence, a consultant psychiatrist with special interest in psychiatric disorders of pregnancy should be clearly signposted in each maternity unit.
- For women with severe and enduring mental disorders, an advance directive, covering interventions in pregnancy/labour in the event the woman becomes incompetent to give informed consent, should be considered at a time when she is stable.

### 6.2 Care pathway after delivery

- Women at high risk of postpartum major mental illness should be managed along high-risk pathways in maternity care.

- Women at high risk of postpartum major mental illness should have a detailed plan for their late pregnancy and early postpartum psychiatric management, agreed with the woman and shared with maternity services, the community midwifery team, GP, health visitor, mental health services and the woman herself. With the woman's agreement, a copy of the plan should be kept in her hand-held records. The plan should identify what support will be in place and who to contact if problems arise, together with their contact details (including out of hours), and address decisions on medication management in late pregnancy, the immediate postpartum period and with regard to breastfeeding.
- A locally agreed protocol should be in place with child safeguarding services allowing for their involvement where there are issues of concern for women with pre-existing mental illness or at high risk of postpartum mental illness. Mental illness of itself need not be an indication for referral.
- Each organisation should have a list of local support groups in the voluntary sector which could provide support to women and the service during pregnancy and following childbirth.

### 6.3 *Staffing and training*

- Maternity services should work closely with specialised perinatal mental health services to develop local care pathways and training programmes, and to ensure that there is a seamless clinical service along the patient journey during and following pregnancy. A named obstetrician should be identified to lead service and training development along with the named perinatal psychiatrist and midwifery lead (who may be the local disability midwife). The important role played by primary care should be fully recognised.
- All maternity staff should have basic training in the identification of current, and past history of, mental health problems in pregnancy and the postpartum period and when to refer to mental health and primary care services. Training should be provided locally in collaboration with specialised perinatal mental health services.
- Midwifery staff should be trained to support women during pregnancy and to aid decision making during labour and after delivery.

### 6.4 *Commissioning of services*

- There is an overlap between health and social problems. The provision of care for women with mental health problems should be through integrated multistakeholder teams, ideally reflecting the needs of the population.
- Healthcare commissioners should quality assure service provision by using auditable standards and metrics.<sup>2,4-6,8</sup>

## References

1. Lewis G, editor. The Confidential Enquiry into Maternal and Child Health (CEMACH). *Why Mothers Die 2000–2002. The Sixth Report on Confidential Enquiries into Maternal Deaths in the United Kingdom*. London: RCOG Press; 2004.
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8. Hepburn M, Brogan K. Prepregnancy services for women with social needs. In: Mahmood T, Owen P, Arulkumaran S, Dhillon C, editors. *Models of Care in Maternity Services*. London: RCOG Press; 2010.

## Further reading

- Royal College of Nursing. *Pregnancy and disability. RCN guidance for midwives and nurses*. London: RCN; 2007 [<http://www.rcn.org.uk/development/publications/publicationsA-Z#P>]

This Good Practice guidance was produced on behalf of the Safety and Quality Committee by **Dr Roch Cantwell, Glasgow and Dr Tahir A Mahmood FRCOG, Fife**.

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The RCOG will maintain a watching brief on the need to review this guidance.

# APPENDIX 1

## Sample care plan\*

*Pregnancy and early postnatal care pathway (to be completed between 28 and 32 weeks of gestation)*

Name

DOB:

EDD:

Date plan agreed:

CPN:	Contact info:
Health visitor:	Contact info:
Midwife:	Contact info:
Social worker:	Contact info:
Obstetrician:	Contact info:
Psychiatrist:	Contact info:
GP:	Contact info:
Other professional:	Contact info:
Family member/named person:	Contact info:

Risk of illness:

Early warning signs:

- 1.
- 2.
- 3.

Current management:

- 1.
- 2.
- 3.

Planned antenatal changes:

- 1.
- 2.
- 3.

Immediate postnatal plan:

Intention to breastfeed?

Yes

No

- 1.
- 2.
- 3.

Advance statement completed?

Yes

No

Sign/print name (PMHS worker):

Date:

Sign/print name (patient):

Date:

\*Adapted from the Glasgow Pregnancy and Early Postpartum Care Pathway.