UH Sussex Perinatal Mental Health Guideline

Summary statement: How does the document support patient care?	By providing guidance for staff within maternity on detection and identification of perinatal mental health risk and subsequent care pathways.
Staff/stakeholders involved in development: *Job titles only*	Senior midwifery staff, obstetric consultants and obstetric anaesthetists
Division:	Women and Children's
Department:	Maternity
Responsible Person:	Chief of Service
Author:	PNMH Midwife
For use by:	All Obstetric and Midwifery staff
Purpose:	To provide evidence based guidance on the perinatal mental health pathway of care.
This document supports: *Standards and legislation*	CNST Maternity Standards Care Quality Commission NICE 2020 Antenatal and Postnatal Mental Health CEMACE Saving Mothers Lives 2006 – 2008
Key related documents:	**UH Sussex Maternity Guidelines:** Antenatal Care and Patient Information, Postnatal Care
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1.0	March 2023	Eli. Hibberd, Perinatal Mental Health Midwife (SRH & WH) Ali Clifton Specialist Mental Health Midwife (RSCH & PRH) Maria Jesse Specialist Mental Health Midwife (RSCH & PRH)	LIVE	New merged Trust wide PNMH guideline

The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert.

Contents

Perinatal Mental Health Guideline

1.0 Key Principles

A protocol is a set of measurable, objective standards to determine a course of action. Professional judgement may be used in the application of a protocol.

2.0 Scope

This protocol applies to any woman and birthing person requiring support with their Mental Health.

3.0 Responsibilities

Midwives & obstetricians:

- To access, read, understand and follow this guidance.
- To use their professional judgement in application of this protocol.

Management:

- To ensure the protocol is reviewed as required in line with Trust and National recommendations.
- To ensure the protocol is accessible to all relevant staff.
- To ensure the protocol is available for service users on request.

4.0 Abbreviations used within this guideline

DSH – Deliberate Self-Harm	**PTSD –** Post-Traumatic Stress Disorder
GAD – Generalised Anxiety Disorder	**RMN –** Registered Mental Health Nurse
OCD – Obsessive Compulsive Disorder	**LBW -** Low Birth Weight
MBRRACE – Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK	**SPMHS -** Specialist Perinatal Mental Health Service
MBU – Mother and Baby Unit	**SSRIs –** Selective Serotonin Reuptake Inhibitors

5.0 Definitions

Anxiety Disorders: These include generalised anxiety disorder, panic disorder, obsessive-compulsive disorder, phobias, post-traumatic stress disorder and social anxiety disorder.

Baby: Refers to an infant aged between 0 and 12 months.

Perinatal: This is defined in this guideline as from pregnancy and up to 1 year after childbirth.

Postpartum psychosis: Psychosis often with mania and/or depressive symptoms in the immediate postnatal period, which can become very severe extremely quickly (also known as puerperal psychosis).

Psychotropic medication: This is defined in this guideline as all medication used to treat mental health problems.

Severe mental illness: This is defined in this guideline as severe and incapacitating depression, schizoaffective disorder, schizophrenia, bipolar disorder, psychosis and postpartum psychosis.

Traumatic birth: Includes births, whether preterm or full term, which are physically traumatic (for example, instrumental or assisted deliveries or emergency caesarean sections, severe perineal tears, postpartum haemorrhage) and births that are experienced as traumatic, even when the delivery is obstetrically straightforward.

Trauma informed care: Is care that shifts the focus from "*What's wrong with you?"* to *"What happened to you?"* A trauma-informed approach to care acknowledges that health organisations and care teams need to have a complete picture of a patient's life situation, past and present, to provide effective health care services with a healing orientation (TICIRC, 2021).

Valproate: Refers to 3 formulations of valproate available in the UK: sodium valproate and valproic acid (licensed for the treatment of epilepsy) and semi-sodium valproate (licensed for the treatment of acute mania and continuation treatment in people whose mania responds to treatment).

6.0 Introduction

The objective of this guideline is to advise healthcare providers on the clinical management and services available for women and pregnant people with mental health problems during pregnancy and the immediate postnatal period. The aim is to reduce perinatal morbidity and mortality, to provide a framework that is underpinned by evidence-based practice and to facilitate collaboration of multidisciplinary teams.

The 2021 MBRRACE report demonstrates that poor mental health continues to be one of the leading causes of maternal and parental death during the perinatal period whilst maternal suicide remains the leading cause of death occurring within a year of the end of pregnancy (Knight et al 2021). Lessons derived from the enquiries emphasise the importance of prevention and effective identification and management of mental health problems and highlights the work required to mitigate against the stark inequalities of care between women and pregnant people of different ethnic backgrounds.

The level of care for pregnant women and people with mental health problems, during the intrapartum period, should be the same as for anyone with a mental health problem. However, treatment and management decisions are complicated by the presence of the developing foetus, choices concerned with infant feeding and the timescales imposed by pregnancy and birth.

Mental health issues during the intrapartum period can have serious consequences for the health and wellbeing of a mother or pregnant person and their baby, as well as other family members. This guideline makes recommendations for the prediction, detection, and management of mental health problems for women and pregnant people who are accessing maternity services.

7.0 Prediction and detection

Pregnant women and people have increased contact with health services, which provides an opportunity for identifying those with mental illness, or those at an increased risk of developing one. The risk factors that consistently show reasonable predictive value, particularly for the development of depression, psychosis and recurrence of bipolar disorder, include past psychiatric history (especially previous puerperal psychosis) and current mental disorder, or symptoms.

Perinatal mental health problems are very common, affecting up to 20% of women and pregnant people at some point during the perinatal period (Bauer et al, 2014). Disclosing mental health problems is difficult, 70% of women and birthing people will hide or underplay their illness (MMHA, 2022). Findings of a UK survey reveal almost a third of women and pregnant people have never disclosed to a health professional that they were unwell with a mental health problem. 34% of those who had hidden their feelings, did so because they were concerned their baby might be taken away (Boots Family Trust, 2013). Reassurance and good communication is imperative.

By careful planning with the woman or pregnant person, and good communication between services, it may be possible to reduce the rate of onset of mental illness, its severity, and its impact on the woman or pregnant person and their families.

8.0 Booking

The lead professional/midwife providing care at booking must routinely ask all women and pregnant people about any current or previous mental health issues, including:

- Past or present severe mental illness – (including schizophrenia, bipolar disorder, psychosis or severe depression).
- Postnatal mental health problems, e.g. depression, postpartum psychosis.
- A family history of perinatal mental illness, or other severe mental health illness.
- Past or present treatment by a psychiatrist / specialist mental health team, including inpatient care (please document which hospital, date of admission and whether admission was voluntary or involuntary).
- Past or present psychotropic medication.

- Anxiety or panic disorder.
- Obsessive-compulsive disorder (OCD).
- Post-traumatic stress disorder (PTSD).
- Eating disorders.

Additional questions (Whooley Questions) to determine current depression should be asked by the booking midwife:

- 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?

(Consider using the Patient Health Questionnaire PHQ-9, Appendix 3).

Also consider asking about anxiety using the 2-item Generalised Anxiety Disorder scale (GAD-2):

- During the past month, have you been feeling nervous, anxious or on edge?
- During the past month, have you not been able to stop or control worrying?

If the woman or pregnant person answers 'yes' to one of more of the first four detection questions, and would like help, follow the maternal mental health antenatal care pathway (Appendix 1a & Appendix 1b)

9.0 Acting on screening information

All healthcare professionals should follow the antenatal care pathway (Appendix 1a & Appendix 1b) and the urgent review pathway (Appendix 2a & Appendix 2b). The Specialist Perinatal Mental Health Midwife can be contacted to assist with any queries that may arise from the referral process.

The midwife providing care should document the woman or pregnant persons mental health history on the booking risk assessment form and in the maternal notes, and document and upload any external referrals made.

Copies of any referrals to the Specialist Perinatal Mental Health Service (SPMHS) should be uploaded onto the maternity information system (eg Badgernet or Medway).

Inform the Specialist Mental Health Midwife and the GP with consent if referring to the SPMHS.

10.0 NHS Talking Therapy

If a woman or pregnant person's mental health problem is mild to moderate, consider a referral to NHS Talking Therapy. They provide talking therapy for people experiencing:

- Stress, worry and general anxiety
- Depression
- Panic attacks and agoraphobia
- Phobias
- Social Anxiety
- Obsessive-Compulsive Disorder (OCD)
- Post-Traumatic Stress Disorder (PTSD)
- Health Anxiety
- Post Natal Depression
- Low self-esteem or low confidence
- Relationship difficulties
- Bereavement and reactions to loss

Women/people can self-refer to all NHS Talking Therapy services, but may welcome support in doing so. Talking Therapy services in the patch include:

Time to Talk South Team (Henfield, Lancing, Littlehampton, Shoreham, Steyning, Storrington and Worthing): 01903 703540 Time to Talk - NHS talking therapies in West Sussex (sussexcommunity.nhs.uk)

Time to Talk West Team (Bognor, Arundel, Chichester, Selsey, Southbourne, Midhurst, Petworth, Pulborough, Loxwood, Witterings): 01273 265967

Time to Talk North Team (Crawley, Horsham): 01403 620434

Health in Mind (East Sussex excluding Brighton and Hove) e.g. Lewes, Eastbourne, Hastings https://www.healthinmind.org.uk/

The Wellbeing Service (Brighton and Hove (patient's address or registered GP practice in BN1, BN2, BN3 or BN41) https://www.brightonandhovewellbeing.org/

11.0 Specialist Perinatal Mental Health Team

The Specialist Perinatal Mental Health Service (SPMHS) is a community-based service for pregnant women and people with severe mental health difficulties, either now or in the past, during pregnancy and up to a year after birth. The service is provided by Sussex Partnership NHS Foundation Trust.

Who should be referred?

- Women and people who are prescribed mood stabilising or antipsychotic medication and requesting preconception advice.
- Women and people with primary tocophobia (fear of childbirth not linked to previous traumatic birth).
- Women and people with a past history of severe mental illness (e.g. bipolar disorder, schizophrenia or severe depression or anxiety).
- Women and people experiencing current symptoms of severe mental illness (e.g. bipolar disorder, schizophrenia or severe depression or anxiety) and/or not responding fully to treatment in the community and/or areas of high risk (please circle any which apply).
- Women and people with personal or family history of bipolar disorder, postpartum psychosis or severe postnatal depression (e.g. requiring admission or secondary care).

Referrals can be made online: Perinatal services :: Sussex Partnership NHS Foundation Trust

Perinatal staff are happy to discuss whether a referral is appropriate:

Coastal West Sussex: 0300 304 0214 admin-perinatalcws@spft.nhs.uk
Brighton and Hove: 0300 304 0097 admin-perinatalbh@spft.nhs.uk
Northwest Sussex and East Surrey: 0300 304 0213 adminperinatalnws@spft.nhs.uk
East Sussex: 0300 304 0212 admin-perinataleast@spft.nhs.uk

11.1 Healthy Futures Team (Brighton and Hove only)

The Healthy Futures Team is a Specialist Public Health Nursing Service (health visiting and school nursing). It utilises an early intervention model to improve health outcomes and reduce inequalities for families facing disadvantage in Brighton & Hove.

The team will deliver the Healthy Child Programme to families meeting following criteria:

- Antenatal mothers and pregnant people who are under 18 at conception.
- Anyone subject to a pre-birth child protection conference that is not already known to the public health community nursing service. Consideration will be given to those undergoing a pre-birth Strengthening Families Assessment.
- A parent with a history of being looked after that is not already known to the public health community nursing service.
- Refugees, Asylum seekers, undocumented migrants and Travellers and those in emergency housing (including the women's refuge) who are pregnant or with a child under the age of 19 that is not already known to the public health community nursing service.
- Migrant families housed in temporary on-campus accommodation provided by the University of Sussex who are pregnant or with a child under the age of 19 that is not already known to the public health community nursing service.
  (See Appendix 5)

11.2 Perinatal Bereavement Service

Anyone who has been pregnant and experienced a stillbirth (when a baby dies during pregnancy from 24 weeks gestation) or neonatal loss (when a baby dies during the first 28 days of life) within the last year can be referred to the Perinatal Bereavement Service.

The Perinatal Bereavement Service is a new service and applies to anyone who has experienced a stillbirth or neonatal loss on or after 25th July 2022. Referrals can be made by a health professional via the following link.

https://www.sussexpartnership.nhs.uk/perinatal

12.0 Factors important to maintaining maternal emotional wellbeing

Greater understanding of how to reduce stressors for women and pregnant people can have a significant impact on maternal and infant welfare.

The following measures can help:

- Encourage skin-to-skin contact between mother/birthing parent and baby to promote and encourage bonding and to initiate breastfeeding.
- Prevention of separation from the family unit (maternity and mental health services have a duty to ensure that, where a baby requires inpatient neonatal care and the mother requires inpatient psychiatric care, neonatal services are informed of the mother/birthing parent's admission and visits to the baby are appropriately facilitated).
- Regular assessment of pain and appropriate management.
- Encourage good diet and rest.
- Ensure women/people are aware of the support services available.
- Appropriate communication with the GP, health visitor, community midwives and social services.
- Signpost to Birth Afterthoughts or Birth Stories following birth, if appropriate.
- Use of trauma-informed care by staff.

13.0 Management of high risk women/people

If there is a family history of postpartum psychosis or bipolar disorder, maternity and primary care services should be alert for change in mental state in late pregnancy and the early postpartum and, if present, should refer for urgent psychiatric assessment.

High risk women and pregnant people should be referred into the local specialist perinatal mental health service (SPMHS) in early pregnancy and should have a 32 week pre-birth planning meeting organised by the SPMHS, which should include professionals from across the perinatal mental health care pathway.

A perinatal mental health care plan should be drawn up after this pre-birth planning meeting. It should detail diagnosis, medication, risk factors, early warning signs of relapse and actions taken in the event of a deterioration of mental state in the perinatal period, including contact details of all professionals.

There should be an expectation of early consultant perinatal psychiatrist involvement in the assessment and management of high-risk women/people and of women/people exhibiting sudden alterations in mental state in late pregnancy or the early puerperium (Knight *et al.* 2015)

14.0 Inpatient psychiatric emergency

- If psychosis is suspected or identified in hospital, the Hospital Mental Health Liaison Team must be contacted (see Appendix 2a and Appendix 2b) to conduct an assessment and plan the necessary on-going care.
    - Worthing Hospital: this is via telephone x85252
    - St Richards Hospital via referral form (Appendix 4) which should be emailed to: spnt.mhlt.chichester@nhs.net
    - For RSCH & PRH complete an online referral form via the intranet: https://nww.bsuh.nhs.uk/clinical/teams-and- departments/mental_health-services/rsch-mental-health-services/rsch-mental- health-liaison_referrals/mhlt-inpatient-referral-form-working-age-adults/
- The Specialist Perinatal Mental Health Midwife, Safeguarding Midwife, Labour Ward Co-ordinator, Consultant on-call and Manager on-call must be informed.
- The woman/person must not be left unattended.
- The woman/person and their family must be kept informed.
- Safeguard the needs of the baby.
- Lone working should be avoided, it may be necessary to have a Registered Mental Health Nurse (RMN) present while the mother remains on the maternity unit. When making a booking via a nursing agency, a female RMN should be requested if possible.
- Documentation should be detailed and concise.
- Admission to a psychiatric unit may be arranged either with the woman/person's consent, or if severely ill and unwilling to be admitted, may be admitted involuntarily under the Mental Health Act (1983).
- Transfer to a Mother and Baby Unit (MBU) should be considered in the first instance. The woman/person should be escorted by an appropriately qualified person.

15.0 Outpatient psychiatric emergency

- If suspected psychosis occurs in the community, follow the Urgent Review Pathway (Appendix 2) and notify the GP, the Specialist Perinatal Mental Health Midwife, Safeguarding Midwife, Labour Ward co-ordinator, Consultant on-call and Manager on-call.

- If support services are delayed consider transfer (with agreement) to Accident & Emergency where assessment by the Hospital Mental Health Liaison Team will be carried out.
- Admission to a psychiatric unit may be arranged either with the woman/persons consent, or if severely ill and unwilling to be admitted, may be admitted involuntarily under the Mental Health Act (1983).
- The woman/person and their family must be kept informed.
- Safeguard the needs of the baby.
- Documentation should be detailed and concise.
- Women and people who require psychiatric admission following childbirth should ideally be admitted to the nearest MBU to avoid separation of mother or birthing parent and their baby.

16.0 Tocophobia

In the UK, the term tocophobia was first reported by Hofbert and Brockington in 2000 and is now widely recognised as a pathological intense dread and avoidance of childbirth. Identifying tocophobia can be difficult because women/people are often reluctant to discuss their fears and presentation can be diverse (Mycroft and Taha, 2018, p.2). There is no consensus on the operational definition of tocophobia and varying classification exists in the literature (O'Connell et al. 2017). It is commonly categorised into 'primary tocophobia' – affecting nulliparous women/people, and 'secondary tocophobia' – affecting multiparous women/people who have had a previous traumatic birth experience (Hofberg and Ward, 2003, p.507).

All women and pregnant people presenting with primary tocophobia at Worthing and St Richards should be referred to the Counselling Midwife for further assessment, who can then refer on to the PNMH Service following consultation. Women and pregnant people at RSCH and PRH should be referred to the PNMH Service. If primary tocophobia is identified at booking, the booking midwife should indicate this on the risk form.

Women and pregnant people with secondary tocophobia can be referred to NHS Talking Therapy and the Birth Afterthoughts service (SRH&WH) or Birth Stories (RSCH & PRH). If secondary tocophobia is identified at booking, the booking midwife should indicate this on the risk form.

17.0 Postnatal Care

For high risk women/people it is good practice to inform all teams of discharge.

18.0 Use of interpreters

Women and pregnant people should always have the opportunity of being seen alone and, where there are language barriers, family or friends should not be used as interpreters (National Institute for Health and Care Excellence 2010).

19.0 Mental capacity

Mental capacity is a person's ability to make a decision at the time it needs to be made. All healthcare staff have a duty to ensure that patients have the mental capacity to make decisions regarding their physical and mental health care. Healthcare professionals should assume a woman/person has the capacity to make a decision themselves, unless it is proved otherwise. Where there is doubt, an assessment of capacity should be undertaken (Knight *et al.* 2015, Appendix 3).

20.0 Medication

When giving advice about medication in pregnancy and breastfeeding encourage people to take into account the risks and benefits, based on the best available evidence. Take into consideration their history, current symptoms and stressors. Plans should address immediate, short-term and long-term risk. Ideally with the input of an expert in, prescribing in pregnancy.

- It is essential to recognise there are risks associated with not treating mental health problems in pregnancy and the postnatal period. Due to a culture focusing entirely on potential risk, rather than benefit (Saving Lives, Improving Mothers' Care 2018).
- Decisions on continuing, stopping or changing medication in pregnancy should be made only after careful review of the benefits and risks of doing so, to both mother and infant (Saving Lives, Improving Mothers' Care 2018).
- Thought should be given to the patient's wishes concerning breastfeeding.
- Patients will perceive risk differently.
- Early re-evaluation in the postnatal period is required to assess whether the patient would benefit from recommencing medication, either prophylactically or to manage emergent symptoms carried out either by the GP or mental health service depending on the level of pre-existing mental health care. There should be clear communication (Saving Lives, Improving Mothers' Care 2018)

For guidelines regarding specific medication see the Perinatal Mental Health: Prescribing Guidance for Trust Prescribers and GPs: Perinatal services :: Sussex Partnership NHS Foundation Trust

20.1 Medication pathway referral

Single medication is prescribed with no other medication; see the advice from UK Teratology below in the recognised resources for information on drugs in pregnancy and breastfeeding section.

Multiple medication treatments can create complex medicine information questions, see below.

- When discussing medication in pregnancy, acknowledge that there is uncertainty surrounding risks and that there is conflicting advice.
- Explain the risks of treating versus not treating mental health conditions.
- Discuss the risk of relapse. Consider when the last episode was, its severity and the response to treatment.
- Discuss the risks of stopping medicines suddenly.
- Discuss the robust evidenced surrounding attachment and bonding, and that poor attachment and bonding can have potentially long-term consequences on children.
- Try to avoid using the term 'withdrawal' when discussing SSRIs and neonates, it is inappropriate, and can increase patient's guilt around choosing to continue medication, because of the association with recreational drugs.
- As always, respect the woman or pregnant person's decision to make an informed choice.
- Always document discussion.

Patients who are prescribed multiple medications and already under the Specialist Perinatal Mental Health Service need no further action. The SPMHS always discuss prescribed medications and matters relating to the neonate.

Those who are not under the SPMHS should be referred for a medication review at:

- **SRH & WH only:** the Joint Obstetric Clinic.
- **RSCH & PRH only:** One Stop Prescribed Medications Clinic.

If in doubt seek guidance from Specialist Mental Health Midwife, the Consultant Neonatologist, Specialist Perinatal Mental Health Services or the Pharmacy Team. Note the Specialist Pharmacy Service provide online training resources, see recognised resources for information on drugs in pregnancy and breastfeeding.

20.2 Recognised resources for information on drugs in pregnancy and breastfeeding

The UK Teratology Information Service (UKTIS)
(Patient information leaflets available)

http://www.uktis.org.html/maternal_exposure.html

NICE

Antenatal and postnatal mental health: clinical management and service guidance Clinical Guideline [CG192]

CKS Depression – antenatal and postnatal

https://cks.nice.org.uk/topics/depression-antenatal-postnatal/

Sussex Partnership NHS Foundation Trust: Perinatal Mental Health: Prescribing Guidance for Trust Prescribers and GPs

Specialist Pharmacy Service: Safety in Pregnancy

https://www.sps.nhs.uk/home/guidance/safety-in-pregnancy/

Training resources

- Questions to ask when giving advice on medicines in pregnancy.
- Information resources that give advice about medicines in pregnancy.
- Assessing risk and informing the risk versus benefit decision for medicines in pregnancy.
- The principles of prescribing in pregnancy.
- Formulating your advice on the use of medicines in pregnancy.

Treatment resources

- Both pre-existing and new conditions need to be managed carefully during pregnancy. Maintaining good maternal health supports good fetal health and development. Articles discuss and signpost to advice on safe and effective treatment during pregnancy for a range of common conditions, including mental health and pregnancy.

Specialist Pharmacy Service: Safety in Breastfeeding

https://www.sps.nhs.uk/home/guidance/safety-in-breastfeeding/

Training resources

- Why breastfeeding is important and how pharmacy can help
- Questions to ask when giving advice on medicines and breastfeeding
- Information resources that give advice on medicines and breastfeeding

Treatment resources

- Searching on SPS website for the medication will provide information

20.3 Medications with specific cautions

Carbamazepine - NICE recommend that this drug is not routinely prescribed during pregnancy due to the risk of neural tube defects; (risk raised from 6/10,000 to 20-50/10,000). It has also been linked to other major malformations, gastrointestinal tract problems and cardiac abnormalities.

Women and pregnant people who continue on Carbamazepine should have a growth scan at 32 weeks.

Lamotrigine – NICE recommend that this drug is not routinely prescribed during pregnancy citing a risk of oral cleft of around 9/1,000. However, a recent study suggests that the risk is lower or not present. Data is limited at present but the available evidence does not suggest it is a major teratogen.

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

Lithium – Should be avoided, if possible, especially in the first trimester and, where possible, stopped before conception. If it is continued, this must be under secondary care supervision. There is a possible increase in the risk of congenital malformations. Ebstein's anomaly was previously considered to be 20 times more likely if a foetus was exposed to lithium but this has not been replicated in further studies.

Cessation of lithium should be done gradually over at least four weeks. If the woman or pregnant person is not well, they can be switched to an antipsychotic or lithium restarted in the second trimester if they are not planning to breastfeed (Breastfeeding is contraindicated in women and pregnant people taking lithium). If lithium is continued, the Specialist Perinatal Mental Health Service will arrange for serum levels to be checked every four weeks until week 34 and then weekly thereafter.

Women and pregnant people taking lithium should have a growth scan at 32 weeks.

Women and pregnant people taking lithium need to have an appointment in the Joint Obstetric Mental Health Clinic where a plan for delivery can be made. Women and pregnant people taking lithium should be advised to have their baby in hospital so they can be closely monitored during labour. Monitoring should include fluid balance, because of the risk of dehydration and lithium toxicity. In prolonged labour, it may be appropriate to check serum lithium levels.

Women and pregnant people who are taking lithium and having a planned caesarean section should have serum levels checked prior to caesarean section.

Staff on the Postnatal or Labour Ward must check serum levels within 24 hours of the birth, at least 12 hours after the last dose of lithium has been administered.

It is the responsibility of the midwife on Labour Ward and/or the Postnatal Ward looking after any women and pregnant people taking lithium, to ensure serum levels are taken and to report these results to the SPMHS in a timely manner. The interpretation of serum lithium level results, and any subsequent management is solely the responsibility of the Specialist Perinatal Mental Health Service or, if out of hours, the on-call Consultant Psychiatrist. The Paediatric Team is responsible for checking serum levels in the baby.

Paroxetine – If a woman or person is taking paroxetine and is planning a pregnancy or has an unplanned pregnancy, they should be advised to stop taking the drug (with guidance). It is the only antidepressant fully contraindicated by NICE because it is associated with foetal heart defects (first trimester).

Sodium Valproate – This drug is absolutely contraindicated in pregnancy and should also not be prescribed to any woman or person of child-bearing potential unless absolutely necessary. If prescribed, the rationale for this must be clearly documented and the person/client must be aware of the risk. Refer to Valproate Pregnancy Prevention Programme.

There is a high risk of neural tube defects (risks raised from 6/10,000 to 100-200/10,000). It can also affect intellectual development of children in up to 30% of cases (Valproate Syndrome).

Women and pregnant people who continue on valproate should have a growth scan at 32 weeks.

Olanzapine and Quetiapine – Olanzapine and quetiapine are associated with weight gain and gestational diabetes so this needs to be monitored closely during pregnancy. Women or pregnant people on olanzapine should have a GTT at 24 – 28 weeks even if they have no other risk factors for GDM.

Venlafaxine – Although venlafaxine is not recommended by NICE, perinatal psychiatrists and obstetricians use it frequently in treatment-resistant patients. However, blood pressure must be monitored more closely throughout pregnancy.

21.0 Psychotropic Medication Pathway SSRI Referral

- When discussing medication in pregnancy, acknowledge that there is uncertainty surrounding risks and that there is conflicting advice.
- Explain the risks of treating versus not treating mental health conditions.
- Discuss the risk of relapse. Consider when the last episode was, its severity and the response to treatment.
- Discuss the risks of stopping medication suddenly.
- Discuss the robust evidence surrounding attachment and bonding, and that poor attachment and bonding can have potentially long-term consequences on children.
- Try to discourage the term 'withdrawal' when discussing SSRIs and neonates, it is inappropriate and can increase women/people's guilt around choosing to continue on medication, because of the association with drugs such as heroin.
- As always, respect the woman or pregnant person's decision to make an informed choice.

What does current research suggest?

The information below is intended to help you talk with women/people, and for them to understand where the concerns come from, and how the evidence has changed. Women/people need to understand that research continues, and therefore our guidance is not definitive, but is based on best evidence, current thinking and clinical experience.

- Some studies have shown an increase in fetal cardiac defects from 0.8% (normal background incidence) to 1.2% when women/people were prescribed an SSRI in the first 12 weeks of pregnancy (i.e. a very slight increase in risk) but the evidence is conflicting and confounded.
- Some babies do experience transient disturbances in muscle tone and tremors (which can also present during sleep), but this resolves within 48-72 hours and does not require treatment.
- Research from about nine years ago suggested women/people's mental health was the priority, and that SSRI's were safe to take in pregnancy.
- A 2015 study looked at 49,000 women/people and behavioural problems in their children at age 7 and found that while untreated depression was associated with an increased risk of problem behaviours, this was not seen with children whose mother/birthing parent took SSRIs.

Women and birthing people prescribed single SSRI (e.g. fluoxetine, citalopram, sertraline) and where no other medications are prescribed	**Women and birthing people prescribed multiple psychotropic medication**
↓	↓
• Advise woman/person that Sertraline, Citalopram and Fluoxetine are the preferred antidepressants for pregnancy and that Sertraline and Citalopram are preferred for breastfeeding. • Consider signposting to BUMPS website. • Reassure that homebirth is <u>not</u> contraindicated. • Reassure that breastfeeding is not contraindicated. • Contact SPMH Midwife if GP has advised discontinuation. • If the woman/person is still seeking further reassurance, consider referral to SPMHT for medication review.	Refer to SPMHT for medication review if not already under their care. If not, refer for medication review at: • **RSCH / PRH only** – Perinatal Service • **WH & SRH only** – Joint obstetric Clinic.

22.0 Sources of information

There are several sources of evidence which are helpful in contributing to the discussion that you can have with mothers and birthing parents:

BUMPS: (Best Use of Medication in Pregnancy)
https://www.medicinesinpregnancy.org/
The number of medicines listed on this website has grown over the last few years and is a useful resource.

TOXBASE:
This contains the resources of the UKTIS (UK Teratology Information Service). It contains information about fetal exposure to drugs and medicines in pregnancy and information regarding breastfeeding. When you have logged in, click on the menu option: 'exposure in pregnancy' and select the drug you are looking for from the drop-down list.

They have information about manufacturer's data and pre-release trials which you won't find elsewhere, and they are helpful in placing the context in terms of fetal exposure (i.e. the risk compared to the normal rate of malformations).

LACTMED:
A useful resource from the National Library of Medicines based in the United States.
https://www.ncbi.nlm.nih.gov/books/NBK501922/

BOOKS:
Drugs During Pregnancy and Lactation C. Schaeffer, P Peters, RK Miller (2014, 3rd edition)

Drugs in Pregnancy and Lactation GG Briggs, RK Freeman, CV Towers, AB Forinash (2017, 11th edition)

BNF and eBNF:

Not particularly comprehensive but some useful information.

UK DRUGS IN LACTATION ADVISORY SERVICE (UKDILAS)

The lactation information has now merged with the specialist pharmacy service and this website can be found on:

https://www.sps.nhs.uk/articles/ukdilas/

23.0 Useful contacts

WH & SRH	
Specialist Perinatal Mental Health Midwife Mon - Thurs	e.hibberd@nhs.net 07775 778 176
Safeguarding Midwives Sarah Barwick Clare Hosking	uhsussex.safeguardingmidwives@nhs.net 07899 915875 07808 099824
Counselling Midwife – Birth Afterthoughts Annie Hamilton	ann.hamilton4@nhs.net 07876 475772
Obstetric Mental Health Lead – Worthing Shaz Salim **Obstetric Mental Health Lead – Chichester** Niamh Maguire	 shahzad.salim2@nhs.net niamh.maguire@nhs.net
Psychiatric Liaison Team – Worthing **Psychiatric Liaison Team – Chichester**	x85252 x33443
Perinatal Mental Health Team – Coastal **Perinatal Mental Health Team – North West** **Perinatal Mental Health Team – OOA Brighton**	0300 304 0214 0300 304 0213 0300 304 0212
Sussex Mental Health Line (24/7)	0300 5000 101
WORTH - West Sussex	0300 222 8181 Text 07834 968539
My Sister's - House Bognor/Chichester	01243 697800
The Life Centre – Worthing/Chichester (Support around sexual abuse & trauma, postnatal women/people only)	0800 8020808 (Sun-Thurs 7.30pm-10pm) Text 07717 989022 (every Wednesday)
Samaritans	116 123 0300 094 5717

RSCH & PRH	
Specialist Perinatal Mental Health Midwife	07867929439/07900716105 x63613
Obstetric Mental Health Lead	07884054020
Safeguarding Midwives	01273 696955 X 62523 07920 503354
Substance Use, Homeless & Travellers Specialist Midwife	07795 498509
Perinatal/Infant Mental Health (PIMH) Nurse Specialist Brighton and Hove	01273 666484 07827898942
Perinatal Mental Health Specialist HV	0127369011 X 65283 07795355437
Psychiatric Liaison Team PRH	01444 441881 X 68338, or via switchboard for bleep holder
Psychiatric Liaison Team RSCH	01273 696955 X 64248 or the Mental Health bleep: 8484

Sussex Mental Healthline	0300 5000 101
Mental Health Rapid Response Service	0300 304 0078
SPMHS Brighton and Hove	03003040097
SPMHS North West Sussex	03003040213
SPMHS East Sussex	03003040212
BSUH HELP Service	01273 696955 X 63692
Independent Domestic Violence Advisory Service	07792276165 01273 696955 X 64366
Victim Support	0300 323 9985 (9am-5pm) 08 08 16 89 111 (out of hours support line)
The Portal (Help to find support and advice for survivors of Domestic Abuse and Violence in Brighton and Hove and East Sussex)	03003239985
Worth (Domestic Abuse Services West Sussex)	07834 968539 or 033 022 28181 (9am-5pm Mon Fri)domesticabuseservicescentral@westsussex.gov.uk
MIND (Mental Health Charity) Brighton and Hove	01273 666950 info@mindcharity.co.uk
Threshold (Women's Mental Health Support) Brighton	01273 645455 threshold@bht.org.uk
Brighton Women's Centre	01273 698 036 07842 311 406 (Weds & Thurs 10am-12pm) support@womenscentre.org.uk

24.0 Audit

Suggested areas for audit:

- Women/people with positive response to Whooley questions antenatally and postnatally have appropriate action taken
- Women/people with identified mental health concerns have a documented individual management plan of care during pregnancy/birth/postnatal period
- Women/people with identified mental health concerns have necessary interventions delivered in a timely manner, taking into account the stage of pregnancy/age of baby

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Perinatal Mental Health MP014 University Hospital Sussex NHS Trust East Page 27 of 32 *Maternal Mental Health Alliance. 2022. Key statistics about perinatal mental health in the UK.* [Online] London: Maternal Mental Health Alliance. Available from: https://maternalmentalhealthalliance.org/about/perinatal mental-health/

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National Institute for Health and Care Excellence (2010) *Pregnancy and Complex Social Factors -Clinical guideline* [Online] Available at: https://www.nice.org.uk/guidance/cg110

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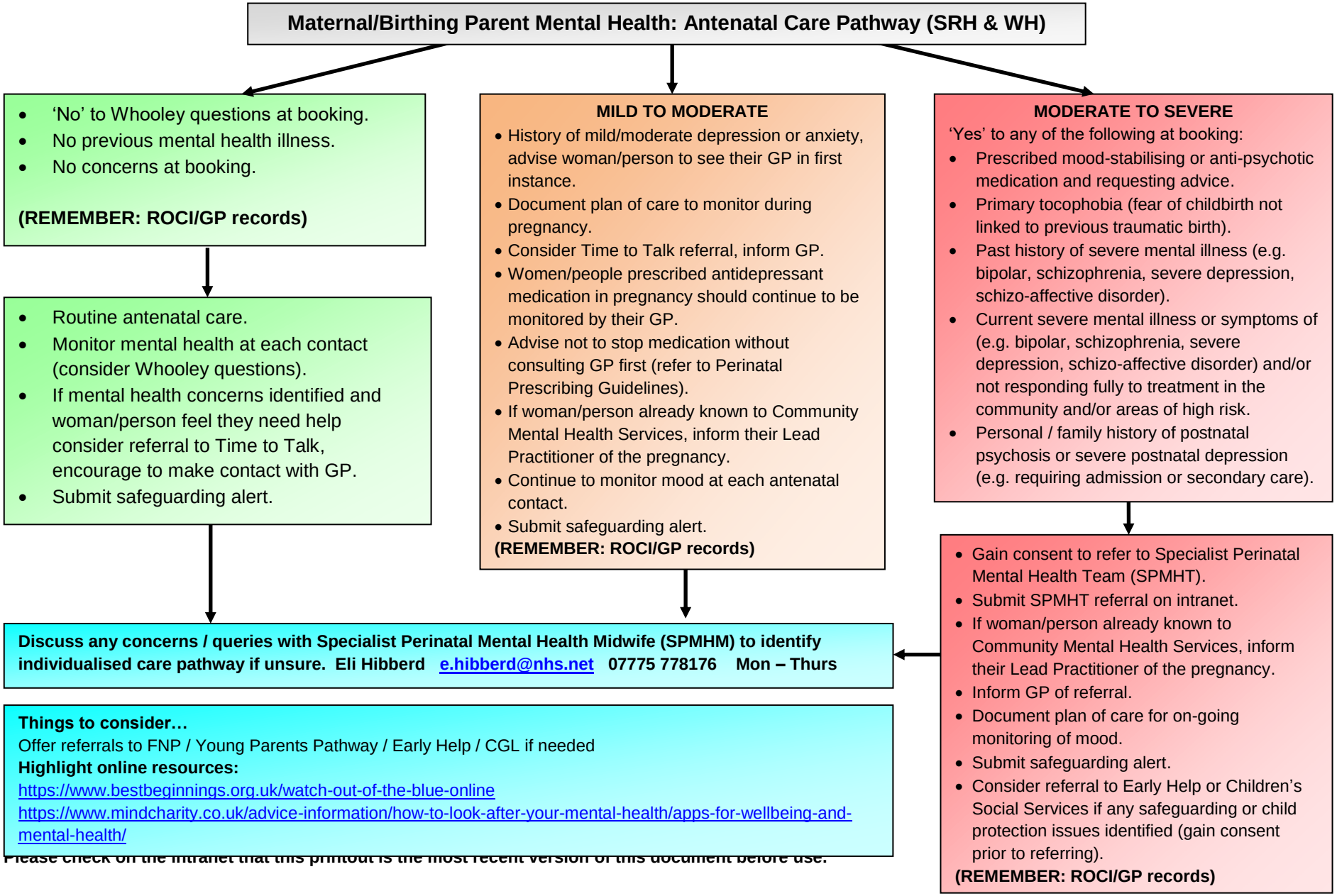
Appendix 1a: Maternal/Birthing Parent Mental Health: Antenatal Care Pathway (SRH &WH)



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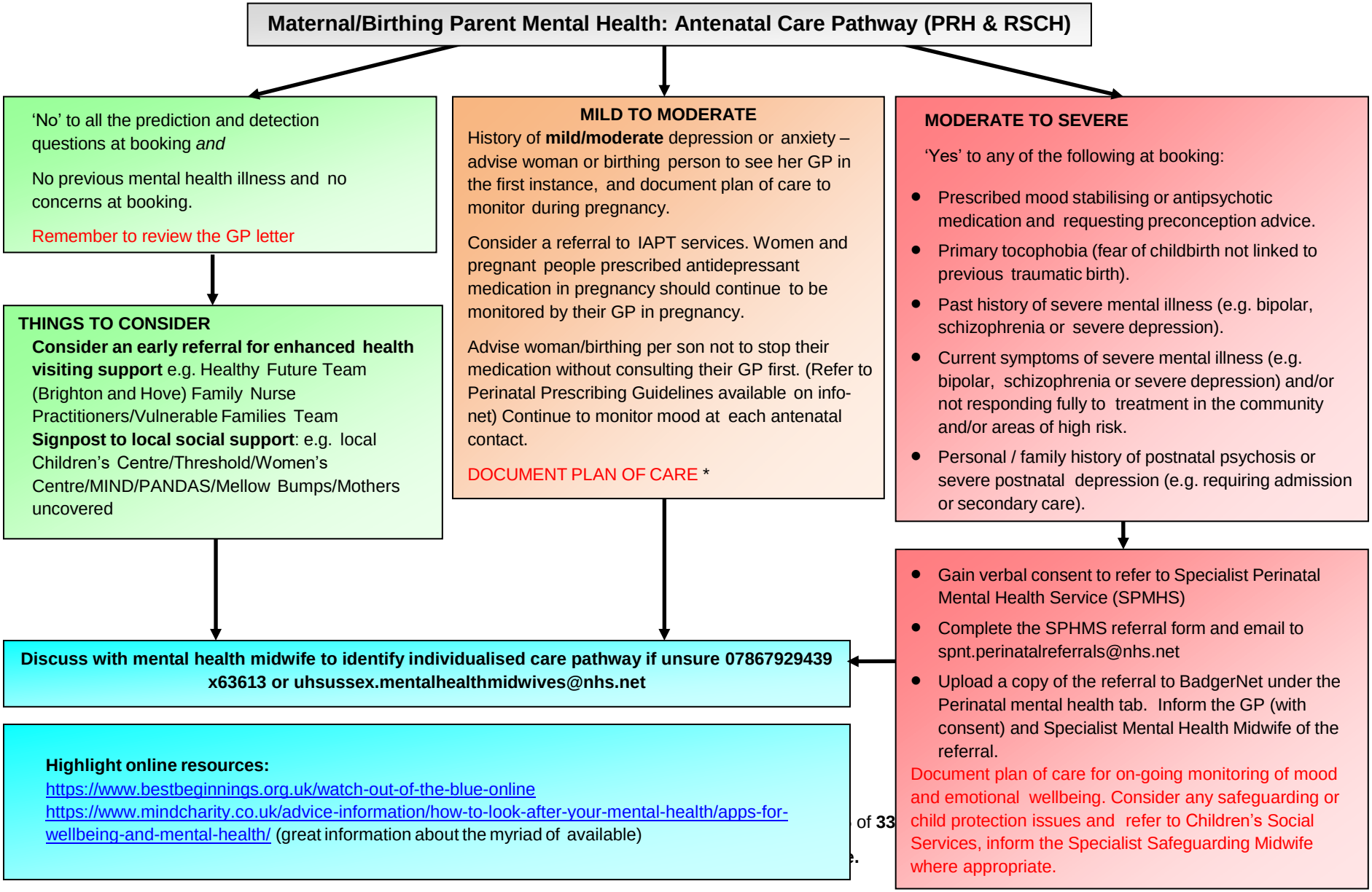
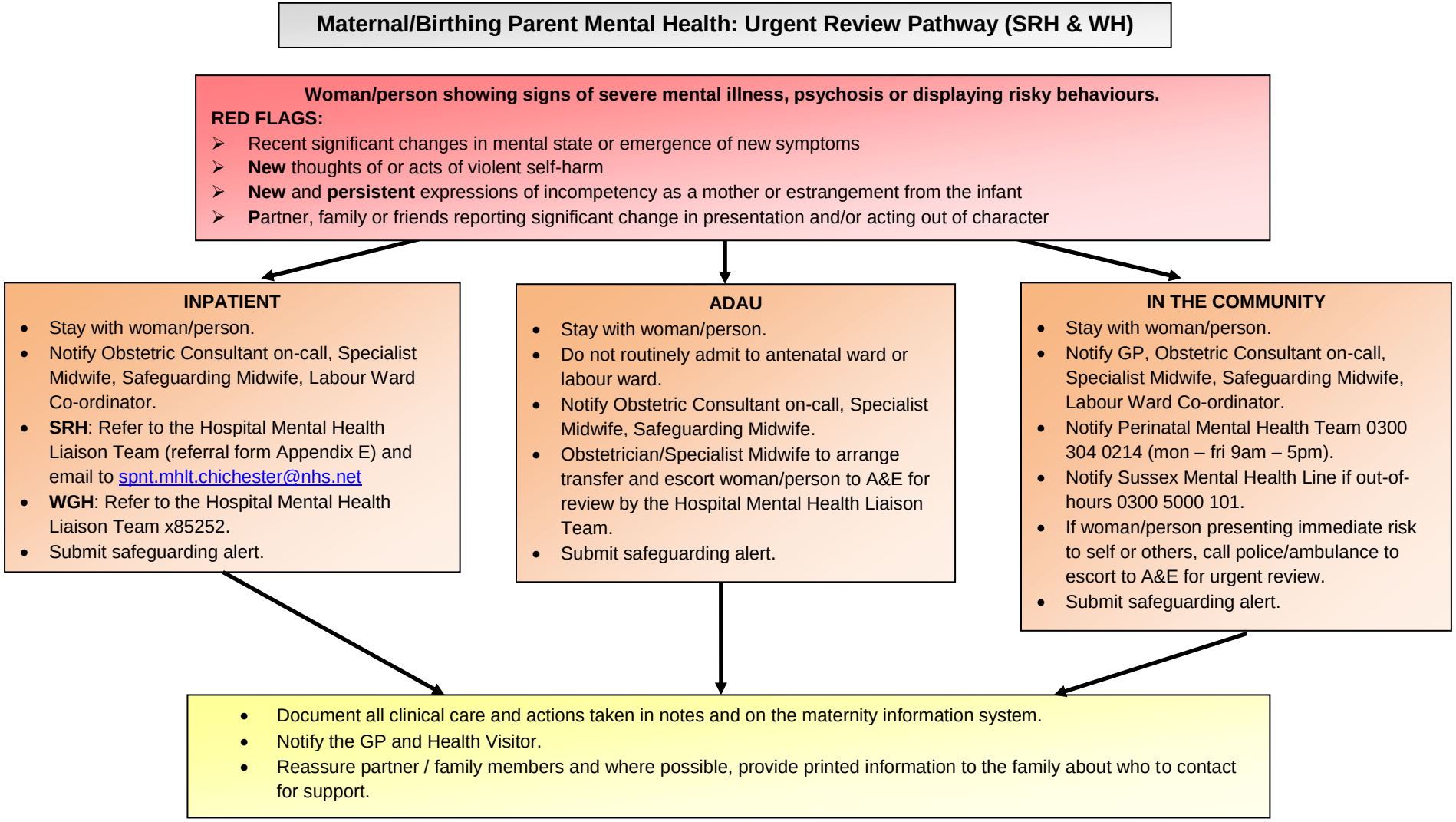
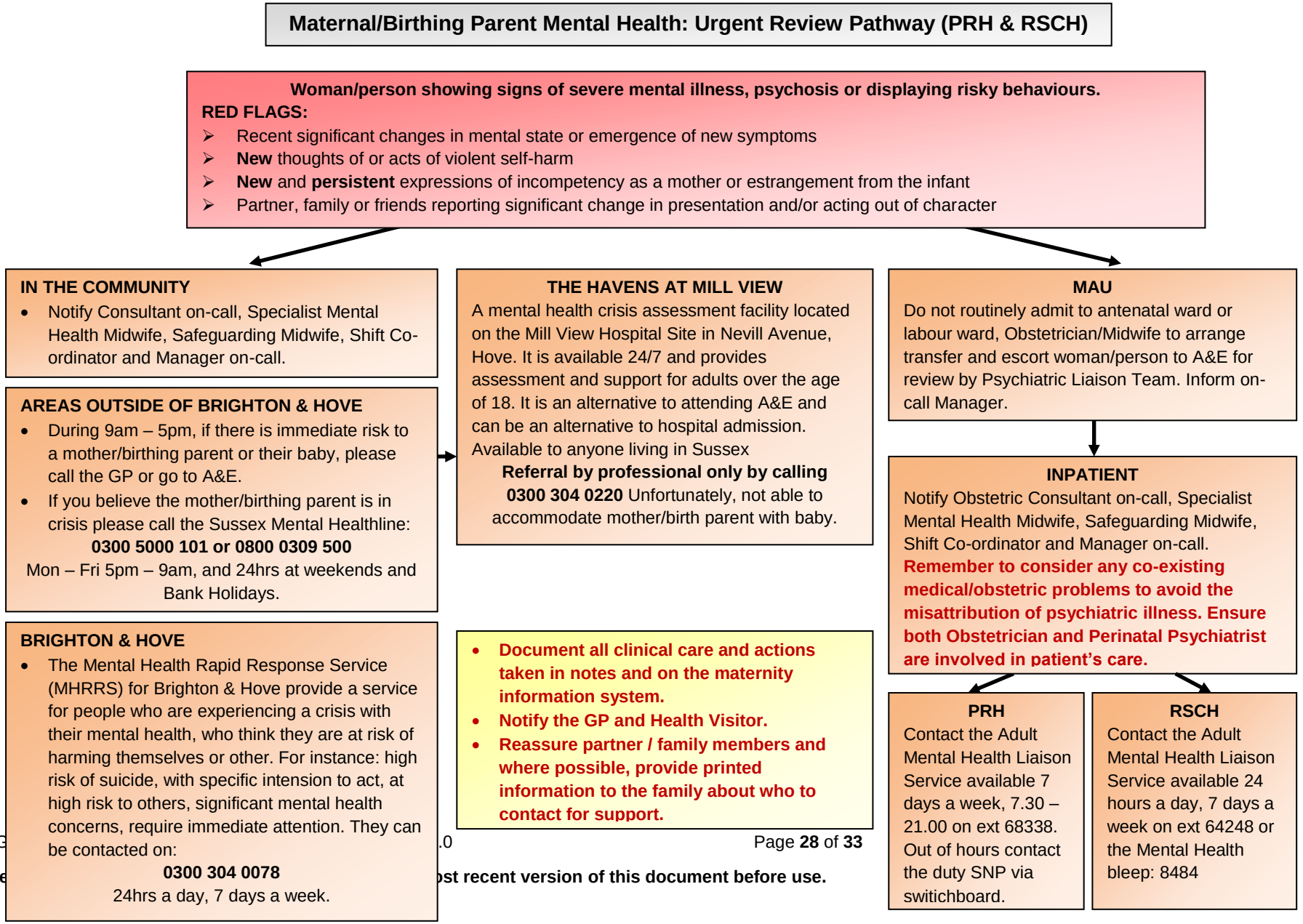
Appendix 1b: Maternal/Birthing Parent Mental Health: Antenatal Care Pathway (PRH & RSCH)



Appendix 2a: Maternal/Birthing Parent Mental Health: Urgent Review Pathway (SRH & WH only)



Appendix 2b: Maternal/Birthing Parent Mental Health: Urgent Review Pathway (PRH & RSCH)



Appendix 3: Patient Health Questionnaire - PHQ-9

Patient Health Questionnaire – PHQ-9

Name: **Date:** **Today's Date:**

Fill in the boxes with pen or pencil to mark your answers.

A. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Little interest or pleasure in doing things?				
2. Feeling down, depressed or hopeless				
3. Trouble falling/staying asleep, sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				
Total Score _____ =	**+**	**+**	**+**	

B. If you have been bothered by any of the 9 problems listed above, please answer the following:

How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all difficult	Somewhat difficult	Very difficult	Extremely Difficult
☐	☐	☐	☐

This health survey was adapted from the PRIME-MD® Patient Health Questionnaire© 1999, Pfizer. Inc. Reproduced with permission. For research information, contact Dr. Robert. L. Spitzer at rls8@columbia.edu

Appendix 4: Hospital Mental Health Liaison Referral Form (SRH only)

Working Age Mental Health Liaison E-Referral Form (V4)

Referrer Details:

Referrer Name:	
Speciality/ Designation:	
Contact Number/ Bleep:	
Date & Time of referral:	

Patient Details:

Patient Name (*required*):	
Date of Birth (*required*):	
NHS Number (*required*):	
GP:	Choose an item.

- **Does this patient require an interpreter?**
  Yes ☐ No ☐ **Language Required?**
- **Has this referral been discussed with the patient?**
  Yes ☐ No ☐ Best Interests ☐
- **Attitude to referral?**
  Positive ☐ Neutral ☐ Negative ☐ **Comments:**
- **Is the patient physically well enough to undertake a psychiatric interview with mental health staff?**
  Yes ☐ No ☐
- **Does this person have responsibility as a carer (for children <18 or a vulnerable adult)?**
  Yes ☐ No ☐

Admission Details:

COVID Status? (required): Positive☐ Negative☐ Pending☐

Ward:	Choose an item.
Bay & Bed Number	
Date and time of arrival at Hospital (*required*):	
Reasons for admission: (*Please include any long-term conditions and known diagnosis*)	
Current treatment plan: (*please include any psychiatric treatment known*	
Expected length of stay:	

PLEASE EMAIL THIS COMPLETED FORM TO SPNT.MHLT.CHICHESTER@NHS.NET (INBOX MONITORED 07:00 - 21:00), Referrals received after 21:00 will be processed the next day. If you do not receive an acknowledgement of referral within four hours, please contact Ext 33443

Reasons for Referral (*required*):

Please describe the patients mental state, any evidence of self-neglect, current medication, longevity of concerns/symptoms, your impression, what you would like from this referral.

Is the patient under Drug or Alcohol Services? Yes ☐ No ☐

Requested Intervention (*drop down menu*):	Choose an item.

Risk screening Checklist (*required*)

The greater the number of positive responses, the higher the risk.

	YES	NO		YES	NO
Possible					
Previous self-harm	☐	☐	Family history of suicide	☐	☐
Previous suicide attempt	☐	☐	Unemployed	☐	☐
Current suicidal thoughts	☐	☐	Male, younger men and middle age (35-55)	☐	☐
Current suicide plan	☐	☐	Separated/widowed/divorced/ domestic violence	☐	☐
Hopelessness/helplessness/ burdensomeness	☐	☐	Lack of support or breakdown in social circumstances	☐	☐
Sense of "entrapment" *e.g. feeling 'overwhelmed' by their problems*	☐	☐	Family concerned about risk	☐	☐
Low in mood	☐	☐	Recent stressful life event	☐	☐
Displaying bizarre or unpredictable behaviour	☐	☐	Psychotic symptoms e.g. *persecutory/nihilistic delusions/command hallucination beliefs that don't fit with evidence or culture*	☐	☐
Alcohol/drug misuse	☐	☐	Poor adherence to psychiatric treatment	☐	☐
Chronic pain or illness	☐	☐	Access to lethal means of harm	☐	☐

Summary of risk

If any of the above are ticked then please briefly describe how you are managing these. Ensure you state clearly any concerns that you may have and actions being taken to reduce risk and keep patient safe:

Appendix 5: Healthy Futures Team (Brighton & Hove only)

Acting early to enhance outcomes for children

The Healthy Futures Team is a newly commissioned 0-19 Specialist Public Health Nursing Service (health visiting and school nursing). It utilises an early intervention model to improve health outcomes and reduce inequalities for families facing disadvantage in Brighton & Hove.

Team members
Linda Evans – Clinical Service Manager
Candy Barrett and Amanda Brooks- Specialist Public Health Nurses – BME/Travellers
Julie Davidson –Specialist Public Health Nurse – Teenage parents
Denise Ranger – Specialist Public Health Nurse – Senior School Nurse
Amanda Brooks – Health Visitor
Charlotte Crisswell – Health Visitor
Cathy Lovejoy – Health Visitor
Louise Stewart-Roberts – Health Visitor
Bernie Sweatman – Health Visitor
Mary Frankland – Healthy Child Practitioner
Naomi Potter – Healthy Child Practitioner
Val Milton – Team Administrator

The team will deliver the Healthy Child Programme (0-19) to families meeting following criteria:

- Antenatal mothers and pregnant people who are under 18 at conception.
- Anyone subject to a pre-birth child protection conference that is not already known to the public health community nursing service. Consideration will be given to those undergoing a pre-birth Strengthening Families Assessment.
- A parent with a history of being Looked After that is not already known to the public health community nursing service.
- Refugees, Asylum seekers, undocumented migrants and Travellers and those in emergency housing (including the women's refuge) who are pregnant or with a child under the age of 19 that is not already known to the public health community nursing service.
- Migrant families housed in temporary on-campus accommodation provided by the University of Sussex who are pregnant or with a child under the age of 19 that is not already known to the public health community nursing service.
- Children registered as home educated.
- Children missing education or educated other than at school.
- Children excluded from school and within the Pupil Referral Unit.
- Children who are registered as young carers and not in local authority education.

The Healthy Futures Team will:

- Provide a city-wide service enabling continuity of care to families with specific vulnerabilities, predominantly at Healthy Child Programme universal partnership plus level.

- Offer early assessment and intervention at the point of referral into the team, promoting positive parenting and reducing the impact of disadvantage on families.
- Develop an intensive 0-19 service, delivering the five core health visiting contactsand progressive intensive support and interventions with families.
- Deliver a service focused on the health visiting and school nursing high-impact areas.
- Work towards the ongoing development of the Healthy Futures Team service, including specific pathways and interventions.
- Act as a specialist resource for colleagues in the 0-19 Healthy Child Programme service.

Referrals
Referral should be made via the 'Healthy Futures Team' email –
Email: SC-TR.healthyfuturesteam@nhs.net
Referrals will be triaged by Linda Evans, Clinical Service Manager
Please contact Linda Evans or team members if you would like to discuss a family.

Contact details:
Roundabout Children's Centre, Whitehawk Road, BN2 5FL.
Telephone number: 01273 666484 Email: SC-TR.healthyfuturesteam@nhs.net