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An overview of PMH & why motherhood can be dangerous Prescribing to women

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Purpose of this session

- Why is PMH important?
- Why do we want mothers to be well?
- Overview of MH & pregnancy
- ‘Dangerous Motherhood’
- Prescribing

What do we mean by the perinatal period?

- Conception to 1 year post-partum
- Do see women at risk for preconception counselling
- Out of step with 1001 days (HV)

Perinatal Team

- County-wide
  - 2 consultants
  - Manager
  - Psychologist
  - Nursery Nurse
  - OT
  - 5.6 CPNs (2 WTE for York)
  - Peer support workers
- Live since Jan 2019

Perinatal Service Specification

- We accept women at high risk of major perinatal MH problems or new onset illness:

- Preconception counselling

- Assessment & monitoring in pregnancy

- Medication advice & management

'How can we plan to keep you well?

Exclusions

- Exclusions:

- Mum not going to be primary carer

- Parenting assessment

- Primary LD/ substance abuse

- Refer as you would anyone else (through SPA)

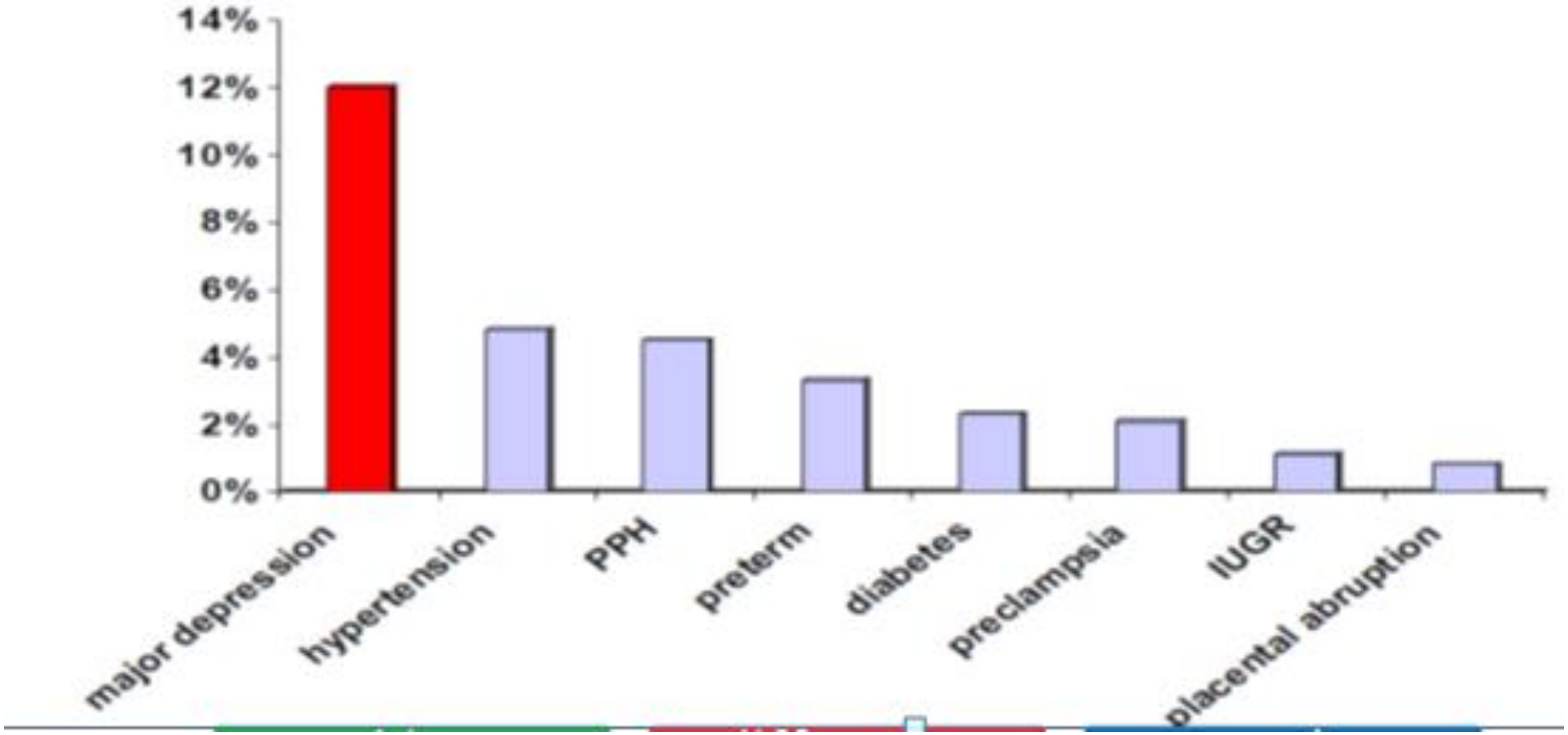
Numbers locally…

Women with…… Per year	York 3,500 deliveries
PP	7
Chronic SMI	10
Severe depression	110
Mild-mod dep/ anx	325-490
PTSD	100
Adjustment/distress	490--975
PD	?

Mum - Why is PMH important?

- Mental illness is common
- All illnesses are present at the usual population rate at conception
- Mental illness increases adverse obstetric outcomes for women and their babies
- **20% postnatal women have mental health problems = 525 in primary care**
- **5% warrant secondary care = 175 with us**

Depression: the most common major complication of maternity



Baby - Why is this important?

Foetal environment

- Affects long-term development
- *Developmental Origins Health and Disease*
- Affected by maternal:
  - Nutrition
  - Smoking/ Alcohol/ Toxins
  - Mental illness
  - Stress (includes social challenge such as poverty/ DV)
  - Infection/ physical health

Baby - Why is this important?

- Low birth weight reflects FE & predicts likelihood physical/ mental health problems through the lifespan
- *Antenatal depression associated with 39% increase low birth weight*
- MI associated high stress hormones/ adrenalin – cross placenta better than drugs

Antenatal Mental Illness itself can be harmful/ toxic

- All MI associated with poor baby outcomes *even if not on medication*
- Premature/low birth weight babies/ SCBU
- Measurable effects emotional/ cognitive/ social development throughout childhood
- *What harm might I do by NOT taking this medication?'*

Post-natally - Babies are social animals

- https://www.youtube.com/watch?v=JPejofp9BnQ
  - Baby interacting
- (https://www.youtube.com/watch?v=VY01SPU99oo
  - Baby recognising voice)

- Born primed & needing interaction to develop brain to full potential
- Long-term effects if Mum not able to interact through MI (Still Face)

- Problems can occur with even quite mild maternal MI
- Early
- Effects – measurable into adult life
  - Attachment predicts many adult outcomes
  - Social/ emotional/ cognitive development is affected
  - Increases rates of all MI in child (GAD =x2 ADHD)

Overview of MH & pregnancy

- **Eating Disorders** -
- Changing body shape
- How do they understand normal feeding/ fullness in baby
- May ask for early CS or induction

- **OCD** – 2-9%
- Very severe – normal worries but abnormal response

Overview of perinatal illness

Personality disorder

Very problematic – emotional regulation, self-harm.

Distress tolerance/ emotional regulation

PTSD – 20% post delivery

Mild-mod Depression

All outcomes worsened independent of meds

Evidence that offspring untreated depressed mothers do worse

Treatments

- NICE
- Support/ socialising
- Non-stat, children's centres, HV listening visits
- Prioritised for psychological interventions
  - IAPT do this
- Medication?
  - NICE states meds & psychological therapy more effective than either alone

The big ones… Perinatal relapse risk

Risk drops to 1 in 10 on effective medication

	Risk perinatal relapse
Bipolar type 1	**1 in 4**
Schizo-affective disorder	**1 in 4**
Schizophrenia	**1 in 4**
Previous Perinatal (postpartum) psychosis/ major depression	**1 in 2**

Post-partum Psychosis

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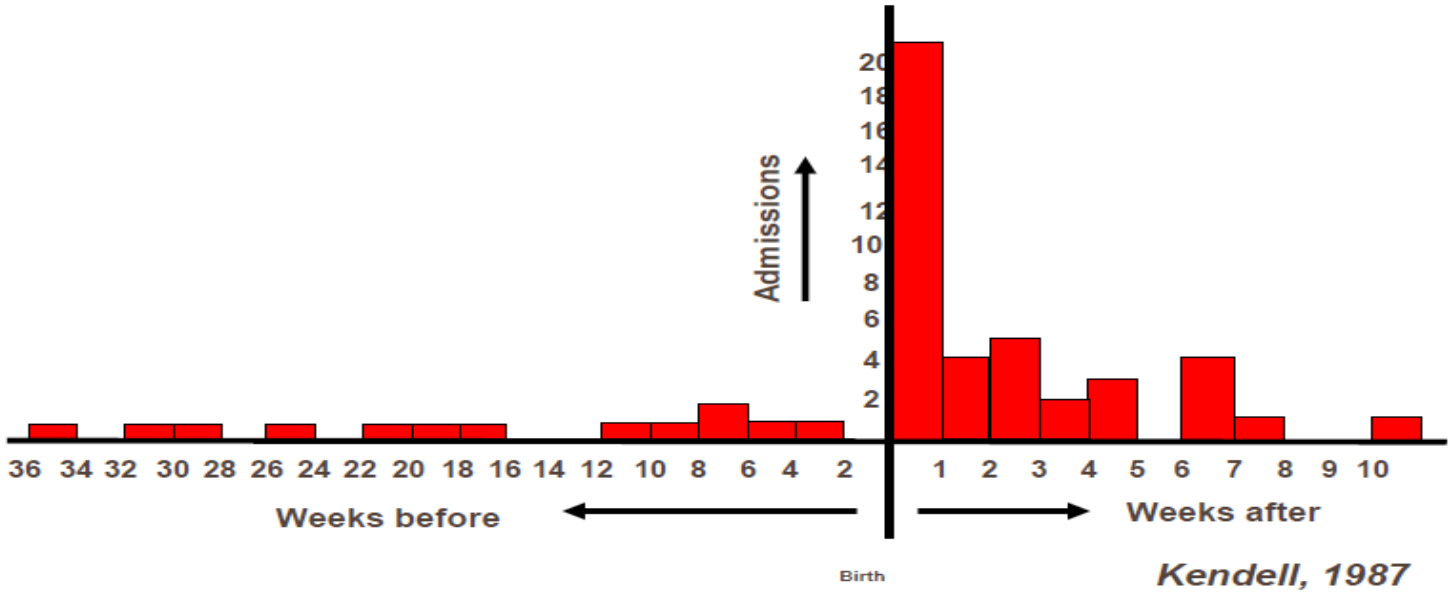
Maternity: the highest ever risk of psychosis



Kendell, 1987

Puerperal psychosis: more rapid onset, more severe, and higher risk than at any other time (Oates, 1996; Appleby et al 1998)

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Clinical picture PP (2 in 1000)

- Fearful – health/ safety self or baby
- Perplexed/ confused
- Agitated – purposeless activity
- Hallucinating
- Delusional – bizarre and florid beliefs
- Unable to care for self or baby
- Often mixed mood state
- Fluctuates – lucid periods

Depression

- 1 in 10= Depression
- 3 in 100= severe depression (peaks 6/52)
- 2 in 1000 = warrant admission

- Cognitive symptoms more helpful
- Profound
- Merges into psychosis

Management of PP/ severe depression

- A psychiatric **emergency**
- **Should NOT be left alone with baby**
  - **PP or severe suicidal depression**
- **Admit** (Mother & Baby Unit)
  - Families are NOT MH professionals
- Medication/ ECT
- Support/ monitoring with parenting
- Prognosis

Why motherhood can be dangerous

The pitfalls for generic services

So who gets severe mental illness?

Who completes suicide?

How do women usually commit suicide?

Who gets severe perinatal MH problems

Who dies from it?

So, who dies from perinatal psychiatric illness?

- NOT usual suspects - >50% suicides were white, married and employed
- Older
- Stable relationships >50%
- Professionally employed >50%
- Wanted & planned baby – assisted conception

- 82% died violently
- Previous history BUT ½ are new onset

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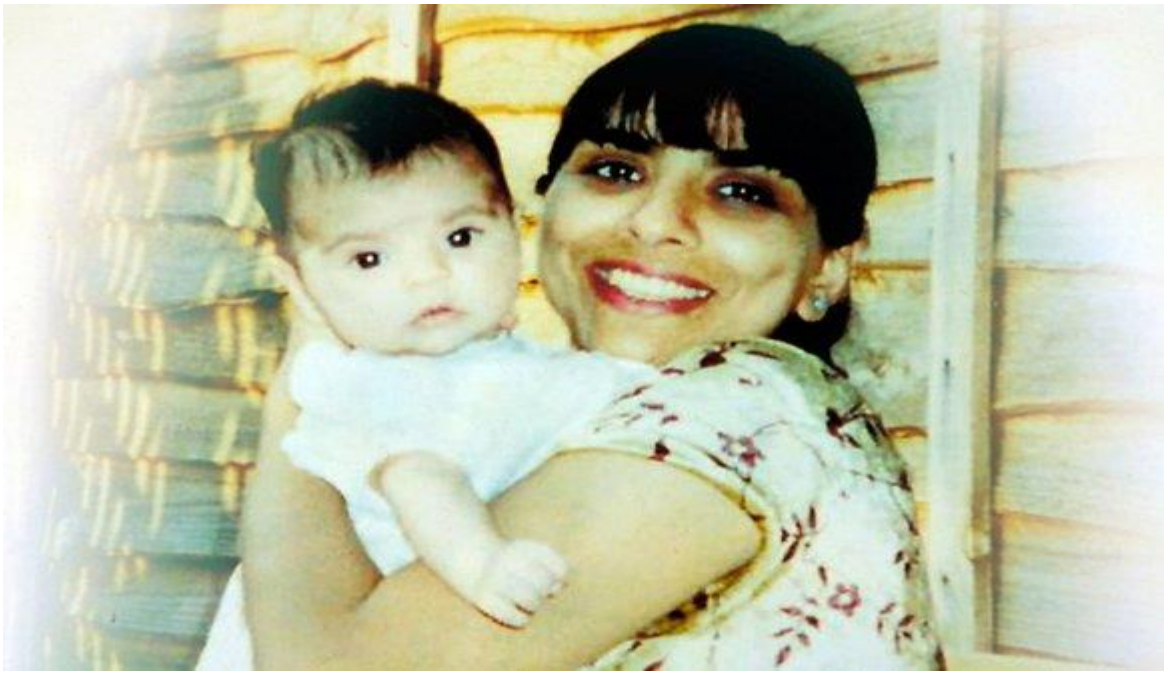

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RISK – Confidential Enquiry themes for MH services

- MBU not considered – ‘keep people out’
- No specialist input/ multiple teams
- No senior review - **Diagnosis**
- **Underplay - ?accept their words ‘Anxiety’ might be paranoia**
- **Not recognising change**
- Not reviewing notes
- Safeguarding – a trigger for many

Patient factors

- 3rd trimester/ first 3 months
- Personal or FH PP/ major mood disorder/ near fatal suicide attempts
- **Violent thoughts**
- Guilt/ **estrangement** from baby
- Early onset/ **rapid deterioration**
- Change in meds
- Well pre-pregnancy

- Perinatal demographic

Risks

- To woman – self-neglect, acting on delusions
- To baby – due to inability to care properly for it; neglect, unsafe handling, inattention

  Longer term emotional impacts if untreated
- Aggression to the baby is rare

  Increased with delusions/ lack of connection
- Suicide/ infanticide is rarer

  1 in 600 with PP completes suicide BUT

The real risk – for every death 150 have come close

What should I do about this?

- Postnatal women becoming unwell/ agitated
- Refer – crisis team

- Options for advice
  - Local team – 01904 556724
- Leeds MBU (24/7)
  - 0113 8555505

Prescribing to women – a plea

- 1.5% women have unplanned pregnancy per year
- Often people do not realise they are pregnant for 6-8 weeks
  - Neural tube closed by 8 weeks
  - Heart beating by 5 weeks
- Possible pregnancy needs discussing/ building in with ANY prescription to women 12-55
- Some MI is life-threatening

Why would we prescribe psychotropics to a pregnant woman?

- To prevent effects on baby
  - Bonding starts antenatally, needed for healthy attachment
  - Foetal environment
- To prevent serious relapse
  - Relapse/deterioration
  - Self-medicating?
  - Self-neglect/ other risks from illness
  - Poor functioning
  - Post-natal relapse

Advising women is difficult

- Complicated
- Time-consuming
- Requires knowledge of evidence base/ background risks
- Individualised comparison risks taking vs not taking
- I can’t do them all!

Generalities

- Background risk congenital abnormalities 3%
- Miscarriage rate 15% known pregnancies
- Much of the evidence for harmful effects meds is poor – no control for smoking/ alcohol use/ severity illness
- Studies conflict
- Does medication increase/ decrease/ not affect rate of poor outcomes?

Limit number of exposures

- If a woman is on something effective to which her baby has already been exposed what is the value in changing?
- Risks:
  - Relapse if it isn't effective – so exposes baby to a toxic event
  - Exposes baby a second agent (third if also unwell)
  - 1st trimester likely over by the time of changeover completion.

PMH will see & manage:

- Lithium
  - Risks CVS abnormalities overstated
  - Will need closer monitoring
  - Cannot breastfeed
- Valproate – we will see urgently
  - 10-20% chance physical abnormality
  - 30-40% chance developmental delay
  - No evidence for high dose folate
  - Need to be off it but be ready for relapse

PMH will see & manage:

- Antipsychotics (BAD/ Sz)
  - Hyperglycaemia, weight-gain, Gestational DM
  - No convincing evidence poor baby outcome
- Clozapine - always
  - Cannot breastfeed

Antidepressants - SSRI

- **Concerns**
  - **Persistent Pulmonary Hypertension**

    SSRI antidepressants, 3rd trimester?
  - **Developmental delay** ?possible association ADHD, ASD

    Is an association but far smaller than risk illness & confounded
  - **Neonatal adaptation syndrome**

    self-limits, agitated baby, seizures

    Not recommended to reduce late pregnancy

Antidepressants (2)

- Stay on what works
- Little evidence older medications safer
- Don’t reduce pre-delivery

Please do not just stop as a reflex

- Anecdotally many women speak of GP scaring them with risk of meds but never mentioning risks illness
- Women then suffer
- Their babies suffer & may have lifelong consequences
- Tales of being made to feel selfish for wanting treatment

- You would not stop physical health medications?

Examples

- Bipolar – quetiapine stopped, PICU
- AN – fluoxetine stopped – relapse, growth restricted baby
- Depression with ECT – needed ECT in pregnancy

Resources

- E-learning for health modules
- MMBRACE – Saving Lives, Improving Mothers' Care
- BUMPs / UKTIS website
  - http://www.medicinesinpregnancy.org/Medicine--pregnancy/
- Lactmed
  - https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm
- Red Flags
- Decision aid

What ALL women with SMI should know

- SMI & pregnancy affect each other & certain illnesses have major risk serious relapse
- EVEN if well will need monitoring in pregnancy – so back to MHS if discharged
- May need medication to reduce relapse risk (choice)
- Better planned
- ‘How can we keep you well?’

- No automatic safeguarding

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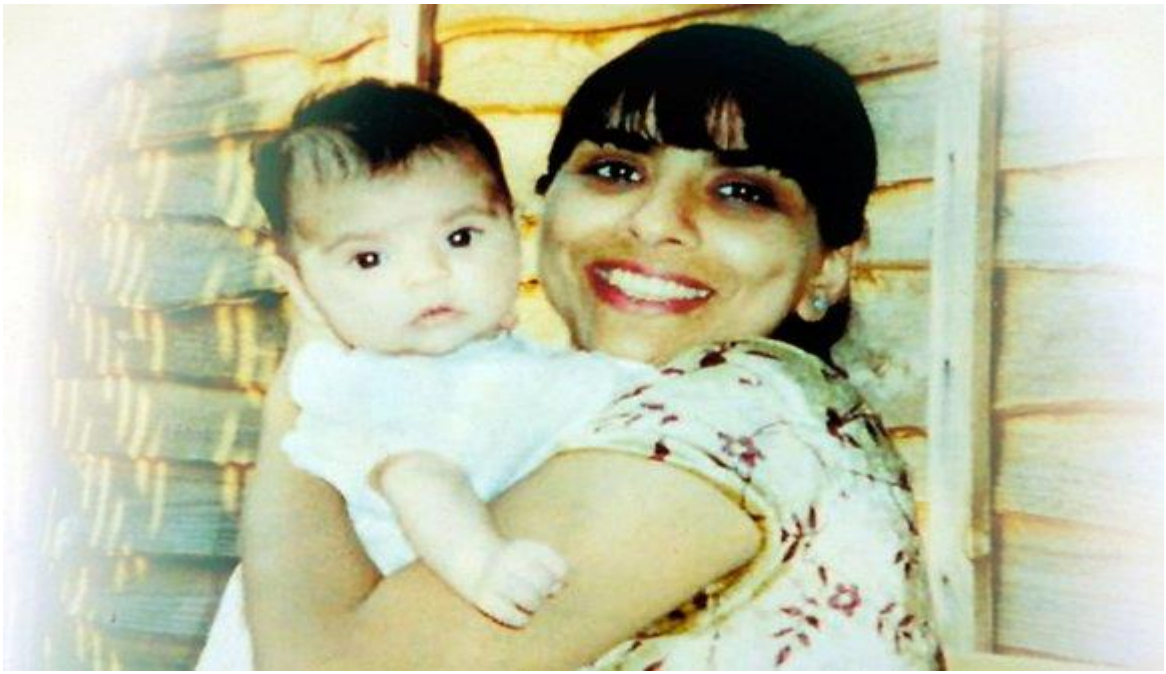

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