Frimley Health
NHS Foundation Trust

# Perinatal Mental Health

**Key Points**

- Suicide is currently the leading direct cause of maternal death (MBRRACE 2022)
- Some women will have their first presentation of mental illness during or after pregnancy
- Pre-conceptual advice is available
- Do not stop medication without specialist advice
- Act upon positive answers to red flag questions immediately to ensure safety and care planning
- Neonatal observations are recommended for babies whose mothers take mental health medications

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## Abbreviations

| | |
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| AMHT | Adult Mental Health Team |
| CAMHS | Child and Adolescent Mental Health Service |
| CMHT | Community Mental Health Team |
| EPR | Electronic Patient Record |
| FNP | Family Nurse Practitioner |
| MH | Mental Health |
| PMH | Perinatal Mental Health |
| PMHS | Perinatal Mental Health Service – specialist community service provided by mental health services |
| PMH/PNMH MW | Perinatal Mental Health Specialist Midwife |

**Contents**

## 1. Introduction

Suicide is currently the leading direct cause of maternal death (MBRRACE 2022).

Pre-conception:
Women who have a history of severe mental illness have a higher risk of it happening again during or after their next pregnancy (Mental Health Foundation, 2016). Pre-conception advice, preventative treatment and plans for action may stop relapse in future pregnancies. It is important they talk to specialists and find out what might be done to help prevent future problems. Women should not change their treatment without advice from their prescriber or treatment provider. Medication advice can also be sought from the Perinatal Mental Health Service (PMHS) if required (MBRRACE-UK, 2022).

Antenatal / Postnatal:
Women with any past history of psychotic disorder should be regarded as at elevated risk in future antepartum and postpartum periods. Therefore, these women should be referred to the PMHS in pregnancy at the initial clinical contact. Thereby, an individualised assessment of risk can be completed (MBRRACE-UK, 2022).

Some women will have their first presentation of mental illness during or after pregnancy. Therefore, it is important to be aware of the signs and symptoms. Health care providers, women and their families should be aware, the onset of symptoms can be rapid and severe. Any threat of suicide should be taken very seriously, and advice sought at the time of disclosure by the clinician from the perinatal mental health midwife (PNMH MW) if working, senior staff members, PMHS or the psychiatric liaison team if they are unsure of actions needed.

Where women have a severe mental illness and need admission for specific mental health unit care. They and their family should be made aware of the benefits of joint mother and baby admission, preferably in a mother and baby mental health unit meets criteria. Keeping a mother and her baby together is often best for both individuals (MBRRACE-UK, 2022). Staff should refer to the local safeguarding policy, to identify other sources of support or referrals needed for the family.

### 1.1 Screening for Mental Health and Risk-Assessment

Consideration should be made to the use of translation/interpreter services if the woman is unable to understand such complex enquiries without assistance. Trust policy is for friends and relatives not to be used as interpreter or translator in such circumstances, in order to ensure transparency between the woman and the health professional.

Self-disclosure at the booking appointment should identify:

- Dates of occurrence
- Clinical presentation when unwell & current clinical presentation
- Severity (any inpatient mental health stay/ history of being detained under the Mental Health Act)
- Care and/or medication (including doses if possible) received
- Compliance with treatment/ medication

- Details of referrals to psychiatric, social services, or other appropriate agencies.
- Outcome
- Family history, severity, clinical presentation
- Whether treatment/care is on-going
- Extent to which a woman's psychological well-being has an impact upon her ability to function on a day-to-day basis

### 1.2 Medication

The effects and potential side-effects of psychiatric medications during pregnancy and when breastfeeding is complex  Anti-psychotic medication can increase the women's risk of developing gestational diabetes in pregnancy and should be offered screening by oral glucose tolerance test or home monitoring alternative, see appendix 7 for commonly used anti-psychotic medication. The woman should be encouraged to seek advice and raise any concerns with her GP, obstetrician, or mental health professional. Information about drugs can be obtained from the PNMH Specialist Midwives and PMHS. Patient information leaflets are available:

**http://www.medicinesinpregnancy.org/Medicine--pregnancy/**

**https://www.choiceandmedication.org/nhs24/printable-leaflets/drugs-in-pregnancy/**

**National Breastfeeding helpline: 0300 100 0212**

- **Do not** stop medication without specialist advice
- Refer to the PMHS for a medication review if desired

Sodium Valproate

Women of childbearing age should not be prescribed Sodium Valproate in accordance with NICE (2018) guidelines. Pregnant women who have been prescribed Sodium Valproate for their mental health will require an urgent referral to the Perinatal Mental Health Service and PNMH MW. Women prescribed Sodium Valproate for other medical indications such as epilepsy, will need to be urgently reviewed by their prescriber and the lead for their care.

### 1.3 Medication and Breastfeeding

Ideally the woman will have had the opportunity to have discussed the risks and benefits of breastfeeding whilst taking medication during the antenatal period. Breastfeeding can be supported and encouraged with most psychiatric medication. Where there is complex polypharmacy, we would recommend specialist advice is sought from the Perinatal Mental Health Service. Doctors and midwives are to follow any perinatal mental health care plans for birth and medication which have been provided – these will be in the media section of the EPR record. In the presence of the

following medications, specialist advice should be sought from the perinatal mental health team: Lithium, Carbamazepine & Benzodiazepine, Sodium Valproate.

The Pan London Perinatal Mental Health: Guidance for Newborn Assessment (2017) have established a method for estimating risk to babies from exposure to maternal psychotropic treatment in breast milk by calculating the Relative Infant Dose (RID). The RID scores are calculated by dividing the baby's dose via milk (mg/kg/day) by the mother's dose in mg/kg/day. If the RID is less than 10% most medications are considered safe to use. The RID score the vast majority of drugs is < 1%. The RID of each medication can be found the LactMed website:

https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm

Information may also be obtained from the specialist pharmacists at each site, or from Pharmacy Medicines Information on:

Tel: 0300 6134744 (ext. 134744) email: fhft.medicines.information@nhs.net

### 1.4 Postnatal care of the neonate after maternal MH medication

A clinicians guide as regards common mental health medications, antenatal and postnatal care is in Appendix 7. The list of medications is not exhaustive. Any mental health care plans created by external mental health services supersede the information in Appendix 7.

At the present time, there is insufficient conclusive evidence or guidance surrounding the adaption of the neonate when the birth parent has taken SSRIs/SNRIs. Therefore, all babies are recommended to have postnatal observations (neonatal adaption/abstinence/withdrawal). These indicate whether the baby is potentially withdrawing from maternal mental health medications.

The incidence of withdrawal symptoms from maternal mental health medications is rare ranging from 1.26-2.26% depending on the type and number of different medications taken (Gastaldon et al 2023). Symptoms may occur between birth and up to 7 days postnatal Thames Valley & Wessex Neonatal Abstinence Syndrome Guideline (2023)

Please be aware symptoms of illness in the neonate may also have other clinical causes, i.e., infection. It must not be presumed mental health medications are the cause without clinical evidence such as blood/urine screening. (Franz 2023, Kautzky et al 2022, Gastaldon et al 2023, NICE 2023, Thomas et al, 2017).

Neonatal medication withdrawal observations should be recorded on the baby's Epic chart in the Flowsheets search 'withdrawal' (Appendix 8).

- If a symptom is present, score 2, if not score 0 (there is no score of 1)
- Record one score for each section
- If possible, document the score one hour after a feed

- Document the score 3-4 hourly, after two consecutive scores of 6 or more, document the score 2 hourly and inform the paediatric team
- Following two consecutive scores of 8 or above, inform the paediatric team and request a review of the infant – as pharmacological intervention may be indicated.

Thames Valley & Wessex Neonatal Abstinence Syndrome Guideline (2023)

On discharge an information list of symptoms of neonatal medication withdrawal should be provided to the care givers via the baby's EPR record (Appendix 9). If the care givers have any concerns, they should call the MAMA's line – 0300 013 2004.
This can be printed if the individual does not have the Frimley health app.

## 2. Care Pathways

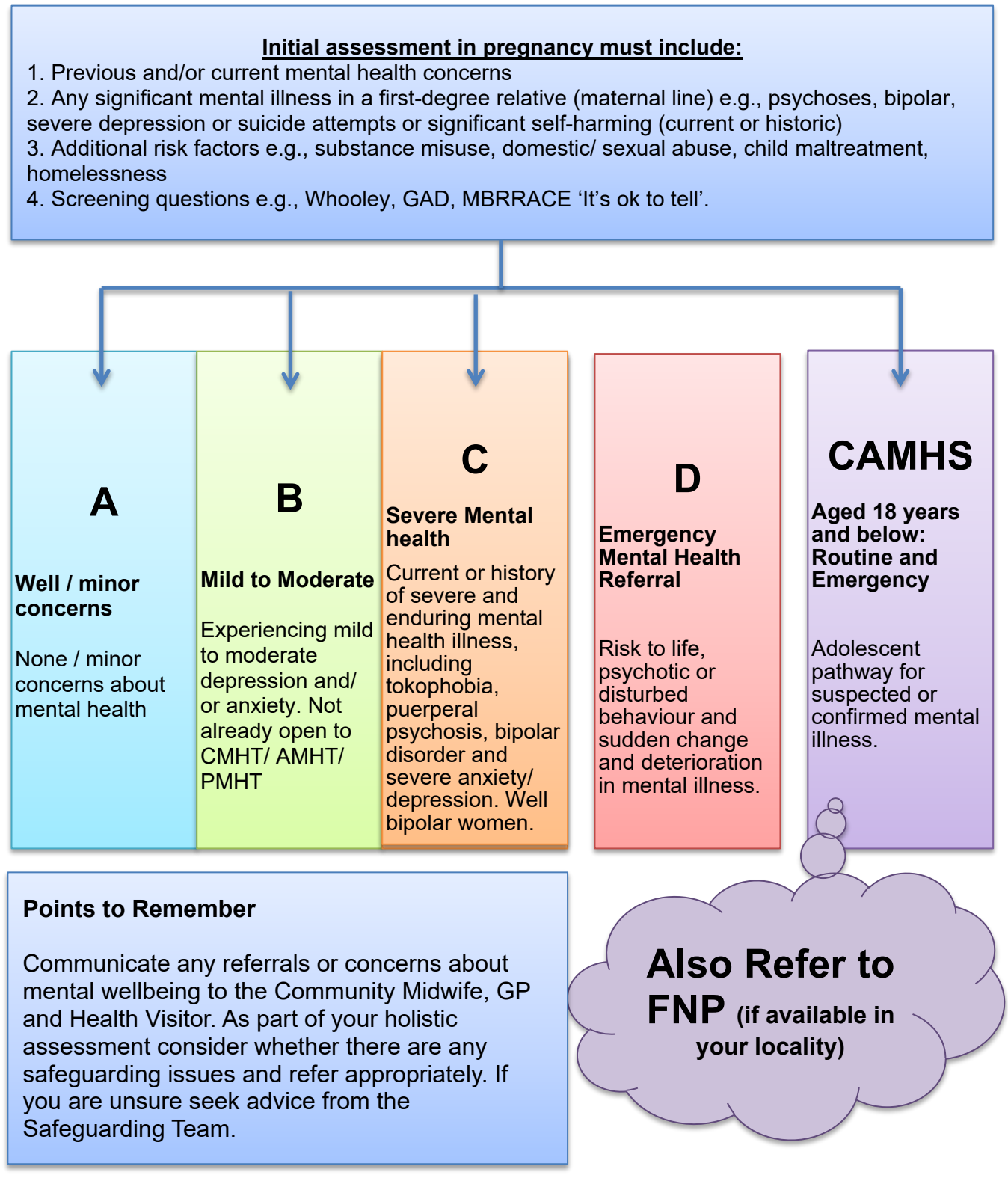
Upon identifying the diagnostic information, the midwife will need to agree with the woman and her family the appropriate care pathway.

If emailing the PNMH MWs, please contact the appropriate one for the intended hospital for birth and use the generic email only. This ensures absence cover is provided.

**Frimley Park Hospital**
Perinatal Mental Health Midwives
Maternity Department, Frimley Park Hospital
0300 6139339 or ext. 139339
Mobile: 0772 123 7434
Email: fhft.pmhmidwives@nhs.net

**Wexham Park Hospital**
Perinatal Mental Health Midwives
Maternity Department, Wexham Park Hospital
0300 6152369 or ext. 152369
Mobile: 0778 986 8268
Email: fhft.pmhmidwivesHWPH@nhs.net

See information pages on the maternity FHFT website and FHFT Intranet pages for contact numbers for all mental health service across the FHFT integrated care system (ICS) across the different counties.




## 2.1 Pathway A

Women who are well or have a minor history of mental health problems with no on-going concerns follow local care pathways for maternity.

If at booking, the Whooley Questions/ GAD screening have not highlighted mood or mental health concerns but at subsequent contact, the woman, midwife and/or the obstetrician, develop concerns about her psychological well-being, these should be

discussed with the woman and advice sought from the PNMH MW, GP or PMHS. Consideration should be given to move to pathway B, C or D as appropriate.

### 2.2 Pathway B

Women with pre-existing mental health problems which are deemed to be mild or moderate and under the care of the GP, may remain under midwife led care. Move to pathway C or D if symptoms worsen.

### 2.3 Pathway C

Women who report current or historical severe mental health illness, psychotic illness, previous admissions to psychiatric ward and/or are currently in the care of mental health professionals (CMHT/ AMHT/ PMHS).

**FPH:** Identify at booking if there is a need for specialist mental health care and indicate this requesting consultant led care. The booking will then be forwarded to the PNMH MWs to be triaged.

All women with a history of a severe psychiatric disorder, postpartum or non-postpartum, should be referred to PMHS who will offer assessment, advice and treatment. This can be completed at the point of booking by the booking midwife, GP or health visitor.

Any of the following, should lead to referral - with agreement of the woman - alongside the completion of a maternity concern form in order to communicate with health professionals:

- Women with a diagnosis of bipolar, even when well.
- History of post-partum psychosis.
- Severe anxiety / depression / OCD / phobia (including tokophobia) – where there may be suicidal thoughts / self-harm / significant impact on level of functioning.
- Any mental health condition where there are significant concerns regarding the mother / infant relationship, such as estrangement from baby.
- Personality disorders where there are clear concerns regarding the mother / infant relationship.

**WPH:** Identify at booking: Women with moderate to severe Mental Health including history of severe Mental Health should be given a choice of Referral to Crystal Team. Women with mild or history of mental health issues, or those declining Crystal Team care will remain under the care of the Community Midwife.

**Women with the following MH issues should be referred to MH services with consent:**

- Women with a diagnosis of bipolar, even when well.
- History of post-partum psychosis.
- Severe anxiety / depression / OCD / phobia (including tokophobia) – where there may be suicidal thoughts / self-harm / significant impact on level of functioning.
- Any mental health condition where there are significant concerns regarding the mother / infant relationship, such as estrangement from baby.
- Personality disorders where there are clear concerns regarding the mother / infant relationship.
- History of psychosis or in-patient psychiatric admission

**Request for PNMH MW input after booking**

Complete a referral via EPIC by creating an order. Search for Perinatal Mental Health, complete the form ensuring you select the hospital to which the person is booked to birth and what type of advice/action is appropriate.

The PNMH MW from the appropriate hospital base will respond or action.

This is identical for inpatient or outpatient settings. It is not an emergency/crisis response, please see pathway D in these cases.

**Referral to PMHS**

Referral to the Perinatal Mental Health Service (PMHS) should be made electronically via an 'nhs.net' account using the correct referral form and sent to the appropriate email address. Some areas overlap; therefore, a telephone call should be made to the service to ensure the correct referral is completed. Criteria for the services are on the maternity shared drives for each hospital site.

Blank electronic PMHS referral forms can be found on your local SHARED drive.

Referrals should be discussed with the woman and her consent for referral gained. Discussion concerning referral should include ensuring the woman is aware of the team's specialist role, the capacity to work in conjunction with any existing community mental health team (CMHT) and that referral should result in her being contacted within 14 working says (NICE, 2020), either:

- To provide advice
- To arrange a one-off visit
- To arrange a 'plan of action' with further follow-up if required
- To undertake a review of medication to ensure it is suitable for use in pregnancy/postpartum/breastfeeding
- Or to confirm that action is not required at this time.

**When a PMHS referral is deemed appropriate and is declined by the woman, it is essential the reasons are explored and documented, and the woman given the option to change her mind at any point during the perinatal period. It is recommended, even when a woman is reluctant to see a mental health professional, GP, midwife or obstetrician, specialist psychiatric advice should be sought, particularly in cases where a history of severe mental illness is apparent. Discussion with the perinatal mental health specialist midwife should take place. The discussion will be followed by a professional meeting with the core group professionals looking after the woman. The meeting will be chaired by the appropriate PMHS or PMH Specialist Midwife.**

### 2.4 Pathway D

Treatment and management of acute antenatal / postnatal psychiatric emergency – See Appendix 3 & 4

**Red Flag Questions:**

1. Do you have new feelings and thoughts which you have never had before, which make you disturbed or anxious?
2. Are you experiencing thoughts of suicide or harming yourself in violent ways?
3. Are you feeling incompetent, as though you can't cope, or estranged from your baby?
4. Are these feelings persistent?
5. Do you feel you are getting worse?

MBRRACE-UK 2015 & 2022

If a woman answers YES to any red flag questions, initiate immediate referral to the appropriate specialist perinatal mental health service for her area and consider if she also requires an urgent psychiatry referral.

PMHS and PNMH Midwives are not an emergency service but can advise within working hours.

**Obstetric / midwifery assessment prior to urgent psychiatry referral**

Midwives should ensure they review the information available regarding a woman's mental health history and diagnoses prior to the contact.

**Consider the following:**

- Does the woman have a diagnosis?
- Read any information, history or mental health care plans for this woman paying attention to early warning signs.
- If 'one-to-one' care is required, please contact the relevant bleep holder for support
- The well-being of the baby and any other children involved? (Refer to local trust safeguarding policy)
- Is the woman is displaying any of the following:
  - abnormal mood states (high or low)
  - abnormal beliefs
  - abnormal experiences (hallucinations etc.)

- abnormal behaviour
- talk of self-harm

If the answer to any of these is YES, this may be a psychotic episode.

- Is the woman's family concerned?
- Is there is a previous history of similar episodes?

Keeping mum and baby together must remain a priority. If there is a need to find a mother and baby mental health unit bed (MBU), use the Capacity Planning and Monitoring system https://perinatal.cpms.necsu.nhs.uk/ to check nationwide availability to aid discussion with the family.

In the community setting call the appropriate mental health crisis line and GP to respond or call 999 for emergency services if imminent harm likely.

In the hospital bleep the psychiatric liaison service. The response time in maternity in emergency situations is the same as for the emergency department

### 2.5 CAMHS

CAMHS runs alongside pathways A, B, C & D according to individual need.

## 3. Postnatal Management

Follow any care plan in place – this will be uploaded to the media section in Epic.

Where a plan has not been formulated, or an existing plan does not appear to be appropriate or adequately meeting individual needs, advice may be sought from the PNMH MW and non-urgent advice may be sought from PMHS in conjunction with her obstetric consultant, while she remains in hospital or GP if she is at home.

Postnatal care, in any setting, should include clear documentation of the following at each face-to-face contact:

- Emotional wellbeing
- Review of risk factors and diagnoses
- The opportunity for the mother to discuss her birth experience in relation to her expectations
- Reflection upon the family's transition to parenthood
- The mother's relationship with and care of her baby
- Discussion of feeding, sleeping and crying patterns including the extent to which the mother considers her baby irritable, fussy, and difficult to console.
- ICON Head Trauma https://www.hampshiresafeguardingchildrenboard.org.uk/toolkits/abusive-head-trauma/
- **Be aware of the Red Flag Symptoms (MBBRACE-UK 2022)**

## 4. Roles and Responsibilities

This guideline applies to all clinical staff employed or contracted to Frimley Health NHS Foundation Trust, who provide care to women in the maternity setting. All midwifery and obstetric staff have a responsibility to ensure that they are aware of this guideline and its contents. It should be clearly documented in the individual's medical record, any reason for non-compliance with the recommendations detailed in this guideline. It is the responsibility of department managers, consultants, team leaders and education leaders to ensure staff are aware of this guideline.

## 5. Related Trust Policies

Frimley Health NHS Foundation Trust policies may vary across the different sites, but all sites will hold local policies relating to:

- Substance misuse
- Safeguarding
- Neonatal withdrawal
- Domestic abuse
- Care of babies of women on antidepressants and/or antipsychotics
- Mental capacity act
- Detention under the Mental Health Act
- Rapid tranquilisation

## References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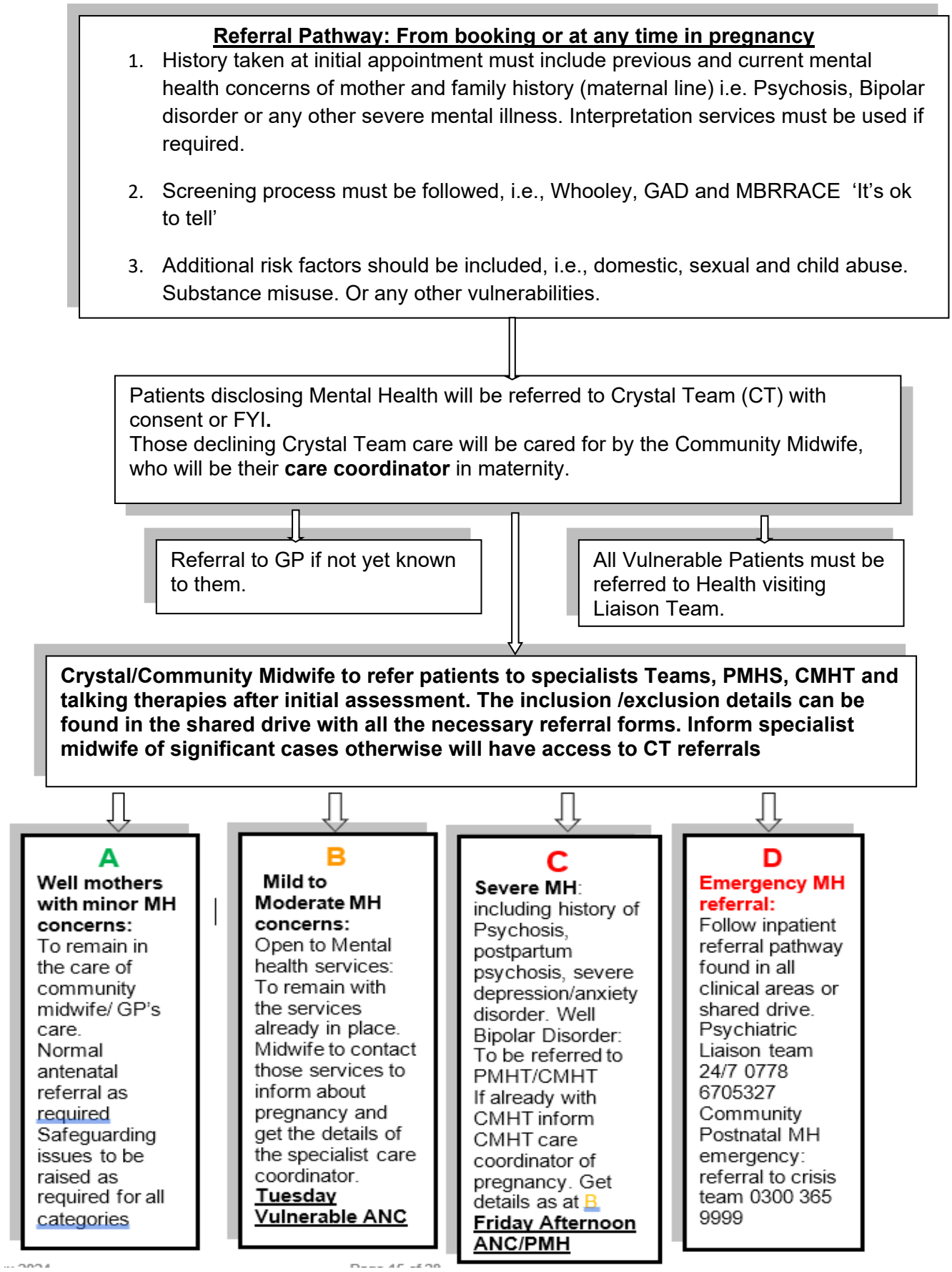
Thomas, E. *et al.* (2017) 'Variation in the management of SSRI-exposed babies across England', *BMJ Paediatrics Open*, 1(1), article number e000060. Available at: https://doi.org/10.1136%2Fbmjpo-2017-000060

## Appendix 1: Referral pathway - Wexham Park Only



## Appendix 2: Referral pathway - Frimley Park Only

**Referral Pathway: From booking or at any time in pregnancy**

4. History taken at initial appointment must include previous and current mental health concerns of mother and family history (maternal line) i.e. Psychosis, Bipolar disorder or any other severe mental illness. Interpretation services must be used if required.
5. Screening process must be followed, i.e., Whooley, GAD and MBRRACE 'It's ok to tell'
6. Additional risk factors should be included, i.e., domestic, sexual and child abuse. Substance misuse. Or any other vulnerabilities.

**Community Midwife to refer patients to specialist Teams, PMHS, CMHT and talking therapies after initial assessment. The inclusion /exclusion details can be found in the shared drive with all the necessary referral forms. Inform PMH MW of significant cases'**

**A**

**Well mothers with minor MH concerns:**
To remain in the care of community midwife/ GP's care.
Normal antenatal referral as required
Safeguarding issues to be raised as required for all categories

**B**

**Mild to Moderate MH concerns:**
Open to Mental health services or deterioration of mental health in pregnancy: To remain with the services already in place.
Midwife to contact those services to inform about pregnancy and get the details of the specialist care coordinator.

**If high moderate to be seen by PMH MW**

**C**

**Severe MH**: Tokophobia, including history of Psychosis, postpartum psychosis, severe depression/anxiety disorder. Well Bipolar Disorder:
To be referred to PMHT/CMHT
If already with CMHT inform CMHT care coordinator of pregnancy. Get details as at B

**To be seen in PMH MW clinic or PMH Obstetrician clinic (if not under another specialty consultant)**

**D**

**Emergency MH referral:**
Follow inpatient referral pathway found in all clinical areas or shared drive.
Psychiatric Liaison team 24/7 **Ext 13 6215 Bleep 5255**
Community Postnatal MH emergency: referral to crisis team
**Surrey & Hants 0300 456 8342**

**Berkshire 0300 365 9999**

## Appendix 3: MH Emergency Pathway - WEXHAM PARK

### Maternity Pathway for Emergency Inpatient Psychiatric Review

Mental health concern identified by maternity staff.

1. Call Liaison Team to make a referral. Please have all relevant clinical details to hand.
   Mobile: 07786705327
2. Email Sebensia Barnett (Perinatal Mental Health Midwife) to ensure she is aware of the patient.

Referral to EBPM should be made via Epic

**Emergency** (possible psychosis)

Liaison Practitioner to attend the ward as soon as possible.

Escalate via information in blue box below if does not occur.

**Urgent**

Liaison Practitioner to attend the ward within 24 hours.

Liaison Practitioner to seek advice from BHFT Perinatal Team (Gateway)
Tel: 0300 365 2000

- Liaison Practitioner and Perinatal Team to agree management plan and update maternity staff.
- This plan should be clearly documented in the clinical notes (Epic) with clear guidance and contact numbers for if further advice and support is required.
- Ward staff to contact Matron/Manger on Call to discuss ward staffing requirements based on the outcome of individual assessments.

If you are unable to speak with the liaison staff or review is not available within the set timeframes please call
Berkshire Mental Health Crisis Resolution Home Treatment Team
0800 129 9999, select option 2
Berkshire Health Foundation Trust Director on Call via Prospect Park switchboard
0118 960 5000

**Appendix 4: MH Emergency Pathway - FRIMLEY PARK**

Emergency Mental health concern identified by maternity staff

1) If **inpatient** call PsychLiaison Team to make a referral. Please have all relevant clinical details to hand **Tel: 0300 613 6215 / Bleep 5255**
2) If **in community** call the MH Crisis Team for the area: **Surrey & NE Hampshire 0300 456 8342 – Berkshire 0800 129 9999**
3) Email the Perinatal Mental Health Specialist Midwife to ensure she is aware of the patient – **fhft.pmhmidwives@nhs.net**.
4) Inform the senior MW on call – bleep 5399

**Emergency**
(Possible Psychosis)
Liaison Practitioner to attend ward within 1 hour
Escalate via information in Blue box below if does not occur.

**Urgent**
Liaison Practitioner to attend the ward within 4 hours

**Routine**
Liaison Practitioner to attend ward within 24 hours

Liaison Practitioner to seek advice from appropriate Perinatal Mental Health Service & if needed arrange admittance to mental health unit (preferably MBU)

- Liaison Practitioner and PMHS to agree management plan and update maternity staff
- This plan should be clearly documented in patients EPR with clear guidance and contact numbers for if further advice and support is required.
- Ward staff to contact Matron/Manager on call to discuss ward staffing requirements based on the outcome of individual assessments.

If you are unable to speak with the psychiatric liaison staff or review is not available within the set timeframe please call Melbury Lodge Mother and Baby Mental Health Unit for interim advice Tel: 01962 897711

## Appendix 5 – Mental Health Services Contact details

**Perinatal Mental Health Service**
Melbury Lodge, Romsey Road, Winchester, SO22 5DG
Tel: 01962 897780
Email: SHFT.Perinataloutreach@nhs.net

**Mother and baby Unit**
Melbury Lodge, Romsey Road, Winchester, SO22 5DG
Tel: 01962 897711

**Acute Mental Health Teams/Crisis Teams:**

North Hampshire Team
(Parklands, Basingstoke)
01256 316300/ 01256 817718

North East Hampshire and Farnham
(Aldershot Centre for Health)
0300 4568342

Surrey
0300 456 8342

Berkshire
0300 365 9999

Buckinghamshire
01865 902000

Alternatively call 111

**Psychiatric Liaison Services**
Frimley Park Hospital - Psychiatric Liaison Team bleep #5255 (24/7 service)
Wexham Park Hospital – Psychiatric Liaison Team – contact through switchboard

## Appendix 6 – Sources of Support

**See Intranet pages –** Patient Care → Maternity mental health support services

**Association for Post Natal Illness (APNI)**
Promotes research into postnatal illness. Runs a countrywide network of volunteers who have had and recovered from PND and provide one-to-one support for mothers currently suffering, throughout the illness and recovery period
Tel. 02073 860868 or www.apni.org

**Meet a Mum Association**
Aims to provide friendship and support to mothers and mothers-to-be
Tel. 0845 1203 746 (7pm – 1-pm weekdays only) or www.mama.org

**Mind**
Works with and for people suffering from emotional distress – developing locally based services and a providing a national information line. Tel. 0845 766 0163 or www.mind.org.uk

**Triumph Over Phobia (TOP UK)**
A network of support groups for people with phobias and obsessive-compulsive disorder
Tel. 0845 600 9601 or www.triumphoverphobia.com

**The Manic Depression Fellowship**
Works to enable people affected by manic depression to take control of their lives
Tel. 02077 932600 or www.mdf.org.uk

**The Mental Health Foundation**
Pioneers new approaches to prevention, treatment and care. Also works to reduce stigma and educate policy makers and health professionals.
Tel. 02078 031100 or www.mentalhealth.org.uk

**The Birth Trauma Association**
Provides women who are traumatised by childbirth or suffering from postnatal Post Traumatic Stress Disorder with basic advice and support.
www.birthtraumaassociation.org.uk or enquiries@birthtraumaassociation.org.uk

**Hampshire Lanterns**: www.HampshireLanterns.com

**Maternal Mental Health Alliance** https://maternalmentalhealthalliance.org/

**Perinatal Positivity** https://perinatalpositivity.org/

**PANDAS Foundation** http://www.pandasfoundation.org.uk/

**Action on Postpartum Psychosis** https://www.app-network.org/

**Wessex Healthier Together** https://what0-18.nhs.uk/

**ICON (preventing abuse head trauma)**
https://www.hampshiresafeguardingchildrenboard.org.uk/toolkits/abusive-head-trauma/

Appendix 7 – page 1

# Perinatal MH Medications– clinicians quick guide

## Anti-depressants & anti-anxiolytics

- Citalopram/escitalopram, Fluoxetine, Sertraline, Mirtazapine, Duloxetine, Amitriptyline
- Paroxetine
- Venlafaxine

| Pregnancy | Breastfeeding | Antenatal Care | Postnatal Care Mother | Postnatal Care Baby |
|---|---|---|---|---|
| | | Remind GP to review medications | GP MH assessment at 6-8 week check | **Minimum of 24 hours withdrawal observations – followed by 1 set when at home by CMW on following day** |
| Increased chance heart malformations | | Remind GP to review medications | GP MH assessment at 6-8 week check | |
| | Increased amounts in breastmilk | Remind GP to review medications | GP MH assessment at 6-8 week check | |

**Use caution when there is polypharmacy**

**Quick guide MUST be used in conjunction with the WHOLE guideline (N.B. not all medications are listed)**



Legend - Safer | Caution | High Risk

# Perinatal MH Medications– clinicians quick guide

## Anti-psychotics

| | Pregnancy | Breastfeeding | Antenatal Care | Postnatal Care Mother | Postnatal Care Baby |
|---|---|---|---|---|---|
| • Quetiapine, lamotrigine, Aripiprazole, Olanzapine, Diazepam, Risperidone, Lorazepam etc. | | | Remind GP to review medications.<br>GTT.<br>Serial growth scans from 32 weeks | GP MH assessment at 6-8 week check | **72 hours withdrawal observations – Paed review if earlier discharge requested by parents** |
| • Lithium | Increased chance heart malformations | Increased amounts in breastmilk & lithium toxicity | Lithium levels each trimester.<br>Fetal Heart scan.<br>GTT.<br>Serial growth scans.<br>**Mental health birth care plan.** | Lithium levels at 6 hours and 24 hours.<br>Inform MH teams of birth<br>GP MH assessment at 6-8 week check | **Paed at birth.**<br><br>**72 hours withdrawal observations.**<br>**Paed NIPE.**<br><br>**Lithium levels.** |
| • Sodium Valproate | Increased chance fetal abnormality | Increased amounts in breastmilk.<br>Affect on liver enzymes and platelets | Fetal Medicine appointment.<br>GTT.<br>Serial growth scans.<br>Fetal Heart scan.<br>**Mental health birth care plan.** | Inform MH teams of birth<br>GP MH assessment at 6-8 week check | **Paed at birth.**<br><br>**72 hours withdrawal observations.**<br><br>**Paed NIPE.** |

**Use caution when there is polypharmacy**

**Quick guide MUST be used in conjunction with the WHOLE guideline (N.B. not all medications are listed)**

Legend - **Safer** | **Caution** | **High Risk**

## Appendix 8 – Example Neonatal Withdrawal observation chart on EPR

| Withdrawal Syndrome | |
|---|---|
| Hypertonia | |
| High Pitched Cry | |
| Jitteriness/Tremor - Undist... | |
| Jitteriness/Tremor - Disturbed | |
| Sleep/Wake Pattern | |
| Pyrexia | |
| Respiratory Symptoms | |
| Projectile Vomiting | |
| Loose Watery Stool | |
| Neonatal Withdrawal Score | |

Neonatal medication withdrawal observations should be recorded on the baby's Epic chart in the Flowsheets – search 'withdrawal'.

- If a symptom is present, score 2, if not score 0 (there is no score of 1)
- Record one score for each section
- If possible, document the score one hour after a feed
- Document the score 3-4 hourly, after two consecutive scores of 6 or more, document the score 2 hourly and inform the paediatric team
- Following two consecutive scores of 8 or above, inform the paediatric team and request a review of the infant – as pharmacological intervention may be indicated.

Thames Valley & Wessex Neonatal Abstinence Syndrome Guideline (2023)

## Appendix 9 – Neonatal Withdrawal Symptoms Information for Care Givers

### Symptoms of Neonatal Withdrawal from maternal medication

The incidence of withdrawal symptoms from maternal mental health medications is rare, ranging from 1.26-2.26% depending on the type and number of different medications taken (Gastaldon et al 2023). Symptoms may occur between birth and up to 7 days postnatal (Thames Valley & Wessex Neonatal Abstinence Syndrome Guideline (2023).
Please be aware symptoms of illness in the neonate may also have other clinical causes, i.e., infection. It must not be presumed mental health medications are the cause without clinical evidence such as blood/urine screening. (Franz 2023, Kautzky et al 2022, Gastaldon et al 2023, NICE 2023, Thomas et al, 2017).

If the baby is showing the below symptoms, please call the MAMAs line on **0300 013 2004** for advice.

**HYPERTONIA**
- Persistent hypertonic (stiff) posture, hyperflexion/ hyperextension or extended stretch position

**HIGH PITCHED CRY**
- An excessive or persistent high-pitched cry which is not resolved by a reduction in stimuli (bright lights, lots of interaction), swaddling or cuddling, skin to skin and responding early to infant cues

**JITTERINESS/TREMOR**
- a shaking which lasts longer than

**SLEEP/WAKE PATTERN**
- Falls asleep within an hour after a good feed

**FEEDING**
- Excessive hunger and sucking which causes overfeeding (more than 220ml/Kg/day)

**PYREXIA>38ºC**
- exclude other causes, e.g., too many blankets or close to heat source

**RESPIRATORY SYMPTOMS**
- Tachypnoea>60 breaths per minute
- Recession
- Nasal flaring

**PROJECTILE VOMITING**

**LOOSE WATERY STOOLS**

Thames Valley & Wessex Neonatal Abstinence Syndrome Guideline (2023)

## Full version control record

| | |
|---|---|
| **Version:** | 4.0 |
| **Guidelines Lead:** | Liz Hopkinson – Lead Perinatal Mental Health Midwife, Frimley Park Hospital |
| **Contributor:** | Seb Barnett – Lead Perinatal Mental Health Midwife, Wexham Park Hospital |
| **Lead Director / Chief of Service:** | Miss Anne Deans, CoS for Obstetrics & Gynaecology |
| **Library check completed:** | 22 April 2024 |
| **Ratified at:** | Cross-site Obstetrics Clinical Governance meeting, 30 July 2024 |
| **Date Issued:** | 1 August 2024 |
| **Review Date:** | July 2027 |
| **Pharmaceutical dosing advice and formulary compliance checked by:** | Ruhena Ahmad, Lead Pharmacist for Women and Children, 1 August 2024 |
| **Key words:** | Perinatal mental health |

This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

### Version History

| Version | Date | Guideline Lead(s) | Status | Comment |
|---|---|---|---|---|
| 1 | May 2016 | Debbie Wilde<br>Ian Jones | Final | Due for review and update May 2019 |
| 2 | March 2019 | Liz Treen<br>Kate Pampin-Cao<br>Seb Barnett | Final | Due for review and update 2022 |
| 3 | May 2023 | Liz Hopkinson<br>Seb Barnett | Final | Due for review and update 2026 |
| 4 | May 2024 | Liz Hopkinson<br>Seb Barnett | Final | Updated due to new evidence and national guidelines.<br>Due for review and update 2027 |

### Related Documents

None