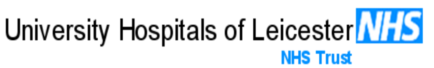
Mental Health - Antenatal and Postnatal UHL Obstetric Guideline



Trust ref: C18/2011

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1. Introduction and Who Guideline applies to

This guideline applies to obstetric, midwifery and psychiatric staff working within the Maternity Service.

Background:

Pregnancy has been described as a developmental phase when a woman or person acquires a representation of self as a mother and a sense of ability to perform mothering behaviours whilst they develop an emotional tie to the child. A disruption of this process by mental health disorders may have consequences for the mother, infant and other children.

Depression and anxiety are recognised as the most common mental health problems during pregnancy, with around 12% of pregnant women/people experiencing depression and 13% experiencing anxiety at some point; many will experience both.

Depression and anxiety also affect 15-20% of birthing women and people in the first year after childbirth. During pregnancy and the postnatal period, anxiety disorders, including panic disorder, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and tokophobia (an extreme fear of childbirth), can occur on their own or can coexist with depression.

Psychosis can re-emerge or be exacerbated during pregnancy and the postnatal period. Between one and two pregnant or postnatal women and people in 1000 will require admission with puerperal psychosis.

Women and people who have had a past episode of severe mental illness following birth have a 1 in 2 to 1 in 3 chance of recurrence.

The aim of this guideline is to promote early identification of women and people who are at risk or who are ill and outline care pathways for these women and people.

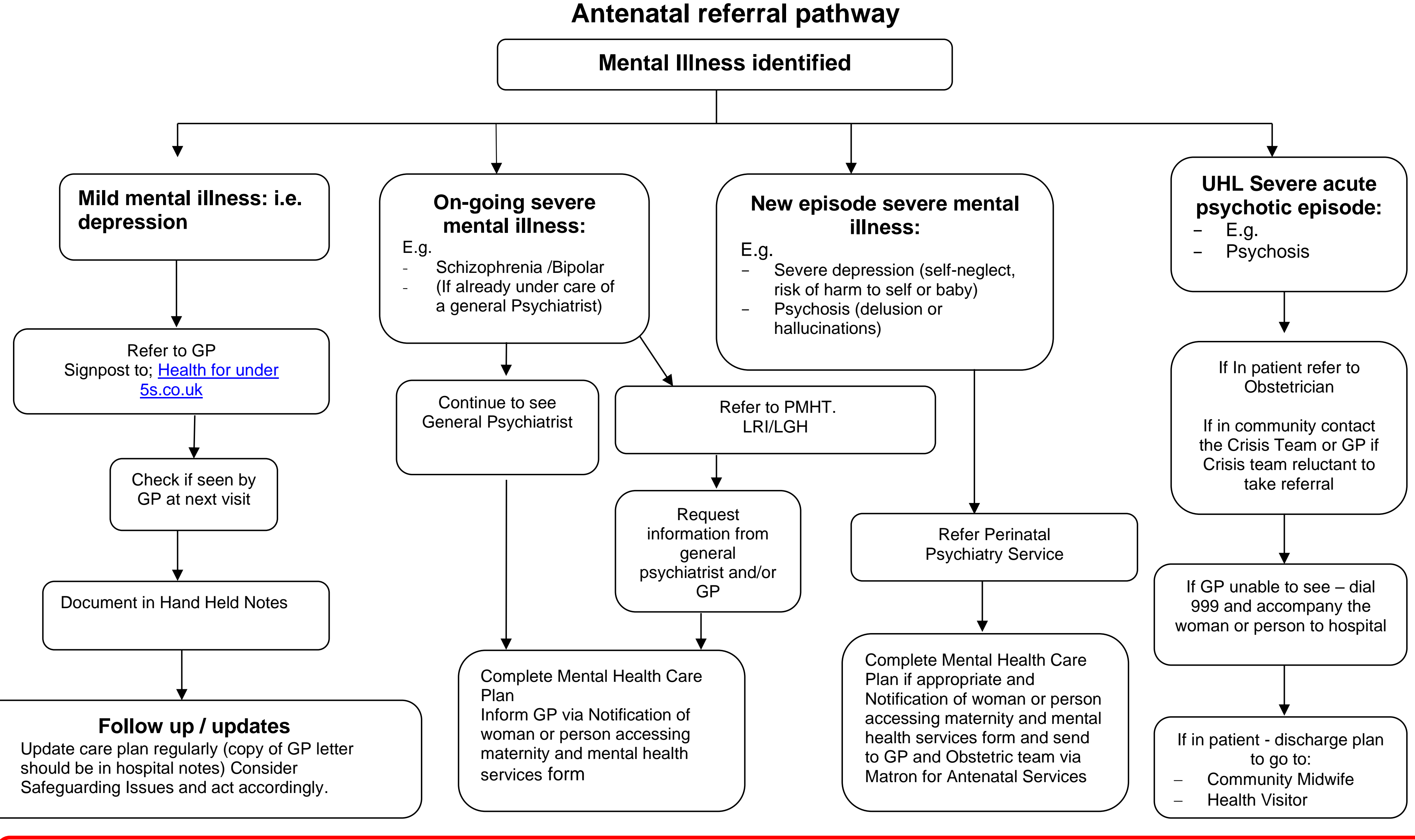
The MBRRACE UK: Saving Lives, Improving Mothers' Care 2019 identified Maternal suicide as the fifth most common cause of death during pregnancy and immediately afterwards, but is the leading cause of death over the first year after pregnancy.

The Department of Health's Maternal Mental Health Pathway (2012) recognises the essential contributions of partners in midwifery and mental health, and it endorses joint working and an integrated approach to service delivery. Good communication and partnership working between all professionals involved will ensure that antenatal and postnatal maternal mental health is coordinated, systematic and documented.

A communication protocol has been developed to identify clear points of contact for staff within UHL and the Leicester Partnership NHS Trust (LPT). The proforma "Perinatal Mental Health Referral Form" (see Appendix 1) will assist staff to gather information that may be required, and can then be filed in the medical/pregnancy notes as a record of the outcome of discussions. The proforma has been designed for use both within UHL and LPT.

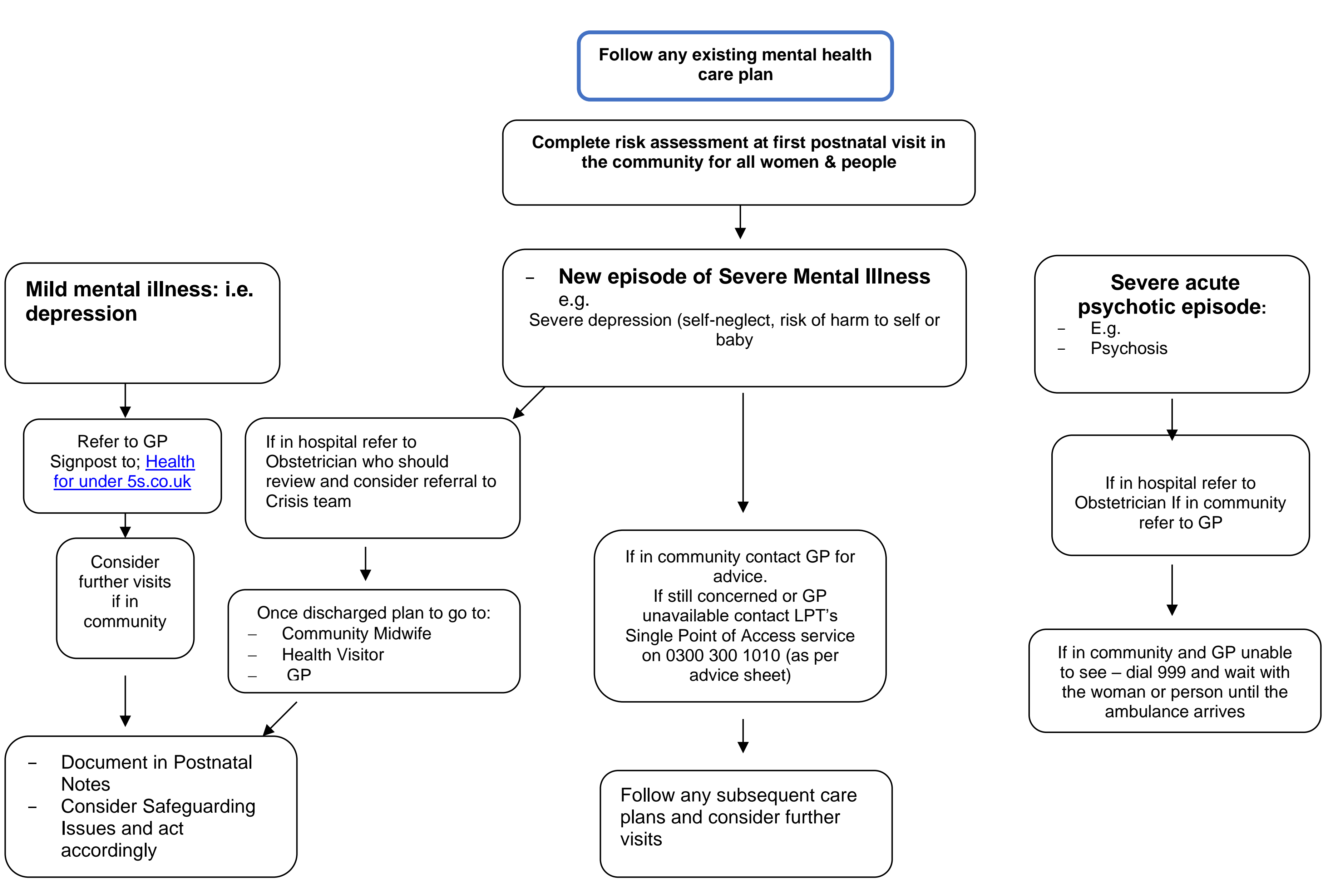
Any unbooked pregnant, birthing or postnatal woman or person requires a risk assessment

Antenatal referral pathway



Any pregnant woman or person on medication for their mental health MUST be referred to the joint Obstetric Perinatal Mental Health Clinic for review.

Postnatal referral pathway



2. Guideline recommendations:

2.1 Pregnant women and people with on-going serious mental illness who are under the care of a General Psychiatrist

- Pregnant women and people with on-going serious mental illness who are under the care of a General Psychiatrist should continue to be seen by them and also need to be referred to the Specialist Joint Mental Health Clinic.
- Pregnant women and people who are already being managed by a general Psychiatrist should continue to do so and should also have access to a Community Psychiatric Nurse in pregnancy. The general Psychiatrist is to do a direct referral to Perinatal Mental Health. Referral accepted via email to the Obsmentalhealth@uhl-tr.nhs.uk.
- Pregnant women and people who are already on medication for their mental health should be referred to the Specialist Joint Mental health Clinic and Perinatal Mental Health
- These women and people should be assessed at booking as high risk and a referral to the Specialist Joint Mental Health Clinic should also be made this can be identified by the Antenatal Core Midwives (see Booking Process and Risk Assessment UHL Obstetric Guideline).
- Pregnant people will be seen by either an obstetrician and or a midwife and a Perinatal practitioner dependant on their individual need. This clinic runs twice a week cross site at LRI and LGH weekly.
- Referral to be seen can be dependent on assessment of needs and can be as urgent as within a week but normally for a new booking, contact will be 16-20 weeks of pregnancy but can be as late as 24 weeks. Any referral can be accepted at any gestation up to expected due date or birth, but there is no current postnatal facility within this clinic.
- At the Specialist Clinic the Obstetrician should facilitate effective communication between the Psychiatrist and the Maternity Service by:
  - Dictating a letter to the Psychiatrist informing them of the woman's or person's pregnancy
  - Request further information regarding the pregnant woman or person's condition and treatment
  - Request a management plan for the antenatal, intrapartum and postnatal period
- An Intrapartum care plan should be completed for every woman or person and a Paediatric Alert Form sent for pregnant women and people who have been on medication in pregnancy or commence medication in pregnancy.

2.2 Pregnant women and people with a previous history of serious mental illness outside of pregnancy and currently not under the care of a Psychiatrist

- Pregnant women and people with a previous history of serious mental illness outside of pregnancy and currently not under the care of a Psychiatrist should be referred to the Perinatal Psychiatric Team.

- If a pregnant woman or person with a previous history of serious mental illness such as Schizophrenia, Bipolar Disorder, or severe depression outside of pregnancy is currently not under the care of a Psychiatrist, they should be referred to the Perinatal Psychiatric Team (Appendix 1). Pregnant women and people with a previous puerperal psychosis should also be referred to the Perinatal Psychiatric Team.

- Pregnant women and people with a history of previous serious mental illness, who are not under the care of a Psychiatrist, must be seen by the Perinatal Mental Health Team for a preliminary Assessment.

- The Psychiatrist will discuss their care plan and the likelihood of a recurrence if they are currently well.

- The referral should be made using the Perinatal Psychiatry Form and can be completed by the Community Midwife, Hospital Midwife, Obstetrician, GP or Health Visitor. The referral form is available on ICE.

- A management plan may be made by the Psychiatrist and documented in the health records. This may not be required in all cases, in which case information will be cascaded as in the point below.

- Information will be communicated to the hospital team and GP in the form of a letter or electronically on System One.

2.3 Pregnant women and people who have first degree female relatives with a history of serious mental illness (e.g. Psychosis, severe depression and severe anxiety)

- Pregnant women and people who have first degree female relatives with a history of serious mental illness should be referred to the Perinatal Psychiatric Team

- Pregnant women and people who have a first degree female relation (i.e. mother, sister) with serious mental illness such as Schizophrenia, Bipolar Disorder or severe depression are at risk of developing serious perinatal psychiatric disorder.

- A referral should be made using the “Perinatal Mental Health Referral Form” (appendix 1) and can be completed by the Community Midwife, Hospital Midwife, Obstetrician, GP or Health Visitor

- A management plan may be made by the Psychiatrist and documented in the health records in the form of a Perinatal Psychiatry Form. This may not be required in all cases in which case information will be cascaded as in the point below.

- There must be liaison between Perinatal Mental Health Team, Obstetricians and Specialist Midwife. This will be a one off appointment offered by the Joint Obstetric Perinatal Mental Health Clinic; referrals for this will be through the E3 booking pathway.

2.4 Detection

- All pregnant women and people will be assessed at booking, 28 weeks, 36 weeks and prior to discharge from hospital following delivery. They should also be asked a minimum of twice during the postnatal period. They should be asked if there has been any past or present serious mental illness (especially bipolar disorder, psychosis and severe depression) or family mental health issues and this should be documented on the relevant page in the hand held notes. If so they should be asked if they have seen a psychiatrist or had a hospital admission related to their mental illness. The mental health care pathway should be followed (pages 3 & 4)

- Case finding may be achieved with specific sets of questions (Whooley questions) as recommended in NICE guidelines (nice.org.uk/guidance/cg192/antenatal-and-postnatal-mental-health 2014, Updated 2020). These questions are:

  A During the last month, have you often been bothered by feeling down, depressed or hopeless?
  B During the last month have you often been bothered by having little interest or pleasure in doing things?
  C Is this something with which you would like help?

- These questions will be asked as above as a minimum and repeated if appropriate during the pregnancy and documented on the relevant page of the hand held notes.

- Postnatal women and people who have not had an antenatal risk assessment should be asked these questions in the postnatal period prior to discharge from hospital.

- The mental health care pathway will be followed if any problems are identified.

- Consider whether there are any safeguarding issues and if so complete the local safeguarding form.

- A "Perinatal Mental Health Referral Form" should be completed and emailed to the Perinatal Psychiatry Service for information purposes. Completed forms should be sent to: Perinatalreferrals@.nhs.net

- This should be documented in the health record and the woman or person informed.

2.5 Risk assessment referrals

- Pregnant women and people, who in response to the risk assessment have expressed concerns, should be referred to the GP and seen within 24 hours

- If the pregnant woman or person has answered yes to any of the questions when the risk assessment is made at booking or any other time they should be referred to their GP and seen within 24 hours and this should be documented in the health record.

- At the next follow up appointment the outcome of this referral should be documented in the health record and on System One.

2.6 Mild mental illness

- Pregnant women and people who have been diagnosed with a mild mental illness should be signposted to the Vitaminds service as a self-referral or speak to their GP - they will be assessed by a practitioner to ensure the best pathway provision and referral.
- Pregnant women and people who have mild mental illness including anxiety and/or depression should continue to be managed by the GP (seek specialist support if there any concerns).
- Where necessary there should be effective communication between the GP and the maternity service.
- The Community Midwife should be aware of the consultations with the GP and update the health records accordingly
- Pregnant women and people should be signposted where applicable to Birth Reflections, Clinical Psychology or any other specialised service (i.e. eating disorders service, needle phobia service)
- Your Maternity Service | Health for Under 5s- website comtains all the links for maternity services.

2.7 Other pre-diagnosed concerns

- Pregnant women and people should be signposted where applicable, to Birth Reflections, Clinical Psychology or any other specialised service (i.e. eating disorders service, needle phobia service, personality disorders services).
- Any pregnant woman or person who has a severe phobia, PTSD and primary/secondary tocophobia should be referred to the MMH team (hyperlink to referral form)

2.8 New episodes of severe mental illness

- Pregnant women and people who appear to have a new episode of severe mental illness should be referred to the Perinatal Psychiatric Team
- Pregnant women and people on risk assessment may demonstrate symptoms that may be concerning such as:
    - A change in behaviour from what is normal for them.
- A referral form (see Appendix 1) should be emailed to the Perinatal Psychiatric Team: perinatalreferrals@leicspart.nhs.uk.
- This should be done following discussion with the pregnant woman or person and with their agreement
- Concerns about the safety of the unborn child / other siblings will override maternal disagreement
- All discussions should be documented in the health record
- A mental health management plan may be made by the Psychiatrist and documented in the health records – This will be on a Perinatal Psychiatry Form. This may not be required in all cases in which case information will be cascaded and communicated appropriately and the form uploaded onto E3.

2.9 Suspected severe psychotic episode

Pregnant/birthing/postnatal women and people with a suspected severe psychotic episode should be assessed as soon as possible by the Perinatal Psychiatrist Team and / or a General Psychiatrist. If they are in the community they should be assessed as soon as possible by the Crisis Team or the GP or the Central Access Point (CAP). (0808 8003302 or 0300 3001010 for crisis team out of hours & perinatal mental health team Mon-FRi 01162256846)

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Inpatients:

- Where the pregnant/postnatal woman or person is currently an in-patient in hospital (other than Maternity) they should be referred to the Obstetrician if Obstetric review is required.
- The Clinician should assess and liaise with the Crisis team.
- Where the pregnant/postnatal woman or person is currently an in-patient within the Maternity Service they should be assessed by the Perinatal Psychiatric Team or if out of hours, via the General Psychiatric Team based at the LRI / LGH (see appendices 2 and 3 for contact numbers).

Community:

- Where the pregnant/postnatal woman or person is at home or in an outpatient setting the midwife should contact the Crisis Team and the GP for an urgent assessment.
- If the crisis team refuse the referral from a midwife the GP must be contacted to make the referral.
- If there are immediate concerns for the welfare of the pregnant woman or person and their unborn child / baby / other siblings or family members the Community Midwife should dial 999 and request urgent admission to the Emergency Department. They must remain with the pregnant woman or person until the ambulance arrives.
- All discussions should be documented in the health record.
- A management plan may be made by the Perinatal Psychiatrist / General Psychiatrist and documented in the health records in the form of a Perinatal Psychiatry Form. This may not be required in all cases in which case information will be cascaded.
- Pregnant/postnatal women or people with Psychosis should not be admitted to a maternity ward to await assessment or following assessment. The AMP (Advance Mental Health Practitioner) should either allow them home or admit to a mental health ward. If the pregnant/postnatal woman or person becomes psychotic as an inpatient, a discussion should take place between the psychiatrist and obstetrician as to where is best to provide treatment.

2.10 Communication between services & teams

- Communication between Mental Health and Midwifery / Obstetric staff must be effective particularly at the time of any admissions via local E3 network use and System one (safeguarding & mental health services) via letter which needs to be added to E3.

- All pregnant/postnatal women or people with a recognised mental health illness receiving care from the maternity service should notify the lead clinicians. They are:
    - The Specialist Midwife for Maternal Mental Health
    - The Obstetrician leading the Mental Health Clinic
    - The Perinatal Psychiatric Team
- If a pregnant/postnatal woman or person is already receiving on-going mental health care with a General Psychiatrist (and is not under the care of the Perinatal Psychiatry Team) there is a point of contact with the local Community Mental Health Team (see Appendix 3)
- If a pregnant/postnatal woman or person is an inpatient at the Bradgate Mental Health Unit there is a point of contact which in the first instance should be the Specialist Midwife for Mental Health (see Appendix 2)
- There is out of hours or urgent support available (see Appendix 3)

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- If a pregnant/postnatal woman or person with an existing mental health condition is admitted to Maternity services the Midwife in charge must contact the Bradgate Mental Health Unit to inform them of this (see Appendix 3)
- If a pregnant/postnatal woman or person presents on medication a conversation must be had between them and the GP about the risks and benefits of continuing the medication. The GP must liaise with the Perinatal Mental Health Team if unsure.

2.11 Safeguarding

- A local safeguarding form (AForm) will be completed and a referral made to the Children and Families Social Work Team if risk is identified following risk assessment. This will be done following discussion with the pregnant/postnatal woman or person and with their agreement. However, concerns about the safety of the unborn child/other siblings will override maternal disagreement. (Refer to safeguarding guidelines)

- A local safeguarding form should be completed only if risk has been identified following the risk assessment.

- The safeguarding team/ Social Services do not need to be contacted for every pregnant/postnatal woman or person with serious/ enduring mental illness.

- If routine referrals are made the pregnant/postnatal woman or person may become distressed and this may increase the risk of suicide.

- Pregnant/postnatal women or people also may have difficulty in engaging with maternity/ mental health services if they fear a referral will be made which in turn increases the risk as a result.

2.12 Declining treatment

- Where a pregnant adult patient has capacity to consent to or refuse treatment they should be informed of all of the risks and advantages of the treatment recommended to enable them to make a fully informed decision regarding their care. If following this they continue to decline treatment their wishes must be respected. There should be full documentation of the discussion around the decision making and the subsequent plan that is made should be documented in the patient records.

- In law, a fetus has no “legal personality” and therefore what is in the interests of the unborn child is not a relevant factor in purely legal terms.

- If a pregnant/postnatal woman or person is assessed at any contact by the health care professional and considered to not have the capacity to consent to treatment. Capacity can be assessed using the “Mental Capacity Consent Form (form 4) these forms are available on the labour wards, where a pregnant/postnatal woman or person is assessed as lacking mental capacity a referral should be made to the Mental Health Clinic and a safeguarding form completed. They will be treated as recommended by the Mental Capacity Act and in their “best interests”. This encompasses best interests from a purely medical perspective and the broader issues of the general welfare and wellbeing of the patient concerned. Advice should always be sought through the Trust’s legal services. (Mental Capacity Act UHL Policy)

- The liaison psychiatrist / obstetric team will consider requesting a psychiatric assessment from the appropriate mental health team:

  - The Crisis Team (to be seen within 4 hours)
  - The GP
  - The Perinatal Psychiatry
  - The on call Psychiatrist.

This can be done directly by the psychiatrist. This decision should involve the pregnant/postnatal woman or person. If they refuse and they appear unwell and /or is a risk to self or others an assessment under the Mental Health Act should be sought.

If admission is required, it is the responsibility of the adult mental health service to arrange this. (AMP) The midwife must escalate this to the on call obstetrician and on call team lead.

2.13 Postnatal care

- In the postnatal period, any mental health care plans made during pregnancy must be followed, and a repeated risk assessment should be performed at the first postnatal visit.

- The antenatal notes should be reviewed and any concerns or management plans for the postnatal period noted.

- Any care plan in place should be followed. Please ensure that ward referrals are sent at the point of delivery and NOT on discharge from the postnatal ward.

- Postnatal women and people with on-going mental health illness who are under the care of a General Psychiatrist must be seen by a registered mental health practitioner prior to discharge.

  - On discharge from the hospital the Community Midwife should be made aware of any mental health issues and details of the multi-disciplinary team involvement given by documenting in the postnatal diary. Community Midwife to contact perinatal mental health if required.

- Details will then be passed to the health visitor on transfer of care from the Community Midwife via the local handover form.

- At the first scheduled visit in the postnatal period and at least once more prior to discharge by the community midwife or by the health care professional postnatal women and people should be asked the following questions about their emotional wellbeing:

  A During the last month, have you often been bothered by feeling down, depressed or hopeless?’
  B During the last month have you often been bothered by having little interest or pleasure in doing things?
  C Is this something with which you would like help?

- This will be documented in the postnatal record.

- If the answer to these questions is yes and the postnatal woman or person requests help, the Community Midwife should advise them to see their General Practitioner at the earliest opportunity, notify the GP and document the discussion and actions taken in the postnatal record.

- Consideration should be given to offering further visits and an individualised plan of care should be made with the postnatal woman or person and documented.

- A local safeguarding form should be completed if following risk assessment there are any concerns.

3. Additional Resources

- vitahealthgroup.co.uk
- Pan-London Perinatal Mental Health: Guidance for Newborn Assessment
- Further information regarding medication can be found at the choiceandmedication website.
- health for under 5s.co.uk/pregnancy/

4. Education and Training

- Mental health training is mandatory for all Obstetricians and Midwives

- All Midwifery and Medical staff will have training and supervision as identified in the Training Needs Analysis. This should include:

- Knowledge of mental disorders

- Assessment methods

- Referral routes to enable them to follow care pathways.

5. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
Patient view of why they are coming and how they feel.	Audit	Specialist midwife	Annually	CMG Clinical Audit leads Community Midwifery Lead Consultant Lead
Patient attendance/DNA's	Audit	Specialist midwife	Annually	CMG Clinical Audit leads Community Midwifery Lead Consultant Lead

6. Supporting References

Antenatal and postnatal mental health (2014) NICE. London (updated 2020)

MBRRACE UK: Saving Lives: Improving Mothers Care - 20014-2016

Confidential Enquiries into Maternal and Child Health: Why Mother's Die. 2002-02.

7. Key Words

Mental Health, Perinatal Mental Health, Joint Obstetric Perinatal Mental Health Clinic, depression, anxiety, severe psychiatric condition, Pregnancy, Postnatal, Safeguarding

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The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

Development and approval record for this document			
Author / Lead Officer: Andrea Akkad - Consultant Obstetrician Lorraine Matthews - Specialist Midwife – Quality and Safety			**Executive lead:** Chief Nurse
REVIEW RECORD			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
11.04.13	V2	A Akkad and L Matthews	Well-being questions in antenatal period reduced to minimum of once at booking with additional questions as required
26.09.13	V3	M Tonks, L Payne, J Morrissey and L Matthews	Referral and communication pathways made clearer.
October 2016	V4	G Twist, T Singhal and L Matthews	Amendments in line with NICE 2015 guidance. Referral pathway made clearer
January 2021	V5	G Twist, L Robinson, H Archer, Dr Kumar and Dr Motsi	Statistics updated. Additional resources added. Phone numbers updated. Hyperlinks added.
April 2024	V6	G Twist	Added in clinic details and average/expected referral times. Updated references and statistics Replaced 'Lets Talk Wellbeing' with 'VitaMinds' Updated format and terminology throughout

Appendix 1 – referral form

PERINATAL MENTAL HEALTH REFERRAL FORM

☐ **Community Referral** ☐ **Maternity Ward Referral** **LGH / LRI Ward _____**

ALL INFORMATION REQUESTED IS REQUIRED. PLEASE COMPLETE **FULLY** IN **BLOCK CAPITALS**

Title:	Surname:	Preferred Language:
Forename:		Translator Needed: No
Address: Patient's Postcode:		Pregnant: Expected / Actual **date** of Delivery: (Antenatal) Expected **place** of delivery:
Dob:		GP Name
NHS No:		GP Address:
Patient's Phone No:		
Marital Status:		
Religion:		GP's Post code:
Ethnicity:		GP's Phone No:
Current Medication:		

Current Mental Health Concerns **(Please continue on separate sheet if necessary)**

URGENT

Consider: past history, family history of mental illness, alcohol and substance misuse, suicidal thoughts, attitude towards pregnancy, etc.

Referrer Name and Designation:	
Contact Address and Number:	**Postal Address:** Perinatal Mental Health Team Farm Lodge, C/O Bradgate Unit, Glenfield Hospital, LE3 9EJ **Tel. 0116 225 6846** **Email: Perinatalreferrals@.nhs.net**

Information for Clinicians:

Referrals are accepted for women or people who are registered with a GP in Leicester, Leicestershire and Rutland.

Referrals can be made by Healthcare professionals who include: GP's, Midwives, Health Visitors, Obstetricians and Mental Health Professionals.

We accept referrals for pregnant women and people and up to one year after childbirth who present with a current/previous history of:

- Schizophrenia
- Psychosis / Postpartum (Puerperal) Psychosis
- Bipolar Disorder
- Moderate to severe depression
- Anxiety disorders including OCD and PTSD
- Eating disorders or Personality disorder *with* severe impairment of day to day functioning
- Post-natal depression requiring contact with mental health services
- Several co-existing mental health diagnoses – complex cases
- Psychiatric Inpatient / Mother and Baby Unit Admission
- Serious mental illness who are considering pregnancy, for pre conception counselling

Women and people under care of secondary mental health teams, such as CMHT's, will be offered an assessment to determine if joint working is clinically indicated.

Exclusion Criteria

- Women and people with a condition which is of mild to moderate severity that could be managed within the Primary care services / IAPT
- Women and people with a primary diagnosis of substance misuse, learning disability or personality disorder, with the absence of a concurrent severe mental illness

Appendix 2 – INPATIENT CARE within either UHL Maternity Services or The Bradgate Mental Health Unit

Advice for staff when pregnant or post-partum women & people with a mental health illness are receiving INPATIENT CARE within either UHL Maternity Services or The Bradgate Mental Health Unit

When a pregnant or postpartum woman or person is admitted to the Bradgate Mental Health Unit, Leicestershire Partnership NHS Trust mental health staff must inform Maternity Services as detailed below.

- The central point of contact for midwifery services is the Specialist Mental Health Midwife in the first instance (Tel: 07717694373). When they are not available the central point of contact should be the Maternity bleep holder at LRI, who is available across 24 hours. The Maternity bleep holder will liaise with midwifery colleagues to inform them that the woman or person is under the care of mental health services, and will make the necessary arrangements for midwifery input.

- Telephone the Leicester Royal Infirmary switchboard on 0300 303 1573 and ask for the maternity bleep holder number 4001. For LGH the maternity bleep holder number is 3209.

- Please have the following information available: the patient’s name, due date (or how many weeks post-partum they are) and the contact details of their named midwife and midwifery team.

- Please do not ring the named midwife directly, as they may be unavailable and there may be a delay in your message being received.

- Usually after two weeks postpartum the lead professional will be the Health Visitor – in such cases, please call the Health Visitor Helpline on 0300 3000 007

When a pregnant or postpartum woman or person with a Mental health illness is admitted to UHL Maternity Services UHL Maternity staff must inform the Bradgate Mental Health Unit team.

- The central point of contact is the coordinator at the Bradgate Mental Health Unit, who is available across 24 hours.

- Telephone the LPT switchboard on 0116 225 6000 and ask for the Bradgate Unit Coordinator

- Each patient under the care of LPT will have a named worker who will be the contact point during admission. If on-going mental health care is appropriate, a named community worker will be identified.

Appendix 3 - Advice for community mental health service users around OUTPATIENT care

Contact details for Perinatal Psychiatry Services Users

- Please call the service on 0116 225 6846
- Please use the standard perinatal psychiatry Service referral Form for making referrals.
- For patients receiving on-going mental health care, (and who are not under the care of the Perinatal Psychiatry Service) the point of contact will be the local community mental health team (CMHT) as follows:
- Please ring the CMHT which you feel is likely to be closest to the patient's home address and ask for the duty officer or team manager. Subject to confirmation of identity, the CMHT will be able to inform you of the lead worker involved with the care of the woman or person.

City West 0116 295 3322
City Central 0116 295 7070
South Leicestershire 0116 225 5700
West Leicestershire 01455 443 950
Market Harborough 01858 445 450
City East 0116 294 3167
North West Leicester 01530 453 800
Rutland 01572 756 032
Charnwood 01509 553 900
Melton Mowbray 01664 504 202

- If the duty officer or team manager is unavailable, please leave the name and date of birth of the woman or person along with the reason for your enquiry and arrange to call the manager back. This will give the manager the opportunity to seek the information you need before you call again.

For out of hours or urgent support

- Out of hours, if you need to access emergency, crisis or urgent mental health assessment you can ring LPT's Single Point of Access to acute mental health assessment and recovery service on **0116 295 3060.**

OOH service for inpatient psychiatry patients

LRI – call switchboard and ask for on call psychiatry reg who is the CDR Doctor at LRI

LGH – call switchboard and ask for the EAST SPR on call for psychiatry and not the crisis team

Dr Kumar has discussed with the psychiatry team and no referrals should be deferred/declines. Please avoid calling the crisis team.

Patients at A&E should be seen directly by the psychiatry team and not accepted into maternity first. If they need admission, they will go to the Bradgate Unit until a mother and baby bed is identified outside of Leicester.

Dr Kumar Team: 0116 225 6846

perinatalreferrals@nhs.net

CAP: 0808 800 3302 (7 days a week, 24 hours a day)

For deaf patients they can use the NHS 111 British Sign Language Service available at https://interpreternow.co.uk/nhs111

Richmond House: 0808 800 3302

Vitaminds website and telephone can be found; https://www.vitahealthgroup.co.uk/nhs-services/nhs-mental-health/leicester-leicestershire-rutland/

Appendix 4 - TREATMENT

TCAs, SSRIs, (S)NRIs

- When choosing a tricyclic antidepressant (TCA), selective serotonin Re uptake inhibitor (SSRI) or (serotonin-) noradrenaline reuptake inhibitor [(S)NRI], take into account:
    - the woman or person's previous response to these drugs
    - the stage of pregnancy
    - what is known about the reproductive safety of these drugs (for example, the risk of fetal cardiac abnormalities and persistent pulmonary hypertension in the newborn baby)
    - the uncertainty about whether any increased risk to the fetus and other problems for the mother or baby can be attributed directly to these drugs or may be caused by other factors
    - The risk of discontinuation symptoms in the woman or person and neonatal adaptation syndrome in the baby with most TCAs, SSRIs and (S)NRIs, in particular paroxetine and venlafaxine.

- When assessing the risks and benefits of TCAs, SSRIs or (S)NRIs for a Woman or person who is considering breastfeeding, takes into account:
    - the benefits of breastfeeding for the mother and baby
    - the uncertainty about the safety of these drugs for the Breastfeeding baby
    - The risks associated with switching from or stopping a previously effective medication.
    - Seek advice from a specialist (preferably from a specialist perinatal mental health service) if there is uncertainty about specific drugs.

Benzodiazepines

- Do not offer benzodiazepines to women or people in pregnancy and the postnatal Period except for the short-term treatment of severe anxiety and agitation.

- Consider gradually stopping benzodiazepines in women woman or people who are planning a pregnancy, pregnant or considering breastfeeding.

Antipsychotic medication

- When assessing the risks and benefits of antipsychotic medication28 for a pregnant woman or person , take into account risk factors for gestational diabetes and excessive weight gain.
- When choosing an antipsychotic, take into account that there are limited data on the safety of these drugs in pregnancy and the postnatal period.
- Measure prolactin levels in women and people who are taking prolactin-raising Antipsychotic medication and planning a pregnancy, because raised Prolactin levels reduce the chances of conception. If prolactin levels are Raised, consider a prolactin-sparing antipsychotic.
- If a pregnant woman or person is stable on an antipsychotic and likely to relapse Without medication, advise them to continue the antipsychotic.

- Advise pregnant women and people taking antipsychotic medication about diet and monitor for excessive weight gain, in line with the guideline on weight management before, during and after pregnancy (NICE public health guidance).
- Monitor for gestational diabetes in pregnant women and people taking antipsychotic medication in line with the guideline on diabetes in pregnancy (NICE clinical guideline 63) and offer an oral glucose tolerance test.
- Do not offer depot antipsychotics to a woman or person who is planning a pregnancy, pregnant or considering breastfeeding, unless they are responding well to a depot and has a previous history of non-adherence with oral medication.

Anticonvulsants for mental health problems (valproate, carbamazepine and lamotrigine)

- Do not offer valproate for acute or long-term treatment of a mental health problem in women and people who are planning a pregnancy, pregnant or considering breastfeeding.
- If a woman is already taking valproate and is planning a pregnancy, advise her to gradually stop the drug because of the risk of fetal malformations and adverse neurodevelopment outcomes after any exposure in pregnancy.
- If a woman or person is already taking valproate and becomes pregnant, stop the drug because of the risk of fetal malformations and adverse neurodevelopmental outcomes.
- Do not offer carbamazepine to treat a mental health problem in women and people who are planning a pregnancy, pregnant or considering breastfeeding.
- If a woman or person is already taking carbamazepine and is planning a pregnancy or becomes pregnant, discuss with the woman or person the possibility of stopping the drug (because of the risk of adverse drug interactions and fetal malformations).
- If a woman or person is taking lamotrigine29 during pregnancy, check lamotrigine levels frequently during pregnancy and into the postnatal period because they vary substantially at these times.

Lithium

- Do not offer lithium30 to women and people who are planning a pregnancy or pregnant, unless antipsychotic medication has not been effective.
- If antipsychotic medication has not been effective and lithium is offered to a woman or person who is planning a pregnancy or pregnant, ensure:
  - the woman or person knows that there is a risk of fetal heart malformations
  - when lithium is taken in the first trimester, but the size of the risk is uncertain the woman or person knows that lithium levels may be high in breast milk with a risk of toxicity for the baby
  - lithium levels are monitored more frequently throughout pregnancy and the postnatal period.

- If a woman or person taking lithium becomes pregnant, consider stopping the drug gradually over 4 weeks if she is well. Explain to them that:

  - stopping medication may not remove the risk of fetal heart
  - malformations
  - there is a risk of relapse, particularly in the postnatal period, if they have bipolar disorder.

- If a woman or person taking lithium becomes pregnant and is not well or is at high risk of relapse, consider:

- switching gradually to an antipsychotic or stopping lithium and restarting it in the second trimester (if the woman or person is not planning to breastfeed and their symptoms have responded better to lithium than to other drugs in the past) or -
- continuing with lithium if they are at high risk of relapse and an antipsychotic is unlikely to be effective.

- If a woman or person continues taking lithium during pregnancy:
    - check plasma lithium levels every 4 weeks, then weekly from the
    - 36th week
    - adjust the dose to keep plasma lithium levels in the therapeutic range
    - ensure the woman or person maintains an adequate fluid balance
    - ensure the woman or person gives birth in hospital
    - ensure monitoring by the obstetric team when labour starts,
    - including checking plasma lithium levels and fluid balance because of the risk of dehydration and lithium toxicity
    - stop lithium during labour and check plasma lithium levels
    - 12 hours after their last dose.

Appendix 5 – MBRRACE-UK

Saving Lives, Improving Mothers' Care 2018:

Lay Summary

In 2014-16 **9.8** women per 100,000 died during pregnancy or up to six weeks after childbirth or the end of pregnancy.

Most women who died had multiple health problems or other vulnerabilities.

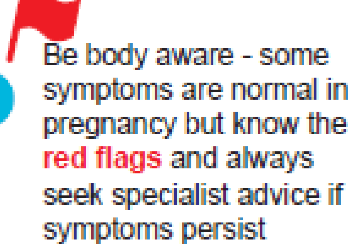
Balancing choices:

Always consider individual benefits and risks when making decisions about pregnancy

Things to think about:

Many medicines are safe during pregnancy

Continuing medication or preventing illness with vaccination may be the best way to keep both mother and baby healthy - ask a specialist



Be body aware - some symptoms are normal in pregnancy but know the red flags and always seek specialist advice if symptoms persist

Black and Asian women have a higher risk of dying in pregnancy

White women		8/100,000
Asian women	2x	15/100,000
Black women	5x	40/100,000

Older women are at greater risk of dying

Aged 20-24		7/100,000
Aged 35-39	2x	14/100,000
Aged 40 or over	3x	22/100,000

Overweight or obese women are at higher risk of blood clots including in early pregnancy

MBRRACE-UK - Saving Lives, Improving Mothers' Care 2018 - Lay Summary 1

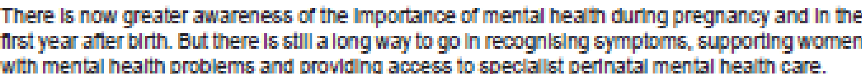
Cancer

Cancer in pregnancy is rare, but just because you are pregnant, it doesn't mean you can't develop it. So it is important to know your body, and if you have any symptoms you are worried about, check them out. Being pregnant can delay your diagnosis if symptoms you are worried about are not checked out. Investigations to check for cancer, including x-rays, can be done safely when you are pregnant.

Being pregnant doesn't mean you can't receive treatment for your cancer either. Many cancer treatments are safe to use during pregnancy. Do not feel you need to refuse treatment just because you are pregnant without taking the best advice. You should see a specialist who can assess what treatments are advisable for you and your baby.

Mental Health

Mental health is special in pregnancy - the mind can change as well as the body

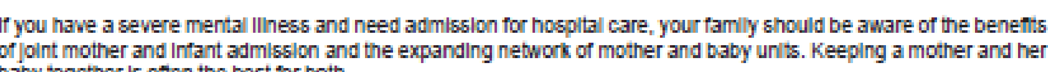


There is now greater awareness of the importance of mental health during pregnancy and in the first year after birth. But there is still a long way to go in recognising symptoms, supporting women with mental health problems and providing access to specialist perinatal mental health care.

Signs to be aware of – red flag symptoms

(In yourself, a loved one, or friend)

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



If you have a severe mental illness and need admission for hospital care, your family should be aware of the benefits of joint mother and infant admission and the expanding network of mother and baby units. Keeping a mother and her baby together is often the best for both.

And finally –

Think about your health before and after, as well as during your pregnancy. Stay connected with your usual care teams, and keep your GP informed.

Where to find trusted information

NHS Website https://www.nhs.uk

NHS Direct Wales https://www.nhsdirect.wales.nhs.uk

Ready Steady Baby http://www.readysteadybaby.org.uk

NB: Paper copies of this document may not be most recent version. The definitive version is held in the Policies and Guidelines Library

Appendix 6 – Mums Mind