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PERINATAL MENTAL ILLNESS

Dr Umesh Gowda
Consultant Psychiatrist

With **all of us** in mind.

Overview

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- Statistics
- Presentations
- Medications
- Perinatal Psychiatry Services
- Resources

Perinatal Mental Health Matters

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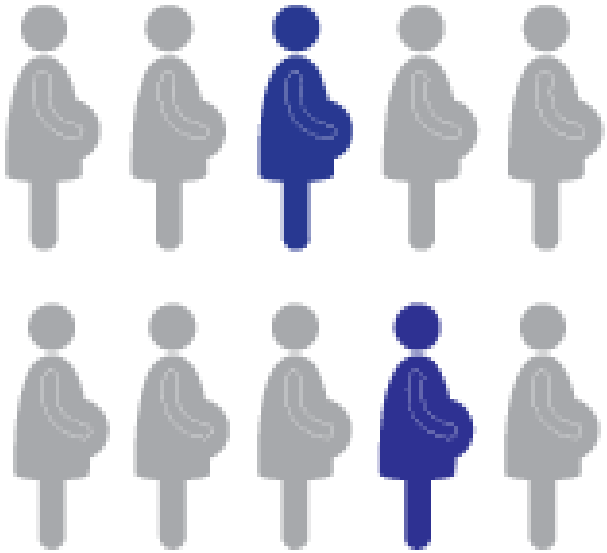

Up to 20%

of women develop a mental health problem during pregnancy or within a year of giving birth

from The Costs of Perinatal Mental Health Problems, available at:
http://www.centreformentalhealth.org.uk/perinatal

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Perinatal Mental Health Matters

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Costs v improvement

The cost to the public sector of perinatal mental health problems is **5 times** the cost of improving services.

from The Costs of Perinatal Mental Health Problems, available at:
http://www.centreformentalhealth.org.uk/perinatal

mind.

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Of these costs

28%

relate to the mother

72%

relate to the child

from The Costs of Perinatal Mental Health Problems, available at:
http://www.centreformentalhealth.org.uk/perinatal

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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.

There is a need for practical national guidance for the management of women with multiple morbidities and social factors prior to pregnancy, and during and after pregnancy.

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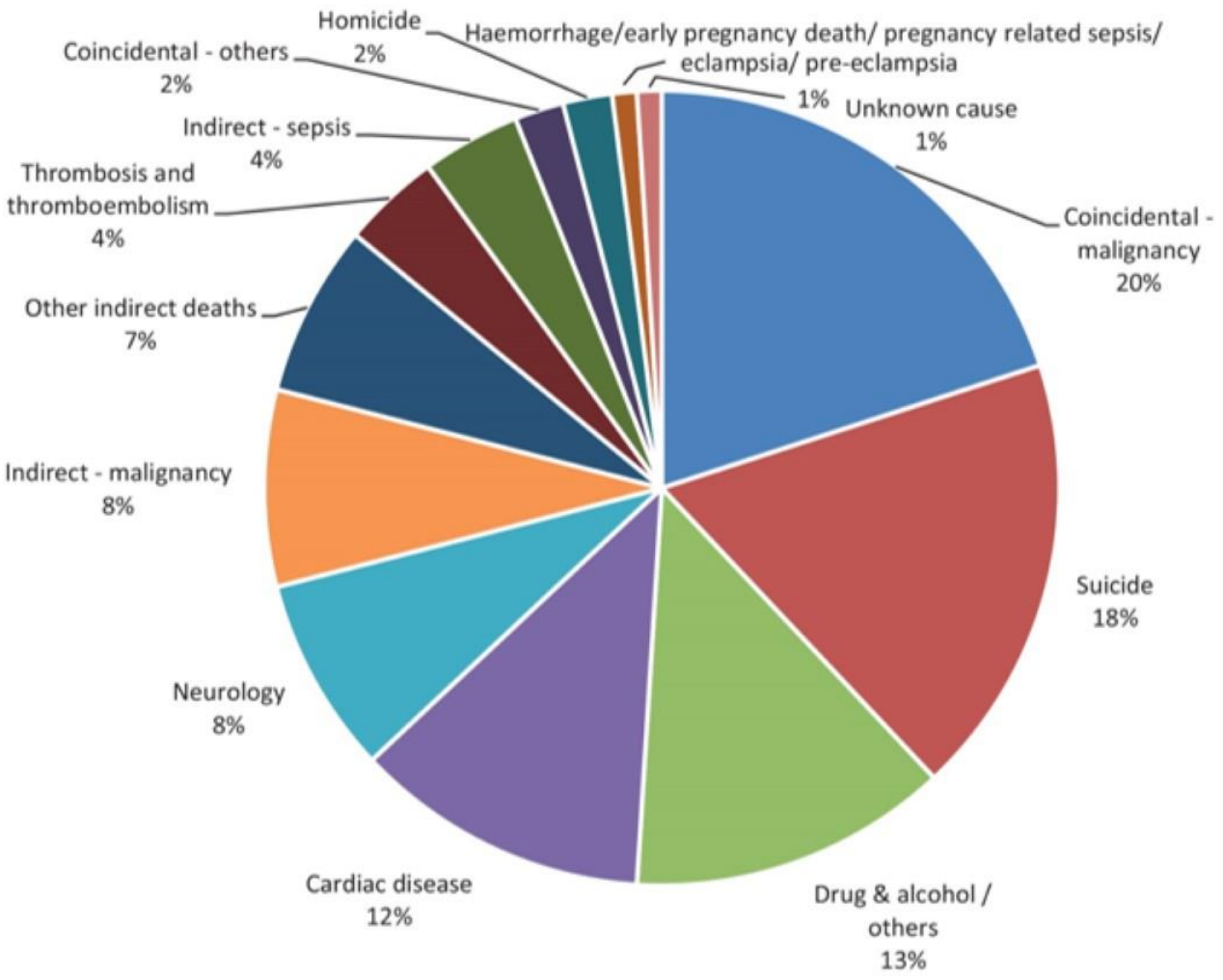
Late maternal deaths UK 2014-16



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Underlying diagnosis

- Complicated by absence of mental health records

- Commonest diagnosis - recurrent depressive disorder
- Majority - prior history of mental ill health
- Small number - previous psychosis

Statistics

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Pregnant

- Depression – 12%
- Anxiety – 13%

Postnatal

- Depression & Anxiety – 15-20%
- Psychosis – 1-2/1000

Only half - Diagnosed.
Fewer – receive adequate treatment

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Questions:

- Q: If you are pregnant or just had a baby and were referred to mental health services, what would your first thought be?
- A: “They want to take my baby away from me”
- A: “They think that I’m an unfit mother”

- Q: What % of mums hide or downplay their symptoms?
- A: 70%

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Barriers

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- Women were **put off disclosing** to health practitioners due to:
  - Feeling dismissed or told that what they were feeling was ‘normal’.
  - Feeling rushed, judged or processed
  - Lack of continuity/fragmentation of care: different GPs, midwives, health visitors
  - Experiencing inconsistent responses

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What women want from their HCPs

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- Wanted them to be more **proactive** in asking about mental health
- Give **time** and be **compassionate**
- Needed to feel **hopeful** that something could be done
- **Falling through the gaps 2015**

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Red Flags

- Recent significant change in mental state or emergence of new symptoms
- New thoughts or acts of violent self-harm
- New and persistent expressions of incompetency as a mother or estrangement from the infant

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Other warning signs

- Mum presenting in the first 6 weeks post-delivery with a severe depressive illness
- Mum having thoughts of running away
- Previous history of attempted suicide or self-harm
- Any thoughts of harm to child or psychotic thoughts relating to child

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Be especially careful with:

- Mums who have a history of bipolar disorder
- Mums who have a history of psychosis (incl. post natal)
- Mums with a family history of the above
- Refer these mums during pregnancy, **even if they are well**

Reduced threshold for care/admission in the perinatal period than at other times

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Depression and Anxiety in pregnancy

- Poor maternal mental health may cause long term changes in baby's mental health due to exposure to increased stress hormones ?epigenetic cause via DNA
- Preference for talking therapies – NICE guidance is for IAPT and secondary care psychology to have reduced waiting times for treatment antenatally and postnatally
- High relapse rate in mums who stop an antidepressant
- Women who have had an episode of depression in the two years prior to childbirth are at increased risk of a postnatal episode
- Depression in 3rd trimester is also associated with increased postnatal depression risk

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Post Natal Anxiety & OCD

- Large overlap of symptoms with postnatal depression. Perhaps best viewed in the early stages as one broader disorder.
- Obsessions can be extremely distressing and often take the form of “I might hurt the baby”, which escalates to such an extent that mum feels the baby is at risk from herself, even though hurting the baby is the last thing she wants to do
- Such “ego-dystonic” ideas are so horrifying that mums often fear that their child will be taken away from them. Therefore they don’t tell us and struggle with their thoughts alone

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Post Natal Anxiety & OCD 2

- Mum then becomes increasingly depressed because she believes she is a horrible mother and the child doesn't deserve her - estrangement
- Obsessional thoughts can respond very well to SSRI antidepressants alongside CBT, plus explanation that such thoughts are surprisingly common in mums and are not a sign of madness
- Severe OCD can easily be misdiagnosed as psychosis because of perceived risks in professionals' minds.
- Understanding that a distressing thought is not the same as a safeguarding concern

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Puerperal/ postpartum psychosis

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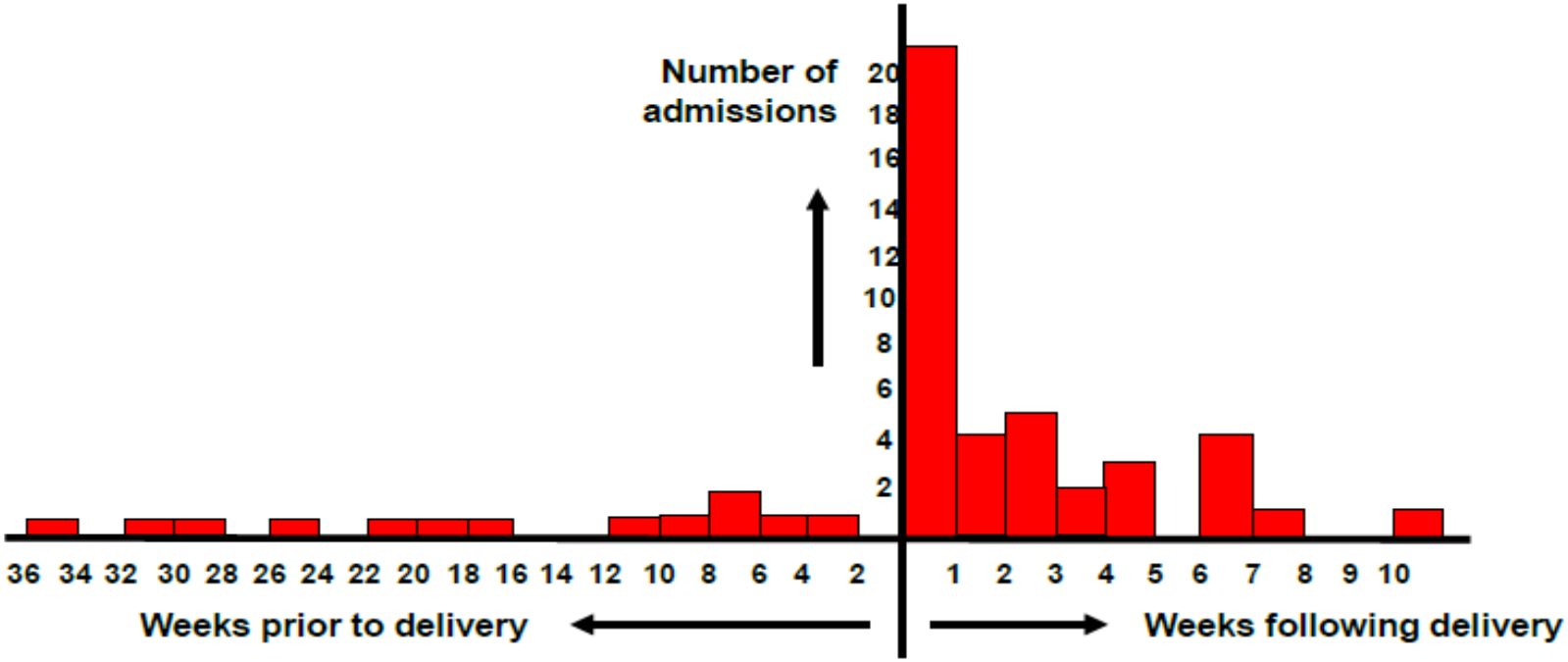
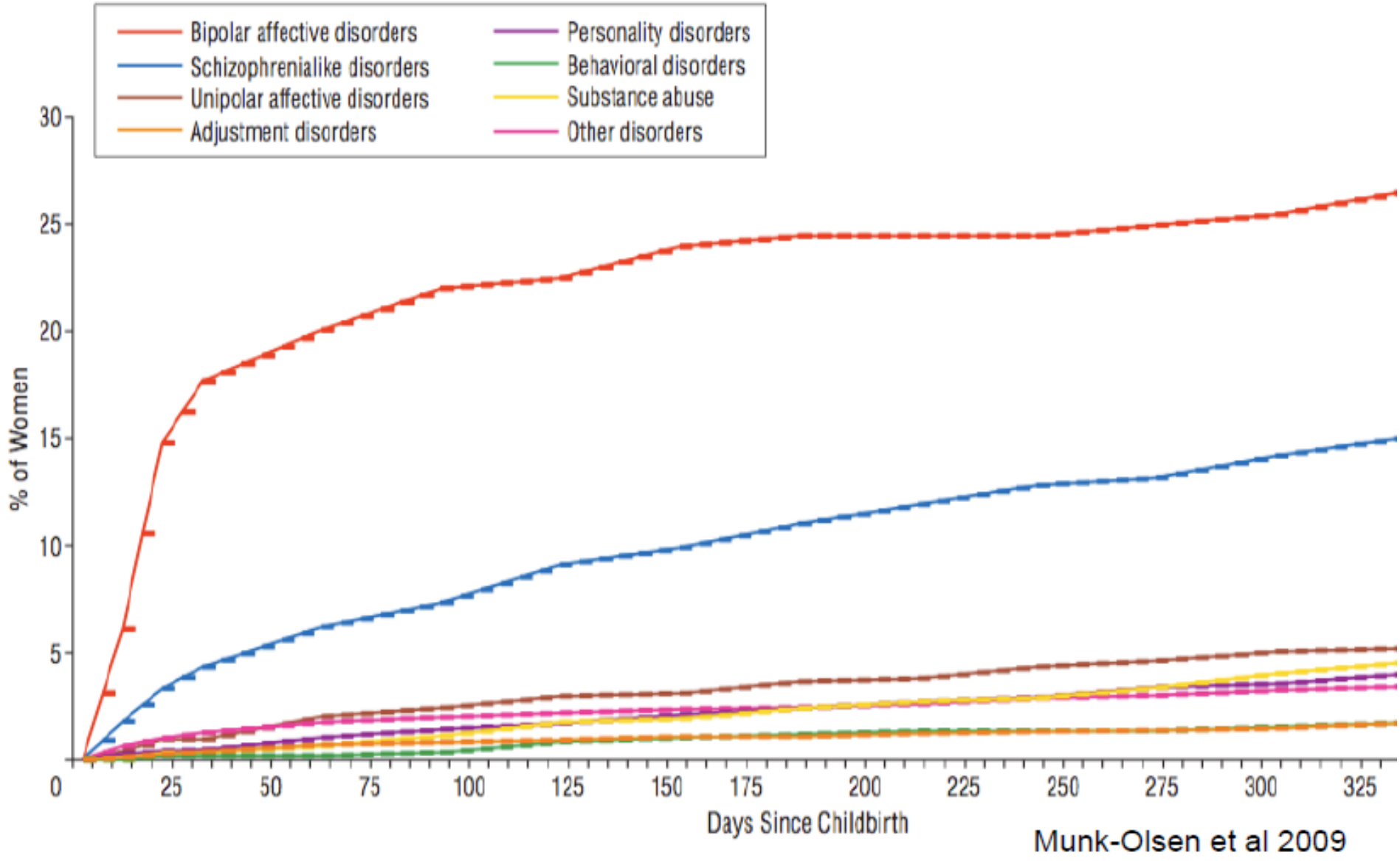


Onset of major functional psychiatric disorders in the puerperium

Kendell et al 1987

Relapse rates of various conditions



Postnatal psychosis

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- Days or weeks after delivery
- Symptoms can change rapidly – onset, progress, window of normality

- Early signs can be non-specific with insomnia, agitation, perplexity or odd behaviour

- Labile mood, Elated or depressed, Confusion
- Hallucinations and delusions
- Agitation, Poor sleep

- Higher risk – bipolar, h/o first degree relative, past h/o.

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Postnatal psychosis

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- Emergency
- Urgent assessment – within 4 hours

- Risk – mortality – mother and baby

- Consider Mother & Baby Unit (MBU) admission rather than IHBT/crisis team
- Bipolar 1 disorder/1st degree relative/history

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Medication

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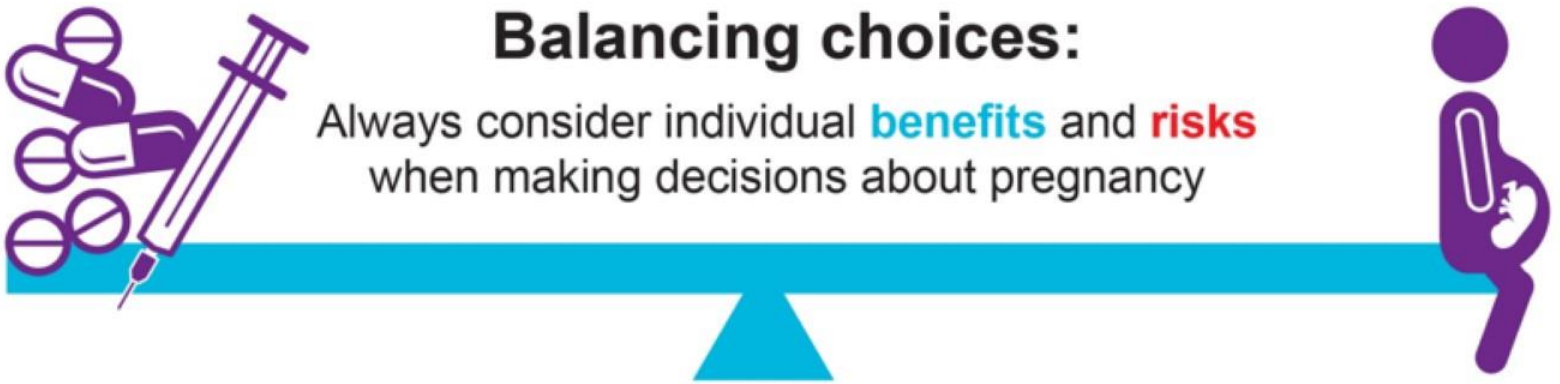
Prescribing issues – de-prescribing

Decisions on continuing, stopping or changing medication in pregnancy should be made only after careful review of the benefits and risks of doing so, to both mother and infant.



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Prescribing issues – de-prescribing

- *A woman died violently in her third trimester. She had a previous history of anxiety and depression, with depression in a previous postnatal period. She had been prescribed venlafaxine prior to the pregnancy to good effect, but it was stopped on discovering the pregnancy, either by the woman herself or by her GP. No alternative was suggested and there does not appear to have been any specialist service within her area.*
- *She developed worsening anxiety, and then depression, with a range of physical complaints, poor coping and suicidal ideation. As her symptoms worsened, she was referred to a low intensity psychological therapies service. She returned to her GP asking to restart her previously effective venlafaxine.*
- *It is clear from the consultation notes that her GP was very reluctant to prescribe and placed responsibility for the decision entirely on the woman, documenting an explanation of the risks, but not the benefits, of taking medication. She died a week later on the day she was due to undergo a mental health assessment.*

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Questions

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- Q: What is the relapse rate of depression in mums who stop taking antidepressants in pregnancy?
- A: 70%
    - more severe depression = higher likelihood relapse

- Q: What happens when people get stressed/depressed?
- A: Increased use of alcohol, nicotine, drugs; worse diet; reduced/delayed engagement in antenatal care; 4-fold increase in reduced birth weight in depressed vs non-depressed mums; increased rate of ADHD, conduct disorder & ?autism

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Psychotropic medications

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- Safety in pregnancy cannot be clearly established – limited data and robust prospective trials are unethical
- lowest risk profile for women, fetus and baby
- lowest effective dose
- Preferably single drug

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Women on psychotropic discovers that she is pregnant

- consider remaining on current medication
- Avoid abrupt discontinuation

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Learning point

- Automatically stopping antidepressants if a woman becomes pregnant is not necessarily the safest option for baby
- Risks of treating vs. risks of not treating
- Support mum to make the best choice for her and her family (?effects of depressed mum on other children)
- **Babies do best with well mums**

Pregnancy

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- Depression/Anxiety – sertraline, fluoxetine
- Psychosis – quetiapine and olanzapine
- Mood stabiliser – antipsychotic
- Sedatives – non drug measures, promethazine

Breastfeeding

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- Antidepressant – Sertraline, Mirtazapine
- Antipsychotics – quetiapine or olanzapine
- Mood stabiliser – antipsychotic
- Sedatives
  - lorazepam for anxiety, promethazine for sleep.

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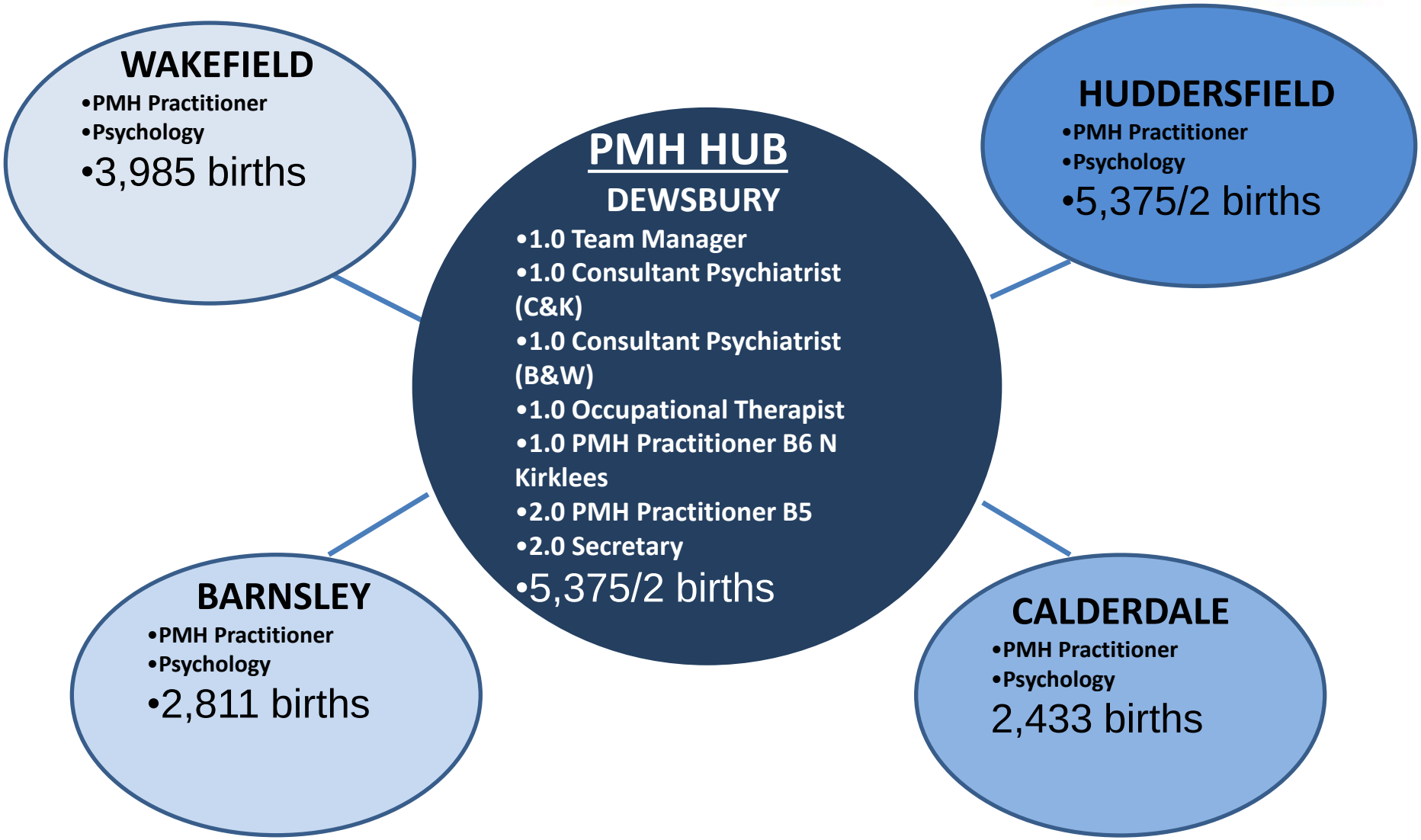

What we offer

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- Assessment, diagnosis and treatment - Moderate to severe mental health problems during and after pregnancy.
- Medication advice - pregnancy and postnatal period.
- Preconception counselling
- Individualised plans of care and treatment for pregnancy and the postnatal period.
- We will work together with service users, families, MH teams and all the services involved in perinatal pathway

Preconception counselling

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- Refer – if planning pregnancy

- Current/past – severe mental health problems e.g Bipolar disorder, Schizophrenia, Schizoaffective disorder

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Please give out our leaflets!

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

- Specifically written for pregnancy and breastfeeding
- Easy to read

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Resources

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- Royal College of Psychiatry
- https://www.rcpsych.ac.uk/members/your-faculties/perinatal-psychiatry/news-and-resources

- https://www.nice.org.uk/guidance/cg192
- (Antenatal and postnatal mental health: clinical management and service guidance)

- Teratogenicity – BUMPS

http://www.medicinesinpregnancy.org/

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Contact us:

Tel: 01924 316009

9.00 to 5.00pm Monday-Friday

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Take home message

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- Don’t stop medications suddenly.
- Seek advice – medications
- Sertraline – good choice, especially if planning to breastfeed
- Red flags
- SMI - Refer to Perinatal service
- Postnatal period - ? sudden onset psychosis – emergency.

Thank you