Perinatal mental health cases

- Kate is a 26 year old woman who attends her GP 18/40 into her first pregnancy
- No previous attendances with mental health issues
- No family history of mental health problems
- Describes history since early teenage years of ‘OCD’
- Takes the form of checking behaviour – switches, locks etc and cleanliness routines such as hand washing
- Worse at times of stress but has adapted to thoughts and not unduly distressing unless she tries to resist the rituals

- During pregnancy thoughts and rituals have increased in intensity
- Centred on causing baby harm through contamination, diet etc
- Also concerned that she could harm or abuse the baby postpartum
- Very distressed, not sleeping, has missed days off work

- Does she meet criteria for referral to specialist services?
- Should she be medicated immediately?

- Criteria 5
- Other diagnoses such as moderate depression, anxiety disorder or OCD where there is

- A significant effect on functioning for example parenting or ability to work
- A previous puerperal component to illness
- A significant family history, particularly a history of bipolar disorder or puerperal psychosis on the maternal side

- Triage meeting – full review of referral
- Urgent / routine
- Assessment – medical/ nursing
- Discussed at MDT
- Wrap around care

- Key worker
- Psychoeducation
- Containment
- Group work
- Family work
- Parent infant work
- Psychology
- Medication

- Medication involves full risk benefit analysis
- PEPP plan A/N, intrapartum, P/N

- Intrusive thoughts are unwanted repetitive thoughts, images or impulses
- Can be strange/ disturbing
- Can be violent/ sexual/ socially unacceptable
- Fear that we will do something directed at those closest to us
- Bring feelings of worry/ shame

- New mother – core value is to protect and nurture baby, any thought that contrasts with this will be fixated on with horror
- Studies suggest as many as 50% of mothers experience intrusive thoughts of intentionally harming their babies
- Thoughts may be frequent and distressing
- Rarely disclosed to healthcare professionals
- Thoughts do not predict harmful actions

- Safeguarding strategies may be employed that are harmful to resolution of symptoms, such as caregiving duties being removed from mother

- Kate has N/D
- All seems to go well for 7-10 days then describes increasing preoccupations that the Labour ward was dirty and baby has become infected
- Assessment of family support
- Medical review two days later at which she describes thoughts that baby would be better off dead
- Assessment of mental state suggests mood congruent with depressive cognitions

- Referral to family and childcare
- Safety plan in place
- Medication started

- Kelly 18years old 14/40 into 1st pregnancy
- Previous CAMHS involvement with diagnosis of EUPD
- Previous 3 day admission with drug induced psychosis, responded to quetiapine
- H/o domestic violence, partner and father of baby has been in jail for GBH. Kelly still has contact with him

- Does she meet threshold for referral to services?
- Should UNOCINI be completed?

- Triage and assessment
- CAMHS
- Previous admission
- Maternity engagement
- Family support

- Plan will be a multi – agency approach
- Early assessment by family and childcare
- Engagement with keyworker and development of therapeutic relationship will be crucial
- Assessment of ongoing drug issues in pregnancy
- Opportunities for psychological intervention and attachment work
- Conflict between patient advocacy and child protection concerns
- Any benefit for medication?

- Good outcome
- Supportive aunt who offers 24 hr care
- Remains drug free
- Ceases contact with partner
- Engages with services
- Pregnancy is time of opportunity

- Poor outcome
- Struggles to engage
- Uses drugs intermittently
- Maintains contact with partner
- When baby is born initially does well. Works with safety plan and remains drug free
- When baby is 3 months old starts missing appointments, no evidence of mood disorder but aunt reports going out at night and has resumed drug usage and contact with ex

- Sara 32 year old woman with h/o BPAD
- Three previous admissions with manic episodes
- Stable on lithium
- H/o postpartum psychosis on maternal side

- Does she meet threshold for referral?
- Do you stop lithium immediately?

- Preconceptual counselling
- Aim to reduce lithium over 3-6 month period, monitoring for signs of relapse
- Explore all medication options ie quetiapine, olanzapine etc

- 14/40 pregnant
- Decision needs to be made re reintroduction of lithium
- Breastfeeding considerations
- Care planning with maternity
- Family support
- Monitoring

- If lithium is reintroduced levels are monitored monthly then weekly from 36 weeks
- Withhold from onset of labour
- Ensure adequate fluid balance
- Aim to reinstate rapidly in postpartum period

- Highest risk of relapse is within first six weeks postnatal
- Close monitoring- daily contact
- Ensure adequate sleep

- Clare is mother of four children
- No previous history and no family history
- Two weeks postnatal
- GP receives call to say she has turned up at home of priest and asked him to bless her house. Agitated and distressed.
- GP and SW visit house to assess under MHL
- Partner is with her
- Appears plausible and rational

- Pt makes reference to bad smell in vicinity of baby's cot
- GP and SW do not feel meets threshold for detention as partner is present at all times and states he feels she is well
- Both contact psychiatry for advice
- Subsequently woman is admitted under MHL and within 1-2 hrs of admission there is a rapid deterioration in mental state with florid psychotic symptoms, disinhibition and aggression necessitating short PICU admission
- Good short term recovery although long term symptoms of recurrent psychotic illness develop

Referral criteria

- Women with past or present serious mental illness, including bipolar disorder, schizophrenia, schizoaffective disorder and psychotic depression. It should be noted that this criterion includes women who are currently well but who, due to their diagnosis, are at a high risk of relapse in the postnatal period.
- Women with past or present psychosis in pregnancy or the postnatal period
- Women with past or present severe depression that has required acute care or involved a serious attempt on their life

- Women with a primary diagnosis of substance misuse and/or eating disorder and/or an established diagnosis of personality disorder will be accepted if there is a co-existing diagnosis of mental illness as specified previously
- Women with a history of past/present mental illness who are planning a pregnancy and would benefit from preconceptual counselling

- Any questions?