# PREDICTING AND REDUCING RISK

## Antenatal risk reduction – postnatal depression
- All pregnant women should be asked about family history of bipolar disorder.

## Antenatal risk reduction – postpartum psychosis
- Women who have been treated with effective prophylaxis for psychotic disorder should have prophylactic treatment reinstated after birth.

## Detection of postpartum psychosis
- Any significant and unexpected change in mental state in late pregnancy or the early postnatal period should be closely monitored and should prompt referral to mental health services for further assessment.

## Psychosocial assessment in the antenatal period for the purposes of identifying risk of postnatal depression should not be routinely offered.

## Detection of antenatal and postnatal depression
- When assessing women in the perinatal period it is important to remember that normal emotional changes may mask depressive symptoms or be misinterpreted as depression.
- Tools to detect depression will not aid in the detection of other mental illnesses, such as anxiety, obsessive compulsive disorder, eating disorders or psychotic disorders.

## Prevention and detection

### Psychopharmacological management

#### Antidepressants
- Selective serotonin reuptake inhibitors and tricyclic antidepressants may be offered for the treatment of moderate to severe postnatal depression, but with additional considerations regarding the use of antidepressants when breast feeding.

#### Postnatal depression

- EPDS or the Whooley Questions may be used in the antenatal and postnatal period as an aid to clinical monitoring and to facilitate discussion of emotional issues.
- Where there are concerns about the presence of depression, women should be re-evaluated after two weeks. If symptoms persist, or if at initial evaluation there is evidence of severe illness or suicidality, women should be referred to the general practitioner or mental health service for further evaluation.

## Psychotropic medications in pregnancy

### Antidepressants
- General practitioners should review antidepressant therapy as soon as possible in pregnancy to discuss whether the current medication should be continued and any other alternative pharmacological or non-pharmacological treatments initiated.

### Lithium
- Any woman taking lithium in pregnancy should have an individualised psychiatric care plan, involving maternity services and the woman herself, for lithium management throughout pregnancy and the peripartum. This should include consideration of:
  - frequency of monitoring and dose adjustment
  - potential for interaction with medications prescribed in pregnancy
  - preparation for and mode of delivery
  - risks to the neonate.
- Women taking lithium in early pregnancy should be offered detailed ultrasound scanning for fetal abnormality.
- Where a woman is taking lithium in pregnancy, mental health services should provide maternity services with information on the recognition of lithium toxicity, lithium-drug interactions and pregnancy-related events which may precipitate toxicity.

### Antiepileptic drugs
- In view of the risk of early teratogenicity and longer term neurobehavioural toxicity, valproate (when used as a mood stabiliser) should not be routinely prescribed to women of childbearing potential.
- If there is no alternative to valproate treatment for a woman of childbearing potential, long-acting contraceptive measures should be recommended.
- Valproate should be avoided as a mood stabiliser in pregnancy.
- Lithium management throughout pregnancy and the peripartum. This should involve a detailed plan for their late pregnancy and early postnatal psychiatric management, identifying risk of postnatal depression should not be routinely offered.

### Mother-infant interventions
- Where there is evidence of impairment in the mother-infant relationship, additional interventions, specifically directed at that relationship, should be offered.

### Physical activity
- Support for structured exercise may be offered as a treatment option for parents with postnatal depression.

### Psychological therapies
- Practitioners delivering psychological therapies should be trained to accepted levels of competency, participate in continuing professional development and receive ongoing supervision.
- Given the importance of early intervention in a maternity context, services delivering psychological therapies should prioritise early response to pregnant and postnatal women.

### Cognitive behavioural therapies should be considered for treatment of mild to moderate depression in the postnatal period.

### Referral for specialist psychiatric assessment should be considered for women with current mood disorder of mild or moderate severity who have a first degree relative with a history of bipolar disorder or postpartum psychosis.

### In the absence of current illness, such a family history indicates a raised, but low, absolute risk of early postpartum serious mental illness. Where family history only is identified, information should be shared between primary care and maternity services, and any evidence of mood disturbance during pregnancy or in the postnatal period should lead to referral to mental health services.
This Quick Reference Guide provides a summary of the main recommendations in SIGN 127 Management of perinatal mood disorders. Recommendations are graded A B C D to indicate the strength of the supporting evidence.

Good practice points ✓ are provided where the guideline development group wishes to highlight specific aspects of accepted clinical practice.

Details of the evidence supporting these recommendations can be found in the full guideline, available on the SIGN website: www.sign.ac.uk.

This Quick Reference Guide is also available as part of the SIGN Guidelines app.