Antipsychotics

C **Women taking antipsychotics during pregnancy should be monitored for alterations in fetal growth. Additional monitoring for blood glucose abnormalities is required where olanzapine or clozapine are prescribed.**

Hypnotics and sedatives

C **In women taking benzodiazepines the need for continued use in pregnancy should be reviewed and use should be restricted to short term and low dose where possible. Consideration should be given to tapering the dose prior to childbirth.**

Psychotropic medications during breast feeding

✓ Breast feeding is an individual decision for each woman. Clinicians should support women in their choice and be mindful that taking prescribed psychotropic medication is not routinely a contraindication to commencing or continuing breast feeding.

Antidepressants

D **Avoid doxepin for treatment of depression in women who are breast feeding. If initiating selective serotonin reuptake inhibitor treatment in breast feeding, then fluoxetine, citalopram and escitalopram should be avoided if possible.**

✓ When initiating antidepressant use in women who are breastfeeding, both the absolute dose and the half life should be considered.

Lithium

D **In view of the potential risks to the infant of a breastfeeding mother taking lithium, mothers should be encouraged to avoid breast feeding. In mothers taking lithium who have decided to breast feed, close monitoring of the infant, including serum lithium levels, thyroid and renal monitoring should be provided.**

Antiepilectic drugs

✓ Antiepileptic mood stabiliser prescription is not, of itself, a contraindication to breastfeeding, but decisions should be made individually with the woman, after full discussion of the risks and benefits.

Hypnotics and sedatives

✓ If a benzodiazepine is required during breast feeding short-acting agents should be prescribed in divided doses. Mothers should be advised not to stop medication suddenly and to contact their doctor if the infant is observed to have sleepiness, low energy or poor suckling.

Antipsychotics

D **Women who are taking clozapine should not breast feed.**

✓ All breastfed infants should be monitored for sedation and extra-pyramidal adverse effects where mothers are taking antipsychotic medications.

Service design

D **A national managed clinical network for perinatal mental health should be centrally established in Scotland. The network should be managed by a coordinating board of health professionals, health and social care managers, and service users and carers. The network should:**

- **establish standards for the provision of regional inpatient specialised mother and baby units, community specialised perinatal teams** (or specialised perinatal functions of general adult mental health teams in smaller, or more remote, areas)**, and maternity liaison services**
- **establish pathways for referral and management of women with, or at risk of, mental illness in pregnancy and the postnatal period**
- **establish standards** (in liaison with specialist mental health pharmacists) **for the provision of advice and guidance to maternity and primary care services on the use of psychotropic medication in pregnancy and breast feeding**
- **establish competencies and training resources for health professionals caring for pregnant or postnatal women with, or at risk of, mental illness, at levels appropriate to their need**
- **ensure that all pregnant and postnatal women with, or at risk of, mental illness have equitable access to advice and care appropriate to their level of need.**

D **Mothers and babies should not routinely be admitted to general psychiatric wards.**

Helplines

Breathing Space
Tel: 0800 838 587

Samaritans
Tel: 0845 790 9090

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.

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SIGN 127 • Management of perinatal mood disorders

Quick Reference Guide *March 2012*

Evidence

PREDICTING AND REDUCING RISK

Antenatal risk reduction – postnatal depression

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

Antenatal risk reduction – postpartum psychosis

D **All pregnant women should be asked about personal history of postpartum psychosis, other psychotic disorders** (especially bipolar affective disorder and schizophrenia)**, and severe depressive disorder.**

D **All pregnant women should be asked about family history of bipolar disorder or postpartum psychosis.**

D **The following groups should be considered as high risk for post partum psychosis:**

- **women with a personal history of postpartum psychosis**
- **women with a personal history of bipolar affective disorder.**

Risk is further increased if there is additional family history of postpartum psychosis or bipolar affective disorder.

D **Women at high risk of postnatal major mental illness should have a detailed plan for their late pregnancy and early postnatal psychiatric management, agreed with the woman and shared with maternity services, the community midwifery team, GP, health visitor, mental health services and the woman herself. With the woman's agreement, a copy of the plan should be kept in her hand held records. The plan should identify what support should be in place and who to contact if problems arise, together with their contact details** (including out of hours)**, and address decisions on medication management in late pregnancy, the immediate postnatal period and with regard to breast feeding.**

D
- **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.**

PREVENTION AND DETECTION

Prevention of postpartum psychosis

✓ Women who have been treated with effective prophylaxis for psychotic disorder should have prophylactic treatment reinstated after birth.

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.

D **Enquiry about depressive symptoms should be made, at minimum, on booking in and postnatally at four to six weeks and three to four months.**

D **For women regarded to be at high risk** (those with previous or current depressive disorder)**, enquiry about depressive symptoms should be made at each contact.**

✓ 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 their general practitioner or mental health service for further evaluation.

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 MANAGEMENT

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.

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

Mother infant interventions

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

Physical activity

B **Support for structured exercise may be offered as a treatment option for patients with postnatal depression.**

PHARMACOLOGICAL MANAGEMENT

Postnatal depression

Antidepressants

B **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.**

Hormonal therapies

B **The use of oestrogen therapy in the routine management of patients with postnatal depression is not recommended.**

St John's Wort

✓ St John's Wort and other alternative medicines should not be used during pregnancy and lactation.

Postpartum psychosis

D **Postpartum psychosis should be managed in the same way as psychotic disorders at any other time, but with the additional considerations regarding medication use during breast feeding.**

Psychotropic medication use in the pre-pregnancy period

D **All women of childbearing potential who take psychotropic medication should be made aware of the potential effects of medications in pregnancy. The use of reliable contraceptive methods should be discussed.**

✓ If a woman taking psychotropic drugs is planning a pregnancy, consideration should be given to discontinuing treatment if the woman is well and at low risk of relapse.

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.

C **In view of the association with harms to the fetus and neonate, paroxetine should not generally be initiated as first line therapy in pregnancy. For women already prescribed paroxetine an evaluation of individual risks and benefits should be carried out before a decision is made to continue use or switch to another antidepressant.**

✓ Choice of antidepressant in pregnancy should take into account implications for breastfeeding.

✓ Since the evidence base for safety of antidepressant prescribing in pregnancy is a rapidly developing area, clinicians should update their knowledge frequently.

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

C **In view of the risk of early teratogenicity and longer term neurobehavioural toxicity, valproate** (when used as a mood stabiliser) **should not be 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 put in place. Check the Medicines and Healthcare products Regulatory Agency (MHRA) website for current advice.

C **Valproate should not be used as a mood stabiliser in pregnancy.**

D **All women taking antiepileptic drugs as mood stabilisers should be prescribed a daily dose of 5 mg of folic acid from preconception until at least the end of the first trimester.**

✓ Women taking antiepileptic drugs in early pregnancy should be offered detailed ultrasound scanning for fetal abnormality.

✓ Maternal lamotrigine levels should be monitored throughout pregnancy and the early postpartum period.