

Preconception care for women with mental health conditions

Pregnancy is associated with a number of specific risks for women with mental health conditions. This article outlines the important issues to discuss with women who have a current or previous mental illness and who are planning a pregnancy.

Mental health conditions are common in women of childbearing age. Pregnancy is not protective against mental illness and for some psychiatric disorders there is a high risk of relapse, particularly in the postnatal period. It is important that each woman has individualized preconception counselling to consider the implications of her illness for pregnancy and parenting. There will be many issues she needs to consider, including:

- n The frequency and severity of episodes of illness
- n Her experience of current and previous treatments
- n The impact of her illness on her daily functioning and her relationships with others
- n Her own experience of being parented
- n Her social circumstances
- n The presence or absence of a supportive partner or other family members.

She will need to be given up-to-date information about the risks and benefits of specific medications in pregnancy.

It is essential that women with a current or previous severe mental illness are offered preconception counselling by a psychiatrist, ideally a perinatal psychiatrist, as there are a number of complex issues to discuss.

General health advice

As highlighted in the accompanying article (p. 312), there are a number of issues which need to be considered by all women when planning a pregnancy. This general health advice, for example regarding smoking and alcohol use, is particularly important for women with mental health problems. Women with mental illness have higher rates of smoking, alcohol and illicit drug use in pregnancy than other women (Zuckerman et al, 1989; Zhu and Valbø, 2002; Shah and Howard, 2006; Bodén et al, 2012a). Self-neglect and lack of motivation in depression, and other mental disorders, may mean that women are less likely to look after themselves and to eat healthily. Women need dietary advice and should be informed about the need to take folic acid.

Risk of relapse in pregnancy and the postnatal period

The risk of relapse in pregnancy for women who discontinue medication is high. For example Cohen et al (2006) found that 68% of women relapsed after stopping anti-

depressants, compared with 26% who continued medication. There are similarly high rates of relapse in women with bipolar affective disorder who discontinue mood stabilizers (Viguera et al, 2007).

Women need to be informed if they have a high risk of postpartum mental illness, either postnatal depression or postpartum psychosis. Postpartum depression occurs in 10–15% of women in the general population with previous depression being one of the strongest predictors (Robertson et al, 2004). Rates of postpartum psychosis are 1–2 per 1000 women in the general population, whereas women with a history of psychotic illness, particularly bipolar affective disorder, have a risk of between 25 and 50% (Kendell et al, 1987; Jones and Craddock, 2001; Harlow et al, 2007; Munk-Olsen et al, 2009). *Figure 1* provides further sources of information about these disorders for women and their families.

Genetic risk of inheriting a psychiatric disorder

Some women may be concerned about the risk of their child inheriting their psychiatric disorder. The genetic risk is highest for the more severe disorders. For example the risk of inheriting schizophrenia if one parent is

Figure 1. Further information for patients.

Royal College of Psychiatrists – information leaflets (Mental Health in Pregnancy, Postnatal Depression, Postpartum Psychosis) (www.rcpsych.ac.uk/expertadvice/problemsdisorders.aspx)

The Association for Perinatal Illness – provides telephone helpline, information leaflets and a network of volunteers who have themselves experienced postnatal depression (www.apni.org helpline: 020 7386 0868)

Action Postpartum Psychosis Network – information about postpartum psychosis and peer support (www.app-network.org)

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affected is approximately 13% but rises to 46% if both parents have the disorder (Slater and Cowie, 1971).

Medication in pregnancy

Apart from the general issues to be considered by any woman deciding about whether or not she should take medication in pregnancy (such as the background risk of congenital malformation), there are specific issues relating to the use of psychotropic medication in pregnancy. These include: her diagnosis, the severity and duration of previous episodes of illness and time to relapse when medication has been discontinued. The discussion between the woman and psychiatrist regarding the implications of relapsing in pregnancy should include: self neglect, self harm, use of illicit drugs or alcohol, and the possible need for psychiatric admission. If a woman relapses towards the end of pregnancy or in the early postnatal period this may affect attachment and may also mean she is temporarily unable to care for her baby. The risks associated with medication need to be balanced against the risk of untreated illness, which can lead to poor obstetric outcomes (Lin et al, 2010; Davalos et al, 2012) and have long-term implications for the child's emotional, social, cognitive and behavioural development (Grace et al, 2003) and later mental health (Murray et al, 2011).

Women should be given up-to-date advice regarding the safety of psychotropic medications in pregnancy and breastfeeding. This evidence is complex, and is beyond the scope of this article. For detailed information prescribers should be familiar with relevant guidelines and seek up-to-date advice (*Figure 2* gives some sources of information for clinicians).

For many women with severe mental illness the benefits of continuing medication will outweigh the risks, but for women with mild to moderate mental illness it may be possible to stop medication. Women who find it difficult to conceive when taking a prolactin-raising antipsychotic (e.g. sulpiride, amisulpiride or risperidone) may need to change their medication to improve their chance of getting pregnant. There are some medications which are highly teratogenic and which it is usually advisable to stop before conception, e.g. sodium valproate, which is associated with high rates of malformations and cognitive impairment. Some medications

require specific monitoring in pregnancy, e.g. lithium levels need to be monitored more frequently (National Institute for Health and Clinical Excellence, 2007; Scottish Intercollegiate Guideline Network, 2012). Blood glucose levels should be monitored in women taking antipsychotic medications as these are associated with an increased risk of gestational diabetes (Bodén et al, 2012b).

Maternity care and risk of obstetric complications and poor neonatal outcome

It is important to advise women that when they do conceive, they should be referred early in pregnancy to the maternity service they choose, as there can be concerns that women may not engage in antenatal care (Kelly et al, 1999; Kim et al, 2006). It is important that women inform their midwife at the booking appointment about their mental health history, to ensure that they receive appropriate mental health and obstetric care. This is important, not only so that midwives are aware of the risk of relapse of their mental illness and consider the implications for parenting. There is also an association between mental illness and poor obstetric and neonatal outcome for a range of mental disorders and for both treated and untreated illness. Pregnancies may need additional monitoring. Some examples include:

- n Increased rates of low birth weight and preterm delivery in patients with untreated depression (Davalos et al, 2012)
- n Increased stillbirths and neonatal deaths in patients with psychosis (Webb et al, 2005)
- n Increased low birth weight and babies small for gestational age in patients with untreated schizophrenia (Lin et al, 2010)
- n Increased rates of preterm delivery, small for gestational age babies and low birth weight in patients with eating disorders (Franko et al, 2001; Morgan et al, 2006).

Joint working in pregnancy

It is important that women know what to expect from local services during pregnancy. Women with a current or previous severe mental illness will need care from perinatal mental health services in pregnancy or, where these do not exist, a general adult mental health service. Mental health, maternity and primary care services (and in some cases children's social services) need to work jointly with the woman and her family. There needs to be good communication and a jointly agreed plan for the woman's care in pregnancy, for maternity admission at delivery and for the postnatal period.

Consideration of safeguarding issues

It is important not to make judgments about a woman's potential parenting capacity based on any particular psychiatric diagnosis. For many women with a diagnosis of a severe mental illness there may be no concerns about

Figure 2. Further information for professionals.

National Institute for Health and Clinical Excellence (2007) Antenatal and postnatal mental health: clinical management and service guidance. NICE Clinical Guideline 45. National Institute for Health and Clinical Excellence, London (www.nice.org.uk/CG045)

Scottish Intercollegiate Guidelines Network (2012) Management of perinatal mood disorders. SIGN publication no. 127. Scottish Intercollegiate Guidelines Network, Edinburgh (www.sign.ac.uk/pdf/sign127.pdf)

UK Teratology Information Service – provides a national service on all aspects of the toxicity of drugs and chemicals in pregnancy (www.uktis.org)

parenting when they are well. However, it is also important that where a woman's mental disorder is likely to give rise to serious safeguarding concerns that this is discussed at the time a woman seeks preconception counselling. This may particularly be the case for a woman with chronic schizophrenia whose level of functioning is so significantly impaired that she is unable to cope with independent living. Discussion with women about the potential need for involvement of children and families social services, a Child Protection Plan or care proceedings may be necessary in some cases.

How to stay well and to optimize mental state before pregnancy

There should be some consideration of how to improve the woman's mental health and address unresolved issues before she tries to conceive. For example women may benefit from psychological therapies or engaging with local voluntary sector organizations offering support. Ensuring effective contraception is used while medication changes are made in preparation for pregnancy is important in order to minimize adverse fetal outcomes.

Conclusions

It is important that women with current or previous mental illness, particularly if this is severe mental illness, are routinely asked about pregnancy planning and are offered preconception counselling. This will ensure they have up-to-date information to enable them to make informed decisions about treatment options. It will also give women an opportunity to make changes to their lifestyle and treatment which will hopefully improve their mental and physical health before they try to conceive.

More information on this complex subject is available in the National Institute for Health and Clinical Excellence (2007) and Scottish Intercollegiate Guideline Network (2012) guidelines (Figure 2). [BJHM](#)

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KEY POINTS

- n Pregnancy planning should be routinely discussed with women who have current or previous severe mental illness and preconception counselling offered.
- n Women should be offered general health advice about smoking, alcohol and illicit drugs in pregnancy and the importance of taking folic acid when trying to conceive.
- n The risk of relapse in pregnancy and the postpartum period should be explained.
- n Discussion about the risks and benefits of treatment in pregnancy should be individualized.