NATIONAL CLINICAL GUIDELINES

DIAGNOSIS & MANAGEMENT OF OBSTETRIC MENTAL HEALTH DISORDERS

Ministry of Public Health

P.O. Box 42,
Doha, Qatar
Phone: (+974)4 407 0969
Email: clinicalguidelines@moph.gov.qa

Valid From: 3rd March 2020
Date of Next Revision: 3rd March 2022

المبادئ الإرشادية السريرية لدولة قطر
NATIONAL CLINICAL GUIDELINES FOR QATAR

وزارة الصحـــــة العامـــــة
Ministry of Public Health
State of Qatar • دولـــة قطـــر

View Pathway

Version History

Version	Status	Date	Editor	Description
1.0	Final	3rd March 2020	Guidelines Team	Final version for publication.

Citation

Suggested citation style:

Ministry of Public Health Qatar. National Clinical Guideline: Diagnosis & Management of Obstetric Mental Health Disorders (2020).

Abbreviations

The abbreviations used in this guideline are as follows:

CBT	Cognitive Behavioural Therapy
CBT-ED	Eating-Disorder-Focused Cognitive Behavioural Therapy
ECT	Electroconvulsive Therapy
EMDR	Eye Movement Desensitization and Reprocessing Therapy
EPDS	Edinburgh Postnatal Depression Scale
FPT	Focal Psychodynamic Therapy
GAD-2	2-Item Generalised Anxiety Disorder Scale
GAD-7	7-Item Generalised Anxiety Disorder Scale
IPT	Interpersonal Therapy
IUFD	Intrauterine Foetal Death
MANTRA	Maudsley Anorexia Nervosa Treatment for Adults
MDD	Major Depressive Disorder
MDE	Major Depressive Episode
MDT	Multidisciplinary Team
MOPH	Ministry of Public Health of Qatar
NAS	Neonatal Abstinence Syndrome
OD	Opioid Dependence
PHCC	Primary Health Care Corporation
PHQ-2	Patient Health Questionnaire Two-Question Tool
PHQ-9	Patient Health Questionnaire Nine-Question Tool

View Pathway

PST	Problem-Solving Techniques
PTSD	Post-Traumatic Stress Disorder
SSCM	Specialist Supportive Clinical Management
TMS	Trans Magnetic Stimulation
TSH	Thyroid Stimulating Hormone

View Pathway

Table of Contents

View Pathway

1 Information about this Guideline

1.1 Objective and Purpose of the Guideline

The purpose of this guideline is to define the appropriate diagnosis and management of mental health disorders presenting in the antenatal, perinatal and postnatal periods of pregnancy. The objective is to improve the early recognition and diagnosis of mental health problems, reduce inappropriate management and improve referral of patients presenting to provider organisations in Qatar. It is intended that the guideline will be used by healthcare professionals across all care settings.

1.2 Scope of the Guideline

The following aspects of care are included within this Guideline:

- Screening and assessment of women for mental health disorders.
- Preconception counselling of patients with existing or history of severe mental health illness.
- Management of women in pregnancy and the postnatal period with:
    - Major Depressive Disorder.
    - Generalised Anxiety Disorder.
    - Tokophobia.
    - Obsessive-Compulsive Disorder.
    - Post-Traumatic Stress Disorder.
    - Bipolar Affective Disorder.
    - Schizophrenia and other psychotic disorders
    - Postpartum psychosis.
    - Sleep Disorders.
    - Eating Disorders.
    - Borderline personality disorders.
    - Alcohol and Substance Abuse.
- Intrapartum care considerations.
- Prescribing psychotropic medications in pregnancy and breastfeeding.

1.3 Editorial Approach

This guideline document has been developed and issued by the Ministry of Public Health of Qatar (MOPH), through a process which aligns with international best practice in guideline development and localisation. The guideline will be reviewed on a regular basis and updated to incorporate comments and feedback from stakeholders across Qatar.

The editorial methodology, used to develop this guideline, has involved the following critical steps:

- Extensive literature search for well-reputed published evidence relating to the topic.
- Critical appraisal of the literature.
- Development of a draft summary guideline.
- Review of the summary guideline with a Guideline Development Group, comprised of practising healthcare professionals, subject matter experts and patient representatives, from across Qatar.
- Independent review of the guideline by the National Clinical Guidelines & Pathways Committee, appointed by the MOPH, from amongst stakeholder organisations across Qatar.

Whilst the MOPH has sponsored the development of the guideline, the MOPH has not influenced the specific recommendations made within it.

1.4 Sources of Evidence

The professional literature has been systematically queried using specially developed, customised, and tested search strings. Search strategies are developed to allow an efficient yet comprehensive analysis of relevant publications for a given topic and to maximise retrieval of articles with certain desired characteristics pertinent to a guideline.
For each guideline, all retrieved publications have been individually reviewed by a member of the Editorial Team and assessed in terms of quality, utility, and relevance. Preference is given to publications that:

1. Are designed with rigorous scientific methodology.
2. Are published in higher-quality journals.
3. Address an aspect of specific importance to the guideline in question.

Further information about the literature search and appraisal process is included in the appendix.

1.5 Evidence Grading and Recommendations

Recommendations made within this guideline are supported by evidence from the medical literature and where possible the most authoritative sources have been used in the development of this guideline. To provide insight into the evidence basis for each recommendation, the following evidence hierarchy has been used to grade the level of authoritativeness of the evidence used, where recommendations have been made within this guideline.

Where the recommendations of international guidelines have been adopted, the evidence grading is assigned to the underlying evidence used by the international guideline. Where more than one source has been cited, the evidence grading relates to the highest level of evidence cited:

- **Level 1 (L1):**
  - Meta-analyses.
  - Randomised controlled trials with meta-analysis.
  - Randomised controlled trials.
  - Systematic reviews.

- **Level 2 (L2):**
  - Observational studies, examples include:
    - Cohort studies with statistical adjustment for potential confounders.
    - Cohort studies without adjustment.
    - Case series with historical or literature controls.
    - Uncontrolled case series.
  - Statements in published articles or textbooks.

- **Level 3 (L3):**
  - Expert opinion.
  - Unpublished data, examples include:
    - Large database analyses.
    - Written protocols or outcomes reports from large practices.

In order to give additional insight into the reasoning underlying certain recommendations and the strength of recommendation, the following recommendation grading has been used, where recommendations are made:

- **Recommendation Grade A (RGA):** Evidence demonstrates at least moderate certainty of a net benefit from the recommendation.

- **Recommendation Grade B (RGB):** Evidence is insufficient, conflicting, or poor and demonstrates an incomplete assessment of net benefit vs harm; additional research is recommended.
- **Recommendation Grade C (RGC):** Evidence demonstrates potential harm that outweighs benefit; additional research is recommended.
- **Recommendation of the GDG (R-GDG):** Recommended best practice on the basis of the clinical experience of the Guideline Development Group members.

1.6 Guideline Development Group Members

The following table lists members of the Guideline Development Group (GDG) nominated by their respective organisations and the Clinical Governance Group. The GDG members have reviewed and provided feedback on the draft guideline relating to the topic. Each member has completed a declaration of conflicts of interest, which has been reviewed and retained by the MOPH.

Guideline Development Group Members		
Name	**Title**	**Organisation**
Dr Nisha Abdul Kader	Consultant Psychiatrist	Hamad Medical Corporation
Dr Onoliode Agbetunsin	Attending Physician, Obstetrics & Gynaecology	Sidra Medicine
Ms Safia Ahmed	Clinical Nurse Leader, Perinatal Mental Health Clinic	Sidra Medicine
Dr Maryam Al-Hitmi	Consultant Family Medicine	Primary Health Care Corp
Ms Maleeha Khamis Alshamali	Social Worker, Head of Social Services, Mental Health Service	Hamad Medical Corporation
Ms Naheed Ilyas Arshad	Clinical Midwife, Antepartum Unit	Sidra Medicine
Dr Abdulmalik Umar Bako	Senior Consultant in Obstetrics and Gynaecology	Hamad Medical Corporation
Ms Zahra N. Darwish	Senior Social Worker	Hamad Medical Corporation
Mr Yasin Hassan Eltorki	Clinical Pharmacy Specialist, Mental Health Hospital	Hamad Medical Corporation
Dr Naomi Hynd	Consultant Clinical Psychologist	Sidra Medicine
Ms Faten Jabnouni	Midwife	Al Ahli Hospital
Ms Giulia Martini	Information Services Librarian	Patient Representative
Dr Mohamed Omar Salem	Associate Professor, Consultant Psychiatrist & Head of Department	Al Ahli Hospital
Dr Bindu Salim	Psychologist & Lead of Psychology Services, Child and Adolescent Mental Health Services	Hamad Medical Corporation
Ms Zahra Sayed	Midwife Psychologist	Primary Health Care Corp
Dr Nivedhitha Shivashankar	Specialist Obstetrics & Gynaecology	Aster DM

Guideline Development Group Members		
Name	**Title**	**Organisation**
Dr Abdulrashid Siddique	Consultant Family Medicine	Primary Health Care Corp
Dr Felice Watt	Division Chief, Women's Mental Health, Department of Psychiatry	Sidra Medicine
Dr Ovais Wadoo	Senior Consultant Psychiatrist, Chair Clinical Practice Guidelines Committee Mental Health Services	Hamad Medical Corporation

1.7 National Clinical Guidelines & Pathways Committee members

The following table lists members of the National Clinical Guidelines & Pathways Committee (NCGPC), appointed by the MOPH. The NCGPC members have reviewed and provided their feedback and approval of the guideline document. Each member has completed a declaration of conflicts of interest, which has been reviewed and retained by the MOPH.

National Clinical Guidelines & Pathways Committee (NCGPC) Members		
Name	**Title**	**Organisation**
Ms Huda Amer Al-Katheeri	Chair of the NCGPC, Director- Strategic Planning & Performance Department	Ministry of Public Health
Shk Dr Mohammed Hamad J. Al Thani	Co-Chair of NCGPC, Director of Public Health	Ministry of Public Health
Prof Anthony Akobeng	Chair Clinical Practice Guidelines Committee	Sidra Medicine
Dr Alshaymaa Mohammed A. M. Al-Motawa	Consultant Family Medicine	Qatar Petroleum
Dr Basil Bashqawi	Accreditation Coordinator, Dept of Health Professions	Ministry of Public Health
Dr Abi Khalil Charbel	Associate Professor of Medicine Consultant Cardiology	Weill Cornell Medicine-Qatar
Dr Paul Dijkstra	Director of Medical Education	Aspetar
Dr Mohamed Elrishi	Consultant Endocrinology and Internal Medicine	Al Ahli Hospital
Dr Dahlia Mustafa Hassan	Consultant Family Medicine	Primary Health Care Corp
Dr Ghassan Youseph Hommos	Consultant Endocrinology	Al Emadi Hospital
Dr Chris Kenny	Executive Director Clinical and Service Development, Office of the Chief Medical Officer	Hamad Medical Corporation
Dr Egon Toft	VP and Dean of College of Medicine	College of Medicine, Qatar University

View Pathway

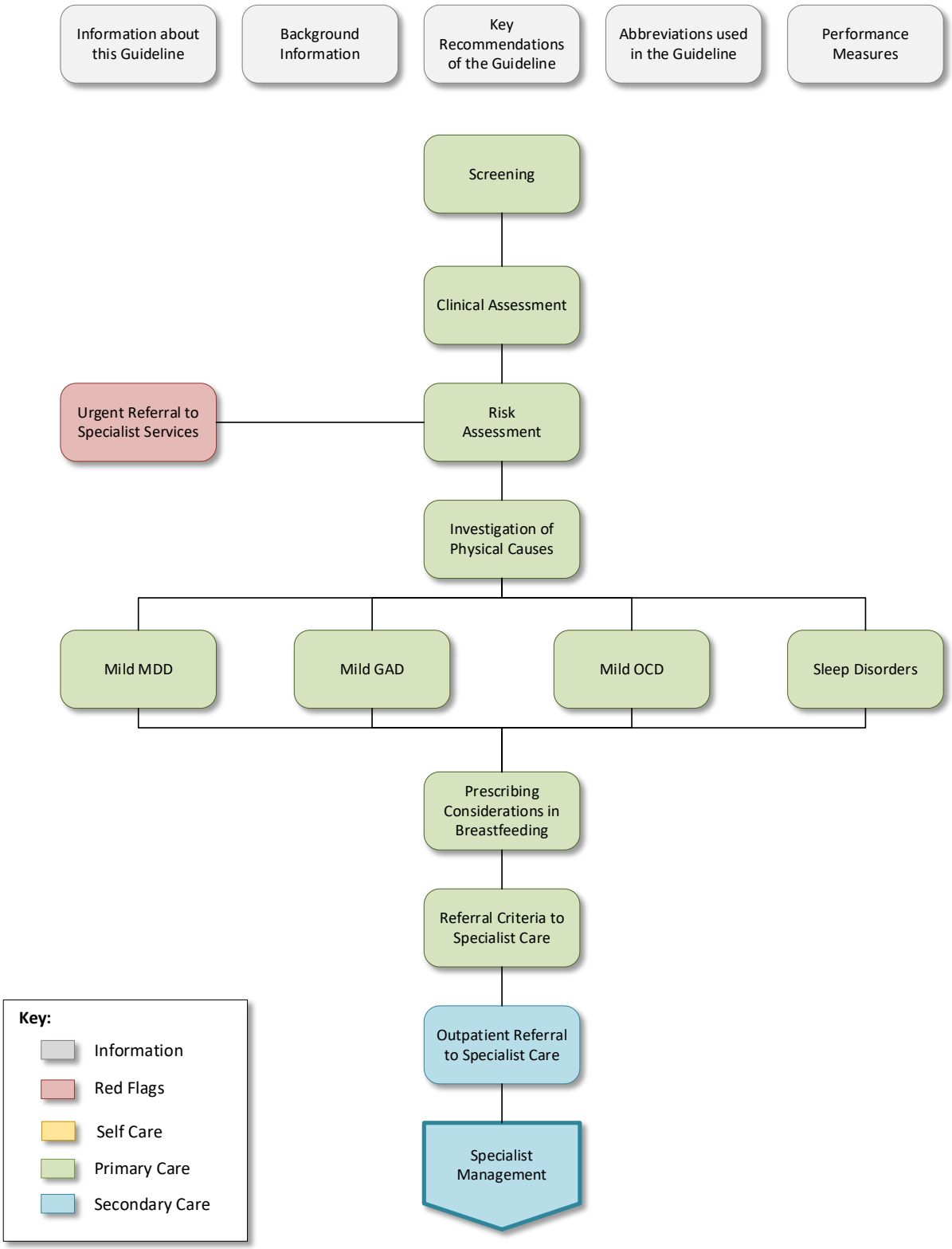
1.8 Responsibilities of Healthcare Professionals

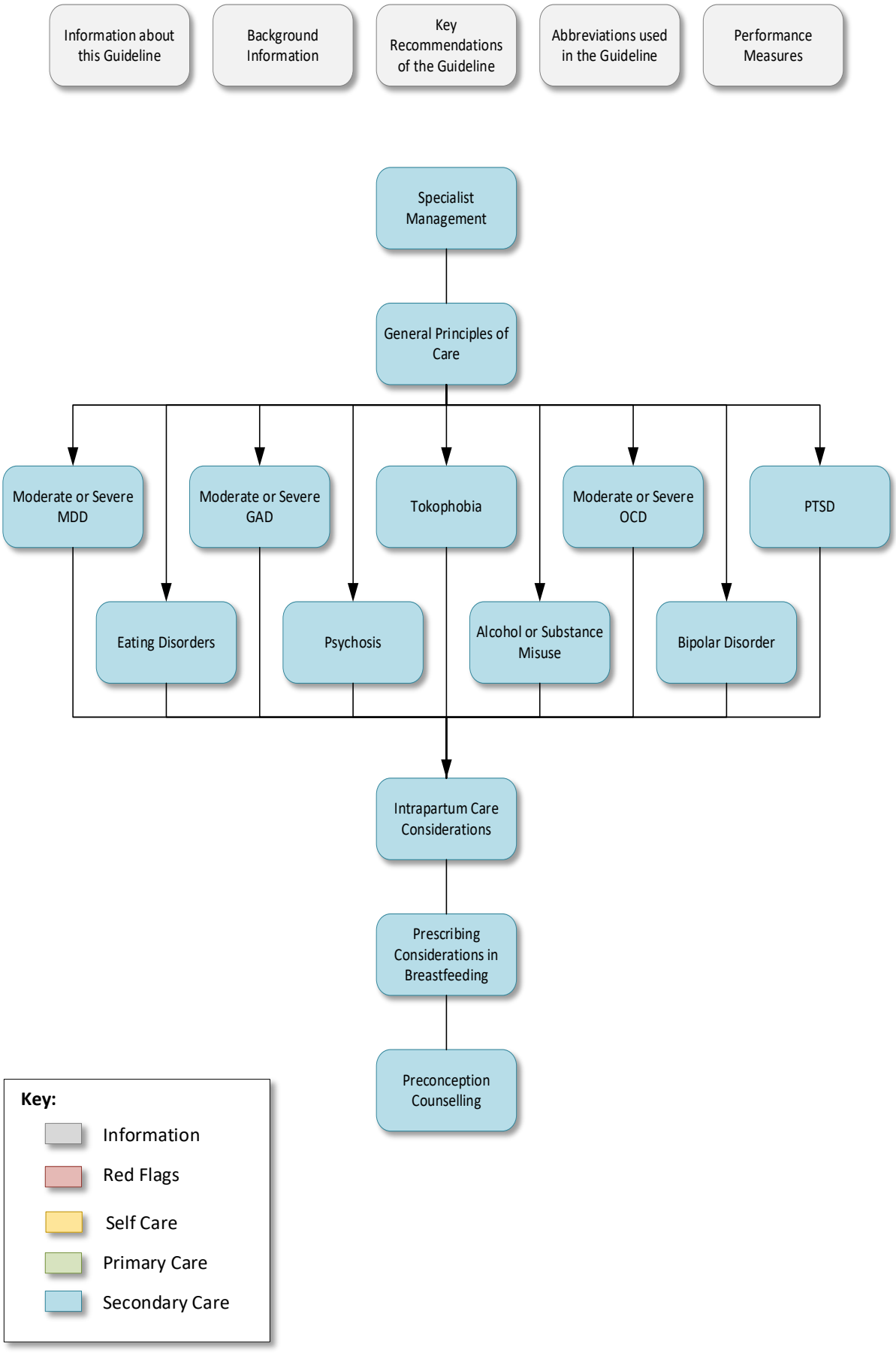
This guideline has been issued by the MOPH to define how care should be provided in Qatar. It is based upon a comprehensive assessment of the evidence as well as its applicability to the national context of Qatar. Healthcare professionals are expected to take this guidance into account when exercising their clinical judgement in the care of patients presenting to them.

The guidance does not override individual professional responsibility to take decisions that are appropriate to the circumstances of the patient concerned. Such decisions should be made in consultation with the patient, their guardians, or carers and should consider the individual risks and benefits of any intervention that is contemplated in the patient's care.

2 Obstetric Mental Health Pathway

Click on a box below to see the relevant page of the Pathway.




Information about this Guideline
Background Information
Key Recommendations of the Guideline
Abbreviations used in the Guideline
Performance Measures
Specialist Management
General Principles of Care
Moderate or Severe MDD
Moderate or Severe GAD
Tokophobia
Moderate or Severe OCD
PTSD
Eating Disorders
Psychosis
Alcohol or Substance Misuse
Bipolar Disorder
Intrapartum Care Considerations
Prescribing Considerations in Breastfeeding
Preconception Counselling
Key:
Information
Red Flags
Self Care
Primary Care
Secondary Care

3 Key Recommendations of the Guideline

General Principles of Care (*Section 5*):

- Mental health care should be patient-centred, culturally responsive and involve the family, where the patient consents [**R-GDG**].
- Women who have a history of mental health problems (or are worried that they might have a problem) may be unwilling to discuss their symptoms because of fear of stigma, negative perceptions of them as a mother, or fear that their baby might be taken into care[1].
- Healthcare practitioners should be sensitive to these fears when communicating with patients[1].
- Women with severe mental health problems should be managed by multi-disciplinary teams, where there is minimal disruption to continuity of care[1].
- Any decision on treatment should be made in collaboration with the woman, her husband (upon her agreement), and healthcare practitioner[1–3].

Referral Criteria to Specialist Care (*Section 6*):

- Refer to Section 6 for specific criteria for referral from Primary to Specialist Care.

Preconception Counselling (*Section 7.1*):

Women with pre-existing mental health conditions or previous perinatal mental health problems, who are planning to become pregnant should be offered a specialised mental health review over 1-2 sessions [**R-GDG**]. Issues to discuss include[1]:

- Risks to mother and baby.
- Risks of relapse during and after pregnancy.
- Medication optimisation prior to conception and during pregnancy.
- Smoking cessation and the use of Nicotine Replacement Therapy.

Screening for Depression (*Section 7.2*):

- All pregnant women should have a psychosocial assessment at first contact with antenatal services which should include screening for depression[4].
- The Patient Health Questionnaire 2-question tool (PHQ-2) is recommended for routine screening for depression in pregnant patients[1] [**L1, RGA**].
- If the PHQ-2 is >3, administer the PHQ 9-question tool (PHQ-9)[5] or the Edinburgh Postnatal Depression Score (EPDS)[1,2].
- The PHQ-2 or EPDS questions should be used to screen for depression at the 6-week postpartum obstetric visit (or at first postpartum visit), and after 2, 4, 6, and 12 months of childbirth[12,13].
- In EPDS use:
    - Complete the first antenatal screening as early as practical in pregnancy and repeat screening at least once later in pregnancy.
    - For a woman with an EPDS score between 10 and 12, monitor and repeat the EPDS 2–4 weeks later as her score may increase subsequently.
    - Use appropriately translated versions of the EPDS. Repeat the EPDS at any time in pregnancy and in the first postnatal year if clinically indicated.

NB: EPDS can be used as first line in the initial screening for depression, depending on the health service undertaking screening [**R-GDG**].

Screening for Anxiety (*Section 7.3*):

- All pregnant women should have a psychosocial assessment at first contact with antenatal services which should include screening for anxiety[6].

- The 2‑item Generalised Anxiety Disorder scale (GAD-2)[7] is recommended for routine screening for anxiety in pregnant patients[1] [**L1, RGA**].
- If a woman scores ≥3 on the GAD-2 scale, administer the 7-item GAD (GAD-7) scale for further assessment[7] and/or consider referral to a mental health professional if a severe anxiety disorder is suspected[1].
- Complete the first antenatal screening as early as practical in pregnancy and repeat screening at least once later in pregnancy.

NB: GAD-7 can be used as first line in the initial screening for anxiety, depending on the service undertaking screening.

Screening for Psychosocial Risk Factors (*Section 7.4*):
Screening for psychosocial risk factors includes as a minimum [**R-GDG**]:

- Enquiring as to the presence of family and domestic violence
- Enquiring about available levels of emotional support
- Enquiring about alcohol and other substance use

Providers should ensure that these questions are completed and that any positive responses require further evaluation [**R-GDG**].

Clinical Assessment (*Section 7.5*):

- If a patient is suspected to have a mental health problem, a thorough clinical assessment should be undertaken that includes an assessment of the patient's risk of harm to self and others[1] (see *Section 7.4.1* for further detail).
- Client with normal screening score who has risk factor (See *section 4.2*) should be assessed by physician.
- Arrange further assessment for woman with an EPDS score of 13 or more with prenatal mental health physiatrist or General physiatrist if prenatal mental health physiatrist is not available in facility [**R-GDG**].
  For a woman with a positive score on Question 10 on the EPDS, perform or arrange further assessment with prenatal metal health physiatrist (or General physiatrist at PHCC). If there is any disclosure of suicidal ideation, take urgent action. [**R-GDG**]
- If the patient is assessed to be at increased risk of self-harm or suicide:
  - A safety care plan should be developed in consultation with the patient, clinicians involved in her care and family members/other community supports as appropriate [**R-GDG**].
  - Ensure adequate social support for the patient[1].
  - Consider admission to hospital [**R-GDG**].
  - Inform all relevant healthcare professionals involved in the patient's care[1].

Management of Depression (*Section 8*):

- All women with depressive symptoms should receive psychoeducation about the condition, and lifestyle modification advice[8] [**L1, RGA**]:
- Treatment of mild depression is comprised of:
  - Guided Self-help[4,8,9] [**L1, RGA**].
  - Referral to Support clinics in Primary Care for CBT-based interventions[4].
- Treatment of moderate or severe depression includes all of the above interventions as well as[4]:
  - Individual CBT[4].
  - Group-CBT[4].
  - Interpersonal therapy (IPT)[4,10].
  - Pharmacotherapy.

- Electroconvulsive therapy (ECT) may be used during pregnancy according to patient's preferences [11] and in patients with severe MDD, whose physical health or that of the foetus is at serious risk, or other therapies have been ineffective[1] [**L1**].
- If the above services are unavailable in a primary care setting, patients should be referred to appropriate specialist services [**R-GDG**].

NB:

- Severe Postnatal Depression is not suitable for IPT, first line should be medication then IPT introduced, thus IPT and group IPT are better for moderate cases.
- ECT should only be undertaken in conjunction with close foetal monitoring and access to specialist maternal-foetal medical support [**R-GDG**].
- Transcranial magnetic stimulation (TMS) is not currently recommended in pregnancy[8] [**L1, RGB**].

Management of Generalised Anxiety Disorder (*Section 9*):
Be aware that anxiety disorder is very common in the perinatal period and should be considered in the broader clinical assessment [**R-GDG**].

- Management of patients with mild GAD in pregnancy, should include[6,12]:
  - Provide educational material for self-help about anxiety.
  - Avoid precipitating factors.
  - Encourage lifestyle changes [**L1, RGA**].
  - Low intensity psychological interventions, where available.
  - Individual non-facilitated self-help.
  - Individual guided self-help.
  - Psychoeducational groups.
- Management of Moderate and Severe GAD, includes[3,6,12,13]:
  - High-intensity psychological interventions.
  - Pharmacological therapy, if appropriate.
- If the above services are unavailable in a primary care setting, patients should be referred to appropriate specialist services [**R-GDG**].

Management of Tokophobia (*Section 10*):

- Tokophobia is a pregnancy-related phobic disorder which occurs when a woman has an extreme dread of childbirth[14].
- Management of tokophobia requires specialist management in an MDT with obstetric specialist input [**R-GDG**].

Management of Obsessive-Compulsive Disorder (*Section 11*):

- Management of patients with mild OCD in pregnancy, should include[3,15]:
  - Encourage lifestyle changes.
  - Provide educational material for self-help about OCD.
  - Low intensity psychological interventions, where available, including:
    - Individual non-facilitated self-help.
    - Individual guided self-help using principles of Exposure and Response Prevention.
- Pregnant women with severe or complex GAD should ideally be managed in a multidisciplinary team [**R-GDG**]. The specialist and/or MDT should offer:
  - Higher intensity psychological treatments e.g. CBT and Exposure-and Response Prevention.
  - Pharmacotherapy.

Management of Post-Traumatic Stress Disorder (*Section 12*):

- Management of PTSD in pregnant patients is similar to that of non-pregnant women and includes [**R-GDG**]:
    - High intensity psychological interventions:
        - Trauma-focused CBT.
        - Postnatal Eye Movement Desensitization and Reprocessing (EMDR) therapy.
    - Pharmacological treatment [1,16].
- The patient should be managed in a multidisciplinary team setting and a care plan developed that takes into account the traumatic event(s) and potential triggers for PTSD symptoms [**R-GDG**].
- Beware that postpartum PTSD can result in in secondary tokophobia[17].

Management of Bipolar Affective Disorder (*Section 13*):

- All women with bipolar disorder including those with previous history of postpartum psychosis who are pregnant or planning a pregnancy, should be managed in a specialist setting [18].
- be offered preconception planning.
- be managed by a specialist perinatal mental health MDT with close obstetric collaboration during pregnancy [18]. Early referral to a Feto-Maternal Unit for review and monitoring during pregnancy may be required, depending on drug exposure.
- If already on anti-psychotic medications, the women should be advised not to stop antipsychotics suddenly when they become pregnant, but instead advised to seek urgent perinatal psychiatry review.

- Antipsychotics:
    - May be considered for a pregnant woman who develops psychosis[1] [**L1, RGC**) and for women with schizophrenia or other psychotic disorder at risk of relapse.
    - The woman should be informed about possible adverse effects of antipsychotics on the foetal development[19].
    - The risks of untreated disorder should also be discussed with patient [**R-GDG**].
- The following psychological interventions are recommended.
    - Prebirth planning meeting – ideally involving the patient and her family, obstetric and mental health stakeholders, social worker and community support agencies involved in the woman's care.
    - Psychological therapies, particularly in the presence of comorbid anxiety and depressive symptoms:
        - Social rhythms therapy.
        - Psychoeducation
        - Family support including psychoeducation

    - Electroconvulsive Therapy (See *Section 8.5*).

Management of Sleep Disorders (Section 14.1):

- All pregnant women with sleep disturbances should be offered non-medical interventions [1,9,20] [**L1, RGA**].
- Antihistamines (promethazine or hydroxyzine) may be considered for women who failed to respond to non-pharmacological treatment[1,20] [**L1, RGA**].

Management of Eating Disorders (*Section 14.2*):

- All pregnant patients diagnosed with an eating disorder should be managed in a multidisciplinary team setting [**R-GDG**].

- A more intensive prenatal care may be considered for pregnant women with current or remitted anorexia nervosa.
- Foetal growth scans should be performed when needed[21] [**L1, RGA**].

Management of Alcohol and Substance Abuse (*Section 14.3*):

- Acute intoxication with cocaine, amphetamines, ketamine or other hallucinogens may be misdiagnosed as pre-eclampsia[22].
- If alcohol or substance misuse is identified in pregnancy, the following interventions should be considered and offered to the patient[1,23–26] [**L1, RGA**]:
    - Group-based psychoeducation.
    - Motivational interviews focused on:
        - Contingency management.
    - CBT.
    - Assisted withdrawal or help to reduce the alcohol or substance intake.
    - Opioid replacement therapy.
    - A consultation with the obstetric anaesthetist may be required[22].
- The risk of accidental overdose should be assessed in women who stop or reduce drug misuse in pregnancy but start misusing again after childbirth[1].
- The possibility of child abuse or neglect resulting from maternal substance abuse, should be reviewed regularly[27].

Management of Schizophrenia and other Psychotic Disorders (*Section 14.4*):

It is recommended that women with schizophrenia and other psychotic disorders, including those with a previous history of postpartum psychosis[1,28] [**L1, RGA**]:

- be offered preconception planning.
- be advised not to stop antipsychotics suddenly when they become pregnant, but instead advised to seek urgent perinatal psychiatry review.
- should be managed by a specialist perinatal mental health MDT with close obstetric collaboration during pregnancy[18].
- Antipsychotics:
    - May be considered for a pregnant woman who develops psychosis[1] [**L1, RGC**) and for women with schizophrenia or other psychotic disorder at risk of relapse.
    - The woman should be informed about possible adverse effects of antipsychotics on the foetal development[19].
    - The risks of untreated psychosis should also be discussed with patient [**R-GDG**].
- The following psychological interventions are recommended.
    - Pre-birth planning meeting – ideally involving the patient and her family, obstetric and mental health stakeholders, social worker and community support agencies involved in the woman's care.
    - Family support including psychoeducation.
    - Psychological therapies; particularly in the presence of comorbid anxiety and depressive symptoms.

Acute postpartum psychosis should be regarded as a psychiatric and obstetric emergency and should be assessed within 4 hours of referral [**L1, RGA**].

Intrapartum Care Considerations (*Section 15*):

- The management of pregnant women with psychiatric disorders during the three stages of labour is comparable to the management of uncomplicated pregnancies[29] [**L1, RGA**].

- Women who are psychotic at the time of delivery may require additional midwifery and mental health nursing support as well as close supervision of their infant care post-delivery.
- A neonatologist should be contacted at the onset of labour and should be present at the time of delivery for women taking medications for treatment of mental illness (including antipsychotics, antidepressants, mood stabilizers and benzodiazepines as well as at the delivery of any opioid-dependent mother[31,32] [**L2**].
- Post-delivery it is recommended that these infants are monitored for neonatal discontinuations symptoms.

- For women who are opioid-dependent, a neonatologist should be contacted at the onset of labour and should be present at the time of delivery[30,31] [**L2**].
- Infants of opioid dependent women should be monitored to evaluate the risk of neonatal abstinence syndrome (NAS)[30,31] [**L2, RGA**]. The condition of the infant can be assessed every few hours using the Finnegan scale[30,31] [**L2, RGA**].
- Infants with neonatal abstinence syndrome should be closely monitored and prescribed opioids such as methadone or morphine in a stable dose to avoid withdrawal syndrome[30,31] [**L2, RGA**].

Prescribing Considerations in Pregnancy & Breastfeeding (*Section 16*):

- If medication is required during pregnancy[1,4]:
    - The lowest effective dose should be used[1].
    - Adjustment of doses should be considered along the course of pregnancy and breastfeeding, as clinically indicated[1,4].
    - Monotherapy is preferred over the use of two or more drugs[1].
    - Medication should be chosen with consideration of the risk/benefit profile for mother and foetus.
    - If a medication has been used successfully previously and is not contraindicated, this should be the first choice.
    - The physician should outline the risks for both the mother and the infant, that may occur at different stages of pregnancy, early postpartum period and during breastfeeding.

4 Background Information

Mental health problems can arise for the first time either during pregnancy or the postnatal period (defined as the period up to one year after childbirth[1]) or may exacerbate pre-existing mental health issues. Maternal mental health problems are considered a major public health challenge internationally[32].

4.1 Prevalence

Anxiety and depression are the commonest perinatal mental health disorders[1,32] and have similar prevalence both antenatally and perinatally[8]. The risk of depression appears to be higher in the second and third trimester of pregnancy compared to the first trimester [**R-GDG**].

In developed countries, 10-15% of women meet criteria for depression at some point during their pregnancy or the postpartum period[8,33]. In developing countries, the prevalence of depression is increased 18-36%[33,34].

A single study conducted on Qatari and other Arab women living in Qatar, suggested that 17.6% of mothers suffer from postpartum depression[33].

4.2 Risk Factors

Risk Factors for mental health problems in the antenatal and postnatal periods, include[32]:

- Poverty.
- Migration.
- Extreme stress.
- Exposure to violence (domestic, sexual and gender-based).
- Emergency and conflict situations.
- Natural disasters.
- Low social support.
- Low self-esteem.

The following risk factors are particularly recognised for maternal depression and anxiety [8,33]:

- Insufficient social support.
- Living alone or lack of family supports.
- Marital discord or disapproved marriage.
- Traumatic birth experience.
- Unwanted or unplanned pregnancy.
- Pregnancy with twins, triplets, and other multiples.
- Advanced maternal age.
- Teenage pregnancy.
- Personal or family history of affective illness.
- Discontinuation of antidepressants.
- IUFD/neonatal death/preterm birth/baby with health problem or special needs.

5 General Principles of Care

Mental health care should be patient-centred, culturally responsive and involve the family, where the patient consents [**R-GDG**]. Women with severe mental health problems should be managed by multi-disciplinary teams, where there is minimal disruption to continuity of care[1].

Women who have a history of mental health problems (or are worried that they might have a problem) may be unwilling to discuss their symptoms because of fear of stigma, negative perceptions of them as a mother, or fear that their baby might be taken into care[1]. Healthcare practitioners should be sensitive to these fears when communicating with patients[1].

Any decision on treatment should be made in collaboration with the woman, her partner (upon her agreement), and healthcare practitioner[1–3]. The following should be discussed:

- The natural history of the disorder during the perinatal period.
- Potential risks and benefits of treatment/non-treatment for mother and baby, should be discussed and evaluated.
- The woman's autonomy to take decisions about her health, should be respected by the healthcare practitioner, except where she lacks the capacity to make informed decisions.
- Selected treatment should optimise outcomes for both mother and baby.
- An integrated care plan involving both obstetric and mental health care providers, should be developed and provided to the patient. With the patient's consent, the care plan can be shared with other family members and other stakeholders. The care plan should include [1]:
    - Treatment goals.
    - Ways of the outcome monitoring.
    - Names and contact details of key professionals.

Social support in the context of perinatal maternal health and well-being determines structural and functional dimensions which facilitate a woman's transition from pre-pregnant status to pregnancy and subsequent motherhood[35].

Perinatal social support should be[35,36] [**L3**]:

- Individualised and aligned with women needs and expectations.
- Provided by a trained healthcare professional.
- Assessing medical challenges.
- Helpful in processing complex information about pregnancies and neonates.
- Designed in a way to alleviate stress to facilitate health and well-being.
- Supporting during the transition to parenthood.
- Assisting in creating healthy relationships between the child and parents.
- Helps families to cope with feelings of grief in case of perinatal loss (e.g., miscarriage, still birth or neonatal death).

Perinatal social support may be provided in hospitals or in the community settings[36]. Out-patient mental health services may also be considered[36].

View Pathway

6 Referral Criteria to Specialist Care

Consider referring women to specialised perinatal mental health services, if the patient has any of the following[1,37]:

- If medication is required.
- Symptoms of psychosis.
- Moderate to severe anxiety.
- Moderate to severe depression.
- Moderate to severe OCD.
- PTSD related to previous traumatic delivery.
- Phobias that cannot be effectively managed in primary care (e.g., tokophobia).
- Comorbid mental health problems.
- Substance misuse/abuse.
- Current significant risk to self or others.
- Self-neglect.
- Significant interference with daily functioning.
- History of bipolar disorder, schizophrenia or other psychotic disorder (including postpartum psychosis).
- Mild or moderate mental health disease and the presence of a first-degree relative with bipolar disorder or puerperal psychosis.
- Complex psychotropic medication regimens.
- Lack of adequate response to therapy.
- Previous periods of inpatient mental health care.
- Learning disabilities or cognitive impairments.

7 Screening and Assessment

7.1 Preconception Counselling

Women with pre-existing mental health conditions or previous perinatal mental health problems, who are planning to become pregnant should be offered a specialised mental health review over 1-2 sessions [**R-GDG**]. Issues to discuss include[1]:

- Risks to mother and baby.
- Risks of relapse during and after pregnancy.
- Medication optimisation prior to conception and during pregnancy.
- Smoking cessation and the use of Nicotine Replacement Therapy.

All women of child-bearing potential, who are diagnosed and/or treated for mental health conditions should be counselled by their physician on the above issues, even if they are not planning to become pregnant[1]. Contraception should be discussed by trained health care practitioner.

7.2 Screening for Depression

All pregnant women should have a psychosocial assessment at first contact with antenatal services which should include screening for depression[1,4]. The Patient Health Questionnaire 2-question tool (PHQ-2) is recommended for routine screening for depression in pregnant patients[1] [**L1, RGA**].

Ask the patient:

- ***During the last month, have you often been bothered by:***
  - ***Feeling down, depressed or hopeless?***
  - ***Having little interest or pleasure in doing things?***

If the answer is "yes" to either of these questions[1,2]:

- Administer PHQ 9-question tool (PHQ-9)[5] or the Edinburgh Postnatal Depression Score (EPDS) Arrange further assessment of perinatal woman with an EPDS score of 13 or more..
- Manage in Primary Care, where possible, as described in *Section 8.*
- Consider referral to Specialist Care if indicated (see *Section 6*).

7.3 Screening for Anxiety

All pregnant women should have a psychosocial assessment at first contact with antenatal services which should include screening for anxiety[6]. The 2-item Generalised Anxiety Disorder scale (GAD-2)[7] is recommended for routine screening for anxiety in pregnant patients[1] [**L1, RGA**].

The GAD-2 Score is evaluated by summating the scores resulting from the two questions in *Table 7.3*[7].

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1 Feeling nervous, anxious or on edge	0	1	2	3
2 Not being able to sleep or control worrying	0	1	2	3

***Table 7.3*: GAD-2 Scoring Tool[7].**

If a woman scores ≥3 on the GAD-2 scale:

- Administer the 7-item GAD (GAD-7) scale for further assessment[7] and/or
- Consider referral to a mental health professional if a severe anxiety disorder is suspected[1].

If a woman scores < 3 on the GAD-2 scale, but there is still a concern that she may have an anxiety disorder, ask the following question:

- ***Do you find yourself avoiding places or activities and does this cause you problems?***

If the woman responds positively, treat her as if she had scored ≥3[1].

7.4 Screening for Psychosocial Risk Factors

Screening for psychosocial risk factors includes as a minimum [**R-GDG**]:

- Enquiring as to the presence of family and domestic violence.
- Enquiring about available levels of emotional support.
- Enquiring about alcohol and other substance use.

Clinicians and relevant healthcare providers should ensure that these questions are completed and that any positive responses require further evaluation [**R-GDG**].

7.5 Clinical Assessment

If a woman is suspected to have a mental health problem, a thorough clinical assessment should be undertaken that includes[1]:

- Patient and family history (first-degree relatives) of any mental health problem.
- Physical wellbeing (including weight, smoking, nutrition, and activity level).
- History of physical health problems.
- Alcohol and substance misuse.
- Attitude towards the pregnancy (including denial of pregnancy).
- Experience of pregnancy.
- Past or present treatment for a mental health problem and response to it.
- Social networks and quality of interpersonal relationships.
- Living conditions and social isolation.
- Housing, employment, economic and immigration status.
- Responsibilities as a carer for other children or other adults.
- Risk assessment.

NB:

- Clients with normal screening score who have risk factors should be assessed by physician.
- Arrange further assessment for woman with an EPDS score of 13 or more with prenatal mental health physiatrist or General physiatrist if prenatal mental health physiatrist is not available in the facility [**R-GDG**].
- For a woman with a positive score on Question 10 on the EPDS, perform or arrange further assessment with prenatal metal health physiatrist (or General physiatrist at PHCC) if there is any disclosure of suicidal ideation, take urgent action [**R-GDG**].
- Any woman who has sudden onset of symptoms suggesting postpartum psychosis, should be referred to a specialist Mental Health Service[1] [**L1**]. The presentation should be regarded as a psychiatric and obstetric emergency and should be assessed within 4 hours of referral[1] [**L1, RGA**].

View Pathway

7.5.1 Risk Assessment

A risk assessment should be conducted which covers the following areas[1]:

- Self−neglect.
- Self−harm.
- Suicidal thoughts and intent.
- Risks to others (including the baby).
- Smoking.
- Alcohol or substance misuse.
- Domestic violence and abuse.

If a risk or concern of child maltreatment is identified, contact Social Services or a Paediatric Specialist for advice and guidance [**R-GDG**].
If the patient is assessed to be at increased risk of self-harm or suicide:

- Ensure adequate social support for the patient[1].
- Consider admission to hospital [**R-GDG**].
- Inform all relevant healthcare professionals involved in the patient's care[1].

7.6 Investigation

Before a diagnosis of a mental health disorder can be made, physical causes which may present with similar symptoms, should be excluded by history and examination. If necessary, investigation of physical causes may be required [**R-GDG**].

The following tests may be considered and ordered when necessary[9,16,38]:

- Complete blood count.
- Thyroid function tests (thyroid stimulating hormone, TSH).
- Calcium, magnesium and electrolytes.
- Liver function tests.
- Vitamin D level.
- Drug screening.
- Neurological evaluation.

8 Management of Depression

8.1 Diagnostic Criteria

Depression is a mood disorder that involves disturbances in emotional, cognitive, behavioural, and somatic regulation and interferes with the functioning of daily life[39,40].

The following DSM-5 criteria should be met to diagnose Major Depressive Disorder (MDD)[40]:

- 5 or more symptoms should be present most of the day, nearly every day during the same two-week period and represent a change from previous functioning:
  - Depressed mood (patient's report or observations).
  - Diminished interest or pleasure in activities (patient's report or observations).
  - Significant changes in appetite leading to weight loss or gain (>5% of body weight in a month).
  - Insomnia or hypersomnia.
  - Psychomotor agitation or retardation (observations by others).
  - Fatigue or loss of energy.
  - Feelings of worthlessness or excessive/inappropriate guilt (e.g., guilt about being sick).
  - Diminished ability to think or concentrate (patient's report or observations).
  - Recurrent thoughts of death, suicidal ideation with or without a specific plan; suicide attempt.
- At least one of symptoms is:
  - Depressed mood; or
  - Loss of interest or pleasure.
- The symptoms cause clinically significant distress or impairment in daily functioning.
- The Major Depressive Episode (MDE) is not due to the physiological effects of a substance or another medical condition.
- The occurrence of MDE is not better explained by schizophrenia, delusional disorder or other psychotic disorders.
- There has never been a manic or hypomanic episode (not applicable to substance-induced episodes or to the physiological effects of another medical condition).
- The perinatal onset of depression should be specified.
- When possible, specify the severity (see below) and other features (with or without melancholic, psychotic, atypical, mixed features; catatonia), seasonal pattern, and remission.

If criteria for MDD are continuously present for at least 2 years and have not vanished for more than 2 months at a time [40], the *persistent depressive disorder* should be considered.
If a woman agrees, provide information to and involve her significant other(s) in discussions about her emotional wellbeing and care throughout the perinatal period.

The severity of MDD can be classified by the number and severity of symptoms[4].

- **Mild form**:
  - At least 5 symptoms of MDD are present.
  - The intensity of symptoms is distressing but manageable.
  - Symptoms result in minor social or occupational functioning.
- **Moderate form**:
  - The number of symptoms, their intensity, and the degree of functional impairment are between those specified for 'mild' and 'severe' MDD.
- **Severe form**:
  - The number of symptoms is substantially in excess of the 5 required to make the diagnosis.
  - The intensity of symptoms is seriously distressing and unmanageable.
  - Symptoms markedly interfere with social and occupational functioning.
  - Can occur with or without psychotic symptoms.

8.2 Management of Mild MDD

All women with depressive symptoms should receive active and passive psychoeducation about the condition, and lifestyle modification advice, including[8] [**L1, RGA**]:

- Provide health promotion information such as improvement in nutrition and diet (e.g. elimination of caffeine, nicotine, and alcohol).
- Discuss any support the woman may require.
- Behavioural activation (e.g. exercise and pleasurable activities).
- Awareness of impact of stressful events.
- Developing social networks.
- Sleep hygiene.
- Information on relaxation techniques.
- Passive psychoeducational interventions (for example, leaflets).

Additional treatment of mild depression is comprised of:

- Guided Self-help – where available, such programmes provide guidance based on the principles of[4,8,9] [**L1, RGA**]:
    - Individual cognitive behavioural therapy (CBT).
    - Problem-solving techniques (PST).
    - Behavioural activation.
    - Conjoint therapy (with the partner).
- Referral to Support clinics in Primary Care for CBT-based interventions[4].
    - CBT is focused on determining distorted negative thinking patterns[41].
    - It reduces depressive symptoms by challenging and reversing irrational beliefs and distorted attitudes and by encouraging patients with MDD to change their maladaptive behaviours in real life[11,42].

8.3 Management of Moderate & Severe MDD

For patients with moderate or severe depression, all of the above interventions outlined for mild depression, should be provided[4]. In addition, the following should also be offered:

- Higher level interventions[4]:
    - Individual.
    - Group-CBT, ideally group CBT should:
        - Be based on a structured model such as *'Coping with Depression'.*
        - Be delivered by two trained and competent practitioners.
        - Consist of 10-12 meetings of 8-10 participants.
        - Take place over 12-16 weeks, including follow-up.
    - Interpersonal therapy (IPT). IPT should ideally:
        - Resolve interpersonal problems.
        - Be supported by a trained specialist, who reviews progress and outcome.
        - Include 16 to 20 sessions and follow-up.
- Consider pharmacotherapy, according to the patient's preferences and previous response to medication[4] (see *Section 16*).

8.4 Electroconvulsive Therapy

Electroconvulsive therapy (ECT) may be used during pregnancy according to patient's preferences[11] and in patients with severe MDD, whose physical health or that of the foetus is at serious risk, or other therapies have been ineffective[1] [**L1**].

The patient should be informed about possible side effects and carefully monitored for the following[8]:

- Premature labour.
- Uterine contractions.
- Vaginal bleeding.
- Gastric regurgitation.
- Pulmonary aspiration.

NB:

- ECT should only be undertaken in conjunction with close foetal monitoring and access to specialist maternal-foetal medical support [**R-GDG**].
- **Transcranial magnetic stimulation (TMS) is not currently recommended in pregnancy[8] [L1, RGB].**

8.5 Postnatal Depression

The PHQ-2 or EPDS questions should be used to screen for depression at the 6-week postpartum obstetric visit (or at first postpartum visit), and after 2, 4, 6, and 12 months of childbirth[43,44].

The risk of postpartum psychosis is increased in women with[1,38,45]:

- Any past severe mental illness.
- Present mental illness.
- Family history of severe perinatal mental illness.
- Traumatic birth or pregnancy experience
- IUFD, stillbirth or foetal anomaly

Management of postnatal depression should concord with management of depression in other adult groups. Refer to the MOPH National Guideline: *Diagnosis & Management of Depression in Adults* for further information[9]. Refer to *Section 16* for prescribing considerations in breastfeeding mothers.

View Pathway

9 Management of Generalised Anxiety Disorder

9.1 Diagnostic Criteria

Generalised Anxiety disorder (GAD) is an unreasonable, excessive, ongoing, and uncontrollable anxiety and worry that could interfere with the person's ability to perform daily functioning[40].

The following DSM-5 criteria should be met to diagnose GAD[40]:

- Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about several events or activities.
- The individual finds it difficult to control the worry.
- The anxiety and worry are associated with 3 or more of the following 6 symptoms. At least some of the symptoms should be present for most days over the last 6 months:
    - Restlessness or feeling 'keyed up' or on edge.
    - Being easily fatigued.
    - Difficulty concentrating or mind going blank.
    - Irritability.
    - Muscle tension.
    - Sleep disturbance (difficulty falling or staying asleep, or restless, unsatisfying sleep).
- The anxiety, worry or physical symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
- The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition (e.g. hyperthyroidism).
- The disturbance is not better explained by another mental disorder.

The GAD-7 Scoring system can be used to classify the severity of GAD, based on the total score as shown in the table below[46]:

GAD-7 Score	Classification
0 – 4	Minimal Anxiety
5 – 9	Mild Anxiety
10 – 14	Moderate Anxiety
15 – 21	Severe Anxiety

Table 9.1: Classification of anxiety based on the GAD-7 score[46].

9.2 Management of Mild GAD

Management of patients with mild GAD in pregnancy, should include[6,12]:

- Provide educational material for self-help about anxiety.
- Avoid precipitating factors.
- Encourage lifestyle changes [**L1, RGA**]:
    - Avoid substances that trigger anxiety such as caffeine, nicotine and any illicit substances.
    - Reduce work/home stress.
    - Sleep hygiene for improvement in quantity and quality of sleep.
    - Exercise to improve cognitive functions and psychological wellbeing.
- Low intensity psychological interventions, where available, including:
    - Individual non-facilitated self-help:
        - Limited contact with the therapist (occasional 5-min call).

        - Involves age appropriate written or electronic materials and instructions to use these materials systemically for at least 6 weeks.
        - Based on the principles of cognitive behavioural therapy (CBT).
    - Individual guided self-help:
        - Involves age-appropriate written or electronic materials.
        - A trained practitioner* is involved to facilitate the self-help and monitor the progress and outcomes of the interventions.
        - 5 – 7 weekly or fortnightly sessions (20 – 30 min) over the telephone or face-to-face.
        - Based on the principles of CBT.
    - Psychoeducational groups:
        - Involves presentations and self-help manuals with interactive design, to promote observational learning.
        - Based on the principles of CBT.
        - 6 weekly sessions (2 hours each), involving 12 patients and 1 trained practitioner.
- Monitor symptoms on a regular basis and reassess using GAD-7.

9.3 Management of Moderate GAD

Management of Moderate GAD, includes[3,6,12,13][**L1, RGA**]:

- High-intensity psychological interventions.
- Pharmacological therapy, if appropriate.

High-intensity psychological interventions for GAD, involve[3,6,12,13] [**L1, RGA**]:

- CBT:
    - Provided by trained practitioners.
    - 12 – 15 weekly sessions (of at least 1 hour each), depending on the rate of recovery.
- Applied relaxation:
    - Provided by trained practitioners.
    - 12 – 15 weekly sessions (of at least 1 hour each), depending on the rate of recovery.

All interventions should be completed in the preferred language of the patient[6]. The efficacy of the treatment should be evaluated using serial assessment of the patient using GAD-7 [**R-GDG**].

If the above services are unavailable in a primary care setting, patients should be referred to appropriate specialist services [**R-GDG**].

9.4 Management of Severe GAD

Pregnant women with severe or complex GAD should be managed in a multidisciplinary specialist setting [**R-GDG**]. The specialist and/or MDT should offer a combination of psychological and pharmacological treatments according to the patient's requirements and previous treatments[3,6,12,13] [**L1, RGA**].

Treatment may include [**R-GDG**]:

- Complex pharmacological and/or psychological treatment regimens.
- Day hospitals.
- Inpatient care.

View Pathway

NB:

- The treatment plan should be discussed with the patient, who should be actively involved in the decision-making process[3,6,12,13] [**L1, RGA**].
- If the patient has refused some of the treatments that were offered in previous Steps, provide information about the benefits of these treatments and encourage the patient to try them[3,6,12,13] [**L1, RGA**].
  - Benzodiazepines are not recommended for pregnant women but may be justified for short-term treatment of severe anxiety and agitation[1] [**L1**].

10 Tokophobia

10.1 Diagnostic Criteria

Tokophobia is a pregnancy-related phobic disorder which occurs when a woman has an extreme dread of childbirth[14]:

- Primary tokophobia is when severe fear precedes conception and leads to avoidance of pregnancy and childbirth[47].
- Secondary tokophobia is defined as phobic fear resulting from a distressing or even traumatising childbirth experience[47].

The following DSM-5 criteria should be met in order to diagnose specific phobias, including tokophobia[40]:

- Marked fear or anxiety about a specific object or situation.
- The phobic object or situation almost always provokes immediate fear or anxiety.
- The phobic object or situation is actively avoided or endured with intense fear or anxiety.
- The fear or anxiety is out of proportion to the actual danger posed by the specific object or situation and to the sociocultural context.
- The fear, anxiety or avoidance is persistent, typically lasting 6 months or more.
- The fear, anxiety or avoidance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.
- The disturbance is not better explained by the symptoms of another mental disorder.

10.2 Management of Tokophobia

Common features of tokophobia include, fears of[14]:

- Intolerable pain during labour and birth.
- Being in bad physical condition for childbirth (e.g., having a too narrow pelvis).
- Long labour.
- Panicking during labour.
- Being unable to perform correctly.
- Losing self-control.
- Lack of support (e.g., not being treated with empathy).
- Interventions in labour (e.g., a caesarean section, episiotomy, vaginal-operative birth).
- Possible complications and death.
- Loss of their own life.

Possible health-related consequences of the fear should be addressed whenever possible. They include[14]:

- During pregnancy:
    - Recurring, aggravating and painful thoughts.
    - Nervousness.
    - Restlessness.
    - Nightmares.
    - Lack of concentration.
    - Physical symptoms.
- During childbirth:
    - Feeling unbearable pain including after an epidural anaesthesia.
    - Prolonged duration of birth.
    - Negative childbirth experience.

The request for a caesarean section due to tokophobia should be interpreted as a sign that the woman needs help[14].

View Pathway

The following should be offered[1,14] [**L1, RGA**]:

- An opportunity to discuss patient's fears.
- Careful exploration of the underlying causes.
- The promotion of evidence-based decisions about the mode of birth.
- Counselling and support from a midwife.

Management of tokophobia requires specialist management in an MDT with obstetric specialist input [**R-GDG**].

View Pathway

11 Obsessive-Compulsive Disorder

11.1 Diagnostic Criteria

Obsessive-Compulsive Disorder (OCD) is characterised by the presence of obsession and/or compulsions[40].

Obsessions are defined by[40]:

- Recurrent and persistent thoughts, urges, or images that are experienced, at some time during the disturbance, as intrusive and unwanted, and in most individuals cause marked anxiety or distress.
  AND:
- The individual attempts to ignore, suppress such thoughts, urges or images, or to neutralise them with some other thought or action (i.e. performing a compulsion).

Compulsions are defined by[40]:

- Repetitive behaviours (e.g. handwashing, ordering, checking) or metal acts (e.g. praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
  AND:
- The behaviours or mental acts are aimed at preventing or reducing anxiety or distress. Or preventing some dreaded event or situation; however, these behaviours or mental acts are not connected in a realistic way to what they are designed to neutralise or prevent; or are clearly excessive.

The following DSM-5 criteria should be met in order to diagnose OCD[40]:

- Presence of obsessions, compulsion or both.
- The obsession or compulsions are time-consuming (e.g. take more than an hour per day) or cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
- The obsessive-compulsive symptoms are not attributable to the physiological effects of a substance (e.g. drug of abuse or medication) or another medical condition.
- The disturbance is not better explained by the symptoms of another mental disorder.
- The degree of insight should be specified.

11.2 Management of Mild OCD

Management of patients with mild OCD in pregnancy, should include[3,15]:

- Encourage lifestyle changes.
- Provide educational material for self-help about OCD.
- Low intensity psychological interventions, where available, including:
  - Individual non-facilitated self-help.
  - Individual guided self-help:
    - Based on the principles of CBT or Exposure and Response Prevention.

11.3 Management of Moderate or Severe OCD

Pregnant women with moderate, severe or complex OCD should ideally be managed in a multidisciplinary team [**R-GDG**]. The specialist and/or MDT should offer:

- Higher intensity psychological treatments e.g. CBT and Exposure-and Response Prevention.
- Pharmacotherapy.

View Pathway

12 Post-Traumatic Stress Disorder

12.1 Diagnostic Criteria

Post-Traumatic Stress Disorder (PTSD) is a trauma- or stressor-related disorder. It is triggered by emotional reactions to a stressful event (e.g., traumatic birth or miscarriage)[40]. The onset of PTSD can precede pregnancy or occur during the perinatal period[48]. PTSD can also develop in response to traumatic pregnancy complications[3].

The following DSM-5 criteria should be met in order to diagnose PTSD[40]:

- Exposure to actual or threatened death, serious injury, or sexual violence in one or more of the following ways:
    - Directly experiencing the traumatic event(s).
    - Witnessing in person the event(s) as it occurred to others.
    - Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
    - Experiencing repeated or extreme exposure to aversive details of the traumatic event(s).
- Presence of one or more of the following intrusion symptoms associated with the traumatic event(s), beginning after the event(s) occurred.
    - Recurrent, involuntary and intrusive distressing memories of the traumatic event(s).
    - Recurrent distressing dreams in which the content or effects of the dream are related to the traumatic event(s).
    - Dissociative reactions (e.g. flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring.
    - Intense or prolonged psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event(s).
    - Marked physiological reactions to internal or external cues that symbolise or resemble an aspect of the traumatic event(s).
- Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the event(s) occurred as evidence by one of the following:
    - Avoidance of, or efforts to avoid, distressing memories, thoughts or feelings about, or closely associated with, the traumatic event(s).
    - Avoidance of, or efforts to avoid, external reminders that arouse distressing memories, thoughts or feelings about, or closely associated with, the traumatic event(s).
- Negative alterations in cognitions and mood associated with the traumatic event(s) beginning or worsening after the traumatic event(s) occurred, as evidenced by 2 or more of the following:
    - Inability to remember an important aspect of the traumatic event(s).
    - Persistent or exaggerated negative beliefs or expectations about oneself, others or the world.
    - Persistent distorted cognition about the cause or consequences of the traumatic event(s) that lead the individual to blame themselves or others.
    - Persistent negative emotional state.
    - Markedly diminished interest or participation in significant activities.
    - Feelings of detachment or estrangement from others.
    - Persistent inability to experience positive emotions.
- Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by 2 or more of the following:
    - Irritable behaviour and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
    - Reckless or self-destructive behaviour.
    - Hypervigilance.
    - Exaggerated startle response.

    - Problems with concentration.
    - Sleep disturbance.
- Duration of the disturbance is more than 1 month.
- The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.
- The disturbance is not attributable to the physiological effects of a substance, medication or another medical condition.

12.2 Management of PTSD

Management of pregnant patients is similar to that of non-pregnant women and includes [**R-GDG**]:

- High intensity psychological interventions:
    - Trauma-focused CBT.
    - Postnatal EMDR.
- Pharmacological treatment[1,16].

The patient should be managed in a multidisciplinary team setting and a care plan (including care in future pregnancy and childbirth) developed that considers the traumatic event(s) and potential triggers for PTSD symptoms [**R-GDG**].

12.3 PTSD Following a Traumatic Birth or Miscarriage

The factors listed below contribute to the development of PTSD following traumatic childbirth [48,49]. They should be accounted by healthcare professionals and used for a decision about preventive interventions.

- Pregnancy or postpartum complications and admission to Intensive Care Unit.
- Preterm labour.
- Emergency caesarean.
- Caesarean hysterectomy or postpartum hysterectomy.
- Episiotomy or instrumental delivery.
- Inadequate care during the labour.
- Severe pain experienced during the birth.
- Level of social support following childbirth.

Postnatal PTSD symptoms are similar to PTSD symptoms of other events. Management of different kinds of PTSD is also similar[50] [**L2, RGA**].

In addition to psychological and pharmacological interventions[1] [**L1, RGA**]:

- Advice and support to women who wish to talk about their experience.
- Pay attention to the effect of the birth or miscarriage on the partner.
- Encourage parents to accept support from family and friends.

NB:

- Depression should be reviewed as a comorbid condition of PTSD[48].
- Single-session high-intensity psychological interventions with a focus on 're-living' the trauma are not recommended for women experienced a traumatic birth[1] [**L1**].
- Beware that postpartum PTSD can result in in secondary tokophobia[17].

View Pathway

13 Bipolar Affective Disorder

13.1 Diagnostic Criteria

Bipolar and related disorders are mental health disorders that cause mood swings from emotional highs (manic or hypomanic episodes) and lows (major depressive episodes)[40].

In order to make the diagnosis of bipolar disorder the patient must be diagnosed with at least one manic episode in their lifetime, which may be immediately preceded or followed by an episode of hypomania or a Major Depressive Episode (MDE)[40].

The following DSM-5 criteria for a manic episode must therefore be met in order to diagnose a patient with bipolar disorder[40]:

- A distinct period of abnormally or and persistently elevated, expansive or irritable mood and abnormally and persistently increased activity or energy, lasting at least 1 week and present most of the day, nearly every day.
- During the period of mood disturbance and increased energy or activity, 3 or more of the following symptoms (4 if the mood is only irritable) are present to a significant degree and represent a noticeable change in behaviour:
    - Inflated self-esteem or grandiosity.
    - Decreased need for sleep.
    - More talkative than usual or pressure to keep talking.
    - Flight of ideas or subjective experience that thoughts are racing.
    - Distractibility as reported or observed.
    - Increase in goal-directed activity or psychomotor agitation.
    - Excessive involvement in activities that have a high potential for painful consequences (e.g. engaging in unrestrained buying sprees, sexual indiscretion, foolish business investments).
- The mood disturbance is sufficiently severe to cause a marked impairment in social or occupational functioning or to necessitate hospitalisation to prevent harm to self or others, or there are psychotic features.
- The episode is not attributable to the physiological effects of a substance, medication or another medical condition.

13.2 Management of Bipolar Affective Disorder

All women with bipolar disorder who are pregnant or planning a pregnancy, should be managed in a specialist setting[18]. Women with bipolar disorder are at high risk of relapse particularly if they have ceased medication[18]. These women should:

- be offered preconception planning.
- be managed by a specialist perinatal mental health MDT with close obstetric collaboration during pregnancy[18]. Early referral to a Feto-Maternal Unit for review and monitoring during pregnancy may be required, depending on drug exposure.
- If already on anti-psychotic medications, the women should be advised not to stop antipsychotics suddenly when they become pregnant, but instead advised to seek urgent perinatal psychiatry review.
- Pharmacological treatment should be prescribed following a risk/benefit discussion with the patient:
    - Consider typical antipsychotic (haloperidol)[18].
    - Valproate must not be used in pregnancy[1].
    - Consider atypical antipsychotics (olanzapine, risperidone, quetiapine)[19].

  - Lithium is not routinely recommended for use in pregnancy but may be considered if there is no response to antipsychotics and the woman has severe mania[1].
  - If there is a previous response to lithium, it should be avoided in the first trimester if possible.
- Antipsychotics:
    - May be considered for a pregnant woman who develops psychosis [1][**L1, RGC**) and for women with schizophrenia or other psychotic disorder at risk of relapse.
    - The woman should be informed about possible adverse effects of antipsychotics on the foetal development [19].
    - The risks of untreated disorder should also be discussed with patient [**R-GDG**].
- The following psychological interventions are recommended.
  - Prebirth planning meeting – ideally involving the patient and her family, obstetric and mental health stakeholders, social worker and community support agencies involved in the woman's care.
  - Psychological therapies, particularly in the presence of comorbid anxiety and depressive symptoms:
    - Social rhythms therapy.
    - Psychoeducation
    - Family support including psychoeducation

- Electroconvulsive Therapy:
  - See *Section 8.5.*

- Women with bipolar disorder who have an unplanned pregnancy may have had exposure to teratogenic agents and therefore require early referral to a Feto-Maternal Unit for review and monitoring during pregnancy [**R-GDG**].

14 Management of Other Mental Health Problems

14.1 Sleep Disorders

All pregnant women with sleep disturbances should be offered non-medical interventions[1,9,20] [**L1, RGA**]:

- Sleep hygiene education:
  - Establishing regular sleep and wake times.
  - Creating a proper environment for sleep.
  - Minimising sleep-disrupting substances (alcohol, tobacco, caffeine).
  - Avoiding excess eating.
  - Avoiding excessive light at night.
  - Regular physical exercise during daytime.
  - Reducing activity before sleep.
- CBT for insomnia.

Antihistamines (promethazine, doxylamine or hydroxyzine) may be considered for women who failed to respond to non-pharmacological treatment[1,20] [**L1, RGA**].

NB: Some pharmacological interventions (e.g. melatonin) may be considered for those unresponsive to the above measures [**R-GDG**].

14.2 Eating Disorders

Eating Disorder Examination Questionnaire (EDE-Q) is recommended for the diagnosis and outcome measure in pregnant patients[21] [**L1**].

All pregnant patients diagnosed with an eating disorder should be managed in a multidisciplinary team, comprising of the following professionals [**R-GDG**]:

- Psychologist.
- Psychiatrist.
- Obstetrician.
- Midwife.
- Dietician.
- Feto-Maternal Medicine Specialist.
- Internal Medicine
- The patient's primary care physician.

Also provide the patient with[1,21]:

- Advice about healthy eating and feeding their baby.
- Advice to take an age-appropriate oral multi-vitamin and multi-mineral supplement until their diet includes enough to meet their dietary reference values.
- Information about possible health risks to the mother and child.
- Psychological treatment.

The following psychological interventions are recommended[1] [**L1, RGA**]:

- For pregnant patients with anorexia nervosa:
    - Individual eating-disorder-focused cognitive behavioural therapy (CBT-ED):
        - Up to 40 sessions over 40 weeks, with 2 sessions/week in the first 2 or 3 weeks.
    - Maudsley Anorexia Nervosa Treatment for Adults (MANTRA):
        - 20 sessions, with weekly sessions for the first 10 weeks, and a flexible schedule after this; extra sessions may be considered for people with complex problems.
    - Specialist Supportive Clinical Management (SSCM):
        - 20 or more weekly sessions (depending on severity).
    - Eating-disorder-focused Focal Psychodynamic Therapy (FPT):
        - Up to 40 sessions over 40 weeks.
- For patients with binge eating disorder:
    - Binge-eating-disorder-focused guided self-help programme:
        - 4-9 sessions lasting 20 minutes each over 16 weeks.
    - Group or individual CBT-ED:
        - 16-20 weekly sessions over 4 months.
- For patients with bulimia nervosa:
    - Bulimia-nervosa-focused guided self-help programme:
        - 4-9 sessions lasting 20 minutes each over 16 weeks.
    - Individual CBT-ED:
        - Up to 20 sessions over 20 weeks.
- For patients with other specified feeding and eating disorders:
    - Consider using treatment for the eating disorder that it resembles.

The patient's condition should be carefully monitored throughout pregnancy and the postnatal period[1,21]. A more intensive prenatal care may be considered for pregnant women with current or remitted anorexia nervosa. Foetal growth scans should be performed when needed[21] [**L1, RGA**]. Obstetrics Endocrinologist consultation should be considered [**R-GDG**].

View Pathway

14.2.1 Postnatal Management of Patients with Eating Disorders

A physical and mental health review should be offered at least annually to people with anorexia nervosa who are not receiving ongoing treatment for their eating disorder[21] [**L1**]. The following should be assessed, and treatment options should be discussed with the woman[21]:

- Weight or body mass index.
- Blood pressure.
- Relevant blood tests.
- Problems with daily functioning.
- Assessment of risk (related to both physical and mental health).
- Electrocardiogram (for people with purging behaviours and/or significant weight changes).
- Bone density (when necessary).

NB:

- Patient may require support in making feeding decisions related to her infant.

14.3 Alcohol and Substance Abuse

If hazardous alcohol misuse is identified in pregnancy, the woman should be informed about its adverse effects on foetal development, including[22,24]:

- Physical, cognitive, and emotional impairments.
- Behavioural deficits.
- Foetal Alcohol Spectrum disorders.

NB: Acute intoxication with cocaine, amphetamines, ketamine or other hallucinogens may be misdiagnosed as pre-eclampsia[22].

Opioid dependence (OD) is associated with various complications during pregnancy, including[30,31,52]:

- Low birth weight.
- Need for neonatal intensive care admission.
- Neonatal abstinence syndrome (NAS).
- Increased used of healthcare resources.
- Comorbid psychiatric disorders.

If alcohol or substance misuse is identified in pregnancy, the following interventions should be considered and offered to the patient[1,23–26] [**L1, RGA**]:

- Group-based psychoeducation, providing information about:
    - Reducing exposure to blood-borne viruses.
    - Reducing sexual and injection risk behaviours.
- Motivational interviews focused on:
    - Increasing motivation to change behaviour.
    - Providing non-judgemental feedback.
- Contingency management.
- CBT.
- Assisted withdrawal or help to reduce the alcohol or substance intake:
    - Acute alcohol withdrawal may cause foetal distress, autonomic instability, seizures, and maternal cardiac failure[22].
    - Acute opioid withdrawal is associated with the risk of spontaneous abortion, foetal distress, preterm labour, illicit drug use[30,31,52].
- Opioid replacement therapy.
- A consultation with the obstetric anaesthetist may be required in order to discuss aspects of[22]:

- Antenatal pain management planning.
- Analgesia and anaesthesia during childbirth.
- Management of overdose or withdrawal.

The risk of accidental overdose should be assessed in women who stop or reduce drug misuse in pregnancy but start misusing again after childbirth[1].

14.3.1 Postnatal Management of Substance Abuse

Treatment for postpartum women should be gender-specific, build self-efficacy, include children and integrate infant and early-childhood parent training[27] [**L2, RGA**]. Specific intervention programs are still to be determined[27].

Women who subsequently relapse into drug abuse should be advised against breastfeeding with the exception of those who take[22,26]:

- Methadone (transfer to breast milk is low).
- Buprenorphine (transfer to breast milk is low).
- Alcohol (breastfeeding is prohibited after ingestion but is safe 2 hours after an intake of 8 oz of alcohol).
- Caution is advised with codeine.

The possibility of child abuse or neglect resulting from maternal substance abuse, should be reviewed regularly[27].

14.4 Schizophrenia and Other Psychosis

14.4.1 Diagnostic Criteria

Psychotic disorders are defined by abnormalities in one or more of the following domains: delusions, hallucinations, disorganised thinking, grossly disorganised or abnormal motor behaviour and negative symptoms[40].

The following DSM-5 criteria must be met for a patient to be diagnosed with schizophrenia[40]:

- Presence of two or more of the following, each present for a significant amount of time during a one-month period or less if successful treatment was achieved), **with at least 1 of them being any of the first three symptoms stated below.**
    - Delusions.
    - Hallucinations.
    - Disorganized speech.
    - Grossly disorganized or catatonic behaviour.
    - Negative symptoms.
- Level of functioning in one or more major areas (personal care, interpersonal relationship, or work activity) is significantly lower than the premorbid level for a significant portion of the time since the onset of the disturbance.
- Continuous signs of the disturbance had persisted for a period of at least six months, which must include at least one month of symptoms or less if successful treatment was achieved.

  NB: Prodromal symptoms usually start before the active phase, and residual symptoms may follow it, characterized by mild or subthreshold forms of hallucinations or delusions.

The following DSM-5 criteria must be met for a patient to be diagnosed with a Brief Psychotic Disorder[40]:

- Presence of one or more of the following symptoms:
    - Delusions.
    - Hallucinations.
    - Disorganised speech.
    - Grossly disorganised or catatonic behaviour may also be present but if alone, is insufficient for the diagnosis to be made.
- Duration of an episode of the disturbance is at least 1 day but less than 1 month, with eventual full return to premorbid level of functioning.
- The disturbance is not better explained by MDD or bipolar disorder with psychotic features or another psychotic disorder (e.g. schizophrenia) and is not attributable to the physiological effects of a substance (e.g. alcohol).

14.4.2 Management of Schizophrenia and other Psychotic Disorders

Any current symptoms or history of psychosis should warrant urgent referral to specialist services.

It is recommended that women with schizophrenia and other psychotic disorders, including those with a previous history of postpartum psychosis[1,28] [**L1, RGA**]:

- be offered preconception planning.
- be advised not to stop antipsychotics suddenly when they become pregnant, but instead advised to seek urgent perinatal psychiatry review.
- should be managed by a specialist perinatal mental health MDT with close obstetric collaboration during pregnancy [18].
- Antipsychotics:

- May be considered for a pregnant woman who develops psychosis[1] [**L1, RGC**) and for women with schizophrenia or other psychotic disorder at risk of relapse.
- The woman should be informed about possible adverse effects of antipsychotics on the foetal development[19].
- The risks of untreated psychosis should also be discussed with patient [**R-GDG**].

NB:

- Use caution when prescribing antipsychotics and monitor for excessive weight gain and the development of gestational diabetes and refer them for advice on weight management as required.
- Do not commence clozapine in pregnant women. If a woman conceives whilst taking clozapine, she should be monitored by a specialist perinatal mental health team in consultation with obstetric specialist.
- Use clozapine with caution in women who are breastfeeding. (COPE)

- The following psychological interventions are recommended.
  - Pre-birth planning meeting – ideally involving the patient and her family, obstetric and mental health stakeholders, social worker and community support agencies involved in the woman's care.
  - Family support including psychoeducation.
  - Psychological therapies; particularly in the presence of comorbid anxiety and depressive symptoms

14.4.3 Postpartum Psychosis

Any woman who has sudden onset of symptoms suggesting postpartum psychosis, should be referred to a specialist Mental Health Service[1] [**L1**]. The presentation should be regarded as a psychiatric and obstetric emergency and should be assessed within 4 hours of referral[1] [**L1, RGA**].

Prompt recognition, diagnosis, and referral are important for ensuring the safety of mother and infant. A detailed medical workup and thorough education for the woman and her family should be undertaken. Close mental health follow-up and informed decision making about breastfeeding, and sleep-wake cycle should be implemented[53] [**L3 RGA**].

Treatment in mother and baby unit should be considered and the necessity of separation of the mother and infant should be reviewed[54,55] [**L2, RGC**].

15 Intrapartum Care Considerations

The management of pregnant women with psychiatric disorders during the three stages of labour is comparable to the management of uncomplicated pregnancies[29] [**L1, RGA**]. However, special considerations for psychotropic medicines use and anaesthesia during labour should be implemented[37].

NB:

- Women who are psychotic at the time of delivery may require additional midwifery and mental health nursing support as well as close supervision of their infant care post-delivery.
- A neonatologist should be contacted at the onset of labour and should be present at the time of delivery for women taking medications for treatment of mental illness (including antipsychotics, antidepressants, mood stabilizers and benzodiazepines as well as at the delivery of any opioid-dependent mother[31,32] [**L2**].

- Post-delivery it is recommended that these infants are monitored for neonatal discontinuations symptoms.

15.1 Opioid-Dependent Women

Opioid maintenance treatment is required for confirmed opioid-dependent (OD) patients during pregnancy, labour, and delivery. The treatment involves the use of a full mu-opioid agonist (methadone) or a partial mu-opioid agonist (buprenorphine) in a monitored setup[30,31] [**L2, RGA**].

Since opioid maintenance therapy does not provide sufficient pain management, epidural or spinal anaesthesia should be offered during labour and delivery, if needed[30,31] [**L2, RGA**]. The use of a combination of agonist-antagonist (such as nalbuphine, butorphanol, pentazocine) with methadone, is not recommended[30,31] [**L2, RGC**].

NB: A neonatologist should be contacted at the onset of labour and should be present at the time of delivery of any opioid-dependent mother[30,31] [**L2**].

During the immediate postpartum period, additional analgesia should be administered to OD patients[30,31] [**L2, RGA**]. Patients receiving any of the following treatments should be monitored for over sedation:

- Oral or injectable nonsteroidal anti-inflammatory agents for vaginal birth.
- Oral or intravenous short-acting opioids for caesarean section.

15.2 Neonatal Abstinence Syndrome

Infants of OD women should be monitored to evaluate the risk of neonatal abstinence syndrome (NAS)[30,31] [**L2, RGA**]. The condition of the infant can be assessed every few hours using the Finnegan scale[30,31] [**L2, RGA**]:

- Monitoring for 3-4 days for women taking short acting opioids.
- Monitoring for 5-7 days for women taking long acting opioids.

NAS is characterised by the following symptoms[30,31]:

- Extreme high-pitched cry.
- Increased muscle tone.
- Decrease in the amount and quality of sleep.
- Tremors.
- Excessive sucking? Or poor sucking.
- Poor feeding.
- Vomiting and/or diarrhoea.
- Sweating.
- Increased respiration.
- Yawning., stuffy nose, and sneezing
- Irritability.
- Hyperactive reflexes.
- Vomiting.
- Diarrhoea.
- Dehydration.
- Fever or unstable temperature.
- Seizures.

Infants with NAS should be closely monitored and prescribed opioids such as methadone or morphine in a stable dose to avoid withdrawal syndrome[30,31] [**L2, RGA**]. The dose of the prescribed opioid should be reduced gradually over the following weeks and once the infants are discharged, they should be followed up by an experienced paediatric specialist with careful developmental monitoring performed thereafter[30,31] [**L2, RGA**].

16 Prescribing Considerations in Pregnancy and Breastfeeding

Refer to the latest literature when prescribing [**R-GDG**]. When psychotropic medication is to be prescribed in the antenatal period, consider seeking the advice of a specialist[1].

If medication is required during pregnancy[1,4]:

- The lowest effective dose should be used[1].
- Adjustment of doses should be considered along the course of pregnancy and breastfeeding, as clinically indicated[1,4].
- Monotherapy is preferred over the use of two or more drugs[1].
- Medication should be chosen with consideration of the risk/benefit profile for mother and foetus.
- If a medication has been used successfully previously and is not contraindicated, this should be the first choice.
- The physician should outline risks for both the mother and the infant, that may occur at different stages of pregnancy, early postpartum period and during breastfeeding.
- Arrange observation of infants exposed to psychoactive medications for the first three days postpartum (see COPE Perinatal Mental Health Guideline).
- Discuss the potential risks and benefits of pharmacological treatment in each individual case with the woman and, where possible, her significant other(s).
- Ensure that women are aware of the risks of relapse associated with stopping medication and that, if a medication is ceased, this needs to be done gradually and with advice from a mental health professional.
- Use caution when prescribing any antipsychotic to pregnant women, particularly for women with a propensity for weight gain and metabolic syndrome
- If women commence or continue antipsychotic treatment during pregnancy, monitor them for excessive weight gain and the development of gestational diabetes and refer them for advice on weight management as required.

All breastfeeding women prescribed psychotropic medication should be informed that the drugs are secreted in breast milk at varying concentrations and risks to the mother and infant must be considered[8]. They should also be informed of the benefits to mother and infants of breastfeeding and assisted to make an informed decision, weighing up the risks and benefits for mother and infant.

Medication doses should be adjusted along the course of breastfeeding[4] [**L1, RGA**]. Attempt to minimise the toxic effect of medications by[56] [**L2, RGA**]:

- Using the lowest effective dose.
- Avoiding polypharmacy.
- Dividing daily doses.

Support with nocturnal infant care and feeding should be discussed [**R-GDG**].

16.1 Antidepressants

NB: Psychological interventions should be offered for all depressed pregnant patients with or without medication[1,11,39] [**L1, RGA**].

Except where a woman has previously responded to a specific antidepressant, the following recommendations are made:

- SSRIs are preferred and chosen according to the woman's symptom profile[2,8,9,57].
    - Commencing paroxetine during pregnancy should be avoided, where possible but may be considered in patients who are already taking the medication[11].
- Other types of antidepressants may also be considered[8,9,57]:
    - Desipramine and nortriptyline are the preferred tricyclic antidepressants (TCAs) for use in pregnancy[8].
    - Consider mirtazapine in patients with hyperemesis gravidarum[8].
- Venlafaxine should be reviewed in cases of preeclampsia[8].

Antidepressants are excreted into breast milk in low amounts[58]. The following antidepressants are preferred in breastfeeding women[57,59] [**L1, RGB**]:

- Sertraline[45,57–60].
- Escitalopram.
- Citalopram[59].
- Nortriptyline[60].
- Paroxetine[60].

NB:

- Before prescribing SSRI's to women who are breastfeeding, consider the infant's health and gestational age at birth.
- Bupropion is not recommended to lactating women[58] [**L2, RGC**].

16.2 Antipsychotics

If a pregnant woman is stable on an antipsychotic and likely to relapse without medication, it is recommended to continue antipsychotic medication with consideration of the overall risks and benefits to mother and baby[1].

A detailed anomaly scan should be performed at 18-20 weeks gestation in all patients taking antipsychotic medication [**R-GDG**]. Weight gain and gestational diabetes should also be monitored[1].

If antipsychotics are required during breastfeeding, consider the following[61] [**L2, RGB**]:

- First-line antipsychotics:
    - Olanzapine.
    - Quetiapine.
- Second-line antipsychotics (with medical supervision):
    - Chlorpromazine.
    - Haloperidol.
    - Risperidone.

16.3 Mood Stabilisers

When using mood stabilisers during pregnancy, consider the following:

- Sodium valproate is contraindicated[1].
- Lamotrigine and carbamazepine should only be prescribed after an evaluation of the risk/benefit profile and if prescribed[1,3]:
    - Therapeutic levels should be performed in early pregnancy and monitored throughout the pregnancy and early post-partum period, according to the patient's clinical status[1].
    - Folic acid 5 mg daily should be prescribed with anticonvulsants[62].
- Lithium may be the treatment of choice for certain women, however prescription of lithium during pregnancy requires careful consideration of the risk and benefits[1]
- Ideally, it is best if lithium is avoided in the first trimester, however this may not be possible in women maintained and stabilised on lithium[1].
- Women taking potentially teratogenic medication (including lithium and valproate) require a referral to an appropriate Feto-Maternal Unit for further investigation of congenital abnormality[1].
- Lithium levels need to be maintained at the lowest effective dose and monitored every 4 weeks until 36 weeks and then more frequently thereafter, until delivery[1].
- Cessation of lithium should occur the night before a planned delivery and lithium levels taken on admission and after delivery[1]. Pay attention to adequate hydration of the woman during labour and delivery. Aim to recommence treatment immediately after the birth at a pre-pregnancy dose (where possible, avoid the use of lithium during breastfeeding).

Carbamazepine should be avoided in women considering breastfeeding[1] but may be used to manage severe postnatal psychosis in certain circumstances[63] [**L2, RGC**]. Valproate is contraindicated for pregnant and breastfeeding women and should be avoided in women of childbirth age[1,45,63] [**L1, RGC**].

Lamotrigine may be used with caution during the postpartum period[1,45,58] [**L1, RGB**]. Lamotrigine levels should be frequently monitored during the postnatal period [1]. If anticonvulsants are prescribed to a woman who is breastfeeding, arrange close monitoring of the infant and specialized neonatologist consultation where possible.

16.4 Lithium

Lithium is not usually recommended for the postnatal period due to its toxicity to the infant[1,45] [**L1, RGC**].

If lithium is prescribed, monitoring of the following parameters in the mother are mandatory[1]:

- Lithium levels.
- Adequate hydration.

16.5 Benzodiazepines

Benzodiazepines are not recommended for the short-term treatment of severe anxiety, agitation or sleep disturbance (including when commencing an SSRI), during pregnancy[1].

Consider the short-term use of benzodiazepines for treating moderate to severe symptoms of anxiety and agitation while awaiting onset of action of an SSRI or tricyclic antidepressant in pregnant or postnatal women[1] [**L1, RGC**].

Monotherapy with benzodiazepines is not recommended as a treatment approach for postnatal psychosis[64] [**L2, RGB**].

If a rapid tranquilisation is required, intramuscular lorazepam or haloperidol combined with intramuscular promethazine may be used[65] [**L1, RGB**]:

- If it is unclear what medication to choose, lorazepam should be used.
- The minimum effective dose should be applied.
- If response to lorazepam is partial, consider a further dose.
- If there is no response to lorazepam, the other medication option should be applied.
- If the patient does not respond to any the medications listed above, an urgent team meeting should be arranged to carry out a review and seek a second opinion.

After rapid tranquillisation, monitor the following parameters at least every hour until there is no further concern about patient's health:

- Side effects of the applied medication.
- Pulse.
- Blood pressure.
- Respiratory rate.
- Temperature.
- Level of hydration.
- Level of consciousness.

17 Key Considerations for Patient Preferences

Patient preferences refer to patient perspectives, beliefs, expectations, and goals for health and life, and to the steps employed by individuals in assessing the potential benefits, harms, costs, and limitations of the management options in relation to one another. Patients may have preferences when it comes to defining their problems, identifying the range of management options and selecting or ranking the outcomes used to compare these options.

It is important for healthcare professionals to develop an understanding of the patient as an individual and the unique way in which each person experiences a condition and its impact on their life.

The following recommendations are therefore made for physicians and other healthcare professionals regarding general principles of patient care in Qatar:

- **Respect Patients:** Treat patients with respect, kindness, dignity, courtesy and honesty. Ensure that the environment is conducive to discussion and that the patient's privacy is respected, particularly when discussing sensitive, personal issues. Ask the patient how they wish to be addressed and ensure that their choice is respected and used.

- **Maintain Confidentiality:** Respect the patient's right to confidentiality and avoid disclosing or sharing patients' information without their informed consent. In this context, students and anyone not directly involved in the delivery of care should first be introduced to the patient before starting consultations or meetings, and let the patient decide if they want them to stay.

- **Clarify Third-Party Involvement:** Clarify with the patient at the first point of contact whether and how they like their partner, family members or carers to be involved in key decisions about their care or management and review this regularly. If the patient agrees, share information with their partner, family members or carers.

- **Obtain Informed Consent:** Obtain and document informed consent from patients, in accordance with MOPH policy and guidance.

- **Encourage Shared Decision Making:** Ensure that patients are involved in decision making about their own care, or their dependent's care, and that factors that could impact the patient's participation in their own consultation and care including physical or learning disabilities, sight, speech or hearing impairments and problems with understanding, reading or speaking English are addressed.

- **Disclose Medical Errors:** Disclose errors when they occur and show empathy to patients.

- **Ensure Effective Communication:** Explore ways to improve communication including using pictures, symbols or involving an interpreter or family members. Avoid using medical jargon. Use words the patient will understand and confirm understanding by asking questions.

- **Ensure Continuity of Care:** Provide clear and timely sharing of patient information between healthcare professionals especially at the point of any transitions in care.

18 Performance Measures

A list of performance measures is given in the table below. Healthcare organisations are encouraged to monitor service performance using the indicator definitions below.

Number	Numerator	Denominator
OMH01	The number of women in the denominator who were offered pre-conception counselling.	The number of women who have given birth during a 12-month period, who have a recorded diagnosis of a mental health disorder and seen at least once during prenatal period.
OMH02	The number of women in the denominator who were referred for specialist review during the antenatal period.	The number of women who have given birth within the past 12 months, who have a recorded diagnosis of a mental health disorder
OMH03	The number of women in the denominator who are assessed for treatment within 2 weeks of referral.	The number of women who have given birth within the past 12 months, who have a recorded diagnosis of a mental health disorder.
OMH04	The number of women who had a thorough clinical assessment undertaken including an assessment of the patient's risk of harm to self and others during antenatal period.	The number of women who have given birth within the past 12 months, who have a recorded diagnosis of a mental health disorder.
OMH05	The number of women in the denominator prescribed valproate.	The number of women who have given birth within the past 12 months, who have a recorded diagnosis of a mental health disorder.
OMH06	Number of women with spontaneous labour without induction and no forceps or vacuum assistance and who had normal delivery.	The number of women who have given birth within the past 12 months, who have a recorded diagnosis of a mental health disorder.
OMH07	Number of women whose infants were monitored for neonatal discontinuations symptoms at delivery by neonatologist.	The number of women who have given birth within the past 12 months, who have a recorded diagnosis of a mental health disorder.
OMH08	Number of breastfeeding women prescribed psychotropic medication who were informed of the risks and benefits for mother and infant.	The number of women who have given birth during a 12-month period, who have a recorded diagnosis of a mental health disorder and seen for post-partum care visit.

Table 18.1: Performance measures.

19 References

1. National Institute for Health and Care Excellence (NICE). *Antenatal and postnatal mental health: clinical management and service guidance. NICE clinical guideline [CG192]. (Last updated: April 2018)*. (NICE, 2014).
2. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). Mental Health Care in the Perinatal Period. (Last apdated July 2018). (2012).
3. Katzman, M. A. *et al.* Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders. *BMC Psychiatry* **14**, S1 (2014).
4. National Institute for Health and Care Excellence (NICE). *Depression in adults: recognition and management. NICE clinical guideline [CG90]. Last updated: 2018.* (NICE, 2009).
5. Kroenke, K., Spitzer, R. L. & Williams, J. B. The PHQ-9: validity of a brief depression severity measure. *J. Gen. Intern. Med.* **16**, 606–613 (2001).
6. National Institute for Health and Care Excellence (NICE). *Generalised anxiety disorder and panic disorder in adults: management. NICE clinical guideline [CG113]. Last updated: July 2019*. (NICE, 2011).
7. Kroenke, K., Spitzer, R. L., Williams, J. B. W., Monahan, P. O. & Löwe, B. Anxiety disorders in primary care: prevalence, impairment, comorbidity, and detection. *Ann. Intern. Med.* **146**, 317–325 (2007).
8. Wichman, C. L. & Stern, T. A. Diagnosing and Treating Depression During Pregnancy. *Prim. Care Companion CNS Disord.* **17**, (2015).
9. Ministry of Public Health (MOPH) Qatar. National Clinical Guideline: The Diagnosis and Management of Depression. (2019).
10. Markowitz, J. C. & Weissman, M. M. Interpersonal psychotherapy: principles and applications. *World Psychiatry* **3**, 136–139 (2004).
11. Gelenberg, A. J. *et al. Ppactice Guideline for the Treatment of Patients With Major Depressive Disorder*. (American Psychiatric Association (APA), 2010).
12. Locke, A. B., Kirst, N. & Shultz, C. G. Diagnosis and management of generalized anxiety disorder and panic disorder in adults. *Am. Fam. Physician* **91**, 617–624 (2015).
13. Kehoe, W. A. Generalized Anxiety Disorder. in *Neurologic/Psychiatric Care* (eds. Melton, S. & Gregory, C.) vol. ACSAP 2017 Book 2 21 (American College of Clinical Pharmacy, 2017).
14. Striebich, S., Mattern, E. & Ayerle, G. M. Support for pregnant women identified with fear of childbirth (FOC)/tokophobia – A systematic review of approaches and interventions. *Midwifery* **61**, 97–115 (2018).
15. Seibell, P. J. & Hollander, E. Management of Obsessive-Compulsive Disorder. *F1000Prime Rep.* **6**, (2014).
16. Ministry of Public Health (MOPH) Qatar. National Clinical Guideline: The Diagnosis and Management of Anxiety. (2019).
17. Menage, J. Post-traumatic stress disorder in women who have undergone obstetric and/or gynaecological procedures: A consecutive series of 30 cases of PTSD. *J. Reprod. Infant Psychol.* **11**, 221–228 (1993).
18. National Institute for Health and Care Excellence (NICE). *Bipolar disorder: assessment and management. NICE clinical guideline [CG185]. (Last updated: April 2018)*. (NICE, 2014).
19. Epstein, R. A., Moore, K. M. & Bobo, W. V. Treatment of bipolar disorders during pregnancy: maternal and fetal safety and challenges. *Drug Healthc. Patient Saf.* **7**, 7–29 (2014).
20. Hashmi, A. M., Bhatia, S. K., Bhatia, S. K. & Khawaja, I. S. Insomnia during pregnancy: Diagnosis and Rational Interventions. *Pak. J. Med. Sci.* **32**, 1030–1037 (2016).
21. National Institute for Health and Care Excellence (NICE). *Eating disorders: recognition and treatment. NICE guideline [NG69]*. (NICE, 2017).
22. Daykin, D. H. & Miller, L. Management of pregnant women with a history of addictions or substance misuse. *Anaesth. Tutor. Week* 6 (2018).
23. National Institute for Health and Care Excellence (NICE). *Drug misuse in over 16s: psychosocial interventions. NICE clinical guideline [CG51].* (NICE, 2007).
24. Charlet, K. & Heinz, A. Harm reduction - a systematic review on effects of alcohol reduction on physical and mental symptoms: Effects of alcohol reduction. *Addict. Biol.* **22**, 1119–1159 (2017).
25. Forray, A. Substance use during pregnancy. *F1000Research* **5**, (2016).

26. Gopman, S. Prenatal and Postpartum Care of Women with Substance Use Disorders. *Obstet. Gynecol. Clin. North Am.* **41**, 213–228 (2014).
27. Chapman, S. L. C. & Wu, L.-T. Postpartum Substance Use and Depressive Symptoms: A Review. *Women Health* **53**, 479–503 (2013).
28. National Institute for Health and Care Excellence (NICE). *Psychosis and schizophrenia in adults: prevention and management. NICE clinical guideline [CG178]. (Last updated: March 2014)*. (NICE, 2014).
29. Ministry of Public Health (MOPH) Qatar. Antenatal, Intrapartum and Postnatal Care. National Clinical Guideline. (2019).
30. Committee on Obstetric Practice. Committee Opinion No. 711: Opioid Use and Opioid Use Disorder in Pregnancy. *Obstet. Gynecol.* **130**, e81–e94 (2017).
31. Krans, E. E., Cochran, G. & Bogen, D. L. Caring for Opioid-dependent Pregnant Women: Prenatal and Postpartum Care Considerations. *Clin. Obstet. Gynecol.* **58**, 370–379 (2015).
32. World Health Organization (WHO). Maternal mental health. *WHO* https://www.who.int/mental_health/maternal-child/maternal_mental_health/en/.
33. Burgut, F. T., Bener, A., Ghuloum, S. & Sheikh, J. A study of postpartum depression and maternal risk factors in Qatar. *J. Psychosom. Obstet. Gynecol.* **34**, 90–97 (2013).
34. Ghubash, R. & Abou-Saleh, M. T. Postpartum psychiatric illness in Arab culture: prevalence and psychosocial correlates. *Br. J. Psychiatry J. Ment. Sci.* **171**, 65–68 (1997).
35. Leahy-Warren, P., Newham, J. & Alderdice, F. Perinatal social support: panacea or a pitfall. *J. Reprod. Infant Psychol.* **36**, 219–221 (2018).
36. National Association of Perinatal Social Workers (NAPSW). What is a Perinatal Social Worker. https://www.napsw.org/what-is-a-perinatal-social-worker.
37. Royal College of Obstetricians and Gynaecologists. *Management of Women with Mental Health Issues during Pregnancy and the Postnatal Period*. (2011).
38. O'Hara, M. W. Postpartum Mental Disorders. *Glob. Libr. Womens Med.* (2009) doi:10.3843/GLOWM.10420.
39. Mitchell, J. *et al. Health Care Guideline: Adult Depression in Primary Care (Last updated: 2013).* (Institute for Clinical Systems Improvement, 2013).
40. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders: DSM-V*. (American Psychiatric Association, 2013). doi:10.1176/appi.books.9780890425596.
41. Stamou, G., García-Palacios, A. & Botella, C. Cognitive-Behavioural therapy and interpersonal psychotherapy for the treatment of post-natal depression: a narrative review. *BMC Psychol.* **6**, (2018).
42. Beck, A. T., Rush, A. J., Shaw, B. F. & Emery, G. *Cognitive therapy of depression*. (Guilford Press, 1979).
43. National Health Service (NHS). Postnatal depression. *nhs.uk* https://www.nhs.uk/conditions/post-natal-depression/ (2018).
44. Yeaton-Massey, A. & Herrero, T. Recognizing maternal mental health disorders: beyond postpartum depression. *Curr. Opin. Obstet. Gynecol.* **31**, 116–119 (2019).
45. Cohen, L. S. *et al.* Treatment of Mood Disorders During Pregnancy and Postpartum. *Psychiatr. Clin. North Am.* **33**, 273–293 (2010).
46. Spitzer, R. L., Kroenke, K., Williams, J. B. W. & Löwe, B. A brief measure for assessing generalized anxiety disorder: the GAD-7. *Arch. Intern. Med.* **166**, 1092–1097 (2006).
47. Hofberg, K. & Brockington, I. Tokophobia: an unreasoning dread of childbirth. A series of 26 cases. *Br. J. Psychiatry J. Ment. Sci.* **176**, 83–85 (2000).
48. Yildiz, P. D., Ayers, S. & Phillips, L. The prevalence of posttraumatic stress disorder in pregnancy and after birth: A systematic review and meta-analysis. *J. Affect. Disord.* **208**, 634–645 (2017).
49. Shaban, Z. *et al.* Post-Traumatic Stress Disorder (PTSD) Following Childbirth: Prevalence and Contributing Factors. *Iran. Red Crescent Med. J.* **15**, 177–182 (2013).
50. James, S. Women's experiences of symptoms of posttraumatic stress disorder (PTSD) after traumatic childbirth: a review and critical appraisal. *Arch. Womens Ment. Health* **18**, 761–771 (2015).
51. Kuczkowski, K. M. The effects of drug abuse on pregnancy. *Curr. Opin. Obstet. Gynecol.* **19**, 578–585 (2007).
52. Spinelli, M. G. Postpartum psychosis: detection of risk and management. *Am. J. Psychiatry* **166**, 405–408 (2009).

53. Cranford, K., Gedzior, J. & Su, V. Postpartum Psychosis in a Young VA Patient: Diagnosis, Implications, and Treatment Recommendations. *Fed. Pract.* **35**, 28–33 (2018).
54. Osborne, L. M. Recognizing and Managing Postpartum Psychosis: A Clinical Guide for Obstetric Providers. *Obstet. Gynecol. Clin. North Am.* **45**, 455–468 (2018).
55. Chaudron, L. H. & Jefferson, J. W. Mood stabilizers during breastfeeding: a review. *J. Clin. Psychiatry* **61**, 79–90 (2000).
56. National Health Service (NHS). Selective serotonin reuptake inhibitors (SSRIs). *nhs.uk* https://www.nhs.uk/conditions/ssri-antidepressants/ (2018).
57. Meltzer-Brody, S. *et al.* Postpartum psychiatric disorders. *Nat. Rev. Dis. Primer* **4**, 18022 (2018).
58. Molenaar, N. M., Kamperman, A. M., Boyce, P. & Bergink, V. Guidelines on treatment of perinatal depression with antidepressants: An international review. *Aust. N. Z. J. Psychiatry* **52**, 320–327 (2018).
59. Weissman, A. M. *et al.* Pooled analysis of antidepressant levels in lactating mothers, breast milk, and nursing infants. *Am. J. Psychiatry* **161**, 1066–1078 (2004).
60. Klinger, G., Stahl, B., Fusar-Poli, P. & Merlob, P. Antipsychotic drugs and breastfeeding. *Pediatr. Endocrinol. Rev. PER* **10**, 308–317 (2013).
61. MGH Center for Women's Mental Health. Folic Acid, Women Taking Anticonvulsants and Pregnancy. *MGH Center for Women's Mental Health* https://womensmentalhealth.org/posts/folic-acid-supplementation-is-recommended-for-all-women-taking-anticonvulsants/ (2008).
62. Bergink, V. *et al.* Prevention of Postpartum Psychosis and Mania in Women at High Risk. *Am. J. Psychiatry* **169**, 609–615 (2012).
63. Bergink, V., Lambregtse-van den Berg, M. P., Koorengevel, K. M., Kupka, R. & Kushner, S. A. First-onset psychosis occurring in the postpartum period: a prospective cohort study. *J. Clin. Psychiatry* **72**, 1531–1537 (2011).
64. National Institute for Health and Care Excellence (NICE). Restrictive interventions for managing violence and aggression in adults - NICE Pathways.

View Pathway

Appendix: Detailed Description of the Literature Search

A systematic search for existing literature on Obstetric Mental Health was performed in the period July 14th – August 5th, 2019.

The search for clinical practice guidelines on Obstetric Mental Health diagnosis and/or management was performed in the *PubMed* database and websites of relevant organisations and societies including the *The Massachusetts General Hospital (MGH) Center for Women's Mental Health*, *American College of Obstetricians and Gynecologists (ACOG)*, *National Association of Perinatal Social Workers (NAPSW)* and others. The present guideline is primarily based on UK NICE and is supplemented with recommendations from MOPH guidelines on Depression and Anxiety and other relevant studies.

Peer-reviewed scientific publications were found in *PubMed* and via *Google Scholar* Internet search engine. Non-peer reviewed studies were identified in *bioRxiv*. Books were checked on *PubMed*. Personal opinions of healthcare professionals, information published on medical websites, and drug prescribing information sheets were found via Google search engine.

The included publications were identified using the term "pregnancy AND psychiatry" and specified with the following terms in combinations:

Depression, general/social anxiety, PTSD, bipolar/sleep/eating disorder, tokophobia, psychosis, mania, DSM 5, prevalence, risk factors, complications, mental, screening, diagnosis, management, pregnancy, behavioural/psychological therapy, treatment, antipsychotics, antidepressants, SSRI, lithium, peripartum/intrapartum/antenatal/postnatal/postpartum care, alcohol/drug abuse/misuse.

Figure A.1 below demonstrates graphically the results of the search and application of exclusion criteria.

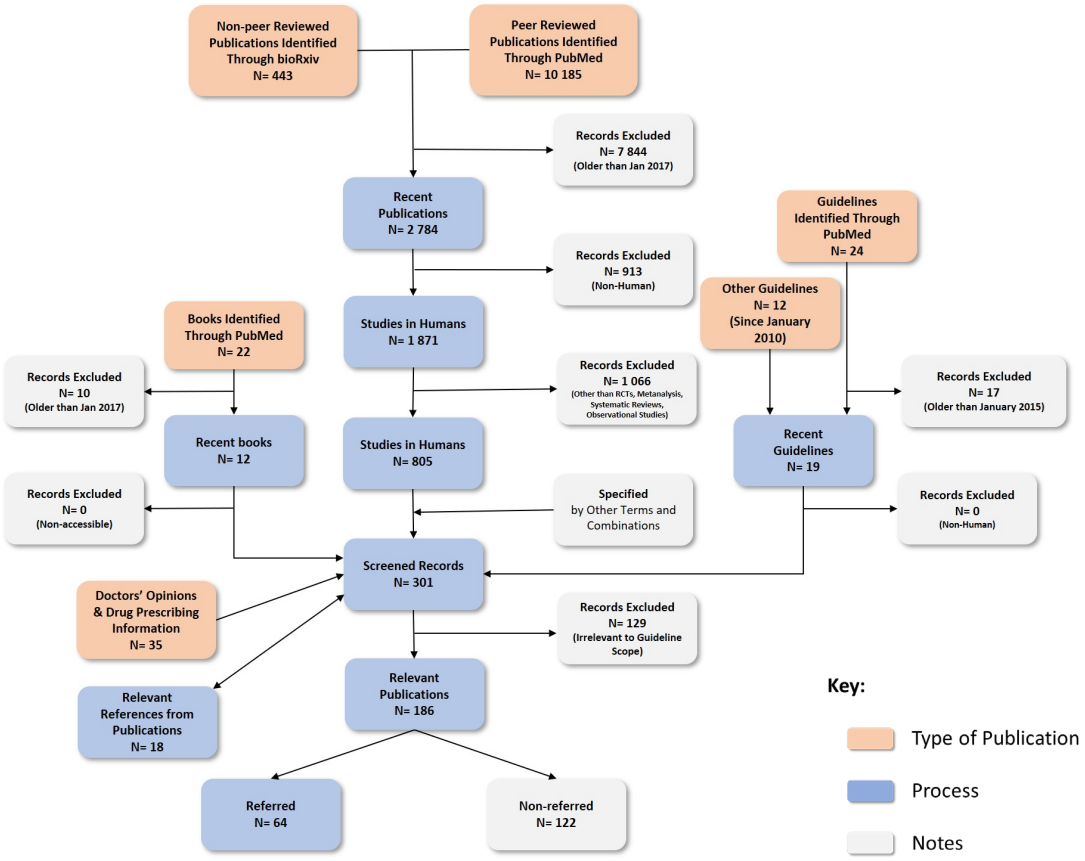


Fig A.1: Literature search results and application of exclusion criteria.

Acknowledgements

The following individuals are recognised for their contribution to the successful development of the National Clinical Guideline.

MOPH National Clinical Guidelines Team:

- **Ms Huda Amer Al-Katheeri**, *Director of Strategic Planning & Performance Dept, MOPH*.
- **Dr Rasmeh Ali Salameh Al Huneiti**, *Guideline & Standardisation Specialist, MOPH.*
- **Dr Bushra Saeed**, *Quality Improvement Coordinator, MOPH.*
- **Dr Mehmood Syed,** *Project Clinical Lead.*
- **Dr Samuel Abegunde,** *Physician Executive.*
- **Dr Natalia Siomava,** *Senior Medical Writer.*
- **Ms Rouba Hoteit,** *Medical Writer.*

.

National Lead for Mental Health and Wellbeing (NHS 2018-2022):

- **Mr Iain Tulley**, *CEO Mental Health, Hamad Medical Corporation*.

Please use the following email address to provide feedback on this guideline:
clinicalguidelines@moph.gov.qa