
Reproductive Mental Health Guideline 1
REPRODUCTIVE MENTAL ILLNESS DURING THE PERINATAL
PERIOD: PRINCIPLES AND FRAMEWORK

INTRODUCTION

The care of women experiencing a mental health problem during the perinatal period has been a concern for British Columbia health providers. These guidelines outline best practices for the care of women with mental illness, their partners, and their fetuses/newborns during the perinatal period. These guidelines are written to promote and facilitate collaborative and supportive care of the mother-infant dyad by general practitioners, psychiatrists, midwives, community health nurses, hospital nurses, mental health counselors, Ministry of Children and Family Development (MCFD), child protection and other community support agencies.

GUIDELINE PRINCIPLES

- 1) All women, from a variety of social, economic, educational, racial and cultural backgrounds are at-risk for mental health illnesses during the perinatal period.
- 2) Providing services that preserve the mother-infant dyad is optimal. Supporting women, children, and their families is the responsibility of all services providers: hospital authorities, public health care bodies, MCFD, and Aboriginal Child Welfare Agency workers.
- 3) Service providers need to provide a sensitive, caring and humane environment for women with mental illness during the perinatal period in order that they feel strengthened and supported while being treated. These women will often:
 - present in an acute state of distress
 - have fragile self-esteem
 - experience multiple complex stressors.
- 4) It is important to notice and highlight the strengths and protective factors of women, newborns, their families, and their communities.
- 5) There is a continuum of help that can be offered to women, children and their families including early identification, assessment, treatment and follow-up supports.
- 6) A collaborative team approach is needed to offer families help and support as early on as possible. When difficult decisions are required, a supportive team approach to decision making is optimal.
- 7) Every effort should be made within communities to link existing services to provide supports to women with mental health illness during the perinatal period.

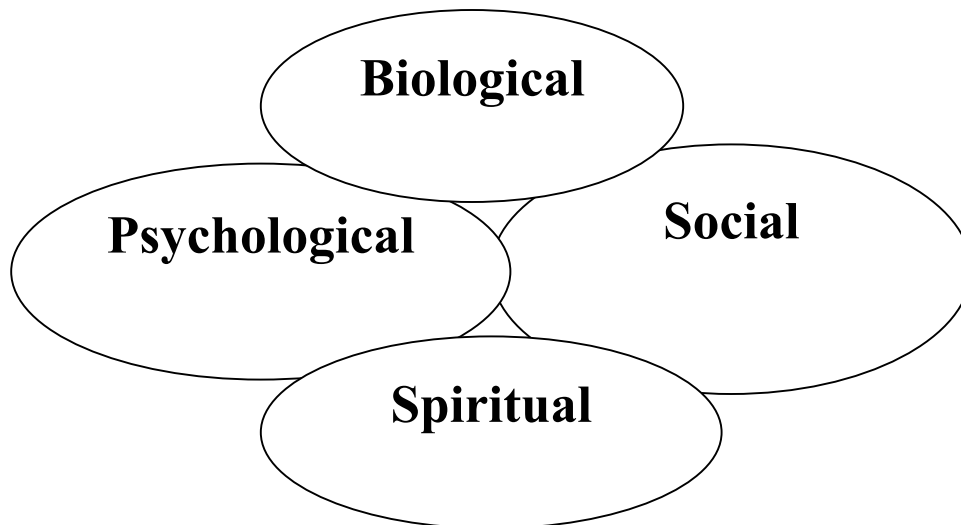
- 8) In communities where services are lacking, service providers should advocate for existing agencies to extend their criteria and add on services for women with mental health illness during the perinatal period.
- 9) It is the mother's, her family's, and the community's responsibility to ensure her newborn child is both protected from abuse, neglect, harm or threat of harm, and cared for in a safe and nurturing environment.

FRAMEWORK OF THE REPRODUCTIVE MENTAL HEALTH GUIDELINES

In the past, mental illness during the perinatal period was solely focused on postpartum depression. Today, we also know that anxiety disorders and obsessive compulsive disorders may have an onset during the pregnancy and/or postpartum periods. With the introduction of new medications, women with a history of serious mental illness are choosing to become pregnant. Along with this awareness about mental illness in the perinatal period, there are new advances in the biological and psychological treatments. These developments suggest that the complexity of women's situations need to be addressed through an *integrated approach* to services. A fragmented delivery system to patient care is suboptimal in providing quality care to women experiencing perinatal mental illness. Service providers need accurate information, screening tools, assessments, diagnosis, intervention and follow-up guidelines to facilitate their development of an integrated approach to this population within their community.

At the core of this integrated approach to treating mental illness in the perinatal period is the woman herself. Locicero, Weiss & Issokson¹ emphasised the need for service providers to view the woman in the context of the complexity of her life. In order to capture this complexity in women's lives, a *Bio-Psychosocial-Spiritual Framework* is utilised throughout these guidelines (see Figure 1).

Figure 1: The Bio-Psychosocial-Spiritual Framework for Early Identification, Assessment, Treatment, and Follow-Up of Women with Mental Illness during the Perinatal Period



The bio-psycho-social framework has been seen frequently in the literature. In relationship to perinatal mental illness however, Kleiman and Raskin² discussed a bio-psychological focus for the treatment of postpartum depression in 1994. Dunnewold and Sanford³ encouraged women to develop a self-care plan based on a bio-psycho-spiritual framework. The spiritual aspect was, in the broadest sense, a form of doing a fun activity to energise the body and build positive thoughts. Most recently, Sickel and Driscoll⁴ advocated that women use the NURSE Program, which is a self-care program incorporating nutrition, understanding, rest and relaxation, spirituality and exercise. Their definition of spirituality includes any activities that rejuvenate the body and mind and helps a woman feel uplifted and brings joy into her life. This may take the form of appreciation of nature, music, writing in a journal, buying fresh flowers, gazing at an extraordinary view, meditation or belief in a higher being. Therefore, spirituality in this context is any activity that the woman perceives nourishes her soul.

Locicero, Weiss and Issokson¹ emphasised the need for a strong social context in providing an integrated approach to caring for women experiencing mental illness in the perinatal period. The woman is not only dealing with depression but also with being pregnant, being a mother-to-be or a mother, a partner, a family member and a member of the community. Locicero et al. believes that a woman's treatment and recovery depends on the supports within her community. This not only includes her relationship with her partner and family but her friendships and social networks within her community. These social networks may be either formal or informal. Examples of formal networks include contacts with service providers from community agencies or formal groups e.g. postpartum support groups, or mom and baby drop in. Informal groups may take the form of women who meet for coffee, at church, at the community recreation centre or at the playground.

The Bio-Psychosocial-Spiritual Framework is threaded throughout the Reproductive Mental Health Guidelines and forms the foundation for the treatment modalities that are outlined for specific disorders.

LEGAL ASPECTS

In some very rare cases women in the perinatal period may experience a psychotic episode that will necessitate admission to hospital for treatment. The first-onset of psychosis in the perinatal period is reported to occur approximately 1 per 1000 live births.^{5,6} Some of these women will be experiencing a psychotic depression but most will be diagnosed with schizoaffective disorders, schizophrenia or schizophrenia with depression (refer to Guideline 6: Psychotic Disorders). Since the risk of suicide and/or infanticide with perinatal psychoses, is estimated as high as 4%⁷ this constitutes a psychiatric emergency.⁸

The Ministry of Health and Ministry Responsible for Seniors has published a *Guide to the Mental Health Act: Effective November 15th, 1999*⁹ which outlines the responsibilities of medical practitioners regarding voluntary and involuntary admission of women to hospitals in BC. Voluntary and involuntary admission of women in the perinatal period will be discussed in view the Mental Health Act.

I. VOLUNTARY ADMISSION

Voluntary admission of women in the perinatal period is rare but most commonly occurs when a woman suffers from major depression and has suicidal tendencies. Voluntary admissions under the *Mental Health Act* require the person to request admission using Form 1, Request for Admission (Voluntary Patient). A physician and the director must agree to the person's admission. A signed Form 2, Consent for Treatment (Voluntary Patient), is also required.⁹

II. INVOLUNTARY ADMISSION

Women who are experiencing a psychotic episode are often out of touch with reality and may be experiencing delusions and hallucinations. These symptoms may limit a woman's ability to give informed consent or to have insight into her illness.

Involuntary admissions can be arranged through a physician's Medical Certificate, police intervention, or a judge's order. A physician who examines a woman who meets the committal criteria should complete a *Medical Certificate (Involuntary Admission)*, Form 4. Any physician licensed to practice medicine in British Columbia is qualified to complete a Medical Certificate.⁹

In order for a physician to fill out a Medical Certificate, four criteria must be met. "The physician must have examined the patient and be of the opinion the patient meets **all** four of the following criteria:

- is suffering from a mental disorder that seriously impairs the person's ability to react appropriately to his or her environment or to associate with others;
- requires psychiatric treatment in or through a designated facility;
- requires care, supervision and control in or through a designated facility to prevent the person's substantial mental or physical deterioration or for the person's own protection or the protection of others; and
- is not suitable as a voluntary patient.

The Medical Certificate provides authority for anyone, including ambulance personnel, police or, if the physician believes it is safe, relatives or others, to take the person to a designated facility with the consent of the director or designate, the person may be admitted for up to 48 hours.

A second Medical Certificate by a different physician must be completed within 48 hours of initial admission, otherwise the patient must be discharged or admitted as a voluntary patient. The two certificates are authority for the person to be an involuntary patient for up to one month from the day of initial admission. The second certificate should be completed as soon as possible, taking into account the necessity for a thorough inpatient examination, which may include receiving information from other sources. The patient must be informed that the second Medical Certificate has been completed.

Prior to treatment of involuntary patients, Form 5, Consent to Treatment (Involuntary Patient) must be completed. A Medical Certificate is valid for only 14 days following the date of examination. If the woman is not admitted to hospital during this 14-day period, the certificate becomes invalid."⁹

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