Clinicians Manual

Healthy Babies for Mothers with Serious Mental Illness:

A Case Management Framework for Mental Health Clinicians




Delivering a **Healthy** WA

Healthy Babies for Mothers with Serious Mental Illness: A Case Management Framework for Mental Health Clinicians

This project, sponsored by North Metropolitan Area Health Service (NMAHS) Mental Health was developed in collaboration with the Centre for Clinical Research in Neuropsychiatry (CCRN), Telethon Institute for Child Health Research (TICHR) and Curtin University of Technology.

As an entity, CCRN incorporates the University of Western Australia (UWA) School of Psychiatry and Clinical Neurosciences, World Health Organisation, Executive of Graylands Hospital and Department of Health Western Australia. It is a specialised research facility funded and jointly operated by the UWA School of Psychiatry and NMAHS Mental Health.

Healthy Babies for Mothers with Serious Mental Illness: A Case Management Framework for Mental Health Clinicians was developed by Associate Professor Yvonne Hauck (Curtin University of Technology), Associate Professor Daniel Rock (NMAHS Mental Health & CCRN), Tanyana Jackiewicz (TICHR) and Professor Assen Jablensky (CCRN, UWA).

Online Resource for Consumers and Clinicians

The Framework Overview and Clinicians Manual for *Healthy Babies for Mothers with Serious Mental Illness: A Case Management Framework for Mental Health Clinicians* can be downloaded at http://www.nmahsmh.health.wa.gov.au/projects/healthybabies.cfm.

This web page also provides access to a range of consumer support services and information about women's reproductive and pregnancy needs.

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World Health Organization

The University of Western Australia

Graylands Hospital

Curtin University of Technology

Telethon Institute for Child Health Research

Government of Western Australia Department of Health

Background

Women with serious mental illness (SMI) are at high risk for pregnancy and birth complications that increase neurological developmental risks for their children. Lifestyle factors such as smoking, use of illicit drugs and poor nutrition as well as failure to access antenatal care have been implicated in this increased risk. The provision of specific support by mental health clinicians/case managers to pregnant women with SMI is an important primary prevention strategy with the goal of improving obstetric and neonatal outcomes for these women and their children.

Purpose of Framework

This framework has been designed to assist you, the mental health clinician, in managing the reproductive and pregnancy needs of female clients with SMI. Whilst the framework does not require you to deliver antenatal care, it will encourage you to be an advocate for your client by initiating referrals to appropriate antenatal and/or family planning services. This support may assist your client in making more informed choices and providing linkage to early and ongoing antenatal care for the best possible outcomes for her and her baby.

As a mental health clinician, you are well placed to be an advocate (support person) for your client. This is because you are likely to have regular and consistent contact with the client; a therapeutic relationship with the client which facilitates client compliance with care; are best placed to identify changes in the client's mental status; know the client's current circumstances and have the ability to link and refer clients to appropriate agencies/services.

The Framework

This framework is for your consideration as a mental health clinician caring for female clients of childbearing age with SMI. You may need to modify its use to suit the individual needs of your client.

The overriding concepts of a holistic care approach are emphasised in the framework by three key elements:

- Providing reproductive choices for your client
- Early detection and monitoring of pregnancy
- Implementing a *"Small Known Team Approach"* in the management of the pregnant client with SMI

The small known team approach includes the woman's community mental health clinician, a named midwife at the antenatal clinic and a general practitioner if the client chooses a shared care option of antenatal care. If the client attends the Childbirth and Mental Illness (CAMI) antenatal clinic at King Edward Memorial Hospital, she will be cared for by the clinic's 'named' midwife and GP. This small team operates amongst a potentially larger team that includes the psychiatrist, obstetrician and hospital social worker.

The framework is presented in six modules:

- Establishing a Professional Support Network
- Assessment of Pregnancy Risk
- Early Detection of Pregnancy
- Monitoring During Pregnancy
- Preparation for Birth
- Preparation for Postnatal Period

Each module contains a set of recommendations and substantiating rationale as well as a flowchart highlighting key processes. Where appropriate, relevant tips/screening questions/prompts and checklists are provided.

Table of Contents

Module 1: Establishing a Professional Support Network

Recommendation	Rationale
Holistic Care Approach	
Ensure that clients are aware of the reasons why mental health clinicians are now collecting assessment data relevant to pregnancy sexual and general health.	Client may think mental health clinicians view their clients in relation to mental health only and may not share physical health issues.
	In the past, mental health clinicians have not collected information on physical and sexual health and this could be a new and unexpected practice to the client.
	Being informed of the rationale behind this change in practice can enhance trust and rapport with the mental health clinician and promote compliance with care.
General Practitioner (GP) Linkage	
Recommend that your client has a GP if they don't currently have one.	A GP can address physical needs (i.e. pap smear and contraception advice) beyond the scope of mental health clinicians - which facilitates the linking between mental and physical health needs.
If client does not have a GP, provide names and contact details of local GP's.	Clients may not have the capacity to seek a GP. Your clinic may have a list of recommended GP's considered to be supportive of mental health clients.
Provide contact details of Women's Health Services or Family Planning WA (FPWA) Sexual Health Services.	Client preference for GP services may include financial issues (Medicare rebate), access to public transportation, gender preferences, convenience and flexibility in availability (days and/or evening availability).
Offer to make appointment and provide client with a letter to take to appointment **(Client Referral Proforma available)**.	Clients may need encouragement to follow through with this recommendation and bringing a proforma letter to the GP from the mental health clinician can contribute to an accurate and concise medical history.

Role of mental health clinician

Discuss how mental health clinicians can be a client advocate (support person).

The mental health clinician:

1. Has regular and consistent contact with client
2. Has a therapeutic relationship with client which facilitates compliance with care
3. Is best placed to identify changes in client's mental status
4. Knows the client's current circumstances
5. Has the ability to link/refer client to appropriate agencies/services (i.e. providing names of local general practitioners if client doesn't have one)

Module 2: Assessment of Pregnancy Risk

Recommendation	Rationale
Assessment of Pregnancy Risk	
Include the following assessment data relevant to women's health and the date on standard assessment documentation.	Up to date relevant information is necessary to enable mental health clinicians to be effective decision-makers in their advocacy role. This may involve appropriate referral(s) to other health care professional(s) or support agencies.
Name and contact details of current **psychiatrist**.	If client demonstrates relapse behaviour or is concerned about psychotropic medication during pregnancy, prompt referral can be made.
Client's **current** psychotropic, antidepressant and mood stabiliser **medication** (names, dose, route, date commenced).	Clinicians need to know if the client has recently changed medication and how long they have been on current medication in order to provide correct information in referral letters to other health care professionals as needed.
Side effects of the current psychotropic medication experienced by client and its impact on client's menstrual cycle.	Side effects may change depending upon the psychotropic medication and dosage. Side effects may mask the symptoms of early pregnancy (i.e. missed period, nausea and breast tenderness).
Date of client's **last normal menstrual period** (LNMP).	Awareness of client's last menstrual period provides more data for the clinician to assess pregnancy risk given that psychotropic medication can mask the symptoms of pregnancy.
Client's current use of **contraception** and client perception of its suitability.	To determine if client is at risk of sexually transmitted infections (STI) and/or unplanned pregnancy and for the appropriate referral to other health care professional(s) to address this need. This information is also an indicator of sexual activity and if the client is effectively using the contraceptive choice or if another method might be more suitable.
Plans for pregnancy.	If client has plans to become pregnant they need to be referred to a general practitioner and/or Family Planning WA (FPWA) Sexual Health Services for pre-conception advice (i.e. commencing folate supplementation before pregnancy, nutrition, medication, smoking and lifestyle advice) and psychiatrist for adjustment of psychotropic medication.
Brief history of **past pregnancies**.	A woman who becomes pregnant for the first time may have more information and support needs. A client who has previously had a normal pregnancy with no complications and whose child is well may not require the same amount of support from their mental health clinician as a first time mother. However, a woman with a past history of complications may require additional support.

Recommendation	Rationale
Assessment of Pregnancy Risk (Continued)	
Name and contact details of current **general practitioner (GP)**.	For appropriate referral for physical concerns and for preventative women's health care (i.e. pap smear and contraception).
Name and contact details of **current social support** (i.e. family and/or friend).	To enlist support of significant people in client's life in case of emergency or to reinforce clinical care decisions and assist in contacting clients who may have moved.
Current and past **smoking status** (non-smoker, ex/smoker, smoker) including number of cigarettes smoked per day, quit date and if anyone at home smokes (Refer to Tips/Questions/Prompts).	Identifies current smokers and ex-smokers. If client is interested and receptive to quitting smoking then offer support and resources. If the client is already a parent or planning a pregnancy then positively reinforce efforts towards quitting for the benefit of their child(ren). Children with a smoking parent have an increased risk of disease, hospitalisation, Sudden Infant Death Syndrome and taking up smoking themselves in adolescence.
Other drugs client may be taking such as short or long-term prescription **medications** or over-the-counter medications (i.e. antibiotics, antihypertensives, cold and flu or decongestants).	Combination of medications may impact on the effectiveness of a drug and drugs may be contraindicated in certain combinations. With any suspicion of pregnancy, medication use must be reconsidered as soon as possible due to potential damage to the developing embryo.
Current and past use of any other **drugs (illicit or authorised)** such as cannabis, amphetamine, benzodiazepine, marijuana, opiates, cocaine, and barbiturates (amount, route, age began). If client has ceased using, include the date.	Should the client become pregnant it is crucial that she cease using during the important first trimester of pregnancy, when major damage can occur to the developing embryo, and ideally throughout the remainder of the pregnancy.
Current and past **alcohol** intake (how often, how much, age began). If client has ceased drinking, include the date.	Alcohol has a negative impact on pregnancy and the growing foetus. The newborn can be born with foetal alcohol syndrome, which contributes to abnormal development. If a client does become pregnant - stopping or decreasing alcohol consumption is strongly advised.
Screen for current and past history for family **domestic violence** when client is alone (Refer to Tips/Questions/Prompts).	Client may be at risk of domestic violence. Pregnancy may be a stimulus for the first episode of domestic violence and client may be reluctant to bring up the issue. Women may be more inclined to discuss this issue when asked with simple, direct questions in a non-judgemental manner in a safe setting. The woman can be offered a Domestic Violence Advocacy Support Central (CVAS Central) card, which provides written information including a safety plan and contact phone number. Women who disclose abuse will need to be referred to a social worker.
Current **accommodation** needs.	Client may be of no fixed address and require stable accommodation or supported housing.

Assessment of Pregnancy Risk

TIPS / QUESTIONS / PROMPTS / CHECKLISTS

Possible Contraception Questions

- Are you currently using any contraception?
- Are you currently sexually active?
- Do you require contraception?
- Do you have a current partner?
- Do you think you might be at risk of becoming pregnant?
- Are you happy with the contraception you are currently using?
- Are you planning to become pregnant in the near future?

Checklist for signs of pregnancy

PLEASE NOTE that some psychotropic medications can have the same side effects which could 'mask' pregnancy.

- Missed period
- Breast tenderness
- Nausea and/or vomiting
- Increased tiredness

Tobacco Smoking assessment

- Have you ever smoked?
- Are you currently smoking?
- If not smoking, when did you quit?
- Does anyone at home smoke?
- How many cigarettes do you smoke per day?
- Are you interested in quitting?
- Are you interested in cutting down the number of cigarettes you smoke in a day?
- Would you like assistance to quit? **Quitline Number** 131 848 (or toll free for country callers on 1800 198 024) to order a quit kit or to talk to a counsellor (24 hours a day).

Screening for Family and Domestic Violence

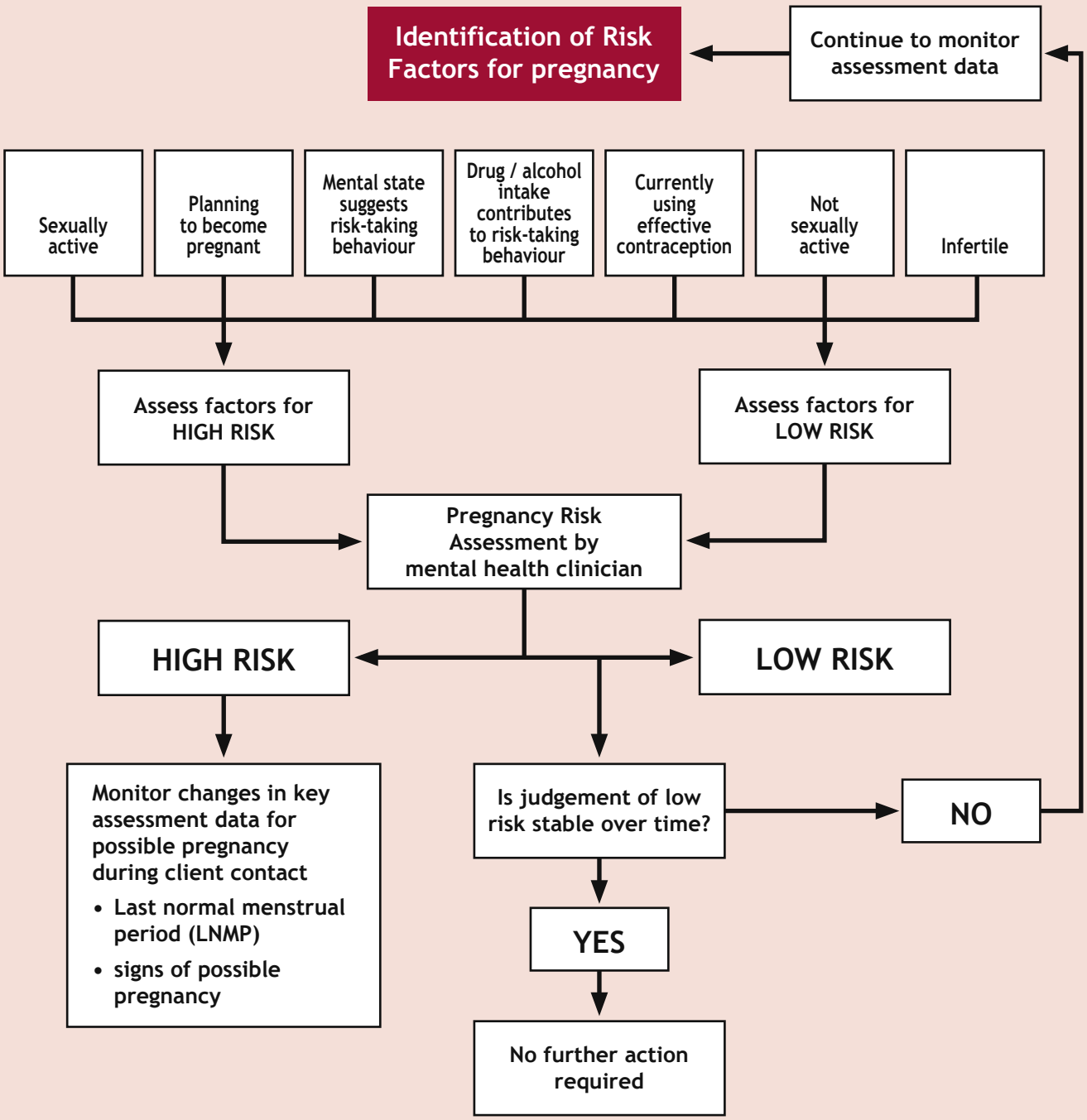
Ask the woman when she is alone.

Questions:

- Have you ever been afraid of someone close to you (i.e. friend, partner, family member)?
- Has anyone close to you ever hit, kicked, punched or otherwise hurt you?
- Has anyone close to you ever put you down, humiliated or embarrassed you or tried to control what you can do?
- Has anyone close to you ever threatened you?
- Would you like help with any of this now?
- Ask the woman if it is safe to give her written information?

A Domestic Violence Advocacy Support Central (DVAS Central) card provides written information including a safety plan and contact phone numbers. If a woman discloses abuse, she will need to be referred to a social worker.

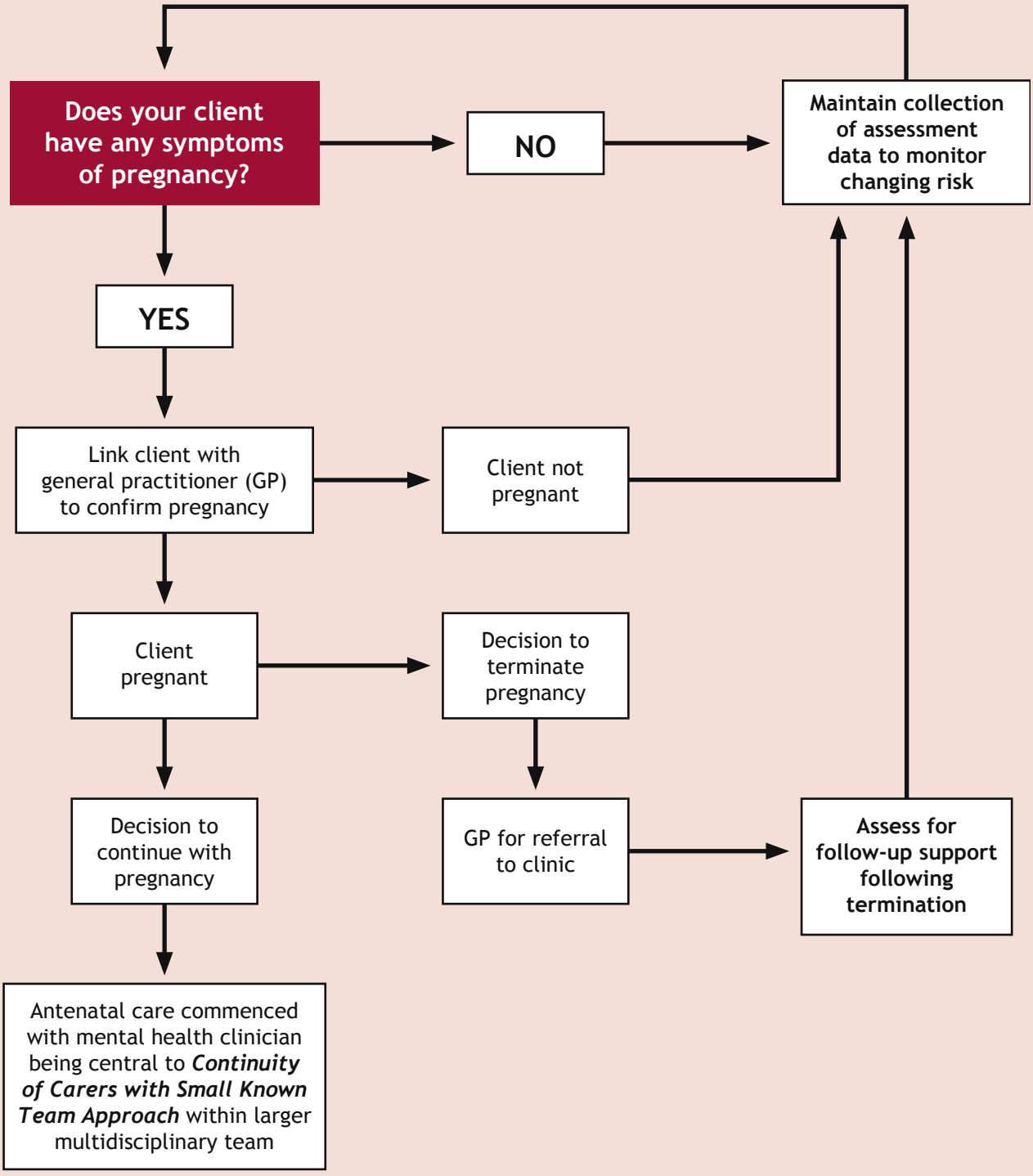
Flowchart: Assessment of Pregnancy Risk



Module 3: Early Detection of Pregnancy

Recommendation	Rationale
Monitoring for Risk of Pregnancy	
Ask client if she is concerned that she may be pregnant.	Client should be referred to general practitioner (GP) as early as possible to confirm possible pregnancy and have choice in follow up options.
Offer to make an appointment with local GP, Family Planning WA (FPWA) Sexual Health Services or any health service in your area that focuses on women's health.	Client may need support in making an appointment and following through with attendance.
Ask client to sign the completed referral letter **(Proforma available)** which outlines a brief history (i.e. diagnosis, pregnancy symptoms, current medications) for client to take to appointment.	Providing a proforma letter with a brief current history can assist the GP with relevant up to date data on client's current concerns and decreases potential stress for the client in providing that information, especially if the doctor is not familiar with the client.
Contact the client or GP (if client consents) to determine if pregnancy was confirmed and decision made by client regarding options (i.e. termination or continuation of the pregnancy).	Mental health clinician needs to be informed of pregnancy and client's decision regarding options available. Client may need time to consider options with partner/family and a second appointment may be necessary with the GP or an independent counselling agency.
Pregnancy Has Been Confirmed	
If client has decided upon a termination, assess the implications for follow-up assessment and support.	The client may require assistance with transportation to and from the clinic. They may need more intensive follow-up following a termination due to the potential of emotional trauma.
If the client has decided to continue with the pregnancy, find out from client and/or GP the antenatal care option chosen: 1. Attendance at Childbirth and Mental Illness (CAMI) antenatal clinic at King Edward Memorial Hospital (KEMH) 2. Attendance at public hospital antenatal clinic with named midwife 3. Shared-care with GP and hospital antenatal clinic with a named midwife 4. Specialist clinic options may be more appropriate for some women such as the Chemical Dependency Clinic or Adolescent Clinic at KEMH	The mental health clinician continues contact with the woman during her pregnancy to ensure *continuity of carers with a "**Small Known Team**"* (i.e. mental health clinician, named midwife and GP if shared-care was chosen). Pregnant women with serious mental illness are considered 'high risk' and having access to a *small known team* throughout the pregnancy is a 'safety net' to avoid the woman getting lost in a large team with multiple health care professionals (i.e. psychiatrist, obstetrician, registrars, social worker, occupational therapist and mental health nurse). Should the woman not attend antenatal visits or require reinforcement of health information, the *small known team* are best placed to follow up with the woman. The client will then have the opportunity to become familiar and comfortable with one named midwife. Having this consistency of care should decrease the client's stress and hopefully decrease the possibility of non-attendance at ongoing appointments.
Make follow-up appointment for client to see psychiatrist.	The psychiatrist may need to assess the current psychotropic medication choice and dosage based upon pregnancy.

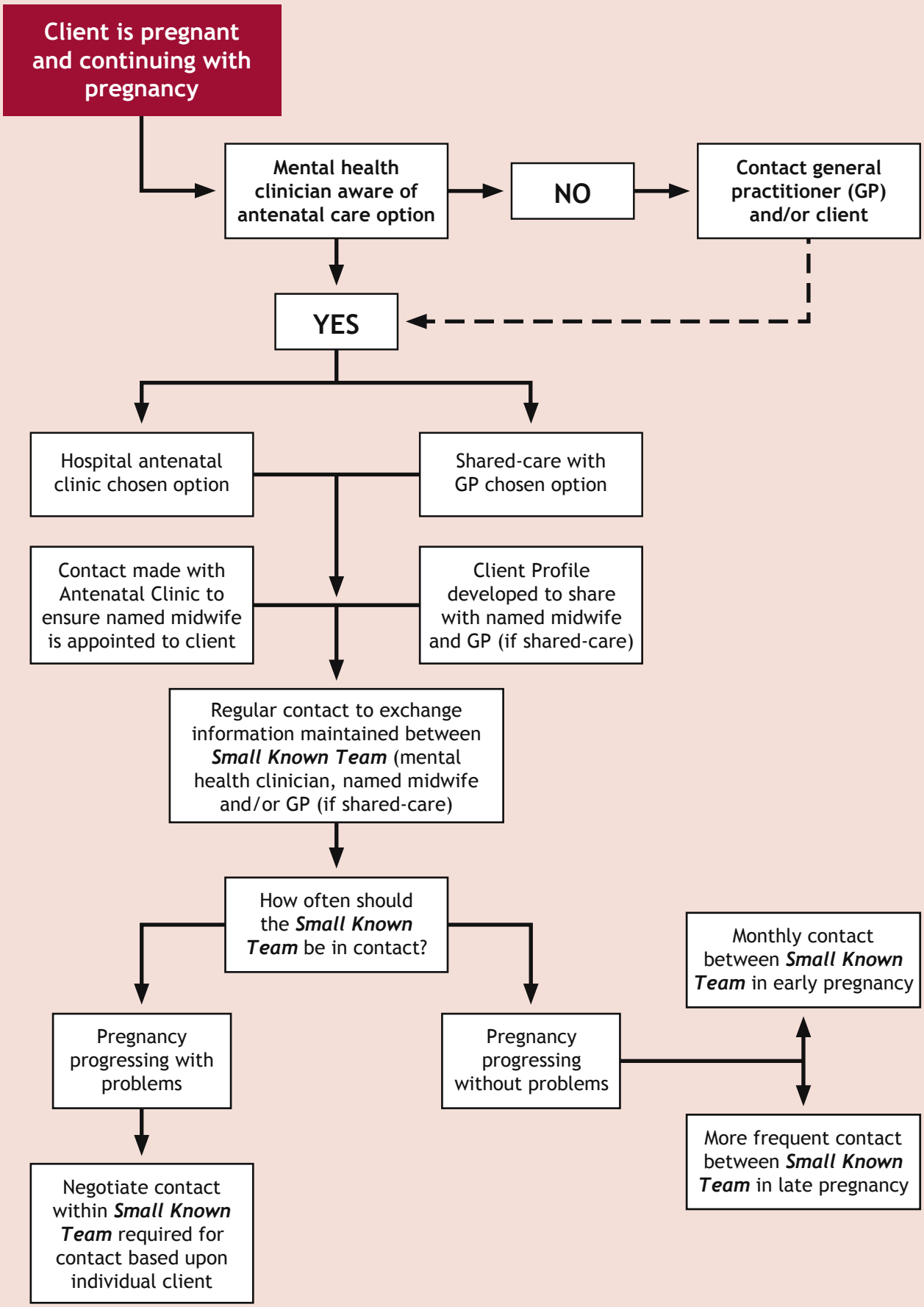
Flowchart: Early Detection of Pregnancy



Module 4: Monitoring During Pregnancy

Recommendation	Rationale
Monitoring During Pregnancy	
Confirm with general practitioner (GP) that initial booking to antenatal clinic has been made.	Mental health clinician remains involved and informed of client booking with antenatal clinic and/or attendance at GP clinic if shared-care has been chosen.
Contact the antenatal clinic to ensure that a named midwife has been chosen for this client and during first appointment, client will meet named midwife.	If client has chosen to attend a local antenatal clinic affiliated with a hospital, the clinic must be made aware that this client with a serious mental illness requires a consistent named midwife to be present for each visit. The clinic will then nominate a midwife who will ensure that all follow-up appointments are scheduled when (s)he is available.
Assess whether to attend the first antenatal clinic appointment with the client based on client's preference and the assessment of the client's current mental status.	Based on the mental health clinician's assessment of the client's current mental status, appropriate arrangements can be made for the first antenatal visit. This could involve the mental health clinician negotiating the possibility of a home visit should it be warranted. Having the mental health clinician attend the first appointment may set a positive introduction to the antenatal clinic and promote compliance with ongoing attendance throughout the pregnancy.
Develop a Client Profile **(Proforma available)**, with client consent, that includes contact details of mental health clinician, client diagnosis, medications, psychiatrist contact details, and relapse indicators. The client takes the Profile to the first antenatal appointment where it is kept on the client's antenatal records.	The Client Profile will provide valuable assessment data that is relevant and current for this pregnant woman. This information benefits the named midwife, medical staff at the antenatal clinic and the GP if shared-care was chosen.
Contact named midwife and GP if shared-care, (via email, phone or in person), monthly during early pregnancy and more frequently during late pregnancy. This may assist in ensuring ongoing appointments are made when named midwife is available and enables discussions to take place about client attendance, information to be reinforced with client and any concerns regarding the ongoing pregnancy.	Exchange of information between the mental health clinician, named midwife and/or GP ensures that care is tailored appropriately to the individual to engender increased compliance with care and/or educational advice. The client is more likely to attend appointments if their considerations are taken into account at the time of making the appointment. This ensures that appointments scheduled are most suitable for the client, (i.e. not during busiest times as noise and congestion may make client uncomfortable), with preference given to late morning appointments to allow for travel on public transport or to accommodate child care arrangements.

Flowchart: Monitoring During Pregnancy



Module 5: Preparation for Birth

Recommendation	Rationale
Preparation for Birth and Postnatal Period	
In collaboration with the named midwife, establish if the client will be attending any hospital parent education classes.	The client may be reluctant to attend 'traditional' antenatal classes provided by the hospital due to their personal circumstances, current mental status and comfort level with receiving information in a group setting.
If the client is not attending parent education classes, liaise with named midwife to determine the most suitable strategy for ensuring the client receives the essential information covered in parent education classes.	The named midwife may chose to cover the essential information presented in parent education classes in a one-on-one session with the client during an antenatal clinic visit or over several antenatal clinic visits. The named midwife informs the mental health clinician about what information was covered so this can be reinforced during contacts in late pregnancy.

TIPS / QUESTIONS / PROMPTS / CHECKLISTS

Checklist for Essential Information Covered in Parent Education Classes

- Possible signs of labour have been discussed with client
- Pain relief options for labour have been discussed with client
- Client and support person offered a hospital tour of birth suite if interested
- Infant feeding options have been discussed with client. Client is prepared to initiate breastfeeding or is prepared to formula feed upon discharge from hospital

Possible Signs of Labour

- Regular contractions coming 5 to 10 minutes apart and lasting 30 to 40 seconds
- Membranes have ruptured (i.e. gush or leaking amniotic fluid from vagina)
- Mucous plug is being expelled (i.e. pink or reddish mucous discharge from vagina)

Checklist for Preparing for Birth

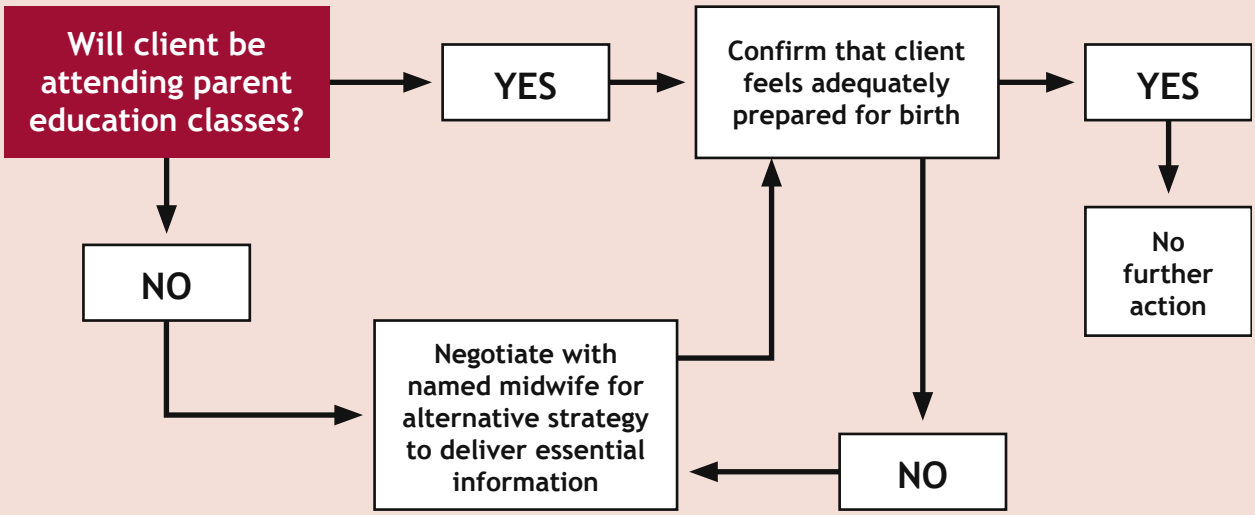
- Client is aware that she must bring her Pregnancy Health Record with her for each antenatal visit and whenever she goes to hospital (i.e. for special tests such as an ultrasound or when she thinks she is in labour)
- Client has contact details to phone hospital if she has questions or concerns
- Client has list of what to bring to hospital for herself and her baby
- Client has made arrangements for a support person to accompany her in labour (i.e. partner, family member and/or friend)

When to Phone the Hospital

- Client to phone hospital if she experiences any of these danger signs:
  1. Vaginal bleeding
  2. Baby isn't moving as much as it normally does
  3. Persistent headache
  4. Blurred vision
  5. Upper abdominal pain
  6. Significant and sudden swelling of face and hands
  7. Persistent abdominal pain

- Client encouraged to phone hospital if she has any questions or concerns.

Flowchart: Preparation for Birth



Module 6: Preparation for Postnatal Period

Recommendation	Rationale
Preparation for Postnatal Period	
Attend one of the antenatal appointments (or liaise via email) to initiate the development of a Client Management Plan **(Proforma available)** in preparation for the postnatal period. Ideally this could be planned during late pregnancy (28+ weeks).	The Client Management Plan in preparation for the postnatal period needs to be initiated early enough to ensure referrals/ liaisons with postnatal resources are in place prior to labour. The client may experience an early labour, which occurs before the expected/anticipated due date - which is only an estimate.
The Client Management Plan in preparation for the postnatal period appointment/meeting should ideally involve the mental health clinician, client, named midwife and GP if shared-care.	The ***Small Known Team*** who have provided the continuity of care throughout the pregnancy are in the best position to know the client's personal circumstances for support after the birth and are more likely to gain cooperation from the client and their informal support network.
The Client Management Plan in preparation for the postnatal period is documented and shared between the mental health clinician, named midwife and GP.	Documentation must be shared to be clinically effective. Ensure all of the team are informed (i.e. electronically or hard copied) with current records of objectives, decisions and referrals made in preparation for the postnatal period.
A copy of the Client Management Plan in preparation for the postnatal period is kept by the mental health clinician, the GP (if appropriate) and in the antenatal client notes for access by a potentially larger health care team.	The Client Management Plan in preparation for the postnatal period must be available to all health care professionals (HCP) involved in caring for the client. If all HCP are informed of referrals and support services put in place, this will reduce the possibility of duplication or strategies being overlooked.
A copy of the Client Management Plan in preparation for the postnatal period is sent to the client's psychiatrist.	The psychiatrist will need to be informed of referrals and support services put in place for the client during the postnatal period.

TIPS / QUESTIONS / PROMPTS / CHECKLISTS

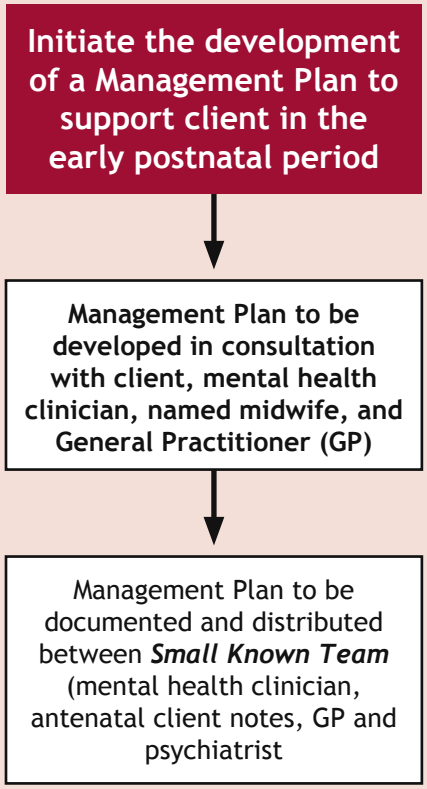
Checklist for Client Management Plan in preparation for the postnatal period

Liaisons made with:

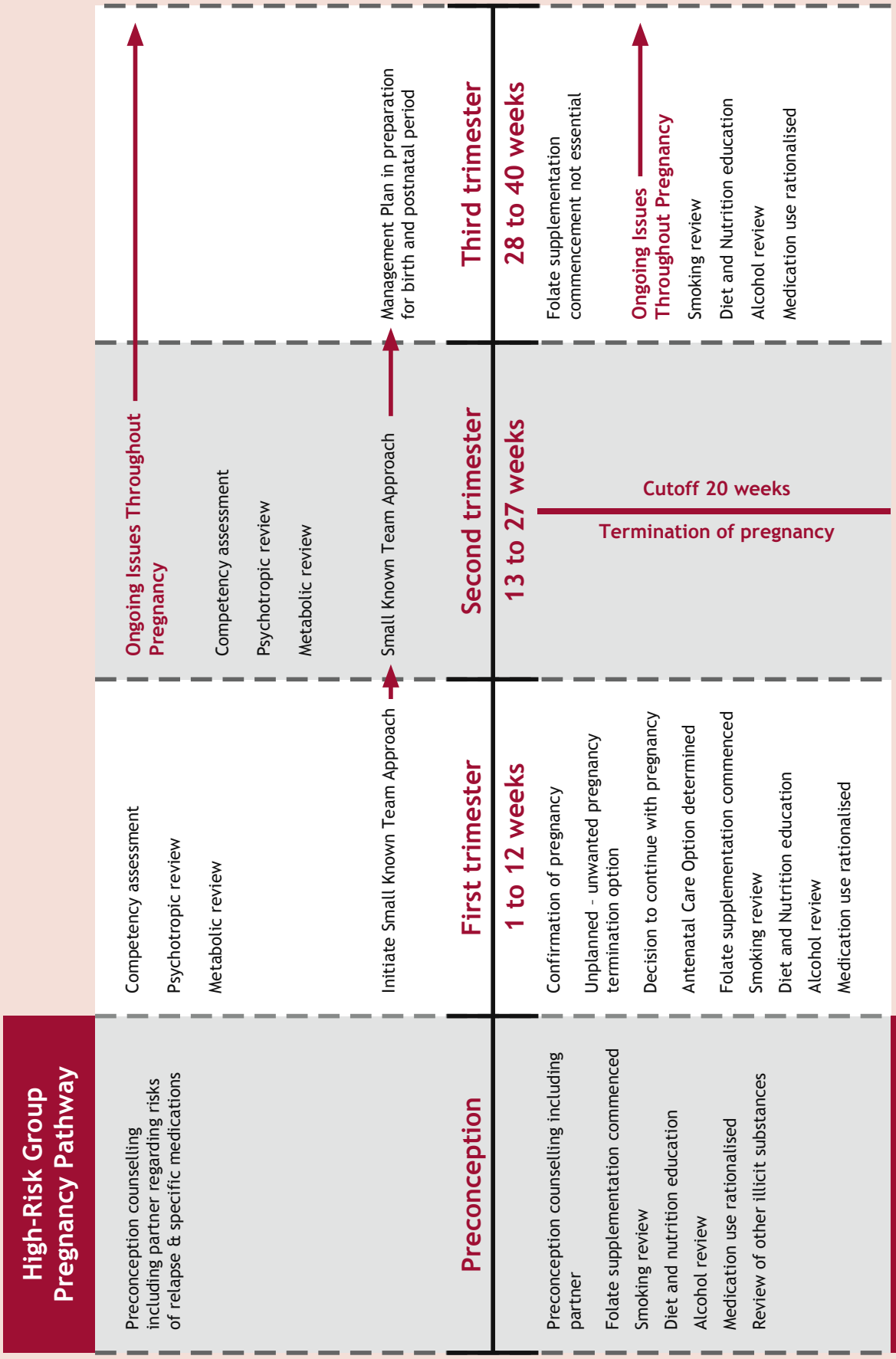
- Child health nurse
- Social worker
- Department of Community Development support
- Appropriate community support services (i.e. RUAH, ISHAR)
- Best Beginnings contact at Department for Communities
- General Practitioner
- Mother and Baby Unit at King Edward Memorial Hospital (KEMH) for Women

For a list of parent services and support groups visit NMAHS Mental Health Online Resource at http://www.nmahsmh.health.wa.gov.au/projects/healthybabies.cfm

Flowchart: Preparation for Postnatal Period



Appendix 1: Overview of Special Issues in High Risk Pregnancy



Appendix 2: Literature Review — Key Points for Consideration

Childbearing Issues for Women with Serious Mental Illness such as Schizophrenia and Major Affective Disorders

Women with a serious mental illness (SMI) are just as likely to be mothers and their fertility rates are no different from the general population of women (Nicholson & Biebel, 2002).

Obstetric and Neonatal Risks and Complications

- There is a need to improve antenatal services for women with schizophrenia in light of the growing evidence that the offspring of these women are at increased risk of complications (Barkla & McGrath, 2000).
- Genetically predisposed foetuses apparently have a special vulnerability that amplifies the damage which perinatal complications inflict on their brains (Mednick et al., 1987).
- These women have an increased relative risk for pre-term births, low birth weight, small-for-gestation babies and postneonatal deaths (Bennedsen et al., 1999; 2001a & 2001b).
- Complications associated with schizophrenia include: 1) complications of pregnancy (bleeding, diabetes, Rh incompatibility, preeclampsia); 2) abnormal foetal growth and development (low birth weight, congenital malformations, reduced head circumference) and 3) birth complications (uterine atony, asphyxia, emergency caesarean section) (Cannon et al., 2002).
- Intensive intervention during the pregnancy with a high-risk foetus may reduce the likelihood of obstetric complications, thus reducing a potential risk factor for schizophrenia in the offspring (Barkla & McGrath, 2000).

Contraception and Pre-Conception Issues

Women with serious mental illness are:

- More likely to have had more than one sexual partner; have a negative sexual experience, to have been raped or been in receipt of payment for sex and have a higher incidence of unplanned and unwanted pregnancies (Miller & Finnerty, 1996).
- More likely to be without the support of a spouse or significant other and have higher rates of separation and divorce (Rudolph et al., 1990).
- At high risk with suicide attempts, substance abuse, more likely to have been victims of violence whilst pregnant and less likely to have received antenatal care (Miller, 1990).
- In need for appropriate contraception based upon individual client assessment as there have been reports of non-reliable use with barrier methods and oral contraceptives for certain clients (McCullough et al., 1992).
- In need of family planning with emphasis on a thorough sexual history encompassing a holistic approach (i.e. eliciting information that will reveal whether she may be pregnant, at risk of denying a pregnancy, at risk of unwanted pregnancy, and at risk of sexually transmitted infections (STI) (Coverdale et al., 1997).

Pregnancy Issues

- Pregnancy at a younger age is associated with poorer education, a diagnosis of schizophrenia and early age of illness onset (Zemencuk et al., 1995).
- Weight gain is more common with more recent psychotropic medications (personal communication Prof A. Jablensky, July, 2006), which may contribute to risk of gestational diabetes in pregnancy or later Type 2 diabetes.
- Amenorrhoea and menstrual cycle disruption are commonly a side effect of psychotropic medications and therefore pregnancy can occur and pass unnoticed for several months (Fitgerald & Seeman, 2000).
- Some early pregnancy symptoms (i.e. nausea or breast swelling) may be discounted and attributed to the effects of psychotropic medications (Fitzgerald & Seeman, 2000).
- A diagnosis of pregnancy may be delayed due to psychotic denial, poor self-observation, or fear/suspicion of health professions (Barkla & McGrath, 2000).
- A denial in pregnancy can occur whereby women experience psychotic denial if they have schizophrenia, have lost custody of children and have ambivalent feelings toward the father (Miller, 1990).
- Women with SMI may have difficulty cooperating with antenatal procedures (Barkla & McGrath, 2000).
- There is a risk associated with unplanned pregnancy and need for education about family planning, especially considering how important the first trimester is for risks to embryonic development (Barkla & McGrath, 2000).

WA Study of Birth Complications in Schizophrenic Women (Jablensky et al., 2005)

- Mothers with schizophrenia are more likely to be <19 years or >35 years.
- They have more obstetric complications (placental abnormalities, antepartum haemorrhages and drug toxic side effects because of alcohol, tobacco & illicit substances).
- They are more likely to experience foetal distress during labour with their neonate requiring naloxone with a resulting suboptimal 5 minute Apgar score.
- An increase in incidence of cardiovascular system defects among children of mothers with schizophrenia has been noted.
- There is a 60.5% prevalence of smoking amongst women with schizophrenia.
- Aboriginal women experienced a marked excess of pregnancy, labour/delivery and neonatal obstetric complications.
- Mothers whose psychiatric illness commenced before the birth of the infant were more likely to experience obstetric complications.

Potential of Community Mental Health Nurse

- Nurse/patient relationships enhance treatment compliance. Through the relationship nurses influence patients to make changes, which leads to recovery. In addition, nurses can visualise the results of treatment compliance over time (Dearing, 2004).
- The importance of continuity of carer and the relationship with health care professionals must be recognised. Women clients are often better able to form therapeutic relationships but may be sensitive to frequent changes in health care professionals (Fitzgerald & Seeman, 2000).
- Factors amenable to intervention involve enhancing compliance with antenatal attendance, stop-smoking programs and nutritional advice plus facilitating existing social support (Barkla & McGrath, 2000).
- The goal is to link the pregnant woman with serious mental illness to appropriate services at earliest opportunity (Barkla & McGrath, 2000).
- Education and early referral to appropriate services is facilitated due to the advantage of mental health service staff having a better understanding of individual client situations (Barkla & McGrath, 2000).

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Appendix 3: Proforma 1. Client Profile

Proformas can be downloaded from http://www.nmahsmh.health.wa.gov.au/projects/healthybabies.cfm

NORTH METROPOLITAN AREA HEALTH SERVICE
MENTAL HEALTH

_____ **Hospital**

CLIENT PROFILE

Surname	Sex	U.R. No.
Forenames		D.O.B.
Address		
Ward	Registrar	Consultant
Use Patient I.D Label When Available		

CLIENT PROFILE

Purpose - This form is to be completed when your client is pregnant and they have been referred to antenatal services (i.e. Antenatal clinic and/or GP for shared care).

Date:

Mental Health Clinician Preparing Client Profile

Contact Details:

Client Diagnosis

Medications

Psychiatrist and Contact Details

Support Person Contact Details	**Relationship to client**

Relapse Indicators (management of challenging behaviour or behaviour changes that may indicate the need for referral for mental health re-assessment)

Additional Relevant Information

Gravity: Parity: EDD:

Significant Obstetric Hx:

Significant Medical Hx:

Other services and care that the client may need or already has:

Client Consent (In Client's Own Handwriting):

Client's Full Printed Name: _____

Client's Full Signature: _____

Dated: _____

G2/12
MAY 08

CLIENT PROFILE

Appendix 3: Proforma 2. Client Referral

Proformas can be downloaded from http://www.nmahsmh.health.wa.gov.au/projects/healthybabies.cfm

NORTH METROPOLITAN AREA HEALTH SERVICE
MENTAL HEALTH

_____ **Hospital**

CLIENT REFERRAL

Surname	Sex	U.R. No.
Forenames		D.O.B.
Address		
Ward	Registrar	Consultant
Use Patient I.D Label When Available		

CLIENT REFERRAL

Purpose - This form is to be completed when referring your client to another health service provider / agency (i.e. General Practitioner, Women's Health Services, Family Planning WA Sexual Health Services or other)

Date:

Referral Agency:

Mental Health Clinician Preparing Client Referral

Contact Details:

Client Diagnosis

Medications

Psychiatrist and Contact Details

Reason for Referral

Additional Relevant Information

Client Consent (In Client's Own Handwriting):

Client's Full Printed Name: _____

Client's Full Signature: _____

Dated: _____

G2/10
MAY 08

CLIENT REFERRAL

Appendix 3: Proforma 3. Client Management Plan

Proformas can be downloaded from http://www.nmahsmh.health.wa.gov.au/projects/healthybabies.cfm

NORTH METROPOLITAN AREA HEALTH SERVICE
MENTAL HEALTH

_____ **Hospital**

MANAGEMENT PLAN

Surname	Sex	U.R. No.
Forenames		D.O.B.
Address		
Ward	Registrar	Consultant
Use Patient I.D Label When Available		

MANAGEMENT PLAN - PREPARATION FOR POSTNATAL PERIOD

Purpose - This form is to be completed by the 'Small Known Team' to ensure liaison has occurred with relevant service and/or agencies in preparation for the client's postnatal period.

Date:	**Pregnancy:**	**Due Date:**

Management Plan Team Members	**Contact Details**
Mental Health Clinician Name: Named Midwife: General Practitioner's Name (if shared care):	

Patient Assessment (considering current and future health care needs)

Arrangements / referrals made	**By Whom**	**Date:**

Actions / follow up	**By Whom**	**Date:**

Next Review date	Copy sent to all team involved in management's plan? Yes _____ No _____

Client Consent/Acknowledgment of involvement in the Management Plan (In Client's Own Handwriting):

Client's Full Printed Name: _____

Client's Full Signature: _____

Dated: _____

G2/11
MAY 08

MANAGEMENT PLAN

North Metropolitan Area Health Service

Mental Health

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