



**OBSTETRICS AND GYNAECOLOGY
 CLINICAL PRACTICE GUIDELINE**

Childbirth and Mental Illness (CAMI) Clinic

Scope (Staff):	Health professionals caring for women with mental illness, including midwifery, medical and allied health staff working in the Childbirth and Mental Illness Clinic
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas at KEMH
This document should be read in conjunction with this Disclaimer	

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Aims

To improve obstetric and neonatal outcomes for women with a diagnosed severe mental illness (SMI) by:

- utilising a multidisciplinary team approach as recommended by the [National Pregnancy Care guidelines](#) (external website): see Section 5: [Pregnancy care for Women with Severe Mental Illness](#) (external website)
- small identified team providing individualised comprehensive continuity of care
- management of psychotropic medications and potential effects in pregnancy and postpartum
- increasing the rate of attendance to antenatal services
- monitor closely for obstetric complications
- liaison with psychiatric, obstetric and primary care providers
- planning for birth and postnatal support

Key points

1. Women attending the CAMI clinic require routine antenatal care. Additionally specific vigilance for obstetric and psychosocial complications is required, entailing detailed information about medical, physical, psychiatric, social, history of drug and alcohol use, and current and recent medication history.
2. Women attending the CAMI clinic should be provided with additional information regarding:
 - Psychotropic medications in pregnancy
 - relative risks of relapse of their disorder in pregnancy and postpartum
 - nutrition and dietary requirements
 - psychosocial supports
3. Discharge planning and documentation commences at the first visit.
4. Women are informed the proposed postnatal stay is extended as required to allow monitoring of the mental state and assist parenting.
5. Women attending the CAMI clinic should not be discharged from hospital prior to being seen by the psychiatrist and the social worker.

Referral

Criteria for CAMI referral

- Chronic psychotic disorders such as schizophrenia
- Severe mood disorders e.g. Bipolar Affective Disorders or recurrent major depression with a history of psychiatric hospitalisation
- Past history of postpartum psychosis
- Severe non-psychotic disorders with significant impairment to functioning and/or complex care (discussed with the CAMI team).

Referral process

Antenatal referrals are received by:

- CNMM Referrals Coordinator for the antenatal clinic at KEMH
- Department of Psychological Medicine, and then forwarded to the CAMI clinic.

All referrals are triaged in the CAMI clinic. Women triaged to the CAMI clinic will be given appointments and registered with the Department of Psychological Medicine under the CAMI clinic program.

Referrals for women who do not meet the criteria to attend the CAMI clinic are sent to the CNMM Referrals Co-ordinator who arranges appointments at other obstetric clinics.

CAMI clinic

	Procedure	Additional information
<p>1 Initial assessment and triage</p> <p>Conduct the booking visit and follow up antenatal visits as for all pregnant women attending KEMH. See Clinical Guidelines: Obstetrics and Gynaecology: Antenatal Care Schedule</p> <p>The timing of the booking visit will be determined following CAMI review. The first visit may be as early as 12 weeks gestation depending on individual clinical circumstances.</p>	<p>Women with SMI may present later in their pregnancy than other women.¹</p> <p>Poor or late attendance may be due to unplanned pregnancy, previous poor experiences with health services, and lifestyle issues.²</p> <p>Fear of statutory involvement includes fear of a child being placed in care.</p>	
<p>2 Medical history and physical assessment</p> <p>2.1 General medical health</p> <p>2.2 Sexually transmitted infections (STIs) and cervical screening test</p>	<p>Women who have a SMI may be at greater risk of metabolic complications in pregnancy e.g. diabetes, obesity and hypertension.³</p> <p>Psychotropic medication may have an impact on general medical disorders e.g. lithium is associated with thyroid dysfunction⁴, and antipsychotics and cardiac effects⁵.</p> <p>Women with SMI may be at greater risk of STIs⁶ and may be less likely to</p>	

Procedure	Additional information
	receive regular cervical screening and should therefore be fully investigated.
<p>2.3 Drug and alcohol screening</p> <p>Refer to Women and Newborn Drug and Alcohol Service (WANDAS) for consultation if substance misuse is an issue.</p>	<p>Women with SMI are at increased risk of smoking, alcohol and substance abuse.³ Counselling should be offered in regard to smoking and alcohol use.</p>
<p>2.4 Monitor for complications</p> <p>Women with SMI have increased rates of pregnancy and birth complications.^{3, 7}</p>	
<p>3 Mental health history</p>	
<p>3.1 All CAMI women on initial assessment will be reviewed by the psychiatric team.</p>	<p>A history of diagnosis, hospitalisations, and medication use, including during the first trimester exposure is documented.</p>
<p>3.2 Liaise with the Community treating team / case manager / Private Psychiatrist.</p>	
<p>3.3 Conduct an individualised risk / benefit analysis e.g. information regarding the safety data for medication in both pregnancy and breastfeeding. Discuss the relative risks of relapse of their disorder and the possible consequences of a relapse of their disorder in pregnancy and postpartum.</p>	<p>Assess information about the use of mood stabilisers in pregnancy and fetal effects.^{8, 9}</p> <p>See also WNHS Psychological Medicine guidelines and 'Useful resources' section at end of this guideline for fact sheets/articles.</p>
<p>3.4 Provide information to woman about antenatal support groups.</p>	
<p>3.5 Discuss with the woman the role of the Mother and Baby Unit (MBU). If transfer to MBU postpartum is being considered, provide the woman with a brochure and arrange a tour of the unit.</p>	<p>Women with SMI are at increased risk of psychiatric relapse postpartum.^{10, 11}</p> <p>Liaise with the MBU in high risk cases.</p> <p>See also MBU webpage.</p>

Procedure	Additional information
<p>4 Social assessment</p>	
<p>4.1 Refer women to Social Work according to their criteria. See Clinical Guideline Social Work Working with Obstetric Patients- Social Work and e-Referrals.</p> <p>In addition refer:</p> <ul style="list-style-type: none"> • women with schizophrenia • primigravid women • women with no support network 	<p>All patients who are seen at CAMI Clinic are reviewed by social work to identify possible child protection or other risk factors that may impact on the woman's ability to care for herself and baby. See Allied Health, Social Work: 'CAMI- Social Work' guideline.</p>
<p>4.2 Child protection:</p> <ul style="list-style-type: none"> • any woman who is assessed may require involvement with the Department for Communities: Child Protection and Family Support (DCFS). The Social Worker will discuss this with the CAMI team as well as the Head of the Social Work Department. • should the case already be open or opened as a result of a referral made by KEMH to CPFS the pre-birth planning process needs to commence as soon as possible • Complex care planning will be documented regarding the antenatal and postnatal management of women with complex psycho-social circumstances. 	<p>Women with SMI have significantly higher rates of DCFS involvement, and women with schizophrenia are less likely to have care of their children.²</p> <p>See: Reciprocal Child Protection procedures between KEMH and DCP within the WA Health Guidelines for Protecting Children 2020.</p> <p>Housing situation – SMI women are at risk for homelessness.</p> <p>Partner and supports – women with schizophrenia may have higher rates of being single and less likely to be supported in their pregnancy.² Data collaborated from the CAMI clinic has shown women with SMI are more likely to have a partner who is suffering a SMI.</p>
<p>4.3 At the earliest opportunity complete screening for Family and Domestic Violence (FDV).</p>	<p>Women with SMI are at increased risk of FDV.²</p>

5 Current pregnancy

Monitoring (scans, tests)

5.1 Ultrasounds

Ultrasounds are individualised according to risk factors, such as medication exposure in the first trimester and fetal wellbeing.

Consider:

- First trimester screen
- Anatomy scan
- Fetal growth and wellbeing

Additional information: Women with SMI should be referred to the KEMH CAMI clinic for early pregnancy care. Women with SMI may have been exposed to medication in the first trimester. This has been associated with increased fetal abnormalities e.g. mood stabiliser, lithium^{9, 12, 13}. As such a tertiary level quality ultrasound should be arranged. Antipsychotic medication exposure during pregnancy may be associated with abnormalities in fetal growth.¹⁴

5.2 Blood investigations

Routine antenatal screening tests, **plus** include consideration for:

- B12, folate
- Ferritin
- Thyroid function tests (TFTs)
- Liver function tests (LFTs)
- Urea and electrolytes (U&Es)
- Lithium levels each trimester, then weekly from 28 weeks gestation
- Vitamin D- Women with SMI are considered at high risk and discretionary screening recommended
- Fasting: blood sugar level (BSL) at booking / early in pregnancy and early glucose tolerance test (GTT)

Additional information: Alcohol, drug and medication use may lead to the deficiency of essential vitamins¹⁵ which can be exacerbated by poor nutrition. Anorexia or [eating disorders in pregnancy](#) can lead to nutritional deficiency. Nutritional deficiency may increase risk of depression.¹⁶ Vitamin D is reduced in women with SMI¹⁷ and the risk can be exacerbated by women with increased BMI¹⁸.

Women with SMI may be more at risk of metabolic disorders¹⁹. Antipsychotic medication has the potential to increase the risk of abnormal glucose

metabolism,²⁰ and has been linked with an increased risk of gestational diabetes mellitus (GDM).

Thyroid dysfunction may be an aggravating factor to mental illness in pregnancy.²¹ Antipsychotic medication e.g. lithium may precipitate abnormal thyroid function.⁴

Medications are metabolised through the liver and kidneys and these may need monitoring during pregnancy.

Lithium levels should be monitored frequently in pregnancy (see above). An individual lithium management plan will be done with each pregnancy and attached to the perinatal management plan. This will be placed in the front of the patient's medical record notes where appropriate.

See relevant forms:

- [Perinatal Mental Health Plan Special Instruction Sheet MR006](#)
- [Pregnancy Monitoring Anti-Epileptics MR215.11](#)
- [Pregnancy Monitoring Lithium Carbonate MR215.12](#)
- [Pregnancy Monitoring Anti-Psychotics MR215.13](#)

5.3 Electrocardiogram (ECG)

Antipsychotics, lithium and some antidepressant medication at increased doses can affect the conduction of the heart. An ECG should be performed.²²

6 Nutritional advice

6.1 Assess the BMI at the booking visit

- Document weight each visit, and monitor throughout the pregnancy

Women with SMI are at risk of increased BMI.^{3, 23} Medication used in the treatment of mental disorders can increase appetite and sugar cravings leading to excessive weight gain.¹⁹

6.2 Arrange dietician review for women with:

- increased BMI
- low BMI
- increased weight gain due to medication
- positive GTT

Consider dietician review in all women taking antipsychotic medication.

7 Parent education

Additional information is given about:

- medications and breastfeeding

- blood borne viruses
- effects of drug, alcohol misuse and smoking
- risk behaviours, consequences and increased surveillance as deemed necessary
- extended hospital stay as required
- management and frequency of ongoing antenatal care
- postnatal support services

Women with SMI are at increased risk of postpartum relapse¹⁰ and as such require close monitoring in the immediate postpartum period.

Neonates are at risk of Neonatal Adaptation Syndrome and may have increased need for Special Care Nursery.³

8 Referrals

- **Consider contraception**

Contraception is discussed with all women at the 36 week antenatal visit. Some medications may interfere with the use of contraception. Certain contraception may aggravate the woman's mental state.

For women requiring an Intrauterine Contraceptive Device (IUCD) insertion postpartum clear documentation for plan should be recorded in the notes. .

9 Management plans

All CAMI patients: Completed antenatally:

- A Perinatal Mental Health Plan Special Instruction Sheet (MR006)

Additional: Considered on an individual basis:

- Refer on an individual basis for '[Complex Care Management Planning](#)'
- Sensitive birth plan (MR215.10): Some women may also need a sensitive birth plan due to a history of childhood sexual abuse (CSA)
- 'Lithium Management Plan': Filed in their Medical Record notes for women with Bipolar on lithium. Patients with SMI are at increased risk of relapse postnatally and that risk can be exacerbated by sleep deprivation postpartum²⁴ and individual needs for women will be documented.

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Related WNHS policies, procedures and guidelines

KEMH Guidelines:

- [Psychological Medicine](#): including [Eating Disorders in Pregnancy](#)
- Obstetrics and Gynaecology:
 - [Anaemia](#)
 - [Antenatal Care Schedule](#) (initial & subsequent visits); [Complex Care: Planning](#)
 - [Vitamin B12 Deficiency: Management](#)
 - [Vitamin D: Deficiency in Pregnancy](#)
- Social Work:
 - Clinical Practice with Childbirth and Mental Illness (CAMI)- Social Work
 - [Working with Obstetric Patients- Social Work](#)

Useful resources

Resources

- Department of Health Australia / NHMRC: [Pregnancy Care guidelines](#) (external site): see Section 5: [Pregnancy care for Women with Severe Mental Illness](#) (external site)
- Department of Health WA: Guidelines for Protecting Children 2020
- WNHS [Social Work Hub page](#) (via Intranet)
- WNHS Pharmacy [Pregnancy and Breastfeeding Medicines Information](#)
- Fact sheets: Mother to Baby <http://mothertobaby.org/fact-sheets> (external site)
- Bumps (Best Use of Medicines in Pregnancy) www.uktis.org (external site)









Forms: [links below are to show images, order through usual hospital process]

- MR 006 [Perinatal Mental Health Plan- Special Instruction Sheet- Department of Psychological Medicine](#)
- MR 215.10 Sensitive Care Plan- Mental Health
- MR 215.11 [Pregnancy Monitoring Anti-Epileptics](#)
- MR 215.12 [Pregnancy Monitoring Lithium Carbonate](#)
- MR 215.13 [Pregnancy Monitoring Anti-Psychotics](#)

- MR 248: Childbirth and Mental Illness Antenatal Checklist

Patient information:

- **Internet pages:** [Childbirth and Mental Illness Service](#) and the [MBU webpage](#)

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Version history

Version number	Date	Summary
1	Aug 2012	First version
2	Aug 2015	Archived- contact OGD Guideline Coordinator if required
3	Aug 2018	For a list of changes- see OGD Guideline Updates by month/year of review date
4	Oct 2021	<ul style="list-style-type: none"> • New medical record forms in use- see forms list above • Extended hospital stay as required • Contraception- clear documentation for plan should be recorded in the notes.

This document can be made available in alternative formats on request for a person with a disability.

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