NHS
Avon and Wiltshire
Mental Health Partnership
NHS Trust

AWP

Post Partum Psychosis (PPP) Pathway

SPECIALIST COMMUNITY PERINATAL MENTAL HEALTH SERVICE

Post Partum Psychosis Pathway

UNDERSTAND

Is this Post-Partum Psychosis? Check PPP Symptoms & Presenting Situation - **Page 3,4 & 5**

Do they present with one or more of the following Red Flags:

Recent significant change in mental state/new symptoms

New thoughts or acts of violent self harm, however fleeting

New and persistent expressions of incompetency as a mother/estrangement to infant

REFER

Treat as Psychiatric Emergency

Refer to Local Intensive / Crisis Service

Highlight potential Post Partum Psychosis

Follow guidance - **Page 5**

RESPOND

Intensive / Crisis Team - Arrange face to face assessment within 4 hours

Seek specialist advice BNSSG 01179195826, BSW 01249767851, MBU 0117 4147270

Consider Mother & Baby Unit bed

Follow guidance - **Page 6**

TREAT

Initiate medication early

Maintain low threshold for admission to MBU

Follow guidance - **Page 7**

What is Post Partum Psychosis?

Post-Partum Psychosis is a severe, but treatable, form of mental illness that occurs after having a baby.

KEY BACKGROUND INFORMATION

- PPP can emerge unexpectedly and deteriorate rapidly.
- PPP is a PSYCHIATRIC EMERGENCY as risks to mother and infant can be extremely high and hard to predict.
- Any suspected case should be treated as a PPP until it has been proven otherwise.
- Most women will require medication AND admission to hospital.
- An episode of PPP most often occurs in the first month post-delivery, but it can also so occur later than this.
- Mothers with a previous history of bipolar affective disorder, schizoaffective disorder or those who have had a previous episode of post-partum psychosis will be at increased risk of PPP.
- **50% of affected mothers will have had no history of mental illness.**

PPP Symptoms

Distinctive Clinical features	Common Symptoms:
• Sudden onset and rapid deterioration • Fluctuating presentation (rapid change from appearing well to unwell and well again can occur over minutes to hours) • Insomnia (even when baby asleep or cared for by others) • Majority have onset within first 2 weeks of delivery – over 50% of symptom onset occurs on days 1-3	• Impaired attention • Perplexity, • Agitation • Affective (mood) symptoms – elation or depression - Labile mood, irritability, restlessness, over-activity, • Disturbance of consciousness marked by apparent confusion, disorientation, bewilderment or perplexity (*need to exclude organic cause*) • Family often report subtle changes: "*I can't put my finger on it, but she is just not herself*"

- Typical psychotic symptoms (hallucinations, delusions with content often related to the new baby) are often not present to start with and may only emerge later on.

- *<u>Any</u> psychotic symptoms, particularly delusions or hallucinations, substantially increase risk for both mother and baby.*

ACTION 1
Understand and Refer

Clarify Presenting Situation

- Has patient had a baby in the last year?
- Does the patient present with any symptoms consistent with PPP?
- Do they present with one or more of the following Red Flags :

➢ **Recent significant change in mental state/new symptoms**

➢ **New thoughts or acts of violent self harm, however fleeting**

➢ **New and persistent expressions of incompetency as a mother/estrangement to infant**

Refer to mental health services

- Treat as a PSYCHIATRIC EMERGENCY until proven otherwise
- Refer immediately to your local Intensive service, stating this is a potential PPP.
- If mum or baby in immediate danger call 999!
- A four hour response by mental health services is essential. Any delay in appropriate assessment and treatment can lead to rapid deterioration and escalation of risk.
- A lower threshold compared to non-perinatal patients should be maintained for accepting referrals, admissions and interventions. This is due to the additional risks posed to mother and infant and the fact that disorders in the early postpartum period can deteriorate quickly.

ACTION 2

Crisis Team Response*

- MH professional should contact most appropriate person (service user, family member/carer or health social care professional) without delay and agree next steps to be provided in the service users care and support.
- **A face to face assessment within 4 hours of referral is required.**
- Failure to provide an emergency referral and adequate assessment or start treatment immediately poses significant risk to mother and baby
- Consider and assess the need for Safeguarding if Mother or baby is felt to be at risk
- **Refer to community perinatal mental health service within 1 working day**
  awp.perinatalmentalhealthservice@nhs.net. - BNSSG
  awp.referralsbswperinatal@nhs.net - BSW
- On call Consultant is available for advice and guidance or Perinatal Consultant Psychiatrist within working hours On call Rota's are available on Ourspace or via AWP switchboard – 01225 325680)
- Specialist advice is available through -
  Mother and Baby Unit, all hours on 0117 4147270
  Community Perinatal Teams during working hours
  BNSSG 01179195826 & BSW 01249767851
- Prior to assessment check Webbeds for MBU bed availability:
  https://www.nhswebbeds.co.uk

*Liaison Psychiatry if service user is presenting at hospital emergency department

NICE recommend treatment of Mum and baby together. Severity of symptoms and nature of risk may result in MBU not being an appropriate environment. This should be considered as part of MBU discussion.

"There should be an expectation of early consultant involvement in assessment & management"
MBRRACE-UK 2018

ACTION 3
Emergency Medical Treatment

1. Exclude physical health cause i.e delirium
2. Maintain low threshold for admission to MBU
3. Aim to keep mum/baby together unless risks posed to baby's safety
4. Initiate antipsychotic treatment early; we recommend Olanzapine or Quetiapine which are both effective and suitable for use while breastfeeding.
5. Consider use of Lorazepam if required to manage acute agitation
6. Regularly Review diagnosis in light of physical health/blood results etc

Further medical resources:

LactMed https://www.ncbi.nlm.nih.gov/books/NBK501922/

BUMPs bumps - best use of medicine in pregnancy: medicinesinpregnancy.org

Choiceandmedication Avon and Wiltshire Mental Health Partnership Trust Home (choiceandmedication.org

Predicting Risk for PPP

- Background rate 0.1-0.2% (1-2/1000)
- If bipolar affective disorder Type I or Schizoaffective disorder – 20%
- If bipolar/schizoaffective disorder and female first degree relative had PPP – 50%
- If have bipolar/schizoaffective disorder and previous PPP – 50%
- If had previous PPP – 50% in next pregnancy
- If first degree relative had PPP - 3%