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SHORT REPORT

Fertile ground: reproductive health consideration in mental health ward policy

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Objectives: Women of childbearing age often experience mental health problems, receive psychotropic medication and are admitted to mental health units. Approximately 40% of pregnancies are unplanned and many women experience perinatal mental health problems. It is therefore vital that consideration is given to reproductive health in mental health policy. We aimed to evaluate the consideration of pregnancy and breastfeeding in the policies of an inpatient mental health service.

Methods: The policies of a regional inpatient psychiatric unit were independently reviewed by two researchers. Policies that had implications for pregnancy and breastfeeding for patients were identified. Whether or not these policies considered pregnancy and breastfeeding and the detail of this consideration was evaluated.

Results: One hundred and thirteen policies were evaluated. Forty had implications for pregnancy but only 10 of these mentioned pregnancy and only 3 in detail. Only 3 of the 28 policies that had relevance to breastfeeding mothers mentioned it and none discussed it in detail. Key areas of omission included prescribing, seclusion and restraint and cultural and religious considerations.

Conclusion: Pregnancy and breastfeeding were almost entirely absent in the ward policies of our inpatient unit. Their consideration in the acute setting is vital. An individual or group of individuals should be responsible for ensuring that reproductive health is considered in all policies as well as in a larger specific policy suitable for referencing. The rights of the reproductive woman should be comprehensively considered in inpatient mental health care policy.

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Introduction

The age of onset for many mental health disorders coincides with a key period in a woman's reproductive life (Gelder *et al.* 2001). More than one in 10 women of reproductive age have experienced a major depressive episode in the last year (Ko *et al.* 2012). Consequently, many women of childbearing age receive inpatient mental health care and take psychotropic medication.

Internationally, approximately 40% of all pregnancies are unplanned (Sedgh *et al.* 2014; Bearak *et al.* 2018). Many factors associated with unplanned pregnancies are also associated with mental illness. These include substance misuse, lower levels of educational attainment, social stressors and intimate partner violence (Goossens *et al.* 2016). The association between unplanned pregnancy and mental health problems is bidirectional – an unplanned pregnancy increases the risk of developing mental health problems, and individuals with mental health problems are more likely to experience an unplanned pregnancy (du Toit *et al.* 2018).

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Mood and anxiety disorders are common in the perinatal period, occurring at least as frequently during pregnancy as in the post-partum period (Howard *et al.* 2014). Illness during this period can have a significant and detrimental impact not only on the mother but also on the new baby, her partner and the family unit as a whole (HSE, 2017). It can precipitate a disorganised attachment style between the mother and child which can have long-term detrimental effects on the child's cognitive function (Stein *et al.* 2014), and on their behaviour and emotional development (Leis *et al.* 2013). It is therefore of the utmost importance that consideration is given to the specific requirements of women of childbearing age with mental health needs.

While care in the community is the preferred treatment option for mental health disorders, admission is sometimes required. Both women of childbearing age and women in the perinatal period who have mental health care needs may require admission. Health Research Board data from 2016 found that between 40 and 60 patients diagnosed with perinatal mental health disorders required admission over a 1-year period in Ireland (HSE, 2017).

Despite plans in the Model of Care for Specialist Perinatal Mental Health Services (HSE, 2017), no

Mother and Baby Unit currently exists in Ireland. Consequently, it is necessary for local units to have appropriate facilities available to treat women during this time and policies that give their needs due consideration (HSE, 2017).

Inpatient facilities are accredited by the Irish Health Services Accreditation Board. Their standards are laid out in the Quality Framework for Mental Health Services by the Mental Health Commission (Mental Health Commission, 2006). Each inpatient unit must develop its own local policies to align with this document. Unfortunately, this framework gives no specific consideration to reproductive choices, pregnancy or breastfeeding.

We aimed to evaluate consideration of pregnancy and breastfeeding in the policies of an inpatient mental health service. We hoped to identify key areas where policy could be improved in order to enhance the reproductive rights and optimise the future perinatal choices of women admitted under mental health teams.

Methods

The adult mental health unit in which this study was based is a regional, acute unit with 32 beds and a seclusion area. It is a mixed ward with segregated sleeping areas only. There are no specific facilities to accommodate the pregnant or breastfeeding woman nor is there a dedicated mother and baby room. All of the policies in the designated mental health unit were identified. Those that related only to staff were excluded. The remaining policies were independently read and reviewed by two researchers. In the case of disagreements, a third researcher cast the deciding vote. Those policies that had no bearing on pregnancy or breastfeeding were excluded. The remaining policies were then assessed for the extent of consideration given to these topics. These steps are summarised in Figure 1. All policies that considered the topic were classified as either considering it in detail or superficially. Examples of this process can be found in the accompanying supplementary materials. All steps were carried out independently by two researchers, with a perinatal psychiatrist casting the deciding vote in disputed cases.

Results

In total, 113 policies were identified, 45 of which were excluded as they related only to staff. Of the remaining 68, 28 were excluded as they were not deemed to be relevant to pregnancy or breastfeeding. Forty policies were therefore identified as having relevance to pregnancy and 28 to breastfeeding. Thirty of the policies that related to topics that are relevant to pregnancy gave pregnancy no consideration and of the remaining 10 policies, only 3 considered it in a comprehensive manner. Only 3 policies of the 28 identified addressed breastfeeding, all in a superficial manner. The policies relating to the prescription of lithium and sodium valproate gave a significant amount of consideration to the pregnant or breastfeeding patient. However, none of the other drug-specific prescribing policies considered this. In a broader context, in the policy relating to practice standards for nurse prescribers, both pregnancy and breastfeeding were mentioned, with the recommendation to refer to the appropriate guidelines.

The policy relating to ECT (electroconvulsive therapy) gave due consideration to pregnancy, advising that an obstetrician should be consulted prior to administration, that resources for managing obstetric and neonatal emergencies should be available, and that foetal monitoring should be available past the first trimester.

Some of the policies that considered pregnancy and breastfeeding are outlined in Table 1 along with examples of policies that failed to consider them. It should be noted that the ward in question did not have any policy specific to pregnancy or breastfeeding.

Discussion

It is evident from this study that while there was commendable thought given to the pregnant and breastfeeding inpatient in some areas, there was a significant lack of consideration in most of the policies. There are a number of potential explanations for this. Firstly, it may relate to the fact that overall, there are relatively low numbers of women in the peripartum period requiring admission to mental health facilities, for example, in 2016, only 40 to 60 women in Ireland with perinatal mental health issues required admission (HSE, 2017). Secondly, decisions around medication management in pregnancy can be difficult due to lack of or conflicting data regarding safety (Niethe & Whitfield, 2018). Finally, one paper (Stotland, 2017) suggests that there may persist, even subconsciously, outdated coercive perceptions that women with major mental health disorders should not conceive.

As mentioned, apart from lithium and valproate, no other drug-specific prescribing policies considered pregnancy or breastfeeding nor did they mention preconceptual advice despite the fact that international guidelines clearly recommend this practice (NICE, 2018). It has been demonstrated that withholding or withdrawing psychotropic medications in pregnancy in women with mental illness can be detrimental to both maternal and foetal outcomes (Niethe & Whitfield, 2018). Clinician anxiety about inducing such an effect may result in women remaining on medi-

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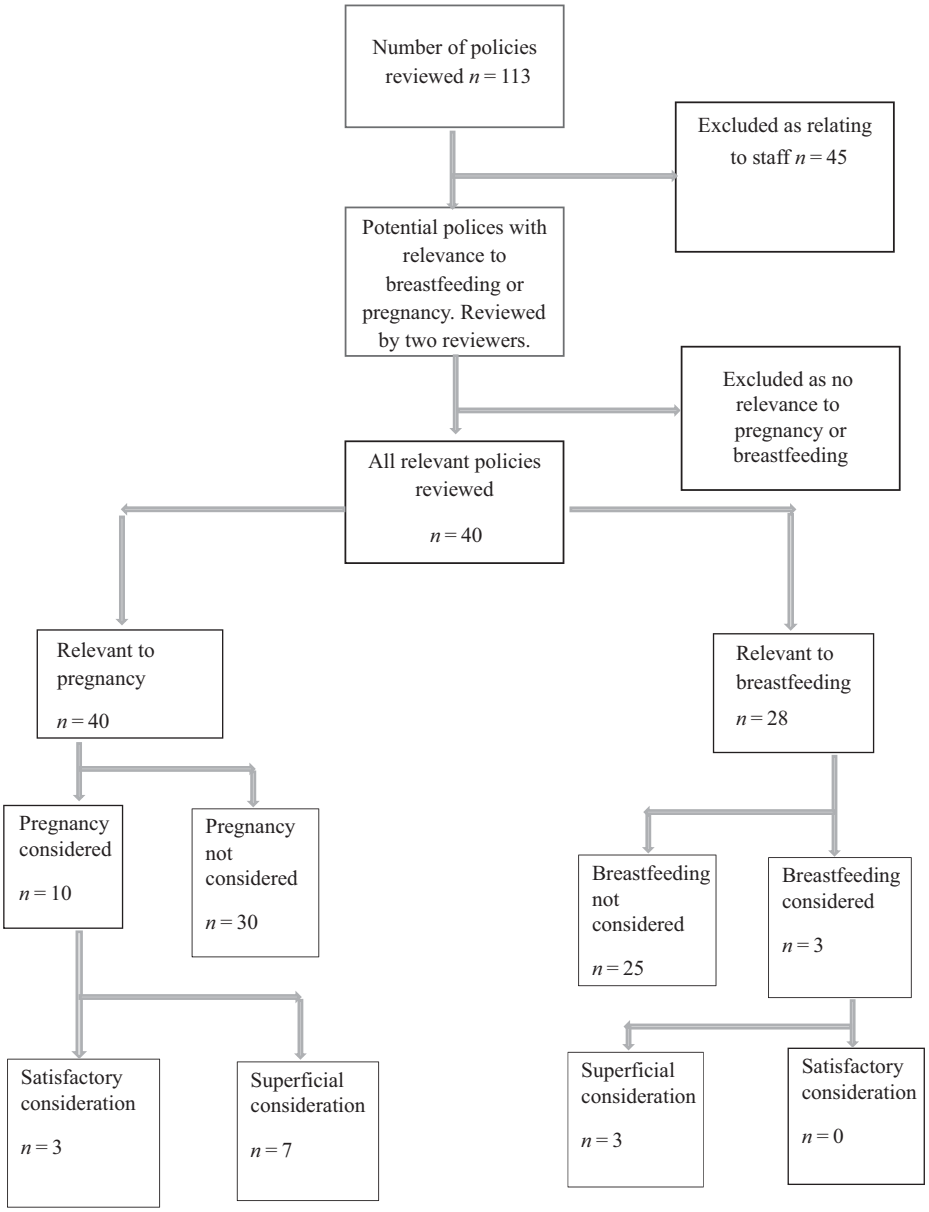

Fig. 1. Flow chart of selection of policies, with reasons for exclusion of policies.

cations unnecessarily throughout their pregnancy. This could potentially be avoided if the recommended pre-conceptual advice had been administered.

Also, as 40% of pregnancies (Bearak *et al.* 2018) are unplanned, it might be wise to consider all women pregnant until proven otherwise, when making prescribing decisions.

While there was evidence of consideration given to pregnancy and breastfeeding in other policies, the superficial nature of it rendered it somewhat meaningless. For example, pregnancy is mentioned as a risk factor for suicide in the policy relating to suicide murder clusters, but there is no reference associated with this statement nor is there any recommendation on how to address or assess this risk. In the policy on religion and cultural diversity, the only reference to pregnancy is in relation to the practice of the Muslim faith.

This fails to address the huge variance in attitudes towards reproductive health problems across religions (Schenker, 2000). It also neglects the fact that rural and isolated women, women coming from areas of civil unrest or war, and refugee and immigrant women are more vulnerable to mental health disorders (Stewart *et al.* 2001). This policy should be updated to reflect the significant body of research available in this area.

There are a number of policies where it was felt that the omission of consideration of pregnancy and

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Table 1. *Examples of policies that were considered relevant to pregnancy and breastfeeding*

Policies where pregnancy mentioned	Sodium valproate
	Lithium
	Protection of life
	ECT
	Practice standards for nurse prescribers
	National consent policy
	Religion and cultural diversity
	Catheterisation guideline
	Suicide murder clusters
	Clostridium difficile
Policies where breastfeeding mentioned	Lithium
	Practice standards for nurse prescribers
	Clostridium difficile
Neither mentioned, both considered relevant sample $n = 10$ of 30	Physical restraint
	Seclusion
	Clozapine
	Olanzapine zyphadera
	Falls
	Premises
	Visiting
	Legionellosis
	Assisted admission
	Safeguarding vulnerable persons at risk of abuse

breastfeeding was of particular importance. For example, the policy in relation to premises does not mention accommodation for a mother and baby should this be required.

Similarly, the policy relating to privacy, confidentiality and intimate care does not make reference to the needs of the woman to have access to a private area for breastfeeding. Neither the policy relating to physical restraint nor seclusion makes reference to the safe management of the pregnant woman. Physical restraint can pose significant risks to the pregnant patient, particularly in the second and third trimester where the development of supine hypotensive syndrome can be precipitated by being placed in the supine position (Humphries *et al.* 2019). Some consideration has been given to this in the prison system but it has not been highlighted in mental health policy (National Task Force on the Use of Restraints with Pregnant Women under Correctional Custody, 2012). The importance of this is increased as it appears that rates of restraint are increasing in Irish mental health services (Mental Health Commission 2018). While the literature pertaining to seclusion in pregnancy is scant, the safety of the mother and foetus should be considered before a period of seclusion is initiated. These policies should at least recommend training and education for staff involved in these procedures. As there are no studies that address the pharmacological management of agitation during pregnancy, clinicians should use the minimal amount necessary to reduce the risk of agitation and aggression (Ladavac *et al.* 2007). While the provisions relating to ECT are in accordance with many of the latest recommendations on the use of ECT in pregnancy (Ward *et al*, 2018), the policy's scope could be broadened to encompass all of these recommendations.

It is well documented that pregnant women are at increased risk of violence and physical abuse. One in eight women experience abuse during pregnancy (Kenny & Ni Riain, 2014), and the potential for intimate partner violence to begin or escalate increases during pregnancy (Higgins *et al.* 2017). Of the women who suffer from domestic violence, up to 30% are assaulted for the first time during pregnancy (Tallieu & Brownridge, 2010). The policy on safeguarding the vulnerable person at risk of abuse should be adapted to include pregnant and perinatal patients.

In other policies, such as those relating to falls or food safety, the pregnant or breastfeeding woman should be considered. In relation to falls, the physiology of pregnancy causes loosening of ligaments and an alteration in the woman's centre of gravity predisposing her to instability (Dunning *et al.* 2010). Sedative medication may further complicate these difficulties. Falls may result in significant injury to the mother including fractures, organ damage, or abruptio placenta and may result in foetal death (Dyer & Barclay, 1962). This policy should give due consideration to the pregnant population. Immune changes in the pregnant or breastfeeding woman make her, her foetus and newborn more susceptible to foodborne illnesses (US government, 2019). When providing nutrition for these women, it should be clear to both staff and patients which foods are safe to be consumed and this should be clear in the policy.

These are but a few examples of where changes could be made. Ideally, each policy that was identified as being relevant to the topics of pregnancy or breastfeeding should be reviewed and rewritten. It is also important that these vital topics are not only considered as an afterthought in an isolated policy, but rather that they are integrated into all relevant policies to facilitate the holistic care that should be provided for all women of childbearing age.

Conclusion

In conclusion, the needs of pregnant or breastfeeding women with mental health disorders differ from those of other patients. Their needs are no less important, and in the spirit of equitable and accessible provision of mental health services, all policies should give

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consideration to these needs. The Quality Framework for Mental Health Services (Mental Health Commission, 2006) on which inpatient policies are based is now 14 years old and should also be updated to reflect these needs. Policies governing mother and baby units in other countries, for example, the UK (Royal College of Psychiatrists Centre for Quality Improvement, 2018), would make a useful reference point on which to base these proposed changes.

Supplementary material

To view supplementary material for this article, please visit https://doi.org/10.1017/ipm.2020.27.

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Conflict of interest

Dr Eimear McGuire has no conflicts of interest to disclose. Dr Camilla Curtis has no conflicts of interest to disclose. Dr Richard Duffy has no conflicts of interest to disclose.

Ethical standards

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008. The authors assert that ethical approval for publication of this service evaluation was not required by their local Ethics Committee.

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