

**Best Practice when Working with Women with Serious Mental
Illness in Pregnancy**

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Abstract

Introduction

The current literature highlights that the key treatment and management of women with psychosis is with atypical antipsychotic medications. However, many clinicians lack the knowledge and confidence in the management of the woman who is pregnant or planning to be, whilst taking antipsychotic medication. To maintain her optimal mental health status they require access to the most current evidence at the time when decisions must be made about ongoing care. Clinicians who provide care for this vulnerable group of women, their families and their babies during pregnancy, birth and postpartum encompasses those in both maternity and mental health services. They work in a variety of different ways with their clients, however most recognise that they work to achieve the best outcome for both mother and baby, but struggle at times to know how best to achieve this because working with this group of women requires specialist skills and knowledge.

Method

A qualitative descriptive design, using semi structured interviews to explore and describe the experiences of clinicians in three health care settings in Victoria, Australia was adopted. The emergent themes related to the current management, issues and problems that arise for clinicians, particularly in relation to the management of medications.

Findings

An optimal outcome was described by clinicians as 'both mother and baby were well and healthy and that mother and baby developed a good bond and who remain together as a family'. Clinicians are clearly concerned that harm could be caused particularly to the baby, with the use of medications. Clinicians ask 'can we really use that?' and state that 'we just don't know!'

Discussion

Clearly there is a need for further education of all clinicians in the management of women with serious mental illness during pregnancy and postpartum. Particularly important is the need for development of a specialist clinician to act as the key professional in initiating and maintaining care and contact with women and their clinicians. A Perinatal Mental Health Nurse Practitioner would be available to work with women in both services and to act as a professional resource for clinicians in providing the optimal care for women and their babies.

Introduction

Being pregnant and needing medication is problematic. Women with serious mental illness are having babies and they are being medicated with antipsychotic medication. Clinicians, researchers, women and their families are concerned about the safety of the use of antipsychotic and other medications during pregnancy and breast feeding (Altshuler et al 1996; Cohen & Rosenbaum 1998; Jain & Lacy 2005; Littrell, Johnson, Peabody & Hilligoss,

2000; McKenna, et al 2005; Pinkofsky 2000; Trixler & Tenyi 1997; Usher, Foster, & McNamara 2005). The current literature highlights that the key treatment and management of women with psychosis is atypical antipsychotic medication.

Recent studies have involved the establishment of pregnancy registries in several countries. These are not drug company registers. They aim to gather independent information about the use of antipsychotic medications in pregnancy and include the National Register of Antipsychotic Medications in Pregnancy (NRAMP) in Australia, (Kulkarni, McCauley-Elsom et al 2008) and in the United States, the National Pregnancy Register for Atypical Antipsychotics (Massachusetts General Hospital and Harvard Medical School 2009). Such registers provide the opportunity to disseminate current and accurate information about the outcomes for mothers and babies when antipsychotic medications are used during this vulnerable time for both.

There are a variety of practices and opinions held by clinicians regarding the use of antipsychotics in pregnancy. In some instances clinicians cease the woman's antipsychotic medications prior to pregnancy while other clinicians are happy to continue with the medication regime which maintain the woman's mental status and well-being (Kulkarni et al 2008; McCauley-Elsom & Kulkarni 2007). In other cases, clinicians increased the dose in early pregnancy, while others decrease the dose in late pregnancy, several weeks prior to birth of the baby, with the idea that this would reduce the likelihood of effects on the neonate (Mendhekar, War, Sharma & Jiloha 2002).

The risks associated with discontinuing medications in pregnancy and the subsequent relapse have been well reported in the literature (Altshuler et al 1996; Baldessarini & Viguera 1995; Cohen & Rosenbaum 1998; Lamberg, 2005; Mendhekar et al 2002; Misri Corra, Wardrop, & Kendrick 2006; Patton, Misri, Corral, Perry & Kuan 2002; Pinkofsky 1997, 2000; Trixler & Tenyi 1997; Viguera et al 2000). The most recent concern with the use of antipsychotic medication in pregnancy relates to weight gain. There are known risks of weight gain to both mother and baby including metabolic syndrome. This has been associated with olanzapine, clozapine and quetiapine (Newcomer 2007). An association has been reported between the use of olanzapine, maternal weight gain and the development of gestational diabetes, leading to macrosomia of the baby and shoulder dystocia at birth (Gentile 2006).

Outcomes for Babies

Everyone (clinicians, women and their families) is concerned about the safety for the foetus and baby with the use of antipsychotic medications in pregnancy. Risk to the developing foetus is identified (Cohen & Rosenbaum 1998; Pinkofsky 1997; Sacker, Done & Crow 1996) though many identify little or no risk ((Altshuler et al 1996; Goldstein, Corbin & Fung 2004; Hill et al 2000; Koren et al 2002; MacKay, Wilton, Pearce, Freemantle & Mann 1998; Nagy et al 2001; Yaris et al 2004). Some assert that the risks are uncertain and recommend caution in the use of antipsychotic medication during pregnancy (Ernst & Goldberg 2002).

In a recent study of ten cases, several minor conditions were possibly attributable to the maternal antipsychotic medication (McCauley-Elsom 2009). These included mild hypotonia and respiratory depression at birth (risperidone 'Consta') and neonatal withdrawal syndrome with irritability and unsettled behaviour postnatally (quetiapine). Two babies had umbilical hernias. Two prematurely born infants also experienced the problems commonly associated with prematurity such as Hyaline Membrane Disease, jaundice and feeding difficulties. No major abnormalities were reported in this cohort.

Discussion and documentation of the woman's preferences for medication use in pregnancy, as well as other choices such as whether to continue the pregnancy or not, are

clearly topics that must be addressed when the woman is well, and in the presence of her partner and family. The risk of harm to mother and baby and the use of antipsychotic medications in pregnancy continue to cause dilemmas for clinicians regarding the best management. Depending on the clinician, management may include the use of antipsychotic medications (Littrell et al 2000; McKenna, Einarson, Levinson & Gideon 2004). Other interventions used by clinicians with this group of women include psycho education, support groups and psychotherapy (Kreidler 2006; Talbot et al 2005). Nevertheless there is a paucity of information about the outcomes of these therapies in pregnant women with serious mental illness.

Background

This study sought to identify clinicians' beliefs about the use of antipsychotic medications in pregnancy for women with serious mental illness. Clinicians who provide care for this vulnerable group of women, their families and their babies include those in maternity and mental health services. This study involved clinicians in Victoria, Australia, who specifically work with pregnant or postnatal women diagnosed with serious mental illness.

Advances in the ways in which nurses and midwives work are seen in the development of new roles and recognised areas of advanced practice, designed to meet the changing needs in health care service delivery today (Elsom 2006, 2007). Clinicians work with people in a variety of ways.

Mental health nurses are described as working within a complex therapeutic relationship (Wallace, O'Connell & Frisch 2005). The therapeutic relationship between the clinician and the patient is based on the development of trust, rapport, the level of interaction, and the use of a range of psychotherapeutic interventions (Fakhoury, White & Priebe 2007; Iliffe, Wilcox & Haworth 2006; Scanlon 2006; Stone & Hazelton 2008).

Mental health services are provided within the inpatient psychiatric setting (Hangan, 2006) and community based services. These include case management models and crisis intervention teams (Hangan 2006; Hopkins, Deltodesco & Wasley 2002; Simpson 2007; Street & Walsh 1998). Recent advancements in mental health nursing practice have seen the development of new roles such as Psychiatric Consultation Liaison Nurse (PCLN) and Mental Health Nurse Practitioners (Wortans, Happell & Johnstone 2006). Nurse practitioners are based in a variety of settings including emergency departments (Wand 2005), community mental health services and general hospitals (Lomas 2006; Sharrock & Happell 2001).

Midwives' work also involves the development of a relationship with women working in a partnership model (Guilliland & Pairman 1995; Kirkham 2000). Midwifery care is focused on midwives 'being with' women through pregnancy and childbirth. In this way midwives are said to provide individualised woman-centred care. Midwifery led models of care include caseload midwifery and shared care arrangements with general practitioners, for the delivery of antenatal care and care during labour and birth (Wilde 2006). Continuity of care is essential in woman-centred care.

Doctors, however, work in a medical model (Morris 2006; Pope 2002). They manage the treatment of the physical and mental health needs of patients (Anema et al 2006; Beecroft et al 2001; Bick, Knoesen & Castle 2007). Approaches to treatment used by doctors include the use of psychotherapeutic and behavioural interventions as well prescribing medications (Miller, Moyers, Archiniega, Ernst & Forcehimes 2005).

In a recent national study clinicians were interviewed regarding the need for and implementation of a Perinatal Mental Health Nurse Practitioner (McCauley-Elsom, Elsom, et

al 2009). The mental health nurses, midwives and doctors who participated worked at that time with pregnant and postpartum women who also had a diagnosis of a serious mental illness. The perinatal period has been described as being from pregnancy to one year after birth (Austin & Priest 2004). While the numbers in this study were small, the participants clearly supported the development of such a role within maternity services across the country. It was recommended that the clinician would require a combination of midwifery and mental health qualifications and skills. The community case management approach was identified as the most appropriate model of care, however, both the case load and length of follow up care would need to be evaluated to ensure that this model achieved better outcomes for women and their babies.

There are several descriptions in the literature of clinicians working together. The aims of such collaborations are to deliver an integrated service, provide optimum care and achieve better outcomes for their clients (McGeehan & Applebaum 2007). Collaboration between services is important to ensure that women with mental health disorders are receiving appropriate individualised care. While collaborative approaches to care are found more commonly in community services (Connor, Rainer; et al 2007), other examples include clinicians working with particular population groups such as the indigenous populations (de Crespigny, Emden et al 2004) and obese individuals (Bennett 2004). In reality, however, clinicians' report that collaboration, while ideal, is difficult and is seldom achieved (McCauley-Elsom 2009).

Aim of the Study

This study sought to identify how clinicians in maternity and mental health services in Victoria, Australia, work with pregnant women with a diagnosis of serious mental illness.

Method

A qualitative descriptive design was used. Qualitative research such as this study provides descriptions and interpretations of peoples' experiences. These experiences are able to be recognised by those to whom the experiences belong and can also be understood by those who are reading about them (Carolan 2006; Sandelowski 1986). Personal interviews are regarded as the best way of collecting this type of information with the sample number established by theoretical saturation of data rather than a pre-determined number which aims to achieve statistical significance as seen in quantitative studies (Polit & Beck 2004; Schneider, Elliot, LoBiondo-Wood & Haber 2005). A process of thematic analysis was used to identify key themes (Roberts & Taylor 2002).

Semi structured interviews explored and described the experiences of clinicians in three health care settings in Victoria, Australia. The interviews were conducted in conversational style (Roberts & Taylor 2002). The emergent themes related to the current management, issues and problems that arise for clinicians when providing care for women with serious mental illness either during pregnancy or postpartum, which are most likely to influence the achievement of positive outcomes for both mother and baby.

Recruitment

Three sites were approached and permission was gained for clinicians to be involved in this study. Convenience sampling was used to recruit the clinical sites in this study (Polit & Beck 2004). It is recognised that a key problem with this method of sampling is that it is accidental and therefore this sometimes means that the sample may not be truly representative of all subjects of interest (Roberts & Taylor 2002). However, the hospitals in this study were chosen as they covered different geographical catchment areas for mental

health care in Victoria and all offered maternity and mental health services. The recruitment strategy was proposed to provide a snapshot of clinicians' experiences of the current management strategies and the problems associated with providing care for this vulnerable group of women and their babies. The hospitals included one large metropolitan tertiary level hospital, a regional service and a rural service.

Ethical approval for the interviewing of clinicians was attained from Monash University Standing Committee for Ethical Research in Humans, and from each of the three clinical sites.

Clinicians

The participants were clinicians working within maternity and mental health services, including midwives, mental health nurses and doctors. They were invited to attend the interviews which were conducted within their clinical areas, on an advertised day. The researcher was available during both morning and afternoon shifts to capture clinicians with a range of experience and to ensure that the interviews were conducted without disruption to patient care. Participants were asked to identify the key issues in providing care and the problems experienced in relation to the management of women with a diagnosis of serious mental illness, during pregnancy and postpartum.

Forty seven clinicians participated in the interviews: 27 mental health nurses and doctors, 20 midwives and maternity doctors. The gender mix included 40 females and 7 males. All the males worked in mental health services. As mental health nurses, midwives and doctors, the participants had a variety of roles within mental health and maternity services.

Only five medical staff participated in the interviews, including senior and junior registrars (n = 4) and one intern. No consultants in either obstetrics or psychiatry attended the interviews despite invitation, stating they were 'too busy' or had other priorities. Of the participants, one doctor worked in maternity services in the antenatal clinic and four worked in one acute inpatient psychiatric/mental health unit. Written consent was obtained from all participants interviewed.

Interviews

The semi-structured interviews were performed between May and October in 2005. Clinicians were notified of the time, date and location of the proposed interviews. Those who wished to be interviewed presented voluntarily. The interviews were conducted using a list of questions to guide the exploration. Several broad descriptive questions were developed to elicit the key issues (Grbich 1999; Schneider, Elliott, LoBiondo-Wood & Haber 2003). These were:

- What are the current issues in managing women with serious mental illness in pregnancy and postpartum?
- What were the problems, if any, you experienced in the management of the women and/or their babies?

Table 1 Clinicians’ Roles in Mental Health Services

Mental Health Clinicians roles	Number of Clinicians
Mental Health Nurse (with midwifery qualifications)	1
Senior Nurse	1
Associate Nurse Manager of acute inpatient unit	1
Nurse Manager of acute inpatient unit	1
Clinical Nurse Educator	2
Crisis Assessment Team Nurse	2
Community Mental Health Nurse	1
Case Manager	2
Consultation Liaison Psychiatry Nurse Specialist	2
Mental Health Nurses in acute inpatient unit	12
Doctors	4
Total	27

Table 2 Clinicians’ roles in maternity services

Maternity clinicians roles	Number of clinicians
Midwife in Antenatal clinic	4
Midwifery Clinical Educator	2
Midwifery Unit Manager	2
Associate Midwifery Unit Manager	1
Midwife in postnatal unit and birthing suites	3
Midwife (with Lactation Consultant certificate)	2
‘Special Needs’ Midwife	2
‘ADAPT’ Midwife (with Alcohol & Drug qualifications)	2
Midwife (with Mental Health nursing qualifications)	1
Doctors	1
Total	20

Data Collection and Analysis

The interviews were recorded using a digital audio recorder. These recordings were then transferred into an electronic version which enabled the transcription of the voice recordings to be performed by the researcher. Each transcription was given a code which recognised the participant's profession, area of clinical work and health care setting (see Table 3).

Table 3 Codes for identification of interview participants

Hospital	S	Tertiary
	P	Regional
	L	Rural
Interview number/site		
Profession	p	'psych' or mental health nurse
	m	Midwife
	d	Doctor

The code represents firstly the health service, the interview number from each site, and the profession of the clinician. The letter 'd' was used to represent the doctors in combination with either 'm' for maternity services or 'p' to represent those working in mental health (psychiatric services). Where the midwife also has mental health nursing qualifications 'mp' was used and the reverse if a mental health nurse was also a midwife (pm). An example of a code for an interview with a mental health nurse based in the tertiary service would include: site, interview number and profession (S10p).

Reliability and Validity

The voice recordings were transcribed by being played and replayed for clarification. Written transcripts were made verbatim. These written transcriptions were then printed and analysed using thematic analysis (Gooden & Winefield 2007; Polit & Hungler 1995; Tuckett 2005). Responses were read and re-read to acquire a sense of the essence of the dialogue until saturation of data was reached and no new themes emerged. Saturation is recognised as the 'repetition of data obtained in a qualitative study [which] signifies the completion of data collection on a particular culture or phenomenon' (Streubert & Carpenter 1995, in Schneider et al 2005: 147).

The key themes were then examined by an external academic who cross checked the data to ensure the researcher's interpretation of the information was representative of the content of the interviews (Grbich 1999). Quotations from participants provide a 'cross-referencing of opinion' (Grbich 1999: 269) and are commonly used to illustrate typical comments found in the themes. Significant statements and phrases were extracted to provide examples of the key themes. The two main themes related to issues with medication management and the clinicians' lack of knowledge, skills and understanding of mental illness.

Findings

The provision of care for the woman and her baby was seen as an essential role for all clinicians. Mental health nurses described their responsibility as ensuring adequate care for mother and baby, providing psycho-education, advocating for the woman, promoting 'bonding' between mother and baby; and to oversee the management of medications, ensuring the woman received adequate medication and providing education about these

medications. The need for extra care was described: 'a psychotic woman needs one to one care, [you] are looking after two [mother and baby]' (P8p). The key responsibilities for the mental health nurse were identified as: the assessment and monitoring of the woman's mental health state; the assessment of risk of the woman harming herself and or her baby (or others); and the development of a treatment plan.

Midwives described their role as to ensure women received the best care possible, at the same time recognising that this particular group of women had 'special needs' (P5m). Continuity of care was identified as an important and beneficial approach for these women where the same midwife would be available to provide care when required. Midwives provide childbirth education for women, including information about pregnancy, birth and parenting; and co-ordinate discharge from the postnatal units. In one midwife's words it is important to ensure 'they [the woman] keep well, their baby keeps well and they bond and have a good relationship' (L2m). The midwives described the need to check which medications the woman was prescribed, and taking, and whether these were recommended in breastfeeding.

Issues with Medication Management

The key theme identified in relation to the care of women and their babies included medication management. The main problem for clinicians was the lack of knowledge regarding medication use in pregnancy and in breast feeding mothers, and the use of other substances.

Can We Really Use That?

Management of medications was identified by clinicians as the key form of treatment. The use of medications such as antipsychotics in pregnancy and postpartum were usually included in the management plan. It was recognised that ceasing treatment or changing medications or dosage may possibly lead to the women relapsing and increasing the likelihood of the woman causing harm to herself and/or her baby. However the use of medications raised many concerns for all clinicians, as is seen in the following statement: 'Can't stop the medication that is keeping them on an even keel'.

You suddenly stop it you're going to do more harm than good...stop taking their medications they become unstable and erratic in their behaviour and they are more likely to cause the baby harm then, maybe not intentionally. (L2m)

The clinicians justified the use of medications explaining women who 'become unstable and unpredictable in their behaviour, are more likely to do themselves and the baby harm' (L12m) and 'it is a very fine line ... you have to step in and do something otherwise it can be just as detrimental to the baby in the womb anyway' (P9p).

The clinicians were concerned about their lack of knowledge related to the use of medications in pregnant women, or post natally during lactation. Throughout the interviews they expressed their fear of causing harm to the baby. Midwives reported several concerns related to the use of medications in pregnancy. Firstly they were concerned that GPs often stop the woman's medications when pregnancy is confirmed for fear the antipsychotic will harm the baby. In some cases the women stop taking their medication because they are worried about the effect on the baby. Secondly, they worry that 'what tends to happen is that the woman gets sick again, mentally unwell, at the same time as trying to cope with the pregnancy' (S8p). Most clinicians recognised the need for closer monitoring to ensure the medication does not have an adverse effect on the baby.

Generally clinicians were unsure which medications were safe to use. This was described by one mental health nurse who spoke of an instance when they 'had to tranquilise this lady as she was at great risk to herself and others as well as the baby'. They were concerned about the use of some medications. In particular, asking 'Acuphase'[zuclophenthixol], can you really give that?' and 'if you give them heaps of 'benzos' [benzodiazepines] what happens after?' (L13p). Several nurses described their concern regarding the doctors' use of medications and their lack of knowledge about these: 'often the doctors will use haloperidol to treat because they know that this is relatively safe in pregnancy' (S8p). However, one doctor identified that 'the drug of choice that I know of, that we have used here with people in that situation, is olanzapine' (P9p). Another doctor reported the use of 'Stelazine' [trifluoperazine] in pregnant women (P17dp).

Doctors Lack Medication Knowledge

Mental health nurses were also of the opinion that the doctors' knowledge of medication use in pregnancy was limited. They mentioned that medical officers are not familiar with which medications cross over the placenta and therefore doctors tend to 'err on the side of caution and often are reluctant to give lots of antipsychotics' (L13p).

Many clinicians commented about the lack of knowledge held, in particular by the GPs, who will often stop medications or change the dose, without consultation with a psychiatrist. They also identified that if the doctor does not, the woman may do so herself. One doctor described the consequences of this as follows: 'they [the women] become agitated, [then] it is difficult to pacify them' (S1dm). Other doctors, particularly in the mental health service, described avoiding the use of medication because most have 'potential to harm the baby and can lead to a baby born with abnormalities' (P4dp). This general lack of confidence in using medications is seen in their statements: 'I don't think we have enough information about new ones [antipsychotics] but the old ones [are] not good for the pregnancy' (P3dp). Another stated that 'atypical [antipsychotic] medication, for example olanzapine, we can use this medication' (P1dp), while yet another doctor was 'not sure in the pregnancy which one [antipsychotic] is contraindicated. There isn't any hard evidence of the antipsychotics' (P2dp).

Conflict in Care?

Generally clinicians were unsure about the safety of medications used in women who were breast feeding, the transfer of medications through breast milk and the effects on the baby. In the mental health services conflict was reported by clinicians when considering how to meet both the needs of the baby and the needs of the mother. One example given was that while the baby may need to feed frequently, to assist the mother's milk to establish and be maintained, the mother may need longer periods of sleep due to her illness or to the medications. One mental health nurse was concerned that such inconsistent feeding patterns could lead to a decrease in the woman's milk supply and thereby interfere with her breastfeeding successfully. She described conflict between the staff, identifying how clinician's attitudes can influence the outcomes for women:

Some staff were saying this woman needs her medication to get her well because the longer she is unwell she is going to miss the important bonding with her child. Other staff were saying 'but if medicated she would not be able to breastfeed, we all have a right to breastfeed'. Others would say...'Who are you to decide that this woman can't breastfeed? You haven't got children so how would you know?'...'The woman wanted to breastfeed [but] she was medicated and stopped breastfeeding'. (P3m)

Clinicians also expressed concern that this group of women had a high use of other substances in pregnancy including cigarettes, alcohol and illicit drugs such as cannabis, marijuana and heroin. They identified this as a potential problem in the woman's adherence with antenatal care and her ability to establish a rapport with clinicians. They also felt that the baby was at risk from these activities. Most clinicians described the continued use of illicit substances and cigarettes by women as a problem because they (the clinicians) were aware of the possible consequences for the baby and the increased likelihood that this behaviour could lead to separation of the mother and baby by child protection authorities. It was felt that the women were disregarding the possible outcomes, and the advice clinicians were providing about this.

Knowledge, Skills and Understanding

Many clinicians recognised their lack of knowledge, skills and understanding with regard to the specific needs of this group of women and their babies. They also identified that they, and the other professional groups, had little knowledge of each other's specialty. For example, midwives thought mental health nurses lack knowledge of the care required by women in pregnancy and postpartum; mental health nurses identified that the midwives were lacking in knowledge and skills related to mental health care; and both thought doctors lacked mental health knowledge.

We Just Don't Know!

Midwives did recognise their own lack of knowledge of mental illness particularly with regard to best practice and medication use in pregnancy. It was explained that

'we don't understand the medications they are on and sometimes the psychiatric people come and review the woman, but there doesn't seem to be much communication between the obstetric and the psychiatric team' (P5m).

The lack of understanding by midwives of mental illness was thought to result in a lack of trust between the midwife and the woman, leading to the woman becoming defensive. Pregnancy in this group of women is regarded as 'high risk' due to the risks of relapse and possible effects of medications, therefore the woman must receive care within the obstetric services within a hospital which also has a mental health service. One midwife explained after providing care for several women in the maternity service that midwives could do with a lot more education, to improve staff knowledge. We as midwives don't realise how sick they are. It is quite a shock; it really took a toll on the staff' (L6m).

Difficult to Manage!

Another midwife explained that they are not trained to look after psychotic women. Many described the women as difficult to manage: causing disruption to the ward with bizarre behaviour, problems with parent craft and aggressive incidents. One manager of maternity services stated that 'it's a specialty area that we don't have the expertise in' (P5m). This difficulty in working with women with mental illness was described by several midwives.

'Sometimes [it is] difficult to be with someone, to special them. They need a psychiatric trained staff member. We fear how to manage these people, afraid we don't know what we are doing, fearful of doing the wrong thing, fear of the unknown'. (P5m)

Mental health nurses also thought midwives had little understanding of the medications and the problems experienced by women with a mental illness. One mental health nurse

explained ‘maternity people don’t understand psychiatry so are likely to miss conditions, either not able to assess, or over assess so rate the risk more highly’ (S8p). Mental health nurses believed that midwives generally had a lack of knowledge about how to manage pregnant women who were psychotic. Midwives, on the other hand, described problems they experienced in communicating with the mental health team even when they did identify a mental health problem. They felt they were not listened to and their opinion was not valued.

Midwives were concerned about the mental health nurses’ lack of knowledge and skills relating to their care of mother and baby. When discussing the mental health nurses’ provision of care for postnatal women the one midwife explained:

‘They [mental health nurses] don’t like coming here. I don’t think they care for women during pregnancy very often and it is something that is out of their league. They generally treat most of the psychiatric people in their own area.’ (P10m)

Implications for Provision of Services

Clinicians identified the increasing incidence of women with serious mental illness who are pregnant or who have just had a baby that require care in an acute inpatient unit. The implications of this were described by one unit manager (P20p) who was concerned about the level of care the women receive:

‘[With the] lack of specialised support, they [the women] are getting a lesser service. It is difficult to get DHS [child protection services] involved without reporting. It is more prevalent, Mums [mothers] and babies needing acute treatment. We need more knowledge of how to work with them and how to treat them better.’ (P20p)

Discussion

This study has provided an outline of key themes of the interviews conducted with mental health nurses, midwives and doctors within the mental health and maternity services of three Victorian hospitals, in Australia. The clinicians working with women with serious mental illness in pregnancy or postpartum identified that their aim was to ensure that optimal outcomes were achieved for both mother and baby. An optimal outcome was described as ‘both mother and baby were well and healthy and that mother and baby developed a good bond and were able to remain together as a family’. Clinicians are clearly concerned that harm could be caused to either mother or baby, with the use of medications which is consistent with the findings and views of most authors previously mentioned ((Altshuler et al 1996; Cohen & Rosenbaum 1998; Jain & Lacy 2005; Littrell et al 2000; McKenna et al 2005; Pinkofsky 2000; Trixler & Tenyi 1997; Usher et al 2005).

Limitations

While clinicians involved in this study included midwives, mental health nurses and doctors, it is noted that no consultant psychiatrists or obstetricians participated in the interviews despite being invited and this is recognised as a major limitation in this report.

It is recognised that there were clinicians who chose not to participate and therefore the results are describing only those findings related to the participants and it cannot be assumed that they are representative of all clinicians. In this study it is not known how many

clinicians did not participate, either due to workload or personal choice. This is an important bias (Polit & Beck 2004).

The ongoing debate relating to the safety and risks associated with the use of antipsychotic medication in pregnancy and decisions regarding the best management of women is commonly made by their clinicians. Management issues and lack of knowledge and understanding of the best practice in this area place both mother and baby at a greater risk of harm. This dilemma has been well considered in the literature with optimum care delivery requiring a close collaboration between the woman, her clinician, and health care services (Miller 1991; Miller & Resnick 1991; Nishizawa, Sakumoto, Hiramatsu & Kondo, 2007). Health services and clinicians must ask 'How can this best be achieved?' There are serious gaps evident in service provision in the care of women with serious mental illness.

Importantly, there need to be clearly documented pathways of collaboration within each health service. The review and implementation of appropriate treatment plans and practice policies is urgently required. Policies must be developed to guide clinicians in the process of decision making, choices, and include a woman-sensitive, client focused approach to care. Policies such as those described as 'risk assessment' need to be reviewed to ensure that the intent of these policies is clarified and that all staff have an understanding of the use of these in ensuring the safety of mother and baby within the health service. In-service education for all clinicians regarding perinatal mental health and the needs of women during this important period of their lives is critical to break down judgemental attitudes held by health care providers and community alike.

There is a clear need to address the mental health needs of women during pregnancy and postpartum at both state and national level. Any new perinatal mental health policy and service development must have a focus on antenatal and postnatal depression and the needs of women with serious mental illness must be considered. Women need to be educated about their choices for treatment and a program of community awareness of the needs of this group of women must be raised and services must be provided with access and assistance accordingly. In maternity services, antenatal education specifically designed to meet the special needs of this group of women could also focus on the importance of relationships, life style choices, and coping strategies such as relaxation and other therapies.

It is perhaps unrealistic to expect midwives and mental health nurses to have a high level of understanding of each other's specialty skills and knowledge. McCauley-Elsom et al, (2009) in their survey of clinicians' working in the perinatal care delivery recommended that a specialist role needs to be developed. This role would embrace the gaps currently existing between the services and provide support for all clinicians involved in the care of women with serious mental illness in the perinatal period. Importantly, the development of such a role would involve this specialist clinician as the key professional in initiating and maintaining care and contact with women and their health care professionals. The provision of current evidence-based information, especially regarding the use of medications in pregnancy, would be invaluable to all clinicians. It has been suggested that as a consultant this clinician (a perinatal mental health specialist) could liaise between all service and act as a professional resource for clinicians in providing the optimal care for women and their babies.

Conclusion

The desire to have a baby is a normal healthy part of being a woman. Women with serious mental illness have the same desire to become mothers (McKenna et al 2005; Montgomery 2005). The use of antipsychotics in pregnancy is evident and efforts are being made to gather adequate data to show the safety of this practice (Kulkarni et al 2008;

McCauley-Elsom 2009). However, in the meantime, the majority of clinicians remain unsure of the best practice and management of women with serious mental illness during pregnancy and postpartum. As a consequence they err on the side of ceasing or changing current medications risking the possibility of relapse rather than harm to the baby with antipsychotic use.

This study has identified that current practices in the delivery of maternity and mental health care for women with serious mental illness need improvement to ensure optimal outcomes. The introduction of a Perinatal Mental Health Nurse specialist at each maternity service would facilitate the development of an evidence based resource for other clinicians, upon which evidence based decisions could be made. A collaborative approach to care is essential to provide the opportunity for optimal care and outcomes for this vulnerable group of women, their babies and their families.

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