Prescribing Psychotropic Medication in Pregnancy and Breastfeeding – general principles.

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Challenge is to ensure that up to date knowledge and evidence is communicated and applied effectively and compassionately to the individual woman.

Establish the correct diagnosis, any co-morbidities, illness course etc and review the indications for treatment, the treatment options and associated risks

Thoughtfulness of clinician in prescribing psychotropic medication to ALL women of childbearing potential.

Contraception should be used on every conceivable occasion

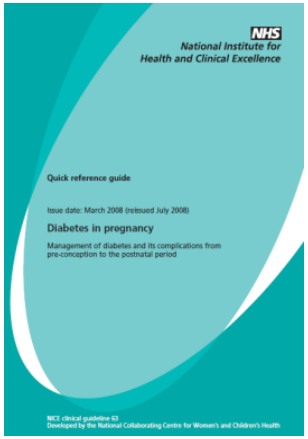
Spike Milligan 1972

Prescribing for women:

- **Physical attractiveness:** weight, hirsutism, dermatological side-effects, galactorrhoea
- **Femininity:** fertility, libido, body shape, polycystic ovaries, menstruation
- **Health and well-being:** weight gain, metabolic syndrome, osteopenia, raised prolactin, EPSEs, interaction with pregnancy, effects on fetus/ infant, interaction with other prescribed medication/ herbal remedies/ alcohol/ illicit drugs
- **Emotional/ Psychological:** general 'dulling', sleepiness/ fatigue, lack of emotional responsivity/ availability
- **Social:** stigma, impairment of occupational function, impact on parental and caring roles and responsibilities

Gestational diabetes:

Oral glucose tolerance test at 24 – 28 weeks [in] all women taking antipsychotic medication in pregnancy



1. National Institute of Health and Care Excellence (2014) Clinical Practice Guideline 192
2. National Institute for Health and Care Excellence (2008) Diabetes in pregnancy. Clinical Practice Guideline 63.

Adverse Treatment Effects

Women experience *more* side-effects including:

- Parkinsonism
- Tardive dyskinesia: severity greater in older women, continues to increase in women with age
- Agranulocytosis
- Acute dystonia occurs more readily in young women

Raised prolactin (dose dependent effect; reduces with chronic treatment; threshold for disruption of normal HPO function varies widely between women)

- Amenorrhoea
- Menstrual cycle disruption
- Ovulation may cease
- Galactorrhoea
- Impaired libido and anorgasmia
- Lowered oestrogen increases risk of osteoporosis and cardiovascular damage
- May affect compliance

Culture has an impact on the individual's acceptance of advice about treatment

(attitude towards and beliefs about mental illness, the culture that is perceived as providing the advice, religious beliefs, stigma etc)

Individual risks have different subjective experience to different women

Prescribers' personal attitude towards risk.

Other clinician's understanding of role of medication.

Clinicians' cognitive biases: a potential barrier to implementation of evidence-based clinical practice

Dobler et al 10.1136/bmjebm-2018-111074

Omission:

Antipsychotic would be indicated but she might gain weight and get DM, so it would be safer if I don't prescribe

Availability: the woman who broke down in April might not have done so if I had increased her dose earlier. This time I will give my patient with mild symptoms an AD before she gets a psychotic depression

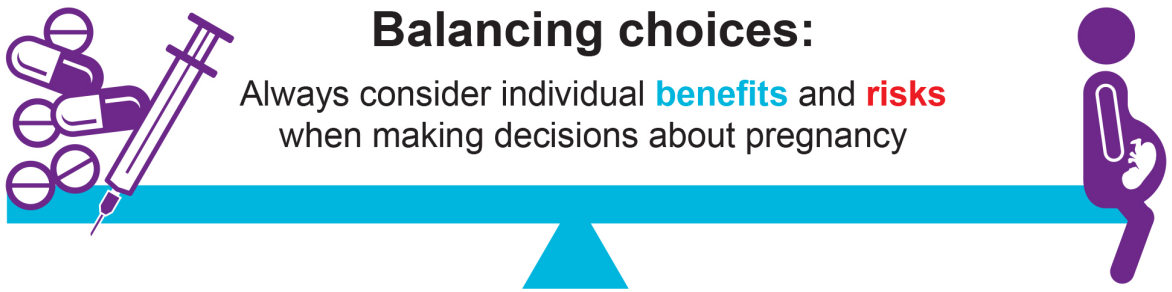
Status quo: she has been hearing voices for the last year but it could be worse so I better leave things the way they are

Framing: 2% risk of a particular side-effect vs 98% risk of not (positive/negative: absolute/ relative)

Commission: it is very unlikely she will break down in pregnancy but I will treat her anyway so I don't make a mistake (action vs inaction)

Prescribing issues – de-prescribing

Decisions on continuing, stopping or changing medication in pregnancy should be made only after careful review of the benefits and risks of doing so, to both mother and infant.



Decisional conflict among women considering antidepressant medication use in pregnancy

Georgia D. Walton

Archives of Women's Mental Health
December 2014, Volume 17, Issue 6,

Decisional conflict was assessed using the Decisional Conflict Scale (DCS) among pregnant women considering antidepressant medication treatment (*N* = 40). 52 % had moderate or high decisional conflict (DCS ≥ 25). Overall DCS scores did not differ between groups, but antidepressant use was associated with feeling more adequately informed .

Barriers to decision-making were

(1) difficulty weighing maternal versus infant health

(2) lack of high quality information

(3) negative external influences

(4) emotional reactions to decision-making.

Facilitators were

(1) interpersonal supports

(2) accessible subspecialty care

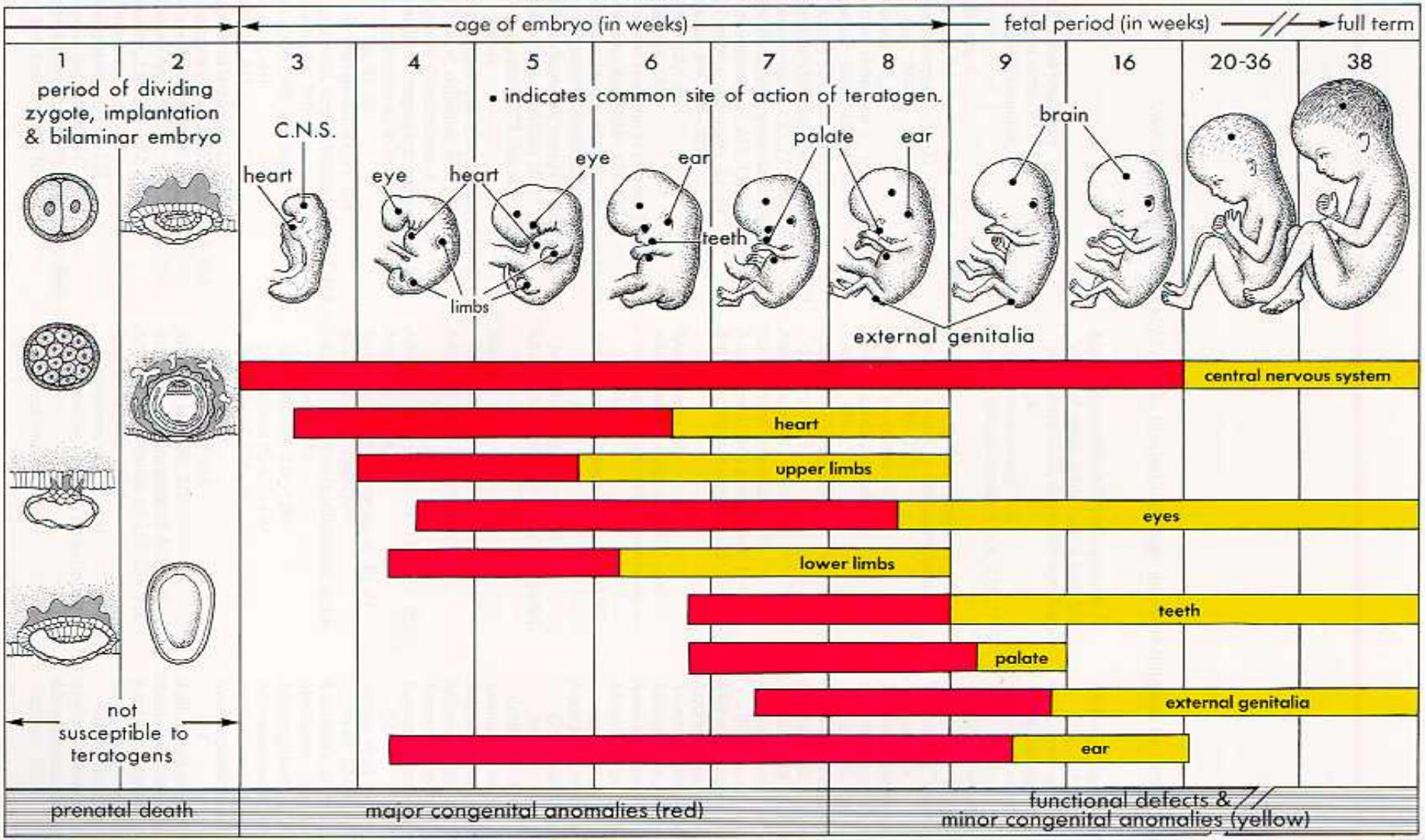
(3) severe depressive symptoms

What are the dilemmas facing women and clinicians?

- Planning a pregnancy while taking medication for a known disorder
- Unplanned pregnancy while taking medication for a known disorder: *confirm pregnancy, scan, discussion of risks*
- New illness episode in pregnancy: *how to treat, what to initiate if unmedicated, what changes to existing medication, addressing potential non-adherence*
- Onset of illness in pregnancy: *how to treat, what medication to initiate*
- Medication in the intra-partum period: *risk of relapse, risks to mother, risks to fetus, drug interaction*
- Prophylaxis
- How to re-instate medication post-delivery in woman at high risk of relapse
- Breastfeeding

Required to calculate risk profiles for 2 individuals involving multiple predictors and outcomes

CRITICAL PERIODS IN HUMAN DEVELOPMENT*



* Red indicates highly sensitive periods when teratogens may induce major anomalies.

Threshold for pharmacological interventions higher arising from the changing risk–benefit ratio for psychotropic medication at this time

- Choose the drug with the *lowest risk profile* for the woman, fetus and baby, taking into account a woman's previous response to medication and her preference
- Avoid *polypharmacy*
- Take into account that *dosages* may need to be adjusted in pregnancy
- *Effective*

Risks of Drugs

- Risk of teratogenicity
- Risk of neonatal toxicity and withdrawal
- Risk of longer term neurobehavioural / cognitive problems
- Risks mediated by incompatibility with breastfeeding
- Physical risks to mother eg gestational diabetes, obesity etc
- Effects on parenting and social function

Risks of illness

- May affect birth weight and gestational age at delivery
- Accessing antenatal care
- Relationships with family, carers and professionals
- Diet, smoking, alcohol, illicit drugs, risk taking behaviours
- Possible detrimental effect of the mental disorder in pregnancy and on the fetus
- May impact on mother-infant attachment and capacity to parent
- Relapse, hospitalisation, worsening of prognosis, suicide

Issues: the Patient

- What are her worries?
- How to stay well?
- Risk of relapse
- Previous history
- Risks
- Prompt and effective treatment
- Planning for parenthood
- Who needs to be involved?

Issues: the Clinician

- Who is she?
- What are the risks: of not treating; relapse in pregnancy, in labour, post-natally; medication- teratogenesis, neuro-behavioural sequelae, withdrawal in neonate, toxicity in neonate, metabolism in fetus, breastfeeding, interaction with other meds, differences in metabolism during pregnancy, specific risks in pregnancy (DM, BP, sedation) ; swopping or stopping; monitoring – compliance, mental state, blood Li level, side-effects, blood tests, need for change in dose, medication free; risks assoc with other patient factors eg smoking, alcohol, domestic abuse, poor living conditions, poor social support, finances, cognitive dysfunction, co-morbidity
- How to explain risk
- Patient consent
- Recording of discussions
- Communication with other professionals
- Seeking advice

Information and advice *for women who are planning a pregnancy, pregnant or in the postnatal period*

Mental health professionals providing detailed advice about possible risks of mental health problems or the benefits and harms of treatment should include discussion of the following, depending on individual circumstances:

- the *uncertainty* about the benefits, risks and harms of treatments
- the *likely benefits* of each treatment, taking into account severity of the problem
- the woman's *response* to any previous treatment

Mental health professionals providing detailed advice about possible risks of mental health problems or the benefits and harms of treatment should include discussion of the following, depending on individual circumstances:

- the *background risk of harm* to the woman and the fetus or baby and the risk to mental health and parenting associated with no treatment
- the possibility of *sudden onset* of symptoms, particularly in the first few weeks after childbirth (for example, in bipolar disorder)
- the risks or harms to the woman and the fetus or baby associated with treatment options
- the need for *prompt* treatment
- the risk or harms to the woman and the fetus or baby associated with *stopping or changing* a treatment

Discussions about treatment options should cover

- Exploring the individual woman's views, wishes, fears, and priorities
- Her risk of relapse/ deterioration and ability to cope with this
- Severity of previous episodes, previous response to treatment, woman's preference
- Stopping drug with known teratogenicity may not remove risk of malformation
- Risks of sudden discontinuation
- Need for prompt treatment
- Increased risk of harm associated with drug treatment
- Withdrawal or reduction of medication before delivery if appropriate
- Treatment options to enable breastfeeding
- Don't assume it is always better to stop medication

Information and Advice

When discussing likely benefits and risks of treatment with the woman and, if she agrees, her partner, family or carer:

- acknowledge the woman's central role in reaching a decision about her treatment and that the role of the professional is to inform that decision with balanced and up-to-date information and advice
- use absolute values based on a common denominator (that is, numbers out of 100 or 1000)
- acknowledge and describe, if possible, the uncertainty around any estimate of risk, harm or benefit
- use high-quality decision aids in a variety of numerical and pictorial formats that focus on a personalised view of the risks and benefits (in line with the guidance on patient experience in adult NHS services, NICE guideline CG138)
- consider providing records of the consultation, in a variety of visual, verbal or audio formats.

NICE APMH 2014

Adjust plan according to her decision

Monitoring babies for effects of psychotropic medication taken in pregnancy

If a woman has taken psychotropic medication during pregnancy, carry out a *full neonatal assessment* of the newborn baby, bearing in mind:

- the variation in the *onset* of adverse effects of psychotropic medication the need for further monitoring
- the need to *inform* relevant healthcare professionals and the woman and her partner, family or carer of any further monitoring, particularly if the woman has been discharged early.

https://www.healthylondon.org/wp-content/uploads/2020/01/FinalNeodoc-v3.pdf

- Discuss breastfeeding with all women who may need to take psychotropic medication in pregnancy or in the postnatal period.
- Explain the benefits of breastfeeding, the potential risks associated with taking psychotropic medication when breastfeeding and with stopping some medications in order to breastfeed.
- Discuss treatment options that would enable a woman to breastfeed if she wishes and support women who choose not to breastfeed.

"Generally the unlicensed use of medicines becomes necessary if the clinical need cannot be met by licensed medicines; such use should be supported by appropriate evidence and experience."
SIGN 127, 2012

No psychotropic medication is licensed for use in pregnancy or in breastfeeding mothers. The BNF and product information advise at least caution in their prescription at this stage or in most cases contraindication. Drug trials exclude pregnant or breastfeeding women and no randomised controlled trials of psychotropic medication have been conducted in pregnancy or lactating women. Despite this, prescribing of psychotropic medication is commonplace in women of reproductive age and up to 27% of women are receiving psychotropic medication at the time when their pregnancies are first diagnosed (Rubin *et al*, 1986; Williams *et al*, 1998).

Advice for prescribers says you need to :

- be satisfied that an alternative treatment would not meet the patient's specific needs before prescribing the unlicensed medicine
- be satisfied that there is a sufficient evidence base and/or experience of using the medicine to show its safety and efficacy…*following a risk benefit analysis*
- take responsibility for prescribing the medicine and for overseeing the patient's care, including monitoring and follow-up
- record the medicine prescribed and the reasons for prescribing this medicine
- record that you have discussed the issue with the patient
- give the patient sufficient information about the proposed treatment, including known serious or common adverse reactions, to enable her to make an informed decision
- answer questions from patients (or 'carers') about medicines fully and honestly.

Medicines and Healthcare products Regulatory Agency 1 April 2009

GMC Good practice in prescribing and managing medicines and devices (2013)

Sources of information

- NICE APMH Guideline 2014
- www.motherisk.org
- Reprotox
- National Teratology Information Service UKTIS BUMPS
- LactMed https://toxnet.nlm.nih.gov/newtoxnet/lactmed.htm
- Breastfeeding Information Services
- www.womensmentalhealth.org
- BAP consensus paper 2017
- Local expert advice: eg Perinatal Psychiatrist, specialist pharmacist

An individualised, biopsychosocial, thoughtful approach bearing in mind the current evidence, the patient’s and clinician’s attitudes to risk and the need for clear communication with and between all involved.