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## Prenatal Care for Women with Serious Mental Illness

### Abstract

The lifetime prevalence of serious mental illness (SMI) for women in the United States is nearly 6% (NIMH, 2012). Women in this group often have lifestyle and socioeconomic characteristics that lead to poor health status and delays in seeking health care. While women with SMI are just as likely to have children as their non-mentally ill counterparts, they are more likely to experience pregnancy complications and negative birth outcomes. Prenatal care must take into consideration the unique needs of these women and the challenges they face. Recommendations for improving practice include increasing pregnancy screening, using multidisciplinary teams to provide holistic care, and involving the patient in shared decision-making. This care should be continuous throughout the woman's childbearing years. Further research is needed to test the effectiveness of models of prenatal care tailored to women with SMI.

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The lifetime prevalence of serious mental illness (SMI) for women in the United States is nearly 6% (NIMH, 2012). Women in this group often have lifestyle and socioeconomic characteristics that lead to poor health status and delays in seeking health care. While women with SMI are just as likely to have children as their non-mentally ill counterparts, they are more likely to experience pregnancy complications and negative birth outcomes. Prenatal care must take into consideration the unique needs of these women and the challenges they face. Recommendations for improving practice include increasing pregnancy screening, using multidisciplinary teams to provide holistic care, and involving the patient in shared decision-making. This care should be continuous throughout the woman's childbearing years. Further research is needed to test the effectiveness of models of prenatal care tailored to women with SMI.

### Prenatal Care for Women with Serious Mental Illness

Nearly 6% of adult women in the United States will suffer from serious mental illness (SMI) in their lifetimes. The National Institutes of Health define SMI as "A mental, behavioral, or emotional disorder resulting in serious functional impairment which substantially interferes with or limits one or more major activities" (NIMH, 2012). This includes diagnoses such as schizophrenia, schizoaffective disorder, bipolar disorder, and major depressive disorder. Women with SMI are generally in poorer health than their counterparts without SMI, due to effects of both mental illness treatment and lifestyle factors such as smoking and lack of exercise (De Hert et al., 2011). Socioeconomic factors such as unemployment and negative stigma that affect access to health care, especially primary and preventive care, further distinguish women with SMI from those without mental illness.

As recovery and community re-integration increasingly become the goals of mental health treatment, women with SMI are equally likely as those without SMI to become pregnant and have children. Mental illness, especially clinical depression, usually strikes women during their prime childbearing years, making it likely that a woman with SMI will be receiving some form of mental health treatment during pregnancy. Research shows that women with SMI are more likely to have late entry into prenatal care, complications during pregnancy, and poor birth outcomes compared to women without mental illness (Jablensky, Morgan, Zubrick, Bower, & Yellachich, 2005; Nguyen et al., 2012). These disparities surrounding pregnancy

and childbearing in this population highlight a distinct need for improvements in prenatal care for women with SMI.

### Literature Review

Many studies examine the incidence of pregnancy complications and negative birth outcomes for women with SMI, with an emphasis on the effects of using psychiatric medication during pregnancy. Much of the research on this population is international, and healthcare systems in other countries differ greatly from those in the United States. One such study, conducted in Sweden, used prospective cohort data from a registry of over 1.5 million women to compare birth outcomes for mothers with affective psychosis to birth outcomes for unaffected mothers (MacCabe et al., 2007). Mothers with affective psychosis were more than twice as likely to have a preterm delivery, low birth weight, or stillbirth, even after controlling for maternal factors such as tobacco use. This study was somewhat limited due to exclusion of women with mental illnesses besides affective psychosis. However, studies of more inclusive populations consistently show higher rates of negative birth outcomes for women with SMI (Jablensky, et al., 2005; Nguyen, et al., 2012).

A 2010 literature review compiled original research, previous reviews, and existing guidelines for prenatal care for women with bipolar disorder and schizophrenia. Based on the results of this review and input from relevant providers, the authors developed a set of guidelines for clinicians treating this population. These guidelines cover aspects of prenatal care beyond

medication management such as maternal nutrition, screening for fetal abnormalities, and advance planning for delivery and post-partum care. There is a strong focus on identifying and managing risks for potential complications early in prenatal care, as women with SMI require enhanced monitoring of maternal and fetal condition throughout pregnancy (Galbally, Snellen, Walker, & Permezel, 2010).

Few studies explore specific models of care designed to improve outcomes for childbearing women with SMI. One successful program, studied by Nguyen et al. (2010), is the Childbirth and Mental Illness Antenatal Clinic (CAMI) in Western Australia. This clinic uses multidisciplinary teams of obstetrics, nurse midwives, social workers, and psychiatrists to care for women with SMI before, during, and after pregnancy. This study used a retrospective cohort design to explore treatment outcomes of women receiving prenatal care at CAMI. Results showed a reduction in depression and anxiety symptoms over the course of treatment at CAMI, measured by the Edinburgh Postnatal Depression Scale. Women in the study attended 90% of scheduled prenatal visits, with an average of 9.4 visits per person. Another study of the same clinic found the number of prenatal visits per woman attending CAMI to be equivalent to that of the general Western Australia population (Nguyen, et al., 2012).

### Recommendations

Based on findings from current research, pregnancy outcomes for women with SMI are best when care is holistic, multidisciplinary, and continuous. During the woman's childbearing years, this care begins with family planning and education about prospective pregnancy. Women with SMI have higher rates of unplanned pregnancy and HIV than the general population, and information about safe sex and family planning should be incorporated into regular care (Miller & Finnerty, 1996). Additionally, the risk of teratogenic effects from psychiatric medications is highest during the first eight weeks of pregnancy, thus all women with SMI must be advised of this risk prior to conception. With estimates of late entry into prenatal care as high as 49%, women with SMI of childbearing age should consistently be screened for pregnancy more frequently at mental health clinics and upon hospital admission for a psychiatric condition (Kim, Mandell, Crandall, Kuskowski, Dieperink, & Buchberger, 2006; Miller, 1997).

Once a woman with SMI enters prenatal care, a multidisciplinary team should be established to pro-

vide ongoing mental and physical health care. Similar to the approach used at the CAMI clinic, the team should include a midwife, psychiatrist, case manager, and obstetric specialist, and bridge the gaps between outpatient and inpatient care. The care plan should involve shared decision-making among the healthcare team, patient, and patient's family or support system. The article written by McCullough, Coverdale, and Chervenak (2002) outlines seven steps for ethical decision making with pregnant women with SMI. Shared decision-making is especially important when discussing the use of psychiatric medication during pregnancy, because the risks and benefits are unique to each patient. It is also important for nurses and other providers to not let negative stigma cloud their guidance of women with SMI. They should not view pregnancy as a negative event in the woman's life but rather a positive experience with a chance for the woman to increase her responsibility and self-efficacy (Miller & Finnerty, 1996).

Several barriers exist to applying these recommendations to practice, beginning with a lack of awareness of the number of women with SMI who become pregnant and successfully raise children. Providers should offer unbiased, evidence-based advice to women and help them understand all available choices (Galbally et al., 2010). Second, multi-disciplinary teams are time and resource-intensive, and most physical and mental health providers lack specific training in prenatal care for this population. Some psychiatric facilities may even refuse to admit pregnant women because they are not equipped to treat pregnancy and delivery complications (Miller, 1997). Overall access to health care is often restricted for this population due to the financial and social barriers that typically accompany SMI. Furthermore, since SMI often affects cognitive processes, patient education and shared decision-making strategies may require modification (Desai & Chandra, 2009). Patient education should focus on a few key points at each visit, using concrete language that is easier for patients to comprehend than abstract concepts.

### Conclusions

Based on the current state of the science, it seems that there is a need for system-level improvement in coordinating prenatal care for this distinct group of women. As patient advocates, nurses have an especially important role in shared decision-making. Nurses help determine whether or not to discontinue psychiatric medication during pregnancy, assess the

parenting competency of women with SMI, and support patient decisions in the face of pressure from spouses and other providers. Nurses also function as part of a multidisciplinary team and assist with coordination of care between physical and mental healthcare providers. There are currently very few clinics that specifically address the unique needs of childbearing women with SMI, and further research is needed to establish these models of care as evidence-based practice. As the concept of the medical home becomes more popular, it will be interesting to see if this model is adapted to provide holistic care for this population. Women with SMI can, with proper prenatal care and support, successfully give birth to healthy babies, and nurses can lead the way to ensuring positive outcomes for all of these women.

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