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Case Report

Management of the Pregnant Patient in a British Medium Security Psychiatric Hospital: A Case Report

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Abstract

Background: Ardenleigh is a medium secure hospital in Birmingham, UK, and the regional provider of medium secure beds for women in the West Midlands. In recent years we have managed two women through pregnancies whilst being detained in Medium Security. We have not heard of other pregnancies being managed in Medium Security and believe it to be a rare occurrence. **Aim:** This article is intended to share our experience of managing these uncommon and complicated situations. **Case Presentation:** In both cases there were significant risks of violence justifying their placement as a least restrictive setting and in both cases seclusion facilities were used to manage immediate risk of violence during the pregnancy. Both resulted in healthy uncomplicated deliveries without harm caused to either mother or child. This was facilitated through effective multiagency communication as described in our paper. Written informed consent was received from one of the women to include her case study in this paper and we have attempted to remove all identifiable information in doing so. She has been shown this report and was invited to contribute. **Conclusions:** We propose that our experience demonstrates that pregnancy can be safely managed within a Medium Security setting where the particular circumstances justify its use as a least restrictive setting.

Keywords: Secure care; Pregnancy; Obstetric; Risk management; Perinatal; Violence

Introduction

Managing patient pregnancy in a secure psychiatric setting is a rare clinical challenge and comes with significant risks to mother and unborn child. It should not be undertaken lightly but will occasionally be clinically necessary, as we outline in our case report. Recent statistics indicate pregnancy rates higher than 1% for women detained in the prison estate in England and Wales, whilst the tragic death of a newborn child in an English prison has generated calls for improved understanding of this population and better tailored services for pregnant women in prisons [1]. The overlap between the prison population and that in secure psychiatric hospitals is substantial, and with pregnancy being a high risk time for relapse of severe mental illness it is perhaps surprising that this is the first case report to our knowledge addressing the management of pregnancy within a secure psychiatric setting.

Aim

This paper intends to outline details of a case we have managed at Ardenleigh and within the obstetric department at University Hospitals, Birmingham. We aim to share our experience and provide a framework for other services to address the management of similar cases in the future. We hope that this paper will promote discussion about service provision for this vulnerable population and these high risk clinical situations.

Summary of Case

The patient was in her early 20s at the time of admission. She had a complex history of recurrent psychotic illness, disordered conduct and aggression from adolescence and had been detained under the Mental Health Act on six previous occasions from the age of 16. At the time of admission she was under the care of her local Early Intervention Service and was diagnosed with Paranoid Schizophrenia. She had been pregnant twice before but neither had progressed to a live birth.

She was arrested after an act of serious violence committed whilst acutely psychotic and approximately 15 weeks pregnant. At the time she had been experiencing delusional beliefs which generated a sense of threat that was heightened by her pregnancy. She later reported having stopped her regular antipsychotic medication on learning of her pregnancy for fear of potential teratogenic effect.

She was assessed at the police station and detained under Section 3, initially admitted to a non-secure Psychiatric Intensive Care Unit (PICU) before transfer to Ardenleigh. She remained on police bail throughout her pregnancy, later receiving a conviction and a Section 37/41 Hospital Order.

Although she was previously maintained on a second generation antipsychotic, in the interests of safety in pregnancy she was prescribed Haloperidol 5 mg bd and her psychosis resolved over a period of 4-6 weeks. She continued to present as intermittently confrontational and aggressive, typically when challenged by her peers or when faced with ward boundaries. This would result in episodes of shouting, verbal threats and occasional outbursts of violence which in some cases resulted in injury to staff. Such episodes were often managed by brief periods in seclusion, indeed the patient was being nursed in seclusion when her labour commenced at 35/36 weeks, 24 hours after an act of aggression which may have contributed to the onset of labour. Health anxiety was a notable feature of her pregnancy, and a common source of dispute between the patient and the clinical staff.

Labour commenced around 2 pm on a working day. She had a three hour labour before delivering of a healthy child, having been transported to the hospital by the ambulance service as an emergency. The delivery itself was uncomplicated and she was discharged back to Ardenleigh around 7 hours after delivery, from where she could receive scheduled visits from the child as organised by her social work team.

The patient and clinical team agreed to cross titrate from Haloperidol to Olanzapine at 4 weeks post-partum as she was experiencing akathisia and loss of appetite. Two weeks into cross-titration she suffered a sudden relapse of her psychotic illness which required assertive management, but fully resolved within a further 3 weeks.

An Interim Care Order placed the child with a relative and the patient was granted twice weekly contacts with her by the Family Court. The frequency of these contacts was later revised to fortnightly on application by the Social Care team. The patient was understandably upset at the reduction in contacts, highlighting the importance of setting realistic expectations early in the process.

Planning the Admission

Least restrictive setting: Consideration was given to whether these admissions could be contained in a less restrictive environment. Concerns were raised regarding the wellbeing of the unborn child if exposed to potential violence in a Medium Secure Unit (MSU), and to the rights of the mother to be cared for in the most appropriate environment during her pregnancy. Potential alternatives would include management at a lower level of security or, where a serious offence is alleged, in one of six women's prisons in England with a Mother and Baby Unit. These discussions were held in a multidisciplinary forum with participation of NHS commissioners.

Admission planning: As in all planned admissions to secure care, a detailed collateral history and handover of information was arranged with the local services which had prior experience of working with the patient. In planning the admission, a list of relevant stakeholders was generated and they were kept informed of circumstances, with due consideration being given to appropriate information sharing. An initial Positive Behavioural Support (PBS) formulation was developed in anticipation of the admission, and adapted early in the admission, with the intent of enabling our patient and the staff to manage emotional arousal proactively and reduce the need for restrictive practice which may put mother and child at risk. The care plan was clearly and explicitly developed for pregnancy with instructions, in the event that manual holds were required, to restrain vertically wherever possible and to attempt left-lateral position if supine. Patients on the admitting ward were informed of the imminent arrival of a pregnant patient as it was considered that this would be a potentially destabilising event for some. The unit arranged for specific training to be delivered across site for immediate life support in pregnancy, which was delivered to staff across the multidisciplinary team.

Relevant stakeholders: The following relevant stakeholders were identified. This is not an exhaustive list and other cases may consider additional professionals as relevant.

- Patient
- Unborn child
- Patient's Legal Representative

Mental Health

- Forensic psychiatrist
- Inpatient ward manager and senior nursing leads
- Social worker from the forensic mental health team
- Named clinician from the liaison/perinatal psychiatry service located within maternity unit
- Care coordinator from Community Mental Health Team
- Independent Mental Health Advocate
- Mental Health Trust Legal Team
- NHS England Commissioner

Obstetrics

- Consultant obstetrician
- Designated community midwife
- Specialist midwife for mental health
- Lead midwife
- Safeguarding lead for Acute Trust (located within maternity unit)
- Acute Trust Legal Team

Other agencies

- Social worker for unborn child
- Police
- Ambulance service
- Secure transport

Patient's family

As directed by patient. This may include the father of the unborn child.

Planning the Obstetric Care

Obstetric Care Plan

From admission, the relevant stakeholders developed and shared a document outlining plans for the provision of holistic care during the pregnancy and delivery. This was led by the Consultant Forensic Psychiatrist but was modelled on a template developed by the Perinatal Psychiatry service within Birmingham & Solihull Mental Health Trust and consistent with recommendations from Royal College of Obstetricians & Gynaecologists (RCOG) [2]. It addressed the following matters:

- Current circumstances including expected delivery date, next of kin and contact details.
- Details of detention including MHA status, name address and contact number of ward, consultant psychiatrist and on-call teams.
- Details of obstetric team including consultant obstetrician, lead midwife, safeguarding lead and community midwives, and contact numbers for obstetric ward and delivery suite in receiving acute hospital.
- Details of perinatal psychiatry team including team manager and consultant psychiatrist names, contact details and availability.
- Details of local authority, including contact number of social worker for the child, team leader and out of hours duty worker.
- Details of the trust solicitors in case of out of hours medicolegal issues.
- A brief summary of the case including psychiatric and forensic history.
- A brief formulation of identified risks.
- A full list of current medication, dated to ensure accuracy.
- Obstetric history.
- Plans for antenatal care including frequency and location of obstetric appointments, agreed escort level, plans for management of pregnancy symptoms such as pelvic pain, p/v bleeding and other possible presentation.
- Patient's expressed wishes for her delivery plan including who would be present at the birth, analgesia options, wishes in the event of a psychiatric emergency.
- Documentation of the date of an assessment of her capacity to make specific decisions about her obstetric care, to be used in the event that capacity to give informed consent is lost during the pregnancy or labour [3].
- Recommendations for dose adjustments to prescribed medications in labour and post-partum.

Professional roles were delineated, in accordance with the RCOG Good Practice guidelines which state that "where more than one mental health team is involved, there should be a clearly identified individual who coordinates care" [2].

This information was held as a live document on the patient's electronic mental health case file, such that it could be updated when changes occurred and printed to be taken with her at any scheduled or unscheduled hospital visits.

Both NHS England and the RCOG highlight the importance of effective partnership working [2,4]. With this in mind, the obstetric department hosted multiagency meetings in which many of the stakeholders met to discuss clinical, pragmatic and risk related issues. Such face-to-face contact was important for the development of a cohesive management plan and for the effective discussion of points of disagreement.

Delivering care

Antenatal care: People with mental health conditions can expect to receive the same level and quality of healthcare as the general population, with additional input as relevant to the complexities of the case. This is regardless of circumstances or offending history. The Royal College of Obstetricians and Gynaecologists recommend that "women with complex social, medical, obstetric or fetal conditions should have a named lead professional who works with the woman's named midwife" [5]. We were advised that, in obstetric cases with comorbid severe mental illness of psychotropic medication, it would be recommended for the mother to have hospital-based Consultant Obstetrician led care and to receive extra support from her mental health team. In this case a specialist midwife in Mental Health was allocated to coordinate care, ensuring that her individual mental health needs were met by the obstetric team, and to provide continuity of midwifery care throughout her pregnancy.

For reasons of bed availability, the patient in this case study was initially admitted to a PICU 150 miles from her place of residence before being transferred to Ardenleigh. Her antenatal care travelled with her, being provided by a unit local to the psychiatric hospital in which she was admitted. Transfers and exchange of information were planned in advance, where possible.

She would attend the antenatal clinic on a monthly basis until 30 weeks gestation, at which point she received fortnightly appointments with her obstetrician at the acute hospital. On alternative weeks, when these appointments were not scheduled, the community midwife would visit her at Ardenleigh. Understandably as a young first-time mother separated from her community support network, the patient expressed frequent anxieties about her pregnancy and often reported potentially worrying physical health symptoms such as pelvic pain, reduced fetal movements and spotting. The antenatal unit were able to provide clear instructions to the mental health nursing team as to which symptoms were of concern and when to escalate her symptomatic complaints. It was considered appropriate that nursing staff on the psychiatric unit were encouraged to defer clinical opinion to midwives, and to discuss her presentation on the phone with staff from the antenatal ward before planning further action. This arrangement was able to contain the anxiety of the nursing staff, who had limited experience of obstetric nursing

care and who were empowered to minimise unnecessary visits to the acute hospital.

Where transfers to the acute hospital were necessary, consideration was given to the risk of disordered conduct and absconding. Appropriate escort levels were agreed and secure transport coordinated. The use of handcuffs was discussed within the team and with the patient, but not considered clinically proportionate.

Provision was made in case of premature delivery. We were informed that a Special Care Baby Unit (SCBU) placement would be required should the baby be born prior to 34 weeks. Attempts would be made to source a local bed but there was potential for the patient to be transferred anywhere in the country to receive this care. We identified a bank of staff who would be willing to participate in long distance escorts with accommodation provided, and sought approval for funding in this eventuality. We also discussed the risk implications for this distant transfer with the senior obstetricians and paediatricians to influence admission to a more local bed if feasible.

The patient was able to give informed consent to aspects of her treatment throughout the latter stages of her pregnancy. We were able, therefore, to ascertain her views with regards to foreseeable obstetric complications such as the requirement for emergency Low Segment Caesarean Section (LSCS). It was felt important to gather and document these views in advance in case of loss of capacity at a later stage. Legal teams for both the Acute and Mental Health Trusts were informed of the case as a precaution and to consider certain potential complex outcomes. It was clarified that the Acute Trust's legal team would lead on any legal matters relating to the patient's obstetric care.

The patient delivered after an uncomplicated pregnancy. Her conduct within the acute hospital was appropriate, without significant boundary pushing or disordered behaviour. She was not acutely psychotic at the time of the delivery although challenging behaviour had been present in the immediate period leading up to the birth.

Postnatal care: Upon her return to the mental health unit after delivery, the patient was offered extensive emotional and practical support including 1:1 sessions with nursing staff and enrichment sessions with Occupational Therapy. Common postnatal psychiatric presentations were discussed with her and her mental state was regularly assessed by medical and nursing staff. She was comforted by the possession of keepsakes of her child, in the form of photographs and a soft toy. Consideration was given to the interactions with her peer group, many of whom had their own experience of motherhood and separation from their children. In eventuality her peers were mostly supportive and compassionate towards her.

She continued to receive postnatal appointments with her community midwife until day 11, although the department is able to see women up to 28 days after delivery if needed in cases of complex health needs. As she had been separated from her child she did not receive a routine 6-8 week follow up, but this was requested by her psychiatric team and subsequently provided. The Confidential Enquiry into Maternal Deaths in the UK recommends that follow up appointments are arranged before the mother is discharged [6], but this may be overlooked should clinical urgency or security considerations warrant swift discharge return to the psychiatric unit.

She was offered the option to breastfeed by proxy, whereby she would express milk that would be transferred to the child whilst the child remained in the acute hospital. She elected not to do so, and was encouraged to bind her breasts for 72 hours to limit engorgement. The community midwife recommended the dopamine agonist cabergoline to suppress lactation, but this prescription was declined by her psychiatrist due to risk of psychotic relapse.

Child protection, as relevant to practice within the United Kingdom

The social worker for the child requested to be informed of any significant changes in patient care and any transfers to the hospital for possible delivery. At birth, the child was made subject to a Child In Need Plan and after birth the Local Authority made an application for an Interim Care Order. We were informed that this process could not begin prior to birth as the child does not have legal status until that time. As a result, for a period between the birth and the granting of the Interim Care Order, the patient would be entitled to full access to her child until her return to Ardenleigh. However, she remained a detained patient on Section 17 leave and therefore there would be legal authority under the Mental Health Act to intervene and separate mother and child if deemed clinically appropriate on the grounds of risk.

After an Interim Care Order is approved, the child is placed in the care of an individual identified by the social care team. A legal process then follows as this placement is reviewed and consideration is given to a more permanent arrangement. Should specific family members volunteer to take parental responsibility they are assessed by the social care team. Where no individuals volunteer the child may be put up for foster care or adoption. Consideration is given as to whether the child's mother may regain capability to provide parental responsibility in the future, and a parenting assessment may be scheduled for some future time.

Depending on these arrangements, the Family Court will direct on whether the mother can have contact with the child. In this patient's case, under the Interim Care Order the child was placed with a family member and she was initially granted twice weekly visits which were facilitated at Ardenleigh, although in time the frequency of such visits was reduced by the Family Court. We understand that twice weekly contact was considered a generous judicial decision. We found that regular contact was a very important aspect of the patient's care plan, as it provided evident motivation for her to adopt more prosocial behaviours and engage in her recovery programme. In other cases such visits may not be provided; the Family Court may not approve contact between mother and child, or frequent visits may be limited by physical distance between child's placement and mother's detention. The patient expressed a desire to attend Family Court proceedings and this was facilitated when her mental state allowed.

In the UK it is a legal requirement for a child's birth to be registered within 42 days of birth. This may prove difficult for a mother detained in a secure psychiatric hospital. Where neither parent is able to register the birth a secondary informant can do so on their behalf, and this may be somebody who has charge of the child. In certain districts, a representative of the registry office may be able to visit the patient in hospital to complete this process.

Points of Reflection

In our experience, the psychiatrist takes on a variety of roles in this process. Beyond the immediate management of the psychiatric condition, s/he provides a focal point for communication with the other relevant stakeholders and takes on primary responsibility for appropriate information sharing across agencies. Whilst modern electronic communication supports fast and wide dissemination of information we felt that face-to-face meetings, where possible, helped to generate better multiagency understanding and better working relationships. We would recommend that meetings between stakeholders be arranged at a monthly interval once the mother enters her third trimester.

Another important role is that of patient advocate. The psychiatrist will have the most complete understanding of the patient's condition and their risk formulation, which may be highly complex. The stigma attached to a patients' mental health diagnoses and their detention within a secure hospital may have influenced a tendency towards risk-averse decisions from a multi-disciplinary group. Where such stigma exists, the psychiatrist has a role to inform and enable a realistic balance to discussions about their patient's psychiatric condition and the associated risks. This requires that patient strengths are fully considered and misconceptions around psychiatric conditions are recognised and allayed. Where discussions are focussed on risk, there is a danger that the wishes of the patient are not fully heard and again it may fall upon the psychiatrist to ensure these are appropriately considered.

In our experience, it is prudent to anticipate maternal anxiety during the pregnancy. Many women admitted to secure care are from socially disadvantaged backgrounds and may be lacking in effective social support networks. Patients will be limited in their ability to access social support by virtue of their detention and consideration should be given to frequency of visits and phone calls from supportive family members. Patients should be encouraged to think about whether she would like a birth partner, and directed towards charitable organisations or advocacy if no birth partner is available through their own social support group. The admitting hospital may take on a role as surrogate support and the patient must be given adequate opportunity to speak about her understanding, anxieties and expectations relating to her pregnancy with the staff around her where friends and family may otherwise provide this important guidance. The Community Midwife should be used as a further source of information and support in such situations. This is particularly relevant for women experiencing their first pregnancy, those with a history of complicated pregnancies or pregnancies that have not resulted in live births, and for women who have been victims of sexual abuse or violence. There may be a need for psychological treatment for anxiety, such as simple CBT, to be delivered during the pregnancy.

Such anxiety may lead to many visits to the antenatal unit for physical health check-up. Some secure units may have junior doctors with recent obstetric experience, such as GP trainees, but on the whole there will be little professional experience of obstetric management across the MDT. We sought guidance directly from the midwives on the antenatal unit and were given explicit instructions on how to respond to predictable symptoms of pregnancy including when to seek further intervention. This empowered ward staff to manage simple concerns and gave confidence that the antenatal unit would be responsive to any presentation out of the unit's capability to manage.

Where transfer out of hospital was required, consideration was given to level of escort and means of transport, to contain disruptive behaviour and mitigate risk of absconding. Each decision on this matter will need to be case-specific. For reasons of practicality and dignity, we concluded that a very high threshold of risk would be required for us to approve the use of handcuffs and at no time did we conclude that handcuffs were a proportionate response in spite of the legal circumstances.

Consideration must be given to the welfare of staff within the mental health unit, who may find themselves intensely affected by the process of caring for a pregnant woman within a secure setting. This may relate to their own experience of motherhood or pregnancy, or an emotional response to potentially distressing encounters such as the restraint of a pregnant patient. Supervision must be available and regularly provided to ward staff, and those with particular vulnerabilities should be supported and employed understandingly.

Consideration must also be given to the wellbeing of other women detained within the hospital. Those who work with women in long-stay psychiatric units and custodial settings will recognise motherhood and maternal responsibility as important themes influencing behaviour and emotion. It was important that the women on the ward were given time to consider their personal responses to being detained alongside a pregnant peer and that their thoughts and feelings were raised in 1:1 sessions with relevant staff members.

Conclusion

In summary, we have found it possible to safely manage patient pregnancy within a female Medium Secure psychiatric unit through effective multiagency working, anticipation of foreseeable complications and regular review of the formulation and multidisciplinary care plan. We hope that our experience will support other units to manage these vulnerable women safely and compassionately, giving confidence and guidance to the professionals involved.

Declarations

Ethics approval and consent to participate. Consent for publication

Ethical approval was not sought. The patient referenced gave informed consent for the writing and submission of this article and a copy of her signed consent form was submitted with this article. She has seen the final article and has agreed to its submission. A second patient declined to have details of her case included and her wishes were respected.

Competing interests

No competing interests are declared

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Authors Contributions

All authors made equivalent contributions to the body of the text, with JR leading on the details of the case as he was the treating psychiatrist. All three authors have read and approved the final manuscript

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Supporting information

There is no supporting information available as to share it would be in breach of patient confidentiality

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