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Wales Maternity and
Neonatal Network

All Wales Maternity & Neonatal Guidelines

Management of Babies Born to Mothers Requiring Psychotropic Medication during Pregnancy

Documents to read alongside/ support this guideline	Appendix 1 - Drug Specific Guidance Appendix 2 - Poor Neonatal Adaptation Syndrome (PNAS) Monitoring Chart Appendix 3 - Patient Information Sheet Appendix 4 - Letter Prescribing antidepressants in the perinatal period – Guidance and patient poster
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Version Control					
Version	Date of Review	Reviewer name(s)	Ratified on	New review date	Date of Publication
V2	3.12.24	Rachel Morris Elisa Smit	17 th January 2025	17 th January 2029	19 th February 2025
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V1 Current		Rachel Morris, Lynsey Edwards, Kate Cornelius, Jo Webb, Jo Noblett & Elisa Smit	December 2019	December 2023	

Disclaimer: These guidelines have been ratified at the Maternity/Neonatal Guideline Meeting; however clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This document sets out to standardise and optimise the care given to newborn term babies when their mothers have taken psychotropic medication during pregnancy.

Introduction

Around 15% of all pregnant women suffer from a significant mental health problem leading to around 10 - 13% of babies exposed in utero to psychotropic medication¹. The most common risk to babies exposed to antenatal psychotropic drug use is poor neonatal adaptation syndrome (PNAS). Other risks such as the increased risk of malformations and incidence of preterm birth are uncommon.

In case of a mother taking psychotropic medication, the following points should be taken into consideration at the midwife booking appointment:

- provide parent information leaflet (Appendix 3)
- referral to local perinatal mental health team if threshold met
- if threshold not met, GP to review psychotropic medication and discuss taking in pregnancy and whilst breastfeeding

Any antenatal plans for postnatal management of the newborn should be communicated to the paediatric team and reviewed and acted on by the midwifery and paediatric teams following birth

Poor Neonatal Adaptation (PNA)

Symptoms of PNA are caused by exposure to psychotropic drugs. The underlying aetiology is unclear but thought to be due to withdrawal of drug after birth (all psychotropic medication crosses the placenta - onset usually within 8 hours), toxicity (apparent immediately after birth) or a combined effect².

Symptoms of PNA

PNA symptoms are summarised in [Table 1](#). PNA is a diagnosis of exclusion – do not assume the symptoms seen are due to maternal medication and exclude other causes first (sepsis, hypoglycaemia, electrolyte disturbances, polycythaemia). Any symptomatic infant should have a **FBC, U&E, Ca²⁺, Mg²⁺, and blood gas (ionised calcium), as well as an infection screen if any red flags for infection or meeting the criteria as per EOS risk calculator.**

Symptoms occur mainly in the first 48 hours and most babies present in the first 24 hours^{2, 3}. In most babies' symptoms are mild. If PNA symptoms do not occur in the first 48 hours after birth, development of PNA is very unlikely. If symptoms occur, they usually resolve by 72 hours, but it can take longer (up to a week). Some studies suggest that breast fed babies are less likely to develop PNA³.

	Common Symptoms	Rare Symptoms
Neurological	Jitteriness or tremors/myoclonus Hyper or hypotonia Sleeping difficulties High pitched cry or frequent crying Agitation and irritability	Convulsions Hyperreflexia Lethargy
Gastro-intestinal	Feeding difficulties	Diarrhoea Uncoordinated/ weak sucking Vomiting/regurgitation
Respiratory	Respiratory distress	
Autonomic		Temperature instability Mottling Excessive sweating Nasal congestion

Table 1 Symptoms of PNA

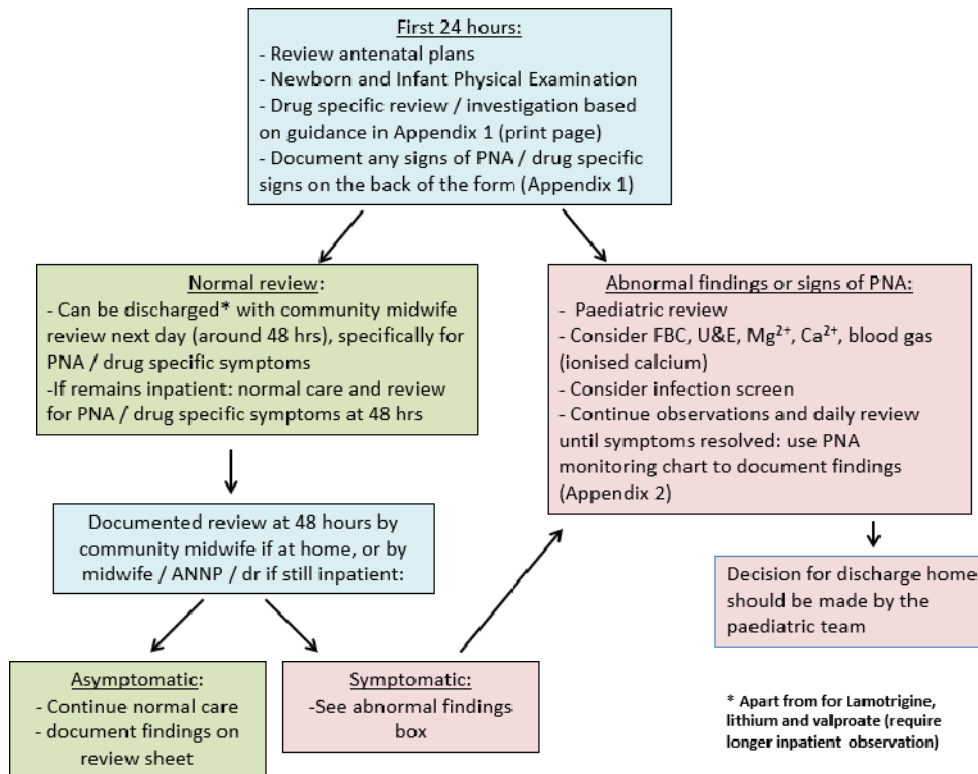
Management

The exact monitoring and management of the baby will depend on the type of psychotropic medication taken by the mother (see [Appendix 1](#) and summary table at the end of this guideline). The **flowchart below** will guide management. Be aware that if expectant mothers are taking both opioid and psychotropic medications together the risk of withdrawal is increased, and the NAS symptoms appear to be more severe. Therefore PNA (48 hours) and NAS observations (5 days) should be performed concurrently.

The baby should remain with the mother unless a safeguarding alert says otherwise, or a medical decision is made to admit the baby.

All infants should undergo a full newborn and infant physical examination (baby check) in the first 24 hours, with particular attention to the spine, palate, cardiovascular system, and review of the antenatal scans.

Interventions to be considered are assessment and monitoring of the baby by the post-natal team, communication with the baby's family and healthcare practitioners, information sharing and consideration of any safeguarding concerns.



Breastfeeding

Most of the maternal psychotropic drugs are present in breastmilk, but in the majority of cases taking these medications is not a reason to stop breastfeeding (see Appendix 1). The clinician should be familiar with the antenatal plan for infant feeding before starting the newborn and infant physical examination (NIPE, baby check), and support the family with breastfeeding if this is appropriate and what the mother has planned for. Successful, well supported breastfeeding is a positive indicator for maternal mental health outcomes. Thus, mothers with existing mental health issues should be identified early as requiring additional breastfeeding support. Early input from a lactation specialist should be arranged if breastfeeding issues arise.

No changes or advice should be given to the mother regarding their psychotropic medication. This should be managed by their psychiatrist or GP, but discuss with the psychiatrist or GP if queries or concerns are raised.

References

Briggs, G. G., Freeman, R. K., Yaffe, S. J. (2017) *Drugs in Pregnancy and Lactation*. 11th Edition, Philadelphia. Wolters Kluwer.

Chisolm, M., Payne, J. L., (2016) Management of Psychotropic Drugs in Pregnancy. *BMJ*, 352:h5918

Die, S. D., Weissenburch, M. M. Maternal Use of SSRI, SNRI and NaSSA: Practical Recommendations During Pregnancy and Lactation. *Archives of Disease in Childhood (fetal and Neo Ed)* 2012 97, (6) 472-476

Huybrechts, K. F., Patorno, E. Risk of Neonatal Drug Withdrawal After Intrauterine Co-exposure to Opioids and Psychotropic Medications: Cohort Study. *BMJ* 358:j3326

Kieviet, N., Dolman, K. M. (2013) The Use of Psychotropic Medication During Pregnancy: How About the Newborn. *Neuropsychiatry disease*. 9: 1257-1266

Pan-London Perinatal Mental Health: Guidance for Newborn Assessment. The Pan-London Perinatal Mental Health Network and the London Neonatal Operational Delivery Network (June 2017).

LActMed – Drug and Lactation database: <https://www.ncbi.nlm.nih.gov/books/NBK501922/> (accessed November 2024)

<https://www.gov.uk/guidance/valproate-use-by-women-and-girls> MHRA guidance (accessed November 2024)