

CASE REPORT**Coordinated Care in Managing a Postnatal Mother with Delusional Disorder and Opioid Use Disorder: A Case Report**

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Abstract

Mothers with severe mental illness and comorbid substance use disorder or dual diagnosis have complex needs and usually require specialized services. Their care usually involves collaboration of different healthcare professionals, with involvement of social services to ensure wellbeing of both mother and child. This case report illustrates the importance of coordinated care of a mother with delusional disorder and opioid use disorder with poor psychosocial support in order to manage her and baby during postnatal period.

Keywords: Dual Diagnoses Mother, Coordinated Care, Perinatal Mental Health

Introduction

Perinatal mental health problems can complicate perinatal care; affect the mother's ability to adjust to motherhood and compromise newborn's care.

Services for mothers with severe mental illness (SMI) and comorbid substance use disorder (SUD) need to involve collaboration of different healthcare professionals and social welfare services to ensure wellbeing of mother and child [1]. During perinatal period, care involves the obstetrician as the primary team with consultation liaison psychiatry (CLP) team focusing on management of underlying mental illness throughout perinatal period and parenting capacity assessment while addiction psychiatry team manages underlying SUD with aim for abstinence and

rehabilitation. Post-discharge, the community mental health team (CMHT) and maternal and child health services will ensure continuity of care in community with continuous monitoring of baby's welfare by social services. The case discussed illustrated coordinated care approach in managing a postnatal mother with dual diagnosis.

Case Report

We illustrate a case of Mrs. SMY, a 42-year-old unemployed mother, G7P4+2 at 38 weeks period of gestation (POG) presented to Emergency Department in labour, alone via public transport. Hospital didn't manage to contact her current 4th husband. During her first antenatal check-up at 28 weeks POG, she admitted to persistent opioid and

occasional amphetamine use during pregnancy.

In the labour room, she claimed her life was in danger, as she believed there were people following her with plans to harm her. Her urine toxicology was positive for opioid. She delivered a baby boy weighed 2.36 kg and baby was transferred to Neonatal Intensive Care Unit (NICU) for observation. She was referred to the CLP team for psychiatric and parenting capacity assessment. Her family was contacted for corroborative history.

Mrs. SMY chased heroine since 16 years old with severe opioid use disorder at 18 years old. She had recurrent family conflict with three previous failed marriages due to her opioid use. Estranged by her family, she stayed alone with 3 children from her 3rd marriage and inconsistently cannabis, amphetamine and alcohol.

She started to have persecutory delusion towards her neighbours in her 30s, with associated auditory and visual hallucinations. Her psychotic symptoms persisted even during substance abstinence. Frequent arguments, lodged police reports against neighbours and physical aggression led to a psychiatric admission in 2012 in Hospital Kuala Lumpur. She was prescribed Risperidone and defaulted medications post-discharge. As she was still distressed with her delusions, she continued using heroine and amphetamine. She frequently moved houses and reported to Social Welfare Department that her children needed protection resulted them being put under placement. In 2019, she moved to southern Malaysia to 'escape' from neighbours and married her current husband. Subsequently she went back to Kuala Lumpur while pregnant and with no partner or family support. She had no other psychotic or mood

symptoms during current or previous pregnancies. She was diagnosed with Delusional Disorder and severe Opioid Use Disorder, subsequently referred to Addiction Psychiatry team for co-management, Medical Social Worker (MSW) for psychosocial assessment and Child Protector to decide for baby's guardian.

In the postnatal ward, Madam SMY established breastfeeding and good mother-baby interaction was observed. She had no withdrawal symptoms and was motivated to stop heroine. She was not keen for Methadone Maintenance Therapy, therefore she received brief cognitive behavioural intervention and motivational interviewing to maintain abstinence from illicit substances. Risperidone was switched to Olanzapine 5mg at night due to over-sedation. Post-discharge plan was discussed collaboratively. Madam SMY's family agreed to supervise Madam SMY's treatment and baby's care with aids from social services. Patient was referred to CMHT with follow up at CLP, addiction team clinic and nearest health clinic for maternal and child services.

She stopped heroine post-discharge but was still delusional. Her Olanzapine was optimized to 10 mg at night and later switched to intramuscular Fluanxol 20 mg 4 weekly due to poor compliance. She continued breastfeeding and was able to take care of her baby with her family's supervision. The social services continued monitoring and provided financial aid for baby's necessities. She defaulted appointments in CLP and addiction clinic but CMHT continued provision of psychiatric care.

Discussion

Perinatal chronic SMI was reported as 2 per

1000 maternities [1] with schizophrenia at 0.03% and was associated with adverse neonatal outcomes such as preterm delivery and low infant birth weight [2]. Another growing concern is perinatal SUD, where 2% pregnant mothers report opioid use, 8% smoked cigarette and 10% took alcohol antenatal use [3].

Madam SMY had dual diagnosis with poor psychosocial support that posed significant risks to mother and baby [4,5]. NICE recommended urgent referral for women in mental health crisis to liaison mental health care team under a perinatal specialist's supervision and referral to Addiction specialist for perinatal mothers with SUD. Biopsychosocial assessment and management should be provided under a specialized perinatal CMHT or considered for Mother-Baby Unit (MBU) admission [5]. In Malaysia, CLP team is responsible to coordinate care with other healthcare professionals, social services and patient's family to provide care and support for both mother and baby. There is no local MBU at the time of writing, but family support and acute care services of CMHT can be utilized to ensure community care for these mothers when suitable.

Postnatal mothers with dual diagnosis have high risk of further relapse; thus coordinated care plan agreed by patient and clinician with referral to appropriate services prior to discharge is recommended [5]. It may involve collaborative care, case management and multidisciplinary team. Collaborative care model, defined as an integrated treatment approach between different healthcare providers managing patients in a primary care setting [6] is definitely the way forward to deliver mental health services for perinatal population in the community.

Remission rate for postnatal mothers with SMI on psychotropic at week 12 and 9 months was 98.4 % and 79.7% respectively [7]. Therefore, discussion on risk and benefit for psychotropic use should be conducted [4,8]. Depot antipsychotics were not recommended for women planning a pregnancy, pregnant or considering breastfeeding [8] but Madam SMY's oral antipsychotic was switched to depot due to poor adherence. Due to anticipated higher defaulter risk among postnatal mothers with dual diagnosis, early engagement with CMHT was crucial and useful. Management plan must also emphasize continuation of antipsychotic treatment, abstinence from illicit substance use, importance of contraception and assessment of mother's parenting capacity.

Coordinated care with other healthcare professional, social services and family members is important for postnatal mother with dual diagnosis and her baby. Specialized perinatal mental health services, perinatal CMHT and establishment of a MBU should be incorporated as part of the implementation strategies for perinatal mental health services.

References

- [1] Royal College of Psychiatrists' Faculty of Perinatal Psychiatry. Perinatal mental health services: recommendations for the provision of services for childbearing women. College Report CR197 (Revision of CR88). July 2015.
- [2] Mongan D, Lynch J, Hanna D, Shannon C, Hamilton S, Potter C et al. Prevalence of self-reported mental disorders in pregnancy and associations with adverse neonatal outcomes: a population based cross-

- sectional study. *BMC Pregnancy and Childbirth* [Internet]. 2019; 19:412. Available from: <https://doi.org/10.1186/s12884-019-2572-4>.
- [3] Ordean A, Graves L, Chisamoe B, Greaves L and Dunlop A. Prevalence and consequences of perinatal substance use- growing worldwide concerns. *Substance Abuse: Research and Treatment* [Internet]. 2017; 11: 1-4.
- [4] Austin MP, Hight N and the Expert Working Group. Mental health care in the perinatal period: Australian Clinical Practice Guideline. Melbourne: Centre of Perinatal Excellence. 2017.
- [5] National Collaborating Centre for Mental Health. The Perinatal Mental Health Care Pathways. Full implementation guidance. London: National Collaborating Centre for Mental Health. 2018.
- [6] Ministry of Health, Malaysia. CPG Management of Major Depressive Disorder (Second Edition). Putrajaya: MoH; 2019.
- [7] Taylor CL, Boradbert M, Khondoker M, Stewart RJ and Howard LM. Predictors of severe relapse in pregnant women with psychotic or bipolar disorders. *Journal of Psychiatric Research*. 2018; 104:100-107.
- [8] National Institute for Health and Care Excellence (UK). Antenatal and postnatal mental health: clinical management and service guidance (CG192). The British Psychological Society and The Royal College of Psychiatrists. 2014.

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