PIMH: Clarification of the Terminology

Perinatal Mental Health

- As more evidence emerges about the effects of PMI on the mother, developing foetus/infant and family, the term perinatal mental health, is now commonly used to describe mental health in the period from conception to 1 year following the birth of the child

- PMH in the context of this training is about the emotional wellbeing of women, their children, partner and families from conception to 1 year following the child's birth

The Importance of Perinatal and Infant Mental Health: Prevalence and Impact

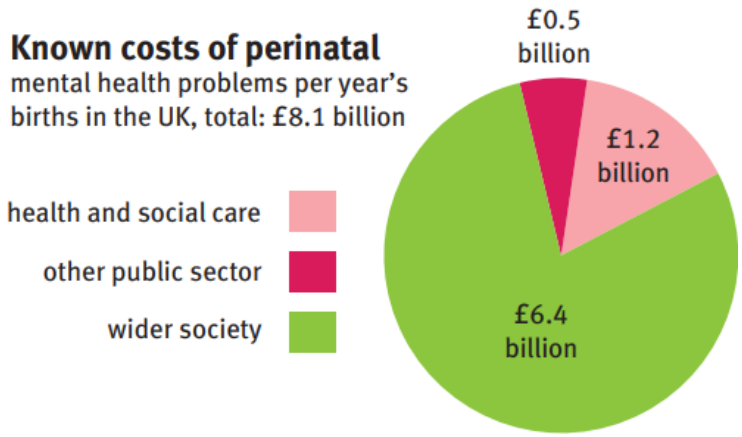
1 in 4 women are affected by perinatal mental health problems

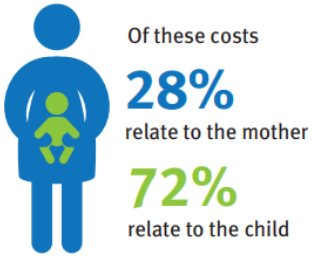
Maternal suicide is still the leading cause of death when looked at over the perinatal period

Mental illness is the most common serious health problem that a woman can experience in the perinatal period.

Approximately 10% fathers experience PMI but 25-50% of fathers will experience perinatal anxiety or depression when the mother also has a PMI.

The impact for the fetus, the infant/child having a parent with MI is not inevitably negative, but they are at increased risk for a range of poorer outcomes- essential that we are proactive and intervene at the earliest opportunity.





Costs v improvement

The cost to the public sector of perinatal mental health problems is **5 times** the cost of improving services.

The Perinatal Frame of Mind: Mental health across the life-course

"The environment in the womb, during different sensitive periods for specific outcomes, can alter the development of the fetus, with a permanent effect on the child. We are now beginning to understand this at the molecular level"

(V. Glover, oral evidence to Marce Society, 2016).

Seeing the woman - holding the child

History of childhood abuse or trauma is associated with increased risk of perinatal mental illness..

Practitioners should take into account the potential experience and impact of trauma during perinatal period.

Pregnancy, maternity care, birth and transition to parenting and postnatal period can be extremely triggering, particularly for women who have experienced childhood sexual abuse (1 in 4 women).

Establishing and maintaining an effective therapeutic relationship (Lowenhoff, 2016)

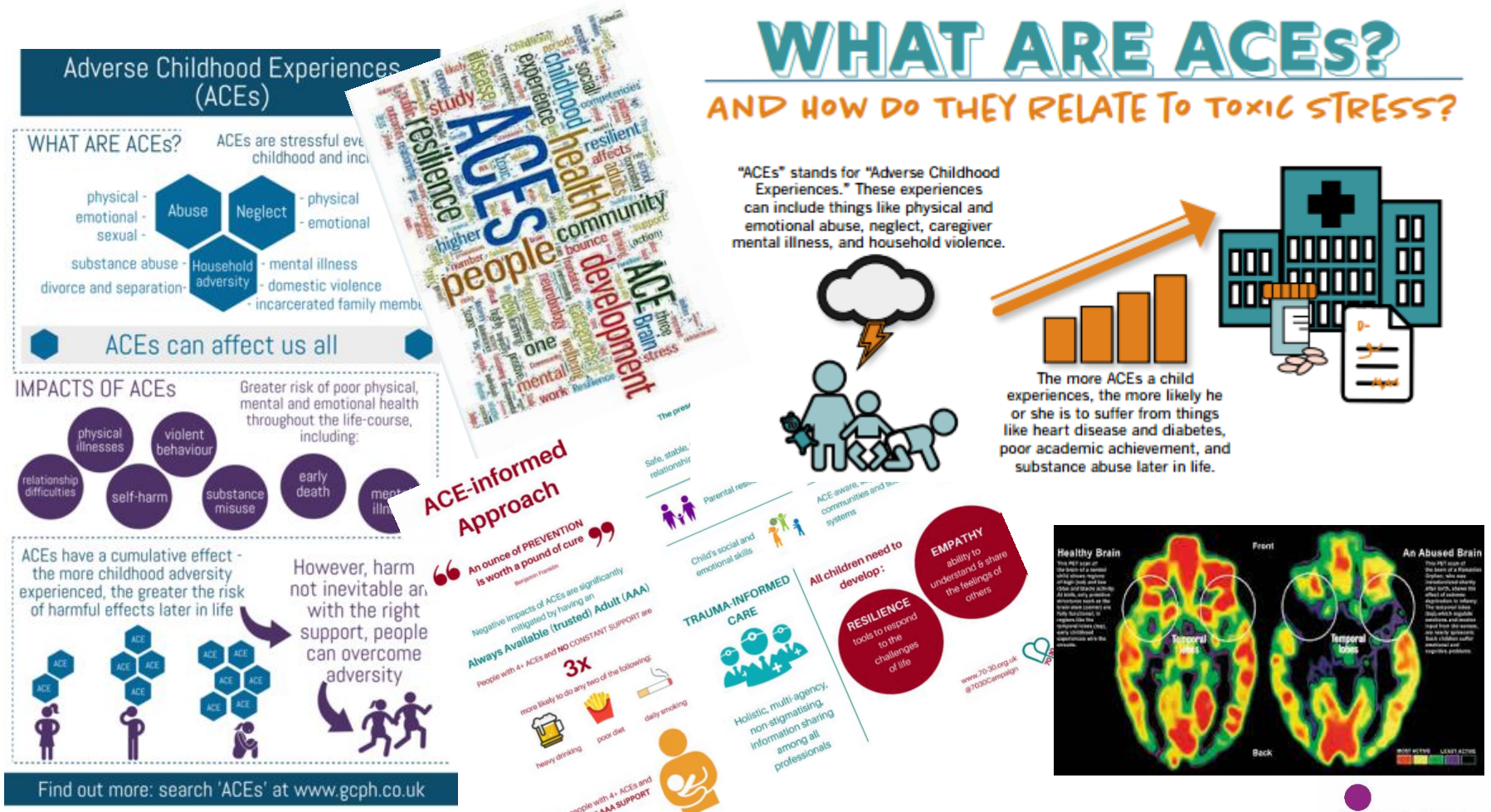
What is needed

- Genuineness
- Unconditional positive regard
- Empathy
- Warmth
- Flexibility
- Responsiveness
- Listening skills
- Reflection skills
- Summarizing
- Questioning skills
- Ability to collaboratively problem solve any difficulties in the person's treatment plan or the relationship between the therapist and the patient
- Time

What women want

- Single, known person for coordinating assessment and management of mental health problems (NICE 2014)
- Sufficient listening (clinical interested and willing to hear about each woman's unique experience in a non-judgmental way)
- To offer choice and negotiate appropriate focus of treatment (directive / non-directive?)
- To be trustworthy, genuine and warm
- Technical competence (skilled and possessing the right qualifications to be helpful)
- To instill hope and optimism

Adverse Childhood Experiences



https://www.youtube.com/watch?v=XHgLYI9KZ-A

Trauma-informed approaches in the antenatal period to support mental health across the life-course

Trauma-informed care - changing the narrative from:

What's wrong with you?

To…….

What happened to you?

"To understand how to really care for women, we must first understand where she came from"

Antenatal Stress and Anxiety

- Stress and anxiety are different but often occur together and can be in the absence of depression
- Pregnancy is a time of increased vulnerability for the development of anxiety (and depression) anxiety disorders are present in significant numbers in perinatal period *(15%)
- Anxiety disorder is a strong predictor of PND, general anxiety disorder in the antenatal period predicts depression at all time points after delivery
- Symptoms of anxiety and depression often occur together
- NICE (2014) recognises the need to identify and support women who do not necessarily meet diagnostic criteria for mental illness but do experience a range of symptoms that cause distress
- Essential that stress and anxiety are detected during pregnancy and appropriate interventions offered

Obstetric Consequences of PMI

Antenatal identification of women with a mental illness and / or a history of mental illness is important to protect the health of the mother and may also impact upon the health of the neonate. PMIs in pregnancy have been associated with adverse obstetric and neonatal outcomes, for example:

- Pre-term birth
- Low birth weight
- Small-for-gestational-age births
- Increased likelihood of caesarean / instrumental delivery

However, it is important to bear in mind co-morbidity and the multiple factors that may influence the association between maternal mental disorder and adverse neonatal outcomes

Impact of Adverse Prenatal Mental Health

- Adverse prenatal mental health has been shown to be associated with a wide range of outcomes both in the short (i.e. immediately following birth) and longer term (i.e. through to adolescence and adulthood).
- Children of women who are experiencing adverse pre natal mental health during pregnancy have an increased risk of adverse neurodevelopmental, physical, social, emotional, behavioural and cognitive outcomes.
- **Important to emphasise this is not inevitable, there is opportunity to ameliorate effects, and most children born to mothers with PMI will be ok.**

Supporting Parental Emotional Wellbeing and Infant Development in Your Practice

- Support mothers and fathers/partners to negotiate the emotional, as well as the physical transition to parenthood
- Nurture healthy couple relationships
- Encourage the development of sensitive, reflective parent-child relationships, starting in the antenatal period
- Help mothers and their partners to begin to relate to their baby as a person through informing them of the research
- Explore with the mother how they imagine their baby to be.
- Encourage positive images of the baby. Explorations that identify extremely negative images or that suggest the mother is very 'disengaged' should involve referral to a psychologist
- Integrate the emotional wellbeing alongside physical wellbeing at all opportunities. For example; asking a mother/father during listening for the heartbeat, "how does hearing your baby's heartbeat make you feel?"

Supporting the Parent/Infant Relationship: Family Mental Health

PMI can influence the way in which a parent thinks about, interprets, describes, cares for and interacts with their baby.

This can affect the way a parent feels about their ability to care for their baby, their enjoyment of parenting, their parenting styles and their developing relationship with their baby.

Interaction with caregivers is the most important element of a child's early experience and lays the foundations for his or her social and emotional development

It is through these early interactions that babies learn how to recognise and regulate their own emotions, and build the foundations for later relationships.

Support for the affected parent, and for the rest of the family, can make a really positive difference to the outcome for everyone in the family.

Infant Development

- Nature AND nurture
- Brain is not mature at birth
- Brain is changed by experience
- Timing of experiences is important
- Relationships influence social and emotional functioning

Mental Health Conditions Occurring in the Perinatal Period

Psychotic Disorders	Bipolar & related disorders	Depressive Disorders	Anxiety Disorders	Obsessive Compulsive & related Disorders	Trauma- & Stressor- Related Disorders	Eating Disorders	Personality Disorders
•Post Partum Psychosis * •Schizophrenia •Brief Psychotic Disorder •Schizoaffective Disorder •Substance/Medication-Induced Psychotic Disorder	•Bipolar I •Bipolar II •Cyclothymic Disorder	•Major Depressive Disorder •Persistent Depressive Disorder	•Social Anxiety (social phobia) •Panic Disorder •Agoraphobia •Generalised Anxiety Disorder •Specific Phobias e.g. Tokophobia, Animal, Blood, situational	•Obsessive Compulsive Disorder •Body Dysmorphic Disorder	•PTSD (as a result of trauma including birth trauma) •Acute stress disorder •Adjustment Disorder •Attachment Disorder	•Anorexia Nervosa •Bulimia Nervosa •Binge-Eating Disorder	•Sometimes referred to as complex trauma. •DSM V describes 10 types of personality disorders.

Substance Misuse Disorders

DSM-5 (2013) *PPP not referenced in DSM-5

Risk factors for PMI (*not determinants)

- Past history of mental illness
- Family history of mental illness
- History of childhood trauma and poor parenting
- Antenatal depression/anxiety
- Pregnancy related
- Major life events/stresses
- Low social support (especially poor support from current partner)
- Domestic abuse
- Substance misuse
- Relationships problems
- Major life events
- Loss of own mother
- Birth trauma
- Baby with special needs/on neonatal units
- Teenage mothers/fathers
- Insecure environment – housing
- Financial worries – employment / debt
- Housing problems
- Natural disasters - earthquakes, extreme weather (floods /drought)
- War/conflict
- Long-standing personality vulnerabilities

Birth Trauma

- Is a subjective experience rather than as a result of obstetric complications.
- Support can buffer negative consequences such as PTSD.
- 20-45% of women meet the criteria for having experienced a traumatic birth (Ayers 2020).

Support

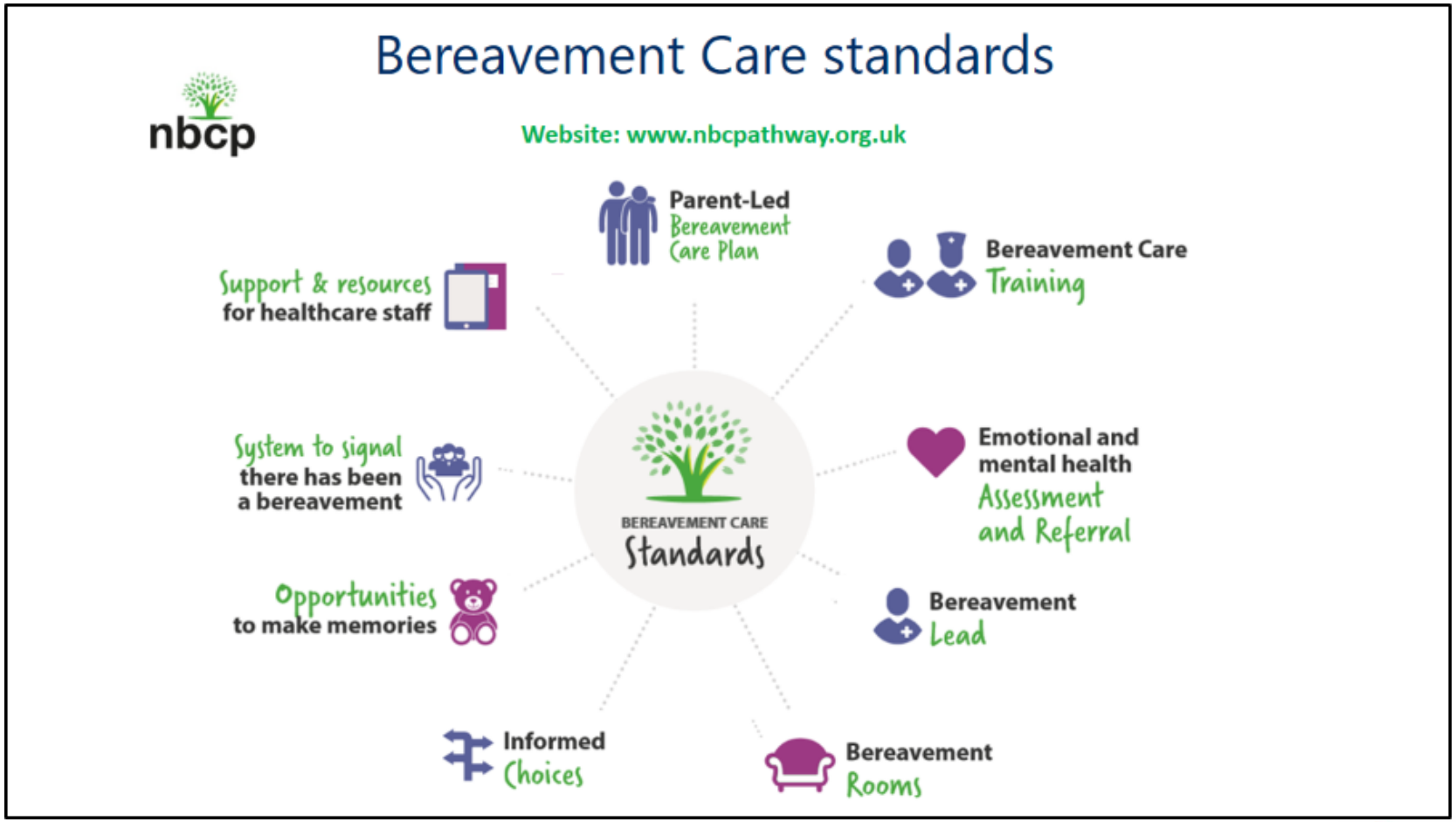
- Offer advice and support to women who have had a traumatic birth or miscarriage and wish to talk about their experience. Take into account the effect on the partner and encourage them to accept support from family and friends.
- Offer women who have post-traumatic stress disorder, which has resulted from a traumatic birth, miscarriage, stillbirth or neonatal death, a high-intensity psychological intervention
- Do not offer single-session high-intensity psychological interventions with an explicit focus on 're-living' the trauma to women who have a traumatic birth.
- PTSD can occur in men and women as a result of complications of pregnancy & birth

Stillbirth and Miscarriage

Discuss with a woman whose baby is stillborn or dies soon after birth, and her partner and family, the option of: seeing a photograph of the baby; having mementos of the baby; seeing the baby; holding the baby. This should be facilitated by an experienced practitioner and the woman and her partner and family should be offered a follow-up appointment. (NICE CG 192, 2014)

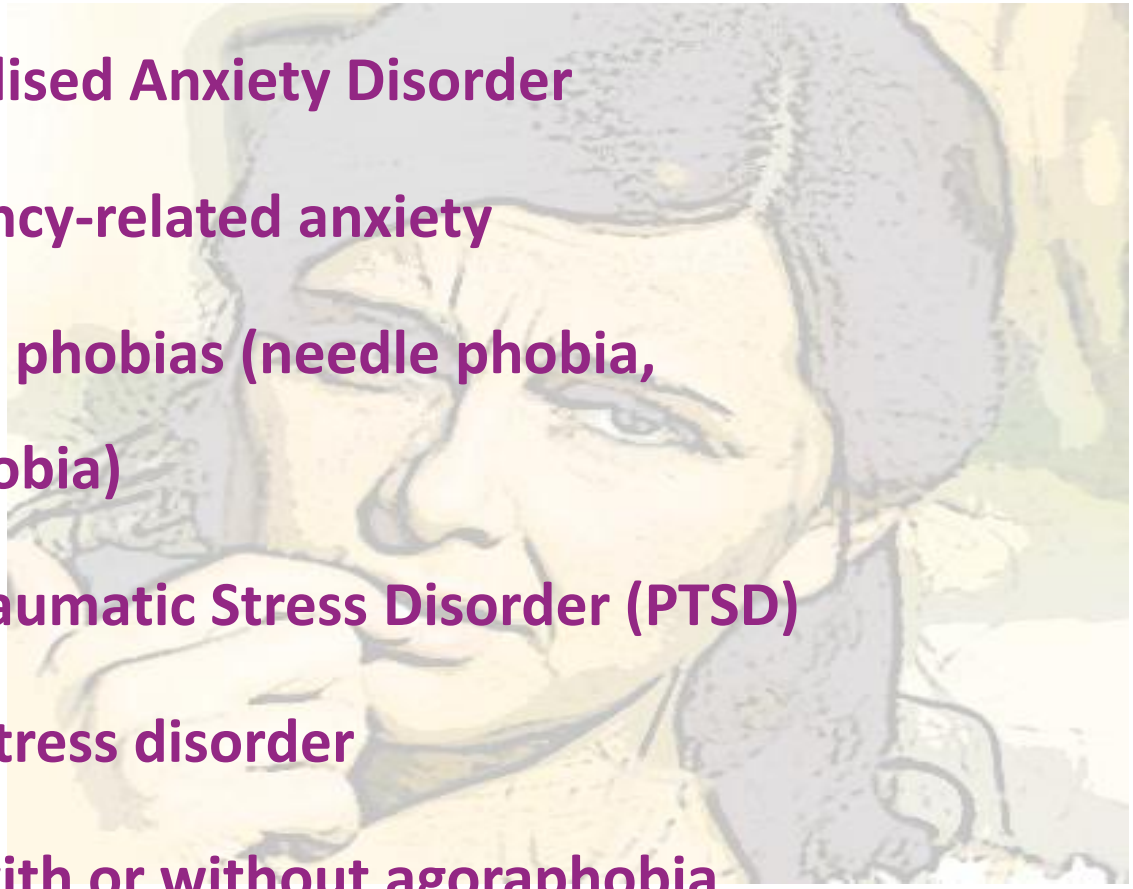
http://www.birthtraumaassociation.org.uk/

Bereavement Care Pathway



www.nbcpathway.org.uk

Anxiety Disorders



- Generalised Anxiety Disorder
- Pregnancy-related anxiety
- Specific phobias (needle phobia, tokophobia)
- Post-Traumatic Stress Disorder (PTSD)
- Acute stress disorder
- Panic with or without agoraphobia

General Symptoms of Anxiety

Physical

- **Cardiovascular** – palpitations, chest pain, rapid heart beat, flushing
- **Respiratory** – hyperventilation, shortness of breath
- **Neurological** – dizziness, headache, sweating, tingling and numbness
- **Gastrointestinal** – choking, dry mouth, nausea, vomiting diarrhoea
- **Musculoskeletal** – aches, pains, restlessness, tremors, shaking

Psychological

- **Feeling nervous, anxious or on edge**
- Unrealistic &/ or excessive fear or worry,
- Mind racing or going blank
- Indecisive
- Confusion
- Decreased concentration and memory

Behavioural

- Avoidance of situations
- Obsessive /compulsive behaviour
- Distress in social situations
- Sleep difficulties

Tokophobia (Fear of Childbirth)

- Tokophobia is the extreme fear of childbirth and can lead to women avoiding pregnancy, terminating pregnancy of a wanted baby, sever anxiety and request for caesarean section
- Primary tokophobia predates childbirth, secondary may relate to previous birth trauma
- Severe anxiety about childbirth in the form of tokophobia is relatively common, affecting around 14% of women
- Range of symptoms including sleep problems, panic, anxiety, crying episodes, paranoia and desire for caesarean section due to fear of vaginal delivery
- Early identification of fear of childbirth is essential if there is to be time for effective treatment and management

Fear of Childbirth (Tokophobia) and Traumatic Experience of Childbirth: Best Practice Toolkit

Post-Traumatic Stress Disorder (PTSD)

- PTSD can occur for the first time, reoccur or worsen during the perinatal period
- Prevalence 1% in the perinatal period.
- Risk factors include: domestic abuse, history of sex trauma (e.g. sexual abuse, rape), history of mental health problems, migration, previous adverse reproductive events (e.g. ectopic pregnancy, miscarriage, stillbirth), poor postnatal care, baby's stay in NICU/SCBU, traumatic birth experience
- Both tokophobia and PTSD more likely to result in requests for an elective LSCS or result in an emergency LSCS
- Symptoms include: flashbacks, nightmares, repetitive and distressing images, avoidance of usual activities, emotional numbness, hyperarousal
- Highly comorbid with depression

https://www.youtube.com/watch?v=vZp6lausZp8

General Symptoms of Depression

Physical

- Tired all the time
- Lack of energy
- Crying, sad
- Sleep disruption
- Appetite disruption
- Changes in weight
- Pain
- Loss of libido
- Personal neglect
- Psychomotor agitation or retardation

Psychological

- Self blame, criticism, guilt
- Impaired concentration
- Hopelessness
- Depressed mood
- Withdrawal from family and friends
- Loss of motivation
- Suicidal ideation
- Anhedonia

Behavioural

- Self neglect/ avoidance
- Insomnia/ hypersomnia

Perinatal Depression

Baby Blues

- Usually mild and transient low mood affecting between 30-80% of new mothers in the first few days

Perinatal Depression

- Persistent and pervasive low mood of varying severity and duration. Frequently missed
- Incidence of 10-15%
- Antenatal as common as postnatal
- The most common complication of pregnancy
- 40% of women are likely to experience subsequent postnatal or non postnatal relapse - with new research showing that women with persistent PND showed elevated depressive symptoms up to 11 years after childbirth.

Obsessive Compulsive Disorder

Symptoms of perinatal OCD often impair a parent's ability to care for their infants and can include:

- obsessions, also called intrusive thoughts, which are persistent, repetitive thoughts or distressing mental images sometimes related to the baby.
- compulsions, where the individual may do certain things over and over again to reduce their fears and obsessions e.g. those related to cleaning / washing and checking
- fear of being left alone with the infant
- hypervigilance in protecting the infant
- tremendous guilt and shame

Fathers and Perinatal Mental Health

- Pregnancy is the most demanding period for the father's psychological reorganisation of self
- Labour and birth the most emotional moments
- Postnatal period is the most challenging time

The most common risk factors (factual or perceptual):

- Maternal depression
- Poor social support
- Low emotional support

Prevalence Rates in Fathers

Antenatal depression: 11-12%

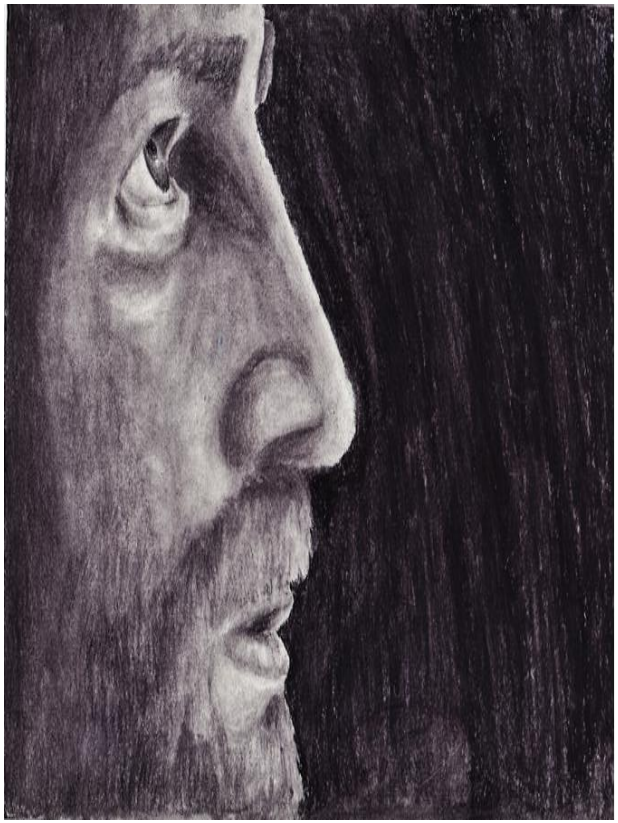
Postnatal depression: 8-26%

Overall rates of perinatal mental illness in fathers 9%

These rates rise to 50% if their partner is experiencing mental ill health in the perinatal period

Risk Factors for Anxiety

- Anxiety and stress often co-exist with depression in pregnancy and in the postpartum in men (Figueiredo and Conde, 2011)
- High anxiety and depressive symptoms during pregnancy are the most significant predictors of depression in men in the postpartum period (Ramchandani et al, 2008)
- Anxiety in men ranges between 4.1% - 16.0% in the antenatal period and 2.4% – 18.0% in the postnatal period (Leach et al, 2016)
- Anxiety may be the most common mental illness experienced by fathers (Winter, Rowe & Fisher, 2013).



Paternal Perinatal Depression

Estimates of paternal depression vary widely, ranging from 1.2–25.5% (Goodman, 2004). A meta-analysis (43 studies) found an average 10.4% of fathers depressed both pre- and post-natally (Paulson & Bazemore, 2010)

Having high anxiety and depressive symptoms during pregnancy are the most significant predictors of depression in men in the postpartum period (Ramchandani et al, 2008). Other risk factors include:

- being young
- having a low income
- being unsatisfied with the couple-relationship
- timing of the pregnancy
- poor social and emotional support (either factual or perceptual)

Severe depression in fathers is associated with high levels of emotional and behavioural problems in children 3.5 years, particularly in boys (Ramchandani et al, 2005)

Children with 2 depressed parents = higher risk of poor development outcomes (Brennan et al 2002)

Postpartum Psychosis and Mothers

- Affects 1-2 in 1000 mothers – cases are rare
- Immediate hospitalisation
- Rapid onset – usually 3- days but can take several weeks to detect
- Often detected by midwives
- In women with bipolar disorder and family history of postpartum psychosis in first degree relative, the rate of postpartum psychosis is almost double that of women with bipolar without family history

(Jones and Craddock 2001)

Symptoms of Postpartum Psychosis

- Rapidly changing mood
- Bizarre behaviour
- Lack of inhibition
- Hallucinations – distortion of the 5 senses
- Delusions – thought disorder
- Confusion
- Agitation
- Flight of ideas
- Lack of insight
- Risk to mother and infant

Bipolar disorder

Episodes of mania or depression are experienced either alternately or together. During periods of mania symptoms may include:

- increased energy
- loss of inhibitions
- delusions of grandeur
- euphoric mood
- irritability
- rapid speech

During bouts of depression, the usual symptoms associated with lowered mood are experienced and the individual may be at risk of suicide

Past history of bipolar disorder, increases risk of PP.

A review of research around children whose parents have mental illness (Reupert, Maybery & Kowalenko, 2012), found that compared with control groups, offspring of parents with bipolar disorder are at increased risk for mood and other disorders, including substance use, ADHD, conduct disorder and oppositional defiance disorder

Schizophrenia

Schizophrenia The symptoms of schizophrenia include:

Positive symptoms: Hallucinations, delusions, thought interference.

- **Psychotic delusions concerning fetus/infant are significantly different to the obsessive and intrusive thoughts associated with OCD. Delusions involving the fetus, infant or any older children, are extremely concerning and should always trigger an immediate and thorough risk assessment by specialist services**.

Negative symptoms: losing interest and motivation in life, activities and relationships, fewer spontaneous movements, spending time doing nothing, facial expressions do not change much and the voice may sound monotonous, emotions may become flat and an individual appears to be disinterested or disengaged

- **Negative symptoms of schizophrenia can have a devastating impact on the parent-infant relationship and infant development**.

Cognitive symptoms of schizophrenia: difficulties understanding information, memory problems, reduced concentration, inability to organise time effectively, difficulties in prioritising and planning tasks

- **Cognitive symptoms can severely effect the capacity of parenting**

Personality Disorder

"Personality" refers to the collection of characteristics or traits that we have developed as we have grown up and which make each of us an individual.

People with personality disorders are associated with:

- higher rates of substance misuse
- deliberate self harm
- suicidality
- increased risk of social services
- poor engagement with antenatal and postnatal care which can lead to poor outcomes for the individual and the infant

Eating Disorders

- May impact on a woman's fertility, but does not preclude pregnancy
- Between 2-7.5% of women may experience an eating disorder
- For many women, eating disorder symptoms improve during pregnancy BUT, relapse of symptoms and postnatal depression is common following birth
- Associated with adverse obstetric outcomes, difficulties with infant feeding and family mealtimes
- Highlights the importance of preconception advice, and consistent antenatal and postnatal care

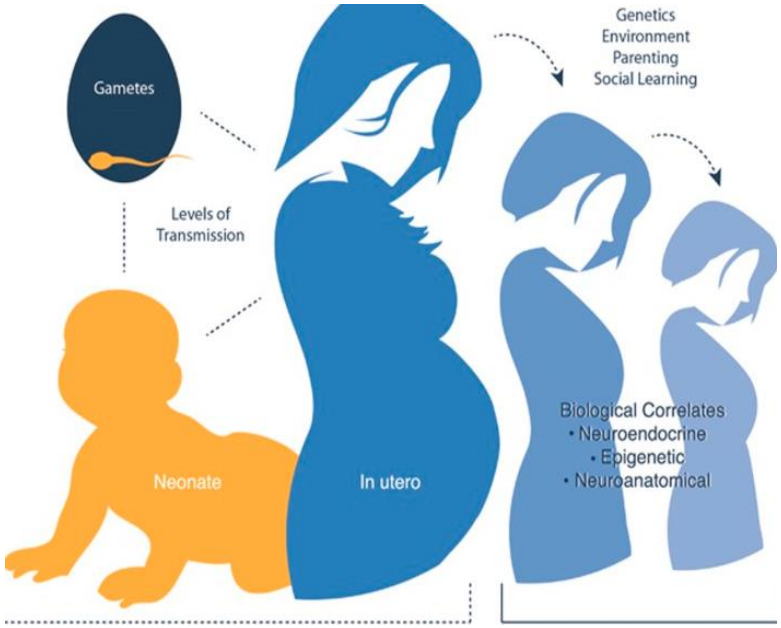
http://www.eatingdisordersandpregnancy.co.uk

Intergenerational transmission

Mechanisms behind the intergenerational patterns of mental health reflect a complex web of genetic and environmental factors (e.g. genes, poverty, disadvantage, attachment, parenting, social support, education).

Childhood abuse (including CSA) or trauma can increase the risk of perinatal mental illness and research shows that the earlier the abuse, the worse the effects.

Parental MH is an important determinant of a child's mental health – if we want to improve the emotional health of children, we should focus on families.



https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4677138/

Self-Harm/ Suicide in the Perinatal Period

- Pregnancy and childbirth is a time of significant adjustment.
- When a person has poor coping abilities and have experienced a difficult past they are more likely to find the perinatal period difficult to adjust to. Risk factors include: Childhood adversity, difficult social situations, poor relationships, history of self-harm, previous suicide attempt
- Self-harm is not usually the same as attempted suicide but the risk of killing yourself is greater than for people who don't self-harm
- **Clinicians should feel confident that they will not trigger someone to harm themselves by asking if they are experiencing thoughts of self-harm/suicide**
- **If mothers answer yes to self-harm question, enquiries should be made about thoughts of harming their baby**

Suicide Risk: Considerations

PAIN

- How painful is the experience?
- Is there a lack of hope?

PLANS

- Made specific plan/active preparation?
- Method /availability/ effectiveness?
- Timing, strength and frequency of suicidal thoughts/urges

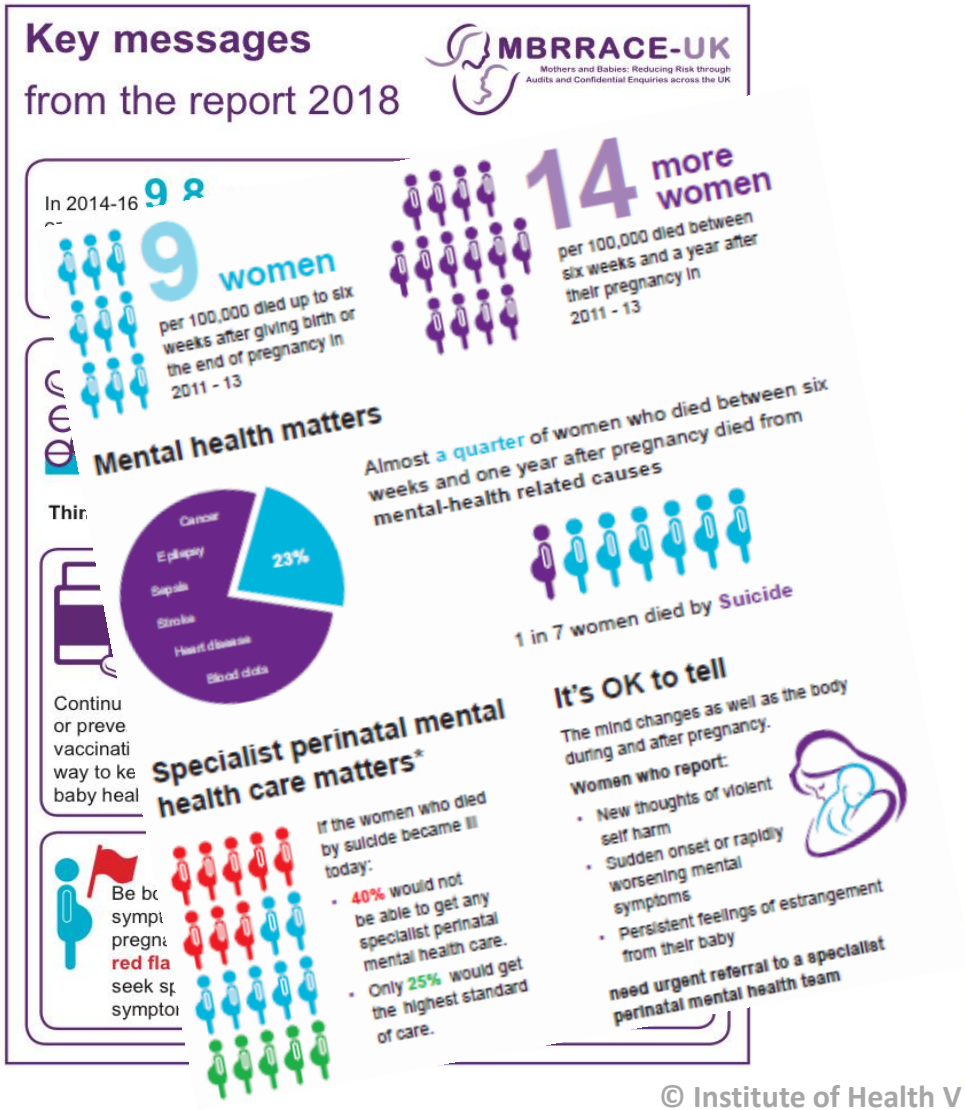
PROTECTIVE FACTORS

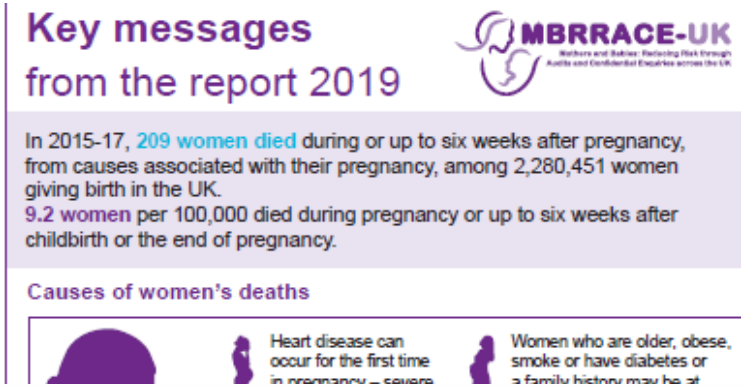
- Internal/external resources self/actual?
- What has she got to live for?
- What support does she have (what support do the people who support her have)?

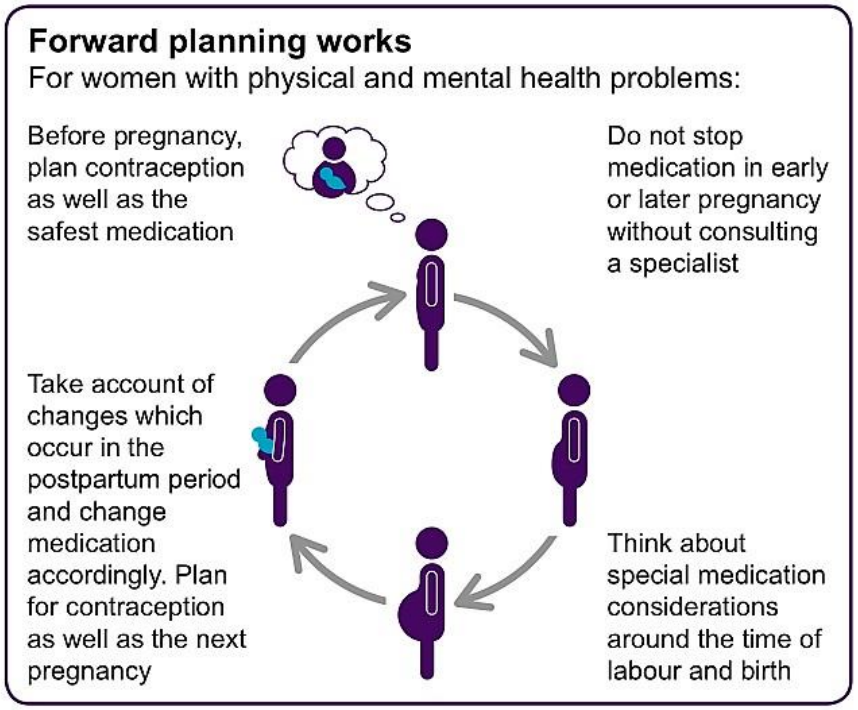
PREVIOUS ATTEMPTS

- Serious attempt by self or significant other

MBRRACE 2015-2020







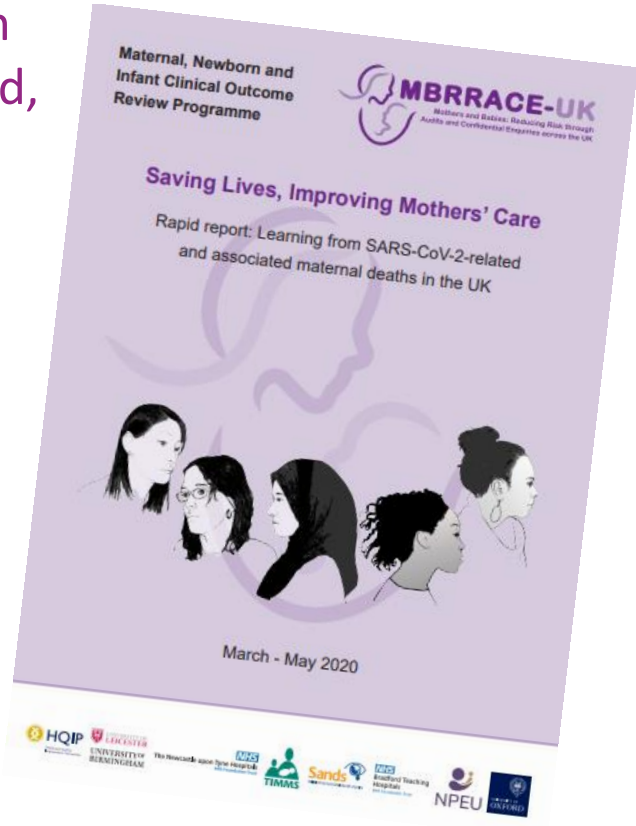
MBRRACE 2020

- Establish triage processes to ensure that women with mental health concerns can be appropriately assessed, including face-to-face if necessary, and access specialist PMH services in the context of changes to the normal processes of care due to COVID-19.

- PMH services are essential and face to face contact will be necessary in some circumstances.

- There is a clear role for involvement of the lead mental health obstetrician or midwife in triage and clinical review.

- Ensure that referral with mental health concerns on more than one occasion is considered a ‘red flag’ which should prompt clinical review, irrespective of usual access thresholds or practice.



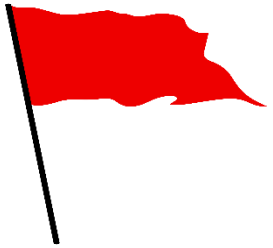
SUICIDE: Amber Flags (MBRRACE 2017)

Women with any past history of psychotic disorder should be regarded as at elevated risk in future postpartum periods and should be referred to mental health services in pregnancy for an individualised assessment of risk and development of a postpartum plan

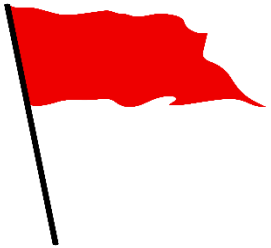
Women with a family history of postpartum major mental illness should be closely monitored by maternity and primary care services in late pregnancy and the early postpartum period. Where they themselves are currently unwell in pregnancy or have had previous postpartum mood destabilisation, they should be referred to mental health services as soon as possible in pregnancy to receive an individualised assessment of risk and development of a plan

The personal and familial pattern of occurrence and re-occurrence of postpartum mood disorder should inform risk minimisation strategies.

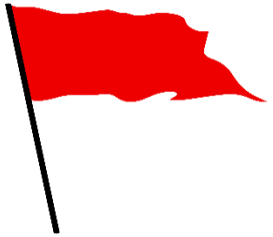
SUICIDE Red Flags



Recent significant change in mental state or emergence of new symptoms



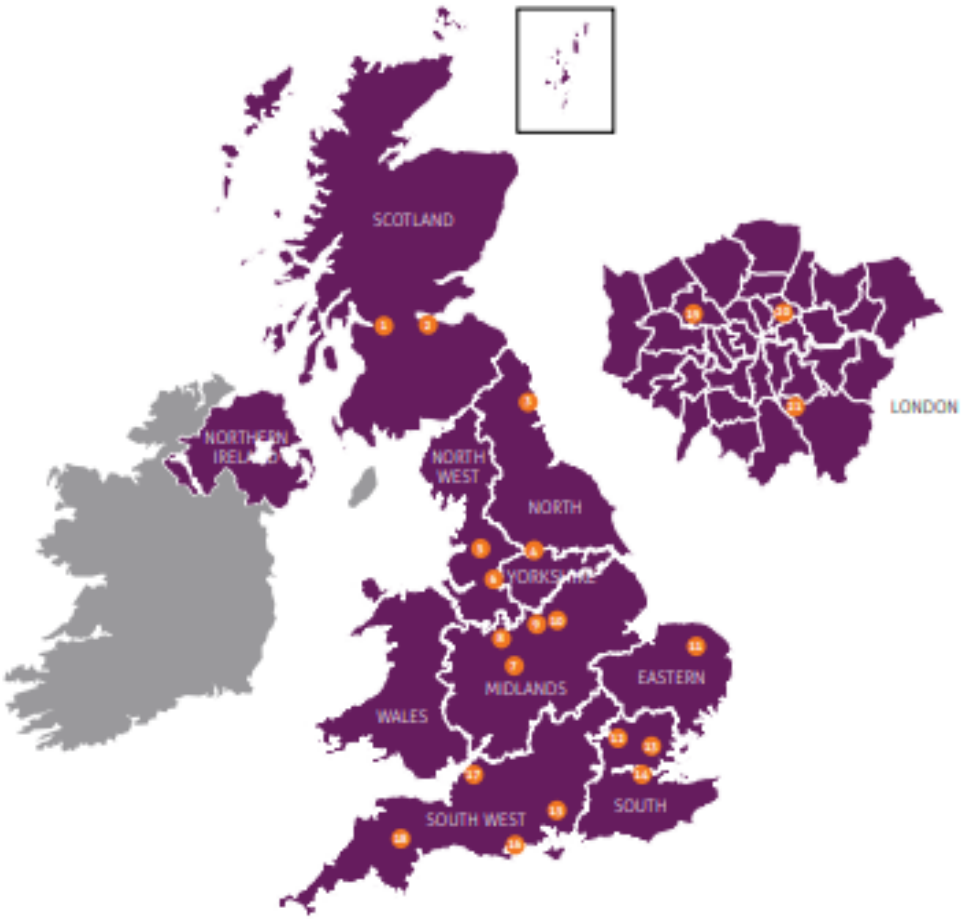
New thoughts or acts of violent self-harm



New or persistent expressions of incompetency as a mother or estrangement from the infant

Admission to a Psychiatric MBU should always be considered when:

- Rapidly changing mental state
- Suicidal ideation (particularly of a violent nature)
- Pervasive guilt or hopelessness
- Significant estrangement from the infant
- Beliefs of inadequacy as a mother
- Evidence of psychosis



SCOTLAND

1. **NHS Lothian Livingston Mother and Baby Unit (6 beds)**
   St Johns Hospital, Howden Road West, Howden, Livingston, West Lothian, EH54 6PP
   Tel: 01506 523000

2. **West of Scotland Mother and Baby Mental Health Unit (6 beds)**
   Leverndale Hospital, 510 Crookston Road, Glasgow, G53 7TU
   Tel: 0141 211 6500

NORTH EAST / YORKSHIRE

3. **Beadnell Mother and Baby Unit (6 beds)**
   Northumberland, Tyne and Wear NHS Trust, St Georges Hospital, Morpeth, Northumberland, NE61 2NU
   Tel: 01670 501869

4. **Leeds Partnership NHS Foundation Trust Mother and Baby Unit (8 beds)**
   The Mount, 44 Hyde Terrace, Leeds, LS2 9LN
   Tel: 0113 8555509

NORTH WEST

5. **Ribblemere Mother and Baby Unit (8 beds)**
   Chorley and South Ribble District General Hospital, Preston Road, Chorley, PR7 1PP
   Tel: 01772 520780

6. **Manchester Mother and Baby Unit (10 beds)**
   Andersen Ward, Laureate House, Wythenshawe Hospital, Southmoor Road, Wythenshawe, Manchester, M23 9LT
   Tel: 0161 291 6829; Fax: 0161 291 6821

   Please note, although located in the North East, the Beadnell Mother and Baby unit is also able to take referrals from the North West. Please see the North East section for contact details.

MIDLANDS

7. **Barberry Mother and Baby Unit (10 beds)**
   Barberry National Centre for Mental Health, 25 Vincent Drive, Edgbaston, Birmingham, B15 2FG
   Tel: 0121 3012090

8. **Brockington Mother and Baby Unit (8 beds)**
   South Staffordshire and Shropshire Foundation Trust, St Georges Hospital, Corporation Street, Stafford, ST16 3AG
   Tel: 01785 221560 / 01785 221554

9. **Derby Mother and Baby Unit (6 beds)**
   The Beeches Unit, Radbourne Unit, Uttoxeter Road, Derby, DE22 3WQ
   Tel: 01332 625828

10. **The Margaret Oates Mother and Baby Unit (8 beds)**
    Hopewood, Foster Drive, Nottingham, NG5 3FL
    Tel: 0115 952 9481 ext. 12825

EASTERN

11. **Kingfisher Mother and Baby Unit (8 beds)**
    Hellesdon Hospital, Drayton High Road, Norwich, Norfolk, NR6 5BE
    Tel: 01603 786745

SOUTH / SOUTH WEST

12. **Thumbswood Mother and Baby Unit (6 beds)**
    Hertfordshire Partnership NHS Foundation Trust, 2 Bowlers Green, Kingsley Green, Harper Lane, Nr Radlett, WD7 9HQ
    Tel: 01923 633880

13. **Rainbow Mother and Baby Unit (5 beds)**
    The Linden Centre, Pudding Woods Drive, Chelmsford, CM1 7LF
    Tel: 01245 315629

14. **Rosewood Mother and Baby Unit (8 beds)**
    Greenacres, Bow Arrow Lane, Dartford, Kent, DA2 6PB
    Tel: 01322 622101

15. **Winchester Mother and Baby Unit (10 beds)**
    Southern Health Foundation Trust, Melbury Lodge, Romsey Road, Winchester, SO22 5DG
    Tel: 01962 897711

16. **Florence House (5 beds)**
    St Ann's Hospital, Dorset Health Care University NHS Trust, 49 Alumhurst Road, Bournemouth, BH4 8EP
    Tel: 01202 584320

17. **The New Horizon Mother and Baby Centre (4 beds)**
    Avon and Wiltshire Mental Health Partnership and NHS Trust, Southmead Hospital, Dorian Way, Westbury-on-Trym, Bristol, BS10 5NB
    Tel: 0117 414 7270

18. **Jasmine Lodge Mother and Baby Unit (8 beds)**
    Wonford House, Dryden Road, Exeter, EX2 5SN
    Tel: 01392 539100

LONDON

19. **Coombe Wood Perinatal Health Unit, (10 beds)**
    Park Royal Centre for Mental Health, Acton Lane, London, NW10 7PL
    Tel: 020 8955 4495/6/8

20. **East London Mother and Baby Unit (12 beds)**
    Homerton Hospital, Homerton Row, Hackney, London, E9 6SR
    Tel: 020 8510 8620

21. **Channi Kumar Mother and Baby Unit (13 beds)**
    South London and Maudsley NHS Foundation Trust, Bethlem Royal Hospital, Monks Orchard Road, Beckenham, Kent, BR3 3BX
    Tel: 020 3228 4255

https://maternalmentalhealthalliance.org/campaign/maps/
https://www.nhswebbeds.co.uk/

Medication in pregnancy and breastfeeding: Resources for families and professionals

The UK Teratology Information Service provides information for healthcare professionals on the safely of drugs in pregnancy.

Best Use of Medicines in Pregnancy provides information leaflets on the safety of drugs in pregnancy.

UK Drugs in Lactation Service (UKDILAS) The UKDILAS service provides evidence based information on the use of drugs during the breastfeeding period. This website contains links to articles on the safety profile of individual drugs or groups of drugs.

Breastfeeding Network a useful website for families including factsheets on safety of medications in breastfeeding.

LactMed the Drugs and Lactation Database of the US National Library of Medicine.

MHRA Toolkit on the Risks of Valproate Medications in Female Patients MHRA film on the risks of taking Valproate medications during pregnancy.

Royal College of Psychiatry: the use of antipsychotics in pregnancy and breastfeeding

Royal College of Psychiatry: the use of lithium in pregnancy and breastfeeding

Options for help: How does your local area compare?

- MBU/Hospital Admission
- Parent-Infant Psychotherapy
- IAPT: Talking Therapies
- Specialist PMH/IMH/P-I/HV/MW Services
- CAMHS
- Health Visitor Therapeutic Interventions (Emotional Well-Being Visits)
- Medication
- Cognitive Behavioural Therapy (CBT)
- VIG/VIPP
- Motivational and Promotional Interviewing
- Solution-Focused/Problem Solving
- Person-centered therapy/ Non Directive Counselling/ Counselling
- Mindfulness
- Exercise and Healthy Eating (local healthy lifestyle schemes: RSM, Yoga)
- Social inclusion/Groups/Social Prescribing/Bibliotherapy
- Family Support, Children Centres, Home Start, Sure Start
- Facilitated self-help
- Online resources and information: NHS Choices, IAPT, Getting to Know your Baby,
- Groups (peer led/professional led)

Challenges to timely identification and help

Families

- Stigma
- Fear of what others think- being judged
- Fear of social services and baby being removed
- Cause of PMH problems
- Mental health literacy
- Practical barriers (access, availability/affordability)
- Previous experience
- Time

Practitioner

- Opportunity to build trusting relationships
- Continuity of care
- Lack of knowledge, confidence and training
- Lack of services to refer on to
- Systems- IT, Referral pathways
- Poor integration
- Staff shortage
- Supervision

PMH Experiences of Women and Health Professionals: Wellbeing Plan

[Your baby's Mum- digital wellbeing plan]

Boots Family Alliance Survey (2013) collated the PMH experiences of:

- 2070 health professionals
- 269 Other Professionals
  - 1330 HVs
  - 365 MWs
  - 106 FNP
- 1547 women

Safeguarding and Parental Mental Illness

Over 2 million children are estimated to be living with a parent who has a common mental health disorder

Many parents with a PMH problem can parent well, however, PMH problems are frequently present in cases of child abuse or neglect

A diagnosis alone does not equate to safeguarding issues. Most parents who experience mental illness do not neglect or harm their children simply because of the disorder

Children become more vulnerable to abuse and neglect when parental mental illness coexists with other problems such as substance misuse, domestic violence or childhood abuse

Where risk is present, it is important to balance this with known protective factors, being mindful of the impact of parental difficulties on the daily lived experience of the child

https://www.youtube.com/watch?v=XHgLYI9KZ-A

Drug and alcohol use & Parental Mental Illness

- *It's OK to tell:* It's OK to ask for help for help if you are worried about your drug or alcohol intake.

- *It's OK to ask:* You are entitled to support and referral to addiction services in your area.

"I *sometimes did feel safe with mummy and sometimes I didn't. Because there was safe people and unsafe people [in the house], and I didn't like when mummy was ill, and she was drinking. Because she was ill and sometimes she would shout at us." –* 8 year old girl"

DVA & Parental Mental Illness

Domestic violence and abuse:

- Perinatal period represents period of higher risk of domestic abuse. Practitioners need to be alert to signs and women should be given opportunity to disclose in safe environment
- **All professionals should ask about DVA routinely, whether there are indicators or not ***
- Women in perinatal period who repeatedly attend A&E and/or with unusual symptoms should be discussed with maternity team and GP informed
- Practitioners should know local options for help and be clear how to escalate concerns

"If they, my parents, are fighting then I normally go with my brother and hide upstairs and we don't feel very safe in that environment where something is going on downstairs, we're not very aware of what's happening. You can hear my mum crying, my dad shouting and screaming and sometimes you can hear whacks of my mum being hit and when my dad eventually goes to work we come downstairs knowing it's quite safe, seeing my mum in tears and having bruises all over herself." 10 year old girl

https://www.vamhn.co.uk/

Reflection and share point:
PMH, Equality, diversity and inclusive services

How do you and your service ensure ALL families receive high quality, safe and effective care?

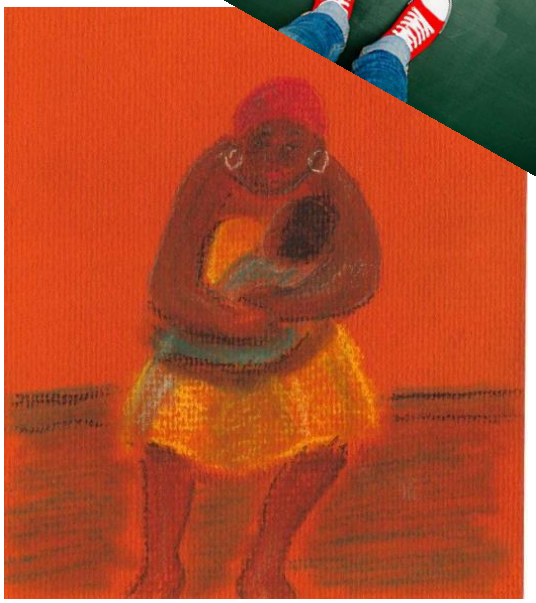
For example:

1. Parents who identify as LGBTQ

2. Parents from an ethnic minority group

3. Parents with a learning disability

4. What other groups?



Policy and Research

- Mental health and the Journey to Parenthood (2019)
- Infant Mental Health Competencies Framework (AIMH, 2019)
- PMH Curricular Framework: A framework for maternal and infant mental health (2019)
- The NHS Long Term Plan (2019)
- WHO's Nurturing Care Framework (2018)
- From bumps to babies: PMH care in Wales (2018)
- The Perinatal Mental Health Care Pathways (2018)
- MBRRACE-UKSaving Lives, Improving Mothers' Care (2015, 2017, 2018, 2019)
- Every mother must get the help they need (2017)
- Womens Voices (2017)
- Next Steps on the Five Year Forward View for Mental Health (2017)
- The Prevention Concordat (2017) -Call to Action (2017)
- Specialist Health Visitors in PIMH: What they do and why they matter (2016)
- Associations between maternal-foetal attachment and infant dev. outcomes (2016)
- NICE QS 115 (2016)
- National Maternity Review (2016)

Policy and Current Research

- Falling Through the Gaps Practical implications for primary care of the NICE CG192 (2015)
- Building Great Britons (2015)
- NICE CG 192 (2014)
- Cost of Perinatal Mental Health Problems (2014)
- Service Standards: Second Edition Perinatal Community Mental Health Services (2014)
- Psychological adversity in pregnancy (2014)
- DOH -6 High Impact Areas (2014)
- Futures in Mind (2014)
- Cross Party Manifesto, The 1001 Critical Days (2013)
- NSPCC -Prevention In Mind (2013)
- Wave Trust -Conception to Two (2013)
- Boots Family Trust -Wellbeing Plan (2013)
- Joint Commissioning Panel for MH: Guidance for Commissioners of PMH Services (2012)
- Management of Women with Mental Health Issues during Pregnancy and the Postnatal Period (2011)
- No Health without Mental Health (2011)