Keeping Bristol Safe Partnership

Multi-Agency Protocol for Perinatal Mental Health

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V2	30/04/20	JSBU PSO ZC	Rebranding of protocol to incorporate new KBSP logo.
V3	13/5/20	JSBU PPO OK	Full review of protocol to include changes to Appendix 4 -Specialised Community Perinatal Mental Health Team Interim Postnatal Pathway. All links in protocol checked. Postpartum psychosis added to include 4 hour timescale for patient to be seen. All links to documents checked for accuracy.

Keeping Bristol Safe Partnership
Multi-Agency Protocol for
Perinatal Mental Health

July
2020

PERINATAL POSITIVITY

Looking after your MENTAL WELLBEING...

...through pregnancy and beyond

Be kinD to YouRselF.

BE PREPARED

(Educate yourself and others) ★ IMPORTANT

BUILD YOUR VILLAGE

It takes a village to raise a child

REMEMBER

Even though you feel alone

You are not the only one

The Voice of Bristol Women– tips for professionals to remember

Work carried out by Bluebell Care and the KBSP with families affected by Perinatal Mental Health

Courtesy of ForMed Films CIC and Bristol City Council

Women will talk openly and honestly if:

- They are amongst non-judgmental people
- Given more privacy
- Contact with fully trained staff that understand
- Given enough time to discuss feelings
- Better signposting of services
- Better relationships with professionals takes time
- Not in a clinical environment
- Not given answers such as 'It gets easier.'
- Professionals asking how are you feeling
- Better access to support services
- To be taken seriously
- No clock watching

Barriers that stop (have stopped) women accessing services they need(ed):

- Guilt
- Feeling not listened to and misunderstood
- Not knowing they are for me
- I don't have a diagnosis of depression but feel unwell
- Distance to services and transport
- Long waiting lists
- Fear
- Thinking I would be branded as a bad mum
- Not knowing if I am unwell enough
- Feeling that services are only for people with a diagnosis
- Feeling that a GP did not understanding Mental Health and was saying the wrong thing

The importance of a key worker:

- Important that someone knows you
- So helpful and more organised
- Access to professionals with expertise from conception until 2 years after birth would help
- Repeating everything is really difficult
- It stops you slipping through the net
- For people really struggling it would help a lot
- Info sharing between professionals needs to be better
- Someone who can sort things out and put things in place straight away

What more could be done to help:

- Being listened to
- Information given earlier
- A point of contact with someone that knows you
- More collaboration
- A clear Care Plan
- More services for Dads and better awareness of
- De-briefings for patients that need answers to get extra help
- Stop the miscommunication between professionals
- Reduce the fear
- Childcare

Contents

Introduction

The Perinatal Period includes pregnancy and the year following birth. During this period women can be affected by a whole range of mental health problems. These can range from mild anxiety such as panic attacks through to depression and sometimes severe mental illness after child birth such as Postpartum Psychosis (Puerperal Psychosis). All conditions can be prevented, treated or managed.

Statistics

Out of 6000 woman who give birth every year, over 500 of these mothers will experience levels of depression or anxiety sufficient for them to benefit from some form of treatment or support

IMPROVE HIT Bristol Health Partners

Mental illness can have a devastating effect on woman and their families. Effective and timely detection, intervention and support can prevent and minimise the harm that can be done. Illnesses such as this can be diverse and complex. A good understanding of the signs, symptoms, effects and consequences that mental health can have is vital. It is important to mitigate the effects it can have on the woman and their family and improve the wellbeing of children and their health. This is every professional's responsibility and requires a well-defined coordinated Multi-Agency response.

"By intervening early, providing specialist advice, interventions and education, we have the perfect opportunity to facilitate recovery, promote well-being and attachment between mothers and their babies, to raise awareness and to reduce the impact of mental health conditions on the next generation."

Dr. Leanne Hayward, Avon and Wiltshire Mental Health Partnership Trust
Consultant Psychiatrist and Clinical Lead

Purpose of Protocol

The purpose of this protocol is to ensure that there is a clear understanding of the systems/pathways in place within Bristol. It will address the importance of professionals taking collective responsibility for the woman, her baby and the family and responding effectively to concerns around Perinatal Mental Health. This will be achieved by signposting at the earliest opportunity, greater role awareness and maintaining clear, concise and regular communication between professionals and partner agencies to achieve better outcomes for women, babies, fathers/partners and their families.

It is important to note that this protocol is for professionals to increase their awareness of Perinatal Mental Health to enable them to work more robustly and with confidence. Through their commitment and awareness, professionals will be able to encourage and
nurture openness, honesty and trust with woman to break down the barriers and sigma that
exists.

"Knowing that what I'm feeling isn't unusual or odd has been such a relief."

Quote from a woman supported by Bluebell Care.

Perinatal Mental Health

Women that experience mental health issues in the perinatal period can often have no history of mental illness. Any women regardless of socio economic status can be affected. Others with pre-existing issues could experience a deterioration or reoccurrence of past health issues as a result of the changes to the woman's body emotionally and physically or because of a change in medication.

Anxiety can also be caused from an adjustment in lifestyle, increase in financial pressures, poor heath, and problematic/abusive relationships. We must also acknowledge significant pressure and adjustment faced by the fathers who too can experience depression. Considerable pressure can also be placed on the family dynamics.

The negative impact of mental illness can be exaggerated by the stigma associated with mental illness. Women and their families can feel isolated and alienated and disguise their symptoms due to negative comments or attitudes that may surround them. This can cause further mental health deterioration.

Mental Illness during pregnancy, birth and the postpartum period can present itself in many different ways, each with their own symptoms but all requiring some form of support or intervention.

Prevalence Data

In 2015 there were 6,200 maternities in Bristol. Rates (per 1,000 maternities) of new mothers with Perinatal Psychiatric Disorders are shown below, along with estimates of how
many women are affected locally:

Severe perinatal Mental Health conditions	**Rates (per 100 maternities)**	**Estimated numbers in Bristol (2015)**
Post-Partum psychosis	**2 per 1000**	**12**
Chronic Serious Mental Illness	**2 per 1000**	**12**
Severe Mental Illness	**30 per 1000**	**186**
Mild to Moderate illness and anxiety states (lower estimate)	**100-150 per 1000**	**620**
Mild to Moderate illness and anxiety states (higher estimate)		**930**
Post-traumatic Stress Disorder	**30 per 1000**	**186**
Adjustment disorders and distress (lower estimate)	**150-300 per 1000**	**930**
Adjustment disorders and distress (higher estimate)		**1, 860**

Rates of Perinatal Psychiatric Disorder (per 1000 maternities) Source: Royal College of Psychiatrics, 2012 supplied via Bristol Public Health Knowledge Service, 2016

It is important to note that each of these conditions often do not happen in isolation, there can be secondary mental illnesses. The severity and risks for woman with perinatal mental health issues can also alter quickly and can often be complex.

Postpartum psychosis

This is a severe mental illness that affects woman after the birth of their child. It is typically after the weeks that follow delivery. It can become severe very quickly and should be treated as a psychiatric emergency, with the woman being seen within 4 hours.

Symptoms can be;

- Hallucinations – seeing or hearing things that are not there
- Delusions – thoughts or beliefs that are not true
- High mood (mania) she may talk to herself, too much or too quickly and feel on top of the world or be more social than they would be normally.
  Loss of inhibitions
- Paranoia – feeling suspicious or fearful
- Low mood – signs of depression, withdraw, anxiety, irritability, tearful, lack of energy, loss of appetite, aggressive, trouble sleeping
- Severe Confusion
- Rapid change of mood
- Behaviour out of character
- Feeling as if in a dream
- Thinking about suicide and self-harm
- Frightening thoughts such as hurting the baby
- Feeling of guilt, hopelessness and blame
- Difficulty bonding with the baby
- Withdrawing from contact with people
- Neglecting themselves such as not washing
- Losing sense of time
- Constantly worrying

Chronic Serious Mental Illness

These are longstanding Psychotic illnesses such as Schizophrenia, or Bipolar disorder. These are more likely to develop, reoccur or deteriorate in the perinatal period, with women who are diagnosed as having bi-polar at increased risk of relapse post birth and with postpartum psychosis

Symptoms can be very specific to that particular condition however symptoms could be:

- ☐ Manic or hypomanic episodes (feeling high). This may make the woman behave in a very specific way
- ☐ Depressive episodes (feeling low)
- ☐ Potentially some psychotic symptoms during manic or depressive episodes
- ☐ Mixed episodes (feeling high and low)
- ☐ A lack of interest in things
- ☐ Feeling disconnected from their feelings
- ☐ Wants to avoid people
- ☐ Hallucinations
- ☐ Delusions
- ☐ Disorganised thinking and speech
- ☐ Self-neglect

According to MIND[1] manic episode can lead the woman to:

- ☐ Feel unhappy or ashamed about how they behaved **(This is important to note as this could significantly increase the risk of self-harm and suicide).**
- ☐ make commitments or take on responsibilities that now feel unmanageable
- ☐ have only a few clear memories of what happened when you were manic, or none at all
- ☐ feel very tired and need a lot of sleep and rest
- ☐ mental health problem, such Bipolar Disorder and Schizophrenia may be followed by an episode of Depression

Severe depressive illness

This is the most severe form of Depression and can be life threatening. This is where the woman's ability to function normally can be impaired. The symptoms can be severe and persistent[2]

- ☐ feelings of being overwhelmed
- ☐ intense anxiety
- ☐ frequent crying or weeping
- ☐ irritability or anger
- ☐ pervasive sadness
- ☐ fatigue or low energy
- ☐ feelings of worthlessness, hopelessness, or guilt
- ☐ changes in sleeping or eating habits

- ☐ lack of concentration or forgetfulness
- ☐ intense worries about the baby
- ☐ a lack of interest in the newborn or once pleasurable activities
- ☐ physical symptoms such as headaches, chest pains, or hyperventilation
- ☐ frequent crying or weepiness
- ☐ trouble sleeping not related to frequent urination
- ☐ fatigue or low energy
- ☐ changes in appetite
- ☐ loss of enjoyment in once pleasurable activities
- ☐ increased anxiety
- ☐ poor fetal attachment
- ☐ rapid mood change

Obsessive Compulsive Disorder (OCD) and intrusive thoughts

OCD is a condition whereby you have repetitive thoughts and behaviors which you are unable to control. Intrusive thoughts are unwanted and unpleasant thoughts or images that can cause anxiety, stress and impair an individual's functioning. They can be harmful, violent and sexually inappropriate.

Symptoms can include:

- Impact on/reduced functioning
- Disturbing thoughts to harm others and children
- Pre occupation
- Increased and anxiety and stress
- Avoidance specific triggers and/or tasks
- Ritualized behaviors
- Obsessive thoughts, images or worries

Intrusive thoughts are a symptom OCD

Post-traumatic stress disorder (PTSD)

Post-traumatic stress disorder can develop following a major traumatic event. It can affect people of all ages. This could be in response to 'a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone' or a major traumatic event such as 'exposure to actual or threatened death, serious injury, or sexual violence.'

Complex post-traumatic stress disorder may develop after extreme prolonged or

repeated trauma (such as repeated childhood sexual abuse or prolonged captivity involving torture) and is particularly prevalent in those who have experienced a major

disaster such as refugees or asylum seekers. Mental health problems, particularly post-traumatic stress disorder (PTSD), are associated with experiencing a traumatic childbirth, stillbirth or the death of a baby1, 2:

"Specific traumas including stillbirth, infant complications and other forms of traumatic childbirth experiences are associated with mental health problems, particularly PTSD."2 (pg.31)

NICE defines traumatic births as: "births…which are physically traumatic…and births that are experienced as traumatic, even when the delivery is obstetrically straightforward."1

A stillborn baby is one born after 24 completed weeks of pregnancy with no signs of life. The stillbirth rate is the number of stillbirths per 1,000 total (live and still) births. There were 97 stillbirths in Bristol in the period 2011-2013: a stillbirth rate of 4.8 stillbirths per 1,000 births. (Source: ONS Births).

Symptoms can be:

Re-experiencing symptoms — which may occur in the daytime when the person is awake flashbacks, or intrusive images or thoughts) or as nightmares when asleep. Avoidance of people or places that remind the person of the event

Emotional numbing/negative thoughts, where the person expresses a lack of ability to experience feelings or feels detached from other people, or has negative thoughts about themselves

Hyperarousal/hyper reactivity, where the person is on guard all the time, looking for danger (hypervigilance), or the person has irritable behaviour or angry outbursts with little or no provocation. The need for emergency medical or psychiatric referral should be assessed by looking for the presence and severity of secondary psychological disorders

Secondary psychological difficulties can occur and increase the risks and severity and include :

- ☐ Depression such as feeling down, depressed, or hopeless. Little interest or pleasure in doing things that were previously enjoyed
- ☐ Generalized anxiety disorder
- ☐ Panic disorder.
- ☐ Drug or alcohol misuse

Personality Disorders

Personality disorders can include borderline, emotionally unstable, narcissistic and avoidant.

The most common type is emotionally unstable personality disorder and more recently this has also been referred to as complex post traumatic stress disorder (PTSD)

Fear of abandonment

Intense emotions that rapidly change

Difficulties in relationships

Emotional dysregulation

Impulsive acts including self-harm, overdose

Suicidal thoughts

Potential for paranoia and psychotic experiences when stressed e.g. hearing/seeing things that are not there

Often linked to childhood trauma

Mild to Moderate depressive illness and anxiety

This can be can be anything from persistent sadness, fatigue, loss of interest and can occur with anxiety, stress, uncomfortable worries, panic and obsessive thoughts:

- ☐ feeling tense, nervous and on edge
- ☐ having a sense of dread, or fearing the worst
- ☐ feeling like the world is speeding up or slowing down
- ☐ feeling like other people can see that you're anxious and are looking at you
- ☐ feeling your mind is really busy with thoughts
- ☐ dwelling on negative experiences, or thinking over a situation again and again (this is called rumination)
- ☐ feeling restless and not being able to concentrate
- ☐ feeling numb
- ☐ tense muscles and headaches
- ☐ pins and needles
- ☐ feeling light headed or dizzy
- ☐ faster breathing
- ☐ sweating or hot flushes
- ☐ a fast, thumping or irregular heartbeat
- ☐ raised blood pressure
- ☐ difficulty sleeping
- ☐ needing the toilet more frequently, or less frequently
- ☐ churning in the pit of your stomach
- ☐ Experiencing acute panic attacks

Adjustment disorders and distress

This happens when a woman is unable to adjust or cope with factors such as a changing body, birth, becoming responsible for a child. There can be a distress reaction that lasts longer, or more excessive than would be expected, but does not significantly impair normal function Symptoms can be;

- ☐ feeling sad and low
- ☐ tearful for no apparent reason
- ☐ worthless
- ☐ hopeless about the future
- ☐ tired
- ☐ feeling unable to cope
- ☐ irritable and angry
- ☐ guilty
- ☐ hostile or indifferent to woman's husband or partner
- ☐ hostile or indifferent to the baby
- ☐ lose of concentration
- ☐ disturbed sleep
- ☐ Finding it hard to sleep – even when there is an opportunity
- ☐ have a reduced appetite
- ☐ lack of interest in sex
- ☐ thoughts about death

Risk factors for mental health problems during pregnancy and after childbirth

Many of the risk factors associated with mental health problems during pregnancy and after childbirth reflect those associated with mental illness in the general population.[5] [6] These risk factors increase the likelihood of maternal mental health problems in a local population. Remember that at a clinical level individuals are much more complex than this, and there is
a wide range of factors that can contribute to their risk of mental illness.

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[4] Hogg, S. (2013) Prevention in mind: All Babies Count: spotlight on perinatal mental health. [London]: NSPCC. p.11

[5] National Collaborating Centre for Mental Health. Antenatal and postnatal mental health: clinical management and service guidance. Updated edition. NICE guideline (CG192). Leicester and London: The British Psychological Society and The Royal College of Psychiatrists, 2014 (cited 2015 Jun 8). Available from: www.nice.org.uk/guidance/cg192/evidence

[6] National Collaborating Centre for Primary Care. Clinical guidelines and evidence review for post-natal care: routine post-natal care of recently delivered women and their babies. NICE guideline (CG37). London: National Collaborating Centre for Primary Care and Royal College of General Practitioners, 2006 (cited 2015 Jun 8). Available from: http://www.nice.org.uk/guidance/cg37/evidence

Factors associated with an increased risk of (but do not determine) perinatal mental illnesses

- History of Mental illness
- Drug or alcohol usage or addiction
- Traumatic childbirth, stillbirth and infant mortality
- Psychological disturbances during pregnancy such as anxiety or depression
- Lone parent and couple relationship
- Lack of support
- Domestic Violence and abuse
- Stress from other issues
- Socio-economic disadvantage
- Teenage parenthood
- Early trauma or experience of abuse
- Unwanted pregnancy
- Eating Disorders
- Other (some cases can be complex

History of mental health problems

Women who have a history of mental health problems before becoming pregnant are at increased risk of certain mental health conditions during pregnancy and the year after childbirth[7] [8] [9] therefore if there is a higher than average rate of mental health problems in your local general population, there may be a higher level of maternal mental health problems as well. This also refers to a history within the family of mental health problems but refers specifically to the first degree female relative such a mother or sister with a history of postpartum psychosis, bi-polar affective disorder and severe depression.

[7] National Collaborating Centre for Primary Care. Clinical guidelines and evidence review for post-natal care: routine post-natal care of recently delivered women and their babies. NICE guideline (CG37). London: National Collaborating Centre for Primary Care and Royal College of General Practitioners, 2006 (cited 2015 Jun 8). Available from: http://www.nice.org.uk/guidance/cg37/evidence

[8] NICE (Internet). NICE clinical knowledge summaries. Depression - antenatal and postnatal. London: National Institute for Health and Clinical Excellence; 2013 (updated 2013 Jan; cited 2015 June 08). Available from: cks.nice.org.uk/depression-antenatal-and-postnatal

[9] NICE. Antenatal and postnatal mental health: clinical management and service guidance. NICE guidelines (CG192). London: National Institute for Health and Care Excellence, 2014 (cited 2015 Jun 8). Available from: www.nice.org.uk/guidance/cg192

Domestic violence and abuse

Living in a household where domestic abuse is occurring is also a risk factor for poor mental health in babies and toddlers: “The impact of living in a household where there is a regime of intimidation, control and violence differs by children's developmental age. However, whatever their age, it has an impact on their mental, emotional and psychological health and their social and educational development. [10]

Drug and alcohol misuse

If a parent or caregiver misuses alcohol or drugs, there can be an impact on a baby or toddler’s development, often due to parenting problems:

Research has shown that parents misusing substances are at risk of a wide range of difficulties associated with their role as a parent. These may include a lack of understanding about child development issues, ambivalent feelings about having and keeping children and lower capacities to reflect on their children’s emotional and cognitive experience.

In terms of alcohol misuse, NICE guidance stresses the importance of taking account of “the impact of the parent's drinking on the parent–child relationship and the child's development, education, mental and physical health, own alcohol use, safety, and social network”[12].

The NSPCC report ‘All babies count: spotlight on drugs and alcohol’ highlights the effect of alcohol misuse on parenting:

“Problematic drinking by parents is associated with negative parenting practice…and parenting capacity can be compromised when parents become increasingly focused on drinking and as a result become less loving, caring, nurturing, consistent or predictable.” 13 (pg. 6)

10

[11] Rayns G, Dawe PS, Cuthbert C. All babies count: spotlight on drugs and alcohol. London: NSPCC, 2013 (cited 2015 Jul 22). Available from: www.nspcc.org.uk/services-and-resources/research-and-resources/2013/all-babies-count-drug-alcohol/

[12] NICE. Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence. NICE guidelines (CG115). National Institute for Health and Clinical Excellence, 2011 (cited 2015 Jul 15). Available from: www.nice.org.uk/guidance/cg115

Poor social support

Women who lack social support have been found to be at increased risk of antenatal and postnatal depression· Having a poor relationship with a partner is also a risk factor for postnatal depression[10].

ONS statistics show that infant mortality rates are higher among babies that are sole registered than for other registration types[14]

The number of births which were registered by just the mother is presented here to give a rough indication of the number of women in our local area that are likely to lack the support of the father during pregnancy and as a new mother. The following table shows the proportion of births that were sole registrations

Sole registrations of births

Bristol	5.4% (346)
South West	4.5%
England	5.4%

Source: Office for National Statistics

Balancing the needs of the service user with the needs of the child

In order to balance the needs of the service user with the needs of the child it is important that professionals have an understanding of the effects that perinatal mental health can have on the child both pre and post birth.

"Failure to treat (perinatal depression) promptly may result in a prolonged, deleterious (negative) effect on the relationship between the mother and baby and on the child's psychological, social and educational development."15 (p. 1)

SIGN Guidelines 127

[13] Rayns G, Dawe PS, Cuthbert C. All babies count: spotlight on drugs and alcohol. London: NSPCC, 2013 (cited 2015 Jul 22). Available from: www.nspcc.org.uk/services-and-resources/research-and-resources/2013/all-babies-count-drug-alcohol/

[14] Office for National Statistics. Gestation-specific infant mortality, 2013 (Internet). Newport: ONS, 2015 (cited 2015 Nov 19). Available from: www.ons.gov.uk/ons/rel/child-health/gestation-specific-infant-mortality-in-england-and-wales/2013/stb-gestation-specific-infant-mortality.html

It is important to remember that not all babies or toddlers with certain risk factors will have poor mental health however it is important to note that there is evidence to suggest that depression and anxiety during these periods have adverse effects on a child's outcome where they fail to reach their potential. The NICE guidance on social and emotional wellbeing in the early years states that:

"A complex range of factors have an impact on social and emotional development. Knowledge of these factors may help encourage investment at a population level in early interventions to support health and wellbeing."[16]

Being exposed to more than one risk factor may have an increased impact on a young child. Research from the Centre for Longitudinal Studies (CLS), using data from the Millennium Cohort Study (MCS), examined "the associations of multiple risks to deficits in developmental outcomes at three and five years of age for children born in 2000 to 2001"[15 (pg. 3)]. It found that: "analyses of MCS children's outcomes at ages three and five suggested that being exposed to two or more risks in first years of life is likely to disadvantage children's cognitive and behavioural development as they grow up…..The greater the number of risks experienced by the child, the greater the problems that the child will face during the lifecourse."[15 (p.22)]

When considering social and emotional development in babies, toddlers or young children, it is useful to understand the importance of attachment and how it relates to other risk factors. NICE defines attachment as "a secure relationship with a main caregiver, usually a parent, allowing a baby or child to grow and develop physically, emotionally and intellectually. Babies and children need to feel safe, protected and nurtured by caregivers who identify and respond appropriately to their needs. Unmet attachment needs may lead to social, behavioural or emotional difficulties, which can affect the child's physical and emotional development and learning." [5]

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[15] Scottish Intercollegiate Guidelines Network (SIGN). Management of perinatal mood disorders SIGN guideline 127. Edinburgh: SIGN, 2012 (cited 2015 Jun 8). Available from: www.sign.ac.uk/guidelines/fulltext/127/index.html

[16] NICE. Social and emotional wellbeing: early years. NICE guideline (PH40). London: National Institute for Health and Clinical Excellence, 2012 (cited 2015 Jun 8). Available from: www.nice.org.uk/guidance/ph40

The NSPCC sets out the different kinds of attachment relationship in its report 'Prevention in mind'. Attachment can be secure, which "enables the child to feel safe, secure and protected"[6 (pg.13)], or insecure. There are three categories of insecure attachment- ambivalent, avoidant and disorganised- and in these cases children "may have experienced inconsistent or insensitive care and therefore are not able to rely upon their relationship with their primary caregiver"[6 (pg.13)]. It is insecure attachment, particularly disorganized attachment that can lead to problems with a baby or toddler's development.

All regional and local policy and procedures for safeguarding children should always be followed. All staff providing care and services for women and their families during the perinatal period should have relevant up-to-date knowledge and training in local child protection policies and procedures.

In the event of a woman's admission to hospital during the perinatal period, staff should consider whether adequate and safe arrangements are in place for the care of any dependent children. If there is any doubt an urgent telephone referral needs to be made to First Response.

Paternal and Partner Mental Health

Depression and Anxiety in the perinatal period for fathers (i.e. from conception to 1 year after birth) is approximately 5–10%[17]

Morgan et al (1997) report that in a group programme for women with postnatal depression and their partners, the men reported that their attempts to support the women resulted in increased tensions between the partners and feelings of exasperation by the men because they felt unappreciated by their partners.

While it is accepted that a woman's psychological well-being is more vulnerable during the antenatal period, it can be seen that it is also a time when partners are at increased risk. The fear of change, responsibility and the unknown make partners more vulnerable to poor mental health. Partners face a period of upheaval and uncertainty during their partner's pregnancy therefore can experience psychological, social, emotional and even physical changes during a partner's pregnancy.

"The love you feel for a child is indescribable, I had the unbearable fear that I was dangerous! in fact it was just the love I felt." **Quote from a Bristol Dad, Dad's in Mind, Bluebell www.bluebellcare.org**

[17] https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-017-1229-4

Research evidence supports something that we know intuitively, that fathers' positive involvement in family life leads to less chance that their children will experience emotional or behavioural difficulties, even if their mother is affected by depression (Chang et al, 2007; Mesuliz et al, 2004) therefore it is important that partners involvement is considered and they are signposted to the appropriate support.

Teenage parents

Pregnancy in under-18 year olds can lead to "poor health and social outcomes for both the mother and child" [18]for example:

"…resulting children are at greater risk of low educational attainment, emotional and behavioural problems, maltreatment or harm, and illness, accidents and injuries"[19].

The NICE guidance on social and emotional wellbeing in the early year's lists being born to parents aged less than 18 years as a factor that can make children vulnerable to poor wellbeing. Young mothers are also more at risk of developing postnatal depression than average[20].

Children in care, looked after children and child maltreatment

There are risks to babies' and toddlers' mental health associated with the experience of being in care, as mentioned in the NICE guidance on looked after children and young people:

"Evidence suggests that frequent moves…can adversely affect the ability of babies and very young children to form healthy attachments that lead to healthy emotional and physical development." [21]

"The absence of a permanent carer at such a young age can jeopardise children's chances of developing meaningful attachments and have adverse consequences for their long-term well-being

[18] NICE. Prevention of sexually transmitted infections and under 18 conceptions. NICE guidelines (PH3). London: National Institute for Health and Clinical Excellence, 2007 (cited 2015 Oct 16). Available from: www.nice.org.uk/guidance/PH3/chapter/About-this-guidance

[19] NICE. Contraceptive services with a focus on young people up to the age of 25. NICE guidelines (PH51). London: National Institute for Health and Care Excellence, 2014 (cited 2015 Oct 16). Available from: www.nice.org.uk/guidance/ph51

[20] Mental Health Foundation. Young mums together: promoting young mothers' wellbeing. London: Mental Health Foundation, 2013 (cited 2015 Nov 11). Available from: www.mentalhealth.org.uk/content/assets/PDF/publications/young-mums-together-report.pdf

[21] NICE. Looked-after children and young people. NICE guidelines (PH28). London: National Institute for Health and Clinical Excellence, 2010 (cited 2015 Jun 17). Available from: www.nice.org.uk/guidance/ph28

Many looked after children have suffered abuse or neglect, which can be very damaging to their development, wellbeing and attachment relationships[23]: Experiences of child maltreatment, whether in looked after children or others, can have very serious effects on a young child's development:

"There is strong evidence of the harmful short- and long-term effects of child maltreatment. All aspects of the child's health, development and wellbeing can be affected."[24]

Homelessness

Babies and toddlers that live in families that are homeless are vulnerable to poor social and emotional wellbeing[25]. The NSPCC explains the effects of homelessness on babies in their report 'An unstable start':

"Babies living in homeless families can be extremely vulnerable. This is because babies' development is reliant on the quality of the care their parents are able to provide and for some parents who are homeless, providing this care can be difficult."[24(pg. 5)]

Concealed Pregnancy

An additional consideration is that of concealed pregnancy. Concealed pregnancy is when:

An expectant mother knows she is pregnant but does not tell any professional; or

An expectant mother tells another professional but conceals the fact that she is not accessing antenatal care; or

A pregnant woman tells another person or persons and they conceal the fact from all health agencies

For further information please refer to the Concealed Pregnancy Protocol.

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[22] NICE. Looked-after children and young people. NICE guidelines (PH28). London: National Institute for Health and Clinical Excellence, 2010 (cited 2015 Jun 17). Available from: www.nice.org.uk/guidance/ph28

[23] NICE. Looked-after children and young people. NICE guidelines (PH28). London: National Institute for Health and Clinical Excellence, 2010 (cited 2015 Jun 17). Available from: www.nice.org.uk/guidance/ph28

[24] Hogg S, Haynes A, Baradon T, Cuthbert C. An unstable start: All babies count: spotlight on homelessness. London: NSPCC and Anna Freud Centre, 2015 (cited 2015 Jul 22). Available from: www.nspcc.org.uk/services-and-resources/research-and-resources/2015/all-babies-count-spotlight-homelessness-an-unstable-start/

Maternal suicides

Mental illness is the biggest factor in maternal deaths across the UK. Between 2006 and 2008, 29 women were known to have died by suicide during pregnancy or in the 6 months after delivery. Psychiatric disorder is also associated with maternal deaths from other causes, with 67 dying during this period. [25]

Some red flags in terms of suicide can include:

- Feeling a burden
- Access to means
- Plan of suicide and intent
- In the perinatal period – fluctuation can be dramatic and quick
- Current psychosis
- Discharge from psychiatric hospitals within the last month

The Perinatal Journey

During the pregnancy and postnatal period there may be changes to a woman's presentation which would be deemed 'normal' during pregnancy, for example changes in appetite (NICE 2015).26 However such changes may also be a sign of an emerging mental health issue (Mind 2016).27

There are known challenges throughout the perinatal period for women suffering from mental health problems. For example issues associated with certain psychotropic medication when breastfeeding. This being associated to the risks linked to ceasing or change of medication for their existing mental health problems during pregnancy and the potential impact this may have on their mental health (NICE 2015).[28]

Early identification and provision of appropriate treatment for women suffering from mental health issues during the perinatal period has a significant impact on the outcomes for mother and baby. If left untreated or unsupported, mental health issues have the potential to have implications on parent-child attachment, on the level of responsive and sensitive care that the mother is able to provide and, can have negative impacts on infant mental health and wellbeing (NSPCC 2013).[29]

[25] Oates, M., & Cantwell, R. (2011). Deaths from psychiatric causes in 2011 *Centre for Maternal and Child Enquiries (CMACE), BJOG* 118 (Suppl. 1): 132-203.

26 Antenatal and postnatal mental health: clinical management and service guidance. Clinical guideline [CG192]. Available from: https://www.nice.org.uk/guidance/cg192/chapter/1-Recommendations

27 Mind, 2016. Understanding postnatal depression and perinatal mental health. Available from: https://www.mind.org.uk/media/4852718/understanding-postnatal-depression-2016.pdf

28 Antenatal and postnatal mental health: clinical management and service guidance. Clinical guideline [CG192]. Available from: https://www.nice.org.uk/guidance/cg192/chapter/1-Recommendations

Women who are not currently experiencing mental health issues will receive support from universal services such as Midwives and Health Visitors through the universal visiting patterns outlined in their local procedures. These Universal Services are key in the early identification of mental health issues and signposting to the appropriate support (NSPCC
2013).

Should a woman be identified as requiring additional support, for example expressing symptoms of mild depression and/or anxiety then additional support could be offered at a Universal Plus level by Health Visiting services, and Midwifery services. Alternatively, GPs can support women who have been identified by the Midwife or Health Visitor as needing additional support. Women can also self-refer to their GP for support. GPs can treat uncomplicated non-psychotic depression and anxiety.

This may include prescribing medication or signposting to more specialist services. It is important for GPs and mental health workers to be aware of the potential risks associated with mental health needs versus the benefits and potential harm of prescribed medication in pregnancy and postnatally, including whilst breastfeeding.

GPs can refer women to Vitaminds for further support, for example for educational courses on self-help and one-to-one therapies. The individual would also be able to self-refer to the wellbeing service. This service is designed to support individuals with mild to moderate depression and anxiety using a Cognitive Behavioural Model of therapy. Other self-help provision and charitable organisations are available for the individual to access. For example Mother's for Mother's and Bluebell Care (Bristol) service provides resources about common mental health issues during the perinatal period, amongst other support services such as groups and the 'Buddy Service' for 1:1 face to face support

If more specialist support and advice be required then GPs should refer to secondary mental health services for more complex or significant disorders. This specialist support can take three forms:

1. The Specialist Perinatal Mental Health service can provide advice to the GP and or Midwifery service, with the GP and midwife remaining the lead professionals.

2. Should the individual already be under Secondary Mental Health services then the Secondary Mental Health team continues leading on the mental health care provision whilst being supported by the specialist Perinatal Mental Health Team ,as an adjunctive service, on areas where perinatal expertise are required to manage the individual's care.

3. Should the individual referred not be open to secondary mental health services, and meet the threshold for high risk mental health need (see attached care pathways) then the Specialist Perinatal Mental Health Team would coordinate care under non- CPA where the perinatal psychiatric illness is the primary need. Should the mental health concerns pre-date pregnancy or be expected to continue beyond perinatal period, referral to Recovery teams may ensue.

Red flag signs/activators

It is important for practitioners working with women within the perinatal period to be aware of **'red flag' signs/ 'activators' for action.** These signs are indicative of severe maternal mental illness and require urgent assessment:

- ☐ Recent significant change in mental state or emergence of new symptoms
- ☐ New thoughts or acts of violent self-harm
- ☐ New and persistent expressions of incompetency as a mother or estrangement from the infant

Lead Professional

The professional who leads on the mental health care for the individual may be subject to change throughout their mental health episode. This will be dependent on which services the individual has been referred into and/or discharged from. For example, once Specialist Perinatal Mental Health Services discharge an individual back to Primary Care, the lead professional would be the GP.

If a woman during her pregnancy is solely accessing universal health services, with no identified mental health concerns, the lead professional for her care would be her GP. The allocated Health Visitor and Midwifery teams are essential in continual engagement with the service user and are well positioned to identify any early indicators of concern regarding mental health issues during the perinatal period. Should concerns become apparent regarding the service user's mental health which require additional support (but do not include psychotic depression and anxiety) then the GP and Obstetrician will continue to lead on her care. Specialist advice can be sought by these professionals through speaking to the specialist Perinatal Mental Health Team.

[30] https://www.npeu.ox.ac.uk/downloads/files/mbrrace-uk/reports/MBRRACEUK%20Maternal%20Report%202015.pdf

Should the service user already be open to secondary mental health services prior to the mental health episode in the perinatal period, for example receiving care from the Recovery or Early Intervention teams, then the lead professionals will be the Obstetrician and Consultant Psychiatrist for the Recovery or Early Intervention team. Specialist advice can be sought by these professionals through speaking to the specialist Perinatal Mental Health Team.

When the individual is solely open to the Perinatal Mental Health Team the lead professionals for her care will be the Obstetrician and the Consultant Psychiatrist for the Perinatal Mental Health Team.

Lead Professionals and Discharge

It is essential that any discharge from a service is clearly communicated to all agencies who continue to provide care to the individual. Communicating this information will help provide clarity around who is leading on the individual's care, and avoids assumptions regarding service intervention and provision. It also helps to prevent the potential loss of focus on the service user and unborn baby's needs when care planning.

Should there be concerns around potential or actual risks to the unborn baby, practitioners are advised to follow recommendations set out in the Expected Baby Policy. Concerns relating to the unborn baby must be referred to First Response as soon as possible following the 12th week of pregnancy).

Roles and Responsibilities

Lack of Role awareness between professionals has been highlighted as a learning point in many serious case reviews. Knowledge and an understanding of each other's role will lead to smoother transition between services, more effective information sharing and collaborative working. Greater knowledge about how each professional needs to work within their own organisation, complying with their own guidance, procedures and pathways will lead to swifter and more effective support and better outcomes for the Service User and their family (see Appendix 1 – mapping system for multi-agency Professionals).

Best practice would be to appoint a key worker or lead professional in as many cases as possible to coordinate the required support. Learning and feedback from those affected by Mental health find it difficult to develop relationships with the amount of professionals that they are likely to come into contact with. They reflected that it was difficult to be honest about how they were feeling if they had to engage with lots of different people.

Whooley Questions are used by a range of professionals to scope how a woman is feeling.

Whooley Questions

The two questions are:

During the past month, have you often been bothered by feeling down, depressed, or hopeless?

During the past month, have you often been bothered by having little interest or pleasure in doing things?

There is also a third question if the woman answers yes to either of the initial questions:

Is this something you feel you need or want help with?

Professional judgement should be used when a professional suspects the woman is depressed but she is answering “no” to the questions, the questions should be repeated at subsequent visits. If significant concerns are present these concerns should be discussed with the GP.

It is important to note that any woman, who has a history of past or present severe mental ill health or mental health issues requiring ongoing mental health services, should be advised to arrange an immediate appointment with their GP following a positive pregnancy test. These women may require more intensive support in the perinatal period.

Health Visitors

'Health visitors are registered nurses/midwives who have additional training in community public health nursing. They provide a professional public health service based on best evidence of what works for individuals, families, groups and communities. ,[31]

Health visitors can play a significant role in the early identification and management of maternal mental health in the perinatal period. Their knowledge of the signs, symptoms and the impact mental health can have upon the child both pre and post-natal and the effects on the wider family means they must play an integral part in the Multi-Agency approach.

The role of the Health Visitor is to proactively identify women during the antenatal and postnatal period (taking account of different dynamic and needs) that may be at risk of developing mental ill health, and to assess women during the same period who are currently suffering from mental ill health. They will liaise with all relevant health care, social care professionals, GP and the woman to assist in finding the most appropriate intervention.

Midwifery

Midwives play a central role in ensuring that pregnant women with mental ill health achieve the best possible health outcomes for themselves and their babies. Midwives should work collaboratively with Obstetricians, GPs, Health Visitors, Social workers and Mental Health professionals when appropriate. Midwives may provide care in many locations, e.g. at home, clinics, birth centres and hospitals.

Midwives should co-ordinate the maternity care for women with mental ill Health by:

- ☐ Ensuring all women should be asked by their Midwife about their mental health when they book for ante-natal care, using the Whooley questions (see below) for prediction and detection of mental ill health at the first booking clinic, Mental health should be assessed at every contact and recorded in the hand-held notes (yellow book).
- ☐ Ensuring that they use a risk notification form to refer to a weekly maternal mental health clinic.

Triage and Perinatal Mental Health Specialist team

Triage of women with mental health needs during pregnancy currently operates differently across the two main maternity sites. At St Michaels, the triage is run

jointly by an MDT team including Obstetrician, a clinical nurse specialist from liaison psychiatry, midwife, health psychologist and Consultant/ specialist perinatal clinician from Specialist Community Perinatal Mental Health Team. At Southmead Maternity, all referrals are triaged according to the level of risk by clinical nurse specialist (mental health) and member of the Specialist Community Perinatal Mental Health Team.

At both sites, women assessed as being at low risk will be managed by their Community Midwife and G.P who can seek advice and guidance on managing the woman's mental health as required from the Specialist Community Perinatal Mental Health Team. Women assessed as moderate risk will continue to be managed in ante-natal care in a shared care model with advice and guidance from the Specialist Community Team. Women assessed as being high risk will have an assessment with the Specialist Community Team and a management plan, including signposting and prescribing where needed, will be agreed. Assessment outcome letters will be sent to the patient, the referrer, their GP, Midwife and Obstetric team.

The team have close working links with the designated mother and baby unit and manage women discharged from inpatient mother and baby units with perinatal mental illness and work collaboratively with colleagues in maternity services for women on the team caseload.

The team also operate as an adjunctive service to adult mental health teams with women who have serious mental health conditions that pre-date conception at the point of referral. The adjunctive role is to lead a pregnancy planning meeting in early pregnancy with adult mental health care coordinator to determine the roles and responsibilities of each service for the duration of the pregnancy, and to chair the Maternal Mental Health Care Plan at 28- 32 weeks of pregnancy. In addition, full advice and guidance on prescribing in pregnancy and breast-feeding is available.

The team will co-ordinate the care of women under non-CPA (Care Programme Approach) in the following circumstances:

• When a woman presents with a severe perinatal mental health condition and has no known history of serious mental illness.

• When a woman has a known history of Bi-Polar Affective Disorder, Post-Partum Psychosis or Severe Post Natal Depression and is currently symptom free and in good mental health. The rationale for this is that women with such known history are at significant risk of relapse during the perinatal phase and will therefore benefit from support and close monitoring at such a vulnerable time.

[31] http://ihv.org.uk/families/what-is-a-hv/

https://bristolsafeguarding.org/children/child-safeguarding-practice-reviews/zbm/

The Team will care coordinate women under CPA where they have recently been discharged from a Specialist Mother and Baby Unit / adult inpatient bed (where specialist MBU was not available or deemed too high risk).

The Bristol MBU is a specialist in patient facility for women and their babies. Women can be admitted informally or under a section of the Mental Health Act (MHA). Bristol have a MBU facility along with other areas of the country e.g. Exeter, Winchester. Women and babies can stay up until the babies first birthday, partners/carers/husbands are able to visit the ward and provide ongoing support.
Referrals can be made after 36 weeks of pregnancy and before 9 months of the babies first birthday for women who are experiencing severe mental illness in the perinatal period. The community perinatal mental health service will offer advice to all professionals. To contact them e mail awp.perinatalmentalhealthservice@nhs.net or telephone 0117 919 5826

For interim pathways refer to Appendices 3, 4 and 5

GP

A GP may have an established relationship with women before they conceive and hold detailed information within their patient's care record. Partners, other children and members of the wider family may also be known to the practice and be aware of a relevant family history of mental health. Practices can offer continuity of care over many years and are often well placed to identify perinatal mental health problems early and offer treatment, sign-posting and referral to other agencies and communication with other community teams including HVs, midwives and the mental health services.

When any pregnant woman first presents to their GP they should be asked about previous
or present mental ill health, including details of any care provided by mental health services. They should also be asked if there is any close family history of perinatal/ mental ill
health. This information should be clearly identified in the referral information from GPs to antenatal services. All other members of the primary care team, for example nurse practitioners, should be aware of the importance of including this information in antenatal referrals.

For any woman taking psychotropic medication while planning pregnancy or in the antenatal period, consideration should be given to the risks and benefits of their individual circumstances. It may be appropriate for the GP to refer to mental health

services in the case of women who are not under active follow up.

GPs like midwives should ask women the ‘Whooley Questions’ during any attendance in pregnancy. Any positive response to these questions should be followed up in line with the local pathway.

Pregnant women, who have symptoms of anxiety and/or depression, severe enough to interfere with personal and social functioning but do not meet the diagnostic criteria for a formal diagnosis, should be referred to the Health Clinic.

Most practices offer a routine 6 week check for babies and mothers (and their partners)
which is an important opportunity to assess maternal (and paternal) wellbeing.

Practices can code concerns on their clinical system (EMIS in Bristol) and this information is transferred to the new practice when patients move. EMIS records can now be shared with a variety of other agencies.

The Police

The Police will use referral pathways if they have concerns for a person or child, for example a pregnant woman involved in suspected domestic violence and abuse. Police officers have legal powers under Section 136 of the Mental Health Act to detain people who appear to them to be “mentally disordered” and who are “in immediate need of care and control”. Officers typically transport detained people to safe places (currently specially built and commissioned NHS mental health facilities) where their mental health can be assessed by appropriately trained and experience health and social care professionals.

This assessment will usually result in either a discharge with the patient given access to voluntary mental health services and support or a Section 2 Mental Health Act admission for a more lengthy assessment.

Officers are also involved in supporting Mental Health professionals to carry out warrants. These warrants involve entry into private properties to assess a person who may not willingly engage and whose health is thought to have significantly deteriorated. Officers will also be able to use different premises, for example a local office or the staff room of a nearby business – as places of safety provided the patient and the premises’ owner agrees. This will mean that patients may receive mental health screening much closer to their home or the site of their detention and will be more focused on the patient’s needs.

Prisons

Perinatal mental health needs are assessed by medical professionals at HMP Eastwood Park and individuals needing support can also have access to the Specialist perinatal team whilst in Eastwood Park. See Appendix 5 for pathway links to the service.

Social Care

Social workers are trained to work in partnership with people using services, their families and carers, to optimise involvement and collaborative solutions. Social workers also manage some of the most challenging and complex risks for individuals and society, and take decisions with and on behalf of people within complicated legal frameworks, balancing and protecting the rights of different parties.

Children's Social care

There is joint-working at an early stage and joint care planning when cases are known to perinatal mental health teams and social care. This should include regular multi-professional meetings, information sharing and all agencies contributing to a streamlined plan where appropriate.

Whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm (see appendix 2) children's social care should consider the need for a strategy discussion with other agencies including health agencies, the police, education,
social care and any other appropriate agency. This strategy discussion should be convened by
children's social care.

A strategy discussion may take place following a referral, or at any other time. The discussion should be used to:

- ☐ Share available information.
- ☐ Agree the conduct and timing of any criminal investigation.
- ☐ Decide whether a core assessment under s47 of the Children Act 1989 (s47 enquiries) should be initiated, or continued if it has already begun.
- ☐ Plan how the s47 enquiry should be undertaken (if one is to be initiated), including the need for medical treatment, and who will carry out what actions, by when and for what purpose.
- ☐ Agree what action is required immediately to safeguard and promote the welfare of the child, and/or provide interim services and support.
- ☐ Determine what information from the strategy discussion will be shared with the family, unless such information sharing may place a child at increased risk of significant harm or jeopardise police investigations into any alleged offence(s); and
- ☐ Determine if legal action or advice is required.

Pre-birth assessments are started as early as possible in pregnancy so that, when significant concerns are identified Child Protection Conferences are held by 30 weeks of pregnancy (as recommended in the SWCPP).

Parenting assessments are different from admission to a Mother and Baby Unit for assessment and treatment of perinatal mental illness. They are commissioned by local authorities to assess parenting capacity. If mental illness is present, this should be treated and/or stabilised before a parenting assessment takes place.

All teenage parents will receive specific support and evidence-based parenting programmes are available to support vulnerable families experiencing perinatal mental illness.

Adult Social Care

A referral to adult social care can be made where it appears an adult may need care and support. A need can relate to a number of tasks and activities including personal care, accessing the community, caring responsibilities and maintaining the home environment. Any referral should be made with the consent of the person concerned unless the person appears to lack capacity to agree to an assessment. The referrer should identify what they believe the needs are for adult care services. Adult social care work with people using a strength based approach and in the first instance will carry out a support conversation to work with an someone to identify their strengths, assets and to identify universal services that they can access for themselves to maximise their independence. This may then lead onto a fuller assessment under the Care Act if services need to be put in place.

Safeguarding Adults

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. The KBSP Abuse and neglect policy sets out how people and organisations work together to prevent and stop both the risks and experience of abuse or neglect for Adults at Risk. At the same time it details how to make sure that the adults wellbeing is promoted including, having regard to their views, wishes, feelings and beliefs in deciding on any action. The response to safeguarding concerns must be personal to the individual, it is also important that all safeguarding partners take a broad community approach to establishing safeguarding arrangements. It is vital that all organisations recognise that adult
safeguarding arrangements are there to protect individuals.

The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect. Some of the duties include:

- ☐ leading a Multi-Agency local adult safeguarding system that seeks to prevent abuse and neglect and stop it quickly when it happens
- ☐ make enquiries, or cause others to make them, when they think an adult with care

and support needs may be at risk of abuse or neglect and they need to find out what action may be needed

- ☐ arrange for an independent advocate to represent and support a person who is the subject of a safeguarding enquiry or review, where the adult has adult has
  'substantial difficulty' in being involved in the process and where there is no other
  suitable person to represent and support them.

The Care Act 2014 outlines the principles of: Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability.

These should always be considered when working with a single or Multi-Agency approach to address such concerns. Failure to identify and engage with adults at risk could have serious implications on their health and wellbeing and their family. The duty for agencies to integrate, cooperate and work in partnership, is a legal requirement placed on all Local Authorities and all agencies involved in care such as the NHS, independent and private
sector organisations, housing providers and the Police. Cooperation will allow early intervention and this is seen as the best way to prevent, reduce or delay the need for care, support and safeguarding adults at risk.

Mental Capacity Act (2005) MCA

For those people who lack capacity the MCA providers a legal framework to promote and safeguard decision-making.. It does this by empowering people to make decisions for themselves wherever possible, and by protecting people who do not have the capacity to protect themselves

Mental Health Act (MHA)

Under Section 2, a referral for a Mental Health Act Assessment can only be made where there is an active and acute mental disorder and the person may require compulsory admission to hospital. It **cannot** be used for example when there are risks around a physical health need i.e. a person refusing care/treatment for physical health needs or social issues. Usually diversion via I secondary mental health services via triage/crisis team is the normal initial referral route rather than direct response via use of the MHA.

In crisis situations, if a person appears to be suffering from mental disorder and is in need of immediate care or control the police can remove them to a place of safety and detain them for a short period.

Good Practice - Information Sharing, Referrals and Record keeping

Learning form Serious Case and Adult Reviews details that key issues such as information sharing, the quality of referrals and detailed record keeping are areas where organisations need to improve.

Information Sharing

Sharing the right information, at the right time, with the right people, is fundamental to good practice in safeguarding children and adults.

When working with children and young people, it's important to keep in mind two essential
factors:

- ☐ timely information sharing is key to safeguarding and promoting the welfare of children. It enables intervention that crucially tackles problems at an early stage
- ☐ if a child is at risk or suffering significant harm, the law supports you to share information without consent.

This must be balanced with ensuring that personal information will be treated respectfully and confidentially. Sharing information appropriately is key to putting in place the right support. When making these decisions, the safety and welfare of the child must be the key consideration. For detailed guidance for Children's Services refer to the KBSP Information sharing policy

For Adults at Risk given the duty to cooperate in the Care Act 2014, there are only a limited number of circumstances in which it would be acceptable not to share information
pertinent to safeguarding with relevant multi-agency safeguarding partners. These would be where the person involved has the mental capacity to make the decision in question and does not want their information shared, and:

- ☐ their 'vital interests' do not need to be protected
- ☐ nobody else is at risk
- ☐ there is no wider public interest
- ☐ no serious crime has been or may be committed
- ☐ the alleged abuser has no care and support needs
- ☐ no staff are implicated
- ☐ no coercion or duress is suspected
- ☐ the risk is not high enough to warrant a referral to a Multi-Agency Risk Assessment Conference (MARAC)
- ☐ No other legal authority has requested the information

If there is continued reluctance from one partner to share information when there is a safeguarding concern or in instances where an alerting organisation thinks that the local authority response is not sufficient, then the matter should be escalated using the relevant Escalation Policy.

Referrals

Referrals to Children's Social Care that are made later in the pregnancy are shown to impact negatively on pre-birth planning and risk assessment prior to the baby's arrival. It is vital
that throughout the pregnancy, a multi-agency approach is adopted to ensure pre-birth planning and support is joined-up and effective.

Any child protection concerns must be referred to First Response for a child or children and Care Direct for an Adult at Risk. If a professional is unhappy with the outcome of the referral or advice given this should always be escalated using the Escalation Procedure for Children and Resolution of Professional Differences for Adults.

It is vital that the language used for a referral is clear and easy to understand. It is important to remember to use words and description that all professional will understand across the Multi-Agency landscape of services.

Useful Contacts

Community perinatal mental health service will offer advice to all professionals. To contact them email awp.perinatalmentalhealthservice@nhs.net or telephone 0117 919 5826 Each organisation identifying any safeguarding concerns should also initiate making a separate referral to Children's services.

Bluebell – Support for Women and families.
Offering a variety of free, weekly activities designed to help parents manage feelings of anxiety and depression related to pregnancy and birth with group programmes including therapeutic, creative and pampering sessions with an occupational therapist and a Buddy worker including Dad's support line on Tel no. 07730 367 483. Further information is available at http://www.bluebellcare.org or telephone Tel 0117 922 0746

MotherforMothers – Mon-Fri 10:00am-2:00pm Telephone 0117 2397389 or email support@mothersformothers.co.uk

Bristol Sanctuary - Bristol Sanctuary is a place which feels safe, comfortable and welcoming, where people who are experiencing severe emotional distress can go for help outside of normal working hours.

http://www.bristolmentalhealth.org/services/bristol-sanctuary/ Tel 0117 954 2952

Action Postpartum Psychosis (APP) - Information and support for anyone who's experienced postpartum psychosis, including a peer support network and an online forum. app-network.org

Anxiety UK Support, help and information for anyone with an anxiety disorder Tel - 0844477 5774 anxietyuk.org.uk

Appendix 1 - Flow charts – a mapping system for Multi-Agency professionals

Universal services – universal pregnancy/postnatal period

Presentation
No history/ sign of mental health problem

Intervention/Service
Mental health to be monitored

Lead Professional
GP

Primary Care Services – Universal Plus pregnancy/postnatal period

Presentation
Non-psychotic depression and/or anxiety

Intervention/Service
Self-referral or signposting to GP
Listening visits from health visiting service
VITA Health
Voluntary/Charitable self-help resource e.g. Mind resource, Bluebell, Mothers for mothers

Lead Professional for Mental Health
GP and Obstetrician

Secondary Care Mental Health Services

Presentation
Mental health problems that are not possible to manage within the primary care setting and therefore under secondary or already in receipt of secondary mental health services. Significant concern regarding risk to self/others in the context of suspected mental illness
Any women who may be well and under primary care who have a history of psychosis/Bipolar Disorder or significant perinatal mental illness during the perinatal period.

Intervention/ Service
Medication advice/prescribing
Psychosocial assessment
Care planning / 32 week maternal mental health plan
Parent infant interventions
Psychological assessment and intervention
Pre-pregnancy planning

Multiagency working and liaison services
Lead Professional for Mental Health
Perinatal Mental Health Team unless women is already care coordinated by a secondary mental health service.
Where there is a clear high risk perinatal mental illness i.e. BPAD or postpartum psychosis, Consultant Psychiatrist becomes lead Medic.

Specialist Perinatal Mental Health Services- (if not already open to Secondary Mental Health Services)
Presentation
Complex mental health history
Psychosis/ Bi-Polar presentation Not open to Secondary Care Mental Health Services prior to the onset of the mental health problem during the perinatal period

Intervention/ Service
Specialist Perinatal Mental Health intervention

Lead Professional for Mental Health
Perinatal Mental Health Team

Appendix2-Referral to Children's Social Care

You have concerns about a child/unborn child (after 12 weeks of pregnancy)

Child Protection concern – take action now.

Go to speak with Safeguarding Lead immediately. If not available, find the deputy or you act.

Agree who will make the referral to First Response (and call the police on 101 if necessary).

Referral is made to First Response/Police, stating that it is a Child Protection concern.

Action is taken by the appropriate agencies

You will need to record on your own system in writing ASAP (within 24 hours). This applies whether or not you make the actual referral.

Your agency continues to participate in Child Protection Strategy or S.47 Enquiries.

Child is in immediate danger – phone 999

All other welfare and safeguarding concerns

Complete internal concern form and pass to Safeguarding Lead

Lead will assess (with discussion with staff and consultation of any safeguarding file held) to agree actions required.

Concern meets threshold for referral to First Response

Agency led interventions/refer direct to other agencies (e.g. Perinatal team, counselling, Bluebell etc.)

No further action – will monitor.

Complete web form referral to First Response (copy of referral kept for file). **Parental consent is required.**

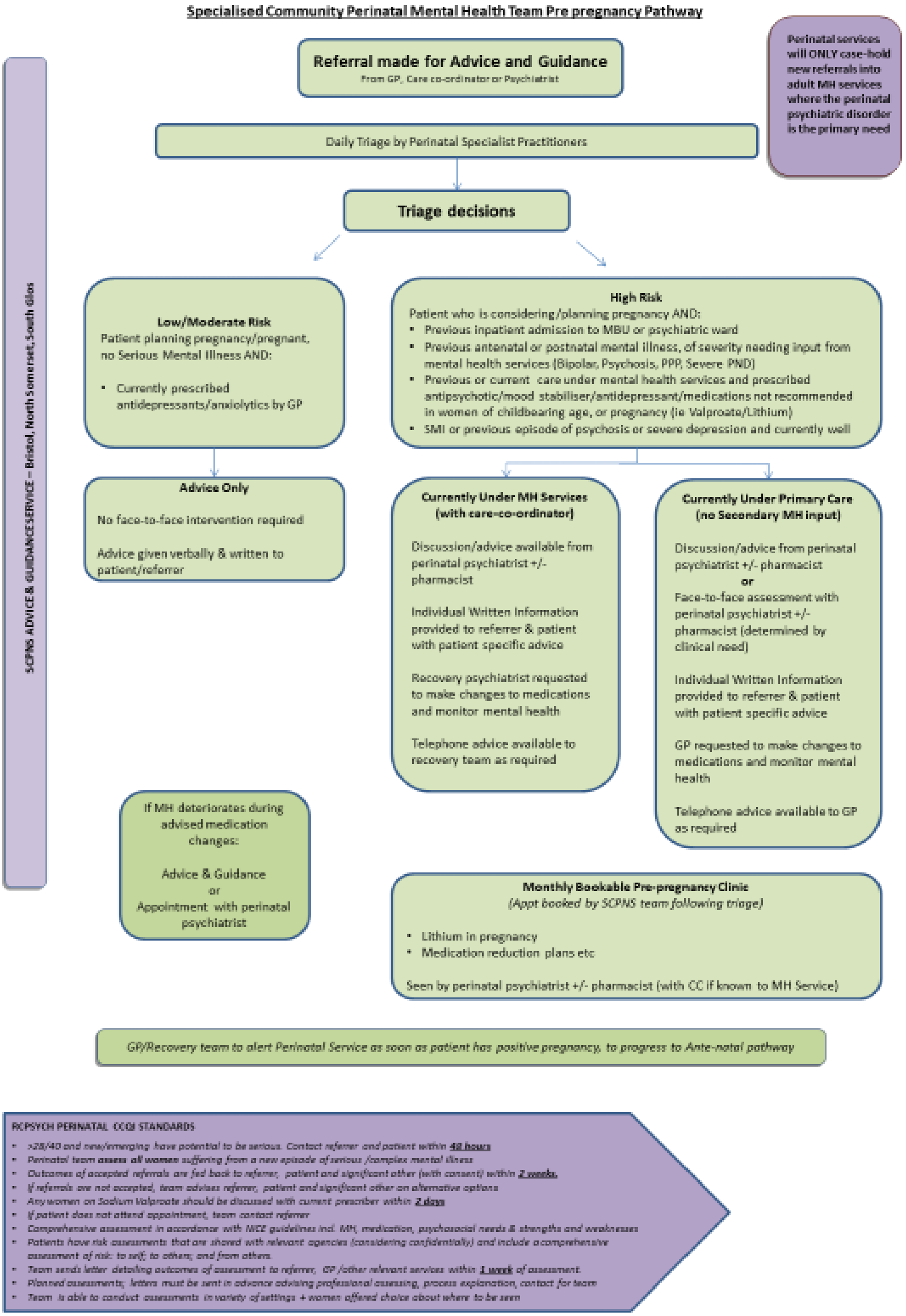
First Response CONSIDER REFERRAL AND THRESHOLD and direct to:

Early Help Team appropriate. – SAF allocated and referrer informed. Your agency participates in Pre-birth assessment, assessment and plan.

Child in Need s17 enquiries. Allocated to Social Care Unit, referrer informed. Your agency participates in assessment and plan.

Decide no further action and inform your agency.

Appendix 3 -Specialised Community Perinatal Mental Health Team Interim Prenatal Pathway



The Community Perinatal Service: "Supporting & Empowering Recovery whilst Valuing Individuals, their Children & families and Enhancing perinatal partnership networks

Post Partum Psychosis (PPP) Pathway

KEY BACKGROUND INFORMATION

- Post-Partum Psychosis is a is a severe, but treatable, form of mental illness that occurs after having a baby.
- Those with Bipolar disorder and previous PPP are at highest risk, as are those with pre-existing SMI, but it can also occur out of the blue in mothers with no pre-existing mental health history.
- The highest risk time for developing a PPP is the first few days to weeks post-delivery, but it can also occur later than this.
- **PPP can emerge and deteriorate rapidly and is a PSYCHIATRIC EMERGENCY**
- Most women will require medication AND admission to hospital
- **Any suspected case of PPP, should be treated as a PPP until it has been proven otherwise**, as risks to mother and infant are extremely high.

Predicting Risk for PPP

Bipolar Affective Disorder 1 (BPAD-1)	= 25% risk PPP, 25% risk PND
BPAD-1 + Family History PPP	= >50% risk PPP
Previous PPP	= >50% risk PPP
BPAD-1 + previous PPP	= 70% risk PPP
FH of PPP alone	= 3% risk PPP
FH of BPAD-1 alone	= 1.5% risk

>50% of women who develop PPP have **no previous mental health history**

Common Presenting features of PPP include:

Distinctive Clinical features:

- Sudden onset and rapid deterioration
- Majority have onset within first 2 weeks of delivery – over 50% of symptom onset occurs on days 1-3
- Clinical picture changes rapidly with wide fluctuations in intensity of symptoms and severe swings of mood. (rapid change from appearing well to unwell, which can occur over minutes to hours)

Common Symptoms:

- Wide variety of psychotic phenomena:
  - Hallucinations, delusions, thought disorder – *content often related to the new baby*
- Affective (mood) symptoms – both elation & depression
  - Labile mood, irritability, restlessness, over-activity,
- Disturbance of consciousness marked by apparent confusion, disorientation, bewilderment or perplexity (*need to exclude organic cause*)
- Family often report subtle changes: *"I can't put my finger on it, but she is just not herself"*

Any *psychotic symptoms, particularly delusions or hallucinations, substantially increase risk for both mother and baby. Refer for emergency assessment (within 4hr face-to-face).*

Post Partum Psychosis (PPP) Pathway

Referrer makes contact with mental health services

First person to receive referral must immediately clarify presenting situation:

(1) Has patient had baby in last 3 months? Or in the last 1 year?
(2) Does patient present with distinctive clinical features; or any psychotic symptoms; or common symptoms of PPP?
(3) Does the patient present with 1 or more of the following:

- Recent significant change in mental state or emergence of new symptoms?
- New thoughts or acts of violent self-harm, however fleeting?
- New and persistent expressions of incompetency as a mother or estrangement from the infant?

If YES to Q1 + 2

If YES to Q1 + 3 & NO to Q2 Go to Red Flag Pathway

If NO to all, or YES to Q1, & NO to Q2 + 3 Triage under standard protocol

This is a PSYCHIATRIC EMERGENCY and must be treated as a likely PPP until proven otherwise

(1) Make immediate referral to Crisis Team

MH professional should contact most appropriate person (woman, family member/carer or health social care professional) without delay and agree next steps to be provided in the woman's care and support. Failure to provide an emergency referral and adequate assessment or start treatment immediately poses significant risk to mother and baby

(2) EMERGENCY "face to face" assessment MUST start within 4 hours
If patient poses immediate risk to herself/others, call for MHA.
In hospital setting consider need for immediate assessment for 5(2)

National Perinatal Emergency Pathway

Within 4 hours the woman should have had a biopsychosocial assessment and an urgent and emergency mental health care plan in place, AND as a minimum:

- Be enroute to next location if geographically different **or**
- Have started referral process for admission to MBU **or**
- Been accepted and scheduled for IST follow-up care at home or by Perinatal MH team **or**
- Have immediate access to care and support if she is waiting for admission to MBU **or**
- Have started assessment under the MHA

In Working hours (Mon-Fri 9-5pm)
Contact Perinatal team:

Is patient known to caseload? – **Get info**
Can Perinatal Psychiatrist attend Emergency Assessment within 4hrs? **If YES Crisis team joint assess with Consultant**
If Perinatal Psychiatrist is not available – see Out of Hours

Out of Hours and/or Perinatal Psychiatrist Unavailable

Contact On-call Consultant. Advise of a suspected PPP
Request Consultant attendance at Joint Emergency assessment with Crisis team, to start within 4 hrs.
If unavailable - Crisis team assess & discuss with on-call

"There should be an expectation of early consultant involvement in assessment & management" MBRRACE-UK 2018

(3) Prior to assessment check Webbeds for MBU bed availability: https://www.nhswebbeds.co.uk/login

(3) Conduct Emergency Assessment or start MHA – within 4 hours of referral
If there is any suggestion that this presentation is a suspected or emerging PPP:
Treat as if PPP, until proven otherwise while excluding differentials (eg: sepsis/infection/delirium/hyponatraemia)

Nb: if there is a history of BPAD/PPP the risk of this presentation being PPP is even higher, BUT remember >50% of women who present with PPP have no previous history

(4) Where admission required;
Download Universal MBU Referral Form (https://www.nhswebbeds.co.uk/login) and send to preferred MBU

(5) Inform Community Perinatal team as soon as possible of outcome: BNSSG 0117 9195826 BSW: 01249 767851

Emergency Treatment for PPP

Check BP/Temp/Pulse/Bloods to assist diagnosis
Seek admission to MBU/Acute where clinically indicated and safe.
Aim to keep Mum/baby together unless risks posed to baby's safety

Commence Antipsychotic treatment. Options include:
Olanzapine
Quetiapine
Haloperidol

Consider use of Lorazepam 0.5-1mg TDS PRN

Regularly Review diagnosis in light of physical health/blood results etc

*MBU beds are centrally commissioned and funded by NHS-England, so **permission is not required** to seek funding for out of area placements if no local MBU bed is available.*

Red Flag Perinatal Pathway

History of mental illness
Women with current or historical:
Bipolar Disorder / Schizophrenia / Schizoaffective Disorder / Major Depression are at particularly high risk of Perinatal Mental Health deterioration

Risk for Women with Bipolar Disorder:
More than **one in five risk** of suffering from postnatal psychosis
Almost **one in two risk** of experiencing severe postnatal depression
One in two for women with a history of previous postnatal psychosis
One in two with bipolar disorder **and** a family history of postnatal psychosis

Management of High Risk women
Require input from secondary mental health services in pregnancy, preferably a specialist in Perinatal Mental Health **even if they are well,** so a personalised care plan can be made

Postpartum Psychosis is a Psychiatric emergency. Any case of suspected PPP should be treated as post-partum psychosis until proven otherwise, and requires specialist assessment and treatment within 4 hours. **(see separate Post-Partum Psychosis pathway)**

50% of women who get postnatal psychosis have **no** history of mental health problems

Women with severe depression
40% risk of subsequent postnatal and non-postnatal relapse

Detection
If a woman consults a GP saying she thinks she has a perinatal mental health problem, she is almost certainly right. **Do not** dismiss her or normalise her

(Adapted from: Judy Shakespeare RCOP 2018)

Presentations which should prompt urgent senior psychiatric assessment

- Recent significant change in mental state or emergence of new symptoms
- New thoughts or acts of violent self-harm, however fleeting
- New and persistent expressions of incompetency as a mother or estrangement from the infant

Remember "Have a low threshold for escalating for advice and action planning."

Call the Community Perinatal Service for BNSSG on: 0117 919 5826 or BSW on:

Any case of suspected PPP should be treated as post-partum psychosis until proven otherwise – see separate PPP Pathway

Red Flag Perinatal Pathway

Referrer makes contact with mental health services

First person to receive referral must immediately clarify presenting situation:

(1) Has patient had baby in last 3 months? Or in the last 1 year?
(2) Does the patient present with any symptoms consistent with PPP?
(3) Does the patient present with 1 or more of the following:

- Recent significant change in mental state or emergence of new symptoms?
- New thoughts or acts of violent self-harm, however fleeting?
- New and persistent expressions of incompetency as a mother or estrangement from the infant?

If YES to Q1, but NO to Q2 + 3 continue under standard triage protocol

If YES to Q1 + 3 Go to (Box 1)

If YES to Q1 + 2 See Post Partum Pathway

(1) Make immediate referral to Crisis Team

MH professional should contact most appropriate person (woman, family member/carer or health social care professional) without delay and agreement steps to be provided in the woman's care and support. Failure to provide urgent assessment/treatment poses significant risk to mother and baby

An URGENT "face to face" assessment MUST be offered the SAME DAY
If patient poses immediate risk to herself/others, call for MHA.
If in hospital setting consider need for immediate assessment for use of S(2)

This is a PSYCHIATRIC EMERGENCY and must be treated as a likely PPP until proven otherwise

See Postpartum Psychosis Pathway

In Working hours (Mon-Fri 9-5pm) contact Perinatal team:

Is patient known to caseload? – **Get info**
Can Perinatal Psychiatrist or Duty Perinatal Nurse attend Urgent Same Day assessment?
If YES – arrange joint same day assessment
If NO – see Out of Hours section

Out of Hours or if Perinatal Psychiatrist or Perinatal Duty Nurse Unavailable

Crisis team to undertake same day assessment.
Contact Perinatal Consultant or On-call Consultant for case discussion & treatment plan, advising of potential new onset of Severe Perinatal Mental Health presentation.

(2) **Prior to assessment check Webbeds for MBU bed availability**
https://www.nhswebbeds.co.uk/login

(3) **Conduct Urgent Same Day Assessment or start MHA**
If there is any suggestion that this presentation is a suspected or emerging PPP:
See PPP pathway and treat as if it is PPP, until proven otherwise, whilst excluding differentials

Nb: if there is a history of BPAD/PPP the risk of this presentation being PPP is even higher, but remember >50% of women who present with PPP have no previous history

(4) Where admission required;
Download Universal MBU Referral Form (https://www.nhswebbeds.co.uk/login) and send to preferred MBU
Inform Community Perinatal team as soon as possible of outcome:
BNSSG (0117) 9195826 BSW:

(5) Where admission not required;
Inform Community Perinatal team as soon as possible of outcome:
BNSSG (0117) 9195826 BSW:

Perinatal service book next Urgent Senior Medical review slot

MBU beds are centrally commissioned and funded by NHS-England, so ***permission is not required*** *to seek funding for out of area placements if no local MBU bed is available.*