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Perinatal Mental Health Services in the UK

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Introduction

The UK perspective

The English perpective

The ‘local’ (south East London) perspective

My perspective

Most importantly- the evidence base

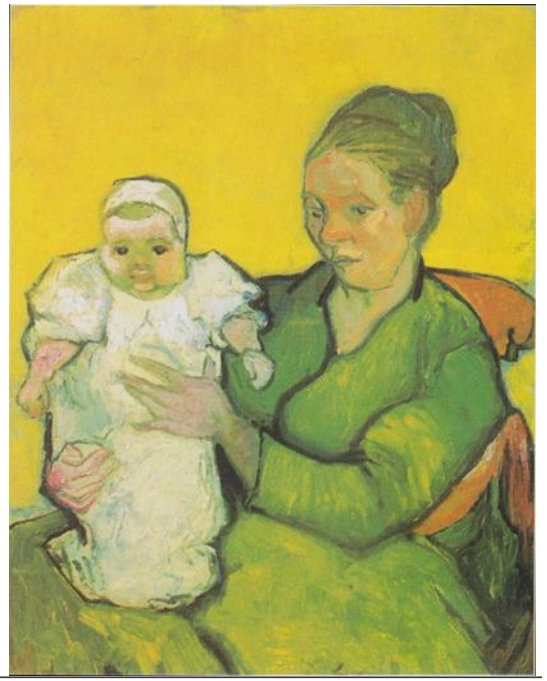
NICE

- NHS: National Health Service
- NICE: National Institute for Health and Care Excellence
- CG192- Antenatal and postnatal mental health: clinical management and service guidance
- www.nice.org.uk/guidance/cg192
- Last updated Aug 2017

NICE CG192

Recommendations cover:

- **Recognition, assessment, care and treatment of mental health problems in women during pregnancy and the postpartum (up to 1 year after childbirth) and in women who are planning a pregnancy**
- **Depression, anxiety disorders, eating disorders, drug and alcohol-use disorders and severe mental illness (psychosis, bipolar disorder, schizophrenia and severe depression)**
- **Also covers subthreshold symptoms**
- **Quality standards**



Quality Statement 1: Valproate

- MHRA Jan 2015 and recent update by EMA Feb 2018 (Pregnancy Prevention Programme)
- Valproate to be avoided in women of childbearing potential- high risk of congenital malformations and developmental disorders
- Only used to treat mental health problems in women of childbearing potential in EXCEPTIONAL circumstances when no alternative agents available (lowest effective dose and fetal monitoring)
- Folate does not prevent malformations
- Discuss:

✓ risks associated with valproate during pregnancy

✓ need to use effective contraception

✓ need for regular review of treatment

✓ need to rapidly consult if she is planning a pregnancy or becomes pregnant

Quality Statement 2: Pre-conception information

- **Women of childbearing potential with a severe mental health problem are given information at their annual review about how their mental health problem and its treatment might affect them or their baby if they become pregnant**

- **Discuss with all women of childbearing potential who have a new, existing or past mental health problem:**

✓ **use of contraception and any plans for pregnancy**

✓ **how pregnancy and childbirth might affect a mental health problem, including risk of relapse**

✓ **how a mental health problem and its treatment might affect the woman, fetus and baby**

✓ **how a mental health problem and its treatment might affect parenting**

Quality statement 3: Information for pregnant women

- **Pregnant women with previous severe mental health problem or any current mental health problem are given information at their booking appointment about how their mental health problem and its treatment might affect them or their baby**
- **Includes:**

✓ **potential benefits of psychological interventions and psychotropic medication**

✓ **possible consequences of no treatment**

✓ **possible harms associated with treatment**

✓ **what might happen if treatment is changed or stopped, particularly if psychotropic medication is stopped abruptly**

Risk: Benefit Discussion

- Capacity
- Good therapeutic relationship
- Individualise risks and benefits (inc baseline risk)
- Be up to date with evidence
- www.uktis.org
- Seek advice
- Discuss wishes and values of patient and family
- Review decisions over time
- Monitor outcomes
- Acknowledge uncertainty
- Breastfeeding

Challenges of evidence around medication

- Database and case studies
- No RCTs
- Association does NOT mean causality
- Residual confounding e.g. by indication
- All pregnancies have risk of adverse outcomes
- Higher quality studies find smaller effects

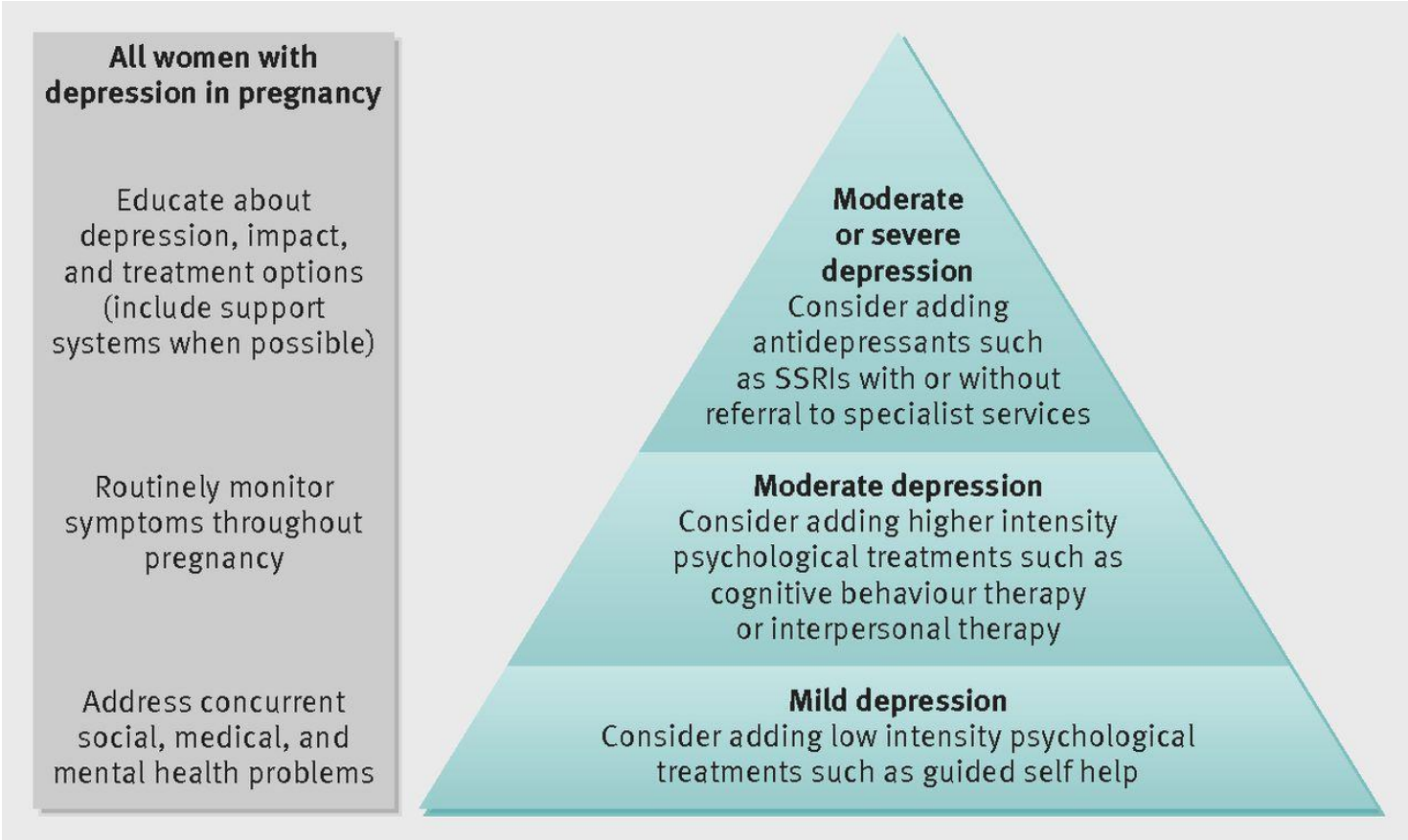
References to medication in CG192

- No psychotropic medication has a UK marketing authorisation specifically for women who are pregnant or breastfeeding. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. The woman (or those with authority to give consent on her behalf) should provide informed consent, which should be documented

- There is a higher threshold for pharmacological interventions arising from the changing risk-benefit ratio for psychotropic medication at this time

General Principles

- Aim for psychology as first line management if possible in mild to moderate common mental disorders, especially if no current medication
- **Limit exposure to multiple agents (try to avoid switching medication to limit fetal exposure)**
- **Always use the lowest effective dose (but doses may need adjusting)**
- **Individual**
- **Collaborative risk: benefit discussion**



S Vigod, C Wilson, L Howard. Depression in pregnancy. BMJ, 2016, 352:492-5

Quality Statement 4: Asking about mental health and wellbeing

- **Women are asked about their emotional wellbeing at each routine antenatal and postnatal contact.**
- **Consider asking the following depression identification questions (Whooley questions) as part of a general discussion about a woman's mental health and wellbeing:**

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

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

- **Consider asking about anxiety using the GAD-2:**

1) Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious or on edge?

2) Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?

What contacts are there during the perinatal period?

Routine antenatal contacts include:

- **pregnant woman's first contact with a midwife or doctor to discuss pregnancy**
- **booking appointment (8-12 weeks gestation)**
- **dating scan (8-14 weeks gestation)**
- **16 week check**
- **anomaly scan (18-20 weeks gestation)**
- **further routine scheduled checks (the frequency of these will vary depending on whether it is the woman's first pregnancy)**

Number of postnatal contacts varies depending on need but women should have a postnatal check about 6 weeks after their baby's birth to make sure that they feel well and are recovering properly

Quality Statement 5: Comprehensive mental health assessment

- **Women with a suspected mental health problem in pregnancy or the postnatal period receive a comprehensive mental health assessment.**
- **Include:**

✓ **mental health history, including family history**

✓ **physical wellbeing, alcohol and drug misuse**

✓ **attitude towards and experience of pregnancy, including denial of pregnancy**

✓ **the mother–baby relationship**

✓ **social networks, living conditions, employment and immigration status**

✓ **domestic violence and abuse, sexual abuse, trauma or childhood maltreatment**

Domestic violence (DV)

- ‘Any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between those aged 16 years or over who are, or have been, intimate partners or family members, regardless of gender or sexuality’ *(UK Home Office 2013)*
- Can occur in perinatal period and increased risk of perinatal anxiety and depression
- UK Enquiry into Maternal Deaths (2009-13): 33 women were DV victims of homicide (most UK citizens, BME women higher risk (RR 2.56))
- DV a factor in >50% perinatal suicides
- Increased prevalence of DV victimisation and perpetration among those with psychiatric disorder compared to the general population

Domestic violence and abuse: multi-agency working (NICE PH50) (1)

www.nice.org.uk/guidance/ph50 (2014), www.who.int/reproductivehealth/publications/violence

1. **DV and abuse services are developed according to need and gaps in current service provision**
2. **Local, strategic, multi-agency partnerships to prevent DV**
3. **Develop an integrated commissioning strategy for service delivery (defining outcomes and identifying resources available to deliver those outcomes)**
4. **Integrated care pathways for identifying, referring and providing interventions to support people who experience domestic violence and abuse and to manage those who perpetrate it**
5. **Create an environment conducive to disclosure of DV: provision of information, private spaces and clear pathways following disclosure**
6. **Train staff in how to enquire about DV (see WPA curriculum: http://www.wpanet.org/uploads/Latest_News/News_from_WPA_Sections/WPA_IPV_SV_Curriculam.pdf)**
7. **Clear policies for data sharing between agencies**

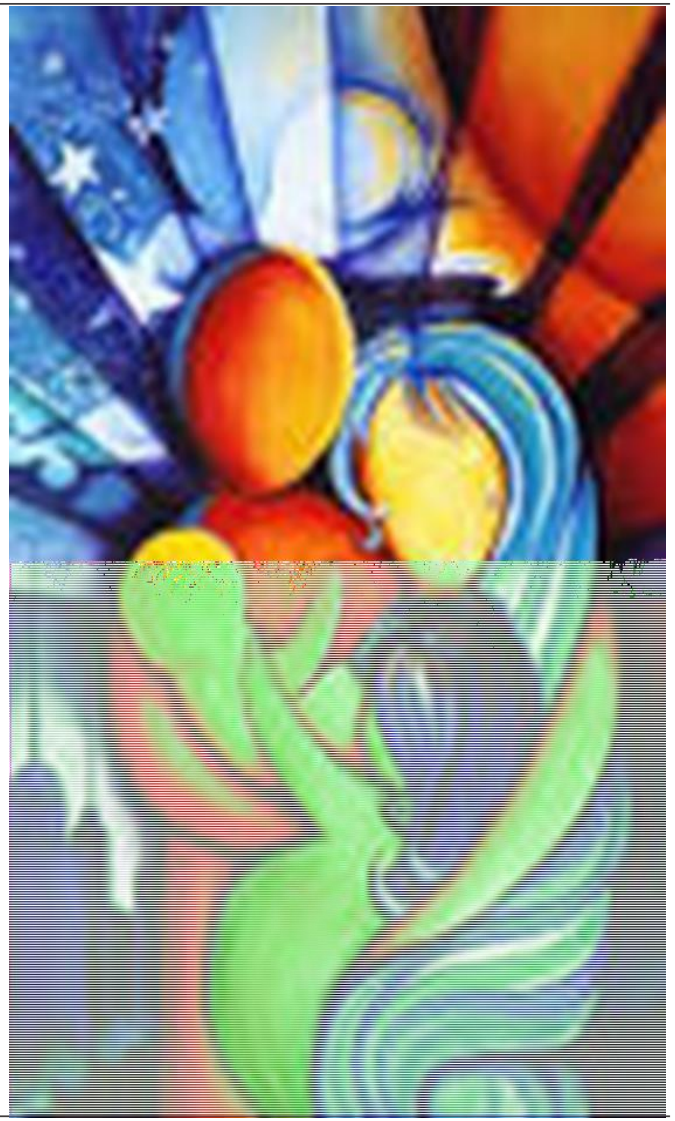
Domestic violence and abuse: multi-agency working (NICE PH50) (2)

8. Tailor support to meet people's needs
9. Help people who find it difficult to access services (identifying and overcoming barriers)
10. Identify and refer children and young people affected by DV
11. Provide coordinated support for children and young people affected by DV
12. Provide specialist DV services with advocacy and advice services tailored to level of risk and specific needs
13. Provide people who experience DV and mental health condition with evidence-based treatment
14. Commission and evaluate tailored interventions for people who perpetrate DV and abuse
15. There should be different levels of training for health and social care professionals on DV issues depending on degree of expertise
16. Primary care services (including GPs) should include training and referral pathways for DV
17. Provision of pre-qualification and ongoing post-qualification education and training on DV

Quality Statement 6: Psychological interventions

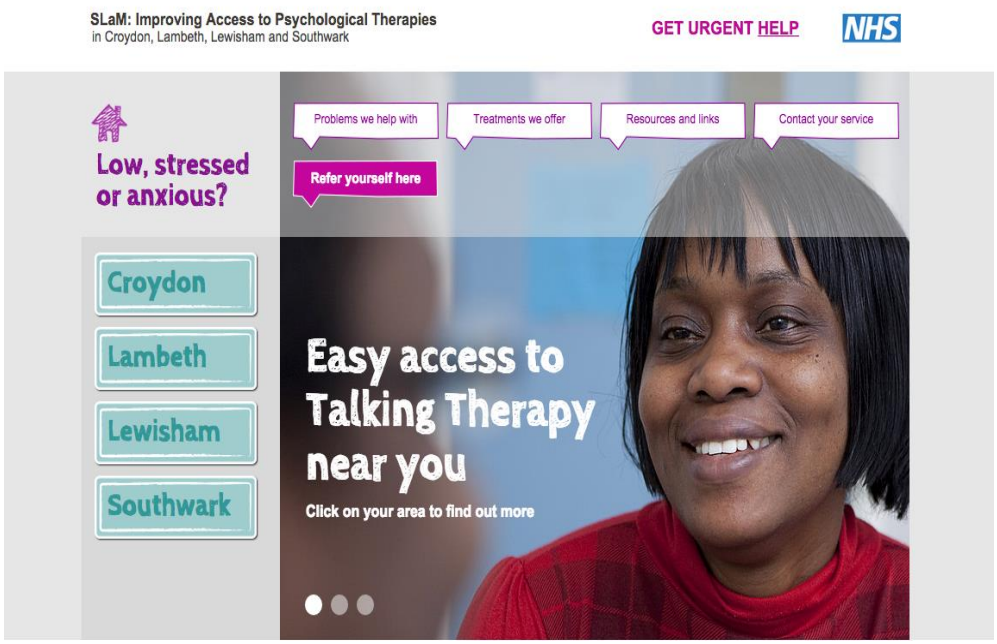
- Women referred for psychological interventions in pregnancy or the postnatal period start treatment within 6 weeks of referral.

- Psychological interventions should be tailored to the (sometimes highly specialist) needs of women in pregnancy and the postnatal period, and to support the baby's development, attachment and mental health.



IAPT: Improving Access to Psychological Therapies

- Since 2008, psychological therapies provision in England for adult common mental disorders
- Psychological Wellbeing Practitioners (PWPs)
- Evidence-based therapies, e.g. CBT (cognitive behavioural therapies)
- ‘Stepped care’ (low and high intensity)
- Routine outcome monitoring
- 900,000 people access the service each year
- GP or self-referral

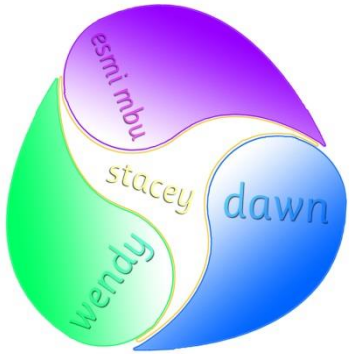


ESMI: Effectiveness of Services for Mothers with Mental Illness

NHS
National Institute for Health Research

Examine the effectiveness and cost-effectiveness of perinatal psychiatry services

@swmh_ioppn @ESMI_Research



DAWN: Depression- an exploratory parallel-group randomised controlled trial of antenatal guided self-help for women (1)

- Mild to moderate antenatal depression (no current treatment)
- Pilot RCT guided-self help vs care as usual
- Primary outcome: EPDS score at 14 weeks post-randomisation (also measured at 12 weeks postpartum)


Trevillion *et al. Trials* (2016) 17:503
DOI 10.1186/s13063-016-1632-6

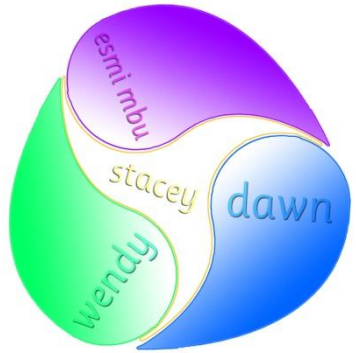
Trials

STUDY PROTOCOL Open Access

Depression: an exploratory parallel-group randomised controlled trial of Antenatal guided self help for WomeN (DAWN): study protocol for a randomised controlled trial

Kylee Trevillion[1], Jill Domoney[1], Andrew Pickles[1], Debra Bick[2], Sarah Byford[1], Margaret Heslin[1], Jeannette Milgrom[3], Rachel Mycroft[1], Carmine Pariante[1], Elizabeth Ryan[1], Myra Hunter[1†] and Louise Michele Howard[1*†]

Trevillion K, Domoney J, Pickles A, et al (2016). Depression: an exploratory parallel-group randomised controlled trial of Antenatal guided self help for WomeN (DAWN): study protocol for a randomised controlled trial. Trials, 17(1), 503

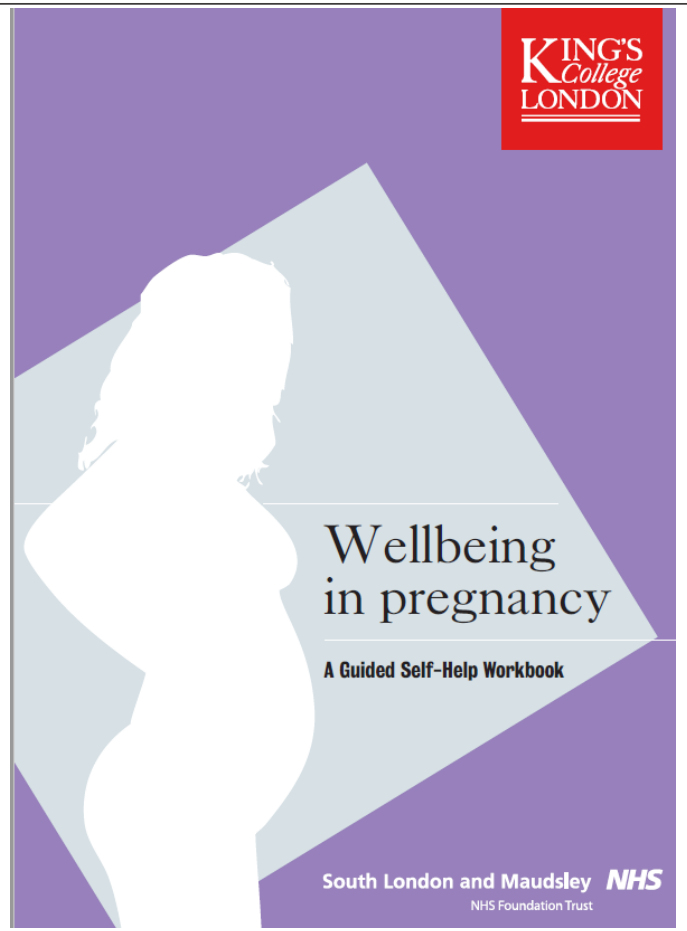


DAWN: Depression- an exploratory parallel-group randomised controlled trial of antenatal guided self-help for women (2)

- Minimum 4 sessions assumed to be needed
- PWPs supervised by experienced perinatal psychologist
- Additional training on perinatal mental health
- Up to 8 sessions and 1 postnatally (12 weeks)

Includes:

- ✓ Psycho-education about symptoms and causes of depression; focus on pregnancy
- ✓ Introduction to CBT model
- ✓ Managing relationships in perinatal period
- ✓ Development of maternal-fetal attachment and reflecting on how we learn to be parents
- ✓ Health and lifestyle, including smoking and nutrition
- ✓ Preparing for parenthood



To obtain a PDF, e-mail: admin-swmh@kcl.ac.uk

WENDY: Well-being in pregnancy in an inner city maternity service

- **545 women in South London interviewed 2014-2016.**
- **Prevalence on SCID of any mental disorder in the antepartum: 27%.**

Howard L, et al (2018). Accuracy of the Whooley questions and the Edinburgh Postnatal Depression Scale in identifying depression and other mental disorders in early pregnancy. BJPsych, 212(1), 50-56.

Quality statement 7 (developmental): Specialist multidisciplinary perinatal mental health services

Specialist multidisciplinary perinatal community services and inpatient psychiatric mother and baby units are available to support women with a mental health problem in pregnancy or the postnatal period.

- **Clinical networks should be established for perinatal mental health services**
- **These networks should provide:**

✓ **specialist multidisciplinary perinatal service in each locality**

✓ **access to specialist expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding**

✓ **clear referral and management protocols for services**

Perinatal services in South London and Maudsley (SLaM)

- Four community perinatal teams across four boroughs in South East London
- Mother and baby unit at Bethlem Royal Hospital

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Community Perinatal Team

- From pre-conception counselling up to one year postpartum
- Referrals from GPs, midwives, general psychiatric services (we may co-work or provide advisory role)

South London and Maudsley NHS Foundation Trust

Team members and services include:

- Clinical psychology
- Nurses who can visit patients at home
- Perinatal psychiatrist
- Nursery nurse for support with parent-infant relationship
- Occupational therapist
- Pharmacist

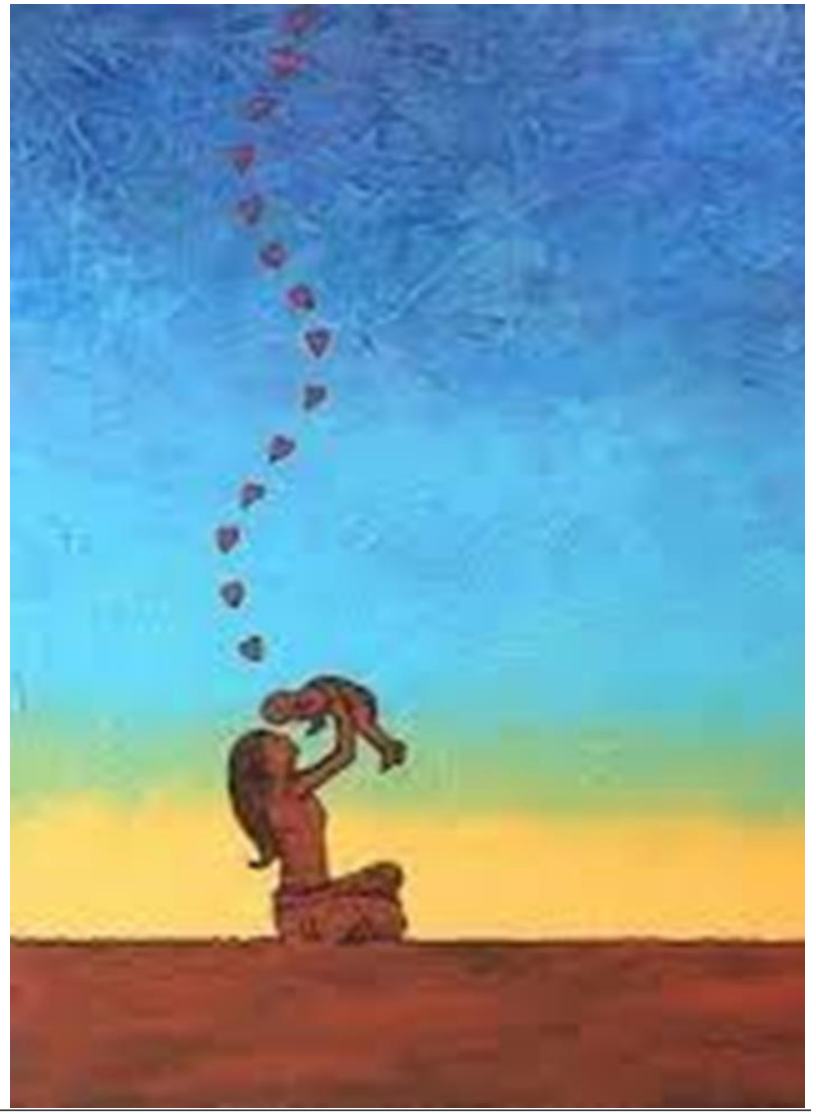
Perinatal Care Plan (1)

- **NICE CG192: develop an integrated care plan for a woman with a mental health problem in pregnancy and the postnatal period that sets out:**

✓ **care and treatment for the mental health problem**

✓ **roles of all healthcare professionals, including who is responsible for: 1) coordinating the integrated care plan, 2) the schedule of monitoring, 3) providing the interventions and 4) agreeing the outcomes with the woman**

- **Pre-birth Planning Meeting**



Perinatal Care Plan (2)

Name: DOB: Address and tel: **EDD:**

Perinatal Mental Health Service:

Maternity service:

Psychiatric diagnosis:

Current medication:

IDENTIFIED PROBLEMS / NEEDS / RISKS:

PLAN:

During Pregnancy:
Labour / Delivery:
Postpartum Period:

CRISIS/CONTINGENCY PLAN:

Relapse indicators: *also include safety plan*
If an urgent assessment is needed:

- Contact your GP
- Attend your nearest Accident and Emergency department
- Contact your CMHT

CHILDREN & FAMILIES SOCIAL CARE:

Any safeguarding concerns with past pregnancies?
Any concerns with current pregnancy?

Current Children & Families Social Worker:

PROFESSIONAL CONTACTS:

GP:
Midwife:
Health visitor:
Also known to:

Care plan written by: Date:

If you or any of the professionals involved in your care have any questions about this plan please leave a message with our team administrator on:

Liaison with OB/GYN

- Midwives and obstetricians invited to pre-birth planning meeting.
- Sharing of perinatal care plan.
- Weekly meeting to discuss patients.
- Midwives phone team if concerned about patients in hospital.

Mother and Baby Unit (MBU) at Bethlem Royal Hospital

- Referrals from across the UK
- 13 beds for mothers and their babies
- Holistic treatment programme also involving fathers/partners
- Specialist clinical psychology assessment- impact of trauma and child abuse, mother-infant relationship and assessment of cognitive functioning
- Psychological therapies inc couples and family therapy
- Mother-infant relationship support, inc baby massage, video feedback with nursery nurse, infant physical and emotional development, parenting skills and promotion of attachment
- Occupational therapies for mother and baby (e.g. cooking, finances, swimming, art, music, dance)

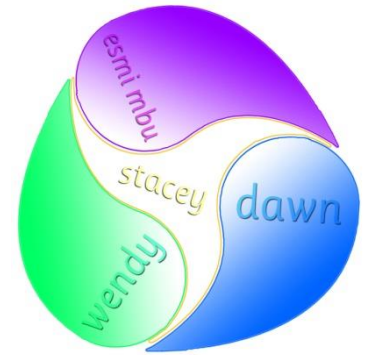
South London and Maudsley NHS Foundation Trust

Effectiveness and cost-effectiveness of services for women with acute severe mental disorders (ESMI-MBU)

Observational study comparing effectiveness of:
- **Psychiatric mother and baby units**
- **Generic inpatient wards**
- **Home Treatment Teams/Crisis Resolution Teams**

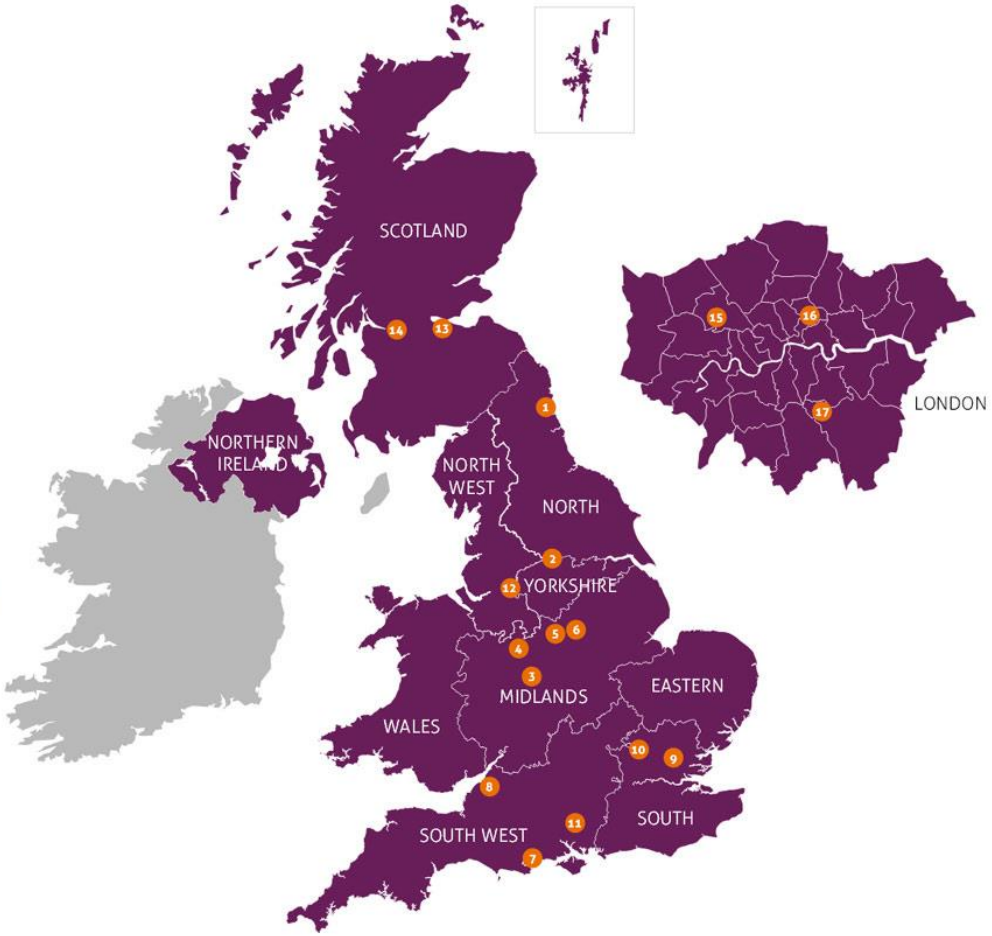
Primary one year outcomes:
- **Readmission rate**
- **Number of inpatient days**

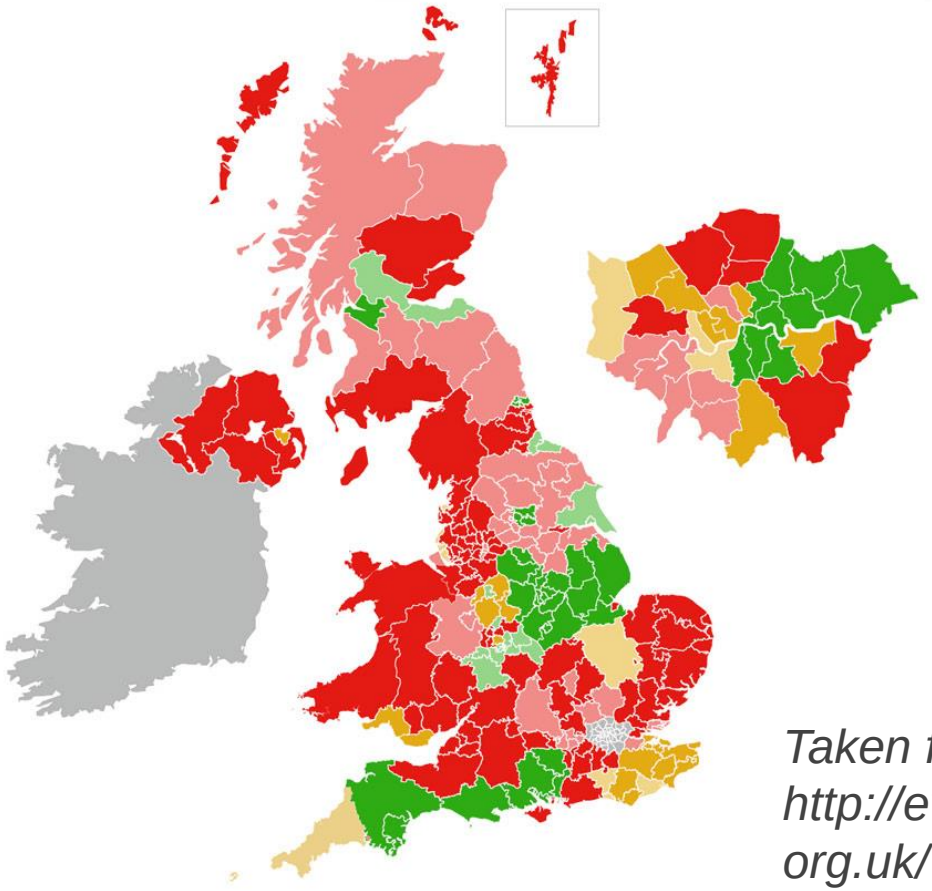
Secondary outcomes:
- **Service use and cost-effectiveness**
- **Quality of life**
- **Unmet needs**
- **Service user experience**



Recent Visit from Duchess of Cambridge

Maternal Mental Health Alliance: Everyone's Business





Taken from http://everyonesbusiness.org.uk/?page_id=349

Other networks promoting perinatal mental health

APNI (Association for Postnatal Illness): www.apni.org

APP (Action on Postpartum Psychosis): www.app-network.org

PANDAS Foundation: www.pandasfoundation.org.uk

SRIP (Society for Reproductive and Infant Psychology): https://srip.org

IFWIP (International Forum for Wellbeing in Pregnancy): www.ifwip.org

Marce Society: https://marcesociety.com

NHS England Perinatal mental health community services development fund

- Five Year Forward View for Mental Health 2016: by 2021, increased access to specialist perinatal mental health support in all areas of England
- £365 million
- Phased, 5 year transformation programme: build capacity and capability in specialist perinatal mental health services
- Establishing regional networks of experts and workforce development
- Increasing MBU provision
- Community development fund:

✓ Organisations submit funding proposals for up to 3 years

✓ Expanding existing specialist community teams into a wider geography
Resourcing small new teams with limited provision to meet the needs of local populations more comprehensively

RCPsych Perinatal Quality Network

- https://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualitynetworks/perinatal/perinatalqualitynetwork.aspx
- Evaluation of performance
- Peer review
- Accreditation

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