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The new Perinatal MH service

Launching fully 1st December 2017

With **all of us** in mind.

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Our mission and values

We exist to ***help people reach their potential***

With **all of us** in mind.

Charlotte Bevan

South West Yorkshire Partnership NHS Foundation Trust

- Charlotte had a history of psychosis and was detained 4 times under MHA
- She was prescribed risperidone
- She stopped her medication in pregnancy so she could breast feed her baby
- She relapsed quickly despite restarting medication
- She was filmed on CCTV walking off the post natal ward unseen with her 4 day old child
- Her and her baby's bodies were found at the base of the nearby Avon Gorge cliff in Dec 2014

HM Coroner's comments:

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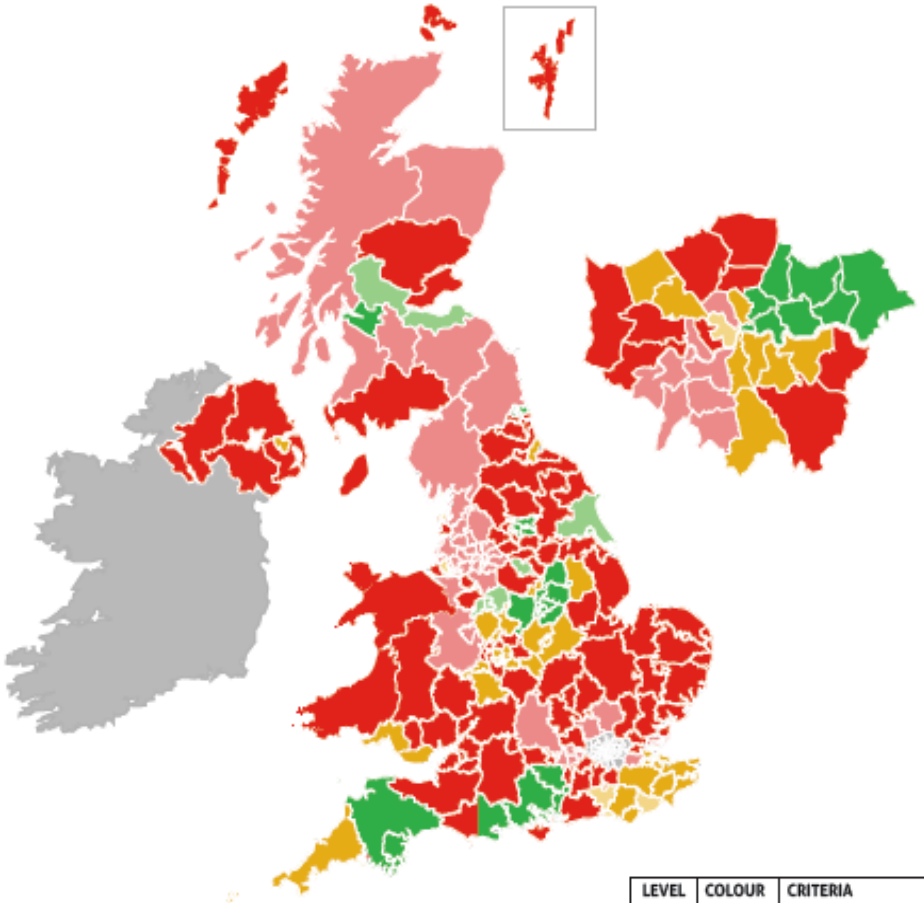
- "Once Charlotte gave birth her mental health began to deteriorate and she suffered a relapse which should have been diagnosed and managed appropriately"
- "That failure was contributed by the fact there was no care plan".
- "A chain of failures contributed to Charlotte's and Zaani's deaths."
- HM Coroner made a ***Prevention of Further Deaths*** order to NHS England and other commissioning groups requiring them to respond outlining what action will be taken

UK Specialist Community Perinatal Mental Health Teams (current provision)

MATERNAL MENTAL HEALTH
everyone's business

NHS England



LEVEL	COLOUR	CRITERIA
5		Specialised perinatal community team that meets Perinatal Quality Network Standards Type 1 http://www.rcpsych.ac.uk/pdf/Perinatal%20Community%20Standards%201st%20edition.pdf
4		Specialised perinatal community team that meets Joint Commissioning Panel criteria http://www.rcpsych.ac.uk/pdf/perinatal_web.pdf
3		Perinatal community service operating throughout working hours with at least a specialist perinatal psychiatrist with dedicated time AND specialist perinatal mental health nurse with dedicated time, with access to a perinatal psychiatrist throughout working hours
2		Specialist perinatal psychiatrist AND specialist perinatal nurse with dedicated time
1		Specialist perinatal psychiatrist or specialist perinatal nurse with dedicated time only
0		No provision

Disclaimer Levels of provision in this map have been assessed using the best information available to us from local experts but have not been independently verified. Please contact info@everyonesbusiness.org.uk if you suspect any inaccuracy or know of recent developments that may alter the level of provision level in any area listed here.

2015

www.england.nhs.uk

NHS England Response

Preparation and planning

- Develop and publish robust, **evidence-based care pathways** that incentivise early intervention, holistic approaches to care and recovery to support commissioning and delivery.
- Invest in **perinatal MH networks** and ensure operating in all regions of the country to provide clinical expertise and leadership and support strategic planning (including local workforce strategies).
- Develop and deliver comprehensive **workforce strategy** to increase supply of specialist workforce. Develop and publish **MDT skills and competency framework** for recognition, treatment and support for

Building capacity

- **Increase mother and baby unit provision**, including delivery of new MBUs and increasing existing capacity where needed.
- Develop and implement strategic **collaborative commissioning models** so that inpatient mother and baby units serve the needs of large populations and are closely integrated with specialised community perinatal mental health teams.

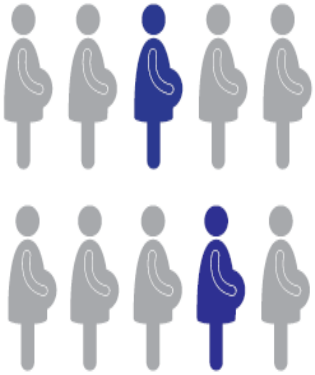
Securing transformation

- Ensure that NICE-recommended, **specialist community perinatal services** are available in each locality, which provides direct services, consultation and advice to maternity, other MH and community services.
- Develop **standardised data and outcomes measures** for all perinatal mental health services.

NHS England: Commitments

Funding	• **£365m** from 2015/16-2020/21 (Government announced £290m in January 2016, building on spring budget announcement)
MH5YFV	• Additional investment so that by 2020/21, an additional **30,000** women in all areas of the country should receive access to evidenced-based specialist support, closer to their home, when they need it.
NHS England programme	• Phased approach to build capacity & capability in specialist perinatal mental health services. • 3-wave implementation strategy • Outcomes focused on improving access and experience of care with joined up approaches; early diagnosis and intervention

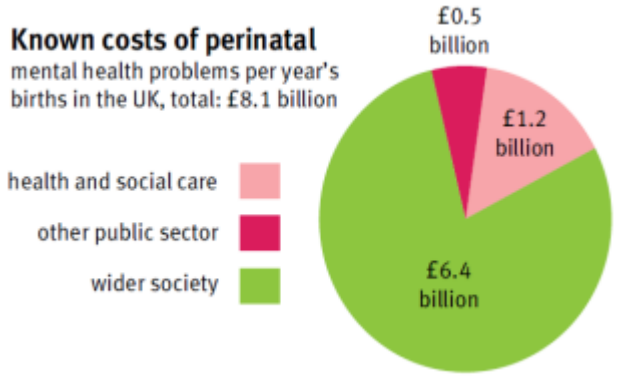
Specialist care matters



Up to 20%

of women develop a mental health problem during pregnancy or within a year of giving birth

Known costs of perinatal
mental health problems per year's births in the UK, total: £8.1 billion



Of these costs

28% relate to the mother

72% relate to the child

Key messages

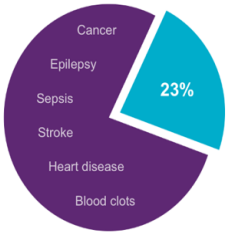
from the report 2015

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

9 women per 100,000 died up to six weeks after giving birth or the end of pregnancy in 2011 - 13

14 more women per 100,000 died between six weeks and a year after their pregnancy in 2011 - 13

Mental health matters



Almost **a quarter** of women who died between six weeks and one year after pregnancy died from **mental-health related causes**

1 in 7 women died by **Suicide**

Specialist perinatal mental health care matters*

If the women who died by suicide became ill today:

- **40%** would not be able to get any specialist perinatal mental health care.
- Only **25%** would get the highest standard of care.

It's OK to tell

The mind changes as well as the body during and after pregnancy.

Women who report:

- New thoughts of violent self harm
- Sudden onset or rapidly worsening mental symptoms
- Persistent feelings of estrangement from their baby

need urgent referral to a specialist perinatal mental health team

*Mapping data from the Maternal Mental Health Alliance (http://everyonesbusiness.org.uk)

Source: LSE and Centre for Mental Health, *The cost of perinatal mental health problems* (2014)

SWYPFT 1st Wave PMH Bid

Bid development project group:

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The Proposed Service will -

- Be a specialist community mental health team, working through a 'hub and spoke' model.
- Directly manage care for the most complex cases
- Provide specialist support and co-working with existing local mental health and maternity pathways, blending specialist expertise with local service delivery
- Manage the patient journey into and out of specialist Mother and Baby units.
- Provide education and advice
- At a cost £1m per year

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SWYPFT Plan

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- 14,600 births per year
- Make a difference to 2,920 women per year
- Provide a specialist community perinatal mental health service for 730 people per year.

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What is perinatal mental health?

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- Time specific – preconception to one year post-natal
- All mental illnesses
  - Some illnesses specific to this time period
- Needs a specialised service who are expert in these illnesses at this time
- Expertise in medication, psychological and social interventions during pregnancy and post-natally
- Meeting the needs of the mother, the baby and the family

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Red Flags – Warnings of potential suicide

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

- These are signs of severe mental illness and require urgent senior psychiatric assessment

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Other warning signs

- Mum presenting in the first 6 weeks post-delivery with a severe depressive illness
- Mum having thoughts of running away
- Previous history of attempted suicide or self-harm
- Any thoughts of harm to child or psychotic thoughts relating to child

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Be especially careful with:

- Mums who have a history of bipolar disorder
- Mums who have a history of psychosis (incl. post natal)
- Mums with a family history of the above
- Refer these mums during pregnancy, **even if they are well**

Reduced threshold for care/admission in the perinatal period than at other times

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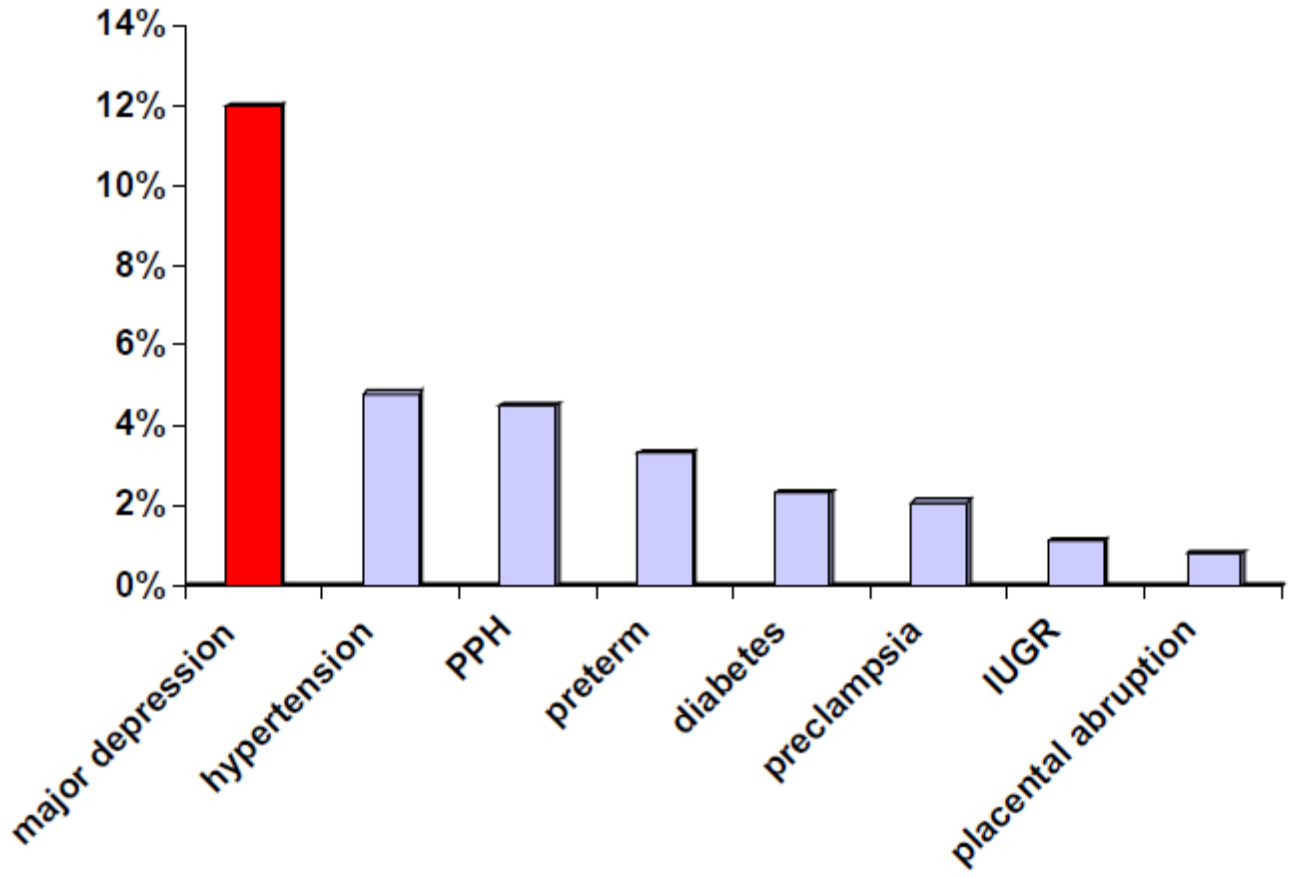
Incidence of Perinatal Mental Disorder



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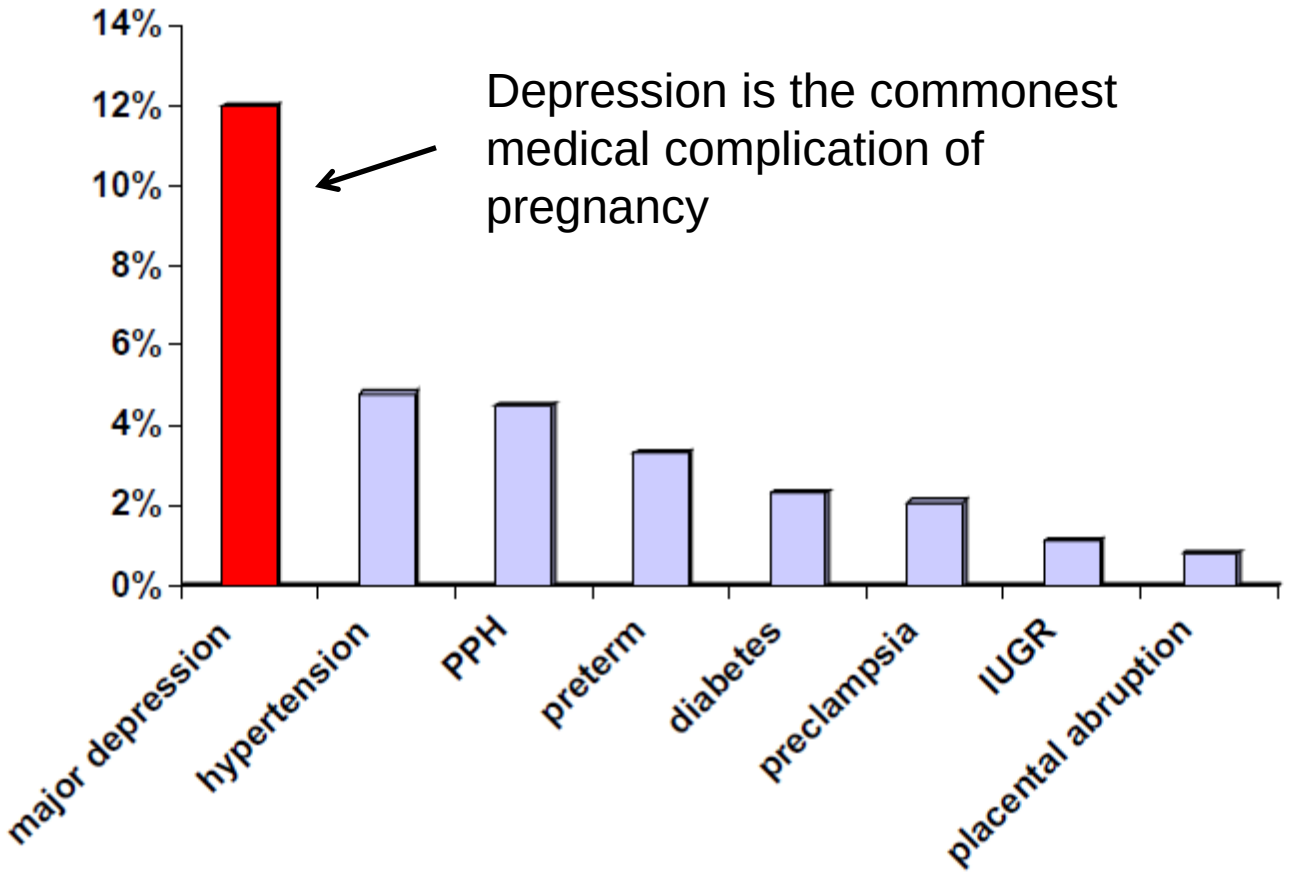

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Learning point 1

- Making mums-to-be more aware of the risks of post natal depression during pregnancy makes it easier for them to ask for help later
- This might be the most important thing you can do

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Questions:

- Q: If you had just had a baby and were referred to mental health services, what would your first thought be?
- A: “They want to take my baby away from me”
- A: “They think that I’m an unfit mother”

- Q: What % of mums hide or downplay their symptoms?
- A: 70%

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Learning point 2

Have reduced thresholds for:

- accepting what is a symptom of post natal mental illness
- treating any illness that you discover

- think of it a bit like alcohol – hear the level of symptoms someone says, then double it

Questions

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- Q: What is the relapse rate of depression in mums who stop taking antidepressants in pregnancy?
- A: 70%
    - more severe depression = higher likelihood relapse

- Q: What happens when people get stressed/depressed?
- A: Increased use of alcohol, nicotine, drugs; worse diet; reduced/delayed engagement in antenatal care; 4-fold increase in reduced birthweight in depressed vs non-depressed mums; increased rate of ADHD, conduct disorder & ?autism

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Learning point 3

- Automatically stopping antidepressants if a woman becomes pregnant is not necessarily the safest option for baby
- Risks of treating vs. risks of not treating
- Support mum to make the best choice for her and her family (?effects of depressed mum on other children)
- Keep an eye out for post natal anxiety and OCD too
- **Babies do best with well mums**

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Some facts about antidepressants

- There is no “safest” antidepressant in pregnancy
- Antidepressants are not major teratogens
- Avoid sub-therapeutic doses
- Avoid multiple drug combinations
- A drug with known efficacy may be preferable to one with unknown efficacy and lower potential risk (e.g. if mum has never responded to multiple SSRI’s but has responded well to venlafaxine, venlafaxine may be more appropriate than an SSRI, even though less evidence)

Some facts about other drugs

- The group to avoid in pregnancy are anti-epileptic mood stabilisers:

  Valproate

  Carbamazepine

  Lamotrigine (9 fold increase in risks of ASC's)

  - Cardiac risk of lithium is raised, but is lower than we used to think
  - If a mood stabiliser is required, olanzapine, quetiapine and aripiprazole are safer choices

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Breastfeeding

- Most drugs are at lower levels in breast milk than in utero
- Don’t breastfeed on valproate, lithium or clozapine (doubts about lamotrigine and carbamazepine)
- Sertraline & paroxetine are the most appropriate SSRI’s if a new treatment is needed, nortriptyline and imipramine if SSRI not appropriate
- LactMed is a good app for your phone

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WAKEFIELD
- PMH Practitioner
- Psychology
- 3,985 births

HUDDERSFIELD
- PMH Practitioner
- Psychology
- 5,375/2 births

PMH HUB
DEWSBURY
- 1.0 Team Manager
- 1.0 Consultant Psychiatrist (C&K)
- 1.0 Consultant Psychiatrist (B&W)
- 1.0 Occupational Therapist
- 1.0 PMH Practitioner B6 N Kirklees
- 2.0 PMH Practitioner B5
- 1.0 Secretary
- 5,375/2 births

BARNSLEY
- PMH Practitioner
- Psychology
- 2,811 births

CALDERDALE
- PMH Practitioner
- Psychology

2,433 births

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What are we?

- A specialist, multi-disciplinary perinatal community team with strong operational and clinical leadership
- An agile, Trust-wide service
- Part of an integrated system working with mental health, maternity, primary care, and acute services
- Excellent links with Leeds Mother & Baby Unit
- Delivering NICE concordant care and producing better outcomes for women and families

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What we offer

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- We specialise in the assessment, diagnosis and treatment of women affected by a moderate to severe mental health problems during and after pregnancy.
- Provide advice about medication both in pregnancy and postnatal period.
- Advice for women planning pregnancy who have concerns about their mental health.
- We will agree individualised plans of care and treatment for pregnancy and the postnatal period.
- We will work together with service users, families, MH teams and all the services involved the perinatal pathway

PERINATAL CARE AND REFERRAL PATHWAY

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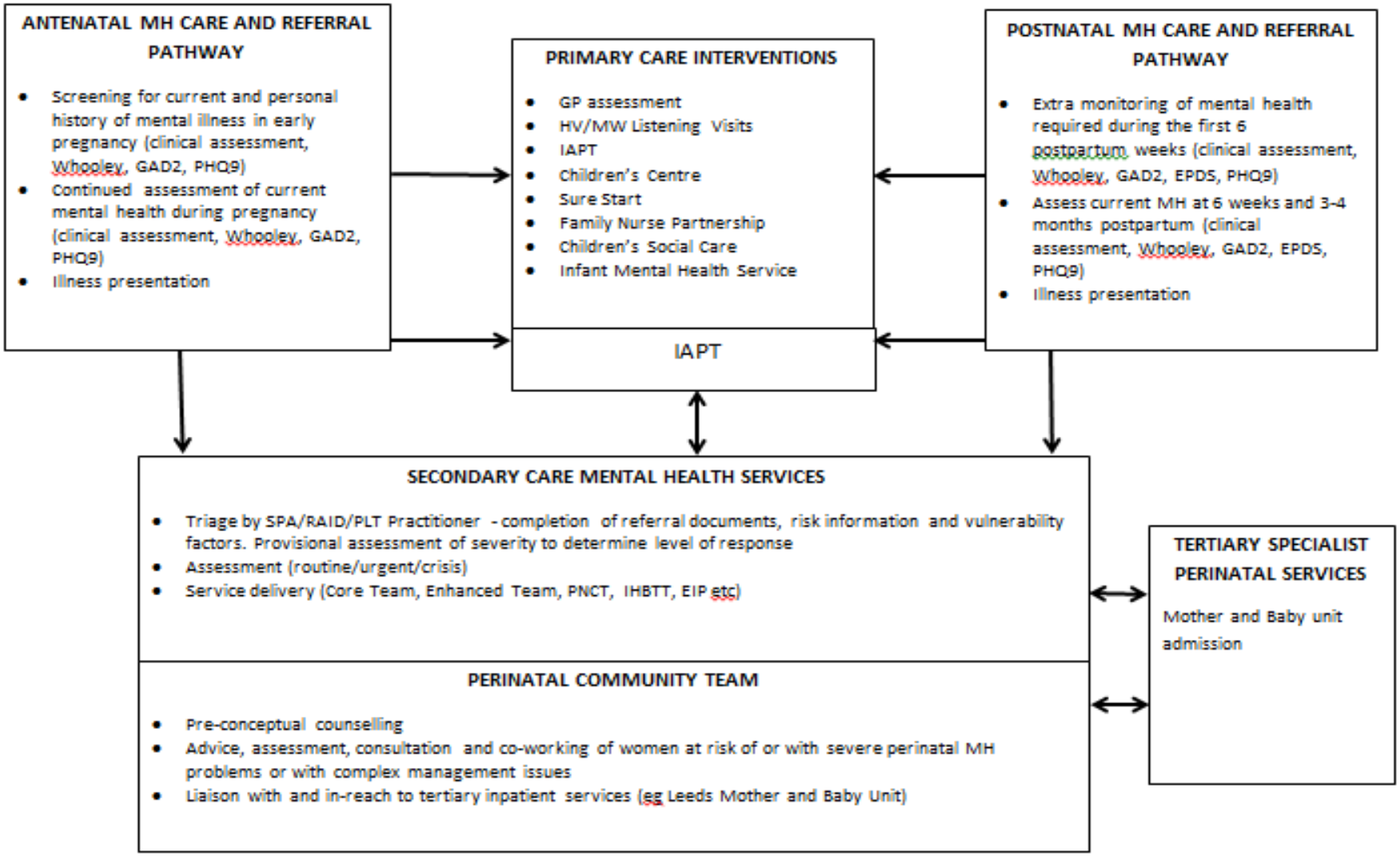

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Descriptor	PMH Team role
1. Crisis/urgent referrals of women suspected of a rapid onset or a first episode of SMI in the perinatal phase.	The team will be available to do a joint assessment with CRHTT within 4 hours during normal working hours. Consider MHA assessment.
2. Women with serious mental disorder for whom it may be possible to offer home-based treatment rather than inpatient care	As above plus joint provision of a community crisis care plan. Daily review of risk and need for M&B admission.
3. Women stepping down from inpatient care	Where appropriate/necessary PMH can care coordinate. Care will be transferred to the most appropriate team as needs indicate. Joint working with pre-existing care coordinator Relapse planning/prevention
4. Women in the early postnatal period who are suffering from a new episode/significant maternal MH difficulty requiring secondary care.	Joint assessment if possible. PMH will lead the care and engage the most appropriate team as needs indicate.
5. Existing service users in the early postnatal period who are suffering from a significant maternal MH difficulty requiring secondary care.	Ideally a care/contingency plan would have been jointly developed during pregnancy. Some joint working may be offered – particularly in Core pathway.

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6. Women who are currently suffering from significant mental health problems who become pregnant	Advice and help with care/contingency plan. Some joint working may be offered
7. Pregnant women who have been identified as being at high risk of serious postnatal illness or relapse.	To develop a contingency plan (including M&B unit, IHBTT and a care coordinator/team 'in waiting' for potential future need) Maintain contact, particularly in later stages of pregnancy and following birth.
8. Women with a history of SMI who are planning a pregnancy.	Advice regarding available support and specialist advice regarding use of psychotropic medication in pregnancy
9. Consultation and advice on for pregnant/post-partum women receiving treatment in IAPT	Specialist advice regarding use of psychotropic medication in pregnancy and post-partum Group-work for higher volume, lower risk mothers
10. Consultation and/or advice on medication for women receiving treatment in primary care.	Specialist advice regarding use of psychotropic medication in pregnancy and post-partum

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Contact us:

Tel: 01924 316009

Intranet site:

http://nww.swyt.nhs.uk/perinatal/Pages/default.aspx

To Refer:

Please contact your local SPA in the first instance

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Thank you