Perinatal mental Health

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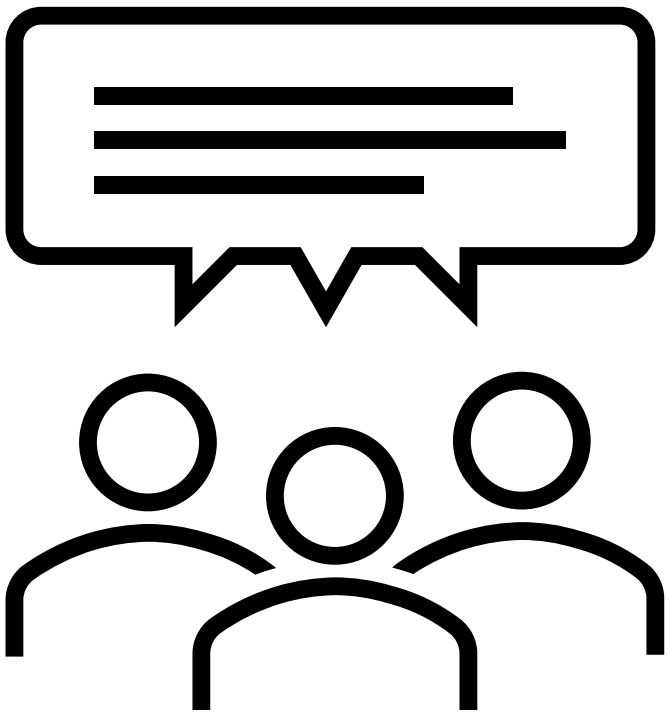
Ocean
Birth Trauma and Loss Service

Aims of the session.

- What is Perinatal Mental health and why is it important?
- A brief overview of some common perinatal mental health problems.
- Who might be vulnerable to perinatal mental health difficulties?
- What services are available locally?

Take care of yourself.

What would you like from today?



Perinatal mental health (PMH) has typically been understood to refer to the mental health of mothers during pregnancy and the first year after birth. There is now an expanded definition of PMH as the mental health and wellbeing of the whole family in the period relating to:

preconception
conception
pregnancy
up to 24 months following birth of a child

- During this time birthing people have lots of contact with services.
- Creating a window of opportunity for health and wellbeing promotion.

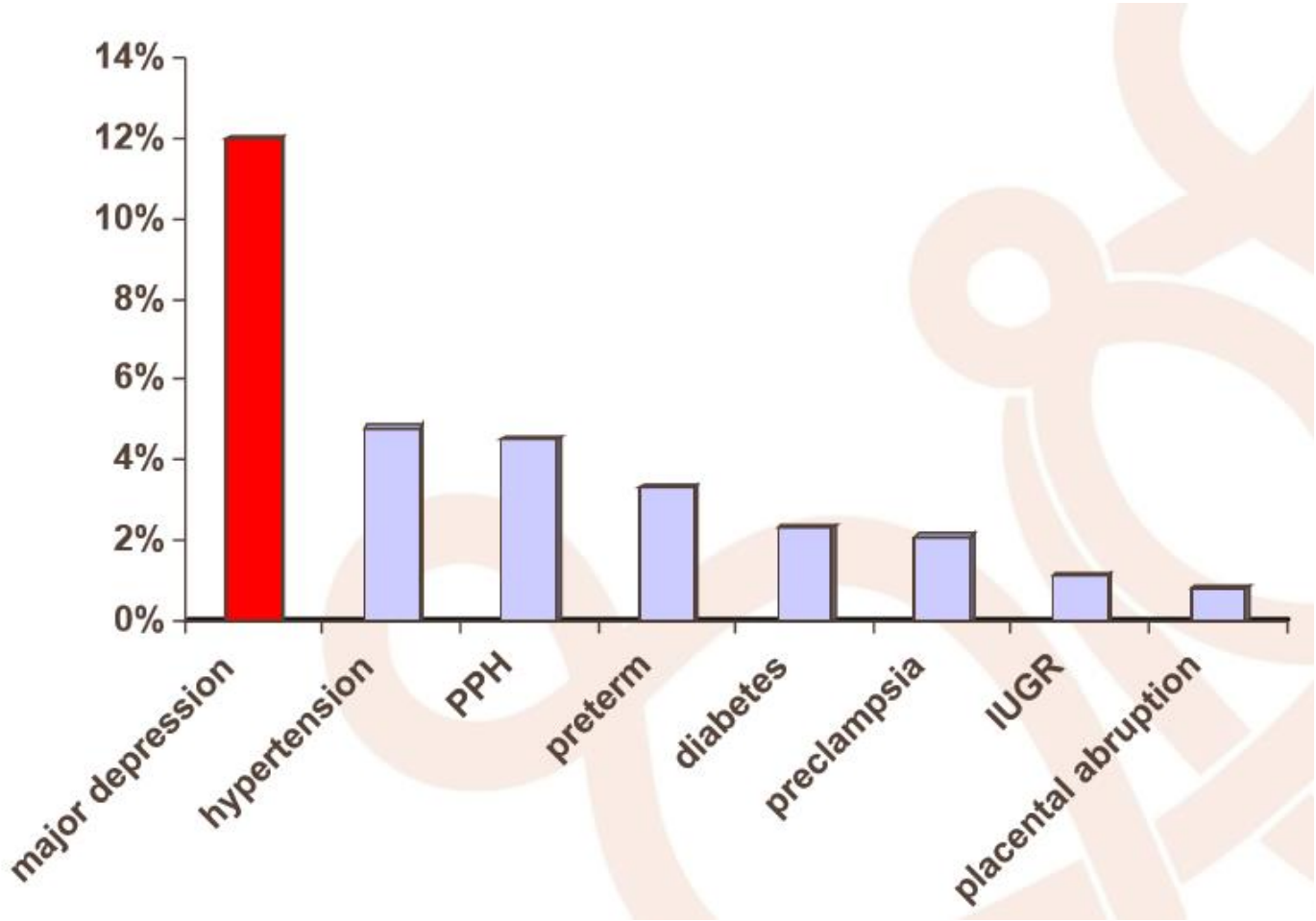
BUT……..

Table 1 shows the rates of perinatal psychiatric disorders per 1000 maternal deliveries [8],[9].

Psychiatric disorder	Rate
Postpartum psychosis	2/1000
Chronic serious mental illness	2/1000
Severe depressive illness	30/1000
Mild-to-moderate depressive illness and anxiety states	100-150/1000
Post-traumatic stress disorder	30/1000
Adjustment disorders and distress	150-300/1000

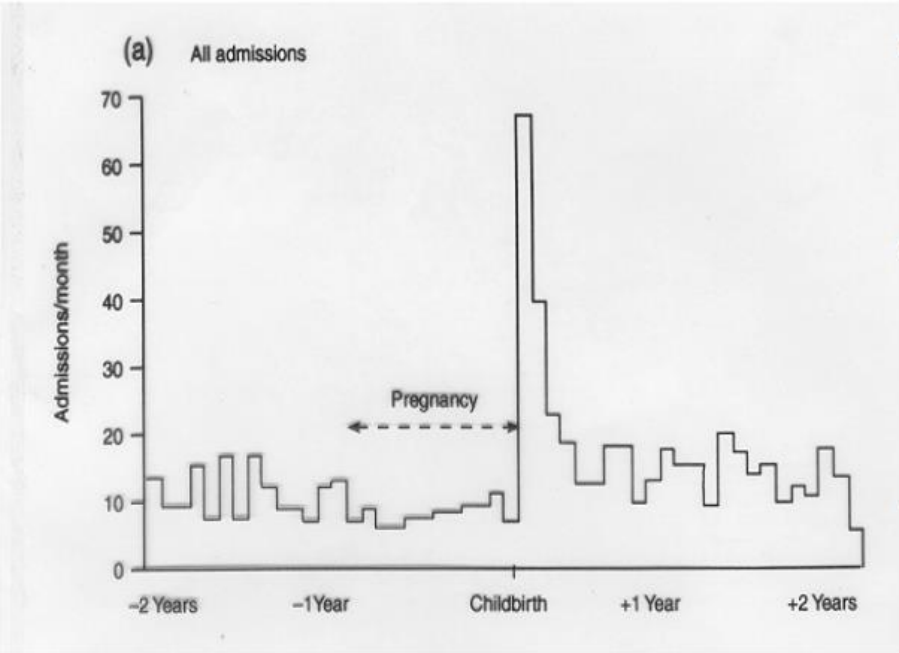
Table 1 Perinatal psychiatric disorders per 1000 maternal deliveries

Depressive illness. The most common major complication of maternity



What factors in perinatal period might impact on a birthing persons mental health?

Epidemiology of Perinatal Mental Illness

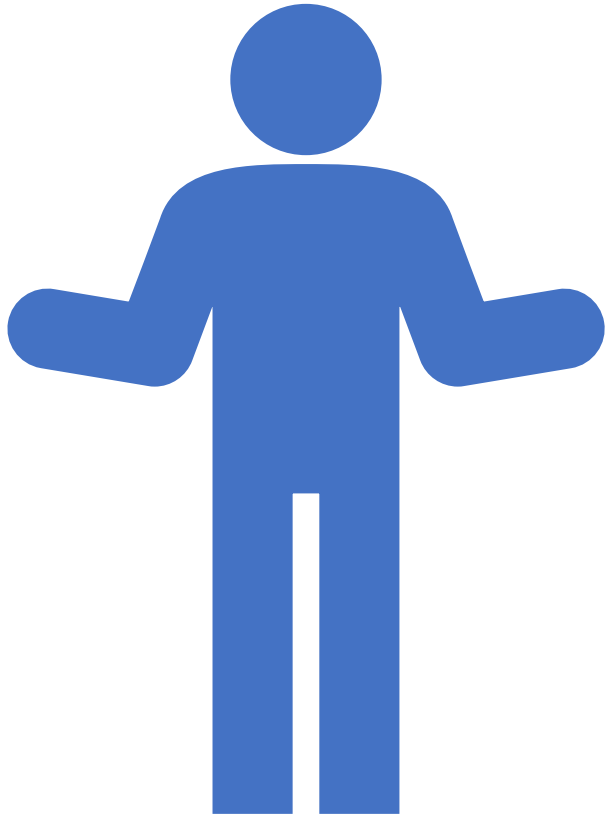


- Pregnancy does not protect against new mental illness
- Women are at particular risk of new onset severe mental illness in the early postpartum
- Clinical picture characterised by rapid deterioration

Up to 20%

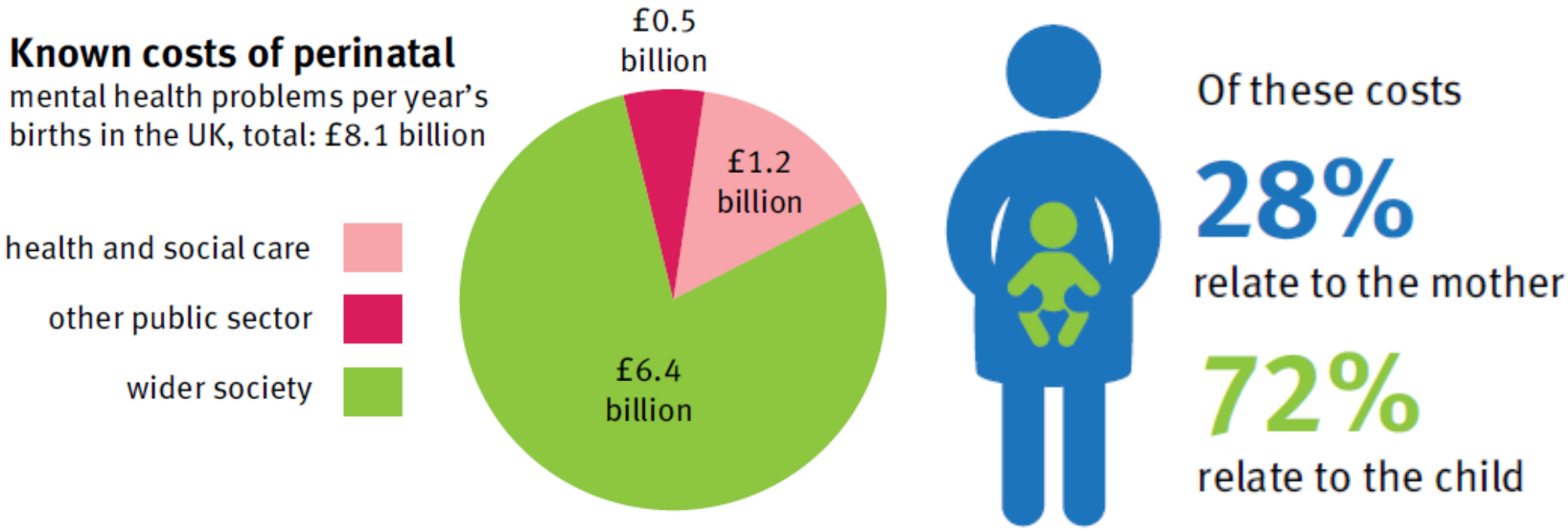
of women develop a mental health problem during pregnancy or within a year of giving birth

Why do you think this might be?



Film: Holding the baby in mind.

- What Happens In The Womb Can Last A Lifetime - Begin Before Birth - YouTube



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

Impact of the perinatal experience.

Tokophobia (Severe fear of childbirth) and Birth trauma.

- A recent large metanalysis suggests that 14% of women experience a severe fear of childbirth(tokophobia),this rate has been increasing since 2000. Indicating across BSW approximately **1267** women per a year are experiencing severe fear of birth and may benefit from treatment. (O'Connell et al 2017)
- The prevalence of PTSD are thought to range from 0-7% with rates for women in higher risk groups of up to 26% (Ayres et al 2008) If we take a **conservative** estimate of 4% of women developing PTSD as a result of her birth experience that would equate to approximately **362** women (Dikmen Yildez et al. 2017).
- In practice there is a huge overlap between these two groups.

Birth and PTSD

A review and meta-analysis of 59 studies of the prevalence of PTSD during pregnancy and postpartum showed that **4%** of women develop PTSD after birth (Dikmen Yildez et al., 2017).

Ayers 2017:
Factors that increase the likelihood of Perinatal PTSD.

A meta-analysis of 50 studies found that key vulnerability factors were

- A history of PTSD.
- depression in pregnancy.
- fear of childbirth.
- poor health or complications in pregnancy .
- The strongest risk factors during birth were a negative subjective birth experience.
- having an operative birth (i.e. assisted vaginal or caesarean section) .
- lack of support during birth, and dissociation.
- After birth, PTSD was associated with poor coping and stress, and was highly comorbid with depression.

The impact of neonatal admissions.

- 1 in 7 babies are admitted to a neonatal unit which across BSW equates to approximately **1293** babies per a year.
- A recent meta analysis estimated that around 27.1% of parents experience high levels of post traumatic stress symptoms as a result of their baby being admitted to a neonatal unit more than one year after the admission. Indicating around **350** parents per a year across BSW (Malouf et al 2020)
- Levels of anxiety were also found to be high at 24.5% one year after birth. Equating to approximately **317** parents per a year across BSW.

PTSD following pregnancy loss:

- **29%** of people who experience **miscarriage** go on to develop PTSD
- **21%** of people who experience **ectopic pregnancy** go on to develop PTSD
- **64.5%** of people who experience **Termination for Medical Reasons (TFMR)** go on to develop PTSD
- **30%** of people who experience **stillbirth** have PTSD (even 5-18 years later)
- People who experience **Sudden Infant Death Syndrome (SIDS)** are **7 times more likely** than the general population to develop PTSD
- **39%** of mothers who experienced **infant death** go on to develop PTSD
- **15%** of fathers who experienced **infant death** go on to develop PTSD

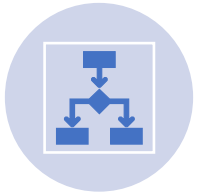
(PTSD UK)

What factors do you think might reduce these problems?

Trauma informed care:

Safety

Trustworthiness



Choice

Collaboration

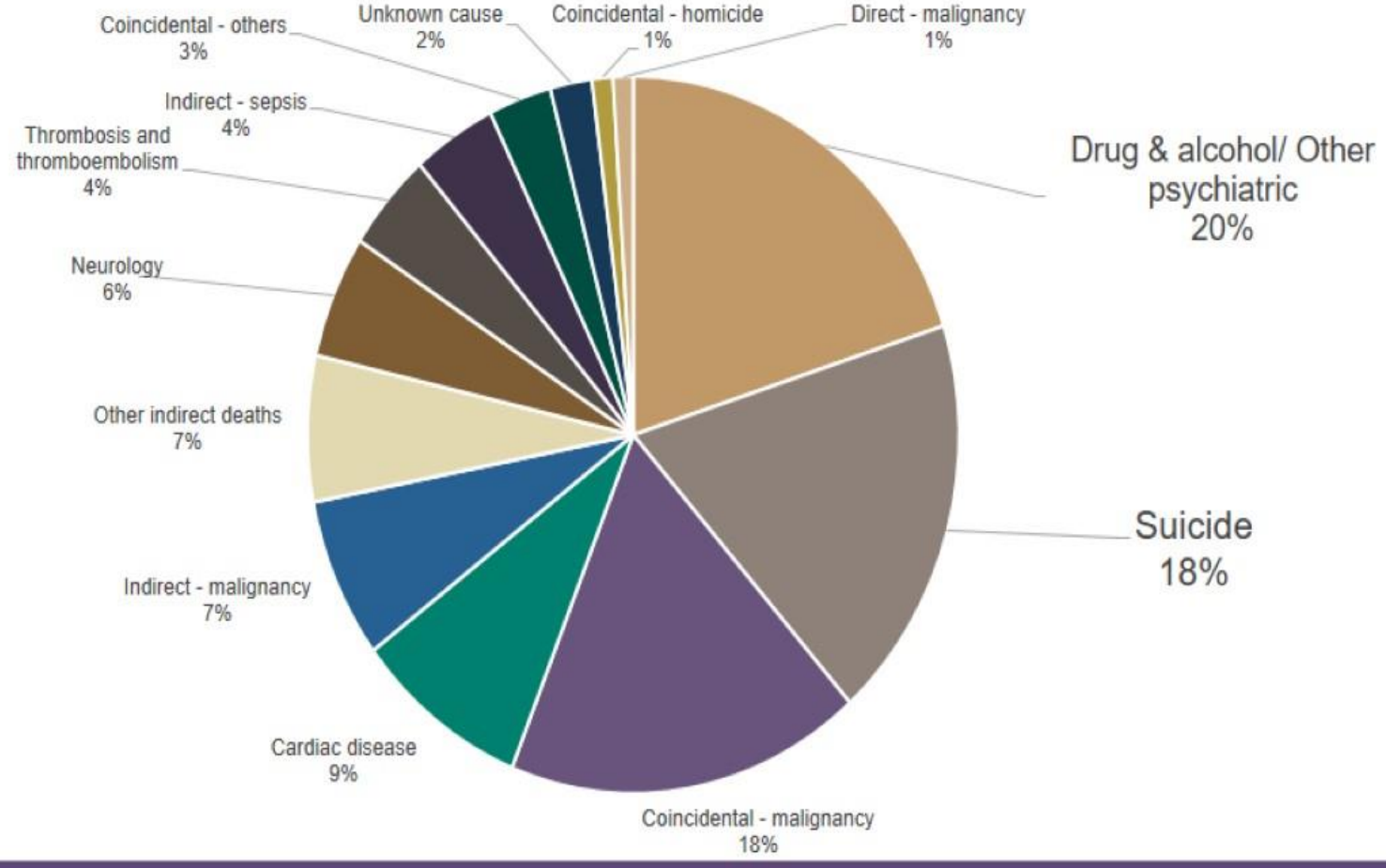
Empowerment

Cultural consideration

The impact of PMH problems on maternal health can be significant and long-lasting. Suicide is a leading cause of death in the perinatal period; 40% of deaths within the year after pregnancy are from mental-health related causes [11].

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

Causes of death amongst women who died between six weeks and one year after the end of pregnancy, UK 2018-20



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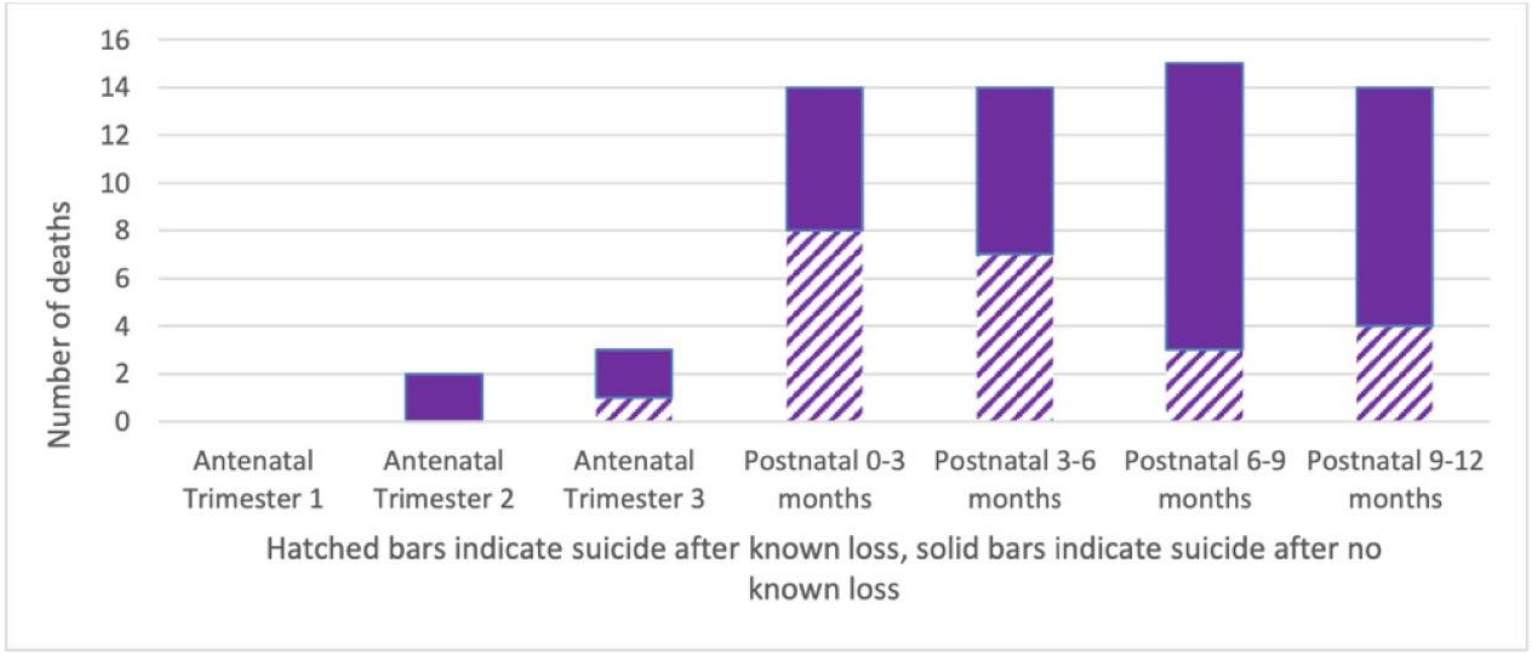
Suicide – timing



MBRRACE 2022 Report

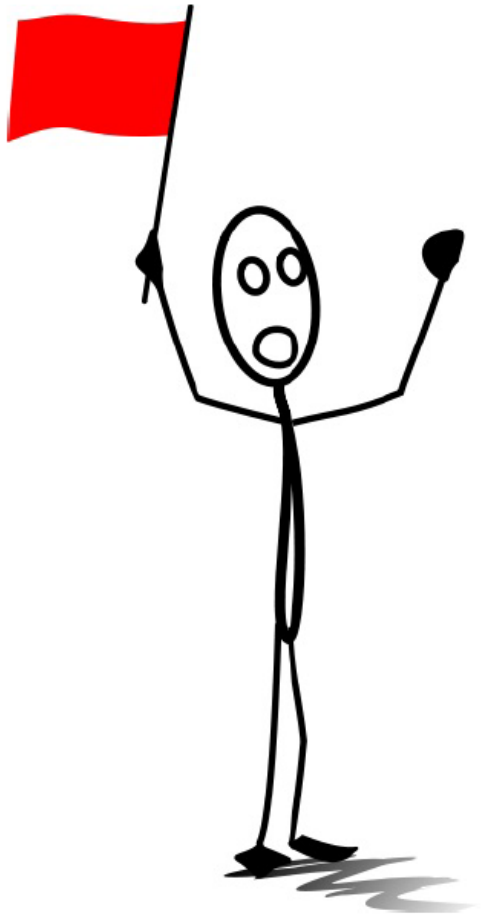
- **40%** of deaths within the year after pregnancy were from mental health-related causes.
- Suicide remains the **leading cause** of direct maternal death in the first postnatal year.
- Suicide during pregnancy or up to six weeks after is increasing:
  In 2020, women were **three times more likely** to die by suicide during this period compared to 2017-19.
- Very few women who died by suicide in 2020 had formal mental health diagnoses, but significant numbers had a **history of trauma**.
- Young mothers are at increased risk of experiencing mental illness during pregnancy and after birth compared to those over 25, with postnatal depression up to twice as prevalent in teenage mothers
- compared to those over 20 (Salisbury et al., 2021).

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

Teenage Suicides

	SUICIDE N (%)	RATE
2014-2016	2 (3)	2.5/100,000
2017-2019	7 (11)	11/100,000
2020	5 (18)	27/100,000

RR 11.44 (1.87-120.12) p=0.0056 compared to 2014-16



1. Recent significant change in mental state or emergence of new symptoms

2. New thoughts or acts of violent self-harm

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

Red Flag presentations

A moment to reflect:

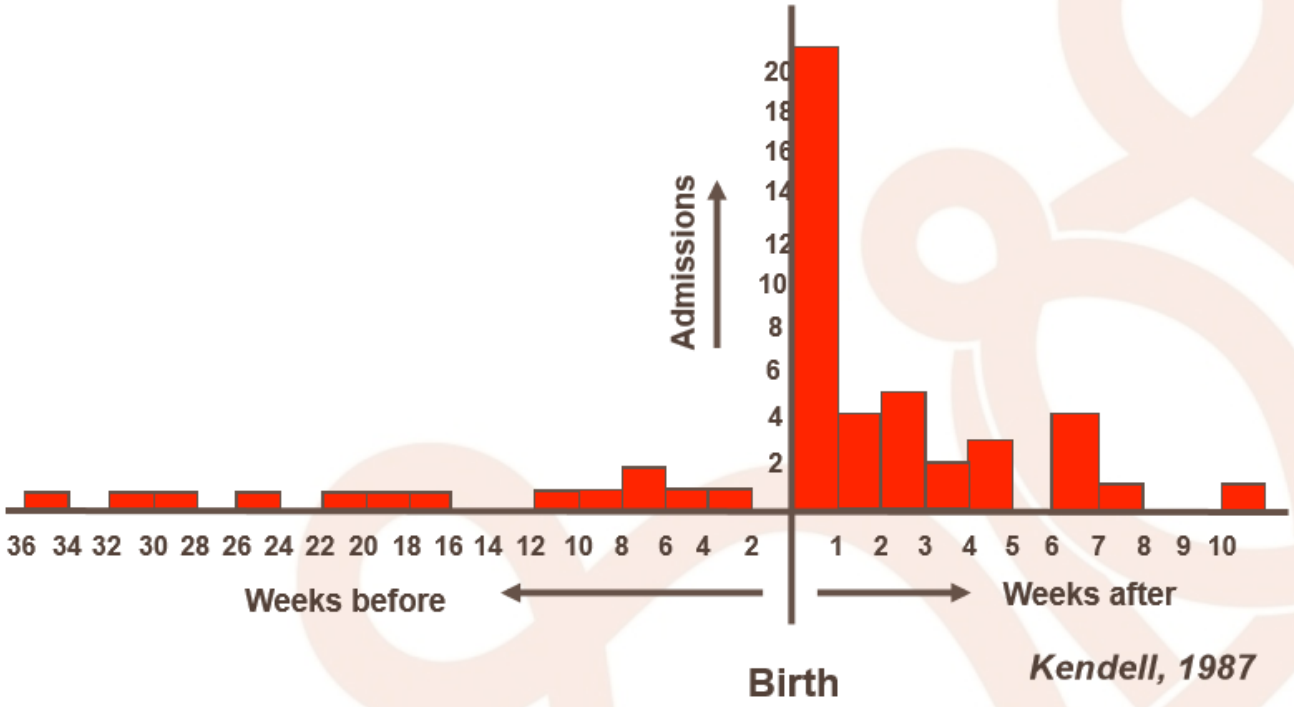
Thinking about the Family.

- Good practice: supporting partners and family members in specialist perinatal mental health services (youtube.com)

What do we know about postpartum Psychosis?

- Rare but serious (1-2/1000 births)
- True psychiatric emergency
- Often missed/underestimated
- Some are predictable therefore preventable
- Action on Postpartum Psychosis | The national charity for mums and families affected by postpartum psychosis (app-network.org)

Highest ever risk of psychosis…



Puerperal psychosis: more rapid onset, more severe, and higher risk than at any other time (Oates, 1996; Appleby et al 1998)

Common Symptoms of PPP include:

Fluctuating presentation (rapid change from appearing well to unwell, can occur over minutes to hours)
Confusion, disorientation (need to exclude organic cause)
Impaired attention
Perplexity
'Kaleidoscopic'
Restlessness, over-activity
Insomnia
Labile mood, irritability
Affective mood symptoms – depression/elation
Hallucinations, delusions, thought disorder
Family will often report subtle changes:
eg: "*I can't put my finger on it, but she is just not herself*"

Early symptoms

(Heron 2008, on Action on Postpartum psychosis website)

Symptom	number (%)
Excited, elated, high, 'over the moon' giggly	66 (52)
Active, energetic, overactive	47 (37)
Chatty, sociable, talking more, always on the phone	45 (35)
Busy mind, racing thoughts, lots of ideas	40 (31)
Muddled thinking, mixed up, confused, not with it, disorientated	37 (29)
No need for sleep	32 (25)
Not able to sleep	29 (23)
Irritable, people getting on nerves, arguing, angry, impatient	29 (23)
Anxious	24 (19)
In a dream world, unreal, detached from world	21 (17)
Efficient, organising, lots of housework, making lists, lots of jobs	20 (16)
Distractible, getting nothing finished	19 (15)
Fearful, 'paranoid'	16 (13)
Disinhibited, saying/doing things would not normally say/do	14 (11)
Looking after baby easy, 'super-mum', capable, self-confident	13 (10)

Can't sleep even when its possible to…

Avon and Wiltshire Mental Health Partnership NHS Trust

AWP

Predictable therefore preventable?

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**

I suspect PPP. What do I do?

- Refer immediately to your local Intensive service, stating that you think this is a potential PPP.
- If mum or baby in immediate danger call 999!

This will trigger the post partum psychosis pathway within MH services

First person to receive referral must immediately clarify presenting situation:

Has patient had a baby in the last year?
Does the patient present with <u>any</u> symptoms consistent with PPP?
Do they present with one or more of the following:
Recent significant change in mental state/new symptoms
New thoughts or acts of violent self harm, however fleeting
New and persistent expressions of incompetency as a mother/estrangement to infant

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

Crisis Team Response:
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
Face to face assessment within 4 hours of referral

Increasing access by reducing health inequalities

Reaching women from groups who are currently under-represented in services is an essential element of the LTP expansion:

- Women from **ethnic minority backgrounds**, particularly Black African, Asian and White Other (*who have lower rates of access to MH services in the perinatal period*)

- **Young mothers** (*45% PMH needs in 16-25 year olds*)
- Women living in deprived areas

Women in the criminal justice system or prison estate

- Migrant or trafficked women
- Women escaping domestic abuse
- Neurodivergent women
- Women with learning disabilities
- Parents from LGBT communities

For these women, an assertive outreach approach and co-working into community and faith groups may be needed.

This work can be slow to reap rewards: so measurement of success needs to allow for this.

For more **information**, **resources** and **case studies**, please see the **Addressing Health Inequalities** section of the Perinatal MH Future NHS Collaboration Platform.

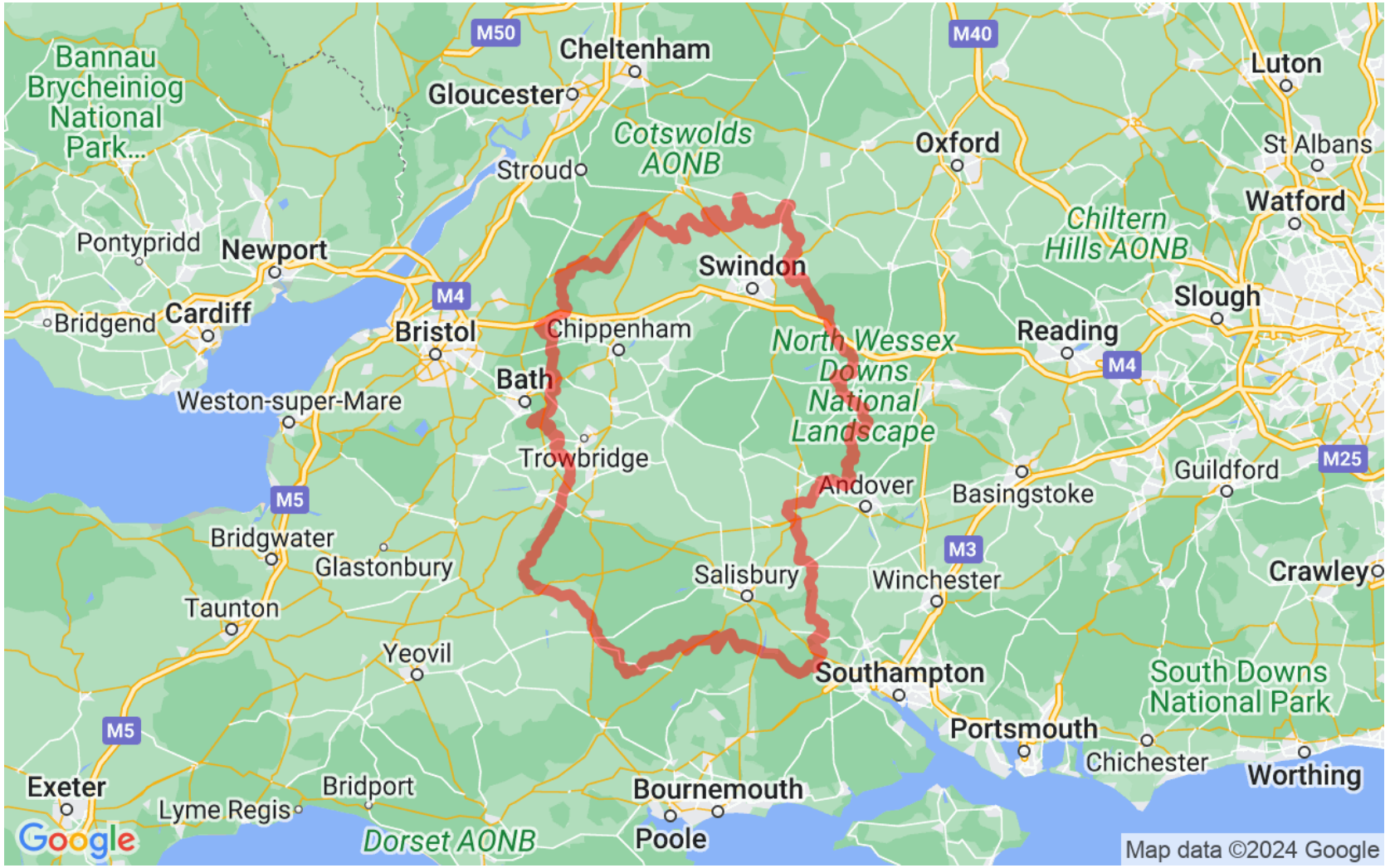
Up to 20%

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

Film

Perinatal Mental Health Awareness Video - Antenatal Education (youtube.com)

Services in our area



ABOUT THE PERINATAL TEAM…

- Two teams operate over the Bristol, North Somerset and South Gloucestershire (BNSSG) and Bath, Swindon and Wiltshire (BSW) localities.
- Our teams are made up of Admin, Mental Health Nurses, Social Workers, OT's, Nursery nurses, Recovery Practitioners, Wellbeing practitioner (BSW), Psychologists, Parent Infant Therapists (BNSSG) Peer support (BSW), Consultant, speciality Doctor and Pharmacist
- Service operates during normal office hours
- BSW are the access service for all perinatal women from 12 weeks gestation until 9 months postnatal
- BNSSG accept referrals from 12 weeks until 20 months postnatal

Perinatal Service - criteria

- Pre-pregnancy, for pre-conceptual medication advice
- During pregnancy for medication advice
- During pregnancy (from 12 weeks gestation) for assessment
- BSW: Up to 9 months post-partum (we can currently work with people until baby reaches 12 months if there is an ongoing perinatal mental health need)
- BNSSG: Up to 20 months post-partum, working up to 24months for Perinatal Mental Health need
- For postnatal women, they **must have** baby in their care for the Perinatal Service to accept referral
- Those already under care of secondary mental health services for adjunct working in pregnancy and up to 12 weeks postnatal where clinically indicated

Perinatal Work-streams

Advice & Guidance Service to Professionals

- *Available to all professionals involved in their care*
- *Case discussions*
- *Referral queries*
- *Medication advice in pregnancy and breastfeeding*
- *Signposting to other available services*

New referrals

- *Assessed according to presenting risk where **moderate to high risk** is:*
  - *Women where new and emerging mental health disorder arises during perinatal period*
  - *Women with existing serious mental illness*
- *Where patient meets need for input, PMHT will accept for active review/management*

Perinatal – Urgent referrals

The Perinatal Team **IS NOT** a crisis/emergency service

Timeframe for assessment – **within two weeks**

Perinatal Duty Practitioner triages referral the same day

If triage/contact identifies assessment required sooner, or urgently (E.G. concerns regarding risk to self/others, or presenting with **perinatal red flags**), PMHT may refer to PCLS/triage or Intensive services.

Patients presenting with symptoms of Post-Partum Psychosis is classed as **PSYCHIATRIC EMERGENCY**, and must be referred to **Intensive Team** for urgent review (**within 4 hours**).

Interventions offered

- Pre-conception advice
- Bio-Psycho-social Assessment
- Medical reviews
- Medication advice & guidance
- 32 week Maternal Mental Health Planning
- Evidence based Psychological interventions; CBT, IPT, EMDR, DBT skills: maternal emotional coping skills group/COPE, Behavioural couples therapy
- Care coordination/adjunct key working
- Nursery nurse interventions
- OT interventions
- Peer support (BSW)
- Parent-Infant interventions; including Mellow Bumps, Neonatal Behavioural Observation, Infant massage, Video Interaction Guidance

Ocean: Birth Trauma and Loss service

BSW Ocean: Birth Trauma and Loss
(Maternal Mental Health Service)

Women who are experiencing moderate/severe/complex mental health problems which are directly linked to pregnancy, childbirth and baby loss:

Trauma

Trauma occurring in the perinatal context (e.g. those experiencing PTSD following a traumatic birth or PTSD as a result of NICU experience).

Loss

This may include those who have experienced loss of a baby through miscarriage, stillbirth, neonatal death or termination of pregnancy for any reason

Fear

A severe fear of childbirth (tokophobia) regardless of previous experience of pregnancy.

What are we seeing in practice?

- In reality it is difficult to fit people into a specific pathway; For example, a woman may have PTSD as a result of her perinatal loss, in addition she has a high level of anxiety in her subsequent pregnancy. In effect she would sit in all three pathways.
- This highlights the importance of careful assessment and individualized, personalized treatment plans.
- However, this does present challenges when recording the service statistics.

Our aim is to offer care that meets the needs of the individual in collaboration with the wider MDT.

Ocean service offer.					
	Loss			**Perinatal trauma.**	**Fear**
	Miscarriage, ectopic and recurrent miscarriages	Stillbirth and Neonatal death	Removal of baby by social care.	• Birth trauma • Traumatic loss (Any gestation) • Trauma experinced in Neonatal unit.	• Primary Tokophobia. • Pregnancy specific anxiety. • Fear of Birth.
Access route	• Clinician referral • Self-referral	• Clinician referral	TBC	• Antenatal self-referral • Clinician referral.	• Antenatal self-referral • Clinician referral
Ocean Midwife and Early loss Support Practitioner.	Early loss support Practitioner offers: • Screening assessment. • Psychoeducation around normal reactions to loss. • Self-care. • Signposting to local and national support.	Ocean team work closely with local Bereavement Midwives. Local bereavement midwife will usually provide support in the immediate postnatal period and during subsequent pregnancy. Bereavement midwives invited to discuss cases in fortnightly MDT meetings.		Ocean Midwife offers a range of individualised support: • understanding previous experience. • Development of a birth preferences document. • Navigating the maternity system • Advocating. • Targeted antenatal education. • Psychologically safe maternity unit visits. • Post-natal follow up.	Ocean Midwife offers a range of individualised support: • understanding previous experience. • Development of a birth preferences document. • Navigating the maternity system • Advocating. • Targeted antenatal education. • Psychologically safe maternity unit visits. • Post-natal follow up.
Courses: Facilitated by two team members.	Pregnancy after loss course. Aim to run first course Summer 2023				Manging anxiety in pregnancy course: First course running June 2023.
Ocean Psychological Therapists.	Formulation-driven psychological intervention offered - Trauma-focused CBT, EMDR if PTSD present, or personalised psychology.				

Training sessions offered to a range of staffing groups across BSW, each session tailored to the requirements of the group.

Mother and Baby Units

Avon and Wiltshire Mental Health Partnership NHS Trust

- Specialist inpatient units for the treatment of Mum and baby together
- Commissioned from 32 weeks gestation to 1 year postnatal
- NICE recommends treatment of Mother and baby together where safe to do so
- New Horizons (AWP local 4 bedded Bristol Unit) BSW: Closest are Bournemouth and Winchester but New Horizons approached first
- It is not a parenting assessment unit
- Partners support and perinatal mental health is paramount: Paternal depression increases to 24-50% where partner experiences PND (Goodman 2004) Partners have higher rates of paternal depression when partner on MBU.

AWP

Any Questions?

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