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Perinatal Mental Health

Dr C I Okocha
MB,BS; Ph.D; FRCPsych
Medical Director

improving lives
Perinatal mental health: what and why?

- MH problems in pregnancy to one year post partum
- MH disorders are a leading cause of maternal death*
  - 50% by suicide
  - 60% of suicides in 6 weeks before delivery & 12 weeks post delivery
- Period of significant vulnerability
- Impact on child/children and family
- Safeguarding
- Majority of women with perinatal illnesses are treated in Primary care
- Antenatal and postnatal mental health NICE guidelines
Pregnancy: some issues for women

• Pregnancy
  – Obstetric risk & risk of congenital malformation (2 - 4% of population)
  – Physical, psychological & social adjustments

• Peurperium
  – Physical distress/pain
  – Shifting moods (euphoria, elation, accomplishment, anxiety, sadness)

• Postpartum
  – Physical exhaustion
  – Breast feeding
  – Insomnia
  – Loss of libido
  – Recovery of figure & attractiveness
  – Social privation with confinement and loss of employment
Perinatal mental health issues for women

• Pre-existing mental illness
  – Compliance with treatment
  – Additional burden of symptoms with exacerbation/relapse
  – Risks of medication
  – Increased monitoring

• Emergence of mental illness in pregnancy
  – Increased risk of depression (and anxiety)

• Recurrence of previous mental illness in pregnancy
  – Family history of puerperal illness
  – Any mental illness previously suffered especially depression and psychosis

• Mental illness in the postnatal period
  – Relapse or worsening of any pre-existing illness
  – Maternity Blues, postnatal depression and puerperal psychosis
Perinatal mental health consequences

• Increased risks of:
  – obstetric complications
  – pre-term deliveries
  – still birth
  – specialist care for infant
  – Low birth weight and small for gestational age infants
  – suicide attempts

• Mother-infant relationship disorders (30% of postnatal depression)
  – Lack of emotional response
  – Rejection of infant
  – Pathological anger

• Infant and Siblings
  – Cognitive delay
  – Emotional and behavioural problems
  – Social isolation
  – Psychological & physical health problems
  – Reduced IQ in 11 year olds (esp boys) with PND mothers
  – Neglect and abuse (emotional and/or physical)
Perinatal psychiatric disorders

• Epidemiology
  – Limited research
  – Excess use of ‘self report’ at isolated time points
  – Most research focussed on depression & psychosis
• Same range, nature and course of disorders as other adults
• WHO ICD-10 and APA DSM-IV: no diagnostic guidelines for perinatal mental illnesses.
• ICD-10 & DSM-IV ‘Use of descriptors’ and usual diagnostic guideline for each condition
• Treatment and implications of conditions in antenatal/postnatal period should be paramount
  – Increased risk of episode
  – Rapid onset and so urgent response (Puerperal psychosis)
  – Risk benefit of medication and need for psychological Tx
  – Effect on infant/siblings and families
Perinatal psychiatric disorders

• Anxiety disorders: often co-exist with depression
  – Panic disorder: No increase in prevalence
  – GAD: Higher prevalence of ‘anxiety symptoms’ with 2/3rds continuing into postnatal period
  – OCD: No studies of prevalence but an increase of symptoms reported in established cases and in 41% with depression
  – PTSD: Symptoms following childbirth that decline over time reported. Still birth is a stressor for PTSD in subsequent pregnancy
Perinatal psychiatric disorders

- Eating disorders:
  - Anorexia Nervosa: onset in adolescence, reduced fertility and fecundity so less common in pregnancy
  - Bulimia Nervosa: Amenorrhea and oligomenorrhea are common but fertility and fecundity unaffected

- Higher obstetric risks of miscarriage, C/S, SGA
- Some reports of improvement in pregnancy based on scores on eating attitudes questionnaire.
- Worsening on scores associated with
  - Younger age
  - Previous symptoms and miscarriage
  - LSEC and academic attainment
Perinatal psychiatric disorders

- **Maternity blues**
  - Common and not considered a mental disorder
  - 50% experience dysphoria and uncharacteristic weeping
  - Occurs 3-5 days postpartum but lasts 2-3 days
  - Associated with trait anxiety, depression in late pregnancy & postpartum depression

- **Depressive episode/ recurrent depressive disorder**
  - 10-20% experience symptoms of depression with anxiety about baby’s health, fear of harming baby or baby being deformed or not hers, self blame, irritability & worry at rejection of baby.
  - 2-4 weeks postpartum
  - Resolves with treatment in 4-6 weeks but up to 1 year if untreated
  - Early identification is desirable
Perinatal psychiatric disorders

• Psychosis:
  – Can occur de-novo but rare (2 cases per 1000 live births)
  – Usually a previous history of MDP (70%), puerperal psychosis or family history of puerperal illness
  – 1/3rd present with mania/schizoaffective illness
  – Usually 1 – 3 weeks postpartum but can present at 3 months
  – 21 fold increase in admissions as a result of symptoms of manic disruption, confusion, perplexity and lability of mood
  – No organic or physical causes
  – Hormonal changes that interfere with receptor sensitivity thought to play a role in aetiology
  – Associated with unmarried, primiparity, perinatal death and C/S
Screening and detection: risk factors

• Screening to detect people at risk of developing perinatal MI or identify those with perinatal MI
• Pregnant women generally have frequent contact with healthcare workers
• Risk factors for perinatal MI should be rehearsed e.g.,
  – History of any form of mental disorder or symptoms
  – Family history of MI and puerperal illness
  – Past obstetric history of concern like still birth
  – Pregnant women with difficult social circumstances
• Use of screening questions such as the following for depression
  – 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?
  – A third question should be considered if the woman answers ‘yes’ to either of the initial questions
  – Is this something you feel you need or want help with?

Consider the use of other screening tools e.g., PHQ-9
Safeguarding in the perinatal period

Richard Anderson
Greenwich Safeguarding Lead
Our legal duty

- NHS trusts have a legal duty relating to safeguarding and promoting the welfare of children.
- Children Act sets out ‘being safe’ as one of the five important outcomes for children and young people. In this context, a key provision relates to the duty on all agencies to make arrangements to safeguard and promote the welfare of children.

(Children Act/CQC)
Background and context

• Between one in four and one in five adults will experience a mental illness during their lifetime.
• At the time of their illness, at least a quarter to a half of these will be parents.
Analysis of Serious Case Reviews 2003-2005
161 cases, 47 intensively
and 2005-07
183 cases (123 deaths) 40 intensively
Age at time of Incident 2003-05

- 47% > 16 yrs
- 20% 11-15 yrs
- 16% 6-10 yrs
- 7% 1-5 yrs
- 9% < 1 yr

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Characteristics of parents from intensive study of 47 cases 03-05

- Mental health problems: 55%
- Domestic violence: 66%
- Substance misuse: 57%
- Learning disability: 11%
- Care history: 30%
- Childhood abuse: 43%
- Criminal record: 53%
- Violence: 70%
- Sex offender: 9%
- Offender posing risk to child: 6%
- Previous child death: 9%
Information Sharing

- Key factor in many Serious Case Reviews has been a failure to share information.
- You should always share information with LA children’s social care where there is a reasonable cause to suspect that a child may be suffering or may be at risk of suffering significant harm.
- You should normally seek agreement from the family unless to do so would increase the risk.
• A referral should be made to the local authority children’s service (telephone discussion followed by written referral if appropriate) to initiate a multi-agency assessment (including pre-birth assessment) when:
• The service user (mother or father) is on enhanced Care Programme Approach (CPA)
• There is a previous postnatal illness
• Domestic violence is known to have occurred
• Other children in the family are known to CSSC or previously known
• A person has offences that may suggest that they are a ‘risk to children’
• There is dual diagnosis (substance misuse or disability)
• There are concerns about service user’s own self care
• The degree of mental illness/drug misuse/ learning disability negatively impacts on parenting
• The service user is ambivalent or feeling negative about the pregnancy
• The unborn child is featured in the parent’s delusional thoughts or obsessional compulsive behaviours
• The service user has poor compliance or engagement
• The pregnant mother has been a mental health inpatient during the pregnancy
• There are issues of self-harm/suicidal behaviour during pregnancy
• The pregnant service user has a diagnosis of Bipolar Affective Disorder or Schizophrenia / Schizoaffective Disorder
• Pregnant service user has an eating disorder
• There is contact with an adult (e.g. father) who is known to have a major mental disorder or severe personality disorder involving known risk of harm to self and/or others