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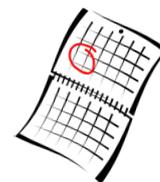
# WELCOME

Welcome to the relaunch of a very overdue Perinatal Quality Network Newsletter! It has been a long while since the last one and with so much going on in the perinatal community we thought it an ideal time to reintroduce it.

In this edition we look over the last few months of work within the quality network and we also welcome several articles from contributing authors. These cover a wide range of topics covering personal journeys, service developments and research. Please take the time to read through these contributions and consider if there might be anything you to want to share!

## Upcoming Dates

Some important dates for your diary in the next few months. Please contact the team if you would like any further information. Full contact details are on the back page.



When	What	Where
Wednesday 20th July	Senior Team Leaders Day: Open to all senior team leaders in perinatal teams	Royal College of Psychiatrists, Aldgate, London
Friday 12th August	Accreditation Reviewer Training: This training will allow you to attend accreditation reviews	Livingston, Scotland
Monday 12th September	Patient Representative Day: Open to all interested in involving patient reps in service development	Royal College of Psychiatrists, Aldgate, London
Friday 23rd September	Nursery Nurse's Day: Open to Nursery Nurses working in perinatal services	Royal College of Psychiatrists, Aldgate, London
Tuesday 15th November	Perinatal Network Annual Forum	Royal College of Psychiatrists, Aldgate, London

# Involving Patient Representatives in Service Development

In 2008 after the birth of my first child, I became extremely mentally unwell with severe depression and anxiety. I had never experienced mental illness and it was a huge shock, but I was treated successfully with antidepressants and was well again within six months, finishing taking my medication within a year. Two years after the birth of Zach I was pregnant again, blissfully unaware that without specialist expert planning and medication I was very likely to fall ill again.

This time I became even more unwell in pregnancy at about 8 weeks. A particular low was when I lay on the kitchen floor for a whole day refusing to move, as the cold floor was distracting me from the unbearable torment I was feeling. This time I was admitted into an adult acute psychiatric ward where I was eventually rescued by the newly-formed community perinatal mental team in Exeter, who expertly cared for me throughout the pregnancy.

People ask me why I think that specialist care is so important, and in response I ask them if they think that their general services would be able to advise which medication is safe to take in pregnancy? Would they be able to help with

bonding and offer appropriate psychological therapy? Would they be able to admit me into hospital if necessary with a cot by my side for my baby? Would they be able to write a birth plan with me? Would they be able to give conception counselling?

As a result of my two very different experiences, I became passionate about helping mothers all over the UK access the kind of specialist perinatal mental healthcare that I had received with my second baby. I wanted every family in all four nations to be as fortunate as I had been. This prompted me to mention in passing to my consultant Dr Jo Black that I was willing to be involved in the future in any way I could to help her in developing the local service. She immediately took me up on the offer and used me in training health professionals, interviewing candidates for roles within the team, lobbying commissioners and also making a film on recovery from serious perinatal mental illness to offer encouragement to those who are currently suffering.

Through being involved in this work I was offered the opportunity to be a part of CCQI's peer review team as a patient representative. One of my favourite parts of this work is the time I spend visiting Mother and Baby Units as it gives me such hope for the future of Perinatal Mental Health in the UK. I find the units so incredibly nurturing of both mother and child, and it leaves me with further impetus to campaign for the service to be available to all. The staff in these

## Network News:

- Our inpatient members are now in their 9th cycle with a total of 17 participating units.
- Our community members are now entering cycle 4 this summer with 5 of our 20 members looking to take part in the accreditation process for the first time.
- We would like to welcome the Leicester Perinatal Community Team

who have recently joined the network as new members!

- The CCQI's core standards have now been incorporated into both inpatient and community perinatal standards.
- If you would like to find out more about becoming a member of the perinatal quality network please get in touch with a member of the project team. All our contact details can be found on the back page of the newsletter.

settings are just wonderful, and you can see the necessity of the service in the fantastic outcomes they enjoy. I also find it very rewarding interacting with other women who have suffered with severe perinatal mental illness; we are a determined and outgoing bunch on the whole and, once well, prove very active and effective in campaign work and destigmatisation.

Latterly I have been employed by the Maternal Mental Health Alliance on the Everyone's Business Campaign as the campaign assistant. This has given me an even greater opportunity to see the work going on in perinatal mental health nationally, and I feel privileged to work alongside so many talented and visionary people in the field.

I would encourage any clinician to use patients who are well enough as much as possible,

particularly locally in encouraging services to be commissioned, as well as highly recommending patients to use their experience to effect change.

It is so rewarding to be able to use something that was so painful to make a very small difference, and it can bring a bit of meaning to the suffering.

**By Joanna Friend, Patient Rep with the Perinatal Quality Network**

If you are interested in finding out more about working with patient representatives the network are running a special interest day on the 12th September. Please contact the project team for more details.

## From Conception to Delivery and Beyond

***The development of Perinatal Response and Management Services (PRAMS) in Abertawe Bro Morgannwg Health Board***

'When women thrive, all of society benefits, and succeeding generations are given a better start in life'

*Kofi Annan, Nobel Peace Prize Winner and Former Secretary-General of the United Nations*

### **Introduction:**

PRAMS is an innovative and specialist service for women who have perinatal mental health problems living in the county borough of Bridgend. This is approximately one third of the health board catchment area. The geographical area covered by the team is a mix of urban and rural communities, some of which are classed as areas of deprivation. There are now high number of Flying Start projects in the area hoping to address some of the local issues.

We are based in the Princess of Wales Hospital, Bridgend, South Wales but are not a completely hospital based service. The hospital has a

maternity unit and there are approximately two thousand births in the area each year.

### **Conception...**

- Why Mothers Die 1997 – 1999; 2000 – 2002 (*Confidential Enquiry into Maternal Deaths in the UK 2001; 2004*)
- Women's Mental Health: into the mainstream (*DoH 2002*)
- Independent enquiry into the care and treatment of Daksha Emson and her daughter Freya (*North East London HA*)

The full time team was established in 2008 following a piece of collaborative work between mental health and midwifery and a consequent review of local mental health services. This involved the secondment of a nurse to look at referral pathways and patient need as well as establishing positive working relationships with midwifery service (which sadly hadn't been done before). There was a growing awareness in mental health services that the needs of a group of patients weren't being met by current service provision. At the same time, the above reports had been published and were evidence to back up this need.

The team currently consists of a full time

perinatal nurse, an occupational therapist, two sessions of psychiatrist time and a lot of good will. We work very closely with our colleagues in Primary and Secondary care as well as the inpatient unit and the local Crisis and liaison teams.

We have established close links with our midwives and health visitors and developed a greater understanding of the need for cohesive working in the best interests of the women and their babies.

### Delivery...

“Perinatal refers to the prediction, detection and treatment of mental disorders in women during pregnancy and the postnatal period (up to 1 year after delivery). It includes advice on the care of women with an existing mental disorder who are planning a pregnancy”

NICE 2007

### How do we do what we do?

The team is constantly looking at ways in which to improve its service delivery and tries to be responsive to the needs of women who access the service. We have used the NICE guidelines to shape our service delivery

We will endeavour to describe the service as it currently stands.

1. In order to have ease of access, the team accepts referrals from midwives, health visitors, social workers and doctors, referrals must be made in writing or by email.
2. The service is age blind.
3. Assessment and review clinics with team members or with the psychiatrist. Home visits are offered on a need basis e.g. someone who cannot access transport, cannot leave the home because of anxiety or physical health issues.
4. Preconceptional counselling regarding medication and choices.

5. Multi agency management plans for women who have a diagnosis such as schizophrenia, manic depression or severe depression. They are also available to women who have complex issues. This includes the woman, her relatives where relevant, and anyone she wishes to have involved. These plans are copied to all involved and are also put in the maternity hand held notes. It may also include advanced prescribing where a prescription is given for a woman to bring into hospital with her, ready to commence when needed.

6. In the cases of women who are already under secondary care with a care coordinator the service will work alongside (as an add on not instead of service) being written into the Care and Treatment plans and allowing continuity of care.

7. A structured treatment group for women with Post Natal Depression including sessions on managing mental health, education, developing method of coping and a one off session for the fathers /mothers /carers.

8. Ante natal anxiety management and relaxation.

9. A link to midwifery and requests for debriefing from maternity service if needed/ requested.

10. Delivering training sessions for professionals and students, including raising awareness for SCBU staff around PTSD and other mental health problems.

### Beyond...

For some time the team has been keen to establish and develop services across the health board as we were aware that there was an inequitable service. New reoccurring money from the Welsh Assembly to allow health boards to expand/develop Perinatal provision has become available. We are currently in the process of expanding the existing service into Neath and Post Talbot and setting up a replica service in Swansea. Added to this will be a day of psychology so women with a need for psychological therapy will be able to access it quickly instead of being referred on.

This is a challenging time and has involved visiting other mental health teams, explaining the remit of our service and sharing, developing skills, improving understanding and awareness of perinatal mental health.

As a service we look forward to offering all women who live within ABMU a quality, responsive and relevant service.

“The mental health and wellbeing of women in pregnancy is pivotal to ensuring a good clinical, social and other outcomes for both mother and baby and a healthy start to family life”

#### Why Mother’s Die Report 2000-2002

**By Francesca Fearn, Occupational Therapist, PRAMS.**

## Reflecting and appraising the effectiveness of initial assessments within a NHS perinatal mental health service linking the promotion of healthier lifestyle and mental health

As a specialist perinatal practitioner, assessing pregnant and post-natal women’s mental health is regular practice with the aims of prediction, detection and treatment and forms the basis of this claim. This assignment will also consider the importance of assessing women’s lifestyle choices as this is policy of many health organisations. Common lifestyle issues that individuals might be encouraged to discuss tend to focus on smoking, diet, weight, alcohol consumption, exercise and improving mental health.

As a commissioned service, recent government policies (The Mandate to the Government from NHS England 2014, Closing the Gap 2014 and Priorities for Changing Essential Change in Mental Health 2014) emphasised the need for improving mental health care for mothers in the perinatal period. These documents stress that better support for women can improve mental health outcomes and lifetime wellbeing. In response to

these reports, a specialist community perinatal mental health team was created to support women and where necessary facilitate admission to mother and baby units.

The aim of an initial assessment, is to build up an objective picture based upon the woman’s needs, taking into account the severity of current or past mental health problems and a range of other factors that may impact on their mental health (Halpern 2014). Szmukler (2013) suggested this collated information is critical in determining the most appropriate support or treatment that may be offered.

Appleby (2012) identifies the importance of assessments in identifying and reducing the risk women may pose to themselves and others. Working with these women in collaboration with the multi-disciplinary team (MDT) can allocate enhanced support to encourage independence, confidence and self-esteem.

The assessment follows national guidelines (NICE 2014, Royal College Psychiatry 2014, and Joint Commissioning Panel for Mental Health 2014) although this has been adapted in perinatal care to an in house framework. The assessment incorporates risk factors and a care plan to be shared with the women, and their General Practitioner. NICE (2014) suggest a care plan should be developed in partnership with the women and other services, coordinated with clarity of all the roles of those involved in providing support and follow up with a named person responsible for formulating the care plan.

In relation to this, the main body of this assignment will evaluate and appraise the effectiveness of initial assessments as carried out by perinatal mental health services and my development as a professional specialist perinatal practitioner nurse.

Perinatal mental health services endeavour to highlight preventative practice to avoid relapse in mental health, and by reducing the likelihood of future generations coming into contact with mental health services (Biglan 2012). One way in which this is achieved is through initial assessments. Assessments are a pivotal and proactive aspect of the workplace and facilitate the opportunity to discuss lifestyle issues such as mental wellbeing, exercise and diet.

In 2009 I was asked to be part of the pilot scheme with the consultant psychiatrist attached to my workplace (see appendix A: testimonial 1).

I was pleased, and honoured that he recognised my competence and passion. Having run this pilot for a substantial period of time together, we decided upon an assessment form format. This was based upon the theory, practice and research.

The pilot scheme demonstrated that the original form was too complex as it appeared to take away the emphasis on assessing mental health by introducing issues that could be addressed as follow up discussions. The need to make changes to the format was based upon the decision that the original had too much detail and so it was decided to condense the lifestyle area into one paragraph instead (see appendix B and C).

The revised format devised and trialled, demonstrated a more streamline and focussed approach that could be shared by the MDT. By removing some aspects of the form for example questions around employment and housing this proved to be more effective because it ensured that the focus is primarily on mental health yet still addressing issues of lifestyle (Doucet 2011).

Perinatal assessments can take the form of a documented interview between the woman and professional following a format of open and closed questions, as well as professional observations with conclusive objective and subjective outcomes (Wiscarz 2014).

One important aspect of the initial assessment is to look at a woman`s lifestyle in relation to her mental health. It is important to note that the assessment form is a tool designed to share information with other professionals and the client. As such it does not reflect the complexity of the initial meeting for both client and practitioner.

It is vital that the client feels welcome when they initially meet the assessing practitioner; a friendly but professional manner is paramount to put the woman at ease (Heron 2012).

Information sharing, detailing the purpose of the assessment, who made the referral and information that was supplied can provide a gentle introduction. Explanation about the structure of the perinatal service in which the woman has been referred in to can enhance the woman's awareness, whereas in my experience too often, women arrive to their assessment with no idea what and why they are attending. Demonstrating empathy, warmth, reassurance and understanding are key to enhance trust building whilst remaining non-judgemental, ensuring the women have adequate time to express themselves and share their feelings and thoughts, which until initial assessment, may have been unspoken to anyone. Townsend (2014) demonstrates the importance of noting body language and suggests minimal eye contact or guarded body language from the women can provide more insight into the difficulties they may be experiencing with her mental health that she may struggle to verbalise.

In terms of my practice, I rarely consult the form as I have become very familiar with it. Instead, I tend to make brief notes as I go along which allows me to be more open in my approach towards the women whilst giving eye contact, as opposed to be looking down at the paperwork whilst writing. As an experienced practitioner, I have developed these skills which is why student nurses or newly qualified practitioners do not undertake assessments on their own initially. Carrying out assessments in partnership, enables them to develop these skills for themselves.

### **Good News Corner:**

'We are pleased to announce that the Yorkshire and Humber Perinatal Outreach Service is now fully recruited to. Of relevance to the network is the number of high calibre applications received for the consultant post, the social work post and the generic outreach post. We were pleasantly surprised, of course it made shortlisting and appointment challenging given the strength of applicants, but it was a very reassuring position to be in. There is a lot of training and awareness out there across many professional groups. This feels like a shift from where we were 10 or even 5 years ago being such a niche area of mental health. We have also successfully to 4 vacant RMN posts on the inpatient unit. Again, even though we had to work within the constraints of the new trust wide centralised recruitment process, the candidates were strong with a clear knowledge base and interest.'

***By Deborah Page, Clinical Team Leader, Yorkshire and Humber Perinatal Outreach Service***

From my experience and in relation to current research (Coombs 2011), assessments are most effective if they only contain essential data, and can be shared in a concise, accurate and relevant document. This will enable professionals to intervene as soon as possible, reduce the likelihood of maternal morbidity and enhance parent / infant bonding and attachment (Knight 2014)

An important aspect of the initial assessment involves assessing current and past medication. Reviewing medication is an essential element of practice in order to help reduce negative symptoms of mental health from impacting on day to day functioning and motherhood (Doucet 2011).

The form should not dictate the process especially when a different focus emerges during the assessment for example, a woman presenting with psychotic features may need to be assessed for admission and this will be the focus of the assessment. As a practitioner, experience has taught me, that empathy needs to be a high priority when assessing (O'Carroll 2007). I have also learned that allowing sufficient time, whilst building up a relationship remain essential, without which, these women may not engage in any subsequent follow up and monitoring of their mental health or perhaps remain guarded (Knight 2014). Assessments require more than a completed form, they necessitate a holistic approach unique to mental health nursing skills (Roberts 2009) Experience plays a vital role in enabling further exploration into difficulties the woman may be experiencing impacting on her mental health.

For the purpose of gaining some constructive feedback in relation to my ability to assess and document initial assessments, a questionnaire was compiled (see appendix D) for colleagues to complete. A total of seven questionnaires were sent out to colleagues and six replies were returned. The feedback did suggest that I am good at my work and well respected which I take with great pride. I had hoped the feedback, both negative and positive, would enable me to improve and enhance my professional practice to provide the best possible outcomes and experiences. However, possibly due to the working relationship we share, the results and additional comments made were all positive which could be considered subjective and biased. The table below represents the findings from the responses

collated.

Testimonials were collated (see appendix A: testimonials 1, 2 and 3) from consultant psychiatrists and senior members of staff I have direct contact with. I felt surprised by the comments made but also very chuffed, respected, valued and proud. Overall, feedback failed to identify any areas requiring improvement and was an exercise worthy of its merit and worth repeating at a later date to enable practice to be constructively scrutinised and challenged. However, another method of evaluation could be through direct supervision and joint working.

Women have an opportunity to reflect upon their experience of initial assessments within our service by anonymously completing Fr3dom Health Solutions Friends and families Test (2014) (see appendix E) to provide feedback of their opinions and ratings. This most recent report demonstrates overall positivity and satisfaction (November 2015).

Lifestyle choices will focus predominantly on eating a healthier diet, undertaking the recommended amount of physical activity and improving mental health. Whilst all the suggested lifestyle choices are of equal importance, these aspects for perinatal women appear to be most compromised.

Assessments address most aspects of the lifestyle issues mentioned but the focus given to each area from the person being assessed will vary depending on the priority of each presentation. For example, a women who presents with sleep deprivation, unable to leave the house to gain any physical exercise may find their mental health is compromised (McGrath 2013). Pregnancy and motherhood can be an especially challenging time due to the role and responsibility changes (Zauderer 2009).

Most perinatal women tend to have an element of sleep deprivation which may be pregnancy related or affected by interrupted sleep to feed their baby. Appetite can be variable with nausea, and hormonal changes. Other women may struggle to find time to eat or merely forget (Knight 2014).

In 2012, NHS Future Forum made the recommendation that every healthcare organisation should deliver Making Every Contact Count (MECC). This was based upon the earlier work in 2011 and was developed to assist all

organisations responsible for the delivery of health, care, safety and wellbeing of the public to implement and deliver healthy messages systematically. The NST (2011) and HGP (2011) highlighted that health and social care providers had not been systematically offering support to the suggestion to improve lifestyle change and outcomes.

MECC (2012), was devised to encourage healthier lifestyle choices. Professionals should be enabled, with the necessary skills, knowledge and confidence, to discuss health style choices with individuals and ultimately to access the most effective support for women to take control and make the necessary changes they need to do to improve their health. MECC (2012) recommends that staff should respond appropriately to lifestyle issues and take the appropriate action to either give information, signpost or refer individuals to the support they need.

Pregnancy and post-natal weight changes can be a very sensitive area for women which needs to be responded to carefully (Davies 2014).

MECC (2012) suggests that service users expect to be asked about their health and are often wanting advice. Women are encouraged to talk about lifestyle issues whilst it is acknowledged that practitioners cannot change the lifestyles of others, suggestions and support can be offered. There will inevitably be limitations and barriers affecting physical or mental health and their willingness to engage and change.

Ensuring every relevant opportunity of maintaining training and further education can enable professional learning to be assessed and recognised, as well as enabling practitioners to ensure they remain updated on current research, policies and the most effective manner in which this client group can be cared for. This has been evidenced with attachments and current curriculum vitae, with associated copies of relevant certificates, accomplishments and outcomes (see appendix F). The Nursing and Midwifery Council's Code of Practice (2015) sets out key principles that should underpin nurses' practice with particular importance stressed upon professional responsibility. This is evidenced in the accompanying portfolio of significant learning experiences and accomplishments demonstrating continuous learning and professional development (CPD).

In conclusion, this assignment reflects upon both the development of initial assessments within the perinatal mental health setting I practice, as well as my learning journey. It clearly demonstrates the effectiveness of the initial assessment process as well as my skills in this area and provides supporting appraisal documentation. In addition, it evaluates the effect of promoting healthier lifestyles for women during the perinatal period who come into our service. It is clear that lifestyle issues for women are complicated by pregnancy and the postnatal period and it would be helpful and beneficial if these issues are addressed. No one women's presentation resembles another but similarities are evident and the associated feelings they share at a challenging time in their life.

***By Sharon Scotford-Smith, specialist perinatal mental health practitioner, Sussex. Completed as part of APEL.***

A full list of references for this assignment is available if requested.

## Women's Perceptions of their Experiences of Puerperal Psychosis

### Abstract:

The purpose of this literature review was to access current research in order to gain an understanding of women's perceptions of their experiences of puerperal psychosis, professionals' responses and the process of recovery.

This work was undertaken because of the relevance to my professional practice and is an area of special interest to me.

The method undertaken was that of a literature review focusing primarily at qualitative studies within the United Kingdom. The research sample

selected was exclusively based on patients who had been admitted to mother and baby units. Literature was sparse, but nevertheless, comprehensive and assisted the emergence of the major themes which were: emotional impact of puerperal psychosis, recovery from puerperal psychosis and women's` perceptions of professionals responses.

This research acknowledges recovery to be a long and often, difficult process. Doucet (2011) describes puerperal psychosis as a devastating illness with severe consequences to mother, baby and families. It also shows that women are at an increased risk of experiencing subsequent psychiatric episodes related and unrelated to childbirth (Robertson 2005).

The results demonstrated an over-riding perception of the illness and its treatment as negative.

In conclusion, while women's experiences, as demonstrated in the literature, were negative, it should be noted that women may have been confused, angry and possibly irrational. A limitation of this study is that it is restricted to the personal perceptions of these women who have been diagnosed and treated for puerperal psychosis, and makes no reference to the perceptions of the professionals, but this is not what the study set out to achieve.

The relevance of this research is that it provides insight into women's perceptions of their experiences of puerperal psychosis and may lead to a greater understanding and empathy from professionals supporting and treating them

***A dissertation in part fulfilment of BSc (Hons) Professional Practice by Sharon Scotford-Smith, Sussex Perinatal Team.***

If you would like to read the full dissertation please contact the project team who can provide a PDF copy.

## **POEM - Patient Outcome and Experience Measure**

**The POEM tool was designed by Dr. Alain Gregoire and since the 1st March has been hosted by the network.**

The tool was developed to capture satisfaction over time and detect fluctuations within a service. It is themed around communication, care environment, information provision, and infant care. The idea for services to invite patients and partners/family members to complete the POEM when the patient is discharged from inpatient or community perinatal care.

Members are able to access the survey tool via a web link to input data and are encouraged to ask as many patients and partners as possible to complete it online. For inpatient units, this might mean using a laptop or tablet to support data collection. Paper versions can also be provided but the long term use of the POEM is likely to be more sustainable, the greater the number of electronic returns.

The project team will be collating the data centrally using the responses submitted via the survey link. If any paper versions are used then teams can either enter this data themselves via the link or send to the project team to input. The data will then be organised and sent back to teams in a report for benchmarking with each service/unit only identifiable to themselves. Copies of raw data for each service can also be sent on request with the process intended to be used as a continuous routine evaluation.

The tool can be accessed from the perinatal webpage [here](#) and we'd like to strongly encourage all our members to take part!

If you have any questions or queries please contact:

Hannah Moore at  
hannah.moore@rcpscyh.ac.uk  
or on 0203 7012626

## Establishing a Wellbeing Support Group for New and Expectant Parents in Gloucester

This was after my own pregnancy and subsequent maternity leave, which was wonderful, but I became all too aware that this is not always the case for many women and their families.

Understanding how risky the perinatal period can be for mental health, I was keen to get a greater understanding of how we as a branch could support women and our wider community during this naturally stressful time. This came alongside developing my professional interests.

Setting the scene for our branch members (Around 285) the statistics make for enlightening reading. As the Maternal Mental Health Alliance states more than 1 in 10 women develop a mental illness during pregnancy or within the first year after having a baby.

Based on figures from Public Health England we in Gloucestershire may expect up to 15 cases of Postpartum Psychosis at the most severe end, but between 620 and 930 cases of mild to moderate Depressive Illness and Anxiety.

With this in mind, we considered if there would be a role for us to offer support, what this might look like and how we could embed it within our current branch activities.

NHS provision in Gloucester is provided by the Together NHS Foundation Trust and is one of many identified that doesn't currently provide a specialist perinatal service. At present there is a county wide operational policy and care pathway offering guidance to health care professionals, a lead clinician available for advice and an Infant Mental Health Team.

In October 2015 we ran an online survey, open for 2 months, via our social media pages to see what our members and local parents would like to see as part of an emotional wellbeing support system. A sample representing nearly 10% of our membership responded to the following enquiries.

Offering a really informal, friendly & safe space as an interface into other local services was the most popular concept. We included a free text box for reflections and talking about shared experiences, developing a 'friendship network' and knowing you are not alone in suffering were key themes.

Research has pointed to benefits peer support can provide; 'The mutuality and reciprocity that occurs, builds social capital, which in turn is associated with well-being and resilience'.

Our next challenge was how and where to start running a potential group.

After discussions with a well used local Barnardo's Children Centre, networking with the health visiting teams, community midwives and charitable services ensuring excellent links within our locality we were finally in a position to launch 'Safe Space' in April 2016. We designed the logo ourselves; the idea of providing shelter and safety from the storm and the rainbow; that glimmer of hope.

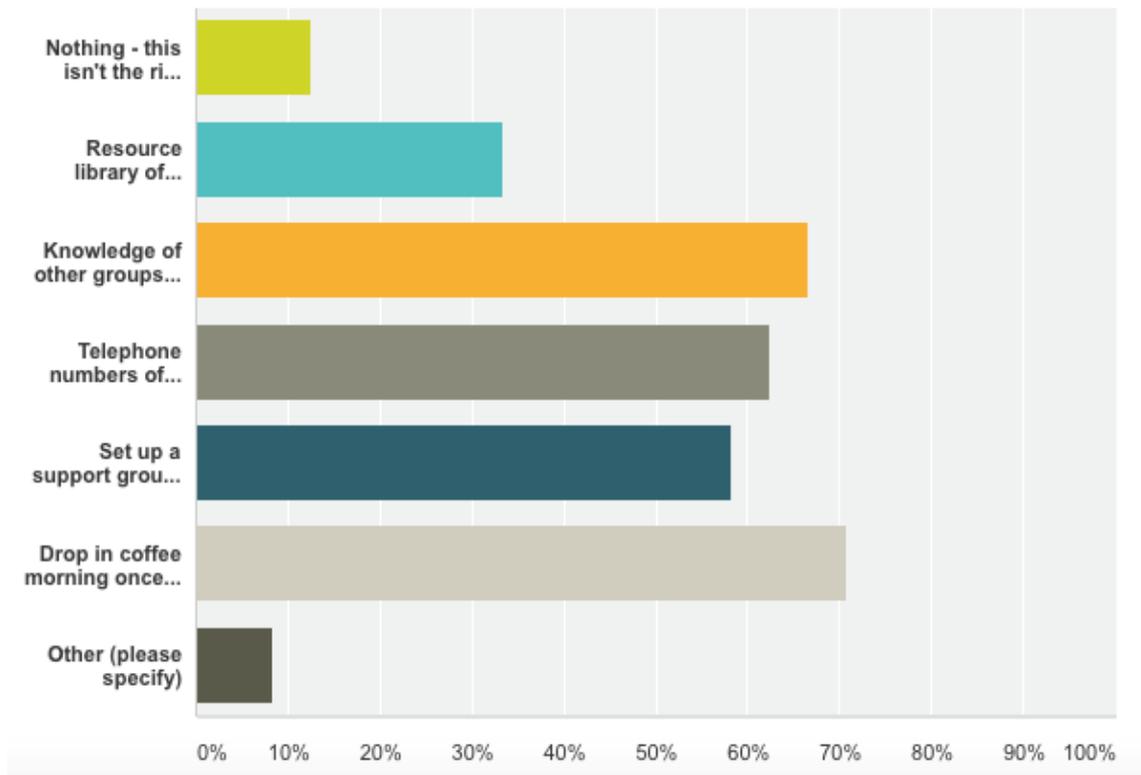
We have kindly been allowed a wonderfully resourced play-room to use free of charge on a monthly basis at 'The Compass' Children's Centre in Gloucester City. Refreshments have been provided through the Community Champion scheme at a Tesco superstore nearby. This allows us to ensure the group is free, a real bonus!

We hope peer support will be the mainstay of what we help facilitate, but reflecting suggestions we also have a 'wellbeing toolkit' of resources. This includes information about voluntary sector services such as free counselling from Footsteps, self referred NHS 'Lets Talk' IAPT service and a library of texts from the 'Reading well' books on prescription programme.

Mindfulness colouring and inspirational stories of 'lived experience' complete what we offer to anyone that may need it, NCT member or not.

## What support could we provide within the NCT Gloucester branch that you would find helpful if you needed it? Tick all that apply.

Answered: 24 Skipped: 0



▼ Nothing - this isn't the right place	12.50%	3
▼ Resource library of books / leaflets that can be borrowed	33.33%	8
▼ Knowledge of other groups and services in the area that offer specific support i.e. PANDAS for post natal depression	66.67%	16
▼ Telephone numbers of helplines - charitable or NHS	62.50%	15
▼ Set up a support group within the NCT	58.33%	14
▼ Drop in coffee morning once a month or so for a general chat about any worries	70.83%	17

We have advocated throughout that a GP, Midwife or Health Visitor should always be the first port of call for Mental Health concerns. We hope to exist as an adjunct with peer support as outlined by the DoH as helping people manage their own mental health better in the community.

well received. We are operating monthly for six months as a pilot, inclusive of the summer holidays. We hope it will slowly gain ground and become a group run by members for members.

### Watch this space!

Our first group ran in early April and was really

Looking nationally the NCT has been awarded a

grant by the Department of Health's Innovation, Excellence and Strategic Development to develop a safe, effective and sustainable model of perinatal mental health peer support.

This is really exciting news. Small projects like ours and the latest NCT initiative on a national scale may slowly increase parity of care for those women who do not live in an area served by a specialist service. Shining the spotlight on gaps in services and making sure every woman gets the care she needs and deserves.

**By Emily Thomas, Trainee Psychiatrist,  
Mother and NCT Volunteer**

A full list of references for this assignment are available if requested



The poster features a colorful umbrella with the text 'SAFE SPACE' written across it. In the top right corner, there is the NCT logo and the text 'Believe in children' and 'Barnardo's'. The main text of the poster reads: **'Safe Space' is an emotional wellbeing peer support group run by NCT Gloucester**. **Our first group will run on: Friday 8<sup>th</sup> April 2016 10-11.30 am @ Compass Children's Centre, Gloucester**. **Come along for a chat, support & access to resources and information about local services that may be able to help. Anyone welcome - both new and expectant parents**. **The group is FREE and child friendly with refreshments kindly provided by Tesco Gloucester. No need to be an NCT member**. At the bottom right, contact information is provided: **The Compass Children's Centre, Coney Hill Road, GL4 4NA, 01452 522738, www.nct.org.uk/Gloucester, Facebook.com/GloucesterNCT**. A small image of hands clasped together is visible in the bottom left corner of the poster.

## Five Years In:

### **Service Developments in the Devon Perinatal Team**

Summer 2011. I had just started a nursing role within the newly expanded Devon Perinatal Service. We would be setting up the team in a new hospital and a new area. The team had been running in another location for 2 years on a part time basis but this was a new service locally and though excited, I was also very nervous.

I remember not long after starting I attended a study day where I first heard Alan Gregoire speak about perinatal services across the UK. He talked with great passion about the lack of equitable access to perinatal teams in some areas and about the implications for Mums, babies and the wider family if women are unable to access the specialist advice they need. I recall that although I was inspired I was also mildly terrified thinking "How will we manage this?"

The responsibility of working with women at potentially one of the most vulnerable times in their lives (and their precious babies) was not something I had my head in the clouds about. For every person who assumed my new job would involve cuddling babies there was another person

reminding me of how vital our role was and how high the stakes were if we got it wrong.

This coupled with the fact that perinatal mental health can present quite differently to what I had been used to as a more generic mental health nurse meant that the learning curve was steep and swift. There were stories in the newspapers of tragedies that I had never been aware of until working in the perinatal team but now they seemed to be reported with frequency. Amongst those stories were other stories of hope, of recovery, and communities of people doing amazing pieces of work. I began to think we might be able to do this and maybe even do it well.

The support from others that we needed cannot be overemphasised! We had to ask already busy midwives to fill out one more forms at antenatal appointments. We asked them to enquire about a woman's emotional wellbeing and then to trust that we would share those worries. We were asking midwives to let us into their antenatal department and take one of their precious room spaces so we could embed ourselves in their team at a time when all services are pressured.

I remember taking a call from a midwife one day who had a woman in a clinic with her who had

disclosed she felt like she didn't want to go on. It was late in the day and I was about to leave the office when the phone rang but I stopped and took the call.

I heard the relief in that midwife's voice reach out to me from the other end of the phone when I picked up. Afterwards the midwife had thanked me so profusely that I felt a bit of a fraud! After all I was a mental health nurse. My professional purpose is to talk with a woman at her darkest hour and walk alongside her. But when I thought about it later I imagined the anxiety I would feel if someone asked me to do an antenatal check on a woman (or deliver a baby!) and it made sense.

As time went on midwives would pop into our office and ask questions about women they had seen or ring up for advice. In the antenatal clinic where we were based if a woman was in clinic or on the postnatal ward we were easily accessible. This I believe is one of the reasons our service has been embraced so wholeheartedly by our wonderful midwifery colleagues.

Women would come to see us as it was part of their routine midwifery care and in the same clinic where they received all their other appointments. Our colleagues in Improving Access to Psychological Therapies set up "perinatal assessment" appointments we could refer into with practitioners who had a special interest. The postnatal pathway started to expand and we began to work more with other teams such as health visitors. The team continued to grow slowly but surely.

Of course there were those who believed in the service and had been championing it long before I had ever even heard of perinatal mental health. I hope we are providing the service that they envisioned for women. There are still many amazing people working tirelessly and often with little acknowledgement trying to get what we have been able to build.

But like so many things once you have a taste of the good life you want more! We have managed to expand beyond recognition in the past 5 years. When Clare Mcadam and Dr. Jo Black started 7 years ago perinatal mental health in Devon was a part time operation with a desk in a shared office at one hospital. Now we are a team who work across three hospital sites almost county wide. The hospitals and midwifery teams have all made

us very welcome and allowed us to utilise some of their precious and limited work space because they believed in the service.

We can now share our learning and indeed continue to learn as we have student nurses on placement and are able to sow the seeds of good perinatal mental health care in a way that was never done when I was student. We have doctors, health visitors, mental health colleagues and many other professionals who work alongside us and so the service grows.

Finally and most importantly I have had the honour and privilege of working with some of the most amazing and inspiring women and their families over the past 5 years. They are the reason I come to work every day enjoying what I do and feeling hopeful about the future of perinatal mental health.

***By Jacky Francis, Acting Clinical Team Leader, Devon Perinatal Service***

### **Annual Reports and Standards:**

The annual report for community members was published in March and is accessible via the perinatal page on the rcpsych website.

Here you will also find all the previous years reports for both inpatient and community teams.

You will also be able to access copies of the networks inpatient and community standards.

These can be found in the useful downloads section of the page.

To link to this page please click [here](#)

# Birth Trauma

As the consultant in the Tower Hamlets Perinatal Service I have become increasingly aware over the last few years that many women are talking to me about experiencing traumatic births.

I feel concerned that we often do not identify this group of women well leading them to experience frightening symptoms which are often not diagnosed or treated or misdiagnosed as postnatal depression.

I am now running a monthly joint clinic at the London Hospital with a consultant midwife and myself to provide timely additional support to women after birth trauma and identify any PTS early.

Most studies estimate that around 20-25 % of women perceive some element of their birth as traumatic. 3% of women will experience clinical symptoms of Post Traumatic Stress Disorder/ PTSD following a traumatic birth and where women have a prior psychiatric history this can rise to 15%.

If we take the annual birth rate in England and Wales from 2014 of 695,233 this would indicate at least 34,000 women per year are experiencing PTS symptoms related to birth. This would be a higher rate than UK military personnel returning from conflict!

Women's experience of their birth is subjective and the trauma often relates to several key themes such as loss of control in labour, the mode of delivery, fearing they or their unborn child will die, attitudes of staff during and after labour and the perceived care and support after birth. Women often feel guilty or ashamed and may not readily feel able to talk about these issues.

Bridget Hargreave, author of *Fine Not Fine*, a book of mother's experiences of birth and depression, said "The phrase "you can't afford to cry", tutted at me by a midwife during one of my first interminable nights on the postnatal ward stands out. Not "are you ok?" Not "how can I help?" Not even simply "Why are you crying?"

The key issue for me is that it is the woman's subjective experience that matters, the birth could be medically straightforward but if the woman perceived it as traumatic that is the important issue.

Not all women who have a traumatic birth will experience PTS but many will have subclinical symptoms and will still benefit from support. Symptoms required to make a formal diagnosis of PTS include;

- Persistent reliving of the event with recurrent intrusive memories or thoughts, flashbacks and/or nightmares, women may replay their birth over and over in their minds.
- Feeling distressed, anxious or panicky when exposed to things which remind them of the event, this may be hearing other women talk of their birth or having to return to hospital.
- Avoidance of anything that reminds of the trauma (this may include talking about it). This can lead to emotional detachment or numbing.
- Bad memories and the need to avoid any reminders of the trauma often results in difficulties with sleeping and concentrating.
- Sufferers can feel angry, irritable and be hypervigilant (feeling jumpy or on edge).

A second pregnancy can be anxiety provoking after birth trauma and women need education about what is supposed to happen in a normal childbirth, about options during the birth such as pain management, birthing positions, breathing, and how to deal with complications during birth. Women can benefit from additional support such as a Doula. Women need to feel they can freely voice any concerns or wishes and writing a detailed birth plan can help some women.

This link has some lovely tips and advice.

<http://wholewoman.com.au/birth/1411>

Recovery from birth trauma/ PTS requires time. The journey to health can take months or years, and sometimes needs professional support.

Practical tips can be prioritising sleep, eating a healthy diet, regular exercise, yoga, meditation or mindfulness. When working through PTSD after a birth, any activity or process that brings healing can help. Drawing, painting or sculpting can help some women document their experience as can writing a diary or letter to those people who involved at the birth even if the letter is never sent.

Many women find support online and/or with face to face support groups.

Body work can include aromatherapy or massage. This link highlights this type of work and how it can help some women.

<https://www.psychotherapy.net/interview/interview-peter-levine>.

Therapeutic approaches can include trauma focussed CBT, psychotherapy or EMDR.

There is a role for medication in some cases, the American PTSD National Centre states "The current evidence base for PTSD psychopharmacology is strongest for SSRIs, and currently only Sertraline and Paroxetine are approved by the Food and Drug Administration for PTSD.

There is a growing literature that dads/birth partners can experience PTS after being a birth companion.

One father said; "Two years ago, I witnessed my girlfriend go through major blood loss and pass out in the operating theatre. The medical professionals were busy trying to save my girlfriend and child, I was left in a room, on my own, for nearly an hour, without any updates, information, or access to my family. I presumed the worst, and I was left with those feelings of grief and helplessness for what seemed like forever – and this was compounded by the fact that I simply didn't have any idea what was happening. I didn't know if the baby was even going to be alright."

Any father/birth partner experiencing PTS symptoms should be encouraged to seek support

from their GP or PANDAS helpline.

If you are interested in finding out more Dr Moore runs an annual Birth Trauma event at Mile End Hospital.

The next event is on 9th December 10am-5pm and is free to attend.

To book contact  
Rebecca.moore@elft.nhs.uk

### **Some helpful websites on the topic of birth trauma:**

[www.unfoldyourwings.co.uk](http://www.unfoldyourwings.co.uk)

<https://blogs.city.ac.uk/birthptsd>

<http://www.birthrights.org.uk>

<http://www.sheilakitzinger.com/BirthCrisis.htm>

<http://matexp.org.uk>

***By Dr Rebecca Moore, Consultant Psychiatrist, Tower Hamlets Perinatal Service***

### **Article Submissions:**

Want to share your work or present your findings to a wide audience?

Submit an article for our next newsletter!

If you would like to submit a piece please send a short paragraph describing your topic to: [hannah.moore@rcpsyh.ac.uk](mailto:hannah.moore@rcpsyh.ac.uk)

The newsletter will be published twice a year in a Summer and Winter edition.

## Perinatal Design Competition

**We are looking for some artwork to form the front cover of our new perinatal community standards!**

### **Design requirements:**

**The network name should be featured (pictured top right) and make it clear that it is for the community standards but other than that it is entirely up to you. The more the creative the better.**

### **How to Apply:**

Please send your design along with these details; First name, unit you're from or service you visit

**By Email:** hannah.moore@rcpsych.ac.uk

**By post:** Hannah Moore, Perinatal Network, CCQI 2nd Floor,  
21 Prescott Street, London, E1 8BB

**1st Prize: £20 voucher**

**2 Runner-Up Prizes**

**Conditions: The page must include the network name 'Perinatal Quality Network' in order to qualify for consideration.**

**Disclaimer: The winner will have their front cover printed in our next newsletter with their first name ONLY. The name of their unit/service will NOT be printed in the issue but we ask for this information so we know where to send the prize. The winner's unit/service will be notified by email, and staff will be expected to forward on their prize. We reserve the right to amend the price or close the competition at any time.**

# Perinatal Mental Health in the News

*Here we provide some snippets of perinatal mental health stories in the news*

*'Don't suffer in silence is the message to mums on World Maternal Mental Health Day'  
4th May 2016*

As part of World Maternal Health Day on the 4th May, the National Childbirth Trust (NCT) encouraged patients to talk about how they're feeling by dispelling 10 myths surrounding parenthood and mental health.

To read the article in full click [here](#)

*'We should follow Westminster and Wales on Perinatal Mental Health'  
20 April 2016*

Matt Forde, National Head of Service at NSPCC Scotland argues that there are significant gaps in the provision of mental healthcare in Scotland.

'The UK and Welsh Governments have made a range of specific commitments to increase mental health support for mums in the perinatal period. If we're serious about prevention and about improving Scotland's mental health, the next Scottish government needs to do the same.'

To read the article in full click [here](#)

*'Guidance highlights the role of Specialist Health Visitors in Perinatal and Infant Mental Health'  
19th April 2016*

Health Education England has released guidance that all women and their partners should have access to a perinatal and infant mental health (PIMH) specialist health visitor.

To read the article in full click [here](#)  
For the guidance itself click [here](#)

*'Northern Ireland Health: Lack of perinatal services 'endangering lives'  
24th February 2016*

Northern Ireland's only specialist psychiatrist in perinatal mental health says the lack of services for NI women who are chronically ill is endangering their lives.

To read the article in full click [here](#)

If you spot any articles that you think would be good to share with the network please let one of the project team know!

## Useful links

### College Centre for Quality Improvement

<http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement.aspx>

### Quality Network for Perinatal Mental Health Service

<http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqipprojects/perinatal/perinatalqualitynetwork.aspx>

### National Collaborating Centre for Mental Health

<http://www.nccmh.org.uk/>

### National Institute for Health and Clinical Excellence

[www.nice.org.uk](http://www.nice.org.uk)

### Scottish Intercollegiate Guidelines Network

<http://www.sign.ac.uk/>

### London Perinatal Mental Health Network

<http://www.londonscn.nhs.uk/networks/mental-health-dementia-neuroscience/mental-health/perinatal-mental-health/>

### New Parent Support

<https://www.nct.org.uk/>

### PANDAS Foundation

[www.pandasfoundation.org.uk/](http://www.pandasfoundation.org.uk/)

### National Perinatal Epidemiology Unit

<https://www.npeu.ox.ac.uk/>

[www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)

## Perinatal Chat

The purpose of this group is to provide a platform to gain advice from contributors and share best practice from Perinatal colleagues across the UK.

The Perinatal Quality Network (PQN) team also use the group to distribute information about the network such as reviews that we are recruiting reviewers for as well as events, special interest days and the annual forum.

If you aren't a member you can join by emailing join to:

[perinatal-chat@rcpsych.ac.uk](mailto:perinatal-chat@rcpsych.ac.uk)

## Contact the Team

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### Royal College of Psychiatrists Centre for Quality Improvement

21 Prescott Street London E1 8BB

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