WHO, WHY & WHEN DO I TO ADMIT TO A MOTHER & BABY UNIT?

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DETECT
SCREEN
PREVENT
INTERVEN

UK LEADS THE WAY ..... 

...............BUT   WE CAN DO MORE
Key Messages & National Standards
• Access to MBU Beds
• Each CCG to have Specialist Community Perinatal Mental Health Teams – adequately resourced MDT to meet demand (psychiatrist and specialist nurses Type 1 standard)
• Assessment within 24 hours to 2 weeks
• Emergency provision
• Psychological treatment within 1 month if assessment
• Do not offer valproate for acute or long term treatment of mental health problems in women of childbearing potential
Impact of not Intervening: Devastating

- Impact on maternal health: suffering and isolation
- Impact on family
- Small for dates foetus
- Prematurity and longer term physical health problems
- Subsequent Reciprocal attachment with mother disrupted
- Infant temperament & Mother’s ill health
- Emotional neglect
- Physical harm........suicide /homicide

• £8.1 bn
Admitted perinatal mental health care: Mother & Baby Units
Mother and baby units and patient spread across England*

Location of patients admitted during 2014/15

*Dorset HealthCare University NHS Foundation Trust excluded as they did not submit any patient level data
South London and Maudsley NHS Foundation Trust
Location of patients admitted during 2014/15
Non-admitted perinatal mental health care

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>COLOUR</th>
<th>CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Green</td>
<td>Specialised perinatal community team that meets Joint Commissioning Panel criteria <a href="http://www.rcpsych.ac.uk/pdf/perinatal_web.pdf">http://www.rcpsych.ac.uk/pdf/perinatal_web.pdf</a></td>
</tr>
<tr>
<td>3</td>
<td>Orange</td>
<td>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</td>
</tr>
<tr>
<td>2</td>
<td>Yellow</td>
<td>Specialist perinatal psychiatrist AND specialist perinatal nurse with dedicated time</td>
</tr>
<tr>
<td>1</td>
<td>Red</td>
<td>Specialist perinatal psychiatrist or specialist perinatal nurse with dedicated time only</td>
</tr>
<tr>
<td>0</td>
<td>Red</td>
<td>No provision</td>
</tr>
</tbody>
</table>

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.
Referrals to MBU  HTT Use !!!

• Adult Mental Health Teams, CAMHS and other mental health services
• Internally from Specialised Perinatal Community Psychiatric Teams
• GPs
• Maternity Services and Obstetricians

Emergency Admissions. Majority
• Acutely ill and usually within 12 weeks of childbirth.
• Assessed accepted by a senior clinical team member/outreach team
• Admissions can be accepted 24 hours a day, 7 days a week. A
• Avoid delay in admission and the intermediate use of an admission to a General Psychiatric Unit without their baby
Referrals  MBU Admission

Planned admissions : Minority

• Non-urgent, serious/complex conditions
• Assessed by senior clinical member(s) of the MBU or the Outreach Team at a site most suited to the woman’s needs.
• The potential admission discussed with the MDT and referrer.
• Those at high risk of an early postpartum relapse or recurrence of a pre-existing condition.
• The planned admission will be part of the patient’s perinatal care plan drawn up by the Specialised Perinatal Mental Health Service.
Admission Criteria MBU

Last trimester of pregnancy or the first 9 months following delivery who are suffering from an acute episode of serious mental illness including:

- Postpartum Psychosis.
- Bipolar Affective Disorder.
- Schizo-affective Disorder and other psychoses.
- Severe Depressive Illness.
- Other serious/complex conditions.
- Under the age of 18, if there is significant perinatal mental illness and they are likely to be the infant’s principal carer.

Collaboration with Child and Adolescent Mental Health Services (CAMHS) and Social Services.

Acutely ill women. PICU and General Adult ward RARE
Exclusion Criteria

• Parenting assessment unless they are also suffering from, or there is a suspected/potential, serious or complex mental illness.

• Women with severe personality disorder, learning disability or substance misuse unless they are also suffering from, or there is suspected, serious mental illness.

• If there is evidence that the mother will not be capable of independent functioning in caring for her infant in the community even with reasonable support?

• If there is evidence of serious violence/aggressive behaviour that might pose a risk of harm or injury to her own or other babies on MBU
Estimated numbers of women affected by perinatal mental illnesses in England each year

- **1,380** Postpartum psychosis
  - Postpartum psychosis is a severe mental illness that typically affects women in the weeks after giving birth, and causes symptoms such as confusion, delusions, paranoia, and hallucinations.
  - Rate: 2/1000 maternities

- **1,380** Chronic serious mental illness
  - Chronic serious mental illnesses are long-standing mental illnesses, such as schizophrenia or bipolar disorder, which may be more likely to develop, recur or deteriorate in the perinatal period.
  - Rate: 2/1000 maternities

- **20,640** Severe depressive illness
  - Severe depressive illness is the most serious form of depression, where symptoms are severe and persistent, and significantly impair a woman’s ability to function normally.
  - Rate: 30/1000 maternities

- **20,640** Post traumatic stress disorder (PTSD)
  - PTSD is an anxiety disorder caused by very stressful, frightening or distressing events, which may be relieved through intrusive, recurrent reollections, flashbacks and nightmares.
  - Rate: 30/1000 maternities

- **86,020** Mild to moderate depressive illness and anxiety states
  - Mild-moderate depressive illness includes symptoms such as persistent sadness, fatigue and a loss of interest and enjoyment in activities. It often co-occurs with anxiety, which may be experienced as distress, uncontrollable worries, panic or obsessive thoughts.
  - Rate: 100–150/1000 maternities

- **154,830** Adjustment disorders and distress
  - Adjustment disorders and distress occur when a woman is unable to adjust or cope with an event such as pregnancy, birth or becoming a parent. A woman with these conditions will exhibit a distress reaction that lasts longer, or is more excessive than would normally be expected, but does not significantly impair normal function.
  - Rate: 150–300/1000 maternities

* There may be some women who experience more than one of these conditions.

Source: Estimated using prevalence figures in guidance produced by the Joint Commissioning Panel for Mental Health in 2012 and ONS data on live births in England in 2011.
Inpatient Typical Profile

30 years old

NO substance misuse code (=82%)

NO history of prior maltreatment code (=90%)

Known to MH services

New to MH services

Inpatient Typical Profile

Mental and behavioural disorders associated with the puerperium, not elsewhere classified
Depressive episode
Other anxiety disorders
Bipolar affective disorder
Recurrent depressive disorder
Acute and transient psychotic disorders
Schizophrenia
Other

29%
19%
9%
9%
7%
6%
6%
15%
**Community Typical Profile**

- **30 years old**
- **Known to MH services**: 39%
- **New to MH services**: 61%

**Pie Chart**
- **White British**: 61%
- **Any other White Background**: 9%
- **Other**: 27%

**Bar Chart**
- Depressive episode: 27%
- Recurrent depressive disorder: 20%
- Other anxiety disorders: 11%
- Bipolar affective disorder: 9%
- Reaction to severe stress and adjustment disorders: 8%
- Specific personality disorders: 7%
- Mental and behavioural disorders associated with the perinatal period: 4%
- Obsessive-compulsive disorder: 3%
- Schizophrenia: 3%
- Other: 8%
Antenatal depression

- 7% women
- 3\textsuperscript{rd} Trimester.....Continues postnatally
- Often do not report low mood, biological features masked by baby care eg sleep, appetite
- Suicidal and lack of ‘bonding with unborn baby’
- Biological features depression
- Minimising of symptoms
- Stigma
POSTNATAL DEPRESSION.

PREVALENCE 10-20% VERY COMMON (Pitt ’68, Cox ’82, Kumar ’84)

AETIOLOGY

• Postulated hormonal effect: tryptophan metabolism

• Psychosocial stressors
ASSOCIATIONS

INCREASED AGE
CHILHOOD SEPARATION
CONFLICT RELATIONSHIP
LACK SOCIAL SUPPORT
AMBIVALENCE RE BABY
PHYSICAL COMPLICATIONS
PAST Hx DEPRESSION
FAMILY Hx DEPRESSION
PATERNITY PROBLEMS
IVF PREGNANCY
CHILDHOOD TRAUMA

HYPOTHYROIDISM
ONSET
WITHIN 4-6 W
UP TO 6 MONTHS

DURATION
4/6 WEEKS IF TREATED
UP TO 1 YEAR IF NOT
(NB EFFECTS ON DEVELOPING INFANT)

CLINICAL FEATURES
ANXIETY, IRRITABILITY
FEELINGS OF GUILT
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Maternal OCD

- Commoner than you think 3-6 %
- Presents antenatally and increases postnatally
- New onset and recurrence
- Obsessions might harm the baby
- Compulsions around cleaning, germs, infection
- maternalocd.org
Emotionally Unstable Personality Disorder

• 1.6 % population. Women

• Negative emotions
  – Emotional lability
  – Anxiety
  – Suicidal behaviour
  – Separation insecurity

• Antagonism
  – Disinhibition Impulsivity and risk behaviours

• Comorbid alcohol/substance misuse

• Parenting problems
Temporal relationship between psychiatric admission and childbirth
A) All admissions  B) Psychosis admissions (Kendell et al '87)
Oestrogen and Progesterone Plasma Levels in Pregnancy and Early Pueperium

(Data from Willcox et al 1985, Cinque et al 1985)
PEURPERAL PSYCHOSIS

PREVALENCE

0.1-0.2 % RARER

(1-2/1000 LIVE BIRTHS)

(Kendall et al 87, Terp et al 98)

AETIOLOGY

GENETIC

Family history major psychiatric disorder predisposes to PP (Jones et al 2001, 2009)

SCREEN AND ANENATAL CARE PLAN !!

BIOLOGICAL

Sudden decrease oestrogen /progesterone affecting Tryptophan metabolism. Interactions with 5HT/DA and neuroendocrine mechanisms (Wieck 91, 98)
ASSOCIATIONS

PRIMIGRAVIDA
SINGLE
PERINATAL DEATH
STRESSFUL DELIVERY
HISTORY BIPOLAR AFFECTIVE
DISORDER PREDICTS 30-70 %RISK
FAMILY Hx BPAD
INFECTION/ PRE-ECLAMPSIA

ONSET
DURATION
CLINICAL

3 – 14 DAYS : RAPID !!
6 – 12 WEEKS ++
INSOMNIA FEATURES
CONFUSION
IRRITABILITY

75% AFFECTIVE SYMPTOMS
MOOD CHANGE

25% SCHIZOPHRENIA LIKE
DELUSIONS
MANAGEMENT

ADMISSION TO HOSPITAL
MBU:
PSYCHIATRIC EMERGENCY
CHECK PHYSICAL HEALTH
PRE-ECLAMPSIA, INFECTIONS

PSYCHIATRIC
COMMON
MENTAL HEALTH ACT
MENTAL CAPACITY

1ST CONTACT

MIDWIFE
HEALTH VISITOR
GP
OBSTETRIC WARD

PSYCHIATRIC
REFERRAL

NEUROLEPTICS → ECT
PSYCHOLOGICAL
SOCIAL
SAFEGUARDING INFANT
PROGNOSIS

GOOD
70 % FULL RECOVERY

RISK PSYCHOTIC EPISODE:
FUTURE PREGNANCY 20%
ANY TIME FUTURE 50%

POORER PROGOSIS:
FAMILY HISTORY
SEVERE PSYCHOSOCIAL
SHIZOPHRENIA LIKE
Maternal death rate

- Direct 4.67 100,000
- Indirect 6.72 100,000
Mental health-related deaths

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.
Timing of suicide

Number of women who died

<table>
<thead>
<tr>
<th>Time period</th>
<th>Number of women who died</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal 0-42 days</td>
<td>12</td>
</tr>
<tr>
<td>Postnatal 43-84 days</td>
<td>10</td>
</tr>
<tr>
<td>Postnatal 85-126 days</td>
<td>8</td>
</tr>
<tr>
<td>Postnatal 127-168 days</td>
<td>14</td>
</tr>
<tr>
<td>Postnatal 169-210 days</td>
<td>18</td>
</tr>
<tr>
<td>Postnatal 211-252 days</td>
<td>6</td>
</tr>
<tr>
<td>Postnatal 253-294 days</td>
<td>4</td>
</tr>
<tr>
<td>Postnatal 295-365 days</td>
<td>12</td>
</tr>
</tbody>
</table>
Method of violent suicide

<table>
<thead>
<tr>
<th>Method</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hanging</td>
<td>46</td>
</tr>
<tr>
<td>Fall from a height</td>
<td>15</td>
</tr>
<tr>
<td>Railway line</td>
<td>7</td>
</tr>
<tr>
<td>Drowning</td>
<td>4</td>
</tr>
<tr>
<td>Self-strangulation/asphyxiation</td>
<td>2</td>
</tr>
<tr>
<td>Stabbing</td>
<td>2</td>
</tr>
<tr>
<td>Intentional RTA</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>5</td>
</tr>
</tbody>
</table>
Red Flag Presentations

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
Total HoNOS Score (Adjusted for missing scales) at first and last HoNOS

HoNOS1 adjusted for missing values to max 48
HoNOS2 adjusted for missing values to max 48

Team

INPATIENT
COMMUNITY
Importance of multidisciplinary support for mothers bonding with their babies

Mother-infant interaction on admission and discharge from MBU 2012-3

- **N=21**

- **p<.01; *p<.05**

- **CARE-Index score**

- **m sensitivity**
- **m unresponsive**
- **b co-operative**
- **b passive**

- **Admission**
- **Discharge**
**Mother & baby units (patient level)**

**SAFE DISCHARGE ESSENTIAL**

**Length of time on MBU**

88% stay < 3 months

**NB:**

12% stay less than 1 week,
12% stay more than 3 months

- Under 1 week, 12%
- Under 2 weeks, 20%
- Under 1 month, 38%
- Under 2 months, 69%
- Under 3 months, 88%
Key Papers

- MBRACE-UK Mother and babies: Reducing risk through Audits and Confidential Enquiries across the UK https://www.npeu.ox.ac.uk/mbrrace-uk
- Service Standards: Perinatal Community Mental Health Services. Royal College Psychiatry. College Centre for Quality Improvement CCQI – 2012. Available at: www.rcpsych.as.uk