PERINATAL
QUALITY NETWORK FOR PERINATAL MENTAL HEALTH SERVICES

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Service Standards

Perinatal Community Mental Health Services

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Introduction

Background

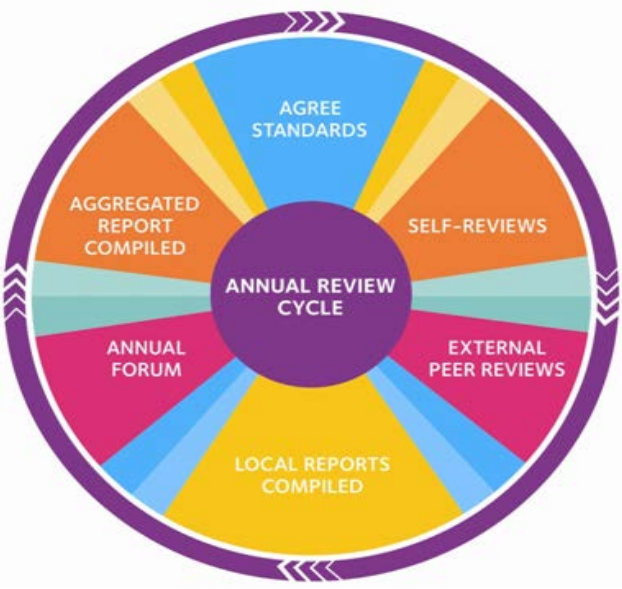
Following the inquiry into the deaths of Daksha and Freya Emson in October 2003 and the publication of the Confidential Enquiries into Maternal Deaths in 2001 and 2004, the Royal College of Psychiatrists made a commitment to promote perinatal mental health.

Initial funding was provided for the College Centre for Quality Improvement (CCQI) to complete a national survey of Specialist Perinatal Mental Health Services and to set up a network.

The Quality Network for Perinatal Mental Health Services was launched in June 2007, as part of this commitment, to develop and maintain standards for mother and baby units. The network engages with frontline staff and applies a clinical audit method within a peer-support network. Since 2007, over 80% of mother and baby units in the UK have participated in the process. In 2012, the network has now developed standards for community perinatal mental health services.

The Review Process

The standards represent just one part of the cycle: the real benefit for services is in taking part in the process of reviews. These reviews aim to gradually improve services using the principles of the clinical audit cycle (see figure below).



If you are interested in joining the network please contact Peter Thompson on 020 7977 6693 or pthompson@cru.rcpsych.ac.uk.

Important Note

Data collection tools adapted from these standards will be provided with guidance notes to members before reviews take place. This document is provided for reference and not for data collection.

These are best practice statements and consequently we would not expect services to meet every standard. While there are some statements that are based upon legal requirements, this document is not intended to act as a legal guide in any way. This is not intended to be a guide to any reviews conducted by regulatory bodies.

If you have any questions about these standards please contact Peter Thompson on 020 7977 6693 or email pthompson@cru.rcpsych.ac.uk.

Std No	Standard	Type
1	**ACCESS AND REFERRAL**	
1.1	*The Service provides information (in written and electronic form) for patients and professionals on:*	
1.1a	A description of the service	2
1.1b	Referral criteria	2
1.1c	Clinical pathways	2
1.1d	How to make a referral	2
1.1e	Contact details, including emergency details	1
1.2	*The service is provided for the following groups in a defined catchment area:*	
1.2a	Women following discharge from an inpatient stay	1
1.2b	Women suffering from bipolar illness / puerperal psychosis, other psychoses and serious affective disorder, who can be safely managed in the community	1
1.2c	Women with other serious non-psychotic conditions	1
1.2d	Women identified in pregnancy who are at risk of a recurrence / relapse of a psychotic or serious / complex non-psychotic condition	1
1.2e	Women requiring pre-conception counselling	2
1.3	The service only works with women who cannot be effectively managed by primary care services	2
1.4	The service only works with women with alcohol/substance misuse problems if there is also (or suspected) serious mental illness	2
1.5	Patients under age 18 can be referred if perinatal psychiatric disorder dominates the clinical picture	1
1.6	The perinatal service works with the local CAMHS service to provide care to patients under the age of 18	1
1.7	Referrals are accepted from any health professionals working with women in the perinatal period and discussed with GPs	2
1.8	Referrals from Children's Social Services can only be accepted if they meet the usual clinical criteria	2

Std No	Standard	Type
1.9	The referral criteria ensure that personality disorder is not a barrier to appropriate service response	2
1.10	All referrals are made directly to the service during working hours i.e. not to single point of access teams or other referral centres	1
1.11	The service responds to requests for telephone advice from other professionals within one working day	2
1.12	A clinical member of the team is available to discuss and respond to emergency referrals during working hours	1
1.13	In exceptional circumstances, when the team are unable to make an emergency assessment, there are arrangements in place with another service to cover this	1
1.14	Out of hours emergency referrals should be made to the out of hours psychiatric services who will refer the patient to the Perinatal Service the next working day	1
1.15	The service only accepts emergency referrals made by the referrer personally to a member of the clinical team and supported by written documentation which can be faxed or emailed	1
1.16	The team responds to non-urgent referrals within 6 weeks that are not included in the Priority Care Pathway (Appendix 2)	2
1.17	A written acknowledgement is sent to the patient within two working weeks of receipt of the referral, giving details of proposed actions and information about the service	2
1.18	The acknowledgement letter is copied to the referrer and the patient's GP	2
1.19	If a referral is not accepted, the team advise the referrer on alternative options	2

Std No	Standard	Type
2	**ASSESSMENT**	
2.1	Teams assess all women who are suffering from a new episode of serious or complex mental illness (in pregnancy and until 6 months postpartum with follow up to 12 months)	1
2.2	An integrated care pathway including screening questions is agreed with maternity services for midwives and other health professionals to detect those at risk of a recurrence of serious mental illness following delivery	1
2.3	The team assess women who have been identified at booking as being at risk of serious mental illness in the perinatal period, even if currently well, due to past psychiatric illness	1
2.4	Women are offered a choice of where they would like their assessment to take place, taking into consideration clinical need	3
2.5	The service is able to conduct assessments in a variety of settings where a crisis may occur *Guidance: This could include a friend or relative's house, an Accident & Emergency department, police custody, etc.*	1
2.6	New onset conditions after 28 weeks of pregnancy and within 6 weeks of delivery should be assessed within the timeframes of the Priority Care Pathway (Appendix 2)	1
2.7	Pregnant women referred with a past history of serious affective disorder / psychosis / severe panic disorder / obsessive compulsive disorder, even if currently well, should be assessed in pregnancy *Guidance: Women referred before 28 weeks should be seen no later than this point in their pregnancy*	1

Std No	Standard	Type
2.8	Pregnant women receiving mood stabiliser medication should be discussed with the referrer and their usual psychiatrist within 2 working days and appropriate advice given prior to being seen within 2 weeks	1
2.9	Women currently in the care of psychiatric services should be assessed and treated in collaboration with their usual psychiatric care team	1
2.10	All women have a comprehensive assessment of their health and social care needs taking into consideration the needs of their children and family	1
2.11	Practitioners gather additional information reflecting the perinatal context (for example, current and past obstetric history, breastfeeding, contraception, contact details of the midwife and health visitor etc)	1
2.12	All women have a named mental healthcare professional. They are told how and who to contact if this person is not available and in an emergency	1
2.13	All women have a care plan which is regularly reviewed	1
2.14	Care plans are reviewed at least every 3 months and following changes in the maternal condition At this review, the following are included: • Assessment of maternal condition • Risk assessment (mother and child) • Assessment of mother-infant interaction and care • Patient rated outcome measure	1
2.15	The care plan is developed collaboratively with the patient	1
2.16	The views of the patient's partner, family and carers is incorporated into the care plan as appropriate	1

Std No	Standard	Type
2.17	*For women seen in pregnancy, there is a peripartum management plan formulated and recorded in the handheld records by 32 weeks of pregnancy shared with the woman, her family, GP, Midwife and obstetrician. This includes:*	
2.17a	Nature of the risk and condition	1
2.17b	Details of current medication and any intended changes in late pregnancy and the early postpartum	1
2.17c	Consideration of whether the mother intends to breastfeed	1
2.17d	Those involved and frequency of contact	1
2.17e	Emergency contact details	1
2.17f	Admission to a mother and baby unit if necessary	1
2.17g	Plans for a maternity admission, including notifying the perinatal team once the patient has delivered	1
2.18	Women referred in pregnancy who are at risk of serious illness are seen by a member of the team prior to delivery and regularly thereafter until the period of maximum risk has passed	2
3	**DISCHARGE**	
3.1	Prior to discharge from the Perinatal Service, the progress and remaining / continuing care needs of the woman are assessed and discussed with adult psychiatric services (if appropriate)	1
3.2	*Before discharge the following should be undertaken:*	
3.2a	Assessment of the maternal condition	1
3.2b	Risk assessment (mother and child)	1
3.2c	Patient outcome measure including patient satisfaction / feedback	2
3.2d	Advice regarding further pregnancies (including risk and benefits of medication)	2
3.2e	Contraception advice	2

Std No	Standard	Type
3.3	Mother-infant assessments should be completed prior to discharge from the service and a copy sent to the health visitor, general practitioner and others involved emphasising any continuing care needs	2
3.4	Any remaining concerns / needs for intervention and support in relation to mother-infant care or older children are communicated to the GP or Health Visitor if indicated	2
3.5	Any safeguarding concerns are referred to children's social services	
3.6	The information collected in standards 3.2, 3.3 and 3.4 is documented in a summary and shared with the patient and all professionals involved in their care	1
3.7	Women requiring continued psychiatric care are handed over to the appropriate team at the final review	1
4	**CARE AND TREATMENT**	
4.1	*There should be a range of evidence based / best practice therapeutic interventions available including:*	
4.1a	Pharmacological treatments	1
4.1b	Psychological interventions *Guidance: This includes problem solving, stress management, brief supportive counselling and relapse prevention*	1
4.1c	Therapies that promote / improve mother-infant interaction	2
4.2	The service has access to medication during working hours	2
4.3	Staff promote patients accessing social and recreational activities	3
4.4	*The clinical members of the team are able to advise the patient, partner, family and other healthcare professionals on:*	
4.4a	Early mother-infant care and attachment	1
4.4b	Infant development	1

Std No	Standard	Type
4.4c	Promoting involvement of partner / family members	1
4.5	Carers are given a pack with information on perinatal mental health problems, what they can do to help, their rights as carers and an up to date directory of local services they can access	2
4.6	The service ensures that older children and other dependents are supported appropriately *Guidance: This may be done via other services, e.g. social services, health visitor*	2
4.7	The team have established relationships with local mother and baby units	1
4.8	The team informs the mother and baby unit of all women at risk of potential admission *Guidance: This includes women with a past history of puerperal psychosis / bipolar disorder / serious affective disorder and women with serious illness currently managed in the community*	2
4.9	The potential for admission is communicated verbally to the woman and her family and recorded in the written care plan and communicated to her GP, midwife and health visitor if appropriate	1
4.10	Written and verbal information is given to the woman, her partner and family about the mother and baby unit and an opportunity to visit the unit is offered	2
4.11	As soon as possible after admission to a mother and baby unit a perinatal community psychiatric nurse should be allocated. Her perinatal psychiatric nurse should attend multidisciplinary ward rounds as appropriate and pre-discharge meeting and establish a working relationship with the woman prior to her discharge	1
4.12	Following discharge from an inpatient stay, the woman is contacted in the community by a member of the perinatal team within 7 days	1

Std No	Standard	Type
	INFANT WELFARE AND SAFEGUARDING	
5.1	*During the first assessment of the patient, the infant's care needs will be assessed. This assessment will include:*	
5.1a	The baby's age and date of birth	1
5.1b	Parental responsibility	1
5.1b	Name and contact numbers of GP, health visitor, midwife and any social worker or paediatrician involved	1
5.1c	If the child is the subject of a Child Protection Plan (formerly known as the Child Protection Register or At Risk Register) or Care Proceedings	1
5.1d	Mode of delivery and problems during gestation	1
5.1e	Mode of feeding and any previous problems with feeding	2
5.1f	Vaccinations - date given and due	2
5.1g	A brief structured assessment of mother-infant interaction, care and attachment	2
5.2	If areas of concern are highlighted then the care co-ordinator ensures a full assessment is completed using a validated instrument, working collaboratively with the health visitor, psychologist or social worker if involved	2
5.3	The level of support and assistance the patient requires to meet her child's needs is determined and recorded	2
5.4	Mother-infant assessments are conducted every 3 months with input from the health visitor or more frequently should the patient's mental state and behaviour change	2
5.5.	All mother-infant assessments are fed back to and discussed with the patient with particular reference to progress and problem areas	2
	Risk Assessment of the Infant	
5.6	*A risk assessment of mother and infant must be undertaken at first assessment by the service. This should include:*	
5.6a	Disclosures of harmful or potentially harmful acts	1

Std No	Standard	Type
5.6b	Any delusions / overvalued ideas or hallucinations involving the infant	1
5.6c	Any thoughts, plans or intentions of harming the child	1
5.6d	Hostility and / or irritability towards the baby	1
5.6e	Any involvement with Children's Social Care *Guidance: e.g. baby or older children subject to child protection plan or child care proceedings*	1
5.6f	Any concern about any other family member who may pose a risk to the child	1
5.7	The risk assessment tool is specifically designed and standardised for use by perinatal psychiatric services	1
5.8	The risk assessment is repeated every 3 months or more frequently if the mother's state changes	1
5.9	Risk assessments are completed prior to discharge and sent to all other agencies involved in the their care	1
5.10	At each stage of Care and Risk Assessment consideration is given as to whether it is appropriate to initiate a CAF to better assess any additional needs the baby or older children of the family may have (www.ecm.gov.uk/caf)	1
	Care and Treatment of the Infant	
5.11	The patient's wishes, parenting style and preferred routines are respected at all times unless there are clinical and safety reasons not to do so (i.e. It is not in the child's best interest)	1
5.12	*Case notes include:*	
5.13a	Any maternal concerns	2
5.13b	Her care of the infant	2
5.13c	Her enjoyment of the infant	2
5.13d	If appropriate, the reason for the infant's absence from the contact	1
5.14	Service information states that the involvement of partners and/or other significant family members in the care of the mother and her infant is encouraged	2

Std No	Standard	Type
5.15	*Women who choose to breastfeed are supported and encouraged by the following:*	
5.15a	The prescribing of psychotropic medication in breastfeeding mothers is tailored to their needs both in terms of the choice of medication, its dosage and frequency of administration	1
5.15b	The patient's medication chart clearly states whether she is breastfeeding	2
5.15c	Access to up to date and expert information about medication in relation to breastfeeding is available to all clinicians	1
5.16	If a patient and infant or older children are seen in an outpatient clinic or other psychiatric facility, the waiting area is exclusively for the use of the perinatal service during that session and equipped with age appropriate toys	3
	Safeguarding of the Infant	
5.17	Local safeguarding and child protection guidance is available and accessible to all staff members	1
5.18	The child protection status and the responsible social worker are recorded in the patient's notes, with contact details	1
5.19	A senior clinician from the perinatal mental health services is a member of the local safeguarding or child protection group	3
5.20	*Referral to Children's Social Services should be made on the basis of a risk assessment and should not be "routine" (i.e. only because the mother is mentally ill), except when the following factors are identified:*	
5.20a	Concern from risk assessment about the immediate safety of the infant from its mother, partner or frequently visiting relative	1
5.20b	An assessment identifies that the child is at ongoing risk of harm	1

Std No	Standard	Type
5.20c	The infant or older siblings have been subject to a child protection plan or care proceedings	1
5.20d	Current domestic violence	1
5.20e	Evidence that harm has already occurred	1
5.21	Any referral to social services is made initially by telephone, backed up within 24 hours in writing with copies to the Trust Named Doctor for Child Protection and Named Nurse	1
5.22	Antenatal referrals are copied to the safeguarding midwife	1
5.23	Protocols and procedures are in place to ensure perinatal and children's social services work collaboratively	3
6	**STAFFING AND TRAINING**	
6.1	All staff receive a specialist induction when they first join the service	1
6.2	*All clinical staff involved in the care of mothers and infants receive education and training within 3 months of their appointment (and updated on a regular basis) in the following areas:*	
	The range of perinatal disorders including aetiology, clinical presentation, course and prognosis (updated annually)	1
6.2a	Mother-infant assessment including risk assessment	1
6.2b	Infant development (physical, emotional and cognitive)	2
6.2c	Cultural differences in infant feeding care / interaction and family relationships	3
6.2d	Prescribing in pregnancy and breastfeeding	1
6.2e	Understanding and promoting mother-infant interaction and attachment	2
6.2f	Level 2 Safeguarding for Children or local equivalent	1
6.2g	Common Assessment Framework (CAF) training (England and Wales only)	2
6.2h	Infant mental health training (e.g. Solihull, Watch Wait Wonder or Mellow Babies)	2

Std No	Standard	Type
6.2i	Early parent skills (practical and emotional)	2
6.2j	Referral criteria, specialised assessment including risk assessment and specialised care planning (within 6 weeks of appointment and updated annually)	1
6.2k	The organisation and delivery of maternity care (within 6 weeks of appointment and updated if changes)	2
6.2l	The role and responsibilities of the health visitor (within 6 weeks of appointment and updated if changes)	2
6.2m	Normal emotional changes in pregnancy and after birth	1
6.2n	The assessment and management of pregnancy in high risk conditions (updated annually)	1
6.2o	Pharmacological interventions, risks and benefits in pregnancy and breastfeeding (updated annually)	2
6.2p	Basic psychological interventions (updated annually)	2
6.2q	The use of contraception including emergency contraception (updated every 2 years)	3
6.2r	Counselling skills	2
6.2s	The relevant Mental Health Act	1
6.2t	Alcohol and substance misuse	2
6.2u	Best practice in self harm	2
6.3	Specialised training needs are informed annually through staff appraisal, individual development plans and supervision	2
6.4	The team completes a annual skill mix review to inform decisions about training	2
6.5	All clinical staff attend a specialist perinatal training day at a minimum of once every two years	2
6.6	The team provide an annual training plan or strategy about perinatal mental health and its services which is appropriate for and accessible to midwives, health visitors, GPs, obstetricians, social workers and mental health workers	2

Std No	Standard	Type
6.7	All staff involved in the care of mothers and infants receive monthly clinical supervision *Guidance: This will include child protection and infant mental health issues*	2
6.8	One member of the team has received level 4 safeguarding training (or local equivalent) and acts as a safeguarding lead for the service	2
6.9	*The service consists of:*	
6.9a	Sessions from a dedicated specialised consultant perinatal psychiatrist	1
6.9b	Non-consultant medical input	2
6.9c	Dedicated perinatal community psychiatric nurses	1
6.9d	Dedicated sessions of a social worker	2
6.9e	Dedicated clinical psychologist sessions	2
6.9f	Dedicated nursery nurse (1 per team)	3
6.9g	Dedicated OT sessions	2
6.9h	Administrative and data entry support	2
6.10	Members of the team have timely access to advice and support from a specialist perinatal psychiatrist during working hours	1
6.11	The service has access to interpreters within working hours	1
6.12	The team has a base and office accommodation including satellite bases if serving a large geographical area	2
6.13	All staff access performance and quality data on both their own patients and the team as a whole, including the regular reviewing of outcome measures to inform patient care and team development	3
7	**RECORDING AND AUDIT**	
7.1	*The community perinatal psychiatric service keep records of :*	
7.1a	Referrals that have been declined and the reasons for this and any alternative actions suggested	2

Std No	Standard	Type
7.1b	Transfers of care of any woman during pregnancy and the postpartum year to another psychiatric service	2
7.1c	Prolonged periods of mother-infant separation / care of the infant by family members or inability of the mother to care for her infant	1
7.1d	Women involved in care proceedings / child safeguarding protection plans (including within 3 months of discharge)	1
7.2	The service should have a clearly defined list of adverse occurrences including those listed above	2
7.3	There is a programme of audit including at least two audits a year and annual service evaluation	2
7.4	Any serious untoward incident including those involving a child and any emergency child protection order should be audited within 6 weeks and chaired by a suitably qualified clinician external to the service	1
7.5	*The service keeps a record of:*	
7.5a	Emergency Protection Orders / care proceedings / child safeguarding protection plans (including within 3 months of discharge from the service)	2
7.5b	Any difficulties / undue delay in transferring the patient to another psychiatric service	2
7.6	Service protocols, policies and procedures are reviewed at least every two years	2

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