NHS Education for Scotland

PERINATAL MENTAL HEALTH CURRICULAR FRAMEWORK:

A framework for maternal and infant mental health

Perinatal Mental Health Network Scotland
National Managed Clinical Network

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MINISTERIAL FOREWORD

The Scottish Government believes that all women, infants and their families should enjoy high levels of wellbeing and positive mental health. However, we know that pregnancy can be a time of both transition and stress which can affect emotional well-being. We also know that untreated mental health difficulties in the perinatal period can lead to poor outcomes, which can include maternal and infant deaths, and that the quality of early relationships between infants and their care-givers are crucial in determining a child's long-term physical and mental health outcomes. We cannot overstate the importance of supporting the mental health and well-being of all mothers, infants and their families.

Since the publication of the first Perinatal Mental Health Curricular Framework in 2006, the Scottish Government has highlighted its ongoing commitment to perinatal mental health in the Mental Health Strategy (2017-2027), and has funded a Managed Clinical Network (MCN) for Perinatal Mental Health. NHS Education for Scotland and the MCN have collaborated to develop this document, which sets out the competencies required by all those in the Scottish workforce who come into contact with pregnant women and their families. We want to ensure an optimal experience for new mothers and their families, and the best possible start to life for infants. We will use this Framework to design and deliver training across the Scottish workforce so that women, infants and families receive the right level of care, appropriate to their needs.

Our vision, shared by partners in perinatal mental health and maternity services, is of a Scotland where pregnant women, their partners and families receive the level of support they require so that they can experience optimal health and wellbeing, including mental wellbeing, during the perinatal period, so that infants get the best possible start in their lives. With that in mind, this Framework contains an emphasis on the following:

- Promoting the understanding that mental wellbeing is determined by many factors, including biological, psychological and social factors
- The importance of promoting mental wellbeing across the whole spectrum of mental health
- The perinatal period, and the parent-infant relationship, are crucial for the health and wellbeing of the infant, as well as any other children in the family, both in the present and in terms of long-term outcomes
- The importance of the mental wellbeing of not only the mother, but her infant, partner and other family members
- The safety and wellbeing of infants and children should always remain central
- Discrimination and stigma related to mental health difficulties needs to be eliminated or reduced
- A strengths-based approach to the care of all women, infants and their families should be adopted.

This competency framework has been developed with partners, stakeholders and those with lived experience of perinatal mental ill-health. I am very grateful to all those who shared their views and experiences to inform and shape this document.

Clare Haughey
Minister for Mental Health

INTRODUCTION

Mental health is an issue for us all. It is estimated that one in four people in Scotland experience mental health problems (SIGN 2014). Mental health problems are often associated with times of stress or change in our lives. Perinatal - the period of pregnancy, childbirth and the first year after the birth - mental health is an area where workers can play significant roles in mental health promotion, the prevention of mental health problems and in the care, treatment and intervention for women and their families whose lives may be impacted by mental health problems. Perinatal mental health has been recognised, over many years now, as a major public health concern and is a key priority within the Scottish Government's Guidance for Commissioners of Perinatal Mental Health Services, 2012; and the Mental Health Strategy (2017-27). Researchers, policy makers, service users and health professionals have highlighted the huge impact of mental health problems during the perinatal period and the need for improved care in this area (NICE; 2014, Galloway & Hog 2015; MIND; 2006) Royal College of Psychiatrists, 2015) as well as their high prevalence and wide societal effects (Cooper and Murray 2005; Manning and Gregoire 2006; Meltzel et al. 1995). and costs (Centre for Mental Health, 2014; Doyle et al., 2009; Heckman 2006; Knapp et al., 2011). 1 in 5 women (over 11,000 per year in Scotland) experience a mental health problem during this time (RC Psych 2016). The most common perinatal mental health problem is postnatal depression, with rates ranging between 13% in the first few weeks to 20% in the first year after the birth (Ban et al. 2012; Munk-Olsen et al. 2006). Studies have documented the profound effect untreated postnatal depression can have on relationships, families and children; linking it to depression in partners, higher rates of divorce, lower levels of emotional and cognitive development and higher levels of behavioural problems and psychological disorders among children (Boyce 1994; Cox et al 1993. Evans et al 2001. Hay et al 2001. Holden 1991; Murray and Cooper 2003; Murray 1992; Sharp 1994; Webster 2002).

The NICE Guideline 127 (2014) captures the potential consequences of mental health difficulties in the perinatal period as follows:

> **'The concept of prognosis must therefore be extended to consideration of not only the future course of the mental health problem and its impact on the woman, but also its impact on the other family members. The increased vulnerability of children whose parents have a mental health problem (Beardslee et al.1983; Rubovits 1996; Gray 2013) argues strongly for the effective and prompt treatment of mental health problems in pregnancy and the postnatal period. There are many opportunities for pregnant or postnatal women to be identified and treated because they are in frequent contact with universal services (maternity, health visiting and primary care) for their and their baby's care. However, healthcare professionals should also consider that women with a mental health problem may be less likely to access regular physical care, and for those who do, many might have considerable anxiety about disclosing a mental health problem. The focus on the needs of the fetus/baby by both the mother and healthcare professionals should not obscure the needs of the mother', NICE 2014.**

POLICY CONTEXT

NICE (2014) also identify the following ways in which mental health difficulties during pregnancy can differ from those at other times:

- **Women might not want to tell anyone about their feelings because of the stigma of mental health problems during a period that is broadly associated with happiness; they might also worry that social care will become involved, which they might fear could lead to loss of custody (Dolman et al. 2013).**
- **There is a risk of pregnant women with an existing mental health problem stopping medication, often abruptly and without the benefit of an informed discussion, which can precipitate or worsen an episode.**
- **In women with an existing mental health problem (for example, bipolar disorder), there is an increased risk of developing an episode during the early postnatal period. There are also some other differences in epidemiology, which are reviewed for the specific disorders.**
- **The impact of any mental health problem may often require more urgent intervention than would usually be the case because of its potential effect on the fetus/baby and on the woman's physical health and care, and her ability to function and care for her family.**
- **Postnatal-onset psychotic disorders may have a more rapid onset with more severe symptoms than psychoses occurring at other times (Wisner & Wheeler; 1994) and demand an urgent response.**
- **The effects of mental health problems, at this time, require that not only the needs of the woman but also those of the fetus/baby, siblings and other family members are considered (including the physical needs of the woman or fetus/baby) – for example, when considering waiting times for psychological interventions, acute treatment for severe mental illnesses or admission to an inpatient bed.**
- **The shifting risk-benefit ratio in the use of psychotropic medication during pregnancy and the postnatal period (particularly when breastfeeding) requires review of the thresholds for treatment for both pharmacological and psychological interventions. This may result in a greater prioritisation of prompt and effective psychological interventions.**

The Scottish Intercollegiate Guidelines Network Clinical Guideline 127 (SIGN CG 127) for Management of Perinatal Mood Disorders (2012) make the following recommendations based on their expert review of current research:

PREDICTING AND REDUCING RISK

- All pregnant women should be asked about personal history of postpartum psychosis, other psychotic disorders (especially bipolar affective disorder and schizophrenia), and severe depressive disorder.
- All pregnant women should be asked about family history of bipolar disorder or postpartum psychosis.
- Women at high risk of postnatal major mental illness should have a detailed plan for their late pregnancy and early postnatal psychiatric management, agreed with the woman and shared with maternity services, the community midwifery team, GP, health visitor, mental health services and the woman herself. With the woman's agreement, a copy of the plan should be kept in her hand held records. The plan should identify what support should be in place and who to contact if problems arise, together with their contact details (including out of hours), and address decisions on medication management in late pregnancy, the immediate postnatal period and with regard to breastfeeding.

PREVENTION AND DETECTION

- Enquiry about depressive symptoms should be made, at minimum, on booking in and postnatally at four to six weeks and three to four months.

MANAGEMENT

- Cognitive behavioural therapies should be considered for treatment of mild to moderate depression in the postnatal period.

PRESCRIBING ISSUES

- All women of childbearing potential who take psychotropic medication should be made aware of the potential effects of medications in pregnancy. The use of reliable contraceptive methods should be discussed.
- In view of the risk of early teratogenicity and longer-term neuro-behavioural toxicity, valproate (when used as a mood stabiliser) should not be prescribed to women of childbearing potential.
- If there is no alternative to valproate treatment for a woman of childbearing potential, long-acting contraceptive measures should be put in place. Check the Medicines and Healthcare products Regulatory Agency (MHRA) website for current advice.

IMPROVING CARE OF WOMEN WITH MENTAL HEALTH PROBLEMS

The Confidential Enquiries into Maternal Deaths in the UK (Oates & Cantwell, 2011) find that psychiatric causes of maternal death, particularly suicide, continue to be a significant cause of maternal mortality in the UK. More rarely, severe mental illness, particularly in the first postnatal month, may lead to infanticide (Flynn et al., 2007). The high human cost of perinatal mental illness has been starkly highlighted by the Confidential Enquiries into Maternal Deaths. The 1997-99, 2000-02 and 2006-08 Triennial reports found that suicide and psychiatric causes were the leading causes of indirect maternal death in the United Kingdom; 'between 2006-2008, 261 women in the UK died directly or indirectly related to pregnancy' (p.1). The most recent enquiry report (CMACE 2006-08) highlights six key learning points where improvements in care may have prevented the deaths or reduced the risk as follows:

SUICIDES

Over half of the maternal suicides were White, married, employed, living in comfortable circumstances and aged 30 years or older. In contrast, suicides associated with substance misuse were mostly young, single and unemployed. Care needs to be taken not to equate risk of suicide with socio-economic deprivation.

PREVIOUS PSYCHIATRIC HISTORY AND SUICIDE

Most women who suffer maternal deaths from suicide will have a history of serious affective disorder. Women with previous bipolar disorder, other affective psychoses and severe depressive illness face a substantial risk of recurrence following delivery even if they have been well during pregnancy. Previous psychiatric history must be identified in early pregnancy. Psychiatrists should proactively manage this risk and, at the very least, frequently monitor and support these women in the early weeks following delivery.

PUERPERAL PSYCHOSIS

Puerperal psychosis (including recurrence of bipolar disorder and other affective psychoses) is relatively uncommon in daily psychiatric practice. The distinctive clinical features, including sudden onset and rapid deterioration, may be unfamiliar to non-specialists. Psychiatric services should have a lowered threshold to intervention including admission. They should ensure continuity and avoid care by multiple psychiatric teams. Specialised perinatal psychiatric services, both inpatient and community, should be available.

CHILD PROTECTION ISSUES

Morbid ideas of maternal incompetence and danger to the infant are a common feature of maternal mental illness, as is a fear that their children will be removed. Referral to safeguarding teams should not be routine when mothers develop a mental illness but should take place as the result of a risk assessment. When referral to the safeguarding team is necessary because the infant has or is likely to suffer from harm, then extra vigilance and care are required. Referral to social services may otherwise result in avoidance of care and necessary treatment and may increase the risk of deterioration in the mother's mental health and suicide.

SUBSTANCE MISUSE

Women may conceal or minimise the nature and extent of their substance use, often fearing a censorious approach or child protection involvement. Early information sharing between the GP, maternity and addiction services is essential. Management should include drug monitoring measures, such as regular urine screening, particularly where substitute prescribing is used. All women who are substance users should have integrated specialist care. Women should not be managed solely by their GP or midwife. Integrated care should include addictions professionals, child safeguarding, and specialist midwifery and obstetrics.

MISATTRIBUTION OF PHYSICAL SYMPTOMS TO PSYCHIATRIC ILLNESS

The misattribution of physical symptoms and of distress and agitation to psychiatric disorder has led to a failure to investigate and delays in diagnosis and treatment of serious underlying medical conditions in several deaths. Caution needs to be exercised when diagnosing psychiatric disorder if the only symptoms are either unexplained physical symptoms or distress and agitation. This is particularly so when the woman has no prior psychiatric history or when she does not speak English or comes from an ethnic minority.

INFANT MENTAL HEALTH

The issue of maternal perinatal mental health is closely connected to that of infant mental health. Research in this area emphasises the need to focus care not solely on the mother but also on the relationship between mother and baby (Cuthbert, Rayns & Stanley, 2011). Working with mothers and infants to improve their interaction and attachment is a primary prevention of the development of mental health problems in children. The Scottish Government's 2005 framework, The Mental Health of Children and Young People: A Framework for promotion, prevention and care stated:

'Interventions focused during pregnancy and at the time around the birth are likely to be the most effective in preventing mental health problems of a child. These include interventions which improve and enhance the well-being of the mother and of the baby and promote the mother-infant bond, and which take into consideration the psycho-social aspects of pregnancy, promote good early parent-child interaction, attachment and support problem-solving skills'

The knowledge and competencies required to support good mother-infant relationships are explicitly outlined within dimension three in the present framework.

POLICY CONTEXT

There has been much professional and political guidance on the improvement of perinatal mental health services in Scotland and in the UK in recent years. The Mental Health Strategy's (2017-2027) Action 16: Fund the introduction of a Managed Clinical Network (MCN) to improve the recognition and treatment of perinatal mental health problems led to the institution, in January 2017, of a Scottish National Managed Clinical Network for Perinatal Mental Health. In common with other MCNs, it has the following remit:

1. **Service improvement and planning** – mapping services across Scotland; designing models of care
2. **Education to build capacity and capability in specialist care** – for both professionals and carers
3. **Collecting and reporting data:** to measure and improve quality of care
4. **Communicating and engaging with stakeholders** – ensuring that we understand what they want and involve them in shaping services that meet patient and carer needs.

The new MCN has been a key stakeholder in the development of this refreshed curricular framework.

The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland, the new policy for NHS Scotland, was published in 2017 and sets out the case for significant change in maternity and neonatal services in Scotland in a series of key recommendations (click here for the full list of recommendations from this report:

http://www.gov.scot/Publications/2017/01/7728/12)

- **Continuity of Carer:** all women will have continuity of carer from a primary midwife, and midwives and obstetric teams will be aligned with a caseload of women and co-located for the provision of community and hospital-based services.
- **Mother and baby at the centre of care:** Maternity and Neonatal care should be co-designed with women and families from the outset and put mother and baby together, at the centre of service planning and delivery, as one entity.
- **Multi-professional working:** Improved and seamless multi-professional working.
- **Safe, high quality, accessible care:** including local delivery of services, availability of choice, high quality postnatal care, co-location of specialist maternity and neonatal care, services for vulnerable women and perinatal mental health services.
- **Neonatal Services:** proposes a move to a new model of neonatal intensive care services in Scotland in the short and long term.
- **Supporting the service changes:** recommendations about transport services, remote and rural care, telehealth and telemedicine, workforce, education and training, quality improvement and data and IT.

Both the Mental Health Strategy and the five-year forward plan for Maternity and Neonatal Care in Scotland have informed the development of this framework, complementing the Scottish policy emphasis on addressing health inequalities and supporting social inclusion. Additionally, the Mental Health (Care and Treatment) (Scotland) Act 2003 set out a legal requirement that arrangements should be made by all health boards to accommodate women and their baby where the woman is experiencing a severe perinatal mental illness requiring admission. Admission can be at any time until the baby is one year old.

This is consistent with the Council Report of the Royal College of Psychiatrists into perinatal mental health services which stated that:

'Organisation of services should ensure that intervention is delivered at the level appropriate to need, with links across Health Boards and regions to make best use of resources. Joint working between mental health and partners in maternity services, primary care, social services, child health, education and the third sector will be essential to the delivery of promotion, prevention and early recognition of those in need of specialist mental health services for both parents and children. For the most vulnerable families, GIRFEC ('Getting it Right for Every Child') systems (Children and Young People (Scotland) Act, 2014) will provide a structure for coordination of professional input and monitoring of the child and family'. (RC Psych 2016, p11)

A study by the charity MIND (Out of the Blue? Motherhood and Depression, 2006) identified a number of key areas in which maternal mental health care in England and Wales falls short of expected standards:

- lack of provision, particularly specialist services including mother and baby units
- failure to identify risk factors
- inadequate treatment of severe disorders
- lack of coordination between services
- the study stated that all health professionals caring for all women during the perinatal period should be expected to have the following skills:
  - an understanding of the importance of identifying women at risk of developing serious mental health problems and the associated risk factors
  - an ability to understand and distinguish normal emotional changes and common difficulties from a mental health problem and being able to recognize the first signs of a problem
  - listening skills and the ability to be supportive, reassuring and understanding;
  - awareness of when and how to make referrals, and the range of different treatment options available

The NSPCC in their Getting it Right for Mothers and Babies (Galloway and Hogg, 2015) make five key recommendations as follows:

1. All health professionals working with women in pregnancy or the first postnatal year, and those working with women of childbearing potential who have pre-existing mental health problems, should complete at least biennial update training on perinatal mental health (e.g., by completing the NES Maternal Mental Health e-Learning module)
2. Women whose pregnancies are likely to be complicated by serious pre-existing mental health conditions, or who develop new significant mental ill health, should be immediately referred to appropriate specialist services.
3. Psychological services (at primary and secondary care level) should prioritise timely interventions for pregnant and postnatal women. Waiting times should be monitored in line with GIRFEC principles.
4. The Scottish Government should ensure a nationally co-ordinated systematic approach by all NHS Boards to developing local specialist perinatal mental health services. A national Perinatal Mental Health managed Clinical Network should be established to provide leadership on this.
5. Local multi-professional Perinatal Mental Health networks should be established in each NHS Board area to promote multidisciplinary/agency working, ensure clear pathways for referral and assessment, and to share skills and knowledge.

More recently, in the Mental Welfare Commission's Perinatal themed visit report: Keeping mothers and babies in mind (2016), inequalities in provision of specialist perinatal mental health services were highlighted as folows:

> **'When women we spoke with did seek help, the significance of their symptoms and associated risks were sometimes not recognised. We were concerned about a lack of perinatal training and knowledge among health professionals in some cases, both within primary care and mental health services. Severe perinatal mental illnesses can have rapid onset (within hours or days) and may present differently to those seen in the general adult population. Women's symptoms can fluctuate and the risks can be significant. The majority of consultant psychiatrists we surveyed told us they felt confident recognising and treating these illnesses, but over 90% (of 70) said they would value local perinatal expertise when treating women during pregnancy and following childbirth. One third of those surveyed (33%, 23 of 70) said this specialist advice was not currently available in their local NHS board'.**

Similarly, SIGN Guideline 127 (2014) reported that:

- Perinatal mental illnesses affect between 10 -15% of women in Scotland
- 71% of health boards in Scotland do not have any midwives or health visitors with accredited perinatal mental health training.
- Only five Scottish health boards (36%) have a specialist community perinatal mental health service.
- 90% of NHS boards supported a National Managed Clinical Network for perinatal mental health and advises that we: 'Establish competencies and training resources for health professionals caring for pregnant or postnatal women with, or at risk of, mental illness, at levels appropriate to their need. Ensure that all pregnant and postnatal women with, or at risk of, mental illness have equitable access to advice and care appropriate to their level of need' (SIGN 127). For these evidence-based recommendations to be fully implemented in Scotland, those providing care, in the broadest sense, for families in the childbearing period need to have received adequate education and training and that is the purpose of this Curricular Framework.

LEVELS WITHIN THE CURRICULAR FRAMEWORK

The original Perinatal Curricular Framework was developed by a multi-disciplinary national group and published by NES in 2006. This formed the basis for the Specialist Perinatal Mental Health Module at Glasgow Caledonian University, launched in 2007, and informed the **Introductory Online Maternal Mental Health Courses** developed by NES in 2015. Since its publication in 2006, however, research and key policy documents have informed and changed recommendations and practices in perinatal and infant mental health.

For example, our knowledge around the interactional nature of neuro-development and the impact of its absence for the infant's physical and mental health outcomes highlights the crucial window of opportunity that exists during the perinatal period to enhance outcomes for mothers and their babies. A multi-disciplinary working party of those with expertise around Perinatal Mental Health and Infant Mental Health were involved in the production of the new framework which aims to guide educationalists in developing curricula for pre-registration and undergraduate programmes for a range of professionals as well as CPD for those already working in health, social care and the third sector. We were inspired by the structure of the NES Transforming Psychological Trauma Knowledge and Skills Framework which aims to capture the learning needs of all those in the Scottish workforce, across disciplines and agencies, who may come into contact with people who have experienced trauma. To meet the aspirations for enhanced perinatal and infant mental health care outlined above we will require the broadest possible engagement with all those who may come into contact with women and their families during the perinatal period and so there were obvious parallels between the present framework and the Trauma Framework. The Trauma Framework stratifies these learning levels as follows:

1. Informed;

2. Skilled;

3. Enhanced and

4. Specialist

and we have a dapted these in the table **on page 12**. The knowledge and skills outlined at each level of the framework are constructed in an incremental way meaning that, for example, staff operating at the Enhanced Practice level would also be expected to possess the knowledge and skills described at the Informed and Skilled Practice level. The framework does not aim to specify which staff roles correspond to which practice level. The expectation instead is that workers and their employers will take responsibility for ensuring that they relevantly interpret and apply the content and aspirations of the framework.

INFORMED	Baseline knowledge and skills required by all staff working in health, social care and third sector settings. **(All staff)**
SKILLED	Knowledge and skills required by staff who have direct and/or substantial contact with women during pregnancy and the postnatal period, their infants, partners and families. **(All maternity, health visiting, primary care, children & families social work, relevant third sector)**
ENHANCED	Knowledge and skills required by staff who have more regular and intense contact with women who may be at risk of/affected by perinatal mental ill health, their infants, partners and families. **(All mental health, including adult, CAMHS, addictions etc. as well as maternity, primary care, health visiting and third sector staff who work in an enhanced role)**
SPECIALIST	Knowledge and skills required by staff who, by virtue of their role and practice setting, provide an expert specialist role in the assessment, care, treatment and support of women who may be at risk of/affected by perinatal mental ill health, their infants, partners and families. They will often have leadership roles in education, training and service co-ordination and development. **(Staff working within specialist perinatal and infant mental health services)**

These learning outcomes set out the minimum level of knowledge and competence required by any professionals working in or linked closely to perinatal mental health services. Where an area does not have a complete defined perinatal mental health team, individuals should be identified who will work as local specialist level four practitioners.

DIMENSIONS WITHIN CURRICULAR FRAMEWORK

During this review of the 2006 Framework, an expert working party considered the existing 5 dimensions and their suitability in the context of recent research and policy documents. In 2006, the following Dimensions were applied: **1.** Underpinning Knowledge; **2.** Prevention; **3.** Detection; **4.** Management, and **5.** Professional, Ethical and Legal Practice. Our aim in reviewing these dimensions was a desire to bring the terminology up to date to fit with current views and policy direction, to emphasise infant mental health & attachment relationships, the promotion of positive mental health and wellbeing and a focus on health and well-being rather than a narrower focus on illness. Finally, we were keen to consider explicitly the needs of not just mother and infant, but also their partners and other children too.

DIMENSION 1: HEALTH AND WELL-BEING:

All women, babies and partners experience optimal health and well-being during the perinatal period

- Women are supported to manage factors which may impact on mental health and well-being during the perinatal period
- Professionals have an understanding of mental health problems, both in general and during the perinatal period
- Professionals can obtain a mental health history through sensitive and systematic enquiry
- Professionals can detect signs and symptoms of distress and disorder in the perinatal period
- Professionals can identify biological, psychological, social and environmental risk factors which influence the development and/or maintenance of perinatal mental distress and disorder

DIMENSION 2: FAMILY SUPPORT

Partners and family members are closely involved in perinatal mental health care for women and babies

- Partners and other family members should expect to be included in information provision and decision making regarding the woman's mental health, in accordance with the duty of confidentiality to the woman
- Partners and other family members should expect that professionals are mindful that they may have their own mental health needs
- Professionals should be mindful of the potential effects of partners' or other family members' mental distress or disorder on the woman's and infant's mental health

DIMENSION 3: PARENT-INFANT RELATIONSHIP

Parent-Infant Relationship: Parent-infant relationships are warm, secure and attuned during the perinatal mental health period

- Professionals should practice in a way which supports the parent-infant relationship and facilitates optimal infant development.
- Professionals should recognise when problems arise in parent-infant interactions and/or infant Development
- Professionals should recognise when a child may be at risk of harm and be able to act to safeguard the child

DIMENSION 4: STIGMA

Discrimination and stigma relating to perinatal mental health difficulties are eliminated or reduced

- Women and their families can expect professionals to be aware of perceived stigma around mental wellbeing and ill health during the perinatal period
- Women and their families should expect professionals to be aware of and understand cultural barriers and differences
- Practice in an anti-discriminatory manner

DIMENSION 5: INTERVENTIONS

Women receive specific interventions or treatments appropriate to their perinatal mental health needs

- Women should be aware of their right to treatment and to have the information needed to make an informed choice about treatment options
- Women who have a history of mental ill health should receive preconceptual advice regarding the likely effects of pregnancy and childbearing on course of illness and the risks and benefits of treatment
- Women and their families are aware of the range of services available to them to manage Perinatal mental distress and disorder, and have easy access to services when required
- Women receive care from professionals who work as part of a multidisciplinary team and who collaborate across agencies to ensure seamless care
- Women and their families can expect to be offered an appropriate level of support and intervention based on their individual needs
- Women and their families know that any risks faced by themselves, their infant, older children or others are adequately managed through the care they receive
- Practice within legal, professional, national and local policy frameworks

DIMENSION 1 HEALTH AND WELL-BEING:

All women, babies and partners experience optimal health and well-being during the perinatal period

	INFORMED	SKILLED	ENHANCED	SPECIALIST
1.1	1.1 What practitioners know:			
Women are supported to manage factors which may impact on mental health and well-being during the perinatal period	• The perinatal period is a time of increased emotional change and challenge for women, their partners and families • The common emotional changes associated with the perinatal period, including expectations, understanding and reactions related to pregnancy and motherhood • When and how to seek additional advice about physical or psychological changes which may not be within the usual range	• That common emotional changes during the perinatal period may affect the presentation of physical changes • The common physical changes associated with the perinatal period and how they may affect psychological well-being • Common physical and emotional complications and minor disorders that can occur during the perinatal period • Routine maternity, postnatal and infant care pathways, including the nature and timings of routine maternity and health visiting / primary care assessments and interventions • How societal, cultural and religious beliefs and rituals influence a woman's understanding and behaviour in relation to pregnancy, childbirth and infant care • The social and environmental factors which promote good physical health during pregnancy and good pregnancy outcomes	• That women with pre-existing mental ill health, or psychosocial adversity, may face additional difficulties in managing common physical and emotional changes that occur during the perinatal period • Normal emotional changes may be misattributed to mental disorder • How to access maternity care and advice directly, both routinely and urgently	• Have a detailed understanding that physical and emotional changes in pregnancy, and responses to pregnancy complications, vary widely between individuals and are strongly influenced by the woman's own understanding of her pregnancy, infant and parenting role, her past experiences and her perceptions of support and adversity

	INFORMED	SKILLED	ENHANCED	SPECIALIST
1.1	1.1 What practitioners do:			
Women are supported to manage factors which may impact on mental health and well-being during the perinatal period	• Listen, in an empathic, non-judgemental way, to women who wish to discuss issues in relation to pregnancy planning and contraception, pregnancy, childbirth, infant feeding and infant care • Seek advice and guidance from appropriately skilled professionals where necessary	• Discuss the normal physical, psychological, social and cultural processes that occur during the perinatal period, and the interaction of these factors, and incorporate an understanding of this into sensitive person and family-centred care for women, their partners and children • Discuss the impact of minor physical ailments and mild emotional / psychological complications associated with the perinatal period and incorporate an understanding of these into sensitive person and family-centred care for women, their partners and children • Discuss the importance of healthy lifestyle choices in pregnancy, e.g., in relation to smoking, drinking and eating	• Provide women, their partners and families, with an understanding of how normal physical and emotional changes in the perinatal period may impact on mental health, particularly in the presence of pre-existing mental disorder or psychosocial adversity • Evaluate and communicate the significance of physical and emotional changes in the perinatal period for individual woman, given their own history and experiences • Recognise when symptoms or signs may be indicative of more significant physical disorder related to pregnancy or childbirth (e.g., pre-eclampsia, venous thrombosis, pulmonary embolism, miscarriage or threatened abortion) and refer appropriately	• Assist other professionals to understand, and respond to, common physical and emotional changes in women during the perinatal period, particularly in the context of current or previous adversity/ trauma

	INFORMED	SKILLED	ENHANCED	SPECIALIST
1.1	1.2 What practitioners know:			
Women are supported to manage factors which may impact on mental health and well-being during the perinatal period	• That a woman's culture, ethnicity, past experiences, and present social circumstances may affect her current mental health and well-being	• That specific maternal, fetal, neonatal and infant complications may affect a woman's well-being and mental health • That psychosocial and environmental adversity may affect a woman's well-being and mental health • Factors which impact on mental health and well-being may also affect a woman's ability to engage with routine preconceptual, antenatal, postnatal and infant care • The ways in which women can feel empowered to make changes in their personal and social environment to enhance their mental health and well-being • The particular challenges women face when there are child protection concerns • The qualities associated with supportive care-giving relationships and the role they play in enhancing the well-being of all women, (including those who have vulnerabilities) during the perinatal period	• How obstetric, neonatal and infant complications, including pregnancy loss and termination, and neonatal loss, may affect emotional and psychological well-being	• A detailed understanding of research evidence and theoretical frameworks underpinning the complex inter-play between biological, psychological and social factors for the woman, her pregnancy and infant, which may impact on mental health and well-being

	INFORMED	SKILLED	ENHANCED	SPECIALIST
1.1	1.2 What practitioners do:			
Women are supported to manage factors which may impact on mental health and well-being during the perinatal period	• Sensitively ask women if they are facing any additional difficulties in their adjustment to the perinatal period	• Actively promote optimal mental, and physical, health and well-being by identifying, encouraging and focusing on individual and contextual strengths associated with positive coping in the perinatal period. • Discuss the impact of psychosocial and environmental adversities (e.g., intimate partner violence, relationship difficulties, social isolation and exclusion, poverty, housing problems, neighbourhood violence and substance misuse) that can negatively affect maternal mental and physical health and well-being and incorporate this awareness into sensitive person, and family, focused care for women during the perinatal period • Discuss concerns related to child protection and safe-guarding in a sensitive, supportive way • Provide supportive care-giving relationships to all women, (including those with vulnerabilities), their partners and children, during the perinatal period with attention to good continuity of care	• When necessary, incorporate an understanding of the psychological impact of specific untoward obstetric, neonatal and infant complications into sensitive person-and family-focused care for women during the perinatal period (examples include, infertility, assisted conception, pregnancy and neonatal loss, birth of a premature or unwell baby, difficult birth, Caesarean section and other emergency procedures) • Be able to support and assist women in choices they may face regarding unwanted or unintended pregnancy	• Provide advice, guidance and support to other professionals about their assessment and management of women facing physical or mental health-related adversity in the perinatal period

	INFORMED	SKILLED	ENHANCED	SPECIALIST
1.2	1.3 What practitioners know:			
Professionals have an understanding of mental health problems, both in general and during the perinatal period	• That women in the perinatal period are as likely, as at other times, to experience mental distress and disorder • For some women, the perinatal period may be a time of greater risk of mental distress and disorder • That perinatal mental health distress and disorders may present in distinctive ways, in terms of their symptoms and course	• There is a spectrum of well-being and mental health problems, both in general, and in the perinatal period • Wellness indicators • Be aware of the biopsychosocial risks and protective factors most clearly associated with recurrence and relapse of pre-existing mental health problems, and with the development of new mental health problems during the perinatal period • The progression of perinatal mental disorder may be more rapid than at other times • The characteristic features of psychological distress and disorder, particularly for those conditions most closely associated with the perinatal period • Mental distress and disorder may have an impact on a healthy pregnancy and the child-bearing process; including the awareness and understanding of pregnancy planning, pregnancy, child-bearing and infant care • That mental distress and disorder may have an impact on engagement with services, including preconceptual, maternity, neonatal and infant care • The impact of substance misuse on maternal well-being and maternal mental state in the perinatal period • The potential impact of learning difficulties for adjustment to pregnancy and parenting	• A detailed knowledge of the prevalence of mental distress and disorder in the perinatal period, and the distinctive patterns of occurrence and recurrence (including, but not limited to; psychotic disorders, affective disorders, anxiety disorders, substance misuse, eating disorders, personality disorders and complex trauma) • How the symptoms, signs and course of any mental disorder may be altered in the perinatal period • How mental well-being, distress and disorder can be conceptualised in a dimensional framework which recognises individual strengths and vulnerabilities	• In detail, how pre-existing mental disorders may affect pregnancy and postnatal outcomes (including, but not limited to; psychotic disorders, affective disorders, anxiety disorders, substance misuse, eating disorders, personality disorders and complex trauma) • Understand that complex and atypical presentations may reflect co-morbidity (physical or psychological) or altered adjustment to the perinatal period • Understand how the symptoms and signs of underlying physical disorder may be misinterpreted as mental distress or disorder

	INFORMED	SKILLED	ENHANCED	SPECIALIST
1.2	1.3 What practitioners do:			
Professionals have an understanding of mental health problems, both in general and during the perinatal period	• Recognise the need to provide additional support to women who face mental health distress or disorder in the perinatal period • Seek advice and guidance from appropriately skilled professionals when necessary	• Promote factors contributing to maintenance of wellbeing in the perinatal period, • Identify individual and contextual risk and protective factors most closely associated with recurrence and relapse, and with the development of new mental health problems in the perinatal period • Appreciate the impact of mental distress and disorder on daily functioning of women, their partners and children and adjust care accordingly • Assist women and their families to engage with care, and make supportive adjustments to care giving, in the context of mental distress and disorder • Assist women and their families to manage the challenges brought about by substance misuse and seek specialist help where appropriate • Assist women and their families to manage any challenges brought about by learning difficulties and seek specialist help where appropriate • Demonstrate sensitivity to the impact that culture and ethnicity may have on diagnosis and illness manifestations	• Assist women and their families to explore both individual and contextual risk and protective factors associated with recurrence and relapse, and with the development of new mental health problems in the perinatal period • Assist women and their families to modify the impact of mental distress and disorder on daily functioning and on infant care in particular	• Provide advice, guidance and support to other professionals about their assessment and management of women facing physical or mental health-related adversity in the perinatal period • Assist other professionals to recognise barriers to their engagement with women displaying mental distress or disorder • Monitor and evaluate their own practices and organisational structures required to respond appropriately to perinatal mental distress and disorder

	INFORMED	SKILLED	ENHANCED	SPECIALIST
1.3	3.1 What practitioners know:			
Professionals can obtain a mental health history through sensitive and systematic enquiry	• The common symptoms and signs of mental distress and disorder • The importance of establishing empathic, non-judgemental professional relationships with women who experience distress or disorder in the perinatal period • That mental distress and disorder may be associated with risk to self or others • The pathways to access mental health care, particularly where urgent assessment and care is required	• The core components of a mental health history and mental state examination • The features of care-giving encounters that promote the establishment of supportive relationships, co-operation and the sharing of sensitive information such as active listening, a non-judgemental response style and the use of appropriate care environments (including; pacing, time and privacy) • The importance of information gathering from family members and other professionals, where that can add to the understanding of the woman's difficulties • The historical and current symptoms and signs which may be associated with maternal self-harm and suicide, or harm to others • Understand the boundaries of confidentiality in a clinical setting	• The need to adapt history-taking to include information relevant to the perinatal context • The need to adapt history-taking in environments specific to the maternity context (e.g., in labour ward settings or when a woman is acutely distressed) such that essential information gathering and risk assessment is prioritised • All clinical encounters are opportunities for therapeutic intervention • The distinctive features associated with maternal suicide risk	• The importance of supporting more junior staff, and those from other disciplines, to interpret symptoms and signs of mental distress and disorder in the perinatal period • A detailed understanding of research evidence regarding risk assessment in relation to maternal self-harm, suicide, and harm to the infant or others

	INFORMED	SKILLED	ENHANCED	SPECIALIST
1.3	3.1 What practitioners do:			
Professionals can obtain a mental health history through sensitive and systematic enquiry	• Enquire sensitively about symptoms of distress and disorder • Seek advice and support when symptoms of distress or disorder are disclosed, particularly if there is evidence of risk to self or others	• Obtain core information from the woman and, where relevant, family members, which identifies current and past symptoms of mental distress and disorder • Provide time, privacy and an appropriate environment to obtain additional aspects of a detailed history where required • Ensure that there is an accurate record of current and past mental health history obtained, and that it is communicated appropriately to other professionals involved in the woman's care • Sensitively enquire about contraception, pregnancy planning, pregnancy and child care in routine clinical encounters • Sensitively explain to women and their families about the boundaries of confidentiality in a clinical setting • Ensure a woman's safety when there is evidence of risk to her, or others • Use a range of strength-based communication skills including active listening, non-judgemental response style and the securing of appropriate care environments when seeking sensitive information from women, their partners and children during the perinatal period. • Make appropriate adjustments to the interview process when communication may be impaired due to language differences, speech or hearing difficulties or mental state disturbance	• Provide time, privacy and an appropriate environment to obtain all aspects of a detailed history • Accurately record a woman's history and mental state examination, including individual and contextual protective and risk factors, associated with her mental health in the perinatal period • Incorporate a detailed enquiry of risk to self or others into history taking and mental state examination • Where professionally relevant, use information gathered to construct a formulation of the woman's difficulties and establish a diagnosis	• Support more junior staff and those from other disciplines to gather relevant information and make appropriate evaluation of mental state and risk • Interpret assessments from other professionals to evaluate adequacy of information and requirement for more detailed assessment

	INFORMED	SKILLED	ENHANCED	SPECIALIST
1.4	3.3 What practitioners know:			
Professionals can detect signs and symptoms of distress and disorder in the perinatal period	• Understand, at a basic level, the differences between symptoms and signs, and between distress and disorder • The importance of non-verbal signs of mental distress and disorder • Recognise barriers to communication of symptoms of distress and disorder during the perinatal period	• That clinician communication skills and environmental factors can influence symptom presentation	• How clinician and service-user factors, and the circumstances of the perinatal period, may influence symptom presentation • The importance of establishing a therapeutic relationship and how the therapist's own experiences and beliefs around pregnancy, childbearing and childcare may affect that relationship • How symptoms and signs of mental distress and disorder may be modified in the context of communication difficulties and physical disability • The distinctiveness of symptom change and progression in the perinatal period	• The challenges other professionals may experience when asking about symptoms and signs of distress and disorder in the perinatal period, and in how to react to such presentations

	INFORMED	SKILLED	ENHANCED	SPECIALIST
1.4	3.3 What practitioners do:			
Professionals can detect signs and symptoms of distress and disorder in the perinatal period	• Recognise when mental distress or disorder may be present • Respond sensitively to disclosure of signs and symptoms of mental distress and disorder • Seek advice and guidance when there is evidence of mental distress or disorder or where there is disclosure of risk to the woman herself, her pregnancy, infant or others	• Facilitate the development of a supportive, non-judgemental clinical relationship which encourages symptom disclosure	• Interpret current symptoms and signs of mental distress and disorder in the context of recent and historical presentations	• Assist women and their families to recognise signs and symptoms of mental distress and disorder during the perinatal period • Assist colleagues to understand, detect and interpret signs and symptoms of mental distress and disorder during the perinatal period

	INFORMED	SKILLED	ENHANCED	SPECIALIST
1.5	3.3 What practitioners know:			
Professionals can identify biological, psychological, social and environmental risk factors which influence the development and/or maintenance of perinatal mental distress and disorder	• A prior or current history of mental ill health may place women at increased risk of developing or worsening mental distress and disorder in the perinatal period • The presence or lack of supportive relationships may influence the development of perinatal mental distress and disorder	• The importance of the woman's own experiences of being parented on her preparedness for, and adjustment to, becoming a parent herself • How current and past experiences of adversity may increase the risk of perinatal mental distress and disorder • Be aware of how a partner's and family's mental health can have an impact on the woman's ability to cope in the perinatal period, and that they can influence the development of mental distress and disorder in the woman herself • A personal or family history of bipolar affective disorder, postpartum psychosis or other psychosis can increase the risk of this occurring in the woman herself	• The biopsychosocial risks associated with the spectrum of disorders which may arise or worsen in the perinatal period • The inter-related roles of predisposing, precipitating and maintaining factors in the development of mental distress and disorder	• A detailed understanding of the research evidence and theoretical framework underpinning the range and interplay of biopsychosocial factors associated with occurrence and recurrence of mental distress and disorder in the perinatal period

	INFORMED	SKILLED	ENHANCED	SPECIALIST
1.5	What practitioners do:			
Professionals can identify biological, psychological, social and environmental risk factors which influence the development and/or maintenance of perinatal mental distress and disorder	• Describe factors associated with the greatest risk of developing perinatal mental disorder • Enquire about the presence of relevant prior history in women who are planning, or in the early stages of, pregnancy • Enquire about psychological and social factors which impact on the mother's mental health and which may play a part in the causation and/or maintenance of mental ill health	• Identify the increased risks of postpartum psychosis and other severe postpartum mental disorder for women with previous history of postpartum psychosis, bipolar affective disorder or other psychosis, or with a family history of these disorders • Use knowledge of individual and contextual protective and risk factors for relapse, recurrence and development of mental health problems to construct an individualised bio-psychosocial understanding of women's coping and vulnerability, particularly in relation to self-harm and suicide.	• Use strength-based communication skills to assess and communicate bio-psychosocial risk factors to women and their families to assist them to make informed decisions about their care	• Assist professional colleagues to understand and evaluate bio-psychosocial risk in relation to perinatal mental distress and disorder • Promote service structures and pathways which prioritise risk evaluation and reduction

DIMENSION 2: FAMILY SUPPORT

Partners and other family members have their own needs recognised and are closely involved in perinatal mental health care for women and infants

	INFORMED	SKILLED	ENHANCED	SPECIALIST
2.1	What practitioners know:			
Partners and other family members should expect to be included in information provision and decision making regarding the woman's mental health, in accordance with the duty of confidentiality to the woman	• Be aware that partners and other family members may have limited understanding of mental distress and disorder	• Be aware that partners and other family members may have limited understanding of the woman's mental distress or disorder • Recognise that, in almost all circumstances, there is a shared desire among partners and other family members to see the woman return to full health and functioning • Understand the important role that partners and other family members have in providing infant care and in developing their relationship with their infant	• Understand how prejudice, stigma and fear regarding mental disorder may play a part in partners' and family members' reactions to the woman's ill health	• Understand the breadth of knowledge and understanding that partners and other family members may require in order to help the woman recover and to recognise risk to the woman, her infant or others where appropriate • Understand the important role that partners and other family members have in supporting the woman in her role as a mother

	INFORMED	SKILLED	ENHANCED	SPECIALIST
2.1	**What practitioners can do:**			
Partners and other family members should expect to be included in information provision and decision making regarding the woman's mental health, in accordance with the duty of confidentiality to the woman	• Listen, in a non-judgemental manner, to partners' and other family members' concerns for the woman's health and wellbeing • Share information regarding the woman's health and care only with her permission, unless in circumstances detailed in local and professional guidance on duty of confidentiality • Seek help and advice in supporting partners and other family members where appropriate	• Support and inform partners and other family members to acquire knowledge and understanding of mental distress and disorder by signposting to appropriate resources, including age-appropriate information for children • Act according to legislation and local guidance regarding duty of candour in informing women, their partners and other family members when things go wrong	• Provide support and advice to partners and other family members to allow them to assist the woman in her recovery	• Provide support and advice to partners and other family members to recognise risk in relation to maternal mental distress and disorder • Provide support and advice to partners and other family members to help them balance their own needs, their infant's and other children's needs, and the woman's needs, at a time of great change in all their lives

	INFORMED	SKILLED	ENHANCED	SPECIALIST
2.2	**What practitioners know:**			
Partners and other family members should expect that professionals are mindful that they may have their own mental health needs	• Be aware that partners, and other family members, can experience mental health difficulties during the perinatal period and that this may impact on the woman's and infant's mental health	• Be aware that partners and other family members, including older children, may require support in adjusting to the woman's pregnancy or the birth of a baby • Be aware that partners or other family members may have pre-existing mental health difficulties which compromise their ability to cope with changes brought about by pregnancy and childbirth	• Understand the differences between normal adjustment and mental distress or disorder in partners and other family members in the perinatal period	• Understand the complex challenges brought about by the need to address mental distress or disorder in more than one family member • Recognise how an absent partner, or lack of support from the family, may affect the mother and infant's mental health and their relationship
	What practitioners can do:			
	• Provide a supportive environment for partners and other family members to discuss their own mental health needs • Seek advice and guidance where concerns arise about family members' mental health	• Sensitively enquire about any additional support needs that partners and other family members may require • Signpost partners and other family members to sources of information and support for their own mental health	• Evaluate whether partners or other family members require more specialist assessment and intervention and refer appropriately (referral may be to the individual's GP)	• Reflect upon and manage the emotional needs of the mother, infant, partner and wider family as part of the care plan

	INFORMED	SKILLED	ENHANCED	SPECIALIST
2.3	**What practitioners know:**			
Professionals should be mindful of the potential effects of partners' or other family members' mental distress or disorder on the woman's and infant's mental health	• Be aware that a partner's or other family member's mental distress or disorder may affect the woman herself, her pregnancy or her infant	• Be aware that the woman may require help in supporting her partner or other family member through their own mental distress or disorder	• Understand the circumstances in which mental distress or disorder in a partner or other family member may pose a risk to that family member, the woman, infant or older children	• Understand the responsibility that professionals have to all family members in the perinatal context and how these responsibilities can be balanced, particularly where there may be conflicting needs for different family members
	What practitioners can do:			
	• Listen to women, their partners and other family members if they disclose concerns about mental distress or disorder in the family • Seek additional support and advice regarding a family member's ill health where appropriate • Act urgently to safeguard the infant, older children or the woman herself, where risks are identified	• Assess the impact of a partner's or other family member's distress or disorder on the woman's ability to manage her pregnancy or infant care • Be able to access additional practical and emotional support to families in crisis	• Assess risk in the context of complex family dynamics, recognising that there may be a fear of disclosure by the woman or others	• Support and advise other professionals to provide best care in complex family situations, where there may be multiple joint and individual needs

DIMENSION 3 PARENT-INFANT RELATIONSHIP

Parent-infant relationships are warm, secure and attuned during the perinatal mental health period

	INFORMED	SKILLED	ENHANCED	SPECIALIST
3.1	**3.1 What practitioners know:**			
Professionals should practice in a way which supports the parent-infant relationship and facilitates optimal infant development.	• Be aware that infant development results from a combination of genetic and environmental influences • Be aware that the infant's early relationship with his or her primary caregiver is critical to how a child develops • Be aware that encouraging good parent-infant relationships promotes optimal child development	• Be aware of the concept of infant mental health and the impact of early life development on later life outcomes • Be aware of the stages of fetal, infant and early childhood development • Be aware of the components of a healthy parent-infant relationship • Have a broad understanding of the factors which promote good parent-infant relationships and infant development, including an understanding of attachment theory	• Be aware that the promotion of good infant development can start before pregnancy by addressing parental disadvantage and vulnerability • Be aware of how bio-psychosocial influences affect the developing foetus • Understand the factors that support optimal brain and psychological development in infancy including primary caregiver wellbeing, mind-mindedness, and sensitive, attuned interactions	• Have a detailed understanding of fetal and infant development and their relationship to longer its' term outcomes for children growing up, including an understanding of the fetal neurohormonal environment and of the principles of the developmental origins of health and disease • Have a detailed understanding of the theoretical underpinnings of infant psychological development and of the caregiver-infant relationship, including an understanding of attachment and related theories

	INFORMED	SKILLED	ENHANCED	SPECIALIST
3.1	3.1 What practitioners know:			
Professionals should practice in a way which supports the parent-infant relationship and facilitates optimal infant development.		• Be aware of the importance of good maternal mental health for the mother-infant relationship and infant development • Have a good working knowledge of resources available to support families, particularly those facing additional vulnerability		• Have knowledge and expertise in at least one theoretical model and applied evidence-based intervention to support the developing infant-carer relationship. • Understand the principles of infant observation and how this can contribute to assessment of the mother-infant relationship

	INFORMED	SKILLED	ENHANCED	SPECIALIST
3.1	What practitioners can do:			
Professionals should practice in a way which supports the parent-infant relationship and facilitates optimal infant development.	• Direct pregnant women, those planning a pregnancy, new parents and their families to sources of information on maintaining good health, preparing for parenthood and caring for their infant	• Explain to women and their families the approaches available to promote parent-infant interaction and infant development • Incorporate knowledge about fetal and infant development, and parent-infant relationships, into sensitive person- and family-centred interactions with women, their partners and children • Develop trusting and therapeutic relationships with infants and their carers which facilitates further assessment and understanding of the positive and negative factors influencing the outcome for the parent, infant and the relationship between them	• Support maternal emotional capacity and confidence to understand her infant's needs and, in this context, identify those families needing more specialist or intensive intervention	• Assist and advise other professionals in their assessment of parent-infant interactions and promotion of positive infant mental health • Contribute to public mental health interventions which seek to explain and promote healthy parent-infant relationships and optimal infant development

	INFORMED	SKILLED	ENHANCED	SPECIALIST
3.1	3.1 What practitioners can do:			
Professionals should practice in a way which supports the parent-infant relationship and facilitates optimal infant development.		• Support women to recognise the importance of good mental health to the developing relationship with their infant • Support families facing additional adversity, including partner or older children's mental distress or disorder, to maintain good parent-infant relationships and promote infant development • Support families caring for a sick infant to maintain good parent-infant relationships and promote infant development		

	INFORMED	SKILLED	ENHANCED	SPECIALIST
3.2	3.2 What practitioners know:			
Professionals should recognise when problems arise in parent-infant interactions and/or infant development	• Be aware that women with poor experiences of being parented, and those facing additional vulnerabilities, including mental distress and disorder, may have extra challenges in preparing for parenthood and forming positive mother-infant relationships • Be aware of the common features which may indicate a disturbed parent-infant relationship and/or poor infant development	• Be aware of the bio-psychosocial influences that impede optimal fetus development, including maternal stress and substance misuse • Be aware of factors that impede optimal fetal and psychological development in infancy including primary caregiver stress, parental mental distress and disorder, parental substance misuse, social adversity and toxic stress, and concern arising from the infant's failure to thrive in any aspect of development and for any reason • Be aware of the potential impact of maternal mental distress and disorder on other members of the family including partners, infants and older children	• Understand the pathways by which different maternal mental disorders may adversely impact on fetal, infant and older children's development, and on the developing mother-infant relationship	• Understand the concept of Adverse Childhood Experiences (ACEs) and how they relate to outcomes for children growing up

	INFORMED	SKILLED	ENHANCED	SPECIALIST
3.2	**3.2 What practitioners know:**			
Professionals should recognise when problems arise in parent-infant interactions and/or infant development	• How to assess for risk of neglect, sexual,emotional and physical abuse of children	• Be aware of the potential impact of partner or other children's mental distress or disorder on other members of the family, including mothers, infants and older children • Be aware of the potential impact of infant adversity on other members of the family, e.g. if premature, disabled or unwell • Be aware of the factors and processes associated with neglect, emotional, physical and sexual abuse of children		
	3.2 What practitioners can do:			
	• Be able to seek advice and support from professional colleagues where necessary • Be able to discuss concerns about child development and the mother-infant relationship with parents in a supportive manner	• Engage parents in supportive discussions regarding problems in child development and parent-infant relationships which imparts understanding to parents and facilitates changes in behaviour • Contribute effectively to multi-agency discussions regarding child welfare, in both statutory and non-statutory settings	• Make informed assessments of mother-infant interaction in the context of maternal mental distress and disorder	• Conduct detailed assessments of mother-infant interaction in the context of maternal mental distress and disorder • Where appropriate, lead complex multi-disciplinary discussions regarding child welfare in the context of maternal mental distress or disorder

	INFORMED	SKILLED	ENHANCED	SPECIALIST
3.3	**3.3 What practitioners know:**			
Professionals should recognise when a child may be at risk of harm and be able to act to safeguard the child	• Be aware of the signs which indicate a child may be at risk, including failure to thrive, unexplained injury, parental substance misuse and multiple adversities • Have a basic awareness of child protection legislation and guidance	• Be aware of parental actions and behaviours which may be associated with child abuse or neglect, or with long-term impaired development • Understand local, national and professional guidance and legislation on child protection	• Understand the ways in which different maternal mental disorders may place a child at risk • Understand risk factors for infanticide, including extended suicide	• Understand the complex bio-psychosocial factors underpinning child neglect and abuse
	3.3 What practitioners can do:			
	• Be able to discuss concerns regarding infant development and safety with parents in a supportive manner, and which does not place the child at further risk • Communicate concerns about child welfare to appropriate professionals in a timely manner • Act urgently, in conjunction with other professional colleagues, to safeguard a child where there is evidence of immediate risk	• Use knowledge of factors and processes associated with neglect, emotional, physical and sexual abuse of children to assess risk to any child	• Incorporate understanding of child risk into pregnancy planning discussions with women who have pre-existing mental disorder	• Contribute to the development of policies and guidance regarding maternal mental distress and disorder and child protection • Support colleagues who seek advice regarding the management of child risk in relation to mental distress and disorder

DIMENSION 4: STIGMA

Discrimination and stigma relating to perinatal mental health difficulties are eliminated or reduced

	INFORMED	SKILLED	ENHANCED	SPECIALIST
4.1	**What practitioners know:**			
Women and their families can expect professionals to be aware of perceived stigma around mental wellbeing and ill health during the perinatal period	• Be aware that mental health and wellbeing is as important as physical health during pregnancy and the postnatal period • Their code of professional conduct	• Be aware that stigma can lead to discrimination • Be aware that stigma may be experienced more acutely in the perinatal period • Understand that women may be reluctant to seek help for fear of being stigmatised	• Be aware that there may be a lack of understanding of mental health issues by family, friends, co-workers and others • Understand how bullying, physical violence or harassment may influence the development of distress and mental ill-health and impede help-seeking behaviour	• Understand that stigma and discrimination can have a negative impact on adherence to treatment plans and on the professional-patient relationship in the perinatal period • Understand that stigma and discrimination may have an adverse impact of on the fetus' and infant's development and wellbeing.

	INFORMED	SKILLED	ENHANCED	SPECIALIST
4.1	**What practitioners are able to do:**			
Women and their families can expect professionals to be aware of perceived stigma around mental wellbeing and ill health during the perinatal period	• Link diet, exercise and healthy life styles to improving physical and mental wellbeing and health • Listen to, and acknowledge, women's experiences of stigma and discrimination • Apply anti-discriminatory legislation appropriately	• Make women and family aware of helpful literature and websites • Incorporate an awareness of issues relating to stigma surrounding mental health concerns into sensitive and respectful communication with the woman, her family and other professionals • Contribute to the development of local strategies to encourage women at high risk of experiencing mental health problems to seek appropriate advice prior to embarking on a pregnancy	• Challenge stigma by informing and educating about mental wellbeing and distress/disorder, and the possible intervention options • Empower women to be active participants in their care and treatment, including assisting them to recognise when they may be subject to discriminatory and stigmatising practice	• Instigate and coordinate the development of local strategies to encourage women at high risk of perinatal mental distress/disorder to seek appropriate advice prior to embarking on a pregnancy • Challenge stigma in multi-disciplinary and professional settings. • Develop a robust assessment and intervention plan with woman, and their support network when appropriate, which addresses their risk of stigma and discrimination

	INFORMED	SKILLED	ENHANCED	SPECIALIST
4.2	**What practitioners know:**			
Women and their families should expect professionals to be aware of and understand cultural barriers and differences	• Be aware of common cultural, social and religious differences in relation to pregnancy, childbearing and infant care. • Be aware that that cultural beliefs and practices may influence approaches to pregnancy and parenting style	• Be aware that symptoms of perinatal mental distress and disorder are influenced by culture and background • Be aware of the range of cultural, social and religious differences in relation to childbearing and infant care that are likely to be present in the local population	• Understand that mental health, distress and disorder is viewed through the lens of cultural, religious and social norms, and gender, and that these may impact on the woman's mental health and her infant's wellbeing.	• Understand that professional practice, including their own, may be influenced by personal, cultural and societal beliefs and expectations around pregnancy, childbearing and parenting • Have a detailed understanding of how individual, family and social practices vary in relation to childbearing and infant care in different cultures, and the pressure faced by some women to conform to cultural and societal expectations

	INFORMED	SKILLED	ENHANCED	SPECIALIST
4.2	**What practitioners are able to do:**			
Women and their families should expect professionals to be aware of and understand cultural barriers and differences	• Practice in a manner that respects and supports parental autonomy and choice in childbearing and infant care, while always prioritising the woman's and infant's safety and welfare • Seek advice and support where parental practice may seem in conflict with the need to safeguard mother and infant	• Challenge discrimination by ensuring that services are delivered in a manner which respects, as far as possible, differing cultural expectations • Assess how differences in language, literacy, culture and disability may affect the relationship with the mental health professional and how to manage this, and be able to arrange appropriate support, e.g., interpreting services, where appropriate	• Assess and respond to women's and families' understanding and beliefs regarding parenting and what it means to be maternal • Assess and respond to women's and families' understanding and beliefs regarding mental health and disorder • Assess and respond to women's and families' understanding and beliefs regarding risk in the perinatal context	• Contribute to, or lead, multi-disciplinary/agency assessments, share information confidentially, and provide advocacy for families from ethnic, cultural, disability and LGBTI minorities to ensure equitable standards of care.

	INFORMED	SKILLED	ENHANCED	SPECIALIST
4.3	**What practitioners know:**			
Practice in an anti-discriminatory manner	• Recognise a shared desire among parents and professionals for healthy outcomes of pregnancy and infant development • Be aware of legislation and local guidance regarding anti-discriminatory practice (including the protection of vulnerable adults and children) • Be aware that stigma and discrimination is commonly experienced by those with mental distress or disorder • Be aware of the principles of social Inclusion, equality and diversity	• Be aware of the concept of direct and indirect discrimination • Be aware that internal beliefs and expectations may affect a woman's ability to engage with helping agencies	• Understand how stigma can affect the mental health of women, and that it can have both external 'perceived' factors and internal factors, or 'self-stigma' • Understand that there are layers of stigma involving factors such as mental ill health, race, gender, gender identity and disability	• Understand that complex team and organisational dynamics may contribute to stigma and discriminatory practice

	INFORMED	SKILLED	ENHANCED	SPECIALIST
4.4	**What practitioners are able to do:**			
Practice in an anti-discriminatory manner	• Practice in an anti-discriminatory manner • Work with statutory and voluntary services to promote anti-discriminatory practice and social inclusion • Use awareness of stigma and discrimination in relation to mental health to ensure non-judgemental, sensitive interaction with women, their partners and families • Complete relevant training regarding diversity and anti-discrimination	• Actively promote anti-discriminatory practice, in relation to culture, race, religion and sexuality, when caring for women, their partners and children • Assist women who may struggle to disclose their difficulties within their community, taking this into account when accessing interpreting services or groups which provide support to people from a particular cultural, ethnic, religious or disability background. • Increase awareness of the benefits of social inclusion on health during interactions with women, their partners and families	• Support colleagues to practice in an anti-discriminatory manner	• Assist practitioners to explore the idealisation of family life and motherhood with women, and how culture plays a part in an individual's role as a mother • Intervene proactively to address discriminatory practices at individual, team and orgnisational levels

DIMENSION 5: INTERVENTIONS

Women receive specific interventions or treatments appropriate to their perinatal mental health and well-being needs

	INFORMED	SKILLED	ENHANCED	SPECIALIST
5.1	**What practitioners know:**			
Women should be aware of their right to treatment and to have the information needed to make an informed choice about treatment options	• Be aware that mental distress and disorder in the perinatal period can be treated • Be aware that there are risks and benefits associated with both treating and not treating • Be aware that women have the right to receive information about their treatment • Be aware that pharmacological and/or psychological treatments may be appropriate for women experiencing mental distress or disorder in the perinatal period	• Be aware of common pharmacological and evidence-based psychological treatment options for women experiencing mental distress or disorder during the perinatal period • Be aware of social support options for women experiencing mental distress or disorder during the perinatal period • Be aware of the common risks and benefits relating to pharmacological and psychological treatments in the perinatal period • Be aware of the risks associated with treating and not treating mental distress and disorder for both the woman and her pregnancy/infant • Have an understanding of what constitutes informed consent	• Be aware of the range of pharmacological and evidence-based psychological treatment options for women experiencing mental distress and disorder during the perinatal period, and for women of childbearing potential • Be aware of the modifying effects of pregnancy and child-birth on medication availability and elimination • Understand the role of prophylactic medication in high risk women • Be aware of factors associated with treatment adherence and non-adherence, behaviour change and self-efficacy theory • Be aware of mental health and incapacity legislation pertaining to the right to have or refuse treatment	• Have a detailed understanding of pharmacological and evidence-based psychological treatment options for women experiencing distress or disorder during the perinatal period, and for women of childbearing potential, including a contemporary understanding of treatment issues in relation to pregnancy, fetal development, child-birth, breastfeeding and child care • Have a detailed understanding of the range of social treatment and support options for women experiencing mental distress and disorder during the perinatal period • Understand the distinctive legal and ethical issues pertaining to capacity and informed decision making about mental health treatments in the context of pregnancy and child care

	INFORMED	SKILLED	ENHANCED	SPECIALIST
5.1	**What practitioners are able to do:**			
Women should be aware of their right to treatment and to have the information needed to make an informed choice about treatment options	• Be able to explain to women that advice and treatments are available for their mental distress or disorder • Seek advice and guidance from skilled professionals where necessary	• Incorporate knowledge of pharmacological, psychological and social treatment options for women experiencing distress and mental health problems during the perinatal period into sensitive person- and family-focused care for women, their partners and children • Direct women to sources of further information on treatment options in the perinatal period • Deliver brief interventions appropriate to practitioner's level of training and supervision	• Incorporate knowledge of pharmacological, psychological and social treatment options into individualised management plans in collaboration with the woman and her family • Be able to explain the range of treatment options to women, their partners and families, including an explanation of the risks and benefits of treating and not treating • Take pregnancy status, and the possibility of future pregnancy, into account in any treatment decisions made with the woman • Deliver interventions (as part of a multi-disciplinary team) • Assess the woman's capacity to collaborate with, and consent to, management plans developed for her and her pregnancy/infant	• Evaluate current research in relation to pharmacological, psychological and social treatment options for women experiencing mental distress or disorder during the perinatal period to provide guidance for women, their partners and families, and other professionals, in decision making around the management pre-conceptually, in pregnancy, during breastfeeding and when caring for young children • Deliver complex interventions (as part of a multi-disciplinary team) • Provide expert advice and guidance to other professionals in assessing capacity to collaborate with, and consent to, management plans for her and her pregnancy/infant

	INFORMED	SKILLED	ENHANCED	SPECIALIST
5.2	**What practitioners know:**			
Women who have a history of mental ill health should receive preconceptual advice regarding the likely effects of pregnancy and childbearing on course of illness and the risks and benefits of treatment	• Be aware that women with mental distress and disorder require information and assistance to help them plan a pregnancy	• Be aware that pre-existing mental distress and disorder may affect a woman's ability to make informed reproductive choices, including those around pregnancy planning • Be aware that decisions around continuing, changing or stopping pharmacological treatments in women of childbearing potential, or those planning a pregnancy, require detailed consideration of risks and benefits • Be aware that the course of pre-existing mental distress and disorder may be altered by pregnancy and childbearing	• Be aware of the factors influencing choices and decisions around pregnancy planning and medication management in women with mental distress and disorder	• Have a detailed understanding of individual, familial and societal factors which influence women's choices around contraception and pregnancy planning, and medication management, and how these are affected by mental distress and disorder

	INFORMED	SKILLED	ENHANCED	SPECIALIST
5.2	**What practitioners are able to do:**			
Women who have a history of mental ill health should receive preconceptual advice regarding the likely effects of pregnancy and childbearing on course of illness and the risks and benefits of treatment	• Direct women to appropriate information and professional support in making decisions around medication management and pregnancy planning	• Assist women in recognising the need to make informed decisions around pregnancy planning in relation to their mental distress and disorder, and its treatment	• Incorporate an understanding of risks and benefits of medication in relation to pregnancy in management plans for all women of childbearing potential • Incorporate advice and information on pregnancy planning and contraception in management plans for all women of childbearing potential • Incorporate an understanding of behaviour change into self-efficacy-promoting conversations with women and their partners during the perinatal period	• Provide critical evaluation and advice to women, their families, and other health professionals on the risks and benefits of pharmacological treatments in women of childbearing potential

	INFORMED	SKILLED	ENHANCED	SPECIALIST
5.3	**What practitioners know:**			
Women and their families are aware of the range of services available to them to manage perinatal mental distress and disorder, and have easy access to services when required	• Be aware that women and their families have the right to information on, and access to, specialist assessment and care appropriate to their level of need • Be aware of the range of services available to women and their families in your local area	• Be aware of the network of third sector, health and local authority services available to meet the needs of women and their families experiencing mental distress and disorder in the perinatal period • Be aware of the roles of other professional colleagues who provide a service to women and their families • Be aware of the pathways into and from other services for women and their families, including specialist mental health services, • Understand concepts of client choice, consent and involvement in care	• Have a detailed understanding of primary, secondary and tertiary care mental health services and how they can adapt to meet the needs of women in the perinatal period	• Have a detailed understanding of the distinctive structure and function of specialist perinatal mental health services, including community, maternity liaison and inpatient mother and baby provision

	INFORMED	SKILLED	ENHANCED	SPECIALIST
5.3	**What practitioners are able to do:**			
Women and their families are aware of the range of services available to them to manage perinatal mental distress and disorder, and have easy access to services when required	• Explain to women, and their families, about their right to care and treatment • Signpost women and their families to sources of information, assessment and treatment	• Contribute to the development of management plans which address mental distress or disorder in the perinatal period • Refer women in a timely manner to services appropriate to their need • Work collaboratively with women and their families to ensure awareness of choices in care and to gain informed consent	• Develop management plans, in collaboration with women and their families, which use knowledge of third sector, health and social care services to ensure effective co-ordination of care • Develop management plans, in collaboration with woman and their families, which take into account the distinctive needs and service responses for the woman, her infant and other family members during the perinatal period • Contribute to the development of a local strategy to encourage women at high risk of experiencing mental health problems to seek appropriate advice prior to embarking on a pregnancy	• Evaluate and plan local policies, pathways and guidance in relation to the prevention, detection and management of perinatal mental distress and disorder • Contribute to, or lead, the design and implementation of local and national guidelines • Instigate modifications to improve service provision in the light of regular review and new evidence • Assist other professionals in understanding routes into appropriate treatment for women under their care

	INFORMED	SKILLED	ENHANCED	SPECIALIST
5.4	**What practitioners know:**			
Women receive care from professionals who work as part of a multi-disciplinary team and who collaborate across agencies to ensure seamless care	• Be aware of the importance, and limitations, of confidentiality and right to privacy • Be aware of your responsibilities to the woman and her family, and to colleagues, as part of the system of care she receives	• Be aware of one's own individual professional responsibility to ensure that effective communication and information sharing takes place with the woman and her family, and between members of your service and relevant other services • Be aware of which professionals and teams carry lead responsibility for relevant aspects of the woman's care	• Have a detailed awareness of the routes of referral into specialist perinatal and infant mental health care and the principles and practicalities of joint working with other colleagues where most clinically appropriate • Have a detailed understanding of how multi-disciplinary and multi-professional teams function, including methods of overcoming barriers to effective functioning	• Have a detailed understanding of the tiers, structure and function of services available to women in the perinatal period, their infants and families (including third sector, maternity, health visiting, primary care, mental health services and social care), the professional context and timescales within which they work, and how pathways of care operate between services • Understand that care networks may extend beyond local boundaries, e.g. when referring to/discharging from regional mother and baby inpatient care

	INFORMED	SKILLED	ENHANCED	SPECIALIST
5.4	**What practitioners are able to do:**			
Women receive care from professionals who work as part of a multi-disciplinary team and who collaborate across agencies to ensure seamless care	• Work collaboratively with colleagues and other multi-sector agencies to support women, their partners and children	• Ensure that all assessments, interventions and communication are completed in a timely fashion, recorded adequately and appropriately shared • Enable women, their partners and children to access services to improve their physical and social circumstances e.g. assistance with housing and financial needs, promotion of exercise programmes etc.	• Lead and co-ordinate mental health care where appropriate	• Lead, co-ordinate and monitor specialist perinatal mental health multi-disciplinary and multi-professional care • Provide expert advice and clinical leadership in the management of complex perinatal mental health problems • Lead and contribute to the development of systems that ensure specialist case co-ordination, care planning, practices around women and family engagement, confidentiality, risk management, and communication follow local and national guidance

	INFORMED	SKILLED	ENHANCED	SPECIALIST
5.5	**What practitioners know:**			
Women and their families can expect to be offered an appropriate level of support and intervention based on their individual needs	• Be aware that support and intervention should take into account the woman's particular individual, social and cultural needs	• Be aware of factors that contribute to some women and their families requiring enhanced care because of increased vulnerability • Be aware that pregnancy and infant care responsibilities may alter thresholds of need for services addressing maternal distress and disorder • The importance of incorporating women's views and wishes, and those of their families where appropriate, in any proposed interventions	• Recognise that women with additional vulnerabilities may require more assertive attempts at engagement	• Understand the factors which promote individual engagement and participation in care in individuals during the perinatal period
	What practitioners are able to do:			
	• Consider the woman's particular circumstances when evaluating the need for additional help • Seek advice and support from appropriately trained colleagues	• Consult with colleagues and refer women with mental distress and disorder onto appropriate services in a way that promotes a seamless transfer of care • Identify women who are particularly vulnerable to poor outcomes and provide them with enhanced continuity of care • Develop and follow individualised plans of care	• Consult with colleagues and refer women with moderate to severe mental disorder onto appropriate services in a way that promotes a seamless transfer of care • Incorporate understanding of altered levels of need related to pregnancy and the postnatal period into the referral process	• Incorporate an understanding of altered levels of need related to pregnancy and the postnatal period into the development of referral guidance and protocols for specialist services • Support the development of women and families led support groups and third sector provision appropriate to local need

	INFORMED	SKILLED	ENHANCED	SPECIALIST
5.6	**What practitioners know:**			
Women and their families know that any risks faced by themselves, their infant, older children or others are adequately managed through the care they receive	• Be aware that mental distress and disorder may occasionally be associated with risk to the woman herself or to others, by neglect or harmful acts • Be aware that mental distress or disorder may place a woman at greater risk of harm from others	• Identification and timely referral of women, their partners and children at high risk of mental health problems to appropriate services • Antenatal management plans for high risk women and families • "Relapse signatures" • Child protection legislation and guidelines • Assess risk in relation to child protection	• Risk of infanticide linked to suicide risk	• Assessment and development of care plans for high risk women, their partners and children • Prophylactic interventions • Assessment of incapacity • Assessment of parenting competence and capacity

	INFORMED	SKILLED	ENHANCED	SPECIALIST
5.6	What practitioners are able to do:			
Women and their families know that any risks faced by themselves, their infant, older children or others are adequately managed through the care they receive		• Identifies women, their partners and children at risk of mental health problems in the perinatal period and using strength based communication skills discusses these risks with women and their families and refers to appropriate services • Participates in development of management plan		• Recognises that presentation of a serious mental health problems in late pregnancy is of particular concern and provides rapid response and appropriate intervention • Instigates and coordinates the development of an antenatal management plan for high risk women • Discusses personal "relapse signatures" with women at high risk and their families and records appropriately • Applies knowledge of child protection legislation and guidelines to assessment of risk in relation to child protection and prioritises the safely and welfare of the child • Reacts appropriately to risk factors for maternal suicide and infanticide

	INFORMED	SKILLED	ENHANCED	SPECIALIST
5.7	What practitioners know:			
Practice within legal, professional, national and local policy frameworks		• Policies and national guidelines relating to perinatal mental health including MBRRACE-UK, NICE, SIGN, NSFs etc • Own professional code of conduct and rules, statutory supervision requirements • Child protection legislation and local guidelines • Issues relating to confidentiality in the context of the multi-disciplinary team, carers and other staff involved in care of women, their partners and children during the perinatal period		• Influences and contributes to the development of appropriate policies and protocols
	What practitioners are able to do:			
		• Practice within legal, professional and national policy frameworks • Works within the boundaries of their professional role as outlined by their professional body • Follows best practice guidelines relating to confidentiality in the context of the multi-disciplinary team, carers and other staff involved in care of women, their partners and children in the perinatal period	• Contribute to the development of appropriate local evidence-based guidelines	• Recognises when the need to protect a vulnerable person outweighs the need to preserve confidentiality

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GLOSSARY OF TERMS:

There is much debate about how difficulties with mental health should be defined with the terms 'mental health problems', 'mental distress', 'mental disorder' and 'mental illness' variously used, often associated with the views of different stakeholder groups and models they use to understand what helps people maintain their mental health and what causes this to be compromised. All these terms have been employed in the Curricular Framework and so brief definitions have been given below to provide some clarity for readers.

PERINATAL PERIOD

In the context of this document the perinatal period here refers to the period of pregnancy, childbirth and the first year after the birth. This is the definition of "perinatal" commonly employed in the mental health field, but differs from the definition of perinatal used in the midwifery and obstetric fields where it is generally meant to refer to pregnancy, childbirth and the first six postnatal weeks.

MENTAL ILLNESS/ MENTAL DISORDER

Mental illnesses/disorders are conditions that can be categorised, defined and diagnosed in accordance with an internationally recognised classification system such as ICD and DSM. A mental illness is diagnosed where the symptoms experienced reach a level and present a picture reaching diagnostic criteria as described in these classification systems. It is increasingly recognised that mental illnesses may have a combination of causes and etiologies including biological, organic, genetic, psychological and social factors.

MENTAL DISTRESS

Mental distress is commonly used to describe symptoms which fall below the threshold of diagnosis for mental illness. Mental distress may share many of the characteristics of a mental illness but will generally be less severe and enduring. However, people suffering from mental distress would not be considered to have full mental health and their daily functioning may be impaired.

INFANT MENTAL HEALTH

Infant mental health refers to the emotional and cognitive development of infants from birth. The emotional environment of infancy is primarily their relationship with their primary caregiver (generally the mother). The nature of this primary attachment relationship has very significant long term implications for the mental health of the baby, and the child and adult they become. Early intervention to promote a positive attachment can help prevent later mental health problems and benefit the baby's emotional and cognitive development.

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Royal College of Psychiatrists Report on Recommendations for the Provision of Services for Childbearing Women (2015) http://www.rcpsych.ac.uk/files/pdfversion/CR197.pdf

SIGN Perinatal Mood Disorders Guideline (2012) http://www.sign.ac.uk/guidelines/fulltext/127/

APPENDIX 1: 2006 DIMENSION DEFINITIONS:

DIMENSION 1: UNDERPINNING KNOWLEDGE

1.1 Women are supported with the common physical and emotional changes they experience in the perinatal period

1.2 Women are supported to manage factors which may impact on mental wellbeing during the perinatal period

1.3 Professionals have an understanding of mental health problems, both in general and during the perinatal period

1.4 Demonstrates knowledge of parent-infant relationship, normal infant development and the possible impact of parental mental health problems on the infant's development and the family

DIMENSION 2: PREVENTION

2.1 Demonstrate ability to enable all women to optimise their mental health.

2.2 Provide preconceptual advice for women with a history of mental illness.

DIMENSION 3: DETECTION

3.1 Obtain a detailed mental health history through sensitive and systematic history taking.

3.2 Assess the level of risk associated with a woman's previous history.

3.3 Detect signs and symptoms of distress in the perinatal period.

3.4 Assess the level of current distress.

3.5 Identify psycho-social risk factors in pregnancy and their impact on individual mental health.

3.6 Recognise level of risk to self and others, including children.

3.7 Have knowledge of specialist services, referral routes and care pathways

DIMENSION 4: MANAGEMENT

4.1 Work as part of the multi-disciplinary team and collaborate across agencies.

4.2 Offer appropriate level of support and intervention based on individual need.

4.3 Implement appropriate risk management strategies.

DIMENSION 5: PROFESSIONAL, ETHICAL AND LEGAL PRACTICE

5.1 Practice within the legal, professional and national and local policy frameworks.

5.2 Support colleagues and participate in clinical supervision.

5.3 Practice in an anti-discriminatory manner.

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The views represented in this bulletin are those of individuals / NHS Boards and do not necessarily represent that of NHS Education for Scotland.

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