Perinatal Service

A national service specialising in the management and treatment of antenatal and postnatal mental illnesses.
My time at the Bethlem has had a lasting impact. I’m pleased I was able to recover so well and come off the medication. They have a good recovery rate at the Mother and Baby Unit. It’s a supportive environment and on the whole, people recover well. « Eleanor
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Service overview

Our team is committed to providing cost-effective, evidence-based treatments for mothers with mental health problems and their babies. We aim to reduce risk and establish a relationship between the mother and her baby, which prepares them for a lasting return to the community.

We offer a holistic treatment programme and encourage the involvement of fathers or partners in the process. We admit mothers with babies where it is the wish of the mother and it is clinically safe to do so. We are also able to take mothers without their babies, and offer a programme of gradual re-introduction to the mother.

We provide a unique, parenting assessment service for local and national authorities across the United Kingdom. We undertake assessment of women or couples and their infant, where there is potential risk or safeguarding issues arising from the parents’ mental health problems.

**King’s Health Partners**

Our service is part of the Psychological Medicine Clinical Academic Group. SLaM has joined with King’s College London, Guy’s and St Thomas’ NHS Foundation Trust, and King’s College NHS Foundation Trust to establish King’s Health Partners, an Academic Health Sciences Centre. King’s Health Partners involves bringing clinical care, research and education much more closely together. Our aim is to reduce the time it takes for research discoveries and medical breakthroughs to become routine clinical practice. This will lead to better care and treatment for patients.

Visit www.kingshealthpartners.org for more information.
Our philosophy

We aim to provide early identification and treatment of antenatal and postnatal mental health problems. Our service helps to maintain the mother’s mental health, develop a relationship between the mother and her baby, reduce the impact of the mother’s mental illness on the child, and provide support for the mother in her community.

- We believe that for each of our patients, in childbirth and parenthood, there are fundamental changes in their role, environment and relationships and that the health of the mother and infant depend largely on their maturation and adaptation to these changes.
- We recognise that mental health problems related to childbirth may have a profound impact on the lives of women, their infants and families. We aim to help them improve their mental well-being and understand their health problems through a diverse approach to their treatment.
- We acknowledge cultural differences in parenting practices and the contributions to the health of the mother and infant made by partners, families and important others.
- We work in conjunction with patients and carers and encourage liaison with external agencies throughout admission. We formulate cohesive discharge plans with the professionals who are involved in the patient’s care in the community.
- We acknowledge that in accordance with the Children’s Act (1989), the welfare of the child is paramount. We also strive to work closely with child and family social services.
Who is our service for?

Our service is for women who develop a mental illness or have a relapse of serious mental illness during pregnancy, and women who have developed postnatal depression, post partum psychosis or have had a relapse of serious mental illness following the birth of their baby.

Eligibility

- Severe mental illness during pregnancy, and post partum up until one year after birth
- Psychosis
- High risk of relapse of psychosis or depression after delivery
- Assessment of new onset disorder and women chronic disorder
- Assessed for safeguarding of unborn or infant by relevant agencies prior to admission
- Care is taken to ensure a safe environment; people with a history of violence or forensic issues are specifically assessed to ensure suitability for admission

» Our research has shown that the effects of untreated maternal depression in the perinatal period can be far reaching. Perinatal depression was found to be associated with problems in adolescence in terms of school achievement, depression and violent behaviour. « South London Child Development Study
National Services: Perinatal Service
Interventions

Our interventions are designed to address a range of difficulties faced by mothers with mental health problems, and focus on enhancing and improving the relationship between mother and baby.

These may include:

- Psychiatric assessment
- Medication
- Specialist psychological assessment
- Risk assessments for mother, baby, husband, partner, carers and siblings
- Psychological therapies including psychotherapy, cognitive behavioural therapy (CBT), cognitive analytical therapy (CAT) and family and couple therapy
- Mother-infant relationship support
- Occupational therapy
- Pre-conception advice

Psychiatric assessment
This assessment is conducted on the ward by a specialist team which includes psychiatrists, psychologists and nurses with a focus on both the mother and her relationship with the baby. It includes a mental state examination, a full physical, obstetric and paediatric health history, previous psychiatric history and personal, relationship and family analysis, as well as any history of drug or alcohol abuse.

Medication review
We will undertake a review of any previous and current medications for both mother and baby. We work in conjunction with GPs when reviewing the infants’ medical history and medication. Any new medication required is monitored over the course of the treatment.

Specialist psychological assessment and treatment
Assessment includes analysis of the psychological aspects of any mental health problems, interpersonal and emotional issues, and an assessment of the mother and baby relationship. We also provide a cognitive assessment of the mother and detailed developmental assessment of the infant. Our therapeutic interventions include an extended exploratory therapeutic assessment, CBT, video feedback and guidance on mother and baby interaction.

We provide psychological support for fathers and significant others involved in the care of the baby, either individually or as a family group. This may include the provision of psychoeducation or emotional support, or addressing relationship difficulties via sessions with the couple. Video feedback may also be used as a tool to support the relationships between the baby and other family members.

Risk assessment
On admission to the ward, a full risk assessment is conducted. Strict importance is placed on assessing any safeguarding issues for vulnerable adults, unborn children, the baby and any other children involved. A child screening is conducted, which includes a parenting skills assessment examining whether the child’s needs are being met, a review of any previous domestic violence and social services history, suicide risk and any child neglect or abuse.

Mother and infant relationship support
We provide interventions to establish and improve a positive relationship between the mother and baby. This may include
baby massage, video feedback, parenting skills support, education on the infant’s physical and emotional development, promotion of attachment and play stimulation.

Specialist nursing care
Our specialist nurses provide one-to-one support on the ward. On admission, our nursery nurses assess the level of support each mother needs to care for her baby, and identifies any difficulties. Their role includes formulating a care plan in conjunction with other team members, and providing liaison and support for family members and other agencies throughout the admission.

Occupational therapy
A wide and varied occupational therapy programme is available to both mothers and babies. Occupational therapy provides people with an opportunity to explore and develop their interests and set practical goals.

We offer life skills therapies, including shopping, cooking, negotiating public transport and budgeting. We also assess the patients’ current home environments and offer advice and support on developing skills at home.

We provide specific therapies focusing on health, diet and nutrition, as well as dancing, swimming, art, photography, pottery, computing and woodwork.

Parenting assessments
We provide residential and community parenting assessments to assist courts and local authorities. We assess parenting capacity and safeguarding of the baby, in the context of severe maternal mental illness. The assessment includes observations of the mother, father and baby, as well as individual, detailed assessments with various different professionals, either in a residential or community setting. A detailed court report is provided.

Outpatient assessment and treatment
We provide outpatient assessment and treatment for mothers with mental health problems who have babies up to 12 months old.

Assessment is undertaken by a doctor and specialist mental health nurse to establish the treatment needed. Community psychiatric nursing and other community staff provide in-home support and facilitate the process of assessment, treatment and recovery.

We use psychological, medical, social and cognitive behavioural therapies. Community interventions focus on the treatment and management of the mother’s mental health, relapse prevention work, safety management, occupational therapy, advice on parenting skills, the mother-infant relationship and providing advice and support regarding childcare.

Pre-conception advice
We provide pre-conception advice to mothers who have a history of mental illness, are currently on medication and are looking to conceive. We review the current physical and mental state of patients and work alongside their GP and local support services.

» I went for 10 sessions initially, and I’ve gone back occasionally since. The therapy really gave me the tools to look after myself. « Eleanor
### Weekly programme

<table>
<thead>
<tr>
<th>Time</th>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WEDNESDAY</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
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<tbody>
<tr>
<td>08.00 – 10.00</td>
<td>Breakfast Medication</td>
<td>Breakfast Medication</td>
<td>Breakfast Medication</td>
<td>Breakfast Medication Parenting assessment</td>
<td>Breakfast Medication</td>
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<tr>
<td>10.00 – 12.00</td>
<td>Computers Dance therapy Jewellery making</td>
<td>Baby massage Walking group Drumming Retreat Aikido</td>
<td>Creative art Sewing and textiles Computers Drumming</td>
<td>Pottery Woodwork</td>
<td>Computers Swimming Dramatherapy</td>
</tr>
<tr>
<td>12.00 – 13.00</td>
<td>Lunch Medication</td>
<td>Lunch Medication Ward rounds</td>
<td>Lunch Medication</td>
<td>Lunch Medication</td>
<td>Lunch Medication</td>
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<tr>
<td>14.00 – 16.00</td>
<td>Creative art Computers Digital photography</td>
<td>Pottery Woodwork Gardening group Reiki</td>
<td>Creative art Sewing and textiles Computers Dramatherapy</td>
<td>Cookery Pottery Drama workshop</td>
<td>Computers</td>
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<tr>
<td>17.30 – 18.30</td>
<td>Dinner Medication</td>
<td>Dinner Medication</td>
<td>Dinner Medication</td>
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A range of evening and weekend activities are organised as required.
National Services: Perinatal Service
Our care model

RISK MANAGEMENT
- Safeguarding issues
- Maintaining medical needs
- Routine blood investigations
- Understanding blood results
- Psychological and physical risk management
- Discharge planning
- Recommendations for managing the illness in the community
- Appropriate use of MHA, MCA and DOLS legislation

FAMILY AND CARERS
- Joint understanding of the illness
- Provide education on maternal illness and associated risks
- Skills-based training and interventions for family members
- Community meetings for patients and partners
- Holistic treatment including child and partner

BABY
- Physical health check-up
- Weekly baby activities
- Specialist nursery, midwifery, health visitor and psychological care

WORKING WITH OTHERS
- Facilitating local therapists to provide support and treatment
- Working with the patient’s local CMHT, other health providers and voluntary organisations
- Providing information, reports and liaison as appropriate, for work or housing purposes
- Working with local authorities and child and family services
- Working with legal authorities

PATIENT
- Support to develop parenting skills
- Support to develop social skills
- Re-integration into the community
- Experimental home leave
- Attention to spiritual needs
- Understanding how the maternal illness started and how it is maintained
- Attending to bonding, attachment and relationship needs

THERAPIES
- CBT
- Occupational therapy
- Relapse prevention groups
- Medication information group
- Complementary therapies
- Art therapy
- Mother and baby relationship therapy
- Life skills therapies

ASSESSMENT
- Multidisciplinary formulations
- Neurological assessments with feedback
- Specialist psychological assessment

EDUCATION AND VOCATIONAL OPPORTUNITIES
- Support to achieve or continue with further education
- Support to start planning for possible employment
Our care pathway
Outcomes

Our service aims to help people gain control over their illness and encourages patients and partners to develop an understanding of antenatal and postnatal mental health problems.

Outcomes may include:

- Reduction or absence of mental health symptoms
- An understanding of the diagnosis and appropriate treatment for mental health issues
- Understanding and development of the relationship between mother and baby
- Knowledge of emotional and practical care of the baby
- Awareness of resources available in the community which supports the mother and father’s parenting skills and mother’s mental health needs
- Referrals to any community services for long-term management of any outstanding issues, like welfare and housing needs
- Positive relationship between the mother and other members of her family and support networks, including older children
- Assessment of mother’s or parent’s capabilities of parenting
- Discharge planning between our team, the community mental health team and children and family services

**Graph 1** Shows the improvement in mental state from scores taken at admission and discharge, for the period April 2006 to March 2007 using the Clinical Global Impression Scales.

- 78% of women had an improved mental state
- 11% stayed the same
- 11% became worse

**Graph 2** Maternal sensitivity was compared at admission and discharge with a control group of well mothers. Mothers with schizophrenia and postpartum psychosis showed significant improvement in sensitivity when interacting with their babies at discharge.

**Graph 3** During therapy, infant co-operativeness with their mothers was measured both at admission and discharge. The babies of mothers with schizophrenia, psychosis and depression showed significant improvement at discharge, demonstrating the benefit of treatment for both mother and baby.
2. Maternal sensitivity

3. Infant co-operativeness
Research

Our service works closely with the Institute of Psychiatry, King’s College London, on research related to mental health problems in pregnancy and postpartum.

Our perinatal research is headed by world renowned psychiatrists Dr Carmine Maria Pariante and Professor Louise Howard, who lead many of our staff in carrying out research of international significance. By learning more about these presentations we continue to work towards developing innovative diagnostic and treatment options.

Our ongoing research topics for mothers with mental health problems include:

- Stress hormones in pregnancy and effects on obstetric outcomes
- Hormones and the brain in pregnancy and after delivery
- Breast feeding
- Neonatal behaviour
- Mother-infant interaction
- Effects of maternal mental illness on offspring into adulthood
- Care options for mothers and their babies
- Effectiveness of a video-feedback intervention on infant attachment

» It was good to get into a routine with her, and having other mothers and babies around was helpful. «  Eleanor
Our facilities

Our inpatient unit is based at the Bethlem Royal Hospital. The Bethlem offers the perfect therapeutic environment for promoting recovery for both mother and baby, set in 270 acres of green space, with woodland and meadows that are designated as a ‘site of importance for nature conservation’.

Facilities at the Bethlem include a swimming pool, art gallery, walled garden, a chapel, nature walks and an extensive occupational therapy programme, utilised by many of our patients. The programme provides a wide choice of creative activities which give mothers the opportunity to rekindle old skills, learn from new experiences and build their confidence on their pathway to recovery.

The inpatient unit has:

- 12 beds
- Private rooms for each mother and their baby
- Separate living areas
- Shared spaces for dining and living
- Group and individual therapy rooms
- Private visitors room
- Fully-equipped nursery
- Ward garden
- Baby feeding and changing rooms

» They were there for the basics, like the daily physical routine; and for the mental side, if I had any worries about my daughter. « Denise
Our team

Our specialist team includes psychiatrists, psychologists, nurses, midwives, pharmacists, occupational therapists, social workers, healthcare assistants and administrators.

**Dr Trudi Seneviratne** MBBS, MRCPsych
Consultant Adult and Perinatal Psychiatrist

Dr Trudi Seneviratne is a consultant adult and perinatal psychiatrist. She is the lead consultant for our specialist perinatal services and a lead for children's safeguarding at the Trust.

She leads the team in the assessment and management of women who experience a mental illness either during pregnancy or in the postnatal period, and their families.

**Other roles**

Dr Seneviratne works in the outpatient clinics offered at Lewisham Hospital and at King’s College Hospital.

She was a committee member with the perinatal psychiatry section of the Royal College of Psychiatry and was the first chair of the London regional network in perinatal psychiatry.

**Background**

Dr Seneviratne qualified as a medical practitioner in 1992, having trained at St Bartholomew’s Medical School, London. She has been an adult psychiatrist since 1995 and has specialised in perinatal mental health since 1998.

**Research**

Her special interest, clinically and academically, is perinatal psychiatry. She has collaborated on a range of activities including service development, the use of mother and infant interaction videos, service evaluation, and effectiveness and outcomes research.
Dr Carmine Maria Pariante  MD, MRCPsych, PhD
Consultant Psychiatrist | Senior Lecturer

Dr Carmine Pariante is a consultant psychiatrist and also works in the division of psychological medicine at the Institute of Psychiatry, King's College London. He is head of the perinatal psychiatry section and head of the stress, psychiatry and immunology section and laboratory.

Other roles
Since 2001, Dr Pariante has been involved in planning and implementing the Maudsley Forum, a course for European psychiatrists, held at the Institute. This is an annual, one-week course, with lectures and small group workshops for 50 select European psychiatrists.

Background
Dr Pariante completed a degree in medicine in 1990. Since then, he has conducted research in Italy (1990-1994), America (Emory University School of Medicine, Atlanta 1995-1997), and in the UK (Institute of Psychiatry, 1997-present).

In 1997, he passed the Membership of the Royal College of Psychiatrists examination and started a clinical training fellowship.

In 2002, he became a clinical lecturer, obtained a PhD in 2003, and became senior lecturer and MRC clinician scientist fellow in 2004. In 2007, he became a reader.

Research
Dr Pariante is particularly interested in the pathogenesis of major depression and the mechanism of action relating to antidepressant drugs. More recently, he has been extending this research stream into studying depression in pregnancy and postpartum.

He has studied the role of glucocorticoid hormones and their receptors in the pathogenesis of major depression and in the molecular mechanism of antidepressant drugs in-vitro. The main research finding is the description of the mechanism by which antidepressants increase the function of the transcription factors named ‘glucocorticoid receptor’.
Dr Paola Dazzan MD, MSc, PhD, MRCPsych
Honorary Consultant Psychiatrist | Clinical Senior Lecturer

Dr Paola Dazzan is an honorary consultant psychiatrist, a senior clinical lecturer in neuroimaging and early psychosis and head of section of early psychosis with the department of psychosis studies at the Institute of Psychiatry, King’s College London.

Background
Dr Dazzan completed her honours degree (MD) in medicine and surgery in 1991 and her training in psychiatry in 1995, both at the University of Cagliari in Italy. She then became a member of the Royal College of Psychiatrists in 1998.

In 2002, she sat a masters (MSc) in psychiatry at the Institute of Psychiatry, King’s College London. She received her certificate of completion of specialist training in general adult psychiatry (CCST) in 2003 and completed her PhD at the Institute of Psychiatry in 2006.

Research
Dr Dazzan’s main area of research interest is neuroimaging and its application to the study of early and postpartum psychoses.
Professor Louise Howard  MSc, PhD, MRCP, MRCPsych
Honorary Consultant Perinatal Psychiatrist

Professor Louise Howard is an honorary consultant perinatal psychiatrist, working with outpatients.

She is also a professor of women’s mental health, teaching medical students, midwives and postgraduate students, and a member of the Royal College of Psychiatrists.

Other roles
Professor Howard has given lectures on perinatal mental health and domestic violence, and has also been guest editor for a special issue of the International Review of Psychiatry on gender and mental health.

Background
Professor Howard studied medicine at University College London and completed an intercalated BSc in psychology, before finishing her undergraduate studies in 1988. She trained in general medicine in Bloomsbury, obtaining membership of the Royal College of Physicians in 1991.

She spent a year as a psychiatry trainee at St George’s Hospital Medical School and then came to the Maudsley Hospital in 1992. After completing her general psychiatric training and becoming a member of the Royal College of Psychiatrists, she was awarded a Wellcome Trust health services research training fellowship in perinatal psychiatry.

Research
Her research has informed the NICE guidelines on antenatal and postnatal mental health, the British Association of Psychopharmacology (BAP) guidelines on depression and bipolar disorder, as well as national guidance on the health service response to violence against women and children.
Janice Rigby BA (Hons), MPsychol, CPsychol
Consultant Clinical Psychologist

Janice Rigby is a consultant clinical psychologist for the Perinatal Service.

She is also professional head of psychology for the Trust’s Psychological Medicine Clinical Academic Group, which covers a diverse range of clinical specialities including adult mental health, clinical health psychology and neuropsychology.

Other roles
She is a key member of the parenting assessment service, which provides expert assessment and court reports relating to families who are involved in care proceedings. She is registered as a clinical psychologist with the Health Professions Council and has chartered status with the British Psychological Society.

Background
Janice’s professional training was completed at the University of Sydney in 1988.

In Sydney, she worked with the Multiple Sclerosis Society of New South Wales and a specialist brain injury rehabilitation unit at Lidcombe Hospital, where she developed skills in neuropsychological assessment. She relocated to the UK in 1993 and began to specialise in adult mental health disorders, working with a community mental health service that was part of the South West London Mental Health Trust. Here she was appointed to her first position as a consultant clinical psychologist.

In 2003, she began work with the Trust as head of psychology for the national division.
Research
Her current research interests include the relationship between social cognition and aspects of parenting capacity, particularly maternal sensitivity.

**Pamela Prescott** RMN BSc Post Graduate Management Studies
Service Lead

Pamela is the service lead for the Perinatal Service. She is also a qualified mental health nurse and family work practitioner.

She offers clinical and managerial leadership to the service and is responsible for performance and the allocation of resources. She provides team support for national referrals and she plays a key role in the development of care packages designed specifically to meet the needs of mothers and babies with complex needs and safeguarding issues.

Other roles
Pamela works alongside professionals in the inpatient and outpatient teams, and she plays a key role in the implementation of safeguarding protocols across the service. She also provides training and team support both internally and externally.

Background
Pamela began working with the service in 2009. Since 1992 she has worked in various roles in mental health services, managing acute wards, case management teams, home treatment teams and early intervention services in Lambeth.
Simon Abel
Administrator

Simon Abel is an administrator for the Perinatal Service.

He co-ordinates all referrals to the outpatient services across several locations, and liaises with commissioners and referrers to arrange funding for outpatient assessments and treatment. He also arranges all care programme approach meetings for patients and co-ordinates the panel reports for all national patients on a monthly basis.

Carol Levey
Administrator

Carol Levey is an administrator for the inpatient service.

She provides comprehensive, professional and confidential administrative support to the service, based at the Bethlem Royal Hospital. This includes liaising with commissioners and referrers to resolve contract queries and funding issues relating to inpatient assessments and admissions. Carol also provides a complete day-to-day administration and secretarial service to the members of the team.
Training and consultancy

We offer a range of training courses and consultancy in the assessment, treatment and management of different aspects of perinatal mental health.

The purpose of our training is to increase awareness and knowledge of the management, care and treatment for mothers with mental health problems and their babies, as well as promoting safeguarding practices.

Training can be provided to GPs, community mental health teams, midwives, obstetricians, child and family social services and other mental health professionals.

For more information about training, contact Pamela Prescott on 0203 299 3277 or pamela.prescott@slam.nhs.uk

» They made sure you were doing most of this by yourself, which was good, but they were very gentle and never pushed. As you got better, you’d take on more things. «  Denise
Eleanor

“I had severe postnatal depression.”

My pregnancy went well, but the depression came straight after giving birth. I was having a lot of negative thoughts, wasn’t sleeping, and day-to-day I couldn’t work out how to do anything. Everything just seemed to slow down.

My husband took time off work and I went to see my doctor, who prescribed me an anti-depressant and put me in touch with our local mental health team. Someone came to the house to assess me, but his advice was to take a long holiday. My GP looked into other options and found the Perinatal Service at the Maudsley Hospital.

My daughter had arrived in April and we were in touch with the Maudsley by July. I was still trying to breastfeeding during this time, but I was in a bad way.

“I can’t say I was 100% aware, but I recognised I needed help.”

I couldn’t get any rest from what was happening to me and actually became suicidal. One day, I left my daughter in the house and jumped in my car to drive down to the River Thames and throw myself in. I had a clear plan in my head and that’s a really scary thought.

It wasn’t straightforward with our local authority. It was extremely difficult to get them to agree to send me to the service for an assessment and my husband had to contact the service directly.

After my first appointment at the Maudsley, things went very fast. The assessment was on Tuesday and by Friday I’d been admitted to the Mother and Baby Unit at the Bethlem Royal Hospital. Their clinical decision fast tracked the bureaucracy process, which I’m grateful for. It was a huge relief for my husband too. After three months’ leave, he could go back to work. Luckily, the people he worked for were amazing about the whole thing.

“I was on the unit with my daughter.”

It was good to get into a routine with her, and having other mothers and babies around was helpful. It’s a beautiful site, the Bethlem, and the staff were really relaxed about my husband visiting, it was really good to have him there.

They put me on several medications straight away and I started taking part in occupational therapy. I did photography and other activities that built up my confidence again. And there were everyday things too, like making dinner in the kitchen with my baby.

There was a very good child development psychologist who, among other things, would video me with my daughter. That was useful because, even though I felt hopeless, the videos showed I actually responded to her quite naturally. As I felt better, I could see other things were getting better.
There were also visits from people who had been with the Service before. The thing about the depression is that you never feel like things will improve, but these people were evidence that you could survive and get through it. I try and visit the unit myself now because I know how important it was to me.

“I went into the Bethlem in August and came out in January.”

I felt about 60 per cent better when I came out. On discharge, I was transferred to a local consultant who knew someone working at the Mother and Baby Unit. She was really good. I saw her regularly at first and then every three months. She increased the medication I had just started taking on discharge from the Mother and Baby Unit, which my husband told me made a massive difference.

During that time I did go up and down a lot. They say that postnatal depression can be like bipolar disorder – I’d be up but then come crashing down, which was really draining. My consultant drew diagrams to help me visualise my peaks and troughs. The diagrams showed how the peaks and troughs would eventually balance out and that was helpful because I have quite a visual mind.

“It was a long period of recovery really.”

Hand on heart, I’d say it’s taken me a full four years to recover, but I have been able to come off the medication and anti-depressants. It was hard. Some people might experience it differently, but you definitely have to be prepared to give yourself time.

I was also fortunate to be able to afford cognitive behaviour therapy (CBT) after I was discharged. I saw someone who worked at the Bethlem and the sessions really helped me come to terms with what had happened to me – to find some meaning in it, because in the thick of it all you can’t see what’s going on.

In the therapy, we called the negative thoughts ‘invader thoughts’, like a radio transmission I could learn to ignore. I went for ten sessions initially, and I’ve gone back occasionally since. The therapy really gave me the tools to look after myself.

“It sit and wonder at my daughter now... how beautiful she is.”

It was like I had my head below water and now my head’s above so I can breathe. I have energy and can relax, daydream and plan if I want to. I can live a full life and I work three days a week.

My time at the Bethlem has had a lasting impact. I’m pleased I was able to recover so well and come off the medication. They have a good recovery rate at the Mother and Baby Unit. It’s a supportive environment and, on the whole, people recover well.

It was so good to have my baby with me while I was there. I could take my time and our bond grew stronger and stronger. I sit and wonder at her now... how beautiful she is. We’re really close.
“I realised things weren’t right.”

I had classic bipolar symptoms as a teenager, though I used to get the depression without the highs until I came out of puberty, and the condition was only diagnosed years later when I was engaged to my husband and going through a period of depression. That’s when I realised things weren’t right, because I knew I wasn’t unhappy – the engagement and depression were definitely not linked!

I had a bit of a breakdown and a manic mixed episode in the mid-90s, when I had to drop out of work, but that episode was put down to a bang on the head when I was seven years old. I recovered quite quickly from the episode and the medication I was put on worked brilliantly, so we thought no more about it. In a way, it was good because I’d already experienced medication before I got an official diagnosis.

“When I was pregnant, I didn’t have the energy to do anything.”

I had our daughter in 2003 and two weeks after the birth, which happened to be right after Christmas, I knew I was going ‘up’. I couldn’t sleep and I was having problems with mastitis and breastfeeding. The outpatient team treated me at home and knocked me out so I got my sleep back. But, a month later, it escalated and I really lost the ability to recognise what was happening. I was completely psychotic; I thought that North Korea had invaded the world and that it was my fault.

I was staying with my parents on the south coast, so I was admitted to the A&E at a local hospital before they could move me to London. Then, in London I was on an inpatient unit and actually tried to set fire to my room to kill myself. That’s when I was sectioned and admitted to the Mother and Baby Unit at the Bethlem Royal Hospital.

Going psychotic was far from great, of course, but it was positive in some ways because I’ve been on good medication since.

“At the Bethlem, it was wonderful to be surrounded by people with such great experience.”

I was under 24-hour care and my daughter was with me from the start, which was a huge thing. The medication they used at the time made me feel like a bit of a zombie, but I had so much support to get into a routine and I always knew my baby would be safe. I compare it to how it might have been in the old days when you’re surrounded by women in your family – people who have such great experience. When you give birth for the first time, you might not have held a child before, so it was wonderful to be surrounded by these people.
They were there for the basics, like the daily physical routine; and for the mental side, if I had any worries about my daughter. Some of the day-to-day things like meals were taken care of so you could concentrate on being with your baby. They made sure you were doing most of this by yourself, which was good, but they were very gentle and never pushed. As you got better, you’d take on more things.

“The set-up is lovely.”

There are nice communal areas, and you can go to your room if you want a bit more privacy. I was involved in occupational therapy sessions like digital photography, baby massage – which was lovely – and, oh yes, taking walks around the garden in the morning. That might seem basic, but the walks were really important.

It’s so good when you see the medication working. Chemically, there’s a big difference between being ill and getting better. Your thoughts are paranoid and jumbled and then slowly you start to come out of the fog. All the time, there’s a net around you – people you can turn to; people who can see when you’re having a bad day.

I remember one lapse when I was in a cookery session. I measured out the flour wrong when we were baking – that was all – but I remember going into a panic and getting flashbacks. It can be a slow process, where you are taking two steps forward and one back, but you always have the support.

“I think leaving the unit was the hardest thing about being ill.”

I had a really good community psychiatric nurse, who visited every week, but being with others who were going through the same thing had been so nice.

Another thing that was hard, at first, was joining coffee mornings and making polite conversation with women who had already bonded with each other and seemed on top of their routines. I could look after my daughter, but felt like I was a couple of months behind. And, it was weird to think that, just months ago, I’d been suicidal.

Things took a while after I left the Bethlem, but I became stronger, better, less moody and volatile. It probably took a good five years to get to where I am now.

“I think the Mother and Baby Unit saved my life.”

You know, it would have been such a different experience without my daughter there with me. With her, I felt people trusted me. I wasn’t so barmy, and it was a reality check because my child needed me.

I made two really good friends on the unit and still see one of them regularly. She’s bipolar too, so she’s a really good person for me because it can be such a hard condition to explain to others – that you’re just not in control of your moods. We had such a laugh on the unit actually. That might sound weird, but when you’re in a situation like we were, you have to see the funny side at times.
Referring to our service

Referrals are accepted from consultant psychiatrists, community mental health teams, GPs and GP consortia. Referrals for parenting assessments can be made by any healthcare professional provided they are accompanied by a written confirmation of funding.

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Dr Trudi Seneviratne