London Neonatal
Operational Delivery Network

Identifying need for psychological support for babies and families on neonatal units

Striving for compassionate, kind, joined up psychologically informed neonatal care for all, across London

1 Objectives

- To support psychological professionals and MDT staff to be able to identify families who need support.
- To enable auditing of psychological support, including gaps in provision.

This guidance considers the needs of the infant and the needs of significant people in the infant's life (such as parents/carers and family members) and considers universal, targeted and specialist psychological support. Psychological professionals also support staff and work to develop psychologically informed care, addressing culture, communication and wellbeing at unit level. Other guidance will be developed focused on the support provided to staff and units.

This document lays out what should happen in identifying needs of family and responding to these needs. It also highlights that for all units in London provision does not meet minimum staffing requirements. This means there must be contingency for where there is not enough capacity, with an awareness that this will result in gaps in the care and poorer quality of care provided to babies and families.

2 Background

Neonatal units (NNUs) are inherently stressful environments for all those who stay, visit, live, and work in them. Prematurity and/or illness and the intensive care setting can result in uncertainty, distress, and trauma for the child and family. Psychological professionals focus on the wellbeing, mental health and psychological needs of both the identified patient (the baby) and their family, regardless of the medical status or prognosis of the baby. Psychological professionals may consult to other team members and engage in discussions as part of the multidisciplinary team.

Neonatal admission can have long-lasting consequences on child development, parental and infant mental health, and family functioning. The mental health and wellbeing of parents directly impacts the mental health and wellbeing of the baby. Families with a history of trauma or other adversities may encounter additional challenges within the healthcare environment (Okito et al., 2022). Some families may face increased access difficulties, caregiving responsibilities, language and communication barriers, financial constraints, and may also experience or fear discriminatory practices, which can lead to heightened stress and a more challenging experience on the unit (Profit et al., 2017; Taylor & Brown, 2020). Suicide and substance misuse account for one third of maternal deaths in the post-natal period (MBRRACE-UK, 2024), highlighting just how critical psychological wellbeing and support is.

Psychological professionals are well placed to provide trauma-informed, targeted and evidence-based interventions, working with acute distress and symptoms, as well providing specialist individual and family support (Atkins *et al.,* 2022).

This document should be read alongside the BAPM standards for psychological support BAPM_Service_Quality_Standards_FINAL.pdf (P33 and 34) and the NHS-E service specification for neonatal care Neonatal-critical-care-service-specification-March-2024.pdf, which recommend 1-1.2WTE per 20 cots as a minimum staffing requirement for psychological professionals.

3 Identifying needs for psychological support on NNU

Neonatal admission is difficult for babies and families. When a baby is admitted to a neonatal unit, this is a difficult and distressing situation. Family members have anormal and understandable distress responses. Everyone is different and responds to stressful or challenging situations differently. For this reason, many families on a neonatal unit may need targeted or specialist psychological support. Psychological professionals are embedded team members who have the expertise to identify who needs additional support and what level of support should be provided. This is **best** determined by psychological professionals rather than other MDT members, where provision allows. Where there is not enough psychological provision it is often left to other clinicians to flag families whom they think need support. This can be helpful but will inevitably mean that some families are not offer the support they need.

4 Identifying needs for targeted and specialist psychological support

All families will need universal support from the psychological professional as part of the MDT. This includes screening of families, involvement of psychological expertise in MDT ward rounds and discussions, offering consultations to staff about families, and collaboration with the MDT to deliver family integrated, psychologically informed, developmentally appropriate care. The universal offer includes the development and dissemination of resources, collaborating on parent groups with the MDT, and signposting to other mental health and wellbeing support offers. The universal offer is laid out in the best practice guide to be found here: London-Neonatal-Network-AHPPP-Best-Practice-Guide-2025secure.pdf. See also appendix C.

Where the psychological service is fully staffed, Psychological professionals should screen the whole patient cohort to ascertain who might benefit from psychological support. We know there are many barriers to accessing psychological and these add to health inequalities and may increase risk of poorer outcomes of families. The screening of all families, if working well, should go some way to addressing these discrepancies. Screening of psychological need should be relationship-based and not solely based on a measurement tool.

Following screening, if provision is available, the psychological professional may offer a family support at the targeted or specialist level. This might include (but is not limited to) assessment using standardised or qualitative measures, direct one-to-one or couple's therapeutic work, work with parent and infant, NICE guidance-recommended and evidence-based interventions such as CBT, EMDR, VIG and other models, sibling work, risk assessment and monitoring, involvement in a specialist group, support to engage with community mental health services or other agencies providing support and MDT interventions.

Table 1 below is intended to help provide a guide to how units should log and make requests for psychological support or input based on the level of available psychological provision. See Appendix C for further information about the kinds of presentations that may warrant further psychological support and Appendix D for more information about the kinds of psychological support offered.

Where there is limited or no psychological provision and/or where a psychological professional is not embedded on the unit, families will miss out on many or all of these universal, targeted and specialist offers, but it is nonetheless important that the need is recorded and evidenced.

Where there is limited psychological capacify due to low staffing, any requests for support which are unable to be fulfilled should be logged as a datix/risk log. This includes when the embedded psychological professional is on annual leave or attending training, where there is no capacity for cross-cover.

Where there is staffing which meets the minimum staffing requirements as laid out by NHS-England and by BAPM there may still not be cover out of hours and at weekends. This remains a problem and may mean that some families are missed.

5 Talking to families about psychological professions

For staff wishing to inform families about the targeted and specialist psychological support, particularly availability of direct therapeutic support, there is a useful guide in Appendix B of this document.

If the psychological professional is screening or working directly with a family, they will gain and record consent for specialist and targeted intervention.

6 Dissemination & implementation process

Once finalised, ratified and approved by the London Neonatal Psychology ODN, this document will be disseminated through Clinical Oversight Group meetings for implementation.

Staff may value training to identify families in need of psychological support and how to introduce psychological support to families in a way which is non-stigmatising. Guidance on all aspects of referral and consent will be available from psychological professionals or the ODN where there is no embedded psychological professional.

7 Audit & assurance

Quarterly data returns and brief snapshot data returns collect information on requests for psychological support and families seen. This can be compared with national data on levels of need to review whether families in need are being identified in line with expected estimates and are being appropriately directed to psychological support. Additionally, internal caseload reviews for a set time period can capture whether all families in need are being directed to the psychological professional, and job planning with supervisors and line managers will support the psychological professional to manage the workload where the unit is not fully staffed.

8 Review

This document was completed in January 2026 following consultation with stakeholders. It will be reviewed in January 2028.

Provision	Who should log requests/need for support?	Triage/screening	Universal support	Attendance at WR/MDT meetings	Targeted support	Specialist support
No psychological professional	Unit team	✘	✘	✘	✘	✘
Less than 50% provision	Unit team/ Psychological professional	Triage only Based on need	Limited capacity	No capacity	Limited capacity	Some capacity
50-99% provision	Psychological professional	Weekly screen Triage Targeted/ specialist based on need	Some capacity	Limited/some capacity	Some capacity	Some capacity
100% minimum staffing standards	Psychological professional	✓	✓	✓	✓	✓

Table 1: Capacity to deliver psychological service based on staffing levels (see Psychology_Staffing_on_the_Neonatal_Unit.pdf).

All potential requests/identified needs for psychological support should be logged to build data for a business case developing psychological provision, even where there is no capacity to deliver an intervention. Unmet need can be calculated based on psychological support requests that are made but not seen due to lack of provision, although this will not be a true picture as many families will need support but not be identified due to a lack of capacity to assess and screen in understaffed units.

Appendices

Appendix A: Managing provision depending on psychological workforce

Level of psych provision	Unit team tasks	Psychological professional's tasks
Units with **no psych professional** embedded on the unit	• Log need/request for psychological support and reason for request in a database, maintained by the unit/trust, in order to develop evidence of need. • Where there is ad hoc access to a psychological professional based outside of the unit, the unit needs to log requests for psychological support in a database as well as informing the psychological professional. • **Team to log Datix/risk log** where there was a need for a psychological professional but none available.	• If there is an ad hoc service, respond when able. • No capacity to attend ward rounds or MDT meetings. • No capacity to screen and assess families. • No capacity for universal support.
Units with psych provision **under 50% staffing**	• **Team member** to log need/request for psychological support and reason for request, and patient identity in a database maintained by the unit/trust. • Requests for psychological support picked up verbally via MDT meetings or team discussion should be logged by the psychological professional or MDT team member. • **Team to log Datix/risk log** where there was a need for a psychological professional but none available.	• No capacity to assess or screen families – reliant on team identifying need. Review log and, in discussion with senior staff (lead nurse and/or medic), ***triage patients based on need***. • There is not capacity to see all requests for psychological support. Limited or no capacity for universal support. • Requests for psychological support picked up verbally via MDT meetings or team discussion should be logged by the psychological professional or MDT team member. • No capacity to attend ward rounds and limited capacity to attend MDT or discharge planning.
Units with psych provision **50% -99% staffing**	• Log need/request for psychological support, reason for request, and patient identity in a database maintained by the unit/trust in order to develop evidence of need. • **Team to log Datix/risk log** where there was a need for a psychological professional but none available.	• Requests for psychological support picked up verbally via MDT meetings or team discussion should be logged by the psychological professional. • Screen all cases on the unit weekly and triage patients requiring targeted or specialist support based on need. • Limited capacity to see all requests for psychological support. • Limited capacity to attend ward rounds, MDT and discharge planning. • Some capacity for universal support.
Optimal provision that meets **full minimum staffing standards**	• Support with dissemination of information about psychological services available, including how to self-refer. • Highlight any families you are concerned about to psychological professional as normal.	• Screen all families within 48 hours of admission and triage cases appropriately. • Maintain database of work by the unit/trust to develop evidence of need. • Offer support at targeted and specialist level to anyone who requests or who is flagged in screening process. • Providing universal support to entire patient/family cohort.

Table 2: Unit and psychological professional roles depending on staffing

Appendix B

Briefing document: Talking with families about psychotherapeutic support

Why is this important?

This briefing supports neonatal staff in understanding when and how to introduce psychological support to families and colleagues. Your role matters. By being thoughtful in how you talk about psychological support, you help build trust, reduce stigma, and ensure families and staff receive the help they need.

Where the neonatal unit is fully staffed, the psychological professional may meet every family after admission. Most of our units do not have full staffing so you may be helpful in supporting families to access psychological support.

What are psychological professionals, and what do they do?

Psychological professions are part of the unit MDT. They provide psychological expertise to the unit to consider culture, communication, well-being, and unit functioning. You can read more about this role in the BAPM service standards: BAPM_Service_Quality_Standards_FINAL.pdf

A key aspect of this role is providing direct support to families. Psychological professionals may meet with a family one or more times to support their well-being and mental health, providing a space for them to process what is happening to them and their baby, and to help them prepare for and face challenges. You can find out more about psychological professionals and their work here:
Psychology_Staffing_on_the_Neonatal_Unit.pdf

Why families might see a psychological professional

Neonatal admission is stressful for babies and families. Finding this hard and distressing is a normal reaction to a difficult event. Families come to psychological support for a variety of reasons.

Psychological support is a regular and helpful part of caring for babies on the neonatal unit, just like other support services on the unit.

Do's and Don'ts	What to say	Why
Do speak about support to everybody. Being on the ward can be difficult for some families. Don't ignore families who are not visibly distressed families.	"*We know that being on the ward can be difficult for so many reasons…. If you are happy for us to speak with a psychological professional to come and check in with you. would this be okay?*"	People show distress in different ways so you won't know who needs psychological support. Talking to everyone can normalise speaking about a psychological professional It gives them time to choose can help them feel in control.
Do reassure people that it's normal to need support, but remind them it is optional.	"*We know that having a baby in neonatal care can be very tough; it's normal to feel overwhelmed. We have a psychological professional on our team who supports families and staff going through this.*"	People may think they have to cope alone. Normalising psychological support helps reduce shame and encourages people to reach out early. People often worry they'll be judged or told something is wrong with them.
Do tell them it is normal to find it hard Don't use language which makes it seem like their	"*Just like our babies need specialist care, parents and staff sometimes need specialist emotional support too; that's*	Saying "*when something is wrong*" can make people feel like they've failed or are broken. We want to normalise

reaction is wrong or unusual (Avoid "*When you can't cope…*" or "*because you are struggling…*")	*what the psychological professional is here for*." *"Psychological professionals can help with tools to deal with this admission"*	getting support as a healthy and routine part of care.
Don't use medicalised or pathologising language such as "*mental illness*," "*disorder*", or diagnosis-specific terms like depression. Do use words such as "*emotional support*", "*making sense of*", or "*well-being during a difficult time.*"	"*Lots of people value emotional support to help them cope at difficult times."* *"It is normal to be upset when your baby is unwell"* *"Talking about things is a sign of strength, not of weakness"*	Medical terms can sound scary or serious. These terms may also make the parent feel wrong, broken or pathologised when, in fact, they are just in a difficult environment. Everyday language feels safer and more relatable for families and staff.
Do use accessible language.	*"They're here to help you make sense of all the emotions that can come with this journey, whether it's anxiety, stress, or just needing space to talk."*	Simple, clear language helps everyone understand, especially people with different levels of English or who are feeling overwhelmed.
Do spend extra time with families who are from minoritised backgrounds and may have experienced discrimination. Consider bringing a leaflet with you if your unit has one.	*"Would it be helpful for me to explain more about what they do?"* *"Would you like to meet them before you decide your next steps?"*	Some families will find it harder to access psychological support and may benefit from extra time to talk through their concerns.

Table 3: Talking to families about psychological support

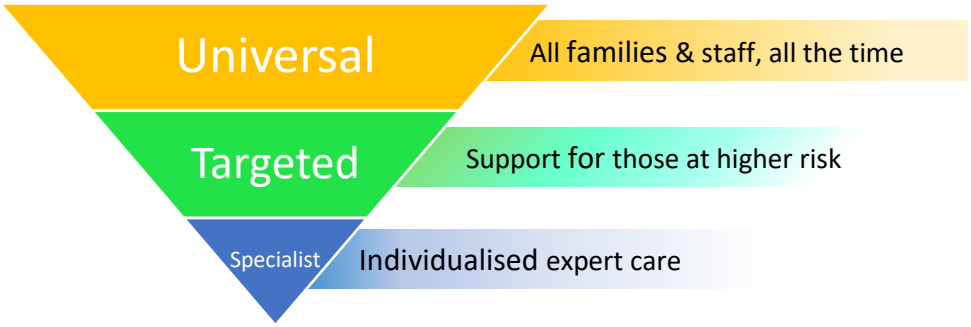
Some parents are keen to see a psychological professional. Other parents might feel quite anxious about the suggestion that they talk to a psychological professional or might not want to. The way you talk about psychological support can help families who need it.

Here are some of the reasons that a family might struggle to accept a referral or ask for help:

- Parents may feel they should be strong for their baby and view seeking psychological support as a sign of personal weakness.
- Fear of judgment: Parents may be worried that others will judge them as unfit parents if they admit to mental health struggles.
- Cultural stigma: In some cultures, discussing mental health is taboo, making it harder for families to seek help. Culturally and psychologically, it can also be perceived as wrong or bad.
- Lack of understanding of psychology: Families and even staff may not understand what a psychological professional does and how they can support families.
- Too much at once: Parents often feel overwhelmed with medical information, decisions, and trauma. Seeing a psychological professional may be one more thing on top of everything else they are coping with.

Appendix C: Highlighting gaps where there is no psychological professional.

The lack of psychological provision can mean the needs of families or staff members cannot be addressed. This document provides a brief summary of when a datix or other safety log should be raised. More detail can be found here Psychology_Staffing_on_the_Neonatal_Unit.pdf



Universal psychological support should be offered to all families and all staff members, all the time. It is normal for families to be affected by a neonatal admission, and for staff to struggle sometimes because of the work they do. Where there is no psychological professional universal support is always lacking.

Targeted support is the proactive provision of psychological provision to support families and staff. The evidence tells us that some families are more likely to struggle. Therefore, targeted psychological support should **always** be offered in the following circumstances:

- Loss of one or more babies from a multiple pregnancy
- Limited parental presence on the ward (less than daily unless there are extenuating circumstances) *Limited presence should be seen as an indication of need not a reason for criticism.*
- Neonatal stay of longer than 2 weeks
- When babies are undergoing genetic testing, have life limiting diagnosis or uncertainty relating to survival of the baby(ies)
- Safeguarding concerns being raised by the ward including risk of placement outside the biological family
- When you are concerned about the relationship between the two parents or between the parent and the baby(ies)
- History of mental health concerns or neurodivergence and distress being triggered in the current situation
- Parental physical health difficulties, learning disability or neurodiversity which is impacting their ability to be on the unit or engage with the baby or staff
- Where there is a concern about the relationship between the parent(s) and staff
- Where there is concern because of complex family dynamics (siblings of the baby, extended family)
- Where a parent has no support network around them (no partner, family etc)
- Parents under the age of 20
- Where families are experiencing poverty or financial pressures which impact their ability to be present or engage with staff or their baby(ies)
- Families who have (or may have) experienced discrimination, exclusion, barriers to access or been subject to health inequalities at any point in their journey or who are worried about this in the current setting.
- Where there have been errors in or disagreements about care
- Where a family has experienced displacement, domestic violence or has refugee status.
- Where a parent has witnessed the death or deterioration of another baby on the unit

- Where a parent thinks their child is going to die (whether or not this is the medical opinion)
- Where staff have been exposed to high stress situations for extended periods (the death of a baby, racism from parents, challenging relationship(s) on the ward)

Some families in the targeted category will go on to need specialist support.

Specialist support is when individualised care plans and direct intervention are provided for families or staff members. The skills of the psychological professional to assess, formulate and provide an evidence-based intervention are crucial. The psychological professional may seek additional consultation (e.g. psychiatric input) where needed. Specialist psychological support should always be provided when:

- Person is experiencing distress including low mood, anxiety, trauma symptoms or ongoing mental health difficulties (e.g. OCD, anxiety, low mood, psychosis) **Not everyone who is distressed will show this in the same way*
- Person who is having unusual experiences (e.g. hearing voices, significant paranoia)
- Where there is any concern re risk (suicidal, very low mood, self-harming)
- Person is struggling to function or manage (e.g. in relationships, at home, at work, on the unit or with the neonatal team, with their baby)
- Where there is complexity (use of substances during pregnancy, safeguarding concerns related to parenting capacity, parental early trauma or a diagnosis of a personality disorder)
- Where there is complexity in the system such as lack of clarity re treatment outcomes or disagreements in care team
- Where there are noticeable issues related to bonding or attachment, or parent does not want to touch or interact with their baby(ies)

Additionally. the evidence suggests that the following factors make a parent at **higher risk of suffering negative outcomes** (poorer mental or physical health or family functioning) after the admission. These families need psychological support to ameliorate future risk and morbidity.

- Previous need for Psychosocial care
- Stressful life events before the admission
- Poor coping strategies
- Difficulties talking about feelings
- Acquired morbidity or worse functional status because of, or following admission
- Parent perceiving their child will die (whether or not this is the medical opinion)
- Difficulties with communication
- Watching procedures
- Re-admission to intensive care
- Child has a chronic illness
- Parent is hyper-aroused, avoidant or anxious
- High family burden (e.g. other siblings, other caring responsibilities, long journeys)

See: Yagiela, L. M., Carlton, E. F., Meert, K. L., Odetola, F. O., & Cousino, M. K. (2019). Parent medical traumatic stress and associated family outcomes after pediatric critical illness: a systematic review. *Pediatric Critical Care Medicine*, *20*(8), 759-768.

If you are unable to access psychological support for any of the cases above, we recommend that you put in a datix. Not providing support represents a risk to the adult and the baby(ies). Suicide and mental health difficulties remain the leading cause of preventable death in the year after having a baby (Maternal mortality 2022-2024 | MBRRACE-UK | NPEU). Raising a datix also highlights the gap in provision on your unit and supports your case for developing psychological provision.

Appendix D: Psychological support request form

Where there is not enough psychological provision to screen and triage all families, please use this form to highlight a family to the psychological professional. Please do this even if you do not think the psychological professional will have capacity to see the family (e.g. if they are on leave or not in for a few days). By logging all requests for psychological support, we build an understanding of need which can support development of psychological provision.

Name of baby_____ Hospital number _____

Cot number _____ ICU / HDU / SCBU (please circle)

Parent(s) names _____

Reason for request _____

Other relevant psychosocial information (e.g. Family make-up, engagement with team, neurodivergence, health of baby, gestation at birth, investigations pending, transfer history etc).

_____

_____

_____

_____

_____

Ethnicity of the baby (we ask this because we want to see who and think about how we meet the needs of all families. See Ethnicity - NHS England Digital for more information).

Please tick	
☐ White - British	☐ Asian or Asian British - Bangladeshi
☐ White - Irish	☐ Asian or Asian British - Any other Asian background
☐ White - Any other White background	☐ Black or Black British - Caribbean
☐ Mixed - White and Black Caribbean	☐ Black or Black British - African
☐ Mixed - White and Black African	☐ Black or Black British - Any other Black background
☐ Mixed - White and Asian	☐ Other Ethnic Groups - Chinese
☐ Mixed - Any other mixed background	☐ Other Ethnic Groups - Any other ethnic group
☐ Asian or Asian British - Indian	☐ Not stated
☐ Asian or Asian British - Pakistani	☐ Not known

Appendix E: Database of requests for psychological professional support

This table can form the basis of a database (for example in an excel spreadsheet) to log all requests for psychological support. It will be particularly useful where there is no neonatal psychological provision or much less than minimum staffing standards. This database will allow unit staff to keep track of families and staff members who needed support, providing evidence for the risk register, datix logs and ultimately building the case for psychological provision.

Requests for infant, parent or family support

Name and role of person making request	Name of baby	Baby's hospital number	Reason for request	Outcome (seen, referred on, not seen)		

Requests for staff support

Name and role of person making request	Type of support being requested (individual, reflective practice, teaching, debrief etc)	Reason for request	Outcome (seen, referred on, not seen)			