Improving Access to Perinatal Mental Health Services in England – A Review
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Acknowledgements

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Improving Access to Perinatal Mental Health Services in England - A Review

Introduction

NHS Improving Quality was commissioned by the NHS England Medical Directorate to undertake a three month scoping exercise to identify current guidance and practice relating to Perinatal Mental Health services.

This report aims to:

- Provide an overview of Perinatal Mental Health care and support for people with, or at risk of, Perinatal Mental Health problems.
- Highlight gaps and opportunities for improvement.
- Provide examples of where interventions have been implemented.
- Share feedback from women on their lived experience of Perinatal Mental Health and the care available to them.
- Provide some examples of where the charities and volunteers provide services to support women and their families.

It is anticipated that the findings in this review will prompt further discussion, help share learning and help inform future improvement activities.

The perinatal period, as defined in relation to mental illness, spans the time of conception to when the infant reaches the age of one. Perinatal Mental Health services are concerned with the prevention, detection and management of Perinatal Mental Health problems during this time. Perinatal mental illness is relatively common and affects at least 10% of women. The severity of the condition will vary from individual to individual and may have some serious consequences if not identified and managed early and effectively.

Improving quality and access to Perinatal Mental Health services is identified as a priority in the NHS England Mandate¹ and NHS England Business Plan² for 2014 onwards. The NHS Mandate identifies mental health as one of two key areas requiring further improvement during 2014/15. NHS England have been asked to improve the standards of care and experience for women and families during pregnancy and in the early years for their children and specifically to ensure a reduction in the incidence and impact of post-natal depression through earlier diagnosis, and better intervention and support. The NHS England business plan for 2014/5 onwards has committed to help improve services to support mothers with Perinatal Mental Health problems.

The NHS ‘A Five Year Forward View’³ sets out how despite all its achievements to date, the NHS will need to continue to change in order to keep people well for longer. This will be achieved by promoting equally both mental and physical wellbeing, through earlier intervention including a greater emphasis on prevention activities and by actively engaging citizens in decisions about their health and wellbeing. It also highlights the importance of addressing the care and quality gap which includes having flexible and responsive services, reducing variation in services and ensuring the health needs of people are met.
As promised in the Five Year Forward View, a National Review of Maternity Care, has recently been launched that will give consideration to current service provision and assess how services should be developed to meet the changing needs of women and babies including Perinatal Mental Health. The review aims to be completed by late 2015 and it is hoped that the findings from this study can contribute to this.

Monitor and NHS England have produced a document entitled Reforming the Payment System for NHS services in support of the Five Year Forward View. It sets out an ambition to achieve parity of esteem for mental health and acute services by 2020.

In March 2015, after the completion of the scoping exercise the result of which is this report, the then Government announced that £1.25bn would be spent on mental health services for children and new mothers over the next parliament, with £75m over 5 years, earmarked for providing the “right care to more women who experience mental ill health during the perinatal or antenatal period.”
Key findings

1. There are good examples of best practice based on NICE recommendations and the Quality Network for Perinatal Mental Health. However it appears that good practice is not necessarily evident as ‘standard practice’ across England.

2. The provision of specialist mother and baby units across England is not consistent e.g. not relevant to population and need. There is variability in the scope and provision of services to support local obstetric units.

3. There are some excellent examples of charitable and Third sector support services, often led by service users. Some are commissioned however most are self-funded and rely on local support and volunteers to be maintained.

4. Funding and staffing levels is frequently cited as a major constraint for many units and lack of service provision for Perinatal Mental Health support and training is more often due to lack of funding and resources rather than lack of recognition of its importance. Improved local payment approaches as part of the payment system reform for NHS services could be an important lever for change going forward.

5. Specialist midwives with experience of mental health are a major asset to those units fortunate to employ them. Access to local expertise and training offers great value.

6. The use of social media was found to be a highly effective way to learn about peoples experiences and to connect people who would otherwise not have felt able to share their concerns and wishes. There is an excellent vibrant community on both Facebook and Twitter. A number of the women run ‘Tweet-chats’ on a weekly basis offering support to others including providing insight to health professionals.

7. The revised National Institute of Clinical Excellence (NICE) guidance (Dec 14) recommends changes to the identification and assessment of Perinatal Mental Health problems. Organisations will have responsibility for ensuring these are shared amongst teams and that changes are made in local practice.

8. It is unclear what proportion of women who are asked about their mental health history at their ‘booking’ appointments or in pre-conception planning appointments. Health care professionals say they do always ask about mental health at booking and at each contact however, women often say they did not.

9. Women consulted during this study said they were afraid to talk about mental health problems for fear of having their baby taken away. This needs to be recognised by health professionals and techniques learnt and shared about how to best elicit crucial information.
10. There is considerable stigma associated with Perinatal Mental Health problems. There is a need (as with all mental health issues) for more openness and transparency on the subject in order that partners, families, employers and the public at large can support women with perinatal mental health problems.

11. Women's experience of treatment for mental health problems during pregnancy or afterwards was variable. Improving Access to Psychological Therapies (IAPT) services were not always found to be of benefit or suited to women with maternal mental health issues.

12. The GP has a crucial role in providing support to women during pregnancy. The RCGP has identified some proposed actions in their Action Plan for 2015-2016 to improve the detection and treatment of women with Perinatal Mental Health problems.

13. Health care professionals often lack confidence and training in the recognition, treatment and support for women with Perinatal Mental Health problems. Improved training and awareness would be of benefit to all health and social care professionals (doctors, midwives, health visitors and social care).

14. The lack of integrated IT systems results in poor communication between teams and increases the risk of women ‘falling through the net’ between service providers. Lack of integration between mental health and acute health records is a prime example.

15. There is no central knowledge repository or ‘go to place’ for data, policy guidance, and best practice examples. The ability to learn and spread information could be a valuable route to improvement.

16. Access to comprehensive data on the prevalence, incidence and treatment outcomes is difficult to find. The absence of key indicators and metrics means that the impact of improvement activity cannot be measured and evaluated.

17. There are no incentives (Commissioning for Quality and Innovation (CQUIN) framework and Local Enhanced Services (LES)) in the system to support improvement to practice.

18. Improving Perinatal Mental Health does not appear to be a priority within Clinical Commissioning Groups (CCG’s) business plans. Lack of awareness and understanding amongst commissioners may be an issue.

19. There appear to be opportunities to work more collaboratively across organisations on activities aimed at supporting change and improvement to Perinatal Mental Health services. These include but are not limited to: Academic Health Science Networks, Health Education England, Institute for Health Visiting, Local Education and Training Boards, Maternal Mental Health Alliance, NHS Confederation Mental Health Network, Quality Network for Perinatal Mental Health Services, Royal College of General Practitioners, Royal College of Midwives, Royal College of Psychiatrists, Strategic Clinical Networks both Maternity & CYP and the Mental Health SCNs, including Perinatal Mental Health Networks, where they exist.
Approach

As part of this scoping study, NHS Improving Quality has examined national policy and guidelines, key publications, research papers, national data and analysis. Knowledge and information has also been drawn from:

- attending national and regional specialist conference events
- attending Royal College meetings and master classes
- visits to centres of good practice
- telephone calls to Maternal Mental Health Network leads
- telephone, email, or face to face meetings with key stakeholders/partners
- capturing women’s stories face to face or via social media including Twitter by utilising a series of TweetChats.

See appendix 1 for a summary of the key publications reviewed.

The Change Model

The Change Model is the recognised model for change and improvement in the NHS. It allows for adaptation of tools used for improvement and can also give a structure to which any team can plan their improvement programme of work. The Change Model can be helpful to identify areas for development and support local care system partners, agree and create their shared purpose. With this in mind, the Change Model was utilised in the scoping of this report.

The Change Model underpinned the overall approach of identifying the levers for change that exist in the system and the importance of measurement and evidence to build the case for change.
Context

Perinatal Mental Health problems can be described as those which can complicate pregnancy and post-partum year. They include both conditions with their onset at this time and pre-existing conditions that may relapse or recur in pregnancy or in the post-partum year. Perinatal mental illness is relatively common and affects at least 10% of women. If left untreated it can have significant and long lasting effects on the woman and her family. Approximately half of all cases of perinatal depression go undetected in routine clinical practice and of those that are detected; many do not receive the evidenced based treatment they need.

Mental health disorders commonly associated with Perinatal Mental Health include anxiety and/or depression, obsessive compulsive disorder, post-partum psychosis, post-traumatic stress disorder (PTSD), adjustment disorders, distress and eating disorders.

Post-natal depression is an illness following birth of a baby with symptoms similar to those in depression at other times. These include low mood and other symptoms lasting at least two weeks. Depending on the severity, women may struggle to look after themselves and find simple tasks difficult to manage. There is little information available on the prevention of antenatal depression. More is available on the benefits of psychological interventions for those diagnosed with post-natal depression.

Post-natal depression prevalence within the first few post-natal months is estimated to be 13%. Most cases develop within the first three months of birth with a peak in incidence at about 4-6 weeks. Results of a study in the US suggest that 33% of post-natal depression begins in pregnancy and 27% pre-pregnancy. Women with post-natal depression often recover within a few months from onset, but around 30% of women still have depression beyond the first year after delivery and there is a high risk of around 40% of subsequent post-natal and non post-natal relapse. Post-natal depression can have substantial impact on the mother, her partner, mother-baby interactions and the longer term emotional and cognitive development of the baby, especially when it occurs in the first year of life.

Because of these potentially serious consequences there has been a lot of work undertaken to try and improve the identification and assessment of disorders and increase referral for support or treatment. Following identification of a potential mental health problem (using the screening questions recommended in the NICE guidance), the Edinburgh Post-natal Depression Score (EPDS) is most frequently used although the cut off points to distinguish different levels of depression does appear to vary. Some research has been undertaken and a recent article in The Lancet highlights the ongoing debate about the clinical effectiveness, acceptability and cost effectiveness of using screening tools to detect perinatal illness. The new NICE guidance (CG192) recognises this and advocates the use of a wider range of questions to detect those at risk.
Policies and guidelines provide fairly consistent recommendations about the care that every pregnant woman should expect whether this be for a mild depression or anxiety condition or the specialist care needed for a severe mental illness requiring inpatient admission. Findings from this initial scoping work, largely derived from the plethora of publications on this subject suggest that improvements are taking place to better support the detection and management of perinatal mental illness but that these improvements remain patchy and fragmented and some way from meeting the standards identified through NICE and the Royal Colleges. For instance we know that specialist Perinatal Mental Health services are needed for women with complex or severe conditions but less than 15% of localities provide these at full levels of provision and 40% provide no service at all. Almost half of Trusts do not have access to any specialist mental health midwives which results in women continuing to report a poor experience of their mental illness.

Other publications have relevance to this work. For example an earlier report produced in February 2014 by NHS Improving Quality entitled ‘A review of support available for loss in early and late pregnancy’ found that support comes in many forms both from within the NHS and from national and local charities. It was found that:

1. Support required was individual to the people who suffer the loss.

2. Some parents want to remember their baby whatever the gestation and should have the opportunity to do so.

3. Compassion and attitude of the staff have a lasting impact on the experience.

4. The environment of care during and after loss needs to be somewhere away from the main business of the maternity ward or gynaecology ward.

5. Staff want to provide emotional support but struggle with the workload and competing priorities.

The Royal College of Psychiatrists (RCPsych) leads the Quality Network for Perinatal Mental Health. They have developed two sets of standards for mother and baby units and community mental health teams and these are now incorporated within national service specifications. They support clinicians to evaluate their performance across a range of standards, reflect on their findings through a peer review process and share best practice and approaches to service improvement through an active network. All 18 mother and baby units participated in the 2014 audit. Given the high profile and reach of the RCPsych further work with them to support the spread of learning and notable practice would be advantageous in taking this work forward.
Cost and quality gap

The timely publication from the Centre for Mental Health, ‘The costs of Perinatal Mental Health problems’, seeks to provide comprehensive estimates of the costs of perinatal health problems, including the adverse effects of maternal mental illness on the child as well as the mother. It acknowledges the importance of addressing post-natal depression, but it also sets out what is known about other mental health problems that can occur during the antenatal period and demonstrates that the problems go beyond depression, and can include anxiety, psychosis, post-traumatic stress disorder and other conditions. It emphasises that these varied needs warrant attention to ensure they do not go unmet.

Whilst acknowledging the limitations in data availability, the Centre for Mental Health report goes on to estimate that taken together, post-natal depression, anxiety and psychosis carry an overall total long term cost to society of about £8.1 billion for each one year cohort of births in the UK. Nearly three-quarters [72%] of this cost relates to adverse impacts on the child rather than the mother.

Over a fifth of total costs (£1.7 billion] are borne by the public sector, with the bulk of these falling on the NHS and social services (£1.2 billion). Finally the report goes onto suggest that additional expenditure of around £280 million a year would be required to close the quality gap and raise mental health care up to the level and standard recommended in national guidance.

The Prevention in Mind – All Babies Count – NSPCC and Maternal Mental Health Alliance report [2013] consolidates latest evidence about Perinatal Mental Health illness and suggests a call to action for key decision makers at a national and local level to work together to close the gaps in services. The report outlines what success might look like with a vision that women who are at risk of, or suffering from mental illness are identified at the earliest opportunity and given appropriate and timely expert care thus preventing their illness from occurring or escalating, and certainly strives to minimise harm suffered by them and their families. This report also acknowledges that supporting the family as a whole is an important part of minimising depression amongst fathers whose partners are affected by perinatal mental illnesses. Finally this report outlines a set of recommendations for improvement. These 21 recommendations are grouped under five key recommendations and they are:

1. Universal services must be able to identify issues early and ensure that all women get the support they need.
2. Timely psychological support must be available to all expectant and new mothers with mild or moderate mental illness.
3. Women should be able to access specialist Perinatal Mental Health teams and inpatient units when necessary.
4. Services must address the impact of Perinatal Mental Health illnesses on babies and other family members.
5. There must be strategic commissioning of Perinatal Mental Health care based on need.

These recommendations could form the basis on which NHS England explores new models of care that will give women and their families more choice and control and ensure outcomes are ultimately improved in line with the NHS Mandate.
What are the facts?

There are two main sources of national data relating to Perinatal Mental Health.

- Maternity data set – now managed by the Health & Social Care Information Centre
- Mental Health Minimum data set

The Maternity Services Data Set (MSDS) Information Standards Notice (ISN), that mandates the national collection of the MSDS, was published in May 2014.

The MSDS was approved by the Standardisation Committee for Care Information (SCCI) Board on 30 April 2014. SCCI replaces the Information Standards Board (ISB) and is a sub-group of the National Information Board (NIB). The ISN requires that maternity information systems must be fully conformant with the standard by 1 November 2014. Maternity service providers must collect data locally from 1 November 2014, with central submissions commencing from 1 May 2015. The only data item within this dataset that concerns perinatal health is the “MENTAL HEALTH PREDICTION AND DETECTION INDICATOR (MOTHER AT BOOKING)”. The purpose of this indicator is to determine whether the appropriate questions were asked to identify mental health problems during the booking appointment. The purpose of this data item is not to capture mental health issues.

The DSM-5 (Diagnostic and Statistical Manual of mental disorders) and ICD-10 (International classification of diseases) provide diagnostic criteria for depression. They distinguish between levels of depression from severe, major, moderate and minor.

Perinatal Mental Health is currently under the remit of specialised commissioning. The service specification for Perinatal Mental Health states that for serious emergency acute cases women should be managed by specialised mother and baby care units. However mild to moderate depressive illness and anxiety is approximately 100-150/1000 births. Perinatal Mental Health of a mild to moderate nature is currently accessed via a referral to a general psychiatric unit or outreach team referral for further assessment/treatment.

There is a Clinical Reference Group (CRG) for Perinatal Mental Health who developed the service specification (C 06).

1. Incidence and prevalence of perinatal mental illness

Accurate national data on the incidence and trends in perinatal mental illness are not available. Using the birth rate of their area, commissioners simply estimate the Perinatal Mental Health morbidity in order to determine necessary service provision. Estimates vary from 10% to 20% depending on which publication is read. Several use the term ‘at least 10%’. It is thought that about 50% of cases are undetected.

The CRG for Perinatal Mental Health estimates based on the known epidemiology of postpartum psychosis (2 per 1,000 live births) and the rate of admission for other serious and complex disorders (a further 2 per 1,000 live births), around 2,750 women need access to specialist mother and baby units each year.
2. Incidence and prevalence of post-natal depression

Prevalence of post-natal depression varies from 7.4%–11% in the three months after childbirth, 7.8-12.8% in 3–6 months and 8.5–12% in 6-9 months\textsuperscript{16}. Using the latest Office for National Statistics (ONS) figures for live births, there are a potential 70,000 women per annum suffering from post-natal depression.

The absence of accurate national data poses a challenge in terms of demonstrating reduction in the incidence of post-natal depression. What is the measurable goal that we should be aspiring to assuming we implement the ‘good Perinatal Mental Health service’ outlined in the Joint Commissioning Panel for Mental Health (JCPMH) Guidance for Commissioners of Perinatal Mental Health Services\textsuperscript{17}? Further work to identify European comparator data may help identify a reasonable goal for this.

There are a number of Quality Outcome Measures [QOF] indicators for those patients with a new diagnosis of depression, but they do not identify Perinatal Mental Health issues specifically. (Note: A prevalence calculator developed for dementia\textsuperscript{18} and on which the two thirds dementia diagnosis rate is based may be a model worth considering. The aggregated CCG performance is used to measure national performance and improvement and is helping to improve waiting times, access and provision of post diagnostic support.)
3. Inpatient admission with a diagnosis of post-natal depression


Please note the live births data is presented as an illustration for comparison purposes and reflects the number of live births recorded by the ONS in England & Wales, whereas the PND (F53) inpatient admissions reflects data from England only.

Overall the average percentage change of live births in England & Wales has increased on average 0.6% from 1998/99–2013/14. Conversely, hospital admissions for post-natal mental health conditions (mostly post-natal depression) have fallen on average 2.3% per year from 1998/99 to 2013/14. Likewise the rate of hospital admissions for post-natal mental health conditions per 100,000 live births has fallen on average 2.9% per year from 1998/99 to 2013/14. This decrease seems to accompany a 4.8% drop in live births between 2012/13 and 2013/14 of around 31,000.

Both live births and hospital admissions for post-natal mental health conditions decrease from 1998/99 to 2002/03 and then start to increase again in 2003/04, showing an increasing trend to 2013/14 with some slight oscillations in the period – average annual increases of 0.8% and 1.5%, respectively. The rate of hospital admissions for these conditions by 100,000 live births reflects this increase and shows an annual average increase of 0.7% from 2003/04 to 2013/14. This raises questions about the underlying reasons for the increase in admissions from 2002/03 – changes in services, changes in coding? These could be further investigated. Data to support improvement to perinatal services appears to be lacking across all sectors. For example the stated incidence of perinatal health is highly variable (10%-25%) and does not provide an accurate baseline position on which to measure national improvement. The new national maternity data set is under construction, will be implemented in April 2015 and launched in October 2015. An Atlas of Variation is being considered by the Child and Maternal Health Intelligence Network (ChiMat)/ Public Health England (PHE) and the SCN network is developing a dashboard to support commissioners. Access to robust data is a key component of any improvement work and a high priority needs to be given to supporting and accelerating this work.

4. Perinatal Mental Health incidence by type (based on a series of references within the JCPMH Guidance for Commissioners 2012)

- Postpartum psychosis 2/1000 births (1,400 cases per annum)
- Chronic serious mental illness 2/1000 births (1,400 cases per annum)
- Severe depressive illness 30/1000 births (21,000 cases per annum)
- Post-traumatic stress disorder 30/1000 births (21,000 cases per annum)
- Mild to moderate depressive illness and anxiety states 100-150/1000 births (105,000 cases per annum)
- Adjustment disorders and distress 150-300/1000 births (up to 210,000 cases per annum)

5. Births

There are approximately 700,000 births per year in England. This has remained essentially static since 1992, with a high of 729,000 in 2012, but numbers falling back to the level in 1992.
6. Maternal Deaths (source CEPOD)

The Confidential Enquiries into Maternal Deaths (CEMACH) reports for 1997–1999, 2000–2002 and 2003–2005 found that suicide and psychiatric causes were a leading cause of indirect maternal death in the UK. The reports highlight the need for availability of Perinatal Mental Health services for all women who need them.

Between 2006–2008 there were 261 women who died from causes directly or indirectly related to a pregnancy. Of these 107 died of direct causes that could only have occurred as a result of being pregnant and the remaining 154 died of indirect causes associated with underlying medical conditions such as heart disease or suicide caused by puerperal psychosis aggravated by their pregnancy. Of the 154 deaths, 67 were associated with psychiatric causes.

The table below shows timing of these 67 deaths that were from, or associated with, psychiatric causes. 12 deaths occurred pre delivery, 29 up to 6 weeks after delivery and the remainder between 6 weeks and 6 months after delivery.

The report found that some women who had died and had a history of mental health problems, had not been identified and did not have a care plan in place.

Table 11.1 Timing of death from or associated with psychiatric causes UK 2006–08

<table>
<thead>
<tr>
<th>Cause</th>
<th>Pregnancy Undelivered</th>
<th>Up to 42 days after end of pregnancy</th>
<th>Late deaths 43-182 days after pregnancy</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>Suicide</td>
<td>4</td>
<td>9</td>
<td>16</td>
<td>29</td>
</tr>
<tr>
<td>Accidental overdose from drugs misuse</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Medical conditions, including those with substance abuse</td>
<td>2</td>
<td>16</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Accidents</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>29</td>
<td>26</td>
<td>67</td>
</tr>
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</table>

7. Costs associated with Perinatal Mental Health

The average cost to society of one case of perinatal depression is around £74K. The costs of perinatal anxiety alone is around £35K per case. Taken together, perinatal depression, anxiety, and psychosis carry a long term cost to society of £8.1 billion for each year of births in the UK.
8. Specialist mother and baby units

There are 18 mother and baby units in England of which six are located in the Midlands and North East/Yorkshire. This shows there is an uneven distribution across the country making access inequitable.

There are 139 (57%) specialist community Perinatal Mental Health teams in England but levels of service vary from the 36 (15%) that meet the Perinatal Quality Network Services Standards to 55 (23%) that provide either a perinatal psychiatrist or specialist nurse service for limited time only. 40% offer no specialist community perinatal health service.

9. Commissioning for Quality and Innovation (CQUIN) framework

‘The Five Year Forward View into action’ plan recognises the importance of incentivising local systems to improve the quality of care. The recently commissioned review of NHS Maternity Services which will include Perinatal Mental Health should provide an ideal platform on which to explore current and future levers for change in the system both nationally and locally across England.

10. Specialist Maternal Mental Health Midwives

In a recent survey23 (Oct 14) of Heads of Midwifery, of the 45% of responses received:

- 18 (23%) said they had one or more specialist mental health midwives
- 22 (29%) said they included mental health in a wider specialist midwifery role or case loading team for vulnerable women
- 37 (48%) said they did not have any specific midwifery post.
What is known about current services?

There is clearly variation in service provision across England which is recognised by most stakeholders and whilst data quality and data availability is also variable, there do seem to be areas across England where needs of women, particularly with regard to early detection and intervention, continue to go unmet.

The following provides an overview of findings from our short study.

**Assessment and identification of women who may be at risk of Perinatal Mental Health issues**

The new NICE Guidelines ([http://www.nice.org.uk/guidance/cg192](http://www.nice.org.uk/guidance/cg192)) recommend that at first contact clinicians within primary care or at booking visit consider asking the following depression identification questions as part of the general discussion about a woman’s health and wellbeing.

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

(Previously referred to as the Whooley questions)

Also consider asking about anxiety using the 2-item Generalised Anxiety Disorder scale (GAD-2)

- During the past month, have you been feeling nervous, anxious or on edge?
- During the past month have you not been able to stop or control worrying?

The two GAD-2 questions have been added to the new NICE guidance and reflect feedback from service users and professionals of the importance of assessing for anxiety as well as signs of depression. Professionals suggested the Whooley questions used in isolation, did not encourage an open or extensive discussion.

The supplementary question to women which asked ‘Is this something you feel you need or want help with?’ has been removed from the new guidance suggesting that action of some sort should be taken if any risk of anxiety or depression is identified.

Two thirds of professionals reported that they use the Whooley questions, followed up by further questioning using tools such as the Edinburgh Post-natal Depression Scale.

**Other tools identified include;**

- Hospital Anxiety and Depression Scale (HADS)
- General anxiety disorder/GAD 7
- Patient health questionnaire/PHQ 9
Interventions

Dependant on the severity of the mental health issue a woman presents with, there are a range of interventions which may be appropriate. Improving Access to Psychological Therapies (IAPT) may be appropriate for women with mild to moderate depression. IAPT is an NHS programme for treating people with depression and anxiety disorders. For women with perinatal health problems referrals are accepted from health professionals including GPs and midwives. Some centres offer self-referral. For more severe cases referral to specialist services and possibly medication would be appropriate. All women who have a history of mental health illnesses should be referred to a specialist Perinatal Mental Health service, even if they are ‘well’ at the time of booking. This is a preventative and positive approach which is recommended and present within some protocols and pathways.

The IAPT Perinatal Positive Practice Guide (2009)\textsuperscript{24}, aimed primarily at commissioners, found that in one pathfinder site between 5% and 11% of referrals to the service were for women with Perinatal Mental Health problems. The guide recognises the need for training IAPT workers on normal emotional changes associated with motherhood and family and the clinical features of perinatal disorders, risks etc. To what extent training in such topics is delivered to the IAPT workforce has not been verified as part of this study but anecdotal feedback (face to face and social media interactions) suggests that provision of support focusing on topics such as parenting or mother/infant interaction is not always available.

Strategic Clinical Networks (SCN)

Strategic Clinical Networks focus on priority service areas to bring about improvement in the quality and equity of care and outcomes of their population. They bring together those who use, provide and commission the service to make improvements in outcomes for complex patient pathways using an integrated whole system approach.

There are 12 SCNs in England which have both Children & Maternity and a Mental Health Dementia and Neurology network. For most, the work relating to Perinatal Mental Health sits in the Children and Maternity network, with cross sharing/networking with the Mental Health SCNs. The aspirations and action plans shared with NHS Improving Quality vary, with some work at planning, development and implementation stages.

There is a local work plan within each SCN which is driven by local demographics, is evidence based and aimed at supporting the local commissioners deliver improved services to their population.

Whilst the SCNs are currently subject to a review led by NHS England we know that eight of them are currently working on improvements to Perinatal Mental Health with some being more established than others, and two are considering work around this area for next year. It is expected that the new networks will be known as Clinical Networks. Below are examples of current SCN work:
Midlands and East

The launch of the Healthy Child Programme Commissioning and Delivery Toolkit in December 2014 followed a successful pilot of different elements of the toolkit across five geographical areas. The toolkit provides clear pathways for a wide variety of services for children in the 0-5 age group to promote optimal health outcomes and it is intended that this will be rolled out across women and children up to the age of 17 in the future. The toolkit is designed for commissioners and providers within primary care, the community and acute trusts.

One element focused on the mental health pathway and this was piloted across Suffolk and included two learning and sharing events in March 2015 for all key stakeholders. This provided the launch of the revised Healthy Child Programme Commissioning and Delivery Toolkit.

The Strategic Clinical Network Family Health and Experience Forum are now using the Suffolk pilot experience to help implement the Perinatal Mental Health pathway across the region. The first stage will be to audit current service provision against the best practice in Perinatal Mental Health standards. This is expected to complete during the summer 2015 and will be followed by development of regional implementation plans.

This work programme links closely with the Child and Adolescent Mental Health Service work plan to ensure effective integration of service provision and patient transition.

London

A six month Perinatal Mental Health training pilot in Barnet, Enfield and Haringey was developed in response to bids submitted to Health Education, North Central and East London (HENCEL) by the three CCGS. The remit was that the training had to be sustainable, multiagency and delivered by the end of March 2015. A five stage training programme was put together:

1a Training of 22 Perinatal Champions as a Train the Trainer model – two day training delivered by the Institute of Health Visitors who were commissioned to write multiagency training

1b Delivery of Multiagency Perinatal Awareness Training by the Perinatal Champions (Maternity Champions delivered half day awareness sessions on site at three hospitals to 165 staff; other Champions delivered one day training in the three Boroughs to 88 staff)

2 GP Masterclasses run by Dr Judy Shakespeare (65 GPs trained to date – two more masterclasses still to run)

3 Perinatal Simulation Training run by South London and Maudsley at Lambeth Hospital (60 attended)

4 Perinatal Mental Health training event run by Edge Consultancy – 61 attended

5 ITSEY is the International Training School for Infancy & Early Years – It is a modular course run by The Anna Freud centre. ITSEY Modules 1 and 2 – 11 attended in Jan/March Cohort and 35 are due to attend in June/July Cohort.

In total over 500 people have attended and further rollout of training is now planned. Feedback for all training has been very positive and the Perinatal Champions are keen to continue training.
The proposal for 2015/16 submitted to HENCEL is to deliver more training in these three boroughs and to roll the programme out to the other boroughs in HENCEL and will complement existing perinatal/parent-infant training in some areas. It is also proposed to link with other perinatal training initiatives to support long term sustainability of training across London.

South West

In November 2014 the CCGs within the South West SCN completed a self-assessment baseline audit against the standards and recommendations set out in the NSPCC report ‘Prevention in Mind’ report. The outcome of this exercise is being used to inform the future work programme, identify priorities and develop short and long term goals for the network plan of action.

For anonymised results see appendix 2.
Workforce

Health Education England (HEE) and Local Education Training Boards have the lead responsibilities for both planning the workforce of tomorrow and building capability in the existing workforce. Other key partners are the Nursing Directorate of NHS England who have responsibility for professional practice of nurses. To this end this initial scoping work has not set out to detail workforce issues other than to highlight that women and their families say that there are training issues across the NHS workforce particularly where staff are involved in assessing needs early on. Depending on the experience and interpersonal skills of the individual member of staff it can have a significant impact on the women’s experience and access to services if required. This scoping study recommends exploring with HEE whether there is further work that can be done together to address workforce capability to achieve improved experiences for women accessing services.
What do service users and health care professionals say about Perinatal Mental Health services?

The Five Year Forward View sets out the importance of engaging the public in their healthcare along with giving them a voice to shape services going forward. This scoping exercise has looked at surveys which have captured feedback from women and their families. It has also sought current views by undertaking one to one interviews and using social media in the form of three Twitter clubs led by NHS Improving Quality which took place over a three week period.

The following are findings from a literature search along with an overview of a small number of charities across the NHS in England who are already working formally through a contract arrangement with NHS CCGs and may offer potential for wider adoption.

1. Tommy’s Perinatal Mental Health²⁵ – Experiences of women and Health Care Professionals (HCP) – Oct 2013 (Survey results from 1500 women and 2000 HCP)

Key findings:
Almost all midwives reported that they ask women about emotional wellbeing at booking but only 1:10 women recalled being asked. Health care professionals said there was over reliance on the Whooley questions alone as recommended within the previous NICE guidelines. Women with a previous history of mental health problems are at increased risk of developing mental health problems during pregnancy and the post-natal period, but only half of professionals said that they were confident that they knew about the previous history of the women in their care. They acknowledged a lack of confidence due to poor or insufficient training, availability of information from other professionals, undocumented history in maternity notes, poor continuity of care, lack of support services and the reluctance of women to discuss their mental health issues.
What women say helped them

**Figure 8. What was most helpful for recovery**

- **Time** 36%
- **Recognising illness** 26%
- **Medication** 24%
- **Support of family** 24%
- **Self-help** 19%
- **Reduction of stress** 17%
- **Peer support** 17%
- **Talking to experts** 13%
- **Counselling** 13%
- **Exercise** 13%
- **Healthy eating** 8%

**Service users said:**

- There can be difficulty in recognising when symptoms are illness and not just a temporary failure to cope.
- Partners are not only a source of support, but can also be the first to recognise illness in a loved one.
- Relationship difficulties can also arise through poor mental health, or indeed be the cause of it.
- It is important to remember partners and husbands can develop mental health problems during this time too.
- Many women are reluctant to discuss the type and depth of their feelings. Almost a third (30%) never tell a health professional.
- Hiding the extent of symptoms is common, one key reason is the fear that a baby might be taken away.
- When they are ready to talk, a quarter of women turn to their health professional first, although it is most likely that a woman will talk to her husband or partner first.
- Women reported that a wide range of support acts as treatment, from talking with family and friends through to local support groups or advice provided via the internet.
Mary’s story – November 2014

I started suffering with prenatal depression during my pregnancy. I had waited for this baby for nearly 4 years. I felt so ungrateful and selfish because I wasn’t enjoying the pregnancy because I was sick all the way through it.

My post-natal depression didn’t kick in until Adam was four months old. I started realising it shouldn’t feel this rubbish. I should be enjoying motherhood more. I googled PND symptoms and basically ticked all the boxes! I finally got the courage to go to the doctors for help.

That help came from Acacia. I visited them without Adam as felt I couldn’t cope taking him. Everyone was lovely and put me at ease straight away. I got referred for one-to-one counselling which helped loads. I also did a workshop for my anxiety. If it wasn’t for Acacia I dread to think how I would be feeling now.

This time last year I was a mess and now I volunteer for Acacia and love helping other moms beat PND.

2. An exploration of perception of post-natal depression in African women in Greenwich Community Healthcare Services (October 2010)26

This study explores African women’s perception of post-natal depression. The study aimed to explore the cultural determinants of post-natal depression and to help health professionals understand and recognise symptoms in these groups of women.

Findings revealed that almost half of the participants in the study exhibited undiagnosed symptoms of post-natal depression. Equally, these women did not perceive the symptoms as abnormal or related to illness. This study highlighted that these symptoms were not identified by health visitors despite having prolonged contact with the women. It states that it is imperative that health professionals who are in contact with women are educated and prepared to recognise subtleties in symptoms and manifestation of the illness and are conversant with the diagnostic tools. This study provided an insight into the complex values and belief systems in a group of African women which shape their perception of post-natal depression.

3. Acacia Charity

Acacia family support is a charity working to improve the lives of families suffering varying levels of need. It is a third sector provider working in collaboration and partnership with NHS Birmingham primary care services. Acacia is commissioned through a partnership with the joint mental health commissioning team in Birmingham which consists of Birmingham City Council and three CCGs. This service partnership has been running successfully for several years and could be a transferable model for other parts of the country. NHS Improving Quality collaborated with Acacia to capture patient stories. The following story is just one of many examples. These have been recorded and are available on request. They could be used to create greater awareness amongst professionals and the public.
Examples of practice

The map below is an illustration of examples of practice gathered during this scoping exercise. No specific criteria were used for their selection. These are a combination of both innovation solutions as well as examples of expected practice as recommended within national guidance. It is recognised that there is under-delivery of normal practice and not every area is currently able to provide the level of recommended services.
James Cook Hospital NHS Trust (South Tees Hospital NHS FT) – Middlesbrough:
A multi-agency approach including providers, commissioners, local authority and women and families affected by Perinatal Mental Health that has worked together to provide a range of services to support women and families. The acute Trust works with community services and in General Practice to ensure that pathways implemented are robust and fit for purpose. They have a steering group which comprises a wide range of stakeholders including women. They have positioned the IAPT service within the hospital outpatients department, making referrals and appointments convenient for women. Work has been done to improve the maternity notes, the mental health risk assessment questions asked to women and the introduction of interventions to support the wider public health agenda for women and families. By developing a set of maternal mental health pathways they have provided a more structured systematic approach to improve the patient journey and assist practitioners in the prediction and detection of maternal mental health issues.
http://southtees.nhs.uk/hospitals/james-cook/01642 850850

Acacia – Birmingham, West Midlands:
Acacia family support is a charity based in the West Midlands that is working closely with a range of partners including NHS Clinical Commissioning Groups to provide befriending support and therapies aimed at improving the lives of families suffering from post-natal depression. Acacia delivers a range of services for mothers and families with varying levels of need. Acacia has been recognised as a positive contributor to addressing post-natal depression in two recent academic publications and has recently secured additional lottery funding so that in collaboration with local CCGs it can provide services across south and central Birmingham.
http://www.acacia.org.uk

Oxford Parent Infant Project (OXPIP):
OXPIP works closely with GPs, Health Visitors and Midwives from whom they receive the majority of their referrals to support parents and their families to make loving and secure bonds with their babies. Through a combination of listening and exploring thoughts and feelings, OXPIP therapists offer a safe and supportive environment where parents can get to know and understand their baby better. Services are provided around the needs of the families and provided in a range of settings including children centres to make them readily accessible.
http://oxpip.org.uk

Liverpool Parent in Partnership (LIVPIP):
LIVPIP is a service for parents-to-be and parents of babies up to two years of age. It is run by Liverpool Social Enterprise PSS (PSS is Person Shaped Support, more information is available at www.psspeople.com ) and funded by PIP UK and Liverpool CCG. Its service aims to form stronger bonds and positive relationships between parents and their baby. They work closely with other professionals who support families with babies such as GPs, Midwives, Health Visitors, Children's Centres, Family Nurse Partnerships, Perinatal Mental Health teams and many others.
http://livpip.org.uk
Northamptonshire's Parent Infant Partnership (NORPIP):
NORPIP aims to promote an emotionally healthy society by focusing on the need for secure attachment in the critical period of conception to age two years using intensive psychotherapy to help parents form a more secure bond with their babies to promote their lifelong wellbeing. They work to raise awareness amongst professionals, commissioners, investors and policy makers. Women are able to self-refer as well as being referred by other healthcare professionals. They have a pilot underway, due to complete in Sept 2015, which has enabled primary care to have close working relationships with a counselling and support service. GPs are working closely with NORPIP to provide a comprehensive service and appropriate referral routes for families.
http://www.norpip.org.uk

LIFT Psychology – Swindon:
LIFT runs a wellbeing after baby course aimed at any parent who is experiencing anxiety, depression or general stress since the birth of baby which offers evidence based techniques to manage emotional wellbeing. Previously this service also covered Wiltshire but the two have now separated and are funded by different CCGs.
https://lift.awp.nhs.uk/swindonandwils

North East London NHS Foundation:
This service is an integrated obstetric and psychiatric service providing joint consultations for high risk women during pregnancy and post-partum to help plan and support care. This service is well received by service users with fewer appointments, and the opportunity to see both experts at the same time. Women are also offered the opportunity to self-refer via a triage system so that those who need it can access support more speedily. The NHS Trust is also expanding student nurse placements to include GP surgeries so they gain greater insight into the needs of patients across a wide range of conditions.
http://www.nelft.nhs.uk

Bluebell – Bristol:
This charity based in Bristol supports mums, dads and families with a range of services such as providing support within the home via a buddy service and a twelve week programme called “mums comfort zone”. Bluebell is working as an active partner of the South West Perinatal Network to improve services across the region. In particular Bluebell is keen to engage NHS organisations and those providing education across healthcare to develop accredited training for its service user members to ensure the quality of support to women and their families and with building competencies across the multidisciplinary team of the wider NHS.
http://www.bluebellcare.org

Southern Health NHS Foundation Trust – Winchester, Hampshire:
Perinatal community mental health services are available to women pre conceptually, antenatally and post-natally up to baby's first birthday. It provides services in a variety of settings including the family home, GP surgery and clinics.
http://www.southernhealth.nhs.uk
Devon Partnership NHS Trust:
Devon Partnership NHS Trust is an active member of the South West Perinatal Mental Health Network which aims to work collectively across the region to improve local services. On an individual level it offers a range of services to address stress, anxiety and low mood. In particular it uses videos and personal patient stories actively to help individual recovery. Service users are encouraged to engage with the organisation through a range of activities including a recent photographic competition.
http://www.devonpartnership.nhs.uk/Mental-health-information.7.0.html

Liverpool Women’s Foundation Trust:
Provide a Post-natal Depression Service to provide help and support for the whole family, parents, adoptive parents and foster parents. Specialist Practitioners offer advice and listening, and support (emotional and practical) by visiting the home of anyone who is struggling with the symptoms of PND, and signpost them to other services that could be of help. On average women receive 6-8 sessions over a period of time which are discussed and agreed between the individual and the Practitioner. They have also produced a DVD for both professionals and people experiencing post-natal depression. The DVD aims to give an insight into the experiences of men and women with post-natal depression, helping them to understand the condition more and to raise awareness of this challenging experience.
http://www.liverpoolwomens.nhs.uk or www.psspeople.com

Oxford Health NHS Foundation Trust:
Have developed a leaflet Antenatal and post-natal depression and other emotional difficulties during pregnancy and after birth that provides information on various conditions, symptoms to look out for, what people can do to help themselves, what family and friends can do to help and what health care professionals can provide. (http://www.ouh.nhs.uk/patient-guide/leaflets/files/130125perinatal.pdf) General information about mental health and wellbeing and post-natal depression is included in their local pregnancy book which is given to all expectant women.
http://www.oxfordhealth.nhs.uk/about-us

Medway NHS Foundation Trust, Kent:
This hospital provides a specialist mental health midwife service for women who experience mental health problems during pregnancy or after birth. Women are assessed and those requiring further intervention are offered a one hour appointment where mental health needs and wellbeing are discussed and can be triaged to specialist services if required. The specialist midwife provides training to other midwives and is a key member of the Perinatal Mental Health clinical network including children’s services to ensure that services consider the needs of families affected by perinatal mental Illness. This is part of a comprehensive strategy to help women sooner and where possible prevent avoidable hospital admission.
http://www.medway.nhs.uk
South London and Maudsley NHS Foundation Trust (SLAM):
This organisation provides one of the widest ranges of mental healthcare services in the UK. For women who have experienced depression during or after pregnancy there is a range of options including talking therapies as well as dance movement as a form of psychotherapy support to help mothers focus on the more non-verbal aspects of relating with their baby. South London and Maudsley's website contains case studies from women who have experienced depression either after or during pregnancy which can be helpful to other women or to raise further awareness amongst staff of the needs of women experiencing anxiety or depression related to childbirth.
http://www.slam.nhs.uk

Leeds and York Partnership NHS Foundation Trust:
Provide a preconception counselling service for women who might be at risk of mental health issues during pregnancy to facilitate early detection and therefore offer support or treatment as appropriate.
http://www.leedspft.nhs.uk

Coventry and Warwick Partnership Trust:
This organisation uses a range of techniques to deliver effective services for their local population. One approach is to use a model called care clusters. This has been co-produced by clinicians and patients and it describes a group therapy approach for people with similar health needs. This approach can be used to offer support for disorders such as anxiety and depression.
Women who are referred to the service are seen in their own home.
http://www.covwarkpt.nhs.uk

Birmingham and Solihull Mental Health NHS Foundation Trust:
Birmingham and Solihull Mental Health NHS Foundation Trust offers a range of services including a ‘healthy minds’ approach which women can self-refer to and is predominately psychological therapies based. In addition it developed an approach known as ‘the Solihull way’ to build further knowledge and skills across the workforce in order to better support women and their families with pre and post-natal depression. This approach has been replicated in other NHS organisations across England. BABS – Birmingham Amazing Babies has been set up by a full time consultant psychologist and is designed as a bonding programme.
http://www.bsmhft.nhs.uk

The Rosie Hospital – Cambridge University Hospitals:
Offers 32 week pregnancy pre-birth planning meeting. Everyone involved in a woman’s care is invited to the meeting – from GPs, health visitors, midwives and social services, as well as her friends and family – and she is given control over her plan and what she wants to happen. Women say they like this support and really value the time and care devoted to the planning. The Rosie team has recently appointed a new Perinatal Mental Health specialist midwife who plays a pivotal role in the women’s journey through pregnancy, birth and beyond. The combination of this and the planning meeting has proved successful. The PETALS service provides a counselling service to women and partners as appropriate. They can be referred through the Rosie Maternity Hospital, and other routes which include direct referrals from health professionals.
http://www.cuh.org.uk/robbie-hospital
Charities, voluntary sector and not for profit organisations

There are several third sector charities providing support in many areas of the country. Some are commissioned by local CCG’s as in the case of Acacia which we discussed previously. Below are examples of some of these organisations, please note that this is not an exhaustive list.

**Smile Group** – Macclesfield, a registered charity set up to support families affected by post-natal illness by offering weekly peer support group at a community level.  
http://www.thesmilegroup.org/

**Pandas** – Shropshire: Fathers Reaching Out was founded in 2011 by Mark Williams. He set up the organisation after going through the illness himself. In 2004 he found that there was no help for his wife Michelle and even less for himself.  
http://www.pandasfoundation.org.uk/index.html

**Baby Steps** is a perinatal educational programme designed by NSPCC and Warwick University.  
http://www2.warwick.ac.uk/fac/med/study/cpd/module_index/md963/

**Minding the Baby** is based on attachment theory, which is about the importance of the emotional bond between a parent and child.  
http://www.mtb.yale.edu/index.aspx

**‘Thumbswood’ Mother and Baby Unit** at Queen Elizabeth II Hospital in Welwyn Garden City offers music therapy to help build attachment relationships between mothers and their babies.  
http://www.hpft.nhs.uk/our-services/specialist-services/mother-baby-unit/

**Petals** charity provides a specialised counselling service in Cambridgeshire, and parts of Bedfordshire, Herts, Suffolk and North Essex. Its particular focus is on counselling for trauma or loss during pregnancy or birth and it is funded through Lottery grants and voluntary contributions. It has no funding from any CCG. The service has been very well evaluated and provides a free service for woman (and partners) across a large geographic area. Clients can self refer as well as be referred.  
www.petalscharity.org
MumsAid offers perinatal and post-natal counselling to women living within the Royal Borough of Greenwich.
http://www.netmums.com/greenwich/local/view/support-groups/antenatal-postnatal-support/mums-aid

House of Light (Hull) is a registered charity that has been providing support, advice and information for women and their families affected by post-natal depression since 2007.
http://www.pndsupport.co.uk/

The Cedar House Support Groups (based in Guildford, Surrey and Clapham) are for women who are experiencing post-natal depression.
http://www.postnataldepression.com/cedar-house-support-group

Best Beginnings – a service set up by a service user to raise awareness and help to train professionals. Funding provided by the Department of Health has enabled the production of videos, apps and training materials available free to the NHS. They have a range of resources to support parents and families as well as health professionals. This includes a Baby Buddy app for smart phone users which tracks and monitors a mum’s feelings and offers trigger information and support.
http://www.bestbeginnings.org.uk/babybuddy

NHS Choices – Postnatal depression

NHS England – Maternity Services review
http://www.england.nhs.uk/2015/06/22/julia-cumberlege-3

Netmums list of services in your area
http://www.netmums.com/parenting-support/postnatal-depression

The SMILE group
http://www.thesmilegroup.org

PANDAS (Pre) and Post Natal Depression Advice Group
http://www.pandasfoundation.org.uk

Best Beginnings
http://www.bestbeginnings.org.uk
Use of social media to link with women with lived experience of Perinatal Mental Health

The NHS Improving Quality team utilised Twitter to engage with women who have had experience of Perinatal Mental Health services. Two twitter chats were set up using the unique hashtag of #pnmhstories.

The first one took place on Tuesday 11th November in the evening and the second on Friday lunchtime on 14th November 2014.

For the Tuesday night session
- 14 people took part
- 75 retweets and 63 favourite tweets (measured during the hour of the Tweetchat session)
- The STORIFY summary is linked here https://storify.com/NHSIQ/pnmhstories-tweet-chat-11-november-2014

On Friday lunchtime
- 16 people took part
- 137 retweets and 211 favourite tweets measured of the hour long tweetchat session
- The STORIFY summary is linked here https://storify.com/NHSIQ/pnmhstories-tweet-chat-14-november

The conversation continued after the Tweetchats and as recently as January 2015, #pnmhstories has been used, showing engagement with the topic. The potential reach is difficult to measure as a number of the participants have followers in excess of 1000. This means any communications and conversation with these people have a potential to reach thousands of other people. Even if others do not engage in the conversation it does not mean that they are not aware of the content.

During the TweetChats, there have been interactions with over 30 people linking the hashtag #pnmhstories. There is difficulty in measuring conversation and communication that have not included the hashtag (#pnmhstories), as these are ‘lost’ in the general Twitter conversation. However, although it is difficult to measure the additional conversation, the interactions tracked by the NHS Improving Quality team have shown hundreds of tweets. These interactions have continued to build the relationships over a period of time, creating a community which is ready for action and engagement.

There were a number of women, fathers, doctors, midwives, a psychiatrist, support organisations and charities taking part in the chat. The conversation using the hashtag continued to be used over the following few days after the Tweet chat took place. A community of interest is being developed as we extend the reach and build on existing communications. A number of women have shared blogs detailing their experiences and some were happy to be contacted by phone to share them. The team has been contacted to ask if there will be more Twitter chats as the feedback was very positive for the two we ran. Since the chats a number of women have kept in contact with the NHS Improving Quality team and have met up in person. There is huge potential to develop this network as a community of interest.
Improving Access to Perinatal Mental Health Services in England - A Review
Knowing I wasn’t alone helped me, it made me feel normal at a time I wasn’t normal.

Better training for health care professionals to know warning signs and compassion.

In one town they wanted to fill me with antidepressants in another town I was supported by mental health midwife.

I felt ashamed and weak and unable to seek help because I felt like I should just get over it and get on with life.

Blog is helping me and hope it will help others.

I feel awareness needs raising amongst med professionals as much as the general public in some ways.

Specialist perinatal MH services fab with preventative work for having my 2nd baby after PP psychosis with 1st.

Yes definitely. Professional knowledge for spotting and treating PND can be very poor.

It would be good if more training were offered online for mums in this situation.

General MH services didn’t explain pp psychosis diagnosis or prognosis and didn’t give safe meds for breastfeeding.

Any opportunity for self-referral instead of needing to beg/bully a potentially unhelpful GP would be excellent.

Need for telephone call to get referral puts off mums suffering with PND/anxiety – phone too hard.

Was lucky if I saw same midwife twice.
Appendix 1

National guidance and recommendations

The following publications provide the key national guidance, expectations and recommendations of clinicians, health care providers and commissioners of Perinatal Mental Health services.


- Considerations for women of childbearing potential.
- Principles of care in pregnancy and post-natal period.
- Treatment decisions, advice and monitoring for women who are planning a pregnancy, pregnant or in post-natal period.
- Recognising mental health problems and referral.
- Assessment and care planning.
- Providing interventions.
- Treating specific mental health problems.
- Considerations for women and their babies in the post-natal period.
- The organisation of services.


This document highlights the role of maternity services in the early identification of high-risk women and assessment of current illness, and describes principles of service organisation for health providers to meet these needs. Recommendations to clinicians are currently based on the previous NICE standards.

- Pre-pregnancy - Women should be asked about history of mental illness or associated medications and referred to specialist Perinatal Mental Health services if necessary. It calls upon good communication between maternity, mental health and primary care teams.
- At booking – women should be asked about previous of current mental health issues, family history and explore risk factors e.g. domestic abuse.
- Antenatal care – each unit to have clear pathways for referral to specialised perinatal mental health services and protocols for risk identification, scans, etc.
- At each antenatal visit women should be asked about their current mental health.
- Post-partum - any change in mental state should be referred urgently and women of high risk of mental illness should be managed along high risk pathways with comprehensive care plans shared with health care professionals. Women need to know what support will be in place and who to contact if problems arise.
3. Standards for Maternity Care 200829 a joint working party publication from the Royal Colleges.

Provides guidance for the development of equitable, high-quality services across the UK and provides a valuable resource for commissioners and providers to plan and quality assure maternity services. Standard 8 (of 30) for managing pre-existing and developing mental health conditions in pregnancy includes seven standards for providers of maternity care covering:

1. History taking
2. Access to multidisciplinary care information
3. Written management plan
4. Access to specialist mother and baby units
5. Agreed pathways for referral to MH
6. Provision of culturally sensitive information
7. Staff competencies.

A set of indicators enable commissioners and providers to monitor clinical performance and implementation of the standards. This includes documentary evidence of:

- Local joint working arrangements within a Perinatal Mental Health network
- Information given to women at risk of or developing mental health problems in pregnancy
- Percentage of staff trained in mental health issues
- Percentage of maternity case notes recording that women are asked about family and personal history of mental health problems
- Percentage of at-risk women who received pre-pregnancy counselling
- Percentage of at-risk women with a written plan of care from booking.


The Confidential Enquiries into Maternal Deaths (CEMACH) reports for 1997–1999, 2000–2002 and 2003–2005 found that suicide and psychiatric causes were a leading cause of indirect maternal death in the UK. The reports highlight the need for availability of Perinatal Mental Health services for all women who need them. This most recent report identifies and examines incidence of maternal death and sets out ten overarching recommendations, which, where possible, are accompanied by suggested benchmarks and/or auditable standards to ensure more consistent implementation, monitoring and feedback. There were 37 cases of maternal death due to or associated psychiatric disorders in 2003-5 representing the third highest cause of maternal death in that time period.

5. Guidance for commissioners of Perinatal Mental Health services – Joint Commissioning Panel for Mental Health (JCP-MH) (2012)31

This provides a comprehensive practical guide for commissioners of Perinatal Mental Health services. It identifies ten key principles with focus on integration and collaboration across agencies. These include the need for Perinatal Mental Health strategies, integrated care pathways, accreditation of mother and baby units, formal links with specialised community Perinatal Mental Health teams, parent-infant services provided by child and adolescent mental health services (CAMHS). It also includes standards for admission to mother and baby units, IAPT, counselling services, training and data collection.
Other documents reviewed during this scoping exercise

1. The costs of Perinatal Mental Health problems[^32] – report estimates that the total economic cost of perinatal mental illness to society is £8.1 billion for each one year cohort of births. Costs calculated include: perinatal depression, anxiety and psychosis; adverse impacts on the child, which make up 72 per cent of the costs; and adverse impacts on the mother. It reports that one fifth of the total cost is borne by the public sector, mainly the NHS and social services. It estimates that a further NHS expenditure of £280 million a year (£400 per birth) would be needed in England to bring Perinatal Mental Health care up to the level recommended in national guidance.

2. 1001 Critical Days[^33] – a publication by the cross parliamentary group calls on a refocus on the first 1001 days of life from conception to 1 year. Their goal is for every baby to receive sensitive and responsive care from their main caregiver in the first year of life. Their report identified:
   - 26% of babies in the UK have a parent affected by domestic violence, mental health or drug/alcohol problems
   - Identifying needs early is critical to preventing the abuse and neglect of babies
   - A babies development can be dramatically improved with early and effective support
   - Damage early can cause stress related conditions in later life
   - High levels of stress in early childhood can be ‘toxic’ to the developing brain
   - Mental health problems affect 144,000 babies
   - Domestic violence affects 39,000 babies.

They identify a four tier approach to parent/infant services.

3. Prevention in Mind – All Babies Count – NSPCC and Maternal Mental Health Alliance[^34] (2013) – consolidates latest evidence about Perinatal Mental Health illness and makes a call to action for key decision makers at a national and local level to work together to close the gaps in services. The report outlines what success looks like with a vision that women who are at risk of, or suffering from mental illness are identified at the earliest opportunity and given appropriate and timely expert care which prevents their illness from occurring or escalating, and minimises the harm suffered by them and their families.

This report focus on the services and support needed for women who experience Perinatal Mental Health illnesses. It acknowledges the prevalence of depression amongst fathers and the need to support men whose partners are affected. Their report findings state:
   - There is a shortage of 5,000 midwives in England
   - 73% of maternity services do not have a specialist mental health midwife
   - 29% of midwives say they had received no content on mental health in the pre-registration training
   - 42% of GPs said they lacked knowledge about specialist services for people with severe mental illness
   - 40% of women say they saw a different midwife at every appointment
   - 41% say their health visitor never asked about depression
   - There is a shortage of 50 mother and baby beds.
This report also provides an overview of what a good service looks like and recommendations for improvement. The 21 recommendations grouped under five key recommendations are:

1. Universal services must be able to identify issues early and ensure that all women get the support they need
2. Timely psychological support must be available to all expectant and new mothers with mild or moderate mental illness
3. Women should all be able to access specialist Perinatal Mental Health teams and inpatient units when necessary
4. Services must address the impact of Perinatal Mental Health illnesses on babies and other family members
5. There must be strategic commissioning of Perinatal Mental Health care based on need.

4. Perinatal Mental Health: Experiences of Women and Health Care Professionals – Boots Family Trust Alliance (Oct 2013) – this report describes the key finding of a survey of 1,500 women and 2,000 health professionals. In the survey, women who had experienced some form of mental health problems participated. The results provide useful insight into the personal experience of the illness, reasons for illness, how they felt and the symptoms they experienced impact on relationships and the treatment that helped. Health care professionals identified that even when trained and confident in their skills to support women they lack time provision to adequately explore mental wellbeing. They also highlighted the lack of Perinatal Mental Health services available and the need for further resources to support the early identification of problems.

The report suggests fourteen steps for professionals working with women to adopt. These range from introducing the use of a ‘wellbeing plan’, improved sharing of documentation between professionals, myth busting, involvement of partners, minimum standards for midwife training to name a few.

5. No Health Without Perinatal Health – a series of publications in The Lancet (15 Nov 2014) ed by Professor L Howard reviews a wide spectrum of disorders that can occur in pregnancy and post-partum. They stress the need for recognition and treatment of perinatal mental illness. Professor Howard was on the committee that revised the NICE guidance.
## Appendix 2

The South West SCNs self-assessment against the NSPCC Prevention in Mind standards (Quarter 2, 2014/15)

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>Partly</th>
<th>No</th>
<th>Partially</th>
<th>Fully</th>
<th>Date</th>
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<tbody>
<tr>
<td>Is there a perinatal mental health service in your area? (This is a mental health service for pregnant women and women with perinatal mental health problems related to pregnancy, postnatal depression and postnatal psychosis.) Please note any other organisations providing perinatal mental health services that you are aware of in your area, e.g. charities, other NHS providers.</td>
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<tr>
<td>Does the maternity service in your area have a specialist mental health midwife championing the needs of women with perinatal mental illness? If so, please specify the Whole Time Equivalent of the specialist midwife and the training that has been received for this role.</td>
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<td>Is there a perinatal mental health specialist health visitor in your area? If so, please specify the Whole Time Equivalent of the mental health specialist health visitor and the training that has been received for this role.</td>
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<tr>
<td>Are there local clinical leadership to champion the needs of women with perinatal mental illness in your area? Please provide contact details.</td>
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<td>Are there mothers requiring inpatient psychiatric care in your area? Are they able to access to a nationally accredited Mother and Baby Unit?</td>
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<td>Are there prescription services in your area for women with long-term mental health issues? If so, please provide details.</td>
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<td>Are there services in place in your area for women planning a subsequent pregnancy who have experienced perinatal mental health issues previously? If so, please provide details.</td>
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<td>Is there an organisational perinatal mental health strategy in your area? If so, please provide details and a copy of the strategy.</td>
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<td>Do the Child and Adolescent Mental Health Services and Adult Mental Health Services in your area have a joint approach to perinatal and infant mental health? If so, please detail.</td>
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<td>Is data collected in your area regarding the need for perinatal mental health services to inform local commissioning and planning? If so, please detail who collects this data and who has access to it.</td>
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<td>Do the following staff in your area receive pre-registration training on perinatal mental illness? If so, please specify in content and who delivers it.</td>
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<td>Midwives</td>
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<td>Do the following staff in your area receive refresher training on perinatal mental illness? If so, please specify the frequency of this training, its content and who delivers it.</td>
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<td>Midwives</td>
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<td>Do you assess how comfortable and confident staff are asking women about their mental health? If so, please detail how this is assessed.</td>
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<td>Is a seamless service provided during the transition from Midwifery to Health Visitor-led care?</td>
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<td>Are Midwives, Health Visitors and GP’s in your area informed mothers and partners about perinatal mental illness? Please state how and when this is done.</td>
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<td>Health Visitors</td>
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<td>Is the emotional wellbeing of women routinely assessed? Please provide details, including frequency.</td>
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<td>Health Visitors</td>
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<td>Are notes about a women’s risks or symptoms of mental illness shared appropriately between professionals? Please note how this is done.</td>
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<td>Are the maternity and perinatal mental health services accessible to those who do not have English as their first language? Please specify what guidance is provided.</td>
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<td>Are the healthcare professionals in your area assessing the cultural needs of the communities that they serve? Please provide details.</td>
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<td>Are antenatal/maternity classes provided in your area? If so, please provide details of any content focused on perinatal mental health.</td>
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<td>Do the following staff in your area have access to sources of social support, including the opportunity to share experiences and support one another? Please detail where appropriate.</td>
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<td>Do services in your area include and support partners? Please specify how this is done.</td>
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<td>Are social/psychological support offered before prescribing medication to women with mild or moderate mental illness? Please provide details of how this is done.</td>
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<td>In additional support offered for those women who are prescribed medication? Please note in what form this is provided.</td>
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<td>Are women have access to individual and group therapeutic services, e.g. improved access to psychological therapies in your area? If so, please note service details, approximate waiting times and how this is monitored.</td>
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</table>
Improving Access to Perinatal Mental Health Services in England - A Review

References

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27 http://www.nice.org.uk/guidance/cg192
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