Thames Valley Children and Maternity Strategic Clinical Network

Scoping Report: Perinatal Mental Health Services within Thames Valley
Prepared by Michaela Finegan for the Thames Valley Children & Maternity SCN
Thames Valley Strategic Clinical Network
Children and Maternity:
Perinatal Mental Health Services Scoping

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Thames Valley Children & Maternity Strategic Clinical Network (TVSCN)

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Woman in pregnancy and postnatally are the most important population in mental health care

Dr Alain Gregoire. Consultant Hon Senior Lecturer in Perinatal Psychiatry. Southampton.
Chair of Maternal Mental Health Alliance

More than 1 in 10 women develop a mental illness during pregnancy or within the first year after having a baby.

Source www.everyonesbusiness.org.uk

July 2014
Amended January 2015
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Executive Summary

The purpose of this scoping report was to gather intelligence about the services available to women across Thames Valley, to look at current thinking and guidance, to consider what is deemed as ‘best practice’ and to make recommendation on next steps for the Thames Valley SCN Children & Maternity Steering Group.

Pregnancy and birth, an exciting time for many women, can be stressful and anxious for others. Estimates suggest that of 1000 live births, 200 women will suffer emotional distress and 1 – 2 women will develop a puerperal psychosis. Suicide is one of the leading causes of maternal death in the UK. There are short term and long-term effects of maternal mental health on the health and wellbeing of the child.

Improving perinatal mental health services is seen as a national priority and there is abundant evidence available to inform commissioners, primary care, mental health and maternity providers on best practice. (Section 2) Despite this a huge variation in care exists.
across England and has been clearly illustrated in a very recent review. [http://maternalmentalhealthalliance.org.uk](http://maternalmentalhealthalliance.org.uk)

In this review they state that almost half of the UK, women have no access to community specialist perinatal mental health service provision and not all of the services that do exist meet national quality standards. They estimate a shortfall of 60 specialist inpatient mother and baby unit beds (and accompanying staff) across the UK. National strategies are required to rectify this shortfall.

Their review shows that the Thames Valley has poorly resourced and poorly organised perinatal mental health services and this has been confirmed in our extensive discussions with maternity service providers and commissioners.

We have attempted a preliminary analysis of the available services (as described to us) for each county against a commissioning check list for CCGs (based on NICE guidance) with the following preliminary findings:

- No county has an established specialist perinatal mental health service that fulfils guidance requirements
- Training of maternity and primary care staff in perinatal mental health is highly variable within and across counties/CCGs
- The available specialist inpatient facilities are underused with mothers who have a primary diagnosis of puerperal psychosis admitted to other hospitals in Thames Valley

However we are encouraged that there is recognition across CCGs and maternity providers that provision of perinatal mental health services is a problem area and projects to improve perinatal mental health services have been initiated in Buckinghamshire and Oxfordshire; in addition there is extensive work either completed or underway in Berkshire.

We hope to use this preliminary scoping report to precipitate a process to:

- stimulate conversations and validate information assessed against standards
- share current good practice across Thames Valley (TV)
- facilitate a forum for development of a perinatal clinical network across TV and Milton Keynes
Section 1: Context

Pregnancy, birth and the postnatal period are a time of major psychological and social change for women as they negotiate their roles as mothers. So much so that more than 1 in 10 women develop a ‘mental illness’ during pregnancy or within the first year after having a baby. If these conditions are left untreated it can have a devastating impact on women, the babies and the families. Perinatal mental illness can be life threatening with suicide one of the leading causes of death for women during pregnancy /one year after birth.

Perinatal mental disorders are particularly significant as they have the potential to interfere with or prevent the development of mother-child attachment and the caregiving relationship. This can lead to longstanding, harmful effects on the child’s emotional, social and cognitive development (GLA 2014). One of the strongest predictors of wellbeing in childhood early years is the mental health and wellbeing of the mother or caregiver. Long term effects can also be demonstrated, for example, in a recent study the prevalence of depression at the age of 18 years was 41.5% in children of postnatally depressed mothers vs. 12% in controls (Murray et al 2011).

Therefore supporting mothers’ emotional wellbeing during the perinatal period has been recognized as being just as important as the traditional focus on the physical health of the mother and child. However across almost 50% of the UK, these pregnant women and new mothers do not have access to specialist perinatal mental health services. This has the potential impact of leaving them and their babies at risk.

The Maternal Mental Health Alliance’s (MMHA) new campaign – Everyone’s Business – calls for all women throughout the UK who experience perinatal mental health problems to receive the care they and their families need, wherever and whenever they need it. – (http://maternalmentalhealthalliance.org.uk)

The MMHA states that in almost half of the UK, women have no access to community specialist perinatal mental health service provision. Not all of the services that do exist meet national quality standards.

Many areas of the UK do not have local plans or strategies in place to ensure that NHS perinatal mental health services are available to local women and families, despite the development of comprehensive models that show these specialist services are necessary and possible.

Perinatal Mental Health (PNMH)

Definition; Perinatal mental health services provide specialist care for women who become ill during pregnancy or in the year after giving birth.

Perinatal mental health services are concerned with the prevention, detection and management of perinatal mental health problems that complicate pregnancy and the postpartum year. These problems include both new onset problems, recurrences of previous problems in women who have been well for some time, and those with mental health problems before they became pregnant. Promoting emotional and physical wellbeing and development of the infant is central to perinatal mental health services. Psychiatric disorder during pregnancy and following delivery is common in both new episodes and recurrences of pre-existing conditions.
Ten to fifteen per cent of new mothers are likely to develop a depressive illness in the year following the birth of their baby of whom between a third and a half will be suffering from a severe depressive illness. At least two in every hundred new mothers will be referred to a psychiatric team during this time and four women per thousand will be admitted to a psychiatric hospital, of whom two per thousand will be suffering from a puerperal psychosis.

All mental disorders in the antenatal and postnatal period may have a significant impact on the mother-infant relationship. In addition, the mother-father/partner and family relationship may be affected. It is reported that that psychiatric disorders contributed to 12% of all maternal deaths (10% of which were due to suicide).

If untreated, women may remain depressed, sometimes for many years, with consequent negative impact not only for the mother but also for other family members. The rate of recurrence of postnatal depression after a subsequent birth is about 30%.
Frequency and type of mental illness in pregnancy

<table>
<thead>
<tr>
<th>Condition</th>
<th>Rate per 1000 pregnancies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpartum psychosis</td>
<td>2</td>
</tr>
<tr>
<td>Chronic serious mental illness</td>
<td>2</td>
</tr>
<tr>
<td>Severe depressive illness</td>
<td>30</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>30</td>
</tr>
<tr>
<td>Mild-moderate depression and anxiety state</td>
<td>100-150</td>
</tr>
<tr>
<td>Adjustment disorder and distress</td>
<td>150-300</td>
</tr>
</tbody>
</table>

Maternal and professional feedback.

Despite the fact that nearly three in five women admit that they feel down or depressed after giving birth, 24.9% of 500 women polled by the Royal College of Midwives and Net-mums said that they were not asked how they were coping during post-natal visits from their maternity team.

Just 40% of 2,100 midwives questioned by the RCM said they have enough time to support and inform women about emotional well-being. Of 950 student midwives questioned, a quarter said they had not been taught enough theoretical knowledge about post-natal mental illness and 29% said they would not feel confident to recognise mental health problems in post-natal women.

In response to these findings Health minister Dan Poulter said: “Every woman should have a named midwife making sure they receive personalised care, which will help identify mental health problems early on.

Source; Maternal Mental Health Alliance / Royal College of Midwives

Commissioning

Clinical Commissioning Groups (CCGs) are responsible for commissioning maternity services and mental health services including perinatal mental health services. CCGs commission activity from those perinatal community teams that are not provided by or through Specialist Mother and Baby Units. CCGs commission all perinatal mental health services for women with non-psychotic conditions who are either not admission vulnerable or do not require such a high level of intensity.

Specialist commissioning are responsible for commissioning specialist perinatal mental health services.

“These are provided by Specialist Mother and Baby Units. Services include inpatients and associated non-admitted care including outreach provided by these units when delivered as part of a provider network. This applies to provision for adults and young people.

There are 17 Specialist Mother and Baby Units in England, 12 of which have integrated community teams. In their report, the Maternal Mental Health Alliance state there is an estimated shortfall of 60 specialist inpatient mother and baby unit beds (and accompanying staff) across the UK.

Specialist perinatal mental health services provide a safe and secure environment for the care of seriously mentally ill women and their infants. These psychiatric units are separate from other acute mental health admission facilities.
They provide care for women with serious mental illness including postpartum psychosis, schizophrenia, bipolar illness and other serious affective disorders and those with complex needs. They provide expert psychiatric care for the mother whilst at the same time ensuring the care of the infant and avoiding unnecessary separation of mother and baby.

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), about 2,750 women need access to Specialist Mother and Baby Units each year.

Specialist Perinatal Psychiatric (Outreach) Teams assess and manage women with serious mental illness or complex disorders in the community who would otherwise be admitted to the unit or who are in the transition phase from being an inpatient. Patients usually meet the following criteria:

- Women with acute serious mental illness in late pregnancy and the postpartum year
- Women discharged from Inpatient Mother and Baby Units
- Women for whom close collaborative working with the mother and baby unit is essential to avoid admission or promote early discharge
- Women with serious mental illness in pregnancy who require close collaborative working with Maternity Services and/or Adult Mental Health Services
- Women with pre-existing serious mental illness, particularly bipolar disorder and other serious affective disorders, who are at high risk of developing postpartum illness and require preventative and therapeutic interventions in pregnancy and the postpartum period
- Women who require high intensity of specialist community input on a weekly or more frequent basis

Specialist Perinatal Psychiatric (Outreach) Teams also offer preconception counselling to women with pre-existing serious mental health disorders and those who are well but at high risk of a postpartum condition. “

*NHS manual for prescribed specialist services.*

**Economics**

A report on the economic burden and the costs of providing treatment associated with perinatal mental health conditions is being prepared by the London School of Economics and will be available end October 2014.
Section 2: National Policy & Guidance

The NHS England Strategic and Operating Plan [http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf) has a number of references to mental health including improvements to IAPT, and for perinatal mental health focusing on postnatal depression. The NHS mandate requires NHS England to ‘reduce the incidence and impact of postnatal depression through earlier diagnosis, and better intervention and support’. Over the past few years there has been a plethora of reports and evidence based guidance to help clinicians, managers and commissioners ensure that adequate good quality services are available.

1. **NICE Antenatal and postnatal mental health**: Clinical management and service guidance was published in 2007 and is under review with the recommendations currently out for consultation (publication date December 2014). This gives detailed advice on the steps midwives; health visitors or general practitioners should take to identify problems and when referral should be made for specialist help. It provides detailed guidance on evidence based interventions and provides recommendations on the organisation of services – these have not changed since 2007.

"1.8 The organisation of services

1.8.1 Women who need inpatient care for a mental health problem within 12 months of childbirth should normally be admitted to a specialist mother and baby unit, unless there are specific reasons for not doing so. [2007]

1.8.2 Managers and senior healthcare professionals responsible for perinatal mental health services (including those working in maternity and primary care services) should ensure that:

- There are clearly specified care pathways so that all primary and secondary healthcare professionals involved in the care of women during pregnancy and the postnatal period know how to access assessment and treatment
- Staff has supervision and training, covering mental health problems, assessment methods and referral routes, to allow them to follow the care pathways. [2007]

1.8.3 Clinical networks should be established for perinatal mental health services, managed by a coordinating board of healthcare professionals, commissioners, managers, and service users and carers. These networks should provide:

- A specialist multidisciplinary perinatal service in each locality, which provides direct services, consultation and advice to maternity services, other mental health services and community services; in areas of high morbidity these services may be provided by separate specialist perinatal teams
- Access to specialist expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding
- Clear referral and management protocols for services across all levels of the existing stepped-care frameworks for mental health problems, to ensure effective transfer of information and continuity of care
- Pathways of care for service users, with defined roles and competencies for all professional groups involved. [2007]

1.8.4 Each managed perinatal mental health network should have designated specialist inpatient services and cover a population where there are between 25,000 and 50,000 live births a year, depending on the local psychiatric morbidity rates. [2007]

1.8.5 Specialist perinatal inpatient services should:

- Provide facilities designed specifically for mothers and babies (typically with 6–12 beds)
- Be staffed by specialist perinatal mental health staff
- Be staffed to provide appropriate care for infants
- Have effective liaison with general medical and mental health services
- Have available the full range of therapeutic services
- Be closely integrated with community-based mental health services to ensure continuity of care and minimum length of stay. [2007] "[http://guidance.nice.org.uk/CG45](http://guidance.nice.org.uk/CG45)"
2. **The Joint Commissioning Panel for Mental Health** in November 2012 produced Guidance for commissioners of perinatal mental health services. This excellent document gives clear information on the service, provides information on what good perinatal services should look like and gives 10 key messages for commissioners. (See below) [www.jcpmh.info](http://www.jcpmh.info)

### Ten key messages for commissioners

1. Ensure that a regional perinatal mental health strategy is present and that all providers of care for perinatal mental health problems are participating.

2. Ensure that there is a perinatal mental health integrated care pathway in place which covers all levels of service provision and severities of disorder. All service providers should be compliant with this so that there is equitable access to the right treatment at the right time by the right service.

3. Mother and baby units should be accredited by the Royal College of Psychiatrists’ quality network for perinatal services, and have formal established links with a number of specialised community perinatal mental health teams in their region.

4. Specialised perinatal community mental health teams should be members of the Royal College of Psychiatrists’ quality network for perinatal services and should care manage serious mental illness. They should have a formal link with a mother and baby unit.

5. Parent-infant services provided by child and adolescent mental health services (CAMHS) and maternal mental health teams provided in primary care and by non-health organisations are an addition to, not a substitute for, services provided for women with serious mental illness. They should work collaboratively with specialist services.

6. When commissioning adult mental health services there is a need to ensure that:
   - these either provide a mother and baby unit, or have formal links to ensure access to one
   - all women requiring admission in late pregnancy or after delivery are admitted with their infant to a mother and baby unit not an adult admission ward

7. Ensure that adult mental health services:
   - counsel women with serious affective disorder about the effects of pregnancy on their condition
   - provide information and advice about possible effects of their medication on pregnancy
   - provide additional training to psychiatric teams about perinatal mental health
   - routinely collect data on which female patients are pregnant or in the postpartum (following childbirth) year.

8. Ensure that when commissioning maternity services the needs of pregnant and postnatal patients are met. This includes:
   - mothers receiving additional training in perinatal mental health and the detection of at-risk patients
   - maternity services asking all women at early pregnancy assessment about previous psychiatric history, and referring or those with a part history of serious mental illness
   - maternity services should routinely inform the GP about the pregnancy, and ask for further information

9. Ensure that when commissioning IAPT services (Improving Access to Psychological Therapies) that the needs of pregnant and postnatal patients are met. This includes:
   - routinely collecting data on whether referrals are pregnant or in the postpartum year
   - receiving additional training in perinatal mental health
   - ensuring that pregnant and postpartum women are assessed and treated within three months.

10. Ensure that when commissioning primary care services that the needs of pregnant and postnatal patients are met. This includes:
    - General Practitioners (GPs) and other primary care staff receiving additional training in perinatal mental health
    - GPs and other primary care staff being made familiar with the perinatal mental health integrated care pathway
    - Health Visitors receiving additional training in perinatal mental health.

3. **The Perinatal Quality Network for Perinatal Mental Health Services** has produced Services standards: second edition for Perinatal Community Mental Health Services in April 2014. These are best practice statements produced by members of the Specialist Perinatal Mental Health Services Network at the Royal College of Psychiatrists. [http://www.rcpsych.ac.uk](http://www.rcpsych.ac.uk)
4. Maternal Mental Health Alliance (MMHA) The Maternal Mental Health Alliance is a coalition of over 60 UK organisations committed to improving the mental health and wellbeing of women and their children in pregnancy and the first postnatal year. They are motivated by the current shortfall in the quality, availability and accessibility of antenatal and postnatal mental health care and the lack of knowledge about this issue amongst health and social work professionals and the wider public and have just launched a campaign calling for equitable access to high quality services for women with, or at high risk of, mental illness in pregnancy and post-natally. #everyonesbusiness. Their website aims to provide the key information and tools to support commissioners and service providers to make improvements. www.everyonesbusiness.org.uk http://maternalmentalhealthalliance.org.uk/ The Maternity Alliance has produced a check list for CCG commissioners for locality needs based on the reports above (NICE 2007, Joint Commissioning Panel for Mental Health Guidance for commissioners 2012.)

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<tbody>
<tr>
<td>1</td>
<td>Have the numbers of women needing care / treatment been calculated based on the most up-to-date birth rate for your locality &amp; the above statistics?</td>
</tr>
<tr>
<td>2</td>
<td>Is there a specialist perinatal mental health service including a funded consultant perinatal psychiatrist and access to psychological therapy; providing direct services, consultation &amp; advice to maternity services, other mental health services &amp; community services?</td>
</tr>
<tr>
<td>3</td>
<td>Do health and social care professionals (including Crisis and Home Treatment teams) ensure women needing inpatient care are referred to a designated specialist psychiatric inpatient Mother and Baby unit?</td>
</tr>
<tr>
<td>4</td>
<td>Does your specialist perinatal mental health service provide advice to health &amp; social care professionals (and women themselves) on risks and benefits of psychotropic medication during pregnancy and breastfeeding?</td>
</tr>
<tr>
<td>5</td>
<td>Are there clear pathways of care, referral and management protocols for women with perinatal mental illness? Do these take into account that 7 out of 10 women will hide their illness /severity?</td>
</tr>
<tr>
<td>6</td>
<td>Do all relevant health &amp; social care professionals, including midwives, GPs and health visitors, access regular training in perinatal mental illness &amp; specialist perinatal mental health care? Does this training involve hearing first-hand experience from service users?</td>
</tr>
<tr>
<td>7</td>
<td>Is information readily available for women and their partners, and is this routinely discussed in appropriate contacts with health and children’s services? Are teenagers, including those leaving the care system, and women with a pre-existing bi-polar disorder included in information dissemination? Is information available in all languages?</td>
</tr>
<tr>
<td>8</td>
<td>Is your locality part of a regional perinatal clinical network (covering a population of 25- 50k live births a year), managed by a coordinating board of commissioners, health care professionals, managers, service users and carers?</td>
</tr>
</tbody>
</table>

5. The Royal College of Midwives published one of its series of Pressure Point documents on maternal mental health – improving emotional wellbeing in postnatal care In January 2014. (https://www.rcm.org.uk/content/pressure-points) This document reports on
surveys from midwives, maternity support workers, student midwives and mothers (through netmums.com) on experience in the postnatal period. It found that NHS staff did not have the time or confidence to deal with mental health issues and were uncertain about referral. They suggest 4 areas need to be addressed.

1. Education commissioners and providers should review pre-registration and continuing professional development programmes to ensure that midwives gain the knowledge, skills and confidence to deal with perinatal mental health issues. Once qualified, midwives should be encouraged to attend refresher training related to perinatal mental health.

2. Every maternity service provider should employ at least one specialist perinatal mental health midwife.

3. The establishment of more Mother and Baby Units, with sufficient beds, in order to ensure that Women with serious mental illness in late pregnancy or in the first year of their baby’s life should have access to an accredited unit.

4. Commissioners and providers of maternity services must develop and implement a perinatal Mental health strategy in order to ensure that:
   - The needs of women with perinatal mental health issues are recognised and addressed.
   - Funding arrangements support preventative work and promote Multi-professional collaboration.
   - Commissioning, planning and service delivery are based on accurate information, so that issues are identified early and women get the support that they need.

They also expand on the role of the Midwife.

- The provision of high quality antenatal and postnatal care allows both for early detection and better universal health promotion for all women and families;
- Specialist midwives, working alongside other services, can provide valuable support to women and families in respect of public health issues such as smoking cessation or substance misuse;
- Midwives working for or alongside the Family Nurse Partnership or the Troubled Families Programme can provide the most disadvantaged or marginalised families with targeted support, particularly in relation to developing parenting skills.

Ensuring that a midwife assesses a woman by no later than her twelfth week of pregnancy is particularly critical and can have a positive influence on the health and wellbeing of both mother and baby. The midwife can

- Promote the health emotional wellbeing and positive mental health of the mother
- Prepare mothers and fathers for parenthood
- Promote the neurological development of the child, the negative impact of stress and the importance of attachment

The midwife can also use the assessment to notify the health visiting team of the pregnancy and the needs of the family and, in the case of women with complex social factors, alerting other health and social care agencies.

Other practical actions that midwives can undertake during the antenatal period include:

- Encouraging an anxious or depressed pregnant woman to consult her GP or link her with local groups that support pregnant women who are anxious or depressed. The midwife can also encourage the woman to be ‘mindful’, which may increase feelings of being in control.
- Referring a woman who abuses substances to an appropriate pre-birth assessment and intervention by social services or offering the support of a dedicated substance/alcohol misuse support worker.
• Screening for domestic abuse, offering multiple opportunities for a woman to make a disclosure about domestic abuse and encouraging the woman to refer herself to social services or an agency that supports victims of domestic abuse.

The RCM suggest that each locality consider the importance of having a specialty mental health midwife in place. The role is to coordinate the activities around Mental Health support. The midwife needs to have a clear understanding of the statistics and consider key links to social care.

6. The NSPCC are very involved in raising awareness of perinatal mental health and the need for improving services. They produced a report in 2013 (see link below) and this year have issued a Freedom of Information request (FOI) on what perinatal mental health services and support is available across the country. The findings are expected to be published at the end of August 2014. Some of the questions posed included asking if a specialty mental health midwife is in place in a unit. For example, Head of Midwives at NHS Trusts were asked?

• Do you have a specialist-trained midwife in place?
• What qualifications did they have?
• What do they do?

The idea is to gain an understanding of the provision available, build a specification of what a specialist midwife would do and what qualifications they would have. All Heads of Midwifery were polled. There is a perception that Midwives in Scotland are further ahead with their provision and support than we are in England.

http://www.nspcc.org.uk/inform/resourcesforprofessionals/underones/spotlight-mental-health-landing_wda96578.html
Section 3: Key Findings: Overview of existing service in Thames Valley / including key contacts and organisations

Purpose: The purpose of this scoping report is to gather intelligence about the services available to woman across Thames Valley, to look at current thinking and guidance, to consider what is deemed as ‘best practice’ and to make recommendation about what could be next steps for the Thames Valley SCN Children & maternity Steering Group.

The Maternal Mental Health Alliance issued a coloured coding map showing the service provision of perinatal mental health services across the UK. The details for the local Thames valley area are shown below. It gives a fairly bleak picture for the woman and families in our region. This summary is in line with my findings in relation to what is available. However it should be noted that although services provision is variable there is a great deal of positivity and drive to make improvements.

By Thames Valley CCG; Specialist Community Perinatal Mental Health Services as determined by the Maternal Mental Health Alliance (MMHA) July 2014

<table>
<thead>
<tr>
<th>Area</th>
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<tbody>
<tr>
<td>Aylesbury Vale</td>
</tr>
<tr>
<td>Bracknell And Ascot</td>
</tr>
<tr>
<td>Chiltern</td>
</tr>
<tr>
<td>Milton Keynes</td>
</tr>
<tr>
<td>Newbury And District</td>
</tr>
<tr>
<td>North &amp; West Reading</td>
</tr>
<tr>
<td>Oxfordshire</td>
</tr>
<tr>
<td>Slough</td>
</tr>
<tr>
<td>South Reading</td>
</tr>
<tr>
<td>Windsor, Ascot And Maidenhead</td>
</tr>
<tr>
<td>Wokingham</td>
</tr>
<tr>
<td>West Hampshire (Inc. Winchester) / North Hampshire / East Hampshire</td>
</tr>
<tr>
<td>/ Southampton</td>
</tr>
</tbody>
</table>
LEVEL COLOUR CRITERIA

5  Specialised perinatal community team. Perinatal Quality Network Standards Type 1
   http://www.rcpsych.ac.uk/pdf/Perinatal%20Community%20Standards%201st%20edition.pdf

4  Specialised perinatal community team that meets Joint Commissioning Panel criteria
   http://www.rcpsych.ac.uk/pdf/perinatal_web.pdf

3  Perinatal community service operating throughout working hours with at least a
   specialist perinatal psychiatrist with dedicated time AND specialist perinatal mental
   health nurse with dedicated time, with access to a perinatal psychiatrist throughout
   working hours

2  Specialist perinatal psychiatrist AND specialist perinatal nurse with dedicated time

1  Specialist perinatal psychiatrist or specialist perinatal nurse with dedicated time only

0  No provision

Disclaimer  Levels of provision in this map have been assessed using the best information available to us from
local experts but have not been independently verified. Please contact info@everyonesbusiness.org.uk if you
suspect any inaccuracy or know of recent developments that may alter the level of provision level in any area
listed here.

Perinatal mental health numbers per CCG.

<table>
<thead>
<tr>
<th>CCG</th>
<th>Births 2012</th>
<th>Estimated births 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rate per 1000</td>
<td>Chronic serious mental illness</td>
</tr>
<tr>
<td>Slough</td>
<td>2703 2805</td>
<td>2 6 2 30 30 125 225</td>
</tr>
<tr>
<td>Bracknell and Ascot</td>
<td>1701 1745</td>
<td>3 6 3 52 52 218 393</td>
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<tr>
<td>Windsor</td>
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<td>N and W Reading</td>
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<td>Newbury</td>
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<td>South Reading</td>
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<tr>
<td>Wokingham</td>
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<td>Aylesbury Vale</td>
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</tr>
<tr>
<td>Milton Keynes</td>
<td>3918 4138</td>
<td>8 8 8 124 124 515 927</td>
</tr>
<tr>
<td>Total TV and MK</td>
<td>30984 32301</td>
<td>65 65 65 969 969 4038 7268</td>
</tr>
</tbody>
</table>


Specialist commissioning.

The services provided by specialist commissioning for the Thames Valley are underused. The nearest Mother and Baby Unit is in Winchester. (Southern Health NHS Foundation Trust) This unit is well evaluated unit and seen as offering a ‘best practice’ service. From HES data with primary diagnosis puerperal psychosis the following information on maternal admissions is available by CCG.

<table>
<thead>
<tr>
<th>CCG</th>
<th>Bucks Health-care</th>
<th>Frimley Park</th>
<th>Oxford Health</th>
<th>Oxford University Hospital</th>
<th>Southern Health Trust</th>
<th>Grand Total</th>
</tr>
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<td>BRACKNELL AND ASCOT</td>
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<tr>
<td>WOKINGHAM</td>
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<td><strong>2011-12 Total</strong></td>
<td><strong>1</strong></td>
<td><strong>1</strong></td>
<td><strong>2</strong></td>
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<tr>
<td>CHILTERN</td>
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<tr>
<td>NORTH &amp; WEST READING</td>
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<tr>
<td>WINDSOR, ASCOT AND MAIDENHEAD</td>
<td></td>
<td>1</td>
<td>1</td>
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<tr>
<td>WOKINGHAM</td>
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<td>1</td>
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<tr>
<td><strong>2012-13 Total</strong></td>
<td><strong>2</strong></td>
<td><strong>1</strong></td>
<td><strong>4</strong></td>
<td><strong>7</strong></td>
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</table>

Revealing that in 2011-12 only 5 out of 9 admissions were to the Mother and Baby unit and in 2012-13 only 4 out of 7.
Buckinghamshire:

Bucks Healthcare NHS Trust working with Bucks CC to implement an improved service and introduce a pathway as there is nothing structured in place. Women that suffer from mild depression, the ‘baby-blues’ have a wide range of locally available groups or informal services. There can be referral to ‘talking therapies e.g. Healthy Minds. (As per IAPT) but these are only accessed when a woman is referred by the midwife, health visitor or her GP.

If there is a case of a severely depressed woman or known cases of psychosis, the woman would be put under consultant care for her pregnancy and ‘closely observed’ and concerns would be referred back to the GP / consultant for referral, which could mean specialist services like those provided in the Winchester ‘mother & baby unit’.

For woman who may fall in the middle of these situations, it is hard to define where a pathway exists. This has been confirmed by both the Council (Bucks CC commissioners) and the NHS partners e.g. Stoke Mandeville and Bucks Healthcare Trust.

Actual referral data (provided by the CCG) is as follows:

Healthy Minds (IAPT):
01/01/13 to 31/12/13 - 2,669 women (aged 18-40) referred and 1874 women treated
46 women (2.5 % of women treated) aged18-40 had post-natal depression (Others detected but not identified as primary referral.)

CMHT & CAMHS data presently unavailable

MBU Winchester – no data available

There is a firm plan in place to improve these services offered to woman and a working party has been set up, with support being given by colleagues in both Oxfordshire and Berkshire. Jackie Prosser (project lead for mental health Chiltern CCG) is leading this work. There is a project with both Buckinghamshire CCGs, which is supported by the Public Health team who provided funds from the HV transformation funds to develop and improve the management of perinatal mental health by the HV service. The aim is to develop and implement a Perinatal and Infant Mental Health Pathway across Buckinghamshire.

- **Integrated infant and perinatal quality marker document** - this document outlines the quality improvements recommended by the countywide Perinatal MH Pathway Group and is being used to inform the pathway for Buckinghamshire.
- **Perinatal Mental Health Action Plan** - this document outlines progress in relation to HV Transformation Fund and additional actions
<table>
<thead>
<tr>
<th></th>
<th>BUCKINGHAMSHIRE</th>
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<tbody>
<tr>
<td>1</td>
<td>Have the numbers of women needing care / treatment been calculated based on the most up-to-date birth rate for your locality &amp; the above statistics?</td>
<td>YES</td>
</tr>
<tr>
<td>2</td>
<td>Is there a specialist perinatal mental health service including</td>
<td>NO</td>
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<tr>
<td></td>
<td>• a funded consultant perinatal psychiatrist and access to psychological therapy;</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td>• providing direct services,</td>
<td>YES</td>
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<tr>
<td></td>
<td>• consultation</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>• advice to maternity services, other MH health &amp; community services?</td>
<td>YES</td>
</tr>
<tr>
<td>3</td>
<td>Do health and social care professionals (including Crisis and Home Treatment teams) ensure women needing inpatient care are referred to a designated specialist psychiatric inpatient Mother and Baby unit?</td>
<td>As appropriate</td>
</tr>
<tr>
<td>4</td>
<td>Does your specialist perinatal mental health service provide advice to health &amp; social care professionals (and women themselves) on risks and benefits of psychotropic medication during pregnancy and breastfeeding?</td>
<td>UNCLEAR</td>
</tr>
<tr>
<td>5</td>
<td>Are there clear pathways of care, referral and management protocols for women with perinatal mental illness?</td>
<td>IN PLANNING STAGES</td>
</tr>
<tr>
<td></td>
<td>Do these take into account that 7 out of 10 women will hide their illness /severity?</td>
<td>IN PLANNING STAGES</td>
</tr>
<tr>
<td>6</td>
<td>Do all relevant health &amp; social care professionals, including midwives, GPs and health visitors, access regular training in perinatal mental illness &amp; specialist perinatal mental health care? Does this training involve hearing first-hand experience from service users?</td>
<td>NO but IN PLANNING STAGES</td>
</tr>
<tr>
<td>7</td>
<td>Is information readily available for women and their partners, and is this routinely discussed in appropriate contacts with health and children's services? Are teenagers, including those leaving the care system, and women with a pre-existing bi-polar disorder included in information dissemination? Is information available in all languages?</td>
<td>IN PART IMPROVEMENTS IN PLANNING STAGES</td>
</tr>
<tr>
<td>8</td>
<td>Is your locality part of a regional perinatal clinical network (covering a population of 25- 50k live births a year), managed by a coordinating board of commissioners, health care professionals, managers, service users and carers?</td>
<td>NO but IN PLANNING STAGES</td>
</tr>
</tbody>
</table>
**Oxfordshire**

Oxford Health NHS Foundation Trust provide The Infant-Parent Perinatal Service (IPPS) which is a tier two specialist nurse led service for women during pregnancy and families up until the baby is one year old where there might be mild- moderate mental health problems related to being pregnant or problems bonding with the baby. This is a small team offering flexible treatment and support covering the whole of Oxfordshire.

IPPS also works closely with the health visitors in Oxfordshire who have been providing structured postnatal depression groups for the last 10 years. IPPS offers training to the health visitors in facilitating the groups and provides regular clinical supervision while the groups are running. Currently there are six groups running for ten weeks each term.

IPPS also provides teaching sessions in perinatal mental health to midwives as part of their mandatory training. Teaching is also offered by IPPS to student nurses and midwives at Oxford Brookes University in perinatal mental health and also advanced training to health visitors in clinical skills in working with complex families and in attachment.

There is also a telephone consultancy service to GPs, Social workers and other clinical teams.

IPPS also attends a monthly perinatal mental health antenatal clinic at the John Radcliffe Hospital and liaises closely with the public health midwives and the specialist consultant obstetrician. There are clear referral pathways both antenatally and postnatally for referral into mental health services.

If a woman is already known to adult mental health services, she would be referred back to the team. Even if this meant that a woman had used the services for a number of years, if previously on a caseload, she would be referred back to adult mental health team. If a woman who was previously under psychiatric care became pregnant, she would be put on an as ‘high risk’ category. It would also be the case that social services would be informed. Woman with complex needs or alcohol and drug dependant would also be defined as potentially ‘high risk’. There is a 24-hour on call assessment process.

If a mother was under 18, there is a different process and they would be referred through to the CAMHS service. High-risk woman ideally should have daily postnatal visits to mum and baby, by the appropriate professional.

In the acute Trusts, there is a campaign called ‘Every Contact Counts’ where health professionals can use every contact with a woman to define aspects of health including mental health. The Trusts also use Mindfulness as a programme of support for woman.

There is work underway in Oxfordshire to improve perinatal mental health services, including supporting and training the Health Visitors across the region.
<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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<tbody>
<tr>
<td>OXFORDSHIRE - Have the numbers of women needing care / treatment been calculated based on the most up-to-date birth rate for your locality &amp; the above statistics?</td>
<td>YES</td>
</tr>
<tr>
<td>Is there a specialist perinatal mental health service including a funded consultant perinatal psychiatrist and access to psychological therapy; providing direct services, consultation &amp; advice to maternity services, other mental health services &amp; community services?</td>
<td>NO NO YES YES</td>
</tr>
<tr>
<td>Do health and social care professionals (including Crisis and Home Treatment teams) ensure women needing inpatient care are referred to a designated specialist psychiatric inpatient Mother and Baby unit?</td>
<td>YES – as required</td>
</tr>
<tr>
<td>Does your specialist perinatal mental health service provide advice to health &amp; social care professionals (and women themselves) on risks and benefits of psychotropic medication during pregnancy and breastfeeding?</td>
<td>NO</td>
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<tr>
<td>Are there clear pathways of care, referral and management protocols for women with perinatal mental illness?</td>
<td>YES IN PART</td>
</tr>
<tr>
<td>Do these take into account that 7 out of 10 women will hide their illness /severity?</td>
<td>NO IN PLANNING STAGES TO ENSURE 100%</td>
</tr>
<tr>
<td>Do all relevant health &amp; social care professionals, including midwives, GPs and health visitors, access regular training in perinatal mental illness &amp; specialist perinatal mental health care?</td>
<td>NO IN PLANNING STAGES TO ENSURE 100%</td>
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<tr>
<td>Does this training involve hearing first-hand experience from service users?</td>
<td></td>
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<tr>
<td>Is information readily available for women and their partners, and is this routinely discussed in appropriate contacts with health and children’s services?</td>
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<tr>
<td>Are teenagers, including those leaving the care system, and women with a pre-existing bi-polar disorder included in information dissemination?</td>
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<tr>
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<tr>
<td>Is your locality part of a regional perinatal clinical network (covering a population of 25- 50k live births a year), managed by a coordinating board of commissioners, health care professionals, managers, service users and carers?</td>
<td>NO</td>
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</table>
**Berkshire**

Across the Thames Valley region, it is Berkshire that has the most robust service provision. There is excellent training available for midwives, health visitors and other appropriate health and social care colleagues. It raises awareness of the conditions, what to look for and importantly where to refer woman in need. It has to be noted that the service is not well financed and much of the service provision has grown through dedicated hard work and passion of a few dedicated individuals. They admit that if there is sickness or if people left or moved roles there would be a deficit which may be hard to fill.

There are clear and very strong links to colleagues in Winchester and they refer appropriate cases to the Mother and Baby unit.

Service provision in Berkshire is probably the most organised and established although there are still areas for improvement. There is a common point of entry; referrals are up by 25% which is felt is attributed to increased awareness and recent training in local health professionals. Regarding the referrals - ¼ to acute services, ¼ are closed, ¼ to talking therapies, the remainder may be to local groups etc., relaxation classes etc. There is a named PNMH lead (specialist midwife) in the area, who is involved principally in clinical work.

It is reported that the service in Berkshire has reduced acute admissions in the first year.

The awareness training has been delivered to over 850 health professionals including midwives at Royal Berkshire Hospital and Wexham Park. In fact 100% of midwives at WP and RB have been trained and 75% of midwives at Frimley Park Hospital have received training. There has also been training with local health visitors and social care colleagues. There has also been a very well attended conference, which created greater awareness of the issue and the potential referral choices. One very positive improvement is the tracking of woman, the numbers of referrals, outcomes and the changes over time. This will support both commissioners and providers.

There is a process in place where ‘Emotional Wellbeing’ elements are to be included into the handheld records a pregnant woman holds.

However successful the service is in Berkshire it is recognised there are still areas in which improvements could be made. There needs to be more engagement and awareness with primary care colleagues. There is was also comment that coding of PNMH issues could be improved and therefore better tracked and information could be improved for both commissioners and providers. In terms of the checklist below, there are identified areas such as requirement for more trained health professionals.
<table>
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<tr>
<th>BERKSHIRE</th>
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<tr>
<td>Have the numbers of women needing care / treatment been calculated based on the most up-to-date birth rate for your locality &amp; the above statistics?</td>
<td>YES</td>
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<tr>
<td>Is there a specialist perinatal mental health service including</td>
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<tr>
<td>a funded consultant perinatal psychiatrist and</td>
<td>NO</td>
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<tr>
<td>access to psychological therapy; providing direct services,</td>
<td>NO</td>
</tr>
<tr>
<td>consultation &amp; advice to maternity services,</td>
<td>YES</td>
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<tr>
<td>other mental health services &amp; community services?</td>
<td>YES</td>
</tr>
<tr>
<td>Do health and social care professionals (including Crisis and Home Treatment teams) ensure women needing inpatient care is referred to a designated specialist psychiatric inpatient Mother and Baby unit?</td>
<td>YES</td>
</tr>
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<td>Does your specialist perinatal mental health service provide advice to health &amp; social care professionals (and women themselves) on risks and benefits of psychotropic medication during pregnancy and breastfeeding?</td>
<td>IN PART</td>
</tr>
<tr>
<td>Are there clear pathways of care, referral and management protocols for women with perinatal mental illness?</td>
<td>YES</td>
</tr>
<tr>
<td>Do these take into account that 7 out of 10 women will hide their illness /severity?</td>
<td>IN PART</td>
</tr>
<tr>
<td>Do all relevant health &amp; social care professionals, including midwives, GPs and health visitors, access regular training in perinatal mental illness &amp; specialist perinatal mental health care?</td>
<td>YES (service users and families have been involved)</td>
</tr>
<tr>
<td>Does this training involve hearing first-hand experience from service users?</td>
<td></td>
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<tr>
<td>Is information readily available for women and their partners, and is this routinely discussed in appropriate contacts with health and children’s services?</td>
<td>YES</td>
</tr>
<tr>
<td>Are teenagers, including those leaving the care system, and women with a pre-existing bi-polar disorder included in information dissemination?</td>
<td>UNCLEAR</td>
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<tr>
<td>Is information available in all languages?</td>
<td>YES- as requested</td>
</tr>
<tr>
<td>Is your locality part of a regional perinatal clinical network (covering a population of 25- 50k live births a year), managed by a coordinating board of commissioners, health care professionals, managers, service users and carers?</td>
<td>NO</td>
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**Milton Keynes**

Please note that at the time of writing this scoping paper Milton Keynes wasn’t part of TVSCN and so was not covered in the initial scoping exercise. It will be included in future development and progress of a TV Perinatal Mental Health Network as it is now part of TVSCN and Milton Keynes services will undergo a scoping exercise as for the other counties.
Section 4. Conclusions and Provisional Recommendations for progressing project
We have attempted a preliminary analysis of the available services (as described to us) for each county against a commissioning check list for CCGs (based on NICE guidance) with the following preliminary findings:

- No county has an established specialist perinatal mental health service that fulfils guidance requirements
- Training of maternity and primary care staff in perinatal mental health is highly variable within and across counties/CCGs
- The available specialist inpatient facilities are underused with mothers who have a primary diagnosis of puerperal psychosis admitted to other hospitals in Thames Valley

We recommend that:

All maternity service providers should ensure

1. All midwives are trained and feel confident to
   a. Ask the right questions to detect mental health problems prenatally and postnatally
   b. Know when to refer and how and who to refer to
2. They have an identified specialist mental health midwife
3. They have evidence of a continuing educational development programme in perinatal mental health available to all staff

Each CCG should ensure their population has

1. Access to an identified perinatal mental health service which follows national guidance and has at its core minimum
   a. A Consultant Perinatal Psychiatrist
   b. One or more perinatal community psychiatric nurses.
2. Access to a mother and baby unit for all cases where the mother needs to be admitted
3. Primary care staff (General practitioners and Health visitors) who feel confident to
   a. Ask the right questions to detect mental health problems prenatally and postnatally
   b. Know when to refer and how and who to refer to
4. Evidence of a continuing educational development programme in perinatal mental health available to all primary care staff.

And that they commission their services to be compliant with NICE guidance

The SCN Maternity and Children’s Steering group should consider a process to use this preliminary scoping report to engage with maternity services providers and CCGs to:

- Validate the information gathered and assess against standards
- Share current good practice across CCGs
- Facilitate the development of a perinatal clinical network across TV and MK.

The Steering group should also consider adding ‘improvements to Perinatal Mental Health’ to the TV SCN work plan.
Section 5: Appendices; Key Contacts, Documents, Support Organisations and Good practice examples

National Contacts and links

The Royal College of Midwives 15 Mansfield St, London, W1G 9NH Tel: 0300 303 0444.

National Organisations / Lobbying / policy making
http://maternalmentalhealthalliance.org.uk

National Support Groups and Helplines:
- **Action Postpartum Psychosis**
- **Association of Postnatal Illness**
  - Telephone support available Monday to Friday 10.00am and 2.00pm on 020 7386 0868
  - Email support: info@apni.org
- **Maternal OCD**
  - Email support: info@maternalocd.org
- **PANDAS**
  - Telephone helpline available Monday to Sunday 9am-8pm on 0843 28 98 401
- **Fathers Reaching Out** email support: fathersreachingoutpmh@gmail.com
- **MIND**: Tel 02085192122 or mind info line 0845 7660163 Web: www.mind.org.uk
- **Relate**: 0845 456 1310 Web www.relate.org.uk
- **Rethink**: advice line: 020 8974 6814, tel. 0845 456 0455 web: www.rethink.org
- **Samaritans**: helpline: 08457 90 90 90, text phone: 08457 90 91 92 web: www.samaritans.org
- **Saneline**: helpline - 0845 7678000 Samaritans website

Key Documents

- NHS England ‘Everyone Counts; Planning for Patients’ Plan
- A significant amount of information for this report has been sourced from Maternal Mental Health Alliance - http://maternalmentalhealthalliance.org.uk
- Via links as shown http://everyonesbusiness.org.uk/?page_id=24 and http://everyonesbusiness.org.uk/?p=53
- **Resources for Health professionals**
- **Quality Network for Perinatal Mental Health Services – Standards for perinatal community mental health services**
- **Joint Commissioning Panel Criteria – Guidance for commissioners of perinatal mental health services 2012**
• Quality Network for Perinatal Mental Health Services – Standards for mother and baby inpatient units
• Ten key recommendations for commissioners
• Joint Commissioning recommendations for perinatal mental health
  http://www.rcpsych.ac.uk/pdf/perinatal_web.pdf
• http://www.nspcc.org.uk/inform/resourcesforprofessionals/underones/spotlight-mental-health-landing_wda96578.html

Good Practice;
• Examples from the Maternal Mental Health Alliance
• Department of Health - Reducing Postnatal Depression
• Children & Young People – Mental Health Coalition
  http://www.cypmhc.org.uk/media/common/uploads/PB1_healthvisitors_WEB_.pdf
• Health Visitor – Case studies / best practice
  https://www.eoedeanery.nhs.uk/document_store_2/Case_Study.pdf
• Solihull Approach to Training Health Visitors

Report from MumsNet site

Almost half of all women surveyed said they had suffered with either depression or anxiety when they were pregnant and two thirds had suffered from postnatal depression. Two per cent had suffered with puerperal psychosis.

What symptoms did the mums report?

The most common symptoms mums reported were low mood and tearfulness. Other symptoms included feelings of anger, finding it hard to leave the house, a change in appetite and finding it hard to bond with their baby. A fifth of the mums surveyed admitted to having suicidal thoughts.

Why did the women think they felt depressed?

Women put their mental health problems down to trying to live up to unrealistic expectations. A high proportion said they had also experienced additional pressures such as a traumatic birth, financial or relationship problems or an unsettled baby. One in seven women said they felt they were prone to having mental health problems.

What is the best way for women to take the first step to get help?

The results indicated that the first step towards getting better was for women to recognise they were unwell and to talk about how they feel. Women's resistance to talking their feelings through was the biggest barrier to being unable to access help, with less than a fifth saying they had been completely honest when questioned about how they were feeling and coping as a new mum. A third of those questioned said they had never told a health professional that they felt unwell.

Over a quarter of mums surveyed admitted they were worried about admitting their true feelings in case their baby might be taken away.

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.

For those that did seek help a quarter confided in a health professional before telling anyone else, whilst just under half talked to their partner or husband first.

Women reported that they had recovered or improved through a variety of support and treatment. Half of them had used medication, such as anti-depressants and around four in ten had tried counselling. The support of loved ones and friends, talking to experts, self-help strategies and exercise were all identified as being important on the road to recovery.

The two biggest healers were considered to be time and the recognition and acceptance for mums that they had mental health problems.

**The survey results suggested that for women to ask for help they need to:**

- Recognise the symptoms they have as being unusual
- Accept the possibility of an illness
- Have trust in the individuals they would approach for support

**How can health professional ensure mums receive enough support?**

The following steps have been identified to help professionals work with women more effectively and help mums and their families to be more open and better supported when they become unwell.

- Mums to be, with the support of their midwives should draw up a **Wellbeing Plan** during pregnancy in a similar way to a **Birth Plan** to provide information and open up discussions.
- There needs to be more time to open up discussions with parents about emotional wellbeing throughout pregnancy and the post-natal period.
- Health professional should receive better guidance on what questions to ask to find out how a mum is feeling and coping during and after pregnancy.
- Professionals must dispel the myth that babies are taken away from mothers with depression or anxiety, while also explaining to mothers that it is common for them to have this concern.
- Partners must be routinely involved, where appropriate, so they are in a position to help identify difficulties and provide early support.
- Explore issues that may have affected the mother-to-be or mother, such as worries and expectations, a traumatic birth or wider family issues including financial concerns, relationships and coping with other children.
- When women reveal they feel unwell to a professional it may be the first time they have spoken to anyone and so a significant opportunity to provide help and support.
- Women should be helped to talk with family and friends where appropriate and signposted to sources of information about their condition.

Some women will suffer in silence, so advice on maintaining mental wellbeing should be provided to all women as routine. There should be focus on prevention and early recognition of symptoms as much as recovery.
The Whooley questions are a generic screening tool for depression. If a woman has a diagnosed mental health disorder or is undergoing treatment from the mental health services, it may not be appropriate for a midwife or obstetrician to ask these questions. The Whooley Questions should be asked in order to identify current depression;

‘During the past month, have you 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?’

If the women answers yes to either of the two initial questions, a third question should be considered:

‘Is this something you feel you need help with?’

If the answer is yes, liaise with her GP

RCM planning an event at Kings Fund. They also wish to build a network to support change and improvement. There is also a need for an ‘electronic’ support e.g. an ‘e- platform’ to share good practice, to record case studies, and other good practice. On this site there will be a private area as well as an open space for advice and information for all midwives. Conference where the education standards and the network will be launched

The Royal College of Psychiatrists Service Standards from 2012 is detailed here. [http://www.rcpsych.ac.uk/pdf/Perinatal%20Community%20Standards%201st%20edition.pdf](http://www.rcpsych.ac.uk/pdf/Perinatal%20Community%20Standards%201st%20edition.pdf). Below are questions that commissioners should be asking when designing a service, or a provider should consider when providing a service (taken from the Maternal Mental Health Alliance July 2014)

Guidance for optimum service provision and commissioning; as stated in the Maternal Mental Health Alliance documentation in terms of the contribution of maternity services:

- The provision of high quality antenatal and postnatal care allows both for early detection and better universal health promotion for all women and families;
- Specialist midwives, working alongside other services, can provide valuable support to women and families in respect of public health issues such as smoking cessation or substance misuse;
- Midwives working for or alongside the Family Nurse Partnership or the Troubled Families Programme can provide the most disadvantaged or marginalised families with targeted support, particularly in relation to developing parenting skills.

Ensuring that a midwife assesses a woman by no later than her twelfth week of pregnancy is particularly critical and can have a positive influence on the health and wellbeing of both mother and baby. The health and social care assessment of needs, risks and choices is when the midwife is able to:

- Promote the health emotional wellbeing and positive mental health of the mother
- Prepare mothers and fathers for parenthood
- Promote breastfeeding and the specific support that fathers and the wider community can give
- Promote the neurological development of the child, the negative impact of stress and the importance of attachment
• Provide smoking cessation support
• Provide information about folic acid

The midwife can also use the assessment to notify the health visiting team of the pregnancy and the needs of the family and, in the case of women with complex social factors, alerting other health and social care agencies.

Other practical actions that midwives can undertake during the antenatal period include:

• Encouraging an anxious or depressed pregnant woman to consult her GP or link her with local groups that support pregnant women who are anxious or depressed. The midwife can also encourage the woman to be ‘mindful’, which may be helpful in slowing the body and mind and increasing feelings of being in control.
• Referring a woman who abuses substances to an appropriate pre-birth assessment and intervention by social services or offering the support of a dedicated substance/alcohol misuse support worker. In some areas there are multi-disciplinary teams who provide integrated maternity drug and alcohol services.
• Screening for domestic abuse, offering multiple opportunities for a woman to make a disclosure about domestic abuse and encouraging the woman to refer herself to social services or an agency that supports victims of domestic abuse.

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Word</th>
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</thead>
<tbody>
<tr>
<td>BCC</td>
<td>Buckinghamshire County Council</td>
</tr>
<tr>
<td>BHFT</td>
<td>Berkshire Health Foundation Trust</td>
</tr>
<tr>
<td>Bucks</td>
<td>Buckinghamshire</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>HWPHFT</td>
<td>Heatherwood and Wexham Park NHS Foundation Trust</td>
</tr>
<tr>
<td>RBFT</td>
<td>Royal Berkshire NHS Foundation Trust</td>
</tr>
<tr>
<td>IAPT</td>
<td>Improving access to psychological therapies</td>
</tr>
<tr>
<td>LA</td>
<td>Local Authority</td>
</tr>
<tr>
<td>LAC</td>
<td>Looked After Children</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute of Clinical Excellence</td>
</tr>
<tr>
<td>OUH</td>
<td>Oxford University Hospitals</td>
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<tr>
<td>OHNHSFT</td>
<td>Oxford Health NHS Foundation Trust</td>
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<td>Oxon</td>
<td>Oxfordshire</td>
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<tr>
<td>QSGs</td>
<td>Quality Surveillance Groups</td>
</tr>
<tr>
<td>WAM</td>
<td>Windsor Ascot and Maidenhead</td>
</tr>
</tbody>
</table>