Perinatal mental health services for London

Guide for commissioners

January 2017

Healthy London Partnership – Transforming London's health and care together

Contents

Foreword

A lived experience of perinatal mental health care

I was diagnosed with bipolar in my early twenties. I've worked hard, with the support of many services, to understand my condition and gain stability in my life. I knew pregnancy and motherhood posed significant risks and that it was not a decision to be taken lightly. I wanted support to make an informed decision about my life, but getting expert advice on the implications of pregnancy and how to approach issues like medication and physical health proved difficult.

After much searching, I learnt of a pilot service running at my local hospital that could help me. A perinatal psychiatrist supported me and gave me the information I needed. My pregnancy went well and after a pre-birth planning meeting coordinated by my psychiatrist, midwife and local mental health trust I was confident about the future.

The birth was difficult. We spent time within a special care baby unit and then were sent home. Like most new mothers, my new baby brought exhaustion, lack of sleep and disruption. I clung to my birth plan with its details of services and professionals identified to help me. When I organised myself to get out and ask for help, I was sent home and told that I should just give it time. I was left feeling really isolated. About six weeks after my baby was born I admitted to my husband that I thought we should consider putting the baby up for adoption.

Motherhood felt like a terrible mistake, I was deeply unhappy, very lonely and overwhelmingly anxious. In desperation, after trying and failing to access a number of services, I ended up under the care of the mental health trust. They provided a combination of talking therapies and medication, enabling me to get through this difficult period.

Now, it's two years on and I really enjoy my son. Without a doubt, this has been made possible thanks to the care and support my family and I received from so many different professionals – perinatal psychiatry, the adult mental health trust, health visitors, my GP, IAPT (Improving Access to Psychological Therapies) and children's centre staff.

My personal experience gives me a unique view of London's perinatal mental health services. I'm endeavouring to use it to improve mental health experiences for Londoners. I have helped implement a specialist perinatal mental health service in west London by contributing to the service requirements and design work and in 2015 became an active member of the London perinatal mental health work. I co-chair the perinatal mental health task and finish group.

The co-production event we set up as part of this work generated a lot of energy and enthusiasm from people with lived experience and the wide range of professionals who attended. We found that when services across the pathway work together, and focus on the needs of the woman, her partner, their baby and wider family to provide timely access, the results improve outcomes for the whole family. I hope this guide for commissioners will support the development of effective, high quality perinatal mental health services across the whole of London.

Emma Fox
Co-chair of the task and finish group, perinatal mental health commissioning project

A clinician's view

Right now, we have a unique opportunity to develop comprehensive and equitable perinatal mental health services across London. We need to ensure that all women receive excellent care from skilled professionals, during pregnancy and in the baby's first year. This guide clearly sets out what is needed and why, and how excellent provision can be achieved. It is a map for what the NHS, social care and the voluntary sector can achieve in partnership with women and their families.

The task is complex. Managers and clinicians from multiple disciplines and agencies need to work together. London has already shown its potential for effective multi-agency working and there are plenty of examples of good practice for us to share and learn from.

Mental health problems in the perinatal period are one of the leading causes of maternal deaths. There is a long and documented history in the UK of mental illness experienced by women during childbearing.

The healthy development of infants and children depends on having healthy parents who can love, nurture and guide them.

Our communities and society depend on having resilient, happy, thriving children and young people who are able to learn and contribute positively. Ensuring the wellbeing of families by enabling appropriate and prompt interventions and support when things go wrong is essential.

The cost of attempting to repair the damage done by not providing services for perinatal women is five times that of providing the services in the first place.

Commissioners and providers must work together in a systematic, thoughtful, responsive and timely manner to ensure that services are in place for all women and their families across London. This guide provides clarity of purpose and action for all involved in the commissioning of perinatal mental health services.

Liz McDonald

MB BCh BAO FRCPsych MPhil
Chair of the Pan-London PMH Clinical Network

A guide for commissioners

This guide has been developed to help commissioners understand the complexity of the perinatal mental health pathway.

It outlines the necessary components of the perinatal mental health pathway according to how they are accessed and commissioned. The guide highlights key priorities for commissioning perinatal mental health services based on existing national standards and takes account of London's unique challenges and demographics. It has been produced with input from health and social care professionals and people with lived experience of mental ill health.

Key points for commissioners to note are **highlighted** throughout the guide, with signposting to further sources of information.

We hope you find it useful.

Working in Partnership

This guide has been produced by the London Clinical Networks and Healthy London Partnership, working together to improve services for Londoners.

Healthy London Partnership is a collaboration of London's health and care system to support the delivery of better health in London. We aim to work with a growing community of people and organisations across London to make it the healthiest global city in the world by 2020.

The London Clinical Networks provide clinical expertise and leadership to drive decision-making, reduce variation and improve services. The vision is to create clinical leadership which links health and social care for consistent, evidence-based, high quality, efficient health and wellbeing for the capital.

Acknowledgements

We would like to thank all stakeholders and partners for their time and commitment in providing their expertise and for sharing their experiences.

Our special thanks go to:

- All healthcare professionals and people with lived experience who attended the co-production workshop and contributed to the rich discussion on what services should be aspiring to achieve – appendix 1.
- Everyone who provided comments and expert opinion during the consultation phase.
- The task and finish group for their vision and support in developing this guide.

We are grateful to the teams who submitted case studies highlighting good practice, providing an opportunity for shared learning.

Special thanks to Claire Ruiz, Clinical Network senior project manager for her help and support to produce the document. Finally, thank you to the co-authors of this guide, Dr Sarah Taha, Perinatal Consultant Psychiatrist, Emma Fox, Co-Chair Task and Finish Group and Temo Donovan, Clinical Network Project Manager.

Executive summary

This guide has been produced to enable fundamental changes to how perinatal mental health services are commissioned across London. It follows the recommendations in The Five Year Forward View for Mental Health[1] and aims to improve access to high quality perinatal mental health services for women, their babies and families.

It highlights the **importance of collaborative commissioning** to prevent the confusion and variation in care that can arise when a pathway is commissioned across a range of commissioning and provider organisations.

The guide combines existing national standards with London-specific information to provide key priorities for commissioning perinatal mental health services. It aims to help improve access to high quality perinatal mental health services across London, and acknowledges that there should be a seamless care pathway from primary through to specialised commissioning.

Key messages for working in partnership

To deliver safe, effective, person-centred care, commissioners should demonstrate that:

- **The needs of the woman, her partner, their baby and wider family have been identified using a Joint Strategic Needs Assessment (JSNA). This should then be used to inform a perinatal mental health specific needs assessment and strategy.**
- **There is a collaborative commissioning group working with providers and service users to plan and deliver perinatal services.**
- **A clear, care pathway and governance framework is used, including clear referral criteria and advice and information on what to do at each stage of the pathway. This should include guidance on referrals across boroughs.**
- **Service users and professionals should know where to get support and should have access to the right treatment, at the right time, by the right service.**
- **Services comply with national standards.**

How this guide was developed

A multidisciplinary project team reviewed national clinical and commissioning guidelines, outcome measures and strategy to provide a strong and appropriate evidence base for the guide.

In January 2016, a co-production event brought together professionals and a wide and diverse stakeholder group that included people with lived experiences of perinatal health, see appendix 1 for details of the workshop. The event aimed to encourage participation and mutual understanding of the issues and challenges involved. Contributions made by participants provided opportunities for shared learning and helped to inform the development of this specification and guide.

A draft specification was shared with key stakeholders across London in a targeted consultation process and revised in light of their comments. It was then reviewed by experts in each field. See appendix 2 for the list of stakeholders who were involved in shaping the guide.

Note

Mother and baby units are commissioned by NHS England specialised commissioning and are not included in this guide.

What people told us

"I want information that explains what perinatal mental health is, what to look out for, where I can get help and what I can do for myself"

"I want a service that treats us as a family"

"I want to be seen in a place that is supportive and nurturing, where I can go with my baby and I don't feel stigmatised and separate"

"I want to see the same professional over time so that I can get to know them, and so that they can get to know me, so when I'm struggling I can trust them to support me"

"I want a service that treats me as a whole person, so I don't have to go to different places for different things and tell my story over and over again"

A sample of feedback provided by service users at our co-production January 2016 event (Appendix 1)

1 Introduction

Why perinatal mental health matters

When a woman and her family's care is provided by a number of different health and social care professionals across different providers, services can seem fragmented, difficult to access and not based around their needs.

Commissioning effective perinatal mental health services, needs a collaborative approach that considers the whole care pathway and the multiple needs of the individual and family.

The Five Year Forward View for Mental Health[1], National Maternity Review[2], Future in Mind[3] and the Chief Medical Officer Report[4], all emphasise the strong link between maternal/paternal mental health, children's mental health and the importance of good mental health during pregnancy and after birth.

Perinatal mental health problems range from mild to severe and complex, requiring different levels of intervention at different times. For women experiencing mild to moderate mental health problems, primary care and third sector organisations provide care and support. However, women with more severe mental illness are likely to need a range of services in primary and secondary care (including general adult mental health services, liaison services and specialist perinatal services).

Promoting psycho-social wellbeing, prevention and early intervention is key throughout the perinatal mental health pathway.

Pre-conception advice is also very important, especially for women at high risk of becoming unwell in the perinatal period.

The Five Year Forward View for Mental Health by the Mental Health Taskforce says that by 2020/21 there will be increased access to specialist perinatal mental health support in the community or in-patient mother and baby units, allowing at least 30,000 more women to access evidence-based specialist mental health care during the perinatal period.[1]

Postnatal depression has been linked with depression in fathers and with high rates of family breakdown.

The perinatal period is defined as conception until the end of the first postnatal year. For up to 20 per cent of women, it can be the start of mental health problems that affect their wellbeing and their families.

Commissioning along the perinatal mental health pathway

The lifespan approach to the perinatal mental health pathway includes the key components involved in caring for a woman and her baby, from maternity and neonatology, through to social care and health visiting.

Those responsible for commissioning services across health, local authorities and the third sector need to work together to make collaborative commissioning work (see figure 2).

Commissioners and providers should look beyond their geographical boundaries and specialist areas to develop services that meet the needs of their communities.

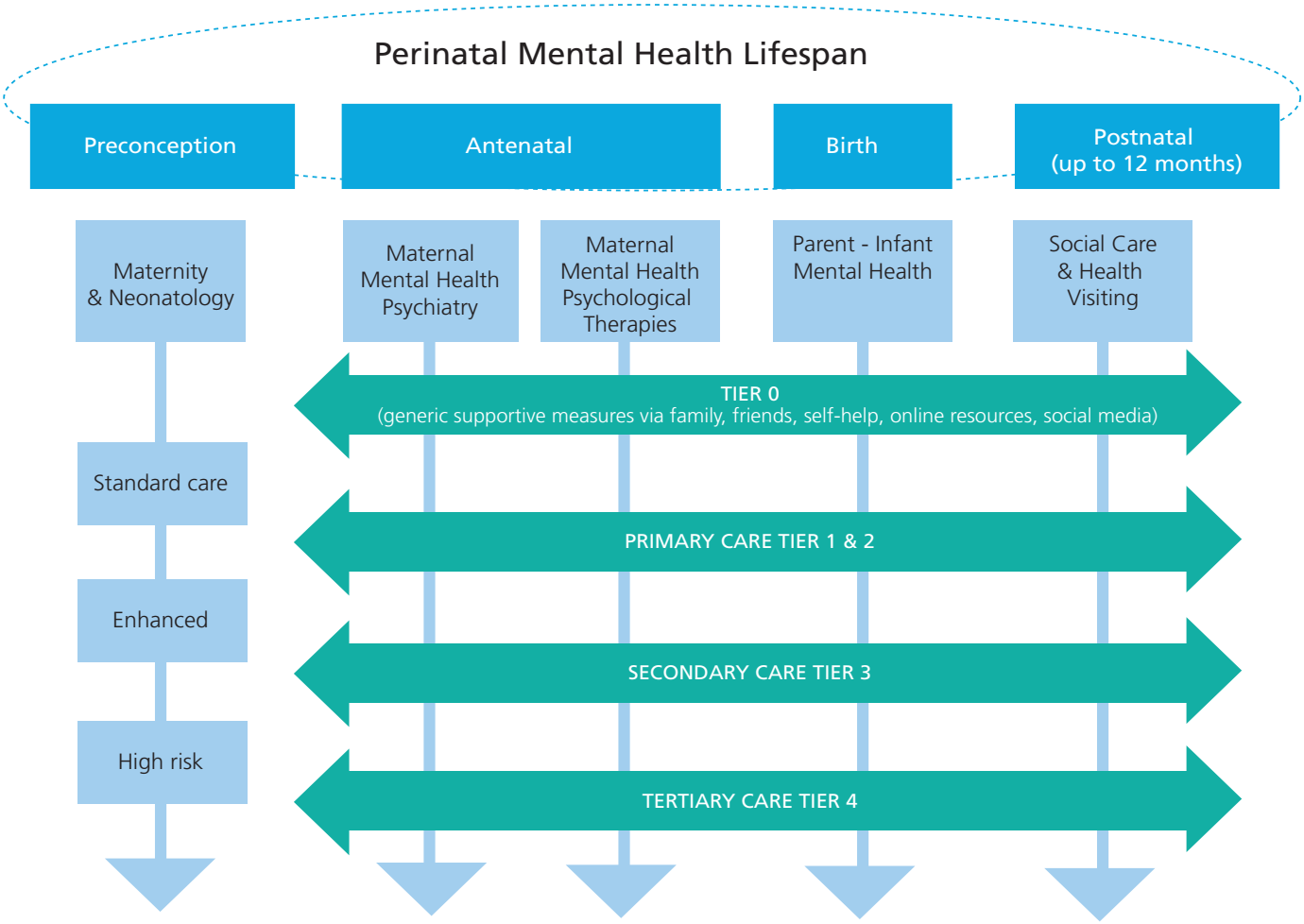

Figure 1 An overview of the London perinatal mental health pathway[5]

Examples of interdependencies

The interdependencies across commissioning bodies demonstrate how essential it is to ensure that services are designed to work together across the perinatal pathway.

- Access to IAPT (Improving Access to Psychological Therapies) by individuals and groups can be improved by placing them in settings such as children's centres. Local authorities responsible for commissioning children's centres, and the CCGs commissioners who commission IAPT services, must consider this factor.
- CCGs commission specialist perinatal mental health services and these services should offer consultation/ training to other agencies' workforce. For example, health visitors and early years workers who are commissioned by local authorities and third sector providers.
- CCGs commission maternity and mental health services. The maternity commissioner must work with the mental health commissioner to ensure there is a specialist mental health midwife and a lead obstetrician for mental health with dedicated time to work with the specialist perinatal mental health team.
- Child and adolescent mental health services (CAMHS) provide services from 0-18 years. These services should include parent-infant interventions. At secondary care level, practitioners offering parent-infant work should ideally be part of the specialist perinatal mental health team. It will be key for CAMHS commissioners to work closely with adult mental health commissioners.
- The Perinatal Quality Network[7] sets the standards for specialist perinatal services. These standards include dedicated input from local authority commissioned social workers to the specialist perinatal mental health teams that are commissioned by CCGs.

Benefits of collaborative commissioning

There are many benefits to be gained when third sector organisations are included in commissioning. Third sector organisations and public sector agencies can work together to provide a diverse range of services to families, including community support, self-help, peer support, counselling and advisory services through to national campaigns, for example, Maternal Mental Health Alliance's 'Everyone's Business[6] campaign.

The benefits of this way of working include:

- **A better understanding of the needs of service users and the communities that public sector organisations serve.**
- **A closeness to the people that the public sector wants to reach.**
- **An ability to develop innovative solutions to health and social care challenges.**

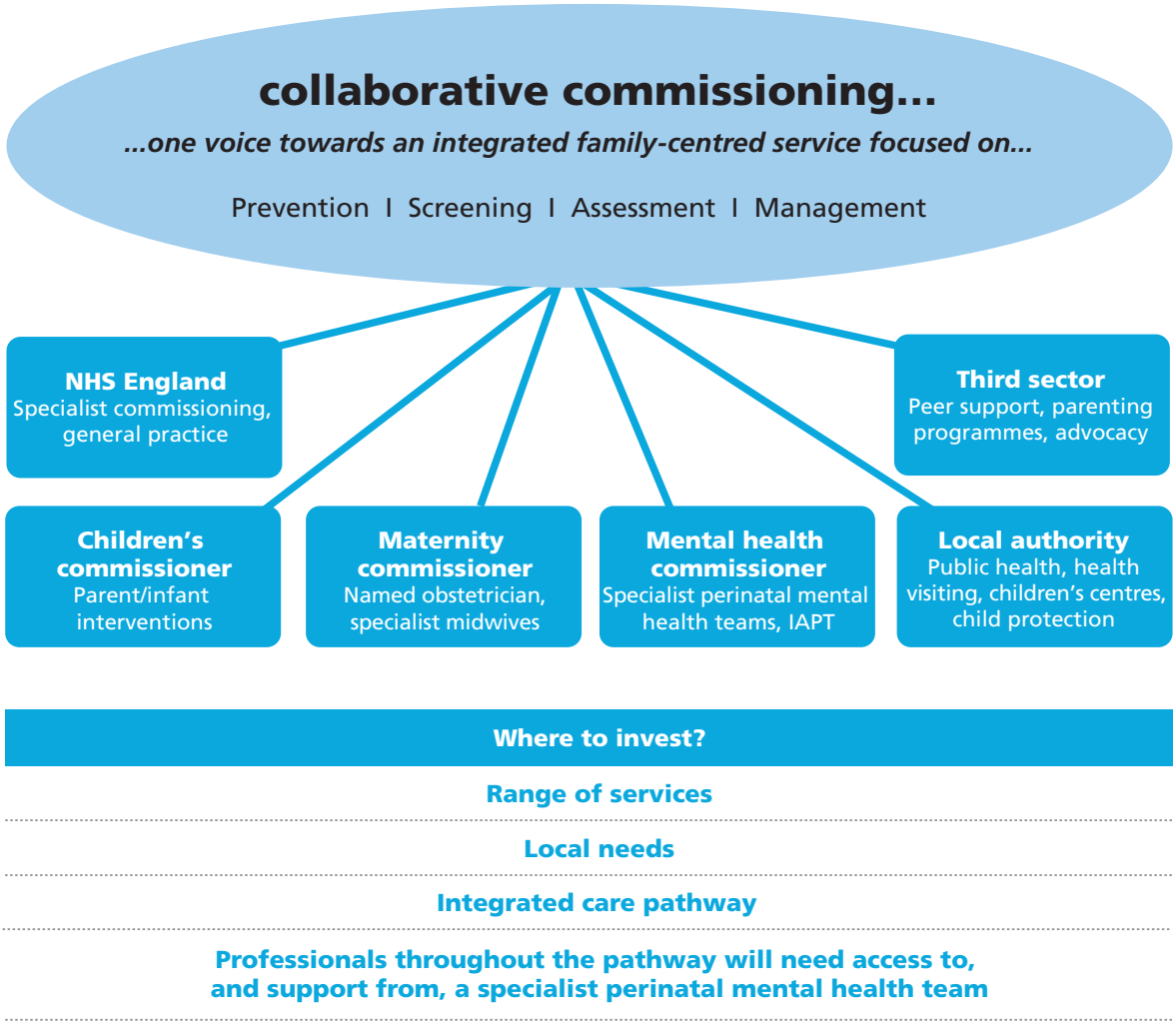

Figure 2 an overview of the collaborative commissioning needed to improve perinatal mental health services

To develop and commission an effective integrated pathway, it is important to understand how people access services, and which organisations are responsible for commissioning different parts of the service (see figure 3 below).

Perinatal services sit alongside a range of universal and other specialist services

Nature of Access	Service	Commissioner
Universal services, care accessed by all mothers	Maternity	Clinical Commissioning Groups (CCGs)
	Health Visitors	Local Authorities
	Sure Start	Local Authorities
	Third sector organisations (e.g. Home Start)	Local Authorities/ CCGs
	General Practice	NHS England/CCGs
Other non-perinatal services accessed by some mothers	IAPT	CCGs
	Family Nurse Partnership	Local Authorities
	General secondary mental health e.g. Community Mental Health Teams (CMHT), Child and Adolescent Mental Health Services (CAMHS)	CCGs
	Troubled Families	Local Authorities
	Third sector organisations (e.g. Mind)	Local Authorities/ CCGs/Mental Health Trusts (MHTs)
	Social Care (Adult or Children's)	Local Authorities
Specialised perinatal mental health services	Specialist Community Perinatal teams	CCGs
	Inpatient Mother and Baby Unit and linked outreach teams	NHS England Specialised Commissioning

Co-production of services in Ealing, Hammersmith & Fulham and Hounslow with lived experience experts

Case Study

Key to the success of the project was the strong engagement with participants from the start. It encouraged people to feel like core members of the project team and enabled them to be involved at every step of the process, from design requirements, through to the practical implementation of the service.

The approach was shaped around the needs of women and families and helped the team to create a practical service that delivers what families really need. Inviting individuals with lived experience to co-chair reinforced the message that all opinions were equal within the group.

Practical decisions were made about how to run the project, such as holding meetings in child-friendly locations, using children's centres to provide childcare and using email. The financial cost of the project was outweighed by the value of working with people using the services.

The project secured funds from the three CCGs. The service was launched on time and provides equal access to specialist perinatal mental health services where previously there was variable provision.

Closing the health and wellbeing and quality gap

The first 18 months of life are a crucial period in a child's development. The parent-infant relationship, specifically the quality of emotional attachment, are important influential mediating factors for outcomes. Pregnancy and early parenthood are times of unparalleled contact with health services, and the perinatal period is an important opportunity for health education, promotion and screening.

Preventing ill health and early intervention are key to developing an effective perinatal mental health service. Early intervention can play a vital role in optimising the emotional, behavioural and cognitive development of every child, preventing abuse and neglect and the likelihood of requiring long term use of mental health services.

Depression and anxiety are the most common complications of maternity above diabetes, hypertension and other physical complications affecting maternal wellbeing during the perinatal period. They are associated with adverse effects, such as poorer cognitive, emotional and behavioural outcomes for children. Depression in mothers increases the risk of poor obstetric outcomes and outcomes for children, including higher rates of spontaneous abortion, low birth weight babies and developmental delay.

Perinatal mental health problems can contribute to poor marital/partner relationships and depression in fathers — both of which are associated with poorer outcomes for mothers and their infants. A lack of social support is also a well-recognised risk factor for the onset of mental disorder during the perinatal period.

Suicide is a leading cause of maternal deaths, and enquiries into maternal deaths have consistently identified the following themes:

- poor communication between services
- poor identification of risk in the perinatal population
- problems with referral for assessment
- lack of access to specialist perinatal mental health services
- the rapidity of progression of postnatal mental illness and the need for continuity of care and co-ordinated case management

The postnatal period poses a higher risk of psychosis than at any other time during the pregnancy pathway (or indeed a woman's life).

Postpartum psychosis presents with a rapidly evolving picture, and timely access to specialist care is critical to avoid significant and immediate risks to the mother and infant.

23% of women who died between six weeks and one year after pregnancy, died from mental health related causes[9]

Closing the finance and efficiency gap – economic benefits

The case for investing to save is compelling. Failing to prevent and support perinatal mental illness results in estimated annual costs of around £8.1billion in the UK. Most of these costs are associated with the impacts of under-treated perinatal mental illness on the child. A single case of perinatal depression costs society an average of around £74,000, of which £23,000 relates to the mother and £51,000 to impacts on the child. Failing to meet this need affects health, social care, education, welfare and the criminal justice system.[10]

In comparison, £337 million a year is needed to ensure perinatal mental health care is funded to the recommended level called for in national guidance. Universal approaches and early identification are central to the perinatal mental health pathway. There is good evidence that cost-effective interventions improve quality of life.

Two reports, Mental Health Promotion and Prevention: the Economic Case report[11] and Future in Mind[3] highlight the importance of improving access for parents to evidence-based programmes of interventions and support to strengthen attachment between the parent and child, to avoid early trauma, build resilience and improve behaviour.

2 Understanding population need and provision of perinatal mental health services

Commissioners need to have an accurate understanding of their population needs. Using the birth rate in their area, commissioners can estimate the perinatal mental health morbidity and service uptake for their population. There were over 129,615 live births in London across 22 maternity units in 2015.

Table 1 Live births (numbers, age of mother at birth split by borough of usual residence), source ONS London, 2015[12]

	All	Under 18	Under 20	20-24	25-29	30-34	35-39	40-44	45+
LONDON	129,615	608	2,394	13,495	31,723	44,784	29,330	7,064	825
Camden	2,699	12	34	179	487	1,026	756	195	22
City of London	69	0	0	4	12	26	22	2	3
Hackney	4,500	24	100	711	1,042	1,329	998	284	36
Hammersmith & Fulham	2,345	7	35	168	411	894	648	175	14
Haringey	4,108	20	97	495	957	1,277	1,005	246	31
Islington	2,939	13	43	277	604	1,022	787	192	14
Kensington and Chelsea	1,805	0	16	78	293	681	555	160	22
Lambeth	4,620	27	95	421	945	1,602	1,181	333	43
Lewisham	4,814	25	116	499	1,032	1,612	1,228	292	35
Newham	6,226	36	142	858	2,055	1,956	970	218	27
Southwark	4,587	18	78	435	1,018	1,545	1,180	297	34
Tower Hamlets	4,560	15	58	501	1,345	1,545	908	192	11
Wandsworth	5,038	6	39	298	787	1,954	1,595	331	34
Westminster	2,707	7	27	169	494	1,009	760	215	33
Outer London									
Barking and Dagenham	3,850	29	100	573	1,215	1,210	601	128	23
Barnet	5,261	15	66	466	1,290	1,890	1,233	289	27
Bexley	3,162	21	70	376	872	1,108	583	138	15
Brent	5,204	32	106	644	1,491	1,678	973	270	42
Bromley	4,098	11	58	345	864	1,467	1,117	220	27
Croydon	5,833	44	174	775	1,493	1,980	1,114	272	25
Ealing	5,210	21	89	488	1,327	1,819	1,133	313	41
Enfield	5,027	46	142	642	1,375	1,590	997	246	35
Greenwich	4,644	32	110	519	1,149	1,579	1,033	218	36
Harrow	3,601	11	64	422	959	1,319	668	152	17
Havering	3,275	21	85	434	916	1,113	588	128	11
Hillingdon	4,394	22	79	508	1,192	1,564	836	190	25
Hounslow	4,455	13	62	452	1,191	1,595	919	202	34
Kingston upon Thames	2,350	7	31	169	419	896	654	165	16
Merton	3,412	11	50	274	721	1,270	891	185	21
Redbridge	4,798	19	71	448	1,455	1,733	905	169	17
Richmond upon Thames	2,609	8	25	116	330	963	910	245	20
Sutton	2,764	10	50	254	687	1,008	608	149	8
Waltham Forest	4,651	25	82	497	1,295	1,524	974	253	26

The National Child and Maternal Health Intelligence Network[13] (ChiMat) has produced a number of tools, including the Mental Health in Pregnancy, the Postnatal Period and Babies and Toddlers: Needs Assessment Report.[13] The report brings together data and evidence on mental health in the antenatal and postnatal periods, and the social and emotional development and wellbeing of babies and toddlers.

The information on the following pages provide an indication of perinatal and infant mental health needs presented for each CCG and local authority to support writing a local needs assessment.

Tables 2 to 6 summarise the current estimates of numbers of women with mental health problems during pregnancy and after childbirth by CCG and strategic planning group area, with data gathered from the following sources:

- **deliveries data:** Hospital Episode Statistics, Health and Social Care Information Centre.
- **rates of disorders**: Joint Commissioning Panel for Mental Health. Guidance for commissioners of perinatal mental health services.

Table 2 Estimates of numbers of women with mental health problems during pregnancy and after childbirth in south west London	Croydon	Richmond	Kingston	Wandsworth	Sutton	Merton
Postpartum psychosis	10	10	5	15	5	10
Chronic Serious Mental Illness	10	10	5	15	5	10
Severe depressive illness	125	80	75	170	70	90
Mild-moderate depressive illness and anxiety (lower estimate)	405	260	235	555	230	300
Mild-moderate depressive illness and anxiety (upper estimate)	610	385	355	835	345	450
Post-Traumatic Stress Disorder	125	80	75	170	70	90
Adjustment Disorders and Distress (lower estimate)	610	385	355	835	345	450
Adjustment Disorders and Distress (upper estimate)	1,215	770	705	1,665	685	900

Table 3 Estimates of numbers of women with mental health problems during pregnancy and after childbirth in north west London	Brent	Harrow	Hillingdon	Kensington and Chelsea	Westminster	Hammersmith & Fulham	Ealing	Hounslow
Postpartum psychosis	10	10	10	10	5	5	15	10
Chronic Serious Mental Illness	10	10	10	10	5	5	15	10
Severe depressive illness	150	95	120	85	60	75	170	130
Mild-moderate depressive illness and anxiety (lower estimate)	495	320	385	270	190	245	560	425
Mild-moderate depressive illness and anxiety (upper estimate)	740	475	580	405	280	365	835	635
Post-Traumatic Stress Disorder	150	95	120	85	60	75	170	130
Adjustment Disorders and Distress (lower estimate)	740	475	580	405	280	365	835	635
Adjustment Disorders and Distress (upper estimate)	1,475	950	1,155	805	560	730	1,670	1,265

Table 4 Estimates of numbers of women with mental health problems during pregnancy and after childbirth in south east London	Lambeth	Southwark	Lewisham	Greenwich	Bromley	Bexley
Postpartum psychosis	10	10	10	10	10	10
Chronic Serious Mental Illness	10	10	10	10	10	10
Severe depressive illness	150	135	140	135	130	85
Mild-moderate depressive illness and anxiety (lower estimate)	495	440	465	440	420	280
Mild-moderate depressive illness and anxiety (upper estimate)	740	655	695	660	630	420
Post-Traumatic Stress Disorder	150	135	140	135	130	85
Adjustment Disorders and Distress (lower estimate)	740	655	695	660	630	420
Adjustment Disorders and Distress (upper estimate)	1,475	1,310	1,385	1,315	1,255	835

Table 5 Estimates of numbers of women with mental health problems during pregnancy and after childbirth in north London	Barnet	Enfield	Haringey	Camden	Islington
Postpartum psychosis	15	10	10	10	10
Chronic Serious Mental Illness	15	10	10	10	10
Severe depressive illness	155	135	130	80	90
Mild-moderate depressive illness and anxiety (lower estimate)	520	440	420	260	290
Mild-moderate depressive illness and anxiety (upper estimate)	775	660	630	390	435
Post-Traumatic Stress Disorder	155	135	130	80	90
Adjustment Disorders and Distress (lower estimate)	775	660	630	390	435
Adjustment Disorders and Distress (upper estimate)	1,550	1,320	1,255	780	870

Table 6 Estimates of numbers of women with mental health problems during pregnancy and after childbirth in north east London	Havering	Barking & Dagenham	Redbridge	Waltham Forest	City & Hackney	Tower Hamlets	Newham
Postpartum psychosis	10	10	10	10	10	10	15
Chronic Serious Mental Illness	10	10	10	10	10	10	15
Severe depressive illness	110	120	140	140	140	140	190
Mild-moderate depressive illness and anxiety (lower estimate)	355	390	460	460	455	460	635
Mild-moderate depressive illness and anxiety (upper estimate)	530	585	685	690	680	690	950
Post-Traumatic Stress Disorder	110	120	140	140	140	140	190
Adjustment Disorders and Distress (lower estimate)	530	585	685	690	680	690	950
Adjustment Disorders and Distress (upper estimate)	1,055	1,165	1,370	1,380	1,355	1,380	1,900

The following note accompanies the tables above.

Adding all these estimates together will not give you an overall estimate of the number of women with antenatal or postnatal mental health conditions in your area, as some women will have more than one of these conditions. It is believed that overall, between 10 per cent and 20 per cent of women are affected by mental health problems at some point during pregnancy, or the first year after childbirth.

These estimates are based on national estimates of these conditions and local delivery figures only, and have been rounded up to the nearest five. They do not take into account socio-economic factors or anything else that is likely to cause local variation.

3 London's current perinatal service

The Maternal Mental Health Alliance's campaign, Everyone's Business[6], compiled data as part of an initial three year campaign (2013-2016), which demonstrated that the picture across London for community perinatal mental health teams varied and illustrated how inconsistent service provision is.

Since the data was published in 2015 there has been some improvement across boroughs, instigated through the political momentum building in the field of mental health generally and the continuing focus on perinatal mental health maternity services.

- In 2015, commissioners in Bromley announced their intention to launch a perinatal community support service for pregnant women and new mothers.
- Haringey CCG was one of three successful bids for funding in London to the NHS England Perinatal Mental Health Community Development Fund to support the delivery of their perinatal mental health strategy for Barnet, Enfield and Haringey.
- In February 2016, a new perinatal mental health service was launched in Ealing, Hammersmith & Fulham and Hounslow, provided by a collaboration of maternity and mental health services.

The availability of perinatal services, and the different ways to access them, presents several challenges for commissioners:

- Approximately 10% of women in London deliver their baby in one NHS trust, but receive postnatal maternity care in another area.
- Services provided by the local authority and community mental health services tend to be borough-based.
- Services provided by GPs and acute trusts cross borough boundaries.
- London has a transient and mobile population, resulting in movement across boroughs and through providers.

It is common for a woman to receive her maternity care in a different borough to her mental health and social care. She could also have a GP in another borough altogether, presenting challenges in ensuring continuity and safety. Three mother and baby units (MBU) with a total of 32 beds provide specialist mental health care for women in London. The MBUs mean mothers can stay with their babies when they are acutely unwell.

- Coombe Wood MBU, Park Royal Centre for Mental Health (north-west London)
- Channi Kumare MBU, Bethlem Royal Hospital (south London)
- Margaret Oates MBU, Homerton Hospital (east London)

LEVEL	COLOUR	CRITERIA
5		Special, see perinatal community team that meets Perinatal Quality Network Standards Type 1
4		Specialised perinatal community team that meets Joint Commissioning Panel criteria
3		Perinatal community service operating in working hours with at least a specialist perinatal psychiatrist and specialist perinatal mental health nurse ***both with dedicated time and access*** to a perinatal psychiatrist
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 from local experts — the information it shows has not been independently verified.

Please contact info@everyonesbusiness.org.uk if you think any of the information is incorrect, or if you know of any recent developments that may change the level of provision in any part of London.

4 Safeguarding

Safeguarding is a critical practice that seeks to mitigate harm and support families where needed. Commissioners, providers and clinicians alike, must be aware of emerging trends, understand the evidence relating to perinatal mental health, and be trained to understand the risks and how to safeguard against them.

Safeguarding is a core function in all settings, and is particularly critical during the perinatal period. Failings identified in serious case reviews (SCRs), domestic homicide reviews (DHRs) and mental health homicide reviews (MHHRs), consistently identify several safeguarding shortcomings, including the lack of:

- early help
- professional curiosity and screening
- adequate assessment
- information sharing
- focus on the whole family
- effective supervision

One study found seven key themes across mental disorder groups for the time during pregnancy and up to one year after the birth of the child for women in the UK:[35]

- An unmet need for collaborative and integrated care
- Stigma and fears about loss of custody
- Healthcare professionals unable or unwilling to address psychological needs
- Focus on babies over mothers
- Failure to recognise the importance of non-judgemental and compassionate support
- An unmet need for information
- Lack of service user involvement in treatment decisions

Where to look for guidance

The Royal College of Paediatrics and Child Health's Safeguarding, Children and Young People: roles and competencies for health care staff intercollegiate document (2014), sets out a minimum standard for safeguarding training for healthcare staff and professionals.[28]

The Department of Health's, Working Together (2015) is the overarching statutory guidance for all commissioners who provide services for children and families.[29] Safeguarding Vulnerable People in the NHS – Accountability and Assurance (NHS England, 2015) clearly defines safeguarding roles, duties and responsibilities of all organisations commissioning NHS health and social care.[30]

The Social and emotional wellbeing in early years [PH40] (NICE 2012) guidance, defines the support needed for children aged under five years who are at risk of, or who are already experiencing, social and emotional problems and need additional support through home visiting, childcare and early education.[31]

Other documents such as, Female Genital Mutilation Risk and Safeguarding: Guidance for professionals (DoH, 2015),[32] and Domestic violence and abuse NICE quality standard [QS116] (NICE, 2016)[33] are also key for safeguarding practice in health. Domestic violence and abuse: multi-agency working [PH40] (NICE, 2014)[34] recommends how organisations can work together and respond effectively.

5 Equality and diversity

Services should explicitly target inequalities in health and aim to meet the needs of vulnerable and socially disadvantaged groups. Third sector, community agencies and peer support will be key in engaging with these groups.

It is important that local areas actively engage with women with complex social factors (NICE, 2010) who may be less likely to access or maintain contact with services. This includes ensuring information about treatment and care is culturally appropriate.[19]

Treatment and care should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. This should include easy reading information available in a range of formats and languages appropriate to the local community and the use of independent interpreters.

A helpful example of how to approach meeting the needs of black and minority ethnic women is provided in a report, Perinatal Mental Health of Black and Minority Ethnic Women, from the National Mental Health Development Unit (NMHDU 2011)[36], the report outlines the extent to which current and planned perinatal provision is capable of meeting the needs of black and ethnic minority women Additional research on some of the issues involved for black and ethnic minority women and those with a disability can be found in the reference section of this guide.[53, 54, 55, 56]

6 National guidance and standards

National recommendations covering perinatal mental health exist across several health and social care disciplines. The National Institute for Health and Care Excellence (NICE) updated its Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance[17] in December 2014 and recently published the Antenatal and Postnatal Mental Health: Quality Standard[18] in February 2016.

Other NICE guidance, including pregnancy and complex social factors: a model for service provision[19] outlines how pregnant women with complex social factors may need additional support to use antenatal care services. Examples of complex social factors include:

- substance misuse
- recent arrival as a migrant
- asylum seeker or refugee status
- difficulty speaking or understanding English
- under 20 years old
- domestic abuse
- poverty
- homelessness

Key consistent themes in national guidance relating to perinatal mental health include:

- Integrated care and multi-agency working
- Early detection and prediction of risk and promotion of mental health and wellbeing
- Rapid access to intervention
- Access to perinatal psychological therapies
- The need for specialist perinatal mental health services
- Parity of physical health and mental health care

The National Maternity Review[2] highlights the historic underfunding and provision of mental health services that can significantly affect the life chances and wellbeing of the woman, baby and her family.

A welcome focus in addressing the need to reduce variation and ensure parity of mental with physical health has been provided with the recent investment in perinatal mental health services. The investment comes as a result of the Five Year Forward View for Mental Health[1] and the access and waiting times standards expected in 2016-17.

Multi-agency integrated care pathway

Recommendations include:

- An integrated care pathway covering all levels of service provision and all severities of disorder as outlined in the joint commissioning guidance for perinatal mental health services (2012).[20]
- The need to share relevant mental health history between primary care, maternity and mental health services so women receive appropriate care based on an informed risk assessment of their mental health and social care needs (MBRACE 2015).[9]
- Ensuring partnership working with parents and agencies exists where intensive multi-agency packages are needed as specified in the National Health Visiting National Service Specification 2014/15.[21]
- A smooth transition between care settings and organisations, including between primary and secondary care, mental and physical health services, children's and adult services and health and social care. This is strongly emphasised in the Government's mandate to NHS England for 2016-17.[22]

Partnership working in Newham

Case Study

Five different organisations have been working together to develop an integrated referral and care pathway for women with mild to moderate perinatal mental health concerns: the perinatal mental health team, midwifery team, IAPT team, CCG and substance misuse service. They aim to provide a safe, high-quality, family-friendly mental health service - including assessment, treatment, care, support and information for the families of the women using services, as well as consultancy, advice and support to other professionals and are an educational resource for professionals caring for families. Together, they work with social services and family teams to protect children who may be vulnerable as a result of their mother's illness.

Early detection, prediction, and promotion of mental health and wellbeing

Recommendations include:

- Universal services including midwives, GPs, nurses, health visitors, nursery nurses, day care staff and children's centre staff should be able to identify mothers, fathers and infants at risk, and offer early support and intervention. Prevention in mind[23], NICE Guideline for Antenatal and Postnatal Mental Health (2014)[17], 1001 Critical Days.[8]
- Providing training for primary care, midwives and health visitors on detection and prediction of mental illness (NICE Guideline for Antenatal and Postnatal Mental Health (2014)[17], Joint Commissioning Guidelines (2012)[20])
- As part of the Department of Health's healthy child programme, health visitors should routinely visit all women at around 28 weeks of pregnancy, enquire and provide information on maternal and paternal mental health, bonding with their infant and local support services such as children's centres.[24]

Rapid access to intervention

Recommendations include:

- Ensuring rapid access to evidence-based psychological therapies for parents and infants during the perinatal period NICE Guideline for Antenatal and Postnatal Mental Health (2014),[17] (assessment within two weeks, treatment started within four weeks) IAPT Perinatal Positive Practice Guide (2013),[25] British Psychological Society Briefing Paper: The role of perinatal clinical psychology (2016).[26]
- A rapid response when infant and parental mental health needs are identified, National Service Specification for Health Visiting (2014/15).[21]
- The sudden onset and rapidity of progression in severe postpartum mental illness is highlighted by MBRACE[9] which requires clinicians to be trained in perinatal risk assessment and have access to specialist assessment and management.

Specialist perinatal mental health service

Recommendations include:

- Access to specialist perinatal provision for all women during the perinatal period, regardless of area of residence: access to the right treatment, at the right time, by the right provider (NICE Guideline for Antenatal and Postnatal Mental Health (2014)[17] Joint Commissioning Guidelines (2012)[20] Prevention in Mind (2014)[23]).
- Ensuring proactive planning and management of women with severe mental illness including those who are well during the perinatal period (NICE Guideline for Antenatal and Postnatal Mental Health (2014)[17]).

The Royal College of Psychiatrists Perinatal Quality Network[7] sets national standards for perinatal community teams, outlines the required workforce and operates a scheme for peer review and accreditation.

Parity of mental health and physical interventions in maternity care

Recommendations include:

- Specialist mental health midwives: What they do and why they matter[51] recommends that there is a specialist mental health midwife in every maternity service, promoting parity between physical and mental health in maternity care, improving midwife knowledge and skills, developing pathways, supporting colleagues, mothers and their families. (Maternal Mental Health Alliance[6], Prevention in mind (2014)[23]).

The cross-government mental health strategy developed in 2011, No Health without Mental Health,[27] outlined the Government's commitment to parity of esteem between mental and physical health care. The Five Year Forward View for Mental Health[1] builds on this commitment.

7 Commissioning high quality, timely and effective perinatal mental health services

Key priorities for commissioning

This section provides the aims, objectives and key priorities for commissioning perinatal mental health services.

Aims

Women, their partners, their infants and wider family:

1. Have access to services to support their psychosocial wellbeing and to prevent mental illness during the perinatal period.
2. Are able to access quality perinatal mental health care and treatment at the right time, at the right level and in the right location.
3. Have access to competent practitioners who have received perinatal mental health training appropriate to their role.
4. Are seen by services that strive to continuously improve outcomes and reduce the risk of morbidity and mortality relating to physical and mental health in the perinatal period.

Objectives

Overarching objectives for perinatal mental health services:

- Ensure women and their families have timely access to a full range of pre-conception advice, antenatal, intra-partum and postnatal care, taking account of individual choice and clinical need.
- Promote the psychosocial wellbeing of mothers, fathers, their babies and surrounding family.
- Promote prevention and early identification of mental health problems and ensure that all professionals working with families in the perinatal period are trained to identify and, where appropriate, refer women and families with identified need.
- Provide specialist medical, nursing, psychological and social care, to women with severe and complex mental health needs.
- Support the developing relationship between mother and infant, providing short to long-term benefits for the infant's and mother's mental health.
- Prevent avoidable relapse of mental illness and reduce crises and admissions in women at high risk of mental illness during the perinatal period.
- Work in partnership to deliver community-based care close to home across organisational and geographical boundaries. This may require multiple agencies from neighbouring areas to work together, including CCGs, local authorities and third sector organisations.

Achieving these objectives

These outcomes can be achieved by:

- Delivering care that is compliant with national reviews, standards and evidence-based practice.
- Delivering care that is responsive to local needs.
- Engaging women and their families in shaping their local perinatal mental health care pathway so that it best reflects their needs and priorities, leading to improved access and choice.
- Working across multiple agencies to improve access to domestic abuse and substance misuse services.
- Working across multiple agencies to improve public health outcomes such as healthy eating, reducing smoking in pregnancy and pregnancy planning for women with pre-existing conditions.
- Embedding safeguarding across the pathway in line with local safeguarding procedures.
- Ensuring access to translation, interpreting and advocacy services based on an assessment of need.
- Maintaining strong communication links to relevant health professionals and the woman's GP throughout the perinatal lifespan.
- Encouraging an open and transparent environment where staff members feel comfortable raising concerns and challenges and learn from incidents and user feedback.

8 Commissioning by NHS England and Clinical Commissioning Groups

Responsibilities and partnership working

Partnership working is essential to meet the requirements of the perinatal mental health care pathway. In this section, services are grouped by the commissioning organisation. However, the expectation is that commissioners will work together to develop and deliver integrated care.

NHS England's role as the commissioner of mother and baby units is beyond the scope of this guide; however, there should be close liaison along the whole pathway from primary care through to specialist provision. Key priorities for perinatal mental healthcare are listed below for each part of the pathway.

Primary care services [17, 37, 38]

- GPs are competent in prescribing during pregnancy and lactation, and can provide preconception counselling to women at risk of mild to moderate perinatal mental health problems.
- GPs and other primary care staff are familiar with their local perinatal mental health care pathway.
- Each practice has an identified lead for perinatal mental health.
- At the six to eight-week postnatal check, GPs ask about the emotional and psychological wellbeing of the mother; the mother-baby relationship; the mother's recovery from birth; and future family planning.
- Women in the perinatal period experiencing mental health difficulties are offered priority booking.
- GPs work closely with maternity services, health visitors and IAPT to support women with mild to moderate illness.
- GPs are routinely sharing information that is relevant to the safe and effective care of women and their families in the perinatal period, with maternity services and other health and social care providers. This should include the woman's current or previous mental health history.
- Primary care staff are included in local reviews of serious incidents involving perinatal mental health care.

Maternity services

CCGs should consider the following points when commissioning maternity services.

- Midwives and obstetricians are equipped with the skills to screen and identify women at risk of perinatal mental illness and have a good understanding of the types of services available in their locality for women and their families.
- Midwives ask all women at the booking assessment about: previous or current psychiatric history, previous or current treatment and any severe perinatal mental illness in a first-degree relative. There is screening of all women using the Whooley and GAD-2 questionnaires and positive responses are acted upon.
- Midwives ensure pregnant women with a previous or current severe mental illness are given information about how their illness and its treatment might affect them or their baby at their booking appointment, and where appropriate, refer them for specialist management.
- Midwives and obstetricians enquire about emotional and psychological wellbeing at every contact (NICE Quality Standard).[18]
- Midwives routinely ask women about domestic abuse in a safe and supportive way; at a defined point during the booking appointment, when the woman is seen away from her partner, and there is a clear pathway when domestic abuse is disclosed.
- There is a dedicated specialist mental health midwife for each maternity unit, and a specialist midwifery service providing caseload support to women with severe or complex mental illness so they are offered continuity of care. A woman seeing the same midwife is more likely to disclose symptoms of mental illness, and a midwife who knows the woman is more likely to pick up early symptoms.[51]
- There is a lead obstetrician for mental health with dedicated sessions of clinical and non-clinical time. Examples of how sessions can be used include a joint clinic with the perinatal psychiatrist; attending multidisciplinary meetings; guideline development; and quality improvement. to ensure providers are in line with the latest national policies, evidence and best practice.

- Maternity services have access to perinatal mental health teams and work together e.g. multidisciplinary team meetings, birth planning meetings and joint obstetric and psychiatric clinics.
- There are dedicated sessions of perinatal clinical psychology in each maternity unit.[26]
- Timely access to psychological inventions are available to women presenting with maternity specific mental health problems such as fear of childbirth or a traumatic stress response to childbirth.
- Providing access to counselling therapies for women and families who have difficult experiences, particularly families who have had a stillborn baby or whose baby has died after birth.
- Women with a primary alcohol or substance misuse diagnosis have access to specialist substance misuse interventions, ideally a specialist antenatal substance misuse service via a clear pathway.
- All women have access to antenatal parenting classes that address both physical and emotional aspects of parenthood, the baby's wellbeing and healthy social and emotional development.[8]
- Every woman has a personalised care plan (e.g. Tommy's Wellbeing Plan). [39] Women with severe and complex mental illness should have a pre-birth perinatal care planning meeting with the professionals involved in her care, and where appropriate, her partner or family. There should be systems in place to ensure that this plan is shared appropriately.

Continuity of care: Tower Team midwifery team

Case Study

The Tower Team is a high risk caseload midwifery team that works closely with the perinatal mental health team and the consultant obstetrician for mental health at St. Thomas' hospital.

The Tower Team offers continuity of care for women with severe mental illness from their maternity booking appointment, throughout pregnancy, intrapartum and for up to 28 days postpartum. Team midwives attend the perinatal mental health team's weekly clinical meeting to ensure there is good information sharing between the perinatal mental health team, safeguarding midwife and the liaison social worker from children's social care.

Women are seen in the antenatal clinic for appointments alongside the consultant perinatal psychiatrist and other members of the team.

Tower Team midwives participate in perinatal mental health pre-birth planning meetings which are attended by the pregnant woman, her partner or other family member, the perinatal psychiatrist, perinatal mental health nurse, health visitor and others (e.g. social worker and CMHT care coordinator). During the postnatal period, joint home visits with other professionals can be arranged.

Women value the continuity of care provided by midwives who have a good understanding of their mental illness, offer extended appointments where needed and work closely with the other professionals involved in their care.

Improving Access to Psychological Therapies (IAPT)

Key priorities for CCGs to consider when commissioning Improving Access to Psychological Therapies (IAPT) services[25, 26] include:

- Ensuring IAPT services have a system for identifying women who are pregnant or within the first postnatal year.
- Developing IAPT services with a flexible approach, including the need for childcare, to ensure they are meeting the needs of women, their partners and families. For example, by providing services in child friendly settings, such as children's centres and places where mothers attend with their babies.
- Ensuring pregnant and postpartum women are seen within two weeks of referral and access treatment within one month of assessment (NICE guideline and quality standard).[18]
- Making a range of evidence-based interventions available that target the mental health of the mother and father, the parental-couple relationship and the parent-infant relationship. Interventions include cognitive behaviour therapy (CBT); interpersonal psychotherapy (IPT); trauma focused CBT; eye-movement desensitisation and reprocessing (EMDR); couple's therapy; perinatal-specific group based CBT or IPT for depression: and in children, IAPT interventions to support healthy bonding and attachment.
- Establishing clear pathways between IAPT, perinatal mental health services, parent-infant psychotherapy services and clinical psychologists within maternity settings, to ensure that women are seen promptly by the most appropriate psychological therapy professional, and to ensure continuity of care during this critical period. Thresholds for referring between IAPT and specialist perinatal mental health services should be adjusted to take account of the perinatal period and the presenting problem.
- Providing additional training for IAPT practitioners in perinatal mental health, including perinatal specific needs, infant needs and bonding and attachment.
- Encouraging awareness of IAPT services within maternity services, children's centres and health visiting services, including how they can be accessed.

IAPT and a children's centre partnership Westminster IAPT

Case Study

Westminster IAPT set up a postnatal group based on the CBT program outlined by Milgrom, Martin and Negri.[(1999)] The group runs for ten weeks from a children's centre with crèche facilities and provides support for women struggling with low mood and/or anxiety in the postnatal period. Evaluation showed over 70 per cent of those attending the group recovered from symptoms of depression and anxiety.

The children's centre manager reports that: "Working in partnership with IAPT to provide this service has proved invaluable for some very vulnerable clients who would have been far less likely to engage with our services otherwise, as their low mood or anxiety made attending baby groups very difficult for them. We also know that without crèche provision these mothers would not have been able to access a group. We have seen the expertise of the practitioners and the experience of getting to know other women who have faced similar challenges has been transformative for these families and hope that an equivalent service could be made available to all who need it".

Feedback from those attending the group has been positive."A lovely atmosphere to talk to people who understand your problems" and "I am much better as a mum and can value myself more".

- Encouraging local community groups to recommend IAPT services and helping IAPT link women and families to these groups.
- Having an identified lead for perinatal mental health within each IAPT service with dedicated time for perinatal work, including training, supervision, coordination and liaison to achieve the recommendations listed under points above.
- Commissioning IAPT services that include staff trained in perinatal psychological work who can supervise other IAPT practitioners. These staff members should be supported and have access to supervision with a specialist perinatal clinical psychologist.

Adult mental health services

- Services should be required to routinely collect data on women who are pregnant or in the first postpartum year.
- Women of childbearing potential with serious mental illness in contact with adult mental health services are given information at least yearly, about how their mental illness and any treatment might affect them or their baby if they become pregnant (NICE Quality Standard).[18]
- Adult mental health teams, liaison and crisis/home treatment teams have access to specialist advice and training so they understand the distinctive features and risks of perinatal mental illness (MBRACE 2015).[9]
- Adult mental health teams, including crisis/home treatment teams and liaison services, should have a clear understanding of the mother and baby unit (MBU) admission protocol, the lower thresholds for admission to an MBU and be aware of the importance of not separating mother and baby. All women admitted after 32 weeks of pregnancy, and up to a year postnatally, should be offered admission to an MBU and not to a general adult ward, unless there are specific reasons.
- Adult mental health teams should have an identified perinatal and infant mental health lead.
- Adult mental health teams should consider the impact of perinatal mental illness on the infant and rest of the family. Teams should help families to access support and involve them in care planning. Teams are aware of, and can access, parent-infant interventions for women presenting with bonding and attachment difficulties and available parenting support for families with older children.
- Providing timely access to evidence-based psychological therapies for women in the perinatal period.
- Access to specialist advice when prescribing in pregnancy or lactation.
- Women of childbearing potential **are not prescribed valproate** to treat a mental health problem (NICE Quality Standard).[18]

Child and adolescent mental health services

- Ensure services have a comprehensive and clear parent-infant pathway from birth upwards which provides therapeutic support for vulnerable infants, toddlers and their families (1001 Critical Days Manifesto).[8]
- At secondary care level, CAMHS services providing parent-infant interventions should be integrated with, or work jointly with, specialist perinatal mental health services. CAMHS providers have an identified lead for perinatal mental health and links with specialist perinatal mental health teams and community services.
- Ensuring parents have access to evidence-based programmes of intervention and support to improve parental sensitivity and strengthen attachment between the parent and child, avoid early trauma, build resilience and improve behaviour (Future in Mind).[3]
- Ensure evidence-based parent training programmes are non-stigmatising so vulnerable parents are encouraged to engage, for example peer-led approaches in universal settings such as children's centres.
- Making sure there are effective family/relationship therapies in place for partners who should be involved, and provide support for siblings.
- Transitions between specialist perinatal teams, CAMHS and adult services should be seamless. For young mothers aged 18 and under, psychiatric care is usually led by CAMHS and provided jointly with the specialist perinatal mental health team. However, there should be flexible arrangements between services that take into account the preferences of the mother and which service is best placed to meet her needs.

Specialist perinatal mental health services

- Services provide pre-conception advice to women with severe and complex mental illness. This includes advice on planning a pregnancy, the risk of relapse in pregnancy/postpartum, the risks and benefits of medication in pregnancy and lactation, psychological interventions and the maternity and mental health care available locally.
- Specialist perinatal mental health services case manage women with severe and complex mental illness from conception to the end of the first post-partum year.
- The service is multidisciplinary and meets the standards for accreditation set out by the Royal College of Psychiatrists' Perinatal Quality Network.[7]
- Ensuring that the service provides community outreach and direct services to maternity settings.
- A specialist team that works in partnership with all professionals involved in the family's care, including midwives, obstetricians, health visitors, social workers, children's centres, third sector and GPs, through joint assessments, joint clinics, multidisciplinary team meetings and care planning.
- Ensuring specialist perinatal mental health service works jointly with general adult mental health services, and other specialist services, including drug and alcohol services, eating disorder services, personality disorder services and learning disability services.
- The service provides consultation, advice, supervision, education and training to other professionals in the pathway, for example IAPT, midwives, GPs, health visitors, social care professionals and adult mental health teams.
- The specialist perinatal mental health teams include clinical psychologists and parent infant therapists.[26] These disciplines have a key role in providing evidence-based interventions for families that address all members of the family system, especially the developing infant. Where perinatal psychiatry, clinical psychological and psychotherapy services are dispersed, for example where infant mental health is provided within CAMHS or universal services, or clinical psychology is provided in the maternity hospital, these services should work in close partnership.
- Psychological/psychotherapeutic therapies should be delivered by practitioners with expertise and training in perinatal mental health. This will help to provide interventions that take into account the baby and the developing attachment, safely and effectively manage risk, and allow the interagency working necessary during the perinatal period.

9 Commissioning by local authorities

Public health

- The development of a Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy in each locality for perinatal mental health. These are key to informing service development and targeting areas of need. CCGs, local authorities and other partners should utilise these when developing services.
- Commissioning and implementation of the Healthy Child 0-19 programmes, particularly for under-fives.
- Embedding a preventative approach across the local system, including promoting the importance of parent and infant mental health/attachment. Giving every child the best start in life is crucial to reducing health inequalities across the course of life.
- Oversight of the local perinatal mental health care pathways and working with commissioners to evaluate the impact of services on the local population.
- Wider strategies between health, social care and housing. Joining up different portfolios in public health, for example children's, maternity and mental health.
- Prevention and early intervention through health promotion, family planning, sexual health, reducing obesity, smoking cessation and breastfeeding. Smoking is the single, biggest modifiable risk factor for poor birth outcomes and a major cause of inequality in child and maternal outcomes. Smoking rates among people with a mental health condition are significantly higher than in the general population. Obesity rates are increasing in women of reproductive age influencing physical and mental health, and increasing the risk of complications in pregnancy.
- Ensuring perinatal mental health is part of any work towards reducing stigma and promoting positive mental health, through education, campaigns and public information.

Health visiting services

Health visiting service commissioning key priorities for local authorities include the following elements:[41, 42]

- Health visitors ask about maternal and paternal emotional and psychological wellbeing and the parent infant relationship at each contact. This includes the antenatal, new birth, six to eight weeks and 12 month visits, by asking appropriate questions for the identification of depression as recommended by NICE (Whooley, GAD-2, Edinburgh Postnatal Depression Scale).
- All women should be offered an antenatal health and psychosocial assessment home visit, which includes preparation for parenthood. This is especially important for vulnerable women and women who have a mental illness.
- Health visitors have a clear understanding of local care pathways and where to refer parents and infants requiring secondary care/specialist input.
- Health visitors receive specific training on identifying mild through to severe mental health illness, and supporting mothers with mental ill health during the perinatal period and beyond.
- Health visitors develop close links with GPs and midwives to ensure good communication, sharing of information and a proper handover of care from maternity services to general practice and health visiting when a woman is discharged from maternity care.
- Ensuring there are joint visits/clinics with midwives for women identified with a mental health need.
- Having identified leads for perinatal and infant mental health in each health visiting team.
- At least one specialist health visitor in perinatal and infant mental health in every health visiting service. Ideally aligned with a specialist perinatal mental health team due to the complexity of high risk cases. These practitioners should be responsible for a specialist caseload, as well as delivering training and consultation on perinatal and infant mental health to the wider health visiting workforce. They should also have access to supervision from a colleague with perinatal psychiatric expertise as well as a clinician with expertise in therapeutic work with parents and infants.[41]
- Health visitors take part in multidisciplinary meetings and the development of care plans, working in close partnership with women and families with mental health needs.

The Family Nurse Partnership Programme is available in some areas to support young mothers and works closely with the other professionals involved in the young mothers' care. Health visiting and the Family Nurse Partnership Programme are both commissioned through the Healthy Child Programme and should work closely together.[43]

Early identification and supportive interventions

Early identification and supportive interventions for parents and infants lead to more timely intervention and can reduce the need for medical or social care intervention. Examples of supportive interventions for women identified as having mild anxiety or depression include:

- Listening visits or referring to IAPT for assessment and treatment of mild to moderate difficulties. Listening visits are unstructured, client-led discussions involving the counsellor in: active listening; reflection; providing empathic responses; encouraging the expression of experiences and acceptance of the emotions expressed; and not offering information or advice.
- Parent-infant interventions to increase parental sensitivity, e.g. interaction and baby cues guidance, observation feedback, raising parental confidence and self-efficacy in parenting role.
- Evidence-based antenatal and postnatal groups to promote infant mental health and attachment, for example, parenting classes, infant massage and parent–infant groups with enhanced components for fathers.

Children's centres

Children's centres are ideally placed to act as community hubs. A variety of family-orientated services across the perinatal care pathway should be provided in parallel, enabling care to 'wrap around' the woman, her partner, their baby and wider family. This includes smoking cessation, midwifery care, health visiting, mental health services, social services and third sector services. (National Maternity Review 2016).[40] See Figures 7 and 8 for more detail.

- Provide space for IAPT appointments and perinatal mental health clinics, ideally with childcare support for parents during appointments.
- Provision of parenting support groups, parenting programmes and universal parent-infant interventions such as baby massage.
- Ensuring childcare settings for under-twos have a good understanding of infant mental health and attachment, through regular training, and practitioners know where to refer families when difficulties arise.[8]
- Providing families with advice on how to access housing, finance and benefit support. Good quality advice is essential, it is well evidenced that financial anxieties, debt and housing problems contribute to poor mental health at a time when families experience additional pressures in these areas with the arrival of a new baby.
- Providing health promotion, awareness and early intervention around perinatal mental health and the available support services in the local community across the third sector, health and social care.

Examples of health and wellbeing services in children's centres

- Antenatal registration and checks (midwives)
- Antenatal activities with partners (children's centre service providers) and parents-to-be, preparing for parenthood
- Healthy eating and nutrition
- Healthy lifestyle sessions
- Safety in the home — avoiding/ limiting accidents
- Including brothers and sisters — a welcoming family for baby
- Postnatal checks for mum and baby
- Family nurse partnership activities
- Birth registration
- Baby massage
- Baby-friendly environment
- Baby cafe (breastfeeding peer support)
- Weaning, baby food menus and cooking
- Managing childhood illness
- Two-year child development reviews
- Paediatric first aid
- Maternal mental health and wellbeing
- Maternal sexual health
- Managing substance misuse
- Managing stress
- Exercise and fitness activities (e.g. parent and baby yoga)
- Buggy-cise (outdoor activities with parents and babies)
- Healthy menus and cooking on a budget

Figure 7: Examples of health and wellbeing services in children's centres[44]

Examples of parent development and support services in children's centres

- Childcare
- Safeguarding
- Universal drop-in sessions covering topics by parental request
- Attachment promotion and learning
- Motivating and sustaining positive behaviour in the family
- Advice and guidance sessions
- Money management and budgeting advice
- Housing advice and support
- Domestic violence intervention and support (Freedom programme)
- Light touch (universal) parenting programmes
- Bespoke parenting programmes for priority families
- Family support activities in groups (centre-based; community and homebased)
- Programmes for working carers/families
- Programmes for dads and male carers (with children and/or as a peer group)
- Specific support/activities for teen parents-to-be and parents
- Specific support/activities for ethnic community, faith or interest groups
- Managing transitions for your child (home to childcare; home/childcare to school)
- Volunteering opportunities

Figure 8: Examples of parent and support services in children's centres[44]

10 Commissioning third sector services

Children's social care

- There are close links between children's social care and specialist perinatal mental health teams, and teams have dedicated sessions with a children's social worker.
- There are identified social work leads for perinatal mental health in early help, referral and assessment and child protection teams providing timely assessments.
- There is joint-working at an early stage and joint care planning when cases are known to perinatal mental health teams and social care. This should include regular multi-professional meetings, information sharing and all agencies contributing to a streamlined plan where appropriate.
- All teenage parents should receive specific support.[58]
- Early help and evidence-based parenting programmes should be available to support vulnerable families experiencing perinatal mental illness.
- Information about childcare options and family support is available to families experiencing more severe perinatal illness.
- Pre-birth assessments are started as early as possible in pregnancy so that, when significant concerns are identified Child Protection Conferences are held by 30 weeks of pregnancy (as recommended in the London Child Protection Procedures).[45] Time should be given for women and families to access care and treatment and work with professionals to identify solutions.
- Where a decision is made to remove a child, parents have access to psychological support.

Parenting assessments

Parenting assessments are different from admission to a Mother and Baby Unit for assessment and treatment of perinatal mental illness.

They are commissioned by local authorities to assess parenting capacity. If mental illness is present, this should be treated and/or stabilised before a parenting assessment takes place.

Community and voluntary organisations can be a vital source of support, advice and information for women and families. Smaller unfunded, community groups may be difficult to engage, and some may not provide services using formal commissioning arrangements. It is helpful to work with them to agree the best way to include them, particularly with regard to awareness raising activities.

- Ensure there is a good understanding of available local third sector services and their part in the perinatal pathway.
- Involving third sector agencies in the development of the local pathways to enable more support to be provided across the spectrum of perinatal illness.
- Consideration is given to a range of interventions to support families including peer support, parenting programmes, parent-infant, counselling and advice on areas that can increase stress in parenthood, e.g. benefits and housing.
- Clear referral pathways between statutory and third sector services.
- Provision of specialist domestic abuse services that have a link to maternity services and offer training to professionals working with women, partners and their families.
- Ensuring that awareness of perinatal mental health problems and the available support services is widely disseminated – i.e. not just within the mental health arena but across community groups.
- Services target hard to reach groups, including those for whom English is not a first language or cultural groups where mental health may be more stigmatised.
- Sharing of public sector resources with third sector groups, including: facilities, training, and events.

Substance misuse

Women with primary substance misuse diagnoses should be referred to substance misuse services (these services are provided by health, social care and/or the third sector depending on local arrangements). Substance misuse services should have links with maternity services and provide outreach for hard to engage women. This should preferably be a specialist antenatal substance misuse service including midwifery/obstetric clinicians with expertise in substance misuse. If there is a co-morbid mental illness, the specialist perinatal mental health team should joint work with the substance misuse service.

11 Workforce and training

Trained specialists and non-specialists are needed to identify, assess, treat or refer cases appropriately. Across London, work in this area is ongoing, however it is not fully developed across the whole pathway. Commissioners need to develop an understanding of the current workforce across London. Figure 9 provides an overview of perinatal mental health service provision for psychiatrists, social workers and community psychiatric nurses (2015)[6].

Training

The National Maternity Review[2] (2016) highlights the need for multi-professional education and training for those at the start of their careers and emphasises the need for shared training to continue as part of continuous professional development.

Training and supervision should be available for all professionals and agencies involved in the care of pregnant women and young mothers, as well as those involved in the care of pregnant and postnatal women with mental illness, so they can deliver high quality care that complies with NICE guidance.

Training should be tailored for each level of the care pathway to improve detection and screening for mental disorders, with those with the relevant competencies and professional accreditations delivering training on perinatal mental health. This will help to support the workforce to make best use of the opportunities to promote positive mental health, wellbeing and parent-infant attachment.

Training packages should include ongoing supervision/ reflective practice, and they should be embedded in local staff training and development strategies.

The local specialist perinatal mental health team, including specialist perinatal clinical psychologists and perinatal psychotherapist, should play a key role in delivering training to the wider system.

The perinatal clinical psychologist, in particular, has an important role in providing supervision for local IAPT service team members, including the designated perinatal mental health lead within IAPT. The parent-infant therapist plays a part in providing training and consultation for health visitors, family nurses and early years staff, to ensure they are able to identify, support and refer families requiring more specialist intervention.

All professionals should receive training in safeguarding which includes domestic abuse, sexual exploitation, honour based violence, female genital mutilation, forced marriage and slavery; to enable routine, safe enquiry and knowledge on how to respond and where to refer.

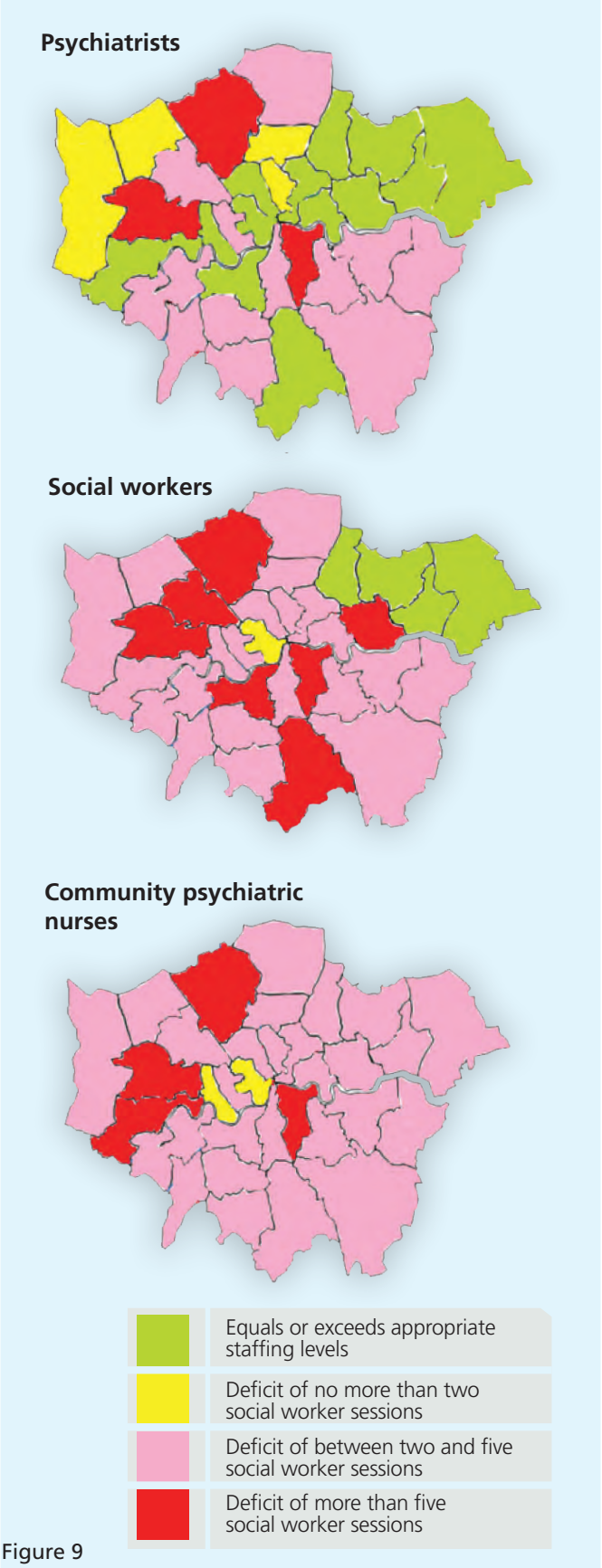

Figure 9

Health Education England's (HEE) mandate[48] document, Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values (2015), recognises the importance of maternal and infant mental health.

HEE is working with the medical royal colleges, the Nursing and Midwifery Council and the Royal College of Midwives to develop educational frameworks for different professional groups focusing on perinatal mental health and ensuring there is a workforce in place to deliver high quality care.

Maternal mental health psychiatry

The Royal College of Psychiatrist's Perinatal Quality Network Standards[7] and The Royal College of Psychiatrists,[46] both provide guidance on the levels of staffing necessary for community perinatal mental health teams. The following table sets out the staff needed to be accredited as a good psychiatric service, based on 10,000 deliveries.

Role	Numbers
Consultant perinatal psychiatrist	1 WTE
Trainee psychiatrists/ non-consultant grade doctor	1 WTE
Community team manager (50% managerial, 50% clinical)	1
Specialist community nurses	5
Psychologist	1 WTE
Occupational therapist	1 WTE
Social worker	0.5 WTE
Community nursery nurses	2.5 WTE
Link midwife	1.5 day
Link health visitor	1.5 day
Team secretary/administrator	1 WTE

WTE (whole time equivalent)

Table 7 Perinatal community mental health team staffing per 10000 deliveries[46]

Where the team provides obstetric liaison to maternity services in areas of high socio-economic deprivation across a wide geographical area, additional workforce requirements should also be considered.

Maternity and neonatology

Each maternity unit should have a dedicated (i.e. with clinical sessions additionally funded) obstetric consultant as the obstetric perinatal mental health lead, with at least one whole time equivalent (wte) specialist perinatal mental health midwife. The midwife should work closely with the child safeguarding midwife and the specialist perinatal mental health team in a dedicated multi-professional team.

Maternal mental health psychological therapies

Staffing levels for clinical psychology provision will depend on the scale and distribution of maternity services in the area and the configuration of related medical and mental health services.

The British Psychological Society recommends:[26]

- Where services are provided within a specialist community perinatal mental health team, providing integrated services into maternity hospitals, a range of recommended options exist. Oversight should be provided by a Consultant Clinical Perinatal Psychologist (Band 8c or 8d according to the number of services and staff overseen) with a minimum total of 0.4wte for the first 6000 births and a minimum of one extra session for every additional 3000 births thereafter. This post may sit within MBU, maternity or community. There must be 0.3-0.4wte Band 8a per 1000 births (equating to 1.0wte Band 8a per 3000 births). Where there are 12,000 births or more (or the Consultant Clinical Psychologist oversees three settings or more), there must also be 0.1wte Band 8b per 1000 births. These are minimum recommended levels.
- A maternity hospital with 3000 deliveries per annum, should have access to a minimum 0.6wte Consultant Clinical Perinatal Psychologist (minimum Band 8c) and one whole-time Specialist Clinical Perinatal Psychologist (Band 8a) to support the maternity service.

- Where a Neonatal Intensive Care/Special Care Baby Unit is also supported this would require a further half-time Specialist Clinical Perinatal Psychologist (Band 8a). The service will require an additional band 8a Clinical Perinatal Psychologist per additional 3000 women (for example, a 0.6wte 8c Consultant and two band 8a Clinical Psychologists in a hospital with 6000 deliveries per year).

	8a	8b	8c/d
3000 births	1.0	-	0.4
6000 births	2.0	-	0.4
9000 births	3.0	-	0.5
12000 births	4.0	1.2	0.6
15000 births	5.0	1.5	0.7
18000 births	6.0	1..8	0.8
24000 births	7.0	2.4	0.9

Table 8 clinical psychology workforce recommendations for increasing numbers of births[26]

Parent-infant mental health

It is recommended that teams should be formed based on practitioners' clinical skills and their ability to provide the most evidence-based interventions. Clinicians should be recruited into generic posts – 'parent-infant mental health practitioner' reflecting a range of seniority (band 6 through to consultant).

At least one member of staff in the service should have an intensive outreach role to engage families in the community. Clinical backgrounds that might fit these posts include Child Psychiatrists, Clinical Psychologists, Parent-Infant Perinatal Psychotherapists, therapeutically trained Nurses and Social Workers, Child Counsellors and Systemic Family and Couples Therapists[5].

Social care

Integration and joint working with others services are key. It is recommended that each specialist perinatal mental health team has input from a children's social worker.[29]

Psychotherapy consultations to healthcare professionals: Basildon and Thurrock NHS Foundation Trust

Case Study

In Basildon and Thurrock, healthcare professionals in,cluding health visitors, social workers and children's centre workers, benefit from consultations that may also include non-mental health care workers.

This helps professionals to discuss their own observations and concerns about a mother or baby they might be worried about. It also enables health visitors to think about the impact of perinatal mental health issues on the emotional development of the child and, if appropriate, refer for parent-infant psychotherapy.

Specialist health visitors offer parents with young children group work and the consultations ensure there is a focus on the child and not just on the parent/mother. Other areas focus on the mother-child relationship and possible risk to the young child in order to identify resources to support and improve the relationship between mother and young child.

Having a better understanding of the difficulties helps professionals to identify concerns and assess safeguarding issues. The earlier this happens, the safer and better it is for the infant and his/her family. This includes thinking about the support the mother or pregnant woman can gain from her partner, her family or the community.

12 Quality and standards

Outcomes

This section draws together the existing NHS and Public Health outcome frameworks, examples of outcome measures in use across London, and the related NICE quality standards.

Commissioners in London inevitably use a range of measures to assess quality along the perinatal mental health pathway, and should be aware of the national outcome measures.[52]

The use of a variety of different measures means that services must be able to clearly demonstrate that they are providing safe and effective services for people to ensure they have a positive experience of care.

The experience of providing IAPT services has shown for the vast majority of people who use them, it is possible to monitor clinical outcomes in every session.

Providing perinatal mental health care is relevant to the NHS Outcomes Framework 2015/16[48]: National perinatal mental health outcome measures are expected in early 2017.

Table 9 NHS Outcomes Framework domains, perinatal mental health-related outcomes

Domain 1	Preventing people from dying prematurely	Reducing the risk of avoidable mortality in infants, children and women with serious mental illness, by ensuring high risk women are identified early, and engaged with services in a timely manner.
Domain 2	Enhancing quality of life for people with long-term conditions	Women with severe and enduring mental illness deserve every opportunity to be the parents they wish to be. Excellent perinatal services help facilitate this.
Domain 3	Helping people to recover from episodes of ill-health or following injury	By commissioning a perinatal mental health pathway that will enable women, their partners and families to access the right treatment at the right time, they will recover more quickly, establish good relationships and parenting practices with their infant and resume their normal social functioning.
Domain 4	Ensuring people have a positive experience of care	Services should seek out, listen to and act on patient feedback.
Domain 5	Treating and caring for people in a safe environment and protecting them from avoidable harm	Perinatal mental health services address the risks to parents and infants associated with mental illness in pregnancy and the postpartum period and will reduce both maternal, paternal and infant mortality and morbidity.

It is beyond the scope of this guideline to define the core outcomes measures that should be used in each part of the pathway.

A series of validated measures covering the perinatal period for parents/partners is listed in Table 11 on page 39. More information on developing a structured and standardised approach to assessment can be found in the Analysis of Care Environments (FACE) perinatal toolset[50].

The indicators shown below are part of the Public Health Outcome Framework, and can be influenced by improvements to perinatal mental healthcare. Many of these are long-term outcomes influenced by multiple factors, particularly the early years' experience.

Public Health Outcomes Framework	Indicators
Domain: Wider determinants of health	• Children in poverty • School readiness at reception year • Pupil absence • First time entrants to the youth justice system • 16-18 year olds not in education, employment or training • Domestic abuse • Violent crime • Statutory homelessness
Domain: Health improvement	• Breastfeeding initiation • Breastfeeding prevalence at 6-8 weeks • Smoking status at time of delivery • Under-18 conceptions • Excess weight in 4-5 year olds • Excess weight in 10-11 year olds • Hospital admissions caused by unintentional and deliberate injuries in children • Emotional wellbeing of looked after children • Self-reported wellbeing • Average Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) score
Domain: Healthcare and premature mortality	• Infant mortality • Suicide rate

Table 10 Public health outcomes framework, factors affecting perinatal and child mental health

NICE Quality Standards

NICE Antenatal and Postnatal Mental Health Quality Standards[18] describe high-priority areas for quality improvement.

Each standard consists of a prioritised set of specific, concise and measurable statements. The associated quality measures are detailed in the guidance.

- **Statement 1.** Women of childbearing potential are not prescribed valproate to treat a mental health problem.
- **Statement 2.** Women of childbearing potential with a severe mental health problem are given information at their annual review about how their mental health problem and its treatment might affect them or their baby if they become pregnant.
- **Statement 3.** Pregnant women with a previous severe mental health problem or any current mental health problem are given information at their booking appointment about how their mental health problem and its treatment might affect them or their baby.
- **Statement 4.** Women are asked about their emotional wellbeing at each routine antenatal and postnatal contact.
- **Statement 5.** Women with a suspected mental health problem in pregnancy or the postnatal period receive a comprehensive mental health assessment.
- **Statement 6.** Women referred for psychological interventions in pregnancy or the postnatal period start treatment within 6 weeks of referral.
- **Statement 7** (developmental) Specialist multidisciplinary perinatal community services and inpatient psychiatric mother and baby units are available to support women with a mental health problem in pregnancy or the postnatal period.

CQUIN goals completed locally

Location of provider premises completed locally

Table 11 Validated measures covering the perinatal pathway for parents (and others where indicated)

	Clinician rated	Patient rated
Parental mental health measures	Camberwell Assessment of Needs – Mother's version	*Depression* Edinburgh Postnatal Depression Scale (EPDS) *Anxiety* Pregnancy-Related Thoughts (PRT) Questionnaire *Birth trauma* City University Postnatal PTSD Scale
Generic adult mental health measures*	Health of the Nation Outcome Scales (HoNOS)	*Global mental health and wellbeing* Kessler-10 Clinical Outcomes in Routine Evaluation (CORE-10) *Depression* Patient Health Questionnaire (PHQ-9) *Anxiety* Generalised Anxiety Disorder (GAD-7) *Post-traumatic stress disorder* Impact of Events Scale *Obsessive-compulsive disorder* Obsessive compulsive inventory
Measures of parent infant interaction and parenting behaviour	Keys to Interactive Parenting Scale (KIPS) Parent–Infant Relationship Global Assessment Scale (PIR-GAS) Crittenden Care Index Parent–Infant Interaction Observation Scale (PIIOS)	Antenatal Attachment Scale (Maternal and Paternal version) Postnatal Attachment Scale (Maternal and Paternal version) Post-partum Bonding Questionnaire (PBQ) Maternal Object Relations Scale (MORS) Brief Parenting Self-Efficacy Scale (BPSES)
Measures of infant outcomes and development	Alarm Distress Baby Scale (ADBB)	Infant Behaviour Questionnaire Ages and Stages Questionnaire (ASQ-SE and ASQ-3)
Measures of the clinician-patient relationship		Session rating scale Group session rating scale
Measures of patient experience and satisfaction		Patient Outcome and Experience Measure (POEM) Experience of Service Questionnaire (CHI ESQ)

* validated for parents in the perinatal period

Appendix 1
Co-production event to review a London-wide perinatal mental health service specification

Introduction

The collaborative approach needed to ensure integrated services across the perinatal mental health pathway, lay at the heart of the co-production event that ran on the 28th January 2016.

The aim of the event was to encourage participation and shared relationships, valuing the contributions of each person. It was important to include a broad range of stakeholders in order to capture as much expertise and experience as possible from every area within the pathway.

Health experts were invited to develop the perinatal mental health service specification for London. These included practitioners from mental health, maternity, CAMHS, local authorities and the third sector, along with the important voice of people with lived experiences. It provided opportunities for learning, building relationships and developing a sense of community.

Attendees worked together to review a template for the service specification and define priorities for the pathway. Looking at the whole pathway as well as the services within it, the collaboration ensured a joined-up approach to delivering high quality services within the perinatal pathway for women and families across London.

The information collated at the event was used to inform the content and help shape the final service specification. Contacts made at the event were also called upon to review and comment on the final specification for London. The specification gives commissioners high-level guidance based on the outcomes that are important to women and their families.

The day was chaired and facilitated by Clair Rees, Executive Director, Parent-Infant Partnerships UK. Clair provided the group with a thought-provoking start to the day by asking everyone in the room to write down what they wanted perinatal mental health services to look like in 20 years' time.

A key message was the need to commission collaboratively across health, local authority and NHS England to ensure integrated provision with focus on community services across the perinatal pathway.

Presentations

Presentations focused on giving the audience an understanding of the needs and benefits of providing appropriate perinatal mental health services. They drew upon a wealth of experience and information and included the following elements:

- personal experience stories
- why perinatal mental health matters
- what specialist perinatal mental health services currently exist across London
- what the perinatal mental health care pathway should look like, including the roles of health professionals along the pathway
- existing model of care and their development

Information captured from delegates emphasised the complexity of the perinatal mental health pathway which combines specialist and generalist care, commissioned by different agencies. The desire to work together to ensure one clear care pathway for women and their families was clearly articulated. Key messages from the day included:

- **The importance of joint-working**
  This included the collaboration of services commissioned through public health and social services.
- **The value of children's centres**
  Often cited as providing safe environments for the whole family and locations that provide access for peer support using a variety of different agencies.
- **The need for training and education programmes**
  To ensure up-skilling of the workforce, including raising awareness across the varied multidisciplinary teams and providing support from specialists across the pathway.

Workshop 1
'I' Statements

The 'I statement' workshop asked delegates to work in groups to define what they wanted to see and experience within a perinatal mental health service. 'I statements' were produced to reflect the perspective of both those using the service and those working within the service.

The task enabled delegates to express their beliefs and feelings about what is important to them when thinking about perinatal mental health. The following themes were identified as priorities for perinatal services.

Themes

- **Consistency**
  - Continuity of care, Same midwife/health visitor
  - Handovers are seamless
  - Information is shared, no repetition of story/history
  - Wellbeing question asked by all professionals
- **Access**
  - Close to home
  - Referral to service relevant for my needs and my family
  - 24 hours
  - Emergency – I know where to go, what to do and who to call
- **Social**
  - Consider cultural/social beliefs
  - Ongoing support – including peer support
  - Support for the whole family, not just mum
  - Social needs considered e.g. debts, housing, work etc.
- **Communication**
  - Between professionals and across care agencies
  - Shared language
- **Information**
  - Understanding the conditions and knowing the risks
  - Preconception advice
  - Signposting for help and advice

Workshop 2
What matters most?

The second workshop asked the audience to review each of the specific services within the perinatal care pathway and identify what matters most within each area, focusing on how priorities could be practically delivered. Services reviewed were:

- Adult mental health service (e.g. general adult mental health and liaison psychiatry)
- Specialist perinatal mental health
- CAMHS
- Children's services
- Maternity
- Health visitor
- IAPT
- GP
- Public health
- Voluntary sector

The following themes were identified as relevant across the whole pathway.

Themes

- **Training**
  - Building up confidence
  - Train the trainer/third sector provision
  - Accredited and recognised
  - Supervision from specialist teams
  - Training across services e.g. maternity
- **Joined up working and working in partnership**
  - Commissioners across services
  - Links with early help teams/family services
  - Substance and misuse services
  - Joint clinics
  - MDTs from across the pathway
  - Working across boundaries e.g. council, CCG, hospital etc.
- **Workforce**
  - Champions: identified leads across the pathway for all disciplines
  - PMH practitioners within crisis teams, home treatment teams and day hospitals
  - Adequate workforce support (peer support)
- **Information**
  - Referral routes
  - Third sector
  - Public health messages
  - Knowing what's available locally

APPENDIX 2 Best practice contact details

Name/role	Area of best practice	Organisation
Jen Barker, Specialist Health Visitor for Parental Mental Health	Specialist health visitor	Oxleas NHS Foundation Trust
Dr Sarah Healy, Clinical Psychologist	IAPT	CNWL, Westminster
Marigemma Rocco-Briggs, Consultant Child & Adolescent Psychotherapist	Psychotherapy	Basildon and Thurrock
Lucinda Green	Preconception counselling	St Thomas and WMUH
Tower Team	Midwives	St Thomas Hospital
Emma Fox	Lived experience/co-production	NWL
Sarah Garner, Associate Director of Delivery	Working across partners to deliver perinatal services in MH	Newham CCG
Alison Wright, consultant obstetrician and gynaecologist Jude Bayly, Named midwife for child protection and vulnerable families	Multi-discipline team working	Camden & Islington NHS Foundation Trust, The Royal Free NHS Foundation Trust
Teresa Bell	Specialist Health Visitor	Brentwood Community Hospital
Dr Sushma Sundaresh, Consultant Perinatal Psychiatrist Jill Demilew, Consultant Midwife PH	Joint working between perinatal psychiatry and maternity	South London and Maudsley NHS Foundation Trust (SLaM) and King's College Hospital
Dr Carol Broughton	Parent-infant project	Homerton University Hospital, Mother & Baby Unit/Anna Freud Centre
Dona Thomas, specialist midwife/mental Health Wiece Koniman, obstetrician Olivia Protti, consultant perinatal psychiatrist Maryam Parisaei, consultant obstetrician	Working across services	Homerton University Hospital/East London Mother & Baby Unit
Michela Biseo, Consultant Parent Infant Psychotherapist	Parent infant project (PIP)	Anna Freud Centre
Kathryn Fenton	Parent and infant relationship service (PAIRS)	Lambeth Early Action Partnership (LEAP), CAMHS/SLaM
Christine Wood, Senior Midwifery Manager, Gateway PH midwifery team	Working across services	Royal London Hospital, Barts Health NHS Trust
Sarah Finnis, Specialist Principle Clinical Psychologist (Obstetrics and Gynaecology)	Care plan	CNWL
Natalie Vrahimides	Working with children's centres	West London Mental Health NHS trust
Marie Trueman, Programme Manager, maternity; Rhiannon England, GP commissioning lead	Partnership working	City and Hackney CCG
Nicola Kirkland, CBT Therapist	IAPT	Enfield IAPT services
Dr Nisha Shah, Consultant Perinatal Psychiatrist	Joint-working	NELFT
Julia Lidderdale, Senior midwife/Perinatal Mental Health Midwife Specialist	Training	Queen Mary's Maternity Unit West Middlesex Hospital
Miriam Donaghy, MumsAid	Public health	Public Health England/MumsAid
Miriam Philip Senior Co-ordinator	Third Sector	Home-Start Westminster

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