Integrating perinatal mental health care and support across the Maternity Transformation Programme

1. Background

1.1. It has been recognised by members of the Maternity Transformation Programme (MTP) Board that the MTP *as a whole* could be doing more to ensure that high quality, evidence-based perinatal mental health care and support is integrated into all of its work streams.

1.2. It is recognised that developing the strength of perinatal mental health care within the MTP should include a focus on protecting good mental health, reducing the risks of women developing mental health difficulties, supporting the early identification of women who are experiencing mental illness (from mild to severe) and ensuring the care pathways are in place so they are able to access evidence-based care. It should also focus on tackling inequalities in access to perinatal mental health care.

1.3. Currently perinatal mental health work is being actioned within three of the MTP work streams, as outlined below:

- **Work stream 1 (Local Transformation):** WS1 supports Local Maternity Systems (LMS), which have the responsibility to lead change locally. Through a forum of national and regional stakeholders, it provides strategic direction, shares best practice and ensures that appropriate support is provided to local systems as they seek to deliver the vision of Better Births. The WS1 Delivery Group set out to LMSs what action they should consider in relation to perinatal mental health in the LMS Resource Pack (March 2017). In October 2017, LMS shared draft local transformation plans, which they are now iterating and implementing. All plans should cover the improvement of perinatal mental health provision. The Regional Maternity Programme Boards are responsible for assuring the contents of plans, and their delivery.

- **Work stream 4 (Perinatal Mental Health):** WS4's core objectives are aligned with delivering the *Five Year Forward View for Mental Health* which states that by 2020/21 at least an additional 30,000 women each year will receive evidence-based treatment, closer to home, when they need it, by increasing access to specialist perinatal mental health support in the community or through inpatient Mother and Baby Units. This transformation is backed by £365million of additional funding to support the new specialist perinatal mental health services to provide care for women and their families who are experiencing moderate to severe mental illness. As part of this funding, specialist services are also required to support their colleagues in universal services by delivering supervision, training and consultation to raise awareness of perinatal mental health difficulties. The wider system is further supported through the creation of 12 perinatal mental health clinically-led networks whose function is around supporting strategic local perinatal mental health planning, developing integrated clinical pathways between specialist services and the wider system, ensuring pathways are accessible to all women and families, promoting co-produced systems, and the coordination of

training and education opportunities. All perinatal clinical networks work closely with their colleagues in maternity clinical networks.

- **Work stream 9 (Prevention):** WS9 has a focus on prevention in relation to protecting good mental health and reducing the burden of perinatal mental illness. This includes a range of topics which increase protective factors and reduce risk to mothers and babies. Including preconception health and ways to promote resilience reduce isolation and protect the parent-child bond. This involves prevention, early intervention and recovery across the life-course, both up to the first pregnancy as well as for second and subsequent pregnancies. There is a continued focus on perinatal mental health as part of the PHE led national Prevention Concordat for Better Mental Health and the Local Authority Elected Member Mental Health Champions initiative

2. Aims

2.1 The aims of this paper are to:

- Support LMSs to transform perinatal mental health care by setting out the current programme of work across the MTP.
- Outline any gaps in current perinatal mental health care provision which may be addressed with the support of work stream 1.
- Propose a range of perinatal mental health care initiatives to address the identified gaps by 2020/21 and to invite the WS1 Delivery Group to comment on these initiatives (as outlined in section 4). **Please note – as this paper is for the purposes of discussion, a number of the proposals require further engagement with key stakeholders and will go through appropriate sign-off. They are presented here to get an early steer from the WS1 DG.**

3. What is the scale of the problem?

3.1. Mental health problems in pregnancy and the first year after birth are experienced by up to 27% of women in the UK[1].

3.2. There are a number of significant adverse long term outcomes to mothers, partners, babies, families and communities when perinatal mental health problems are left unidentified and untreated. These include poor developmental outcomes to offspring such as elevated rates of mental health difficulties, poor educational attainment and an increased risk of anti-social behaviour. There are also poorer maternity outcomes such as increased risk of complications, shorter gestational period, lower birth weight infants, increased risk of instrumental delivery and postnatal stay. The personal, societal and financial costs of such failures are high and often preventable[2].

[1] Howard, L. M., Ryan, E. G., Trevillion, K., Anderson, F., Bick, D., Bye, A., ... & Milgrom, J. (2018). Accuracy of the Whooley questions and the Edinburgh Postnatal Depression Scale in identifying depression and other mental disorders in early pregnancy. *The British Journal of Psychiatry*, *212*(1), 50-56.

Asmussen, K. & Brims, L. (2018). *What works to enhance the effectiveness of the Healthy Child Programme: An evidence update*. London: EIF.

[2] Bauer et al. (2011). *The costs of perinatal mental health problems*. London: LSE.

3.3. Effective and timely intervention can prevent much of the harm this can cause. A range of provision must be in place to ensure that women who are at risk of or experiencing perinatal mental health difficulties are given appropriate, evidence-based support at the earliest opportunity. A stepped care model for perinatal mental health is included at **Appendix A**, showing current care for targeted prevention / early intervention, mild to moderate and moderate to severe conditions.

4. Perinatal mental health service provision – gaps and solutions?

Perinatal mental health problems range from mild to severe and complex, requiring different levels of intervention at different times. A stepped care model of support is recommended in the NICE clinical guidance for antenatal and postnatal mental health[3].

4.1 Step 1: Prevention and early intervention – what are the gaps?

4.1.1 Step one in this pathway relates to women who are not currently experiencing mental health difficulties but may be 'at risk'. The biggest predictor of perinatal mental health difficulties is a previous experience of mental health difficulties (which is further heightened if this episode occurred in a previous pregnancy). Further risk factors include:

- **Obstetric and neonatal factors** – pregnancy complications, hyperemesis, prematurity, neonatal stay, instrumental or surgical delivery.
- **Sociodemographic and economic factors** – age (under 24 or over 40), experiencing financial hardship, being from a minority ethnic group or living in a deprived area, having a low level of education, unemployment
- **Psychological factors** – having experienced a previous perinatal loss, having an unplanned or unwanted pregnancy, having experienced adverse childhood events or gender-based violence in adulthood
- **Relationship factors** - Low partner and social support, couple relationship conflict, being a single mother, being in a short-term relationship

4.1.2 With the exception of pre-conception counselling for women with a history of severe mental health difficulties, Step 1 services are designed and offered to protect good mental health universally and a more targeted prevention offer to women identified 'at risk'. In Step 1, women and their families do not yet need interventions from specialist mental health clinicians, and can instead be supported to protect good mental health by maternity services.

4.1.3 Early identification and universal evidence-based screening is a core part of Step 1 care and is recommended as part of the NICE guidance on the clinical management of antenatal and postnatal mental health. In Quality statement 4 in the associated NICE quality standards (QS155), it states: *Women are asked about their emotional wellbeing at each routine antenatal and postnatal contact*. Despite this guidance the maternity services dataset (MSDS) currently indicates that emotional wellbeing is enquired about at only 50% of routine antenatal appointments.

[3] NICE. (2014). *Antenatal and postnatal mental health: clinical management and service guidance*. London: NICE.

4.1.4 Similarly, NICE guidance recommends GPs enquire about a new mother's emotional wellbeing at the 6-week postnatal check as this is an ideal opportunity for a GP to spot any mental health problems that are developing. This routine mental health enquiry postnatally via the GP is poor, with the NCT's hidden half campaign which found that one fifth of women were not asked about their emotional wellbeing and out of those that did, half of the mothers who had an emotional or mental health problem that they wanted to discuss didn't feel able to due to the meeting being rushed or the GP seeming not interested. One of the main barriers is this appointment is not currently in the GP contract.

4.1.5 Within maternity services themselves, there is patchy provision of specialist mental health support – with examples of excellent practice but many others where mental health is not prioritised. A national stocktake of universal perinatal mental health services in England was commissioned by Health Education England (HEE) in 2017 regarding 2016 provision. The findings are summarised below (referencing data from 141 obstetric services and 123 midwifery services). The report found that the provision of perinatal mental health care within universal services is highly variable across England, with some areas having no, or limited provision. Obstetric or midwifery mental health leads were found in 61% of maternity providers. Where there was provision, it was typically limited to a small number of specialist roles in each service. In total, in obstetric services 40.8 WTE specialist practitioners were identified (1.3% of total obstetric capacity) and in midwifery services 228 WTE specialist practitioners were identified (1.4% of total midwifery capacity). The role of a specialist perinatal mental health obstetrician was typically filled by a Consultant Obstetrician (78%). The role of a specialist mental health midwife was found to be typically filled by a band 6 post (58%), with 57% of specialist Midwives being over 50. This will have workforce planning implications within these specialist services in the future. On average, 17% of obstetricians and 65% of midwives were found to have taken part in a local perinatal mental health training programme

4.1.6 Within the risk groups identified in 4.1.1, there are two key 'at risk' groups that currently are rarely picked up for mental health support, these are families who require **neonatal support** and families who experience a **loss in pregnancy.** This is likely to be due to their increased risk occurring before or after their booking-in visit and no-one enquiring about their mental health after their loss/premature birth/unwell baby and/or no-one in that service having specialist mental health skills/knowledge. This is a real concern as both of these groups are unfortunately at increased risk of experiencing mental health difficulties (particularly PTSD) and miss out on the opportunity to access evidence-based psychological therapy if the not screened and identified. They are also at elevated risk of experiencing severe mental health difficulties and bonding difficulties in subsequent pregnancies – so particularly under-served groups

4.2 Step 1: Prevention and early intervention – what are the possible solutions?

Possible solutions are described below and have been broken into (a) what is being done now; (b) what could be achieved by 2020/21 without additional investment; and (c) what could be achieved by 2020/21 with additional investment.

4.2.1 What is being done now?

- Access to training and supervision from specialist PMH teams. There are now specialist community PMH teams in every CCG in the country. It is within the service specification of all these teams (when fully staffed/mobilised) to consult, train and supervise colleagues in the maternity pathway and to have joint protocols with maternity services to ensure robust, transparent, collaborative care pathways between the two services.

- National PMH training fund. The national perinatal mental health programme have made £601,000 available in Q2 of 2018/19 for a regional training fund which includes a focus on disseminating perinatal mental health training for professionals working in services outside of specialist teams – including maternity services, neonatal services, and early years community and educational services.

- PMH competency framework Health Education England (HEE) have published a multi-disciplinary perinatal mental health competency framework that outlines the skills and knowledge expectations for all professionals coming into contact with mothers and families from preconception until 1 year postnatally – including those working in the maternity settings. It is planned for this tool to be full digitalised on e-lfH by September 2018. This tool will help to identify the skills and competences required by (clinical and non-clinical) maternity professionals, map gaps in competencies and therefore provide a foundation with which specialised professional training can be developed and disseminated.

- Training directory To further complement this work, HEE have gone out to tender to procure a provider to conduct a national scoping exercise of current quality and coverage of perinatal mental health training and how it aligns to the competency framework – this will include training targeted at those working in maternity services, neonatal services, and early years community and educational services. This will be translated into a national training directory and be delivered within 2018/19.

- Mental health services data set & maternity services data set linkage. Following a series of test reports, the MSDS and MHSDS have been successfully linked and NHS Digital will publish publically available information annually on the following areas:
    A. Total number of women per year using specialist community perinatal MH services (with at least one contact)
    B. Number of women per year admitted to Mother and Baby Units

C. Total number of women using secondary mental health services during perinatal period
D. Which secondary MH services are accessed by women in perinatal period
E. Age and ethnicity of women in each group above
F. Pathways and caseloads for PMH teams – including source of referral, number of contacts, interventions offered, length of time on caseload, discharge destination.

- Maternity Services Dataset 2.0. The content of version 2.0 of the MSDS has been defined and due to go live in May 2019. It will elaborate on the binary yes/no mental health query record of MSDS 1.0 and include the two Whooley questions (depression identification questions):
    1. During the past month, have you often been bothered by feeling down, depressed or hopeless?
    2. During the past month, have you often been bothered by having little interest or pleasure in doing things?

- GP 6-week postnatal check. The Postnatal Care Expert Reference Group, chaired by Jacqueline Cornish, has identified the check undertaken by GPs at six to eight to weeks after the birth as being important to the early identification of maternity-related mental health conditions. The NHS England Primary Care, Mental Health and MTP team have been working with the GP contracting groups to identify whether there might be opportunities to amend the GP contract during this year's contracting negotiation round. In conjunction, the perinatal mental health programme have put forward QOF NM156 (routine mental health enquiry during postnatal visits) as an indicator for consideration as part of the network QOF pilot.

- Best practice guidance on maternity and perinatal service access for hard-to reach groups. Public Health England (PHE), the mental health policy team and the maternity transformation programme were successful in a Health and Wellbeing Alliance bid and are working with Maternity Action who have been commissioned by the Department Health and Social Care, to develop some best practice guidance and case studies of VCSE-led strategies to address barriers to access to maternity and perinatal services and support by women facing inequalities such as young age, being from a BAME group, identifying as LGBTQI, being from a traveller community or a refugee, or not having English as their first language.

4.2.2 What could be done with no additional investment by 2020/21?

- Closer working with perinatal mental health and maternity clinical networks to review PMH offer in the local system. For the perinatal and maternity national programmes to provide guidance to their respective strategic clinical networks that could be integrated in their 2018/19 or 2019/20 strategies to develop closer working relationship with each other based around the following priority areas:

    A. ensuring that there is respective representation from each of the maternity and perinatal networks at each other's clinical network meetings and strategy planning meetings;
    B. working together to share a local baseline provision (based on the NHS Benchmarking universal survey) of specialist mental health maternity staff (i.e. obstetricians and midwives and any others staff members with dedicated time to support women with mental health difficulties)and update it in real time to understand any development since last data collection and any ongoing gaps in provision. This should also include specific assessment of the current provision of the link midwife role to specialist perinatal teams as specified in CR197;
    C. ensuring the presence of a robust, shared and transparent maternity-mental health care pathway, alongside a training, supervision and consultation protocol that takes into account the degree of mobilisation of the specialist PMH teams and their role in providing this support to their maternity colleagues;
    D. if there is additional capacity, to also work together to undertake local reviews of the antenatal and postnatal mental health support offer guided by a system wide tool such as perinatal pathway assessment tool. This would be helpful informed by understanding more about mental health referral practice from maternity departments, and how successful referral are at being accepted. Many PMH clinical networks will have already done this/be doing it and will be able to easily share learning or lead on the work. Many of the perinatal mental health network leads also work on the maternity networks so close working relationships are likely to be in place for many.

    Engagement would be required with Clinical Network leads and other colleagues on the feasibility of this.

- Closer working with perinatal mental health clinical networks and neonatal ODNs. For the perinatal national programme to provide guidance to the strategic clinical networks when planning their 2019/20 strategies to develop closer working relationship with neonatology based around the following priority areas:
    A. ensuring that there is a member of the local PMH network on the neonatal ODN;
    B. ensuring that a member of the ODN/a local neonatologist is a member of their PMH clinical network;

C. ensuring there is a local PMH training plan that includes staff working in local neonatal units;
D. ensuring there is a robust, evidence-based PMH care pathway for parents accessing local neonatal services that includes universal emotional wellbeing enquiry;
E. working with the neonatal ODNs to consider the universal implementation of a psychosocial tool for parents accessing local units – such as the digital app Small Wonders developed and evaluated by Best Beginnings.

Engagement would be required with Clinical Network leads, Neonatal ODN leads and other colleagues on the feasibility of this.

4.2.3 What could be done with additional investment?

Develop a best practice guide of trauma informed care. As identified by the Women's Mental Health Taskforce and NHS England's 2018 Sexual Assault and Abuse Strategy, women who have experienced gender-based violence are both at risk of mental health difficulties and can find accessing maternity and perinatal mental health services extremely challenging. Due to the physicality of pregnancy, childbirth and breastfeeding, becoming a parent has the potential to be a re-traumatising time for women who have experienced gender-based violence and at times the maternity context can contribute to this through physical exams, a need for reduced mobility or to lie on a bed, the power imbalance between clinicians and patient can inadvertently serve to reinforce this re-traumatisation. WS4 are planning on procuring the development of a best practice guidance and case study series of on routine enquiry for gender-based violence, supporting women through the maternity setting and on care pathways for further support from the perinatal mental health team.

4.3 Step 2: Managing and treating mild to moderate perinatal mental health difficulties – what are the gaps?

4.3.1 For women experiencing mild to moderate mental health problems support and care can be accessed through Increasing Access to Psychological Therapies (IAPT) services, local authority and third sector organisations.

4.3.2 The majority of women experiencing mild to moderate perinatal mental health difficulties will be seen in an IAPT service, where they will be able to access a range of evidence-based interventions described in Figure 1. They may also access a range of community and voluntary sector provision such as peer support and counselling where it is likely they will be able to access evidence-based psychological therapy.

4.3.3 Currently IAPT services are designed to meet the needs of all women of working age and therefore theoretically are able to accept referrals for perinatal women experiencing mild to moderate mental health difficulties. There is a significant gap in step 2 provision however for mothers experiencing mild to moderate mental health difficulties who also require support in their

relationship with their baby. Some areas of the country (in London, Exeter and Manchester) are able to access support through the 0-5 CYP IAPT programme within CAMHS but the parental mental health support and the parent-infant support would have to be accessed in separate services.

4.3.4 Core IAPT training does not sufficiently or consistently cover perinatal mental health therapy skills and as such there is the potential for a gap in the perinatal specific skills and knowledge of most IAPT staff. The perinatal mental health clinical networks have identified this gap and developed some tailored training and supervision offers in collaboration with IAPT colleagues – including across London and in the West Midlands.

4.3.5 Another challenge with accessing IAPT services for perinatal women is that there can be long waiting times for psychological therapy that is inappropriate for the perinatal period and IAPT services do not always accommodate babies in session or do home visits which can be essential in the perinatal period to achieve accessibility. Although some IAPT services do offer online therapies which may be particularly suited to new parents as can be delivered in the home and waiting times are short

4.3.6 Through PMH service reporting, network reporting and national stakeholder events, WS4 are coming to understand that there are a number of presentations, such post-traumatic stress disorder (PTSD) following childbirth, PTSD and/or anxiety disorder following perinatal loss (including miscarriage, stillbirth neonatal death and termination as a result of fetal abnormality), mental health difficulties following neonatal complications, and tokophobia that are particularly under-served between IAPT and specialist perinatal mental health teams. Despite the huge distress these presentations can cause the women experiencing them, they often do not lead to mental health difficulties that meet the acuity threshold to access a specialist perinatal mental health community team. On the other hand they require the specialist knowledge and skills of the perinatal period and the maternity context so are not always best seen in a generic IAPT service and the women experiencing them may not identify with having 'mental health difficulties' so prefer to seek support within the maternity system – which feels less stigmatising.

4.3.7 We do not yet have a full understanding of the pattern of service provision between maternity services and mental health care, and in particular the extent to which Local Maternity Systems rely on specialist perinatal mental health services versus standard IAPT services. We also do not have a good understanding of how well standard IAPT services are meeting the needs of women experiencing perinatal mental health difficulties

4.3.8 In collaboration with a number of charities, and with funding from DHSC, Sands has developed a **National Bereavement Care Pathway (NBCP)** to improve the bereavement care parents receive after pregnancy or baby loss. The pathway covers five bereavement experiences: miscarriage, termination of pregnancy for fetal anomaly, stillbirth, neonatal death, and sudden unexpected death in infancy (SUDI). It centres around providing families with compassionate, bereavement personalised care, with appropriately trained staff and suitable facilities.

4.3.9 One of the underlying standards for the pathway centres on information and referral for emotional and specialist mental health support when needed. However, there is little reference to

mental health in the pathway documents, and no reference to routine mental health screening or what evidence-based interventions women can be referred to. This presents a missed opportunity for ensuring that every women and her partner can access evidence based care following a perinatal loss.

4.3.10 The pathway has been piloted with an initial wave 11 Trusts, and initial evaluation using qualitative surveys with parents and clinicians has been positive. In addition, evaluation of the pathway has not addressed clinical outcomes for bereaved parents or any financial burden on trusts in terms the appointment of additional bereavement leads, additional staff hours, or any costs relating to training or estates. The Postnatal ERG has internally recommended that these pathways should be adopted across the NHS, *subject to positive evaluation*.

4.4 Step 2: Managing and treating mild to moderate perinatal mental health difficulties – what are the possible solutions?

Possible solutions are described below and have been broken into (a) what is being done now; and (b) what could be achieved by 2020/21 with additional investment**.**

4.4.1 What is being done now?

- Linking IAPT dataset and the MSDS. Accurate data on perinatal women's access to IAPT services is currently unknown. NHS Digital are in the process of linking the maternity and IAPT datasets so as to enable Local Maternity Systems and IAPT services to monitor where women with perinatal mental health difficulties are accessing services and identify areas for improvement.

4.4.2 What could be done with additional investment by 2020/21?

- An evaluation and expansion of the bereavement care pathway. The NBCP does not currently involve mental health screening or linking to mental health services including psychological therapy services. To ensure that every women and her partner can access evidence based care following a perinatal loss, the NBCP should be developed to include this. It is envisaged that this would involve minor amendments to the overview of the pathway, and development of an additional annexed guidance document setting out recommended routine screening tools, and evidence based interventions. There is also a need to expand the evaluation of the pathway to account for clinical outcomes relating to parent's wellbeing and mental health, and any implementation costs for pilots. In an initial conversation in September, Sands

were receptive to these proposals, though further discussion is required around whether this work take place in 18/19, rather than Sand's proposal of 19/20.

- Establishing a national perinatal IAPT training programme. Implementing a national perinatal IAPT training programme is being scoped between WS4, the national IAPT team and HEE for implementation from April 2019.

- Transformation/innovation fund for psychology-midwifery led emotional support clinics.

THIS PROPOSAL REQUIRES FURTHER SCOPING AND WOULD BE SUBJECT TO SIGNIFICANT MENTAL HEALTH TEAM APPROVAL PROCESSES FOLLOWED BY STRATEGIC FINANCE SIGN OFF.

- The proposal would be to set up an innovation fund in 2019/20 for LMSs and CCGs to bid to pilot innovative models of integrated perinatal psychology and maternity support for women experiencing one or all of the following difficulties that do not currently meet the threshold for perinatal specialist services (with the potential for new MH staffing input to be recurrent):
- post-traumatic stress disorder (PTSD) following childbirth;
- PTSD and/or anxiety disorder following perinatal loss (including miscarriage, stillbirth neonatal death and termination as a result of fetal abnormality)
- mental health difficulties following neonatal complications;
- and tokophobia

4.5 Step 3: Managing and treating moderate to severe mental health difficulties – what are the gaps?

4.5.1 Women with moderate to severe mental illness are likely to need a range of services in secondary care (primarily specialist perinatal mental health services but also other mental health services such as general adult mental health services, liaison services and crisis services).

4.5.2 In 2014, the Mental Health Taskforce recommended investment in perinatal mental health services on the basis of significant geographical inequity of provision in specialist inpatient and community perinatal mental health services across England, resulting in a huge variation in access to care for women and their families.

4.5.3 The Five Year Forward View for Mental Health addresses this gap in specialist services with a package of £365 million of investment which means that by 2020/21, 30,000 more women (approximately 5% of the birth rate) will be able to access appropriate, high-quality specialist evidence-based mental health care, closer to home. This will be both from increasing coverage of specialist community teams and inpatient Mother and Baby Unit beds.

4.5.4 To ensure the new specialist teams are embedded within the wider perinatal mental health care pathway and that they receive timely and appropriate referrals, it is essential that clinicians from primary care, maternity, neonatal, early years community and educational

services, and emergency services – who are not mental health specialists – have the perinatal mental health knowledge and skills to confidently screen and identify mental health difficulties and refer on to the relevant services in the care pathway. There is evidence from key perinatal stakeholders representing professions working in the wider care pathway that without effective training, women in the perinatal period fall through the gaps and are not able to access evidence-based services.

4.5.5 It is included in the service specification of all specialist perinatal community mental health teams and mother and baby unit to have a dedicated 'link midwife' to support the team. As well as providing midwifery care to the women accessing the service, they would attend team meetings and act as a conduit for mental health training. In Wave 1 of CSDF funding, WS4 funded a number link midwife roles, bit it was decided in Wave 2 not to continue doing this as this needed to be the responsibility of the LMS in the long term. The presence of the link midwife role in all specialist teams is unknown.

4.6 Step 3: Managing and treating moderate to severe mental health difficulties – what are the possible solutions?

Possible solutions are described below and have been broken into (a) what is being done now; (b) what could be achieved by 2020/21 without additional investment; and (c) what could be achieved by 2020/21 with additional investment

4.6.1 What is being done now?

<u>FYFVMH perinatal mental health transformation programme (WS4).</u>

- As previously mentioned, £365 million of investment has been dedicated to perinatal mental health transformation so that by 2020/21, 30,000 more women (approximately 5% of the birth rate) will be able to access appropriate, high-quality specialist evidence-based mental health care, closer to home.

- This includes four new, eight-bedded Mother and Baby Units being built in 2018/19 which have been commissioned to provide specialist care and support to mothers who experience severe mental ill health during and after pregnancy in areas of the country with particular access issues. WS4 are also increasing the number of beds in existing units - expanding the current capacity by 49 per cent by 2020/21.

- During the first two years since the FYFVMH was announced, two rounds of Community Service Development Funding (CSDF) have been completed for service mobilisation in 2017/18 (20 service/CCG/STP-led bids were awarded £40 million across 2 years) and 2018/19 (35-STP led bids were awarded 23.5million across one year). By the end of 2018/19, all CCGs across England will have received some funding to set up a perinatal mental health team and all LMSs will have access to these teams. This has enabled more than 7000 additional women to receive specialist perinatal mental health care in 2017/18. For 2018/19 this trajectory increased to 9000 additional women.

- In May 2018, the Perinatal mental health care pathways were published which describe to provide evidence on what works in perinatal mental health and case studies of positive practice in the following 5 pathways:
    A. Preconception advice
    B. Specialist assessment
    C. Emergency assessment
    D. Psychological interventions
    E. Inpatient care (admission to Mother and Baby Units)

4.6.2 What could be done with additional investment by 2020/21?

Develop best practice guidance for managing mental health and emotional wellbeing in a maternity setting.

WS4 are planning on procuring the development of a best practice guidance and case study series. We would be keen to address the following in the best practice guidance:

- The antenatal and postnatal care pathway for women with mental health difficulties
- Which women specialist perinatal mental health teams are designed to support and how to access these teams
- Which women IAPT teams are designed to support and how to access these teams
- Obstetric-mental health co-worked clinics, including prescribing responsibilities
- Access to specialist perinatal consultation, training and supervision
- Using perinatal mental health screening questionnaires
- Maternity-led psychosocial interventions after a traumatic event in the maternity context (*NB formal debriefing is expressly **not** recommended in NICE guidance as can trigger PTSD. As well as debriefing, we are seeing a proliferation of non-evidence based interventions such as the Rewind Technique which again can be very dangerous in the context of PTSD)*

5. Conclusion

The programme has a clear plan to substantially develop and improve specialist services, underpinned by significant financial investment. The plans in this paper outline the start of a plan to improve services available for those with mild to moderate difficulties and ensure that the whole system of care is joined up. For prevention and early intervention, there is a good offer of universal services available however these services should be better supported to do more to help women and their partners protect their mental health particularly amongst those most at risk. Action seems most important at local level, taking particular advantage of the rollout of community hubs, but Local Maternity Systems will need national support. The MTP provides an exciting opportunity to consider the whole pathway for women and their families to have a lasting effect on reducing the burden of perinatal mental illness.

Appendix A

Targeted prevention and early intervention
No current mental health difficulties but may be at risk or have experienced them previously

Service providers:
Midwifery, Health Visiting, Family Support, Children's Centres, GPs & Specialist perinatal mental health community teams (for preconception clinics).

Support may include:

- *NICE* – Identification (Including asking the Whooley Questions and GAD-2 at all routine antenatal and postnatal contacts), assessment, psychoeducation, active monitoring; referral for further assessment and interventions.
- Preconception counselling for women with a previous history of mental health difficulties
- Preparation for parenthood programmes – such as Family Foundations, Baby Steps
- Baby feeding support and advice
- Exercise and fitness activities
- Peer support

Commissioners
Local Authority
CCG
Third sector

Mild to moderate mental health difficulties

Service providers:
IAPT, CAMHS (if the mother is under 18), Specialist midwifery support, Specialist health visiting support, Children Centres, Third sector

Support may include:

- *Depression*: Individual facilitated, self-help, computerised CBT,
- structured physical activity, group-based peer support, non-directive counselling delivered at home, antidepressants, self-help groups.
- *GAD and panic disorder*: Individual non-facilitated and facilitated self-help, psychoeducational groups, self-help groups.
- *OCD:* Individual or group CBT (including ERP), self-help groups.
- *PTSD*: Trauma-focused CBT or EMDR.
- *Tokophobia*: Psychological consultation and birth planning support
- *Parent-infant relationship difficulties:* Parenting programmes (i.e. Incredible Years and Triple P), , structured videofeedback approaches (i.e. ViPP), infant massage, NBO, Watch Wait Wonder, Family Nurse Partnership
- *All disorders*: Support groups, educational and employment support services; referral for further assessment and interventions.

Commissioners
Local Authority
CCG
Third sector

Moderate to severe mental health problems and/or a personality disorder

Service providers:
Specialist perinatal mental health community teams, mother and baby units, adult mental health community and inpatient teams, & CAMHS (if the mother is under 18).

Support may include:

- *Depression*: CBT, IPT, behavioural activation, BCT, antidepressants, and self-help groups.
- *GAD:* CBT, applied relaxation, drug treatment, self-help groups.
- *Panic disorder*: CBT, antidepressants, self-help groups.
- *OCD:* CBT (including ERP), antidepressants, self-help groups.
- *PTSD*: Trauma-focused CBT, EMDR or drug treatment
- *Psychosis*: antipsychotics, CBT & Family therapy
- *Bipolar depression:* drug treatment, CBT, IPT, Family therapy, BCT
- *Anorexia:* drug treatment, IPT, CBT, Family therapy
- *Tokophobia*: Psychological consultation and birth planning support
- *Bulimia/ Binge eating*: Guided self-help (binge eating only), drug treatment, CBT, IPT, DBT
- *Personality disorder:* DBT, MBT, Structured clinical management
- *Parent-infant relationship difficulties:* videofeedback approaches, mentalisation based parenting, Circle of Security, child-parent psychotherapy
- *All disorders*: Support groups, befriending, occupational therapy support, educational and employment support services; referral for further assessment and interventions.

Commissioners
CCG
NHS England