

# Perinatal Mental Health

Early scoping across Greater Manchester  
Lancashire & South Cumbria

Julia Charnock, January 2016



**Introduction: What is the problem?**

Perinatal mental illnesses are a major public health issue that must be taken seriously. If untreated, these illnesses can have a devastating impact on women and their families. They are one of the leading causes of death for mothers during pregnancy and the year after birth.

Between 10 and 20% of women develop a mental illness during pregnancy or within the first year after having a baby. Examples of these illnesses include antenatal and postnatal depression, obsessive compulsive disorder, post-traumatic stress disorder (PTSD) and postpartum psychosis. These conditions often develop suddenly and range from mild to extremely severe, requiring different kinds of care or treatment.

They are also of major importance as a public health issue, not just because of their adverse impact on the mother but also because they have been shown to compromise the healthy emotional, cognitive and even physical development of the child, with serious long-term consequences.<sup>1</sup>

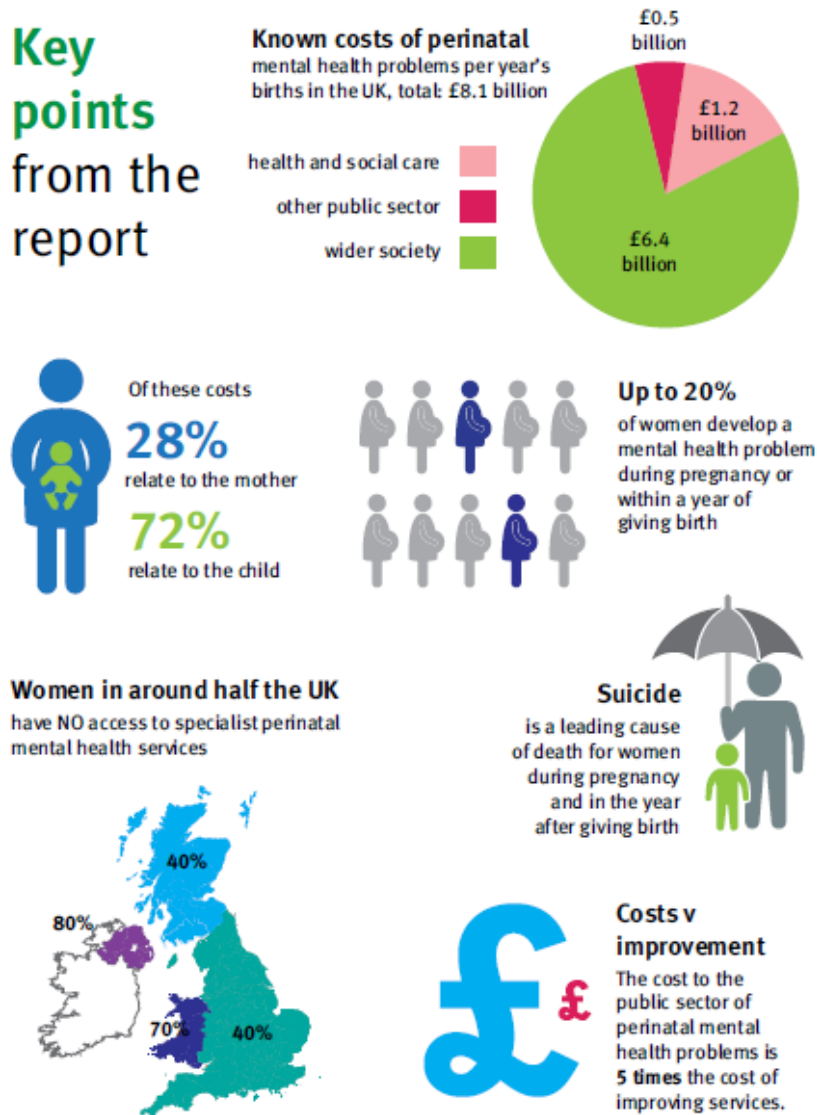


Figure 1: The costs of perinatal mental health problems: Key points (2014)<sup>1</sup>



The independent report, 'The costs of perinatal mental health'<sup>1</sup> published in 2014 documents the economic costs of perinatal mental illness for UK society. It shows that perinatal depression, anxiety and psychosis carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK. Nearly three-quarters (72%) of this cost relates to adverse impacts on the child rather than the mother. Figure 1 shows the key points for the report.

In March 2015 Future in Mind<sup>2</sup> published by the Department of Health prioritised the enhancement of Perinatal Mental Health Service as a key step to promoting, protecting and improving our children and young people's mental health and well-being:

***“Improving access for parents to evidence-based programmes of intervention and support to strengthen attachment between parent and child, avoid early trauma, build resilience and improve behaviour.”***

The document also outlines that:

***“With additional funding, this would be delivered by: enhancing existing maternal, perinatal and early years health services and parenting programmes”***

In support of these recommendations the government pledged an additional £75 million to be allocated over the next 5 years to the care of women who experience mental ill health during the perinatal or antenatal period.

In July 2015 the Mental Health Forum (NCB) and the National Children's Bureau (NCB) held a national seminar on Perinatal and Infant Mental Health to:

***“Identify the work being done and the support needed by NHS England Strategic Clinical Networks (SCN's) across the country to share this more widely, with the overall intent of providing a national picture that supports the commissioning of perinatal mental health services”***

In the report published after the seminar a number of conclusions were made including the following specific references to the work of Strategic Clinical Networks:<sup>3</sup>

- The range of different issues highlighted in this report are fundamentally linked by an emerging narrative that more integrated support is needed from the centre to SCNs and CCGs to achieve commissioning at scale, and for the leads to be in a better position to support and learn from one another.
- SCNs are working in the absence of a clear national long term plan for perinatal and infant mental health underpinned by coherent commitments to achieving this across the whole delivery system. The development of such a robust plan is likely to require significant further national leadership probably including ministerial sign-up.

Further national directive and financial allocations are still awaited, however, as part of their support to CCG's in the development of the wider Transformation Plans for Children and Young People's Mental Health and Wellbeing Strategic Clinical Networks have begun to scope Perinatal Mental Health (PNMH) Services both nationally and locally.

This paper sets out the findings of an early scoping exercise carried out across the whole of the Greater Manchester, Lancashire & South Cumbria footprint with a view to providing some insight into the key local priorities for the development of Perinatal Mental Health Services.



**What we did:**

Building on a scoping questionnaire sent out to all SCN's from the PNMH Expert Reference Group <https://www.england.nhs.uk/commissioning/spec-services/npc-crg/group-c/c06/> a short survey was developed using national guidance to include questions for commissioners and providers. (Appendix1)

Clinical Commissioning Groups	Local Authorities	NHS Maternity Services	Mental Health Services	Community Services
Blackburn with Darwen CCG	Blackburn with Darwen Council	Blackpool Teaching Hospital Trust	5 Boroughs Trust	Bridgewater Community Healthcare Trust
Blackpool CCG	Blackpool Council	Bolton Hospitals Trust	Cumbria Partnership Trust	
Chorley & South Ribble CCG	Bolton LA	Central Manchester Foundation Trust	GM West Mental Health NHS Foundation Trust	
Cumbria CCG	Bury LA	East Lancashire Hospitals Trust	Manchester Mental Health and Social Care Trust	
East Lancashire CCG	Cumbria CC	Lancashire Teaching Hospitals Trust	Pennine Care Trust	
Fylde & Wyre CCG	Lancashire CC	Pennine Acute Hospitals Trust	Lancashire Care Trust	
Greater Preston CCG	Manchester	Stockport Foundation Trust		
Lancashire North CCG	Oldham	Tameside Hospitals Trust		
West Lancashire CCG	Rochdale	University Hospitals South Manchester		
Bolton CCG	Salford	University Hospitals Morecambe Trust		
Bury CCG	Stockport	Wrightington, Wigan & Leigh Foundation Trust		
Central Manchester CCG	Tameside		Completed surveys	
Heywood, Middleton & Rochdale CCG	Trafford		<input type="checkbox"/>	Lancashire & S Cumbria
North Manchester CCG	Wigan		<input type="checkbox"/>	Greater Manchester
South Manchester CCG				
Oldham CCG				
Salford CCG				
Stockport CCG				
Tameside and Glossop CCG				
Trafford CCG				
Wigan Borough CCG				
<b>NHS England- Area Team</b>				
GMLAT				



The survey was circulated to fifty-two organisations (See Table 1) across Greater Manchester, Lancashire & South Cumbria to the following stakeholder groups:

- Commissioners
- Clinical leads for Obstetrics and Gynaecology
- Heads of Midwifery
- Directors of Nursing
- Clinical Leads for Mental Health
- Directors of Public Health

In total seventeen completed surveys were received. NB These included joint responses from both the Blackpool and Tameside health economies.

Table 1 has been colour coded to denote which organisations returned the survey/ contributed to the scoping exercise.

In addition to the survey, information about current tertiary services was also sought from the regional Psychiatric Referral, Assessment and Management of Mothers and Babies Service (PRAMMBS) provided by Manchester Mental Health & Social Care Trust via the Anderson Ward at Wythenshawe Hospital.

The Andersen Ward Mother and Baby Unit (MBU) is the only inpatient Specialist PNMH facility and covers the entire North West. The unit's core purpose is to provide a consistently high level of quality specialist mental health care to both women who are pregnant and mothers following child birth. The unit admits both mother and baby up to the age of one year.

Central to the philosophy of the MBU is to promote the mother and baby relationship within a secure and supportive environment while incorporating evidence based practice drawn from the fields of both peri-natal and general mental health knowledge.

The time around childbearing may make some women vulnerable to recurrences of, or new mental health problems. In cases of depression, puerperal psychosis and other mental disorders, the separation of mother and baby can create a secondary disturbance of bonding.

The unit provides comprehensive advice, medical and psychological assessment and treatment for women with previous or current mental health problems, who have recently given birth, are pregnant or who wish to become pregnant. It also offers support and supervision which is tailored to the individuals needs to promote and ensure the infants safety.

The unit is run by professionals who have longstanding experience in perinatal psychiatry and work as a cohesive and highly motivated team. The team includes a Consultant Psychiatrist, In-patient Nurses, Nursery Nurses, and a Clinical Psychologist and also has access to Occupational Health Services and Physiotherapists.

Mothers who are admitted to the ward may be experiencing maternal mental health difficulties such as post-natal depression or post-partum psychosis or an exacerbation of existing mental health difficulties such as schizophrenia or bipolar affective disorder.

The involvement of partners, family members and friends is encouraged and the unit offers support and education for all who visit.



Andersen Ward provides facilities for up to ten mothers and babies including:

- Single rooms with separate shower rooms
- Two nurseries
- A dining area
- A fully equipped milk kitchen
- An observation room
- A fenced garden, patio and outside play area
- A ladies only lounge
- A self-contained flat

In addition to the above Andersen Ward, with prior agreement and discussion, also offer a Parenting Assessment service for those who are considered by the local authority to present an identified or potential risk to their child as a result of existing mental health problems.

### **Findings**

For full details of the responses received please see Appendix 2.

### **Commissioning**

Feedback from the survey showed that across the network a number of CCG's are starting to work with multiple stakeholders to establish Perinatal Mental Health Groups to develop a plan to support the improvement of Perinatal Mental Health Services in line with current national guidance. The early objectives of these groups include:

- Scope of current service provision
- Gap analysis
- Training needs assessment
- Development of evidence based clinical pathways

Early indications from the survey suggest that the gaps in current service identified by commissioners include:

- Collection of specific Perinatal Mental Health data
- Availability Specialist Perinatal Mental Health Consultants
- Access to Specialist Community Perinatal Mental Health Services including Specialist PNMH Psychiatry, preconception advice and management of complex cases
- Referral and clinical pathways
- Access and waiting times for Psychological Therapies inc. Cognitive Behavioural Therapy (CBT)
- Access to Specialist Perinatal Mental Health in-patient beds
- Support for fathers and families

Current barriers to closing the gaps in Perinatal Mental Health suggested by those commissioners who contributed to the survey include:

- Access to consistent high quality data
- Specialist training required for staff in all areas
- Lack of funding and dedicated resources
- Access to Specialist Perinatal Mental Health Psychiatrist support
- Mainstreaming PNMH into wider mental health and Early Years services/pathways.
- Large and complex geographical footprint and demography



Whilst all CCG commissioners should now have included Perinatal Mental Health as a priority in their Transformational Plans, most are waiting for further national guidance before developing comprehensive plans around PNMH.

Commissioners highlighted that it is difficult to identify the current funding for PNMH as most services are provided within block contracts. The priorities identified for investment by the commissioners who responded include:

- Support to increase the number of specialist inpatient beds and develop community outreach from the Specialist Mother and Baby Unit at Wythenshawe Hospital
- Addressing current variation in services
- Improving access to specialist support
- Prevention and early intervention
- Specialist training
- Dedicated PNMH workforce
- Access to Community Consultant PNMH Psychiatrist
- Improving access to Psychological Therapies (IAPT)
- Early access to Mental Health Services

Commissioners suggested that the SCN had an important role to play in supporting the development of an integrated pathway for Perinatal Mental Health across the whole network footprint.

It was also highlighted that as per NICE Clinical Guidance 192.1.10.3 (See Appendix 3) clinical networks should be established for Perinatal Mental Health Services managed by a coordinating board of healthcare professionals, commissioners, managers, service users and carers.

It was therefore suggested that the SCN has a role in supporting and facilitating a clinical network of this nature to oversee implementation of national guidance and good practice across the network.

### **Provider services**

Again as reflected in the response from commissioners, provider organisations in some areas are starting to work with their health economy partners to develop a plan to support the improvement of Perinatal Mental Health Services in line with current national guidance.

Some providers did report the existing provision of specific PNMH services but these appear to be limited and variable across the network often driven by an individual clinician with a special interest in PNMH. The Joint Commissioning Panel for Mental Health<sup>4</sup> (2012) also found that PNMH services are often delivered by a small number of professionals or a single clinician providing partial care or 'signposting' services to women.

The survey indicated that data currently collected in line with PNMH appears to be limited to quantitative data focusing on:

- How many women were asked the 2 depression questions at the 6-8 week and 3-4 months for post-natal depression
- Number of referrals for PNMH support and or Mental Health Services
- Data relating to GAD and PHQ scores

Some of the respondents also reported that no data is currently collected in relation to PNMH.





Priorities identified by providers include:

- Development of a model/pathway and improving outcomes for PNMH and attachment
- Implementation of NICE Guidance
- Addressing variation in access to services
- Workforce – specialist training/accreditation and sustainability
- Support groups
- Integration of mental health, primary care and other services to deliver seamless PNMH services
- Priority for PNMH within IAPT
- Early detection
- Reducing inpatient admission and length of stay
- Access to Specialist PNMH Psychiatrist
- Highlight to commissioners that PNMH services are not currently funded and there is no access to PNMH specialist services in their health economy.

One provider indicated that no plans are currently in place which may indicate that CCG's are waiting for national funding and directive before developing future plans.

When asked to identify the gaps in current services provider responses were wide and varied ranging from those where a gap analysis has not yet been completed, to very specific gaps in local service identified by Lancashire & South Cumbria. The main gaps identified across the network however include:

- Lack of PNMH and attachment pathway/services
- Specialist Community Psychiatrist/Psychologist
- Community PNMH Services
- IAPT – Specialist PNMH
- Admin support
- Education and training
- Inpatient crisis facilities inc. safe space for families
- Relationship therapy and support for fathers and families
- Restrictions of current commissioned service
- Specialist midwives and health visitors
- Variable access to services
- Communication with adult mental health services

The current barriers to closing the gaps in Perinatal Mental Health highlighted by providers were:

- Lack of resources – funding, time and staffing
- Access to specialist PNMH Practitioners inc. Psychiatry and Psychology
- Workforce training and development
- Additional requirements of IAPT
- Stigma around access to support for women without judgement





- Access to Mental Health Services
- Commissioning priorities
- Impact of geography on delivery of services

Interestingly, although all commissioners should now have included PNMH as a priority in their Transformational Plans it would seem that most providers are not aware of this or do not know the content of the plan for Perinatal Mental Health.

When asked about the best use for the pledged national funding the providers suggested the following actions:

- A sustainable infant mental health tool
- Clear care pathway across all organisations in line with NICE Guidance
- Specialist mental health providers involved in the delivery of PNMH services
- Specialist PNMH Community Teams – multidisciplinary
- Development of IT to support delivery of services into homes
- Increase provision of specialist training across all services
- Provision of Specialist Inpatient beds via a Specialist PNMH Mother and baby unit in Lancashire & South Cumbria

The survey also asked providers to provide information about individuals with Specialist PNMH expertise within or linked to their organisations as follows:

- Named Obstetric Lead for PNMH
  - 5 Provider organisations have named Obstetric Leads for PNMH
  - 1 organisation has an Obstetrician with a special interest in mental health
  - 3 organisations reported they did not have an Obstetric Lead for PNMH
- Named Midwifery Lead for PNMH
  - 5 Provider organisations have named Midwifery Leads for PNMH
  - 3 organisations reported they did not have an Midwifery Lead for PNMH
  - 1 gave Public Health Midwives as the answer to this question
- Named Psychiatric Lead for PNMH
  - 3 Provider organisations have named Psychiatric Leads for PNMH - This includes one organisation where the PNMH Psychiatrist provision is 2 hours per week
  - 6 organisations reported they did not have an Psychiatric Lead for PNMH
  - 2 organisations gave the names of the Psychiatrist they link with in other organisations
- Midwives/Health Visitors with a special interest and time dedicated to PNMH
  - 4 organisations employ Health Visitors with a special interest and dedicated time for PNMH
  - 7 organisations employ Specialist PNMH Midwives
- Midwives/Health Visitors with time dedicated to bereavement
  - 7 organisations employ Midwives/Health Visitors with time dedicated to bereavement; however these are temporary contracts in 2 organisations.



It was noted that provision between organisations is variable and more detailed workforce analysis would need to be completed with all organisations across the SCN footprint to gain a clear picture of the actual provision.

The survey asked Providers about any formal links and referral pathways into a special Mother and Baby Unit (MBU) with responses as follows:

- 5 Provider organisations in GM identified the MBU at Wythenshawe Hospital
- 1 Lancashire Provider reported that formal links and referral pathway to MBU at Wythenshawe Hospital are currently being developed
- 1 Lancashire Provider reported that they did not have a formal link or referral pathway into a specialist MBU
- 1 Lancashire & South Cumbria Provider reported that referral to the specialist MBU at Wythenshawe are sent via mental health services. Over past 12 months – patients have been admitted to MBU at Morpeth and Leeds from UHMB area due to a lack of bed availability at Wythenshawe. Distance to MBU at Wythenshawe from Cumbria / North Lancashire particular issue for women / families

Although the MBU at Wythenshawe provide 10 specialist beds responses from Providers of maternity or mental health care showed a variation in knowledge around the number of beds provided as per the responses below:

- 4 Providers reported 10 beds
- 1 Provider reported: 10 beds but has increased provision at times when staff can be increased
- 1 Provider reported 1 or 2
- 3 Providers didn't know with a comment from 1 – based on need at any one time but few beds are used.

Again providers did not all know if the Specialist Mother and Baby Unit is accredited by the Royal College of Psychiatrists:

- 3 Providers – Yes
- 2 Providers – Don't know
- 1 Providers – No

When asked about access to a Specialised Perinatal Community Mental Health Team linked to the Specialist Mother and Baby Unit it became clear that access to Specialist PNMH services is an issue. See responses as follows:

- 10 Providers – No
- 1 Provider - Yes, they will provide an assessment and reviews but rarely used service due to the distance from us (57 miles)

The responses also included the following comments:

- A business case is being processed for the role of the previous PNMH Nurse who has retired.
- We have links to some community based CPNs or crisis intervention depending on the Borough arrangements - they are not linked to the Specialist unit but we liaise and refer to the Specialist MBU. Women do have outpatient appointments at the specialist mother and baby unit but there is a high DNA rate due to the distances



involved and travel demands. We hope to address this with the developments described above and are also looking at an interim arrangement for NMGH site with Manchester Mental Health Trust.

- We have a primary / intermediate level perinatal team. Not affiliated to the quality network.

9 Providers indicated that access to psychological therapies was available

The responses also included the following comments:

- 5 Boroughs Psychiatric Services and IDAP Team
- Self-Help, IAPT and Anxiety UK are based locally. Also online resources provided
- We have 1 x WTE Band 7 counsellor who is also qualified to provide CBT
- Babies Can't Wait priority treatment within step 2/3 of step care model (IAPT compliant service)
- Staff in Early Attachment Service is trained specifically in psychological therapies to meet needs of women during perinatal period. They also supervise staff in Adult Mental Health. e.g. CBT
- If pregnant priority for counselling and CBT is given.
- Referral to a Women's Centre by the booking midwife
- They are prioritised if perinatal
- Referral pathway to Lancashire care IAPT service
- Via IAPT - First Step Cumbria / Minds matter Lancashire

Responses around training for staff in universal services, particularly midwives, GP's and health visitors, around perinatal mental health and detection of at risk patients are detailed as follows:

- 4 Providers – Training for Midwives
- 2 Providers – Training for Health Visitors
- 1 Provider – Training for both Health Visitors and Midwives
- 1 Provider – Training for Consultant and Medical staff
- 1 Provider – No training provided
- 1 Provider – Don't know

The responses also included the following comments:

- Health Visitors - Solihull, motivational and promotional interviewing, iHV Perinatal mental health 2 day course, which includes detection, 1 Day iHV infant mental health, 2 day infant feeding which includes attachment and bonding and Ages and Stages training.
- Mental Health Module for Midwives delivered by Salford University. MMHSCT does not provide regular training to GPs and health visitors
- We provide mandatory public health training to midwives; that includes mental health awareness. We have provided multidisciplinary training to junior doctors and some consultants on MH with the specialist midwife and perinatal psychiatrist. We have recently started to provide training to trust staff using the 'Mental Health First Aid' package - a 2 day course. The consultant midwife has developed a Level 7 module with colleagues at Manchester University in Mental health, which can be accessed by any health and social care professional and this will commence in September 2016. A one day workshop on MH is planned for 2016 at Manchester University.



- Multi-disciplinary training provided to front line staff 6 x per year. Full day training from Health Visitor, Midwife and Mental Health professional perspective based on Sheila Seeley Perinatal Mental Health Training.
- Multi-agency training has been devised and delivered by and to the partner agencies signed up to the integrated Parent Infant Mental Health Care Pathway within Tameside and Glossop.
- For CFHS staff; online training is available plus specialist training for Health Visitors with updates as required. Training is offered from mental health midwife and colleagues.
- Internal mandatory training for maternity staff. Further more detailed training being planned. Quarterly NW Perinatal Meetings at Wythenshawe Hospital. PNMH Modules at Salford and Manchester Universities - funding required to attend.
- Mandatory training for all midwifery and medical staff in women's health 2016.
- Annual mandatory training session - regarding perinatal mental health - case study - scenarios - identification - referral pathways. Current training in relation to sexual abuse / Fear of childbirth - Tokophobia + update re: recent perinatal mental health guideline / pathways. + ELearning module re: maternal mental health

### **Perinatal Mental Health (PNMH) Pathway**

The survey asked providers if a perinatal mental health integrated care pathway is in place covering all levels of service provision and severities of disorder. Responses were received as follows:

- 7 Providers – 4 pathways provided
- 2 Providers – have no pathway

The responses also included the following comments:

- St. Mary's PNMH Policy attached. Currently being reviewed to ensure Trust compliance with NICE<sup>5</sup> and changes made since Manchester Specialist Midwifery Service (city-wide) was decommissioned in March 2015
- The Mental Health Trust is using the same pathways as UHSM and CMFT and has inputted to the pathways
- We do with limitations due to access to the perinatal psychiatric service in Wythenshawe which we are addressing as outlined above. Pathway attached, which also takes into account the demands of the PAHT working across 5 Boroughs with different provision and 2 different mental health trusts.
- Comprehensive integrated care pathway in process of being updated
- Not an integrated pathway across the Trust.

Providers also indicated that the following assessment tools are in use across the pathway to assess perinatal mental health:

- 4 Providers – PHQ9
- 3 Providers – GAD7
- 3 Providers - Other



Responses also included the following comments:

- Traffic light system used to triage referrals to specialist midwives. Criteria currently being reviewed due to unmanageable volume of referrals
- A 12 page assessment tool is being used by the Manchester Mental Health and Social Care Trust. This covers all mental health, social and medical aspects that are relevant to mental health. The tool is available on the MMHSCT website
- Staff use the pathway initially and refer to the criteria based on NICE. When a woman meets the criteria for further referral, she is referred to the specialist midwife who will undertake further screening as necessary using one of 2 tools: GAD and PHQ; see attached
- Maternal Antenatal Attachment Scale, Paternal Antenatal Attachment Scale, PHQ-9, GAD-7, PIR-GAS, MORS, PIRAT, PIMH risk assessment
- Quick verbal screen

Providers were also asked if clear referral and management protocols linked to the integrated care pathway for perinatal mental health were in place. Responses are listed below:

- St. Mary's PNMH Policy attached - being updated
- There is a large element of perinatal mental health care missing in Greater Manchester and that is specialist service provision in the community. For existing parts of the services there are protocols available.
- 8 Providers indicated that referral and management protocols were in place however the following comments we also noted:
- Direct referral into Single Point of Access or Crisis Home Treatment Team as per pathway.
- The guideline is for when and where to signpost women
- The CFHS has a protocol as to how women are referred into mental health services (noted they are not specialists in perinatal mental health); but this does not link to an integrated care pathway.

### **Role of the Strategic Clinical Network**

As suggested earlier the importance of the SCN's role around this agenda has been emphasised nationally therefore providers were asked what role the Strategic Clinical Network could play in coordinating PNMH Networks in line with NICE Guidance.

Responses from this question are provided as follows:

- Currently no PNMH clinical network in GM
- It is difficult to see how adopting one integrated pathway would work across the different Boroughs and mental health trusts and differing primary care provision? The SCN could support the proposals to the CCGs to improve perinatal access across Greater Manchester.
- ERG may be recommending establishing a Managed Clinical Network so this would need coordinating for GM.



- Specialist Training to ensure we have access to a range of programmes for all staff
- To oversee and promote good practice
- Ensuring standardised practice and learning and sharing good practice
- Regular network meetings - bench mark service provision to ensure NICE compliance in all areas. Ensure Specialist Service availability to all women. Consider distance of MBU
- As recommendation NICE<sup>5</sup> CG192 1.10.3 (see Appendix 3)

The survey also highlighted that none of the Providers who responded are currently part of a clinical network for PNMH although 2 organisations describe links with Wythenshawe for clinical support and training.

Finally at the end of the survey there was an open text section for additional comments. See the comments provided below:

- **Central Manchester Foundation Trust**

*Referrals 2013-2014 for women with PNMH = circa 600  
Drugs and Alcohol= 88*

- **Bridgewater Community Healthcare NHS Foundation Trust.**

*Parental support for transition to parenthood IY baby and IY toddler are provided by Action for children. This is a new service and is in the process of being developed.*

- **Lancashire Care Foundation Trust**

*The main problem for us and our service users is the distance to Wythenshawe, about 57 miles from Lancaster and through heavy traffic, can take 2 hours.*

*This is difficult for families to maintain links and visits, and potentially harmful for father- baby bonding/relationships. It can put people off going to a mother and baby unit as they prefer to be local, even if it means separation from their baby. This happened recently with a lady who had already had an admission to Wythenshawe with her baby and was being recommended for readmission. She was very reluctant to return because of the distance. As it turned out, she was treated at home, but it was a risky situation.*

*Another problem can be securing a bed at the local M and B unit. Women have to go elsewhere, sometimes even further away from their families. Most of the in-patient beds are used by Manchester patients, leaving minimal access to other areas.*



## Conclusions

Although it should be noted responses only came from a sample cross section of commissioners, maternity providers, and mental health providers the information gained from the survey provides a good insight into current service provision and the following themes have emerged that will help to identify the priority areas for improvement.

1. **Collection of/access to consistent high quality PNMH data**
2. **Development of a PNMH clinical network (as per NICE)**
3. **Development of a clear multidisciplinary PNMH pathway in line with NICE**
4. **Specialist PNMH training for staff in all areas**
5. **Development of Specialist multi-disciplinary PNMH Community Teams**
6. **Improving access to Specialist PNMH Psychology/Psychiatry**
7. **Improving access to psychological therapies**
8. **Early access to mental health services**
9. **Improved access to specialist inpatient beds**

### 1. Data

A key theme identified by Commissioners is the need for **access to consistent high quality data**.

Interestingly the National Child and Maternal Health Intelligence Network has published a new needs assessment report<sup>6</sup> for each local authority and clinical commissioning group on perinatal and infant mental health.

The report brings together local data and evidence on risk factors and estimates of the number of women with a range of maternal mental health conditions. It can be used to inform local needs assessments by giving commissioners an indication of perinatal and infant mental health need in their area.

[Mental health in pregnancy, the postnatal period and babies and toddlers: needs assessment report](#)

Whilst this report will indeed be a useful tool for commissioners beginning to assess local need moving forward access to specific, robust data relating to both maternal and infant emotional health and well-being should be developed to support benchmarking and quality improvement of services.

The JCPMH<sup>4</sup> (2012) also highlights the need for PNMH data and recommends routinely collecting data on a range of data in relation to PNMH.

Within the SCN's remit to reduce variation in access to services across the network this may be a role that commissioners would like the SCN Team to develop.





## 2. Perinatal Mental Health Clinical Network

It was suggested that the SCN could play a key role in supporting the establishment of a clinical network for Perinatal Mental Health across the network footprint.

NICE<sup>5</sup> Clinical Guidance 192.1.10.3 (See Appendix 3) recommends Clinical networks should be established for perinatal mental health services, managed by a coordinating board of healthcare professionals, commissioners, managers, and service users and carers.

These networks should provide:

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

In its guidance to commissioners, the JCPMH<sup>4</sup> (2012) highlighted that managed (strategic) clinical networks should be set up and commissioned covering populations of patient flow of approximately four to five million (delivered population 50,000): to advise commissioners, assist in the development of strategic plans and commissioning frameworks, advise provider organisations, assist with workforce development and training, develop integrated care pathways and develop and maintain a network of involved clinicians and other stakeholders including patient organisations.

JCPMH<sup>4</sup> also highlighted that Perinatal Mental Health clinical networks should be further developed across England and fit into this structure as “enclave” networks under the mental health strategic clinical network “umbrella” suggesting that this will not only promote equity of access, regional integration and clinical excellence but also provide a conduit for advice to both specialised and local Commissioners.

It would therefore be beneficial for the SCN to begin the process of bringing together this group as a structure to support providers and commissioners in anticipation of the expected national guidance and build a more comprehensive picture of current service provision.

## 3. Perinatal Mental Health Pathway

The development of PNMH pathways in line with NICE Guidance appeared to be a common priority identified by many respondents. Input from the SCN to ensure that consistent care pathways exist across all organisations was also identified as a key role for the SCN.

NICE<sup>5</sup> Clinical Guidance 192.1.10.3 recommends that:

- Managers and senior healthcare professionals responsible for perinatal mental health services (including those working in maternity and primary care services) should ensure that there are clearly specified care pathways so that all primary and secondary healthcare professionals involved in the care of women during pregnancy and the postnatal period know how to access assessment and treatment



NICE<sup>5</sup> guidance also states that PNMH Clinical Networks should provide:

- pathways of care for service users, with defined roles and competencies for all professional groups involved.

In its key messages the Joint Commissioning Panel for Mental Health<sup>4</sup> recommend that commissioners should ensure that there is a perinatal mental health integrated care pathway in place which covers all levels of service provision and severities of disorder. All service providers should be compliant with this so that there is equitable access to the right treatment.

Once again the Strategic Clinical Network is well placed to facilitate discussions between stakeholders to support the development of consistent clinical pathways across network organisations.

#### **4. Specialist PNMH training for staff in all areas**

The scoping exercise clearly identified an acknowledgement of the need for training for all staff who are in contact with women during the peri-natal period. This should include both specialist and non-specialist staff.

The JCPMH<sup>4</sup> (2012) states that maternity services should ensure that midwives and obstetricians should receive additional education and training in perinatal mental health.

Research also suggests that Health Visitors with additional training in listening visits and cognitive counselling can significantly improve the outcome of women with postnatal depression compared to standard health visitor care. Interventions by additionally trained health visitors are clinically and cost effective.<sup>7</sup>

Conversely the JCPMH<sup>4</sup> (2012) highlight the concern that none of the training schemes for IAPT workers of any grade include training on the normal emotional changes associated with motherhood, the change in relationships and family dynamics, clinical features of perinatal psychiatric disorder and the additional risks to both mother and infant of perinatal mental health problems.

The JCPMH<sup>4</sup> (2012) therefore recommend that staff in IAPT services should receive additional training to ensure they understand the maternity context and the additional clinical features and risk factors associated with perinatal psychiatric disorder.

The Joint Commissioning Panel for Mental Health<sup>4</sup> (2012) highlighted that good perinatal mental health services should include an education and training programme which should be provided for non-specialists involved in the care of pregnant and postpartum women including general psychiatric teams, GPs, midwives, Health Visitors and IAPT workers to ensure the early identification of those at high risk:

- early diagnosis
- an understanding of the maternity context
- the additional clinical features and risk factors associated with perinatal disorders
- the developmental needs of infants.

The early development of a PNMH clinical network supported by the SCN would provide a structure to take forward comprehensive training needs analysis that would inform the development of a MDT PNMH training strategy.



## 5. Development of Specialist multi-disciplinary PNMH Community Teams

The development of Specialist multi-disciplinary PNMH Community Teams across the network was highlighted by the scoping exercise.

The JCPMH<sup>4</sup> (2012) report indicated that the provision and function of these specialist services is variable and inequitable. There is little available data to estimate the unmet need but it is likely to be considerable.

NICE<sup>5</sup> (2014) recommended that clinical networks should be established and should provide:

*“a specialist multidisciplinary perinatal service in each locality, which provides direct services, consultation and advice to maternity services, other mental health services and community services; in areas of high morbidity these services may be provided by separate specialist perinatal teams”*

The JCPMH<sup>4</sup> (2012) report states that a good specialised community perinatal mental health team will be a member of the Royal College of Psychiatrists' quality network. It will assess and manage women with serious mental illness or complex disorders in the community who cannot be appropriately managed by primary care services. It should:

- respond in a timely manner and have the capacity to deal with crises and emergencies and assess the patients in a variety of settings including their homes, maternity hospitals and outpatient clinics
- have close working links with a designated mother and baby unit
- manage women discharged from inpatient mother and baby units
- work collaboratively with colleagues in maternity services (including providing a maternity liaison service) and in adult mental health services with women with prior or longstanding mental health problems.

A good community perinatal mental health service will offer pre-conception counselling to women with pre-existing mental health problems and to those who are well but at high risk of a postpartum condition.

A key message from the JCPMH<sup>4</sup> report highlights that:

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

The Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) has a quality network for both mother and baby units and specialised perinatal community mental health teams. The overwhelming majority of such teams are members of the CCQI Network.

They have developed consensus standards of care to which all members adhere and are subject to annual peer appraisal visits.

<http://www.rcpsych.ac.uk/systempages/gsearch.aspx?cx=005217297982068972824%3aqhx0tmhjcsy&cof=FORID%3a9&q=perinatal+mental+health+standards>

Once again the early development of a PNMH clinical network supported by the SCN would provide a structure to take forward a comprehensive stakeholder group to inform the development of Community PNMH Services across the network.



## **6. Improving access to Specialist PNMH Psychology/Psychiatry**

Access to Psychology and or Psychiatry was identified as a current issue and therefore a priority area to be addressed across the network.

All women should be asked about previous mental health problems at early pregnancy assessment. Those who have had a serious mental illness should be referred to a psychiatrist (preferably a perinatal psychiatrist) for proactive management during pregnancy.<sup>4</sup>

According to the National Survey of Psychiatric Mother and Baby Units in England, the provision of specialised perinatal psychiatric care in England is patchy and inequitable<sup>8</sup>

The JCPMH<sup>4</sup> (2012) highlight that good Perinatal Mental Health services (sometimes referred to as parent-infant mental) will assess and provide care for mothers with complex perinatal mental health problems who have or are at risk of parenting difficulties. These include less severe depression, anxiety and personality difficulties. They will also work with mothers with more serious problems who have parenting difficulties. They provide a variety of psychotherapeutic, psychological and psychosocial treatments and parenting interventions. They are able to see mothers and their infants at home as well as in the clinic setting.

The service is staffed by a multidisciplinary team whose skill mix and competencies reflect their ability to deal with both maternal mental health problems and infant mental health issues and the interaction between the two. At least one clinician should have the clinical skills and experience to identify and if necessary refer on more serious perinatal problems. These services should work collaboratively with other psychiatric services, both specialised perinatal services and mother and baby units, adult psychiatric services and children's social services. These services should provide advice and training to enhance the skills of IAPT workers and health visitors.

The JCPMH<sup>4</sup> (2012) key messages also state that maternity services should have access to designated specialist clinical psychologists.

It is clear that there would be benefits to addressing the issue of access to specialist PNMH Psychology and Psychiatry on a network footprint aligned with an integrated pathway for PNMH. Therefore once again the establishment of a PNMH clinical network supported by the SCN would provide a structure to begin to take this work forward.

## **7. Improving access to psychological therapies**

From the scoping exercise access to IAPT services was highlighted as an area of need, although it is unclear if this is an issue that relates to general access to IAPT or access to specific PNMH IAPT services.

IAPT services are now established throughout England with access via self-referral or health professional. It is estimated that approximately 27% of IAPT clients will be pregnant and postpartum women.

To support the development of PNMH IAPT services specific guidance (the IAPT Perinatal Positive Practice Guide) was published by the Department of Health (2007).<sup>9</sup> However, as alluded to earlier in this document IAPT treatment modalities may not include a focus on parenting or mother-infant interaction. The concern around this is that women presenting initially with depression and anxiety in the early postpartum period who subsequently develop a more serious illness may have delayed access to the appropriate level of care.

Clearly further investigation is needed around these concerns which could once again fall under the remit of a managed PNMH Clinical Network.



## 8. Early access to mental health services

Early access to mental health services was noted across the network as a key priority for improvement. Once again it would be beneficial to consider early access to Mental Health Services on a network footprint tying with an integrated pathway for PNMH.

NICE<sup>5</sup> (2014) provides guidance around the treatment of patients with mental health disorders during the perinatal period and advocates the use of clear referral and management protocols which will inform the development of pathways and early access to mental health services as appropriate.

The JCPMH<sup>4</sup> (2012) also outlines that a good general adult mental health service should:

- regard women of reproductive age as having the potential for childbearing. They should ensure that patients with serious mental illness receive pre-conception counselling and are aware of the risks to their mental health of becoming pregnant. They should also take into account the possible adverse effects of psychotropic medication in pregnancy when prescribing to women of reproductive potential and provide women with this information.
- wherever possible, redirect referrals of pregnant and postpartum women to specialised perinatal psychiatric services. Where these do not exist, they should be aware of a differing threshold of response to all interventions including admission and the capacity of perinatal conditions deteriorating rapidly and being associated with substantial morbidity and mortality
- if a woman, already under their care, because of a longstanding serious mental health problem, becomes pregnant, they should work collaboratively with maternity services to develop a peripartum management plan and wherever possible, seek advice and support from a specialised community perinatal mental health team
- if admission is necessary, consider admission to a mother and baby unit even if this means an out of area placement
- demonstrate that their systems and practice consider their patients as parents and the welfare of their children.

Once again a managed clinical network would be the ideal vehicle to facilitate communication between all stakeholders around the development of this area of PNMH services.





## 9. Improved access to Specialist Perinatal Mental Health Mother & Baby inpatient beds



Figure 2: Distribution and location of Perinatal Mental Health Inpatient Mother & Baby Units nationally

According to the RCPMH<sup>10</sup> (2012) report there is a national shortfall in the number of inpatient mother and baby beds of approximately beds (between 5 and 8 units depending on size)

There are still large areas of the country which have no specialised facilities. Women are either admitted without their babies to general adult wards or have to travel long distances to an out of area mother and baby unit.

Fewer than half of all mental health trusts in Great Britain provide a specialised perinatal mental health team that is staffed by at least a consultant perinatal psychiatrist and specialised community perinatal mental health nurses.<sup>11</sup>



In addition, there is a variable and patchy provision of services often involving a single or small number of professionals who provide partial care or “signposting services” to women. However none of these will be able to provide comprehensive services, particularly for women with serious mental illness. To summarise, the provision of specialised perinatal psychiatric care in England is patchy and inequitable.<sup>8</sup>

Women with acute severe mental illness needing inpatient care or needing specialised community care are not able to access the appropriate type and standard of care as recommended by NICE<sup>5</sup> guidelines and other national guidance.

From the scoping exercise carried out across Greater Manchester Lancashire & South Cumbria there were a number of issues highlighted around access to specialist inpatient beds including:

- Knowledge around the specialist inpatient unit, the Anderson Unit, and the services provided seems to be variable
- The Anderson unit does not provide any community PNMH services
- The Anderson unit provides specialist PNMH inpatient beds for the whole of the North West. This creates issues with regards to access and for patients particularly in South Cumbria due to travel distances of up to 60 miles and travel networks
- Due to a lack of beds some patients have been admitted to specialist units out of area. e.g. Leeds
- The Anderson Unit does not provide any inpatient family facilities therefore admission can result in separation from partners and wider family networks.

Whilst the inpatient PNMH service provided at the Anderson unit is a tertiary service and is therefore managed by the North West Specialist Commissioning Team access to specialist inpatient PNMH services does seem to have been identified as an issue nationally.

It may therefore be useful for the SCN support team to work with the Anderson Unit to review patient activity data and prepare a short report to be discussed with the North West Specialised Commissioning Team in order to support any potential changes to the service.

Following further discussions at national level the policy direction for PNMH has been identified under the compressive spending review as a priority area with initial funding in 2015/16 being dedicated to mother and baby units.

Lancashire and Cumbria have been identified as an area of need for inpatient beds, and as such the SCN along with Specialised Commissioning will jointly support these discussions across the patch drawing on the expertise and learning of the Anderson Unit (North West PNMH Mother & Baby Inpatient Unit) at Wythenshawe Hospital, in Manchester. A round table discussion will take place in February 2016.

### **Recommendations**

It is recommended that a PNMH group should now be established to review the findings of this report and formulate next steps in line with the conclusions made around the priorities for development of PNMH services across Greater Manchester Lancashire & South Cumbria in addition to the round table discussions.





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## APPENDICES

### Appendix 1



GMLSC SCN PNMH  
Questionnaire.xlsx

### Appendix 2



Themes from GMLSC  
SCN PNMH Questionn

### Appendix 3

Antenatal and postnatal mental health: clinical management and service guidance

NICE guidelines [CG192] December 2014

Section 1.10.3

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

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

<https://www.nice.org.uk/guidance/cg192/chapter/1-recommendations>

