

**INFANT AND MATERNAL MENTAL HEALTH  
SERVICES ACROSS THE NORTH WEST:  
MAPPING PROVISION**

**REPORT PREPARED FOR THE NORTH WEST REGIONAL NETWORK FOR  
INFANT AND MATERNAL MENTAL HEALTH**

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## **EXECUTIVE SUMMARY**

### ***Perinatal mental health problems and services***

Women who experience perinatal mental health problems [from pregnancy through to one year after the birth] present with symptoms which span the spectrum of mental distress, from mild to moderate depression through to puerperal psychosis. Perinatal mental health problems can emerge and escalate extremely quickly, so that emergency care is often needed. But perinatal mental health issues do not only affect the woman: her whole family is affected.

In 2007, the National Institute for Health and Clinical Excellence [NICE] published guidance on antenatal and postnatal mental health (NICE 2007). The NICE guidance advocates a network approach to the organisation and provision of perinatal mental health services managed around the woman and her family, and sets out the evidence base for clinical management of specific mental health problems, many of which respond well to treatment (Oates 2000). Crucially, such a network of services needs to work across the three separate service ‘worlds’ of maternity, children and adult mental health, including social care and the third sector.

### ***A survey of perinatal mental health services in the North West***

This report summarises the findings from a scoping study of infant and maternal mental health services across the North West which was conducted between April and September 2008, following publication of the NICE guidance. The work was commissioned by the North West Regional Network for Infant and Maternal Mental Health, to:

- [i] map current perinatal mental health services across the North West;
- [ii] identify gaps in provision; and
- [iii] contribute to discussions guiding the development of perinatal mental health services in the North West, including a perinatal mental health managed clinical

network, in line with the 2007 NICE guideline on antenatal and postnatal mental health.

### ***Key findings and recommendations***

The scoping study identified a number of challenges to the development of high quality perinatal mental health services across the North West, with equitable access for women across the Region. There are exemplary pockets of good practice and impressive professional commitment, but they need to be systematised to be sustainable and equitably available. The challenges are:

- data availability and quality
- championing the service
- agreeing a service model
- agreeing local care pathways
- commissioning sustainable services
- workforce development

The report sets out issues which need to be addressed to meet each of these challenges. Above all, unless a co-ordinated approach is adopted, developing managed clinical networks in line with NICE guidance across health economies, and addressing the challenges set out above, women with perinatal mental health problems will continue to be poorly served by health and social care in the North West.

## **INTRODUCTION**

This report sets out findings from a scoping study of infant and maternal mental health services across the North West which was conducted between April and September 2008. It sets out the background to the study, including the challenges which perinatal mental health problems pose and the national policy context within which perinatal mental health services need to be designed, organised and provided. It goes on to summarise the key recommendations from the NICE and other policy guidance for the delivery of a perinatal mental health service and network. The scale of the challenge in the North West, in terms of the estimated incidence of perinatal mental health problems is presented, and the key findings of the survey, in terms of challenges which need to be addressed to embed equitable and high quality perinatal mental health services across the North West.

### ***The North West Infant and Maternal Health Network***

The survey was sponsored by the North West Regional Network for Infant and Maternal Mental Health [IMMH]. The Network was set up in September 2007 by the Care Services Improvement Partnership (CSIP) working with the Cheshire and Merseyside Child Health Development Programme.

The purpose of the NW IMM Network is to:

- provide a forum for the community of stakeholders from across the North West who are working to promote the provision of a sustainable maternal and infant mental health service
- create a strategic profile for the development of maternal and infant mental health services across the North West
- to build clinical and practitioner capacity across the service.

From September 2007 to September 2008, the Network programme has focused on improving outcomes for families experiencing maternal and infant mental health problems by:

- providing leadership

- working with partner organisations to share learning and positive practice
- raising awareness of the health needs of the client group
- highlighting gaps in service provision
- influencing local policy implementation across the North West.

### *Potentially unmet need*

While the scale and exacerbation of mental health problems in the perinatal period [from pregnancy to one year after birth] has been recorded since the 1850's (Brockington, 1996), we know that only 2% of newly delivered women are referred to psychiatric services with a new episode of illness (Oates 2000). This suggests there is significant unmet need and untreated distress in both pregnant women and women with newborn babies. A previous report on perinatal mental health services in the Five Boroughs Partnership NHS Trust (Pearson 2008) confirmed this picture of unmet need and uneven, sometimes ad hoc, provision.

### *A study to map provision*

In this context of potentially unmet need, the scoping study was designed to:

- map the current level of provision of perinatal mental health services across the North West
- gather information about gaps in provision to inform service development
- contribute to discussions guiding the development of perinatal mental health services in the North West including a perinatal mental health managed clinical network in line with the 2007 NICE guidelines on antenatal and postnatal mental health.

## STUDY METHODOLOGY

The work underpinning this report comprised the following components:

1. Desk research and literature review to identify national guidance, professional advice and models of good practice.
2. Attendance at NW IMMH Steering Group and other meetings as required, where issues in current service provision were discussed.
3. Contribution to stakeholder events organised by the Network Steering Group to discuss the vision for perinatal mental health services across the North West.
4. Development and distribution of questionnaire to stakeholders across the North West (Appendix 5). These stakeholder respondents include Primary Care Trusts, Children's Trusts, community maternity service providers, hospital based maternity service providers and mental health service providers. The questionnaire asked two questions:
  - Please would you briefly describe the perinatal mental health services which are provided by you and your team.
  - Are these services explicitly commissioned, provided through block contracting arrangements, or through good will?

The resource constraints of the study were such that it was not possible to follow up questionnaires with reminders, or to pursue responses in depth. The questionnaire responses were collated into a report for the Network Steering Group.

5. Individual discussion with stakeholders across the North West to gather information on model care pathways and examples of good practice in the delivery of services.

6. Presentation of interim findings for discussion to the Network Steering Group at a meeting on 12 September 2008.
7. Drafting of final report and presentation of the main findings at a conference on 25 September 2008.

## THE CASE FOR INVESTMENT: THE EVIDENCE BASE

Women who suffer from perinatal mental health problems present with symptoms which span the spectrum of mental distress: from mild to moderate postnatal depressive illnesses to puerperal psychosis. Women suffering from the most severe forms of perinatal illness such as puerperal psychosis and very severe depressive illness are among the most seriously ill patients presenting to psychiatric services (Oates 2000). Where women are presenting for care, and often this will be for emergency care, they need prompt and careful treatment to return them to health as soon as possible and to protect their infant from any adverse development effects of a maternal illness. Additionally, the care which is offered should recognise the needs of the whole family so that a woman's partner and her other children receive proper support with appropriate interventions.

The impact of a mother's perinatal mental health problems is profound as the impact is felt across her whole family: by her infant, her partner and other children she has as well as by herself and possibly her own parents. There is compelling evidence that perinatal mental health problems in a mother are strongly associated with adverse effects on her relationship with her baby (Martin and Gaffney 2000), and on her children's physical and social attachment and cognitive development (Murray 2001, Hay et al 2001, Weissman et al 2006). This is particularly marked in boys, but has potentially serious consequences for the later lives of both boys and girls. Chronic or relapsing severe maternal mental health problems where intensive support at home is not available can result in children being taken into care.

### ***Maternal and infant mental health: affecting the whole family***

It is important to remember that perinatal mental health issues do not only affect the woman: the whole family is affected.

#### *The mother*

Perinatal mental illness covers a spectrum from mild to moderate perinatal depression to puerperal psychosis and very severe depressive illness. It bears repeating here

that women suffering from the most severe forms of perinatal illness are among the most seriously ill patients presenting to the psychiatric services. The risk that women who have experienced a previous episode of puerperal psychosis or a severe depressive illness will suffer again from such an illness if they give birth to further children is between 1 in 3 and 1 in 2 (Oates 2000).

National epidemiological studies suggest that 11% of women suffer from mild to moderate postnatal depression but it is important to note that for women living in areas of high socio-economic deprivation, as many as 40% will report depressive symptoms (personal communication K Cartmel, J Lythgoe and M Finnigan 2008).

### *Her newborn*

Mothers who are depressed are not always able to establish a satisfactory interaction with their baby which is essential for a child's psychosocial and psychoneurological development. It is the mother's ability to interact emotionally with her baby that is crucial: while a depressed mother may be physically able to care for her newborn she may struggle to give appropriate emotional and psychological responses if she is depressed (Murray 2001). Research studies (Field 1993, 1995) where depressed mothers and their babies were videotaped, as they were interacting show that depressed mothers:

- spend less time looking at their infants
- spend less time touching them and talking to them
- they smile less and frown or show sadness more when they are with them.

In return during these interactions, their babies:

- smile less and frown or show more negative affect
- look away more frequently, look wary and protest more often.

Field suggests that these babies are mirroring their mothers' predominantly depressed mood. And furthermore, the evidence suggests that, for infants of chronically depressed mothers, this depressed mode of interacting is generalised across their interactions with other adults – including those who are not depressed.

### *Her growing child*

There is evidence that maternal depression has a longer-term negative impact on a child's language development (Coghill et al 1988); on social and emotional development (Cooper and Murray 1997) and on cognitive skills. Children of mothers with perinatal depression are more vulnerable to mental health problems and have a higher rate of referral to children's mental health services (Murray 2001, Hay et al 2001).

### *Her older children*

Children of depressed parents are two to three times more likely to present with childhood anxiety, and disruptive and depressive conditions (Weissman et al 2006).

### *Her partner*

Research evidence demonstrated that 50% of the partners of women, who are depressed, are depressed themselves (Ballard 1994, Mathery et al 2000). This depression could compromise their ability to care for and meet the emotional needs of their baby, where the mother herself is not able to provide this behavioural and emotional environment.

This brief summary of the growing body of evidence underlines the key impact of a baby's early care environment on his/her mental health, emotional well-being, and social and cognitive development. It also suggests that effective interventions to protect the mental health of mothers and their babies should include:

- treatment for women themselves
- support for the whole family
- access to programmes which encourage positive interaction between mothers and their babies
- access to programmes which support mothers with their growing and older children.

## THE POLICY CONTEXT

Table 1 outlines recently published policy and professional guidance within which an integrated infant and maternal mental health service would need to be designed, developed and delivered.

<b>Table 1: Recent policy and professional guidance</b>	
DH 2008	Child Health Promotion Programme: pregnancy and the first five years of life
Healthcare Commission 2008	Towards better births: A review of maternity services in England
DH 2007	Antenatal and postnatal mental health: clinical management and service guidance: NICE guidance
CEMACH 2004	Confidential Enquiry into Maternal and Child Health: Why Mothers Die
DfES 2004	Every Child Matters: Change for Children
DH 2004	National Service Framework for Children, Young People and Maternity Services
DH 2003	Antenatal care: routine care for the healthy pregnant woman – NICE guidance
DH 2002	Women's Mental Health into the Mainstream
RCPsych 2000	Perinatal Mental Health Services

### ***NICE guidance on antenatal and postnatal mental health***

NICE guidance, which represents the view of the Institute, is published after careful consideration of the evidence available. Healthcare professionals are expected to take NICE guidance fully into account when exercising their clinical judgement. NICE guidance is important, and the Department of Health's *Standards for Better Health*, published in July 2004, include the implementation of clinical guidelines and also state that national guidance should be taken into account when NHS organisations are planning and delivering care. The Healthcare Commission assesses the performance

of NHS organisations in meeting core and developmental standards set out in *Standards for Better Health*.

NICE clinical guideline 45 gave clinical management and service guidance in respect of antenatal and postnatal mental health (NICE 2007), and included advice on the most appropriate organisation of services for the delivery of effective treatment, within a stepped care framework. A key principle of the NICE guideline was that treatment and care should take account of the woman's individual needs and preferences, and that good communication between healthcare professionals and women, their partners, families and carers is essential.

The guideline identified the establishment of clinical networks for perinatal mental health services as a key priority for implementation, with the following features:

- the clinical network should be managed by a coordinating board of healthcare professionals, commissioners, managers, service users and carers;
- the network 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 disorders, to ensure effective transfer of information and continuity of care;
  - pathways of care for service users, with defined roles and competencies for all professionals involved.

The guideline went on to recommend that each perinatal mental health network should have designated specialist inpatient services and cover a population with

between 25,00 and 50,000 births a year, depending on local psychiatric morbidity rates. The guideline also specified that perinatal inpatient services should:

- provide facilities designed specifically for mothers and infants (typically with 6-12 beds);
- be staffed by specialist perinatal mental health staff;
- be staffed to provide appropriate care for infants;
- have effective liaison with general medical and mental health services;
- have available the full range of therapeutic services;
- be closely integrated with community-based mental health services to ensure continuity of care and minimum length of stay.

### ***Healthcare Commission Review of Maternity Services***

The Healthcare Commission undertook a major review of maternity services in England in 2007 (Healthcare Commission 2008). In respect of the identification and management of mental health needs, the review found that:

- recording of mental health needs by maternity staff in trusts is inconsistent, and it is therefore difficult to gauge how common such problems are;
- all trusts reported that they covered mental health at the booking appointment, and just over half (55%) used the specific questions recommended by the NICE guidance (NICE 2007);
- approximately one third of trusts had joint clinics with mental health teams for previous perinatal mental health disorders;
- only a fifth had specialist midwives for women with previous postnatal psychosis (19%) or to support women with a psychiatric disorder (21%), compared with nearly two thirds (63%) of trusts which had specialist midwives supporting women who misuse substances;
- only 40 out of 148 trusts were able to provide data on the prevalence of mental health problems at ante-natal clinic booking;
- only 29 trusts could give data on mental health referrals.

The Maternity Service Review recommended that trusts need to improve their provision for women with mental health needs in several ways:

- Trusts and PCTs should secure access to a specialist perinatal mental health service with acceptable waiting times for referral. Midwives should be authorised to make referrals;
- Trusts need to incorporate NICE guidelines into their booking appointment checklist;
- Trusts need to review their provision of specialist midwives for mental health needs;
- All trusts should have access to a psychiatric mother and baby unit providing care for mothers with serious mental health needs and their babies.

### ***A model perinatal mental health service***

The key recommendations from the NICE guidance and the Healthcare Commission, coupled with other Department of Health policy, particularly in respect of children's services, and recommendations of CEMACH (2004, 2007) and the Royal College of Psychiatrists (Oates 2000), suggests that the needs of mothers, their infants and their families will be best served through services organised and managed around the woman and her family. These services need to be provided through integrated, whole system perinatal mental health networks, working across the three separate service [and policy] "worlds" of maternity, children and adult mental health.

This co-ordinated service would demonstrate:

- a "whole system approach" which could include social care and third sector partners, and which would focus on the needs of the infant as well as the mother;
- perinatal mental health pathways agreed between all care providers including NHS partners in commissioning services, primary, secondary and tertiary care providers, social care and the third sector.

- the basis of a perinatal mental health service in high quality multidisciplinary primary mental health services, including social work and the third sector.
- a specialist multidisciplinary perinatal mental health team made up of (at least) psychiatrist(s), community psychiatric nurses, and social worker(s). This team should support and act as a resource for primary mental health practitioners. Members of the team should be trained and competent in perinatal mental health issues, but may work on a sessional basis whilst also working in other mental health services.
- general practitioners alert maternity services to any previous or current mental health problems in the referral letter to the antenatal clinic.
- at their first contact with services in the antenatal and postnatal periods, all women are asked about current or previous mental health problems and their family history of mental illness. The two “Whooley” key detection questions are used to identify possible depression (See Appendix 1). After the “Whooley” questions, the Edinburgh Postnatal Depression Scale (EPDS) may be used as part of a further assessment of mental health status.
- there is an identified lead obstetrician and midwife in each maternity service, to whom any woman assessed as at risk is immediately referred.
- patient information systems clearly record whether there are perinatal mental health issues and, in the case of women in contact with mental health services, whether they have children and/or are currently pregnant.
- where there is concern about any woman, and where health visitor “listening visits” are felt to provide insufficient support, she is referred to and assessed immediately by a member of the specialist perinatal team, and is then supported by the primary mental health team.
- there are clear co-ordination and liaison arrangements for each maternity unit, encompassing referring GPs, community midwives and health visitors, hospital maternity services, primary care mental health teams and the specialist multidisciplinary perinatal mental health team which includes social workers, an children’s centres and the third sector as appropriate.
- there is access to inpatient beds in a specialist Mother and Baby Unit, which is a last treatment of choice for any mother.

- there is psychological support for parents whose baby is in the Special Care Baby Unit or in Paediatric Intensive Care to maximise a positive relationship.
- there is overall co-ordination and development of the network exploring new ways of working across the health, social care, children's services and third sector systems. Whilst overall direction and clinical leadership of the network will be a continuing requirement, the need for initial investment in systems and workforce development could be time limited.

The NICE guidance (NICE 2007) recommends a birth cohort size of 25,000 – 50,000 for a managed perinatal mental health network. Across the North West, this gives scope for services to be provided as part of a wider geographical network particularly in respect of access to specialist Mother and Baby Unit inpatient beds and cots.

## THE SCALE OF THE NORTH WEST CHALLENGE

The initial development or exacerbation of mental health problems in the perinatal period is well documented (Brockington 1996). The epidemiology of perinatal mental health problems is well established, and was summarised in the Royal College of Psychiatrists report in 2000 (Oates 2000). National and international studies reveal that:

- 10% of all recently delivered women experience a major depressive illness
- between 3% and 5% of delivered women meet the criteria for moderate to severe depressive illness
- 2 per thousand delivered women are admitted to hospital with puerperal psychosis
- a further 2 per thousand delivered women are admitted to hospital with non-psychotic conditions
- approximately 2 per thousand newly delivered women will have pre-existing severe, chronic or enduring mental illness, predominantly schizophrenia
- relapse or recurrence of previous post-partum mental illness is well established and believed to be a risk of between 33% and 55%
- however, only around 2% of women are referred postnatally to psychiatric services with a new episode of illness, indicating significant unmet need and untreated distress.

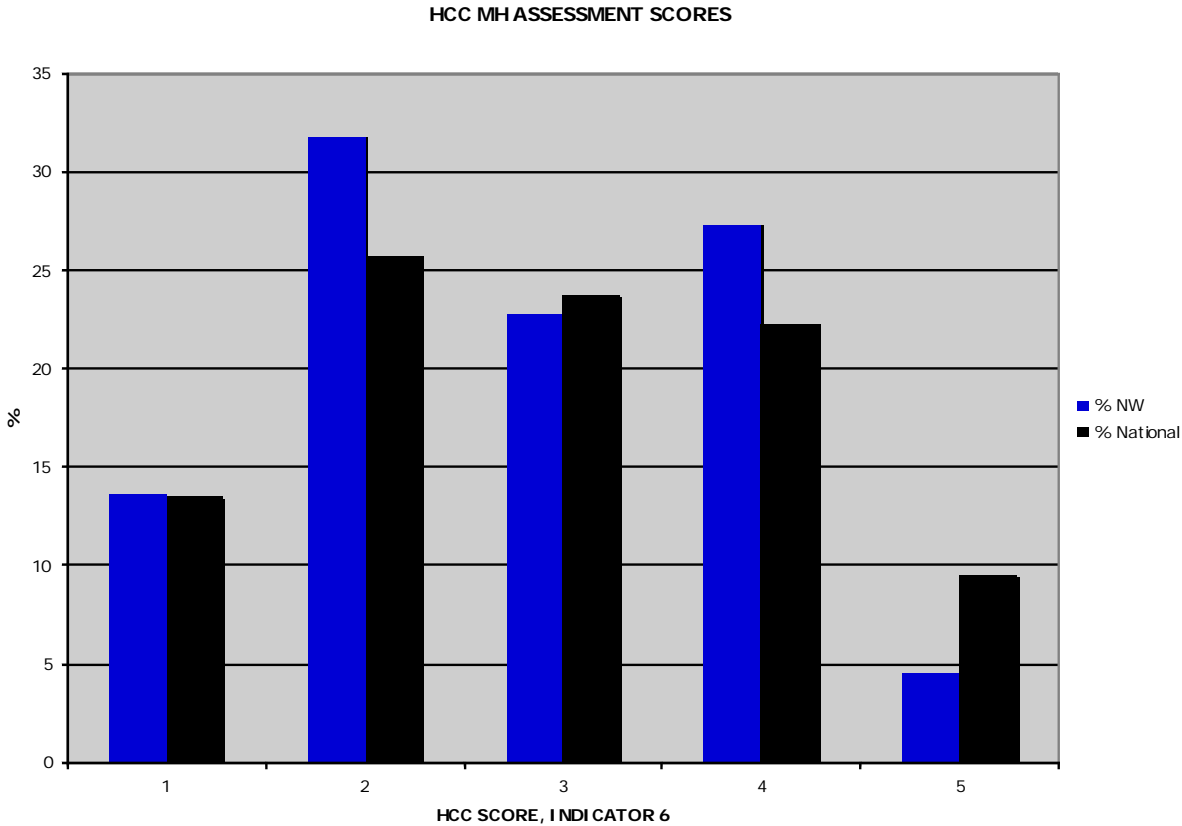
Appendix 2 shows the expected incidence of perinatal mental health problems in the North West by PCT, applying the incidence figures derived from international and national studies (Oates 2000) to live births by PCT. In PCTs with high levels of poverty and lone mothers, these figures may be quite significant underestimates.

**FINDINGS: GAPS AND CHALLENGES**

*Healthcare Commission Maternity Services Review*

The Healthcare Commission Maternity Services Review (Healthcare Commission, 2008) published its findings for each NHS Trust. Appendix 3 summarises the findings in respect of detection and management of mental health issues for each of the trusts in the North West. Only one Trust, North Cumbria scored the top possible score of 5. The range of scores was comparable to England, but generally slightly lower (Figure 1).

**Figure 1: Healthcare Commission Assessment of Maternity Services' Identification and Management of Mental Health Problems, NW compared with England**



## *Responses to the questionnaire*

Responses to the questionnaire identified a number of challenges to embedding equitable and high quality infant and maternal mental health services across the North West. These include:

- extracting data and improving data quality
- championing the service
- agreeing a service model
- agreeing a local care pathway
- commissioning sustainable services
- workforce development

### *Challenges: extracting data and improving data quality*

A recent survey of perinatal mental health services conducted across the 5 Boroughs Partnership NHS Trust has pointed to the lack of robust data on women who are using the service (Pearson 2008). Discussions across North West stakeholder groups has confirmed that information on perinatal mental health problems is not routinely and systematically collected by service providers.

It is therefore difficult to know with confidence:

- how many women are receiving care
- how are the needs of women who do not access services being met? Are they being met?
- whether this matches the demand for care suggested by consideration of local epidemiological data
- whether those services which are available are adequate to respond to levels of need in the population
- whether evidence is available to support a case for integrated investment

The requirement to provide robust data to support improved patient access to services has acted as a powerful lever in raising the profile of data collection and data

management systems across the NHS. Having access to the reliable data which is made available through these mandatory collections can be used by both commissioners and service providers to inform discussions about the development and delivery of services and should be used routinely.

### ***Challenges: championing the service***

The North West for IMM Network Steering Group provides an important forum for stakeholders from across the North West who are working to promote the provision of a sustainable maternal and infant mental health service. Over the last twelve months, it has successfully raised the profile of these issues across the Region.

In the short term, it is important to make the provision of these services both a regional and a local priority using the leverage available through local and regional policy and implementation groups with explicit service championing. Services need to be available to support women across the spectrum of maternal mental ill health and which also support and promote their emotional attachment to their babies. Services meeting needs across the spectrum of this distress need to be in place before any claim is made for a comprehensive maternal and infant mental health service.

In the longer term, these services should be recognised as part of a standard package of care – ‘the way we do things’ – which would reduce the need for active advocacy.

### ***Challenges: agreeing a service model***

The recommended model of care is for women and their babies to be managed at home, by primary care and maternity teams with specialist perinatal mental health support within managed clinical networks. This model of care is supported through recently published policy and professional guidance. CEMACH (2002) explicitly recommends that specialist care for seriously ill women is provided by:

*"A specialist perinatal mental health team, with the knowledge, skills and expertise to provide care for women at risk of suffering from serious post-partum illness, should be available to every woman."*

It is clear that pathways into inpatient mother and baby services are a last resort. There is evidence that the provision of high quality perinatal mental health expertise in the community can reduce the need for inpatient mother and baby beds and cots by up to a half (BPS and RCPsych 2007).

Appendix 4 shows the specialist perinatal mental health workforce which would be required, by PCT, to meet the service levels recommended by the Royal College of Psychiatrists (Oates 2000), and endorsed by the NICE guidance (NICE 2007). Those recommended service levels are:

- 1 Programmed Activity [PA] Consultant Perinatal Psychiatrist per '000 births
- 0.5 wte multidisciplinary perinatal team per '000 births
- 0.1-0.5 psychological therapists per '000 births
- 0.3 mother and baby unit beds per '000 births [assuming community-based multidisciplinary team is in place].

The National Service Framework for Children, Young People and Maternity Services (DH 2004) recommends that services are explicitly integrated through a managed clinical network:

*"A linked group of health professionals from primary, secondary and tertiary care and social services and other services working together in a co-ordinated manner with clear governance and accountability arrangements."*

A Managed Clinical Network (MCN) can deliver a whole systems approach to the provision of care to women and their babies, ensuring that local services work together effectively to give both improved care outcomes and a better care experience for mothers and babies. Because MCNs have clear and transparent governance and accountability arrangements in place, they can be more effective than other types of partnership for delivering multi-professional and cross-agency services which are responsive to the needs of individual women and their families (DH 2005).

To move forward, all stakeholder partners across the region will need to endorse this model. The model will be flexibly adapted by local health economies so that it is both affordable and meets the needs of their local populations. Additionally, it will provide a framework for local discussion about the configuration of service provision and can inform local service level agreements.

### ***Challenges: agreeing a local care pathway***

Survey respondents agree that there is no agreed understanding across all providers about what constitutes the clinical range of infant and maternal mental health problems. There is therefore no consensus in respect of the services which should be provided to support mothers experiencing mental distress, and their families. As set out in the NICE guideline (NICE 2007), the establishment of a Clinical Network for perinatal mental health, with a stakeholder co-ordinating board, will establish a local forum to:

- jointly agree the definition of perinatal mental health
- agree the support services which should be available to women and their families
- discuss and agree how this support and care can be provided locally
- discuss and agree detailed local care pathways which provide integrated care across all service providers
- manage the implementation of these pathways.

### ***Challenges: commissioning sustainable services***

Respondents report that few services are explicitly commissioned – most are provided through block contracting arrangements (where the provision of the perinatal mental health services is not detailed) or are provided through goodwill.

There is some history of services being provided through short term funding opportunities which has led to a recurring pattern of services being established only to

be decommissioned when funding streams are withdrawn. This has created instability in service providers and has demoralised front line clinical staff.

Embedding a secure sustainable funding platform for these services would have great benefits for women and their families:

*"Although associated with very serious disturbance, early onset of puerperal psychosis and severe depressive illness are usually very responsive to treatment and may have a better short and long term prognosis than non post-partum conditions."*  
(RCPsych 2000)

While the development of high quality perinatal mental health services will require the investment of additional resources, it is important these developments are overall affordable. Considerable resources are already invested in addressing maternal and infant mental health issues through existing services and by practitioners with a special interest. However, these investments and professional interests are not always co-ordinated and directed to maximum effect.

In particular, investment in liaison across services – ideally through a Managed Clinical Network – is needed to ensure that services are delivered as effectively and efficiently as possible.

### ***Challenges: workforce development***

There is a need to develop the skills of all staff who contribute to the care of women and their families who have mental health problems. Establishing a high quality perinatal mental health service will require a development in practice for all practitioners so they are all alert to potential problems, are comfortable and confident in addressing them and will share information appropriately. It is still the case that women are booked into antenatal care without mentioning a previous mental illness, and some practitioners feel uncomfortable asking for a mental health history.

Training programmes, like that developed in Cumbria, offer examples of good practice

in skill development and could be widely disseminated across the North West workforce.

Appendix 4 shows the workforce requirement, by PCT, to deliver the levels of service recommended by the Royal College of Psychiatrists (Oates 2000).

## **CONCLUSION**

The NICE guideline (2007) and Royal College of Psychiatrists report (Oates 2000) give set out a clear vision for the networked provision of perinatal mental health services. Across the North West there is considerable expertise, ad hoc investment and professional commitment to perinatal mental health issues. What is now required is for stakeholders to come together at different geographical levels across the Region to design and develop managed perinatal mental health network[s] which can deliver the pathways and services which the women of the North West, and their families, deserve.

## APPENDIX 1: QUESTIONS FOR A WOMAN'S FIRST CONTACT WITH SERVICES

The NICE guidance (Antenatal and postnatal mental health: clinical management and service guidance, DH 2007) recommends that:

- At a woman's first contact with services in both the antenatal and postnatal periods, healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask questions about:
  - ® past or present severe mental health illness including schizophrenia, bipolar disorder, psychosis in the postnatal period and severe depression
  - ® previous treatment by a psychiatrist/specialist mental health team including inpatient care
  - ® a family history of perinatal mental illness.

Other specific factors, such as a poor relationship with her partner, should not be used for the routine prediction of the development of a mental disorder.

- At a woman's first contact with primary care: at her booking visit (4-6 weeks) and postnatally (3-4 months), healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask two key detection questions to identify possible depression (Whooley et al \*\*\*\*):
  - ® During the past month, have you often been bothered by feeling down, depressed or hopeless?
  - ® During the past month, have you often been bothered by having little interest or pleasure in doing things?

If the woman answers "yes" to either of the initial questions, a third question should be asked:

- ® Is this something you feel you need or want help with?

**APPENDIX 2**

## ESTIMATED INCIDENCE OF PERINATAL MENTAL HEALTH PROBLEMS IN NW, BY PCT (boundaries as of October 2006)

	TOTAL LIVE	MAJOR	MOD TO	NEW PSYCH	ADMITTED W	ADMITTED W	ADMITTED W
	BIRTHS	DEPRESSION	SEVERE	EPISODES	PSYCHOSIS	NON-PSYCHOT	LONG TERM
			DEPRESSION	REFERRED		DEPRESSION	SCHIZOPHRENIA
		10%	< 5%	1.7%	2 per '000	2 per '000	2 per '000
Ashton, Leigh and Wigan PCT	3694	369	185	63	7	7	7
Blackburn With Darwen PCT	2284	228	114	39	5	5	5
Blackpool PCT	1648	165	82	28	3	3	3
Bolton PCT	3576	358	179	61	7	7	7
Bury PCT	2282	228	114	39	5	5	5
Central Lancashire PCT	5287	529	264	90	11	11	11
Central and Eastern Cheshire and Western Cheshire PCT [combined]	7316	732	366	124	15	15	15
Cumbria PCT	4782	478	239	81	10	10	10
East Lancashire PCT	4808	481	240	82	10	10	10
Halton and St Helens PCT	3577	358	179	61	7	7	7
Heywood, Middleton, Rochdale PCT	2853	285	143	49	6	6	6
Knowsley PCT	1915	192	96	33	4	4	4
Liverpool PCT	5190	519	260	88	10	10	10
Manchester PCT	6706	671	335	114	13	13	13
North Lancashire PCT	2990	299	150	51	6	6	6
Oldham PCT	3201	320	160	54	6	6	6
Salford PCT	2916	292	146	50	6	6	6
Sefton PCT	2585	259	129	44	5	5	5
Stockport PCT	3151	315	158	54	6	6	6

Tameside and Glossop PCT	2498	250	125	42	5	5	5
Trafford PCT	2632	263	132	45	5	5	5
Warrington PCT	2208	221	110	38	4	4	4
Wirral PCT	3591	359	180	61	7	7	7
NORTH WEST REGION	81751	8175	4088	1390	164	164	164
Greater Manchester (Met County)	33553	3355	1678	570	67	67	67
Merseyside (Met County)	15196	1520	760	258	30	30	30
Cheshire County	7316	732	366	124	15	15	15
Cumbria County	4782	478	239	81	10	10	10
Lancashire County	13086	1309	654	222	26	26	26
NOTE: STILL BIRTHS NOT INCLUDED [453 IN NW IN 2006] AS DATA ARE CONFIDENTIAL BY PCT AREA							

**APPENDIX 3: HEALTHCARE COMMISSION RATING OF MENTAL HEALTH NEEDS ASSESSMENT BY NW MATERNITY UNITS, JANUARY 2008**

**INDICATOR 6: PROGRESS ON IMPLEMENTING MENTAL HEALTH NICE GUIDANCE**

<b>Trust</b>	<b>SCORE</b> 5 high 1 low	<b>PROVIDER OF MENTAL HEALTH SERVICE</b>	<b>MENTAL HEALTH SUBJECTS COVERED AT BOOKING</b>
Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust	2	No specialist service	Following NICE guidance <sup>1</sup>
Bolton Hospitals NHS Trust	2	No specialist service	Following NICE guidance
<b>Central Manchester and Manchester Children's University Hospitals NHS Trust</b>	<b>4</b>	<b>Adult psychiatrist with special interest</b>	<b>Following NICE guidance</b>
<b>Countess of Chester Hospital NHS Foundation Trust</b>	<b>4</b>	<b>Adult psychiatrist with special interest with nurses</b>	<b>Following NICE guidance</b>
<b>East Cheshire NHS Trust</b>	<b>4</b>	<b>Adult psychiatrist with special interest with nurses</b>	<b>Following NICE guidance</b>
East Lancashire Hospitals NHS Trust	2	No specialist service	Following NICE guidance
Lancashire Teaching Hospitals NHS Foundation Trust	1	No specialist service	Current, previous and family MH
Liverpool Women's Hospital NHS Foundation Trust	2	No specialist service	Following NICE guidance
Mid Cheshire Hospitals NHS Foundation Trust	3 <sup>2</sup>	No specialist service	Following NICE guidance
North Cheshire Hospitals NHS Trust	3	CPN-led service	Following NICE guidance
<b>North Cumbria Acute Hospitals NHS Trust</b>	<b>5<sup>3</sup></b>	<b>Adult psychiatrist with</b>	<b>Following NICE guidance</b>

<sup>1</sup> Highest possible category on this indicator: booking appointment covers woman's history, family history and woman's current emotional stability

<sup>2</sup> Score raised to 3 at Mid Cheshire by better than median access to mother and baby unit beds per '000 births

		<b>special interest with nurses</b>	
Pennine Acute Hospitals NHS Trust	2	No specialist service	Following NICE guidance
Salford Royal NHS Foundation Trust	2	No specialist service	Following NICE guidance
Southport and Ormskirk Hospitals 3: NHS Trust	2	No specialist service	Following NICE guidance
St Helens and Knowsley Hospitals NHS Trust	3	CPN-led service	Following NICE guidance
<b>Stockport NHS Foundation Trust</b>	<b>4</b>	<b>Adult psychiatrist with special interest</b>	<b>Following NICE guidance</b>
Tameside Hospital NHS Foundation Trust	1	No specialist service	Current, previous and family MH
Trafford Healthcare NHS Trust	1	No specialist service	Current, previous and family MH
<b>University Hospitals of Morecambe Bay NHS Trust</b>	<b>4</b>	<b>Adult psychiatrist with special interest with nurses</b>	<b>Following NICE guidance</b>
<b>University Hospital of South Manchester NHS Foundation Trust</b>	<b>4</b>	<b>Adult psychiatrist with special interest with nurse</b>	<b>Following NICE guidance</b>
Wirral University Teaching Hospitals NHS Foundation Trust	3	Adult psychiatrist with special interest with nurses	Following NICE guidance
Wrightington, Wigan and Leigh NHS Trust	3	CPN-led service	Following NICE guidance
<b>AVERAGE FOR NORTH WEST</b>	<b>2.77</b>		

*Measurement and scoring system for this indicator*

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<sup>3</sup> Highest possible score because also has above average access to mother and baby unit beds [Newcastle]

- ❖ Start at 1 point
- ❖ If a specialist perinatal service is available add 1 point, and if this includes a psychiatrist, add a further point
- ❖ If booking documentation covers areas identified in NICE guidance, add 1 point
- ❖ If the number of available Mother and Baby Unit beds per 1000 deliveries at the nearest unit to which the community refers is greater than, or equal to the median (0.1826), add 1 point

**APPENDIX 4**

## ESTIMATED SPECIALIST PERINATAL MENTAL HEALTH WORKFORCE REQUIREMENT IN NW, BY PCT (boundaries as of October 2006)

	TOTAL LIVE	CONSULTANT	MULTIDISCIPLINE	PSYCHOLOGY	MOTHER AND
	BIRTHS	PERINATAL	PERINATAL	THERAPISTS	BABY UNIT
	2006	PSYCHIATRIST	TEAM		BEDS
		0.1 per 1000	0.5 per 1000	<0.5 per 1000	0.3 per 1000
Ashton, Leigh and Wigan PCT	3694	0.3694	1.847	1.847	1.1082
Blackburn With Darwen PCT	2284	0.2284	1.142	1.142	0.6852
Blackpool PCT	1648	0.1648	0.824	0.824	0.4944
Bolton PCT	3576	0.3576	1.788	1.788	1.0728
Bury PCT	2282	0.2282	1.141	1.141	0.6846
Central Lancashire PCT	5287	0.5287	2.6435	2.6435	1.5861
Central and Eastern Cheshire and Western Cheshire PCT Combined	7316	0.7316	3.658	3.658	2.1948
Cumbria PCT	4782	0.4782	2.391	2.391	1.4346
East Lancashire PCT	4808	0.4808	2.404	2.404	1.4424
Halton and St Helens PCT	3577	0.3577	1.7885	1.7885	1.0731
Heywood, Middleton, Rochdale PCT	2853	0.2853	1.4265	1.4265	0.8559
Knowsley PCT	1915	0.1915	0.9575	0.9575	0.5745
Liverpool PCT	5190	0.519	2.595	2.595	1.557
Manchester PCT	6706	0.6706	3.353	3.353	2.0118
North Lancashire PCT	2990	0.299	1.495	1.495	0.897
Oldham PCT	3201	0.3201	1.6005	1.6005	0.9603
Salford PCT	2916	0.2916	1.458	1.458	0.8748
Sefton PCT	2585	0.2585	1.2925	1.2925	0.7755

Stockport PCT	3151	0.3151	1.5755	1.5755	0.9453
Tameside and Glossop PCT	2498	0.2498	1.249	1.249	0.7494
Trafford PCT	2632	0.2632	1.316	1.316	0.7896
Warrington PCT	2208	0.2208	1.104	1.104	0.6624
Wirral PCT	3591	0.3591	1.7955	1.7955	1.0773
NORTH WEST REGION	81751	8.1751	40.8755	40.8755	24.5253
Greater Manchester (Met County)	33553	3.3553	16.7765	16.7765	10.0659
Merseyside (Met County)	15196	1.5196	7.598	7.598	4.5588
Cheshire County	7316	0.7316	3.658	3.658	2.1948
Cumbria County	4782	0.4782	2.391	2.391	1.4346
Lancashire County	13086	1.3086	6.543	6.543	3.9258



## **APPENDIX 5**

### **MAPPING INFANT AND MATERNAL MENTAL HEALTH SERVICES ACROSS THE NORTH WEST**

While the scale and exacerbation of mental health problems in the perinatal period (from pregnancy to one year after birth) has been recorded since the 1850s, only 2% of women are referred postnatally to psychiatric services with a new episode of illness, which indicates significant unmet need and untreated distress in both pregnant women and women with newborn babies.

The North West Regional Network Steering Group for Infant and Maternal Mental Health is a community of stakeholders from across the North West who are working to promote sustainable perinatal mental health services across the Region.

To contribute to this work programme, we would be very grateful if you would complete and return this survey which will help us to map the current level of provision of perinatal mental health services across the North West. It will also give us useful information about gaps in provision to inform service development and to guide the development of a perinatal mental health managed clinical network.

I hope you will be able to take part in this work. If you have any queries, please contact Lesley Burn on 07831 114445.

#### **1. Some information about you and your organisation**

We hope you will be happy to be contacted to expand on any of the information you provide.

Name	
Job title	
Organisation name	
Tel no	
Email	

**2. Please would you briefly describe the perinatal mental health services which are provided by you and your team.**

**3. Are the services explicitly commissioned?  
If they are not, do you provide them through block contracting arrangements or do you provide them through good will?**

**4. Thank you very much for providing this information.  
Please return this survey as soon as you can to:**

Fax: 0151 546 2890  
 Email: [lynn@living-media.com](mailto:lynn@living-media.com)

OFFICE USE	
Data received:	
Data provider:	
1. Primary Care Trust	
2. Children's Trust	
3. Community maternity service provider	
4. Hospital based maternity service provider	
5. Mental health service provider	

LB/LW - Version 2  
 01/07/08

## REFERENCES

Ballard (1994) cited in Cartmell (2007)

Bates S and Coren E (2006) Systematic map report 1: the extent and impact of parental mental health problems on families and the acceptability, accessibility and effectiveness of interventions. London: Social Care Institute for Excellence (SCIE).

Brockington I (1996) Maternal Mental Health Oxford: Oxford University Press.

Cartmell K (2007) Strengthening Attachment in Families: a report on a proposed strategy for perinatal mental health in Cumbria prepared for Cumbria County Council, Cumbria Partnership NHS Trust, Cumbria PCT and North Cumbria Acute Hospitals NHS Trust.

CEMACH (2007) Saving Mothers' Lives: Reviewing Maternal Deaths to Make Motherhood Safer 2003-2005. The Seventh Report of the Confidential Enquiry into Maternal Deaths in the United Kingdom. London: Confidential Enquiry into Maternal and Child Health.

CSIP (2008) Children and Families Programme .Perinatal and Infant Mental Health (PIMH) Network for England and Wales.

Department of Health (2007) Maternity Matters: Choice, Access And Continuity Of Care In A Safe Place. London: Department of Health

Lancashire Local Safeguarding Children's Board (2006) Protocol for the identification and management of perinatal maternal depression. September.

Lewis G and Drife J (2004) Why Mothers Die 2000-2002. The Sixth Report of the Confidential Enquiry into Maternal Deaths in the United Kingdom. London: Confidential Enquiry into Maternal and Child Health.

Martin and Gaffney (2000) cited in Cartmell (2007)

Matthey et al (2000) cited in Cartmell (2007)

Murray (2001) cited in Cartmell (2007)

National Collaborating Centre for Mental Health (2007) Antenatal and Postnatal Mental Health, Clinical Management and Service Guidance. London: British Psychological Society and Royal College of Psychiatrists.

National Institute for Health and Clinical Excellence (NICE) (2007) Antenatal and Postnatal Mental Health, Clinical Management and Service Guidance. NICE Clinical Guideline 45. London: NICE.

Oates M (1997) Patients as parents: the risk to children. British Journal of Psychiatry 170 (supplement 32) pp 22-27.

Oates M (2000) Perinatal Mental Health Services Council Report CR88. London: Royal College of Psychiatrists.

Pearson M (2008) The Case for Perinatal Mental Health Services Confidential Final Report for Five Boroughs Partnership NHS Trust.

Sidebotham P, Fox J, Horwath J, Powell C and Perwez S (2008) Preventing Childhood Deaths: a study of early starter child death overview panels in England Report DSCF-RR036. University of Warwick with the Universities of Sheffield and Southampton.

Weissman et al (2006) cited in Cartmell (2007)

Whooley MA, Avins AL, Miranda J et al (1997) Case finding instruments for depression. Two questions are as good as many. *Journal of General Internal Medicine* 12 pp 439-445.