REPORT

LSE CPEC CARE POLICY AND EVALUATION CENTRE

Centre for Mental Health

# A sound investment

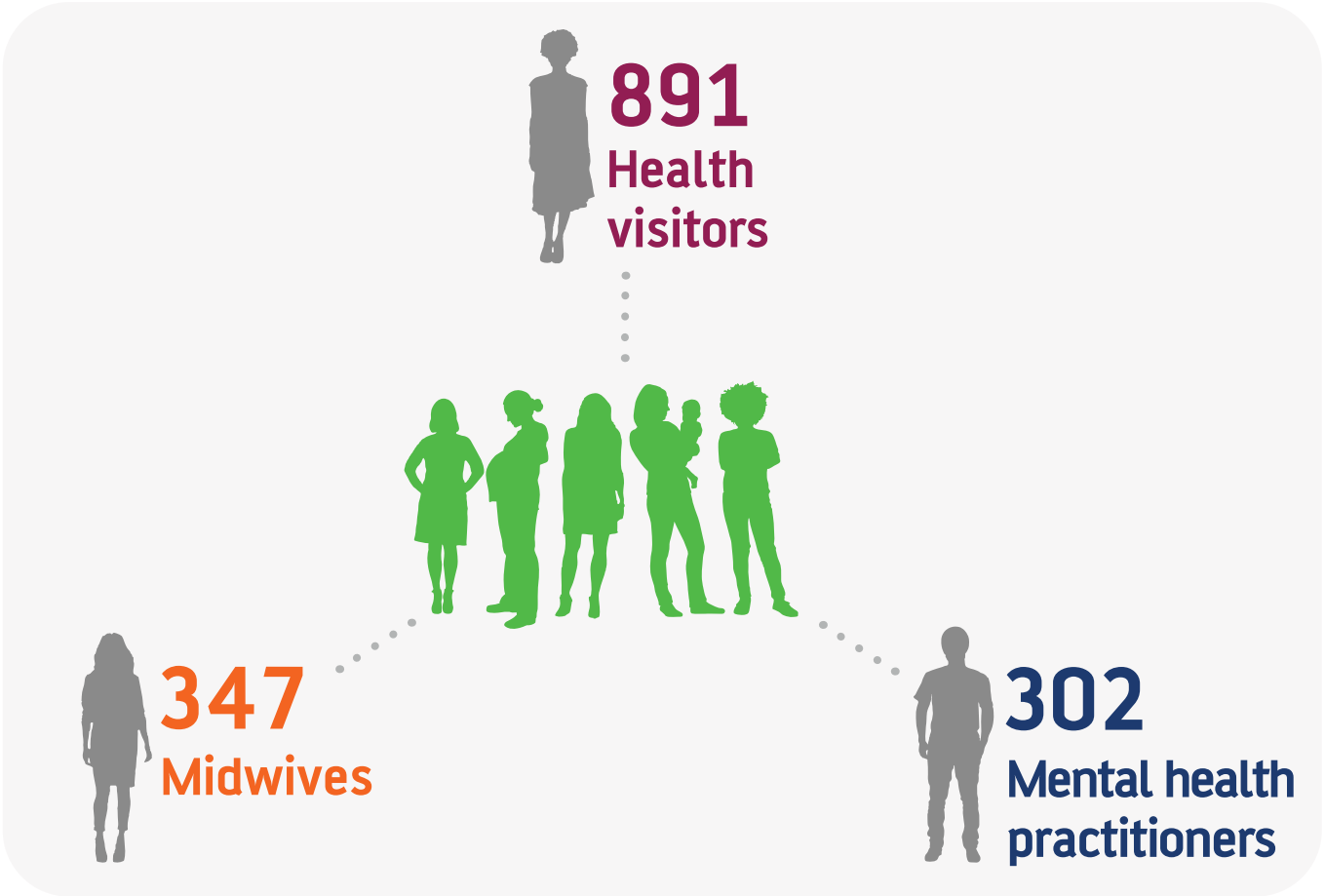
## Increasing access to treatment for women with common maternal mental health problems

Maternal Mental Health Alliance

# 1 in 5

women experience a mental health problem during pregnancy or after they have given birth.

## What additional workforce is needed to support mothers' mental health?*




* This is in addition to externally identified shortages of 2,000 midwives and 5,000 health visitors

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# Acknowledgement

*The economic case for increasing access to treatment for women with common mental health problems during the perinatal period* is a publication by Annette Bauer, Michela Tinelli and Martin Knapp from the Care Policy and Evaluation Centre, London School of Economics and Political Science.

It calculates costs and benefits to create a return-on-investment comparison of two options that expand perinatal mental health care and a cost of implementation for the option that promises highest return-on-investment.

The report is available **here** and any questions on the content of the report should be directed to **Annette Bauer**.



This briefing paper provides a summary of that research and its implications for policy and practice.

Both the report and this briefing were commissioned by the Maternal Mental Health Alliance.

# Foreword from Dr Alain Gregoire

In 2014, The Maternal Mental Health Alliance (MMHA) commissioned independent research from the London School of Economics and Political Science and Centre for Mental Health, which resulted in their ground-breaking report *The Costs of Perinatal Mental Health Problems*.

A significant proportion of women develop a perinatal mental health problem during pregnancy or within the first years after having a baby. Without treatment, these problems can have a devastating impact on women and their families.

The findings from that report were clear: as well as human suffering, perinatal mental illnesses carry a total long-term cost to society, calculated conservatively, of more than £8.1 billion for each annual group of births in the UK.

Since that report was published, there has been an important investment in specialist services in all four nations. The resulting new services, rapidly and effectively developed by the NHS, are already transforming the health care and the lives of women with the most severe and complex maternal mental health problems and their babies.

To ensure all women and babies who need care have access to it, more action and more commitment is now urgently required. This includes the large number of women who suffer with common mental health problems like depression and anxiety at this critical time for them and their babies. For at least two decades the research evidence has told us clearly what needs to be done to help these women and their families, yet most of them are very far from receiving the quality of care for their mental health that they can rightly expect for their physical health.

That is why the MMHA commissioned the Care Policy and Evaluation Centre, London School of Economics and Political Science to conduct new independent research to see whether increasing access to treatment for women with common mental health problems during pregnancy and after birth can help women and families, and be economically beneficial.

This new report demonstrates that universal services such as health visiting and maternity have a clinically effective and cost-effective role in perinatal mental health care, identifying women in need or at risk, and facilitating access to or providing treatment as part of their routine work with women during and after pregnancy.

Importantly, the research finds that developing a model of service delivery in which mental and physical health care are integrated into the work of maternity and health visiting services generates nearly half a billion pounds of net benefit over a ten-year period. The investment included in the calculation involves training and staffing to ensure the skills, time and systems are in place to transform the care we provide to mothers and babies.

The findings of this report are very welcome. Women, their families, and professionals are united in calling for parity of care between mental and physical health at this time, and an end to the huge and costly, yet avoidable, suffering and disability caused by perinatal mental health problems.

This research provides important evidence guiding us towards a realistic, desirable and cost-effective solution that could improve the lives of so many in this generation and the next.

Society has waited a long time for an understanding of the critical importance of mental health, and of the earliest years of our lives, to our wellbeing and our future. Women, babies and families have already waited too long for us to do something with this powerful knowledge. Now we have a solution: let us not wait any longer to implement it.

**Dr Alain Gregoire, MMHA President**

# Foreword from Luciana Berger

In the UK, maternal mental health problems before, during and after pregnancy too often go unrecognised, undiagnosed, and untreated.

The Maternal Mental Health Alliance's (MMHA) Everyone's Business campaign calls for all women and their families in the UK to get the perinatal mental health (PMH) care and support they need.

MMHA's new phase of work 'Make all care count', highlights what services need to be in place alongside specialist PMH services, so a woman and her family can access the right care, at the right time.

The eight services that we have identified as essential are: specialist PMH services; health visiting; maternity services; GPs and other primary care; voluntary and community support; parent-infant services; mental health services; and children's services.

All these services are vital and need to be appropriately commissioned, funded and resourced.

This important research, commissioned by the MMHA and conducted by the Care Policy and Evaluation Centre at London School of Economics and Political Science (LSE), has focused specifically on evidence relating to health visitors and maternity services.

It concludes that investing in an integrated service model would not only help women experiencing the most common PMH problems, but could also generate an economic net benefit of nearly half a billion pounds over a ten-year period, primarily in health-related quality-of-life improvements.

An integrated service model would ensure health visitors and midwives are trained and skilled, so women are asked about their mental health and offered low-intensity treatment where needed. Such a model could help to achieve parity between mental and physical health care within well-established universal maternity and health visiting services.

Policy analysis by MMHA member, Centre for Mental Health, helps situate LSE's research in the current UK landscape. Whilst funding and service delivery models vary across all four nations, what remains constant is the needs of women and families for comprehensive, integrated PMH care.

This research was carried out during the Covid-19 pandemic, when PMH risks for women and their families have increased; additional pressure has been placed on already stretched services; and the workforce supporting women and families is facing its own wellbeing challenges.

Existing inequalities have also worsened as a result of the pandemic, with women and babies of colour and families from poorer backgrounds impacted the most.

Now, more than ever, it is time to look at the gaps that exist within PMH care and find solutions which deliver the care women and their families urgently need.

The MMHA won't stop until every woman and family in the UK gets the perinatal mental health care and support they need.

This includes:

- A confident, well-equipped workforce
- Care for all women, including those impacted by inequalities
- Specialist PMH services that meet national standards and act as a catalyst for change within the wider system.

There has been welcome progress with the provision of specialist PMH services in many, but not all, areas of the UK. For those women who do not meet the threshold for specialist care, services need to be in place to ensure they can get timely support for their PMH needs.

This research provides evidence for how to respond to a major gap in services. I hope national and local decision makers grasp the opportunity to act to reduce the costs of PMH problems, improving the lives of more women and families.

**Luciana Berger, MMHA Chair**

# Executive summary

This report summarises the findings of *The investment case for increasing access to treatment for women with common mental health problems during the perinatal period*, published by the London School of Economics (LSE) Care Policy and Evaluation Centre (CEPC), and explores their implications for policy and practice.

One woman in five experiences a mental health problem during pregnancy or after they have given birth. The most common mental health problems during pregnancy and after giving birth are depression and anxiety. Maternal mental health problems can have a devastating impact on the women affected and their families.

Guidance for the NHS states that perinatal mental health problems always require a speedy and effective response, including rapid access to psychological therapies when they are needed.

Across all four nations, there has been significant investment in specialist perinatal mental health services for women experiencing the most complex and severe conditions. This leaves a major gap for women with common mental health needs who do not meet the threshold for specialist services.

New service models are required. While some innovative models are already being delivered in some parts of the UK, they are not part of routinely funded provision. We still do not offer a comprehensive system of mental health support to women before, during and after pregnancy. In maternal health, parity of esteem between mental and physical health is still some way off.

The LSE report proposes that health visitors, midwives and mental health practitioners receive specific training and are employed to offer additional support for women's mental health alongside supporting them and their baby with their physical health and wellbeing. This would be alongside existing support offered by GPs and other universal services.

In this **integrated service provision** model, women are asked about their mental health and offered low-intensity treatment if they are struggling and feel stressed, anxious or depressed.

Integrated service provision would provide the following key elements of care, all within a system that is integrated with physical antenatal and postnatal care for a mother and her baby:

- Screening: Asking every woman in a skilled way about their mental health
- Assessment: Assessing women's mental health needs
- Treatment: Offering low-intensity treatments for common mental health problems
- Coordination: Ensuring women receive necessary subsequent care and support.

The report estimates that full-scale integrated provision across the UK requires an additional 347 midwives, 891 health visitors and 302 mental health practitioners. This would cost £124 million a year across the whole of the UK to train and employ the new staff.

Investing in integrated service provision would achieve cost savings to the NHS over 10 years of £52 million and improvements in women's quality of life estimated at £437 million. This means it has a net benefit of £490 million over 10 years.

Integrated service provision achieved through increasing the capacity of universal health services is the logical next step in the evolution of perinatal mental health care in the UK. Together with investment in specialist perinatal mental health care, it would close a major gap and ensure women get timely and efficient access to effective and tailored help for emerging mental health needs. And it would help the NHS and local authorities in all four UK nations to offer all children a good start in life during their 'first 1,001 days'.

# Introduction

At least one woman in five experiences a mental health problem during pregnancy or after they have given birth (Bauer *et al.*, 2014). Depression and anxiety are by far the most common of all the serious health complications of maternity. They are not only highly distressing to women and families at a critical time in their lives but can have lasting adverse consequences for the health and wellbeing of mothers and their children.

Guidance for the NHS states that perinatal mental health difficulties always require a speedy and effective response, including rapid access to psychological therapies when they are needed (NICE, 2014; NICE, 2021; SIGN, 2012).

Across the UK, there has been investment in specialist perinatal mental health services. In most areas these include both community and inpatient services, which are commissioned to work with women experiencing the most complex and severe conditions.

This is welcome and it is already helping to make a big difference (MMHA, 2020). There are plans and commitments to try and ensure specialist services are available across all areas. But it still leaves a major gap for women and families who do not meet the threshold for specialist services, who are missing out on essential care for their mental health. The majority of women with the most common perinatal mental health problems throughout the UK do not have access to evidence-based care.

Many women find that they have no opportunity to disclose if they are struggling and seek help. And if they do, they may not get access to support that will meet their needs. Unmet need from common maternal mental health problems can last for a long time, cause suffering and have significant consequences for a woman and her family. In some cases, when these needs are not met early they can escalate into more serious problems and reach crisis point. This means greater distress for women and their families, and ultimately it generates higher costs for the NHS.

This briefing summarises the findings of *The investment case for increasing access to treatment for women with common mental health problems during the perinatal period* published by the London School of Economics (LSE) Care Policy and Evaluation Centre (CEPC). The report sets out the case for investing in support for women who fall into one of the current gaps in the system.

Full detail is provided in the LSE technical report which can be found **here**. It can be read in conjunction with previous research on this topic by LSE with Centre for Mental Health (Bauer *et al.*, 2014) which calculated a total economic and social long-term cost to society of perinatal mental health problems of about £8.1 billion for each one-year cohort of births in the UK.

The aim of this policy briefing is to summarise the research and the case for action in the context of this new economic evidence. It explores the current policy context for perinatal mental health care and how the case for investment can be implemented in practice.

This briefing, with the LSE report, was commissioned by the Maternal Mental Health Alliance (MMHA), a UK-wide charity and network of over 100 organisations, dedicated to ensuring women, babies and families affected by perinatal mental problems have access to high-quality comprehensive care and support.

## Current service provision

Since 2015, there has been significant investment in services to support women with perinatal mental health problems. Funding has gone into specialist perinatal mental health services to address complex and severe mental health problems.

The UK Government has invested £365 million (up to 2021) in England as part of the Five Year Forward View for Mental Health and additional recurrent funding has been committed in the NHS Long Term Plan (NHS England, 2019a) with some additional funding allocated in the 2021 Spending Review, including £100m for perinatal and infant mental health and more possible funding to support parents through a network of 75 local 'family hubs'. Investments in the devolved nations include £4.7 million in Northern Ireland (MMHA, 2021a), £52 million in Scotland for improving access to perinatal and infant mental health services (Scottish Government, 2019a), and £3 million in Wales (Welsh Government, 2021).

In England, the NHS Long Term Plan's proposals for maternal mental health focus on expanding specialist community and inpatient perinatal mental health services. It pledges to:

*"Increas[e] access to evidence-based care for women with moderate to severe perinatal mental health difficulties and a personality disorder diagnosis, to benefit an additional 24,000 women per year by 2023/24, in addition to the extra 30,000 women getting specialist help by 2020/21. Care provided by specialist perinatal mental health services will be available from preconception to 24 months after birth (care is currently provided from preconception to 12 months after birth), in line with the cross-government ambition for women and children focusing on the first 1,001 critical days of a child's life."* (NHS England, 2019a, p48)

The Mental Health Implementation Plan (NHS England, 2019b) specifies two additional elements:

- Partners of women accessing specialist community care will be able to access an assessment for their mental health and signposting to support as required
- Maternity Outreach Clinics will be available across the country, combining maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience (NHS England, 2019b, p5).

It also sets out the additional funding required for this expansion (rising year by year up to £239 million by 2023/24) and the workforce required (an additional 990 whole time equivalent staff across a wide range of disciplines) (NHS England, 2019b, p18).

More recently, NHS England (2021) announced the establishment of a nationwide network of maternal mental health hubs, which would provide psychological therapies to women and training for maternity staff.

## Developments in the devolved nations

### Northern Ireland

- 2020: The Mental Health Action Plan agreed to fund a new service model for specialist community maternal mental health services
- 2021: Northern Ireland's Health Minister, Robin Swann, approved funding for the development of a new Perinatal Mental Health Delivery Model, including specialist multi-disciplinary perinatal mental health teams in each of the five trust areas to be delivered by Spring 2022
- 2021: Improving access to community and inpatient PMH services was included as a key priority in the Department of Health's 10-year Mental Health Strategy (2021-31).

## Scotland

In Scotland the Programme for Government, 2018-19 committed to providing:

*"...three tiers of support across Scotland, in line with the needs of individuals:*

- *For those 11,000 women a year who would benefit from help such as counselling we will support the third sector to provide this*
- *For those 5,500 women in need of more specialist help we will ensure rapid access to psychological assessment and treatment*
- *For those 2,250 women with the most severe illness we will develop more specialist services and consider the need for a small number of additional inpatient beds or enhanced community provision."* (Scottish Government, 2018, p64)

Based on recommendations in Delivering Effective Services (2019), a four-year programme of investment has focused not only on specialist services, but also on developing training needs across universal services and supporting the third sector through two funding streams which, by October 2021, had distributed more than £1.8 million to successful organisations.

In parallel, Delivering Effective Services also recommended the development of maternity and neonatal psychological interventions (MNPI) services, providing psychological therapies to women and their partners attending maternity services or whose infant requires additional neonatal care. They are staffed by clinical psychologists and perinatal mental health midwives and are now established in a number of health board areas.

Dedicated infant mental health services are also being rolled out across Scotland in a series of waves of investment.

## Wales

- 2015: Welsh Government announced £1.5m in new and recurrent funding for specialist community perinatal mental health services
- 2018-2020: Additional investment from Government in 2018 and 2019 increased recurrent annual funding to £2.5m for specialist perinatal mental health services
- 2020: Improving access and quality of specialist maternal mental health services identified as a key priority in Welsh Government's Together for Mental Health Delivery Plan (2019-2022)
- 2020: Perinatal Mental Health Network Board established to advise on the development of perinatal mental health services in Wales
- 2021: Funding allocated to specialist maternal mental health services in Wales confirmed as £3m.

While ambitions remain for improvements to specialist maternal mental health care, focused attention and investment have not yet begun to provide treatment for less severe but much more common mental health problems during the perinatal period, which cause suffering to women and their families. Common mental health difficulties can have a significant and lasting effect on a child's wellbeing, especially among the most disadvantaged families (Glover, 2015).

A wide range of professionals is needed to provide comprehensive maternal mental health care. Midwives and health visitors are well placed to identify problems early on, provide support, and – where needed – coordinate care with specialist perinatal and other mental health, primary care, maternity and early years services, including in voluntary and community sector organisations. This includes ongoing support after women have been discharged from services. But they can only do this if they are in sufficient numbers and have the resources – including training and time – to take on this responsibility in practice.

It is estimated that women should have an average of at least 16 appointments with either a midwife or a health visitor during the perinatal period. This will vary in different parts of the UK, where the number of contacts may be greater at different stages of pregnancy and post-birth. All of these are opportunities to have a conversation about mental health, identify any needs and plan timely, evidence based interventions, as recommended in both NICE (2007, 2014 and 2021) and SIGN (2012) guidelines. Perinatal mental health is among six 'high impact areas' for health visitors (PHE, 2021) which means that they are mandated to conduct a needs assessment including asking women about past or present mental illness or treatment.

In most localities, however, maternity and health visiting services are not resourced or staffed to carry out the activities required, or, for example, as recommended by NICE (2014, 2021), SIGN (2012) and Public Health England (2021) to support women's mental health. This risks opportunities to intervene being missed and places additional pressure on professionals, women and families.

# The existing workforce

This section reviews the current health visiting, midwifery and psychological therapy workforce in England. The funding and employment arrangements for these professions are different in each of the devolved nations.

## Health visitors

Health visiting services are commissioned by local authority public health departments. An analysis by The Health Foundation (2021) has shown that investment in public health services (through the Public Health Grant) was cut by 24% in real terms in England between 2015/16 and 2021/22. It estimated that to restore public health spending to previous levels, an extra £1.4 billion would be required by 2024/25. During that time, health visitor numbers have fallen by 35%, from over 10,000 to less than 7,000 (Children's Commissioner, 2020). The most recent count of the number of health visitors working in the NHS was 6,480 (NHS Digital, 2021), with a further 900 estimated to be working in other settings. Prior to the 2021 Spending Review, the Institute of Health Visiting (2021), supported by a group of more than 700 children's charities led by the National Children's Bureau (2021), stated that an extra 3,000 health visitors were needed in the next three years to offset the national shortage of 5,000 health visitors and rebuild lost capacity (Institute of Health Visiting, 2021). Even greater numbers will be required to build parity in their work between physical and mental health.

## Midwives

Midwife numbers have risen slowly over the last decade in England, from 19,442 (whole time equivalent) working in the NHS in April 2010 to 22,374 in April 2021 (NHS Digital, 2021) but continue to cause concern. In 2014, the House of Commons Public Accounts Committee (2014) reported that the NHS in England needed an extra 2,300 midwives to keep up with birth rates. In July 2021, the Royal College of Midwives (2021) warned that the NHS in England still faced a shortage of 2,000 midwives and that the numbers leaving work in the NHS had risen in the last year. Again, this is without taking account of the need for parity between their physical and mental health responsibilities to women and babies.

## Psychological therapists

Psychological therapists work in a wide range of contexts, including in the NHS, local authorities, voluntary and community organisations and in private practice. In 2020, the NHS's major psychological therapy programme in England, Improving Access to Psychological Therapies (IAPT), employed 9,102 whole time equivalent patient-facing staff, an increase of 11% on the previous year, providing treatment to over 1.1 million people (Health Education England, 2020). The NHS Long Term Plan aims to increase the workforce further, with an extra 2,940 staff to extend capacity to treat 1.9 million people by 2023/24 (NHS England, 2019). The IAPT programme does not currently provide specific support to women during the perinatal period, which may mean that it misses opportunities to offer treatment that responds to their needs. NHS England has, nonetheless, commissioned a competency framework for IAPT services in perinatal mental health needs (O'Mahen and Healy, 2021) and the LSE report notes that in some areas, specialist midwives and health visitors have provided training to IAPT practitioners to help to close this gap.

## Barriers to accessing mental health support

Many women experience problems accessing the right kind of support, especially when their problems mean they do not meet the threshold for specialist services that are designed for women with the most complex and severe problems. Women report they have not been asked about their mental health by a midwife or health visitor or other health professional, or not in a way that makes them feel that they can disclose problems. Research by the National Childbirth Trust (2017) found that half of women who experienced a mental health difficulty during or after pregnancy did not have their need identified by a health professional and hadn't received treatment. The most commonly cited barriers by women were:

- Worrying the health professional would think they were incapable of looking after their baby (46%)
- Embarrassment or shame (37%)
- Assuming their feelings were normal for a mother with a new baby (33%)
- Health professionals not seeming interested (28%).

Centre for Mental Health research found similar barriers within primary care. GPs described feeling unable to know how to respond, and having rushed appointments that made it difficult to find the space for a conversation about mental health (Khan, 2015).

The NHS in England has since provided funding for additional six-week health checks for new mothers with their GP to give extra time to discuss their (mental and physical) health as well as their baby's. A survey by NCT (2021), however, suggests that in the first year of this being available, there has been little sign of improvement, with a quarter of new mothers reporting that they were not asked about their emotional wellbeing and 85% saying the appointment focused mainly on their baby.

New service models are required. While some innovative models are already being delivered in some parts of the UK, they are not part of routinely funded provision. Without it, we still do not offer a comprehensive system of mental health support to women during pregnancy and after they have given birth. In maternal health, parity of esteem between mental and physical health is still some way off.

## Integrated service provision: the proposed model

The LSE report examined the economics of a model in which health visitors, midwives and mental health practitioners receive specific training and are employed to offer tailored support for women's mental health alongside supporting them and their baby with their physical health and wellbeing.

This model would strengthen existing provision by ensuring that all women are asked at every opportunity about their mental health and are then promptly offered evidence-based interventions to support good mental health and wellbeing if they feel stressed, anxious or depressed or have other common mental health problems.

This **integrated service provision** model would provide significant additional support for women with common mental health needs. Locally developed models would ensure that midwives and health visitors work closely with psychological therapy professionals alongside third sector services, existing primary care services and specialist mental health practitioners to provide:

- Screening: Asking every woman in a skilled way about their mental health
- Assessment: Assessing women's mental health needs
- Treatment: Offering low-intensity treatments, for example evidence-based psychological interventions such as listening or emotional wellbeing visits, non-directive counselling and cognitive counselling (Royal College of Psychiatrists, 2021)
- Coordination: Ensuring women receive necessary subsequent timely care and support.

Crucially, any treatment or support offered would be evidence-based (i.e. drawing on NICE and SIGN guidelines). Support would also be offered to women and families without requiring a formal diagnosis. This could help to reduce suffering and prevent the onset or escalation of parental or infant mental health difficulties.

The specialist perinatal mental health midwives and health visitors employed in this model would provide supervision, training and strategic support in setting up relevant collaborative service arrangements.

The model assumes that midwives will not provide psychological interventions themselves, but work closely in a multidisciplinary way with mental health practitioners, who would provide treatment. Health visitors could provide low-intensity interventions themselves, given the appropriate time, resources, training and supervision.

## Resources required for integrated service provision

The LSE report examines the resources that would be needed to set up and provide integrated service provision. This includes the costs of training and employing the necessary workforce of midwives, health visitors and mental health practitioners. It is in addition to addressing existing underinvestment in and shortages of both midwives and health visitors.

### Staff numbers

The report estimates that full-scale integrated provision across the UK requires an additional 347 midwives, 891 health visitors and 302 mental health practitioners in total (full-time equivalent; see Table 1). The mental health practitioners would be broadly equivalent to the current IAPT workforce of psychological wellbeing practitioners (PWPs) in England, and to similar roles in the devolved nations.

The additional 347 midwives and 891 health visitors would scale up the numbers of both 'regular' and specialist perinatal mental health practitioners already working in each profession. The numbers of specialist perinatal mental health midwives and health visitors that would be required to offer the proposed model nationwide is shown in Table 2.

**Table 1: Number of full-time equivalent staff needed to scale up integrated provision**

| | England | N Ireland | Scotland | Wales | UK Total |
|---|---|---|---|---|---|
| Midwives | 268 | 17 | 42 | 20 | 347 |
| Health visitors | 754 | 29 | 70 | 39 | 891 |
| Mental health practitioners | 258 | 10 | 22 | 13 | 302 |

**Table 2: Specialist midwives and health visitors required for scaled-up integrated service provision, in full-time equivalent (FTEs)**

| | Current staff | Staff required for scaled-up integrated provision | Additional staff for scaled-up integrated provision |
|---|---|---|---|
| Health visitors specialised in perinatal mental health | | | |
| England | 60.6 | 149.0 | **88.4** |
| N Ireland | 0 | 5.0 | **5.0** |
| Scotland | 0 | 14.0 | **14.0** |
| Wales* | 1.0 | 7.0 | **6.0** |
| Midwives specialised in perinatal mental health | | | |
| England | 233.2 | 300.0 | **66.8** |
| N Ireland | 0 | 10.0 | **10.0** |
| Scotland | 3.0 | 28.0 | **25.0** |
| Wales | 4.0 | 14.0 | **10.0** |

## Costs

The financial costs of providing this model are divided between the costs of training for midwives, health visitors and mental health practitioners, and the costs of employing them. The first is predominantly a one-off cost to get the new model started; the second is an annual cost.

### Training costs

The training required for this model includes:

- Strengthening skills in screening, assessment and care coordination for midwives and health visitors
- Skills in providing low-intensity treatment for health visitors and mental health practitioners.

The total one-off training cost required to create the initial workforce for integrated service provision across the UK is £1.2 million (Table 3).

While further training will be needed in future to sustain this workforce, it will not need to be at the same scale.

### Employment costs

The yearly budget needed for additional staff time to deliver integrated service provision across the UK is £122.6m per year (Table 4). This includes the costs of employing additional staff, or extending contracts for existing staff to reflect additional hours required for enhanced care. This is in addition to the costs of addressing wider shortages in the number of health visitors and midwives working in the NHS and other settings.

### Combined costs

Table 5 shows the combined costs (of training and staffing) for each of the four nations (in 2021 prices). Across the UK, this equates to £124 million a year.

**Table 3: One-off budget for training needed to scale up integrated provision**

| | England | N Ireland | Scotland | Wales | UK Total |
|---|---|---|---|---|---|
| Midwives | £190k | £9k | £15k | £7k | £220k |
| Health visitors | £600k | £31k | £51k | £22k | £700k |
| Mental health practitioners | £240k | £12k | £20k | £8.6k | £280k |
| **Total** | **£1.03m** | **£52k** | **£86k** | **£37.6k** | **£1.20m** |

**Table 4: Yearly budgets for staff time needed to scale up integrated provision (Specialist and non-specialist staff)**

| | England | N Ireland | Scotland | Wales | UK Total |
|---|---|---|---|---|---|
| Midwives | £21.8m | £1.6m | £3.7m | £1.8m | £28.9m |
| Health visitors | £59.3m | £2.4m | £5.7m | £3.2m | £70.5m |
| Mental health practitioners | £19.8m | £0.7m | £1.6m | £1m | £23.2m |
| **Total** | **£100.9m** | **£4.7m** | **£11m** | **£6m** | **£122.6m** |

**Table 5: Yearly total budgets needed to scale up integrated provision (2021)**

| England | N Ireland | Scotland | Wales | UK Total |
|---|---|---|---|---|
| £102m | £4.6m | £11.2m | £6m | **£123.8m** |

## The benefits of integrated service provision

The LSE's analysis explores the costs of not providing support to women with common mental health problems during the perinatal period and compares this with the costs of the proposed model. While specialist services are now offering treatment and support for women with the most complex and severe maternal mental health problems in many parts of the UK, there are still gaps. Whilst there are plans and commitments to try and close these gaps, many more women and families who do not meet the threshold for specialist services are missing out on essential care.

This gap in provision means the NHS is not offering essential care and treatment for women's mental health on a par with the treatment they expect for their or their baby's physical health during this crucial time in their lives. Not providing timely help is a false economy.

The report calculates that investing fully in integrated service provision would generate two major financial benefits:

1. Over ten years, it would produce savings to the NHS of £52 million. This is because women receiving timely support for common mental health difficulties will reduce the cost of later treatment for more serious problems.
2. Over the same period, it would also produce quality of life improvements for women and their families totalling £437 million. This is calculated using the same method NICE employs for giving a financial value to the improved quality of life that a health intervention produces.

This means that in total, integrated service provision could generate a net financial benefit to society and the NHS of £490 million over ten years. The costs of implementing the service would be offset by both cost savings and quality of life improvements.

## Addressing inequalities

For the proposed model to be effective, it will be important that it addresses inequalities in women's experiences of maternity and mental health care. Women from racialised communities, for example, have poorer outcomes from maternity services, including higher mortality rates (MBRRACE, 2021) and may find mainstream mental health support less accessible, relevant and helpful (Papworth *et al.*, 2021). Improving Access to Psychological Therapies services are also less likely to produce positive outcomes for people from racialised communities (Commission for Equality in Mental Health, 2020).

It will therefore be vital that integrated service provision is developed in an equitable way, proactively seeking to meet the needs of women who are less well served in existing arrangements. This may cover a number of areas and have multiple benefits, including:

- Building closer connections between mental and physical health: for example by combining mental health support with help relating to contraception, smoking cessation, drugs and alcohol, nutrition and prescription medications
- Working alongside communities and community organisations: building alliances with community groups, user-led organisations and faith groups may help to build bridges and reach women and families that mainstream services often fail to reach effectively (Commission for Equality in Mental Health, 2020)
- Using a wider range of approaches to meeting women's needs, including through creative arts and physical activity
- Working with social care and children's services more effectively, ensuring families connected with social services receive holistic support
- Offering support prior to conception: A space for women who have had previous mental health concerns to come to consider preparation for parenthood, to have a chance to ask questions and get good quality information to help with informed family planning
- Adopting trauma-informed approaches, which are known to benefit women who have experienced traumas as well as providing safe and open environments for all (Wilton and Williams, 2019).

This will have implications for recruitment, training and employment of the new workforce – seeking to ensure it is culturally competent, representative of the communities it serves, and able to adapt to women's specific needs – for example, to respond effectively to neurodiversity. The Advancing Mental Health Equalities strategy (NHS England, 2020) sets out the principles of equitable access to mental health care and its principles could be applied equally in the devolved nations.

## Conclusions

Integrated service provision that is family centred is the logical and economical next step in the evolution of perinatal mental health care in the UK. It would close a major gap and ensure women get timely access to help for emerging mental health needs.

The cost of implementing integrated service provision is estimated at £124 million annually, UK wide, comprising £102 million in England, £4.6 million in Northern Ireland, £11.2 million in Scotland and £6 million in Wales.

Integrated service provision is a sound investment. It will produce quality of life improvements for women and families nationwide and at the same time generate savings in excess of its costs. In total, it could generate an economic benefit of £490 million over a decade.

How this additional provision would work in practice may vary between the four nations and across localities. It would be important for implementation to integrate with existing maternity, primary care, talking therapy and maternal mental health services to maximise the benefits and ensure no woman is left behind. In England, integrated care systems would be well placed to design services according to the needs and assets of their areas. But this is contingent on the initial investment and ongoing commitment to create the vital workforce described in this briefing and the LSE report.

Across the UK, there are commitments from governments to give families and children a good start in life. The UK Government has committed to giving all children in England the best start in life, with a focus on improving support to families during a child's 'first 1,001 days' (Leadsom, 2021). It is also investing, through the NHS Long Term Plan, in high quality specialist perinatal mental health services (NHS England, 2019a). Each of the devolved nations have also offered investment, with some differences in funding and scope. But still in many areas, the current perinatal mental health pathway of support is too fragmented, services are poorly coordinated, and there are still gaps that need to be filled. Too many women's needs are not noticed, let alone met, by the existing networks of maternity, public health, primary care and mental health services.

The model proposed in the LSE report, and summarised here, provides a crucial link in the system, that will help the whole system to work effectively. By working proactively to prevent mental health problems and speed up the identification of mental health needs, it will ensure fewer women and their families miss out on essential support. By integrating services, it will offer women and their families timely help and support close to home. And by providing psychological interventions through practitioners who understand women's concerns about their pregnancy and their baby, it will offer more effective and responsive early help that reduces the need for later and more expensive intervention.

Investing in integrated service provision is the next logical step for the development of comprehensive perinatal mental health care in the UK. It will give women and families a better chance of good mental health, with both immediate and long-term benefits. It will be a sound investment.

# References


Bauer, A., Parsonage, M., Knapp, K., Iemmi, V., Adelaja, B. (2014) *The costs of perinatal mental health problems*. London: Centre for Mental Health. Available from: **https://www.centreformentalhealth.org.uk/publications/costs-perinatal-mental-health-problems** [Accessed 27 January 2022]

Children's Commissioner (2020) *Best beginnings in the early years*. London: Children's Commissioner. Available from: **https://www.childrenscommissioner.gov.uk/wp-content/uploads/2020/07/cco-best-beginnings-in-the-early-years.pdf** [Accessed 27 January 2022]

Commission for Equality in Mental Health (2020) *Briefing 3: Inequalities of experience and outcomes*. London: Centre for Mental Health. Available from: **https://www.centreformentalhealth.org.uk/publications/commission-equality-mental-health-briefing-3** [Accessed 27 January 2022]

Glover, V. (2015) Pre-natal stress and its effects on the fetus and the child. *Adv Neurobiol* 2015;10:269-83 doi: 10.1007/978-1-4939-1372-5_13 **https://pubmed.ncbi.nlm.nih.gov/25287545/**

Health Education England (2020) *Adult IAPT workforce census 2020*. Available from: **https://www.hee.nhs.uk/sites/default/files/documents/IAPT%20Census%202020%20-%20National%20report%20Final%20-%20August%202021.pdf** [Accessed 27 January 2022]

Health Education England (n.d.) *Making Every Contact Count factsheet*. Available from: **https://www.makingeverycontactcount.co.uk/media/27613/mecc-resources-fact-sheet-v9-20180601.pdf** [Accessed 27 January 2022]

Health Foundation (2021) *Why greater investment in the public health grant should be a priority*. Available from: **https://www.health.org.uk/news-and-comment/charts-and-infographics/why-greater-investment-in-the-public-health-grant-should-be-a-priority** [Accessed 27 January 2022]

House of Commons Public Accounts Committee (2014) *Maternity services in England*. London: The Stationery Office Limited. Available from: **https://publications.parliament.uk/pa/cm201314/cmselect/cmpubacc/776/776.pdf** [Accessed 27 January 2022]

Institute of Health Visiting (2021) *iHV representation to the multi-year spending review 2021*. London: IHV. Available from: **https://ihv.org.uk/news-and-views/news/ihv-submits-powerful-evidence-to-governments-multi-year-spending-review-2022-23-to-2024-25/** [Accessed 27 January 2022]

Khan, L. (2015) *Falling through the gaps*. London: Centre for Mental Health. Available from: **https://www.centreformentalhealth.org.uk/publications/falling-through-gaps** [Accessed 27 January 2022]

Leadsom, A. (2021) *The Best Start for Life: A vision for the 1,001 critical days*. London: HM Government. Available from: **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973085/Early_Years_Report.pdf** [Accessed 27 January 2022]

Maternal Mental Health Alliance (2020) *Map of specialist community perinatal mental health teams (UK)*. London: MMHA. Available from: **https://maternalmentalhealthalliance.org/wp-content/uploads/170820-UK-specialist-PMH-map.pdf** [Accessed 27 January 2022]

Maternal Mental Health Alliance (2021a) *Funding approved for Specialist Perinatal Mental Health Services in Northern Ireland*. Available from: **https://maternalmentalhealthalliance.org/news/funding-specialist-perinatal-northern-ireland/** [Accessed 27 January 2022]

MBRRACE (2021) *Saving lives, improving mothers' care*. Available from: **https://www.npeu.ox.ac.uk/assets/downloads/mbrrace-uk/reports/maternal-report-2021/MBRRACE-UK_Maternal_Report_2021_-_Lay_Summary_v10.pdf** [Accessed 27 January 2022]

National Childbirth Trust (2017) *The Hidden Half*. London: NCB. Available from: **https://www.nct.org.uk/sites/default/files/2019-04/NCT%20The%20Hidden%20Half_0.pdf** [Accessed 27 January 2022]

National Childbirth Trust (2021) *Revisiting #HiddenHalf – what's changed?* Available from: **https://www.nct.org.uk/get-involved/campaigns/hidden-half-campaign/revisiting-hiddenhalf-whats-changed** [Accessed 27 January 2022]

National Children's Bureau (2021) *Build Back Childhood*. London: NCB. Available from: **https://www.ncb.org.uk/sites/default/files/uploads/attachments/2021Oct_BuildBackChildhood%20FINAL.pdf** [Accessed 27 January 2022]

NHS Digital (2021) *NHS workforce statistics – April 2021*. Available from: **https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/april-2021** [Accessed 27 January 2022]

NHS England (2019a) *The NHS Long Term Plan*. London: NHSE. Available from: **https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/** [Accessed 27 January 2022]

NHS England (2019b) *NHS Mental Health Implementation Plan*. London: NHSE. Available from: **https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf** [Accessed 27 January 2022]

NHS England (2020) *The Advancing Mental Health Equalities strategy*. London: NHSE. Available from: **https://www.england.nhs.uk/publication/advancing-mental-health-equalities-strategy/** [Accessed 27 January 2022]

NHS England (2021) *'New dedicated mental health services for new expectant and bereaved mums'*. Available from: **https://www.england.nhs.uk/2021/04/dedicated-mh-services/** [Accessed 27 January 2022]

NICE (2014) *Antenatal and postnatal mental health: clinical management and service guidance. Clinical guideline GC192*. Available from: **https://www.nice.org.uk/guidance/cg192** [Accessed 27 January 2022]

NICE (2021) *NG194 Postnatal care*. Available from: **https://www.nice.org.uk/guidance/ng194** [Accessed 27 January 2022]

O'Mahen, H. and Healy, S. (2021) *IAPT Perinatal Competency Framework*. Exeter: University of Exeter. Available from: **https://www.ucl.ac.uk/pals/sites/pals/files/iapt_perinatal_competancy_framework_final_version_sept_2021-1.pdf** [Accessed 27 January 2022]

Papworth, R., *et al.* (2021) *Maternal mental health during a pandemic*. London: Centre for Mental Health. Available from: **https://www.centreformentalhealth.org.uk/publications/maternal-mental-health-during-pandemic** [Accessed 27 January 2022]

Public Health England (2021) *Early years high impact area 2: Supporting maternal and family mental health*. Available from: **https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children/early-years-high-impact-area-2-supporting-maternal-and-family-mental-health** [Accessed 27 January 2022]

Royal College of Midwives (2021) *Midwife numbers drop in latest NHS report*. Available from: **https://www.rcm.org.uk/news-views/rcm-opinion/2021/midwife-numbers-drop-in-latest-nhs-report/** [Accessed 27 January 2022]

Royal College of Psychiatrists (2021) *Perinatal mental health services*. London: RC Pscyh. Available from: **https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2021-college-reports/perinatal-mental-health-services-CR232** [Accessed 27 January 2022]

Scottish Government (2019a) *Mental health care for new mums*. Available from: **https://www.gov.scot/news/mental-health-care-for-new-mums** [Accessed 27 January 2022]

Scottish Government (2019b) *Perinatal mental health services: needs assessment and recommendations*. Edinburgh: Scottish Government. Available from: **https://www.gov.scot/publications/delivering-effective-services-needs-assessment-service-recommendations-specialist-universal-perinatal-mental-health-services/** [Accessed 27 January 2022]

Scottish Intercollegiate Guidelines Network (SIGN) (2012) *SIGN 127: Management of perinatal mood disorders*. Edinburgh and Glasgow: Health Improvement Scotland. Available from: **https://www.sign.ac.uk/assets/sign127_update.pdf** [Accessed 27 January 2022]

Welsh Government (2021) *Plenary 29/09/21 Welsh Parliament*. Available from: **https://record.senedd.wales/Plenary/12434#C377476** [Accessed 27 January 2022]

Wilton, J. and Williams, A. (2019) *Engaging with complexity*. London: Centre for Mental Health. **https://www.centreformentalhealth.org.uk/publications/engaging-complexity** [Accessed 27 January 2022]

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Published February 2022
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