

North Central London Clinical Commissioning Groups Perinatal Mental Health Strategy

1 Introduction

Pregnancy and the period after childbirth can be a life changing event for new parents and the wider family. With it comes a range of emotional changes as the mother, her partner and other siblings adjust to the impact on their lives. Many mothers find that these changes are a positive experience, but for some the emotional upheaval as well as the chemical changes that take place within the body can result in mental health problems. The impact of parental mental health difficulties can in turn affect the emotional life, development and welfare of the infant in their care.

Depression and anxiety are common during pregnancy and the postnatal period, symptoms include persistent sadness, fatigue and loss of enjoyment in activities (Hogg 2013). Between 10 and 20% of women develop a mental illness of some kind during pregnancy or within the first year after the baby's birth (Centre for mental Health / LSE 2014). Such problems may go unrecognised and untreated and symptoms can continue for many years having a detrimental effect on the whole family. It is also acknowledged that up to 10% of fathers will suffer from postnatal depression (Paulson et al, 2010).

Women with severe mental illness such as bipolar or schizophrenia are at particular risk of relapse, while a small number of women may develop a psychotic illness during the perinatal period. Suicide is one of the leading indirect causes of death (CMACE 2011).

Future in Mind (2015) set out proposals to support the improvement in children's and young people's mental health, maintaining that by 2017, every birthing unit should have access to a specialist perinatal mental health clinician. In January 2016 the Prime Minister announced that £280 million would be made available for the establishment of specialist perinatal mental health services in England. This was followed by the publication of the Independent Mental Health Taskforce report in February 2016, which stated that by 2020/21 30,000 more women in England should have access to specialist mental health support during the perinatal period.

2 Prevalence

2.1 Demand for services

The table below identifies the number of maternities (2014), by borough and by hospital site along with the prevalence of mental health problems expected for that population. In many cases while universal services will provide care to many of these women and their families, much of the need may currently be unidentified and unmet.

	Barnet		Enfield		Haringey		Camden		Islington	
	Total	Prevalence	Total	Prevalence	Total	Prevalence	Total	Prevalence	total	Prevalence
Royal Free Barnet Site	2396	359	1056	158	79	12	19	3	5	0.75

Royal Free	1324	199	66	10	127	19	768	115	79	12
North Middlesex	27	4	2741	411	1714	257	1	0	0	0
Whittington	340	51	171	26	1516	227	103	15	1042	156
UCLH	611	92	270	40	393	59	1383	207	1700	255
CCG total	4698	705	4304	645	3829	574	2274	340	2826	423.75

Total maternities based on Trust reported data for January to December 2014
Incidence based on 15% of total births

2.2 Demand for services by type of disorder

Outlined below are the rates of perinatal psychiatric disorder per thousand births and the numbers that would be expected by borough.

2014 births ONS			Barnet 5244	Enfield 4824	Haringey 4006	Camden 2700	Islington 2879
Disorder	Established rate per 1000 births	% women affected	Expected cases	Expected cases	Expected cases	Expected cases	Expected cases
Postpartum psychosis	2/1000	0.2%	10	10	8	5	6
Chronic serious mental illness	2/1000	0.2%	10	10	8	5	6
Severe depressive illness	30/1000	3%	157	145	120	81	86
Mild-moderate depressive illness	100-150/1000	10-15%	524-786	482-724	400-601	270-405	287-431
Post-traumatic stress disorder	30/1000	3%	157	145	120	81	86

Birth Data: ONS, July 2015

The availability of services for families affected by perinatal mental illness in North Central London is dependent on where a woman lives and where she chooses to have her baby. Only women who choose to give birth at the Whittington can expect to have access to a comprehensive, specialist perinatal mental health service. Services are in effect provider delivered, rather than effectively commissioned.

There is a need to develop a pathway which ensures that all women in North Central London are able to access not only the physical care they need during the perinatal period but the emotional and mental health care too.

This strategy sets out why commissioners need to address this issue now, examines what is needed – setting out our vision for the future. Current services are mapped against those recommended by the Royal College of Psychiatrists in order that NICE guidance can be met. Through this strategy, commissioners and clinicians from primary care, maternity, children's and mental health services will work together to plan, develop and implement a pathway of care for North Central London. The London School of Economics in conjunction with the Maternal Mental Health Alliance have examined the costs of perinatal mental health problems and set them against the costs of providing a service. These costs are considerable for children and are often only recognised when they begin school.

This work will be used to map the relevant cost benefits for the sector so that a case can be made for the 2016-17 commissioning round.

3 Evidence Base

A mother's mental health and wellbeing during pregnancy and the perinatal period (up to a year after birth), can significantly affect outcomes for herself, her relationship with her partner and children as well as the child itself. Women may be unwilling to disclose or to discuss mental health problems because of the risk of stigma or negative perceptions of them as a mother. The fear that their baby might be taken into care may be a very real one (NICE 2014).

Women can be affected by a range of mental health problems during this time, often with no previous history of mental illness. While the incidence of many mental health disorders is the same as for other adults, they are likely to have a more significant impact on her life.

Hogg (2013), identified in her report, *Prevention in Mind* for the NSPCC that mental health problems during pregnancy and the postnatal period are extremely common. Depression is the most prevalent mental illness; approximately 10-14% of mothers will be affected. While this is likely to be mild to moderate, a significant minority will suffer from a severe depression. Anxiety, often in conjunction with depression is also common (13-20%). Other conditions include Obsessive Compulsive Disorder (3%) and Post Traumatic Stress Disorder Triggered by pregnancy or birth (3%).

Rates of perinatal depression are higher amongst women who experience poverty or social exclusion and are twice as high amongst teenage mothers. Stress caused by poor housing, domestic violence and poverty can exacerbate symptoms of anxiety and depression. While anxiety and depression is exacerbated by issues such as social deprivation, women from all areas of society can be affected by mental illness. Over half of those who committed suicide during the perinatal period between 2006 and 2008 were white, married, employed, living in comfortable circumstances and aged 30 years or over.

Such conditions are likely to be under reported and therefore under-recognised, perhaps by as much as 50%. This may be because health professionals are unable to communicate in such a way as to identify problems or that the woman herself is unable or unwilling to divulge the information (NICE 2014, Centre for Mental Health / LSE 2014). In addition many pregnant women who are taking medication may stop because of the perceived effect on the baby.

However for women with pre-existing serious mental illness, postpartum psychosis, severe depressive illness, schizophrenia or bipolar disease are at significantly increased risk of recurrence (up to 50%), even if they have been previously well. (Hogg 2013) 1-2% of women will fall into this category.

Serious perinatal mental disorders are associated with an increased risk of suicide, which has been shown to be a leading cause of maternal death (CMACE 2011). Between 2006 and 2008, there were 1.27 maternal deaths per 100,000 maternal deliveries in the UK as a result of mental health problems.

Severe mental illness and their treatments can complicate the management of pregnancy, which may lead to poorer outcomes, including an increased risk of preterm delivery, still birth, perinatal death and neurodevelopmental disorders (JCPMH 2012). A mother's mental health can affect the way in which her baby's neurological and hormonal systems develop. It is believed that stress chemicals produced by women who experience anxiety and depression during pregnancy can pass through the placenta and affect fetal development.

During the first year of life, a baby should develop their first attachment relationship with their primary care giver, who is usually their mother. The nature of this early attachment relationship forms the basis for future relationships as well as physical, emotional and cognitive outcomes. Even mild mental illness, if untreated can inhibit a mother's ability to provide their baby with the sensitive, responsive care they need to ensure an effective attachment relationship is achieved (Hogg 2013, Gerhardt 2009).

3.1 Financial Evidence

National research (Centre for Mental Health / LSE 2014) highlights the following:

- Mental health problems are estimated to cost £8.1 billion per year's births in the UK, this equates to £10,000 per birth (based on 2012 birth data).
- Nearly three quarters (72%) of these relate to adverse impacts upon the child rather than the mother.
- More than a fifth of the total costs (£1.7 billion) are borne by the public sector, with most of these falling on the NHS and social services (£1.2 billion).
- The average cost to society of one case of perinatal depression is around £74,000 of which £23,000 relates to the mother and £51,000 to impacts on the child.
- The average costs per case; of perinatal psychosis is at least £52,000; however this is likely to be greatly underestimated due to the lack of data on the long term outcomes for the child.

National data can be used to extrapolate the impact of financial costs (and savings) to North Central London, both within individual borough areas and as a sector. With total births of over 19,000 a year, lifetime costs of untreated illness could be significant. Improved services would provide significant quality benefits and contribute to the longer term economic and societal benefits for women and their children.

3.2 Serious Incidents and Serious Case Reviews

The lack of a defined pathway and of specialist perinatal mental health services in much of London has been identified within serious incident (SI) and serious case reviews as a matter of concern.

A review of maternal death SIs in London 2012-13 showed that of 20 cases, 5 were due to suicide, one case of liver disease was mental health related. Postnatal mental illness had been diagnosed in 4 cases.

A serious case review in Haringey completed in 2014 recommended that:

“The LSCB should seek assurance that the needs of children are met when any agency is aware of significant parental mental health concerns. Consideration should be given to

developing a pathway if one is not already in place. This pathway should include signposting to early help services.”

4 Policy Guidance

An updated NICE Clinical Guideline (CG 192) was published in December 2014 and should be used in conjunction with the guidance on service user experience in adult mental health (CG 136) and patient experience in adult NHS services (CG 138) to support the improvement in experience of women with mental health problems during pregnancy and the postnatal period.

In 2014, the Maternal Mental Health Alliance launched a campaign “Everyone’s Business” with the aim of improving the lives of all women throughout the UK who experience perinatal mental health problems by 2020. This campaign identifies that:

- Accountability for perinatal mental health care should be: directed nationally from ministerial level down.
- There should be Community specialist perinatal mental health teams, which meet national quality standards available in all areas of the country.
- All professional staff involved in the care of women and families during the perinatal period access and receives training in perinatal mental health.

5 What do we need?

Our vision is that all women and their families in the five North Central London boroughs (Barnet, Enfield, Haringey, Camden, Islington) who experience mental health problems during pregnancy or the postnatal period have access to appropriate, timely, consistent, high quality, universal and specialist health and local authority services. These services will be integrated into existing mental health, women’s and children’s services. The staff working within these services will be appropriately educated and supported to deliver such care.

6 What will an integrated specialist service look like?

6.1 Commissioning and service delivery

The Royal College of Psychiatrists set out the general principles and core standards for perinatal mental health (2014). This identifies the need for a strategy which sets out how local services will be delivered and how those services will work together to ensure that the most appropriate care can be accessed depending upon need. The strategy should set out an integrated care pathway, which encompasses all levels of service provision no matter how those services are commissioned (JCPMH 2012). NICE 2014 recommend that there are clearly specified care pathways so that healthcare professionals involved in the care of women during pregnancy and the postnatal period know how to access assessment and treatment. Staff within other universal services such as those delivered from children’s centres should be trained to recognise and refer women to appropriate services.

The London Perinatal Mental Health Network has produced a pathway document which is currently being consulted on (August 2015) and which informs this document (London SCN 2015)

NICE guidance (2014) identifies that clinical networks should be established for perinatal mental health and that these should provide:

- A specialist multidisciplinary perinatal service in each locality which provides direct services, consultation and advice to maternity services, other mental health and community services.
- Access to specialist advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding
- Clear referral and management protocols for services across all levels of stepped care frameworks for mental health problems
- Pathways of care for service users, with defined roles and competencies for all professional groups

The business cases which supplement this strategy include investment in specialist, multi-professional teams (where they do not currently exist), the configuration of which will be identified through further local work.

6.2 The role of universal services

All women need to be cared for by health professionals who are able to assess and screen them for potential mental health problems during pregnancy and the postnatal period. Midwives have a key role in determining which women require the additional input of obstetricians and other services. Midwives, health visitors, GPs and children's centres, as providers of universal services have contact with most families during pregnancy and the postnatal period. This provides the opportunity to play an important role in identifying those at risk of, or suffering from perinatal mental illness and to ensure that appropriate care, treatment and support is offered at the earliest opportunity.

Models of midwifery care which provide continuity of care to the woman and her family are recognised to improve effectiveness, outcomes and experience (Sandall 2014). The development of a relationship between the woman and a small group of health professionals including a named midwife will help in improving communication and understanding.

NICE guidance (2014) recommends that women should be asked a series of simple questions about their mental health during pregnancy and after child birth. These should be asked at the first antenatal visit and early in the postnatal period. Detection rates for common mental health problems are known to be only around 50% (Centre for Mental Health / LSE 2014), therefore it is important that health professionals have the necessary knowledge and skills to do so. Health professionals need appropriate materials to reinforce messages about mental health issues.

Health professionals providing assessment and interventions for mental health problems in pregnancy and the postnatal period should have an understanding of the ways in which mental illness may present. They will also need to understand the way in which such illnesses may progress during pregnancy and following birth and how they can be managed (NICE 2014). This will include antenatal and postnatal interventions by the midwife and

health visitor as part of the healthy child programme, the 6 week postnatal check undertaken by the GP, and immunisation appointments with the practice nurse. The postnatal interventions in primary care tend to focus on the development of the baby but with additional education and training, practice staff will have the skills to recognise maternal and infant mental health problems. Staff working in local authority nurseries and children's centres also has a role to play in this area.

6.3 Specialist Provision

Women with serious mental illness during pregnancy and the postnatal period need people with specialist knowledge and skills to care for them. In addition women planning a pregnancy and who have a previous history of mental illness should have access to preconceptual advice (NICE 2014)

Most women with a perinatal mental illness will not need to see a psychiatrist; however where the need arises there should be access to a specialist service comprising a perinatal mental health psychiatrist who has a special interest in this field of psychiatry. Moreover this service should include a wider team of health professionals who can meet the wider needs of that woman and her family. (RCPsych 2014, JCPMH 2012)

Women who have suffered a stillbirth or neonatal death, and those for whom a previous birth experience was traumatic should receive psychological support from an experienced practitioner so that resulting issues can be explored and managed (NICE 2014).

Specialist perinatal mental health services are different from general adult mental health services. They need to be organised so that they respond to the time frames of pregnancy, they should be able to recognise and respond to rapidly developing and deteriorating conditions particularly in the early postpartum period. Those delivering such services also need to be able to work closely with and relate to other health professionals, particularly maternity, mental health and children's social services.

A critical mass of patients is essential to the maintenance of experience and skills when managing complex and difficult conditions. An individual mental health service will not have sufficient experience in managing severe perinatal illness. Such services instead need to be managed as a specialist community mental health team with clear links to regional mother and baby units (RCPsych 2014).

The pathway of care should ensure seamless, integrated care can be provided across the clinical pathway and across organisational and professional boundaries (JCPMH 2012). Such services should ensure that no woman is separated from her baby unless there is a good reason to do so; where possible and appropriate inpatient admissions for women with severe mental illness should be to a specialist mother and baby unit. These services are directly commissioned by NHS England.

7 Current provision

7.1 How services are configured

Perinatal mental health services in North Central London are patchy and are dependent on the woman's choice of place of birth and the CCG area in which she lives. A survey carried out by the Royal College of Psychiatrists and Maternal Mental Health Alliance (MMHA 2014) reviewed the availability of specialist community mental health services across the England CCG localities. In London, only 7 out of the 32 CCG areas provide services at the highest level. None of these were in North Central London; Barnet, Enfield and Haringey were shown to have no service at all.

In the absence of specialist perinatal mental health services, the care of women with severe mental illness is provided by general adult services. This is likely to lead to lower referral rates, slower response times and inappropriate care and treatment (LSE 2014).

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7.2 Maternity provision

Most women who live in the North Central London CCG areas access maternity services at one of the 5 hospitals within the area. In 2014 there were 19,653 births to women living in the 5 NCL boroughs.

All women receive an initial, comprehensive health and social care assessment by a midwife during the first few weeks of pregnancy. Although there are variations most women will receive this booking assessment by 12 completed weeks of pregnancy. The social element of the assessment will focus on issues such as the composition of partner and family relationships, housing, work and language difficulties as well as mental health needs, domestic violence and safeguarding issues.

Most Trusts providing maternity services have a specific team of midwives who provide care for women with additional social needs. This team often includes those with responsibility for safeguarding. Mental health falls within the remit of these teams; however none of the Trusts have a midwife post with a specialised remit around mental health, although a number are in the process of developing the relevant business case to appoint one. Vulnerable women such as teenagers, identified misusers of drugs and alcohol and those with an identified psychiatric condition may also be under the care of an obstetrician. Each Trust has identified

a lead obstetrician for mental health, who will in future take the lead on such issues within maternity.

Psychology provision is available within women's services; these were initially set up to help women to deal with traumatic events such as the death of a baby (miscarriage, stillbirth or neonatal death) or with a previous traumatic delivery. Increasingly this work has developed to include women who fear giving birth and those who have been identified as having mild to moderate anxiety and depression during pregnancy and the postnatal period.

Staff working in gynaecology services has a role in identifying those women who may require psychological or psychiatric services, but will require additional training to ensure they are able to identify and detect such need.

7.3 Health Visiting

Health visiting services are charged with leading the delivery of the healthy child programme which sits at the heart of children's universal services and is prevention and early intervention programme for children and families. As part of their role, health visitors identify and support those who need additional support and targeted interventions including perinatal and infant mental health. They also promote parent and infant mental health and secure attachment through the use of neonatal behavioural observation and assessment tools.

Health visitors across North Central London offer targeted antenatal visits to women with mental health concerns. All areas are working towards the implementation of a universal antenatal visit at 32 weeks as recommended in the Healthy Child Programme. These initial assessments will include maternal mental health.

In Enfield the HV service has a specialist HV for perinatal and infant mental health (PIMH) who is also part of the Enfield Parent Infant Partnership (EPIP) team. The SpHV PIMH offers consultation and support to the HVs in their work with families who have mental health issues and challenges to the earliest relationships with their infants.

The Enfield HV PIMH working group have developed an antenatal and postnatal PIMH pathway with additional guidance on identification and risk assessment of parental mental health illness. All the HVs, EYPS and HVAs are trained in the Solihull Approach and the HVs have had the iHV PMH training. An on-going programme of training in PIMH is planned alongside that offered by the London Perinatal network.

7.4 Family Nurse Partnership

All NCL boroughs offer family nurse partnership (FNP) services to young women who are 19 or under at the time of their last menstrual period and who meet the agreed criteria. FNP services offer emotional and psychological support as part of their programme.

7.5 General Practice

While most women will be registered to a GP during their pregnancy they may not be seen in general practice during this time. Maternity care in the community is predominantly provided by midwives, with GPs delivering shared care in a small proportion of cases in most areas. GPs will receive notification of booking and discharge by maternity services; however improvements in communication systems are needed to ensure information about issues such as mental health are always shared.

As there is no specified perinatal mental health pathway, there is no clear process for GPs to refer women with a previous history of mental illness or to ensure that they can be seen by a specialist service.

7.6 Mental health provision

Most acute and community mental health services in North Central London are provided by either Barnet, Enfield and Haringey MH Trust (BEH) or Camden and Islington MH FT (C&I).

BEH provide services within North Middlesex and Barnet hospitals, which for maternity patients takes the form of a liaison psychiatry service and acute outpatient provision. Patients are able to access community mental health services depending on where they live. During the past year acute and mental health trusts have worked together to improve communication and detection of women with mental health needs.

BEH employs a number of psychiatrists within its liaison service who have an interest in perinatal mental health. BEH use the RAID model at Barnet and North Middlesex; the psychiatrist and nurse covering this service are able to identify whether a woman is known to mental health services and provide advice to maternity services. However the Trust does not currently employ any specialist perinatal mental health psychiatrists. This is mainly because it has never been specifically commissioned to do so.

C&I provide mental health services for maternity patients at the Whittington, UCLH and Royal Free. However these take a very different form at each Trust. Women booked to have their babies at the Whittington receive the most comprehensive service and have access to perinatal psychiatry, psychology, and mental health nursing and depending on where they live to Parent Infant Mental Health services. The service is hospital based, however both the psychiatrist and nurse can see patients in the community. The psychiatrist who is full time combines her role with a liaison psychiatry one. This means that patients also have access to other, junior members of the team. Joint clinics with an obstetrician are now in place.

At UCLH a perinatal psychiatrist who works 3 sessions per week in this role provides perinatal mental health services. There is no other mental health team support, however there is a weekly joint clinic with an obstetrician and support from the maternity unit psychology services. The service is limited by the capacity of those who provide it and by home address to an assessment and one or two appointments. Women can also be seen if they are in patients, but services stop once they go home following the birth of their baby.

At the Royal Free a perinatal psychiatrist is employed by the Trust, but they are currently not used in this role. The Acute trust employs psychology support, however the lack of a specialist service means that there is no referral route other than into liaison services.

There is currently no access for new patients into specialist perinatal mental health services once women have been discharged by maternity services.

7.7 Parent infant mental health services

Parent Infant Psychology Service (PIPS) provides evidence based, attachment focused, early intervention psychological assessment and intervention to the parents and infants. This or a similar service is available in Haringey, Enfield, Islington and Camden, but not in Barnet.

PIPS work antenatally and up to the infant's second birthday as this is a critical time for preventative work in the parent-infant relationship and for baby brain development. The service works closely with midwives, health visitors, Family Nurse Partnership and other early years colleagues such as Family Support Workers and Children's Centre staff, as well as colleagues in Social Care, and Adult Mental Health. In addition to the direct therapeutic work, PIPS offer Psychology Consultations where there are concerns about the parent infant relationship for all under-fives, and any colleague can make a request for this directly with the PIPS team.

Referral pathways for therapeutic work is through the family's midwife in antenatal cases, and from the health visitor once the child has been born as both are in an ideal place to identify early difficulties in their contact with the families, and best placed to prepare the family for a referral to PIPS for extra support. Families are usually seen together with the health visitor for a joint first visit if possible.

Clinical psychologists and psychotherapists working within PIPS services have experience of working across the lifespan, having worked both in adult mental health and in child and adolescent mental health and child development. This is crucial in the work that is done within PIPS, which can involve working with parents who have a range of mental health difficulties (not exclusively PND) that are having an impact on their experience of the transition to parenthood. They also work with parents who have had difficult experiences in their own childhood, perhaps growing up in care or having experienced other trauma who worry about becoming a parent. Sometimes there are no identified mental health concerns in the parent, but perhaps there has been the impact of previous pregnancy loss, or stillbirth or a traumatic birth experience that is having an impact on the parent-infant relationship. Couples may be seen for support in their transition to parenthood, and work with fathers and other family members' takes place where possible to ensure support for all the family.

PIPS offer parent-infant based interventions such as Video Interaction Guidance (VIG) and Watch, Wait and Wonder, where the parent-infant relationship is at the centre of the work, and parents can feel more confident about reading their baby's cues with greater sensitivity and awareness of the baby's needs.

7.8 CAMHS

CCGs and Local Authorities are currently reviewing their Child and Adolescent Mental Health Services as part of the NHS England Future in Mind proposals. CAMHS services may be involved within the healthcare provision of families affected by perinatal mental illness because of the age of the woman or because other children fall under its care. While informal relationships will exist between CAMHS and other services in most areas, the Enfield PIP service is part of CAMHS

7.9 Improving Access to Psychological Therapies (IAPT)

IAPT services are commissioned by all of the CCGs across the sector, a significant proportion of clients seen by these services are likely to be pregnant or postpartum. While guidance on treating this group of women was developed by the Department of Health in 2009, current training schemes do not include perinatal mental health. This situation is currently being addressed by the London Perinatal Mental Health Network, who is developing education initiatives for IAPT practitioners as part of their wider programme of work. The links between IAPT and other mental health services require further development.

Enfield IAPT services for women are collocated with the maternity services at North Middlesex and Barnet, which has enabled closer working relationships.

7.10 Mapping

A detailed mapping of current service commissioning and provision has been undertaken and is demonstrated in appendix 1

7.11 Mother and Baby Units

Commissioned by NHS England, specialised Perinatal Mental Health Services provide In-Patient Mother and Baby Units. They avoid the separation of mother and baby, wherever possible, by joint admission. They enable the treatment and recovery of the mother whilst ensuring the developing relationship with the baby and its physical and emotional wellbeing. The nearest such unit is situated at the Homerton, however beds may be allocated further afield if unavailable locally.

8 Commissioning arrangements

8.1 Maternity

Maternity services are commissioned by each CCG as part of the acute contract with each acute Trust. Reimbursement for activity is through a payment by results pathway system. Maternity care is divided into three distinct pathways – antenatal, birth and postnatal. Antenatal care begins at the booking appointment, when a decision about the level of care required, based on the outcomes of the health and social care assessment is made. Women with a previous history of mental illness requiring an intervention such as medication, psychiatric or psychological treatment are placed on the intermediate pathway. This provides the maternity provider with some additional funding to provide specialist midwifery or obstetric support. This funding can be used to support joint clinics between maternity and specialist psychiatry but is not intended to fund a specialist perinatal mental health service. However increased levels of detection will lead to increased levels of funding for maternity services. Women who require additional interventions during the birth or postnatal period also trigger a higher level of payment.

8.2 Mental Health Services

Acute and community mental health services are commissioned by CCGs and Local Authorities, some of them jointly through a block contract arrangement.

Islington, Haringey and Camden CCGs specify some specialist perinatal mental health and parent infant services as part of their contract with Camden and Islington MH Trust. Enfield parent infant mental health service is commissioned by the local authority and their staff is directly employed by the council. Part of the funding comes from charitable funds. Barnet does not commission any parents infant service.

8.3 Health Visiting Services

In October 2015 commissioning of health visiting services will move from NHS England to Local Authorities. A national specification for delivery of services is in place.

8.4 Future funding for Specialist Perinatal Mental Health Services

CCGs are currently awaiting a decision from NHS England regarding future funding of specialist perinatal mental health services which has been proposed as part of the Future in Mind policy proposal (DH / NHS England 2015) and the funding announcement by the Prime Minister in January 2016.

9 Pathway development

Since March 2013, there have been discussions with BEHMHT, health visiting and with maternity units on how to improve services in Barnet, Enfield and Haringey. While these have been productive in improving communication and working relationships it has not been possible to introduce new services in the absence of a formally commissioned specialist service.

In order to consider future services across North Central London, a multi-professional workshop to map the preferred pathway and model of care was held on 20 May 2015. Participants included commissioners and providers from primary care, maternity, mental health and health visiting. Two groups were formed to examine the pathway from preconception, through pregnancy, birth to one year postnatally.

The London Perinatal Mental Health Network has developed a [pathway of care for London](#), on which the North Central London pathway and model of care will be based.

10 The proposed pathway and model of care

10.1 Single point of access

It is proposed that the specialist perinatal mental health services in North Central London create a single point of access through which referrals can be made, triage can occur and signposting can take place. The mechanisms for this will be developed through the implementation steering group for this project.

10.2 Preconception

10.2.1 The importance of preconception care in providing education, in the detection of potential problems and in preventing a relapse in those with previous mental health problems cannot be over emphasised. The pathway for preconceptual care can be separated into two areas – the general population of childbearing age and those who need to be specifically targeted due to increased risk factors.

10.2.2 **General population** – Improved education is required for women and their families to raise awareness of perinatal mental illness and its potential effects on their own lives and those of their partners and children. This can be achieved through the availability of leaflets, posters, website and app links in health, social care and other areas across the 5 NCL boroughs. These might include GP surgeries, hospital services (maternity, mental health), children’s centres, family planning clinics, schools and colleges, libraries etc. In order that this can take place there will be a need for improved education and awareness for health professionals and others who will come into contact with the public in this context.

10.2.3 **Targeted pathway** – There are a number of women within the general population who are at increased risk of developing a perinatal mental illness, this may be because they have a pre-existing or previous severe mental health condition, because of their previous obstetric or perinatal history or other risk factors including:

- Drugs and alcohol misuse
- Those previously in care
- Domestic violence
- Homelessness
- Sexually transmitted diseases
- Previous traumatic pregnancy or birth
- Previous stillbirth / neonatal death
- Partner history of mental illness

Additional information and support is required for women who fall into these categories. This may be in terms of written information, or face to face advice and support through existing universal or specialist services (e.g. HV, children’s centres, GP surgeries, postnatal services, mental health services etc.)

The specialist perinatal mental health service should offer a preconception service so that advice on medication, psychological and psychiatric care can be provided to those most at risk. A helpline for health professionals, such as the one currently offered to GPs by BEH mental health Trust will be established.

Access into such a service should not just be for those who have previously been a patient of that service

11 Early Pregnancy

11.1 First presentation of pregnancy

When a woman discovers she is pregnant she will need to make contact with the maternity service of her choice either through self-referral or GP referral. She may however divulge that she is pregnant to other services she is accessing. This may be a children's centre, acute, community or liaison psychiatry services, health visiting or gynaecology / early pregnancy. Professionals working in these areas need to have some knowledge of how and where to signpost women for maternity services and in ensuring they are able to access the most appropriate mental health support at the earliest opportunity.

11.2 First (booking) appointment

The first booking appointment will be carried out by a midwife in a hospital or community based antenatal clinic. During this appointment a detailed health and social care assessment will be undertaken and screening blood tests will be taken. Where the referral / self-referral indicates a previous history of mental illness or one of the other risk factors mentioned above that referral should be screened by a specialist midwife for perinatal mental health. Where a self-referral is made, the maternity service should request further information relating to past medical (including mental health) and obstetric history from the GP. Information can also be requested / received from a preconceptional care clinic.

At the booking appointment all women should be asked a series of questions about their current and past mental health. These will consist of the whooley questions plus some that are additional, these need to be consistent across the sector and be evidence based.

11.3 Mental health Triage

At this point women will be triaged into one of three categories – low, medium or high risk (from a mental health point of view). At any point during their pregnancy they may be reassessed and allocated onto a different pathway. This process will be agreed by maternity providers and the specialist perinatal service.

- 11.3.1 Low risk: community midwifery care with information about how to identify problems and who to contact if things change.
- 11.3.2 Medium risk: specialist midwifery care (may be in conjunction with community midwifery or obstetric care). Additional input may be required from IAPT, women's health psychology, parent infant mental health services, specialist mental health nursing
- 11.3.3 High risk: women with a history of psychotic illness, previous severe perinatal illness or those in vulnerable groups with mental health problems will need to be under the care of a specialist perinatal mental health service as well as midwifery and obstetric care (NICE 2014). A perinatal mental health care plan will be developed in conjunction with the woman, her family and health professionals involved in her care.
- 11.3.4 Prescribing advice: Universal services (maternity, GP health visiting etc.) will require access to prescribing advice from the specialist perinatal mental health service.

12 Pregnancy up to Birth

During pregnancy women will be seen at regular intervals according to a schedule of appointments as determined through NICE antenatal guidelines (2008). At all appointments with maternity health professionals, women should be reassessed in relation to their mental health needs. At any time during pregnancy women may develop anxiety, depression or other symptoms which may lead to the need for further assessment and referral. Information should be given to all women during pregnancy about the kinds of symptoms they may encounter and what help may be available for them to access. Much of this will be provided through self-help information and websites, or through community provision.

Women with more severe mental illness may need to be seen much more frequently, as an outpatient (specialist midwifery, obstetric or mental health or through joint clinics) or through home visits by a midwife or mental health nurse where appropriate and available. Such women should have a named obstetrician and may need to be seen within a joint perinatal mental health / antenatal clinic

Referrals to other agencies may include health visiting, Family Nurse Partnership (for those 19 or under at the time of their last menstrual period), safeguarding or social care. Liaison meetings between professionals should take place as needed.

It may be necessary for women to be hospitalised during pregnancy, either for obstetric or mental health reasons. Consideration should be given to the most appropriate place of admission, ensuring that both physical and mental health needs are taken into account. A prophylactic referral to the Mother and Baby service may be required during this period if the woman meets the relevant criteria. Wherever a woman is hospitalised, clinicians will need to be able to have an understanding of both her obstetric and mental health needs and to work together to ensure these needs are met.

At 32-36 weeks of pregnancy all women should be seen by a e health visitor for antenatal assessment. Work is underway to ensure booking information is routinely shared with health visiting services, so that antenatal visits can occur.

Women with severe mental health problems will need to have a multiprofessional pre-birth perinatal mental health planning meeting. This will include the woman and partner along with relevant professionals depending on who is or will need to be involved in her care.

During pregnancy, discussions will take place between the woman and her midwife and obstetrician about both choice and suitability of place of birth, and type of birth. Information about potential changes to mental health and wellbeing should be provided to all women and their partners during this time.

Psychological services within maternity services are available to support women who have had a previous history of complex experiences or the loss of a baby. Consultant midwives for normal birth work alongside obstetric and psychology colleagues to manage women's who maybe fearful of the delivery and birth.

13 Delivery and Birth

As mentioned above, a plan will have been put into place to take account of the mental health needs of the woman during labour and birth.

Where women have an identified mental health need there may be a need to make a change to medication during the delivery, or to introduce a new medication immediately post-delivery. Where necessary a mental health nurse may be required to provide support, and additional input from psychiatry and paediatrics may also be required.

14 Postnatal Care

14.1 Initial postnatal care

This will be provided by the maternity team, and initially takes place on the labour ward, birth centre or at home depending on place of birth. Women in hospital may be discharged from the room where birth took place, or they may be transferred to the postnatal ward. Mental health screening will take place alongside assessments for the physical wellbeing of both mother and baby.

Inpatient care and support by the perinatal mental health team should be provided and discharge planning should take place.

Where the woman lives outside of the community catchment area of the hospital where the birth took place, communication with local maternity services are important to ensure that discharge can be facilitated smoothly and any issues discussed. Where necessary, discharge may be delayed to ensure services are in place. It is important for maternity services to share policies with surrounding Trusts to ensure that there is an understanding of differing service and pathway structures.

Postnatal information in written form should include details of what they family should look for in terms of anxiety or low mood and information about who to contact if they are concerned.

14.2 Community postnatal care

Following discharge from hospital women will remain under midwifery care for the first 14 and up to 28 days following the baby's birth. Where there is an existing mental health problem or where a new one is suspected additional support should be given. This will be dependent on assessment of need and may include care from the specialist midwife or Parent Infant service. Additional input may be provided by other psychology services or the specialist perinatal mental health service.

Consideration needs to be given to providing continuity of care through a named midwife, particularly where there is mental health or other concerns. Home visits may be required rather than those within a clinic setting depending on individual need.

During this time notification of birth to the GP will take place, it is important that information about emotional needs is included within this and any discharge summary sent to the GP and where possible a face to face or telephone conversation should take place about the ongoing care of mother and her baby. Liaison with the health visitor at this time should also take place.

The specialist perinatal mental health service will, where necessary ensure that the most appropriate practitioner is involved in on going care this may include PIPs, women's health psychology services, community psychiatry services or IAPT.

14.3 The needs of fathers

The baby's father will often be closely involved in the care of mother and baby during the first days and weeks. Their role in helping to identify where anxiety, depression or more serious mental health problems are emerging cannot be underestimated. It is important for professionals who engage with fathers to take time to listen to their concerns regarding the health of their partners. At the same time, it is important to observe for signs of problems in the relationship of the parents or that the father is suffering from anxiety or depression himself.

14.4 Health Visiting and Primary care support

The health visiting service provides a universal service to all families with children under 5. They also provide a targeted offer to those families assessed as requiring additional input.

The health visitor will conduct a first visit at approximately 10-14 days after birth, and at this visit will talk about mental health and book future mood assessment. Where necessary there will also be midwifery input up to 28 days.

Over the following weeks there will be a number of times when the new mother and her baby will come into contact with the health visitor, GP and practice nurse, where opportunities will exist to identify potential mental health problems. These will include:

- 6-8 week check for both mother and baby
- Immunisations at 8, 12 and 16 weeks
- Baby clinics, breastfeeding support groups

Families may also visit their local children's centres and come into contact with the services they offer. They may also be referred to homestart which is in place across the sector.

14.5 Training to support development and service delivery

Over the past two financial years, multiprofessional training and education opportunities in perinatal mental health have been made available to professionals working in maternity, health visiting, mental health and primary care. During 2014-15 this was specifically for those working in Barnet, Enfield and Haringey but has now been rolled out across North East and North Central London. Specific training initiatives include awareness raising sessions, the development of perinatal champions who can then run the awareness training, simulation training, mental health training for mental health staff, GP master classes and a more in depth parent infant mental health module.

These initiatives will need to continue, and ultimately be provided and supported by the specialist perinatal mental health service.

15 Specialist Service provision

15.1 How a specialist service should be constructed and what it should provide

The Royal College of Psychiatrists recommends that the provision of local perinatal mental health services should be through specialist community mental health teams. These teams should have a core staff of at least perinatal psychiatrist and community psychiatric nurses. They should provide a maternity liaison service; manage new onset conditions and high risk patients in the community. They should also offer preconception counselling and arrange admissions to a mother and baby unit where necessary.

Key responsibilities of the team will be:

- To respond in a timely manner (waiting time standards will be introduced in 2016-17) and have the capacity to deal with crises and emergencies and assess patients in a variety of settings, including the patient's home, maternity hospitals and outpatient clinics.
- Have close working links with a designated mother and baby unit or be part of an integrated mother and baby unit and community service.
- Provide a liaison service to the local maternity unit(s).
- Manage women discharged from in patient mother and baby units.
- Work collaboratively with colleagues in maternity services and in adult mental health services with women with prior or longstanding mental health problems and case manage them if it is in the woman's best interests.
- Assess and proactively care for those at high risk of a postpartum condition.
- Offer preconception counselling to women who are well but at high risk of a postpartum condition and those with pre-existing mental health problems.

Adult mental health services will need to remain available providing crisis and home treatment where necessary. However, the admission of a mother and infant together to a non-specialised adult psychiatric ward is not acceptable (RCPsych 2014).

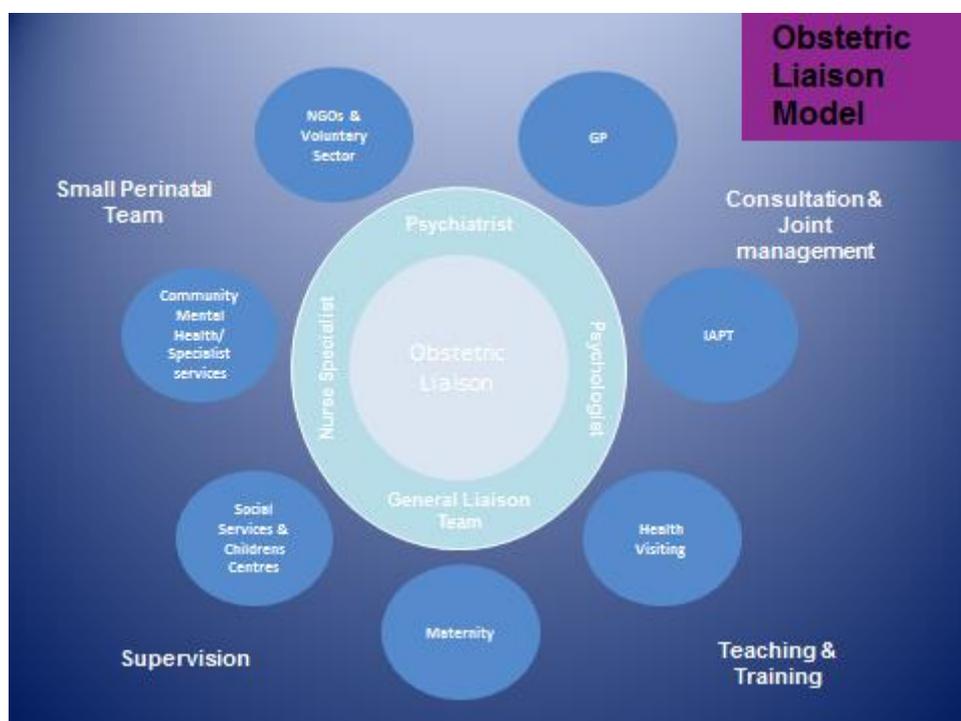
Recommended staffing per 10000 deliveries

Specialist	Numbers
Consultant perinatal psychiatrist	1 WTE
Trainee psychiatrists /non consultant grade doctor	1 WTE
Community team manager (50% managerial, 50% clinical)	1 WTE
Specialist community nurses	5 WTE
Psychologist	1 WTE
Occupational therapist	1 WTE
Social worker	0.5 WTE
Community Nursery Nurses	2.5 WTE
Link Midwife	
Link Health Visitor	
Administrator	1 WTE

(WTE – whole time equivalent)

15.2 Developing a specialist perinatal mental health service where none currently exists – Obstetric Liaison model

In Barnet, Enfield, Haringey (with the exception of the Whittington service) and Camden no specialist perinatal mental health service exists. By developing services at the hospital sites, an obstetric liaison model can be established as a first stage towards a specialist service. This would enable recruitment of specialist psychiatrist and nursing and for systems and processes to be established. The recruitment of perinatal psychiatrists (1 WTE) and specialist nurses (2.5 WTE per 10,000 deliveries), would allow a service to be delivered from Barnet, Royal Free, NNUH and UCLH.



Costs:

Specialist	Number	Total cost	Cost per birth
Psychiatrist	2 WTE	£300,448	£15.02

Nurse (Band 6)	5 WTE	£271,980	£13.60
Total		£572,428	£26.62

Approximate costs (rounded up) by CCG, using ONS birth data:

Barnet 5244 - £150,100
 Enfield 4824 - £128,420
 Haringey 4006 - £106,640
 Camden 2700 - £71,880
 Islington 2879 - £76,700

Advantages:

- Costs minimal while service established and relationships developed.
- Allows time for relationships to be developed, audits of need undertaken, and models of care developed.

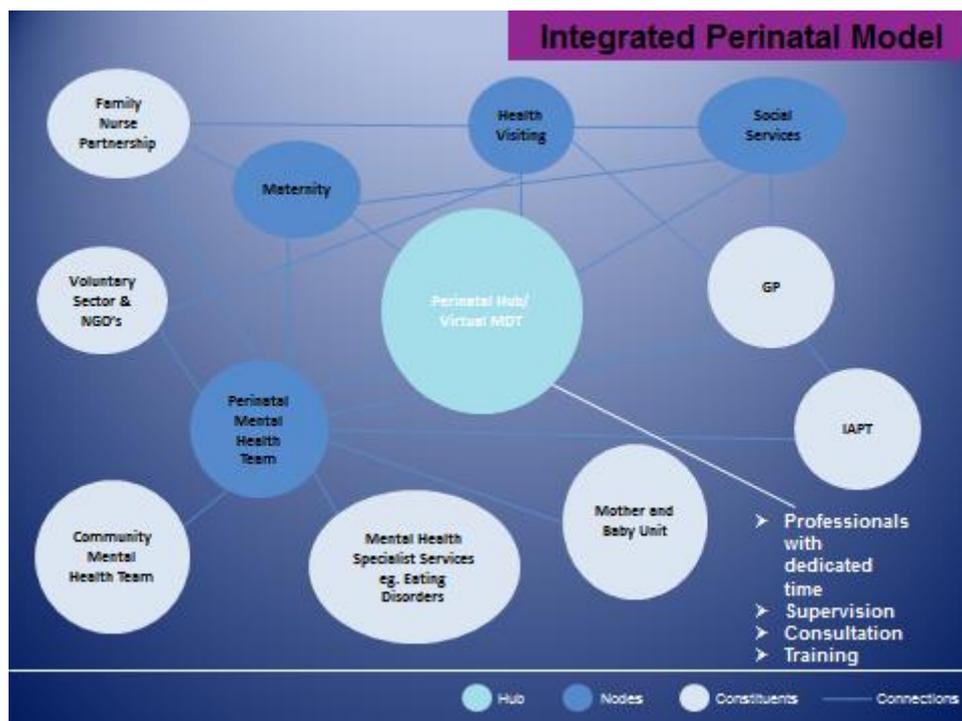
Disadvantages:

- Each service will be separate and hospital based
- Each CCG would need to agree reciprocal arrangements with the others as women can choose maternity provider
- Not a specialist service and an inferior service to the one currently provided at the Whittington.
- Cover would rely on local agreement with mental health Trust liaison service.

15.3 Developing a specialist perinatal mental health service where none currently exists – Integrated Liaison model

The liaison model would allow perinatal mental health teams to be established in each area which could immediately develop relationships (including joint clinics) with other services; undertake audit and a defined model of care. In addition to specialist psychiatry and nursing, to be classed as a specialist service nursery nursing, OT and psychology / psychotherapy would also be required. Psychology / psychotherapy is already in place in all Trusts and in most boroughs other than Barnet.

The perinatal hub would require maternity, health visiting and social services to identify individuals to be given time within their work plans to undertake perinatal work. Each maternity service has identified a lead obstetrician and midwife (usually from the safeguarding team), however the development of specialist midwifery roles would be a preferred option. In Enfield a specialist HV role exists, however this is not currently available elsewhere.



Costs:

Specialist	Number	Total cost	Cost per birth
Psychiatrist	2 WTE	£300,448	£15.02
Nurse (Band 6)	5 WTE	£271,980	£13.60
OT	2.5 WTE	£135,990	£6.79
Total		£708,418	£35.41

Approximate costs (rounded up) by CCG, using ONS birth data:

Barnet 5244 - £185,700
 Enfield 4824 - £170,900
 Haringey 4006 - £141,900
 Camden 2700 - £95,610
 Islington 2879 - £102,000

N.B Barnet requires psychology / psychotherapy input.

Advantages:

- Could work towards above staffing, so long as able to develop a perinatal hub with the other disciplines.
- Service would be much more integrated than liaison model
- Could be or become a cross borough service (would need a service lead though).
- The perinatal hub could become the single point of access
- Islington service already running along these lines
- Could be further developed into an integrated cross borough service

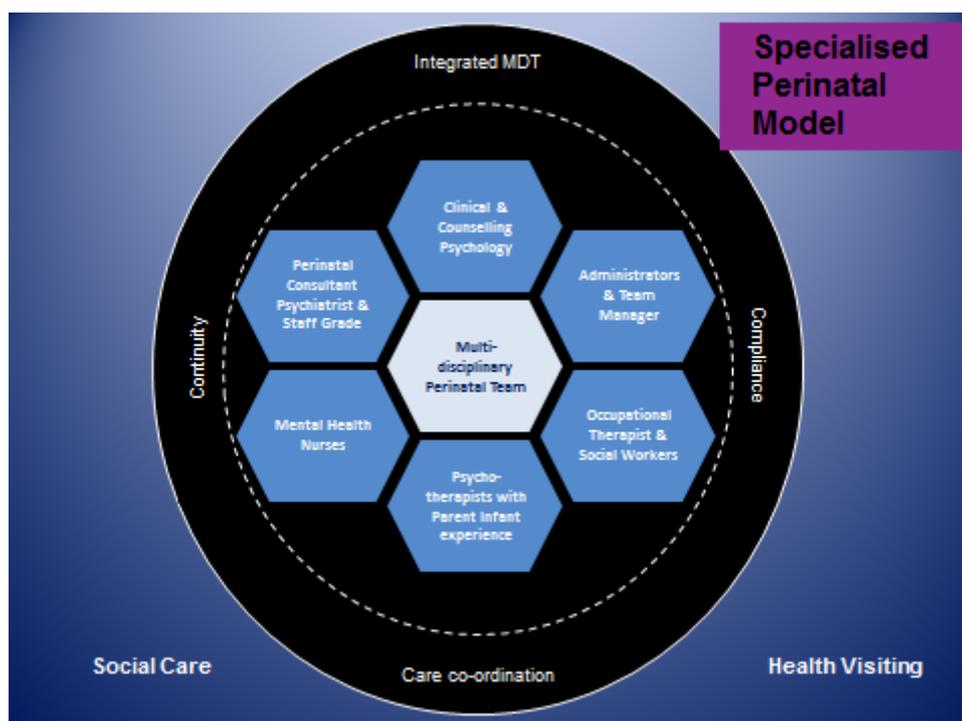
Disadvantages:

- Relies on maternity, health visiting and social services to provide their staff with dedicated time (may impact on other commissioner's e.g. public health).
- If run as separate services, would need to consider how services would work together to prevent fragmentation of care.
- No cover arrangements built in, though these would emerge if service was cross borough

15.4 Specialised Perinatal Service

Islington are in the best position to develop a fully integrated specialist perinatal mental health service, however this would require changes to the way in which services at UCLH are provided as well as requiring the development of the outreach and community services.

For the other CCGs in NCL, this should be the ultimate aim, but would be the most challenging and expensive to achieve. It would be best achieved by pooling resources across the sector to utilise opportunities for multiprofessional team working with the aim of a comprehensive seamless service which provides the best outcomes for women and their children.



Total provision:

Specialist	Number	Total cost	Approximate costs per birth
Psychiatrist	2 WTE	£300,448	£15.02
Nurse (Band 6)	5 WTE	£271,980	£13.60
OT	2.5 WTE	£135,990	£6.79
Social Workers	2.5 WTE	£159,948	£8.00

Band 7 Team Manager	1 WTE	£63979	£3.20
Band 8 Service Manager	1 WTE	£77217	£3.86
Band 4 Admin	1 WTE	£37374	£1.87
Total		£1,046,936	£52.34

Approximate costs (rounded up) by CCG, using ONS birth data:

Barnet 5244 - £274,500
 Enfield 4824 - £252,500
 Haringey 4006 - £209,700
 Camden 2700 - £141,320
 Islington 2879 - £150,700

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[Saving Lives, Improving Mothers' Care](#)

Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-13 December 2015 Maternal, Newborn and Infant Clinical Outcome Review Programme

Specialist Community Services 2014 Position (N.B Camden is now red following discontinuation of service at RFH).

Specialist Community Perinatal Mental Health Teams (London)



Level	CCG Name
Dark Green	Barking & Dagenham
Red	Barnet
Red	Bexley
Yellow	Brent
Red	Bromley
Pink	Camden
Light Yellow	Central London (Westminster)
Light Green	City And Hackney
Yellow	Croydon
Red	Ealing
Red	Enfield
Light Green	Greenwich
Pink	Hammersmith And Fulham
Red	Haringey
Yellow	Harrow
Light Green	Havering
Red	Hillingdon
Red	Hounslow
Yellow	Islington
Pink	Kingston
Yellow	Lambeth
Yellow	Lewisham
Pink	Merton
Light Green	Newham
Light Green	Redbridge
Pink	Richmond
Yellow	Southwark
Pink	Sutton
Light Green	Tower Hamlets
Light Green	Waltham Forest
Pink	Wandsworth
Red	West London (Kensington & Chelsea & Queens Park & Paddington)

LEVEL	COLOUR	CRITERIA
5	Dark Green	Specialised perinatal community team that meets Perinatal Quality Network Standards Type 1 http://www.rcpsych.ac.uk/pdf/Perinatal%20Community%20Standards%201st%20edition.pdf
4	Light Green	Specialised perinatal community team that meets Joint Commissioning Panel criteria http://www.rcpsych.ac.uk/pdf/perinatal_web.pdf
3	Yellow	Perinatal community service operating throughout working hours with at least a specialist perinatal psychiatrist with dedicated time AND specialist perinatal mental health nurse with dedicated time, with access to a perinatal psychiatrist throughout working hours
2	Light Yellow	Specialist perinatal psychiatrist AND specialist perinatal nurse with dedicated time
1	Pink	Specialist perinatal psychiatrist or specialist perinatal nurse with dedicated time only
0	Red	No provision

Disclaimer: Levels of provision in this map have been assessed using the best information available to us from local experts but have not been independently verified. Please contact info@everyonesbusiness.org.uk if you suspect any inaccuracy or know of recent developments that may alter the level of provision level in any area listed here.

www.everyonesbusiness.org.uk

More than 1 in 10 women develop a mental illness during pregnancy or within the first year after having a baby.

Levels

Level 5, Dark Green: The specialist community perinatal mental health team must meet all the following standards, developed by the Perinatal Quality Network for Perinatal Mental Health Services Service Standards April 2014

1. Access and referral
2. Assessment
3. Discharge
4. Care and Treatment

5. Infant welfare and safeguarding
6. Staffing and Training
7. Recording and audit

Level 4, Light Green: The specialist perinatal community mental health team must meet the Joint Commissioning Panel criteria as detailed below:

The specialised perinatal community mental health team will be a member of the Royal College of Psychiatrists' quality network. It will assess and manage women with serious mental illness or complex disorders in the community who cannot appropriately managed by primary care services. It should

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

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

Level 3, Amber: The perinatal community service operates throughout working hours with at least a specialist perinatal psychiatrist with dedicated time and a specialist perinatal mental health nurse with dedicated time with access to a perinatal psychiatrist throughout working hours.

Level 2, Yellow: Specialist perinatal psychiatrist and specialist perinatal nurse with dedicated time.

Level 1, Pink: Specialist perinatal psychiatrist or specialist perinatal nurse with dedicated time.

Level 0, Red: No provision