

Joint Commissioning Panel for Mental Health

www.jcpmh.info

Guidance for commissioners of perinatal mental health services

Volume Two: Practical mental health commissioning	

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Ten key messages for commissioners

- 1 Ensure that a regional perinatal mental health strategy is present and that all providers of care for perinatal mental health problems are participating.
- 2 Ensure that there is a perinatal mental health integrated care pathway in place which covers all levels of service provision and severities of disorder.
All service providers should be compliant with this so that there is equitable access to the right treatment at the right time by the right service.
- 3 Mother and baby units should be accredited by the Royal College of Psychiatrists' quality network for perinatal services, and have formal established links with a number of specialised community perinatal mental health teams in their region.
- 4 Specialised perinatal community mental health teams should be members of the Royal College of Psychiatrists' quality network for perinatal services and should case manage serious mental illness. They should have a formal link with a mother and baby unit.
- 5 Parent-infant services provided by child and adolescent mental health services (CAMHS) and maternal mental health teams provided in primary care and by non-health organisations are an addition to, not a substitute for, services provided for women with serious mental illness. They should work collaboratively with specialist services.
- 6 When commissioning adult mental health services there is a need to ensure that:
 - these either provide a mother and baby unit, or have formal links to ensure access to one
 - all women requiring admission in late pregnancy or after delivery are admitted with their infant to a mother and baby unit not an adult admission ward.
- 7 Ensure that adult mental health services:
 - counsel women with serious affective disorder about the effects of pregnancy on their condition
 - provide information and advice about possible effects of their medication on pregnancy
 - provide additional training to psychiatric teams about perinatal mental health
 - routinely collect data on which female patients are pregnant or in the postpartum (following childbirth) year.
- 8 Ensure that when commissioning maternity services the needs of pregnant and postpartum patients are met. This includes:
 - midwives receiving additional training in perinatal mental health and the detection of at-risk patients
 - maternity services asking all women at early pregnancy assessment about previous psychiatric history, and referring on those with a past history of serious mental illness
 - maternity services should routinely inform the GP about the pregnancy, and ask for further information
- maternity services should have access to perinatal mental health teams
- maternity services should have access to designated specialist clinical psychologists
- maternity service midwives should routinely enquire about women's current mental health during pregnancy and the early postpartum period.
- 9 Ensure that when commissioning IAPT services (Improving Access to Psychological Therapies) that the needs of pregnant and postpartum patients are met. This includes:
 - routinely collecting data on whether referrals are pregnant or in the postpartum year
 - receiving additional training in perinatal mental health
 - ensuring that pregnant and postpartum women are assessed and treated within three months.
- 10 Ensure that when commissioning primary care services that the needs of pregnant and postpartum patients are met. This includes:
 - General Practitioners (GPs) and other primary care staff receiving additional training in perinatal mental health
 - GPs and other primary care staff being made familiar with the perinatal mental health integrated care pathway
 - Health Visitors receiving additional training in perinatal mental health.

Introduction

The Joint Commissioning Panel for Mental Health (JCP-MH) (www.jcpmh.info) is a new collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists, which brings together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities. These include:

- Service users and carers
- Department of Health
- Association of Directors of Adult Social Services
- NHS Confederation
- Mind
- Rethink Mental Illness
- National Survivor User Network
- National Involvement Partnership
- Royal College of Nursing
- Afiya Trust
- British Psychological Society
- Representatives of the English Strategic Health Authorities
- Mental Health Providers Forum
- New Savoy Partnership
- Representation from Specialised Commissioning
- Healthcare Financial Management Association.

The JCP-MH is part of the implementation arm of the government mental health strategy *No Health without Mental Health*¹.

The JCP-MH has two primary aims:

- to bring together service users, carers, clinicians, commissioners, managers and others to work towards values-based commissioning
- to integrate scientific evidence, service user and carer experience and viewpoints, and innovative service evaluations in order to produce the best possible advice on commissioning the design and delivery of high quality mental health, learning disabilities, and public mental health and wellbeing services.

The JCP-MH:

- has published *Practical Mental Health Commissioning*², a briefing on the key values and principles for effective mental health commissioning
- has so far published six other practical guides on the commissioning of primary mental health care services³, dementia services⁴, liaison mental health services to acute hospitals⁵, transition services⁶, perinatal mental health services⁷, and public mental health services⁸
- provides practical guidance and a developing framework for mental health
- supports commissioners to deliver the best possible outcomes for community health and wellbeing.

WHO IS THIS GUIDE FOR?

This guide is about the commissioning of good quality perinatal mental health services. It has been written to assist specialised commissioners, as well as Clinical Commissioning Groups and Health and Wellbeing Boards. It will also be of use to provider organisations, service users, patients, carers, and the voluntary sector.

WHAT THIS GUIDE DOES NOT COVER

This guide does not cover the provision of care of postpartum women and their infants by drug and alcohol services or learning disability services.

What are perinatal mental health services?

Perinatal mental health services are concerned with the prevention, detection and management of perinatal mental health problems that complicate pregnancy and the postpartum year. These problems include both new onset problems, recurrences of previous problems in women who have been well for some time, and those with mental health problems before they became pregnant.

Promoting emotional and physical wellbeing and development of the infant is central to perinatal mental health services.

Perinatal mental health problems include a range of disorders and severities which present in a variety of health settings and are currently managed by many different services. Some of these services are specifically designed to meet the needs of pregnant and postpartum women and their infants. Others care for them as part of a general service. These include:

- specialised inpatient mother and baby units
- specialised perinatal community mental health teams
- general adult mental health services including admission wards, community, crisis, early intervention in psychosis and assertive outreach teams
- drug and alcohol services
- learning disability services
- child and adolescent mental health services
- parenting and infant mental health services

- clinical psychology services linked to maternity services
- maternity services
- IAPT services
- health and social care organisations
- children's centres
- General Practitioners, Health Visitors and the extended primary care team
- voluntary and self-help organisations.

Specialised perinatal mental health services which include mother and baby units and their linked specialised perinatal community mental health (outreach) teams are provided by Mental Health Trusts and will be commissioned by the NHS Commissioning Board under specialised commissioning arrangements. Other services that provide care for pregnant and postpartum women, including some of the care provided by specialised perinatal community teams, will be commissioned by Clinical Commissioning Groups.

A comprehensive perinatal mental health strategy should encompass all levels of service provision no matter if those services are commissioned by the NHS Commissioning Board or Clinical Commissioning Groups. Robust care pathways, education, training and resourcing of non-specialists is essential to ensure that *"the right patient reaches the right service where they are seen by the right professional at the right time."*

MANAGEMENT

In this guidance, the term "management" is used to encompass medical, psychological and social treatments, interventions and care.

Why are perinatal mental health services important to commissioners?

PERINATAL MENTAL HEALTH PROBLEMS: AN OVERVIEW

Perinatal mental health problems are those which complicate pregnancy and the postpartum year.

They include both mental health problems that arise at this time and those that were present before the pregnancy.

Childbirth is associated with a substantial psychiatric morbidity. It has long been known to increase the risk to women's mental health, particularly of developing a serious mental illness (postpartum psychosis and severe depressive illness)^{9,10}. It is also known to be associated with an increased risk of recurrence particularly of serious affective disorder (bipolar illness and severe depressive illness)¹¹. Women with chronic longstanding serious mental illnesses such as schizophrenia become pregnant and their condition may deteriorate or recur during pregnancy and the postpartum period¹².

Non-psychotic conditions, particularly depressive illness and anxiety are common during pregnancy and following delivery¹³.

The incidence (new onset) of serious mental illness is not elevated during pregnancy in contrast to the marked elevation of risk in the early weeks following delivery⁹. However, recurrences and relapses of serious affective disorder (bipolar illness and severe depressive illness) do occur during pregnancy particularly if medication has been stopped. The majority of acute onset serious perinatal disorders present as a psychiatric emergency in the days and weeks following childbirth^{14,15}.

In contrast, the incidence and prevalence of mild to moderate depression and anxiety are broadly similar during pregnancy and the postpartum period. However, there is evidence of an increased incidence of severe non-psychotic depressive illness in the early weeks following delivery. These conditions may initially present as anxiety and depression in the first two to six weeks following childbirth and can deteriorate rapidly^{10,16,17}.

Post traumatic stress disorder is estimated to occur in approximately three percent of maternities and six percent of women following emergency caesarean section. Women admitted to high dependency or intensive care units and those suffering obstetric loss are at increased risk¹⁸. Other obstetrically relevant states of distress include women previously abused, those with sick infants in neonatal units and those with very serious medical disorders.

The epidemiology of perinatal psychiatric disorders is well established^{9,10,13}. Using the birth rate of their area, commissioners will be able to estimate the perinatal mental health morbidity and the necessary service uptake for their population.

IMPACT OF PERINATAL PSYCHIATRIC DISORDER

- Childbirth and new motherhood carries an expectation of happiness and is a time of emotional upheaval and adjustment to changes in lifestyle and relationships. Significant mental health problems at this time cause enormous distress and can seriously interfere with the adjustment to motherhood and the care of the newborn baby as well as existing children. Poorly managed, perinatal mental health problems can have lasting effects on maternal self-esteem, partner and family relationships as well as the mental health and social adjustment of the child.
- Acute serious perinatal illness usually presents as an emergency and often requires inpatient care. Separation of mother and infant prevents the early development of mother-infant attachment and relationship. This may be difficult to reverse and have longstanding effects on both child and mother. Separation causes great maternal distress and interferes with treatment of the mother as well as preventing breastfeeding.

Figure 1

RATES OF PERINATAL PSYCHIATRIC DISORDER PER THOUSAND MATERNITIES	
Postpartum psychosis	2/1000
Chronic serious mental illness	2/1000
Severe depressive illness	30/1000
Mild-moderate depressive illness and anxiety states	100-150/1000
Post traumatic stress disorder	30/1000
Adjustment disorders and distress	150-300/1000

Notes: this table is based on information contained in references 9-18.

- Non-psychotic depressive illnesses and anxiety states, particularly if untreated or chronic and associated with social adversity, have been shown to affect the infant's mental health and have longstanding effects on the child's emotional, social and cognitive development¹⁹.
- Serious perinatal psychiatric disorder is associated with an increased risk of suicide. Suicide has been shown to be a leading cause of overall maternal mortality in the last two decades and the suicide rate in pregnancy and the first six months postpartum is not decreasing in contrast to the suicide rate in women in general¹⁷.
- Serious perinatal psychiatric disorder is also associated with an increased risk to both mortality and morbidity in mother and child. Over the last two decades psychiatric disorder has been a leading cause of maternal mortality contributing to 15% of all maternal deaths in pregnancy and six months postpartum. Serious mental illness and its treatments can complicate the management of pregnancy. Psychotic illness in pregnancy is known to be associated with poorer pregnancy outcomes and an increased risk of preterm delivery, stillbirth, perinatal death and neurodevelopmental disorder²⁰.

Perinatal mental health problems are therefore a major public health concern. They have wide ranging impacts on both maternal and infant mental and physical health and make a significant contribution to both maternal and infant morbidity and mortality.

THE NEED FOR SPECIALISED SERVICES

- Women with serious mental illness complicating childbirth need specialised knowledge and skills on the part of the professionals who care for them. These include specialist knowledge of the risks and benefits of medication in pregnancy, the skills to manage and nurse seriously mentally ill women, at the same time as enabling them to meet the emotional and physical needs of their infants. In addition they need an understanding of the emotional and physical changes associated with childbirth and the different organisation of maternity services.
- Services for seriously mentally ill women need to be organised differently from general adult mental health services and need to respond to the maternity context, the timeframes of pregnancy, the differing thresholds and response times to presenting problems, and be able to relate to different health professionals (particularly to maternity services and children's social services).
- Perinatal mental health services require different resources to those of general adult mental health services. Women who are admitted in late pregnancy in the postpartum period require inpatient mother and baby units which are designed and resourced to safely meet the physical and emotional needs of both mother and infant whilst resolving the usually severe mental health problems.
- Women with non-psychotic conditions of moderate intensity may not meet the criteria for access to adult mental health services. The potential risk to the mother of the subsequent development of a more serious condition and additional risks to the infant determine a lowered threshold for referral and intervention.
- Adult mental health services are not organised to respond to the occasional perinatal mental health crisis within their sectors. The organisation of adult mental health services into differing functional mental health teams does not fit easily with the rapid development and deterioration of an early postpartum illness which can move very quickly within days from early concerns about anxiety to a profound psychotic illness.
- Adult mental health services are not accustomed to the proactive management of a well woman in pregnancy, who is nonetheless at a very high risk because of her previous history of becoming profoundly ill within days of delivery.
- Clinicians within adult mental health services are not experienced in the detection of difficulties within an infant-parent relationship which can seriously impact on the infant's mental health and long term development.
- A critical mass of patients is essential to maintain experience and skill in managing complex and difficult conditions. No individual Mental Health Trust or functional psychiatric team will have sufficient experience of managing postpartum psychosis or severe postnatal depressive illness. The epidemiology of these conditions suggest that this critical mass can only be achieved by providing specialised mother and baby units on a regional basis, and at the level of an individual Mental Health Trust by providing a specialised community mental health team. These teams can then work very closely with colleagues in adult mental health to ensure the proper care of women who become pregnant whilst in the care of adult mental health services.

Why are perinatal mental health services important to commissioners? (continued)

OPPORTUNITIES FOR EFFECTIVE INTERVENTION AND MANAGEMENT

Pregnancy and early motherhood are times of unparalleled contact with health services. This should provide the framework to relatively easily:

- identify those at increased risk of developing perinatal conditions
- develop a personalised care plan for each woman at increased risk
- ensure the prompt and early detection of any illness
- ensure early intervention and prompt treatment.

Effective treatments and psychological interventions exist, and timely and appropriate treatment can improve maternal and infant outcomes.

Women with acute serious perinatal illness will have better outcomes and better relationships with their infants if cared for in mother and baby units²¹. If they receive specialised aftercare they will have shorter admissions and fewer readmissions²².

Women with a history of serious illness can be prepared for pregnancy and receive preventative management when pregnant with regard to their high risk of recurrence following delivery.

Health Visitors with additional training in active listening and cognitive counselling have been shown to be effective in both preventing and treating postnatal depression²³.

Parent and infant mental health services, and services with a focus on parenting, can significantly improve both infant mental health and maternal wellbeing in those women who have problems with their relationship with their child.

Psychosocial interventions by health and social care agencies and voluntary agencies can improve both maternal wellbeing and infant outcomes in those with less serious problems or as an adjunct to management by specialist services²⁴.

What do we know about current perinatal mental health services

NATIONAL DRIVERS POLICIES AND GUIDELINES

The policies and guidelines in Figure 2 make consistent recommendations about aspects of care that a pregnant and postpartum woman should receive and the provision of specialised care for perinatal psychiatric disorder should it be necessary. These recommendations effect:

- the provision of specialised services
 - adult mental health services
 - maternity services
 - General Practitioner, Health Visitor and extended primary care team
 - clinical networks.
- All those involved in the care of pregnant or postpartum women should have training in the normal emotional changes associated with pregnancy and the postpartum period, the maternity context, psychological distress, perinatal disorders and early parent-child relationship issues.
 - All women with serious psychiatric disorder should have access to specialist advice before becoming pregnant. This should cover the possible impact of pregnancy and childbirth on their condition, and of their condition and its treatment on the outcome of the pregnancy.
 - All women should be asked about previous mental health problems at early pregnancy assessment. Those who have had a serious mental illness should be referred to a psychiatrist (preferably a perinatal psychiatrist) for proactive management during pregnancy.
 - All women should be regularly asked about their current mental health during pregnancy and the postpartum period and if they have problems whether they would like help.
 - All women requiring admission to a psychiatric unit in late pregnancy or the postpartum period should be admitted together with their infant to a specialised mother and baby unit unless there are specific reasons not to do so.
 - Women with perinatal conditions who require the care of secondary mental health services should receive specialised perinatal community care.
 - Women should have access to psychological and psychosocial treatments including prompt treatment by IAPT and other providers of psychosocial treatments such as listening visits and cognitive counselling by health visitors.
 - Managed (strategic) clinical networks should be set up and commissioned covering populations of patient flow of approximately four to five million (delivered population 50,000) to advise commissioners, assist in the development of strategic plans and commissioning frameworks, advise provider organisations, assist with workforce development and training, develop integrated care pathways and develop and maintain a network of involved clinicians and other stakeholders including patient organisations.

Figure 2

The Royal College of Psychiatrists CR88 2000²⁵
 The Women's Mental Health Strategy 2002²⁶
 The Scottish Maternity Framework 2002²⁷
 The Children and Young People's NSF Maternity Standard 11 2004²⁸
 NICE Guidelines on Antenatal and Postnatal Mental Health Care 2007²⁹
 The Confidential Enquiries into Maternal Deaths 2011¹⁷
 NICE Guidelines Caesarean Section 2011¹⁸
 The SIGN Guidelines 2012³⁰
 The Royal College of Obstetricians and Gynaecologists' Guidelines on Management of Women with Mental Health Issues during Pregnancy and the Postnatal Period (Good Practice No 14) 2011³¹

What do we know about current perinatal mental health services (continued)

WHAT DO WE KNOW ABOUT SPECIALISED PERINATAL MENTAL HEALTH SERVICES?

There are 19 inpatient mother and baby units in England, two in Scotland and one in Wales³². There are none in Northern Ireland. The overwhelming majority of these mother and baby units belong to the Royal College of Psychiatrists' Quality Care Network and adhere to their national standards. They all admit seriously mentally ill women in late pregnancy and the postpartum period together with their infants. They all aim to admit women directly to the mother and baby unit in the early postpartum period without the need for prior admission to a general adult psychiatric ward.

All mother and baby units will continuously assess mother-infant care and attachment determining the level of supervision, support and guidance the mother needs to meet the emotional and developmental needs of her infant. The staff will have skills in promoting attachment and parenting interventions. Many units also have psychologists who will provide additional expertise in psychological treatments and parenting interventions.

Eleven mother and baby units are also integrated with specialised community perinatal mental health teams³². These teams in addition to their other functions can promote early discharge, provide aftercare and manage women with serious illness in the community and decrease the risks to both mother and infant.

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

There are approximately 168 mother and baby beds in England³³. There is a national shortfall in the number of inpatient mother

and baby beds of approximately 50 beds (between five and eight units depending on size).

There are at least 19 specialised perinatal community mental health teams in England, 11 of which are integrated within a mother and baby unit³³. All have at least a core staff of a consultant perinatal psychiatrist and community psychiatric nurse. These teams provide a maternity liaison service, manage new onset conditions and high risk patients in the community, pre-conception counselling and will arrange admissions to a mother and baby unit when necessary.

Fewer than half of all mental health trusts in Great Britain provide a specialised perinatal mental health team that is staffed by at least a consultant perinatal psychiatrist and specialised community perinatal mental health nurses³³.

In addition, there is a variable and patchy provision of services often involving a single or small number of professionals who provide partial care or "signposting services" to women. However none of these will be able to provide comprehensive services, particularly for women with serious mental illness.

To summarise, the provision of specialised perinatal psychiatric care in England is patchy and inequitable³⁴. Women with acute severe mental illness needing inpatient care or needing specialised community care are not able to access the appropriate type and standard of care as recommended by NICE guidelines and other national guidance²⁹.

WHAT DO WE KNOW ABOUT GENERAL ADULT MENTAL HEALTH SERVICES?

Even those areas which do provide specialised perinatal services will need to use crisis and home treatment teams on occasion when capacity is exceeded and out of working hours.

Some Mental Health Trusts do not access or provide mother and baby units nor provide specialised perinatal community teams. In these services, women who require admission will be on a general admission ward without their babies. The admission of a mother and infant together to a non-specialised adult psychiatric ward is no longer acceptable nor should it take place in the UK.

Other Mental Health Trusts that do not have specialised perinatal services of their own may refer to out of area mother and baby units. However, this is rarely done proactively or in an emergency. Women therefore usually spend some time on a general adult admission ward without their babies before a referral is made and funding agreed.

Pregnant and postpartum women in these areas will be cared for by the usual adult mental health, community, crisis, early intervention, assertive outreach and liaison psychiatric team. In these areas, no specialised advice and input into their care will be available to women. In addition it is unlikely that in these areas, women will have access to specialised advice on the management of their pre-existing conditions in pregnancy, advice on medication in pregnancy and breastfeeding, nor the proactive management of their conditions during pregnancy and their risk of a postpartum recurrence.

General adult mental health services in areas without specialised teams do not usually adapt their thresholds for accepting referrals of perinatal patients for intervention or for admission. This is of great concern because of the additional risks posed to the mother and the infant by perinatal psychiatric disorder and because disorders presenting early in the postpartum period can deteriorate very rapidly.

The provision of care for women with less severe conditions in the community is even more variable and inequitable.

WHAT DO WE KNOW ABOUT MATERNITY SERVICES?

Midwives are responsible for early pregnancy risk assessment determining which women will need additional obstetric input and/or other services. It is part of their role to explicitly enquire about a woman's previous psychiatric history and to appropriately refer on those women who are at risk of serious perinatal psychiatric problems. It is also part of their role to ask about a woman's current mental health and to know who and how to refer. They will need to work collaboratively with primary care and mental health services. Obstetricians deal with high risk and complex pregnancies, including women with serious mental illness. They will also see women with a range of other psychiatric disorders in pregnancy and the early postpartum period.

Some maternity services will have access to a specialised perinatal community mental health team, provided by a local Mental Health Trust. This service will see emergencies, provide advice and care as well as work collaboratively in the management of high risk patients.

Other maternity services will have to rely upon adult mental health services including liaison services.

Some maternity services will have a designated clinical psychologist.

The NICE caesarean guidelines recommend that women with traumatic stress responses to childbirth whether in pregnancy or postnatally should have access to psychological interventions at both sub-threshold and threshold levels of post traumatic stress disorder. However, this remains poorly implemented¹⁸.

PARENT-INFANT MENTAL HEALTH SERVICES

Present variably throughout England are a variety of services, some called perinatal services, others called parent-infant mental health services. Whilst the focus is on the infant's current and future mental health, they treat mothers together with their infants who either have parenting difficulties or are thought to be at risk of them. Some of these services are funded by Primary Care Trusts or community health services, some are provided by maternity or children's hospitals, some by adult mental health, and some by child and adolescent mental health services. Some are led by psychologists, working alone or with other psychologists; others include health visitors and midwives. Some services are multidisciplinary. All focus on psychological therapies and parenting interventions, some include child and family psychotherapists. They access additional care from adult mental health services for serious mental illness. Some have a focus on working with a particular vulnerable group such as mothers who have been in care or are referred by social services.

The provision and function of these specialist services is variable and inequitable. There is little available data to estimate the unmet need but it is likely to be considerable. Services with a parenting focus can substantially improve maternal and infant mental health and improve the emotional social and cognitive development of the child. They can offer additional expertise, advice and supervision to adult mental health services who care for parents of young children. They can also provide guidance and training for workers in primary care and childcare social services. They do not provide comprehensive psychiatric care for women with serious disorders. They are an important part of an overall perinatal mental health strategy, and a necessary but not sufficient component of a perinatal mental health service.

IMPROVED ACCESS TO PSYCHOLOGICAL THERAPY TEAMS (IAPT)

IAPT services are now in place throughout England. Patients may self-refer or be referred by their general practitioner or health worker. They are triaged by telephone and offered help using a stepped-care model ranging from guided self-help through to cognitive behavioural therapy (CBT) by specialist workers. Most IAPT services are also linked to a single-point of access scheme for mental health services. Within the perinatal context they will be managing women with mild to moderate conditions, depression and anxiety disorders.

It has been acknowledged that a substantial proportion of their clients will be pregnant and postpartum women. A pathfinder site estimated this to be 27% and specific guidance (the IAPT Perinatal Positive Practice Guide) was published by the Department of Health 2007³⁵.

There are concerns about the current IAPT system within the perinatal context. None of the training schemes for IAPT workers of any grade include training on the normal emotional changes associated with motherhood, the change in relationships and family dynamics, clinical features of perinatal psychiatric disorder and the additional risks to both mother and infant of perinatal mental health problems. None of the treatment modalities include any focus on parenting or mother-infant interaction. It is of concern that women presenting initially with depression and anxiety in the early postpartum period who subsequently develop a more serious illness may have access to the appropriate level of care delayed.

What do we know about current perinatal mental health services (continued)

GENERAL PRACTITIONER, HEALTH VISITOR AND EXTENDED PRIMARY CARE SERVICES

The majority of women with perinatal mental health problems will be seen by these services. Frequently, GPs are no longer involved in the routine care of pregnant and postpartum women and valuable information on a woman's past mental health may not be accessed by midwives or Health Visitors. Midwives must ensure that GPs know that their patient is pregnant and seek to obtain from them information about significant aspects of a patient's medical and psychiatric history.

GPs will see women who refer themselves or who have been identified by the midwife or health visitor. They can treat uncomplicated non-psychotic depression and anxiety themselves, refer to IAPT, or for complex or serious disorders, refer to perinatal mental health services (or in their absence adult services).

The effectiveness of health visitor intervention in the prevention and treatment of mild to moderate postnatal depression is now well established²³. Health Visitors with additional training in listening visits and cognitive counselling can significantly improve the outcome of women with postnatal depression compared to standard health visitor care. Interventions by additionally trained health visitors are clinically and cost effective²³.

CLINICAL NETWORKS

NICE recommends establishing regional perinatal mental health clinical networks³⁴ of perinatal clinicians and resources, and other stakeholders including service users.

These networks will advise commissioners, maintain the integration of providers across the care pathway and promote clinical excellence. They should be funded and have formal status and governance.

The NHS Commissioning Board has released details of 12 strategic clinical networks to be set up in England³⁶. Each of these will consist of four umbrella networks into which existing networks will be placed. One of the umbrella networks is for mental health. Perinatal mental health clinical networks should be further developed across England and fit into this structure as "enclave" networks under the mental health strategic clinical network "umbrella".

This will not only promote equity of access, regional integration and clinical excellence but also provide a conduit for advice to both specialised and local Commissioners.

The Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) has a quality network for both mother and baby units and specialised perinatal community mental health teams. The overwhelming majority of such teams are members of the CCQI Network. They have developed consensus standards of care to which all members adhere and are subject to annual peer appraisal visits. See www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/perinatal/perinatalqualitynetwork.aspx

THE NEED FOR CHANGE: A CASE VIGNETTE

Miss Smith, in her late 20s had been under the care of psychiatric services since her late teens for the treatment of a bipolar illness.

She had had a number of admissions to a psychiatric unit for the treatment of episodes of mania. She was eventually successfully stabilised on Sodium Valproate and had been well for at least the last three years. During this time, she had a baby. She did not have a recurrence of her bipolar illness but there are concerns about the baby's delayed development. She subsequently stopped her Sodium Valproate and was discharged from psychiatric care early in the pregnancy of her second child.

During this second pregnancy, her midwife did not obtain a previous psychiatric history nor did her general practitioner alert the midwife. She was not referred back to her psychiatric team. She remained well during her pregnancy but a few days after delivery the hospital midwife was concerned about her "odd" behaviour. She was seen by a duty psychiatrist who did not feel that she was mentally ill, did not note her risk of a recurrence of her condition and no active steps were taken for her management.

Two weeks after the birth of baby, she went to see her general practitioner complaining of feeling depressed. He did not think she was ill and attributed her difficulties to her recent separation from her partner. She continued to deteriorate and became preoccupied with the idea that she might be pregnant again. Six weeks after the birth of her baby, her family became concerned about her mental health and telephoned the health visitor.

On the next day when the health visitor had planned to visit, Miss Smith committed suicide on a local railway line.

What might have made a difference?

The psychiatric team managing her bipolar illness should have counselled her about the effects of the pregnancy and childbirth on her bipolar illness, the high risk of recurrence following delivery even though she had been well for some time and the risks to the baby of taking Sodium Valproate during pregnancy.

The midwife should have asked her about her previous psychiatric history. She should have obtained further details from the general practitioner and Miss Smith should have been referred back to her psychiatric team.

She should have had a peripartum management plan. Both she and her family should have been aware of the high risk of recurrence following delivery, known what to do if they

became concerned and at the very least, she should have had close support and monitoring in the early postpartum weeks by a community psychiatric nurse.

Both the psychiatrist who saw her after delivery and the GP should have been aware of her high risk of recurrence following delivery and the significance of these early symptoms.

Improved knowledge about perinatal mental health problems in general and the impact of childbirth on bipolar illness in particular, would undoubtedly have improved Miss Smith's outcome. However, this case also demonstrates the need for standards of care and systems of service delivery to be put into place so that there is a seamless continuity from pre-conception to postpartum care. If a specialised perinatal community perinatal mental health team had been available in that area then perhaps the outcome would have been different.

What would a good perinatal mental health service look like?

KEY PRINCIPLES

- A good service requires a perinatal mental health strategy which includes a commissioning framework and service design for populations large enough to provide a critical mass for all the services required across a clinical pathway. This will require collaboration with providers and other commissioners.
- Services should be provided on the basis of the known epidemiology of perinatal conditions taking into account any special geographical or socio-economic features of the area to be covered.
- The delivered population should be the denominator for service planning and provision.
- Good perinatal mental health services will use an integrated care pathway drawn up and agreed by all stakeholders to ensure the timely access of women to the most appropriate treatment and service for their condition.
- All women should have equal access to the best treatment for the condition irrespective of where they live, their socio-economic status, their ethnicity.
- Good perinatal mental health services should promote prevention, early detection and diagnosis and effective treatment.
- The right treatment should be evidence based, effective, personalised and compassionate. It should meet the needs of both mother and infant, respect the wishes of the mother wherever possible and compatible with the safety of the infant and promote optimal care and outcome for the infant.
- A good service should accommodate the cultural and religious practices for a newly delivered woman compatible with the health and safety of mother and infant.
- Good perinatal mental health services promote seamless, integrated, comprehensive care across the whole clinical pathway and across organisational and professional boundaries. This requires close working relationships and collaborative commissioning between mental health services and maternity services, children's services and social care, primary care and voluntary organisations.
- Good perinatal mental health services will ensure that no woman is needlessly separated from her infant and that she receives the appropriate support, care and guidance to safely care for her infant if she is mentally unwell. If she requires admission to a psychiatric unit, she must be admitted to a specialised mother and baby unit unless there are compelling reasons not to do so.
- Good perinatal mental health services should include an education and training programme which should be provided for non-specialists involved in the care of pregnant and postpartum women including general psychiatric teams, GPs, midwives, Health Visitors and IAPT workers to ensure the early identification of those at high risk:
 - ▲ early diagnosis
 - ▲ an understanding of the maternity context
 - ▲ the additional clinical features and risk factors associated with perinatal disorders
 - ▲ the developmental needs of infants.
- Good perinatal services should be part of a clinical network. With so many different agencies and services, providers and differing commissioning arrangements in the pathway of care from early pregnancy through to the postpartum period, it is essential that systems are in place to maintain the integration and collaboration of these agencies. Part of the perinatal mental health strategy should include a managed (strategic) network made up of all stakeholders, including patients' representatives, to ensure the functioning of the whole service pathway and to allow for development and innovation as new evidence arises. A clinical network also has the important function of advising both commissioners and providers.
- Good perinatal mental health services will include a range of services including:
 - ▲ specialised inpatient mother and baby units
 - ▲ specialised community perinatal mental health teams
 - ▲ parenting and infant mental health services
 - ▲ clinical psychology services linked to maternity hospitals
 - ▲ specialist skills and capacity within:
 - maternity services
 - general adult services
 - IAPT
 - general practice and the extended primary care team
 - health visiting.

A good specialised perinatal service should be organised on a hub-and-spoke basis so that inpatient mother and baby units to serve the needs of large populations are closely integrated with specialised community perinatal mental health teams provided by Mental Health Trusts in each locality.

Mother and baby units

A good mother and baby unit should be accredited by the Royal College of Psychiatrists' quality network and meet their standards. It should:

- provide care for seriously mentally ill women or those with complex needs who cannot be managed in the community in late pregnancy and in the postpartum months
- provide expert psychiatric care for seriously ill women whilst at the same time admitting their infants, avoiding unnecessary separation of mother and infant
- offer advice, support and assistance in the care of the infant whilst the mother is ill, meeting the emotional and developmental needs of the infant
- provide a safe and secure environment for both mother and infant
- offer timely and equitable access such that mothers are not admitted to general adult wards without their baby prior to admission
- be closely integrated with specialised community teams to promote early discharge and seamless continuity of care.

Specialised community perinatal mental health team

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

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

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

PARENT-INFANT MENTAL HEALTH SERVICE

A good parent Infant mental health service will assess and provide care for mothers with complex perinatal mental health problems who have or are at risk of parenting difficulties. These include less severe depression, anxiety and personality difficulties. They will also work with mothers with more serious problems who have parenting difficulties. They provide a variety of psychotherapeutic, psychological and psychosocial treatments and parenting

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

GENERAL ADULT MENTAL HEALTH SERVICE

A good general adult mental health service should:

- regard women of reproductive age as having the potential for childbearing. They should ensure that patients with serious mental illness receive pre-conception counselling and are aware of the risks to their mental health of becoming pregnant. They should also take into account the possible adverse effects of psychotropic medication in pregnancy when prescribing to women of reproductive potential and provide women with this information.
- wherever possible, redirect referrals of pregnant and postpartum women to specialised perinatal psychiatric services. Where these do not exist, they should be aware of a differing threshold of response to all interventions including admission and the capacity of perinatal conditions deteriorating rapidly and being associated with substantial morbidity and mortality.

What would a good perinatal mental health service look like? (continued)

- if a woman, already under their care, because of a longstanding serious mental health problem, becomes pregnant, they should work collaboratively with maternity services to develop a peripartum management plan and wherever possible, seek advice and support from a specialised community perinatal mental health team
- if admission is necessary, consider admission to a mother and baby unit even if this means an out of area placement
- demonstrate that their systems and practice consider their patients as parents and the welfare of their children.

MATERNITY SERVICE

A good maternity service should:

- communicate with the GP informing them of the pregnancy, asking for information about any mental health problems and alerting them if difficulties arise
- ensure that women are asked about current mental health problems during pregnancy and the early postpartum period
- ensure that women at high risk of a recurrence of serious psychiatric disorder are identified at early pregnancy assessment are referred for specialised care
- equip its midwives with knowledge and skills to deal with the normal emotional changes of pregnancy and the early postpartum period and common states of distress
- have access to a designated specialised perinatal mental health team able to provide collaborative working with women at high risk of serious mental illness and emergency assessments

- have access to a designated specialised clinical psychologist to advise and treat, if necessary, women with psychological distress particularly relating to obstetric loss, post traumatic stress disorder and other obstetrically relevant conditions (e.g. needle phobias, previous rape, abuse etc)
- ensure that midwives and obstetricians should receive additional education and training in perinatal mental health.

IAPT service

A good IAPT service should:

- ensure that pregnant and postpartum women are “fast tracked”, assessed within four weeks and effectively treated within three months of referral in line with NICE guidance²⁹
- provide additional training to ensure that they understand the maternity context and the additional clinical features and risk factors associated with perinatal psychiatric disorder
- be able to refer to perinatal mental health services in cases of concern and to psychological services in cases of higher complexity.

GP AND PRIMARY CARE TEAM

A good GP and primary care team should:

- ensure that patients with serious mental illness receive pre-conception counselling and are aware of the risks to their mental health of becoming pregnant (they should also take into account the possible adverse effects of psychotropic medication in pregnancy when prescribing to women of reproductive potential and provide women with this information)

- ensure that women are asked about current mental health problems during pregnancy and the early postpartum period in line with NICE Guidelines²⁹. (instruments such as the Edinburgh Postnatal Depression Scale should be used with caution and in conjunction with a clinical assessment)
- communicate with midwives, with the woman's consent, if there is a history of significant mental illness, even if the woman is well
- be alert to the possibility of postnatal depression and anxiety and to the risk of recurrence of pre-existing conditions following childbirth
- use the integrated care pathway so that early onset conditions can be closely monitored and referred on if necessary.

HEALTH VISITOR SERVICE

A good Health Visitor service should:

- have the education, training and skills to detect mental health problems in pregnancy and the postpartum period, to know who to refer and to which service using the integrated care pathway
- be able to undertake basic psychological treatments such as listening visits and non-directive counselling and cognitive counselling group work and understand which women would benefit from additional visits and support.

Health Visitors undertaking psychological interventions will require clinical supervision from an appropriately trained person.

DATA AND OUTCOME MEASURES

Good perinatal mental health services should systematically gather data on the patients they see in such a way that it can be accessed by clinicians to enable them to understand what they are doing and how they perform and measure outcomes. Commissioners can request data to support expected standards of care and contractual arrangements. For both clinical and commissioning reasons it would be helpful if this data was standardised across services nationally so that comparisons of clinical and cost effectiveness can be made.

The current Mental Health Minimum Data Set does not include data on whether a woman is pregnant or in the postpartum year. This may well be changed in the future but in the meantime, it is imperative that commissioners expect providers of adult mental health services to record whether or not female patients are pregnant or postpartum. Without this, it is not possible to measure what proportion of pregnant and postpartum women in the care of adult services are receiving the appropriate care. This also applies to IAPT services.

Information also needs to be recorded by specialised services specifically designed for pregnant and postpartum women to provide data on activity, core standards of expected care and maternal and infant outcomes as well as risk assessments. These will be over and above the data required for Mental Health Trusts³⁷.

Outcome Measures for Specialised Perinatal Mental Health Services

These, together with CQUINS and “dashboards” are currently being developed by the National Perinatal Mental Health Clinical Reference Group and will be available in late 2012.

Supporting the delivery of the mental health strategy

Good perinatal mental health commissioning as described in this guide will support the delivery of the English Mental Health Strategy.

Shared objective 1:
More people will have good mental health.

By prevention and the early identification, diagnosis and effective treatment of women with perinatal mental health problems, the number of women receiving appropriate care and support will increase and the numbers of their children with short and longer term problems will be reduced.

Shared objective 2:
more people with mental health problems will recover.

By commissioning a perinatal mental health programme that will enable women to access the right treatment at the right time, they will recover more quickly, establish good relationships and parenting practices with their infant and resume their normal social functioning.

Shared objective 3:
more people with mental health problems will have good physical health.

The appropriate care by perinatal mental health services of pregnant and postpartum women contribute to improved health in pregnancy and improved maternal and infant outcomes.

Shared objective 4:
more people will have a positive experience of care and support.

Perinatal mental health services provide a special understanding of the issues of new motherhood and the impact of mental health problems at this time.

Shared objective 5:
fewer people will suffer avoidable harm.

Perinatal mental health services address the additional risks to both mother and infant associated with mental health problems in pregnancy and the postpartum period and will reduce both maternal and infant mortality and morbidity.

Shared objective 6:
fewer people will experience stigma and discrimination.

Perinatal mental health services will go some way to reducing the stigma of suffering from mental health problems associated with childbirth because of their special understanding of the perinatal context.

Expert Reference Group Membership

- **Margaret Oates (ERG Chair)**
Consultant Psychiatrist
East Midlands Perinatal Mental Health Clinical Network
- **Judy Shakespeare**
General Practitioner
Royal College of General Practitioners
- **Fiona Seth-Smith**
Clinical Psychologist
NWL NHS Foundation Trust
- **Liz McDonald**
Consultant Psychiatrist
Homerton University Hospital
London
- **Alain Gregoire**
Clinical Director for Mental Health and Learning Disability
South Central
Strategic Health Authority
- **Pauline Slade**
Clinical Psychologist
Institute of Psychology
University of Liverpool
- **Rosie Shepperd**
Consultant Psychiatrist
Oxford Health NHS Foundation Trust
- **Chris Fitch**
Research and Policy Fellow
Royal College of Psychiatrists
- **Roch Cantwell**
Consultant Psychiatrist
Southern General Hospital
Glasgow
- **Jonathan Campion**
Consultant Psychiatrist
South London and Maudsley
NHS Foundation Trust
- **Ian Hulatt**
Mental Health Advisor
Royal College of Nursing
- **Hilary Osborne**
Manager
Child and Maternal Health
Observatory
- **Gerry Byrne**
Clinical lead for Family Assessment and Safeguarding Service and the Infant-Parent Perinatal Service (Oxfordshire)
South Central Strategic Health
Authority

Development process

This guide has been written by a group of perinatal mental health experts, in consultation with patients and carers. Each member of the Joint Commissioning Panel for Mental Health received drafts of the guide for review and revision, and advice was sought from external partner organisations and individual experts. This guide was led and revised by the Chair of the Expert Reference Group in collaboration with the JCP's Editorial Board (comprised of the two co-chairs of the JCP-MH, one service user representative, one carer representative, and technical and project management support staff).

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