Maternal Mental Health Alliance Views on the Long Term Plan for the NHS

The Maternal Mental Health Alliance is a coalition of over 80 national charities and Royal Colleges working together to ensure that **all** women get consistent, accessible and quality care and support for their mental health during pregnancy and in the year after birth.

This submission focuses on how the NHS and partner organisations can ensure that women with a perinatal mental health problem receive the care they and their families need, wherever and whenever they need it. Our policy positions have been co-developed through ongoing discussion with our member organisations and women with lived experience.

Priorities and action (Q1, 2, 6)

Our top three priorities for the NHS are as follows:

1. Specialist community and inpatient perinatal mental health (PMH) services, meeting national quality standards, in every area of England.

We welcome the funding that has been invested in specialist perinatal provision, and NHS England's (NHSE) work to support the development of new specialist community PMH teams and mother and baby units.

These new services must continue to expand their reach to support **all** women who need their care, to develop their offer to deliver NICE compliant care that meets CCQI standards, and to achieve the response times set out in the RCPsych service specifications.[i] Every team should join the CCQI quality network to benefit from regular peer and self-review.

Funding for specialist perinatal services – which will enter CCG baselines in April – **MUST** be used to deliver high quality specialist services. NHSE should publish national spending standards and data about spending in each CCG area. We understand that NHSE will collect information on the number of women seen by specialist services through the Mental Health Data set, and data on local spending through the finance data tracker. This must be publically available to enable all stakeholders to scrutinise spending and hold CCGs to account.

Over the next 5-10 years, NHSE should retain its focus on PMH to consolidate and build on progress to date, and continue to support and challenge local services.

2. Effective services and joined-up pathways of care in each local area.

Whilst specialist services are critically important, the prevention, detection, and timely and appropriate treatment of PMH problems require a range of services and pathways to be in place in every local area and working effectively. This includes universal services (GPs, maternity services and health visitors) and primary and secondary mental health. It is not clear who, at a national or local level is accountable for ensuring that the whole system works together effectively. **Government and NHSE must provide clear whole-system leadership.**

Training

Training of professionals is essential. PMH should be included in pre-qualification and CPD of ALL relevant professionals in the NHS and public services. Strategic Clinical Networks play an important role in facilitating multiagency training and development in local systems, and should continue to be resourced to do so. The

valuable role that specialist services play in providing training and consultancy to local colleagues must also be fully recognised and resourced.

Resourcing

Alongside training, all services must be adequately resourced to carry out their roles. Action is required to address local authority cuts in services including health visiting services and children's centres, which will make it much harder to prevent and detect perinatal mental health problems and to support families who are struggling. There has been a loss of over 1000 health visitors in England since 2015.[ii] PMH is one of six 'high impact areas' for health visiting,[iii] but it is not always included in families' five mandated contacts with health visitors – if indeed these contacts happen at all. There are some exceptions to this trend –Blackpool has increased the number of health visitor contacts and reviewed their content.

GPs must also be adequately funded to carry out maternal postnatal checks, which must specifically include mental health, and these should be included in the GP contract.

Every maternity and health visiting service should have a Specialist PMH Midwife and Health Visitor to champion the needs of women with perinatal mental illnesses and drive improvements. The NHS must deliver on Department of Health's 2013 ambition to have a specialist mental health staff available in every birthing unit – we are currently far from that point. [iv]

IAPT services should be able to offer high-quality, timely psychological therapies, provided by therapists who are trained to meet the specific needs of mothers in the perinatal period.

Integrated Pathways

It is vital that local services work together as part of integrated local PMH care pathways, with clear roles, responsibilities and referral mechanisms to ensure that women receive the right care at the right time. Joint working is difficult given that the system is fragmented with different structures and priorities. Commissioning sits with different agencies, and delivery falls to a number of providers who are rarely co-terminus. The development of local pathways requires joint strategic working between local partners, led by an identified lead commissioner.

Our Mums and Babies in Mind project has identified areas who are taking a whole-system, joined-up approach to PMH. Barnet, for example, have produced an excellent integrated care pathway. In Gloucestershire and Warwickshire, a lead commissioner works strategically with local partners to improve services and pathways for all women in the local area. NHSE should identify and promote effective models of integrated local commissioning and delivery. Continued funding of Strategic Clinical Networks for PMH will also facilitate this integrated working.

3. High quality support for parent-infant relationships to break intergenerational cycles of poor mental health.

Although it is not inevitable, perinatal maternal mental illness substantially increases the risk of a child experiencing a range of poor health, educational and social outcomes across their life. .[v,vi] For example, robust studies have shown relationships between perinatal anxiety and depression doubling the risk of emotional and conduct problems in children into their teens and beyond. [vii] A report by LSE showed that the costs of perinatal mental illness are currently £8.1bn for every annual cohort of births. 72% of these cost relate to the impact on the child. [viii]

The NHS must take action to reduce the impact of perinatal mental illness on children. This includes not only prevention, detection and treatment of perinatal mental illness in the mother, but also – where appropriate – NICE concordant parent-infant interventions to mitigate any impacts of perinatal mental illness on a child's early development.

There are huge gaps in the provision of infant mental health care. Government and NHSE must ensure that maternity, health visiting, early years, children's services and CAMHS take action to protect and promote infant mental health. In particular, NHSE must support CAMHS commissioners and hold them to account for meeting the needs of **ALL** children aged 0-19 with mental health problems, starting from birth and including help for families experiencing problems in early parent-infant relationships, whether due to perinatal mental illness or other adversities.

To fully deliver their contribution to children and young people's mental health, specialist PMH services must include high quality, evidence based interventions to support the mother-infant relationship as well as treating mothers' mental health problems.

Integration of physical and mental health care. (Q3)

Within the perinatal period, there is a need for professionals, services and systems to consider the needs of women holistically – recognising the impact that maternal physical health problems during conception, pregnancy, birth and postnatally can have on a woman's mental health, and vice versa. For example, issues such as fertility problems, miscarriage, premature birth, birth injury and feeding challenges can all have a significant impact on women's and their partners' mental health. There is a need to develop and promote good practice in supporting women's perinatal physical and mental health in an integrated way. Specialist MH midwives in every maternity service would contribute to achieving this.

Inequality and Diversity (Q4)

ALL women and their families affected by perinatal mental illness must receive the right support at the right time. All services across the pathway of care, should monitor, and continually improve their work with traditionally marginalised and underrepresented women and families – considering issues around accessibility, experience of care and outcomes for different groups. NHSE can play an important role in offering scrutiny, support and challenge to local systems. Specific work is required to understand and respond to the needs of particularly disadvantaged families such as women in the criminal justice system, asylum seeking women, and those who have had children removed. More must also be done to improve work with fathers – not only as parents and partners, but as people with their own mental health problems who need support.

Children's and Adult's Mental Health (Q5)

There are three key ways in which children's and adults' mental health services need to work together to promote and protect maternal mental health and reduce the impact of perinatal mental illness on the mental health of children:

- Ensuring that, when required, babies of mothers with PMH problems receive evidence-based parent-infant mental health interventions.
- Providing joined-up services for teenage parents who experience PMH problems.
- Offering early information and advice to young people with severe mental health problems about how these illnesses might affect them during pregnancy and after birth, and how to manage any risks.

Prevention and Early Intervention (Q7 & 8)

The NHS should be doing more to prevent perinatal mental illness, to tackle low levels of identification, and to intervene at the earliest moment when women are ill. This includes:

- System wide, public health approaches to understand and address drivers of perinatal mental illness (recognising, for example, how poverty and adverse childhood experiences can increase the incidence and impact of perinatal mental illness.)
- A trauma-informed health and social care system, which promotes and protects mental health of the most vulnerable service users. (We recommend looking at the trauma-informed work carried out as part of A Better Start in Blackpool).
- Good care pathways, so that women with a history of severe mental illness and trauma receive good support starting from before conception, and that other women with PMH problems are identified and given help at the earliest moment.
- High quality parent-infant interventions for children of women with perinatal mental illnesses, when required, to reduce intergenerational cycles of poor mental health.

Support for people with serious and complex problems (Q9)

Specialist PMH services must be equipped to meet the needs of women with more serious and complex problems, working in partnership with other agencies where necessary.

The growth of specialist mother and baby units is welcome. However some women with serious PMH problems and those with babies older than 1 year will go into general adult psychiatric wards and these wards should be able to meet their, and their family's needs. It is concerning that some hospitals are in breach of requirements to provide same-sex hospital accommodation.

Some women with complex problems may have their baby removed into the child protection system. These women, who can be at increased risk of suicide, must still receive any PMH care they need to deal with any mental health problems and the consequences of their loss.

Examples of innovative/excellent practice (q10)

There are many examples of innovative and excellent practice in PMH care, across universal, specialist services and the voluntary sector, some of which are mentioned in this submission. Many of MMHA members are delivering a range of innovative and excellent practice, which we would welcome the opportunity to share with you.

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[i] https://www.rcpsych.ac.uk/pdf/Perinatal_specialist_community_mental_health_team_service_spec_template_May2018.pdf
[ii] https://www.rcn.org.uk/professional-development/publications/pub-006200
[iii] https://www.gov.uk/government/publications/commissioning-of-public-health-services-for-children
[iv] https://www.nursingtimes.net/roles/mental-health-nurses/all-maternity-units-to-get-specialist-mental-health-staff/5065248.article
[v] Van den Bergh, B. R., Mulder, E. J., Mennes, M., & Glover, V. (2005). Antenatal maternal anxiety and stress and the neurobehavioural development of the fetus and child: links and possible mechanisms. A review. *Neuroscience & Biobehavioral Reviews*, *29*(2), 237-258.
[vi] Center on the Developing Child at Harvard University (2009). *Maternal Depression Can Undermine the Development of Young Children: Working Paper No. 8.*
[vii] O'Donnell, K. J., Glover, V., Barker, E. D., & O'Connor, T. G. (2014). The persisting effect of maternal mood in pregnancy on childhood psychopathology. *Development and psychopathology*, *26*(2), 393-403.
[viii] Bauer, A., Parsonage, M., Knapp, M., Iemmi, V., & Adelaja, B. (2014). *Costs of perinatal mental health problems.*