## North East and Cumbria Perinatal Mental Health Scoping Report 2017

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Abbreviations

BPS - British Psychological Society
CAMHS – Child and Adolescent Mental Health Service
CCG – Clinical Commissioning Group
CCQI – College Centre for Quality Improvement
CMHT – Community Mental Health Team
CORE - Clinical Outcomes in Routine Evaluation
CPN - Community Psychiatric Nurse
CYPS - Children and Young People Service
DDES – Durham Dales, Easington & Sedgefield
EBDS - Edinburgh Postnatal Depression Scale
FNP – Family Nurse Partnership
GAD - Generalised Anxiety Disorder assessment
HoNOS – Health of the Nation Outcome Scales
IAPT – Improving Access to Psychological Therapies
JCPMH - Joint Commissioning Panel for Mental Health
LA – Local Authority
MBU – Mother and Baby Unit
MTR – Movement to Recovery
NBO - Newborn Behavioural Observations
NICE – National Institute of Health and Care Excellence
NECS - North of England Commissioning Support
NTW NHS FT – Northumberland, Tyne & Wear NHS Foundation Trust
PHQ - Patient Health Questionnaire
PIMHS – Parent-Infant Mental Health Service
PNMH – Perinatal Mental Health
PNMHT – Perinatal Mental Health Team
POEM - Patient rated Outcome and Experience Measure
RCGP – Royal College of General Practitioners
RCOG – Royal College of Obstetricians and Gynaecologists
RCPsych – Royal College of Psychiatrists
Executive Summary

This scoping report was commissioned by NHS England to gather information from local Adult IAPT providers on the current IAPT perinatal mental health care provision across the North East and Cumbria.

This report is based upon a previous report prepared by the Cheshire and Mersey Strategic Clinical Network following a wider scoping of perinatal mental health services in their area.


To understand the overall position of perinatal mental health services in the North East and Cumbria contributions from parents, Midwifery, and Health Visiting have also been included in this report.

Recommendations for improvement have been highlighted in the context of current national policy, and the Government’s 2015 budget announcement for perinatal mental health of an increase of £75million over five years.

Key Recommendations

The following recommendations come from the information gathered for this report and previous work completed by the North East and Cumbria Perinatal Mental Health Clinical Network. The recommendations overlap at times and the list is not exhaustive.

Clinical Network recommendations:

- Perinatal Mental Health Clinical Network to advise commissioners, assist in the development of strategic plans and commissioning frameworks, advise provider organisations, assist with workforce development and training and develop integrated care pathways.

- Training in early identification and support for women with Perinatal Mental Health illness should be mandatory and multi-agency. It should be provided by Specialist Perinatal Mental Health Teams where these exist.

- There should be Specialist Perinatal Community Mental Health Teams for all women across the region requiring secondary care.

- There should be prioritisation for psychological therapies which should be delivered by practitioners with expertise and training in Perinatal Mental Health.

- Fast track for referral of women with severe perinatal mental health illness.

- Robust communication pathways between all professional health services.

- All women to have both past and current mental health illness assessed at booking and at antenatal contact with health visitor.

- All women to have their mental health assessed using Gad2 and Whooley questions (depression identification questions) at each contact during perinatal period.
- Perinatal birth plan to be completed with regular reviews with multidisciplinary team for women with severe mental illness.
- Identify women of childbearing age with active or in remission mental illness (e.g. by GP or by adult mental health professional) and discuss pregnancy planning and referral for preconception advice.
- Each service to have a number of mental health champions, who would be responsible for training and advice.
- Measurable outcomes including referral to mental health services and patient rated experience measures.

**Recommendations resulting from this report:**

**IAPT Providers**

**Access**

- To encourage all providers to prioritise women in the perinatal period for access and treatment and ensure this is included in the service specification.
- To ensure that referrers and supporting referral documentation allows and encourages referrers to highlight when the patient is within the perinatal period.
- Where available, specialist perinatal services need to publicise their service better.
- Ensure all IAPT providers are aware of the access routes and the purpose of the Mother and Baby Unit (MBU).

**Referrals and Pathways**

- All IAPT Providers should have a protocol for when to trigger a referral into specialist perinatal MH services, this to be included in the Service Specification.
- All IAPT providers to have a referral pathway for women presenting with a severe mental health problem during the perinatal period.
- Mental Health Providers to identify a perinatal mental health link for IAPT providers.
- The perinatal mental health link to provide regular contact, training and support to the IAPT providers. Build this into the service specification for Mental Health and IAPT providers.
- PNMH Clinical Network to identify the principles and standards for a perinatal MH care pathway which includes protocols for critical decision making and parent/carer support and ask IAPT providers to develop their pathway based upon this.
- Ensure each IAPT provider has an identified link in CMHT and perinatal MH teams for patients in the perinatal period.
- Ensure the links in the CMHT have a named person in the MBU/Adult inpatient services to liaise with regarding patients in the perinatal period.
• The MBU to make contact with the perinatal lead for each IAPT and Mental health provider to identify training and support needs.

**Treatment Completion Recovery and Outcomes**

• IAPT providers to develop systems to ensure perinatal patients can be readily identified within their service.

• PNMH Clinical Network to develop existing outcomes for perinatal patients.

**Workforce Training**

• PNMH Clinical Network to support the MBU, Mental Health providers and IAPT staff to identify training needs and develop a plan to address this.

• Commission a variety of training programmes to address the issues identified in the above plan.

• The above recommendations to be written into the service specifications for IAPT providers and Mental Health providers.

**Local Perinatal Strategies**

• PNMH Clinical Network to provide clear guidance on what should be covered in an IAPT PNMH strategy and standards for a PNMH care pathway.

• Each IAPT service to identify a management and clinical lead to deliver the strategy and for this recommendation to be written into provider service specifications.

**Information and Support Services**

• It is advisable that providers link with all health professionals not just GPs.

• All IAPT providers should provide preconception information when appropriate.

**Service Facilities**

• Good practice is that all providers should be encouraged and supported to provide family friendly environments and emulate the good practice of the provider who involves the child as part of the mother’s support needs.

**Midwifery Services**

• All midwifery services should have a Specialist Mental Health Midwife who links with a Specialist Perinatal CMHT, GPs and IAPT services.

• All midwifery services should have training in respect of detecting at-risk women during pregnancy and in dealing with the normal emotional changes of pregnancy and the early postpartum period; this training should be standardised across the region building on good practice examples.
• Explore if there is a standard tool/best practice guidance available to identify women at risk of a recurrence of a serious disorder.

• All Specialist Mental Health Midwives should receive adequate supervision from a clinical psychologist.

Health Visiting Services

• There should be a consistent regional approach to the training of Health Visitors in PNMH to include the Newborn Behavioural Observations training. All services should take advantage of the Health Education England PNMH E-Learning Modules

• Even if LAs choose not to commission FNP services they should ensure that teenage mothers are screened and supported with PNMH issues

• All Health Visiting services need to have in place a clear pathway to IAPT services

• All Health Visiting services should have in place some form of evidence based supportive psychological treatment such as the Solihull Approach

• All Health Visitor services should have at least one specialist PNMH Health Visitor who should receive specialist training and supervision from a suitably qualified professional such as a Clinical Psychologist

• All Health Visiting services should review the support they offer to partners/carers, aspire to deliver best practice and to actively screen for support needs

• The PNMH Clinical Network should provide a co-ordinating, supportive role in implementing the above recommendations.

Service Organisation

• The Clinical Network to work with CCG’s to ensure equitable access across the region to the services identified as part of a good perinatal pathway as listed in Section 5 of this report.
1. Introduction

Perinatal mental health is a key Government priority. **By 2020/21, NHS England should support at least 30,000 more women each year to access evidence-based specialist mental health care during the perinatal period.** This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.

Perinatal mental health services are concerned with the prevention, detection and management of maternal mental health problems that complicate pregnancy and the postpartum year.

Poorly managed, perinatal mental health problems can have serious consequences for the mother, her infant and other family members.

Perinatal mental health problems affect at least 1 in 5 women, with 3-4% of women experiencing a serious psychiatric disorder, the single greatest indirect cause for UK maternal deaths in the perinatal period.

Examples of these illnesses include antenatal and postnatal depression, anxiety disorders, obsessive compulsive disorder, post-traumatic stress disorder and postpartum psychosis.

Perinatal mental health problems have also been shown to compromise the healthy emotional, cognitive and even physical development of the child with serious long-term consequences. Fathers and partner’s mental health can also be affected as highlighted by responses from parents and providers. It would be useful to complete further work on the experience of fathers to better understand their needs in terms of coping with their partners mental health and how they can be supported.

Growing awareness and understanding of the implications of pre-existing and new onset maternal mental illness in the perinatal period has prompted pressing demands for improved perinatal mental health services as reflected in numerous policy documents, clinical guidelines and a major economic report.

At a conservative estimate, the cost of perinatal mental health problems in the UK is £8.1 billion per year for each one-year cohort of births in the UK, the equivalent of £10,000 for every single birth with the majority of the cost being due to adverse impacts on the child. The estimated cost of extra provision to bring perinatal mental health care up to the level and standard recommended in national guidance is equivalent to about £400 per average birth. Across the North East and Cumbria this would equate to £13.28m based on the Office of National Statistics 2015 birth summary of 33,189.

The National Institute for Health and Care Excellence (NICE) and the Joint Commissioning Panel for Mental Health (JCPMH) have provided advice on how to put evidence-based guidance into practice.

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2. CG195 - Antenatal and postnatal mental health: Clinical management and service guidance, NICE 2014
3. Saving Lives, Improving Mothers Care: Lessons learned to inform future Maternity care, MBRRACE-UK 2014
4. Guidance for Commissioners of Perinatal Mental Health Services, JCPMH 2012
5. The Costs of Perinatal Mental Health Problems, Bauer et al., 2014
As this scoping report highlights there are gaps in the current provision to support the safe and equitable implementation of the pathway for all women and their families.

2. Methodology

In 2017 NHS England commissioned NECS to map the access to and outcomes from services for women in the perinatal period in IAPT, including pathways to and from IAPT. The aim was:

- to understand the access, treatment completion, recovery rates and key pathways into services for women in the perinatal period at a CCG level
- enable the region to understand outcomes overall and identify areas of good practice to build on.
- assess gaps in quality or access, develop a plan to improve them, and take action as possible, being clear on measurable impact.

In 2016 NHS England commissioned the Cheshire and Mersey Perinatal Mental Health Scoping report produced by Dr Tania Stanway and James Smith. This North East and Cumbria report is based upon the background information gathered by Stanway and Smith. The Cheshire and Mersey Perinatal Mental Health mapping work covered a much broader scope undertaking a very comprehensive assessment of Perinatal Mental Health Services gathering information from Commissioners, Midwifery, Obstetrics, GP’s, Health Visitors, FNP’s, Local PNMHT’s, Specialist Community PNMHT’s, Mother and Baby Unit, Adult Mental Health, IAPT, CAMHS, Children’s Centres, Third Sector providers and the NHS England Area Team.

This report has been formulated following a regional event for IAPT providers, discussions with parents, a meeting with Health Visitors and questionnaires completed by IAPT providers, Health Visitor and Midwifery Service leads. NECS, with members of the Clinical Network, have collaborated to produce the report.
3. National Drivers

The national campaign for improving perinatal mental health care is captured in the Everyone’s Business Campaign Everyonebusiness.org.uk. This campaign calls for all women throughout the UK who experience perinatal mental health problems to receive the care they and their families need, wherever and whenever they need it.

A survey was presented by the Royal College of Obstetricians and Gynaecologists (February 2017) of over 2300 women about their experiences of mental health during and after pregnancy.

36 respondents were from the North East (2% of all respondents) and 158 from the North West (7% of all respondents).

Key findings from this survey are:

- Women reported experiencing low rates of referral, long waits, regional variation of care, a lack of continuity of care, misunderstanding and stigma
- The mental health of women’s partners is also often neglected by healthcare professionals and services. (RCOG website Maternal mental health - women’s voices)

The report highlighted a wide variation of services across the country. In almost half of the UK, pregnant women and new mothers have no access to specialist community maternal mental health services.

1 in 8 partners experienced mental health problems, most received no support.

The RCOG have set 4 key priorities going forward

- Women should feel supported by their health care professionals to talk openly and honestly about their feelings.
- Women should have timely and local access to maternal mental health services and continuity of care across midwifery, obstetric and neonatal care wherever they live in the UK.
- Maternal mental health problems are wide ranging and all conditions should receive attention. Training health care professionals to help them recognise symptoms and provide accurate, timely information is crucial.
- Support should be available for partners, as part of a wider approach of treating maternal mental health and limiting the impact it can have on the whole family.

The other policies, publications and guidelines in Figure 1 make consistent recommendations about aspects of care that a pregnant and postpartum woman and their partners should receive and the provision of specialised care for perinatal psychiatric disorder, should it be necessary.

Personalised care and the development of mother-infant attachment are considered central to service provision within high quality perinatal mental health services.

While there is no specific guidance about support to fathers and the wider family, good practice and feedback from parents suggests that fathers, where possible, should be included in the support plan for the mother and receive support themselves if required. Good interagency working and carer support (e.g. via Triangle of Care) is important to recovery.
Figure 1:

- NICE CG192 Antenatal and postnatal mental health 2014
- NICE CG132 Caesarean Section 2012
- Five Year Forward View for Mental Health, Taskforce Report 2016
- JCPMH Guidance for Commissioning Perinatal Mental Health Services 2012
- NSPCC: Prevention in Mind–All Babies Count 2013
- 1001 Critical Days: Cross Party Manifesto 2015
- Royal College of Psychiatrists: Perinatal Mental Health CR197 2015
- Royal College of Psychiatrists: Service Standards 2nd Ed. Perinatal Community Mental Health Services 2014
- Royal College of Obstetricians and Gynaecologists: Management of women with mental health issues during Pregnancy and the post-natal period 2011
- IAPT Perinatal Positive Practice Guide 2013
- Royal College of Obstetricians and Gynaecologists: Maternal mental health – women’s voices report February 2017
4. Epidemiology

Table 1 - Rates of perinatal psychiatric disorder per 1000 births.

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Frequency</th>
</tr>
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<tbody>
<tr>
<td>Postpartum psychosis</td>
<td>2</td>
</tr>
<tr>
<td>Chronic serious mental illness</td>
<td>2</td>
</tr>
<tr>
<td>Severe depressive illness</td>
<td>30</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>30</td>
</tr>
<tr>
<td>Mild to moderate depressive illness and anxiety</td>
<td>100–150 (125)</td>
</tr>
<tr>
<td>disorders and distress</td>
<td>150–300 (225)</td>
</tr>
</tbody>
</table>

*Taken from the Guidance for Commissioners of Perinatal Mental Health Services, JCPMH 2012*

Table 2 – Estimated perinatal mental health numbers per Local Authority

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Births 2015*</th>
<th>Postpartum psychosis</th>
<th>Chronic serious mental</th>
<th>Severe depressive illness</th>
<th>Post-traumatic stress</th>
<th>Mild to Moderate depression</th>
<th>Adjustment disorder and distress</th>
<th>Total per annum</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Durham</td>
<td>5355</td>
<td>11</td>
<td>11</td>
<td>161</td>
<td>161</td>
<td>669</td>
<td>1205</td>
<td>2217</td>
</tr>
<tr>
<td>Cumbria</td>
<td>4789</td>
<td>10</td>
<td>10</td>
<td>144</td>
<td>144</td>
<td>599</td>
<td>1078</td>
<td>1983</td>
</tr>
<tr>
<td>Darlington</td>
<td>1217</td>
<td>2</td>
<td>2</td>
<td>37</td>
<td>37</td>
<td>152</td>
<td>274</td>
<td>504</td>
</tr>
<tr>
<td>Gateshead</td>
<td>2214</td>
<td>4</td>
<td>4</td>
<td>66</td>
<td>66</td>
<td>277</td>
<td>498</td>
<td>917</td>
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<tr>
<td>Hartlepool</td>
<td>1080</td>
<td>2</td>
<td>2</td>
<td>32</td>
<td>32</td>
<td>135</td>
<td>243</td>
<td>447</td>
</tr>
<tr>
<td>Middlesbrough</td>
<td>1925</td>
<td>4</td>
<td>4</td>
<td>58</td>
<td>58</td>
<td>241</td>
<td>433</td>
<td>797</td>
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<tr>
<td>Newcastle upon Tyne</td>
<td>3329</td>
<td>7</td>
<td>7</td>
<td>100</td>
<td>100</td>
<td>416</td>
<td>749</td>
<td>1378</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>2207</td>
<td>4</td>
<td>4</td>
<td>66</td>
<td>66</td>
<td>276</td>
<td>497</td>
<td>914</td>
</tr>
<tr>
<td>Northumberland</td>
<td>2832</td>
<td>6</td>
<td>6</td>
<td>85</td>
<td>85</td>
<td>354</td>
<td>637</td>
<td>1172</td>
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<tr>
<td>Redcar and Cleveland</td>
<td>1431</td>
<td>3</td>
<td>3</td>
<td>43</td>
<td>43</td>
<td>179</td>
<td>322</td>
<td>592</td>
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<tr>
<td>South Tyneside</td>
<td>1647</td>
<td>3</td>
<td>3</td>
<td>49</td>
<td>49</td>
<td>206</td>
<td>371</td>
<td>682</td>
</tr>
<tr>
<td>Stockton on Tees</td>
<td>2274</td>
<td>5</td>
<td>5</td>
<td>68</td>
<td>68</td>
<td>284</td>
<td>512</td>
<td>941</td>
</tr>
<tr>
<td>Sunderland</td>
<td>2889</td>
<td>6</td>
<td>6</td>
<td>87</td>
<td>87</td>
<td>361</td>
<td>650</td>
<td>1196</td>
</tr>
</tbody>
</table>

*Estimates above are based on application of prevalence rates in JCPMH 2012 (table 1) to local birth rate.*

*2015 Birth Rate Summary – Office of National Statistics*
# 5. Service organisation

Cheshire and Mersey examined NICE Guidance\(^6\) and Quality Standards\(^7\), Royal College of Psychiatrists Quality Standards\(^8\) and key publications produced by the NSPCC\(^9\), Royal College of Psychiatrists\(^10\), British Psychological Society\(^11\), IAPT\(^12\) and the Royal College of Midwives\(^13\) and suggest that a good quality perinatal mental health pathway should be managed by a Clinical Network and provide all women with access to the following services based on their level of need:

<table>
<thead>
<tr>
<th>Need</th>
<th>Service</th>
<th>Commissioner</th>
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<tbody>
<tr>
<td>Tier 4</td>
<td>Specialised in-patient Mother and Baby Unit.</td>
<td>NHS Commissioning Board</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Specialised Community Perinatal Mental Health Team.</td>
<td>Local Clinical Commissioning Group</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Parent-Infant Mental Health Service.</td>
<td>Local Clinical Commissioning Group</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Clinical Perinatal Psychology service linked to Maternity Service.</td>
<td>Local Clinical Commissioning Group</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Adult Mental Health and CAMHS with additional training in perinatal mental health.</td>
<td>Local Clinical Commissioning Group</td>
</tr>
<tr>
<td>Tier 2</td>
<td>Specialist skills and capacity within Maternity services.</td>
<td>Local Clinical Commissioning Group</td>
</tr>
<tr>
<td>Tier 2</td>
<td>IAPT service with additional training in perinatal mental health.</td>
<td>Local Clinical Commissioning Group</td>
</tr>
<tr>
<td>Tier 2</td>
<td>Specialist skills and capacity within Health Visiting service.</td>
<td>Local Authority</td>
</tr>
<tr>
<td>Tier 2</td>
<td>Specialist skills and capacity within the Voluntary Sector.</td>
<td>Local Clinical Commissioning Group / Local Authority</td>
</tr>
<tr>
<td>Tier 1</td>
<td>General Practitioners and Extended Primary Care teams with additional training in perinatal mental health.</td>
<td>Local Clinical Commissioning Group</td>
</tr>
<tr>
<td>Tier 1</td>
<td>Self-help and Social Support capacity within the local community.</td>
<td>Local Clinical Commissioning Group / Local Authority</td>
</tr>
</tbody>
</table>

\(^6\) CG195 - Antenatal and postnatal mental health: Clinical management and service guidance, NICE 2014  
\(^7\) NICE Quality Standard 37 – Postnatal Care 2013  
\(^8\) Royal College of Psychiatrists: Service Standards 2\(^{nd}\) Ed. Perinatal Community Mental Health Services 2014  
\(^9\) NSPCC: Prevention in Mind–All Babies Count 2013  
\(^10\) Royal College of Psychiatrists: Perinatal Mental Health Services CR197, 2015  
\(^12\) IAPT: Perinatal Positive Practice Guide 2009  
It is clear that not all areas in the North East and Cumbria have access to all of these services. In particular Specialist Perinatal CMHT and Clinical Perinatal Psychology linked to maternity services are not always available.

A more detailed description of these services is attached as appendix 3.

6. Good IAPT Perinatal Mental Health Services

Good perinatal mental health services will use an integrated care pathway of specialist and universal services drawn up and agreed by all stakeholders to ensure the timely access for women and their families to the most appropriate treatment and service for their condition. **6.1 Improving Access to Psychological Therapies (IAPT)**

A good IAPT service should:

- ensure that pregnant and postpartum women are ‘fast tracked’, assessed and starting treatment within 4 weeks
- receive additional perinatal training to ensure that they understand the maternity context, impact on fathers/partners and the additional clinical features and risk factors associated with perinatal mental health problems\(^\text{14}\)
- be able to refer to specialist perinatal mental health services in cases of concern or higher complexity
- record data on whether the client is pregnant or in the first year post-partum.

\(^{14}\) IAPT: Perinatal Positive Practice Guide 2013
7. Findings

7.1 Parents

The discussion we had with a small number of parents reflected the findings from Maternal Mental Health – women’s voices report mentioned in section 3. In particular the transfer of care between services was not a good experience and it was difficult to understand why one service was provided rather than another. For example a mother was supported by a CPN following the birth of her first child and when she became pregnant again she was also seen by a consultant psychiatrist but was not sure why. Once discharged from the CMHT, a mother was then seen by the IAPT service however this did not focus on perinatal mental health.

The IAPT service was seen as beneficial as an alternative to the GP. Overall the lack of perinatal mental health services meant it was hard to access appropriate care.

A father described the impact of his daughter being “taken away” from him when she was 3.5 weeks old and how not learning to parent his child at the same time as his partner, added stress to his partner as she was the main carer. The father was offered no support for himself until it was too late as he had learned to cope on his own. Support from IAPT at an early stage would have been helpful.

7.2 Clinical Network

The Northern England Clinical Networks hosts a Perinatal Mental Health Clinical Network. This had originally been formed as a working group of the Maternity Clinical Network in 2014 and became a Network in its own right in 2016.


The Network advisory group meets quarterly. The current work plan encompasses:

- Commissioner Engagement
- Patient and Carer Engagement
- Support for Provider Trusts/Commissioners around Wave 2 applications to the NHS England Community Services Development Fund
- Education Training (Pilots of training packages and an initial baseline review)
- Communication

The output of the Network feeds also into both the Mental Health and Maternity Clinical Networks.

In September 2016 the Northern England Perinatal Mental Health Clinical Network carried out an evaluation of current service provision across the North East and North Cumbria region to help identify the gaps in service and provide recommendations to
The recommendations in the Executive Summary (page 4) are intended to assist in driving the transformation of mental health care for pregnant women and to promote equitable access to good quality services throughout the region consistent with NICE guidelines, enabling benchmarking to understand, evaluate and compare services and their outcomes.

7.3 IAPT Providers

On 13 February 2017 NECS held an event to which the 13 regional IAPT providers were invited to inform them about this mapping exercise and to support them to complete the questionnaire which had already been developed by Cheshire and Mersey. The event also provided an educational opportunity with Dr Andrew Cairns, Consultant Perinatal Psychiatrist, NTW NHS FT & Clinical Lead for Perinatal MH, Northern England Clinical Networks, describing the importance of mental health support during the perinatal period. 7 providers came to the event and a further 3 completed the questionnaire electronically. A total of 10 providers responded to the questionnaire, this being 77% of the IAPT providers in the North East and Cumbria region.

Access

8 providers described having good links with a range of family and medical support services including: Health visitors, GPs, SureStart, midwives. However, some providers will only accept referrals from GPs. Our understanding is that the remaining 2 providers would also have these links but may not have understood the question being posed.

Access to treatment is in two stages: step 2 relates to initial support i.e. guided self-help or groups and step 3 is evidenced based therapeutic intervention. Access to Step 2 services ranges from immediate to 34 days (7weeks). Access to step 3, which involves CBT, counselling, Individual Psychotherapy Treatment (IPT) ranges from 17 days to 6 months. 6 of the 10 providers stated that they prioritised women during the perinatal period and on average this halved the waiting times for treatment.

4 CCG areas are able to refer into a specialist community perinatal mental health team. All areas have access to an adult CMHT. None of the IAPT providers were aware of the average waiting times for referrals into specialist community perinatal mental health service or CMHT. All providers were aware of how to access their local CMHT, it appears from the responses that some of the providers within the 11 CCG areas were not aware of specialist perinatal services that were available to them.

None of the providers were aware of the average waiting time for admission to MBU/Adult Psychiatric Unit. However, as it would be very rare that they would have direct contact with these services, that is understandable.

Referrals and Pathways

Mental Health Assessment within the IAPT service would be carried out as part of the initial assessment by a member of the IAPT team, this could be a clinical member of staff, a High Intensive Therapist (HIT) or Psychological Wellbeing Practitioner (PWP). At
the initial contact with the service, the team member will decide if a comprehensive assessment is required.

6 providers offer the same core services to women during the perinatal period as they do to all of their patients. 2 provide additional support services by working in partnership with other services. 1 provides a ‘bump to baby course’ and another provides groups for perinatal MH.

All providers have protocols in place to trigger onward referral for a comprehensive MH assessment for women in the perinatal period.

4 providers do not have a protocol in place to trigger a referral into specialist perinatal MH services for women whose needs cannot be met by the IAPT team. 4 providers have a protocol in place and 2 have a partial protocol in place.

9 providers have a protocol to identify and fast track women with MH needs during the perinatal period for assessment and treatment. 1 has a protocol in place for assessment but not treatment.

8 providers have a referral pathway for women presenting with a severe MH problem during the perinatal period as well as a protocol to trigger the referral. 1 has a protocol to trigger a referral but no specific pathway. The remaining provider relies on standard referral pathways and protocols.

None of the providers were able to identify a named link within their mental health provider organisation however, 5 providers misinterpreted the question and named the perinatal link person within their own organisation.

All providers are aware of which CMHT supports patients in their area. While a specialist community perinatal mental health team is available in 4 areas, only one provider stated they are able to refer patients to it.

5 providers were unaware of which MBU/Psychiatric unit they would refer to.

2 knew which adult psychiatric unit to refer to and 3 named the local MBU.

However, only 3 providers have protocols in place to trigger a referral for women in the perinatal period. A further 2 are developing a protocol.

None of the providers are aware of a link person within the MBU or Adult Mental Health Service.

The care pathway for IAPT provider services is clear and staff know how it works. Referrals on to more intensive services is clear with protocols to identify who and when patients should access secondary services. Links to inpatient services are probably used less frequently and pathways are less clear.

A few providers have identified perinatal patients’ needs and created separate pathways and protocols however, these are not always complete and in most cases do not exist.
Treatment Completion, Recovery and Outcomes

IAPT services are broken down into different steps.

Step 1 offers help in the recognition and assessment of a person’s condition and watchful waiting.

Step 2 can include Behavioural Activation, facilitated self-help, group therapies, computerised CBT, exercise and brief psychological interventions.

Step 3 can include CBT psychological interventions, counselling, Eye Movement Desensitisation and Reprocessing (EMDR), Mindfulness, Cognitive Behavioural Analysis Systems of Psychotherapy (CBASP), Interpersonal Therapy (IPT) and the prescribing of medication.

Step 4 involves delivering more complex psychological interventions, combined treatments and the prescribing of medication.

NHS England has set national targets for IAPT providers to achieve in respect of the following:

- Access – percentage of people seen within 6 weeks for first appointment and percentage of people seen within 18 weeks for first appointment.

- Movement to Recovery (MTR)

Across the North East and Cumbria, as at 30/11/2016, the percentage of people seen within 6 weeks for their first appointment ranged from 67.8% to 99.2%. The national target is 75%. The percentage of people seen within 18 weeks ranged from 67.8% to 100%. The national target is 95%, but the expectation is that 100% of people are seen within 18 weeks.

MTR will be different for each step of the IAPT service as a person’s condition will be more severe the higher the step they are in. The overall national target for MTR is 50%. As at 30/11/2016 Across the North East and Cumbria the overall MTR ranged from 35.21% to 58.33%.

A more detailed breakdown by CCG in respect of the above indicators can be found as Appendix 4.

Although all IAPT providers issue Patient Experience Questionnaires at various stages of treatment, the qualitative information is not routinely reported on.

All IAPT providers complete standard IAPT routine outcome measures, however, none are specifically focused on patients in the perinatal period. One provider is developing a perinatal mental health questionnaire.

Providers feel there would be benefit in using current outcome measures and ensuring perinatal patients can be readily identified.

Some providers have suggested CORE may be useful. It is increasingly likely that CORE (Clinical Outcomes in Routine Evaluation) will be a recommended outcome measure. It
is quite widely used by psychology services. To provide a local example, CORE is used by Northumbria Healthcare FT’s Obstetrics and Gynaecology Health Psychology who provide a similar level of intervention as IAPT services.

IAPT services currently use GAD (Generalised Anxiety Disorder assessment) and PHQ (Patient Health Questionnaire) as a way of evidencing improvement.

**Workforce Training**

In respect of Clinical Staff, 2 providers have accessed training from their Mental Health providers regarding parenting, pregnancy and perinatal mental health. 3 providers have accessed some training via supervision or through university courses on an ad-hoc basis. 5 providers have received no training around pregnancy and perinatal Mental Health although 1 is seeking to source this training.

It is unclear if any support staff have received training around perinatal MH.

In general, PNMH training is not standardised.

**Local Perinatal Strategies**

4 providers have an Executive/Management lead and a Clinical Lead for PNMH. 1 further provider has a Clinical Lead. 5 providers have neither a Management nor Clinical Lead for PNMH.

7 providers state they have an overarching pathway and strategy for PNMH.

There is no clear link between specialist perinatal mental health services and IAPT providers.

While 5 providers have a strategic lead for PNMH, and state there is an overarching strategy, this is not reflected in the information provided about practice.

**Information and Support Services**

1 provider provides pre-conception advice. 4 providers provide some preconception information to women providing they are made aware of potential pregnancy plans. 6 providers do not provide this information.

All providers indicate that health and wellbeing would be discussed by all the team members and discussions about this would commence with initial assessment and continue throughout the treatment. 9 of the providers would liaise with health visitors and midwives, provided consent was given, and all would liaise with the GP.

**Service Facilities**

6 providers are able to provide family friendly facilities. This is often due to providers sharing accommodation with GP practices and Primary Care Health Centres who work to the ‘You’re Welcome’ Standards. Others are accommodated in SureStart Centres which are set up to cater for families. 1 provider even goes so far as considering care for the child during therapy to support the mother’s needs.
4 providers said that they had no family friendly facilities or that this was variable depending on the facilities being used.

Family friendly facilities are very dependent on where the services are delivered and are often at the behest of the organisation providing those facilities.

### 7.4 Findings from Midwives

9 Head of Midwifery Services were contacted covering the North East & Cumbria region. 6 responses were received covering 6 CCG areas.

The questions asked are attached as appendix 5 and were selected because they represented what a good midwifery service should have in place in respect of Perinatal mental health.

**Specialist Mental Health Midwife**

2 out of the 6 midwifery services said that they have a Specialist Mental Health Midwife who links with a Specialist Perinatal CMHT, GPs and IAPT services. 4 services do not have a Specialist Mental Health Midwife.

**Detecting at-risk women during pregnancy**

4 of the midwifery services provide training to midwives in respect detecting at-risk women during pregnancy. 2 services do not provide training in respect of this.

**Current mental health problems during pregnancy and the early postpartum period**

All of the midwifery services address current mental health issues during pregnancy and the early postpartum period.

**Women at high risk of a recurrence of a serious psychiatric disorder**

All 6 midwifery services appear to have an approach to identification of women at high risk of a recurrence of serious psychiatric disorder. Although approaches are not identical, they all undertake a risk assessment at the booking stage. 1 service repeats this risk assessment at the 2nd and 3rd trimester. Another service uses the Whooley screening questions as the basis of their risk assessment. All services refer on to specialised care where appropriate. Specialised care takes a variety of different forms and includes: high risk ante natal clinic, consultant obstetrician with a lead in mental health.

**Dealing with the normal emotional changes of pregnancy and the early postpartum period**

5 services confirmed that midwives are equipped with the knowledge and skills to deal with the normal emotional changes of pregnancy and the early postpartum period and common states of distress through ongoing training. Training is delivered in a number of formats including annual/mandatory training, basic training with staff being signposted to e-learning modules. One service has a Public Health Midwife who facilitates PNMH
updates at Divisional training and is accessible to support and advise midwifery staff as necessary. One service has no specialist training in respect of this.

**Clinical Supervision for specialist PNMH Midwife**

2 services indicated that they have a specialist PNMH midwife and only one of these services provides clinical supervision via a Perinatal Clinical Psychologist.

**Access to a Specialist Perinatal MH Team**

4 midwifery services confirmed that they have access to a specialist PNMH team with a designated Perinatal 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, for example needle phobias, previous rape or abuse. 2 services do not have access to a Specialist Perinatal MH Team.

**7.5 Findings from Health Visitors**

Information was gathered from 7 Health Visiting Services, by means of a face to face discussion and completion of an electronic questionnaire.

The questions asked are attached as appendix 6 and were selected because they represented what a good health visiting service should have in place in respect of Perinatal mental health.

**Universal Plus Service**

All services deliver to the Universal Plus level for all mothers and their families in need.

**Family Nurse Partnership Service (FNP)**

The FNP is a voluntary home visiting programme for first time young mums, aged 19 years or under. A specially trained family nurse visits the young mum regularly, from the early stages of pregnancy until their child is two. The aims of the service are to enable young mums to: have a healthy pregnancy; improve their child’s health and development; plan their futures & achieve their own aspirations.

5 of the services do not deliver the FNP. The service was decommissioned in 3 of these areas as it was not achieving the expected outcomes.

2 services still deliver the FNP.

**Education, training and skills**

All services provide the education, training and skills to their Health Visitors to enable them to detect and support parents with mental health problems in pregnancy and the postpartum period and identify and support problems arising within the parent-infant relationship.

3 services provide training in PNMH and Infant MH. 1 of these services specified that new starters attend a 2 day training course and other Health Visitors receive 3 half day
refresher training. This service also has PNMH champions who offer support and training to other Health Visitors in relation to PNMH.

3 services provide their Health Visitors with Newborn Behavioural Observations (NBO) training. Of these services, one said that not all of their Health Visitors are trained in NBO, but that it would be beneficial if they all were.

2 of the services were aware of the 3 Health Education England perinatal mental health e-learning modules developed by the Institute of Health Visiting. 3 of the services were not familiar with this training.

Referral into Other Services

All services know which other services they can refer into if they are working with a parent with PNMH. 3 services identified their local PNMH service to refer into and also said that they could refer directly into their IAPT services. One of these services has an IAPT service that works into their Antenatal Clinic. These services said that they would not normally refer directly to an MBU or Adult Psychiatric inpatient unit. They would normally refer into their local Crisis Team who would then make the referral. These 3 services knew where their local MBU or Adult Psychiatric inpatient unit was.

Supportive Psychological Treatments

All services provide some supportive psychological treatments to parents. 4 services specified that they provide listening Visits for up to 4 sessions. 1 of these services is planning to roll out the Solihull approach this year. Another of these services advised that if mum had not improved after the 4 listening visits they would make a referral into IAPT or to the GP. Non-directive counselling is also provided by one of these services.

3 services did not specify what supportive psychological treatments they provide.

Additional Visits and Enhanced Support

All services said that their service understands which women would benefit from additional visits and enhanced support. 3 services specified how this would be done. 1 service uses the Whooley questions, another undertakes routine screening at 6 weeks and uses the Edinburgh Postnatal Depression Scale (EBDS) and another would identify needs at the initial assessment.

Clinical Supervision for Specialist Health Visitors

5 services do not have a specialist Health Visitor. 1 of these services provides clinical and Solihull supervision for all its Health Visitors, but the other 3 do not provide clinical supervision.

1 service advised that their Health Visitors have a monthly supervision session with a therapist from CYPS (Children and Young People’s Services).

Understanding the needs of partners/carers

All services say that they understand the needs of partners/carers and Health Visitors would address any concerns in respect of their coping mechanisms/ needs.
1 service has just started delivering a 'Pregnancy, Birth and Beyond' course which they hope will explore dad's/partner's feelings at the postnatal stage.

Another service would discuss with the GP due to partnership working.

One service advised that their Health Visitors have an understanding and that interventions would vary depending on the Health Visitor. Some are better at identifying needs than others. Dads/partners are not always around when the Health Visitor visits. If it was identified that dad/partner needed support an EBDS would be completed for them too.

A fourth service identifies dads/partners and refers them to their GP. They sometimes get listening visits too.

7.6 North East and Cumbria Gap Analysis of Tier 3 by CCG

Not dissimilar to the national picture, there are large gaps in specialist perinatal mental health care across the North East & Cumbria for women with serious mental illness that cannot be managed safely or effectively in Primary Care.

<table>
<thead>
<tr>
<th>CCG</th>
<th>Specialist Perinatal Community Mental Health Service</th>
<th>Parent – Infant Mental Health Service*</th>
<th>Adult Mental Health and CAMHS</th>
<th>Clinical Perinatal Psychology linked to Maternity Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumbria</td>
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<td>R</td>
</tr>
<tr>
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<tr>
<td>North Tyneside</td>
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<tr>
<td>Northumberland</td>
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<td>South Tees</td>
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<td>Hartlepool &amp; Stockton on Tees</td>
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<td>Sunderland</td>
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**Level Colour Criteria**

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<tr>
<th>Colour</th>
<th>Description</th>
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<tbody>
<tr>
<td>G</td>
<td>Concordant with national guidelines and standards for perinatal mental health</td>
</tr>
<tr>
<td>A</td>
<td>Some provision but does not meet national guidelines, recommendations or standards for perinatal mental health</td>
</tr>
<tr>
<td>R</td>
<td>None commissioned</td>
</tr>
</tbody>
</table>
*At present there are no national service standards for PIMHS. Evidence of local provision was benchmarked against good practice recommendations from The Royal College of Psychiatrists (2015) Perinatal Mental Health Services CR197.

### 7.7 North East and Cumbria Gap Analysis of Tier 2 by CCG

Although data availability varied, gaps were found in the specialist skills and capacity within Universal services to detect and support women with mild to moderate mental health needs during the perinatal period.

<table>
<thead>
<tr>
<th>CCG</th>
<th>Specialist Perinatal Mental Health Midwife in Maternity service</th>
<th>IAPT service with additional training in perinatal mental health</th>
<th>Specialist skills and capacity within Health Visiting Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumbria</td>
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<td>None commissioned</td>
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</tbody>
</table>
8. Findings and Conclusion

While there are pockets of good practice, no CCG in the North East and Cumbria meets all of the good practice recommendations for PNMH across the whole pathway of care.

There is evidence that some services are developing innovative/good practice.

The picture in the North East and Cumbria is probably reflective of that across England.

Practitioners are not always aware of PNMH Services available in their area.

The standard of services across the region is very variable.

Services for fathers and wider family members are a rarity.

Training and development of staff in PNMH is ad hoc across the region within IAPT, specialist and universal services.

The process of writing this report has resulted in engagement with providers of PNMH Services, which has started to highlight some examples of really good practice and also what people do not know. In most cases services are now aware of what they do not know and want to fill the gap in their knowledge and skills. It is therefore a good time to begin the process of service transformation.

A regional strategy to improve outcomes for mothers, fathers and families in the perinatal period, based on the recommendations in this report, is required. The Perinatal Mental Health Clinical Network is best placed to develop and oversee the implementation of the strategy, building on the engagement process that has already begun by sharing good practice. Any actions agreed by the Perinatal Mental Health Clinical Network that involve or impact on IAPT services will need to be fed into the IAPT Clinical Network.

The strategy will require the support of each CCG, LA/Public Health commissioner and NHS England, and will need to be addressed in the service specifications of each service involved in providing PNMH services.
Appendix 1 - North East and Cumbria–Perinatal Mental Health Pathway

A North East and Cumbria Pathway in accordance with NICE Guidance

PERINATAL MENTAL HEALTH_PATHWAY.
Appendix 2 - RCGP - NICE Guideline CG192 Antenatal and Postnatal Mental Health
Appendix 3 - Good IAPT Perinatal Mental Health Services

Good perinatal mental health services will use an integrated care pathway of specialist and universal services drawn up and agreed by all stakeholders to ensure the timely access for women and their families to the most appropriate treatment and service for their condition.

Tier 4 – High Specialised In-Patient Units

Mother and Baby Units (MBU)

All women requiring admission to a mental health unit in late pregnancy or after delivery should be admitted with their infant to a specialised mother and baby unit, unless there are compelling reasons not to do so.

A good MBU is accredited by the Royal College of Psychiatrists’ CCQI and meets their standards\textsuperscript{15}. 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 postpartum months
- provide expert psychiatric care for seriously ill women while at the same time admitting their infants, avoiding unnecessary separation of mother and infant
- be closely integrated with specialised community mental health teams to promote early discharge and seamless continuity of care.

Tier 3 – Specialist Community Services for Complex Needs

Specialist Perinatal Community Mental Health Teams (CMHTs)

A good specialised perinatal CMHT will be a member of the CCQI Quality Network for Perinatal Mental Health Services. It will assess and manage women with serious mental illness or complex disorders in the community who cannot be appropriately treated by primary care services. The team will:

- have close working links with a designated mother and baby unit
- 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 health visiting and in adult mental health services with women with prior or long-standing mental health problems and case manage them if it is in the woman’s best interests
- offer pre-conception counselling to women who are well but at high risk of a postpartum condition and those with pre-existing mental health problems.

The Royal College of Psychiatrists\textsuperscript{16} recommend every Mental Health Trust should establish a Specialist Perinatal CMHT and make the following specialist staffing resource requirements for every 10,000 deliveries:

\textsuperscript{15} Royal College of Psychiatrists: Service Standards 2\textsuperscript{nd} Ed. Perinatal Community Mental Health Services 2014

\textsuperscript{16} The Royal College of Psychiatrists: Perinatal Mental Health Services CR197, 2015
Recent guidance from the British Psychological Society\(^\text{17}\) recommend increased staffing levels for Clinical Psychology to be higher than this in the context of NICE guidance on women’s need to access psychological therapies in the perinatal period.

With 33,189 (see table 1 above) births per year across the North East and Cumbria it would require 3 times the number of posts above to provide the recommended service.

**Parent-Infant Mental Health Service (PIMHS)**

Services with a parenting focus should aim to improve maternal and infant mental health; their relationship quality and emotional, social and cognitive development of the child. They can offer additional expertise to other services that care for parents of young children.

A good PIMHS\(^\text{18}\) will be delivered by a qualified provider of psychological assessment and therapeutic care for mothers and their partners with a wide range of vulnerabilities including complex perinatal mental health problems who have or are at risk of parenting difficulties.

A good PIMHS should:

- provide a variety of psychotherapeutic, psychological and psychosocial treatments and parenting interventions.
- be able to see mothers, partners and their infants at home, children’s centres as well as in health centres.
- work collaboratively with specialised perinatal CMHTs and mother and baby units, adult psychiatric services, midwifery, health visiting and children’s Social Services.
- provide advice and training to enhance the skills of a range of professionals providing psychological care such as IAPT workers, midwives and health visitors.

**Adult Mental Health and CAMHS Services**

Good secondary mental health services 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.

\(^\text{17}\) British Psychological Society: Briefing Paper Number 8: Perinatal Service Provision: The Role of Perinatal Clinical Psychology - Guidance for Commissioners 2016

\(^\text{18}\) The Royal College of Psychiatrists: Perinatal Mental Health Services CR197, 2015
New episodes of psychiatric disorder in late pregnancy and the early postpartum period should, wherever possible, be redirected to specialised perinatal psychiatric services.

If a woman is already under their care because of a long-standing serious mental health problem becomes pregnant, they should work collaboratively with the maternity services to develop a peri-partum management plan and, wherever possible, seek advice and support from a specialised perinatal CMHT.

Should admission be necessary, the mother and her infant should be admitted to a mother and baby unit even if this means an out-of-area placement. However, many women do choose to receive care locally either in the community or general inpatient settings in which case care needs to be managed in liaison with the specialist CMHT. The service demonstrates that they consider their patients as parents and consider the welfare of the children. Again the involvement of fathers and family members is desirable in terms of recovery. During admission added stress to family relationships can create barriers to recovery and impact on long term relationships between the father and baby. The NTW Trust BMU provides facilities for fathers to stay overnight (on an occasional basis) and has flexible visiting hours.

**Perinatal Clinical Psychology linked to Maternity Services**

The British Psychological Society 19 (BPS) recommends Clinical Psychology provision in the context of the NICE guidance on women’s needs to access psychological therapies during the perinatal period.

Perinatal clinical psychology staffing levels will depend on the scale and distribution of maternity services in the area and the configuration of related medical and mental health services.

The BPS recommends that a maternity hospital with 3000 deliveries per annum should have access to a minimum 0.6 WTE Consultant Perinatal Clinical Psychologist (minimum Band 8c) and one whole-time Specialist Clinical Perinatal Psychologist (Band 8a) to support the maternity service. This is in addition to the Royal College of Psychiatrists recommendations regarding a Specialist Perinatal CMHT mentioned earlier.

Where Neonatal Intensive Care / Special Care Baby Unit is also supported this would require a further half-time Specialist Clinical Perinatal Psychologist (Band 8a).

The service will require an additional band 8a Clinical Perinatal Psychologist per additional 3000 women (for example, a 0.6wte 8c Consultant and two band 8a Clinical Psychologists in a hospital with 6000 deliveries per year).

**Tier 2 – Universal Services with Specialist Skills for Mild to Moderate needs**

**Maternity Services**

A good maternity service:

- should commit appropriate resources for a Specialist Perinatal Mental Health Midwife20

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• communicates with the patient’s GP, asking for information about any mental health problems and alerting them if difficulties arise

• should have access to a designated Perinatal 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, for example needle phobias, previous rape or abuse.

• ensures that women at high risk of a recurrence of serious psychiatric disorder are identified at early pregnancy assessment and referred for specialised care

• ensures that women are asked about current mental health problems during pregnancy and the early postpartum period

• equips midwives with the knowledge and skills to deal with the normal emotional changes of pregnancy and the early postpartum period and common states of distress

• should 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.

Health Visiting

Health visitors play a crucial role in ensuring children have the best possible start in life, and lead delivery of the 0-5 year elements of the national Healthy Child Programme and Family Nurse Partnership (FNP) programme (where available). Both programmes aim to enable mums to reach their full potential and prevent the use of costly interventions later down the line, such as children going into care.

On 1 October 2015, the responsibility for commissioning public health services for children aged 0-5 transferred from NHS England to local authorities.

A good Health Visitor service should:

• deliver service at the Universal Plus level for all mothers and their families in need

• deliver Family Nurse Partnership service for first time vulnerable mums aged 19 years and under

• have the education, training and skills to detect and support parents with mental health problems in pregnancy and the postpartum period and identify and support problems arising within the parent-infant relationship. This may include training in interventions developed to enhance parents understanding of their baby’s communications e.g. Brazelton Newborn Observation Scale and Neonatal Behavioural Assessment Scale.

• know who to refer and to which service using the integrated care pathway

• be able to undertake supportive psychological treatments such as listening visits, non-directive counselling, cognitive counselling and group-based support.

• understand which women would benefit from additional visits and enhanced support.

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21 Department of Health’s Overview 1: National Health Visiting Programme, 2015
22 http://www.fnp.nhs.uk
Those specialist health visitors undertaking psychological interventions with vulnerable mothers and babies will require clinical supervision from an appropriately trained person.

**Improving Access to Psychological Therapies (IAPT)**

A good IAPT service should:

- ensure that pregnant and postpartum women are ‘fast tracked’, assessed and starting treatment within 4 weeks
- receive additional perinatal training to ensure that they understand the maternity context, impact on fathers/partners and the additional clinical features and risk factors associated with perinatal mental health problems
- be able to refer to specialist perinatal mental health services in cases of concern or higher complexity
- record data on whether the client is pregnant or in the first year post-partum.

**Voluntary Sector**

Psychological assessment and therapeutic services for vulnerable mothers and fathers with mild to moderate mental health needs and their babies are also provided by voluntary sector organisations i.e. Charities and Social Enterprises hosting qualified practitioners of Clinical Psychology and/or Psychotherapy who can provide professional supervision, training and consultation.

A strength of the voluntary sector is their ability to offer specialist support early within accessible venues that women and their partners feel comfortable to attend with their babies, such as Children’s Centres.

Local examples of good service provision from the voluntary sector impacting perinatal mental health and economic outcomes are:

**Bump to Baby course provided by Hartlepool Mind.**

**Raindrops to Rainbows**, based in Teesside, provide support groups to mums and mums-to-be, but also supports their partners & family members too.

**Happy Mums**, based in Carlisle, offer a range of support to prevent and reduce the impact of maternal mental health problems and also offer classes, activities and information to all women through pregnancy, birth, motherhood and beyond.

**The National Childbirth Trust** has a number of branches across the North East and Cumbria offering a range of courses and support to women in the antenatal and postnatal periods.

Although **SANDS (Stillbirth and Neonatal Death Charity)** is a national organisation they have local support groups in Newcastle, Durham, Teesside and East Cumbria.

**Blyth STAR Enterprises** in Northumberland runs a Tots and Tums group which supports families experiencing pre and postnatal depression, anxiety and isolation.

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IAPT: Perinatal Positive Practice Guide 2013
**Tier 1 – Signposting and Social Support**

**General Practitioners and Extended Primary Care Teams**

All GPs and primary care teams should refer to the recently developed implementation tool written by the Royal College of General Practitioners in collaboration with the Maternal Mental Health Alliance titled ‘Practical implications for primary care of the NICE guideline CG192’ (2015). (See Appendix 2)

All good GPs and their extended Primary Care teams should:

- ensure that women with serious mental illness receive pre-conception counselling and are aware of the risks to their mental health of becoming pregnant
- take into account the possible adverse effects of psychotropic medication in pregnancy, when prescribing to women of reproductive potential, or who are breastfeeding and provide them with this information
- ensure that women are asked about current mental health problems during pregnancy and the early postpartum period in line with NICE guidelines
- communicate with midwives 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.

**Self-Help and Social Support**

Many voluntary sector organisations such as the Happy Mums and Raindrops to Rainbows provide self-help and social support services for women and their partner’s/families during the perinatal period. It is not just women themselves who can benefit from self-help information and social support. Such support is also useful for partners, carers and other family members.

Social support can lower the risk of mental illness, reduce symptoms, and improve the quality of life of people affected.25

Typically provided in accessible venues without the stigma of a professional healthcare setting, voluntary sector services can be beneficial for most women with a perinatal mental illness, and, in conjunction with specialist services, can help to aid recovery close to a woman’s home.

**Education and Training**

The North east and Cumbria health and social care workforce should be supported by mandatory perinatal mental health training for frontline staff to ensure:

- knowledge of Perinatal Mental Health Pathways
- early identification of those at high risk
- early diagnosis

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25 Hendryx et al. Social support, activities, and recovery from serious mental illness: STARS study findings 2009
• an understanding of the maternity context
• an understanding of the potential impact on father’s/partner’s mental health
• the identification of additional clinical features and risk factors associated with perinatal disorders
• the developmental needs of infants are met.

Below are examples of perinatal mental health training provision currently offered in The North east and Cumbria:

Midwives in Newcastle are provided with annual refresher training and PNMH is included in the Northumbria University Nurse training syllabus.

Health Education England offers 3 perinatal mental health e-learning modules developed by the Institute of Health Visiting, funded by the Department of Health looking at:

**Module One** – Perinatal depression and other maternal mental health disorders

**Module Two** – How to recognise perinatal anxiety and depression

**Module Three** – Interventions for perinatal anxiety, depression and related disorders

For more information, please visit [www.e-lfh.org.uk/programmes/perinatal-mental-health](http://www.e-lfh.org.uk/programmes/perinatal-mental-health)

NTW provides other adhoc training.

**Data and Outcome Measures**

An important barrier to good perinatal mental health care is the lack of appropriate data sharing to enable organisations to identify risk, anticipate problems and plan care in a holistic fashion.

People with poor mental health may require primary care, secondary physical care and social care, as well as mental health services, but the lack of linked datasets hinders effective provision.

Good perinatal mental health services should systematically gather data on the mothers and their partners/families they see in such a way that clinicians have access to that information; understand how they perform so that outcomes can be measured.

NTW Foundation Trust MBU is using HONOS and the RCPsych POEM but need to become more routine.

**Quality indicators**

Quality indicators are those indices that are likely to reflect access and the quality of clinical care for pregnant women and women with small children.

The Northern Perinatal Mental Health Network suggests the following indicators be considered:

• That there is a comprehensive perinatal mental health care pathway in place
• That providers have a process in place to ensure that women in the perinatal period are prioritised for care.

• That providers have processes in place to ensure that women are seen by the right service at the right time (avoidance of multiple assessments and referrals on).

• That there is access to pre-conceptual counselling for women with a history of severe mental illness.

• That there are direct admissions to a mother and baby unit as opposed to initial adult acute ward.

• That Perinatal Community and Inpatient services are reviewed by the Royal College of Psychiatrists CCQI.

• All women can access appropriate, high-quality specialist mental health care, closer to home, when they need it during the perinatal period.

• Women and their families have a positive experience of care, with services joined up around them.

• There is earlier diagnosis and intervention, and women are supported to recover and fewer women and their infants suffer avoidable harm.

• There is more awareness, openness and transparency around perinatal mental health in order that partners, families, employers and the public can support women with perinatal mental health conditions.

Clinical outcome measures

Clinical outcomes are those that are likely to measure the outcome of a patient or client’s treatment or support.

• There is currently a working group at the Royal College of Psychiatrists Perinatal Faculty writing a report making recommendations on outcome measure to be used. This work is being done in liaison with NHS England. The following measures may be considered: Quantitative measure of improvement e.g. HONOS, CORE.

• Measures of improvement in the quality of parent-infant relationship

• Patient-rated outcome measures e.g. RCPsych POEM.

• Women and their families have a positive experience of care, with services joined up around them.
## APPENDIX 4 – National IAPT Indicators

### Waiting Times as at 30/11/2016

<table>
<thead>
<tr>
<th>CCG</th>
<th>Provider</th>
<th>First Treatment Completed in the Period</th>
<th>Waiting Time Standards</th>
<th>People Entering Therapy</th>
</tr>
</thead>
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<td>First Treatment within 6 Weeks</td>
<td>First Treatment within 18 Weeks</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total</td>
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<tr>
<td>01H</td>
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<td>590</td>
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<td>150</td>
<td>150</td>
</tr>
<tr>
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<td>180</td>
<td>200</td>
</tr>
<tr>
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<td>RX801 DDES</td>
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<td>90</td>
<td>95</td>
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<td>NDC06 HAST INSIGHT HEALTHCARE - AQP-PRIMARY CARE PSYCHOLOGICAL THERAPIES (TEES)</td>
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<td>50</td>
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<td>NFL HAST Hartlepool And East Durham Mind</td>
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<td>325</td>
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<td>00P</td>
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<td>13T</td>
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<tr>
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<td>RX4 Sunderland</td>
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<tr>
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North East & Cumbria Perinatal Mental Health Scoping Report 2017 V3.0
Recovery Rates as at 30/11/2016

<table>
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<tr>
<th>CCG</th>
<th>Provider</th>
<th>Apr-16</th>
<th>May-16</th>
<th>Jun-16</th>
<th>Jul-16</th>
<th>Aug-16</th>
<th>Sep-16</th>
<th>Oct-16</th>
<th>Nov-16</th>
<th>YTD</th>
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</thead>
<tbody>
<tr>
<td>NHS CUMBRIA CCG</td>
<td>All Providers</td>
<td>58.02%</td>
<td>59.52%</td>
<td>57.84%</td>
<td>52.87%</td>
<td>55.17%</td>
<td>50.00%</td>
<td>55.43%</td>
<td>58.33%</td>
<td>55.88%</td>
</tr>
<tr>
<td>NHS DARLINGTON CCG</td>
<td>All Providers</td>
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<td>47.37%</td>
<td>54.17%</td>
<td>44.44%</td>
<td>42.31%</td>
<td>40.74%</td>
<td>41.67%</td>
<td>45.83%</td>
<td>45.45%</td>
</tr>
<tr>
<td>NHS DURHAM DALES, EASINGTON AND SEDGEFIELD CCG</td>
<td>All Providers</td>
<td>51.35%</td>
<td>43.90%</td>
<td>41.86%</td>
<td>47.50%</td>
<td>45.45%</td>
<td>42.55%</td>
<td>42.86%</td>
<td>35.21%</td>
<td>43.01%</td>
</tr>
<tr>
<td>NHS HARTLEPOOL AND STOCKTON-ON-Tees CCG</td>
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<td>52.22%</td>
<td>49.49%</td>
<td>48.54%</td>
<td>48.00%</td>
<td>48.85%</td>
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<td>50.88%</td>
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<td>46.30%</td>
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<tr>
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<td>41.18%</td>
<td>47.54%</td>
<td>42.25%</td>
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<tr>
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<td>49.28%</td>
<td>53.57%</td>
<td>52.44%</td>
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</tr>
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<td>48.78%</td>
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<td>51.52%</td>
<td>50.88%</td>
<td>51.37%</td>
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<tr>
<td>NHS SUNDERLAND CCG</td>
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<td>52.63%</td>
<td>54.00%</td>
<td>54.55%</td>
<td>52.17%</td>
<td>50.00%</td>
<td>50.00%</td>
<td>51.38%</td>
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</table>
## Appendix 5 – Midwife Questionnaire

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have a Specialist Mental Health Midwife who links with a</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Specialist Perinatal CMHT, GPs and IAPT services?</td>
<td></td>
</tr>
<tr>
<td>Is there training for all Midwives to detect at-risk women during</td>
<td>Yes/No</td>
</tr>
<tr>
<td>pregnancy?</td>
<td></td>
</tr>
<tr>
<td>Are women asked about current mental health problems during pregnancy</td>
<td>Yes/No</td>
</tr>
<tr>
<td>and the early postpartum period?</td>
<td></td>
</tr>
<tr>
<td>How do you ensure that women at high risk of a recurrence of</td>
<td></td>
</tr>
<tr>
<td>serious psychiatric disorder are identified at early pregnancy</td>
<td></td>
</tr>
<tr>
<td>assessment and referred for specialised care?</td>
<td></td>
</tr>
<tr>
<td>How do you ensure midwives are equipped with the knowledge and skills</td>
<td></td>
</tr>
<tr>
<td>to deal with the normal emotional changes of pregnancy and the early</td>
<td></td>
</tr>
<tr>
<td>postpartum period and common states of distress?</td>
<td></td>
</tr>
<tr>
<td>If you have a Specialist Mental Health Midwife providing Tier 2</td>
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</tr>
<tr>
<td>psychological interventions, do they receive clinical supervision</td>
<td></td>
</tr>
<tr>
<td>from a Perinatal Clinical Psychologist?</td>
<td></td>
</tr>
<tr>
<td>Do you have access to a designated Perinatal Clinical Psychologist to</td>
<td>Yes/No</td>
</tr>
<tr>
<td>advise and treat, if necessary, women with psychological</td>
<td></td>
</tr>
<tr>
<td>distress particularly relating to obstetric loss, post-traumatic stress</td>
<td></td>
</tr>
<tr>
<td>disorder and other obstetrically relevant conditions, for example</td>
<td></td>
</tr>
<tr>
<td>needle phobias, previous rape or abuse?</td>
<td></td>
</tr>
<tr>
<td>Do you have access to a designated specialised perinatal mental</td>
<td>Yes/No</td>
</tr>
<tr>
<td>health team able to provide collaborative working with women at</td>
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</tr>
<tr>
<td>high risk of serious mental illness and emergency assessments?</td>
<td></td>
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</table>
## Appendix 6 – Health Visitor Questionnaire

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<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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</thead>
<tbody>
<tr>
<td>Does your Health Visiting Service deliver service at the Universal Plus level for all mothers and their families in need?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Does your Health Visiting Service deliver the Family Nurse Partnership service for first time vulnerable mums aged 19 years and under?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Does your Health Visiting Service have the education, training and skills to detect and support parents with mental health problems in pregnancy and the postpartum period and identify and support problems arising within the parent-infant relationship? This may include training in interventions developed to enhance parents’ understanding of their baby’s communications e.g. Brazelton Newborn Observation Scale and Neonatal Behavioural Assessment Scale.</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Does your Health Visiting Service know who to refer to and to which service?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Is your Health Visiting Service able to undertake supportive psychological treatments such as listening visits, non-directive counselling, cognitive counselling and group-based support?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Does your Health Visiting Service understand which women would benefit from additional visits and enhanced support?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Do your specialist Health Visitors who undertake psychological interventions with vulnerable mothers and babies receive clinical supervision from an appropriately trained person?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Does your Health Visiting Service understand the needs of partners/carers and would any concerns in respect of their coping mechanisms/ needs be addressed by health visitors? i.e. referral to IAPT service</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Health Education England offers 3 perinatal mental health e-learning modules developed by the Institute of Health Visiting, funded by the Department of Health. Are you aware of this training and do you use it?</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>
Appendix 7 - Contributors to this Report

Dr Andrew Cairns - Consultant Perinatal Psychiatrist, NTW NHS FT & Clinical Lead for Perinatal MH, Northern England Clinical Networks

Rachel Tomlin - Network Delivery Lead (Maternity), Northern England Clinical Networks, NHS England

Angela Kennedy - Consultant Psychologist, Tees, Esk and Wear Valleys NHS Trust

Katherine Rutherford - Chief Executive, The Happy Mums Foundation

Members of the Institute of Health Visitors for the North East and Cumbria

Heads of Midwifery for the North East and Cumbria

The following IAPT Services for the North East & Cumbria:

Sunderland Psychological Wellbeing Service

Talking Changes

South Tyneside Lifecycle Service

Gateshead Talking Therapies

Talking Helps Newcastle

Alliance Psychological Services

Open Minds Therapies (Middlesbrough and Stockton Mind)

In Mind - Hartlepool & East Durham Mind

North Tyneside Talking Therapies

Talking Matters Northumberland