A SCOTTISH NATIONAL MANAGED CLINICAL NETWORK FOR PERINATAL MENTAL HEALTH

Overview

Mental health problems occurring during pregnancy, and in the first postnatal year, are common and result in significant disability for the woman, her infant and family (SIGN, 2012).

Currently, services in Scotland do not meet the needs of women at risk of, or experiencing, maternal mental illness in an equitable and comprehensive way (Galloway et al, 2015).

While severe illness is relatively rare, its onset is usually rapid and requires urgent intervention. It is a leading causes of maternal death in the UK (Cantwell et al, 2015).

Harm related to all perinatal mental illness is not limited to the woman herself. There is evidence of increased illness in partners, and of adverse effects on child development (Marryat et al, 2010). This has long-term consequences for children growing up and results in significantly greater costs for health, education, criminal justice, and social care provision. The cost of untreated perinatal mental illness is substantial, calculated at £8.1 billion/year, for the UK (Bauer et al, 2014).

If detected, perinatal mental health problems respond well to treatment. Furthermore, a significant proportion of women at risk of the most severe disorders (which usually require hospital admission), have identifiable risk factors, and interventions to prevent the onset of illness are effective (SIGN, 2012; NICE, 2014). In turn this helps ensure the best start in life for infants, improving their outcomes as well.

Women in around half the UK have NO access to specialist perinatal mental health services

The need for specialised service provision is well-evidenced but significant gaps remain in Scotland-wide provision, resulting in a ‘postcode lottery’ of access to appropriate services (Galloway et al, 2015).

Other UK nations have committed specific monies to develop services in 2015/6-2020. England has identified £290 million over 5 years to develop MBUs in areas of need, nationwide specialised community perinatal mental health teams, and perinatal clinical networks in every region (UK Government, 2016). Wales has identified £1.5 million to develop specialised community perinatal mental health teams and a practice network (Welsh Government, 2015).

Why develop a national managed clinical network?

- To co-ordinate, and ensure equitable access to, mental health provision for pregnant and postnatal women across all tiers of delivery.
- To reduce the need for tertiary and inpatient specialist care.
- To ensure best mental health outcomes through effective service delivery and enhanced professional expertise.
- To maximise early years health and development for infants and children growing up.

R Cantwell, Apr 2016
Extent of the problem

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number of women affected in Scotland per year**</th>
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<tbody>
<tr>
<td>Antenatal/postnatal depression and anxiety*</td>
<td>5,600-8,400</td>
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<tr>
<td>Postpartum psychoses</td>
<td>112</td>
</tr>
<tr>
<td>Numbers requiring specialised community care</td>
<td>1,680-2,800</td>
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<tr>
<td>Numbers requiring specialised inpatient care</td>
<td>112-168</td>
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</tbody>
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* Includes other conditions requiring specialised management in pregnancy/postpartum e.g., eating disorders, personality disorder; ** Based on 56,014 total births (2013)

Recommended service provision

Inpatient Mother and Baby Unit (MBU) care
- All women should have the opportunity to be admitted to suitable hospital facilities, accompanied by their babies, where they require inpatient mental health care (SIGN, 2012; NICE, 2014; MH(C&T)(S) Act, 2003).

Community specialised perinatal mental health care
- All women at risk of, or experiencing, significant mental illness in relation to pregnancy or childbirth should be assessed and managed by specialised perinatal mental health services (SIGN, 2012; NICE, 2014). Community specialised perinatal mental health services should include, or work in close liaison with, specialised CAMHS-IMH services.

Current provision in Scotland

<table>
<thead>
<tr>
<th>Service type</th>
<th>Service provision</th>
<th>Comprehensiveness of cover</th>
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<tbody>
<tr>
<td>Specialised inpatient units (MBU)</td>
<td>2 six-bed regional units</td>
<td>Formal access arrangements in place for all but 2 NHS boards</td>
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<tr>
<td>Specialised community perinatal mental health teams</td>
<td>Full provision</td>
<td>1 NHS board</td>
</tr>
<tr>
<td></td>
<td>Partial provision</td>
<td>4 NHS boards</td>
</tr>
<tr>
<td></td>
<td>No provision</td>
<td>9 NHS boards</td>
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Current gaps in service provision
- Possible shorfall of 4 beds nationally based on estimate of need.
- Significant deficits in community specialist provision across almost all health boards.
- Limited models for delivering effective care in remote and rural areas.

Current challenges in providing effective care
- Systems for the prevention, early detection and management of perinatal mental illness need to cross all tiers of service delivery, including primary care (general practice, health visiting), maternity (midwifery, obstetrics), secondary care mental health (general adult,
child, infant mental health, addictions), social care (adult mental health, children & families) and specialised perinatal mental health services (MBUs, perinatal community mental health teams).

- Screening for perinatal mental illness varies widely across Scotland. This may result in illness remaining untreated in primary care, requiring secondary or tertiary care at a later stage.
- Opportunities for preventative work (that is, anticipatory care), which can reduce requirements for inpatient treatment, are missed.
- Inpatient MBUs, delivering multi-professional, highly skilled care, need to be provided on a regional basis, and the small number of beds required makes it sensible that bed usage is co-ordinated at national level.

The evidence base

There is an extensive evidence base for the models of effective intervention and service organisation based on the known epidemiology of maternal mental disorder, adverse effects of lack of treatment, and existing models of care. Evidence-based recommendations, which are almost uniformly in agreement include:

<table>
<thead>
<tr>
<th>Scotland</th>
<th>Title</th>
<th>Source</th>
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<tbody>
<tr>
<td>*Guideline 127: Perinatal Mood Disorders</td>
<td>SIGN, 2012</td>
<td></td>
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<tr>
<td>*Getting it Right for Mothers and Babies: Closing the Gaps in Community Perinatal Mental Health Services</td>
<td>NSPCC Scotland, 2015</td>
<td></td>
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<tr>
<td>UK</td>
<td>*Clinical Guideline 192: Antenatal and Postnatal Mental Health</td>
<td>NICE, 2014</td>
</tr>
<tr>
<td>*Guidance for Commissioners of Perinatal Mental Health Services</td>
<td>Joint Commissioning Panel for Mental Health, 2012</td>
<td></td>
</tr>
<tr>
<td>*Saving Lives, Improving Mothers’ Care: Surveillance of maternal deaths in the UK 2011-13 and lessons learned to inform maternity care from the UK and Ireland. Confidential Enquiries into Maternal Deaths and Morbidity 2009-13</td>
<td>National Perinatal Epidemiology Unit, 2015</td>
<td></td>
</tr>
<tr>
<td>The Cost of Perinatal Mental Health Problems</td>
<td>Baeur et al, London School of Economics, 2014</td>
<td></td>
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<tr>
<td>*Perinatal Mental Health Services: Recommendations for provision of services for childbearing women</td>
<td>Royal College of Psychiatrists, 2015</td>
<td></td>
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<tr>
<td>Prevention in Mind. All Babies Count: Spotlight on Perinatal Mental Health</td>
<td>NSPCC, 2013</td>
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*These reports specifically recommend the development of managed clinical networks to optimise the co-ordination and delivery of perinatal mental health services.
The needs of women and families across Scotland who are at risk of, or experience perinatal mental illness are best met through a National Managed Clinical Network

- Different professions, different organisations and different levels of health care provision are involved in treatment.
- Perinatal mental illnesses vary in severity and frequency, the most severe being rare and requiring highly specialised tertiary services, the milder being more common, being managed at secondary care level and with enhanced skills in primary care.
- Different levels of service provision relate to each other in a hub-and-spoke manner but share common standards, management protocols, and integrated care pathways.
- There is an extensive evidence base for effective treatment.
- Treatment is cost effective.
- Anticipatory care (identifying women at high risk) can prevent onset of illness or reduce progression to more severe illness, enabling community rather than hospital care.
- Patients need rapid access to inpatient MBU care when required (almost all admissions are unplanned), requiring co-ordination for efficient use of expensive tertiary resources.

Cost-effectiveness of improved education, awareness and service provision for maternal mental health

- The Centre for Mental Health/London School of Economics’ report on the costs of perinatal mental health problems (Bauer et al, 2014) provides a detailed analysis of the economic implications of untreated mental illness for the woman and for her child. This is contrasted with the cost of improving perinatal mental health provision to recommended standards.
- Costs include those to the public sector (health and social care, education, criminal justice) and to wider society in terms of QALY, productivity and other losses.
- The total cost of untreated maternal mental illness is calculated at £8.1 billion/year for the UK (equivalent to £577 million/year for Scotland).
- In contrast, the additional cost of providing equitable, comprehensive perinatal mental health care is calculated at £283 million/year for England. While there is no equivalent calculation for Scotland, the ability to co-ordinate services at a national level should facilitate reduced pro-rata costs overall.
- The cost to the public service alone of perinatal mental health problems is 5 times the cost of improving services.

Aims of a National Managed Clinical Network for perinatal mental illness

- To collaboratively work with health boards to design and develop equitable, evidence-based services in Scotland.
- To co-ordinate all services addressing the needs of pregnant and postnatal women with pre-existing and new onset mental illness, their babies and families.
- To reduce the need for tertiary and inpatient specialist services through the early use of evidence-based preventative interventions in primary and maternity care, and in specialist community perinatal mental health services.
- To develop common outcome indicators across all services, which ensure evidence-based interventions for the early detection and management of perinatal mental illness at a level of service appropriate to the woman’s needs, through the use of agreed care pathways.
- To optimise early years health and development through the use of evidence-based interventions which promote and facilitate the mother-infant relationship.
- To develop agreed protocols for access to and use of inpatient mother and baby beds, ensuring equitable access to evidence-based specialist care across Scotland.
Objectives for National Managed Clinical Network

**Phase 1**
1. Review current provision across Scotland and establish need for service development / reconfiguration (including specific needs of remote and rural areas)
2. Identify stakeholder groups from service users & carers, health and social care (support in place from national service user group – Maternal Mental Health Scotland Change Agents)
3. Develop core outcome indicators for care and service provision
4. Establish managed knowledge network, with web and social media presence, for staff involved in the care of pregnant/postnatal women with mental illness, and access to information for all childbearing women, their partners and families
5. Establish systems for professional acquisition of competencies and access to peer support

**Phase 2**
1. Review existing, and if required develop, perinatal mental health-specific outcome measures for effective care
2. Extend NMCN to include outcome indicators, measures and service development for women with addictions
3. Support and facilitate the development of local expertise and clinical networks with identified local leads
4. Work with SGHD and NHS Boards to fill identified gaps in services

**Costs**

<table>
<thead>
<tr>
<th>Network establishment</th>
<th>£</th>
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<tbody>
<tr>
<td>NMCN Manager (0.6WTE)</td>
<td>47,649</td>
</tr>
<tr>
<td>NMCN Clinical Lead (0.4WTE)</td>
<td>41,396</td>
</tr>
<tr>
<td>NMCN Nurse Lead (0.2WTE)</td>
<td>11,528</td>
</tr>
<tr>
<td>NMCN Maternity Lead (0.2WTE)</td>
<td>11,528</td>
</tr>
<tr>
<td>Information Manager (0.4WTE)</td>
<td>8,727</td>
</tr>
<tr>
<td>Administrator (0.6WTE)</td>
<td>12,360</td>
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<tr>
<td>Administrative costs/yr (incl. establishment and running of expert advisory/service user &amp; carer groups to develop care standards)</td>
<td>15,000</td>
</tr>
<tr>
<td>Development and maintenance of web-based knowledge network</td>
<td>15,000</td>
</tr>
<tr>
<td>NMCN evaluation and support for local initiatives</td>
<td>10,000</td>
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<tr>
<td>Total costs/year</td>
<td>173,188</td>
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* Additional costs may be required for the NMCN base/hosting board, in terms of structural provision and operational costs.
References


