The Journey

Development of specialist Perinatal Mental Health services

Service Development

To move forward need understanding of :

* Conditions and epidemiology
* Consequences of no services

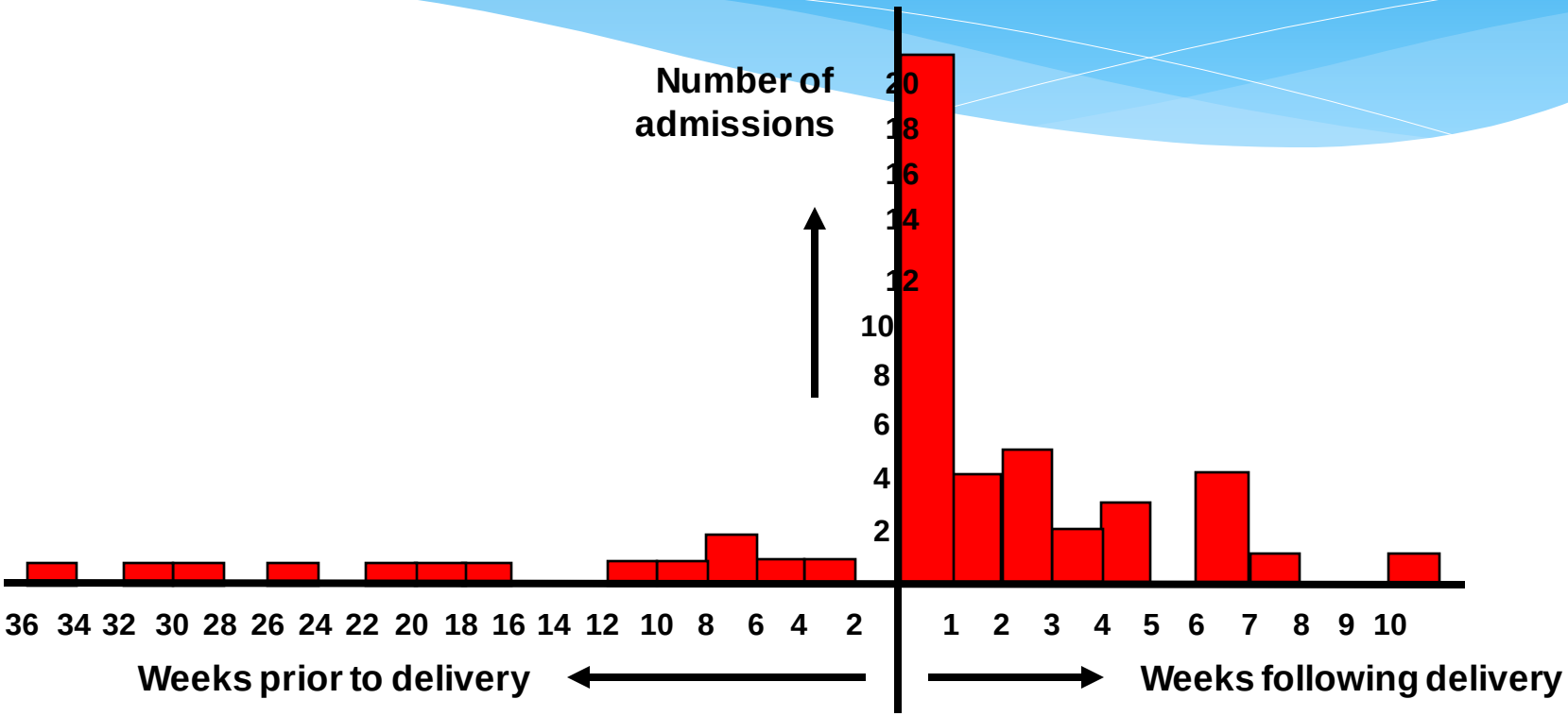
* Growth of speciality
* and specialist services
* context and influences

Conditions and Epidemiology

Centuries to 1960s clinical descriptions , most still true today

* 1970s/80s Kendell, Dean , Paykel , Cox , Brockington , Kumar
* Distinctive clinical features
* Identified & quantified increased rates of occurrence ,recurrence
* Links with Bipolar Illness
* 2000s confirmed by later studies Jones and Scandinavian colleagues and others

Is childbirth associated with increased risk?



Onset of major functional disorders in the puerperium

Kendell et al 1987

Postnatal Depression

1960s/70s B Pitt "atypical depression 10%

K Dalton Postnatal depression

J Cox EPDS

M O'Hara antenatal = postnatal

no significant increase

But others incl Cox and Jones suggest subgroup more severe

PND high public profile

Service development 1940s/80s

* Ad hoc ,depended on personal interest of clinicians
* Some MBUs in mental hospitals
* Most provision side room admissions to general wards and 2 bed annexes
* 1980s gradual closure of mental hospitals
* Early emergence of community care and CPNs
* Many MBUs closed [key clinicians retired or moved away]

Loss of beds

* Some MBUs survived and developed
* 1990s early 8 MBUs
* Admission acute wards stopped
* Remaining 2 bed annexes closed

Fallow years
Why ?

* ? Resistance to specialisation
* ? Belief that part of general psychiatry ,no different
* Childbirth as life event , non specific trigger
* Disappeared from ICD 8 and DSM I
* “‘the power of classification to consign a condition to obscurity “ Brockington
* Despite remaining in all major textbooks
* 20+ years of no growth

Service development 1990s to present day

Role of RCPsych

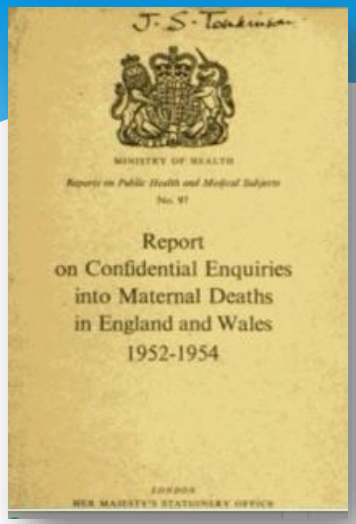
[context Marce society, rise of specialism ,SHAs needs assessments and equity of service provision]

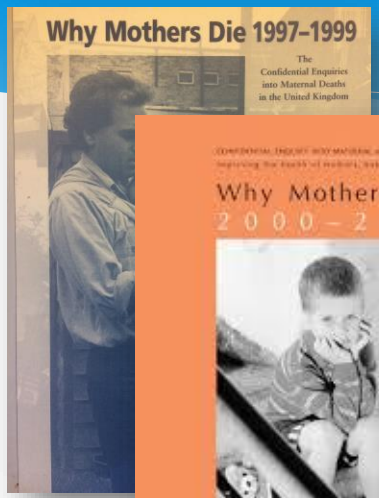
* 1992 General Adult Faculty working group [J COX] recommendations for PN services
* 1994 formation of Special interest group Council report I
* 2000 council report 2 CR 88 . DOH joint strategy

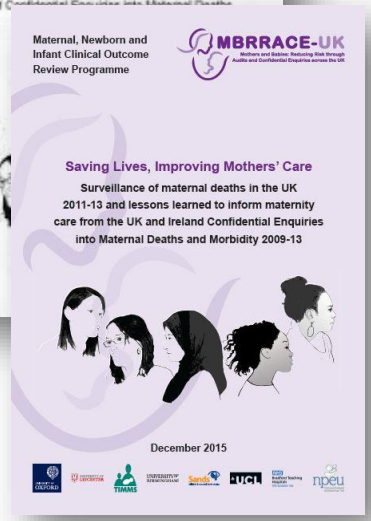
Service development

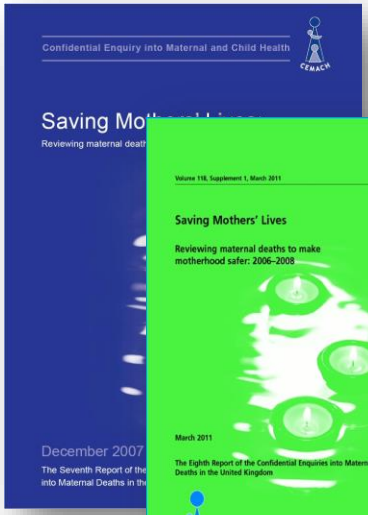
* 2003/4 included MHNSF ,maternity NSF ,Scotland MH act
* 2004 PN section later Faculty
  CCQI PQN MBU standards [response to MDE]
* 2007 accreditation MBUs
  NICE SIGN
* 2017 CR197 [no 3 [
* 2020 no 4 on its way !

Maternal Deaths Enquiries 1994 to present









1990s to present

* [context] NHS ,internal market ,purchaser/provider , trusts and commissioners .SHAs re purposed
* Rise managerialism and centralism
* Competition both opportunity and threat for PN services
* 2007 Specialised Services Commissioning .MBUs included
* Central funding but zero growth

2011 to present

* 2011 “reforms “ NHS Commissioning Board ,Clinical Reference Groups ,National service specs , Strategic Clinical Networks

* 2016 2nd reform NHSE
* PN priority 5yr Plan Funding MMHA influence
* 4 new MBUs /beds increase , Community teams each STP area
* 12 PN clinical networks [not strategic but implementation]
* National clinical directors
* 2019 PN 10yr long term plan
* Expansion of remit beyond “ moderate/severe “
* Funding and implementation 2021

What we have now success

* 4 new MBUs , 23 UK all accredited
* 60+ community teams most PQN members
* Increase women treated
* Increased skill mix and involvement of experts by experience
* Increased attention to needs of infant , fathers and families
* Financial security
* NCD and networks
* Training programme new consultants

New Issues rising demand

* Most previous research on ‘ serious ‘illness based on admissions to hospital
* Most on PND from screening pops with EPDS
* No data on pregnancies at risk with previous illness , on women cared for in general settings , those with long standing illness
* Potential demand never been quantified but is now rising
* Previous estimates for staffing are out of date

Rising demand

* Until the LTP the model was that of Specialised services ie no service creep ,diagnostic boundaries , mod/severe illness
* Concentration of skills and resources to treat relatively rare conditions from large pops
* Now extending to much larger numbers ,mild/sub clinical anxiety and depression , other psychological issues and reproductive health
* No data on prevalence , unclear boundaries
* .Cannot quantify demand

Maintaining excellence reducing risk

* Survival depends on providing better outcomes than “standard “ care
* Not forget our founding principles whilst adapting to change
* Not neglect serious illness in face of increasing demand
* Aim to care for majority from assessment to discharge
* Avoid systems that act as barriers or delays to access or “cherry picking
* Avoid fragmentation and discontinuity of care
* Remember MDE Red Fags

Founding principles

To care for women whose pregnancies and post natal period are complicated by significant mental illness, whether it is new onset or pre existing illness

The care of the infant is a priority