The National Picture: Where are we now and what is your role?

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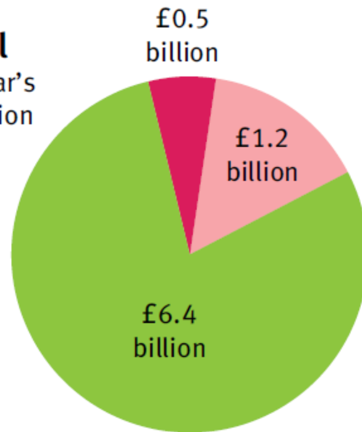
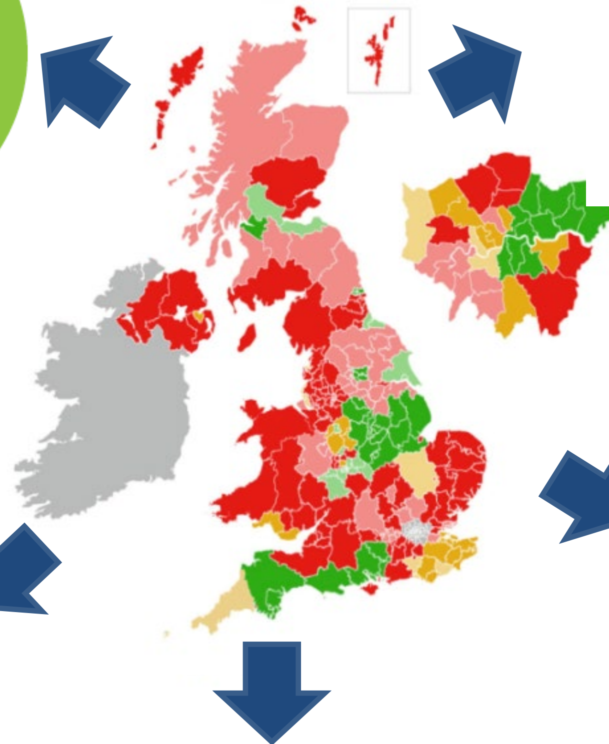
Case for change

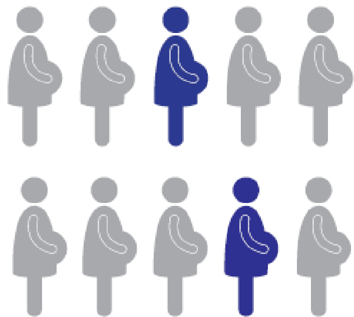
Known costs of perinatal mental health problems per year's births in the UK, total: £8.1 billion



health and social care
other public sector
wider society

Of these costs
28% relate to the mother
72% relate to the child





Up to 20% of women develop a mental health problem during pregnancy or within a year of giving birth

Suicide is a leading cause of death for women during pregnancy and in the year after giving birth

Variation and inequality: in 2014 fewer than **15%** of localities provided specialist services for women with complex or severe conditions at the full level recommended in NICE guidance, and more than **40%** provided **no service at all**.

Source: LSE and Centre for Mental Health, *The cost of perinatal mental health problems* (2014) and Maternal Mental Health Alliance (map)

Perinatal mental health: commitments

Mental Health Five Year Forward View and Implementation Plan

- Implementing the Five Year Forward View for Mental Health outlines a phased approach to **build capacity and capability in specialist perinatal mental health services** (community and inpatient).
- Outcomes focused on improving access and experience of care with joined up approaches; early diagnosis and intervention; and greater transparency and openness to support reduced stigma.

Funding

- **£365m** from 2015/16-2020/21 (prices in £m increase on 14/15)

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21
	15	15	30	60	105	140

  - 2016/17- 2018/19 – setting infrastructure, incl. investment in workforce development, MBU procurement and pump-priming community services.
  - 2019/20 onwards – new money begins flowing to CCG baselines.

What do we want to see

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

The vision...

- **By 2020/21, an additional 30,000 women in all areas of the country should receive access to**
  - **evidenced-based specialist support**
  - **closer to their home**
  - **when they need it**
  - **including access to psychological therapies**
  - **with the right range of specialist community or inpatient care**

How do we achieve this...?

- **Regional clinical networks** across the country
- **Clinical Reference Group** to advise NHS Specialised Commissioning

  New Units and extra beds
- Develop the workforce through **Health Education England**
- Develop community services incrementally –

  Community Services Development Fund
- **Measure and report** on progress

What's happened? Mother and Baby unit developments

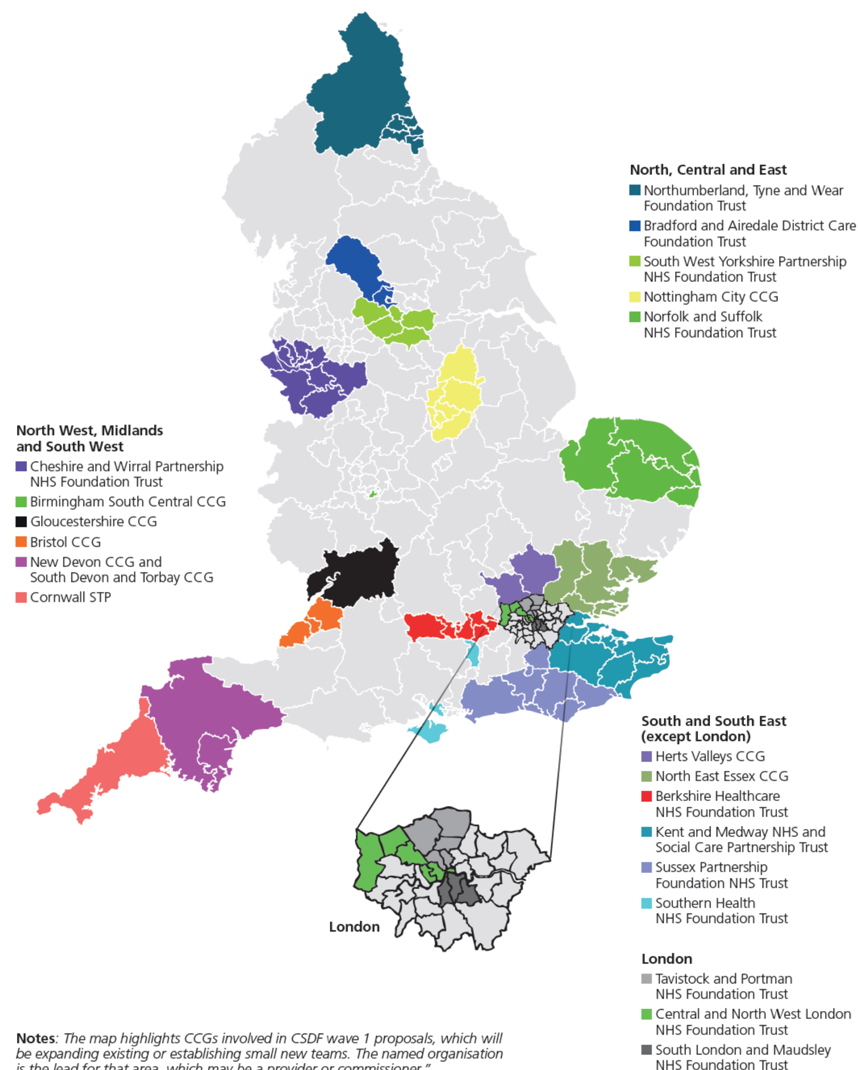
Support for expanding **Mother and Baby unit** capacity

- eight extra beds in existing units commissioned on sustainable basis
- Contracts for four new, eight-bedded units awarded and implementation has started:
    - North West – Lancashire Care FT (July 2018)
    - East Anglia - Norfolk and Suffolk FT (operational 2019)
    - South West – Devon Partnership Trust (2019)
    - South East Coast – Kent and Medway Partnership Trust (July 2018)
- Investment in existing MBUs for quality improvement initiatives.

What's happened? Specialist perinatal mental health community services

Support for developing specialist PMH teams through **Community Services Development Fund**.

- Wave 1 - £40m to 20 areas 16/17-18/19
- Wave 1 coverage: 90 CCGs, 6 STPs
- **Over 236** new specialist staff recruited to date, including **21 consultant psychiatrists, 105 PMH practitioners (nurses and OTs), 28 psychologists.**
- **Wave 2 – 2018** Rest of the country developed services so by 1st April 2019 all areas of the country had specialist teams.
- Over performed against target in 2017, 2018 and 2019.
- 2019/20 over 30 000 women accessed a specialist perinatal mental health team



FYFVMH

LTP

Specialist Perinatal Mental Health Services

Moderate to severe mental illness

APT & specialist universa services

Specialist midwifery & health visiting support, Children Centres, Third sector

Mild to moderate to mental health difficulties

Universal services

Maternity services, Health Visiting, Family Support, Children's Centres, & Primary Care

No difficulties or those at high risk

What are the LTP perinatal policy priorities?

1. **Increasing access to evidence-based care for women with moderate to severe perinatal mental health difficulties** and a personality disorder diagnosis
2. **Extending services to preconception to 24 months after birth**, in line with the cross-government ambition for women and children focusing on the first 1,001 critical days of child's life
3. **Expanding access to evidence-based psychological therapies** within specialist perinatal mental health services so that they also include parent-infant, couple, co-parenting and family interventions
4. Ensuring **partners of women accessing specialist perinatal mental health services and maternity outreach clinics receive evidence-based assessment of their mental health and are signposted to support** as required.

5. *(Increasing access to evidence-based psychological support and therapy in a maternity setting by **implementing maternity outreach clinics**, that will integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience)*

Milestones for perinatal mental health services

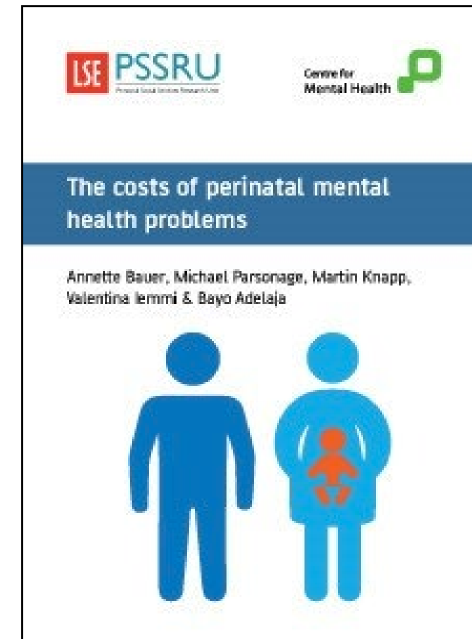
24,000 additional women and their families will be able to access specialist perinatal mental health services by 2023/24.

The current gap 1

Gap 1 – access to all women with moderate to severe perinatal illness including young women, women with personality disorder, eating disorder, OCD and PTSD.

Rationale

- 2018 data from the UK indicates a PMH population prevalence of 27% (with personality disorders - 6%, eating disorders -2%, OCD -2%, PTSD -5%) rising to 45% for 18-24yr olds
- FYFV services report demand beyond their current capacity leading to clinical thresholds for referrals rising to severe mental illness only



Howard, L. M., Ryan, E. G., Trevillion, K., Anderson, F., Bick, D., Bye, A., ... & Milgrom, J. (2018). Accuracy of the Whooley questions and the Edinburgh Postnatal Depression Scale in identifying depression and other mental disorders in early pregnancy. *The British Journal of Psychiatry*, *212*(1), 50-56.

The current gap 2

Gap 2 - Access to specialist ***perinatal care beyond 12 months for the full 1001 critical days***

Rationale

- Self-harm and suicidality rates are highest at 12 months postpartum so this is a risky time to discharge women
- Women frequently return to work at 12 months and this can trigger a relapse of mental health difficulties
- Infant separation anxiety peaks at 12 months, and this can trigger a relapse of mental health difficulties
- Attachment difficulties can be detected from 12 months and referred for evidence-based treatment
- A small sub-group of women accessing FYFVMH perinatal mental health services report *"feeling abandoned"* by services' when they are discharged at 12 months

APPG for 1001 critical days. (2015). *1001 critical days: the importance of the conception to age two period*. London.

Thornton, C., Schmied, V., Dennis, C. L., Barnett, B., & Dahlen, H. G. (2013). Maternal deaths in NSW (2000–2006) from nonmedical causes (suicide and trauma) in the first year following birth. *BioMed Research International*.

Schiff, M. A., & Grossman, D. C. (2006). Adverse perinatal outcomes and risk for postpartum suicide attempt in Washington State, 1987–2001. Pediatrics, 118(3), e669-e675.

The current gap 3

Gap 3 - Access to evidence-based parent-infant, co-parenting and family interventions

Rationale

- **Parent-infant relationship difficulties** in the context of maternal mental health difficulties **(6%)**
- The FYFV services only have 1-2 clinical psychologist to deliver all the aforementioned therapies to every 500 women

- Significant gaps in the delivery of parent-infant therapy, family therapy, and couples therapy

Asmussen, K. & Brims, L. (2018). *What works to enhance the effectiveness of the Healthy Child Programme: An evidence update*. London: EIF.

What are NICE recommended psychological therapies?

See NICE Guideline for Antenatal and Postnatal MH (2014) – Interventions are described in a stepped care model

Depression

- Guided self-help
- Behavioural activation
- IPT
- CBT
- Behavioural couples therapy

Anxiety

- Guided self-help
- CBT

Psychosis

- CBT
- Family therapy

Anorexia

- IPT
- CBT
- Family therapy
- Cognitive analytic therapy
- Focal psychodynamic therapy

Bulimia/ Binge eating

- Guided self-help (binge eating only)
- CBT
- IPT
- Dialectical behavioural therapy

PTSD (including following birth, miscarriage or stillbirth)

- TF-CBT
- EMDR

Tokophobia

- Psychological consultation and birth planning support

Bipolar depression

- CBT
- IPT
- Family therapy
- Behavioural couples therapy

The current gap 4

Gap 4 - Mental health assessment and intervention for partners of women with perinatal mental health difficulties

Rationale

- New and expectant fathers also experience mental health difficulties in the perinatal period.
- In the first 6 months after the birth of their babies the prevalence rates of anxiety and depression symptoms in men are between 5 and 6% .
- Like women they can also be traumatised following birth or the loss of a baby in the perinatal period.
- The most significant predictor of perinatal mental health difficulties in fathers is mental health difficulties in their partners.

Bradley, R., & Slade, P. (2011). A review of mental health problems in fathers following the birth of a child. Journal of Reproductive and Infant Psychology, 29(1), 19-42.

Elmir, R., & Schmied, V. (2016). A meta-ethnographic synthesis of fathers' experiences of complicated births that are potentially traumatic. Midwifery, 32, 66–74. doi:10.1016/j.midw.2015.09.008

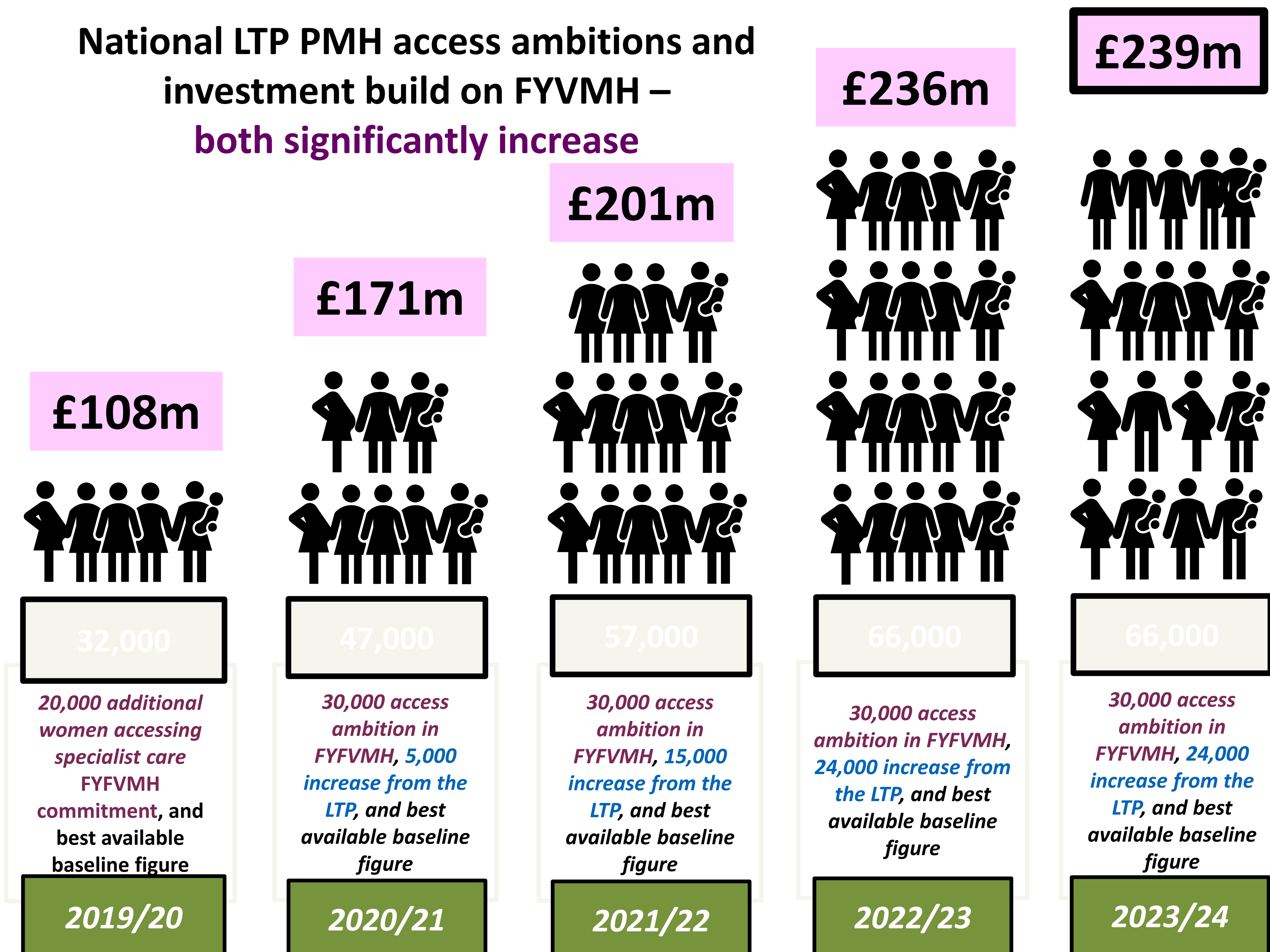
Valizadeh, L., Zamanzadeh, V., & Rahiminia, E. (2013). Comparison of anticipatory grief reaction between fathers and mothers of premature infants in neonatal intensive care unit. Scandinavian Journal of Caring Sciences, 27(4), 921–926. doi:10.1111/scs.12005

Paulson, J. F., & Bazemore, S. D. (2010). Prenatal and postpartum depression in fathers and its

association with maternal depression: A meta-analysis. Journal of the American Medical Association, 303(19), 1961–1969. doi:10.1001/jama.2010.605

The current gap 5

- Maternal Mental Health Services
- Women with moderate to severe or complex mental health difficulties related to the perinatal period who do not have a baby and are currently excluded from specialist perinatal services
- MMHS will integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience



National LTP PMH access ambitions and investment build on FYVMH – both significantly increase
£108m
£171m
£201m
£236m
£239m
32,000
47,000
57,000
66,000
66,000
20,000 additional women accessing specialist care FYFVMH commitment, and best available baseline figure
30,000 access ambition in FYFVMH, 5,000 increase from the LTP, and best available baseline figure
30,000 access ambition in FYFVMH, 15,000 increase from the LTP, and best available baseline figure
30,000 access ambition in FYFVMH, 24,000 increase from the LTP, and best available baseline figure
30,000 access ambition in FYFVMH, 24,000 increase from the LTP, and best available baseline figure
2019/20
2020/21
2021/22
2022/23
2023/24

Other key areas of learning

- Co-production and co-design
- Peer support workers
- Clinician rated, patient rated outcome measures and patient experience measures
- Staffing:
  - Training
  - Development
  - Recruitment/retention
- Developing the evidence base

Gap 1 – access to all women with moderate to severe perinatal illness including young women, women with personality disorder, eating disorder, OCD and PTSD.

- How is your area planning to do this?
- What potential difficulties do you foresee?
- How would you overcome these difficulties?
- Any specific issues re staff training/development?
- What would excellent look like?
- Can you think of a case where this would have been beneficial?

Gap 2 - Access to specialist ***perinatal care beyond 12 months for the full 1001 critical days***

- How is your area planning to do this?
- What potential difficulties do you foresee?
- How would you overcome these difficulties?
- Any specific issues re staff training/development?
- Can you think of a case where this would have been beneficial?

Gap 3 - Access to evidence-based parent-infant, co-parenting and family psychological interventions

- How is your area planning to do this?
- Does this address an issue in your area?
- What potential difficulties do you foresee?
- How would you overcome these difficulties?
- Any specific issues re staff training/development?

Gap 4 - Mental health assessment and intervention for partners of women with perinatal mental health difficulties

- How is your area planning to do this?
- What potential difficulties do you foresee?
- How would you overcome these difficulties?
- Any specific issues re staff training/development?
- Can you think of a case where this would have been beneficial?

5. Women with moderate to severe or complex mental health difficulties related to the perinatal period who do not have a baby and are currently excluded from specialist perinatal services

- How is your area planning to do this?
- What potential difficulties do you foresee?
- How would you overcome these difficulties?
- How could service user input support this?
- Can you think of a case where this would have been beneficial?