

Perinatal mental health services

Recommendations for the
provision of services for
childbearing women

College Report CR197 (revision of CR88)

July 2015

Approved by: Policy Committee, November 2014

Due for revision: 2019

© 2015 The Royal College of Psychiatrists

College Reports constitute College policy. They have been sanctioned by the College via the Policy and Public Affairs Committee (PPAC).

For full details of reports available and how to obtain them, visit the College website at <http://www.rcpsych.ac.uk/publications/collegereports.aspx>

The Royal College of Psychiatrists is a charity registered in England and Wales (228636) and in Scotland (SC038369).

Contents

Working group	4
Executive summary	5
Introduction	7
What are perinatal mental health services?	8
Why is perinatal mental health important?	9
Current care and services for perinatal mental health disorders	12
Good perinatal mental healthcare services	17
Staffing and resources for specialised perinatal mental health services	22
References	27

| Working group

This report was produced by the Royal College of Psychiatrists' Faculty of Perinatal Psychiatry CR88 Revision Working Group.

Chair and author

Margaret Oates OBE Consultant Perinatal Psychiatrist, Clinical Director, NHS England East Midlands Strategic Clinical Network (Mental Health, Dementia & Neurological Conditions)

Members

Roch Cantwell Consultant Perinatal Psychiatrist, Perinatal Mental Health Service and West of Scotland Mother and Baby Unit, Levensdale Hospital, Glasgow

Ian Jones Professor of Psychiatry, Director, National Centre for Mental Health, Cardiff University, and Vice Chair, Faculty of Perinatal Psychiatry, Royal College of Psychiatrists

Liz McDonald Consultant Perinatal Psychiatrist, Hackney Mother and Baby Unit, London, and Chair, Faculty of Perinatal Psychiatry, Royal College of Psychiatrists

With contributions and comments from members of the Faculty Executive Committee 2013/2014.

Executive summary

This report describes the provision of good-quality mental health services to child-bearing women. It will assist those providing and planning services for pregnant and postpartum women across a range of disorders and severities at all levels of service provision. It outlines the particular importance of perinatal mental health problems and the need for specialised services.

Recommendations

- 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.
- All women in pregnancy or following delivery requiring specialist mental health services (including those at risk of serious illness) should have access to care and treatment from a specialised perinatal community mental health team (CMHT).
- Every health region should have a perinatal mental health strategy and a perinatal mental health integrated care pathway. This should cover all levels of service provision and types and severities of disorder.
- Specialised units with at least 6 mother and baby beds should be provided to serve the needs of large populations with 15000 to 20000 deliveries. These should relate to specialised perinatal CMHTs existing within each mental health provider in a hub-and-spoke fashion, promoting seamless continuity of care and the best effective use of resources.
- Mother and baby units should be accredited by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) and specialised perinatal CMHTs should be members of the CCQI Appraisal Network.
- Specialised perinatal services should have close working relationships with adult mental health, child and adolescent mental health services (CAMHS), maternity services, health visitors and children's Social Services.
- Adult mental health services should ensure that perinatal women receive specialised care.
- Adult psychiatric services should ensure that women with a serious psychiatric disorder are counselled about the effects of pregnancy on their condition and receive information and advice about the possible effects of their medication on pregnancy.
- Maternity services should ensure that the mental health needs of women are met, including additional training for midwives to detect at-risk women during pregnancy and to enquire about women's current mental health.
- Psychological therapy service (including Improving Access to Psychological Therapies (IAPT)) should ensure that the needs of perinatal women are met, which includes receiving additional training and ensuring that women are assessed and treated within 1 month.
- Primary care services should ensure that the mental health needs of perinatal women are met; this includes familiarity with the perinatal mental health integrated care pathway and ensuring that health visitors receive additional training.

- Parent–infant services are an addition to, not a substitute for, services for women with serious mental illness. To avoid confusion and assist clarity for the public and planners, these services should be called parent–infant, not perinatal, mental health services.
- Data should be routinely collected by mental health providers on whether female patients of reproductive age are pregnant or in the year following childbirth.

Introduction

Guidance on the provision of services for childbearing women with mental health problems was first produced by the Royal College of Psychiatrists as a Council Report in 1992 and revised as a College Report CR88 published in 2000. In the intervening years CR88 was approved by the Royal College of Psychiatrists' Council but delayed by imminent changes in government and the introduction in England of the internal market and of mental health trusts.

Although the underlying principles of CR88 have remained largely unchanged, once again there have been major changes in the way that the National Health Service (NHS) is organised and the way in which mental health services are delivered, particularly the introduction of functional mental health teams and the greater involvement of expert patients.

The findings of the UK Maternal Deaths Enquiries and the tragic death of Daksha Emson (North East London Strategic Health Authority, 2003) led the Royal College of Psychiatrists to form the Perinatal Section (now Faculty of Perinatal Psychiatry) and the College Centre for Quality Improvement (CCQI) to set up the Quality Network for Perinatal Mental Health Services. Specific guidance on antenatal and postnatal mental health from the National Institute for Health and Care Excellence (NICE, 2014) as well as the Department of Health's (2004a) children and young people's National

Service Framework maternity standards further raised the profile of perinatal mental health problems, not only in psychiatry but also in obstetrics and midwifery.

Changes to the NHS in England took place after the general election in May 2010. The Health and Social Care Act was implemented in April 2012, bringing about a radical change in the commissioning landscape. There may be further changes in the future. There are now significant differences in NHS organisation between England, Wales, Scotland and Northern Ireland. The Perinatal Faculty felt that a revision of CR88 was necessary. We hope that we have managed to make this report applicable to the whole of the UK and internationally and to make it 'future-proof'. We therefore have avoided using the term 'commissioning' wherever possible.

This report does not cover the care of pregnant women with alcohol and substance misuse.

What are perinatal mental health services?

Perinatal mental health services are concerned with the prevention, detection and management of mental health problems that complicate pregnancy and the postpartum year. These include new-onset problems, recurrences of previous problems in women who have been well for some time and in women with existing mental health problems who become pregnant.

Promoting the relationship with the infant and its emotional and physical well-being and development are central to the care provided by perinatal mental health services.

Perinatal mental health problems include a range of disorders and severities which present in a variety of health settings and are managed by many different services. Some of these services are specifically designed to meet the needs of pregnant and postpartum women and their infants. Others care for them as part of a general service. These services include:

- specialised in-patient mother and baby units
- specialised perinatal CMHTs
- maternity liaison services
- adult mental health services including admission wards, community, crisis, early intervention in psychosis and assertive outreach teams
- alcohol and drug misuse services
- intellectual disability services
- CAMHS
- parent-infant mental health services
- maternity services
- clinical psychology services linked to maternity services
- IAPT and national equivalents
- health and social care organisations, children's centres
- general practitioners (GPs), health visitors and the extended primary care team
- voluntary and self-help organisations.

Specialised perinatal mental health services (which include mother and baby units, specialised perinatal community mental health and maternity liaison teams) are provided by mental health services.

In England mother and baby units are commissioned by NHS England's specialised commissioners. Other services that provide care for pregnant and postpartum women, including some of the care provided by specialised perinatal community teams, are commissioned in England by local clinical commissioning groups.

A comprehensive perinatal mental health strategy should encompass all levels of service provision no matter who pays for them or who commissions them. Adequate specialist resources, robust care pathways and education and training of non-specialists are essential to ensure that the right patient reaches the right service where they are seen by the right professional at the right time.

Treatment

In this guidance the terms 'treatment' and 'management' are used to encompass medical, nursing, psychological and social treatments, interventions and care.

Why is perinatal mental health important?

Perinatal mental health problems are those which complicate pregnancy and the postpartum year. They include both mental health problems that arise at this time and those that were present before the pregnancy.

Perinatal mental health problems: an overview

Childbirth is associated with a substantial psychiatric morbidity. It has long been known to increase the risk to women's mental health, particularly the risk of developing a serious mental illness (postpartum psychosis and severe depressive illness) (Kendell *et al*, 1987; Cox *et al*, 1993). It is also known to be associated with an increased risk of recurrence, particularly of serious affective disorder (bipolar illness and severe depressive illness) (Kendell *et al*, 1987; Jones & Craddock, 2005). When women with chronic, long-standing, serious mental illness such as schizophrenia become pregnant, their condition may deteriorate or recur during pregnancy and the postpartum period (Davies *et al*, 1995).

Non-psychotic conditions, particularly depressive illness and anxiety, are common during pregnancy and following delivery (O'Hara & Swain, 1996).

The rate (incidence) of new-onset serious mental illness is not elevated during pregnancy, in contrast to the marked elevation of risk in the early weeks following delivery (Kendell *et al*, 1987). However, recurrences and relapses of serious affective disorder (bipolar illness and severe depressive illness) do occur during pregnancy, particularly if medication has been stopped. The majority of acute-onset serious perinatal disorders present as a psychiatric emergency in the days and weeks following childbirth (Dean & Kendell, 1981; Heron *et al*, 2008).

By contrast, the incidence and prevalence of mild to moderate depression and anxiety are broadly similar during pregnancy and the postpartum period. However, there is evidence of an increased incidence of severe non-psychotic depressive illness in the early weeks following delivery. These conditions may initially present as anxiety and depression in the first 2 to 6 weeks following delivery and can deteriorate rapidly (Cooper *et al*, 2007).

Post-traumatic stress disorder is estimated to occur in approximately 3% of maternities and 6% of women following emergency caesarean section. Women admitted to high dependency or intensive care units and those suffering obstetric loss are at increased risk (NICE, 2011). Other obstetrically relevant states of distress include women previously abused, those with sick infants in neonatal units and those with serious medical disorders.

The epidemiology of perinatal psychiatric disorders is well established. Using the birth rate of their area, planners will be able to estimate the perinatal mental health morbidity and the necessary service uptake for their population (Table 1).

Impact of perinatal psychiatric disorder

Childbirth and new motherhood carries an expectation of happiness but it is a time of emotional upheaval and adjustment to changes in lifestyle and relationships. Significant mental health

Table 1 Rates of perinatal psychiatric disorder per 1000 maternities^a

Disorder	Frequency
Postpartum psychosis	2
Chronic serious mental illness	2
Severe depressive illness	30
Mild to moderate depressive illness and anxiety states	100–150
Post-traumatic stress disorder	30
Adjustment disorders and distress	150–300

a. This table is based on information contained in NICE (2011), Howard *et al* (2014) and Jones *et al* (2014).

problems at this time cause enormous distress and can seriously interfere with the adjustment to motherhood and the care of the newborn baby as well as older children. Poorly managed perinatal mental health problems can have lasting effects on maternal self-esteem, partner and family relationships, and the mental health and social adjustment of the child.

- Acute serious perinatal illness usually presents as an emergency and often requires in-patient care. Separation of mother and infant prevents the early development of mother–infant attachment and relationship, which may be difficult to reverse and have long-standing effects on both child and mother. Separation causes great maternal distress and interferes with treatment of the mother as well as preventing breastfeeding.
- Maternal non-psychotic depressive illnesses and anxiety states, particularly if untreated or chronic and associated with social adversity, have been shown to affect the infant’s mental health and have long-standing effects on the child’s emotional, social and cognitive development (Murray *et al*, 1996).
- Serious perinatal psychiatric disorder is associated with an increased risk of suicide. Suicide has been shown to be a leading cause of maternal mortality in the past 2 decades and the suicide rate in pregnancy and the first 6 months postpartum is not decreasing, in contrast to the suicide rate in women in general (Oates & Cantwell, 2011).
- Perinatal psychiatric disorder is also associated with an increased risk to both mortality and morbidity in mother and child. Over the

past two decades psychiatric disorder has been a leading cause of maternal mortality, contributing to 15% of all maternal deaths in pregnancy and 6 months postpartum. Serious mental illness and its treatments can complicate the management of pregnancy. Psychotic illness in pregnancy is known to be associated with poorer pregnancy outcomes and an increased risk of pre-term delivery, stillbirth, perinatal death and neurodevelopmental disorder (Howard *et al*, 2003).

Perinatal mental health problems are therefore a major public health concern. They have a wide-ranging impact on both maternal and infant mental and physical health and make a significant contribution to both maternal and infant morbidity and mortality.

The need for specialised services

- Women with serious mental illness complicating childbirth need specialist knowledge and skills on the part of the professionals who care for them. These include specialist knowledge of the risks and benefits of medication in pregnancy, and the skills to treat and nurse seriously mentally ill women at the same time as enabling them to meet the emotional and physical needs of their infants. In addition, they need an understanding of the emotional and physical changes associated with childbirth and the organisation of maternity services.
- Services for seriously mentally ill women need to be organised differently from adult mental health services and need to respond to the maternity context, the timeframes of pregnancy, the differing thresholds and response times to presenting problems. Services need to relate to different health professionals, particularly to maternity services and children’s Social Services.
- Perinatal mental health services require different resources to those of adult mental health services. Women who are admitted in late pregnancy or the postpartum period require in-patient mother and baby units which are designed and resourced to safely meet the

physical and emotional needs of both mother and infant while resolving the usually severe mental health problems.

- Women with non-psychotic conditions of moderate intensity may not meet the criteria for access to adult mental health services. However, the potential risk to the mother of subsequent development of a more serious illness and additional risks to the infant determine a lowered threshold for referral and intervention.
- The organisation of adult mental health services into differing functional mental health teams does not fit easily with the rapid development and deterioration of an early postpartum illness, which can move very quickly – within days – from early concerns about anxiety to a profound psychotic illness.
- Adult mental health services are not accustomed to the proactive care of a well woman in pregnancy, who is nonetheless at a very high risk, because of her history, of becoming profoundly ill within days of delivery.
- Clinicians within adult mental health services are not experienced in the detection of difficulties within an infant–parent relationship, which can have a serious impact on the infant’s mental health and long-term development.
- A critical mass of patients is essential to maintain experience and skills in clinicians managing complex and difficult conditions. No individual mental health trust or functional psychiatric team will have sufficient experience of managing postpartum psychosis or severe postnatal depressive illness. The epidemiology of these conditions suggests that this critical mass can only be achieved by providing specialised mother and baby units on a regional basis by establishing a specialised perinatal CMHT at the level of each mental health trust. These teams can then work closely with colleagues in adult mental health to ensure the proper care of women who become pregnant while in the care of adult mental health services.

Opportunities for prevention, intervention and treatment

Pregnancy and early motherhood are times of unparalleled contact with health services. This should provide the framework to:

- identify women at increased risk of developing perinatal conditions
- develop a personalised care plan for each woman at increased risk
- ensure the prompt and early detection of any illness
- ensure early intervention and prompt treatment.

Effective treatments and psychological interventions are available and timely and appropriate treatment can improve maternal and infant outcomes. There is evidence to suggest that women with acute serious perinatal illness will have better outcomes and better relationships with their infants if cared for in mother and baby units (Pawlby *et al*, 2010). If they receive specialised aftercare, they will have shorter admissions and fewer readmissions (Cantwell *et al*, 2002).

- Women with a history of serious illness can be prepared for pregnancy and receive preventative management when pregnant with regard to the high risk of illness recurrence following delivery.
- Health visitors with additional training in active listening and cognitive counselling have been shown to be effective in both preventing and treating postnatal depression (Morrell *et al*, 2009).
- Parent–infant mental health services and services with a focus on parenting can improve both infant mental health and maternal well-being in those women who have problems with the relationship with their child.
- Psychosocial interventions by health and social care agencies and voluntary agencies can improve both maternal well-being and infant outcomes in those with less serious problems or as an adjunct to management by specialist services (Leahy-Warren, 2007).

Current care and services for perinatal mental health disorders

National drivers: policies and guidelines

Policies and guidelines on managing maternal mental health make consistent recommendations about the care that a pregnant and postpartum woman should receive and the provision of specialised care for perinatal psychiatric disorder should it be necessary (Box 1). These recommendations affect:

- the provision of specialised services
- adult mental health services
- maternity services
- GP, health visitor and extended primary care team
- clinical networks.

The main recommendations are as follows.

- 1 All women requiring admission to a psychiatric unit in late pregnancy or the postpartum should be admitted together with their infant to a specialised mother and baby unit unless there are compelling reasons not to do so.
- 2 Women with perinatal conditions who require the care of secondary mental health services should receive specialised perinatal community care.
- 3 All women with a serious psychiatric disorder (current or previous) should have access to specialist advice – before becoming pregnant – on the possible impact of pregnancy and childbirth on their condition, and the impact of their condition and its treatment on the outcome of the pregnancy and child-rearing.

- 4 All women should be asked about previous mental health problems at early pregnancy assessment and those who have had a serious mental illness should be referred for proactive management during pregnancy.
- 5 All women should be regularly asked about their current mental health during pregnancy

Box 1 Policies and guidelines on managing maternal mental health

- *The Women's Mental Health Strategy* (Department of Health, 2004b)
- *National Service Framework for Children, Young People and Maternity Services* (Department of Health, 2004a)
- *NICE Clinical Guideline 195: Antenatal and Postnatal Mental Health* (NICE, 2014)
- *National Service Framework for Mental Health* (Department of Health, 2007)
- *A Refreshed Framework for Maternity Care in Scotland* (Maternity Services Action Group, 2011)
- *UK Confidential Enquiries into Maternal Deaths eighth report* (Centre for Maternal and Child Enquiries, 2011)
- *NICE Clinical Guideline 132: Caesarean Section* (NICE, 2011)
- *Royal College of Obstetricians and Gynaecologists' Good Practice Guideline 14: Guidelines on the Management of Women with Mental Health Issues during Pregnancy and the Postnatal Period* (RCOG, 2011)
- *SIGN Guideline 127: Management of Perinatal Mood Disorders* (Scottish Intercollegiate Guidelines Network, 2012)
- *Joint Commissioning Panel for Mental Health: Guidance for Commissioners of Perinatal Mental Health Services* (JCPMH, 2012)

and the postpartum period and, if they have problems, whether they would like help.

- 6 All those involved in the care of pregnant or postpartum women should have additional training in the normal emotional changes associated with pregnancy and the postpartum period, the maternity context, psychological distress, perinatal disorders and early parent-child relationship issues.
- 7 Women should have access to psychological and psychosocial treatments, including prompt treatment by IAPT and other providers of psychosocial treatments, such as listening visits and cognitive counselling by health visitors.
- 8 Perinatal mental health clinical networks should be set up, covering populations of patient flow of approximately 4 to 5 million (delivered population 50 000) to advise planners/commissioners, assist in the development of strategic plans and service design, advise provider organisations, assist with workforce development and training, develop integrated care pathways and maintain a network of involved clinicians and other stakeholders, including patients.

Specialised perinatal mental health services

Mother and baby units in the UK

There are 15 in-patient mother and baby units in England and 2 in Scotland, but there are none in Northern Ireland or Wales. All of these mother and baby units belong to the Royal College of Psychiatrists' Quality Network for Perinatal Mental Health Services and adhere to their national standards (www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/perinatal/perinatalqualitynetwork.aspx). They all admit seriously mentally ill women in late pregnancy and the postpartum period together with their infants. They aim to admit women directly to the mother and baby unit in the early postpartum period without the need for prior admission to a general adult psychiatric ward. They all accept emergency admissions.

All mother and baby units will continuously assess mother-infant care, relationship and attachment, determining the level of supervision, support and guidance the mother requires to meet the emotional and developmental needs of her infant. Staff will have skills in promoting attachment and parenting interventions. Many units also have psychologists who will provide additional expertise in psychological treatments and parenting interventions.

Most mother and baby units are also integrated with specialised perinatal CMHTs. These teams, in addition to their other functions, can promote early discharge, provide aftercare and manage women with serious illness in the community, and decrease the risks to both mother and infant. They provide maternity liaison services and advise women at risk of serious perinatal mental health problems.

There are still large areas of the country which have no specialised facilities, however. Women either are admitted without their babies to general adult wards or have to travel hundreds of miles to an out-of-area mother and baby unit.

Mother and baby beds

There are approximately 130 mother and baby beds in the UK, but there is a minimum shortfall in England of approximately 60–80 in-patient mother and baby beds (NICE, 2014).

Perinatal CMHTs

There are at least 20 specialised perinatal CMHTs in England, many of which are integrated with a mother and baby unit. All have at least a core staff of a consultant perinatal psychiatrist and community psychiatric nurses. They provide a maternity liaison service, manage new-onset conditions and high-risk patients in the community, offer pre-conception counselling and arrange admissions to a mother and baby unit when necessary.

Fewer than half of all mental health trusts/health boards in the UK provide a specialised perinatal mental health team that is staffed by at least a consultant perinatal psychiatrist and specialised community perinatal mental health nurses (Elkin *et al*, 2009; Maternal Mental Health has mapped perinatal service provision in the UK: http://everyonesbusiness.org.uk/?page_id=349/). In addition,

there is a variable and patchy provision of perinatal mental health services, often involving a single or small numbers of professionals who provide partial care or 'signposting services' to women, but none of these will be able to provide comprehensive services, particularly for women with serious mental illness.

To summarise, the provision of specialised perinatal psychiatric care is patchy and inequitable. Many women with serious illness are not able to access the appropriate type and standard of care as recommended by NICE and other national guidance (SIGN, 2012; NICE, 2014).

Adult mental health services

The majority of women with serious psychiatric disorder in their reproductive years will receive care from general adult mental health services and even those areas which provide specialised perinatal services will need to use crisis and home treatment teams out of working hours and on occasion when specialised service capacity is exceeded.

Some mental health services do not access or provide mother and baby units, nor specialised perinatal CMHTs. In these services, women who require admission will be on a general admission ward without their babies. The admission of a mother and infant together to a non-specialised adult psychiatric ward is no longer acceptable and should not take place in the UK.

Other mental health services that do not have specialised perinatal services of their own will refer to out-of-area mother and baby units. However, this is often not done proactively or in an emergency. Women therefore are at risk of spending time on an adult admission ward without their babies before a referral is made.

Pregnant and postpartum women in areas without specialised services will be cared for by adult mental health, community, crisis, early intervention and assertive outreach teams. Liaison psychiatric services will provide psychiatric input into maternity hospitals. It is unlikely in these areas that women will have access to specialised advice on

the management of their pre-existing conditions, on medication in pregnancy and breastfeeding or on the proactive management of their conditions during pregnancy and their risk of a postpartum recurrence.

Adult mental health services without specialised teams may not adapt their thresholds for accepting referrals of perinatal patients, for intervention or for admission. This is of concern because of the additional risks posed to the mother and the infant by perinatal psychiatric disorder and because disorders presenting early in the postpartum period can deteriorate very rapidly.

The provision of care for women with less severe conditions in the community is even more variable and inequitable.

Maternity services

Midwives are responsible for early pregnancy risk assessment, determining which women will need additional obstetric management and/or input from other services. It is part of their role to explicitly enquire about a woman's psychiatric history and to appropriately refer on those women who are at risk of serious perinatal psychiatric problems. It is also part of their role to ask about a woman's current mental health and to know who and how to refer (RCOG, 2011). They will need to work collaboratively with primary care and mental health services. Obstetricians deal with high-risk and complex pregnancies, including women with serious mental illness. They will also see women with a range of other psychiatric disorders in pregnancy and the early postpartum period (RCOG, 2011).

Some maternity services will have access to a specialised perinatal mental health team, provided by a local mental health service. This service will see emergencies, provide advice and care and work collaboratively in the treatment of high-risk patients.

Other maternity services will have to rely on adult mental health services including liaison services.

Some maternity services will have direct access to a designated clinical psychologist. The NICE caesarean section guideline (2011) recommends that women with traumatic stress responses to

childbirth, at both sub-threshold and threshold levels of post-traumatic stress disorder, whether in pregnancy or postnatally, should have access to psychological interventions. It remains poorly implemented.

Parent–infant mental health services

Present variably throughout the UK are a variety of services, some called perinatal services others called parent-infant mental health services. Whereas the focus is on the infant's current and future mental health, they treat mothers with complex disorders (together with their infants), who either have parenting difficulties or who are thought to be at risk of experiencing difficulties. Some of these services are provided by community health services, some by maternity or children's hospitals and some by CAMHS. Most of these services are multidisciplinary. All focus on psychological therapies and parenting interventions and some access additional care from adult mental health services for serious mental illness. Some have a focus on working with a particularly vulnerable group such as mothers who have been in care or are referred by Social Services.

The provision and function of these specialist services are variable and inequitable. There are few available data to estimate the unmet need but it is likely to be considerable. Services with a parenting focus can aim to improve maternal and infant mental health, and emotional, social and cognitive development of the child. They can offer additional expertise to other services who care for parents of young children. However, they cannot provide comprehensive psychiatric care for women with serious disorders. They are an important part of an overall perinatal mental health strategy, and a necessary but not sufficient component of a perinatal mental health service.

IAPT and other national equivalents

IAPT and similar services are now in place throughout the UK. Patients may self-refer or be referred

by their GP or health worker. They are triaged by telephone and offered help using a stepped-care model ranging from guided self-help through to cognitive–behavioural therapy (CBT) or interpersonal psychotherapy by specialist workers. They treat those with mild to moderate conditions, depression and anxiety disorders.

It has been acknowledged that a substantial proportion of their clients will be pregnant and postpartum women. Specific guidance for IAPT services treating women in the perinatal period is provided by the Department of Health (2009).

There are a number of concerns about the current IAPT system within the perinatal context. None of the training schemes include training on the normal emotional changes associated with motherhood, the change in relationships and family dynamics, clinical features of perinatal psychiatric disorder and the additional risks to both mother and infant of perinatal mental health problems. None of the treatment modalities include any focus on parenting or mother–infant interaction. It is of concern that women presenting initially with depression and anxiety in the early postpartum period who may subsequently develop a more serious illness may have their access to the appropriate level of care delayed.

GP, health visitor and extended primary care services

The majority of women with perinatal mental health problems will be seen by these services. Frequently, GPs are no longer involved in the routine care of pregnant and postpartum women and valuable information on a woman's past mental health may not be easily accessed by midwives or health visitors. Midwives must ensure that GPs know that their patient is pregnant and seek to obtain from them information about significant aspects of a patient's medical and psychiatric history.

GPs will see women who refer themselves or who have been identified by the midwife or health visitor. They can treat uncomplicated non-psychotic depression and anxiety themselves or refer to IAPT,

and for complex or serious disorders refer to perinatal mental health services or, in their absence, general psychiatry services.

The effectiveness of health visitor intervention in the prevention and treatment of mild to moderate postnatal depression is now well established. Health visitors with additional training in listening visits and cognitive counselling can significantly improve the outcome of women with postnatal depression compared with standard health visitor care. Interventions by additionally trained health visitors have been shown to be both clinically and cost-effective (Morrell *et al*, 2009).

Clinical networks

NICE (2014) and SIGN (2012) recommend establishing regional perinatal mental health clinical networks of perinatal clinicians and other stakeholders, including commissioners/planners and patients. These networks will advise commissioners/planners, maintain the integration of providers across the care pathway and promote clinical excellence. They should have formal status and governance.

The Royal College of Psychiatrists' CCQI has a Quality Network for both mother and baby units and specialised perinatal CMHTs. All UK mother and baby units are members of the CCQI Network. They have developed consensus standards of care to which all members adhere and are subject to annual peer appraisal visits. Mother and baby units in the UK have now moved to CCQI accreditation.

Good perinatal mental healthcare services

Key principles

- Good perinatal mental health services will ensure that no woman is needlessly separated from her infant and that she receives the appropriate support, care and guidance to safely care for her infant if she is mentally unwell. If she requires admission to a psychiatric unit, she must be admitted to a mother and baby unit unless there are compelling reasons not to do so.
- A good service requires a perinatal mental health strategy, which includes a planning/commissioning framework and service design for populations large enough to provide a critical mass for all the services required across a clinical pathway. This will require collaboration with and between providers and other commissioners/planners.
- Services should be provided on the basis of the known epidemiology of perinatal conditions, taking into account any special geographical or socioeconomic features of the area to be covered.
- The delivered population should be the denominator for service planning and provision.
- Good perinatal mental health services will use an integrated care pathway drawn up and agreed by all stakeholders to ensure the timely access of women to the most appropriate treatment and service for their condition.
- There should be no unwarranted variation in the standards of care.
- All women should have equal access to the best treatment for the condition irrespective of where they live, their socioeconomic status or their ethnicity.
- Good perinatal mental health services should promote prevention, early detection and diagnosis and effective treatment.
- The right treatment should be timely, evidence based, effective, personalised and compassionate. It should meet the needs of both mother and infant, respect the wishes of the mother wherever possible and compatible with the safety of the infant, and promote optimal care and outcome for the infant.
- A good service should accommodate the cultural and religious practices of a newly delivered woman compatible with the health and safety of mother and infant.
- Good perinatal mental health services promote seamless, integrated, comprehensive care across the whole clinical pathway and across organisational and professional boundaries. This requires close working relationships and collaboration between mental health services and maternity services, children's services and social care, primary care and voluntary organisations.
- Good perinatal mental health services should include an education and training programme, which should be provided for non-specialists involved in the care of pregnant and post-partum women including general psychiatric teams, GPs, midwives, health visitors and psychological treatment services such as IAPT to ensure:
 - the early identification of those at high risk
 - early diagnosis
 - an understanding of the maternity context
 - the identification of additional clinical features and risk factors associated with perinatal disorders
 - that the developmental needs of infants are met.

- Good perinatal mental health services will provide an integrated care pathway with a range of services, including:
 - specialised in-patient mother and baby units
 - specialised perinatal CMHTs including maternity liaison
 - parent and infant mental health services
 - clinical psychology services linked to maternity hospitals
 - specialist skills and capacity within:
 - maternity services
 - general adult services
 - psychological treatment services, such as IAPT
 - general practice and the extended primary care team
 - health visiting.
- be able to admit emergencies
- offer timely, equitable and comprehensive access such that mothers are not admitted to general adult wards without their baby
- be closely integrated with specialised community teams to promote early discharge and seamless continuity of care.

Specialised perinatal 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:

- respond in a timely manner and have the capacity to deal with crises and emergencies and assess patients in a variety of settings including their homes, maternity hospitals and out-patient clinics
- have close working links with a designated mother and baby unit or be part of an integrated mother and baby unit and community service
- 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 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
- assess and proactively care for those at high risk of a postpartum condition
- 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.

Specialised perinatal services

A good specialist perinatal service should be organised on a hub-and-spoke basis so that in-patient mother and baby units to serve the needs of large populations are closely integrated with specialised perinatal CMHTs provided by mental health services in each locality.

Mother and baby units

A good mother and baby unit is accredited by the Royal College of Psychiatrists' CCQI and meets their standards. 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 in the 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
- offer advice, support and assistance in the care of the infant while the mother is ill, meeting the emotional and developmental needs of the infant
- provide a safe and secure environment for both mother and infant

Parent–infant mental health services

A good parent–infant mental health service will assess and provide care for mothers with complex perinatal mental health problems who have or are at risk of parenting difficulties.

- They provide a variety of psychotherapeutic, psychological and psychosocial treatments and parenting interventions.
- They should be able to see mothers and their infants at home as well as in the clinic setting.
- The service should be staffed by a multi-disciplinary team whose skill mix and competencies reflect their ability to deal with both maternal mental health problems and infant mental health issues and the interaction between the two.
- At least one clinician should have the clinical skills and experience to identify and if necessary refer on more serious perinatal problems.
- These services should work collaboratively with other psychiatric services, specialised perinatal services and mother and baby units, adult psychiatric services and children's Social Services.
- These services should provide advice and training to enhance the skills of IAPT workers and health visitors.
- They should be described as parent–infant, not perinatal, mental health services to clearly distinguish their function and avoid confusion.

Adult mental health services

- A good adult mental health service 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.
- They should take into account the possible adverse effects of psychotropic medication in pregnancy when prescribing to women of reproductive potential and provide women with this information.
- New episodes of psychiatric disorder in late pregnancy and the early postpartum period should, wherever possible, be redirected to specialised perinatal psychiatric services. Where these do not exist, adult mental health services should be aware of a differing threshold of response to all interventions including admission and the capacity

of perinatal conditions deteriorating rapidly and being associated with substantial morbidity and mortality.

- If a woman 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 peripartum 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.
- The service demonstrates that they consider their patients as parents and consider the welfare of the children.

Maternity services

A good maternity service:

- communicates with the patient's GP, informing them of the pregnancy, asking for information about any mental health problems and alerting them if difficulties arise
- 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
- should have access to a designated specialised 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.

Both midwives and obstetricians should receive additional education and training in perinatal mental health.

Psychological therapies services

A good psychological therapies service (e.g. IAPT) should:

- ensure that pregnant and postpartum women are 'fast tracked', assessed and starting treatment within 4 weeks
- receive additional training to ensure that they understand the maternity context and the additional clinical features and risk factors associated with perinatal psychiatric disorder
- be able to refer to perinatal mental health services in cases of concern or higher complexity.

GP and primary care teams

A good GP and primary care team 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 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; instruments such as the Edinburgh Postnatal Depression Scale (Cox *et al*, 2014) should be used with caution and in conjunction with a clinical assessment
- 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.

Health visitor services

A good health visitor service should:

- have the education, training and skills to detect mental health problems in pregnancy and the postpartum period
- know who to refer and to which service using the integrated care pathway
- be able to undertake basic psychological treatments such as listening visits, non-directive counselling and cognitive counselling
- understand which women would benefit from additional visits and support.

Health visitors should receive additional training in the detection of perinatal mental health problems. Those undertaking psychological interventions will require clinical supervision from an appropriately trained person.

Special considerations

- Perinatal mental health services will need to serve one or more minority ethnic communities. Such communities may have cultural or religious beliefs and practices which affect marriage and kinship, practices surrounding the birth and early postpartum period as well as child-rearing. These should be respected providing they are compatible with the well-being and safety of the mother and child. It is essential that perinatal mental health clinicians have knowledge and understanding of the cultural beliefs and practices of the communities they serve.
- Asylum seekers and refugees may have experienced trauma and torture, and may have lost or been separated from family including their own children. In addition, they may be facing current deprivation and adversity as well as fear of deportation. Their mental health problems may be compounded by grief and post-traumatic stress disorder. Perinatal mental health services should ensure these patients have access to the additional psychological, social and legal help they require.

- Perinatal mental health services should ensure that there are no barriers to access for childbearing women with other conditions who develop serious postpartum disorders. These include adolescent (teenage) mothers and mothers with intellectual disabilities. In these circumstances perinatal mental health services should work closely with other colleagues and services, for example those in CAMHS, intellectual disabilities, eating disorders and Social Services, contributing to the patients' care as appropriate.

Data and outcome measures

Good perinatal mental health services should systematically gather data on the patients they see in such a way that clinicians have access to that information; understand how they perform so that outcomes can be measured. Commissioners/planners should request data to support expected standards of care and contractual arrangements. For both clinical and planning purposes, it would be helpful if these data were standardised across all services so that comparisons of clinical and cost effectiveness can be made.

The current UK Mental Health and Learning Disabilities Data Set (Health and Social Care Information Centre, 2014) does not include data on whether a woman is pregnant or in the postpartum year. This may be changed in the future but in the meantime, it is imperative that mental health services record whether or not patients are pregnant or postpartum. Without this, it is not possible to identify which pregnant and postpartum women in the care of adult services are receiving the appropriate care. This also applies to psychological therapy services.

Information needs to be specifically designed for pregnant and postpartum women and recorded by services to provide data on performance and quality indicators, standards of expected care and maternal and infant outcomes as well as risk assessments. These will be over and above the data required for mental health trusts. An example of specific perinatal risk assessment and of data collection for specialised perinatal mental health services can be found at www.face.eu.com

Quality indicators and clinical outcome measures

These should be developed in such a way that they are comparable across all providers of specialised perinatal mental health services.

Quality indicators

Quality indicators are those indices that are likely to reflect access and the quality of clinical care, for example:

- length of stay, readmission rates
- direct admissions to a mother and baby unit and length of admission previously to an adult psychiatric ward
- compliance with quality standards.

Clinical outcome measures

These include, for example:

- improvement in maternal condition
- assessment and improvement of infant care
- patient-rated outcome measures
- patient feedback/satisfaction.

Staffing and resources for specialised perinatal mental health services

This guidance is informed by a number of national guidelines and national standards for mother and baby units and specialised perinatal CMHTs. In England, there is also a national service specification for mother and baby units and their linked community outreach teams (NHS England, 2012). The guidance also takes into account information and audit from the 17 mother and baby units in the UK on admission and referral rates and length of stay.

General principles

Estimates of need of a population should be based on the birth rate of that population rather than its size. It should take into account the epidemiology of perinatal psychiatric conditions and their referral rates to psychiatric services which have been established over many years. A critical mass of clinical activity is necessary for both clinical and cost effectiveness. The epidemiology of postpartum psychoses and of all serious and complex conditions requiring admission, a total of 4 per 1000 deliveries, means that only a large population of a minimum of 15 000 births a year will have a sufficient admitted morbidity to justify a mother and baby unit of 6 beds. Smaller units are not only very expensive but also do not have sufficient clinical activity to maintain specialist skills, knowledge and provide the specialist resources and care for mothers and their infants. The occasional admission of a mother and infant to a non-specialised adult psychiatric facility is no longer considered to be safe or of an acceptable quality.

All national guidelines say that women in the last trimester of pregnancy and the first year following delivery who require psychiatric admission should be admitted together with their infant to a mother and baby unit. All women experiencing perinatal psychiatric disorder who require specialised

psychiatric care should have access to specialised perinatal CMHTs.

Between 3 and 5% of the delivered population will require the services of a specialised perinatal CMHT. The critical mass or economy of scale required to maintain clinical and cost effectiveness means that specialised perinatal CMHTs can serve a smaller delivered population than mother and baby units, delivered populations of between 6000 and 10 000 births per year. There will therefore be more specialised perinatal CMHTs than mother and baby units.

Mother and baby units and specialised perinatal CMHTs should be linked to serve the needs of a large population in a hub-and-spoke fashion. These services should work together using a common clinical pathway to ensure timely access to the appropriate level of service and smooth, integrated care. This model of service provision will also be the most cost-effective as it will avoid unnecessary admission and promote appropriate early discharge, reducing lengths of stay on in-patient units.

The provision of all specialised perinatal mental health services should aim for equity of access and no unwarranted variations in the quality of care.

Estimates of workload and necessary resources cannot be based on productivity alone (i.e. the

number of patients assessed and treated). They have to take into consideration an important core function of a specialised service, time spent giving advice, telephone discussions, attending case conferences and other psychiatric teams' reviews, teaching and training.

Staffing and resources are based on the clinical need of mothers and their infants and the core functions of the service. The estimates described in this section are the minimum required for safety and quality of care. They are more fully described in the CCQI Quality Network standards and the National Health Service specifications (NHS England, 2012).

The range of professionals required should reflect the clinical needs of the patients and the function of a specialised perinatal mental health service. This includes a specialist consultant and medical staff, nurses, nursery nurses, visiting midwives and health visitors and also occupational therapists, psychologists and social workers. The specialist training and continuing professional development (CPD) required by these professionals is detailed in the CCQI standards.

The standards of care required by women with serious perinatal psychiatric disorder will be the same no matter who they are or where they live. However, some local variation in service design and provision may be needed. The size of the geographical area served may affect the provision of resources and staffing.

Specialised mother and baby units

Core function

- Mother and baby units provide psychiatric care for women with serious perinatal mental health conditions who cannot be safely or adequately treated at home. They admit mothers together with their infants. They provide medical, nursing, psychological and social care for mothers and their infants, meeting the emotional and physical needs of both. They promote the effective treatment and recovery of the maternal condition while promoting

the developing mother–infant relationship and ensuring the emotional and developmental needs of the child are met.

- They should be able to admit acutely ill mothers as an emergency 7 days a week. Many of the mothers will be newly delivered. The staffing and resources will be determined by these functions.

Number of beds

- The usually quoted number is 0.4 beds per 1000 deliveries. Based on this and an admitted incidence of 4 per 1000 deliveries, a large area with 15 000 deliveries a year will require 8 beds, whereas a typical health region in the UK with a population of 5 million and a birth rate of 55 000 per year would require 22 beds.
- This bed requirement is significantly affected by length of stay. One of the important factors determining the length of stay on an in-patient mother and baby unit is the availability of specialised perinatal community mental health services. These can reduce the need for admission by preventive care of high-risk women and early intervention and they can promote early discharge and reduce re-admissions.
- A mean length of stay of 5 weeks will mean that 1 bed will serve the need of 10 patients a year and a 6-bed mother and baby unit can deal with 60 admissions a year, serving the needs of the delivered population of 15 000, a bed requirement of 0.25 per 1000 deliveries.
- It can therefore be seen that specialised perinatal CMHTs closely integrated with a mother and baby unit can reduce the number of mother and baby beds required for a large population.

The size of the unit

- There is no available evidence for the maximum clinical and cost-effective size of a mother and baby unit. In the UK the largest units have approximately 10 beds. The concentration of a larger number of beds in a small number of mother and baby units will inevitably lead to some patients having to travel very long distances, with implications for themselves and

their families, and increase the difficulties in effective liaison with local community teams. Difficult decisions will need to be made about balancing the need for services to be delivered as close to a woman's home as possible and the clinical and cost-effectiveness of more centralised services.

- The typical UK mother and baby unit has 6 beds. Smaller units than this will cost as much to run and it is probable that at least 40 patients a year are required to maintain the clinical skills of the mother and baby unit. We therefore recommend that mother and baby units have between 6 and 10 beds, determined by the size of their delivered population and the social geography of their area.

Resources

- The details of the physical resources of a mother and baby unit can be found in the CCQI standards for mother and baby units. Essentially, they are determined by the special needs for safety and the special needs of recently delivered mothers and small babies. To provide a safe environment, they should be separate from an adult psychiatric unit with controlled access and facilities used only by mothers and their infants. There will be single-room accommodation and babies can be 'roomed in' with their mothers. There will be sufficient space for private and communal activities and a nursery.
- The mother and baby unit should be on the site of a psychiatric in-patient service so that additional assistance is available in an emergency. Ideally, they should also be on the site of a maternity unit and paediatric unit to allow for early transfer of newly delivered mothers and timely access to the appropriate maternity and paediatric care following delivery.

Staffing

All the staff should be contracted to the mother and baby unit with no other clinical responsibilities during their contracted hours (except for responsibilities to duty rotas). The following are the minimum core requirements for a typical 6-bed unit.

Medical staff

- There should be one lead consultant perinatal psychiatrist who devotes at least 0.5 whole time equivalent (WTE) to the mother and baby unit. The consultant will need to be supported by a junior doctor (in training) or a non-consultant grade equivalent. The contracted, designated medical staff should be available to the mother and baby unit during working hours. Further details on job planning and perinatal consultant responsibilities can be found in the Royal College of Psychiatrists' report CR174 (2012).

Nursing staff

- There should be a ward manager and at least one ward sister/charge nurse.
- A permanent qualified member of the nursing team should be on duty at all times, there should be a minimum of two qualified nurses supported by nursing assistants on duty during daytime hours and a minimum of two nursing staff, one of whom is qualified, at night.
- The numbers of nursing staff should be readily increased, determined by the acuity of the patients on the unit and in an emergency. However, the numbers of nurses should meet the needs of the patients for the majority of the time and the use of emergency, bank or agency staffing should account for less than 15% of the total numbers of nurses on duty in any week.
- An establishment of 4.5 nurses is required to provide one nurse on duty, 7 days a week for 24 hours.

Nursery nurses

- There should be at least one nursery nurse on duty during the extended daytime hours. Their time should be protected to allow them to assist mothers caring for their babies, ensure that the emotional and physical needs of babies are met and engage in activities to promote the mother–infant relationship. They should not be used, except in emergencies, as nursing assistants.

- There will need to be an establishment of 2.5 nursery nurses to provide one nursery nurse on duty during two daytime shifts.
- The number of both qualified mother and baby unit psychiatric nurses and of nursery nurses will need to be increased proportionately for units of larger size.

Psychologists

- For a 6-bed unit there should be 0.5 WTE clinical psychologist. Their role will include providing psychological assessments and treatments for the patients, supervising other staff delivering psychosocial interventions and leading mother and infant interventions.

Occupational therapists

- There should be 0.5 WTE occupational therapists devoted to the mother and baby unit. Their role will include assessing and assisting activities of daily living for new mothers and organising personal and group activities for mothers and their infants.

Midwife

- A designated midwife is required to visit the mother and baby unit as clinically necessary to see pregnant and recently delivered mothers and advise on the care of newborn infants. They should be available for advice at all times. This is an important team member as many of the mothers will not be able to access their usual community midwife because of distance. Mothers should receive at least the same level of maternity care while an in-patient that they would receive at home.

Health visitor

- There should be a designated health visitor who provides at least 1 half-day a week. They will see all the mothers and babies and advise on infant care as well as advising the nursing staff and providing clinical supervision for the nursery nurses. They also have an important role in liaising with the mother's own health visitor prior to discharge. Many mothers will not be able to access their own usual health visitor in the community, either because of the acuity of their illness or because of distance.

Audiovisual technology

- Facilities for teleconferencing are important to enable community staff at some distance from the unit to participate in care planning and pre-discharge planning. A personal computer or laptop with video-call facilities will enable mothers to keep in touch with older children and the family outside of visiting hours.

Specialised perinatal CMHTs

Specialised community teams that are provided by the same mental health service that provides a mother and baby unit can 'share' consultant medical staff, psychologists and occupational therapists, allowing for full-time appointments to the service as a whole.

Specialised perinatal CAMHS that are provided by other mental health services should have a close working relationship with the nearest mother and baby unit and use a common integrated care pathway (Table 2).

Function

The staffing of the community team will reflect the clinical needs of the mothers and their babies and the core functions of the service. The team members will include a consultant perinatal psychiatrist, specialised community psychiatric nurses and, ideally, occupational therapists and psychologists and nursery nurses. The core functions are to care for recently admitted and admission-vulnerable women, and managing women with perinatal mental health conditions, such as severe postnatal depression, which cannot be adequately managed by primary care services. They also provide a maternity liaison service both at home and in the maternity hospital and treat – during pregnancy and after delivery – women who have been identified as at high risk of developing serious illness. They will also provide pre-conception counselling.

Specialised perinatal CMHTs can improve the quality of care women receive as well as significantly reducing the duration of their stay on a mother and baby unit and preventing some admissions.

A typical mental health service will serve a general population of between 600 000 and 1 million delivering between 10 000 and 15 000 babies a year; 3 to 5% of the delivered population will be assessed and cared for by mental health services, although the number of referrals may be higher. A typical specialised perinatal community mental health service will therefore assess and care for between 300 and 500 new patients a year.

Staffing

Consultant perinatal psychiatrist

There should be one session (half-day) of consultant time for 1000 deliveries. A service with a delivered population of 10 000 will therefore require a full-time consultant. Their work should be supported by a junior (trainee) doctor or a non-consultant grade doctor. Further details on job planning and perinatal consultant responsibilities can be found in the Royal College of Psychiatrists' report CR174 (2012).

Specialised community psychiatric nurses

Community nursery nurses have an important function in advising and assisting mothers who are experiencing problems in caring for their infants.

There should be at least 0.5 specialised community psychiatric nurses per 1000 deliveries. For a delivered population of 10 000 there will therefore need to be 5 community psychiatric nurses and for 15 000 that number will be 8. If the service has a large geographical area there will be a need to proportionately increase the numbers of community psychiatric nurses to allow for travelling time to the patient's home.

Health visitors and midwives

A designated liaison health visitor and liaison midwife are desirable members of the CMHT. They do not provide a sessional contribution to the work of the team but act as links to their own services, providing advice to other midwives and health visitors, improving the appropriateness of referrals and contributing to the education and training programmes of both the team and other agencies.

Clinical psychologist and occupational therapist

These should be provided on the basis of 1 WTE per 10 000 of the delivered population.

Table 2 Perinatal community mental health team staffing per 10 000 deliveries

Specialist	Numbers
Consultant perinatal psychiatrist	1 WTE
Trainee psychiatrists/non-consultant grade doctor	1 WTE
Community team manager (50% managerial, 50% clinical)	1
Specialist community nurses	5
Psychologist	1 WTE
Occupational therapist	1 WTE
Social worker	0.5 WTE
Community nursery nurses	2.5 WTE
Link midwife	1.5 day
Link health visitor	1.5 day
Team secretary/administrator	1 WTE

WTE, whole time equivalent.

References

- Cantwell R, Sisodia N, Oates M (2002) *A Comparison of Mother and Baby Admission to a Specialised Inpatient Service with Postnatal Admission to General Services*. Proceedings of the Marcé Society Biennial Conference, Sydney.
- Centre for Maternal and Child Enquiries (2011) *Saving Mothers' Lives. Reviewing maternal deaths to make motherhood safer: 2006-2008. The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom (CMACE)*. *British Journal of Obstetrics and Gynaecology*, **118** (suppl 1): 1–203.
- Cooper C, Jones L, Dunn E, *et al* (2007) Clinical presentation of postnatal and non-postnatal depressive episodes. *Psychological Medicine*, **37**: 1273–80.
- Cox J, Murray D, Chapman G (1993) A controlled study of the onset, prevalence and duration of postnatal depression. *British Journal of Psychiatry*, **163**: 27–41.
- Cox J, Holden J, Henshaw C (2014) *Perinatal Mental Health (2nd edn): The Edinburgh Postnatal Depression Scale (EDPS) Manual*. RCPsych Publications.
- Davies A, Mclvor R, Kumar R (1995) Impact of childbirth on schizophrenic mothers. *Schizophrenic Research*, **16**: 25–31.
- Dean C, Kendell R (1981) The symptomatology of puerperal illness. *British Journal of Psychiatry*, **139**: 128–33.
- Department of Health (2004a) *National Service Framework for Children, Young People and Maternity Services: Core Standards*. Department of Health.
- Department of Health (2004b) *Women's Mental Health Strategy*. Department of Health.
- Department of Health (2007) *National Service Framework for Mental Health: Modern Standards and Service Models*. Department of Health.
- Department of Health (2009) *Improving Access to Psychological Therapies (IAPT): Perinatal Positive Practice Guide*. Department of Health.
- Elkin A, Gilbert H, Slade M, *et al* (2009) A national survey of psychiatric mother and baby units in England. *Psychiatric Services*, **5**: 629–33.
- Health and Social Care Information Centre (2014) *Mental Health and Learning Disabilities Data Set*. HSCIC (www.hscic.gov.uk/mhldds).
- Heron J, McGuinness M, Blackmore E, *et al* (2008) Early postpartum symptoms in puerperal psychosis. *British Journal of Obstetrics and Gynaecology*, **115**: 348–53.
- Howard L, Goss C, Leese M, *et al* (2003) Medical outcome of pregnancy in women with psychotic disorders and their infants in the first year after birth. *British Journal of Psychiatry*, **182**: 63–7.
- Howard L, Molyneaux E, Dennis C-L, *et al* (2014) Non-psychotic mental disorders in the perinatal period. *Lancet*, **384**: 1775–88.
- Joint Commissioning Panel for Mental Health (2012) *Guidance for Commissioners of Perinatal Mental Health Services*. JCPMH.
- Jones I, Craddock N (2005) Bipolar disorder and childbirth – the importance of recognising risk. *British Journal of Psychiatry*, **186**: 453–4.
- Jones I, Chandra PS, Dazzan P, *et al* (2014) Bipolar disorder, affective psychosis, and schizophrenia in pregnancy and the post-partum period. *Lancet*, **384**: 1789–99.
- Kendell R, Chalmers K, Platz C (1987) Epidemiology of puerperal psychoses. *British Journal of Psychiatry*, **150**: 662–73.
- Leahy-Warren P (2007) Social support for first-time mothers: an Irish study. *American Journal of Maternal Child Nursing*, **32**: 368–74.
- Maternity Services Action Group (2011) *A Refreshed Framework for Maternity Care in Scotland*. Scottish Government.
- Morrell C, Slade P, Warner R, *et al* (2009) Clinical effectiveness of health visitor training in psychologically informed approaches for depression in postnatal women: pragmatic cluster randomised trial in primary care. *BMJ*, **338**: a3045.
- Murray L, Hipwell A, Hooper R, *et al* (1996) The cognitive development of 5-year old children of postnatally depressed mothers. *Journal of Child Psychology and Psychiatry*, **37**: 927–35.
- National Institute for Health and Clinical Excellence (2011) *Caesarean Section* (Clinical Guideline 132). NICE.
- National Institute for Health and Care Excellence (2014) *Antenatal and Postnatal Mental Health* (Clinical Guideline 195). NICE.
- NHS England (2012) *Specialised Commissioning Specifications: Perinatal Mental Health Services*. NHS England.
- North East London Strategic Health Authority (2003) *Report of an Independent Inquiry into the Care and Treatment of Daksha Emson MBBS, MRCPsych, MSc and Her Daughter Freya*. North East London SHA.
- Oates M, Cantwell R (2011) Deaths from psychiatric cause. In *Saving Mothers' Lives. Reviewing maternal deaths to make motherhood safer: 2006-2008. The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom (CMACE)*. *British Journal of Obstetrics and Gynaecology*, **118** (suppl 1): 132–42.

O'Hara M, Swain A (1996) Rates and risk of postpartum depression - a meta-analysis. *International Review of Psychiatry*, **8**: 37–54.

Pawlby S, Fernyhough, Meins E, *et al* (2010) Mind-mindedness and maternal responsiveness in infant-mother interactions in mothers with severe mental illness. *Psychological Medicine*, **40**: 1861–9.

Royal College of Obstetricians and Gynaecologists (2011) *Guidelines on the Management of Women with Mental Health Issues during Pregnancy and the Postnatal Period* (Good Practice Guideline 14). RCOG.

Royal College of Psychiatrists (2012) *Safe Patients and High-Quality Services: A Guide to Job Descriptions and Job Plans for Consultant Psychiatrists* (CR174). RCPsych.

Scottish Intercollegiate Guidelines Network (2012) *Management of Perinatal Mood Disorders* (Guideline 127). SIGN.

Additional perinatal mental health data

Functional Analysis of Care Environments (FACE) Perinatal Toolset: <http://www.face.eu.com/solutions/assessment-tools/perinatal-psychiatry>

