

CR232

Perinatal mental health services:

Recommendations for the
provision of services for
childbearing women

September 2021

COLLEGE REPORT

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How to cite this publication:

Royal College of Psychiatrists (2021) College Report CR232: ‘Perinatal mental health services: Recommendations for the provision of services for childbearing women’

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

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Foreword

This update of the 2015 CR197 College Report on Perinatal Mental Health Services comes at a time of increasing international recognition of the wide-ranging and enduring impact of perinatal mental illness and a welcome commitment by the four UK nations to greater investment in perinatal mental health services.

Findings from the UK Maternal Death Enquiries (Oates, 2003) and the tragic death of Dr Daksha Emson (North East London SHA, 2003) highlighted suicide as a leading cause of maternal deaths. The recognition of the high morbidity and mortality associated with perinatal psychiatric disorders led the Royal College of Psychiatrists to establish the Perinatal Section (now the Perinatal Faculty) and the Perinatal Quality Network. Since then, there has been a significant expansion in the provision of specialist in-patient and community perinatal mental health services in England and Scotland and a commitment to ongoing expansion of these services in Wales and Northern Ireland. This has been driven by the evidence base, by the voices of women and their families (amplified by the third sector) and by the commitment and advocacy of perinatal mental health practitioners and clinical networks. There is a growing evidence base on effective interventions and service models for the prevention and treatment of perinatal mental illness, with an emphasis on helping women to recover and establish a strong bond with their infant and to ameliorate any adverse impacts on the wider family. In addition, there are recently developed quality standards, policies, guidelines and training resources that can inform the development of high-quality, evidence-based perinatal mental health services.

This College Report summarises the evidence base for the extent and impact of perinatal mental disorder and opportunities for intervention. The report sets out best practice principles, guidance and workforce recommendations. It recognises that the provision of high-quality mental health care in the perinatal period is not solely the responsibility of specialist perinatal mental health teams; it involves all psychiatrists and mental health practitioners working with women of childbearing potential and their families, such as general adult, liaison, CAMHS, eating disorders, learning disabilities, forensic and psychotherapy teams. It is essential that there is an integrated perinatal mental health care pathway across all health and social care services so that people using services, their families/supporters and all professionals, know what should be expected at any point along a woman's journey of care and that there is a consistent and coordinated response.

The Report describes exemplary perinatal mental health care for women and families who live in England, Wales, Scotland and Northern Ireland. We hope it also provides a helpful framework across a wider geography. Perinatal mental health conditions affect women and girls globally, in high-, middle- and low-income countries. The Perinatal Faculty fully supports the Royal College of Psychiatrists International Strategy. Under the leadership of Executive Members with international experience we are exploring opportunities to support perinatal mental health developments elsewhere in the world (Patel, Saxena et al, 2018) and to create forums for shared learning.

Executive summary: Principles and recommendations

This report describes the provision of good-quality mental health services to women with moderate to severe mental illness in the perinatal period and those planning a pregnancy. It will assist those planning and providing services for pregnant and post-partum women across a range of disorders and severities. It outlines the particular importance of perinatal mental health problems and the need for specialist perinatal mental health services in community and in-patient settings.

Recommendations

What perinatal mental health services should provide:

- Perinatal mental health services must be available to all women with severe mental illness and moderate mental illness with additional complex psychosocial needs or comorbid conditions.
- Thresholds of access to specialist perinatal mental health services need to take into account the modifying effects of pregnancy and infant care on the course of mental illness and offer lower thresholds and prompt access when needed.
- All women requiring admission to a mental health unit in late pregnancy or after delivery should be admitted with their baby to a specialist mother and baby unit, unless there are compelling reasons not to do so.
- All perinatal mental health services have a dual function to assess and treat maternal mental illness and assess and actively support the mother-infant relationship.
- All women should have equal access to individualised evidence-based treatment, irrespective of their age, socioeconomic status, ethnicity, gender or family structure. The cultural and religious practices of pregnant and newly delivered women should be accommodated, whilst ensuring the health and safety of mother and infant
- Good perinatal mental health services should promote seamless, integrated, comprehensive care across the whole clinical pathway, with clear communication across organisational and professional boundaries. This requires close working relationships between specialist perinatal in-patient and community teams, other mental health services, parent-infant mental health services, maternity services, extended primary care and universal services, social care and voluntary sector organisations.
- Services should work in collaboration with fathers/co-parents and other family members to help them to support mothers in their recovery and to support fathers and co-parents to develop his/her relationship with their baby. They should assess the mental health needs of the father/co-parent and offer support or signposting where indicated.
- Women who have experienced serious mental illness in the perinatal period (defined as pregnancy until the end of the first postnatal year) may require continued access to specialist support into the second postnatal year, in

order to complete an episode of care, mitigate maternal relapse and suicide risk and support the parent-infant relationship.

- Women with serious mental illness have a relatively high morbidity and mortality from physical health causes. Perinatal mental health services have a role to play in ensuring women have access to assessment, monitoring and interventions to improve their physical health.
- Perinatal mental health teams should routinely collect recommended process and outcome measures on women's mental health and experience of care, and on the mother-infant relationship.
- Good perinatal mental health services should include an education and training programme, including provision for the specialist perinatal mental health workforce and for non-specialists involved in the care of pregnant and postpartum women, including general psychiatric teams, GPs, obstetricians, midwives, health visitors and psychological treatment services such as Improving Access to Psychological Therapy (IAPT) and other national equivalents.
- Mother and baby units and community perinatal mental health teams should aim to be accredited by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI).

What a joined up perinatal mental health pathway should provide:

- Adult mental health services should ensure that women with a serious psychiatric disorder are counselled about the potential effects of pregnancy on their condition and receive information and advice about the possible effects of their medication on pregnancy and the developing foetus.
- Women under the care of adult mental health services, who are planning a pregnancy, must be able to access a pre-conception appointment within a specialist perinatal mental health team.
- Protocols for joint work between perinatal mental health teams and other mental health teams, such as adult mental health, learning disabilities, addictions, eating disorders and child and adolescent teams, should be locally agreed and have robust clinical governance. Continuity of relationship with a pre-existing team should not be a barrier to also accessing specialist perinatal mental health support.
- Psychological therapy services, including IAPT, and other national equivalents, should ensure that the needs of perinatal women and their co-parents are met. This includes receiving additional training and ensuring that women are assessed within two weeks of referral and start treatment within four weeks of assessment.

What primary care and maternity services should provide:

- All women who are planning a pregnancy and who have a history of mental illness should be offered appropriate pre-conception support and referred to a perinatal mental health service if they have a history of severe mental illness.
- Primary care, maternity and health visiting services should ensure that the mental health needs of women are met (in line with their statutory bodies and Royal Colleges). They should enquire about a woman's current mental health at all routine antenatal and postnatal checks and enquire about her

past mental health, including liaising with the woman's GP. Those who have a history of serious mental illness should be referred to the specialist perinatal mental health team.

- Maternity services (via integrated maternal mental health services or equivalents) should have access to specialised clinical psychology input for psychological distress relating specifically to obstetric care, including: obstetric loss; PTSD and birth trauma; tokophobia; and needle phobia.

What strategic networks should provide:

- Perinatal mental health managed clinical networks should be established 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.
- 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, types and severities of disorder.

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, revised as College Report CR88 (published in 2000) and subsequently revised as College Report CR197 (published in 2015). This revision of CR197, while adhering to the underlying principles of CR197, reflects the significant service development and ongoing expansion of specialist perinatal mental health services across the UK. We hope that we have managed to make this revised CR197 applicable across the UK and of value internationally.

When CR197 was published in 2015, specialist perinatal mental health services in the UK were fragmented and provision was variable across the UK despite SIGN 2012 and NICE 2014 guidance stipulating the need for women to be able to access specialist perinatal mental health care (SIGN, 2012; NICE, 2014). Since the publication of CR197, there have been significant and unprecedented increases in the provision of perinatal mental health services across the UK, particularly in England and Scotland. It must be noted that CR197 has played a pivotal role in supporting the development and design of these new services. The drivers for the expansion of perinatal mental health services are numerous and include the evidence base on the health, societal and economic impact of perinatal mental illness, the work of professional bodies and the voice of the voluntary sector and lived experience, including the Maternal Mental Health Alliance's Everyone's Business campaign (MMHA, 2021), in raising the profile of, and need for, specialist perinatal services.

The high costs of perinatal mental illness are well documented. An economic report from the London School of Economics outlined that, in the UK, failure to address perinatal mental health problems costs approximately £8.1 billion for each one-year cohort of births, 72% of which is due to the longer term associated effects on child well-being (Bauer, Parsonage et al, 2014). The annual cost to the NHS was estimated at £1.2 billion whilst the annual extra cost to develop perinatal care pathways in line with national guidance was estimated at £280 million (Bauer, Parsonage et al, 2014). The tri-annual Confidential Enquiries into Maternal Deaths and Morbidity have repeatedly shown that maternal mental illness is a leading cause of maternal death in the weeks and months after birth (Oates, 2003; Oates and Cantwell, 2011; Knight, Bunch et al, 2019). Almost one in eight women who died during pregnancy, or up to one year after pregnancy, died by suicide (Knight, 2018).

UK-wide national policies and guidelines make consistent recommendations that pregnant and postpartum woman with moderate to severe mental illness, and those who are well but are at high risk of experiencing serious perinatal mental illness, should access specialist care for perinatal psychiatric disorders (NHS England, 2019; Scottish PNIMH-PB, 2019; Welsh Government, 2019; Northern Ireland DoH, 2020). These recommendations impact on the provision of multiple universal and specialist services across the care pathway, including: specialist perinatal mental health services; adult mental health services; IAPT and national equivalents; maternity services; and GP, health visiting and extended primary care services.

Key policy and service developments in specialist perinatal mental health services in each of the devolved nations since 2015 are summarised in Appendix 1. It is positive that

the development of these services continues to be prioritised but the pace of change is variable across the devolved nations, as evidenced by a recent mapping exercise carried out by the Maternal Mental Health Alliance (MMHA, 2020) (see Appendix 1, Table A1 for details). Equity of access to, and provision of, high-quality specialist perinatal mental health services across the devolved nations is essential.

Specialist perinatal mental health services in the UK continue to be evaluated through the standards set out by the accreditation and peer review processes of Perinatal Quality Network (PQN), a member of the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) since 2007. The standards are regularly updated and are currently in their 7th edition for MBUs and in their 5th edition for specialist community perinatal mental health services (PQN/CCQI, 2019; PQN/CCQI, 2020). These national standards, as well as best practice guidelines set out by the National Institute for Health and Care Excellence (NICE, 2014) and other national professional bodies, have been important in maintaining high-quality care across existing and new services (see Appendix 2 for details).

What are specialist perinatal mental health services?

Specialist perinatal mental health services (PMHS) are concerned with the prevention, detection and management of mental health problems that can complicate pregnancy and the postnatal period. This includes offering pre-conception counselling, caring for women with new-onset or pre-existing moderate to severe mental illness, as well as caring for women with a history of illness who are currently well but who are at high risk of serious mental illness during the perinatal period. Promoting the emotional and physical well-being and healthy development of babies and infants, through supporting a secure and attuned relationship with their parents, is central to the care provided by a specialist PMHS.

Specialist perinatal mental health services (which include specialist community perinatal mental health teams and MBUs) are provided by mental health services. Specialist community perinatal mental health teams have the dual role of assessing and treating severe and moderate mental illness with additional complex psychosocial needs or comorbid conditions, as well as assessing and actively supporting the mother-infant relationship. Women who need admission in late pregnancy or the postpartum period should be admitted to specialist mother and baby units which are designed and resourced to safely meet the physical and mental health needs of both mother and infant. Each specialist perinatal mental health service should be part of a managed clinical network.

Perinatal mental health problems include a range of disorders and severities, which present in a variety of health settings and are managed by multiple 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:

- specialist community perinatal mental health teams (PMHTs)
- specialist in-patient mother and baby units (MBUs)
- adult mental health services (including community and in-patient services and psychological therapy services). Community services include intellectual disability services, eating disorder services, forensic services and alcohol and drug treatment services
- Child and adolescent mental health services (CAMHS)
- parent-infant mental health services
- maternity services (and any linked psychological therapy services)
- primary psychological services such as IAPT and other national equivalents
- general practitioners (GPs)
- health visitors and the extended primary care team
- Children's services and social care organisations
- voluntary/third sector and peer support organisations.

A comprehensive perinatal mental health strategy should encompass all levels of service provision, requiring collaboration across commissioning and provider organisations. Adequate specialist provision, robust care pathways and education and training of the specialist perinatal workforce and non-specialists are essential to ensure that patients can access the right service at the right time.

Why is perinatal mental health important?

Perinatal mental health problems: An overview

Childbirth is associated with substantial psychiatric morbidity. Pregnancy does not protect against the development or relapse of mental illness and the postnatal period is associated with substantially increased risks of severe mental illness and psychiatric admission (Howard, Molyneaux et al, 2014; Jones, Chandra et al, 2014; Howard and Khalifeh, 2020).

It has long been known that women are more likely to require psychiatric admission in the early postnatal period than at other times in their lives, for women both with and without prior psychiatric illness (Kendell, Chalmers et al, 1987; Langan Martin, McLean et al, 2016; Munk-Olsen, Maegbaek et al, 2016).

The risk of severe postnatal relapse is particularly high among women with bipolar disorder, with around one in five experiencing postpartum psychosis (Kendell, Chalmers et al, 1987; Jones and Craddock, 2005; Munk-Olsen, Maegbaek et al, 2016; Wesseloo, Kamperman et al, 2016). In contrast to the greatly increased risk of severe illness during the first few postnatal weeks, pregnancy is not associated with an increased risk of new or recurrent severe mental illness (Jones, Chandra et al, 2014; Munk-Olsen, Maegbaek et al, 2016). However, relapses of serious affective disorders do occur during pregnancy, particularly if medication has been stopped (Viguera, Whitfield et al, 2007; Jones, Chandra et al, 2014; Stevens, Goossens et al, 2019). Women with schizophrenia have high treatment needs in the perinatal period, given not only their

risk of relapse but also their complex physical health needs and potential safeguarding concerns (Howard, Thornicroft et al, 2004; Jones, Chandra et al, 2014).

Anxiety and depressive disorders constitute a significant proportion of treatment need for perinatal services, given their high prevalence, chronicity and associated adverse maternal and child outcomes (Howard, Molyneaux et al, 2014; Munk-Olsen, Maegbaek et al, 2016). Antenatal and postnatal anxiety and depression affect around 10–15% of women (Dennis, Falah-Hassani et al, 2017; Shorey, Chee et al, 2018) and their prevalence may be increasing over time (Pearson, Carnegie et al, 2018). The incidence and prevalence of mild to moderate anxiety and depression are broadly similar within and outside the perinatal period but there may be an increased risk of severe non-psychotic depression in the months following delivery (Cox, Murray et al, 1993; Munk-Olsen, Laursen et al, 2006). Obsessive compulsive disorder (OCD) may be more common in pregnant and postnatal women than in the general population, affecting around 2.0–2.5% of perinatal women (Russell, Fawcett et al, 2013; Fairbrother, Janssen et al, 2016). Pre-existing OCD can refocus on aspects of pregnancy and infant care, requiring specialist interventions to mitigate adverse effects on mothers and infants.

Post-traumatic stress disorder (PTSD) after childbirth is a condition reported by approximately 3% of women, rising to 5–9% when sub diagnostic PTSD is included (Yildiz, Ayers et al, 2017; Slade, West et al, 2020). Potential risk factors for PTSD include poor-quality interactions with staff, medical interventions such as emergency caesarean section, previous psychiatric history or prior abuse or trauma (Grekin and O'Hara, 2014; Yildiz, Ayers et al, 2017), as well as perinatal loss or premature delivery (Gold, Leon et al, 2016; Beck and Harrison, 2017). Early detection is important, so that NICE-recommended trauma-informed therapy can be provided when indicated (NICE, 2018).

Around 5% of pregnant women have an eating disorder and many experience persistence or worsening of symptoms in the perinatal period (Knoph, Von Holle et al, 2013; Howard, Molyneaux et al, 2014; Watson, Torgersen et al, 2014), with associated maternal physical and psychiatric comorbidity, and problematic infant feeding and temperament (Stein, Pearson et al, 2014; Watson, Torgersen et al, 2014). Pregnancy presents the opportunity for behaviour change and may be associated with increased motivation to engage with services.

Perinatal women with personality disorders, substance use problems, ADHD, ASD or learning difficulties have high morbidity and unmet needs for themselves and their infants. However, they are under-researched, experience stigma and discrimination in society and within healthcare settings and have difficulty accessing specialist perinatal mental health services and appropriately tailored interventions.

Notwithstanding the potential stigma related to a diagnosis of personality disorder, recognising the presence of longstanding personality difficulties in women (and their partners), often in conjunction with a history of childhood and more recent or chronic traumatic experiences, is important in the perinatal context because of the implications for treatment, co-working or transitions of care between services and teams, and for effective support of the parent-infant relationship (Royal College of Psychiatrists, 2018). Research into the prevalence of women meeting the criteria for a diagnosis of personality disorder within the community and those admitted to MBUs has provided estimates ranging from 3% to 23% (Tyrer, Reed et al, 2015; Yelland, Girke et al, 2015;

Connellan, Bartholomaeus et al, 2017; Judd, Newman et al, 2018; Winsper, Bilgin et al, 2020). Comorbidity with other perinatal mental health conditions, particularly anxiety, is common (MacLeod Hall, Molyneaux et al, 2019; Hudson, Spry et al, 2017) and the potentially increased risk of adverse child behavioural outcomes (Huntley, Wright et al, 2017) should prompt early consideration of the provision of relational psychological therapies that aim to guard against intergenerational transmission of adverse mental health outcomes to babies and children (Petfield, Startup et al, 2015). The impact of recent changes in ICD-11 in relation to the diagnosis of personality disorder and the new category of Complex PTSD (CPTSD) remain to be seen.

Fundamental principles for providing good care for women with complex needs, including relational continuity, shared ownership and attention to the training, supervision and support needs of staff and the wider organisation, have recently been highlighted (Royal College of Psychiatrists, 2020) and have elements in common with the principles of trauma-informed care (Law, Wolfenden et al, 2021).

There is increasing recognition of the serious short- and long-term consequences of alcohol or drug use in pregnancy and the postnatal period, for the mother and the developing foetus or infant, even with non-dependent use. The UK and Ireland were among the top five of 187 countries in a global survey of alcohol use in pregnancy, which also estimated that one in every 67 women who consumed alcohol during pregnancy would deliver a child with foetal alcohol syndrome (FAS) (Popova, Lange et al, 2017). NICE (2020) published draft quality standards on FAS disorder which emphasise the importance of encouraging abstinence from alcohol during pregnancy and recording any use of alcohol throughout pregnancy.

The links between mental disorders (including severe mental illness) and substance use are often complex and bidirectional. Women who have an active addiction in pregnancy often have vulnerabilities linked to adverse childhood experiences or gender-based trauma and may meet diagnostic criteria for borderline personality disorder, PTSD or complex PTSD (Brewin, Cloitre et al, 2017). Women with comorbid substance use disorders and mental illness have high rates of adverse maternal and infant outcomes, including increased risk of maternal suicide, and they require specialist, joined-up and proactive care (Knight, Tuffnell et al, 2015; Knight, Bunch et al, 2018). See Appendix 4 for further considerations on the impact and management of substance use disorders in the perinatal period.

Women with intellectual disabilities (ID) have poorer access to antenatal care and increased rates of adverse maternal and neonatal outcomes (Mitra, Parish et al, 2015), as well as increased rates of perinatal mental illness (Brown, Cobigo et al, 2016). Despite national initiatives to safeguard the rights of people with ID – including the rights to marriage and family life, independence, choice and inclusion (Department of Health, 2001) – there are significant pregnancy and parenting challenges for women with ID and the services supporting them. Women with ID and co-occurring moderate to severe mental illness require perinatal mental health services that meet recommended principles of care for people with ID – including the right to accessible information, tailored support and access to advocacy (NHS England, 2015; WTPN, 2017).

Domestic violence is an important risk factor for perinatal depression, anxiety and PTSD (Howard, Oram et al, 2013) and is highly prevalent among women with severe mental

illness under general and specialist perinatal mental health services (Khalifeh, Moran et al, 2015; Taylor, Stewart et al, 2015). Domestic violence often starts or escalates in pregnancy and is strongly associated with maternal suicide, homicide and adverse obstetric and neonatal outcomes (Palladino, Singh et al, 2011; Knight, Bunch et al, 2018). There is growing evidence that interventions that integrate domestic violence advocacy (usually provided via partnerships between health and voluntary sector organisations) and trauma-informed psychological therapies are effective at reducing domestic violence-associated morbidity (Oram, Khalifeh et al, 2017). Domestic violence voluntary sector organisations offer unique and necessary expertise in safeguarding women in the perinatal period.

Impact of perinatal psychiatric disorders

Childbirth and new motherhood carries an expectation of happiness but it is also a time of emotional upheaval and adjustment to significant changes in lifestyle and relationships. Significant mental health problems at this time cause enormous distress and can seriously interfere with the adjustment to motherhood and the care of the newborn baby and older children (Dolman, Jones et al, 2013). Poorly managed perinatal mental health problems can have lasting effects on maternal self-esteem, partner and family relationships, and the mental health, emotional and social development of the child (Stein, Pearson et al, 2014).

Pregnancy and the first few months and years of a child's life are critical for brain development, laying the foundation for future learning, behaviour and health (Glover, 2015). Longitudinal studies have shown that some perinatal mental health problems may be associated with long-term negative effects on the infant's cognitive, social, emotional and behavioural development, if timely and appropriate support is not received (Suri, Lin et al, 2014; Netsi, Pearson et al, 2018; Rees, Channon et al, 2019). The mechanisms underlying these associations are complex and they include a range of genetic, other biological and environmental pathways (Entringer, Buss et al, 2015; Glover, 2015). For example, foetal exposure to the maternal stress hormone, cortisol, may lead to alterations in the developing infant's stress response system and/or epigenetic change and associated phenotypic alterations (Glover, O'Connor et al, 2010; Brummelte, Mc Glanaghy et al, 2017). Postnatally, perinatal mental health problems may cause altered maternal behaviours and deficits in the quality of the mother-infant interaction (Stein, Pearson et al, 2014; Erickson, Julian et al, 2019). The chronicity of exposure is important and co-occurring environmental risks and other adverse childhood events are also known to impact, for example through exposure to co-occurring parental conflict (Stein, Pearson et al, 2014). Around three quarters of the high economic cost of perinatal mental disorders are attributable to long-term adverse effects on children (Bauer, Parsonage et al, 2014). Positive experiences and good relationships between child and caregiver may protect against changes in biological stress responses to early adversity (Dozier, Peloso et al, 2008).

Acute serious perinatal illness usually presents as an emergency and often requires in-patient care (Jones, Chandra et al, 2014; Howard and Khalifeh, 2020). Separation of mother and baby at this point is likely to have a significantly adverse impact on the developing relationship between the mother and infant, which may have longstanding effects on both mother and child. Separation causes great maternal distress and interferes with treatment of the mother, as well as preventing breastfeeding (where it is the mother's choice).

Serious perinatal mental disorders are associated with increased maternal deaths from suicide, substance use-related problems and misattribution of physical symptoms to psychiatric illness (Cantwell, Clutton-Brock et al, 2011; Johannsen, Larsen et al, 2016; Knight, Bunch et al, 2018). Suicide has been shown to be a leading cause of maternal mortality in the past two decades (Oates, 2003; Knight, Bunch et al, 2019). A significant proportion of women who die by suicide in the perinatal period have early life adversity, multiple social disadvantages and comorbid substance use (Knight, Tuffnell et al, 2015; Knight, Bunch et al, 2018). Perinatal suicide is strongly associated with a diagnosis of depression and the presence of domestic violence, and it may be associated with under-treatment (particularly with psychotropics) (Palladino, Singh et al, 2011; Khalifeh, Hunt et al, 2016; Howard and Khalifeh, 2020). There is some evidence that suicide risk peaks towards the end of the first postnatal year (Thornton, Schmied et al, 2013; Grigoriadis, Wilton et al, 2017). This highlights the importance of early detection, proactive treatment and safe discharge planning for women with perinatal mental disorders.

Serious perinatal mental health problems are associated with increased risks of obstetric and neonatal morbidity – including obstetric near-misses – and risks are elevated regardless of psychotropic use in pregnancy (McAllister-Williams, Baldwin et al, 2017; Howard and Khalifeh, 2020; Easter, Sandall et al, 2021). Psychotic illness in pregnancy is associated with severe complications, including an increased risk of placental abruption, postpartum haemorrhage, stillbirth and neonatal deaths (Howard, Goss et al, 2003; Vigod, Kurdyak et al, 2014).

Perinatal mental health problems are therefore a major public concern. They make a significant contribution to both maternal and infant morbidity and mortality, as well as having a potentially long-term adverse impact on children's development. Perinatal mental health services that address maternal mental illness and optimise the parent-infant relationship are expected to be cost effective because of the benefits for mothers' physical and mental health, and for the longer-term developmental outcomes for children (Bauer, Parsonage et al, 2014). More detailed research on the effectiveness and cost-effectiveness of in-patient and community perinatal mental health services is currently underway (NIHR 2013, NIHR 2019).

Perinatal mental health problems in fathers

The importance of addressing fathers' mental health problems in the perinatal period is increasingly recognised with potential benefits for fathers, mothers and infants and this is reflected in recent perinatal policy recommendations that call for assessment and support/signposting for fathers' mental health within perinatal mental health services (NHS England, 2019).

A significant proportion of partners of women with perinatal mental health problems experience mental health difficulties themselves during this time (Munk-Olsen, Laursen et al, 2007; Thiel, Pittelkow et al, 2020). Fathers have similar rates of perinatal depression and anxiety to mothers (Cameron, Sedov et al, 2016; Leach, Poyser et al, 2016) and this is associated with prior mental illness, relationship difficulties and socioeconomic adversities (Thiel, Pittelkow et al, 2020; Ansari, Shah et al, 2021). The prevalence of longstanding personality difficulties in fathers in the perinatal period and how this might interact with maternal mental health, couple functioning and child outcomes has had little attention in research (Steele, Townsend et al, 2019). Perinatal mental illness in fathers may be linked to adverse child developmental outcomes and child maltreatment (Ramchandani and Psychogiou, 2009; Sweeney and MacBeth, 2016; Ayers, Bond et al, 2019; Gutierrez-Galve, Stein et al, 2019), particularly in the context of additional familial risk factors such as substance use, inter-parental conflict and socioeconomic disadvantage (Stein, Pearson et al, 2014; Sweeney and MacBeth, 2016; Ayers, Bond et al, 2019). There is a limited but growing evidence base on interventions for perinatal mental disorders among fathers (Rominov, Pilkington et al, 2016). In recent qualitative studies, fathers report feeling marginalised by perinatal mental health services and having unmet information needs but also express ambivalence about involvement and support; some mothers, conversely, report uncertainty about involving fathers, especially where relationships are poor (Lever Taylor, Billings et al, 2018). This underlines the complexity of addressing fathers' mental health needs within the setting of perinatal mental health services.

Opportunities for prevention, intervention and treatment

A detailed review of the evidence base on interventions for perinatal mental illness is beyond the scope of this report. However, this evidence is well summarised in recent systematic and narrative reviews, NICE Guidelines and perinatal prescribing guidelines (Dennis and Hodnett, 2007; Howard, Molyneaux et al, 2014; Jones, Chandra et al, 2014; NICE, 2014; Stein, Pearson et al, 2014; Barlow, Bennett et al, 2015; McAllister-Williams, Baldwin et al, 2017; van Ravesteyn, Lambregtse-van den Berg et al, 2017; Howard and Khalifeh, 2020; Brown, Wilson et al, 2021). In addition to this evidence, service provision and development should be guided by recent studies on stakeholder's treatment needs and experience of services (O'Mahen, Fedock et al, 2012; Dolman, Jones et al, 2013; Dolman, Jones et al, 2016; Lever Taylor, Billings et al, 2018; Watson, Harrop et al, 2019; Lever Taylor, Kandiah et al, 2020; Rubio, Lever Taylor et al, 2021). Common themes include the centrality of motherhood among women with severe mental illness (Dolman, Jones et al, 2013), the value of accessing specialist perinatal care from pre-conception to the postnatal period, the importance of continuity of care for women with chronic illnesses and the need to tailor crisis interventions for perinatal women and their families (Lever Taylor, Kandiah et al, 2020; Rubio, Lever Taylor et al, 2021). There is evidence

that, where admission is needed, service users and staff prefer admission to specialist perinatal rather than generic psychiatric wards (Griffiths, Lever Taylor et al, 2019).

Services should offer evidence-based interventions aimed at supporting the parent-infant relationship and mitigating the transgenerational effects of perinatal mental disorders (Stein, Pearson et al, 2014; Stein, Netsi et al, 2018; Erickson, Julian et al, 2019). Trauma and familial psychosocial adversities are common comorbidities of perinatal mental disorders across the diagnostic spectrum and are important contributors to negative parenting and child outcomes. Therefore trauma-informed care and family-based interventions may be particularly important in mitigating risks for children (Barker, Iles et al, 2017; Chamberlain, Gee et al, 2019; Howard and Khalifeh, 2020; Law, Wolfenden et al, 2021).

Within the stepped-care model approach recommended by NICE (NICE, 2014), evidence across universal, primary and secondary care settings is relevant to the planning and delivery of perinatal mental health services. In primary mental health care settings, IAPT and national equivalents can deliver evidence-based psychological interventions for perinatal mental disorders (Dennis and Hodnett, 2007; McAllister-Williams, Baldwin et al, 2017; van Ravesteyn, Lambregtse-van den Berg et al, 2017; Furuta, Horsch et al, 2018; Nillni, Mehralizade et al, 2018; Stevens, Miller et al, 2020). This includes promising psychological interventions specifically adapted to the perinatal period for the treatment of perinatal depression (O'Mahen, Richards et al, 2014; Trevillion, Ryan et al, 2020), OCD (Challacombe, Salkovskis et al, 2017) and generalised anxiety disorder (Wilkinson, O'Mahen et al, 2016). There is promising evidence for the effectiveness of internet-based psychological therapy for the treatment of perinatal anxiety and depression (Loughnan, Joubert et al, 2019) – an important finding in the context of COVID-19 related restrictions and subsequent remote service delivery. Within health visiting services, there is evidence for the effectiveness of psychologically informed treatments such as listening visits, non-directive counselling and cognitive counselling (Morrell, Slade et al, 2009; Brugha, Morrell et al, 2011; Morrell, Sutcliffe et al, 2016; Henderson, Dixon et al, 2019).

The provision of specialist pre-conception care and counselling for women with moderate to severe mental illness (or those at high risk of serious perinatal illness) is key to preventing maternal psychiatric and physical morbidity, and associated harms to the unborn baby and infant (NICE, 2014; Public Health England, 2018; Catalao, Mann et al, 2020). Pre-conception care as recommended by NICE (2014) includes individualised discussion on risks and benefits of psychotropic use in pregnancy, family planning and advice and signposting to address common important comorbidities such as smoking, obesity, diabetes, hypertension and domestic violence and abuse.

Pregnancy and early motherhood are times of unparalleled contact with health services. This should provide the framework to identify women at increased risk of perinatal mental illness, ensure early diagnosis, the development of a personalised care plan for each woman at increased risk and to offer prompt interventions for mothers and the mother-infant relationship.

Good practice guidance for perinatal mental health care services

In this section we outline good practice guidance for specialist community and in-patient perinatal mental health services, and for other specialist and universal services involved in the perinatal mental health care pathway. These recommendations are underpinned by the principles outlined in the Executive Summary.

Specialist community perinatal mental health teams

A good specialist community perinatal mental health team will be a member of the CCQI Quality Network for Perinatal Mental Health Services and aim to be accredited. It will assess and manage women with moderate to severe mental illness in the community, who cannot be appropriately treated by primary care services. It should:

- assess and care for pregnant and postnatal women with moderate to severe mental disorder who require secondary care mental health services, adjusting referral thresholds for distinctive perinatal need and complexity
- provide pre-conception advice to women who are at high risk of early post-partum major mental illness
- assess and proactively care for women who are well but who are at high risk of a severe postnatal illness
- assess the mother-infant relationship and infant development in the context of maternal mental disorder
- prioritise the management of women on leave, or recently discharged, from MBU care
- provide a regular point of contact with local maternity units to co-work on delivery plans for patients and to support maternity staff
- be able to respond in a timely manner which takes into account the maternity context, needs of the developing infant and alterations to presentations brought about by the perinatal period
- provide a range of evidence-based psychological, pharmacological and psychosocial interventions that are adapted for the perinatal period to treat maternal mental health problems and support the mother-infant relationship, promoting the best outcomes for infant development
- 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

- provide in-home and remote treatment options, where these suit the mother and infant and may improve treatment adherence
- provide advice, support and signposting to partners of women under the care of the service, who may themselves have mental health difficulties, and support the development of the father/partner-infant relationship
- assess women accessing perinatal mental health services in the first postnatal year who may require ongoing care into the second postnatal year, to complete individual or parent-infant interventions. This may require close working between specialist community perinatal teams, local parent-infant mental health services, where available, and CAMHS.
- provide clinical advice and guidance to other mental health, maternity, health visiting, primary care and social care colleagues on the assessment and management of maternal mental disorder.

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:

- assess and care for women in late pregnancy and postnatal women (to 12 months) with mental disorder who require in-patient care, accompanied by their infants
- provide care across the range of conditions, complexity and severity usually managed on a general adult mental health in-patient unit
- be able to respond in a timely manner which takes into account the maternity context, needs of the developing infant and alterations to presentations brought about by the perinatal period
- ensure that the infant's health, care and developmental needs are fully met
- assess the mother-infant relationship and infant development in the context of maternal mental disorder
- provide a range of evidence-based psychological, pharmacological and psychosocial interventions that are adapted for the perinatal period to treat maternal mental health problems and support the mother-infant relationship
- offer timely, equitable and comprehensive access such that mothers are not admitted to general adult wards without their baby
- be closely integrated with specialist community perinatal and outreach teams to promote early discharge and seamless continuity of care
- provide advice, support and signposting to partners of women under the care of the service, who may themselves have mental health difficulties, and support the development of the father/partner-infant relationship.

Psychological therapy provision within IAPT and national equivalents, specialist community perinatal mental health teams, MBUs and maternity services

Psychological therapies include guided self-help, group, individual, couples, family and parent-infant interventions. Evidenced-based psychological therapies are essential treatments for mental health problems in the perinatal period and are key to supporting disrupted parent-infant relationships (NICE, 2014).

Good psychological therapy provision should:

- be available to all women across the pathway from primary, through to specialist perinatal mental health services in the community and in MBUs
- accept referrals from a range of healthcare professionals and accept self-referrals in the case of IAPT and other national equivalent services

- take into consideration the needs and context of the wider family (e.g. fathers/partners, children and other important family members)
- be adapted to take into account the perinatal context and be designed to mitigate the impact of mental ill health on the infant
- be available for the full range of presenting problems – including psychosis, mood and anxiety disorders, PTSD, OCD, personality disorder, complex PTSD – and provide a range of evidence-based interventions
- be available to women who have substantial psychological needs relevant to childbearing (e.g. tokophobia, birth trauma, infant loss), which require specialist psychological input
- prioritise referrals for pregnant women and women in the postnatal period to avoid delays in assessment and treatment. In line with NICE guidance, women should be assessed within two weeks of referral and start treatment within four weeks of assessment.
- provide robust supervision of therapists and other health professionals delivering psychologically informed interventions, to ensure high-quality and safe provision of psychological therapies
- provide additional training to staff to ensure that they understand the psychological, emotional and social challenges of the transition to parenthood, and how to adapt the delivery of evidence-based interventions to meet the parents' needs
- have flexible cancellation and rescheduling policies and provide additional outreach to perinatal parents, to ensure engagement with treatment
- establish clear pathways with GPs, midwifery and health visiting to ensure smooth and rapid referral processes, and coordinated care across the care pathway
- provide child-friendly spaces which enable women to be seen with their infant, where appropriate, or crèche services (i.e. within a children's centre), where it is not appropriate for a woman to be seen with her infant
- seek to provide care within locations that are de-stigmatising to parents, e.g. local charities, children's centres, maternity centres
- offer parents remote-delivery treatment options where appropriate.

Parent–infant mental health services

In the UK there is wide variety in the set-up, funding and therapeutic model of teams and services which provide therapeutic interventions for parent-infant relationships in pregnancy and the early years (see Appendix 3). This includes variations in the target population and configuration of services with some standalone services as well as services embedded within specialist perinatal services or CAMHS. Ideally, a combined perinatal and infant mental health strategy and integrated pathway should be drawn up together, acknowledging the overlap in populations served and the need to collaborate with providers and other commissioners/planners. This guidance does not recommend a specific model but the good practice guidance below applies to standalone parent-infant services.

Good quality parent-infant mental health services should:

- be multidisciplinary teams with expertise in supporting mothers and fathers/partners/other carers to develop sensitive and attuned relationships with their babies, infants and toddlers, including in the antenatal period
- offer direct support to parents and carers using a variety of evidence-based therapeutic parent-infant interventions
- work collaboratively with local perinatal, adult and child and adolescent mental health services, primary care, social care, third sector and peer support organisations to establish protocols for discussing referrals and joint working so that parents experiencing perinatal mental health difficulties, which are impacting on their developing relationship with their baby/infant, can access the right help at the right time. This is particularly important where parents may have complex mental health difficulties, including complex trauma and personality difficulties.
- have clear lines of leadership, systems for data collection and outcome monitoring, and a commitment to protected time for reflective supervision and continued professional development for all staff involved in clinical work
- have a care pathway for consultation with, and possible onward referral/joint working with, relevant specialists, including child psychiatrists with specialist training in infant mental health and developmental paediatric teams (for when there are concerns about the baby's development, social interaction or general physical well-being, particularly for babies with risk factors for neurodevelopmental problems)
- work collaboratively with local perinatal and CAMHS leads to provide parent-infant mental health training, consultation and supervision for the local workforce.

Child and adolescent mental health services (CAMHS)

CAMHS services can play a role in service provision for infants of mothers accessing perinatal mental health services, as well as service provision for teenage and young parents. The current provision for children aged 0–5 and their parents/carers within CAMHS is highly variable across the UK but a forthcoming College Position Paper will provide some detail on this and potential future developments. Services for young people aged 18–25 are in the early stages of development and young mothers can fall between the gap in CAMHS and adult mental health services, including perinatal mental health services. The good practice guidance below relates to service provision for infants and for young mothers.

In terms of service provision for infants and their parents/carers, a good CAMHS should:

- collaborate with perinatal mental health services, parent infant mental health teams, adult mental health services, substance use services, primary care, paediatric teams and other relevant statutory and third sector agencies to provide high-quality, accessible mental health provision for the 0–5-year-old population and their parents/carers
- provide consultation, training and supervision for the wider maternity and early years workforce, around the particular mental health needs of this age group and their parents/carers.

In terms of service provision for teenage mothers, a good CAMHS should:

- establish clear pathways of care for young mothers aged under 18 years, requiring community psychiatric intervention or admission to an MBU, in close collaboration with specialist perinatal mental health services, primary care and social care. This will be especially important for young mothers with pre-existing mental disorders, including those with symptoms of complex trauma.
- ensure that where specialist perinatal mental care is needed for young women, this care is delivered using close collaboration between CAMHS, perinatal mental health services, other relevant adult mental health services (including substance use, personality disorder services and intellectual disability services, if needed), parent-infant mental health services, maternity, primary care, social care and, where available, Family Nurse Partnership (FNP) programmes
- ensure young women under the care of CAMHS access pre-conception advice where needed and that underlying complexities which may create risk for a future pregnancy, e.g. substance use, relationship difficulties/abuse, childhood trauma, are identified and individuals are signposted to sources of support, as well as directed to family planning advice.

Adult mental health services

A good general adult mental health service should:

- regard men and women of reproductive age as having the potential for childbearing and ‘think family’ for clients under their care
- where relevant, demonstrate that they consider their patients as parents and consider the welfare of all children in their patients’ care
- ensure that patients with serious mental illness receive pre-conception counselling and are aware of the risks to their mental health of becoming pregnant, and identify underlying complexities which could create risk for future pregnancy, e.g. substance use, relationship difficulties/abuse, childhood trauma and signpost to sources of support as well as directing to family planning advice
- take into account the possible adverse effects of psychotropic medication in pregnancy when prescribing to women of reproductive potential and provide women with relevant information
- redirect, wherever possible, women with new episodes of serious mental health problems in late pregnancy and the early post-partum period to specialist perinatal mental health services; where these do not exist, adult mental health services should be aware of the differing threshold of response (including admission) and the capacity for mental illness to deteriorate rapidly during the perinatal period and be associated with substantial morbidity and mortality
- have arrangements in place so that when a woman already under their care, because of a long-standing serious mental health problem, becomes pregnant, she is referred to a community perinatal mental health team and that an agreement is then made regarding joint working and lead management (based on the woman’s clinical needs and local models of care)
- work collaboratively with maternity services, perinatal services and other services involved in a woman’s care to develop a perinatal mental health care plan
- ensure that when admission is needed in late pregnancy or in the postnatal period, the mother (and her infant) are admitted to a mother and baby unit, even if this requires an out-of-area placement. The referral should be carried out proactively to avoid women spending time on an acute adult ward, unless clear evidence of risk to the baby exists. An admission of a mother and infant together to a non-specialist psychiatric ward is not acceptable and should not take place.

Maternity services

A good maternity service should:

- communicate with the patient's GP, informing them of the pregnancy, asking for information about any mental health problems and alerting them if difficulties arise
- provide trauma-informed care to promote feelings of psychological safety, choice and control
- ensure that women are asked sensitively about their mental health at their initial midwifery appointment and at all subsequent appointments
- equip all midwives with the knowledge and skills to deal with the normal emotional changes of pregnancy and the early post-partum period and common states of distress
- ensure that women with moderate to severe mental illness, and those who are currently well but who are at high risk of severe postnatal mental illness, are identified at early pregnancy and referred to a specialist perinatal mental health team
- ensure that women with significant mental health problems have a clear perinatal mental health care plan, documented in both the woman's electronic and hand-held records
- ensure that women with identified mental illness are able to access appropriate support within maternity services, including specialist perinatal mental health midwives
- ensure continuity of care; based on the strong evidence base for the benefits of one midwife or a small team of midwives caring for women with mental illness
- ensure that women with psychological distress related to the maternity context, such as obstetric loss, needle phobia, obstetric trauma and previous rape or abuse, are able to access appropriate psychological interventions
- be alert to the possibility of issues such as pre-existing or newly arising domestic violence (including coercive control), substance use or homelessness and be able to ask sensitively about this and liaise with relevant local teams and agencies so that women experiencing these difficulties can quickly access the right support
- ensure both midwives and obstetricians receive additional education and training in perinatal mental health
- address the importance of immediate access to post-pregnancy contraception, in line with guidance from the Royal College of Obstetrics and Gynaecologists. (FRSH Guideline Contraception After Pregnancy, 2017).

Neonatal services

A good neonatal unit should:

- provide access to specialist clinical psychologists who can provide care for the whole family unit whilst their infant is an in-patient. These psychologists are typically part of a paediatric psychology service and may also work alongside other senior clinicians with appropriate perinatal and parent-infant mental health training, counsellors and family support workers, as well as close working with the neonatal team.
- offer psychological interventions focused on issues specific to neonatal care, for example trauma related to medical events such as resuscitation, adjustment to parenting in the context of critical care and/or disability, help with complex decisions and work around bereavement and loss. This work is with individuals and couples and may also include siblings.
- ensure clinical psychologists in the neonatal unit treat a full range of parental psychological distress related to neonatal admission, such as associated depression, anxiety and trauma reactions
- ensure specialist psychologists work closely with perinatal mental health teams, where it is clear that there are significant maternal mental health needs in addition to the issues that arise directly as a result of a neonatal admission
- ensure, where there is joint working between a neonatal unit and a perinatal mental health team, close liaison on discharge of the baby from hospital (a time of increased vulnerability and distress) and for mothers facing additional parenting challenges (such as caring for a child with a disability or on-going medical needs)
- facilitate input from paediatric occupational therapists with neonatal experience, where available, to support parents to manage soothing, feeding and sleeping difficulties arising from the baby's experience on the neonatal unit
- ensure clinical psychologists work closely with the wider neonatal team, consulting on systemic interventions, communication and conflict resolution and contributing to the implementation of family-centred care.

GP and primary care teams

A good GP and primary care team should:

- ensure that women with serious mental illness receive pre-conception counselling from specialist perinatal mental health teams 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 relevant information
- know where to access information on the benefits and risks of psychotropic use in pregnancy, either from online sources or local specialist services, and understand the risks of suddenly stopping medication
- ensure that women are asked about current mental health problems during pregnancy and the early post-partum period in line with NICE guidelines; instruments such as the Edinburgh Postnatal Depression Scale (Cox, Holden et al, 2014) should be used with caution and in conjunction with a clinical assessment
- communicate with midwives and consult with the local specialist perinatal mental health team if a woman with a history of significant mental illness becomes pregnant or if there is a maternal family history of significant perinatal mental illness, even if the woman is well or showing mild symptoms of relapse
- be alert to the possibility of onset of depression and anxiety in the perinatal period and to the risk of recurrence or persistence of pre-existing mental illnesses
- be competent in the treatment of uncomplicated non-psychotic depression and/or anxiety, and refer to primary care psychological therapies as required
- be alert to the possibility of mental health difficulties arising, or being exacerbated in the perinatal period, in fathers and partners and provide support, refer to primary care psychological therapies and/or provide information about community and peer support resources as required
- be provided with training to identify parent-infant relationship difficulties. Where there are concerns, the team should liaise promptly with the local parent-infant mental health service or specialist perinatal mental health team, according to local care pathways.

Health visitor services

A good health visiting service should:

- consider the mental health needs of both parents and the potential impact of parental mental illness on infants and older children, signpost or refer to relevant services using the integrated perinatal care pathway
- ensure that all mothers and fathers/partners are asked about their mental health in line with NICE guidelines at each contact of the Healthy Child Programme, using recommended screening tools
- have the training and skills to detect mental health problems in pregnancy and the postnatal period
- promote positive infant mental health and parent/carer and infant relationships, beginning in the antenatal period and continuing at every further contact until the child reaches school age
- use a strengths-based approach to promote sensitive, consistent, responsive, nurturing relationships between parents and infants in the first few years of life
- deliver recommended evidence-based psychological treatments such as listening visits, non-directive counselling and cognitive counselling
- understand which families would benefit from additional visits and support
- provide continuity of care when a family is under the care of specialist perinatal mental health services and enable safe and effective care during 'stepping up and stepping down' between specialist services and universal care
- have access to advanced/specialist lead health visitors at a local level, as recommended by national bodies including HEE and the MMHA
- ensure supervision from an appropriately trained person to health visitors providing psychological interventions.

The third sector and peer support

The third and voluntary sector plays an important role in providing accessible, often peer-led, support to women experiencing perinatal mental health problems across all ranges of severity. There has been a significant growth in voluntary sector organisations focusing on perinatal mental illness, ranging from local to national and international organisations; with most focusing on specific illnesses and offering information, peer networks and/or individual support.

The support offered by third sector and voluntary organisations can make a lasting difference to women, families and communities. Ensuring that organisations have sustainable funding is outside the remit of this report. However, examples of third sector organisations being commissioned to deliver an agreed part of the pathway by health or social care teams have proved effective and well received by women and their families.

Good practice for voluntary or third sector organisations:

- For women with mild problems that do not require access to perinatal mental health services, these organisations may provide the primary source of support.
- For women accessing perinatal mental health services in primary or secondary settings, voluntary sector organisations can add value in terms of peer-led interventions, psychosocial support and specialist interventions, for example domestic violence interventions. In addition, they can provide a safety net and on-going support for women stepping down from perinatal mental health services.
- Domestic violence voluntary sector organisations are key partners for perinatal mental health services and can offer advocacy and other evidence-based interventions to women, as well as training and consultation to health and other professionals.
- Peer support workers should be involved in perinatal training, service development and direct support for mothers accessing perinatal mental health services. They should be given appropriate training and support, governed by appropriate principles (such as the Perinatal Peer Support Principles developed by the Maternal Mental Health Alliance).
- The responsibility for women's care and access to the best evidence-based treatments needs to be held by health, social care and other statutory services.

Drug and alcohol services

Women with co-occurring moderate to severe mental illness and alcohol/drug use in the perinatal period should not be excluded from perinatal mental health services, as recommended by guidance from Public Health England (2017) and NICE (2019). They should have access to an integrated care pathway which brings together a range of health professionals who can collaboratively address their mental disorders, including substance use, obstetric and physical healthcare and social issues.

This good practice guidance relates to the care of women with co-occurring perinatal mental illness and alcohol/drug misuse across substance use, perinatal mental health and other relevant services:

- Women with harmful or dependent drug or alcohol use in pregnancy or the postnatal period should be referred to a specialist drug/alcohol service for advice and treatment.
- Mental health and drug and alcohol services should be mindful that co-occurring mental health and alcohol and/or drug use conditions are common. Rather than solely focusing on a 'primary problem', both conditions must be treated to achieve the best possible outcomes. This will often require help across multiple agencies.
- Women with alcohol/substance use problems and co-occurring moderate to severe mental illness should have access to specialist perinatal mental health services.
- There should be a policy or protocol for the integrated care of patients with dual diagnosis that includes liaison and shared protocols between relevant services, including: substance use services, specialist perinatal mental health services, maternity services and Children's Services.
- Services should carry out drug/alcohol screening to support decisions about care/treatment options.
- Women with a substance use disorder should be offered a named midwife or doctor who has specialist knowledge of, and experience in, the care of women with substance use disorder and should be provided with a direct-line telephone number for the midwife or doctor (NICE, 2010).
- Services should have specific funding and access to appropriate residential rehabilitation placements. During pregnancy, withdrawal from dependent use of alcohol and some drugs (such as benzodiazepines, opioids and gabapentoids) is likely to require specialist in-patient management, with input from a suitably qualified addictions practitioner. In cases where there is coexisting severe perinatal mental illness and substance use, admission to a mother and baby unit should be considered with in-reach from addiction services.
- Where the removal of a child from a mother's care is being considered, the possibility of giving the woman the opportunity to demonstrate safe parenting skills, with a commitment to recovery, should be carefully considered – taking into account legal and policy safeguards for the infant's safety and best interests. There should

be close liaison between children's social services and addiction/mental health services.

- Training should be provided to all perinatal mental health staff on working with women with substance use problems.
- Perinatal mental health clinical networks should include specialist addictions services (MBRRACE-UK, 2018).
- Perinatal mental health and addiction services should advocate for better understanding of the challenges faced by perinatal women who suffer from addiction disorders and for better services for this group.

Personality disorders services

Working effectively with women with personality difficulties entails:

- a thorough psychological assessment and formulation of women's individual and systemic needs, leading to a shared model that centrally features the mother-infant relationship. A good assessment should include consideration of overlapping or comorbid conditions, e.g. eating disorder or autism spectrum disorder.
- recognition of the changing diagnostic approaches to personality difficulties and that this needs to be approached collaboratively with patients and with reference to the latest NICE guidelines
- assessment of the extent to which these needs can be met within perinatal services. A good perinatal service should offer specific psychoeducational interventions tailored to this population, e.g. DBT Emotional Regulation Groups, as well as Couple Therapy and EMDR.
- there should be an established process for consultation with PD services for this group of patients, in line with local provision
- willingness to work across service and organisational boundaries, including the voluntary sector, and with particular reference to potential safeguarding issues
- delineation of the short- and longer-term pathways to effective treatment, which is likely to involve collaboration with existing personality disorder services. Such consideration is particularly important at the time of discharge, often a vulnerable time for this population who may be symptomatically improved but still struggling with significant personality difficulties.

Eating disorder services

A good eating disorder service:

- Monitors physical health and weight gain closely during pregnancy and the postnatal period, in keeping with eating disorder guidelines and, where necessary, provides additional foetal monitoring. Multidisciplinary care planning is advised, including relapse prevention.
- Assesses and manages the impact of an eating disorder on the mother's experience of pregnancy, her changing body and her relationship with/care of her infant.
- Women with an eating disorder are at increased risk of antenatal and postnatal depression and should be monitored, screened and treated appropriately.
- In the presence of active features of eating disorder, appropriate intervention from an eating disorder service, with routine sharing of information with maternity, health visiting and maternity liaison and perinatal services, is advisable. Primary care and maternity services should share information and agree physical health monitoring.
- Women who are currently well should be given information about the risks of relapse and have a relapse prevention plan in place. Perinatal mental health services may be positioned to provide this advice, alongside input from eating disorder services where necessary.
- In women requiring in-patient admission, specialist eating disorder intervention is required and may require interface between regional eating disorder in-patient units and mother and baby units.

Intellectual disability services

A good intellectual disability (ID) service should:

- provide accessible information and good communication, in a format that is meaningful to the individual; this can include: easy read versions, audio/visual information, fully accessible websites and creating opportunities to tell people with ID face-to-face about services for parents and parents-to-be
- ensure joint working between perinatal mental health services and the community learning disabilities team, with clear referral pathways and shared protocols
- be aware that IQ is not considered a good indicator of parenting capacity but it can affect reading, writing and executive functioning skills which can highlight areas that need support. Services should provide parents with ID additional support to develop the understanding, resources, skills and experience to fulfil their parental role as required.
- provide support designed to meet the requirements of parents and children, based on an assessment of their needs and strengths. The use of a multi-agency assessment model known as The Parental Skills Model which focuses on individual ability and living skills, family history and support and resources, is recommended if ID is suspected.
- be aware that women with autism may have particular challenges related to communication, decision making and sensory overload, including during childbirth. Women with high functioning autism might face particular challenges in their relationships with midwives and other caregivers (Rogers, Lephert et al, 2017).
- provide access to independent advocacy
- ensure access to family planning as, due to individual and contextual factors, people with ID struggle to access mainstream services for family planning.

Forensic mental health services:

Women in prison or under forensic mental health services will have equal, or even greater, need for perinatal health services. Around 600 women in prison each year receive antenatal care and, in the prison population, mental health problems are common.

In addition to the guidance set out for adult mental health services (above), a good forensic service should:

- ensure the woman has access to appropriate perinatal mental health services, as well as general maternity and health services, regardless of whether she is detained in hospital, prison or is cared for in the community
- work towards the woman's longer-term management in the safest and least restrictive environment possible including, where appropriate, through liaison and referral to MBUs
- undertake robust risk assessment and management and make appropriate referrals to partner agencies where indicated
- undertake liaison with other agencies that might be involved in the care of the woman and her unborn baby (e.g. drug and alcohol services, children and families services, domestic violence agencies, police, courts etc.)
- ensure that the woman has access to advocacy services
- involve the woman's partner, family and support network as much as possible
- prepare the woman for delivery, including birth planning and arrangements for admission to hospital for delivery, taking into account any security procedures that may be required
- prepare the woman for the postnatal period, including the possibility of separation from her baby
- ensure good postnatal care regardless of where this is delivered and whether the baby remains in the care of the mother and supporting safe access to the baby where they do not.

Diversity and inclusion

Perinatal mental health services will need to serve multiple minority ethnic communities. Such communities may have cultural or religious beliefs and practices which affect marriage and kinship, practices surrounding the birth and early post-partum 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.

We know that those in our communities from black and minority ethnic backgrounds are more likely to have adverse maternity outcomes, including a shocking and unacceptable five times higher risk from all maternal deaths (Knight, Bunch et al, 2019). We know that women from some black and minority ethnic communities find accessing perinatal mental health support challenging (Watson, Harrop et al, 2019). Women cite a number of reasons, including language barriers, lack of accessible information, cultural factors or complex social or financial issues. It is essential that perinatal mental health clinicians have a good 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 be aware of a range of family structures, including LGBTQ+, and seek to provide care that recognises the challenges and needs of these families, including barriers to care, the double stigma associated with mental health problems and being an LGBTQ parent, and how the challenges of being an LGBTQ parent affect both the individual and the partner/co-parent (where there is a partner/co-parent) and the impact of this on mental health (Ross, Steele et al, 2006). Recent perinatal policy recommends that partners of women accessing specialist perinatal mental health services and maternal mental health services should receive an evidence-based assessment for their mental health and signposting to support as required (NHS England, 2019).

Transgender people have experienced significant discrimination and lack of societal acceptance. As awareness of transgender rights and issues have been raised, ensuring parity of healthcare access within all healthcare settings (including perinatal mental health) has become more pressing. There has been little research about the desire of transgender people to create families biologically and genetically or via fostering and adoption, and to parent a child. Transgender men have successfully conceived and carried pregnancies, planned and unplanned, even after endocrine treatment using testosterone. There are some specific implications for the psychological health and well-being of transgender men in these situations, as a result of the internal and external conflicts and tensions between the social norms that define a pregnant person as woman and a gestational parent as mother (Light, Obedin-Maliver et al, 2014; Ellis, Wojnar et al, 2015). Perinatal mental health services should work in partnership with specialist gender services, maternity and adult mental health services where applicable, to ensure that

the physical, mental and psychological health and well-being of transgender people is supported throughout pregnancy and the perinatal period and should follow relevant GMC guidance (GMC, 2020).

Data suggests that there are high rates of mental health problems in teenage and young mothers. Where these are untreated it impacts on both the mother and on the developing child. A recent study based in South London, suggested that rates of mental health problems in young women aged 16–25 are much higher than in older women and need particular attention (Lockwood Estrin, Ryan et al, 2019). Young mothers can fall between the gap in child and adolescent mental health services (CAMHS) and adult mental health services, including perinatal mental health services. Family Nurse Partnership (FNP) is a home visiting programme for first-time young mothers and families, that can offer additional support. Teenagers who become mothers in the context of street gang sexual exploitation have become an additional group of concern. Young mothers aged under 18 years requiring community psychiatric intervention or admission to an MBU, require the combined expertise of specialist perinatal mental health clinicians and CAMHS clinicians. This will be especially important for young mothers with pre-existing mental disorder, including those with symptoms of complex trauma.

Women with a history of serious mental illness have more barriers in accessing good overall physical health support. Some physical health problems may be directly related to the treatment used for their mental health problem, including raised BMI and glucose intolerance. Risk of adverse pregnancy outcomes are directly related to suboptimal pre-conception and antenatal maternal physical health. Specialist perinatal mental health teams have a role in assessing, signposting and supporting women to optimise their physical as well as mental health.

Strategic planning and quality of perinatal mental health services

Clinical networks

Clinical networks play a key role in supporting the strategic planning and local delivery of perinatal mental health services. They are made up of stakeholders from across the perinatal mental health care pathway, including clinicians, commissioners, people with lived experience and the third sector. Networks ensure the integration of services across the care pathway and promote clinical excellence, so that women and their families are able to access the right care at the right time according to their needs.

Royal College of Psychiatrists' perinatal quality network and quality indicators

The Royal College of Psychiatrists' Centre for Quality Improvement has an established Perinatal Quality Network (PQN) for both mother and baby units and specialist perinatal community mental health teams. All mother and baby units, and a growing number of community perinatal mental health teams, are part of the network. The PQN has developed standards of care, which all members are reviewed against through a programme of annual peer appraisal and accreditation visits.

Quality indicators should be developed in such a way that they are comparable across all providers of specialist perinatal mental health services. Quality indicators are those indices that are likely to reflect access and the quality of clinical care. The standards set out by the accreditation and peer review process of the Royal College of Psychiatrists Centre for Quality Improvement (CCQI) PQN, as well as those set out by the National Institute for Health and Care Excellence (NICE, 2014), have been important in maintaining high-quality care across existing and new services.

Other quality indicators include:

- length of stay on MBUs
- readmission rates to MBUs
- admission of mothers to an adult psychiatric ward
- ethnicity of women under the care of specialist perinatal services.

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 and understand how they perform against national data. The Mental Health Service Data Set (MHSDS) in England can provide perinatal-specific, nationally consistent and comparable person-based information of those in contact with mental health services. In Scotland, the Information and Statistics Division (ISD) of the Scottish Government has produced comprehensive information on in-patient MBU care, using linkage of national data-sets, and is exploring how specialist community activity data can be captured. This allows the comparison of the clinical and cost effectiveness of different services, enabling providers to make evidence-based recommendations to commissioners/planners on service activity, local trajectories and funding, whilst also demonstrating value.

In 2018 the Royal College of Psychiatrists published the *Framework for routine outcome measures in perinatal psychiatry* which set out guidance on the use of routine outcome measurements in perinatal mental health services, to enhance uniformity of the data collection across services at a local and national level (Royal College of Psychiatrists, 2018). These included measures to assess changes to both maternal mental health and the quality of interaction between mother and infant. Detailed information on the embedding of outcome monitoring within perinatal mental health services can be found in *Implementing outcome monitoring in specialist perinatal services* (Marriott, Slead et al, 2019). Additionally, the *Perinatal mental health care pathway guidance* (NCCMH, 2018) includes a number of outcome measures suitable for use in perinatal mental health services.

Staffing and resources for specialist perinatal mental health services

It is recognised that, across the UK nations, there is variation in the level of investment and the establishment of perinatal mental health services, as well as varying needs according to population and geography. The *NHS England Long Term Plan* proposes a major expansion in the scope and function of perinatal mental health services and this has important implications for an expanded perinatal mental health workforce (NHS England, 2019). The wider context of health provision and the models of care adopted may vary, including the percentage of the birth population targeted, the length of follow up and how some of the aspects of specialist provision are organised (for example provision of specialist parent-infant interventions and psychological therapy within maternity and neonatal settings). Each of the four UK nations has developed distinct policies, guidance and service models (see Appendix 1). While it remains a priority that all women, regardless of where they live, should have access to high-quality perinatal mental health care, the factors above will impact on workforce modelling.

Previous versions of this guidance have defined specific staffing numbers for MBUs and community perinatal mental health teams. However, given the context above, defining a workforce model that is applicable to the whole of the UK is beyond the scope of this guidance. What has been included are examples of workforce modelling in England and Scotland, as well as workforce guidance for specific disciplines where available. This is informed by a number of national guidelines and national standards, many of which predate the publication of the Long Term Plan. We have therefore made a distinction between recommendations developed prior to and since its publication.

Workforce planning should be guided by the local epidemiology of perinatal mental illnesses and associated risk factors. The overall incidence of mental disorders in pregnancy is up to 20% (see Table 1). Between 3% and 5% of the delivered population will have a serious mental illness or a mental illness that places them at high risk of recurrence or relapse in pregnancy and/or after delivery; providing services to this cohort of women is an essential function of specialist perinatal mental health services. It is recognised that women with less-severe illness may also benefit from specialist care. In England the *NHS Long Term Plan* commits to increasing access to specialist perinatal mental health services to 10% of the birth population (NHS England, 2019).

Table 1: Rates of perinatal psychiatric disorders per 1,000 maternities

Disorder	Rate (per 1,000 deliveries)
Post-partum psychosis	2
Chronic serious mental illness	2
Severe depressive illness	30
Mild to moderate depressive illness and anxiety	100-150
Post-traumatic stress disorder	30
Adjustment disorders and distress	150-300

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

General principles related to staffing:

- The provision of specialist perinatal mental health services should aim for equity of access and no unwarranted variations in the quality of care.
- The standards of care required by women with perinatal psychiatric disorder will be similar no matter who they are or where they live. However, some local variation in service design and provision may be needed.
- Estimates of need in 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, referral rates to psychiatric services, local variations in sociodemographic characteristics and local variation in the service provision of allied services, including any gaps in provision.
- MBUs and specialist community perinatal mental health teams should be staffed by a range of professionals with the requisite skills and knowledge to meet the clinical needs of their patients. This includes perinatal consultant psychiatrists and junior medical staff, nurses, clinical psychologists and psychological therapists (including parent-infant therapists), nursery nurses, occupational therapists, social workers, peer support workers, pharmacists and linked obstetricians, midwives and health visitors. In addition, teams need dedicated operational and management input. Teams will require knowledge and expertise in the delivery of a range of evidence-based interventions for parents, infants and their families, including a range of parenting programmes that focus on developing sensitive and attuned relationships.
- A critical mass of clinical activity is necessary for both clinical and cost effectiveness, in order to maintain the specialist skills and knowledge of clinicians and to provide the specialist resources and infrastructure needed to deliver high-quality care to women and their families.
- Estimates of workload and necessary resources cannot be based on productivity alone (i.e. the number of women assessed and treated). They have to take into

consideration the important core functions of the specialist service:

- promoting prevention and early identification of perinatal mental health problems
 - giving expert advice to non-specialist health professionals
 - providing a training and education programme for non-specialist health professionals
 - attending multi-agency meetings, including safeguarding meetings, to mitigate harm and support families where needed.
- There needs to be collaborative working across and within services, with clear lines of leadership, partnership and clarity of expectations. At every level of the system, resources must be protected to provide supervision, coaching and consultation, which is crucial in order to manage risk.

Remote and rural specialist service provision

Staffing numbers should take into consideration the differing populations and geography of the UK and consideration is needed to ensure there are sufficient staffing levels for perinatal community mental health services covering large rural areas with lower birth rates, due to the considerable travelling time that is required. Scotland has outlined a model for service delivery to remote and rural areas (PMHN-Scotland, 2019):

Principles of service delivery

- 1** The model of service delivery will be appropriate to birth population numbers and geographical factors.
- 2** All staff allied to the service will have:
 - a** protected time for specialist direct clinical care, case management, clinical supervision, multidisciplinary team meetings (MDT) and peer support
 - b** appropriate specialist training (including continuing professional development).
- 3** All staff will have access to senior clinical expertise, either within their own NHS area or from a neighbouring area.
- 4** At a minimum, services must be able to:
 - a** provide access to expert direct clinical care which includes consultant psychiatrist, senior mental health nurse, consultant clinical psychologist
 - b** work in collaboration with general adult services to provide adequately resourced occupational therapy and mental health social work
 - c** work in collaboration with health visiting to provide access to health visiting assistant/nursery nurse
 - d** have access to parent–infant mental health services where appropriate.

Recommended models of care

- 1** A standalone team of specialist professionals may be possible in some small- to medium-sized areas, following the standard model recommended.
- 2** In low birth number areas or in sparsely populated large geographical areas, the service may be provided by a ‘satellite’ sub-team, linked to a larger team, using video technology. The larger team would be able to provide access to the full range of specialist expert roles and may offer direct patient assessment (either by video or face-to-face) where indicated.

- 3 In very low birth number areas (e.g. small/remote island services) a service may be provided by general mental health services with additional training and formal links to a neighbouring specialist service which would provide support, clinical supervision, access to ongoing training and, where appropriate, direct patient assessment, using video technology.

Staff roles and responsibilities

All clinical staff working in MBUs and specialist community perinatal mental health teams should have an understanding of maternal and paternal mental illness, child development, parent-infant relationships, the transition to parenthood, changes in the couple relationship, assessing risk and safeguarding. There will be some variation in the roles and responsibilities of staff depending on whether they are working in community or in-patient settings. The Perinatal Mental Health Network Scotland have produced detailed guidance on role definitions and support structures for clinical staff working within specialist perinatal mental health in-patient and community teams, and those working in maternity and neonatal psychological services (PMHN-Scotland, 2019). The following highlights particular areas of expertise that different members of the perinatal multidisciplinary team contribute.

Medical staff

Perinatal psychiatrists have a leadership role in the assessment, diagnosis, care coordination and management of perinatal mental illness, alongside providing medical leadership for the multidisciplinary team and in the development of services and the wider care pathway. Medical staff in community perinatal mental health teams and MBUs should include consultant psychiatrists, specialty doctors and junior doctors in training. Their role will include: diagnosing and formulating management plans in complex cases, including decisions on prescribing in pregnancy and breastfeeding; assessing and managing risk, including suicide risk, in relation to the pregnancy and any potential risk to children; understanding the physical health problems which may arise during the patient journey through pregnancy and the puerperium, including the physiology and complications of childbirth; understanding foetal and early infant development; and understanding legislation and guidance in relation to the Mental Health Act and Mental Capacity Act. Detailed guidance on job descriptions for consultant perinatal psychiatrists can be found in the *Royal College of Psychiatrists' College Report CR207* (RCPsych, 2017).

Perinatal mental health nursing

Perinatal mental health nurses work collaboratively with a mother (and the extended family where relevant) in: assessing mental state; setting mutually agreed goals for treatment and recovery; care planning and monitoring a woman's response to treatment; supporting women with the parent-infant relationship and helping them to develop confidence in their role as a mother; liaising with other agencies; and advocating on the behalf of women when needed. Perinatal mental health nurses will deliver evidence-based interventions and many will have undertaken extended training to provide interventions such as cognitive behavioural therapies. A working knowledge of the Mental Health Act in relation to both in-patient care and caring for mothers in the community is essential.

The perinatal mental health nurse on an in-patient mother and baby unit will be experienced in the management of the acutely disturbed mother, including: verbal de-escalation skills; restraint (including of pregnant woman); and the safe and appropriate

administration of emergency psychotropic medication in the perinatal context. The perinatal mental health nurse in a community setting will be an autonomous practitioner and be experienced in the care coordination role.

Alongside delivering clinical care, some nursing staff will offer specialist supervision, consultation, teaching and training to the service and wider maternal mental health workforce. Senior nursing roles, such as the nurse consultant in perinatal mental health, are key to strengthening clinical leadership, developing nursing practice and improving patient experience. They deliver expert direct clinical care, regional care pathway development and innovation in service delivery, research and audit.

Clinical psychologists and other psychological therapy professionals (including parent-infant therapists)

Clinical psychologists and other psychological professions lead the perinatal psychology provision for the service and work with the multidisciplinary team to ensure the provision of psychologically informed and trauma-informed care, utilising psychological theory and research to support improved outcomes for mothers, infants and families. A variety of psychological professions including clinical psychologists, counselling psychologists, cognitive behaviour therapists, systemic family therapists, adult psychotherapists and parent-infant psychotherapists will work in MBUs and community perinatal mental health teams. These roles include conducting psychological assessments and developing a psychological formulation of the mother, her infant and the relationship between them.

Clinical psychologists and other psychological professions will deliver a range of interventions adapted to the perinatal period. These may focus on the woman's mental health, the couple relationship, the family, the parent-infant relationship and/or infant mental health, being attentive to the interplay between all of these. They may also be involved in the assessment and provision of support for fathers/partners where they are struggling with their own mental health.

Specific evidence-based psychological therapies used in perinatal mental health services include (but are not limited to): cognitive behaviour therapy (CBT) (this includes trauma-focused CBT), eye movement desensitisation reprocessing (EMDR), interpersonal therapy (IPT), dialectical behaviour therapy (DBT), dynamic interpersonal therapy (DIT), mentalisation-based therapy (MBT), transference focused psychotherapy (TFP), systemic family therapy (FT), behavioural couples therapy (BCT) and parent-infant psychotherapy (PIP). Forms of video feedback intervention, for example video interaction guidance (VIG), are also commonly used in perinatal settings.

Clinical psychologists and other psychology staff (according to training, seniority and job description) offer specialist supervision, consultation, teaching and training to the service and wider maternal mental health workforce. They also provide clinical leadership and are involved in service evaluation, service development, research and attending to team dynamics and staff well-being. The role of the perinatal clinical psychologist is described in more detail in a 2016 British Psychological Society Briefing Paper (BPS 2016).

Nursery nurses

Nursery nurses provide expert nursery nursing assessment, intervention, monitoring and risk assessment to infants of mothers with perinatal mental ill health. Nursery nurses support the mother with her adjustment to pregnancy and infant care, promoting and enhancing the developing parent-infant relationship. Nursery nurses will have a key role in developing and coordinating the baby's care plan, working in collaboration with the mother, family, health visitor and other professionals to ensure the baby receives care which will optimise their emotional, cognitive and behavioural development. Nursery nurses will advocate for babies at multidisciplinary meetings, safeguarding forums and in meetings with other agencies. They will contribute to the assessment of the mother-infant relationship and the woman's ability to parent in the context of mental illness. Nursery nurses will promote the baby's relationship with the mother's partner and other family members. They will respect individual parenting choices and cultural differences regarding childcare, while at all times prioritising the safety and welfare of the infant. Their interventions will be tailored to the needs of the family, whilst encouraging parents to 'keep the baby in mind' and promote responsive parenting.

Nursery nurses offer a range of interventions that build confidence in understanding baby's behaviour, cues and communication. These include:

- Parent/infant relationship building; such as infant massage sessions, play sessions and newborn behavioural observations.
- Parenting advice including practical skills (physical baby care, safety at home, first aid).
- Information and guidance on baby's developmental milestones (sleep, feeding, weaning).
- Visits to children's centres/local groups/libraries to reduce social isolation and build confidence.

Occupational therapists

Occupational therapists provide specialist assessment, intervention and monitoring of the mother's occupational needs and functioning in the context of perinatal mental ill health and parenthood. They will work with women in both individual and group settings, to help them overcome barriers that prevent them from carrying out everyday activities that are important to them and their families. Their role includes enabling women to carry out personal care activities (such as healthy eating and sleeping), adjust to changes in role (such as becoming a parent) and develop routines that meet their needs and those of their families. They will also help women to access community activities and leisure activities that support their health/well-being and that of their infant. They will support mothers to engage positively in parent-child co-occupations such as feeding, bathing and playing. Occupational therapists can identify reasonable adjustments and self-management strategies to support women's recovery and performance of activities that matter to them at home, at work, in education and in the community. Occupational therapists will work collaboratively with other professionals to support and promote the mother's occupational needs.

Social workers

Social workers will have specialist expertise in safeguarding and understanding the complexities involved in balancing the needs of the child and the adult. Their role will include providing a coordinated and proportionate multi-agency response to the infant and family's needs in complex cases. They will have an excellent understanding of the support that is available from universal, targeted and specialist support services to babies, children and their families, and should maintain good working relationships with other professional agencies under the 'Think Family, Work Family' ethos and guidance (Think Family, Work Family, 2019). Though not an exhaustive list, this may include: team safeguarding supervision; early help assessments and plans; carer's needs assessments; systemic family work; direct work with children; and assistance with housing, welfare benefits and child care.

Social workers can offer support and supervision to staff around baby, child and adult safeguarding and also supporting the MDT to understand the process of assessment and intervention when there are serious concerns about child or adult welfare. This can include supporting staff to attend initial and review child protection conferences and also assisting with the completion of relevant reports that are required. They will aim to build good working relationships with adult and child social care services to enable a more collaborative approach to supporting children and adults.

Peer support workers

Peer support workers use their lived experience to offer support, hope and encouragement to mothers and families in similar situations. They will also use their experience to inform the clinical practice and service development of the specialist multidisciplinary perinatal mental health team. Their role will include providing practical and emotional support to women under the care of perinatal mental health services, in one-to-one and group settings. They will support women to access their local community and explore local resources and groups. They will help promote recovery and inclusion and address social isolation. They can have a unique role in empowering women and their families to become experts in their own recovery. They will ensure that information given to mothers and families avoids jargon, is understandable, meaningful, and uses inclusive language. They will also have a role building networks with other local services and agencies, including the third sector and children's centres, and contribute to the multi-agency training delivered by the specialist perinatal services. Male peer support workers may help to build relationships with male partners to support their well-being and, by extension, that of the family.

Perinatal pharmacists

Perinatal pharmacists support women, partners, carers and healthcare professionals to make informed treatment decisions during the perinatal period. Their role enables access to specialist medicines information, opportunities for evidence-based discussion, exploration of treatment options, optimisation of treatment plans and medicines-related communication between care providers, e.g. GPs, midwives and obstetricians. Perinatal pharmacists offer medication reviews, pre-conceptual counselling and pregnancy/

breastfeeding medication advice through one-to-one consultations and group sessions; this can be completed in a ward-based environment or in the community, either face-to-face, virtually or over the telephone. They are often responsible for ensuring the perinatal team proactively prevent, identify, monitor and report medication-related adverse events; particularly those associated with 'high-risk drugs' such as lithium and clozapine. Perinatal pharmacists also contribute to quality improvement initiatives through research and audit, in addition to development, implementation and review of guidelines. Many perinatal pharmacists are involved in the training and education of other healthcare professionals, up-skilling and promoting awareness of perinatal mental health, as well as medication-related issues. Using values-based practice and a collaborative approach, perinatal pharmacists work with women and professionals to develop personalised treatment plans, supporting the best possible outcomes for mothers, babies and their families.

Specialist and link midwives

Specialist mental health midwives based in maternity units play a key role in integrating maternity and mental health care. Their role includes providing maternity care to women with severe and complex mental illness, liaising with community perinatal mental health teams and MBUs, raising awareness and tackling stigma, alongside providing education, training and advice within maternity settings.

A designated 'link' community midwife is required to visit the mother and baby unit as clinically necessary to provide care for pregnant and postnatal women and give advice on the care of newborn infants. There should be a midwife available for advice at all times. Their role is key, as many of the mothers will not be able to access their usual community midwife due to distance. Mothers should receive the same level of maternity care while an in-patient that they would receive at home.

Specialist and link health visitors

Health visitors play an important role within perinatal and infant mental health systems. Through their universal reach and holistic family-centred approach, they support good family mental health and well-being, the healthy physical and emotional development of infants, the parent-infant relationship, the couple relationship and the wider needs of fathers/partners and other children in the family. Alongside being responsible for a caseload of mothers and or fathers/partners with mental illness and delivering evidence-based interventions, they will provide training and consultation on perinatal and infant mental health to the wider health visiting workforce, acting as a point of reference and providing supervision.

Health visitors aligned to or working as part of an MBU team will ensure the infant and family are in full receipt of the respective national Healthy Child Programmes. They will consider the health and well-being needs of the mother, her baby and the wider family. They will act as a point of reference and support for nursing and medical staff and provide clinical supervision for nursery nurses. 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. Link/specialist health visitors have an important

role in liaising with the mother's own health visitor during her admission. This will ensure that the needs of the whole family are catered for and appropriate support is in place prior to discharge.

Team leaders and service managers

Good and effective operational leadership is essential to providing high-quality care. The role of team leader and service manager will include: supervising staff; ensuring that systems are in place to monitor quality and performance; liaising with the senior management and leadership teams within their trust to ensure that the perinatal voice is represented; and to be visible to external partner health and social care agencies across the perinatal care pathway.

Workforce guidance for mother and baby units and community perinatal mental health teams

The multidisciplinary staffing of specialist MBUs and community perinatal mental health teams will reflect the clinical needs of the mothers and their babies and the core functions of these services (as outlined in the good practice guidance above). The specialist training and continuing professional development (CPD) required by these professionals is detailed in the CCQI standards.

The section outlines workforce recommendations made by national or regional bodies in England and Scotland for MBUs and community perinatal mental health teams.

For England, we outline workforce recommendations based on the CR197 report (RCPsych, 2015) and the PQN/CCQI standards (PQN/CCQI, 2019; PQN/CCQI, 2020), developed prior to the *Long Term Plan* (LTP). For community perinatal mental health teams, we outline new recommendations for an expanded workforce, designed to meet the objectives of the LTP; this workforce modelling is based on a working example of a community perinatal mental health service based in an urban area. In our expert opinion this workforce model meets the requirements to successfully achieve the objectives set out in the LTP. NHSE have also produced an indicative workforce profile for community perinatal mental health teams which builds on the *Five Year Forward View/CR197 Report* (RCPsych, 2015), (NHS England, 2019). We also include staffing recommendations for a standalone model of the Maternal Mental Health (psychological therapy) Service.

In Scotland, the 2019 *Needs Assessment and Service Recommendations* of the national perinatal mental health network made recommendations for perinatal service models and staffing appropriate to the Scottish setting (PHMN-S, 2019), endorsed by the *Perinatal and Infant Mental Health Programme Board delivery plan* (PIMH-PB, 2020). The Scotland workforce tables on page 61 are taken from this report, including staffing recommendations for MBUs, community perinatal mental health team and maternity and neonatal psychological services.

In addition, we include the recommendations for clinical psychology staffing in community perinatal mental health services, made by the British Psychological Society (BPS, 2019).

Specialist mother and baby units (MBUs)

Function

Mother and baby units provide psychiatric care for women with serious perinatal mental health conditions who cannot be safely or adequately treated in the community. They should be able to admit acutely ill mothers as an emergency seven days a week. Many of the mothers will be newly delivered. The staffing and resources will be determined by the core functions of an MBU team, as outlined in the good practice guidance above.

Number of beds

- The usually quoted number is 0.4 beds per 1,000 deliveries, based on the epidemiology of severe perinatal mental illness requiring admission. Based on an admitted incidence of four per 1,000 deliveries, a large area with 15,000 deliveries a year will require eight beds. A typical health region in the UK, with a population of five million and a birth rate of 55,000 per year, would require 22 beds across a number of MBUs. It is recognised that where community perinatal mental health services exist, the number of beds required is reduced.
- 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 specialist 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 readmissions.

The size of the unit

- There is no available evidence for the maximum clinical and cost-effective size of an MBU. Nor is there specific information on the essential therapeutic offer for an MBU in relation to its size. In the UK the average number of beds is eight/unit (range 4–13 beds). The concentration of a larger number of beds in a small number of centralised MBUs means that it is inevitable that some patients have to travel longer distances, with implications for the women and their families, and increased difficulties in effective liaison with local community teams. There is a balance to be struck between MBU services being delivered as close to a woman's home as possible and the clinical and cost-effectiveness of more centralised, larger services. We therefore recommend that MBUs have between six and 10 beds, determined by the size of their delivered population and the social geography of their area.

Estates and physical resources

- The details of the physical resources of a mother and baby unit can be found in the CCQI standards for MBUs. 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 have 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 MBU 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.
- MBUs should provide a safe space accessible for family members to ensure regular contact with the wider family, including other siblings, where the mother's mental health needs permit and this is within the mother's wishes.
- 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 tablet or laptop with video-call facilities will enable mothers to keep in touch with older children and the family outside of visiting hours.

Staffing

All the staff should be contracted to the MBU with no other clinical responsibilities during their contracted hours (except for responsibilities to duty rotas). The CCQI perinatal in-patient standards (CCQI, 2019) and the Scottish Perinatal Mental Health Network (PMHN-S, 2019) have each made minimum staffing recommendations for a typical six-bed MBU. These recommendations are summarised below. These staffing numbers will need to be increased proportionately for units of a larger size.

Table 2: Minimum staffing recommendations for in-patient perinatal mental health services in England (for a six-bed MBU)

Recommendations based on CR197 (RCPsych, 2015) and PQN Standards (PQN/CCQI, 2019)		
Discipline	WTE	Notes
Consultant psychiatrist ¹	0.5	For details on roles and responsibilities see RCPsych CR207 (RCPsych, 2017)
Specialty doctor or junior doctor (or equivalent) ¹	0.5	There is an identified duty doctor available at all times to attend the ward/unit, including out of hours. The doctor can attend the ward/unit within 30 minutes in the event of an emergency
Ward manager ¹	1	The ward manager is rostered as supernumerary and only used in a clinical role if necessary
Charge nurse	1	
Nurse ¹	9	<ul style="list-style-type: none"> At least two registered mental health nurses (RMNs) per day shift and at least two nurses at night (one of which is an RMN) A permanent qualified member of the nursing team should be on duty at all times The numbers of nursing staff should be readily increased, determined by the acuity of the patients on the unit and in an emergency Bank or agency staffing should account for less than 15% of the total numbers of nurses on duty in any week
Clinical psychologist ¹	0.5	Their role will include providing psychological assessments and treatments for the patients, supervising other staff delivering psychosocial interventions and leading mother and infant interventions
Nursery nurse ¹	2.5	<ul style="list-style-type: none"> There is at least one specialist nursery nurse to cover day duty (including early and late shifts) 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
Additional nursery nurse ²	2.5	There is at least one specialist nursery nurse covering the unit 24 hours a day
Occupational therapist ¹	0.5	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
Social work input ²	0.5	
Designated 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

Designated health visitor		There should be a designated health visitor who provides at least one 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
Administrative support ¹	0.5	
Specialist pharmacist ¹		A specialist pharmacist is a member of the MDT
Creative therapist ³		There is dedicated sessional input from creative therapists
Peer support worker ³		The team includes input from peer support workers. This could be through a paid or voluntary arrangement
Additional recommended staff		
Discipline	WTE	
Parent–infant therapist	0.5	

¹ PQN Type I standard; ² PQN Type II standard; ³ PQN Type 3 standard – for past recommendations (PQN/CCQI, 2019)

Table 3: Minimum staffing recommendations for in-patient perinatal mental health services in Scotland (for a six-bed MBU), taken from the Scotland Perinatal Mental Health Network: needs assessment and service recommendations (PMHN-Scotland, 2019)

Recommended MBU staffing (based on a six-bed unit)		
Discipline	WTE	Notes
Consultant psychiatrist	0.5	
Junior psychiatrist or specialty doctors	0.5	Core trainee or specialty doctor
Senior charge nurse (Band 7)	1.0	
Charge nurse (Band 6)	2.0	
Consultant clinical psychologist (Band 8C)	0.5	
Occupational therapist (Band 6)	0.5	
Social worker	0.5	
Parent-infant therapist (Band 7–8C)	0.5	Grading may vary depending on overall provision across the MBU and community team
Mental health nurse (Band 5) -To provide three Band 5 nurses on each day shift and two Band 5 nurses on night shift	14.0	
Nursery nurse (Band 4) -To provide one Band 4 nursery nurse on each day and night shift	5.3	
Health visitor (Band 7)	0.2	
Administrative staff (Band 3–4)	0.5	

Specialist community perinatal mental health teams

Function

Specialist community perinatal mental health teams have the dual role of assessing and treating moderate to severe perinatal mental illness and actively supporting the mother-infant relationship. They are at the centre of an integrated perinatal care pathway, providing community-based treatments, maternity liaison and close working with MBUs. The staffing and resources will be determined by the core functions of community perinatal mental health team, as outlined in the good practice section above.

Staffing

As previously stated, there is recognition that areas across the UK are at varying stages of service development and have varying needs according to their population and geography. In addition, the wider context of health provision and the models of care adopted may vary, e.g. the percentage of the birth population targeted, the length of follow-up and how some of the aspects of specialist provision are organised (for example specialist parent-infant provision and psychological therapy provision within maternity and neonatal settings). The indicative staffing/workforce modelling below is reflective of this and outlines guidance produced across the devolved nations of the UK.

Where the specialist perinatal community mental health team is provided by the same mental health trust as the MBU, staff can be 'shared' across the two services, for example allowing for full-time appointments to the service as a whole. However, it should be made clear which part of the service they are contracted to work in, at which times.

England

Current staffing recommendations based on *CCQI Standards for Community Perinatal Mental Health Services* (CCQI, 2020) are summarised in Table 4 below, alongside a recommended workforce model that will enable perinatal community mental health teams to meet the objectives set out in the NHS LTP. The LTP objectives aim to expand access and provision beyond the core functions of a community perinatal mental health team to allow:

- 10% of the delivered population to have access to specialist community care from preconception to 24 months after birth, with increased availability of evidence-based psychological therapies to include parent-infant, couple, co-parenting and family interventions
- partners of women accessing specialist community perinatal mental health teams to have access to an assessment for their mental health and signposting to support as required

- maternal mental health services (formerly referred to as maternity outreach clinics) to be developed to increase access to evidence-based psychological support and therapy in a maternity setting, and to integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, their maternity experience.

Table 4: Minimum staffing recommendations for community perinatal mental health services in England (per 10,000 births)

Discipline	Past staffing recommendations		New staffing recommendations	
	WTE	Notes	WTE	Band/Notes
Consultant psychiatrist ¹	1.0		2.5	
Non-consultant psychiatrist input ²	1.0	There is an identified duty doctor available at all times to attend the ward/unit, including out of hours. The doctor can attend the ward/unit within 30 minutes in the event of an emergency	2.5	Specialty doctor/higher trainee/core trainee
Team manager ¹	1	The team has a dedicated specialist team manager. 0.5 clinical/0.5 managerial	2	Band 8a managerial 1.0 Band 7 deputy 0.5 clinical/0.5 managerial
Clinical psychologists ¹ and other psychological therapy professionals	1.0		8	Clinical psychology Band 8d/8c/8b/8a/7 Other psychological professionals: <ul style="list-style-type: none"> counselling psychology CBT therapist systemic psychotherapist adult psychotherapist To include 2.0 parent–infant therapists/staff trained in parent infant therapy
Addition clinical or counselling psychologist ²	1.0	This should be a qualified professional and not an assistant or trainee	See above	
Parent-infant therapist ³	1.0	Band 3 or above or local equivalent	See above	
Nurse ¹	5.0		8	Consultant nurse/advanced nurse practitioner/clinical nurse manager/Band 7/ Band 6

Nursery nurse ²	2.5		4	Band 4
Occupational therapist ¹	1.0		2	Band 8c/8b/8a/7/6
Social worker ²	0.5		2	Band 7/6
Administrator ¹	1.0		5	Band 5/4
Peer support worker (to include a peer support lead)	N/A		4	Band 4
Pharmacist	N/A		0.5	Band 8a/8b
Total	15		40.5	
Additional recommended staff				
Medical clinical lead	N/A		0.4	
Senior service manager (operational)			0.5	
Assistant psychologist	N/A		1.5	Band 4
Health visitor	0.3		0.3	Band 7
Mental health midwife	0.3		0.3	Band 7
Consultant obstetrician	N/A		0.2	

¹ PQN Type I standard; ² PQN Type II standard; ³ PQN Type 3 standard – for past recommendations (PQN/CCQI, 2020)

In the LTP, there are different proposed models for psychological therapy provision to maternity services, including models embedded within perinatal community teams and standalone services. There are plans to pilot different models to inform future service recommendations. The LTP's recommended workforce for a standalone maternal mental health psychological therapy service is shown in Table 5 below.

Table 5: Example LTP workforce recommendations for staffing for a standalone maternal mental health service (per 10,000 births)

Indicative service model		
Role	Banding	WTE
Specialist mental health midwife*	7*	2.0
Nurse/AHP/midwife (Reproductive health practitioner)	6	0.5
Senior administrator	4	1
Senior clinical psychologist	8a	0.5
Clinical psychologist	7	0.5
Assistant psychologist	4	1.0
Peer supporter	3	1.0

Scotland: Community perinatal mental health teams

The perinatal mental health network in Scotland recommended that all Scottish NHS boards should have community specialist perinatal mental health provision, with the specific model being dependent on birth numbers, sociodemographic and geographical needs, as described previously (PMHN-S, 2019). For areas with high birth numbers (of >5,000 annual births), they recommended the development of standalone community perinatal mental health services. For smaller boards where a standalone service is not feasible, they recommended a dispersed model of care delivered via regional collaborative structures and networks. Table 6 below shows staffing recommendations for standalone perinatal mental health teams per 10,000 births (the equivalent size to the CCQI community team staffing recommendations summarised above). In general, they recommend somewhat higher staffing levels than CCQI, particularly for psychological provision. This is in line with the proposed expansion of perinatal psychology provision set out in England's LTP.

Table 6: Minimum staffing recommendations for a specialist community perinatal mental health team in Scotland (per 10,000 births), taken from the Scotland Perinatal Mental Health Network: needs assessment and service recommendations (PMHN-Scotland, 2019)

Recommended specialist community team staffing for delivered populations over 6,000/year		
Discipline	WTE per 10,000 births ¹	Notes
Consultant psychiatrist	1.0 (+0.1/ 0.2)	Add 0.1–0.2 WTE to calculated WTE for education/training responsibilities and regional role ²
Junior psychiatrist	1.0	This may be a core trainee or a specialty doctor
Nurse consultant (Band 8B)	1.0	Three regional posts in total ³
Nurse team leader (Band 7)	1.0	
Mental health nurse (Band 5–6)	5.0	Either all Band 6 or a mix of Bands 6 and 5
Consultant clinical psychologist (Band 8C)	0.5 (+0.1/ 0.2)	Add 0.1–0.2 WTE to calculated WTE for education/training responsibilities and regional role
Clinical psychologist (Band 8A–8C)	2.0	
Parent-infant therapist/Lead (Band 8A–8C)	0.5 (+0.1/ 0.2)	These staff may come from a variety of professional backgrounds
Occupational therapist (Band 6)	1.0	
Nursery nurse (Band 4)	2.5	
Social worker	0.5	
Administrative staff (Band 3–4)	2.0	

¹ Birth numbers of 10,000 per year would be expected to generate 300–500 new assessments. However, it should be borne in mind that large metropolitan areas will have drift in of births from neighbouring areas and so may require higher overall staffing for their maternity liaison role.

² 0.1 or 0.2 WTE dependent on the extent of local or regional education/training roles and leadership of regional networks.

³ There should be three regional posts, two hosted/co-located with existing MBU services and one within northern regional structures (and hosted/co-located with a third MBU, if provided).

⁴ The clinical psychologist provision is within the range recommended in the British Psychological Society report on perinatal provision (2019) and significantly above that recommended by the *RCPsych Perinatal Quality Network Standards and College Report 197* (2015).

⁵ Parent-infant therapists are likely to have a regional clinical advisory role. Where this is the case, boards should consider providing additional sessional time funded through regional structures.

Scotland: Maternity and neonatal psychological services

The perinatal mental health network in Scotland recommended the development of maternity and neonatal psychological services, to address the needs of women with more complex difficulties in relation to previous or current pregnancy and neonatal complications, or who have mental health problems which directly affect maternity care, and who require additional, or more specialist, interventions than those provided within maternity, neonatal or primary care settings. This includes interventions for difficulties related to pregnancy and birth complication or loss, infant ill health following NICU admission and tokophobia. They recommend that whilst maternity and neonatal psychological interventions may be provided by independent teams, there should be close working arrangements with local perinatal mental health services and agreed referral criteria and pathways into care. They acknowledged the recommendations of the British Psychological Society re clinical psychologist staffing recommendations for such services (BPS, 2019) but recommended the need to explore models with a multidisciplinary structure within maternity services, which could also include midwifery, or other mental health staff, with additional psychological therapies training. Suggested staffing recommendations for maternity and neonatal units per 3,000 deliveries is shown below.

Table 7: Minimum staffing recommendations for maternity and neonatal psychological interventions teams in Scotland (per 3,000 births), taken from the Scotland Perinatal Mental Health Network: needs assessment and service recommendations (PMHN-Scotland, 2019)

Maternity and neonatal psychological interventions team staffing		
	WTE consultant clinical psychologist per 3,000 deliveries	WTE psychological therapist per 3,000 deliveries
Maternity hospitals with 3,000 or more deliveries/year	0.6 Band BC	1.0 Band 6–8A
Maternity hospitals with fewer than 3,000 deliveries/year	Clear pathways into local primary care psychological therapies services, adult mental health psychological services or perinatal mental health clinical psychology	

Clinical psychology and other psychological therapies staff: CCQI and British Psychological Society (BPS) recommendations

The CCQI and Scottish Perinatal Clinical Network staffing recommendations for clinical psychology in in-patient and community perinatal services are shown above. The 2019 *British Psychological Society (BPS) Position Paper on perinatal psychology provision in specialist perinatal community mental health services* highlighted limited clinical psychology provision within existing perinatal services and, in particular, limited senior commissioned and appointed clinical psychology roles. The Position Paper recommended the following minimum staffing and seniority levels for community perinatal teams: 0.6 WTE consultant clinical psychologist (Band 8c or above) and 3.0 WTE clinical psychologists (Band 8a or 8b) per 10,000 births (BPS, 2019).

Healthy teams: Staff well-being

Unresolved feelings from one's past experience of being parented and traumatic experiences, both childhood and more recent, can be re-experienced in pregnancy and the postnatal period in a powerful way. Certain clinical and management situations can also evoke powerful feelings in members of the perinatal team, related to their own past or current experiences. External pressures such as structural reorganisations in the wider service, budget cuts, upheavals in wider society (such as a pandemic) and highly distressing events, such as the suicide of a patient or non-accidental injury to an infant, can all place pressure on the ability of the multidisciplinary team to function effectively, compassionately and safely for both patients and staff.

It is therefore crucial that, in addition to good line management, attention to caseload numbers, high-quality clinical supervision, continuous professional development, training opportunities and inclusive business meetings, there is also protected time and space for individual or group reflective practice for all levels of staff. Mentoring and facilitated away days, alongside attention to the basic needs of staff (e.g. protecting space for breaks and informally catching up) also contribute to both improved well-being in the team and the capacity for delivering compassionate and effective clinical care. Staff well-being measures should follow best practice guidance.

COVID-19 and perinatal mental health

The COVID-19 pandemic placed patients and staff under unprecedented pressure and required rapid adaptations to perinatal service provision during a time of planned significant service change and expansion. Here we briefly review the evidence on the impact of COVID on perinatal mental health and on the experiences of patient and staff of service adaptations (namely remote working) during the COVID period.

There is evidence from the research literature on natural disasters, including the COVID-19 pandemic, of associated increases in perinatal symptoms of depression and anxiety (Hessami, Romanelli et al, 2020; Preis, Mahaffey et al, 2020; Yan, Ding et al, 2020; Zeng, Li et al, 2020; López-Morales, del Valle et al, 2021). Women at increased risk include women with a history of mental disorders, poor social support, loneliness, domestic abuse and other trauma, and increased insecurity – whether this is due to housing problems, financial difficulties or other adverse social circumstances (Ayaz, Hocco lu et al, 2020; Preis, Mahaffey et al, 2020; Harrison, Moulds et al, 2021; Liu, Erdei et al, 2021). In the case of COVID-19, women have also had less support from face-to-face maternity, primary care (including health visiting) and perinatal mental health services, reduced number of contacts and increased use of digital technology in service delivery, and evidence of alteration to perinatal appointments has been associated with perceived stress (Preis, Mahaffey et al, 2020; Zeng, Li et al, 2020). There is no known research that has examined the impact of the pandemic on outcomes for women with pre-existing severe mental illness.

Two studies have directly examined the experiences of perinatal mental health care during the pandemic. The first was part of a larger online mixed methods survey disseminated by the NIHR Mental Health Policy Research Unit, open to all mental health care staff in the UK. A secondary analysis of responses from 363 staff working with women in

the perinatal period reported that staff perceived the mental health of perinatal women to be particularly vulnerable to the impact of stressors associated with the pandemic, such as social isolation and domestic violence. Staff also reported feeling less able to assess women, particularly their relationship with their baby, and less able to mobilise safeguarding procedures, as a result of changes to mental health and other health and social care (Wilson, Dalton-Locke et al, 2020). The Confidential Enquiry into Maternal Deaths during the pandemic has highlighted potential opportunities for prevention of suicides and domestic homicides, through assessing potentially high-risk women face to face (Knight, Bunch et al, 2020). Evidence-based guidance has been published on how to assess women during the pandemic, similarly highlighting that remote assessment and delivery will not always be appropriate and staff therefore need to maintain face-to-face assessments when needed and ensure risk assessment and safeguarding procedures are not compromised (NIHR Oxford Health BRC (a), 2020, NIHR Oxford Health BRC (b), 2020).

Two UK studies have examined women's experiences of remote delivery of care. The first, the Policy Research Unit survey described above (Wilson, Dalton-Locke et al, 2020), reported that while 42% of staff found some women engaging poorly with virtual appointments, flexible remote consulting was perceived to be beneficial for others, including with time management due to reductions in travel time. The second, part of an NIHR-funded research programme on the effectiveness of perinatal mental health services has, to date, carried out 127 interviews with women, significant sources of support and staff members (O'Mahen, Howard et al, 2020). Women reported that blended treatment delivery, both in person and remotely via video conferencing, was preferred (though telephone was not preferred unless in the context of a pre-existing relationship); this was also an option for MBU post-discharge care before engagement with local specialist community teams but access to resources including mobile data and Wi-Fi to take part in video calls was critical (O'Mahen, Howard et al, 2020). These findings echo the findings of a systematic review and meta synthesis of telemedicine which concluded that remote delivery can be effective, (Batastini, Paprzycki et al, 2021) but could increase inequalities in perinatal mental health outcomes particularly in low income, minoritised and diverse groups (Brown, 2020). It is already known that there are significant evidence gaps related to treatment efficacy for perinatal women facing difficulties related to poverty, racism, stigma and interpersonal violence (Howard and Khalifeh, 2020), which means research into optimal service delivery during the pandemic is needed urgently. From a clinical perspective, delivery of perinatal care continues to need to be tailored to the needs of individual women.

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Appendices

Appendix 1 Perinatal mental health service developments across the four UK nations since 2015

The key developments in perinatal mental health services across the four UK nations since the publication of the CR197 report in 2015 are summarised below. Key national policies, guidance, service development reports and strategic leadership structures within each nation are summarised in Table A1.

1 England

In 2016 maternity services began a major transformation, *Better Births: improving outcomes of maternity services in England*, with the aim of putting women and their families at the centre of care planning and decision making, and providing continuity of midwifery care.

2016 – *Five Year Forward View (5YFV)* from NHSE committed £365m to increase access to specialist perinatal mental health care across England, enabling an additional 30,000 women/year to be seen by 2020/21, enabling the expansion of community perinatal mental health services and MBUs. All MBUs are members of the Royal College of Psychiatrists' Quality Network and adhere to their national standards.

There are 42 sustainability and transformation partnerships (STPs), including 14 integrated care systems in England¹. These are funded to provide specialist perinatal mental health community services in England. The NHS LTP requires every STP to become an integrated care system by April 2021.

The NHS LTP (2019) builds on the commitments outlined in the 5YFV to transform specialist perinatal mental health services in England. The aim by 2023/24 is for at least 66,000 women with moderate-severe or complex perinatal mental health difficulties to access specialist care. This will bring the total fund for community perinatal mental health services to £223m per year (an increase from £140m for the FYFV). Additional objectives include:

- Increasing the availability of care to 24 months after birth. Evidence shows that some women will benefit from specialist perinatal mental health care in the second year after birth.
- Improving access to evidence-based psychological therapies within specialist perinatal mental health services, to include parent-infant, couple, co-parenting and family interventions.
- Mental health checks for the partners of those accessing specialist perinatal services and signposting to support as required.

Psychological support for those who experience mental health difficulties arising from, or related to, the maternity experience, through the development of maternal mental health services/clinics, delivered in partnership with the maternity services, specifically for those women who could not ordinarily access perinatal mental health due to not having a baby. In England, new maternal mental health services (MMHS – referred to in the NHS LTP as maternity outreach clinics) are being developed. These are psychology-led services which aim to integrate maternity, reproductive health and psychological therapy for women experiencing moderate to severe mental health difficulties related to their maternity experience, specifically for those women who could not ordinarily access perinatal mental health due to not having a baby. Early Implementer and Fast Follower sites are implementing from 2020/21 and evaluation of these sites will inform service development going forward. All other areas of England will set up these services from 2022/23 to ensure national coverage by 2023/24.

Some neonatal units have specialist psychology or psychotherapy provision but many do not and there are differences in funding routes. The *Getting It Right First Time* (GIRFT) programme has highlighted the lack of psychology provision, with only one fifth of neonatal intensive care units having access to a psychologist in 2020. The *Neonatal Critical Care Review* recommends a strategy for developing psychologists and other allied health professional roles in neonatology, with action plans and implementation in progress. Work is underway via the Neonatal Operational Delivery Networks to coordinate development of services and training for psychological support and intervention for families accessing neonatal units.

Footnote 1: Definition of integrated care systems (ICSs): “ICSs are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners, to collectively plan and integrate care to meet the needs of their population” (The King’s Fund, 2019)

2 Scotland

In 2017 the Scottish Government Mental Health Strategy committed to establishing a national managed clinical network for perinatal mental health

In 2018 the Scottish Government committed £52m funds to establish perinatal and infant mental health across all tiers of service delivery, to be delivered in a five-year programme from 2019–2024

In 2019 the Scottish Perinatal Mental Health Network made recommendations on future specialist services, including a tiered model of specialist community teams, with standalone teams in high birth areas (four boards), a dispersed model of specialist team in low birth numbers (seven boards) and a regional model for the island boards (three boards). In addition, it recommended an additional 2–4 MBU beds for Scotland, building on the current provision of 12 beds across two MBUs.

Other recommendations included the development of maternity and neonatal psychological interventions services based in maternity hospitals, the development of a national curricular framework (NES 2019) and induction training for all specialist perinatal and infant mental health professionals.

The widening of the remit of the Perinatal and Infant Mental Health Programme Board delivery plan in 2019 to include planning and development of all Infant Mental Health (IMH) services highlights the importance of the interface between perinatal and infant mental health strategy and policy (Perinatal and Infant Mental Health Programme Board, 2020) which fits with the Scottish Government's aspirations to make Scotland the 'best place to grow up', and has a strong focus on reducing inequalities in outcome. There is a strong and consistent focus on early years, prevention and early intervention in Scottish Government policy, and it has promised that all infants and parents who need such support should have access to specialist infant mental health services (The Scottish Government, 2019). It recommends that each MBU and specialist community perinatal mental health team should have a parent-infant therapist embedded within the team.

In Scotland, there is currently significant development of psychological services within maternity and neonatology in keeping with recommendations from the *Delivering effective services: Needs assessment and service recommendations for specialist and universal perinatal mental health services report* (2019). Maternity hospitals with more than 3,000 births are setting up maternity and neonatal psychological interventions (MNPI) teams. These are clinical psychology-led multidisciplinary teams which also include specialist midwives and/or other psychological therapists, and are co-located within maternity and neonatal services. Smaller maternity and neonatal units must ensure that they have clear pathways for access to psychological therapies.

3 Wales

In 2015 the Welsh Government invested £1.5m into perinatal mental health care, divided between seven boards. Prior to this investment only two boards had perinatal mental health services and only one (Cardiff and Vale) met the perinatal quality network (PQN) standards.

The Welsh Government's programme, *Prosperity for All 2016–2021*, includes a cross-cutting priority for all children to have the best start in life, recognising the importance of the first 1,000 days.

In 2017 the Children, Young People and Education Committee (CYPE) of the National Assembly for Wales undertook investigation into perinatal mental health services in Wales and produced a report compelling the Welsh Government to continue the expansion of services. In addition, the report led to the establishment of a national clinical lead for perinatal mental health position and development of a Wales perinatal mental health clinical network; the aim being to strengthen collaboration between health boards, third sector, voluntary organisations, service users and further develop high-quality, evidence-based services. This work is supported by a Perinatal Mental Health Board, National Clinical Network Steering Group, professional forums and a third sector and voluntary group.

The CYPE report also highlighted a lack of specialist perinatal mental health in-patient provision in Wales and plans are now underway to develop a six-bedded interim unit in South Wales. Discussions are also taking place with colleagues in England to explore the potential of developing a joint unit for North Wales and England.

In Wales, there is increasing recognition of the importance of support parent-infant relationships and further developing parent-infant services. Colleagues from all health boards are working with the Parent Infant Foundation to explore what this could look like for Wales.

Work is also underway to develop a fully integrated perinatal mental health care pathway for Wales, with recognition being given to all service areas supporting emotional health and well-being and mental health difficulties across that pathway. A framework for psychological interventions will also be part of this work.

In Wales there is, to date, no dedicated specialist psychology provision for maternity or neonatology. Individual health boards have local guidance about interfaces between maternity and perinatal mental health services. The report *From bumps to babies: Perinatal mental health care in Wales (2018)* identified gaps in perinatal mental health services but did not include specialist provision for maternity or neonatology services. A clinical psychology post has been created in the regional Neonatal Intensive Care Unit based at the University Hospital Wales, Cardiff.

All health boards in Wales are now signed up to the PQN and all have been encouraged to benchmark against the RCPsych standards for specialist community teams, with an expectation that they will have met the standards by March 2021.

Work to strengthen data collection and develop a national data-set and outcome measures framework is also taking place.

Throughout 2019-2020, training was provided for the specialist teams and wider workforce. Health Education and Innovation Wales are supporting the network to review workforce and training needs, with a plan to develop an online training resources and competency framework to include both perinatal and parent-infant mental health.

4 Northern Ireland

In Northern Ireland (NI), perinatal mental health care for more severe illness has been largely delivered by generic community and in-patient mental health services. As of February 2021, only one of five NI health and social care trusts had a specialist community perinatal mental health service (Belfast) and there were no MBUs. However, in January 2021 the Health Minister committed to fund the development of specialist community PMH services in each of the five Trusts and an MBU business case is under development.

In 2017, the *Models of care for specialist perinatal mental health services report* recommended the development of a distinct 'hub and spoke' model of care; linked to maternity hospital groups (with each large maternity 'hub' having a specialist PMH service and smaller 'spoke' units continuing to be served by liaison psychiatry, with added mental health midwife roles and links to the hub specialist PMH service). This has now been superseded by a commitment to the development of specialist community PMH services.

In 2019, all NI political parties committed to a consensus statement developed by the *Maternal Mental Health Alliance Everyone's Business Campaign*; committing to close the gap in specialist mental health service provision.

In 2020, the *NI Mental Health Action Plan* made a funded commitment to the development of perinatal mental health services, with a focus on specialist community PMH services.

In January 2021, the NI Health Minister approved funding for the development of specialist community perinatal mental health teams in each of the five health and social care trusts (with an annual budget of £4.7m). The MBU business case was still under development.

In terms of infant mental health, in 2016 NI was the first part of the UK to publish an infant mental health strategy, led by the Public Health Agency (IMH Plan 2016) which, together with the Early Intervention Transformation Programme, represented a coordinated approach across different agencies and government departments to mental health provision in the early years.

There are specific recommendations for specialist psychology provision into all maternity and neonatal units in Northern Ireland but, as yet, no implementation plan (Regulation and Quality Improvement Authority Review of Perinatal Mental Health, 2017; BLISS and Tinylife Northern Ireland Baby Report, 2018). As of January 2021, only one out of five trusts had a dedicated perinatal clinical psychology service for their maternity services (Belfast Trust) and only one out of seven neonatal units had a commissioned specialist clinical psychology service (Northern Trust).

Table A1 – The development of specialist perinatal mental health services across the devolved nations since CR197 (2015): Key national policies, guidance and strategic leadership structures

Policy or guidance	Summary
1 England	
Perinatal Mental Health for NHS England and regional/ local perinatal mental health networks (PMH)	In England, strategic bodies supporting PMH service development include the national Perinatal Mental Health for NHS England as well as regional and local PMH networks (some of which are linked with Strategic Maternity Clinical Networks and other local strategic bodies).
Perinatal Mental Health in Health Education England	Perinatal Mental Health in Health Education England focuses on workforce training and education across the perinatal pathway. It has developed a perinatal mental health competency framework for specialist and universal services. It has developed e-learning modules, including generic as well as profession-specific training resources (e.g. for health visitors and occupational therapists).
The NHS Long Term Plan (NHS England, 2019)	<p>The 2019 <i>NHS Long Term Plan</i> sets out priorities for care quality and outcomes improvement for the decade ahead, and related costed work programmes.</p> <p>The LTP includes priorities directly related to perinatal mental health (within the strong start in life maternity and neonatal work programme): the LTP will improve access to and the quality of perinatal mental health care for mothers, their partners and children by:</p> <ul style="list-style-type: none"> • Increasing access to evidence-based care for women with moderate to severe perinatal mental health difficulties and a personality disorder diagnosis and making care provided by specialist perinatal mental health services available from conception to 24 months after birth. • 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. • Increasing access to evidence-based psychological support and therapy, including digital options, in a maternity setting and developing Maternity Outreach Clinics to integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience. • In addition to the above, there are priorities relevant to PMH services within the adult mental health services work programme; including priorities related to common mental disorders, severe mental health problems, crisis and in-patient care and suicide prevention.
NHS Mental Health Implementation Plan 2019/20 – 2023/24 (NHS England, 2019)	This implementation plan set out fixed, flexible and targeted deliverables related to the LTP. For PMH Services there are fixed targets (with annual goals) for access to specialised PMH services and flexible targets (to be reached by 2023/24) for other LTP PMH goals. The plan sets out a national funding profile (including a mixture of central/transformation funding and CCG baseline programme funding) and an indicative workforce profile for PMH services.

<p>The Five Year Forward View for mental health (and related implementation plan) (NHS England, 2016)</p>	<p>This national mental health plan pledged £365m for the development of PMH services. A key funded priority was improving access to PMH services, including in-patient and community specialist services and access to psychological therapy; “allowing at least an additional 30,000 women each year to receive evidence-based treatment, closer to home, when they need it”. It recommended the establishment of perinatal MH clinical networks.</p>
<p>The maternity transformation programme (NHS England, 2017)</p>	<p>The maternity transformation programme seeks to achieve the vision set out in <i>Better Births</i> by bringing together a wide range of organisations to lead and deliver across 10 work streams. This includes a work stream on improving access to perinatal mental health services, a joint work stream between the Maternity Transformation Programme and the Mental Health Programme.</p>
<p>Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care (NHS England, 2016)</p>	<p>This NHS England-commissioned review sets out wide-ranging proposals designed to make maternity care safer and give women greater control and more choices. It identifies seven priority areas, including better perinatal mental health care, personalised care and continuity of carer.</p>

<p>2 Scotland</p>	
<p>Perinatal Mental Health Network (PMHN) Scotland and Perinatal and Infant Mental Health Programme Board (PIMH-PB)</p>	<p>PMHN Scotland is a national managed clinical network that aims to help develop and improve access to high-quality PMH care. The related Perinatal and Infant Mental Health Programme Board (PNIMH-PB) was established in March 2019 to help drive implementation of the Scottish Government’s Programme on perinatal and infant mental health.</p>
<p>Perinatal and Infant Mental Health Programme Board (PIMH-PB) delivery plan: 2020–21 (PIMH-PB, 2020)</p>	<p>This is the second PNIMH Programme Board delivery plan. It sets out two overlapping delivery plans: for perinatal mental health and for infant mental health (IMH). A key development is a broadened remit and scope for IMH, to include IMH services for all families facing significant adversity from pre-conception to three years, across all tiers from universal to specialist settings (so including but not limited to services that interface with perinatal mental health care).</p>
<p>Protecting Scotland. Renewing Scotland: the Government’s Programme for Government 2020–21 (Scottish Government, 2020)</p>	<p>This report sets out the Scottish Programme for Government for 2020–2021. It highlights the relatively high impact of COVID-19 on women and commits to supporting women during the perinatal period through the work of the Perinatal and Infant Mental Health Programme Board as well as addressing the mental health impact on women of domestic violence and abuse.</p>
<p>Perinatal and infant mental health programme board (PIMH-PB): delivery plan 2019–2020 (PNIMH-PB, 2019)</p>	<p>This was the first PNIMH programme board delivery plan. It sets out plans to develop perinatal MHS Services, focusing on four areas: more capacity (including specialist, third sector and peer support); more staff; more voices (centring the voice of women and their families); and the development of infant mental health networks and services (where these interfaced with PMH services).</p>

<p>Protecting Scotland's Future: the Government's Programme for Government 2019–20 (Scottish Government, 2019)</p> <p>https://www.gov.scot/news/mental-health-care-for-new-mums/</p>	<p>This report sets out the Scottish Programme for Government for 2019–2020. It highlights the £52m fund pledged in 2019 for developing perinatal and infant mental health care over a five-year period, including: £5m in investment for community PMH services, £3m in investment for integrated infant mental health hubs, increased specialist staffing in MBUs and third sector support for counselling and befriending services.</p>
<p>Delivering Effective Services: Needs Assessment and Service Recommendations for Specialist and Universal Perinatal Mental Health Services (Perinatal Mental Health Network Scotland, National Managed Clinical Network, 2019)</p>	<p>This report by the Scottish Perinatal Mental Health Network assesses current PMH service provision and makes 28 recommendations for the development of PMH services in specialist and universal settings. This includes recommendations for: specialist in-patient and community PMHS; infant mental health; primary care; specialist midwives; maternity and neonatal psychological services; third sector and peer support; substance misuse; training; quality indicators/ outcomes and local/regional networks.</p>
<p>Delivering for today, investing for tomorrow: the Government's Programme for Scotland 2018–19 (Scottish Government, 2018)</p>	<p>This report sets out Scottish Programme for Government for 2018–2019. It highlights the commitment to invest in perinatal and infant mental health and to substantially expand and transform service provision for women with PMH problems, their infants and families. It commits to PMH service transformation across specialist, universal and third sector settings.</p>
<p>Perinatal Mental Health Curricular Framework: A framework for maternal and infant mental health (NHS Education for Scotland (NES, 2018)</p>	<p>This curricular framework “sets out the levels of knowledge and skills required by the Scottish workforce to promote well-being and good mental health during the perinatal period and to intervene when mental ill-health is present”.</p>
<p>The Scottish Government's Mental Health Strategy: 2017–27 (Scottish Government, 2017)</p>	<p>The Scottish Government's 10-year strategy for mental health, that commits to improving mental health services to pregnant and postnatal women, their infants and their families, including a pledge to “Fund the introduction of a Managed Clinical Network to improve the recognition and treatment of Perinatal mental health problems.</p>
<p>The Best Start: A five-year forward plan for maternity and neonatal care in Scotland (Scottish Community, Health and Social Care Directorate, 2017)</p>	<p>The Scottish Government's five-year forward plan for the improvement of maternity and neonatal services, that includes the following recommended action on PMH: “All NHS Boards should review their current access to perinatal mental health services to ensure early and equitable access is available to high quality services, with clear referral pathways”.</p>
<p>Getting It Right for Mothers and Babies. Closing the gaps in community perinatal mental health services (NSPCC Scotland, 2015)</p>	<p>This NSPCC report reviews current PMH service provision and makes recommendations for service development, with a focus on: training; expanding specialist services (particularly community PMH services); improving access to psychological therapies and leadership for service design (including the establishment of a national ‘managed clinical network’; and local perinatal mental health networks).</p>

3 Wales	
Wales perinatal mental health network (NHS Wales and RCPsych Wales) and the All Wales Perinatal Mental Health Steering Group (NHS Wales)	<p>The Wales perinatal mental health network (a collaboration between NHS Wales and RCPsych Wales) and the All Wales Perinatal Mental Health Steering Group (with representation from service users, third sector, specialist PMH services and other health services) were established in 2017 to provide strategic leadership for service development.</p>
Together for Mental Health Delivery Plan: 2019–22 (Welsh Government, 2019)	<p><i>Together for Mental Health</i> outlines the Welsh Government’s 10-year cross-governmental strategy to improve mental health and well-being across all ages. This linked three-year action plan identifies “improving access and quality of perinatal mental health services” as a key priority area. It commits to further development of perinatal mental health services, including the establishment of a PMH Network, development of community PMH services to meet national quality standards, and the establishment of an MBU.</p>
From Bumps to Babies: Perinatal Mental Health Care in Wales (NSPCC, 2018)	<p>This report provides an overview of the findings from the Perinatal Mental Health in Wales project, a collaboration between NSPCC Cymru/Wales, National Centre for Mental Health (NCMH), Mind Cymru and Mental Health Foundation (with support from the Maternal Mental Health Alliance). The project explores PMH care provision in Wales and how care is experienced by women and their partners. It makes recommendations on service development, including: service expansion; equity of access; awareness raising; training; and clinical networks.</p>
Perinatal Mental Health in Wales (Welsh Government, National Assembly for Wales, Children, Young People and Education Committee, 2017)	<p>This report by the Welsh Children, Young People and Education Committee summarises the findings of their inquiry into current national PMH service provision and makes recommendations for perinatal MH service development, with a focus on: in-patient specialist care following the closure of the sole Welsh MBU; equitable access to high quality perinatal MH care; and access to psychological therapy.</p>
Prosperity for All: the national strategy (Welsh Government, 2017)	<p>This report set out the Welsh Programme for Government in 2017–2021, with five priority areas including early years and mental health. This includes a commitment to: “deliver a new community perinatal mental health service and review the need for in-patient facilities in Wales, to stop postnatal depression worsening and to allow mothers to form a strong early bond with their child”.</p>

4 Northern Ireland (NI)	
<p>Swann (Northern Ireland Health Minister) approves Funding for New Perinatal Mental Health Delivery Model (January, 2021)</p>	<p>In January 2021, the NI Health Minister approved annual funding of £4.7m for the development of specialist community perinatal mental health teams in each of the five Health and Social Care Trusts. The service will include a new stepped care model to ensure regional consistency.</p>
<p>The Northern Ireland Regional Perinatal Mental Health Group (Public Health Agency and Health and Social Care Board, 2020)</p>	<p>Specialist PMH services in Ireland are currently limited to one community PMH service in Belfast and no MBUs nationally. “To further the development of specialist services a regional perinatal mental health group, led by the Public Health Agency in partnership with the Health and Social Care Board, has been set up to co-produce an updated service model, including comprehensive community-based services”.</p>
<p>Northern Ireland Mental Health Action Plan (Department of Health, Northern Ireland, 2020)</p>	<p>This <i>Mental Health Action Plan</i> commits to service developments that will underpin the upcoming 10-year Mental Health Strategy. In this Action Plan, “the primary development is the determination and creation of a specialist community perinatal mental health service”. It commits to an “agreement on new service model for specialist perinatal mental health services by September 2020” and to funds of up to £3.6m annually for PMH services, including £900,000 in 2020/21.</p>
<p>Northern Ireland Maternal Mental Health Consensus Statement (Maternal Mental Health Alliance, 2019)</p>	<p>In 2019, all political parties in Northern Ireland co-signed a consensus statement, drafted as part of the <i>Maternal Mental Health Alliance Everyone’s Business campaign</i>, committing to close the gap in specialist mental health provision for women during pregnancy and the first year after giving birth: “We in Northern Ireland urgently request the commitment of investment and ring-fencing of funds required to ensure women, babies, families and communities get the care and support they need and deserve”.</p>
<p>Specialist Perinatal Mental Health Services: Models of Care for Northern Ireland (National Mental Health Division, Health Service Executive of Northern Ireland, 2017)</p>	<p>The Models of Care for PMH services in Northern Ireland is based on the maternity networks recommended in the National Maternity Strategy and uses a ‘hub and spoke’ model aligned to hospital groups. NI has 19 maternity units organised into six hospital groups, with the largest maternity service within each group designated as the hub and the smaller hospitals as ‘spokes’. The PMH ‘hub and spoke’ recommends that for each maternity ‘hub’, a multidisciplinary ‘Specialist Perinatal Mental Health Service’ is developed (led by a consultant psychiatrist, with 0.1 WTE consultant sessions per 1,000 deliveries). For ‘spoke’ maternity units, liaison psychiatry teams will continue to provide PMH care, with the addition of a specialist mental health midwife role and links with the ‘hub’ specialist PMH service (for advice and training). The report also recommends the development of a single national MBU.</p>
<p>National Maternity Strategy – Creating a Better Future Together 2016–2026 (Department of Health of Northern Ireland, 2016)</p>	<p>This is Northern Ireland’s first National Maternity Strategy. It highlights the high prevalence of perinatal mental illness but the very limited provision of PMH care in NI. It commits to improving the identification and care of women with perinatal mental illness, through awareness raising and training on screening for all staff involved in the maternity care pathway, and increased access to specialist PMH care, at least at the maternity network level.</p>

<p>The Regional Perinatal Mental Health Care Pathway (Northern Ireland Public Health Agency, 2017)</p>	<p>This 2017 revision of Northern Ireland’s 2012 PMH Care recommends a stepped care framework (based on NICE Guidance). The majority of the care pathway refers to existing universal and secondary mental health services, with care pathways for the most severely ill women involving accessing adult secondary MH community and crisis services. It recommends that women with the most complex needs access a specialist joint perinatal mental health clinic (to be developed in large maternity ‘hub’ hospitals).</p>
<p>Regulation and Quality Improvement Authority Review of Perinatal Mental Health (The Regulation and Quality Improvement Authority, 2017)</p>	<p>This review “examined the implementation and effectiveness of the Integrated Perinatal Mental Health Care Pathway which was developed by the Public Health Agency (PHA) in December 2012”. It highlighted the lack of specialist PMH services (with no MBUs and only one community PMH service in Belfast). It made recommendations for the development of a single MBU, community PMHS in each of the five trusts and increasing access to psychological therapy.</p>
<p>Infant Mental Health Framework for Northern Ireland: Promoting positive social and emotional development from pre-birth to three years (2016)</p>	<p>This framework aims to provide evidence and guidance to commissioners, policy makers and practitioners in Northern Ireland that support the development of evidence-based infant mental health service and practice.</p>

Survey of UK PMH services in 2019 by the MMHA	
<p>Maternal Mental Health Alliance (MMHA) PMH Service Maps</p>	<p>The MMHA <i>Everyone’s Business Campaign</i> has reviewed specialist PMH provision across the UK and estimated the number of services that meet ‘green criteria’ (i.e. services that meets nationally agreed standards; i.e. PQN Type I standards or Joint Commissioning Panel criteria).</p>
<p>Map of Specialist Community Perinatal Mental Health Teams (UK) (MMHA, 2020)</p>	<p>The percentage of areas meeting green criteria in 2019:</p> <ul style="list-style-type: none"> • In England, 80% of CCGs met green criteria • In Scotland, 14% of Mental Health Boards met green criteria • In Wales, 29% of Health Boards met green criteria • In Northern Ireland, 0% of Health and Social Care Trusts met green criteria in 2019.
<p>Accredited mother and baby units (MMHA, 2019)</p>	<p>This MMHA survey summarises the details of accredited MBUs as of July 2019; including 19 MBUs in England and two MBUs in Scotland.</p>

Appendix 2 Key governance bodies, policies, guidance and research reports driving developments in perinatal mental health services

Policy, report or guidance 21/02/2021): PERINATAL mental health: RCPsych, NICE, NHSE, HEE and sign resources	Summary
Perinatal Quality Network (PQN) for Perinatal Mental Health Services , Royal College of Psychiatrists	The PQN is one of the quality networks of the RCPsych's College Centre for Quality Improvement (CCQI). It works with MBUs and community PMH services to promote high quality care and share best practice at a national level. It sets quality standards for in-patient and community PMH services and runs a review and accreditation programme for network members.
Standards for Community Perinatal Mental Health Services , 5th Edition (Perinatal Quality Network, RCPsych, 2020)	The PQN's Standards for Community PMH Services, used in the PQN's peer and self-reviews and accreditation process.
Standards for Inpatient Perinatal Mental Health Services , 7th Edition (Perinatal Quality Network, RCPsych, 2019)	The PQN's Standards for Inpatient PMH Services, used in the PQN's peer and self-reviews and accreditation process.
Perinatal Mental Health (NHS England, 2019)	PMH services. This includes data on local demographics, disorder and risk factor prevalence, access and identification and PMH services. The related Joint Strategic Needs Assessment (JSNA) toolkit aims to support the development of a local JSNA for perinatal mental health services.
The Perinatal Mental Health Care Pathways. Full implementation guidance (National Collaborating Centre for Mental Health NCCMH, 2018)	This NMCC Guidance sets out Care Pathways to support the goals of the Five-year Forward View for Mental Health. It highlights the principles of timely access to evidence-based care for all women who need it. The report details five PMH care pathways for: pre-conception advice; specialist assessment; emergency assessment; psychological interventions; and in-patient care (MBUs).
RCPsych College Report 216 – FROM-Perinatal: Framework for Routine Outcome Measures in Perinatal Psychiatry (RCPsych, 2018)	This report sets out guidance on the use of routine clinical outcome measurement in perinatal services. This includes measure of maternal mental health, the quality of mother-infant interactions and patient-reported experience measures.
NICE Clinical guideline CG192 – Antenatal and Postnatal Mental Health: clinical management and service guidance (National Institute for Health and Care Excellence (NICE), 2014)	This is the first NICE clinical guideline on perinatal mental health, providing a robust systematic review of the evidence underpinning PMH services and interventions.

<p>NICE Quality Standard 115 – Perinatal Mental Health</p>	<p>The <i>NICE Quality Standards for perinatal mental health</i> include standards on: not prescribing valproate; information on MH and its treatment for pre-conception and pregnant women; identification of MH problems in maternity setting; comprehensive MH assessment; access to psychological treatment (within six weeks of referral); and access to in-patient and community specialist PMH services.</p>
<p>The costs of perinatal mental health problems (LSE and Centre for Mental Health, 2014)</p>	<p>This highly influential report was commissioned by the Maternal Mental Health Alliance to investigate the economic costs of perinatal mental illness in the UK. The authors estimated that perinatal mental illnesses carried a long-term cost to society of £8.1bn pounds for each annual cohort of birth with 72% of this cost related to adverse impacts on the child. The annual cost to the NHS was estimated at £1.2bn (in comparison, the annual extra cost to develop PMH care pathways in line with national guidance was estimated at £280m).</p>
<p>The 1001 Critical Days: The Importance of the Conception to Age Two Period (Wave Trust, 2014) and the 1001</p>	<p>In 2014, the Wave Trust published this highly influential cross-party manifesto, highlighting the importance of the early years. It set a vision for early intervention, from pre-conception to the age of two years, to enhance outcomes for children. The influence of the 1001 Critical Days manifesto continues through the work of the First 1001 Days Movement. The movement's vision and mission are set out in their consensus statement: "Our vision is that every baby has loving and nurturing relationships in a society that values emotional wellbeing and development in the first 1001 days, from pregnancy, as the critical foundation for a healthy and fulfilling life. As a movement of organisations and professionals, our mission is to drive change together by inspiring, supporting and challenging national and local decision makers to value and invest in babies' emotional wellbeing and development in the first 1001 days".</p>
<p><i>Guidance for Commissioners of Perinatal Mental Health Services (Joint Commissioning Panel for Mental Health (JCPMH), 2012)</i></p>	<p>The JCPMH, co-chaired by the RCGP and the RCPsych, produced this guidance for commissioners on the need for specialist PMH service, opportunities for prevention, current PMH service provision, what a good PMH service looks like and how commissioning PMH service would support national mental health strategies.</p>
<p><i>SIGN 127 – Management of perinatal mood disorders: a national clinical guideline</i> (SIGN, 2012)</p>	<p>This guideline provides recommendations based on current evidence for best practice in the management of antenatal and postnatal mood and anxiety disorders.</p>
<p>Maternity (including MBBRACE reports)</p>	
<p>MBBRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK</p>	<p>MBBRACE-UK runs a national programme of work on the surveillance and investigation of the causes of maternal deaths, stillbirths and infant deaths. It makes quality improvement recommendations based on lessons learnt from these inquiries. It has identified mental illness and substance misuse as leading causes of maternal mortality and morbidity and made recommendations relevant to PMH care across universal and mental health settings.</p>

<i>MBBRACE-UK: Saving Lives, Improving Mothers' Care. Rapid report: learning from SARS-CoV-2-related and associated maternal deaths in the UK March – May 2020 (MBRRACE-UK, 2020)</i>	This MBBRACE-UK report into maternal deaths in March–May 2020, during the first wave of COVID-19, identifies key lessons learnt, including lessons for mental health and for care of women who died as a result of domestic violence.
<i>MBBRACE-UK: Saving Lives, Improving Mothers' Care. Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16 (MBRRACE-UK, 2018)</i>	This MBBRACE-UK report into findings from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014–16 includes a section on 'messages for mental health'.
<i>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)</i>	This RCOG report highlights the role of maternity services in the early identification and assessment of mental illness and describes principles of service organisation to meet these needs. This includes recommendations on the development of care pathways, training and commissioning across maternity services, perinatal mental health services and primary care.
Primary care	
<i>RCGP Perinatal Mental Health Resources and Toolkit (RCGP)</i>	An RCGP resource list and perinatal mental health toolkit ("a set of relevant tools to assist members of the primary care team to deliver the highest quality care to women with mental health problems in the perinatal period"), developed with the RCGP's PMH Special Interest Group and PMH Steering Group.
<i>RCGP Position Statement: Perinatal Mental Health (RCGP, 2017)</i>	This RCGP Position Statement on perinatal mental health, created as part of the RCGP's Clinical Priority programme, makes recommendations for GPs, commissioners and NHS England to support women facing perinatal mental illness.
<i>RCGP Position Statement: The Role of the General Practitioner in Maternity Care (RCGP, 2017)</i>	This RCGP Position Statement on the role of GPs in maternity care includes recommendations on the management of perinatal mental health problems in primary care.
Health visiting	
<i>Health Visiting in England: A Vision for the Future (Institute of Health Visiting, 2019)</i>	This report presents the Institute of Health Visiting's vision for health visiting services in England, including a vision for their role in relation to perinatal mental health (in mothers, fathers and partners) and infant mental health.

<p><i>Specialist Health Visitors in Perinatal & Infant Mental Health: What they do and why they matter</i> (Health Education England, 2016)</p>	<p>This HEE document, aimed at health visitor commissioners and managers, makes recommendations regarding specialist perinatal and infant mental health visitor posts.</p>
<p>Psychology and parent-infant therapy</p>	
<p><i>Position Paper: Perinatal psychology provision in specialist perinatal community mental health services</i> (British Psychological Society, 2019)</p>	<p>This position paper by the British Psychological Society outlines the role of perinatal psychology in specialist community teams and provides guidance for good perinatal clinical psychology provision and staffing levels.</p>
<p><i>Briefing Paper 8. Perinatal service provision: The role of perinatal clinical psychology</i> (British Psychological Society, 2016)</p>	<p>This briefing paper from the British Psychological Society details the role of perinatal clinical psychology in maternity services, neonatal units, specialist community perinatal mental health services, and mother and baby units.</p>
<p><i>Rare Jewels: Specialised parent-infant relationship teams in the UK</i> (Parent-Infant Partnership UK, 2019)</p>	<p>This report by the PIP-UK Foundation surveyed current provision of ‘specialised parent-infant relationship teams’ (defined as standalone ‘multidisciplinary teams with expertise in supporting and strengthening relationships between babies and their parents or carers’. These teams work as expert advisors and champions for the local workforce, as well as offering direct work with families (including parents and other carers of infants aged two and under). The report identifies 27 such teams across the UK as of 2019 and recommends national expansion.</p>
<p>Substance use disorders (generic guidance of relevance to PMH services)</p>	
<p><i>NICE Quality Standard 188: Coexisting severe mental illness and substance misuse</i> (National Institute for Health and Care Excellence Quality (NICE, 2019)</p>	<p>This set of <i>NICE Quality Standards for people with coexisting SMI and substance misuse</i> includes quality standards on identification of substance misuse among patients with SMI and for those with co-occurring disorders: non-exclusion from services, care coordinator allocation and follow-up after missed appointments. These standards are relevant to the care of women with co-occurring SMI and substance misuse in the perinatal period.</p>
<p><i>Better care for people with co-occurring mental health and alcohol/drug use conditions. A guide for commissioners and service providers</i> (Public Health England, 2017)</p>	<p>This guidance aims to inform the commissioning and provision of effective care for people with co-occurring mental health and alcohol/drug use conditions. It promotes the two key principles of joint responsibility by mental health and alcohol/drug services, and a provider ‘open-door policy’ for people with co-occurring conditions. These principles are relevant to the care of women with co-occurring SMI and substance misuse in the perinatal period.</p>
<p>Learning disabilities (generic guidance of relevance to PMH services)</p>	
<p><i>The Working Together with Parents Network (WTPN) update of the DoH/DfES Good Practice Guidance on working with parents with a learning disability (2007)</i> (WTPN, University of Bristol, 2017)</p>	<p>This WTPN update of the 2007 DoH/DfES Guidance on working with parents with a learning disability updates the relevant policy and legislative framework, and presses for compliance with the basic principles of the original report, in order to respect the human rights of parents with learning disabilities and their children. The principles include the right to accessible information, tailored support and access to advocacy. This guidance is therefore relevant to the care of women with learning disability and perinatal mental illness.</p>

<p><i>Transforming Care for People with Learning Disabilities – Next Steps</i> (NHS England, 2015)</p>	<p>This NHS England-commissioned report aims to accelerate the transforming of care for people with a learning disability and/or autism who have a mental illness or whose behaviour challenges services. It highlights key principles, including: empowering people and families; getting the right care in the right place; driving up quality through regulation and inspection; and workforce development. The principles are relevant to the care of women with a learning disability/autism and perinatal mental illness.</p>
<p><i>Good Practice Guidance on Working with Parents with a Learning Disability</i> (Department of Health and Department for Education and Skills, 2007)</p>	<p>This <i>Good Practice Guidance on working with parents with a learning disability</i>, includes a summary of relevant legislation and policy, and recommendations on how adult and children’s services should work together to improve support to parents with a learning disability and their children (including recommendations on safeguarding procedures and commissioning). This guidance is therefore relevant to the care of women with learning disability and perinatal mental illness.</p>
<p>Other guidance: Trauma-informed care, child safeguarding, liaison services, preconception care and mood disorders</p>	
<p><i>A good practice guide to support implementation of trauma-informed care in the perinatal period</i> (commissioned by NHSE and NHSI, 2021)</p>	<p>This good practice guide was commissioned by NHSE and NHSI and aims to help staff and services understand the impact of psychological trauma on women in the perinatal period and respond in a sensitive and compassionate way. It sets out principles of care, including: compassion and recognition; communication and collaboration; consistency and continuity; and recognising diversity and facilitating recovery.</p>
<p><i>Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children</i> (Department for Education, 2018; updated December 2020)</p>	<p>Statutory guidance that covers the legislative requirements and a framework for inter-agency working to safeguard and promote the welfare of local children, including identifying and responding to their needs.</p>
<p><i>How are people’s mental health needs met in acute hospitals and how can this be improved?</i> (CQC, 2020)</p>	<p>This CQC report reviewed findings from more than 100 acute hospital inspections to investigate how well the mental health care needs of patients were met. It made commissioning, trust-level and training recommendations to improve mental health care within acute hospital settings. Perinatal mental health was not specifically investigated but the recommendations are relevant to the provision of perinatal mental health care within acute trusts (including perinatal liaison work).</p>
<p><i>Making the case for preconception care</i> (Public Health England, 2018)</p>	<p>This PHE report highlights the importance of pre-conception care. It advocates for services to promote healthy behaviours and support early interventions to manage emerging risks across the life-course – prior to first or subsequent pregnancies – including risks related to mental illness and related social adversities.</p>
<p><i>Involving and supporting partners and other family members in specialist perinatal mental health services: good practice guide</i> (NHS England 2021)</p>	<p>This good practice guidance, about involving and supporting partners and significant others, is for commissioners and those working in specialist perinatal mental health services.</p>

Appendix 3: Parent-infant therapy services – current provision and recent guidance

Currently, there is wide variety in the set-up, funding and therapeutic model of teams and services which provide support and therapeutic interventions for parent-infant relationships in pregnancy and the early years in the UK. Some services provide interventions (parent-infant, individual and group) for a wide range of parents/carers where there is a concern about the developing parent-infant relationship. Others are targeted at specific groups of parents considered at high risk or disruption of the parent-infant relationship, such as those where parents are struggling with substance use problems or domestic violence and may be involved in care proceedings. The age range may focus on pregnancy and the first postnatal year or may extend up until the fifth year.

Some teams are embedded within the local Child and Adolescent Mental Health Services (CAMHS), while others are primarily funded through public health budgets, local authority children's services budget, the voluntary sector or partnerships between these. A recent UK-wide survey found that many areas in the UK do not have access to specialist parent-infant mental health provision and that many teams lack sufficient resources to meet local demands (Hogg, 2019). Alongside perinatal mental health services, these teams and services form a vital part of the network available to parents experiencing perinatal mental health difficulties.

When planning and developing parent-infant mental health provision in an area, including that provided within perinatal mental health services, commissioners and their equivalents, in consultation with local stakeholders including parents and those with relevant lived experience, should map the different teams and services which work with parents, babies and infants, their 'target' populations and the existing level of collaboration and co-working between them. This will help identify gaps in provision, e.g. for parents with comorbid substance use or intellectual difficulties, or for parents struggling with emotional and behavioural issues with their preschool aged children, and support planning to address these gaps.

Appendix 4: Specific consideration for substance misuse in pregnancy

This appendix includes a summary of the impact and management of nicotine, alcohol and specific drugs use in pregnancy. It also includes a list of key resources relevant to the care of women with substance misuse in pregnancy. This is included here to assist non-specialists in managing this group of patients. (Wilson, Finch et al,2020).

Perinatal mental health care for women with co-occurring substance misuse and moderate to severe mental illness is discussed in the main report. Substance misuse is an important contributor to maternal and infant mortality and morbidity but women with substance misuse problems are at risk of having poor access to care and of receiving fragmented care. To improve service provision for this group, MBRRACE-UK recommends that perinatal mental health clinical networks “should always include specialist addictions services” (Knight, Bunch et al, 2019).

Nicotine use in pregnancy: Smoking tobacco products significantly increases risk for developing miscarriage, stillbirth, prematurity and low birth weight. Helpful guidance to support smoking cessation in pregnancy and beyond can be found on the National Centre for Smoking Cessation and Training (NCSCT) website.

Cannabis use in pregnancy: Smoking cannabis during pregnancy shares or amplifies the health risks associated with smoking nicotine products but there are additional concerns that cannabis use in pregnancy may be associated with behavioural problems in childhood.

Alcohol use in pregnancy: Both the UK and Ireland were among the top five of 187 countries in a global survey of alcohol use in pregnancy, which also estimated that one in every 67 women who consumed alcohol during pregnancy would deliver a child with FAS (Popova et al, 2017). UK Chief Medical Officers’ Low Risk Drinking Guidelines (2016) identified a range of harms associated with alcohol use in pregnancy and gave the following clear advice:

- “If you are pregnant or think you could become pregnant, the safest approach is not to drink alcohol at all, to keep risks to your baby to a minimum”.
- “Drinking in pregnancy can lead to long-term harm to the baby, with the more you drink the greater the risk”.

Prenatal alcohol exposure is a leading preventable cause of birth defects and developmental disabilities and also increases risks of spontaneous abortion, stillbirth, weight and growth deficiencies, birth defects and prematurity.

A low threshold should be adopted for admitting pregnant women who may be dependent on alcohol to hospital for assisted withdrawal from alcohol (using reducing courses of chlordiazepoxide, diazepam or possible oxazepam in the lowest dose for the shortest possible time). Benzodiazepine use by the mother at the time of delivery can result in floppy infant syndrome or neonatal withdrawal symptoms (Thibaut et al, 2019).

A Scottish national clinical guideline on children and young people exposed prenatally to alcohol, found evidence of considerable under-reporting of affected children. Moreover, the possible role of prenatal exposure to alcohol was not always considered as the cause of neurodevelopmental disorder in some children. The same report emphasises the importance of high-quality screening for alcohol use in pregnancy and the need for ongoing monitoring of those children who were prenatally exposed to alcohol (SIGN, 2019).

Opioid use in pregnancy: Addiction services not only treat people who are addicted to heroin but also those who have become addicted to the range of opioids including heroin, oxycodone, tramadol, fentanyl, codeine and dihydrocodeine. In some cases, these medications were initially prescribed for pain, while others have accessed these drugs through illegal means. In most cases the best approach is to stabilise the patient on to a long-acting opioid substitute treatment, usually methadone but sometimes buprenorphine, and to maintain the patient on this treatment throughout pregnancy.

The management of opioid dependence in pregnancy should be done in collaboration with a senior doctor who has the required competences and in line with best practice (ACOG DH, 2017).

Additional resources

Detailed guidance on the assessment and management of drug misuse, including guidance on drug use in pregnancy and beyond, has been produced by the Department of Health across the UK (Department of Health, 2017). More specific resources on substance use in pregnancy can be accessed online from NHS Scotland, the World Health Organization (2014) and the US-based Substance Abuse and Mental Health Services Administration (SAMSHA), CDC Centers for Disease Control and Prevention, and the National Institute on Drug Abuse (NIDA).

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