Luton Perinatal Mental Health Needs Assessment

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Commissioned by the Luton Borough Council Public Health Team

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Executive Summary

Introduction

Perinatal mental health problems are a major public health concern. Mental illness affects more than 1 in 10 women during the perinatal period - defined as pregnancy and the year following birth. Prevention and early identification is important and appropriate management is vital. Poorly managed perinatal mental health problems can have lasting effects on maternal wellbeing, partner and family relationships as well as the mental health and social adjustment of the child.

This needs assessment was commissioned by Public Health to improve the local understanding of perinatal mental illness and to form the basis for developing a strategic response to local needs.

What we know about perinatal mental illness

Perinatal mental illnesses are diverse and complex and cover a range of conditions: Postpartum psychosis, Chronic serious mental illness, Severe depressive illness, Post-traumatic stress disorder (PTSD), Perinatal obsessive compulsive disorder (OCD), Mild-moderate depressive illness and Adjustment disorders and distress.

For many disorders, pregnant women and new mothers have the same level of risk as other adults, although the effects may be more significant at this critical period. However for certain serious mental illnesses – postpartum psychosis, severe depressive illness, schizophrenia and bipolar illness – the risk of developing or experiencing a recurrence of the illness increases after childbirth.

The causal pathways that lead to maternal mental illness are neither simple nor well understood, but it is important to identify women who are at risk and ensure they get timely and appropriate support. Some factors known to be associated with increased risk are:

- history of mental illness
- family history of mental illness
- lone parent or poor couple relationship
- low levels of social support
- recent adverse or stressful life events
- socio-economic disadvantage
- teenage parenthood

- early emotional trauma/childhood abuse
- unwanted pregnancy.

There is also emerging evidence that it is important to consider ethnicity, given that fewer than expected women of black and minority ethnic origin receive diagnosis and treatment for perinatal mental illness, despite high levels of morbidity and high associated social risk factors.

Perinatal mental illness in Luton

Luton has a relatively high proportion of the female population of childbearing age and the birth rate is high compared with national and regional averages. Consequently, there is a high demand for maternity services in the borough and a high number of women at risk of experiencing perinatal mental illness.

Each year around 3,500 women in Luton give birth. Evidence that at least 1 in 10 women experience perinatal mental illness suggests that there at least 350 women in Luton each year. Based on NICE estimates of service requirements, the annual estimated number of cases in Luton are:

- 142 women (4% of deliveries) requiring advice and care from a specialist perinatal mental health service, including 14 admissions to mother and baby unit
- 284 women (8%) require and accept referral for psychological therapies
- 284 women (8%) who experience mental health disorders but do not require or do not take up the offer of therapy.

Benchmarking of key measurable risk factors highlights that Luton is a relatively deprived borough, with 27% of the population living in areas classified as within the most 20% in England and 1 in 5 children living in poverty. Moreover, there are significant inequalities within Luton with pockets of extreme deprivation. The overall proportion of all households which are lone parent families is relatively high in Luton and some wards have more than a fifth of births registered to a sole parent or parents with different addresses.

There is a paucity of data about number of women diagnosed with perinatal illness both in Luton and nationally. The information items extractable from routine information systems are about women considered to be ‘at risk’ of illness and do not capture detail about diagnosis or severity.

The main source of data within Luton to measure perinatal mental illness is when mental health issues are identified as a primary “cause for concern” by midwives during their care of pregnant and

postpartum women. Data from Luton & Dunstable Hospital shows there were 1,060 pregnant or postpartum women in Luton for whom mental health was identified as a main cause for concern during a two-year period, representing 15% of all women giving birth. Data collected to support "Payments by Results" (PbR) over a six month period identified 179 women (9%) in Luton as having a mental health issue during the antenatal period and 77 women (4.5%) during the postnatal period.

Identification of mental health issues varies by ethnic group. The percentage for White British women is significantly higher than the Luton average. The percentage is significantly lower for Indian, Other White, African, Bangladeshi and Pakistani women. All of these groups have a percentage identification rate lower than the 20% suggested by NICE guidance. Whilst this may be because women in these ethnic groups have genuinely lower rates of perinatal mental illness, it does strongly indicate that there is unmet and undiagnosed need among these groups.

There are also differences across the Borough. The three wards with high prevalence of indentified mental health issues were Round Green, Leagrave and Northwell. Biscot and Lewsey wards had a low percentage of women with mental health identified as a cause for concern. Overall, there is no clear evidence of a relationship between identified mental health issues and socio-economic deprivation in Luton. Whilst this may be because women in some areas have genuinely lower rates of perinatal mental illness, it does indicate that there is unmet and undiagnosed need.

Very little is known about how many women with identified mental health issues are treated or the quality or outcomes of their treatment. This represents a major gap in understanding about how perinatal mental illness is managed in Luton.

Luton services for the care of women with a perinatal mental illness

A series of interviews were undertaken with key stakeholders within the Luton services which work to prevent and treat perinatal mental illness. The following service elements were considered:

- Overall system and management of services
- Mother and Baby unit
- Community Perinatal Mental Health services
- Parent-Infant Mental Health services
- Specialist Adult Mental Health services
- Psychological Therapies
- Maternity services

- Primary Care
- Health Visiting
- Social Care type interventions

Local service models were compared with national recommendations for good practice.

Key findings

Based on the review of research, analysis of data and interviews with stakeholders the following key themes have emerged:

Committed workforce: There are already a range of good services in place across Luton and there is strong local staff commitment to the importance of the topic and the need to improve and develop services across the care pathway.

Numbers, prevalence and complexity: Given the high proportion of women aged 15–45 in Luton, the relatively high fertility rate and levels of social deprivation, there is pressure on maternity services and high estimated prevalence of perinatal mental illness. A further challenge is supporting women who do not speak English well or are coming into contact with services for the first time.

Management and strategy: Recent guidance literature is clear that effective management and support begins with having a perinatal strategy in place that has been developed by and is owned by a multi-disciplinary group and is monitored and reviewed by a senior level body that meets routinely. Luton does not yet have a perinatal mental health strategy.

Care pathway: Luton has evidence-based perinatal mental health care pathways to cover serious mental illness, crisis intervention and mild to moderate mental illness. However, these pathways are not well known and used outside the maternity unit and adult mental health services. This is particularly an issue for the mild-moderate pathway, where many universal agencies have a role.

Data and monitoring: A number of services could not provide detailed service data relating to perinatal mental illness. Both national and local action is required to enable the use of data within service monitoring and improvement.

Focus on mother and baby: Current services in Luton respond to the mental health needs of the mother (e.g. adult mental health) or the risk to the child (e.g. CAMHS, social services). National guidance stresses

the value of considering the mother-baby relationships and working to ensure there is every possibility of bonds forming.

Perinatal specialism: There is no specialist perinatal mental health team (or individuals) or parent-infant mental health team in Luton and neither CAMHs or AMH have a specific brief to undertake parent-infant work. National guidance stresses the value of having specialist roles in perinatal mental health. Given the size of the population in Luton, it may be that any such development requires regional agreement or shared commissioning arrangements.

Differences in perinatal mental illness by ethnicity: local data supports emerging national evidence that women from some ethnic groups have unmet need and are not well served by mainstream services. If women from some ethnic groups prefer community-based models, it may be that greater emphasis should be placed on creating care pathways in which non-statutory agencies are more formally integrated into mainstream services. It is also vital to improve data collection around ethnicity so that these differences can be better understood.

Geographic differences in perinatal mental illness: The geographic patterns did not show the expected relationship with socio-economic deprivation (you would expect higher prevalence in more deprived areas given that socio-economic variables are key risk factors). This could indicate that there is unmet need in some areas or particular groups.

Hard to reach groups: Interviews with stakeholders identified three groups at particularly high risk: women living in traveller communities, women who have recently arrived in Luton (such as immigrants from Eastern Europe or people seeking asylum) and women for whom English is not their first language. Concerns were expressed about the challenges of providing appropriately for these women and, in some cases, the need for more resources to do so.

Continuity of care and information sharing: The review of services highlighted there were many agencies working to prevent, treat and identify perinatal mental illness in Luton. However, some concerns were expressed about lack of information sharing across agencies. If information sharing protocols could be agreed this may improve continuity of care for women and increase opportunities to prevent, identify or intervene.

Postnatal care: Although there are many services supporting women during the perinatal period, the effectiveness of care during the postnatal element was less clear. The Health Visiting team is currently very short-staffed and, although vulnerable groups are being targeted, they are unable to fulfil all monitoring and treatment requirements in relation to mothers with mental illness.

Education and training: The need for training in the knowledge and skills to recognise and treat perinatal mental illness emerged as a common theme across interviews with stakeholders. Appropriate training can help ensure early identification of those women at high risk and provide an understanding of: the maternity context, the additional clinical features and risk factors associated with perinatal disorders, and the developmental needs of infants.

Prevention and holistic approach: Across the Luton stakeholders there was consensus view that targeted primary (e.g. pre-birth parenting skills) and secondary (e.g. crisis support or family key worker) prevention is required.

Psychological therapies: There are a range of psychotherapy services available to women across the perinatal period, including a dedicated antenatal service and general services targeted at particular ethnic groups. The provision of a new IAPT service with a longer intervention presents an opportunity to support more complex cases. However, there needs to be greater consideration of how best these services can meet the needs of pregnant and postpartum women and their children.

Recommendations

These are broad recommendations to be considered at a strategic level:

1) **Develop perinatal mental health strategy/network**
2) **Audit existing care pathways and consider widening scope**
3) **Focus on the relationship between mother and baby**
4) **Consider establishing a community perinatal mental health team and / or parent-infant mental health team or developing specialised roles**
5) **Review psychological interventions**
6) **Investigate disparity between expected prevalence and service uptake among BME group**
7) **Review social support type initiatives and interventions**
8) **Improve data collection, monitoring and sharing**

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1. Introduction

Why perinatal mental health is important

Perinatal mental health problems are a major public health concern. Mental illnesses affect more than 1 in 10 women during pregnancy and the following year. Childbirth is associated with increased risk of development and recurrence of serious mental illness. Non-psychotic conditions, such as depressive illness and anxiety, are common during pregnancy and following delivery, and can deteriorate rapidly.

Prevention and early identification is important. Maternal mental illness and its treatment can complicate pregnancy. Psychotic illness in pregnancy is associated with an increased risk of preterm delivery, stillbirth, perinatal death and neurodevelopmental disorder.

Appropriate management is also vital. Poorly managed perinatal mental health problems can have lasting effects on maternal self-esteem, partner and family relationships as well as the mental health and social adjustment of the child. In particular, separation of mother and infant can prevent the early development of mother-infant attachment and relationship. This may be difficult to reverse and have longstanding effects on both child and mother.

Why do a needs assessment for Luton

Mental disorders during pregnancy and the postnatal period can have serious consequence for the health and wellbeing of a mother and her baby, as well as for her partners and for other family members. This needs assessment was commissioned by Public Health to improve the local understanding of maternal mental health illness in Luton and to form the basis for developing a strategic response to local needs.

In particular Luton Public Health commissioned this work to:

- understand local risk and need, and variation in these across the borough
- summarise latest guidance on what an effective services looks like
- assess how well current services meet need
- make recommendations on how to address gaps in services and areas of under-provision.

How this needs assessment works

The report aims to be useful to service commissioners and is informed by the following principles:

- Transparency – all assumptions should be explicit and open to challenge/change
- Simplicity – it should be straightforward and understandable

- Relevance to commissioning – it should focus on evidence that is directly relevant to the commissioning and health improvement processes
- Practicality – it should use data that are readily available and of reasonable quality
- Participation – needs assessment should be carried out with key stakeholders.

Needs assessment is a population-based assessment approach that provides evidence to inform decision-making. It gather findings from analysis of; epidemiological information, service activity data, evidence based literature, and the inputs of stakeholders.

This report aims to identify where attention should be focussed. Where possible, demographic and epidemiological information has been split to help understanding of need in the following ways:

- Geography: where possible need, risk and service delivery data has been split by ward in an effort to broadly highlight where in Luton these factors occur more often.
- Ethnicity: evidence on the exact impact of ethnicity on perinatal mental illness is limited and inconclusive. However, in Luton there are many and varied ethnic groups and this report aims to gain an understanding of need and how well need is met for them.
- Vulnerability: perinatal mental illness should not be viewed in isolation. It is often associated with or the result of a combination of social factors. There are groups in Luton that are likely to be more vulnerable to maternal mental illness. This report seeks to identify and understand them.

Note: views of service users were not sought during this process.
Note: stakeholder interviews were conducted during October 2013. It must be acknowledges that some elements of the services reviewed have changed / developed in the intervening period and this report is not able to reflect that.

2. What we know about perinatal mental illness

Introduction

This chapter provides a summary of guidance literature on perinatal mental health. Given the recent focus on this important topic this review draws on recent published guidance documents as these reflect the latest evidence and the current strategic thinking. Given the focus on understanding need and providing services to meet need effectively this review is primarily based on commissioning type guidance, supplemented where necessary. The review particularly draws upon:

- NICE Commissioning guide: Implementing NICE guidance on antenatal and postnatal mental health services, NICE. August 2008
- Prevention in mind. All Babies Count: Spotlight on Perinatal Mental Health, National Society for the Prevention of Cruelty to Children (NSPCC). June 2013
- Guidance for commissioners of perinatal mental health services, Joint Commissioning Panel for Mental Health (JCPMH). November 2012

The three key documents that form the basis of this chapter are recognised here and are only referenced when directly quoted. Additional supporting documents are referenced when drawn upon.

Guidance materials have been summarised to address three aims: 1) provide a summary of key issues 2) Identify good practice – particularly around improving access to services and improving outcomes. 3) Provide a focus on the vulnerable and 'at risk' groups.

Why focus on perinatal mental health?

NICE Clinical Guidance 45 states it plainly - 'mental disorders during pregnancy and the postnatal period can have serious consequences for the health and wellbeing of a mother and her baby, as well as for her partner and other family members.' The recent NSPCC report supports this when saying 'mental illnesses affect more than 1 in 10 women during pregnancy and the first year after childbirth, and can have a devastating impact on them and their families.'

With the correct approach and appropriate intervention much perinatal mental illness can be prevented or treated effectively. NICE commissioning guidance states 'the detection of women at risk of developing a mental disorder and the identification of those with a current mental disorder, followed by prompt intervention at all levels of healthcare provision, can help to minimise maternal morbidity and limit

adverse effects on the baby and other family members.' The NSPCC report suggests that 'effective and timely action by public services can prevent much of the harm done by perinatal mental illnesses'.

What do we mean by perinatal mental illness?

Within this work we define the perinatal period as the period of pregnancy and the 12 months following birth. The term 'perinatal mental illness' is used to describe the range of mental health problems that women can be affected by during pregnancy and after birth.

Some women who experience mental illness in the perinatal period may have no history of mental illness and experience it for the first time. Other women may have a pre-existing mental illness which persists, deteriorates or recurs during the perinatal period as the result of the intense social, psychological and physical changes occurring at this time, for example because of a change in medication or as a result of the events of childbirth.

For many disorders, pregnant women and new mothers have the same level of risk as other adults, although the effects of these illnesses are likely to be more significant at this critical period in their lives. However for certain serious mental illnesses – postpartum psychosis, severe depressive illness, schizophrenia and bipolar illness – the risk of developing or experiencing a recurrence of the illness increases after childbirth.

The NSPCC report describes the mental illnesses included within the broad term 'perinatal' as:

- **Postpartum psychosis** - a severe mental illness that typically affects women in the weeks after giving birth, and causes symptoms such as confusion, delusions, paranoia and hallucinations.
- **Chronic serious mental illnesses** – which are longstanding mental illnesses, such as schizophrenia or bipolar disorder, which may be more likely to develop, recur or deteriorate in the perinatal period.
- **Severe depressive illness** – this is the most serious form of depression, where symptoms are severe and persistent, and significantly impair a woman's ability to function normally.
- **Post-traumatic stress disorder (PTSD)** - is an anxiety disorder caused by very stressful, frightening or distressing events, which may be relived through intrusive, recurrent recollections, flashbacks and nightmares.
- **Perinatal obsessive compulsive disorder (OCD)** – this causes women to experience severe anxiety, obsessions and compulsive behaviours, it can occur at any time, but the onset or worsening of symptoms has been associated with pregnancy and childbirth.

- **Mild-moderate depressive illness** – this includes symptoms such as persistent sadness, fatigue and a loss of interest and enjoyment in activities. It often co-occurs with anxiety, which may be experienced as distress, uncontrollable worries, panic or obsessive thoughts.
- **Adjustment disorders and distress** occur when a woman is unable to adjust or cope with an event such as pregnancy, birth or becoming a parent. A woman with these conditions will exhibit a distress reaction that lasts longer, or is more excessive than would normally be expected, but does not significantly impair normal function.

What are the impacts of maternal mental illness?

Whilst the majority of adults with mental illnesses are good parents, and others can manage if appropriate support is provided, there is a risk that, without the right support, perinatal mental illnesses can have a lasting effect on their children. The JCPMH summarises this when saying 'significant mental health problems at this time (perinatal period) cause enormous distress and can seriously interfere with the adjustment to motherhood and the care of the newborn baby…Poorly managed perinatal mental health problems can have lasting effects on maternal self esteem, partner and family relationships as well as the mental health and social adjustment of the child.' The report goes on to say 'non-psychotic depressive illnesses and anxiety states, particularly if untreated or chronic and associated with social adversity, have been shown to affect the infant's mental health and have longstanding effects on the child's emotional, social and cognitive development.'

The NSPCC report suggests that a mother's mental health can affect her baby before birth, stating 'studies show a range of mental illnesses … increase the risk of both early delivery and low birth weight, which in turn increases the risk of infant mortality, suboptimal growth, illnesses, neuro-developmental problems and long-term cognitive outcomes.'

After birth, the interaction with the primary caregiver is the most important element of a child's early experience, and lays the foundations for their social and emotional development. In the first year of life, a child should develop their first attachment relationship, usually with their mother. The NSPCC report describes a secure attachment as one that 'enables the child to feel safe, secure and protected, and is likely to result in them developing social competence and resilience which helps them to cope in later life.' The report describes an insecure attachment as one where 'a child may have experienced inconsistent or insensitive care and therefore are not able to rely upon that relationship.'

To develop a secure attachment relationship, babies need their primary caregiver to be able to recognise and understand their behaviour and feelings, and respond appropriately. This can be impaired in women

who have even relatively mild mental illnesses. In some cases it can lead to mothers being distant and detached, and in extreme cases can lead to mothers interacting with their babies in an intrusive or aggressive way. In serious cases, parental mental illness increases the risk that children will be abused or neglected. In very rare cases, babies have been killed by mothers suffering from postnatal psychotic illnesses that have not been effectively treated.

The JCPMH report makes the point in relation to treatment that 'separation of mother and infant prevents the early development of mother-infant attachment and relationship. This may be difficult to reverse and have longstanding effects on both child and mother.'

Children whose mothers experience mental illnesses can also be affected indirectly. Mental illnesses often co-occur with, and in some cases cause, other forms of disadvantage. For example, mothers with mental illnesses are at greater risk of unemployment and marital conflict, which are associated with worse outcomes for children.

Mental illness is one of the leading causes of maternal death. The NSPCC report states that 'many of these deaths could have been prevented with prompt referrals to specialist services, and in particular specialist inpatient Mother and Baby Units.'

What are the risk factors for maternal mental illness?

The causal pathways that lead to maternal mental illness are neither clear nor simple, but it is important to identify women who are at risk and ensure they get timely and appropriate support. The onset and escalation of symptoms of mental illness can often be prevented through proper management of a woman's condition. Some risk factors are understood, these include:

- **history of mental illness** - women who have suffered from a severe perinatal mental illness such as postpartum psychosis or severe depression in the past have around a 50% chance of it recurring in a subsequent pregnancy. Women who have had a previous episode of bipolar disorder are also at an increased risk of having a severe episode in the perinatal period.
- **family history of mental illness** - having a first-degree relative affected by mental illness is a risk factor for perinatal mental illness
- **lone parent or poor couple relationship**
- **low levels of social support** - Rates of perinatal depression are higher amongst women experiencing disadvantages such as social exclusion. Stress caused by issues such as poor housing, domestic violence and poverty can exacerbate symptoms of anxiety and depression

- **recent adverse or stressful life events –** PTSD is estimated to occur in 6% of women following emergency caesarean section. Women admitted to high dependency or intensive care units are at increased risk. Mothers with sick infants in neonatal units and those with very serious medical disorders are also at increased risk.
- **socio-economic disadvantage** - rates of perinatal depression are higher amongst women experiencing disadvantages such as poverty
- **teenage parenthood -** the risk of depression is twice as high amongst teenage mothers.
- **early emotional trauma/childhood abuse**
- **unwanted pregnancy**

It is important to remember that despite increased risk of some perinatal mental illness amongst some disadvantaged groups, women from all parts of society can be affected.

How does risk of perinatal mental illness differ by ethnicity?

The potential relationship between ethnicity and perinatal mental illness is not well explored in the national guidance documents. This is probably because there is a paucity of research on the topic and associations between ethnicity and mental illness in general are poorly understood and highly contested, not least because of the challenges of unpicking and understanding the potential role of ethnicity as a factor alongside socio-demographic variables.

A national review of the perinatal mental health of black and minority ethnic women stresses the importance of considering ethnicity, given that fewer than expected BME women receive diagnosis and treatment, despite high levels of morbidity and high associated social risk factors. This review found that, based on limited research into among BME women in the UK, levels per perinatal mental illness are higher among some BME groups. They suggest that this might be linked to unmet need, as few of the women in studies among Pakistani or Black Caribbean women access care and treatment. For example, a study in the North of England found that more than a quarter of Black Caribbean women had clinically significant postnatal depression, but only seven percent received formal care or treatment. They were rarely offered talking therapies and were more likely than their White British counterparts to be referred to secondary care, rather than be treated by the GP.

Work undertaken within Luton found that families from Bangladeshi and Pakistani communities were at particular risk of poor mental health after giving birth to a child diagnosed as having a lifelong/ life

limiting conditions. The research found that these women were rarely referred to mental health support services and that there was significant unmet need in this group.

Why provide services for women with perinatal mental illness?

Effective treatments and psychological interventions exist, and timely and appropriate treatment can improve maternal and infant outcomes. Pregnancy and early motherhood are times of regular contact with health services which should provide the opportunity to:

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

Services for seriously mentally ill women during this period need to be organised differently from general adult mental health services. They need to respond to the maternity context, timeframes of pregnancy, differing thresholds and response times to presenting problems. They also need to be able to relate to different health professionals, particularly to maternity services and children's social services. The benefits of this kind of service are clear across the pathway:

- Women with a history of serious illness can be prepared for pregnancy and receive preventative management with regard to their high risk of recurrence following delivery.
- Women with serious mental illness complicating childbirth can be supported by professionals with the specialised knowledge of the risks and benefits of medication in pregnancy and skills to manage and nurse women while enabling them to meet the emotional and physical needs of their child.
- Women with acute serious perinatal illness will have better outcomes and better relationships with their infants if admitted promptly to a mother and baby unit. If they also receive specialised aftercare they will have shorter admissions and fewer readmissions.

Multi-disciplinary services with the skills to identify and support women with a mild to moderate perinatal mental illness can ensure interventions and support are timely and appropriate and improve maternal and infant outcomes.

- GPs will see women who refer themselves or who have been identified by the midwife or health visitor. They can treat uncomplicated non-psychotic depression and anxiety or refer on for more complex disorders.

- NICE CG45 suggests for pregnant women with symptoms of depression and/or anxiety that do not meet diagnostic criteria but interfere with personal and social functioning, those who have had a previous episode of depression or anxiety are offered brief psychological treatment, and women who have not had a previous episode are offered social support such as regular informal individual or group-based support.
- Health Visitors with additional training in active listening and cognitive counselling have been shown to be effective in both preventing and treating postnatal depression.
- Services with a focus on parenting can significantly improve both infant mental health and maternal wellbeing in women who have problems with their relationship with their child.

What does a good maternal mental health service look like?

The NSPCC report suggests a good service ensures that women at risk of, or suffering from mental illness are identified at the earliest possible opportunity and given appropriate and timely expert care which prevents their illness from occurring or escalating, and minimises the harm suffered by them and their families. The JCPMH report adds that a good service will also ensure that no woman who is mentally unwell is needlessly separated from her infant and that she receives the appropriate support, care and guidance to safely care for her infant. Services should meet the needs of both mother and infant, and respect the wishes of the mother wherever possible. All women should have equal access to treatment and services should accommodate cultural and religious practices where compatible with the health and safety of mother and infant. Good services should promote prevention and early detection.

The recent guidance documents offer detail on what comprehensive perinatal mental health service may look like. A summary of this, drawn primarily from the NSPCC and JCPMH reports, is presented in the later chapter ‘Luton services for the care of women with a perinatal mental illness’ to enable direct comparison with current services. It is important to state that these sections should be viewed as a description of service requirements rather than an attempt at defining a service model for Luton.

Bibliography

- NICE clinical guideline 45: Antenatal and postnatal mental health, Clinical management and service guidance: April 2007
- NICE Commissioning guide: Implementing NICE guidance on antenatal and postnatal mental health services: August 2008

- Hogg, Sally. Prevention in mind: All Babies Count: spotlight on perinatal mental health. NSPCC June 2013
- Guidance for commissioners of perinatal mental health services, Joint Commissioning Panel for Mental Health. November 2012
- The IAPT guidance document – Perinatal Positive Practice Guide. January 2009
- Health Visiting Programme: Pathway to support professional practice and deliver new service. Maternal mental health pathway. DH, August 2012.
- Perinatal mental health experiences of women and health professionals, Boots Family Trust Alliance, October 2013
- National Perinatal Mental Health Project Report: Perinatal Mental Health of Black and Minority Ethnic Women: A Review of Current Provision in England, Scotland and Wales Commissioned by: National Mental Health Equalities Programme, National Mental Health Development Unit, 2011
- Exploring the needs of children with multiple, complex disability and learning difficulties from the Pakistani and Bangladeshi Communities in Luton. Kaur-Bola, Kulwinder. Institute of Health Research, University of Bedfordshire. September 2009.

3. Perinatal mental illness in Luton

3.1 Births and maternities

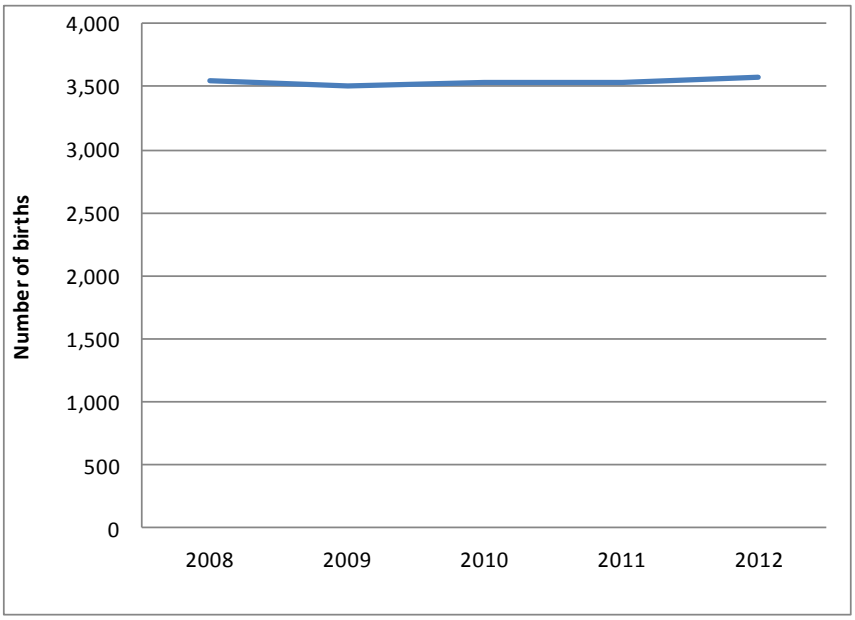
This section describes the maternity context in Luton.

How many births are there each year in Luton?

Each year around 3,500 women in Luton give birth. The latest data for 2012 shows that there were 3,578 live births and 13 still births, with 3,554 women having a pregnancy resulting in the birth of one or more children. Population estimates for 2013 show that there are 45,500 women of childbearing age (15-44) resident in Luton and there are 3,540 children resident in the Borough aged less than 1 year.

The trend in number of births (figure 1) shows that the number of births has remained stable over time.

Figure 1: Trend in number of live births in Luton 2008-2012



Source: Births by usual area of residence, Office for National Statistics

How many births are there estimated to be in future years?

Nationally produced birth projections for Luton predict no overall change in the birth rate in the coming years[1]. The number of women aged 15-44 is estimated to increase by around 8% in Luton between 2011

[1] *http://www.ons.gov.uk/ons/rel/snpp/sub-national-population-projections/Interim-2011-based/stb-2011-based-snpp.html* Note that the ONS projections take no account of unknown future changes in the population, such as

and 2021 and so you would expect a similar increase in the number of births (up to 3,780) across this time period.

How do maternity statistics in Luton compare with other areas?

Table 1 benchmarks Luton against the national average, the East of England region and ONS statistical neighbours for key available indicators related to births and maternities. The data shows that Luton has a relatively high proportion of the female population of childbearing age (15 to 44) and that the birth rate is high compared with the national and regional average. This means that, per capita, Luton has a high number of pregnant women and children.

Table 1: Summary of birth and maternity statistics

	Luton	ONS statistical neighbours	East of England	England
Proportion of female population aged 15 to 44, 2012 (1)	44.5%	44.1%	37.4%	39.4%
Crude live birth rate, 2012 (2)	17.4	16.4	12.6	13.0
General fertility rate, 2012 (3)	78.6	73.8	66.5	64.9
Total fertility rate, 2012 (4)	2.22	2.1	2.02	1.94
Proportion of population age <1, 2012 (5)	1.7%	1.8%	1.3%	1.3%
Maternity rate, 2012 (6)	78.1	73.1	65.7	64.2
Proportion of births in NHS hospitals, 2012 (7)	98.5%	98.8%	96.3%	97.2%

ONS statistical neighbours: Slough, Hillingdon, Birmingham, Wolverhampton, Redbridge

Definitions:

(1) Mid 2012 population estimates (2) Live births per 1,000 population (all ages), 2012 (3) Number of live births per

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through immigration, or make any adjustment for contextual differences between areas which may affect future birth trends.

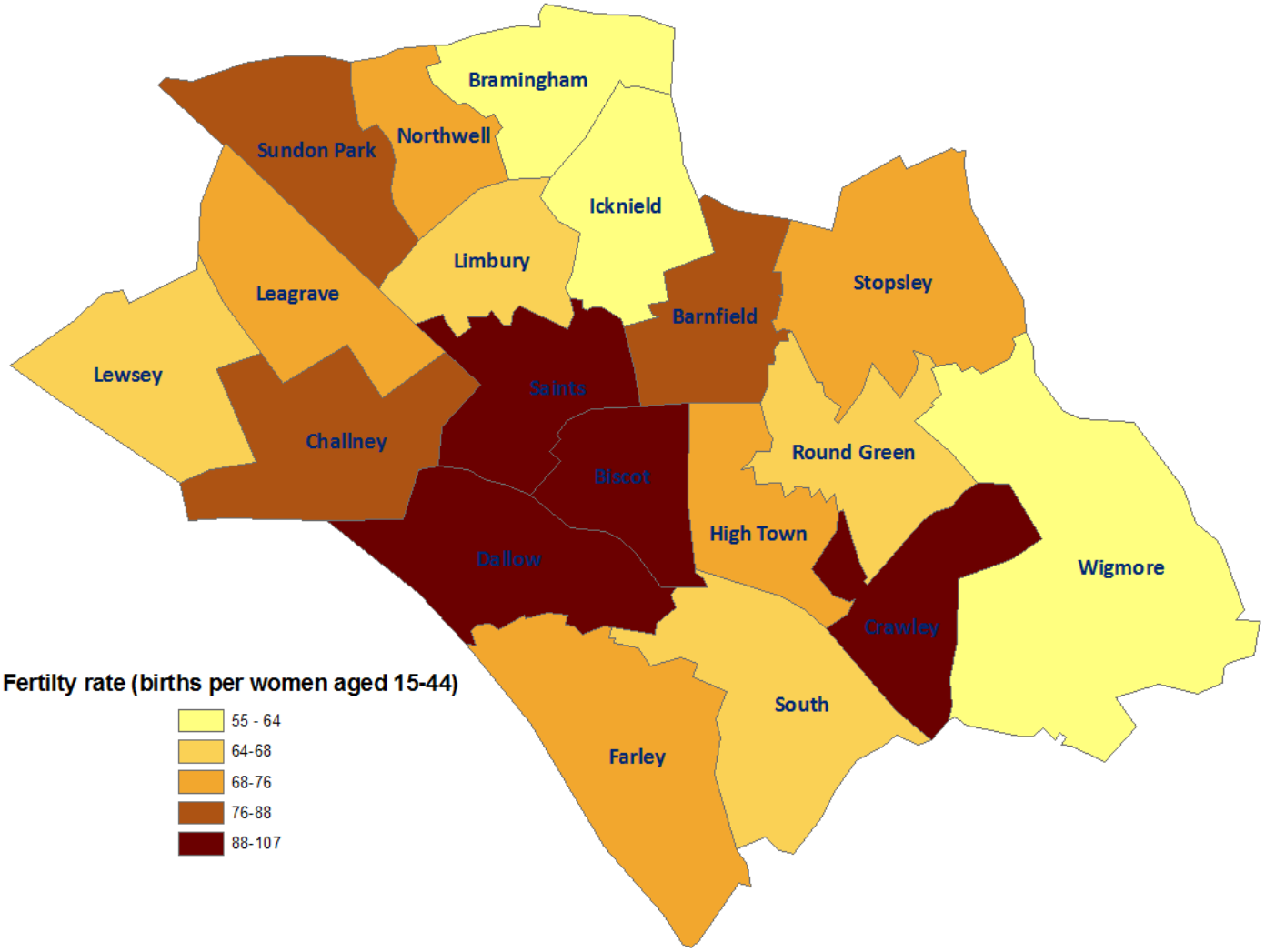
1,000 women aged 15-44, 2012 (4) Average number of live children that a woman would bear if they experienced the age-specific fertility rates of the calendar year, 2012 (5) Mid 2012 population estimates (6) Maternities per 1,000 women aged 15-44, 2012. A maternity is a pregnancy resulting in the birth of one or more children, including stillbirths (7) Live births by Area of Usual Residence (ONS) 2012
All sourced from ONS http://www.ons.gov.uk apart from (7) from HSCIC https://indicators.ic.nhs.uk/webview/

How do birth rates vary across Luton?

The fertility rates (births per 1,000 women aged 15-44) at ward level are shown in figure 2. Birth rates are highest in Biscot, Dallow and Saints wards, with rates around 30% higher than the Luton average. Almost a third of all births in Luton are to women resident in these three wards. The lowest birth rates are in Bramingham and Icknield wards.

The underlying data for this map and the number of births by year for 2008-2012 are available in the accompanying ward-level data pack.

Figure 2: Fertility rate (births per 1,000 women aged 15-44) by ward, 2012



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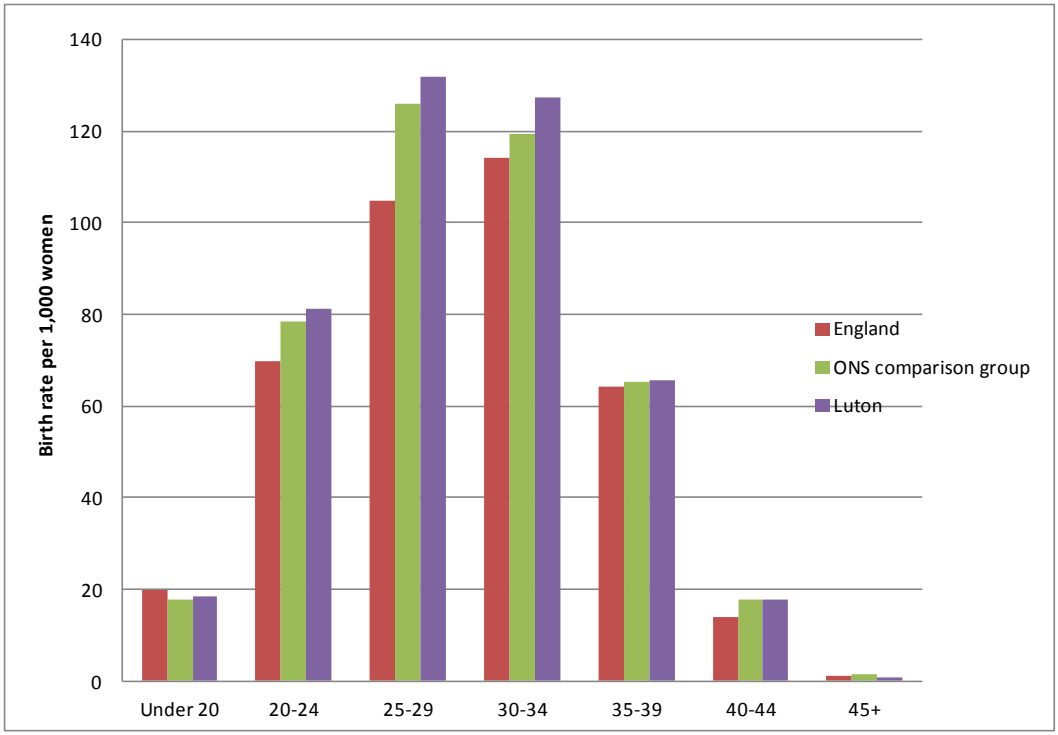
What is the age and ethnic profile of mothers in Luton?

Figure 3 shows the age-specific birth rates for Luton. The chart shows that Luton has relatively high fertility rates for all age groups other than the very young (aged <20 years). In 2012, 3.5% births were to women aged <20 compared with 4.5% for England. There is some evidence that younger women are at higher risk of experiencing perinatal mental illness, although this may be largely due to social stresses.

There is a documented trend in women delaying motherhood and an increasing proportion of people giving birth aged over 35. In Luton, 16% of births were to women aged over 35 in 2012. Whilst older age may not be a particular risk factor for perinatal mental illness, older women may experience increased risk of medical complications during pregnancy and the birth period, such as increased rates of premature birth[2]. This increased health risks are in turn are associated with increased risk of mental illness and, furthermore, increase pressures on maternity services.

Figure 3: Age specific fertility rates in Luton, England and ONS comparison group, 2012



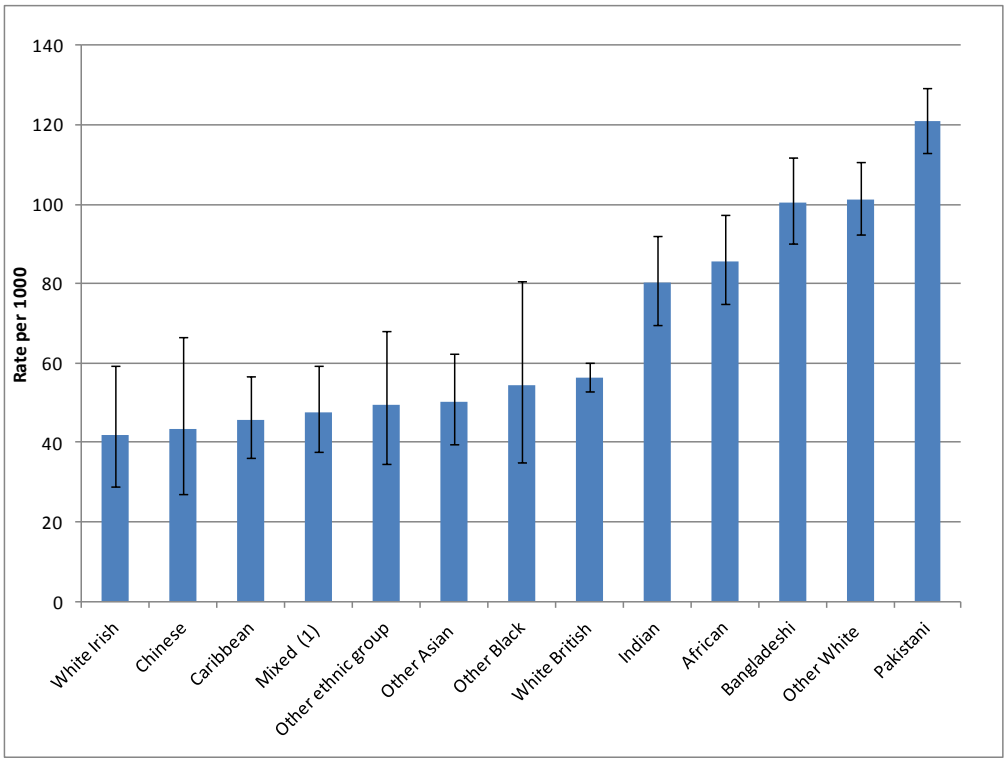
ONS statistical neighbours: Slough, Hillingdon, Birmingham, Wolverhampton, Redbridge
Source: Births by usual area of residence, Office for National Statistics

Figure 4 shows the general fertility rates (births per year per women aged 15-44) in Luton by ethnic group. The ethnic group with the highest birth rate is Pakistani women and rates are also high for 'Other

[2] http://www.ons.gov.uk/ons/rel/child-health/gestation-specific-infant-mortality-in-england-and-wales/2011/sty-gsim.html

White', Bangladeshi, African and Indian women. This picture is reasonably consistent with some national level analysis supporting the population projections, although this uses broader ethnic groups. The national analysis documented that birth rates were highest among Pakistani and Bangladeshi women, relatively high for Indian women and lower for White, Black and "Chinese and other" groups. [3]

Figure 4: Fertility rates by ethnic group, April 2011-March 2013 (average annual rate)



Source: Births data by ethnic group from Luton & Dunstable Hospital Maternity services applied to number of women aged 15-44 by ethnic group (2011 census, ONS)

(1) Mixed group: White and Asian, White and Black African, White and Black Caribbean and Other Mixed

[3] http://www.ethpop.org/Presentations/pn-ethnic-fertility-bsps-09.pdf

3.2 Risk and related factors

The review of evidence highlighted that some groups of women are particularly vulnerable to experiencing perinatal mental health issues. This section draws upon available risk indicators to consider how perinatal mental illness risk in Luton compares with other areas and across the Borough. Knowing which particular groups of women in Luton are most "at risk" can help targeting of resource and interventions.

How does the risk of perinatal mental illness in Luton compare with other areas and vary within Luton?

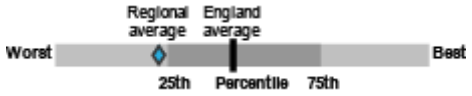
In order to the influence of key factors on the Luton population, figure 5 presents a summary spine-chart of a selection of perinatal mental illness risk indicators. For each indicator the spine-chart plots Luton's position relative to all areas in England and highlights, where available, indicators where the Luton figure is statistically significantly higher or lower than the national average value.

The figure presents available indicators which the evidence suggests are related to perinatal mental health or key markers of the wider pregnancy experience. As highlighted in the review chapter, perinatal mental illness risk factors are complex and not well understood. Furthermore, many key risk factors are not easily measured or quantified and thus cannot be benchmarked. Some of the indicators in the profile serve as a 'proxy' or an imprecise measure of a topic - for example, the rate of children in care measures a vulnerable young population who may be at future risk of perinatal mental illness when they become mothers (there is a wealth of evidence showing that adults previously in care are over-represented in mental health statistics and also evidence that trauma or abuse in childhood is associated with greater risk of perinatal mental health).

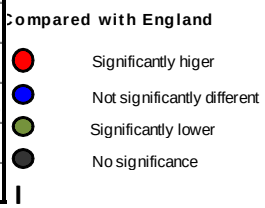
The indicators in the 'related maternity factors' includes low birth weight which is a key perinatal health marker and associated with a range of mental illnesses, including depression, anxiety, PTSD and Schizophrenia.[4] Psychotic illness in pregnancy is associated with poorer pregnancy outcomes, including infant mortality[5]. Babies of low birth weight may also be medically vulnerable and require extra care from mothers, which can pose a challenge and be associated with mental health problems[6].

[4] http://www.nspcc.org.uk/spotlight
[5] http://www.jcpmh.info/resource/guidance-perinatal-mental-health-services/
[6] http://www.pediatricnursing.org/article/S0882-5963%2802%2939521-6/abstract

Figure 5: Summary of risk and related factors for perinatal mental illness in Luton



Indicator	Local Number	Luton value	Eng Avg	Eng Low	England Range	Eng High
History and family history of mental illness						
(1) Estimated prevalence of pyschosis (whole population*) 2012	6	0.4	0.4	0.2		0.8
(2) Estimated prevalence of common MH disorders (whole population*) 2012	30543	20.8	16.6	10.1		26.6
(3) Serious mental illness prevalence (GP registers, whole population*) 2012/13	1956	0.9	0.8	0.5		1.5
(4) Depression prevalence (GP registers, whole population*) 2012/13	7659	4.7	5.8	2.9		11.5
Lone parent. poor couple relationship and domestic abuse						
(5) Proportion of births out of marriage, 2012	1108	31.0	46.5	18.8		71.7
(6) Proportion of birth sole registration of diff addressess, 2012	474	13.2	16.1	5.8		37.5
(7) Proportion of households which are lone parent, 2011	6066	8.2	7.1	2.1		14.4
(8) Rate of domestic abuse (see caveat)*, 2012/13		17.4	18.8	5.6		30.2
Social and economic disadvantage, early emotional trauma						
(9) Proportion of population in 20% most deprived area*, 2010	55454	27.2	20.3	0.0		83.7
(10) Familes on low incomes (child poverty measure)*, 2011	11840	24.9	20.6	2.8		43.6
(11) Rate of looked after children*, 2012/13	390	73.0	60.0	0.0		166.0
Teenage and young parenthood						
(12) Teenage conception rate, 2012	115	29.3	27.7	14.2		52.0
(13) Proportion mothers aged <20, 2012	125	3.5	4.5	1.2		10.6
Maternity factors						
(14) General fertility rate, 2012	3578	78.6	64.9	43.9		90.0
(15) Infant mortality rate, 2010-12	55	5.2	4.1	1.1		7.5
(16) Low birth weight babies, 2011	171	5.3	2.8	1.6		5.3
(17) Legal abortion rate (proxy for unwanted pregnancy), 2012	1013	21.7	16.6	7.9		33.6



(1) APMS 2007 www.hscic.gov.uk/pubs/psychiatricmorbidity07 applied to 2012 populations, www.ons.gov.uk (2) NEPHO age-specific estimates *www.nepho.org.uk* uplifted to 2012 population, www.ons.gov.uk (3) (4) QOF www.hscic.gov.uk/**qof**, (5) (6) (13) (14) Live births by usual areas of residence, www.ONS.gov.uk (7) 2011 census, www.ONS.gov.uk (8) (9) (10) (11) (12) (15) (16) PHE fingertips, http://fingertips.phe.org.uk/ / (17) Report on abortion statistics in England & Wales: www.gov.uk

Data caveat for (8) Rate of domestic abuse: Rate shown is for Bedfordshire and Luton. *The Luton Domestic Abuse Strategy 2000-2002 stated that there were* 3744 incidents of Domestic Abuse in Luton reported during a one-year period.

*** These indicators are for the general population in Luton and do not relate specifically to pregnant women, mothers or children <1. They represent the background risk of mental health conditions.**

To consider how risk of perinatal mental illness varies across Luton, the supporting data pack presents available related indicators at ward level. This includes the following tables:

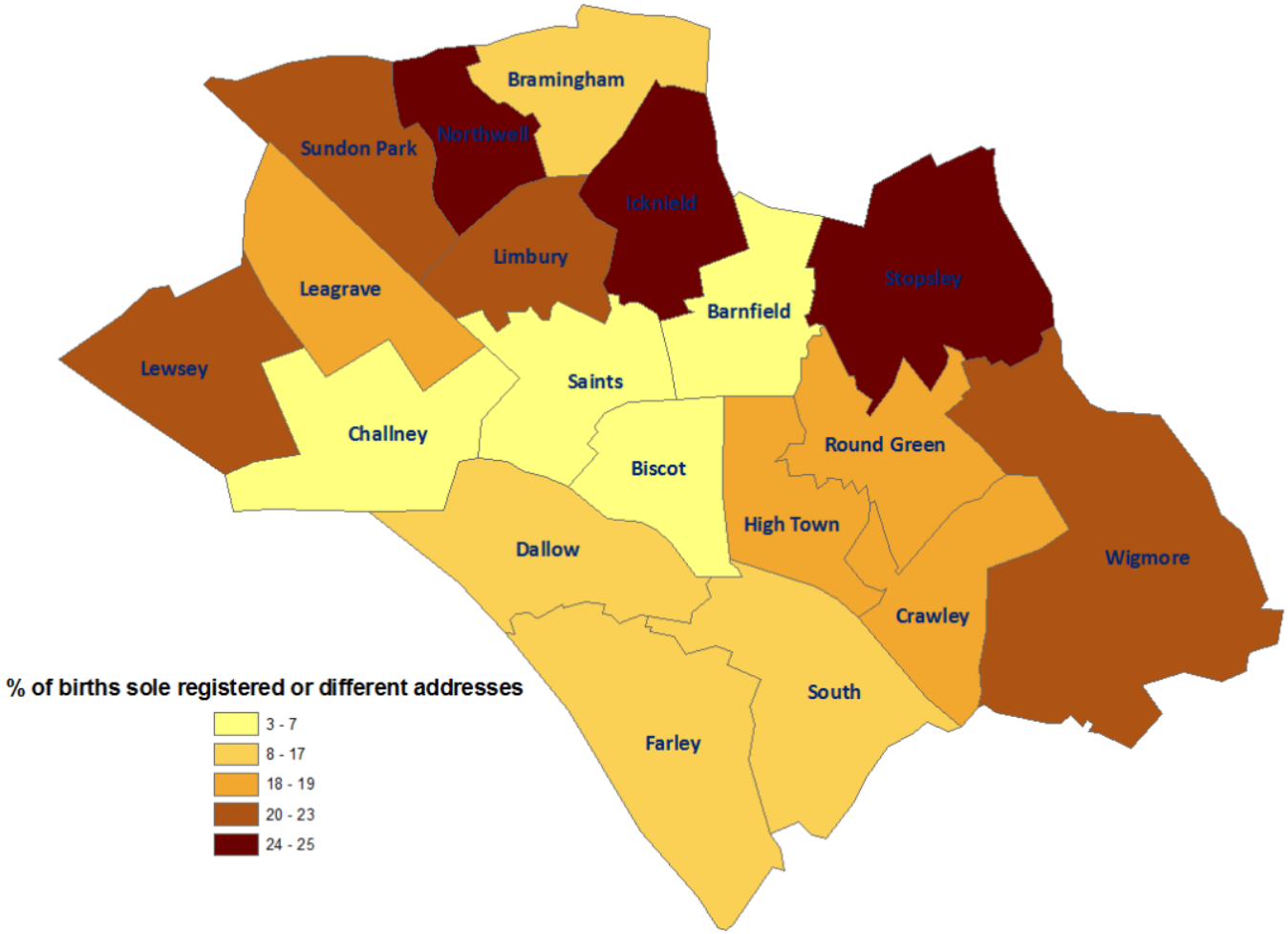
- Number of births by marital status (table)
- Percentage of births which are low birth weight (table)
- Infant mortality rates (table)
- Teenage pregnancy rates (map)
- Percentage of population on GP register for serious mental illness (table at GP practice level)
- Percentage of adult population on GP register for depression (table at GP practice level)

Table 2 summarises key findings from the spine-chart and the ward level data.

Table 2: Summary of perinatal mental illness risk within and across Luton

History and family history of mental illness	Estimated prevalence of psychosis in the general population is around average in Luton (0.4%) but there is a higher than average percentage of people known to GPs diagnosed with serious mental illness. Within Luton the practices with the highest percentage of people diagnosed with serious mental illness are Whipperly Medical Centre in Farley (1.7%) and Wenlock surgery in High Town (1.3%) The estimated prevalence of common mental health disorders in the general population is relatively high in Luton (20.8%) but there is a lower than average percentage of people known to GPs diagnosed with depression (4.7%). Within Luton, the practices with the highest percentage of adults diagnosed with depression are Neville Road Surgery in Limbury (10.2%) and White Horse Vale in Bramingham(9.6%)
Families and relationships	The proportion of births registered as out of marriage or sole registered/different addresses are relatively low in Luton. However, there is variation across Luton. More than a fifth of births are sole registered or different addresses in Icknield, Lewsey, Limbury, Northwell, Stopsley and Sundon Park wards (illustrated in figure 6). The overall proportion of all households which are lone parent families is relatively high in Luton. The police recorded rate of domestic abuse is relatively low (although there are caveats to this data, see notes with spinechart) but this still represents over 3,500 records of abuse per year.
Social and economic disadvantage	Luton is a relatively deprived borough, with 27% of the population living in areas classified as within the most 20% in England and 1 in 5 children living in poverty. Furthermore, there are significant inequalities within Luton with pockets of extreme deprivation. Northwell, Dallow, High Town and Biscot wards contain neighbourhoods which are ranked within the 10% most deprived areas in England.
Teenage and young parenthood	The rate of teenage pregnancy in Luton is around average and the proportion of all births born to women aged <20 years is relatively low. The four wards with the highest rates of teenage pregnancy are Farley, South, SundonPark and Northwell.
Maternity	The spine chart highlights the high fertility rate in Luton. The rate of babies born at low birth weight is very high for Luton and statistically significantly higher than the England average in 8 wards. The rate of infant mortality is high for Luton and the wards Chalney, Lewsey, Northwell and South wards have rates significantly higher than the national average. The rate of legal abortions is relatively high in Luton.

Figure 6: Percentage of births which are sole registered or at different addresses by ward, 2012



Source: Data from Luton Public Health

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3.3 Prevalence estimates

This section applies national estimates of perinatal illness in Luton in two ways. Firstly an estimate of numbers of women with different types of conditions, and secondly to suggest likely numbers requiring types of service intervention. The service level estimates are also presented at ward level. It is important to be aware that these estimates do not take into account differences in background risk as discussed in the previous section.

How many women are estimated to suffer from perinatal mental illness in Luton?

The evidence review indicated that at least 1 in 10 women experience perinatal mental illness. Based on 3,500 births per year, this equates to at least 350 women in Luton with perinatal mental illness each year.

Prevalence figures in guidance produced by the Joint Commissioning Panel for Mental Health give prevalence estimates for specific conditions. Figure 7 shows a breakdown of the estimated numbers of women in Luton with specific perinatal mental illness.

NICE commissioning guidance provides benchmarking figures to estimate the number of women likely to require antenatal and postnatal mental health services. The guidance suggests that around 20% of deliveries will be to women who experience mental disorders of varying degrees of severity, with a breakdown of:

- 40 per 1000 deliveries (4%) to women who require advice and care from a specialist perinatal mental health service; this includes 4 per 1000 deliveries to women who are likely to require admission to a mother and baby unit = **142 women in Luton**, including 14 requiring admission to mother and baby unit

- 80 per 1000 deliveries (8%) to women who require and accept referral for psychological therapies (e.g. IAPT, talking therapies) = **284 women**

- 80 per 1000 deliveries (8%) to women who experience mental health disorders but do not require or do not take up the offer of therapy (e.g. people supported through social type interventions such as parenting support, group participation, key worker support or managed by self/with family support) = **284 women**

These figures are illustrated graphically in figure 8. Table 3 shows these rates applied to the number of births per ward to estimate the need for treatment at ward level. Highest numbers are seen in Biscot, Dallow and Saints.

NOTE: The estimated numbers of women with specific conditions does not relate directly to the NICE estimated numbers requiring treatment as not all women with mild-moderate conditions will require or access treatment (depending on severity) and also many women will have more than one condition. For this reason and due to small numbers for some conditions, a condition-specific breakdown is not shown at ward level.

Figure 7: Estimated numbers affected by perinatal mental illnesses each year

		In Luton
Postpartum psychosis Severe mental illness that typically affects women in the weeks after giving birth, and causes symptoms such as confusion, delusions, paranoia and hallucinations	2/1000 maternities	7
Chronic serious mental illness Longstanding mental illnesses, such as schizophrenia or bipolar disorder, which may be more likely to develop, recur or deteriorate in the perinatal period	2/1000 maternities	7
Severe depressive illness The most serious form of depression, where symptoms are severe and persistent, and significantly impair a woman's ability to function normally.	30/1000 maternities	107
Post traumatic stress disorder (PTSD) An anxiety disorder caused by very stressful, frightening or distressing events, which may be relived through intrusive, recurrent recollections, flashbacks and nightmares.	30/1000 maternities	107
Mild to moderate depressive illness and anxiety states Includes symptom such as persistent sadness, fatigue and a loss of interest and enjoyment in activities. It often co-occurs with anxiety, which may be experienced as distress, uncontrollable worries,	100-150/1000 maternities	355-533

panic or obsessive thoughts.

Adjustment disorders and distress

150-300/1000 maternities

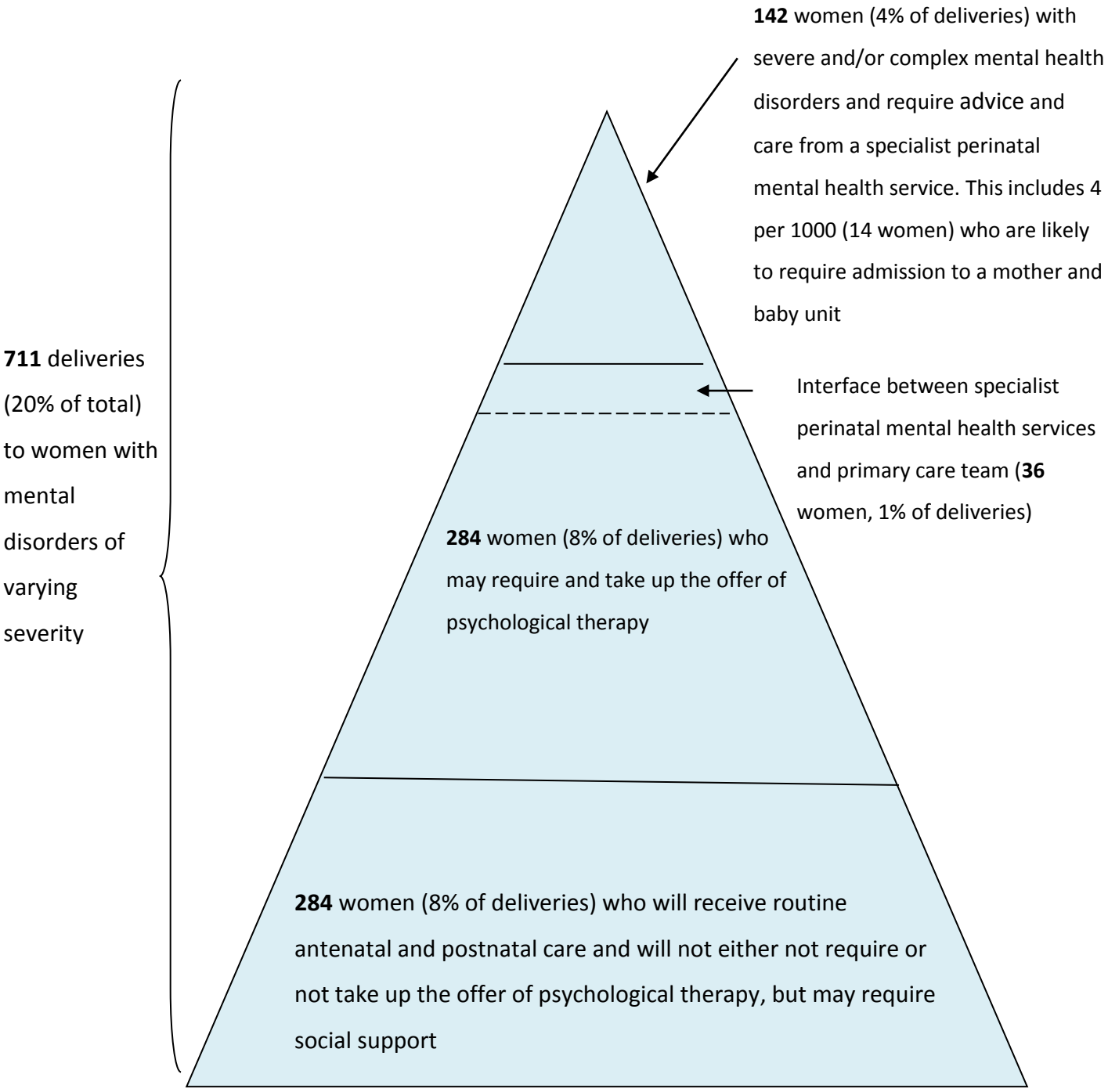
533-1066

A woman is unable to adjust or cope with an event such as pregnancy, birth or becoming a parent. A woman with these conditions will exhibit a distress reaction that lasts longer, or is more excessive than would normally be expected, but does not significantly impair normal function.

Source: NSPCC report.

Note that some women experience more than one condition

Figure 8: Estimated number of women requiring treatment in Luton



Source: Based on NICE Commissioning guide: Implementing NICE guidance on antenatal and postnatal mental health services: August 2008

Table 3: Estimated need for treatment each year by ward in Luton (based on NICE commissioning guidance)

	Number of births (5 year average)	Any MH disorder (all severities) : 20% of births	Severe and/or complex cases : 4%	Require and take up psychological therapy : 8%	Not take up or below threshold for therapy (8%)
Barnfield	112	22	4	9	9
Biscot	408	82	16	33	33
Bramingham	90	18	4	7	7
Challney	234	47	9	19	19
Crawley	116	23	5	9	9
Dallow	422	84	17	34	34
Farley	206	41	8	16	16
High Town	160	32	6	13	13
Icknield	80	16	3	6	6
Leagrave	210	42	8	17	17
Lewsey	190	38	8	15	15
Limbury	104	21	4	8	8
Northwell	143	29	6	11	11
Round Green	165	33	7	13	13
Saints	324	65	13	26	26
South	239	48	10	19	19
Stopsley	69	14	3	6	6
Sundon Park	121	24	5	10	10
Wigmore	155	31	6	12	12
Luton total	**3548**	**710**	**142**	**284**	**284**

3.4 Service data: Identification

This section describes data obtained from services to measure how many women with perinatal mental illness are currently being identified in Luton. These numbers are benchmarked against the prevalence estimates shown previously in order to consider whether need is being met.

It is important to highlight that there is lack of data about number of women diagnosed with perinatal illness both in Luton and nationally. The information items easily extractable from routine information systems are about women considered to be 'at risk' of perinatal mental illness and do not capture detail about diagnosis or severity.

How many women with perinatal mental illness are identified by services during the antenatal period?

The main source of data within Luton to measure perinatal mental illness is when mental health issues are identified as a primary "cause for concern" by midwives during their care of pregnant and postpartum women. Causes for concern can be identified at booking-in during early pregnancy or raised later during pregnancy, during the birth period, or following delivery until discharge from midwife care (usually 10 days but up to 28 days when extended support is needed).

Data from Luton & Dunstable Hospital (L&D) shows that during the two-year period 2011/12 and 2012/13 there were 1,060 pregnant or postpartum women in Luton for whom mental health was identified as a main cause for concern.[7] This represents 15% of the 6,970 women who gave birth during this period.

A new data source about perinatal mental health is information collected to support "Payments by Results" (PbR), the financial tariff system used in commissioning. PbR has only recently been implemented in maternity services. Given that this is still an early stage of implementation, only six months data are currently available and it should be viewed as somewhat experimental. Based on PbR antenatal data collected between April and September 2013, there were 179 women in Luton identified as having a mental health issue. This is based on medical history and factors identified at the booking appointment. This represents 9.8% of the 1,813 women. Within this group, 162 (90%) were on the 'intermediate' PbR pathway and 17 (10%) were on the 'intensive' pathway[8].

[7] Database only codes main cause for concern (others are recorded in comments section)

[8] At the booking appointment midwives collect comprehensive information on a woman's health and social care characteristics. This is used to determine a payment level based on expected average resource useage (then

How many women with perinatal mental illnesses are identified by services during the postnatal period?

Postnatal PbR collected between April 2013 and September 2013 shows that 77 women in Luton were identified as having a mental health issue when commencing their postnatal pathway (discharge from hospital), representing 4.5% of 1,727 women. All were on the 'intermediate' PbR pathway. It is surprising that this percentage is much lower than the antenatal percentage but this may be an artefact of the fact that PbR data collection has only recently commenced.

Data from health visitors showed that 100 women registered with the service during 2013 were asked (or declined) the PHQ-9 questionnaire[9] and/or had one or more of following diagnosis codes on their records: "feeling depressed", "feeling hopeless", "loss of interest in previously enjoyable activity" or "feeling low or worried." This represents 3.1% of the 3,248 women registered during 2013. These codes do not represent a formal diagnosis of mental illness, as this information is not recorded in the available data, but represent a summary of available information about mental health which is easily extractable from health visitor electronic records.

How many women with perinatal mental health illnesses are known to primary care?

Although discussions were held, it was not possible to obtain data from primary care systems about the number of women with perinatal mental illness within the timeframe of this project. GPs hold registers of their patients diagnosed with serious mental illness or depression but the extracted data published on a national scale gives not breakdown of this information specially for women of childbearing age or for women who are pregnant or recently given birth. Obtaining this information would require each individual practice to extract the figures.

How do these figures compare with estimated levels of need?

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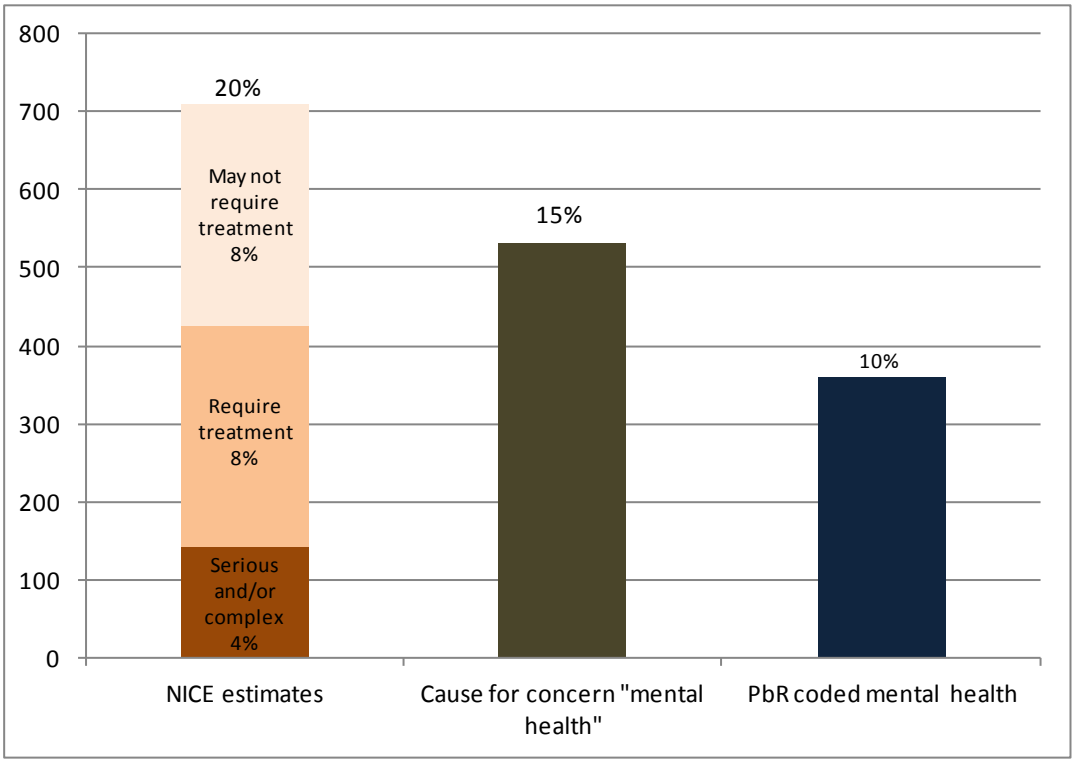
adjusted for local market forces): standard (tarrif £1,126 in 2012/13) , intermediate (£1,803) or intensive (£3,000). This payment covers all care up to labour or induction. Women identified as having mental health issues are assigned to the intermediate pathway. Reasons for allocation to the "intensive" pathway include previous fetal complications, expecting twins and health conditions such as diabetes, diabetes and HIV. Note that the pathways are determined at booking in and women do not change pathways for issues which arise later (the prices are adjusted to take account of these changes).

[9] PHQ9 is diagnostic instrument for depression. Health visitors attempt to complete the questionnaire for women for whom there is concern about their mental health status

Figure 9 compares three summary figures for Luton: 1) the number of women with mental health identified as a cause for concern, 2) the number of women with mental health identified on antenatal PbR data and 3) NICE estimates of numbers of women with perinatal mental illness, including the proportion needing treatment. All figures are scaled to represent one year's data. The NICE estimate of 20% of women requiring treatment equates to 711 women per year in Luton, with 426 receiving treatment. The observed yearly figures were 530 women with mental health raised as a cause for concern and 358 with mental health issues identified on their antenatal PbR records.

The percentage of mental health issues identified in the PbR records is particularly low (you may expect it to be more similar to the "cause for concern" data). One possible reason for the lower percentage is that the PbR information is collected early in pregnancy whereas causes for concern can be raised by midwives during the pregnancy or until release from care of the midwives following the birth.

Figure 9: Comparison of service identified cases with NICE estimates



The postnatal PbR data indicated that 4.5% of women had mental health as an identified issue and 3.1% women were identified on the health visitor records as having information on their record suggestive of a possible mental health concern. Both these figures are much lower than would be expected. Given the issues around data quality with both these sources, it may be that this is a low estimate of postnatal perinatal illness in Luton. It could also indicate that there is unrecognised need in the postnatal period

and that women who develop mental illness following discharge from midwife care are not being adequately identified by services.

How do these figures compare with national and comparison areas?

Analysis supporting the implementation of maternity PbR data[10] estimated that there would be 5.5% of women with mental health issues identified at booking and 0.7% women with mental health issues commencing during pregnancy/identified after booking, give an overall percentage of 6.2% for the pregnancy period. If this scoping work is correct as a national benchmark, this indicates that, based on the first six months of PbR data, the percentage of women in Luton with identified mental health issues is relatively high.

Are there differences in identification of mental illness by ethnicity?

Figure 10 shows the percentage of women for whom mental illness issues were identified as a cause for concern by ethnic group. The percentage for White British women is significantly higher than the Luton average. Rates are highest for women classified as "Mixed" but this figure should be interpreted with caution, given some evidence of inconsistency of coding across the data sets and the documented potential for misclassification in this group[11].

The percentage is significantly lower for Indian, "Other White", African, Bangladeshi and Pakistani women. All of these groups have a percentage identification rate lower than the 20% suggested by NICE guidance. Whilst this may be because women in these ethnic groups have genuinely lower rates of perinatal mental illness, it does strongly indicate that there is unmet and undiagnosed need among these groups.

The antenatal PbR is presented in figure 11. The data shows significantly higher rates of mental illness issues in Mixed and White British women and significantly lower rates among African, Indian, Bangladeshi and Pakistani women. Rates for postnatal PbR are not shown due to small numbers of people with identified mental health issues.

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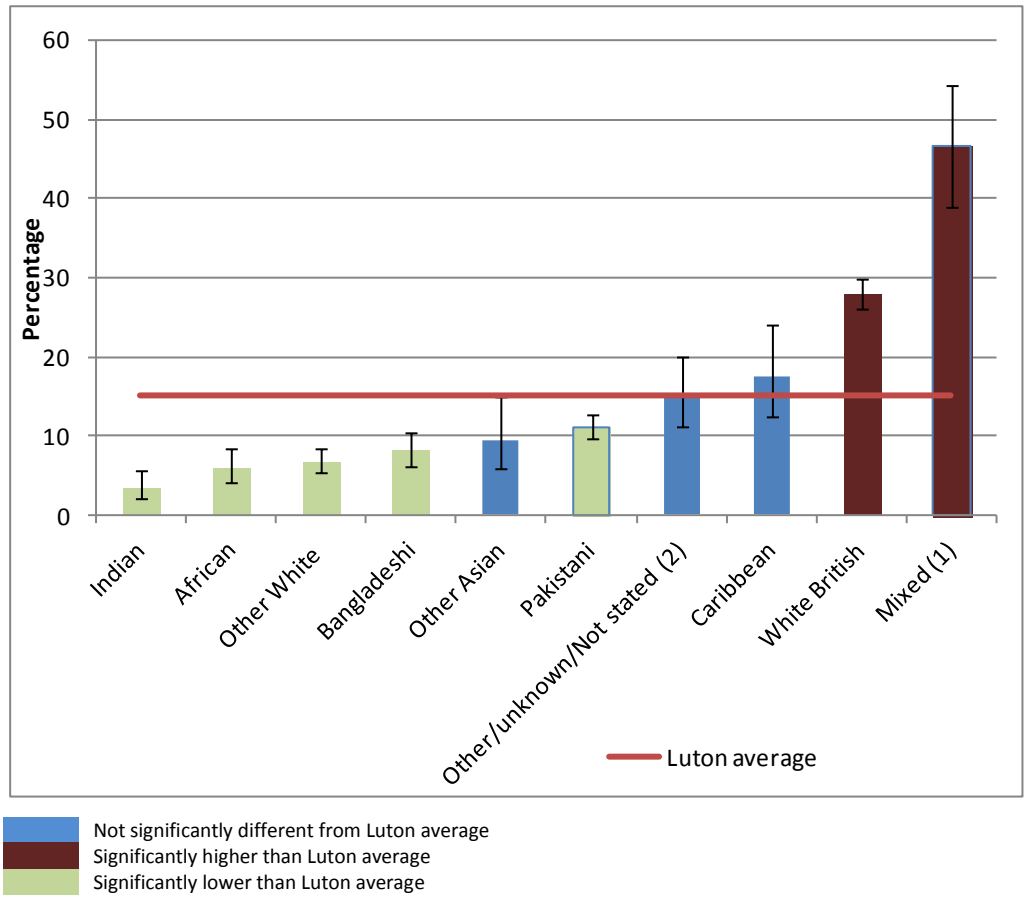
[10]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216445/dh_132664.pdf

[11]For example an evaluation of the accuracy of ethnicity coding in hospitals found that coding of "Mixed" groups was substantially less accurate than other groups. The highest accuracy was for "White British" and intermediate accuracy for 'Indian', 'Chinese', 'Black-Caribbean' and 'Black African' groups) http://bmjopen.bmj.com/content/3/6/e002882.abstract

Figure 10: Percentage of women with mental health as a primary "cause for concern" by ethnicity, April 2011-March 2013



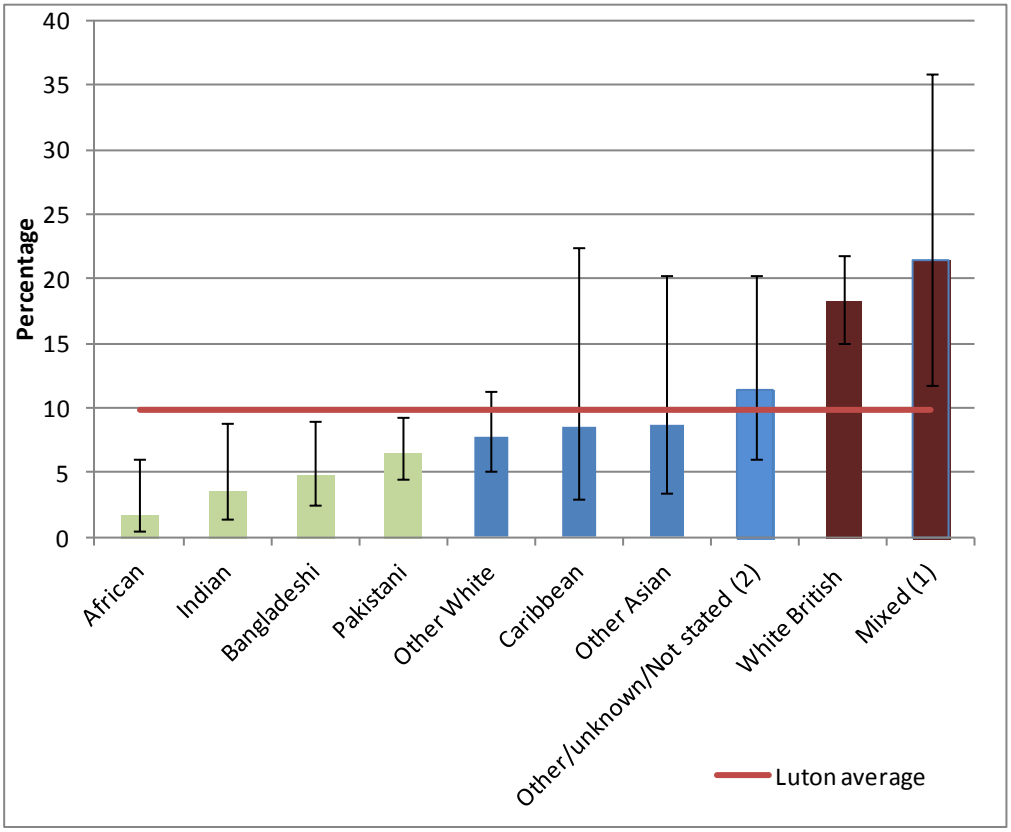
Source: L&D Hospital maternity services

NOTE: Due to small numbers and potential miscoding, only groups for whom a sufficient sample size was available (>100 events within the 2 year period) and where coding appeared consistent and accurate.

(1) 'Mixed' includes "White and Asian", "White and Black African", "White and Black Caribbean", and "Any other Mixed background". These are not shown separately due to small numbers in each group and some evidence of differences in classification across the data set.

(2) 'Other' includes groups with too small sample sizes to produce a meaningful estimate (Chinese and Irish) and those were ethnic group was not available (unstated or unknown)

Figure 11: Percentage of women with mental illness identified as an issue in antenatal PbR data by ethnic group, April 2013 – September 2013



Source: L&D Hospital maternity services

NOTE:

Due to small numbers and potential miscoding, only groups for whom a sufficient sample size was available (>100 events within the 2 year period) and where coding appeared consistent and accurate.

(1) 'Mixed' includes "White and Asian", "White and Black African", "White and Black Caribbean", and "Any other Mixed background". These are not shown separately due to small numbers in each group and the some evidence of differences in classification across the data set.

(2) 'Other' includes groups with too small sample sizes to produce a meaningful estimate (Chinese and Irish) and those were ethnic group was not available (unstated or unknown)

Table 4 summarises all ethnic specific data, showing the proportion of women in each ethnic group living in Luton alongside the proportion giving birth and proportions identified as having mental illness issues in

service data. The groups are ordered by the percentage of births. The table clearly highlights key differences by ethnicity: White British women have relatively low birth rates but have a high risk of identified perinatal mental health issues, accounting for more than half of identified mental illness but less than a third of births. Conversely, Pakistani women have relatively high birth rates and a low risk of identified mental health issues recorded during the perinatal period.

Table 4: Summary of data by ethnic group

	% women aged 15 - 44	% of women giving birth	% mh cause for concern	% mh identified in antenatal PbR
White British	38.2%	28.2%	51.7%	50.3%
Pakistani	15.7%	24.9%	18.1%	15.1%
White – Other	12.1%	13.9%	6.1%	12.3%
Bangladeshi	7.5%	9.9%	5.3%	5.0%
Other	11.0%	7.9%	10.9%	12.3%
African	5.9%	6.6%	2.5%	.
Indian	5.5%	5.8%	1.3%	.
Caribbean	4.0%	2.4%	2.7%	.
Unknown	0.0%	0.4%	1.2%	0.0%

Categories marked –<5 women and so meaningful percentage cannot be computed

Source: L&D Hospital maternity services

Are there differences in identification of mental illness by area of residence?

Figure 12 shows the percentage of women for whom mental health was identified as a cause for concern by ward of residence. Areas which are statistically significantly higher or lower than the Luton average are highlighted. Figure 13 shows this data on a map, showing how the figures compare with the NICE estimates that 20% of women have perinatal mental illness, with 12% receiving treatment.

Figure 14 shows the percentage with mental health issues identified in the PbR data. Due to the small sample size of this data, these figures are not shown on a map. Note that the underlying data for both graphs are included in the accompanying ward level data pack.

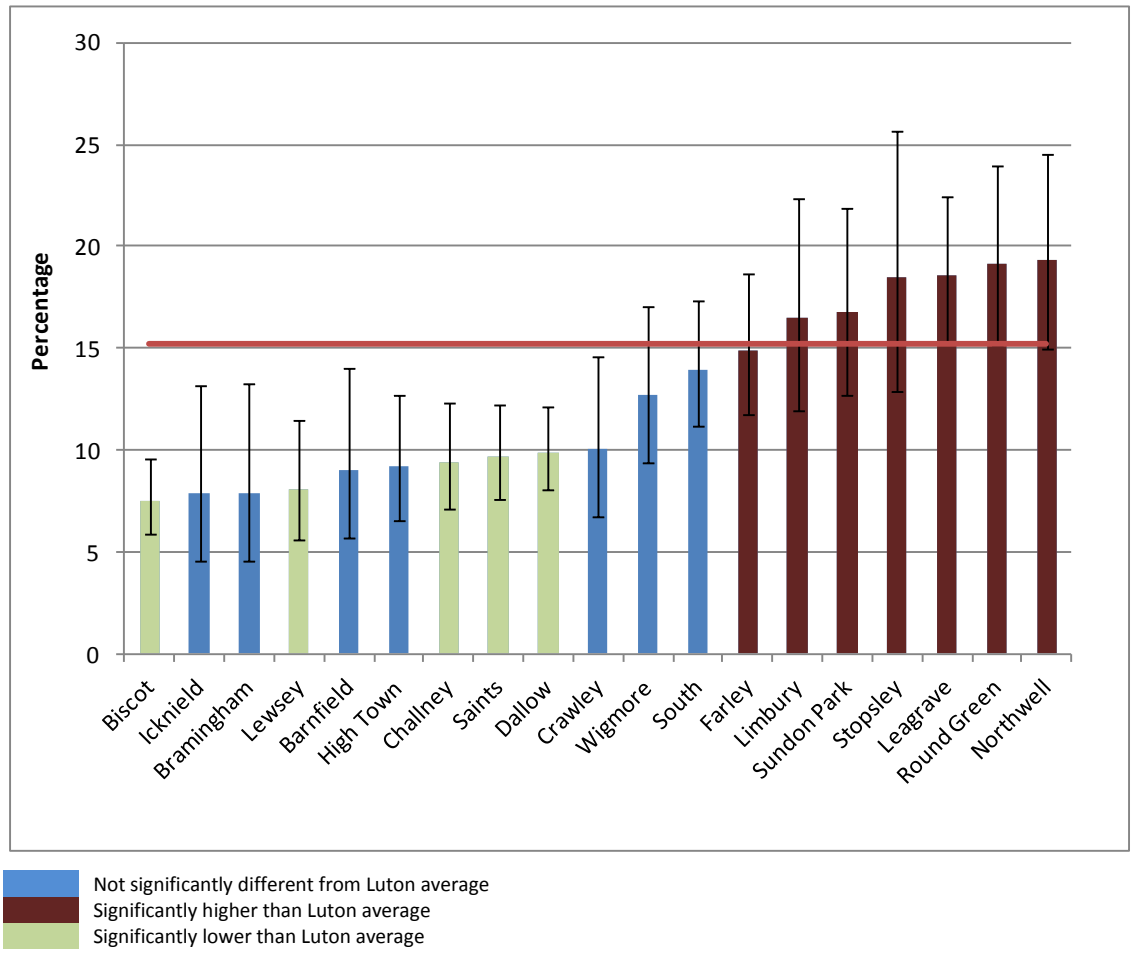
Data are not shown for postnatal PbR due to the small numbers of women with identified mental health issues.

The three wards which are relatively high in both data sets are Round Green (the one ward which is statistically significantly higher than the Luton average in both), Leagrave (above average in both and significantly higher for cause for concern) and Northwell, which has the highest percentage of women with mental health identified as a cause for concern. South and Farley have a relatively high percentage of women with mental health identified as a cause for concern.

Biscot and Lewsey wards have a low percentage of women with mental health identified as a cause for concern. Given that it is a deprived ward, the percentage identified in Dallow ward is also relatively low. These wards all have identification rates lower than the 20% suggested by NICE guidance. Whilst this may be because women in these areas have genuinely lower rates of perinatal mental illness, it does indicate that there is unmet and undiagnosed need in these areas. Overall, there is no clear evidence of a relationship between identified mental health issues and socio-economic deprivation in Luton.

Results are mixed across the data set, with wards such as Icknield and Stopsley appearing at opposite ends of the scale. This may be partly because the data sets cover differing time periods and, in particular, that the PbR data are new and there is not yet a long time series available.

Figure 12: Percentage of women with mental health as a primary "cause for concern" by ward, April 2011-March 2013



Source: L&D Hospital maternity services

NOTE: As 21% of the 'cause for concern' data were missing ward codes, the ward rates (which use the number of births per ward as a denominator) have been scaled up to represent the rates that would be found if the missing data were allocated to the wards in the observed proportions. This assumes that there is no bias in data completion.

Figure 13: Comparison of percentage women with mental health identified as a primary "cause for concern" with NICE estimates, April 2011-March 2013

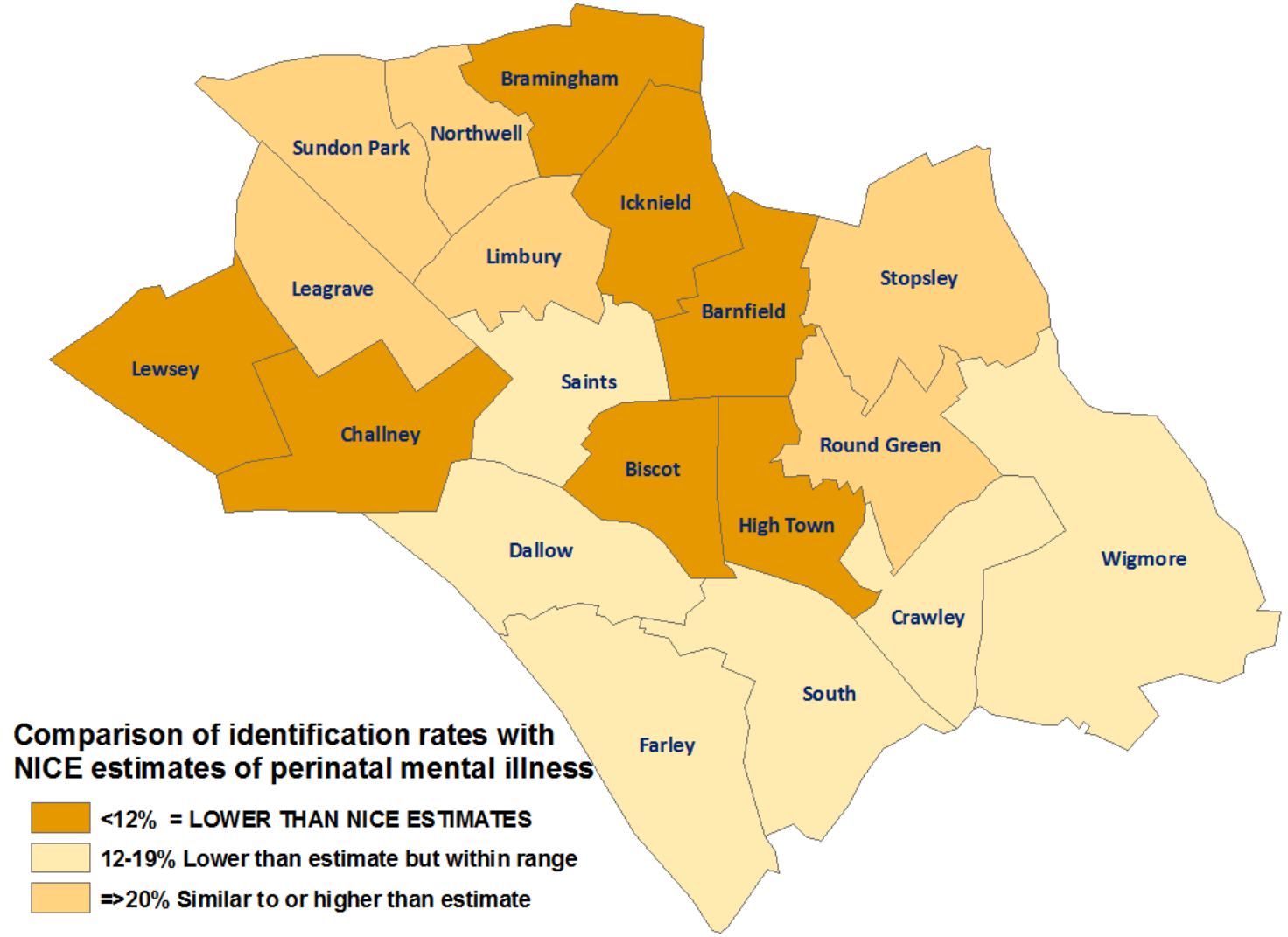


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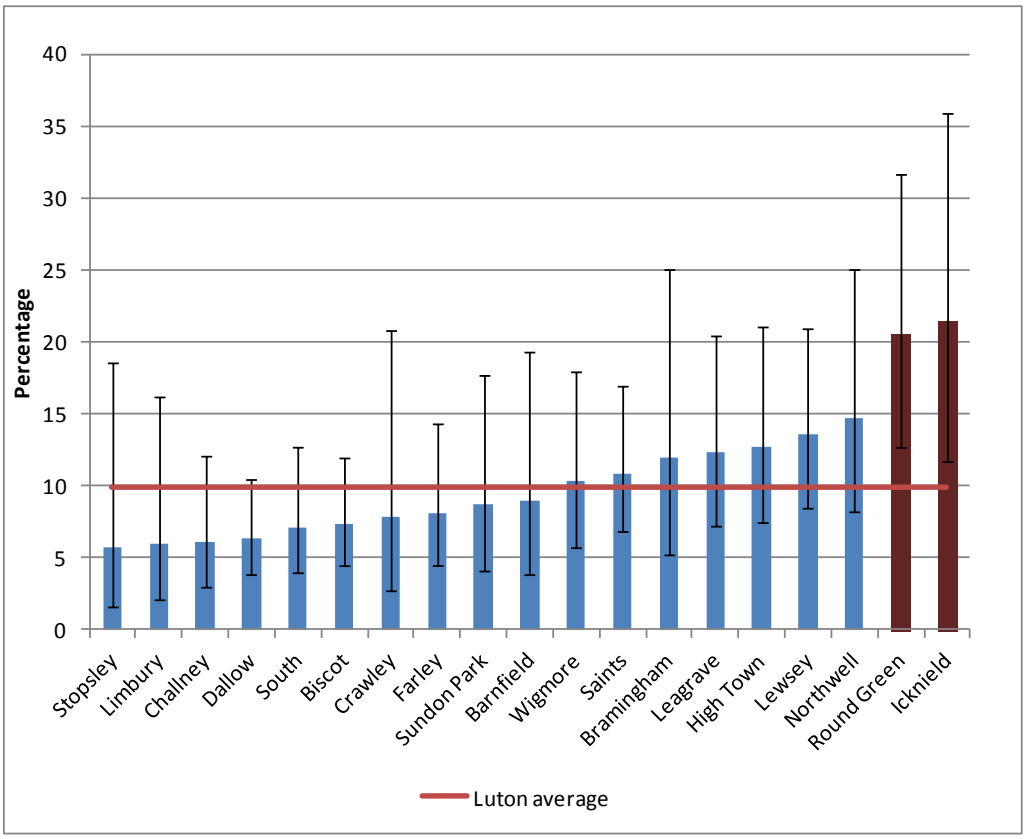
Figure 14: Percentage of women with mental illness identified as an issue in antenatal PbR data by ward, April 2013 – September 2013



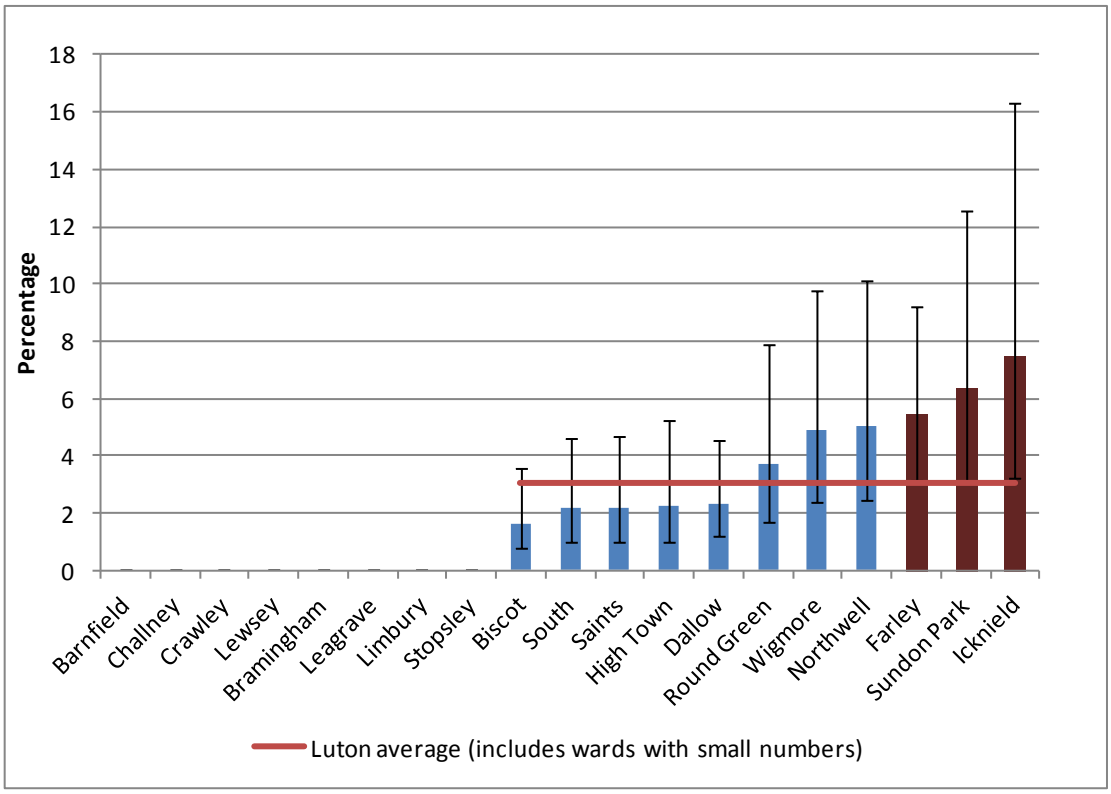
Not significantly different from Luton average
Significantly higher than Luton average
Significantly lower than Luton average

Source: L&D Hospital maternity services

Figure 15 shows the data collected from health visitor records, showing the percentages of women registered during 2013 who were asked (or declined) the PHQ-9 questionnaire and/or had one or more of following diagnosis codes on their records: “feeling depressed”, “feeling hopeless”, “loss of interest in previously enjoyable activity” or “feeling low or worried.” There was no specific identification or measure of perinatal mental health within the health visitor information system. The PHQ-9 questionnaire is used by health visitors when there was a concern about a woman’s mental health status and was therefore used as a proxy measure for likely perinatal mental illness.

Areas shown as “missing” on the graph had <5 women with these characteristics present on their record. The data shows that Icknield, Sundon Park and Farley wards have percentages significantly higher than the Luton average, but only marginally so.

Figure 15: Percentage of women with records containing information suggestive of potential mental health issues by ward, 2013



Not significantly different from Luton average
Significantly higher than Luton average
Significantly lower than Luton average

Source: Health visitor data

What does service data tell us about risk and related factors?

The "cause for concern" forms completed during pregnancy record other causes for concern in addition to mental health. During the two year period April 2011 to March 2013, there were 1,594 women with an identified cause for concern, of whom 67% had mental health as the primary cause. The other causes for concern were domestic abuse (24%), drug abuse (9%) and alcohol abuse (1%). As a percentage of all women, 7.7% had a cause for concern raised other than mental health.

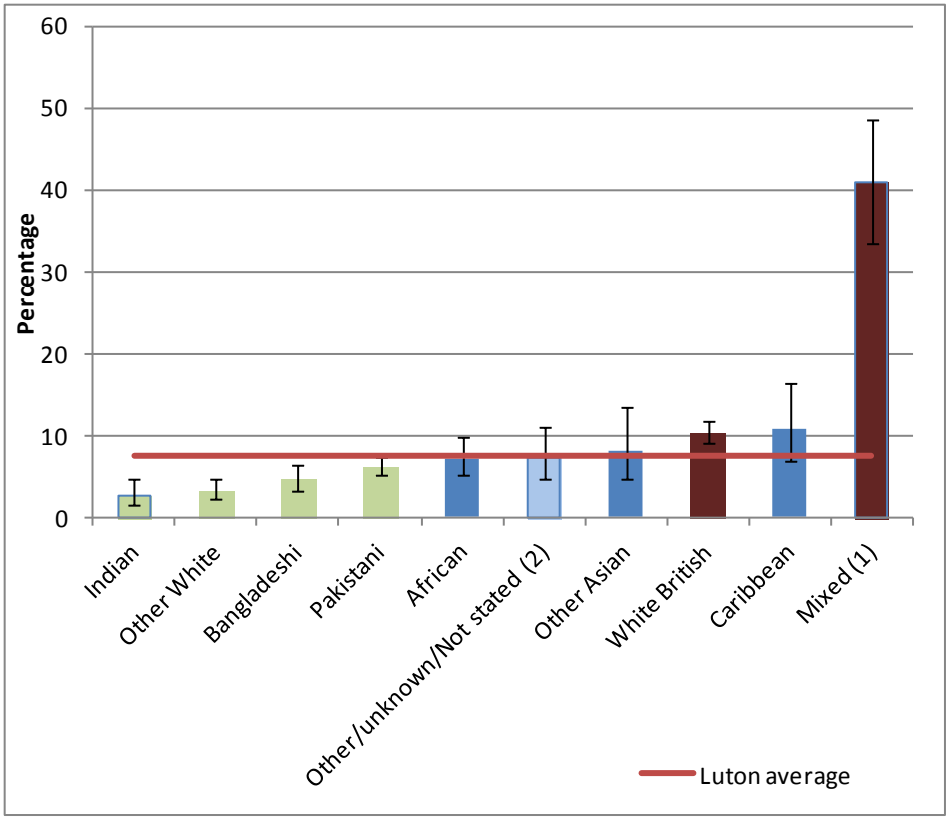
These other causes for concern are potentially related to perinatal mental health and thus may indicate women at risk of experiencing mental health issues. There are well established links between substance misuse and mental health[12]. Domestic abuse is known to be a risk factor for mental health and research indicates that abuse may begin or escalate during pregnancy or the postpartum period.[13] Moreover, the data only records the primary cause for concern and so it may be that some of these women also have known mental health issues but they are missing from the statistics. Also we do not know how many of women with mental health as a primary cause for concern are experiencing domestic abuse. Data from other services shows how incomplete the picture may be: The Luton Domestic Abuse Strategy 2010-2012[14] stated that, in addition to cases identified by midwives during a one-year period, 311 cases of domestic abuse affecting pregnant women were identified by Luton Police Domestic Abuse Unit and a further 120 cases were identified by other health services including Accident and Emergency and Paediatric Services.

Figure 16 shows a breakdown of the percentage of women with other cause for concerns by ethnic groups. The rate of other cause for concern is particularly high among women of mixed ethnicity, although this should be regarded with caution due to the coding issues discussed above and also the relatively small numbers in this group. The high rate in this group is predominantly due to a large number of mixed White and Black Caribbean women with domestic abuse highlighted as a primary cause for concern (36 out of 77 over the 2-year period = 47%)

[12] http://www.scie.org.uk/publications/briefings/files/briefing30.pdf
[13] http://www.nct.org.uk/sites/default/files/Domestic%20abuse.pdf
[14] http://www.learning.luton.gov.uk/l2g/custom/files_uploaded/uploaded_resources/5255/Domesticabusestrategy2010-2.pdf

Rates of other causes for concern are presented at ward level in figure 17. Leagrave, Limbury and South wards have the highest rates.

Figure 16: Percentage of women with "other" primary cause for concern (domestic abuse, alcohol or drug abuse) by ethnic group, April 2011-March 2013

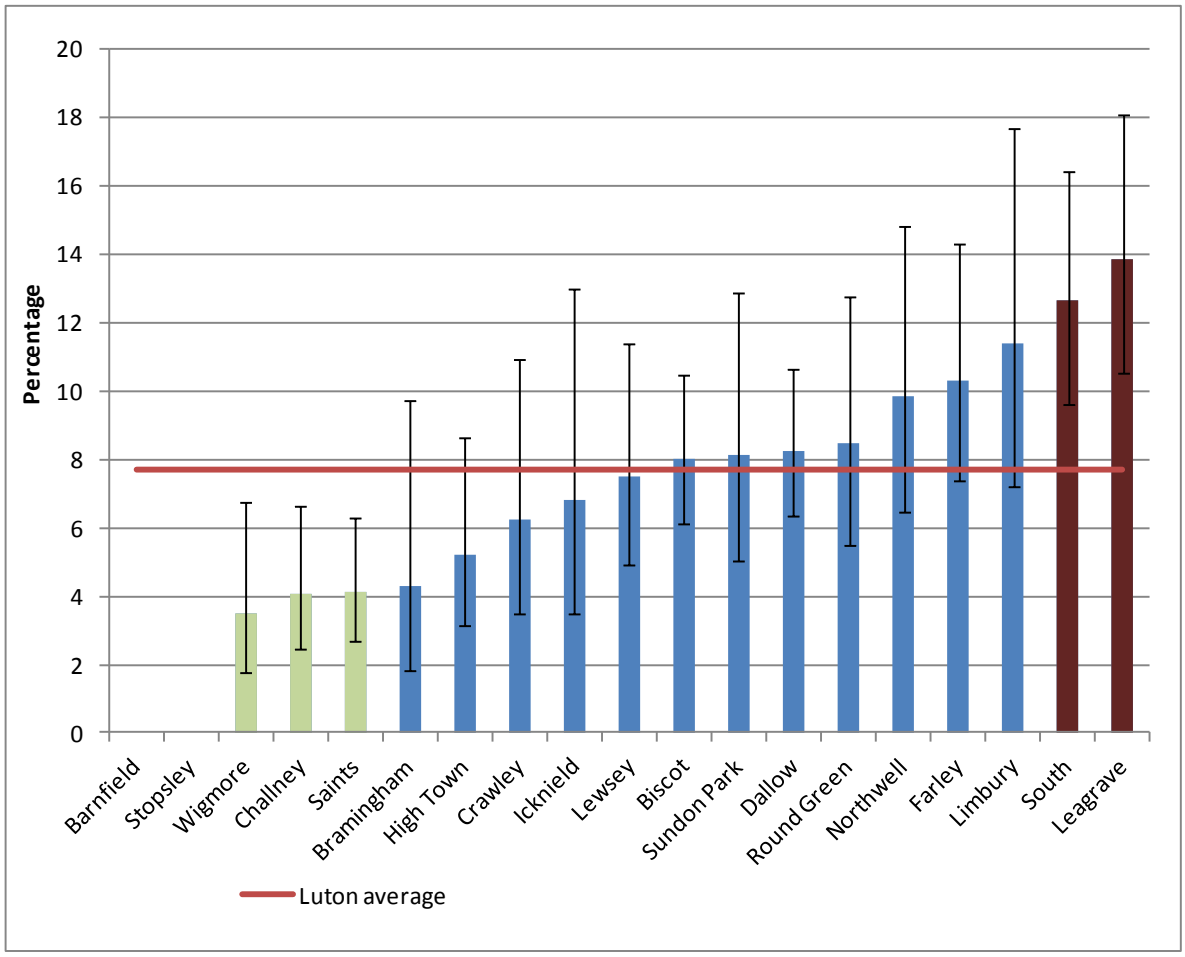


Not significantly different from Luton average
Significantly higher than Luton average
Significantly lower than Luton average

Source: L&D Hospital maternity services

(1) and (2): see data quality notes in ethnicity section

Figure 17: Percentage of women with "other" primary cause for concern (domestic abuse, alcohol or drug abuse) by ward, April 2011-March 2013



Source: L&D Hospital maternity services

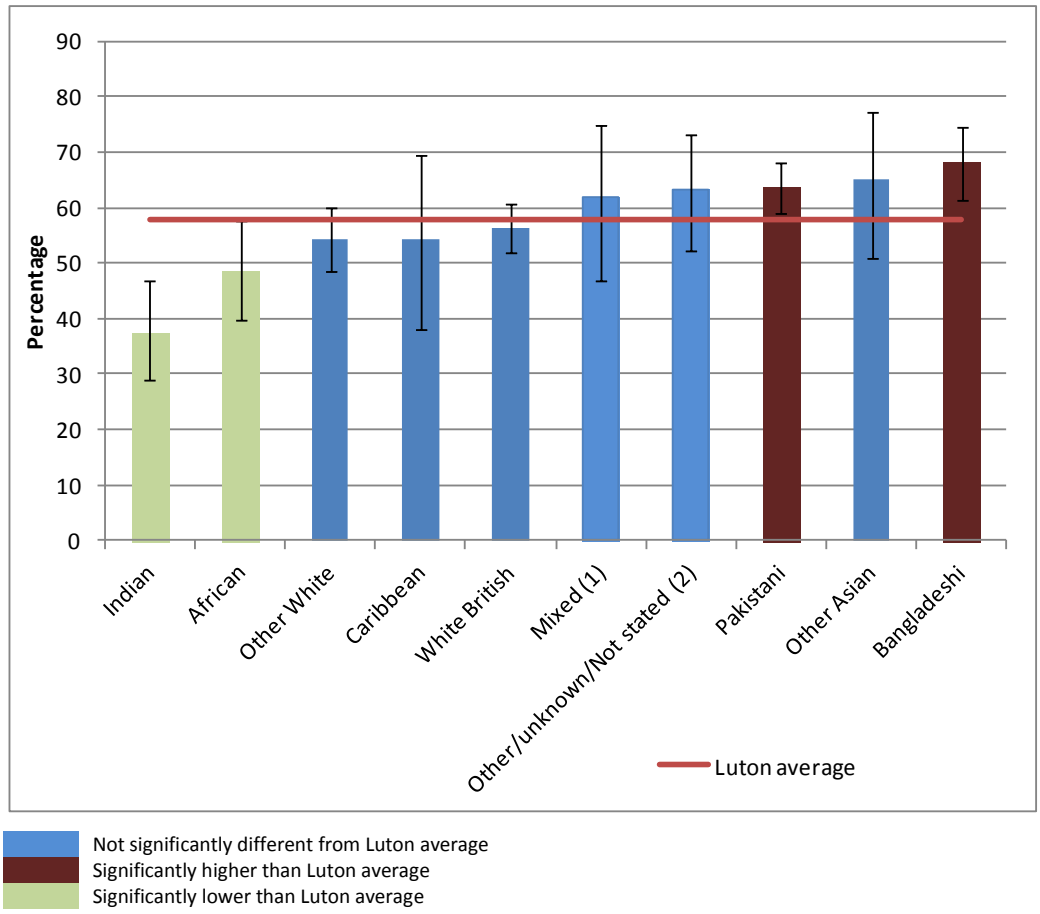
Note: rates not shown for Barnfield and Stopsley wards as <5 women with other causes for concern

The payment by results data shows the number of women on payment pathways other than the standard one. Women on intermediate or intensive pathways may have other risk factors which relate to mental illness risk, for example physical health problems for mother or baby. Data from April to September 2013 shows that 50.1% of women were classified as the intermediate pathway and 7.8% were on the intensive. The indicative national proportions suggested by the preliminary analysis suggested the national figures would be

28.5% and 6.9% respectively[15]. This would indicate that a relatively high proportion of women in Luton are classified as requiring non-standard care.

Figure 17 presents the proportion of women on the intermediate or intensive antenatal pathways by ethnic group and figure 18 shows the breakdown by ward. The proportion on non-standard pathways is particularly high for Bangladeshi and Pakistani women. *Data at ward level are shown in the accompanying datapack.*

Figure 17: Proportion of women on intermediate or intensive PbR pathway by ethnic group, April 2013 – September 2013



Not significantly different from Luton average
Significantly higher than Luton average
Significantly lower than Luton average

(1) and (2): see data quality notes in ethnicity section

15 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216445/dh_132664.pdf

3.5 Service data: Treatment

The previous chapter describes identification of mental illness during the perinatal period. Very little is known about how many of these women are treated or the quality or outcomes of their treatment.

Women with mental health raised as a "cause for concern" are referred to a specialist consultant, who then decides upon appropriate action depending on the severity and circumstances of each woman.

Limited data are available regarding this treatment and this represents a major gap in understanding how perinatal mental illness is managed. What little data are available are presented below.

How many women are admitted to mother and baby units?

Exact figures for admission to Mother & Baby units are not available, however the Thumbswood unit, to where Luton referrals are generally made, indicated that between 4-8 women from Luton are admitted each year. This is below the estimated number of 14 per year.

How many women are referred to adult mental health services?

Adult mental health services support pregnant and postpartum women but it has not been possible to extract any data on numbers of admissions or numbers receiving specialist support. Comprehensive data is collected from adult mental health services in the form of the "mental health minimum data set" but this does not currently record whether a woman is pregnant or postpartum or have sufficient information about referral source to identify these women. This represents a major gap in data availability.

How many women are referred to talking therapies?

Some data has been obtained on antenatal referrals to talking therapies. There are no figures on postnatal referrals.

Data from the “talking therapies” service shows that 134 antenatal referrals were made to the Talking Therapies service between October 2012 and October 2013. Of these, 21 women (15.7%) completed the twelve sessions of therapy.

Some diagnostic data is available for these 21 women:

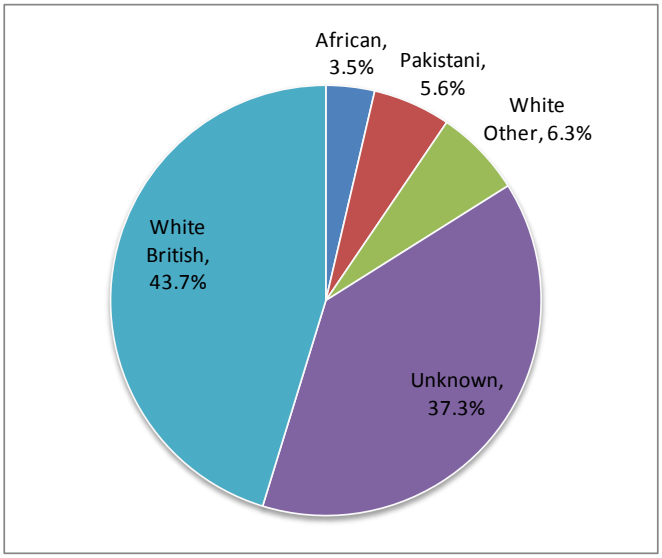
- The PHQ9 is diagnostic instrument for depression which can measure severity and response to treatment. The 21 attending women scored average 13.15 at first and scored average 6.0 upon completion of treatment. The scale ranges from 1-27; the cut-off scores for mild, moderate and severe depression are 5, 10 and 20 respectively.

- The GAD-7 is used to assess severity of generalized anxiety disorder. The 21 attending women scored average 12.97 at first and scored average 5.69 upon completion of treatment. The cut-off scores for mild, moderate and severe GAD are 5, 10 and 15 respectively.

These scores do indicate an improvement in condition upon completion of treatment and therefore suggest the service is beneficial to the women. However, with such a small sample of data and a low percentage of women completed the therapy sessions, it is not meaningful to evaluate the quality of this treatment or possible to quantify how these outcomes compare to those achieved by women receiving other services or those not receiving any treatment at all.

An ethnic breakdown of antenatal referrals to the talking therapies service is shown in figure 18. A particular data quality issue of this data is that almost 40% of referrals are coded as “unknown” ethnicity, despite ethnic coding being almost 100% complete in the hospital records.

Figure 18: Antenatal referrals to talking therapies by ethnic group



NOTE: figures for Bangladeshi, Caribbean, Indian and "Other" not shown as <5 women

The NICE estimates suggest that around 284 women per year In Luton would take up psychological therapies, Therefore, the 134 referrals to talking therapies seems relatively low, particularly as such a small percentage go on to complete treatment.

An IAPT service is currently being established in Luton but there are not data yet available. Even when the service is established, it may not be possible to easily identify women in the perinatal period as the national IAPT data does not include this information.

How many women are supported by wider support services?

There is a paucity of data about wider support services for pregnant women or mothers with mental health issues.

Children's centres support families with young children through a hub and spoke model with 7 centres and many spokes. Using the Children's Centre Manager database the team identified that of the 7 children centres in Luton, 3 recorded families with under 5s currently being supported for mental health issues (89 families with a CAMHs flag supported by ABC, Building Blocks, Community Link). The ABC and Community Link centres are in areas of high deprivation in the south west of Luton, with ABC approximately covering Farley and South wards and Community Link covering Biscot and Saints.

The ‘Stepping Stone’ service supports many women who have mental health issues. Staff estimate about 50% of clients are pregnant or have a child in the first year of life and that 65 – 70% of clients have mental health problems. The service has received 665 referrals in two years. The current caseload is over 150 and the waiting list is 82.

‘Changing Lives’ have also supported many women with mental health issues during the perinatal period and beyond.

4. Luton services for the care of women with a perinatal mental illness

The basis of this chapter is a series of interviews undertaken with key stakeholders within the Luton services which work to prevent and treat perinatal mental illness. To enable comparison, each sub-section begins with a summary of recent guidance 'good practice,' it then describes the local services and ends with a description of the main gaps and issues identified. Issues were predominantly raised by those interviewed but this is supplemented by the views of the authors having had the benefit of assessing the pathway in its entirety.

The chapter broadly follows the structure of the NICE guidance pyramid of need, i.e. beginning with the 4% of births that require specialist intervention, then the 8% that will benefit from psychological intervention followed by the 8% that will manage their needs through 'social support.' The document 'Guidance for commissioners of perinatal mental health services' (JCPMH) also guides the chapter structure in that it is used to outline the elements within each tier, i.e. it begins with overall management, then specialist services, psychological support, universal services and ending with services that are broadly termed 'social support.'

Interviews with the following stakeholders were undertaken during October 2013:
Maternity services - Clinical Director, Consultant Obstetrician, Clinical Manager
Adult mental health – Medical Director, Liaison consultant, Associate Director of Social Care
Mother and Baby unit - Unit Manager
Child and Adolescent Mental Health - psychiatric consultant, consultant clinical psychologist, Clinical Group Manager, Deputy Lead Clinician
Primary Care – Children's services lead, mental health lead
Commissioning / Planning – CCG Commissioning manager
Public Health – Public Health consultant
Social Care Children's Services – Area manager
Talking Therapies - Counselling service manager
Relate - CEO - Beds and Luton Relate
Children's Centres - Children's centre manager
Troubled Families - Practice and performance manager
Vulnerable populations – specialist health visitor, lead for new arrivals to the UK

Stepping Stones – Project Director

MIND – Service Manager

Mellow Parenting – Programme Manager

4.1 Overall system and management of services

National recommendations for best practice

There must be strategic commissioning of perinatal mental health care based on need. A perinatal mental health strategy is required that covers all levels of the service and uses an integrated care pathway agreed by all stakeholders. Services should promote seamless, integrated care across the pathway and organisational boundaries. This requires close working relationships and collaborative commissioning. With many different agencies, services and commissioning arrangements it is essential that systems are in place to maintain integration and collaboration. There needs to be a managed network made up of stakeholders to ensure the functioning of the pathway and to allow for development and innovation. There must be local clinical leadership involved to champion women's needs. There must be accurate data to inform local commissioning and planning, and there should be a focus on prevention.

A good service will ensure that no woman who is mentally unwell is needlessly separated from her infant and that she receives the appropriate support, care and guidance to safely care for her infant. Services should meet the needs of both mother and infant, and respect the wishes of the mother wherever possible. All women should have equal access to treatment and services should accommodate cultural and religious practices where compatible with the health and safety of mother and infant. Good services should promote prevention and early detection.

What happens in Luton?

Treatment, prevention and detection of perinatal mental illness involve a range of services across Luton. 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.

Care Pathways - Luton (led by the Luton and Dunstable hospital) has documented evidence-based patient pathways for prediction, detection and management of women with mental

health disorders during pregnancy and the postnatal period. These are outlined in the document 'Perinatal mental Health Guidelines.' (See Appendix 1). Development of the guidelines has been led by the L&D obstetricians with input from Consultant Psychiatrists, Mental Health Commissioning, GP lead for mental health, Head of Midwifery, Midwifery Matrons, Delivery Suite Manager and the Practice Development Midwife. The care pathways covers detection, assessment / referral and a tiered mental health care model.

The pathway for mild to moderate mental illness is shown in figure 19. The pathway includes assessment, guided self-help, psychological interventions, medication, combined treatments and social support, and the management team consists of the GP, Midwife, Health visitor, Obstetrician, Psychologist.

The pathway for severe mental illness is shown in figure 20. The pathway includes complex assessments, complex psychological interventions, medication, and combined treatments, and the management team consists of the GP, Midwife, Health visitor, Obstetrician, Psychologists, Psychiatrist / mental health team. (note there is also an additional more detailed pathway for women in crisis).

Strategy and management – although Luton has a multi-agency partnership approach to the planning and management of mental health, which by definition includes perinatal mental health, there does not appear to be a work strand or sub-group with perinatal mental illness as its focus. As far as the authors know there is not a local perinatal mental health strategy.

Regional Clinical Network – the authors are not clear on the role the clinical network plays with regards to perinatal mental health or of Luton's participation within the network. This is a gap in knowledge. Regional level discussion would be required if there were to be changes to specialist services such as the Mother and Baby unit or consideration of developing a specialist perinatal team.

Figure 19: Mild and moderate mental health care pathway from Perinatal mental health guidelines, Luton and Dunstable Hospital NHS Foundation Trust

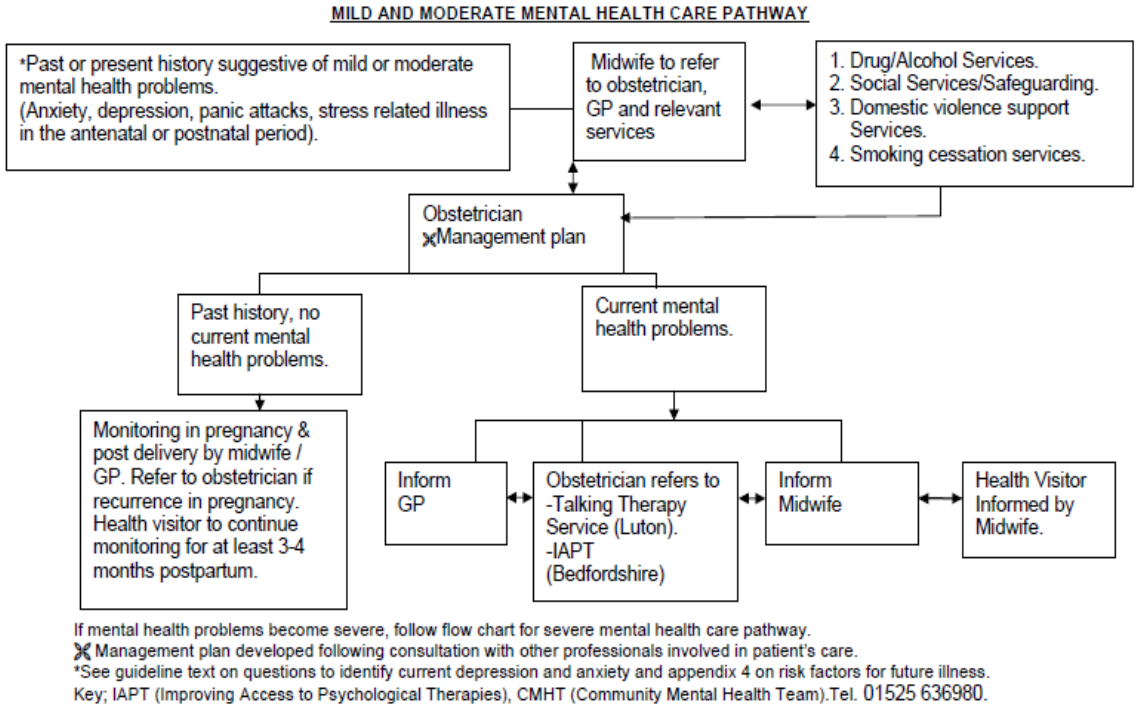
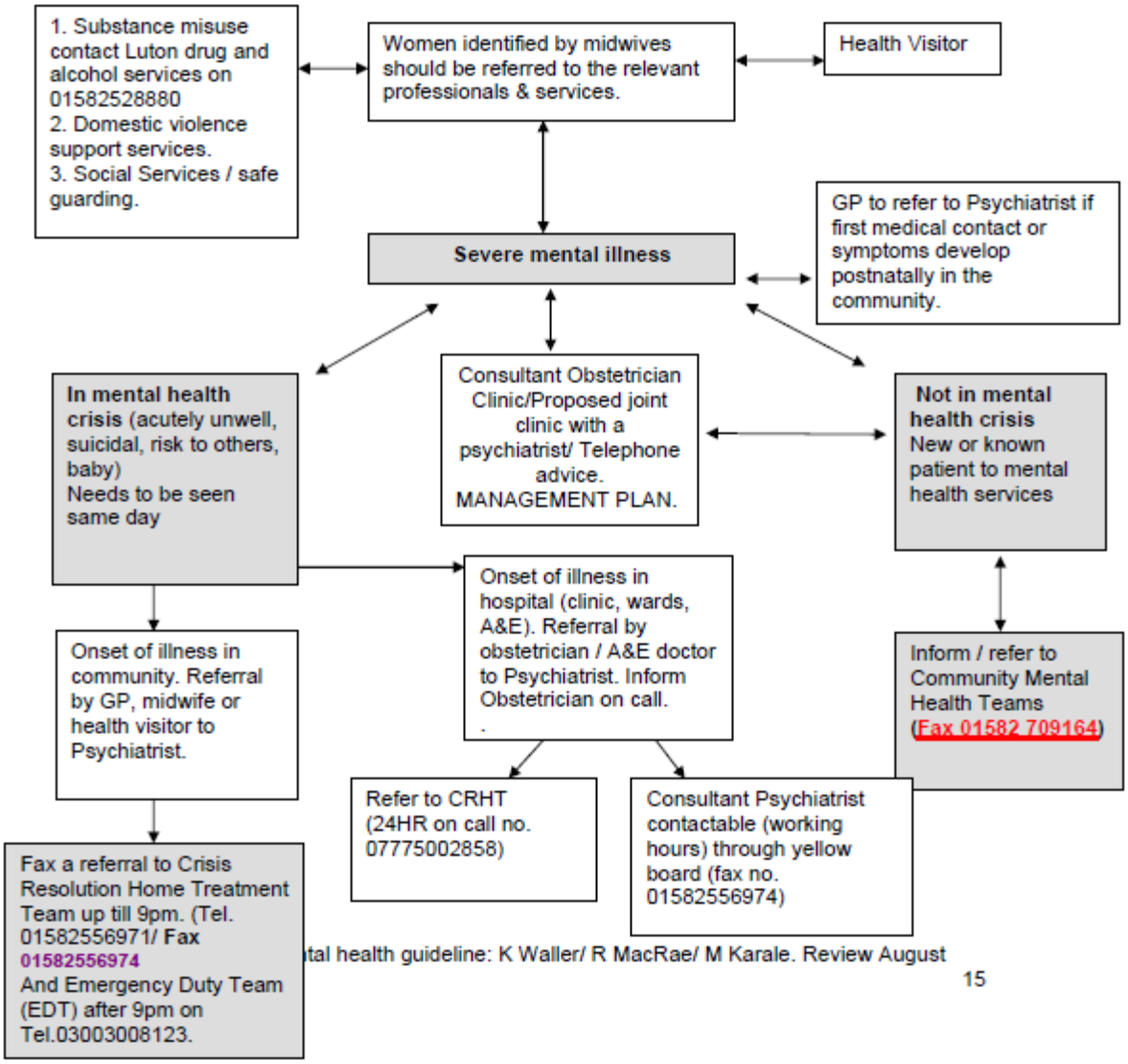


Figure 20: Severe mental health care pathway from Perinatal mental health guidelines, Luton and Dunstable Hospital NHS Foundation Trust

At first contact with women in both the antenatal and postnatal periods, healthcare professionals should ask questions about:

- Past or present severe mental health illness including schizophrenia, bipolar disorder, severe depression and psychosis in the postnatal period.
- Previous treatment by a psychiatrist/specialist mental health team.
- A family history of perinatal mental illness.
- Mental health symptoms.

Women should be referred by the GP or Obstetrician to CMHT (Community Mental Health Team) or CRHT (Crisis Resolution & Home Treatment Team) depending on the clinical situation..



tal health guideline: K Waller/ R MacRae/ M Karale. Review August

15

What issues or areas for improvement were identified locally?

- **Organisational roles in pathways** - the documented patient pathways are evidence-based and clearly outline the roles and relationships of key clinical agencies. However, it is less clear how well the pathways are known and operational across the wide range of stakeholders who have a role in managing, preventing and detecting perinatal mental illness. This is particularly the case for the mild-moderate pathway where a range of non-specialist and universal services have a role.
- **Use of data** - As was shown in the previous chapter, securing access to service data across the pathway is not easy. There are a number of reasons for this - primary amongst them is that most of the services are not in place solely to respond to perinatal mental health needs, and separating out data in this way is not done routinely. This is the case nationally as well in Luton. It was difficult to access data on service use, and more difficult to access data relating to service quality or outcomes. Although the care pathway is in place there has been limited success in accessing data to shows how well it is working beyond the identification phase.
- **Audit the care pathway** - The obstetric consultants suggested they would welcome an audit of the perinatal care pathway and the care provided.

4.2 Mother and Baby unit

National recommendations for best practice

Every new mother who needs inpatient psychiatric care must be able to access a nationally accredited Mother and Baby Unit (M&B). A good Mother and Baby unit should provide care for seriously mentally ill women or those with complex needs who cannot be managed in the community in late pregnancy and in the postpartum months whilst at the same time providing a safe and secure environment to admit their infants, avoiding unnecessary separation of mother and infant. They need to be closely integrated with specialised community teams to offer timely access so that mothers are not admitted to general adult wards without their baby prior to admission. They should also promote early discharge and seamless continuity of care.

What happens in Luton?

Luton referrals to a specialist M&B Unit are generally made to the Thumbswood Specialist Unit provided by Hertfordshire Partnership University NHS Foundation Trust. The unit has six

beds and would expect to see between 4 and 8 Luton women in a year. Once admitted the length of stay is generally 6 – 8 weeks ending with graduated leave as the patients returns home.

The mother (not the child) is first admitted into Adult Mental Health (AMH) then the Thumbswood team do their own assessment and admit if appropriate and a bed is available. Discharge is generally into the care of the local Community Mental Health Team. Patients are discharged with a personalised care plan. Re-admission is rare, although relapse does happen on occasion (often due to the patient not taking their medication), this is generally managed by the adult mental health team.

What issues or areas for improvement identified locally?

- **Data –** commissioning of some specialist services, such as M&B units is undertaken at a regional level. The data for the Luton element of this does not appear to be accessed routinely, this has particularly impacted on understanding of Luton's use of Mother and Baby Units.
- **Admission process** - women are generally admitted to AMH before assessment and transfer to the Mother & Baby Unit. This means they are separated from their baby.
- **Insufficient service** - the obstetric team suggested that there are, on occasion, not enough M&B beds available.
- **Out of county resource –** the main local M&B is in Hertfordshire, AMH report that some Luton mums prefer a local admission even though there is no capacity to take the child.

4.3 Community Perinatal Mental Health services

National recommendations for best practice

Women should be able to access a specialist perinatal mental health team when necessary. A good specialised community perinatal mental health team will assess and manage women with serious mental illness or complex disorders in the community who cannot be appropriately managed by primary care services. It should respond in a timely manner and have the capacity to deal with crises and emergencies and assess the patients in a variety of settings including their homes, maternity hospitals and outpatient clinics. It should have close working links with a designated mother and baby unit and work collaboratively with

maternity services (including providing a maternity liaison service) and adult mental health services. A good service will offer pre-conception counselling to women with pre-existing mental health problems and those who are well but at high risk of a postpartum condition.

What happens in Luton?

There is no specialised community perinatal mental health team supporting women in Luton. These services, including maternity liaison are provided by Adult Mental Health.

What issues or areas for improvement identified locally?

- There is no specialised community perinatal mental health team supporting women in Luton.
- The consultant obstetricians expressed that there was a need for two midwives with a perinatal specialism.

4.4 Parent-Infant Mental Health services

National recommendations for best practice

Services need to address the impact of perinatal mental illnesses on babies and other family members. They should help mothers to provide sensitive and responsive care, and develop healthy relationships with their babies. Services should also involve and support fathers. In the worst cases, where a baby is removed or a mother dies, professionals must ensure that ongoing support is available for the family.

Parent infant services should assess and treat mothers (and their babies / infants) who are at risk of developing attachment and relationship difficulties with their babies. Infant mental health is contingent on good maternal sensitivity and responsiveness, and mothers who are depressed, anxious or experiencing a serious mental illness may find it hard to meet their infant's emotional needs. The service should provide a variety of psychotherapeutic, psychological and psychosocial treatments and parenting interventions. They are able to see mothers and their infants at home as well as in the clinic setting. The service is staffed by a multidisciplinary team whose skill mix and competencies reflect their ability to deal with both maternal mental health problems and infant mental health issues and the interaction between the two. These services should work collaboratively with specialised perinatal services, adult psychiatric services and children's social services.

What happens in Luton?

There is no dedicated parent-infant mental health service in Luton. These services are provided by a mixture of teams, with mental health input from AMH. The Child and Adolescent Mental Health Multi-Agency Liaison Team do input but services generally only work the most vulnerable or at risk infants, children and young people aged 0-18yrs. CAMHs can be involved in perinatal care if:

1) The client is already known to CAMHs (i.e. through teenage pregnancy) – if there is involvement in this way the team are able to offer perinatal type support (i.e. considers the needs of the mother and the child, and enable them to stay together).
2) The 0 – 4 Liaison team can be involved if the case requires tier 3 / 4 type input – i.e. known issues related to child in need / child protection register / domestic violence issues.
3) If contacted directly by a professional the service would give brief support to assist in understanding the needs of both mother and child.

What issues or areas for improvement identified locally?

- There is no specialised parent-infant mental health service supporting women in Luton.
- **Not full service** - parent-infant services provided by CAMHS are an addition to, not a substitute for, services provided for women with serious mental illness. They should work collaboratively with specialist services.
- **Limited capacity** – the CAMH multi-agency liaison team currently do not have the capacity to work more substantially with children's centres, health visitors and midwives in order to target those in need.

4.5 Specialist Adult Mental Health services

National recommendations for best practice

A good **general adult mental health service** should regard women of reproductive age as having the potential for childbearing and ensure patients with serious mental illness receive pre-conception counselling and are aware of the risks to their mental health of becoming pregnant. They should also take into account the possible adverse effects of psychotropic medication in pregnancy and provide women with this information. Where possible they should redirect referrals of pregnant and postpartum women to specialised perinatal

psychiatric services. Where these do not exist, they should be aware of and be able to respond to the capacity of perinatal conditions to deteriorate rapidly. If a woman, already under their care, because of a longstanding serious mental health problem, becomes pregnant, they should work collaboratively with maternity services to develop a management plan and seek advice and support from a specialised community perinatal mental health team. If admission is necessary, they should consider admission to a mother and baby unit even if this means an out of area placement.

What happens in Luton?

Once Adult Mental Health (AMH) services are aware of pregnancy for a women with a pre-existing mental illness in their care, assessment and review takes place that includes assessment of client's resilience to be a mother. Patients are generally appointed a care co-ordinator from within the mental health team (nurse or social worker), have increased input from the team during the perinatal period, and have an agreed post natal care plan. Medication is reviewed and changed dependant on requirements. If appropriate the team will begin to build relationships with appropriate other services (e.g. child protection). The crisis resolution and home treatment team (CRHT) offer assessments for those in mental health crisis and then home treatment if appropriate as an alternative to hospital admission. This service is available 9am- 9pm with 24 hour support through the A&E service.

Women with a new mental illness identified during the perinatal period have a condition specific pathway. If SMI, the Obstetrician or GP should refer to adult mental health services via the Crisis Resolution team if in crisis or Assessment and Single Point of Access (ASPA) teams if not. Outside of 9am – 9pm access if through A&E or via the emergency duty team if an emergency referral. For non-urgent cases referrals should be made through the same route to the community mental health team. Once admitted into the service care is as above.

Following discharge from maternity services all women with SMI will pass into the care of AMH and/or the GP.

There has been a recent addition of an in-reach liaison service to the L&D. This is predominantly for older people but does include maternity. This Liaison Service is consultant level, available 9am – 5pm five days a week. The service responds to obstetric consultant

calls as they arise, it is not for planned support of known women with SMI. The Consultant generally makes two or three visits and then refers on to the appropriate AMH team. So far most referrals have been for English speaking women aged over 30. The liaison consultant believes the service works well, in part because the obstetric consultants have an interest in perinatal mental health.

What issues or areas for improvement identified locally?

- **Cross team communication** - AMH view the working relationship with maternity services at the L&D as good but do acknowledge some co-ordination issues. The obstetric team echoed this, citing an examples as contact details for CMHTs can quickly become out of date, and the admissions process being sometimes too slow.
- **Mother focussed service** – the AMH service role, within a multi-disciplinary team, is to focuses on the mental health needs of the mother. The needs of the child are considered by the midwife / health visitor / social care worker but no agency is responsible for assessing them together.
- **Threshold for support** – some respondents believe there are occasions where a child is removed from its mother because she does not meet AMH criteria for support, but had ongoing family support been provided the removal may have been prevented. This view is somewhat supported by the Social Care Child Support team who spoke of the difficulties social workers have with assessing risk in relation to mother's mental illness which can lead to what might be termed an 'over-reaction' to ensure child safety.
- **Language issues / people new to the UK** - AMH have a specialist Asian team and an African / Caribbean team, however they acknowledge that consideration of how to support Eastern European women is needed.
- **Service data** - there is no perinatal mental illness data available from adult mental health. Activity statistics are collected in the 'mental health minimum data set,' if a perinatal team exists (it does not in Luton) then work undertaken is coded to the perinatal clinical team, if similar support is provided by the AMH it will not be recorded as perinatal. Plans are in place to add a perinatal treatment code to MHMDS; this is likely in 2014/15.
- **Referrals** - the Obstetrics team suggested that on occasion referrals to AMH resulted in appointments that were too late to meet need, and also that because of the clinic location women sometimes do not attend. One GP also offered this view.

- **Group therapy** - the AMH team would like to make a group therapy intervention part of services available for women with mild / moderate post natal illness.
- **Liaison service** - the new service has been welcomed however the fact that it is not specifically for perinatal women and is only available at certain times (9-5 Mon-Fri) has been highlighted.
- **Knowledge of referral route** - the AMH team highlighted occasions when midwives and health visitors do not know the referral route when mental health difficulties first arise.
- **Partner service expectation** – the AMH team spoke of occasion when children services staff expect that when mental health issues involving the child arise the AMH team address them.

4.6 Psychological Therapies

National recommendations for best practice

Timely psychological support must be available to all expectant and new mothers with mild or moderate mental illnesses. Medication should be prescribed cautiously and women should also be offered additional support. There should be evidence-based individual and group therapeutic services and expectant parents and those with young children should be a priority for IAPT services.

A good IAPT or psychological therapies service should ensure that pregnant and postpartum women are assessed quickly. The NICE guidance says that women requiring psychological treatment should be seen for treatment within 1 month of initial assessment. The IAPT Positive Practice guidance (2009) suggests that women should be assessed within four weeks and effectively treated within three months of referral. Services should provide training to ensure staff understand the maternity context and the additional clinical features and risk factors associated with perinatal psychiatric disorder. They should be able to refer to perinatal mental health services in cases of concern and to psychological services in cases of higher complexity.

The IAPT guidance goes on to suggests that engagement with pregnant and new mothers is required when designing and evaluating services as mums may need:

- to bring their baby to the appointment;

- home visits;
- appointments at specific times or dates to accommodate childcare arrangements or to coincide with the baby's routine;
- longer sessions than others because of having to change or feed the baby;
- additional support from therapists or the presence of an additional carer to watch the child.

What happens in Luton?

To focus on wellbeing Luton operate a stepped model of care to support people to access the right kind of psychological support at the right time. Steps 2 and 3 of the model in relation to perinatal mental health are discussed in detail in this section, i.e. talking therapy services are Step 2 and IAPT Step 3. The earlier steps may also support some women with mild to moderate perinatal mental illness, they are:
Steps 0-1: Awareness and recognition of mental health – this includes; CBT web based free programmes for self directed support, downloadable CDs and e-books, online support help booklets, and books on prescription, and Step 1: Assessment, care planning and short term intervention – this includes; a wellbeing project, structured volunteering schemes, a peer support programme, and mental health public health. Detailed information on this can be found on the CCG platform Gelifish.

There is one route for women with mild to moderate perinatal mental illness into the main CCG funded counselling services. For information on the service go to https://www.lutonccg.nhs.uk/page/?id=3893.

Antenatal - the Talking Therapies service has a route specifically for women in the period from conception to 6 weeks post birth. Referrals are made by the consultant obstetrician (or on occasion the GP) and the woman will get the next available appointment within a service standard of gap from referral to therapy being no more than three weeks. Contact is maintained during the intervening period with women communicated with twice. The intervention is six weeks. It is not common, but if ongoing therapy is required and the women remains in the antenatal period then therapy will be extended.

Postnatal - beyond 6 weeks post birth the women will be seen within the normal range of Talking Therapies services, which includes a service specifically for Asian and Black ethnic groups. The service is accessed by GP referral letter and those accepted are classified as urgent or routine. If the referral letter mentions the women is a new mother this will be classified urgent and seen within three weeks. This treatment is also a six week intervention. There are no facilities to accommodate a child aged under one year.

IAPT - the new IAPT service in Luton is an addition to the range of psychological interventions available and is able to support the more complex cases. The service offers a 13 week intervention that is available to women with a perinatal illness, but as far as the authors could ascertain the service does not deliver evidence based interventions specific to mother and baby, and is not designed to respond to the particular needs of a mother with a young child.

What issues or areas for improvement identified locally?

- **type of intervention offered** - no psychological service in Luton is providing evidence based parent-infant therapy
- **IAPT** – the service does not explicitly cover the perinatal period and no current treatment focuses on parenting or mother-infant interaction. The service will not prioritise these bookings and additional facilities to accommodate children (e.g. longer sessions, allow child to attend) are not in place.
- **Post natal access** – records cannot be interrogated to identify women who access talking therapies services post-natally.
- **Post natal services** – the routine talking therapies service is not set up to accommodate women with children.
- **Antenatal intervention completion** - the antenatal service received 134 referrals last year and for those that completed treatment the outcome was generally positive. However only 21 (16%) of 134 completed treatment. Both the lead Obstetrician and lead GP expressed doubts as to whether women referred to Talking Therapies would a) attend, or b) complete treatment.
- **Referral route** - The talking therapies manager highlighted concerns about the current referral route prevents support being available to all Luton women. They only accept referrals from patients registered with a practice within Luton CCG - this excludes un-registered women and those women living in Luton but registered with

Wheatfield Road (very close to Luton but not part of Luton CCG). They also suggested that the GP only referral route can present a barrier, in that the GP is not always the best placed to make a referral, and post-natally the referral letter needs to mention 'recent pregnancy' to be classified as 'urgent' and often does not.

- **Flexible services** - Views were expressed that Luton services should be flexible enough to recognise and respond to the inherent challenge of delivering predominantly 'talking' type therapies to a population containing significant numbers of people who do not have English as a first language. They believe this should be taken into consideration in terms of length of intervention and likely outcomes when planning capacity and skill mix.

4.7 Maternity services

National recommendations for best practice

Maternity services should be able to identify perinatal mental health issues early and ensure that all women get the support they need. The service should actively manage cases where a risk of mental illness has been identified and information about risks or symptoms should be shared appropriately between professionals. Perinatal mental illness should be incorporated into training and individuals should be encouraged to attend refresher training. Midwives should feel comfortable and confident asking women about their mental health, and use evidence-based tools to help them to detect problems antenatally and postnatally. Midwives should tell mothers and fathers about perinatal mental illnesses. Every maternity service should have a Specialist Mental Health Midwife to champion the needs of women with perinatal mental illnesses.

A good maternity service should communicate with GPs, informing them of the pregnancy, ask about any mental health problems and alerting them if difficulties arise. They should ensure that women are asked about current mental health problems during pregnancy and the early postpartum period, and ensure that women at high risk of a recurrence of serious psychiatric disorder are identified at early pregnancy assessment and referred for specialised care. The service should have access to a specialised perinatal mental health team to work collaboratively with women at high risk of serious mental illness and undertake emergency assessments. They should also have access to a specialised clinical psychologist to advise and treat.

What happens in Luton?

Midwives are the first point of contact with maternity services for most women. The midwife taking the booking history (or other professional who is first contact with the woman in the antenatal or postnatal period) asks questions to identify current mental illness and predict future illness. In Luton all women are assessed at booking using the NICE recommended assessment tool. Those identified as having a mental illness will be recorded in the PBR process and will have a Cause For Concern (CfC) form raised. CfC forms can be raised at any point from booking through to 28 days post delivery. CfC forms can be raised in relation to mental health, domestic violence, drug and alcohol and requirements for social support. The raising of a form must result in an action, generally this begins with an obstetric consultant appointment leading on to care by the appropriate service as required.

Obstetricians deal with high risk and complex pregnancies, including women with serious mental illness. They will also see women with a range of other psychiatric disorders in pregnancy and the early postpartum period. Within Luton, women with significant previous or current mental health problems are assessed by or reviewed with the obstetric consultants with special interest in perinatal mental health at the antenatal clinic. When there is a past history of serious mental illness or uncertainty about the severity of the illness, the woman is referred by the obstetrician to the psychiatrist for assessment and care plan. A written care plan covering pregnancy, delivery and the postnatal period are developed for pregnant women with a current or past history of severe mental illness. The consultants are advocates of ensuring there is social support available to women with mild to moderate mental illness. They also believe this should not be restricted to mental health, as other areas of vulnerability such as alcohol or drug issues or domestic violence are also common and sometimes linked to a diagnosis of perinatal mental illness.

Maternity services generally stay involved with a woman's care until 10 days post delivery, after which care is handed over to the health visitor team. As part of the individual care plan maternity involvement can be extended up to the 28th day post delivery if there is good reason (e.g. a mental illness where ongoing monitoring is required) and if this happens care will be passed on to the community midwife.

The obstetric team suggested there are likely to be fewer referrals than expected to specialist mental health services because two consultants have an interest in mental health and the service has an effective early identification system where women at risk during the perinatal period are identified and cared for in the community (with CMHT / crisis team input as required).

What issues or areas for improvement were identified locally?

- **Data on continuity** - although maternity service data on identifying mental illness is good, maternity services were not able to provide data on numbers of women with an existing SMI condition or on diagnosis / referral / outcomes for those identified as being at risk.
- **Increased psychiatric input** - the obstetric consultant's spoke of a time when a psychiatric consultant undertook joint clinics and how well that worked. They would welcome its return.
- **Improve discharge process** - the consultant obstetricians believe that although there is a discharge summary ready for all women when they leave maternity services that it may not always contain sufficient detail to ensure ongoing care.
- **Midwife training** - there is a local study day on perinatal mental health available to acute and community midwives and ongoing in house training on mental health issues. However, the consultant obstetrician's believed training on mental health to be limited.
- **Over identification** - the consultant obstetrician's expressed the view that the CfC process may over reports mental illness as midwife identification could improve and be less risk averse.
- **Supporting non English speakers** - the midwifery team highlighted that language difficulties, particularly within the Asian and Polish communities, can make it more challenging to provide support. They suggested numbers of bilingual workers and languages spoken were insufficient.

4.8 Primary Care

National recommendations for best practice

Primary care services should be able to identify perinatal mental health issues early and ensure that all women get the support they need. The service should actively manage cases

where a risk of mental illness has been identified and information about risks or symptoms should be shared appropriately between professionals. Perinatal mental illness should be incorporated into training and individuals should be encouraged to attend refresher training.

A good GP and primary care team should ensure patients with serious mental illness receive pre-conception counselling and are aware of the risks to their mental health of becoming pregnant (they should also take into account the possible adverse effects of psychotropic medication in pregnancy when prescribing to women of reproductive potential and provide women with this information). They should ensure that women are asked about current mental health problems during pregnancy and the early postpartum period. They should communicate with midwives, with the woman's consent, if there is a history of significant mental illness, even if the woman is well. They should be alert to the possibility of postnatal depression and anxiety and to the risk of recurrence of pre-existing conditions following childbirth so that early onset conditions can be closely monitored and referred on if necessary.
GPs have contact with nearly all families during pregnancy and the postnatal period. This provides a great opportunity for them to play an important role in identifying mothers who are at risk of, or suffering from, perinatal mental illnesses and take action to ensure that these women get the support they need at the earliest opportunity

What happens in Luton?

The GPs interviewed acknowledged that comprehensive care plans are shared, that they are generally aware of and involved in care of women with perinatal SMI, and that the care pathway works. They admitted to knowing less about the mild / moderate care pathway and being less clear about the volume of depression and anxiety based perinatal mental illness among their patients. An exercise to interrogate GP information systems to assess practice level perinatal mental illness was discussed but found to be not possible within the time-frame. This is not to say practices cannot do this, interrogation of appropriate Read Codes should be possible, but there was nothing said within discussions to suggest this was happening as a matter of routine.

Within Luton primary care there is a model of stepped care for mental health and there is an ambition for each practice to have a lead GP for mental health in each practice. Surgeries are coming together for peer meetings and secondary care also attend. GPs are positive about

the Primary Care Link Worker pilot programme introduced by with AMH. Currently one post supports five practices providing prompt short term interventions. The post holder also offers guidance and training to primary care staff and can make referrals to talking therapies.

What issues or areas for improvement were identified locally?

- **Information sharing** – GPs expressed the wish to know about all Cause for Concern forms being raised for their patients. They said 'all' because they see them as an indicator of vulnerability and believe a holistic approach to care can impact on a range of issues that includes mental illness. Also all GP referral letter must highlight if mental health issues if identified.
- **Non English speakers accessing services** - GPs highlighted the challenge of supporting those who do not speak English and the delays and problems associated. They noted that the language (and dialect) in question changes over times as new populations arrive. They also pointed out that there is significant mental illness stigma within certain communities.
- **New arrivals** – some primary care professionals highlighted that there is problems with new populations (most recently Romanian / Bulgarian) settling in Luton but not using health services until they have a health need, which is often pregnancy.
- **Fear of professionals** - GPs suggested that some service users perceive services to be judgemental rather than supportive and in particular mother's fear of their children being taken away.

4.9 Health Visiting

National recommendations for best practice

Health Visitor services should be able to identify perinatal mental health issues early and ensure that all women get the support they need. The service should actively manage cases where a risk of mental illness has been identified and information about risks or symptoms should be shared appropriately between professionals. Perinatal mental illness should be incorporated into training and individuals should be encouraged to attend refresher training.

A good Health Visitor service should have the skills to detect mental health problems in pregnancy and the postpartum period, to know who to refer and to which service. They

should be able to undertake basic psychological treatments such as listening visits and non-directive counselling and cognitive counselling group work and understand which women would benefit from additional visits and support. Health Visitors undertaking psychological interventions will require clinical supervision.

What happens in Luton?

Health visitors support families from pregnancy through to the child's fifth birthday. They are the main postnatal support service for mothers upon discharge from maternity services. All parents are offered a new birth visit between 10 and 14 days. If there are concerns during this visit the HV may do a PQ9 questionnaire to assess their mental health state. Due to reduced numbers the Health Visiting service is not able to provide all core services and has adopted an approach of focussing support on 'targeted women'. The authors were unable to define how women were defined as 'targeted'.

HVs have minimal antenatal involvement and the pre-birth universal home visit is not routinely happening, although targeted checks are being done. There is an expectation that the midwife is the lead professional at this time. HV involvement in the preparation for parenthood course is also not consistent across Luton. There is also a reduced post natal service, the birth to one week universal contact is with breastfeeding support team only and there is no routine maternal health check between 3 and 4 month currently taking place. Note: authors understand there have been some service developments, detail not known.

What issues or areas for improvement were identified locally?

- **Under-staffed service** - the health visiting service is operating with reduced numbers, this has compromised its ability to provide a full service and to play a full role in monitoring the mental wellbeing during the perinatal period.

4.10 Services for women requiring social support

The range of services and interventions described within the 'social support' are broad. Included within them are non-specific mental health support interventions, targeted and universal parenting interventions, facilitated group support, targeted individual support, and accessible drop-in and telephone contact facilities. These services will often address both mothers' mental illness and support their relationships with their infants. The organisations described below may provide one or many services. The services are grouped together here because in general they are non-statutory provision, accessed by the individual or are referred to as part of a support package of care.

These services are vital to help effectively meet need. NICE commissioning guidance estimates that around 8% of deliveries (284 in Luton) are to women with 'subthreshold' symptoms (for example some symptoms of depression but no previous episodes of depression of anxiety) who will receive routine antenatal and postnatal care and not require (or not take up the offer of) psychological therapies. These women may manage with the support of family and friends but are also likely to benefit from contact with social support services.

These services are important beyond the needs of these 8% of new mothers. They will play a role in the step down management of women in receipt of specialist mental health care or psychological interventions. They can also help prevent the development of mental illness among vulnerable women and help with identification of perinatal mental illness.

National recommendations for best practice

Social support, which may take the form of regular, informal individual or group-based sessions during pregnancy and the postnatal period, can support women with mild or moderate symptoms of depression and/or anxiety. Whilst psychological and social support will not be sufficient for women with more serious mental illness, they can also provide an important part of the package of care that they receive.

Women with perinatal mental illness (or at risk of) should have access to sources of social support, including the opportunity to share experiences and support one another.

Therefore, commissioners should ensure that there are evidence-based individual and group therapeutic services in their area and that key practitioners (such as midwives, GPs etc) are

aware of what services are available so that they can share details with women. These service should be offered in accessible venues that women feel comfortable to attend.

What happens in Luton?

Mellow Parenting – is a programme that supports parents and parents to be. There are three courses focussing on prior to birth, new parents and parents of toddlers. Courses generally focus on the more vulnerable parents and the programme manager explained that recent courses participants have generally been from the 'high end' of need. Services are delivered from a number of sites including Stepping Stone and Children's Centres and the programme will also soon be delivered by 'Community Links'. Mellow parents is currently being evaluated by CAMHS. There is evidence that these courses make a difference. The courses directly related to the perinatal period are:

- Mellow Bumps – a 6 weeks group based ante-natal programme provided jointly with midwives that is aimed to support families with additional health and social care needs. If parents attend this course they will also have access to ongoing support, depending on their need and existing support network. There will be six courses in the coming year and there are normally 10 or 11 participants per course. There is a tight window for this course as expectant parents need to be identified, referred and complete the course prior to birth.
- Mellow Babies - a 14 week, 1 day a week course developed for vulnerable parents and babies under 1. The course uses life story work and CBT approaches to help mothers reflect on their own experiences (either current or past) in order to help them make sense of their parenting difficulties. This does not specifically treat mental health problems but does provide social support and opportunities for reflection for mothers with mental health and social care difficulties. There will be five courses run in the coming year with 10 or 11 participants per course. If parents attend this course there will be ongoing support available.

Children's Centres - get informed about around 50% of the children born in Luton but not about which mother have a perinatal illness or are considered vulnerable. They have Outreach workers, Family Workers and Family Support workers, all are able to support women and identify attachment issues but they are not trained in mental health. Children's centres also link well with Nurseries which is another way to identify families that may be in

need of support. They do assess and when appropriate focus their support on maternal mental wellbeing. They see mothers with post natal depression and also identify children with attachment difficulties, in these instances they offer social support and signpost women to their GP.

The centres have programmes and tool that can offer social support to women with a perinatal illness:

- Baby PEEP – a universal programme where staff support parents to make the most of everyday learning opportunities – listening, talking, playing, singing and sharing stories and books. Spending time with their parents and carers in these ways helps children become confident communicators and active learners.
- FamilyStar - is a holistic assessment tool that looks at what's working well for families and also not so well. It advocates a 'bite sized' approach to identifying the main issues and what the family can do about them. It's a family lead and supportive rather than a directive intervention. The Family are supported to revisits these issues and revise priorities.

The centres also provide a range of parenting courses, including Mellow Parenting and Bumps to Babes, which is an ante-natal programme covering pregnancy, birth and beyond and focussing on parenting standards, bonding, attachment and relationship building.

The service is currently in discussion with the L&D about an in-reach service where they would be on site to triage women referred from the obstetric clinics. This would enable them to provide a service focussing on a range of issues including maternal mental wellbeing.

Stepping Stone - supports women affected by mental health and domestic abuse, drug/alcohol and social care related issues. They except referrals from a range of agencies and also self referral. The service supports many women who have mental health issues (mild / moderate through to SMI). Staff estimate 50% of clients are pregnant or have a child under one and that 65 – 70% of clients have mental health problems. The service received 665 referrals in two years, current caseload is over 150 and the waiting list is 82. They do not prioritise but if a woman is young and pregnant every effort is made to support her. There is a drop-in service for those not yet accepted on to the caseload. All women on the caseload

are allocated a key worker and have access to a range of 1-1 support including counselling, motivational interviewing and advocacy. They offer childcare for 0 – 5s.

The service also provides a range of parenting courses, including four Mellow Bumps and three Mellow Babies run in the last year.

Changing Lives - offers services in community languages and delivers mental wellbeing programs within schools, children's centres and community centres across Luton. In addition to mental wellbeing programs they offer counselling/ psychotherapy, group counselling, various support groups, parenting skills programs and systemic family interventions in Bengali, English, Farsi, Hindi, Pahari/ Urdu, Portugese and Somali. They deliver the Triple P program in community languages with adaptations to take account of issues such as migration, forced marriages, domestic abuse, honour based violence. They aim for their work to recognise the wider context of culture, religion and disability to support parents to meet their own needs, understand the needs of their children and develop parenting skills that respond to the developmental needs of the children. Whilst there is not a targeted perinatal service, the service reports that it has supported mothers affected by pre and/or postnatal depression, particularly in those who experienced the birth of a child with complex disabilities or experience the death of a child.

MIND – offer a range of services to support people with mental illness, none are specifically for perinatal mental illness or considerate of their specific needs, but all are available. The Luton Local Group provides many activities that promote social inclusion and encourage individuals to be active in the community through programmes such as:

- Supporting Mental Wellbeing – which delivers 1:1 short-term, low intensity support to help provide client-focused support that targets confidence, self-esteem, anger, assertiveness and social phobia to help individuals build and maintain relationships with others;
- Recovery Star - a mentoring programme where trained volunteers give time to support and encouragement in a one-to-one non-judgmental relationship.
- Healthy Aspirations - which provides an opportunity to learn techniques designed to support emotional wellbeing. The programme aims to build an individual's interpersonal skills and assist with individual learning goals.

- Healthy Minds – specially designed courses which provide individuals with mild to moderate mental health problems with practical tools to support their wellbeing.

Relate - run counselling services commissioned by the CCG and others. They do not offer services specifically for perinatal mental illness but their service remit does include women (and families) where the mum to be / new mum may be experiencing mental illness. Luton services focus on relationship counselling, which can be adult relationships or families, although the relationship between mother and baby would not be assessed. There is also a service provided to young people (aged 10 – 21) which may include young parents needing support.

Troubled Families – is a programme aimed at supporting Luton's most complex families. Nine services have come together to link data to identify the most vulnerable families. The aim is to help whole families (average 6 people per family). There is a dedicated team of support workers who include a focus on maternal wellbeing and maternal mental illness. There is also recognition that some families have disengaged with services and the initiative adopts an inclusive approach to address this. There is an issue that the targeting process identifies troubled families who are in contact with services while families that do not access services will still not be reached.

Support to vulnerable populations - Luton has a 1 wte Hard to Reach health visitor who focuses on homeless women (in particular those in a refuge), women experiencing domestic abuse, and Gypsy, Roma and other traveller groups. The health visitor said she spends little time discussing maternal mental illness with clients, primarily because they have other needs such as stress around finances and fear around having their children removed which they see as higher priority. She is aware of depression and anxiety among pregnant and postnatal women but believes they are generally unlikely to admit to mental illness and wouldn't access counselling. She identified that domestic abuse is common among traveller families and that generally stress is greater within the unauthorised camps.

There is also a Luton Borough Council post which supports people new to the UK, such as refugees and asylum seekers. There are many pregnant women and new mothers within these groups and they face many pressures. Some will be ask to pay for maternity services. The officer suggested her experience was that maternal mental illness does occur, but it is

rare and generally only identified f it is SMI. Her view was that those seeking asylum or with refugee status, although facing many difficulties and increasing pressures, do not generally experience or acknowledge mental illness. She attributes this, in part, to people being extremely resilient, and also to there being a strong support network in most ethnic communities. She also acknowledged that many of these ethnic groups do not recognise or acknowledge mental illness so there may be a hidden problem. She did also acknowledge that lack of English among new arrivals could contribute to an under identification of mental illness.

What issues or areas for improvement were identified locally?

- **Co-ordinated targeted care** - the obstetric consultants are advocates of social support type services, recognising that targeted primary (e.g. pre-birth parenting skills) and secondary (e.g. crisis support or family key worker) prevention is required. They see this type of actions as going beyond meeting mental health needs to supporting vulnerable women and impacting on causal factors for mental illness. The CAMHs team agreed suggested that a key-worker approach for the most vulnerable was required to help identify and promote protective factors alongside assisting with issues such as budgeting and attending housing meetings etc. GPs also agreed, adding that services need a family focus and to act with empathy and encourage individuals to find their own solutions and to identify small manageable goals.
- **Service levels** - it is not clear whether the service levels available meet need. Some services raised the issue of waiting lists and that they lack the capacity to meet all needs. They also suggested that with additional capacity they would provide more early intervention type services to help prevent women becoming vulnerable.
- **Collaboration** – it is not clear if collaboration and communication between services enables them to meet need in a timely and effective way.
- **Are services in the pathway?** - it is not clear how widely these services are known about and if knowledge of them is communicated to the women for whom they may benefit. For instance do all midwives and health visitors recommend and provide information on social support?
- **Sub threshold support** - both Stepping Stone and Children's Centre staff discussed providing social support to women with mental health needs who failed to get support from AMH or CAMHs due to the threshold for those services.

- **Step down planning** - both Stepping Stone and Children's Centre staff expressed frustration at picking up ongoing support for individuals when interventions end (both specialist services and talking therapies) but not being involved in step down planning.
- **Information sharing** - Children's centres expressed the wish to receive information about the more vulnerable women seen in maternity services.
- **Increasing incidence** - Children's centre staff believe they are seeing an increasing incidence of maternal mental illness and that poverty is playing a part in adding to pressures.
- **Engagement difficulties –** Children's centre staff believe that women in some communities are reluctant to seek support (or are difficult to engage with) for cultural reasons, such as the stigma attached to mental illness.
- **Onward referral** – social support groups are unlikely to be sufficient on their own for women with perinatal mental illness. It is important that referral / support / communication routes are clear, known about and work.
- **Vulnerable groups not accessing services** – the Changing Lives team reported that a mental wellbeing impact assessment with Somali women who experienced trauma identified that out of 27 women who attended only 1 was offered talking therapy for postnatal depression. The views of the LBC staff that supported hard to reach groups also suggested people with needs were not accessing services.
- **Why vulnerable groups do not seek support** - the Changing Lives team suggest that language, literacy, lack of understanding of mental health conditions compounded by the stigma attached to mental illness can deter the parents from seeking professional help.
- **Need for culturally sensitive services:** Developing risk based culturally sensitive and responsive care pathways are important to meet the needs of Luton's diverse population, particularly where issues of consanguinity, low birth weight, late presentation to services and lifestyle can be addressed. Whilst there are local voluntary groups working to meet some of this need, views were expressed that mainstream services could be more culturally responsive and aim to remove barriers to access.
- **Consanguinity** - Stepping Stones staff raised the issue that a large proportion of children born with congenital disabilities are from south Asian communities. They suggest that a lack of knowledge and understanding of consanguinity can leave women feeling solely responsible both for "causing" the disability and for the care of the child. The isolation

and stigma the women experience can affect their mental wellbeing and the needs of the siblings of such a child.

- **Children with life limiting conditions:** Work undertaken by the local authority and tPCT found that women from the Bangladeshi and Pakistani communities, were at particular risk of poor mental health after giving birth to a child that was later diagnosed as having a lifelong/ life limiting conditions. These women felt they had little or no access to mental health services.
- **Crisis management** - the view was expressed that there is a crisis approach to supporting vulnerable families / women in Luton and there is a need for it to be better planned.

5. Key findings

The previous chapters have highlighted specific findings, issues and potential areas for improvement or further investigation which were identified through analysis of available data, review of services and interviews with stakeholders. This section considers all of this evidence and highlights the key themes which have emerged.

Committed workforce

Interviews with a range of planners, managers and service providers were undertaken in the course of this work. These highlighted that there are a range good services across the pathway and people work hard to support and provide care to women and their families. All participants recognised the importance of this topic; they also recognised that some change and development is required, and contributed many ideas about what was needed.

Numbers, prevalence and complexity

Given the high proportion of women aged 15 – 45 in Luton and the relatively high fertility rate, services can expect to see large numbers of clients with a perinatal mental illness. Add to that the high prevalence linked to social deprivation and the likelihood of higher numbers of complications associated with women who do not speak English well or who are coming into contact with services for the first time, it is likely that Luton services experience significant demand on their time. The complexity point is borne out by the new Maternity services PbR data where a high proportion (more than 50%) of Luton women receive intermediate or intensive support.

Management and strategy

Recent guidance literature is clear that effective management and support begins with having a perinatal strategy in place that has been developed by and is owned by a multi-disciplinary group and is monitored and reviewed by a senior level body that meets routinely. It was not clear to the authors whether perinatal mental illness was routinely discussed in a management forum and there does not appear to be a single multi-agency planning and management body with a specific focus on perinatal mental illness. There is not a perinatal mental health strategy for Luton

and the authors were not aware of a regional level strategy or planning body that Luton is part of.

Care pathway

Guidance literature highlights that effective perinatal mental health care follows a care pathway. Luton has perinatal mental health care pathways to cover serious mental illness, crisis intervention and mild to moderate mental illness. These are based on evidence, developed across agencies and identify individuals with management responsibility. Although the care pathways document key relationships within the health sector, it appears unlikely that it is well known and used outside the maternity unit and Adult Mental Health services. This is particularly an issue for the mild-moderate pathway, where a range of universal agencies have a role. As it was not possible to access referral, treatment or outcome data for women it was not possible to assess how well the care pathways are working. There would be value in reviewing the care pathways, broadening their remit and identifying a process to routinely audit their effectiveness.

Data and monitoring

A number of services could not provide detailed service data relating to perinatal mental illness. This included maternity services (good detail on identification but not on treatment or outcome), adult mental health, mother and baby unit, general practice, health visiting, talking therapies (service undertook manual trawl to provide data) and Children's Centres. This suggests that services are not routinely using data to monitor effectiveness for this client group. This paucity of data needs to be addressed. There are recognised issues with recording at a national level where data on pregnancy and early motherhood is not routinely collected in mental health minimum data set. These are beginning to be addressed but local action is also required to enable the use of data within service monitoring and improvement.

Focus on mother and baby

Current services in Luton respond to the mental health needs of the mother (e.g. adult mental health) or the risk to the child (e.g. CAMHS, social services). A disadvantage of this approach is a lack of a systematic understanding of the whole picture, i.e. not just the patient but her relationship with her child and also the

influences on her, including those that are protective. An admission to the local mental health facilities means that women are separated from their baby, and IAPT and Talking Therapies services (even those specifically for pregnant/postnatal women) are not equipped for the child to attend and are not trained to consider the context of the family and the relationship between mother and child. It appears that currently only some social support type services meet needs of mother / child / family together. National guidance stresses the value of considering the mother-baby relationships and working to ensure there is every possibility of bonds forming. However, it is also important to note that some local stakeholders raised the concern that a focus on the relationship between mother and baby may increase maternal worries about child removal.

Perinatal specialism

There is no specialist perinatal mental health team (or individuals) or parent-infant mental health team in Luton and neither CAMHs or AMH have a specific brief to undertake parent-infant work. National guidance stresses the value of having specialist roles in perinatal mental health and representatives of local adult mental health, CAMHs, maternity services and GPs all expressed the desire for there to be staff with such a specialism in Luton. Given the size of the population in Luton, it may be that any such development requires regional agreement or shared commissioning arrangements. What may be possible is that there are certain posts within existing teams that could take on this specialism. For instance there was a suggestion that there could be two midwives with a special interest in perinatal mental health, and also that there could be a number of primary care link workers with this special interest.

Differences in perinatal mental illness by ethnicity

The rate of identified mental health issues in Luton was low for some ethnic groups (Indian, Black African, Other White, Bangladeshi and Pakistani) and highest for Mixed and White British women. Also, a low proportion of women accessing talking therapies were Non-White British. There has been some suggestion that women from some ethnic groups have greater than expected resilience and also that within some communities there is stigma associated with mental illness and because of that some women may not acknowledge their need. However, it is important to

stress that the reasons for these ethnic differences are not yet well understood. This local data supports the emerging national evidence that women from some ethnic groups have unmet need and are not well served by mainstream services. If women from some ethnic groups prefer community-based models, it may be that greater emphasis should be placed on creating care pathways in which non-statutory agencies are more formally integrated into mainstream services. It is also vital to improve data collection around ethnicity so that these differences can be better understood.

Geographic differences in perinatal mental illness

Across the Borough there was some geographical variation. Women in Biscot and Lewsey wards had less perinatal mental illness identified than expected. Northwell, Round Green, Leagrove, Stopsley, Sundon Park and Limbury wards had more illness identified than expected. Some of this variation may be explained in part by the ethnic differences discussed above (Biscot in particular is a very diverse ward). The geographic patterns did not show the expected relationship with socio-economic deprivation (you would expect higher prevalence in more deprived areas given that socio-economic variables are key risk factors). This could indicate that there is unmet need in some areas or particular groups.

Hard to reach groups

Interviews with stakeholders identified key local groups viewed at particular risk of not accessing services: women living in traveller communities, women who have recently arrived in Luton (such as immigrants from Eastern Europe or people seeking asylum) and women for whom English is not their first language. Views were expressed about the challenges of providing appropriately for these women and, in some cases, the need for more resources to do so (e.g. language support). Concerns were also raised of high risk of perinatal mental illness among mothers giving birth to a child with life-limiting conditions, in particular mothers from South Asian communities. There was also recognition that women in particularly vulnerable situations (such as those seeking asylum) may have other concerns which feel more of a priority than mental health. Given evidence that these groups are at particular risk of experiencing mental illness, it is important that their mental health needs at not overlooked. Concerns were expressed about the situation worsening for the

more vulnerable among these groups because they do not receive support, others expressed the expectation that recent increased enforcement of payment for maternity and other services will lead to there being more difficulties. Cultural factors and the fear of stigma of mental health may prevent women from these groups engaging with mainstream services. Some agencies in Luton provide services specifically targeted at such groups but whether there is capacity to meet need is not clear. It is important that trusted relationships and routes of referral are in place so that these women can engage with mainstream support when needed.

Continuity of care and information sharing

The review of services highlighted there were many agencies working to prevent, treat and identify perinatal mental illness in Luton. There were examples of these agencies working well. However, some concerns were also raised. The Social Care Child Support team suggested they are reliant on AMH services for monitoring the progress of mother in relation to their concerns for the child and that there are some difficulties in this. GPs expressed the wish to be informed about all 'cause for concern' forms raised about their patients. Children's centres too believed they could do their work better if 'cause for concern' type information was shared. If information sharing protocols could be agreed this may improve continuity of care for women and increase opportunities to prevent, identify or intervene. Social support organisations also expressed the wish to improve continuity of care through involvement in step down planning so they can develop support packages ready for when psychiatric or psychological interventions come to an end.

Postnatal care

Although there are many services supporting women during the perinatal period the effectiveness of care during the postnatal element was less clear. Some of this concern is linked with the lack of data on treatment and outcome that enables assessment but both midwives and obstetricians expressed concern about lack of support for women once they are discharged from maternity services. The Health Visiting team is currently very short-staffed and, although vulnerable groups are being targeted, they are unable to fulfil all monitoring and treatment requirements in relation to mothers with mild to moderate mental illness. This gap may be filled by GPs but those interviewed suggested that they had limited knowledge of their

patients with mild to moderate mental illness during the perinatal period. Postnatal referral to talking therapies is also dependent on the GP which may suggest there is risk that women do not access services they require.

Education and training

The need for training in the knowledge and skills to recognise and treat perinatal mental illness emerged as a common theme across interviews with stakeholders. Appropriate training can help ensure early identification of those women at high risk and provide an understanding of: the maternity context, the additional clinical features and risk factors associated with perinatal disorders, and the developmental needs of infants.

Prevention and holistic approach

Across the Luton stakeholders there was consensus view that targeted primary (e.g. pre-birth parenting skills) and secondary (e.g. crisis support or family key worker) prevention is required. Whilst there are several good examples in Luton, some of these services lack capacity and views were expressed that there is a 'crisis approach' to supporting vulnerable women. Mothers with mild /moderate mental illness are often part of a vulnerable group where other factors such as domestic abuse, social isolation and financial difficulties are likely to be part of the picture. Although many services do already support women at this difficult time it may be that there needs to be a referral route to ensure that support reaches those that need it most.

Psychological therapies

There are a range of psychotherapy services available to women across the perinatal period, including a dedicated antenatal service and general services targeted at particular ethnic groups. The provision of a new IAPT service with a longer intervention presents an opportunity to support more complex cases. However, there are issues to consider. It appears that none of the services have practitioners trained to deliver evidence based parent-infant interventions. The antenatal service data shows that generally those that complete the intervention benefit but that the completion rate is 21%. There should be consideration of how to support women to complete this 6 week intervention. It has not been possible to identify post natal

referrals, which should be addressed; what is known is that referrals are by Luton GPs only which excludes some Luton women from the service. Some national level evidence suggests that as many as 27% of IAPT clients are women during the perinatal period, if this is the case locally it is important that the service is able to meet the needs of these women (i.e. cater for the child as well as the mother).

6. Recommendations

These are broad recommendations to be considered at a strategic level. The section outlining the service contained other specific suggestions raised by interviewees.

1) Develop perinatal mental health strategy/network - there are a number of areas for Luton to consider when thinking about how to maintain and develop perinatal mental health services. Some are possible now at little cost where as others may require the development of a business case. Agreeing a strategy will ensure that priorities are shared and development timeframes are understood. With many different agencies, services and providers involved a system is required to maintain integration and collaboration. There should be a managed network made up of stakeholders to ensure delivery of strategy, functioning of the pathway and allow for development and innovation.

2) Audit existing care pathways and consider widening scope- having the care pathways in place is an excellent way to ensure high quality evidence based care. However, the effectiveness of parts of the existing pathway does not appear to be known, an audit should address this and identify areas for improvement. There may also be benefit in broadening the pathway remit to include child social care teams and those that contribute to social support and lower level psychosocial interventions, i.e. agencies such as Children's Centres, Stepping Stone, MIND, and Relate. There may also be value in ensuring all those who play a role in care delivery know of the care pathway and deliver to the standards within it, this may be particularly relevant to primary care.

3) Focus on the relationship between mother and baby

Regardless of any service developments that may occur, within existing services there should be consideration of how to increase the focus on the relationship between mother and baby.

4) Consider establishing a community perinatal mental health team and / or parent-infant mental health team or developing specialised roles - recent guidance suggests all areas should have a specialised community perinatal mental health team. The 3500 maternities per year in Luton may mean this is not feasible for Luton alone and therefore consideration of commissioning jointly with neighbours or within the clinical network may be required. An

alternative may be to develop specialism through implementing one or more of the following locally made suggestions:

- Have 1-2 midwives with perinatal mental health as a specialist role (each would have a case load and also offer advice to a range of professionals and provide training).
- Provide joint clinics between maternity and AMH (two sessions per month would make a difference, preferably the psychiatrist would have a perinatal interest).
- Further involve the CAMHS team to provide specialist input and increase planning focus on the needs of the child and the mother-child relationship.
- Develop the primary care link worker role with a specialist interest in perinatal mental health.
- Develop perinatal mental illness education and training programme for non-specialists involved in the care of pregnant and postpartum women such as general psychiatric teams, GPs, midwives, Health Visitors and IAPT workers.

5) Review psychological interventions – these services are key to the mild to moderate care pathway. Of particular importance is the delivery of evidence based interventions for both mother and baby. A service review may consider:

- Making perinatal mental illness training available to practitioners
- Making service appointments flexible enough to allow the child to be in attendance
- Amend data collection to record pregnancy / early motherhood
- Add/amend referral pathway so all post natal women in Luton can access services
- Consider how to increase completion rate of antenatal intervention.

6) Investigate disparity between expected prevalence and service uptake among BME group – available data suggests that Indian, Black African, Other White, Bangladeshi and Pakistani women in need are not being identified by services. The reasons for this disparity should be investigated. It may be that more alternative services (such as community services or voluntary groups) are required to meet this need of there needs to be greater integration with mainstream services. It is also vital to improve collection of data about ethnicity in some services (e.g. talking therapies) so that the picture is complete.

7) Review social support type initiatives and interventions – there are many organisations working hard to support women with perinatal mental illness or who are vulnerable and at

risk. There are a number of elements worth considering when assessing key service element and how best to provide support:

- Is there sufficient capacity within the current range of providers?
- Could improving integration with mainstream services, communication and data sharing help providers meet needs well? Could service outreach be part of this model?
- Is there capacity / willingness across providers to adopt the key-worker approach for the most vulnerable?

A good start point for this work is to use the National Collaborating Centre for Women's and Children's Health Guidance, 'Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors' (2010) as a start point to this process.

8) Improve data collection, monitoring and sharing - there should be a robust system for measurement of services use and outcomes to inform all involved in the pathway. Some specific suggestions for information sharing were identified, such as Cause for Concern information being shared with primary care. Ensuring there is appropriate data collection and the capacity to use this data to inform pathway monitoring and development should be a priority as work moves forward. Some of the analysis contained within this report can serve as a baseline position and can be updated over time to monitor future trends. It is also important to be pragmatic about what data collection is possible and recognise that some gaps will be addressed at a national level.

Appendix 1

Luton and Dunstable Hospital NHS Foundation Trust

Title	**Perinatal Mental Health guideline**
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Version Number	3
Name & Date of Previous Document (if applicable)	None Perinatal Mental Health Policy. Version 2 March 2011
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Staff with overall responsibility for development implementation and review	Kathy Waller, Consultant Obstetrician and Gynaecologist
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Associated Trust Documents	Management of drug and alcohol use in pregnancy. Recognition and management of Domestic abuse in pregnancy. Safe guarding in maternity. Maternal care pathway and risk assessment.

LUTON AND DUNSTABLE HOSPITALS NHS TRUST

PERINATAL MENTAL HEALTH POLICY

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AIM

To provide evidence-based guidance for the multidisciplinary team in the prediction, detection and management of women with mental health disorders during pregnancy and the postnatal period.

INTRODUCTION

The majority of women who develop mental health problems during pregnancy or following delivery suffer from mild depressive illness, often with accompanying anxiety. With appropriate management the prognosis is good. However if untreated there can be prolonged morbidity. This can have adverse effects on the mother – infant relationship and on the later social, emotional and cognitive development of the child.

The last three confidential enquiries into maternal death highlighted the serious implications of severe mental illness in pregnancy and the postnatal period. Many of the women had previous psychiatric illness. The causes of death included suicide, overdose of drugs of abuse (including alcohol), violence and physical illness. Some children also came to harm. These findings underpin the need for prediction / early detection of psychiatric illness, effective treatment and collaboration between agencies and services.

In view of the importance of both mild/moderate and severe psychiatric disorders and certain differences in their management, this guideline has outlined different care pathways for these disorders.

EMOTIONAL CHANGES AND MENTAL DISORDERS IN PREGNANCY AND THE POSTNATAL PERIOD.

All types of mental (psychiatric) disorders can complicate pregnancy and the postnatal period. These can present for the first time or as a recurrence or relapse of a pre-existing condition. However some disorders deserve special attention because of their increased incidence, seriousness or distinctive clinical presentation and course. These are discussed below. In addition certain emotional and behavioural changes which are essentially normal are discussed because they may be misdiagnosed as an illness or mental disorder.

'BABY BLUES'

- This is a brief episode of misery and tearfulness that affects at least half of all women following delivery. It is due to emotional and behavioural changes which occur between days 3 and 5. The changes are essentially normal and self-limiting.
- It typically lasts for about 48 hours but can recur periodically over the next 6-8 weeks.
- The symptoms generally pass with rest, support and reassurance.

ANXIETY DISORDERS

- These are affective (mood / emotional) disorders in which anxiety or fear interferes with normal functioning.
- Common categories include panic disorder, post-traumatic stress disorder and obsessive compulsive disorder.
- Many women suffer from either new onset or worsening of existing anxiety disorders during pregnancy and postnatally.
- The occurrence of an anxiety disorder during this time has important consequences. It not only impacts on the woman's mental health but also increases the risk of other postnatal disorders like depressive illness.

DEPRESSIVE ILLNESS

- An affective (mood / emotional) disorder where there is a lowering of mood (sadness), reduction of energy and decrease in activity.
- In the mild episode it is possible to continue with most activities while in moderate depression there is great difficulty in continuing with ordinary activities. Severe depression is associated with loss of self esteem and ideas of worthlessness.
- May present antenatally for the first time or as a recurrence especially if antidepressant therapy has been discontinued. May also develop in the postnatal period (often referred to as postnatal depression).

Postnatal depressive illness

- The symptoms are the same as at other times.
- The mild / moderate form develops gradually usually manifesting 3 months or later after childbirth.
- Severe postnatal depressive illness has an early onset but develops gradually usually manifesting 4-6 weeks postpartum or later.
- With appropriate management both types should improve within weeks while untreated cases could result in prolonged morbidity.
- The term 'postnatal depression' should not be used as a generic term for all mental illness following delivery. This can lead to misdiagnosis as depression may be due to other disorders like puerperal psychosis.

PUERPERAL PSYCHOSIS

- An acute illness with psychotic features – a disconnect from reality. The features include delusions, hallucinations and perceptual disturbance. In addition there is abnormal behaviour and mood is disturbed varying from profound depression to elation or irritability (bipolar nature).
- The risk with a previous history of either puerperal psychosis or bipolar illness is 1:2 while the risk with a family history of bipolar illness is 1:3.
- Arises within a defined period after birth; 50% within the first week, 75% within the first 6 weeks and 90% within 90 days.
- Puerperal psychosis can be mistaken for 'Baby Blues' because both occur in the first postpartum week and initial symptoms are similar. It is important to distinguish between these two conditions. The 'Blues' quickly respond to reassurance and support in 24-48 hours while puerperal psychosis will deteriorate over the same period. Postnatal depressive illness has gradual onset and manifests much later in the postnatal period. It is important to exclude organic causes for the symptoms by careful physical examination.
- With appropriate treatment, the majority of women with puerperal psychosis will recover fully although they may need to continue medication for some time and there is a high rate of recurrence at another time in their life.

DISTINGUISHING BETWEEN SEVERE AND MILD / MODERATE MENTAL ILLNESS.

This distinction is made because of certain differences in their management (Appendices 1-3). However it may on occasion be difficult to make clear distinction between moderate and severe illness. In these cases the illness should be regarded as severe subject to review by the psychiatrist.

SEVERE MENTAL ILLNESS.

This is difficult to define. However it is important to distinguish this from other mental health problems so that it is clear who can receive specialist mental health care from secondary services in addition to primary care services. A woman's mental illness should be considered severe if:

- She suffers substantial disability as a result of her illness, such as inability to care for herself independently or sustain relationships or work.
- She is currently displaying florid symptoms or suffering from a chronic enduring condition.
- She has suffered recurring crises leading to frequent hospital admissions or interventions and/or places a significant burden on her informal carers.

- On occasion she poses significant risk to her own health or safety or to that of others due to relapse even if she is well and capable for much of the time.

MILD / MODERATE MENTAL ILLNESS.

In comparison with severe mental illness, the woman with mild / moderate mental illness does not have florid symptoms, can cope with some or most of her day to day activities and does not pose a significant risk to herself and others.

MANAGEMENT OF MENTAL ILLNESS

The management of mental illness involves the following:

1. Prediction - the use of risk factors to identify women who may become mentally ill.
2. Detection – identification of women with current mental health disorder.
3. Assessment /Referral – to relevant health professionals and agencies.
4. Development of an individual management plan where appropriate.
5. Stepped / Tiered mental health care model.
   - Mild and moderate mental illness (Appendix1).
     (i) Assessment.
     (ii) Guided self help.
     (iii) Psychological interventions.
     (iv) Medication (Pharmacological treatment)
     (v) Combined treatments.
     (vi) Social support.
     Management team (Consists of the GP, Midwife, Health visitor, Obstetrician, Psychologist).

   - Severe mental illness (Appendices 2&3).
     (i) Complex assessments.
     (ii) Complex psychological interventions.
     (iii) Medication (Pharmacological treatment).
     (iv) Combined treatments.
     Management team (Consists of the GP, Midwife, Health visitor, Obstetrician, Psychologists, Psychiatrist / mental health team).

The care pathway for women with mild and moderate mental illness is illustrated in appendix 1 and for women with severe mental illness in Appendices 2 and 3. The key management issues illustrated above are incorporated in the pathways and the responsibilities of different health professionals in the care of these women are discussed below.

ANTENATAL PERIOD

General Practitioners

- General practitioners and community midwives should ensure that all relevant information concerning a woman's current or previous psychiatric history is included in the referral letters to the booking clinic.

- If a woman has recently moved area, and no psychiatric or GP records are available, these should be requested by the general practitioner and information passed to the obstetrician.

- If the midwife, health visitor or the woman has concerns, the woman should be referred to the GP for further assessment if an earlier antenatal appointment cannot be arranged with the obstetrician or the woman presents postpartum in the community.

Midwives

- Women with mental health problems should receive the support and advocacy of a known midwife throughout their pregnancy.

- The midwife taking the booking history or any professional who is first contact with the woman in the antenatal or postnatal period must ask questions to identify current mental illness and predict future illness (appendices 1 and 2). Certain risk factors should increase vigilance for possible mental illness (Appendix 4) Interpreters should be provided for women who do not speak English.

- Women should also be asked questions to identify possible depression in the antenatal and postnatal period (usually at 4-6weeks and 3-4 months): Appendices 1 and 2;

  – During the past month, have you often been bothered by feeling down, depressed or hopeless?

  – During the past month, have you often been bothered by having little interest or pleasure in doing things?

  A third question should be considered if the woman answers 'yes' to either of the initial questions
  - Is this something you feel you need or want help?

- Questions should be asked to identify anxiety or panic disorders:
  - Do you have episodes of anxiety, panic attacks, irritability, poor concentration / sleep and do you want help? (Appendix 1).
- Information should be sought from all women about alcohol, tobacco and drug misuse as well as history of domestic abuse.

- The midwife must refer all women with previous or current mental health problems to the consultant antenatal clinic. Women with problems of tobacco use, alcohol or drug misuse, domestic abuse or safe guarding issues should be referred to the appropriate services (Appendices 1 and 2).

- The midwife should refer women who present with mental health crisis in the community to the psychiatrist (Appendix 2).

- The obstetric consultant and GP should be informed by the midwife if the woman fails to attend two or more consecutive appointments with any of the services involved in her care.

Obstetricians

- All women with significant previous or current mental health problems should be assessed by or reviewed with the obstetric consultants with special interest in perinatal mental health at the antenatal clinic. The obstetrician should request for detailed medical history from the GP and previous hospital records if these are not available in the antenatal clinic. Women with mild/moderate mental illness can be referred to any obstetric consultant clinic.

- When there is a past history of serious mental illness or uncertainty about the severity of the illness, the woman should be referred by the obstetrician to the psychiatrist for assessment and care plan (Appendix 2).

- Women with mild / moderate previous or current mental health illness should be managed as outlined in Appendix 1. Women with previous or current severe mental illness should be managed as illustrated in Appendices 2 and 3.

- The obstetrician should ensure that women with problems of tobacco use, alcohol or drug misuse, domestic abuse or child protection issues are referred to the appropriate services (Appendices 1 and 2).

- The obstetric consultant should ensure good communication with the psychiatrist, general practitioner, community midwife together with any other health professionals involved with the woman's care.

- A written care plan covering pregnancy, delivery and the postnatal period should be developed for pregnant women with a current or past history of severe mental illness.

- The care plan should preferably be developed at the booking visit in the consultant's antenatal clinic, in collaboration with the woman, her partner, family, carers and relevant health care professionals. The plan should be recorded in the handheld and hospital notes and the neonatal unit informed.

- A management plan should also be written for women with previous or current mild /moderate mental illness to address issues of concern.

Psychiatrists

The psychiatrist's input in the care plan for women with severe mental illness should include the following;

- Diagnosis.
- Therapy /Medication (including risks, benefits and consideration of breast feeding).
- Follow-up during antenatal period.
- Contingency and crisis plan.
- Any specific plans during labour.
- Risk of Relapse postpartum.
- Follow-up and management postpartum including possibility of care in a mother-baby unit.

Contact details of Psychiatrists are available in Appendix 4.

SAFEGUARDING

- This is everyone's responsibility. For all women with significant psychiatric illness a cause for concern form (information sharing form) should be completed by the midwife. Referral should be made to Social care if there are concerns about the woman's ability to take care of the unborn child and the Safeguarding midwife should be informed.
- Discharge plans for the baby should be documented in the maternity record.

INTRA-PARTUM PERIOD

When the woman is admitted in labour the woman's mental health issues should be noted by her midwife. She should be reviewed by the obstetric team and managed according to the care plan.

Women with past or current history of severe mental health problems are not suitable for early discharge and should be admitted to the ward after delivery.

The midwife transferring the woman to the postnatal ward should ensure handover of information about mental health issues to staff on the postnatal ward.

POSTNATAL PERIOD IN HOSPITAL

Any postnatal woman with mental health concerns must be reviewed by the obstetric team. Management should be according to the care plan. Referral to the psychiatrist may be required from the postnatal ward – see appendix 2.

The woman's mental health issues must be included in the postnatal discharge summary to alert the GP, community midwife and health visitor.

The community midwife and health visitor must be alerted about mental health concerns by telephone by the midwife on the ward discharging her. The psychiatrist / community mental health team (CMHT) must be informed when a woman with history of severe mental illness is discharged home even if she is asymptomatic at the time of discharge.

Plans made during the antenatal period and hospital postnatal period must be put into place before discharge.

1. Check women aware of date of psychiatric outpatient appointment and explain importance of attending.
2. Check extended midwifery care in place if required
3. Check client aware of contact details of community psychiatric nurse / CMHT if required.

Some women will benefit from an extended postnatal stay for further evaluation, which should be planned in advance. Women with a past history of psychosis, whether pregnancy related or not, have a 30% recurrence risk. It may be necessary for them to stay for 7 – 10 days.

MENTAL HEALTH CRISIS

The management of the woman presenting in mental health crisis (such as acute psychosis) in hospital or the community is illustrated in Appendices 2 and 3.

Psychosis arising in the perinatal period is a serious condition.
Until assessment is complete the patient should not be allowed to leave the Hospital and can be detained under common law or Section 5.2 of the Mental Health Act.

The psychiatrists should urgently be called to make appropriate arrangements as acute psychosis is **unpredictable and will therefore always require admission** under the care of the psychiatrists to reduce the risk of harm to mother and baby.

The woman's own consultant obstetrician should be informed and should ensure that appropriate action is taken to ensure the safety of the woman and her baby.
When the woman presents in the community the Crisis Resolution Team can be contacted by the midwife and the GP should be informed. An acutely psychotic patient should not be left alone particularly with young children because of the potential risk of harm to herself and the children.

CONTRACEPTION

This should be discussed with all women. Those with serious mental health problems are more at risk of unplanned pregnancy in general and careful discussion should take place so that the woman leaves the postnatal ward with a method in place.

TREATMENT WITH PHARMACOLOGICAL AGENTS

The following principles should guide the practice of clinicians treating women in pregnancy or the postnatal period:

- The balance of risks and benefits of pharmacological treatment should be discussed with the woman. This may favour the provision of psychological treatment instead, particularly in the first trimester.
- The woman's views, wishes and previous treatment response should guide treatment decisions.
- Drugs with the greatest evidence of safety for mother and fetus/infant should be considered first (Appendix 6).
- Monotherapy should be used in preference to combination therapy. The lowest effective dose should be used and an appropriate time allowed for response before increasing the dosage.
- When changing medication because of risks, this must be balanced against the disadvantages of switching.
- Where possible suitable treatment options should be found for women who wish to breastfeed rather than recommend avoidance of breastfeeding (Appendix 6).

ADOLESCENTS

Healthcare professionals working with adolescents experiencing a mental disorder during pregnancy or the postnatal period should:

- Contact the child and adolescent mental health services (CAMHS) on 01582708140.
- Obtain appropriate consent, bearing in mind the adolescent's understanding (including Gillick competence), parental consent and responsibilities, child protection issues, and the use of the Mental Health Act and of the Children Act (1989).

STAFF TRAINING

This is as outlined in the training needs analysis.

AUDITABLE STANDARDS

1. Questions asked to identify women who have a current medical health problem or who are at risk of developing a mental health problem during the antenatal period.
2. Questions asked to identify women who are at risk of developing a mental health problem or getting worse from a pre-existing mental illness during the postnatal period.
3. Development of an individual management plan for women with past or current severe mental illness.
4. Staff attendance at training programmes (as identified in the staff training needs analysis).

The process for monitoring compliance with the guideline by audit of the above standards is outlined in the document" Maternity Guidelines Auditable Standards."

REFERENCES:

1. Colon O and Lynch J. Maternal depression: risk factors and treatment options during pregnancy. The Obstetrician and Gynaecologist. 2008;10(3):145-150.

2. Confidential Enquiries into Maternal Deaths in the United Kingdom. (2001). Why Mothers Die 1997-1999. The fifth report of the Confidential Enquiries into Maternal Deaths in the United Kingdom. Available at www.cmace.org.uk

3. Confidential Enquiries into Maternal and Child Health. (2004).Why Mothers Die 2000-2002 The sixth report of the Confidential Enquiries into Maternal and Child Health in the United Kingdom. Available at www.cmace.org.uk

4. Confidential Enquiries into Maternal and Child Health. (2007) Saving Mother's Lives: Reviewing maternal deaths to make motherhood safer – 2003-2005. London: CEMACH. Available at: www.cmace.org.uk

5. National Institute for Health and Clinical Excellence. (2007). Antenatal and Postnatal Mental Health. London: NICE. Available at: www.nice.org.uk

6. National Institute for Health and Clinical Excellence. (2007) Management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. . London: NICE. Available at: www.nice.org.uk

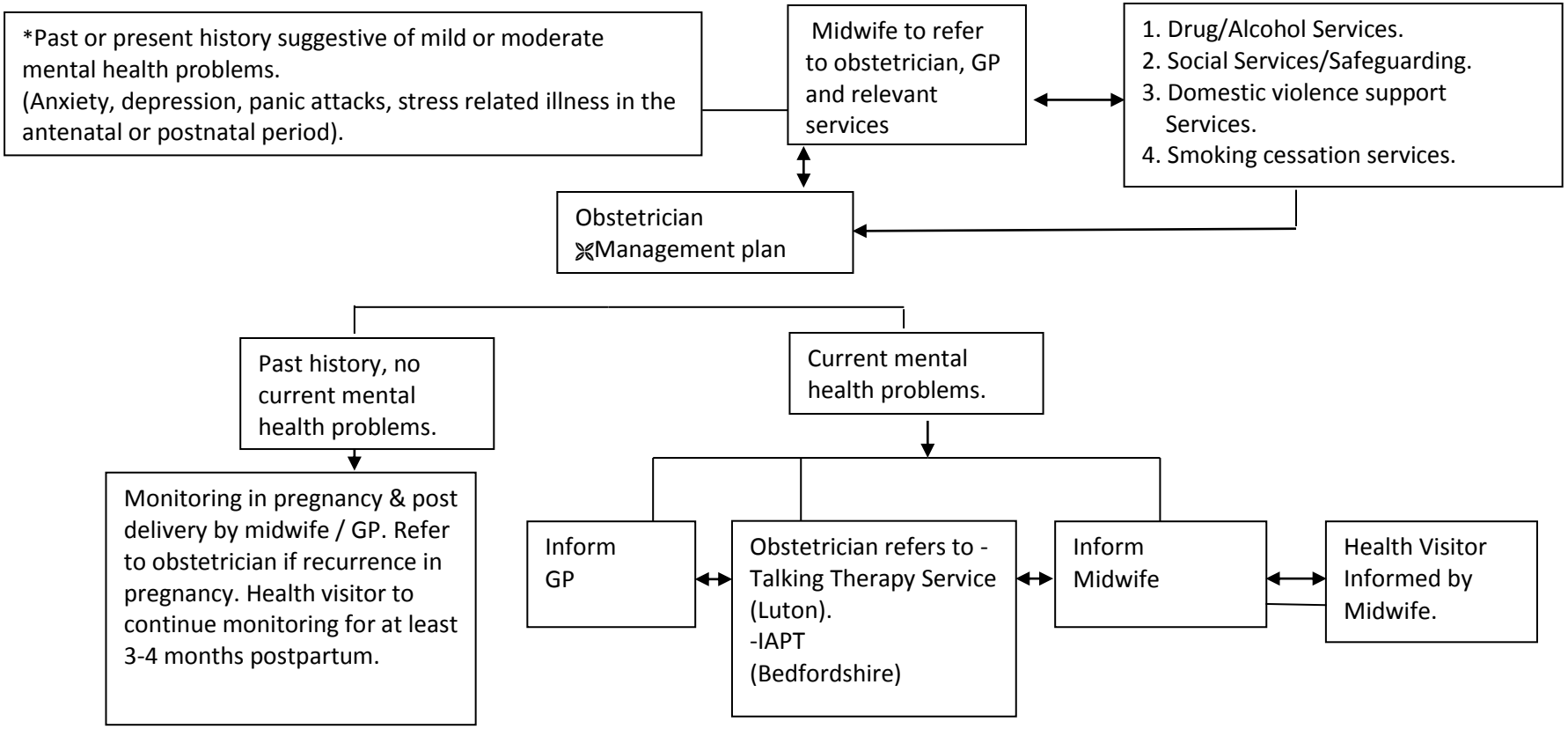
7. Oates M. Postnatal affective disorders. Part 1: an introduction. The Obstetrician and Gynaecologist. 2008; 10(3):145-150.

8. Oates M. Postnatal affective disorders. Part 2: prevention and management. The Obstetrician and Gynaecologist. 2008; 10(4):231-235.

9. Royal College of Obstetricians and Gynaecologist. (June 2011). Management of Women with Mental Health Issues During Pregnancy And The Postnatal Period. Available at: www.rcog.org.uk

APPENDIX 1

MILD AND MODERATE MENTAL HEALTH CARE PATHWAY



If mental health problems become severe, follow flow chart for severe mental health care pathway.
⌘ Management plan developed following consultation with other professionals involved in patient's care.
*See guideline text on questions to identify current depression and anxiety and appendix 4 on risk factors for future illness.
Key; IAPT (Improving Access to Psychological Therapies), CMHT (Community Mental Health Team).Tel. 01525 636980.

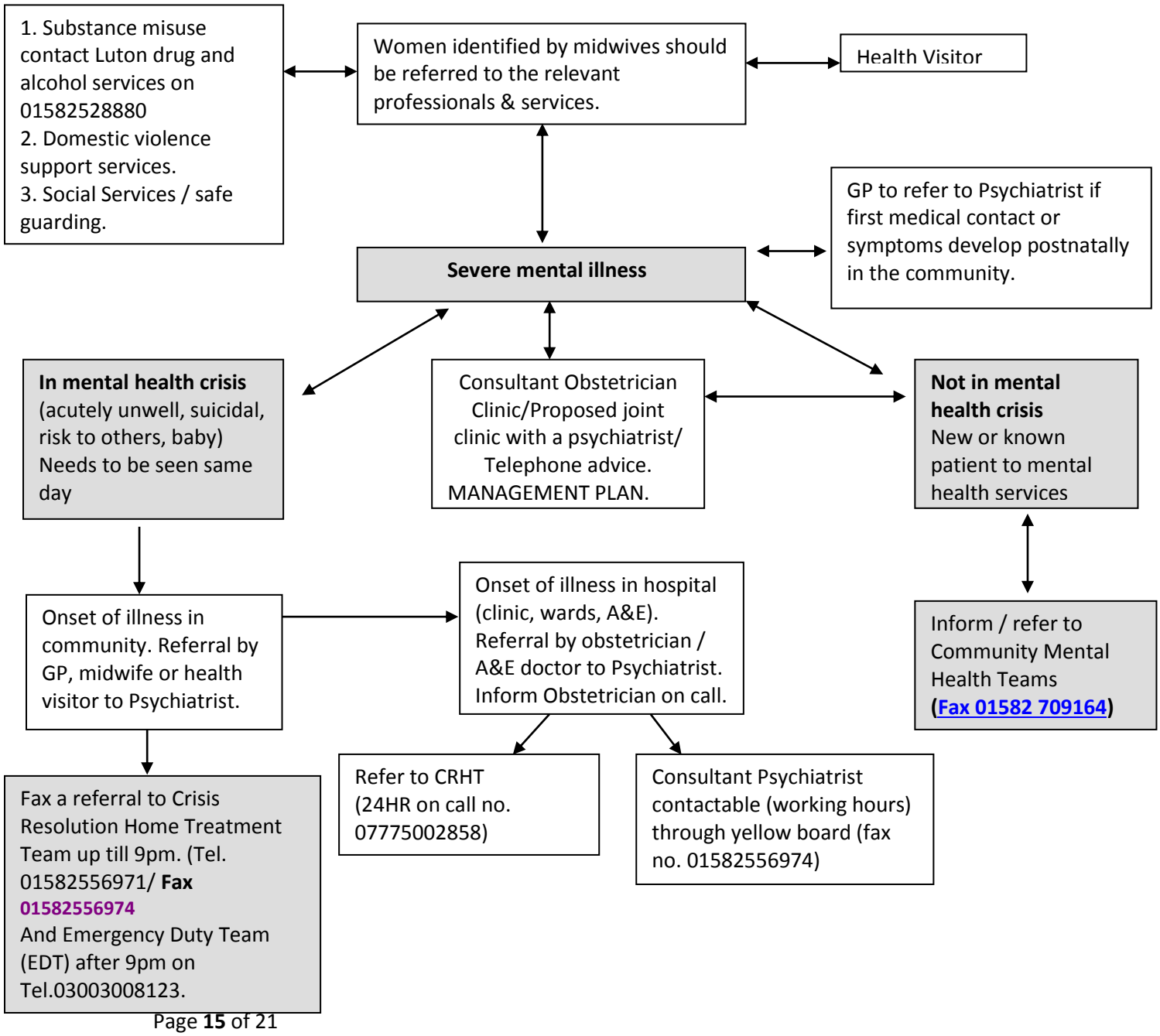
APPENDIX 2.

SEVERE MENTAL HEALTH CARE PATHWAY

At first contact with women in both the antenatal and postnatal periods, healthcare professionals should ask questions about:

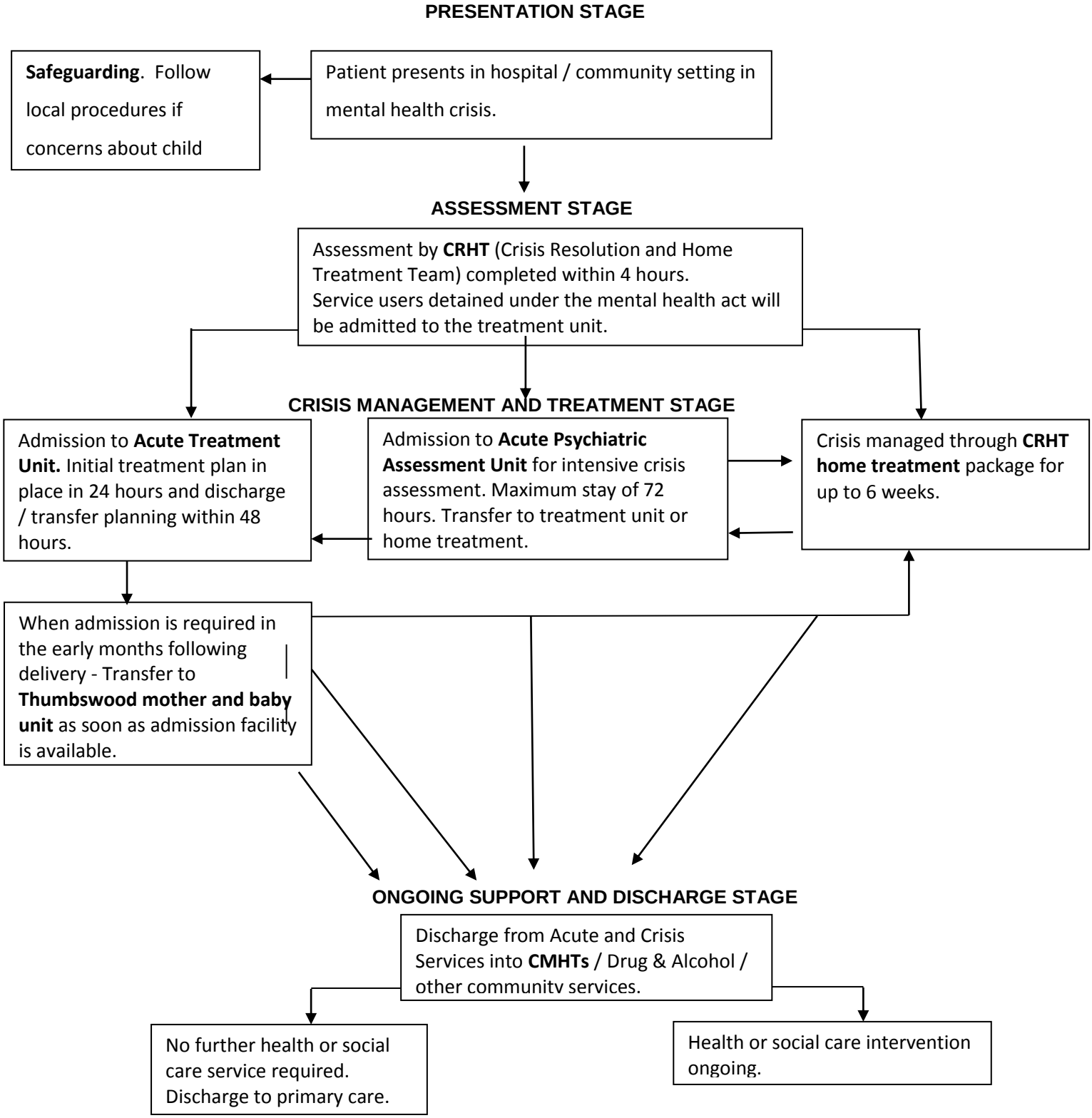
- Past or present severe mental health illness including schizophrenia, bipolar disorder, severe depression and psychosis in the postnatal period.
- Previous treatment by a psychiatrist/specialist mental health team.
- A family history of perinatal mental illness.
- Mental health symptoms.

Women should be referred by the GP or Obstetrician to CMHT (Community Mental Health Team) or CRHT



APPENDIX 3

***CARE PATHWAY FOR ACUTE & CRISIS SERVICES**



*Adapted from Acute and Crisis operational policy and care pathway (2009) - Bedfordshire and Luton mental health and social care partnership NHS Trust.

APPENDIX 4

RISK FACTORS FOR CERTAIN MENTAL HEALTH DISORDERS.

Post natal depressive illness
Depressed mode or anxiety during pregnancy
Poor social support
Adverse life events
Poor marital relationship
Psychiatric history including depression

Psychosis
Previous bipolar illness or psychosis.
Schizophrenia.
Schizoaffective disorder
Family history of psychosis

Post traumatic stress disorder (in the postnatal period)
Perceived low control in labour
Low levels of support from partners and staff**.**
Patterns of blame.

The findings from epidemiological studies indicate that enquiry about a previous severe mental illness is important to identify women with an increased risk of puerperal psychosis or relapse of severe mental illness.

Several risk factors have been identified that may be associated with the development of depression in the postnatal period. However a validated reliable prediction tool has not yet been developed for routine clinical assessment and these factors should not be used to predict future illness. This does not mean that
healthcare practitioners should take no interest in these factors.

APPENDIX 5: CONTACT DETAILS OF MENTAL HEALTH AND ALLIED SERVICES.

CONSULTANT	SECRETARY	BASE	POSTCODE	SERVICE
Dr Muthiah	01582 538614	Calnwood Court	LU1 & LU2 (East Luton)	CMHT
Dr Pillai	01582 709153	Calnwood Court		Inpatients
Dr Patel	01582 709162	Calnwood Court	LU3 & LU4 (West Luton)	CMHT
Dr Samuels	01582 657505	Robin Pinto Unit		Secure unit
Dr Hussein	01525 751133 fax 01525 751134	Crombie House	Leighton Buzzard	CMHT
Dr Shah	01582 709200 fax 01582 709201	Beacon House	Dunstable Houghton Regis	CMHT
Dr Karale	01582556979 (5979) Fax 01582556974 (5974)	Lime Trees, off Calnwood court, Luton. LU4 OFB		Crisis Resolution and Home treatment Service. (CRHT)
Dr Mohiuddin	01582538614	Calnwood Court		ASPA team

CMHT= Community Mental Health Team. ASPA= Assessment and single point of access team. CRHT = Crisis Resolution and Home treatment.

Women who live in Hertfordshire or outside Luton can be referred by their general practitioner or through the CMHT at Calnwood Court (fax. 01582 709164).

Inpatients

The duty psychiatrist can be contacted on Tel. 07775002858. The duty psychiatrist should discuss the case with the on call consultant.

If senior review is required a yellow board referral letter should be faxed to the appropriate consultant.

OTHER USEFUL CONTACT DETAILS PLACE	NUMBER	
Oakley Court	01582 709180	Psychiatric ward
Acute Unit	01582 707 596	Psychiatric ward
Robin Pinto unit	01582 657 532	Secure unit
Luton Drug and Alcohol Services 15-17 Cardiff Road, Luton	01582 528880	Dr Cohen.

APPENDIX 6: PHARMACOLOGICAL AGENTS.

MEDICATION	COMMENTS
ANTIDEPRESSANTS A. Selective serotonin re-uptake inhibitors (SSRIs).	SSRIs are relatively new compared to Tricyclic antidepressants but are the most used antidepressants outside pregnancy. Paroxetine is associated with increased risk of fetal heart defects when taken in the first trimester. SSRIs taken after 20 weeks gestation may increase the risk of persistent pulmonary hypertension of the new born. Fluoxetine is the safest SSRI in pregnancy however there are high levels in breast milk. SSRI use in pregnancy associated with adverse effects in newborns (such as sleeplessness, poor feeding, irritability, constant crying, hypertonia and rarely seizures). Many of these symptoms are mild and self-limiting. However neonates of mothers taking these drugs should be carefully monitored. **Breast-feeding** Sertraline and paroxetine are recommended because of undetectable levels in breast milk. The manufacturers advise against the use of Citalopram, Escitalopram and Fluvoxamine. An SSRI used successfully in pregnancy may be continued in the breast feeding mother if the risk of relapse for the mother is greater than the risk to the infant. Preterm babies and those with respiratory depression exposed to SSRIs are at increased risk of adverse effects and an individual risk assessment needs to be made in these cases.
ANTIDEPRESSANTS B. Tricyclic antidepressants (TCAs)	Since they have been in use for a relatively long period of time, they are considered to have the lowest risk in pregnancy and breast-feeding. However other than Lofepramine TCAs are more dangerous in overdose than other anti-depressants. Use of TCAs in the third trimester known to produce neonatal withdrawal effects such as agitation, irritability, seizures and respiratory distress. These are usually mild and self-limiting but there is need for monitoring exposed neonates. **Breast-feeding** Nortriptyline and imipramine are recommended because they are present at relatively low levels in breast milk.
ANTIDEPRESSANTS C. Other antidepressants.	Venlafaxine may be associated with increased risk of high blood pressure at high doses and higher toxicity in overdose than SSRIs and some TCAs. The manufacturers advise against its use in breast-feeding. Monoamine oxidase inhibitors (MAOIs) should be avoided in pregnancy because of a suspected risk of congenital malformations and risk of hypertensive crisis.
RECOMMENDED ANTIDEPRESSANTS. (MAUDSLEY)	Pregnancy: Nortriptyline, Amitriptyline, Imipramine and Fluoxetine. Breast-feeding: Sertraline, Paroxetine, Nortriptyline and Imipramine. (This does not exclude the use of other antidepressants not listed).

MEDICATION	COMMENTS
ANTIPSYCHOTICS. **A. First generation antipsychotics (FGAs)** Examples: Haloperidol, Chlorpromazine, Trifluoperazine.	The wide use of these drugs over several decades and the findings from most studies suggest that any risk to the fetus is small. There is risk of neonatal withdrawal effects with antipsychotics (first and second generations). **Breast-feeding** They pass into breast milk but fetal exposure is believed to be small especially when the dose is small and divided.
ANTIPSYCHOTICS. **B. Second generation antipsychotics (SGAs)**	**Breast-feeding** The manufacturers' advice against breast-feeding reflects lack of data rather than evidence of harm. Olanzapine and Sulpiride are recommended because of low levels in breast milk (Maudsley).
Olanzapine	Risk factors for gestational diabetes and weight gain should be considered when considering prescription of Olanzapine.
Clozapine	Should not be used in pregnant or breast-feeding women because of theoretical risk of agranulocytosis in the fetus and newborn (NICE). However a switch to a different antipsychotic usually results in relapse and on the balance of available evidence Clozapine should be continued (Maudsley).
	When extra pyramidal side effects occur with antipsychotics (FGAs or SGAs) the dose and the timing of the drug should be adjusted or the drug changed. Anticholinergics should not be prescribed except for acute short-term use.
RECOMMENDED ANTIPSYCHOTICS (MAUDSLEY)	Pregnancy: Haloperidol, Chlorpromazine, Trifluoperazine. Breast feeding: Olanzapine, Sulpiride. (This does not exclude the use of other antipsychotics not listed).
MOOD STABILISERS	Used as prophylactic mood stabilising agents in bipolar disorder. **Breast-feeding** The manufacturers of Carbamazepine and Valproate advise that breast-feeding can be considered if the benefits outweigh the risks to the child. The infant must be observed for possible adverse effects (eg. Transient hepatic dysfunction, hyper excitability, poor feeding with Carbamazepine; hepatic toxicity with Valproate).
Lithium	Should not be routinely prescribed in pregnancy, particularly in the first trimester (risk of fetal cardiac malformations) and during breast feeding (high levels in breast milk). Where appropriate an alternative drug (usually an antipsychotic) should be considered.
Valproate	If a woman becomes pregnant while taking Valproate she should be advised to stop because of the increased risk of neural tube defects and other major congenital anomalies. Where appropriate an alternative drug (usually an antipsychotic) should be considered.

MOOD STABILISERS (continued)	
Lamotrigine and Carbamazepine	Should not be prescribed routinely in pregnancy because of limited evidence of efficacy and high risk of congenital anomaly (eg. oral clefts with Lamotrigine; neural tube defects, facial clefts, cardiac anomalies with Carbamazepine). Lamotrigine should not be routinely prescribed for women who are breastfeeding because of the risk of severe dermatological problems (like Stevens-Johnson syndrome) in the infant.
RECOMMENDED MOOD STABILISERS (MAUDSLEY)	Consider using an antipsychotic as mood stabiliser rather than an anticonvulsant drug (during pregnancy and breast-feeding).
ANXIOLYTICS AND HYPNOTICS	
Benzodiazepines and related sedatives	Unclear if associated with increased risk of congenital malformations in the first trimester. In later pregnancy may be associated with floppy baby syndrome, withdrawal symptoms and restlessness in the neonate. There is risk of CNS depression and apnoea in breastfed infants. In view of the above risks, non-drug measures are recommended in preference to sedatives. Use of benzodiazepines in pregnancy should therefore be restricted to treatment of acute and severe symptoms for a maximum period of 4 weeks. **Breast-feeding** Those with a long half-life like diazepam should be avoided in breast-feeding. Lorazepam, Temazepam and Clonazepam are excreted in breast milk in small amounts. Any infant exposed to benzodiazepines in breast milk should be monitored for CNS depression and apnoea.
'Z' hypnotics (zopiclone, zolpidem and zaleplon)	Scarce data available on their use in pregnancy or breast-feeding to recommend them.

Adapted from NICE, 2007(Antenatal and Postnatal Mental Health) and Maudsley Prescribing Guidelines, 2010.

Glossary of acronyms and abbreviations

AMH	Adult Mental Health
ASPA	Assessment and Single Point of Access
BME	Black & Minority Ethnic
CAMHS	Child and Adolescent Mental Health Services
CMHT	Community Mental Health Team
CRHT	Crisis Resolution & Home Treatment
HV	Health Visitor
IAPT	Improving Access to Psychological Therapies
JCPMH	Joint Commissioning Panel for Mental Health
L&D	Luton & Dunstable
M&B unit	Mother and Baby unit
MHMDS	Mental Health Minimum Data Set
NICE	National Institute for Clinical Excellence
NSPCC	National Society for the Prevention of Cruelty to Children
OCD	Obsessive Compulsive Disorder
PbR	Payment by Results
PTSD	Post Traumatic Stress Disorder
SMI	Severe mental illness