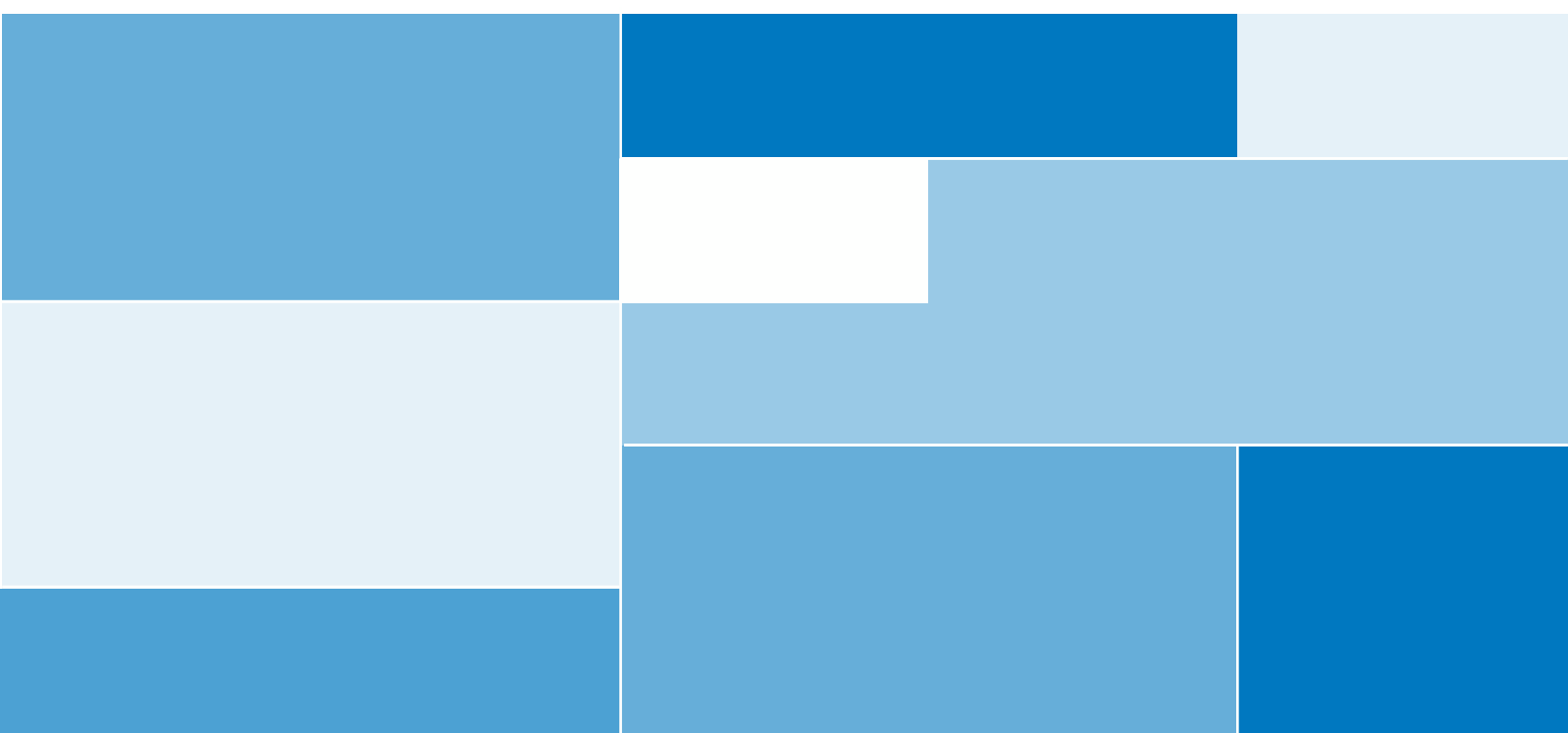


Perinatal

Positive Practice Guide



March 2013

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1. Background and policy framework

- 1.1 Pregnancy and the period after childbirth can bring a range of emotional changes for mothers, fathers and other members of the family. Many mothers find these changes to be a positive experience, but some undergo distressing emotional upheaval that can result in the onset or exacerbation of mental health problems. This perinatal period is an ideal time for preventive perinatal interventions that promote strong attachment and positive parenting, thereby reducing the risk of later mental health problems for both mother and child.
- 1.2 The National Institute for Health and Clinical Excellence (NICE) *Guidance for Antenatal and Postnatal Mental Health (April 2007)*¹ recognises that mental health disorders during pregnancy and the postnatal period can have serious consequences for the health and wellbeing of the mother, her baby and other family members.
- 1.3 Mothers experiencing emotional distress and psychological ill health in the perinatal period (that is during pregnancy, childbirth and the first postnatal year) frequently do not receive the care they need, even though perinatal mental health has been recognised as a significant public health concern².
- 1.4 Investment in mental health provision during the antenatal period can have a significant cost-benefit in terms of future use of health and social services, by both parents and children.
- 1.5 Improving Access to Psychological Therapies (IAPT) services should be commissioned to meet the needs of everyone in the community who will benefit from them, including parents with perinatal mental health problems.
- 1.6 Recent policy initiatives have emphasised the need for a perinatal mental health strategy in every locality. In May 2012, the Government pledged that women who have postnatal depression will get more support from the NHS. An extra 4,200 health visitors will get enhanced training so they can spot the early signs of postnatal depression.
- 1.7 Health visitors and midwives will be supported to work together to provide expert joined up care for new parents, with a focus on emotional wellbeing. These key healthcare professionals will be able to access new evidence and training so they

¹ This document is currently being reviewed with a planned publication date of January 2015.

² Oates, M. (2008) 'Managing perinatal mental health disorders effectively: Identifying the necessary components of service provision and delivery', *Psychiatric Bulletin*, 32:131-133

can identify and support women with postnatal depression. Where extra help is needed, they will be able to refer women to counselling, backed by a £400 million investment in psychological and talking therapies.

- 1.8 *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages* (February 2011)³ promotes that early years, children, young people and families are critical priority areas for improving outcomes for people who develop mental health problems.
- 1.9 Maternity and support staff can do much to help, and can be used to refer into the IAPT service. Normalising of experiences and the provision of basic information can be a powerful preventative tool. New guidance, *a Pathway to support professional practice and deliver the new service offer - Maternal mental health pathway*⁴, provides a structured approach for health visitors and midwives on common issues associated with maternal mental health and wellbeing, from pregnancy through the early months after the birth. The pathway aims to strengthen consistent, seamless support and care and to recognise that enhanced partnership working will achieve quality outcomes for children and parents. It:
- Sets out the benefits and principles for health visitors, midwives, specialist mental health services and GPs working together in pregnancy and the first postnatal year, as the basis for the detailed local pathway to meet the physical and mental health and wellbeing needs of parents, babies and families;
 - Builds on good practice and evidence drawn from the profession;
 - Outlines the challenges and potential opportunities; and
 - Endorses the practice of joint working and encourages an integrated approach to service delivery.
- 1.10 The Eighth Report of the Confidential Enquiries into Maternal Deaths in the United Kingdom (March 2011)⁵ found that psychiatric disorder is common in pregnancy and after delivery. The report found that suicide and psychiatric causes were a leading cause of indirect maternal death in the UK and there had been no significant reduction in maternal suicide within 6 months of delivery since 1997. Since 1994, the number and rates of maternal deaths from indirect causes including suicide have been consistently higher than those for causes directly related to pregnancy. The report highlighted the need for the availability of perinatal mental health services for all women who need them.

³ Department of Health (2011) *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*, London,

⁴ <https://www.wp.dh.gov.uk/publications/files/2012/08/Maternal-mental-health-pathway-090812.pdf>

⁵ 2011 Centre for Maternal and Child Enquiries (CMACE), *BJOG* 118 (Suppl. 1), 1–203

- 1.11 The *Healthy Child Programme* (October 2009)⁶ places emphasis on the emotional health and wellbeing of child and mother, and on the importance of early identification of mental health problems.

Hertfordshire IAPT Pathfinder

A Joint Strategic Needs Assessment identified perinatal mental health provision as an area that the local primary care trust wanted to develop further. Stevenage and Letchworth Enhanced Primary Care Mental Health Services (EPCMHS) were commissioned to develop a pilot service for mild to moderate anxiety and depression in the perinatal period, for use within the overall IAPT service.

In the first eight months of setting up the IAPT service, 11% of the referrals to Stevenage EPCMHS and 5% of referrals to Letchworth EPCMHS were perinatal. This represented a significant percentage of overall referrals to IAPT service. It suggests that commissioners need to develop services that are effective for those individuals with perinatal mental health problems, and essentially to provide resources for an unmet need that has major implications for the future health of parents and their children.

A major concern was that many of the perinatal referrals were at step 3 (complex) and were only referred after other health professionals (such as health visitors) had gone as far as they could within existing services.

⁶ Department of Health, Department for Children, Schools and Families (2009) *The Healthy Child Programme: Pregnancy and the first five years of life*, London, Department of Health

2. Understanding the needs of parents with perinatal health problems

- 2.1 Commissioners must fully understand demographic profiles and epidemiological data for their local community in order to provide appropriate IAPT services for the whole population, including mothers, infants and their families during the perinatal period. However, it is important to recognise the normal anxieties and concerns associated with this time, and the normal problems of adjustment associated with the perinatal period.
- 2.2 Researchers, policy makers, health professionals and service users have identified that mental health problems during the perinatal period have wide-ranging societal effects.
- 2.3 The most common perinatal mental health problem is postnatal depression. Between 10% and 15% of women have postnatal depression in the first year after birth⁷. Many research studies have identified profound effects on relationships, families and children that are linked to:
 - Higher rates of depression in partners;
 - Higher levels of divorce;
 - Lower levels of cognitive development in children;
 - Lower levels of emotional security in children;
 - Higher levels of behavioural problems in children; and
 - Higher levels of psychological disorders among children.
- 2.4 There is also evidence that depression during pregnancy can confer similar risks (Pawlby et al, 2011; Barker et al, 2011), and that antenatal depression has been found to be the largest single predictor of postnatal depression (Beck 1996).
- 2.5 Maternal perinatal mental health is closely linked to that of the infant. Research increasingly shows a need to focus on the infant as well as the mother and on the developing relationship between mother and baby. Working with mothers and their infants to improve their interaction and attachment is important in preventing mental health problems from developing in children. It can also increase maternal engagement in therapy.
- 2.6 It is important for commissioners to ensure that IAPT services are able to meet the needs of both the mother (and/or father) and the infant. There is growing evidence

⁷ Department of Health, Department for Education and Skills (2004) *National Service Framework for Children, Young People and Maternity Services*, London, Department of Health

that treating maternal (or paternal) mental health problems can reduce the future incidence of mental health problems in children. It is crucial for commissioners of adult mental health services to work together with commissioners of children's mental health services, and commissioners of children's services, so that the needs of mothers and/or fathers and infants are met effectively and concurrently. This has the added benefit of reducing duplication of interventions.

- 2.7 Most perinatal mental illness research has been concerned with depression, but commissioners also need to be aware of anxiety disorders, such as obsessive-compulsive disorders, generalised anxiety disorder and post-traumatic stress disorder which recent research has indicated are also highly prevalent. Psychological therapies should be available to pregnant and new mothers (and new fathers) for both depression and anxiety disorders, as it is now well established that high levels of stress and anxiety in the mother during the pregnancy will have a detrimental impact on the infant⁸. Enquiry as to past history of mental health problems, past experiences of pregnancy loss and current stressors can help identify parents in need of help.

⁸ Glover, V. and O'Connor, T. (2002) 'Effects of antenatal stress and anxiety', *British Journal of Psychiatry*, 180: 389–391

3. Removing barriers to access

- 3.1 Anyone accessing psychological therapies for depression and anxiety will have potential barriers to overcome, such as the perceived stigma of being labeled as someone with mental health problems. However, there may be additional barriers that face a pregnant woman or new mother (and/or new father) and commissioners of IAPT services should consider these barriers when developing and designing the service.
- 3.2 Three other important factors with the potential to affect access to psychological therapy services are described below. These are the views, attitudes and behaviour of:
- The person experiencing perinatal mental health problems, who would benefit from psychological intervention;
 - Primary care professionals; and
 - People working in specialist mental health services.
- 3.3 The views, attitudes and behaviour of parents with perinatal mental health problems may prevent a person from receiving psychological therapies if they:
- Believe that mental health problems are shameful and should be hidden from everyone, including GPs, health professionals or people in a position to help or provide information;
 - Feel tremendous guilt because they believe they should be enjoying their pregnancy and then their baby;
 - Have physical health problems that distract them (and their GP) from recognising the co-morbid mental health problem;
 - Use language to express their problems that fails to communicate the seriousness of those problems;
 - Wish not to 'cause a fuss', bother a busy GP or burden other people with their problems;
 - Self medicate with alcohol (particularly men), masking their moods or problems and stopping them being detected; or
 - Feel too hopeless to ask for help because they are depressed or anxious.
- 3.4 An additional barrier may be the mother's (and/or her partner's) fear that mental health diagnoses will invite investigation by child protection services and could result in the removal of the infant from their care.
- 3.5 A pregnant woman or a new mother breastfeeding her baby may be reluctant to discuss or disclose her mental health problems in case medication is prescribed that has side effects on the baby.

- 3.6 General practitioners and other primary care professionals may also inadvertently prevent parents with perinatal mental health problems from accessing psychological therapies services because they may:
- Not have the skills to identify and manage perinatal mental health problems;
 - Have time constraints in their surgeries that prevent them from diagnosing mental health problems effectively;
 - Recognise symptoms of depression or anxiety but fail to recognise that they can be treated with psychological therapies;
 - Believe that treating physical health problems is a higher priority than treating mental health problems, and consequently do not refer patients to psychological therapy services; and/or
 - Mistakenly believe that psychological therapies do not work.
- 3.7 Specialist mental health services may inadvertently prevent mothers and fathers with perinatal mental health problems from accessing services providing psychological therapies because they:
- Lack confidence in working with parents with perinatal mental health problems;
 - May not understand or diagnose the full range of perinatal mental health problems
 - Do not understand the significance of the mother's (and/or father's) mental health in relation to the child's development, attachment and mental health
 - Often are not able to offer choice of venue or appointment time;
 - Generally do not have the facilities to accommodate children at the appointments; and/or
 - Consider that psychological therapies would be better used on other people.

Hertfordshire IAPT The service is currently developing a self-help guide for those who are experiencing mild to moderate postnatal depression. The guide will discuss symptoms and possible cause of postnatal depression and describe techniques based on cognitive behaviour therapy (CBT) principles that can be useful in addressing difficulties.

It is intended that the self help guide will be used by Psychological Wellbeing Practitioners (PWP) working within Hertfordshire IAPT to support women with mild to moderate post natal depression. It is also envisaged that self help guides will be given to GP's and Health Visitors to be distributed to women who might find difficulty in accessing IAPT services or who would prefer to work through a self help guide on their own.

4. Engaging mothers and fathers with perinatal health problems

- 4.1 Commissioners should ensure that proper and effective engagement with pregnant and new mothers (and/or new fathers) is undertaken in designing and evaluating IAPT services, so that the needs of parents with perinatal mental health problems are met.

St Albans EPMHS

The team has developed links with local Health Visitors. By attending their meetings, the aim has been to improve the knowledge of mental health difficulties that could be experienced in the perinatal period. A further aim has been to promote the awareness of the psychological therapies that are offered via IAPT and how these can be accessed. It is envisaged that other EPMHS teams within Hertfordshire IAPT will be developing similar links with their local Health Visitor teams in the near future.

- 4.2 IAPT services will have to take a flexible approach when providing effective psychological therapies for individuals (or families) with perinatal mental health problems. Some mothers (or fathers) may need:
- To bring their baby to the appointment;
 - To give parents choice of venue and appointment times;
 - Home visits;
 - Appointments at specific times or dates (in order to accommodate childcare arrangements for the baby or other children), or appointments may need to coincide with the baby's routine or carer availability etc;
 - Longer sessions than others because of having to change or feed the baby;
 - To give parents a choice about how the interventions are delivered, for example face to face, telephone, or email; and / or
 - Additional support from therapists or the presence of an additional carer to watch the child.
- 4.3 It is important to raise awareness of the IAPT service and its referral routes through:
- GPs;
 - Obstetric and maternity services;
 - Midwives;
 - Health visitors;
 - Child and adolescent mental health services (CAMHS);
 - Children's centres;
 - Social workers; and
 - Occupational therapists.

Hertfordshire IAPT Pathfinder sites

Hertfordshire IAPT Pathfinder developed a Guide for Professionals which included information on referral and care pathways, in collaboration with the EPCMHS teams in Stevenage, Letchworth, other community mental health team professionals, including psychologists and psychiatrists, and local midwives and health visitors. The guide was distributed to all local participating GPs, midwives, health visitors and other professionals and agencies encountering expectant and new parents. The guide also provided general information about the IAPT service and informed where to refer pregnant and postnatal women and their partners for assessment and support where it was suspected that the patient was suffering from mild to moderate anxiety and depression.

4.4 Parents should also be made aware that they can self-refer to IAPT services.

Salford IAPT Pathfinder sites

The Salford Perinatal Project was able to take referrals only from the five relatively deprived SureStart areas of the city. It received approximately 160 referrals per year from these areas, and estimates based on birth rates and incidence rates for postnatal depression are that, if the service were provided across the city, around 360 referrals would be received per year. Approximately 60% of women referred went on to access therapy within the service, the remainder either being signposted to other services as appropriate, or failing to access the service.

4.5 The voluntary sector and self-help groups also have an important role in ensuring that pregnant and new mothers (and/or new fathers) engage with IAPT services when necessary. Local community groups should be encouraged to recommend IAPT services.

Hertfordshire IAPT Pathfinder sites

Hertfordshire IAPT Pathfinder carried out a scoping exercise of existing services for pregnant and new mothers and their babies in Stevenage and Letchworth. This exercise identified voluntary sector organisations and self-help support groups within the local community.

The purpose of the scoping exercise was to ensure that the perinatal services within Hertfordshire's IAPT service were developed to add value and complement existing voluntary sector services in the local area. The exercise provided Hertfordshire with the relevant knowledge to develop an IAPT service that delivered an unmet need.

Hertfordshire's IAPT service was also able to develop good relationships with the local voluntary sector organisations, which have helped to raise awareness of the IAPT service.

4.6 Commissioners will want to ensure that the location of IAPT services encourages engagement. A service located in an independent and neutral environment, such as a children's centre or early years nursery, would encourage engagement. Also, a

location that offers some form of anonymity would be helpful to individuals worried about the perceived stigma attached to mental health services.

Northampton IAPT service

When the Northampton IAPT service was established, there was provision made for a worker with specialist knowledge of Perinatal Mental Health to work within the IAPT team. A pathway was developed for Health Professionals to refer pregnant mothers and parents with children under 5 directly to our Parental Wellbeing Worker for a step 2 assessment and interventions using the IAPT model.

This service is delivered along side 5 Children’s Centres in the Borough of Northampton, to provide a non stigmatised setting with the option of Crèche facilities as suggested in the Perinatal Positive Practice guidelines. A choice of venue and longer appointments are offered if they are needed to accommodate someone bringing their baby with them. Since June 2010 over 950 referrals to the Parental Worker have been received showing there is an obvious need for a more specialised Worker.

To make this service effective and accessible the role of integrated working with other services has been vital. Strong links have been established with Primary Care, Children’s Centres, Health Professionals involved in the care of antenatal and postnatal women and Secondary Care. This promoted more joined up working and for the patients a seamless service. Developing and maintaining these links has been challenging at times, but it has been essential in establishing and embedding the service.

The service also offers an 8 week course called New Beginnings for new mothers who are experiencing mild to moderate mental health problems called New Beginnings. This is jointly run with two Children’s Centres that support the group by providing a Family Worker and a crèche. The objective of the course is to look at IAPT interventions, lifestyle, and normal emotional changes following birth. Health Visitors and fellow IAPT Workers refer parents to the group and they are contacted directly to offer them a place and discuss any concerns that they may have. This group is well attended and using the PHQ7 and GADS, the service is able to see how many parents move into recovery.

- 4.7 The Healthy Child Programme (HCP) is a programme of health reviews, screening, parenting support and health promotion from pregnancy to adulthood. Drawing on a review of the evidence by Warwick University, the HCP recommends a proactive role in identifying and promoting the social and emotional wellbeing of young children and their parents. The HCP is a progressive universal service, which means that it is offered to all families with children and includes additional and different services and programmes for those with further needs and risks. As a universal, non-stigmatising service, the professionals delivering the HCP (especially health visitors) are ideally placed to identify mental health problems and ensure access to psychological therapies.

Family Nurse Partnership Programme

The Family Nurse Partnership (FNP) programme is an intensive, nurse-led and preventive home visiting programme for first-time young mothers. The programme has been developed over 30 years in the US, where three randomised controlled trials have demonstrated significant short- and long-term benefits for mothers with low psychological resources, and their children. We are currently testing this in England and the findings of the first-year evaluation look promising.

The family nurses visit weekly, fortnightly and monthly from early pregnancy until the child is two years old. The programme is strength-based and focused on client goals. The programme consists of structured home visits using materials and activities that aim to build self-efficacy, change health behaviour, and improve care giving and economic self-sufficiency. At the heart of the model is the relationship between the client and the nurse. A therapeutic alliance is built by highly skilled nurses and maintained over several years, which enables the most at-risk families to make changes to their behaviour and form a more secure attachment to their infant.

The programme material opens up personal issues such as past or present loss and/or trauma, and any resulting mental health problems. The nurses are trained in a solution-focused, strength-based approach and also in motivational interviewing, which enables them to establish the aforementioned therapeutic alliance. This therapeutic relationship often enables the family nurse to contain mild to moderate mental health problems and in this respect, family nurses could be seen as functioning as Tier 1 and 2 psychological therapists, particularly by alleviating the impact of the mental health problems of the parent(s) on the developing child.

Through their early engagement with the family and their trusting relationship, the family nurse is also able to help with the early identification of more complex mental health problems for onward referral. They will then work collaboratively with the IAPT service while continuing to deliver the FNP programme.

5 Training and developing the workforce

- 5.1 It is an important principle that the IAPT workforce should reflect and be representative of the local community. The capacity and capability of therapists must be appropriate for the people that they will be seeing. IAPT services need to recruit, develop and retain a workforce able to deliver high-quality services that are fair, accessible, appropriate and responsive to the needs of parents with perinatal mental health problems.
- 5.2 Commissioners developing IAPT services that are effective for parents with perinatal mental health problems should ensure that therapists understand the (sometimes highly specialist) needs of expectant and new mothers, new fathers and the infant – and the relationship to the child’s development, attachment and mental health.
- 5.3 Commissioners should ensure that therapists are able to identify and respond to violence and abuse, and have training in safeguarding issues and child protection processes. Therapists should understand that referrals for those with perinatal mental health problems might need to be made quickly, in order to ensure the safety of both adult and infant. Other staff, such as midwives and health visitors, may already deliver low-intensity interventions for this group.

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