Perinatal Mental Health in Camden: Prevention and Early Intervention

Needs Assessment

Camden & Islington Public Health

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Abbreviations:
AFC = Anna Freud Centre
AND = Antenatal depression
CAF = Common Assessment Framework
CBT = Cognitive Behavioural Therapy
CC = Children’s Centres
CAMHS = Child and Adolescent Mental Health Services
CIN = Child In Need
CPP = Child Protection Plan
DVA = Domestic Violence and Abuse
EPDS = Edinburgh Postnatal Depression Scale
FNP = Family Nurse Partnership
FSW = Family Support Worker
GAD-2 = Generalised Anxiety Disorder Scale (Appendix 4)
GAD-7 = Generalised Anxiety Disorder Scale (Appendix 7)
HEE = Health Education England
HV = Health Visitor
IEYS = Integrated Early Years Service
LAC = Looked After Child
LSPMHN = London Strategic Perinatal Mental Health Network
IAPT = Improving Access to Psychological Therapy
MBU = Mother Baby Unit
PHQ-9 = Patient Health Questionnaire (Appendix 6)
PIP = Parent Infant Psychotherapy
PND = Postnatal depression
PNMH = Perinatal mental health
PTSD = Post Traumatic Stress Disorder
YPS = Young Parent’s Service
Executive Summary

Overview of Perinatal Mental Health

This report is an assessment of the needs of Camden residents with mild or low-level PNMH (perinatal mental health) difficulties. It has arisen from the First 1001 Days Group with the objective of focusing on promoting resilience in families to prevent perinatal mental illness, as well as improving identification of early difficulties. PNMH has been identified as a priority due to the high incidence of mental illness and its impact on children and family life. Protecting good PNMH will help to promote better outcomes the whole family.

When discussing PNMH, the perinatal period begins at conception, includes the antenatal period and continues up to 1 year post-delivery. During this time, women are particularly vulnerable and 15-20% of women are affected by mental health difficulties. Estimates of the number of women in Camden affected ranges from 455 to 1270 women per year, meaning that up to half of all pregnant women may have PNMH difficulties. Focusing on low-level mental health difficulties for mothers is important so that these can be prevented from occurring, or duration / severity of symptoms can be minimised, to in turn reduce impacts on the future generations.

A family-centred model of care to support PNMH includes support for relationships with partners and parent-infant relationships. Services in Camden are organised into Tiers:

- Tier 0 is self-help.
- Tier 1 is universal care, where maternity, primary care and HVs (health visitors) promote health and resilience and assess mental health need as required. Most healthcare practitioners use the Whooley and GAD-2 score, progressing to EPDS (Edinburgh Postnatal Depression Scale) for further assessment.
- Tier 2 focuses on supporting at-risk and vulnerable families by promoting healthy behaviours and providing social and practical support.
- Tier 3 provides psychological and psychiatric support for parents and infants, once low-level problems are present. This is in the community, or associated with maternity services.
- Tier 4 is support based within the Mother-Baby Units.

Summary of areas highlighted

The needs assessment has highlighted several areas for improvement for PNMH services in Camden. These are:

1. Service overview
   1.1. Better identification of need in the community: There is a paucity of data currently recorded looking at number of women screened, where they are signposted, and their outcomes. Therefore the gap between need and services available is unclear. Improved data collection is essential to accurately assess the level of need.
1.2. **More effective collaboration between services**: Referral and signposting pathways are complex and not fully understood. Clear pathways are essential to ensure families access the most appropriate services.

1.3. **Strategic ownership**: This is an opportunity to create a clear strategy to coordinate care of patients across services. This will require clear ownership and leadership for PNMH service provision in Camden. This could be facilitated through the appointment of PNMH champions in each service.

2. **Universal services**

2.1. **Reducing stigma**: Stigma continues to be associated with PNMH problems, and as such symptoms and signs are often not disclosed. Tackling stigma is essential to enable parents to recognise problems early and be willing to access services.

2.2. **Increased capacity for programmes that promote resilience**: There is insufficient capacity to offer programmes promoting resilience universally. There should be an ambition to reach the whole population, and provide prevention strategies at scale to promote good mental health.

2.3. **Improved identification of families in difficulty**: Women are usually identified by frontline workers who may not have received specialist training, including GPs, HVs (health visitors), midwives, FSW (family support workers) and social workers. Appropriate training and support of these healthcare professionals is essential.

3. **Targeted prevention**

3.1. **Greater capacity of preventative targeted services**: Targeted strategies to build resilience for at-risk families reduce development of PND. These include parenting classes, social support and practical help, promotion of coping strategies, motivating individuals, problem-solving techniques and health-promoting practices, and facilitating peer-support. Greater capacity is required due to the small capacity of existing services. This includes antenatal input, which is currently limited.

3.2. **Improved access through logistics of provision**: Practical difficulties include childcare and geography. Barriers to accessing care should be removed so that parents are able to access services they need, without obstacles related to location, logistics and perception.

4. **Early intervention**

4.1. **Delivery at scale, so that the correct evidence-based services are available for improved prevention of early problems**: The offer for early support is uneven. There is no consistent and effective PNMH service across Camden, with inequity of availability and access to services. Services are available across a range of locations and providers including IAPT, CAMHS and Anna Freud. Some services offer mental health support, some offer relationship support and some offer parent-infant relationship support, with capacity reported as limited. Psychological interventions to improve maternal mental health should be coupled with support for parenting and creating healthy parent-child bonds.
4.2. **Appropriate training of healthcare professionals:** Services such as IAPT do not have specialist training for PNMH. Specialist knowledge and support is required to manage women and families.

4.3. **Ensuring patient safety:** There is an incomplete specialist mental health service with limited access to a specialist perinatal psychiatrist at UCLH and no access at the Royal Free. There is no community specialist perinatal mental health service which is required for the step-down of patients from Tier 4. A PNMH specialist service is essential so that patients can be appropriately managed if they become more unwell, and to provide support and training to Tier 1-3 services.

**Recommendations**

Recommendations from this report will inform the ongoing delivery of the CAMHS (Child and Adolescent Mental Health Services) Transformation Plan 2015-20 and will be used to inform work for the First 1001 Days Group. Specific recommendations are made as part of this report to address each of the areas highlighted. These require a coordinated approach across the services to improve collaboration. The recommendations include:

- Improving data collection in maternity, HV and primary care services.
- Improving education for families in the antenatal and postnatal period.
- Supporting health professionals to identify early difficulties.
- Ensure that services for available are appropriate, accessible and have sufficient capacity.
- Creation of specialists and champions in each service to provide strategic support, manage referral pathways between services and improve communication, as well as provide training.
- Working alongside the NCL perinatal mental health strategy for specialist services.

The next steps will be to create a working group to decide on feasibility and implementations.
1. Introduction
There has been growing interest nationally in recent years regarding poor maternal mental health. This is due to an increased awareness of its prevalence during pregnancy and the first year of a child’s life, and the resulting impact on families and children. The Millennium Cohort Study\(^1\) looked at outcomes of 18,000 children at 3 and 5 years of age.\(^1\) It showed that poor maternal mental health is associated with negative neurodevelopmental, emotional and behavioural outcomes for children. This needs assessment has arisen from the First 1001 Days Group and focuses on improving outcomes for Camden residents by promoting resilience to prevent PNMH (perinatal mental health) difficulties, as well as improving identification of difficulties so that interventions can be accessed. The emphasis on low-level mental health difficulties for mothers is important due to the possibility of either preventing them from occurring, or minimising duration / severity of symptoms, to in turn minimise impacts on the future generations.

PNMH falls across a number of specialities and commissioning areas including mental health, maternity and children’s services. This needs assessment looks at the national and regional context when considering PNMH. It covers the background of what perinatal mental illness is, who is at risk of developing problems in the perinatal period, and the impact of this on individuals and society as a whole. It considers strategies for improving PNMH, focusing on prevention of poor mental health by building resilience, identification of difficulties and early support interventions to prevent problems or minimise problems that already exist. This report considers the local need in Camden, with an overview of services available locally. These include primary care, health visiting (HV), maternity, Children’s Centres, CAMHS and Children’s Centres, IAPT and the voluntary sector. The report outlines findings from engagement work, and concludes with recommendations to improve outcomes for families in Camden in the perinatal period.

This needs assessment has included engagement with local stakeholders, including maternity, HVs and local charities. The sources of information are summarised below (Table 1), and the reports used have been referenced throughout the text.

<table>
<thead>
<tr>
<th>Type of engagement</th>
<th>Services engaged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus group</td>
<td>Midwives (Royal Free Hospital: December 2015), (University College Hospital: December 2015), Cocoon, local parents (May-June 2015).</td>
</tr>
<tr>
<td>Interviews with service leads / commissioners</td>
<td>HV, GP, maternity, IAPT, CCs (Children Centres), IEYS, community CAMHS, Cocoon</td>
</tr>
</tbody>
</table>

\(a\) Dependent on risk factors present at 9 months of age, which included parental depression, substance or alcohol misuse, DVA, teenage parenthood, lack of basic skills, and other stressors. 1 in 5 had a parent with depressive symptoms.
2. Context of PNMH

2.1 National context

In recent years, there has been increasing focus nationally to improve PNMH services. The NHS Improving Quality Report in August 2015\(^2\) identified several priorities nationally:

1. **Reducing stigma.**
2. **Improving identification.** The proportion of women actually screened for difficulties in the perinatal period is unclear. Healthcare professionals report they screen women, but a recent PNMH report found that 41% of women reported their midwife or HV had never about depression (NSPCC).\(^3\)
3. **Improving access.** Suitability of available services to managing PNMH varies across England. For example IAPT (Improving Access to Psychological Therapy) provides support to women in the perinatal period, but services are not always suitable for this cohort.

The impacts of mental health on mothers have been highlighted by the MBRRACE report.\(^4\) Of those who died as a result of suicide, only 1 in 4 had received the recommended level of care, and over half had a previous history of mental health problems. Poor communication between maternity services and primary care was highlighted. NICE guidelines recommend there should be: “clearly specified care pathways so that all primary and secondary healthcare professionals […] during pregnancy and the postnatal period know how to access assessment and treatment” and “staff have supervision and training, covering mental health problems, assessment methods and referral routes, to allow them to follow the care pathways.”\(^5\)

Several quality standards are associated with improving PNMH at the national level including the NHS Outcomes Framework 2015-6 (NHSOF)\(^6\), the Adult Social Care Outcomes Framework 2015-6 (ASCOF)\(^6\), and the Public Health Outcomes Framework 2013-6 (PHOF)\(^7\). NICE Quality Statements recommend that:\(^8\)

- Women are asked about their emotional wellbeing at each routine antenatal and postnatal contact.
- Those with a suspected mental health problem in pregnancy or the postnatal period receive a comprehensive mental health assessment.

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\(^1\) Antenatal and postnatal mental health: clinical management and service guidance, NICE guidelines [CG192] Published: Dec 2015

\(^2\) Antenatal and postnatal mental health, NICE guidelines [qs115] Published: February 2016
• If referred for psychological interventions in pregnancy or the postnatal period start
treatment within 6 weeks of referral.

The 2016 National Maternity Review⁸ recommends that by 2020 “there should be significant
investment in perinatal mental services in the community and in specialist care.”

2.2 Regional context
The London Perinatal Mental Health Strategic Clinical Network, in conjunction with the
London Maternity Strategic Network,⁹ has a current work stream around PNMH, aiming to
reduce inequity of mental health services across London. It has formed a network to provide
support to commissioning groups and local services. Work is ongoing and includes:

- Specifications for PNMH services
- Pathways for referral within each area, that can be used as a measuring standard
- Description of the different services that should be available

A National Transformation Board for PNMH started in April 2016, which will focus on
workforce and training issues, models of care, and creation of local networks.

2.3 Local context
There is strong local interest in improving PNMH in Camden. Preserving and protecting good
PNMH has been locally identified as a priority to promote resilience in families (Health and
Wellbeing Strategy 2016-8¹⁰) and to ensure best outcomes for children by promoting parent-
child attachment (Camden 1001 Days strategy, October 2015). The importance of PNMH
was identified by the Camden and Islington Annual Public Report 2014-5: “Reviewing local
perinatal mental health services should be a priority, including how opportunities can be
further developed to link into ‘best start in life’ programmes and the new health visiting
responsibilities of local authorities.”

Camden PNMH services met Level 1 criteria (out of Levels 0-5)¹² in the Maternal Mental
Health Alliance¹¹ evaluation, which is a benchmarking tool that was created in 2015 to
compare PNMH services across different areas. Over half of the other boroughs in London
offer a more comprehensive specialist Community PNMH service than Camden.
Recommendations from this report will inform the ongoing delivery of the CAMHS (Child and

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¹ These are funded by NHS England. It was established in 2013 to improve quality of maternity care
across London, by supporting the London networks – South, North-East, and North-West.
² Camden’s Joint Health & Wellbeing Strategy 2016-8, Living Well, Working together, Oct 2015 (Draft)
³ Camden and Islington Public Health ‘Healthy Minds, Healthy Lives: Widening the focus on Mental
Health, Annual Public Health Report 2014-5’
⁴ Levels defined as: Level 0 = No provision; Level 1 = Specialist perinatal psychiatrist or specialist
perinatal nurse; Level 2 = Specialist perinatal psychiatrist AND specialist perinatal nurse ; Level 3 =
Perinatal community service with specialist perinatal psychiatrist AND specialist PNMH nurse, with
access to a perinatal psychiatrist throughout working hours; Level 4 = Specialised perinatal
community team, meets Joint Commissioning Panel criteria; Level 5 = Specialised perinatal
community team, meets Perinatal Quality Network Standards Type 1
Adolescent Mental Health Services) Transformation Plan 2015-20 and will be used to inform work for the First 1001 Days Group.

### PNMH Context: Key messages

- There has been increasing national interest around PNMH, with a focus on reducing stigma, improving identification and ensuring access to appropriate services.
- The London Perinatal Mental Health Strategic Clinical Network was established in 2013 to improve PNMH.
- Camden council and CCG have recognised the impacts of perinatal mental health in the Health and Wellbeing Strategy. Improving PNMH has been identified as a priority in the 1001 Days strategy to create resilient families and ensure best outcomes for children.

### 3. PNMH

#### 3.1 What is poor perinatal mental health?

The mental health of a woman is particularly vulnerable during the perinatal period, which begins at conception, includes the antenatal period and continues up to 1 year post-delivery. PNMH difficulties include depression, anxiety, adjustment disorders, eating disorders, drug and alcohol disorders, PTSD (Post Traumatic Stress Disorder) and psychosis.

This needs assessment focuses on prevention and identification of mental illness at the mild end of the spectrum, particularly mild-moderate AND (antenatal depression) and PND (postnatal depression), anxiety, and adjustment disorders. A person can have either low mood or anxiety, although they also often occur together. Adjustment disorders occur when depression (low mood) or anxiety symptoms have arisen in response to a stressful life event. Adjustment disorders are a problem because the individual finds it difficult to cope and manage everyday life events. Low-level PNMH difficulties include women and families with early signs or symptoms who do not need inpatient or intensive support. They also include women who have not developed signs or symptoms but are at risk of developing these. Full definitions are outlined in Appendix 1.

#### 3.2 Who is at risk of poor PNMH?

Specific risk factors which often co-exist (Table 2) increase the likelihood of problems in the perinatal period, and in turn PNMH problems may exacerbate some of these risk factors. Some are risk factors that exacerbate risk of mental health problems in the general population, and some are specific risk factors in pregnancy.

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*a Antenatal and postnatal mental health: clinical management and service guidance, NICE guidelines [CG192] Published: Dec 2015*
Table 2: Risk factors* for poor PNMH

<table>
<thead>
<tr>
<th>High risk of problems in the perinatal period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological / psychiatric factors / life events¹⁰</td>
</tr>
<tr>
<td>- Prior mental health problems are associated with AND and PND. There are reports of some women with previous mental illness stopping their prescription medication whilst pregnant due to concerns to the unborn child, increasing risk of mental illness relapse.</td>
</tr>
<tr>
<td>- Family history of mental illness.</td>
</tr>
<tr>
<td>- Previous poor experiences as a child, including abuse.</td>
</tr>
<tr>
<td>- Recent adverse life events and stresses are associated with AND and PND. This includes in some cases trauma that refugees or trafficked women may have faced.</td>
</tr>
<tr>
<td>Obstetric factors</td>
</tr>
<tr>
<td>Obstetric complications or poor health of the baby (or a stillbirth or neonatal death) increase the risk of PND. The impact of this is related to the perception of the birth by the parents, even if medically there were few complications.</td>
</tr>
<tr>
<td>Relationships</td>
</tr>
<tr>
<td>Strong supportive relationships play a protective role. Specific risk factors include:¹⁰ ¹¹</td>
</tr>
<tr>
<td>- Single parents or those who have a poor relationship with their partners.</td>
</tr>
<tr>
<td>- Those with a poor social support network, poor relationship with their parents, or are isolated.</td>
</tr>
<tr>
<td>- Unplanned pregnancy is associated with AND.</td>
</tr>
<tr>
<td>- There is an association between DVA (domestic violence and abuse) and depression, anxiety or PTSD.</td>
</tr>
<tr>
<td>- Depression in the father increases the risk of PND in the mother.</td>
</tr>
<tr>
<td>Socioeconomic factors</td>
</tr>
<tr>
<td>- Low socio-economic status.</td>
</tr>
<tr>
<td>- Two or more children.</td>
</tr>
<tr>
<td>- Housing insecurity or financial difficulties.</td>
</tr>
<tr>
<td>- BME groups.</td>
</tr>
<tr>
<td>- Teenage mothers are more prone to mental health difficulties.³ There is increased risk of stigma and fear of engaging with service.¹²</td>
</tr>
</tbody>
</table>

However mental health problems can also occur for any woman, from any socio-economic background, with no prior history of mental health problems.

3.4 What is the impact of poor PNMH?

Impact on women

During the antenatal period, depression and anxiety are the most common difficulties, affecting 12% and 13% of women respectively.³ There is some overlap and some women

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¹⁰ SIGN 127, Management of Perinatal Mood Disorders, March 2012, Scottish Intercollegiate Guidelines Network

¹¹ Antenatal and postnatal mental health, NICE guidelines [qs115] Published: February 2016
experience both. The peak incidence for mental health difficulties in the perinatal period is at around 4-6 weeks postnatally. 15-20% of women are affected by mental health difficulties in the postnatal year following delivery. Many of these women may have had symptoms in the antenatal period / preconception. Mental health difficulties have a high risk of relapse later in life. They may also have negative impacts on physical health in the long-term.

**Impact on the family**

144,000 babies under the age of 1 in the UK live with a parent who has a mental health problem. Poor PNMH will impact on not only on parental health, but also affects the outcomes for their children. Children learn as they grow, forming bonds with their primary caregivers. Mental health difficulties may affect a parent’s ability to provide a safe and nurturing environment for their child and impact on the parent-child bond. As a result, maternal anxiety and depression have been linked to behaviour and emotional problems in their children. Disorganised parent-child attachments are associated with long-term adverse outcomes for the child. These cumulative impacts on long-term behaviour may be passed onto future generations. Maternal depression or anxiety are linked to lower IQ in their children at 11 and 16 years of age; increased violence behaviour at 11 and 16 years; and increased risk of depression at age 16.

Poor maternal mental health also impacts negatively on relationships with families and partners.

The impacts of poor paternal health are less well known. 1 in 25 men experience depression in the perinatal period, most likely at 3 to 6 months after delivery, and there is an association with maternal depression. Poor paternal mental health may impact on the relationship with the mother and cause stress to the child.

**Impact on society**

PNMH difficulties have high a high financial impact on UK society. One report by the LSE estimated these costs as £8.1 billion per one-year cohort of births, three quarters due to adverse impacts on the child. This includes £1.2 billion costs associated with health and social care. This translates as current costs to the public sector of £2,100 per birth; whereas bringing PNMH services to national standards is estimated to cost £400 per birth. The report concludes: “even a relatively modest improvement in outcomes as a result of better services would be sufficient to justify the additional spending on value for money grounds.”

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* NICE guidelines [PH40], Social and emotional wellbeing: early years, Published October 2012
**PNMH Impacts: Key messages**

- The perinatal period includes the antenatal period and continues until 1 year post-delivery.
- Low-level mental illness includes mild-moderate depression, anxiety, and adjustment disorders. Depression and anxiety can co-occur.
- Specific risk factors increase the likelihood of developing PNMH problems, including a previous history of mental illness, obstetric complications, socioeconomic factors and lack of supportive relationships.
- Poor PNMH affects the outcomes of children, and impacts relationships. These can have long-lasting repercussions.
- PNMH ill-health is estimated to cost the UK taxpayers £8.1 billion per one-year birth cohort.
- Poor paternal mental health is likely to be underreported. It may impact on relationships within the family and affect outcomes for their children.

### 4. Improving PNMH

The impact of poor PNMH does not equate to all children born to these families having poor outcomes. However, promoting family resilience and protecting healthy parent-child bonds can mitigate these risks. Interventions to protect the child are likely to be most effective before age 2.\(^5\)

The healthcare needs of a woman change during pregnancy, birth and postnatally. Therefore families have contact with some healthcare providers throughout the perinatal period, and others only at certain stages. Services managing mental health disorders can be considered as prevention, identification, and treatment/management of symptoms.\(^6\)

**4.1 Prevention strategies** are universal\(^a\) (Tier 0 and 1, see Figure 5) or targeted\(^b\) (Tier 2, see Figure 5). These focus on:

1. Education to tackle mental health stigma and increase awareness:
   - Highlighting social ‘norms’ and positive behaviours.
   - Providing information regarding services available.

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\(^a\) Universal strategies reach the general population, including all women and men in the pre-conception and perinatal period

\(^b\) Targeted strategies are for vulnerable and high-risk women and families at risk of developing symptoms. Interventions are targeted to individuals/subgroup of the population with an increased risk of developing ill-health.
2. Resilience building to reduce isolation. Targeted strategies to build resilience have been shown to reduce development of PND (SIGN guidelines\(^a\) and 2013 Cochrane review\(^b\)) include:
   - Parenting classes. Several parental education and support programmes have been evaluated (Appendix 2).
   - Targeted social support and practical help.
   - Promoting coping strategies, motivating individuals, problem-solving techniques and health-promoting practices.
   - Facilitating peer-support.

3. Early identification of difficulties, including onward referral and signposting as necessary.

4.2 Identification of PNMH difficulties:
PNMH difficulties are often recognised by non-mental health specialists. Identification occurs by healthcare professionals who are also managing the patient’s medical or social needs (Tier 1, Figure 5). Only a small number of women access specialist mental health professionals (Tiers 3-4, Figure 5). By the time women and families access help and support via IAPT / iCOPE, or CAMHS in the CCs (Children Centres), or other services outlined below, they have been signposted or have self-referred. Therefore both families in the community and frontline workers must be aware of signs and symptoms so that they can identify early problems and understand what steps to take. Training for professionals to identify PNMH problems is outlined in Appendix 3.

A woman might present with mental health difficulties at several stages of her pregnancy or postnatally. Low-level difficulties might be noted by themselves, by their immediate family or friends, or by healthcare professionals who have contact with them. At the booking appointment, women should be triaged into the following categories (Figure 1):

- Routine pregnancy assessment;
- Assessment of those with previous / current mental health difficulties;
- Screening of women who are vulnerable / with risk factors. There is no agreed consensus on which factors exactly identify a woman as high-risk.\(^b\)\(^17\)

\(^a\) SIGN 127, Management of Perinatal Mood Disorders, March 2012, Scottish Intercollegiate Guidelines Network
\(^b\) NICE guidelines CG 110: ‘Pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors’ September 2010
Figure 1: Opportunities in the perinatal period to identify mental health difficulties or women at risk of developing problems. All women should be assessed by their midwife, HV and GP if concerns arise.

<table>
<thead>
<tr>
<th>Preconception</th>
<th>Antenatal: screening</th>
<th>Postnatal (details of screening pages 19-21)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing awareness</td>
<td>Screening of all women via maternity (8-10 weeks) / GP / HV (from 28 weeks) †</td>
<td>Maternity care up to 1 month (communication to HV if concerns)</td>
</tr>
<tr>
<td>Pregnancy counselling for women with previous mental illness history including medication advice *</td>
<td>Support and referral for women with previous mental illness history †</td>
<td>Notification of GP - 6 week check</td>
</tr>
<tr>
<td>Mental health screening for high-risk women **</td>
<td>Support and referral for vulnerable women at risk of PNMH difficulties † †</td>
<td>HV at regular intervals</td>
</tr>
</tbody>
</table>

*N Via Mental Health services
** Via services in contact e.g. social service
† † Communication between groups
† † † Birth plan would be implemented
† † † † Including teenagers, previous difficult social circumstances

NICE guidelines recommend two stages to detect mental illness.""".² Healthcare professionals should use these at each contact. The initial screening questions consist of the Whooley Questions to screen for low mood, and GAD-2 to screen for anxiety (Appendix 4). There is an emphasis on the new updated NICE guidelines regarding anxiety. The Whooley questions are sensitive but less specific.²⁺ However some recent studies have highlighted that this is dependent on how the Whooley questions are used.²⁻¹

If these screening questions raise concerns, the next steps will depend on the experience and role of the frontline worker. Either further assessment takes place using structured tools to detect depression or anxiety, or the patient is referred to their GP or for further evaluation.

¹ Antenatal and postnatal mental health: clinical management and service guidance, NICE guidelines [CG192] Published: Dec 2015
² Sensitivity 96%, specificity 57%
assessmen. They may be referred / signposted to IAPT. The EPDS (Edinburgh Postnatal Depression Scale) is usually used to assess further for low mood, and GAD-7 is used to assess symptoms of anxiety (see Appendix 5 for the pathway and Appendix 6, Appendix 7 and Appendix 8 for the assessment tools). EPDS is the most common tool used to assess PND\(^a\). Other tools used to assess and monitor mental health status include the Hospital Anxiety and Depression Scale (HADS) (see Appendix 9).

### 4.3 Early support interventions\(^b\)

aim to prevent symptoms from occurring, or to minimise their impact and / or duration to improve quality of life.

Principles that apply to mental health services for people outside the perinatal period can also be applied to PNMH. This includes early support interventions to promote resilience, and the specific psychological therapies recommended for PNMH are the same as those outlined for common mental health problems (see Appendix 10). All women requiring support for PNMH should receive a psychological intervention in the perinatal period within 6\(^c\) weeks of referral (2016 NICE Quality Statement Guidelines).\(^d\) An overview of evidence for specific management strategies is outlined in supporting documents for the Healthy Child Programme\(^e\) (summary of evidence is listed in Appendix 11).

However, managing PNMH also requires some additional considerations:

1. Clinical management of mental health involves psychology and pharmacology interventions. However in the perinatal period psychological support is preferred to medication due to the effect of medications on the unborn child or whilst breastfeeding.
2. Mental health of the mother will impact on the parent-child relationship.
3. The perinatal period is a time of change in the lives of the mother, father, and has a large impact on the child’s life. Strengthening relationships has a protective effect on PNMH and mental health difficulties can in turn propagate breakdown of relationships during this sensitive time. Therefore this is a unique opportunity to intervene and promote resilience to improve outcomes for the whole family.

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\(^a\) Sensitivity ranges from 31-91% and specificity ranges from 67-99%, when looking at minor or major depression.

\(^b\) Targeted to those showing early symptoms of mental health difficulties

\(^c\) Assessment within 2 weeks and intervention within 1 month of assessment.

\(^d\) Antenatal and postnatal mental health, NICE guidelines [qs115] Published: February 2016

\(^e\) Antenatal and postnatal mental health: clinical management and service guidance, NICE guidelines [CG192], Dec 2015
Effective PNMH strategies do not manage just the clinical signs in isolation. Psychological interventions to improve maternal mental health should be coupled with support for parenting and creating healthy parent-child bonds (NSPCC “All Babies Count”). Figure 2 shows the interaction between approaches used to promote resilience and protective factors to improve outcomes for mothers, their children and the whole family. Therefore the aims of early support interventions should be to limit or reduce symptoms of low-level difficulties by supporting maternal mental health, infant development and family relationships. NICE calls for further research to assess psychological interventions focused on improving mother-baby relations (Research recommendation 2.3).a

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**Improving PNMH: Key messages**

- Some prevention strategies are universal, and some are targeted to those who are vulnerable or at risk of developing difficulties. Prevention strategies focus on education; resilience building; and early identification.

- Women at booking are triaged into routine pregnancy assessment; those at risk of mental health difficulties; or existing mental health difficulties.

- Identification of problems often occurs by professionals who are also managing their medical or social needs. Women are screened using the Whooley questions / GAD-2, with further assessment if concerns are raised.

- PNMH is a unique time period, and hence management strategies must reflect this. Specific psychological therapies are the same as those for common mental health problems; however in PNMH these should be coordinated with supporting infant development and strengthening family relationships.

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*a Antenatal and postnatal mental health: clinical management and service guidance, NICE guidelines [CG192] Published: Dec 2015*
5. PNMH need and services in Camden

5.1 Local epidemiology

In 2014, there were 2700 deliveries in Camden. There were 2274 births to Camden female residents recorded in hospitals. The majority were under care of UCLH (1383), the Royal Free (768) and the Whittington (227).

However there is a lack of data locally collected to quantify PNMH need. In primary care, there are codes for PND screening and PND diagnosis; however it is likely that these are underused when considering the low numbers identified across Camden (Appendix 12).

According to EMIS data, only 8 women were screened for PND, and only 64 were diagnosed with PND over the one year period until March 2015. According to EMIS data, women were also diagnosed with anxiety or depression; however it is not possible to distinguish which of them were in the perinatal period. 86% of women underwent a mood assessment by their health visitor by 4-12 weeks following delivery in 2014/5. However neither HV nor maternity were able to provide robust data regarding the outcomes of mood screening.

Public Health England has produced estimates of local mental health need (Figure 3). In the absence of other data, the evaluation of need is based on these modelled estimates.

![Figure 3: Estimated prevalence of women in Camden with perinatal mental health problems (2013/4)](image)

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a Data from Trust data January-December 2014, Juliff J, North Central London CCG Perinatal Mental Health Strategy document, draft (version 7)
b Data provided by HV commissioners. The data collection system moved from Rio to System in 2015, so data collection for 2015/6 is inaccurate.
c Via ChiMat (the Child and Maternal Health Observatory). This data is an estimate, and does not take into account socio-economic factors. These are estimates to the nearest 5 women. Diagnoses may co-exist with each other, and so the total number of women affected with mental health difficulties is not the sum total of all of the women affected.
These modelled estimates span a potentially wide range of need. There is an overlap between some of these diagnoses as they may co-exist with each other, i.e. the totals shown are not cumulative. Therefore the number of women in Camden affected by PNMH difficulties in one year ranges from (a conservative estimate of) 455 women, to a maximum estimate of 1270 women. This means that up to half of all women in the perinatal period are estimated to have PNMH difficulties.

Universal Plus provides additional support through health visiting to vulnerable families with an additional level of need (see Table 3 for further details). Data from this caseload shows that principal reason for referral\(^a\) to Universal Plus was parental mental health\(^b\) (Figure 4). The majority of these families have a child under 1 year old.

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\(^a\) This does not include 151 cases currently on the caseload due to complex medical needs only.

\(^b\) There is also co-existence of risk factors with mental health difficulties including drug abuse, DVA, alcohol, housing or child illness.
5.2 Overview of Camden services

Perinatal mental health services span a range of needs, and can be categorised in the following ways:

1. Timing of patient contact: contact with women and their families during pre-conception and planning, through antenatal care, delivery and then postnatal care.
2. Type of service offered: this includes services for maternal mental health (psychology / psychiatry), parent-infant mental health, social care and health visiting. Level of service offered: services are arranged by tiers (see Figure 5).

There is an overlap between services offered by each professional group and charity. The CAMHS transformation uses the THRIVE model when considering service structure (Appendix 13). The tiered-approach has been used in this report as many adult mainstream mental health services are included.

**Figure 5: Tiered Approach to Parent-Infant Services (adapted from 1001 Critical Days Manifesto)**

- **Tier 0**: Self care / resilience building
  - Includes self-help, support from the local community and family and friends. This is focused around resilience building.

- **Tier 1**: Universal Support (prevention / early identification) e.g. primary care, HVs, CCs
  - Is based around universal standard care, with a progressive level of support which increases as required. Support focuses around education of new parents and parents-to-be; and screening families for risk factors and mental health difficulties.

- **Tier 2**: Targeted Prevention e.g. FNP, Baby Steps, Mellow Babies

- **Tier 3**: Specialised family services for families under stress e.g. Anna Freud

- **Tier 4**: Psychiatric / parent-infant e.g. MBU
Tier 2 is aimed at high-risk families and mothers, who are vulnerable to developing mental health problems. In this tier, social and practical support is offered with the objective of building resilience and identification of early problems. Little Connections is available in the postnatal period. Antenatal Little Connections (not yet available), and FNP (Family Nurse Partnership) offer services starting in the antenatal period. Other services offer support across the postnatal period with some support in the antenatal period.

Tier 3 is targeted for families requiring early intervention for low-level mental health difficulties. These services offer psychological support, relationship counselling services, and parenting guidance. CAMHS and IAPT are available across the perinatal period, but hospital based PNMH services are variable and usually only available antenatally until a short time postnatally. Anna Freud offers PIP⁴ to build on parenting capacity as well as mental health difficulties. Tier 3 also includes specialist and hospital-based care, including obstetric / psychiatric clinics for women with SMI; PNMH service in hospital with outreach; perinatal psychological services working with adult mental health, drugs and alcohol, eating disorders, LDs (learning difficulties); and child protection and safeguarding.

Tier 4 includes inpatient care such as on a MBU (mother-baby unit).

There are difficulties with interpreting data and estimating service use. Some families or individuals access several services simultaneously. Some services are open access⁵ making current caseload numbers difficult to interpret. The following sections outline healthcare providers of PNMH services in Camden. Acute services are described in further detail in the NCL Strategy document⁶.

General practice (Tier 1)
Most residents are registered with a GP. GPs receive a notification of births and their role includes screening and diagnosis of PNMH difficulties, management and onwards referral if necessary. An example of the pathway is given in Appendix 14 (primary care pathway).

- Universal support: The GP may review women at the pre-conception stage and during pregnancy opportunistically. However they may not see the pregnant woman at all if she books directly with maternity. There are several opportunities for contact in the postnatal period with the GP and / or practice nurse to screen for PNMH difficulties. These include the 6 week check for mother and baby; routine immunisations at 2, 3, 4 months; and baby clinics.

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¹ Parent Infant Psychotherapy, specialist psychotherapist works alongside the family to address the parent-infant relationship
² Services users can continue to access the service as required
³ Juliff J, North Central London CCG Perinatal Mental Health Strategy document, draft (version 7)
• Early support: GPs receive referrals from HVs / midwives who have screened women and have concerns. There are multiagency meetings for vulnerable families in each practice, who may be at risk of developing mental health difficulties. GP will assess these patients and may manage the cases themselves or refer onwards.

• Onwards referral: GP will either refer into hospital services (see below), will refer to non-perinatal specific services (e.g. IAPT). They might refer to the Crisis team or to the Assessment and Advice Team, depending on urgency of healthcare input required.

The numbers of women diagnosed with perinatal depression in Camden in primary care is low (Appendix 12) compared to the prevalence figures modelled by ChiMat (Figure 3). This suggests problems in diagnosis or coding / data entry.

Maternity (Tier 1)
Midwives will look after the pregnant woman from her booking appointment until up to one month after delivery. This includes her physical and mental health needs.

• Universal support:
Midwives complete a PNMH assessment during the booking appointment in the first few weeks of pregnancy. Midwives should screen all mothers for PNMH difficulties. UCLH midwives use screening tools (Appendix 4) at the booking appointment antenatally and an adapted proforma postnatally. They screen for depression and not for anxiety. There is no routine screening antenatally apart from at booking. At the Royal Free, screening questions are used antenatally and postnatally, and are again screened for depression but not anxiety. Women are also screened on discharge from maternity services.

Antenatal support for women booked at UCLH is offered to women by maternity services during one-day antenatal education classes, with a small amount of information regarding PNMH. Women at the Royal Free are offered a full day Life with Baby course, with some mental health coverage. There are an additional 4 hours of midwifery classes and information. This is universally offered but mostly attended by first time mothers, and fathers. Some women access National Childbirth Trust classes.

• Targeted prevention:
Families with social concerns such as previous safeguarding concerns or DVA (domestic violence and abuse) are referred onto additional social support. Vulnerable groups including teenagers will be referred onto relevant services e.g. FNP. At the Royal Free, there is a Red Folder of high risk families, which is discussed at the fortnightly psychosocial MDT meeting. There are weekly MDT team meetings on a Thursday at UCLH to discuss cases. If concerns are identified, further support is offered directly face-to-face, and by telephone contact.

• Early support:
Those with previous mental health difficulties, a difficult previous delivery or neonatal death will be referred onto additional psychological services. Midwives at UCLH approach the Liaison HV directly to discuss complex cases, both in the antenatal and

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* Data from EMIS, from Camden CCG, extracted December 2015
postnatal period. If they have further concerns, midwives refer or signpost to primary care, HV, iCOPE or a FSW (family support worker).

**Hospital Care (Tiers 2, 3, 4)**

The mental health support offer in hospitals is complex. Some services are commissioned by Camden and Islington NHS Trust, and some have been commissioned within the services themselves. Hospital-based mental health services for maternity patients vary between locations. The services available are outlined in the NCL PNMH Strategy, which are mostly antenatal, with more limited provision postnatally.

- **At the Royal Free Hospital**, there is currently no access to a Perinatal Psychiatrist and specialist Perinatal Psychiatry Service. There are plans for access to this specialist service to be arranged. If a woman needs to be urgently assessed, she will be seen via the Liaison Psychiatry service. There are two psychology services available. Women can self-refer to the open-access Women’s Health Counselling Service. There is also a Unity service that health professionals can refer into. There is a maternity support service for women with difficulties around alcohol, DVA, and substance abuse at the Royal Free Hospital, with a caseload of approximately 60 women.

- **A limited service is provided at UCLH** by a Perinatal Psychiatrist and a psychologist, into which primary care, maternity, and IAPT will refer. The Psychiatrist has 2-3 sessions per week, and runs one clinic jointly with an Obstetrics Consultant. This service is only offered in the antenatal period, with no service available postnatally. In 2015/6, 32 women seen by this service were from Camden. The service includes signposting into other areas, including CCs (Children Centres). If difficulties occur postnatally, women are referred to their GPs or to the Liaison Team.

- **The Whittington** has a PNMH specialist service, with a perinatal psychiatrist in post. In 2014/5, 18 women from Camden were seen, and in 2015/6, 26 women from Camden were seen. Preconception counselling is offered, and there is follow up in the community with a PNMH nurse. PIP is also offered.

Any woman presenting acutely with mental health difficulties will be reviewed by the Liaison team. If inpatient help is required, women are referred to a mother baby unit (MBU). There is no provision for women in the perinatal period to access perinatal hospital services at UCLH or the Royal Free Hospital once they have been discharged from maternity (up to a

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a Juliff J, North Central London CCG Perinatal Mental Health Strategy document, draft (version 7)
b The waiting times in December 2015 were approximately 6-8 weeks.
c The Unity Service is a team of midwives who support women at risk of PND, who had a previous traumatic delivery or who have complex social issues. This service has a current caseload of approximately 30-40 women.
d This includes Camden residents and women from other boroughs

e This represents 30% of their referrals, Data provided by Camden and Islington NHS Trust, May 2016

f This represents 6-8% of their referrals, Data provided by Camden and Islington NHS Trust, May 2016
g Usually based in the A&E departments
month after delivery of the baby). If mental health support is required, they will be referred to adult mental health services.

**Health visiting (Tiers 1-2)**

HVs (Health Visitors) aim to promote good health outcomes for children from pregnancy until up to 5 years of age. HVs make contact with women face-to-face in community centres, CCs and at some GP practices. They sometimes offer additional support via telephone consultations. HVs in some areas offer ‘listening visits’ but this is not offered in Camden as no HV has undergone this additional specialised training. There are four stages to the HV offer with a current total caseload of approximately 10,000 per year.

Further details are outlined below:

Table 3: Overview of levels of HV services relevant to PNMH

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communities</td>
<td>This includes CC, increasing community engagement and HV increasing awareness of services available in the local community.</td>
</tr>
<tr>
<td>Universal</td>
<td>The Universal offer should be offered to all families to ensure access to the Healthy Child Programme. There are several points of contact:</td>
</tr>
<tr>
<td></td>
<td>• HVs should make contact with the pregnant woman at around 28-30 weeks, which is a mandated visit. This includes a home visit and inclusion into a preparation for parenthood programme. This is currently targeted, not universal.</td>
</tr>
<tr>
<td></td>
<td>• The new baby review takes place by day 14, and includes an assessment of maternal mental health.</td>
</tr>
<tr>
<td></td>
<td>• Another review takes place at 6-8 weeks, with a further assessment of the mother’s mental health status.</td>
</tr>
<tr>
<td></td>
<td>However no data is collected on the results of these screenings, and whether women are referred or signposted onwards.</td>
</tr>
<tr>
<td>Universal Plus</td>
<td>If there are concerns regarding the family, or the mother’s mood, they will be added to the Universal Plus caseload. Mental health difficulties were the reason for referral in half of these cases (Figure 4).</td>
</tr>
</tbody>
</table>

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[a] Juliff J, North Central London CCG Perinatal Metal Health Strategy document, draft (version 7)
[b] The levels are: Communities (Level 1), Universal (Level 2), Universal Plus (Level 3), and Universal Partnership Plus (Level 4). The level of interaction required is dependent on the needs of the family, with Level 4 requiring the greatest level of input. All children must have a named HV until the age of 12 months minimum, and this is extended to up to 5 years if the family meets the thresholds for Universal Plus / Universal Partnership Plus.
[c] Estimate from Q1-2 commissioner report, Camden Children's Services Report, September 2015
[d] Data from Health Visiting Services, November 2015
[e] 13 women were seen in the antenatal period during Q1-3 2015/6. Data from PHE, Statistical Release: health visitor service delivery metrics, Q3 2015/6, http://www.chimat.org.uk/transfer#3
[f] 90-91% of mothers are seen, Information from HV commissioning, April 2016
[g] Up to 74% seen by 12 weeks, Q1-2 commissioner report, Camden Children's Services Report, September 2015
[h] Data from Health Visiting Services, November 2015
HV currently offers one specific targeted service to support parenting, which is Little Connections (Tier 1-2). Little Connections is offered by the HV service and CCs, and is delivered by FSW and HVs. It is aimed at parents with children aged 0-8 months. It is universally available but preference is given to high-risk parents in need of additional support. The four-week course aims to increase confidence of parents in managing their child, promoting bonding opportunities, improving understanding of development, and providing opportunities to participate with CC and local peer support groups. 172 families booked onto the course January-September 2015. (further data awaited from the HV service)

Family Nurse Partnership (Central and North West London NHS Foundation Trust), Tier 2
The FNP is provided as part of the HV Universal Partnership Plus offer, for teenage parents. All new referrals are screened using the HAD score (Hospital Anxiety and Depression Scale). The HAD score is used both antenatally and postnatally. Of the current caseload of 28 girls, 13 have a history of mental health difficulties, including depression, anxiety, personality disorders and self-harm suicide attempts. FNP nurses liaise with the GP and share information regarding mental health status. FNP may refer to the YPS (Young Parents Service) or the Brandon Centre if further support is required.

CAMHS / the Tavistock and Portman NHS Trust (Tier 2, 3)
Services offered by CAMHS in Camden for families in the perinatal period include:

1. Children’s Centres (CC)
2. The Tavistock has a national psychotherapy offer and also offers some services to families with children under the age of 5 in Camden. In 2014/5, 3 families were seen with children aged under 1 year.

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This includes families with a child identified as a Child in Need, or with a Child Protection Plan. There are currently 195 families identified in Camden on the Universal Partnership Plus Programme.

b e.g. CAF, CIN (Child In Need), CPP (Child Protection Plan), or LAC (Looked After Child).

c 64 families completed the full course. 22% of families booked onto the course were from high-risk groups, 71% were from an area of high deprivation LSOA, Data from Little Connections Report Q4 2014/5, Q1 2015/6, Camden Children’s Centres

d A depression and/or anxiety score: <7-8 = depression / anxiety unlikely; 7/8-11 = mild; 11-14 = moderate; >14 = ‘severe’ (University of Colorado guidelines, as used by FNP). Four of these patients scored 11 and above on at least one of the anxiety or depression scores when screened in the antenatal period.

e Data from FNP, on 30th December 2015
3. Children and teenagers under 19 years may access the CAMHS community team.
4. Pregnant women are seen by CAMHS if they have a child accessing CAMHS services.
5. Informal support services for families are offered at the weekly James Wigg baby clinic by the CAMHS team.
6. One family with a child under 5 years is offered 5 parental support sessions. These are run by child psychotherapists from CAMHS at the Tavistock or in GP practices, and are based on a psychodynamic framework.

The Tavistock provides CAMHS to the CCs locality multi-agency teams. Children’s centres in Camden are managed by IEYS (Integrated Early Years Service) and the services are provided by the CAMHS-IEYS team. Families where the mother is pregnant or there is a child under 5 years will be assessed by a FSW (family support worker).

Referrals are made to CAMHS services in CCs directly from professionals, or through the fortnightly Joint Intake meeting. Parents may be referred or signposted by HVs, maternity and nurseries for family mental health support in CCs. Some families who are referred may be signposted onto other services instead if this is more suitable. This support is targeted to families at risk of developing problems or families who are experiencing low-level mental health difficulties. Families targeted for additional support include young parents, single parents, households with unemployment, BME groups, physical or learning disability, non-English speakers, LAC or child protection concerns. Problems commonly seen include social isolation, DVA or behavioural difficulties in the child. If further input is required, CAMHS will refer onwards to specialist services or iCOPE.

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* Additional services outside the perinatal period include Webster-Stratton Parenting Groups, CAMHS for other adults and children. 138 families were seen for assessment by the IEYSCC locality team CAMHS clinicians in Quarter 1-4 of 2014-15 across the borough.
* There are 14 CCs across the borough, organised in 5 localities - Kings Cross & Holborn, Euston, Kentish Town East, Kentish Town West and Kilburn Priory. There 2-3 CCs in each area.
* Each CC has a core family multiagency team, including SALT (Speech and Language Therapists), CAMHS, welfare, employment and housing support, and child psychotherapy students.
Table 4: Overview of CAMHS PNMH services in Children’s Centres in Camden

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incredible Years Toddler Programme&lt;sup&gt;a,b&lt;/sup&gt;</td>
<td>The Incredible Years Toddler Programme&lt;sup&gt;a,b&lt;/sup&gt; was extended last year to include one Incredible Years Baby Group per year&lt;sup&gt;c&lt;/sup&gt;.</td>
</tr>
<tr>
<td>IEYS CAMHS</td>
<td>This consists of CAMHS clinicians working across all the localities alongside FSWs. For Q1-4 2014/5, IEYS CAMHS assessed 11 people in the antenatal period (9 families) and 32 in the postnatal period (29 families, 28 women and 4 men).&lt;sup&gt;d&lt;/sup&gt; The ethnicity of women undergoing mental health assessment is shown in Appendix 15. The service includes psychology support and support for parent-infant relationships. CAMHS clinicians may refer onwards to other CC services such as baby massage, or may signpost to further mental health services.</td>
</tr>
<tr>
<td>Young Parent’s Service (YPS)</td>
<td>This service has three members of staff. The YPS provides mental health support to parents aged under 25 years with a child under 5 years or currently expecting a child, within the CC setting. These parents are often vulnerable and at risk of difficulties. Many have previously been had social service support when they were children. YPS completed 33 assessments in Q1-4 2014/5&lt;sup&gt;e&lt;/sup&gt; with a caseload of 15-27 people.&lt;sup&gt;f&lt;/sup&gt; Services offered include individual, couple, and family therapy.</td>
</tr>
</tbody>
</table>

Feedback from parents accessing these services is summarised in Appendix 16.

Camden and Islington NHS Foundation Trust (Psychology) *(Tier 2-3)*

The Camden Parents’ Wellbeing Service is an outreach service, seeing parents in GP practices, community centres and CCs. Parents are referred by primary care, IAPT or CAMHS in CCs. There is one clinical psychologist from this service (parental mental health worker) who works in a CC. In the last 12 months this psychologist engaged with 9 families in the perinatal period. The service is offered weekly for up to 2 years. Women have presented with a combination of depression, anxiety and personality disorders, and the treatment offered is CBT and systemic psychotherapy.

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<sup>a</sup> The Toddler Programme is an 11-week parenting programme for parents of children aged 1-3 years old. It focuses on promotion of children’s social, emotional and language development. The programme, which took place September-December 2014, offered 11 parents a place on the programme, with availability of a crèche.

<sup>b</sup> Evaluation of the Incredible Years Toddler Programme, Q3 September-December 2014-15

<sup>c</sup> This was trialled in July 2015, but there was a low level of engagement with the service. Location of the classes and travel difficulties were cited as a reason.


<sup>e</sup> YPS received 41 referrals of which 31 were in the antenatal and postnatal period, including both men and women. 50% of those having mental health assessments made were white-British. The average waiting time between referral and first appointment was less than 6 weeks in over 60% of referrals, and all were seen within 12 weeks.

There are a further 4 psychologists in this service who work across a range of locations, including the Royal Free Hospital, and another due to start in September (through children’s commissioning). They have seen 7 parents in the postnatal period (including one father) and one during pregnancy.

iCOPE / IAPT (Tiers 0, 2-3)
Camden Psychological Service (iCOPE)\(^b\) offers support to women with PNMH difficulties. Services users can access support individually, in groups, or access self-help resources. The self-help resources include a library resource and online modules (via Silvercloud). Patients are offered telephone screening or face-to-face assessment. Assessment and treatment will take place in a range of locations, such as GP surgeries, community venues (including health centres and job centres), and team bases. They assess and manage conditions using a range of psychological treatments including CBT (Cognitive Behavioural Therapy), workshops, and mindfulness. IAPT also provide some services at Women in Health, and are sometimes able to utilise their crèche facilities. Previously IAPT also provided a service within CCs. IAPT are currently piloting providing support via Skype and are considering further online access in a collaboration with IESO.

They refer onwards / signpost to hospital based services, Anna Freud, the Tavistock, Camden Parent’s Wellbeing Service or charities (e.g. City Pregnancy Counselling and Psychotherapy).

Currently, there is no data available for PNMH services provided by IAPT / iCOPE since pregnancy / recent childbirth is not recorded. In a pilot service for specific IAPT for PNMH in other areas, 5 - 11% of referrals\(^c\) were for women with PNMH problems, representing a significant proportion of the overall referrals.

Additional support services
There are additional mental health IAPT services provided by IESO and by Lea Vale. IESO provides online support via an instant messaging service. The Big White Wall has also been commissioned locally to provide online support.

Anna Freud (Tier 3)
Anna Freud runs the PIP Project for parents with babies up to 12 months of age. It offers a range of psychotherapeutic interventions for families, with ongoing treatment for up to one year. The PIP Project is commissioned to see 40 Camden families per year. They receive support services.

\(^a\) Data from Camden Parents Wellbeing Service, May 2016, incomplete (recent changes to service)
\(^b\) iCOPE is part of the national NHS programme Improving Access to Psychological Therapies (IAPT). It is a joint service across Camden and Islington, and provides mental health support to adults presenting with symptoms of depression and/or anxiety. Patients can either be referred into the service or can self-refer. The focus is on improving access to help and support, rather than providing specialist support.
\(^c\) Stevenage and Letchworth
\(^d\) DoH, IAPT, Perinatal Positive Practice Guide, January 2009
approximately 100 referrals per year and have been providing a service to 42-76 families per year since 2012. Fathers are actively included in management, and have attended 45% of initial assessments and consultations since 2010. Appendix 17 shows some details of families referred to the PIP Project, including ethnicity of children, referring agencies, and reasons for accessing the service. During interviews and focus groups, HVSs and midwives commented that mothers needed to be motivated to successfully engage with this service.

HV and Anna Freud work together to support homeless families at England’s Lane hostel at the Hunter Street Baby Clinic. A specialist parent infant psychotherapist and a play support worker work within the baby clinic. Evaluation of the clinic has shown that this high-risk population engages well, with feedback that parents felt supported by the clinic and peer-support networks.

Voluntary sector
Most of these services are based around self-referral. Further details are below:

Table 5: Overview of voluntary / charity services in Camden offering PNMH support

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cocoon Family Support</td>
<td>Cocoon is a Camden-based charity providing support for families suffering from low mood or depression. Families are signposted to this service by primary care, maternity, HVS, or self-present. No formal referral is required. All initial conversations are conducted within 48 hours of initial contact, with the first face-to-face meeting within one week. Cocoon facilitates peer support, access to counselling and self-help workshops and practical support, complimentary therapies and information on PND by way of a library. Three volunteers are trained to provide home visits. Childcare services are provided for those accessing counselling. Cocoon services are being expanded to establish an antenatal education and support service. This will start in June 2016, and will run alongside local maternity clinics.</td>
</tr>
</tbody>
</table>

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* Data obtained from Anna Freud Centre, extracted November 2015
* Data obtained from Anna Freud Centre, 47% fathers did not attend, 7% not recorded, extracted November 2015
* England’s Lane Baby clinic Project: Integrating Health Visiting and Parent-Infant Specialist Support
* It was founded in 2012 and has been a registered charity since October 2014. It is a run by volunteers, and currently does not receive additional funding. Volunteers receive training, which they currently fund themselves, or which has been provided free-of-cost by the training provider.
* This includes emotional support and befriending. There are drop-in walking groups every weekend and this includes a befriending service for fathers with peer-support.
* Including group counselling and individual counselling sessions. Counselling sessions are offered every Monday at the Winch for mothers and fathers.
* There is a weekly transition group on Mondays at the Sheriff Centre for mothers, which is a course offered over 6-12 weeks.
* Complimentary therapies include a massage therapist, a Reiki practitioner, a shiatsu massage therapist, a reflexologist, monthly mindfulness groups and a nail technician.
In 2015, 90 people accessed services, approximately 75 women and several men. 8 men received counselling, 5 accessed group and a further 3 accessed walking groups. Around 25 people were accessing their services at any point in time. Common problems seen include isolation, lack of confidence and a low level of mental health support.

**Hopscotch**  
**Tier 2**  
Hopscotch is a Camden-based charity that offers parental support to women in the community. Services are focused on South Asian women, but does also offer advice and support to non-BME women. Isolation and low mood are commonly seen. Hopscotch runs social and extra-curricular activities aimed to improve English-speaking skills and reduce isolation. FSW provide support via home visits and there is also a parenting course. Employment support and practical advice is provided by individual appointments or drop-in sessions. In a one-year period until November 2015, Hopscotch offered support to 166 women. 107 of these were offered employment support and 20-30 undertook family support. There is a waiting list for services, 3-4 weeks for a FSW.

**Homestart**  
**Tier 2**  
Homestart offers support and practical help to Camden residents with children under 5 years. No formal referral is required, and many families are signposted from social services. Homestart volunteers see vulnerable families and isolated parents, including those with twins or triplets, disability or housing difficulties, and mental health difficulties. This includes families in the antenatal period. Homestart has recently started to focus more on PNMH.

Homestart offers face-to-face support, via one-to-one advice and counselling including home visits. They see families on a weekly basis for 3-4 hours. The support includes practical and emotional support such as preventative and coping strategies, and signposting to other services. Homestart in Camden sees around 70 families per month.

**The Winch**  
**Tier 2-3**  
The Winch provides support to parents within Camden by working alongside the Parent Council to promote and encourage community and peer-support of parents. It also provides support and play services for parents and children.

**Brandon Reach in the Brandon Centre**  
**Tier 2**  
Brandon Reach offers specialised support for parents up to 25 years old who have lost the care of their child. They are commissioned for a caseload of 10 parents. The service offered is via two part-time clinical psychologists. Services offered include individual work, home visits, group sessions (less commonly), and group activities including art mostly based outside of the base centre.

People usually self-refer and often have been recommended to access services by their peers. Most difficulties revolve around forming and maintaining relationships. Many have low mood, anxiety or signs of personality disorders.

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a Data from Cocoon, December 2015  
b It offers support to women who are mostly based in Camden, although non-Camden residents also access services.

c Data from Hopscotch  
d There are four training sessions per year for Homestart volunteers.

e Data from Homestart  
f This service has been running since 2013.
There are multiple other regional and national charities including the National Childbirth Trust, the Association for Postnatal Illness, City Pregnancy Counselling & Psychotherapy, Nordoff Robbins and PANDAS. Relate is a national charity offering relationship support. MIND is a national charity which offers mental health support, and so women in the perinatal period may also access these services.

There are also private associations offering payment-dependent services, e.g. Women and Health Camden.

**Coram**

Coram is a children’s charity based at Brunswick Square, which provides support to families either via one-to-one support, or through groups. Support is offered to parents at any stage, and there is a specific focus on young parents aged 13-25, and those from BME groups.

**PNMH services in Camden: Key messages**

- The number of women in Camden affected by PNMH difficulties is estimated at 455 to 1270 per year.
- Services are arranged by timing of contact (preconception, antenatal, postnatal), type of service offered, or level of service (Tiers). There is an overlap.
  - Tier 0 includes self-help, support from the local community, with support from the voluntary sector.
  - Tier 1 is universal standard care, with a progressive level of support (primary care, maternity, HVs).
  - Tier 2 focuses on resilience building for high-risk families including CAMH services in Children’s Centres (Incredible Years), IEYS and HV services (FNP, Little Connections, England’s Lane) and the voluntary sector.
  - Tier 2-3 supports families requiring early intervention through CAMHS in Children Centres (Parental Mental Health Support, Young Parent’s Service), Camden Parents’ Wellbeing service, CAMHS in the community, IAPT, Anna Freud, and the voluntary sector.
  - Tier 4 provides specialist care (inpatient hospital care).

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*Source: data obtained from the Brandon Centre*
6. Assessment of current PNMH services in Camden

The methods of engagement used for this report are summarised in the introduction (Table 1). This work highlighted some key areas for improvement, with many stakeholders reporting similar observations. These are outlined below, with further details in Appendix 18 and Appendix 19, including areas of good practice in this area, nationally and in other areas.

6.1 Understanding the needs of the local population

Currently there is a lack of data regarding baseline need in the population, so that services are based on modelled estimates produced by PHE (Figure 3). The number of women being screened in primary care is unclear. Midwives and HVs report they should be screening all women in the perinatal period, but the outcomes of these contacts are not recorded. Currently there is no data recorded by IAPT in the perinatal period.

6.2 Stigma and lack of understanding regarding PNMH problems

Access to antenatal education was reviewed in the Long 2015 antenatal survey, which was presented to 1001 Days Group. The survey found that the following groups were the least likely to access antenatal education:

- BME
- Younger parents (aged under 31)
- Those in social housing
- Unemployed

Parents have report a lack of understanding of what is normal in pregnancy and what to expect, as well as signs and symptoms to be aware of. All parents at the Cocoon focus group\(^a\), including fathers, felt they did not receive enough education on PNMH illness during pregnancy, and felt they would have benefited from learning more about this pre-conception or antenatally.

> ‘I didn’t even realise I was slipping into postnatal depression’

(Parent focus group)

Parents reported barriers to disclosing difficulties, including worries of appearing as if they “cannot cope”, and resulting concerns regarding involvement from child protection services.\(^b\) They reported a tendency to minimise symptoms and their impact on their lives.

\(^a\) Cocoon Focus Group, 27th June 2015
\(^b\) Cocoon Focus Group, 27th June 2015
HVs reported that Bengali women often do not seek support even if they feel isolated. They reported some women do not want to access local charities such as Hopscotch due to concerns of rumours in their small community and resulting stigmatisation.

Midwives reported some difficulties with women with pre-existing mental health problems. They reported some cases where women had stopped their anti-depressants without communicating this due to concerns regarding the potential effect on the unborn child and not understanding the risk to their own mental health.

6.3 Identifying early difficulties
Some women do not access primary care during pregnancy if they register directly with a midwife. Some GPs have suggested it may be useful to include an EMIS template for consultations in the perinatal period including screening questions and EPDS.

Midwives reported that time limitations and work pressures sometimes make conversations about sensitive issues more difficult. Midwives also reported that it is not always clear that problems are related to mental health as they sometimes manifest as pain or other non-specific symptoms in some BME groups. This makes it difficult to recognise symptoms, and to discuss PNMH as a mental health problem.

Some mothers reported needing more support once the father returns to work. This would provide additional opportunity to identify problems and provide support.

HV antenatal visits at 28 weeks are currently being implemented, which will improve continuity of care.

---

a HV engagement
b Midwife focus group
c Midwife focus group
6.4 Early intervention and minimisation of symptoms

**Accessibility:** There is an unequal offer across the borough, with services unevenly distributed. Some service restrictions may limit access to vulnerable parents e.g. inclusion criteria. For example Brandon Reach can only provide support to parents aged under 25, but older high-risk parents might also benefit. In addition, logistic help to attending services is often absent such as providing child-care, or allowing the child to attend. IAPT note this has been a particular problem, as it may be inappropriate for older children to be present during these consultations. HVSs and parents also mentioned that Children’s Centres are sometimes difficult to access due to associated stigma.

**Capacity:** Women in the perinatal period access some mainstream mental health services, such as IAPT, as well as some specific services for PNMH. Parents and midwives report finding some therapies are more acceptable, e.g. baby massage being particularly well-received. Parents reported wanting access to further peer-support groups at the Children’s Centres. Some parents feel that there is limited access to services providing support for relationship difficulties and parent-child bonds. Voluntary services report that there is a large unmet need in the community and that existing service capacity is insufficient to meet demand:

> “There is a huge unmet need in our community. All mothers have needs as this is a time of huge change and pressure. There is very little support in our society”

(Cocoon)

> “There aren’t enough services for vulnerable parents”

(The Winch)

> “Staffing numbers are insufficient for services [and we] are overwhelmed with the need”.

(Hopscotch)

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a Midwives focus group  
b Cocoon Focus Group, 27th June 2015
Table 6 outlines the estimated number of women in Camden seen at Tiers 2-4. These include women and families at risk and those with mental illness. Some families are likely to be engaging with several services, so the numbers of individuals actually seen may be smaller. Some women at Tier 3 will be seen by other mental health services. This table shows the lack of data available, as well as the small capacity of services that see women at Tiers 2-3.

Table 6: Summary of the number of women in the perinatal period accessing preventative and early intervention mental health services Tiers 2-3 in Camden (voluntary sector not included)

<table>
<thead>
<tr>
<th>Level</th>
<th>Service</th>
<th>Number of women seen 2014/5</th>
<th>Number of women seen 2015/6</th>
<th>Caseload</th>
<th>Estimated number of women seen*</th>
<th>Estimated need in Camden (women per year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 2-3 Targeted services – prevention</td>
<td>FNP (Family Nurse Partnership)</td>
<td></td>
<td>28</td>
<td></td>
<td></td>
<td>Likely need: 15% of the population = 1,025 (Range 455 to 1185*)</td>
</tr>
<tr>
<td></td>
<td>Little Connections</td>
<td>110 (Jan-Sept 2015)</td>
<td></td>
<td></td>
<td>63 for PNMH (3 of 4 services)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Universal Partnership Plus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>England’s Lane</td>
<td>Unknown</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 2-3 Early intervention Community based</td>
<td>CAMHS (outside children’s centres)</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IEYS (CAMHS in CCs)</td>
<td></td>
<td>37</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Young Parents Service</td>
<td>33</td>
<td></td>
<td></td>
<td>15-27</td>
<td>152 +/-</td>
</tr>
<tr>
<td></td>
<td>Brandon Reach</td>
<td></td>
<td>22 (Q1-3 only)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Camden Parents Wellbeing Service (incl Royal Free)</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IAPT</td>
<td>unknown</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Anna Freud</td>
<td>41</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 3 Early intervention Hospital based</td>
<td>UCLH</td>
<td>32</td>
<td></td>
<td></td>
<td>58 (other women seen in general mental health service)</td>
<td>Likely need: 85-160⁷</td>
</tr>
<tr>
<td></td>
<td>Whittington</td>
<td>26</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: this does not include management of families by their GP, or HV, or the voluntary sector.

*Some women may be seen in multiple services, so estimates only

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⁷ Range: Adjustment disorder lowest estimate, to Adjustment disorder plus mild-mod depression highest estimate

⁸ SMI plus psychosis plus severe depression +/- PTSD
Some of these services offer mental health support, some offer relationship support, and some offer parent-infant support. The suggested model of care for Tiers 2-3 (Figure 2) which supports all of these is not available as a cohesive offer across Camden.

6.5 PNMH for men
Some men have reported difficulties understanding how best to offer support to their partners. Men may themselves experience difficulties with their own mental health. New fathers reported requiring support and being affected by traumatic births. They requested support from services including counselling, practical support and peer-to-peer support. The Winch reported that they found it more difficult to encourage men to engage with their services.

6.6 Collaboration between services
Referrals: Midwives estimated that a quarter to a third of the mothers report low mood, but do not meet the threshold for intervention such as CAMHS. They expressed concern that referrals to CAMHS with no clear diagnosis were often not accepted, and HV expressed being unclear what the referral thresholds were. The interactions between different agencies are complex. IAPT report that when previously based in CCs, they did not receive many referrals. Stakeholders reported they felt referral routes were unclear.

Signposting: There are multiple services and charities available locally that do not require referrals. Stakeholders repeatedly mentioned that the pathways are unclear and were unclear on which services were available locally. An added difficulty is the lack of feedback from organisations that do not require a referral, such as IAPT. Women and men can self-

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a Cocoon Focus Group, 27th June 2015
b Cocoon Focus Group, 27th June 2015
c Midwife focus groups
d HV engagement
refer, which means that the HV or midwife does not receive feedback regarding whether the contact occurred and what its outcome was.

**Communication:** A pregnant woman can be referred to maternity via primary care, in which information regarding the mother will be shared between services. However, some women refer themselves directly to maternity services, meaning that information is not always provided by the GP. This risks missing medical information regarding women who have a previous or current history of mental illness. There is also no formalised system for passing information between maternity and HVs, also risking loss of information regarding high-risk or vulnerable families.

**Cross-border care:** Families often cross geographical boundaries for perinatal care. Their GP and HV may be in one borough, but they may access maternity care in another borough, or choose an alternative hospital. This creates complicated referral pathways and signposting.

### PNMH services in Camden: Key messages

- This needs assessment highlighted some key difficulties. These are categorised into identification and services available to prevent / minimise mental health difficulties.

**Key areas identified:**
- Identification – Lack of PNMH education in the community; understanding the needs of the local population; stigma; screening methods; high risk BME families; fathers are not prioritised.
- Services – Unclear referral pathways and referral thresholds; signposting; appropriate services being available; accessibility of services; collaboration between services; training; maintaining PNMH on the agenda

### 7. Summary and recommendations

The above sections have outlined the existing services to support mental health in the perinatal period in Camden. Further information is outlined in Appendix 18 and Appendix 19.

The main points highlighted regarding PNMH in Camden are summarised below, followed by specific recommendations (Table 7). Achieving these would enable Camden to successfully deliver a comprehensive PNMH service.

#### 7.1 Service overview

**Findings**
- There is limited information regarding need in the Camden population.
- PNMH is currently commissioned across a range of providers, and so falls across mental health, children and maternity commissioning. This is especially complex since services
commissioned at the hospital will serve the population of more than one borough. This risks communication breakdown between services. There is lack of strategic ownership of perinatal mental health due to the spread across services, which creates a risk for patients falling between services.

- There is no clear pathway for women and families with PNMH needs, which leads to a lack of clarity on available services.

**Recommendations**

I. Improved data collection

II. This is an opportunity to create a clear strategy to coordinate care of patients across services. This will require clear ownership and leadership for PNMH service provision in Camden. This could be facilitated through the appointment of PNMH champions in each service (see Table 7 for further details).

III. Cooperation between services to work in a patient and family-focused manner, rather than being stratified according to type of service.

**7.2 Universal services**

**Findings**

- Over a third of all women in the perinatal period are at risk of mental health problems. Therefore services to reduce stigma, increase identification and promote good mental health should be universal.

- However, capacity is limited. There is insufficient access to information and peer-support groups. Many preventative and resilience-building services such as antenatal maternity education, antenatal health visits and parental support classes are targeted at high-risk families. There is not the capacity to deliver these universally currently.

- Professionals managing PNMH may require additional training to recognise difficulties (FSW, social workers, primary care, HVs, maternity). There are limited opportunities to bring healthcare professionals together for training, and specialist training is more readily available in some services than others.

**Recommendations**

I. Remove stigma surrounding mental illness in the perinatal period, to enable parents to recognise problems early and be willing to access services.

II. There should be an ambition to reach the whole population, and provide prevention strategies at scale to promote resilience.

III. Health professionals should be supported to ensure they are confident to identify difficulties.

**7.3 Targeted prevention**

**Findings:**

- Targeted strategies to build resilience for at-risk families reduce development of PND. These include parenting classes, social support and practical help, promotion of coping
strategies, motivating individuals, problem-solving techniques and health-promoting practices, and facilitating peer-support.

- Access to services that promote resilience is limited. There are practical difficulties with accessing services, including childcare and geography.

**Recommendations:**
I. Greater capacity is required due to the small capacity of existing services. This includes antenatal input, which is currently limited.
II. Access to these services should be improved.

### 7.4 Early intervention

**Findings:**
- There is no consistent and effective PNMH service across Camden, with inequity of availability and access to services. Services are available across a range of locations including via IAPT, CAMHS and Anna Freud. There is an incomplete specialist mental health service with limited access to a specialist perinatal psychiatrist at UCLH and no access at the Royal Free.
- Psychological interventions to improve maternal mental health should be coupled with support for parenting and creating healthy parent-child bonds. There is an uneven offer for supporting relationship difficulties and parent-infant relationships.
- Non-specialist services such as IAPT do not have specialist training in the management of PNMH difficulties.
- There is no community specialist perinatal mental health service which is required for the step-down of patients from Tier 4. This is a risk for patient care.

**Recommendations**
I. Delivery at scale, so that the correct evidence-based services are available.
II. Remove barriers to accessing care so that parents are able to access services they need, without obstacles related to location, logistics and perception.
III. A PNMH specialist service is essential so that patients can be appropriately managed if they become more unwell, and to provide support and training to Tier 1-3 services.

Table 7 outlines specific recommendations to be discussed and taken forwards by the Perinatal Mental Health Working Group, to be reported back to the 1001 Days Group and inform the CAMHS Transformation Plan.
Table 7: Specific Recommendations for PNMH in Camden

<table>
<thead>
<tr>
<th>Area</th>
<th>Recommendation</th>
<th>Number</th>
<th>Group</th>
<th>Action</th>
<th>Comments</th>
<th>Level</th>
<th>Service involved</th>
<th>Named person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service overview</td>
<td>Understanding the needs of the local population</td>
<td>1.1</td>
<td>Data</td>
<td>Record number of antenatal visits by HVs</td>
<td>HV / maternity reviewing data collection system</td>
<td>Local</td>
<td>HV</td>
<td>MCC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.2</td>
<td>Data</td>
<td>HV: Improve data collection to record outcome of mood assessments</td>
<td>Under discussion, how best to introduce this</td>
<td>Local</td>
<td>HV</td>
<td>MCC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.3</td>
<td>Data</td>
<td>Maternity: collect data on outcomes of screening contacts</td>
<td>Outcomes of contacts - by individual hospitals. Under review</td>
<td>Hospital</td>
<td>Maternity</td>
<td>JJ</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.4</td>
<td>Data</td>
<td>IAPT: add data collection methods regarding recent / current pregnancy</td>
<td>Consider parameters at local versus national level</td>
<td>Local</td>
<td>IAPT</td>
<td>JL</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.5</td>
<td>Data</td>
<td>Improved understanding of IAPT PNMH caseload</td>
<td>Audit of IAPT data e.g. deep-dive of current case load. Focus on referral route and diagnosis in the context of perinatal mental illness. Look at women and men. To be presented to steering group</td>
<td>Local</td>
<td>IAPT</td>
<td>JL</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.6</td>
<td>Data</td>
<td>Improve data collection on EMIS</td>
<td>Review coding around perinatal mental health used by GPs - template as a reminder being created</td>
<td>Local</td>
<td>GP</td>
<td>LB</td>
</tr>
</tbody>
</table>
2. Creation of PNMH Champions and Leads within each service – Health Visiting, maternity, IAPT, general practice, children’s Centres, CAMHS. See Appendix 19 for examples of this.

The role and responsibilities of PNMH Champions / Leads in each service could include the following clinical and / or strategic responsibilities.

<table>
<thead>
<tr>
<th>Clinical support</th>
<th></th>
<th></th>
<th>Clinical support</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Capacity</td>
<td>2.2 Training</td>
<td>Maternity: Provide support to mothers with PNMH difficulties, be the point of liaison for midwives to discuss difficult cases</td>
<td>There should to be sufficient leads in each service to cover the needs of the population (already exist within maternity).</td>
<td>Hospital</td>
<td>maternity</td>
</tr>
<tr>
<td>2.2 Training</td>
<td>2.3 Pathways</td>
<td>Ensure training needs are met within each service, regarding identification and early management</td>
<td>Champion training through the SCN (Jo Maitland) is in four levels. Champions who are trained then go on to train other members of staff. Full review of existing training and training needs should be completed</td>
<td>Local</td>
<td>maternity, HV, GP, IAPT</td>
</tr>
<tr>
<td>2.3 Pathways</td>
<td>2.4 Pathways</td>
<td>Clarify pathways for mothers delivering out-of borough</td>
<td>Work across NCL, PNMH Champions / Leads to clarify routes of communication</td>
<td>Local</td>
<td>HV, maternity</td>
</tr>
<tr>
<td>2.4 Pathways</td>
<td></td>
<td>Clarifying referral and signposting pathways between services to improve communication between services</td>
<td>Creation and updating of clear referral routes and referral criteria into services. Regular updates of services that can be signposted into, mapping to be available on GP website, and distributed to services</td>
<td>Local</td>
<td>HV, GP, maternity, IAPT</td>
</tr>
<tr>
<td>Pathways</td>
<td>Improve communication between GP and maternity, especially if pre-existing mental illness</td>
<td>New EMIS referral template is being rolled out across Camden, which will standardise information sharing from GPs to midwives. Data sharing from maternity --&gt; GP can be improved</td>
<td>Local</td>
<td>GP, maternity</td>
<td>LB</td>
</tr>
<tr>
<td>Pathways</td>
<td>Improve communication and information sharing between maternity and HVs</td>
<td>Information sharing could become opt-out rather than opt-in. Transformation of maternity services is occurring at NCL level, which will include centralisation of data sharing, centralised point of contact, electronic system across services</td>
<td>All</td>
<td>Maternity, HVs</td>
<td>JJ</td>
</tr>
<tr>
<td>Pathways</td>
<td>PNMH team within the borough by liaising with other leads</td>
<td>MDT approach, collaborate across NCL, with PNMH Champions liaising with each other</td>
<td>Local</td>
<td>Champions</td>
<td></td>
</tr>
<tr>
<td>Capacity</td>
<td>Peer-support network to promote learning for the Champions, pan-London</td>
<td>This was suggested by the SCN, to be developed by the IAPT leads working together</td>
<td>All</td>
<td>IAPT</td>
<td></td>
</tr>
<tr>
<td>Education / reducing stigma / building resilience</td>
<td>Improved mental health education antenatally by HV (mandated to be universal)</td>
<td>Review support provided by HV service including possibility of HV listening visits. Implementation of antenatal parent support programmes (targeted vs. universal). Development, evaluation, expansion of these services.</td>
<td>Local</td>
<td>HV, 1001 Days</td>
<td>MCC</td>
</tr>
<tr>
<td>Section</td>
<td>Topic</td>
<td>Activity</td>
<td>Status/Details</td>
<td>Department</td>
<td>Notes</td>
</tr>
<tr>
<td>---------</td>
<td>-------</td>
<td>---------</td>
<td>----------------</td>
<td>------------</td>
<td>-------</td>
</tr>
<tr>
<td>3.2</td>
<td>Prevention</td>
<td>Review antenatal support in CC</td>
<td>CC to review support available</td>
<td>Local CC</td>
<td>JH</td>
</tr>
<tr>
<td>3.3</td>
<td>Capacity</td>
<td>Universal coverage of antenatal maternity classes, with a focus on mental health</td>
<td>To be developed through maternity, review of existing capacity</td>
<td>Hospital maternity</td>
<td>JJ</td>
</tr>
<tr>
<td>3.4</td>
<td>Prevention</td>
<td>Promotion of Baby Buddy app for support to parents-to-be</td>
<td>Currently being trialled at the Whittington, await feedback. Routinely promoted at UCLH, could be promoted at Royal Free</td>
<td>Local Maternity, GP, HV, Voluntary sector</td>
<td>JJ</td>
</tr>
<tr>
<td>3.5</td>
<td>Prevention</td>
<td>Promotion of booklets / leaflets for distribution to parents-to-be and new parents in maternity</td>
<td>Recently developed postnatal booklet given on discharge from hospital following birth to all women across NCL. Await feedback, if successful can be printed and distributed in Camden. Antenatal information is also available, but is due to be updated.</td>
<td>NCL Maternity, HV, GP, Voluntary sector</td>
<td>JJ/JH</td>
</tr>
<tr>
<td>3.6</td>
<td>Prevention</td>
<td>Improve pathways, capacity and access to services from the voluntary sector</td>
<td>Work with local voluntary sector to outline and strengthen preventative services</td>
<td>Local Champion</td>
<td></td>
</tr>
<tr>
<td>3.7</td>
<td>Pathways</td>
<td>Outlining prevention services available for universal prevention, and how to access these</td>
<td>PNMH Champions to complete pathway using Needs Assessment</td>
<td>Local Maternity, HV, GP, Voluntary sector</td>
<td></td>
</tr>
<tr>
<td>3.8</td>
<td>Prevention</td>
<td>Parent Champion in CC</td>
<td>To start in Autumn</td>
<td>Local CC</td>
<td>JH</td>
</tr>
<tr>
<td>Pathways</td>
<td>Antenatal contact currently being implemented by HV</td>
<td>Extend from targeted to universal, collect data</td>
<td>Local</td>
<td>HV</td>
<td>MCC</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------------------</td>
<td>------------------------------------------------</td>
<td>-------</td>
<td>----</td>
<td>-----</td>
</tr>
<tr>
<td>4.1</td>
<td>Increasing identification of difficulties</td>
<td>4.1 Pathways</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.2</td>
<td>Increasing identification by maternity</td>
<td>Adding anxiety screening questions into booking appointment; screening all women at 28 weeks; mandating discharge mood screening questions.</td>
<td>Hospital</td>
<td>maternity</td>
<td>JJ</td>
</tr>
<tr>
<td>4.3</td>
<td>Add “talk to me alone” session at the end of the booking appointment</td>
<td>Provisionally agreed by maternity and HV</td>
<td>All</td>
<td>Midwifery, HV</td>
<td>MCC / JJ</td>
</tr>
<tr>
<td>4.4</td>
<td>Support to FSW and social workers to ensure training includes PNMH</td>
<td>Liaise with CC and Safeguarding to ensure training, via Champions</td>
<td>All</td>
<td>CC</td>
<td>Champions</td>
</tr>
<tr>
<td>4.5</td>
<td>Adding templates for GPs to screen women in the antenatal / perinatal period</td>
<td>To be implemented via EMIS - in progress</td>
<td>Local</td>
<td>GP</td>
<td>LB</td>
</tr>
<tr>
<td>4.6</td>
<td>Support in identification for maternity, HVs and GPs in the identification of PNMH difficulties</td>
<td>Additional specialist training, via Champions</td>
<td>All</td>
<td>maternity, HV, GPs</td>
<td>Champions</td>
</tr>
<tr>
<td>5.1</td>
<td>Increase availability and access to peer-support</td>
<td>Improve facilitation of these, include in CCs, include available peer-support groups in the pathways. Part of the business case</td>
<td>Local</td>
<td>CCs, Voluntary sector</td>
<td></td>
</tr>
<tr>
<td>Section</td>
<td>Topic</td>
<td>Action</td>
<td>Responsible</td>
<td>Local</td>
<td></td>
</tr>
<tr>
<td>---------</td>
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<td>--------</td>
<td>-------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td>5.2</td>
<td>Capacity</td>
<td>Increase coverage of targeted preventative services</td>
<td>Review capacity of these services</td>
<td>HV, CCs, maternity</td>
<td></td>
</tr>
<tr>
<td>5.3</td>
<td>Access</td>
<td>Relaxing strict commissioning criteria, for example age threshold for services such as the Brandon Centre</td>
<td>Being reviewed by Children's Health commissioners</td>
<td>Brandon Centre / CC CAMHS</td>
<td></td>
</tr>
<tr>
<td>5.4</td>
<td>Capacity</td>
<td>Support services for vulnerable populations</td>
<td>HV / Anna Freud clinic run at England Lane Hostel to be supported</td>
<td>Commissioning / HV / Anna Freud</td>
<td></td>
</tr>
<tr>
<td>5.5</td>
<td>Pathways</td>
<td>Clarifying referral and signposting pathways between services around targeted prevention including threshold criteria</td>
<td>PNMH Champions to complete pathway using Needs Assessment</td>
<td>Maternity, HV, GP, Voluntary sector</td>
<td></td>
</tr>
<tr>
<td>Early intervention</td>
<td>Improving logistics of access to early intervention services</td>
<td>6.1 Access</td>
<td>Increase equity of accessibility with psychologists linked to baby clinics</td>
<td>Ensure psychologists can access GP practices when baby clinics occurring</td>
<td>GPs, CAMHS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6.2 Pathways</td>
<td>Clarifying referral and signposting pathways between services around early intervention including threshold criteria</td>
<td>PNMH Champions to complete pathway using Needs Assessment</td>
<td>Maternity, HV, GP, Voluntary sector</td>
</tr>
<tr>
<td></td>
<td>Access</td>
<td>Increasing access to IAPT Service</td>
<td>Encouraging referrals into the service, liaising between HV and maternity to strengthen referral routes. Providing services through range of methods – online, face-to-face (range of locations), via telephone, instant messenger, Skype.</td>
<td>Local</td>
<td>IAPT</td>
</tr>
<tr>
<td>---</td>
<td>----------------</td>
<td>-----------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>6.4</td>
<td>Access</td>
<td>Ensuring child-minding services are available so that parents with children can practically access services, or allowing parents to attend with the child</td>
<td>Crèche availability. Increased availability of services within the community. Part of business plan.</td>
<td>Local</td>
<td>IAPT / maternity / CCs</td>
</tr>
<tr>
<td>6.5</td>
<td>Access</td>
<td>Link IAPT to maternity to increase availability of service</td>
<td>Logistics of arranging IAPT in maternity services. Some difficulties related to commissioning.</td>
<td>Local</td>
<td>IAPT, maternity</td>
</tr>
<tr>
<td>6.6</td>
<td>Access</td>
<td>Link IAPT to CC to increase availability of service</td>
<td>Logistics of arranging IAPT in CC</td>
<td>Local</td>
<td>IAPT, CC</td>
</tr>
<tr>
<td>6.7</td>
<td>Access</td>
<td>Increased prioritisation of PNMH in IAPT services, to be seen more quickly</td>
<td>IAPT referral pathways to be developed by IAPT (NICE guidance)</td>
<td>Local</td>
<td>IAPT</td>
</tr>
<tr>
<td><strong>Ensuring services provided are appropriate</strong></td>
<td><strong>Access</strong></td>
<td><strong>Specific PNMH support on IAPT</strong></td>
<td>Online support is available in Camden via Silvercloud. Specific PNMH could be added. The IAPT leads across London may be</td>
<td>Local</td>
<td>IAPT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Access</th>
<th>Increasing access to IAPT Service</th>
<th>Encouraging referrals into the service, liaising between HV and maternity to strengthen referral routes. Providing services through range of methods – online, face-to-face (range of locations), via telephone, instant messenger, Skype.</th>
<th>Local</th>
<th>IAPT</th>
<th>JL</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.4</td>
<td>Access</td>
<td>Ensuring child-minding services are available so that parents with children can practically access services, or allowing parents to attend with the child</td>
<td>Crèche availability. Increased availability of services within the community. Part of business plan.</td>
<td>Local</td>
<td>IAPT / maternity / CCs</td>
<td></td>
</tr>
<tr>
<td>6.5</td>
<td>Access</td>
<td>Link IAPT to maternity to increase availability of service</td>
<td>Logistics of arranging IAPT in maternity services. Some difficulties related to commissioning.</td>
<td>Local</td>
<td>IAPT, maternity</td>
<td></td>
</tr>
<tr>
<td>6.6</td>
<td>Access</td>
<td>Link IAPT to CC to increase availability of service</td>
<td>Logistics of arranging IAPT in CC</td>
<td>Local</td>
<td>IAPT, CC</td>
<td></td>
</tr>
<tr>
<td>6.7</td>
<td>Access</td>
<td>Increased prioritisation of PNMH in IAPT services, to be seen more quickly</td>
<td>IAPT referral pathways to be developed by IAPT (NICE guidance)</td>
<td>Local</td>
<td>IAPT</td>
<td>JL</td>
</tr>
<tr>
<td><strong>Ensuring services provided are appropriate</strong></td>
<td><strong>Access</strong></td>
<td><strong>Specific PNMH support on IAPT</strong></td>
<td>Online support is available in Camden via Silvercloud. Specific PNMH could be added. The IAPT leads across London may be</td>
<td>Local</td>
<td>IAPT</td>
<td>SCN, JL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>working on some material that could be used.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.2</td>
<td>Training</td>
<td>Ensure specific PNMH training for IAPT professionals</td>
<td>Liaise with IAPT leads to develop additional training required – can be provided by IAPT lead / champion</td>
<td>Local</td>
<td>IAPT</td>
<td>IAPT lead</td>
</tr>
<tr>
<td>7.3</td>
<td>Capacity</td>
<td>Increased availability of family support services, e.g. PIP, parenting support, social support, within CCs</td>
<td>To be discussed with Children's Centres</td>
<td>Local</td>
<td>CCs</td>
<td></td>
</tr>
<tr>
<td>7.4</td>
<td>Capacity</td>
<td>Acute service - no community PNMH offer</td>
<td>Establish community PNMH offer, part of business plan</td>
<td>NCL</td>
<td>Champion, psych, IAPT, CAMHS, maternity</td>
<td>Commissioners</td>
</tr>
<tr>
<td>7.4</td>
<td>Pathways</td>
<td>Acute service - Link in with acute services (psychiatry)</td>
<td>Establish full acute PNMH offer, PNMH Champions to link in with this</td>
<td>NCL</td>
<td>Champion, psych</td>
<td>Commissioners</td>
</tr>
<tr>
<td><strong>Future work</strong></td>
<td><strong>BME</strong></td>
<td><strong>8.1</strong></td>
<td><strong>Prevention</strong></td>
<td><strong>Focus on BME: Reduce stigma and improve disclosure, improve access to services</strong></td>
<td><strong>Liaise with Hopscotch; ensure material is produced that is culturally appropriate. Include support and charitable sector, including signposting to language support. Further information is required locally. The IAPT demographics will show whether access is issue. Look at number of late bookings.</strong></td>
<td><strong>Local</strong></td>
</tr>
<tr>
<td>----------------</td>
<td>--------</td>
<td>--------</td>
<td>----------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td><strong>Fathers</strong></td>
<td><strong>8.2</strong></td>
<td><strong>Prevention</strong></td>
<td>Improve education antenatally and postnatally, what to look out for and focus on their own mood</td>
<td>Information for fathers-to-be has been developed, re what is ‘normal’ in the perinatal period, in the booklet</td>
<td><strong>Local</strong></td>
<td><strong>tbd</strong></td>
</tr>
<tr>
<td></td>
<td><strong>8.3</strong></td>
<td><strong>Prevention</strong></td>
<td>Looking after their own mental health, and signs to look for in their partners</td>
<td>Include fathers in screening questions and ask them about their wellbeing. An audit of IAPT data will show some demographics of these groups, and will guide further work.</td>
<td><strong>Local</strong></td>
<td><strong>tbd</strong></td>
</tr>
<tr>
<td><strong>Reducing stigma</strong></td>
<td><strong>8.4</strong></td>
<td><strong>Prevention</strong></td>
<td>In the general population</td>
<td>Focus on vulnerable women in the community. Improve education. This could include: awareness-raising, leaflets for dissemination, education campaigns</td>
<td><strong>Local</strong></td>
<td><strong>tbd</strong></td>
</tr>
</tbody>
</table>
Summary and Recommendations: Key messages

- The objectives are to create more resilient families to ensure the best start in life for children. The recommendations above have been identified from the findings of this report to improve:
  - Understanding of good PNMH.
  - Identification of early difficulties.
  - Access to services.
  - Collaboration between services.
  - Ensuring that services are patient-focused, not stratified by healthcare provider.
  - Provision of specialist PNMH service.
  - Creation of Leads and Champions.
Appendices
Appendix 1: Definitions of mental illness used in this document

The following definitions are taken from the NICE clinical guidelines.a

Severe mental illness includes the following, alone or in combination:

- Severe & incapacitating depression
- Psychosis & postpartum psychosis (which includes mania and/or depressive symptoms in the immediate postnatal period)
- Schizophrenia
- Bipolar disorder
- Schizoaffective disorder

Anxiety disorders include:

- Generalised anxiety disorder
- Panic disorder
- Obsessive-compulsive disorder (OCD)
- Phobias
- Post-traumatic stress disorder (PTSD)
- Social anxiety disorder

The two principal accepted methods of classifying mental disorders are DSM-5 (Diagnostic and Statistical Manual of mental disorders) and ICD-10 (International classification of diseases). They provide a system of classifying disease by type and severity. Mental illness in the perinatal period will follow the same diagnostic criteria as mental illness outside the perinatal period. These classification systems differentiate between mild, moderate and severe disease, as well as having a classification for co-existence of other illnesses.

The ICD-10 definitions:b

1. Anxiety: anxiety is the major symptom and this is not restricted to any particular environmental situation.

2. Depression: the following symptoms may be present, which vary little from day to day, and are unresponsive to circumstances. The number and severity of symptoms will classify the depression as mild, moderate or severe:
   - Lowering of mood
   - Reduction of energy
   - Anhedonia
   - Reduced concentration
   - Lethargy

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a Antenatal and postnatal mental health: clinical management and service guidance, NICE guidelines [CG192] Published: Dec 2015
b ICD-10, version 2016 (WHO)
• Sleep disturbance
• Reduced appetite +/- weight loss
• Reduced self-esteem / self-confidence
• Feelings of guilt or worthlessness
• Early-morning wakening
• Psychomotor retardation
• Agitation
• Loss of libido.

3. Adjustment disorder: distress and emotional disturbance, interfering with social functioning and performance, arising in the period of adaptation to a significant life change or a stressful life event. Symptoms include:
   • Depressed mood, anxiety or worry (or mixture)
   • Inability to cope, plan ahead or continue in the present situation
   • Difficulty in the performance of daily routine
Appendix 2: Evaluation summary of services to provide support to parents in the perinatal period

The Newpin model was developed in the UK as a model to provide high risk and disadvantaged new mothers, with a focus on preventing harm in the child. It has been adopted as a model in several areas of Australia, as well as being continued in the UK. Other models have developed from an adaptation of the Newpin Model, including the Family Action Perinatal Support Project (PSP), which provides assistance and practical help as well as peer-support. This programme has shown improved outcomes for mothers and there are discussions to increase its reach to the antenatal period also. Perinatal mental health programmes were set up at four sites across the UK in 2010.

The Solihull Approach was developed to promote family wellbeing by supporting parent-child relationships when behavioural difficulties are present. Multiple studies have suggested a positive effect on parental stress and improved parental satisfaction. There is currently an RCT in process to evaluate its effectiveness more fully there is evidence supporting its effectiveness.

The following summarises some parental support programmes that have been evaluated (adapted from the Early Intervention Foundation)

<table>
<thead>
<tr>
<th>Name of Service</th>
<th>Parents targeted</th>
<th>Antenatal / postnatal</th>
<th>Programme outline</th>
<th>Overview of service</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>FNP</td>
<td>Young parents, expecting first child</td>
<td>Antenatal &amp; postnatal</td>
<td>Weekly home visits, then fortnightly until age 2</td>
<td>Motivational element, building strong support network and creating a positive environment for the child</td>
<td>Improved outcomes for mother and child, including ten year follow up</td>
</tr>
<tr>
<td>Baby Steps</td>
<td>Parents-to-be</td>
<td>Antenatal &amp; postnatal</td>
<td>6 weekly antenatal sessions, then 3 postnatal</td>
<td>Building on parenting skills</td>
<td>Improved outcomes for mothers, improved relationships</td>
</tr>
<tr>
<td>Family Foundations</td>
<td>Parents-to-be</td>
<td>Antenatal &amp; postnatal</td>
<td>5 weekly antenatal sessions, then 4 postnatal</td>
<td>Communication skills, preparation for parenthood</td>
<td>Improved outcomes for child and parent</td>
</tr>
<tr>
<td>New Beginnings UK</td>
<td>Mothers and infants</td>
<td>Postnatal</td>
<td>12 sessions, over 6 weeks</td>
<td>Building on parent-infant interaction</td>
<td>Improved functioning from parents towards the child</td>
</tr>
<tr>
<td>Mellow Parenting</td>
<td>Child under 5</td>
<td>Postnatal</td>
<td>13-14 weekly sessions</td>
<td>Build on relationship between child and parent</td>
<td>Reported improvement in parenting skills and outcomes for the child</td>
</tr>
<tr>
<td>Parents as Partners</td>
<td>Mothers &amp; fathers</td>
<td>Postnatal</td>
<td>16 weekly sessions</td>
<td>Parenting support</td>
<td>Improved child behaviour and satisfaction</td>
</tr>
</tbody>
</table>
Ongoing research by the NSPCC:

1. Minding the Baby: focusing on improving the emotional bond between a vulnerable parent and child, building on maternal reflexive capacities (randomised controlled trial underway by UCL and Reading University)

2. Pregnancy in Mind: providing support to the family in the perinatal period, to support mothers and fathers, and build on parenting skills and capabilities
Appendix 3: Training of frontline healthcare workers

The NHS Improving Quality and Access to PNMH Services Review (August 2015) stated “Health care professionals often lack confidence and training in the recognition, treatment and support for women with Perinatal Mental Health problems. Improved training and awareness would be of benefit to all health and social care professionals (doctors, maternity, health visitors and social care).”

The following is not a comprehensive overview of training for each group, but some key points that were highlighted during stakeholder engagement. Further work is required to determine what further training is required.

- Maternity: Training around perinatal mental health is part of midwifery student training. The NSPCC found that 29% of midwives reported they had received no training on perinatal mental health in their pre-registration training. At UCLH, midwives are offered yearly 1 hour training in perinatal health. There is the potential to pursue further interests, for example masters in midwifery have modules in perinatal mental health, but this is optional. Some specific training sessions have been commissioned at the Royal Free.

- IAPT: There is no specific training for IAPT professionals regarding PNMH.

- Primary care: PNMH is not a compulsory part of GP training. GPs may complete part of their training in general mental health, but this is not a core requirement. There are regular optional CPD events for training and trained GPs, as well as online guidance available.

- HV: During stakeholder engagement, it was acknowledged that HV confidence and knowledge in managing PNMH difficulties was variable. Following accreditation, further knowledge and training in PNMH is currently self-directed. The Institute of Health Visiting promotes two training opportunities. The first is a one-day Perinatal Mental Health Awareness day focused on supporting recognition and management of PNMH difficulties. The second is a 2-day course offered to become a local Perinatal Mental Health Champions.

- FSW: There is no specific training for FSW around PNMH. They are provided with support and supervision from IEYS.

During qualification and basic training in midwifery and health visiting, there are modules based around perinatal mental health. However, following qualification training depends on what is available for CPD. There are often multiple topics of education competing for the available CPD training slots. An online resource has been developed by HEE (Health Education England) to provide additional training regarding perinatal mental health, using input from the royal colleges including the RCGP, RCOG, RCN, and RCPsych. There are local training days for healthcare professionals based at each hospital, depending on locally available resources.
There is an emphasis on training in the commissioning guidelines produced by the Joint Commissioning Panel for Mental Health (which is a collaboration between the RCGP and RCPsych). The recommendations include specific additional training for midwives in the detection of at-risk patients, IAPT professionals and GPs. In the focus groups and in discussions with stakeholders, frontline workers almost universally expressed the need for further training.
Appendix 4: Screening for PNMH problems

**The Whooley Questions**

- 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?

  - This can be followed up with:
  - Is this something with which you would like help?

**GAD-2: 2-item Generalized Anxiety Disorder scale**

- Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious or on edge?
- Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?
Appendix 5: Screening and Assessment of perinatal mental health difficulties, adapted from NICE guidance

Screening for PNMH

Whooley Questions

If YES to either question OR if high risk OR clinical concern

EITHER refer to GP or mental health professional

OR assess using EPDS or PHQ-9

GAD-2

If score >3 OR if high risk OR clinical concern

EITHER refer to GP or mental health professional

OR assess using GAD-7

If score <3 but concerns

Ask: "Do you find yourself avoiding places or activities and does this cause you problems?"

Antenatal and postnatal mental health: clinical management and service guidance, NICE guidelines [CG192] Published: Dec 2015
Appendix 6: Patient Health Questionnaire (PHQ-9)

<table>
<thead>
<tr>
<th>Over the last two weeks, how often have you been bothered by any of the following problems?</th>
<th>Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Little interest or pleasure in doing things?</td>
<td>Not at all 0</td>
</tr>
<tr>
<td>Feeling down depressed or hopeless</td>
<td>Not at all 0</td>
</tr>
<tr>
<td>Trouble falling asleep or staying asleep, or sleeping too much?</td>
<td>Not at all 0</td>
</tr>
<tr>
<td>Feeling tired or having little energy?</td>
<td>Not at all 0</td>
</tr>
<tr>
<td>Poor appetite or overeating?</td>
<td>Not at all 0</td>
</tr>
<tr>
<td>Feeling bad about your self – or that you are a failure or have felt yourself or your family down?</td>
<td>Not at all 0</td>
</tr>
<tr>
<td>Trouble concentrating on things, such as reading the paper or watching TV?</td>
<td>Not at all 0</td>
</tr>
<tr>
<td>Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?</td>
<td>Not at all 0</td>
</tr>
<tr>
<td>Thoughts that you would have been better off dead, or hurting yourself in some way?</td>
<td>Not at all 0</td>
</tr>
<tr>
<td>If you checked off any problems, how difficult have these problems made it for you to work, take care of things at home or get along with other people?</td>
<td>Not at all 0</td>
</tr>
</tbody>
</table>

Depression severity: 0-4 None; 5-9 Minimal; 10-14 moderate; 15-19 moderately severe; 10-17 severe
# Generalised Anxiety Disorder Questionnaire (GAD-7)

Over the last two weeks, how often have you been bothered by any of the following problems?  

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling nervous, anxious or on edge?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Not being able to stop or control worrying?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Worrying too much about different things?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Trouble relaxing?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Being so restless that it is hard to sit still?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Becoming easily annoyed or irritable?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feeling afraid as if something awful might happen?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Scores: 5 = mild anxiety; 10 = moderate anxiety; 15 = severe anxiety  
Further evaluation by GP/ specialist mental health service is required when the score is 10 or greater
Appendix 8: Edinburgh Postnatal Depression Scale (EPDS)\textsuperscript{38}

<table>
<thead>
<tr>
<th>Over the last one week, how have you felt?</th>
<th>Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have been able to laugh and see the funny side of things</td>
<td></td>
</tr>
<tr>
<td>As much as I always could</td>
<td>0</td>
</tr>
<tr>
<td>Not quite so much now</td>
<td>1</td>
</tr>
<tr>
<td>Definitely not so much now</td>
<td>2</td>
</tr>
<tr>
<td>Not at all</td>
<td>3</td>
</tr>
<tr>
<td>I have looked forward with enjoyment to things</td>
<td></td>
</tr>
<tr>
<td>As much as I ever did</td>
<td>0</td>
</tr>
<tr>
<td>Rather less than I used to</td>
<td>1</td>
</tr>
<tr>
<td>Definitely less than I used to</td>
<td>2</td>
</tr>
<tr>
<td>Hardly at all</td>
<td>3</td>
</tr>
<tr>
<td>I have blamed myself unnecessarily when things went wrong</td>
<td></td>
</tr>
<tr>
<td>Yes, most of the time</td>
<td>3</td>
</tr>
<tr>
<td>Yes, some of the time</td>
<td>2</td>
</tr>
<tr>
<td>Not very often</td>
<td>1</td>
</tr>
<tr>
<td>No, never</td>
<td>0</td>
</tr>
<tr>
<td>I have been anxious or worried for no good reason</td>
<td></td>
</tr>
<tr>
<td>No, not at all</td>
<td>0</td>
</tr>
<tr>
<td>Hardly ever</td>
<td>1</td>
</tr>
<tr>
<td>Yes, sometimes</td>
<td>2</td>
</tr>
<tr>
<td>Yes, very often</td>
<td>3</td>
</tr>
<tr>
<td>I have felt scare or panicky for no very good reason</td>
<td></td>
</tr>
<tr>
<td>Yes, quite a lot</td>
<td>3</td>
</tr>
<tr>
<td>Yes, sometimes</td>
<td>2</td>
</tr>
<tr>
<td>No, not much</td>
<td>1</td>
</tr>
<tr>
<td>No, not at all</td>
<td>0</td>
</tr>
<tr>
<td>Things have been getting on top of me</td>
<td></td>
</tr>
<tr>
<td>Yes, most of the time I have not been able to cope at all</td>
<td>3</td>
</tr>
<tr>
<td>Yes, sometimes I have not been coping as well as usual</td>
<td>2</td>
</tr>
<tr>
<td>No, most of the time I have coped quite well</td>
<td>1</td>
</tr>
<tr>
<td>No, I have been coping as well as ever</td>
<td>0</td>
</tr>
<tr>
<td>I have been so unhappy that I have had difficulty sleeping</td>
<td></td>
</tr>
<tr>
<td>Yes, most of the time</td>
<td>3</td>
</tr>
<tr>
<td>Yes, quite often</td>
<td>2</td>
</tr>
<tr>
<td>Not very often</td>
<td>1</td>
</tr>
<tr>
<td>No, not at all</td>
<td>0</td>
</tr>
<tr>
<td>I have felt sad or miserable</td>
<td></td>
</tr>
<tr>
<td>Yes, most of the time</td>
<td>3</td>
</tr>
<tr>
<td>Yes, quite often</td>
<td>2</td>
</tr>
<tr>
<td>Not very often</td>
<td>1</td>
</tr>
<tr>
<td>No, not at all</td>
<td>0</td>
</tr>
<tr>
<td>I have been so unhappy that I have been crying</td>
<td></td>
</tr>
<tr>
<td>Yes, most of the time</td>
<td>3</td>
</tr>
<tr>
<td>Yes, quite often</td>
<td>2</td>
</tr>
<tr>
<td>Only occasionally</td>
<td>1</td>
</tr>
<tr>
<td>No, never</td>
<td>0</td>
</tr>
<tr>
<td>The thought of harming myself has occurred to me</td>
<td></td>
</tr>
<tr>
<td>Yes, quite often</td>
<td>3</td>
</tr>
<tr>
<td>Sometimes</td>
<td>2</td>
</tr>
<tr>
<td>Hardly ever</td>
<td>1</td>
</tr>
<tr>
<td>Never</td>
<td>0</td>
</tr>
<tr>
<td>Scores &gt;12 likely depression</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 9: HAD score (Hospital Anxiety and Depression)

This is an example of the HAD scale that can be used (this copy obtained from the FNP programme in Camden)

The Anxiety and Depression Scale (HADS)

Antenatal or Postnatal

Name: ___________________________ Date: __________

This questionnaire is designed to help us to know how you feel. Ignore the numbers printed on the left of the questionnaire. Read each item and tick or cross the reply that comes closest to how you have been feeling in the past week. Don’t take too long over your replies; your immediate reaction to each item will probably be more accurate than a long, thought-out response.

<table>
<thead>
<tr>
<th>Anxiety</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>I feel tense or ‘wound up’:</td>
<td></td>
</tr>
<tr>
<td>3 Most of the time</td>
<td></td>
</tr>
<tr>
<td>2 A lot of the time</td>
<td></td>
</tr>
<tr>
<td>1 From time to time, occasionally</td>
<td></td>
</tr>
<tr>
<td>0 Not at all</td>
<td></td>
</tr>
<tr>
<td>I still enjoy the things I used to enjoy:</td>
<td></td>
</tr>
<tr>
<td>0 Definitely as much</td>
<td></td>
</tr>
<tr>
<td>1 Not quite so much</td>
<td></td>
</tr>
<tr>
<td>2 Only a little</td>
<td></td>
</tr>
<tr>
<td>3 Hardly at all</td>
<td></td>
</tr>
<tr>
<td>I get a sort of frightened feeling as if something awful is about to happen:</td>
<td></td>
</tr>
<tr>
<td>3 Very definitely and quite badly</td>
<td></td>
</tr>
<tr>
<td>2 Yes, but not too badly</td>
<td></td>
</tr>
<tr>
<td>1 A little, but it doesn’t worry me</td>
<td></td>
</tr>
<tr>
<td>0 Not at all</td>
<td></td>
</tr>
<tr>
<td>I can laugh and see the funny side of things:</td>
<td></td>
</tr>
<tr>
<td>0 As much as I always could</td>
<td></td>
</tr>
<tr>
<td>1 Not quite so much now</td>
<td></td>
</tr>
<tr>
<td>2 Definitely not so much now</td>
<td></td>
</tr>
<tr>
<td>3 Not at all</td>
<td></td>
</tr>
<tr>
<td>Worrying thoughts go through my mind:</td>
<td></td>
</tr>
<tr>
<td>3 A great deal of the time</td>
<td></td>
</tr>
<tr>
<td>2 A lot of the time</td>
<td></td>
</tr>
<tr>
<td>1 From time to time, but not too often</td>
<td></td>
</tr>
<tr>
<td>0 Only occasionally</td>
<td></td>
</tr>
<tr>
<td>I feel cheerful:</td>
<td></td>
</tr>
<tr>
<td>3 Not at all</td>
<td></td>
</tr>
<tr>
<td>2 Not often</td>
<td></td>
</tr>
<tr>
<td>1 Sometimes</td>
<td></td>
</tr>
<tr>
<td>0 Most of the time</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 10: Stepped-care model: a combined summary for common mental health disorders (taken from NICE guidelines)

<table>
<thead>
<tr>
<th>Focus of the intervention</th>
<th>Nature of the intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 3:</strong></td>
<td></td>
</tr>
<tr>
<td>• Persistent sub-threshold depressive symptoms or mild-moderate depression that has not responded to a low-intensity intervention;</td>
<td>Depression: CBT, IPT, behaviour activation, behaviour couples therapy, counselling*, short-term psychodynamic psychotherapy*, antidepressants, combined interventions, collaborative care**, self-help groups.</td>
</tr>
<tr>
<td>• Initial presentation of moderate-severe depression;</td>
<td>GAD: CBT, applied relaxation, drug treatment, combined interventions, self-help groups.</td>
</tr>
<tr>
<td>• GAD with marked functional impairment or that has not responded to a low-intensity intervention;</td>
<td>Panic disorder: CBT, antidepressants, self-help groups.</td>
</tr>
<tr>
<td>• Moderate-severe panic disorder;</td>
<td>OCD: CBT (including ERP), antidepressants, combined interventions and case management, self-help groups.</td>
</tr>
<tr>
<td>• OCD with moderate-severe functional impairment;</td>
<td>PTSD: Trauma-focused CBT, EMDR, drug treatment.</td>
</tr>
<tr>
<td>• PTSD.</td>
<td><strong>All disorders:</strong> Support groups, befriending, rehabilitation programmes, educational and employment support services; referral for further assessment and interventions.</td>
</tr>
<tr>
<td><strong>Step 2:</strong></td>
<td></td>
</tr>
<tr>
<td>• Persistent sub-threshold depressive symptoms or mild-moderate depression;</td>
<td>Depression: Individual facilitated self-help, computerised CBT, structured physical activity, group-based peer support (self-help) programmes**, non-directive counselling delivered at home†, antidepressants, self-help groups.</td>
</tr>
<tr>
<td>• GAD;</td>
<td>GAD and panic disorder: Individual non-facilitated and facilitated self-help, psycho-educational groups, self-help groups.</td>
</tr>
<tr>
<td>• Mild-moderate panic disorder;</td>
<td>OCD: Individual or group CBT (including ERP), self-help groups.</td>
</tr>
<tr>
<td>• Mild-moderate OCD;</td>
<td>PTSD: Trauma-focused CBT or EMDR.</td>
</tr>
<tr>
<td>• PTSD (including people with mild-moderate PTSD).</td>
<td><strong>All disorders:</strong> Support groups, educational and employment support services; referral for further assessment and interventions.</td>
</tr>
<tr>
<td><strong>Step 1:</strong> All disorders – known and suspected presentations of common mental health disorders.</td>
<td>All disorders: Identification, assessment, psycho-education, active monitoring; referral for further assessment and interventions.</td>
</tr>
</tbody>
</table>

* Discuss with the person the uncertainty of the effectiveness of counselling and psychodynamic psychotherapy in treating depression.
** For people with depression and a chronic physical health problem.
† For women during pregnancy or the postnatal period.

CBT, cognitive behavioural therapy; ERP, exposure and response prevention; EMDR, eye movement desensitisation and reprocessing; GAD, generalised anxiety disorder; OCD, obsessive compulsive disorder; IPT, interpersonal therapy; PTSD, post-traumatic stress disorder.

---

*NICE guidelines [CG123]: Common mental health problems: identification and pathways to care, May 2011*
## Appendix 11: Evidence regarding early support interventions for PNMH

<table>
<thead>
<tr>
<th>Early support interventions</th>
<th>Impact</th>
<th>Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT / psychotherapy delivered by HVs</td>
<td>Reducing symptoms of PND</td>
<td>Positive results, continued at 12 months postnatally.</td>
</tr>
<tr>
<td>Complementary therapies</td>
<td>Prevention of antenatal depression</td>
<td>Insufficient evidence, further research required.</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>Manage symptoms of antenatal depression</td>
<td>Insufficient evidence.</td>
</tr>
<tr>
<td>Post-partum home visits*, telephone support and interpersonal psychotherapy</td>
<td>Prevention PND</td>
<td>Strong evidence of beneficial effect (Cochrane review: trials of 17,000 women).</td>
</tr>
<tr>
<td>Peer-support</td>
<td>Reducing anxiety</td>
<td>Encouraging trials</td>
</tr>
<tr>
<td>Peer-support</td>
<td>Reducing symptoms of PND</td>
<td>Further evidence required (NICE: Research recommendation 2.3).</td>
</tr>
</tbody>
</table>

---

*a* Specifically: intensive nursing, or flexible post-partum maternity care

*b* NICE guidelines [CG37]: Postnatal care up to 8 weeks after birth, July 2006
Appendix 12: Primary care data for Camden

Figure 6: Number of patients coded with PND in the previous 12 months on EMIS in Camden April 2014 - March 2015

Only 8 women were coded with having been screen for PND in the previous 12 months, suggesting underuse use of primary care codes. Data is awaited to see if this data can be cross-referenced with current pregnancy or pregnancy in the previous 12 months. It would be useful to have the demographic breakdown of this information, and prevalence of previous mental health difficulties.

*Data from EMIS, from Camden CCG, extracted December 2015*
Appendix 13: The THRIVE model (adapted from the AFC-Tavistock model)\(^2\)

- **COPING**
  - Education
  - Self-help

- **GETTING HELP**
  - Evidence-based interventions

- **GETTING RISK SUPPORT**
  - Social care
  - Health care

- **GETTING MORE HELP**
  - Specialised
  - Inpatient and outpatient

**THRIVING**
Appendix 14: Proposed Perinatal Mental Healthcare Pathways

The following service flowcharts and algorithms are taken from the Pan-London Perinatal Mental Health Network

---

*MATERNAL MENTAL HEALTH - PERINATAL PSYCHIATRIC SERVICES: ALGORITHM FOR PRECONCEPTION ADVICE*

- Identify women of childbearing age with active or in remission mental illness (e.g., by GP or by adult mental health perinatal champion or care-coordinator at CPA)
- Discuss pregnancy planning and referral for preconception advice
- NOT severe mental illness
  - Information leaflets for all women and encourage discussion with GP
- Severe mental illness
  - Preconception counselling appointment with perinatal mental health service (1)

*SMI are schizophrenia, schizoaffective disorder, other psychoses, bipolar affective disorder, severe unipolar depression.*

---

MATERNAL MENTAL HEALTH PERINATAL PSYCHIATRIC SERVICES: ALGORITHM FOR PREGNANCY

Routine mental health screening questions at maternity booking (2)

Pregnant woman with current or past history of mental illness identified by any professional

Current or past history of severe mental illness (3)

Current or past history of mild/moderate mental illness

No mental illness – continue to ask about mental wellbeing during pregnancy & postnatally

To primary care pathway

Consider whether CAF needed (4)

Referral to accredited perinatal mental health service (5)

if urgent → A&E, general liaison psychiatry or adult mental health if perinatal team unable to assess

Refer for antenatal care if not done (if available specialist midwife/midwifery team and Consultant Obstetrician)

Perinatal team to check mental health records and/or request mental health history from GP

SMI criteria met

Assessment by perinatal team (6)

Refer back to primary care following assessment and advice

Ongoing care by perinatal mental health team (7) and circulate Perinatal Mental Health Care Plan (8)

If admission needed consider MBU after 32/40 weeks of pregnancy (10)

Pre-birth perinatal mental health planning meeting (by 32/40) (9)

Refer to maternal mental health psychological therapies/parent-infant psychotherapy

Review and update Perinatal Mental Health Care plan – copy to woman and all professionals (8)
MATERNAL MENTAL HEALTH - PERINATAL PSYCHIATRIC SERVICES: ALGORITHM FOR DELIVERY

For women already known to perinatal mental health services:
- Review of mental health by perinatal mental health professional or postnatal ward (or other mental health professional if no perinatal service).
- Action perinatal mental health care plan.
- Ensure all involved professionals informed of delivery.
- Discharge planning meeting for complex cases.
- Urgent concerns during maternity admission: Follow hospital protocol for urgent assessment. Perinatal liaison / general liaison psychiatry

For women not previously known to perinatal mental health services where new mental health concerns identified:
- If severe mental illness: Review of mental health by perinatal mental health professional or postnatal ward (or other mental health professional if no perinatal service); agree plan and ensure relevant professionals informed.
- If mild to moderate mental illness:
  - Review by specialist mental health midwife.
  - Urgent concerns during maternity admission: Follow hospital protocol for urgent assessment. Perinatal liaison / general liaison psychiatry

POSTNATAL PATHWAY

Refer back to primary care following assessment and advice.

Refer to maternal mental health psychological therapies/parent-infant psychotherapy.

If admission needed refer to MBU (10)
Maturel Mental Health - Perinatal Psychiatric Services: Algorithm for the Postpartum

For women known to perinatal mental health services during antenatal period follow care plan.

Pregnant woman with current or previous mental illness identified by any professional.

Current or previous severe mental illness (3).

If urgent concern—same day assessment in A&E or CMHT if perinatal team unable to assess.

Referral to perinatal mental health service (or CMHT if no perinatal team) (5).

Consider whether CAF needed (4).

Perinatal team to check mental health records and/or request mental health history from GP.

Assessment by perinatal team (6).

If admission needed refer to MBU (acute ward only if MBU criteria not met) (10).

Ongoing care by perinatal mental health team in partnership with other services.

Advise re local postnatal psychological support e.g. children’s Centre/ Voluntary sector/ Websites.

Refer to maternal mental health psychological therapies/parent-infant psychotherapy.

Following MBU discharge – review in community by perinatal mental health team within 7 days.

Discharge to CMHT (or other mental health service) or GP (11).
MATERNAL MENTAL HEALTH - PRIMARY CARE PATHWAY

Routine mental health screening questions at maternity booking (2)

Pregnant woman with current or previous mental illness identified by any professional

Current or previous mild / moderate mental illness

Current or previous severe mental illness

No mental illness – continue to ask about mental wellbeing during pregnancy & postnatally

Refer to perinatal mental health team

GP to assess mental health and inform midwives and HV of any concerns

Prescribe medication
(request advice from perinatal mental health team if needed)

Consider and complete CAP if needed

Refer to IAPT

Wellbeing plan

Information and advice re voluntary sector and other resources including Family Nurse Partnership, local support services, and websites etc.

Continue to review mental health during pregnancy and postnatal period

Ongoing liaison between GP, HV, midwives and any other involved professionals

If urgent concern → M&H or CMHT if perinatal team unable to assess

Refer to perinatal mental health team if severe mental illness

To severe mental illness pathway
Appendix 15: Demographics of women accessing CAMHS in Camden

Figure 7: Women undergoing mental health assessed by CAMHS in CC in Q1-4 2014/5, by ethnicity

Appendix 16: Feedback from families accessing CAMHS in CC.

<table>
<thead>
<tr>
<th>Service</th>
<th>Feedback</th>
</tr>
</thead>
</table>
| IEYS  | 75% of children and parents or carers reported improved mental health\(^a\) and 80% of parents reported satisfaction with the service\(^b,c\). Feedback from parents highlighted the importance of facilitating peer-support.  
   “I felt that I wasn’t alone. Everyone was in the same situation as me”  
   “The good things were mixing with parents who have the same parenting problems.” |
| YPS  | 75% of children and parent/carer reported improved mental health\(^d\) and 100% of parents reported satisfaction with the service\(^e\). \(^f,g\) One service user said:  
   “Having a person who was listening/understanding was very helpful” |

\(^a\) Measured against across two goals on the Goal-based Measure: At assessment, the respondent lists 3 goals and rates how close they are to reaching each. 6 months later or at case closure, the respondent again rates how close they are.  
\(^b\) Measured against CHI-ESQ: Experience of Service Questionnaire  
\(^d\) Measured against across two goals on the Goal-based Measure: At assessment, the respondent lists 3 goals and rates how close they are to reaching each. 6 months later or at case closure, the respondent again rates how close they are.  
\(^e\) Measured against CHI-ESQ: Experience of Service Questionnaire  
\(^f\) The service compiled feedback for Q1, 2, 4 (Q3 data was irretrievable).  
Appendix 17: Information on patients accessing Anna Freud services

Almost 50% of those who have accessed the service since 2010 were of white ethnicity. 38% were referred via mental health services, and 15% self-referred. Where the reason for accessing the service was recorded, almost half of these accessed the service for depression / anxiety. Data was also collected at 6 months following start of engagement with services. However, this data was more than 50% incomplete and so has not been included.

Figure 8: Patients accessing PIP at the AFC, by ethnicity of the child, January 2010-November 2015
Figure 9: Patients accessing PIP at the AFC, by mode of referral, January 2010-November 2015

- Mental Health Service: 63
- Health Service: 46
- Self-referred: 24
- Social Services: 23
- Other: 7

Source: data obtained from Anna Freud Centre, patients accessing PIP at the AFC (extracted November 2015)

Figure 10: Patients accessing PIP at the AFC, by principle reason for referral, January 2010-November 2015

- Depression / Anxiety: 79
- Bonding & attachment: 42
- Relationship Conflict / Isolation: 22
- Past experiences: 13
- Other / Missing: 8

Source: data obtained from Anna Freud Centre, patients accessing PIP at the AFC (extracted November 2015)
### Appendix 18: Key areas highlighted regarding identification of need

<table>
<thead>
<tr>
<th>Key area identified</th>
<th>Key statement</th>
<th>Overview</th>
<th>Impact</th>
<th>Examples of practice elsewhere</th>
<th>Proposed Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding the needs of the local population</td>
<td>Lack of baseline data</td>
<td>Further data collection is required from each agency as currently information available is very limited.</td>
<td>There is a lack of data regarding at-risk groups. This includes understanding demographics of population affected / at risk in Camden.</td>
<td>The PNMH Value Scorecard has been piloted at Newham, Tower Hamlets, Hackney and NELFT Basildon and Thurrock. The Scorecard is a quality improvement tool, focused on improving identification of mothers PNMH difficulties by reviewing local data on screening and services. There are three quality improvement strands: 1. Routine recording of all mood assessments at new birth contact 2. Using the EPDS at 6-8 week contact 3. Using the EPDS following listening visits, with intention of monitoring</td>
<td>Data should be an integral part of each service. Further primary care data is currently awaited, which will cross-reference recent / current pregnancy with mental health diagnosis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The primary healthcare practitioners identifying PNMH problems are maternity, GPs and HVs. GPs collect data, but there are difficulties around coding.</td>
<td>There may be an unmet need in Camden, as the only data available is based on modelling estimates.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>It is especially difficult to diagnose men affected by PNMH difficulties as their medical records are not linked to their partner’s.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of information regarding identification</td>
<td>There is no information collected by HV or maternity regarding the number of women screened for depression and anxiety, and how many meet the threshold for further assessment or intervention.</td>
<td>Collecting information on whether women have been screened for PNMH problems at each antenatal and postnatal contact, and then have been fully assessed is part of the 2016 NICE Quality Statement Guidelines.</td>
<td></td>
<td>Collecting information on screening methods used for women by GPs / HVs / maternity would ensure standardisation. GPs could have screening questions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The experience reported by mothers is different reported by</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

A Antenatal and postnatal mental health, NICE guidelines [qs115] Published: February 2016
<table>
<thead>
<tr>
<th>Lack of PNMH education in the community</th>
<th>Outcomes of women referred or signposted are largely unknown</th>
<th>If vulnerable women are not assessed, they may not be referred or signposted onwards.</th>
<th>impact on mood.</th>
<th>automatically added into the templates to ask trigger questions. This would facilitate data collection also.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Camden residents have reported there is generally an unachievable expectation of motherhood. This includes women from middle and high-income groups who have high expectations and may become isolated due to a limited social network.</td>
<td>There is a lack of information regarding where women and families are signposted. The number of women accessing services such as IAPT in the perinatal period is unknown.</td>
<td>It is unclear if women are identified, whether they are not accessing services or whether this is not recorded.</td>
<td>Further data is required from IAPT to understand how many women are seen during the perinatal period. This could be added into the screening questions (currently proposed).</td>
<td></td>
</tr>
</tbody>
</table>

| Lack of PNMH education in the community | Unrealistic parenting expectations are a risk factor for PNMH difficulties. | The Baby Buddy app was developed by Best Beginnings, which provide support and useful helpful advice. This is currently being promoted at the Whittington, results awaited. It is routinely distributed to all parents at UCLH. There is the Direct Action Project in Islington, which is a health voluntary organisation | These services could be promoted. There are plans to develop a version for fathers also. |

---

*a* Cocoon Focus Group  
*b* Midwifery focus group
<table>
<thead>
<tr>
<th>Poor understanding in new parents and their families of signs and symptoms of difficulties.</th>
<th>Some parents(^a), especially fathers, felt they did not receive enough education on PNMH illness during pregnancy. They reported they would have benefited from this antenatally or pre-conception.</th>
<th>Reduced identification of difficulties.</th>
<th>NCL has recently developed information leaflets for distribution to parents (postnatal information, antenatal information available electronically)</th>
<th>Many agencies and parents suggested written information and leaflets to parents-to-be would be useful. This would include general information on being a new parent, signs of PNMH to look out for.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-disclosure by patients of existing risk factors / lack of understanding their relevance</td>
<td>One of the indicators of mental health difficulties is a lack of insight into the problems being faced, an example being women who stop their anti-depressants without communicating this(^b). This can lead to non-recognition of signs and a delay in accessing support.</td>
<td>Increased risk of difficulties and reduced likelihood of early recognition of signs</td>
<td></td>
<td>Further pre-conception mental health education and advice.</td>
</tr>
<tr>
<td>Stigma and fear of disclosing symptoms</td>
<td>Parents feel there are barriers to disclosure and so minimise symptoms and impact of mental health difficulties. These include fear of being labelled as “cannot cope”, concerns regarding child protection services(^b), and stigma.(^c)</td>
<td>This makes it difficult to identify early difficulties and offer appropriate support. Families may not engage with services even after difficulties have been identified.</td>
<td>Universal education of the role of PNMH support. De-stigmatisation through education and normalisation of the reality of the perinatal period.</td>
<td></td>
</tr>
</tbody>
</table>

\(^a\) Midwife focus group  
\(^b\) Cocoon Focus Group, 27th June 2015  
\(^c\) Midwife focus group
<table>
<thead>
<tr>
<th><strong>Screening for difficulties</strong></th>
<th>Lack of continuity with healthcare professionals</th>
<th>At UCL, midwives carrying out booking appointments are often different to those the mother will see at follow up care.</th>
<th>This makes it difficult to create an environment for disclosure, and difficulty building trust between healthcare professionals and those accessing services.</th>
<th>Continuity of care is likely to improve disclosure. Including mental health services within other services – e.g. GP / baby clinic – may improve continuity of care.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Difficulties of disclosure when family members present</strong></td>
<td>Time limitations and work pressures sometimes make conversations about sensitive issues more difficult.</td>
<td>Non-disclosure of symptoms</td>
<td>‘Talk to me alone’ session at the end of the booking appointment, which provides the opportunity for woman to disclose without her family present.</td>
<td></td>
</tr>
<tr>
<td><strong>Mental health is not always considered on the agenda, and problems may develop later</strong></td>
<td>Mothers need more support once the father returns to work. There may be a gap in services just after the baby has been born, and before the 6-week check with the GP. During this time, HV contact is new.</td>
<td>Missing opportunities to identify problems and provide support.</td>
<td>There has now been implementation of antenatal visit at around 28 weeks with the HV, which will help to improve this continuity of care.</td>
<td></td>
</tr>
<tr>
<td><strong>Health professionals may not use standardised methods for screening</strong></td>
<td>NICE guidelines offer recommendations in screening tools to be used, however currently there is no record of tools used by maternity / HVs</td>
<td>Using tablet computers to implement NICE antenatal mental health guidance to screen women using the Whooley questions or the EPDSb. ⁴³</td>
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</tbody>
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⁴³ Mother’s focus group

b A study is currently being conducted looking at the feasibility of this
<table>
<thead>
<tr>
<th>Problems in high risk BME families may be missed</th>
<th>Some BME groups might feel especially stigmatised when accessing services</th>
<th>HVs reported that Bengali women, if they feel isolated, may not want to seek support and might feel stigmatised. Some women do not want to access Hopscotch due to concerns of rumours in their small community and resulting stigmatisation.</th>
<th>Vulnerable groups not accessing support.</th>
<th>Focus on reducing stigma in BME groups, including further engagement with Hopscotch on how to approach this. There may be lessons learnt from the recent Hopscotch DVA campaign.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language and cultural barriers make discussion of sensitive subjects more difficult. Symptoms are interpreted differently by residents and healthcare professionals</td>
<td>It is not always clear that problems are related to mental health as they sometimes manifest as pain or other non-specific symptoms in some BME groups. This makes it difficult to recognise symptoms, and to discuss PNMH as a mental health problem. If healthcare providers and parents speak different languages, this reduces their ability to engage with each other.</td>
<td>Not identifying vulnerable and at-risk women.</td>
<td>Training of healthcare professionals in appropriate cultural sensitivity. Education of women and their families on looking for signs of PNMH difficulties. Signposting to English language support.</td>
<td></td>
</tr>
<tr>
<td>Fathers are not prioritised in the perinatal mental health</td>
<td>Lack of understanding regarding how to support</td>
<td>Men may find it difficult to offer support to their partners. Some men might benefit from services including counselling, practical</td>
<td>Breakdown of relationships leads to less resilient families and is a further risk factor for PNMH difficulties.</td>
<td>Including fathers in services offered, including practical support in supporting</td>
</tr>
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</table>

a HV engagement  
b Midwife focus group
<table>
<thead>
<tr>
<th>agenda</th>
<th>their partners</th>
<th>support and peer-to-peer support, including how to support their partners.(^a)</th>
<th>their partners.</th>
</tr>
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<tbody>
<tr>
<td>There is a lack of national and local data regarding the number of men affected</td>
<td>Men may themselves experience difficulties with their own mental health. New fathers reported requiring support and being affected by traumatic births.(^a)</td>
<td>Lack of identification of vulnerable fathers, and lack of support for the whole family. Men not engaging with services.</td>
<td>Education of new fathers regarding their mental health. New targeted approaches are required for fathers, with inclusion into the strategy. Considering PNMH as family-focused rather than just a problem for mothers.</td>
</tr>
<tr>
<td>Men have been more difficult to engage with some services.(^b)</td>
<td>Fathers are not always present during the contact with HV/midwives so cannot be assessed.</td>
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\(^a\) Cocoon Focus Group, 27\(^{th}\) June 2015  
\(^b\) Engagement with the Winch
Appendix 19: Key areas highlighted regarding provision of service

<table>
<thead>
<tr>
<th>Key area identified</th>
<th>Key statement</th>
<th>Overview</th>
<th>Impact</th>
<th>Examples of practice elsewhere</th>
<th>Proposed action</th>
</tr>
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</table>
| Unclear pathways    | Unclear threshold criteria for providing care in specific services | Midwives estimated that a quarter to a third of the mothers report low mood, not meeting the threshold for intervention.¹  
Midwives² expressed concern that referrals to CAMHS with no clear diagnosis were often not accepted, and HV expressed being unclear what the referral thresholds were.³ | This may deter referrals. |  | Clarification of acceptance criteria and pathways |
|                     | Unclear pathways and referral routes for healthcare professionals including local charity organisations | The interactions between different agencies are complex. Understanding where to refer and signpost parents is not clear. | Healthcare professionals do not know where to refer and signpost women. | One HV in Camden has compiled a list of agencies together.  
Also the London Strategic Network has produced proposed pathways which can be locally adapted (Appendix 14) | Creation and regular updates of service pathways for referral, and another one for signposting. This process may facilitate collaboration between boroughs.  
Some information is |

¹ Midwife focus groups  
² Midwife focus group  
³ HV engagement
| Unclear methods of signposting or referrals between areas | Families often cross boundaries for perinatal care. This creates complicated referrals and signposting due to geographical borders and locally available services. | Risk of vulnerable women falling between services, out of sight.  
This is a risk as there can be loss of information, or the family may not access support required | Options include:  
- Centralised system for HV referral  
- A single form for referral  
- A named liaison person  
Easily accessible information for referral pathways is essential. |
|---|---|---|---|
| Appropriate services available | Acceptability of offer | Parents would like access to further peer-support groups at the Children’s Centres.  
Some therapies are more acceptable than others, including baby massage. | Parents may be more likely to engage with certain services | Providing access to a wider range of services may improve engagement, especially through the voluntary sector. |
| Specific focused services are | Dealing with mental health issues should not be the sole focus of preventing problems, and this | Improving outcomes for families and children is also dependent on supporting | Incorporation of relationship and parent-child bonding |

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\[ ^a \text{Public Health Agency, Integrated Perinatal Mental Health Care Pathway, December 2012} \]
\[ ^b \text{This provides information via Mental Health, Children’s Services, and Women’s Health links.} \]
\[ ^c \text{Midwives focus group} \]
| Lack of specialisation within mental health | Women in the perinatal period access some specialist and some mainstream mental health services, such as IAPT. | Mainstream mental health services may not offer appropriate for women in the perinatal period. | The Pan-London Perinatal Mental Health Strategic Network has brought together Perinatal Leads from IAPT across London to:  
- Develop information leaflet for IAPT for parents  
- Adaptation of self-help online services for PNMH  
- Creating a peer-supervision network to enable learning across areas / support professional development  
- Adaptation of triage questions for PNMH  
Looking to increase contacts between Children’s Centres, HVs, maternity services to increase referrals into the service | Continue to support this implementation. |

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Cocoon Focus Group, 27th June 2015
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<tr>
<th><strong>Accessibility of services</strong></th>
<th><strong>Limited access to PIP</strong></th>
<th><strong>PIP is focused on improving and strengthening relationships</strong></th>
<th><strong>Loss of opportunity to promote healthy relationships</strong></th>
<th><strong>There is PIP available at CCs across Islington</strong></th>
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<tr>
<td><strong>Capacity: high demand for early intervention / support</strong></td>
<td>The voluntary sector reports their capacity is insufficient to meet demand.æ</td>
<td>Vulnerable parents may not be access the help they need.</td>
<td>Promoting and supporting evidence-based services.</td>
<td></td>
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<tr>
<td><strong>Inequity of service across the borough</strong></td>
<td>There is an uneven offer over the borough. Some areas offer services that have developed from a need, outside the healthcare provider’s job plans. As such they are often not included in the pathways.</td>
<td>Women and families do not have equitable access to care.</td>
<td>Including the services available in any mapping of services to ensure equity of access.</td>
<td></td>
</tr>
<tr>
<td><strong>Services are not child-friendly</strong></td>
<td>Practical and logistic help to attending mental healthcare services is not always present – e.g. providing child-minder support, or allowing the child to attend</td>
<td>Parents may not attend services if they cannot bring their children with them.</td>
<td>Ensuring all services are child-friendly.</td>
<td></td>
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<tr>
<td><strong>Restrictive access criteria due to contracts</strong></td>
<td>Some restrictions on services may limit access to vulnerable parents if they do not meet strict inclusion criteria. e.g. Brandon Reach can only provide support to parents aged 25, but older high-risk parents might also benefit.</td>
<td>Capacity to provide support to vulnerable parents</td>
<td>Changing of commissioning criteria.</td>
<td></td>
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æ Engagement with Hopscotch, Cocoon, the Winch
| **Stigma associated with location of services** | **HV’s and parents mentioned that Children’s Centres are difficult to access in the antenatal period without a child, or postnatally as this may be seen as needing help.** | **Parents may avoid Children’s Centres if they feel stigmatised.** | **Continuing to offer services across a range of locations. Mental health services available during baby check clinics and HV clinics may be more accessible.** |
| **Collaboration between services** | **Communications between GP and maternity** | **Women can self-refer to services. Open-door access encourages engagement. However communication lines between agencies are sometimes unclear and information may be lost, e.g. women with a history of mental health problems may register directly with their midwife rather than their GP and not disclose a history of mental illness.**<sup>a</sup> When information is requested, midwives report this is often poorly filled out. | **Reduced identification of high-risk women and loss of trust between the woman and healthcare services.** The MBRRACE-UK 2015 report<sup>4</sup> highlighted the importance of communication between services, especially GP and maternity services, to highlight mothers at risk. | **Further work is required to establish how to improve communication between agencies.** |
| **Communications between HV and maternity** | **Women at 28-30 weeks should be visited by a HV. This requires clear communication between the HV & GP / maternity i.e. if the pregnancy** | **Reduced identification of high-risk women. Breakdown in communication between** | **Currently meetings between FSW, HV liaison and Children’s Centres are** |

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<sup>a</sup> Midwife focus group, midwifery interviews
<table>
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<tr>
<th>Community between acute and community services</th>
<th>Risk of loss of information between services</th>
<th>established.</th>
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<tr>
<td>There are no clear communication pathways for referring women who deliver at one hospital but live in an area served by another hospital.</td>
<td></td>
<td>Appropriate data sharing methods need to be established</td>
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<tr>
<th>Difficult to resolve some contributing elements to socio-economic factors that influence mental health resilience</th>
<th>Unable to improve the factors contributing to poor mental health.</th>
<th>Bump Start has been developed in Westminster as an extension to the Homestart model. They focus on promoting and protection relationships and attachment between parents and child. They currently work with 35 families. Psychology support is available, which was accessed by 79% of families in 2015.</th>
</tr>
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<tr>
<td>Social difficulties including housing highlight vulnerable women and families.</td>
<td></td>
<td>Better integration of social support into healthcare.</td>
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<tr>
<th>Improved collaboration, working together.</th>
<th>Not knowing outcome would be frustrating for the healthcare professional signposting the mother. This</th>
<th>Tower Hamlets has developed an integrated PNMH service, with an emphasis on working closely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information is not always shared between services. Maternity services, HVs or GPs may signpost women towards IAPT. Currently no</td>
<td></td>
<td>Improving lines of communication for patients seen and assessed in IAPT</td>
</tr>
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*a* HV engagement  
*b* Data from Bumpstart Westminster, 15th January 2016
Services are currently service-centred rather than patient-centred. Feedback is received, so that the healthcare worker may not be informed about outcome and if services were accessed. Together, including GPs and IAPT. NICE CG192: 1.5.2: “All healthcare professionals referring a woman to a maternity service should ensure that communications with that service (including those relating to initial referral) share information on any past and present mental health problem.”

North Middlesex Hospital currently has a service where IAPT runs a clinic based within the clinical services in the hospital, and every antenatal clinic has a close relationship with IAPT/psychological services. This has promoted closer working practices and has enabled women to access services as required in a patient centred approach.

Enfield has IAPT professionals working in maternity services. This is difficult if the patient was signposted rather than referred. Relocating services to other areas could improve communication and collaboration between services.

Examples would include having psychologists or IAPT available in maternity clinics.

### Training

| Health professionals managing | The LSPMHN\(^a\) noted that many mental health professionals have not received training to develop | Healthcare professionals are not confident in their ability to identify and manage | The LSPMHN is facilitating training of healthcare professionals across a range | Provide the training, and request a minimum percentage |

\(^a\) Antenatal and postnatal mental health: clinical management and service guidance, NICE guidelines [CG192] Published: Dec 2015

\(^b\) London Strategic Perinatal Mental Health Network
| Women in the perinatal period are not always trained and ready to manage these complex cases | The skills required for dealing with mental health difficulties in the perinatal period. These include Registered Mental Health Nurses, Psych Liaison Services, CRISIS team, IAPT | Cases. |
| GPs have variable levels of confidence in managing PNMH problems | The variability in levels of training, confidence in managing and understanding of perinatal mental health has been previously highlighted amongst GPs. | GPs are well-placed to identify problems if they feel confident to, due the relationship they build with families over years. |
| Communication skills are difficult | Further training, especially regarding language to use and communication skills would be useful. Junior members of the team might not have the experience to deal with complex cases. | Improving relationship and building between professionals and new parents is essential. |

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a 5 stages: 1) Delivery of Perinatal Mental Health Champions training (through the Institute of Health Visiting). This course offers the opportunity to become a trainer in this field to provide support to other colleagues (“Train the trainer”). This has created Champions, who have now delivered training themselves to their colleagues; 2) GP masterclasses; 3) Perinatal Simulation Training (South London and Maudsley at Lambeth Hospital); 4) Perinatal Mental Health training event (Edge Consultancy); 5) ITSEY (International Training School for Infancy & Early Years), a modular course run by the Anna Freud Centre

b This was highlighted during the focus groups with midwives, and interviews with HVs
Charities provide an invaluable support network, but governance pathways not always clear. There are multiple charities working in the voluntary sector to offer invaluable support to families in difficulties and promote peer support and resilience. The governance of these agencies is not always clear. Transparent governance is essential so that services can be promoted, supported, and included in care pathways. Support to the charity sector regarding governance and training requirements.

| Maintaining PNMH on the agenda | Pathways for accountability and training are not always clear. | PNMH is falls across a number of services and commissioning responsibilities. Therefore this can mean that the shared responsibility makes it difficult to identify primary responsibility for ensuring it is maintained on the agenda. | The creation of PNMH Champions has been suggested and supported by multiple professional recent guidelines, for several specialities:  
- RCM recommends every maternity service provider should employ at least one specialist PNMH midwife.  
- Implementation of | Creation of PNMH champions, to ensure governance of the pathways  
An IAPT Perinatal Mental Health Lead has been appointed in Camden  
A PNMH champion will be trained in Camden 2016-7 by |
Specialist PNMH GPs is supported. 44
- Guidelines have been produced (endorsed by the Institute of HV, Association for Infant Mental Health and RCPsych) for a Specialist HV in Perinatal & Infant Mental Health, with guidance there should be at least one within every HV service.
Newham has two perinatal mental health HV specialists. They work closely with mental health services including IPAT and are particularly focused on women who do not meet the threshold for higher tier services.

b A specification for this role has been produced by the LSPMHN
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