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Quality standards and indicators

Briefing paper

Quality standard topic: Antenatal and postnatal mental health

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1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for antenatal and postnatal mental health. It provides the Committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 *Structure*

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the Committee in considering potential statements and measures.

1.2 *Development source*

The key development source(s) referenced in this briefing paper is:

- Antenatal and postnatal mental health (2014) NICE guideline CG192

This guideline updates and replaces NICE guideline CG45 (published February 2007), and updates and replaces section 1.5.6 in NICE guideline CG62 (published March 2008). New recommendations have been added in all sections except the section on the organisation of services.

2 Overview

2.1 *Focus of quality standard*

This quality standard will cover the recognition, assessment, care and treatment of mental health disorders in women during pregnancy and the postnatal period (up to 1 year after childbirth). It will also include the care of women with an existing mental health disorder who are planning a pregnancy and the organisation of mental health services needed in pregnancy and the postnatal period.

2.2 *Definition*

The majority of mental health disorders, such as depression, anxiety disorders, eating disorders, drug and alcohol-use disorders and severe mental illness (including psychosis, schizophrenia and severe depression) occurring during the perinatal period are similar to those occurring at other times, in their nature, course and potential for relapse. However, there can be differences, for example bipolar disorder has an increased rate of relapse and first presentation in the postnatal period.

Some changes in mental health state and functioning (for example appetite) may represent normal pregnancy changes, but they may be a symptom of a mental health problem.

2.3 *Incidence and prevalence*

Depression and anxiety are the most common mental health problems occurring during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point, and many women experiencing both. Depression and anxiety also affect 15-20% of women in the first year after childbirth.

During pregnancy and the postnatal period, anxiety disorders, including panic disorder, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and tokophobia (an extreme fear of childbirth), can occur on their own or can coexist with depression. Psychosis can re-emerge or be exacerbated during pregnancy and the postnatal period. Postpartum psychosis affects between 1 and 2 in 1000 women who have given birth. Women with bipolar I disorder are at particular risk, but postpartum psychosis can occur in women with no previous psychiatric history.

If mental health problems are left untreated, women can continue to have symptoms, sometimes for many years, and these can also affect their babies and other family members.

Between 2006 and 2008 there were 1.27 maternal deaths per 100,000 maternal deliveries in the UK as a result of mental health problems. In the same period, there were 13 indirect deaths due to psychiatric illness[1].

Management

The management of mental health problems during pregnancy and the postnatal period differs from at other times because of the nature of this life stage and the potential impact of any difficulties and treatments on the woman and the baby. There are risks associated with taking psychotropic medication in pregnancy and during breastfeeding and risks to stopping medication taken for an existing mental health problem. There is also an increased risk of psychosis in the immediate postnatal period (postpartum psychosis), which can have an increased speed of onset and severity than at other times.

The majority of mental health problems during pregnancy and the postnatal period are mild to moderate, and those that are treated are treated in primary care, however women with mental health problems during pregnancy and the year after giving birth are treated in a variety of NHS settings, including primary care services, obstetric

[1] Centre for Maternal and Childhood Enquiries (2011) 'Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008'.

and gynaecological services, general mental health services and specialist secondary care mental health services.

See appendix 1 for the associated care pathway from NICE clinical guideline CG192.

2.4 *National Outcome Frameworks*

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS Outcomes Framework 2014–15

Domain	Overarching indicators and improvement areas
1 Preventing people from dying prematurely	***Overarching indicator*** 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare i Adults ***Improvement areas*** **Reducing premature death in people with serious mental illness** 1.5 Excess under 75 mortality rate in adults with serious mental illness* (PHOF 4.9)
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** (ASCOF 1A) ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Enhancing quality of life for people with mental illness** 2.5 Employment of people with mental illness ** (ASCOF 1F & PHOF 1.8)
3 Helping people to recover from episodes of ill health or following injury	***Overarching indicators*** 3b Emergency readmissions within 30 days of discharge from hospital* (PHOF 4.11) ***Improvement areas*** I**mproving outcomes from planned treatments** 3.1 Total health gain as assessed by patients for elective procedures v Psychological therapies
4 Ensuring that people have a positive experience of care	***Overarching indicators*** 4a Patient experience of primary care 4b Patient experience of hospital care Placeholder 4c Friends and family test ***Improvement areas*** **Improving hospitals' responsiveness to personal needs** 4.2 Responsiveness to in-patients' personal needs **Improving women and their families' experience of maternity services** 4.5 Women's experiences of maternity services **Improving experience of healthcare for people with a mental illness** 4.7 Patient experience of community mental health services **Improving people's experience of integrated care** 4.9 People's experience of integrated care** (ASCOF 3E)

5 Treating and caring for people in a safe environment and protecting them from avoidable harm	***Overarching indicator*** 5c Hospital deaths attributable to problems in care **Improvement area** **Improving the safety of maternity services** 5.5 Admission of full-term babies to neonatal care
Alignment across the health and social care system * Indicator is shared ** Indicator is complementary	

Table 2 Public health outcomes framework for England, 2013–2016

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors that affect health and wellbeing and health inequalities ***Indicators*** 1.6 Adults with a learning disability/in contact with secondary mental health services who live in stable and appropriate accommodation* (ASCOF 1G and 1H) 1.7 People in prison who have a mental illness or a significant mental illness 1.8 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services* (NHSOF 2.2) ** (ASCOF 1E) ** (NHSOF 2.5) ** (ASCOF 1F) 1.9 Sickness absence rate 1.18 Social isolation*(ASCOF 1I)
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.1 Low birth weight of term babies 2.5 Child development at 2 – 2 ½ years 2.7 Hospital admissions caused by unintentional and deliberate injuries in under 18s 2.10 Self-harm 2.23 Self-reported well-being
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities. ***Indicators*** 4.3 Mortality rate from causes considered preventable** (NHSOF 1.1) 4.9 Excess under 75 mortality rate in adults with serious mental illness* (NHSOF 1.5) 4.10 Suicide rate 4.11 Emergency readmissions within 30 days of discharge from hospital* (NHSOF 3b)
Alignment across the health and social care system * Indicator shared with the NHS Outcomes Framework. ** Complimentary indicators in the NHS Outcomes Framework	

Table 3 The Adult Social Care Outcomes Framework 2014–15

Domain	Overarching and outcome measures
1 Enhancing quality of life for people with care and support needs	***Overarching measure*** 1A Social care-related quality of life* (NHSOF2) ***Outcome measures*** **People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation** 1F Proportion of adults in contact with secondary mental health services in paid employment* (PHOF 1.8, NHSOF 2.5) 1H Proportion of adults in contact with secondary mental health services living independently, with or without support** (PHOF 1.6) 1I. Proportion of people who use services and their carers, who reported that they had as much social contact as they would like**(PHOF 1.18)
3 Ensuring that people have a positive experience of care and support	***Overarching measure*** **People who use social care and their carers are satisfied with the experience of care and support services.** 3A Overall satisfaction of people who use services with their care and support. Placeholder 3E The effectiveness of integrated care*(NHSOF 4.9))
4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	***Overarching measure*** 4A The proportion of people who use services who feel safe* (PHOF 1.19) ***Outcome measures*** **Everyone enjoys physical safety and feels secure** **People are free from physical and emotional abuse, harassment, neglect and self-harm** **People are protected as far as possible from avoidable harm, disease and injuries** **People are supported to plan ahead and have the freedom to manage risks the way that they wish** 4B The proportion of people who use services who say that those services have made them feel safe and secure
Aligning across the health and care system * Indicator complementary ** Indicator shared	

3 Summary of suggestions

3.1 *Responses*

In total 14 stakeholders responded to the 2-week engagement exercise [22/01/15 05/02/15].

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 4 for further consideration by the Committee.

NHS England's patient safety division did not submit any data for this topic.

Full details of all the suggestions provided are given in appendix 3 for information.

Table 4 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Considerations for women of childbearing potential o pre-conception counselling for women with a current or previous mental health problem o prescribing of valproate	RCM, SCM x 2, RCP.
Identifying and assessing mental health problems in pregnancy and the postnatal period o assessing the mental health of all pregnant women and diagnosing any mental health problems o assessment of the severity of mental health problems	SCMx4, RCM, PF, NCT, HQTD, RCP.
Access to specialised perinatal mental health care o specialist perinatal services in each locality o mother and baby units	SCMx2, RCM, MNFT, NCT, RCP, BCECD.
Individualised care plans for women with a mental health problem in pregnancy and the postnatal period	SCMx4, NCT, RCM.
Care of pregnant women with a severe mental illness, or history of a severe mental illness by a mental health specialist	SCMx2.
Treatment for antenatal and postnatal mental health problems o access to psychological therapies o information about pharmacological treatment o family support	MNFT, RCP, SCMx3, PF, NCT.
Counselling for women with adverse outcomes in pregnancy and birth o loss of their baby o neonatal health of baby o traumatic birth o premature/unwell baby	B, PETALS.
Additional suggestions not meeting technical criteria for statement development: o Support for women requesting a caesarean section o Training and supervision o Cultural competence o Understanding the specific prodromal symptoms for postnatal psychosis	SCM, RCM, NCT, BCECD, PF, MNFT.

BCECD, Blackpool Centre for Early Child Development
B, Bliss
HQTD, HQT Diagnostics
MNFT, Medway NHS Foundation Trust
NCT, National Childbirth Trust
PETALS, Pregnancy Expectations Trauma and Loss Society
PF, PANDAS Foundation
RCM, Royal College of Midwives
RCP, Royal College of Psychiatrists
SCM, Specialist Committee Member

4 Suggested improvement areas

4.1 *Considerations for women of childbearing potential*

4.1.1 Summary of suggestions

Pre-conception counselling for women with a current or previous mental health problem

Stakeholders suggested that pre-conception counselling was important for all women with a history of mental health problems, or an existing mental health problem. This is to provide information and advice, both to raise awareness of mental health during pregnancy and the postnatal period, and to support women to make informed decisions. Information needs that were identified by stakeholders include pregnancy planning and contraception, the potential effects of pregnancy and childbirth on mental health and existing mental health problems, and the potential effects of a mental health problem and its treatment on the woman and/or her baby.

Prescribing of valproate

One stakeholder indicated that there is a particular concern around the prescribing of valproate to women of childbearing potential who have bipolar disorder.

4.1.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 5 to help inform the Committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Pre-conception counselling for women with a mental health problem, or history of mental health problems	**Considerations for women of childbearing potential** NICE CG192 Recommendation 1.2.1 (KPI) **Treatment decisions, advice and monitoring for women who are planning a pregnancy, pregnant or in the postnatal period** NICE CG192 Recommendation 1.4.2
Prescribing of valproate	**Considerations for women of childbearing potential** NICE CG192 Recommendation 1.2.3

Considerations for women of childbearing potential

NICE CG192 Recommendation 1.2.1 (key priority for implementation)

Discuss with all women of childbearing potential who have a new, existing or past mental health problem:

- the use of contraception and any plans for a pregnancy
- how pregnancy and childbirth might affect a mental health problem, including the risk of relapse
- how a mental health problem and its treatment might affect the woman, the fetus and baby
- how a mental health problem and its treatment might affect parenting. [new 2014]

NICE CG192 Recommendation 1.2.3

Do not offer valproate for acute or long-term treatment of a mental health problem in women of childbearing potential. **[new 2014]**

Treatment decisions, advice and monitoring for women who are planning a pregnancy, pregnant or in the postnatal period

NICE CG192 Recommendation 1.4.2

Consider referring a woman to a secondary mental health service (preferably a specialist perinatal mental health service) for preconception counselling if she has a current or past severe mental health problem and is planning a pregnancy. [new 2014]

4.1.3 Current UK practice

A 2013 national survey of women's experiences of maternity services reports that 56% of respondents in 2013 felt they were definitely given enough information about any emotional changes that they might experience after the birth of their baby compared with 42% in 2010. The percentage who felt they were not given enough information about any emotional changes after the birth fell from 21% in 2010 to 14% in 2013[2].

Data from the Clinical Practice Research Datalink for 2010-2012 indicates that approximately 35,000 women aged 14 to 45 had a prescription for sodium valproate per year (although the majority of prescriptions were for epilepsy). Of these women, at least 375 per year had a prescription for sodium valproate while pregnant[3].

A 2013 audit of one NHS Foundation Trust found that NICE guidance for prescribing of valproate to women of child bearing age was not being followed. In a trust-wide audit of female inpatients of childbearing age, 13% were prescribed sodium valproate. A re-audit eight months later found that 9% of female inpatients of childbearing age were still being prescribed sodium valproate[4].In the initial audit, 86% had not been provided with contraception, which had reduced to 58% 8 months later.

The draft NICE quality standard for bipolar disorder in adults includes the following quality statement:

- (Draft) QSt Statement 5: Women of childbearing potential are not prescribed valproate for long-term treatment or to treat an acute episode of bipolar disorder.

[2] Care Quality Commission (2013) Maternity services survey 2013
[3] Medicines and Healthcare Products Regulatory Agency (2015) 'Medicines related to valproate: risk of abnormal pregnancy outcomes'
[4] Jones, S; Melville, J and McDonald, L (2014) 'Prescribing sodium valproate to women of childbearing age'

4.2 *Identifying and assessing mental health problems in pregnancy and the postnatal period*

4.2.1 Summary of suggestions

Assessing the mental health of all pregnant women and diagnosing any mental health problems

Stakeholders suggested that women should be assessed for mental health problems at all universal contacts during pregnancy and the postnatal period, with validated screening tools used as required. One stakeholder stated that the 6 month postnatal check should be used to assess women's health, as well as that of the baby. The issue of lack of disclosure of mental health problems in pregnancy and the postnatal period was raised.

Assessment of the severity of mental health problems

Stakeholders emphasised the importance of timely assessment of mental health problems to identify the severity of symptoms and agree appropriate treatment. Two stakeholders highlighted the importance of considering and optimising the physical health of women with severe mental health problems.

4.2.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 6 to help inform the Committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Assessing the mental health of all pregnant women and diagnosing any mental health problems	**Recognising mental health problems in pregnancy and the postnatal period and referral** NICE CG192 Recommendations 1.5.4 (KPI), 1.5.8, 1.5.9
Assessment of the severity of mental health problems	**Recognising mental health problems in pregnancy and the postnatal period and referral** NICE CG192 Recommendations 1.5.5, 1.5.10

Recognising mental health problems in pregnancy and the postnatal period and referral

NICE CG192 Recommendation 1.5.4 (key priority for implementation)

At a woman's first contact with primary care or her booking visit, and during the early postnatal period, consider asking the following depression identification questions as part of a general discussion about a woman's mental health and wellbeing:

- 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?

Also consider asking about anxiety using the 2-item Generalized Anxiety Disorder scale (GAD-2):

- During the past month, have you been feeling nervous, anxious or on edge?
- During the past month have you not been able to stop or control worrying? **[new 2014]**

NICE CG192 Recommendation 1.5.5

If a woman responds positively to either of the depression identification questions in recommendation 1.5.4, is at risk of developing a mental health problem, or there is clinical concern, consider:

- using the Edinburgh Postnatal Depression Scale (EPDS) or the Patient Health Questionnaire (PHQ-9) as part of a full assessment or
- referring the woman to her GP or, if a severe mental health problem is suspected, to a mental health professional. **[new 2014]**

NICE CG192 Recommendation 1.5.8

At all contacts after the first contact with primary care or the booking visit, the health visitor, and other healthcare professionals who have regular contact with a woman in pregnancy and the postnatal period (first year after birth), should consider:

- asking the 2 depression identification questions and the GAD-2 (see recommendation 1.5.4) as part of a general discussion about her mental health and wellbeing and
- using the EPDS or the PHQ-9 as part of monitoring. [new 2014]

NICE CG192 Recommendation 1.5.9

At a woman's first contact with services in pregnancy and the postnatal period, ask about:

- any past or present severe mental illness
- past or present treatment by a specialist mental health service, including inpatient care

- any severe perinatal mental illness in a first-degree relative (mother, sister or daughter). [2014]

NICE CG192 Recommendation 1.5.10

Refer to a secondary mental health service (preferably a specialist perinatal mental health service) for assessment and treatment, all women who:

- have or are suspected to have severe mental illness
- have any history of severe mental illness (during pregnancy or the postnatal period or at any other time).

Ensure that the woman's GP knows about the referral. **[new 2014]**

4.2.3 Current UK practice

The 2013 national survey of women's experiences of maternity services reports that 96% of women responding to the survey were asked how they were feeling emotionally by a midwife or health visitor at the postnatal stage, however a survey of mothers by the National Childbirth Trust reports that 29% of those who attended their 6 week postnatal check said their GP did not ask them about any emotional or mental health issues, and 22% of respondents did not tell the truth about how they were feeling, but 'put on a brave face'[5]. A Royal College of Midwives (RCM) survey conducted on the Netmums website, found that fewer than 25% of those who reported feeling down or depressed during pregnancy or the postnatal period sought help from a member of the maternity team, and a quarter of all women participating in the study said their maternity team did not make use of postnatal visits to discuss how they were coping[6].

A study of parent perspectives of access to clinical psychology services when experiencing emotional distress during the first year of their baby's life identified that some parents found frontline health care limited to the physical needs of their baby, and felt uncomfortable raising issues about their own wellbeing. Some parents felt unable to discuss their emotional difficulties because they were unable to "connect" with frontline staff, and some felt that health professionals only responded to their emotional needs if they believed there was a potential for serious risk to the parent or child, or that they could be blamed. Other parents were concerned about disclosing emotional distress in case professionals felt they were not coping, and felt it necessary to remove their child from them[7].

[5] National Childbirth Trust (2014) 'Mind the Gap'
[6] Royal College of Midwives (RCM) (2014), 'RCM surveys find worrying flaws in postnatal mental health care', The Practising Midwife, March 2014, p. 7.
[7] Cooke, S; Smith, I; Turl, E; Arnold, E (2012) 'Parent perspectives of clinical psychology access when experiencing distress', Community Practitioner, volume 85, issue 4, pp. 34-38.

Health professionals have reported barriers to being able to effectively assess and support women's mental health during pregnancy and the postnatal period. A small-scale study of health visitors found shortfalls in using certain standard assessment tools, such as the Edinburgh Postnatal Depression Scale. Measures used to assess perinatal mental health were not always in keeping with national guidelines, with a flexible approach used to applying prediction and detection questions as part of a broad decision- making process[8]. In addition, more than 40% of midwives responding to an RCM survey, reported difficulties in referring women to an appropriate health professional when they had a concern about the woman's mental health[9].

A 2011 confidential enquiry into maternal deaths reported that there were 29 indirect and late deaths due to psychiatric illness (this includes women who committed suicide during pregnancy or within 182 days of delivery). The report states that in all cases, there was sufficient information to make a definite or probable psychiatric diagnosis, with evidence in the women's notes of signs and symptoms of a severe depressive illness with psychotic features or, for two women, of mixed affective psychosis. Eight of the women were wrongly diagnosed with anxiety or moderate depression, as well as one occurrence of puerperal psychosis, adjustment disorder. Only 47% of those at risk of a recurrence of their disorder following delivery were identified, and there was only evidence that a plan was in place to manage the risk of postpartum recurrence in 21% of cases. However, in 3 cases, women who died in pregnancy were not booked, meaning there was no opportunity to identify this risk[10].

The NICE quality standard for postnatal care (QS37) includes the following quality statements:

- QSt 2: Women are advised, within 24 hours of the birth, of the symptoms and signs of conditions that may threaten their lives and require them to access emergency treatment.

- QSt 9: Women have their emotional wellbeing, including their emotional attachment to their baby, assessed at each postnatal contact.

- QSt 10: Women who have transient psychological symptoms ('baby blues') that have not resolved at 10–14 days after the birth should be assessed for mental health problems.

[8] Jomeen, J; Glover, L; Jones, C; Garg, D and Marshall, C (2013) 'Assessing women's perinatal psychological health: exploring the experiences of health visitors', Journal of Reproductive and Infant Psychology, volume 31, number 5, pp. 479-489.
[9] Royal College of Midwives (RCM) (2014), 'RCM surveys find worrying flaws in postnatal mental health care', The Practising Midwife, March 2014, p. 7.
[10] Centre for Maternal and Childhood Enquiries (2011) 'Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008'.

4.3 *Access to specialised perinatal mental health care*

4.3.1 Summary of suggestions

Access to specialist perinatal services in each locality

A number of stakeholders suggested access to specialised mental health services in pregnancy and the postnatal period as an area for improvement, with a current lack of provision highlighted as a concern. One stakeholder highlighted that perinatal mental health clinical networks should support coordination of services.

Requirements set out in comments included access to health professionals with specialist knowledge for assessment of mental health problems and expert advice on treatment, including psychotropic medication. The specific needs of women with personality disorder were highlighted by one stakeholder who suggested that IAPT services are often unable to meet their needs.

Mother and baby units

The provision of mother and baby units was indicated by a number of stakeholders to be an area where improvement is required. Stakeholders reported that although it is recognised that joint admission of mother and baby is the gold standard for women in the postnatal period, there is disparity in provision of mother and baby unit beds.

4.3.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 7 to help inform the Committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Access to specialist perinatal services in each locality	**The organisation of services** NICE CG192 Recommendation 1.10.3 (KPI)
Mother and baby units	**The organisation of services** NICE CG192 Recommendations 1.10.1, 1.10.05

The organisation of services

NICE CG192 Recommendation 1.10.1

Women who need inpatient care for a mental health problem within 12 months of childbirth should normally be admitted to a specialist mother and baby unit, unless there are specific reasons for not doing so. **[2007]**

NICE CG192 Recommendation 1.10.3 (Key priority for implementation)

Clinical networks should be established for perinatal mental health services, managed by a coordinating board of healthcare professionals, commissioners, managers, and service users and carers. These networks should provide:

- a specialist multidisciplinary perinatal service in each locality, which provides direct services, consultation and advice to maternity services, other mental health services and community services; in areas of high morbidity these services may be provided by separate specialist perinatal teams
- access to specialist expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding
- clear referral and management protocols for services across all levels of the existing stepped-care frameworks for mental health problems, to ensure effective transfer of information and continuity of care
- pathways of care for service users, with defined roles and competencies for all professional groups involved. [2007]

NICE CG192 Recommendation 1.10.5

Specialist perinatal inpatient services should:

- provide facilities designed specifically for mothers and babies (typically with 6-12 beds)
- be staffed by specialist perinatal mental health staff
- be staffed to provide appropriate care for babies
- have effective liaison with general medical and mental health services
- have available the full range of therapeutic services
- be closely integrated with community-based mental health services to ensure continuity of care and minimum length of stay. **[2007]**

4.3.3 Current UK practice

The National Audit Office reported that in 2013, despite some improvements since the publication of the Department of Health's Maternity Matters strategy, fewer than 30 per cent of trusts belonged to a perinatal mental health network[11]. The Maternal Mental Health Alliance indicates that many areas of the UK do not have local plans or strategies in place to ensure that NHS perinatal mental health services are

[11] National Audit Office (2013) Maternity services in England

available to local women and families[12]. This is reflective of a 2014 report from the National Childbirth Trust, which requested information from Clinical Commissioning Groups (CCGs) under the Freedom of Information Act (FOA) and found that, of the 186 CCGs who responded to the FOI request, only 3% had a perinatal mental health strategy in place, and of the 97% of CCGs without a perinatal strategy, 60% had no plans to put one in place in the future[13].

The NHS standard contract for perinatal mental health services 2013/14 estimated that a minimum of 168 In-Patient Mother and Baby beds are required in England to meet the needs of women with mental health problems. The contract stated that there were 122 beds provided by 17 In-Patient Mother and Baby Units, 11 of which had integrated Perinatal Community Psychiatric Teams[14].

Women who require admission for mental health problems in the postnatal period, and who are using services where mother and baby units are not provided, will be admitted to a general admission ward without their babies. In some cases, women may be referred to out of area mother and baby units but this is rarely done proactively or in an emergency[15]. The 2011 confidential enquiry into maternal deaths reported that of 29 women that committed suicide during pregnancy and the postnatal period, 6 of the women who had given birth had been admitted to a general psychiatric unit and separated from their babies, although two of these women were eventually admitted to a mother and baby unit. For 3 of the women who had given birth, there was no evidence that admission to a mother and baby unit had been considered[16].

[12] Maternal Mental Health Alliance (2014) UK specialist community perinatal mental health teams (current provision).
[13] National Childbirth Trust (2014) 'Mind the Gap'
[14] NHS England (2013) The NHS standard contract for perinatal mental health services 2013/14
[15] Joint Commissioning Panel for Mental Health (2012) 'Guidance for commissioners of perinatal mental health services'
[16] [16] Centre for Maternal and Childhood Enquiries (2011) 'Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008'.

4.4 *Individualised care plans for women with a mental health problem in pregnancy and the postnatal period*

4.4.1 Summary of suggestions

Individualised care plans for women with a mental health problem in pregnancy and the postnatal period was raised as an area for improvement to address current variations in continuity of care. Stakeholders suggested that everyone involved in providing care need to ensure that information and services are provided in a coordinated manner to facilitate the care plan.

4.4.2 Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 8 to help inform the Committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Individualised care plans for women with a mental health problem in pregnancy and the postnatal period	**Principles of care in pregnancy and the postnatal period** NICE CG192 Recommendations 1.3.5 (KPI), 1.3.6

Principles of care in pregnancy and the postnatal period

NICE CG192 Recommendation 1.3.5 (Key priority for implementation)

Develop an integrated care plan for a woman with a mental health problem in pregnancy and the postnatal period that sets out:

- the care and treatment for the mental health problem
- the roles of all healthcare professionals, including who is responsible for:
- coordinating the integrated care plan
- the schedule of monitoring
- providing the interventions and agreeing the outcomes with the woman. **[new 2014]**

NICE CG192 Recommendation 1.3.6

The healthcare professional responsible for coordinating the integrated care plan should ensure that:

- everyone involved in a woman's care is aware of their responsibilities

- there is effective sharing of information with all services involved and with the woman herself
- mental health (including mental wellbeing) is taken into account as part of all care plans
- all interventions for mental health problems are delivered in a timely manner, taking into account the stage of the pregnancy or age of the baby. **[new 2014]**

4.4.3 Current UK practice

A 2014 report by the National Childbirth Trust highlights inconsistent service provision being provided to women with antenatal and postnatal mental health issues[17]. The 2011 confidential enquiry into maternal deaths also reports issues with continuity of care. It concludes that in some, cases there were problems with aftercare by non-specialised community care services that seemingly were unable to appreciate the continued risks of relapse in mothers with mental health problems[18].

The NICE quality standard for service user experience in adult mental health (QS14) contains the following quality statements:

QSt 8: People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it.

QSt 9: People using mental health services who may be at risk of crisis are offered a crisis plan.

[17] National Childbirth Trust (2014) 'Mind the Gap'
[18] Centre for Maternal and Childhood Enquiries (2011) 'Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008'.

4.5 *Care of pregnant women with a severe mental illness, or history of a severe mental illness by a mental health specialist*

4.5.1 Summary of suggestions

Stakeholders highlighted that women with a severe mental illness should be provided with specialist perinatal mental health care, so that they can receive the appropriate level of support and have their care effectively managed.

4.5.2 Selected recommendations from development source

Table 9 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 9 to help inform the Committee's discussion.

Table 9 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Care of pregnant women with a severe mental illness, or history of a severe mental illness by a mental health specialist	**Recognising mental health problems in pregnancy and the postnatal period and referral** NICE CG192 Recommendations 1.5.10 **Assessment and care planning in pregnancy and the postnatal period** NICE CG192 Recommendation 1.6.6

Recognising mental health problems in pregnancy and the postnatal period and referral

NICE CG192 Recommendation 1.5.10

Refer to a secondary mental health service (preferably a specialist perinatal mental health service) for assessment and treatment, all women who:

- have or are suspected to have severe mental illness
- have any history of severe mental illness (during pregnancy or the postnatal period or at any other time).

Ensure that the woman's GP knows about the referral. **[new 2014]**

Assessment and care planning in pregnancy and the postnatal period

NICE CG192 Recommendation 1.6.6

Professionals in secondary mental health services, including specialist perinatal mental health services, should develop a written care plan in collaboration with a woman who has or has had a severe mental illness. If she agrees, her partner, family or carer should also be involved. The plan should cover pregnancy, childbirth and the postnatal period (including the potential impact of the illness on the baby) and should include:

- a clear statement of jointly agreed treatment goals and how outcomes will be routinely monitored
- increased contact with and referral to specialist perinatal mental health services
- the names and contact details of key professionals.

The care plan should be recorded in all versions of the woman's notes (her own records and maternity, primary care and mental health notes) and a copy given to the woman and all involved professionals. **[new 2014]**

4.5.3 Current UK practice

Guidance produced for commissioners of perinatal mental health services in 2012 highlighted that existing services, often involving a single or small number of professionals who provide partial care or "signposting" for women, will not be able to provide comprehensive services, particularly for women with serious mental illness"[19].

The 2011 confidential enquiry into maternal deaths indicated that within the last three reports, over half of the women who died from suicide had a previous history of serious mental illness. It reported that in 11 cases of 29 suicides over 2006-2008, women were cared for in the community by general psychiatric teams rather than specialised community perinatal teams. The enquiry suggested an apparent lack of awareness by general psychiatric services of the high risk of relapse for women who have experienced serious mental health problems, and the need for continuing care[20]. A 2010 retrospective study of the management of the care of women with previous history of schizophrenia during pregnancy also identified a clear lack of awareness amongst health professionals about how to manage the women's care[21].

[19] Joint Commissioning Panel for Mental Health (2012) 'Guidance for commissioners of perinatal mental health services'
[20] Centre for Maternal and Childhood Enquiries (2011) 'Saving Mothers' Lives: Reviewing maternal deaths to make motherhood safer: 2006-2008'.
[21] Samyraju, M; Natarajan, D; Waller, K and Macrae, R (2010) 'Managing mental health for women with previous history of schizophrenia during pregnancy – how can we improve our care?', British Journal of Obstetrics and Gynaecology, volume 109, p. 106.

4.6 *Treatment for antenatal and postnatal mental health problems*

4.6.1 Summary of suggestions

Access to psychological therapies

Timely referral and access to a range of psychological therapies was raised as an area for improvement to support early intervention where women would benefit from psychological therapy. This included the risk benefit balance of psychological therapies in preference to pharmacological treatment during pregnancy and the postnatal period, including during breastfeeding. Attachment between mother and baby was highlighted as an area where additional support might benefit the woman and /or her baby's mental health and emotional wellbeing.

Information about pharmacological treatment

Stakeholders indicated a need for improved information for women regarding the impact of medication on themselves and their baby during pregnancy and the postnatal period, including breastfeeding. This included side effects of medication for women, and any effects on development of the child.

4.6.2 Selected recommendations from development source

Table 10 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 10 to help inform the Committee's discussion.

Table 10 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Access to psychological therapies	Key recommendations identified: **Treatment decisions, advice and monitoring for women who are planning a pregnancy, pregnant or in the postnatal period** NICE CG192 Recommendation 1.4.10 (KPI) **Providing interventions in pregnancy and the postnatal period** NICE CG192 Recommendations 1.7.3, 1.7.5
Information about pharmacological treatment	**Treatment decisions, advice and monitoring for women who are planning a pregnancy, pregnant or in the postnatal period** NICE CG192 Recommendations 1.4.3, 1.4.4
Family support	**Principles of care in pregnancy and the postnatal period** NICE CG192 Recommendation 1.3.4

Treatment decisions, advice and monitoring for women who are planning a pregnancy, pregnant or in the postnatal period

NICE CG192 Recommendation 1.4.3

Discuss treatment and prevention options and any particular concerns the woman has about the pregnancy or the fetus or baby. Provide information to the woman and, if she agrees, her partner, family or carer, about:

- the potential benefits of psychological interventions and psychotropic medication
- the possible consequences of no treatment
- the possible harms associated with treatment
- what might happen if treatment is changed or stopped, particularly if psychotropic medication is stopped abruptly. **[new 2014]**

NICE CG192 Recommendation 1.4.4

Discuss breastfeeding with all women who may need to take psychotropic medication in pregnancy or in the postnatal period. Explain to them the benefits of breastfeeding, the potential risks associated with taking psychotropic medication when breastfeeding and with stopping some medications in order to breastfeed. Discuss treatment options that would enable a woman to breastfeed if she wishes and support women who choose not to breastfeed. **[new 2014]**

NICE CG192 Recommendation 1.4.10 (Key priority for implementation)

Before starting any treatment in pregnancy and the postnatal period, discuss with the woman the higher threshold for pharmacological interventions arising from the changing risk-benefit ratio for psychotropic medication at this time and the likely benefits of a psychological intervention. **[new 2014]**

Providing interventions in pregnancy and the postnatal period

NICE CG192 Recommendation 1.7.3

When a woman with a known or suspected mental health problem is referred in pregnancy or the postnatal period, assess for treatment within 2 weeks of referral and provide psychological interventions within 1 month of initial assessment. **[new 2014]**

NICE CG192 Recommendation 1.7.5

Provide interventions for mental health problems in pregnancy and the postnatal period within a stepped-care model of service delivery in line with recommendation 1.5.1.3 of the guideline on common mental health disorders (NICE guideline CG123). **[new 2014]**

Principles of care in pregnancy and the postnatal period

NICE CG192 Recommendation 1.3.4

Take into account and, if appropriate, assess and address the needs of partners, families and carers that might affect a woman with a mental health problem in pregnancy and the postnatal period. These include:

- the welfare of the baby and other dependent children and adults
- the role of the partner, family or carer in providing support
- the potential effect of any mental health problem on the woman's relationship with her partner, family or carer. **[new 2014]**

4.6.3 Current UK practice

A 2013 audit of an East London psychiatric service found that for 86% of female inpatients of childbearing age prescribed sodium valproate, there was no documented discussion regarding the teratogenicity and other effects on their baby. A re-audit 8 months later found only a slight drop to 83%[22].

The NICE quality standard for postnatal care (QS37) includes the following quality statement:

- QSt 11: Parents or main carers who have infant attachment problems receive services designed to improve their relationship with their baby.

[22] Jones, S; Melville, J and McDonald, L (2014) 'Prescribing sodium valproate to women of childbearing age'

4.7 *Counselling for women with adverse outcomes in pregnancy and birth*

4.7.1 Summary of suggestions

Loss of their baby

One stakeholder highlighted the need for support for women and their families who suffer loss of their baby through stillbirth, miscarriage or neonatal death. Suitable intervention at an early stage is intended to reduce the duration and severity of symptoms and improve subjective wellbeing. This may also prevent depression and anxiety in the case of any future pregnancies.

Poor fetal diagnosis

One stakeholder highlighted the need for support for women who experience poor fetal diagnosis and decisions regarding continuation of pregnancy. The stakeholder indicated that 'Parity of esteem' is key in ensuring that women's psychological health is attended to alongside physical health to support women to feel that they have had sufficient time, space and support to reach a decision.

Traumatic birth

One stakeholder indicated that women who experience trauma during birth would benefit from specialist counselling to process their experience and to support them to positively consider future pregnancies.

Premature/unwell baby

One stakeholder suggested that mothers of premature/unwell babies are at increased risk of developing mental health problems, particularly babies being cared for in specialist neonatal settings.

4.7.2 Selected recommendations from development source

Table 12 below highlights recommendations that have been provisionally selected from the development source(s) that may support potential statement development. These are presented in full after table 12 to help inform the Committee's discussion.

Table 12 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Loss of their baby	**Considerations for women and their babies in the postnatal period** NICE CG192 Recommendations 1.9.4, 1.9.5, 1.9.7 (KPI)
Poor fetal diagnosis	**Treatment decisions, advice and monitoring for women who are planning a pregnancy, pregnant or in the postnatal period** NICE CG192 Recommendation 1.4.15 (KPI)
Traumatic birth	**Considerations for women and their babies in the postnatal period** NICE CG192 Recommendations 1.9.4, 1.9.5, 1.9.6
Premature/unwell baby	No recommendations identified

Considerations for women and their babies in the postnatal period

NICE CG192 Recommendation 1.9.4

Offer advice and support to women who have had a traumatic birth or miscarriage and wish to talk about their experience. Take into account the effect of the birth or miscarriage on the partner and encourage them to accept support from family and friends. **[new 2014]**

NICE CG192 Recommendation 1.9.5

Offer women who have post-traumatic stress disorder, which has resulted from a traumatic birth, miscarriage, stillbirth or neonatal death, a high-intensity psychological intervention (trauma-focused CBT or eye movement desensitisation and reprocessing [EMDR]) in line with the guideline on post-traumatic stress disorder (PTSD) (NICE guideline CG26). **[new 2014]**

NICE CG192 Recommendation 1.9.6

Do not offer single-session high-intensity psychological interventions with an explicit focus on 're-living' the trauma to women who have a traumatic birth. **[new 2014]**

NICE CG192 Recommendation 1.9.7 (Key priority for implementation)

Discuss with a woman whose baby is stillborn or dies soon after birth, and her partner and family, the option of 1 or more of the following:

- seeing a photograph of the baby

- having mementos of the baby
- seeing the baby
- holding the baby.

This should be facilitated by an experienced practitioner and the woman and her partner and family should be offered a follow-up appointment in primary or secondary care. If it is known that the baby has died in utero, this discussion should take place before the delivery, and continue after delivery if needed. **[new 2014]**

Treatment decisions, advice and monitoring for women who are planning a pregnancy, pregnant or in the postnatal period

NICE CG192 Recommendation 1.4.15 (Key priority for implementation)

If a pregnant woman has taken psychotropic medication with known teratogenic risk at any time in the first trimester:

- confirm the pregnancy as soon as possible
- explain that stopping or switching the medication after pregnancy is confirmed may not remove the risk of fetal malformations
- offer screening for fetal abnormalities and counselling about continuing the pregnancy
- explain the need for additional monitoring and the risks to the fetus if she continues to take the medication.

Seek advice from a specialist if there is uncertainty about the risks associated with specific drugs. [new 2014]

4.7.3 Current UK practice

NHS England has produced guidance for healthcare providers on the implementation of the Friends and Family Test in relation to women who suffer either miscarriage or stillbirth[23].

[23] NHS England (2014) 'Guidance on friends and family test for women who suffer miscarriage or stillbirth'

4.8 *Additional suggestions not meeting technical criteria for statement development:*

Support for women requesting a caesarean section

One stakeholder highlighted that perinatal mental health services should be able to support maternity services in cases where women do not have a medical indication for caesarean section but request elective caesarean.

The NICE quality standard for caesarean section (QS32) includes 2 quality statements on maternal request for caesarean section:

- QSt1: Pregnant women who request a caesarean section (when there is no clinical indication) have a documented discussion with members of the maternity team about the overall risks and benefits of a caesarean section compared with vaginal birth.
- QSt2: Pregnant women who request a caesarean section because of anxiety about childbirth are offered a referral to a healthcare professional with expertise in perinatal mental health support.

The quality standard for antenatal and postnatal mental health should be used in conjunction with other relevant guidance, including NICE QS32.

Training and supervision

A number of stakeholders highlighted the need for training and supervision of particular groups of staff to ensure that women receive high quality support for mental health problems when planning a pregnancy, during pregnancy and in the postnatal period.

The quality standard should not contain any statements on training and competencies. Staff being trained and competent is an underpinning concept of all quality standards. An additional paragraph has been added to the overview for each quality standard which can make reference to specific examples of training and competency frameworks where the QSAC feel this is important.

Cultural competence

One stakeholder highlighted that mental health problems can be a taboo subject within BME groups, and suggested that BME service users receive disproportionately worse care due to access and language issues.

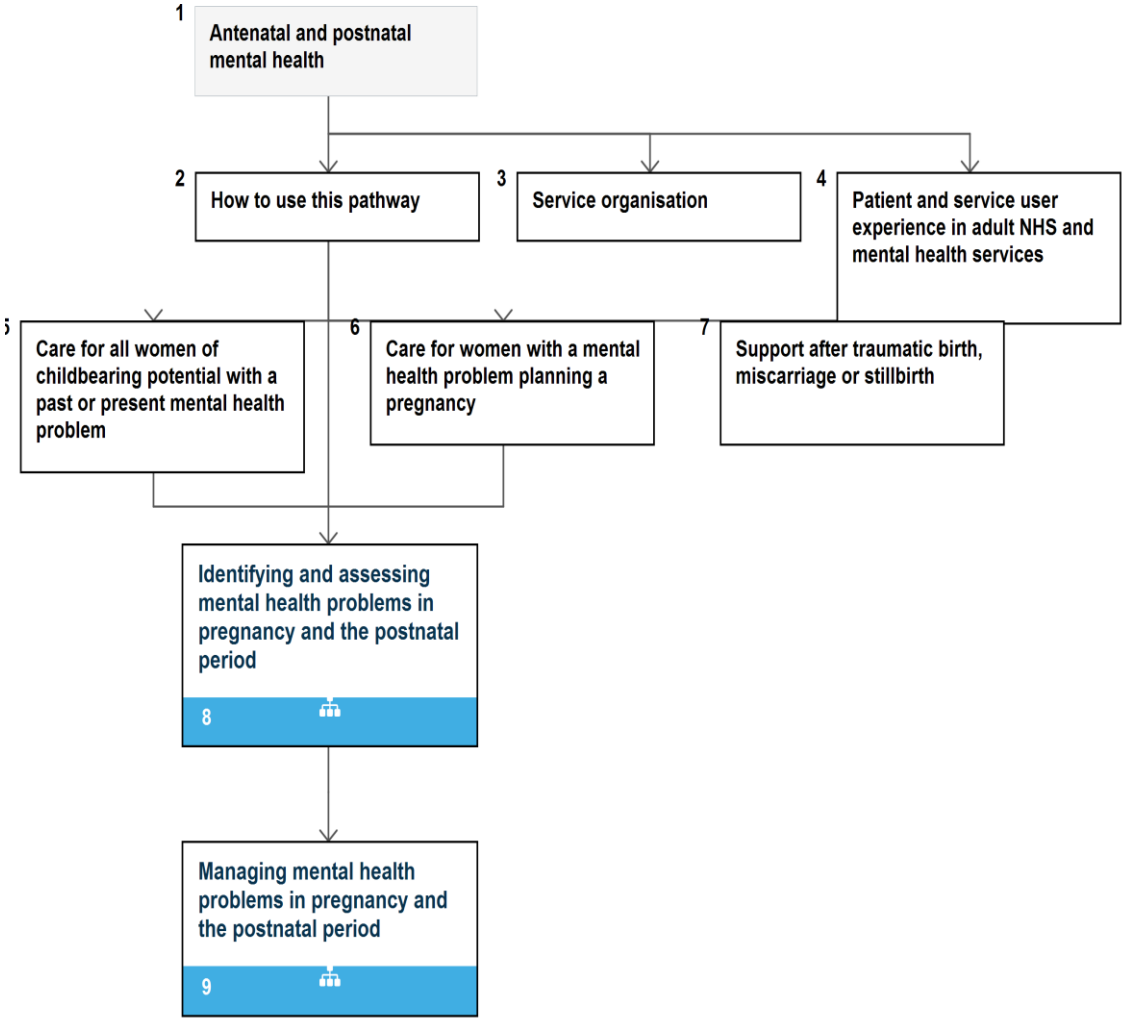
The needs of different groups will be considered throughout development of the quality standard. Equality and diversity will be considered for each quality statement to ensure that the statement promotes equality.

Understanding the specific prodromal symptoms for postnatal psychosis

One stakeholder suggested a need to gather and use data to better understand specific prodromal symptoms for postnatal psychosis in order to better manage the care of women with this condition.

NICE quality standards do not suggest areas for epidemiological research.

Appendix 1: Care pathway for antenatal and postnatal mental health



Appendix 2: Key priorities for implementation (CG192)

Recommendations that are key priorities for implementation in the source guideline and that have been referred to in the main body of this report are highlighted in grey.

Considerations for women of childbearing potential

- Discuss with all women of childbearing potential who have a new, existing or past mental health problem:
    - the use of contraception and any plans for a pregnancy
    - how pregnancy and childbirth might affect a mental health problem, including the risk of relapse
    - how a mental health problem and its treatment might affect the woman, the fetus and baby
    - how a mental health problem and its treatment might affect parenting. [new 2014]
- Do not offer valproate for acute or long‑term treatment of a mental health problem in women of childbearing potential. [new 2014]

Principles of care in pregnancy and the postnatal period

- Develop an integrated care plan for a woman with a mental health problem in pregnancy and the postnatal period that sets out:
    - the care and treatment for the mental health problem
    - the roles of all healthcare professionals, including who is responsible for:
        - coordinating the integrated care plan
        - the schedule of monitoring
        - providing the interventions and agreeing the outcomes with the woman. [new 2014]

Treatment decisions, advice and monitoring for women who are planning a pregnancy, pregnant or in the postnatal period

- Mental health professionals providing detailed advice about the possible risks of mental health problems or the benefits and harms of treatment in pregnancy and the postnatal period should include discussion of the following, depending on individual circumstances:

- the uncertainty about the benefits, risks and harms of treatments for mental health problems in pregnancy and the postnatal period
- the likely benefits of each treatment, taking into account the severity of the mental health problem
- the woman's response to any previous treatment
- the background risk of harm to the woman and the fetus or baby associated with the mental health problem and the risk to mental health and parenting associated with no treatment
- the possibility of the sudden onset of symptoms of mental health problems in pregnancy and the postnatal period, particularly in the first few weeks after childbirth (for example, in bipolar disorder)
- the risks or harms to the woman and the fetus or baby associated with each treatment option
- the need for prompt treatment because of the potential effect of an untreated mental health problem on the fetus or baby
- the risk or harms to the woman and the fetus or baby associated with stopping or changing a treatment. [new 2014]

- Before starting any treatment in pregnancy and the postnatal period, discuss with the woman the higher threshold for pharmacological interventions arising from the changing risk‑benefit ratio for psychotropic medication at this time and the likely benefits of a psychological intervention. [new 2014]

- If a pregnant woman has taken psychotropic medication with known teratogenic risk at any time in the first trimester:
  - confirm the pregnancy as soon as possible
  - explain that stopping or switching the medication after pregnancy is confirmed may not remove the risk of fetal malformations
  - offer screening for fetal abnormalities and counselling about continuing the pregnancy
  - explain the need for additional monitoring and the risks to the fetus if she continues to take the medication.

- Seek advice from a specialist if there is uncertainty about the risks associated with specific drugs. [new 2014]

- When choosing a tricyclic antidepressant (TCA), selective serotonin reuptake inhibitor (SSRI) or (serotonin‑) noradrenaline reuptake inhibitor [(S)NRI][1], take into account:
  - the woman's previous response to these drugs
  - the stage of pregnancy
  - what is known about the reproductive safety of these drugs (for example, the risk of fetal cardiac abnormalities and persistent pulmonary hypertension in the newborn baby)
  - the uncertainty about whether any increased risk to the fetus and other problems for the woman or baby can be attributed directly to these drugs or may be caused by other factors
  - the risk of discontinuation symptoms in the woman and neonatal adaptation syndrome in the baby with most TCAs, SSRIs and (S)NRIs, in particular paroxetine and venlafaxine. [new 2014]

Recognising mental health problems in pregnancy and the postnatal period and referral

- At a woman's first contact with primary care or her booking visit, and during the early postnatal period, consider asking the following depression identification questions as part of a general discussion about a woman's mental health and wellbeing:
  - 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?

  Also consider asking about anxiety using the 2‑item Generalized Anxiety Disorder scale (GAD‑2):
  - During the past month, have you been feeling nervous, anxious or on edge?[2]

- During the past month have you not been able to stop or control worrying? [new 2014]

Providing interventions in pregnancy and the postnatal period

- All healthcare professionals providing assessment and interventions for mental health problems in pregnancy and the postnatal period should understand the variations in their presentation and course at these times, how these variations affect treatment, and the context in which they are assessed and treated (for example, maternity services, health visiting and mental health services). [new 2014]

Considerations for women and their babies in the postnatal period

- Discuss with a woman whose baby is stillborn or dies soon after birth, and her partner and family, the option of 1 or more of the following:
  - seeing a photograph of the baby
  - having mementos of the baby
  - seeing the baby
  - holding the baby.

  This should be facilitated by an experienced practitioner and the woman and her partner and family should be offered a follow‑up appointment in primary or secondary care. If it is known that the baby has died in utero, this discussion should take place before the delivery, and continue after delivery if needed. [new 2014]

The organisation of services

- Clinical networks should be established for perinatal mental health services, managed by a coordinating board of healthcare professionals, commissioners, managers, and service users and carers. These networks should provide:◦
  - a specialist multidisciplinary perinatal service in each locality, which provides direct services, consultation and advice to maternity services, other mental health services and community services; in areas of high

morbidity these services may be provided by separate specialist perinatal teams

- access to specialist expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding
- clear referral and management protocols for services across all levels of the existing stepped‑care frameworks for mental health problems, to ensure effective transfer of information and continuity of care
- pathways of care for service users, with defined roles and competencies for all professional groups involved. [2007]

Appendix 3: Suggestions from stakeholder engagement exercise

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
Royal College of Midwives	Pre-conception counselling for women with a mental health problem, or history of mental health problems	Key area for quality improvement 1 Pre- conception - information giving Including - pregnancy planning and contraception - how pregnancy and childbirth might affect a mental health problem, - how a mental health problem and its treatment might affect her and her baby	All members of the primary care team should be aware of the importance of this discussion. This is particularly relevant for GPs who should know of existing mental health problems before the woman encounters the maternity services	Women continue to report lack of information on this subject.	Perinatal Mental Health Experiences of women and health professionals (2013) http://www.tommys.org/perinatal-mental-health-report Royal College of Midwives (2014) Maternal mental health: improving emotional wellbeing in postnatal care
SCM 2	pre-conception counselling for women with a mental health problem, or history of mental health	Every woman of childbearing potential who has had a mental illness diagnosed at any time in her	Size of problem i.e Number of women have or had diagnosed mental illness Not fully informed of risks prior to pregnancy Not had opportunity to	Safer and improved quality of life for women, their babies and for whole family Contribute to reduce stigma Improve knowledge and understanding of mental health professionals of perinatal illness	Sequential triennial Confidential Enquiry into Maternal Death (UK) since 2000 onwards outline quality indicators to improve care of pregnant and postnatal women who

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	problems	life prior to first pregnancy, should be given information and offered appointment with mental health professional who has the perinatal expertise to support her making fully informed decisions about and be able to plan as safe a pregnancy, birth and first postnatal period as possible	discuss options for treatment minimising risk to both self and baby during pregnancy and breastfeeding Not had opportunity to consider risks of stopping treatment if pregnant and options for alternative safest care Not had opportunity to consider that if choose less effective treatment by choice, benefit of closer monitoring	Give a real hope that women who experience mental illness can have family life, recognize any deterioration and encourage earliest seeking for help and treatment Provision of improved and optimal treatment likely to support healthy attachment and attunement between mothers and babies preventing or minimising any harm	have mental illness (Why Mothers Die / Why Mothers Live)
SCM 4	pre-conception counselling for women with a mental health problem, or history of mental health problems	Additional developmental areas of emergent practice	Pre-conception counselling has been recommended for women with severe mental illness by Confidential Enquiries and NICE CG192. Women in some part of the country are currently unable to access this specialist		

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			service. This could also be considered key.		
Royal College of Psychiatrists	pre-conception counselling for women with a mental health problem, or history of mental health problems	Key area for quality improvement 1 Access to preconception counselling for women with severe mental illness	Women with severe mental illness are at very high risk of significant recurrence in the perinatal period – women and their partners need to understand the risk Difficult decisions are needed with regard to management – particularly with regard to continuing, stopping or changing medication	Area of unmet need with many women having great difficulty accessing information Many women with severe mental illness (e.g. bipolar disorder) are not now under the care of secondary care mental health services and find it difficult to access the advice they need.	
SCM 4	pre-conception counselling for women with a mental health problem, or history of mental health problems – prescribing of valproate	Key area for quality improvement 2 Preventing prescription of valproate to women of child bearing age	Evidence from a Europe wide review showed that children exposed in utero to valproate are at a high risk of serious developmental disorders (in up to 30-40% of cases) and/or congenital malformations (in approximately 10% of cases). This led the MHRA to strengthen its warnings against prescription of	Despite previous recommendations eg NCE 2007 valproate continues to be prescribed to women with bipolar disorder without trials of all other drugs first.	Please see the MHRA drug safety update on medicines related to valproate: adverse pregnancy outcomes https://www.gov.uk/drug-safety-update/medicines-related-to-valproate-risk-of-abnormal-pregnancy-outcomes Also, the NICE guideline on antenatal and postnatal

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			valproate to women of childbearing potential or pregnant women unless other treatments are ineffective or not tolerated. Recently updated NICE guidelines (antenatal and postnatal mental health update; bipolar update) recommend that health professionals do not offer valproate for acute or long- term treatment of a mental health problem in women of childbearing potential.		mental health http://www.nice.org.uk/guidance/cg192 Evidence of continued prescribing: Data from the Clinical Practice Research Datalink suggest that approximately 35,000 women aged 14 to 45 per year had a prescription for sodium valproate between 2010 and 2012. Of these, at least 375 per year had a prescription for sodium valproate while pregnant. Although the majority of the prescriptions were for epilepsy, there is also evidence that NICE guidance is also not being followed by mental health professionals. http://www.rcpsych.ac.uk/pdf/Jones%20Sarah.pdf Evidence from the CRIS database (http://www.slam.nhs.uk/a

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
					bout/core-facilities/cris) also finds valproate exposure in pregnancy since 2007 (Taylor et al, under review)
SCM 1	Identifying and assessing mental health problems in pregnancy and the postnatal period – Assessing the mental health of all pregnant women and diagnosing any mental health problems	Key area for quality improvement 4	Assessment for mothers at 'Universal' contacts. The assessment needs to be explicit: What is assessed and how. 100% of women will be asked the Whooley questions at Universal contacts	This needs to be described in more detail as some staff groups are confusing this will 'all contacts' Assessments in practice are not completed accurately and in inappropriate venues. Also consider how many women are then offered further assessments following the Whooley assessment. Does this follow that evidence that is known.	10%-15% women suffer from postnatal depression (Cox et al 1996, Wisner 2012)
SCM 2	Identifying and assessing mental health problems in pregnancy and the postnatal period – Assessing the mental health of all pregnant	All pregnant and postnatal women routinely asked about their mental wellbeing at every health appointment with further structured or	To increase the identification of mental illness that adversely impacts on a woman, her baby and family and increase early access to further assessment and treatment To prevent some women if not treated from	Individual Psychological Therapies in a variety of formats and intensity are effective at treating many types depressive illnesses and anxiety disorders. Women's, babies and families lives would be significantly improved and be healthier physically, emotionally and a healthier emotional and	NSPCC Report on Services for 0-3yr olds an in depth look at 3 different Boroughs/Councils (Lambeth was 1 of the 3) demonstrated a very large burden of unmet need for pregnant and postnatal women experiencing mild/moderate mental

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	women and diagnosing any mental health problems	validated screening as required	developing chronic mental illness To prevent developmental problems and for some later mental illness in some children	developmental environment for children	illness and a large gap in service provision
SCM 4	Identifying and assessing mental health problems in pregnancy and the postnatal period – Assessing the mental health of all pregnant women and diagnosing any mental health problems	Key area for quality improvement 3 Improving identification of mental health disorders during pregnancy and the postpartum	Perinatal mental disorders are common affecting over 1 in 10 women in the perinatal period. Depressive and anxiety disorders are the commonest diagnosis with both having an estimated prevalence of 13%. The NICE guideline on antenatal and postnatal mental health states that health professionals should have a discussion about mental health at all contacts and recognise the range of mental disorders that may affect women. Health professionals should also recognise that women may be reluctant to disclose their problems due to fear of stigma, negative perceptions of	As above, there is evidence of under-detection of disorders and women's experience is of either not being asked or being asked badly eg "you don't have any problems with your mental health do you"	As for Key area 1 and NICE guideline on antenatal and postnatal mental health http://www.nice.org.uk/guidance/cg192 Royal College of General Practitioners Background Paper on Perinatal Mental Health http://www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/Perinatal%20Mental%20Health/RCGP-PMH-Background-Paper-December-2014.ashx

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			them as a mother or fear that their baby might be taken into care.		
Royal College of Midwives	Identifying and assessing mental health problems in pregnancy and the postnatal period – Assessing the mental health of all pregnant women and diagnosing any mental health problems	Key area for quality improvement 2 Recognising mental health problems in pregnancy and the postnatal period and referral	Midwives, who are key to the initial discussion at booking, as well as postnatally, will need specific training in the use of the recommended diagnostic scales and adequate time to facilitate the discussion.	There is a wide body of evidence demonstrating that many pregnant or postnatal women are reluctant to discuss their feelings with health professionals. There is also evidence that rushed postnatal care focuses on clinical observations rather than mental well being	Royal College of Midwives (2014) Maternal mental health: improving emotional wellbeing in postnatal care 4Children (2011) Suffering in silence: 70,000 reasons why help with postnatal depression needs to be better
PANDAS Foundation	Identifying and assessing mental health problems in pregnancy and the postnatal period – Assessing the mental health of all pregnant women and diagnosing any mental health problems	New diagnostic criteria for perinatal mental illness	The current method for diagnosing perinatal mental illness is the Edinburgh scale, which is overly simplistic and several service users have said they found easy to 'fake' the results of.	Service User who have come to PANDAS have said that they have done so due to the fact that their diagnosis was 'missed'. They felt that the test had right and wrong answers and many feared if they answered 'wrong' then they could lose their children. Because the test was the sole attempt to check their mental health they slipped through the system and were left without support.	There are numerous reports across the forums both of PANDAS and of parenting sites across the web of mothers whose only brush with diagnosis was a test pushed in their faces and several others who did not even receive this.

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
National Childbirth Trust	Identifying and assessing mental health problems in pregnancy and the postnatal period – Assessing the mental health of all pregnant women and diagnosing any mental health problems	Key area for quality improvement 4 A mother's postnatal check at six weeks postpartum should be ADDITIONAL to the check made upon her baby and should be carried out by an appropriately trained GP who is aware of local care pathways	The 6-8 week checks are routinely carried out by GPs and just 10 minutes allotted. Our research shows that examining the baby can easily take up all of this time, resulting in only cursory questions being asked about the mother's health (physical and emotional). 45% of mothers felt their six week postnatal check-up was not thorough enough and a quarter (26%) felt their check was rushed. 3 out of ten women (29%) said their GP did not ask them about any emotional or mental health issues.	Women need to be given the time and sense of security in which to feel safe to share their feelings (see comments above). One reason which many women gave for not discussing their emotional wellbeing was that very little time is allowed for the 6-8 week check and that the health professionals they were in contact with always seemed to be in a rush.	http://www.tommys.org/file/Perinatal_Mental_Health_2013.pdf Mind the gap: perinatal mental health service provision, NCT 2014.
SCM 5	Identifying and assessing mental health problems in pregnancy and the postnatal period – Assessment of the severity of mental health problems	Individuals with antenatal or postnatal mental health illnesses receive an assessment which identifies the severity of the symptoms.	To allow health professionals to provide a choice of treatments and signpost to other services.	To ensure that individuals are provided with the correct care, there needs to be a sufficient assessment carried out to ensure that all symptoms and issues are recorded and treated.	To bring in line with the Depression in Adults quality standard. https://www.nice.org.uk/guidance/qs8/chapter/quality-statement-1-assessment

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
SCM 4	Identifying and assessing mental health problems in pregnancy and the postnatal period – Assessment of the severity of mental health problems	Key area for quality improvement 4 Improving access to timely assessment and treatment by perinatally competent practitioners	Untreated perinatal mental disorders are associated a significant risk of long-term psychiatric morbidity and mortality for new mothers. However, evidence-based effective interventions are available and include psychosocial interventions, psychological therapies and psychotropic medication. The NICE guidelines on antenatal and postnatal mental health recommend that when a woman with known or suspected mental health problems is referred in pregnancy or the postnatal period, she should be assessed for treatment within 2 weeks of referral and given psychological interventions within 1 month of initial assessment. Furthermore, the perinatal period is associated with increased risk of severe	Early interventions could result in savings in additional interventions, support and pharmacological treatments, and to improvements in a woman's quality of life. It would also decrease the cost to society of childhood health problems in addition to the maternal costs (Costs of perinatal mental health problems Centre for Mental Health 2014). Although new targets for access to mental health services have been promised by the government recently pregnant women and postpartum women need quicker access to assessment and treatment in view of the impact on them and their fetus/infant. Data from the HSCIC Annual Report on IAPTs 2013- 2014 shows that only about 6 in 10 people had their appointment within 28 days of referral. Of the 920,000 referrals that ended only 40% had finished a course	Evidence review on women's experience of care in the UK included in full NICE guideline on antenatal and postnatal mental health http://www.nice.org.uk/guidance/cg192 Confidential Enquiries: http://www.hqip.org.uk/cmace-reports/ HSCIC Annual report on Improving Access to Psychological Therapies 2013-2014 http://www.hscic.gov.uk/catalogue/PUB14899 Centre for Mental Health Report on Costs of Perinatal Mental Health http://www.centreformentalhealth.org.uk/publications/costs_perinatal_mh_problems.aspx?ID=711

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			mental disorder. Postpartum psychosis, a severe and rapidly progressive condition, affects between 1 and 2 in 1000 women who have given birth and often requires admission to specialized mother-baby units. NICE guidance recommends that if a woman has sudden onset of symptoms suggesting postpartum psychosis, she should be referred to a secondary mental health service (preferably a specialist perinatal mental health service) for immediate assessment (within 4 hours of referral).	of treatment and 37% ended without being seen by the IAPT service. No specific data on the proportion of women referred, thus highlighting the lack of recognition of this group needing speedier access. Also whereas service development work streams were created for old age and children and young people, women in pregnancy and the postpartum period remained overlooked. In addition, specialist perinatal mental health services are needed for women with complex or severe conditions and should, according to NICE, preferably be the first port of call in cases of severe mental illness. However, less than 15% of localities provide comprehensive specialist perinatal services (Cost of Perinatal mental health report, centre for mental health).	
HQT Diagnostics	Identifying and assessing mental health problems in	Test Fatty Acids Supplement so that:	There is good evidence that many mental health problems have an underlying physical cause.	Major improvements in mental health have been seen within 3 months of adjusting the levels of Omega-3 and Omega-6 Fatty	www.expertomega3.com/omega-3-study.asp?id=38 http://www.expertomega3.

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	pregnancy and the postnatal period – Assessment of the severity of mental health problems	Omega-3 Index: >8% Omega-6/3 Ratio: <3:1		Acids This is important before, during and after pregnancy. It is relevant for Depression, Bipolar Disorder, Borderline Personality, Substance Abuse, Schizophrenia and Psychotic Disorders There are additional benefits for both the physical and mental health of the mother and the development and health of the baby	com/omega-3-study.asp?id=21 www.hqt-diagnostics.com/Products/HQT-Analysis
HQT Diagnostics	Identifying and assessing mental health problems in pregnancy and the postnatal period – Assessment of the severity of mental health problems	Test Vitamin D Supplement so that: 25(OH)D = 100-150 nmol/L	There is good evidence that many mental health problems have an underlying physical cause.	Major improvements in mental health have been seen within 3 months of adjusting the levels of Vitamin D This is important before, during and after pregnancy. It is relevant for Depression, Bipolar Disorder, Borderline Personality, Substance Abuse, Schizophrenia and Psychotic Disorders There are additional benefits for	http://www.vitamindwiki.com/Depression http://www.vitamindwiki.com/44X+increase+in+Bipolar+Disorder+in+youth+in+a+decade+%E2%80%93+Sept+2007 http://www.vitamindwiki.com/Overview+Schizophrenia+and+Vitamin+D http://vitamindwiki.com/tiki-index.php?page_id=4658

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				both the physical and mental health of the mother and the development and health of the baby	http://www.vitamindwiki.com/Overview+Pregnancy+and+vitamin+D
Royal College of Psychiatrists	Identifying and assessing mental health problems in pregnancy and the postnatal period – Assessment of the severity of mental health problems	Key area for quality improvement 2 Optimisation of the physical health in pregnancy and postpartum for women with severe mental illness	These are high-risk pregnancies. There is poor obstetric outcome for these women and for the baby.	Because this would lead to better outcomes for women and their children.	
SCM 3	Access to specialist perinatal mental health care – Specialist multidisciplinary perinatal services in each locality	Key area for quality improvement 1	Provision of community, specialised and maternity perinatal mental health services around the UK which meet nationally ag reed standards and specifications	There is a strong evidence base for the need for specialist perinatal mental health services (NICE APMH guideline). Recently published data from the Maternal Mental Health Allliance has highlighted the significant inequality of provision around the UK	See everyonesbusiness.org.uk
Royal College of Midwives	Access to specialist perinatal mental health care -	Key area for quality improvement 5 The provision of	As above		

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	Specialist multidisciplinary perinatal services in each locality	a specialist multidisciplinary perinatal service in each locality which includes access to specialist expert advice on the risks and benefits of psychotropic medication			
Medway NHS Foundation Trust	Access to specialist perinatal mental health care – Specialist multidisciplinary perinatal services in each locality	Key area for quality improvement 2 Women and parents with personality disorder need specialist services	The incidence of borderline PD is documented as 1% up to 22% Delivery PD services which meet the needs of parents is an essential part of improving perinatal mental health. Avoidance of the specialist needs of PD parents will have a detrimental effect on the subsequent generation.	At the moment most IAPT services do not meet the needs of PD parents and secondary MH services are reluctant to deliver help for women in pregnancy and the early PN period. PD services are specialised and must take into account the poor reflective functioning and difficulties in the mother baby and family relationship. Women are usually told to wait for treatment until after the baby is about 6 weeks to 6 months, with the explanation that treatment would interfere with their relationship with the baby. There is no evidence for this assumption. In	See http://www.bioportfolio.com/resources/pmarticle/424462/New-Beginnings-for-mothers-and-babies-in-prison-A-cluster-randomized-controlled.html This programme enhances reflective functioning and is known to be a problem for women with personality disorder.

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				fact there is evidence to refute this assumption. The new beginnings programme can be delivered by low intensity wellbeing practitioners as long as they are able to access effective supervision from a trained therapist.	
National Childbirth Trust	Access to specialist perinatal mental health care - Specialist multidisciplinary perinatal services in each locality	Key area for quality improvement 1 All CCGs to have a perinatal mental health strategy in place	Care of a mother's emotional health and wellbeing is key to both her recovery from birth and the health and wellbeing of her baby. Current service provision for women with antenatal and postnatal mental health issues is inadequate and inconsistent, and there is great concern about the capacity of current services to implement the NICE Postnatal Care guidance (sections 1.2.22-1.2.26). The development of perinatal mental health strategies across all CCGs is essential.	Of the 186 CCGs who responded to NCT's FOI request (see p3-5 of the attached draft report) only 3% had a perinatal mental health strategy in place. Out of the 97% of CCGs without a perinatal strategy, 60% had no plans to put one in place.in the future. Fifteen percent of CCGs were unable to offer any information and directed the charity to local NHS trusts or NHS England. This indicates a lack of clarity about who is responsible for commissioning and providing services.	Report attached: NCT (2014).Mind the gap: perinatal mental health service provision. The Costs of Perintatal Health Problems: http://everyonesbusiness.org.uk/?p=742 NICE Guidance (CG37): Postnatal Care
SCM 5	Access to specialist	Specialist mental health	To ensure that any mental health illness are	The occurrences of both pre and postnatal depression are high.	Maternal Mental Health Alliance

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	perinatal mental health care – Specialist multidisciplinary perinatal services in each locality	midwives accessible for individuals suffering antenatal and postnatal mental health illnesses	recognised, assessed, signposted and treated to ensure mums to be are supported and receive the treatment they require.	It is estimated that 7-20% of pregnant mothers have Antenatal, or prenatal depression**. This would have been a minimum of 51,000 women in 2012. Furthermore, at least 10% of mothers would have experienced postnatal depression***, giving a figure of over 72,000* for 2012. * Office of National Statistics **Wilson, Pamela. "Antenatal Depression". health.ninemsn.com. Retrieved 4 April 2013 *** Royal College of Psychiatrists	'What they do and why they matter' http://everyonesbusiness.org.uk/wp-content/uploads/2014/07/MMHA-Specialist-Mental-Health-Midwives.pdf
Blackpool Centre for Early Child Development, Blackpool Council	Access to specialist perinatal mental health care - Specialist multidisciplinary perinatal services in each locality	Every women in the UK should have easy access to community specialist perinatal mental health teams which meet national quality standards.	More women and families in the UK must have access to community specialist perinatal mental health teams. These teams must meet UK national quality standards as set by NICE.	Almost half of the UK, women have no access to community specialist perinatal mental health service provision. Not all of the services that do exist meet national quality standards. If it were mandated that these Quality standards had to be adhered to alongside the accountability then the quality of services would improve. Even though the setting up of these specialist perinatal mental	This attached document reveals the heavy economic cost of perinatal mental illness to our society and public services. It shows that the long-term costs to society of perinatal mental illness are more than £8bn for each annual cohort of births in the UK. Nearly three quarters of this cost results from the adverse impacts of perinatal

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				health teams initially would cost more money and funds would have to be found in the long term the savings would be huge.	mental illness on the child.
SCM 1	Access to specialist perinatal mental health care - Specialist multidisciplinary perinatal services in each locality	Key area for quality improvement 1	A Health Visitor specialist post/s that focuses on PMI in primary care.	This was recommended by DH in 2012 – most organisations have not taken the opportunity to implement this. Having a role that focuses on this agenda will drive up quality of care, assessment and faster effective referrals to appropriate services	
Medway NHS Foundation Trust	Access to specialist perinatal mental health care - Clinical networks	Key area for quality improvement 5 Setting up of local perinatal mental health clinical networks.	These networks bring all the stakeholders together including users of the services. The network ensures that families are at the centre of planning because uncoordinated clinical services induce and enhance unhelpful competition between agencies.	At the moment networks are not coordinated and some areas are more developed than others. Delivering managed clinical networks should be part of the NHS England contract.	I have been involved with a PMHCN for the last 13 years and its rise and fall has been mainly due to lack of investment. The managed network must be supported by funding.
Royal College of Psychiatrists	Access to specialist perinatal mental health care –	Key area for quality improvement 4 Timely access	It is recognised that joint admission with her baby is the gold standard for women in the postnatal period but there remains a	A postcode lottery in provision of specialist services exists at present. Addressing this issue will significantly increase the quality of care women receive.	

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	Specialist multidisciplinary perinatal services in each locality - Mother and baby units	to the appropriate level of specialist perinatal mental health care - including inpatient mother and baby units and specialist community perinatal mental health teams	postcode lottery for provision of mother and baby unit beds. Services need to collect data on provision of services to women in the perinatal period – both inpatient and outpatient contacts.		
Blackpool Centre for Early Child Development, Blackpool Council	Access to specialist perinatal mental health care – Specialist multidisciplinary perinatal services in each locality - Mother and baby units	There needs to be clear lines of accountability for perinatal mental health care which should be set at a national level and complied with.	Accountability is important because perinatal mental health care must be formally clarified within national NHS mandates and included in the portfolio of a named minister in each of the UK's four nations.	If this does not happen this work will not be moved forward and the situation that currently exists will remain. A national strategy that addresses the shortfall of beds in specialist inpatient mother and baby units must be established. The shortfall and current postcode lottery is not acceptable. Maternal mental illness affects more than 10 percent of new mothers. It can also be severe, with suicide a leading cause of maternal death. In addition to the devastating consequences to the woman, untreated illness can have adverse effects on	

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				child development and long-term outcomes.	
Royal College of Midwives	Access to specialist perinatal mental health care – Mother and baby units	Additional developmental areas of emergent practice Provision of and access to specialist mother and baby units	A minimal number of such units currently exist	The separation of the mother and baby from their support networks is clearly unhelpful to her early recovery Admission of mothers and babies to general psychiatric wards is not safe for the baby.	Maternal Mental Health Alliance (2014) UK specialist community perinatal mental health teams (current provision) SIGN (2012) Management of perinatal mood disorders
SCM 1	Coordinated care for women with a mental health problem in pregnancy and the postnatal period	Key area for quality improvement 1	Having a 'integrated' clinical pathway for women with PMI.	Many organisations still do not have clinical pathways in place. Others that do are not integrated, in part or fully, into the 'wider' service providers.	
SCM 3	Coordinated care for women with a mental health problem in pregnancy and the postnatal period	Key area for quality improvement 2	Perinatal mental health services should be well-integrated with local maternity and mental health services across the patient pathway	It has been highlighted in the NICE guideline that perinatal provision, where it does exist, is provided in a range of settings and services. This contributes to the 'postcode lottery' experience for women. Where services are not integrated within maternity, poor communication is more likely	

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				and outcomes worse.	
SCM 4	Coordinated care for women with a mental health problem in pregnancy and the postnatal period	Additional developmental areas of emergent practice	Integration of physical and mental health in care plans for pregnant and postnatal women is also recommended by NICE CG192 and is increasingly seen as important in government policy on mental illness		
SCM 2	Coordinated care for women with a mental health problem in pregnancy and the postnatal period	Provision of an individualised Perinatal Mental Health Care Plan integral to maternity care and postnatal first year	Where provided for example through a variety of Perinatal Psychiatry services, treatments appear more effective, more acceptable to women and families, is safer in earlier recognition of deterioration and swifter access to assessment and treatment. Reduce serious morbidity and maternal/perinatal or infant mortality	Clarity of roles, responsibility for the woman, her family and professionals working with her. Clarity of when and how to access information, further assessment and treatment, most importantly during key transitions in life and key transitions across different parts of the health sector. The quality directly affects the mother, the baby, any siblings, her partner and wider family	
National Childbirth Trust	Coordinated care for women with a mental health problem in pregnancy and the postnatal	Key area for quality improvement 3 Each mother to have an individualised care plan (for	Many women suffer in silence. The Tommy's report *Perinatal Mental Health Experiences of Women and Health Professionals* found that women's resistance to	Women need to be able to access support and services which enable mental equilibrium without having to be diagnosed as clinically depressed. Discussion in the antenatal period can help to prepare	Tommy's (2013). Perinatal Mental Health: Experiences of Women and Health Professionals. Available at: http://www.tommys.org/file/Perinatal_Mental_Health_

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	period	both antenatal and postnatal care) which includes information on maintaining mental wellbeing	talking about their feelings was the biggest barrier to being able to access help, with less than a fifth saying that they had been completely honest and almost a third having never told a health professional that they felt unwell. It is therefore important that information on maintaining mental wellbeing is provided to all women antenatally and postnatally, and that mental health is a routine discussion with midwives and other health professionals (as per physical health). All women who suffer a traumatic birth should be given the opportunity to talk through the experience with an appropriately trained health professional, with referral for further support where appropriate.	women (and their partners) for what is normal and how to recognise signs of poor mental health. Tools such as a Wellbeing Plan can help both parents think through the possibility of illness and how to manage it, and also make it easier for health professionals to introduce the topic of mental health problems.	2013.pdf
Royal	Coordinated	Key area for	There are multiple sources	Many areas of the UK do not	Royal College of Midwives

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College of Midwives	care for women with a mental health problem in pregnancy and the postnatal period	quality improvement 3 Co-ordinated care involving integrated care plans for women with a mental health problems in pregnancy and the postnatal period Everyone involved in a woman's care being aware of their responsibilities and there is effective sharing of information with all services involved and with the woman herself	of evidence of the lack of implementation of care pathways in mental health The presence of the specialist mental health midwife would support the appropriate care planning and delivering a continuous pathway of care	have local plans or strategies in place to make sure specialist perinatal mental health services are available. This is despite evidence that these specialist services are necessary and possible. Midwives continue to report difficulty with referring women to perinatal mental health experts, which demonstrates the lack of integrated care planning for these women	(2014) Maternal mental health: improving emotional wellbeing in postnatal care Royal College of Midwives (2014) Postnatal care planning https://www.rcm.org.uk/sites/default/files/Pressure%20Points%20-%20Postnatal%20Care%20Planning%20-%20Web%20Copy.pdf Maternal Mental Health Alliance (2013) Specialist Mental Health Midwives: what they do and why they matter
National Childbirth Trust	Coordinated care for women with a mental health	Key area for quality improvement 2 Each trust to	Reorganisation of NHS commissioning and services, and the creation of Public Health England,	Women transfer between acute, primary care and public services at a very vulnerable period during the postnatal period.	Tommy's (2013). Perinatal Mental Health: Experiences of Women and Health Professionals.

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	problem in pregnancy and the postnatal period	ensure robust mechanisms are in place in order to enable communication of key information between acute services, primary care and public health	means that the care of women during pregnancy and the postnatal period is split between midwives (acute services), GPs (primary care) and health visitors (public health), which can lead to fragmented services and women with mental health problems falling through the gaps.	Given how difficult women find it to be open about how they feel at this time, it is really important that they develop trusting relationships with the health professionals supporting them and that handover is effective from one service to another. Midwives know that women in their care are showing signs of poor mental health but are unable to offer the continuity of relationship that women would value. The Royal College Midwives Pressure Point report says: "It is clear that midwives want to help and support women with mental health issues but are restricted by their current workload and inability to deliver continuity of care".	Available at: http://www.tommys.org/file/Perinatal_Mental_Health_2013.pdf
SCM 4	Care of pregnant women with a severe mental illness, or history of a severe mental illness by a	Key area for quality improvement 5 Women with a history of severe mental illness should be under	Anecdotal evidence is that women with severe mental illness e.g. bipolar disorder are often discharged from community mental health services when seen as well even if pregnant, without professionals	An audit carried out by the Royal College of Psychiatrists for the Maternal Mental Health Alliance collected information on the availability of specialist community services in all health localities in the UK. This showed that more than 40% of	NICE guideline on antenatal and postnatal mental health http://www.nice.org.uk/guidance/cg192

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	mental health specialist	the care of mental health services during pregnancy and in the early postpartum period	realising there is an increased risk of relapse and that a comprehensive care plan is needed including care of mental health services, preferably specialist perinatal mental health services, through the perinatal period. As detailed above, maternal deaths and near misses have resulted and NICE CG192 recommends that women are cared for by secondary mental health care through the perinatal period and are provided with a comprehensive care plan	England's CCGs have no specialist service at all and the situation is the same for about 40% of health boards in Scotland, 70% of those in Wales and 80% of those in Northern Ireland. At the other end of the spectrum, less than 15% of localities in the UK offer comprehensive provision.	Centre for Mental Health Report on Costs of Perinatal Mental Health http://www.centreformentalhealth.org.uk/pdfs/Costs_of_perinatal_mh.pdf Maternal Mental Health Alliance http://maternalmentalhealthalliance.org.uk
SCM 2	Care of pregnant women with a severe mental illness, or history of a severe mental illness by a mental health specialist	All pregnant/postnatal women with previous or current diagnosis SMI be offered a referral to a mental health specialist with perinatal	There is good evidence that access to this level of expertise and individualised plan supports better outcomes for women, babies and families General Psychiatry especially where there is no one with a 'special interest' in Perinatal	Guaranteed access to the required level of specialist Perinatal Mental Health expertise and effective service provision to afford timely advice, assessment and treatment will prevent or at the least reduce unacceptable levels of harm and distress to women with SMI, their children, their families.	The Maternal Mental Health Alliance commissioned analysis and Report

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		psychiatry expertise for assessment and agree together her individualised Perinatal Mental Health Care Plan including arrangements for admission to a MBU if required	related work, has supported delayed recognition, timely response and effective treatment for women experiencing sudden and acute episodes of their illness leading to morbidity and at times deaths	If is made in these services to meet current demand then the effectiveness of the services will exponentially increase and the quality of the services will exponentially improve. The services have a chance at becoming cost effective instead of current investment and service availability having limited effect and unintended impact of preventable harm on lives of many children and adults	
Medway NHS Foundation Trust	Treatment for antenatal and postnatal mental health problems – psychological therapies	Key area for quality improvement 4 The interpersonal aspect of the mother baby relationship must be recognised as a potential for enhanced and depleted maternal and infant mental health	There is clear evidence of the cost of not fully accepting this as a key public health indicator.	The access to psychological therapies (IAPT) must develop services which are responsive to this need. IPT and attachment based interventions must supplement CBT for mothers with depression and anxiety around the time of childbirth with or without attachment concerns.	The costs of perinatal mental health problems 2013 See http://www.bioportfolio.com/resources/pmarticle/424462/New-Beginnings-for-mothers-and-babies-in-prison-A-cluster-randomized-controlled.html This programme enhances reflective functioning and is known to be a problem for women with personality disorder.
Royal	Treatment for	Key area for	The risk benefit balance of	Although NICE state that	

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College of Psychiatrists	antenatal and postnatal mental health problems – psychological therapies	quality improvement 5 Prioritised access to a range of evidence bases psychological therapies for women in the perinatal period who want to engage	use of medication is different in pregnancy and breastfeeding changing the balance in favour of greater use of psychological therapies. The perinatal period is an ideal time to intervene early to prevent the development of long term problems A range of approaches are required including those addressing the relationship of mother and baby	women in the perinatal period should be fast-tracked for psychological treatments, this does not happen in large parts of the country	
SCM 4	Treatment for antenatal and postnatal mental health problems – psychological therapies	Key area for quality improvement 4 Improving access to timely assessment and treatment by perinatally competent practitioners	Untreated perinatal mental disorders are associated a significant risk of long-term psychiatric morbidity and mortality for new mothers. However, evidence-based effective interventions are available and include psychosocial interventions, psychological therapies and psychotropic medication.	Early interventions could result in savings in additional interventions, support and pharmacological treatments, and to improvements in a woman's quality of life. It would also decrease the cost to society of childhood health problems in addition to the maternal costs (Costs of perinatal mental health problems Centre for Mental Health 2014).	Evidence review on women's experience of care in the UK included in full NICE guideline on antenatal and postnatal mental health http://www.nice.org.uk/guidance/cg192 Confidential Enquiries: http://www.hqip.org.uk/cmace-reports/

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			The NICE guidelines on antenatal and postnatal mental health recommend that when a woman with known or suspected mental health problems is referred in pregnancy or the postnatal period, she should be assessed for treatment within 2 weeks of referral and given psychological interventions within 1 month of initial assessment. Furthermore, the perinatal period is associated with increased risk of severe mental disorder. Postpartum psychosis, a severe and rapidly progressive condition, affects between 1 and 2 in 1000 women who have given birth and often requires admission to specialized mother-baby units. NICE guidance recommends that if a	Although new targets for access to mental health services have been promised by the government recently pregnant women and postpartum women need quicker access to assessment and treatment in view of the impact on them and their fetus/infant. Data from the HSCIC Annual Report on IAPTs 2013- 2014 shows that only about 6 in 10 people had their appointment within 28 days of referral. Of the 920,000 referrals that ended only 40% had finished a course of treatment and 37% ended without being seen by the IAPT service. No specific data on the proportion of women referred, thus highlighting the lack of recognition of this group needing speedier access. Also whereas service development work streams were created for old age and children and young people, women in pregnancy and the postpartum period remained overlooked.	HSCIC Annual report on Improving Access to Psychological Therapies 2013-2014 http://www.hscic.gov.uk/catalogue/PUB14899 Centre for Mental Health Report on Costs of Perinatal Mental Health http://www.centreformentalhealth.org.uk/publications/costs_perinatal_mh_problems.aspx?ID=711

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			woman has sudden onset of symptoms suggesting postpartum psychosis, she should be referred to a secondary mental health service (preferably a specialist perinatal mental health service) for immediate assessment (within 4 hours of referral).	In addition, specialist perinatal mental health services are needed for women with complex or severe conditions and should, according to NICE, preferably be the first port of call in cases of severe mental illness. However, less than 15% of localities provide comprehensive specialist perinatal services (Cost of Perinatal mental health report, centre for mental health).	
SCM 2	Treatment for antenatal and postnatal mental health problems – information about pharmacological treatment	Any woman treated with antipsychotics have full information and support to manage and reduce harmful side effects relating to pregnancy and later life	Reduce levels of maternal obesity Reduce levels of gestational diabetes Reduce levels of Type 2 diabetes Reduce levels ‘ trans generational’ obesity	A woman can be supported to increase her knowledge how to attain a healthy weight and nutrition Be motivated and have more control in her daily life – potential to improve self-efficacy, hope and quality of life within context of living with a ‘chronic condition’.	Weight management and activity levels contribute to reduction in obesity, gestational and Type 2 diabetes. (NICE guidelines – weight management in pregnancy / Pregnancy and diabetes
Medway NHS Foundation Trust	Treatment for antenatal and postnatal mental health problems – information	Key area for quality improvement 3 There must be systematic	In order to give women and families information so that they can make informed choices about treatment for anxiety and depression, we need to	Maternity services gather a great deal of electronic information and this resource must not be wasted.	Euroking maternity patient information systems have fields to systematically gather information about medication use in pregnancy and the early

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
	about pharmacological treatment	collection of follow-up data on child development when women use psychotropic medication in pregnancy and breast feeding	provide evidence. A national research project must be set up to collect data but specifically for psychotropic medication use.		postnatal period. This early data can then begin a prospective study of a large cohort of infants. In Medway NHS FT use this initial data in out audit cycle of NICE CG 45 and now will do for CG192
Royal College of Psychiatrists	Treatment for antenatal and postnatal mental health problems – information about pharmacological treatment	Key area for quality improvement 3 Documentation and information provision, including discussion of risks and benefits, of prescribing medication in pregnancy and breastfeeding	A number of audits around the UK find that this is still poorly done and documented.	This will empower women to make decisions in this difficult area.	
SCM 5	Treatment for antenatal and postnatal mental health problems – family support	Individuals suffering perinatal mental health illnesses have access to peer support to	Study published by BMJ added: What this study adds Telephone based peer support might be effective in preventing postnatal	The NSPCC report found 'Clinical Commissioning Groups, Local Authorities and the voluntary sector should work together to ensure that there is social support available in their	NSPCC report 'social support network can be difficult for women with mental illness and a new baby, and therefore services can play an

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		compliment treatment they are receiving	depression among women at high risk Lay people who have experienced a similar health problem or stressor can have a positive effect on psychological wellbeing. http://www.bmj.com/content/338/bmj.a3064	area for families affected by perinatal mental illness and social isolation.'	important role in facilitating and fostering social support networks' http://www.nspcc.org.uk/globalassets/documents/research-reports/all-babies-count-spotlight-perinatal-mental-health.pdf
SCM 5	Treatment for antenatal and postnatal mental health problems – family support	Fathers/ significant others receive a post birth interview to ensure there mental health wellbeing is cared for	4Children report 'Most mums (and dads) who suffer from depression during the first year of their child's life will make a full and speedy recovery and no long lasting adverse effects will be felt...' 'http://www.4children.org.uk/Files/6017b334-eb37-4db1-b2b2-9f7b00d9ea9a/Suffering-in-Silence.pdf	There are currently no guidelines for paternal mental health. Fathers and significant others not only can be effect by the birth of a child but also offer insight into how the mother might be 'coping' inside of the family unit.	The effects of postnatal depression on infant development have been detailed in http://adc.bmj.com/content/77/2/99.full
PANDAS Foundation	Treatment for antenatal and postnatal mental health problems – family support	Guidelines need to expand to include the entire family. There are currently no guidelines for paternal or	The role of the partner in PND has been often studied in relation to the mother and focus on PND in fathers themselves is a growing concern, but there are no current guidelines in place	The role of the partner (not always a father, same sex relationships also apply as do adoptive parents) is often a vital resource. Not only mat the partner offer insight into the wellness of the mother, but they are also at risk of Perinatal	A study by the Medical Research Council in 2010 found that one in 28 dads experienced depression in the first year after the birth of their child. There have been

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		partners mental health.	regarding their care.	illness themselves. Neglecting their care may significantly reduce the effectiveness of treatment for the mother and illness in the partner may trigger illness in the mother.	numerous other studies into the effect of partners on maternal PND.
National Childbirth Trust	Treatment for antenatal and postnatal mental health problems - family support	Additional developmental areas of emergent practice Any group-based antenatal education programmes to include information and signposting on mental health of mother, partner and their baby	Many women (and their partners) attend antenatal workshops or education (by NHS, third sector, or private providers). This is an opportune moment to raise awareness and provide information about what to expect and look out for. Group based antenatal education has been shown to reduce symptoms and improve mental health in women with low to moderate levels of anxiety or depression. In addition, partners are usually the first people women confide in about, or to become aware of, mental health issues (Tommy's, 2013). Information about and acknowledgement of the key role they have to play	Parents-to-be are particularly motivated to seek out help and support and are generally keen to access courses to help them prepare for parenthood. Well-facilitated antenatal education groups can inform about the prevalence (and normality) of negative emotions in both parents, encourage discussion of how to manage such feelings and signpost to sources of professional support. In addition, this can be done in a way which is non-judgmental and does not require women or their partners to divulge hidden feelings.	DoH (2012): Preparation for Birth and Beyond. Available at: https://www.gov.uk/government/publications/preparation-for-birth-and-beyond-a-resource-pack-for-leaders-of-community-groups-and-activities Tommy's (2013). Perinatal Mental Health: Experiences of Women and Health Professionals. Available at: http://www.tommys.org/file/Perinatal_Mental_Health_2013.pdf

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			in supporting their partners, as well as acknowledging the emotional needs of fathers or life partners, will lead to greater involvement with and support of their partner, family and baby.		
SCM 3	Support for women requesting a caesarean section	Key area for quality improvement 3	Perinatal mental health services should be able to support maternity services with women requesting elective caesarean section in the absence of any medical indication	Caesarean section rates are rising, and are generally well above the levels recommended as most appropriate by the WHO. Part of this increase is driven by maternal request for caesareans. Although the NICE Caesarean Section guideline highlights the need for referral of these women to perinatal mental health specialists, these do not exist in many areas within the UK	NICE Caesarean Section guideline
PETALS (Pregnancy Expectations Trauma And Loss Society)	Counselling for women with adverse outcomes in pregnancy and birth – Loss of their baby	Specialist Counselling for women who suffer stillbirth	The death of an infant is recognised as one of the most stressful life events that an adult may experience[1][2]. The importance of providing quality care in the time surrounding an infant's death has been repeatedly demonstrated	It is not currently a statutory service requirement and therefore is not provided However, national policy and clinical guidelines call for improved provision of perinatal mental health services including those that can respond to adverse pregnancy outcomes: • Support commissioners	CG192 Nice Guidance on antenatal and postnatal mental health Green Top Guidelines No.55 – Late intrauterine fetal death and stillbirth Please see report published May 2014:

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			[2][3][4][5][6] to prevent a wide range of short- and long-term negative outcomes for the parents and wider family including anxiety, depression, complicated grief, PTSD, alcoholism and marital breakdown. RCOG green top guidelines no.55 recommends: *'Counselling should be offered to all women and their partners. Other family members, especially existing children and grandparents, should also be considered for counselling.'* Counselling can reduce the duration and severity of symptoms [7] and improve subjective wellbeing (Petals paper) Parity of Esteem' agenda – womens psychological health should be attended to equally alongside physical health.	to ensure services are holistic in meeting both physical and mental health needs (Parity of Esteem) • Develop and deliver a pathway to support women with post-natal mental health problems by March 2015 • Deliver post-registration training in perinatal mental health to ensure that trained specialist mental health staff are available to support mothers in every birthing unit by 2017 • Support specific perinatal mental health training being incorporated into the syllabus for doctors in postgraduate training • Deliver a core training module for those entering midwifery training in 2015. *NHS England Business Plan 2013/2014*	https://www.npeu.ox.ac.uk/listeningtoparents This states that one of *the initiatives or improvements that could impact on care directly:* *Funded options for counselling and support in the short and longer term available for women and partners* http://www.petalscharity.org/wp-content/uploads/Petals-Dnb-26_S1-45_P9-2-1.pdf References: 1.Fish W. Differences in grief intensity in bereaved parents. Champaigne, IL: *Research Press Company*, 1986. 2.Wing D, Clance P, Burge-Callaway K, Armistead L. Understanding gender difference in bereavement following

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			Loss of a baby at term is traumatic and results in a complex grief process that can lead to depression, and high anxiety for future pregnancy. Psychological intervention following the loss can prevent this	NICE guidance on traumatic birth, stillbirth and miscarriage recommends: 'offer advice and support to women who have had a traumatic birth or miscarriage and wish to talk about their experience. Take into account the effect of the birth or miscarriage on the partner and encourage them to accept support from family and friends.' However it is not clear who has the skills, capacity and resources to do this. In reality, services for this do no exist. 1.9.5 Offer women who have post-traumatic stress disorder, which has resulted from a traumatic birth, miscarriage, stillbirth or neonatal death, a high-intensity psychological intervention (trauma-focused CBT or eye movement desensitisation and reprocessing [EMDR]) in line with the guideline	the death of an infant: implications for treatment. *Psychotherapy* 2001;38(1):60–72. 3. Janzen L, Cadell S, Westhues A. From death notification through the funeral: bereaved parents' experience and their advice to professionals. *Journal of Death and Dying* 2003–2004;48(2):149–64. 4.Kirkley-Best E, Kellner KR. The forgotten grief: a review of the psychology of stillbirth. *American Journal of Orthopsychiatry* 1982;52(3):420–9. 5. Mashegoane S, Mabasa L, Mashego T. Stillbirth grief in hospital settings: assessing the intervention practices of professional helpers. In: Madu S, Baguma P, Pritz A. *Cross-cultural Dialogue on Psychotherapy in*

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				on post-traumatic stress disorder (PTSD) In addition, the NHS outcomes framework demands that there is parity of esteem between psychological and mental health, and that people are helped to recover as quickly as possible from episodes of illness (Domain 3)	*Africa.* Sovenga, South Africa: UNIN Pres, 1999:374. 6. Murray JA, Terry DJ, Vance JC, Battistutta D, Connolly Y. Effects of a program of intervention on parental distress following infant death. *Death Studies* 2000;24(4):275–305. 7. Forrest GC, Standish E, Baum JD. Support after perinatal death: a study of support and counselling after perinatal bereavement. *Br Med J Clin Res Ed* 1982
PETALS (Pregnancy Expectations Trauma And Loss Society)	Counselling for women with adverse outcomes in pregnancy and birth – Loss of their baby	Specialist Counselling for women who suffer neonatal death of their baby	Increased infant attachment associated with modern obstetric practices, such as prenatal diagnostic procedures, assisted reproduction and graphic ultrasound imaging has been reported to increase the intensity of	It is not currently a statutory service requirement and therefore is not provided However, national policy and clinical guidelines call for improved provision of perinatal mental health services including those that can respond to adverse pregnancy outcomes:	Please see report published May 2014: https://www.npeu.ox.ac.uk/listeningtoparents This states that one of *the initiatives or improvements that could impact on care directly:*

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			mothers' grief [8] Loss of a baby shortly after birth is traumatic and results in a complex grief process that can lead to depression, and high anxiety for future pregnancy. Psychological intervention following the loss can prevent this	• Support commissioners to ensure services are holistic in meeting both physical and mental health needs (Parity of Esteem) • Develop and deliver a pathway to support women with post-natal mental health problems by March 2015 • Deliver post-registration training in perinatal mental health to ensure that trained specialist mental health staff are available to support mothers in every birthing unit by 2017 • Support specific perinatal mental health training being incorporated into the syllabus for doctors in postgraduate training • Deliver a core training module for those entering midwifery training in 2015. *NHS England Business Plan*	*Funded options for counselling and support in the short and longer term available for women and partners* http://www.petalscharity.org/wp-content/uploads/Petals-Dnb-26_S1-45_P9-2-1.pdf Reference: 8. Robinson M, Baker L, Nackerud L. The relationship of attachment theory and perinatal loss. Death Studies 1999; 23(3):257–70.

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				2013/2014	
PETALS (Pregnancy Expectations Trauma And Loss Society)	Counselling for women with adverse outcomes in pregnancy and birth – Loss of their baby	Specialist Counselling for women who suffer miscarriage of pregnancy	'Parity of Esteem' agenda – womens psychological health should be attended to equally alongside physical health. The loss of a child has a devastating impact on a woman and creates anxiety for future pregnancy	It is not currently a statutory service requirement and therefore is not provided. However, national policy and clinical guidelines call for improved provision of perinatal mental health services including those that can respond to adverse pregnancy outcomes: • Support commissioners to ensure services are holistic in meeting both physical and mental health needs (Parity of Esteem) • Develop and deliver a pathway to support women with post-natal mental health problems by March 2015 • Deliver post-registration training in perinatal mental health to ensure that trained specialist mental health staff are available to support mothers in every birthing unit by 2017 • Support specific perinatal mental health	http://www.petalscharity.org/wp-content/uploads/Petals-Dnb-26_S1-45_P9-2-1.pdf

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				training being incorporated into the syllabus for doctors in postgraduate training • Deliver a core training module for those entering midwifery training in 2015. NHS England Business Plan 2013/2014	
Bliss	Counselling for women with adverse outcomes in pregnancy and birth – Neonatal health of baby	Key area for quality improvement 1: Post natal mental health services for mothers of premature and sick babies in neonatal care settings	For mothers of premature and sick babies, their baby's birth and admission to neonatal care settings can be a particularly difficult time. There is strong evidence that mothers of premature and sick babies have an increased risk of developing mental health problems, and that for mothers of premature and sick babies being cared for in specialist neonatal settings, this risk is greater (Davis et al, 2003), (Tahirkeheli et al, 2014).	Bliss' 2010 Baby Report found that under half of all neonatal units provided specific mental health services for mothers of premature babies being cared for on neonatal units. This is despite the evidence that there is a greater risk of post natal mental health problems for this group. Providing services in neonatal settings can help ensure this group of mothers have access to appropriate support at a time when they are at greater risk of developing mental health problems, and in a setting that is close to where their baby is being cared for in hospital.	Please see Bliss' 2010 Baby report for more information on the number of neonatal units providing mental health services of mothers. http://www.bliss.org.uk/campaigns-and-policy-reports Please see Bliss' 2014 'It's not a game' report for more information about the impact having a premature baby can have on mothers' mental health. http://www.bliss.org.uk/its-not-a-game-britain Additional research:

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			Many mothers of premature and sick babies will be spending significant periods of their time with their baby in neonatal care settings. Providing appropriately tailored services for mothers in these settings would ensure this at risk group are able to receive appropriate care and support.	Ensuring these services are consistently available across England and Wales will ensure a higher standard of care. In addition, access to services via self-referral in a unit is extremely helpful as having to go through a referral process may mean that those most in need may not seek support. There is also evidence that providing a choice of psychological treatment options improves recovery, which is particularly relevant for mothers of premature and sick babies.	Davis L., Edwards H., Mohay H., Wollin J. (2003), The impact of very premature birth on the psychological health of mothers. *Early Hum Dev* 73 (1-2) p61-70 Tahirkeheli N. N., Cherry A. S., Tackett A. P., McCaffree M. A., Gillaspy S. R. (2014), Postpartum depression on the neonatal intensive care unit: Current Perspectives. *Int J. Womens Health* 24 (6) p975 – 987 Mind (2013), *We Still Need to Talk. A report on access to talking therapies.* Mind: London
PETALS (Pregnancy Expectations Trauma And Loss Society)	Counselling for women with adverse outcomes in pregnancy and birth – Neonatal health of baby	Specialist Counselling for women who experience poor fetal diagnosis and decisions regarding continuation of	'Parity of Esteem' agenda – womens psychological health should be attended to equally alongside physical health. Making life or death choices during a pregnancy is very	It is not currently a statutory service requirement and therefore is not provided However, national policy and clinical guidelines call for improved provision of perinatal mental health services including those that can respond to	Please see 2013 report: Parliamentary Inquiry into Abortion on the Grounds of Disability: Recommendation 12 *There should be counselling and support*

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		pregnancy	traumatic for a woman and requires unbiased emotional support which cannot be provided by family and friends. The decision has to be lived with for the rest of life so it is important that parents feel they have had the time, space and support to reach the right decision for them. Obstetrics is an area of medicine where parity of esteem in care is essential for good outcomes – psychological needs as well as physical ones should be met in a holistic way.	adverse pregnancy outcomes: • Support commissioners to ensure services are holistic in meeting both physical and mental health needs (Parity of Esteem) • Develop and deliver a pathway to support women with post-natal mental health problems by March 2015 • Deliver post-registration training in perinatal mental health to ensure that trained specialist mental health staff are available to support mothers in every birthing unit by 2017 • Support specific perinatal mental health training being incorporated into the syllabus for doctors in postgraduate training • Deliver a core training module for those entering midwifery training in 2015.	*offered and available for those who choose an abortion on the grounds of disability both before and after abortion.* http://www.petalscharity.org/wp-content/uploads/Petals-Dnb-26_S1-45_P9-2-1.pdf

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				NHS England Business Plan 2013/2014	
PETALS (Pregnancy Expectations Trauma And Loss Society)	Counselling for women with adverse outcomes in pregnancy and birth - Traumatic birth	Specialist Counselling for women who suffer post traumatic stress due to delivery of their baby	'Parity of Esteem' agenda – womens psychological health should be attended to equally alongside physical health. Women who experience trauma during the delivery of their baby benefit from specialist counselling to process their traumatic experience enabling them to contemplate future pregnancy with less clinical support and intervention	It is not currently a statutory service requirement and therefore is not provided However, national policy and clinical guidelines call for improved provision of perinatal mental health services including those that can respond to adverse pregnancy outcomes: • Support commissioners to ensure services are holistic in meeting both physical and mental health needs (Parity of Esteem) • Develop and deliver a pathway to support women with post-natal mental health problems by March 2015 • Deliver post-registration training in perinatal mental health to ensure that trained specialist mental health staff are available to support mothers in every birthing unit by 2017 • Support specific	http://www.petalscharity.org/wp-content/uploads/Petals-Dnb-26_S1-45_P9-2-1.pdf

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				perinatal mental health training being incorporated into the syllabus for doctors in postgraduate training • Deliver a core training module for those entering midwifery training in 2015. *NHS England Business Plan 2013/2014*	
SCM 1	Training and supervision	Additional developmental areas of emergent practice	Joint training package 'Generic Awareness of PMI' Training and education for all staff in cultural competence – Specific education for those working in mental health services.	Increased understanding and appreciation of role and purpose, individual and organisational, along the patient pathway (clinical pathway) Pan London Education group commissioned this training package. It is based on the successful Institute of Health Visiting MMH Package.	The training has be delivered and has enjoyed positive evaluation from staff including HVs, Midwives, Social Care Staff, Social Work, Voluntary Sector, Criminal Justice, mental health and Obstetric and Gynaecologist.
SCM 4	Training and	Key area for	Perinatal mental disorders	Despite their significant	Evidence review on

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	supervision	quality improvement 1 Perinatal mental health training of health professionals who see women in the perinatal period to achieve perinatal mental health competencies	are amongst the commonest morbidities of pregnancy and the postpartum and they are known to make a significant contribution to both maternal and infant morbidity and mortality. The perinatal period provides a unique opportunity for health professionals to identify and intervene as women are in regular contact with health services. About 90% of the care for women with perinatal mental health illness will be in primary care and in other universal services like health visiting or midwifery. The recently updated NICE guideline on antenatal and postnatal mental health recommends that health professionals should be perinatally competent, ie, health professionals should understand the	prevalence and the availability of effective interventions, perinatal mental health disorders are poorly recognised and understood by health professionals. There is evidence of under-detection, and women report being asked about mental health in unhelpful and often stigmatising ways. Many practitioners have little if any specific training and/or CPD in perinatal mental health including front line IAPT workers, GPs, obstetricians, nurses, midwives etc though there are some local current initiatives for training of midwives and health visitors. Where mention is made in curricula there is a focus on postnatal depression even though this is just one of the many mental health conditions that can occur through pregnancy and postnatally. This has led to inappropriate labelling of very serious conditions such as postpartum psychosis as postnatal depression, failures to respond quickly and	women's experience of care in the UK included in full NICE guideline on antenatal and postnatal mental health http://www.nice.org.uk/guidance/cg192 Confidential Enquiries: http://www.hqip.org.uk/cmace-reports/ Other reviews on women's experiences: Dolman C, Jones I, Howard LM. A systematic review and meta-synthesis of the experience of motherhood in women with severe mental illness. Archives of Women's Mental Health 2013 Jun;16(3):173-96. Curricula: Royal College of General Practitioners Curriculum : Being a General Practitioner

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			variations in assessment and care needed during the perinatal period while using NICE CG192 guideline in conjunction with other relevant NICE guidelines to improve the experience of care for women with a mental health problem in the perinatal period. EG For GPs who prescribe antidepressants to childbearing aged women, competence in explaining the risks and benefits in pregnancy is needed. General adult psychiatrists need to discuss risks and benefits of their treatment to childbearing aged women if they become pregnant or are planning a pregnancy or are pregnant and be aware of the impact of pregnancy and childbirth on the mental illness and share this	appropriately to developing psychosis and subsequent maternal deaths as reported in Confidential Enquires.	http://www.rcgp.org.uk/training-exams/~/media/Files/GP-training-and-exams/Curriculum-2012/RCGP-Curriculum-1-Being-a-GP.ashx Nursing & Midwifery Council (NMC): Standards of pre-registration midwifery Education http://www.nmc-uk.org/documents/nmc-publications/nmcstandardsforpre_registrationmidwiferyeducation.pdf Royal College of Obstetricians and Gynaecologists Core curriculum https://www.rcog.org.uk/en/careers-training/specialty-training-curriculum/core-curriculum/

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			information with women. For midwives, competence in discussing mental health and knowing referral and care pathways is needed.		
Royal College of Midwives	Training and supervision	Key area for quality improvement 4 Ensuring that all healthcare professionals providing assessment and interventions for mental health problems in pregnancy and the postnatal period understand the variations in their presentation and course at these times, how these variations affect treatment, and	There needs to be skilled members of the multidisciplinary team who can remain up to date with knowledge in this area and be accessible as a source.	There is a need for more accessible training for health professionals such as midwives and health visitors.	Perinatal Mental Health Experiences of women and health professionals (2013) http://www.tommys.org/perinatal-mental-health-report

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		the context in which they are assessed and treated.			
National Childbirth Trust	Training and supervision	Key area for quality improvement 5 Each trust should have a team of health professionals with appropriate qualifications in perinatal mental health	The Tommy's report found that one in seven health professionals wanted more training in diagnosing and treating perinatal mental health issues. The Institute of Health Visiting has run a successful and well received programme to train perinatal mental health champions among health visitors; this now needs to be rolled out throughout the NHS and across specialisms (particularly GPs and midwives).	The availability of 'expert colleagues' will enable more rapid and up to date responses to questions re diagnosis and referral.	http://www.e-lfh.org.uk/programmes/perinatal-mental-health/more-information/
Blackpool Centre for Early Child Development, Blackpool Council	Training and supervision	All professionals involved in the care of women during pregnancy and the first year after birth should be provided with	Perinatal mental health training must be incorporated into the undergraduate and postgraduate syllabuses for all GPs, health visitors, midwives, (practice) nurses, obstetricians and mental health	If training packages for all were available and staff trained then fewer women would go undetected in the early stages and support could be given sooner. This would also provide an understanding of the condition and should be delivered for current staff	

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		comprehensive training in perinatal mental health care.	professionals. National training strategies must be established to ensure all relevant existing health and social care professionals who have contact with women during the perinatal period have access to dedicated high-quality training. This includes people who work in the community and voluntary sectors.	alongside which services are available to refer the woman on to. A set of training standards need to be developed by professional bodies and training quality assured to ensure compliance.	
SCM 5	Training and supervision	Health professionals working within the antenatal and postnatal period receive compulsory training in perinatal mental health illnesses.	To ensure that all health professionals are aware of the correct care/ treatment pathways available in their area.	Ensuring that all health professionals reach a measurable standard in training for perinatal mental health will ensure that service users receive continuity of care regardless of their postcode.	Feedback from student midwives, midwives, GP's, health visitors and community mental health teams. Have mentioned they would require talks and workshops on external charitable organisations and what they do to support individuals with pre and postnatal mental health illnesses as there is minimal training provided.
SCM 5	Training and supervision	Health professionals	To ensure that all health professionals are aware of	Ensuring that all health professionals reach a	Feedback from student midwives, midwives, GP's,

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		working within the antenatal and postnatal period receive compulsory training in perinatal mental health illnesses.	the correct care/ treatment pathways available in their area.	measurable standard in training for perinatal mental health will ensure that service users receive continuity of care regardless of their postcode.	health visitors and community mental health teams. Have mentioned they would require talks and workshops on external charitable organisations and what they do to support individuals with pre and postnatal mental health illnesses as there is minimal training provided.
SCM 1	Training and supervision	Key area for quality improvement 2	Education/training for Health Visitors on the assessment and management of mild to moderate PMI. Standard should outline aspects of training – specific/mandatory to role	The majority of women can be treated effectively within primary care. Drive up quality of care: Education and training in assessment and management of PMI by HVs Increasing confidence and competence. Women can by identified earlier and receive timely treatment and faster recovery and reducing the impact on the infant	MMHA & LSE Economic report provides evidence of getting treatment in primary care. Secure/insecure attachment (Angela Underdown, Lynne Murray)
PANDAS	Training and	Training for	Many Health Visitors miss	There have been several	There does not seem to

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Foundation	supervision	Health Visitors to ensure that they recognise the signs of PND and other illnesses.	vital signs of perinatal illness and misjudge circumstances. It is important that they receive the correct training to ensure they can adequately perform their job roles.	accounts of a Health Visitor appearing at the door, seeing a house that is spotless, a baby that is clean and well fed and a mother who is dressed and in full makeup at 9am in the morning and declared the individual must be well. Unfortunately, this level of organisation two weeks post birth is often a sign that the mother is not coping and that they are suffering sever anxiety at the thought of being judged.	have been a formal survey into the effectiveness of Health Visitors which is unfortunate. Service User's report a variety of reactions and views on Health Visitors, but many agree that they struggle to see beyond their expectations and fail to understand that each woman will react differently. There have been several complaints that Health Visitors have a 'one rule for all' attitude and fail to notice warning signs.
Medway NHS Foundation Trust	Training and supervision	Key area for quality improvement 1 Developing competent and confident midwives	Midwives are often the first point of contact for women and families and in accordance with the new 192 guidance on acknowledging the higher threshold for medical treatment of depression and anxiety midwives need to be capable of providing accurate information to women and	Midwives are the experts in understanding behavour around the time of childbirth and an essential part of provision of Maternity services underpinned by statute. Midwives work using a psychosocial model of care and are well placed to provide low level interventions for women and their families to enhance and facilitate emotional wellbeing and resilience. Often	WHO Europe Mental health, resilience and inequalities Dr Lynne Friedli http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf See the midwives contribution in: Specialist Mental Health Midwives: what they do

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			their families about the risks and benefits of treatment and non-treatment.	the first contact with a midwife will identify inequalities and a plan for 'early help' can be put in place both facilitated and sometimes appropriately delivered by the midwife. The midwife then alerts her allied colleagues to the vulnerability of the women and in some cases the family. Midwives are one of the key professional in facilitating the development of the mother baby relationship right from the outset and often the first professional to identify signs that the mother may be struggling with her concept of the baby.	and why they matter 2013 and Prevention in mind: All babies count: spotlight on perinatal mental health Both document use my role in Medway as an example of what can be achieved with competent and confident midwives. See Sollihull Approach The journey to parenthood a manual for midwives and other professionals
PANDAS Foundation	Training and supervision	Compulsory mental health training for midwives.	One of the primary complaints PANDAS Foundation receives is the lack of understanding of mental health from Midwives.	PANDAS Service Users often say they felt let down or ignored by their midwives. The focus was purely on baby's welfare and not on that of the mother's experience. Key signs were often missed and there are numerous SU's who report that their birth trauma was treated as unimportant by the midwives	The NCT has conducted research into the treatment of women after birth, https://www.nct.org.uk/sites/default/files/related_documents/women'sexperience sofpostnatalcare.pdf in particular offers insight into postnatal care on the wards and at home and how

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				present at birth and in postnatal wards.	mothers often felt their emotional needs had been neglected.
PANDAS Foundation	Training and supervision	Guidelines on the Differences between preexisting mental illness and that which develops as a result of pregnancy.	Many midwives lack the mental health training to know what an appropriate response to concerns from a parent. Depression is often assumed to cause anxiety and so concerns are dismissed unnecesarily.	Studies have shown there is an increased risk of perinatal illness if the patient has previously experienced mental illness. However, there is also evidence that PND and depression have different diagnostic criteria and must be treated as seperate illnesses.	One service user reported that her claims of shortness of breath were ignored as the midwife informed her she was getting 'worked up' because of her anxiety. When the SU corrected the diagnosis to depression, the midwife dismissed her concerns stating that they were linked and she was not unwell until the SU's partner asked if she required her inhaler, at which point the midwife began to check the SU's breathing. These judgements must be reduced by appropriate training guidelines.
SCM 1	Training and supervision	Key area for quality improvement 3	Specialist supervision to staff providing support /supervision for PMI.	Staff providing low intensity therapeutic interventions are not always given the opportunity to access 'appropriate supervision'	

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			This should include timelines – E.G. minimum of 4 sessions per quarter	and often 'burn out' in practice. Not be confused with clinical supervision.	
SCM 1	Cultural competence	Key area for quality improvement 5	Cultural Competence.	Mental health issues remain a highly taboo subject that causes much distress in the wider BME community that it is often not admitted to or hidden. BME service users still get disproportionally worse care due to access and language issues. Access to appropriate services, E.G. interpreters.	Delivering Race Equality in Mental Health: A call for action (2005)
Medway NHS Foundation Trust	Understanding the specific prodromal symptoms for postnatal psychosis	Additional developmental areas of emergent practice Understanding the specific prodromal symptoms for postnatal psychosis	We must understand more the development of postnatal psychosis in order to prevent its development using alternative along and in conjunction with medical treatment.	We are not using the data available to better understand the development and management of postnatal psychosis. There should be a morbidity reporting section of MBRRACE to collate factors in the development of Postnatal psychosis with the intention to develop a model of preventative management.	https://www.mbrrace.ox.ac.uk/Home/Index?ReturnUrl=%2f
NHS England	NO COMMENTS	Thank you for the opportunity			

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		to comment on the above QS engagement exercise. I wish to confirm that NHS England has no substantive comments to make regarding this consultation			
Royal College of Paediatrics and Child Health	NO COMMENTS	Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the engagement exercise for the quality standard on Antenatal and postnatal mental health. We have not received any responses for this consultation			
Royal College of Nursing	NO COMMENTS	This is to inform you that the Royal College of			

Stakeholder	Area for improvement	Key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
		Nursing have no comments to submit to inform on the above quality standards topic engagement at this time.			