KENT PUBLIC HEALTH OBSERVATORY

Perinatal Mental Health

Health Needs Assessment for Kent 2016

2016

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1 Introduction

Mental disorders are among the most common illnesses experienced by women during pregnancy and the postnatal period. The mental health problems that pregnant women or new mothers can experience are the same as those that can affect people at other times, and they are often similar in nature. They cover a diverse range of mental health conditions, such as anxiety, depression and psychotic disorders. These mental health problems can arise for the first time during pregnancy or post-partum, but can also include recurring disorders that were present before pregnancy. Often postnatal depression is used as generic term for all perinatal mental health disorders, when in fact this is one of a number of conditions.

The causes of perinatal mental illness are varied and complex, and can affect women from all backgrounds. However, there are factors associated with increased risk of perinatal mental illness, such as a history of mental illness, family history of mental illness, low level of social support and adverse or stressful life events e.g. domestic abuse.

Adverse impacts of perinatal mental illness are by no means inevitable, however early detection is critical, in order to ensure that women can receive the appropriate intervention in a timely fashion. It is currently estimated that around 50% of cases are undetected.

In a Kent County Council review of the relationship between Public Health and Maternity Services (Buttivant, 2014), it was found that perinatal mental health pathway across Kent was not robust or comprehensive, with a significant disparities in the provision of Mother and Infant Mental Health Services and a lack of a specialist mother and baby unit provision. The review recommended:

> "For commissioners and providers to collaborate to produce a Kent-wide perinatal mental health pathway with equitable access to perinatal mental health support at all levels of need, including prevention services, for pregnant women across Kent."

A Kent and Medway Perinatal Mental Health Clinical Network was established in 2015 to improve partnership working across agencies and explore joint opportunities to improve the local perinatal mental health pathway. The purpose of this health needs assessment is to provide information and analysis to support the clinical network, informing decisions and priorities relating to their planning, redesign and management. A shared understanding of the health needs of women suffering from or at risk of mental illness during pregnancy and the postnatal period can help commissioners, clinicians and other key stakeholders to develop an integrated care pathway that complies with best practice guidance and meets national access and quality standards.

2 National Policy Context

Over the past five years, there has been an increased national focus on maternal mental health within the UK. In 2011, the Coalition government published its mental health strategy, 'No health without mental health', in which it noted the importance of maternal mental health to ensuring the best start in life (Department of Health, 2011). The Joint Commissioning Panel for Mental Health subsequently formed to support the implementation of the Government's mental health strategy, produced guidance on commissioning perinatal mental health services. There were 10 key recommendations for commissioners covering prevention, detection and improving primary, secondary and tertiary mental health provision for pregnant and postpartum women. The Joint Commissioning Panel also stressed the importance of participation of CAMHS, adult mental health services, maternity services and primary care in the development of local integrated care pathways (Joint Commissioning Panel for Mental Health, 2012).

In their mid-term review, the Government specifically pledged to reduce "the incidence and impact of post-natal depression through earlier diagnosis and better intervention and support" (The Cabinet Office, 2013). This pledge was echoed in 'Closing the Gap: Priorities for essential change in mental health', where offering better support to new mothers to minimise the risks and impacts of postnatal depression was identified as one of the 25 priority areas for action within the next two years. Specific interventions included equal access to specialist community perinatal mental health teams and mother and baby units, and improved training and support for health visitors and midwives so they are better equipped to spot the early signs of maternal mental health problems (Department of Health, 2014)

The All Party Parliamentary Group for Conception to Age Two – the First 1001 Days launched a cross party manifesto in October 2013 to promote the case for early intervention between conception and two years old, to ensure the best outcomes for children. '1001 Critical Days' recognised the importance of identifying pregnant women and mothers suffering from mental illness and providing the earliest access to appropriate mental health services. Their more recent report, 'Building Great Britons' included a significant focus on emotional and mental health. This document pulled together evidence and expertise on the impacts of perinatal mental illness (e.g. child maltreatment) and the importance of early intervention and prevention (The All Party Parliamentary Group for Conception to Age Two - First 1001 Days, 2015).

The NHS Five Year Forward Plan outlined the vision for the NHS to 2020, including an objective to "achieve genuine parity of esteem between physical and mental health by 2020" (NHS England, 2014). NHS England and the Department of Health produced 'Achieving Better Access to Mental Health Services by 2020', which set out the concrete steps that would be taken to achieve this vision, such as establishing access and waiting standards for mental health services from April 2015 (Department of Health and NHS England, 2014). Specific actions regarding perinatal mental health included:

- Rapid access to services within 24 hours for post-partum psychosis, in the perinatal period for women who have a mental health condition.
- A clear strategy for improving the commissioning of specialised mental health care, including perinatal mental health services

In 2014, a multi sector children and young people's mental health and well-being taskforce was established to improve the way children's mental health services are organised, commissioned and provided and examine how to improve young people's access help and support. The resulting report recognised the importance of maternal mental health and its links to children's mental health. Although the taskforce highlighted work in progress nationally to improve maternal mental wellbeing, the authors pointed out that additional resources are required to enhance existing maternal, perinatal and early years health services in order to strengthen attachment between parent and child, avoid trauma and improve resilience (Department of Health and NHS England, 2015).

There has also been great interest in maternal mental health from national agencies, such as the NSPCC, Centre for Mental Health, and the Royal Colleges of GPs, Midwives and Psychiatrists who have pushed Government and public agencies for improvements to perinatal mental health services (Hogg, 2012; Bauer *et al.*, 2014; Khan, 2015). For example, the Maternal Mental Health Alliance, a multi sector coalition of 74 organisations, is currently running a national campaign to raise awareness of maternal mental health, including the significant geographical inequality that currently exists in service provision. To illustrate the problem, the Alliance has mapped current specialist community perinatal mental health provision and mother and baby units across the UK, highlighting where services meet or fall short of national standards (Maternal Mental Health Alliance, 2014).

These collective voices calling for improved maternal mental health services appear to have been heard by Government. In his March 2015 budget, the Chancellor announced an additional £75 million over the next 5 years to give the right care to more women who experience perinatal mental ill health (Gauke, Great Britain and HM Treasury, 2015).

In October 2015 the Pan-London strategic clinical network (SCN) for perinatal mental health established new models and pathways of care (Green, 2015) that adhere to service guidance established by NICE and the Royal College of Psychiatrists (2015).

In February 2016, the Government launched "The Five Year Forward View for Mental Health" (Mental Health Taskforce, 2016). This included the aspiration that,

> "By 2020/21, NHS England should support at least 30,000 more women each year to access evidence-based specialist mental health care during the perinatal period. This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high quality services are in place across England."

This commitment to increased investment in perinatal mental health was reiterated in the Five Year Forward View for Maternity Care (National Maternity Review, 2016). It is not yet clear how the increased funding for perinatal mental health will be distributed, but clearly this is an area that has a lot of attention from leaders in the health service, and political support, and there is a lot of work taking place nationally, regionally and locally to determine what perinatal mental health services should deliver.

3 Definitions and Scope

3.1 What do we mean by 'perinatal'?

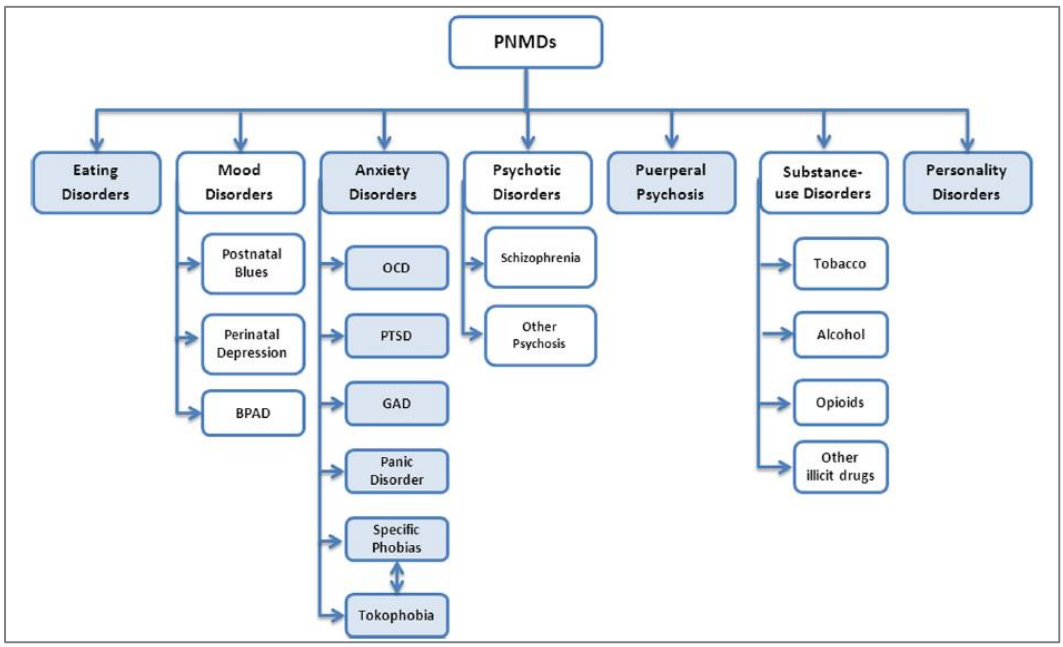
The terms 'maternal' and 'perinatal' are often used interchangeably. The most common definition is the period from conception to one year after birth (WHO, 2008; Perinatal Institute, 2011; Joint Commissioning Panel for Mental Health, 2012; Maternal Mental Health Alliance, 2014; NICE, 2014; NHS Improving Quality, 2015).[1]

When considering priorities for action that may emerge from this needs assessment, the steering group agreed to extend this timeline to five years after birth in line with the Healthy Child Programme (Shribman and Billingham, 2009) and Marmot Review (Marmot, 2010). A similar approach has also been adopted by London Perinatal Mental Health Network (Luckie, 2015).

3.2 What is a perinatal mental illness?

Perinatal mental illnesses are those that complicate pregnancy and the year after birth. They can be common or severe mental illnesses and include both mental health problems that newly arise at this time and those that were present before the pregnancy (Joint Commissioning Panel for Mental Health, 2012; Paschetta *et al.*, 2014). Figure 4 provides a diagrammatic summary of common perinatal mental health conditions.

Figure 1: Classification of common perinatal mental disorders (Paschetta *et al.*, 2014)[2]



[1] The ICD-10 definition of the perinatal period commences at 22 completed weeks (154 days) of gestation (the time when birth weight is normally 500 g), and ends seven completed days after birth. (WHO, 2015)

[2] PNMD: perinatal mental disorders; BPAD: bipolar affective disorder; GAD: generalized anxiety disorder; OCD: obsessive-compulsive disorder; PTSD: posttraumatic stress disorder.

- **Common mental health problems** are mental health conditions with a mild to moderate and/or time-limited impact on the person, such as depression, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder and social anxiety disorder. Although episodes can be time limited, individuals can experience a pattern of relapse and remission throughout their lives.

- **Severe mental illnesses** (SMI) are serious, high-risk or complex forms of mental distress, such as psychosis, schizophrenia, bipolar disorder and schizoaffective disorder, although some common mental disorders can also become severely debilitating and distressing, e.g., severe depression. People with severe mental illness often have physical or mental co-morbidities. (Joint Commissioning Panel for Mental Health, 2011; NICE, 2011, 2014)

3.3 The scope of this report

This report will focus on the health needs of the following population groups within the county of Kent (*excluding* the Medway Unitary Authority area). In some cases the data obtained includes data for Medway, but this is always specified. The report focuses on:

1. Pregnant women and mothers of children under five years of age:
    - At risk of developing perinatal mental health problems
    - With new onset perinatal mental illness
    - Experiencing recurrences of previous perinatal mental illness
    - With pre-existing mental illnesses

2. Women with a history of mental illness who are planning a pregnancy

4 Statement of the Problem

Perinatal mental illness affects up to 20% of women at some point during pregnancy and for the first year after birth, with around 15% of women experiencing common mental health problems such as perinatal depression and anxiety (Khan, 2015).

Childbirth is associated with an increased risk to women's mental health, particularly serious mental illnesses such as post-partum psychosis and severe depressive illness. Although rates of depression do not appear to be higher in women postpartum compared to age matched control women (10-15%), the rates of first onset and severe depression are elevated by at least three-fold. It is estimated that to 12.5% of psychiatric hospital admissions of women occur during the postpartum period (Robertson, Celasun and Stewart, 2003).

Childbirth is also associated with the recurrence of serious mental illness (Joint Commissioning Panel for Mental Health, 2012). That said, women who have had a previous episode of a serious mental illness whether in pregnancy, shortly after birth or at other times in their lives, have a 50% chance of developing a postpartum onset illness, even if they had been well during their pregnancy and for many years beforehand (Oates and Cantwell, 2011). Perinatal mental illness is often complicated by drug and alcohol misuse and domestic violence (Austin, Priest and Sullivan, 2008).

Serious perinatal mental disorders are associated with an increased risk of suicide. Suicide is a leading cause of maternal mortality, and accounts for between 23% and 28% of maternal deaths (Oates, 2003; Knight *et al.*, 2015). Over the past two decades, the suicide rate in pregnancy and six months postpartum has not decreased, in contrast to the general suicide rate for women (Joint Commissioning Panel for Mental Health, 2012). Between 2006 and 2008, over half of the women who committed suicide during pregnancy or shortly after birth in the UK were white, married, employed, living in comfortable circumstances and aged 30 years or older (Oates and Cantwell, 2011).

4.1 Impact on children and families

When mothers suffer from perinatal mental illnesses, it is not only her health and well being that is impaired. The health of the mother is very closely linked to the health of her child during pregnancy and her condition often has significant impacts on her child and family after birth, especially if left untreated (Pawlby *et al.*, 2008; Hay *et al.*, 2010; Howard *et al.*, 2014).

Perinatal depression can impact negatively on the interaction between mother and infant (Martins and Gaffan, 2000) and also the cognitive, social emotional and behavioural development of the child and can increase the likelihood that children will experience learning difficulties and do less well educationally (O'Connor, 2002; Milgrom, Westley and Gemmill, 2004; Hogg, 2012). Children of depressed or anxious mothers are more likely to be diagnosed with depression themselves by age 16 (Hay *et al.*, 2010). There is also an association between antenatal anxiety and distress and the emotional and behavioural development of the child in utero (O'Connor, 2002).

Maternal mental illness can also impact negatively on the physical health of children, particularly among disadvantaged groups. These impacts can include higher rates of spontaneous abortion, low birth weight babies, developmental delay, impeded physical growth, and physical illnesses such as chronic diarrhoeal illness (Edge, 2011).

Postnatal depression has also been associated with depression in fathers and with high rates of family breakdown (Goodman, 2004). Paternal depression is also associated with increased risk of emotional and behavioural difficulties in children (Lane, 2014).

4.2 Impact on society

Perinatal mental illness (specifically depression, anxiety and psychosis) costs the UK £8.1 billion per year, equivalent to £10,000 for every single birth. Health and social care services bear £1.2 billion of this cost (£1.7 billion is borne by public services in total). In comparison, the estimated cost of bringing maternal mental health services in England up to the standards within current national guidance is £280 million – five times the current health and social care cost. Given the cost of perinatal mental health problems, it has been argued that "even a relatively modest improvement in outcomes as a result of better services would be sufficient to justify the additional spending on value for money grounds" (Bauer et al, 2014).

4.3 Commissioning and provision of services

Currently, specialized perinatal mental health services are commissioned by clinical commissioning groups (CCGs). Despite national policy being strongly supportive of improvements in this area of healthcare, only 3% of CCGs have a commissioning strategy for perinatal mental health (Bauer *et al.*, 2014).

Provision of perinatal mental health services across England is patchy and inequitable. Women are often not able to access the appropriate type or standard of specialized care and the responsibility for care is sometimes confused between mental health, primary care and maternity services (Tyler, 2012); over 40% of GPs report insufficient knowledge of specialist mental health provision within their locality. Across England, 40% of all CCG areas have no specialist community perinatal mental health teams, and only 15% meet Perinatal Quality Network Services Standards (NHS Improving Quality, 2015). Mother and baby units are not evenly spread across the country (Maternal Mental Health Alliance, 2014). In these underserved areas, women with severe perinatal psychiatric disorders are either forced to travel long distances to an out of area mother and baby unit or are admitted to general adult wards without their babies (Joint Commissioning Panel for Mental Health, 2012).

Appropriate training and development of healthcare professionals is also a key issue. For example, 73% of maternity services in England do not have a specialist mental health midwife. More generally, 29% of midwives report that they receive no content on mental health as part of their pre-registration training (Hogg, 2012).

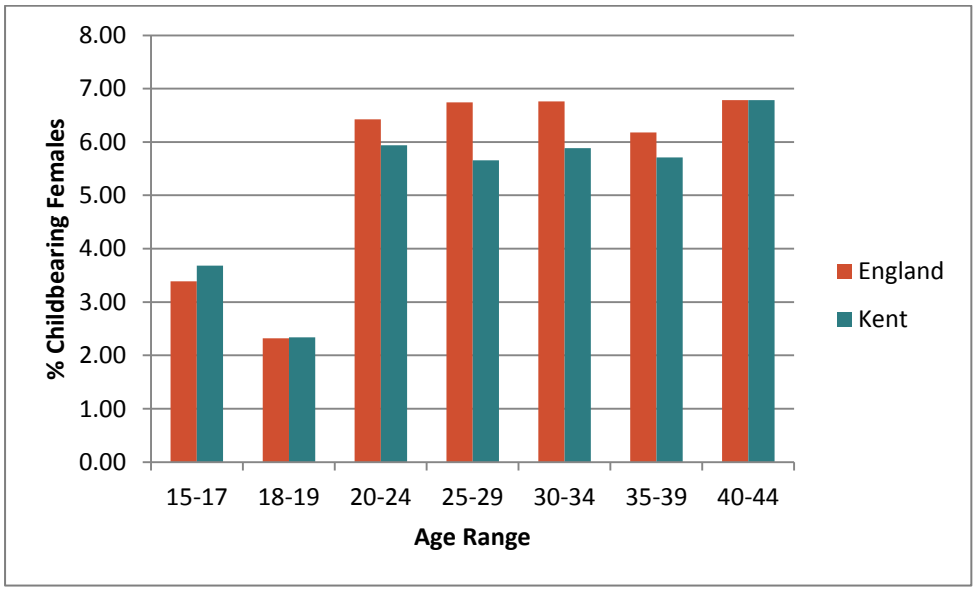
5 Kent Population

Main points

- The overall percentage of women of childbearing age within Kent is lower than that of England. By 2030, the population of this cohort will increase by 5.1% overall, but there is considerable variation by district.
- Canterbury has the lowest maternity rate in Kent, and also the lowest rate of any local authority in England, with the exception of the City of London.
- The maternity rate is decreasing very slightly across Kent, but the number of births is set to remain stable for several years, at 18,000 births per annum.

Kent lies in the south east of England and has an estimated population of 1,510,400, 51% of whom are female (770,297). Of the total female population, approximately 36% (277,274) are between the ages of 15 and 44 years compared to 38.5% for England as a whole; this is the 'child bearing' age range used by the Office of National Statistics to calculate fertility and maternity rates (ONS, 2015a). Kent has a lower proportion of 20-39 year olds, than nationally.

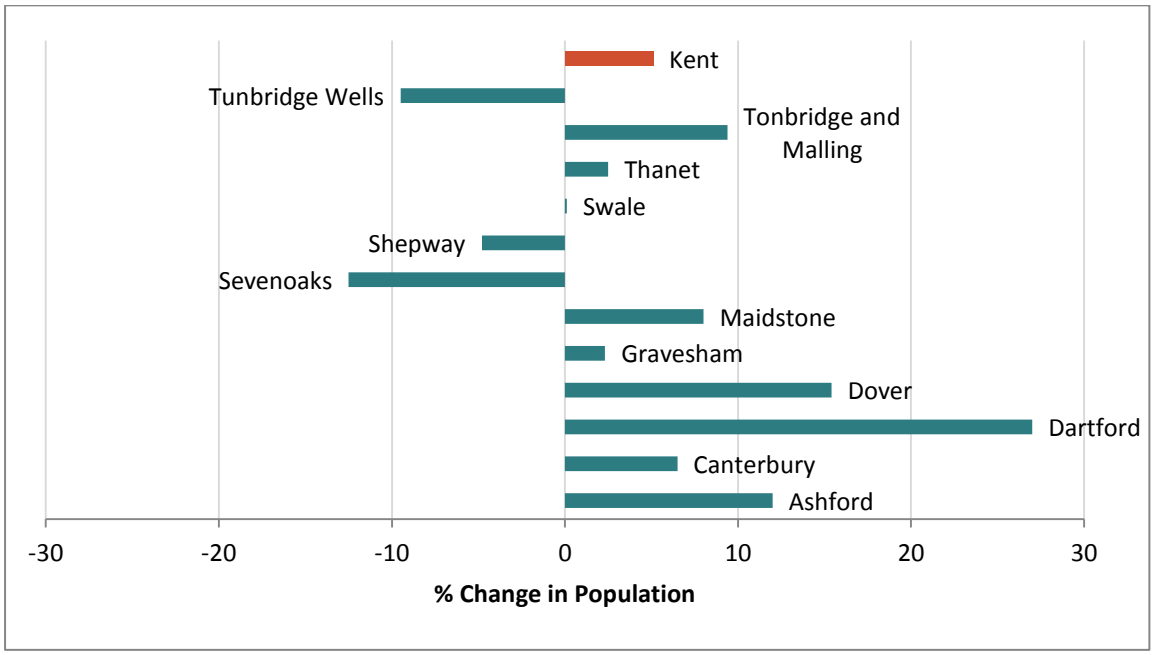
Figure 2: Number of females of childbearing age as a percentage of all females, Kent and England & Wales, 2014



Source: (ONS, 2015c)

Estimates show that between 2000 and 2014, the population of females of childbearing age in Kent rose by 7.2%. Between 2015 and 2030 it is set to increase by a further 5.1%, however, this general increase masks significant differences between localities. For example, Dartford's population of females aged between 15 and 44 years is forecast to increase by 27%, while in Sevenoaks the figure is set to reduce by 12.5% (Kent County Council, 2015).

Figure 3: Forecast % change in population of females aged 15 to 44 years across Kent and constituent local districts between 2015 to 2030



Source: Kent County Council, 2015

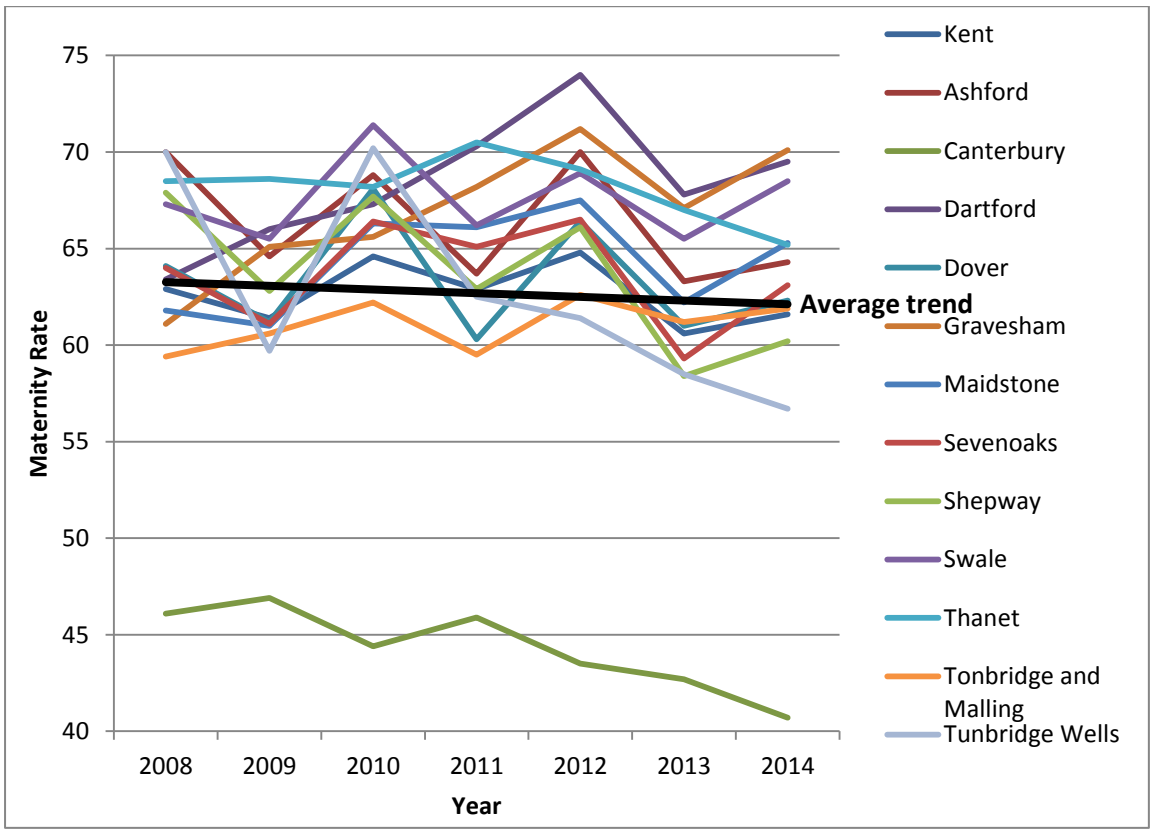
In 2014, the number of maternities across Kent totalled 17,089. The number of maternities per 1000 women aged between 15 and 44 years was 61.6, and this maternity rate for Kent is the same as the England average. Within Kent, maternity rates varied considerably across local authority areas. At 70.1, Gravesham has the highest maternity rate in Kent. Of note, Canterbury has by far the lowest maternity rate in the county (40.7) and also has the lowest rate among all districts in the UK, with the exception of the City of London (37.3) (ONS, 2015a).

Table 1: Number of maternities, female population of child bearing age and maternity rates for Kent and constituent local districts, 2014

Area	Number of Maternities	Female Population 15-44 years	Maternity Rate
Ashford	1,462	22700	64.3
Canterbury	1,346	33100	40.7
Dartford	1,476	21300	69.5
Dover	1,159	18600	62.3
Gravesham	1,442	20600	70.1
Maidstone	1,953	29900	65.3
Sevenoaks	1,274	20200	63.1
Shepway	1,076	17900	60.2
Swale	1,752	25600	68.5
Thanet	1,568	24000	65.2
Tonbridge and Malling	1,403	22700	61.9
Tunbridge Wells	1,178	20800	56.7
Kent	**17089**	**277300**	**61.6**

Source: ONS, 2015

Figure 4: Annual maternity rates for Kent and its constituent districts, 2008-2014



Sources: Kent County Council, 2015; ONS, 2015b

Over time, the maternity rate fluctuates year to year, but the general trend has been a very slight decrease in the maternity rate across Kent. This does not translate into a decrease in the total number of births, because of the increasing proportion of women of childbearing age. Data for the projected annual number of births in Kent shows a marginal increase to 2018, after which the number remains stable at around 18,000 births per year

Table 2: Projected number of births in Kent (2012 based)

Number of births projected in 2016	17,900
Number of births projected in 2018	18,000
Number of births projected in 2020	18,000
Number of births projected in 2022	18,000
Number of births projected in 2024	18,000

Source: ONS

6 Epidemiology

Main Points

- Between 10% and 20% of women will suffer from a perinatal mental illness
- For most common mental health disorders i.e. mild depression or anxiety, the level of risk is the same as other women. For severe mental illnesses, such as psychosis or severe depression, the risk increases significantly after childbirth
- The most significant predictor of perinatal mental illness is a previous history of mental health issues. Other key risk factors include: traumatic birth or perinatal death, family history of mental illness, domestic violence or abuse, poor emotional and social support and low socio economic status
- Between 2009 and 2013, 23% of all maternal deaths (during pregnancy and one year postpartum) were from psychiatric causes. Although the overall maternal mortality rate is decreasing, both the number and rates of maternal deaths from psychiatric causes have been increasing for several years.

Although studies have shown significant differences in incidence for different population groups, it is estimated that between 10% and 20% of women across the country will suffer from a perinatal mental illness (Hogg, 2012; Maternal Mental Health Alliance, 2014; Khan, 2015). Of women who do experience perinatal mental illness, 31% will have a prior mental health problem (Witt *et al.*, 2010). Within the UK, the most prevalent perinatal psychiatric disorders are:

Adjustment disorders and distress	Occur when a woman is unable to adjust or cope with an event such as pregnancy, birth or becoming a parent. A woman with these conditions will exhibit a distress reaction that lasts longer, or is more excessive than would normally be expected, but does not significantly impair normal function	Common
Mild-moderate depressive illness and anxiety states	Mild depression is when a person has a small number of symptoms that have a limited effect on their daily life. Moderate depression is when a person has more symptoms that can make their daily life much more difficult than usual. Includes symptoms such as persistent sadness, fatigue and a loss of interest and enjoyment in activities. It often co-occurs with anxiety, which may be experienced as distress, uncontrollable worries, panic or obsessive thoughts.	
Post traumatic stress disorder (PTSD)	An anxiety disorder caused by very stressful, frightening, or distressing events, which may be relived through intrusive, recurrent recollections, flashbacks and nightmares. These traumatic events can occur before pregnancy, during pregnancy or at childbirth.	
Severe depressive illness	The most serious form of depression, where symptoms are severe and persistent, and significantly impair a woman's ability to function normally.	Severe
Chronic serious mental illness	Longstanding mental illnesses, such as schizophrenia or bipolar disorder, which may be more likely to develop, recur or deteriorate in the perinatal period.	
Postpartum (puerperal) psychosis	Severe mental illness that typically affects women in the weeks after giving birth, and causes symptoms such as confusion, delusions, paranoia and hallucinations.	

(Hogg, 2012; Joint Commissioning Panel for Mental Health, 2012)

For most common mental health disorders pregnant women have the same level of risk as other adults – the incidence does not change during the perinatal period. However for certain serious mental illnesses, such as postpartum psychosis, severe depressive illness, schizophrenia and bipolar illness, the risk of developing or experiencing a recurrence of the condition does increase after childbirth. (Cox, Murray and Chapman, 1993; Witt *et al.*, 2010; Hogg, 2012; Joint Commissioning Panel for Mental Health, 2012)

6.1 Perinatal mental health disorders

Postnatal blues

Postnatal blues or baby blues is a normal variation in mood experienced by 50-85% of women due to the hormonal and chemical changes that take place in a woman's body after childbirth (Paschetta *et al.*, 2014). Women often experience mild depressive symptoms, increased tearfulness, anxiety and mood swings. Unlike postnatal depression, baby blues are transient, peaking at around four or five days after birth and usually subsiding within 10 days (Howard *et al.*, 2014; Paschetta *et al.*, 2014; NHS Choices, 2015). Baby blues is unrelated to history of mental illness, environmental stressors, cultural context, breastfeeding, or number of births, however, those factors may impact on whether the blues lead to major depression. Up to 20% of women experiencing baby blues will go on to develop major depression in the first year after birth (Robertson, Celasun and Stewart, 2003).

Depression

Depression is the most common perinatal mental illness and affects around 10-15% of women during pregnancy or the first year after birth (Cox, Murray and Chapman, 1993; Larsson, Sydsjö and Josefsson, 2004). Some researchers assert that antenatal and postnatal depression are distinct conditions, while others see both as part of a continuum, and as postpartum depression is often preceded by antepartum depression (Edge, 2011); a study found that for 23% of women with postnatal depression this began during pregnancy (Evans *et al.*, 2001). A higher prevalence of antenatal and postnatal depression is generally reported in women in low and middle-income countries than in women in high-income countries (WHO, 2008). A number of studies and reviews report no significant difference in prevalence of mild to moderate depression between women in the postnatal period and women who are not pregnant or have given birth within the last 12 months, however the rates of first onset and severe depression increase threefold within the first five weeks after birth (Cox, Murray and Chapman, 1993; Witt *et al.*, 2010). Women with postnatal depression often recover within a few months from onset, but around 30% of women still have depression beyond the first year after delivery. There is also a 40% risk of subsequent postnatal and non postnatal relapse (Howard *et al.*, 2014).

Anxiety Disorders

Reported prevalence rates for anxiety disorders range from 4.5% to 15% (Paschetta *et al.*, 2014); a large US based population study reported a prevalence of 13% (Vesga-López *et al.*, 2008). Although the evidence on the prevalence of perinatal obsessive-compulsive disorder (OCD) is not definitive, some studies suggest that it is experienced by around 3% of new mothers (Hogg, 2012). The prevalence of posttraumatic stress disorder (PSTD) is estimated at between 1% and 2% in high income countries, with higher rates found in low and medium income countries, although higher rates have been found in studies that consider a diverse range of trauma experiences than those associated with childbirth (Howard *et al.*, 2014). PSTD is highly comorbid with depression; evidence suggests that women with diagnoses of both PTSD and a major depressive episode are at increased

risk of preterm birth (Yonkers *et al.*, 2014). Due to its high perinatal comorbidity with mood and anxiety disorders, tokophobia is gaining increased attention in clinical practice (Paschetta *et al.*, 2014). Over 20% of pregnant women report fear of childbirth and 6% describe a fear so significant as to be disabling (Hofberg, 2003). A high incidence of PTSD has been found in women with secondary tokophobia (fear of childbirth after a traumatic obstetric event). The condition has also been observed as a symptom of perinatal depression (Hofberg, 2000).

Postpartum psychosis

Women are 22 times more likely to experience a psychotic episode after birth than at any other time of her life (Heron *et al.*, 2008). Episodes of post-partum psychosis usually have their onset within 2 weeks of delivery (a retrospective study found that more than 50% of symptom onsets occurred on days 1 to 3) however onset can also occur several weeks after birth (Kendell, Chalmers and Platz, 1987). It is estimated that around two thirds of women suffering from post partum psychosis will experience a relapse after subsequent deliveries (Howard *et al.*, 2014).

Bipolar affective disorder and schizophrenia

There is a strong association between post-partum psychosis and bipolar affective disorder (BPAD). Data from retrospective and population registry studies suggest that women with bipolar disorder have at least a one in five risk of suffering a severe recurrence of psychosis following delivery (Jones *et al.*, 2014). Up to 50% of women with a history of bipolar disorder will be at risk of experiencing a perinatal relapse, especially after childbirth where the risk of recurrence is higher for BPAD than any other mental illness (Paschetta *et al.*, 2014). The risk of relapse for schizophrenia during the first three months after birth is approximately 24-25%, especially if treatment is discontinued (Paschetta *et al.*, 2014)

6.2 Risk factors for perinatal mental illness

Perinatal mental health disorders can affect pregnant women and new mothers of any age, ethnicity, and socioeconomic background. However, studies have shown that there are psychological, biological and social factors that may put women at a greater risk of perinatal mental illness.

Table 3: Estimates of at risk populations in Kent

Risk factors	Figures for Kent	As a percentage of the whole population
Total population[1]	1,510,400	100%
Population with any mental illness[2]	310,202	20.5%
Living in bottom quintile areas for deprivation[3]	196,352	13.0%
Ethnic minority population[4]	11.4%	11.4%
Population with serious mental illness[5]	0.77%	0.77%
Risk factors		**Annual numbers in Kent**
Maternities[6]		17,089
Deliveries to women over 35 years[7]		3,276
Deliveries to teenage mothers (under age 18)[7]		214
Births registered to a single parent[8]		925
Perinatal deaths[9]		157
Estimate:* Maternities in those with any prior mental illness (20.5%)		3650
Estimate:* Maternities in those living in bottom quintile areas for deprivation (13.0%)		2,221
Estimate:* Maternities in those of ethnic minority (11.4%)		1948
Estimate:* Maternities in those with prior serious mental illness (0.77%)		132

Sources: [1]ONS, 2015. [2]NEPHO, ONS 2013/14. [3]PHE, DCLG, 2015. [4]Census 2011. [3]QOF 2014/15. [6]ONS, 2015. [7]HES 2012/13. [8]ONS, 2014. [9]ONS 2011-2013.

*estimates, assuming no difference in the rates of each risk factor between the whole population and those women becoming pregnant.

Previous history of mental health problems

A history of mental health problems before becoming pregnant is the most significant predictor of perinatal mental illness (Kendell, Chalmers and Platz, 1987; O'Hara and Swain, 1996; Howard *et al.*, 2014; Jones *et al.*, 2014; Biaggi *et al.*, 2016). This could be a long-standing mental health condition or a previous episode of perinatal mental illness. The strongest risk factor for susceptibility to post-partum psychosis is a history of bipolar disorder or previous severe post-partum episodes, however at least 50% of women diagnosed with psychosis have no prior history of mental illness (Jones *et al.*, 2014).

Family history of mental health problems

There is a strong relationship between perinatal mental illness and a family history of mental ill health, particularly in relation to postpartum psychosis (Hogg, 2012; Jones *et al.*, 2014). Evidence also indicates that offspring of mothers with antenatal or postnatal depression are at greater risk of experiencing mental illness in adulthood (Pearson *et al.*, 2013).

Parity

An association has been found between postpartum psychosis and women giving birth to their first child (Kendell, Chalmers and Platz, 1987; Blackmore, 2006; Jones *et al.*, 2014). It may be argued that this association is skewed by the probability that women who experienced psychosis with their first child are unlikely to go on to have more children. However, even when studies have controlled for this confounder, the association still remained (Jones *et al.*, 2014). The role of parity in increasing the risk of anxiety and depression is less clear (Biaggi *et al.*, 2016).

Traumatic birth and perinatal death

Traumatic births are those which are physically traumatic, or are experienced as traumatic even when the delivery is obstetrically straightforward (National Collaborating Centre for Mental Health, 2015). This can include events such as delivery complications, stillbirths and sudden infant death syndrome (SIDS). Perinatal mental health problems, particularly post-traumatic stress disorder, are associated with experiencing a traumatic childbirth, stillbirth or the death of a baby (Kendell, Chalmers and Platz, 1987; Boyle *et al.*, 1996; Jones *et al.*, 2014; Paschetta *et al.*, 2014; Biaggi *et al.*, 2016). Depression and anxiety associated with a prenatal loss shows a pattern that continues after the birth of a subsequent (healthy) child. There is also evidence to suggest an association between depression and anxiety and miscarriage, as well as stillbirth (Blackmore *et al.*, 2011). A stillborn baby is one born after 24 completed weeks of pregnancy with no signs of life. The stillbirth rate is the number of stillbirths per 1,000 total (live and still) births. Stillbirth rates in the UK are higher than might be expected in a high income country: approximately one in 200 babies is still born (4.9 stillbirths per 1,000 births). The perinatal mortality rate is the number of stillbirths and the number of early neonatal deaths (under 7 days) per 1,000 total births. This rate is trending downwards both nationally (7.1) and in Kent (5.9) for the latest data from 2011-2013 (ONS atlas.chimat.org.uk)

"Fair" or "poor" self-rated physical health

There is an established link between physical and mental health. Women who report 'fair' or 'poor' self-rated physical health during pregnancy are at greater risk of experiencing poor perinatal mental health compared to women reporting their health as 'excellent', 'good' or 'very good' (Witt *et al.*, 2010). A moderate association has also been found between postnatal depression and chronic or medical illness (Howard *et al.*, 2014)

Unplanned or unwanted pregnancy

Up to 50% of pregnancies in the general population are unplanned and the percentage among women suffering from mental illness is even higher (Paschetta *et al.*, 2014). Often women become pregnant without having their medication optimised or stop taking their medication altogether, which results in a relapse of their condition. A few studies have observed that an unwanted pregnancy is a significant predictor of depression in the early stages of pregnancy but becomes less significant over time (Biaggi *et al.*, 2016).

Younger age

There is conflicting evidence on the association between age and perinatal mental illness (Vesga-López *et al.*, 2008; Howard *et al.*, 2014; Jones *et al.*, 2014; Paschetta *et al.*, 2014). One study reported that women who had a history of mental health difficulties during adolescence and early adulthood have a higher risk of experiencing postnatal depression compared with pregnant women with no previous history of mental illness (Patton *et al.*, 2015). Other studies have asserted that becoming pregnant at an older age is associated with a greater risk of perinatal mental illness (Biaggi *et al.*, 2016).

Domestic violence and abuse

One third of women who experience domestic violence are hit for the first time whilst pregnant (Kent County Council, 2015). There is a very strong association between domestic abuse and poorer perinatal mental health. Antenatal domestic violence is associated with high levels of depressive symptoms in women during pregnancy and after birth (Flach *et al.*, 2011; Van Parys *et al.*, 2015). Not only do women experiencing domestic violence have a higher risk of developing post-natal depression, symptoms of depression can also increase a woman's vulnerability to domestic violence (Howard *et al.*, 2013). Living in a household where domestic violence is occurring is also a risk factor for poor mental health and behavioural disorders in babies and toddlers (Flach *et al.*, 2011; Hogg, 2012). Kent's rate of domestic abuse per 1000 of the population is 14.4, less than the national rate of 15.6, above the South East regional rate of 14.0 (ONS), although this data is for both male and female victims and for all ages.

Recent traumatic or adverse life events

Exposure to traumatic or stressful life events increases the risk of mental disorders in pregnant and postpartum women (Vesga-López *et al.*, 2008; Silva *et al.*, 2012; Howard *et al.*, 2014). Additional stressful events during this period may play a causal role in postpartum depression (Stewart *et al.*, 2003)

Insufficient emotional and social support e.g. lone mother

Women who lack social support have been found to be at increased risk of antenatal and postnatal depression (Silva *et al.*, 2012). Having a poor relationship with a partner (or absent partner) is also a risk factor for postnatal depression. The number of births in Kent that were registered by the mother only during 2014 was 925 – 5.3% of all registered births. This gives an indication of the potential number of women in Kent that are likely to lack the support of the father during pregnancy and as a new mother. This was the similar to the national rate (5.4%) but higher than the South East region (4.2%)

Ethnicity

The association between ethnicity and risk of perinatal mental illness remains unclear. Some authors suggest that certain ethnic groups may experience higher rates of postnatal depression than others (Wei *et al.*, 2008; Edge, 2011; Gavin *et al.*, 2011). But whilst psychosocial risks such as poverty, gender discrimination and marginalisation may be higher, for example, in Black British Caribbean women, in practice, they are less likely than their White British counterparts to be diagnosed with perinatal depression and receive appropriate mental healthcare (Edge 2013). A review of postnatal depression among refugee, asylum seeker and immigrant women indicated that up to 42% might be affected compared to 10-15% of native-born women, with history of stressful life events, lack of social support and cultural factors cited as the most common risk factors (Collins, Zimmerman and Howard, 2011). Of all maternal deaths in the UK between 2011 and 2013, a quarter were born outside the UK (Knight et al, 2015)

Low socio-economic status

Though perinatal mental illness affects women right across the social spectrum, deprivation is related to an increased risk of antenatal and postnatal depression, especially among women from low and medium income countries (Silva *et al.*, 2012; Howard *et al.*, 2014; Paschetta *et al.*, 2014). Unemployment and financial strain (arguably indicators of low socioeconomic status) have been significantly associated with postpartum depression (Stewart *et al.*, 2003). In Kent, areas of higher deprivation (urban areas and coastal towns) also have higher rates of mental health contacts. Given that a prior history of mental illness is the most significant risk factor for the development of perinatal mental illness, rates of perinatal mental illness are likely to be higher in areas of deprivation.

6.3 Maternal deaths due to mental illness

A maternal death is usually defined as the death of a women while pregnant or within 42 days of the end of the pregnancy[3] from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. Between 2011-2013, there were 214 maternal deaths, 13% of which were mental health-related, and 7% were substance users. Although the overall maternal mortality rate is decreasing, the number and rate of deaths from psychiatric causes appears to have steadily increased in recent years. In a report on maternal mortality (Knight *et al.*, 2015), deaths from psychiatric causes were the fifth most common individual cause of maternal death during pregnancy or up to six weeks after the end of pregnancy. When including late deaths, almost a quarter (23%) of all maternal deaths were related to mental illness in the UK and Ireland between 2009 and 2013 (Knight et al., 2015).

Suicide is the leading cause of mental-health related maternal death. Of the 161 deaths from mental health-related issues in the UK and Ireland between 2009 and 2013, 101 were by suicide. Over half of the women who died by suicide (n=57) had a diagnosis of a recurrent mental health disorder (Knight *et al.*, 2015). Between 2009 and 2013, there were 58 maternal deaths as a result of substance misuse. This group of women was more likely to be from deprived backgrounds and less likely to be employed. Over a third (34%) were known to social services. Fourteen of the women who died by suicide had comorbid substance misuse (Knight *et al.,* 2015.

6.4 Kent estimates of perinatal mental illness

The Joint Commissioning Panel for Mental Health (2012) produced estimated rates of the most prevalent perinatal mental health disorder. Using the number of deliveries within Kent we can calculate the numbers of women with perinatal mental health conditions we would expect to see across the county. It should be noted that one woman might present with more than one perinatal psychiatric disorder; therefore a total estimate of women with a perinatal mental health condition cannot be obtained by simply adding the separate estimates together.

Table 4: Estimated numbers in Kent of perinatal mental disorders, 2014

Perinatal Psychiatric Disorder	Expected Rates per 1000 Maternities[4]	Estimated Numbers within Kent, 2014
Adjustment disorders and distress	150-300	2460 - 4920
Mild-moderate depressive illness and anxiety states	100-150	1640 - 2460
Post-traumatic stress disorder (PTSD)	30	495
Severe depressive illness	30	495
Chronic serious mental illness	2	35
Postpartum (puerperal) psychosis	2	35

Source: atlas.chimat.org.uk

Table 5: Estimated numbers of perinatal psychiatric disorders by CCG, 2013/14

Perinatal Psychiatric Disorder	Ashford	C&C	DGS	SKC	Swale	Thanet	West Kent
Adjustment disorders and distress	210-420	270-535	480-955	290-580	210-415	240-475	755-1510
Mild-moderate depressive illness and anxiety states	140-210	180-270	320-480	195-290	140-210	160-240	505-755
Post-traumatic stress disorder (PTSD)	45	55	100	60	45	50	155
Severe depressive illness	45	55	100	60	45	50	155
Chronic serious mental illness	5	5	10	5	5	5	15
Postpartum (puerperal) psychosis	5	5	10	5	5	5	15

Source: atlas.chimat.org.uk

It is difficult to obtain data on the true number of cases of perinatal mental illness in Kent. The table below shows all maternity-related admissions in Kent with a recorded co-morbidity of mental illness, for the 2013/14 year. The numbers are far smaller than we would expect from the literature (10-20% of all maternities experience some form of perinatal mental illness – Khan, 2015). However the data below would only show those mental illnesses identified *before birth,* not those cases where mental illness developed in the 12 months after delivery. Furthermore we are unable to distinguish in this list the cases of current, active mental illness, compared to cases where there has been a prior history of mental illness. There are also likely to be many cases which are not recorded on hospital systems due to lack of disclosure or inaccuracies in the recording of information.

Table 6: All maternity admissions 2013/14 with a mental illness co-morbidity recorded (Source: KPHO)

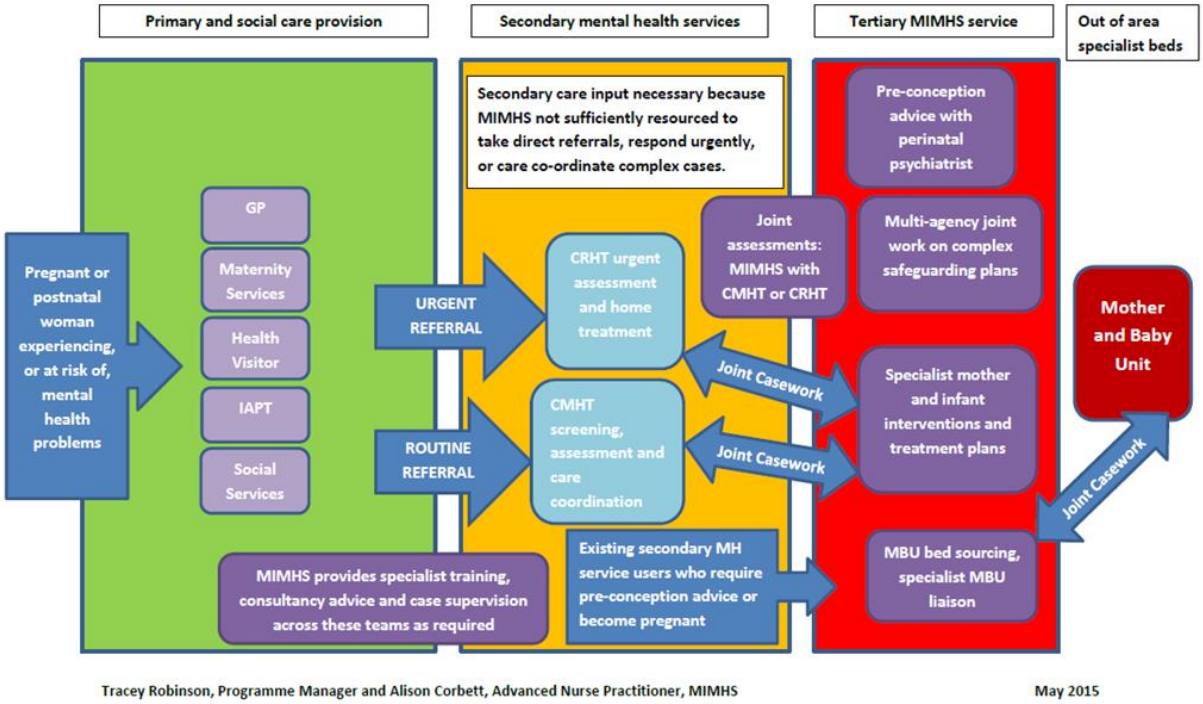
Mental Condition	Number of Maternity Admissions 2013/14
Depressive Episodes	309
Other Anxiety Disorder	263
Bipolar Affective Disorder	35
Disorders associated with puerperium	18
Specific Personality Disorders	16
Specific Development Disorders in Scholastic Skills	7
Hyperkinetic Disorders	6
Pervasive Developmental Disorders	5
Schizophrenia	5
Conduct Disorders	4
Obsessive Compulsive Disorders	3
Reaction to Severe Stress	3
Phobic Anxiety Disorder	3
Other	9
Grand Total	**686**

7 Existing Service Provision

7.1 Existing service model

The provision of perinatal mental health spans across universal services of health promotion and prevention, through to specialist services. The current perinatal mental health pathway for severe mental illness relies on universal services (in primary and social care) providing the majority of management for mild perinatal mental illness, and referring through to more specialised providers when required. Secondary mental health services become necessary as an intermediary to facilitate referrals and provide urgent care, with joint casework with the tertiary mother and infant mental health service (MIMHS). The MIMHS service provides a specialist service, and facilitates referrals to the MBUs in other areas of the country.

Figure 5: Existing service model for specialist perinatal mental health services in Kent



There is a varied commissioning landscape for these services. The tertiary MIMHS service is commissioned by CCGs. CCGs also commission secondary mental health services, primary care and maternity services. MBUs are commissioned by NHS England. In terms of health promotion and prevention, Local Authorities have recently taken on public health commissioning responsibilities for age 0-5 children, for example, the commissioning of Health Visitor services and Family Nurses.

7.2 Wider Perinatal Mental Health Provision

GPs

GPs have a key role in identifying women at risk of perinatal mental illness (for example, those with a prior history of mental illness). GPs should refer for preconceptual advice in these cases. It has been suggested that often GPs do not know when women with a history of mental illness become pregnant, as the existing information systems do not alert when this happens. Following birth, GPs can screen all women for mental health issues at the 6 week check. Training of GPs in perinatal mental health is important, but sometimes difficult to book in to GP training sessions.

Improving Access to Psychological Therapies (IAPT)

IAPT services offer psychological therapies for common mild to moderate mental health problems, including perinatal mental illness. Access to the service is either through self-referral, GP referral or referral by a health care professional. There has been low awareness of the service amongst midwives, though this is improving with training.

Midwives

Midwives provide direct care to women in the antenatal period and so are key to identifying and referring on women at risk of mental illness. Midwives should always ask about mental health history at the initial booking appointment, so that this can be recorded, and provide basic information on how to recognise symptoms and seek help when required. A recent audit by East Kent Hospitals Trust (Ladd, 2015) on 36 community midwives found that only 33% of midwives 'always' discuss mental health at routine antenatal appointments, and if concerns were identified, only 42% felt they could access advice and support 'always' or 'often'. Only 36% felt that the mandatory staff training in perinatal mental health was sufficient. East Kent Hospitals Trust currently does not have a lead specialist midwife role, and 94% expressed they would welcome such a post. Currently, specialist midwives are provided at Maidstone and Tunbridge Wells NHS Trust and Dartford and Gravesham NHS Trust.

Health visitors

Health visitors provide direct care to women and their children in the postnatal period, and therefore play a key role in discussing and recognising postnatal mental illness. Health visitors receive training on the topic and on when to refer for specialist care. The 6 week visit is particularly focussed on perinatal mental health. They continue to offer 4-6 listening sessions to meet mild-moderate mental health needs, although this is outside commissioned activity. There are also some lead health visitors specialising in perinatal mental health in Kent, delivering more specialised support, coordinating training, and liaising with the MIMHS service.

Voluntary sector – peer support groups

Peer support groups for perinatal mental health can be a valuable resource for patients, but these services have not been systematically mapped across Kent. With groups that have been set up independently, it is important these service providers receive training to ensure that safe advice is provided. There is little available support for baby bereavement in Kent, and also for families (e.g. the partners of those with perinatal mental illness)

Other Provider Groups

There many other service providers where professionals come in to contact with new mothers at risk of perinatal mental illness. For example, Early Help services (e.g. Children's Centres) and targeted services (such as the Family Nurse Partnership and the Troubled Families Programme) may all be opportunities for professionals to identify those at risk of perinatal mental illness and provide support, advice and referral through to the appropriate channels. Many of these groups of professionals and service providers will not have the training that health visitors and midwives receive, so there is likely poor awareness of perinatal mental health and the services available.

Secondary mental health services

The tertiary MIMHS service does not have the capacity to take direct referrals into the service. Referrals therefore must come through the secondary general mental health services such as the Community Mental Health Teams (CMHT) for routine referrals, and Crisis Resolution and Home Treatment teams (CRHT) for urgent referrals. This process may be frustrating for health professionals in primary and social care, who may prefer to refer directly into the MIMHS service. Cases referred to the CMHT may be predominantly managed by that service, with minimal input needed from the MIMHS service. Where specialist input is required, the MIMHS service is more directly involved in the care provision. There is ongoing training and consultation between MIMHS and secondary MH teams about how to respond to perinatal MH referrals.

7.3 Tertiary MIMHS Service

The Mother and Infant Mental Health Service (MIMHS) is a highly specialist community service for perinatal mental illness. It is provided across Kent by the Kent and Medway NHS and Social Care Partnership Trust (KMPT), one of the largest mental health trusts in the country. The MIMHS service provided by KMPT has existed since 2001, commencing in West Kent and achieving funding to expand into East Kent and Medway in 2010. The service operates 9am-5pm Monday to Friday, in 4 different localities across Kent as below. The services delivered by the MIMHS service include:

- **Preconception advice** for women with existing moderate to severe mental illness
- **Liaison, advice and consultation for primary care**, regarding women experiencing perinatal mental illness
- **Assessment** of women with a history of severe mental illness for the risk of relapse during the perinatal period (in conjunction with secondary mental health services)
- **Management and treatment** of severe perinatal mental illness (in conjunction with secondary mental health services who provide care co-ordination).
- **Provision of training** to midwives, health visitors, social workers, acute hospitals and GPs to enable them to identify women at risk and signpost them to the appropriate service
- **Provision to general secondary mental health services** of advice, support and supervision, such as the Crisis Resolution and Home Treatment teams (CRHT) and community mental health teams (CMHT)
- **Liaising with MBUs** in assessment, referrals, arranging admissions, discharge planning and supporting transition back to local services.

Table 7: MIMHS Workforce per locality in Kent

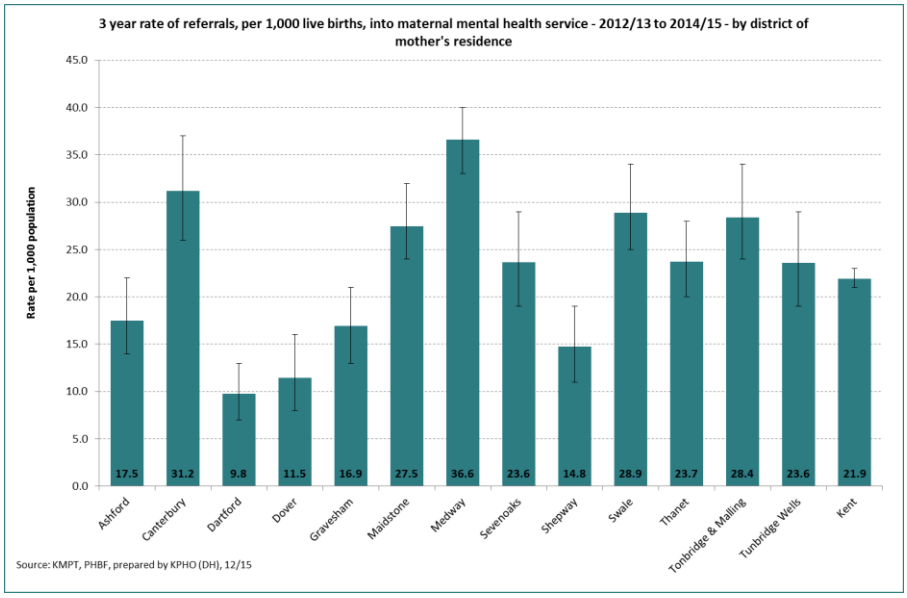
Locality	Maidstone & South West Kent	Dartford Gravesham & Swanley	Medway and Swale	East Kent
Commissioner	West Kent CCG	DGS CCG	Medway CCG, Swale CCG	East Kent Federation CCG
Births (2014/15)	5243	3192	4883	6611
Advanced Nurse Practitioner/ Service Manager Band 8A	1.0 across service			
Consultant Perinatal Psychiatrist	0.5	0	0.5	0.8
Clinical Nurse Specialist Band 7	1.0	1.0	1.0	2.0
Administration Band 4	1.0		1.0	

Guidelines from the Royal College of Psychiatrists (2015) state that for consultant psychiatry sessions there should be 1PA per 1000 births. This suggests that DGS is short of the required consultant sessions. Specialist nurse sessions should be at 0.5WTE per 1000 births, suggesting that all four local services fall short of the nurse requirements. Other gaps include the lack of a wider multidisciplinary team such as psychologists, nursery nurses and occupational therapists, and junior doctor support. See the appendix for a full break down of the required staff by role for each CCG area and service, according to the guidelines.

7.4 MIMHS service data

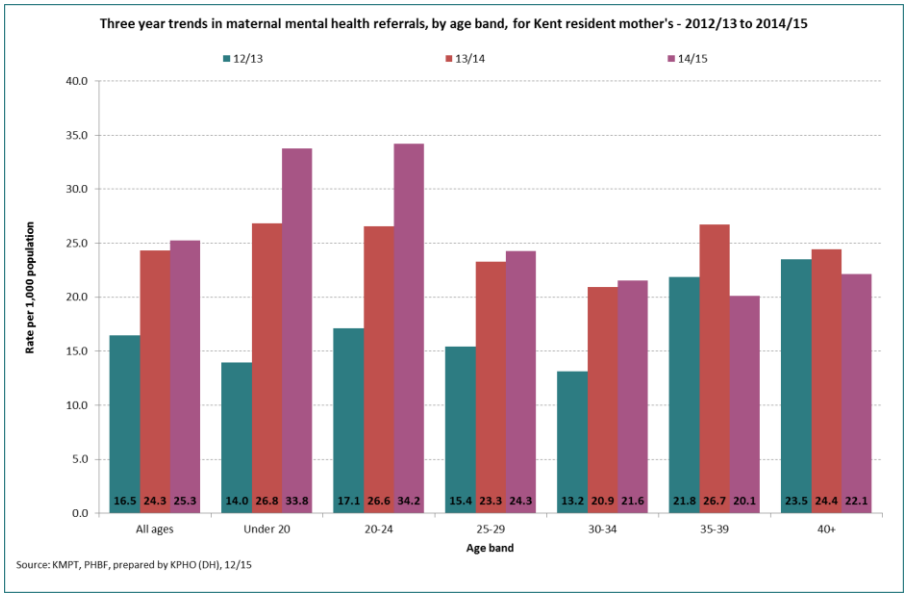
Across Kent and Medway, there were 1541 referrals made to MIMHS between 2012/13 and 2014/15. Approximately a quarter (25.5%, 393) of these referrals were for mothers in Medway unitary authority. Across Kent there have been 21.9 referrals per 1,000 live births during the last three years, ranging from 9.8 in Dartford, to 31.2 in Canterbury (Figure 9). Across Kent, the referral rate increased from 16.5 referrals per 1,000 live births in 2012/13 to 25.3 in 2014/15. This increasing trend is most marked in the youngest age groups – the under 20s and 20-24 year olds (Figure 10).

Figure 5: Three year rate of referrals per 1,000 live births into MIMHS by district of mother's residence, 2012/13 to 2014/15



Source: Kent MIMHS referrals data, Kent Public Health Observatory

Figure 6: Three year trends in MIMHS referrals, by age band, for Kent resident mothers, 2012/13 to 2014/15



Source: Kent MIMHS referrals data, Kent Public Health Observatory

Within the dataset, there is insufficient information to be able to identify number of contacts per individual; however, the number of contacts per referral can be calculated at an aggregated level. Across Kent, there were approximately 4.5 contacts per referral. This varied within Kent, from 2.9 contacts per referral in Swale to 8.7 in Gravesham. In this regard, it may be significant that the MIMHS service in Gravesham does not have consultant psychiatrist sessions. Across Kent and Medway, 60.8% (935) of services users were discharged on professional advice; however, 27.0% (416) were discharged due to an inappropriate referral. This highlights the importance of training in wider primary and social care, as there is probably uncertainty with regards to what constitutes an 'appropriate' referral.

Figure 7: MIMHS contacts per referral by district, pooled 2012/13 to 2014/15

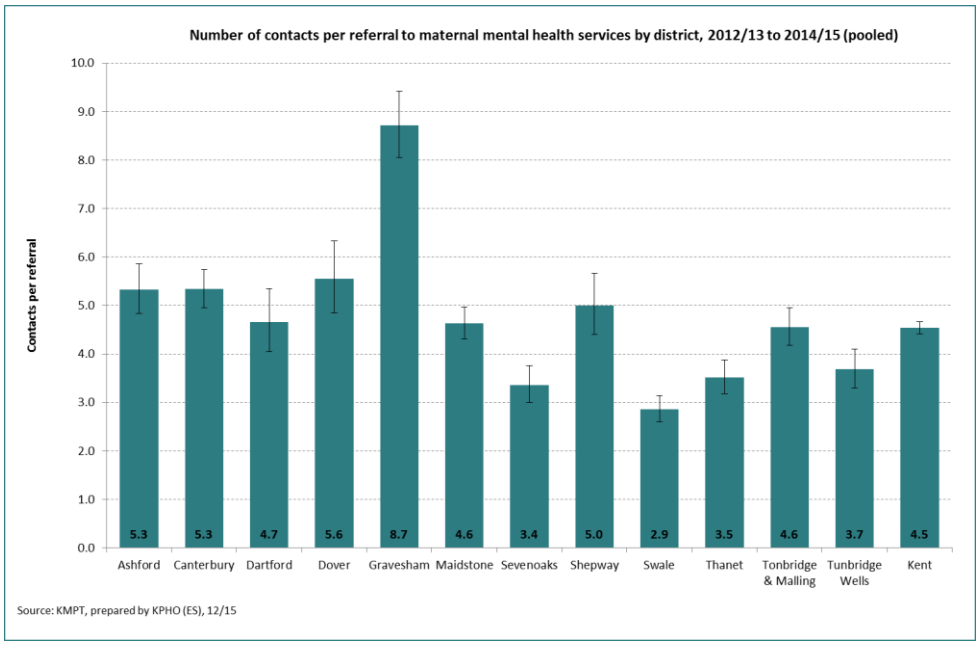
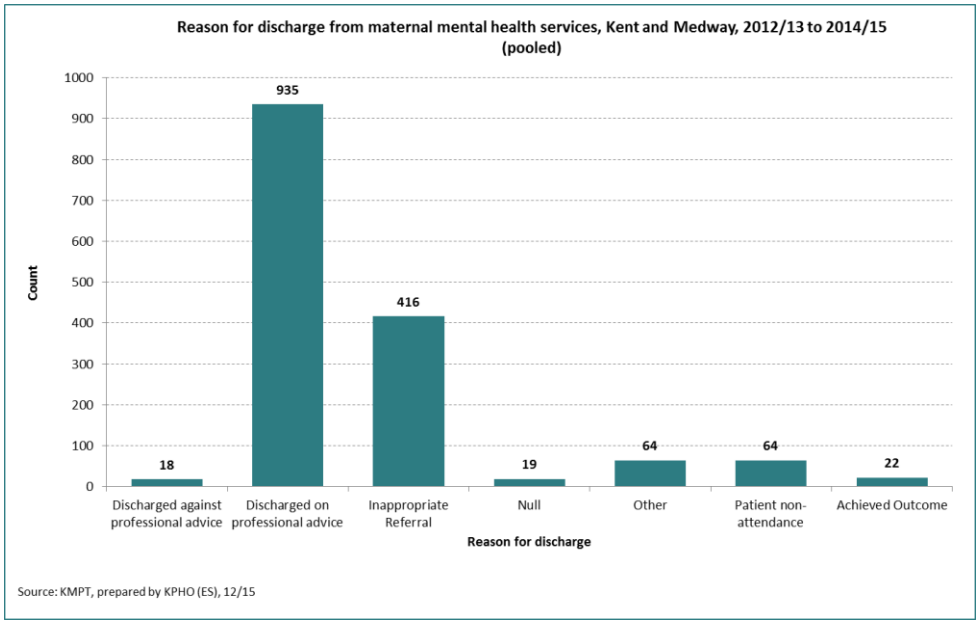


Figure 8: Reason for discharge from MIMHS, pooled 2012/13 to 2014/15



7.5 Mother and Baby Units

For the most severe cases of perinatal mental illness, admission is required to ensure the safety of the mother and child. Mother and Baby units are highly specialised centres where mothers can remain with their babies while receiving treatment, which is highly preferable to being admitted to general adult mental health beds, where the mother would be separated from her child. The mean bed occupancy rate is 82% and the mean cost per admission is £34,450 (Hibbert, 2015). Bed availability can be an issue, dependent on fluctuations in demand, but another big issue is travel distance and access. There are no MBUs in Kent, the nearest MBUs being the 3 units that are in London. This means that there are significant travel distances involved for Kent patients and some will decline a stay at an MBU unit because of the travel involved for family members. The distribution of MBU units in the UK is shown below.

Figure 9: Mother Baby Unit locations in the UK, Source: Maternal Mental Health Alliance

7.6 Comparing needs with service use

	Kent 2013/14
Total maternities	17,102
* **Expected number of cases of <u>any</u> perinatal mental illness**	1,710 - 3,420
** **Maternity admissions with <u>any</u> co-existing mental illness recorded**	689
*** **Expected number of cases of <u>severe</u> perinatal mental illness**	420
**** **MIMHS appropriate referrals into the service**	414

Table 8: Estimates of perinatal mental health needs and service use in Kent

** Based on estimation that in 10-20% of pregnancies the woman will experience some form of perinatal mental illness (Hogg, 2012; Maternal Mental Health Alliance, 2014; Khan, 2015)*

*** All maternity-related admissions in Kent with a recorded co-morbidity of mental illness (Table 6, page 21)*

**** Estimated numbers of severe depressive illness, chronic serious mental illness and postpartum psychosis in Kent given prevalence estimates as per Table 4 (page 20)*

***** All referrals into MIMHS 2013/14 (565) minus inappropriate referrals 2013/14 (151) Source: KPHO*

Not all cases of perinatal mental illness need to be referred to the MIMHS service, as milder cases can be managed in primary and social care services. There is no data available from the wider primary and social care system on the numbers of cases of perinatal mental illness. Maternity admissions with a recorded co-existing mental illness likely underrepresent the true number of cases, because not all co-morbidities will be accurately recorded by staff during an admission. Furthermore, this method will not pick up newly arising mental illness that occurs in the postnatal period. These two reasons are likely why the 689 figure is so much lower than the estimate of 1710 – 3420.

A crude estimate comparing severe perinatal mental health needs in Kent against appropriate referral into the tertiary MIMHS service data shows broad equivalence. But in reality it may in fact be appropriate for referral into the service with more moderate disease, and this may account for a number of the cases in the MIMHS service. This means that significant perinatal mental health needs might be going unmet in Kent, though with the paucity of available data, particularly regarding the number of cases of specific conditions, it is difficult to assess the extent to which this is the case.

8 Service Users Feedback

The MIMHS service has very high levels of satisfaction from service users. In 2012 a service evaluation audit was completed, analysing responses from patient experience questionnaires sent to all MIMHS patients on discharge. The survey results from 2010-2012 indicated that:

- 88% (n=44/49) of respondents were either satisfied or very satisfied with the service they received.
- 90% (n= 45/49) of service users stated yes they would definitely, or yes they thought they would, recommend this service to a friend or relative.

Feedback from mothers has continues to be collected since the audit. Some of the latest quotes from mothers are:

‘The service was excellent and greatly reduced the risks of anything going wrong.’

‘All things during my pregnancy and post went smoothly and well, but it was a real asset to have the team keeping an eye out’

‘I think it’s a fantastic service and I’m sure many women benefit from it as I did’

‘They were absolutely fab’

‘I don’t think I would have coped as well as I did without knowing I had contacts coming to see me so often, or numbers to call for help’

‘I was so worried I would be ill, and the team was so good reassuring me if I was it could be sorted’

‘I must give extra thanks to ‘nurse name’. She was my rock, such a support’

‘It was also great, they came to my home, it made it so much easier with a new born’

9 Models of Care

9.1 Kent service quality compared to the UK

The 'Everyone's Business Campaign' (Maternal Mental Health Alliance, 2014), sought to map service shortfalls and inequalities across the UK. The map below demonstrates that Kent is somewhere in the middle, providing a specialist perinatal mental health service, but falling short of the Royal College of Psychiatrists' Perinatal Quality Network service standards.

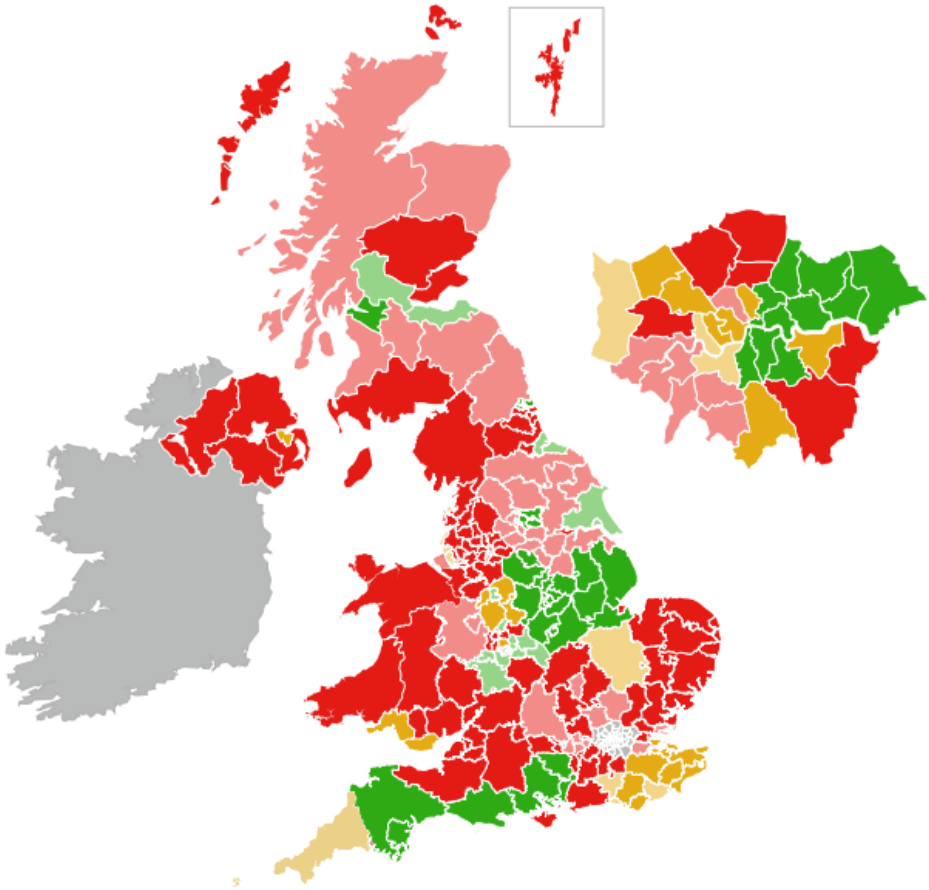


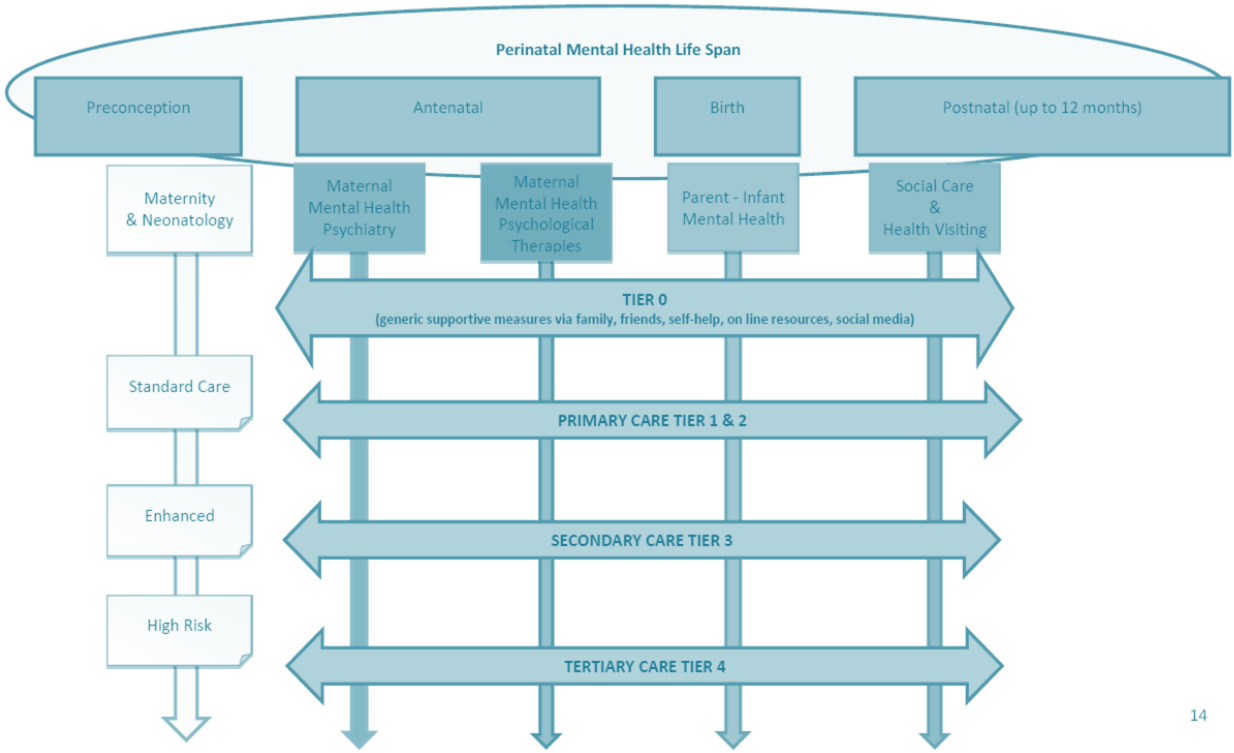
Figure 10: Perinatal mental health service quality in the UK, Source: Maternal Mental Health Alliance

LEVEL	COLOUR	CRITERIA
5		Specialised perinatal community team that meets Perinatal Quality Network Standards Type 1 http://www.rcpsych.ac.uk/pdf/Perinatal%20Community%20Standards%201st%20edition.pdf
4		Specialised perinatal community team that meets Joint Commissioning Panel criteria http://www.rcpsych.ac.uk/pdf/perinatal_web.pdf
3		Perinatal community service operating throughout working hours with at least a specialist perinatal psychiatrist with dedicated time AND specialist perinatal mental health nurse with dedicated time, with access to a perinatal psychiatrist throughout working hours
2		Specialist perinatal psychiatrist AND specialist perinatal nurse with dedicated time
1		Specialist perinatal psychiatrist or specialist perinatal nurse with dedicated time only
0		No provision

Disclaimer Levels of provision in this map have been assessed using the best information available to us from local experts but have not been independently verified. Please contact info@everyonesbusiness.org.uk if you suspect any inaccuracy or know of recent developments that may alter the level of provision level in any area listed here.

9.2 Recommended model of care

A thorough perinatal mental health pathway has recently been developed by the pan-London perinatal mental health network (Green, 2015), concordant with NICE guidance (NICE, 2014) and the Royal College of Psychiatrists' Perinatal Quality Network service standards (NHS Improving Quality, 2015). An overview of the pathway, which is divided across 5 streams, is found below. The full details of each stream with detailed treatment algorithms, can be found at: http://www.londonscn.nhs.uk/wp-content/uploads/2015/10/mh-care-pathway-231015.pdf



9.3 Gaps identified in the Kent service

Data Issues

This needs assessment has identified a significant lack of data regarding perinatal illness in Kent. A majority of cases of perinatal mental illness are managed outside of the MIMHS service. Yet there is no data available from the wider primary and social care system on the numbers of cases of perinatal mental illness. Amongst cases referred into the MIMHS service, there is no data regarding diagnosis and the counts of specific conditions. This makes it very difficult to assess the unmet needs and so it is difficult to plan and commission services, or to track how changes to the system impact on outcomes. The main specific issues are:

- Lack of data on numbers of perinatal mental illness cases seen in primary & social care (e.g. from GPs, health visitors, midwives, etc.)
- Lack of data of counts of specific diagnoses in the MIMHS service, which would allow for analysis of the caseload severity compared to prevalence estimates, variation across Kent, and greater clarity around the appropriate referral pathway.

MIMHS Workforce Issues

Guidelines set by the Royal College of Psychiatrists (2015) stipulate the minimum workforce capacity and skill mix that perinatal mental health services should deliver (see appendix). Current gaps in the MIMHS service include:

- Lack of capacity at MIMHS to take direct referrals, leading to delays on the referral pathways
- No dedicated consultant perinatal psychiatrist sessions in the DGS area.
- Shortage of specialist nurses (across all areas) compared to recommended levels in the guidance.
- Lack of non-consultant medical staff across the MIMHS service (e.g. junior doctor support)
- No holistic MDT in the MIMHS service, including social workers, psychologists, nursery nurses or occupational therapists, as recommended in the guidance.
- Lack of specialist parent-infant psychological services for perinatal mental health.

Wider System Issues

The system for addressing perinatal mental health needs is much wider than the MIMHS service, and in fact a majority of the cases will be seen by primary and social care services. Gaps in understanding and awareness of responsibilities towards perinatal mental illness may lead to failure to identify cases, or inappropriate referrals to the MIMHS service. Specific issues include:

- GPs are not always aware of when women with a history of mental illness become pregnant, when these women have the highest risk of experiencing perinatal mental illness.
- Lack of lead specialist mental health midwives in East Kent Hospitals Trust
- Inconsistent funding/provision across the county for voluntary sector provision of peer support groups.
- Lack of support for baby bereavement, which can be a trigger to mental illness
- Services tending to focus on individuals rather than taking a whole family approach (e.g. support for fathers)
- Lack of MBU in Kent, with significant travel distances involved to MBU in other regions
- Services for mothers under the age of 18 are not equitable and the transition between CAMHS and adult services transition is not smooth.

10 Recommendations

To address the gaps identified, we recommend the following; taking into account both the data from this needs assessment, and the views of service professionals in the clinical network:

- Introduce or improve routine data collection and data systems for perinatal mental illness in Kent, to allow for better long term planning and commissioning.
    - From primary care
    - From health visitors
    - From midwives and maternity services
    - From secondary mental health services
    - From the MIMHS service

- Address workforce gaps in the MIMHS service
    - Introduce consultant psychiatrist sessions in DGS
    - Consider increasing levels of specialist nursing staff
    - Junior doctor support for consultants in the MIMHS service
    - MDT support e.g. by social workers, OTs, nursery nurse
    - Specialist parent-infant psychological services

- Explore the potential for MIMHS to take direct referrals to streamline the referral pathway and reduce delays.

- Develop lead specialist mental health midwife posts in East Kent Hospitals Trust, as per other hospital trusts in Kent.

- Improved information for families about the range of perinatal mental health services available in Kent (e.g. via an app or publicity campaign)

- Whole system workforce education, with a particular focus on GPs

- Explore the potential for alerts on GP software systems when a woman with a history of mental health becomes pregnant.

- Commissioning of an ageless pathway so that services can be provided to mothers under the age of 18

- Mapping of voluntary sector peer support groups, systematically involving these groups in training, and ensuring equitable service availability in all localities

- Increased training and support for baby bereavement

- Ensure that IAPT services include staff with perinatal mental health training, and these cases are prioritised to ensure shorter waiting times for them in the maternity period.

Summary

This needs assessment has attempted to highlight the needs for perinatal mental health services in Kent. We have described the increasing policy interest in this area nationally, including a commitment for increased funding. We describe the latest population trends in Kent, such as an increase in the proportion of women of child-bearing age, the slight decrease in the maternity rate, and that the number of births will be stable in the near future at around 18,000 per year. Districts have similar maternity rates apart from Canterbury which is much lower. We explore the literature for risk factors for perinatal mental illness, with the most significant being: previous history of mental illness, traumatic birth or perinatal death, family history of mental illness, domestic violence, poor emotional and social support and low socio-economic status. We go on to described the current service provision across primary and social, secondary and tertiary care in Kent, and gaps in the service compared to the latest guidance and models of care. The main gaps identified are around data collection and systems, the workforce in the MIMHS service, and wider system issues around awareness and education of all professionals that interact with new mothers. Lastly, we propose a number of recommendations to meeting these needs, advocating for a 'whole system' approach to perinatal mental health in Kent.

APPENDIX: Workforce requirements for specialist perinatal mental health service as per Royal College Psychiatrists (2015) CR197

SPECIALIST	RECOMMENDED NUMBERS per 10,000 births	CCG AREA	REQUIRED NUMBERS PER CCG								
			Kent & Medway	Kent	Medway	Ashford	Canterbury	DGS	SKC	Swale	Thanet	West Kent
		BIRTHS 2014/15:	19929	16323	3606	1430	1730	3192	1919	1277	1532	5243
Consultant Perinatal Psychiatrist	1.0 WTE		2 WTE	1.6 WTE	0.4 WTE	0.1 WTE	0.2 WTE	0.3 WTE	0.2 WTE	0.1 WTE	0.2 WTE	0.5 WTE
Non-Consultant Grade Doctor	1.0 WTE		2 WTE	1.6 WTE	0.4 WTE	0.1 WTE	0.2 WTE	0.3 WTE	0.2 WTE	0.1 WTE	0.2 WTE	0.5 WTE
Community Team Manager (50% Manager/Clinical)	1.0 WTE		2 WTE	1.6 WTE	0.4 WTE	0.1 WTE	0.2 WTE	0.3 WTE	0.2 WTE	0.1 WTE	0.2 WTE	0.5 WTE
Specialist Community Nurses	5.0 WTE		10 WTE	8.2 WTE	1.8 WTE	0.7 WTE	0.9 WTE	1.6 WTE	1.0 WTE	0.6 WTE	0.8 WTE	2.6 WTE
Psychologist	1.0 WTE		2 WTE	1.6 WTE	0.4 WTE	0.1 WTE	0.2 WTE	0.3 WTE	0.2 WTE	0.1 WTE	0.2 WTE	0.5 WTE
Occupational Therapist	1.0 WTE		2 WTE	1.6 WTE	0.4 WTE	0.1 WTE	0.2 WTE	0.3 WTE	0.2 WTE	0.1 WTE	0.2 WTE	0.5 WTE
Social Worker	0.5 WTE		1 WTE	0.8 WTE	0.2 WTE	0.1 WTE	0.1 WTE	0.2 WTE	0.1 WTE	0.1 WTE	0.1 WTE	0.3 WTE
Community Nursery Nurses	2.5 WTE		5 WTE	4.1 WTE	0.9 WTE	0.4 WTE	0.4 WTE	0.8 WTE	0.5 WTE	0.3 WTE	0.4 WTE	1.3 WTE
Link Midwife	1.5 DAY		3 DAY	2.4 DAY	0.5 DAY	0.2 DAY	0.3 DAY	0.5 DAY	0.3 DAY	0.2 DAY	0.2 DAY	0.8 DAY
Link Health Visitor	1.5 DAY		3 DAY	2.4 DAY	0.5 DAY	0.2 DAY	0.3 DAY	0.5 DAY	0.3 DAY	0.2 DAY	0.1 DAY	0.8 DAY
Team Secretary/Admin	1 WTE		2 WTE	1.6 WTE	0.4 WTE	0.1 WTE	0.2 WTE	0.3 WTE	0.2 WTE	0.1 WTE	0.2 WTE	0.5 WTE

SPECIALIST	RECOMMENDED NUMBERS per 10,000 births	REQUIRED NUMBERS FOR CURRENT MIMHS COMMISSIONING CONFIGURATION				
		SERVICE	Maidstone & South West Kent	Dartford Gravesham Swanley	Medway & Swale	East Kent
		BIRTHS 2014/15	5243	3192	4883	6611
Consultant Perinatal Psychiatrist	1.0 WTE		0.5 WTE	0.3 WTE	0.5 WTE	0.7 WTE
Trainne Psychiatrist/Non-Consultant Grade Doctor	1.0 WTE		0.5 WTE	0.3 WTE	0.5 WTE	0.7 WTE
Community Team Manager (50% Manager/Clinical)	1.0 WTE		0.5 WTE	0.3 WTE	0.5 WTE	0.7 WTE
Specialist Community Nurses	5.0 WTE		2.6 WTE	1.6 WTE	2.4 WTE	3.3 WTE
Psychologist	1.0 WTE		0.5 WTE	0.3 WTE	0.5 WTE	0.7 WTE
Occupational Therapist	1.0 WTE		0.5 WTE	0.3 WTE	0.5 WTE	0.7 WTE
Social Worker	0.5 WTE		0.3 WTE	0.2 WTE	0.2 WTE	0.3 WTE
Community Nursery Nurses	2.5 WTE		1.3 WTE	0.8 WTE	1.2 WTE	1.7 WTE
Link Midwife	1.5 DAY		0.8 DAY	0.5 DAY	0.7 DAY	1.0 DAY
Link Health Visitor	1.5 DAY		0.8 DAY	0.5 DAY	0.7 DAY	0.9 DAY
Team Secretary/Admin	1 WTE		0.5 WTE	0.3 WTE	0.5 WTE	0.7 WTE

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