



Bristol Clinical Commissioning Group

Bristol JSNA Chapter

Perinatal Mental Health

November 2019

Chapter information	
Chapter title	Perinatal Mental Health
Chapter reference group	BNSSG Perinatal and Infant Mental Health Strategy Group
Chapter author(s)	Charly Williams, Senior Public Health Specialist and Nikki Symes, Principal Public Health Specialist (now left Bristol City Council), Public Health, Bristol City Council
Quality reviewed by who/date	BNSSG Perinatal and Infant Mental Health Strategy Group, 18.06.19; IMPROVE HIT, 16.07.19
Chapter approved by	Jo Williams, Consultant in Public Health, Bristol City Council
Linked JSNA chapters	Breastfeeding

Executive summary

1). Introduction

- 1.1 Improving support for mental health is high on local, regional, national and international agendas (HM Government 2011, WHO 2013, NHS 2015a, NHS 2015, NHS 2016, BCC 2018). The Department of Health has developed a plan for improving mental illness support and provision in England in their 5 year review. This identifies the need for improving mental health across the population throughout the life course, and emphasises that mental health should be afforded equal parity with physical health (NHS 2016).
- 1.2 Bristol City Council (BCC) has identified mental health as a priority and adopted a 10 year programme to support mental health and wellbeing via Thrive Bristol, launched in 2018. This programme aims to ensure that there is an integrated approach to mental health for all ages and communities, within and across services (BCC 2018).
- 1.3 The aim of this JSNA is to identify the mental health and well-being needs of women and families in Bristol during pregnancy and in the year after birth (the 'perinatal period'), review how well these needs are met, highlight gaps in service provision and make recommendations for improvements.
- 1.4 Perinatal mental health (PMH) care that supports women during pregnancy and the year after childbirth, has been identified as being variable across the UK, especially for the most vulnerable women, in terms of both reach and quality (NICE 2007, Hogg 2013, RPSYCH 2015).
- 1.5 The 5 Year NHS Plan seeks to address this by increasing the availability of support for mothers with the highest mental health needs with an increase in Mother and Baby in-patient beds in specialised units and the development of Specialist Community PMH Services (Hogg 2015). The plan also includes commissioning new PMH training, awareness-raising and education programmes, covering the full spectrum of needs. Regional Perinatal and Infant Mental Health Networks have been set up to enable this collaborative work to take place effectively (NHS 2016).
- 1.6 Maternal suicide is the third largest cause of direct maternal deaths occurring during or within 42 days of the end of pregnancy. However, it remains the leading cause of direct deaths occurring during pregnancy or up to a year after the end of pregnancy, with 1 in 7 women who die in the period between 6 weeks and one year after pregnancy dying by suicide (MBRRACE 2017).

- 1.7 It is vital that women with the highest need can access appropriate care to reduce the risk of maternal suicide. Women with existing severe and persistent depression/anxiety, personality disorder, bipolar or eating disorders and drug/alcohol problems may also require additional and specialist support throughout this vulnerable period as will women who develop the rare, but serious condition, puerperal psychosis (RCGP 2014). There is also a need for a greater focus on lower level PMH issues, in order to prevent needs from escalating.
- 1.8 The effects of PMH illness are often felt by the wider family, particularly children and partners/ fathers. It is acknowledged that a child's life experience from conception until age three can have a significant impact on their long-term health and social outcomes, and therefore effective PMH support during this period is equally as vital for children as it is for adults (Marmot 2010, Wave Trust 2013, EIF 2015, 1001 Critical days 2015, PHE 2016). There is also a need for a greater focus on infant mental health specifically.
- 1.9 Furthermore, it is critical to consider the needs of partners/ fathers experiencing PMH issues themselves or affected by their partner's PMH issues. However, data on mental health issues in new fathers is limited and there is often a lack of support available. This needs to be addressed.
- 1.10 Although exact figures are unknown, it is estimated that 10-20% of women experience mental health issues during pregnancy and the first year of life. This could mean that around a third of all children are born to a mother who has experienced mild-moderate mental health issues, and up to 1:20, to a mother who has an acute mental health issue. Research suggests that one in ten men may suffer from depression after becoming fathers (Fatherhood Institute 2010).
- 1.11 This suffering can go unnoticed and undiagnosed particularly as there may be isolation, stigma and fear associated with disclosure (RCGP 2014, Hogg 2014, Khan 2015, PHE 2016, RCOG 2017, BCC 2018). The NSPCC and Boots Family Trust (2013) report that 58% of mothers delay seeking support for fear of what may happen, and 30% never seek support. Generally, men are even less likely than women to seek support for mental health issues (Mental Health Foundation 2016).
- 1.12 Some mental health conditions are on-going, some are dormant but may exacerbate and others are new episodes. New episodes of poor mental health that develop perinatally are most commonly depression, anxiety and post-traumatic stress disorder (RCGP 2014). If undiagnosed and untreated, poor PMH can have an effect upon the attachment relationship, family relationships and long-term physical, emotional and social outcomes for all affected (Bauer 2014).

- 1.13 Some women are at increased risk of developing mental health illness perinatally. This includes women who have experienced a high number of Adverse Childhood Events (ACEs), young mothers, women living in poverty and those experiencing domestic violence (PHE 2016) and migration (Felmeth et al 2016).
- 1.14 Previous pregnancy loss such as a stillbirth, a neonatal death or recurrent miscarriage can also increase the risk of developing psychological problems. Some women experience difficulty during birth and develop post-traumatic symptoms where they re-live these difficult experiences and feelings.
- 1.15 Early intervention and improved diagnosis, treatment and support for women and their families can significantly reduce the impact of poor PMH on all affected (Hogg 2014, Khan 2015, RCGP 2016, RCOG 2016, PHE 2017).

2). Summary of key issues, gaps and recommendations

2.1 Below is a summary of key issues, gaps and recommendations identified for PMH support in Bristol. Section 7 describes the issues and gaps in more detail, while section 9 provides full recommendations.

Issues and gaps

Overarching

- 2.2 There is not currently an overarching, multi-agency PMH care pathway.
- 2.3 There are gaps in PMH training, for example, insufficient focus on infant mental health.
- 2.4 There is a need for more skill-sharing and co-delivery of PMH support across agencies.
- 2.5 There is a need to improve data and data sharing on PMH and infant mental health.
- 2.6 There is insufficient understanding and support for specific groups, including partners/ fathers.

Service specific

- 2.7 Mothers value continuity of midwifery care, but this is not always achieved.
- 2.8 There is insufficient coverage of PMH and infant mental health in antenatal classes.

- 2.9 The capacity of the Health Visiting Service to undertake home visits is limited.
- 2.10 There has been a reduction in Children’s Centres staff, impacting on their ability to meet rising need.
- 2.11 There is good breastfeeding support available but take up needs to be improved, especially amongst low prevalence groups.
- 2.12 There is good voluntary and community sector PMH provision, but families are not always aware or able to access it easily.
- 2.13 The need for the Primary Infant Mental Health Specialist Service outstrips its capacity. There is a rise in demand for infant mental health training.
- 2.14 There are not enough Mother and Baby Unit beds available locally.

Recommendations

Overarching

- 2.15 Develop an over-arching, multi-agency PMH care pathway.
- 2.16 Ensure that families and professionals are aware of, and can easily access, existing universal provision that supports good mental health.
- 2.17 Ensure that the voices of those with lived experience are acted upon.
- 2.18 Consider how to better understand and meet the needs of specific groups in relation to PMH.
- 2.19 Increase multi-agency training opportunities for PMH and infant mental health.
- 2.1 Increase skill-sharing, partnership working and co-delivery of PMH support across agencies.

Service specific

- 2.20 Improve PMH and infant mental health input into antenatal classes.
- 2.21 Progress and prioritise LMS plans to achieve continuity of care.
- 2.22 Raise the profile of breastfeeding support services across the city.

- 2.23 Facilitate greater involvement of social workers in PMH planning and delivery.
- 2.24 Raise awareness of VCS PMH provision.
- 2.25 Consider how best to meet the rising demand for the Primary Infant Mental Health Specialist Service.
- 2.26 Ensure there is a clear pathway and ease of access for parents into the Improving Access to Psychological Therapies (IAPT) service.
- 2.27 Review the role of the Specialist Community PMH Service in training, upskilling and outreach to the wider workforce.

JSNA chapter report

A: What do we know?

1). Who is at risk and why?

- 1.1 PMH conditions are common, they can be new or long standing and exacerbate, there may be co-morbidity, and they can sit anywhere along a spectrum of mild to severe. There are numerous factors that increase the risk of developing PMH conditions.
- 1.2 Mothers are at increased risk of developing new mental health conditions, such as depression, anxiety, adjustment disorder and post-traumatic stress disorder, during the perinatal period (RCOG 2015, RCGP 2014 and 2016). There is also a greater risk of existing mental health conditions, such as bipolar disorder or schizophrenia, becoming worse. Some mothers experience a recurrence of former mental illness, and the risk of a psychotic episode is increased.
- 1.3 The RCOG (2017) identify several 'red flags' for developing a serious PMH illness, including severe mental health issues in pregnancy, previous history of mental health problems, a family history of poor mental health and a difficult birth.
- 1.4 The early identification of women who are at risk of developing or experiencing a deterioration of their mental health is essential to support good outcomes. Partners/fathers may also experience mental health issues for the first time during this period, or an exacerbation of existing mental health condition(s) (PHE 2017).

Partners/fathers

- 1.5 The effects of PMH problems are often felt by the wider family, particularly partners/fathers. For example, maternal depression is the strongest predictor of paternal depression during the postpartum period and studies into postnatal depression in men suggest that one in ten may suffer from depression after becoming fathers (Fatherhood Institute 2010).
- 1.6 However, data on mental health issues in new fathers is limited, partly because of under-diagnosis. Recent research by the Mental Health Foundation (2016) highlighted high rates of undiagnosed mental health problems in men that are not being adequately identified or supported through current service provision. This emphasises the importance of addressing PMH issues in order to support partners/fathers as well as mothers.

Children

- 1.7 Babies and children thrive when secure emotional attachments are made in the first few weeks, months and years of life, with the first 1001 days being considered a particularly critical time period during which there is significant brain development (The 1001 Critical Days 2015). Emotional attachments are formed through close and

responsive interactions between infants and their primary carer(s), and are considered to be the foundations upon which good mental health is laid down (EIF 2018).

1.8 PMH issues experienced during this period can adversely affect the ability of a mother/carer to parent positively, and is the most prevalent risk factor for poor child development. The partner/ father-infant relationship is also important in terms of infant mental health and child development. Severe depression in fathers has been found to be associated with high levels of emotional and behavioural problems in their infant children, particularly boys (Bauer et al 2014).

1.9 Overall, poor PMH of mothers or fathers/ partners can have a significantly detrimental impact on the physical, psychological, behavioural and educational outcomes of children, and incurs considerable health, social care and societal costs in both the short and long term (Bauer et al 2014).

1.10 However, timely identification, treatment and support for those experiencing PMH issues can minimise the effects on children, as well as their parents (RCGP 2014), improving short and long term outcomes (Khan 2015). As part of this, infant mental health specialists are able to provide support to parents where the attachment relationship is at risk.

Risk factors for PMH illness

1.11 The causes of PMH illness are complex but there are some risk factors that increase the likelihood of this being experienced (Hogg 2013, BCC 2018), including:

- History of mental illness
- Family history
- Anxiety/depression in pregnancy
- Lone parenthood/ poor couple relationship
- Low levels of social support
- Recent adverse stressful life events
- Socio-economic disadvantage (poverty, social exclusion, domestic violence and poor housing)
- Teenage parenthood (risk is twice as high)
- Early emotional trauma/abuse
- Unwanted pregnancy
- Traumatic birth

1.12 A previous bereavement caused by miscarriage, stillbirth or neonatal death can also increase the risk of mental health problems in both parents (RCGP 2014). The risk of developing puerperal psychosis is increased if there is a family history of psychosis or a personal history of bipolar disorder (RCGP 2014).

Adverse Childhood Experiences (ACEs)

1.13 ACEs can have a significant impact on lifelong health and opportunity.

Experiencing high numbers of ACEs has been linked to poorer outcomes, an increase in risky health behaviours, chronic health conditions, a shorter life span and even early death. ACEs are often linked to the development of poorer mental health. Experiencing multiple ACEs increases the risk of developing PMH issues. ACEs are defined as stressful events experienced during childhood and include;

- Domestic violence
- Parental abandonment through separation or divorce
- A parent with a mental health condition
- Being the victim of abuse (physical, sexual and/or emotional)
- Being the victim of neglect (physical and/or emotional)
- A member of the household being in prison
- Growing up in a household in which there are adults misusing substances

Teenage parents

1.14 Teenage parents experience many health and social inequalities and may have experienced high numbers of ACEs. They are more likely to enter parenthood with existing vulnerabilities, including poorer mental health. Teenage mothers are three times more likely to experience postnatal depression and have higher rates of poor mental health than older mothers. Young fathers are more likely to have pre-existing mental health issues such as anxiety, depression and conduct disorder. In addition, teenage mothers are a third less likely to start breastfeeding and half as likely to still be breastfeeding at 6-8 weeks (PHE 2016).

Breastfeeding and mental health

1.15 Breastfeeding can support the development of close and loving relationships between mothers and babies, supporting attachment and psychological 'attunement'. Mothers who breastfeed have a reduced risk of developing postnatal depression (PHE and UNICEF 2016), as it can increase resilience to stress, improve the quality of sleep (Kendall Tackett K et al 2011) and promote bonding.

1.16 However, in the UK where breastfeeding rates are low, women experience many social, cultural and physical barriers to successful breastfeeding and sometimes do not receive the practical support they need to successfully breastfeed. In the last National Infant Feeding Survey, 8:10 women stopped breastfeeding before they wished to do so (McAndrew et al 2012). This can be a source of sadness and grief (Jacobsen 2016, Trickey 2017).

1.17 When breastfeeding has not worked out, this can adversely affect women's mental health (RCOG 2017). Women who experience anxiety in the perinatal period may also find the establishment of breastfeeding difficult (Fallon et al 2016). The women who are least likely to breastfeed (white women living in deprived areas, and

women under 25) are also at increased risk of developing postnatal depression.

The incidence of PMH illness

1.18 Although absolute numbers are not known nationally, it is estimated that 10-20% of women develop mental health issues during pregnancy and the year after childbirth, including depression, anxiety and more rarely, psychosis. Approximately 13% experience an anxiety disorder and 12% experience depression (PHE 2017). Not all PMH illness involves a single diagnosis. Anxiety and depression are often co-morbid (RCGP 2014).

1.19 Up to one in five women and one in ten men are affected by mental health problems in the perinatal period. It is thought that up to 50% of cases of depression or anxiety may go undetected and, of those detected, many are not treated (Hogg 2014). Even if women confide in a health professional, many mothers feel that they are unable to voice the true depth of their feelings (Hogg 2014). Men are generally even less likely than women to seek help for mental health issues (Mental Health Foundation 2016). It is estimated that for every 12,000 mothers who give birth each year, over 1,000 will experience depression and/or anxiety sufficient for them to benefit from treatment (Bauer 2014).

1.20 Severe mental health issues are estimated to occur in 1-2:1000 women. This includes; severe depressive illness, schizophrenia and bipolar disorder (PHE 2017). Death from suicide remains the leading cause of direct maternal deaths occurring during pregnancy and up to a year after the end of pregnancy (MBRRACE 2017). This was sadly experienced in Bristol in 2014, with the double tragedy of a mother and baby death (Keeping Bristol Safe Partnership, Serious Case Review 2017).

The costs of PMH illness

1.21 It has been estimated that the costs of treating mothers with perinatal depression, anxiety and psychosis in England is around £8.1 billion per year. This is just under £10,000 per birth. Almost three-quarters (72%) of this cost relates to adverse impacts on the child. Over a fifth of the total costs (£1.7 billion) are borne by the public sector, with the bulk of these falling on the NHS and social services (£1.2 billion) (Centre for Mental Health 2014).

1.22 The average cost to society of one case of perinatal depression is around £74,000, of which £23,000 relates to the mother and £51,000 relates to impacts on the child. When it exists alone and is not co-morbid with depression, anxiety costs about £35,000 per case, of which £21,000 relates to the mother and £14,000 to the child (*Ibid.* 2014).

1.23 Perinatal psychosis costs around £53,000 per case, however, this is almost certainly an under-estimate because of the lack of evidence about the impact on the child; costs relating to the mother are about £47,000 per case, roughly double the equivalent costs for depression and anxiety (*Ibid.* 2014).

1.24 The costs incurred by the impact of perinatal depression on children are estimated in the table below, and include the impact on health and social care, education, the criminal justice system, quality of life year losses and productivity.

Table 2: Costs of perinatal depression, impact on children, £ per case

	Public sector			Wider society			Total
	Health and social care	Education	Criminal Justice	QALY losses	Productivity losses	Other	
Pre-term birth	974	-	-	418	22	14	
Infant death	-	-	-	22,157	-	-	
Emotional problems	1,020	-	-	4,609	2,169	-	
Conduct problems	837	-	1,974	3,396	1,797	7,446	
Special educational needs	-	3,166	-	-	-	-	
Leaving school without qualifications	-	-	-	-	1,463	-	
Total	2,831	3,166	1,974	30,580	5,451	7,460	51,462

Figure 1: Costs of perinatal depression – Impact on children (Centre for Mental Health 2014)

1.25 The costs of PMH problems demonstrate the huge potential benefits of intervention. Even modest improvements in outcomes as a result of better services would justify the additional spending in terms of value for money (Centre for Mental Health 2014).

2). What is the size of the issue in Bristol?

2.1 In 2017/18, there were 6,171 births (live and stillbirths) in Bristol and 6,067 maternities (women who gave birth) (South West Clinical Network Maternity Dashboard 2019).

2.2 Rates per 1,000 maternities of new mothers with perinatal psychiatric disorders are shown in the table below, with estimates of how many women are affected locally.

2.3 Limited research on prevalence rates in men means that local estimates would be unreliable. This is recognised as a gap locally and nationally, with actions planned to address this.

Severe PMH conditions	Rates per thousand maternities	Estimated numbers in Bristol
Postpartum psychosis	2 per 1,000	12
Chronic Serious Mental Illness	2 per 1,000	12
Severe depressive illness	30 per 1,000	186
Mild/moderate depressive illness and anxiety states	100-150 per 1,000	620-930
Post- traumatic stress disorder	30 per 1,000	186
Adjustment disorders and distress	150-300 per 1,000	930-1860

Figure 2: Rates of perinatal mental health conditions per 1000 maternities (Royal College of Psychiatrists 2015) and estimated local prevalence rates

3). What is the evidence of what works?

3.1 Best practice guidance has been developed for women identified as needing PMH treatment/support. This includes women being seen within two weeks of referral and beginning treatment within a month (NICE 2006). The RCOG (2017) recommends that there should be lots of information about PMH available to women and their families during pregnancy and there should be clinically supervised and trained local peer support networks available with appropriate referral pathways.

3.2 The RCOG also recommends that bereavement and couple support after stillbirth and multiple miscarriages is automatically offered to women and their partners. Women who have experienced a traumatic birth should be seen and assessed before discharge, and delivery wards should have a mental health lead (RCOG 2017).

3.3 In addition, the RCOG recommends that high-quality support is available for partners before and after birth. Addressing the needs of partners/ fathers and the wider family, as well as mothers, should be standard practice according to NICE guidelines and national policies, which all reference family centred care.

3.4 The National Maternity Review: Better Births highlights the importance of continuity of care as it improves safety and is better for mental health support, as well as a wide range of other maternal and child outcomes (NHS 2016, RCOG 2017)

3.5 Effective identification, treatment and support for women and fathers/partners with PMH issues requires timely interventions from a range of universal and specialist services working in partnership. A multiagency approach is important and should include Maternity Services, Health Visiting Services, Children's Centres and, often, VCS services. Women and families require care that is co-ordinated within and between services. This requires clear care pathways and excellent communication

between agencies.

3.6 The aim of PMH services should be to identify, as early as possible, actual or potential mental health issues, refer/signpost to appropriate support as needed, minimise risk, enhance wellbeing, and support mothers/ carers and babies to form a secure emotional attachment.

3.7 Specialist support is sometimes required, including generic mental health hospital/community and crisis services, Specialist Community PMH Services, Infant Mental Health Services and in-patient Mother and Baby services.

3.8 It is also thought that work to improve the management of mental illness, including avoidance of environmental risk factors e.g. stress/sleeplessness, and prompt and informed choices around medication, can reduce risk further (Hogg 2015).

3.9 It is hoped that the recent rise in awareness of mental health issues across the life course will help to increase acceptance and reduce stigma around PMH issues. Being able to ask for help from family, friends, the wider community and professionals without fear is important for those struggling with PMH issues.

3.10 In addition, it is important to ensure that families and practitioners are aware of, and can easily access, high quality universal services that promote good mental health and reduce the risk of needs escalating. Promoting a healthy pregnancy through self-help tools such as exercise, meditation, peer support and a personal wellbeing plan (e.g. Tommy's Wellbeing Plan) can be very effective in terms of prevention and early intervention.

Antenatal routine contacts should involve:

- Knowledgeable professionals, who can identify PMH issues, support and promote mental wellbeing, and offer effective coping mechanisms e.g. Five Ways to Wellbeing.
- Clear referral pathways when issues are identified
- Community and leisure services, to promote health and wellbeing
- Activity to support women to reduce smoking, drugs and alcohol

Women who are coping with new parenthood should have access to:

- Programmes and multiagency pathways that reduce risk factors affecting pregnant women e.g. caused by poverty and abuse
- Advice to promote good mental health e.g. mindfulness and relaxation
- Breastfeeding support which promotes good bonding and attachment
- Baby massage to encourage strong attachment and build supportive relationships

Women who are struggling should have access to:

- Immediate evidence based mental health support, at the intensity required, including:
 - A clear, integrated care pathway
 - Facilitated self-help
 - Advice re. sleep hygiene
 - Breastfeeding support
 - A Specialist Perinatal Clinician at each birthing facility

Women who are unwell should have access to:

- A fast track to a high quality psychological intervention (e.g. IAPT)
- Access to Specialist PMH Services
- Integrated services that work together

NICE guidance

3.11 NICE antenatal and postnatal mental health clinical management and service guidance recommends that there should be a Specialist Multi-disciplinary Mental Health Service, with mental health access to specialist advice about psychotropic medication during pregnancy and breastfeeding.

3.12 NICE recommends that sensitive discussions around mental health are held during and after pregnancy at all contacts with health professionals that can support and encourage women to voice how they really feel and gain access to the support they need. They recommend using evidence based screening tools, such as the Whooley questions, Generalised Anxiety Scale questions (GAD 2 scale) and Edinburgh Postnatal Depression scale, to support diagnosis and pave the way for supportive, honest conversations (NICE 2014).

The Royal College of Obstetricians and Gynaecologists (RCOG) guidance

3.13 The RCOG have produced guidance around best practice recommendations to support women experiencing PMH issues:

- All women requiring admission to a Mental Health Unit in late pregnancy or after delivery should be admitted with their infant to a specialised Mother and Baby unit, unless there are compelling reasons not to do so.
- All women in pregnancy or following delivery requiring specialist mental health services (including those at risk of serious illness) should have access to care and treatment from a Specialised Perinatal Community Mental Health Team (CMHT).
- Every health region should have a PMH strategy and a PMH integrated care pathway. This should cover all levels of service provision and types and severities of disorder.
- Specialised units with at least 6 mother and baby beds should be provided to serve the needs of large populations with 15,000 to 20,000 deliveries. These

should relate to specialised perinatal CMHTs existing within each mental health provider in a hub-and-spoke fashion, promoting seamless continuity of care and effective use of resources.

- Mother and Baby Units should be accredited by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) and specialised perinatal CMHTs should be members of the CCQI Appraisal Network.
- Specialised perinatal services should have close working relationships with Adult Mental Health, Child and Adolescent Mental Health Services (CAMHS), Maternity Services, Health Visitors and Children's Social Services.
- Adult mental health services should ensure that perinatal women receive specialised care.
- Adult psychiatric services should ensure that women with a serious psychiatric disorder are counselled about the effects of pregnancy on their condition and receive information and advice about the possible effects of their medication on pregnancy.
- Maternity Services should ensure that the mental health needs of women are met, including additional training for midwives to detect at-risk women during pregnancy and to enquire about women's current mental health.
- Psychological therapy services (including Improving Access to Psychological Therapies (IAPT)) should ensure that the needs of perinatal women are met, which includes receiving additional training and ensuring that women are assessed and treated within one month.
- Primary care services should ensure that the mental health needs of perinatal women are met; this includes familiarity with the PMH integrated care pathway and ensuring that Health Visitors receive additional training.

Recommendations around support with breastfeeding and mental health

3.14 It is important that mothers receive skilled support with breastfeeding given the significant links between breastfeeding and mental health (UNICEF Baby Friendly Initiative 2018). Support is also needed for women who are unable to breastfeed or choose to stop. Delivering or commissioning effective breastfeeding support services is therefore an important element of improving overall PMH support.

3.15 It is important that those involved in breastfeeding support services have effective training in PMH. The Maternal Mental Alliance has published a PMH Competency Framework for professionals and volunteers working in this field, to guide this work (MMHA 2018).

3.16 In addition, women need accurate advice and information about breastfeeding whilst taking medication, including medication for mental health conditions. Professionals should follow The Avon and Wiltshire Prescribing Guidance for Mental Health Prescribers and GPs in PMH (MG18) in relation to this.

Recommendations around parenting and infant mental health support

3.17 Research by the Early Intervention Foundation (2017) found that parents who undertook an evidence-based parenting programme demonstrated increased parenting teamwork, sensitivity and warmth. Children had improved self-regulation and social competence, while parents experienced less stress, conflict and depression. This demonstrates the importance of good quality, evidence-based parenting support, and its potential in reducing PMH issues amongst parents.

3.18 A recent report, 'Rare Jewels', by Parent Infant Partnership UK (2019) highlights the importance of services that support and strengthen the relationship between babies and their parents, and the link this has with PMH. Infant mental health specialists working within these services are able to provide support to parents where the attachment relationship is at risk. This is an important overall component of PMH support.

4). What services / assets do we have to prevent and meet this need?

4.1 Bristol has many universal, targeted and VCS services that provide support for families experiencing perinatal and infant mental health issues, and lots of progress has been made in training staff, however, there are still gaps and areas for improvement.

Services

4.2 General Practitioners (GPs)

- Manage medication pre-conceptually, during pregnancy and after birth.
- Support and monitor mothers mental health pre-conceptually, during pregnancy and after birth.
- Refer to other services for assessment, treatment or support via antenatal and postnatal referral pathways.
- Two local GPs have recently been given temporary, part-time roles, funded by NHSE, as PMH Champions, to promote models of best practice and provide training updates in PMH to GPs across Bristol. They join other PMH GP Champions across the South of England, following the successful 'Spotlight Project' which trialled this approach in Wessex.
- The PMH GP Champions are funded to deliver 20 training sessions across the Bristol area. They have delivered 15 so far and will focus the remaining sessions on the most deprived areas of the city.
- The training gives an overview of PMH, including PMH conditions, explores barriers to disclosure, highlights the need for GPs to be proactive in asking about PMH during routine appointments, covers local services and referral pathways, and provides an update on medication.

4.3 Maternity Service

- Midwives are trained to screen mothers for PMH issues at booking using approved tools - Generalised Anxiety Score (GAD 2 or 7) and the Whooley questions for depression, referring women for further assessment and support as needed.
- Each Maternity Unit has a PMH support service and runs a weekly Consultant clinic and triaging service. The teams consist of a Consultant Obstetrician with a special interest in PMH, a Mental Health Nurse and a Midwife. Pre-clinic, a triage meeting is held supported by a member of the Specialist PMH team.
- Women are also signposted to additional support such as IAPT and local community services.
- The service also run antenatal education sessions, which include PMH.
- Midwives and obstetricians attend various PMH training, for example, the RCOG run a two day multi-agency training conference on PMH once a year and obstetricians from Bristol have attended.

Southmead Hospital

- Has a Bereavement/PMH Mental Health Nurse who supports mothers and staff and runs training. Mothers can self-refer or be referred.
- Run a Birth Afterthoughts service to provide opportunities for de-briefing after a difficult birth.
- Specific antenatal classes are on offer to parents who have experienced a previous pregnancy loss.
- Substance Misuse Midwives provide support for mothers misusing substances in pregnancy, including those in treatment.

St Michael's Hospital

- Has a PMH Midwife and Mental Health Nurse who supports mothers and staff and runs training. Mothers can self-refer or be referred.
- There is a psychology service that provides support to mothers who have found their birth traumatic/suffered bereavement.
- Substance Misuse Midwives are also employed.

4.4 Health Visiting Service

- A Health Visitor Clinical Lead co-ordinates work around perinatal and infant mental health within the service.
- A PMH care pathway, including screening, signposting and referral, is complete and in use.
- The team routinely screen mothers for PMH issues at every mandated contact, with a particular focus on the 6-8 week contact, which is also when PMH data is captured.

- The service is working towards routinely screening fathers/ partners at these contacts, as well as mothers.
- Other contacts include weekly child health hubs, weaning and postnatal groups. All contacts offer opportunities to support women experiencing PMH.
- More home visiting is offered to families with additional identified needs, including women with PMH issues.
- The Health Visiting team are all currently receiving training on PMH (Institute of Health Visiting PMH Champion training). This is expected to be complete by early 2020.
- There are plans for PIMHS to train Health Visitors who have not yet undertaken Solihull training.
- The team refers mothers and children to PIMHS for guidance and support with attachment, behavioural or emotional concerns. In many of the families there is often a PMH component to the referral.
- There is an Early Relationships Health Visitor working in the East/ Central area of the city, who works with families experiencing difficulties, often with a background of PMH and ACEs.

4.5 Family Nurse Partnership (FNP)

- The Family Nurse Partnership (FNP) is an evidence based programme that provides intensive nursing support to teenage mothers, partners/ fathers and babies.
- Bristol has commissioned the service since 2014 and employs 4 nurses who carry a caseload of 23 each.
- Parents are engaged voluntarily in the service from pregnancy until the child is aged 2 years old.
- There is a focus on building the attachment relationship and screening and support for PMH.

4.6 Children's Centres/ Early Years services

- There are a number of services that support attachment and mental health hosted or run by Children's Centres, including:
 - 1:1 family support including some home visits
 - Rockabye and Antenatal Rockabye
 - Video Interaction Guidance, used to support parent-infant attachment and responsive parenting (two members of staff are trained to deliver this)
 - 'Circle of Security', an evidence-based infant attachment programme for parents of 0-2 year olds, which operates in the North, Central and East.
 - A session run by Children's Centre staff as part of the Maternity Service Antenatal Education programme, on infant attachment and mental health.
 - Bluebell Mother's Comfort Zone groups
 - Baby and toddler groups
 - Baby massage and baby yoga
 - Postnatal groups

- Some Children's Centres offer enhanced mental health provision, including St Paul's Children's Centre, which runs a structured 6 week postnatal group that includes a focus on emotional wellbeing and attachment and an 'Art for Mental Health' group.
- Children's Centres also offer enhanced support to families experiencing adversity or from excluded groups, who are at greater risk of PMH issues, including families living in poverty, young parents, families experiencing domestic violence, Gypsies, Roma and Traveller communities and families of prisoners.
- Many Children's Centre staff were trained in Mental Health First Aid in 2017 and some but not all have undertaken specific PMH training. Some staff have received Solihull training, but this is inconsistent across the service.

Rockabye

- Rockabye is a Bristol City Council Early Years commissioned service for Bristol Children's Centres to support mothers with the attachment relationship and to improve 'reflective functioning'.
- It is aimed at parents (mostly mothers) who have babies 2-8 months old.
- Mothers/ families can be referred or self-refer.
- The groups are based on dance movement therapy and include supported 'talk time' and activities to encourage attachment/connection with baby, including music and singing together.
- The Rockabye team have already trained a number of Children's Centre staff and are currently training more Children's Centre staff, as well as staff from Mothers to Mothers. Those who are trained receive ongoing support from the Rockabye team.

Antenatal Rockabye

- Antenatal Rockabye was developed by the Rockabye service to help parents to develop an emotional connection with their baby antenatally.
- The aim is to improve 'reflective functioning' that supports the development of a secure emotional attachment relationship.
- It is being evaluated by Exeter University and two Children's Centres, one in the Central area and one in the North, are delivering this. There are plans to roll this out across the city.
- Mothers who attend include those who have current mental health issues, have experienced ACE's and/or who have suffered a previous bereavement (late miscarriage, stillbirth/neonatal death, termination for abnormality), traumatic birth, or infertility.
- Mothers can be referred or self-refer.

'Welcome to the World' Antenatal Nurturing Programme

- A number of staff in Children's Centres were trained to deliver this programme and, until the restructure in 2018, it was offered in one centre in the North and one in the South. It is not currently being delivered.
- It is an evidence based 8 week programme for parents, run in partnership with Midwives. Parents were referred to the programme.
- The programme includes support around attachment and mental health.

4.7 Breastfeeding support services

- Bristol City Council (Public Health) commissions Bristol Breastfeeding Support Service to provide a network of groups, peer supporters and counsellors to support women with breastfeeding, including 1:1 home visits for women in areas where breastfeeding rates are the lowest. The service also signposts mothers to additional PMH support where needed.
- The volunteer breastfeeding peer supporters cover PMH and signposting in their training/updates.

4.8 Voluntary and Community Sector (VCS) services

Mothers for Mothers

- Established for 38 years.
- Offers 1:1 buddy support, phone support, home visits, peer support groups, counselling, art psychotherapy and dads/ partners support. The Reach service provides a new weekend helpline in partnership with Bristol Mind.

Bluebell

- Bluebell offers:
 - 1: 1 Bluebell buddy service providing home and phone support
 - Structured 12 week groups run in Children's Centres across the city called Mum's Comfort Zone, using Occupational Therapy and Cognitive Behavioural Therapy principles.
 - A service for dads, called 'Dads in Mind', providing telephone and group support across the city.
 - Bluebell Place, a wellbeing hub, which opened in September 2017 and offers weekly antenatal and postnatal drop-in support and activities.

Home Start

- A national charity offering a trained volunteer support worker for families experiencing particular hardship or difficulties e.g. PMH issues or parents with multiples.

Project MAMA

- Project MAMA was set up in 2017 and offers 1:1 and group-based support for asylum seeking and refugee women during pregnancy and postnatally.

4.9 Primary Infant Mental Health Specialists (PIMHS)

- PIMHS is part of CAMHS and supports families with children aged 0-5 who are experiencing difficulties around attachment, including PMH issues.
- They offer supervision, support and training for staff in Health Visiting and Children's Centres.
- There were 240 referrals to the service across Bristol and South Gloucestershire from April 2018 to March 2019, with 64 referrals declined. This is a significant increase compared to the same period last year. Possible reasons for this include a rise in the under 5 population, reductions in funding for early intervention, early years services, and higher thresholds for First Response and Social Care.
- Babies under a year are prioritised and seen within a month.
- Referrals received are often based on difficulties experienced with the attachment relationship and include; behavioural issues, anxiety, emotional dysregulation, social communication, trauma in relation to domestic violence, parental mental health, feeding difficulties, sleeping difficulties, selective mutism and the impact of parental conflict.
- The service uses a variety of tools including; Neonatal Behavioural Observations (NBO) (13 across the city this year), Video Interaction Guidance, 'Watch, Wait and Wonder' and parent-infant relationship work.
- The team also offer Solihull training, run 3-4 times a year across Bristol and South Gloucestershire.
- The team regularly offer consultation to the Health Visiting teams and Children's Centres.

4.10 Increasing Access to Psychological Therapies (IAPT)

- Provides group and individual support – mostly cognitive based therapy (CBT) but also some counselling.
- Clients can self –refer or be referred.
- Bristol IAPT was re-commissioned in May this year.
- The new service specification was developed in line with national guidance and reflects feedback received during the re-commissioning consultation on the need to strengthen access and support for parents with PMH needs.

4.11 Specialist Community Perinatal Mental Health (PMH) Service

- This was launched in February 2017 for women with pre-existing mental health issues that may worsen or women who have developed serious PMH issues. The service:
 - Receives referrals, triages and then either signposts to other services or offers a service itself.
 - Offers multidisciplinary support for women who have moderate to high needs.
 - Cares for approximately 300 women a year.
 - Offers an advisory service including specialist pharmacy information and advice for; GP's, Obstetricians, Midwives, Health Visitors, Children's Centres and other mental health services.
- The service is currently being external evaluated by the IMPROVE HIT (see 4.13). This should be complete by the end of 2019.

4.12 In-patient Services (Mother and Baby Units)

- The New Horizons Mother and Baby Unit (MBU) is based at Southmead Hospital and has space for 4 mothers and babies with high need. NHSE funding has been secured to expand this provision to 8 beds although this has not happened yet.
- Mothers can be admitted from 36 weeks of pregnancy onwards up to one year after birth.
- NHS England also recently commissioned a new 8 bed MBU in Exeter's Wonford House, which opened in May 2019.

Strategic work (PMH networks, groups, research etc.)

4.13 Improving PMH (IMPROVE) Health Improvement Team (HIT)

- The IMPROVE HIT is co-led by Bristol University and Bluebell.
- The IMPROVE HIT is focusing on four main areas; development and evaluation of the Community Specialist PMH team, improving pathways of support, training/education and increasing access to antenatal Children's Centre support.
- The increasing access to antenatal support stream of the HIT worked to register more mothers via the Midwifery Service and has made some films about Children's Centres. Children's Centres in turn invited women to events and introduced their services. An evaluation is planned of the work to see whether registering with a Children's Centre and raising the profile of the support available increased antenatal access and/or engagement with Children's Centres post birth.
- The HIT members engaged in the consultation on the IAPT recommissioning.
- The IMPROVE HIT is currently defining its priorities for the year ahead.

4.14 Bristol, North Somerset and South Gloucestershire (BNSSG) Local Maternity System (LMS)

- The BNSSG LMS is working on four main areas as part of the Local Maternity Transformation Plan; Safer Care, Continuity of Care, Personalisation and Postnatal Care. PMH is included in the Postnatal Care work stream. This work stream is led by the BNSSG Perinatal and Infant Mental Health Strategy Group (described below).
- The Continuity of Care work stream includes a pilot which aims to increase the number of women who receive continuity of care across the maternity pathway. This includes support for women who have experienced previous pregnancy bereavement. There is also a planned subgroup on antenatal education, which should include PMH education and awareness-raising.

4.15 BNSSG Perinatal and Infant Mental Health Strategy Group

- The purpose of this group is to provide strategic oversight, pathway planning and joint working protocols across the BNSSG footprint for perinatal and infant mental health services, with the intention of improving pathways, standards, processes and patient experience.

4.16 Infant Nutrition and Nurture Network

- The multidisciplinary Infant Nutrition and Nurture Network (INNN 2013-2018) and Public Health/Early Years network groups have included presentations by commissioned and voluntary services that support mothers and baby's emotional wellbeing. Both groups stopped running due to changes in services and restructures, however, the INNN recently re-launched as part of the LMS Infant Feeding subgroup.
- The INNN will soon offer 'Lunch & Learn' sessions as an opportunity for shared learning, knowledge and skill development, and networking for anyone with an interest in infant nutrition and nurture in BNSSG.

4.17 Bristol Safeguarding Board

- A PMH protocol and care pathway was developed in 2017 by the Bristol Safeguarding Board following two baby deaths and one maternal death where the mothers were suffering from severe mental ill health.

4.18 Local research

- New research began at Bristol University in 2017 on the intergenerational transmission of mental health issues. €1.5m of European Research Council funds have been won to investigate how a mother's mental health and personality can affect her child. The researchers will look at how 300 mother-and-infant pairs interact with one another by analysing data captured by cameras worn on the head and by devices that track eye movement.

- The data will help the researchers establish how a mother’s parenting behaviour is affected by her personality and mental health and how this can in turn affect her child’s mental health. A further research grant has been awarded and will focus on psychological treatments for prenatal depression.

4.19 Local awareness raising campaigns

- Recent awareness raising campaigns and actions have included:
 - The Perinatal Positivity Campaign (2017), which raised awareness of PMH, including support available. It included a film and posters and cards which were distributed across the city.
 - Local parent’s stories on film, by Bluebell and Sports Relief.
 - Bristol City Council Early Years website, which now has a page for staff and parents on the emotional wellbeing of mothers, fathers and babies.

4.20 Self-care promotion

- Self-care has been highlighted as an important way of managing mild/moderate mental health needs during pregnancy and after the birth.
- This encourages mothers who are currently suffering, or at risk of developing, mental health issues, to look after their own mental health and wellbeing, for example, through exercise or meditation.
- The Tommy’s charity Wellbeing Plan is a NICE endorsed tool to support self-care which should be promoted to pregnant and new mothers.

5). What is on the horizon?

Nationally

5.1 The NICE Antenatal and Postnatal guidelines are currently being reviewed. This will include refreshed guidance on PMH.

Locally

- Commissioning of the IAPT service completed, 2019
- Completion of Health Visitor PMH training, early 2020
- Children’s Centres to re-introduce ‘Five to Thrive’ across all centres to support mental health, wellbeing and attachment, 2019
- Local Maternity System PMH subgroup plans, 2018/19
- Local Maternity System Antenatal Education subgroup plans, 2019
- Evaluation of the Specialist PMH Service, 2019
- Evaluation by Plymouth University of Antenatal Rockabye and Rockabye programmes, 2019
- Evaluation of the IMPROVE HIT increasing access to antenatal support in Children’s Centres research, 2019

6). Local views

Thrive Bristol

6.1 The Bristol Thrive Report (2018) highlights a number of strengths and gaps around PMH. The report identifies that pregnant women prefer to have consistent midwifery support but that this does not always happen. It also notes that women often do not feel there is enough time to open up about their feelings during routine appointments.

6.2 The report recognises that Children’s Centres play an important role in offering support e.g. antenatal groups and parenting classes, but that some women may require outreach support to access these services. They recognise that there are some good exercise and leisure activities available for pregnant women and young families e.g. yoga and swimming, but sometimes there is a charge that can affect access. The report also highlights concerns around capacity issues for community services that support vulnerable women with mental health issues.

Whose Shoes Workshop – 4th May 2017

6.3 An event was held in 2017 to gain the views of parents and stakeholders on PMH, in order to shape services and support. Below are some of the views expressed, grouped under common themes:

Overall PMH

- Hopefully midwifery practice will change so that in 30 years from now ALL parents (including dads!) will have a conversation about mental health in pregnancy
- Mothers need support to meet their own goals – types of birth, breast feeding – for better mental health outcomes
- Those with PND struggle with being told they have ‘failed’ in labour or ‘failed at breastfeeding’
- I had antenatal depression and was asked by several professionals before and after, was it (the pregnancy) planned? Yes – why does this have a link – I didn’t ask to be ill
- I had a different Midwife at every appointment – had to re-tell each one that I had a previous bad experience and postnatal depression
- Being passed around mental health teams and no one taking responsibility – perinatal team hard to get hold of

Antenatal support

- Parenting and emotional support antenatally would have helped me a lot in the postnatal period
- Be honest about birth but don’t terrify me – I need all the information

- Lack of openness in antenatal classes – sense that not everything can be discussed
- Antenatal classes decimated – short sighted thinking
- All the focus was on the birth, I wish there was more about breastfeeding

Postnatal support

- Good postnatal care important for mental health
- We spend less time one to one with mothers after the birth now
- Skin to skin is important throughout the perinatal period
- Very hard to establish skin to skin with an audience – other families very close in busy wards
- Mixed signals about skin to skin, Midwife Care Assistants putting babies back in cots away from mum
- Valuing volunteer support on wards
- Volunteers recognised as a valuable resource for patients and listened to – i.e. breastfeeding counsellors
- Postnatal peer support should be encouraged more in hospitals
- Possible de-brief after birth, not next day but a few weeks after, giving time to digest what happened
- The system being proactive in supporting parents who have had a miscarriage or stillbirth – offering ongoing psychological support
- Lack of support after a neonatal death – i.e. walk out of door and no Midwife / Health Visitor – no follow up care offered – care pathway needed.
- Community hubs can help improve postnatal care and support
- Communicating information to other agencies – Health Visitors, community support etc.
- Health Visitors should promote Facebook and online support for local groups - breastfeeding, mental health, buggy walks
- Big picture- long term financial benefit – so money should be put into postnatal care

Breastfeeding

- Many teenage mums feel too anxious to say what they want. Often too scared to ask for help to breastfeed
- Feeling a sense of shame if you can't breast feed
- Too much pressure to breastfeed can lead women to feel failures and give them depression/anxiety
- The way you feed your baby should not be associated with judgement or failure
- More balanced advice needed about breastfeeding and less judgement about formula
- You can't over breastfeed a baby
- New babies need to be breastfed much more often than 3 hourly – mums hear 3 hourly and try to space feeds out
- Women need more support to meet breastfeeding goals. They need more

input/support to look at how breastfeeding is going rather than automatically using formula for top ups as a quick fix

- We need to improve continuity of breastfeeding support. Making sure both the hospital staff and community are well trained and giving consistent information to women
- Embrace working alongside other agencies who offer support with breastfeeding and PND

Attitudes and expectations

- Consider power imbalances
- Impact of attitude of Midwives on women
- Staff may place own bias on situations and judge by their own morals and standards
- Appreciation of how vulnerable mothers are in pregnancy / postnatal period
- Pregnancy and birth can be sugar coated and raise expectations that may not be met
- How women perceive themselves is important – there is no ‘normal’

B: What does this tell us?

7). Key issues and gaps

7.1 PMH encompasses a wide range of conditions and a wide spectrum of needs. It is a challenge to join services up. High quality perinatal and infant mental health services improve outcomes, achieve cost savings and save lives. A great deal of progress has been made in the city in relation to PMH care over the last few years. Many of the aims of key strategic groups, such as the IMPROVE HIT for example, are in the process of being met.

7.2 There is good specialist provision in the city from the Specialist Community PMH team and from the in-patient service at New Horizons. There is specialist pharmacy provision within the Specialist Service. There has been a lot of training on PMH across the workforce. The universal services are identifying mothers who are referred to the mental health triage and consultant clinics.

7.3 Bluebell and Mothers for Mothers have extended their services and reach, and secured more funding. There is now an extended local telephone helpline during the evenings and weekends and a Father’s Support Worker and service. There is PIMHS support available in the city and the Children’s Centres and health services continue to support and signpost to services. There is also some specialist targeted provision.

7.4 However, despite the progress made, the demand for PMH support often outweighs the capacity available to meet this demand. There are still significant service issues and gaps that need to be met and better join up is required across all services to ensure that women and families experience a more seamless support offer, their needs are prevented from escalating and there less duplication.

7.5 There is a need for a greater focus on early intervention and preventative services, and on maximising opportunities for skill-sharing, partnership working and co-delivery of PMH support across the service landscape. Specific gaps and issues are identified below.

Local PMH services and support

Care pathways

7.6 There are care pathways in place for some but not all of the individual services involved in PMH care locally (for example, for the Specialist PMH Service and Health Visiting Service). These are of variable quality and with variable uptake.

7.7 There is not currently an overarching, multi-agency care pathway that covers all PMH services in Bristol, from universal/ early intervention services to specialist PMH services.

7.8 A multi-agency protocol and care pathway for the Specialist PMH Service has been developed by Bristol Safeguarding Board but not all professionals and agencies are aware of it and apply it in practice.

General Practitioners (GPs)

7.9 GPs do not see women routinely during pregnancy and there is little time during appointments to discuss PMH so opportunities to address this issue are limited.

7.10 Although there is now a bespoke training offer for GPs, this is limited by capacity and inconsistent take up by individual practices and GPs.

Maternity Service

7.11 Some but not all NHS antenatal classes offer a routine component on PMH.

7.12 Mothers value continuity of midwifery care, but this is not always achieved.

7.13 There is limited time available during routine midwifery appointments to cover PMH in depth (although where there is a known PMH issue, extra time can be allocated).

7.14 There is a need to strengthen the referral pathway from Maternity Services to Bristol Breastfeeding Support Service (BBSS) given the importance of good breastfeeding support in promoting positive mental health for new mothers.

Health Visiting Service

- 7.15 The capacity of the service to undertake 1:1 support and home visits is limited.
- 7.16 There are some PMH training gaps within the service, although there are plans to address these.
- 7.17 There is a need for enhanced training in infant mental health and attachment.
- 7.18 There is a need to increase skill-sharing and co-delivery of PMH support with Children's Centres, Midwives and the Voluntary and Community Sector (VCS).
- 7.19 There is an Early Relationships Specialist Health Visitor in the East/Central area of the city but not in the North and South areas.

Family Nurse Partnership (FNP)

- 7.20 FNP Nurses are highly skilled in supporting their clients with mental health issues. However, there is a need to extend the benefits of the programme to reach more women and families.

Children's Centres/ Early Years services

- 7.21 The number of staff in Children's Centres has reduced significantly in recent years. This has impacted on their overall capacity to meet needs.
- 7.22 Many but not all Children's Centre staff have received PMH training, and there are some knowledge gaps around care pathways, wider services available and how to refer.
- 7.23 The evidence-based 'Welcome to the World' Antenatal Nurturing Programme, which supports attachment and PMH, is no longer running in Children's Centres in Bristol.
- 7.24 There is a need to increase skill-sharing and co-delivery of PMH support with Health Visitors, Midwives and the VCS.

Breastfeeding support services

- 7.25 Early support for breastfeeding is very important, however, this is not always available or taken up.
- 7.26 Overall, there is a lot of breastfeeding support available but mothers do not always know how to access it and the referral pathway from the Maternity Service to Bristol Breastfeeding Support Service (BBSS) needs to be strengthened.
- 7.27 There is a need for enhanced breastfeeding support on postnatal wards.

Voluntary and Community Sector (VCS) services

- 7.28 There is a good range of VCS PMH provision across the city, but the availability of 1:1 support and home visiting is limited due to high need and lack of capacity. The sector often 'holds' high need cases, which entails a certain amount of risk.
- 7.29 Families are not always aware of the full range of VCS services available, and/or easily able to access it.
- 7.30 VCS staff and volunteers are also not always fully aware of all services/ support available across the city and how to refer when additional/ alternative support is needed.
- 7.31 The Bluebell charity is able to offer their 1:1 Bluebell Buddy Home Visiting Service and Mum's Comfort Zone Groups in some but not all areas of the city. Some of the gaps include areas of deprivation, including Avonmouth and Stockwood.

Primary Infant Mental Health Specialist (PIMHS)

- 7.32 The need for this service outstrips its capacity. The threshold is necessarily high, with many referrals being declined due to limited resources.
- 7.33 The service does not have capacity to provide intensive, long-term therapeutic support for parents and under 5's with significantly disturbed early relationships; this is an area of unmet need.
- 7.34 The service also has limited capacity to meet a rise in demand for infant mental health training and consultation for front-line services working with under 5s, such as Health Visiting.

Increasing Access to Psychological Therapies (IAPT)

- 7.35 Parents can access IAPT for free but the service does not always meet the needs of those with young children, especially regarding timing of sessions and child care.

Specialist Community Perinatal Mental Health (PMH) Service

- 7.36 Although the Specialist PMH Service is starting to deliver some training to the wider workforce, this could be expanded. This is challenging due to capacity but skilling up universal/ early intervention services will ultimately reduce demand for the Specialist Service by preventing needs from escalating to this level.

In-patient Services (Mother and Baby Units)

- 7.37 There are a limited number of MBU beds available across the South West, meaning that some mothers are placed in units far from home. This has eased somewhat with the recent opening of a new MBU in Exeter, and there are plans to

increase the number of beds in Bristol from 4 to 8, with NHSE funding, but it is unclear when this will happen due to difficulties in finding an appropriate site. The Bristol MBU is currently the smallest in the country.

Understanding and support for specific groups

7.38 There are gaps in our understanding and consideration of the specific needs of particular groups in relation to PMH, including partners/ fathers, women and families who have learning disabilities, are LGBTQ, or are from Gypsy, Roma and Traveller communities, asylum seekers and refugees, women experiencing domestic violence and teenage families. Specific PMH support for these groups is often lacking.

7.39 There are limited options for women and families whose needs fall just below the threshold for specialist PMH services, including those who require ongoing support to prevent their needs from escalating. Many of the intensive but lower-threshold PMH interventions, such as the 'Rockabye' programme, run for a time-limited period only (10 weeks for Rockabye, for example) but the families who access these interventions often need longer-term support at this level.

Training

7.40 There has been lots of PMH training across the city but there are still some gaps amongst certain professional groups, and some inconsistencies across services, for example, GPs do not receive enough PMH-specific training (due to capacity and lack of take-up) and not all training considers the specific needs of partners/ fathers, and women and families with additional vulnerabilities. There is also insufficient training on infant mental health specifically.

Data and information sharing

7.41 There are some gaps in data collection around the needs of specific groups, including partners/ fathers, LGBTQ women/ men and women with additional vulnerabilities, such as learning disabilities.

7.42 The extent to which the views and experiences of women and families are used to shape services varies considerably from service to service.

7.43 At present, data is not routinely collected and utilised on the number of positive PMH screenings using approved tools (Whooley questions, GAD score, EPDS) by Midwifery and Health Visiting Services.

7.44 Overall, there is a need to increase the quantity and quality of data and information gathered on PMH and infant mental health needs, and for better sharing and collating of that data across agencies to determine trends, predict demand, commission effectively and work to prevent needs escalating.

8). Knowledge gaps

8.1 To gain a really full picture of perinatal health need and prevalence across Bristol, additional service data and feedback may need to be collected and collated from the following services:

- GP practices
- IAPT services
- Early Relationships Health Visitor
- Bereavement/PMH Nurse, Southmead
- Perinatal Nurse/ Midwife, St Michael's
- Birth Afterthoughts service, Southmead
- Psychology Service, St Michael's Hospital re. birth trauma, bereavement
- Substance Misuse Midwives

8.2 Where relevant, data should be collected from the above services on numbers of positive screenings using approved tools (Whooley questions, GAD score, EPDS) and numbers of referrals to PMH services, for example, by Midwives, Health Visitors and GPs.

C: What should we do next?

9). Recommendations for consideration

9.1 Recommendations are based on addressing identified gaps. The majority are for short to medium-term implementation. However, a number are for future consideration subject to available resources, these are identified at the end of each section, where relevant. These recommendations will be shared with all relevant stakeholders and action owners, with progress monitored by Public Health and the BNSSG Perinatal and Infant Mental Health Steering Group as part of their wider work plan.

Overarching recommendations

Care pathways

9.2 **Map and review existing PMH care pathways, identify any gaps and strengthen where necessary.** This should be undertaken by the BNSSG Perinatal and Infant Mental Health Strategy Group.

9.3 Develop an **over-arching, multi-agency care pathway** that covers the whole PMH pathway, from universal/ early intervention services to specialist PMH services. This should include services and interventions that support **infant mental health** as well as PMH.

9.4 Share more widely, the **Bristol PMH Protocol (and pathway)**, developed by the Bristol Safeguarding Board in 2017, to ensure that all professionals are aware of it and apply it in practice.

Awareness raising, information and self-help

9.5 Ensure that families and practitioners are aware of, and can easily access, **existing universal services that support good mental health**, including the wider determinants of health. This should include:

- Reviewing and improving the way families access information about support available, including **self-management** of low level mental health needs.
- Raising awareness and promoting take up of the **Healthy Start Scheme**.
- Promoting the **mental health benefits of physical activity**, including free swimming, exercise and leisure activities. This should include promoting the Bristol Girls Can campaign.

9.6 Raise awareness of the **Five Ways to Wellbeing** (New Economics Foundation 2008) for good mental health.

9.7 Promote **Tommy's Pregnancy and Post-birth Wellbeing Plan** to parents to support self-care and mental wellbeing.

9.8 Ensure that PMH is fully embedded within **Bristol's 'Thrive' programme**.

Person-centred care

9.9 Ensure that the **voices and experiences of women, partners/ fathers and wider family members** with lived experience of PMH issues are routinely and consistently captured and acted upon within service planning and provision.

9.10 Consider how to better understand and **meet the needs of specific groups** in relation to PMH, including partners/fathers and women and families who are LGBTQ, have learning disabilities, are experiencing domestic violence, are from Gypsy, Roma and Traveller communities, asylum seekers and refugees and teenagers.

9.11 **Consider routinely asking partners/ fathers the same or similar emotional wellbeing questions** that mothers are asked by Midwives and Health Visitors, if they are present, at antenatal and postnatal appointments or through other means if they are not present.

9.12 Consider how best to meet the **ongoing needs of women and families whose needs fall just below the threshold of PMH specialist services**, to prevent their needs from escalating.

Training

9.13 **Map and promote existing PMH and infant mental health training** opportunities, including Mental Health First Aid, Institute of Health Visiting PMH Champion training and free NHS online training.

9.14 **Increase multi-agency training opportunities for PMH and infant mental health**, including opportunities for **skill-sharing** amongst all professionals working with families in the PMH period, including GPs, Social Workers, the VCS workforce, Obstetricians, Midwives, Health Visitors and Children’s Centre staff.

9.15 Develop an agreed **competency framework for PMH** which informs training and professional development. Consider working with the IMPROVE HIT and Children’s Centres to undertake this and integrating it with other similar frameworks, such as the ACEs Competency Framework, given that poor parental mental health is considered an ACE.

9.16 **Review the content of training** to ensure that it covers the needs of partners/ fathers, women and families with additional needs and vulnerabilities, infant mental health and social and emotional development, and parent-infant attachment.

Service-specific recommendations

General Practitioners (GPs)

9.17 Increase the **provision and uptake of PMH and infant mental health training for GPs**, including:

- **Extending the current training offer** beyond the 20 sessions funded locally by NHSE, with a focus on GP practices that have not yet engaged and those in deprived areas.
- Running an increased number of **larger PMH and infant mental health events** where GPs from multiple practices can attend, potentially on a drop-in basis.
- Promoting the **Royal College of GPs PMH toolkit**.
- Considering the inclusion of PMH and infant mental health within **mandatory training** for GP trainees, the learning from which could be disseminated amongst the trainee’s host practice.
- Training should give GPs the skills, knowledge and confidence to be **proactive in raising PMH** during routine, time-limited appointments.

Maternity Service

9.18 Review the **PMH and infant mental health input into the antenatal education programme** via the Local Maternity System (LMS) and expand as necessary. There could be more co-delivery of this programme with **Children’s Centres and Health Visitors**.

9.19 Progress and prioritise LMS plans to **achieve continuity of care** across the maternity pathway for all women, in light of the impact this would have on PMH and other key pregnancy and birth outcomes.

9.20 Strengthen the **referral pathway from the Maternity Service to the Bristol Breastfeeding Support Service (BBSS)**.

Health Visiting Service

- 9.21 Ensure the full roll-out of **Institute of Health Visiting PMH Champion Training** to all members of the Health Visiting team.
- 9.22 **Increase skill-sharing, partnership working and co-delivery** of PMH support with Children's Centres and VCS services, including Health Visitors offering Institute of Health Visiting PMH Champion training to other services.

For future consideration (subject to available resources and capacity):

- 9.23 Consider making **Solihull training** mandatory again for Health Visitors
- 9.24 Consider how to best address the need for enhanced training in infant mental health and attachment, for example, through **Newborn Behavioural Observation (NBO) training** for key members of staff who could then train others within the service.
- 9.25 Review the potential role of the **Early Relationships Health Visitor** in upskilling the wider workforce, to support families in the North and South of the city as well as the East and Central areas.

Family Nurse Partnership (FNP)

- 9.26 Consider how **FNP can best share its expertise** on supporting young people with PMH issues, and infant mental health, amongst the wider workforce. This would benefit mothers and families of all ages.
- 9.27 As part of the national ADAPT project, which is trialling changes to FNP nationally, consider changing the FNP eligibility criteria locally so that we can **better target the mums and families** who would benefit most from the programme. This would need to happen within the parameters of the programme license and available funding.
- 9.28 Keep abreast of **nationally recommended changes to the FNP programme in terms of PMH and infant mental health**, which are being developed and trialled as part of ADAPT.

Children's Centres/ Early Years services

- 9.29 **Increase PMH and infant mental training** opportunities for Children's Centre staff, including Mental Health First Aid, Five to Thrive and specialist PMH training delivered by the Health Visiting Service. Training should cover care pathways, services available and how to refer.
- 9.30 **Increase skill-sharing, partnership working and co-delivery** of PMH support with the Health Visiting Service, Maternity Service and VCS services.

For future consideration (subject to available resources and capacity):

9.31 Consider the re-introduction of the **Welcome to the World Antenatal Nurturing Programme** for parents during pregnancy. There are trained members of staff within Children's Centres who can deliver this and it was well evaluated. If it is re-instated, train more staff across the workforce, including Midwives, Health Visitors and Children's Centres, to co-deliver the programme.

9.32 Consider expanding the current **Antenatal Rockabye** programme.

Breastfeeding support services

9.33 Raise the profile of **breastfeeding support services** across the city.

9.34 Bristol Breastfeeding Support Service (BBSS) staff and volunteers should receive **specific PMH and infant mental health training**.

9.35 Strengthen the referral pathway from the **Maternity Service into BBSS**.

9.36 Consider integrating '**infant feeding mental health competencies**' into PMH and infant mental health training across the workforce. For example, by training Midwives and Health Visitors in Newborn Behaviour Observation, and reviewing the Maternal Mental Health Alliance's PMH Competency Framework for professionals and volunteers who support breastfeeding (MMHA 2018).

Children and Adult Social Care

9.37 Facilitate **greater involvement of child and adult social workers in system-wide PMH service planning and delivery**, including in strategic groups and networks. This could include **PMH social work 'champion(s)'** to develop PMH specialism within the service, support quality improvement and foster links with other services. This is in recognition of the link between social and economic deprivation and other child and adult vulnerabilities, including Adverse Childhood Experiences (ACEs), and mental health issues.

Voluntary and Community Sector (VCS) services

9.38 Services and professionals should routinely signpost women and families to **peer-run VCS provision that supports PMH**, such as Mothers for Mothers and Bluebell. Raise awareness of this provision amongst professionals and families.

9.39 Ensure that **VCS staff and volunteers are fully aware of wider services and support available across the city and how to signpost and refer** when additional or alternative support is needed.

9.40 **Maximise opportunities to share skills, work in partnership and co-deliver** PMH support with statutory services.

9.41 Consider how to **meet gaps in provision of 1:1 and peer support** in areas of deprivation, including Avonmouth and Stockwood.

9.42 Publicise the work of **Project MAMA** with asylum seekers and refugee families.

9.43 Publicise the **PMH films** developed by the VCS sector to raise awareness of PMH and the support available.

Primary Infant Mental Health Specialists (PIMHS)

9.44 Consider **how best to meet unmet need at this level**, especially in relation to longer-term therapeutic support for under 5s and their families, and the rise in demand for increased training in infant mental health from other services.

Increasing Access to Psychological Therapies (IAPT)

9.45 Ensure there is a **clear pathway and ease of access for parents into IAPT** in the perinatal time critical period, including reviewing opening hours and childcare provision.

Specialist Community Perinatal Mental Health (PMH) Service

9.46 Review the **role of the Specialist Community PMH Service in training, upskilling and outreach** to the wider workforce, including Midwives, Health Visitors, GPs, Bristol Breastfeeding Support Service and other practitioners, with a view to extending this offer. This should include consideration of **skill-sharing** opportunities, for example, BBSS could train the Specialist PMH Service in breastfeeding support, and vice versa.

In-patient Services (Mother and Baby Units)

9.47 Commissioners and providers should continue to work together to achieve the expansion of the 4 bedded MBU in Bristol to 8 beds.

10). Key contacts

Charly Williams, Senior Public Health Specialist: charly.williams@bristol.gov.uk

Jo Williams, Consultant in Public Health: jo.williams@bristol.gov.uk

References

Adverse Childhood Experiences (2018) Violence Prevention Unit Centre for Disease Control and Prevention <https://www.cdc.gov/violenceprevention/acestudy/index.html>

Bauer A, Parsonage M, Knapp M, Lemmi V and Bajo A (2014) The Costs of PMH Problems London School of Economics, Centre for Mental Health, Personal Services Research Unit http://eprints.lse.ac.uk/59885/1/lse.ac.uk_storage_LIBRARY_Secondary_libfile_shared_repository_Content_Bauer%2C%20M_Bauer_Costs_perinatal_%20mental_2014_Bauer_Costs_perinatal_mental_2014_author.pdf

Best Beginnings (2017) 'Out of the Blue' films on PMH <https://www.bestbeginnings.org.uk/out-of-the-blue>

Benchmarking Network (2016) PMH Report: NHS Benchmarking Network Survey: National Findings <http://www.nhsbenchmarking.nhs.uk/CubeCore/.uploads/Mental%20Health/MHReports/NHSBNPerinatalMentalHealthReportGeneric.pdf>

Boots Family Trust (2013) Perinatal Mental Health: Experiences of Women and Health Professionals https://www.tommys.org/sites/default/files/Perinatal_Mental_Health_Experiences%20of%20women.pdf

Bristol City Council (2019) Bristol Early Years: Emotional Wellbeing <https://www.bristolearlyyears.org.uk/health/public-health/emotional-wellbeing/>

Bristol City Council (2019) Bristol Girls Can campaign <https://www.bristolgirlscan.co.uk/>

Bristol City Council (2018) Thrive Bristol: Children and Young People's Mental Health and Wellbeing Report <https://www.bristol.gov.uk/mayor/thrive-bristol>

Brown A, Rance J, Bennet P (2015) 'Understanding the relationship between breastfeeding and postnatal depression: the role of pain and physical difficulty.' <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4738467/>

Chief Medical Officer (2014) Chief Medical Officer Annual Report: Women's Health Annual Report of the Chief Medical Officer - The Health of the 51%: Women. <https://www.gov.uk/government/publications/chief-medical-officer-annual-report-2014-womens-health>

Early Intervention Foundation (2018) Guidebook: Family Foundations <https://guidebook.eif.org.uk/programme/family-foundations>

Early Intervention Foundation (2015) 'The Best Start at Home Report to improve the quality of child parent interaction from conception to age 5' <https://www.eif.org.uk/files/pdf/best-start-at-home-overview.pdf>

Edinburgh Postnatal Depression Scale

<http://www.fresno.ucsf.edu/pediatrics/downloads/edinburghscale.pdf>

Fallon V, Groves R, Halford J (2016) Post-partum Anxiety and Infant Feeding Outcomes
journal of Human Lactation

<http://journals.sagepub.com/doi/abs/10.1177/0890334416662241>

Family Foundations <https://famfound.net/the-program/>

Fatherhood Institute (2010) Research Summary: Fathers and Postnatal Depression.

<http://www.fatherhoodinstitute.org/2010/fatherhood-institute-research-summary-fathers-and-postnatal-depression>

Fellmeth G, Fazel M and Plugge E (2016) 'Migration and PMH in women from low and middle income countries: a systematic review and meta-analysis' British Journal of Obstetrics and Gynaecology <http://onlinelibrary.wiley.com/doi/10.1111/1471-0528.14184/abstract;jsessionid=CFCD30DE6F78D8D7C9D73296BC660EF5.f04t03>

Five Ways to Wellbeing <https://www.gov.uk/government/publications/five-ways-to-mental-wellbeing>

GAD Score Generalised Anxiety Disorder Score 7 <https://www.corc.uk.net/outcome-experience-measures/generalised-anxiety-disorder-assessment/>

Goodman J, H (2004) 'Paternal postpartum depression, its relationship to maternal postpartum depression, and implications for family health' Journal of Advanced Nursing, Vol. 45, Issue 1, p.26-35. <https://onlinelibrary.wiley.com/doi/abs/10.1046/j.1365-2648.2003.02857.x>

Grienenerger J & Slade R (2007) Maternal Reflective Functioning; Mother Infant Affective Communication; implications for psychodynamic treatment with children and families
Keeping the Baby in Mind– Infant Mental Health

<http://mentalizacion.com.ar/images/notas/Maternal%20Reflective%20Functioning.pdf>

Hogg S (2014) NSPCC 'Prevention in Mind; All babies Count: Spotlight on Perinatal Mental Health' <https://www.nspcc.org.uk/globalassets/documents/research-reports/all-babies-count-spotlight-perinatal-mental-health.pdf>

Horrocks S, Naidoo J, Daykin D (2009) Bristol City Council 'I didn't think I'd feel like this'.
Evaluation of the Rock-a- Bye groups Dance Movement Therapy for Postnatal Women and their Infants'

Keeping Bristol Safe Partnership (2017) PMH Protocol

<https://bristolsafeguarding.org/children-home/news/perinatal-mental-health-protocol-launch/>

Keeping Bristol Safe Partnership (2017) ZBM Serious Case Review, April 2017
<https://bristolsafeguarding.org/children-home/serious-case-reviews/bristol-scrs/zbm-2017/>

Khan L (2015) 'Falling through the Gaps' PMH and General Practice Centre for Mental Health
<https://www.centreformentalhealth.org.uk/falling-through-the-gaps>

HM Government (2011) No Health without Mental Health: A Cross Government mental health strategy for people of all ages
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213761/dh_124058.pdf

Horrocks S, Naidoo, J and Daykin, N (2009) 'I didn't think I'd feel like this': Evaluation of the Rock-a-Bye Groups; dance movement therapy for postnatal women and their infants. Report for Bristol City Council. Project Report, University of the West of England

Howard L, Molyneaux E, Dennis C-L, Rachat T, Stein A and Milgrom J (2014) Non-psychotic Mental Disorder in the Perinatal Period The Lancet Vol 384 Issue 9956, p.15-21
<https://www.sciencedirect.com/science/article/pii/S0140673614612769?via%3Dihub>

Jackson R & Beck A (2013-14) An evaluation of services provided by Bluebell Care for parents experiencing perinatal mental illness in Bristol over the two year period
<http://www.bluebellcare.org/uploads/images/bake/referral/Evaluation-report-july2016.pdf>

Jacobsen H (2016) 'Healing Breastfeeding Grief: How mothers feel and heal when breastfeeding does not go as hoped'. Rosalind Press

Joint Commissioning Panel for Mental Health (2012) Guidance for Commissioners of PMH Services http://www.rcpsych.ac.uk/pdf/perinatal_web.pdf

Jones and Craddock (2001) Familiarity of the Puerperal Trigger in Bipolar Disorder: Results of a Family Study <https://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.158.6.913>

Kendall-Tackett K, Cong Z, Hale TW (2011) 'The Effect of Feeding Method on Sleep Duration, Maternal Wellbeing and Postpartum Depression' Clinical Lactation 2 (2):22-26

LGA (2018) Local Government Association 'A Better Start: Supporting Child Development in the Early Years'
https://www.local.gov.uk/sites/default/files/documents/15.51%20A%20Better%20Start_03.pdf

Marmot (2010) The Marmot Review: Fair Society, Healthy Lives Strategic Review of Health Inequalities in England Post 2010 <http://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf>

McAndrew, F., Thompson, J., Fellows, L., Large, A., Speed, M. & Renfrew (2010) M.J. Infant Feeding Survey: 2010 NHS Information Centre (online) <http://data.gov.uk/dataset/infant-feeding-survey-2010>

Maternal Mental Health Alliance (2018) Mums and Babies in Mind; PMH Competency Framework for Professionals and Volunteers who Support Breastfeeding <http://maternalmentalhealthalliance.org/resource-hub/>

MBRRACE (2017) Saving Lives, Improving Mothers' Care <https://www.npeu.ox.ac.uk/downloads/files/mbrance-uk/reports/MBRRACE-UK%20Maternal%20Report%202017%20-%20Web.pdf>

Mental Health Foundation (2016) Survey of people with lived experience of mental health problems reveals men less likely to seek medical support. <https://www.mentalhealth.org.uk/news/survey-people-lived-experience-mental-health-problems-reveals-men-less-likely-seek-medical>

NHS England (2015) 'Perinatal and Infant Mental Health Care in the South West: Improving Care Pathways' South West Strategic Clinical Network http://www.swscn.org.uk/wp/wp-content/uploads/2015/12/PIMH-in-the-South-West-Improving-Care-Pathways_July-2015.pdf

NHS England (2015) Department of Health Future in Mind: promoting, Protecting and Improving Children and Young Mental Health and Wellbeing https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

NHS (2016) National Maternity Review: Better Births: Improving outcomes of Maternity Care <https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf>

NHS England (2016) The Five Year Forward View for Mental Health <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

NHS Health Education England (2016) Specialist Health Visitors in Perinatal and Infant Mental Health: What they Do and Why They Matter <https://www.hee.nhs.uk/sites/default/files/documents/Specialist%20Health%20Visitors%20in%20Perinatal%20and%20Mental%20Health%20FINAL%20low%20res.pdf>

NICE (2006) National Institute for Health and Clinical Excellence Postnatal Care up to 8 Weeks after Birth Clinical Guideline G37 (updated 2015) <https://www.nice.org.uk/guidance/cg37/chapter/1-Recommendations#maternal-health>

NICE (2011) National Institute for Health and Clinical Excellence 'Service User Experience in Adult Mental Health: Improving the Experience of Care for People using Adult NHS Mental Health Services' Clinical Guideline 138 <https://www.nice.org.uk/guidance/cg138>

NICE (2012) National Institute for Health and Clinical Excellence Patient Experience in Adult NHS services: Improving the Experience of Care for People Using adult Mental Health Services <https://www.nice.org.uk/guidance/cg138>

NICE (2014) National Institute for Health and Clinical Excellence Antenatal and Postnatal Mental Health Clinical Guideline and Service Guidance Clinical Guideline 192 (2014) <https://www.nice.org.uk/guidance/cg192/chapter/1-Recommendations#principles-of-care-in-pregnancy-and-the-postnatal-period-2>

NICE (2014) National Institute for Health and Clinical Excellence Clinical Guideline 192: antenatal and postnatal mental health clinical management and service guidance (updated 2018) <https://www.nice.org.uk/guidance/CG192>

Pandas 'Perinatal Anxiety and Depression, Australia' Impact of Postnatal Depression http://www.panda.org.au/practical-information/about-postnatal-depression/30-impact-of-postnatal-depression?show_all=&start=1

PIPUK (2019) Rare Jewels: Specialised parent-infant relationship teams in the UK <https://www.pipuk.org.uk/sites/default/files/PIPUK%20Rare%20Jewels%20FINAL.pdf>

Public Health England (2015) 'A framework for supporting teenage mothers and young fathers' Local Government Association

Public Health England (2015) Better Mental Health: Perinatal Mental Health JSNA Toolkit <https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/4-perinatal-mental-health>

Public Health England (2016), Health Matters: Giving Every Child the Best Start in Life <https://www.gov.uk/government/publications/health-matters-giving-every-child-the-best-start-in-life>

Public Health England/ UNICEF (2016) Commissioning Local infant Feeding Services: a Toolkit for Local Authorities https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/538344/Commissioning_infant_feeding_services_a_toolkit_for_local_authorities_Part_2_.pdf

RCGP Royal College of General Practitioners PMH Toolkit <http://www.rcgp.org.uk/clinical-and-research/toolkits/perinatal-mental-health-toolkit.aspx>

RCGP Royal College of General Practitioners PMH Position Statement <http://www.rcgp.org.uk/policy/rcgp-policy-areas/perinatal-mental-health.aspx>

RCOG (2017) Royal College of Obstetricians and Gynaecologists 'Maternal Mental Health – Women's Voices'
<https://www.rcog.org.uk/globalassets/documents/patients/information/maternalmental-healthwomens-voices.pdf>

SIGN Guideline 127 (2012) Scottish Intercollegiate Guidelines Network 'Management of Perinatal Mood Disorders' <http://www.sign.ac.uk/pdf/grg127.pdf>

SIGN Guideline 127 Scottish Intercollegiate Guidelines Network 'Patient Guideline' on Perinatal Mood Disorders available in English, Polish, Chinese and Urdu
<http://www.sign.ac.uk/pdf/PAT127.pdf>

Sanger C, Iles J, C & Ramchandani P (2014) 'Associations between Perinatal Maternal Depression and Psychological Outcomes in Adolescent Offspring: a Systematic Review' in Archive Women's Mental Health, 18:147-162 DOI10.1007/s00737-014-0463-2

Slade A, Grienenberger J, Berbach E, Levy D, Locker A (2007) Maternal Reflective Functioning, attachment and the transmission gap: a preliminary study
<https://www.ncbi.nlm.nih.gov/pubmed/16210240>

Sinha B et al (2015) 'Interventions to improve breastfeeding outcomes: a systematic review and meta-analysis' Acta Paediatrica, Special Issue: Impact of Breastfeeding on Maternal and Child Health. Volume 104, Issue Supplement S467, pages 114-134

The 1001 Critical Days (2015) Cross Party Manifesto: The importance of the conception to age two period <http://www.1001criticaldays.co.uk/>

Wave Trust (2013) 'Conception to age 2 –the age of opportunity; framework for local area service commissioners' <http://www.wavetrust.org/our-work/publications/reports/conception-age-2-age-opportunity>

WHO (2013) World Health Organisation Mental Health Action Plan
https://www.who.int/mental_health/action_plan_2013/en/

WHO (2014) World Health Organisation Preventing Suicide: A Global Imperative
http://apps.who.int/iris/bitstream/handle/10665/131056/9789241564878_eng.pdf;jsessionid=B38E0C58FDE38A46F5B1456EFABEBC23?sequence=8

WHO (2018) World Health Organisation Preventing Suicide: A Community Engagement Toolkit <http://apps.who.int/iris/bitstream/handle/10665/272860/9789241513791-eng.pdf?ua=1>

Whooley Questions <https://whooleyquestions.ucsf.edu/>

Organisations providing information and support to parents

Local organisations

Bluebell

Bristol based charity supporting mothers and families in structured groups, one to one and via a drop- in service with daily activities.

www.bluebell.org.uk

Home Start

A national charity with a Bristol base offering volunteer support to families in crisis including parental mental health

<https://www.homestartbristol.org.uk/>

Mothers for Mothers

Bristol based charity supporting mothers and families offering support in drop in groups, one to one and a low cost counselling service.

www.mothersformothers.co.uk

Rockabye and Antenatal Rockabye

Bristol based support for mothers supporting emotional connection with their baby

<http://www.rockabye.org.uk/about/>

Increasing Access to Psychological Therapies (IAPT)

Offer short term support using individual and group support using Cognitive Behavioural Therapy and counselling approaches to support individuals

<https://iapt-bristol.awp.nhs.uk/>

Primary Infant Mental Health Specialists (PIMHS)

Part of the CAMHS service providing support for parents with children under 5 years old supporting attachment

<https://cchp.nhs.uk/cchp/explore-cchp/child-family-consultation-services-camhs/primary-infant-mental-health-specialists>

The Improve PMH HIT (Health Improvement Team)

<http://www.bristolhealthpartners.org.uk/health-integration-teams/improving-perinatal-mental-health-hit/>

Specialist Community PMH service is for women with high need for specialist support in pregnancy and a year after birth. They also provide guidance and support to professionals.

<http://remedy.bnssgccg.nhs.uk/adults/mental-health/perinatal-mental-health/>

New Horizons Mother and Baby Unit

Mother and baby unit at Southmead hospital (4 beds) for mothers and babies needing in-patient support <http://www.awp.nhs.uk/services/specialist/mother-and-baby-unit/>

National support

Action Postpartum Psychosis Network

This is a network of women across the UK who have lived experience of postpartum psychosis. They aim to increase public awareness and promote research into the condition. Run by a team made up of academics, health professionals and women who have recovered from postpartum psychosis. Tel: 020 3322 900; email: app@app-network.org

Association for Postnatal Illness (APNI)

The organisation provides support, education and information and has a network of volunteers (telephone and postal) who have experienced perinatal mental illness who support mothers and families.

<https://apni.org/>

Bipolar Education Programme Cymru

This offers information about pregnancy and childbirth for women with bipolar disorder, including an online interactive module.

<http://ncmh.info/bepc/>

Maternal Mental Health Alliance (MMHA) – ‘Everyone’s Business’ Campaign.

The MMHA is a coalition of 80 national professional and patient organisations committed to improving the mental health and wellbeing of women and their children in pregnancy and the first postnatal year

<http://everyonesbusiness.org.uk/>

NHS Choices

Perinatal Mental Health information and signposting

<http://www.nhs.uk/Conditions/pregnancy-and-baby/pages/mental-health-problems-pregnant.aspx>

Pandas

This organisation helps individuals and their families with pre and postnatal depression advice and support. They also offer support to families in the antenatal period. Helpline (open 9am to 8pm) 0843 2898401

www.pandasfoundation.org.uk

Postpartum Progress - blog

Widely read blog about postnatal mental illness

help@postpartumprogress.org

Resources for women and families

The following are personal accounts of postpartum psychosis:

- Sharrock G 'Eyes without Sparkle; Saving Grace: My journey & survival through postnatal depression' by Grace Sharrock
- Shaw F 'Out of me: the story of a Postnatal Breakdown'
- Twomey T Understanding Postpartum Psychosis: A Temporary Madness'
- Martini A 'Hillbilly Gothic: A Memoir of Madness and Motherhood'

Self-help resources

- Tommy's Wellbeing Plan <https://www.tommys.org/pregnancy-information/im-pregnant/mental-health-during-and-after-pregnancy/wellbeing-plan>
- 'Headspace' free app <https://www.headspace.com/> meditation and mindfulness

Films

- Perinatal Positivity - locally made film for parents (also a subtitle version) <https://perinatalpositivity.org/>
- Bluebell – local parent's stories on film funded by Sports Relief <http://www.bluebellcare.org/index.php?page=your-stories>
- 'Out of the Blue' parents stories and information <https://www.bestbeginnings.org.uk/watch-out-of-the-blue-online>

Medication information

- Community Specialist PMH team specialist pharmacy service <http://remedy.bnsgccg.nhs.uk/adults/mental-health/perinatal-mental-health/>
- Breastfeeding Network (BFN) Drugs in Breastmilk Facebook page
- Breastfeeding Network [BFN] Drugs in Breastmilk factsheets <https://www.breastfeedingnetwork.org.uk/detailed-information/drugs-in-breastmilk/>
- Medicines in Pregnancy www.medicinesinpregnancy.org
- Tetralogy information service <http://www.uktis.org/>
- Electronic Medical Compendium (EMC) Bump Site <https://www.medicines.org.uk/emc/>
- Medication and Mothers Milk- Hale on-line support https://www.springerpub.com/medications-and-mothers-milk-digital.html?utm_source=springerpub&utm_medium=link&utm_campaign=062018-hales&utm_content=hale-2019-product-page

Free on-line NHS training

- NHS Health Education England <https://www.e-lfh.org.uk/programmes/perinatal-mental-health/> free PMH on-line training
- NHS Scotland Maternal Mental Health Network <https://www.maternalmentalhealth.org.uk/resources/training/> free PMH on-line training

Infant Feeding and Perinatal Mental Health

- Breastfeeding Counsellor support groups and helpline <https://www.bristol.gov.uk/social-care-health/breastfeeding-in-bristol>
- Infant Feeding competencies <https://www.breastfeedingnetwork.org.uk/wp-content/uploads/2018/11/Infant-feeding-PMH-competencies-FINAL-1.pdf>
- Lactation Consultants of Great Britain information and handout on breastfeeding and maternal mental health <http://www.lcgb.org/resources/breastfeeding-maternal-mental-health/>