

Estimated numbers of women needing perinatal mental health care/support¹ (based on an estimated 7,200 maternities in Cheshire*):

Management by midwife and/or health visitor - up to 1080 women

Management by GP or IAPT services - 720 to 1080 women**

Specialist psychiatric referrals - 216 women

Perinatal mental health service referrals - 72 women

Mother and baby unit admissions (if outreach is also available) - 15 women

Inpatient beds (if outreach is also available) - 2 beds

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Perinatal mental health problems are those which occur during pregnancy and the year after birth. They include ongoing problems that were present before the pregnancy began, newly arising mental health disorders and recurrence in women with a previous history of serious affective disorder.

Separation of mother and infant can have serious effects on the mother-infant relationship that can be difficult to reverse. Without appropriate intervention, maternal mental illness can have long-standing effects on infants' cognitive, emotional and social development and well-being.

Key messages

- Depression and anxiety are the most common mental health problems during pregnancy, and also affect 15 to 20% of women in the first year after childbirth
- Serious perinatal mental health problems affect around 3% of women, who will require referral to psychiatric services
- Currently there is little or no parity for mental health during pregnancy, and most antenatal care is heavily focused on the physical health of the mother
- Low detection rates mean that a high proportion of cases of depression and anxiety go unrecognised and untreated during the perinatal period. Better identification of problems will help ensure that support can be provided
- Opportunities for improvement include:
 - raising awareness of perinatal mental illness and the support available among women, their partners and families
 - improving identification during routine maternity appointments and improving record sharing between professionals
 - improving cross-sector partnership working between organisations providing support (including peer support)
 - establishing new commissioning arrangements for inpatient mother and baby care with the Manchester service
- In the two local maternity units in Cheshire East there are no specialist mental health midwives to provide enhanced care to women with pre-existing serious mental health conditions

* For the purposes of this needs assessment, Cheshire refers to Cheshire East and Cheshire West and Chester Local authority areas

** IAPT (Improving Access to Psychological Therapies) services use psychological therapies to treat anxiety and depression



Each mother’s mental health needs are different



All professionals should:

- detect and treat anxiety and depression
- help with any relationship problems
- help to create more social support, if needed
- advise on practical help with housing conditions
- help to teach sensitive mothering

“Parity of Esteem” is about valuing mental health equally with physical health. Currently there is little or no parity for mental health during pregnancy, and most antenatal care is heavily focused on the physical health of the mother. Midwives are in a good position to ensure that all women who have or develop a mental health problem during their pregnancy can receive appropriate and timely care. However, a recent national survey² found that almost one in five women said that they had not been asked about their emotional and mental health state at the time of booking, or about past mental health problems and family history.

Across the country, women asked for more postnatal support and shared a feeling that services are inadequately resourced for midwives to provide empathetic and comprehensive care. Many women said that they received lots of care and support in the antenatal period which is not continued after birth. For some women, additional support – sometimes simply someone to talk to – could prevent the onset of depression and other mental health conditions, particularly in relation to the days spent in hospital which can often be a low point for women.

Relationship or personal continuity over time has been found to have a positive effect on user experience and outcome. The aim of providing continuity of carer is to ensure a woman will normally be looked after or supported by professionals she knows and trusts. Specialist mental health midwives can provide enhanced care to women with pre-existing serious mental health conditions. The role of both groups of midwives is shown below.

All midwives

- raising awareness
- tackling stigma
- strengthening emotional wellbeing
- promoting emotional wellbeing
- building trust
- identifying risk and current wellbeing
- securing appropriate care
- supporting family members

Specialist mental health midwives

- education and training of midwives
- advice and support to colleagues
- champions and advocates
- point of contact
- quality improvement of services
- integrated care and pathways
- specialist support to women
- training for other groups of staff

The Countess of Chester Hospital maternity services unit has two part time specialist mental health midwives (1 Full-Time Equivalent).

Currently in Cheshire East there are no specialist mental health midwives in either of the two local maternity units that serve most of the residents of Vale Royal, South Cheshire and Eastern Cheshire CCGs.

Opportunities for improvement

Better identification of problems will help ensure that support can be provided to women who have poor mental health in the perinatal period. This could be achieved by:

1. **raising awareness of perinatal mental illness among women, their partners and families**
2. **improved training among all groups of staff to recognise and deal with mental health problems**
3. **better documentation of mental health histories in maternity notes**
4. **increasing depression and anxiety screening during pregnancy including at the health visitor contact**

Estimated number of women requiring perinatal mental health care/ support¹

	Resident maternities (2014)	Minor mental health difficulties: management by midwife/ HV 15% of women	Moderate mental health problems: management by GP/ IAPT services 10-15% of women	Specialist psychiatric referrals: 3% of women of which a third →	may be referred to a perinatal mental health service	Mother and baby unit admissions: based on 2 admissions per 1000 maternities	Inpatient beds: 0.25 beds per 1000 maternities (community team available)
West Cheshire CCG	2401	360	240-360	72 →	(24)	5	0.6
Vale Royal CCG	1079	160	110-160	32 →	(11)	2	0.3
South Cheshire CCG	1859	280	185-280	56 →	(19)	3.7	0.5
Eastern Cheshire CCG	1854	280	185-280	56 →	(18)	3.7	0.5
Cheshire wide	7193	1080	720-1080	216 →	(72)	14.5	1.9

Up to 30% of women may experience some degree of stress or mental disorder during pregnancy, around half of whom will need timely access to high quality, evidence-based care provided by a GP or IAPT psychological therapies. Depression and anxiety are the most common mental health problems during pregnancy, and also affect 15 to 20% of women in the first year after childbirth. Some women need more support and better access over a longer term to counselling and therapy for those who have difficult or traumatic experiences, particularly families who have had a stillborn baby or whose baby has died after birth.

Serious perinatal mental health problems affect around 3% of women, who will require referral to psychiatric services. A third of these (1% of maternities) will meet the referral criteria for care and treatment from a specialised perinatal mental health service. Between 2 to 4 per 1000 women delivered have mental illness that is serious enough to require admission to a specialised mother and baby unit. It is estimated that 0.25 inpatient mother and baby beds per 1000 maternities will be required if specialised perinatal community psychiatric teams are available, or 0.5 per 1000 if no specialised teams are provided.

Maternal psychological distress is defined as stress, depression, or anxiety occurring either during pregnancy or postnatally. There is a growing body of evidence that exposure to distress during pregnancy can negatively influence the baby’s brain and DNA while it is still in the womb.

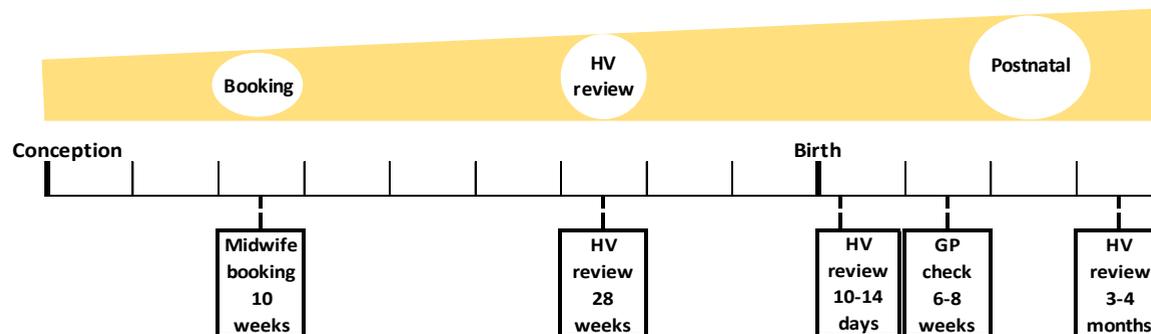
Some women who experience distress during pregnancy have had a history of common mental health disorders that begin in adolescence or young adulthood. These women represent an identifiable high-risk group that should be identified at or shortly after the booking visit, and then receive checks for anxiety and depression at every routine contact during the pregnancy.

Low detection rates mean that a high proportion of cases of depression and anxiety go unrecognised and untreated during the perinatal period. The majority of women can be looked after by their midwife, or in primary care or psychological therapy (IAPT) services. Psychological therapy is the first-line treatment for the majority of women with moderate disorder, with cautious use of medication during pregnancy or when breastfeeding. Women should receive their mental health care within four weeks of identification although there is currently no process locally for measuring whether this happens.

Advice for CCG commissioners

The following requirements should be included in maternity specifications and be closely monitored by CCG commissioners:

- **at booking there should be a routine enquiry about a current or past history of mental health problems, which should cover the full range of mental health issues and not just depression**
- **maternity services should ensure that the general practitioner is made aware of a woman’s pregnancy and enquire of the general practitioner about the woman’s past mental health history**
- **women with a previous history of mental health problems should be assessed for anxiety and depression at every appointment**
- **women requiring mental health care should receive it within four weeks of identification**



Opportunities to identify women with moderate mental health problems

The onset of postnatal depression has been found to start before the baby’s birth in 60% of cases – 27% of women may be already be affected before pregnancy and a further 33% develop during pregnancy. The potential number of women who could be identified at each stage of pregnancy is shown below.

	Booking	HV review	Postnatal	Total
West Cheshire CCG	95	120	145	360
Vale Royal CCG	45	50	65	160
South Cheshire CCG	75	95	110	280
Eastern Cheshire CCG	75	95	110	280
Cheshire total	290	360	430	1080

The new statutory offer of a universal health visitor review for every woman who is more than 28 weeks pregnant brings with it an important opportunity to identify depression and arrange immediate referral for psychological therapy so that her depression can be effectively managed prior to delivery. This should be included in health visiting specifications and be closely monitored by public health commissioners.



A small number of women (a few dozen annually across Cheshire) may experience severe mental illness following childbirth. In some women this may be due to a chronic mental health condition, such as schizophrenia, that has been present throughout pregnancy.

In other women severe mental illness may suddenly occur with a rapid onset shortly after childbirth. These episodes are sometimes called postpartum psychosis, but are often due to bipolar disorder manifesting as mania, severe psychotic depression, or mixed episodes with features of both high and low mood.

Bipolar disorder

Given the critical importance of birth as a life event for families, the detection and treatment of bipolar disorder among childbearing women has major public health significance.

Bipolar disorder causes severe mood swings that usually last several weeks or months, and are far beyond the normal variations in mood that most people experience.

Several factors can contribute to mood destabilisation in vulnerable women. These include sleep deprivation and interference with circadian rhythms during late pregnancy and labour, hormonal changes following childbirth, and breastfeeding. The days and weeks following birth carry the highest lifetime risk for first onset and recurrent episodes of bipolar disorder.

First onset bipolar disorder is about four times more common in women after delivery than among non-pregnant women, and women who have previously had bipolar disorder have a 50% to 70% risk of having a recurrence after giving birth.

Women who present with symptoms of depression may be misdiagnosed initially. Bipolar disorder is difficult to diagnose because a detailed lifetime history search for hypomania (mild manic episodes) and mixed states must be completed.

Failure to correctly identify mania and hypomania can result in the misdiagnosis of postnatal bipolar disorder as depression, and women may then receive incorrect treatment. About half of women with “treatment-resistant” postpartum depression actually have bipolar disorder. Prescribing antidepressants by themselves can increase the risk of rapid mood swings, mania, and treatment resistance.

Advice for Public Health commissioners

The following requirements should be included in health visiting specifications and be closely monitored by public health commissioners.

- **health visitors should assess for depression during the antenatal review (post 28 weeks gestation) and refer for psychological therapy prior to the baby’s birth. This should include checking that maternity services have enquired about past mental health history**
- **health visitors should use networks between primary care and maternity services so that they are informed of women who have previously had bipolar disorder before delivery**
- **health visitors should ensure that women who present with symptoms of depression following delivery are assessed for previous hypomania or mixed states**

Peer support means people supporting each other on an equal basis, to offer something based on shared experiences. It can happen in all sorts of places; informally and formally, in one-to-one settings, self-help or activity groups or online.

Peer support available for perinatal mental health problems

During 2016, Community & Voluntary Services Cheshire East undertook a community JSNA project to:

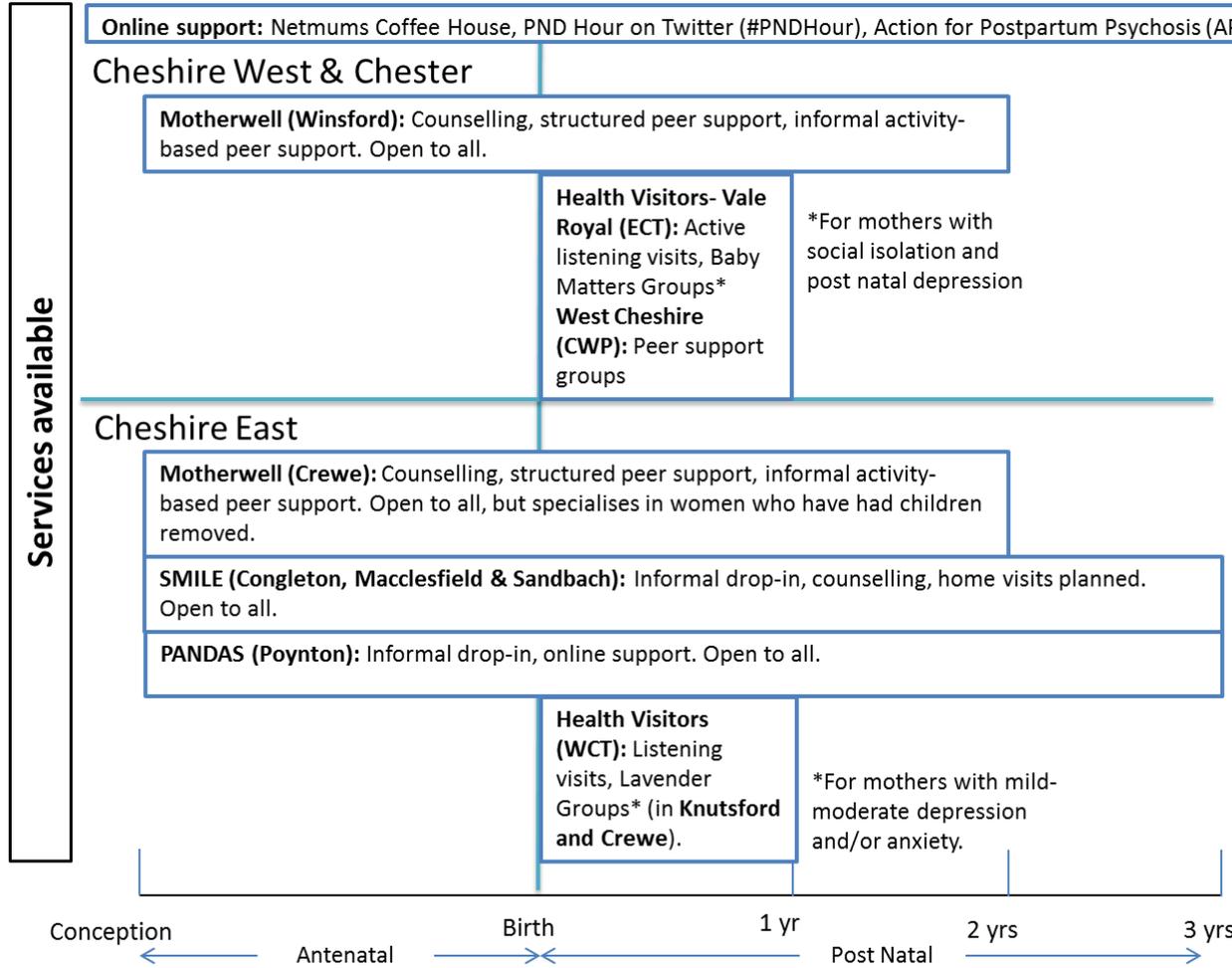
- identify the peer support available in Cheshire for perinatal mental health
- explore the experience of women accessing this support
- Identify the practicalities of setting up peer support

Most peer support available for perinatal mental health in Cheshire is for women experiencing anxiety and depression.

Online peer support is available for women experiencing psychosis.

Formal **telephone peer support** is not provided in Cheshire.

A link to the project reports can be found under "Further information" on page 8.



The impact of peer support:

"I can talk. At other mums and tots groups everyone seems so happy, I felt really isolated. The people here are in the same situation and there is no need to pretend or put on a façade."

"The group has had a tremendous impact. It was the only place I could talk and my first time here I cried for half an hour and offloaded... The group were a bit life-saving."

Abbreviations:
 ECT: East Cheshire Trust
 CWP: Cheshire and Wirral Partnership Trust
 WCT: Wirral Community Trust

Opportunities for improvement

- Raise awareness of perinatal mental health peer support services available in Cheshire among women and families
- Improve cross-sector partnership working to identify and respond to gaps in provision and capacity issues in meeting needs, share best practice and identify where consistent approaches across organisations would be beneficial
- Develop cross-sector pathways which facilitate women to access the right support at the right time for them
- Increase training on perinatal mental health for professionals working with pregnant women and mothers (i.e. health visitors, midwives, children's centre staff and those in the voluntary, community and faith sector)

Specialised perinatal mental health services provide inpatient mother and baby units. These units are designed to offer a safe therapeutic environment to avoid the separation of mother and baby, wherever possible, by joint admission. They enable the treatment and recovery of the mother whilst promoting the developing relationship with the baby. Many units also provide specialised perinatal outreach and community psychiatric teams who facilitate early discharge, help to prevent relapses and reduce re-admission of high risk, vulnerable women.

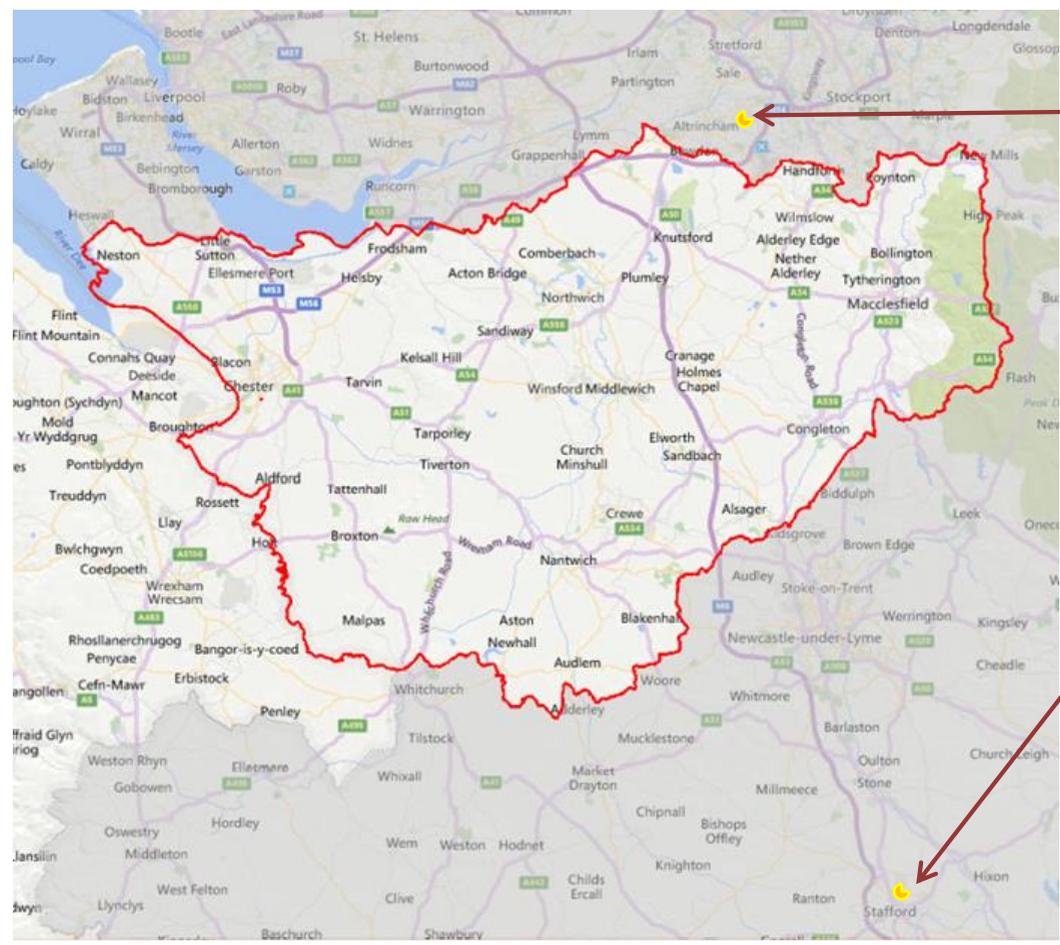
Around 15 women from Cheshire will require admission to a mother and baby unit each year.

There are a limited number of inpatient mother and baby beds across England. Cheshire is fortunate to have two specialist inpatient facilities situated just outside its boundary, with good transport access via either the M56 or M6.

There are currently no other inpatient facilities of this type in the North West, and the next nearest centres are in Derby, Nottingham and Leeds.

Advice for CCG commissioners:

- establish commissioning arrangements that allow women from Cheshire to use inpatient beds in Manchester and Stafford



Andersen Ward Mother and Baby Unit
 Laureate House
 Wythenshawe Hospital
 Manchester M23 9AL

The Andersen Ward is a purpose built Mother and Baby unit with 10 beds and an assessment flat, a specialist perinatal out patients clinic and a perinatal community psychiatric service.

Brockington Mother and Baby Unit
 St Chad's House
 Stafford ST16 3AG

The Brockington Mother and Baby Unit is a 6 bed unit and an outpatient facility providing assessment and treatment.



Estimated rates of perinatal mental health disorders

Actual Number of Maternities in 2014		2,401	1,079	1,859	1,854
	Rate per 1,000 maternities ³	West Cheshire CCG	Vale Royal CCG	South Cheshire CCG	Eastern Cheshire CCG
Postpartum psychosis	2	4.8	2.2	3.7	3.7
Chronic serious mental illness	2	4.8	2.2	3.7	3.7
Severe depressive illness	30	71	34	56	56
Mild-moderate depressive illness and anxiety states	100-150	239-359	109-163	186-278	185-279
Post-traumatic stress disorder	30	71	34	56	56
Adjustment disorders / distress	150-300	359-717	163-327	279-558	278-556
Total		752-1230	341-559	584-956	582-953

Actual number of maternities by CCG and Cheshire wide residents

	2012	2013	2014
West Cheshire CCG	2,441	2,388	2,401
Vale Royal CCG	1,216	1,142	1,079
South Cheshire CCG	1,975	1,781	1,859
Eastern Cheshire CCG	2,074	1,953	1,854
Cheshire total	7,706	7,264	7,193

Actual number of live births by CCG and Cheshire wide residents

	2012	2013	2014
West Cheshire CCG	2,465	2,421	2,428
Vale Royal CCG	1,234	1,156	1,099
South Cheshire CCG	2,007	1,792	1,871
Eastern Cheshire CCG	2,103	1,979	1,872
Cheshire total	7,809	7,348	7,270

Maternity and live births data source: Office for National Statistics Births data

What we don't know but would like to know...

- Actual numbers and rates of women identified as having perinatal mental health disorders and their management in Cheshire East and Cheshire West and Chester
- The range and impact of interventions available in Cheshire in relation to mental health problems, relationship problems, social support, housing conditions and sensitive mothering

Version control

Publication date	Changes made	Sign-off
February 2017	May 2016 JSNA section updated to include findings from peer support JSNA project	May 2016 sign-off: Guy Hayhurst & Helen Bromley (Public Health) Feb 2017 sign-off: Anna Whitehead (Public Health)

JSNA section contributors: Sara Deakin, Rory Strand, Helen John, Gillian Cowan (Public Health), Louise Daniels, Suzanne Thomas (CVS)

References:

¹ NHS England: Service Specification for Specialised Perinatal Mental Health Services, 2013

² NPEU Safely Delivered: a national survey of women's experience of maternity care, 2014

³ Joint Commissioning Panel for Mental Health: Guidance for commissioners of perinatal mental health services

Further information:

- [National Maternity Review](#): Better Births; Improving outcomes of maternity services in England, 2016
- [CVS Perinatal Mental Health Project, 2016](#)
- [Cheshire East Annual Public Health Report, 2015](#)