

Perinatal mental health has been recognised in recent years as a major public health concern. Researchers, policy makers, service users and health professionals have highlighted the huge impact of mental health problems during pregnancy, childbirth and the postnatal year, and the need for improved care in this area.

The government's confidential inquiries into maternal deaths starkly highlighted the high human cost of perinatal mental illness. Both the 1997–1999 and 2000–2002 triennial reports found that suicide and psychiatric illness were the leading causes of indirect maternal death in the UK. As many as one in seven women experience a mental disorder during pregnancy or in the postnatal period.

The inquiry reports highlighted a number of key areas where improvements in care may have prevented deaths or reduced that risk.

In 2007, the National Institute for Health and Clinical Excellence (NICE) published guidance on the clinical management of antenatal and postnatal mental health which underlined the importance of recognising mental health problems during pregnancy and for a year after birth.

The NICE guidance is intended to provide a blueprint for setting up cohesive services throughout England. In particular, it advocates a network approach to the organisation and provision of perinatal mental health services, managed around the woman and her family. It sets out the evidence base for clinical management of specific mental health problems, many of which respond well to treatment (Oates, 2000). The network should have an identified clinical lead who will champion the implementation of the new approach.

National focus

A new perinatal mental health project, set up by the National Institute for Mental Health in England's (NIMHE's) national Gender Equality and Women's Mental Health programme, will be looking at the keys to improving care. The national project lead for perinatal mental health is Cathy Freese (pictured left).

The project aims, in line with NICE guidance, to help set up managed care networks in each region of England and work across government departments to establish ways to encourage different agencies to work together better. The networks will oversee and manage all the clinical elements of a perinatal mental health care strategy. They are also starting to develop links with social care, including the third sector.

Mental health problems are common during pregnancy and following childbirth

Sue Waterhouse looks at what is being done to enable new mothers to access the most appropriate support

NICE guidance recommends managed clinical (or care) networks for perinatal mental health in all parts of the country. It also suggests that networks are an effective way of improving access to services and ensuring that access is equitable. They make sure there are good care pathways for women with perinatal mental health issues and help establish clear national standards for perinatal care services.

Ms Freese says: 'Often communication between maternity services, mental health and social care organisations could be improved. My role is to help facilitate the



Blues for my baby

development of managed care networks in the regions, which would help address these issues. We know that perinatal mental health issues do not only affect the woman: her whole family is affected. The mother's mental health can impact on the quality of her interaction with her baby, and therefore influence the emotional and social development of her child. The NICE guidance is clinically driven, but social care is also likely to be affected if maternal mental health is not sorted out early on.'

Crucially, the network of services needs to work across the three separate service 'worlds' of maternity, children and adult mental health, and incorporate social care and the third sector.

'Currently, we only have a couple of managed care networks in the country,' says Ms Freese. 'Generally, networks and systems of care can vary from region to region and can be disjointed. Some regions have mother and baby units, but others do not. Perinatal community



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mental health services can also vary from region to region, in both size and composition.’

BME group needs

Another area of concern and focus for the new project is women from black and minority ethnic (BME) backgrounds. The project will work to develop a national perinatal mental health network to address issues related to perinatal mental health, develop strategies for addressing the specific needs of women from BME groups and introduce these strategies to the regional networks.

The issue of maternal mental health is closely connected to that of infant mental health. Research in this area is increasingly identifying the need to focus care not solely on the mother but also on the relationship between mother and baby. Working with mothers and infants to improve their interaction and attachment may be seen as primary prevention of the development of mental health issues in children.

‘Infant mental health problems are another area of real concern,’ says Ms Freese. ‘Maternal mental health

can produce adverse outcomes and affect the mother/baby relationship, with particular long-term consequences for the child’s development. In the first two years of the baby’s life, the mental health of both the child and mother are paramount. Organisations working with families – including social services departments – need to work collaboratively to balance the needs of the child and mother.’ It is perhaps no coincidence that the new care programme approach places increased emphasis on families.

‘There needs to be more emphasis on parenting skills and better links with social care organisations, including the third sector,’ says Ms Freese. ■

NICE (2007) *Antenatal and Postnatal Mental Health. The NICE guideline on clinical management and service guidance*. Leicester: The British Psychological Society and The Royal College of Psychiatrists.

Lewis G (Ed) (2007) *Saving Mothers’ Lives 2003–2005: The seventh report on confidential enquiry into maternal death in the United Kingdom*. London: CEMACH.

Oates M (2000) *Perinatal Mental Health Services Council Report CR88*. London: Royal College of Psychiatrists.

The Gender Equality and Women’s Mental Health Programme is developing a website which will contain information about this project and provide updates. See www.nimhe.csip.org.uk

Asian women and postnatal depression

Many women who have migrated to England suffer from isolation and lack of traditional support because their families have been fragmented. They report feeling anxious about not following traditional postnatal practices of rest and seclusion, and some may feel they have experienced racial abuse. Suicide rates among Asian women are much higher than the national average. Asian people are less likely to be offered therapy or counselling services, or be referred to consultants or specialised services.

A number of studies have suggested some reasons for the under reporting of mental health problems by Asian women:

■ language and communication difficulties ■ cultural differences in the way Asian women express distress ■ feelings of exclusion by some services, which may seem alienating or racist ■ the stereotyping of Asian women as non-English-speaking immigrants ■ lack of recognition of maternal depression in the Asian community, leaving women feeling isolated within their own families.

Asian women will describe their feelings as a total body pain down the neck to back; pins and needles; tingling on one side; one side of the body feeling cold; feeling ‘spiders’ in the head or abdomen; a raised temperature; inability to rest or sleep; difficulties in swallowing; palpitations; wanting to run away; sensitivity to noise from children; and an ‘inner churning’. One Asian woman said: ‘It feels like my heart is broken in a love affair, pain and sorrow. My heart feels weak. I feel weak. I have a sinking heart. I have a heavy heart.’

During pregnancy and early motherhood, some women report that they feel angry, stressed, guilty, confused, anxious, resentful, depressed and fearful. Women’s comments include: ‘I’m just so worried about everything’; ‘I want to cry all the time’; ‘I can’t concentrate’; ‘I don’t seem able to do anything’; ‘How can I feel so bad when I’ve got this beautiful baby?’; ‘I’m confused and have no energy’; ‘I’m tired, so tired, but I can’t sleep’; ‘People are only interested in the baby’; ‘No one is interested in how I feel’; and ‘I don’t want to see anyone.’

Source: *Trafford Perinatal Service*

The East Midlands managed care network

The East Midlands perinatal mental health managed care network is one of the first to be set up and follows the NICE guidance, which was designed to ensure co-ordination, primarily across healthcare. Other models are being developed (in the north west region, for example) that also plan to include social work input.

The clinical lead in the East Midlands is Dr Margaret Oates, and the project is managed by Dr Ian Rothera. It covers 4.7 million people in five mental health trusts, nine acute trusts and nine primary care trusts.

The network plans to work with health commissioners to ensure that a comprehensive and integrated specialised perinatal mental health service is provided on a regional basis, offering equal access for all. This will include providing one or more mother and baby inpatient units, as well as specialised perinatal community psychiatric teams, and it will develop a team of health visitors and midwives trained to deal with perinatal mental illness.

The network will monitor and make recommendations on the range and quality of care and services for the East Midlands. Its remit includes: ■ developing, maintaining and updating regional core standards of care and resources for women with serious perinatal mental health disorders ■ overseeing the implementation of these standards and regularly updating them to reflect the best available clinical evidence ■ monitoring standards and clinical outcomes to ensure the most effective care and service provision ■ updating the knowledge and skills of professional groups working within maternity services and perinatal mental health ■ ensuring the ongoing education of specialist and non-specialist health professionals ■ overseeing the development, implementation and maintenance of an integrated care pathway to ensure that all women with maternal mental illness receive the most cost-effective and clinically effective care that is most appropriate to their needs ■ developing and maintaining a clinical network of health professionals committed to improving services and providing high-quality care.