Final Report

Client: Lambeth Early Action Partnership (LEAP)

Title: Perinatal mental health work in Lambeth

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Contents

Key recommendations

1. Consider using available resources to improve continuity across services and service providers;

2. Establish local clinical networks and specific care pathways to reduce variation in service provision and enable local service improvement;

3. Ensure care pathways are relevant to a variety of partners including GPs, health visitors, midwives and Sure Start workers;

4. Address the lack of data supporting the NICE recommended care pathways;

5. Improve the frequency of data collection and publication to support commissioning decisions in what is a rapidly changing landscape of local PMH service provision;

6. Any new interventions should be based on evidence of efficacy and co-produced with service users;

7. Explore the potential for developing peer group interventions, especially to meet he needs of women from key population sub-groups;

8. The data describing women assessed as having severe PMH issues are currently more comprehensive than the data on women assessed as having mild to moderate PMH issues Data collection procedures for women with mild/moderate PMH issues need to be ;

9. Undertake an audit of professional training and support needs and availability for key service providers including GPs, health visitors and midwives;

10. Use existing group antenatal care to provide sessions on emotional well-being;

11. Identify effective therapeutic interventions to supplement IAPT and other community offerings. Interventions addressing the needs of both parents and infants should be included;

12. Decisions around service commissioning should be informed by robust evidence that consistently shows talking therapies are most effective, and cost effective in both prevention and treatment;

13. Local stakeholders and research evidence suggest working effectively with population sub-groups such as minority ethnic groups and the economically disadvantaged requires good communication, cultural sensitivity and collaborative working across professions;

14. Web-based interventions are potentially promising; more work could usefully establish what might be most effective for different client groups or populations.

Summary

Lambeth Early Action Partnership (LEAP) commissioned the RTK Ltd to conduct research to inform its plans for a community-based perinatal mental health (PMH) intervention. We began the project in November 2018 and completed data collection in January 2019.

We define the perinatal period as the time from pregnancy up to one year after having a baby. PMH problems are common, affecting between 10-20% of women. Depression and anxiety are the most common mental health problems during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety; many women experience both. Depression and anxiety also affect 15-20% of women in the first year after childbirth.

Whilst women from all backgrounds and circumstances can experience PMH issues, several factors can increase risk including: poverty, migration, extreme stress, exposure to violence (domestic, sexual and gender-based), and low social support. Public Health England (PHE) statistics suggest Lambeth residents are typically exposed to more risk factors than both the London and national averages; for women living in the four LEAP wards: Stockwell, Coldharbour, Vassall and Tulse Hill, those risks may be even more acute.

PMH problems are an important public health issue because of their adverse impact on the woman but also because they can negatively affect the emotional, cognitive and physical development of the child, with serious long-term consequences.

LEAP asked the project team to review the evidence on effective PMH community-based interventions, including feasibility and generalisability considerations for Lambeth. Their specification set out the need to look at the impacts of social deprivation, cultural diversity and population mobility on intervention design.

The RTK project team were also asked to map all levels of current PMH service provision within Lambeth, including CAMHS, and analyse health data decribing women at significantly increased risk of developing mental health problem.

Finally, LEAP asked that the project interview representative key stakeholders and summarise their views on how existing community-based perinatal mental health provision in Lambeth could be improved.

To summarise, the project had three broad aims:

1. Evidence review - To critically and rapidly review the literature to identify the most effective community-based perinatal mental health practices and interventions;

2. Data mapping - To map and review perinatal mental health service activity in Lambeth, at all levels, against diagnosed and undiagnosed need; and

3. Stakeholder consultation - To elecit the views of key stakeholders on how existing community-based perinatal mental health provision in Lambeth could be improved.

Key findings from the three main strands of the project can be summarised as follows:

Evidence review:

- The issue of PMH service provision is relatively well-researched;
- NICE recommend establishing local clinical networks and specific care pathways to reduce variation in service provision and enable local service improvement;
- Evidence consistently shows talking therapies (specifically CBT & IPT) are most effective in both prevention and treatment;
- Talking therapies offer good value for money;
- Working effectively with population sub-groups such as minority ethnic groups and the economically disadvantaged requires good communication, cultural sensitivity and collaborative working across professions;
- Web-based interventions are potentially promising, but more work is needed to establish what might be most effective for different client groups;
- Ongoing professional training and support is essential to providing good quality, equitable PMH services.

Data mapping:

- ***Lambeth***
    - 3,962 women gave birth over the period April 2017 to March 2018;
    - 18.3% (726) were diagnosed as having a mental health problem;
    - 82% (596) had mild to moderate issues, 18% (130) met perinatal mental health threshold.
- ***LEAP wards***
    - 836 women gave birth over the period April 2017 to March 2018;
    - 16.5% (138) identified as having a mental health issue;
    - 78% (108) had mild to moderate issues, 22% (30) met perinatal mental health threshold.
- Women from LEAP wards are at greater risk from poverty, being from a BME group, aged under 25, and having prior social services involvement;
- Analysis suggests a significant degree of undiagnosed need among women from LEAP wards;
- Around a half of those who might benefit from talking therapies actually get access;

- None of the five care pathways identified by NICE guidelines is supported by systematic data collection and monitoring in Lambeth.

Stakeholder consultation:

- Create a centralised place to hold, coordinate and regularly update an overview of Lambeth-based services;
- Support women earlier and consistently across the perinatal period; consider using peer support groups and/or a peer support worker;
- Network with ward-based GPs to improve assessment and referrals;
- Talk about emotional wellbeing, not mental health;
- Use people, not professionals to facilitate peer groups;
- Consider targeting specific groups;
- Co-produce interventions in collaboration with service users and key partners.

Conclusions

We set out to provide LEAP colleagues with evidence they could use to inform development of a community-based perinatal mental health (PMH) intervention in Lambeth. The project has successfully described what we currently know about cost effective PMH interventions and the landscape of service provision and women's needs in Lambeth. However, just as importantly, it has highlighted significant knowledge gaps that must be addressed to ensure current and future PMH service provision meets the needs of women, children and families effectively.

Priorities for knowledge development include:

1. How services in Lambeth map on to the five care pathways put together by the expert reference group of carers, practitioners, academics, commissioners service managers and representatives from national NHS arms-length bodies convened by NHS England and the National Collaborating Centre for Mental Health;
2. How the rapidly changing landscape of service provision and women's needs can be tracked reliably using robust, current data;
3. How data can be used to assess the impact PMH services have on service users;
4. How the ongoing professional development needs of key professions including GPs, midwives and health visitors, can be identified and met effectively.

Details of the research methods we used, and our findings appear in the main body of our report and its appendices.

Section 1: Perinatal Mental Health (PMH): prevention, identification and treatment - what works?

Section 1 presents the results of a Rapid Evidence Assessment (REA) we conducted to establish the quality and quantity of available evidence on the prevention, identification and treatment of PMH. Full details of the REA method can be found in Appendix 1.

Our brief for the review was to pull together the available research evidence on three issues:

1. The most effective community-based perinatal mental health practices and interventions;
2. The effectiveness and cost-effectiveness of PMH practices and interventions for clients from different socio-economic and cultural backgrounds; and
3. Prevention, identification, and treatment of PMH disorders

We have summarised the findings from 35 papers into a narrative synthesis[1]. Narrative synthesis is a recognized approach to the systematic review and synthesis of findings from multiple studies that relies primarily on the use of words and text to summarise and explain the findings of the synthesis. Its defining characteristic is using text to 'tell the story' of the findings from the included studies.

Evidence from reviews

Existing reviews are the best place to start when assessing the state of current evidence on any topic. For that reason, we started our evidence gathering exercise by looking at existing reviews. We then looked at research published subsequently to address gaps in the evidence base where we found them.

Our initial database searches uncovered several recent very good quality systematic evidence reviews and well-evidenced PMH care pathways. Two are particularly relevant:

National Institute for Health and Care Excellence (NICE). *Antenatal and postnatal mental health NICE clinical guideline 192.* London: NICE; 2018.

NHS England, NHS Improvement, National Collaborating Centre for Mental Health (2018). *The Perinatal Mental Health Care Pathways*. NHS England and NHS Improvement.

We started with the systematic review of evidence published by the National Institute for Health and Care Excellence (NICE) in 2016 and updated in 2018. The NICE guidance on services for antenatal and postnatal mental health highlights the need to set up local clinical networks for PMH services, managed by a coordinating board of healthcare professionals, commissioners, managers, and service users and carers.

The guidelines conclude that local PMH service coordinating boards should ensure there are clearly specified care pathways so that all healthcare professionals (primary and secondary) involved in the

[1] Popay J, Roberts H, Sowden A, Petticrew M, Arai L, Rodgers M. (2006). Guidance on the conduct of narrative synthesis in systematic reviews. Lancaster: ESRC Research Methods Programme.

care of women during pregnancy and the postnatal period know how to access assessment and treatment. Boards need to be satisfied staff have access to regular supervision and training covering mental health problems, assessment methods and referral routes.
Alongside the NICE guidelines, NHS England and the National Collaborating Centre for Mental Health published details of effective Perinatal Mental Health Care Pathways in 2018. The pathways were developed with the support of an Expert Reference Group made up of carers, practitioners, academics, commissioners service managers and representatives from national NHS arms-length bodies. They use the NICE clinical guideline systematic review of current evidence to provide an overview of good practice for each of the perinatal mental health care pathways (see Figure 1.7 below)[2].

NHS England preface explanation of their pathways with the following values statement:

> *This guidance represents a commitment to ensuring that mental health care is delivered in a **person-centred**, **compassionate** and **supportive** way, promoting **safety** and **wellbeing** at the forefront. Mental health service provision should be **needs-led**, **responsive** and delivered in a way that **empowers** people to build on their strengths, promotes **recovery**, supports **families and carers**, and ensures **equality and fairness** for all.* [p.4]

The guidance is very clear that PMH services should be co-produced with services users, including families, carers and local communities, to ensure they reflect their cultural beliefs, needs and values. It describes five pathways designed to help reduce local variation in service provision and drive local service improvements.
We have set out the five pathway model in Figure 1.7. We have provided more detail in Appendix 1, including evidence from the NICE review on what good practice looks like for pathways one to five.

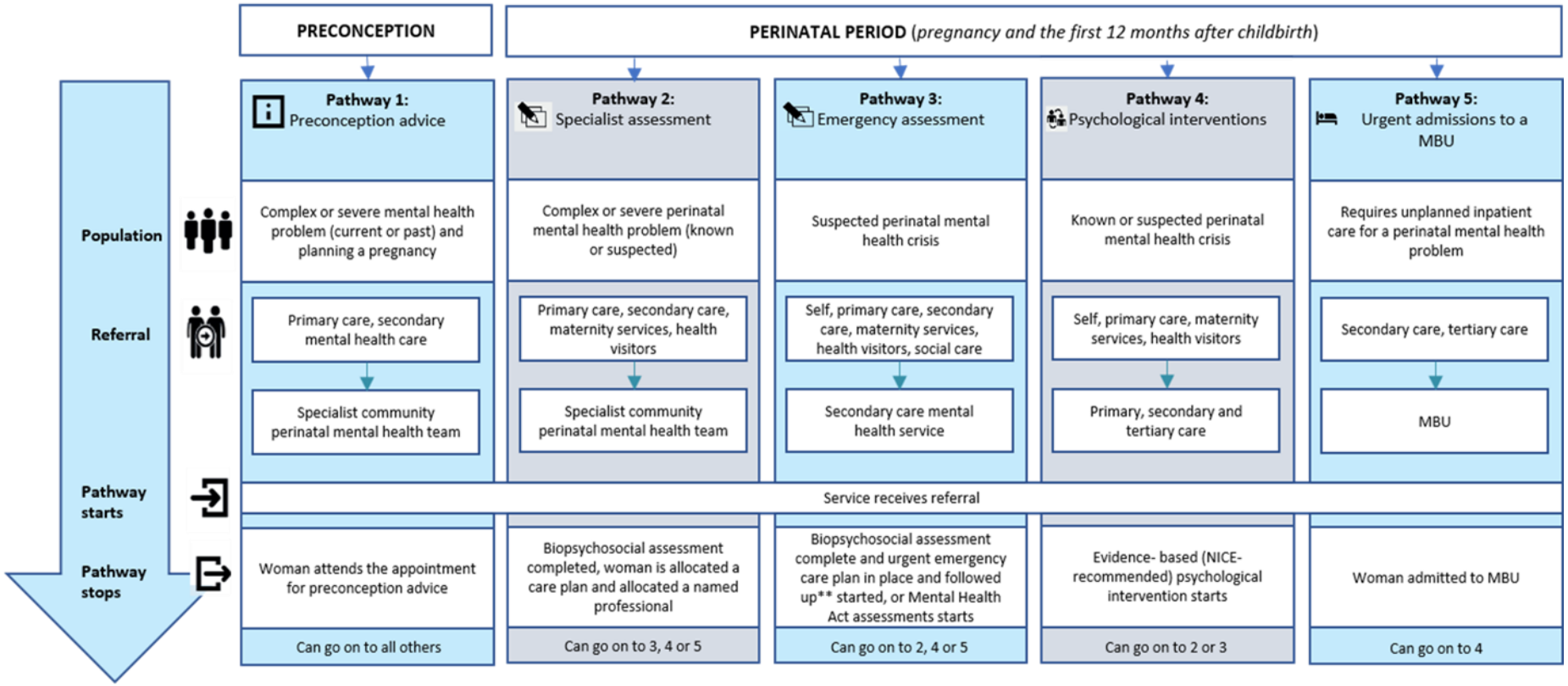
The systematic review conducted to inform the NICE guidance and used to underpin the development of the care pathways provides a robust synthesis of the available evidence published up to and including 2013. Although NICE published subsequent updates, our reasoning was that we should look for more recent reviews that may include papers published since. We have organised our summary of evidence from more recent reviews under the following headings:

A. Treatment;
B. Prevention (all);
C. Cost Benefit;
D. Population subgroups;
E. Web-based interventions; and
F. The role of key professional groups.

The rest of this section looks at the evidence in more detail.

[2] The pathways as described focus very much on women assessed as having complex and severe perinatal mental health problems. Apart from Pathway 4 (Psychological Interventions) they do not specify pathways for women with low/moderate PMH needs. Local care providers may see that as a significant gap.

Figure 1.1. The five Perinatal Mental Health Care Pathways



We have summarised the key evidence identified by NICE that underpins each of the five pathways in Appendix 1 of the report.

A. Treatment

The NICE guidance summarised the evidence on treatment as follows:

- For mild to moderate depression, facilitated self-help is effective[3]. Moderate to severe symptoms respond better higher intensity psychological interventions including cognitive behavioural therapy (CBT) and Interpersonal psychotherapy (IPT) in combination with medication[4];
- Women diagnosed as having persistent subthreshold symptoms of anxiety respond well to facilitated self-help, whilst for full blown anxiety disorders, higher intensity psychological interventions work best;
- CBT, IPT & behavioural couples' therapy are appropriate for women with diagnoses of mental disorders such as bipolar disorder, whilst psychosis is best treated through CBT or family intervention in combination with medication.

We have not found any more recent evidence that would cause the treatment advice from NICE to be revised significantly. Typical of more recent evidence reviews is one from 2017 that concluded both IPT and CBT were effective in the treatment of depression[5]

A review of the evidence concerning treatment of perinatal anxiety published in 2016 similarly concluded that the best interpretation of the available evidence appears to be that CBT should be the first treatment offered to pregnant and breast feeding women with anxiety[6].

A review from 2018[7] concluded that IPT is an effective intervention for perinatal women. As a preventive intervention, IPT reduces depressive symptoms and the prevalence of postpartum depressive episodes. As a treatment, it reduces symptoms of depression and improves relationship quality. However, they also pointed out that the current literature is not sufficient to assess whether adaptations to IPT, such as providing the intervention in a group format or including women's partners, enhance its positive effects.

B. Prevention

A 2016 review of interventions designed to prevent PMH issues was similarly consistent with NICE guidelines on treatment[8]. It found that research into the prevention rather than treatment of postnatal depression shows the most beneficial treatments to be midwifery redesigned postnatal care, PCA-based intervention and CBT-based intervention[9]. However, whilst the effects described in the research literature are significant, they are also small. Although an intervention may not prevent the onset of depression, it may reduce the severity of symptoms and extrapolated to a population level, that would represent a large

[3] Self-help interventions typically use psychological approaches based on cognitive behavioural principles. They provide written materials designed to teach people strategies and techniques to manage their issues effectively. In facilitated self-help, a therapist or alternatively a computer-based system (stand alone or web based) supports the service user apply key principles described in the materials.

[4] See Appendix 1 for definitions of CBT and IPT.

[5] van Ravesteyn, L.M., Lambregtse-van den Berg, M.P., Hoogendijk, W.J. G., Kamperman, A. M. (2017). Interventions to treat mental disorders during pregnancy: A systematic review and multiple treatment meta-analysis. *PLOS One*, **12**(3).

[6] Marchesi, C., Ossola, P., Amerio, A., Daniel, B. D., Tonna, M., & De Panfilis, C. (2016). Clinical management of perinatal anxiety disorders: A systematic review. *Journal of Affective Disorders*, **190**, 543-550.

[7] Sockol, L. E. (2018). A systematic review and meta-analysis of interpersonal psychotherapy for perinatal women. *Journal of Affective Disorders*, **232**, 316-328.

[8] Morrell, C. J., Sutcliffe, P., Booth, A., Stevens, J., Scope, A., Stevenson, M., Harvey, R., Bessey, A., Cantrell, A., Dennis, C., Ren, S., Ragonesi, M., Barkham, M., Churchill, D. Henshaw, C., Newstead, J., Slade, P., Spiby, H., & Stewart-Brown, S. (2016). A systematic review, evidence synthesis and meta-analysis of quantitative and qualitative studies evaluating the clinical effectiveness, the cost-effectiveness, safety and acceptability of interventions to prevent postnatal depression. *Health Technology Assessment*, **20(37).**

[9] See Appendix 1 for definitions.

benefit. The Sockol study noted above[10] also found IPT to be a useful preventive intervention for postpartum depression.

Cluxton-Keller and Bruce looked at the effectiveness of family therapy in the prevention and treatment of perinatal depression[11]. They found evidence that family therapy significantly reduced perinatal depressive symptoms. However, they also noted that the positive impact varied according to how intense the therapeutic intervention was. Overall, they reported statistically significant reductions in perinatal depressive symptoms for mothers who participated in both preventive and treatment interventions.

A 2013 Cochrane review[12]concluded that professionally-based home visits including intensive nursing and flexible postpartum care provided by midwives, postpartum lay (peer)-based telephone support, and interpersonal psychotherapy appeared to show promise in preventing postpartum depression.

Evidence for the effectiveness of drug-based treatments is less consistent. For example, a 2018 review of evidence regarding the efficacy of pharmacological interventions designed to prevent or treat postnatal depression found very little evidence[13]. They only identified two completed studies of antidepressant prevention of postnatal depression, concluding that it was therefore impossible to be definitive about the effectiveness of antidepressants in preventing postnatal depression. Their interpretation of the evidence was that any decision about prescribing antidepressants for preventing postnatal depression should be made on the basis individual risk-benefit analyses taking into account the preferences of the woman as well as severity and recency of previous episodes of depression.

C. Cost benefit

Annette Bauer and her colleagues at the London School of Economics looked specifically at the economic case for best practice in the delivery of perinatal mental health care in their 2016 report[14]. They concluded that investing in a comprehensive range of interventions during the perinatal period is likely to offer good value for money. These interventions might include:

- Multi-step screening and collaborative care to identify and refer women (with a role for midwives);
- Universally provided parent education and infant sleep interventions;
- Mother-infant (as part of wider) support for women with elevated symptoms of perinatal depression;
- Intensive psychological support (including CBT and IPT) during the postnatal period for women with moderate and severe symptoms;
- Multi-disciplinary support for those women with moderate to severe symptoms, offering a range of different support including exercise, yoga; and online support for some of them.

Another cost-benefit analysis looked at economic evaluations of interventions for the prevention or treatment of perinatal anxiety and/or depression[15]. The lack of consistent research designs across studies

[10] Ibid.

[11] Cluxton-Keller, F., & Bruce, M. L. (2018). Clinical effectiveness of family therapeutic interventions in the prevention and treatment of perinatal depression: A systematic review and meta-analysis. *PLOS One*, **13(6)**.

[12] Dennis C.L., & Dowswell T. (2013). Psychosocial and psychological interventions for preventing postpartum depression. *Cochrane Database of Systematic Reviews* 2013, **2**.

[13] Molyneaux ,E., Telesia, L.A., Henshaw, C., Boath, E., Bradley, E., & Howard, L.M. (2018). Antidepressants for preventing postnatal depression. *Cochrane Database of Systematic Reviews*, 2018, **Issue 4**.

[14] Bauer, A., Knapp, M., & Adelaja, B. (2016). Best practice for perinatal mental health care: the economic case. *Personal Social Services Research Unit Discussion paper DP2913.*

[15] Camacho, E. M., & Shields, G.E. (2018). Cost-effectiveness of interventions for perinatal anxiety and/or depression: a systematic review. *BMJ Open*, **8**(8).

made it difficult to draw robust comparisons. However, the researchers found two interventions incorporating talking therapies for both the identification and treatment of perinatal depression to be cost-effective.

The Morell review of preventive interventions cited earlier also included a cost-benefit element[16]. It concluded that psychological approaches (CBT-based, PCA-based and IPT-based) were all possibly cost-effective within the three levels of preventive interventions. Pregnant and postnatal women were more likely to feel their needs were being met by a midwife or health visitor when they could build trust in the context of a continuing, supportive relationship.

D. Population subgroups

A report published in 2018 reviewed the evidence on perinatal health outcomes and care among asylum seekers and refugees[17]. The authors concluded that the healthcare experiences of women with asylum seeker and refugee status needed to be reflected in service delivery. Evidence suggested that interactions with healthcare professionals have room for improvement. Specific issues included communication, discrimination and stereotyping. The authors pointed out that current UK and Australian guidelines both recommended that health professionals need to understand the specific needs of these groups of women; that a variety of means should be used to support women; and that there is a need to inform women of antenatal services and how to use them.

A 2015 study examined issues of how best to support parents from minority ethnic backgrounds[18]. The study evaluated a group-based perinatal education programme known as 'Baby Steps', designed by the NSPCC to meet the needs of a range of disadvantaged parents, including some from minority ethnic backgrounds. In interviews, minority ethnic parents who had completed the programme said it helped them develop a better understanding of pregnancy and parenting, improve relationships with partners and infants, and, for some, changed their attitudes towards gender roles, corporal punishment and female genital mutilation. Parents describing themselves as socially isolated felt the programme was a particularly important source of information and support. Elements that made the programme work included: the use of interpreters; cultural competence among practitioners; and practitioners working flexibly by offering additional support and making themselves available to liaise with other agencies on behalf of the parents.

Another paper published in 2015 looked at services for women from disadvantaged communities[19]. Women took part in focus groups to discuss their mental health needs, help currently accessed and the type of support they wanted. Their preference was for support that empowered them, which in part they thought could be done effectively through peer support. Women wanted access to a wider range of supports for mental health than were currently available to them and wanted help with their social and economic needs. The authors concluded that effective service development for disadvantaged women should be collaborative, building on women's views and experiences to overcome barriers to care.

[16] Morrell, C. J., Sutcliffe, P., Booth, A., Stevens, J., Scope, A., Stevenson, M., Harvey, R., Bessey, A., Cantrell, A., Dennis, C., Ren, S., Ragonesi, M., Barkham, M., Churchill, D. Henshaw, C., Newstead, J., Slade, P., Spiby, H., & Stewart-Brown, S. (2016). A systematic review, evidence synthesis and meta-analysis of quantitative and qualitative studies evaluating the clinical effectiveness, the cost-effectiveness, safety and acceptability of interventions to prevent postnatal depression. *Health Technology Assessment*, **20(37).**

[17] Heslehurst, N., Brown, H., Pemu, A., Coleman, H., & Rankin, J. (2018). Perinatal health outcomes and care among asylum seekers and refugees: a systematic review of systematic reviews. *BMC Medicine*, **16**.

[18] Brookes, H., Coster, D., & Sanger, C. (2015). Baby steps: supporting parents from minority ethnic backgrounds in the perinatal period. *Journal of Health Visiting*. **3** (5), 280-285.

[19] Raymond, N., Pratt, R.J., Godecker, A., Harrison, P.A., Kim, H., Kuendig, J. & O'Brien, J. (2014). Addressing perinatal depression in a group of underserved urban women: a focus group study. *BMC Pregnancy and Childbirth*, **14** (336)

Although we focussed on studies conducted in the UK, the issue of communication came up again in an Australian study that looked at barriers to engaging women at particular risk for poor perinatal mental health outcomes.[20]. Conversations with women and professionals highlighted three issues:

1. Services were very much silo-based, but women typically had issues that cut across professional silos. In those circumstances, women felt they were not always getting access to the support they needed;
2. Communication between professionals and with some groups of women could be improved;
3. Collaboration is hard work. Perinatal and infant mental health clinicians believe they work collaboratively with other service providers. Key stakeholders and documentation in the medical records reveal that collaboration is often nominal.

The authors concluded that health care professionals largely agree collaboration is essential for working effectively with women who have complex needs. However, although perinatal and infant mental health clinicians may be skilled at building relationships with women, they may need additional support when it comes to building trusting relationships with other service providers. Women service-users also need to be involved in the collaborative process to become equal partners in their care.

E. Web-based interventions

Web-based interventions are a relatively recent development in the treatment of PMH. Evidence suggests they can be effective for a variety of mental health disorders. A 2015 review[21] included studies that looked at interventions designed to treat depression, stress, and complicated grief during the antenatal or postpartum period or the time after pregnancy loss. The authors concluded that the evidence suggests computer- or web-based interventions targeted at improving mental health, especially depression and complicated grief, may be effective. However, there are significant gaps in the current evidence-base so further research is needed.

A slightly more recent review looked at the evidence for web-based interventions for prevention and treatment of perinatal mood disorders[22]. It covered interventions delivered exclusively post-partum. All studies included in the review reported an improvement in maternal mood following intervention. However, on the authors' own admission, the quality of the included studies was very variable. They concluded that whilst web-based therapies for perinatal depression delivered in the post-partum period may help, more and better quality studies are needed to provide any definitive evidence.

F. The role of key professional groups

Midwives

A 2015 study looked at the role of midwives in providing PMH services[23]. Recognising that midwives are in a unique position to assess a woman's well-being and to offer appropriate support, the study looked at their understanding and knowledge of perinatal mental health issues. In particular, the research considered whether midwives need better training in this area. Results showed a good level of knowledge

[20] Myors, K.A., Johnson, M., Cleary, M., & Schmied, V. (2015). Engaging women at risk for poor perinatal mental health outcomes: A mixed-methods study. *International Journal of Mental Health Nursing*, **24**(3), 241- 252.
[21] Ashford, M.T., Olander, E.K., & Ayers, S. (2016). Computer- or web-based interventions for perinatal mental health: A systematic review. *Journal of Affective Disorders*, **197**, 134-146.
[22] Lee, E.W., Denison, F.C., Hor, K., & Reynolds, R.M. (2016). Web-based interventions for prevention and treatment of perinatal mood disorders: a systematic review. *BMC Pregnancy & Childbirth*, **16**.
[23] Phillips, L. (2015). Assessing the knowledge of perinatal mental illness among student midwives. *Nurse Education in Practice,* 15(6), 463-469.

amongst student midwives concerning perinatal mental illness and the importance of the midwife's role in assessing and referring women appropriately to specialist services. Rather than a lack of knowledge having an impact on the quality of PMH services, the author concluded it was the lack of time midwives have to think about and act on the important observations they make in practice. Qualified midwives frequently do not have enough time to assess mental illness adequately and make appropriate referrals. Some students perceived risks associated with developing close relationships with patients; it could lead to issues being raised that midwives feel they lack the necessary skills to deal with. Furthermore, all student participants demonstrated both verbally and non-verbally, that the midwives that do take their time with women are perceived as slow and are therefore criticised by their peers.

A 2018 review looked at why perinatal mental health issues might be under-diagnosed and untreated in midwifery settings[24]. They concluded that several issues may be contributing, including insufficient training; lack of clarity regarding the scope of practice; and time constraints. In addition, what they described as system-level barriers have an impact, including:

- unclear pathways and unlinked services;
- lack of local guidelines or policies;
- poor continuity of care;
- inadequate clinical support and supervision and accessible educational resources;
- scarcity of available referral resources;
- complex bureaucratic processes; and
- challenges related to expansion of the scope of practice.

The authors concluded that training, expansion of the scope of practice and collaborative care are central for successful screening, management and appropriate and timely referrals of perinatal mental health issues. They also suggested that an integrative model of care may address fragmentation in perinatal mental health services and enable more holistic midwifery care.

Health visitors

A report from 2015 looking at health visitors asked the question as to whether the introduction of a care pathway for PMH could improve services[25]. In particular, the study looked at the role of health visitors in supporting young parents as a disadvantaged client groups with significantly poorer health outcomes for both themselves and their children. The author described a Health Visiting practice pathway for this specific client group. She argued that a planned pathway would promote a standardisation of services from all the health visiting teams and promote equity of service for all clients in this group. Developing a young parents' pathway could also help development of measurable values and outcomes of health visiting contacts to this client group.

A 2016 systematic review[26] found that extra visits from a health visitor trained in person-centred approaches (PCAs) or cognitive-behavioural therapy (CBT)-based approaches helped in universal

[24] Bayrampour, H., Hapsari, A.P., & Pavlovic, J. (2018). Barriers to addressing perinatal mental health issues in midwifery settings. *Midwifery,* **59**, 47-58.
[25] Jennison, L, (2015). Antenatal young parents: introducing a pathway to enhance health visiting practice. *Community Practitioner*, **88**(7), 37-40.
[26] Morrell, C. J., Sutcliffe, P., Booth, A., Stevens, J., Scope, A., Stevenson, M., Harvey, R., Bessey, A., Cantrell, A., Dennis, C., Ren, S., Ragonesi, M., Barkham, M., Churchill, D. Henshaw, C., Newstead, J., Slade, P., Spiby, H., & Stewart-Brown, S. (2016). A systematic review, evidence synthesis and meta-analysis of quantitative and qualitative studies evaluating the clinical effectiveness, the cost-effectiveness, safety and acceptability of interventions to prevent postnatal depression. Health Technology Assessment, 20(37).

coverage. In a PCA-based intervention of health visitor training (the PoNDER trial) health visitors were trained in the assessment of postnatal women, combined with up to eight treatment sessions for eligible women. An accompanying economic evaluation concluded that the intervention was cost-effective but required what was considered a lengthy training for health visitors, including ongoing clinical supervision and reflective practice, equivalent in total to 8 days. The economic model indicated that, among the universal preventive interventions, the PCA-based intervention was a candidate for introduction in the NHS.

Studies identified in another 2016 review concluded that health visitors had an important role in the early identification of mental health conditions during the postpartum period. The study cited good quality evidence to support the case for building health visitors' capacities to identify women with depressive symptoms postnatally and provide early psychological interventions. This included additional visits and activities from trained health visitors with the aim being to identify and – under clinical supervision - support women at risk of postnatal depression[27].

The NICE review[28] noted that:

> '..... *case identification should be an ongoing and individualised process during pregnancy and the postnatal period and that the most suitable healthcare professionals to perform this ongoing monitoring are those who have most contact with the woman, primarily health visitors*.....' [p.138]

General Practitioners

A report from the Royal College of GPs published in 2015 looked at the role of GPs in supporting women experiencing poor mental health in the perinatal period[29]. The report was based on data from surveys of GPs and women with experiences of common mental health problems in the perinatal period. It concluded the biggest barrier to providing better support is the low level of identification of need. Suggestions to improve the situation included:

- Ensuring equal attention to wellbeing and physical health during every contact with mothers, partners and families during the perinatal period;
- The six-week postnatal health check by GPs offering a crucial safety net for women disclosing later or missed by the system;
- Improving the quality of GP responses when women raise concerns about their wellbeing; and
- Support for partners to understand and act on the signs of distress.

Women responding to the survey said they were offered only a narrow range of treatment options, with the majority claiming GP responses were strongly reliant on prescribing. The report's authors claimed that may be related to a lack of faith as described by GPs in the availability of timely help from local specialist services. Very few women said they accessed mother and baby interventions that evidence suggests could improve the mental health and wellbeing of both mothers and babies.

[27] Bauer, A., Knapp, M., & Adelaja, B. (2016). Best practice for perinatal mental health care: the economic case. Personal Social Services Research Unit Discussion paper DP2913.
[28] NICE. Antenatal and postnatal mental health NICE clinical guideline 192. London: NICE; 2018. Available from: www.nice.org.uk/guidance/CG192.
[29] Khan, L. (2015). *Falling through the gaps: perinatal health and general practice*. Centre for Mental Health: London.

Interestingly, despite good evidence for the effectiveness of psychological therapies, GPs were much more likely to prescribe medication. The report suggested this may reflect referral to Improving Access to Psychological Therapies (IAPT) services often involving lengthy delays which run counter to advice in guidance, and to the need for urgent action during these critical perinatal period to prevent dual damage to mother and baby's wellbeing. It may be this perceived lack of trust in the system that encourages GPs to be over reliant on medication (which they generally control). Most GPs were not linking women up with broader packages of support available in the community and most importantly the survey found little mention of bridging women to mother and baby interventions.

The NICE review[30] noted that many people who visit their GPs with symptoms of depression are not recognised as depressed, mainly because most such patients are consulting for a somatic symptom and do not consider themselves mentally unwell, despite the presence of symptoms of depression. GPs and other non-mental health specialists vary in their ability to recognise depressive illnesses, with some recognising the vast majority of the patients found to be depressed at independent research interview and others recognising very few.

[30] NICE. Antenatal and postnatal mental health NICE clinical guideline 192. London: NICE; 2018. Available from: www.nice.org.uk/guidance/CG192.

Section 2: Local service and need mapping

The research brief was to map local services and patient needs analysing Lambeth (and where possible LEAP) perinatal mental health data. We were asked to consider including the following: maternity booking data; Improving Access to Psychological Therapies (IAPT) data; Public Health England (PHE) data; DataNet; South London and Maudsley NHS Foundation Trust (SLAM) data; and Hospital Episode Statistics (HES) data. More specifically, we were asked to address three issues:

1. Map and review perinatal mental health service activity in Lambeth, at all levels, against diagnosed and undiagnosed need;
2. Identify gaps in PMH service provision in Lambeth; and
3. Map and review mental health care pathways in Lambeth, including in the preconception period.

We have focussed on the Lambeth antenatal and postnatal pathway using the following data sources:

- Public Health England (PHE) Fingertips prevalence statistics and other associated indicators;
- Maternity Service Survey for King's College Hospital NHS Foundation Trust (KCH) and Guy's and St Thomas' NHS Foundation Trust (GSTT);
- Area Wellbeing Survey 2014 reported in Area Wellbeing Profile (0-8) ;
- GLA population statistics;
- Badgernet Maternity Database King's College Hospital NHS Foundation Trust (KCH) and Guy's and St Thomas' NHS Foundation Trust (GSTT);
- Lambeth Talking Therapies (LTT) (PMH lead);
- Health Episode Statistics (HES) data; and
- Mental Health Service Data Set (MHSDS) for South London and Maudsley NHS Foundation Trust (SLaM) perinatal activity.

We have also looked at indicators on early years and summarised data for Lambeth and where possible, provided figures for LEAP and non-LEAP wards for comparison. We have also looked at the estimated prevalence of perinatal mental health and risk factors for Lambeth compared to London and England as a whole, and at data from Lambeth women at booking, i.e.at around 8 to 10 weeks into their pregnancies.

Gaps in the data and further analysis

This analysis draws on a range of different data sources. There are however gaps and opportunities to further understand and improve the data picture in the future:

- **Primary Care**: As part of this analysis we were was unable to source primary care data due to the time constraints of approval and access through the request procedures.
- **Health Visiting**: The Health Visiting data was used to understand the service provided to women and additional insight could be gained through access to MOOD assessment data.
- **SLaM**: Whilst we had access to data on referrals to talking therapies for Lambeth, and the MHSDS provides some insight on perinatal mental health activity, further data was not acquired directly from SLaM.

1. Map and review perinatal mental health service activity in Lambeth, at all levels, against diagnosed and undiagnosed need

Diagnosed need

According to HES data:

- 3,962 women gave birth in Lambeth over the period April 2017 to March 2018;

Using Badgernet data we estimate that during pregnancy:

- Of those 3,962 women, 18.3% (726) were identified as having a mental health problem;
- Of the 726 women with a mental health problem, 17.9% (130) met the perinatal mental health threshold, whilst the remaining 82.1% (596) were diagnosed as having mild to moderate mental health issues.

At delivery:

- Of those 3,962 women, 12.6% (500) had a least one mental health ICD10 diagnosis code on their recorded on their delivery episode.

Similarly, for the LEAP wards 836 women gave birth and a lower proportion 16.5% (138) women were identified with a mental health issue. However, a higher proportion 21.7% (30) met the perinatal mental health threshold and were referred to this service.

In addition, women were admitted to hospital at other stages within the perinatal period had mental health ICD10 codes recorded as one of their diagnosis. Typical diagnoses across these and delivery episodes included 'mental and behavioural disorders due to use of tobacco' (31%), 'other anxiety disorders', (30%), and 'depressive episode' (17%). For admissions other than the delivery episode LEAP women had a statistically higher rate than women living in other Lambeth wards.

Table 2.1. *Summary of diagnosed need*

Description	Source	LEAP	Non-LEAP	Lambeth
Maternity				
Women giving birth	2017/18 HES	836	3,126	3,962
Identified mental health issue during pregnancy:	2017/18 Badgernet	138 (16.5%)	588 (18.8%)	726 (18.3%)
• met the Perinatal Mental Health threshold:		30 (21.7%)	100 (17.0%)	130 (17.9%)
• diagnosed with mild to moderate mental health issues:		108 (78.3%)	488 (83.0%)	596 (82.1%)
Deliveries with a MH diagnosis code	2017/18 HES	112 (13.4%)	388 (12.4%)	500 (12.6%)
Other admissions in perinatal period				
Admissions within the perinatal period with MH diagnosis (Rate per 1,000 mothers)	HES 2016/17 deliveries*	40 (47.8)	106 (31.8)	146 (35.0)

* Note, this may include some maternity related admissions, but they do not share the same admission date as the delivery admission. For the five years we looked at this is 47% of admissions.

Undiagnosed need

Patient needs go undiagnosed for one of two reasons:

1. a patient lives with an undiagnosed condition that should be diagnosed but hasn't been because the patient has not been referred to the appropriate clinician;
2. a patient for whom a diagnostic test is not yet available since the disease has not been characterised and the cause is not yet identified.

Clearly for the purposes of this report, we are concerned with the former. Because we don't have accurate data on the numbers of women who do not get assessed for mental health needs during the perinatal period, the best we can do is to is to provide estimates of unmet need. First, it's worth noting that the proportion of women in Lambeth diagnosed with perinatal mental health issues is broadly consistent with the 20% figure widely cited in the research literature.[31] That figure is slightly lower (16.5%) for women diagnosed in LEAP wards.
In trying to develop a best estimate of undiagnosed need, we have considered two sources: (a) data on the prevalence of known risk factors, and (b) data on children during their early years (as potential indicators of maternal mental health).

(a) Risk factors

PHE data on PMH issues suggest Lambeth residents typically have more risk factors than both the London and national averages. Compared to London and national averages, Lambeth residents are more likely to be living in lone parent households, have children living in poverty, have children on child protection plans and be suffering from severe mental illness. (See Appendix Table A2.1 for a summary of the key PHE data).

The Lambeth maternity booking data also show differences in the prevalence of risk factors between women living in LEAP and non-LEAP wards. Women from LEAP wards are more likely to have no recourse to public funds, be from a BME group, be aged under 25, have been pregnant before and had previous social service involvement. The same women are less likely to live with their husband or partner, and to have planned the pregnancy. (Appendix Table 2.2 summarises the data.)

Based on data regarding risk factors, it seems reasonable to expect the prevalence of PMH issues in Lambeth generally, and LEAP wards more specifically, to be higher the 20% national estimate. As noted earlier, the available data put the rate of diagnosis of PMH issues amongst mothers living in LEAP wards at 16.5%. We would therefore suggest there is likely to be at least some small but nonetheless significant degree of undiagnosed need amongst women living in LEAP wards[32].

(b) Early years data

Indicators for early years may be an indicator for maternal mental health issues. For LEAP wards data from the 2014 Wellbeing Survey showed higher rates of illness compared to Lambeth as a whole. School absence data shows illness authorised absence is 2% on average with a range of 0.9%-3.5% for the local

[31] For example: NICE. Antenatal and postnatal mental health NICE clinical guideline 192. London: NICE; 2018. Available from: www.nice.org.uk/guidance/CG192
[32] A member of the project steering group suggested locally conducted research on maternity service data has the put figure nearer to 27%.

primary schools. Fewer LEAP children reach expected levels of social and emotional development in reception years. Rates of children under five years of age classified as Children in Need or subject to Child Protection Plans are also significantly higher in LEAP wards compared with the rest of Lambeth. Table 2.2 summarises the data.

Table 2.2.

Early years data from children in Lambeth: Lambeth, LEAP wards and non-LEAP Lambeth wards

Description	Source	LEAP	Non-LEAP	Lambeth
Early Years				
Chronic illness, any	2014 AW survey*	37.3%	-	22.5%
- Diabetes	2014 AW survey	0.6%	-	0.0%
- Asthma	2014 AW survey	10.6%	-	10.0%
- Illness days in last 4 weeks	2014 AW survey	29.2%	-	14.6%
School absence: Age four	2016/17 DofE	-	-	4.9%
School absence: Primary relating to illness**	2016/17 DofE	-	-	2.0%
Mental health issues for pre-schoolers (1 in 18)	MCHYP 2018	223	895	1,118
- Girls (1 in 24)	MCHYP 2018	82	328	409
- Boys (1 in 15)	MCHYP 2018	143	576	719
Under 5s classified as Children in Need, rate per 10,000 population	2017/18 local data	697.2	454.1	502.4
Under 5s on a Child Protection Plan, rate per 10,000 population	2017/18 local data	110.1	50.9	62.6
Proportion of reception children achieving a good level of development	2017/18 local data	68.3%	72.8%	71.8%
Proportion of reception children reaching at least expected levels of social and emotional development	2017/18 local data	82.2%	85.0%	84.4%

* Note, the Area Wellbeing Survey was for aged 0 to 8.
** Note, this only uses primary schools rather than schools with both primary and secondary elements.

To summarise the issue of undiagnosed need, given the current availability of relevant data, we can only make informed estimates when it comes to perinatal mental health issues. However, both the risk data, and data from young children under the age of five is consistent with the view that the observed 16.5% rate of PMH diagnoses amongst women living in LEAP wards is lower than one might expect given key characteristics of the cohort. That observed discrepancy in PMH diagnosis is certainly consistent with the

hypothesis that there is some undiagnosed need of PMH services in both LEAP wards and across Lambeth more generally.

Perinatal mental health service activity in Lambeth

The antenatal and postnatal data provide context on the number of women in Lambeth going through the maternity pathway and the opportunities for identification and access to perinatal mental health services. Over the period April 2017 to March 2018, 3,283 Lambeth women were booked with maternity services at either GSTT or KCH; 83% of those women were recorded as having given birth. These women will have been supported through an estimated nine contacts with the community midwifery service, offered at least three health visitor appointments, a six-week review with their GP and ad hoc support as required (See Figure A2.1 in appendix for further details).

Women are routinely screened at booking and throughout the pathway using questions for depression and anxiety:

Screening for Depression

During the past month:

- have you often been bothered by feeling down, depressed or hopeless?
- have you often been bothered by having little interest or pleasure in doing things?

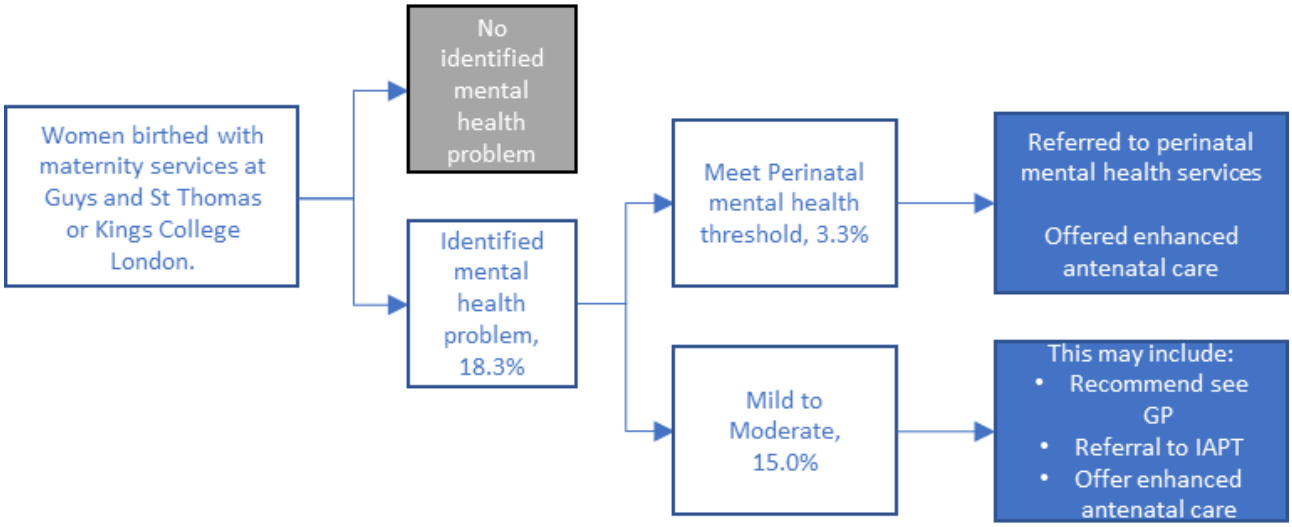
Screening for Anxiety

Over the last 2 weeks:

- how often have you been bothered by feeling nervous, anxious or on edge?
- how often have you been bothered by not being able to stop or control worrying?

At the point at which women booking with the maternity service turned up for their first appointment (typically at 8-10 weeks), 12.9% of women were identified as having a mental health issue and 2.5% were considered to have sufficiently severe symptoms to warrant referring them on to perinatal mental health services. Both these groups of women, at booking, generally have higher rates of risk factors (See Table A2.3 in appendix). They are also assessed and referred throughout the process; we estimate that 3.3% overall were referred on to perinatal mental health services and 18.3% were identified as having a mild or moderate mental health issue (Figure 2.1).

Figure 2.1. Incidence of PMH issues for women birthed with hospital maternity services



Source: Badgernet Maternity Database for Guys and St Thomas and Kings College at booking with an uplift for additional assessments and referrals based on data for Lambeth women from Kings College.

2. Identify gaps in PMH service provision in Lambeth

Part of the process of identifying potential gaps in service provision must invariably involve asking service users for their views. As part of the data analytic strand of work, we have looked at existing evidence on stakeholder views.

The Maternity Service Survey asks women to answer questions about different aspects of their care and treatment. Based on their responses, they give each NHS trust a score out of 10 for each question (the higher the score the better). Four of the questions enquire about being asked and informed about emotional state and emotional changes.

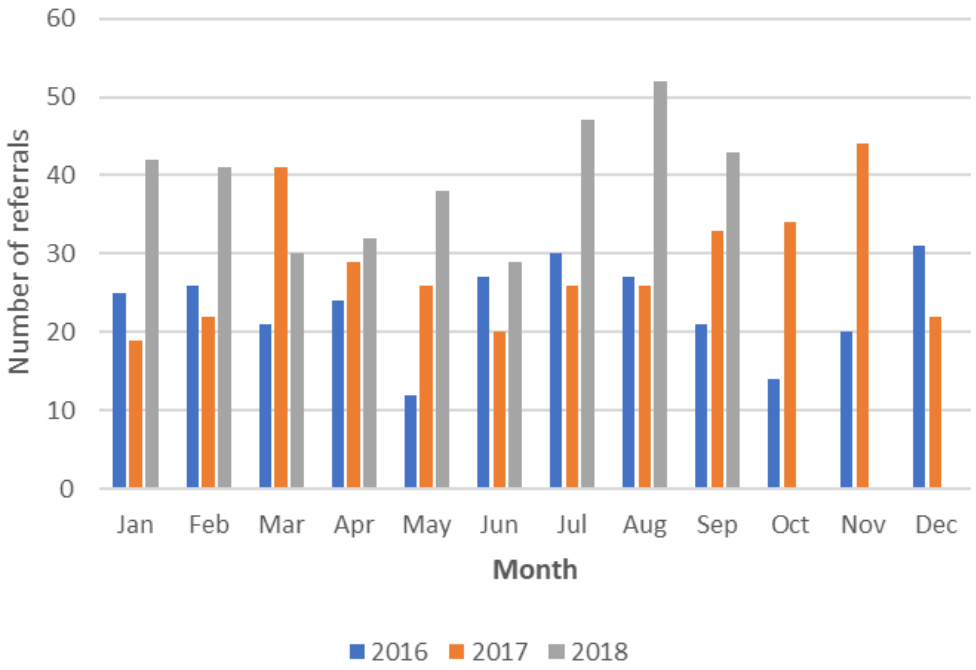
Results suggest that women surveyed in Lambeth hospitals generally found services provided by midwives at least as good as, if not better than, many hospitals (see Figure A2.2 in Appendix 2).

Our review of the evidence found talking therapies to be the most effective treatment for most perinatal mental health issues. Of the 3,962 women who gave birth in Lambeth in 2017/18, 373 (9.4%) were referred for talking therapies (see Figure 2.2).That figure compares with the estimated total of 726 identified in Lambeth as having a mental health problem, of which 130 (18%) met the perinatal mental health threshold, whilst the remaining 596 (82%) were diagnosed as having mild to moderate mental health issues.

The figures would suggest that only around half of those women who might benefit from a cognitive interventions are accessing the service. The figures are less conclusive about why that may be the case.

It could be because health professionals are not making enough referrals; however, because women must self-refer to IAPTS, it might also be because many women given details of IAPTS choose not to follow up by contacting them. The distinction is an important one, worthy of further investigation. If this is driven by poor referrals procedures, then professionals need training; if it something to do with the personal circumstances women find themselves in, then women may need help; if it is purely a practical issue, such as the lack of childcare, then practical steps need to be addressed. That said, the volume of referrals to talking therapies has been increasing; the figure for April to September 2018 is 71% higher than the corresponding figure for the same period in 2017. Also note, talking therapies may not be suitable for all these women. For example, some my refuse, and others may have these skills from previous interventions.

Figure 2.2. Number of referrals to talking therapies for Lambeth women in the perinatal period



Source: Perinatal mental health lead for Lambeth Talking Therapies, monthly data collected since 2016

3. Map and review mental health care pathways in Lambeth, including in the preconception period.

Earlier in this report, we described the five pathways developed by a National Expert Reference Group (see Figure 1.1). These pathways were designed specifically to help reduce local variation in service provision and enable local service improvements.

Currently none of the five pathways are supported by systematic data collection and monitoring in Lambeth. For example, for *Pathway 2: Specialist assessment*, we present the numbers of women referred on for specialist assessment from midwives, the main source of referrals. However, the numbers are likely to be an underestimate as there are other referral routes particularly for later in the perinatal

period. Similarly, for *Pathway 1: Preconception advice*, the data that would inform estimates of service demand and unmet need are not collected. Work with the specialist community perinatal mental health service needs to identify relevant data sources as well as the resources for collecting and monitoring the necessary data

Using data we have identified in an effort to better understand the current antenatal and postnatal pathway in Lambeth, three points are worth noting:

- Dedicated case load teams focus on women who have mild and moderate mental health issues. For example, teams at GSTT have supported 577 women since January 2018[133];
- Care is provided for women with mental health issues admitted to hospital both for delivery and for subsequent admissions during the perinatal period. A small proportion of the admissions we identified within the perinatal period had a primary mental health diagnosis.
- There is a need to understand and support needs of women who experience miscarriage or still birth as the ongoing pathway relates to women with a live birth[34].

Pathway 1: Preconception advice - Lambeth data

Data were not readily available on the number of women referred to perinatal mental health services for pre-conception advice, where referrals would be expected from primary care or secondary mental health care. To understand this pathway, a source for collecting and monitoring this data should be identified with the specialist community perinatal mental health service.

From the booking data we found a rate of 18.0 per 1,000 maternity bookings which mentioned any of secondary mental health service, bipolar, psychosis, PTSD, OCD or medication. However, data are only collected from women who progress to maternity booking; also, worth noting that the figures are based on responses to a free text field, so may only be indicative.

Pathway 2: Specialist assessment – Lambeth data

Women who have a complex or severe perinatal mental health problem are referred into the perinatal mental health service by community midwifes, primary care, health visitors and secondary care.

Based on analysis of the Maternity Services' Badgernet data, we estimate that 3.3% of maternities (130 women), were referred to PMH services by the midwifery team for Lambeth in 2017/18. This is slightly higher than the estimate for women with severe depressive illness for the borough based on national averages, of 120. However, it is worth noting that that although the midwifery team is the main source of referrals there are other sources, so the total cited above may be an underestimate.

Pathway 3: Emergency assessment – Lambeth data

Women who require emergency mental health care may present at primary care, secondary care, maternity services, health visiting or social care.

We have interrogated HES data to establish the number of Lambeth women who present at Accident and Emergency within the perinatal period for an attendance with a flag for mental health. The rate was 3.1 per 1,000 mothers for 2016/17 and a slightly higher 3.4 for mothers from 2014/15 to 2016/17.

[33] Note, this is for the wider population they serve and not specifically Lambeth women.

[34] Currently as part of implementation of Pan London Fear of Birth guidelines, this has been recognized.

Pathway 4: Psychological interventions – Lambeth data

Women in Lambeth can be referred for psychological interventions which may be provided via primary, secondary or tertiary care:

- Lambeth talking therapies, an IAPT service, had an average of 31 referrals a month in 2017/18 for Lambeth women predominately via self-referral. The total referrals of 373 is slightly lower than the estimated range for women with mild-moderate depressive illness and anxiety states (395-595). However, referrals in 2018/19 appear to be higher so far.
- The perinatal mental health service records an average of 34 contacts a month for Lambeth women under MHS29a - Contacts with perinatal MH team in the Mental Health Service Data Set (MHSDS). The average case load is 17 under MHS23a - Open referrals to perinatal MH team. From the referrals from maternity service we saw an average of 11 referrals a month.

Pathway 5: Inpatient care – Lambeth data

Women may be admitted for an unplanned inpatient admission for: the development or relapse of a serious mental illness during their pregnancy, postnatal depression, post-partum psychosis or a relapse of serious mental illness following the birth of their baby[35].

The mother and baby unit at KCH, provided by SLaM, has 13 beds; a typical length of treatment is between 8 to 12 weeks. Assuming an occupancy rate of 85%, they have the capacity to treat around 58 women a year.

Admissions for women within the perinatal period with a mental health diagnosis code was 146 women relating to deliveries in 2016/17. We looked at HES data for women since 2013/14 and of all the admissions within the perinatal period, with a mental health ICD10 code, the mental health diagnosis was the first diagnosis code for 13% of admissions; applying this rate suggests an estimated 19 out of the 146 admissions had a mental health code as the primary diagnosis.

Summary

- ***Lambeth***
  - 3,962 women gave birth over the period April 2017 to March 2018;
  - 18.3% (726) were diagnosed as having a mental health problem;
  - 82% (596) had mild to moderate issues, 18% (130) met perinatal mental health threshold.
- ***LEAP wards***
  - 836 women gave birth over the period April 2017 to March 2018;
  - 16.5% (138) identified as having a mental health issue;
  - 78% (108) had mild to moderate issues, 22% (30) met perinatal mental health threshold.

- Women from LEAP wards are at greater risk from poverty, being from a BME group, aged under 25, and having prior social services involvement;
- Analysis suggests a significant degree of undiagnosed need among women from LEAP wards;
- Around a half of those who might benefit from talking therapies actually get access;
- None of the five care pathways identified by NICE guidelines is supported by systematic data collection and monitoring in Lambeth.

[35] SLaM website: www.national.slam.nhs.uk/services/adult-services/perinatal/

Section 3: Stakeholder engagement

This section of the report summarises the key points raised by stakeholders we spoke to. What follows is a summary of stakeholder views under each of the three elements identified in the project brief:

1. Elicit, present, and synthesise the views of key stakeholders about how existing community-based perinatal mental health provision in Lambeth could be improved;
2. Make recommendations to inform LEAP's approach to implementing a PMH intervention; and
3. Make recommendations on changes in practice that could increase PMH diagnosis/detection rates.

1. PMH provision in Lambeth – what is working well & less well

We look at the issues raised by interviewees under four headings:

A. Multiple barriers to accessing PMH support
B. People around the woman
C. The importance of prevention and early intervention
D. Different structures of support

A. Multiple barriers to accessing PHM support

Public funding of PMH provision has increased significantly over the last five years. Our stakeholders believe this has led to increases in the workforce and the creation of new mother and baby units. They agreed that PMH provision for women had expanded, and awareness of the PMH agenda across the wider system had been raised. However, they also noted that much of the new funding has gone to support what they described as the top five percent of women with mental health concerns (i.e. those with more severe symptoms).

People thought that despite the increased investment, there were barriers preventing some women from accessing PMH provision, both in terms of timely initial diagnosis and referrals onto appropriate services. These barriers are not unique to services in Lambeth but are issues across PMH service provision. they include:

A new and emerging landscape

PMH services received a significant boost of funding over a short period of time[36]. This has created a local system where new practitioners, roles, services and procedures are still becoming established and embedded. Consequently, some professionals continue to grapple with the structure of local PMH provision or Lambeth pathways of care; parts of the system report success, whilst others need to develop awareness of processes and procedures. This emergent landscape means whilst interviewees had specialist knowledge of their own areas, many felt they had less of an overview of how it all joined up. This was exacerbated by the high number of women who elected to come into Lambeth (from different boroughs) to have their child at one of the two hospitals. Interviewees also reported difficulty in keeping

[36] The increased funding is part of a five-year forward plan; it is only for Specialist Community Perinatal Mental Health Teams and MBU provision. It did not have any reference to primary care provision i.e. GP, HVs or midwives. This is an important point, since a focus for LEAP is the greater numbers of women and families designated as 'mild to moderate', for whom there has been no increase in funded provision. However, there are opportunities for improving the coverage and offer of training non-mental health or perinatal mental health professionals to be 'perinatally competent' such as HEE Perinatal modules e-learning available for all levels of practitioner.

up to date with different PMH services, particularly third sector support. This apparent lack of knowledge is potentially critical, given it implies some women do not know how to access services effectively.

Emotional responses to motherhood

Interviewees described the perinatal period as a potentially isolating time for new mothers. With high expectations of motherhood and parent-child bonding, the reality of having a baby could be disorientating, regardless of whether a mother had a previously presented with a mental health issue or not. Experience showed it was common for some mothers to think they are the only ones struggling; many in that situation find their confidence undermined so feel nervous about joining children's groups or reaching out for support:

> *'There's that whole thing that people just think, 'I'm the only one that's struggling. Everyone else is coping really well'. They're anxious. Going into children's centres and groups is too much for them'.*

Some described how women can feel ashamed of struggling with motherhood, particularly in terms of not enjoying their time with their baby. They might worry they were not experiencing natural loving or maternal reactions, raising questions about their fundamental ability to be a mother. Rather than reaching out for help, they become more isolated and withdrawn, concerned that showing signs of not coping might mean that their child would be taken away from them.

Group sessions are being provided by some professionals to help normalise the daily realities and challenges of being a parent. The perception is that they have helped generate more realistic expectations of motherhood and reassured women that they are not alone.

Timing of medical check ups

Professionals we spoke to agreed women were better supported the earlier they were referred for help. For pregnant women, it was especially important to identify potential mental health issues as early as possible before birth disrupted treatment.

Regular antenatal support is critical; lags in care during pregnancy make it more difficult to monitor and respond effectively to potential mental health issues. And yet, as one interviewee explained, it is not unusual for mothers to experience gaps of nine weeks or more before medical appointments:

> *'There's a long period of time when a woman doesn't see a midwife. Between 16 and 25 weeks (when you see a GP) and then between 16 and 28 weeks for a midwife. Which is a long time. And you have a quick 16-week appointment. That can be a long time. Generally, for mental health concerns it's the 34 weeks-time when women begin to start to talk about fear of childbirth. Anxiety comes out around there'.*

Interviewees agreed more regular check-ups with a focus on mental as well as physical wellbeing would help medical and health care professionals best support women throughout the perinatal period. People recognised that whilst it was unlikely that LEAP could affect the timings of medical appointments, increased support for women from as early as possible would help pregnant women and mothers be mindful of their mental health and encourage them to raise potential concerns as and when they emerge.[37]

[37] A consultant midwife on the project steering group suggested that might be achievable through mandating increased or additional focused appointments for women who have already identified previous or current mental health problems. NICE Antenatal Care guidance is the basic standard care with an '*additional appointment* 'to be offered according to any additional needs. NICE antenatal and postnatal mental health guidance mandates for this group of women to have an agreed individualised plan to monitor their

Lack of consistent professional intervention

Stakeholders highlighted continuity of care as critical to service quality, whether that was women having a single point of contact throughout the perinatal period or ensuring effective communication between professionals as women moved between services.

Participants at a maternity network meeting (including service users and service user representatives) described their perceptions of inconsistencies across different healthcare professionals. Their specific issues included:

- the lack of education and training promotes inconsistency in conducting mental health assessments across professionals which can lead to inappropriate referrals; and
- the inequality of experience for BAME women, both in terms of higher rates of death in childbirth but also in terms of ongoing care and support.

Interviewees reported that many BAME women experienced inequalities and feelings of being poorly supported when they approached health professionals. They identified a need to work with the health care system to improve consistency of care, and with BAME women to ensure their needs are being met.

Cultural barriers to accessing support

Cultural specificity can have an impact on BAME women even though they may be second or third generation migrants; the suggestion was they might be prevented from speaking confidently about their feelings or might not receive the support they need from their family or BAME professionals even when they did. People generally felt that further work could take a needs-based approach to designing a service (i.e. evaluating the needs of individual women and coordinating appropriate supports) that is fully cognisant of how cultural barriers might influence access to mental health services.

Similarly, some interviewees suggested that women who didn't grow up in Britain with the NHS had different expectations of health care and might not be as confident requesting support.

On a more practicable level, the suggestion was made that reliance on the written word can be a barrier for those whom English was not a first language. Interviewees were at pains to point out that information should be designed with judicious use of symbols and infographics to ensure they are widely accessible and inclusive.

Lack of childcare

Stakeholders noted that any intervention working with women during the perinatal period must consider childcare needs, as well as timing of sessions (e.g. avoid clashes with school pick up) to ensure the service is genuinely accessible to the women it targets[38]. Different therapeutic interventions have different rules around whether a woman can take her child along to sessions. Some services, particularly those delivering therapy shortly after birth, prefer to see the mother and infant together to help support additional bonding. Other services stipulate that they prefer to see the mother alone, particularly when the child is older and needs more attention. In these instances, services described how they sought to deliver

mental health in pregnancy. It might be helpful to consider with women if, and when some additional contacts could be mandated, for example a 23-25 weeks antenatal visit to focus on baby in mind and look at Wellbeing in Pregnancy planning. An additional visit before 28 weeks for example for women who have history of previous depression or anxiety being medicated but not during pregnancy. This would be to review their mental wellbeing, and their progress from their viewpoint.

[38] This is consistent with findings from a local ESMI DAWN research study that looked at a pregnancy specific adapted IAPT programme and included the views of mothers on barriers to accessibility.

sessions at children's centres so that they could offer childcare provision alongside the session. However, given the stretched capacity at children's centres, it is not always possible to offer a creche facility. This can act as a significant barrier to those mothers who did not have other forms of childcare support.

B. People around the woman

This section explores stakeholder views on the different roles people play in supporting women during the perinatal period as well as potential gaps to inform future service development.

Medical professionals

Stakeholders set out what they saw as the benefits of women having access to a well-trained workforce who took a consistent approach to care provision:

- early identification of potential mental health issues;
- appropriate and timely referrals;
- clear explanation of the reasons for referral to increase the likelihood of attendance; and
- effective oversight and coordination of care pathways.

Stakeholders felt all these behaviours served to ensure women have all the information they need to make informed choices and decisions.

Recent investment in PMH services has led to a significant increases in the numbers of both practitioners and services. Whilst people noted huge benefits, they also recognized that more work needed to be done to train newly recruited practitioners and medical professionals who play key roles in PMH.

People noted the critical role played by GPs in supporting women through the perinatal period; they have a significant role as a gatekeeper, supporting newly pregnant women as well as advising and overseeing care and information during the pre-conception period. They described mixed experiences of GP expertise around PMH. Some GPs they claimed, were offering a service consistent with accepted models of good practice; others were descried as not championing mental health alongside physical health.

The consensus was that further work may be needed to support GPs in Lambeth in both assessing mental health and making appropriate referrals[39].

Interviewees recognised the important work of midwives to identify and support mild mental health issues and refer onto other services effectively. Midwives, they said, were also critical to explaining referrals to women and their families, important in providing reassurance, encouraging attendance and overseeing internal care pathways.

Health visitors have opportunities to provide light touch or more direct support, depending on women's needs. Health visitors had a similar referral role to midwives and could also reassure women about appointments. Both midwives and health visitors need to have a basic understanding of mental health issues, as well as clarity about the local provider landscape and referral processes. Work has taken place in Lambeth to deliver this type of training, and to create a database of borough-wide services; interviewees described training, awareness-raising and oversight of activities as critical ongoing work to help the workforce understand relevant care pathways as suggested below:

[39] The Royal College of GPs can offer training days. HEE has online Perinatal Training available that includes GP specific modules. The London Perinatal Clinical Network or SE London Perinatal Clinical Network could be a potentially useful source regarding advice and planning GP training in the sector.

'For all the different practitioners in Lambeth, for all the women across the care pathway, there are different roles and responsibilities and it's about knowing how Lambeth works.'

Other services

People identified other providers who had contact with women at risk of, or who already presented with, mental health conditions. They described how they both helped and hindered the services they were trying to deliver to women. Examples of cross-system barriers to delivering effective PMH care included:

- a woman already involved with child social services who was reluctant to address her own mental health issues as she felt it might put her child at risk of being taken into a care; and
- a mental health practitioner reluctant to allow their patient to go to secondary PMH psychotherapy, partially down to consistency of care concerns but also due to lack of understanding of PMH services.

Problems with the stigma of PMH and the lack of understanding of new services designed to help again suggests more work needs to be done to educate the wider workforce across services n Lambeth.

For many interviewees, the importance of a collegiate approach – fuelled by collaboration, a learning approach and transparency – was key to delivering appropriate outcomes for families at risk.

Family and friends

As might be expected, interviewees often described the role of friends and family in influencing women in the perinatal period. A wide and supportive network was generally understood to help pregnant women and mothers[40]. Conversely, women who were in abusive or otherwise damaging relationships, or who were isolated in other ways, were assessed as being at significant risk of developing a mental health problem.

Some suggested that BAME groups might not have the language or cultural constructs to conceptualise mental health issues such as depression. One BAME interviewee suggested that she had been encouraged not to talk about her low mood when it first emerged after giving birth. Instead she was told to enjoy the perinatal period, rather than explore it with a GP. As she explained, this denial of her mental health issue was still apparent in her peers:

'I'm of a generation that understands mental health but when we do speak to our mums, aunties, grandmas they say no [it is not a mental health issue], pray to God, to Allah instead. But the new generation are more willing to seek help. Not for mental health, they're in denial that it's mental health related, but they are willing to seek help at least'.

The suggestion from some was that there might be an opportunity to support family and friends in the perinatal period, whether this involved close or extended family.

C. The importance of prevention and early intervention

Stakeholders agreed that there was a need to provide support for women at an earlier stage in their pregnancy, either as a means to identify and treat issues earlier (minimising escalation from mild to moderate) or to prevent issues from emerging altogether. Interviewees agreed that prevention and early intervention were critical points in the PMH care pathway.

[40] This is not to imply that friends and family – or indeed financial security – were key to preventing mental health issues in the perinatal period. Interviewees gave multiple examples of otherwise high functioning, middle class women who presented with their first episode of depression after giving birth.

> *'The focus has been on that ill end. And for this to all work properly it has to work across the care pathway for whether you're mildly unwell or severely unwell. And there has to be an element of prevention, so things not getting to that stage'.*

Whilst women with moderate to severe mental health issues invariably required professional help, interviewees agreed there was space for other organisations and people (beyond medical professionals) to deliver programmes to tackle prevention and early intervention. Indeed, LEAP, with its focus on four wards was considered well placed to contribute to this body of support. In addition, interviewees with knowledge of public health approaches felt LEAP could consider a wider public health approach to PMH, focussing on risk factors, such as obesity and smoking, and talking more generally around wellbeing and feelings as opposed to mental health.

People also described the importance of focussing more generally on wellbeing and emotional health as opposed to mental health problems. The potentially stigmatising nature of PMH issues, not to mention the different cultural understandings of mental health, meant that wellness was a much more accessible and gentle means to support women to explore their feelings. This approach worked during antenatal classes that focussed on the transferable skills gained through breathing and relaxing:

> *'During [antenatal] classes we don't ever [directly] talk about depression or anxiety but we talk it about in a different way. Breathing, relaxing, pelvic floor. Relaxing. Preparing for labour. We hope they take it home to help them deal with anxiety and depression'.*

People also pointed to the Whooley questions as another evidence-based approach to talking about wellness and emotional health more widely, particularly in term of preventative and early intervention interventions[41].

D. Different structures of support

Interviewees described a range of options for delivering early intervention or prevention interventions. Undoubtedly there was considerable support for interventions delivered to women in groups, usually involving them at regular points from as early in possible in pregnancy and into the postnatal period. Groups, people felt, not only offered an opportunity to explore different aspects of motherhood but also helped build up bonds amongst women to strengthen their networks and build trust so they could support each other. They could also be light-hearted and fun, finding humour and relief in an otherwise challenging time.

As well as focussing on bringing different women together, interviewees described other forms of group work. They gave examples of family-based interventions in different formats, bringing together different combinations of mothers, fathers, partners, children and babies. They thought it might prevent or tackle their own mental health issues, or help them support their partners with problems.

Interviewees involved in group work described the benefits of bringing women from across backgrounds together rather than targeting support at a specific group. Referrals to a group are typically based on mental health condition rather than a specific risk factor. The benefit of this approach was that it highlighted commonalities of experience during the perinatal period, regardless of peoples' wider situation or resources.

Although people were generally enthusiastic about group approaches, interviewees raised three key questions:

[41] https://whooleyquestions.ucsf.edu/

1. Could a comprehensive picture of groups being run in Lambeth be developed to make it easier to establish who is delivering what activity and where gaps in provision might lie?
2. Could gaps in the evidence base around the impact of group work and which approaches are most effective with different groups be addressed?
3. Would group work ever be a realistic approach for the borough's most vulnerable women?

For more vulnerable women, people generally believed targeted support by a mental health professional was critical. Examples cited included a programme that engaged parents alongside children with a behavioural disorder; interventions were delivered at the family home, allowing the professional to explore needs in depth. They could liaise with other services working with the family and educate and influence parents about their role within the context of the other services they received.

Another popular way to help vulnerable women was through peer support, seen as an important way of involving people who had been through similar experiences:

> *'Peer support is important. That model of – I've experienced PMH problems and I want to help someone going through difficulties - works. And having it in a paid formalised way. So they are paid and trained and work within specialised services on an equal footing to offer that peer to peer support. It becomes a recognised role – rather than a nice to have. There are one or two services around the country doing that, and a couple of mum and services doing peer support practitioners.'*

Stakeholders suggested a peer support worker could be an effective way to build trust and help explore feelings in a non-threatening way for women suspicious of professionals and the care system more broadly. Some suggested the peer support role could also include elements of care navigation or, as being delivered by one peer worker programme, have the ultimate flexibility to support the women, whether that was to attend medical appointments with her or even join her on a shopping trip.

Stakeholders thought peer support had the added advantage of engaging women with lived experience who could then support the design of services. Interviewees agreed this was an opportunity to promote co-production, one of the markers of good practice essential to delivering quality and effective needs-based services.

2. Recommendations from stakeholders

A. Recommendations to inform LEAP's approach to implementing a PMH intervention

Recommendation 1: Facilitate a centralised place to hold and coordinate an overview of Lambeth-based services. One of the key findings was around the rapid changes to PMH provision over the last few years as the PMH agenda received strategic focus and investment. Despite – or perhaps because of this – stakeholders believe there is a role for LEAP to support PMH champions to compile a full list of Lambeth-based services. This includes the full picture of interventions delivered through groups to help build a comprehensive service overview and identify gaps in delivery. Their view was that such a move would help coordinate service delivery, improve the quality of referrals and raise awareness of all services on offer.

Recommendation 2: Support women earlier and consistently across the perinatal period; consider using peer support groups and/or a peer support worker. Interviewees agreed that there is a

potential role for LEAP to support women in the perinatal period with a focus on earlier intervention to prevent the onset of PMH issues. LEAP should look at the potential role of group level or peer-led interventions, depending on the cohort of women targeted. In keeping with the co-production ethos, peer groups could be encouraged to discuss what earlier 'support' help could look like, for example open conversations what 'extra appointments' could look like in maternity if a woman has a history of mental health problems.

Recommendation 3: Network with ward-based GPs to improve assessment and referrals: Given the importance of GPs as gateways to timely diagnosis and referrals, stakeholders recommended that LEAP work to increase networking with GPs at ward level. This would help raise awareness of the needs of local women around PMH, encourage more constant mental health assessments and improve the quality and efficacy of subsequent referrals. Community Mental Health Teams might have a role to play in this approach. It might also be helpful to consider training professionals together in bite sized modules and creating a method of tracking who has done what.

Recommendation 4: Talk about emotional wellbeing, not mental health: Any early intervention or preventative intervention would benefit from focussing primarily on wellbeing and emotional health before specifically addressing PMH. There might be an opportunity to adapt the Wellbeing Plan for everyone engaged in the intervention and not just those assessed as having PMH needs. For example, this might underpin a universal discussion at agreed times led by people trained to be as comfortable asking well-being questions just as they ask about micturition or foetal movements.

Recommendation 5: Use people, not professionals. There is an opportunity to help normalise the perinatal experience, as well as build up trust with vulnerable groups, by engaging people with lived experience of PMH interventions. This might be through group work or it might be through one-to-one peer support or informal case management.

Recommendation 6: Consider targeting specific groups. Stakeholders did not reveal who to target through PMH interventions. Their view was that interventions should be shaped according to local need at ward level, perhaps by engaging wider stakeholders such as refugee services, hostels and housing officers. Others identified benefits of bringing women together from across backgrounds, rather than targeting specific groups. Professionals did identify specific groups they thought may benefit from building on the development of emerging bespoke interventions:

- Women who experience perinatal loss;
- Refugee women under 25 who are homeless;
- Immediate family including fathers, partners and children; and
- Wider intergenerational family members.

Recommendation 7: Co-produce the final intervention in collaboration with service users and key partners. Stakeholders recommended that any LEAP intervention be designed in collaboration with service users, partners, local networks and communities. They were convinced that building a service around an established need, and engaging people with lived experience, are markers of good practice in service design.

B. Recommendations on changes in practice that could increase PMH diagnosis/detection rates

Recommendation 1: **Keep the conversation going: build momentum around the research and awareness raising of LEAP**. Despite the short window for the research and the busy nature of stakeholder diaries, interviewees involved in PMH showed huge interest in the agenda and passion to improve the service and provision for women in the perinatal period. Interviewees would like to be involved in further LEAP discussions about the research and learn about LEAP more generally. To that

end they recommended that LEAP:

- disseminate findings, potentially through a launch event and invite contributors to discuss the findings; and
- present the findings more widely to key networks, to widen the net of individuals engaged in the discussion.

Recommendation 2: Add voice to the Hidden Half campaign[42]. Stakeholders referred to a national campaign run by the National Childbirth Trust called the #HiddenHalf which was organising in protest around plans to drop the six-week check. They asked whether LEAP is well-placed to add support to this wider national campaign alongside their local PMH activity.

Recommendation 3: Evaluate services to build up a robust evidence base around what works in Lambeth. Finally, given the emergent but patch body of evidence around local PMH provision, interviews recommended that LEAP commission independent evaluations of interventions to measure impact on key mental health outcomes and so generate learning around what works when it comes to effective PMH services for Lambeth.

Recommendation 4: Take a public health approach to prevention by unpicking the underlying symptoms, the indicators of vulnerability. Recognising LEAP's public health remit, and the recommendation to focus more widely on wellbeing, there is an opportunity to target women in the perinatal period by identifying key public health risk factors. Coordinated, cross-service support could look at health behaviours (such as tobacco or alcohol use) as a means of identifying mental health risk.

[42] https://www.nct.org.uk/sites/default/files/related_documents/Hidden%20Half%20shortform%20report.pdf

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Appendix 1

The REA method

REAs use systematic review methods to search and critically appraise existing research. The strength of the method lies in following a clear set of procedures and recording precisely what has been done at each step to enable the process to be replicated if necessary. REAs are characterized by rigorous and explicit methods but provide a quick synthesis of the available evidence by shortening the traditional systematic review process. This can be important when limited time or financial resources mean there is not enough time to conduct a full systematic review. REAs can speed up the review process by:

- Limiting the breadth of the research question;
- Using less developed search strings rather than extensive search of all variants;
- Using 'grey' and print sources but less exhaustively than systematic reviews;
- Establishing good inter-rater reliability for quality assessment using two raters for a sample of relevant papers. Once good interrater reliability has been established, tie and resources are saved by using a single rater for the majority of papers.

We have conducted this review according to guidelines developed and written by Government Social Research (GSR) and the Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre), part of the Social Science Research Unit at the Institute of Education, University of London[43].

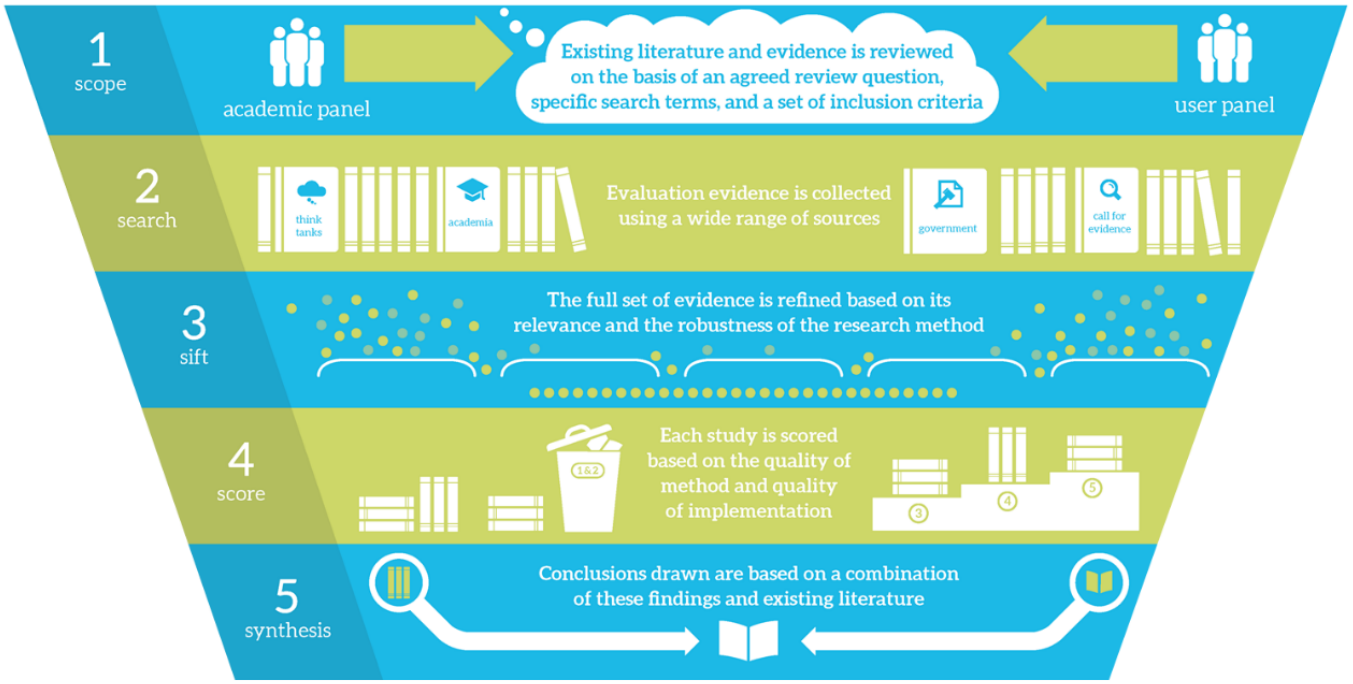
It is worth noting however that limits on resources can create restrictions for REAs relative to full systematic reviews:

- Time constraints mean REAs (a) may miss some literature not catalogued on the key electronic databases, and (b) use a second assessor for rating only a small sub-sample of papers;
- Time does usually not allow for REAs to involve 'pearl growing', i.e. going through the reference lists of selected articles looking for other potentially important sources that searches of electronic databases may have missed;
- All review methods, including REAs, risk generating inconclusive findings that provide a weak answer to the original question if there not enough studies of sufficient methodological quality to address the question. The timescales to which an REA is delivered means that if findings are inconclusive, there is not enough time to go back and reformulate the question or inclusion criteria.

Figure A1.1 summarises the stages of the REA process. Full details of the REA methods, including copies of the quality assessment tools we have used, are in the appendices to this report.

Figure A1.1: Summary of REA methodology.

[43] http://webarchive.nationalarchives.gov.uk/20140305122816/http://www.civilservice.gov.uk/networks/gsr/resources-and-guidance/rapid-evidence-assessment



Assessing the strength of a body of evidence

The last twenty years has seen a real growth in what has become known as Evidence-Based Practice (EBP). Stakeholders have recognised the benefits of developing EBP in areas including public health and social policy. To quote the Treasury's Magenta Book:

> *Good evaluation, and the reliable evidence it can generate, provides direct benefits in terms of policy performance and effectiveness, but is also fundamental to the principles of good government, supports democratic accountability and is key to achieving appropriate returns from taxpayers' resources. A good evaluation is therefore a normal and natural part of policy making and effective government and is a powerful tool available to the policy maker.* [p.12][44]

Evidence reviews are a critical element in developing EBP; they are used to summarise the main characteristics of a body of evidence in relation to a specific issue. Guidance on how to assess the strength of a body of evidence typically highlights four important characteristics:

(a) The **quality** of individual articles or papers that make up the body of evidence;

(b) The **quantity** (number) of papers that make up the body of evidence;

(c) The **consistency** of the findings produced by the studies making up the body of evidence; and

[44] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/220542/magenta_book_combined.pdf

(d) The **context** in which the available evidence has been collected.

The quality of studies

Based on established evaluative methods, we used two different quality assessment systems, one for primary research studies, and a second for evidence reviews, to assess studies included in the review. As noted above, an essential element of a review is to provide a guide to the credibility of each included study.

Quality assessments of single studies
We assessed the quality of primary research studies on seven criteria: rationale for overall research strategy, study design, sampling strategy, data collection procedures, data analysis, interpretation and reporting of results, and the credibility of the conclusions. Where primary studies tested the impact of specific interventions, in addition to the seven criteria listed above, we rated the design of the intervention study using the Maryland Scientific Methods Scale (SMS)[45]. Not all primary studies test interventions, (e.g. some may report survey findings) therefore not all primary studies were rated on the SMS. Details of the quality assessment system for primary studies and quality scores for papers assessed can be found in the appendices, along with a description of the SMS scoring system.

Quality assessments of reviews of studies
For reviews, we used eight criteria: review method, search strategy, data collection (sift), quality appraisal, data analysis (quantitative), qualitative synthesis, interpretation and reporting of results, and credibility of conclusions. Details of the quality assessment system we used for reviews can be found in the appendices of this report, along with quality scores for all the reviews included.

The quantity of papers

One of the key strengths of empirical research the capacity to replicate or repeat investigations to see if the same results are found. That is why it is so important that research papers provide enough detail of how an investigation was conducted to enable someone else to repeat what was done. The more times a finding has been replicated, the more confident we can be that the effect is a real one rather than a product of the way a study was designed and implemented; the more studies done to test a theory or intervention, the stronger the body of evidence. However, there is no rule of thumb for how many studies are needed to constitute an adequate body of evidence. That often depends on the research question being investigated; the more complex the question, then the more studies that are needed to be confident that the evidence base is strong. Certainly, where only one or two studies have been done, even if they are well-designed, it is reasonable to conclude that the body of evidence is limited. Based on recommendations, we take a case by case approach.[46] For each review we undertake we categorise the size of the evidence base as small, medium or large, and specify the number of studies associated with each category. Typically, we might assess the size of the evidence base as 'small' where the review has

[45] Sherman, L. Gottfredson, D. MacKenzie, D. Eck, J. Reuter, P. Bushway, S. (1997) *Preventing Crime: What Works, What Doesn't, What's Promising* Washington: US Department of Justice.
[46] Department for International Development (2013). Assessing the strength of evidence: DfID practice paper. www.gov.uk/government/publications/how-to-note-assessing-the-strength-of-evidence . Last accessed March 10th2014

identified five or fewer studies, 'medium' where we have found between six and ten studies, and 'large' if eleven or more studies were found.

The consistency of the findings

A strong body of evidence is usually defined as one where many studies all report the same or similar findings when a specific intervention is delivered to a clearly defined group of end users. However, social interventions are typically complex. As a result, it is possible to have many studies that, because they have tested slightly different interventions in different social contexts, do not provide entirely consistent findings. Using a review to synthesise the findings from multiple studies helps to establish the degree of consistency in a body of evidence by exploring the impact of these similarities and differences.

The context in which evidence has been collected

A review needs to acknowledge the context in which the evidence cited has been produced. It is important to have a good understanding of how well evidence collected in one context can be generalised to another. In social policy research, country of origin is often, although by no-means always, relevant. Critical elements of social context may include details of the wider landscape of services within which interventions are being delivered. Depending on the level of detail reported in individual papers, it may not always be possible to take such variations into account.

Summary

To summarise, the strength of a body of evidence depends on the quantity of research that has been conducted, the quality of that research, the context in which the research was done, and consistency of findings across papers and articles uncovered by a search of appropriate sources. The rest of this section of the report describes the quantity, quality and context of the evidence we uncovered.

Quantity of research available

Our review set out to:

- Identify the most effective community-based perinatal mental health practices and interventions;
- Cover the effectiveness of PMH practices and interventions for clients from different socio-economic and cultural backgrounds; and
- Span prevention (preventing the onset of mental illness), identification, and treatment of PMH disorders

Because NICE had recently published a high quality systematic review[47] and given the time constraints, we decided in conjunction with the project steering committee, to limit our search to studies that had the following characteristics:

i. Reported in the English language;

ii. Reported the findings from reviews of empirical studies that reported data;

[47] NICE. Antenatal and postnatal mental health NICE clinical guideline 192. London: NICE; 2018. Available from: www.nice.org.uk/guidance/CG192

iii. Were systematic reviews or rapid evidence assessments of empirical papers that at perinatal, postnatal or pre-natal populations;

iv. Assessed the impact of interventions on depression, anxiety, other mental health issues or psychosis;

v. Were published after 2013.

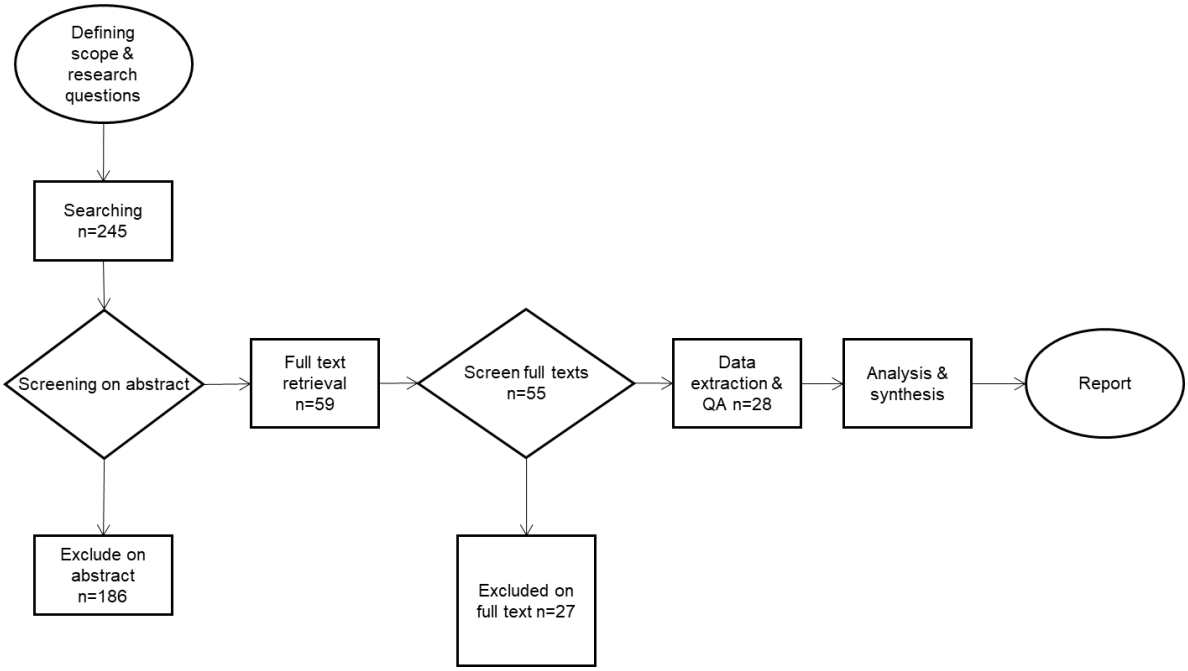
Table A1.1 summarises the number of hits returned from each of the databases we searched.

Table A1.1
Summary search terms and hits returned by database searched

Database	Hits	Full texts selected for retrieval
Cochrane Library	17	9
Web of Science	218	45
Social Policy & Practice	10	5
TOTAL	245	59

The flow diagram below shows the numbers of studies identified at each stage of the REA.

Figure A1.2: Rapid Evidence Assessment (REA) workflow: evidence reviews concerning effective perinatal mental health practices



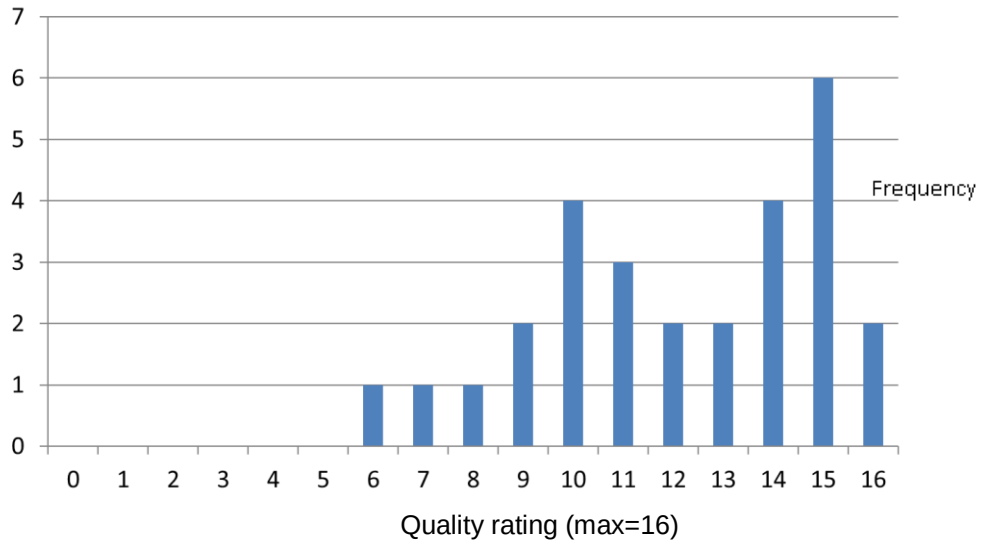
Of the 59 references selected for full text retrieval, we were able to obtain 55. When the full texts were reviewed, a further 27 papers were excluded on the basis they did not meet the inclusion criteria, leaving a total of 28 sources for inclusion in the review. Of those 28 papers in total, all were reviews of research. The inclusion and exclusion criteria used to select texts for full review are in the appendices.

Quality of individual research studies and reviews

We assessed reviews on eight criteria, with each of the criteria has been marked on a scale of 0-2, giving a possible total score of 16. Three papers selected at random were coded independently by two members of the research team to establish there was no systematic bias in quality coding.

Figure A1.3 (below) shows the distribution of the quality ratings across all papers we included in the review. The reviews we included are generally of a good standard.

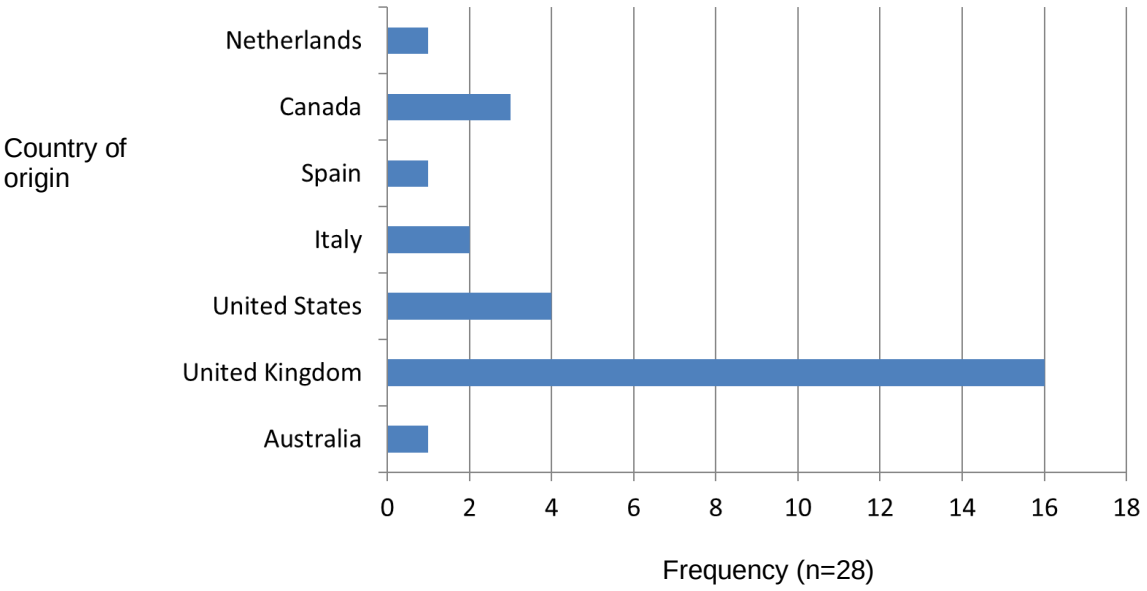
Figure A1.3: Distribution of quality scores across papers included in the review (n=28)



Context - international comparisons

Figure A1.4 (below) shows most research in this area comes from the US and the UK. Of the 41 papers included in the review, 12 originated in the UK. Consequently, we need to consider carefully how relevant research conducted in one region might be to policy and practice in another.

Figure A1.4: Country of origin of papers included in the review



Supplementary review

Having looked at the results of the review of reviews described above, we noted that it provided only limited evidence on the effectiveness of PMH practices and interventions for clients from different socio-economic and cultural backgrounds. Consequently, the project steering group noted that a supplementary review could add value by searching for individual studies that looked at the impact of interventions across relevant population sub-groups.

We limited our supplementary search to studies that had the following characteristics:

vi. Reported in the English language;

vii. Reported the findings from empirical studies or policy position papers;

viii. Were empirical papers that looked at perinatal, postnatal or pre-natal populations;

ix. Assessed the impact of interventions on depression, anxiety, other mental health issues or psychosis amongst economically disadvantaged or minority ethnic women;

x. Were published after 2013.

Table A1.2 summarises the number of hits returned from each of the databases we searched.

Full details of our search results and the inclusion criteria we used are provided in the appendices.

Table A1.2
Hits returned by database searched

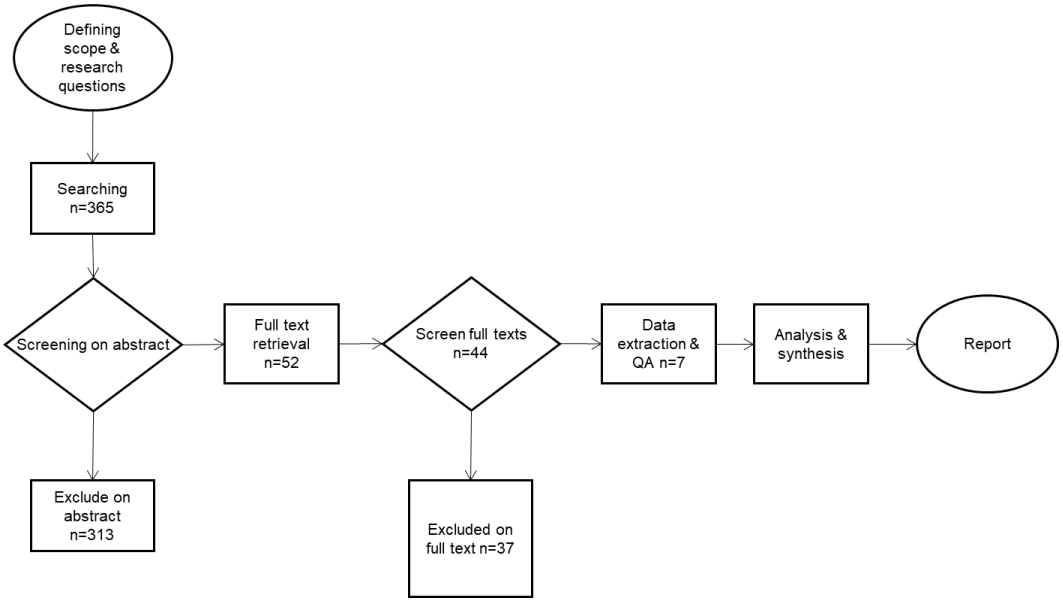
Database	Hits	Full texts selected for retrieval
Embase	67	10
Web of Science	117	31
Social Policy & Practice	4	1
Psych Info	38	2
Maternity & Infant Care Database	21	1
Global Health	7	1
ASSIA	59	3
British Nursing Index	52	3
TOTAL	245	52

We also added one paper eliminated from the previous search for reviews, a report from the Royal College of General Practitioners, giving a total of 53 papers.

Because of time constraints and contextual relevance, we subsequently made the decision to limit selection of papers for quality assessment and analysis to studies conducted in the UK.

The flow diagram below shows the numbers of studies identified at each stage of the REA.

Figure A1.5: Rapid Evidence Assessment (REA) workflow: empirical papers concerning effective perinatal mental health practices for economically disadvantaged or minority ethnic women



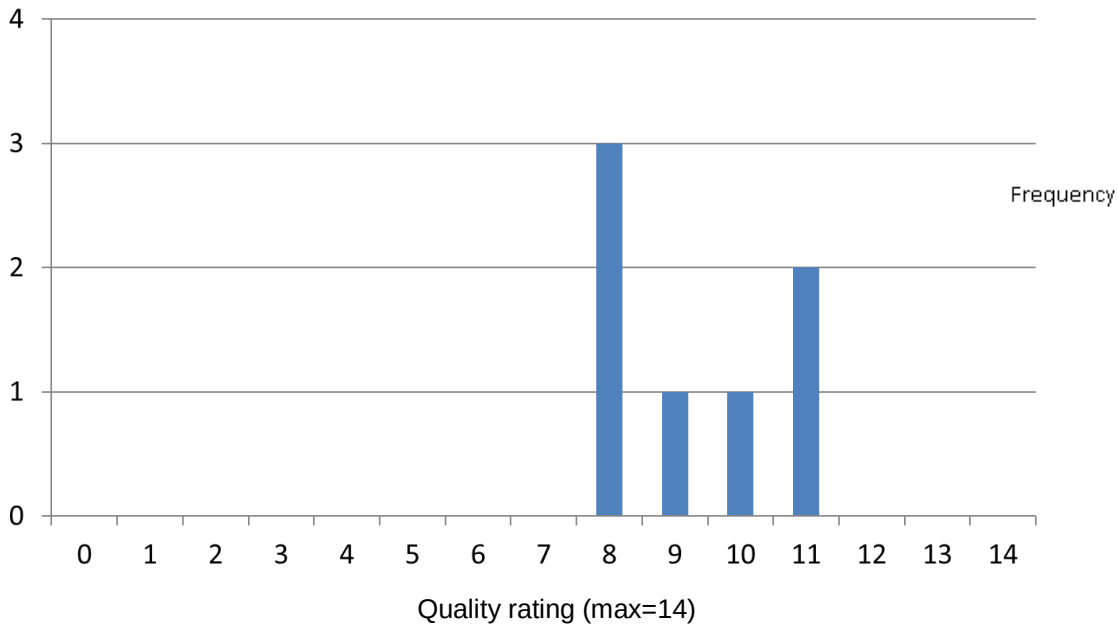
Of the 53 references selected for full text retrieval, we were able to obtain 44. When the full texts were reviewed, a further 37 papers were excluded on the basis they did not meet our extended inclusion criteria, leaving a total of 7 sources for inclusion in the review. Of those 7 papers in total, all described empirical research. The inclusion and exclusion criteria used to select texts for full review are in the appendices.

Quality of individual research studies and reviews

We assessed primary studies on seven quality criteria, each marked on a scale of 0-2, giving a total possible quality score of 14. The full table including details of component quality scores is included in the appendices.

Figure A1.6 (below) shows the distribution of the quality ratings across all papers we included. Again, the papers included are generally of a satisfactory standard.

Figure A1.6: Distribution of quality scores across papers included in the review (n=7)



Context - international comparisons

All studies included were conducted in the UK.

Definitions of psychological and psychosocial interventions:

Cognitive Behaviour Therapy (CBT)

CBT is a discrete, time-limited, structured psychological treatment. The patient and therapist work collaboratively to identify the types of thoughts, beliefs and interpretations and their effects on current symptoms, feeling states and problem areas. The patient then develops the skills to identify, monitor and counteract problematic thoughts, beliefs and interpretations related to the target symptoms. The patient also learns a repertoire of coping skills appropriate to targeting thoughts, beliefs or problem areas. CBT is usually delivered as an individually focused therapy but has also been developed as a group treatment. Common antenatal and postnatal modifications include delivery in the home of the mother or mother-to-be.

Interpersonal psychotherapy (IPT)

IPT is a discrete, time-limited, structured psychological treatment derived from an interpersonal model of affective disorders that focuses on interpersonal issues. The patient and therapist work collaboratively to identify effects of key problem areas related to interpersonal conflicts, role transitions, grief and loss, and social skills, and their effect on current symptoms, feeling states and/or problems. The treatment seeks to reduce symptoms by learning to cope with or resolve these interpersonal issues.

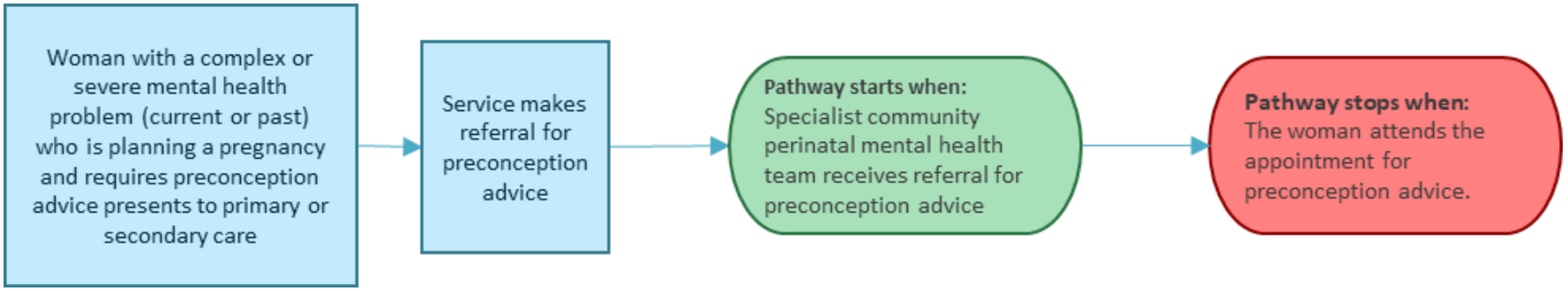
Person Centred Approach (PCA)

PCA emphasizes the idea that the client is in control of the therapeutic process and that the therapist is not the expert. Instead, the therapist is an empathic person who helps the client realize his or her capacity for personal growth. Developed by humanist psychologist Carl Rogers, at its core is the belief that people have the ability for growth and what he called self-actualization, or the capacity to use their inner resources for growth. This model differed from earlier therapies, which emphasized people's problematic behaviors and limitations. To help facilitate this change, the therapist is non-judgmental, allowing the client to direct the therapy when possible.

Midwifery redesigned postnatal care

The intervention was based on UK government reports stating that there was a need for wide-ranging changes to maternity services, emphasising poor assessment and frequently inappropriate delivery of postnatal care. A service led by midwives, with continuity of care and involvement of women, which is supportive and sensitive to individual needs, and preferences is at the centre of the maternity care recommendations.

Pathway 1: Preconception advice



Evidence: NICE (2016)

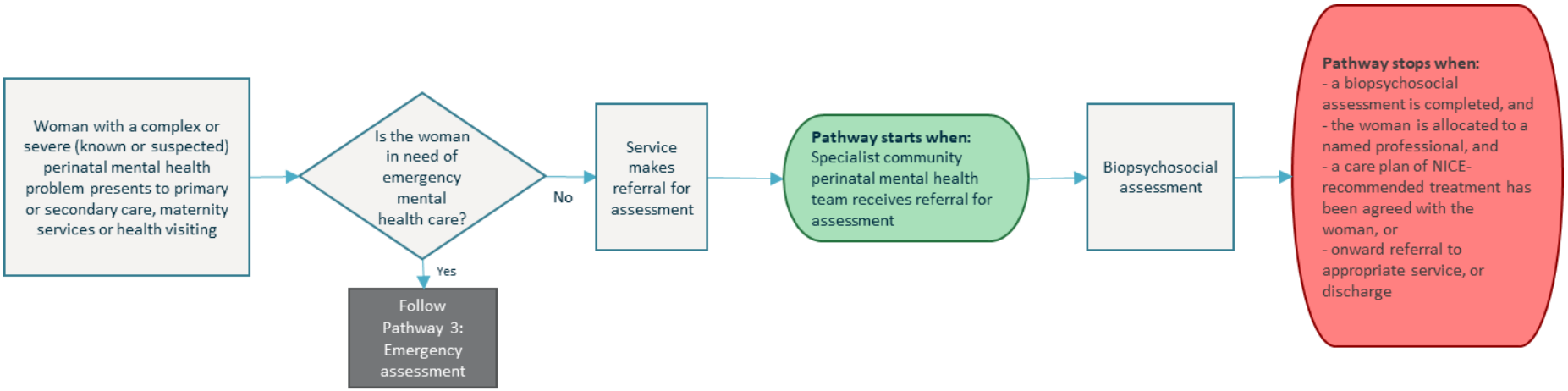
Discuss:

- use of contraception & plans for pregnancy;
- how pregnancy & childbirth might affect mental health problem;
- how a mental health problem & its treatment might affect the woman, the foetus and baby;
- how a mental health problem & its treatment might affect parenting.

Provide:

- culturally relevant information on mental health problems in pregnancy & the post natal period;
- assessment of the level of contact & support needed by women with a mental health problem (current or past) and those at risk of developing one;
- regular monitoring for symptoms.

Pathway 2: Specialist assessment



Evidence: NICE (2016)

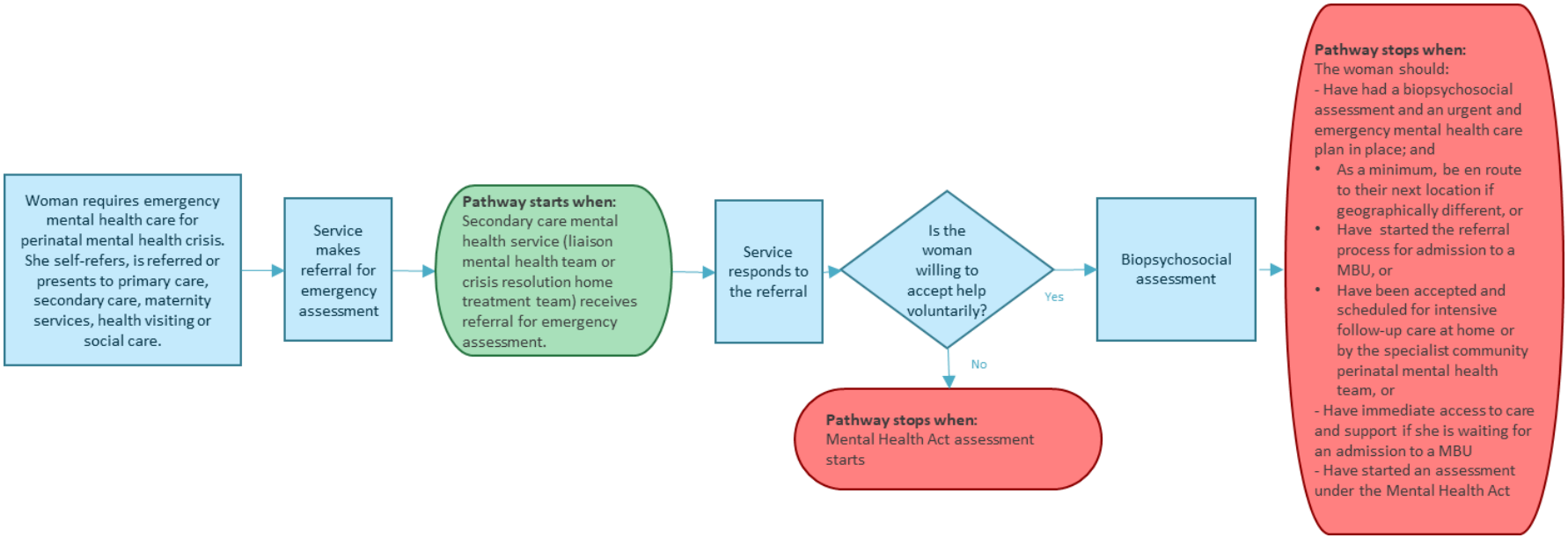
Assessment should include:

- Mental health history, physical wellbeing, alcohol & drug misuse, experience of pregnancy, past or present treatment, social networks, & housing, employment, economic and immigration status;
- Risk assessment conducted in conjunction with partner, family or carer.

Written care plan should include:

- Clear statement of jointly agreed treatment goals & how outcomes will be routinely monitored;
- Increased contact with and referral to specialist perinatal mental health services;
- The names and contact details of key professionals

Pathway 3: Emergency assessment

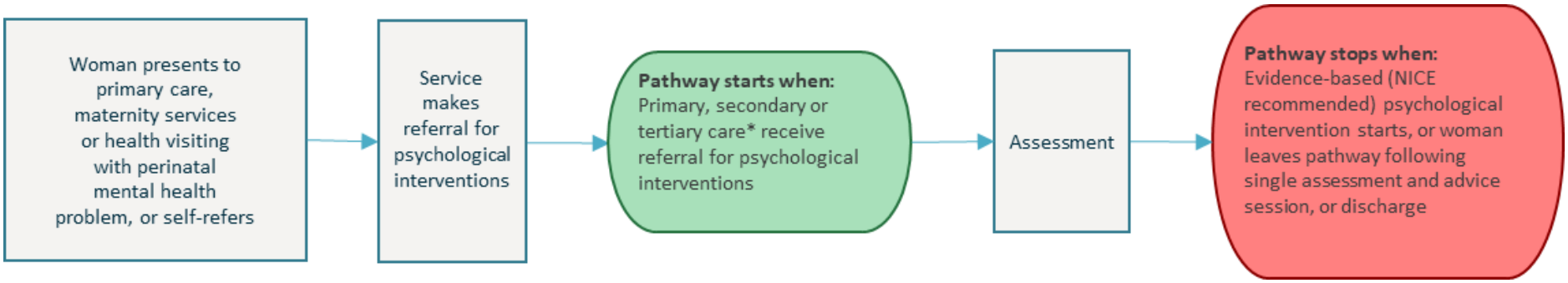


Evidence: NICE (2016)

If there is a risk of self-harm or suicide:

- assess whether the woman has adequate social support and is aware of sources of help;
- arrange help appropriate to the level of risk;
- inform all relevant healthcare professionals (including the GP and those identified in the care plan);
- advise the woman, and her partner, family or carer, to seek further help if the situation deteriorates.

Pathway 4: Psychological interventions



Evidence: NICE (2016)

Interventions for depression:

- mild to moderate – facilitated self-help;
- moderate to severe – high intensity psychological intervention (e.g. CBT) in combination with medication.

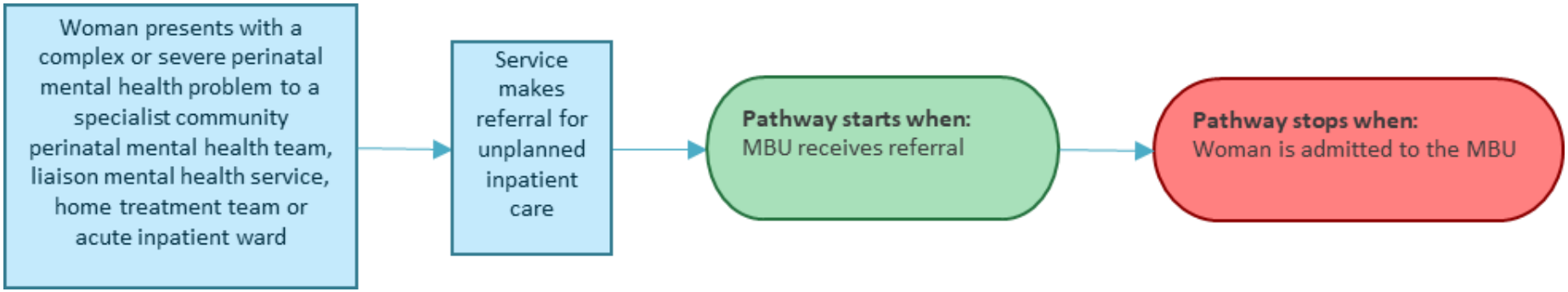
Interventions for anxiety:

- persistent subthreshold symptoms - facilitated self-help;
- anxiety disorder – high intensity psychological interventions (e.g. CBT).

Interventions for severe mental illness:

- bipolar disorder – CBT, IPT & behavioural couples' therapy;
- Psychosis – CBT or family intervention in combination with medication

Pathway 5: Inpatient care



Evidence: NICE (2016)

- Each managed perinatal mental health network should have designated specialist inpatient services and cover a population where there are between 25,000 and 50,000 live births a year, depending on the local psychiatric morbidity rates;
- Women who need inpatient care for a mental health problem within 12 months of childbirth should normally be admitted to a specialist mother and baby unit unless there are specific reasons for not doing so;
- Specialist perinatal inpatient services should:
    - provide facilities specifically designed for mothers and babies (6-12 beds);
    - be staffed by specialist perinatal mental health staff;
    - be staffed to provide appropriate care for babies;
    - have effective liaison with general medical and mental health services;
    - have available the full range of therapeutic services; and
    - be closely integrated with community-based mental health services to ensure continuity of care and minimum length of stay.

Appendix 2

Table A2.1.

PHE Perinatal Mental Health Indicators comparing Lambeth, London and England.

Description	Year	Lambeth	London	England
Risk and related factors				
Sole registered births: % births registered by one parent only	2014	8.9	5.6	5.5
Child poverty: % of children aged 0-15 (IDACI)	2015	30.4	24.4	19.9
Children on child protection plans: Rate per 10,000 children <18	2014/15	61.8	40.6	44.2
Lone parent families: % of households	2011	10.4	8.5	7.2
Severe mental illness: % recorded prevalence	2017/18	1.3	1.1	0.9
Looked after children aged <5: Rate per 10,000 population aged <5	2016/17	28.9	18.8	26.1
Infant mortality: Rate per 1,000 births	2015-17	4.7	3.3	3.3
Under 18s conceptions: Rate per 1,000 females aged 15-17	2016	22.8	17.1	14.1
Depression: % recorded prevalence	2017/18	7.8	7.1	9.9
Homelessness: Rate of acceptances per 1,000 households	2015/16	3.8	5.5	2.5
Domestic abuse-related incidents and crimes: Rate per 1,000 population	2016/17	22.9	22.9	22.5
Stillbirths: Rate per 1,000 births	2014-16	4.2	4.9	3.9
Parents in drug treatment: Rate per 100,000 children aged 0-15	2011/12	115.0	104.1	116.7
Parents in alcohol treatment: Rate per 100,000 children aged 0-15	2011/12	122.3	108.2	149.0

Table A2.2.

Maternity booking data Lambeth, LEAP and non-LEAP wards

Description	LEAP	Non-LEAP	Lambeth	p-value	n=
Risk factors at booking					
No recourse to public funds*	10.1%	6.0%	6.9%	<0.001	3,283
BME	59.3%	46.2%	49.3%	<0.001	2,623
Lives with husband, partner or family	75.0%	80.9%	79.5%	0.003	2,311
Pregnant before	74.9%	68.8%	70.2%	0.001	3,273
Planned pregnancy	62.0%	67.7%	66.4%	0.010	2,517
Aged under 25	16.4%	11.4%	12.6%	<0.001	3,268
Aged 40 or over	8.6%	8.5%	8.5%	0.902	3,268
Feel supported	96.2%	97.4%	97.1%	0.550	1,382
Ever smoked	26.0%	25.9%	25.9%	0.939	3,028
Smoking at booking	6.6%	5.7%	5.9%	0.328	3,110
Domestic abuse, previous	4.6%	3.9%	4.1%	0.491	2,187
Domestic abuse, current	1.1%	0.9%	0.9%	0.784	1,930
Previous social service involvement*	3.5%	2.3%	2.6%	0.067	3,283
Previous Child protection, Child in Need, Foster care, adoption or living elsewhere	1.7%	1.6%	1.6%	0.894	3,283
Relationship Issues	2.3%	1.7%	1.9%	0.474	1,706
Housing Concerns	7.0%	6.0%	6.2%	0.538	1,028
Social risk factors*	14.1%	14.9%	14.7%	0.582	3,283
Mental health risk factors*	16.3%	16.9%	16.7%	0.706	3,283

* Note, these assume that a blank response is a “No” response in the Badgernet database.
In the above table **bold** represents statistically significant results.
Source: Badgernet Maternity Database

Table A2.3.

Maternity booking data Lambeth, those with (n=423) and without a mental health issue identified at booking

Description	No identified issue at booking	Identified mental health problem	Lambeth	p-value	n=
Risk factors at booking					
No recourse to public funds*	6.4%	10.4%	6.9%	**0.003**	3,283
BME	50.6%	51.3%	49.3%	0.806	2,623
Lives with husband, partner or family	81.3%	69.5%	79.5%	**<0.001**	2,311
Pregnant before	69.8%	73.5%	70.2%	0.114	3,273
Planned pregnancy	69.1%	51.5%	66.4%	**<0.001**	2,517
Aged under 25	11.4%	20.8%	12.6%	**<0.001**	3,268
Aged 40 or over	8.4%	9.5%	8.5%	0.469	3,268
Feel supported	97.8%	94.5%	97.3%	**0.004**	1,382
Ever smoked	24.1%	37.5%	25.9%	**<0.001**	3,028
Smoking at booking	4.6%	14.3%	5.9%	**<0.001**	3,110
Domestic abuse, previous	3.0%	10.1%	4.1%	**<0.001**	2,187
Domestic abuse, current	0.5%	3.6%	0.9%	**<0.001**	1,930
Previous social service involvement*	2.3%	4.3%	2.6%	**0.018**	3,283
Previous Child protection, Child in Need, Foster care, adoption or living elsewhere	1.4%	3.1%	1.6%	**0.011**	3,283
Relationship Issues	0.9%	7.0%	1.9%	**<0.001**	1,706
Housing Concerns	4.0%	16.9%	6.2%	**<0.001**	1,028
Social risk factors*	13.1%	25.8%	14.7%	**<0.001**	3,283
Mental health risk factors*	12.0%	48.7%	16.7%	**<0.001**	3,283

* Note, these assume that a blank response is a "No" response in the Badgernet database.
In the above table **bold** represents statistically significant results.
Source: Badgernet Maternity Database
Note, the same statistical significances are seen for the subset who are referred on the PMH services when compared to all other women. This also has the addition of a statistical difference between BME with 64.2% BME for those referred and 49.3% for those not referred, p value = 0.014.

Figure A2.1. The antenatal and postnatal pathway in Lambeth

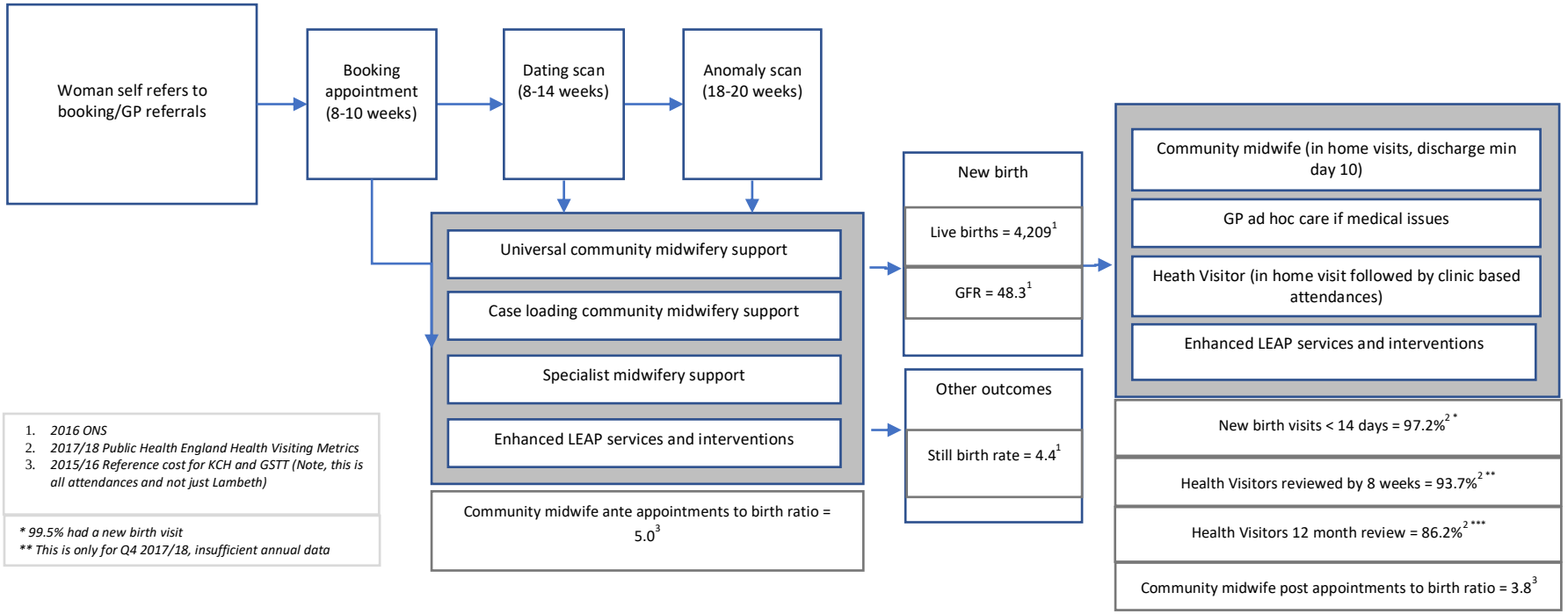
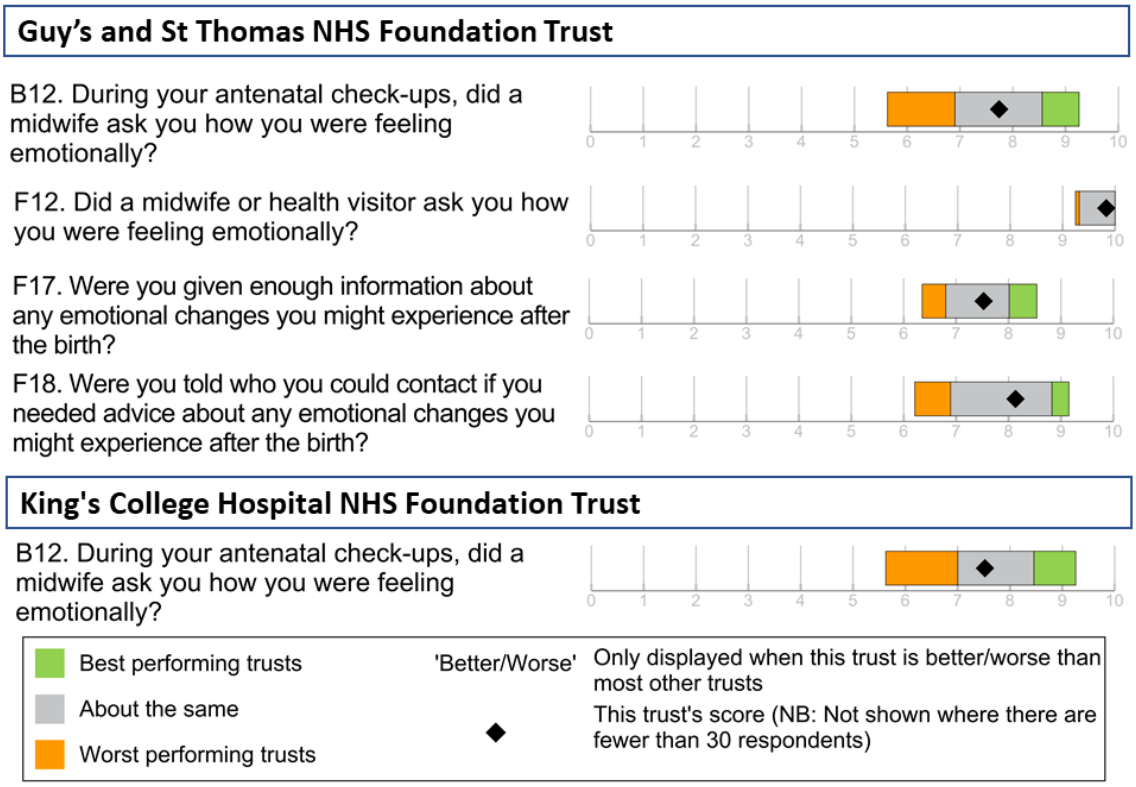


Figure A2.2. Results of the Maternity Service Survey from women referred to GSTT and KCH hospitals



Appendix 3

Stakeholder consultation method

LEAP colleagues identified a small number of stakeholders to approach as part of the first wave of fieldwork. We then added to the numbers by asking interviewees stakeholders and members of the project steering group to identify other key people we should talk to.

We did the interviews either face-to-face or on the telephone. We developed a series of questions to cover which LEAP colleagues signed off before interviews began[48].

We contacted a total of 22 people with an invitation to take part; we attempted to include as many people/professions who provide care to women during the perinatal period, but time constraints meant we were limited to interviewing those people who responded to our call. We also asked our project steering group for additional names. Ten people agreed and were available for interview within the research window (between 23 November 2018 and 17 January 2019, with a break over the Christmas period). Of these, four interviews were face to face and six were by telephone.

Whilst we have not reported the names of those we interviewed, their roles appear in the table below.

Table 3.1. Roles of stakeholders interviewed as part of the project

Role of interviewees
Consultant Midwife Public Health
Perinatal Mental Health Training and Service Development Lead & London Perinatal Mental Health Network Coordinator
Perinatal Mental Health Midwife
CBT Therapist/ Team Lead
Clinical Psychologist MAPPIM
Founder (Prosperities) and service user representative
Head of Section of Women's Mental Health
Consultant Psychiatrist in Psychotherapy
Parental Mental Health/HFT Development lead
Occupational Therapist

As well as these interviews, a member of our research team attended a Maternity Voices Partnership meeting at Kings College Hospital. This meeting included over 20 people, including medical professionals, third sector organisations and service user representatives. We attended the meeting to meet the stakeholder engagement objective of the project brief, to raise awareness about LEAP and the research, and to encourage stakeholders to engage with key issues around PMH services.

[48] See below for details

We aimed to include service users at an early stage in the research to help shape the questions to be asked of professionals. However, despite the best efforts of the research team and LEAP colleagues, it was not possible within the time available. Given the need to meet project deadlines, we made the decision to speak to service user representatives during the interview phase. One service user representative participated in an interview and was able to feed in valuable experiences as both a service user and now practitioner working in PMH provision. However, interviewees alike valued the wider principles of co-production and agreed that people with lived experience should be consulted when planning PMH interventions.

Topic guide: Stakeholder engagement

Semi structured interview guide for LEAP-commissioned research into PMH work in Lambeth

Note to reading this guide

This is a semi-structured topic guide which will be flexed according to the views, experiences and expertise of the individuals who take part in an interview. As such, not all interviewees will be asked every question in the order they are set out below.

For ease of reference for the interviewee, the stakeholder research objectives identified in the initial LEAP research brief are outlined at a glance below.

The research brief calls for the stakeholder consultation to:

- elicit, present, and synthesise the views of key stakeholders about how existing community-based perinatal mental health provision in Lambeth could be improved;
- include service user representatives and co-production; and
- make recommendations e.g.
    - changes in practice that could increase PMH diagnosis/detection rates; and
    - inform LEAP's approach to implementing a PMH intervention.

The research brief calls for the stakeholder consultation to include:

- providers involved in the mental health care pathway and the Pan London Perinatal Clinical Network, given their knowledge of London service provision; and
- service user representatives who will also help co-produce fieldwork materials and refine our overall approach.

Introduction to the research

Purpose of this introduction: to ensure the interviewee is fully briefed on the background to the research, understands that this is a confidential process, understands that their personal data will not be included in any reporting and to gain informed consent before beginning the interview.

The RTK, an independent research consultancy, has been commissioned by LEAP to carry out a review of community-based perinatal mental health provision in Lambeth. The study has three components: a rapid evidence assessment; data mapping; and a series of stakeholder engagement interviews with a range of stakeholders across the field of PMH in Lambeth and beyond.

Thank you for agreeing to take part in a stakeholder engagement interview today. The purpose of the interviews is to understand from your perspective what is working well across Lambeth (and beyond) around PMH, as well as gaps or areas where provision might be patchy or poor. The interview will explore the enablers and barriers to good practice, and draw out any 'quick wins' or longer-term recommendations or considerations for future activity in this area. The findings from across all strands of the research will shape a new LEAP PMH service and inform a series of recommendations for Lambeth-based stakeholders to consider more widely together.

As this is an independent study, this is a confidential interview. Whilst we may include the things you say in our reporting, it will be done in a way which is not attributable to yourself. In other words, please do speak freely as it is really important that we understand the current landscape of PMH in Lambeth.

The final report will be submitted to LEAP and the wider steering group in January 2019. If you would like to be kept updated with the next steps, do let me know at the end of the interview.

I'll take notes of what you say, but no one outside of the project team at RTK will be able to see these notes. These notes will be deleted once the study is completed.

The interview will last up to 60 minutes. Do you have any questions before we begin? Are you happy, based on the introduction just given, to proceed with the interview?

Introduction to the interviewee

Purpose of this section: to establish a relationship with the interviewee, to draw out their background and understand more about their role in relation to PMH in Lambeth. The findings from this section are likely to inform the subsequent questions asked throughout the interview.

1. Tell me a little about your job role and the organisation you work for

2. Do you work directly with service users – and if so, does this include individuals directly affected by PMH?
    a. If yes, can you tell me a bit more about the people you work with?

3. Does your role focus specifically in Lambeth or does it cover a wider or different area?
    a. If it's Lambeth-based, what partners do you work with to deliver your services/role?

4. Are there any other ways you are involved in PMH in Lambeth or beyond e.g. involved in a network; as a service user representative etc?

Exploring current provision

Purpose of this section: use the NICE 5 pathways diagram as a way to open up a discussion about the existing provision in Lambeth including strengths, weaknesses, gaps and opportunities. If it is not possible to share the NICE 5 pathways diagram, questions 5, 6 and 11 will be ignored.

Refer the interviewee to the NICE 5 Pathways diagram

5. Looking at this diagram, where does your work fit into this picture?
    a. Is it across all pathways, in certain pathways – or elsewhere in this picture e.g. in gaps between the pathways?
    b. What other partners/stakeholders work within your pathways?

6. Thinking about the pathways illustrated by this diagram, where does wider PMH provision in Lambeth/beyond currently fall? [Ask the interviewee to list the key services they're aware of].
    a. Do these services run across all pathways, clustered in certain pathways – or do they fall into 'gaps' between the pathways?
    b. What other partners/stakeholders work within these services e.g. GP, community midwife, other referrers etc?
    c. What are the critical referral points?
    d. Who and what is critical to the success of these services?

7. What is currently working well in terms of PMH in Lambeth/beyond?
    a. What does 'good' look like? What outcomes are being achieved – and for whom?
    b. How is success measured e.g. what data/evidence is collected?
    c. Probe why this successful e.g. clear pathway of care, clearly definable cohort/need, strong relationships and communications across stakeholders, partnership working, leadership and political will, efficient data collection etc

8. What is working less well in terms of PMH in Lambeth/beyond?
    a. What does poor practice look like? What outcomes are at risk?
    b. Which groups are being poorly supported e.g. specific mental health diagnoses, those affected by cultural or socio-economic barriers, specific ward prevision etc
    c. Probe why this not working e.g. e.g. lack of clear pathway, ill-defined cohort/need, poor relationships and communications across partners, lack of leadership and political will, poor data collection, stigma of accessing services and/or specific cultural barriers etc

9. [If not already covered] Are there any gaps in PMH provision in Lambeth?
    a. Probe the areas that emerged during the steering group meeting e.g. gap between pathways 1 and 2 of all women who might become pregnant, no pathways to explore mother-child or mother-father relationships, points where care is suddenly withdrawn etc
    b. What data is required to investigate these gaps further e.g. inpatient admissions to the mother and baby unit, emergency assessments at ED, ward-level data etc?

10. What are the risks of not addressing these gaps?

11. [If not already covered] Do you have any other comments on the overall NICE 5 pathways diagram?
    a. Is it fit for purpose for Lambeth or more widely?
    b. Is there anything else missing from a Lambeth or a national perspective?

12. Do you know of or have any tailored PMH pathway maps which accurately reflect your work and which you would be prepared to share with me as part of the research?

Recommendations

Purpose of this section: to reflect on the broader discussion and pull out key quick wins and recommendations for short term provision as well as longer term considerations for future

13. Given the picture of provision we have discussed so far, what would be your key recommendation to LEAP in terms of a potential new service that could start up straight away?
    a. What would make the biggest difference in the short term?
    b. Do you have any quick wins to consider?
    c. Who would need to be involved?
    d. What would have to be in place for this to be successful?
    e. What would success look like – how would it be measured?

14. Do you have any other recommendations to improve provision around PMH in Lambeth in the short term? What are the enablers to build upon, or the barriers to overcome?
    a. Probe: build or strengthen partnerships, improve data flow, design Lambeth-specific pathways etc.
15.
16. What recommendations do you have to improve PMH provision in Lambeth in the longer term e.g. mother and child and/or father relationship building and support, streamlined services across adults and children's services, transferal of specific data-sets across partners etc
    a. Who needs to be involved?
    b. What needs to happen to bring this to life?

17. And what are your recommendations to consider for a national perspective? What needs to be considered at a government or policy level?

18. Is there anybody else or organisation I should approach to speak to as part of this research? Could you broker the introduction to enable it to take place before mid-January?

19. Would you like to be kept updated about the outcomes of this research by the LEAP team, once the research has finished in January?

20. Do you have any other comments or reflections as part of this research?

Thank interviewee and close.