JOINING THE DOTS: A CALL TO ACTION ON MATERNAL AND INFANT MENTAL HEALTH IN SCOTLAND

THE TEMPLETON EXPERT GROUP

On 4th of May 2016 a group of individuals and representatives of organisations actively involved in delivery of care, education and research in the field of perinatal and infant mental health met to discuss current issues in maternal and infant mental health in Scotland. This call to action reflects the concerns and priorities of this expert group.

MATERNAL AND INFANT MENTAL HEALTH MATTERS

The Scottish Government has placed a high priority on maternal and infant health and wellbeing over the past decade as manifested in the Early Years Framework and Getting it Right for Every Child (GIRFEC) and other policy developments. This has been underpinned by evidence identifying spending on maternal and infant mental health as the key to preventing poor mental health outcomes across the life course.

Depression and anxiety affect up to 20% of women during pregnancy and in the first postnatal year (perinatal mental illness) with a societal cost of around £8.1 billion annually.[1] Without the right kind of support and treatment, perinatal mental illness can become long-term and may inhibit a mother's ability to provide her baby with the sensitive, responsive care that he or she needs. This in turn may have an impact on the child's emotional and intellectual development potentially creating a trans-generational cycle of poor mental health and reduced wellbeing.[2] To lessen the impact of perinatal mental illness on mothers, babies and families, timely, safe and evidence-based interventions must be provided by services which explicitly address the mother's own mental health and wellbeing *and* their interactions with their babies; supporting mothers, fathers and families to give babies the physical and emotional care that they need to thrive together.

SOME POSITIVE STEPS

We acknowledge that some positive steps have been taken for example:

- Through health and social care integration, the Scottish Government is seeking to achieve a transformational change in approaches towards prevention and early intervention.
- Significant efforts have been made by the Scottish Government in recent years to endorse the principle that services and interventions should be evidence-based.
- The Scotland-wide clinical guideline on the management of perinatal mood disorders, published four years ago (SIGN 127) provides evidence-based standards of care for all health boards.[3] Implementation of this guideline would help to ensure that women who are at risk of, or suffering from, mental illness are identified at the earliest opportunity and given appropriate, safe and timely expert care that prevents their illness from reoccurring or escalating, and minimises the harm suffered by women and their families.

THE TEMPLETON MEETING

THE PROBLEM

WHILE THERE HAVE BEEN SOME IMPORTANT STEPS IN ESTABLISHING PERINATAL MENTAL HEALTH SERVICES OVER THE LAST DECADE SCOTLAND STILL LAGS WELL BEHIND THE EVIDENCE BASE ON PERINATAL AND INFANT MENTAL HEALTH. THIS IS UNDERLINED IN A NEW REPORT FROM THE MENTAL WELFARE COMMISSION FOR SCOTLAND, WHICH HIGHLIGHTS YET AGAIN INEQUITY OF SERVICES ACROSS THE COUNTRY AND THAT THE EVIDENCE-BASED GUIDELINE IS NOT BEING FULLY IMPLEMENTED.[4]

- Mental health care for expectant and new mothers remains fragmented and inadequate across Scotland.
- Women who have identified needs do not have equitable access to specialist perinatal mental health inpatient and their right to be admitted with their baby is not always ensured, as laid out in the Mental Health Act (Scotland).
- Many health boards still do not have integrated care pathways in place to ensure detection of women at greatest risk of developing the most severe disorders, and to ensure there is timely, safe and rapid escalation to appropriate level of specialist perinatal mental health care, one of the key areas for action identified in the 2015 Confidential Enquiry into Maternal Deaths. [5]
- Only 5 out of 14 health boards currently have a specialist community PMH service. Yet it is clear that community perinatal mental health teams play a vital role in managing the majority of mothers with mental health needs who do not require specialist inpatient care.
- There is a lack staff with sufficient knowledge and expertise within primary or secondary care to ensure that *every woman and her baby* receive the best care for their mental health, in the perinatal period. Few NHS Boards have accredited training programmes for maternal and infant mental health and there are concerns about succession planning and training.
- Specialist support in the community for mothers, fathers and other carers, and babies, to promote good infant mental health is only available in some areas to families in need, despite what is known about early childhood adversity.

THE GAPS IN SERVICES THAT EXIST IN SCOTLAND MEANS THAT WE ARE FAILING TO PREVENT THE HARMS CAUSED BY PERINATAL MENTAL ILLNESS, JEOPARDISING THE CURRENT SAFETY AND WELLBEING OF WOMEN AND CHILDREN, AND THEIR FUTURE LIFE CHANCES. THERE ARE CONCERNS THAT HEALTH AND SOCIAL CARE INTEGRATION MAY ACTUALLY INCREASE FRAGMENTATION OF ADULT, MATERNAL AND INFANT MENTAL HEALTH SERVICES [5] INCREASING THE CHANCES OF THOSE MOST IN NEED FALLING THROUGH THE GAPS.

WE BELIEVE THIS SITUATION CAN AND MUST BE IMPROVED. THIS IS WHAT NEEDS TO HAPPEN:

NATIONAL LEADERSHIP

1. The Scottish Government must demonstrate a clear commitment to prioritise delivery of comprehensive specialist perinatal mental health services across Scotland with clear timelines and funding for implementation.

The new *Mental Health in Scotland* – a 10 year vision (out for consultation until 14/9/16) has identified maternal and infant mental health as a priority. If we are serious about shifting resources towards prevention, then improving perinatal mental health services must be a priority aim of the new strategy. There is a need for a clear time line and commitment to deliver perinatal mental health services taking into account the different geographical and demographic profiles across Scotland. This will need to be achieved within the context of health and social care integration and should include third sector partners.

By prioritising perinatal mental health in the strategy, we can protect two generations at once - we can improve maternal health and child development outcomes - while also placing mental health policy in the wider context of early intervention, the early years and prevention.

2. Monies received from the UK Government for perinatal mental health services should be spent on perinatal mental health services in Scotland.

The UK Government has ring-fenced spending for perinatal mental health services in England. As a result the Scottish and Welsh Governments have received Barnett Consequentials, a proportion of this sum, for spending in Scotland and in Wales. The Welsh Government has announced investment of £1.5m to improving community-based perinatal mental health provision.[7]

However, in Scotland the money has not been ring fenced. We call on the Scottish Government to use this money for perinatal mental health (estimated £7.5m). It is not acceptable for this to be rolled into the general pot of money for mental health while perinatal mental health services remain inadequate.

3. The Government should commit to establishing a national managed clinical network for perinatal mental health to ensure consistent implementation of the national clinical guideline, SIGN 127.

We need a nationally coordinated, systematic approach by all NHS Boards in collaboration with other partner organisations, to developing specialist perinatal mental health services, so that consistently high standards of care are available to mothers and babies, and their families, across the whole country. A national managed clinical network can provide leadership for this. It must consider service development, succession planning and collaboration with voluntary sector partners to ensure the sustainability of the specialist acute services, support services and posts that currently exist. It is imperative the position of maternal and infant mental health services is clarified in relation to local integration of services as part of this strategic work. The network should be managed by a coordinating board of health professionals, health and social care managers, service users and carers.

LOCAL SERVICE DEVELOPMENT

4. Local multi-professional perinatal mental health networks should be established in each NHS Board area to develop local strategies, promote multidisciplinary/agency working across the statutory and voluntary sectors, ensure clear pathways for referral and assessment, and to share skills and knowledge.

5. Specialist community perinatal mental health services should be established in every health board area.

6. Where admission to hospital is required, all health boards should ensure that provision is available for women who want to be admitted with their babies.* This should be a mother and baby unit.

7. In seeking to achieve prevention and early intervention at population level, the new Integration Joint Boards must make perinatal mental health and infant mental health a priority within their plans for children's services and adult mental health, ensuring joint working with maternity service who are key to early identification and signposting.

Community partners in health and social care need to ensure a comprehensive suite of support is available at each stage to meet the full range of mental health problems from low to moderate to severe that present during the perinatal period based upon a stepped care, public health approach.

Tackling perinatal mental illnesses and mitigating their effects requires joint working between adult mental health services, midwifery, primary care, children's services, obstetrics, CAHMs, and the voluntary sector. Therefore it is important that there are local strategies to secure sufficient, high quality, joined up services and clear care pathways in each area. Both statutory and voluntary organisations, and Maternal Mental Health Change Agents† (women and their families with lived experience of perinatal mental illness) must be involved the development of these strategies. There must be a whole family approach, recognising the impact of perinatal mental illnesses on babies and other family members. Services must involve and support fathers and partners.

Identifying and addressing maternal mental illnesses requires there to be a range of high quality services in place in every area. Perinatal mental illness impacts across every socioeconomic group. However, the impact of poverty and deprivation and the particular vulnerability of some groups of women to mental health difficulties must be recognised and responded to. Support is needed that is culturally sensitive, trauma-informed, and able to break down stigma and social isolation.[8]

* In accordance with the duties placed on Health Boards under Section 24 of the Mental Health (Care and Treatment) (Scotland) Act 2003, and revised duties under the new Mental Health (Scotland) Act 2015, due to come into effect in 2017.

† http://maternalmentalhealthscotland.org.uk/

INFANT MENTAL HEALTH

8. We must prioritise the mental health of babies by expanding access to community-based specialist Infant mental health (CAMHs – IMH) support that helps babies form a secure attachment with their carers.

The long term impact of attachment problems *and* mental health problems are well recognised. Social relationships and strong early bonds (in the first year of life) with an infant's primary caregiver are crucial to support optimal social, emotional, cognitive and language development in the infant. In the majority (although not all situations) the mother will be the main caregiver and in addition to supporting mothers' own mental health needs, it is vital that perinatal mental health services also help mothers provide sensitive and responsive care, and to develop healthy relationships with their babies and support babies' relationships with fathers and other important people in their lives. This intimate care giving relationship is essential for promoting the secure attachment that is the foundation of a child's future development.

Our health visiting workforce is central to these issues as are the voluntary sector services that currently provide much of the community based interventions that provide support to strengthen mothers' relationship with their baby. All health visitors should have training in the development of practice skills for understanding and observing parent-infant interaction and supporting this relationship, and also the capacity to spend time with families, as part of the new Universal Health Visiting Pathway. Specialist CAMHS-IMH teams must be established in every area to provide a mental health service for children from birth to five years.

EDUCATION, TRAINING AND RESEARCH

9. All staff working with women in the perinatal period must be appropriately trained to detect and offer intervention for maternal and infant mental health at all levels from peer support through to specialist perinatal mental health.

Local strategies should also set out plans for developing the knowledge, skills and resources necessary for the detection and prompt, effective and safe treatment of perinatal mental illnesses across the local area. As a minimum, the NHS Education for Scotland (NES) online learning resources on maternal and infant mental health should be mandatory training for Health Visitors, midwives, family nurse partnership nurses, neonatal nurses and community mental health nurses, GPs, psychiatrists and mental health officers (social work). Team leaders should ensure that all of these staff groups have allocated time and computer access to undertake the online learning during working hours. The resources are freely available at: www.knowledge.scot.nhs.uk/maternalhealth

10. Robust evaluations of current provision, including longitudinal studies exploring the long term outcomes of interventions on mothers and children are required.

There are numerous examples of promising, often small scale projects implementing interventions that appear to benefit mothers, babies and families. However evidence of improved outcomes and of longer term impact is lacking. We now need robust, timely evidence to know what works and how effective interventions can be implemented at scale and made sustainable.

OUR CALLS TO ACTION:

1. **The Scottish Government must demonstrate a clear commitment to prioritise delivery of comprehensive specialist perinatal mental health services across Scotland with clear timelines for implementation.**
2. **Monies received from the UK Government for perinatal mental health services must be spent on developing comprehensive perinatal mental health services in Scotland.**
3. **The Government should commit to establishing a national managed clinical network for perinatal mental health to ensure consistent implementation of the national clinical guideline (SIGN 127).**
4. **Local multi-professional perinatal mental health networks should be established in each NHS Board area to develop local strategies, promote multidisciplinary/agency working, ensure clear pathways for referral and assessment, and to share skills and knowledge.**
5. **Specialist community perinatal mental health services should be established in every health board area.**
6. **Where admission to hospital is required, all health boards should ensure that provision is available for women who want to be admitted with their babies to a specialist mother and baby unit.**
7. **The new Integration Joint Boards must make perinatal mental health and infant mental health a priority within their plans for children's services and adult mental health.**
8. **We must prioritise the mental health of babies by expanding access to community-based PMH and specialist CAMHs - IMH that helps mothers form a secure attachment with their babies.**
9. **All staff working with women in the perinatal period must be appropriately trained to detect and offer intervention for maternal and infant mental health.**
10. **Robust evaluations of current provision, including longitudinal studies exploring the long term outcomes of interventions on mothers and children.**

References

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THE TEMPLETON MEETING

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