Chapter Three: Perinatal Mental Health

Summary

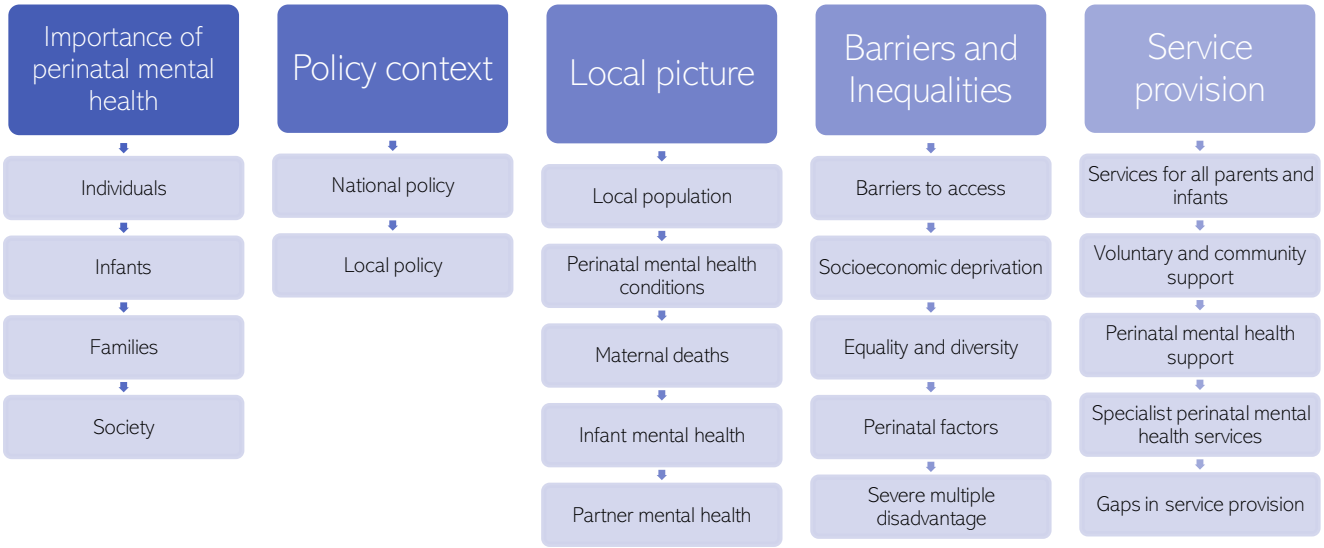
Mental health conditions are some of the most common illnesses experienced during the perinatal period, which is defined as the period from conception to 24 months after birth (1). Around 10 to 20% of mothers will experience a perinatal mental health condition (1); and although anyone can be affected, some groups are more at risk.

Perinatal mental health conditions have a significant influence on maternal mortality, as well as foetal development and child outcomes (2). In Cambridgeshire and Peterborough, there are a range of services offering support and treatment across the perinatal period, ranging from those available to all parents and infants, such as the Healthy Child Programme, to those offering specialist perinatal mental health support.

This chapter will describe:

- The importance of perinatal mental health
- The local and national policy context
- The local picture of perinatal mental health
- Inequalities in perinatal mental health and barriers to accessing care
- Services providing support and treatment for perinatal health problems, including gaps in provision

Figure 1: Structure of chapter 3 of the mental health needs assessment



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Importance of Perinatal Mental Health

Pregnancy, birth and the first two years of a child's life (the perinatal period) are a key period for families (3) and a critical time for the social, physical, emotional and language development of infants (4). Mental health conditions that occur during this time can have a particularly strong negative impact. Whether and to what extent there is a negative impact depends on a range of factors, including quality of parenting and the length and severity of the mental health condition (5).

Figure 2: Impacts of undiagnosed or untreated perinatal mental health conditions

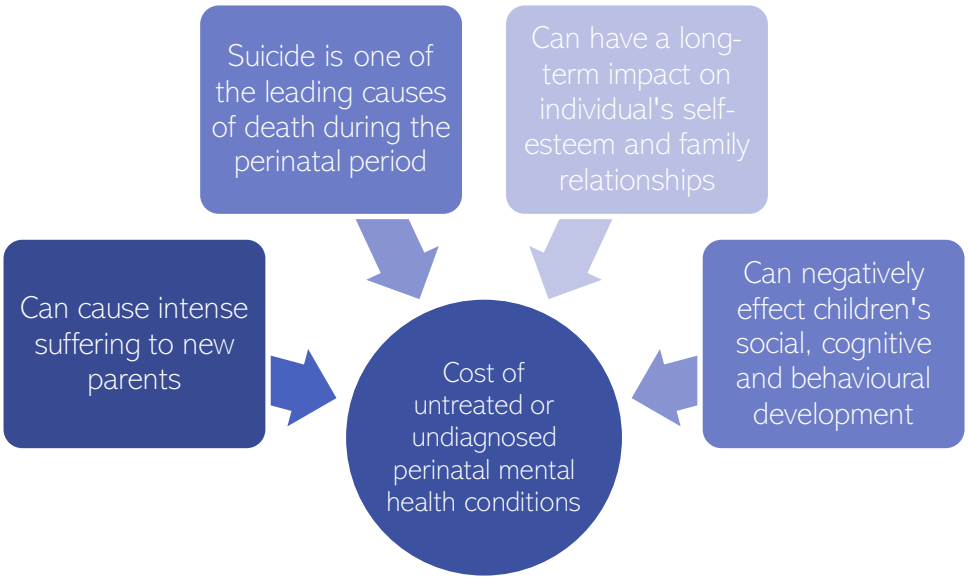


Table 1: Importance of perinatal mental health

Group	Impact of perinatal mental health conditions
Individuals	• Perinatal mental health conditions can be strong predictors of long-term mental health: one study of a mother and baby unit found that, 3.5 years after childbirth, 40% of mothers who had perinatal mental health conditions continued to have depression (6). • Suicide is a leading cause of maternal deaths, accounting for 30% of maternal deaths in 2018 - 20 (7).
Infants	• The first 1,001 days of life are critical for brain development • Perinatal mental healthcare may be a key opportunity to break the cycle of intergenerational trauma and adverse childhood experiences (ACEs) (2). • Although these risks are not inevitable, in some cases mental illness affects parents' ability to bond with and care for their baby (8) and can predict child outcomes (9). For example: o Experiencing mental health conditions during pregnancy is associated with an increased risk of early delivery and low birth weight (10). o Maternal and paternal postnatal depression is associated with an increased risk of emotional and behavioural problems in children (9). o Chronic perinatal depression can impact child cognitive, emotional, social, behavioural and physical development (11). • Perinatal mental health conditions are more likely to impact child development when combined with social adversity and lack of social support (9).
Families	• There is a correlation between paternal depression and maternal depression during the perinatal period (12). • Either parent experiencing a mental health condition during the perinatal period is associated with an increased risk of interparental conflict, relationship breakdown and domestic violence (9,13).

Society	• Inadequate identification and treatment of perinatal depression, anxiety and psychosis has been estimated to cost society of £8.1 billion each year, the majority of which is due to long-term impacts on child outcomes (1). • Children growing up in more deprived areas are more likely to show externalising behaviour problems at age 5. Around 40% of this can be explained by maternal perinatal mental health, suggesting that targeting perinatal mental health may help reduce inequalities (14).

Additional Resources

- Best start for life: A Vision for the 1,001 Critical Days
- Prevention in mind: All Babies Count: Spotlight on Perinatal Mental Health
- Early Moments Matter: Guaranteeing the Best Start in Life for Every Baby and Toddler in England

Policy Context

National policy

There has been an increased focus on perinatal mental health over the past 10 years in national policy; particularly in relation to early years development and the need for greater access to specialist perinatal mental health support.

Table 2: Summary of national policy developments relating to perinatal mental health

Year	Policy/report	Relevance
2010	Fair Society, Health Lives (The Marmot Review)	• Highlighted the importance of focusing on child development to reduce health inequalities
2016	Better Births: Improving outcomes of maternity services in England – A Five Year Forward View for maternity care	• Recommended greater investment in perinatal mental health services; greater resources for postnatal care; and smooth transitions when receiving care from different professionals
2017	Stepping forward to 2020/21: The mental health workforce plan for England	• Set a target that all perinatal mental health community teams and inpatient mother and baby units (MBUs) should be sufficiently staffed by 2020/21
2017	Implementing The Five Year Forward View for Mental Health	• Set target for 'increased access to specialist perinatal mental health support in all areas of England' • Made plans for a competence framework describing the skills needed by the perinatal mental health workforce • Set out funding for perinatal mental health services
2018	Prevention is better than cure: Our vision to help you live well for longer	• Highlighted the importance of encouraging healthier pregnancies to ensure children have the best possible start in life
2019	NHS Long Term Plan	• Renewed commitments to implementing specialist perinatal mental health services across the country • Committed to expanding access to therapies within specialist perinatal services so they include parent-infant, couple, and family interventions; and for services to assess the mental health of partners of people accessing specialist mental health support • Committed to implementing maternal mental health services
2019	NHS Mental Health Implementation Plan 2019/20 – 2023/24	• Set of target that 66,000 women with moderate to severe perinatal mental health conditions will have accessed specialist care by 2023/24

2021	The best start for life: a vision for the 1,001 critical days	• Highlighted the importance of the first 1,001 days in life for child development • Highlighted that parents and carers must have their mental health needs met in order to meet the needs of their baby; and that support services should be accessible to partners
2022	Family hubs and start for life programme: local authority guide	• Gave guidance on the delivery of the Family Hubs and Start for Life programme, including specific guidance on perinatal mental health
2023	Three year delivery plan for maternity and neonatal services	• Set out plans for improving the availability of specialist perinatal mental health services. • Stated the aim of 'all women [being] offered personalised care and support plans which take account of their physical health, mental health, social complexities, and choices'.

Local policy

In Cambridgeshire and Peterborough, policy development has reflected national priorities.

Table 3: Summary of local policy developments relating to perinatal mental health

Year	Policy/report	Relevance
2019	Mental Health and Wellbeing Pre-birth to Age 25 years Needs Assessment	• Highlighted the need to prioritise perinatal mental health • Predicted an increase in the number of local births over the next 5 years
2019	Health and Wellbeing Strategy 2019 - 2024	• Identified 'helping children achieve the best start in life' as one of the top priorities to improving health and wellbeing in Cambridgeshire and Peterborough
2019	Best Start in Life Strategy 2019-2024	• Proposed that vulnerable parents should be identified early and supported, including with perinatal mental health support • Proposed that perinatal mental health support should be extended to promote positive attachment and bonding between infant and parents
2021	Cambridgeshire and Peterborough Early Help Strategy	• Highlighted that strong and supportive families are the 'essential foundation for enabling children and young people to lead safe, healthy and successful lives'
2022	Cambridgeshire & Peterborough Health & Wellbeing and Integrated Care Strategy 2022 – 2030	• Set reducing health inequalities and improving outcomes for all children as key aims • Placed focus on early intervention and prevention, to improve mental health and wellbeing
2022	Cambridgeshire and Peterborough Better Births Equality and Equity Plan	• Prioritised the implementation of perinatal mental health services, with a focus on access across ethnic groups and in more deprived areas
2022	Cambridgeshire and Peterborough Better Births Infant Feeding Strategy 2022 - 2027	• Recognised the impact that infant feeding issues can have on mental health

Perinatal Mental Health: Key Priorities

The following points were agreed by the Cambridgeshire and Peterborough Perinatal Mental Health Network in 2022 as priorities for perinatal mental health:

- A robust antenatal education offer: The introduction of a flexible and accessible antenatal education offer providing a sense of community and peer support throughout the perinatal period, supporting all families in developing strong parent-infant relationships and an awareness of perinatal mental health, including

tackling stigma, recognising risk factors, preventing poor mental health, and knowing how and when to access support.

- Dedicated support from a key contact during the perinatal period: Starting during the perinatal period, families and parents will receive consistent and proactive support from a trained and trusted contact, empowering them to overcoming barriers to accessing perinatal support. Recognising the link between a positive feeding experience and good mental health this will include supporting parents on their infant-feeding journey.
- Promoting strong parent-infant relationships: Holistically supporting parents to develop strong parent-infant relationships through enriching activities which promote good short- and long-term parent and infant mental health and child development.
- Clear and supportive referral pathways: Working with the wider system, we will encourage more parents to access perinatal help by offering clear community perinatal mental health service referral pathways which provide proactive follow-up and reassurance during the referral process, to ensure those identified with mild-moderate perinatal mental health issues feel able to access community support.
- Support for the whole family, including fathers and partners: Information and support, including self-help materials and peer support groups will be easily accessed by families through different platforms intended to meet the perinatal needs of the whole family, including resources and services designed with fathers and partners in mind.
- Working with the wider system to tackle health inequalities and stigma: We will co-design and consult with the wider system to support vital community work engaging vulnerable populations and campaigning against perinatal mental health stigma, to make certain that all communities feel able to access culturally sensitive perinatal support.
- Workforce training, development, and supervision: Training and access to appropriate supervision will be offered to those working with families and parents to encourage the de-stigmatisation of perinatal mental health and providing staff with the ability to identify and support parents at risk of poor perinatal mental health in a sensitive and evidence-based way.

Additional Resources

- Healthy Pregnancy Pathway

Local Picture

Local population

The fertility rate is higher than the national average in Peterborough, but lower than the national average in Cambridgeshire (15).

Table 4: Fertility rate per 1,000 of the population in Cambridgeshire and Peterborough in 2021, relative to national rates. Image source: Fingertips

AreaName	Count	Rate per 1,000	95% Lower CI	95% Upper CI
Cambridgeshire	6,677	50.3	49.1	51.6
Peterborough	2,668	59.1	56.9	61.4
England	595,948	54.3	54.1	54.4

Note: dark blue indicates scores that are lower than the national average; and light blue scores that are higher than the national average.

There were over 9,000 births in Cambridgeshire and Peterborough in 2021.

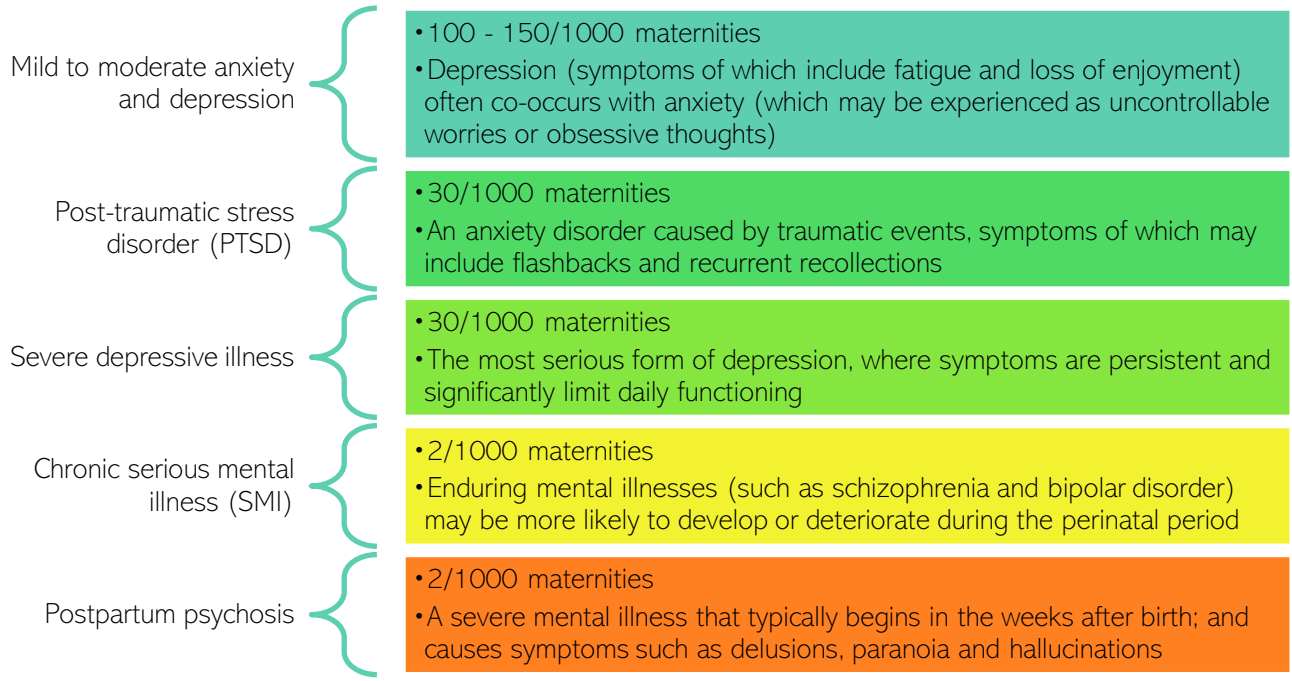
Table 5: Births in Cambridgeshire and Peterborough in 2021. Data source: (16)

Area	Births	Proportion
Cambridge	1,293	14%
East Cambridgeshire	837	9%
Fenland	1,023	11%
Huntingdonshire	1,890	20%
South Cambridgeshire	1,634	17%
Cambridgeshire	6,677	71%
Peterborough	2,668	29%
Cambridgeshire and Peterborough	9,345	100%

Prevalence of mental health conditions

Perinatal mental health conditions can be defined as those that occur during the perinatal period (defined here as the period from pregnancy to 2 years after birth) (1). It includes conditions that arise during this time, and those that were present before pregnancy. Up to 1 in 4 women and birthing people will experience perinatal mental illness, making this of the most common type of health condition during this period (1,17).

Figure 3: Estimated numbers of people impacted by perinatal mental illness. Adapted from: (18)



Note that some people may experience multiple conditions.

- Women and birthing people are around 22 times more likely to be admitted as an inpatient to a mental health unit in the month following birth, compared to pre-pregnancy (19).
- Many cases of perinatal mental illness go unrecognised: around 70% of women with perinatal mental health problems hide or downplay their illness (18); and only half the cases of perinatal depression and anxiety are detected (20).

Estimated prevalence

Using the data above, estimates have been made for the local prevalence of mental health conditions during the perinatal period each year. A group of local stakeholders who formed the expert advisory group for this chapter stated that these numbers are an underestimate of local need, based on their experience in frontline services.

Table 6: Estimated number of cases of perinatal mental health conditions across Cambridgeshire and Peterborough, based on prevalence rates and births in 2021. Data sources: (16,21)

	Births	Mild/moderate anxiety and depression	PTSD	Severe depressive illness	Chronic SMI	Postpartum psychosis
Per 1000 births	-	100 – 150	30	30	2	2
Cambridge	1,293	129 - 194	39	39	3	3
East Cambridgeshire	837	84 - 126	25	25	2	2
Fenland	1,023	102 - 153	31	31	2	2
Huntingdonshire	1,890	189 - 284	57	57	4	4
South Cambridgeshire	1,634	163 - 245	49	49	3	3
Cambridgeshire	6,677	668 - 1,002	200	200	13	13
Peterborough	2,668	267 - 400	80	80	5	5

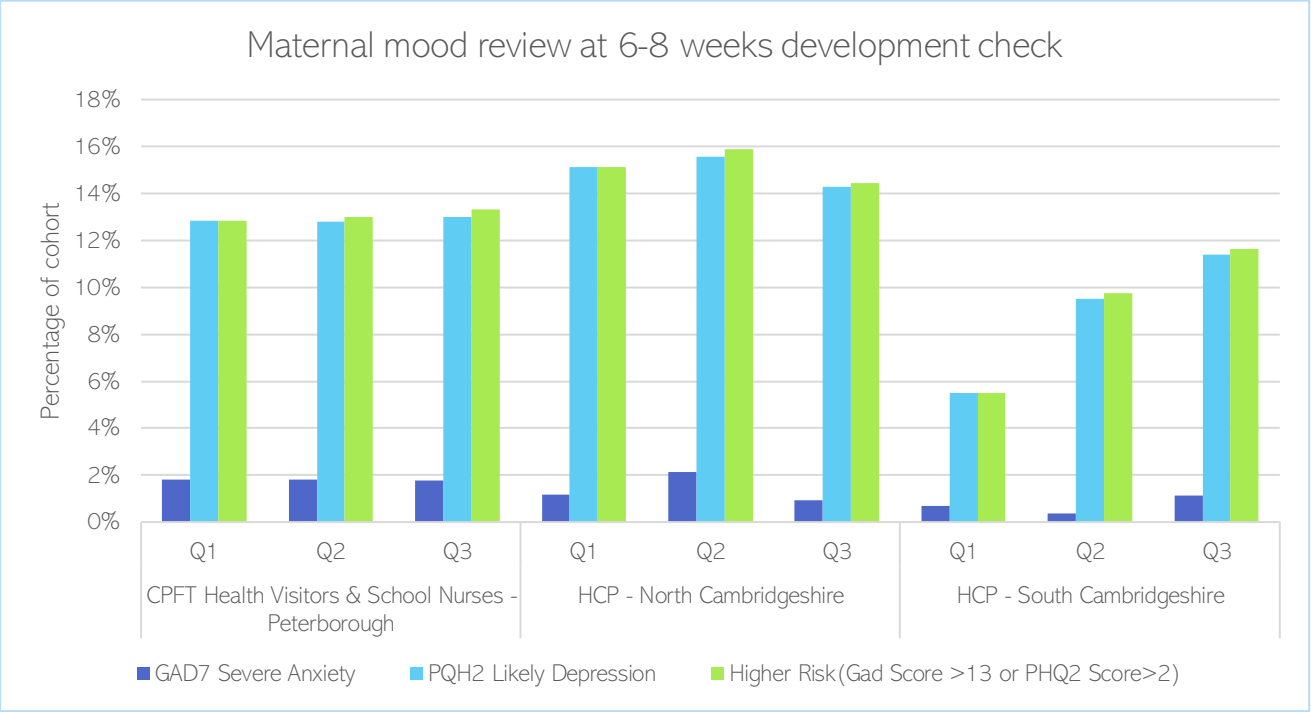
Note that some people will have multiple perinatal mental health conditions, so the total number of people impacted will not equal the sum across all conditions.

Maternal mood reviews

At 6 - 8 weeks and 12 months after birth, health visitors carry out maternal mood reviews during development checks. These checks cover a high proportion of families in Cambridgeshire and Peterborough (link to graph). For those assessed in the maternal mood review carried out at 6 - 8 weeks post-birth:

- In Peterborough, around 13% were likely to have depression and 2% were likely to have severe anxiety.
- In North Cambridgeshire, between 14 and 15% were likely to have depression, whilst levels of severe anxiety varied between 1 to 2%.
- In South Cambridgeshire, an increasing proportion were identified as being likely to have depression, with over double the rate in Q3 (11%) compared to Q1 (5%).

Figure 4: Maternal mood review at 6-8 weeks development check, Q1-Q3 2022/23. Data source: Healthy Child Programme

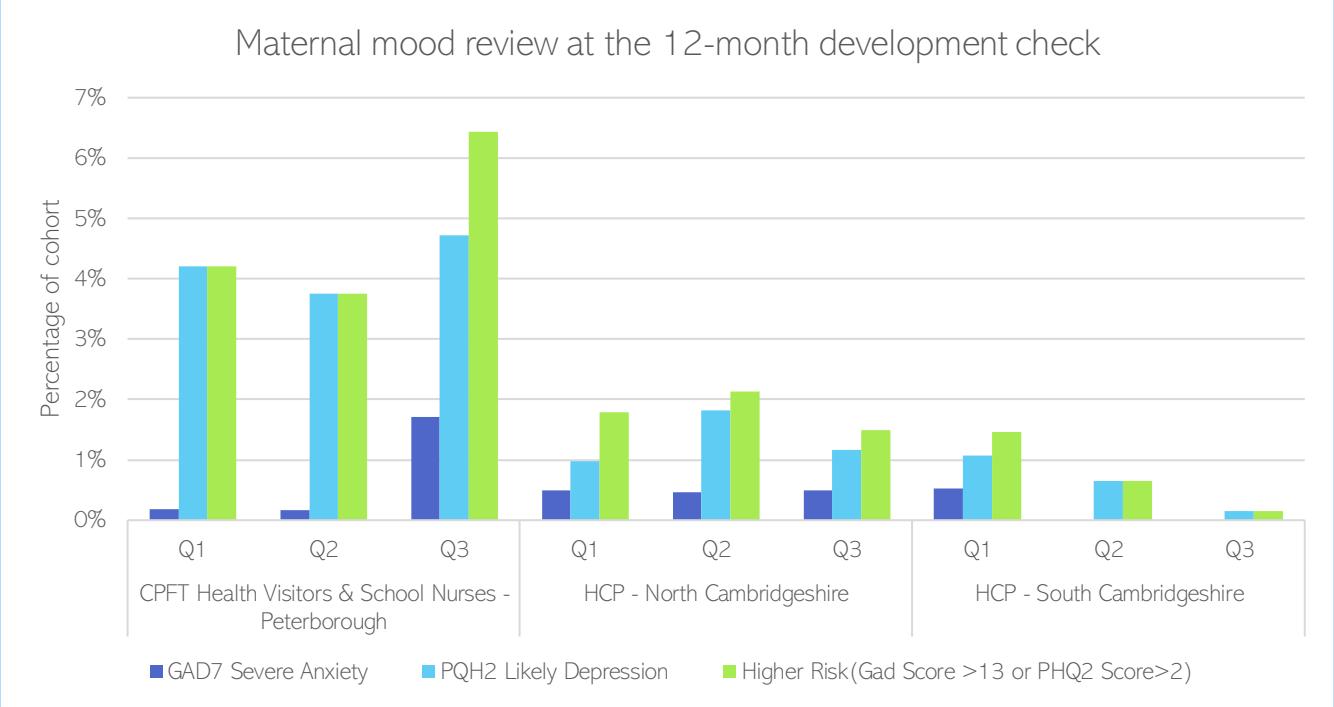


Note: the Generalised Anxiety Disorder Assessment (GAD-7) is a seven-item instrument that is used to assess the severity of generalised anxiety disorder; whilst PHQ2 is a rapid screening test to identify whether a person may be at risk for depression.

Of the cohort assessed in the maternal mood review carried out 12-months post-birth, the levels of depression remained high in Peterborough, but not in North or South Cambridgeshire:

- In Peterborough, a high proportion were likely to have depression or were at high risk for poor mental health (ranging from 4 to 6%); and there was a sharp increase in people meeting the threshold for severe anxiety in Q3.
- In North Cambridgeshire, around 2% met criteria for likely depression and under 1% for severe anxiety.
- In South Cambridgeshire, a very low proportion were identified as being likely to have depression or severe anxiety.

Figure 5: Maternal mood review at 6-8 weeks development check, Q1-Q3 2022/23. Data source: Healthy Child Programme



Note: the Generalised Anxiety Disorder Assessment (GAD-7) is a seven-item instrument that is used to assess the severity of generalised anxiety disorder; whilst PHQ2 is a rapid screening test to identify whether a person may be at risk for depression.

Maternal deaths

Maternal deaths are any deaths occurring during the perinatal period. There were 536 maternal deaths nationally between 2018 and 2020 (7). There are substantial inequalities in national maternal mortality rates (7):

- Compared to White women, Black women are 3.7 times more likely, and Asian women are 1.8 times more likely, to die during the perinatal period.
- 1 in 9 women who died during the perinatal period faced severe and multiple disadvantage (SMD).

Suicide is a leading cause of national maternal deaths, accounting for 30% of deaths in 2018-20 (7).

- In 2020, women were 3 times more likely to die by suicide during or up to 6 weeks post-pregnancy (1.5 per 100,000) compared to 2017-19 (0.5 per 100,000). There was a particular increase in the deaths of young women, many of whom were care leavers (note: these figures may have been impacted by the start of the COVID-19 pandemic).
- At least half the women who died by suicide had multiple experiences of adversity, including a history of childhood and/or adult trauma, domestic abuse and having spent time in care.
- Very few women had a diagnosed mental health condition, and many struggled to engage with health and social care services, for a range of reasons including fear of child removal.

Infant mental health

- Infant mental health can be defined as infants' ability to 'experience, regulate, and express emotions, form close and secure relationships, and explore the environment' (22).
- Positive experiences and good relationships with carers form the basis of infants' mental health (23,24):
    - The ability of infants to obtain comfort from their caregiver when distressed (secure attachment) is associated with a range of positive outcomes, including emotional, social and school achievement.

    - Insecure and disorganised attachment are associated with an increased risk of mental health conditions later in life. Around 15 – 19% of infants have disorganised attachment, which increases to up to 40% in disadvantage populations and 80% in maltreated populations.
- Chronic stress in early childhood, which can be caused by abuse, neglect or extreme poverty, has a negative impact on babies' development and can have long-term consequences on their mental health (3).

Partner mental health

The perinatal period is a time of huge change for all family members. Fathers and partners have to manage their own mental health, and cope with changing relationships and a new baby. If the birth parent experiences a perinatal mental health condition, this is likely to have an impact on their whole family.

- More than 1 in 3 new fathers report being concerned about their mental health (25). During the perinatal period, around 1 in 10 fathers experiences depression (26); and up to 18% experience anxiety in the postnatal period (27).
- The prevalence of perinatal mental health conditions in step-parents, co-mothers and trans/non-binary parents is unknown. However, some evidence suggests that there are particularly high rates of depression in lesbian co-parents and step-fathers during the perinatal period (28).
- LGBTQ+ parents can face distinct challenges during pregnancy, related to discrimination, marginalisation, and legal recognition as parents (28).
- Mental health between parents is often correlated: for example, between 42 to 50% of partners of mothers receiving inpatient mental health care experience depression (28).

Additional Resources

- NIHR summary of the importance of perinatal factors to public mental health
- MBRRACE-UK: Saving Lives, Improving Mothers' Care 2022
- Perinatal mental health leaflets written jointly by perinatal psychiatrists, women with lived experience of perinatal mental illness, and their partners.
- Mental health in pregnancy, the postnatal period and babies and toddlers: Report for NHS Cambridgeshire and Peterborough CCG
- Mental Health and Wellbeing: Pre-birth to Age 25 years Needs Assessment
- Parent-Infant Foundation Implementation Toolkit
- Early Years in Mind resources from the Anna Freud Centre
- Recent research highlighting the importance of father's mental health

Barriers and Inequalities

Anyone can be impacted by perinatal mental health conditions, but some groups are more at risk and may face specific barriers to accessing care. This subsection will detail barriers to accessing perinatal mental health support and the local populations who face inequalities in perinatal mental health.

Barriers to accessing support

- Only a small proportion of people with perinatal mental health conditions currently access mental healthcare, with one national review estimating just 9% of women with antenatal depression and 6% with postnatal depression receive adequate treatment (29).

- A large national survey carried out in 2019 of people who had experienced, or their partner had experienced, a mental health problem during the perinatal period found that nearly half (47%) felt it was 'difficult' or 'very difficult' to access mental health support (30).

Anyone experiencing difficulties with their mental health can face barriers to accessing support (as highlighted in chapter two), but there are also additional barriers specific to the perinatal period. These include:

Table 7: Specific barriers to accessing perinatal mental healthcare

Type	Barrier
Structural	• Practical barriers, such as a lack of childcare or inability to take time of work (31) • Lack of collaborative and integrated care, which can make it difficult to disclose mental health conditions (32) • Fathers can feel felt reluctant or unable to express their needs for mental health support (33). They may feel that they need to prioritise their partner's needs, particularly if they perceive that services were under-resourced (33)
Healthcare	• Perceived focus on infant health and wellbeing to the exclusion of parents' needs (34) • Professionals lacking understanding of the significance of parental mental health to child development (35), or lacking the time to address psychological needs (32) • Professionals lacking skills and/or confidence in treating or making referrals for perinatal mental health conditions (32) • Limited childcare facilities or integration of babies within therapy sessions, which can prevent people from attending appointments (32)
Individual	• Lack of knowledge around perinatal mental health (such as not knowing that to do when symptoms became worse, normalising symptoms due to pregnancy) (32) • Stigma, guilt and shame around being diagnosed with a perinatal mental health condition (particularly in relation to not fulfilling social expectations around parenthood) (32) • Fear that medication will be prescribed whilst pregnant or breastfeeding, and that this will harm their baby (32) • Stigma and fear around losing custody of their child (35), which can mean that some people wait until crisis point before accessing support (34)

Inequalities

Anyone can experience a mental health condition during the perinatal period. A large national survey of people who had experienced, or their partner had experienced, a mental health problem during the perinatal period reflected this, as people felt that their mental health was impacted by severe sickness during pregnancy, physical illness, difficulties with infant feeding, traumatic birth experiences and having a history of mental health conditions (30).

However, some groups experience inequalities in perinatal mental health. They may be more likely to experience poor mental health during the perinatal period or require additional support to have a healthy pregnancy and birth.

- The 2010 Marmot review states that action tackling health inequalities should be universal but proportionate to the level of disadvantage (proportionate universalism) (43). Hence services must respond to each families' health needs and social situation; and provide increasing support as health inequalities increase (44).
- NICE guidelines identifies that some people with 'complex social factors' may face additional barriers to accessing maternity services, and that services should be targeted towards these groups, to improve access (36). Women who attend antenatal care late or receive minimal levels of antenatal care are at higher risk of maternal death (37); and often face barriers to accessing perinatal mental health support.
- The recently developed CORE20PLUS framework highlights maternity care as a key clinical area of focus and prioritises 'ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups' (45). This was chosen to address the significant disparities in maternal mortality between different ethnic groups and areas of greater deprivation (46).

- Work to tackle inequalities locally is being led by the Cambridgeshire and Peterborough Better Births Equality and Equity Plan.

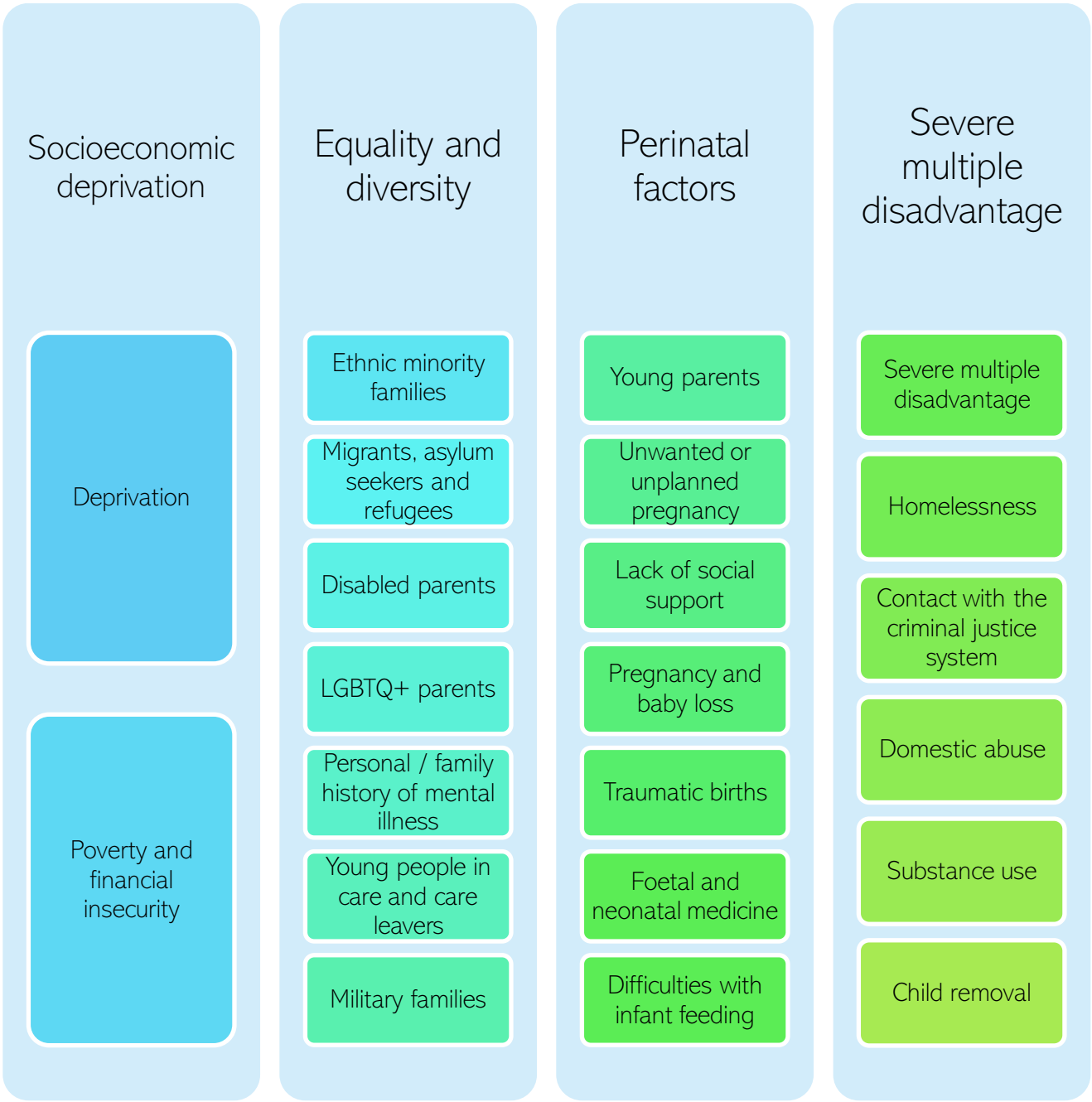
Cambridgeshire and Peterborough Better Births Equality and Equity Plan

The NHS had made pledges to improve equity in maternity services and race equality for NHS staff (38) and has produced guidance for local maternity systems on improve equity and inequality (39). The local Better Births and Equity Plan developed this into an action plan covering five priorities in October 2022:

1) Restoring NHS services inclusively, by continuing to implement the COVID-19 four actions:
    - Increased support for at risk pregnant women
    - Reaching out and reassuring women from ethnic minority groups with tailored communications
    - Discussing nutrition in pregnancy with all women
    - Capturing ethnicity and risk factors
2) Mitigating against digital exclusion
    - Introducing personalised care and support plans in various languages and formats
3) Ensuring datasets are complete and timely
    - Improving the data quality of ethnicity coding and the mother's postcode
4) Accelerating preventative programmes that proactively engage those at greatest risk of poor health outcomes
    - Understanding the local population and co-producing interventions
    - Taking action on maternal mortality, morbidity and experience
    - Taking action on perinatal morality and morbidity
    - Supporting maternity and neonatal staff (cultural competency and implementing the Workforce Race Equality Standard)
    - Enabling community hubs and addressing social determinants of health
5) Strengthening leadership and accountability

The following factors were identified from risk factors for antenatal and postnatal depression (the most well-researched perinatal mental health conditions) (40). This list of factors was added to through discussions with an expert advisory group of local stakeholders.

Figure 6: Factors associated with a higher risk of perinatal mental health conditions.



Who is at the greatest risk of perinatal mental health conditions?

The strongest risk factors for antenatal and postnatal depression identified in the literature are:

Table 8: Risk factors for antenatal and postnatal depression. Adapted from: (2)

	Risk factors
Antenatal depression	• Strong: domestic violence; prior history of mental health conditions • Medium to strong: life stress; anxiety during pregnancy • Medium: lack of social support; intention to get pregnant • Small: young age
Postnatal depression	• Strong: domestic violence; previous experiences of abuse • Medium to strong: negative life events; lack of social support; migration status; depression, unhappiness or anxiety in pregnancy; history of depression

- Medium: lack of support from partner; substance use; neuroticism; multiple births; chronic illness
- Small: low socioeconomic status; family history of any mental health condition; preterm birth

- Risk factors for postnatal post-traumatic stress disorder (PTSD) include previous traumatic experiences, caesarean section or instrumental birth, prior mental health difficulties and complex pregnancies (41).
- The strongest risk factors for post-partum psychosis are a history of bipolar disorder or previous episodes of psychosis (42). Other risk factors include primiparity (first pregnancy), changes in medication and genetic factors; whilst having a supportive partner is a protective factor (42).
- 1 in 5 women with bipolar disorder suffer a severe recurrence after delivery; and half experience some form of mood disorder in the postnatal period (including major depression) (42).
- A substantial proportion of women with pre-pregnancy eating disorders experience continued or recurring symptoms post-partum (40). Pregnancy is also a high-risk period for the onset of binge eating disorder (43).

Some risk factors have been under-researched in the perinatal mental health field: for example, few UK studies have investigated the separate impacts of migration and ethnicity on perinatal mental health (44). It is also important to note that many of these factors interact: for example, there are strong association between deprivation and ethnicity, and infant mortality rates (45).

Furthermore, whilst the focus on this needs assessment is on the services that provide individual-level prevention and intervention of perinatal mental health conditions, it is important to note that social determinants of health (including housing, poverty, racism, and gender-based violence) are the strongest upstream risk factors for poor mental health during the perinatal period (46). Past history of mental illness is an equally important risk factor, which highlights the importance of preconception health (2,47).

Additional Resources

- Tackling inequality in maternal health: Beyond the postpartum
- Five steps to reduce inequalities in healthcare
- Equity and equality: Guidance for local maternity systems
- Peterborough & Hinchingbrooke Maternity Voices Partnership and Rosie Maternity and Neonatal Voices Annual Report 2022
- Maternal Mental Health: Women's Voices

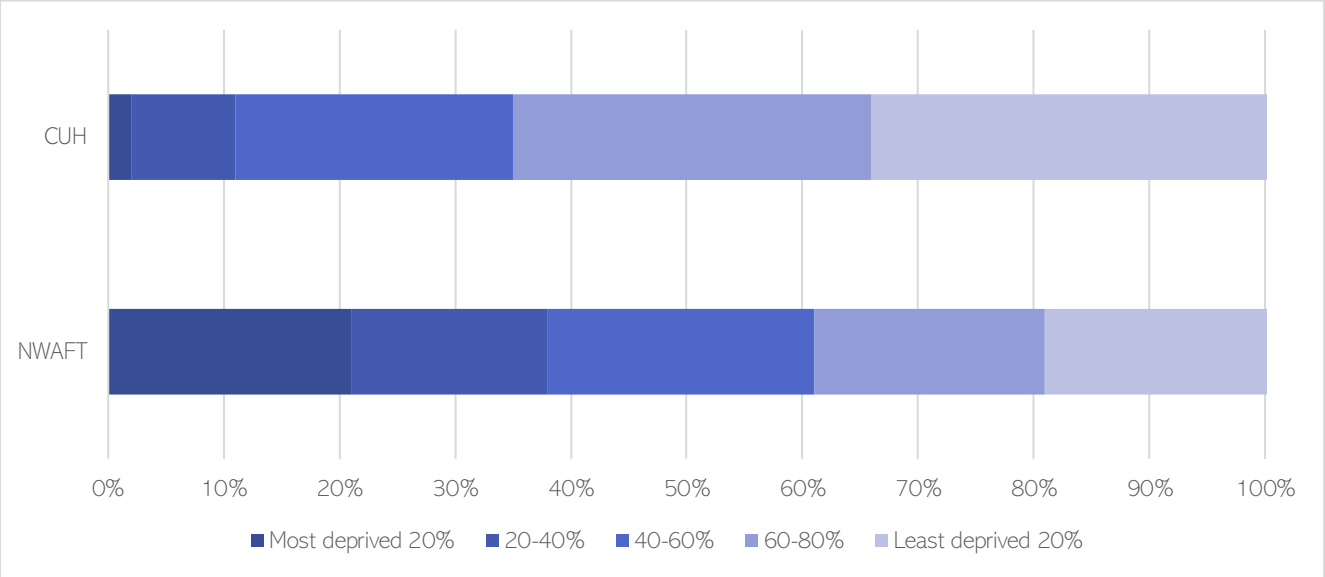
Socioeconomic deprivation

Deprivation

Local population

There is substantial variation in levels of deprivation across Cambridgeshire and Peterborough: 21% of mothers who gave birth in North West Anglia NHS Foundation Trust (NWAFT) in 2022 lived in the top 20% most deprived areas nationally, compared to 2% in Cambridge University Hospitals (CUH).

Figure 7: Births by index of multiple deprivation (IMD) of mother at booking at Cambridge University Hospitals (CUH) and North West Anglia NHS Foundation Trust (NWAFT) in December 2022. Data source: National Maternity Dashboard



Prevalence

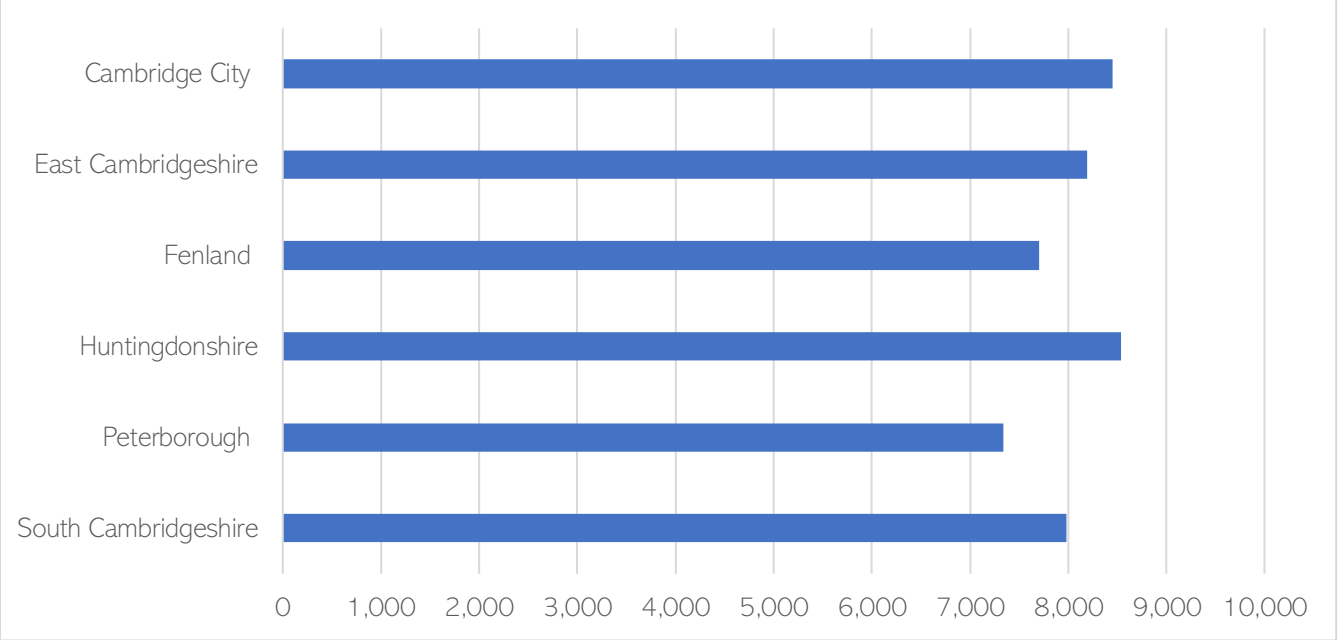
- The Marmot review highlights that there is a strong association between the 'health of mothers and the health of babies', and that there are 'equally strong associations between the health of mothers and their socioeconomic circumstances' (48).
- Women living in more deprived areas are at greater risk of experiencing poor mental health during the perinatal period. The increased risk for women in the most deprived areas, compared to those in the least deprived areas, is greatest for those aged between 35 and 45, who are (49):
    - 2.5 times more likely to experience anxiety.
    - 2.6 times more likely to experience depression.
    - 7.7 times more likely to experience a severe mental illness (SMI).
- Women from the most deprived neighbourhoods are more likely to have pre-existing depression, a SMI or another mental health condition when they become pregnant (50).

Access

Women living in more deprived neighbourhoods are less likely to have been seen by a midwife or GP for their routine 6- to 8-week postnatal review (51). They are less likely to be asked about their mental health during pregnancy and the postnatal period, and to be offered treatment and receive support (52).

Maternity exemption certificates allow anyone who is pregnant or has given birth in the past 12 months to access free NHS prescriptions and dental treatment. Applications have to be authorised by a midwife, doctor or health visitor. The uptake of maternity exemption certificates is lower in more deprived areas and reduced significantly during 2020/21 and 2021/22 (53). Locally, uptake across Cambridge has estimated to vary from 73% in Peterborough to 85% in Huntingdonshire.

Figure 8: Active maternity exemption certificates per 10,000 live births by district (2021/22). Data source: NHSBA



Experience

Women living in more deprived areas are less likely to feel that they have been treated respectfully by healthcare professionals, or that they were spoken to in ways they can understand by midwives and doctors (51).

Poverty and financial insecurity

The local picture on poverty and financial insecurity was covered in chapter one of the needs assessment.

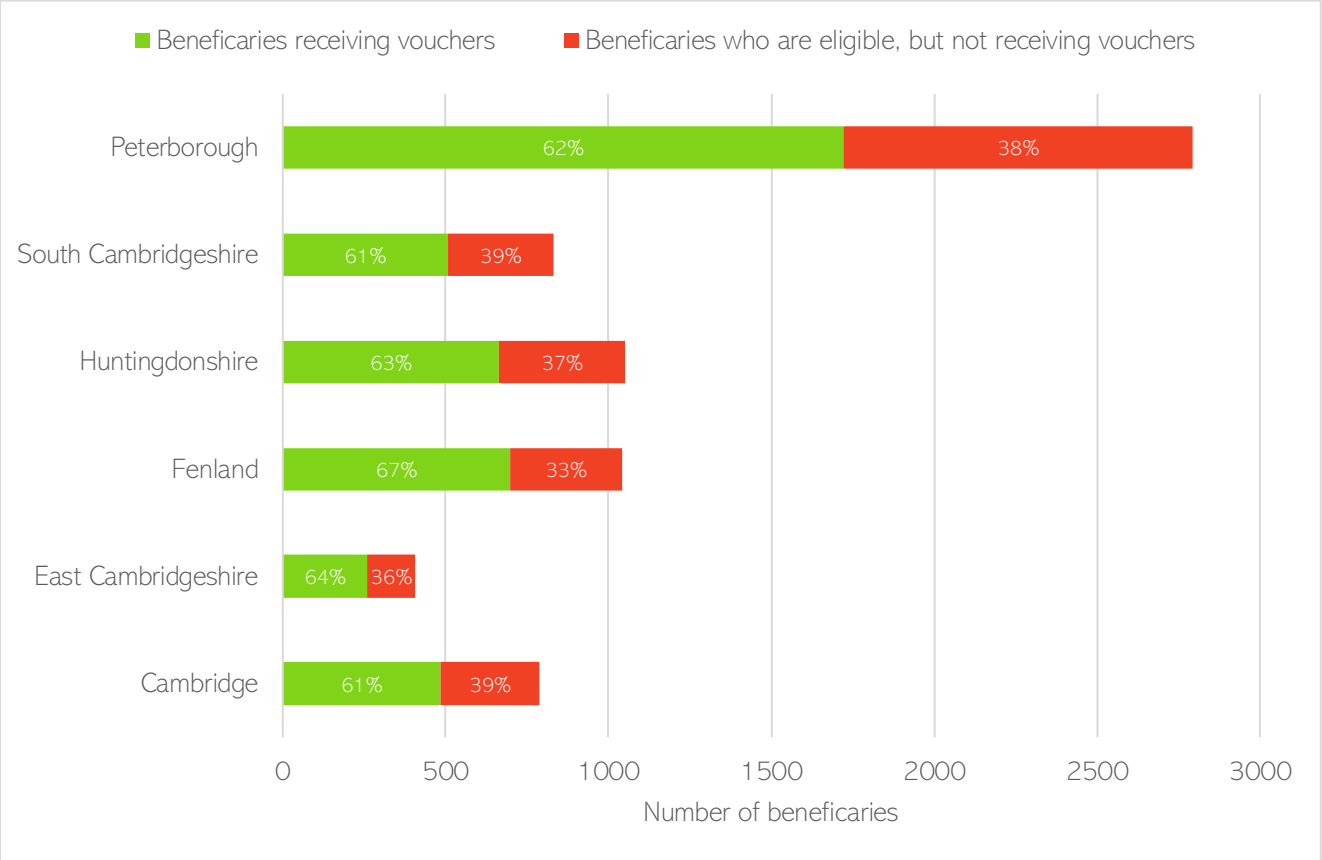
National population

- Statutory maternity and paternity pay is £156.66 per week, which equates to 47% of the National Living Wage (54).
- Over half (57%) of parents found it 'very' or 'somewhat' difficult to pay their bills from September 2022 to January 2023 (55). Parents were more likely to have cut back on costs and taken on more credit than usual over this period, compared to people without children (55).

Local population

The Healthy Start scheme aims to help families on low incomes access healthy food, vitamins and milk, during pregnancy and the early years. Local voucher uptake in January 2023 varied from 61% in Cambridge and South Cambridgeshire, to 67% in Fenland, compared to the national average of 63% (56). This means that a total of 2580 people were eligible for, but did not receive, Healthy Start vouchers.

Figure 9: Number and % of eligible beneficiaries who received the NHS Healthy Start prepaid card in January 2023. Data source: (56)



Prevalence

Poverty is associated with adverse childhood experiences, low birth weight, and poorer physical and mental health (3). National research shows that:

- In a 2023 survey of 500 new mothers, almost 3 in 4 (72%) reported that the cost of living crisis had a negative impact on their mental health (57).
- A survey of women who were on maternity leave in Spring 2022 found that over half felt that money worries impacted their health or wellbeing while they were pregnant or on maternity leave (58). Some were unable to afford to attend baby and toddler groups, which could exacerbate stress and depression.
- Women from black and minority ethnic backgrounds on low incomes often mention poverty as being one of the main issues that affects their health and wellbeing (59).

Additional Resources

- Cambridgeshire Insights provides a general overview of the local impact of the cost-of-living crisis.
- Mothers' voices: Exploring experiences of maternity and health in low income women and children from diverse ethnic backgrounds

Equality and diversity

Ethnic minority families

Local population

In Cambridge University Hospitals (CUH), at least 19% of births in 2022 were from women from ethnic minority backgrounds, predominantly 'Asian or Asian British' ethnicity (10%). In North West Anglia NHS Foundation Trust (NWAFT), at least 21% of births were from women from ethnic minority backgrounds, predominantly 'Asian or Asian British' ethnicity (11%) or 'Black or Black British' (5%).

Table 9: Proportion of births by ethnic category of the mother, in December 2022. Data source: National Maternity Dashboard

Ethnic group	CUH	NWAFT	National average
Asian or Asian British	10%	11%	15%
Black or Black British	3%	5%	6%
Mixed	3%	3%	3%
Other	3%	2%	4%
White	79%	77%	67%
Not known	2%	0%	2%
Not stated	2%	3%	4%

Note that totals may not add up to 100% due to rounding.

Prevalence

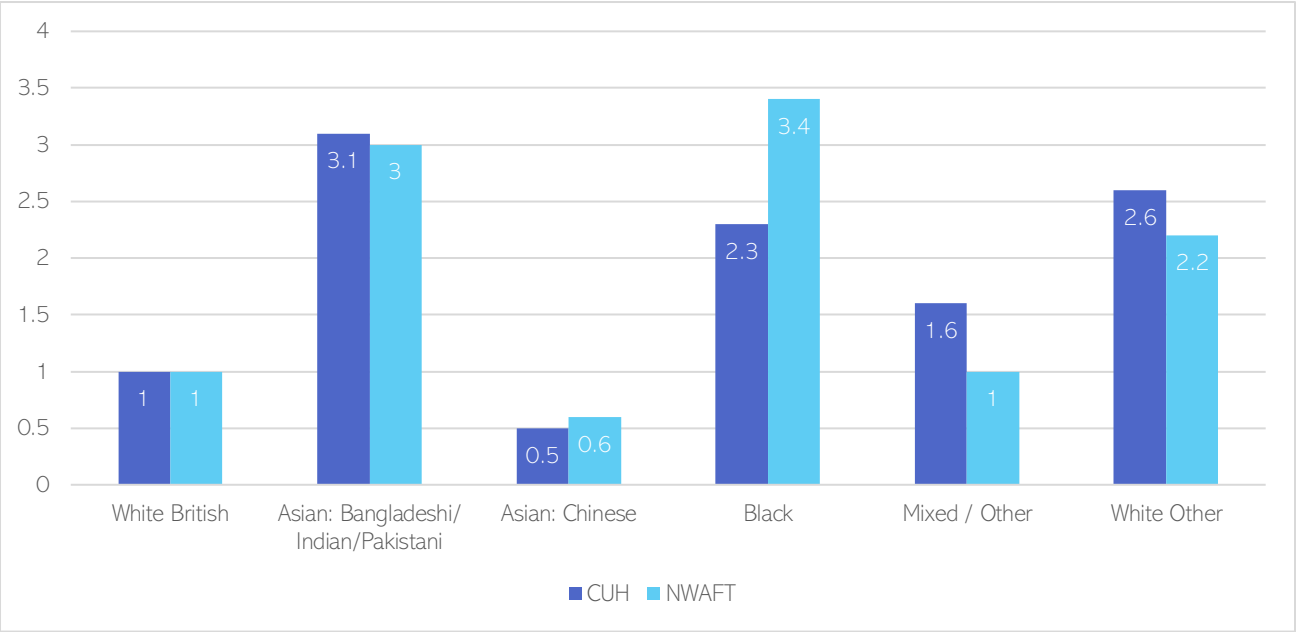
Women from ethnic minority backgrounds are more likely to experience common mental health conditions during the perinatal period (44). For example, compared to White British women, women from Indian and Pakistani ethnic backgrounds are twice as likely to report high levels of psychological distress (44).

Risk factors

People from ethnic minority groups are more likely to experience a range of risk factors for poor maternity outcomes, as listed in chapter 2 of the needs assessment. Specific risk factors relating to the perinatal period include:

- 'A 'one size fits all' approach to maternity care which does not consider differences in women's abilities to understand or access care, or serve the most vulnerable appropriately, can result inequalities in healthcare provision, contributing to structural racism' (60).
- Complications during pregnancy: compared to White ethnic groups, those from Black ethnic groups have higher rates of major postpartum haemorrhage; and those from South Asian and Black ethnic groups are more likely to have their babies admitted to neonatal units (61).
- Preterm births: local preterm birth rates (births before 37 weeks) among mothers from Black ethnic backgrounds are 3.4 times higher in NWAFT, and 2.3 times higher in CUH, than those from White British backgrounds. Mothers with 'Asian (Indian/Pakistani/Bangladeshi)' backgrounds have 3 times the rate of preterm births, and White Other around 2.2 to 2.6 times higher, than White British groups (62).

Figure 10: *Relative rates of preterm births within ethnicity population (per 100,000) across Cambridgeshire and Peterborough, compared to White British groups, 2020/21. Data source:* (62).



Note: the rate of preterm births in White British groups was 23 and 22 per 100,000 of the ethnicity population, in CUH and NWAFT respectively.

Access

National research suggests that:

- Women from ethnic minority backgrounds are less likely to be asked about their mental health during pregnancy and the postnatal period, to be offered treatment and to receive support (52).
- Compared to White British women, women from Black African, Asian and 'White Other' ethnic groups are less likely to access community mental health services, and more likely experience involuntary admission to mental health services during the perinatal period (63).
    - Women from these groups have a higher number of attended community contacts, and fewer non-attendance or cancelled appointments, which suggests there are inequalities in access to services rather than differences in engagement (63).
- Compared to White British women, Indian women are half as likely, and Black African women are a third as likely, to receive treatment for postnatal depression or anxiety (44).
- Gypsy and Travellers may not gain full access to maternity services and some may experience poor continuity of care, such as when forced to suddenly move from a site (64).

Reviews suggests that women from ethnic minority backgrounds may face additional barriers to accessing support services for perinatal mental health problems (43). Many of these were covered in chapter 2 of this needs assessment. International studies also suggest that women from non-Western cultures may be more likely to report somatic symptoms of perinatal mental health conditions, which are not recognised in most screening tests used in the NHS (65).

The NHS has pledged to improve equity in maternity services and race equality for NHS staff (38), which has led to the development of Cambridgeshire and Peterborough Better Births Equality and Equity Plan (add link).

Experience

- The maternity experiences of local families from ethnic minority backgrounds have been collected by the Raham Project. This organisation anonymously informs the local maternity services about the experiences they hear and works with them to change the way care is delivered. Key themes in their 2022 annual report include:

- Many women had positive experiences of birth. However, difficult birthing experiences could have a long-term impact on mental health. Some women experienced disrespectful, discriminatory and stereotyping attitudes from healthcare professionals and did not feel involved in decision making.
- Some women benefited from supportive relationships with midwives, but it could be difficult to establish this without consistency of care.
- Some women felt that their family situation impacted their mental health. Many highlighted the importance of support for breastfeeding to maintaining good mental health.

- Co-production with Muslim women in Peterborough brought together experiences of multiple women into 3 personas, who highlight common experiences and feelings (66). The story of one of these personas, Amal, is given below:

Amal's Story (66)

'Amal has a refugee background. She and her three children had to flee from the dangers of war-torn Syria, her country of birth, leaving her husband behind. Amal and her children had to cross several countries before arriving in England. They subsequently spent six weeks at Yarl's Wood immigration detention centre in Bedford. The prolonged stay, however, meant that she did gain the right to remain in the UK. She was then sent to Peterborough where there was available temporary accommodation. Alongside this ordeal, Amal was grieving the loss of her brother Carim, who was killed during protests of unrest in Syria. This combined experience of loss, grief, stress and uncertainty had a significant negative impact on Amal's mental health.

Amal arrived at her temporary accommodation to be faced by a host of challenges that she hadn't previously considered. She had little understanding of the English language and her ability to speak it was even less, the culture and way of life in the UK was also very different to her home country and she had very little financial support or knowledge as to where to seek help.

Amal feels under enormous pressure, especially given that she has a young baby and two other children under seven years. Her mental health has declined further, not helped by the fact that she suffers flashbacks and nightmares from her time in Syria which are severely affecting her sleep. The housing association responsible for Amal's temporary accommodation has tried to help by referring her to a psychotherapist however as well as the language barrier, she cannot take her children with her to the appointments, and she has no-one to help with her childcare.

Amal feels isolated and frightened. She is used to receiving support from her husband and wider family but is having to face all of these new challenges alone. This isolation is exacerbated by the fact that Amal doesn't have a motivation to go out and meet new people. She fears discrimination and racism because she doesn't speak English and wears a hijab. That said, Amal is very keen to learn English, as she believes this is key to a good life in the UK. She also dreams of getting a job but can't do so because she has no childcare. The only regular communication that Amal has with others is with her immediate family by phone. She strives to apply for a visa for her husband through family reunification scheme and is putting all her effort into getting everything in place to make this happen.' – Source: Starting Well-Perinatal Mental Health Support for Muslim Communities Insight Report

- A review of ethnic minority women's experiences of maternity services in the UK found that (67):
  - Care was often perceived as 'functional' rather than supportive.
  - Some women experienced prejudice or discrimination based on their ethnicity, religion or culture.
  - Several women reported communication failures, including language barriers and inadequate signposting when navigating complex systems.
  - Where resources allowed, there were reports of women-centred care, which was non-judgemental, and provided continuity of carer and cultural safety.
- A review of Muslim women's experience of maternity services in the UK highlighted that (68):
  - The majority of women experienced poor maternity care, which was sometimes the result of discriminatory behaviour.
  - Communication issues, lack of interpreters and inadequate access to appropriate information were key concerns. Many women also felt there was a lack of understanding and awareness of their decision making processes and how these related to Islamic practices.

[Mapping existing policy interventions to tackle ethnic health inequalities in maternal and neonatal health in England: A systematic scoping review with stakeholder engagement] (69)

Existing policy interventions designed to tackle ethnic health inequalities in maternal and neonatal health were reviewed in 2022. This report identified the following actions for integrated care system leaders and voluntary and community sector groups:

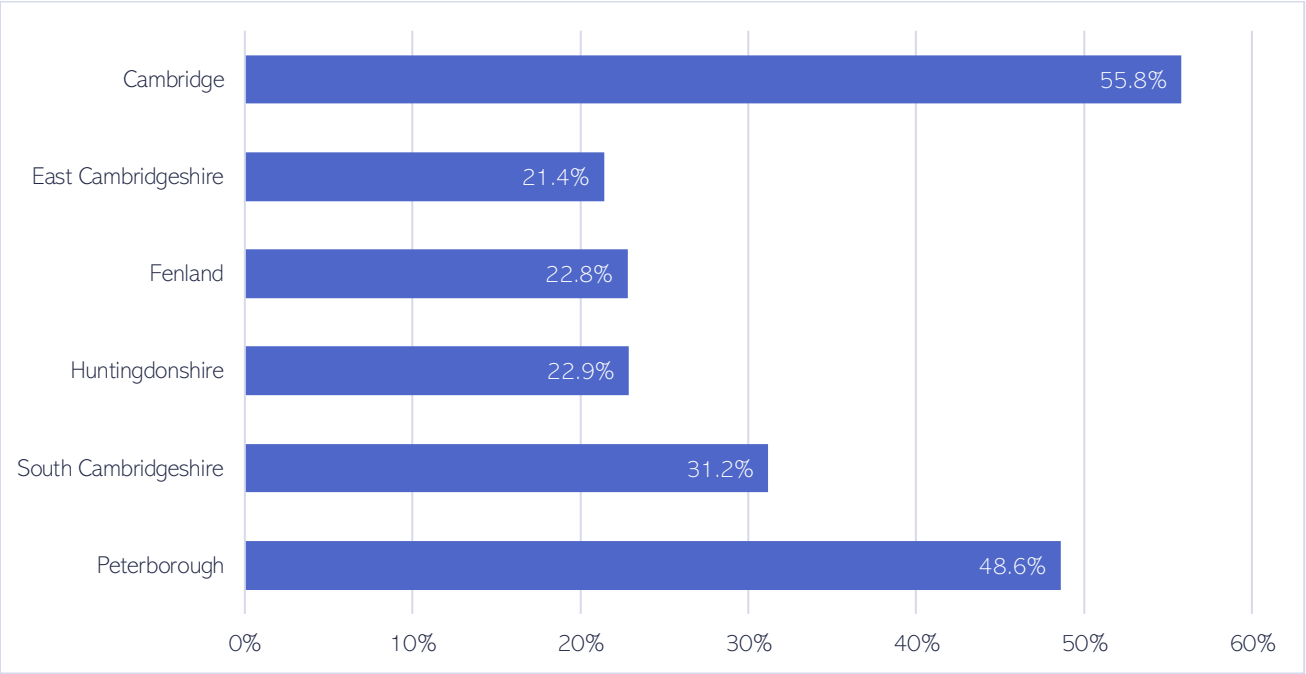
- Evaluations of local interventions should be built into their design. Targets for interventions should be realistic and measurable.
- Family Hubs should provide population health-based interventions to improve pre-conception health and provide a platform that links up local maternity systems and integrated care systems, to meet the specific needs of target populations.
- Voluntary and community sector groups should co-produce interventions and research with women from ethnic minority groups, in particular Black African and Black Caribbean, Roma and Gypsy ethnic groups.

Migrants, asylum seekers and refugees

Local population

There is significant variation in the proportion of live births to non-UK-born women and birthing people across Cambridgeshire and Peterborough. The highest proportions are in Cambridge (55.8%) and Peterborough (48.6%). The national average is 29.6%.

Figure 11: Percentage of live births born to non-UK-born women by local authority district, in 2021. Data source: (70)



Prevalence

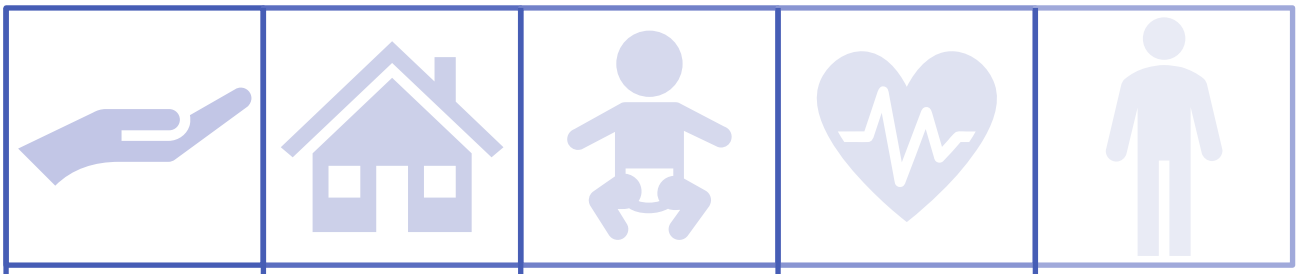
A large scale study found that migrants are 1.2 times more likely to report high levels of psychological distress in the postnatal period than non-migrants (44). A systematic review of systematic reviews about perinatal health among asylum seekers and refugees found that, compared to the general population, these groups are (71):

- Between 1.8 to 2.5 times more likely to experience postnatal depression.
- More likely to experience anxiety and PTSD during the perinatal period.

Risk factors

Risk factors for perinatal mental health conditions amongst people seeking asylum and refugees include:

Figure 12: Factors associated with an increased risk of perinatal mental health conditions in people seeking asylum and refugees. Adapted from: (71)



Stress and support	Adjustment to host country	Pregnancy care and infant feeding	Health status and history	Socio-demographics
•History of violence and abuse •Stressful life events, including being a political refugee •Lack of social support	•Language difficulties •Being unfamiliar with 'local life' in the hose country	•Poor experiences of healthcare, including operative caesarean •Feeding problems	•Poor overall health •History of mental health conditions	•Low income •Unemployment •Low education •First pregnancy •Visible minority status

Refugees and people seeking asylum are also at higher risk of preterm births, having infants with congenital abnormalities and maternal mortality (71).

Access

Compared to non-migrants, migrants are less likely to access perinatal mental health support (71), and are half as likely to receive treatment for postnatal anxiety or depression (44). Specific barriers to accessing care faced by migrants in the perinatal period are similar to those included in chapter 2 (71). Asylum seekers and refugees face many similar barriers to migrants, as well as:

- Mistrust of healthcare professionals, who can be perceived as a threat to the safety of asylum seekers who do not engage with care (71).
- Dispersal (movement to asylum accommodation in a different part of the UK), which can disrupt continuity of care and is associated with late booking for antenatal care (72).
- The policy of charging undocumented migrants for maternity care (60,71).

Impact of charges for NHS care (73)

- People who have been refused asylum, have No Resource to Public funds (NRPF) or are living in the UK without official immigration status may be charged for hospital-based care.
- Evidence suggests that this deters people from accessing maternity care. Some women also report high levels of stress and anxiety around these charges.
- Bills following birth generally start at around £7,000; but can rise to tens of thousands for complex births. The NHS has an obligation to report unpaid debts of £500 or more to the Home Office, which can threaten future immigration applications.
- Charging may increase women's vulnerability to domestic violence, and places them at increased risk of exploitation and abuse.

Experience

An umbrella review of studies found that migrants are less positive about their perinatal care than non-migrants, particularly in relation to mental health (71). Common themes included:

Figure 13: Common themes in migrants, asylum seekers and refugees' experiences of perinatal care. Data source: (71)

A systematic review of systematic reviews found that people seeking asylum and refugees report similar experiences to migrants, with the most vulnerable women in these groups having the most negative interactions with healthcare professionals, including discriminatory care, cultural stigma and stereotyping (71).

Other groups

There are some groups who we know are more likely to experience inequalities in perinatal mental health, yet we do not currently know how many people are impacted in our local population.

Groups	Inequalities in perinatal mental health	
Personal or family history of mental health conditions	Prevalence	• Having previously experienced mental health problems before pregnancy is a strong risk factor for experiencing mental health problems during the perinatal period (74). • Having a family history of mental health conditions can also be a risk factor. For example, having a family history of bipolar disorder is associated with a greater risk of post-partum psychosis (75).
	Experience	A review of qualitative literature about the experiences of motherhood in women with severe mental illness found that (76): • Problems with service provision included: lack of continuity of care; difficulties interacting with healthcare professionals; delayed treatment for postpartum psychosis due to misdiagnosis; not being able to have their baby with them in hospital; drug side effects impacting their parenting; and the need for more practical help during mental health crises (such as childcare). • Women highlighted an unmet need for peer support groups and information provision. • Individual healthcare professionals were often named in positive experiences of services.
Disabled parents	Risk factors	• Disabled mothers are (77): o Twice as likely to experience domestic abuse. o 1.4 times as likely to be a lone parent. o Twice as likely to have a disabled child (by the age of 7 years). • Some physical disabilities are associated with a higher risk of physical health complications during pregnancy and childbirth (78). • People with a learning disability are more likely to experience risk factors for poor perinatal mental health, including social isolation, poverty and poor housing (79).
	Access	Women with physical disabilities often face barriers to accessing maternity care, including around (78): • Physical accessibility (such as a lack of accessible public transport or suitable equipment) • Service design (which can make it difficult to obtain relevant health information) • Relationships with professionals (such as prejudice and lack of knowledge around disability)
	Experience	• Small national surveys have found that disabled parents report walking a 'tightrope' of demonstrating they deserve and are eligible for assistance, but not to the extent that professionals deem them to be a risk to their children (80). • These surveys found that disabled parents: o Tended to acknowledge they would benefit from support but were cautious about having contact with children's services (80). o Rarely had their voices heard, including people not recognising their knowledge of their own disability (80). o Over a quarter felt their rights were poorly respected by maternity care providers because of their disability (81). • A review of the experiences of women with physical disabilities found many had mixed or negative experiences of maternity care (82). • A review of the experiences of women with learning disabilities during pregnancy highlighted that many struggled to understand information that was presented to them (79). Some women endured negative responses towards their pregnancy from professionals (79). Fewer women with learning disabilities are involved in decisions about their perinatal care than women without learning disability (79).
Young people in care and care leavers	Prevalence	Care leavers are twice as likely to have postnatal depression than their counterparts (83).
	Risk factors	Pregnancy and the transition to parenthood can compound the difficulties faced by young care leavers (84).

		• Around 22% of female care leavers become young mothers, which is around 3 times the national average (85). • 1 in 10 young care leavers (aged 16 to 21) who are parents have had a child taken into care in the last year (85). • Many young care leavers report a lack of support when becoming parents (84).
	Access	Many care experienced parents struggle to access mental health services, due to a lack of suitable services and fears around being viewed negatively by social care professionals (86).
	Experience	Care leavers report facing increased scrutiny from social care services; and in particular, many young fathers report feeling judged and stereotyped by professionals (84).
LGBTQ+ parents	Prevalence	• There is evidence to suggest that LGBTQ+ parents are at higher risk for poor mental health during the perinatal period, including low mood, stress and depression (87). • Some perinatal experiences can be distressing for trans and non-binary parents, such as having to discontinue gender-affirming healthcare (87).
	Experience	• A large national survey of trans and non-binary birth parents found that (88): o 30% had given birth without accessing support from midwives. o For those who did access maternity care, 28% felt they were not treated with dignity and respect during labour and birth. o Less than half felt their decisions around infant feeding were always respected by midwives (compared to 85% of the general population). • A review of the experiences of LGBTQ+ parents found examples of exclusion within perinatal mental healthcare (87).
Military families	Prevalence	• There is a higher prevalence of mental health conditions amongst veterans, including anxiety, depression and PTSD; the symptoms of which are likely to persist during the perinatal period (89). • People whose partner is deployed in the military are at higher risk of depressive symptoms and psychological stress during the perinatal period (90).
Adverse life events	Prevalence	• Mothers who have experienced childhood maltreatment (such as emotional and sexual abuse) are more likely to experience (91): o Suicidal ideation during the perinatal period. o Difficulties in maternal and infant emotional regulation. o Disrupted mother-infant relationships. • One study found that women who had two or more stressful life events (including divorce, unemployment, serious illness of a close relative) within the past year were 3 times more likely to have consistently high depressive symptoms throughout the perinatal period (92).

Additional Resources

- Maternity high impact area: Reducing the inequality of outcomes for women from Black, Asian and Minority Ethnic (BAME) communities and their babies
- Perinatal Mental Health of Black and Minority Ethnic Women: A Review of Current Provision in England, Scotland and Wales
- The Black Maternity Experiences Report
- Starting Well - Perinatal Mental Health Support for Muslim Communities captures the experiences of Muslim mums in Peterborough
- Embedding cultural awareness in maternity services
- Royal College of Midwives pocket guide on Caring for vulnerable migrant women
- British Medical Association Refugee and asylum seeker patient health toolkit
- Trans + Non-binary Experiences of Maternity Services
- Gender Inclusive Language in Perinatal Services: Mission Statement and Rationale
- Maternity Action's guidance on Improving access to maternity care for women affected by charging
- An online resource for patients on Pregnancy, Birth and Parenthood after Childhood Sexual Abuse

Perinatal factors

Young parents

Local population

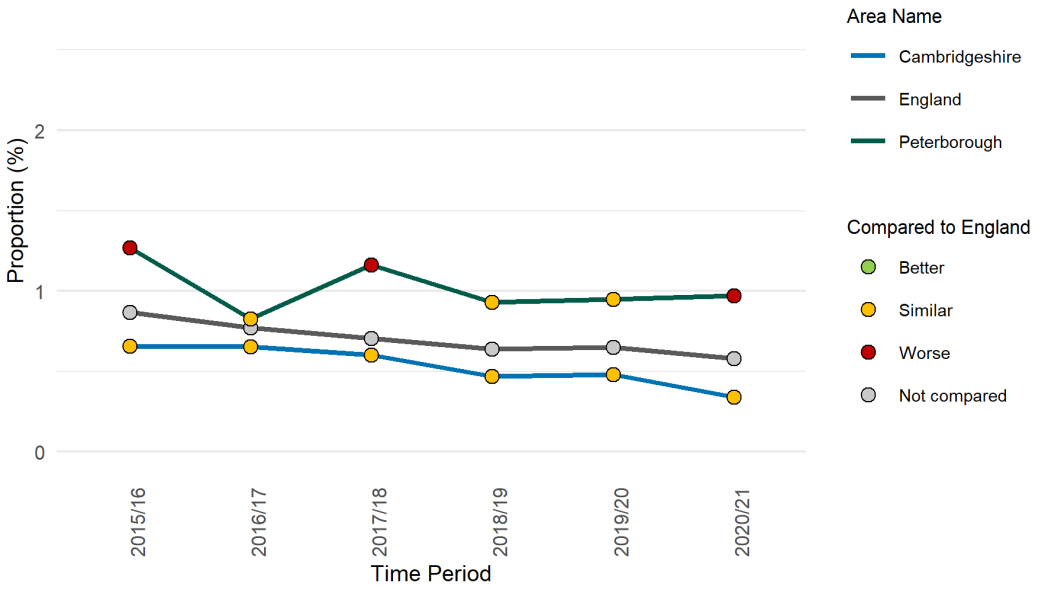
The proportion of births by mothers under 20 is almost twice as high in Fenland and Peterborough, than in Cambridgeshire (93).

Figure 14: Proportion of live births by mothers under 20, 2021. Data source: (93)

Area Name	Number	Proprotion of total live births
Cambridge	17	1.3%
East Cambridgeshire	13	1.6%
Fenland	34	3.3%
Huntingdonshire	30	1.6%
South Cambridgeshire	16	1.0%
Cambridgeshire	110	1.6%
Peterborough	83	3.1%
East of England	1,265	1.9%
England	12,928	2.2%

In 2020/21, there were 15 mothers under the age of 18 in Cambridgeshire and 30 in Peterborough. The proportion of young mothers is significantly higher than the national rate in Peterborough; but similar to the national rate in Cambridgeshire (15).

Figure 15: Proportion of young parents (under 18s) in Cambridgeshire and Peterborough. Data source: Fingertips



Note that around 22% of female care leavers become young mothers, which is around 3 times the national average (85). For more information, see the section on care leavers.

Prevalence

- Mothers under 20 have higher rates of poor mental health for up to 3 years after birth, and are 3 times more likely to experience postnatal depression, compared to older mothers (94). Young mothers are also at higher risk of PTSD during the perinatal period (95).
- In the Children and Young People's Mental Health Strategy for Cambridgeshire and Peterborough Needs profile, Romsey Mill (a local charity that provides support for young parents) reported that over 1 in 3 of young mothers they work with have mental health needs (96).

Risk factors

- Experiencing four or more adverse childhood experiences (ACEs) is associated with a 16 times higher risk of becoming pregnant or getting someone pregnant by the age of 18 (47).
- 2 in 3 young mothers experience relationship breakdown during pregnancy or the 3 years after birth (94).
- Children born to women under 20 are at 63% higher risk of living in poverty (94).

Access

- A 2022 survey of 30 young parents in Cambridgeshire found that 70% felt they would have benefited from mental health support. Over 1 in 3 felt that poor mental health was a barrier preventing them from accessing support services (97). Full results of this survey can be found here.
- National research shows that young mothers are less likely to seek support for their mental health due to fears that their parenting skills will be judged. This is a particular issue for women with histories of abuse and poor mental health (95).

Experience

Nationally, young fathers often report very poor experiences of midwifery and health visiting services, and feelings of exclusion and judgement (98). There is strong evidence showing the interrelationship between a young mother's support systems and positive experiences of the transition to parenthood (99).

Unplanned or unwanted pregnancy

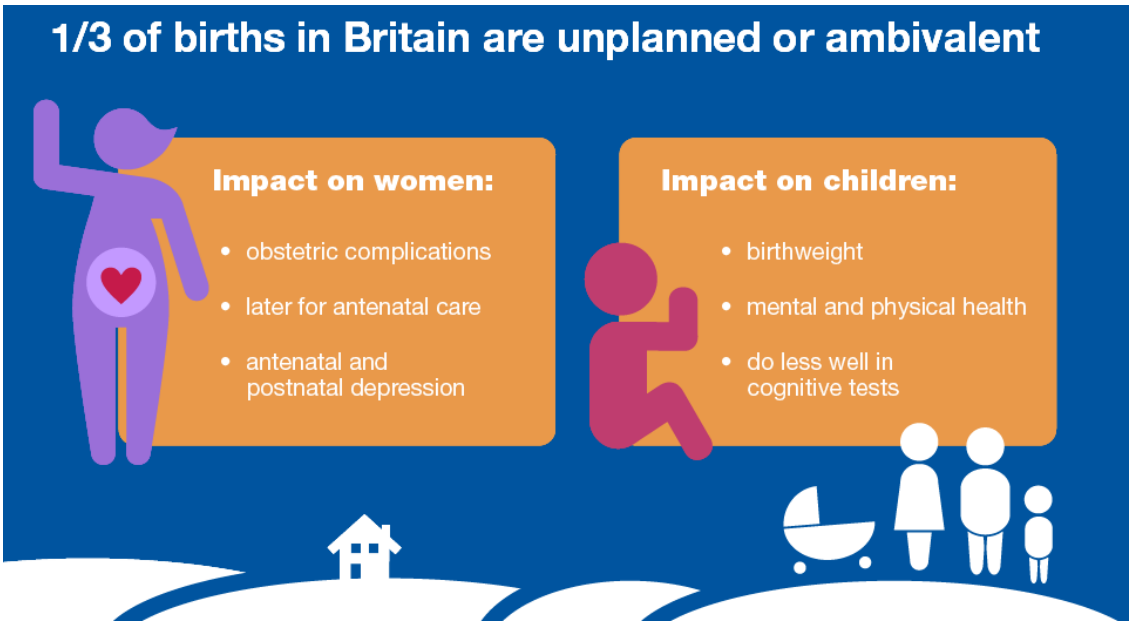
Local picture

45% of pregnancies and 1 in 3 births in England are unplanned or associated with feelings of ambivalence (100). There is no local data on levels on unplanned or ambivalent pregnancies.

Prevalence

Unplanned or unwanted pregnancies are associated with an increased risk of antenatal anxiety of depression (101). Although most unplanned pregnancies continuing to term have positive outcomes, some have adverse effects on the health of parents, infants and children into later life (100).

Figure 16: Health impacts of unplanned or ambivalent pregnancies. Image source: Public Health England



Lack of social support

Local picture

The proportion of sole registrations of live births (births registered to one parent) is above the national average (4.6%) in Fenland (6.0%) and Peterborough (5.8%) (93).

Figure 17: Live births by sole registration, 2021. Data source: (93)

Area Name	Live birth sole registrations	
	Number	Proportion of total live births
Cambridge	58	4.5%
East Cambridgeshire	28	3.3%
Fenland	61	6.0%
Huntingdonshire	56	3.0%
South Cambridgeshire	39	2.4%
Cambridgeshire	242	3.6%
Peterborough	156	5.8%
East of England	2,627	3.9%
England	27,539	4.6%

Prevalence

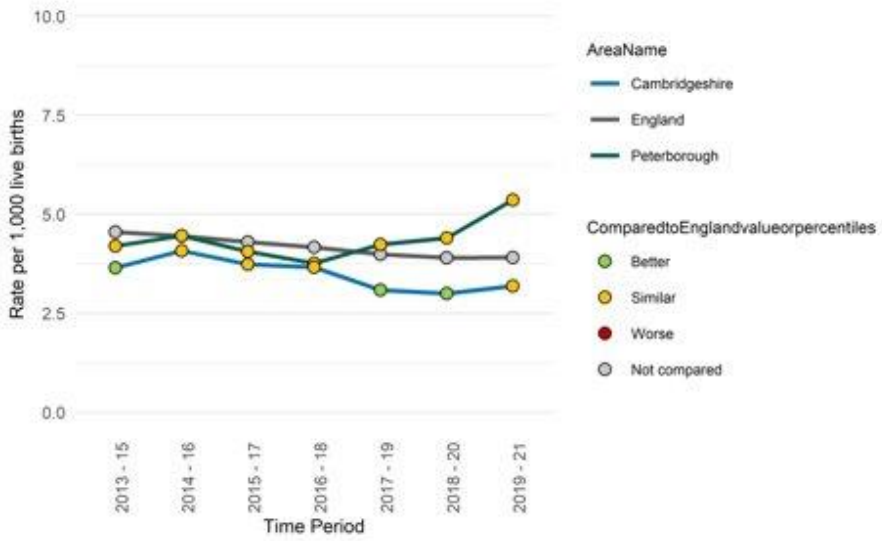
- Pregnant women who report good levels of social support are more likely to have better mental and emotional health (102). Having low levels of social support is associated with a greater risk of depression, anxiety and self-harm (102).
- A lack of partner support is a key risk factor for antenatal anxiety and depression (101).
- One national survey found that over half of parents feel lonely at least some of the time. Some groups were more likely to feel lonely (103):
    - Mothers were twice as likely to report feeling 'left out' than fathers.
    - Twice as many parents in low-income households felt isolated from others, compared to parents in higher-income households.
    - Young parents (aged 18 to 24) were 1.5 times more likely to feel a lack of companionship than parents aged 25 to 34.

Pregnancy and baby loss

Local population

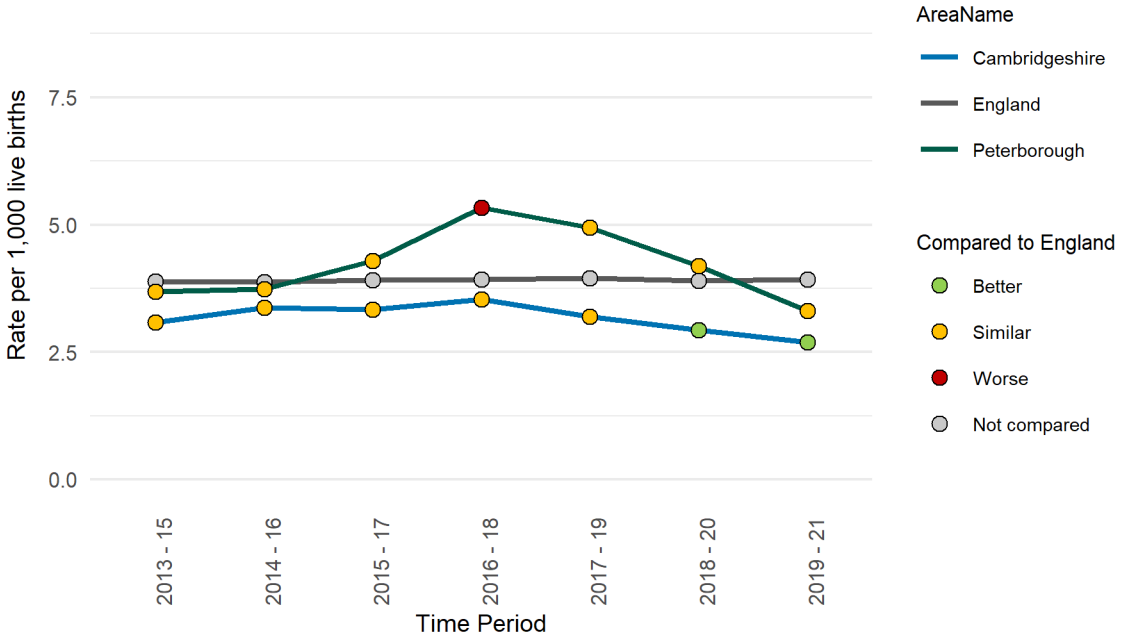
- The stillbirth rate in Peterborough has increased since 2016, whilst it has declined in Cambridgeshire. Both areas have stillbirth rates which are similar to the national average (15).

Figure 18: Stillbirth rate (foetal deaths occurring after 24 weeks of gestation) in Cambridgeshire and Peterborough. Data source: Fingertips



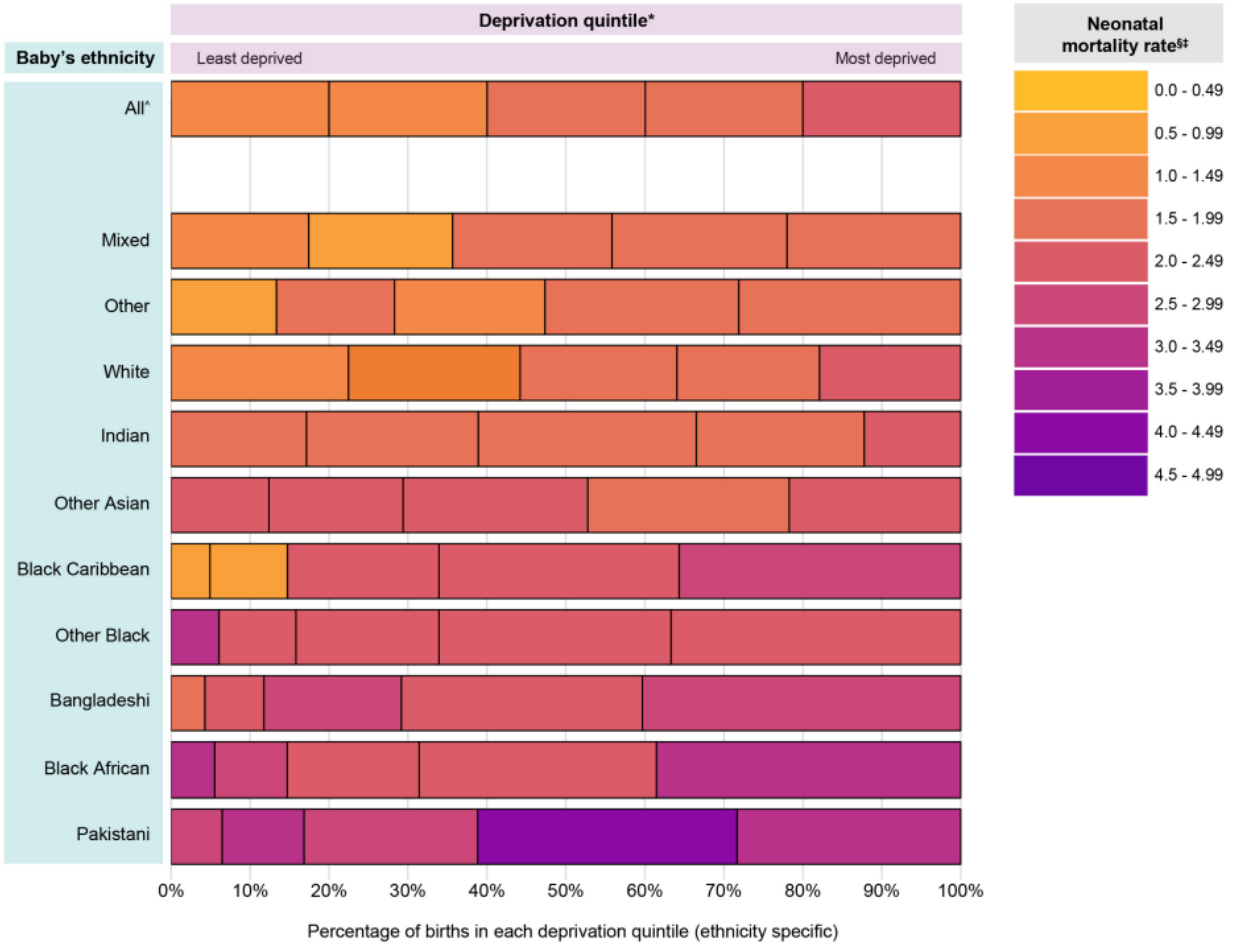
- There has been a decreasing trend in infant mortality rates across Cambridgeshire and Peterborough since 2016. Stillbirth rates in 2019 - 21 were below average in Cambridgeshire and similar to the national average in Peterborough (15).

Figure 19: Infant mortality rate (infant deaths under 1 year of age) in Cambridgeshire and Peterborough. Data source: Fingertips



- National data shows that there are strong association between deprivation, ethnicity, and infant mortality rates. There are 3 deaths per 1,000 live births for babies of Pakistani and Black African ethnicity from the most deprived areas (45). Gypsy and Traveller women also report higher rates of miscarriages and stillbirths (104).

Figure 20: Neonatal mortality rates per 1000 live births by babies' ethnicity and mothers' socio-economic deprivation quintile of residence, for UK births in 2016 to 2020. Image source: MBRRACE-UK



Prevalence

Grief is a natural response to pregnancy or baby loss (miscarriage, stillbirth or neonatal death). However, some parents who experience baby loss will develop mental health difficulties that require specialist support (105).

- Bereavement following baby loss increases risk of mental health problems in both parents (40), including anxiety, depression and PTSD (106).
- The impact of pregnancy or baby loss can be long-lasting: one study carried out 9 months after women had experienced early pregnancy loss (miscarriage or ectopic pregnancy) found that 18% had PTSD and 17% had moderate to severe anxiety (107).
- Women who have experienced miscarriages or stillbirth report there is often a lack of acknowledgement of how this can impact their mental health in subsequent pregnancies (108) and experience high levels of pregnancy-specific anxiety in the first trimester of subsequent pregnancies (109).

Experience

A national survey of parents bereaved by baby loss carried out in 2019 found that 60% felt they needed psychological support; but were not able to access it on the NHS (105). Parents who have experienced pregnancy or baby loss may not meet the criteria for perinatal mental health services, or may not find services appropriate (for example, if clinics are surrounded by families with babies) (105).

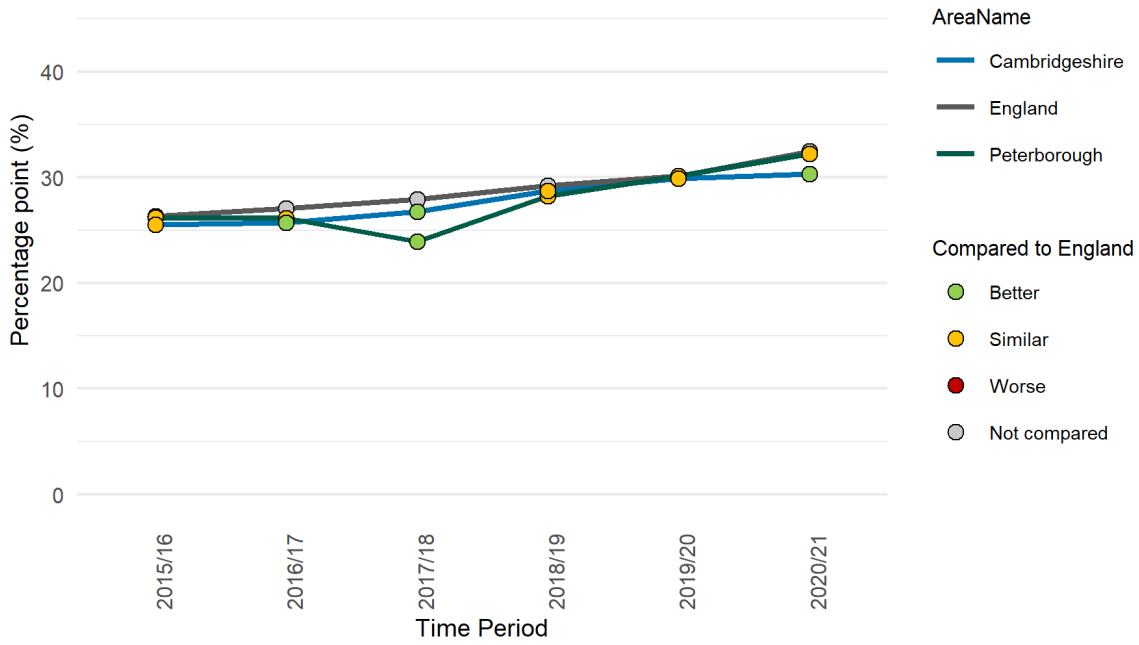
Traumatic births

Traumatic births are births which are physically traumatic (such as emergency caesarean sections, postpartum haemorrhage) and births that are experienced as traumatic, including when delivery is obstetrically straightforward (110).

Local population

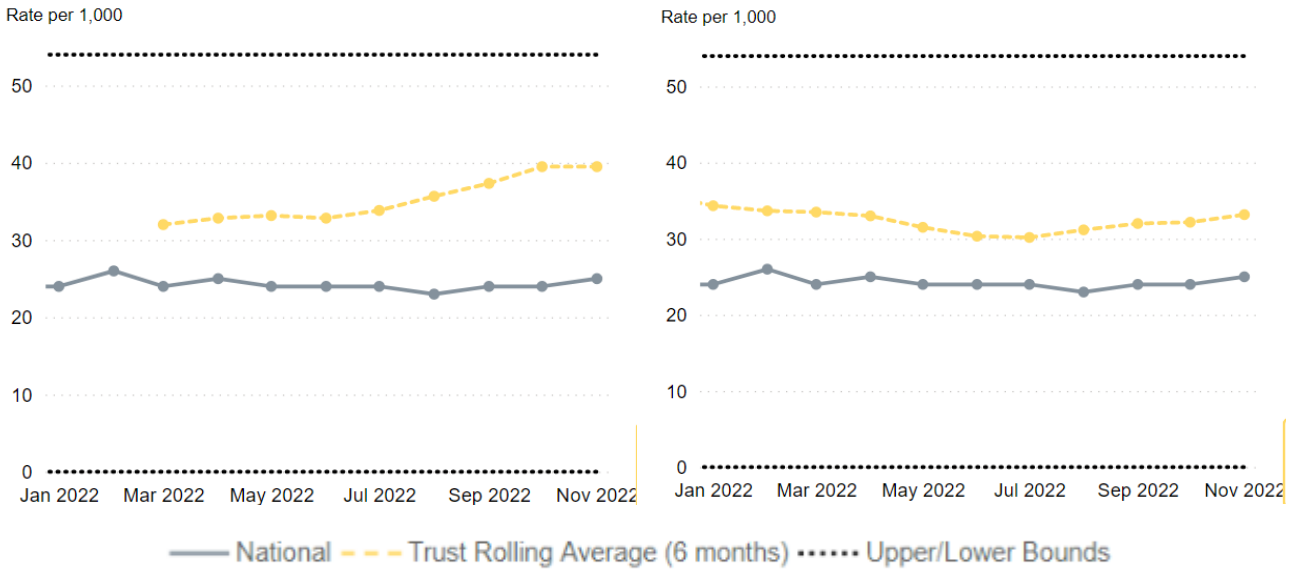
In 2020/21, there were 1,775 births by caesarean section in Cambridgeshire and 830 in Peterborough. The proportion of births by caesarean section rate is lower than the national average in Cambridgeshire, while it is similar to the national average in Peterborough (15).

Figure 21: Proportion of births by caesarean section in Cambridgeshire and Peterborough. Data source: Fingertips



The rate of women delivering vaginally who have a 3rd or 4th degree tear is somewhat higher than the national rate in Cambridge University Hospitals (CUH) and has increased in recent months. In North West Anglia Foundation Trust (NWAFT), there has been a slight increasing trend since July 2022.

Figure 22: Women delivering vaginally who had a 3rd or 4th degree tear, per 1,000, at CUH (left) and NWAFT (right). Data source: National Maternity Dashboard



Prevalence

- Distress in labour and obstetric emergencies are some the strongest risk factors for PTSD in the postpartum period (111).

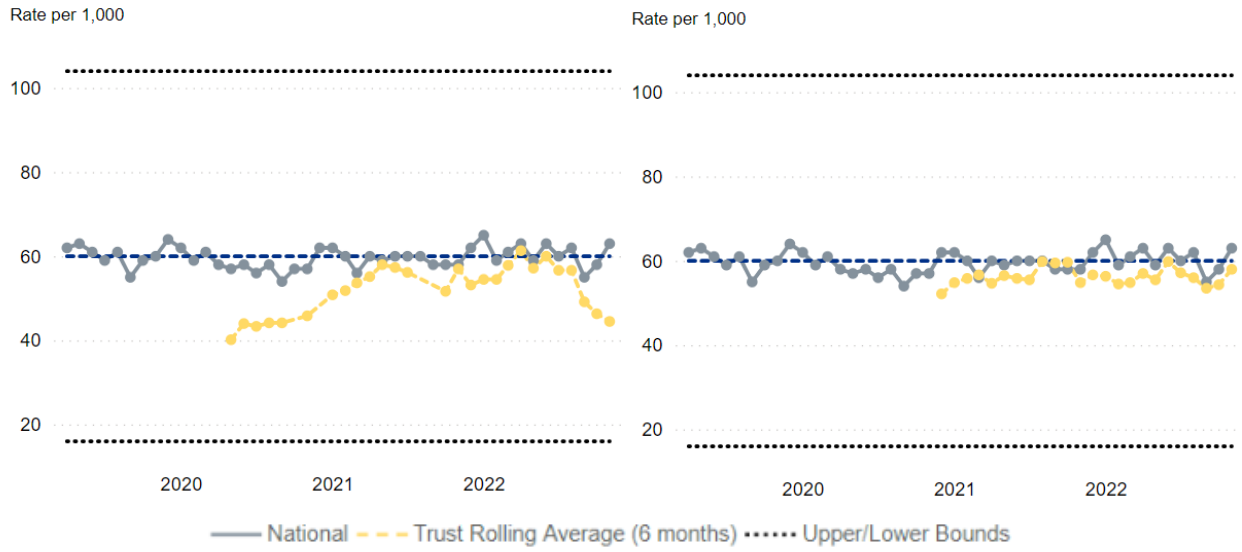
- A small qualitative study of fathers who witnessed their partner's traumatic birth found that they felt there was very little recognition of the impact this had on their mental health and on their relationship with their partner (112).

Foetal and neonatal medicine

Local population

The rolling average of preterm births has declined in Cambridge University Hospitals (CUH) over the past few months; whereas in North West Anglia NHS Foundation Trust (NWAFT), it shows a relatively stable trend which is closer to the national average.

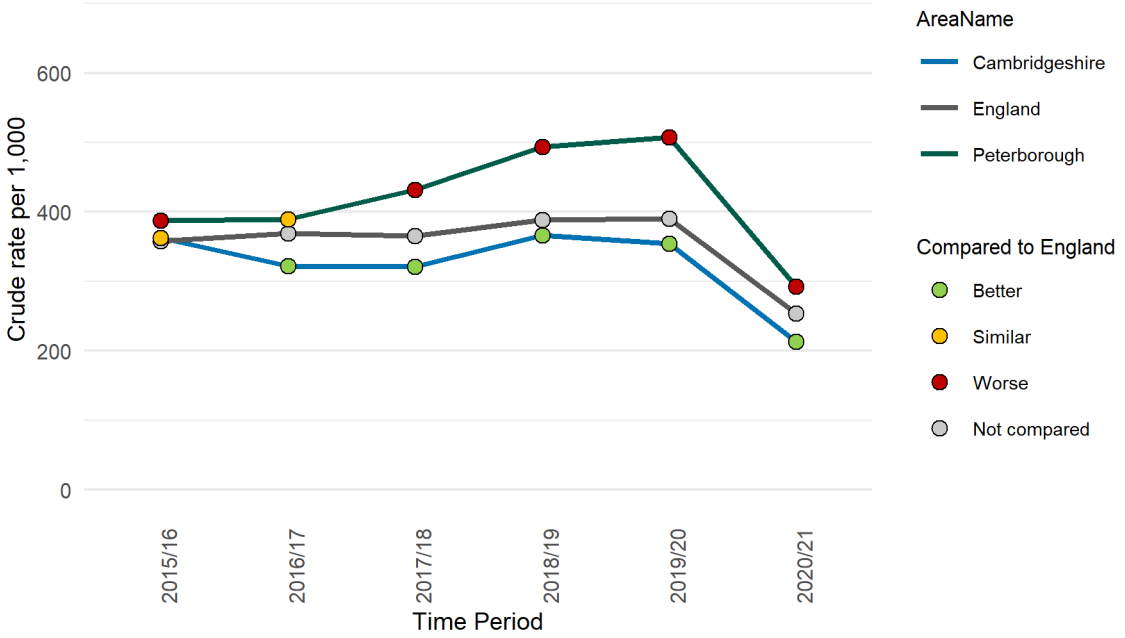
Figure 23: Babies who were born preterm, rate per 1,000, at CUH (left) and NWAFT (right). Data source: National Maternity Dashboard



Note: Preterm births as defined as babies whose gestational length was between 154 and 258 days.

The rate of infant emergency hospital admissions has been significantly higher than the national average in Peterborough since 2017/18, whilst the rate in Cambridgeshire is significantly lower than average (15).

Figure 24: Rate of emergency admissions per 1,000 population aged under 1 year. Note that the COVID-19 pandemic had a significant impact on hospital admissions in 2020/21. Data source: Fingertips



Prevalence

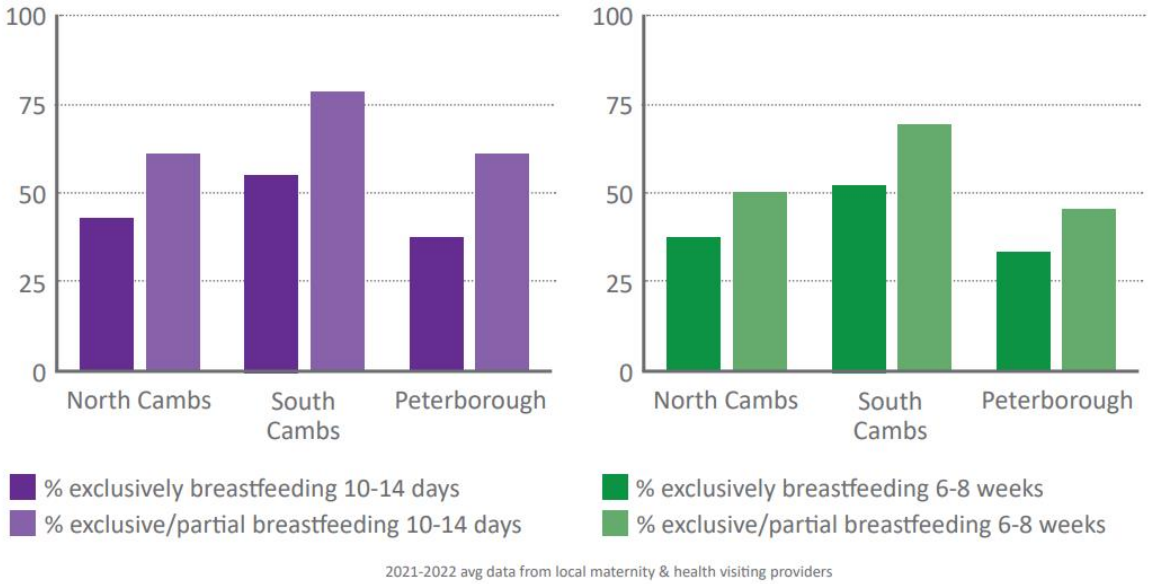
- Poor mental health is common amongst parents whose infants are in neonatal intensive care units (NICU). Parents report feelings of guilt and shame, high levels of stress, and are at greater risk of PTSD, anxiety and major depression (113). Very low birth weight and extremely preterm/extremely low birth weight babies are at greater risk of experiencing anxiety and depression as children (114).
- Diagnoses of foetal abnormalities can lead to an initial period of stress, grief and distress (115).
    - Continuing pregnancy following the diagnosis of an abnormality is associated with increased levels of anxiety in parents (115).
    - Terminating a pregnancy for medical reasons can lead to a complex mix of emotions, including emotional distress, depression, anxiety and shock (116). The course of distress following termination is similar to that of people who experience spontaneous perinatal loss (115).
- Parents are more likely to be diagnosed with depression or another mental health problem following the birth of a child with a developmental disability; and are also more likely to experience poorer social determinants of health, including reduced income and employment (117).

Difficulties with infant feeding

Local population

Rates of breastfeeding are highest in the South of Cambridgeshire and lowest in Peterborough, at both 10 - 14 days and 6 - 8 weeks post-birth (118).

Figure 25: Breastfeeding rates across Cambridgeshire and Peterborough in 2021/22, according to local maternity and health visiting providers. Image source: Infant Feeding Strategy 2022 – 2027



Prevalence

Infant feeding issues can impact mental health; and postnatal mental health conditions can compound infant feeding (118).

- The impact on mental health may be moderated by infant feeding intentions: one study found that mothers who planned to breastfeed their babies, but did not go on to do so, were at the highest risk of postnatal depression (119).
- Women report that pressure to breastfeed can feel 'overwhelming' and that there is judgement and stigma around not being able to, or not wanting to, breastfeed. Many women report feelings of failure and blame if they are unable to breastfeed (108).
- A survey of local people carried out by Rosie Maternity and Neonatal Voices in 2021 highlighted the importance of infant feeding support to perinatal mental health (120).
- The UK has one of the lowest breastfeeding rates in Europe (121). Nationally, the prevalence of breastfeeding is particularly low among more deprived areas and young mothers, which widens pre-existing health inequalities (121).

Additional Resources

- Supporting young parents to reach their full potential

Severe multiple disadvantage

Experiences of domestic abuse, substance use, contact with the criminal justice system and homelessness often overlap. Combinations of these experiences are known as severe multiple disadvantage (SMD), as described in Chapter Two.

There is no local or national data on the prevalence SMD during the perinatal period (122).

Prevalence

Many women with experiences of SMD report experiencing co-occurring or recent trauma around the perinatal period, including from domestic abuse and having their babies removed from their care (122).

Experience

- Experiencing SMD during pregnancy is associated with poor maternity outcomes and poorer experiences of maternity care (123). SMD can contribute to feelings of 'powerless[ness], self-stigmatisation and low self-esteem', which can make it difficult to navigate the maternity care system (123).
- Research led by women with experience of SMD highlighted that many women feared and distrusted services, including maternity services; and felt excluded from decision-making (122). They valued compassionate and non-judgemental approaches to care; continuity of carer; specialist midwives; and ongoing support post-birth.
- Another study in which women with experience of SMD were interviewed about their experienced of pregnancy found that (124):
    - All women brought experiences of prior/current trauma, or 'very difficult life circumstances', to their maternity care.
    - Almost all were living in temporary, unstable or unsuitable housing; many described their housing as a central problem in their life that was either causing or exacerbating mental health problems.
    - 1 in 3 were current or recent asylum seekers, who were less likely to be offered support than other women in this study and more likely to have unstable housing.
    - 3 in 4 had experienced situations in maternity services in which their choices were not respected or they were not supported to give informed consent.
    - Over half received some level of continuity of carer, which helped them build trusting relationships.
    - Many were in contact with a range of support services, which could be confusing to manage.

Homelessness

Local population

The rate of homeless households with dependent children is above the national average in Huntingdonshire and Peterborough, but below the national average in East and South Cambridgeshire (125).

Table 10: Households with dependent children owed a duty under the Homelessness Reduction Act. Image source: Fingertips

Area Name	Count	Rate per 1,000	95% Lower CI	95% Upper CI
Cambridge	138	13.4	11.4	15.8
East Cambridgeshire	126	11.9	10.0	14.2
Fenland	173	15.5	13.3	17.9
Huntingdonshire	333	16.1	14.5	17.9
South Cambridgeshire	147	7.6	6.4	8.9
Peterborough	510	20	18.3	21.8
England	93,310	14.4	14.3	14.4

Prevalence

- Experiencing perinatal mood and anxiety disorders is associated with a 2 times greater risk of becoming homeless (65).

- Experiencing homelessness is likely to lead to feelings of stress, anxiety and exhaustion, and it can be difficult for parents to provide consistent and sensitive care to their baby when coping with this (126).

Risk factors

- Parents who are homeless are often the among the most vulnerable in society, with 74% reporting at least one form of adversity as an adult, such as mental health conditions or domestic violence (126).
- Women who live with young children in homeless hostels and temporary accommodation report having a range of difficulties, including social isolation, significant stress about their living situation, and not having a safe space for their children to play (59).
- Homelessness often means that families cannot receive the support they need, with many types of homeless accommodation lacking the facilities babies need to thrive (126).

Contact with the criminal justice system

Local population

A small proportion of people in contact with the criminal justice system are new or expectant parents. There is a mother and baby unit (MBU) in HMP Peterborough that can hold up to 12 mothers and 13 babies at any one time.

Prevalence

Parental involvement in the criminal justice system is closely linked to poor mental health. For example, it has been estimated that between 70 to 80% of pregnant women in prison have depression (127).

Figure 26: The impact of parental involvement in the criminal justice system. Adapted from: All babies count: Spotlight on the criminal justice system

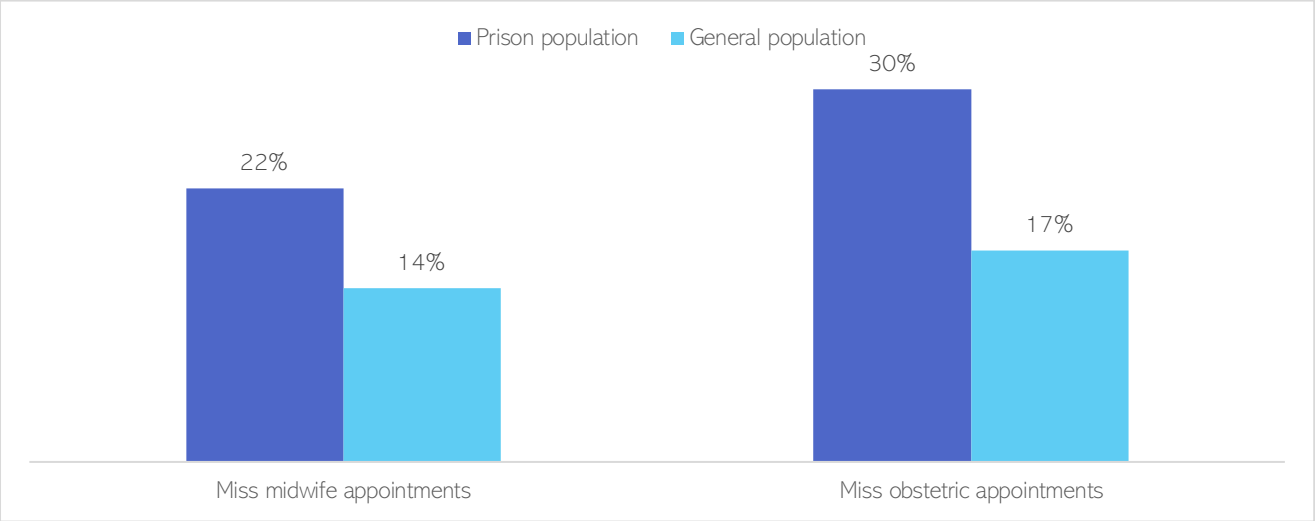
Risk factors

- New parents in contact with the criminal justice system are likely to have complex needs (128). For example, around half of women in prison report having experienced domestic violence (129). Many face overlapping issues of relating to physical and mental ill-health, housing, abuse and unemployment (130).
- Women in prison are 5 times more likely to experience a stillbirth and 2 times as likely to give birth to a premature baby that requires special care, compared to women in the general population (131).

Access

Barriers to engagement with services for women in contact with the criminal justice system include fears that social services involvement will lead to separation from their children; particularly for those who have had their own negative experiences of the social care system (130). Pregnant prisoners are also more likely to miss key maternity appointments than those in the general population (132).

Figure 27: National rates of missed perinatal appointments in the prison population and general population. Data source: (132)



Experience

A focus group carried out in 2021 with 6 women residing in the MBU at HMP Peterborough reported the following experiences (62):

Figure 28: Findings from focus group with women residing at the MBU at HMP Peterborough in 2021. Adapted from: (62)

Experiences of healthcare services

- Some women could not access medication upon arrival in prison and exprienced long waiting lists. There were also long waiting times to access GPs
- Support from the prison midwife was perceived positively
- Support from the prison health visitor was perceived negatively, includingnot having their 6-8 week postnatal check scheduled
- Mental health support was perceived as good but waiting times were long, and people needed to request support multiple times before getting help
- There were issues with appointments at local hospital for both mother and baby, including with how women were treated by hospital staff

Experiences of prison

- Many women experienced stress during their pregnancy, due to lack of information about MBU places
- Many women had fears around not getting to hospital in time to give birth
- Women felt that their hospital labour bag did not include everything they needed.
- Women felt that welfare checks needed to be more detailed

A national survey of professionals who had worked with pregnant women and new mothers in contact with the criminal justice system found that (130):

- 92% felt that working with women who are pregnant or new mothers presents an opportunity to facilitate positive changes in their lives.
- Only half (48%) felt that probation services took 'sufficient account' for the needs of pregnant women and new mothers.
- Effective partnership across criminal justice, health and social care systems was identified as the most important factor for service improvement.

Domestic abuse

Domestic abuse often begins or worsens during pregnancy (59): around 4 to 8% of pregnant woman experience physical abuse (133). Some groups are more likely to experience domestic abuse: it has been estimated that up to 38% of low-income young mothers experience physical abuse during pregnancy (134).

Local population

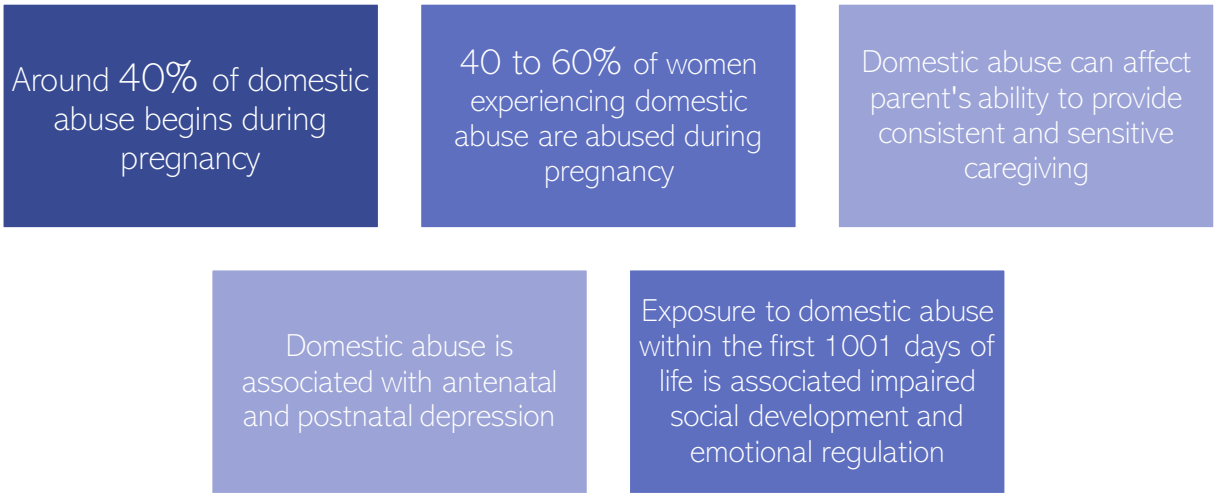
In North West Anglia NHS Foundation Trust (NWAFT), 214 women self-reported having experienced domestic abuse in 2022. This included both current and historic abuse. Approximately 40% were referred in to perinatal mental health support.

Data from Cambridge University Hospital (CUH) will be added here shortly.

Prevalence

Domestic abuse is one the of main risk factors for postnatal depression (59) and can negatively impact the emotional health and social development of infants (135).

Figure 29: Impact of domestic abuse during the perinatal period. Adapted from: For Baby's Sake



- Experiencing domestic abuse during the perinatal period is associated with:
  - 3 times greater risk of depression (136).
  - An increased risk of anxiety, PTSD and suicide (134).
  - 1.9 times greater risk of pre-term birth (137).
  - 2.1 times greater risk of low birth weight (137).
- Domestic abuse can also lead to miscarriage, foetal injury, stillbirth and maternal death (134).

Substance use

Local population

Parental substance use was covered in chapter 2 of the needs assessment. Nationally 1 in 12 women under 20 accessing drug and alcohol services is either pregnant or a mother (47).

Prevalence

Women who use substances during pregnancy often have adverse childhood experiences or traumatic experiences (138). One study found that antenatal depression was associated with a (139):

- 1.2 times greater risk of drinking alcohol during pregnancy.
- 1.7 times greater risk of smoking during pregnancy.
- 2.6 times greater risk of using cannabis during pregnancy.
- Another study found that people with a history of unmet mental health needs were 4.1 times more likely to use illicit drugs during pregnancy (140).

Substance use during the perinatal period is likely to impact infant mental health:

- Drug use can disrupt parents' ability to build strong relationships with their infant (141). Co-occurring substance use and mental health need in parents is associated with high rates of adverse infant outcomes (142) and can place infants at a greater risk of neglect and abuse (143).
- It has been estimated that 32.4 in 1000 people in the UK have foetal alcohol spectrum disorder (FASD) (144). Children and adults living with FASD are at higher risk of mental health conditions (145,146).
- There is some evidence to suggest that prenatal alcohol exposure is associated with mental health problems in children at low to moderate levels of alcohol use (147).

Child removal

Local population

Chapter 4 of this report covers the number of children entering care each year (add link).

Prevalence

Losing custody of a child has far-reaching psychological and emotional impacts. Mothers who have had a child taken into care have significantly higher rates of suicide and suicide attempts (148), and interviews with women who had been through repeat care proceedings found that (149):

- Many women went through an 'acute phase of grief' after their child was removed, which could exacerbate difficulties with mental health and substance use. The majority reported suicidal thoughts and self-harming.
- Women described that, following child removal, other aspects of their lives became worse, including their housing situation and interpersonal violence.
- Having their child removed at birth was a particularly traumatic experience.

Risk factors

Many women who have had a child taken into care have experienced multiple adverse childhood experiences (ACEs): one study of women who had been through repeat care proceedings found that 56% had experienced 4+ ACEs and over half had experienced sexual abuse in childhood (149).

Access

National research involving women whose children who had been removed from their care reported they found it 'very difficult' to access help from mental health services; which could be highly frustrating as mental health therapies were often recommended in care proceedings (148).

Additional Resources

- The impact of parental imprisonment on the mental health of children and young people
- The Birth Companions Birth Charter sets out recommendations for the care of pregnant women and new mothers in prison.
- Maternity high impact area: Reducing the incidence of harms caused by alcohol in pregnancy
- All Babies Count reports from the NSPCC: Spotlight on drugs and alcohol; Spotlight on the Criminal Justice System; Spotlight on Homelessness
- Parental Alcohol Misuse and the Impact on Children: A Rapid Evidence Review of Service Presentations and Interventions
- Supporting Midwives to Address the Needs of Women Experiencing Severe and Multiple Disadvantage

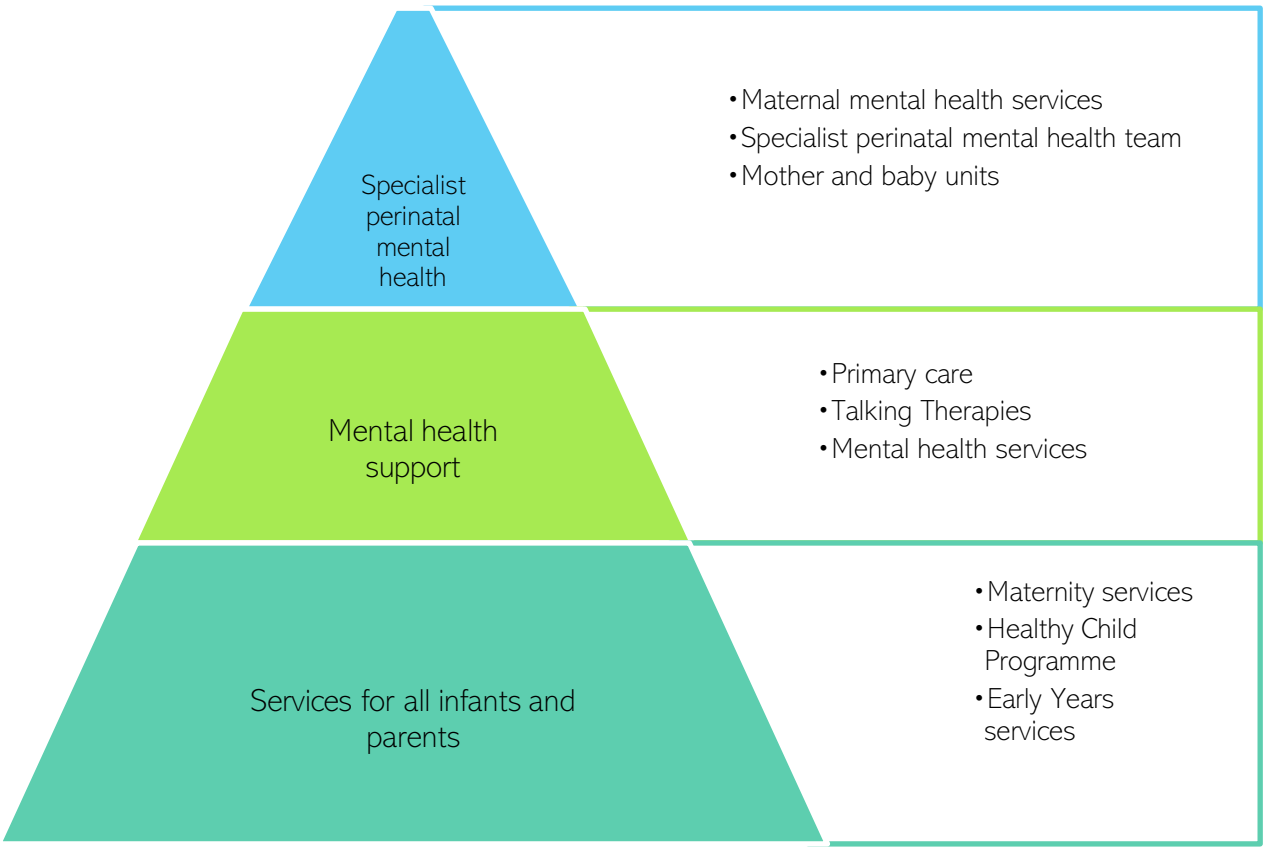
Service Provision

Unusually within mental health contexts, almost the entire population of women and birthing people experiencing perinatal mental health difficulties have routine contact with health services. This provides multiple opportunities for the early identification and treatment of mental health conditions, which may impact up to 1 in 4 women during the perinatal period (1,17).

- Early identification and intervention are particularly important as the adverse impacts of perinatal mental health conditions are not inevitable. Instead, this depends on a range of factors, including parenting skills, social support and the length and severity of mental health conditions (5).
- There are a range of effective interventions that improve the outcomes of perinatal mental health conditions (110). The provision of high quality perinatal mental health support often allows people to have more positive experiences of pregnancy and improves parent-infant interactions (150).
- A meta-analysis of qualitative research based in the UK found that non-judgemental and compassionate support and patient involvement in treatment decisions, are key to good experiences of mental health care during the perinatal period (34). Symptoms of perinatal mental health conditions are more likely to be disclosed when patients have continuity of care and a good relationship with a trusted professional (34).

This needs assessment focuses on local services (as summarised in February 2023 link) providing support during the perinatal period, ranging from universal services to those providing more specialist support (151). It will include voluntary and community sector organisations.

Figure 30: Services covered in this needs assessment.



There have been substantial developments in the provision of perinatal mental health support over the past 10 years, both nationally and locally (152). The strengths and gaps in current local service provision have been evaluated (link) using the Pathway Assessment Tool, which rates services and pathways against national guidelines.

Guidelines

Key guidelines in perinatal mental health include:

- Supporting High-Quality Perinatal Mental Health Care: What does good look like?
- NICE Guidelines on antenatal and postnatal mental health and pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors
- Royal College of Psychiatrists guidelines:
  - Perinatal mental health services: Recommendations for the provision of services for childbearing women
  - The Perinatal Mental Health Care Pathways: Full implementation guidance
  - Standards for Inpatient Perinatal Mental Health Services
- Guidance for commissioners of perinatal mental health services
- Guidelines on specific types of care:
  - Standards for Community Perinatal Mental Health Services
  - Supporting mental healthcare in a maternity and neonatal setting: Good practice guide and case studies
  - Five Principles of Perinatal Peer Support: What does good look like?
  - Guide for delivering preconception care to women with a serious mental illness
- Guidelines on specific aspects of care:
  - Ensuring digitally enabled health care is equitable and effective for all
  - A good practice guide to support implementation of trauma-informed care in the perinatal period
  - Involving and supporting partners and other family members in specialist perinatal mental health services: good practice guide

Switch to telemedicine

Since the early stages of the COVID-19 pandemic, many services have made a switch to telemedicine (the remote or virtual delivery of services).

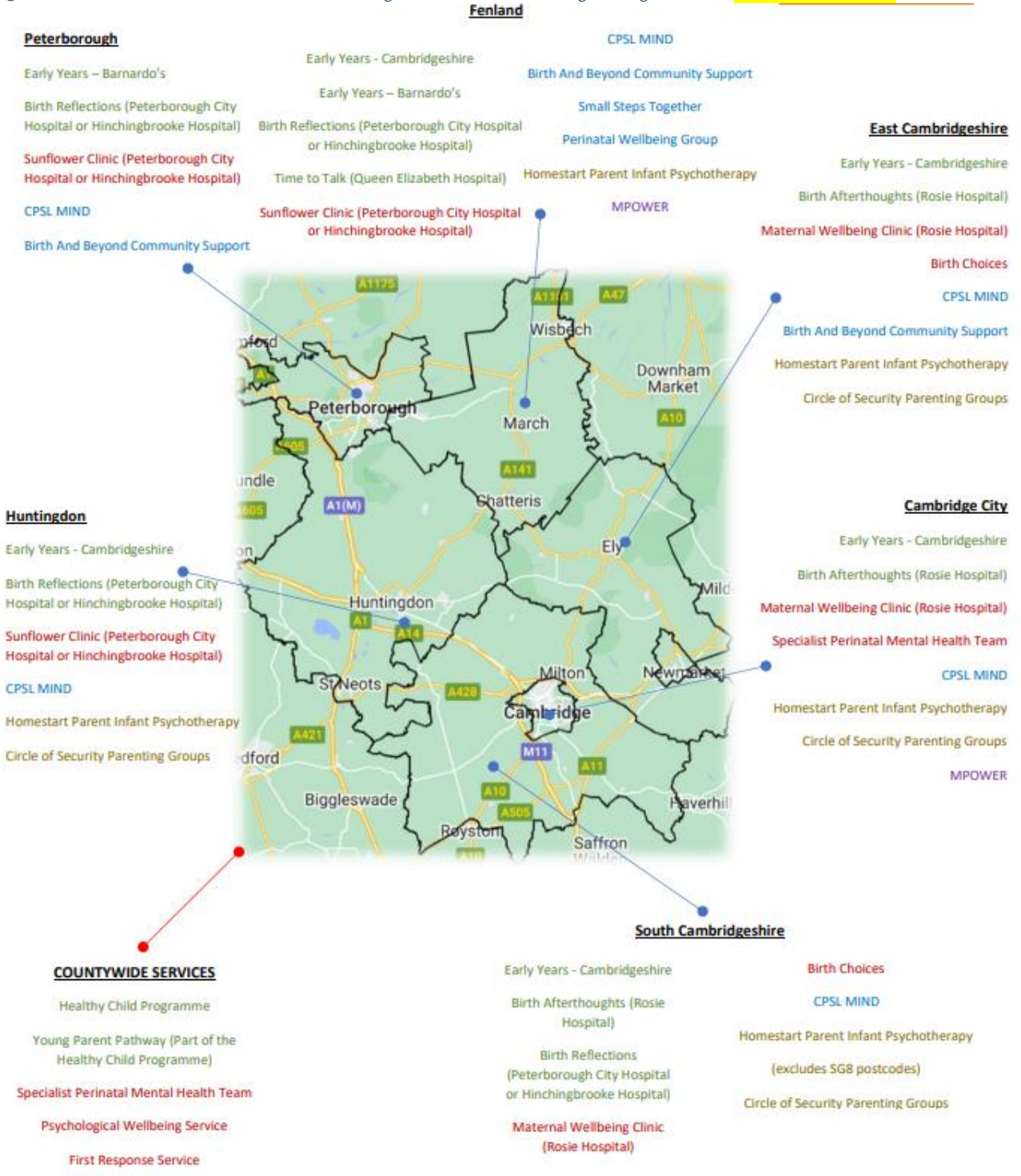
- Telemedicine has a range of advantages, including removing geographic barriers to care; and potentially being more accessible for parents with unpredictable childcare schedules and those who are unable to take time off work (31).
- Online care has been shown to be effective: for example, online psychological interventions are an effective way of delivering treatment for anxiety and depression during the perinatal period (153); and online peer-moderated discussion groups may increase help-seeking and reduce stigma (31).
- Patients report high levels of satisfaction with telemedicine services, and report that they improve their access to healthcare (154).
- However, a complete switch to telemedicine may widen inequalities faced by vulnerable groups (including people with limited access to technology and those who experience domestic abuse) (31).
- It is important to structure services around people's preferences and needs and avoid a 'one-size fits all' approach, in order to prevent digital exclusion (155).

Geographical mapping

A mapping of services was carried out by Susan Sadek in 2022. This map highlighted that there are geographic gaps in service provision across Cambridgeshire and Peterborough. For example:

- MPower offers support to women who have experienced recurrent custody loss. This service currently only operates in Fenland, although there are plans to expand this to cover Peterborough.
- Lack of parent-infant infant therapy in Peterborough and SG8 postcodes
- Varying provision of social support groups, including those providing support for people with low to moderate mental health needs

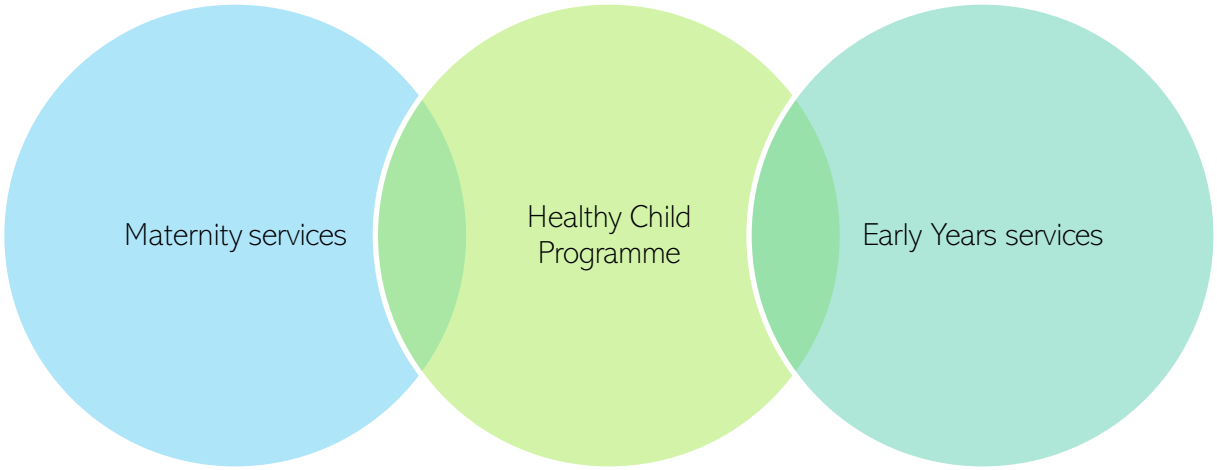
Figure 31: Location of services across Cambridgeshire and Peterborough. Image source: Susan Sadek 2022



Services for all parents and infants

Maternity and health visiting services have frequent contact with parents throughout the perinatal period. This makes them well-placed to identifying people at risk of, or who have, perinatal mental health conditions (10). Professionals in these services also ask about emotional wellbeing at each routine contact, providing support and referring people to specialist services where relevant (110).

Figure 32: Wider support for families and infants during the perinatal period



Maternity services

Families have regular contact with midwives, who provide support throughout pregnancy. Part of midwives' role includes asking about mental health history and identifying experiencing symptoms of poor mental health (156).

- Midwives work collaboratively with primary and secondary care services and voluntary sector organisations; and refer individuals into mental health support services (156).
- Specialist mental health midwives can (10):
    - Provide direct support to people with mental health conditions.
    - Be a key point of contact for mental health services, primary care, and social services.
    - Provide training and advice for other professionals managing perinatal mental health conditions.
- Receiving midwife-led continuity of care results in a 16% reduced risk of baby loss and 24% reduced risk of pre-term birth (157). Having a trusting relationship with a healthcare professional is important to regaining trust in healthcare systems for women with experiences of trauma, or social risk factors (158).
- Nationally, there is a shortage of midwives (159). National evidence suggests that some midwives do not enquire about their patients' mental health as they feel pressurised for time and are nervous about uncovering issues that could be difficult to resolve and might add pressure to already heavy workloads (10,160).

Summary: Staffing shortages in maternity services (159)

- There is a well-recognised national shortage of maternity staff. Although staff are doing their best to deliver care, they are 'stretched to the absolute limit'. The workforce is in 'permanent crisis mode' and staff shortages can mean that training gets cancelled. Some staff report concerns around quality of care and that some patient choices are being limited.
- Antenatal and postnatal care can be rushed due to pressures on staff time; and class closures and cancellations are common. This increases the likelihood of professionals missing important information from patients, such as mental health conditions or domestic abuse.
- Staffing pressures can have a substantial impact on staff morale and mental health; and lead to high levels of stress, exhaustion and burnout. This has led to a 'vicious circle' in many NHS trusts, where difficulties in retaining staff make conditions worse for remaining colleagues.
- Families using maternity services report that services can seem overwhelmed, and that staffing shortages can directly impact the quality of care they received. A survey of over 1,200 people who had given birth between August 2021 and July 2022 found that 1 in 3 had experienced delays in seeing a midwife, receiving pain relief, getting a prescription or being referred to other services.

Local picture

Local maternity services are provided by The Rosie Hospital in Cambridge; Hinchingbrooke Hospital in Huntingdon; and Peterborough City Hospital in Peterborough. Some families in Wisbech are served by Queen Elizabeth Hospital, which is located outside of Cambridgeshire and Peterborough.

All hospitals offer a listening and debriefing service for families who have had traumatic birth experiences, however only The Rosie Hospital provides specific support around birth choices (ensuring that birth experiences are as personalised and as safe as possible).

Table 11: Support services offered at local maternity services. Data source: (151)

Hospital	Offers a support service around birth choices?	Offers a listening and debriefing service for families who have had traumatic birth experiences?
Hinchingbrooke Hospital	No	Yes – Birth Reflections
Peterborough City Hospital	No	Yes – Birth Reflections
The Rosie Hospital	Yes – Birth Choices Clinic	Yes – Birth Afterthoughts

The percentage of women and birthing people who have their booking appointment with a midwife within 10 weeks of their pregnancy was significantly above the national rates in Cambridgeshire and Peterborough in 2018/19 (15). The rate was higher in Cambridgeshire than in Peterborough.

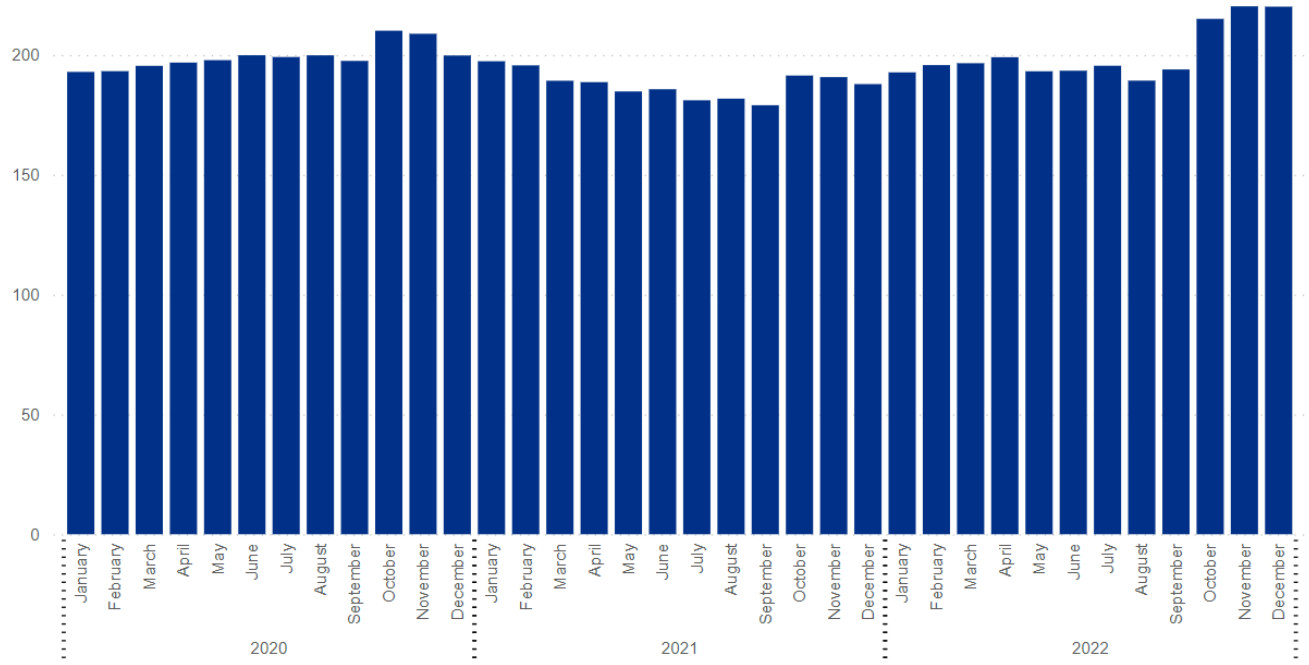
Table 12: Early access to maternity care, 2018/19. Data source: Fingertips

AreaName	Proportion	95% Lower CI	95% Upper CI
Cambridgeshire	76.9	75.9	77.8
Peterborough	62.9	61.1	64.5
England	57.8	57.7	57.9

Workforce

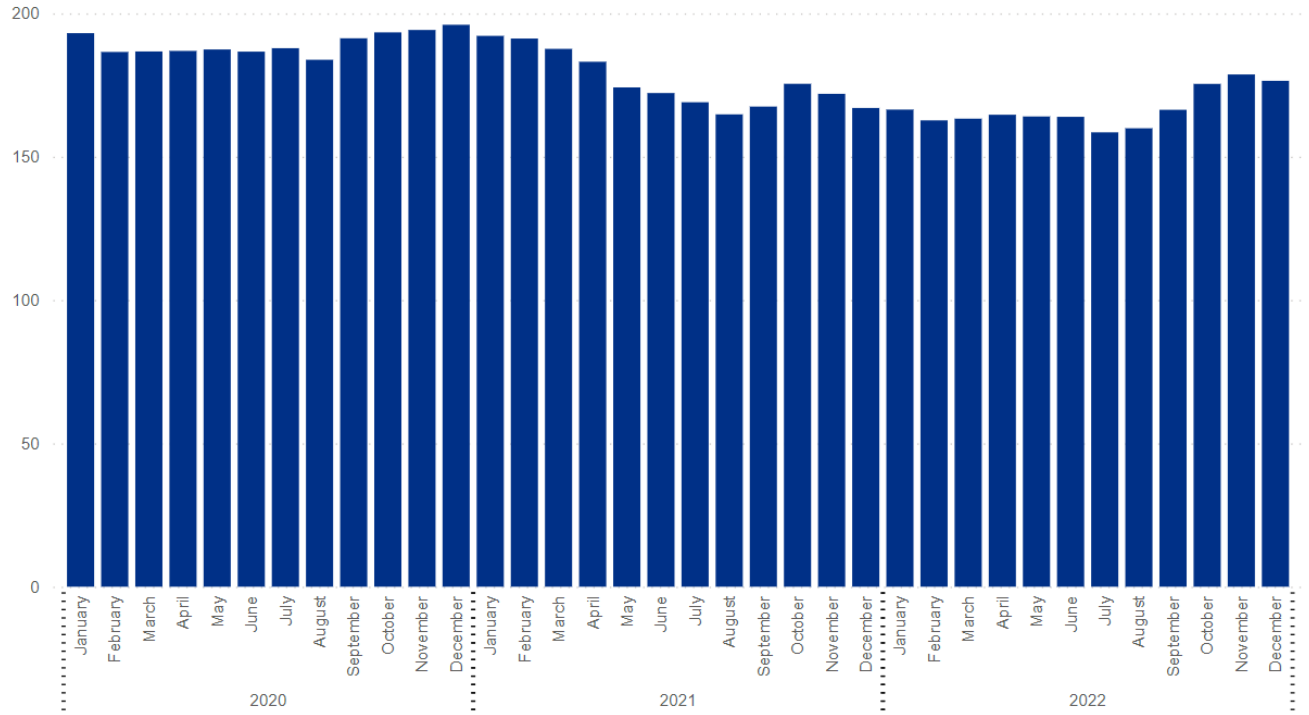
The total number of midwives employed by CUH was similar in 2020 and 2022 (161).

Figure 33: Number of full time equivalent (FTE) midwives employed by CUH, 2020 - 22. 1.0 FTE equates to full-time work of 37.5 hours per week. Image source: NHS Digital



There was a 14% reduction in the number of midwives employed by NWAFT in 2022, compared to 2020 (161).

Figure 34: Number of full time equivalent (FTE) midwives employed by NWAFT, 2020 - 2022. 1.0 FTE equates to full-time work of 37.5 hours per week. Image source: NHS Digital



Experiences of services

The 2022 Maternity Services Survey found that North West Anglia NHS Foundation Trust (NWAFT), which covers Peterborough City Hospital and Hinchingbrooke Hospital, had below average scores for questions relating to antenatal and postnatal mental health support (162). The Care Quality Commission invited people to participate

in this survey if they had a live birth during February 2022. It had 232 responses from CUH and 185 from NWAFT, a 57% and 42% response rate respectively.

Table 13: Results of the NHS Maternity Services Survey 2022 for Cambridge University Hospitals (CUH) and North West Anglia NHS Foundation Trust (NWAFT). Data source: (162)

	CUH	NWAFT	National average
During your antenatal check-ups, did your midwives ask you about your mental health?	8.1	7.0	8.3
Were you given enough support for your mental health during your pregnancy?	8.6	7.7	8.6
Did a midwife or health visitor ask you about your mental health (postnatal care)?	9.5	9.2	9.6
Were you given information about any changes you might experience to your mental health after having your baby?	6.8	7.0	7.2
Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	7.6	8.3	8.1

Note: CUH covers The Rosie Hospital and NWAFT covers Peterborough City Hospital and Hinchingbrooke Hospital. Scores are given between 0 and 10, where 10 indicates the most positive patient experiences possible and 0 considerable room for improvement. Grey indicates results are similar to the national average, yellow that they are 'somewhat worse than expected' and orange that they are 'worse than expected'.

A survey carried out by Rosie Maternity and Neonatal Voices, with over 200 respondents who had predominantly given birth between 2017 and 2021, found that (120):

- The majority of respondents reported having some kind of mental health concern (68%), but only 7% had a mental health diagnosis. 37% of respondents reported having mental health issues in the past; and 14% experienced mental health difficulties for the first time in the perinatal period.
- Over half of people had not received perinatal mental health support (58%), the majority of whom (74%) were interested in finding out about available support. This suggests a lack of awareness of what support is available. For those who did access mental health support:
    - 47% found it hard to find out about support.
    - 39% found it hard to access support.
    - 86% found the support was helpful.
- Community midwives and GPs were the channels through which most respondents initially sought help with their mental health. Almost all respondents felt that perinatal mental health support could be better promoted, particularly within their maternity and discharge packs, and on The Rosie Hospital website.
- The majority of respondents felt that they needed more support to manage their anxiety around pregnancy and parenting (including breast feeding), which could impact their mental health.
- Note that a range of actions have been completed in response to this survey, including the addition of information about perinatal mental health on The Rosie Hospital website.

Healthy Child Programme

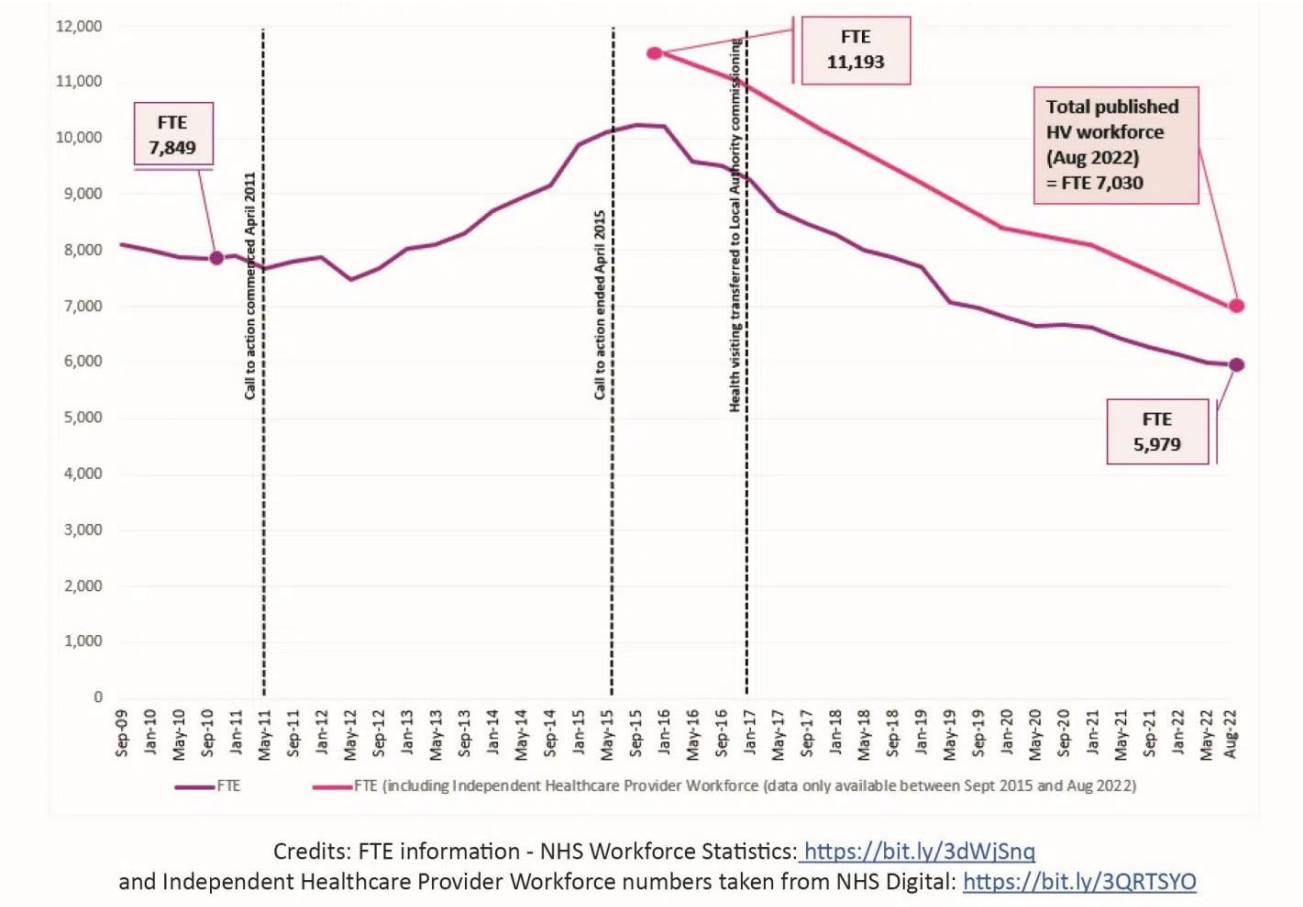
The Healthy Child Programme is run by a multi-disciplinary team of health visitors, nursery nurses and assistant practitioners, who provide community support for infants and children aged 0-5. As part of this programme, all families with babies should be offered 5 mandated health visitor reviews before their child is 2.5 years old (163). The Healthy Child programme is based on the principle of proportionate universalism, so provides a mix of universal and targeted provision.

- Health visitors provide support to all new parents and play a key role in recognising mental health problems and referring to specialist care, particularly during the 6-8 weeks visit post-birth. They aim to improve health outcomes and reduce inequalities across 6 areas (164).

Figure 35: 6 areas of support provided by health visitors. Adapted from: (164)

- Specialist health visitors have additional training in perinatal mental health. They can provide direct support to families, work with and provide referrals to specialist mental health services, and provide training and support for other health visitors (165).
- Nationally, the health visitor workforce has decreased by over a third since 2015 (166). There is an estimated shortfall of 5,000 health visitors in England; and 48% intend to leave the profession within the next 5 years (167).

Figure 36: Size of the health visitor workforce from September 2019 to August 2022. Image source: Institute of Health Visiting



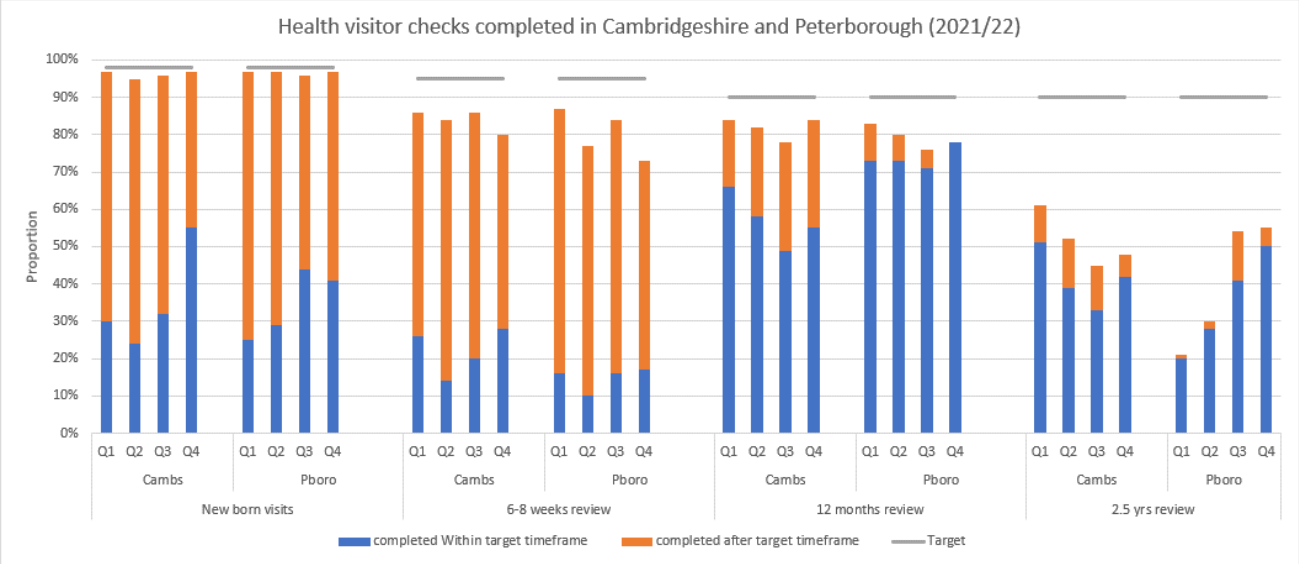
Credits: FTE information - NHS Workforce Statistics: https://bit.ly/3dWjSnq
and Independent Healthcare Provider Workforce numbers taken from NHS Digital: https://bit.ly/3QRTSYO

- Health visitors across the UK report that staff numbers are the biggest barriers to making a difference to families (167). A 2022 survey of health visitors found that (167):
    - 86% reported there is not enough capacity in other services to pick up onward referrals, which is a key driver in families being left without support.
    - 35% believed that the services they provided were inaccessible for some families.
    - 70% felt 'worried, tense or anxious'.
- A 2019 survey of 1000 mothers in England found that 22% felt that their interactions with health visitors felt like a 'tick box exercise'. Key drivers for this were: lack of continuity of care, appointments feeling rushed, and difficulties accessing services when needed (168).

Local picture

- The proportion of 6 - 8 week and 2.5 year reviews carried out by health visitors is substantially lower than the national average in Cambridgeshire and Peterborough (169). Due to ongoing workforce and capacity issues, the local timeframe of new born visits and the 6 - 8 week reviews has been extended to up to 21 days and 12 weeks respectively.
- Average national rates for 2020/21 were:
    - New born visits: 88% within the target timeframe of 14 days.
    - 6-8 weeks review: 80% within the target timeframe of 8 weeks.
    - 12 month review: 66% within the target timeframe of 12 months.
    - 2.5 years review: 72% within the target timeframe of 2.5 years.

Figure 37: Health visitor service delivery metrics in Cambridgeshire and Peterborough in 2021/22. Data source: (169)



Experiences of services

Feedback on health visitors collated by the SUN network includes both positive and negative reports. This may reflect that local voices were collected across different areas of Cambridgeshire and Peterborough.

- Some people felt very supported by health visitors in terms of their mental health and being helped to access services; and felt that there was increasing awareness of perinatal mental health.
- Others felt that health visitors were 'so overworked they are unable to focus on what is being said'.
- Some people felt that health visitors should be more knowledgeable about services they could signpost people to; or that they were unable to access mental health support as they did not meet strict service thresholds.
- Checks can sometimes carried out over the phone due to lack of resource, and weigh-ins are now 'self-weigh-ins'. This can mean that people do not always have someone to answer their questions.

Early Years services

Early Years services provide support to children and families, including baby groups and support with infant feeding. Co-location of services may help facilitate interprofessional collaboration (170).

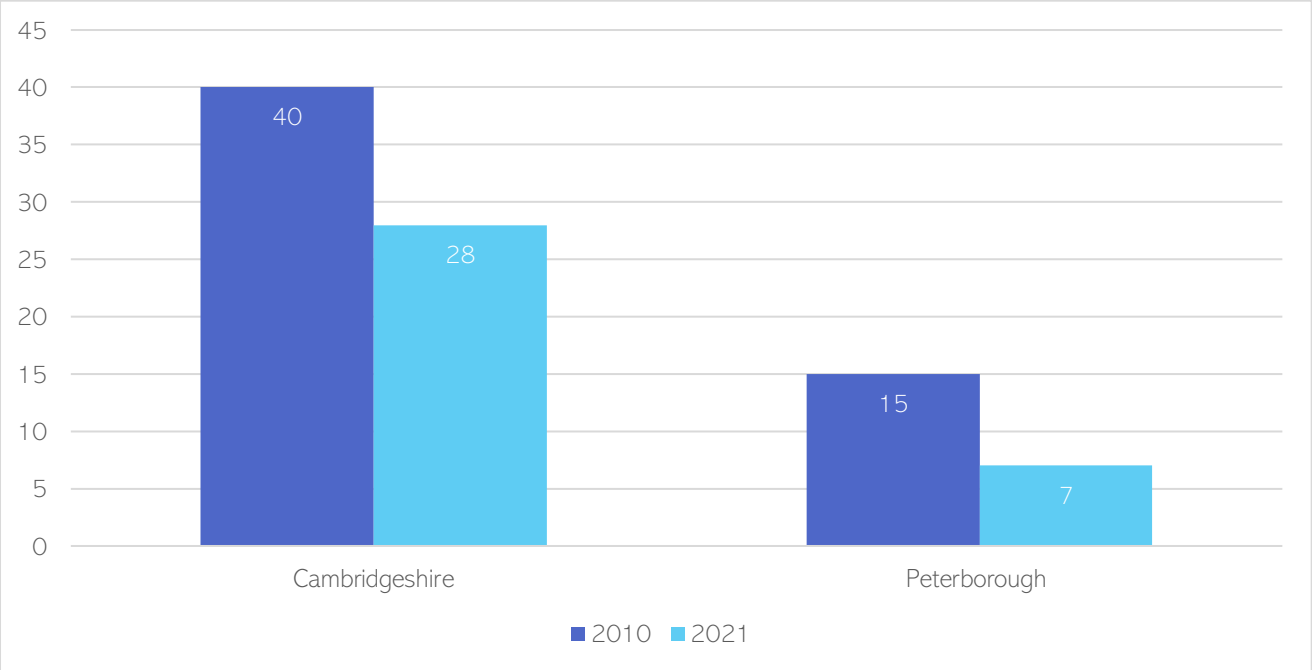
Local picture

There are a range of Child and Family Centres across Cambridgeshire and Peterborough, all of which offer opportunities to meet other parents, and to access a range of information and support. This includes baby groups, young parents groups, self-weigh services, and breastfeeding support. Each child and family centre has its own Facebook page:

- South Cambridgeshire Child and Family Centres
- East Cambs Child and Family Centres
- Cambridge City Child and Family Centre
- Wisbech Child & Family Centres
- Huntingdonshire Child and Family Centres
- East and First Steps C&FCs - Central and East Peterborough
- Honeyhill C&FC – North West and Rural Peterborough
- Orton C&FC – South Peterborough
- March, Chatteris & Whittlesey C&FCs – South Fenland

Since 2010, there has been a 30% reduction in the number of children's centres in Cambridgeshire; and a 53% reduction in the number of children's centres in Peterborough (66).

Figure 38: Number of children's centres in Cambridgeshire and Peterborough in 2010 and 2021. Data source: (66)



There has recently been investment in Family Hubs. Initial funding was for Peterborough (171), but they are also being developed in Cambridgeshire.

- Family Hubs will use a whole family approach to offer a single access point to family support services.
- They will be integrated across the wider system, including voluntary and community organisations, education settings and health and social care.
- They will offer support to families, from conception to 19 years, or up to 25 years for young people with special educational needs and disabilities (SEND).

- A large proportion (31%) of Family Hubs funding will be used to improve perinatal mental health and parent-infant relationships.

Additional Resources

- NICE Guidelines on antenatal and postnatal mental health
- Supporting mental healthcare in a maternity and neonatal setting: Good practice guide and case studies
- A good practice guide to support implementation of trauma-informed care in the perinatal period
- Standards for Community Perinatal Mental Health Services
- Why Health Visitors Matter: Perspectives on a widely valued service
- What works to enhance the effectiveness of the Healthy Child Programme: An evidence update

Voluntary and community support

There is a range of community and voluntary sector organisations operating locally that provide support to families during the perinatal period (151).

Figure 39: Community and voluntary sector organisations in Cambridgeshire and Peterborough providing support to families during the perinatal period

Local community and voluntary sector organisations include:

Table 14: Local community and voluntary sector organisations. Adapted from: (151)

Organisation	Offer	Locality
Barnardo's	Barnardo's Child and Family Centres offer activities for parents/carers and their children (under 5s), to support their development and to help build caregiver-child relationships.	Cambridgeshire & Peterborough
Birth Companions	Supports women in HMP Peterborough when they give birth, by providing practical and emotional support and advocacy.	Peterborough
Connected Lives	Runs the Circle of Security Parenting programme, which is designed to enhance parent-child attachment.	Cambridge
CPSL Mind	Runs a range of support groups, including: • Connecting Mums: a 6-week course for mums, focusing on the 5 ways to wellbeing. • Connecting Muslim Mums: a 6-week course for Muslim mums, focusing on the 5 ways to wellbeing. • Mums Matter: an 8-week course for mums experiencing poor mental health, that provides self-help tools and social connection. • Dads Matter: an 8-week course supporting new dads. Mind also runs peer support groups and offers one-to-one support.	Cambridgeshire & Peterborough
Home Start Cambridgeshire	• Matches parents to volunteers, who provide social support. • Runs groups which children and parents can attend; to provide peer support for parents and to help child development. • Supports parent-infant relationships, through parent-infant psychotherapy.	Cambridgeshire (excluding SG8 postcodes)
NCT Birth and Beyond Community Support	• Runs groups, activities and events (such as walk and talk groups) for new and expectant parents. • Trains local women and birthing people to become volunteer peer supporters. Volunteers can accompany parents to appointments, signpost to local services and provide emotional support.	Peterborough, Fenland & East Cambridgeshire
Ormiston Families MPower	Provides one-to-one goal-oriented support for women whose child or children have been removed into care, including those currently in care proceedings.	Fenland
Ormiston Families Small Steps Together	• An early intervention service that supports mums with low to moderate mental health needs during the perinatal period. • Provides interactive video guidance to promote relationships between parents and children. • Also offers one-to-one counselling and physical activities to support mental health and child development.	Fenland
Raham Project	• Supports mothers and their partners from ethnic minority families, who have recently used, or are currently using, maternity services. • Listens to and advocates for families who faced poor care experiences, and signposts them to support. • Runs an online support group.	Cambridgeshire & Peterborough

Additional Resources

- Five Principles of Perinatal Peer Support: What does good look like?
- Tools and resources for the voluntary and community sector (Maternal Mental Health Alliance)

Perinatal mental health support

Many mainstream mental health services provide support for new and expectant parents, including primary care, Talking Therapies (previously known as IAPT), and other mental health services (such as adult mental health services and child and adolescent mental health services).

Primary care

- Primary care can provide support for new and expectant parents and refer on to voluntary and community organisations, Talking Therapies and secondary mental health services (21).
- National research that highlights that women have mixed experiences of seeking support for their perinatal mental health at GPs (172). They felt more positive about support when it was personalised and integrated, and when they were involved in making decisions about their care.
- The 6-week postnatal health check carried out by general practitioners is a 'crucial safety net' for identifying mental health problems in mothers and birthing parents who have previously not disclosed mental health difficulties, or those who have been missed by the system (172). However, a recent national survey of over 2,600 mothers and birthing people found that (173):
    - 16% of respondents did not have their postnatal health check.
    - Of those who did have a postnatal health check, only 1 in 5 were satisfied with the time their GP spent talking to them about their mental health. 30% said that mental health was not mentioned at all during the consultation.

Talking Therapies

NHS Talking Therapies (previously known as IAPT) provides support for people experiencing mild to moderate mental health difficulties (151).

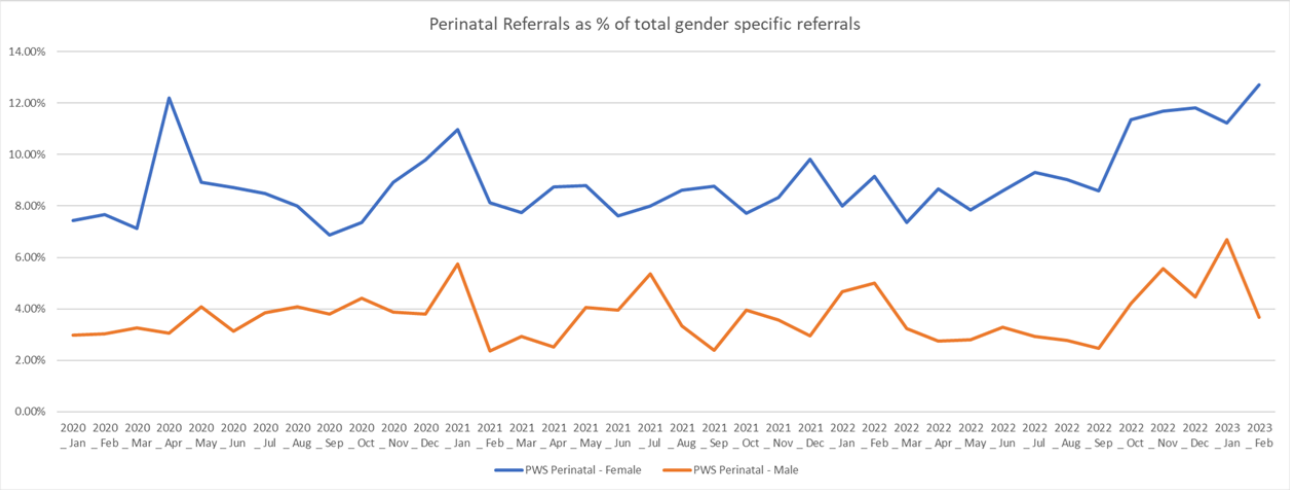
- National research highlights that psychological wellbeing practitioners have limited training on the emotional changes associated with pregnancy, changes in family dynamics associated with the perinatal period and the clinical features of perinatal mental health conditions (21). None of the treatments provided by the NHS Talking Therapies focus on parenting or developing caregiver-infant relationships (21).
- Nationally, women with perinatal mental health conditions report positive experiences of being supported by NHS Talking Therapies. However, they also highlight barriers to access (such as difficulties identifying their own mental health difficulties and insufficient explanation of the services offered by NHS Talking Therapies) and that therapy could sometimes be better tailored to the perinatal period (such as by allowing fathers and babies to attend appointments) (174).

Local picture

NHS Cambridgeshire and Peterborough Talking Therapies offers cognitive behavioural therapy (CBT), interpersonal therapy (IPT) and eye movement desensitisation and reprocessing (EMDR) for people experiencing mild to moderate mental health problems. Therapies are given in person, and via video consultation, telephone or typed chat.

- It has 6 teams based in Cambridge North, South and Central; Huntingdon; Fenland; and Peterborough.
- New and expectant parents are prioritised for assessment (which takes place within 2 weeks)
- Over the past year, there has been a substantial increase in the proportion of referrals into the service for peri/post-natal patients. The most of this increase has been in female patients.

Figure 40: Peri/post-natal patients as a percentage of total referrals into Talking Therapies. Data source: Cambridgeshire and Peterborough Talking Therapies



Recovery rates for patients in the perinatal period are similar to the overall recovery rates of the Talking Therapies service, of around 50 to 60%.

Links with wider mental health and learning disability services

Some new and expectant parents may have continued care during the perinatal period from general mental health or learning disability services. These services should follow guidelines to ensure that they have joined up perinatal mental health pathways (175).

Local picture

The majority of local services work together with the specialist perinatal mental health team to support individuals during the perinatal period. The specialist perinatal mental health team can offer advice or directly provide support, depending on whether patients' primary need is around perinatal mental health.

Table 15: Local mental health and learning disability services and current status of specialist perinatal mental health support

Service	Provision of specialist perinatal mental health support
Adult mental health services	There are strong links with the specialist perinatal mental health team, including a joint working protocol. The specialist perinatal mental health team works in an advisory role for locality teams, to provide advice when people with serious mental illness become pregnant.
Child and adolescent mental health services (CAMHS)	There are limited links between the specialist perinatal mental health team and CAMHS, due to the small numbers of people who are eligible for both services.
Drug and alcohol services	There is joint working with the specialist perinatal mental health team, which can provide advice for practitioners working in drug and alcohol services.
Eating disorder services	There are strong links and a joint working protocol with the specialist perinatal mental health team.
First response service (FRS)	Links between the specialist perinatal mental health team and FRS have recently been developed. FRS can refer people into specialist perinatal services and some staff have received training on perinatal mental health. Crisis support in working hours (9am – 5pm) is provided directly by the specialist perinatal mental health team for people already in contact with this service.
Forensic mental health services	The specialist perinatal mental health team can jointly work with forensic mental health services, although the number of referrals is low. HMP Peterborough has a mother and baby unit (MBU) which has spaces for up to 12 mothers and 13 babies.

Learning disability services	The specialist perinatal mental health team can work jointly with learning disability services. They do not tend to care coordinate as these services already provide this support.
Personality disorder services	The specialist perinatal mental health team can refer people into the Relational, Emotional Difficulties Service (REDS) to meet specific needs around emotional regulation; as well as providing ongoing support to people who attend this group. There is also a joint working protocol in place with the Personality Disorder Community Service.

Additional Resources

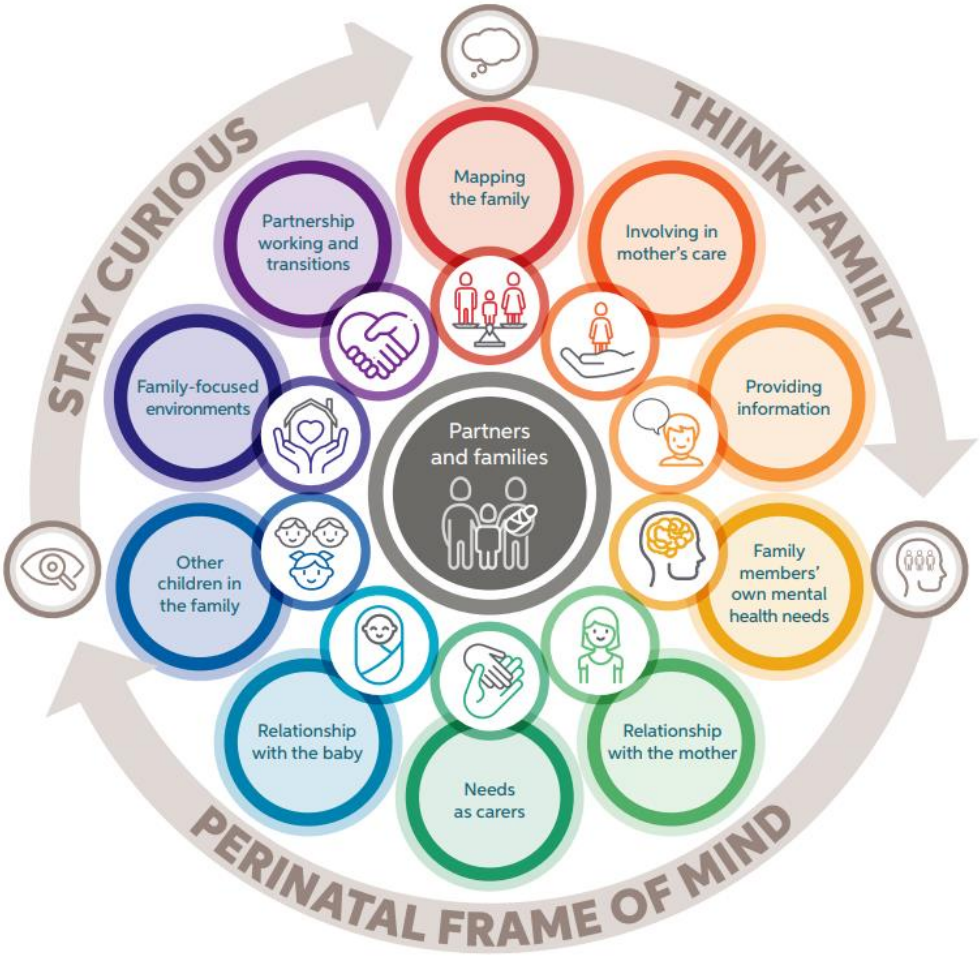
- NICE Guidelines on antenatal and postnatal mental health and pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors
- Perinatal mental health services: Recommendations for the provision of services for childbearing women
- Guidance for commissioners of perinatal mental health services
- Best Use of Medicines in Pregnancy provides evidence-based information about medication use during pregnancy
- A five minute video by the Royal College of GPs on identifying perinatal mental health problems.
- A good practice guide to support implementation of trauma-informed care in the perinatal period
- Standards for Community Perinatal Mental Health Services
- Guide for delivering preconception care to women with a serious mental illness

Specialist perinatal mental health services

Specialist perinatal mental health services support people with severe or complex perinatal mental health needs (176). This includes those with chronic difficulties which may be exacerbated by the perinatal period, or those experiencing an onset of difficulties during this time.

- Specialist perinatal mental health services can advise people with pre-existing mental health conditions to help them make informed decisions around pregnancy, birth plans and postnatal care (176). They also provide advice about the management of pre-existing mental health conditions during the perinatal period, medication in pregnancy and breastfeeding, and the risk of postpartum recurrence of illness (21).
- It has been recommended that specialist perinatal mental health teams are available to everyone, regardless of location. However, the patchy provision of services is a national issue (177).
- The NHS Long Term Plan states that services should assess the mental health of people whose partners are accessing specialist perinatal mental health services, and should signpost them to support (178). Services should 'think family' and involve partners and other family members in care (33).

Figure 41: 3 underpinning principles (outer ring) and 10 key ideas (inner ring) for good practice when involving and supporting partners and families in specialist perinatal mental health services. Image source: Involving and supporting partners and other family members in specialist perinatal mental health services: Good practice guide



Psychotropic medication and perinatal mental health

- Many women and birthing people receiving treatment for mental health conditions with psychotropic medication become pregnant. A large proportion end up stopping taking medication during their pregnancy (179).
- Continuation of medication during pregnancy is a protective factor against illness relapse for women with serious mental illness (180).
- NICE guidelines highlight that healthcare professionals should take into account individual needs and preferences around prescriptions, and work in partnership with patients to support them to make informed decisions about their treatment (110).
- A review of qualitative research highlights that whilst many women do not feel empowered to make decisions about the use of antidepressants during pregnancy, they often want to be involved in collaborative decision-making about antidepressant use (181).
- This toolkit provides a best practice guide for the provision of pre-conception advice by perinatal mental health services.

Maternal mental health services

Maternal mental health services combine maternity, reproductive health and psychological support for women and birthing people who experience moderate and severe or complex mental health needs, which arise from/are related to their maternity experience (182). This includes parents who: develop PTSD following birth trauma, experience

perinatal loss and tokophobia (severe fear of childbirth), and experience loss through separation (custody loss) (182).

Local picture

There are two hospital-based maternity clinics in Cambridgeshire and Peterborough. In addition, The Rainbow Clinic at The Rosie Hospital provides specialist care and support to families who have experienced the death of a baby during pregnancy or shortly afterwards, during their next pregnancy.

Table 16: Hospital-based maternity clinics in Cambridgeshire and Peterborough. Adapted from: (151)

Hospital	Provision
Maternal Wellbeing Clinic (The Rosie Hospital)	An obstetrician run clinic, that supports women antenatally with mental health concerns. Provides advice and support throughout pregnancy regarding mental health, by offering pre-birth planning meetings, supporting birth plans, and signposting to mental health services. This includes advice about medication during pregnancy and breastfeeding.
Sunflower Clinic (Peterborough City and Hichingbrooke Hospital)	Provides mental health support for antenatal patients who are identified by their community midwives as having a serious mental health problem or needing additional support with their mental health during pregnancy.

A new Maternal Mental Health Service is awaiting funding, which will provide support for people with severe mental health difficulties in the context of perinatal loss, birth trauma, tokophobia and custody loss. This service will cover Cambridgeshire and Peterborough but is currently not developed, leaving gaps in NHS provision.

- Note that Ormiston Families MPower provide a person-centred supportive service to women who have experienced recurrent custody loss. They are active in Fenland and currently launching in Peterborough.

Specialist Perinatal Mental Health Team

Specialist community perinatal mental health teams provide support for people with severe or complex mental health needs during the perinatal period (176). NICE guidelines for perinatal mental health highlight that assessments for treatment should take place within 2 weeks of referral; and that psychological interventions should be provided within 1 month of initial assessment (183).

Local picture

The Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) specialist perinatal mental health team is a team of mental health specialists helping women and birthing people with serious and complex mental health conditions during pregnancy and up to a year after birth, including pre-conception counselling and support around birth trauma (151). It opened in February 2019 and provides support across Cambridgeshire and Peterborough.

Progress towards NHS Long Term Plan

The current progress towards NHS Long Term plan ambitions for perinatal mental health are mixed as of May 2023, with the least progress being made towards the provision of support for fathers and partners.

Table 17: Progress towards the ambitions of the NHS Long Term Plan in May 2023. Data source: Specialist perinatal mental health care in the UK 2023

Ambition	Progress
Specialist perinatal mental health services providing care from pre-conception to 24 months after birth	Budget and start data agreed, but service is not currently being delivered
Specialist perinatal mental health services seeing increasing number of women, including those with complex post-traumatic stress disorder (c-PTSD) /personality disorder diagnosis	Service is currently being delivered

Specialist perinatal mental health services offering sufficient psychological therapies including parent-infant, couple, co-parenting and family interventions	Budget and start data agreed, but service is not currently being delivered
Specialist perinatal mental health services offering fathers/partners assessment for their mental health and signposting for support	Service not currently offered. No funding and start date agreed.

Annual peer review

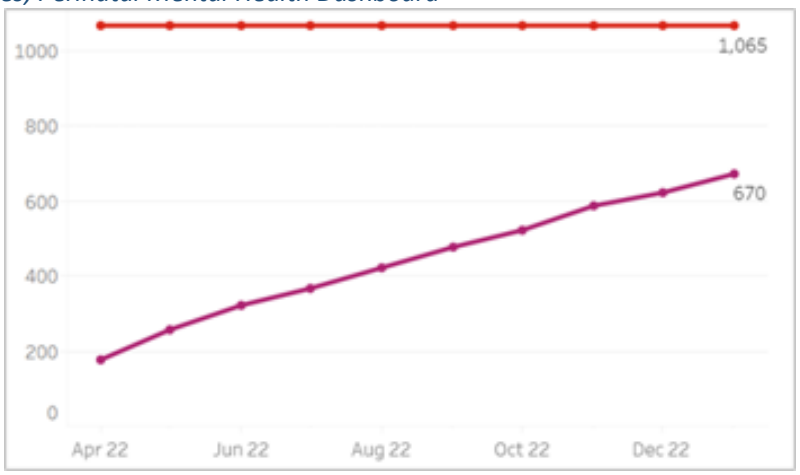
A review carried out in December 2022 found that this service:

- Had a strong multi-disciplinary team, which provided a wide range of support services.
- Had good links with a number of partner agencies, including maternity services, Talking Therapies and voluntary sector organisations.
- Was described as a 'lifeline' by a small sample of mothers who had used this service.
- Faced issues with inadequate estates provision and technical difficulties with SystemOne; and was struggling to meet their access rates target (see slides for further details). Recruitment to some posts (including psychiatrists and nurses) was also challenging.

Access rates

In 2016, the initial target for access to this service covered 10% of births (1,056). As the expected increase in funding did not come through to the services, the target was adjusted to 728 for 2022/23. The current access rate is 670 as of April 2023.

Figure 42: Cumulative year to date access from April 2022 and 22/23 target, Cambridgeshire and Peterborough ICB. Source: NHSFutures, Perinatal Mental Health Dashboard



Mother and Baby Units

Mother and baby units (MBUs) provide inpatient mental healthcare for people with severe postnatal mental health conditions, allowing parents and babies (and sometimes other family members) to stay together (176).

- MBUs are recommended in 2014 NICE guidelines and aim to facilitate mother-infant relationships (110).
- Separation of parents and infants resulting from inpatient mental healthcare causes significant distress; and can prevent breastfeeding and the early development of mother-infant relationships (21).
- A national evaluation comparing MBUs to other types of inpatient mental healthcare found that whilst there was no difference in readmission rates; satisfaction with care was significantly greater for people admitted to MBUs (184). Women and clinicians feel that MBUs provide more family-centred care than general wards, in which separation from babies can be a traumatic experience that is detrimental to recovery (185).

Local picture

The specialist perinatal mental health team has strong links with regional MBUs, including the locally commissioned Kingfisher Unit based in Norwich. Although there are no MBUs within Cambridgeshire and Peterborough (186), the specialist perinatal health team is able to provide intensive support for some women who refuse voluntary admission to MBUs (which may be due to distance).

Figure 43: Location of MBUs in England. Map created by Action of Postpartum Psychosis. Image source: Google Maps

Additional Resources

- Guidance for commissioners of perinatal mental health services
- NICE Guidelines on antenatal and postnatal mental health and pregnancy and complex social factors: a model for service provision for pregnant women with complex social factors
- Royal College of Psychiatrists report Perinatal mental health services: Recommendations for the provision of services for childbearing women
- A good practice guide to support implementation of trauma-informed care in the perinatal period
- Standards for Inpatient Perinatal Mental Health Services
- Specialist perinatal mental health care in the UK 2023
- Involving and supporting partners and other family members in specialist perinatal mental health services: good practice guide
- Guide for delivering preconception care to women with a serious mental illness
- Implementing Routine Outcome Monitoring in Specialist Perinatal Mental Health Services

Gaps in service provision

Service and pathways review

The Pathway Assessment Tool, created by the Mums and Babies in Mind project, was used to rate local services and pathways against national standards and best practice in April 2023. This tool is based on national guidelines

(listed here), including NICE guidelines on antenatal and postnatal care. This review has identified strengths and gaps in local services, using scores given on a scale from 0 to 5.

Figure 44: Scoring for the pathways assessment tool

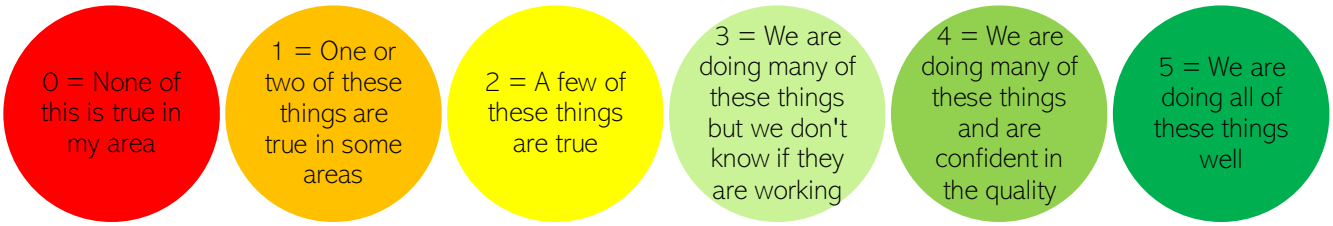


Table 18: Results from the services and pathways review

Service or area	Score (0 - 5)	Key gaps
Care pathway	2	• The clarity of care pathways varies for different levels of mental health need, with some new parents reporting that they do not understand which services are available to support them
Clinical and commissioning networks	3	• Lack of local lead for perinatal mental health, which currently sits between mental health and maternity accountable business units (ABUs) • Lack of structures supporting joined up commissioning
Workforce training and development	3	• There are some gaps in terms of workforce training around perinatal mental health, particularly for health visitors and midwives
Commissioning	2	• A joint commissioning strategy for perinatal mental health is current under development • It is not always clear how services data relates to service quality or how this data can be used to inform improvements
Maternity Services (CUH)	3	• Lack of routine information provided to parents about perinatal mental health • Lack of mental health support for parents who experience baby loss (services are currently in development) • Lack of liaison psychiatrist and psychologist • Geographic gaps in antenatal education (currently in development)
Maternity Services (NWAFT)	2	• Workforce pressures have impacted continuity of care, midwife training, and provision of support for fathers/partners after baby loss • Lack of psychiatrist cover for inpatients in maternity services • Lack of information provision about mental after discharge from maternity services (due to be put in place shortly)
General Practitioners	3	• Further work is needed to understand how well GPs understand the perinatal care pathway
Health Visitors	3	• Lack of training and interventions for infant mental health
Family Nurse Partnership	4	
Specialist Perinatal Mental Health Services	4	
Adult Mental Health Services and CAMHS	4	• Further work is needed to determine the level of training all adult mental health professionals have around perinatal mental health, and the understanding of local care pathways in these services

Community and Children's Services	2	• Limited interventions promoting infant mental health • Provision for dads and partners is not available in all areas
Infant Mental Health	1	• Can be difficult to determine which services provide support for infant mental health
Information for dads/partners	3	• Geographically patchy provision for dads and partners • Lack of lived experience work involving dads and partners
Voluntary and Community Sector	2	• Understanding of local pathways across this sector is patchy • Parents do not always know what support is available from this sector
Overall Score	3	

What do local people think?

Feedback collated by the SUN Network highlights local people's experiences of perinatal mental health support:

- Unless you know where services are, they are hard to find. This can prevent people from accessing support.
- There is a lack of voluntary and community sector groups specific to mental health, other than those run by CPSL Mind.
- There is a lack of choice for people who do not feel that group supports are right for them, or those who find it difficult to leave the house. The need to book classes or groups can act as a barrier to accessing community support services, as this prevents people from being able to attend on the spur of the moment.
- Families can 'fall through the net' in terms of mental health support after their child has been discharged from Neonatal Intensive Care Units (NICU), particularly in areas where units lack clinical psychology provision.
- There are gaps in terms of support for partners.
- People can struggle when reaching the end of NHS support for diagnosed or pre-existing mental health conditions, in terms of integration into less specialist support groups.

Areas for future work

The following questions were raised in the writing of this chapter and highlight potential future areas of future work needed.

Policy Context

- Align integrated care system work and planning with the 7 priorities for perinatal mental health

Local Picture

- Investigate why there are higher levels of anxiety and depression reported in 12-month maternal mood reviews in Peterborough
- Maternal mood reviews provide data on postnatal mental health. Midwives across Cambridgeshire and Peterborough collect data on the prevalence of antenatal mental health conditions. Work with midwives to collate and publish this data, to improve understanding of local antenatal mental health need.

Barriers and Inequalities

- Develop estimates of the number of new and expectant parents who have low levels of social support
- Improve understanding around local uptake of Maternity exemption certificates, with the aim to encourage uptake in families who are eligible but do not currently receive support.
- Improve understanding around local uptake of Healthy Start vouchers, with the aim to encourage uptake in families who are eligible but do not currently receive support.
- Work with midwives to develop the local picture on domestic abuse occurring the perinatal period.
- Investigate the level of unmet perinatal mental health need amongst:
    - Asylum seekers and refugees
    - People with a personal or family history of mental health conditions

- Disabled parents
- Young people in care and care leavers
- LGBTQ+ parents
- Military families
- People who have experienced adverse life events
- New and expectant parents in contact with the criminal justice system
- Parents of disabled infants, including up to the first 2 years
- People with experiences of severe multiple disadvantage

Service Provision

Questions that arose through the service review include:

- Develop mental health pathways for people who experience pregnancy loss and birth trauma.
- Investigate if all women and birthing people with enduring or serious mental health conditions are able to access pre-conception advice.
- Investigate the experiences of dads and partners in Cambridgeshire and Peterborough in terms of mental health support.
- Explore the evidence base around infant mental health and map current service provision.
- Work with commissioners to improve understanding of data around service quality, and to strength lived experience pathways.

Other areas for future work included:

- Understand reasons why people may be offered an assessment from the specialist perinatal mental health team, but not attend
- Explore the barriers to mental health assessment faced by delivery suite inpatients with acute mental health need (raised by the expert advisory group for this chapter).
- Investigate how a communications strategy could be developed to improve new and expectant parents' understanding of perinatal health mental health, self-help and support services
- Evaluate wider support services (including adult mental health services and learning disability services) against Royal College of Psychiatrist guidelines around perinatal mental health
- Work through the Birth Charter toolkit which explores the experiences of pregnant women and new mothers in prisons and helps stakeholders address gaps (note that a previous review has evaluated HMP Peterborough's compliance with 3 out of 10 elements)

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