



For better
mental health

Mind week report, May 2006

Out of the blue?

Motherhood and depression



Background

Mind commissioned Dr Margaret Oates, Lead Clinician, and Dr Ian Rothera, Project Manager for the Perinatal Mental Health Managed Care Network Project, Trent Strategic Health Authority, to survey the views of women, with the assistance of PNI-UK, a charity for women experiencing perinatal ill-health. One hundred and forty-eight women filled out a questionnaire posted on PNI-UK's website, and further in-depth interviews were conducted with a number of women, to provide some of the data and case studies included in the report.

Mind would like to thank PNI-UK for all their assistance with the research published in this report, and all the people who responded to the survey, and agreed to be interviewed in greater depth about their experiences.

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Key findings

What the surveyed women told us

- Women had problems gaining access to advice, information and care.
- Over two-thirds of women had to wait a month or more for treatment, while one in ten had to wait over a year.
- 63 per cent of women admitted were placed on a general psychiatric ward and, of these, four fifths were admitted without their baby.
- A lot depended on where women lived; women in the south of England were more likely to be admitted to mother and baby units, but also more likely to be on waiting lists and be dissatisfied with local services. Of those admitted to a mother and baby unit 67 per cent were in the South, 22 per cent lived in the Midlands and 11 per cent in the North.
- 75 per cent of the women had medication for their problems and just over a third were offered counselling.
- 90 per cent of women in the survey attributed the problems they experienced in obtaining care to a lack of understanding by health professionals and inadequate advice and information.
- The information most women wanted was how to recognise symptoms, with about half also wanting information about common emotional changes, and how and when to access services.
- 63 per cent of women surveyed felt that more support should be available to women's partners and families.
- Women found GPs, health visitors and community psychiatric nurses to be the most helpful professionals.
- The most important professional qualities needed were a knowledge of mental illness around childbirth and the ability to develop an understanding, trusting relationship.
- Women considered that specialist advice, better understanding by health professionals and faster access to care would make the most difference.

Some facts

- One in six women is known to be affected by mental distress during pregnancy or following childbirth.
- 25 per cent of all maternal deaths are linked to mental health problems.
- Mental health problems around childbirth, if not dealt with, can affect the relationship between mother and baby and the child's development over the longer term.
- 30 per cent of women who experience postnatal depression are still ill at one year following childbirth.
- Fewer than half of mental health trusts in England have any kind of perinatal mental health service.
- 75 per cent of trusts have no specialist mother and baby unit or access to one.
- 12 per cent of trusts still admit mothers and babies to general adult psychiatric wards contrary to national recommendations.
- Many health professionals are unclear about their roles and responsibilities in managing perinatal mental health problems.
- There are system failures in identifying known risk factors and providing adequate care for women known to have serious mental health problems.
- Research has revealed a lack of communication and coordination between services and a general shortfall of skills and resources.

Mind's recommendations

- Mind would like all maternity services to pay more attention to emotional well-being, continuity between ante- and postnatal support, and access to practical support and advice.
- Maternity, mental health and primary care trusts should ensure that they conform with, or have plans in place to implement, existing and forthcoming national guidelines for perinatal (around childbirth) mental health care.
- Smaller maternity trusts should allocate the time of consultants with a special interest in perinatal psychiatry and develop community psychiatric nursing teams.
- Larger maternity trusts should develop perinatal psychiatric services led by a specialist psychiatrist.
- Primary Care Trusts and Strategic Health Authorities, and Health Authorities in Wales should ensure that specialist perinatal services, including mother and baby units, are available to all women in their area who need them.
- Mother and baby units should serve large populations across different health communities and establish close working links with local mental health teams.
- The Department of Health, Care Services Improvement Partnership/Healthcare Commission and NHS Wales/Healthcare Inspectorate Wales should monitor commissioning and ensure that there is equitable access to specialist services.
- Every Local Health Board/Local Authority in Wales must develop and publish plans for the assessment, care and treatment of mothers with ante- and postnatal mental health problems.
- Training to enhance the skills and knowledge of all health professionals in contact with pregnant and postnatal women should be provided. The training should be informed by women with experience of perinatal mental distress.
- Maternity services should have a lead clinician with an interest in perinatal mental health and maternity trusts should have access to specialist perinatal psychiatric services.
- Mental health and social care agencies should ensure their services are accessible to mothers of dependent children.
- Parenting issues should be included in anti-discrimination and anti-stigma campaigns to minimise the negative attitudes women with mental health issues may encounter from family, neighbours or within the health services.
- Women should be informed about possible risks to their child when medicines are taken during pregnancy and while breast feeding.
- Information should be available about the best methods of coming off medication.

Introduction

Mental distress during pregnancy or following the birth of a child affects one in six women. Some women will experience relatively mild distress during pregnancy or after the birth, some develop severe depression and a few will experience psychosis.

Women with existing mental health problems may have difficulties around pregnancy and childbirth as well, and with some diagnoses there is a strong possibility that their mental health problems will re-emerge following the birth. Mind's report draws on clinical research, guidelines, and the experience of women who have received mental health services around childbirth (perinatal), to show the current shortfall in skills and services, and what needs to be done to prevent mental distress and help women recover.

Childbirth does not come out of the blue – support for mothers' mental health can be planned for before the baby is born.

There are four main categories of problem:

1. antenatal depression
2. postnatal depression
3. puerperal psychosis
4. pre-existing conditions including bipolar disorder and major depression.

Although the risk of suicide is lower during pregnancy than at other times, suicide is the leading cause of maternal deaths in the UK (Confidential Enquiry into Maternal and Child Health, 2004). The enquiry concluded that many of these deaths* could have been prevented if appropriate steps had been taken to treat the underlying mental health problems:

- 25 per cent of all maternal deaths are due to psychiatric causes.
- 15 per cent of all maternal deaths in the UK are due to suicide.

- 54 per cent of women who took their own lives had diagnoses of psychosis or severe depression.
- 50 per cent of women who took their own lives had been in contact with psychiatric services during their maternity.

Women who are isolated or living with stresses such as bringing up children on their own on a low income are particularly vulnerable to depression.

Looking at maternal deaths from all causes, the Confidential Enquiry (2004) found that women living in families where both partners were unemployed were up to 20 times more likely to die than women from more advantaged groups. Single mothers and women from Minority Ethnic groups were on average three times more likely to die. Black African women, particularly asylum seekers and newly arrived refugees, had even higher mortality rates and major difficulties accessing maternal healthcare.

Identifying, monitoring and supporting at-risk women might prevent many cases of maternal deaths. Support can enable women to recover and prevent both their own continuing distress and difficulties for their children:

- Children of women with untreated postnatal depression show signs of reduced social, emotional and cognitive development (Murray and Cooper, 2003). This effect appears to be stronger in boys and babies from lower socio-economic backgrounds (Murray et al, 1996).
- Children of mothers who have schizophrenia experience greater difficulties forming social attachments (Naslund et al, 1984), and those in unsupported single parent families may be most vulnerable (Webster, 1992).

*"For this Report the concept of psychiatric death has been broadened to include not only deaths from suicide but also includes deaths from substance misuse, physical illness, accidents and other misfortunes which, in the opinion of the assessors, would not have occurred in the absence of a psychiatric disorder." Confidential Enquiry into Maternal and Child Health (2004) *Why mothers die – Deaths from psychiatric causes*. London: RCOG Press

Mental health problems around childbirth

1. Antenatal depression

The most common type of mental health problem that women experience during pregnancy is mixed anxiety and depression, often in the early weeks of pregnancy. The majority of these are associated with stress and social factors such as isolation, discrimination and poverty. For other women they may be a recurrence of a previous mental health problem, such as anxiety or obsessional disorder. There is probably no increased risk of developing serious mental health problems during pregnancy, however, severe depression, bipolar disorder and schizophrenia do occur and can be particularly problematic. Women who have a pre-existing condition may be at risk of a recurrence during pregnancy, particularly if they experience difficulties coming off or being off medication.

Many mild conditions improve as the pregnancy progresses, and for some women giving birth may be enough to resolve the problem. For others, talking therapies or support from health visitors, community psychiatric nursing, the Government's Sure Start programme or support groups can be effective. In some cases, for women with bipolar disorder or severe depression, for example, the cautious use of medication may be advisable. The risks of not treating with drugs may pose a greater risk to the health of some women and their babies than the potential risks of the medication.

2. Postnatal depression

Postnatal depression is the most common of the mental health problems which affect women in the period following childbirth. The most severe forms may merge with puerperal psychosis and at the milder end of the spectrum with difficulties in adjustment and normal emotional changes following childbirth.

Mild depression

Mild depression is the most common mental health problem following childbirth, usually becoming most apparent after the first three months. Although the incidence of mild depression does not increase after childbirth it

poses particular problems. Women who have had previous mental health problems, who do not have relationships or who have inadequate social support, may be especially vulnerable. Others may have had problems conceiving or may have experienced high levels of anxiety during pregnancy or the loss of a baby from a previous pregnancy. They may also have unrealistically high expectations of themselves. Loss of sleep can be a contributory factor, as can stressful events, such as moving house or having an ill baby.

The symptoms of mild postnatal depression vary from person to person and women often report good days and bad days. However, the common features of the condition include:

- feelings of anxiety
- varying degrees of tearfulness and irritability
- difficulty coping with day-to-day tasks
- lack of satisfaction and pleasure with motherhood
- feelings of loneliness and isolation
- loss of confidence
- feeling better in company and worse alone
- dissatisfaction with the quality of relationships
- insomnia
- appetite problems.

Mothers who experience mild postnatal depression may feel let down by motherhood, and worry about their baby. They are often concerned that their feelings of anxiety may affect the baby.

A 27-year-old woman has three children under five, the youngest is four months old and is still waking through the night. She lives many miles away from her own family and has recently moved. Her husband who is in the armed forces is posted abroad. She is tearful, very tired, feels she cannot cope and is guilty that she is not enjoying her children. She has never had mental health problems before. Although she has always had a tendency to worry, she prides herself on being a 'coper'.

Kelly – Postnatal depression

Kelly, a 32-year-old woman with a 16-year-old daughter, had no previous history of mental health problems. She had an uncomplicated pregnancy, with the exception of a medical investigation for a deep vein thrombosis. She had a normal delivery and gave birth to a boy. For the first couple of weeks she was on a 'high' and her husband and daughter were at home to help. When they had gone back to work and school, Kelly began to feel down, was very tearful and started to have disturbing thoughts. This was made worse by the stress of her neighbours' loud music.

Kelly didn't tell anyone she was feeling low because this would mean admitting she wasn't the 'supermum' she'd hoped to be. She was ashamed that she couldn't cope and felt that asking for help would demonstrate her inadequacy as a mother. However, she says if the opportunity had arisen, she would have poured all her problems out.

When she went to the health visitor clinic for her baby to be weighed, she was asked to fill in a questionnaire about how she was getting on. This would have been a good opportunity to tell the health visitor how she was feeling, but she didn't want to do this in a waiting room full of other mothers. If she had been able to speak to a health visitor in private, she would have been more open about her feelings, and this may have been an opportunity to get things moving at an earlier stage. She felt annoyed at missing out on this opportunity.

Kelly wishes she had been given information about maternal mental health problems in advance of the baby being born. This would have helped her differentiate between normal emotional changes and mental health problems. She feels that had she been given such information, she would have been more receptive to sharing her problems with the health professionals she saw. The six-week check-up with

her GP should have been the ideal time to talk about her problems, but a mix-up with the appointment prevented this. A week later she was finally driven to seek help and saw a different GP, who diagnosed postnatal depression. He prescribed an antidepressant and asked her to come back each month for a review.

Shortly afterwards, Kelly and her husband moved house – away from the neighbours – and she had to register with yet another GP. She was concerned about the change, but the new GP turned out to be very good. He explained that he didn't have much experience dealing with maternal mental health problems, but had an interest in the area. He was very supportive and reassuring, telling Kelly that she would get better. This helped instil the confidence she needed to improve. Kelly says it helped immensely that the GP had good listening skills and took the time to consider her problems properly.

After taking antidepressants for six months, Kelly had still not made significant improvements, despite increasing the dose. Her GP referred her to a psychiatrist. Kelly was afraid of the stigma of being a 'mental patient', but was able to see the psychiatrist in the GP's own surgery, which helped reduce her self-consciousness. She says that if she had been forced to see the psychiatrist at the 'mental hospital', she would not have gone. Kelly was surprised to find that the psychiatrist was a great help. Like the GP, he gave her the opportunity to talk about her feelings, was understanding and impartial and built up a trusting relationship.

Importantly, she was able to carry on seeing the same psychiatrist, despite having moved to a different catchment area. Kelly stopped the sessions after she began to feel better. On the advice of her GP and psychiatrist, she continued with the antidepressants, but is reducing the dose gradually, with the aim of eventually coming off medication.

Severe depression

Severe depression usually becomes apparent within four to six weeks after giving birth. The symptoms commonly include:

- sleep disturbance and early morning waking
- low, sad and flat mood, usually worse in the morning
- appetite and weight loss
- slowed mental functioning
- impaired concentration
- extreme tiredness
- loss of vitality and enthusiasm
- morbid thoughts about personal and the baby's health and well-being
- fears about the safety and well-being of the baby
- feelings of guilt, hopelessness and despair.

These symptoms may be blamed by mothers and by healthcare professionals on a crying baby, tiredness, difficulties adjusting to new routines or even 'bonding' problems. A baby's normal behaviour may be misinterpreted by the mother. She may feel the baby is suffering or does not like her, and her fears about incompetence may be exaggerated if the baby settles more easily with a more experienced mother.

A 29-year-old married woman with no previous mental health problems becomes depressed in the first two weeks after giving birth to her second child. At first she blames difficulties with breast feeding, but after six weeks she feels worse and tells her GP at a postnatal check-up. Her pregnancy had been difficult, with a threatened miscarriage early on and concerns about the baby's growth later. She is scared by her feelings of sadness, is waking early even though the baby sleeps and is worried about the baby dying. She feels she can't cope, is a bad mother and has no energy or motivation to go out. She dreads her baby crying and experiences a panic attack, which alerts her husband to the fact that she is not well. She responds gradually to support from a local specialist community psychiatric nurse and her health visitor, together with antidepressants.

Women experiencing severe postnatal depression are often frightened of their own feelings and thoughts and few gain any pleasure or joy from their baby. Most feel a deep sense of guilt and incompetence and doubt whether they are caring for their baby properly. Fears over harming the baby are common, but hostile and aggressive behaviour towards the baby is rare. Most of these women maintain high standards of care for their babies, and a speedy resolution of the condition usually results in a normal mother/baby relationship.

3. Puerperal psychosis

Puerperal psychosis is the most severe of the postnatal disorders. Most often women will have been well before and during the pregnancy. However, some will have experienced a similar condition after a previous birth or may have been diagnosed with bipolar disorder (manic depression) at another time in their lives or may have a family history of mental health problems. For most, it will come as a shock to them and their families.

Women experiencing puerperal psychosis are profoundly disturbed and distressed. Early signs commonly include:

- fluctuation of symptoms and early deterioration
- intense fear and perplexity
- hallucinations and delusions
- restlessness and agitation
- uncharacteristic behaviour
- disinhibited behaviour
- feelings of elation, suspiciousness or deep depression.

Women often mistake the identity and motives of other people including their families and health professionals. They may be unable to function properly because of an inability to concentrate and to begin and finish normal, everyday tasks, which can lead to problems over personal hygiene and nutrition and the care of the baby. Despite the alarming symptoms and the severity of the condition, puerperal psychosis probably belongs to the same range of disorders

Fiona – puerperal psychosis

Fiona had no history of mental health problems, but shortly after the birth of a baby girl began to experience symptoms of puerperal psychosis. During a routine visit, the midwife requested a home visit from Fiona's GP. As it was during the Christmas period, he said he would be unable to arrange a referral. He did not make a diagnosis but prescribed antidepressants, which Fiona was unwilling to take. Although she was unhappy with the outcome, the midwife could not overrule the GP's decision. Fiona was seen by a different midwife on Christmas Day, who suggested admittance to a postnatal ward. However, Fiona did not want to be in the company of other new mothers.

Fiona's care was handed over to a health visitor, who came to weigh the baby at the end of December but did not seem particularly concerned by Fiona's problems. She arranged a visit the next week but this appointment was cancelled and it was then left to Fiona to make contact again. By the end of February, Fiona was finding it increasingly difficult to cope and contacted the health visitor who liaised with Social Services. A week later the decision was made to assess Fiona to see whether she needed to be sectioned. It was decided that she did not fit the criteria. No one explained to Fiona what was happening.

Shortly after, a social worker assessed Fiona to see if her children were at risk. She was given the option of being admitted with her baby to a mother and baby unit (MBU) and she agreed. The MBU was a side room for a single mother and baby on a general mixed-sex psychiatric ward. The only access to the room was through the main psychiatric ward. Fiona felt threatened by some of the other patients on the ward and was disturbed by them banging on her door.

The MBU had no separate kitchen for the preparation of milk, so it was impossible to maintain sterile conditions. Although a fridge was provided, this was also used by ward staff so Fiona suffered constant interruptions. She had to use pre-prepared milk for her baby as she was not allowed to prepare the milk herself, and had to use her teeth to open the container, as she was not allowed scissors. She did have the use of a separate bathroom, but there was nowhere to bathe the baby. Fiona had no personal privacy. As a patient on an adult psychiatric ward, a

member of staff had to be present at all times to ensure the baby's safety. But the MBU was not staffed by specialist medical staff and Fiona only saw general psychiatric nurses, who had no particular expertise or understanding of her problem. She did see a consultant psychiatrist and was told that blood and urine samples would be taken to exclude any physical cause. This did not happen. She was discharged at the end of March and prescribed the same antidepressants, despite her concerns over this medication. Then in early April she received a letter from the psychiatrist to say that she had been diagnosed with puerperal psychosis.

Her condition appeared to improve for a while, but by June she felt worse again, partly because the stability and routine that she had achieved was interrupted by the closure of the local nursery. After her experiences, Fiona couldn't consider going back into the hospital psychiatric unit. She heard there was a very good mother and baby unit in another area and decided to travel there by herself to try and gain admittance.

The MBU was unable to help Fiona because she had not been referred through the proper channels. She was transferred to accident and emergency, who contacted the services in her local area. She was told she would have to go home, with the option of then going back to the local MBU. She refused, and was also turned down by two other out-of-area MBUs on the grounds that her baby was now too old. Fiona was given antipsychotic medication and started a new antidepressant. She was assigned a new community psychiatric nurse (CPN) and given a brief course of cognitive behavioural therapy. She had problems with this CPN, who seemed to doubt the severity of her condition.

Fiona didn't receive information about perinatal mental health problems in her antenatal classes which might have helped her recognise the signs and understand the range of treatment options available. No health professionals with specialist skills and knowledge of perinatal mental illness saw Fiona either before, during or after her hospital admission, which she feels is rather like "a cancer specialist trying to do heart surgery". She did not have the opportunity to properly discuss her illness with people trained to understand it.

as bipolar disorder and most women will recover fully with the same types of treatment that are given for bipolar disorder in general.

Some women experience delusional thoughts about the identity or health of their baby, but it is rare for them to be hostile or aggressive towards the baby. The main risks to the baby lie in the inability of the mother to organise and complete everyday activities. However, such problems will resolve as the mother recovers.

Women with this condition tend to improve rapidly over a two- to four-week period, although relapses may occur in the first few weeks. As the condition improves, it is common for women to be distressed by their experience and how this might impact on their mental health and role as a mother. Most women are fully recovered by three to six months following delivery, but at least 50 per cent will be at risk of a recurrence of the condition after another baby.

Expert help is required to help women gain an understanding of what has happened and to construct a 'working model' of their condition.

A 35-year-old married solicitor has had no previous mental health problems and feels well and happy during her first pregnancy until suddenly, a week after the birth, her husband notices that she is restless, not sleeping and is not making sense when she talks. The next day she runs out of the house in her nightclothes and is taken to accident and emergency where she is admitted to her local psychiatric hospital. Days later she is transferred to a mother and baby unit. The woman remembers everything seemed frightening and threatening, and believed that the television was referring to her, and that familiar people were not to be trusted.

4. Pre-existing conditions

Women who have experienced severe anxiety disorders (including obsessive-compulsive and panic disorder), severe depression, bipolar disorder or certain types of schizophrenia may have a relapse during pregnancy. They may be particularly prone to this if they come off medication once the pregnancy is confirmed. Women with a previous episode of bipolar disorder have a 50 per cent chance of becoming ill after delivery. Even if they have been well for many years, they have a high risk of a recurrence or of developing puerperal psychosis.

A 32-year-old married schoolteacher experienced two episodes of bipolar disorder while at university, but has been well since, taking lithium for many years. She stopped her lithium when she became pregnant. She was not warned about the possibility of a recurrence of the disorder after delivery, and no plans were made to deal with this possibility. She was well and happy during pregnancy, but on the fifth day after delivery experienced acute distress. She became restless and agitated, talking very fast and making grandiose plans for the future. She was admitted to her local hospital and transferred some days later to a mother and baby unit. She recovered fully within six weeks.

Deborah – pre-existing bipolar disorder

In her 20s, Deborah had experienced bipolar disorder and been sectioned, but she then did not experience any mental health problems for many years. When she became pregnant, despite her history, the psychiatrist failed to warn her of the risk of a recurrence around childbirth. Deborah had a normal pregnancy and after a very long labour, gave birth to a girl.

She left maternity with no particular problems, although she had not been sleeping well in hospital and this continued at home. The GP was called out and Deborah explained she felt she “was heading towards something serious”. The GP’s response was that all she needed was a good night’s sleep. She started to have visual hallucinations and after four days was admitted to an acute psychiatric ward in a highly agitated state.

On the ward, Deborah refused to let go of her baby and threatened staff. The decision was made for her to be sectioned. She agreed to be transferred to an out-of-area MBU, as the local unit had no room, and was fortunate to get the last place at the second unit. Once there, she was reassured that her baby would not be taken away from her, and she quickly settled on the ward.

Deborah’s psychiatrist worked closely with the specialist team to ensure Deborah’s risk of developing puerperal psychosis after future pregnancies would be taken into account. When she became pregnant again, Deborah was transferred as a precaution to the same MBU shortly after giving birth. She was fully involved in this process and felt in control of what happened as she had been given a variety of options.

Summary

Perinatal mental health problems are common. They vary considerably in terms of when they develop, severity and the types of treatment required. But if treated properly the long-term prospects for mothers and their babies are positive.

Long-lasting postnatal depression, particularly in the presence of social disadvantage, continuing stress or relationship difficulties, can affect the bond between mother and baby and the child's development over the longer term. It is important that women who experience mild, as well as more serious mental health problems, receive appropriate help and support to ensure that these conditions are swiftly resolved and that any difficulties with their babies are addressed.

Some facts

- Rates for postnatal depression range between 13 per cent in the first few weeks after childbirth to 20 per cent in the first year after giving birth (Priest et al, 2003).
- 10 to 15 per cent of women will experience mild depression, often accompanied by anxiety (Kumar and Robson, 1984).
- 3 to 5 per cent of new mothers will develop moderate to severe depression (O'Hara and Swain, 1996).
- The incidence and severity of postnatal depression is greater in the first three months following childbirth than later in the postnatal period (Cox et al, 1993).
- A further two per thousand mothers are admitted to hospital with puerperal psychosis.
- Two per thousand women will be admitted to hospital diagnosed with a non-psychotic condition, usually very severe postnatal depression (Oates, 1996).

Prevention, care and support

The care of pregnant women and new mothers is provided by a variety of health professionals and services at a number of different levels within the health service. These levels are commonly referred to as primary, secondary and tertiary care. They offer specific types of treatments or interventions, depending on the nature and severity of the mental health problem.

1. Prevention

Women are at increased risk of developing severe depression or puerperal psychosis following the birth of the child, particularly in the first three months after delivery. There is also an increased risk of new mothers being admitted to a psychiatric hospital or of seeing a psychiatrist (Kendell et al, 1987). After the birth of a child, a woman is:

- five times as likely as other women to develop severe depression or to be referred to psychiatric services following childbirth (Oates, 1996)
- 14 times more likely than other women to develop a psychotic condition in the first year and 35 more times likely to do so in the first 30 days after giving birth (Kendell et al, 1987).

Screening

Screening must identify risk factors that can reliably predict the occurrence of a disorder at a later stage. It is known that serious postnatal disorder can be reliably predicted by risk factors that include a past history and family history of serious mental health problems (particularly bipolar disorder), and so widespread screening of pregnant women is advisable. Most serious disorders come on very quickly, deteriorate suddenly and usually require psychiatric services; early screening can detect at-risk women and allow preparation of a management plan well in advance.

More common disorders, including mild depression and mixed anxiety and depression, do not justify large-scale screening programmes because risk factors for these are so commonly found that they do not predict the condition sufficiently well. But health professionals should

identify and monitor vulnerable women and provide extra support as necessary.

Severe mental health problems

In early pregnancy, women should be systematically asked about a past history or family history of serious mental health problems. These questions should be asked routinely and in the same way as women would be asked about their physical health.

Midwives and obstetricians may therefore require guidance about what questions to ask and how. This is particularly important to ensure that screening programmes identify those women with a previous history of serious mental health problems. They need to ask questions which are sensitive to the locality, culture and education of the respondent. They should attend training sessions periodically to refresh their knowledge of maternal mental health problems.

- All maternity trusts are now required to implement screening for a previous history of a mental health problem (Clinical Negligence Scheme for Trusts, 2002).
- Some trusts have their own systems for this, including the use of protocols, flow charts and care pathways to assist midwives and obstetricians.
- Antenatal Screening Wales recommends that pregnant women are offered antenatal screening, which is the responsibility of Local Health Boards and NHS Trusts in Wales to implement.
- The National Service Framework for Children, Young People and Maternity Services in Wales (Welsh Assembly Government, 2005) recommends that women are offered an assessment for mental health problems in the antenatal and postnatal period by appropriately trained health professionals, and there is access to specialised follow-up support services if needed.

Care pathways

Screening for maternal mental health problems is only useful if there are professionals and resources to meet the needs of those women

who are found to be at high risk, and access to appropriate care should be as direct as possible. Care pathways help to ensure that the right level of care is delivered to women at the right time.

2. Treatment and care

Most antenatal care is in the community and provided by a midwife. Following the birth, initial care is from the midwife and then transferred to the GP and health visitor.

Less serious mental health problems are treated in primary care, for example with listening visits by health visitors, services such as Sure Start, Home-Start, counselling and antidepressant medication.

More serious problems are treated by secondary care services, which include community mental health nurses, psychologists, occupational therapists and psychiatrists.

These services provide inpatient, outpatient and community care. Recently, mental health services have been organised into 'functional' teams including Crisis and Home Treatment Teams, Assertive Outreach for difficult and complex cases and community mental health teams. Most trusts do not provide specialist maternal mental health teams, although the provision of these teams in all localities has been recommended by the Department of Health and the Royal College of Psychiatrists.

Few regions provide specialist mother and baby units. These are accessed by a number of secondary care teams and have the expert knowledge and skills to provide the treatment and support required by mothers, their baby and family. Tertiary services usually provide care for women with serious mental health problems, including puerperal psychosis.

Medication

Women who use medication for mental health problems and are pregnant or planning pregnancy should be given information and advice about the relative benefits and harm of different drugs in pregnancy and while breast

feeding. For some drugs the effects are known. But for others there is no clear evidence. Guidance can only suggest that the drug should only be used when the potential risk to the mother and baby of not using the medication is greater than the risk of using it.

Antenatal

Many women who have pre-existing mental health problems become pregnant while still taking medication and have to make decisions quickly about how best to look after both themselves and their baby. They may be reluctant to talk to a professional about this, because they fear that their baby will be taken from them because of their mental health issues. The psychiatric team who look after the woman's long-term mental health needs need to liaise closely with the obstetric team so as to provide the best possible care and avoid potential problems.

Women who have pre-existing mental health problems should discuss their plans to have a baby with their psychiatrist, in order to get advice about treatment and health issues, before getting pregnant.

Most women are reluctant to take any form of medication during pregnancy and while breast feeding and this is of course also the case with psychiatric drugs. There are established risks associated with some drugs, for example lithium and other mood stabilisers, and the British National Formulary advises that most antipsychotic drugs are best avoided in pregnancy unless essential. Recent concerns have also been raised about the use of particular antidepressants, for example SSRIs, during pregnancy (Levison-Castiel, 2006). However, the benefits of using medication to the health and safety of both mother and baby must be weighed against the risks of using the drug.

There are a number of general principles regarding the use of medication during pregnancy that may be applied:

- Women with serious mental health problems and those taking medication should seek the

advice of their GP and psychiatrist if planning to have a baby about the suitability of their medication and about their general health.

- Women at risk of a recurrence of their condition should discuss with their doctor any steps that could reduce this risk, including the safest possible use of medication.
- If medication is necessary, the risks should be minimised by using the lowest effective dose for the shortest possible time, and multiple medication should be avoided.
- Where mental health problems develop during pregnancy, the use of medication in the first 12 weeks should be avoided whenever possible and used only when there are no available alternatives.
- Doctors prescribing medication should access up-to-date information and if necessary seek expert advice.
- Where it is necessary to stop taking a drug, or the woman wishes to do so, she should be advised on the safest possible way to come off it and supported throughout.

Postnatal

There is evidence that severe postnatal disorders can be treated using medication. In particular, very severe disorders are associated with positive long-term outcomes (Royal College of Psychiatrists, 2000). Medication is the same as for severe depression, bipolar disorder and psychosis at other times. However, the British National Formulary advice for antipsychotic drugs is to discontinue breast-feeding during treatment. All drugs are present in breast milk but the quantity and effects on the baby will vary. Where medication is used in pregnancy or while breast feeding, it should be prescribed in accordance with the best available advice.

3. Counselling and support

Where there are family and friends who are able to help with meals and other household tasks, giving the mother time to rest and recuperate and enjoy the baby without having to worry about other responsibilities, this can be very helpful. Mothers without this social support network may need outside help. In the past, mothers usually spent several days in hospital recovering from the birth and learning to care for their baby with help from nurses. Nowadays this is rare, and some people go home from hospital the same day, often with very little support. Women who give birth at home may fare better because the family may feel more involved in the whole process, and become familiar with the midwife and health visitor.

Many of the milder conditions will spontaneously improve during pregnancy. Talking therapies, such as cognitive behavioural therapy (CBT), have been shown to be as effective as antidepressants, and should be available as the first line of treatment, particularly in early pregnancy (National Institute of Clinical Excellence, 2004). Modified antenatal classes (Elliott, 1989) or volunteer mothers' social support (Johnson et al, 1993) are effective in reducing the number of women experiencing perinatal depression and improving other aspects of mothers' and babies' well-being.

Many mental health problems following childbirth appear to be related to social factors and may be helped by:

- social and emotional support
- non-directive counselling – 'listening visits'
- talking therapies, such as CBT, and interpersonal psychotherapy
- a combination of these with medication.

Non-directive counselling has been found to be superior to routine primary care in the treatment of mild to moderate postnatal depression (National Institute of Clinical Excellence, 2004) and CBT can be as effective as antidepressants in the treatment of severe postnatal depression (Appleby et al, 1997). Interpersonal psychotherapy has been used to treat women

with postnatal depression and depressed women during pregnancy, but is not widely available in the UK (O'Hara, 1997).

Psychological therapies used for the treatment of mental health problems affecting the general population, such as milder forms of anxiety, obsessive-compulsive and eating disorders, can be tailored to meet the specific needs of pregnant or recently delivered women.

- Many psychosocial interventions can be delivered in a group setting which provides a forum for mothers to share experiences and coping strategies.
- Group sessions may help reduce the social isolation often experienced by mothers who are experiencing mental distress.
- Group interventions can focus on women with particular problems, such as bereaved mothers.
(Henshaw, 2006)

Problems accessing support

Women who experience serious mental health problems – especially those with dependent children – are particularly likely to be isolated, depressed and dealing with stress, hardship and discrimination. The period around childbirth is therefore a vulnerable time. Mental health services are not generally organised around the needs of parents and their children; for example women may have to miss appointments or have consultations with their child present because of difficulties arranging child care. Fear of having children taken into care can affect the relationship between mothers and health professionals, especially Black African/Caribbean mothers whose children are removed more readily. Mental health and social care services should make themselves more accessible and responsive to mothers with dependent children, by:

- asking service users about parental status
- addressing parenting needs in social care and care programme assessments
- enabling access to children's services as part of the package of care to the mother, not waiting for the child to become unwell

- recognising the centrality of the mothering role, and women's struggles to stay well for their children
- providing child care to facilitate attendance at appointments
- providing opportunities for women to meet other mothers
- providing practical support
- providing flexible support so that women with mental health problems can get help on 'bad days' not just in major crisis
- enabling women to plan what should happen if they become too unwell to care for their children
- providing specialist services available for young, pregnant teenage girls, such as peer parent education and support groups
(Slattery, 2006).

Support for partners

It is also important to involve fathers. Depression in fathers is frequently associated with postnatal depression in mothers and, as with mothers, the father's depression may begin during the pregnancy. Studies have found that both midwives and health visitors may see fathers as problematic and potentially violent, and may marginalise them while working with the family (Webster, 2002). This may be exacerbated by the fact that men sometimes express depression as hostility, and frequently lack close relationships with people in whom they can confide (Webster, 2002).

Shortfalls in perinatal mental health care

A survey of maternal mental health care conducted on behalf of Mind (2006) found that many mothers do not receive the mental healthcare they require. This may be due to failure by primary care, maternity and psychiatric services to identify and treat mental health problems around childbirth.

It showed that a substantial number of women experienced problems gaining access to appropriate healthcare, obtaining advice and information and having access to the right skills and knowledge to deal with the problem (Fig. 1.).

The survey asked women to say what would have improved the care they received. The most common responses were access to specialist advice and a better understanding of perinatal mental health problems by health professionals (Fig. 2.). A substantial number also considered that faster access to care and more information would have been helpful. A third of women felt that keeping the same health professional was important.

These findings show that changes do need to be made so that the care and services for women with postnatal mental distress can be improved. The most important improvements that are needed can be represented by a number of key themes based on national guidelines and

recommendations, prior research and on women's experiences and preferences. In recent years, a growing awareness of the significance of these issues has led to the publication of a series of national guidelines by key organisations that include the Department of Health, NHS Wales, the Royal College of Psychiatrists (England), the Clinical Resource and Audit Group (Scotland) and the Confidential Enquiries into Maternal Deaths.

Mind's survey together with prior research, national guidelines and clinical experience have identified a number of areas in which maternal mental healthcare falls short of expected standards:

1. lack of provision, particularly specialist services including mother and baby units
2. failure to identify risk factors
3. inadequate treatment of severe disorders
4. lack of coordination between services.

1. Lack of provision

Many areas do not have specialist maternal mental health services, such as mother and baby units or specialist liaison psychiatry services to maternity services (Confidential Enquiries into Maternal Deaths, 2001 and 2004). As well as producing national guidelines for the care and

Fig. 1. Difficulties experienced in relation to the care women received (per cent)

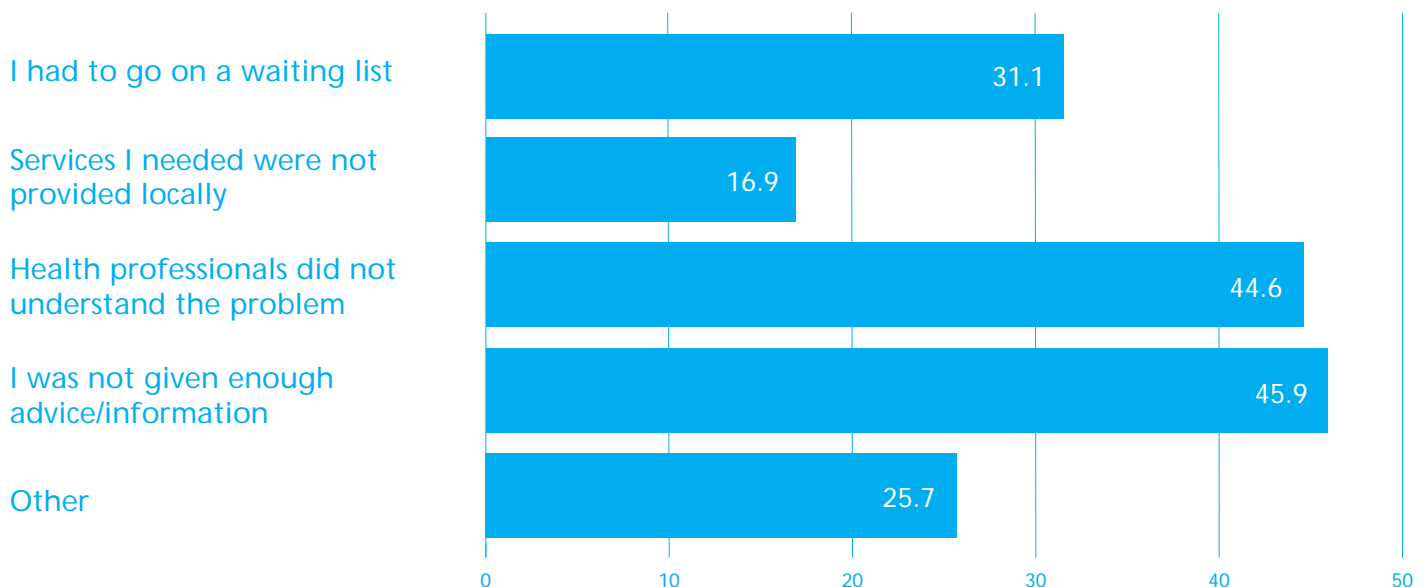
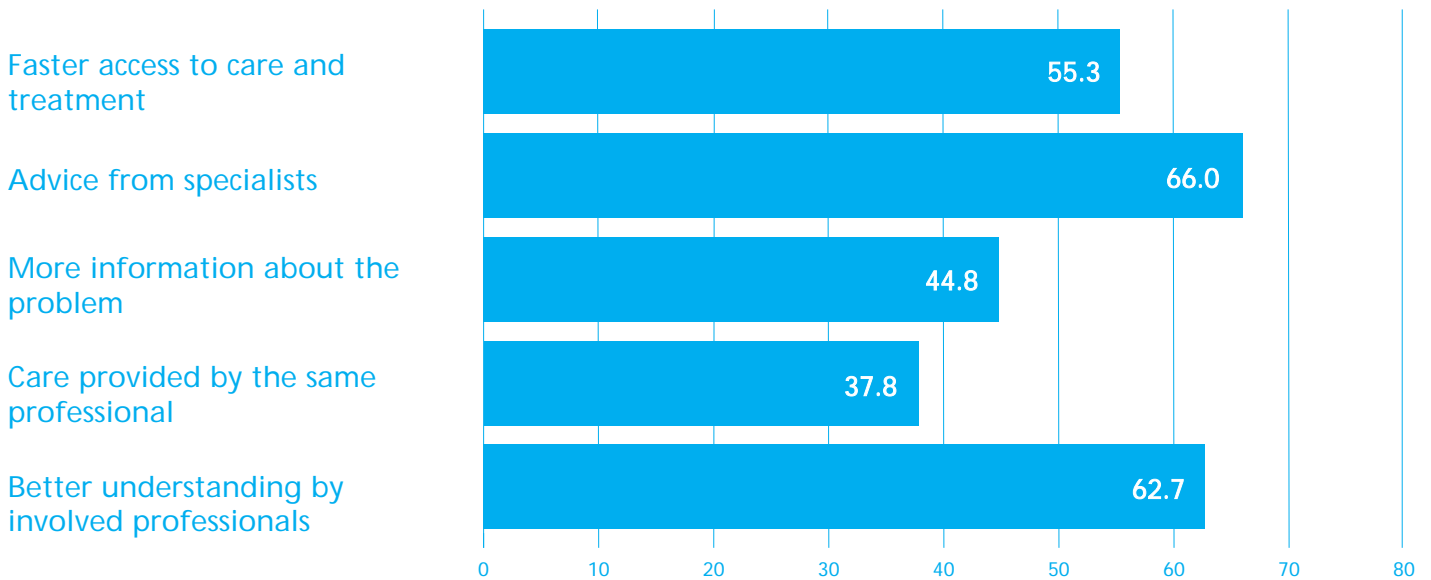


Fig. 2. Factors that women felt would have made most difference to the care they received (per cent)



management of women with perinatal disorders, the Government has also issued guidance on the commissioning and provision of specialist perinatal services in the UK. Some disorders are too infrequent and unpredictable for local services to be made a priority, but services need to work together across a wider geographical area where these disorders maybe present in sufficient numbers to make those specialist services viable. Obtaining a ‘critical mass’ of patients across health authorities also permits the development of specialist skills and experience and is associated with improved outcomes.

The Department of Health now requires that:

- primary care trusts (PCTs) take responsibility for commissioning services for their local populations, and collaborate in the commissioning of specialist services
- women requiring treatment by specialists be entitled to the best standards of care, irrespective of their place of residence
- strategic health authorities be responsible for ensuring that arrangements are in place for commissioning specialist services.

Although some of the work of these trusts is agreed on a national level, each has the freedom to consider issues that are particular to their

region. The Department of Health (2002) also produced guidance on which specialist areas are suitable for collaborative commissioning arrangements, and these include perinatal psychiatric services.

It is now widely recognised that the care and management of women with perinatal mental health problems requires the coordination of services at both a local and national level. The publication of national guidelines and care standards by key organisations provides a preliminary framework for improving existing services and for developing and implementing new approaches. Primary care trusts and strategic health authorities are required to ensure that specialist perinatal services are available to all women who require them irrespective of locality.

A recent survey of mental health trusts in England showed that, nationally, the provision of perinatal mental health services continues to vary considerably, with many areas of the country having few or no services (Oluwatayo and Friedman, 2005). Few had a specialist multidisciplinary perinatal service and there was little evidence of input from community psychiatric nurses, psychologists or social workers. The provision of specialist day hospital or specialist intensive home treatment was also sparse.

- 12 per cent of trusts still admit mothers and babies to beds in non-specialist (general adult) wards contrary to national recommendations.
- 38 per cent of trusts had no specific services or arrangements in place for admitting mothers and their babies.
- Fewer than 50 per cent of trusts had any type of perinatal service.
- Under 25 per cent provided the full range of inpatient and community perinatal services.
- Only 5 per cent had plans for future development of perinatal services.
- 75 per cent of trusts do not have a dedicated inpatient mother and baby unit.

Trusts were asked to identify specific shortfalls in the provision of care and services. Common problems identified included:

- a lack of community nurses, social workers and psychologists
- the need for more primary care services to provide community-based care
- a lack of coordination between different specialist services
- The majority of trusts considered that their existing services were inadequate and supported the provision of specialist services.

Mind's survey showed that out of the 148 mothers who responded, 27 had been admitted

to hospital with a mental health problem and most of these (63 per cent) were admitted to a general psychiatric ward. The majority of these mothers (82 per cent) were admitted without their baby (Fig. 3.)

The provision of mother and baby units and specialist perinatal psychiatric services in the UK is very patchy (Royal College of Psychiatrists, 2006). Some areas of the country are relatively well provided for (London and the South-West, the Midlands and part of the North-West). Other areas, including large areas of Wales, despite their large populations, have no specialist services or mother and baby units. A substantial number of women with serious perinatal disorders will not have access to services with the proper specialist knowledge and skills because of where they live.

Mind's survey demonstrates that where women live affects the care and treatment they receive. Of those women who were admitted to a mother and baby unit, 67 per cent were living in the South, 22 per cent lived in the Midlands and 11 per cent in the North. A higher proportion of women from the Midlands, the North and Scotland, Wales and Northern Ireland were admitted to a general adult psychiatric ward (with or without their baby) than those in the South. However, women who lived in the South said they had to wait longer before receiving treatment

Fig. 3. Place of admission (n=31)

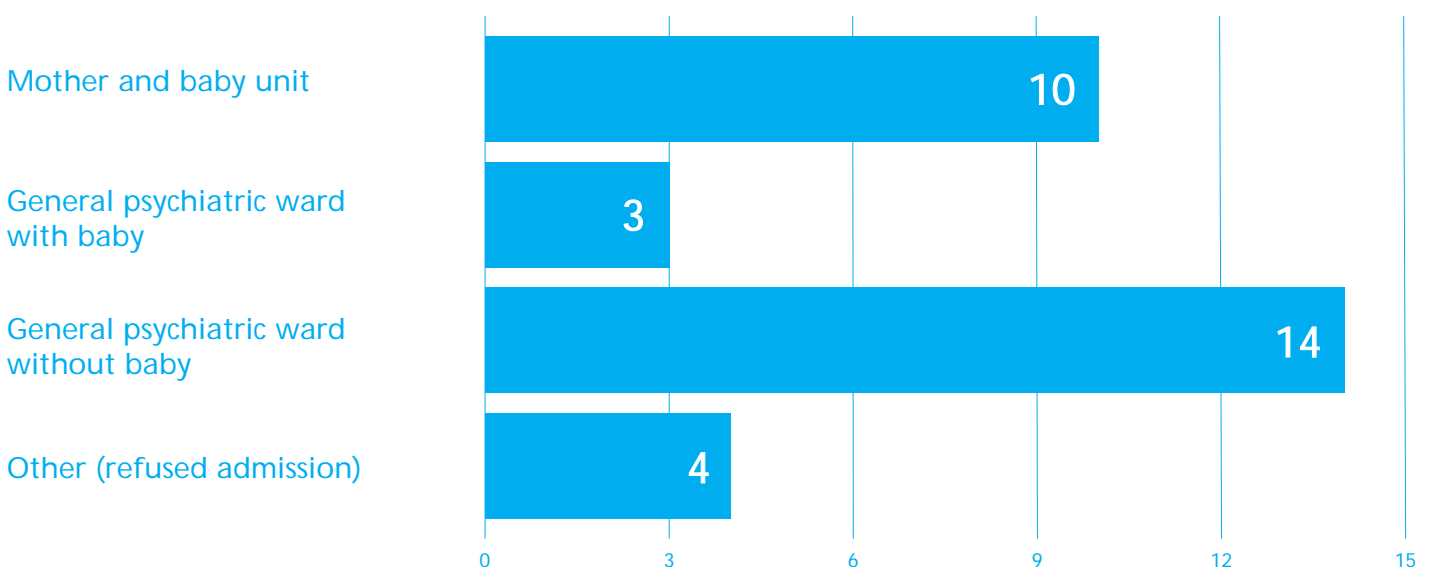
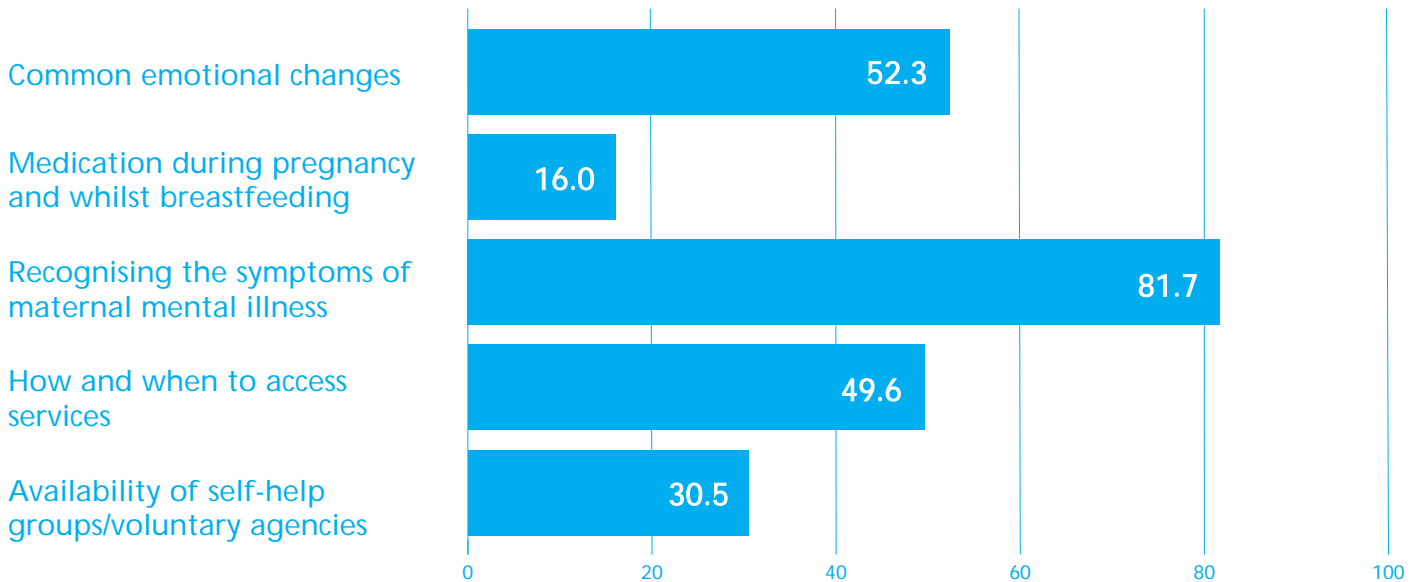


Fig. 4. Women were asked to rank the information they found most useful during pregnancy and following childbirth (per cent)



than women in other areas of the country. They also complained more often about a lack of local services, that health professionals did not understand the problem and that they were not given enough advice or information. These findings reflect those of the Confidential Enquiries of 1997–2002.

Over this six-year period, only one woman who died had been seen by a specialist perinatal mental health team and only one had been admitted (very briefly) to a mother and baby unit. None with previous postnatal admissions had been admitted. The overwhelming majority of women who had been admitted to a psychiatric hospital following the birth of a child had been separated from their babies.

Specialist perinatal psychiatric services (inpatient and community) should be available to all women who need them, during pregnancy and in the postnatal period, irrespective of their place of residence. Systems need to be in place to ensure that areas without specialist services are able to refer to out-of-area specialist teams and health professionals need to understand when and how to refer women for specialist care. Non-specialists also need to be able to access specialist perinatal advice and information in order to effectively manage and refer their patients.

Information

Women, their partners and families require information about perinatal mental health problems. It is important that this should be available to pregnant women in the antenatal period in order to raise their awareness of potential problems and to provide advice on what they should do next. Many women who experience mental health problems feel confused and isolated because they do not know what is happening to them or whom they should turn to for help.

Mind's survey showed that women would most like to receive information on how to recognise the signs and symptoms of maternal mental health problems (Fig. 4.). About a half felt they would like to know more about common emotional changes that occur during pregnancy and after the birth of a child, and how to get in touch with services if these were required. Fewer women felt that information on medication or self-help groups was as important.

Interviews with women showed that the following types of information are important:

- the different types of mental health problems around childbirth and how they are distinct from normal emotional changes

- how these conditions are usually treated and by whom
- the effects of mental health problems on mothers and their families
- long-term outcomes and the timescales involved.

Health professionals should provide information throughout the whole course of the condition and during the period of recovery. Fewer than 25 per cent of women wanted to access information on the internet or by telephone, while 43 per cent supported the development of local self-help/interest groups and 63 per cent felt that more support should be available to women's partners and families.

Tina had no personal or family history of mental health problems. She did not experience any particular difficulties during her pregnancy but soon after the birth of her first child by Caesarean section, she started to hear voices and had negative thoughts towards her baby. These continued while she was on the postnatal ward and after she left the hospital.

Tina tried to conceal her distress as she didn't want to seem a bad mother and was afraid that she would be sectioned or have her baby be taken from her. Nine days after the birth, however, she revealed to her midwife that she was feeling very low and finding it hard to cope. She was told that this was a normal reaction to childbirth and she would be reviewed by her GP at the six-week check. Tina didn't feel she could wait that long. The next day she was seen by a health visitor who advised her to go straight to her GP. She was prescribed antidepressants, but was not offered counselling. She was seen on a regular basis by a mental health nurse, but this person had no specialist skills in mental health problems around childbirth. Tina's problems did not improve and her GP increased the dose of her antidepressant medication. Tina was also put in touch with a charity that offered advice and information about perinatal mental health problems.

2. Failure to identify risk factors

Failure to identify in early pregnancy a past history of serious mental health problems means that the opportunity for drawing up a suitable management plan in advance of the birth is missed. These missed opportunities can give rise to adverse consequences for the mother, her baby and family. The Confidential Enquiries into Maternal Deaths (2001, 2004) showed that over half of the women who took their own lives after the birth of a child had a previous psychiatric history but this risk factor was neither identified nor acted upon by involved health professionals.

Knowledge and skills

Health professionals who are involved in the care of women with perinatal mental health problems require particular knowledge and skills. These are not just required by those who deal with serious mental health problems, but also by health professionals who care for all women (GPs, midwives and health visitors). The particular knowledge and skills required will differ according to where and how different conditions are managed. However, all health professionals involved in the care of women with perinatal mental health problems should be expected to have the following skills:

- an understanding of the importance of identifying women at risk of developing serious mental health problems and the associated risk factors
- an ability to understand and distinguish normal emotional changes and common difficulties from a mental health problem and being able to recognise the first signs of a problem
- listening skills and the ability to be supportive, reassuring and understanding
- knowledge of different types of disorders, their clinical features and an ability to distinguish between them
- awareness of when and how to make referrals, and the range of different treatment options that are available.

Women who responded to the Mind survey also felt strongly about the need for health

professionals to have a good working knowledge of the nature of maternal mental health problems. A similar number also believed that a trusting relationship between the patient and health professional was important. About half felt that being able to offer advice and information was an important quality.

Education and training

The survey conducted by Mind asked women to say in which areas health professionals need to improve in order to deal more effectively with maternal mental health problems. The two key improvements identified were that health professionals need to have a better understanding of perinatal mental health problems and be able to identify these problems more effectively. It is therefore important that health professionals receive the proper education and training in order that they are able to deal effectively with perinatal disorders (Royal College of Psychiatrists, 2000).

The Confidential Enquiry into Maternal and Child Health (2004) recommends that education and training should cover the following areas:

- Basic training for all health professionals involved in the maternity care of women to recognise and be able to access help for mental health problems. This should form part of their undergraduate curriculum.
- Health professionals should be required to maintain their skills and knowledge through continuing professional development.
- Additional training must be put in place before routine screening for serious mental health problems is implemented.

3. Inadequate treatment of severe disorders

Mental health problems that are associated with pregnancy and childbirth can be treated effectively using a number of different approaches. However, even women who are known to have a serious mental health problem may not be cared for or managed in a way that is suitable to their needs.

The Confidential Enquiry into Maternal and Child Health (2004) found that a substantial number of women who killed themselves or died from psychiatric causes had been in contact with psychiatric services during their maternity.

These conditions were therefore neither hidden nor undetected but the seriousness of their condition and the potential for sudden deterioration were not always acknowledged. Seventy-six per cent of women with a past history of serious mental health problems had no management plan in place before the birth.

Findings from the Mind survey showed that the support and help provided by primary care health professionals in the care and management of their maternal mental health problems were particularly valuable. Community psychiatric nurses, and to a lesser extent, the input of midwives and psychologists was also seen as important.

A recent report showed that health professionals working in primary care, maternity and psychiatric services were unclear about their roles and responsibilities in the management of mental health problems around childbirth. This was considered to have a negative effect on patient care (Rothera and Oates, 2006). Many were uncertain as to which aspects of a condition they should treat and which should be looked after by other services. This confusion increased when dealing with more complex disorders. Health professionals considered that such shortcomings could lead to misunderstandings, communication problems and delays to treatment.

Specialist facilities

It is important that every mother who experiences severe mental health problems has access to the right care and treatment. Women who require hospital admission should be admitted, where appropriate, with their baby to a mother and baby unit with special facilities. However, a substantial number of women do not have access to such facilities, and in many cases they may be separated from their baby. In some cases, the practice of admitting mothers to a general adult psychiatric ward still occurs. In all of these cases,

the welfare, health and well-being of these women and their babies may be at risk.

Mother and baby units should form a separate facility with their own amenities. These units should be run by specialist staff with the knowledge, skills and experience to provide appropriate care for women with serious postnatal mental health problems and their babies.

Specialist mother and baby units provide an environment in which women can share their experience and understanding of the condition. Women surveyed who were unable to do this because they had been admitted to non-specialist units felt isolated. Many women considered that the outcome for themselves and their family would have been much less positive if they had not been admitted to a specialist unit.

4. Lack of coordination between services

Effective management of women with maternal mental health problems depends on the coordination and cooperation of services such as general practice, midwifery, obstetrics and psychiatry. These services often fail to communicate important information to one another, resulting in delays to care and treatment or the needs of women not being

properly met (Confidential Enquiries into Maternal Deaths, 2001 and 2004).

Difficulties of communication between services have also been cited as a factor in maternal suicide (Confidential Enquiries into Maternal Deaths, 2001 and 2004). The majority of women who took their own lives following the birth of a child had a previous history of treatment for a psychiatric disorder, but GPs and psychiatric services often failed to provide this information to maternity services. Had there been better communication, it is possible that many of these deaths could have been prevented.

The following have been identified as factors in the breakdown of communication between health professionals:

- geographical distances between maternity and psychiatric services
- different management, information systems and case records used by maternity and psychiatric services (Confidential Enquiry into Maternal and Child Health, 2004)
- lack of liaison services or clinics, where specialist psychiatry teams, maternity services and community mental health teams are able to exchange information and advice (Department of Health, 1999).

Fig. 5. Length of time women had to wait for treatment (per cent)

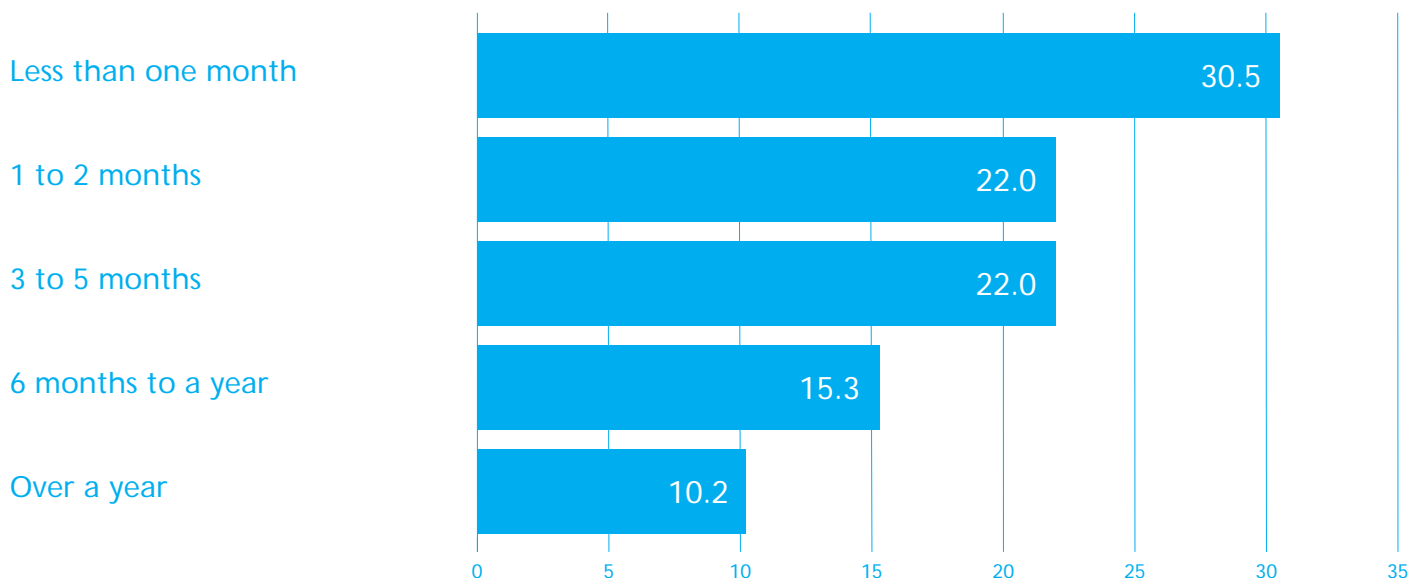
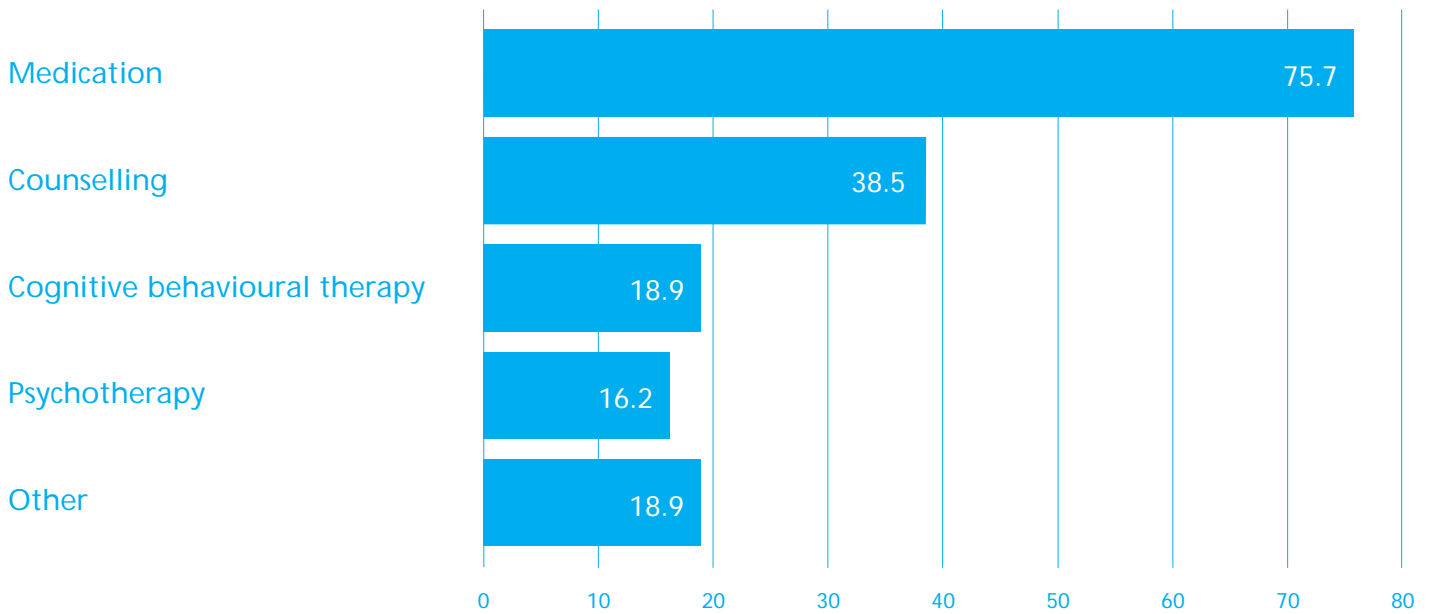


Fig. 6. Therapies/treatment options offered to women (per cent)



Mind’s survey also showed that women with maternal mental health problems were concerned about the amount of time they had to wait before receiving care and treatment. Just under a third of women were required to go on a waiting list, which ranged from up to one month to more than a year (Fig. 5.), with 25 per cent having to wait longer than six months.

- 90 per cent of women complained of health professionals’ lack of understanding and of receiving insufficient advice or information.
- 52 per cent of women who had to go into hospital were admitted to a general adult psychiatric ward without their baby.
- Three-quarters of women felt that their GP and health visitor were of most help to them.

The variation in how and where services are provided across the country affects the care of women who experience mild and moderate mental distress as well as those who have more severe disorders that may require an admission to hospital. The lack of specialist services, together with problems over identifying, recognising and managing maternal mental health problems, can lead to adverse consequences for women and their families.

Comprehensive and integrated services

Perinatal mental health problems of all types often require the input of a variety of services. For more severe conditions, this may involve specialist and general psychiatric services in both the hospital and community and the input of primary care and maternity services. Less serious conditions will often involve a variety of services, including general practice, midwifery, health visiting, social services, child welfare agencies, NGOs and organisations such as Sure Start.

Three quarters of women surveyed by Mind had their mental health problems treated using medication, and just over a third were offered counselling (Fig. 6.). Fewer women had other treatments options, such as cognitive behavioural therapy or psychotherapy. About a fifth were cared for by other services, such as health visitor listening visits, community psychiatric nursing, Sure Start, support groups or MBUs.

Many areas will not have access to all of these services, and where services do exist the provision of care may often be disjointed and uncoordinated. This can lead to delays and disruptions for the patient and unnecessary duplication of services.

Most remote rural areas are poorly served by Community Perinatal Mental Health Teams and may well have problems accessing specialist inpatient care. If participating mental health trusts encompass remote rural areas, then women in those areas will have access to mother and baby units in urban areas. The same will also be true for mental health trusts that have a Community Perinatal Mental Health Team but these are much fewer in number than trusts that have a mother and baby unit.

In order to ensure that women receive the right care at the right time, services should be as streamlined as possible. To achieve this, a number of parameters need to be in place:

- Better coordination is needed between services, so that health professionals are aware of their responsibilities and those of their colleagues.
- Care needs to be planned around women's needs rather than the requirements of the service. Care pathways should be in place to ensure this, to reduce confusion and uncertainty and to help avoid the same care being provided by different services.

- Communication needs to be improved and systems put in place to ensure that management plans or significant concerns about pregnant and postnatal women are communicated between general practice, obstetrics and psychiatric services. The role of the GP has been identified as being central to this process (Confidential Enquiry into Maternal and Child Health, 2004).
- Additional resources need to be in place to ensure that a comprehensive range of treatment options is available to women, which are appropriate to the nature of the condition.

An important part of a comprehensive service is to ensure that women have access to a range of treatment options. Many women noted that often there was no choice over the type of therapy or treatment given. In many cases, this was attributed to the lack of services in a particular area. In many areas, additional resources will therefore be required to ensure that a comprehensive range of services are available to deal with perinatal disorders.

Conclusions and recommendations

It is essential that the mental health and well-being of new mothers is the responsibility of all professional groups and services involved in perinatal care, not just psychiatry. As this report shows, the wide range of perinatal disorders which affect women during pregnancy and after childbirth should be managed at all levels of healthcare by primary, secondary and tertiary services.

An important step is to make sure adequate services are in place to improve the skills, knowledge and confidence of all health professionals who promote the mental health and well-being of pregnant and postnatal mothers. This includes the wide range of common mental health problems and mild disorders that are more often seen by health professionals, which should be dealt with both sympathetically and sensitively.

Audits of mental health service provision should take account of their accessibility and responsiveness to the needs of mothers with dependent children. There should be funding for mental health advocacy that specifically addresses the needs and concerns of parents with mental health problems.

It is also essential that skilled specialist teams and mother and baby units are available to all those with serious mental health problems regardless of where they live.

Mind's recommendations

- Mind would like standard maternity services to pay more attention to emotional well-being and provide continuity between ante- and postnatal support, and access to practical support and advice.
- Maternity, mental health and primary care trusts should ensure that they conform with, or have plans in place to implement, existing and forthcoming guidelines for perinatal mental health care.
- Smaller maternity trusts should allocate the time of consultants with a special interest in perinatal psychiatry and develop community psychiatric nursing teams.
- Larger maternity trusts should develop perinatal psychiatric services led by a specialist psychiatrist.
- Primary Care Trusts and Strategic Health Authorities, and Health Authorities in Wales should ensure that specialist perinatal services, including mother and baby units, are available to all women in their area who need them.
- Mother and baby units should serve large populations across different health communities and establish close working links with local mental health teams.
- The Department of Health, Care Services Improvement Partnership/Healthcare Commission and NHS Wales/Healthcare Inspectorate Wales should monitor commissioning and ensure that there is equitable access to specialist services.
- Every Local Health Board/Local Authority in Wales must develop and publish plans for the assessment, care and treatment of mothers with ante- and postnatal mental health problems.
- Training to enhance the skills and knowledge of all health professionals in contact with pregnant and postnatal women should be provided. The training should be informed by women with experience of perinatal mental distress.
- Maternity services should have a lead clinician with an interest in perinatal mental health and maternity trusts should provide a level of specialist perinatal psychiatric service.
- Mental health and social care agencies should ensure their services are accessible to mothers of dependent children.
- Parenting issues should be included in anti-discrimination and anti-stigma campaigns to minimise the negative attitudes women with mental health issues may encounter from family, neighbours or within the health services.
- Women should be informed about possible risks to their child when medicines are taken during pregnancy and while breast feeding.
- Information should be available about the best methods of coming off medication.

Independent local Mind association services for perinatal mental health

West Suffolk Mind

West Suffolk Mind's Healthy Mind Centre runs a postnatal depression service that comprises a ten-week course and a postnatal depression support group. The course is based on Jeanette Milgrom's respected 'Treating Postnatal Depression' programme and aims to provide an understanding of the condition, drawing on current theories and key research. The ten sessions consist of active intervention to reduce symptoms, improve the relationship between parent and child, address any difficulties with the partner and encourage the formation and development of social networks. Between six and ten women take part in the course each time it is run and since its inception three years ago 70 women have completed the programme.

"The course helped me enormously and has given me insight into why I feel the way I do. I don't feel so alone and helpless now. I know a lot of mums who are suffering postnatal depression who would benefit from groups like this." (Karen, 27)

Before, during or after accessing the course women are also able to attend a weekly postnatal depression support group. A creche working to Ofsted standards allows women to feel at ease leaving their babies to take part in the course. Both services are provided free of charge.

Contact: Rob Lock, Programmes Manager, Healthy Mind Centre, West Suffolk Mind, T: 01284 748 040.

Greenwich Mind

Greenwich Mind offers a range of services to support new mothers experiencing depression, anxiety or other difficulties, which may affect their capacity to care for, and bond with their babies.

Mums are invited to attend a small therapy group with their babies, with a creche provided for older babies and siblings. Each group runs for 12 sessions and is facilitated by a qualified

psychotherapist. For those mums who feel unable, or who do not wish to attend a group there is the option of 12 individual counselling sessions. A counselling service, again 12 sessions, is also available for couples experiencing difficulties together, after the birth of a baby.

"The counsellor helped me understand my feelings. I felt happy as I was able to talk both to my partner and to her." (Naomi, 32)

"The counsellor was very professional, sensitive and diplomatic. It helped me come to understand myself a little better." (Daniel, 35)

Parents may apply themselves, but referrals on their behalf from health visitors, GPs or other health professionals are also welcomed. A lack of statutory services locally means that many women come to Greenwich Mind's postnatal service this way. The service is funded entirely by the fundraising efforts of Greenwich Mind. Contact: Miriam Donaghy, Greenwich Mind, T: 020 8853 2395.

Chichester and Bognor Area Association for Mental Health (AMH)

Chichester and Bognor Mind run two parenting support groups, one for women, called 'Seagulls', and one for men, called 'Mainly Men'.

Women can refer themselves to 'Seagulls' although if postnatal depression has been diagnosed, a health visitor will often make the first referral. The group promotes contact between mothers who may be experiencing feelings of isolation, anxiety, postnatal depression or other mental health problems. The mutually supportive atmosphere encourages the development of social and support networks. Two staff and one or two volunteers facilitate the group and there are quiet areas where the women can take a break from childcare if they need to. 'Seagulls' aims to give the women an emotional boost while also providing pre-school children with a safe and stimulating play environment.

“Seagulls has helped build my confidence and taught me that all mums go through highs and lows of motherhood. It helps to talk about everything.” (Joanne)

The ‘Mainly Men’ group is a support group for fathers who are the primary carers for their pre-school children. The group has been running for two years and is the only service of its kind in West Sussex. The purpose of the group is to support fathers who are experiencing isolation and depression by putting them in touch with others in similar situations. The group was established because men found it difficult to access any support, as they felt unwelcome at mother and toddler groups. A relaxed atmosphere promotes positive interaction between father and child, with play or arts activities put on for the group. The group also receives visitors – recently a first aid instructor taught the fathers basic skills in case their child ever needed first aid.

“I was isolated at home being a house husband and carer to our two young sons. It helped me make friends with fathers in the same position as myself.” (Richard)

Contact: Elaine Ford c/o Chichester and Bognor Area AMH, T: 01243 842 336.

Mind in Birmingham

Mind in Birmingham has been successfully running a series of groups under the ‘Circle of Friends’ scheme since 2005. Funded by North Birmingham PCT, this service aims to support women in mental distress who are consequently at risk of, or currently experiencing, social exclusion. The service has a full-time Support Time Recovery worker and provides a mixture of group and one-to-one work, to suit the individual’s needs. The groups are designed to provide a supportive network for women who, for instance, may have problems getting out of the house and forming social contacts as a result of mental or emotional distress. Members have included women with present or past experience of postnatal illness; often symptoms have not been adequately treated at the time and have

developed into longer-term difficulties. One-to-one work is geared towards helping isolated individuals form relationships with others and join a larger group.

‘Circle of Friends’ groups meet in various community centres and guests often come in from the local area, for example to demonstrate floristry techniques or arts and crafts. Participants have also started off their own activities from within the groups – two women with pet dogs who were both isolated now walk their dogs together, for example, and the ‘Merry Moochers’ enjoy spending time in charity shops and at jumble sales. Trips to the cinema, theatre and restaurants are arranged either through the group or through the social networks that are established between members.

“My confidence has had such a boost since I joined the group. I’ve met new friends and tried things I never thought I’d be able to do when I was really low.” (Jenny, 42)

This group provides a route out of social exclusion and isolation for women experiencing mental distress, whatever their circumstances.

Contact: Carmel Smith, Mind in Birmingham, T: 0121 359 1151.

Stockport Mind

The Depression Recovery Group has been running at Stockport Mind for five years. Open to men and women experiencing depression, the group is run by two facilitators, both of whom are trained counsellors. Sessions run for most weeks of the year and each group is open to a maximum of ten participants. People refer themselves to the service that operates as a self-help group, aiming to empower individuals in the management of their symptoms.

“Meeting new people was really hard when I was at my lowest – but the group has really helped me get my confidence back. I really enjoyed the goal-setting session – and got a real sense of achievement when I completed my tasks.” (Tony, 44)

Each session involves a group discussion so individuals can speak about their weekly progress and talk about their feelings in a supportive and objective atmosphere.

The facilitators work hard to ensure that people feel accepted and understood within the group; for many members the group provides the first social contact they have had for some time. Members are encouraged to share their problems rather than dwell on them, and the facilitators suggest coping techniques and encourage participants to support one another.

"I've found such good support from the facilitators and from the other members. Even on bad days I knew it would be worth making the effort to come." (Sarah, 27)

This service allows people to build supportive friendships with others who have similar experiences and for many is a major first step on the road to recovery. The positive outlook of the group enables people to take their lives back into their own hands.

Contact: Margaret Hall or John Davies, Stockport Mind, T: 0161 480 7393.

Further information and key resources

Mind (National Association for Mental Health)

Mind 15-19 Broadway, London E15 4BQ,
MindinfoLine: 0845 766 0163, T: 020 8519 2122,
F: 020 8522 1725, e: contact@mind.org.uk,
w: www.mind.org.uk

Mind Cymru

3rd Floor, Quebec House, Castlebridge, 5-19
Cowbridge Road East, Cardiff CF11 9AB,
T: 029 2039 5123, F: 029 2034 6585

Rural Minds

Information Unit, Mind 15-19 Broadway, London
E15 4BQ, T: 020 8215 2322, F: 020 8215 2269
e: ruralminds@mind.org.uk

Mind has a network of over 200 local Mind associations throughout England and Wales. These offer supported housing, crisis helplines, drop-in centres, counselling, befriending, advocacy, employment and training schemes, and other services. To find contact details for your local association visit

www.mind.org.uk/Mind+in+your+area

PNI-UK (Perinatal Illness – UK)

PO Box 7066, Ashbourne, Derbyshire, DE6 9AG,
T: 013 3534 7599, e: help@pni-uk.com,
web: www.pni-uk.com

Other useful organisations

Association for Post-Natal Illness

145 Dawes Road, London SW6 7EB,
helpline: 020 7386 0868, F: 020 7386 8885,
e: info@apni.org, w: www.apni.org

British Association for Counselling and Psychotherapy (BACP)

BACP House, 35-37 Albert Street, Rugby CV21
2SG, T: 0870 443 5252, e: bacp@bacp.co.uk,
w: www.bacp.co.uk

See website or send A5 SAE for details of local practitioners.

British Psychoanalytic Council

West Hill House, 6 Swains Lane, London N6 6QS,
T: 020 7267 3626, F: 020 7267 4772,
e: mail@psychoanalytic-council.org,
w: www.psychoanalytic-council.org

Cruse Bereavement Care

Cruse House, 126 Sheen Road, Richmond TW9
1UR, helpline: 0870 167 1677, young person's
helpline: 0808 808 1677,
e: helpline@crusebereavementcare.org.uk,
T: 020 8939 9530, F: 020 8940 7638,
e: info@crusebereavementcare.org.uk,
w: www.crusebereavementcare.org.uk

Depression Alliance

212 Spitfire Studios, 63-71 Collier Street, London
N1 9BE, T: 0845 123 2320,
e: information@depressionalliance.org,
w: www.depressionalliance.org
Provides information and support.

Fellowship of Depressives Anonymous

Box FDA, Self Help Nottingham, Ormiston House,
32-36 Pelham Street, Nottingham NG1 2EG,
T: 0870 774 4320,
w: www.depressionanon.co.uk
A self-help organisation.

MDF – The Bipolar Organisation

Castle Works, 21 St George's Road, London SE1
6ES, T: 08456 340 540, F: 020 7793 2639,
e: mdf@mdf.org.uk,
w: www.mdf.org.uk
Helps people affected by manic depression.

National Family Mediation

7 The Close, Exeter EX1 1EZ, T: 01392 271 610,
F: 01392 271 945, e: general@nfm.org.uk,
w: www.nfm.u-net.com
Network of family mediation services.

NHS Direct

helpline: 0845 4647, textphone: 0845 606 4647,
w: www.nhsdirect.nhs.uk

NICE (National Institute for Health and Clinical Excellence)

MidCity Place, 71 High Holborn, London WC1V
6NA, T: 020 7067 5800, F: 020 7067 5801,
w: www.nice.org.uk
Contact for copies of guidelines for doctors and
medical staff on caring for people with
depression.

Parentline Plus

helpline: 0808 800 2222, textphone: 0800 783 6783, T: 020 7284 5500,
F: 020 7284 5501,
e: centraloffice@parentlineplus.org.uk,
w: www.parentlineplus.org.uk Charity supporting anyone parenting a child.

Relate

Herbert Gray College, Little Church Street,
Rugby CV21 3AP, helpline: 0845 130 4010,
T: 01788 573 241,
e: enquiries@relate.org.uk,
w: www.relate.org.uk
Relationship counselling, mediation and support.

Rethink

28 Castle Street, Kingston upon Thames KT1 1SS,
advice line: 020 8974 6814, T: 0845 456 0455,
e: info@rethink.org,
w: www.rethink.org
Helps those affected by severe mental illness.

Samaritans helpline: 08457 90 90 90,
e: Jo@samaritans.org,
w: www.samaritans.org
24-hour telephone helpline.

Saneline

1st Floor Cityside House, 40 Adler Street,
London E1 1EE, Saneline: 0845 767 8000
(Mon-Fri 12 noon-11pm, Sat and Sun
12 noon-6pm),
T: 020 7375 1002, F: 020 7375 2162,
w: www.sane.org.uk
Saneline is a national out-of-hours telephone
helpline providing information and support for
anyone affected by mental health problems,
including families and carers.

SureStart

w: www.surestart.gov.uk
Government programme to deliver the best
start in life for every child.

UK Council for Psychotherapy (UKCP)

2nd Floor Edward House, 2 Wakley Street,
London EC1V 7LT, T: 020 7014 9955,
e: info@psychotherapy.org.uk,
w: www.psychotherapy.org.uk

Mind publications

Understanding postnatal depression
(Updated in 2006 and now available in French,
Arabic, Turkish, Bengali and Gujarati language
editions.)

How to cope with relationship problems

How to cope with sleep problems

How to help someone who is suicidal

How to look after yourself

How to parent when you're in a crisis

How to rebuild your life after breakdown

*How to recognise the early signs of mental
distress*

How to stop worrying

How to survive family life

Making sense of antidepressants

Making sense of cognitive behaviour therapy

The Mind guide to managing stress

Understanding anxiety

Understanding depression

Understanding psychosis

Understanding talking treatments.

Young person's introduction to mental health

To order any of these titles, or for a catalogue of
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w: www.mind.org.uk

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publications stocked.

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Mind's mission

Our vision is of a society that promotes and protects good mental health for all, and that treats people with experience of mental distress fairly, positively, and with respect.

The needs and experiences of people with mental distress drive our work and we make sure their voice is heard by those who influence change.

Our independence gives us the freedom to stand up and speak out on the real issues that affect daily lives.

We provide information and support, campaign to improve policy and attitudes and, in partnership with independent local Mind associations, develop local services.

We do all this to make it possible for people who experience mental distress to live full lives, and play their full part in society.



For better
mental health



For details of your nearest local Mind association and of local services, contact Mind's helpline, **MindinfoLine** on 0845 7660 163, Monday to Friday 9.15am to 5.15pm. Speech impaired or deaf enquirers can contact us on the same number (if you are using BT Text direct, add the prefix 18001). For interpretation, **MindinfoLine** has access to 100 languages via Language Line.

Mind
15-19 Broadway
London E15 4BQ
T: 020 8519 2122
F: 020 8522 1725
w: www.mind.org.uk

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PNI-UK (Perinatal Illness – UK)
PO Box 7066
Ashbourne, Derbyshire, DE6 9AG
T: 013 3534 7599
e: help@pni-uk.com
w: www.pni-uk.com