

Greater Manchester Perinatal and Parent Infant Mental Health Service:

Championing 1001
Critical Days

**Greater
Manchester
Health and
Social Care
Partnership**



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1. Key Points

- 1.1 The NHS Long Term Plan builds on ambitions of the Five Year Forward View for Mental Health in order to increase access to evidence-based care for women with moderate to severe perinatal mental health difficulties for 66,000 women nationally by 2023/24. In Greater Manchester we are aiming to ensure access for 3,725 women per year by this time. This is equivalent to 10% of Greater Manchester birth rate per year.
- 1.2 As well as providing specialist support to women, the emotional wellbeing of all the 37,000 babies born in Greater Manchester (GM) every year and their parents will be promoted through an emotional and mental wellbeing offer in all universal services, notably maternity, healthy visiting and primary care working together with specialist services for the 1001 critical days from pregnancy to 24 months of age [1].
- 1.3 This period is also critical in laying foundations for school readiness, in respect of which Greater Manchester remains below the national average.
- 1.4 There is no other period in life when so many different services and professionals can become involved with a woman and her baby than during the perinatal period, and it is also a critical time to reach fathers/partners.
- 1.5 This document describes Greater Manchester's pioneering perinatal and parent-infant mental health model that aims to ensure services work in an integrated system. It describes how the key mental health services will integrate and work together during the prenatal and post-natal periods, whilst at the same time supporting the efforts of other services that are frequently involved and creating a shared language and understanding of perinatal and infant mental health.
- 1.6 The GM model establishes integrated working of:
- Specialist Perinatal Community Mental Health Services
 - Parent-Infant Mental Health Services
 - Adult IAPT (Improving access to psychological therapies) PIMH services
 - Volunteer peer support
- Each of these services and the principles under which they operate is presented in some detail in this paper.
- 1.7 The reader will see from the descriptions of these services, particularly the three statutory services, that there is a degree of overlap, both in terms of the families being seen and the nature of the support they need. It is understandable why each of these services has developed along somewhat different lines in the past, but integrated working offers a logical and effective response to the knowledge of these critical days in a child's life. It will support parents with the whole spectrum of mental health needs, deliver on the expansion of the specialist perinatal services as outlined in the NHS Long Term Plan [2].
- 1.8 There is considerable work still to be done to achieve a whole-system integrated model, whilst developing the model in line with the Long Term Plan specialist perinatal targets and developing a business case to support the expansion required.

The Perinatal Requirements in the Long-Term Plan: Ambitions for Specialist Perinatal Community Mental Health Services

- 1.9 Due to the growing awareness and understanding of the implications of mental illness for women babies, their families and wider society, specific funding was identified by NHS England in the Five Year Forward View for Mental Health [3], to increase access to specialist perinatal mental health teams both in the community and the inpatient setting.
- 1.10 The 5 Year Forward View set out to develop specialist perinatal community mental health teams with a target of assessing and treating an additional 30,000 women with mental illness in the perinatal period by 2020/21.

- 1.11 This new investment has translated into four new mother and baby units and specialist perinatal community mental health teams being established. There has been further investment identified in the NHS Long Term Plan as well as an increase in the remit of these services (Five Year Forward View for Mental Health, 2016, and The NHS Long Term Plan (LTP), 2019). The expectation is that the specialist perinatal mental health service will expand to meet the requirements of the NHS LTP. The LTP sets out to see an additional 33,000 women per year by 2023/24.



1.12 The Long-Term Plan aims to increase access to specialist perinatal community mental health teams and to improve the quality of care provided by the teams for mothers, their partners and children by:

- A. Increasing access to the specialist perinatal community service;** this is a fixed access ambition and the target is for 10% of the birth rate to have access to specialist perinatal services. This means nationally at least 66,000 women with complex or moderate to severe perinatal mental health difficulties will have access to specialist perinatal community mental health teams. The NHS LTP clearly sets out the workforce of the specialist perinatal community service must expand to work towards meeting the target. There is an LTP implementation tool which has been completed to drive forward the workforce expansion required to meet the increase in women, who will be helped by the specialist perinatal community service.
- B. Increasing access to evidence-based psychological therapies** including compassion-focussed therapy, parent-infant psychotherapy, couple, co-parenting and family interventions and sign-posting to IAPT where appropriate. The delivery of parent-infant psychotherapy and family interventions within specialist perinatal community mental health teams will require close integration between parent-infant mental health services and the specialist perinatal community mental health team (CMHT). Women with moderate to severe mental illness in the

perinatal period should be offered an assessment and input under the specialist perinatal mental health team with access to parent-infant services. This will include women with a history of current/past psychotic disorder and those with moderate to severe/complex affective disorders. Women presenting with mild mental illness in the perinatal period may still have access to the parent-infant service but will not be assessed or treated under the specialist perinatal community mental health team.

- C. Care provided by specialist perinatal community mental health services will be available from preconception to 24 months after birth by 2023** (care is currently provided from preconception to 12 months after birth), in line with the cross-government ambition for women and children focusing on the first 1,001 critical days of a child's life.
- D. Increasing support for partners of women experiencing moderate to severe mental illness in the perinatal period.** Partners will be able to access an assessment for their mental health and signposting as required. This will contribute to helping to care for the 5-10% of fathers who experience mental health difficulties during the perinatal period.
- E. Maternity outreach clinics** will integrate maternity, reproductive health and psychological therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience by 2023/24.

1.13 In Greater Manchester this translates into the following access rates by Clinical Commissioning Group (CCG), equivalent to around 10% of the births per locality by 2022/23:

		2019/20	2020/21	2021/22	2022/23
Area	Number of Births 2016	4.80%	7.10%	8.60%	10%
Tameside & Glossop	3,233	155	230	278	323
Bolton	3,816	183	271	328	382
Bury	2,362	113	168	203	236
Manchester	7,946	381	564	683	795
Oldham	3,327	160	236	286	333
Rochdale	3,072	147	218	264	307
Salford	3,695	177	262	318	370
Stockport	3,424	164	243	294	342
Trafford	2,813	135	200	242	281
Wigan	3,558	171	253	306	356
Greater Manchester	37,246	1788	2644	3203	3725

NB: Additional investment is required to achieve these targets

1.14 The expansion to reach 10% of the population each year means that a multi-modal offer is required to be well embedded into each locality. The Greater Manchester model gives us this and is the perfect basis for expansion to meet all these aims. An estimate of presenting needs can be found in the **Appendix**.

2. Introduction

2.1 Why is Perinatal Mental Health Important?

The perinatal period is usually defined as the time between conceiving a baby until the end of the first postnatal year. 20% of women (or 1 in every 5 women) experience mental health problems during this time, making this a relatively common experience. Women may have experienced mental health problems prior to pregnancy and/or develop mental health problems during pregnancy or in the postnatal period.

A wide range of mental health conditions can occur during this time, most commonly depression and anxiety.

Research shows that 50% of women with depression go undetected and do not access treatment and support. There are some conditions specific to this time in a woman's life such as tokophobia – a severe fear of child birth, and post-partum psychosis – a severe but treatable illness that occurs after having a baby.

It is not always possible to predict whether or not a woman is likely to experience mental health problems during this time, however, we do know that some groups of women are at much higher risk. For example, 25% (or 1 in 4) women with bipolar affective disorder experience post-partum psychosis.

It is vital that women receive treatment and support as early as possible. We know that if left untreated, mental illness can have a significant and long lasting impact on the woman, her infant and her family. The perinatal period is often a window of opportunity; treating mental health problems at this time prevents avoidable suffering and isolation, strengthens families, ensures children have a healthy start, has economic


benefits and helps to prevent suicide, and is a leading cause of maternal death in the UK.

2.2 Why can't babies wait?

Scientific studies have shown very clearly the crucial significance of the earliest period of an infant's life, the first 1001 critical days. It is now more fully known and acknowledged that the emotional and developmental environment of infancy, consisting almost entirely of relationships with parents and care-givers, shapes the individual emotionally, psychologically, and neurologically. During this period, brain growth is at its fastest, and at its most susceptible to 'pruning away' of neurons if there is inadequate stimulation of the right kind. We used to think babies' brains grew and developed because of physical maturation and genetic inheritance; we now know that brain development depends principally on healthy interactions between a baby and his/her parents.

2.3 Helping services respond effectively to the needs of babies and their families

There is no other period in life when so many different services and professionals can become involved with a parent and their baby than during the perinatal period. The health and care of parents and their new babies are usually provided by a range of services and professionals who not only have different focuses and training, but who also may have different understandings of mental health. Some of this care may focus on the health and development of the infant and some may focus on the parent's problems and anxieties.



Today, we recognise the need to also prioritise the relationship. The wealth of skills provided by these professionals is enormous, yet the coordination between these various services has not always been as good as it could be. This document describes Greater Manchester's pioneering perinatal and parent-infant mental health model that aims to integrate key mental health services involved during the peri- and post-natal periods, support the efforts of other services that are frequently involved and create a shared language and understanding of perinatal and parent-infant mental health.

3. Greater Manchester: A Pivotal Time For Change

3.1 In February 2015 the 37 NHS organisations and local authorities in Greater Manchester (GM) signed a landmark agreement with the government to take charge of health and social care spending and decisions in the GM city region. Devolution has put Greater Manchester in charge of the region's £6 billion health and social care budget to improve the health and wellbeing of everyone who lives here. The ten boroughs are working together to transform public services and tackle the biggest issues affecting the population's health.

3.2 Greater Manchester has identified that poor early years outcomes are harming the life chances of thousands of children, and holding back the region's development. Greater Manchester remains an outlier in Early Years outcomes compared to the national average, with only 68.2% of all eligible children achieving a good level of development (GLD) at the end of the Early Years Foundation Stage (reception) in academic year 2018/19, compared with 71.8% nationally.

In response, GM has developed a model for integrated Early Years services. The GM Early Years Delivery Model (EYDM) is built upon the principles of proportionate universalism. It recognises the 1001 critical days starting at conception and harnesses the universal reach of maternity services and Health Visiting for the crucial early identification of vulnerability in both parents and infants; the parent and infant mental health model is an integral evidence based pathway within the model.

When the EYDM is implemented across GM to a consistently high standard, families will be in receipt of a proportionate, multi-agency tailored response relevant to their level of needs.

3.3 The Marmot review (2010) [4] highlighted the need to take action across the social determinants of health, and called for progress to be made on a clear set of policy objectives. Greater Manchester has had a longstanding focus on reducing inequalities. Adopting an integrated approach to perinatal and parent infant mental health aligns with our GM model for unified public services which has an explicit focus on people, prevention and place and aims to reduce the accumulation of health inequalities throughout the life course. The ambition is that Greater Manchester becomes the first Marmot City Region.

3.4 We recognise that in order to effect a real change in improving people's lives, we need to focus on early intervention and prevention. A key target in Greater Manchester's strategic plan is thus for the region to invest in a whole system approach to perinatal and parent-infant mental health.

3.5 The overall vision for the whole system approach is:

- The early identification, assessment and treatment of women with mental illness in the perinatal period so that women have access to the right treatment, at the right time, in the right place whilst supporting the parent-infant relationship.
- To promote the physical, mental and emotional development of all babies born to women with mental illness and to support partners and families throughout the perinatal period.
- To provide a wider offer to promote the emotional wellbeing of all babies born in Greater Manchester through all universal services for the 1001 critical days from conception to 24 months of age.

3.6 A comprehensive service model that aims to seamlessly integrate all services involved with parents and babies has been developed. The term perinatal and parent-infant mental health is used to represent a frame of mind that encourages us to give equal attention to the parent, the infant and the parent infant relationship, without bias to one or the other.

4. Knitting It All Together – Working Towards Integration

4.1 The various services that will shortly be described represent a wealth of expertise in dealing with the problems of parents and infants across a range of domains including physical and mental health, living environments and risk management. GM aims to work in an integrated system and closely integrate the efforts of all the services, ensuring women, their infants and partners will receive the right support, at the right time, in the right place, from the most appropriate mental health service and to avoid falling into the trap of each service operating within its own “silo”. Services need to be integrated to ensure effective use of resources, and more importantly, ensure the highest quality service for families. Proposals to integrate and expand services in line with the Perinatal requirements of the NHS Long Term Plan are being developed.

4.2 We are using a variety of innovations to maximise and develop an integrated system working of all these services. From a strategic point of view there are various strategies across Greater Manchester that have specifically highlighted the importance of perinatal and parent-infant mental health and these include:

- Greater Manchester Mental Health Strategy
- Greater Manchester Children and Young People’s Plan
- Greater Manchester School Readiness Strategy

4.3 The Greater Manchester Health and Social Care Partnership and the Strategic Clinical Network have pooled resources to recruit clinical leads in perinatal mental health, PIMH IAPT and in PIMH, all of whom work closely

together to ensure both perinatal mental health and parent-infant mental health are held in mind. A range of strategic, operational; and clinical meetings are charged with leading and developing the GM Programme. In addition, professional development groups have been set up to focus on their needs (e.g., GM Specialist Perinatal and IMH Health Visitors). All these meetings and groups help to develop the cross fertilisation of perinatal and parent-infant mental health and knit services together. Most importantly, all strive to work closely in consultation with families to ensure ongoing learning and better support to families going forward.

5. Finding A Common Framework: The Thrive Model

5.1 A crucial part of developing an integrated service has been to find a common framework for conceptualising service delivery from all the various services. Some focus on diagnosis, some on measures of physical health, some on judgements of risk, and many more. Thriving is the concept that links all professionals together. Thriving is something that all can agree is a desirable outcome, and can be adapted in different ways appropriate to the service context. The concept also has additional benefits:

- a. It applies to everyone, whether or not they have “problems”;
- b. It does not require people or families to be labelled as “problems” or having a pathology in order to receive a service;
- c. The strengths of the family or family members are as important to thriving as are problems or weaknesses.

5.2 Responding to different levels of need

Clearly it is essential to provide services that respond appropriately to the specific needs of families. The THRIVE framework provides a way of doing this that gets away from an “escalator” model of increasing severity or



complexity to one that focuses on a wish to build on individual and community strengths wherever possible. The model was developed by the Anna Freud National Centre for Children & Families and the Tavistock & Portman NHS Foundation Trust [5].

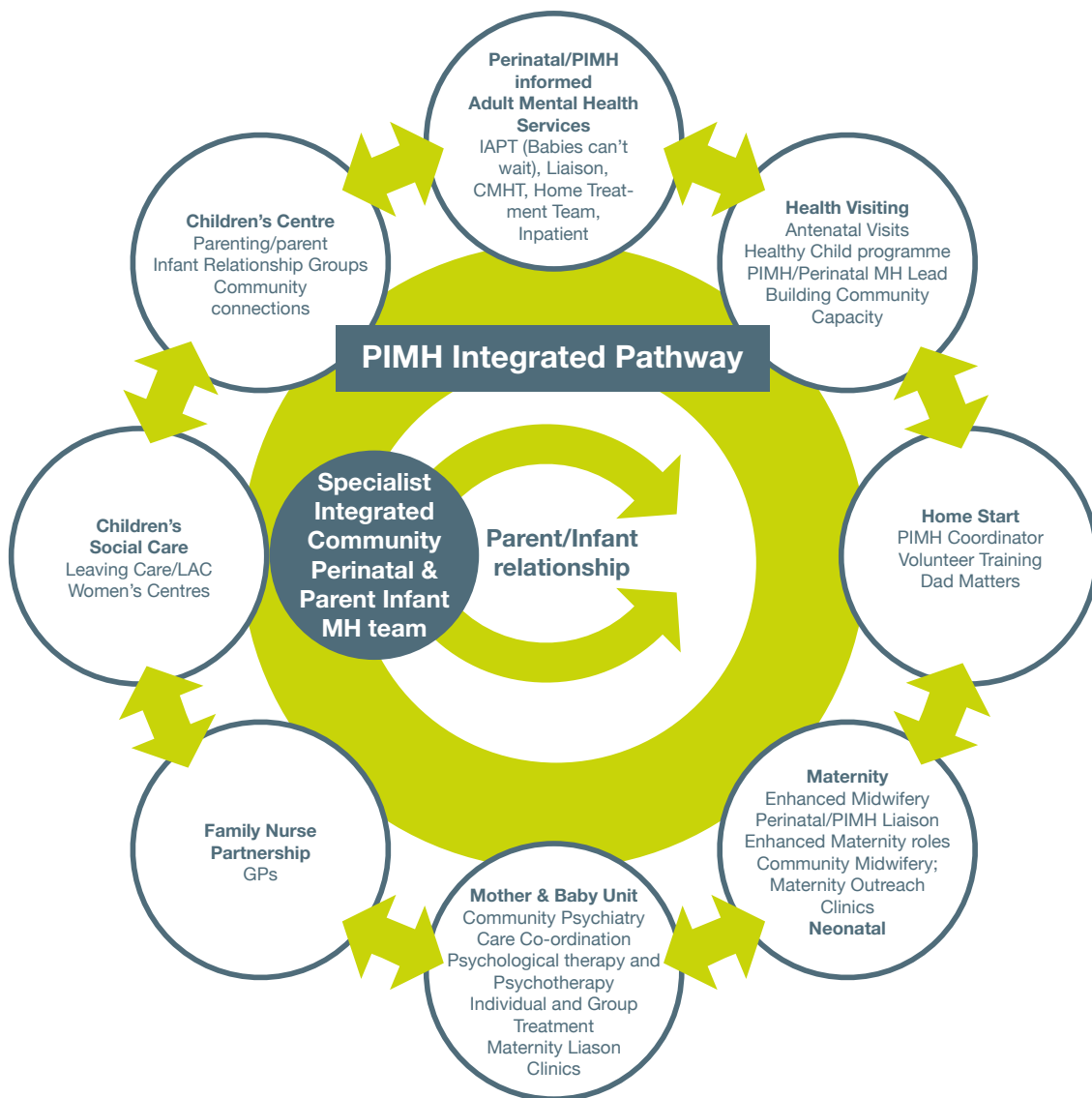
5.3 Greater Manchester has invested in the Thrive model, and in perinatal and parent-infant mental health. The Thrive model has been adopted to guide the development and provision of services. The Greater Manchester i-THRIVE (GM Implementation-THRIVE) [6] programme supports embedding this framework into all service provision.

5.4 Families who need more help will be identified early and offered comprehensive support in their locality. The support is best described through the Thrive model which illustrates how families can access support from different parts of the THRIVE framework depending on their particular needs at the time. The THRIVE framework conceptualises five needs-based groupings. The image on the left below describes the input that is on offer for each group; the image on the right describes the state of being of people in that group.



5.5 Unique in Greater Manchester is the whole system offer, across the wide range of NHS services, children’s services and partners in the voluntary and community sector all working together, supported by integrated Specialist Perinatal Services and Parent Infant Services, in line with each locality’s integrated pathway as the diagram below illustrates:-

Perinatal Infant Mental Health - GM: A Whole System



6. The Principle Services and what they do

The whole system transformation programme focuses on providing expertise and specialist services in perinatal and parent-infant mental health but equally enriches the provision across the whole GM system including mental health, maternity, health visiting, GPs children's services, and voluntary, community and social enterprise, etc. The aim is to promote emotional and mental wellbeing of parents and infants by developing a whole system offer to encompass universal, targeted and specialist offer from conception to the age of 2 in all ten GM localities.

In particular, GM is developing:

1. Parent Infant Mental Health Services
2. Specialist Perinatal Community Mental Health Services
3. Adult Psychological Therapy (IAPT) Perinatal PIMH Services
4. Voluntary and Peer to Peer Services



7. What is Infant Mental Health

Infant mental health describes ‘the young child’s capacity to experience, regulate, and express emotions, form close and secure relationships, and explore the environment and learn. All of these capacities will be best accomplished within the context of the caregiving environment that includes family, community, and cultural expectations for young children. Developing these capacities is synonymous with healthy social and emotional development”. (Zero to Three, 2001. Definition of infant mental health, Washington, CD: Zero to Three Infant Mental Health Steering Committee).

8. What are Parent Infant Mental Health Services?

8.1 Parent-infant mental health teams are multidisciplinary specialist teams. They have two aims:

- a. To promote the importance of the first relationship with the baby and parent/s.
- b. To offer direct therapeutic support to families where necessary, in order to support and strengthen these relationships.

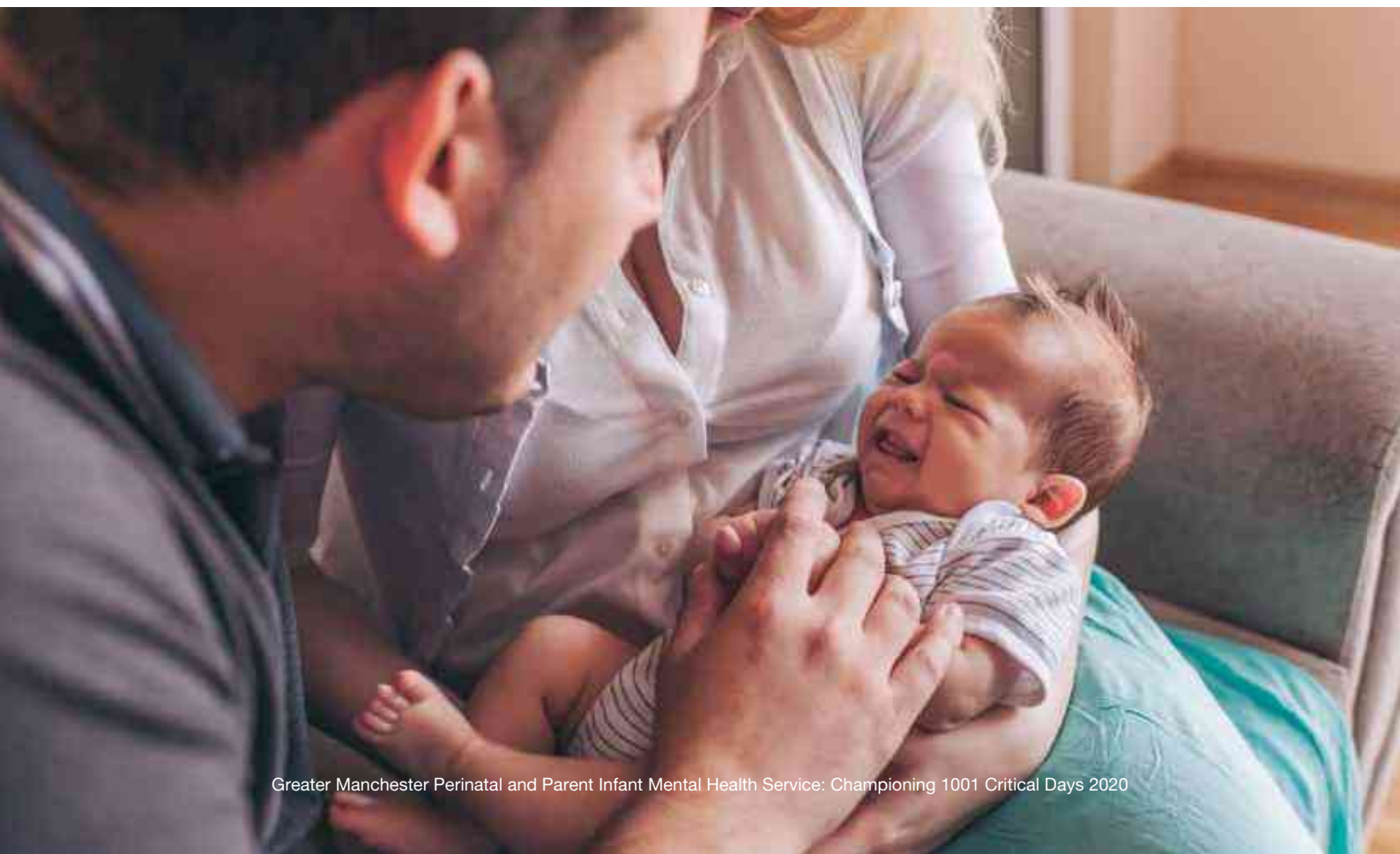
8.2 The teams work at multiple levels.

On one level they offer high-quality therapeutic support for families experiencing severe, complex and/or enduring difficulties in their early relationships.

They also work with colleagues to develop approaches to work with families who need less support and may benefit from time-limited therapeutic groups (such as baby bonding group). The team's expertise is shared with all families, colleagues and, services to ensure that the parent infant relationship is at the heart of the community.

8.3 The teams take a strategic lead across the borough and region.

They use their expertise to help the local workforce to understand and support parent-infant relationships. This may be offered through training, consultation and/or supervision to other professionals and advice to system leaders and commissioners, to enable a shared understanding and language. They also



interpret and respond to the growing evidence base and national guidelines, by developing new resources, and supporting services and colleagues to learn new ways of working, so that families are receiving the most up-to-date support.

8.4 Parent infant mental health services in GM - A local service in each borough

The development of the Tameside and Glossop parent infant mental health team, the Early Attachment Service (EAS) [7] has been adopted as the exemplar model for developing parent infant mental health services across the whole of Greater Manchester.

8.5 Small teams coordinating the efforts of many other people

EAS's innovation has been to provide a small specialist service that binds together many health and social service practitioners, along with volunteers. The team works closely with all colleagues and services, and

anyone who comes into contact with families during pregnancy and up to the child's 5th birthday (this also includes infants and children who are in foster care or have been adopted). This has been achieved through training other services and staff, commissioning specialist training in Tameside & Glossop and a rolling multi-agency staff development programme, including consultation and supervision to colleagues. This has led to a shared language in perinatal and infant mental health across the locality. Helping other services to support families, enables the specialists in EAS to focus more on families who present with more severe problems.

8.6 Psychoanalytic model

The **Early Attachment Service** focuses on both the inner and outer worlds of expectant and new parents and how they adapt to the changes and react to the emotions that are stirred up during the perinatal



period. Neither parent nor infant is a passive recipient of what is going on. While the infant is affected by the parent, the parent is also deeply affected by the infant. We were all once infants ourselves and we carry unprocessed residues of our own childhood experience. [8] Fraiberg referred to the experience as 'Ghosts in the nursery' [9], where a parent's current issues, as well as their own unresolved experience of childhood, may be stirred up and interfere with the relationship with the infant. Thus intergenerational factors, the antenatal experience, and the mental health of both parents are intrinsically linked. While during the perinatal period there is potential for breakdown, there is also potential for breakthrough. It is a time when both the parent and infant are open to new learning and change, making parent-infant intervention vital.

8.7 The Tameside & Glossop EAS has drawn together modern findings on brain development, attachment and social research, and has done so within a broadly psychoanalytic framework that focuses on the crucial significance of the relationship between the infant and its parents. The psychoanalytic perspective has the capacity to recognise and deal with problems that have their roots way back in the parents' own histories. Such problems can remain invisible until the birth of the baby, or around that time. Extending staff recognition beyond the here and now has had major benefits in treating families within the service. The team also focus on infant observation to inform their approach and work with families, so that the infant is central to their understanding and work.

8.8 Closely embedded with other services

EAS staff work within Maternity, Health Visiting, Early years, CAMHS, Home Start, Women's Centre, Social Services and Adult Mental Health Services. This ensures cross fertilisation of the approach and seamless pathways for parents into other services. It also allows EAS to see on the ground what is working, what is not, and where there are gaps, thereby enabling the team to strategically influence and shape services for families. For example, EAS developed a post-natal programme (Early Start) as there was a gap in provision of a parent-infant relationship group for parents and babies post-natally. A number of multi-agency staff have been trained in Baby Bonding which facilitates both individual and group approaches for parents antenatally and post-natally and focuses on reflective functioning and enhancing the parent-infant relationship.

8.9 Core functions of the PIMH

teams PIMH services are specialist psychotherapeutic services, clinically led by a consultant clinical psychologist or child and adolescent psychotherapist. The clinical leads are important not only in clinically managing the service, but strategically leading the development of parent-infant mental health services across the borough. The teams provide consultation services for all children and adult services, as well as providing direct clinical intervention.

8.10 To support the development of PIMH

across the region GM PIMH service standards and a service specification have been produced [10].

9. What is Perinatal Mental Illness?

9.1 Perinatal mental illness is mental illness that occurs in the perinatal period and also mental illness that is at a high risk of recurrence/relapse in the perinatal period for example Bipolar Affective Disorder and Post-Traumatic Stress Disorder. Specialist Perinatal Community Mental Health Teams focus on the assessment and treatment of mental illness in the perinatal period and relapse prevention.

Perinatal mental illness ranges from mild to extremely severe, requiring different pathways, management and care.

Perinatal mental illness includes:

- Affective disorders including depression in the perinatal period.
- Anxiety disorders including generalised anxiety disorder, panic disorder, obsessive compulsive disorder and post-traumatic stress disorder.
- Psychotic disorders including schizophrenia, schizoaffective disorder and bipolar affective disorder and postpartum psychosis.
- Co-morbid personality disorder, substance misuse, eating disorder and learning disability.



10. What are Specialist Perinatal Mental Health Services?

Specialist Mental Health Services in GM comprise:

10.1 Inpatient Perinatal Services (Mother and Baby Units - MBU) provide assessment and inpatient treatment to women with severe mental illness from 28 weeks pregnancy to one year postnatal. Women are admitted with their babies to preserve the mother and baby bond in times of mental ill-health. Women are supported to provide care for their baby whilst receiving treatment for their illness.

An inpatient service for mothers and their babies has been available in Greater Manchester for over 45 years. It is the second largest in the UK and, uniquely compared to all other MBUs, accepts admissions from 28 weeks gestation; all others decline admission until 32 weeks.

Clinical and operational leaders from the mother and baby unit supported the development of the Specialist Perinatal Community Mental Health Team (PCMHT).

The Perinatal Service takes a one team approach and is supported by the Lead Perinatal Consultant Psychiatrist who provides clinical leadership to the inpatient and community perinatal services.

10.2 Specialist Perinatal Community Mental Health Teams offer specialist psychiatric and psychological assessments and treatment for women with moderate to severe mental illness during the perinatal period. The Greater Manchester Specialist Perinatal CMHT is provided by Greater Manchester Mental Health NHS Foundation Trust

and works across all 10 localities of Greater Manchester. The GM Specialist Perinatal CMHT is aligned to the Mother and Baby Unit which has an established reputation for working alongside primary care, parent infant mental health services, maternity services, psychological services, acute adult and community mental health [11].

However, recognising that GM is a vast area, it was identified that more than one base would be required for the community service and therefore three bases are strategically sited across GM based on birth rate. The team works in a hub and spoke model in 3 clusters (localities are grouped together to ensure multidisciplinary team support) and are based at Laureate House (Wythenshawe hospital), Hexagon Tower (Blackley, North Manchester) and Prestwich Hospital.

10.3 Pre-conception Counselling Service is a unique service within the Specialist Perinatal Community Mental Health Team offering pre-conception advice to women with moderate to severe mental illness (past or current) focussing on the risk of relapse, relapse prevention, the optimisation of modifiable risk factors and advice and recommendations around the safety of psychotropic medication in pregnancy and breastfeeding.

10.4 Why are Specialist Perinatal Mental Health Services needed?

- Psychiatric disorder is a leading cause of maternal death, causing 12-15% of all maternal deaths in pregnancy and six months postpartum since 1997 and

remains one of the leading causes of maternal death today. Perinatal mental health problems affect at least 20% with 2-3% of women experiencing a severe psychiatric disorder. Perinatal mental illness can be serious and have devastating consequences for women, families and wider society.

- Women with perinatal mental illness require access to specialist skills and knowledge on the part of the professionals who care for them including specialist knowledge of the risks and benefits of medication in pregnancy and breastfeeding.
- Perinatal mental illness can also compromise the healthy emotional, cognitive and even physical development of the child with serious long-term consequences. Babies and children need to feel safe, protected and nurtured by caregivers who can be sensitive and respond appropriately to their needs. Unmet attachment needs may lead to social, behavioural or emotional difficulties, which can affect the child's physical and emotional development and learning – and therefore their life chances. In addition to this, fathers/partner's mental health can also be affected during this time. Women with perinatal mental illness, therefore, require access to teams who have the capacity to assess and treat mental illness in the mothers whilst at the same time enabling mothers to meet the emotional and physical needs of their infants.
- Women need to be supported by teams who have the capacity to respond to the different thresholds and timeframes related to the maternity experience including pregnancy and childbirth and the sudden onset of postpartum illnesses including postpartum psychosis.
- Services for women in the perinatal period need to be organised differently from general adult mental health services in the need to be responsive to the maternity context, timeframes of pregnancy and the different thresholds and response times to presenting problems. They also need to relate to the organisation of maternity services and children's social services.
- Women with non-psychotic conditions of moderate intensity may not meet the criteria for access to adult mental health services and require access to teams that are able to promote wellbeing, prevent relapse and work with women where the potential risk to her and her infant determines a lower threshold for referral and intervention.
- A critical mass of patients is essential to maintain experience and skill in managing complex conditions. No individual general adult mental health team will have sufficient experience of managing postpartum psychosis or severe postnatal depression. The epidemiology of these conditions suggest that a critical mass can only be achieved by providing specialist perinatal services.

10.5 Key Objectives:

The key objectives of the Specialist Perinatal CMHT is to safely and effectively meet the needs of mothers with moderate to severe mental illness and their infants in a community setting using a recovery model with three clear goals:

- A. **Inclusive** - of all women in Greater Manchester. Experience from the existing outpatient clinics suggests that vulnerable childbearing women (including homeless women, religious and cultural minorities, vulnerable migrants, refugees and asylum seekers, victims of domestic abuse) access secondary mental health services less often or are in a more advanced stage of their illness when they do, compared with the background population.

The Specialist Perinatal CMHT will take steps to provide equitable access to vulnerable groups by linking with universal services which provide general care or support to all women who are pregnant and post-natal. The service was implemented from February 2018 onwards and works with all the Greater Manchester maternity services to ensure early identification of women who require specialist perinatal care from first booking appointment onwards.

They also have strong links with health visitors, primary care, children's social care, and other agencies in the community, providing support for vulnerable women in order to ensure right care at the right time to is likely to be facilitated. The service will also ensure that appropriate interpreting services are available and that educational material and other relevant information is available in required languages.

- B. **'Wrap-around'** – the service provides a structured, creative and individualised planning process, which is relevant to the mother and her child. Care plans will consider the need of the partner/ carer and the infant's siblings and initiate appropriate assessment or support for the family.

- C. **Comprehensive** – by providing medical, nursing, psychological and social care support in a community-based setting and facilitating self-management, input from the third sector, and women with lived experience.

10.6 Multidisciplinary approach:

The mental health multidisciplinary team approach to care and consists of

- Perinatal consultant psychiatrists
- Trainee psychiatrists
- Operational Leads
- Team managers
- Training manager
- Registered mental health nurses
- Occupational therapists
- Psychologists
- Social workers
- Experts by experience peer navigators

10.7 Specialist Perinatal Community Mental Health Team Remit.

The remit of the Specialist Perinatal Community Team is extensive:

- Provide preconception counselling for any woman wishing to discuss how the perinatal period might affect mental health prior to pregnancy.
- Provide preconception counselling for any woman wishing to discuss the risks and benefits of psychotropic medication in the perinatal period.

- Identify and manage women who are at risk of deterioration in their mental health.
- Assess and manage women who present with new or emerging moderate/severe mental illness in the perinatal period in the community.
- Identify women in need of admission to inpatient care at the Mother and Baby Unit (MBU).
- Manage women recovering from moderate/severe mental illness in the perinatal period who are discharged from inpatient care (MBUs).
- Provide support and advice to colleagues in primary and secondary care, maternity, health visiting and social care.
- Co-work with services involved in the care of women presenting with mental illness in the perinatal period and co-morbidities/ complexity e.g. substance misuse services, forensic services, eating disorder services.
- Collaborate with a wide network of agencies involved in the care of women with moderate/severe mental illness in the perinatal period.
- Educate and train colleagues in maternity settings, primary care, secondary care, children's social care, and 3rd sector organisations as well as women and their families on the detection, assessment and management of mental illness in the perinatal period.

The Specialist Perinatal Team uses a bio-psycho-social model to assess and provide care for women in the perinatal period. This includes, but is not exclusive to:

Preconception Counselling:

Preconception counselling allows an opportunity for consideration of an individual's risk of relapse in the perinatal period prior to pregnancy (and possible psychotropic foetal exposure).

Women will be offered a one-off counselling appointment with a Consultant Perinatal Psychiatrist to discuss:

- the risk of perinatal mental illness in a prospective perinatal period
- psychoeducation around the risk of inheritance of a given mental illness (e.g. bipolar affective disorder)
- a risk and benefit discussion around the use of psychotropic medication in pregnancy and breastfeeding
- consideration for the need of specialist perinatal community mental health team input in a prospective pregnancy +/- consideration of MBU admission
- a discussion around addressing modifiable risk factors including smoking cessation and promoting wellbeing in the perinatal period

Assessment and management of women presenting with new/emerging perinatal mental illness in the perinatal period:

- Women presenting with moderate to severe mental illness can be referred to the Specialist Perinatal Community Mental Health Team through a variety of sources including primary and secondary care, maternity services, health visiting and child and family social care.
- Women presenting in pregnancy will have access to obstetric liaison clinics where both maternity and psychiatric care can be provided in a non-stigmatised setting
- Initial assessment will include diagnosis, formulation, risk assessment, developing a shared understanding of an individual's mental health needs and care planning, parent-infant assessment, psychological assessment, occupational therapy assessment and safeguarding assessment.
- Particular focus will be on the impact of a perinatal mental illness on the individual woman and her infant, the mother-infant relationship and the wider family.
- Management of perinatal mental illness includes the use of psychotropic medication, psychological input (through individual therapy and group therapy) including compassion-focussed therapy, cognitive-behavioural therapy, family therapy and parent-infant psychotherapy, occupational therapy (including ADLS assessment, developing coping strategies, structured routine and psychoeducation), relapse prevention work and wellbeing.
- Care is co-ordinated from assessment to discharge by a care co-ordinators within the Specialist Community Perinatal Mental Health Team skilled in multi-agency working. Care plans will be co-produced and will identify the need for psychiatric outpatient review, psychological input including parent-infant work, 32-week pre-birth planning, peri-delivery care planning, postnatal care planning, social care liaison, risk management and transfer of care throughout the perinatal pathway.
- Women requiring inpatient admission will be offered a tour of the Mother and Baby Unit and care co-ordination from the Specialist Perinatal Mental Health Team throughout admission and on discharge to provide continuity of care throughout the inpatient journey.
- Partners of women presenting to the service will be routinely offered an opt-in mental health assessment with a view to supporting their mental health needs by signposting to 3rd sector organisations including Dad Matters and primary and secondary care as appropriate by 2023.

11. What is Adult IAPT?

11.1 Improving Access to Psychological Therapies or (IAPT) services provide evidence based treatments for adults with anxiety and depression.

IAPT services are characterised by 3 domains:

- A. Evidenced based psychological therapies.
- B. Routine outcome monitoring.
- C. Regular, outcomes focused supervision.

11.2 IAPT services traditionally provide evidence based talking treatments to adults who present with a common mental health problem. Since IAPT services were rolled out in 2008 there is evidence of a reduction in the prescription of antidepressants in the long term; this is thought to be due to the effectiveness of talking therapies compared with medication alone. There has also been a reported reduction in use of GP appointments to seek care for common mental health problems.

11.3 Across Greater Manchester IAPT services are commissioned by the ten Clinical Commissioning Groups to meet the needs of the local population in line with the national IAPT targets. These are:

- Prevalence - that access rates meet expected proportion of prevalence.
- Recovery - that at least 50% of people who finish treatment should recover.
- Waiting times - that 75% of people referred should start treatment within 6 weeks of referral, with 95% starting treatment within 18 weeks of referral.

11.4 The staffing of services is based on IAPT recommended skill mix of staff, mainly low intensity Psychological Wellbeing Practitioners and high intensity IAPT trained staff offering high intensity CBT. Some services also offer approved counselling for depression or couples counselling for depression and some teams offer IAPT approved IPT (Interpersonal Psychotherapists). Other interventions offered in some localities are mindfulness and Cognitive Analytic Therapy.

11.5 The teams also have additional staff, usually Clinical Psychologists, who may offer enhanced clinical supervision and interventions.

12. What Is IAPT Perinatal and Parent-Infant Mental Health?

12.1 Health Education England considers the perinatal client to be a system involving the parent, the infant and the parent infant relationship, suggesting professionals:

“Give equal attention to the parent, the child and the parent infant relationship”
(Health Education England 2016)

12.2 Since 2009 the IAPT Positive Practice Guidance has encouraged clinicians to consider the relationship between the mother’s mental health, her infant’s mental health and how working in the parent infant relationship can strengthen both. The more recent Positive Practice Guidance of 2013 broadens this to include fathers [12].

“Maternal perinatal mental health is closely linked to that of the infant. This is a time for preventive perinatal interventions in order to promote a strong attachment and positive parenting, thereby reducing mental health problems later for both mother and child”
(IAPT 2009 Positive Practice Guide)

12.3 IAPT positive practice recommendations advise that:

“There is growing evidence that treating maternal (or paternal) mental health problems can reduce the future incidence of mental health problems in children.”

”Working with mothers and their infants to improve their interaction and attachment can also increase maternal engagement in therapy.”

12.4 IAPT recommend that perinatal clinicians need to keep the baby in mind and to work within the parent infant relationship to promote a positive parent infant attachment. IAPT guidance advises that by focusing on both parent and infant the risks of the infant developing mental health problems in the future, as does the risk of relapse for the parent effectively leading to a reduction in future demand upon health and social care providers.

12.5 Perinatal and Parent-infant Mental Health (PIMH) IAPT in Greater Manchester

In 2015, Tameside and Glossop established a ‘Babies Can’t Wait’ agreement [13] which means all pregnant women or those with children under the age of two years and their partners can access Healthy Minds (IAPT) directly following referral, avoiding any wait. This has meant it is possible for parents to receive support for their own mental health, including through self-referral.

With the close partnership between adult mental health and the local parent infant mental service (Tameside and Glossop Early Attachment Service), this agreement raised the importance of parents needing to access help for their own mental health during the perinatal period, and also raise the importance of the parent-infant relationship.

The ‘Babies Can’t Wait’ agreement widens the focus from parental mental health to also capture parent infant mental health is currently being rolled out across all Greater Manchester IAPT services. The aim is to ensure that all pregnant women or those with an

infant under the age of two, and their partners, can have direct access to a range of psychological therapies.

12.6 The Greater Manchester Perinatal and Parent-infant Mental Health IAPT Project Leads have designed a Train the Trainer training for all IAPT localities. The training enables IAPT services to establish Perinatal and Parent-infant Mental Health Champions. It also details the “Babies Can’t wait” agenda which explains why IAPT services need to prioritise parents on the pathway, provides guidance on the assessment and treatment of parents during the perinatal period, and also how to keep the baby in mind whilst offering interventions to an adult population. Examples of good practice are also being shared with localities to support the development of multi-agency Perinatal and Parent-infant Mental Health pathways.

The IAPT Babies Can’t Wait Training aims to:

- A. Introduce IAPT clinicians to the Perinatal and Parent-infant Mental Health Frame of Mind.
- B. Have space to consider how to adapt routine IAPT therapy in order to hold the Perinatal Parent-infant Mental Health Frame of Mind
- C. Consider how IAPT teams can hold the Perinatal Parent-infant Mental Health Frame of Mind when reviewing service design and policy
- D. Increase understanding in IAPT workers of what “Babies Can’t Wait” and “Keeping the Baby in Mind” means

E. Gain understanding of why IAPT clinicians need to keep babies in mind

F. Develop skills and confidence in how to keep baby in mind during the parents IAPT journey

G. Increase awareness in IAPT to whom they can refer parents for support to keep the baby in mind

H. Find out about other agencies involved in the parents and baby’s journey to wellbeing and learn about who IAPT staff need to be liaising with in order to promote an integrated whole systems approach to PIMH

12.7 Perinatal and Parent-infant Mental Health IAPT Standards [14] have been developed by the Greater Manchester PIMH leads as a guide to the on-going developments in Adult IAPT services in order for us to reach the ambition of meeting the emotional and mental health needs of parents and infants. The Perinatal Parent-infant IAPT Standards are based on the offer and experience of good practice from Healthy Minds IAPT services in Tameside and Glossop and Stockport. It is proposed that all GM IAPT services strive to meet the same standards by March 2020.



13. Peer to Peer Support

13.1 What is peer to peer support?

Peer support is when people use their own experiences to help each other. There are different types of peer support, but they all aim to bring together people with shared experiences to support each other and provide a space where you feel accepted and understood. This represents a very important part of the support available to families. Their contributions are vital, not just because they offer a way of increasing workforce resources for very little cost. The support given by peer support volunteers could probably not be achieved by an equivalent number of paid workers, simply because the nature of the relationship with the family is peer to peer, rather than professional to family. This brings huge potential benefits in terms of

trust, the ability to engage families who are less willing to be involved with statutory services, and the possibility of developing a relationship with the family that can make it more likely that positive change can occur in the future. [15]

13.2 There are many peer support organisations across Greater Manchester supporting families with varying needs, for example, the charity Spoons offers support to families with babies receiving neonatal intensive care in the Greater Manchester area, and the charity Rainbow supports families who have a child with a life threatening or terminal illness.

We are now working to develop partnerships with other peer support organisations, such as Spoons, Rainbow, Proud to Be parents and



community groups from culturally diverse backgrounds, to ensure we are aware of all families who need support and begin to ensure services are better equipped to meet their needs.

An example of well-established good partnership working is with Home-Start.

13.3 Home-Start and Perinatal and Parent-infant Mental Health in Greater Manchester

Manchester Home-Start's role in perinatal and parent-infant-mental health started in Tameside in 2014 when a partnership was formed between Home-Start Oldham, Stockport & Tameside (HOST) and Tameside & Glossop's Early Attachment Service. Families supported through Home-Start PIMH are those that may not require specialist services but who require more than universal services. They are often parents who are suffering from anxiety and depression, who are feeling isolated, who lack additional family support and who would struggle to attend services outside of the home. Sometimes families are in receipt of specialist services and benefit from the support to help them engage and attend appointments. Sometimes, families are referred when specialist services are ready to step out but the family still needs some lower level support.

13.4 Specialist training of volunteers

A review of the Tameside and Glossop integrated parent-infant mental health care pathway in 2012 [16] indicated that more support was required for parents who were at risk due to mild to moderate mental health needs. The existing professional support available for these parents is limited, and professional interventions cannot

replace those functions that would traditionally have been carried out by the communities in which people live. This was felt to be an area where appropriately trained volunteers could have a major impact. The partnership between Home-Start Oldham, Stockport & Tameside (HOST), Tameside & Glossop's Early Attachment service and Tameside Health Visiting service was able to build on the Home-Start's expertise of using peer support volunteers to offer home visiting support to families with children in the early years. As well as receiving Home-Start's standard volunteer training, PIMH volunteers are trained in baby brain development, baby states, containment, reflective functioning and how gently to encourage a positive parent-child relationship to develop. There is a therapeutic benefit to experiencing the training, which better equips the volunteers emotionally for this complex work with families.

Evaluation of this work showed a clear positive difference between the support received by families with PIMH trained volunteers, compared to non-PIMH trained volunteers [17]. As a result of the successful work in Tameside, the work spread to Stockport in 2016 thanks to investment from Stockport CCG. In 2018 the approach was adopted by Home-Starts and CCGs in Manchester, Trafford, Salford and Rochdale with Home-Starts employing a PIMH Co-ordinator and playing a key peer support role in the whole system approach.

13.5 Dad Matters

Dad Matters started at Home-Start Oldham, Stockport & Tameside (HOST) in partnership with Tameside & Glossop's Early Attachment Service and the Child Outcomes Research Consortium from the Anna Freud

Centre in 2016 funded by a grant from The Health Foundation [18]. The grant enabled us to create Dad Matters which aims to support dads in the perinatal period in order to help them have a good relationship with their baby and to ensure they get any help they might need with stress, anxiety and mental health issues. The project also aims to raise awareness of the importance of dads through a wide range of activities and through social media and to help services to think about the way they involve dads in all aspects of the journey through pregnancy and beyond.

A key part of this work is ante-natal “Dad Chats” in which dads-to-be are given the opportunity to share any concerns and anxieties they may have and to ask any questions they might be afraid to ask in front of their partners. This work is also happening with dads on the Mother and Baby Unit.

- 13.6 Dad Matters has been funded from GM Transformation funding for a year until March 2020. The project is working in each locality to establish a team of Dad Matters volunteers to support the development.



14. The Greater Manchester Whole System Approach: How Do We Work Together For Families?

14.1 Integrated Parent Infant Mental Health Pathway

Each locality is being supported to develop an Integrated Parent Infant Mental Health Pathway in order to promote:

- Good infant and parent mental health for the population of Greater Manchester,
- Parent-infant relationships,
- The emotional well-being of children
- Contribute to improved school readiness

14.2 The need for an Integrated Pathway is informed by the wealth of evidence emphasising the importance of supporting child development and family relationships in the first two years of a child's life. As the 1001 Critical days manifesto attested, babies cannot wait. This early period of a baby's life is a key determinant of their future intellectual, social and emotional wellbeing and the economic argument for intervening early is clear.



14.3 Many factors may influence family wellbeing and the parent-infant relationship in the perinatal period. These include parental mental health problems, domestic abuse, substance misuse, trauma, poverty, social exclusion and a lack of social support. This emphasises the importance of services working together effectively.

The underpinning principles of the pathway are:

- Using Thrive as a model to ensure all supports are available to families
- Early Intervention and prevention to support families to stay well and prevent problems developing
- Promoting effective, evidence-based and timely interventions
- Working with, and involving, parents and their families in all decisions
- Ensuring we work with the significant carers in the infant's life. This includes mothers, fathers, partners and/or carers
- Services working together to coordinate care and share information appropriately with documented information about all resources within each locality
- Effectively safeguarding parents and children and considering the voice of the baby
- A commitment to improve the experience of service users by listening to their feedback and using it to improve the training of staff and development of services

14.4

Greater Manchester has developed an integrated perinatal and parent-infant mental health pathway template for localities to draw on. [19]

15. Developing the Workforce

15.1 Across GM the introduction of perinatal and parent-infant mental health services is at a relatively early phase of development. An exception is the Tameside and Glossop Early Attachment Service which has been running for over 13 years. Apart from this, most professionals working in specialist services will not have had access to or undergone comprehensive specialist training prior to starting in their role. This requires a great deal of consideration especially in understanding the needs of our growing workforce in terms of training, supervision and developing peer support networks. This is particularly important given the requirements of staff to hold high risk case loads that can be emotionally, psychologically and intellectually demanding.

We are pleased to report that recruitment to both new and existing posts has attracted lots of interest. At the same time, many applicants are in need of appropriate training, knowledge and experience.

Generally speaking, there has been a lack of investment in training existing staff working with families during the perinatal period. Many midwives, health visitors and mental health nurses report a low level of confidence and knowledge in perinatal mental health and parent infant mental health. It is vital we invest in this training to improve identification of risk factors, to ensure adequate treatment and improve coordination between services. Including a strong focus on the infant, father, parent and other family members is as important as attending to the mother's mental ill health.





It must be remembered training must include professionals and services whose remit is very broad base, example, GPs, Children's services, community groups. For example, in GM we have a community group that offers support to families specifically from Persian communities. Such groups are typically outside the NHS, but their inclusion in the broad framework has the potential to enormously improve the penetration and effectiveness of our provision.

In order to have a competent, confident and resilient workforce, there needs to be:

- A comprehensive induction to empower staff to feel confident in perinatal risk assessment, early detection and diagnosis and developing care plans to comprehensively and thoughtfully meet the mother and infant's mental health needs.
- A rolling training programme focussing not only on the mental health needs of the mother but also the infant, the parent-infant relationship and the wider family.
- Shared learning across the entire workforce.

- Reflective practice and regular supervision.
- A focus on developing a workforce that can disseminate training to the wider professional network to improve working relationships across pathways and across professional interfaces.
- A focus on developing a workforce that is able to promote mental wellbeing in the perinatal period across social communities particularly marginalised and minority populations.
- We need to help services recognise the importance and value of working with peer support.

15.2 Competency and training. Because of the complexity of this field, meeting the training needs of staff is a major and continuing part of service development. Some training will be long term, e.g., achieving a qualification in parent-infant psychotherapy. Other training may be much shorter, but the vital aspect needed by all staff is to gain a firm foundation in the understanding of perinatal and infant mental health.

Training in specific interventions is very valuable, but the use of such therapies needs to be on the basis of a solid foundation in therapeutic clinical skills, and used only where appropriate to the case, and supported throughout by high quality supervision. A high level of clinical skill and judgement is what we are primarily aiming for through the training programme. This foundation needs to be cross-discipline. The Perinatal, PIMH and IAPT services cannot operate in silos; they need to work together in an integrated way.

15.3 Supervision and reflective practice is a key requirement in everyone's clinical practice, but this is not always prioritised. It is recommended that all clinicians receive clinical supervision to support their development and practice and to help them process the emotional strain and distress that can come with working in this vulnerable time with families.

15.4 Given the importance of skills development, we see this time as a real opportunity to develop a multi-agency training matrix which will lead to everyone having a shared language and approach to evidence informed practice which integrates both perinatal mental health and parent-infant mental health.

15.5 **Training Matrix**

A comprehensive training matrix drawing partly on the Tavistock and Portman Perinatal Competencies, partly on the AIMH (Association of Infant Mental Health) Infant mental health competencies, and reflecting GM needs has been developed, with recommended trainings based on the core competencies.

The Thrive model has been used to ensure that not only are the training

needs of staff being met, but that they match the needs of the families.

15.6 The matrix has been developed with consultation from a representative collection of services and professional groups. It is comprehensive in that it addresses both the need to raise awareness of perinatal and parent-infant mental health in the general population and the need to ensure specialist practitioners are trained in the best available interventions to equip them to work with complex families. The matrix is based on experts' views of the essential competencies for staff. It includes both immediate as well as long term training needs, recognising that gaining specialist skills, experience and knowledge takes time [20].

15.7 Perinatal and parent-infant mental health is a growing field and the training needs are vast. There are not always specific trainings available to meet the core competencies; they need to be developed. As the evidence base grows it is important continually, to draw on the developing clinical evidence base.

15.8 **GM training library**

Currently, there is a large training need in perinatal and parent-infant mental health. While Greater Manchester is investing in commissioning training for staff, not all the necessary training is available externally. Therefore, the significant expertise within GM is being drawn on and a task group is developing a training library in perinatal and parent-infant mental health. The task group is made up of a range of professionals who all work in different areas of perinatal and parent-infant mental health, for example, perinatal psychiatry, perinatal mental health nurses, obstetricians, midwives, health visitors, IAPT practitioners, clinical

psychologists, child psychotherapists, social workers and many more.

15.9 The aim is to produce standardised presentations that can be delivered throughout GM. The presentations will undergo review on an annual basis by the SCN training working group to keep them up to date. Feedback will be obtained from audiences which will be used to inform future presentations and the wider training strategy.

15.10 So far the GM IAPT PIMH leads have developed a Babies Can't Wait training for staff working in adult IAPT services. It is a train the trainer model and establishes a PIMH champion within the local IAPT service.

15.11 **Commissioned training:** Funding from Health Education England (HEE) perinatal mental health and from the GM MH Transformation fund has been invested in training at a multi-agency level to facilitate cross fertilisation of ideas, a shared language and understanding and developing relationships across professionals and Greater Manchester. This approach has worked well and has led to a shared approach and language. Commissioned training has included the 2 day iHV in perinatal and parent-infant mental health, Pregnancy to Preschool course, Compassion Focused Therapy in the perinatal period and Neonatal Behavioural Observation training.



Hope

16. Investment and Commissioning: How are GM Commissioners Supporting Parents and The First 1001 Days Of Life?

16.1 The Greater Manchester Health and Social Care Partnership has committed to perinatal and parent-infant mental health as one of the key transformation programmes. The Partnership has recognised the need to take a whole system approach develop a rich offer, developing and building on all existing services in the pathway.

16.2 Not only is significant transformation funding being invested to pump prime the establishment of the GM wide Specialist Perinatal Community Mental Health Service, there is also an expectation that the ten CCGs will mainstream the funding for the Specialist Perinatal Mental Health Teams from 2020 as well as developing Parent-infant focussed IAPT and specialist Parent-Infant Mental Health Teams. This will total an additional £6.3m recurrently by 2021. Since this was agreed the perinatal expectations of the Long Term Plan has meant we need to review our offer and there will be a need for additional investment. This work is being undertaken.

16.3 Commissioning of three key components. In Greater Manchester it is expected that all ten Clinical commissioning Groups (CCGs) will invest in three key parent infant mental health developments

1. Specialist Perinatal Community Mental Health Team – centrally commissioned team covering GM in three clusters
2. Perinatal/Parent Infant focused IAPT – swift and easy access to psychological therapy for all

parents in pregnancy and the first two years of their infant's life. Funded within IAPT growth.

3. Parent Infant Mental Health Team – a psychological and psychotherapeutic focussed multi-disciplinary multi-agency team in each of the ten localities with responsibility for leading, training, supervising across early years services as well as providing therapeutic interventions to families most at risk.

16.4 The key principles for transformation are to:

- Ensure delivery of the NHS Long Term plan and access to the specialist perinatal CMHT for up to 3,665 women with moderate to severe mental illness for up to 24 months across GM by 2023/24
- Promote emotional and mental wellbeing of parents and infants by developing a whole system offer encompassing the universal, targeted and specialist offer from conception to the age of 2 in all ten GM Localities.
- Ensure the Specialist Perinatal CMHT work alongside colleagues in each locality within a rich offer of family focussed services for both mothers and fathers/partners in the 1001 Critical days.
- Offer families choice and control through a wide range of easy accessible, timely, evidence-

based support close to home when they need it, notably connecting families with peers and their community.

- Supporting identification of non-recurrent funding to support workforce development across whole system.

16.5 The commissioning of perinatal and parent infant mental health services requires commitment across the whole system. Commissioners and clinical leads of children's services, CAMHS, public health, adult mental health and children's services need to understand perinatal and parent infant mental health, the GM Model, existing resources and requirements for services within their portfolio. They need to work together to agree roles and responsibilities to drive through the developments required. It is recommended that a lead commissioner and clinical lead are appointed to work with all partners and lead on the following tasks in each locality.

A range of GM resources are available to support this investment

- PQN Community Standards – Specialist Perinatal Mental Health Teams
- GM IAPT PIMH Standards
- GM Parent Infant Mental Health Service Specification (including standards)
- GM Maternity Service Specification (to be revised)
- GM Health Visiting Service Specification (to be revised)
- Exemplar Integrated PIMH Pathway

- Mapping existing resources across all providers and identify elements that can be focussed in line with the GM model
- Facilitating the development of an integrated pathway
- Ensuring development has the profile needed across the whole system to ensure focus and support across all providers, potentially using contractual incentives such as commissioning intentions, local CQUIN and quality, performance and outcome reporting
- Identify all funding streams available to support this priority
- Develop a business case as required bringing together existing resources with new ones

The GM Specialist Perinatal Community MH Team follows the Royal College of Psychiatrists CCQI standards which ensure the distinct function of the team. The Specialist Perinatal CMHT works across the whole of GM in three clusters, commissioned by Manchester CCG on behalf of the ten CCGs.

17. How well are we doing?

- 17.1 GM Specialist Perinatal Community Team** - working in the three-cluster model this team has been building capacity since February 2018. In 2018/19 907 women received a service against a target of 448. The team is on course to meet the GM 5YFV target of 1,120 women seen between 1.04.2019 – 31.03.2020.
- 17.2 The NHS LTP targets** now require an additional 652 women taking the total of women who need to be supported across GM by 2020/21 to 1,772. This is not yet commissioned and will not be achieved.
- 17.3 Parent Infant Mental Health Teams** - since April 2018 all localities have established/are in the process of establishing a Parent Infant MH Team in line with the GM Model. It is recommended that these teams include a VCS partner (such as Home-Start) to provide a wide reach. Standards and service specification templates have been developed for new services to guide their development and growth.
- 17.4 Parent Infant Focused IAPT** - a growing number of IAPT services are developing their offer in line with the GM Babies Can't Wait IAPT standards. All localities have or are working towards achieving these.
- 17.5 Dad Matters** – this Home-Start programme has been rolled out across GM to promote meeting the mental health needs of fathers across all settings. Three localities so far have committed additional investment to establish a local service.
- 17.6 Workforce Development** – funded through the Strategic Clinical Network and GM Transformation Funding an ambitious programme of training, development and supervision is being delivered, led by a multi-disciplinary clinical leads group.
- 17.7 SCN GM Perinatal and Parent Infant Mental Health Steering Group** – this group has been re-established to ensure wide engagement, to provide clinical consensus and promote delivery of the national Better Births requirements.
- 17.8 Peer to peer support** – a project to develop this aspect across all ten localities is underway.
- 17.9 Outcome and Performance Reporting** – a working group has been established to develop shared outcomes and agree a reporting framework.

18. Research in Greater Manchester

The whole system approach to perinatal and parent-infant mental health in Greater Manchester provides a rich opportunity to develop research in all areas and there are a number of research projects currently under way. The advantage of integrated perinatal and parent-infant mental health services and the underpinning of universal services is currently unique within the country. We need to seize the opportunity to encourage large scale university level research on the long-term impact of the services we are providing. We look forward with anticipation to the outcomes of these studies.

19. Summary

Greater Manchester has set itself ambitious plans and investment to develop an integrated system where perinatal and parent-infant mental health services and perinatal IAPT services work closely to ensure every baby and parent gets off to a good start in their new relationship together.

A good start has been made but there is still a lot of work to do. With the NHS Long Term Plan there will be a greater focus on integrating services, continuing to develop close working relationships, reaching out to minority groups and ensuring that families are engaged in the ongoing development and review of services.



Appendix

Public Health England: Perinatal mental Health needs Fingertips Report

Data quality: ■ Significant concerns ■ Some concerns ■ Robust

* a note is attached to the value, hover over to see more details

Indicator	Period	England	Greater Manchester	NHS Bolton CCG	NHS Bury CCG	NHS Heywood, Middleton And Rochda...	NHS Manchester CCG	NHS Oldham CCG	NHS Salford CCG	NHS Stockport CCG	NHS Tameside And Glossop CCG	NHS Trafford CCG	NHS Wigan Borough CCG
Postpartum psychosis: Estimated number of women ■	2017/18	984	55	6	3	4	11	5	6	5	5	4	6
Chronic SMI in perinatal period: Estimated number of women ■	2017/18	984	55	6	3	4	11	5	6	5	5	4	6
Severe depressive illness in perinatal period: Estimated number of women ■	2017/18	14766	823	85	51	67	169	76	83	75	72	61	83
Mild-moderate depressive illness and anxiety in perinatal period (lower estimate): Estimated number of women ■	2017/18	49219	2743	283	171	223	565	254	275	250	241	204	278
Mild-moderate depressive illness and anxiety in perinatal period (upper estimate): Estimated number of women ■	2017/18	73828	4114	425	256	335	847	380	413	375	362	306	416
PTSD in perinatal period: Estimated number of women ■	2017/18	14766	823	85	51	67	169	76	83	75	72	61	83
Adjustment disorders and distress in perinatal period (lower estimate): Estimated number of women ■	2017/18	73828	4114	425	256	335	847	380	413	375	362	306	416
Adjustment disorders and distress in perinatal period (upper estimate): Estimated number of women ■	2017/18	147656	8228	849	512	670	1695	761	825	749	724	611	833

<https://fingertips.phe.org.uk/profile-group/mental-health/profile/perinatal-mental-health/data?page/0/gid/1938132957/pat/120/par/E54000007/ati/154/are/E38000182>

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To access many of the Greater Manchester documents that are listed in this document please go to: <https://hub.gmhsc.org.uk/mental-health/our-work/> and scroll down to the Perinatal and Parent Infant Mental Health Section.

