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**Division of
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Perinatal Service Provision: The role of Perinatal Clinical Psychology

**A British Psychological Society briefing paper for
NHS Commissioners**

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Please note that this paper replaces the Obstetric section of the British Psychological Society's Briefing Paper No 8, which refers to psychology services in Obstetrics and Gynaecology services (1995).

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2. Executive summary

This paper provides full information regarding the key role of specialist clinical perinatal psychologists in the care of women during the perinatal period (pregnancy and up to one year postnatally) and the important contribution they make to perinatal services across the antenatal, intrapartum and postnatal periods. It has been written for service commissioners, clinical psychology service managers, service users and other professionals. The paper details the role of clinical psychology in maternity services, neonatal units, specialist community perinatal mental health services, and mother and baby units (MBUs). The paper concludes with recommendations regarding service structure, service standards and staffing levels to enable the provision of effective and efficient psychological care. The challenge for commissioners of services lies in the patchy and fragmented delivery of current perinatal mental health care.

Key points

- Research evidence suggests that at a conservative estimate, the long-term costs of perinatal depression, anxiety and psychosis in the UK is £8.1 billion per year, the equivalent of £10,000 for every single birth with the majority of the cost being due to adverse impacts on the child (Bauer et al., 2014).
- Women often have a clear preference for psychological support for mental health problems over more medicalised interventions such as pharmacology in the perinatal period. This need underpins the critical role of clinical psychology in the delivery of high quality therapy during the perinatal period (Buist, O'Mahen & Rooney, 2015).
- Psychological interventions are effective in psychotic illnesses, severe depression and anxiety, perinatal OCD, personality disorder, post-traumatic stress disorder and bipolar disorder (BPS, 2000), and it is recommended that every specialist perinatal mental health team should include clinical psychology sessions. In addition, clinical perinatal psychologists are qualified to work with mothers and babies on enabling sensitively attuned mother-infant interaction during this critical period.
- Various national policy drivers that advocate for improved perinatal services emphasise factors that can be directly facilitated by specialist clinical perinatal psychology leadership (e.g. NICE Antenatal and Postnatal Mental Health guidance (NICE, 2014) and guidance from the Joint Commissioning Panel for Mental Health (JCPMH 2012)). These include the provision of high quality evidence-based psychological interventions, clinical supervision and perinatal training for front-line staff, proactive screening and detection, and the need to ensure continuity and integration of holistic care across medical and community settings.
- In their *Guidance for Commissioners of Perinatal Mental Health Services* the JCPMH (2012) also recommend the development of local perinatal mental health strategies that outline local need and focus on the implementation of a high quality perinatal psychology service to meet identified need.
- Clinical psychologists are experts in the delivery of evidence-based psychological therapies and in robust service evaluation and research. They are trained to provide leadership in psychological service development. They have extensive and in-depth training (minimum six years) including a three-year clinical psychology doctoral

degree funded by the Department of Health specifically to fulfil these roles for the NHS. Clinical perinatal psychologists have additional post-qualification training in their perinatal specialism and work in a range of settings such as perinatal mental health teams, mother and baby units, maternity services, neonatal units or parent-infant mental health services.

- NICE (2014) and commissioner guidance (JCPMH, 2012) suggest using clear integrated care pathways and stepped-care models. Clinical psychologists' high level of training and ability to use a range of therapeutic approaches dependent on the needs of the individual enables them to work with moderate to severe cases and complex cases with co-morbid presenting problems. They are most effectively utilised when employed to work with individuals experiencing difficulties in the moderate to severe range in either community or inpatient settings.
- It is important to understand that in contrast, other providers of psychological care (e.g. generic adult mental health services and IAPT) play different but important roles. For example, IAPT services are aimed at the needs of individuals with mild to moderate psychological difficulties. A curriculum of basic core competencies in perinatal psychology for professionals working with women with mild and uncomplicated perinatal difficulties is being developed in some areas of the UK. However, risk and governance issues are paramount here. Clinical perinatal psychologists are ideally placed to offer training and supervision to other health professionals such as specialist midwives or IAPT therapists involved in the delivery of psychological care for mild to moderate perinatal difficulties.
- This paper sets out the core competencies of clinical perinatal psychologists in detail and outlines a range of key performance outcomes associated with aspects of their role; cost savings, psychological and physical health outcomes, enhanced user experience and equality and diversity.
- The important contribution of clinical psychologists has been recognised in a wide range of key documents (British Association of Perinatal Medicine, 2010; JCPMH, 2012; NICE, 2012, 2014; Royal College of Psychiatrists, 2015). A repeated recommendation is the importance of designated specialist clinical psychologists embedded within maternity and perinatal mental health community and inpatient teams to advise, supervise, and train other health care professionals, as well as treat women in psychological distress.
- Where psychological services are dispersed (for example, because of multi-sites and organisations), it is recommended that a Consultant Clinical Perinatal Psychologist will act as professional lead for all psychological services within the perinatal network. This could be a 'virtual' network across a larger region. Actual service delivery may be met by a variety of psychosocial care providers, but in the interest of governance, the overall leadership should rest with a consultant clinical perinatal psychologist who can advise commissioners on directing resources to target clinical needs efficiently and strategically.
- **Staffing levels for clinical psychology provision will depend on the scale and distribution of maternity services in the area and the configuration of related medical and mental health services. We recommend that:**
 - **a maternity hospital or geographic region with 3000 deliveries per annum should have access to a minimum 0.6 wte consultant clinical perinatal psychologist**

(minimum Band 8c) and one whole-time specialist clinical perinatal psychologist (Band 8a) to support the maternity service.

- Where Neonatal Intensive Care/Special Care Baby Unit is also supported this would require a further half-time specialist clinical perinatal psychologist (Band 8a). The service will require an additional band 8a clinical perinatal psychologist per additional 3000 women (for example, a 0.6wte 8c consultant and two band 8a clinical psychologists in a hospital with 6000 deliveries per year).
- Where services are provided within a specialist perinatal mental health team, providing integrated services into maternity hospitals, a range of recommended options exist and examples are detailed in Appendix 3 of this paper.
- Where services are in a local network, or provided across a range of localities, it may be necessary to employ more than one consultant clinical perinatal psychologist to provide oversight and supervision of the perinatal psychology network; equally, one consultant could provide oversight for a number of services, if time is allowed for this to be done effectively. In this latter case, a higher banding at a minimum of 8d would be appropriate.
- The paper concludes with recommendations for staff levels for optimal service provision, a description of essential characteristics of an integrated perinatal service, and additional forms of support required.
- The Appendices of this paper are designed to support the needs of commissioners and NHS service developers. Two case examples for models of service delivery are given in Appendix 1. The current responsibilities for clinical psychologists within the NHS at the different Agenda for Change bandings are detailed in Appendix 2. Appendix 3 outlines different models of services delivery and the associated staffing levels for clinical perinatal psychology provision are recommended.

The British Psychological Society’s Division of Clinical Psychology and the Faculty of Perinatal Psychology recognise the increasing demands on an NHS with limited resources, with a focus on balancing the need to provide evidence-based, high quality and cost-effective treatments that reflect high levels of service user satisfaction. The clinical perinatal psychology services described in this paper are designed to achieve these outcomes.

Note: The paper does not specifically detail the role of clinical psychologists working within Parent-Infant Mental Health (PIMH) services. However, the Faculty recognises that their role closely overlaps with that of a clinical perinatal psychologist in the work they might complete to improve the quality of the parent-infant relationship. The Faculty of Perinatal Psychology endorses the need for close liaison and joint-working between specialist perinatal community mental health teams, maternity staff and parent-infant mental health services. This view is echoed by the Royal College of Psychiatry CR197 report (July, 2015) on Perinatal Mental Health Services – Recommendations for the provision of services for childbearing women. PIMH services typically provide support to families with children aged from 0 to 2, whereas perinatal services are typically from conception to age 1 year. As with perinatal services, provision of PIMH services is fragmented around the UK, and consideration needs to be given to the inclusion of PIMH services within perinatal settings.

This guidance was written by the Faculty of Perinatal Psychology on behalf of the Division of Clinical Psychology for the British Psychological Society and as such, it is focused on the role of clinical psychologists in perinatal services. The Faculty also wishes to recognise the roles that other applied psychologists may play in the delivery of health care services, and to this end the British Psychological Society aims to produce future guidance outlining the range of roles and competencies that applied psychologists can provide as part of high quality multidisciplinary perinatal service provision.

3. Introduction to the role of clinical psychology

3.1 Context

Perinatal mental health has become a significant public health concern (Confidential Enquiry into Maternal And Child Health (CEMACH), 2007). The MBRRACE Report, 'Saving Lives, Improving Mothers' Care' (2015), called for urgent action to address indirect causes of maternal deaths, both medical and psychiatric, as there had been no significant change in death rates since 2003. In addition, research evidence suggests that at a conservative estimate, the long term costs of perinatal depression, anxiety and psychosis in the UK is £8.1 billion per year, the equivalent of £10,000 for every single birth with the majority of the cost being due to adverse impacts on the child (Bauer et al., 2014). The *Guidance for Commissioners of Perinatal Mental Health Services* (JCPMH, 2012) highlights the need for specialist services, pointing out that 'effective treatments and psychological interventions exist, and timely and appropriate treatment can improve maternal and infant outcomes' (p.8).

Despite compellingly high rates of prevalence, service provision in the UK reflects much disparity and fragmentation. This may in part be explained by the difficulties of perinatal mental health issues crossing physical health settings in both primary and secondary care, in community mental health and psychiatric services. There is an unusually high incidence of health care appointments and service contact throughout the perinatal period, providing an excellent opportunity to capture, screen and identify those women who may be developing difficulties, and ensure effective early intervention and management. However, the current lack of consistent care pathways and specialist perinatal staff training means that women face barriers and challenges in accessing adequate psychologically informed services.

The various national policy drivers that advocate for improved perinatal services emphasise factors that require and are dependent on clinical psychology leadership (i.e. NICE guidance and the Joint Commissioning Panel for Mental Health (JCPMH) *Guidance for Commissioners*). These include proactive screening and detection, continuity and integration of holistic care, the provision of high quality evidence-based psychological interventions, psychologically-informed supervision and training of front-line staff.

3.2 Clinical Perinatal Psychology – core competencies

Many of the core competencies involved in the role of clinical psychologists (BPS, 2010) may be seen as central in developing and leading mental health services. Clinical psychologists have extensive and in depth training (a minimum of six years) including a three-year clinical psychology doctoral degree funded by the Department of Health specifically to fulfil these roles for the NHS. Specialist clinical perinatal psychologists have received further post-doctoral training under the supervision of a consultant clinical perinatal psychologist. They bring a unique and advanced skill set to the understanding and treatment of mental health and physical health care problems in the perinatal period. They are trained in the:

- (i) Expert application of psychological theory to mental health and physical health care. This in-depth understanding and ability to integrate knowledge of maternal mental health, infant mental health, developmental psychology, family dynamics and systemic issues ensures optimal care for a wide-range of mental health needs of women and their babies during pregnancy and after birth.
- (ii) Provision of high quality, evidence-based psychological therapy to effectively alleviate moderate, severe, complex or co-morbid forms of psychological distress during pregnancy and the postnatal period.
- (iii) Assessment, identification and effective intervention to improve problematic mother-infant relationships that are otherwise likely to impact adversely on the child's social, emotional or behavioural development.
- (iv) Provision of leadership in psychological service development and service evaluation.
- (v) Delivery of teaching, training and supervision of other health professionals (e.g. Improving Access to Psychological Therapies (IAPT) staff; specialist midwives and health visitors) delivering psychological therapies for mild to moderate mental health problems.

While clinical psychologists are effective in working across the range of perinatal mental health issues, their high level of training and ability to use a range of therapeutic approaches dependent on the needs of the individual enables them to work with complex cases with co-morbid presenting problems and they are most effective when employed to work with individuals experiencing difficulties in the moderate to severe range in either community or inpatient settings.

4. Commissioning, service integration and the role of clinical psychology in achieving optimal outcomes

‘Clinical commissioning groups should prioritise integrating mental and physical health more closely as a key part of their strategies to improve quality and productivity in health care.’

(King’s Fund, February, 2012)

4.1 Commissioning

Clinical psychology services are currently commissioned in a range of ways. Specialist perinatal mental health services, which include psychological provision in inpatient mother and baby units and their linked perinatal community mental health teams, are commissioned by the NHS Commissioning Board under specialised commissioning arrangements (NHS Commissioning Board, 2013). Any other clinical psychology services are commissioned on a local level by Clinical Commissioning Groups (CCGs). However, this provision is currently patchy, and consequently the JCPMH (2012) recommend in their *Guidance for Commissioners of Perinatal Mental Health Services* the development of local perinatal mental health strategies that outline local need and focus on the implementation of a high quality perinatal psychology service to meet identified need.

4.2 The need for integrated services

To ensure high-quality care for women experiencing mental health difficulties in the perinatal period, integration and collaboration between services has been proposed as the best approach to service delivery (for a review, see Myers, Schmied, Johnson & Cleary, 2013). This is a significant challenge as currently women present in a variety of physical and mental health settings across primary and secondary care, including maternity services, adult mental health services, drug and alcohol services, eating disorders services, learning disability services, child and adolescent mental health services, Improving Access to Psychological Therapies (IAPT) services in England, health and social care organisations, and children’s centres. When such services are isolated, service quality falls. Similarly, evidence indicates that integrated working improves mental health difficulties and infant outcomes. Myers et al. (2013) suggest that integrated working may be challenging given the varying professional groups, organisational structures and funding streams for perinatal services. As a solution, both the NICE guidance (2014) and commissioner guidance (JCPMH, 2012) suggest using clear integrated care pathways and stepped-care models. Clinical psychologists are uniquely placed to provide integration of psychological approaches into standard medical care. It is recognised that integration of clinical psychology provision into medical care offers reduction in cost, enhanced quality and improved patient satisfaction and wellbeing.

4.3 The role of clinical psychology

Clinical psychologists work with people with a range of psychological difficulties from moderate to highly complex. In contrast, individuals with more straightforward difficulties (mild to moderate severity) are offered treatment within a primary care setting or universal services. To ensure that clinical psychology skills are targeted where they are most needed in terms of direct work, an important aspect of the role of a clinical psychologist is the ability to consult, supervise and liaise with health professionals who are working with those at the milder end of the range. Clinical psychologists' comprehensive training provides them with skills in a range of evidence-based psychological therapies so they can tailor treatment to the needs of service users. Clinical psychologists are also proficient in research skills for audit and evaluation, teaching and service development. Senior clinical psychologists can offer expert training and supervision for care providers at other levels and lead and input to research. Consultant clinical psychologists can also advise on policy, risk management, governance and commissioning, driving clinical excellence (see Appendix 2).

The potential contribution by clinical psychologists has been recognised in a wide range of key documents from government and the third sector as enhancing women's perinatal experience and contributing to the long-term wellbeing of women and their babies. Such documents make consistent recommendations regarding the high level of specialist care that a woman and her infant should receive across the perinatal period should the mother be experiencing perinatal mental health difficulties (see Figure 1). **One such recommendation is the importance of designated specialist clinical perinatal psychologists embedded within maternity and perinatal mental health community and inpatient teams to advise, supervise, and train other health care professionals, as well as treat women in psychological distress.** Moreover, a number of studies have highlighted that women often have a clear preference for psychological support over more medicalised interventions such as pharmacology; further emphasising the critical role of clinical psychology in the perinatal period (Buist, O'Mahen & Rooney, 2015).

Figure 1: National perinatal policies and guidelines.

2002	Department of Health	Women's Mental Health: Into the Mainstream Strategic Development of Mental Health Care for Women.
2007	Stillbirth and neonatal death charity (Sands)	Pregnancy Loss and the Death of a Baby: Guidelines for professionals.
2008	Healthcare Commission	Towards better births: A review of maternity services in England. Service Review.
2011	Royal College of Obstetricians and Gynecologists	Guidelines on Management of Women with Mental Health Issues during pregnancy and the postnatal period
2012	Scottish Intercollegiate Guidelines Network (SIGN)	Management of perinatal mood disorders.
2012	Royal College of Psychiatrists	Quality Network for Perinatal Mental Health Services.
2012	Joint Commissioning Panel of Mental Health	Guidance for commissioners of perinatal mental health services.
2012	NHS Commissioning Board	Specialised commissioning specifications: Perinatal mental health services.
2012	National Institute of Health and Clinical Excellence (NICE)	Clinical Guideline for Caesarean Section.
2014	National Institute of Health and Clinical Excellence (NICE)	Clinical Guideline Update for Antenatal and Postnatal Mental Health Care.
2013	Improving Access to Psychological Therapies (IAPT)	Perinatal Positive Practice Guide.
2015	MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK	Deaths from psychiatric causes in Saving lives: Improving Mother's Care.
2015	Royal College of Psychiatrists	CR197:Perinatal mental health services: recommendations for the provision of services for childbearing women.
2016	NICE Quality Standard [QS 115]	Antenatal and postnatal mental health.

4.4 Key performance indicators associated with clinical psychology posts in perinatal services

The British Psychological Society’s Division of Clinical Psychology and the Faculty of Perinatal Psychology recognise the increasing demands on an NHS with limited resources, with a focus on balancing the need to provide evidence-based, high quality and cost-effective treatments that reflect high levels of service user satisfaction. Clinical psychology services embedded within a health and/or perinatal setting achieve these outcomes across the domains outlined below. Each area is described in more detail in subsequent sections of the report.

A. Cost savings.

Impact	Mechanism of change by clinical psychology
Reduction in complaints/litigation	Facilitation of information exchange between patient and health professional, and processing of difficult information reduces the need to complain or take legal action.
Reduced length of hospital stay, unnecessary admissions, antenatal monitoring and medical follow-up appointments.	Inpatient interventions to reduce anxiety or stress as well as provision of follow-up outpatient care.
Reduction in non-medically essential elective procedures.	Appropriate information exchange and negotiated care plans informed by understanding of psychological motivation/fears result in reduced desire for elective caesarean.
Reduction in downstream costs.	For example, prevention of a first caesarean can reduce the length of hospital stay, increase the likelihood of a natural birth subsequently, and is linked to faster recovery times, improved mental state and fewer outpatient/primary care contacts postnatally.
Reduction in downstream costs for the infant in terms of reducing the burden of adverse child development outcomes. Two-thirds of costs demonstrated in the figure of £8.1 billion per year were attached to later costs for the child (Buist et al., 2014).	Delivery of high quality, evidence-based psychological intervention improves maternal mental health which is highly protective for children, resulting in better social, emotional, developmental and behavioural outcomes.

B. Psychological outcomes.

Impact	Mechanism of change by clinical psychology
Improved mental health and emotional wellbeing.	High quality psychological interventions provided by clinical perinatal psychologists for women in the moderate to severe range.
Improved psychological adjustment to acute and chronic medical conditions.	Perinatal Mental Health Teams (PMHTs) integrated with health psychology in acute settings ensure appropriately targeted interventions for perinatal women. This has the consequence of improved daily functioning due to improvements in mood and coping.
Improved inclusion and quality of life for individuals and families.	Clinical perinatal psychologists can support women in hard to reach groups to access psychological intervention, and to receive appropriate maternity care, resulting in better outcomes for mothers and babies.
Enhanced parent-infant relationship.	Clinical perinatal psychologists use psychological formulation (knowledge of risks, protective factors and their interplay) to work with mothers antenatally to foster maternal-fetal attachment and then bonding once the baby has been born, on a background of providing effective mental health interventions if necessary.
Improved parenting quality.	Parenting interventions can be provided to individuals with complex and/or moderate to severe mental health needs who show problematic parent-interaction patterns or where significant safeguarding concerns exist regarding capacity to parent, to ensure an optimal quality of provision from both parents.
Enhanced parental adjustment to diagnosis of chronic childhood conditions.	Clinical perinatal psychologists can work with women who are vulnerable to mental health problems such as those whose baby is diagnosed with a health problem. Good interventions will support adjustment and attachment.

C. Physical outcomes.

Impact	Mechanism of change by clinical psychology
Improved coping with and reduction in physical symptoms.	Evidence-based interventions relating to adjustment to physical symptoms increases coping. In pregnancy there is a high frequency of new and distressing physical symptoms and complications following delivery can be prove challenging.
Improved treatment adherence.	Individuals are more able to maintain adherence to treatment once psychological adjustment has been reached.
Better pain management with concomitant reduction in pain medication.	Individuals assimilate pain management techniques and better psychological adjustment reduces reliance on pain medication. In pregnancy women are reluctant to utilise pain medication and psychological pain management techniques can help.
Prevention/reduction of co-morbidities.	Individuals exhibiting better psychological adjustment are more likely to maintain treatment, increase exercise and reduce pain medication, thereby reducing the risk of the onset of comorbidity.
Reduction in surgical interventions.	Women requesting caesarean section in the absence of medical indication can receive evidence-based treatment for trauma (if applicable) and psychoeducation, resulting in a decrease in elective caesarian sections.
Faster recovery from surgical interventions.	Evidence-based techniques in pain management and increased coping speed up recovery and assist women in managing with a new baby post-surgery.
Increasing breastfeeding initiation and maintenance.	Good psychoeducation and clinical supervision of health professionals working with perinatal women (such as breastfeeding support counsellors) can increase breastfeeding and initiation.
Reducing or stopping smoking.	Cessation of smoking in pregnancy is a government priority; clinical psychology contributes to understanding motivational and maintenance cycles, thereby reducing the incidence of smoking.

D. User experience.

Impact	Mechanism of change by clinical psychology
Improved service user satisfaction.	Staff are trained and supported in psychological aspects of care resulting in a better care experience.
Enhanced informed consent procedures.	Appropriate staff training can be provided by clinical psychologists, resulting in women feeling supported during the consent process, especially in emergency situations.
Research and service evaluation.	Service user perspectives can be utilised by clinical psychologists in high quality research and evaluation.
'Joined up' care experience.	Clinical psychologists working within a perinatal team can ensure women experience a seamless transition from mental health to maternity care, and can access appropriate levels of care as necessary.

E. Equality and diversity.

Perinatal mental health services should be culturally sensitive and have access to translation services. Every effort should be made to offer equal support for the emotional and psychological needs of women in the community, including 'hard-to-reach' groups, which may include teenage mothers, minority ethnic communities, women with disabilities, women from travelling communities and women in custody. Clinical psychologists have particular skills in engagement and communication which can contribute to an overall strategy for ensuring that all women have equity of access to perinatal mental health services. In addition to contributing to the development and initiation of local and regional engagement strategies, clinical psychologists are well-placed to work with women from a range of backgrounds as they receive specific training on working in a variety of settings, via interpreters as necessary, and in understanding individual barriers to engagement.

The next section will focus on the importance of a fully integrated perinatal psychology service within maternity services.

5. Maternity services

While the majority of pregnancies run a normal course, pregnancy and the transition to parenthood are recognised as a time when a great number of physical, psychological, financial and practical changes occur and so mental health difficulties and relationship stress are common. This can be further exacerbated when pregnancy complications occur, as they can have a significant negative impact on a woman's psychological wellbeing with negative implications for family and community. Common complications that arise during maternity care are extensive, but examples include loss (such as miscarriage or stillbirth), the diagnosis of fetal abnormality resulting in the need to consider the viability of the pregnancy, or a diagnosis of placenta praevia which may result in long-term admission to hospital during the pregnancy. Psychological interventions which are specific, effective, and valued by women can support them with such difficulties; reducing distress and health care costs, whilst increasing physical and psychological wellbeing. It is essential that all such work is led by a consultant perinatal clinical psychologist, who is able to ensure adequately supervised, targeted, stepped care that is appropriate to individual needs across acute and community settings. The *Guidance for Commissioners of Perinatal Mental Health Services* (JCPMH, 2012) states that maternity services 'should have access to a designated specialised clinical psychologist to advise and treat, if necessary, women with psychological distress particularly relating to obstetric loss, post-traumatic stress disorder and other obstetrically relevant conditions (e.g. needle phobias, previous rape, abuse, etc.).'

A clinical perinatal psychology presence in an acute hospital providing maternity services can make a significant contribution to high quality psychological support for staff and staff training in addition to a central role in developing psychologically-informed individualised care plans for women and their partners. The active integration of clinical psychology into maternity teams supports these activities to benefit all service users. Integration is essential because the nature of the psychological intervention work required often needs close liaison with all other maternity staff within a short time frame, and essential access to the planned place of birth so preparation work can be conducted in situ. Within hospital and community settings, clinical perinatal psychologists can provide specialist training in perinatal mental health issues, enabling midwives, where well supervised, to prevent and intervene for mild mental health difficulties (Brugha et al., 2016). They can additionally provide clinical supervision for specialist midwives such as those working in bereavement, antenatal screening and child protection, group supervision for band 7 midwives, and a focus on improving communication. This ensures that midwives working in specialist roles with a psychological element are well suited to provide support for women presenting with a range of difficulties such as termination for fetal anomaly, miscarriage and stillbirth; diagnosis of a genetic or anatomical anomaly in the fetus; and support for families under scrutiny for child protection concerns. It also ensures that these midwives are well-supported themselves for their own work. Another critical role for suitably trained clinical perinatal psychologists is the assessment of women requesting caesarean sections, in addition to working with the staff supporting those women. Timely access to psychological assessment in these cases assists with compliance with the relevant NICE guideline (Caesarean section guideline, 2012).

In addition, the NICE Antenatal and Postnatal Mental Health (APMH) 2014 guideline highlights the importance of providing access to appropriate psychological support for women with pre-existing mental health problems or those who develop them during the perinatal period. In line with the national focus on the importance of early intervention for at risk parenting situations, clinical psychology is in a position to highlight need, prevent difficulties and support staff working with such families. Arguably the most essential area where clinical psychology may contribute is in ongoing improvements in care to reduce the risk of mental health problems and, when they are present, to identify and manage such problems in a timely and effective way.

The importance of well-integrated psychological support into maternity services is supported by the NICE APMH Guideline (2014). As such, clinical perinatal psychologists should also form part of community based perinatal mental health services. A truly integrated perinatal mental health service provides care to women across both community and acute hospital settings. Teams organised in such a way can provide antenatal, intrapartum and postnatal care in a range of settings in addition to being available to support maternity services. Community-based services engage women by providing local services, including some delivery of home-based services as necessary. Perinatal mental health teams are likely to include (as a minimum) perinatal psychiatry, clinical perinatal psychology and community psychiatric nurse (CPN) provision, and a holistic team will include social work, health visiting and specialist midwifery time in addition. The option to run PMHTs by means of a clinical leadership group comprising a single representative from each involved discipline provides an exciting opportunity to demonstrate collaborative approaches to clinical leadership. Clinical perinatal psychologists are well-placed to support what is currently an innovative approach.

It is essential that perinatal services are appropriately linked with other general mental health services. Many perinatal women are seen in adult mental health services and, in England, in IAPT services. An important aspect of the role of the clinical perinatal psychologist is to ensure that mental health workers have access to perinatal consultation, supervision and training wherever such individuals are working with perinatal women, and that women are appropriately transitioned across services in a timely fashion and with high quality communication throughout. This joined-up working includes the need to link explicitly with specialist mental health midwives and health visitors working in acute and community settings. Clinical psychologists receive a unique training, which ensures that they are able to conduct research and service evaluations within the perinatal context, adding to the knowledge base in this area. A case study is presented in Appendix 1 as an illustration.

The role of clinical psychology will now be described in more detail in specific relation to antenatal, intrapartum and postnatal care.

5.1 Antenatal care

The universal nature of care in the antenatal period, involving multiple contacts with health professionals and medical investigations, means that previously undiagnosed physical and psychological conditions may be identified for the first time, with an increased need for services. This is also true of previous trauma such as sexual abuse, which can have profound implications for the birth experience and mental health outcomes for parent

and baby. The physical and mental challenges of pregnancy bring new and additional pressures. Women with pre-existing mental health problems may have additional psychological needs, which should be considered in their perinatal care. Routine screening for anxiety and depressive symptoms as recommended by NICE will also contribute to this process. Clinical psychology can usefully provide direct and indirect intervention during pregnancy in a wide range of areas including:

- Timely consideration of new onset or pre-existing mental health conditions, such as antenatal anxiety/depression, to allow early intervention and incorporation into care planning. Psychological interventions are particularly appropriate in the context of the altered risk/benefit ratio of psychotropic medication to minimise medication needs where possible;
- Intervention where trauma responses are interfering with routine maternity care, such as vaginal examination, due to a history of abuse or supporting women towards a normal vaginal birth following a previous traumatic experience. Similarly, supporting women with fear of childbirth and other relevant phobias (e.g. blood, needles, hospitals);
- Individual birth planning for women with complex mental health problems;
- Supporting the formation of appropriate bonding with the unborn infant, which later impacts on positive parent-infant attachment;
- Support in high risk pregnancies (e.g. placenta praevia, multiple pregnancy, maternal physical health problems such as HIV, diabetes, cardiac conditions);
- Coping with adverse outcomes including antenatal diagnosis of serious/life limiting conditions in the fetus and facilitation of related complex decision making; also perinatal loss and unexpected hysterectomy following birth;
- Providing support for staff managing prevention and adherence to treatment advice (e.g. smoking cessation, initiating breastfeeding, weight management);
- Assessment and intervention where there are concerns related to maternal relationship to her unborn baby including ambivalence, rejection, concealment of pregnancy, and consideration of adoption or termination;
- Specialist assessment when a mother is working with social services and completing a pre-birth assessment; and
- Providing a couple-focused intervention where couple relationship satisfaction is low and/or conflict high.

Due to the high level of contact with individual women, the antenatal period provides an unparalleled opportunity for identifying and addressing needs. As this is a time of psychological change and the beginnings of relationship formation, input can provide benefit in terms of treatment but also prevent development of chronic complex problems, which incur substantial long-term NHS costs. There are, therefore, a number of areas where clinical psychology can contribute across a range of levels:

- enhancing staff skills through training in communication techniques;
- providing training and supervision to enable maternity staff to provide psychologically informed care for women with mild mood problems;
- supporting staff working with antenatal women with severe mental health problems
- planning for birth and parenting;
- enhancing shared decision-making in pregnancy between the woman and care staff;

- supporting services where there are complex child protection issues;
- inputting into decisions such as mode of birth, including request for caesarean section, where there are relevant psychological factors weighting such decisions; and
- contributing a psychological perspective to service developments and care pathways.

5.2 Intrapartum care

While this is the shortest period of perinatal care, it is often the focus of the woman's attention, particularly as she moves into the third trimester of pregnancy. Good support and care during labour and birth can influence the path of postnatal recovery and adaptation with implications for the mother-baby relationship. Conversely, a poorly managed birth experience can have a lasting detrimental effect on the mother's mental health and key relationships. Clinical perinatal psychology has a role to play here.

For the individual,

- promoting realistic expectations for birth;
- good pain management skills;
- facilitating coping and managing emotions and if required, acceptance of motherhood;
- empowering women and birth partners to be equal partners in the labour/birth;
- support for the maternity staff, particularly following traumatic birth events.

For the system, there is good evidence that labour and birth is the time in which women are most likely to feel vulnerable, and on which their memories centre. Care is, therefore, critical during this period and ensuring consistency of high quality care can be problematic. Staff can be trained and supported in skills to optimise birth experience in a number of areas:

- reducing the risk of psychological trauma;
- interpersonal skills including advanced communication skills;
- facilitating sensitive individualised care for women including an understanding of the particular needs of women with a history of psychological trauma, prior loss or other mental health problems;
- recognising the value and needs of the birth partner and the long-term implications of the birth experience for his or her ability to provide support in the postnatal period;
- reflective practice groups for midwives; and
- debriefing and discussion for staff following involvement in highly challenging deliveries.

5.3 Postnatal care

The postnatal period is one of adaptation and recovery. However, women may be affected by mental or physical health issues, adapting to parenthood, a difficult birth, or social adversity. Postnatal care is provided within a wide-ranging multidisciplinary system including midwifery, health visiting, obstetrics, gynaecology, physiotherapy, general practice, psychology and psychiatry, and the provision of locally-based care is important to ensure good levels of access. When a woman is experiencing a trauma response following childbirth, there is a particular case to be made for their open access to the place of birth as part of a trauma-focused approach to their distress. A well-integrated service is also well placed to contribute to the care of families with a baby in the neonatal or special care unit, or to care of women with medical complications post-childbirth. Clinical perinatal psychology can play a major role in providing interventions in relation to:

- traumatic responses following childbirth;
- facilitating adjustment to birth complications (e.g. incontinence) and adverse incidents;
- psychosexual problems;
- severe and/or complex perinatally-related mood disorders;
- complex mother-infant bonding difficulties;
- psychological difficulties related to loss through death, premature birth or adverse diagnosis for the neonate;
- supporting adjustment for women following recovery from a significant mental health disorder such as postpartum psychosis.

For the system, the postnatal period is one of change, signalling the handover from acute to community-based health professionals and a key necessity is ensuring good information transfer, particularly where a mental health problem has been identified. Maternity and health visiting staff can be trained, supervised and supported in:

- recognising trauma symptoms and mental health problems;
- reassuring highly anxious parents;
- recognising difficulties in the parent-infant relationship and adjustment to parenthood;
- providing support following adverse incidents with the potential to reduce litigation;
- recognising risk issues including domestic violence and child protection.

The clinical perinatal psychologist can also provide a degree of continuity of care at this time of transition when familiar midwives and obstetric staff are no longer involved. This is especially useful for women who are more emotionally vulnerable and also when the baby requires care in a neonatal unit.

6. Neonatal units

The neonatal unit (NNU) is a high stress environment for parents and staff. Improved psychosocial support for parents is a stated imperative of the Department of Health in its plan for neonatal services, which requires integrated clinical psychology. A neonatal service can cover a range of complexity, from Special Care Baby Unit (SCBU), through a High Dependency Unit (HDU), to a Neonatal Intensive Care Unit (NICU).

Admission to a NNU for any reason can have negative psychological consequences for the parents, the neonate, and the parent-baby relationship. The clinical perinatal psychologist is well qualified to support the developing parent-baby relationship and to optimise child development, providing preventative and early intervention to minimise the risk of negative consequences. It is particularly recognised that parents who have a baby admitted to a NNU suffer stress and, especially in a NICU, they may experience significant trauma with the possibility of post-traumatic stress symptoms. In this context it is recommended that parents should have access to psychological support from the time of admission, as well as being provided with on-going support during their time on the NNU (British Association of Perinatal Medicine, 2010).

Psychological support for parents should include direct work with parents and indirect influence through training and support for medical and nursing staff. Particular areas where the clinical psychologist can provide support for parents and staff include supporting parental bonding and the development of a secure attachment relationship, adjustment to bad news, making difficult treatment decisions, specialist bereavement counselling and advice in relation to other children in the family.

Another important aspect of the role within the NNU is in supporting the transition of the family from hospital to home. There is a high level of support and easy access to staff whilst in the hospital setting, and many families struggle to adjust to caring for a baby alone at home, particularly if the baby has ongoing medical needs and/or disabilities. This is of particular relevance due to the need to support the formation of secure parent-infant attachment which takes place over time and is highly linked to positive outcomes.

A number of NNUs employ counsellors and peer support workers to work with families while their baby is on the ward. These individuals often have particular training or skills in providing support to couples who have lost a baby, or those who are trying to understand their particular experience. Whilst valuable, such staff do not have the same range of skills as a specialist clinical psychologist who can bring expertise of a different kind. Clinical psychologists have particular training which enables them to support exploration of the parent-infant attachment relationship, the impact on this of illness, trauma or death (for example in the case of loss of one or more babies in a multiple birth), and the impact of previous life experiences such as a parent who has been abused or in care. They can promote adaptive staff coping styles to ensure staff do not themselves experience trauma following multiple losses, and they can promote positive working relationships and providing psychologically informed training. This highly specialist role requires significant time to integrate within medical and nursing teams, particularly where this has not existed previously.

7. Perinatal mental health services

Perinatal mental health services are concerned with the prevention, detection and therapeutic management of perinatal mental health problems that complicate pregnancy and the postpartum year. Childbirth and the transition to parenthood are associated with substantial psychiatric and psychological morbidity. Severe mental health difficulties in the perinatal period present differently, often occurring with no, or very little, warning, and requiring prompt expert intervention. Health professionals working within specialised perinatal services require a high level of knowledge and experience regarding such presentations. In addition to the focus on maternal mental health, specialist perinatal mental health services uniquely focus on the infant, and the mother-infant relationship. This three-way approach is not available in generic adult mental health services and it is known that promoting emotional and physical wellbeing and development of the infant are central to service provision within high quality perinatal mental health services.

Psychological interventions are effective in psychotic illnesses, severe depression and anxiety, perinatal OCD, personality disorder, post-traumatic stress disorder and bipolar disorder (BPS, 2000), and so we recommend that every specialist perinatal mental health team should include clinical psychology sessions to provide optimal psychological care. In order to be accredited by the Royal College of Psychiatrists Perinatal Quality Network for Perinatal Mental Health Services, inpatient Mother and Baby Units and Perinatal Community Mental Health teams are expected to have dedicated Clinical Psychologist provision.

The role of clinical perinatal psychology in both Mother and Baby Units (MBUs) and in community Perinatal Mental Health Teams (PMHTs) is described below.

7.1 Mother and Baby Units (MBUs)

Specialist in-patient MBUs care for and treat mothers with moderate to severe mental health problems, alongside their babies (and in some cases their partners), from the third trimester of pregnancy up to the first year of their baby's life. Clinical perinatal psychologists work as members of multidisciplinary teams, facilitating the integration of a psychological perspective into the team's understanding of the clinical issues.

One of their roles is to lead in the provision of high quality evidence based psychological treatments, which are delivered with special consideration and understanding of the maternity and perinatal context. They are trained in a variety of psychological treatment modalities. They work with women with complex co-morbidity providing individually tailored psychological treatment programmes. In some units they also work with couples and with groups addressing problems such as severe depression and anxiety, perinatal obsessive compulsive disorder (OCD), bipolar disorder, personality disorder and psychosis.

Clinical perinatal psychologists also support mothers with bonding disorders and mothers and babies with attachment issues, using a range of mother- infant focused interventions such as mentalisation-based therapy, video feedback approaches, Baby Triple P, compassion focused CBT and Watch Wait & Wonder. In some services clinical perinatal psychologists work with couples, providing family interventions during a stressful and very important stage of the couple relationship.

They also provide consultation to psychiatrists and other professionals, especially where there are ambiguities around diagnosis and formulation. They supervise other disciplines in the provision of high quality psychological treatments and carry out and support research to improve the quality of care. Clinical perinatal psychologists also offer training and reflective practice forums to support the professional development of their teams.

7.2 Perinatal Community Mental Health Teams (PMHTs)

Community PMHTs provide treatment and support to minimise the risk to mothers and babies, and in many cases, to prevent or shorten admissions to inpatient units. Clinical perinatal psychologists provide either direct treatment of vulnerable women within their family context, and/or supervision and training to other team members enabling the provision of high quality psychologically informed practice and support both within patients' homes and within outpatient settings. Generally these teams comprise clinical perinatal psychology, perinatal psychiatry and CPN provision, and some will additionally have dedicated specialist midwifery and health visiting time. Such services work with women who are experiencing moderate to severe perinatal difficulties, where the level of these difficulties exceeds the expertise of primary care or general mental health services. In England, IAPT services provide CBT based interventions to perinatal women and their families who are experiencing mild to moderate mood-based disorders. Clinical perinatal psychologists should provide overall supervision for specialist IAPT perinatal workers, as well as training and consultation. Good links between local primary care and adult mental health services with specialist PMHTs is essential to ensure strong seamless transitions for patients as necessary between IAPT services and the specialist PMHT.

8. Service provision

8.1 Staffing

The organisational structure for those providing specialist perinatal services will vary depending on the nature of the service within which they sit and whether there are related clinical psychology posts within the natural geographical or service network.

A clinical perinatal psychologist working in a maternity hospital is likely to sit within a network of clinical health psychologists and may also link easily with clinical psychologists providing services to paediatrics. This has the benefit of providing a clinical psychology network for professional management and supervision through to the most senior members of the service. A consultant clinical psychologist specialising in perinatal work will be required to lead a perinatal psychology service in this context to provide professional management and supervision to junior psychology staff and to contribute to service development (see Appendix 2 for details of clinical psychology banding qualifications and responsibilities).

In addition to hospital based work, clinical perinatal psychologists are likely to work as members of specialist perinatal mental health teams providing services in the community and/or to MBUs, providing for inpatients and outpatients. As psychological interventions are effective in psychotic illnesses, severe depression and anxiety, perinatal OCD, personality disorder and bipolar disorder (BPS, 2000), it is recommended that every specialist perinatal mental health team should include clinical psychology sessions. In addition, clinical perinatal psychologists can work with mothers and babies on fostering sensitively attuned mother-infant interaction during this critical period. Others may have a specialist role or sessions within a more general mental health service. Service management will vary accordingly; however, it is strongly recommended that all clinical psychologists providing perinatal services should have access to regular professional supervision by a clinical psychologist specialising in perinatal psychology, overseen by a consultant clinical perinatal psychologist.

Where psychological services are dispersed (for example, because of multi sites and organisations), it is recommended that a consultant perinatal clinical psychologist will act as professional lead for all psychological services within the perinatal network. This could potentially be a 'virtual' network across a larger region. Actual service delivery may be met by a variety of psychosocial care providers such as more junior clinical psychologists, specialist midwives or counsellors, but in the interest of governance, the overall leadership should rest with a consultant perinatal clinical psychologist who can interpret and synthesise the literature and advise commissioners to direct resources to target clinical needs efficiently and strategically. They will also monitor activity and performance outcomes, to evidence service performance.

Staffing levels will depend on the scale and distribution of maternity services in the area and the configuration of related medical and mental health services. It is recommended that a maternity hospital or geographic region with 3000 deliveries per annum should have access to a minimum 0.6 wte consultant perinatal clinical psychologist (minimum Band 8c) and one whole-time specialist clinical perinatal psychologist (Band 8a) to support the

maternity service. Where Neonatal Intensive Care/Special Care Baby Unit is also supported this would require a further half-time specialist clinical perinatal psychologist (Band 8a). The service will require an additional band 8a clinical perinatal psychologist per additional 3000 women (for example, a 0.6wte 8c consultant and two band 8a clinical psychologists in a hospital with 6000 deliveries per year). Where services are provided within a specialist perinatal mental health team, providing integrated services into maternity hospitals, further examples are given in Appendix 3. Where services are in a local network, or provided across a range of localities, it may be necessary to employ more than one consultant clinical perinatal psychologist to provide oversight and supervision of the perinatal psychology network; equally, one consultant could provide oversight for a number of services, provided appropriate time is allowed for this to be done effectively. In this latter case, a higher banding at a minimum of 8d would be appropriate. See Appendix 3 for examples.

The British Psychological Society specifies a 70:30 clinical:non-clinical split in role for junior staff (bands 7 and 8a), 60:40 clinical:non-clinical split for senior staff (band 8b) and 30:70 clinical:non-clinical split for consultant staff (bands 8c and above).

All clinical psychology staff must be eligible for chartered membership of the British Psychological Society Division of Clinical Psychology and registered with the Health Care Professions Council. They must work within the British Psychological Society *Code of Conduct, Ethical Principles and Guidelines* and the Division of Clinical Psychology *Professional Practice Guidelines*. Time and arrangements must be in place for clinical supervision, peer support and continuing professional development, as set out by the British Psychological Society Division of Clinical Psychology and the Health Care Professions Council.

8.2 Essential characteristics of an integrated service

- A fully integrated psychological service in maternity including a physical presence within the acute hospital as well as a clear presence within the corresponding community-based perinatal mental health team, preferably operating as one service.
- Culturally sensitive teams with straightforward access to translation services as required.
- Regular contact and liaison with senior obstetric, midwifery staff and psychiatry provision.
- Presence at essential multidisciplinary meetings.
- Provision of relevant specialist perinatal training for clinical psychologists and non-psychologists.
- Provision of specialist perinatal services for women and their partners as necessary.
- Liaison between maternity and specialist perinatal mental health services as necessary.
- Broad referral base including midwifery, obstetrics, health visiting, general practice and mental health services with agreed funding pathways.
- Clearly outlined and audited care, communication and liaison pathways.
- Appropriate demonstration of clinical and cost effectiveness.
- Clear definition of all activities (e.g. aims and outcome indicators)
- Risk management.
- Balanced scorecard: all activities are important including assessment and interventions for women and consultation, liaison and training for other health care providers.

8.3 Supporting services

The changing nature of the UK population means that translation services are likely to be necessary with increasing frequency. The perinatal psychology service should be supported by sufficient IT resources and dedicated administrative staff to ensure efficiency of communication and maintenance and storage of clinical information in a secure and confidential system in keeping with local service policies. Appropriate consulting and office space is essential to enable clients to discuss sensitive and confidential issues in a safe, private and comfortable setting.

9. Concluding comments

Perinatal mental health difficulties reflect a serious public health concern; unrecognised and untreated, they can lead to significant adverse consequences for the women affected and their partners, and can also negatively impact on the wellbeing and development of babies and other children. The perinatal period represents a timeframe with particularly frequent input from health care professionals, and, therefore, provides an incomparable opportunity for psychological care. In support of the evidence base, the various national perinatal mental health difficulties policy drivers advocate for more emphasis on proactive screening, continuity of antenatal and postnatal care, integrated care between physical and mental health services, for mothers and babies to remain together in MBUs, and a significant increase in relevant mandatory training for frontline staff. They also recognise that despite the strong evidence base and NICE guideline recommendation (2014) for therapeutic input, psychological input into perinatal mental health difficulties services is currently patchy. Clearly this underlines a well-defined expert role for clinical perinatal psychologists and the need to increase their presence in perinatal mental health services. With a range of core competencies (BPS, 2010) in addition to the domain of individual therapy, clinical perinatal psychologists are also perfectly positioned to take a leading role in training and supervising other health care professionals such as midwives and health visitors, as well as leading on service development and team management. Ameliorating perinatal mental health difficulties within a psychological framework has the potential to pave the way for increased wellbeing on an individual, family, community and societal-level.

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Appendix 1: Case study examples of perinatal services

Example 1: A new perinatal mental health service integrating with existing resources

A CCG for a large city commissioned a business case for a new community-based perinatal mental health team following a fatality due to maternal suicide. Following this, two other CCGs which served the county surrounding the large city commissioned business cases to support this development in their own areas. A business case was submitted to all three which proposed a new single perinatal mental health service to span the county and was approved by all three CCGs. Each CCG contributed the funding needed to ‘fill the gaps’ in their own areas.

The city locality had a well-established community-based perinatal service in place already comprising perinatal psychiatry and CPNs. One of the county localities had a well-established perinatal service within an acute district general hospital comprising clinical perinatal psychology. The other county locality had only very limited access to clinical psychology, also based within the acute district general hospital in that area.

The business case proposed that each locality should have a team comprising consultant perinatal psychiatry, CPNs and clinical psychology. The three localities were funded by the three CCGs; this resulted in all staff being employed by the mental health trust except the county psychologists who were employed by one of the three involved acute trusts.

The business case had taken account of those staff already in post and, therefore, proposed only to fill the gaps in the services where these existed. Hence, clinical psychologists were employed in the city locality, and a consultant perinatal psychiatrist was employed to cover the county localities, together with a number of CPNs. Clinical psychologists were all supervised by a consultant clinical perinatal psychologist who covered all three localities in terms of responsibility. All staff already in post were re-assigned to the newly formed perinatal mental health teams, but remained employed by their original employers.

Thought was given to information and clinical governance issues around record sharing and data collection. Supervision and line management responsibilities were made clear, and these often crossed boundaries of employer or funding. In order to ensure that each clinical area was appropriately led, one individual was designated as the lead for each discipline; this meant that one consultant psychiatrist, one CPN and one consultant clinical psychologist held the responsibility for strategic and service development for their own discipline across the perinatal mental health team. Local leads were found for midwifery and health visiting and an individual for each of these also held responsibility for developing relevant services locally.

The service is now up and running, and women and their families are receiving an equitable and effective service across the city and county locations. Staff work well together and the five discipline leads meet regularly to ensure a shared strategic vision.

Example 2: A flagship service development for post-traumatic stress following childbirth

Services for post-traumatic stress after childbirth have a key requirement to be well integrated with maternity services. In depth knowledge of maternity care practices and excellent working relationships with midwives, obstetricians and gynaecologists are essential to maximise effectiveness.

The service was commissioned after concern from the service user led Maternity Forum and recognition of unmet need. It is located in the acute hospitals trust as a part of health psychology and has good links to the Perinatal Mental Health Team (PMHT). The same provision could be made by an outreach clinical perinatal psychologist from the PMHT.

The service

- Midwives, health visitors, obstetricians or GPs who encounter postnatal women with high levels of distress about childbirth (most within one year of birth, some much later) can refer to a team of midwives led by a consultant midwife. Women can also self-refer.
- The midwife will discuss her concerns. If a woman shows very high levels of distress and signs of post-traumatic stress the midwife refers her to the clinical perinatal psychologist with expertise in birth trauma.
- S/he will complete two assessment sessions and then typically five clinical psychology intervention sessions are offered. These sessions are formulation and not protocol driven. They involve the flexible use of a range of trauma focused approaches including CBT, eye movement desensitisation reprocessing, compassionate mind therapy, metacognitive and narrative therapy as required by the woman. Clinical perinatal psychologists have the skill to adapt and utilise validated approaches as needed by the individual providing individualised care. This is critical when traumatised women have often felt let down by their care providers.

Outcomes and costs

Audit of the first 16 women referred to the pilot service indicated the following:

- 15 of the 16 engaged and completed therapy as planned.
- The average number of sessions was six, involving typically nine hours of therapeutic time.
- Baseline scores for the Impact of Event Scale (IES) indicated high levels of initial distress and caseness. Post-therapy 11/15 women were followed up (four women were not contacted as the audit system was still being established). The mean post-therapy IES score declined significantly, indicating markedly reduced levels of trauma symptoms post-therapy. All women were non-cases post-treatment.
- The cost of the psychological element of this service was costed by internal professional services in 2015 as £688 per woman. An updated audit can be obtained from pauline.slade@liverpool.ac.uk.
- Clinical perinatal psychology services to treat post-traumatic stress after childbirth are simple to set up, lead to high engagement, are highly effective and can be provided for limited cost.
- They are most effective when delivered from within an established PMHT in order to provide integrated care within hospital and community settings.

Appendix 2: Clinical Psychology Agenda for Change grading

Assistant Psychologists (APs) (Bands 4 and 5) are graduate psychologists who must be supervised by an appropriately qualified clinical/health psychologist. The AP role is to assist qualified psychologists; the role is unregistered and unqualified, and individuals require close supervision and may not work independently. Responsibility for clinical interventions, interpreting assessment material and recommendations remains with the qualified psychologist, and not with the AP. If an AP is employed, then costs also need to be included for a minimum of 0.1 wte of a suitably qualified psychologist to provide appropriate induction, training and weekly supervision. APs should be based in a location where they can have frequent contact with qualified psychologists.

Trainee Clinical Psychologists (Band 6) are psychology graduates who are undertaking a three-year applied Doctorate level clinical psychology training. They are assigned to placements within services where an appropriately qualified clinical psychologist is able to provide supervision. Trainee clinical psychologists carry their own caseload whilst on placement and are supported by the supervisor to develop skills in the core competencies of psychological formulation, therapeutic intervention, audit and evaluation, research, teaching, and service delivery.

Clinical Psychologists (Band 7) have completed their Doctorate qualification, and are independent practitioners. They would expect to receive clinical supervision from a more senior psychology colleague, and support in aspects of service development. The expectation would be that perinatal posts would be offered at 8a level as they are specialist in nature, but if it is not possible to fill these posts with appropriately qualified individuals who have specific perinatal experience, newly-qualified clinical psychologists can be appointed at Band 7. In this case, there would be an expectation that they would acquire the necessary skills and knowledge within a two-year period, and be employed at an 8a level from that point.

Specialist/Highly Specialist Clinical Psychologists (Bands 8a/b) have completed appropriate post-qualification experience and training to co-ordinate and manage training placements. They will also have experience and training to undertake more specialist clinical roles within services in keeping with the knowledge and skills attained through CPD. There is an expectation that an 8a clinical psychologist would have reached an advanced level of development following his/her doctoral training in one or more specific theoretical areas along with the expertise and knowledge to employ this additional training. Individuals at an 8b level would expect to be involved in broad level service development as well as the supervision and management of those at a more junior grade.

Consultant Clinical Psychologists (Bands 8c/d and 9) have knowledge and skills that would usually reflect at least six years post qualification experience and an ability to undertake responsibility for professional and service management, development and evaluation. Applicants for such posts are scrutinised by British Psychological Society appointed external assessors who act in an advisory capacity to local service managers to maintain professional standards. Consultant clinical psychologists are generally involved in service development, management, and/or specialist assessment and treatment.

(Edited version from BPS Briefing paper 5: *Commissioning Clinical Psychology Services for older people, their families and other carers*, 2006.)

Appendix 3: Examples of staffing models for perinatal service provision

Model 1: One large perinatal mental health service comprising psychiatry, clinical psychology and CPNs with admin support operates across a geographical area encompassing two district general hospitals and one large teaching hospital and serves a population of 16,000 births per annum. Patients are assessed and treated in a variety of outpatient locations including the acute hospitals. The service is jointly based in the community and the acute hospitals. The clinical perinatal psychologist would provide training, supervision and consultation to midwifery and obstetric staff. This service could be county-wide, or be spread across a large city. Teams A and B serve their local outpatient communities in addition to providing services integrated within the maternity hospitals. The figure below shows the possible distribution of clinical psychologists (but should be viewed within the context of psychologists working within a perinatal multidisciplinary team of psychiatrists and CPNs). Note that in this model, there is no need for all staff to be employed by the same Trust; see Appendix 1 for a case study example.

0.6wte 8d Consultant Clinical Psychologist

Team A	Team C
<p><i>Community-based service and two District General Hospitals (total birth population 6000)</i></p> <p>1wte 8b Clinical Psychologist 1.6wte 8a Clinical Psychologists</p>	<p><i>Community-based service and one large Acute Hospital (total birth population 10,000)</i></p> <p>1wte 8b Clinical Psychologist 2.2wte 8a Clinical Psychologists</p>

Total: 0.6wte 8d consultant; 2wte 8b clinical psychologists; 3.8wte 8a clinical psychologists.

Model 2: In the same geographical area described in Model 1 above, a number of perinatal services exist. Each hospital has its own stand-alone embedded service, and there is a single community-based perinatal mental health team for the entire area. The teams have separate employers, supervision and management.

Team A	Team B	Team C	Team D
<p><i>Hospital-based service (birth population 3000)</i></p> <p>0.6wte 8c Consultant 1wte 8a Clin Psych</p>	<p><i>Hospital-based service (birth population 3000)</i></p> <p>0.6wte 8c Consultant 1wte 8a Clin Psych</p>	<p><i>Hospital-based service (birth population 10,000)</i></p> <p>0.6wte 8c Consultant 2.5wte 8a Clin Psych</p>	<p><i>Community-based service (birth population 16,000)</i></p> <p>0.6wte 8c Consultant 4wte 8a Clin Psych</p>

Total: 2.4wte 8c consultant; 8.5wte 8a clinical psychologists.

Because of the lack of shared supervision, management, systems and strategy, the total number of staff, and the funding required, exceeds the numbers required in the first example. Women do not receive an integrated service, needing to transition between hospital-based and community-based perinatal services. Commissioners are not receiving a single seamless service which ensures equity across the geographical area.

Model 3: Incorporating a Mother and Baby Unit and community PMHT with integrated provision within the acute hospitals’ maternity services.

In this example, a region servicing 24,000 births overall comprises five acute hospitals of varying sizes with maternity provision, a community PMHT and a Mother and Baby Unit. Perinatal psychological services are provided within a perinatal mental health service comprising a minimum of clinical perinatal psychology, perinatal psychiatry and CPN. Thought should be given to including midwifery, health visiting, social work and nursery nursing as part of the perinatal service.

Team A	Team B	Team C	Team D
<i>MBU-based service (serving population 3000)</i>	<i>Community-based service and two acute hospitals (birth population 12,000)</i>	<i>Hospital-based service and two acute hospitals (birth population 8000)</i>	<i>Community-based service and one acute hospital (birth population 4000)</i>
0.8wte 8d Consultant 1.5wte 8a Clin Psych	1wte 8b Psychologist 4wte 8a Clin Psych	1wte 8b Psychologist 2.5wte 8a Clin Psych	1.5wte 8a Clin Psych

Total: 0.8wte 8d consultant, 2wte 8b clinical psychologists; 9.5wte 8a clinical psychologists.

In this example, the 8d Consultant Clinical Psychologist is based in the MBU (but could be based in any Team) and oversees the entire clinical perinatal psychology provision. One 8b psychologist is based in Team B, servicing the largest area, and one 8b psychologist is based in Team C, with responsibility for both Teams C and D. If the 8d psychologist was based within Teams B, C or D, an 8b psychologist would be based in the MBU. 8a psychologists are allocated *pro rata* to the teams, providing a community and acute hospital based service.

This model provides for a fully integrated perinatal psychological service integrating MBU provision, specialist PMHTs based in three localities and an integrated service for the five maternity hospitals.

Notes

Notes

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