



Public Health
England

Protecting and improving the nation's health

Mental health in pregnancy, the postnatal period and babies and toddlers Report for Merton local authority

Purpose

In order to plan services which meet the health needs of your population, you need to carry out a review of those needs in which you:

- identify the needs of a target population
- prioritise those needs to ensure good planning of local services
- ensure effective allocation of resources
- inform the development of an implementation plan that outlines how identified needs will be addressed

This report will help you do the first two of these stages by drawing together key data and information which will measure the extent and nature of the needs of a particular target population. This includes appropriate, evidence-based information on prevalence, demographics and risk factors.

PHE's [National Child and Maternal Health Intelligence Network](#) offers a range of other resources which can also inform the later stages of this process. At the end of this report, the next steps section points you in the direction of some of these.

Using this report

Health and social needs are inherently complex; it is unlikely that there will be a single factor which is responsible for the particular situation in your local area. For this reason, it is important that no single item of information is treated in isolation. Instead the data and evidence should be used as pieces of a jigsaw which when linked together give you a picture of the needs of your local community.

As with all health data and intelligence, it is important to 'sense check' the findings with colleagues and compare it with your own local knowledge. Is the picture given by the data what you would expect? There can sometimes be anomalies in data which have been submitted for central collection or one-off events or changes, for example a new housing development in a local area, which give rise to unexpected results. The data may not be wrong but you should be sure that you understand the reasons why something is not as you might expect.

Contact your local PHE knowledge and intelligence service (see next steps section) if you need further advice.

This report is available for clinical commissioning groups (CCGs) and upper tier local authorities, however a number of indicators are not available for CCGs. Where this is the case, the related tables and charts are not shown.

This report is intended for you to cut and paste text, tables and charts and include them in your own local documents. Please acknowledge the National Child and Maternal Health Intelligence Network as the source and state the date on which you accessed the report. If cutting and pasting sections that quote from or reference other sources, please make sure you also reference the original source. It is recommended that you read our guide on using these reports: fingertips.phe.org.uk/profile-group/mental-health/profile/perinatal-mental-health, to find out more about how to interpret the data.

Definitions

This needs assessment report covers mental health problems in women during pregnancy (the antenatal period) and the postnatal period, which is defined as up to one year after childbirth(1). The antenatal and postnatal periods are often called the perinatal period, when referring specifically to mental health. This definition applies to most perinatal mental health services(2). We recognise that some fathers have mental health problems during this period but for the purpose of this report we will be referring to women only. Mental health problems occurring during the perinatal period can range from symptoms that do not meet the threshold for clinical diagnosis (subthreshold) to severe mental illness(2). This report covers a range of mental health problems including depression, anxiety, post-traumatic stress disorder (PTSD), postpartum psychosis and adjustment disorders and distress.

Mental health in babies and toddlers refers to their social and emotional development and wellbeing. The phrase 'infant mental health' is sometimes used, particularly when referring to services, and is often defined as the "healthy social and emotional development of a child from birth to 3 years"(3). The NICE guidance on 'Social and emotional wellbeing: early years'(4) defines emotional wellbeing as "being happy and confident and not anxious and depressed" and social wellbeing as having "good relationships with others and ...[not having] behavioural problems". Healthy social and emotional development includes attachment which is defined by NICE as "a secure relationship with a main caregiver, usually a parent, allowing a baby or child to grow and develop physically, emotionally and intellectually"(5). This report covers babies and toddlers from birth to three years old.

Background

The mental health problems that pregnant women or new mothers can experience are the same as those that can affect people at other times, and they are often similar in nature(1). However there are a number of reasons why mental health problems in pregnant women and new mothers are different and particularly important to address. These include the effect they can have on the fetus, baby, wider family and mother's physical health(2) and the fact that problems often are not disclosed, recognised or treated during this period(1). Additionally, there are some mental health problems from which women are at increased risk during this period. For example, women with a history of bipolar disorder are at increased risk of relapse in the postnatal period(1).

Healthy social and emotional development in babies and toddlers is important as it is the "building block[s] for healthy behaviour and educational attainment"(4) in the future and helps to prevent behavioural problems and mental illness(4). The social and emotional development of babies and toddlers can be influenced by a wide range of different factors(4). This report aims to provide information on some of these risk factors but this is a complex and wide-ranging topic. It is not possible to provide reliable estimates for the prevalence of poor social and emotional development in babies and toddlers nor exhaustive information on the factors that are thought to influence it.

Estimates of numbers of women with mental health problems during pregnancy and after childbirth in Merton

In order to plan services for pregnant women and new mothers, it is important to understand the likely number of women who are affected by particular mental health conditions.

Based on the number of women giving birth in Merton, the figures below show how many women we would expect to have certain mental health problems in pregnancy and the postnatal period. Definitions of the conditions can be found in the glossary at the end of this report. These estimates are based on national estimates of these conditions and local delivery figures only, and have been rounded up to the nearest five. They do not take into account socioeconomic factors or anything else which is likely to cause local variation. We are not aware of any data or research on exactly how maternal mental health differs by socioeconomic status that would allow us to take this into account in our estimates but appreciate that this would be useful if possible in the future.

Adding all these estimates together will not give you an overall estimate of the number of women with antenatal or postnatal mental health conditions in your area, as some women will have more than one of these conditions. It is believed that overall between 10% and 20% of women are affected by mental health problems at some point during pregnancy or the first year after childbirth(6-8).

In Merton, where 3,205 women gave birth in 2015:

- Estimated number of women with postpartum psychosis: 5
- Estimated number of women with chronic SMI: 5
- Estimated number of women with severe depressive illness: 95
- Estimated number of women with mild-moderate depressive illness and anxiety (lower estimate): 320
- Estimated number of women with mild-moderate depressive illness and anxiety (upper estimate): 480
- Estimated number of women with PTSD: 95
- Estimated number of women with adjustment disorders and distress (lower estimate): 480
- Estimated number of women with adjustment disorders and distress (upper estimate): 960

Source of deliveries: Hospital Episode Statistics, NHS Digital.

Source of rates of disorders: Joint Commissioning Panel for Mental Health. Guidance for commissioners of perinatal mental health services. Volume two: practical mental health commissioning. London: Joint Commissioning Panel for Mental Health; 2012. Available from: www.jcpmh.info/resource/guidance-perinatal-mental-health-services/

Prevalence of poor emotional and social wellbeing in babies and toddlers

It is not possible to reliably estimate how many babies and toddlers have poor social and emotional development or mental health. However, this report includes data on population risk factors which can give an idea of how at risk your local population of children under three is of having poor social and emotional wellbeing.

A population measure of child development outcomes for children aged 2-2½ is currently being developed and will be published in the **Public Health Outcomes Framework**. The measure will cover five domains of development: communication, gross motor skills, fine motor skills, problem solving and personal-social development. The personal-social development domain will be particularly relevant to the issues discussed in this report, and initial findings from the Children and Young People's Health Services dataset (digital.nhs.uk/catalogue/PUB30074) suggest that 95% of boys and 99% of girls are achieving the expected level in this domain, although the dataset has yet to achieve sufficient coverage and robust data quality. A factsheet explaining more about the measure can be found here: www.gov.uk/government/publications/measuring-child-development-at-age-2-to-25-years.

Demographics

The number of births in your local area gives a good indication of the approximate number of mothers and babies in your population overall. It should be remembered that this includes multiple births and so does not give the exact number of mothers. 3,412 babies were born in Merton in 2015.

Population projections describe how the number of births in your area might change over coming years based on what is known of your local population and current trends in births. According to the ONS birth projections, there will be 3,600 births in Merton in 2024.

The general fertility rate is the number of live births for every 1,000 women aged 15 to 44 years in your local population. Merton had a general fertility rate of 73.2 live births per 1,000 women aged 15 to 44 years in 2015. The general fertility rate in England was 62.5 births per 1,000 women aged 15 to 44 years.

Figure 1: General fertility rate per 1,000 population of women aged 15 to 44 years

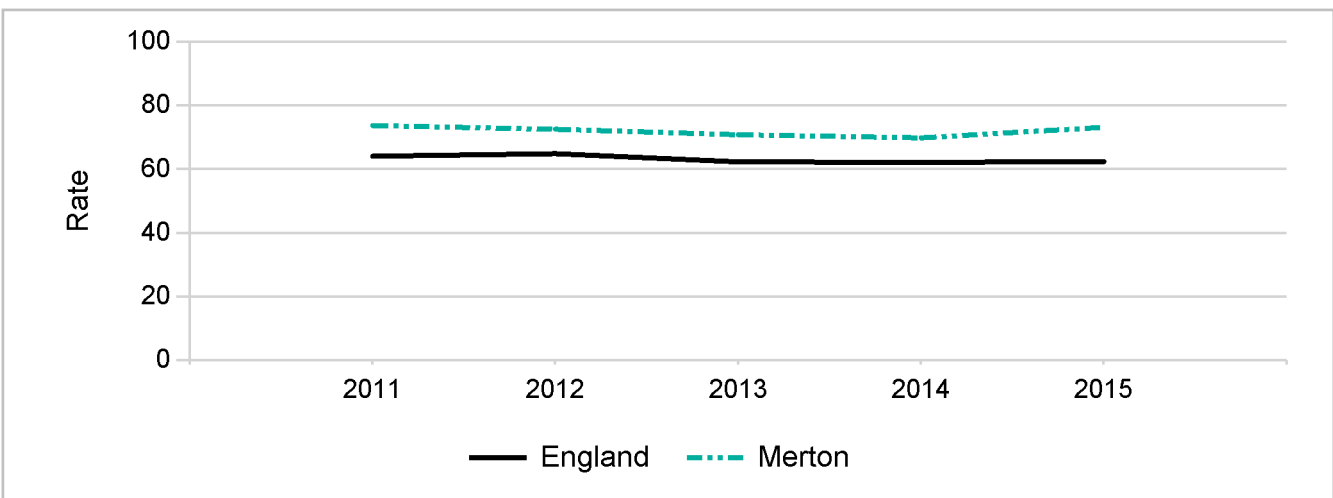


Table 1: General fertility rate

	2011	2012	2013	2014	2015
England	64.2	64.9	62.4	62.2	62.5
Merton	73.8	72.6	70.9	69.9	73.2

Source for table 1 and figure 1: Office for National Statistics

Note: '-1' in any cell indicates the value has been suppressed. Blank cells indicate no data for that area and period.

Risk factors for mental health problems during pregnancy and after childbirth

Many of the risk factors associated with mental health problems during pregnancy and after childbirth reflect those associated with mental illness in the general population(2,9) but evidence and data is provided below on some of the population risk factors for mental health problems in the antenatal and postnatal periods. These risk factors increase the likelihood of maternal mental health problems in a local population. Remember that at a clinical level individuals are much more complex than this, and there is a wide range of factors that can contribute to their risk of mental illness. There will also be women in your area with none of these risk factors who develop mental health problems during pregnancy or after childbirth.

History of mental health problems

Women who have a history of mental health problems before becoming pregnant are at increased risk of certain mental health conditions during pregnancy and the year after childbirth(9-11). Therefore if there is a higher than average rate of mental health problems in your local general population, there may be a higher level of maternal mental health problems as well. The next steps section of this report contains links to resources from the National Mental Health, Dementia and Neurology Intelligence Network (NMHDNIN) that can help you find out more about mental health in your area.

There is likely to be more data available on pre-existing mental health conditions in mothers and pregnant women in the future through the Mental Health Services Data Set (MHSDS - content.digital.nhs.uk/mhsds) and the Maternity Services Data Set (MSDS - content.digital.nhs.uk/maternityandchildren/maternity). Please see the next steps section for more information on these datasets. In the meantime, the Mental Health and Learning Disabilities Data Set (MHLDDS) contains information on mental health conditions in women of childbearing age (see content.digital.nhs.uk/mhldsmonthly for more information on this dataset).

Traumatic childbirth, stillbirth and infant mortality

Mental health problems, particularly post-traumatic stress disorder (PTSD), are associated with experiencing a traumatic childbirth, stillbirth or the death of a baby(1,2): "Specific traumas including stillbirth, infant complications and other forms of traumatic childbirth experiences are associated with mental health problems, particularly PTSD."(2, pg. 31)

NICE defines traumatic births as: "births...which are physically traumatic...and births that are experienced as traumatic, even when the delivery is obstetrically straightforward."(1)

A stillborn baby is one born after 24 completed weeks of pregnancy with no signs of life. The stillbirth rate is the number of stillbirths per 1,000 total (live and still) births. There were 53 stillbirths in Merton in the period 2013-2015: a stillbirth rate of 5.2 stillbirths per 1,000 births. This was similar to the national rate of 4.6.

Figure 2: Stillbirth rate per 1,000 births

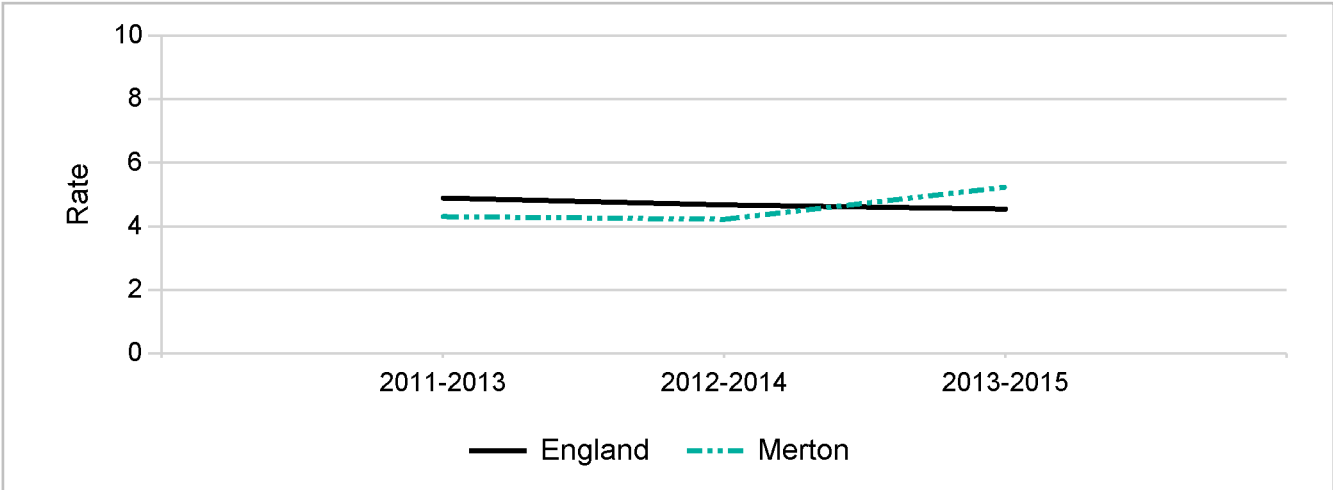


Table 2: Stillbirth rate

	2011-2013	2012-2014	2013-2015
England	4.9	4.7	4.6
Merton	4.3	4.2	5.2

Source for figure 2 and table 2: Office for National Statistics

Note: '-1' in any cell indicates the value has been suppressed. Blank cells indicate no data for that area and period.

The infant mortality rate is the number of infants dying before their first birthday per 1,000 live births. There were 29 infant deaths in Merton in the period 2014-2016: an infant mortality rate of 2.9 per 1,000 births. This is similar to the national rate of 3.9 per 1,000 live births.

Figure 3: Infant mortality rate per 1,000 live births

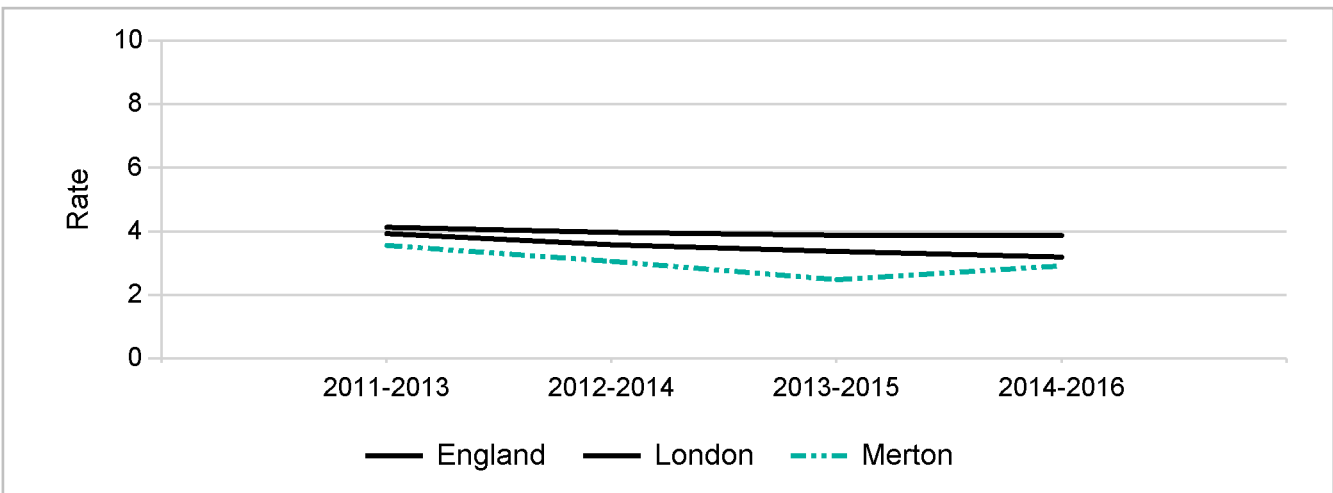


Table 3: Infant mortality rate

	2011-2013	2012-2014	2013-2015	2014-2016
England	4.1	4.0	3.9	3.9
London	3.9	3.6	3.4	3.2
Merton	3.6	3.1	2.5	2.9

Source for figure 3 and table 3: Office for National Statistics

Note: '-1' in any cell indicates the value has been suppressed. Blank cells indicate no data for that area and period.

Domestic violence and abuse

An association has been found between domestic violence and antenatal depression, postnatal depression, anxiety and PTSD, although it is not known whether domestic violence increases the risk of mental health problems or vice versa(12). A systematic review and meta-analysis found that: "... high levels of symptoms of all types of perinatal mental disorders included in studies to date (i.e., antenatal and postnatal anxiety, depression, and PTSD) were associated with having experienced domestic violence, although causality cannot be inferred."(12, pg. 10)

Although we do not know whether it actually causes maternal mental health problems, a high level of domestic violence in your area indicates your population is more at risk of mental health problems in pregnancy and the year after childbirth.

Living in a household where domestic violence is occurring is also a risk factor for poor mental health in babies and toddlers: "The impact of living in a household where there is a regime of intimidation, control and violence differs by children's developmental age. However, whatever their age, it has an impact on their mental, emotional and psychological health and their social and educational development."(13)

In 2015 there were 22.5 domestic abuse incidents per 1,000 population reported to the police force area which covers Merton, compared to 22.1 per 1,000 nationally. Please note these rates relate to all incidents and are not restricted to those involving households containing children or pregnant women.

Poor social support

Women who lack social support have been found to be at increased risk of antenatal and postnatal depression(10). Having a poor relationship with a partner is also a risk factor for postnatal depression (10).

ONS statistics show that infant mortality rates are higher among babies that are registered by just one parent than for other registration types(14).

The number of births which were registered by just one parent potentially gives a rough indication of the number of women in your local area that are likely to lack the support of the father during pregnancy and as a new mother. In Merton, 4.1% of births were registered by just one parent which is lower than the average of 5.4%.

Risk factors for poor social and emotional development in babies and toddlers

There are many factors that have the potential to impact on the social and emotional development of babies and toddlers. In this report, data and evidence is presented on a few key risk factors which are known to have the potential to significantly affect development and wellbeing. The NICE guidance on social and emotional wellbeing in the early years states that "[a] complex range of factors have an impact on social and emotional development. Knowledge of these factors may help encourage investment at a population level in early interventions to support health and wellbeing."(4)

Being exposed to more than one risk factor may have an increased impact on a young child. Research from the Centre for Longitudinal Studies (CLS), using data from the Millennium Cohort Study (MCS), examined "the associations of multiple risks to deficits in developmental outcomes at three and five years of age for children born in 2000 to 2001"(15, pg. 3). It found that "analyses of MCS children's outcomes at ages three and five suggested that being exposed to two or more risks in first years of life is likely to disadvantage children's cognitive and behavioural development as they grow up...The greater the number of risks experienced by the child, the greater the problems that the child will face during the lifecourse."(15, pg. 22)

It is important to remember that not all babies or toddlers with certain risk factors will have poor mental health, as the NICE guidance states: "[t]hese indicators can be used to identify groups of children who are likely to be vulnerable. However, not all of these children will in fact be vulnerable – and others, who do not fall within these groups, could have social and emotional problems."(4)

However, as population risk factors, the following can be used to determine whether your local population of babies and toddlers is at increased risk.

Attachment

When considering social and emotional development in babies, toddlers or young children, it is useful to understand the importance of attachment and how it relates to other risk factors. NICE defines attachment as "a secure relationship with a main caregiver, usually a parent, allowing a baby or child to grow and develop physically, emotionally and intellectually. Babies and children need to feel safe, protected and nurtured by caregivers who identify 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."(5)

The NSPCC sets out the different kinds of attachment relationship in its report 'Prevention in mind'. Attachment can be secure, which "enables the child to feel safe, secure and protected"(6, pg. 13), or insecure. There are three categories of insecure attachment: ambivalent, avoidant and disorganised, and in these cases children "may have experienced inconsistent or insensitive care and therefore are not able to rely upon their relationship with their primary caregiver"(6, pg. 13). It is insecure attachment, particularly disorganised attachment, that can lead to problems with a baby or toddler's development.

There is no reliable data available on parent-baby attachment but it is important to consider whether there is likely to be a high level of disorganised attachment in your local area. Some of the other risk factors discussed below can lead to attachment problems.

Drug and alcohol misuse

If a parent or caregiver misuses alcohol or drugs, there can be an impact on a baby or toddler's development, often due to parenting problems: "Research has shown that parents misusing substances are at risk of a wide range of difficulties associated with their role as a parent. These may

include a lack of understanding about child development issues, ambivalent feelings about having and keeping children and lower capacities to reflect on their children’s emotional and cognitive experience.”(16, pg. 6)

In terms of alcohol misuse, NICE guidance stresses the importance of taking account of “the impact of the parent’s drinking on the parent–child relationship and the child’s development, education, mental and physical health, own alcohol use, safety, and social network”(17).

The NSPCC report ‘All babies count: spotlight on drugs and alcohol’ highlights the effect of alcohol misuse on parenting: “Problematic drinking by parents is associated with negative parenting practice...and parenting capacity can be compromised when parents become increasingly focused on drinking and as a result become less loving, caring, nurturing, consistent or predictable.”(16, pg. 6)

In 2000, the Advisory Council on the Misuse of Drugs launched an inquiry into the children of problem drug users. It found that “parental problem drug use can and often does compromise children’s health and development at every stage from conception onwards.”(18, pg. 10)

Looking at the impact at different stages of a child’s life, the inquiry found that from birth to age two: “The foundation of a child’s normal development is a good relationship with a well parent or primary care giver...who is consistently able to provide nourishment, stimulation and protection from danger and give the child a sense of well-being and security. Much of the potential for parental drug use to damage the child in these early months lies in the way it can obstruct or corrupt this relationship.”(18, pg. 37)

At 3-4 years of age “parental problem drug use can continue to jeopardise the child’s development in many ways”(18, pg. 39), including being left unsupervised or neglected, physical violence or emotional abuse and less time stimulated through play or reading.(18)

The National Treatment Agency for Substance Misuse(19) found that during 2011/12, one third of adults in treatment lived in a household containing children (this includes parents living with their own children and adults living in a house with children who are not theirs, for example step-children or grandchildren). Parents who live with their own children tend to have fewer drug-related problems than others in treatment, are less likely to use the most addictive drugs, and are less likely to inject drugs when compared to non-parents in treatment(19). They are also less likely to be homeless or arrive in treatment via the criminal justice system(19).

Table 4a: Parents in drug treatment, rate per 100,000 children aged 0-15

	2011/12
England	110.4
London	104.1
Merton	102.6

Table 4b: Parents in alcohol treatment rate per 100,000 children aged 0-15

	2011/12
England	147.2
London	108.2
Merton	133.3

Source for tables 4a and 4b: Public Health England

Note: '-1' in any cell indicates the value has been suppressed. Blank cells indicate no data for that area and period.

Maternal mental health

The social and emotional wellbeing of a baby or toddler can be affected by whether the mother has a mental health problem herself, often due to the effect on the mother-baby relationship(1,2,4): “.... emotional distress and problems during pregnancy, childbirth and the postnatal period warrant particular attention because of the longitudinal impact these difficulties have on the developing fetus and newborn baby, effects which are often mediated through the woman’s disrupted relationship with her infant.”(2, pg. 209)

For example, postnatal depression can have serious and long term effects on babies:

“Failure to treat (perinatal depression) promptly may result in a prolonged, deleterious effect on the relationship between the mother and baby and on the child’s psychological, social and educational development.”(11, pg. 1)

There is evidence that postnatal depression “may be associated with lower cognitive and language achievements” in young children(10). Cognitive development is not impaired in all babies and children of mothers with postnatal depression, but “appears limited to those children whose mothers find it difficult to maintain sensitive and active engagement with the infant”(11, pg. 2).

The mental health resources signposted in the next steps section and the estimates of women with mental health problems in pregnancy and the first year after childbirth can be used to give an idea of the scale of mental health problems among mothers in your local area.

Teenage parents

Pregnancy in under-18 year olds can lead to “poor health and social outcomes for both the mother and child”(20) for example: “...resulting children are at greater risk of low educational attainment, emotional and behavioural problems, maltreatment or harm, and illness, accidents and injuries”(21).

The NICE guidance on social and emotional wellbeing in the early years(4) lists being born to parents aged under 18 years as a factor that can make children vulnerable to poor wellbeing. Young mothers are also more at risk of developing postnatal depression than average(22).

The data below shows births to mothers aged under 18 years in your area. Remember that not all babies born to teenage parents will be brought up by them. Also, although a high number of teenage parents in a population is a risk factor for higher levels of poor infant mental health, on an individual level many teenage parents will parent effectively and raise healthy children. In addition, it is worth considering whether younger adult parents (those in their late teens or early twenties) in your area need extra support, especially those who are vulnerable or lack family support.

Figure 5: Percentage of deliveries where the mother is aged under 18 years

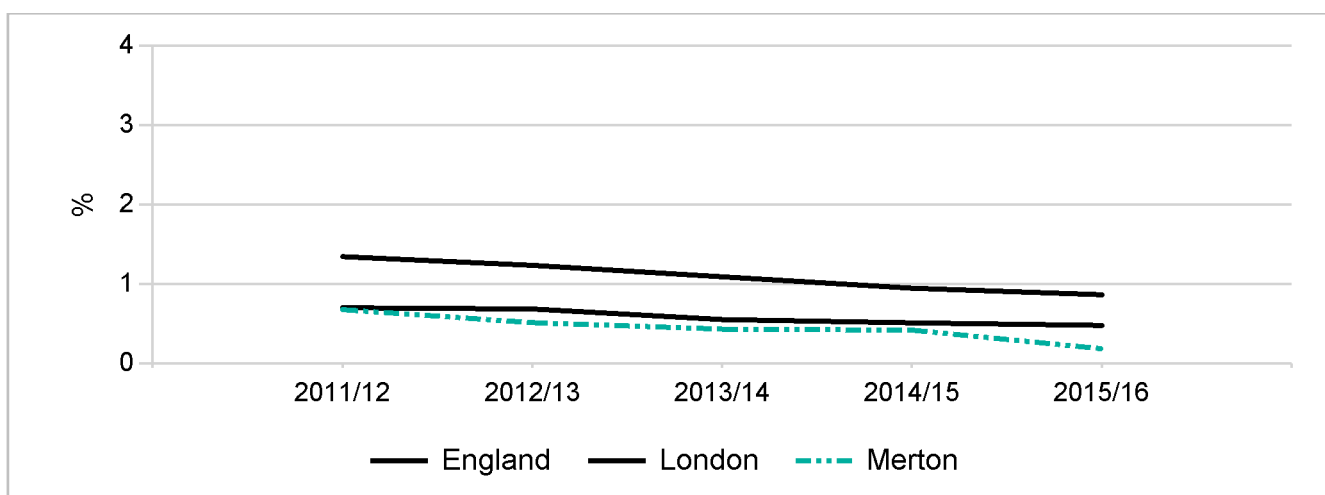


Table 5: Percentage of deliveries where the mother is aged under 18 years

	2011/12	2012/13	2013/14	2014/15	2015/16
England	1.3	1.2	1.1	0.9	0.9
London	0.7	0.7	0.6	0.5	0.5
Merton	0.7	0.5	0.4	0.4	0.2

Source for figure 5 and table 5: Hospital Episode Statistics, Health and Social Care Information Centre.
 Note: '-1' in any cell indicates the value has been suppressed. Blank cells indicate no data for that area and period.

Looked after children and child maltreatment

There are risks to babies' and toddlers' mental health associated with the experience of being in care, as mentioned in the NICE guidance on looked after children and young people:

"Evidence suggests that frequent moves...can adversely affect the ability of babies and very young children to form healthy attachments that lead to healthy emotional and physical development."(5)

"The absence of a permanent carer at such a young age can jeopardise children's chances of developing meaningful attachments and have adverse consequences for their long-term wellbeing."(5)

"Very young children can become closely attached to foster care families and can experience great distress if moved to a new placement." (5)

Data on the number of looked after children in your area is also useful because many children are in care due to circumstances which are likely to have affected their wellbeing:

"Decisive action is of key importance to the wellbeing of very young children who come into the care of local authorities. The majority are from families where parents are struggling with issues such as domestic violence, substance abuse, alcohol abuse and mental health problems, often in combinations."(5)

Many looked after children have suffered abuse or neglect, which can be very damaging to their development, wellbeing and attachment relationships (23):

"A substantial number of children and young people are placed in local authority care as a result of maltreatment.... Many children suffer combinations of different forms of abuse and neglect and, as a result, experience the kind of care-giving in which key nurturing experiences are missing. In maltreated children, the child's primary attachment figure (usually the parent) is likely to be unavailable at times of need and may also be the cause of extreme fear and distress. This can lead to the

development of insecure or disorganised attachment patterns and have an impact on brain development, which can in turn lead to impaired development.”(23)

Table 6: Looked after children aged under 5 years, rate per 10,000 children aged under 5 years

	2014/15	2015/16	2016/17
England	44.9	40.3	36.9
Merton	15.8	12.5	9.4

Source for table 6: Department for Education

Note: '-1' in any cell indicates the value has been suppressed. Blank cells indicate no data for that area and period.

Experiences of child maltreatment, whether in looked after children or others, can have very serious effects on a young child’s development:

“There is strong evidence of the harmful short- and long-term effects of child maltreatment. All aspects of the child's health, development and wellbeing can be affected.”(24)

Data on the number of children on a child protection plan can also give an indication of the numbers of children that have experienced maltreatment in your local area, although this will obviously only include those known to authorities.

Table 7: Children subject to a child protection plan, rate per 10,000 children

	2012/13	2013/14	2014/15
England	37.9	42.0	42.9
London	34.8	37.2	40.6
Merton	36.7	40.5	38.8

Source for table 7: Department for Education

Note: '-1' in any cell indicates the value has been suppressed. Blank cells indicate no data for that area and period.

Homelessness

Babies and toddlers that live in families that are homeless are vulnerable to poor social and emotional wellbeing (25). The NSPCC explains the effects of homelessness on babies in their report ‘An unstable start’: “Babies living in homeless families can be extremely vulnerable. This is because babies’ development is reliant on the quality of the care their parents are able to provide and for some parents who are homeless, providing this care can be difficult.”(25, pg. 5)

“The limited research on the specific impact of homelessness on babies shows that homeless infants experience a significant decline in general developmental function between 4 and 30 months”(25, pg. 8)

The following table shows the rate of family homelessness in Merton, compared with the national average.

Table 8: Family homelessness: households containing children or a pregnant woman per 1,000 households

	2011/12	2012/13	2013/14	2014/15	2015/16
England	1.7	1.7	1.7	1.8	1.9
London	3.0	3.6	4.1	4.1	4.5
Merton	0.8	0.8	0.9	1.5	1.4

Source for table 8: Department for Communities and Local Government

Note: '-' in any cell indicates the value has been suppressed. Blank cells indicate no data for that area and period.

Next steps

The data and information in this report should have given you an indication of risk factors for antenatal and postnatal mental health conditions and poor social and emotional development in babies and toddlers in your local area, as well as estimates for maternal mental health conditions. Combined with local knowledge and data, we hope that this helps you to assess the needs of pregnant women, new mothers and babies and toddlers in your area. The list below sets out some of the other resources and sources of information you may want to look at to help you to do this and to move on to the next stage of planning for services which meet the needs of your population.

- The National Child and Maternal Health Intelligence Network is hosted and facilitated by PHE and provides wide-ranging, authoritative data, evidence and practice in relation to child and maternal health which you can use to improve the quality of care and outcomes for communities, patients and their families. Find out [more about our work, including our data and tools](#).
- If you have not yet read our [guide on using these reports](#) (see supporting documents section), it provides useful information on how to get the most out of this report.
- Find out more about the general population in your area, including child poverty, by looking at the child and maternal health section on PHE's [Fingertips tool](#).
- [Subscribe to PHE ebulletins](#) to keep you up to date with the latest resources and research relating to child and maternal health. Register your email address then change your preferences and select 'Child and maternal health current awareness ebulletin'. The ebulletin is sent every two weeks.
- The [National Mental Health Dementia and Neurology Intelligence Network](#) provides tools and data on the prevalence of mental health problems and a range of risk factors in your local area. Resources include:
 - o A [perinatal mental health catalogue](#) which lists sources of national datasets and indicators on perinatal mental health at clinical commissioning group (CCG), local authority, GP practice and provider level data.
 - o The [perinatal mental health profile](#) which shows data on mental health in pregnancy, the postnatal period and babies under 1 year old. It shows data on the demographics, risk and related factors, prevalence, and identification and access, during the perinatal period. It includes metrics at local authority, CCG and acute trust level.
- You may be able to access better data locally. For example, local authorities could find out up to date numbers of looked after children or children aged under three on a child protection plan in their area from their children's services department. Homelessness and domestic violence are other examples of things that there may be data available on locally.
- NHS England has committed to fulfilling the ambition in the [Five Year Forward View for Mental Health](#), so that by 2020/21 there will be increased access to specialist perinatal mental health support in all areas of England, allowing at least an additional 30,000 women each year to receive evidence-based treatment, closer to home, when they need it. This includes the right range of specialist community and inpatient care. A phased, five-year transformation programme, backed by £365m in funding, is underway to build capacity and capability in specialist perinatal mental health services, focused on improving access to and experience of care, early diagnosis and intervention, and greater transparency and openness.
- Public Health England in 2017 launched the [Prevention Concordat for Better Mental Health](#) and supporting resources (including local prevention planning guidance, Joint Strategic Needs

Assessment and Return On Investment tools), which include explicit references to the importance of multi-disciplinary action to prevent perinatal mental health problems and to intervene early.

- Maternal mental health is one of 6 **Early Years High Impact Areas** for health visiting services.
- Read the Joint Commissioning Panel for Mental Health's **guide to the commissioning of good quality perinatal mental health services**.
- The **NICE Quality Standard (QS115) on antenatal and postnatal mental health** was published in 2016.
- Review learning from serious case reviews, if there has been a maternal suicide in your area. MBRRACE-UK runs the national confidential enquiry into maternal deaths, collecting information on mothers in the UK who die during pregnancy or in the first 12 months after giving birth, including women who died from suicide. Their **reports into maternal death in the UK** are available on their website.
- There is likely to be more data relevant to the commissioning of perinatal and infant mental health services available in the future through the Maternity Services Data Set (MSDS), part of the Maternity and Children's Data Set (MCDS), and the Mental Health Services Data Set (MHSDS). The MSDS will provide a national standard for gathering data from maternity healthcare providers in England. The MHSDS will deliver comprehensive and comparable information for children, young people and adults who are in contact with Mental Health Services. Find out more and sign up for updates about the MSDS **here** and the MHSDS **here**.
- You should consider the views of local women and families when commissioning perinatal and infant mental health services. Your **local Healthwatch** will have more information on ensuring the voice of service users is included in the commissioning and delivery of health and care services.

Contact your local PHE knowledge and intelligence service for further advice and support:

North East	LKISNorthEast@phe.gov.uk
North West	LKISNorthWest@phe.gov.uk
Yorkshire and the Humber	LKISYorkshireandHumber@phe.gov.uk
East Midlands	LKISEastMidlands@phe.gov.uk
East of England	LKISEast@phe.gov.uk
West Midlands	LKISWestMidlands@phe.gov.uk
London	LKISLondon@phe.gov.uk
South East	LKISSouthEast@phe.gov.uk
South West	LKISSouthWest@phe.gov.uk

Glossary: perinatal mental health conditions

Adjustment disorders

Adjustment disorder is a state of mixed emotions such as depression and anxiety which occurs as a reaction to major life events or when having to face major life changes such as illness or relationship breakdown.

Source: Royal College of Psychiatrists (26)

Mild-moderate depression and anxiety

The main symptoms of depression are losing pleasure in things that were once enjoyable and losing interest in other people and usual activities. A person with depression may also commonly experience some of the following: feeling tearful, irritable or tired most of the time, changes in appetite, and problems with sleep, concentration and memory. People with depression typically have lots of negative thoughts and feelings of guilt and worthlessness. Sometimes people with depression harm themselves, have thoughts about suicide, or may even attempt suicide.

Mild depression is when a person has a small number of symptoms that have a limited effect on their daily life. Moderate depression is when a person has more symptoms that can make their daily life much more difficult than usual.

Mild anxiety is experienced as feelings of being overwhelmed by responsibilities and unable to cope. People with depression may have feelings of anxiety as well.

Source: NICE (27), Best Beginnings (28)

Postpartum psychosis

Postpartum psychosis (or puerperal psychosis) is a severe episode of mental illness which begins suddenly in the days or weeks after having a baby. Symptoms vary and can change rapidly. They can include high mood (mania), depression, confusion, hallucinations and delusions.

Source: Royal College of Psychiatrists (29)

Post-traumatic stress disorder

Postnatal Post Traumatic Stress Disorder (PTSD) is experienced as nightmares, flashbacks, anger, and difficulty concentrating and sleeping. It may be a pre-existing condition or be triggered by a traumatic labour.

Source: Best Beginnings (28)

Serious mental illness (severe mental illness)

Serious mental illness includes diagnoses which involve psychosis. The most common disorders which are associated with psychotic symptoms are schizophrenia, bipolar disorder and psychotic depression. Psychosis is used to describe symptoms or experiences that happen together. Each person will have different symptoms, but the common feature is that they do not experience reality like most people. A person with psychosis may have: hallucinations, delusions, muddled thinking, lack of insight.

Source: Mental Health Wales (30), Royal College of Psychiatrists (31)

Severe depressive illness

Severe depression is when a person has many symptoms that can make their daily life extremely difficult. Sometimes a person with severe depression may have hallucinations and delusions (psychotic symptoms).

Source: NICE (27)

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