GIVE ME STRENGTH

A campaign from 4Children to avert family crisis

Suffering in silence

70,000 reasons why help with postnatal depression has to be better

www.givemestrength.org.uk

Suffering in Silence

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Suffering in Silence

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Introduction and Executive Summary

Every year millions of children have their life chances diminished by growing up in families facing serious or multiple challenges, without the practical support they need to prevent problems escalating into crises.

It is increasingly accepted that with the right help early on, many such crises can be prevented for the good of children, the wider family and their community.[1] Yet the huge culture shift we need to move from dealing with the consequences of failure to widespread early intervention and prevention is still a long way off. That is why 4Children launched the Give Me Strength campaign in May 2011.

As part of Give Me Strength we are taking an in-depth look at three of the major causes of family instability and child vulnerability that we believe if more effectively tackled could ensure more families stay together and more children get off to a good start in life; these are domestic violence, parental alcohol abuse and postnatal depression.

This report presents new research from 4Children that shows that many families are suffering the consequences of postnatal depression in silence; that if and when they do seek help mothers are not getting the swift access to the range of treatment options they need; and that this is having a detrimental impact on families across Britain.

The impact of depression

A World Health Organization (WHO) study compared depression with angina, asthma, arthritis and diabetes and concluded that the effect of depression on a person's ability to function was 50% more serious than the impact of any of the four physical conditions on them.[2]

Our case studies tell of the terrible toll that unrecognised and untreated maternal depression can take on families with young children. These are stories of relationship breakdown, conflict within families, older siblings stepping in to look after babies, and children living with the long term consequences of poor early bonding.

Results from our survey, undertaken by the parenting club Bounty for this report, reveal that a toxic combination of lack of awareness of the symptoms of postnatal depression and fear of the stigma attached to it are preventing thousands of new mothers from seeking help at the early stages of this illness. This, despite that fact that an estimated one in ten new mothers will suffer from it – approximately 70,000 women a year in England and Wales – from across the social spectrum.

The good news is that there are relatively simple solutions available. With appropriate and timely treatment mothers make a good recovery and long term negative consequences for children and families can be avoided. But this is not being provided often enough or early enough. Instead, too many mothers are not being given access to the psychological therapies that the National Institute of Clinical Excellence (NICE) recommends, as a result of an over reliance on antidepressants, or being put in touch with support groups which we have been told time and again can make such a difference. Finally, not enough recognition is being given the important role that partners can play or the impact of postnatal depression on couple relationships.

In order to turn this situation around we need to take action now to change the way we as a nation think and talk about postnatal depression; we need to change the speed and nature of the treatment provided; we need to ensure more families get the practical and emotional support available from local support groups; and we need to put families at the heart of our approach.

In Britain today, we are letting families down by not preparing them for the possibility of postnatal depression and not acting quickly or appropriately when it occurs – as a result we are stacking up problems for the future and causing needless misery for thousands. We believe that the recommendations in this report have the potential to give new strength to families at a crucial stage in their lives with long term, positive consequences. Failure to deliver this change means more unnecessary suffering and the spiralling costs of the consequences. We cannot afford to do nothing.

This report highlights some important issues that are contributing to the unnecessary misery of families across Britain. These findings lead us to conclude that the status quo is unacceptable because it is characterised by:

- A chronic lack of awareness of the symptoms of postnatal depression amongst expectant parents, parents and the wider public.
- A fear that admitting to the symptoms of depression will have serious implications or constitute an admission of failure.
- A failure to use the known risk factors for postnatal depression as an effective trigger for earlier intervention.
- Late or mis-diagnosis of postnatal depression by GPs and other primary care professionals.
- A profound lack of local, regional or national information about the prevalence, severity and treatment of postnatal depression gathered by the NHS.
- A postcode lottery in the availability of in-patient care for mothers suffering with acute postnatal depression.
- Non-compliance with NICE guidance which advocates the use of psychological therapies as an equally effective alternative to anti-depressants.
- A failure to value the positive contribution partners can play if availed with the necessary information and support.
- Not enough 'social prescribing' of forms of practical help and support that can make a real difference to families, including access to peer to peer support and befriending.

Recommendations

In order to give new strength to families, in particular the one in ten who will experience postnatal depression after the birth of a child each year, we are making the following recommendations:

1. **A national campaign** – led by the Department of Health but working with civil society, the voluntary sector and the business community – to raise awareness of the symptoms of postnatal depression and to challenge the myths and stigma attached.
2. **Change the way antenatal screening is undertaken** to create a more proactive approach to identifying key risk factors including relationship conflict, social isolation, financial or housing worries or employment issues. Backed up by an offer of practical support when it is needed.
3. **Re-introduce an antenatal role for health visitors** – as their numbers grow – to build relationships with parents earlier and co-ordinate the earlier, practical support needed by some families.
4. **Master classes on postnatal depression for professionals** working with new mothers and families during pregnancy and early years to update and raise awareness of symptoms, available treatments and the benefits of early treatment.
5. **Strengthen the assessment, identification and support skills of health visitors** including training in the cognitive behavioural therapy skills that have been shown in pilot programmes to improve outcomes for children and their families.
6. **Improved collection of data by the NHS** locally and nationally to provide a clear picture of the diagnosis and treatment of postnatal depression.
7. In order to ensure equitable access to in-patient Mother and Baby Units across the UK, **plans need to be developed to provide new units in 'desert' areas** including Northern Ireland, northern Scotland, north Wales, East Anglia and the South West of England.
8. **A new commitment from GPs that psychological therapies will always be offered** in cases of diagnosed postnatal depression and that 'social prescribing' including referral to support groups and befriending schemes will also be a priority.
9. **Explicit priority given to increasing access to 'talking therapies'** during the perinatal period given within the Government's programme for expanding psychological services – the IAPT programme.
10. **Put families at the heart of tackling postnatal depression**, with more information and support for dads and more priority given to strengthening family relationships and bonds as part of treatment programmes.

Chapter 1
What is postnatal depression?

For most families the birth of a child is a joyous occasion; bringing new hope for the future. But for some, events take a difficult turn a few weeks after birth (or sometimes before birth)[3], when mothers start to feel one or more of the following symptoms:

- Low mood/miserable most of the time
- Constantly exhausted
- Feeling unable to cope
- Feeling guilty about not being able to cope about not loving the baby enough
- Overwhelming anxiety about the baby
- Tearful for no reason
- Difficulty in sleeping
- No appetite or the urge to eat
- Difficulties in bonding with the baby
- Difficulties in their relationship with their partner
- Low energy levels
- Low sex drive
- Withdrawal from family or friends

These are the most common symptoms for postnatal depression and can lead to a period of considerable uncertainty, anxiety and disruption.

These are not just baby blues. 'Baby blues' is experienced by an average of eight out of ten women three or four days after birth[4] and the symptoms include feeling upset, mood swings, being mildly depressed and wanting to cry for no particular reason. These feelings tend to disappear within a few days (ten days) after birth. Conversely, postnatal depression is an illness which occurs between four and six weeks after birth[5], resembles the symptoms of 'baby blues' at first, but is more intense and longer lasting.

If a new mother is experiencing around three of the above symptoms, she is considered to have mild postnatal depression. Having five or six of the symptoms is considered moderate postnatal depression, and experiencing more than five or six is considered severe postnatal depression.[6]

The most frequently quoted statistic for women experiencing mild postnatal depression is between 10-15 women out of every 100 women having a baby (i.e. between one in ten and one in eight).[7] However, estimates vary and can be much higher. A recent 4Children survey, conducted by Bounty, of 2,318 new mums[8] suggested that the figure was higher, with three out of ten mums with children under the age of 2 believing that they had suffered some form of postnatal depression[9] [see Figure 1]. This survey found that those with more than one child ('multi mums') are more likely to report experiencing postnatal depression than first time mums.

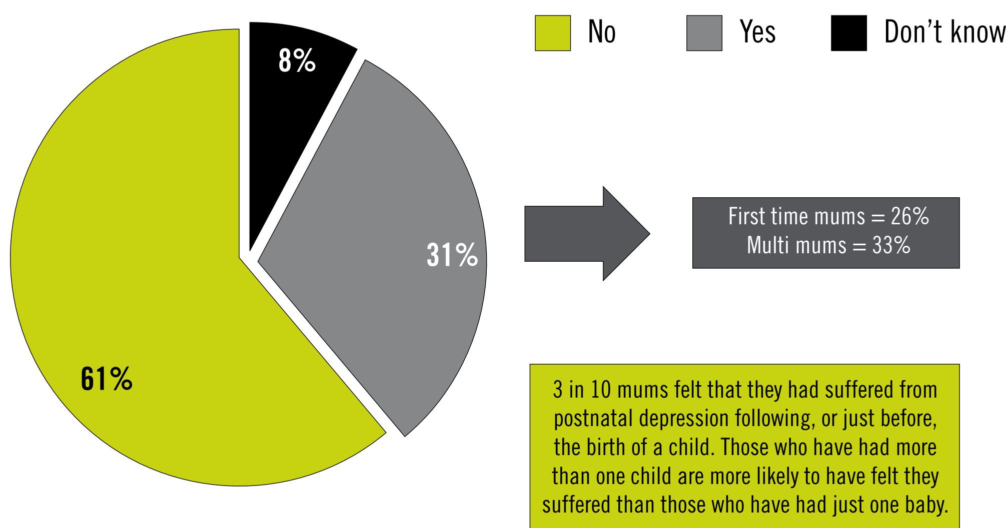
There is some evidence to suggest that one in four mothers are still depressed at their child's first birthday[10] and about a third of women who have symptoms of postnatal depression during pregnancy continue to have postnatal depression after the birth of their child.

The most serious form of postnatal depression is puerperal psychosis (otherwise known as postpartum psychosis). It is an extremely severe but rare form of postnatal depression, affecting around two in 1,000 women. It tends to present itself within a few days after childbirth, manifests in erratic and delusional behaviour by the new mum and requires urgent hospital treatment. The symptoms of puerperal psychosis include: confusion and disorientation, hallucinations, delusions, paranoia and lack of insight and awareness.[11]

Women with puerperal psychosis tend to improve within a one to two month period when treated in a hospital Mother and Baby Unit (or a general psychiatric ward). Significantly, just over half of the women who have experienced puerperal psychosis in their previous pregnancy are likely to be at risk of getting it again in their subsequent pregnancies.[12]

Figure 1: Mums who felt they suffered from PND after the birth of their child

Base: All who have had a child (1.391)



Why do women get postnatal depression?

Theories as to why women get postnatal depression vary enormously. Some experts believe it is caused by hormonal changes after childbirth, but others believe it is a combination of genetic, environmental and social factors.[13]

Generally, a history of (any) depression increases the risk that a new mum will experience postnatal depression. A history of postnatal depression carries risk of >30% reoccurrence in further pregnancies, and one in every three or four women who have had bipolar or schizoaffective disorder will experience puerperal psychosis after the birth of their first child.[14]

Other reasons why postnatal depression might occur include:[15]

- Family history of mental illness
- No supportive partner, family or friends available
- Stressful life event during the pregnancy or after childbirth (including early or difficult birth)
- Relationship or marital problems
- Difficulties in breastfeeding
- Financial worries, housing issues or problems at work.
- Loss of control or change in lifestyle

A meta-analysis review of studies in the United States also suggested that women from lower socio-economic backgrounds and from ethnic minority groups may be at a slightly higher risk of getting postnatal depression[16], although one recent survey in the UK highlighted that a third of new mums from higher income bands (i.e. £60,000–£70,000 per year) had experienced postnatal depression or anxiety.[17]

Whilst research tells us there is no absolute protection against postnatal depression and that almost any pregnant or new mother can get it, the evidence that there are some social and environmental factors that at the very least contribute to the likelihood that a woman will suffer postnatal depression, as well as the frequency with which it occurs, demands that antenatal and postnatal services should be tuned into these risk factors and seeking to actively reduce risk by providing appropriate advice and support in relevant cases.

Chapter 2

Suffering in silence

In the summer of 2011 4Children commissioned the parenting club, Bounty, to undertake a survey of more than 2,000 mums aimed at gathering new evidence about the prevalence, awareness and experience postnatal depression. The results showed that half of the women (49%) who had suffered from postnatal depression had not sought professional treatment. Further analysis showed that this average figure disguised a significant variation with first time mums less likely (42%) than 'multi mums' (54%) to seek professional help.

With 700,000 births in England and Wales each year[18] and at least 1 in 10 of these likely to suffer from postnatal depression, that is 35,000 mums and their families suffering in silence.

So why are so many women not seeking help?

Our survey clearly reveals a lack of awareness of the symptoms of postnatal depression. Almost a third admitted that they had not realised (until later) that they were suffering from postnatal depression. In addition, when they did realise they had postnatal depression, a staggering 60% said they did not feel their condition was serious enough to need professional help. A further 12% felt they did not have enough information 'to know what to do about it'.

Figure 2: Why mums didn't seek treatment for PND

Base: All who feel that they had suffered from postnatal depression but did not seek treatment (209)

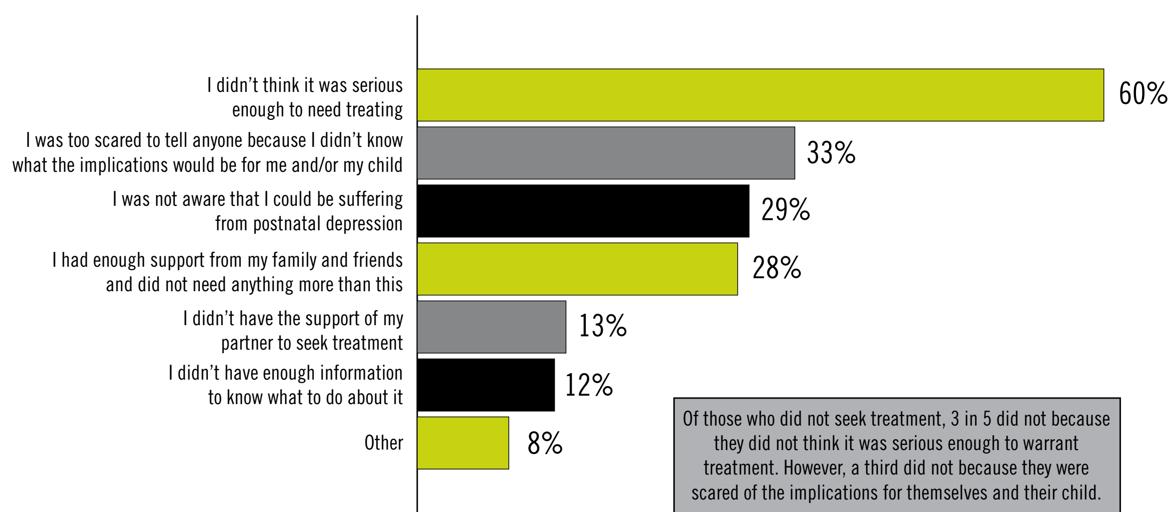
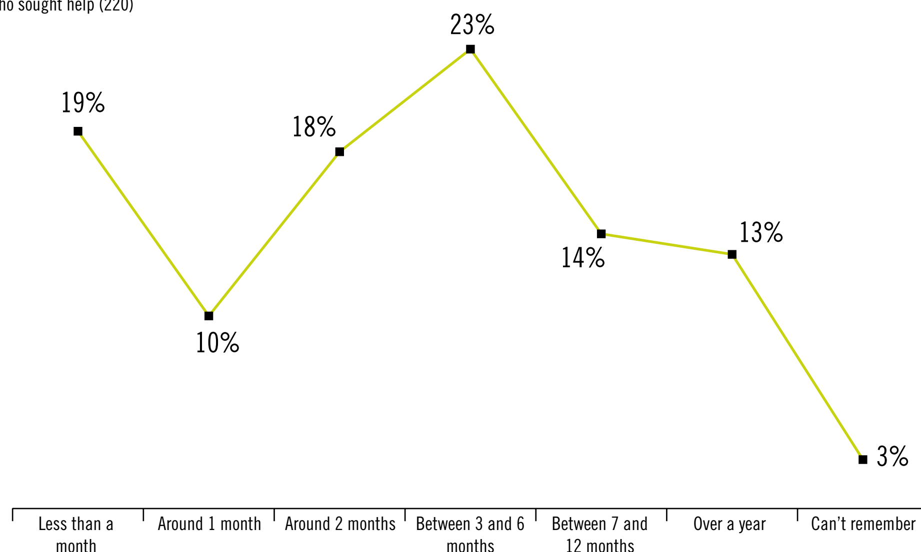


Figure 3: How long mums suffered before seeking professional help

Base: All who sought help (220)



While 1 in 5 of those seeking treatments did so within a month of feeling they were suffering from postnatal depression, many waited for longer. Indeed, half waited for at least 3 months before seeking treatment.

These figures highlight a worrying lack of awareness of postnatal depression that still exists in Britain and make clear the need for more information about the symptoms, the different levels of depression and the impact that untreated postnatal can have on families.

"I first had my suspicions that something wasn't right, but I kept finding other reasons for why I thought I didn't feel good, I thought it was connected with my hormones, or my poor appetite."
Nathalie, who had postnatal depression with her third child

"I remember ringing my dad up and saying things like 'ring me in the morning to make sure I haven't died in the night and the baby won't be left alone'. Looking back now that is not a normal thing to be saying, but nobody recognised it as a symptom of PND as during the day I would be fine, but at night I was just a mess."
Angela, whose postnatal depression after the birth of her first child went undiagnosed

When asked later on in the survey how their partners could have been more effectively supported, 43% said partners needed more information about the frequency and symptoms of postnatal depression.

Ignorance is often a breeding ground for fear, and one of the most startling findings from our survey is that of the women who did not seek treatment, 33% were too scared to tell anyone about their postnatal depression because of the perceived implications for themselves or their child. A further 13% believed that they did not have the necessary support from their partner to do so.

In addition to the survey, 4Children undertook semi-structured interviews with women who had suffered from postnatal depression during the research for this report. These interviews underlined the fact that the lack of awareness extended beyond new mothers, to their partners and parents as well. Several women highlighted the indifference and lack of empathy they experienced within their own family and the shame that they felt outside of their home:

"I didn't want to go out at all. I just stayed at home – I just didn't want to go out. I thought people would look at me and see that I was a bad mother, I felt they could just see it in me."
Nathalie

"… you feel like a failure"
Joanne, mother of two

The fear and ignorance surrounding postnatal depression is compounded by the often lurid media reports about tragic incidents that use the blanket term 'postnatal depression' to describe women

suffering the far more serious, but much rarer condition of 'puerperal psychosis'.

Even for those mothers that did seek help, there was often a significant delay in doing so. Our survey results show that 50% of mother who did seek professional help waited at least three months, with 27% waiting more than six months to do so [see Figure 3]. With evidence (discussed in more detail in the next chapter) showing that the most significant negative impacts are likely to be felt by children and families when depression goes untreated for more than six months, this is of grave concern.

Our findings demonstrate an urgent need to raise awareness of the symptoms of postnatal depression amongst the general population. We also need to challenge the damaging stigma surrounding the issue, as well as fear of the implications of admitting to suffering the symptoms and asking for help.

Myths about postnatal depression

There are many myths surrounding postnatal depression. These include:

- The belief that postnatal depression is less severe than other forms of depression - it is not.
- That it is caused entirely by hormonal changes – instead it is influenced by many factors, including previous experience of depression.
- That it will go away by itself – for some women this is true but for most, postnatal depression requires some form of treatment or therapy to be completely resolved.[19] In addition, waiting for postnatal depression to disappear on its own may mean a great deal of unnecessary suffering and genuinely taint the experiences of a new mother.

Chapter 3
Where's the help?

4Children's Bounty survey revealed that, despite the fact that at least one in ten will experience it, an alarming number of mums (60%) were unaware of what constituted postnatal depression and where they could go for help. The Bounty survey also revealed that many new mums were afraid to ask for help as they were worried about the implications for themselves or their child. Of those who did seek treatment, half had waited for at least three months before asking for help.

When women do seek help it is clearly vital that their postnatal depression is swiftly and appropriately diagnosed and then appropriate and expeditious treatment is offered. Our survey suggests that whilst a majority of mums are content with the treatment they received, a significant 22% were not.

Diagnosis

The National Institute of Clinical Excellence (NICE) guidance on antenatal and postnatal health[20] states that all pregnant women in their first contact with primary care (antenatal visits) and subsequently postnatally (usually four to six weeks after birth, and between three and four months) should be routinely asked three questions by primary care officials (e.g. GPs, midwives, obstetricians or health visitors):

1. 'During the last month, have you often been bothered by feeling down, depressed or hopeless?'
2. 'During the last month have you often been bothered by having little interest or pleasure in doing things?'

This is also supplemented with a third question (which has three possible responses), if the answer to either of the first two is 'Yes':

3. Is this something with which you would like help?

These are known as the 'Whooley questions'. Other professionals use the Edinburgh Postnatal Depression Scale (EPDS)[21] which is a 10 item questionnaire designed to detect depression in pregnancy and postnatally.

Research suggests that this screening process may not be leading to effective identification of postnatal depression, with one academic study finding that more than half the cases of postnatal depression are unrecognised by GPs and health visitors when they are occurring.[22] This finding is supported by our survey results (discussed above) which shows many women are slipping through the net.

In addition, mothers taking part in our interviews revealed some shocking examples of health professionals demonstrating a lack of understanding and empathy when approached about postnatal depression.

"The first thing my new health visitor said when she saw me was 'I am not here for you I am here for the baby'. I felt I was begging for help."
Rebecca

"I felt the GP thought I was neurotic. In the end I just stopped going to the GP as he made me feel like I was wasting his time."
Angela

This is not helped by the low level of contact with health visitors that some families experience and the withdrawal of health visitors from playing an antenatal role. A Netmum's survey[23] in 2010 highlighted that 62% of parents either did not have a health visitor to go to or did not feel they could talk to them if they had a problem.

Ensuring primary care professionals are fully equipped with the knowledge and skills to accurately diagnose and support patients presenting with possible postnatal depression is vital to getting more support to families before mild depression turns into family crisis.

Health visitors are particularly central given postnatal depression usually becomes evident between four and six weeks after birth. Research[24] has found that three in ten cases of postnatal depression could be avoided if health visitors were adequately trained in specific mental health assessment and in psychological approaches based on either cognitive behavioural or listening techniques. The study found that women were less likely to become depressed in the year after childbirth if they were attended by an NHS health visitor who had undergone this additional training.

Other studies have suggested that improved mental health assessment skills and changes in clinical practice of health visitors of this kind can be achieved without an increase in cost or time spent with the patient (despite more assessments and treatment being carried out). Health visitors who had received brief training in cognitive behavioural counselling were found to conduct more mental health assessments, detect more symptoms and treat more patients themselves using learned therapeutic techniques – reducing the burden on other services.[25]

Treatment and support

There is clear recognition that for mothers experiencing postnatal depression, getting early treatment accelerates recovery and minimises the effects on the newborn and the rest of the family.[26]

Getting early treatment accelerates recovery and minimizes the effects

In order to ensure that women experiencing perinatal mental health problems receive the right kind of support, NICE produces guidelines for healthcare professionals setting out best practice in the kinds of support that should be provided, the speed at which they should be available, and the quality of support required.[28] Key exerts from this guidance are set out in Appendix 1.

The focus of the guidance is clear:

- Where possible, postnatal depression should be identified quickly
- Women should be made aware of all the treatment options available to them at the time of diagnosis
- Counselling and talking therapy should be considered in the first instance for mild to moderate cases of depression
- Women in the perinatal period should have quick access to treatment, and should be treated within one month where possible, or otherwise within three months

CASE STUDY
Early intervention and prevention[27]

Health visitors, selected at random, from 101 primary care practices were provided with training in: systematically assessing the symptoms of postnatal depression; developing warm, empathetic and therapeutic relationships with the mother: and learning to deliver a psychologically-informed therapy course (e.g. based on the Cognitive Behavioural Approach (CBA) or Person-Centred Approach (PCA)).

Training was delivered by two experienced psychotherapist practitioner trainers who followed a prepared training programme. This consisted of:

- Training in the identification of postnatal depression using the Edinburgh Postnatal Depression Scale and clinical assessment
- Training focusing on development of the CBA or PCA
- Reflective practice sessions and access to regular supervisory sessions.

Mothers whose clinical assessment suggested that they would benefit from these sessions were offered one hour visits, once a week for a maximum of six weeks.

This approach was successful because the specific training that health visitors received (in identifying postnatal depression and in 'intervention skills') increased health visitors' confidence and focus on the well-being of the mother as well as the child. This approach also meant that women were more likely to open up about their depression without the 'stigma' of outside referral to mental health services.

- Anti-depressants should be considered for treatment, but there are risks associated with their prescription
- Women in need of inpatient treatment should have access to a well-equipped mother and baby unit

The NICE guidelines also recognise the important context in which depression during pregnancy and postnatally is treated. In particular, the potential impacts on the family and the role of non-mental health services are acknowledged.

"Services also need to take into account the needs of fathers/partners, carers and other children in the family. Therefore, services need to be tailored to meet these needs, which may include … integration of specific mental health services and maternity services, and dedicated treatment programmes. These must be provided in a timely fashion to ensure that treatments giving relief to the woman do so before her condition has damaged the health and development of the foetus and other family members. This is particularly relevant for the provision of psychological treatment."[29]

The NICE guidelines clearly state that women with mild and moderate depression should be offered evidence-based psychological therapy (such as cognitive behavioural therapy) as an alternative to anti-depressants. This is based on research clearly showing the benefits of counselling in relation to postnatal depression.

Studies have explored whether anti-depressants (e.g. Fluoxetine), several sessions of counselling or a combination of both are particularly effective in treating women with mild postnatal depression. One study showed how anti-depressants have some benefits – it could lift low mood after one week of taking them, but for those who were not willing to take anti-depressants, six counselling sessions were found to be equally effective in treating mild non-psychotic postnatal depression.[30]

Only 9% of the NHS Trusts … were able to give us figures for the number of women in their area who were diagnosed with postnatal depression

The reality on the ground

In order to gain a better understanding of the treatment actually being offered to women experiencing postnatal depression on a nationwide basis, 4Children wrote to every Primary Care Trust (PCT) in England. We asked them a range of questions to establish: the number of women identified as experiencing postnatal depression in their area; the treatments available to those women; the waiting times to access these treatments; and the treatments that women were receiving (set out in Appendix 2).

From this analysis we hoped to establish further information about the prevalence of diagnosed postnatal depression, and whether NICE guidelines were routinely being followed in terms of treatments prescribed, timescales met and facilities available.

Results

We wrote to all 148 PCTs in the first instance, and were referred on to a more appropriate body (Mental Health Trusts, Foundation Trusts, Mental Health Partnership organisation, etc.) in around 50 cases, bringing the total number of organisations which we contacted to 186. Of these, 150 (81%) responded to our requests for information, though few were able to provide data to answer all of the questions we posed.

Of those that responded:

- 63 trusts (34%) held no information at all which could help with the questions we asked.
- Only 17 trusts (9%) were able to provide information regarding the number of women diagnosed and/or treated for postnatal depression within their Trust boundary.
- No information suitable for analysis was available for the treatment that women received for their postnatal depression, or the severity of their depression.
- Response rates were highest for the questions regarding access to mother and baby units, and treatments available for women experiencing postnatal depression.

The responses to our Freedom of Information (FOI) requests raised an immediate concern – only 9%

of the NHS Trusts we asked were able to give us figures for the number of women in their area who were diagnosed with postnatal depression or were receiving treatment for it.

This low response rate was accompanied by wildly divergent figures for the number of women identified – with two Trusts reporting that only one woman had been diagnosed with postnatal depression within the last year, and another trust identifying 1,350 women experiencing postnatal depression over the same period. Given the widely accepted estimate that approximately one in ten women suffer with postnatal depression, an in-depth analysis is not required before concluding that Trusts are not recording accurate information.

Even those Trusts which were able to provide information about the number of cases of postnatal depression were largely unable to provide further information around the treatment these women received, or the severity of the depression they experienced.

Given the scarcity of local information, 4Children then wrote to Sir David Nicholson, Chief Executive of the NHS, to determine what information was gathered nationally on the prevalence and treatment of postnatal depression. A reply dated 19 September from an official in the Pregnancy and Early Years Branch of the Department of Health states that "The Department of Health and NHS Direct do not hold national data on postnatal depression".

The only conclusion that can be drawn from this exercise is that the NHS is not prioritising postnatal depression as a national issue. It does not have access to clear local, regional or national data on the number of women experiencing postnatal depression, the severity of their depression, or the treatments that they receive for that depression. This must represent a huge barrier to ensuring that women and their families receive the treatment and support they need. Without the local, regional, and national picture it is hard to be confident that:

The NHS is not prioritizing postnatal depression as a national issue

- NICE guidelines around treatment for perinatal mental health are being followed;
- NHS Trusts are effectively identifying women with postnatal depression; and
- Sufficient resources are being made available to the NHS for practitioners to provide suitable treatment to women experiencing postnatal depression.

Access to treatment

The NHS Trusts which we contacted set out a broad range of different treatment options available to women experiencing postnatal depression, ranging from art therapy to cognitive behavioural therapy, to support groups delivered via Sure Start centres. Around 60% of Trusts provided some information and the vast majority detailed two or more available psychological support services, with some offering as many as eight different types of service (a full list can be found at Appendix 3). Where services existed there was usually a choice of service available – only four Trusts (2%) offered only one method of psychological support, and many offered four to five services as standard.

Further, access to psychological treatments was generally described as being within the one month recommendation for treatment set out in the NICE guidelines. Eighty one per cent of Trusts reported that they provided treatment within six weeks – only half of the maximum waiting time suggested by NICE. However, five Trusts reported waiting times in excess of the NICE guidelines, with some reporting waiting times of up to six months – twice the recommended maximum wait and a time period which, empirical evidence shows, significantly increases the risk of adverse effects on bonding between mother and baby.[31]

It is appears that many NHS Trusts provide a range of psychological therapies for women experiencing postnatal depression, and that in general waiting times for accessing these services are within NICE guidelines. However, what is not clear is whether women are being effectively and expeditiously referred to this range of services.

Our Freedom of Information requests failed to shed any further light on what percentage of women were referred to psychological therapies. For psychological therapies to truly provide support to women

experiencing postnatal depression, GPs and other health professionals must offer patients a full range of treatment options at the appropriate time. Indeed, our survey results and interviews suggest that a significant minority of mothers are not satisfied with the treatment they receive from the NHS and confirm the view that the NICE guidelines are not being uniformly implemented.

"The symptoms started at about six or seven weeks after the birth: everyone on both sides of the family was telling me I wasn't right; I didn't want to speak to anyone or see anyone; I would make excuses so people wouldn't come to visit me at home; I didn't want to go out unless it was to take my son to school or go food shopping.

"I went to the GP a few times about the postnatal depression symptoms in the first six months. I was told I had baby blues, then I was given different tablets to try. I was given Citolopram, Prozac and Dosulepin. Citrolpram gave me horrible, vivid dreams that would keep me awake all night. Prozac didn't do a thing. Dosulepin helped a lot but also made me feel dead inside, it was an effort to have a conversation, I had to force myself to show emotions. There was never any talk about other forms of treatment."
Angela, who suffered postnatal depression after her second child

The charts in Figures 4 and 5 show that our survey respondents were almost twice as likely to have been treated with anti-depressants (or other medication) than with counselling or talking therapies. For those mothers who were dissatisfied with their treatment, much of this revolved around the need for greater information about and access to counselling but also the need for more 'social' support including practical help from support groups or voluntary groups.

"I was concerned that I was losing weight, was not eating, was not myself. The GP was dismissive. He said 'You have just had a baby, it's just your hormones. Anti-depressants will help you get through it.' I felt I was pushed out of his surgery with a prescription in my hand that I had said I didn't want. I didn't want to take anti-depressants because I am a single mother of three children and need to be alert if I am to look after them properly. Eventually, I went to the health centre just to get some food vouchers. The health visitor recognised the symptoms of postnatal depression immediately and organised counselling for me. After four weeks I started to feel a great improvement, I began to felt much better. It was sheer luck that I finally got help."
Nathalie

More importantly, research studies clearly show that not only are therapies (such as cognitive behavioural therapy) as effective as anti-depressants in the short term[32], but they are also more effective at preventing

Figure 4: Help that mums received from professionals for PND

Base: All who sought help (220)

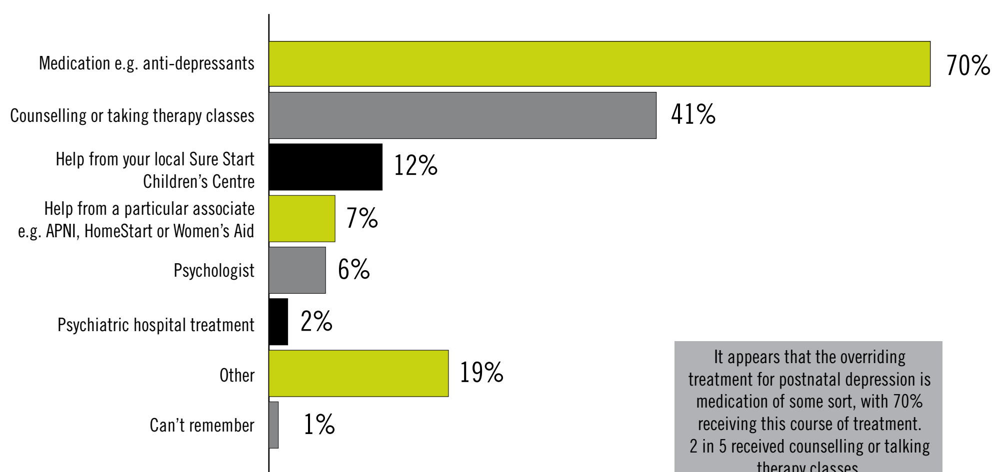
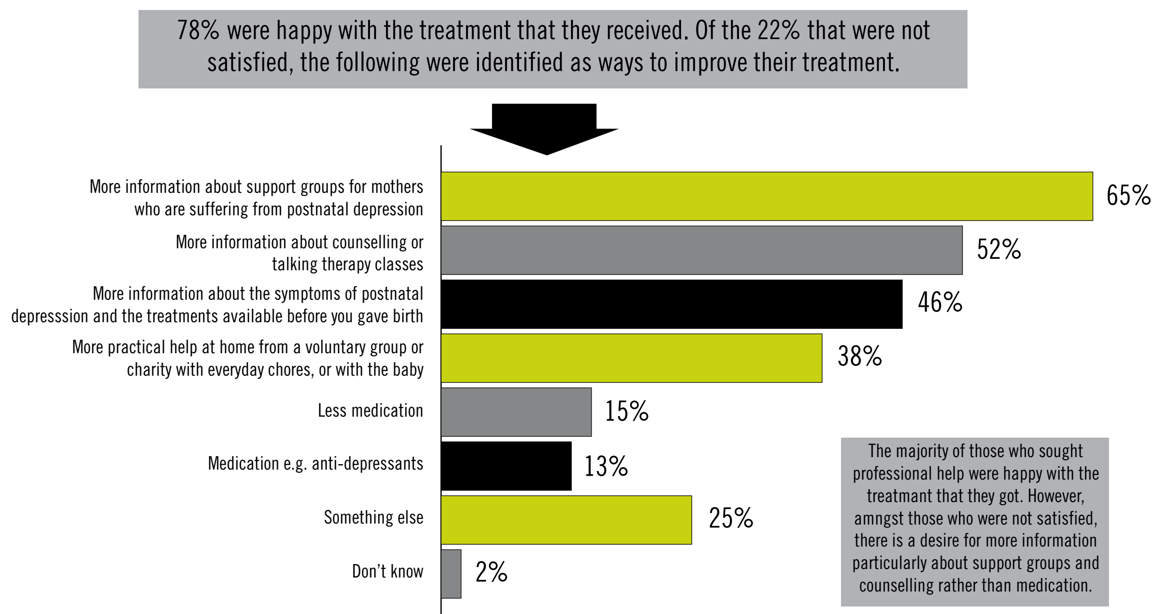


Figure 5: Mums' satisfaction with their treatment for PND

Base: All who sought help (220); All who were not happy with their treatment (48*) *CAUTION VERY SMALL BASE SIZE



relapses[33] and can have a positive impact on issues like parent child attachment.

"The meds put a cap on everything, but when I stopped taking them, I was still in the same place. They didn't help me address the underlying problems."
Stacy, mid 30s

Improving Access to Psychological Treatment

Improving Access to Psychological Treatment (IAPT) is an NHS therapy programme that is being rolled out across England between 2008 and 2015. Its aim is to support Primary Care Trusts in implementing NICE guidelines for people suffering from depression and anxiety disorders. £173 million was dedicated to the programme between 2007/08 and 2010/11. The funding was to allow:

- 34 Primary Care Trusts to implement IAPT services
- Regional programmes to deliver 3,600 newly trained therapists
- 900,000 more people to access treatment

In 2007, 11 IAPT Pathfinders explored specific benefits to particular groups of people, including children and young people, older people, offenders and perinatal groups. The benefits included:

- Better health and well-being
- High levels of satisfaction with the service
- More choice and better accessibility to effective evidence-based services
- Helping people to stay employed and able to participate in everyday living activities

In the last year, a further £400m has been earmarked for the IAPT programme to extend the programme until 2015, and to develop a similar model for children and young people. But whilst the IAPT guidance appears to recognise that perinatal groups are particularly vulnerable to depression, it does not currently explicitly indicate that postnatal depression should be a priority area for the roll out of the IAPT programme.

Treatment for severe depression

For women suffering with severe postnatal depression or puerperal psychosis the NICE guidance recommends in-patient care in a specialist Mother and Baby Unit (MBU).

There are 22 MBUs in the UK, providing around 137 beds:

Glasgow	Edinburgh
Morpeth (Newcastle)	Leeds
Manchester	York
Nottingham	Cardiff

Leicester	Birmingham
Derby	Stafford
Welwyn Garden City	Bristol
Winchester	Poole
Eastbourne	Chelmsford
Brent	Beckenham
Hackney	Maudsley

As part of the Freedom of Information request 4Children sent to NHS Trusts in England, questions were asked about the availability of places in MBUs and about occupancy rates. Of the 150 Trusts that provided us with information, 24 revealed that they did not have access to a local MBU, although many had made arrangements to procure beds from neighbouring providers where this was the case.

Use of MBUs within Trusts also varied enormously – with one Trust reported occupancy above 180% for the previous year, and another indicating that all the beds they had available in the units had been empty for the past two years. This suggests that while some Trusts struggle to cope with the demands placed upon their units, others have significant numbers of beds unoccupied.

Where MBUs were available, NHS Trusts unanimously reported that they met the conditions of service outlined in the NICE guidance. However, some trusts did fail to meet national guidelines on the size of their Mother and Baby units. The NICE guidance states that each MBU should have a minimum of six beds[34]; but our analysis of 22 MBUs showed that there are at least three regions with fewer than the recommended number.

A quick look at the list of MBUs reveals an unequal geographical spread, a potential problem which is supported by existing research. A study of MBUs in 2009[35] argues that their provision is very patchy with very difficult access in some areas. The regional variation of MBUs units is certainly striking, with gaps in Cumbria, East Anglia, Devon and Cornwall and large parts of Wales and Scotland. There is also no provision of MBUs at all in Northern Ireland.[36]

This leaves women in underserved, 'desert' areas in the unenviable position of choosing between being treated in the community, when they need significant mental health support, or travelling great distances – taking mothers and babies away from partners and wider family networks at a time of great stress.

Further, there appears to be an issue of capacity in the existing units. In order to get a more accurate picture of whether the NHS was meeting the demand for hospital treatment of postnatal psychosis, we took steps to calculate the number of women expected to have had puerperal psychosis last year in relation to the actual number of beds that were available in the MBU units.

- Last year, there were 715,467 births in England and Wales. Of these births, approximately 1,431 women (two out of every 1,000 births) would be expected cases of puerperal psychosis.
- Of the 20 MBUs across England and Wales last year[37], we calculated that there were 125 beds across the units, and the mean length of stay was around 56 days (8 weeks).
- There were therefore places available for 815 mums in MBUs who were suffering from puerperal psychosis.[38]
- If the number of expected cases of psychotic postnatal depression was 1,431, this means that there were only places for just over half of the women (57%) suffering from psychosis in MBUs.

We do not know what treatment the remainder may have received, but it leaves an estimated 616 women (43%) with postnatal psychosis being treated either in general psychiatric wards (where a newborn would not generally be allowed) or being treated by community mental health teams who cannot provide round the clock intensive support and treatment that may be required in these 'high-risk' situations. This is clearly against the NICE guidelines (2007) which state that 'women who need inpatient care for a mental disorder within 12 months of childbirth should normally be admitted to a specialist mother and baby unit, unless there are specific reasons for not doing so'.[39]

Chapter 4
Taking its toll

Experts suggest that most women who have mild postnatal depression will find that their depression resolves within a three to six month period[40], but for some women the depression can continue for longer and last well beyond her child's first birthday.[41] Our survey revealed that one in ten women were suffering with postnatal depression for up to a year before seeking help.

Research suggests that the consequences of having a mother suffering with long term depression can be serious for infants, with studies showing that mothers whose depression has lasted beyond six months have fewer positive interactions with their baby than mothers whose depression has been resolved within six months of birth.[42]

Research also shows how untreated, severe[43] or long term postnatal depression can impact on an infant's cognitive and language development. In her research on parental mental health and child development, Smith (2011) illustrates how an infant's language and thought is developed in response to 'talk, touch and gaze' stimulation from the infant's caregiver (see Figure 1 below).

Smith's study, along with others, explains how a depressed mother may struggle to provide the desirable or necessary level of stimulation (touch, talk, gaze, read, play, etc.) required in the early years for the child's linguistic and cognitive development.[44] The consequences are highlighted in additional research showing how children with depressed mothers show lower levels of interaction and attachment as well as more problems with sleeping, eating and tantrums.[45]

A combination of delayed language development, increased stress levels and difficulty socialising can also lead to later problems for the child.[46] Studies have highlighted intergenerational patterns of depression as a result of insecure attachments, with one study showing that among mothers who suffered long term maternal depression, 41.5% of their adolescent children also grew up to suffer from depression.[47]

Moreover, the negative consequences of mothers with long term or severe postnatal depression seem to be stronger among boys than girls, and among low income families.[48] Generally, a child's social class and gender is a good predictor of their behavioural development, but impaired bonding (or lack of maternal responsiveness to the child)[49] appears to exacerbate poor responses. One study showed how in situations of mild stress (e.g. the threat of losing in a competitive card game), 5 year old children of depressed mothers were more likely to show depressive behaviour (e.g. pessimism, hopelessness and low self-worth) than children of mothers who were not depressed.[50] Elsewhere, studies support this pattern, highlighting issues around cognitive and mathematical reasoning of secondary school-aged children of depressed mothers.[51]

The figures below illustrate the positive interactions between a mother and her infant and the consequences of poorer interactions with a new infant.

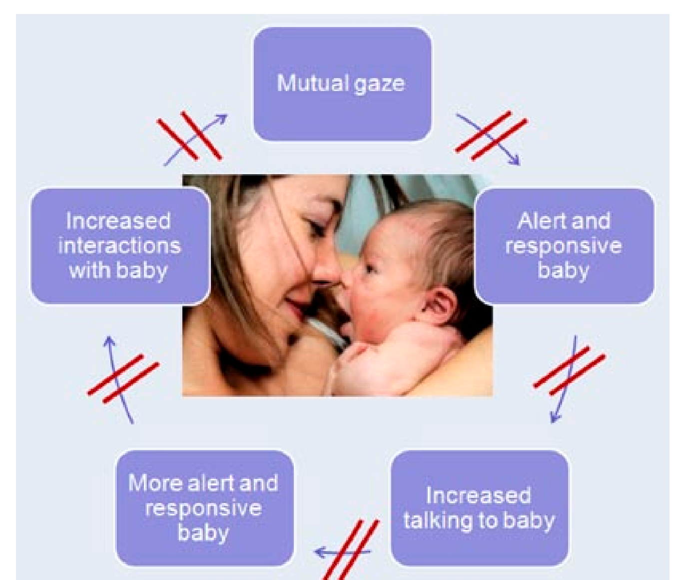


Figure 6: Positive interactions and consequences with a new infant. (Source: Smith, 2011)

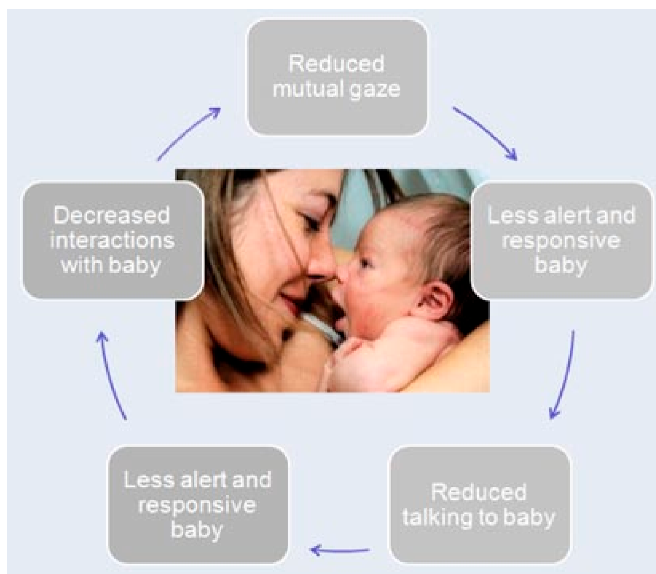


Figure 7: Poorer interactions with a new infant and the negative consequences. (Source: Smith, 2011)

In addition to the evidence of impact on children, more recently research has highlighted the other social consequences of untreated postnatal depression including a link between marital or relationship problems with postnatal depression. A Netmums survey carried out in 2010 found that respondents with postnatal depression were seven times more likely to have relationship problems with their partner.[52]

Our own survey revealed that 60% of women did not feel that they had sufficient support from their partner during their postnatal depression.

Having a baby is often a major adjustment for any family, and postnatal depression can put an additional strain on a couple's relationship as a result of the unexpected tiredness, inability to sleep, anxiety and sense of hopelessness a new mum may be feeling. In addition, a woman with postnatal depression may withdraw from her partner completely because of poor communication, friction, disengagement or sexual problems.[53]

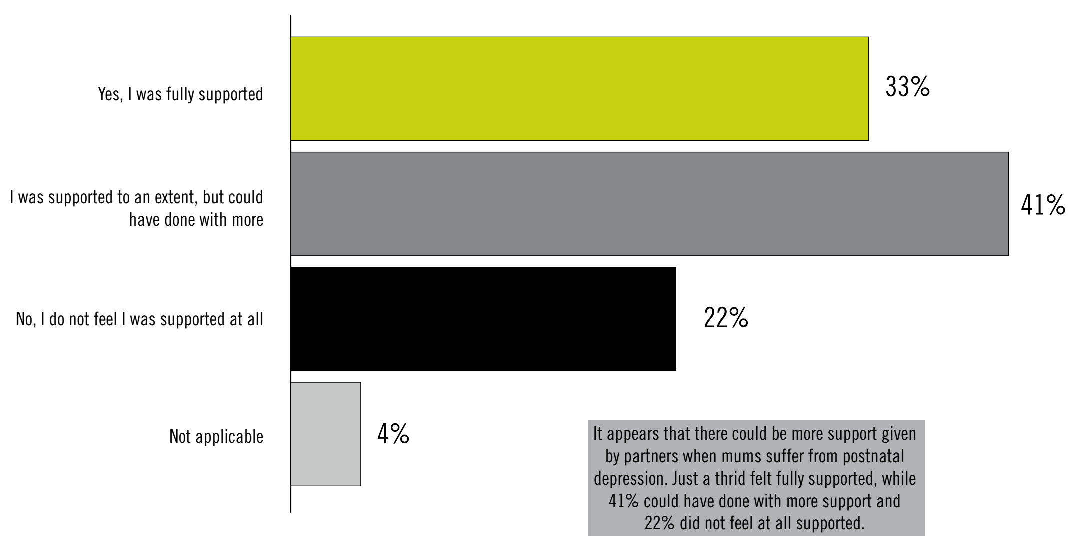
"At the time of the birth I was already having difficulties with my family relationships because my mother and my partner (who was not living with me) didn't get on. I had been able to manage the situation, but when the PND began to show itself it added to the other problems and everything just became too much to handle: my relationship with my partner ended – he interpreted my PND as hostility to him – and I lost the support of my mother. My older daughter had to grow up fast as she had to not only learn how to look after herself and her brother, but also would help me care for the baby. My teenage son is very emotionally sensitive and I can see that my PND has had a negative effect on him."
Nathalie

Dads and postnatal depression

It is increasingly recognised that postnatal depression can also affect men directly, with up to one in 25 men identified as having suffered from paternal depression.[54] A further review of 43 studies

Figure 8: Level of support from partners that mums felt when suffering from PND

Base: All who feel that they have suffered from postnatal depression (429)



from 16 countries (including the UK and the US) involving approximately 28,000 parents argued that as many as one in ten men experience ‘postnatal depression’, with the highest rates being between three to six months after their partner has given birth.[55] Lack of sleep, new responsibilities and supporting a partner with postnatal depression are some of the key triggers of paternal depression after the birth of their child.

From our survey, 11% of respondents felt that their partner should have been provided with medical treatment or counselling ‘because he was depressed as well’.

Paternal depression has substantial emotional, behavioural and developmental effects on children – with more adverse impacts on boys than girls.[56]

CASE STUDY
A stay at home father who developed paternal depression

Alan is a stay at home father of two children aged 7 and 2. He became depressed after the birth of his first child, from a combination of factors including sleep deprivation, dealing with his elder child’s illnesses and a shift in the family dynamics. He currently looks after his 2 year old after closing his business due to the recession.

He says: “Parenting is relentless. There is no hand book! I was reluctant to have kids in the first place, having the fear that although I wanted a better environment for my kids than I had, I was insecure about fulfilling that.”

“The birth was a catalyst, I didn’t know whether I was coming or going. When the older boy was born I was still working, getting up at 6am to get him dressed and fed and taking him to nursery, doing eight hours of very physical work, picking him up giving him supper then doing quotes until midnight... I felt I hated every single minute of looking after him...

“I lost weight and ended up in hospital with cardiac arrhythmia from driving myself too hard, after he was admitted to hospital with severe pneumonia ...I felt the burdens and responsibilities of being a parent without getting much back.”

Similar to maternal depression, paternal depression has a direct influence on the way in which fathers interact with their newborn infants, and compromises the ability of fathers to care for their infants in a responsive and interactive way.

Given that this is the case, and the fact that partners suffering with undiagnosed and untreated depression will be less able to support and nurture mothers and other children, in addition to the negative impact on their own well-being – improved recognition and support for paternal depression is needed.

Supporting families

Our research for this report has highlighted an urgent need for improved social and emotional support which goes beyond the medical treatment of women suffering postnatal depression. Sometimes called ‘social prescribing’, it is recognised that environmental and social factors play an important role for those experiencing mild or moderate mental ill-health. The kind of activities ‘prescribed’ include opportunities for arts and creativity, exercise, learning new skills, volunteering and befriending, as well as support with employment, benefits, housing, debt, legal advice or parenting problems.

Indeed, in implementing the IAPT programme (discussed in Chapter 3), the Department of Health Implementation guidelines[57] state that Primary Care Trusts should ensure that they:

- Develop IAPT services so that they are linked to other family-centred services in the local area
- Ensure that IAPT services are also linked in with other support services that people may need (e.g. around issues of employment, debt or relationship problems)

In particular:

- Our survey shows a demand from mums for greater access to support groups; for more practical help available in the home and for better support for partners
- The evidence reiterates the impact of postnatal depression that can be felt by the whole family – which if left unresolved can be a major cause of ongoing family instability and can negatively impact child outcomes

There are, however, excellent models of social and emotional interventions. Many improve the outcomes for children, including preventing depression in the children of parents with postnatal depression. Others, such as 'peer to peer' support can help ameliorate and address some of the day to day challenges that arise from postnatal depression or provide vital moral support from others in a similar position.

"The great thing about the group is that everyone is on the same level, there is no judgement and no pressure. Although we don't all have the same problems, we all have some kind of problem and being part of the group gave me permission to deal with issues I'd had for years but not recognised."
Joanne, attending a support group in a children's centre

Yet too many families are not benefitting because they are not provided with the information they need to find these services and tap into them – or because they are not yet available in every area. Our survey showed that only 7% of women received help from a voluntary organisation such as Home-Start or Women's Aid, even though 38% felt that they would have benefited from such help. And only 12% received help from their local Sure Start Children's Centre, despite the fact that centres are ideally placed to provide non-stigmatising, family orientated support and many are already offering group sessions for mothers suffering with depression, anxiety or low self-esteem.

"No-one here heard about this group from their GP. GPs just don't seem to know about services such as this that there are locally. If they did know, more people could be referred."
Dianne, attending a support group in a Children's Centre

Children's centres have huge potential to play an increasingly significant role in preventing, identifying and tacking postnatal depression. As universal settings, which do not stigmatise attendees, children's centres are well placed to:

- Ensure more expectant and new parents know the symptoms of postnatal depression
- Identify mums who may be experiencing symptoms and encourage them to seek the full range of treatment options
- Provide practical family support for families where postnatal depression has been diagnosed

CASE STUDY
The importance of practical and emotional support

On returning home after a difficult labour and an unexpected Caesarean birth, Salma, a young British Muslim woman in her late 20s, collapsed and began to behave in a confused and erratic manner. A midwife immediately referred Salma to the general psychiatric ward at the local hospital, which then sent her to a Mother and Baby Unit. Salma remained in the unit for three months, with a psychiatric nurse looking after her baby for most of the time.

When she was allowed to go home, Salma quickly realised that she wasn't coping – despite an abundance of professional help. Salma didn't feel able to talk to them about how she felt about everything. She felt she had very little bonding with her baby, and her situation was made worse by the fact that her parents would not acknowledge that she was suffering from PND because they felt embarrassed and took the view that Salma should just pull herself together.

It was at this point that Salma was introduced to a local befriending scheme and a volunteer began visiting her a few times a week.

"Finally I had a friend that wasn't a professional or an official. The volunteer helped me to improve my bonding with my daughter. One day, we were in the park together chatting away in the playground, and I realised I was the one pushing my daughter on the swing. Without a doubt, without the help of a volunteer – with bonding with my child, with attending mother and toddler groups, with everyday chores – I would not have been able to cope. I was able to talk with her about things that I was unable to talk to others about. I didn't feel judged."

"I hadn't done much cooking or shopping in the last year, and my volunteer started to help me with grocery shopping, cooking and we shared recipes. She visited me a few times a week for almost ten months, after which I began to feel that I would be OK on my own."

- Provide support to promote secure attachment between parents and infants through baby massage and other activities
- Offer peer to peer support – through groups and one-to-one activities – for parents experiencing postnatal depression

Many centres are already playing this role but could do more promote their services, particularly to local GPs. Other centres should develop their offer on postnatal depression as part of current developments to focus on activities which can provide a more targeted focus on early intervention and prevention.

In-patient family support

Some MBUs offer couple or family counselling as well as individual counselling at the units. For instance, in Thumswood MBU, support sessions are offered to partners at admittance and are provided on a spontaneous basis depending on assessed need and individual request. They are delivered either in group settings or on a one-to-one basis and focus on psycho-education about postnatal depression and its effect on families and survival techniques.

The group sessions offer partners the chance to share their experiences with others in their situation. Families, partners and other children are also encouraged to get involved in cooking, eating, washing, ironing and shopping with the mothers to simulate everyday family activities that are interrupted because of inpatient care. There are dedicated ‘family time’ slots in the weekly timetable to ensure families are included regularly.

This kind of work is important in order to reduce the impact of separation between the mother and baby and the rest of the family unit. However, for families living a significant distance from the unit, involvement in these activities can be limited by long journeys.

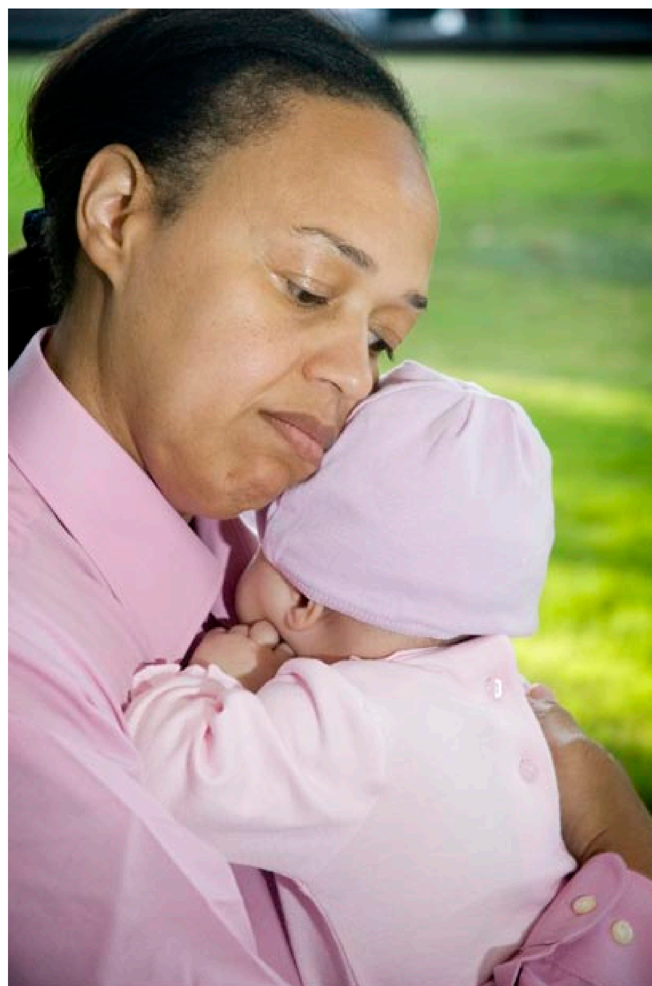
Chapter 5
Making the changes that families need

For most families the birth of a child is source of great joy and excitement. However for one in ten of these families, just a few weeks later things can take a challenging turn with one or both parents beginning to feel a sense of hopelessness and inability to cope that are the tell-tale signs of postnatal depression. This is an illness which can take a considerable toll on the sufferer, other family members and the newborn child – as the interviews and other evidence gathered together for this report show. But, it does not have to be this way.

Most mums (and dads) who suffer from depression during the first year of their child's life will make a full and speedy recovery and no long lasting adverse effects will be felt. However, for an important minority failure to access appropriate treatment and support early on can see things begin to spiral out of control, leading to relationship conflict and breakdown; poor attachment between parents and infants; and emotional turmoil for older siblings.

This report highlights some important issues that are contributing to this unnecessary misery. These findings lead us to conclude that the status quo is unacceptable because it is characterised by:

- A chronic lack of awareness of the symptoms of postnatal depression amongst expectant parents, parents and the wider public
- A fear that admitting to the symptoms of depression will have serious implications or constitute an admission of failure
- A failure to use the known risk factors for postnatal depression as an effective trigger for earlier intervention
- Late or mis-diagnosis of postnatal depression by GPs and other primary care professionals
- A profound lack of local, regional or national information about the prevalence, severity and treatment of postnatal depression gathered by the NHS



- A postcode lottery in the availability of in-patient care for mothers suffering with acute postnatal depression
- Non-compliance with NICE guidance which advocates the use of psychological therapies as an equally effective alternative to anti-depressants
- A failure to value the positive contribution partners can play if availed with the necessary information and support
- Not enough 'social prescribing' of forms of practical help and support that can make a real difference to families including access to peer to peer support and befriending

Recommendations

In order to give new strength to families, in particular the one in ten who will experience postnatal depression after the birth of a child each year, we are making the following recommendations:

1. **A national campaign** – led by the Department of Health but working with civil society, the voluntary sector and the business community – to raise awareness of the symptoms of postnatal depression and to challenge the myths and stigma attached.
2. **Change the way antenatal screening is undertaken** to create a more proactive approach to identifying key risk factors including relationship conflict, social isolation, financial or housing worries or employment issues. Backed up by an offer of practical support when it is needed.
3. **Re-introduce an antenatal role for health visitors** – as their numbers grow – to build relationships with parents earlier and co-ordinate the earlier, practical support needed by some families.
4. **Master classes on postnatal depression for professionals** working with new mothers and families during pregnancy and early years to update and raise awareness of symptoms, available treatments and the benefits of early treatment.
5. **Strengthen the assessment, identification and support skills of health visitors** including training in the cognitive behavioural therapy skills that have been shown in pilot programmes to improve outcomes for children and their families.
6. **Improved collection of data by the NHS** locally and nationally to provide a clear picture of the diagnosis and treatment of postnatal depression.
7. In order to ensure equitable access to in-patient Mother and Baby Units across the UK, **plans need to be developed to provide new units in 'desert' areas** including Northern Ireland, northern Scotland, north Wales, East Anglia, and the South West of England.
8. **A new commitment from GPs that psychological therapies will always be offered** in cases of diagnosed postnatal depression and that 'social prescribing' including referral to support groups and befriending schemes will also be a priority.
9. **Explicit priority given to increasing access to 'talking therapies'** during the perinatal period given within the Government's programme for expanding psychological services – the IAPT programme.
10. **Put families at the heart of tackling postnatal depression**, with more information and support for dads and more priority given to strengthening family relationships and bonds as part of treatment programmes.

Endnotes

1 Frank Field Review (2010); Allen Review (2011)

2 Mousavi et al, 2007

3 BMJ 2010

4 CKS 2010

5 Although a third of women who are diagnosed with postnatal depression have symptoms during pregnancy, which continue after birth (Royal College of Psychiatrists: Postnatal Depression Leaflet. May 2011)

6 www.babycentre.co.uk/midwives, Postnatal depression research brief

7 For example, Kumar and Robson, 1984; Royal College of Psychiatrists, May 2011 (ibid)

8 Bounty Survey, Word of Mum Panel, July 2011

9 Almond, 2009 and Marcus et al, 2003 also suggest that the figure for postnatal depression is much higher

10 BMJ 2010

11 www.nhs.uk/Conditions/Psychosis/Pages/Symptoms.aspx; Mind, 2006

12 Robertson et al, 2005

13 Royal College of Psychiatrists Leaflet: Postnatal Depression. May 2011

14 www.mentalhealthcare.org.uk/puerperal_psychosis

15 NICE, 2007; MIND, 2008

16 O'Hara and Swain, 1996

17 Netmums, July 2010

18 ONS Statistical Bulletin (2011) Births and Deaths in England and Wales in 2010

19 www.nhs.uk/Conditions/Postnataldepression/Pages/Introduction.aspx

20 NICE, 2007

21 Cox et al, 1987

22 Seeley et al (1996)

23 Joint survey with 4Children and Unite/Community Practitioners' and Health Visitors' Association, July 2010

24 Brugha et al, 2011

25 Appleby et al, 2003

26 Royal college of Psychiatrists (May 2011 Postnatal Depression Leaflet): www.rcpsych.ac.uk/mentalhealthinfoforall/problems/postnatalmentalhealth/postnataldepression.aspx

27 Appleby, Warner et al, 1997

28 Antenatal and postnatal mental health, Clinical management and service guidance: www.nice.org.uk/nicemedia/live/11004/30433/30433.pdf

29 Ibid.

30 Appleby et al, 1997

31 Murray et al, 2003

32 Appleby et al, 2003

33 DoH 2008

34 NICE guidelines, 2007, p.37 (1.5.1.3)

35 Elkin et al, 2009

36 A six-bed mother and baby unit is required for a population of one million or more (as 2-3 admissions can be expected for every 1000 births)

37 Chelmsford MBU just recently opened

38 Number of beds x number of days in the year/average length of stay (125*365/56 = 815)

39 NICE guidelines, 2007 p.16 (1.2.2.4)

40 BMJ 2010

41 Ibid.

42 Murray et al, 2003

43 Lyons-Ruth et al, 1986

44 Huang et al, 2006; Smith, 2011

45 Stein et al, 1991; Murray, 1992

46 Stattin et al, 1993

47 Beardslee et al, 1993; Murray, 2011

48 Murray et al, 1996

49 Campbell, Cohn et al (1995)

50 Sinclair and Murray, 1998; Murray et al, 2001

51 DoH, 2010, White Paper

52 Netmums Survey, July 2010

53 Kung, 2000

54 MIND, 2008

55 Paulson et al, 2010

56 Ramchandani et al, 2005

57 DoH 2008

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Appendix 1
Excerpts from *NICE Clinical Guideline: Antenatal and postnatal mental health* (2007)

At a woman's first contact with services in both the antenatal and the postnatal periods, healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask questions about:

- past or present severe mental illness including schizophrenia, bipolar disorder, psychosis in the postnatal period and severe depression;
- previous treatment by a psychiatrist/specialist mental health team including inpatient care; and
- a family history of perinatal mental illness.

Women requiring psychological treatment should be seen for treatment normally within 1 month of initial assessment, and no longer than 3 months afterwards.

For a woman who develops mild or moderate depression during pregnancy or the postnatal period, the following should be considered:

- self-help strategies (guided self-help, computerised cognitive behavioural therapy or exercise);
- non-directive counselling delivered at home (listening visits); and
- brief cognitive behavioural therapy or interpersonal psychotherapy.

When choosing an antidepressant for pregnant or breastfeeding women, prescribers should, while bearing in mind that the safety of these drugs is not well understood, take into account that:

- tricyclic antidepressants, such as amitriptyline, imipramine and nortriptyline, have lower known risks during pregnancy than other antidepressants;
- most tricyclic antidepressants have a higher fatal toxicity index than selective serotonin reuptake inhibitors (SSRIs);
- fluoxetine is the SSRI with the lowest known risk during pregnancy;
- imipramine, nortriptyline and sertraline are present in breast milk at relatively low levels;
- citalopram and fluoxetine are present in breast milk at relatively high levels;
- SSRIs taken after 20 weeks' gestation may be associated with an increased risk of persistent pulmonary hypertension in the neonate;
- paroxetine taken in the first trimester may be associated with fetal heart defects;
- venlafaxine may be associated with increased risk of high blood pressure at high doses, higher toxicity in overdose than SSRIs and some tricyclic antidepressants, and increased difficulty in withdrawal; and
- all antidepressants carry the risk of withdrawal or toxicity in neonates; in most cases the effects are mild and self-limiting.

Women who need inpatient care for a mental disorder within 12 months of childbirth should be admitted to a specialist mother and baby unit unless there are specific reasons for not doing so.

Each specialist perinatal inpatient service should:

- provide facilities specifically for mothers and infants (typically with 6–12 beds);
- be staffed by specialist perinatal mental health staff;
- be staffed to provide appropriate care for infants;
- have effective liaison with general medical and mental health services;
- have available the full range of therapeutic services; and
- be closely integrated with community-based mental health services to ensure continuity of care and minimum length of stay.

Appendix 2
Freedom of Information requests

1. How many women were diagnosed with perinatal mental health conditions over the past three years in your NHS Trust?

2. What proportion of those women developed perinatal:
   a) Mild depression?
   b) Moderate depression?
   c) Severe depression?

3. What services are currently available for women who develop mild or moderate depression during pregnancy or the postnatal period?

4. What services are current available for women who suffer a moderate depressive episode and have a history of depression, or have a severe depressive episode, during their pregnancy or the postnatal period?

5. Which courses of treatment were delivered to the women identified in question 1, and with what frequency were these treatments administered?

6. What is the average waiting time from their initial assessment for pregnant women and women in the postnatal period who require psychological treatment?

7. How many places are there available in specialist Mother and Baby Units for women who are pregnant, or in the postnatal period, and who need inpatient care for a mental disorder? What has the occupancy rate of these places been over the past 24 months?

8. How many of these mother and baby mental health units:
   a) Provide facilities specifically for mothers and infants?
   b) Are staffed by specialist perinatal mental health staff?
   c) Are staffed to provide appropriate care for infants?
   d) Have effective liaison with general medical and mental health services?
   e) Have available the full range of therapeutic services?
   f) Are closely integrated with community-based mental health services to ensure continuity of care and minimum length of stay?

Appendix 3
Types of treatment used to treat postnatal depression

Cognitive-behavioural therapy is a combination of cognitive and behavourial therapy. See below for information about what cognitive therapy. Behavioural therapy is about changing any behaviour that is harmful or unhelpful; it has the objective to help you change the way you think, feel and behave. It can be delivered by a trained professional or through self-help computer programmes.

Cognitive behaviour counselling is a simpler and less intensive version of cognitive behaviour therapy which addresses key problems for depressed mothers such as childcare and the struggle to cope; it has been shown to be an effective treatment for post natal depression.

Cognitive therapy is centered on the idea that certain thoughts can 'trigger' mental health problems, such as depression. A therapist helps you understand how your thoughts can be harmful to your state of mind.

Bibliotherapy is where the patient is given books which provide them with information and give them homework exercises. Most bibliotherapy teaches a person how to use cognitive behavioural therapy on themselves.

Interpersonal therapy focuses on past and present social roles and interpersonal interactions. During treatment, the therapist usually chooses one or two problem areas in a patient's life to focus on. It does not delve into inner conflicts from the past, but attempts to find ways for the patient to deal with current problems.

Problem solving therapy is a type of therapy that switches the focus from the client to the framework of the family unit. This differs from other therapies as it emphasises social context or social situation of human problems.

Psychoeducation is a type of therapy where the patient is provided with knowledge about the psychological condition, the causes of that condition and the reasons why a particular treatment might be effective for reducing their symptoms.

Art therapy is where patients are encouraged to express their feelings by creating art pieces. The issues that come up when creating pieces are used to help the patient deal with and work through stressful or challenging situations.

Music therapy is where patients are either encouraged to make music with the therapist in order to create a better relationship between them or patients can simply listen to relaxing or uplifting music whilst psychological therapy is performed.

Eye movement desensitisation and reprocessing is where the patient is encouraged to think about distressing memories whilst making certain eye movements. It is believed that specific eye movements helps the brain to process these memories which makes them less distressing.

GIVE ME STRENGTH

A campaign from 4Children to avert family crisis

About Give Me Strength

Give Me Strength is a national campaign, run by 4Children, which demands more help for families to avert crisis. The social and economic cost of family crisis is avoidable and this campaign demands that we respond to this call to put an end to wasting money and wasting lives.

To pledge your support to the campaign, visit www.givemestrength.org.uk

Follow the campaign:

@4ChildrenUK on Twitter – and use the hashtag #givemestrength

Facebook – search for the 4Children Facebook group

www.givemestrength.org.uk

About 4Children

4Children is a national charity all about children and families. We support children, young people and families in communities across Britain.

• Our family outreach workers work with parents in their own homes, providing help, advice and practical support.

• Our specialist teams work to support vulnerable families experiencing drug or alcohol addiction, domestic violence and post-natal depression.

• Our youth workers provide positive and engaging activities in what can be tough circumstances.

For more than 20 years we have worked with families, communities, local authorities and governments to develop new policy ideas and delivery solutions to meet the evolving challenge of supporting children and their families. Our Family Commission talked to 10,000 families across Britain during 2009/10 providing us with a unique insight into family life. They asked us to help give them strength.

www.4Children.org.uk
Information Helpline: 020 7512 2100