NHS TALKING THERAPIES FOR ANXIETY AND DEPRESSION PERINATAL POSITIVE PRACTICE GUIDE

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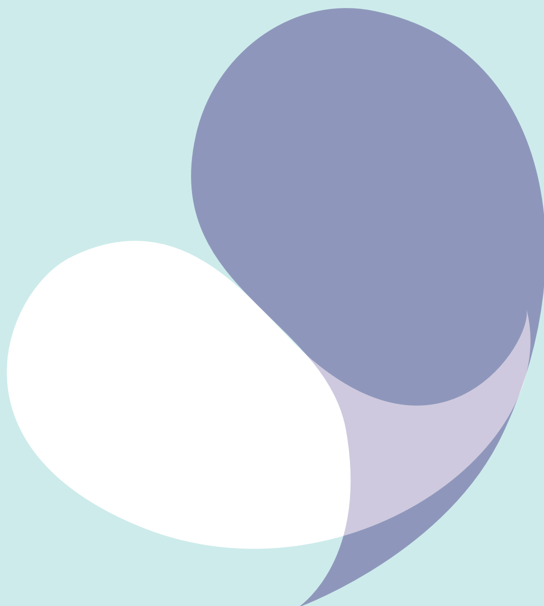

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INTRODUCTION

This guide is for NHS Talking Therapies (formerly known as Improving Access to Psychological Therapies (IAPT)) clinicians, service managers and commissioners involved in the delivery of psychological interventions for perinatal parents. For this guide, a parent is defined as being involved in the creation and/or primary provision of care for a new baby.

Perinatal mental health problems are highly prevalent, affecting 1:5 mothers and 1:7 fathers (Howard et al. 2014). They are distressing and disabling during a period of significant adaptation for the parent(s) and heavy caretaking responsibilities. The impact of these problems is significant, affecting not only the parent and co-parent, but can also have long term negative effects on the foetus and new baby's cognitive, social and emotional development. This relationship is thought to be mediated through the parent-infant relationship (Stein et al. 2014). Poorer child outcomes are particularly likely when parents have chronic or relapsing mental health patterns (Netsi et al. 2018; Pearson et al. 2018), so it is especially important to treat pregnant and new parents with mental health problems quickly and with evidence-based interventions.

This is important because a large number of new parents who suffer from depression and anxiety-related mental health problems will be eligible for services within NHS Talking Therapies, either as direct clients or working jointly with perinatal specialist mental health services (e.g., NHS Talking Therapies providing a specific psychological treatment). **However, rates of perinatal parental treatment access in NHS Talking Therapies for Anxiety and Depression services have historically been low relative to similarly aged individuals who are not in the perinatal period.** Parents report this is due to a number of reasons, including practical and logistical barriers associated with being pregnant or having a small infant, and the stigma of being a parent and suffering from mental health problems (Millet et al. 2018; O'Mahen & Flynn, 2008). Critically, parents report that without appropriate delivery and service adjustments within NHS Talking Therapies, it has been difficult for them to overcome these barriers to access services (Ingram et al. 2021; Patel et al., 2021). This practice guide offers guidance on developing effective services for perinatal clients and should be read in conjunction with the NHS Talking Therapies Manual and the Perinatal Competency Framework. The competency framework provides detail on the skills necessary to successfully address perinatal clients' needs.

NHS Talking Therapies services should work collaboratively as part of a larger perinatal health and mental health care pathway. NHS England has invested in the expansion of perinatal mental health treatment within secondary and tertiary services, providing improved treatment provision, training, supervision and leadership in perinatal mental health to those with moderate to severe and complex mental health problems. Perinatal specialist mental health services provide care that may include medication management, care coordination, and psychological interventions for both maternal mental health and the parent-infant relationship. Critically, for NHS Talking Therapies, they also support other health and mental health care providers in the care pathway by promoting prevention and early identification of perinatal mental health problems, providing expert perinatal mental health advice, training and supervision, and support coordination of perinatal mental health across the perinatal mental health care pathway.

PERINATAL POSITIVE PRACTICE GUIDANCE

PERINATAL SERVICE PROVISION FOUNDATIONS

GUIDANCE: Services should prioritise the treatment of parents (biological and adoptive) in the perinatal period.

Why?

- Antenatal and Postnatal Mental Health Guidelines (NICE 2014) recommend perinatal mothers should receive assessment within 2 weeks and psychological interventions within 4 weeks. This differs from the national waiting time standard for the NHS Talking Therapies programme, which states that 75% of people referred should have their first treatment session within 6 weeks, and 95% within 18 weeks.
- During pregnancy, there is increased urgency for treatment given the impending and unavoidable nature of childbirth.
- Postnatally, to minimise the impact of mental health problems on the developing parent-infant relationship, which can in turn affect long term cognitive, emotional and social outcomes for the child, and in recognition of the impact of mental health related disability on the intensive nature of infant caring demands.

GUIDANCE: All services should have perinatal champions/leads at the psychological wellbeing practitioner (PWP) level and high-intensity therapists who have allocated time (e.g. 0.1-0.2 WTE) to uphold perinatal clinical practice in their service (note this time does not include individual or group therapy but rather is for the additional outreach and liaison work).

Why?

- As a client group with specialist needs, having a perinatal champion/lead ensures that the specific needs of perinatal clients are held in mind in the service and the appropriate training and support is upheld.
- Turnover in both perinatal health services and NHS Talking Therapies services can be high, and perinatal health and mental health services undergo frequent restructuring. Having a named perinatal practitioner in every NHS Talking Therapies aids in ensuring that perinatal support is consistently held in mind in the service, and facilitates ongoing reciprocal liaison between services and the perinatal champion/lead to maintain up-to-date connections and care pathways.

PRACTICE TIPS

Perinatal champion/lead roles:

- Maintain connection with perinatal professionals across the care pathway (e.g., midwifery, health visiting, GP, perinatal community teams).
- Ensure up-to-date internal perinatal training and supervision.
- Act as a "go-to" person in service for perinatal related questions.
- Provide education to perinatal health professionals about mental health problems in the perinatal period and information about what treatment provision is on offer in NHS Talking Therapies.
- Provide perinatal access and adherence Information for commissions.
- Ensure data on perinatal referrals is collected and regularly reviewed.

GUIDANCE: Services should ensure that all clinical staff are aware of the clinical risks in the perinatal period and there are established procedures for escalating concerns and managing risk.

Why?

- There are unique risks during the perinatal period to both parent and child, and risk thresholds are different.
  - Risk can present differently and escalate quickly in the perinatal period. See MBRRACE-UK (maternal perinatal deaths) report.
  - There is heightened risk for psychosis during the perinatal period.
  - Awareness of impact of stigma – parents may not disclose risk because they may be afraid their child will be taken away.
  - Risks in relation to neglect.
  - There is an increased risk of domestic violence during the perinatal period.

  - There is heightened incidence of obsessional intrusive thoughts (e.g., about the infant) during the perinatal period. Obsessional intrusive thoughts should be carefully distinguished from psychotic thoughts about harm to self or baby. Carefully disentangling these thoughts will support more accurate assessments. This process will also help determine when social services should/should not be involved.

- Staff should also be aware that parents may be reluctant to engage with services because they may fear that their baby might be removed from their care. Be transparent about assessments and risks and reassure where appropriate.

PERINATAL MENTAL HEALTH: MANAGING RISK

Presentations which should prompt urgent senior psychiatric assessment.

- Recent significant change in mental state or emergence of new symptoms.
- New thoughts or acts of violent self-harm.
- New and persistent expressions of incompetency as a parent or estrangement from the infant.

Risk in the Perinatal Period, things to consider:

- Risk can present differently and escalate quickly.
- Be aware of the impact of stigma, parents may not disclose risk for fear of social services involvement.
- There is an increased risk of domestic violence during the perinatal period.
- There is a heightened incidence of obsessional intrusive thoughts during the perinatal period, and these should be carefully distinguished from risk of harm and associated social services involvement.
- Consider the possible risk of neglect of infant if parent's mental health is significantly impacting on the ability to parent.
- A history of bipolar disorder (or postpartum psychosis) can markedly increase the risk of postpartum psychosis and should be referred to the Specialist Perinatal Mental Health team for further assessment and monitoring, even if the woman is well and has had no recent episodes of illness.
- Postpartum psychosis is a psychiatric emergency and a woman should be assessed and treated by a psychiatrist, preferably a specialist perinatal psychiatrist, within 4 hours.
- Risk can escalate through pregnancy and approaching delivery (e.g tokophobia, anxiety about becoming a parent).
- Risk can escalate postnatally including rapid deterioration (postpartum psychosis, relapse).

GUIDANCE: Services should consider how perinatal health changes affect client's responses to outcomes measures.

Why?

- Physical changes during pregnancy and the postnatal period can be confounded with somatic symptoms on measures of mood and anxiety (e.g., fatigue, sleep, appetite, concentration).

PRACTICE TIPS

- Consider augmenting NHS Talking Therapies core measures with perinatal specific measures that account for somatic/physical changes or are less reliant on somatic indices (E.g., Edinburgh Postnatal Depression Scale; Depression, Anxiety, and Stress Scale; Wijma Delivery Expectancy/ Experience Scale.
- Provide instructions asking parent to respond to items regarding the impact of their mood, above and beyond their physical changes.

SERVICE LEVEL CHANGES TO IMPROVE ACCESS AND ENGAGEMENT

GUIDANCE: Services should offer a range of modes/locations of delivery around client preferences and these should be applied flexibly based on client needs. First treatment contact should be offered face-to-face in person or if not possible via videoconference (i.e., assessment and first treatment session). Please note that face-to-face is defined as being able to see the client's face. In-person is defined as being in the same physical space as the client.

Why?

- 90% of courses of therapy during COVID-19 lockdown were delivered remotely (video or telephone) and remote delivery will continue to be a significant delivery mechanism in NHS Talking Therapies post-COVID-19. Remote delivery can improve access, particularly for busy parents who lack childcare, would struggle with transport, and are managing multiple medical appointments and changeable infant routines.
- Online groups to perinatal parents during COVID-19 enabled services to recruit across broader geographical patches, resulting in shorter wait times and better treatment adherence.
- The parent's preference for and ability to be seen in person, via videoconference or telephone may change throughout treatment in relation to baby's current needs (e.g., if baby's routine is suddenly off may not be able to take a videoconference call and instead prefer telephone that session, not able to make it to office setting immediately in the postnatal period).
- Face-to-face communication allows clinician to pick up on nonverbal cues in relation to verbal cues. This may aid the development of therapeutic rapport and improve engagement.
- Face-to-face communication allows the clinician to see the parent's developing bump during pregnancy and the parent's interaction with baby following childbirth. This visual information will help clinician to understand and assess parental connection with the baby, and to plan treatment based on upcoming childbirth and baby's developmental age.
- Face-to-face communication allows the clinician to understand events that may be going on during session (e.g., breastfeeding, jiggling baby).

PRACTICE TIPS

- Where it aligns with patient choice / preference to in-person visits, use videoconference software that is secure, freely available and likely to be familiar to the client in order to cut down on technological knowledge barriers (e.g., WhatsApp, Zoom).
- If seeing a client via videoconference, offer to hold an initial "getting familiar with technology" session, or allow extra time at the beginning of the session to help client with technological concerns.
- Individuals who prefer in-person contact but who may have had traumatic experiences in health care settings (e.g., maternity/traumatic childbirth) should be offered an in-person appointment in a suitable alternative location.
- Send client information about managing videoconferencing with an infant/small children around, and spend time at the beginning of the first call discussing how you'll both manage situations where baby might be present but have its own care needs (e.g., baby starts to cry, needs to be breastfed, etc.).

GUIDANCE: Services should be child-friendly. Services should allow infants to be present during treatment (during either remote or in-person sessions), and where feasible, also provide access to childcare (in-person).

Why?

- A child-friendly service normalises being a parent and communicates that the service values the parent.
  - Child-friendly services facilitates access for perinatal parents.
  - Parents with young children are more likely to attend if facilities are set up to meet their needs.
  - Parents may not have access to childcare.
  - The parent's mental health difficulties may mean that they are not comfortable leaving their child with a carer.
  - The unpredictable nature of infant schedules may necessitate bringing child(ren).

– It may be important to have the infant/children in the sessions in order to observe how the parent and infant are together, to pick up on the parent's cognitions about baby (parent thinks baby is rejecting them, doesn't like them, they are a bad parent), or to involve baby in content of sessions (i.e., conducting a behavioural experiment with the baby when parent has OCD). This may be especially true since COVID-19, with parents now increasingly working from home and juggling work with childcare.

PRACTICE TIPS

- Explore child friendly locations to see parents (e.g., children's centres, community centres).
- Offer childcare for in-person sessions where possible (e.g., Devon's parent-champions for mental health in children's centres will look after/play with child in room next door to the treatment rooms).
- Ensure all locations where parents are seen are child friendly.
- Ensure parents know that it's okay to feed/change baby and to work with parents around what would be acceptable to them regarding feeding during session time.
- Discuss with parents how you would like to mutually handle baby crying/distractions (e.g. would parent prefer to try to attend fully themselves to baby during that time or to have you support them by talking to/distracting baby) and to clarify times where they might need to either discontinue the session or take a break to help meet the baby's needs.
- There should be a changing table in the toilets or a portable changing mat.
- There should be space to feed baby and messages about acceptability of feeding (breast or bottle) baby in the service location. Bottle feeding parents may need access to water and warming facilities. Consider booking rooms for longer pre-post session to allow time for parent to feed baby.
- Toys: A box of developmentally appropriate baby toys and play mat should be available. Have space in room for baby and parent to get on floor. Have a spray to quickly sanitise toys between sessions.
- Prams: Have space for prams, ability to bring pram into session (e.g., baby may be asleep in buggy), access to lifts/ramps if needed, bike locks for buggies.
- Remote delivery. If possible try to plan for some sessions when baby/other children may be napping or when there is another carer present.
- Remote delivery. If baby and other children are present, speak to parent about how they would best like to manage children during this time (e.g., what toys/activities might help to keep children engaged while parent does session).

GUIDANCE: Services should provide active outreach to the perinatal community and parents to improve awareness and increase access.

Why?

- Parents have high levels of stigma about having mental health problems during the perinatal period and significant fears of their child being removed from their care because of their mental health problem.
  – In some communities there are high levels of stigma in the family/community about mental health problems that further compound these broader issues.
- Some individuals and communities have low mental health literacy that results in them and their families having a poor recognition and understanding of problems as a mental health problem.
- There is very little knowledge of perinatal mental health services in the broader community and how to engage with these services.
- New parents do not have the time and resources to undertake the burden of finding out how to access perinatal mental health support.
- Difficulties in the perinatal period can be minimised by others (both social support and health care professionals).
- Some mental health difficulties in the perinatal period have been instigated or compounded by healthcare professionals (e.g., maternity during childbirth) leaving the individual wary of the NHS as an organisation. Mental health care based in hospitals and antenatal clinics can compound people's fears of using services if their traumatic experience was based in those settings.

PRACTICE TIPS

Consider the following arenas as pathways to provide parents with information about mental health and treatment during the perinatal period:

- Work with peer support groups and community groups (e.g., parent and baby groups, peer support, library drop-in stay-and-play groups, faith organisations playgroups, "baby church," summer clubs).
- Maternity and health-visitor/GP practice nurse clinics.
- Online support groups – asking groups to post information about the service and being present to offer information about the service.
- Provide posters/written information to act as prompts for information.
- Link with charities (e.g., Make Births Better, Birth Rights) to help women have access to resources / information to support them in their specific needs (e.g., statutory pay, maternity leave). Ensure reciprocal links of referral.

GUIDANCE: Services should actively support parents' ongoing engagement with treatment (e.g., following up cancellations/DNAs) and should have flexible cancellation/DNA policies.

Why?

- The transient and potentially rapidly developing nature of risk in the perinatal period requires closer, more consistent monitoring.
- In pregnancy, physical symptoms and postnatally, physical recovery from childbirth and the demands and changeable nature of childcare (i.e., lack of sleep, changing infant feeding and sleep schedules) can lead to a higher rate of cancellations, DNA, and poor engagement with treatment content.
- Clients have multiple competing health appointments that they may be balancing with work/childcare.
- The reality of getting to appointments is particularly challenging in the perinatal period (e.g., getting out the door with small children can be an unpredictable and time-consuming process often out of the parent's control).
- Some individuals may not trust services and have an ambivalent relationship with the NHS and related services (e.g., traumatic delivery, difficulties with maternity generalised to mental health care). This can also occur with stigma/guilt about mental health problems during the perinatal period and fear that services might take baby away (particularly salient fear in women with low incomes, and histories of abuse and discrimination). It is important for services to take the lead on helping to resolve these therapeutic service ruptures and to provide compassionate outreach.

PRACTICE TIPS

- Schedule appointments around infant/other child schedules (e.g., naps, feeding, school run) and parental work schedules.
- Text reminders for appointments.
- Assertive outreach for DNA and cancellation: For example, text/ call if mother does not attend, offer to do session online or via telephone.
- Be willing to change times of appointments as infant schedules change with development (napping, teething).
- Where feasible, using local community services to support engagement (e.g., using family support worker in children's centre/Home Start to help client get to a session; parent champion who will provide childcare support).
- Take particular care at outset of treatment to be clear about the type, length and purpose of provision (e.g., type of and length of treatment that can be provided, being clear that mental health service has separate function and purpose from maternity services, be honest about what is confidential within therapy session and what might be shared with other healthcare professionals and give client control over what is shared with whom [within legal limits]).
- Facilitate discussion with client about difficulties engaging with service and negative previous experiences within the NHS that may compound these difficulties. Consider modifying location/ type of delivery based on previous negative experiences (e.g., someone with difficult delivery/ miscarriage/stillbirth may not want to have appointment in antenatal clinic/hospital setting).

GUIDANCE: Services should offer weekly sessions to perinatal parents.

Why?

- Meta-analyses have indicated that more closely spaced intervention dates are associated with improved outcomes (Cuipers et al. 2013). This is especially important during the perinatal period because:
  - During pregnancy, the rapidly approaching due date for delivery compresses the therapy time period.
  - The rapidly developing parent-infant relationship requires immediate and efficiently delivered intervention.

SERVICE COMMUNICATION

GUIDANCE: Services should use perinatally friendly language. Services should refer to "parent," which is inclusive of both mothers, fathers and partners. Services should aim to be inclusive of all parents and recognise the range of ways in which "family" may be defined.

Why?

- The definition of family may encompass different family structures, with diverse experiences. These may include:
  - single parent families.
  - same-gender parents.
  - solo parents (person who becomes a parent on their own through donor conception/surrogacy/etc).
  - use of donor egg or sperm and/or adoption/fostering may mean child is not biologically related to the parent.
- Assumptions around gender and roles may be more common in the perinatal period (e.g., individual who has delivered a baby may be assumed to identify as female).

GUIDANCE: Services should develop strong links, reciprocal communication, and referral pathways with relevant health professionals (e.g. maternity, primary care, health visiting, children's centres, specialist community perinatal mental health services and Maternal Mental Health Services (MMHS) and specialist Child and Young People Mental Health (CYMPH) services.

Why?

- To increase access to NHS Talking Therapies, perinatal health professionals should know where and whom to refer to NHS Talking Therapies for Anxiety and Depression.
- NHS Talking Therapies practitioners are well placed to identify parents who may benefit from additional infant mental health support from CYPMH services (including parent-infant services).
- When parents are planning for birth, the NHS Talking Therapies clinician can work collaboratively with the parents and midwife to ensure emotional and psychological needs are considered.
- It is important to ensure that the postnatal plan includes relevant community groups and health professionals (e.g., feeding support, children's centres).
- There may be a need for additional infant mental health support from CYPMH services.
- Early year's workers/homestart may help to support woman to engage with treatment and exposure work (social anxiety with attending mum and baby group).
- See Perinatal Competency Framework Domain 4 for additional examples.

PRACTICE TIPS

- Ensuring the word "parent" is used in all correspondence.
- Not assuming a heterosexual couple in assessment and treatment.
- Use the word "partner" when talking about support individual might have.
- Enquire about any fertility treatments and the impact they may have had on mental health.
- Checking what pronouns the client is comfortable using.

PRACTICE TIPS

Examples of how to form and maintain communication with perinatal services:

- Keep an up-to-date database of relevant perinatal services, this should include organisations that provide services around perinatal loss/safeguarding loss, midwives and health visitors, local community groups/faith organisations, children's centres, etc.
- Ensuring letters are copied to involved perinatal health professionals with client consent.
- Maintain clear referral pathways across services.
- Utilise health professionals to support clinical work where appropriate (e.g., accessing birth notes in a case of birth trauma, involving maternity services in exposure work, joint delivery of group treatments).
- Perinatal flyers posted in perinatal and GP health settings.
- Leaflets about NHS Talking Therapies and mental health in 16-week appointment materials and postnatal materials
- Dedicated perinatal section on NHS Talking Therapies service webpage.
- Make perinatal mental health information available and accessible to new parents.

ETHNICALLY AND CULTURALLY DIVERSE COMMUNITIES

GUIDANCE: Services should implement the NHS Talking Therapies Positive Practice Guide for guide for working with ethnically and culturally diverse populations.

Service perinatal champions/leads should also familiarise themselves with the Equity and Equality Guidance for Maternity Systems

GUIDANCE: Services should adapt provision to reduce the impact of stigma and discrimination on perinatal clients' access, engagement and adherence to treatment.

Why?

- People from ethnically and culturally diverse backgrounds have poorer childbirth outcomes in the UK. Black women are 5 times more likely and Asian women are 2 times more likely to die during the perinatal period compared to White women.
- Many ethnically diverse parents will have personally experienced discrimination in their broader lives and specifically during the maternity period and will also have witnessed or heard about discrimination amongst close and/or similar others. These forms of discrimination may have been perpetuated by a range of health and social services providers, creating a general distrust of providers that may be heightened during the perinatal period because of their recent and increased interactions with these providers.
- Ethnically diverse parents are less likely to receive formal mental health care treatment in primary care.
- Parents from some ethnically and culturally diverse backgrounds are less likely to think about their symptoms as "depression" or "anxiety" and therefore do not perceive formal mental health services as a place to seek help for their mood (e.g., may focus on problems rather than mood, such as not being able to be "financially independent" as a mother, which may threaten a strong cultural value that the mother must have the means to be able to provide for her family).
- Parents from some ethnically diverse communities may perceive other settings and individuals as more appropriate sources of support (e.g., spiritual).

EXAMPLES OF TYPES OF PERINATAL DISCRIMINATION

Discrimination can sometimes be ambiguous and subtle, and this can make it more difficult and confusing for the person who has experienced it.

- Health and mental health providers' unconscious beliefs that maternity patients of colour are "uncooperative".
- Lower quality communication with healthcare providers.
- Less involvement in decision-making including having attempts at self-advocacy for childbirth (e.g., no pain medication) suppressed by healthcare providers (double bind of self-advocacy resulting in poorer care).
- Health providers not referring to parent by name, not making eye contact with parent.

PRACTICE TIPS

To counter worries and concerns of ethnically diverse groups:

- Have consistent interaction and communication with local diverse communities and organisations supporting pregnant and postnatal individuals.
- Have ongoing contact to build trust with community leaders (including faith based leaders).
- Work with local voluntary care sector organisations to help improve outreach to specific communities (e.g., drop-in session opportunities through Voluntary Care Group which could then result in connection to treatment through NHS Talking Therapies).
- Encourage individuals who are part of the NHS Talking Therapies service and may also be part of local communities to act as a liaison between these groups/communities, where appropriate and not a dual relationship.
- When interacting with ethnically diverse individuals take time to explain care offers thoroughly and provide both oral and written information in response to their questions.
- Have a range of multilingual and culturally appropriate leaflets (electronic and paper) about the service offer, using terms that are acceptable to the target community.
- As a provider, be open and willing to acknowledge power and privilege differences between both the system, the specific NHS Talking Therapies worker and the client.
- Take extra care to check assessment and treatment choices with client to ensure understanding and fit with their preferences and needs.
- Be aware of culturally specific phrases that may serve as negative triggers for parents from different backgrounds (e.g., "strong black woman," where it could mean to put aside one's needs for others and not be able to ask for help; "have patience or Sabr in Arabic" in SE Asian/ Pakistani women, where it could mean women should suppress and deny their emotions and needs.
- Wherever possible do not use family and friends as interpreters as they may misrepresent information and/or the parent may feel uncomfortable revealing their difficulties. Use paid/NHS interpreters wherever possible.
- Work closely with services users ethically and culturally diverse backgrounds (see co-production guidance).

GUIDANCE: At assessment and throughout treatment services should ask and integrate into the treatment plan how the person's (family's) culture and traditions affects their experiences of responses to pregnancy and the postnatal period.

Why?

- There is wide variability in traditions, religious beliefs, and expectations between and within ethnic/cultural groups. These traditions can support parents or lead to intrapersonal and interpersonal conflict. (e.g., conflict between culture living in, parent's culture and potentially partner's culture as well if different). Where individuals do not have access to valued traditions (e.g., living away from family or without access to the components of the postnatal traditions, like specific spices) they may have feelings of shame, loss, anger and sadness as a result.

EXAMPLES OF CULTURALLY-SPECIFIC PERINATAL PRACTICES

In Nigerian culture, the Yoruba tribe has a naming ceremony 7 days after the birth that is a large party. It celebrates the joy of having a new baby, but may also be experienced by some as a difficult position if they have had a difficult delivery, feel ambivalent about the baby, struggle with large social events, etc.

In some Chinese cultures, there is a postnatal 40-day period of confinement where the mother and baby are cared for by close family relatives and may eat special foods.

Those practicing Islamic faith may place a high value on privacy during childbirth and breastfeeding that may impact their choices about where and how to deliver and what public places they may feel comfortable going to whilst breastfeeding.

Baby loss in some cultures may be interpreted as a "spiritual curse" (e.g., 'evil eye') resulting from poor behaviour or lack of faith. To prevent this from happening, Black Africans may try to conceal their pregnancy from others as long as possible.

PRACTICE TIPS

Key potential areas of potential cultural differences to ask about:

- Pregnancy – cultural beliefs about what mother should/should not do (e.g., low level of activity, what to eat).
- The impact of religious/cultural beliefs on decision-making across the perinatal period (e.g., not believing in abortion and genetic testing).
- Who baths infant and specific bathing approaches.
- Infant feeding traditions.
- Ideas that 'mental illness' is not an issue for that cultural group, and is due to other causes (e.g., 'loss of faith').
- Periods of confinement (e.g., there may be strict expectations around mother's movement, activities, etc).
- Touching mother (bump)/baby.
- Co-parent's attendance/involvement at birth.
- Circumcision.
- Postnatal healing processes (e.g., cleansing, wrapping, maternal massage).
- Diet/meals that may be specific to the postnatal period. The potential impact of religious beliefs and special periods of the year (e.g., Ramadan) on diet/meals.
- Childbirth (e.g., expectation that family and close friends will be at hospital).
- Who cares for the baby or lives in the house (e.g., only women can come into the house).
- Cultural attitudes towards motherhood.
- Impact of spiritual beliefs on motherhood, childbirth and coping (e.g., using prayer to manage both physical and psychological pain).
- Expectations for each parental/couple's role (e.g., how a Danish mother and a Greek father might perceive the Greek father's involvement in practical caring tasks).
- Expectations for family involvement.
- Cultural beliefs around privacy and their impact on the perinatal experience (e.g., male partners present on hospital wards).
- Ensure active outreach to parents, and support parents to ensure they are able to engage with treatment in accessible, affordable, and acceptable locations.

PARTNER/SIGNIFICANT SOURCE OF SUPPORT WORK

GUIDANCE: Clinicians should be aware of the relationships between couples/family dynamics, pregnancy and adjusting to having a new baby and mental health.

GUIDANCE: Clinicians should aim to involve partner or a significant source of support for at least one session (high intensity, where feasible for low intensity), if the client agrees it would be useful. Where conjoint sessions are the primary treatment modality, at least one session early in treatment should be individual to assess for interpersonal violence risk.

Why?

- In the perinatal period people can have more contact with family members and can have more support needs. This can impact either positively or negatively on mental health.
- When a parent experiences mental health difficulties in the perinatal period, the whole family is affected.
- The early childhood years can be challenging for the couple relationship. The quality of the parental relationship has been shown to play a role in new parents' relationships with their baby (Cowan & Cowan, 2000; Huston & Vangelisti, 1995).
- Relational conflict is associated with increased levels of antenatal and postnatal depression and anxiety, poorer treatment outcome, and greater risk for relapse.
- Emotional closeness, good communication and practical support is associated with decreased levels of antenatal and postnatal depression and anxiety.
- Reciprocally, depression and anxiety can have a negative impact on relationship functioning.
- Partners of individuals with perinatal depression tend to be at greater risk of experiencing depression and anxiety themselves.
- Lone parents without strong additional supports may be at risk for emotional distress and low mood.
- IVF, unplanned, and unwanted pregnancies may place heightened strains on partner and support relationships that can leave couples vulnerable to mood and anxiety problems.
- Saving Lives, Improving Mothers' Care (MBRRACEUK, 2018) : "Partners and other family members may require explanation and education regarding maternal mental illness and its accompanying risks."
- While working with families it is important to be aware that:
  - 1 in 4 mothers in contact with mental health services may be experiencing violence, abuse and coercive control.
  - Domestic violence often starts or intensifies in the perinatal period.

PRACTICE TIPS

- Ask about both sources of support and sources of conflict in the individual's support network. Be aware that sources of support can also be sources of conflict.
- Assess if offers of support will be helpful/what costs are and how to manage boundaries if there are significant costs associated with support.
- Regularly ask about the relationship during treatment as changes in the quality of the relationship may impact on the client's mental health.
- Consider how partner's wellbeing may be doing throughout and offer opportunity for assessment if needed.
- Consider that some clients may not want their partner involved or may feel conflicted about their involvement.
- Where the relationship is central in the maintenance of an individual's depression, Behavioural Couples Therapy should be considered if this is offered in the service and amenable to the client.
- Ask about how cultural mores /practices may impact on expectations and acceptability of support (e.g., traditions, rituals, who might be present, for how long, how much support offered).
- Where individual sessions are the primary treatment modality, if the client has a partner/ significant source of support, aim to involve partner / significant source of support for at least 1 session if the client agrees it is useful (high intensity. Low intensity where feasible).

continued overleaf...

PRACTICE TIPS *continued*

- Where conjoint sessions are the primary treatment modality, at least one session early in treatment should be individual to discuss any issues the client may feel uncomfortable sharing in front of their partner and to assess for interpersonal violence risk.
- Offer flexible appointment times and modes of delivery to enable couples to attend sessions together (e.g sessions during nap times or in the evening, remote delivery may enable both partners to attend sessions).
- All staff working should know how to enquire about, identify, and respond to Domestic Violence and Abuse (DVA), and be aware that domestic violence can be perpetrated by a range of family members (e.g., partner, grandparents).
- See guidance on 'Involving and supporting partners and other family members in specialist perinatal mental health services'.

NEONATAL FAMILIES

GUIDANCE: Services should be aware of the unique impact of the neonatal experience on parents, families and relationships and take steps to improve access to support.

GUIDANCE: Access to support can be improved by: delivering provision within or as close as possible to hospitals whilst the baby is admitted and to remain flexible to the ongoing needs of neonatal families post-discharge which may include flexible service delivery locations and responding compassionately to periods of potentially high levels of distress.

Why?

- Neonatal care represents a series of traumatic events for families, including:
  - Many parents have already experienced a traumatic birth and/or previous losses or complications in pregnancy.
  - Separation at or soon after birth of the infant and parents, often for a prolonged period.
  - Uncertainty about whether a baby will survive or experience significant harm which may continue for weeks to months.
  - Watching the baby going through multiple painful or distressing procedures.
  - Witnessing traumatic events happening to other families often in close proximity.
  - Sense of 'failure' as a parent which can span from birth experiences (e.g. perceived failure to protect from early delivery) to later events (e.g., perceived failure to protect the baby from suffering & distress), and other distress linked to aspects of parental role and identity that have been altered or lost.
  - Feeling detached from the infant due to multiple unique factors (e.g. 1) others are perceived to take a primary caring role for the baby 2) the medical environment (such as incubators) creates physical barriers between infant and parent and 3) nature of critical care (which often mean reduced opportunities for typical parenting tasks which would build a sense of purpose and parental competence under normal circumstances) and 4) the uncertainty of survival presents a complex 'dilemma' for investment in the parent-infant relationship. There are many other factors that may disrupt the bonding relationship which should be understood in the context to which they occur, with the recognition that the circumstances vary substantially to those of a well baby in a non-hospital environment.
  - Complex relationships with medical staff, on whom parents feel entirely dependent and spend long periods of time with.
  - Necessity to make significant and complex medical decisions which may have life-long consequences for the infant and family.
  - Parents may experience the death of their baby whilst on the unit or being aware of or witness to the death of other babies.
  - Parents of multiples can experience the death of one or more babies whilst still parenting a live infant on the neonatal unit.
  - Prolonged hospital admissions which may include stays in paediatrics post neonatal care. Families whose babies are in hospital for months to years face another set of unique challenges.

- Parents whose baby has been in neonatal care have a significantly increased risk of difficulties including anxiety, depression and PTSD. It is often helpful to frame these difficulties as understandable reactions to traumatic events (in line with Ockenden recommendations).
- Many parents are likely to have experienced more than one trauma in the course of a neonatal stay so criteria for trauma-focused treatment should reflect this.
- Given the nature of their experiences parents are more likely to experience difficulties with emotional adjustment – to loss, disability or other life changing circumstances which can cause significant and ongoing distress. For many parents the threat of a further emergency which could be life threatening for their infant remains significant and should be acknowledged in treatment approaches.
- Parent-infant, couple and family relationships can be significantly impacted by a neonatal stay, further impacting the wellbeing of the parents themselves. This can have a long term impact on the development and emotional wellbeing of all family members.
- Families experience a large number of secondary stressors whilst their baby is in neonatal care including financial pressures, difficulties with work and leave, challenges of finding care for other children, strain on the couple relationship and housing needs (homes can be inappropriate for the needs of babies with additional medical needs on discharge).
- Babies can be cared for outside their local area, often significant distances from home, leading to families having reduced access to their social support network.
- Once home from the neonatal unit parents often feel isolated from and different to groups of parents who have not had a neonatal stay. Concerns about infection and physical limitations of a group space often prevent families from accessing group support.

PRACTICE TIPS

- Build relationships with local neonatal units and with the regional Neonatal Operational Delivery Network, to improve access for families and promote sharing of best practice.
- Where neonatal psychological or psychosocial support is already in place, develop clear pathways to ensure a smooth transition for families.
- Consider having a 'neonatal perinatal champion' within the service who can support these links and disseminate information promoting awareness of the neonatal experience.
- See 'Implementing the Recommendations of the Neonatal Critical Care Transformation Review'.

For families currently on the neonatal unit:

- Recognise that they are in an ongoing traumatic situation. The focus may be on counselling strategies aimed at supporting the parents, making sense of the experience, and strategies to promote stabilisation.
- Consider offering support on the unit to reduce the need for parents to be separated from baby.
- Work with neonatal teams to reduce secondary stressors via needs assessment of the family system.
- Work with neonatal teams to understand and plan around the psychological needs of the parent so that systems around the family can be sensitive and responsive.

For parents who have been discharged from the unit:

- Recognise that this experience often has a lifelong impact, so even if parents present many years later the focus of the work may be on the neonate experience.
- Utilise therapeutic approaches that firstly recognise the impact of neonate experience on parenthood before moving to a symptomatic focus where indicated.
- Recognise the transition to home can cause a worsening in distress as parents take sole responsibility for their baby.

continued overleaf...

PRACTICE TIPS *continued*

For any neonatal parent / family:

- Offer flexibility for parents who may have difficulty attending appointments either because they need to be with baby on the unit, the baby has additional needs or are attending lots of follow up appointments once home.
- Allow time for the parents to describe their neonatal journey so the context and experience can be fully understood.
- Recognise parents might be experiencing the impact of multiple traumatic events and multiple losses, some of which may be continuous.
- Recognise a neonatal admission impacts the family system and difficulties of an individual should not be seen in isolation.
- Consider the potential benefit of support to the couple relationship as well as individuals.
- Be alert to the need to refer onward for support for parent-infant relationships.

QUALITY IMPROVEMENT

GUIDANCE: At point of referral services should ask if individual is expecting a baby or has a child under the age of 2. This information should be recorded on information systems.

Annually, data should be reviewed with a focus on:

- Wait times from referral to assessment and first treatment, ensuring equitable rates of access for perinatal parents.
- Identifying successful and unsuccessful referral pathways.
- Treatment adherence.
- Outcomes for perinatal populations.
- Involving perinatal clients to explore ways to adapt and improve the provision of NHS Talking Therapies.
- Data on rates of access should calculate local need based on local area birth rates and local rates of diversity.

CASE EXAMPLES

CASE EXAMPLE: INTERVIEW WITH PERINATAL CLIENT

GETTING PERINATAL MENTAL HEALTH SUPPORT

Asking for and getting mental health help during the perinatal period:

How did you feel about asking for help?

I felt ok about it because I knew I needed help, but there is always reticence because you tell yourself you are ok, managing etc. and you don't want to make a big deal of things. Its wasn't until after my baby was born I realised just how anxious I was.

Tell me about the process of asking for and receiving help.

It took me quite a while to get help, I asked several different practitioners at pregnancy related appointments and they often said they would refer me and then… nothing. I had to do quite a bit of chasing up, which is off putting. I spoke to my midwife on more than 1 occasion, GPs at my surgery and a consultant at the hospital.

What was helpful about this process and what wasn't?

It was useful that I was able to access help easily at my GP and could go to the hospital for early scans.

It wasn't helpful that it took a while to get help. I probably first spoke to a health professional about anxiety when I was 9 weeks pregnant but it took about another 3 months to get to NHS Talking Therapies, as once I had been referred I also had to wait. By 9 weeks I was already incredibly anxious and convinced the baby would not make it full term as I had had a prior miscarriage, some early bleeding that a sonographer had suggested meant the pregnancy was failing and a later threatened miscarriage.

Treatment in the Perinatal Period

What about treatment was helpful and what wasn't?

I liked going to the sessions and talking to the therapist. I found it calming, reassuring and it helped me to rationalise the anxiety somewhat. However the activities I did in between I found less helpful . They were a bit "one size fits all" and I found using them to try to reduce my anxiety didn't work. I also found I was still stuck in repetitive anxious behaviours, like checking for baby movements and the tasks didn't stop or reduce these. That said, over the longer term there was some impact of using the anxiety diary as a process. I also didn't find it helpful that the sessions came to an end well before my pregnancy did! My anxiety lasted until my child was born, so it would have been good to have been able to continue having sessions until the end of my pregnancy.

What would you want other women to have and what would not want other women to have to go through?

I would like women to be able to have quick access to the talking therapy service and to be able to have sessions throughout their pregnancy if needed. I wouldn't want them to have to try and get referred for so long, I had to be quite persistent.

CASE EXAMPLE: GETTING PERINATAL MENTAL HEALTH SUPPORT

2014: FIRST EXPERIENCE TRYING TO (UNSUCCESSFULLY) ENGAGE WITH PERINATAL MENTAL HEALTH SUPPORT

After having my first child in 2014, I was suffering from anxiety and OCD. My GP recommended I receive support from NHS Talking Therapies. My GP gave me an NHS Talking Therapies business card and suggested I call. I didn't follow up, partly because I was reluctant to seek help and partly because I felt that with a new baby I didn't have time to commit to therapy. The main reason I didn't follow up was because I couldn't relate to the words and images on that card. It was black and felt cold and functional. It didn't target "people like me," and I worried about showing up to busy, disruptive service with my new baby.

Weeks later, I did call the number on the card. I left a message and no one got back to me for weeks. When someone did I was asked to spend an hour on the phone with them going through a consultation. It was just another excuse for me to not go through with therapy and I told the person I was too busy with my baby to find the time to do the consultation. I think I made 3 separate phone call appointments before I eventually did the interview. After that, I was told there was a very long waiting list and it was suggested that I join a group stress session at a local Town Hall. I put my name on that list, but when I called back to find out when I could join the group, I was told it wasn't suitable for me! I eventually gave up and went private.

To me, the issue was that there were too many barriers to entry to NHS Talking Therapies. There were many delays, and for someone like me, who was forcing myself to go through with this, this was really detrimental. As time passed without being able to access help, I convinced myself I didn't need it, I wasn't a priority and I could get over this on my own. In reality all of that was far from the truth. The fact that I'd spoken to so many people during that process was also an issue. I felt like a number going through a system. I wanted a feeling of someone showing understanding of what I was going through.

2016: PERINATAL MENTAL HEALTH TREATMENT

In 2016 when I was pregnant with my second child and coping better (or so I thought) with my issues. I mentioned to my midwife at Chelsea and Westminster that I was worried about slipping backwards when my second child was born. It had been hard enough to cope with OCD/anxiety with one child and I wasn't sure I'd be able to with two. She was fantastic, and told me she would find out what help might be available. She took ownership of my issue. She was kind, nurturing, non-judgemental and I'll be eternally grateful to her. She called me the next day and within a week had booked me an appointment with the perinatal mental health team. There was no going back, the process had started, people were involved and I was going to get help. I saw a psychologist for CBT until my second child was 6 months old and I had to be discharged, but in that time I understood my issue and how to cope with it and life was very different. I should also add that I was able to have these appointments privately in a hospital or children's centre (to me, very safe environments) and was also encouraged to take my baby along too.

2017: FOLLOWING UP WITH FURTHER MENTAL HEALTH TREATMENT IN NHS TALKING THERAPIES

In late 2017 I developed health anxiety after having a bad ear infection which caused vertigo and dizziness. I didn't qualify for the perinatal service, so I accessed the local NHS Talking Therapies. Now having had therapy experience I felt better equipped to navigate what I thought were tricky administrative procedures at NHS Talking Therapies. I went to the NHS Talking Therapies centre and was surprised to find I coped better than I expected to. There was one problem though, I didn't like the waiting room. I felt like I was being judged and watched and I felt ashamed of being there. I realise that's not something that's easy to change.

My therapist was understanding and empathetic, but I felt that what she was trying to do was hampered by some of the administrative and clinical procedures she had to follow. I also felt the treatment wasn't as personalised as my former treatment had been. Each week we did a different exercise, but I benefitted less from it because it wasn't specifically targeting my personal problems. When, during the therapy my uncle died suddenly in his sleep and my health anxiety went into overdrive, I didn't feel she had the tools to cope. I appreciated my therapist's empathy, but I felt I needed something more and I didn't feel things were improving in the same way they had with my previous psychologist. That said, I did walk out of those NHS Talking Therapies sessions feeling 'lighter' having had the opportunity to share my thoughts with someone. I just didn't feel able to carry this on on my own. I didn't have a coping strategy or any self-care tools. I thought about asking to change the therapist, but the process of doing that wasn't explained or easy to do, so I didn't. If I'd been able to I think that could have made a big difference.

I moved out of the area so I didn't finish the therapy course with NHS Talking Therapies. On leaving, it felt very much like I was another person ticked off the list. No one asked where I was going, what I was doing and whether I was getting help elsewhere. No notes were supplied when I requested them. It was not a good note to end on.

In my experience, several things made a difference to good treatment. These included, people taking ownership, following up on calls and messages, being flexible when booking appointments and setting out a clear plan of action.

CASE EXAMPLE: HOUNSLOW NHS TALKING THERAPIES

COMPREHENSIVE PERINATAL OFFER

Partnership working:

Hounslow NHS Talking Therapies service has a strong relationship with the Maternity service at West Middlesex Hospital, particularly Perinatal Mental Health midwives. This is supported by:

- Hounslow NHS Talking Therapies Perinatal lead champion offering treatment clinics at West Middlesex Maternity service.
- Offering psychoeducation workshops at Children's centres and for services such as Family Nurse Partnership.
- Attending Hounslow Perinatal Steering group which is a multidisciplinary meeting attended by health visitors, social workers and midwives.
- Joint assessments with the Perinatal Mental Health Team for referrals where there is uncertainty about which service is more suitable for the client.
- Liaison with Maternity Loss service regarding service updates and reviewing referral pathways. The service is in the process of arranging specialist supervision from the Principal Cognitive Behavioural Therapist.
- West London Trust delivers Tri-borough Perinatal Training which has previously been co-produced by NHS Talking Therapies perinatal champions.

Perinatal Champions:

- Lead Band 8a, Step 3 Perinatal lead champion (7.5 hrs per week) and Step 2 champion (3 hours per week).
- Perinatal tasks and duties:
  - Screening health visitor, midwife and family nurse referrals.
  - Monitoring perinatal referrals at different care pathway stages.
  - Clinical skills for trainees.
  - Attending perinatal leads workshops and conferences.
  - Training for outside services (e.g. Homestart charity) and outreach at Children's centres and parent groups, etc.
  - Antenatal workshop - accumulating and creating resources for the packs, creating posters, making room bookings.
  - Create resource lists to share with team - e.g. services for dads, apps for parents.
  - Active Recruitment to Wellbeing for Mums group - finding clients from waiting lists etc, this differs from the passive recruiting for other groups.
  - Wellbeing for Mums - organising locations/ remote set-up and liaising with children centres.
  - Attendance at perinatal meetings in and out of service - e.g. perinatal peer review day.
  - Answering perinatal queries regarding assessment and treatment decisions from S2/ S3 clinician.

Operational Procedures:

- Service has perinatal staff guide. This includes information about the perinatal period, risk factors for perinatal clients and resources that mothers can access.
- Triage script includes ante and postnatal assessment questions.
- Staff and admin who screen referrals search for perinatal referrals, these are prioritised and managed first.
- Partners of perinatal clients are prioritised for treatment in addition to perinatal clients.
- Perinatal champions monitor throughput of perinatal referrals to ensure no unnecessary delays.

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Clinical Offer

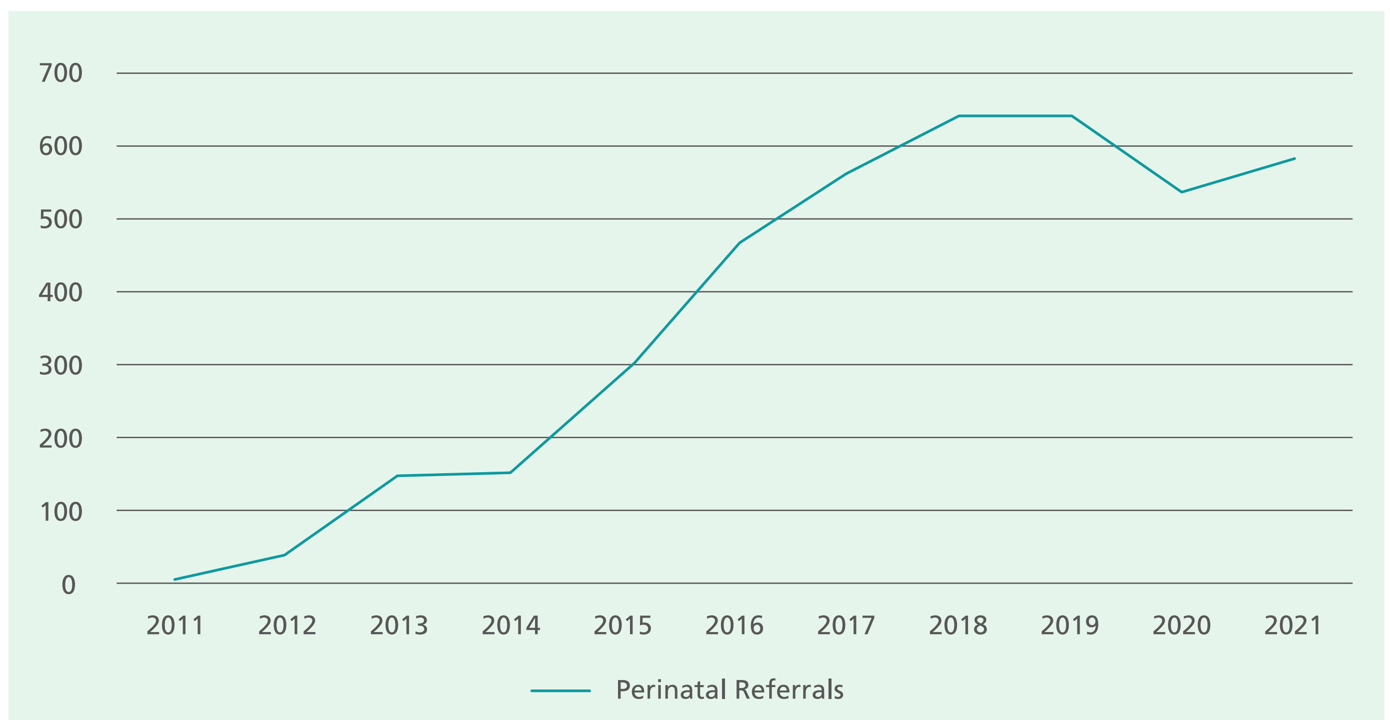
- Perinatal resource sheets provided to clients which include useful Apps and helplines.
  - Antenatal workshops: Abbreviated 1-hour psychoeducational, low-intensity intervention; offered monthly to pregnant women/birthing individuals and their partners. Can be adjunct to those on wait list. Held at maternity unit. Self-referral and professional referrals accepted. Content: Provide information about local statutory and non-statutory resources.
  - Strategies to manage anxiety.
  - Preparing for postnatal period.
- Step 2 perinatal group jointly facilitated by a PWP and perinatal midwife. Later versions were facilitated by PWPs and CBT therapists.
- Step 3 'Well-being for Mums group': CBT, 9 session group co-facilitated by PWP and Step 3 Perinatal champions.

Implications of the Perinatal Competency Framework

- Hounslow NHS Talking Therapies Perinatal team to develop measure to assess competencies against Framework in order to determine learning needs particularly for new perinatal champions. This will then be rolled out to the team.
- The service team have developed an Action plan to focus on improvements to operational and clinical processes.

HOUNSLOW REFERRAL RATES

The graph below shows the increase in perinatal referrals from 2014 onwards, the point at which perinatal champions started to attend multidisciplinary meetings.



CASE EXAMPLE: IMPROVING ACCESS FOR CULTURALLY DIVERSE/UNDERSERVED POPULATIONS I

TALKING THERAPIES SOUTHWARK

At Talking Therapies Southwark, we are currently engaged in a number initiatives which facilitate closer working with the perinatal populations from diverse groups. We have been running a wellbeing group within an active church community in Bermondsey for over 6 years. The group is mainly made up of women who are from diverse communities who have a range of social and mental health needs. The church is actively engaged in a number of social action projects (e.g., Homelessness shelter, social housing provision, food bank). Our aim is to provide psycho-education and treatment to women, who would not usually access mental health services, by de-stigmatising mental health difficulties, providing a referral pathway to access further psychological support and reducing mistrust of mental health services.

We have managed to successfully provide this service, by:

- taking the service to an existing group;
- respecting and working with the existing group dynamics;
- modifying our referral forms and materials based on feedback from the group members;
- delivering evidence-based interventions to target areas they identified as needing help for;
- improving communication and access to the service based on feedback (texting or emailing appointments, flexible appointments, online or face-to-face, allowing children to accompany mothers in sessions); and
- incorporating/re-framing the main aim of the support as health promotion and wellbeing, rather than in relation to mental illness.

This model has also been used with another parenting group who are based in the south of Southwark, who after hearing of this method of partnership working, requested that we develop a similar group with them. We also developed a partnership with a young father's organisation and created a specific pathway to support young fathers to engage with us, by initially educating the keyworker about the step 2 resources we use and then closely working with them to support /coach the client at each stage of treatment pathway. We also review material to ensure the provision of tailored treatment interventions at step 2 to support their experience as fathers.

CASE EXAMPLE: IMPROVING ACCESS FOR CULTURALLY DIVERSE/UNDERSERVED POPULATIONS II

GREENWICH NHS TALKING THERAPIES SERVICE: MILITARY FAMILIES

Greenwich is located near a large military base. To improve access for perinatal parents from military families, we have taken several steps. These include: having two NHS Talking Therapies staff based at a local Children's centre 1-2 sessions/week. A crèche is available for parents. We also offer public "mental health" workshops for parents at the children's centre, and this has proven effective in increasing referrals.

We also have an in-reach service at Woolwich Barracks. We see service users at a centre at the Barracks, pick up referrals and have informal chats or formal treatment contact with mothers and fathers. During the informal chat period, centre welfare staff can also ask NHS Talking Therapies staff to see someone on the day, or a parent can request a 1-1 and there is a room available for these meetings. These meetings often result in formal referrals, or referrals to other appropriate services. The in-reach mornings normalise mental health presence at the Barracks and build trust with the community.

CASE EXAMPLE: IMPROVING ACCESS FOR CULTURALLY DIVERSE/UNDERSERVED POPULATIONS III

EAST SUSSEX NHS TALKING THERAPIES SERVICE: LBGTQI INCLUSION

Promoting engagement for all

- All resources regarding the support offered use inclusive language: "birthing mother," "birthing partner" or "partner".
- Partners are prioritised for treatment within the service as well as birthing Mother.
- Training has been offered by perinatal mental health teams on engaging and working with partners and birthing mother.
- Clinicians may link clients into local community services that offer specific groups for LGBTQIA parents (e.g., Services - Bourne this Way (bournethiswaylgbtparents.co.uk)

Promoting access

- Leaflets have been distributed to labour wards, highlighting inclusivity of birthing partner as well as birthing mother. LGBTQI also included in leaflet.
- NHS Talking Therapies Website has a specific perinatal page for clients.

Integration

- Health in Mind meet with the perinatal mental health team, mental health midwives and health workers quarterly to ensure integration across services.
- Attendance at South East perinatal meetings to ensure new developments are shared and disseminated.
- Perinatal champions are in role across the service offering advice and support to colleagues.

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