Wolverhampton Joint Strategic Needs Assessment

Perinatal Mental Health Rapid Needs Assessment

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1. Scope

The purpose of this rapid needs assessment is to provide an evidence-based, data-informed overview of the mental health needs of women in Wolverhampton during the perinatal period, identify their potentially modifiable risk factors, and map the health services currently available to respond to that need. This report aims to provide information to public health professionals, commissioners, and providers to help shape future interventions and improve current services in line with the needs of the local population.

2. Executive Summary

2.1 Background

Perinatal mental health problems are those that occur during pregnancy (pre-/antenatal period) or the first year following the birth of a child (postnatal or postpartum period).[1] They affect between 10 and 20% of women[2] and include, among others, perinatal depression, perinatal anxiety, postnatal PTSD and OCD, and postpartum psychosis.

Multiple social, psychological, biological, and obstetric risk factors can predispose women for perinatal mental illness. These include domestic abuse, lack of social or partner support, adverse life events and high stress, migration status, previous mental illness, unplanned or unwanted pregnancy, and pregnancy complications.

Perinatal mental illness is a source of additional distress for women, their partners, and their families during pregnancy, childbirth, and new motherhood. Left untreated, it can lead to negative health outcomes, both for mothers (e.g., maternal suicide) and their children (e.g., difficulties in emotional regulation, behavioural problems, insecure attachment, mental illness, poor cognitive development). Moreover, perinatal depression, anxiety, and psychosis alone represent a total long-term cost to society of almost £10,000 per birth, mostly relating to adverse impact on the child, rather than the mother.

2.2 Local Population

Given the lack of systematically collected and/or readily available data on perinatal mental health, it was impossible to understand the true burden of perinatal mental illness in Wolverhampton. As a proxy, the estimated number of expected cases was calculated from literature prevalences based on the 3,205 maternities in Wolverhampton in 2020 (table 1).

	Approximate number of cases per year
Perinatal depression	300
Perinatal anxiety	300-700
Postnatal PTSD	130
Postnatal OCD	80
Postpartum psychosis	3-6

***Table 1** - Estimated number of yearly cases of perinatal maternal illness in Wolverhampton*

However, given the relative high prevalence of most risk factors for perinatal mental illness in Wolverhampton, this is likely to represent a gross underestimation of the actual number of cases.

2.3 Health Services & Community Assets

In the absence of data, a service mapping exercise was conducted to explore the local availability of health services that support mothers and their families with perinatal mental health problems. Universal services, such as general practice, maternity services, and health visiting, mainly support women with mild-to-moderate mental illness. Specialist teams, such as the specialist midwives for vulnerable women, the specialist community perinatal mental health team, and mother-and-baby (inpatient) units, provide care to women with severe or complex mental illness.

Even though community consultation fell outside the scope of this report, a few community assets such as the Council's Strengthening Families Hub were identified.

2.4 Prevention

The Council's upcoming Public Mental Health Strategy presents an excellent opportunity to address the high burden of risk factors for perinatal mental illness in Wolverhampton. A focus on universality should seek to improve the overall (physical and mental) health of mothers, partners, and families throughout the perinatal period. The Start for Life and Healthy Pregnancy programmes could help expand the provision and improve the uptake of universal services, whilst a whole systems approach should be used to address the building blocks of good (mental) health (e.g., housing, employment, education). A focus on equity should drive targeted interventions for high-risk populations in order to reduce inequalities in health outcomes.

2.5 Recommendations

1. Consider **improving the collection of, and access to, data** on perinatal mental health across local services
2. Consider **evaluating specialist services** providing care to women with severe or complex perinatal mental illness
3. Consider **reviewing the support provided to women with mild-to-moderate mental illness**
4. Consider **reviewing the support provided by universal services in promoting healthy pregnancies**
5. Consider **reviewing the training provided to the universal services' workforce on perinatal mental health**
6. Consider **consulting local women with perinatal mental illness**, their partners, their families, and communities
7. Consider **reviewing the existing community assets** that support families during the perinatal period
8. Consider using funding provided for Family Hubs to **expand the provision of universal and specialist services in community settings**
9. Consider **including perinatal mental health in the Council's upcoming Public Mental Health Strategy**

3. Background

3.1 Introduction

Perinatal mental health problems are those that occur *during pregnancy or the first year following the birth of a child*.[1] They affect between 10 and 20% of women.[2]

Pregnancy, childbirth, and new motherhood are periods of expected happiness but also emotional upheaval, requiring adjustments to lifestyle and relationships. Mental illness at this time can lead to additional distress for women, their partners, and their families. It can be seriously disruptive to the adjustment to motherhood, attachment to the newborn, and the care provided to them.[3] Left untreated, perinatal mental illness can lead to adverse impacts on infants' cognitive, emotional, social, educational, behavioural, and physical development.[4]

Most mental health problems during the perinatal period have a similar nature, course, and potential for relapse as at other times. However, their management differs due to the nature of this life stage and the potential impact of both mental illness and its treatments (e.g. psychotropic medication) on the women and the baby.[5]

Perinatal mental health problems can occur during pregnancy (**pre-/antenatal period**) and/or in the first year after childbirth (**postnatal or postpartum period**) and include:

- Depressive disorders – including (clinical) depression, seasonal affective disorder, and dysthymia
- Anxiety disorders – including generalised anxiety disorder (GAD), post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), panic disorder, and tokophobia
- Severe mental illness - including bipolar disorder, postpartum psychosis, and schizophrenia
- Eating disorders – including anorexia and bulimia nervosa
- Personality disorders

Some conditions can precede pregnancy and require continued treatment and close motoring throughout the perinatal period (e.g. depression, bipolar disorder). Others, such as psychotic disorders, can arise, relapse, or exacerbate during pregnancy and the postnatal period.[5]

Due to the lack of literature and data on eating disorders, personality disorders, and substance use disorders during the perinatal period, these were not included in this report.

3.2 Depressive and anxiety disorders

3.2.1 Depression and anxiety

Depression is relatively common both during pregnancy (antenatal depression) and in the postnatal period (postnatal depression), affecting almost 1 in 10 women (9.2% and 9.5%, respectively).[6] About one-third of women with postnatal depression develop symptoms during pregnancy, which continue after birth.[7] Postnatal depression differs from baby blues,

which is a transient, self-resolving period of emotional lability caused by sudden hormonal changes following childbirth. Baby blues affects between 1 in 2 and 1 in 3 women.[8]

Anxiety symptoms are very common both in the pre- and postnatal periods, experienced by 22.9% and 15% of women, respectively. Anxiety disorders are present in around 1 in 6-7 pregnant women (15.2%) and 1 in 10 women (9.9%) in the postpartum period.[9]

Few studies have explored individual risk factors for perinatal anxiety or its links with obstetric, maternal, and child outcomes. This is partially attributable to the significant overlap between perinatal anxiety and depression, co-existing in almost 1 in 10 women (9.3%) in the antenatal period. In the postnatal period, co-morbid anxiety and depression drop to less than 1 in 20 women (4.2%).[10] Risk factors for antenatal depression and/or anxiety and postnatal depression are summarised in figures 1 and 2.

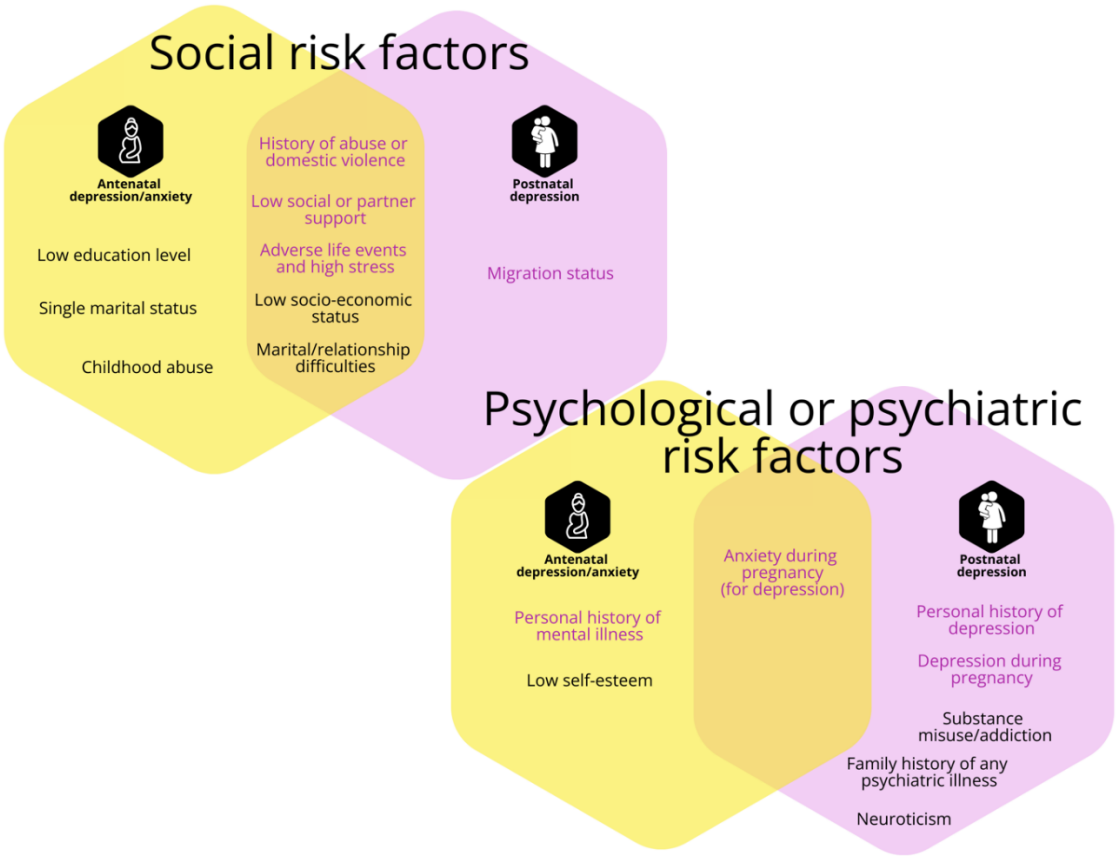


Figure 1 *- Social and psychological or psychiatric risk factors for antenatal depression and/or anxiety and postnatal depression, strongest risk factors highlighted in puple*[4,11]

Perinatal depression and anxiety can have negative consequences for both the woman and her child. Antenatal depression is associated with an increased risk of preterm delivery and is a major risk factor for developing postnatal depression. Perinatal depression has been linked to adverse childhood outcomes, such as difficulties in emotional regulation, behavioural problems, insecure attachment, mental illness (e.g., depression and anxiety, attention deficit and hyperactivity disorder), and, in some studies, poor cognitive development. It can also increase the risk of developing depression in adolescence. Severe perinatal depression, especially if untreated, can also lead to suicide, which is a major cause of maternal mortality.[12,13]

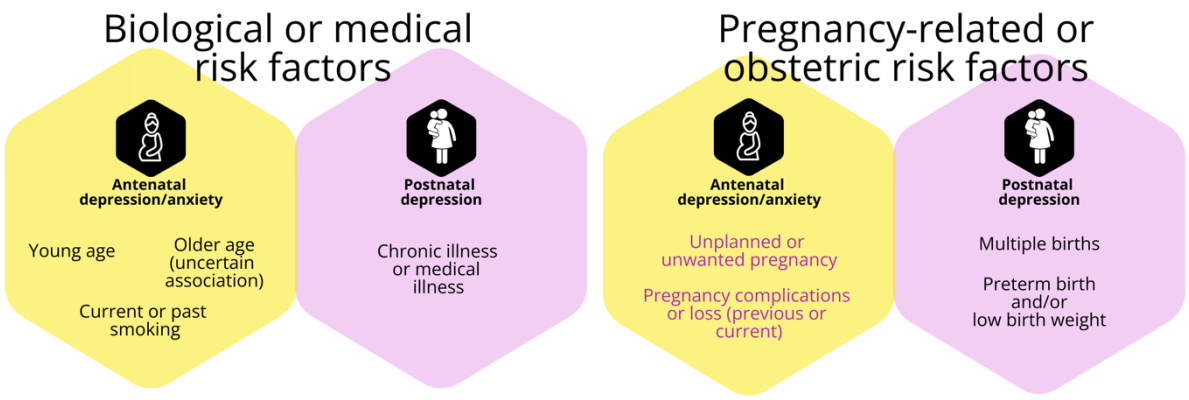


Figure 2 *– Biological or medical and pregnancy-related or obstetric risk factors for antenatal depression and/or anxiety and postnatal depression, strongest risk factors highlighted in puple*[4,11]

3.2.2 Post-Traumatic Stress Disorder (PTSD)

Perinatal PTSD is a type of anxiety disorder which arises in relation to a traumatic event (recent or not). PTSD affects around 1 in 20 women (4.6% antenatally, 5.4% postnatally) but has a much higher prevalence in women at high risk (e.g. previous traumatic birth, emergency caesarean sections or pregnancy complications; severe fear of birth; history of sexual or physical violence or childhood abuse; babies born with very low birth weight, preterm, or diagnosed with foetal anomalies), with almost 1 in 5 (19% prenatally and 18.5% antenatally) at risk of developing PTSD.[14]

Events and experiences surrounding labour and birth such as experienced distress in labour, obstetrical emergencies, and infant complications represent the major risk factors for developing postnatal PTSD (also known as 'birth trauma'). Other risk factors include anxiety and depression during pregnancy, previous psychological trauma or sexual abuse, low support during childbirth, previous mental health difficulties, and poor coping skills.[15]

The consequences of having perinatal PTSD are poorly understood, but there is an association with increased difficulties in children's emotional regulation.[12]

3.2.3 Obsessive-Compulsive Disorder (OCD)

OCD is another type of anxiety disorder, affecting 2-3 in 100 women during the perinatal period (2.1% during pregnancy and 2.4% up to the first year after childbirth).[16] Both pregnancy and birth can act as a trigger for postnatal OCD, and women who previously had perinatal OCD are at higher risk of developing it again.[17]

3.3 Severe Mental Illness

Severe mental illness is a term used to describe people with "psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired".[18] Severe mental illness includes severe and incapacitating depression, psychotic disorders, such as schizophrenia and postpartum psychosis, and bipolar disorder. Severe perinatal mental illness can occur as a continuation of a chronic condition into the perinatal period (e.g., schizophrenia), or as a new onset during pregnancy or shortly after birth (e.g., postpartum psychosis).

3.3.1 Postpartum Psychosis

Postpartum psychosis refers to the sudden onset of psychotic symptoms after childbirth, usually associated with affective (mood) symptoms. It typically presents within days of delivery with rapid deterioration in clinical condition. Postpartum psychosis affects between 1 and 2 in 1,000 women, which is substantially higher than the expected rate of psychosis in non-puerperal women of the same age.[8,19,20]

A previous history of bipolar disorder is the strongest risk factor for developing postpartum psychosis, occurring in at least 1 in 5 women with a bipolar diagnosis. However, about half of women who develop postpartum psychosis have no previous 'high-risk' psychiatric history. Other risk factors include family history of postpartum psychosis, being a first-time mother, and genetic predisposition.[20]

3.3.2 Schizophrenia

Schizophrenia during pregnancy is associated with an increased risk of low birthweight, premature delivery, stillbirth, and infant death. This risk may be only partially attributable to mental illness, with environmental factors associated with adversity (smoking, poverty, poor nutrition, substance use) likely to be partially responsible.[12]

3.4 Partners' Mental Health

There has recently been an increased focus on the mental health of partners and other family members. Where literature refers to paternal mental health, this has been changed to partners' mental health to reflect the diversity of relationships shaping parenthood.

Partners' anxiety has been estimated to affect between 1 in 20 (5.3%) – for clinical diagnosis – and 1 in 8 partners (12.3%) – for self-reported symptoms – whilst depression is likely to affect between 1 in 12 and 1 in 14 partners (7.3-8.4%).[21,22]

Risk factors for partners' depression during the perinatal period include partners' age, level of education, previous mental health history, and exposure to maternal depression. As with maternal depression, partners' depression has been associated with emotional and behavioural difficulties in children, including the development of mental health problems.[22] Few studies have explored the risk factors and potential outcomes of partners' anxiety.

3.5 Costs of Perinatal Mental Illness

According to a 2014 report, perinatal depression, anxiety, and psychosis alone represent a total long-term cost to society of about £8.1bn for each one-year cohort of births in the UK (just under £10,000 for every birth in the country), with nearly three-quarters relating to adverse impact on the child, rather than the mother. Of this cost, about 1.7bn (or £2,100 per birth) falls on the public sector.[2]

4. Local Population

4.1 Demographics

According to the latest Census (2021), Wolverhampton has a population of 263,700, of which almost 1 in 5 (52,400, 19.9%) are women of childbearing age.[23] In 2020, there were 4,606 conceptions in Wolverhampton, resulting in 3,205 maternities and 3,232 births. This means that almost 1 in 3 women decided to have an abortion. Conception, maternity, and fertility rates were higher than the West Midlands region and England averages (table 2).[24,25]

		Wolverhampton	West Midlands (region)	England
Conceptions	Number	4,606	85,850	780,013
	Conception rate (per 1,000 women of childbearing age)	**92.4**	77.1	73.7
	Percentage leading to abortion	**31%**	27%	25%
Maternities	Number	3,205	63,105	578,999
	Maternity rate (per 1,000 women of childbearing age)	**64.3**	56.7	54.7
Live births	Number	3,232	63,748	585,195
	Total fertility rate	**1.86**	1.65	1.59

Table 2 *- Number and rates of conceptions, maternities, abortions, and births in Wolverhampton, West Midlands region, and England in 2020* [24,25]

4.2 Perinatal Mental Health

There is a lack of systematically collected and/or readily available data on local, regional, or national prevalences of perinatal mental health problems. Therefore, the estimated number of cases presented in tables 3 and 4 were calculated from literature prevalences (from high-income countries whenever possible), based on the 3,205 maternities in Wolverhampton in 2020.

However, given the high prevalence of most risk factors for perinatal mental illness in Wolverhampton (see below), this is likely to represent a gross underestimation of the actual number of cases.

	Prevalence from literature (%)	Wolverhampton (estimated number of cases)
Partners' Mental Health[a]		
Perinatal anxiety		
Anxiety		
- Self-reported symptoms[21]	12.3%	394
- Clinical diagnosis[21]	5.3%	170
Perinatal depression		
Depression (self-reported symptoms or clinical diagnosis)[21,22]	7.3%	234
	8.4%	269

Table 3 *- Estimated number of cases of partners' perinatal mental illness in Wolverhampton based on the 3,205 maternities in 2020; [a] An assumption has been made that a partner can have perinatal mental health problems regardless of their relationship status with the mother, which is likely to result in an overestimate.*

	Prevalence from literature (%)	Wolverhampton (estimated number of cases)
Depression		
Antenatal		
Antenatal depression (self-reported symptoms or clinical diagnosis)[6]	9.2%	295
Postnatal[a]		
Postnatal depression (self-reported symptoms or clinical diagnosis)[6]	9.5%	304
Anxiety		
Antenatal		
Anxiety symptoms[9]	22.9%	734
Antenatal anxiety (clinical diagnosis):		
- Any anxiety disorder[9]	15.2%	487
- Generalised anxiety disorder[9]	4.1%	131
- PTSD[14]	3.3%	106
- OCD[16]	2.1%	67
Postnatal[a]		
Anxiety symptoms (first 24 weeks PP)[9]	15.0%	481
Postnatal anxiety (clinical diagnosis):		
- Any anxiety disorder (first 24 weeks PP)[9]	9.9%	317
- Generalised anxiety disorder (first 24 weeks PP)[9]	5.7%	183
- PTSD[b] (first year PP)[14]	4.0%	128
- OCD (up to first year PP)[16]	2.4%	77
Anxiety and Depression		
Antenatal		
Anxiety symptoms and:		
- Mild to severe depressive symptoms[10]	9.5%	304
- Moderate to severe depressive symptoms[10]	6.3%	202
Antenatal depression (clinical diagnosis) and:		
- Any anxiety disorder[10]	9.3%	298
- Generalised anxiety disorder[10]	1.7%	54
Postnatal[a]		
Anxiety symptoms and:		
- Mild to severe depressive symptoms (first 24 weeks PP)[10]	8.2%	263
- Moderate/severe depressive symptoms (first 24 weeks PP)[10]	5.7%	183
Postnatal depression (clinical diagnosis) and:		
- Any anxiety disorder (first 24 weeks PP)[10]	4.2%	135
Severe Mental Illness		
Postpartum psychosis[19]	0.1-0.2%	3-6

Table 4 *– Estimated number of cases of perinatal maternal mental illness in Wolverhampton based on the 3,205 maternities in 2020 (PP = postpartum); [a] The postnatal period the prevalence data is based on is stated where known; [b] PTSD was measured in relation to the birth experience in most studies*

A more detailed version of these tables, including confidence intervals and the number of studies used to base the prevalence estimates, is available on the appendix (page 28).

4.3 Risk Factors

As previously described, there are multiple risk factors for developing perinatal mental health problems. The indicators presented in tables 4 to 7 were chosen as proxies for some of these risk factors. Their local, regional, and national prevalence is given when known.

4.3.1 Social Risk Factors

Social risk factors represent the impact of the building blocks (also known as wider determinants) of health on the mother's mental health, namely the conditions in which they are born, grow, live, work, and age.[26]

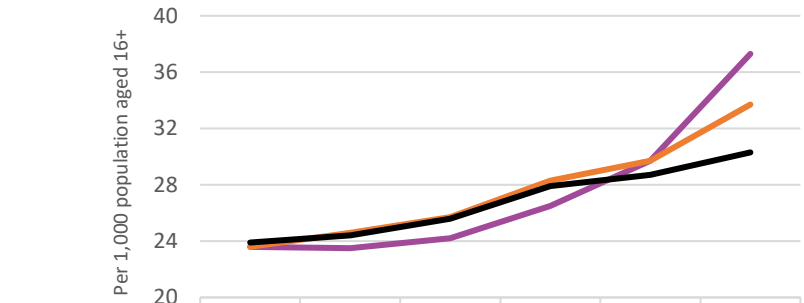
Figure 3 *- The wider determinants of health (adapted from Dahlgren and Whitehead, 1993)* [27]

Most social risk factors for perinatal mental illness have higher prevalences in Wolverhampton when compared with regional and national averages, as seen in table 5.

Indicator		Wolves	WM	England	Proxy for	Risk factor for
Domestic abuse-related incidents and crimes (2020/21)[28]	Count	N/A	160,650	1,375,709	History of abuse or domestic violence	Antenatal depression/anxiety Postnatal depression
	Rate per 1,000 population aged 16+	**37.3**[a]	33.7	30.3		
Live births outside marriage or civil partnership (2020)[25]	Count	1,793	32,778	283,180	Low partner support Marital/relationship difficulties Single marital status	Antenatal depression/anxiety Postnatal depression Postpartum PTSD[b]
	Percentage of live births	**55.5%**	51.4%	48.4%		
Live births sole registration (2020)[25]	Count	272	3,777	30,196		
	Percentage of live births	**8.4%**	5.9%	5.2%		
Live births to non-UK-born mothers (2021)[29]	Count	1,243	17,666	176,123	Migration status	Postnatal depression
	Percentage of live births	**38.3%**	27.7%	29.6%		
Statutory homelessness (2017/18)[30,31]	Count	454	8,020	56,600	Adverse life events and high stress Low social support Low socioeconomic status	Antenatal depression/anxiety Postnatal depression
	Rate per 1,000 households	**4.3**	3.3	2.4		
Index of Multiple Deprivation (2019)[32]		**32.1**	25.3	21.7	Low socioeconomic status	
Children in need due to family in acute stress, family dysfunction, or absent parenting (2021)[33]	Count	750	12,030	103,030	Adverse life events and high stress Low social and partner support	
	Rate per 10,000 population under 18	**119.0**	92.1	85.2		
Children in child protection plans (2021)[33]	Count	571	13,240	113,900	Childhood abuse	Antenatal depression/anxiety
	Rate per 10,000 children aged <18	**90.6**	101.3	94.2		

Table 5 *- Local, regional, and national prevalence of social risk factors for perinatal mental illness, strongest risk factors highlighted in purple, significant outliers highlighted in red (Wolves = Wolverhampton, WM = West Midland region); [a] local authorities are allocated the crude rate of the Police Force Area (PFA) within which they sit (West Midlands PFA for Wolverhampton); [b] low partner support during childbirth only*

The number of police reports of **domestic abuse**, one of the highest risk factors for both antenatal and postnatal depression, has been steadily rising over the last 5 years, both locally and nationally (figure 4). Whilst this may reflect an increased awareness of the problem, it is likely to have been exacerbated in 2020 by the coronavirus pandemic and/or the restrictions put in place to mitigate its spread.[34]



	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Wolverhampton	23.6	23.5	24.2	26.5	29.7	37.3
West Midlands	23.6	24.6	25.7	28.3	29.7	33.7
England	23.9	24.4	25.6	27.9	28.7	30.3

Figure 4 *– Reported domestic abuse-related incidents and crimes in Wolverhampton (West Midlands PFA) and England, 2015/16 to 2020/21 (rate per 1,000 population aged 16+)* [28,31]

In the last 2 years alone, the number of reported cases to the West Midlands Police Force Area (PFA) – which covers Wolverhampton – jumped from 26.7 to 37.3 per 1,000 population. If this increase translates to an actual rise in domestic violence (as opposed to better reporting), it is likely to increase the local prevalence of perinatal mental illness in the upcoming years.

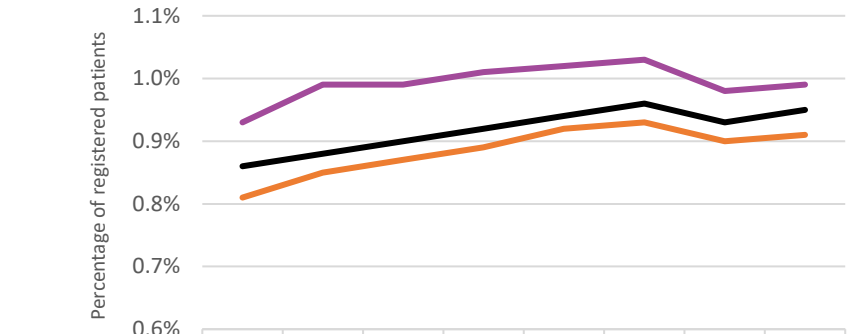
4.3.2 Psychological or Psychiatric Risk Factors

Psychological or psychiatric risk factors relate to women's personality traits, resilience, and mental health history (table 6). Other risk factors not explored below – due to lack of data - include low self-esteem (for antenatal depression/anxiety), poor coping skills (for postnatal PTSD), antenatal anxiety (for ante-/postnatal depression and postnatal PTSD), antenatal depression (for postnatal depression and PTSD), and family history of postpartum psychosis (for postpartum psychosis).

Indicator		Wolves	WM	England	Proxy for	Risk factor for
Depression, ages 18+ (2020/21)[35]	Count	28,018	648,107	5,955,865	Personal history of mental illness	Antenatal depression/anxiety Postnatal depression Postpartum psychosis (bipolar disorder only)
	Percentage of registered patients aged 18+	**12.5%**	13.0%	12.3%		
Severe mental illness, all ages (2020/21)[35]	Count	2,889	57,893	574,227		
	Percentage of registered patients	**0.99%**	0.91%	0.95%		
Hospital admission due to substance misuse, ages 15-24 (2018/19 to 2020/21)[36]	Count	90	1,470	16,053	Substance use/addiction	Postnatal depression
	Rate per 100,000 population aged 15-24	**101.2**	66.9	81.2		
Deaths from drug misuse, female (2019/21)[37]	Count	11	234	2,338		
	Age-standardised rate per 100,00 population	**2.9**	2.8	2.8		

Table 6 *- Local, regional, and national prevalence of psychological or psychiatric risk factors for perinatal mental illness strongest risk factors highlighted in purple, significant outliers highlighted in red (Wolves = Wolverhampton, WM = West Midland region)*

Despite having higher-than-average prevalences of **severe mental illness** ('Mental Health' on the Quality Outcomes Framework, QOF), Wolverhampton has kept a steady number of cases over the last 7 years (figure 5). These prevalences are similar to those expected for postpartum psychosis (see 'prevalences' below), for which severe mental illness – and especially bipolar disorder - are a major risk factor.



	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Wolverhampton	0.93%	0.99%	0.99%	1.01%	1.02%	1.03%	0.98%	0.99%
West Midlands	0.81%	0.85%	0.87%	0.89%	0.92%	0.93%	0.90%	0.91%
England	0.86%	0.88%	0.90%	0.92%	0.94%	0.96%	0.93%	0.95%

Figure 5 *– Prevalence of severe mental illness in Wolverhampton, West Midlands region, and England, 2013/14 to 2020/21*[31,35]

4.3.3 Biological or Medical Risk Factors

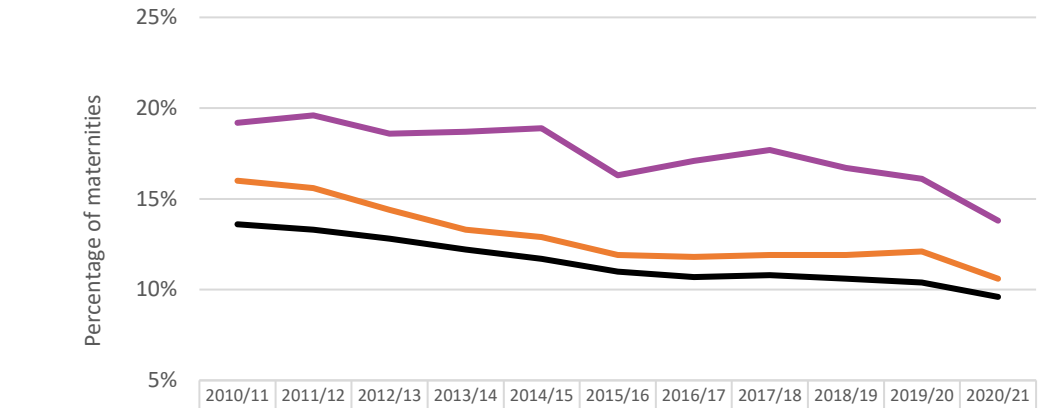
Biological and medical risk factors relate to women's age, constitutional factors, genetics, personal medical history, and individual lifestyle factors (table 7).

Indicator		Wolves	WM	England	Proxy for	Risk factor for
Births to mothers aged <20 (2020)[38]	Count	121	2,005	14,917	First-time mother	Postpartum psychosis
	Percentage of live births	**3.7%**	3.1%	2.5%	Young age	Antenatal depression/anxiety
Births to mothers aged 40+ (2020)[38]	Count	148	2,519	28,414	Older age[a]	
	Percentage of live births	**4.6%**	4.0%	4.9%		
Known smokers at time of delivery (Q4 2021/22)[39]	Count	421	6,398	51,840	Current or past smoking	
	Percentage of all maternities with known smoking status	**13.8%**	10.6%	9.6%		
Healthy life expectancy at birth, female (2018/20)[40]	Years	**59.3**	62.6	63.9	Chronic illness or medical illness	Postnatal depression

Table 7 *- Local, regional, and national prevalence of biological or medical risk factors for perinatal mental illness, significant outliers highlighted in red (Wolves = Wolverhampton, WM = West Midland region); [a] uncertain risk factor*

Despite having only marginally higher overall smoking prevalences than the rest of the country, Wolverhampton has historically had very high rates of **smoking at time of delivery** (figure 6). In addition to being a risk factor for antenatal depression, smoking during pregnancy increases the risk of stillbirth, preterm birth, and other obstetric complications (in turn, risk factors for postnatal mental illness), as well as child developmental and health problems.[41]

Nonetheless, rates of smoking in pregnancy in Wolverhampton have seen a sustained decline over the last decade, from 19.2% in 2010/11 to 13.8% in 2020/21.



	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
Wolverhampton	19.2%	19.6%	18.6%	18.7%	18.9%	16.3%	17.1%	17.7%	16.7%	16.1%	13.8%
West Midlands	16.0%	15.6%	14.4%	13.3%	12.9%	11.9%	11.8%	11.9%	11.9%	12.1%	10.6%
England	13.6%	13.3%	12.8%	12.2%	11.7%	11.0%	10.7%	10.8%	10.6%	10.4%	9.6%

Figure 6 *- Percentage of known smokers at time of delivery in Wolverhampton, West Midlands region, and England, 2010/11 to 2020/21* [31,39]

4.3.4 Pregnancy-Related or Obstetric Risk Factors

Pregnancy-related and obstetric factors are summarised in table 8 and relate to women's reproductive intention, previous pregnancy history, and pregnancy/foetal complications.

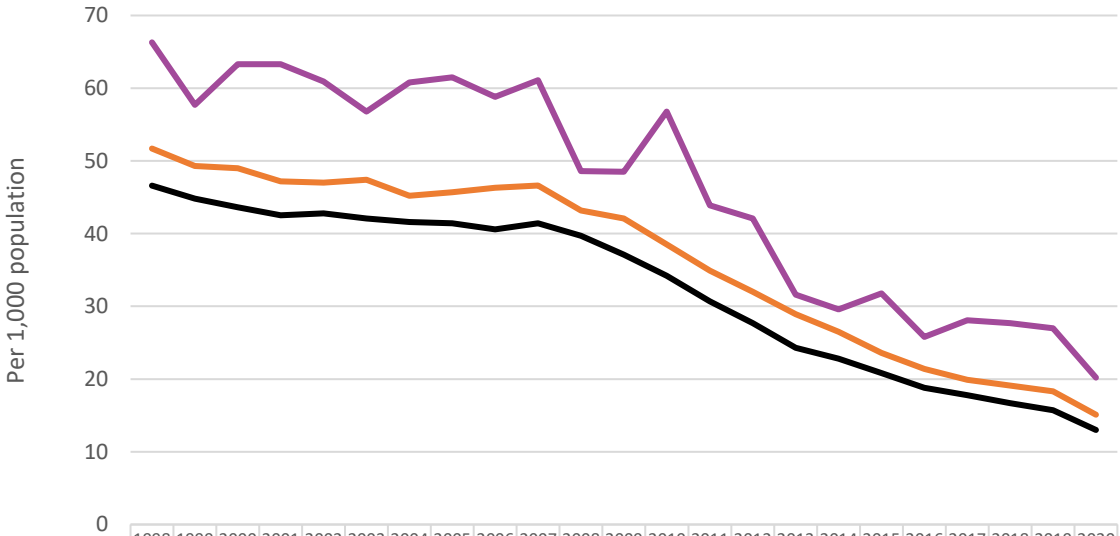
Indicator		Wolves	WM	England	Proxy for	Risk factor for
Conceptions, all ages (2020)[24]	Count	4,606	85,850	780,013	Unplanned or unwanted pregnancy	Antenatal depression/anxiety
	Rate per 1,000 women aged 15-44	**92.4**	77.1	73.7		
	Percentage leading to abortion	**31%**	27%	25%		
Conceptions, ages <18 (2020)[24,31]	Count	90	1,513	11,878		
	Rate per 1,000 women aged 15-44	**20.2**	15.1	13.0		
	Percentage leading to abortion	**46%**	50%	53%		
Conceptions, ages <16 (2020)[24]	Count	19	234	1955		
	Rate per 1,000 women aged 15-44	**3.9**	2.2	2.0		
	Percentage leading to abortion	**53%**	57%	62%		
Multiple births (2022)[25,31]	Count	43	909	8,323	Multiple births	Postnatal depression
	Rate per 1,000 maternities	**13.4**	14.4	14.4		
Premature births (2018/20)[31]	Count	809	17,290	144,544	Preterm birth	
	Rate per 1,000 live births and stillbirths	**82.1**	87.4	79.1		
Live births at term with low birthweight[a] (2020)[25]	Count	106	1,813	15,152	Low birthweight	Postnatal depression Postnatal PTSD
	Percentage of live births at term with known birthweight	**3.6%**	3.1%	2.9%		
Deliveries by caesarean section (2021)[31,36]	Count	995	19,295	173,559	Pregnancy complications	Postnatal PTSD
	Percentage of deliveries	**33.9%**	32.8%	32.5%		
Stillbirths (2018-20)[31,42]	Number	47	860	7,097	Infant complications	
	Stillbirth rate (per 1,000 live births)	**4.8**	4.3	3.9		
Neonatal deaths (2018/20)[31,42]	Number	45	839	5,154		
	Neonatal mortality rate (per 1,000 live births)	**4.6**	4.3	2.8		
Infant deaths (2018/20)[31,42]	Number	62	1,098	7,111		
	Infant mortality rate (per 1,000 live births)	**6.3**	5.6	3.9		

Table 8 *- Local, regional, and national prevalence of pregnancy-related or obstetric risk factors for perinatal mental illness, strongest risk factors highlighted in purple, significant outliers highlighted in red (Wolves = Wolverhampton, WM = West Midland region); [a] birthweight under 2.5kg*

Women in Wolverhampton have a higher rate of conception and abortion than the rest of the region and country. This is likely to result in a higher-than-average number of **unplanned or unwanted pregnancies**, a major risk factor for developing perinatal anxiety and/or depression.

This is even more significant for teenage mothers, for whom around half of pregnancies end in abortion. Even if the pregnancy is terminated, this compounds with the mother's young age to increase the risk of antenatal anxiety and/or depression. Historically, Wolverhampton has had rates of teenage pregnancy well above the national average (figure 7). Rates of conception in under 16s and 18s remain persistently high, with fewer teenage mothers opting to have an abortion compared with the rest of the country.

Nonetheless, over the last 2 decades, rates of teenage pregnancy in Wolverhampton have fallen in line with those of the country at large and continue to trend downwards.



	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Woverhampton	66.3	57.7	63.3	63.3	60.9	56.8	60.8	61.5	58.8	61.1	48.6	48.5	56.8	43.9	42.1	31.6	29.6	31.8	25.8	28.1	27.7	27	20.2
West Midlands	51.7	49.3	49	47.2	47	47.4	45.2	45.7	46.3	46.6	43.2	42.1	38.5	34.9	32	28.9	26.5	23.6	21.4	19.9	19.1	18.3	15.1
England	46.6	44.8	43.6	42.5	42.8	42.1	41.6	41.4	40.6	41.4	39.7	37.1	34.2	30.7	27.7	24.3	22.8	20.8	18.8	17.8	16.7	15.7	13

Figure 7 *– Under 18s conception rate in Wolverhampton, West Midlands region, and England, 1998-2020* [24,31]

5. Health Services

Historically, there has been a lack of integrated physical and mental health care for women during pregnancy and in the weeks and months following birth, and a lack of specialist perinatal mental health services to support women who become unwell.[43]

5.1 National Priorities

In 2016, backed by £365mn in funding, NHS England set out a 5-year plan to increase access to specialist perinatal mental health support through expanding both specialist perinatal community teams and inpatient mother and baby units. This plan, part of the ***NHS Five Year Forward View***, established the objective of supporting an additional 30,000 women per year by 2020/21.[44]

In 2018, the National Collaborating Centre for Mental Health (NCCMH) - a collaboration between the Royal College of Psychiatrists (RCPsych) and the Centre for Outcomes Research and Effectiveness at University College London (UCL) – established evidence-based ***Perinatal Mental Health Care Pathways*** to enable the delivery of the NHS Five Year Forward View's key objectives.[45]

In 2019, the ***NHS Long-Term Plan*** was published. This 10-year plan for the NHS in England incorporated some of the previous targets and set out the following new objectives for perinatal mental health:[46]

- Increase access to care for women with moderate-to-severe perinatal mental health problems, to cover an additional 24,000 women per year by 2023/24;
- Expand perinatal mental health services to cover the entire period from preconception to 24 months after birth (currently up to 12 months), in line with HM Government's priority of improving the first 1,001 critical days of a child's life;
- Expand access to psychological therapies within specialist perinatal mental health services to include parent-infant, couple, co-parenting, and family interventions;
- Offer partners of women attending specialist perinatal mental health services assessments of their mental health and signposting to support as required;
- Increase access to psychological support in maternity settings.

Finally, in 2021 the Department of Health and Social Care (DHSC) published ***The Best Start for Life***, a report setting out a vision for the first 1,001 critical days of a child's life. This document outlines HM Government's intention to improve the support provided to families during the child's early development and create local Family Hubs for them to access Early Years services.[47]

5.2 Benchmark

The 2018 ***Perinatal Mental Health Care Pathways*** established the national benchmark for high-quality, evidence-based care for women with perinatal mental health problems, particularly those with complex mental health problems or severe mental illness.[45]

These are subdivided into 5 separate pathways (figure 8), covering different populations and services:

- Pathway 1: Preconception advice for women with (current or past) complex or severe mental health problems planning a pregnancy
- Pathway 2: Specialist assessment for women with (known or suspected) complex or severe mental health problems
- Pathway 3: Emergency assessment for women with suspected perinatal mental health crises
- Pathway 4: Psychological interventions for women with (known or suspected) perinatal mental health problems
- Pathway 5: Inpatient care (mother and baby units) for women requiring unplanned inpatient care for a perinatal mental health problem

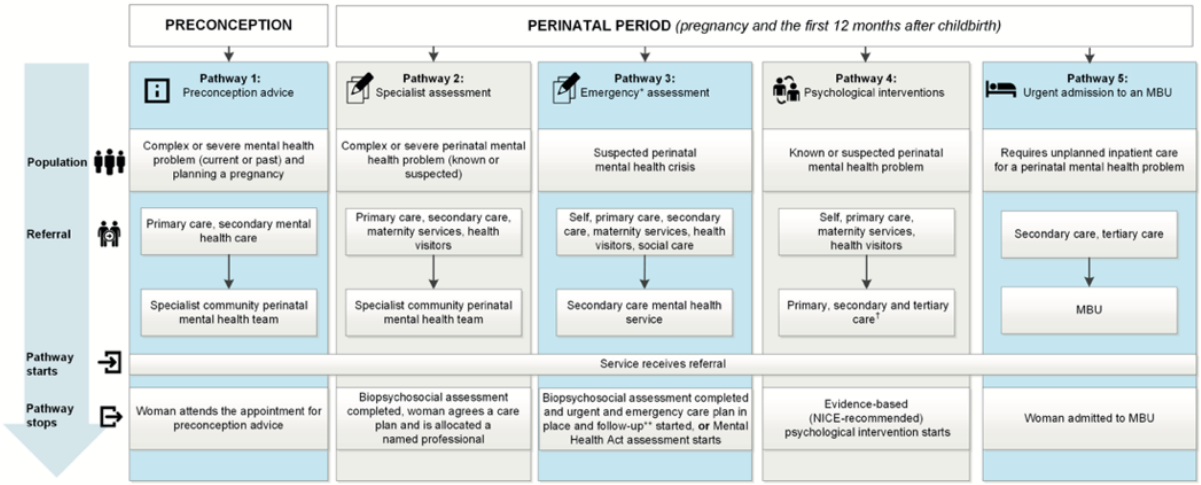


Figure 8 *- NCCMH's perinatal mental health care pathways (2018)* [45]

NCCMH's Full Implementation Guide details the characteristics of each pathway and service involved in their provision, as well as key considerations for commissioning and service delivery.

5.3 Universal Services

Routine antenatal and postnatal appointments are opportunities for health professionals to discuss emotional wellbeing with women and identify potential mental health problems. Maternity, general practice, and health visiting services have frequent contact with the mother, baby, and family during the perinatal period and are well placed to provide support, make an initial assessment, and refer onwards if problems are identified.[43]

Maternity services are responsible for the mother's wellbeing and the baby's safe delivery, overseeing their antenatal care between conception and the first week postpartum (longer if necessary). Afterwards, care is handed over to the health visitors, who are responsible for monitoring the baby's development and supporting parents throughout the entire postnatal period.

According to the perinatal pathways, universal services are responsible for identifying and referring women with complex or severe mental illness during preconception (pathway 1) and the perinatal period (pathway 2). They should also refer women in mental health crises for assessment (pathway 3) and refer or signpost to psychological support accordingly (pathway 4). More generally, they care for, treat, and support women with mild and moderate mental health problems throughout pregnancy, childbirth, and the postnatal period.

5.3.1 General Practice

Primary care is typically the first point of contact for families planning a pregnancy and for pregnant women. Despite no longer having the responsibility for providing routine antenatal care, General Practitioners (GPs) in Wolverhampton are expected to identify, monitor, assess, and treat women with perinatal mental health problems, liaising with, and referring to, mental health services when necessary. They also work in close collaboration with maternity services and health visitors.

More recently, local primary care networks (PCNs) have started employing mental health workers through the Additional Roles Reimbursement Scheme (ARRS). However, given the complex nature of the cases, most women with perinatal mental health problems are still supported by GPs in primary care.

5.3.2 Maternity services

Maternity services provide both universal care to women with low-risk pregnancies – provided by community midwives – and specialist care to women with high-risk pregnancies – provided by obstetricians and specialist midwives. Services in Wolverhampton are commissioned by the Black Country NHS Integrated Care Board (formerly Black Country and West Birmingham CCG) and provided by The Royal Wolverhampton NHS Trust (RWT). Maternity services are based at the New Cross Maternity Unit but many of their midwives are co-located with GPs in primary care facilities to improve care coordination.

5.3.3 Specialist midwives for vulnerable women

The specialist midwifery team for vulnerable women sits within community midwifery services and provides support to both vulnerable women (e.g., women with addictions, victims of domestic violence, women with learning disabilities) and pregnant women with mental health problems. The team was originally established as a specialist service for women with addictions and has seen its remit gradually extend. In 2018, it was commissioned to cover perinatal mental health (during pregnancy and in the immediate postnatal period).

The team currently employs 3 specialist midwives and provides separate referral pathways/caseloads for vulnerable women and perinatal mental health. However, there is no one in post exclusively dedicated to perinatal mental health, with all team members having patients from both caseloads.

Through their perinatal mental health pathway, the team accepts direct referrals from all community and secondary care services in Wolverhampton. Their caseload consists mainly of pregnant women over the age of 16 with severe mental illness or mental illness significantly impacting pregnancy and/or childbirth. The team also provides care for women living in South Staffordshire or registered with a GP there.

This specialist service offers once-weekly face-to-face clinics as well as telephone follow-up. It works in close collaboration, and has a good working relationship with, the specialist perinatal mental health service, attending their weekly multidisciplinary team meetings (MDT) when necessary. They also provide telephone support (e.g., advice, signposting guidance) to community midwives who care for the majority of women with mild-to-moderate perinatal mental health problems.

5.3.4 Health visiting

Health visiting in Wolverhampton is part of the 0-19 services and provides support to the family from birth until the child goes to school. It is commissioned by the City of Wolverhampton Council's public health team and is currently provided by The Royal Wolverhampton NHS Trust.

Every family with a child under 5 is covered by the universal health visiting team. The team offers one antenatal visit to introduce the service and give advice on development, feeding, safety, and parental mental health and takes over the care from the midwives after childbirth. However, parents and professionals can contact the service through the 0-19 service's single point of access (SPA) to raise concerns or ask for advice. The team will also opportunistically identify perinatal mental health problems through other contacts with families (e.g., routine visits, telephone contacts).

Alongside its universal service provision, health visiting has 2 specialist teams:

- Partnering Families Team (PFT), a specialist health visiting team for vulnerable families (e.g., mums whose previous children have been removed) and first-time mums under 25. These families return to the universal health visiting service once the child turns 2.
- High-Intensity Team (HIT), a specialist team created in November 2021 to give additional support to specific populations, including the homeless, Gypsies and Travellers, and asylum seekers, refugees and migrants. The HIT covers the entire 0-19 service and also includes school nurses. The objective is to keep families within this team all the way to adolescence (unless their circumstances change or they move).

In August 2022, a new perinatal mental health specialist health visitor post was created to respond to an increase in demand and lack of specialist expertise within the health visiting team. This role will aim to support the health visiting staff with clinical queries on perinatal mental health, provide perinatal mental health clinical supervision, train and empower the remaining staff to upskill their specialist knowledge, hold a small caseload of more complex perinatal mental health cases (not meeting referral criteria to specialist services), and improve communication and working relationships with the remaining services (especially maternity and specialist perinatal mental health services).

5.4 Mental health services

5.4.1 Improving Access to Psychological Therapies (IAPT)

IAPT services provide primary care level, evidence-based psychological interventions for adults with mild-to-moderate mental health problems, including women and their partners in the perinatal period (in line with pathway 4).

Healthy Minds, the IAPT service in Wolverhampton, is commissioned by the Black Country NHS Integrated Care Board and provided by the Black Country Healthcare NHS Foundation Trust (BCH). It works on a self-referral basis for patients with symptoms of anxiety and depression.

Healthy Minds currently offers a range of interventions based on Cognitive Behavioural Therapy (CBT), including group and individual sessions, and online, video, telephone, and face-to-face appointments.

5.4.2 Secondary Care Mental Health Services

Secondary care mental health services provide different levels of care for women with complex or severe perinatal mental health problems. Their responsibilities include conducting planned or urgent assessments for new presentations (pathway 3), continuing to support women already under their service who become pregnant (under guidance/advice from the specialist perinatal mental health team), and referring to tertiary services (pathways 1, 2, and 5).

In Wolverhampton, these services are commissioned by the Black Country NHS Integrated Care Board and provided by the Black Country Healthcare NHS Foundation Trust (BCH). Some of their teams likely to support women in the perinatal period include:

- Adult Services for women over 18, comprising the Complex Care Service (adult community team) and the Crisis Resolution and Home Treatment Service
- Children and Adolescence Mental Health Services (CAHMS) for women under the age of 18, comprising the Wolverhampton Specialist CAMHS and the CAMHS Crisis Interventional and Home Treatment Team (CIHTT)
- Eating Disorders Service
- Wellbeing Service: provides evidence-based psychological interventions to women with moderate-to-severe mental health problems that are not directly caused by pregnancy or childbirth

GPs refer to secondary care mental health services via the BCH Wolverhampton SPA (a dedicated team of mental health professionals), who triages the referral, does an initial assessment and refers to the most appropriate team.

5.5 Specialist (Tertiary) Services

5.5.1 Specialist Perinatal Mental Health Service

Specialist community perinatal mental health teams provide care and treatment for women with complex or severe mental health problems during preconception, pregnancy, and the first year following childbirth (pathways 1 and 2). They also work in close cooperation with other health services, including mother and baby units (pathway 5).

The specialist perinatal mental health service in Wolverhampton is part of a team that covers the entire Black Country. It is currently commissioned by the Black Country NHS Integrated Care Board and provided by the Black Country Healthcare NHS Foundation Trust (BCH).

The service was set up in 2018 as a pilot perinatal mental health liaison service to respond to a provision gap raised by the NHS Five Year Forward View. With additional funding from NHS England, the service was permanently established in 2019. It is based in Walsall and covers Dudley, Wolverhampton, and more recently Sandwell. Since September 2020, there has been a dedicated consultant perinatal psychiatrist for the population of Wolverhampton.

The Wolverhampton team is multi-disciplinary and currently includes 2 psychiatrists, community psychiatric nurses (CPNs), occupational therapists, psychologists, nursery nurses, and a group of peer supporters. It has 2 referral pathways:

- Mental health professionals (in secondary and tertiary care), health visitors, and specialist midwives refer directly to the service;
- GPs refer via the BCH Wolverhampton SPA.

Its caseload includes women who develop complex or severe mental illness during the perinatal period, women at high risk of developing severe postpartum mental illness (e.g., previous history of postpartum psychosis), and women with personality disorders and other clinical comorbidities requiring specialist input. It also provides support to community mental health teams, sharing patient care according to individual need.

The service currently offers an initial assessment for all new patients; four-weekly clinics (2 at the New Cross Maternity Unit's Antenatal Clinic and 2 virtual, with plans to move all clinics to face-to-face); care coordination; psychological support for moderate-to-severe, pregnancy- or birth-related mental health problems (e.g. tokophobia, traumatic birth); and multiple community groups (e.g., stay and play, walks in the park, baby massage, mindfulness and anxiety management, circle of security). More recently, it has started offering peer-support groups, provided by patients that have previously used the service, which also extends to mothers' partners.

The service works in close collaboration with the obstetrics team at the RWT, which employs an obstetrician with a specialist interest in perinatal mental health. This obstetrician oversees the maternity care of all high-risk pregnant women with perinatal mental health problems, greatly improving care coordination. The service also has good working relationships with the specialist midwives and social workers (for safeguarding issues).

In line with the NHS Long Term Plan and the current focus on children's first 1,001 critical days, the service is looking to extend its service provision to women up to 2 years after childbirth.

5.5.2 Mother and Baby Units (MBUs)

MBUs are specialist inpatient services that provide care for women in the perinatal period with complex or severe mental health problems (pathway 5). They are a tertiary service directly commissioned by NHS England. Women in Wolverhampton requiring inpatient admission are normally referred to the Chamomile Suite at The Barberry, in Birmingham, which is provided by the Birmingham and Solihull Mental Health NHS Foundation Trust.

6. Community Assets

Given the clear association between lack of social support and perinatal mental illness, strong communities play a vital role in preventing the onset of mental health problems in the perinatal period. They also play an active part in supporting women with mental illness from preconception to pregnancy to early motherhood.

As community consultation fell outside the scope of this report, only a few assets were identified.

6.1 Strengthening Families Hubs

There are currently 8 Strengthening Families Hubs[48] in Wolverhampton offering a variety of universal (e.g. antenatal and health visiting clinics), targeted (e.g. domestic violence support), and group (e.g. breastfeeding) support. However, their offer is heterogeneous and focuses mainly on specialist/targeted support.

These hubs are funded by the City of Wolverhampton Council and are located in the following areas:

- Bingley: serving Penn, Merry Hill, and Penn Fields
- Dove: serving Bushbury, Oxley, and Pendeford
- Eastfield: serving East Park, Eastfield, and Portobello
- Graiseley: serving All Saints, Blakenhall, and Spring Vale
- Low Hill: serving Low Hill and The Scotlands
- Rocket Pool: serving Bilston, Bradley, and Ettingshall
- The Children's Village: serving Wednesfield, Ashmore Park, and Heath Town
- Whitmore Reans: serving Tettenhall, Whitmore Reans, and Dunstall

6.2 Aspiring Futures CIC

Aspiring Futures[49] is a women-led social enterprise supporting women in Wolverhampton to improve their confidence, wellbeing, and qualifications. Their services include counselling, mental health workshops, peer support, and a befriending service.

6.3 The Haven Wolverhampton

The Haven[50] is a local charity that supports women and children who are victims of abuse or domestic violence, as well as women at risk of homelessness. Their services include a 24/7 helpline, safe accommodation, support for those living in the local community, advocacy and advice, and counselling and therapy.

7. Prevention

A preventative strategy for improving perinatal mental health in Wolverhampton should seek to address its high burden of risk factors for perinatal mental illness. The Council's upcoming Public Mental Health Strategy presents an excellent opportunity to do just that by focussing on 2 key concepts: universality and equity.

A **universal approach** should focus on improving the overall (physical and mental) health of mothers, partners, and families throughout the perinatal period. One way to achieve this is to expand the provision and improve the uptake of universal services, and the upcoming Start for Life and Healthy Pregnancy programmes can play an important role in facilitating this.

In line with HM Government's first 1,001 critical days agenda, Wolverhampton has been selected as one of the 75 local authorities eligible for funding to support the development of new Family Hubs through the Start for Life programme. This could present an opportunity to expand the existing Strengthening Families Hubs and provide more joined-up care to women, children, and their families during the perinatal period and in the first 2 years of children's lives. This would also align with the Council's plan to invest in Healthy Pregnancies by supporting and promoting behaviour change prior to conception and throughout pregnancy.

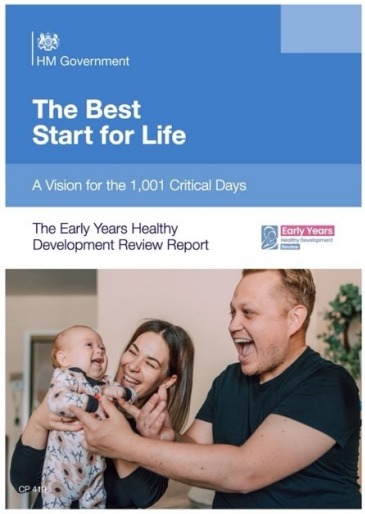


Figure 9 *– DHSC's 'The Best Start for Life' report (2021)*[47]

At the same time, the strategy should address the building blocks of good (mental) health – such as housing, employment, education, and community support – through a whole systems approach.

A **focus on equity** should drive targeted interventions for high-risk populations in order to reduce inequalities in health outcomes. This could build on existing good practices such as the RWT's Maternity Stopping Smoking Support Team addressing smoking in pregnancy, the support provided by The Haven to women escaping domestic violence, and the Council's Housing First model[51] providing rough sleepers with a stable home environment. It should also address the stigma and discrimination associated with mental health and mental illness, which disproportionately affects some communities and populations and prevents them from seeking the care they need.[52]

8. Discussion

Historically, not enough attention has been paid to perinatal mental health and illness. Insufficient data, stigma and discrimination, poor integration between mental and physical healthcare, and a lack of specialist services, all contributed to this issue going largely unaddressed for a long time. However, a growing body of evidence, paired with increasing political interest, investment, and service provision over the last 6 years, has slowly started to change this.

Mental health problems affect up to 1 in 5 women and up to 1 in 8 partners during pregnancy and the first year after childbirth. The absence of data on local prevalences limits a more nuanced and detailed analysis of the problem. Nonetheless, given the high rate of most risk factors, we can expect the burden of perinatal mental illness to be higher in Wolverhampton when compared to the rest of the country. This is likely to result in worse short- and long-term health outcomes for both mothers and their families.

Over the years, health services in Wolverhampton have gradually expanded to improve their specialist care provision. Maternity services extended the remit of their specialist midwifery team, whilst health visiting services recently hired a dedicated mental health specialist health visitor. Specialist mental health services were created to improve the coverage and quality of care provided to women with severe or complex mental health problems. Finally, the proliferation of mother and baby units across the country has led to high-quality inpatient care becoming available within the West Midlands region.

In contrast, the support provided to women with mild-to-moderate perinatal mental illness, as well as their partners and families, has not experienced the same level of attention or investment. Nonetheless, good practice has emerged. GPs routinely ask about mental health at their 6-week maternal postnatal check, whilst health visitors have recently been commissioned to do a routine antenatal visit which covers mental wellbeing. Simultaneously, the expansion of IAPT services allowed for evidence-based psychological interventions to become more easily available.

However, given the lack of data, it is unclear how well these services are faring, if there are difficulties and/or barriers in accessing them, and if the provision is matching the need. A service evaluation, paired with a consultation exercise, could help inform future interventions.

At the same time, despite good communication and working relationship between some services, the fragmented nature of care provision – multiple teams, locations and settings, referral pathways, IT systems – is a pitfall and a potential barrier to access.

Other challenges remain. Workforce shortages, lack of capacity, limited infrastructure, lack of expertise, and insufficient data were some of the issues identified during the production of this report. With staff shortages at over 100,000 FTE across the NHS in England[53] and with capital investment seen as a low priority,[54] these challenges are unlikely to be resolved any time soon.

However, the inclusion of data collection on perinatal mental health in both the NHS Five Year Forward View and the NHS Long Term Plan will hopefully lead to a significant improvement when it comes to understanding local prevalences and services. This data is also likely to become more easily available through the Office for Health Improvement and Disparities' (OHID) Public Health Profiles, which will facilitate future needs assessments (figure 10).

Figure 10 *– OHID's Public Health Profiles on Perinatal Mental Health (screenshot, September 2022)* [31]

At the same time, the upcoming Start for Life and Healthy Pregnancy programmes present opportunities to improve the provision of universal care provided to women and their families and to ensure that women with mild-to-moderate perinatal mental illness are given the support they need.

Given their location within communities, Family Hubs could be used to co-locate universal (e.g., health visitors) and specialist services (e.g., perinatal mental health service, specialist midwives) in order to improve care coordination and collaboration. It would also be important to further explore what community assets exist in Wolverhampton to support women and their families, and how these could be empowered.

Finally, from a public health perspective, it would be important to develop a preventative strategy to address all these issues in a cohesive, joined-up way. The Council's upcoming Public Mental Health Strategy is a great opportunity to do this and should consider both universality, through a whole systems approach, and equity, providing targeted support to reduce health inequalities.

I expect that the findings of this report start an important conversation on how best to improve the perinatal mental health of women and their families in Wolverhampton, to ensure they live longer, healthier lives.

Figure 11 *– City of Wolverhampton Council's Our City: Our Plan (2022)* [55]

9. Recommendations

1. Consider **improving the collection of, and access to, data** on perinatal mental health across local services:
    - To help understand the real prevalence of perinatal mental illness in Wolverhampton
    - To help understand if the services provided match the need
    - To help inform future needs assessments, interventions, and commissioning decisions

2. Consider **evaluating specialist services** providing care to women with severe or complex perinatal mental illness:
    - To help understand if the services provided match the need
    - To help understand the quality of the care provided
    - To help identify potential barriers in service access
    - To help identify areas for improvement

3. Consider **reviewing the support provided to women with mild-to-moderate mental illness:**
    - To help understand if the services provided match the need
    - To help understand the quality of the care provided
    - To help identify potential barriers in service access
    - To help identify areas for improvement

4. Consider **reviewing the support provided by universal services in promoting healthy pregnancies**
    - To help reduce the burden of risk factors for perinatal mental health

5. Consider **reviewing the training provided to the universal services' workforce** on perinatal mental health:
    - To raise the profile of perinatal mental health amongst the workforce
    - To help promote the use of standardised assessments
    - To help deliver evidence-based interventions in a systematic fashion

6. Consider **consulting local women with perinatal mental illness**, their partners, their families, and communities:
    - To help identify potential barriers in service access
    - To help identify gaps in service provision
    - To help understand the degree to which stigma and discrimination affect people with perinatal mental illness, and how this could be addressed

7. Consider **reviewing the existing community assets** that support families during the perinatal period

8. Consider using funding provided for Family Hubs to **expand the provision of universal and specialist services in community settings**

9. Consider **including perinatal mental health in the Council's upcoming Public Mental Health Strategy:**
    - To help address the high burden of risk factors locally
    - To help reduce the stigma and discrimination associated with mental illness

10. Glossary

Overview

- **Anxiety disorder** – Any disorder in which anxiety is a predominant feature.[56]
- **Bipolar disorder** – Affective (mood) disorder characterized usually by alternating episodes of depression and mania.[56]
- **Complex mental health problem** – A function of the interaction between different factors that may vary in nature, intensity, and duration. Factors include: the nature, severity, chronicity, and prognosis of the mental health problem; the degree of cognitive and/or functional impairment of disability; the nature of the interventions being delivered and the setting in which they are provided; and the social and environmental factors that influence access to or delivery of care.[45]
- **Depressive disorder** – Any affective (mood) disorder characterized by prolonged or recurring symptoms of psychological depression without manic episodes.[56]
- **Dysthymia** – A mood disorder characterized by chronic mildly depressed or irritable mood often accompanied by other symptoms (e.g. low self-esteem, fatigue, sleep disturbances).[56]
- **Perinatal mental health problem** – Any mental health problem that occurs during pregnancy and the first 12 months after childbirth.
- **Postpartum psychosis** – The sudden onset of psychotic symptoms after childbirth.[45]
- **Psychosis / psychotic disorder** – Serious mental illness characterized by defective or lost contact with reality, often with hallucinations or delusions.
- **Severe mental illness** – Psychological problems that are often so debilitating that their ability to engage in functional and occupational activities is severely impaired.[18]
- **Tokophobia** – A pathological fear of pregnancy.

Local Population & Risk Factors

- **Abortion** – The legal termination of an unwanted pregnancy under the 1967 Abortion Act.
- **Antenatal** – Refers to the pregnancy period.
- **Conception** – A pregnancy that leads either to a maternity or an abortion.
- **Infant death** – The death of an infant aged under 1 year.
- **Maternity** – A pregnancy resulting in the birth of one or more live or stillborn children.
- **Miscarriage** – A spontaneous abortion.

- **Neonatal death** – The death of an infant aged under 28 days.
- **Postnatal / postpartum** – Refers to the period up to 1 year after childbirth.
- **Stillbirth (antenatal death)** – A baby born after 24 or more weeks' gestation and which did not, at any time, breathe or show signs of life
- **Term pregnancy** – At 37 weeks' gestation or more.
- **Total fertility rate (TFR)** - The average number of live children that a group of women would have if they experienced the age-specific fertility rates for the calendar year in question throughout their childbearing lifespan

Health Services

- **Primary care networks (PCNs)** - Groups of GP Practices working closely together to provide integrated services to the local population.[57]

11. Appendix

This appendix includes a more detailed version of tables 3 and 4 (pages 8 and 9).

	Prevalences from literature			Wolverhampton	
	Percentage	CI 95 (%)	No. studies	Estimate	CI 95%
Depression					
Antenatal					
Antenatal depression (self-reported symptoms or clinical diagnosis)[6]	9.2%	8.4-10.0%	96	295	269-321
Postnatal[a]					
Postnatal depression (self-reported symptoms or clinical diagnosis)[6]	9.5%	8.9-10.1%	96	304	285-324
Anxiety					
Antenatal					
Anxiety symptoms[9]	22.9%	20.5-25.2%	52	734	583-788
Antenatal anxiety (clinical diagnosis):					
- Any anxiety disorder[9]	15.2%	9.0-21.4%	9	487	288-686
- Generalised anxiety disorder[9]	4.1%	1.9-6.2%	10	131	61-199
- PTSD[14]	3.3%	2.4-4.5%	29	106	77-144
- OCD[16]	2.1%	1.3-3.3%	12	67	42-106
Postnatal[a]					
Anxiety symptoms (first 24 weeks PP)[9]	15.0%	13.7-16.4%	39	481	439-526
Postnatal anxiety (clinical diagnosis):					
- Any anxiety disorder (first 24 weeks PP)[9]	9.9%	6.1-13.8%	9	317	196-442
- Generalised anxiety disorder (first 24 weeks PP)[9]	5.7%	2.3-9.2%	6	183	74-295
- PTSD[b] (first year PP)[14]	4.0%	2.8-5.7%	21	128	90-183
- OCD (up to first year PP)[16]	2.4%	1.5-4.0%	7	77	48-128
Anxiety and Depression					
Antenatal					
Anxiety symptoms and:					
- Mild to severe depressive symptoms[10]	9.5%	7.8-11.2%	17	304	250-359
- Moderate to severe depressive symptoms[10]	6.3%	4.8-7.7%	17	202	154-247
Antenatal depression (clinical diagnosis) and:					
- Any anxiety disorder[10]	9.3%	4.0-14.7%	10	298	128-471
- Generalised anxiety disorder[10]	1.7%	0.2-3.1%	3	54	6-99
Postnatal[a]					
Anxiety symptoms and:					
- Mild to severe depressive symptoms (first 24 weeks PP)[10]	8.2%	6.5-9.9%	15	263	208-317
- Moderate/severe depressive symptoms (first 24 weeks PP)[10]	5.7%	4.3-7.1%	13	183	138-228
Postnatal depression (clinical diagnosis) and:					
- Any anxiety disorder (first 24 weeks PP)[10]	4.2%	1.9-6.6%	8	135	61-212
Severe Mental Illness					
Postpartum psychosis[19]	0.1-0.2%	-	-	3-6	-

Table 9 *– Estimated number of cases of perinatal maternal mental illness in Wolverhampton based on the 3,205 maternities in 2020 (PP = postpartum); [a] The postnatal period the prevalence data is based on is stated where known; [b] PTSD was measured in relation to the birth experience in most studies*

	Prevalences from literature			Wolverhampton	
	Percentage	CI 95 (%)	No. studies	Estimate	CI 95%
Partners' Mental Health[a]					
Perinatal anxiety					
Anxiety					
- Self-reported symptoms[21]	12.3%	8.5-17.5%	23	394	272-561
- Clinical diagnosis[21]	5.3%	3.2-8.6%		170	103-276
Perinatal depression					
Depression (self-reported symptoms or clinical diagnosis)[21,22]	7.3%	5.5-9.6%	13	234	176-308
	8.4%	7.2-9.6%	74	269	231-308

Table 10 *- Estimated number of cases of partners' perinatal mental illness in Wolverhampton based on the 3,205 maternities in 2020; [a] An assumption has been made that a partner can have perinatal mental health problems regardless of marital status or of whether they are still in a relationship with the mother, which is likely to result in an overestimate.*

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