Joint Strategic Needs Assessment

Perinatal Mental Health (PMH) and Parent-Infant Relationships (PIR) in Camden

July 2026

Camden

Access Information

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Aims and Objectives

Aim

The Perinatal Mental Health (PMH) and Parent-Infant Relationship (PIR) Joint Strategic Needs Assessment (JSNA) has been carried out with an aim to assess met and unmet need in Camden to achieve good PMH and PIR; through collating data on need, providing trends and projections, pathways for support and identifications of gaps to help inform future strategic and commissioning work.

Objectives

- Outline the **importance of good PMH and PIR**
- Identify **protective** and **risk factors** contributing to worse PMH and PIR
- Outline and overview of national, regional and local policy influencing PMH
- Provide an **overview of existing Camden pathways** for PMH support services for people in the perinatal period
- Estimate the **prevalence** of PMH issues within Camden
- Assess **inequalities** in PMH and PIR and understanding the relationship with wider determinants of health
- Assess the **impact of PMH on service users and in particular vulnerable groups in Camden** especially those from global majority population groups.
- Develop **recommendations in partnership with stakeholders which incorporate service user insight to improve identification and support** for PMH and PIR in Camden.

This JSNA does not evaluate the services performance and does not constitute a clinical audit or an economic evaluation of any kind.

PMH problems are estimated to affect around 1 in 4 women and 1 in 10 men nationally

- PMH problems are defined by the National Institute of Health and Care Excellence (NICE) as those which occur during the perinatal period, which spans pregnancy and up to the first year following birth of a child. Though increasingly definitions and services extend the perinatal period to include the entirety of the second-year post birth as well.
- Estimates from the Office for Health Improvement and Disparities (OHID), based on data from 2019 model national prevalence at 25.8% suggesting **over 1 in 4 women** are affected.
- Previous estimates from NICE state that PMH problems **affect 1 in 5 women** (20%), often arising for the first time during pregnancy, though they may sometimes be an exacerbation of pre-existing or underlying conditions.
- According to NHS England, **up to 27% of new and expectant mothers experience PMH** which includes conditions such as depression, anxiety and postpartum psychosis as well as other conditions.
- The prevalence of **fathers' depression and anxiety** in the perinatal period also carries uncertainty and has been less well quantified but estimates range **from 5–15%. One robust estimate is from a 2016 meta-analysis which identified a prevalence of 8.4% in men for PMH problems.**
- The perinatal period is acknowledged as one of the **riskiest period for development of mental health difficulties** with lasting implications and outcomes for the infant/child.

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Perinatal Mental Health includes a spectrum of severity from anxiety, depression to psychosis

According to ICD-10 :

Table 1: Perinatal Mental Health conditions

PMH conditions are termed as mental disorders complicating pregnancy, covering:	
Anxiety in pregnancy	Psychological disorder during pregnancy
Anxiety in pregnancy antepartum (before childbirth)	Psychological disorder in pregnancy
Depression in pregnancy	Psychological illness, affecting obstetric management
Depressive disorder in mother complicating pregnancy	Psychosis in pregnancy
Emotional and/or mental disease in mother complicating pregnancy, childbirth and/or puerperium	Mental disorder in pregnancy
Major depressive disorder in pregnancy	

The term severe mental illness (SMI) refers to all individuals who have received a diagnosis of schizophrenia or bipolar affective disorder, or who have experienced an episode of non-organic psychosis.

This spectrum of conditions is encompassed by the term 'perinatal mental health,' which will serve as the consistent reference throughout this presentation.

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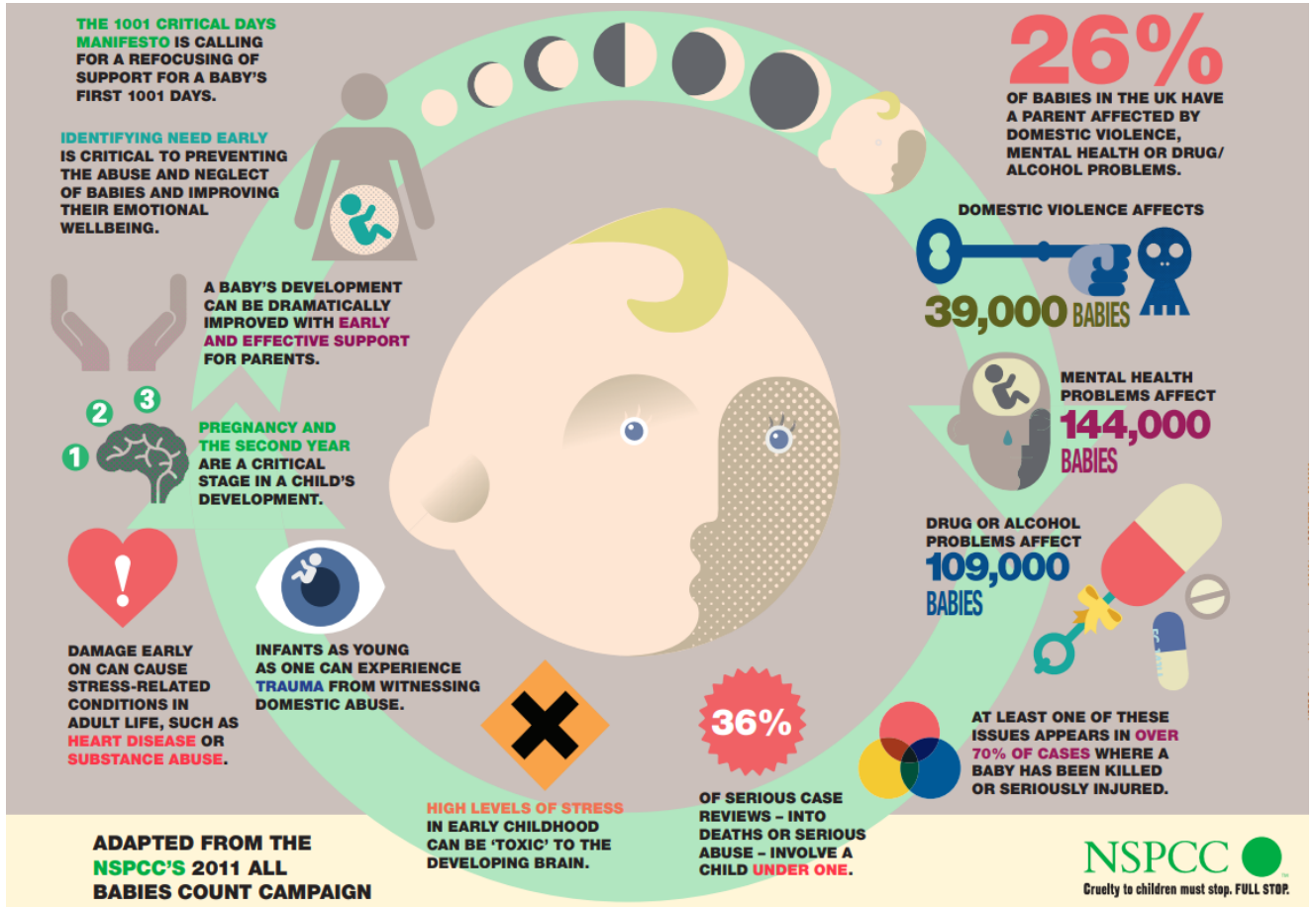
2. NHS England. NHS England» Improving the physical health of people living with severe mental illness [Internet]. www.england.nhs.uk. NHS England; 2024. Available from: https://www.england.nhs.uk/long-read/improving-the-physical-health-of-people-living-with-severe-mental-illness/

PMH is important as the first 1,001 days are critical for child's development and parental attachment

- The 1,001 Critical Days manifesto places emphasis on the perinatal period and how crucial these early years are for the foundation of physical, cognitive, emotional, and social development of the child.
- The first 1,001 days is also the time when babies are the most vulnerable. Early identification of maternal needs is seen as key in preventing abuse and neglect of babies in later life and improving their emotional wellbeing.
- Risk factors like domestic violence, drug and alcohol problems and overcrowded housing, for a parent, can cause high levels of stress in early childhood impacting the child's brain development and leading to stress- related problems in adult life for instance, heart diseases or substance abuse.
- PMH and wellbeing of **birthing and non-birthing parents** is thus important for the development of the baby as poor mental health can impact a parent's ability to bond with their baby.

Figure 1: NSPCC 1,001 Critical Days Manifesto



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Perinatal period raises risk of mental health problems with worse maternal and child outcomes if unsupported

- The perinatal period is a critical time for a baby's brain development. This period may be more challenging for some **birthing and non-birthing partners**, and they may find it difficult to provide the care and attention their baby needs. However, it can also be a chance to nurture strong parent-infant bonding with parents who are more receptive to support and advice.
- During pregnancy and the year after birth, many women experience common mild mood changes. Some women can be affected by common mental health problems, including anxiety disorders (13%) and depression (12%).
- The risk of developing a SMI is low but increase after birth. The impact of poor mental health can be greater during this period, particularly if left untreated.
- Changes to body shape, including weight gain, during perinatal period may be concerning for women with an eating disorder
- Alcohol, smoking and the use of illicit drugs in pregnancy are still common, and can cause intrauterine growth restriction, prematurity and foetal compromise in women who use these substances, particularly those who smoke.
- MBRRACE-UK reports **deaths from mental health-related causes account for nearly 40% of deaths occurring within a year after the end of pregnancy** and **maternal suicide** remains the leading cause of direct deaths, particularly up to 6 weeks after.
- Psychiatric causes alongside drug/alcohol consumption account for 20% of maternal deaths occurring between six weeks and one year after the end of pregnancy.
- A child's subsequent wellbeing is impacted by mothers' mental health during pregnancy with **both antenatal anxiety and depression linked to higher levels of emotional and behavioural problems at age 4.**
- **Depressed fathers** during pregnancy tend to be **more likely to have children with emotional difficulties at age 3**.

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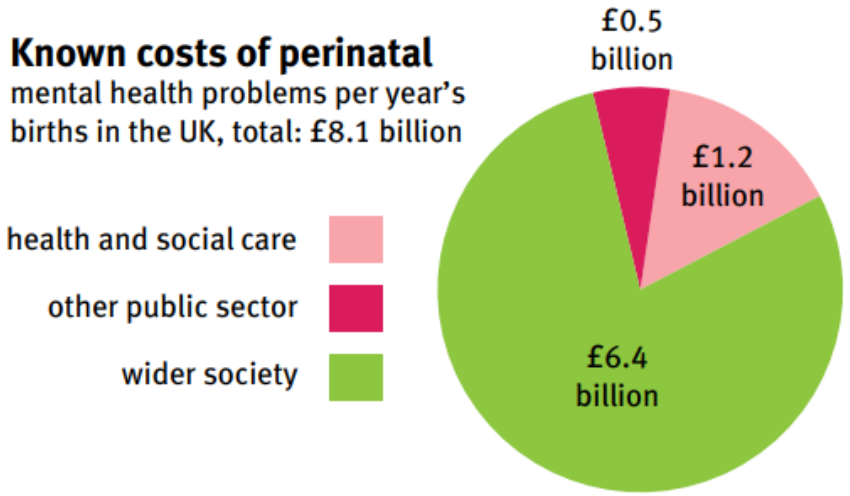
Economic burden of PMH is estimated to be at least £8 billion per annual birth cohort in the UK

The economic costs of PMH problems have been estimated by the Maternal Mental Health Alliance and the Centre for Mental Health, London School of Economics

- Economic burden of mental ill health during the perinatal period is estimated at **£8.1 billion** for each annual birth cohort, or almost **£10,000 per birth in the UK**
- 72% of this cost relates to **intergenerational adverse impacts on the child** over their lifetime rather than the mother
- A bulk of this cost (£1.2 billion) falls on the NHS and social services
- Average per case cost of perinatal depression to society is around £74,000, of which £23,000 relates to the mother and £51,000 relates to impacts on the child.
- Perinatal anxiety alone costs about £35,000 per case, of which £21,000 relates to the mother and £14,000 to the child.
- Perinatal psychosis costs around £53,000 per case, which is greatly under-estimated due to lack of evidence about the impact on the child

Figure 2: Economic costs of PMH problems



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A strong PIR is protective against PMH and improves child outcomes

- PIR refers to the quality of the relationship between a baby and their parent or carer; foundations for optimal infant mental health promoting healthy social, emotional and cognitive development are laid through positive PIRs
- A strong PIR is highly protective against PMH problems and leads to improved outcomes for the child.
- The transition to parenthood is a time of great joy for most. However, some can experience challenges adjusting, which can lead to heightened anxiety, stress or worry. This can contribute to adverse outcomes for families, which represents a significant public health concern given the potential impacts.
- Lack of love, neglect and parental inconsistency can lead to long-term mental health problems
- Without good initial bonding, children are less likely to grow up to become happy, independent and resilient adults.
- Around 15% of babies will not develop an emotional connection with a supportive and nurturing adult, which will go on to have long-term effects on their mental health, social, emotional and cognitive development.
- A strong bond between a parent and their baby is essential, known as secure attachment, and it happens when the parent consistently meets the baby's needs with care and love. Depending on how the parent responds, other attachment styles can also form, like avoidant, anxious, or disorganised, which can affect the child's future relationships.

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Several social and clinical risk factors are known to increase the risk of PMH problems

Whilst any woman or parent may experience mental ill health during the perinatal period, some women are at a higher risk of experiencing perinatal mental health problems.

Risk factors include:

- **History of abuse in childhood**
- **Previous history of mental health problems**
- **Stressful life events**
- **Teenage mothers**
- **Traumatic birth**
- **History of stillbirth or miscarriage**
- **Bereavement**
- **Exposure to violence or other trauma, including Domestic Violence and Abuse (DVA) and Intimate Partner Violence (IPV)**

- **Poverty**
- **Overcrowded and/or poor-quality housing**
- **Maternal obesity**
- **Alcohol or drug use**
- **Relationship difficulties**
- **Social isolation**
- **Unplanned or unwanted pregnancy**

- **Special education needs and disabilities in particular autism**
- **Being a migrant**

1. GOV.UK. Perinatal mental health [Internet]. GOV.UK. 2019. Available from: https://www.gov.uk/government/publications/better-mental-health-jsna-toolkit/4-perinatal-mental-health#fn:1
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Policy Context

- National
- Regional
- Local

National Context: NHS 10-year plan commits to expanding support for PMH

- The Covid-19 pandemic led to an **increased prevalence of anxiety and depression in pregnant women**.(1)
- The NHS Long Term Plan emphasises making sure everyone gets the best start in life, with a focus on expanding support for PMH. The Fit for the Future: 10 Year Health plan published in July 2025 retains this commitment. (2)
- The 10-year plan builds on the commitments outlined in the Five Year Forward View for Mental Health to transform specialist PMH services across England. By 2023/24, NHS has aimed to ensure at least **66,000** women with moderate/complex to severe PMH difficulties can access care and support in the community. (3)
- As part of the **£2.3bn** investment in mental health, additional investment will support further service developments for PMH. Set out in detail in the Mental Health Implementation Plan, this includes (4):
    - Increasing the availability of specialist PMH community care for women who need ongoing support from 12 months after birth to 24 months
    - Improving access to evidence-based psychological therapies for women and their partners
    - Mental health checks for partners of those accessing specialist perinatal mental health community services and signposting to support as required.

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3. NHS England. The NHS Long Term Plan [Internet]. NHS Long Term Plan. 2019. Available from: https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
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National Context: NICE advises women are screened for mental health at each ante- and postnatal contact

- The NICE guidelines for Antenatal and Postnatal Mental Health (2014, last updated 2020) recommends women are asked about their emotional wellbeing and mental health at **each routine antenatal and postnatal contact**. This also gives women an opportunity to talk about any concerns they may have, such as fears around childbirth, multiple pregnancy or past experiences (such as loss of a child or traumatic birth). This will help professionals provide appropriate support.

The guidelines recommend:

- To acknowledge woman's role in caring for her baby and support her to do this in a non-judgmental and compassionate way
- While working with young women under 20, healthcare professionals should encourage them to use antenatal care services by:
    - being aware that the young woman may be dealing with other social problems
    - offering age-appropriate services
    - offering information about help with transportation to and from appointments
    - offering antenatal care for young women in the community
    - providing opportunities for the partner/father of the baby to be involved in the young woman's antenatal care, with her agreement
    - to ensure continuity of care for the mental health problem if care is transferred from adolescent to adult services
    - partnership working with local education authorities and third-sector agencies to improve access to, and continuing contact with, antenatal care services for young women aged under 20
- Consider and, if appropriate, assess and address the needs of partners, families and carers that might affect a woman with a mental health problem in pregnancy and the postnatal period.

1. National Institute for Health and Care Excellence. Recommendations | Antenatal and postnatal mental health: clinical management and service guidance | Guidance | NICE [Internet]. www.nice.org.uk. 2014. Available from: https://www.nice.org.uk/guidance/cg192/chapter/Recommendations

National Context: MBBRACE UK reports on the significant impact of maternal mental health on mortality

- The MBRRACE-UK 2022 report highlights the impact on mothers' mental health with **maternal suicide being the leading cause in the 1-year period after end of pregnancy.**
- The report also reflects on the further rise in suicides among young women many of whom were **care leavers.** It also highlighted that there remains an almost **three-fold difference in maternal mortality rates amongst women from Black ethnic backgrounds** compared to White women, while **women in the most deprived areas have twice as high mortality rates compared to the least deprived areas.**
- The report recommends the following:
    - Commissioning bodies must ensure that providers of specialist PMH teams have sufficient resource to advise, and in complex or high-risk cases, be involved, in mental health assessments when in normal working hours.
    - Importance of a trauma history in the assessment of risk to be recognised.
    - Specialist PMH teams to be involved where there is a history of significant involvement with secondary mental health services or significant risk, particularly if it is a first pregnancy.
    - Allow sufficient opportunity in the electronic records systems for free text comment rather than relying solely on 'tick boxes'. If a woman has a history of mental health difficulties, make a brief (as a minimum) comment on mental health.
    - Health professionals to carefully assess women with persistent and severe insomnia for signs of underlying mental illness
    - Ensure access services such as Psychiatric Liaison, Crisis and Street Triage Teams should alert specialist PMH teams to any referrals of self-harm in pregnant or postpartum women that they have received to allow triage regarding the need for specialist follow-up.
    - Health professionals be alert to factors, such as cultural stigma or fear of child removal from social care, which may influence the willingness of a woman or her family to disclose symptoms of mental illness, including thoughts of self-harm or substance misuse

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National context: Building upon mother-infant focus with a broader, whole family approach

There is a national push to adopt three principles within perinatal support to make services family-inclusive. These include:

1. The Think Family approach:

- Consider the mother in her family's context
- Think about the people who use their services as parents, and consider the needs of the whole family
- Hold in mind that what affects the parent will affect the child, and what affects the child will affect the parent
- Consider ways in which they can involve family members in the mother's care and support family members as individuals, as partners/relatives to the mother, as parents/relatives to the baby

2. The Perinatal Frame of Mind principle: lays out best practice when working with mothers and their families at every stage of perinatal care, focusing on:

- The father/partner's mental health and how this affects the mother and baby
- How the pregnancy affects the father/partner and other family members' mental health and wellbeing
- How the absence of a partner or lack of support from the family may affect the mother, baby and mother-baby relationship.

3. Stay Curious: integrates a more inclusive definition of family structures and diverse experiences that may affect or be important to the mother.

- Being aware of cultural considerations: stigma associated with seeking PMH support, role of men and fathers within the family, cultural assumptions and unconscious biases among professionals, cultural competency training to challenges these biases about which family 'should' be involved with a mother and baby as the definition of family can vary. A few examples of family structures included are:
- Single parent families, separated families, same-sex or same-gender parents, more than two parents being identified by the family, families affected by perinatal loss, families where the gestational parent is a father, social care involvement, care-experienced family members, close friends, multigenerational households, siblings with different parents, etc,.

1. NHS England. NHS England» Perinatal Mental Health» Underpinning principles [Internet]. www.england.nhs.uk. Available from: https://www.england.nhs.uk/mental-health/perinatal/perinatal-mental-health-resources/involving-and-supporting-partners-and-other-family-members-in-specialist-perinatal-mental-health-services-good-practice-guide/underpinning-principles/

Regional Context: NCL ICB hosts quarterly PMH meetings replacing the London network

- The Pan London Perinatal Mental Health Network was formed in 2013. The Network was part of the London Perinatal Mental Health Programme which ran from 2013 to 2023 and has supported the development of specialist PMH services within every London borough.
- The group also developed the Perinatal Mental Health Care Pathway by bringing together senior practitioners within Perinatal Mental Health services in London and sets out guidance on the key components required to develop and deliver Perinatal Mental Health services that meet the needs of women and their families. This is in line with NICE guidance (NICE APMH 2014) and the Perinatal Quality Network (PQN/CCQI) service standards.
- The success of this pathway relies on close integration of community PMH services and maternity provider based obstetric and midwifery leads.
- Although the programme ended in 2023, the programme passed from the Pan London Perinatal Mental Health Network to the North Central London Integrated Care Board which meets every quarter. This work has seen significant growth with the additional Start for Life/Family Hub developments and arranges speakers to share their PMH experiences. Developing work with fathers, what PMH support looks like for the LGBT+ community, those with neurodiversity have been some of the topics covered through these talks.

1. Green DL, Miele DM, Protti DO. PAN LONDON PERINATAL MENTAL HEALTH NETWORK - PERINATAL MENTAL HEALTH CARE PATHWAYS [Internet]. 2015 Oct. Available from: https://www.england.nhs.uk/london/wp-content/uploads/sites/8/2019/07/mh-care-pathway-231015.pdf

Local Context: Camden commits to improving PMH via strategy, programmes and policies

Camden Health and Wellbeing Strategy (CHWBS) 2022-30 places importance on giving our children the best start in life in the first 1,001 days of a child's life, with high quality targeted support for families, early education and a strong focus on community.
It focuses on promoting quality PIR and ensuring our young people are active and health literate, particularly around their mental health and emotional wellbeing. (1)

Camden is one of 75 local authorities delivering the **Start for Life and Family Hubs programme** which:

- Provides support to parents and carers to nurture their babies and children, improving health and education outcomes for all
- Contributes to a reduction in inequalities in health and education outcomes for babies, children and families by ensuring that support provided is communicated to all parents and carers, including those who are underserved and/or most in need of it
- Build the evidence base for what works when it comes to improving health and education outcomes for babies, children and families

In conjunction with this programme, Camden has implemented an enhanced offer through **Best Start for Baby (BSFB)** to support every family in Camden across the first 1001 days of life. (2)

- The BSFB service is being delivered to families through an integrated service model, combining Health Visitors, Community Nursery Nurses, Midwifes and Psychologists.
- These teams will be able to support families directly themselves and provide access to wider support available through Camden Children's Centre and Family Hubs
- The Pathway & Practice Guidance are outlined in the coming slides and are intended to be integrated to facilitate decision-making so families can access seamless and coordinated support in the first 1001 days
- A local PMH and PIR steering group in place in Camden has overseen development of this pathway

1. Camden Health & Wellbeing. Camden Health and Wellbeing Strategy 2022-30. London Borough of Camden; 2022.
2. Best Start for Baby (Camden Integrated Early Years Service) Perinatal Mental Health and Parent-Infant Relationship Pathway and Practice Guidance

Local Context: Camden has developed a traffic light framework for PMH support

- Given promoting PMH and PIR is a core part of Best Start for Baby, Camden Council has developed a **PMH and PIR pathway and practice guidance**
- This has been developed in partnership by Camden's Integrated Early Years and Family Hub Service, with partner agencies/professionals involved in the care and support of families (from pregnancy up to 2 years) and in consultation with families from diverse backgrounds and lived experience of using services in the first 1001 days
- The guidance consists of a traffic light framework for PMH and PIR interventions that are universal, targeted and specialist and is embedded and integrated **into eight health visiting service contacts** during the first 1001 days (antenatal to two years), as follows:
    1. Antenatal Health Promoting visit
    2. New baby review
    3. 6-8 week assessment
    4. 3 months
    5. 6 months
    6. 9 months
    7. 1 year assessment (*15- and 18-month targeted appointment)*
    8. 2 to 2½ year review
- The pathways are traffic lighted and designed to identify interventions to be used following screening of parents for mental health concerns using tools such as Patient Health Questionnaire and General Anxiety Disorder Questionnaire (PHQ-9 and GAD-7)
- They include community and hospital-based services such as those based at the Whittington and UCLH

Source: Best Start for Baby (Camden Integrated Early Years Service) Perinatal Mental Health and Parent-Infant Relationship Pathway and Practice Guidance

Local Context: The traffic light PMH and PIR pathway provides universal, targeted and specialist support

- The figures in Appendix s32 and s33 provide a map of the full Best Start for Baby PMH and PIR pathways across the antenatal and postnatal periods. These pathways includes the eight contacts the family are offered within BSFB, as well as additional routine and targeted appointments
- Both pathways include Green, Amber and Red pathways for intervention based on the presenting complaint, and assessment tools like Whooley and/or GAD questionnaires for each case.
- **The Green Pathway** is to be used where there is no evidence of concern regarding PMH or PIR and signposts to **universal** support services like Health Visitor, GP or Midwife.
- **The Amber Pathway** is **targeted** for mild to moderate concerns around the wellbeing of the mother and ensures support by notifying named midwife, GP and Health Visitor. If the mother or family declines support, referral to Camden Multi Agency Safeguarding Hub (MASH) could be considered. For enhanced individual care, referrals could also be made to Acacia & Unity Midwives at Barnet and Royal Free Hospitals. Escalation to Red pathway is considered in cases of increased risk/ severity like pre-existing or newly suspected severe mental illness.
- **The Red Pathway** is **specialist** support where there is evidence of moderate to severe mental health concerns. Along with interventions from Green and Amber pathways, this would include referral to Camden Specialist Perinatal Mental Health services.
- As part of the postnatal pathway, Newborn Behavioral Observations (NBOs) are advised at the 11-14 days New Birth Visit by Health Visitors who are expected to use clinical judgement for referral to relevant pathway.
  - Camden has established the use of the New-Born Observation tool at the new baby visit, to promote sensitive, attuned parenting. New-Born Observations is now a core element of this contact and the principles of New-Born Observation practice have also been adopted in the delivery of the baby feeding groups and baby bonding (postnatal) groups. Additionally, Health Visitors are trained in the delivery of Emotional Wellbeing Visits and can offer this support antenatally onwards.
- As part of the postnatal pathway, maternal/ paternal/partner Mood Assessment is also advised at the 6-8 weeks postnatal check by GP or Health Visitor.

Source: Best Start for Baby (Camden Integrated Early Years Service) Perinatal Mental Health and Parent-Infant Relationship Pathway and Practice Guidance

Local Context: Multiple services, classes and activities are offered as part of the PMH and PIR support pathways

Green pathway (universal services)

- **Camden Baby Bonding Group**- drop in for parents/ carers with babies aged 0-6 months
- **Camden Baby Feeding Service**
- **Camden Carers** - offers information, advice and support to unpaid adult carers (18+) living, working or studying in Camden
- **Camden fathers** - drop-in service and support for fathers and male carers
- **Camden Kids Talk**- speech language and communication resources for all families
- **Family Lives** - borough-wide perinatal support service for new and expectant parents living in Camden
- **Library Rhyme Time** - story telling sessions for families with children under 5
- **Stay and Play** - universal free drop in playgroups for families with children under 5

Amber pathway (targeted services)

- Acacia Midwives (Barnet)
- Birth Reflections- UCLH and Royal Free
- Camden Bereavement Support Service
- Camden Bump to Baby Group
- Camden Early Help and Family Support
- Camden Safety Net
- Home-Start
- Camden NHS Talking Therapies
- Maple Service- bereavement, child loss and trauma service
- Camden Parents' Wellbeing Service
- Unity Midwives (Royal free Hospital)
- Whole Family Team with Perinatal Specialism (WFT-P) (CAMHS Under 5 service)
- Women in Health- charity supporting isolated and vulnerable women

Red pathway (specialist services)

- Acacia Midwives (Barnet)
- Camden Community Paediatric Service
- Camden MOSAIC Child Development team
- Children's Safeguarding and Social Work Camden Council
- Maple Service- bereavement, child loss and trauma service
- North London Partners Specialist Perinatal Mental Health Service
- Unity Midwives (Royal Free Hospital)
- Whole Family Team with Perinatal Specialism (WFT-P) (CAMHS Under 5 service)

Source: Best Start for Baby (Camden Integrated Early Years Service) Perinatal Mental Health and Parent-Infant Relationship Pathway and Practice Guidance

Local Context: The Camden pathway provides support to help build a strong PIR

As illustrated in the earlier traffic light diagram and appendix, multiple services in Camden support the strengthening of Parent Infant Relationships. In addition to these services and advice from midwives and GPs, consultations with health visitors and BSFB Psychologists can also be requested.

Green pathway (universal services)

- **Family Lives - Parents matter Antenatal and Perinatal Wellbeing Support service**: In close partnership with Children's Centre/Family Hub partners, midwifery, health teams and mental health services, this is a borough wide antenatal and perinatal support service for new and expectant parents living in Camden. This is part of Camden universal offer for those parents who are experiencing isolation and early signs of poor emotional well-being and mental health. It offers opportunities to socialise with other parents within the family hubs network via group sessions and activities and a unique buddying system where a volunteer peer supporter is matched to a parent, to carry out 1-2-1 sessions.

- Camden also has a **Father inclusion lead** who helps coordinate and promote several services and peer support network to help fathers during the perinatal period and beyond to develop strong PIR. Camden fathers WhatsApp group is one such local platform where over 200 fathers stay connected with each other, they can relate to stories/ experiences shared and also learn from them.

- Several perinatal peer support programmes such as **Stay & Play** sessions in Camden help new parents overcome isolation, gain hope of recovery, gain confidence by leaving the house, realise that others have similar experiences and learn to recognise the symptoms of postnatal depression.

Amber pathway (targeted services)

- **Camden Bump to Baby Group** Antenatal group: Is for expectant parents/carers. The group runs over five one-hour sessions across Camden Children's Centres and Family Hubs. Content focuses on a range of themes, including bonding, preparation for parenthood, noticing and responding to signals etc.

- **Whole Family Team with Perinatal Specialism (WFT-P)** offer:
  - **Circle of Security**: Group based parenting intervention for babies and toddlers aged 12-24 months to develop sensitive responding and attachment security. 8 sessions for up to 8-10 families with each session lasting 2 hours, facilitated by CAMHS practitioners.
  - **Together Time**: Specialist psychotherapeutic intervention for families of babies 4-12 months, who are experiencing worries or difficulties in their relationship with their baby. Supports parents to reflect on infant's thoughts and feelings through spontaneous play interactions. Facilitated by Child Psychotherapists.

- **Video Interaction Guidance (VIG)**: Targeted, brief 1-1 intervention delivered by IEYF Family Support Service and CAMHS: WFT-P. Intervention involves a video to record short interactions between caregiver and child to help parent reflect on what they are seeing. Promotes attunement, sensitivity and mentalisation in relationships.

Source: Best Start for Baby (Camden Integrated Early Years Service) Perinatal Mental Health and Parent-Infant Relationship Pathway and Practice Guidance

Camden

Local Context: Camden NHS Talking Therapies, Specialist Perinatal Mental Health and Maple are commonly used PMH services

A description of the some widely used perinatal mental health support services in Camden.

Amber pathway (targeted services)

Camden NHS Talking Therapies: Camden NHS Talking Therapies (formerly ICOPE) service is the local name in Camden for NHS talking therapies which operates under the national Improving Access to Psychological Therapies (IAPT) programme. Free confidential mental health support, therapy and interventions for adults with a range of mild-moderate mental health difficulties and concerns (i.e. depression or anxiety). Patients are triaged to:

- Assessment and guided self-help for General Anxiety Disorder, depression, low mood, sleep and stress; brief intervention over 6 sessions (individual and group).
- Assessment and High Intensity Support over 12-16 sessions, including Cognitive Behavioural Therapy, Interpersonal psychotherapy, dynamic interpersonal therapy, behavioural couples therapy, compassion focused therapy, eye movement desensitization and reprocessing etc.) NB: Camden NHS Talking Therapies have allocated therapists and clinicians with perinatal specialisms.

Maple service: sits across Amber and Red pathways). See Red pathway box for service description.

Red Pathway (specialist services)

North London Partners **Specialist Perinatal Mental Health** Service: North London Partners Specialist Perinatal Mental Health Service (SPMHS) provides specialist care for women with moderate-severe mental health problems who:

- Are planning a pregnancy and need advice
- Are currently pregnant
- Have had a baby in the past 13 months (with follow-up for up to 24 months)

Maple Service (bereavement, child loss and trauma service): NHS specialist therapeutic service for people living in Camden or any of the NCL boroughs who are experiencing trauma symptoms in relation to the pregnancy-related experience, birth of a baby, or loss of a baby. Service works with women and birthing people, as well as fathers and partners. The service offers:

- Support for people experiencing fear, trauma or distress related to fertility, pregnancy, birth or perinatal loss.
- Talking therapy to people who are experiencing emotional distress or symptoms of trauma before and during pregnancy, after birth, or after a loss.
- Works with women and birthing people, in addition to fathers and partners.
- Support for primary tokophobia, birth trauma, perinatal loss, as well as loss of a baby through social care proceedings.

Source: Best Start for Baby (Camden Integrated Early Years Service) Perinatal Mental Health and Parent-Infant Relationship Pathway and Practice Guidance

Camden

Local Context: the Specialist Perinatal Mental Health service is where moderate to severe cases are supported

- Included as part of the red pathway, The North London Foundation Trust (NLFT) Specialist Perinatal Mental Health Service (SPMHS) aims to see new referrals within six weeks of receiving the referral. If the referral is deemed urgent, they aim to see the woman within two weeks.

- Women will generally be seen in outpatient clinics in the hospital or community. The team offers psycho-education and advice, assessment and information about other services. Assessment, advice and treatment may be in collaboration with the woman's usual psychiatric team if they have one, and alongside the midwifery and obstetric teams.

- The service will agree **a personalised care plan** that embraces what is important to the woman during her pregnancy. The aim is to **promote wellbeing** in the woman and her family and **prevent relapse** in pregnancy and the early postpartum period.

- Comprehensive medication advice is available for those with mental illness on psychiatric medications who are planning a pregnancy, are pregnant or breastfeeding.

- The service supports mothers in developing a **healthy relationship with their infants**, thus reducing the impact of maternal mental illness on child development. They also encourage the involvement of fathers or partners in the process.

- They offer outpatient clinic slots for women accessing obstetric care at the following five maternity centres below. SPMHS also see women in the community and in particular circumstances at home.

1. University College London Hospital (UCLH)
2. Whittington Hospital
3. North Middlesex University Hospital (NMUH)
4. Royal Free Hospital (RFH)
5. Barnet Hospital

1. NHS Foundation Trust. Perinatal Mental Health Service [Internet]. University College London Hospitals NHS Foundation Trust. Available from: https://www.uclh.nhs.uk/our-services/find-service/womens-health-1/maternity-services/your-pregnancy/perinatal-mental-health-service

Local Context: UCLH hospital has in-house PMH support to complement the community offer

University College London Hospital

Every year, around 6,000 babies are delivered at UCLH, with 80% of these mothers living outside Camden. This equates to an estimated 1,200 Camden resident mothers, and around 1/5 of them, i.e., 240 Camden women, would be estimated (based on national estimated prevalence) to present with PMH conditions. At the booking appointment, all mothers are offered psychological support and are screened using the Whooley questionnaire. Based on the outcome of screening, mothers will be seen by the following services and/or the community services:

1. Women's Health Perinatal Psychological Service

Brief 1:1 intervention that offers antenatal psychological clinics for women who have psychological difficulties related to their medical health in pregnancy or that of the pregnancy itself such as tokophobia, pregnancy loss, anxiety related to pregnancy and birth trauma. This service is offered to women across NCL and beyond, regardless of catchment area. Women who need continuous support, those experiencing severe mental health conditions or those with a history of psychological issues will be referred to SPMHS or psychotherapy in the community. Depending on wait times, cases can be supported jointly with SPMHS. If needed, perinatal specialist nurses also hold onto a mother's case until psychology teams have capacity. Psychologists see mothers and fathers jointly.

2. Ad-hoc clinics (run by Specialist Midwife for Perinatal Mental Health):

Based on referrals from other midwives, the specialist midwife runs two clinics a week (seeing around 16 women in total per week). These are for women experiencing SMI (and may already have been seen by SPMHS). This is an attempt to maintain continuity of care by ensuring that these mothers have referrals to IAPT and Camden NHS Talking Therapies (SPMHS – see perinatal psychiatrist below), have the same GP throughout, as well as referring women who are unlikely to self-refer. Links to private psychiatrists where appropriate can also be made through this clinic.

- The specialist midwife can also refer mothers to an obstetrician at UCLH who has an interest in PMH. Fathers, if presenting with mental health conditions, can also be referred by the specialist midwife to SPMHS.
- There is also a perinatal psychiatrist, who as part of SPMHS, sits within UCLH and sees women who gave birth at UCLH and live in Camden/Islington. Referral for this must come from the specialist midwife.
- Referrals are also made for Family support workers who link mothers into PIR support including baby-bonding, breastfeeding support etc,.

Source: UCLH Specialist Midwife for Perinatal Mental Health

Local Context: Whittington hospital has in-house perinatal mental health support as well

Whittington Hospital

In 2023/24, the total annual number of deliveries in Whittington hospital trust was 2,773, of which around 112 were deliveries to Camden residents. There is an absence of robust data quantifying PMH need across deliveries but there was general consensus among midwifery leads, and was noted that demand is growing.

1. Women's health psychology team

This service is based on self-referrals for mild-moderate mental health issues including pregnancy related anxiety, needle phobia, previous birth trauma, tokophobia and hospital phobia. The service is comprised of two teams: **Women's health psychology service (WHP)** and **Birth trauma service**

- During the booking appointment, midwives can provide information and self-referral forms for WHP. The early bird classes (talks aimed at pregnant women between 16-20 weeks) also invite people to self-refer to this service if needed.
- The cut off for accessing this psychological support is 32 weeks to allow time for the team to work with the women before they give birth.
- Following review and assessment of need of an individual, the team may refer the patient to community specialist mental health services, and also work in tandem with them, for example, while awaiting appointments from specialist services.

2. Severe Mental Illness clinic with obstetric consultant:

This service is made available at time of booking for women who present at booking with pre-existing SMI or at other antenatal appointments. SMI identified include, but not limited to, bipolar disorder, schizophrenia, previous psychosis, previous postnatal depression, low BMI (to prevent/address eating disorders). As above, the patient is generally referred to SPMHS for follow up. A total of 6-10 patients are seen each week and appointments last 30 minutes, it is available for residents from Camden but potentially anywhere across London and beyond who have chosen the Whittington for maternity support.

3. Fathers service:

Currently, father's birth reflections are the only in-house service offered. In cases of loss/trauma, fathers are seen in the community by the Maple (SPMHS) service.

Source: Whittington Specialist Midwife for Perinatal Mental Health

What does good Perinatal Mental Health and Parent Infant Relationship Support look like?

- Enablers for good perinatal mental health
- Risk factors for poor perinatal mental health
- Case studies

Camden

Enablers of good perinatal mental health span partner, familial, cultural and service factors

Enablers of good PMH can be identified across international and national literature with understanding of cultural beliefs, practices and dynamics having a significant role in determining how services can best support development of a strong PIR and protecting mental health. Across WHO, NICE and published evidence some of the facilitators for what works are listed below:

- **Marriage or intimate relationship is considered the primary source of support** during the perinatal period to deal with psychological distress
- Interpersonal support including **family, social or community support** plays a vital role in coping with perinatal emotional distress though differences in family dynamics across different cultures determine extent and pattern of support
- Across **cultures there is also variation in the extent to which women wish to be socially connected** with the degree of willingness to discuss perinatal issues varying. Hence there may be wide variation in acceptability in speaking to their peers, adhering to advice of family and community leaders, using talking therapies via therapists, or accessing group support. This needs to be explored and understood at an individual level but also at service level. Some cultures from global majority groups perceive certain foods to be important in their pregnancy or worshipping or prayer is especially important for others.
- As part of the care pathway, the evidence clearly identifies 'what works' is having a **health professional who is trustworthy, responsive, non-judgmental**, understanding, caring, interested, warm, empathetic and positive. Moreover, culturally sensitive and trained health professionals are crucial in public health messaging and persuading individuals to engage.
- Across many high-income and low- and middle-income countries, there is emphasis on **community health workers or peer support workers as an integral part** of the health service. In the UK, as part of the multidisciplinary care team, peer support workers are sometimes integrated into outpatient PMH services.
- **Continuity of clinicians** is another factor for women's experience of specialist services which allowed them to establish feelings of safety, comfort, and dependability as having to repeat their issues with unfamiliar clinicians is upsetting and inefficient.
- Access to **good, coordinated antenatal care and support, with strong healthy relationships** of trust between women, families and professionals facilitates early identification and care.
- Having their **baby present during Mother and Baby Unit admission** was reported as positive to women's recovery.

1. Webb R, Uddin N, Constantinou G, Ford E, Easter A, Shakespeare J, et al. Meta-review of the barriers and facilitators to women accessing perinatal mental healthcare. BMJ Open. 2023 Jul 1;13(7):e066703–3.
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4. Webb R, Ford E, Shakespeare J, Easter A, Alderdice F, Holly J, et al. Conceptual framework on barriers and facilitators to implementing perinatal mental health care and treatment for women: The matrix evidence synthesis. Health and Social Care Delivery Research. 2024 Jan 1;12(2):1–187.

Equally, cultural factors, stigma of mental health and service pressures can all contribute to worse PMH

Barriers to good PMH are equally complex and multifaceted:

- From a population standpoint, **PMH problems are common worldwide with diagnostic prevalence varying due to variation in risk factor prevalence but also due to variation in how often, and well, it is screened for and recorded**. This can mean that first generation migrants in particular those from low- and middle-income countries can come from cultural backgrounds where significant stigma remains around mental health, labelling and seeking support
- **Among migrant population groups, refugee and asylum-seeking women** may encounter a range of challenges in accessing healthcare and are particularly susceptible to experiencing perinatal mental illness due to increased history of trauma and adversity; which also predisposes them to a higher prevalence of suicidal ideation
- A **lack of awareness or recognitions of symptom associated with poor PMH** can mean health support is not sought or not sought early enough, stigma associated with seeking mental health support can compound this further.
- **Without appropriate screening tools in place for which they have received training**, healthcare professionals may find it **difficult to identify mental health issues** conflating them with concurrent physiological issues.
- Organisational barriers like **resource inadequacies and service fragmentation** affect access and engagement of women with perinatal mental illness to mental health services
- Negative past experiences with services due to reasons mentioned above can **degrade trust among mothers in their diagnosis**, especially if continuity of care or a trusting relationship with the healthcare professional is not established.
- Some other barriers with regards to service access have been identified as having **limited provision of inpatient Mother and Baby Unit (MBU) beds, long waiting lists, long distances to services, difficulties traveling with their new-born and not being permitted to bring their baby to appointments.**

1. Rahman A, Fisher J, Bower P, Luchters S, Tran T, Yasamy MT, et al. Interventions for common perinatal mental disorders in women in low- and middle-income countries: a systematic review and meta-analysis. Bulletin of the World Health Organization [Internet]. 2013 Apr 18;91(8):593–601I. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3738304/
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Lack of integrated services, referral pathways and increased parental anxiety of social care involvement can worsen mental health outcomes

A few additional factors contributing to worse PMH are:

- Healthcare professionals not having adequate training on perinatal care pathways, and if they are unable to advise individuals in detail about what to expect at booking appointments and beyond, this can increase anxieties about the reason for being invited to appointments and lead to a lack of engagement with services.
- Pathways for PIR and PMH that are not well integrated into universal support services
- **Worries about social services involvement** or being **judged as being a 'bad mum**' are barriers at individual level when deciding to consult on mental health.

1. Rahman A, Fisher J, Bower P, Luchters S, Tran T, Yasamy MT, et al. Interventions for common perinatal mental disorders in women in low- and middle-income countries: a systematic review and meta-analysis. Bulletin of the World Health Organization [Internet]. 2013 Apr 18;91(8):593–601I. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3738304/
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Case Studies: Evidence in Practice

Durham's Health Visiting Initiative

Challenge: Central to their mission has been the enhancement of their PMH support offer. Here, the focus has largely been on offering families targeted early intervention, particularly around PIR, ensuring families are connected to specialist services if or when they may be needed.

Solution: As part of the Family Hubs programme, Durham county's health visiting team recruited **a specialist perinatal mental health visitor**. This lead, along with staff nurses, handles referrals, triages families and completes assessments to connect them to the right support. The team has developed clear service pathways and a robust assessment process receiving referrals from the wider system to ensure the right families are targeted and supported.

Impact:

- The specialist role in PMH has notably increased the capacity for identifying risk factors for mental health issues early, so relevant support is offered in a timely way.
- The Video Interaction Guidance has been especially effective in strengthening parent-infant bonds. The tool has played a significant role in showing parents through recorded micro movements that a bond exists and with the additional support of other interventions within the service, mothers are able to begin working actively on the PIR.
- Reduced the likelihood of families being discharged without support.
- Training and introducing new roles has helped target the families experiencing low to moderate mental health issues.

Wolverhampton Health visiting: partnership approach

Multifaceted challenge: Alongside being the 20th most deprived council area in England, they had issues with staff retention, service continuity, and quality and ability to efficiently meet diverse and complex community needs.

Solution: Began a **partnership with Royal Wolverhampton NHS Trust** and introduced a targeted digital transformation to manage data and service efficiency; a marketing and communications expert for Special Education Needs and PMH to target community engagement. The Health Visiting team also has an **equalities dashboard** which displays percentage uptake by geography, deprivation, ethnic group and GP practice for each KPI.

Impact:

- New birth visits within 14 days; proportion of infants receiving 6-8 week review; proportion of infants receiving 12 month review: All indicators increased from 20/21 – 22/23 period and surpassed England average.
- Dedicated health inclusion team for vulnerable communities.
- More timely contact with families and several needs have been identified and supported earlier.

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2. Local Government Association . Health visiting in Wolverhampton: a partnership approach [Internet]. Local.gov.uk. Local Government Association; 2024. Available from: https://www.local.gov.uk/case-studies/health-visiting-wolverhampton-partnership-approach

Case Studies: Evidence in Practice

ROSHNI-2 Trial

The ROSHNI-2 trial compared culturally adapted cognitive behavioural therapy (Positive Health Programme [PHP]) with treatment as usual for postnatal depression in British south Asian women. The PHP intervention was delivered by non-specialist health workers.

In the randomised controlled trial, British south Asian women aged 16 years or older with a child aged up to 12 months, and meeting DSM-5 criteria for depression, were recruited from northwest England, Yorkshire, the East Midlands, and London.

The PHP intervention involved 12 group sessions delivered by two trained bilingual facilitators, held once per week for 2 months and once per fortnight thereafter, each lasting 60–90 min.

Questionnaires on depression symptoms, quality of life and resource use were completed at baseline, 4 months (end of intervention), and 12 months. 732 woman were ultimately recruited to the study from Pakistani, Indian and Bangladeshi ethnicity primarily.

At 4 months the proportion of participants who recovered from depression was higher in the intervention group indicating that this culturally adapted group CBT-based intervention could aid in quicker recovery from depression compared with treatment as usual. It has since been shown to be a cost-effective model as well.

Quality-adjusted life-years (QALYs) were used for the cost-utility analysis, and recovery from depression at 4 months (the primary clinical outcome), assessed using the Hamilton Rating Scale for Depression, were used for the cost-utility analysis. After the onset of the COVID-19 pandemic, the intervention was adapted for online delivery for the remaining participants.

Maternity Disadvantage Assessment Tool

A tool developed by Lambeth Early Action Partnership Team and later piloted and rolled out by Royal College of Midwifery is the Maternity Disadvantage Assessment Tool. The purpose of this standardised tool is to allow assessment of wellbeing and social complexity in the perinatal period. The tool provides a guide for midwives to systematically identify the woman's care complexity level (1–4) based on social and clinical history and develop a personalised care and support plan (PCSP), as well as facilitating smooth communication with the multidisciplinary teams.

The Motherhood Group

The Motherhood Group, a social enterprise that supports the Black maternal experience by delivering community-based events, training workshops, peer-to-peer support, national campaigns (Black Maternal Mental Health Week UK), and culturally sensitive programmes for Black mothers.

They work across NHS organisations providing training around cultural competence and how to implement peer support programmes a well as wider training and resources.

Five x more

Five X More support Black women and birthing people with our resources, train health professionals and lobby for change. In 2022 they published a survey report designed with input from an expert panel of Black professionals gathered data from 1340 black women and birthing people from around the UK . Negative experiences far outweighed the positive. Three thematic findings were identified 1) Attitudes (e.g., using offensive and racially discriminatory language; being dismissive of concerns), 2) Knowledge (e.g., poor understanding about the anatomy and physiology of Black women; poor understanding of the clinical presentation of conditions in babies of Black women), 3) Assumptions (e.g., racially based assumptions about the pain tolerance, education level, and relationship status of Black women).

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Case Studies: Evidence in Practice

Barnardo's research

Young people leaving care often need support with their mental health and this need can be particularly acute during periods of transition such as when becoming a parent. From interviewing several care-experienced parents, two key needs were identified:

- Suitable, **preventative** services that care-experienced parents could access during the perinatal period:
    - *"Young people leaving care can struggle to assess the mental health support they need, particularly as this group often falls between the cracks of children's and adults' services. They often find themselves too old to access CAMHS and yet not meeting the high clinical thresholds for access to adult mental health services. Access to services can be particularly difficult if the young person has a specific need. For example, one care experienced father we spoke to described the unequal access to mental health support for fathers compared to mothers. Others also mentioned mental health services could have long waiting lists."*
- Supportive, non-judgemental care from professionals towards care-experienced parents:
    - Young parents felt discriminated against because of their care status and felt like their ability to parent was under scrutiny and more emphasis was placed on assessing their parenting ability rather than offering support. This deterred the young people from accessing support.
- Recommendations:
    - One of the 5 recommendations of the Care Experienced Parenthood Report: **providing mental health support for care experienced parents should be a key consideration for ICB CYP plans.**

Maternal Mental Health Alliance – experiences of young mums

Qualitative research by MMHA through focus groups with young mums identified that a **dream city** of mental health support would have:

- Access to childcare alongside having accessible and flexible services that operated outside of 9-5 working hours.
- Activities where they could have time for themselves e.g. gym, arts/crafts/yoga
- Free activities and places to take children
- Non-judgemental services that listened to them and didn't dismiss them
- Professionals who are understanding / receive support from someone who the mum can relate to due to shared similar experiences.
- Professionals who are specifically trained on maternity and mental health.

Sussex Local Maternity Pilot

With an aim to address health inequalities identified within the MBRRACE report, Sussex enlisted the Motherhood Group's expertise in engaging marginalised groups. Two 6-month courses facilitated by peer supporters online, accessed by a total 44 mothers and pregnant people. With 'improving maternity services' as the key topic of discussion, the following recommendations have emerged from service-user led sessions:

- Honest conversations with pregnant women and mums, that focus on **their health and well-being needs** in the perinatal period
- More open dialogues on the **impact of race, faith and stigma** surrounding maternal mental health.
- Clear signposting, clear information to all mums regarding on whether they 'need' mental health support
- Interact with **other diverse services, support groups and the wider community** so that mothers feel like they are being represented.
- Invest in **antiracism training for staff** to identify existing assumptions about ethnic minority women.
- Promote and **recruit racially diverse staff** within the NHS, so that mothers can **feel represented** in healthcare

1. Maternal Mental Health Alliance. The maternal mental health experiences of young mums | Maternal Mental Health Alliance [Internet]. maternalmentalhealthalliance.org. 2023. Available from: https://maternalmentalhealthalliance.org/news/maternal-mental-health-experiences-young-mums/
2. The Motherhood Group. Sussex Local Maternity Pilot [Internet]. The Motherhood Group. 2025 [cited 2025 Feb 7]. Available from: https://themotherhoodgroup.org/sussex-local-maternity-pilot/
3. Journeys C. Care-experienced Parents Unite for Change | Peer researchers' project exploring the experience of becoming a parent [Internet]. 2022. Available from: https://www.barnardos.org.uk/sites/default/files/uploads/Care%20Experienced%20Parenthood%20Report.pdf

Case Studies: Evidence in Practice

A multi-agency roundtable – MMHA Specialists

Perinatal clinical experts, health practitioners, Violence Against Women and Girls (VAWG) specialist organisations and academics have for many years identified and explored issues around domestic abuse. There are examples of exemplary research and practice supporting and safeguarding women, babies and families across the UK and there has been a positive shift towards greater recognition of domestic abuse and its impact on mental health over recent years. **However, it is also widely recognised that this is nowhere near as embedded in services across the perinatal pathway as we might expect**. Key learnings that have emerged from such discussions include:

Key Challenges:
- Only 50% of health professionals feel comfortable asking about domestic abuse
- Fear of offending or re-traumatising patients despite evidence that women want to be asked
- Women experiencing domestic abuse and PMH issues face a double disadvantage

Systemic Gaps:
- Lack of consistent routine enquiry across services
- Inadequate training on how to sensitively ask and respond

Solutions & Resources:
- LARA Manual provides practical guidance for professionals
- Normalise routine enquiry like other sensitive questions in maternity care

Why Recording Matters:
- Making domestic abuse a mandatory field in healthcare records can improve routine enquiry
- Helps identify prevalence and links to perinatal and mental health

Risks with Data Access:
- Legal right to access NHS records is welcome
- But concerns that perpetrators could view disclosed information
- Need for safe, secure and sensitive recording practices across services

What works:
- Independent Domestic Violence Advisors (IDVAs) in healthcare settings improve health outcomes
- Effective GP practices, A&E, maternity and mental health services

1. Maternal Mental Health Alliance. Perinatal Mental Health and Domestic Abuse [Internet]. 2023. Available from: https://maternalmentalhealthalliance.org/media/filer_public/79/63/79635e45-1797-4729-a18b-2ab4c46f4cde/mmha-briefing-perinatal-mental-health-and-domestic-abuse-jan-23.pdf

Case Studies: Evidence in Practice

For Baby's Sake

A service that provides parents with trauma-informed, therapeutic support to break the cycle of domestic abuse and give their baby the best start in life. For Baby's Sake is the first programme for expectant parents that takes a whole-family approach, starting in pregnancy and dealing with the entire cycle and history of domestic abuse, identifying and directly addressing the trauma or traumas that lie at the heart of the problem. It usually continues until the baby is two, covering the important time when a child's brain is developing and bonds are forming.

Why the Whole person, whole family approach works

- Parents form trusting relationships with their For Baby's Sake Practitioner. They feel safe and know that they will not be judged for what they've done, experienced or how they are as parents.
- The strengths-based approach helps parents handle emotions such as anger and fear, so that they can start to enjoy taking responsibility for their own future.
- Parents receive trauma-informed support to acknowledge and explore often unresolved and complex childhood trauma. This helps them build resilience and change harmful patterns of behaviour.
- The Inner Child module is at the therapeutic core of the programme. This is where parents can discover and reconnect with the root of their fears, insecurities and sabotaging life patterns.
- Parenting interventions for mothers and fathers, based on attachment theory, focus on sensitive, attuned interaction with their babies. Parents grow in confidence and ability to support their baby's emotional development.
- The programme has rigorous safety planning and multi-agency working to ensure the safety of both parents and child.

1. For Baby's Sake. Our work - For Baby's Sake [Internet]. For Baby's Sake. 2024. Available from: https://forbabyssake.org.uk/our-work/?_gl=1

Camden Local Picture – approach to identifying and assessing need

- Overview - prevalence and treatment

Camden

Services and service user data was analysed to estimate PMH need in Camden and identify inequalities

In the preceding section we described the importance of PMH and PIR on outcomes for parents and child, the policy context, local pathways in Camden for support and an overview of evidence and case studies.

In this and subsequent sections we will present data we have analysed from service leads, services, service users and wider residents in Camden to help estimate the level of need in Camden and identify inequalities that may exist in prevalence, service usage and outcomes.

- Through the Camden Perinatal Mental health and Parent Infant Relationship steering group, Camden Health and Wellbeing worked collaboratively with partners across NHS, North Central London Integrated Care Board (NCL ICB) and Specialist Perinatal Mental Health services to collate data at three different timepoints in the maternal journey - **Maternity**, **Health Visiting** and **Specialist Services;**
- A list of key indicators was pulled together from these various services to quantitatively assess and estimate the following:
    - Demographics of pregnant population in Camden and implication for PMH
    - Prevalence and risk factors of PMH in Camden
    - Trends in service access, referrals and utilisation

To understand the perspectives, experiences, and challenges faced by service users and residents in relation to PMH the following interview and/or focus groups were organised:

- **Birthing parent (Mothers) focus group discussion -** in partnership with the Whole Family Team with Perinatal Specialism
- **Non birthing parent (Fathers) focus group discussion -** in partnership with Council's fathers Inclusion Network
- **Specialist Midwives discussion** – UCLH and the Whittington Hospital

We aimed to also interview a Camden teenage-birthing parent, a care experienced birthing parent and a birthing parent who had a background of seeking asylum or refugee status. However, our attempts to engage them in interviews were unsuccessful and this has been highlighted as a gap in this needs assessment.

A brief description of datasets used in needs assessment

- **MSDS:** The Maternity Services Data Set (MSDS) is a patient-level data set that captures information about activity carried out by Maternity Services relating to a mother and baby(s), from the point of the first booking appointment until mother and baby(s) are discharged from maternity services. **Data we extracted included** referrals, antenatal screening, disability status, complex social factors, support and employment data.
- **SUS/GP:** The Secondary Uses Service (SUS) is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the NHS in the delivery of healthcare services. GP data contains data for patients registered in Camden and was linked to SUS data to give an indication of who had given birth in the 21 months preceding data extraction indicating there were in the perinatal period. **Data extracted includes** demographics, mental health status, Mother and baby checks, and IAPT (Camden NHS Talking Therapies) referrals.
- **Health Visiting Dataset:** The Health Visiting Service provided a dataset which captures health visits to pregnant women, children and their families during pregnancy and early childhood. Mental health needs from GAD-7/PHQ-9 questionnaires are collected, **data extracted includes** demographics, live births, and 6-8 weeks review.
- **Specialist Perinatal Mental Health Services (SPMHS):** SPMHS is a service provided to women experiencing moderate to severe mental health issues during pregnancy or within the first year postpartum**.** The service data provided is a subset of what is submitted to the Mental Health Services Data Set (MHSDS), **data extracted includes** referrals, new patient assessments, number of psychological therapy attendances and mental health outcomes.

A brief description of datasets used in needs assessment

- **Maple:** Maple is a specialised component service of SPMHS. It is an NHS specialist therapeutic service for people living in NCL who are experiencing trauma symptoms in relation to the pregnancy-related experience, birth of a baby or loss of a baby. **Data extracted include** referrals (from quarterly and annual monitoring reports).
- **ONS 2021 Census:** The census is undertaken by the Office for National Statistics every 10 years and gives us a picture of all the people and households in England and Wales. **Data extracted include** lone parent households.
- **OHID, based on Office for National Statistics data:** OHID utilises data from ONS which collects and publishes statistics related to the economy, population and society at national, regional and local levels. **Data extracted include** conception rates, infant mortality rates, and smoking status at time of delivery.
- **NHS Digital - Civil Registration of Births and Deaths Dataset:** This dataset encompasses information on registered births and deaths in England and Wales. It includes details such as the registration district, date of birth, and other relevant demographic information. **Data extracted include** registered births and deaths.
- **Camden NHS Talking Therapies :** Camden NHS Talking Therapies service is the local name in Camden and Islington for NHS talking therapies which operates under the national Improving Access to Psychological Therapies (IAPT) programme. It offers treatment for a range of psychological problems, including anxiety and depression. The service is for adults registered with a Camden or Islington GP, or people who are resident in these boroughs but do not have a GP. **Data extracted include** demographics, presenting complaints, employment status, referral source, discharge reason, and recovery status.

Demographics and inequalities within the Camden birthing population

Camden

Key findings – capturing the Camden birthing population

Data presented in this section helps understand the demographic make up of birthing people in Camden. It has been extracted from Health Visiting data from CNWL Trust and Civil Registration of Births and Deaths Dataset, NHS Digital.

Key Demographic Patterns in Birth in Camden

- Overall, the rate of live births has decreased over the past ten years from 45 live births per 1,000 women in 2014 to 32 live births per 1,000 in 2024..(1)
- Since 2019/20 the highest proportion of live births was among women aged 30-34. The second largest group is women aged 35-39 years, followed by women aged 40+.
- Since 2019, Any Other White have the highest proportion of live births in Camden; the second highest live births were observed in the White British ethnic group. However, there has also been a declining trend for both the group from 2022 to 2024.
- Live births in the Black and Asian ethnic groups have increased over time
- Data on preferred language of women accessing maternity services is poor however based on recorded data, most women in Camden have used English as their preferred language. However, women with non-English languages as their preferred language has consistently increased (by 11%) between 2019 and 2023; Bengali being the top non-English language.

The following factors are associated with greater risk of PMH

- 50% of all births are non white births in Camden*. Most birth in Camden are taking place in the second most deprived quintile. Black and Asian ethnic groups have more live births in the Most Deprived Quintile.
- 45% of lone parent households are occupied by women under 25 years of age, with younger and lone parents both at greater risk of PMH
- Camden saw a 1.8% rise in the proportion of smokers at delivery between 2019/20 and 2020/21.
- A postnatal mother and infant check was recorded for only 11% of individuals in the GP cohort from 2020-24 which included 8,595 woman.

The following factors are associated with lower risk of PMH

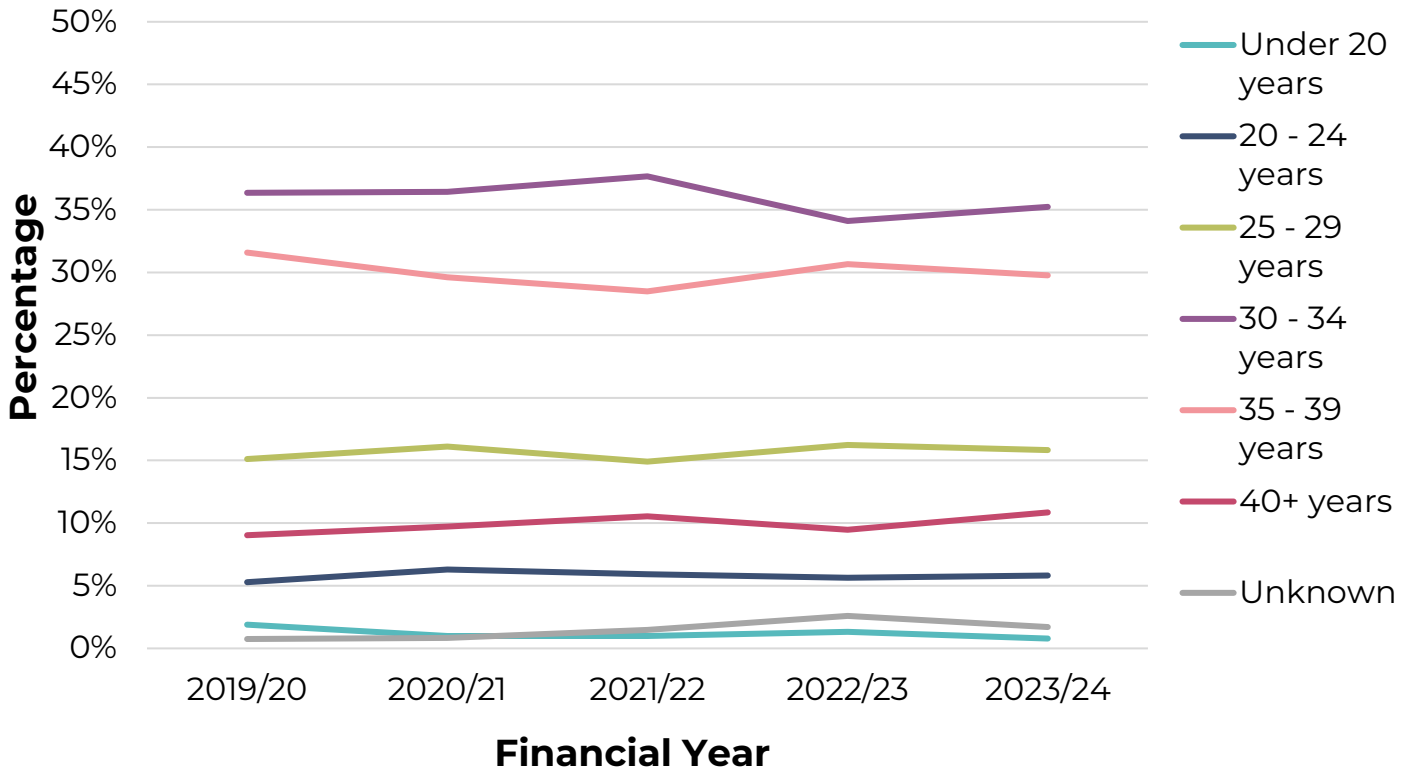
- Recent data on under 18 conception rates is limited but the most recent data available suggests lower rates compared to London and England.
- In Camden a sample of data showed that over 90% of those eligible received a 6-8 week postnatal health visiting review.
- From 2017 to 2022, the infant mortality rates for Camden were lower than England.
- Camden has higher number of children (4 in 5) being breastfed at 6-8 weeks compared to North Central London, London and England.

(1) ONS Population estimates and components of population change. Detailed time series 2011 to 2024

**This figure includes Asian, Black, Mixed and 'other' ethnic groups, with the latter including the Chinese ethnicity.*

Births across age groups remain broadly stable, with the highest proportion of births in the past 5 years among those aged 30-34

Figure 3. Proportion of live births by age group of mother time trend, Camden, FY 2019/20-2023/24



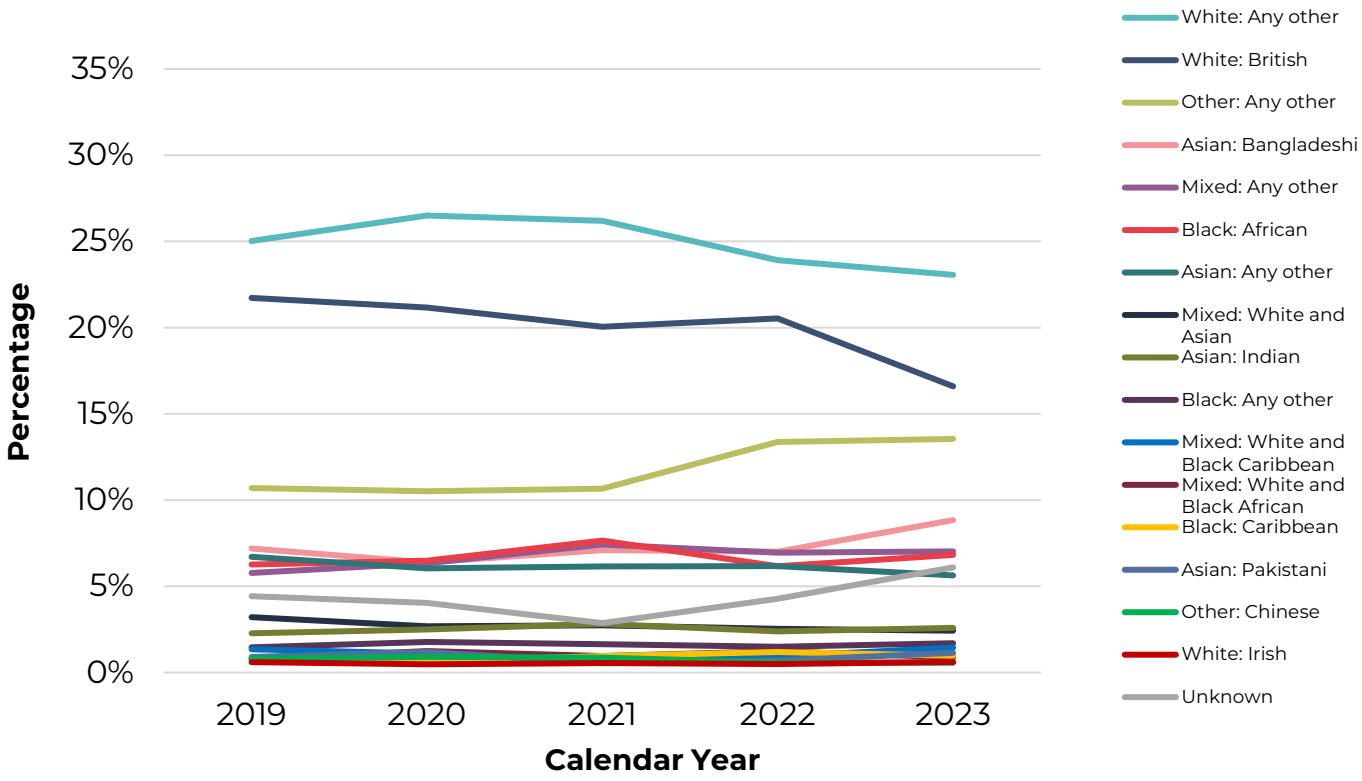
In the past five years (2019/20-2023/24):

- The highest proportion of live births were among women aged 30-34 years, followed by women aged 35-39 years.
- The lowest proportion of live births were among women aged below 20 years which significantly decreased from 1.9% to in 2019/20 to 0.8% in 2023/24.
- Between 2021/22 and 2022/23, the proportion of live births decreased for women aged 30-34 years and increased for women aged 35-49. This was followed by a slight increase in live births by women aged 30-34 years and a decrease by women aged 35-39 years between 2022/23 and 2023/24.

Data source: Health Visiting Dataset
Note: Unknown age is due to mothers' details not being available.

After White ethnic groups, the highest live births were observed among Black and Bangladeshi populations

Figure 4. Proportion of total live births born in Camden by ethnic group, 2019-2023



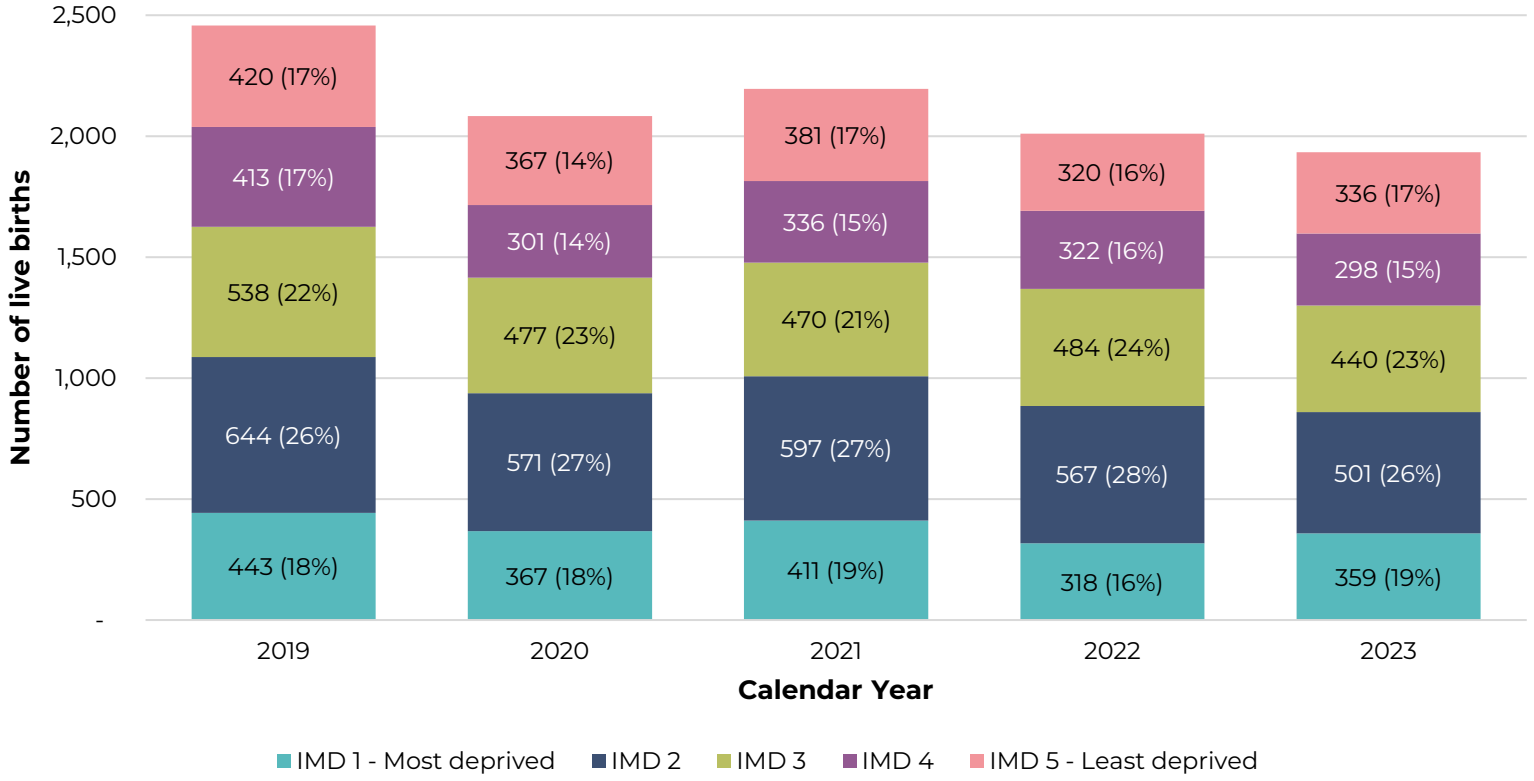
In the last five years (2019-2023):

- Babies born to mothers from White ethnic groups remain the highest proportion of live births in Camden despite a fall in live births from these ethnic groups.
- This is due to a higher proportion of White women living in the borough compared to other ethnic groups.
- Babies born to Black African mothers increased between 2021–2022 and babies born to Bangladeshi mothers increased between 2022–2023.
- Population-adjusted analysis is needed for clearer comparisons.
- The proportion of live births where the ethnicity of the mother is unknown rose from 4.4% in 2019 to 6.1% in 2023.

Data source: Civil Registration of Births and Deaths Dataset - NHS Digital
Note: Year indicates Calendar Year. 2024 data is not included in the analysis as the data are incomplete. "Chinese" ethnicity is included in "Other" ethnic group. The ethnic group reflects that of the mother, not the child.

Highest proportion of live births consistently among women who live in the second most deprived areas in Camden in the past five years (2019-2023)

Figure 5. Number and proportion of live births by IMD quintile, Camden, 2019-2023



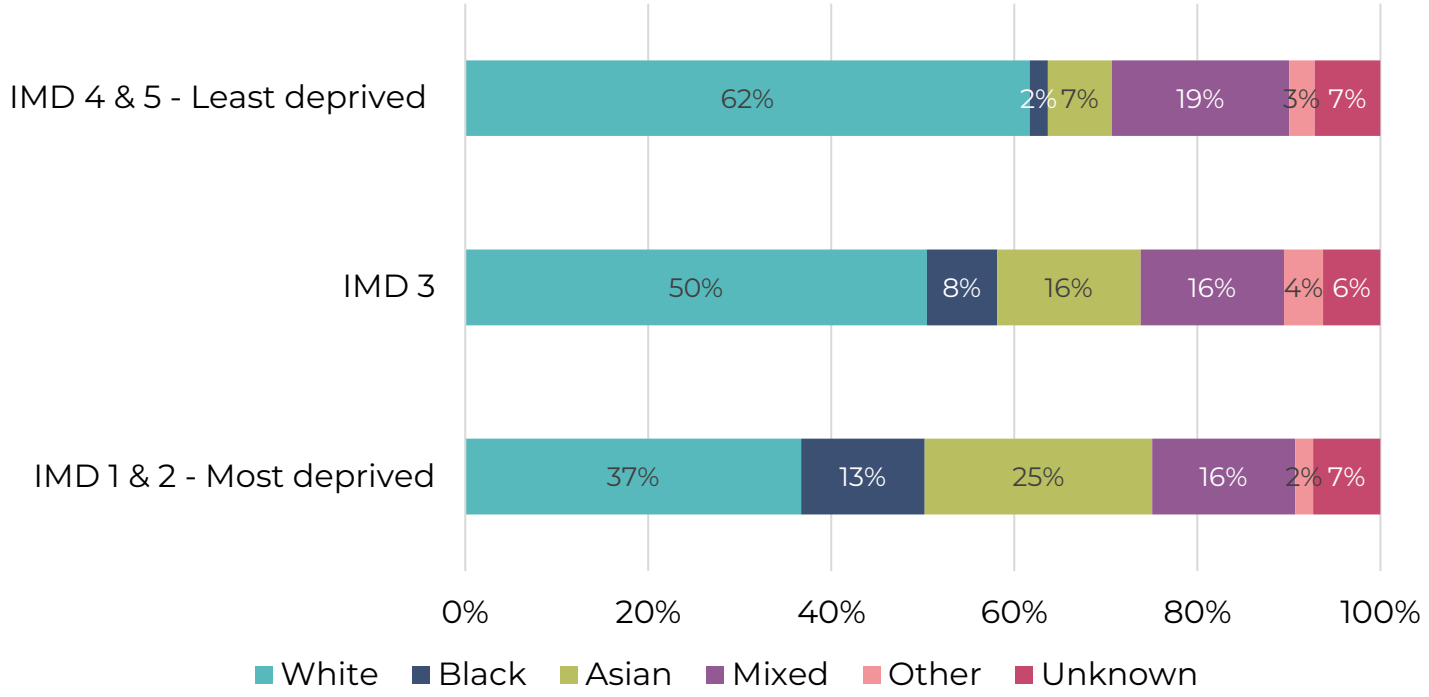
Over the past five years (2019-2023):

- The number of live births have been decreasing across all deprivation quintiles.
- The highest proportion of live births in Camden were observed for women within the second and third most deprived quintiles.
- Similar proportions of live births were observed for the least and most deprived quintiles for all years expect 2020.

Data source: Civil Registration of Births and Deaths Dataset - NHS Digital
Note: Year indicates Calendar Year. 2024 data is not included in the analysis as the data are incomplete.

The highest proportion of babies from a Black or Asian ethnic group live in the most deprived areas in Camden

Figure 6. Proportion of live births by ethnic group of child(ren) and deprivation quintile, Camden, FY 2023/24



- Asian and Black families comprise 20% and 9% of Camden's population respectively - the two largest ethnic groups after White ethnic group.
- In the least deprived quintile, the White ethnic group has the highest proportion of live births but the lowest proportion of live births in the most deprived quintiles (62% vs 37%).
- A similar trend is observed for those with Mixed ethnicity (19% vs 16%).
- The opposite is observed for Black and Asian ethnic groups which have the lowest proportion of live births in the least deprived quintile and the highest proportion of births in the most deprived quintile. (2% vs 13% and 7% vs 25% respectively).

Data source: Health Visiting dataset
Note: Chinese ethnicity is included in Asian or Asian British ethnic group. Unknown ethnic group includes "not stated", "not known" and "missing". The ethnic group is that of the child.

The proportion of women completing 6-8 postnatal health visiting reviews was above 90% on average

Figure 7. Number of live births in Camden, 2023/24

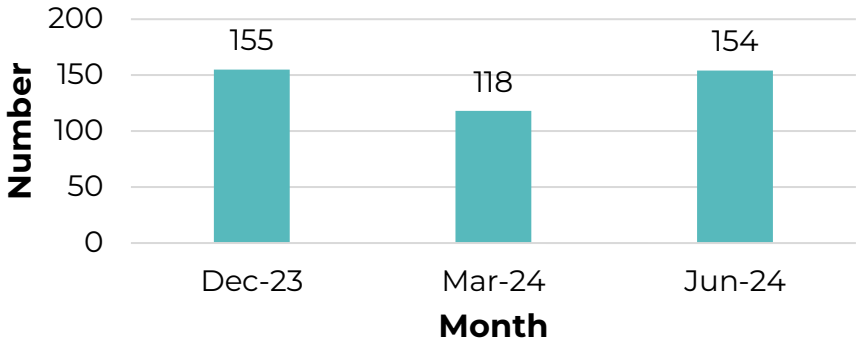
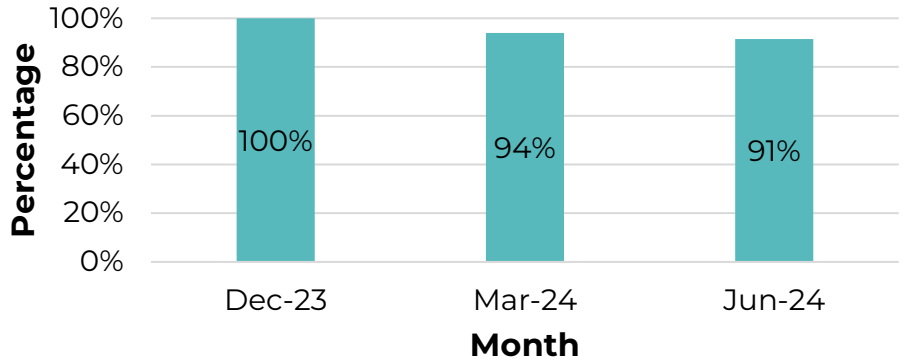


Figure 8. Proportion of women who completed their postnatal review at 6-8 weeks out of all women who were eligible, 2023/24



- Across a sample of 3 months of health visiting data from Dec 23, March 24 and June 24, 155, 118 and 154 births were identified respectively.
- Among the proportion of these women eligible for a postnatal review with a health visitor at 6-8 weeks, more than 90% received the review in each month.
- Reasons for not completing postnatal review include: no response from mother, declined contact, being in hospital, and being abroad for an extended period of time.
- Overall, this indicates good reach of the health visiting service in Camden and more opportunity to potentially identify mental health needs.

Data source: Health Visiting dataset
Note: The postnatal review is taken 6-8 weeks after birth. Caution should be taken when interpreting the data due to data only being available in 3-month time intervals.

A postnatal GP led mother and infant check was recorded as complete in only a minority of patients in Camden

- The GP/SUS dataset contains linked data on 8,595 patients attending General Practices in Camden from 2020-2024
- **On this dataset 965 out of 8,495 total patients, i.e. 11% had a record of having completed a mother and baby postnatal check with their GP***
- One or more of the reasons below have been put forward by primary care colleagues to explain this finding
    - The GP led postnatal mother and baby check is not being coded correctly
    - The GP led postnatal mother and baby check is not being offered systematically
    - The GP led postnatal mother and baby check is not being completed systematically
    - As the GP and mother postnatal check is not being incentivised as it was in the past through the Quality and Outcomes Framework (QOF)*, this may be leading to a reduction in prioritisation of recording and /or completion of the check
- Given that postnatal checks are a key point of contact to assess both mother and baby's wellbeing and make referrals onwards if deemed necessary, it is important that this appointment is offered, recorded and completed to maximise screening and identification of mental health needs
- **Subsequent analysis of EMIS Health data (primary care records) from CHP GP Federation indicated that in 2023/24, 39% of women had a record of having completed a postnatal mother check and 35% of babies had a record of having completed a postnatal baby check.**

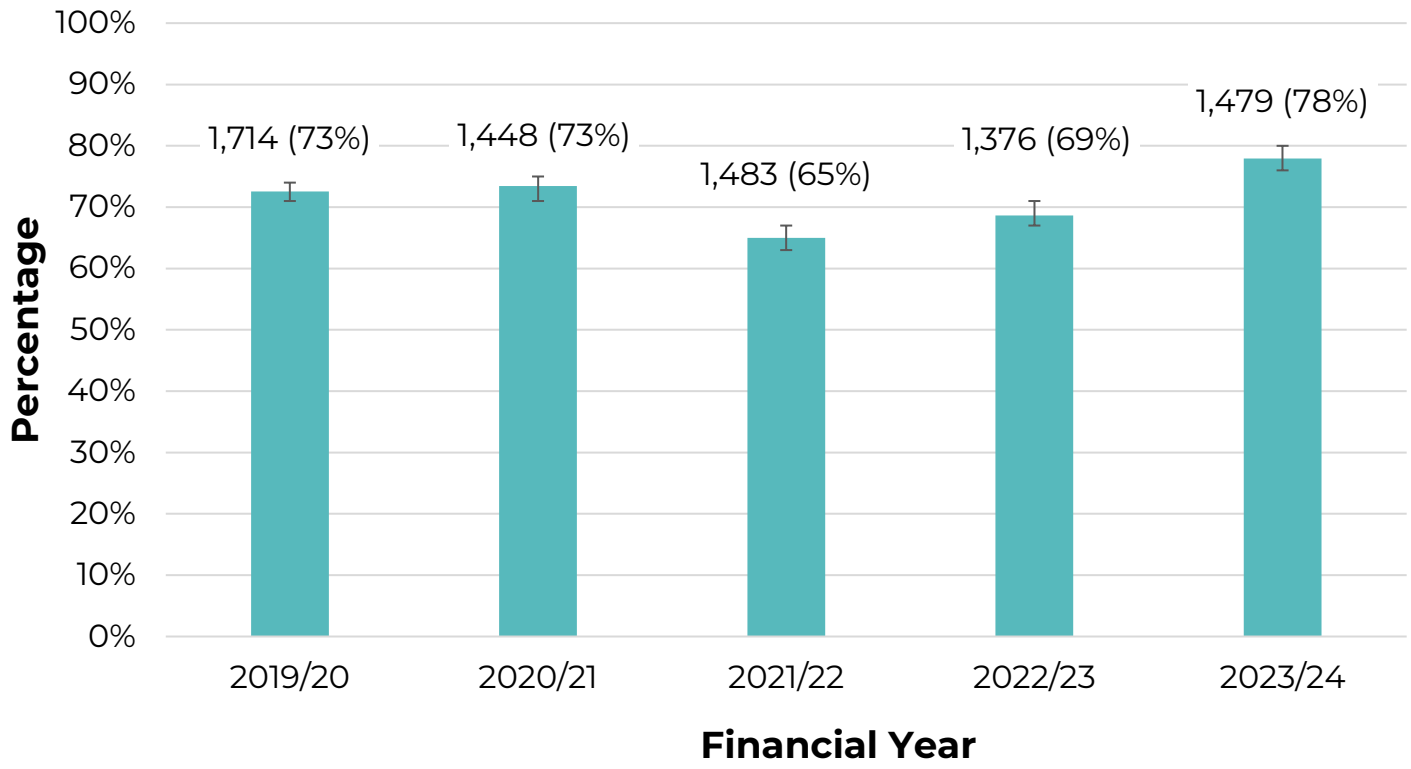
Data source: GP/SUS Dataset

1. NHS England. QOF 2018/19 | NHS Digital [Internet]. qof.digital.nhs.uk. 2023. Available from: https://qof.digital.nhs.uk/

***Note:** The QOF is a voluntary annual reward and incentive programme for all GP practices in England, detailing practice achievement results. It is not about performance management but resourcing and rewarding good practice.

Close to 4 in 5 babies in Camden are breastfed at 6-8 weeks which is higher than seen in NCL, London and England

Figure 9. Proportion of children breastfed at 6-8 weeks time trend, Camden, 2019-2023/24



- Camden has a higher proportion of children breastfed at 6-8 weeks compared to NCL, London, and England.
- The significant drop in breastfeeding rates in Camden between 2020/21 and 2021/22 may be linked to COVID-19 lockdowns and misconceptions about virus transmission through breastfeeding.
- The decline in breastfeeding during 2020/21 to 2021/22 occurred across the NCL region and the London region too but was most pronounced in Camden.

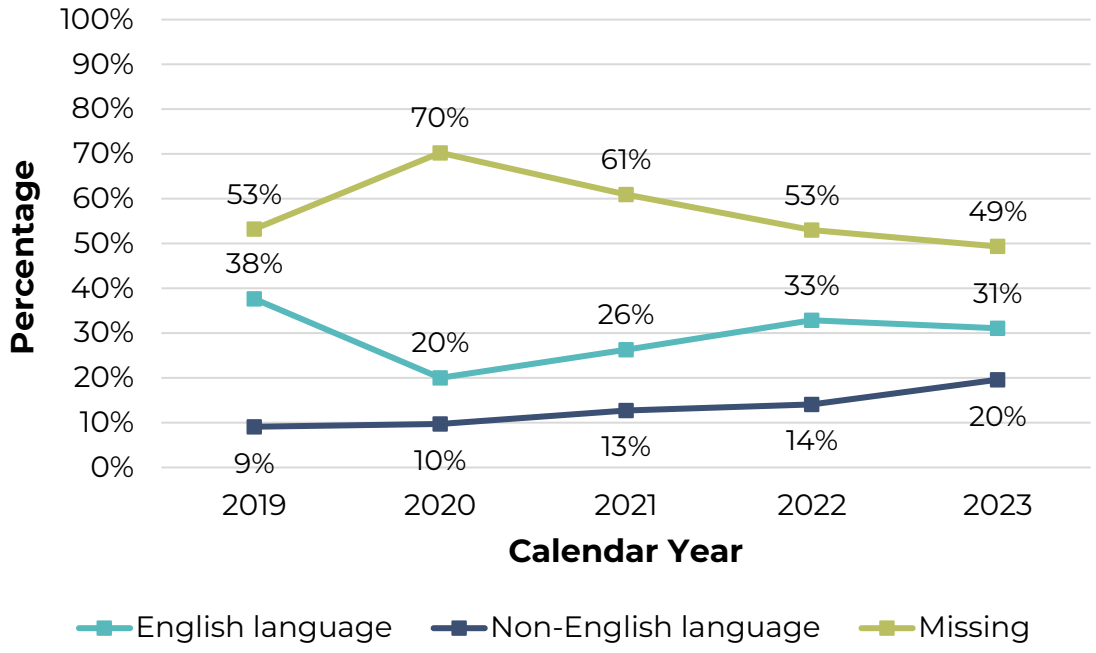
Data source: Health Visiting dataset

68 different languages were recorded for women who preferred a non-English language when seen by maternity services in Camden

In the past five years (2019-2023):

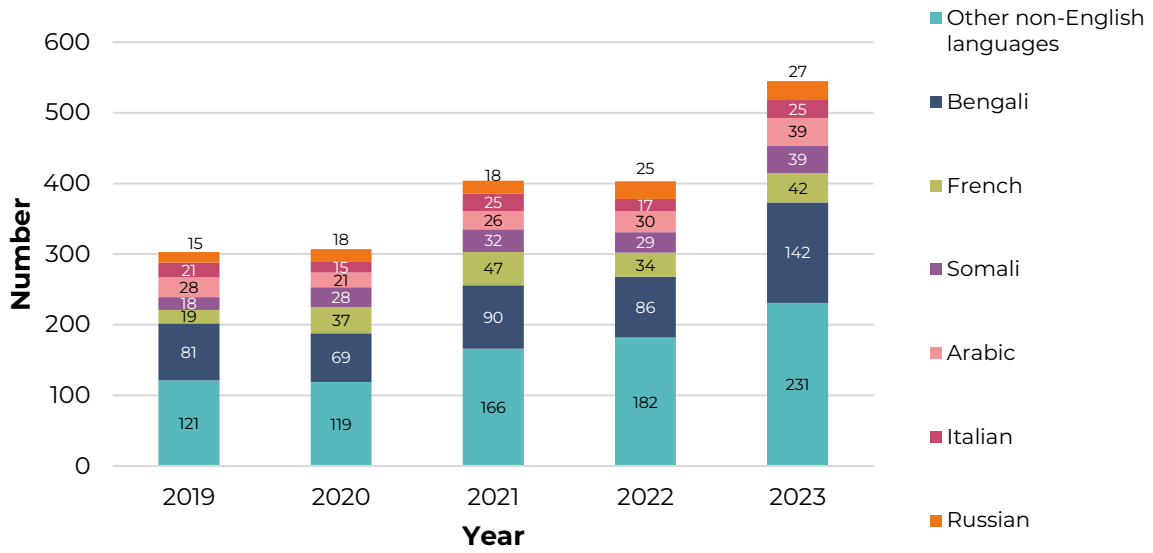
Data recording of preferred language spoken by mothers seen by maternity services in Camden ranged from 30%-51%. Based on the recorded data, a total of 68 preferred languages other than English were recorded. The most common languages spoken other than English were Bengali, French, Somali, Arabic, Russian and Italian.

Figure 10. Proportion of women seen by maternity services by preferred language, Camden, 2019-2023



Data source: MSDS

Figure 11. Preferred language other than English of women seen by maternity services, Camden, 2019-2023



Data source: MSDS

Prevalence and inequalities of PMH in universal services

Camden

Key findings – Modelling prevalence and inequalities in universal services

PMH prevalence modelling

- National data and published literature indicates **around 1 in 4 women** (25.3%) and **around 1 in 10 men** (8.4%) experience PMH problems.
- The Office for Health Disparities and Inequalities (OHID) modelled the prevalence of PMH in each Local Authority in England based on 2019 data. **The Camden estimate calculated was 23.5%.** For the purpose of this JSNA, this estimate will be followed despite its limitations (being a pre-COVID model) as estimates from other sources are not Camden-specific and are older than the OHID modelling.
- Applying the OHID prevalence to the number of women estimated to be in the perinatal period in Camden in 2023 identifies approximately **941 women** with perinatal mental health problems in Camden.*
- Equally applying an estimate form a 2016 meta-analysis of 8.4% prevalence for men, identifies approximately **336** men with PMH issues.

Findings – GP/SUS Dataset

- Most women recorded as having SMI or Depression in Camden were in the age group of 30-34 years (the highest proportion of live births are also seen in this age group); Depression was more likely to be recorded for women from the White ethnic group while SMI was more likely to be recorded for Black and Asian ethic groups. In terms of total counts, after White ethnic groups, postnatal SMI and depression was recorded in greatest number for Bangladeshi, Black African and Any Other ethnic groups.
- Most women with SMI or depression were in the most deprived quintiles. More women with depression from global majority are in the most deprived quintiles. There were data patterns that reenforced wider stakeholder insight and literature of under recording/diagnosis of mild to moderate mental health issues in global majority groups and greater likelihood of SMI. This may suggest that universal services are not reaching global majority families as well for mental health issues and also that help is often only sought when symptoms more severe.
- Postnatal depression is twice as commonly recorded for women in perinatal period who smoke in Camden compared to non-smokers.

*This calculation is based on perinatal period defined as the period of pregnancy plus 1 year after pregnancy.

1. England. Record numbers of women accessing perinatal mental health support [Internet]. www.england.nhs.uk. 2024. Available from: https://www.england.nhs.uk/2024/05/record-numbers-of-women-accessing-perinatal-mental-health-support/
2. Maternal Mental Health Alliance. Over 30,000 new or expectant mothers are on waiting lists for mental health support | Maternal Mental Health Alliance [Internet]. Maternal Mental Health Alliance. 2023. Available from: https://maternalmentalhealthalliance.org/news/labour-party-waiting-lists-perinatal-mental-health-support/
3. Rahman A, Fisher J, Bower P, Luchters S, Tran T, Yasamy MT, et al. Interventions for common perinatal mental disorders in women in low- and middle-income countries: a systematic review and meta-analysis. Bulletin of the World Health Organization [Internet]. 2013 Apr 18;91(8):593–601I. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3738304/
4. Cameron EE, Sedov ID, Tomfohr-Madsen LM. Prevalence of paternal depression in pregnancy and the postpartum: An updated meta-analysis. Journal of Affective Disorders. 2016 Dec;206(1):189–203.

Approximately 941 women and 336 men in the perinatal period are estimated to have mental health issues in Camden in 2023

Table 1: Estimated proportion of perinatal mental health issues in Camden by gender, 2023.

Women	Men
Approximately 1 in 4 women (23.5% prevalence estimate) in the perinatal period are estimated to have a mental health issue in Camden.* This is just below the national estimate of 25.3%.	Approximately 1 in 10 men (8.4% prevalence estimate) in the perinatal period are estimated to have a mental health issue.*
In 2023, approximately 941 out of the 4,003 women in the perinatal period in Camden are estimated to have a PMH problem.	In 2023, approximately 336 men out of the 4,003 men in the perinatal period in Camden are estimated to have a PMH problem.

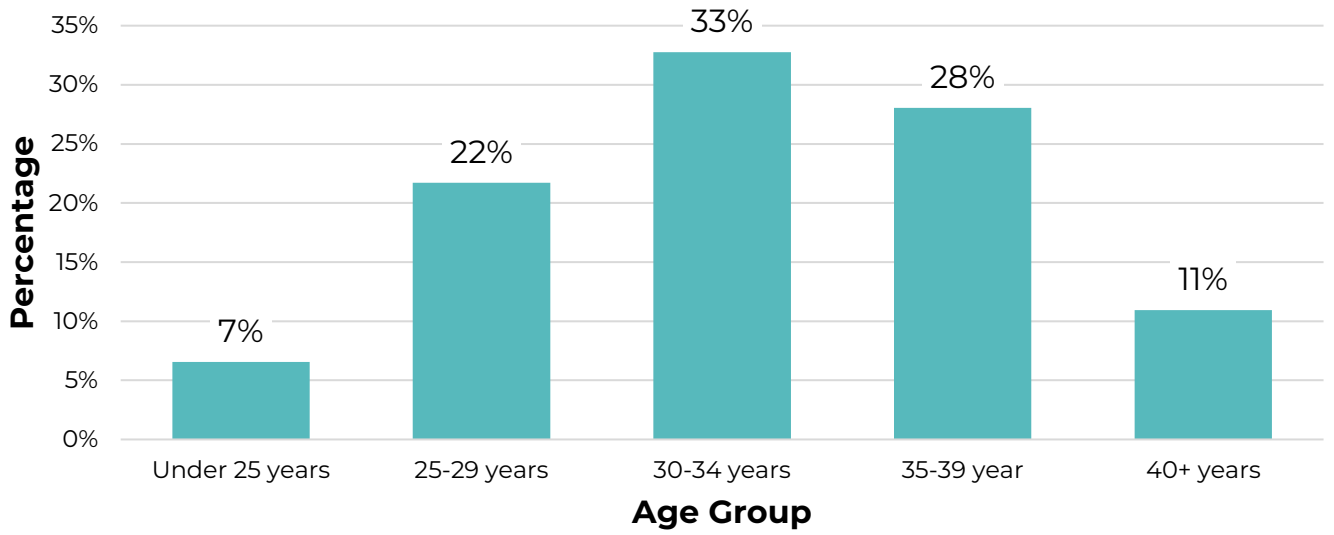
Note*:

- The OHID prevalence estimate for Camden of **23.5%** has been applied to the number of Camden maternities in 2023 to calculate the PMH prevalence estimate for **women**. This is based on the perinatal definition of 1 year post pregnancy.
- An estimate from a 2016 meta-analysis of **8.4%** prevalence for men has been applied to the number of Camden maternities in 2023 to calculate the PMH prevalence for **men**. This is based on the perinatal definition of 1 year post pregnancy.

Source: ONS births characteristics (denominator)
Note: The number of maternities has been used as the denominator to calculate the prevalence rate of PNMH for men due to limited data on the number of men in the perinatal period. Therefore, caution must be taken when interpreting the data and using this figure as an estimate. This analysis does not take into account men in the perinatal period who are not partners of women who gave birth in 2023 (this includes, but is not limited to, men who have adopted a child or had a child via surrogacy). The denominator is likely to be a slight overestimate as it is based on two full years of maternities i.e. 2022 + 2023 (rather than 0-9+ months plus one or two years for each maternity).

Most women with diagnosed severe mental illness (SMI) or depression were in the age group of 30-34 years

Figure 12. Proportion of women with postnatal severe mental illness or depression by age, Camden registered patients, FY 2020-2024



Based on GP and SUS linked data from 2020-2024:

- 8,495 women were identified as being in their perinatal period.
- The proportion recorded with depression across this cohort is 12% and SMI less than 1%.
- The highest proportion of depression and SMI was recorded in those aged 30-34.
- 30-40% of births are seen in the 30-35 cohort and this data indicates around ⅓ of these have depression, and a similar finding holds for SMI.
- Following this age group, depression is most commonly seen in women aged 35-39 years (28%) and 25-29 years (22%).

See appendix (Figure s14 – s16) for SMI data (not presented here due to low numbers).

Data source: GP/SUS dataset
Note: The GP/SUS data extract analysed for this JSNA covers women aged 15-44. One person has been excluded from this analysis due to an error pertaining age category. SMI and depression may be either newly diagnosed or a pre-existing condition. All estimates here are reliant on accurate coding in GP records. As per QOF definition, depression is not included under SMI. Depression can be mild to severe whereas SMI encompasses severe depression only, psychosis and bipolar affective disorder (see slide 7 for SMI definition and source). The demographic finding (that 30-40% of livebirths are to mothers aged 30-35) comes from the HV dataset.

Women from Asian and Black groups were more likely than White women to have SMI recorded but less likely to have depression

Women from Asian and Black ethnic groups were more likely to have SMI recorded than white but less likely to have a diagnosis of any form of severity of depression.

The proportion of women in the whole cohort with depression was highest for women from White British ethnic groups (39%), followed by Any other White background (17%), Asian Bangladeshi (8.2%) and any other Asian ethnic group including Chinese (8.1%).

See appendix (Figure s14 and s15) for SMI breakdown (not presented here due to low numbers).

Figure 13. Proportion of women in postnatal period with depression by ethnicity, Camden registered patients, FY 2020-2024

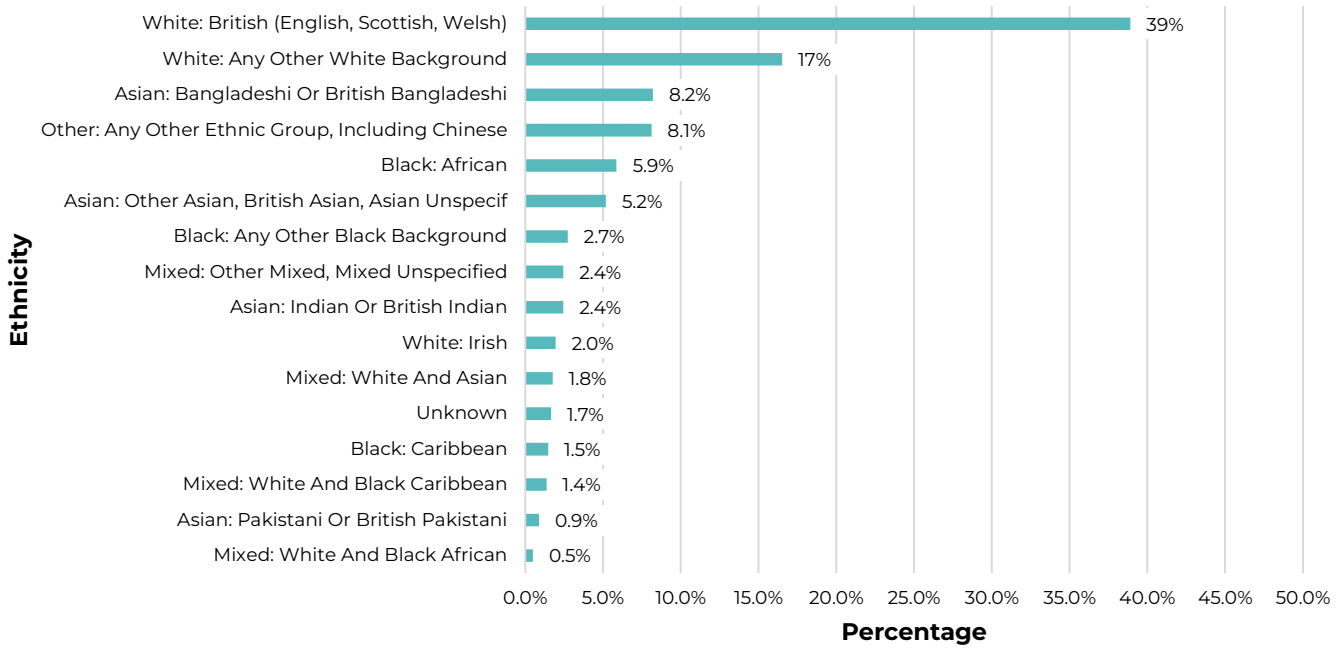


Table 2. Proportion of women in postnatal period with depression or SMI by ethnicity FY 2020-24

Ethnic group	Total	Depression diagnosis Count (%)	SMI diagnosis Count (%)
White	4,455	587 (13%)	32 (0.7%)
Asian	1,729	171 (10%)	17 (0.9%)
Black	825	103 (12%)	8 (0.9%)
Mixed	390	62 (16%)	<5 (0.7%)
Unknown	130	17 (13%)	0
Other	923	83 (9%)	<5 (0.2%)
Total	8,452	1,023 (12.1%)	62 (0.7%)

Note: In the GP/SUS dataset perinatal mental health conditions have been differentiated into “SMI” and “Depression” whereas the other datasets don’t define the type of perinatal mental health. The "Other" ethnic group includes the Chinese ethnic group. SMI and depression may be either newly diagnosed or a pre-existing condition.
Data source: GP/SUS. The GP/SUS data extract analysed for this JSNA covers women aged 15-44.

More women in perinatal period with depression from Black & Asian ethnic groups are in most deprived quintiles

Most women (62%) with SMI and depression were in the two most deprived quintiles.

In the least deprived quintile, White ethnic group has highest proportion of women with depression (68%) which is 16% lower in the most deprived quintile.

The reverse is observed for the Black and Asian ethnic groups which have a larger proportion of women with depression in the most deprived IMD quintiles and a smaller proportion of women with depression in the least deprived quintiles.

Figure 14. Number and percentage of women with postnatal depression by deprivation and ethnicity, Camden registered patients, FY 2020-2024

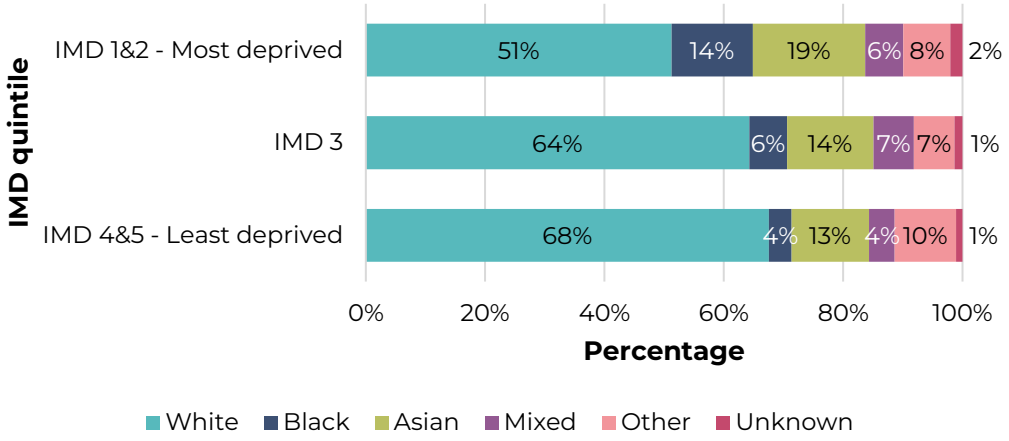
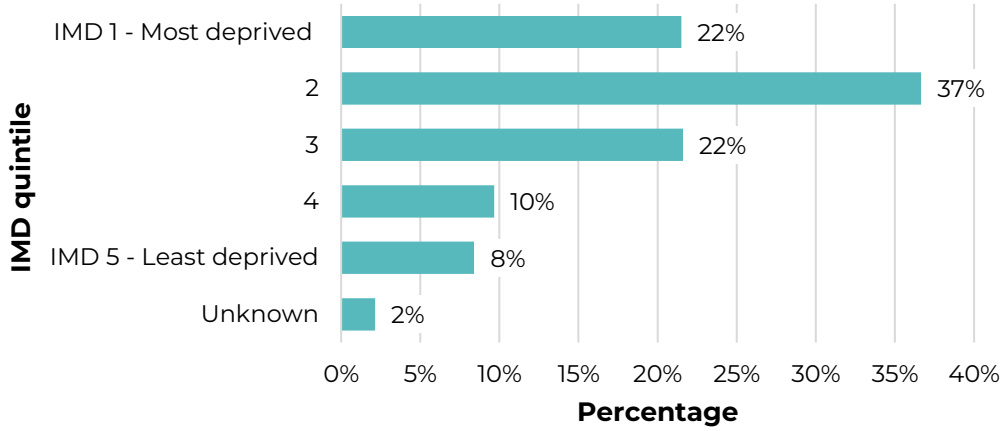


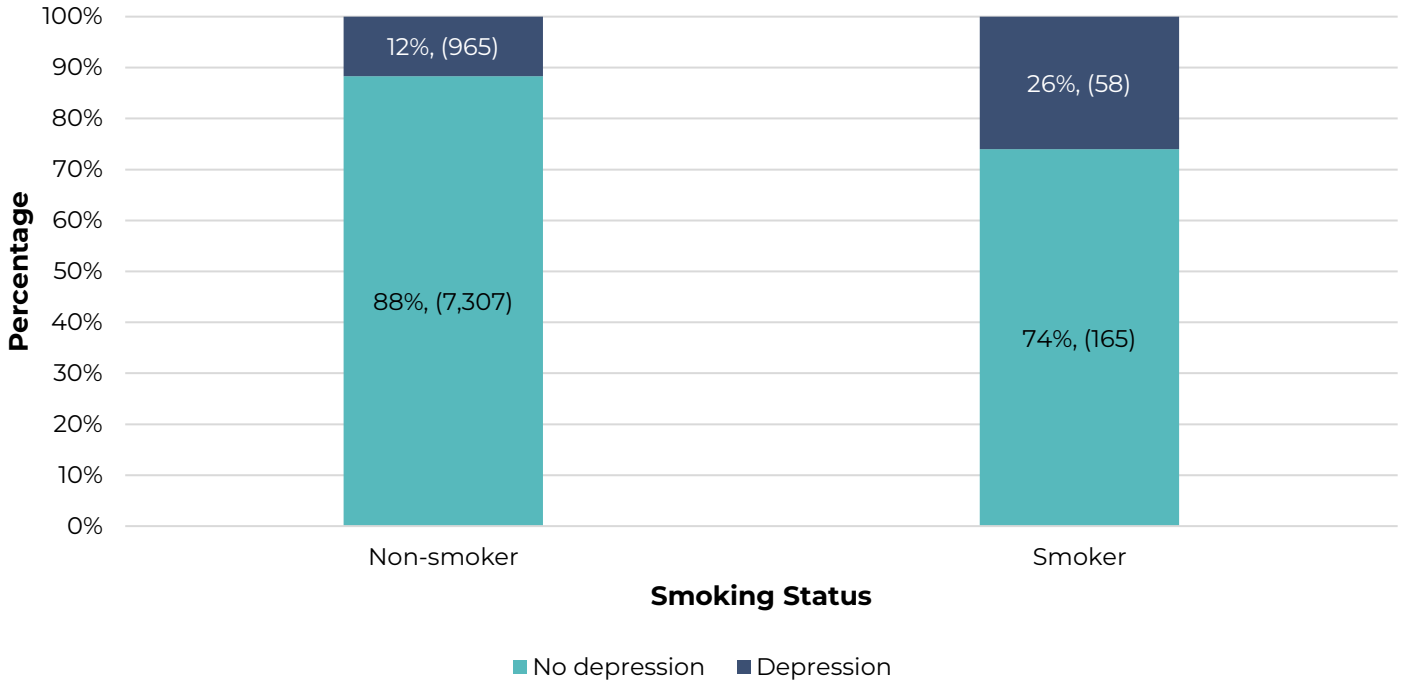
Figure 15. Number and percentage of women with postnatal depression by deprivation, Camden registered patients, FY 2020-2024



Data source: GP/SUS. The GP/SUS data extract analysed for this JSNA covers women aged 15-44.
Note: SMI and depression may be either newly diagnosed or a pre-existing condition. Women with an unknown IMD quintile were not included within the analysis for anxiety due to low numbers. IMD quintiles 1&2 and 4&5 were aggregated for anxiety due to low numbers. SMI and depression may be either newly diagnosed or a pre-existing condition.

Depression is twice as commonly recorded for women in the perinatal period who smoke vs non-smokers

Figure 16. Number and percentage of women with postnatal depression by smoking status, Camden registered patients, FY 2020-2024



The prevalence of depression for women in the perinatal period who smoke is double that compared to women who do not smoke (26% vs 12%, respectively).

These findings must be interpreted with caution given the relatively small sample size of data recorded for smoking.

Data source: GP/SUS. The GP/SUS data extract analysed for this JSNA covers women aged 15-44.
Note: SMI and depression may be either newly diagnosed or a pre-existing condition.

Key findings - Maternity Services Dataset

The **Maternity Services Data Set (MSDS)** is a patient-level dataset that captures information about activity carried out by Maternity Services relating to a mother and baby(s), from the point of the first booking appointment until mother and baby(s) are discharged from maternity services. Data extracted include referrals, antenatal screening, complex social factors, support and employment data however there was a high level of missing data.

- Recording of mental health screening on MSDS has returned to pre-pandemic levels, however due to substantial missing data (approximately 40% between 2020-2022), it is not possible to conclude accurately if screening has increased over the 2019-2023 period. In 2023, the size of the cohort was **2,781** patients, and there was **20% missing data** in this year. Due to lack of data, these findings must not be interpreted as a standalone but triangulated with learning from across the report.
- Between 2019 and 2023, the proportion of women recorded as having **received antenatal mental health screening in Camden has increased from 40% to 50%, yet given missing data** we cannot ascertain if this improvement is due to better recording of screening or increased frequency of screening.
- Of those with recorded data, **a higher proportion of women in the most deprived quintile were screened for mental health** issues during the antenatal period compared to those in the least deprived quintile.
- Among women with a recorded mental health screen (80%), Pakistani, Irish, Mixed, Indian and Bangladeshi families were more likely to have one recorded.
- The proportion of women with recorded 'complex social factors' was low and remained relatively stable between 2019 and 2023 (around 13-14%) and was more an indication that practice to record this was either not consistent or not consistently uploaded to MSDS (may be linked to use of paper records as informed in midwife interviews). Complex social factors are identified at the Booking Appointment and includes substance misuse, domestic violence, recent migration and young maternal age (below 20 years).
- Most women received support from their partner, family or friends during pregnancy and after birth. This was also corroborated from the focus group discussion with fathers who saw their role as mainly being supportive to their partners and also saw cultural factors playing their role.

Key findings - Health Visiting Dataset, Parents Matter (Family Lives)

Data across three timepoints (December 2023, March 2024 and June 2024) was collected and analysed manually by the Lead **Health Visitor** from System One.

- Across these 3 months, 401 (95.2%) of 421 eligible woman received a postnatal review
- 52 (13.0%) of those that received a review were identified following screening as having a mental health need
- 41 (10.2%) were identified with a new mental health need while 11 (2.7%) were identified as having pre-existing mental health need
- This figure of 10.2% is below modelled estimates for Camden of 23.8% and may suggest that validated screening tools for mental health are not proving comprehensive at identifying all mental health need, with likely unidentified and unmet mental health needs.
- 1 in 5 of the woman identified with mental health need at the 6-8 week review, were already known to specialist PMH.

Parents Matter offers universal perinatal support service for Camden parents across the perinatal period. To address issues of isolation and early signs of poor mental health, the service leverages the Family Hubs network to help parents socialise and engage in group sessions and peer support groups.

- Across antenatal and perinatal services, 294 individuals received information and guidance, of which 223 received more intensive support i.e., engaged in 2+ contacts with the service. All parents showed improvements in at least 1 improvement area.

- Across perinatal and antenatal services, 63 parents attended and engaged in Parents Matter Group sessions covering a range of topics and activities i.e. signs of anti-natal and post-natal depression delivered by Camden Public Health colleagues; understanding your baby; father led groups; community-based sessions for parents with English as second language.

Of the 80% of women with a screening record in 2023 at booking, 3 in 5 had a recorded antenatal mental health screen on MSDS

Figure 17. Proportion of antenatal mental health screening as recorded on MSDS, Camden, 2019-2023

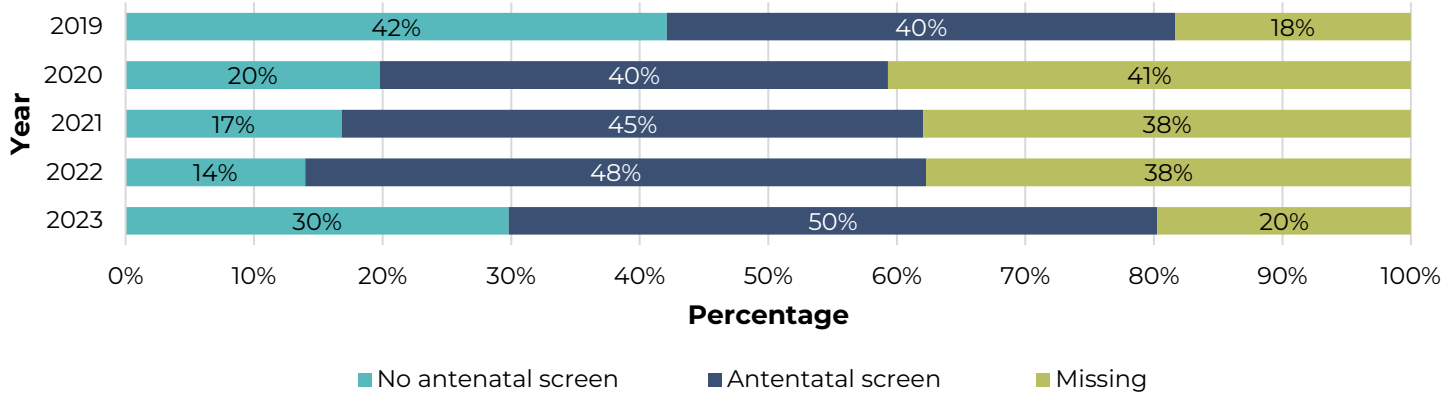


Table 3. Antenatal mental health screening as recorded on MSDS, Camden 2023 figures

Total with records of screening: 2,232 (80%), of which:	Antenatally screened	1,403 (63%)
	No screening	829 (37%)
Total missing records	549 (20%)	

- Antenatal screening is an opportunity to preventatively predict future mental health problems among mothers and direct those showing signs of mental ill-health to services.
- The proportion of women who were recorded as having an antenatal screening on MSDS increased by 10% between 2019 and 2023, rising from 40% to 50%.
- Between 2019 and 2022 the proportion of women recorded as having no antenatal screen decreased by 28%, and the proportion of missing data increased by 20%.
- In 2023, of those with screening recorded, 63% (3 in 5) received antenatal screening.
- The interpretation of this finding is complicated by the fact that 20% of data was missing, and it was unclear if mental health screen were not being recorded or not undertaken.

Data Source:: MSDS.
Note: Bottom chart does not include patients with missing data

.

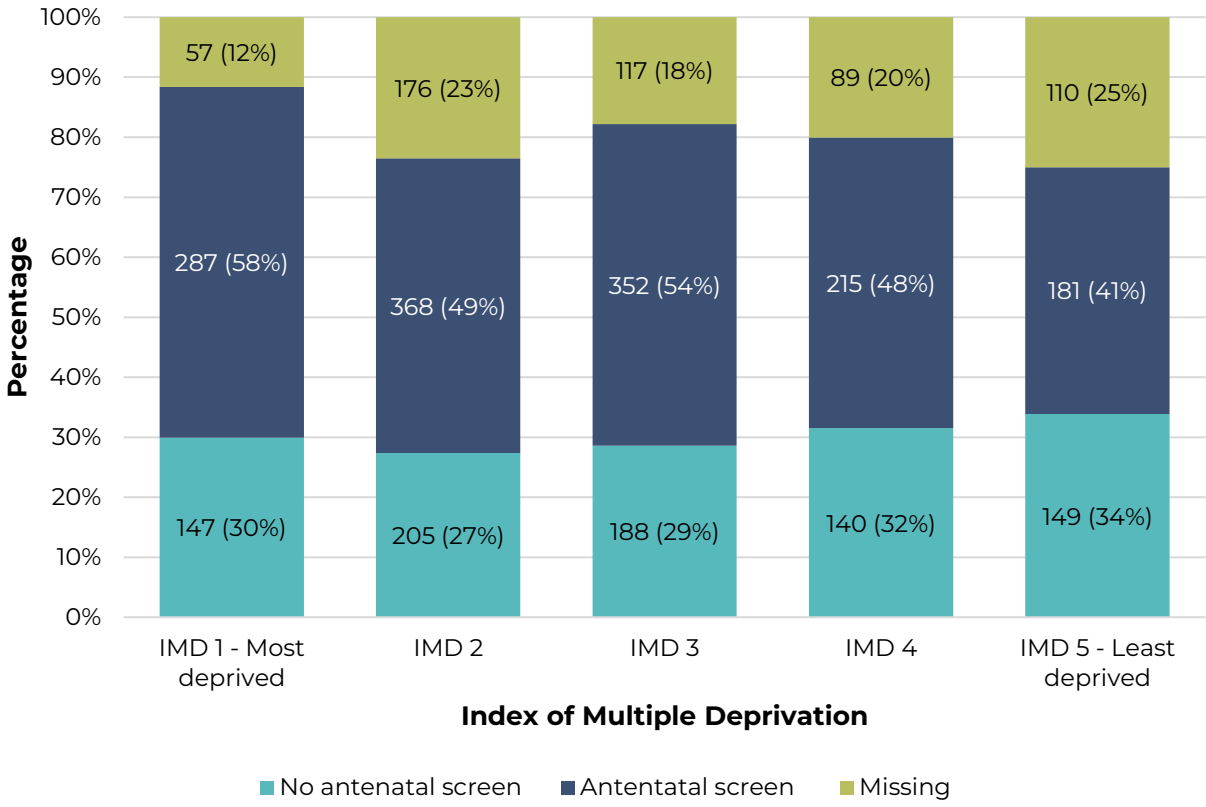
For those recorded as screened, antenatal mental health screening was highest among women living in the most deprived quintile

Table 4. Antenatal mental health screening by IMD, Camden 2023

	Not screened	Screened antenatally
IMD 1 - Most deprived	147 (34%)	287 (66%)
IMD 2	205 (36%)	368 (64%)
IMD 3	188 (35%)	352 (65%)
IMD 4	140 (39%)	215 (61%)
IMD 5 - Least deprived	149 (45%)	181 (55%)
Total	829	1403
Total with records of screening	2,232 (80%)	
Total missing screening records	549 (20%)	

- Of the total of 2,781 women in the MSDS records for 2023, a total of 829 women did not receive an antenatal mental health screen, while 1,403 did. There is missing data for 549 women.
- Of the 2,232 women with records, on average 65% of women in the top 3 deprived quintiles were screened antenatally for mental health issues, while 55% of women in the least deprived quintile were screened.

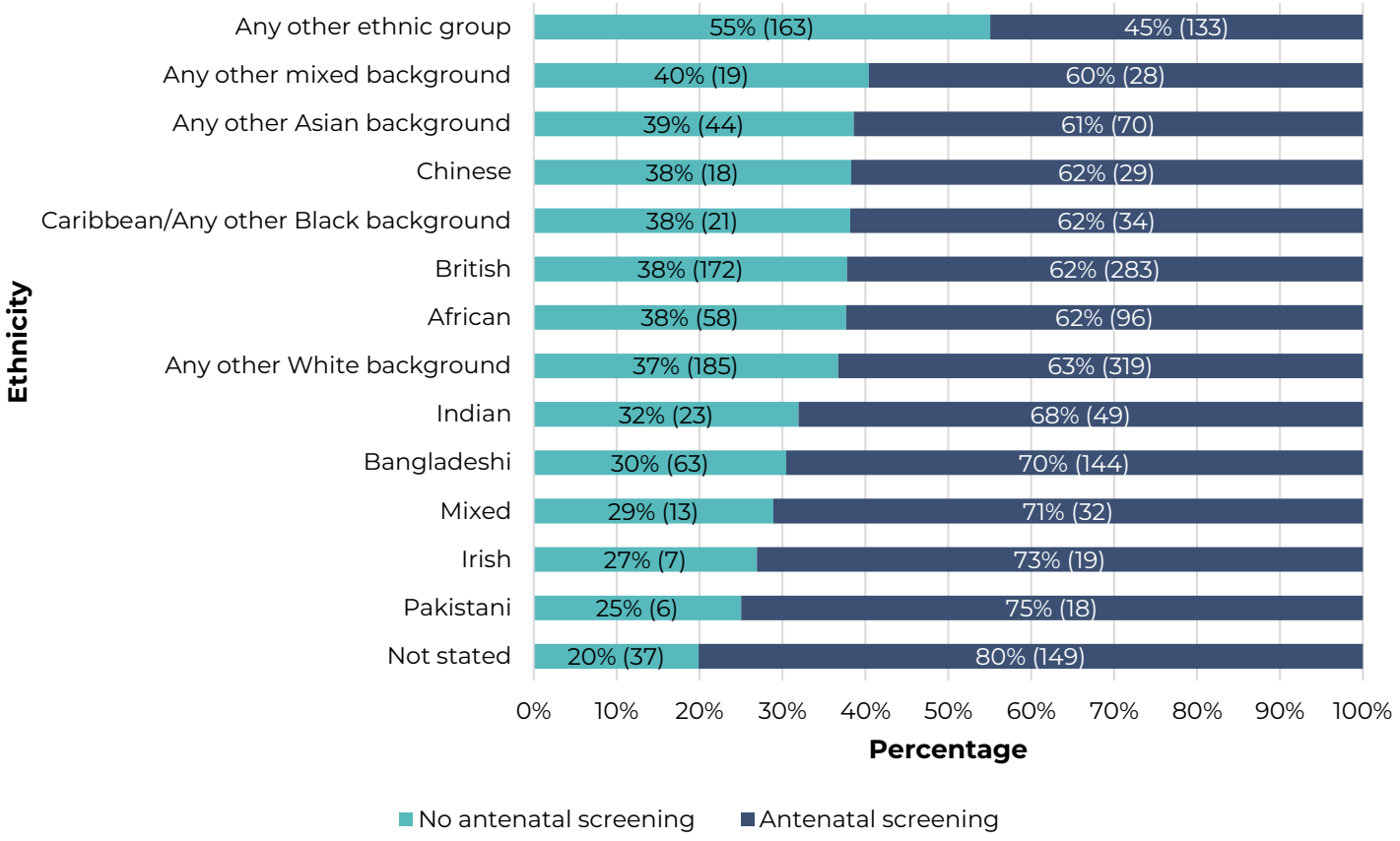
Figure 18. Proportion of mothers screened for mental health in the antenatal period by IMD, Camden, 2019-2023



Data source:: MSDS
Note: Some ethnic groups have been aggregated due to low numbers. Mixed ethnic group includes White and Asian, White and Black African, and White and Black Caribbean.

Among women with a recorded mental health screen (80%), Pakistani, Irish, Mixed, Indian and Bangladeshi families were overrepresented

Figure 19. Proportion of antenatal mental health screening by ethnic group, Camden, 2023

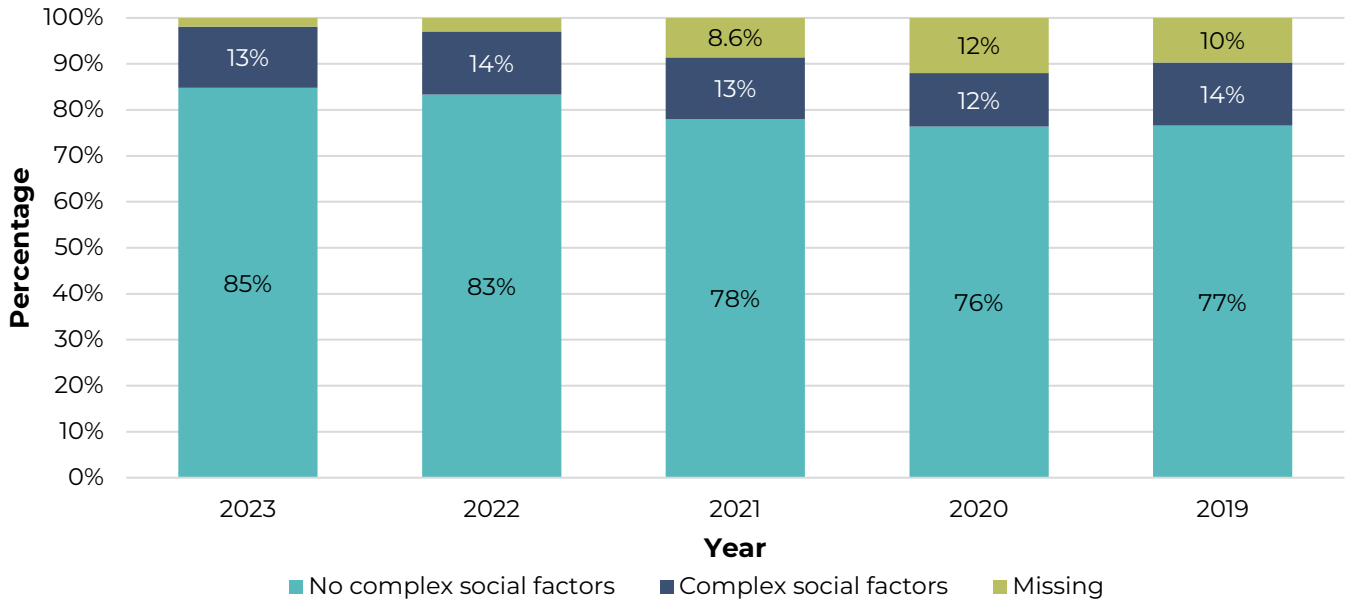


- Of the 2,232 women who had a recorded mental health screen, the highest proportion of women who received an antenatal mental health (80%) screen did not have their ethnicity recorded. This graph must be interpreted with caution to the numbers as the proportions can be misleading.
- Of the groups that have some data, women from the Bangladeshi background (70%). This may reflect a targeted approach in healthcare services, prioritising screening in ethnic groups known to be at higher risk of mental health issues or experiencing more frequent healthcare touchpoints due to socio-economic or cultural factors.
- Women from the Any other ethnic group category had the highest proportion of no antenatal screening (55%). This could possible language barriers or cultural factors that reduce engagement with MSDS services.
- Women from the Indian ethnic group had the highest proportion of missing data for antenatal screening status (33%). This may be due to certain healthcare providers serving a larger Indian population having inconsistent documentation practices or being under-resourced, leading to higher rates of missing data.

Data source: MSDS
Note: Count of screenings are in brackets. Some ethnic groups have been aggregated due to low numbers. Mixed ethnic group includes White and Asian, White and Black African, and White and Black Caribbean.

In 2023, 13% of women were recorded as having ‘complex social factors at booking’

Figure 20. Proportion of women in MSDS with complex social factors, Camden, 2019-2023



- The majority of women accessing MSDS services do not have complex social factors recorded (85% in 2023).
- Complex social factors are identified at the Booking Appointment and includes substance misuse, domestic violence, recent migration and young maternal age (below 20 years), as defined by NICE guidance (CG110).
- The proportion of women with complex social factors remained relatively stable between 2019 and 2023 (around 13-14%).
- The proportion of women with missing data regarding complex social factors decreased significantly, from 10% in 2019 to 1.9% in 2023, likely reflecting improvements in data collection and reporting.

Some reasons as to why this figure is likely to be an underestimate:

- Standardised social risk factor screening tools like MatDAT have been developed but are yet to be widely implemented. This translates to issues not being identified and/or recorded.
- Midwifery continuity of care is associated with more comfort to disclose sensitive information but implementing this remains a challenge.

Data source: MSDS
Note: Complex social factors are identified at the Booking Appointment and includes substance misuse, domestic violence, recent migration and young maternal age (below 20 years), as defined by NICE guidance (CG110).

13% of women on average are identified with a mental health need at the 6-8 week postnatal review with Health Visitors

Table 5. Data points across 3 months were extracted from the health visiting dataset

	Number of clients eligible for postnatal review	No. of clients completed postnatal review i.e., those screened	No. clients with 'new' MH needs (%)	No. clients with 'known' MH needs in antenatal period	Total no. clients with MH needs of those completing review
Dec-23	153	153 (100%)	14 (9.2%)	<5 (3.2%)	19 (12%)
Mar-24	116	109 (93%)	13 (12%)	<5 (2.8%)	16 (14%)
Jun-24	152	139 (91%)	14 (10%)	<5 (2.2%)	17 (12%)
Total	421	401 (95%)	41 (10%)	11 (2.7%)	52 (13%)

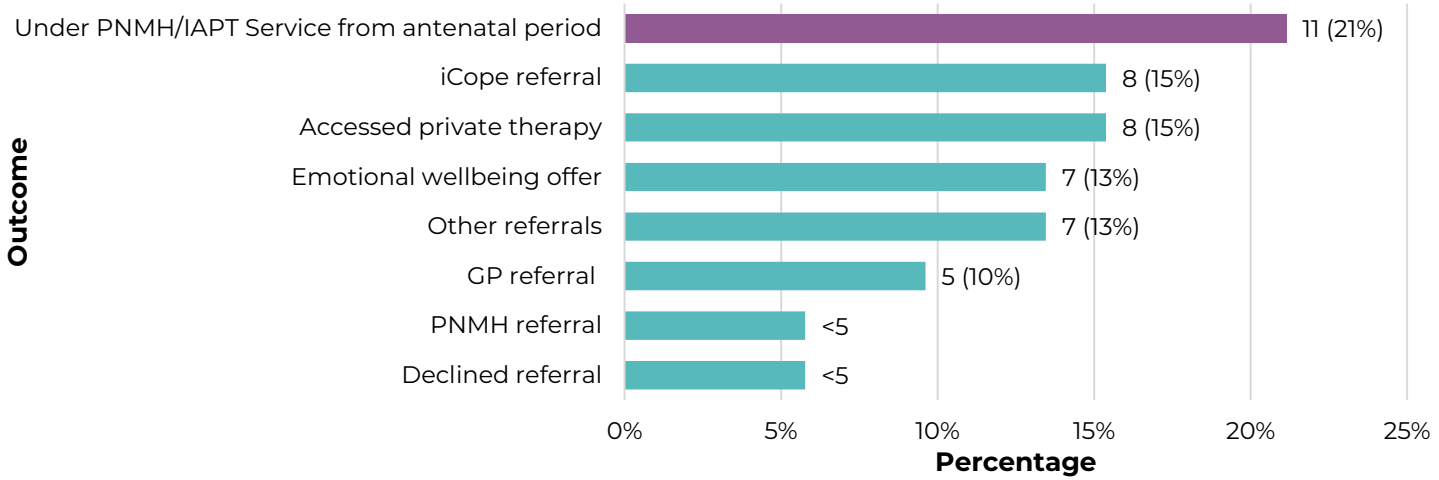
Three months of data was collected and analysed manually by the lead heath visitor from their recording software on system one

- Across these 3 months, 401 (95.2%) or 421 eligible woman received a postnatal review
- 52 (13.0%) of those that received a review were identified following screening as having a mental health need
- 41 (10.2%) were identified with a new mental health need while 11 (2.7%) were identified as having pre-existing mental health needs
- This figure of 13.0% is below modelled estimates for Camden of 23.8% and may suggest that screening tools for mental health may not be proving effective at identifying all expected mental health need

Data source: Health Visiting dataset
Note: The postnatal review is taken 6-8 weeks after birth. There is no standard definition for 'low mood'; the interpretation is left to the discretion of the GP when inputting the code. "Other referrals" include CAHMS, Crisis team and GP, housing referral and emotional wellbeing offer, IAPT referral, Maple service referral and Royal Free Counselling service (midwife referral). Data is aggregated for three time-points : December 2023, March 2024, and June 2024. Caution should be taken when interpreting the data due to data only being available in 3-month time intervals.

1 in 5 of the woman identified with mental health need at the 6-8 week review, were already under perinatal mental health care antenatally

Figure 21. Number and proportion of women with mental health need identified at postnatal review at 6-8 weeks, by outcome, Camden, 2023/24*

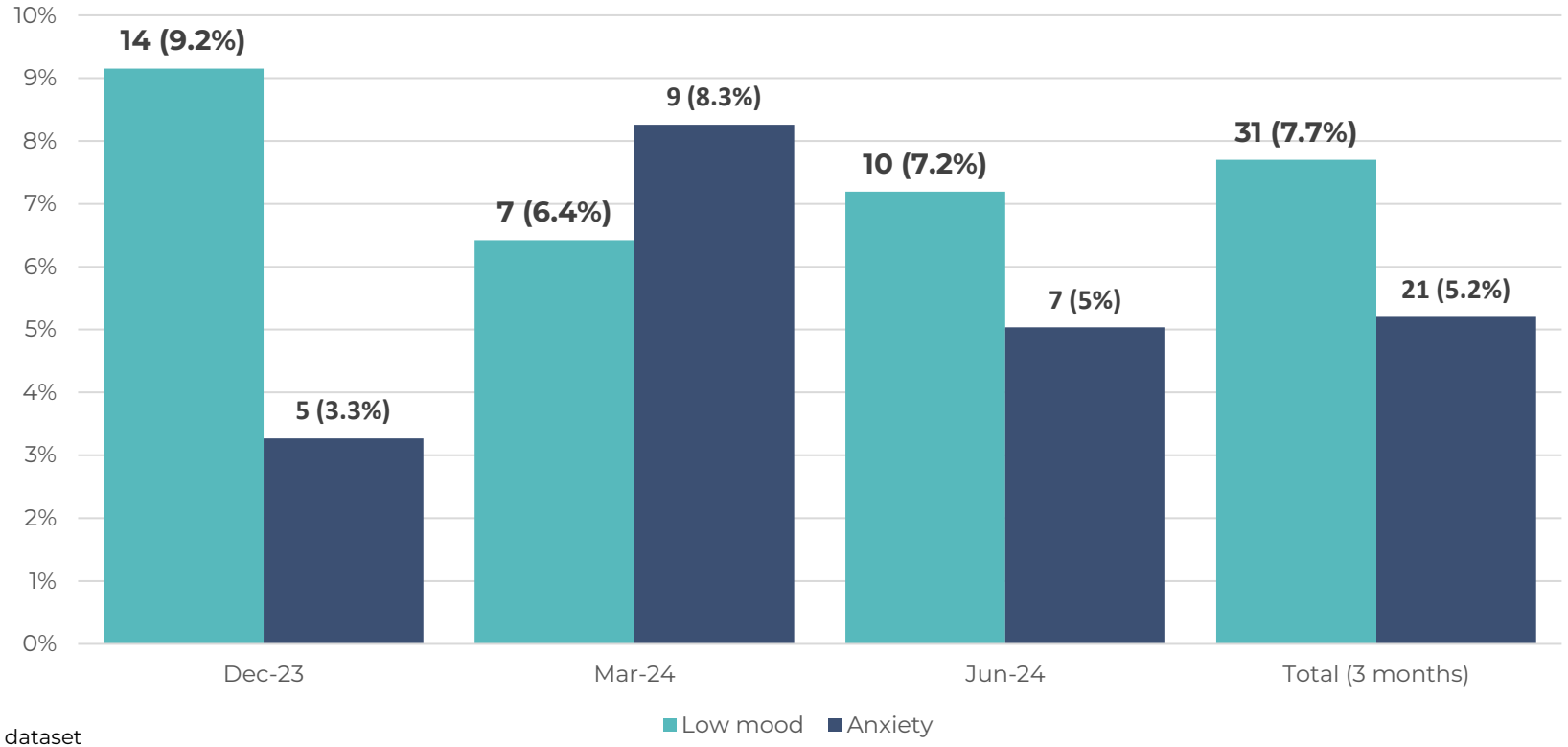


- Of the 52 women with mental health needs identified at the 6-8 week postnatal review, 21% were under specialist PMH services from the antenatal period.
- The second most common outcome for these women was referral to Camden NHS Talking Therapies , and accessing private therapy, followed by receiving emotional wellbeing offer and being referred to other services.

Data source: Health Visiting dataset
Note: The postnatal review is taken 6-8 weeks after birth. There is no standard definition for 'low mood'; the interpretation is left to the discretion of the GP when inputting the code. "Other referrals" include CAHMS, Crisis team and GP, housing referral and emotional wellbeing offer, IAPT referral, Maple service referral and Royal Free Counselling service (midwife referral). Data is aggregated for three time-points : December 2023, March 2024, and June 2024.
Caveat: Caution should be taken when interpreting the data due to data only being available in 3-month time intervals.
*iCope = Camden NHS Talking Therapies

Of the women who completed a postnatal review at 6-8 weeks, approximately 7% of women expressed low mood and 5% were identified with anxiety

Figure 22. Prevalence of perinatal mental health needs (anxiety and low mood) among women who completed a postnatal review at 6-8 weeks in Camden, 2023/24



Data source: Health Visiting dataset
Note: The postnatal review is taken 6-8 weeks after birth. There is no standard definition for 'low mood'; the interpretation is left to the discretion of the GP when inputting the code. "Other referrals" include CAHMS, Crisis team and GP, housing referral and emotional wellbeing offer, IAPT referral, Maple service referral and Royal Free Counselling service (midwife referral). Data is aggregated for three time-points : December 2023, March 2024, and June 2024.
Caveat: Caution should be taken when interpreting the data due to data only being available in 3-month time intervals and low numbers.
Note: The PNMH issues specified within the dataset were low mood and anxiety only.

PMH Services
Access and Utilisation

Camden

Key findings - services

In this section, we present data from three of the most commonly used services for PMH support. These services sit within the **Amber** and **Red** pathways, i.e. addressing patients with mild-moderate and severe perinatal mental health issues, respectively.

1. Whole family team with perinatal specialism

Analysis of the data for the following services was undertaken to help understand service usage: referral rates into the services, and whether any groups are being over or underrepresented, as well as treatment outcomes.

The three services examined and described earlier are

1. Camden NHS Talking Therapies (IAPT)
2. Maple Service
3. Specialist Perinatal Mental Health (SPMH)

Key findings – WFT-P and GP/SUS

Findings – Whole Family Team with Perinatal Specialism (WFT-P)

- The WFT-P team offers both targeted and specialised perinatal parent-infant relationship support, alongside catering to the needs of the wider family system. They also work closely with adult mental health services, including SPMHS and NHS Talking Therapies.
- 2,018 appointments were offered in the year 2023/24.
- Common referral reasons include traumatic experiences, difficulty with transitioning into parenthood, antenatal and postnatal low mood, conflict and relationship difficulties

Findings from GP/SUS dataset

- GP data for the 12 weeks post birth indicates Camden NHS Talking Therapies referrals during this time decreases with increasing age
- Camden NHS Talking Therapies referral rates (by GPs) are highest in the more deprived quintiles.
- The Asian ethnic group follows the mixed, Other/unknown and white ethnic groups in terms of highest Camden NHS Talking Therapies referral rates.

Key findings – Camden NHS Talking Therapies (IAPT equivalent in Camden)

Findings from NHS Talking Therapies

- Camden NHS Talking Therapies, offers free and confidential support for conditions like anxiety, depression and other mental health conditions. Between 2020/21-2021/22 a 35% increase was observed in the number of referrals of expectant parents or parents of children up to 1 year of age. The number of referrals decreased between 2021/22 and 2023/24 to levels below that of 2020/21. All following findings refer to parents in the perinatal period only:
- Camden NHS Talking Therapies referrals fell by 40% from 2021/22 to 2023/24. While self-referrals make up the majority, primary care referrals have risen
- About 60% of the referrals into the service have incomplete information or deemed inappropriate for intervention
- Camden NHS Talking Therapies referrals have declined for both women and men since 2021/23, with the higher proportion of referrals being made for women <34 years
- A higher proportion of women from white ethnic groups are referred into the service compared to global majority groups although referrals for Bangladeshi women have increased by 6.5% in the last 3 years.
- The proportion of referrals to Camden NHS Talking Therapies for unemployed people increased by 6% in the last 3 years, even after accounting for missing employment status.
- In 2023/24, 14% of Camden NHS Talking Therapies referrals were recorded as completed, with 36% not assessed.
- The target of 50% of patients reaching recovery has been met over the past few years. In 2024/25, recovery status for 76% of referrals was unable to be captured.
- An NHS Talking Therapy toolkit has been developed to encourage specific ethnic groups to engage with the service.

Parents Matter (Family Lives) supported 294 parents across the perinatal period in 24/25, with all parents showing improvement in at least 1 outcome area

Table 6. Number of individuals accessing Parent Matters services, 2024-25

	Referrals to Parents Matter Individuals (families)	Individuals receiving support (3-8 contacts with service)	Overall number of individuals informed about Parents matter and community services (Raising awareness)**
Perinatal	95 (68)	139	172
Antenatal	78 (63)	94*	122
Total	173 (131)	223	294

*10 of the 94 in antenatal went into perinatal service as ongoing support after birth.
**This includes support in the form of one to ones, drop ins, outreach or via phone/email etc

Table 7. Number of individuals accessing Parents Matter services, by ethnicity, 2024-25

	Antenatal	Perinatal	Total
Asian	21	34	55
Black	3	8	11
Mixed	<5	<5	<5
Other/Unknown	44	46	90
White	9	<5	13
Grand total			173

- In **24/25** the service received overall **131** referrals from families and **294** parents engaged overall in contacts with Parents Matter staff on a range of issues specific to the perinatal phase and received information about services that can support them.
- Across antenatal and perinatal services, 294 individuals received information and guidance, of which 223 received more intensive support i.e., engaged in 2+ contacts with the service.
- From the 294 individuals receiving some form of support, there appears to be more engagement with the perinatal service than antenatal (60% vs 40%), highlighting a greater need for connection and support during the postpartum phase.
- Across perinatal and antenatal services, **63** parents attended and engaged in **Parents Matter Group sessions** covering a range of topics and activities i.e. signs of anti-natal and post-natal depression delivered by Camden Public Health colleagues; understanding your baby; father led groups; community-based sessions for parents with English as second language.
- **Outcomes for the antenatal support service**: Based on reflections of 21 parents engaging with the service, the key areas of improvement that were self-reported are confidence in looking after your baby, mental and emotional health, housing essentials and support networks.*
- **Outcomes for the perinatal support service:** Based on reflections of 27 parents engaging with the service, the key areas of improvement that were self-reported are mental and emotional health, support network, physical health and housing essentials.*
- Of the Asian ethnic group engaging with Parents Matter, the highest proportion of engagement was seen in the Bangladeshi community.

Data Source: Family Lives
*The review of progress with parents is still ongoing, due to which the outcomes data is based on experiences of 27 and 21 parents for perinatal and antenatal service, respectively.

Whole Family Team with Perinatal Specialism, WFT-P

Table 8. Number of individuals accessing WFT-P services, by ethnicity, 23/24.

Number of appointments offered in the year 2023/24: **2,018**

Ethnic groups	Counts
White	34
Asian	9
Black	8
Mixed	12
Other	9
Unknown	5
Refused	<5
Total	**78**

Data source: WFT-P

WFT-P is both a targeted (for group interventions such as Circle Of Security and Together Time – see slide 23) service (**Amber pathway)** as well as a specialist service (**Red pathway**) for interventions focused on the PIR. The Whole Family Team with **perinatal** specialism provides **psychological** support for mums, dads, and carers with **children up to 5 years old**. They are a highly specialist service offering psychological and psychotherapy therapy to families during **pregnancy** and **with babies, toddlers and children up to the age of 5 years.**

To address any barriers to accessing services, particularly during the perinatal period, the service takes on a flexible and outreach approach with the aim of facilitating engagement with their team. They are co-located in the Family Hubs across Camden and offer consultation and support to other professional working with the Integrated Early Years Service.

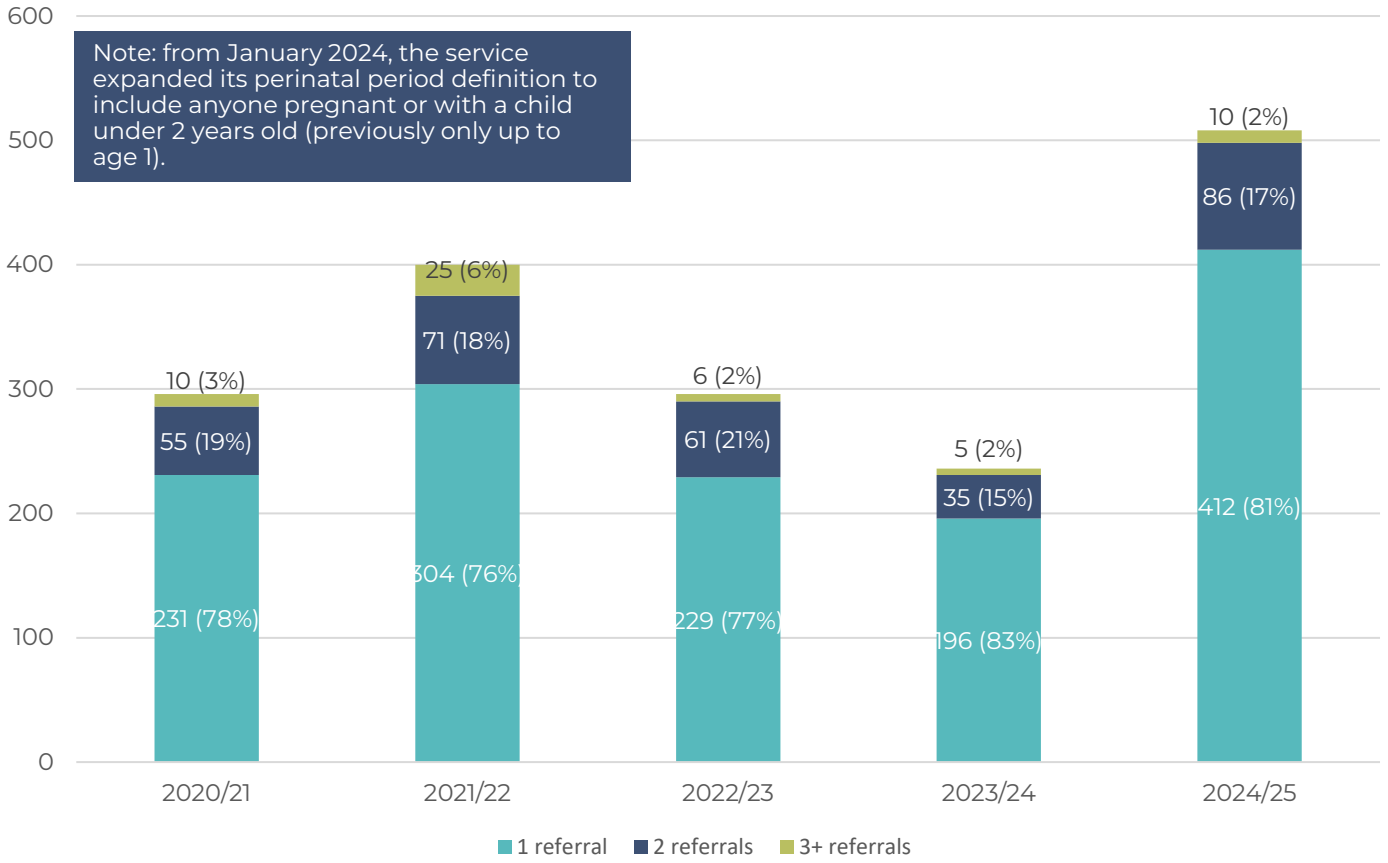
They support a wide range of need, ranging from mild adjustment difficulties to high level child protection concerns. They also offer extensive 'risk support' for complex cases where there are significant concerns for the infant. The service has a wide remit to work from adjustment to parenthood to edge of care.

Common referral reasons include:

- Babies/young children and their carers who have had difficult or traumatic experiences
- Parents/carers who struggle with the transition to parenthood
- Parents/carers who experience antenatal or postnatal low mood, stress or anxiety, or experienced trauma where this is having an impact on their parenting or relationship with their child.
- Parents/Carers who are experiencing difficulty mentalising for their child
- Parents/carers who are in conflict and experience relationship difficulties
- Parent/carers who are concerned about aspects of their child's behaviour or emotions
- Parents who have had complex life experiences that may affect how they relate to their baby
- Parents who experienced difficulties during pregnancy or birth where this is impacting on their parenting or relationship with their baby.

Camden NHS Talking Therapies referrals fell by 40% from 2021/22 to 2023/24. While self-referrals make up the majority, primary care referrals have risen

Figure 21. Number and proportion of referrals per person for parents and expectant parents of children under 1 years or 2 referred to Camden NHS Talking Therapies, Camden, FY 2020/21-2024/25

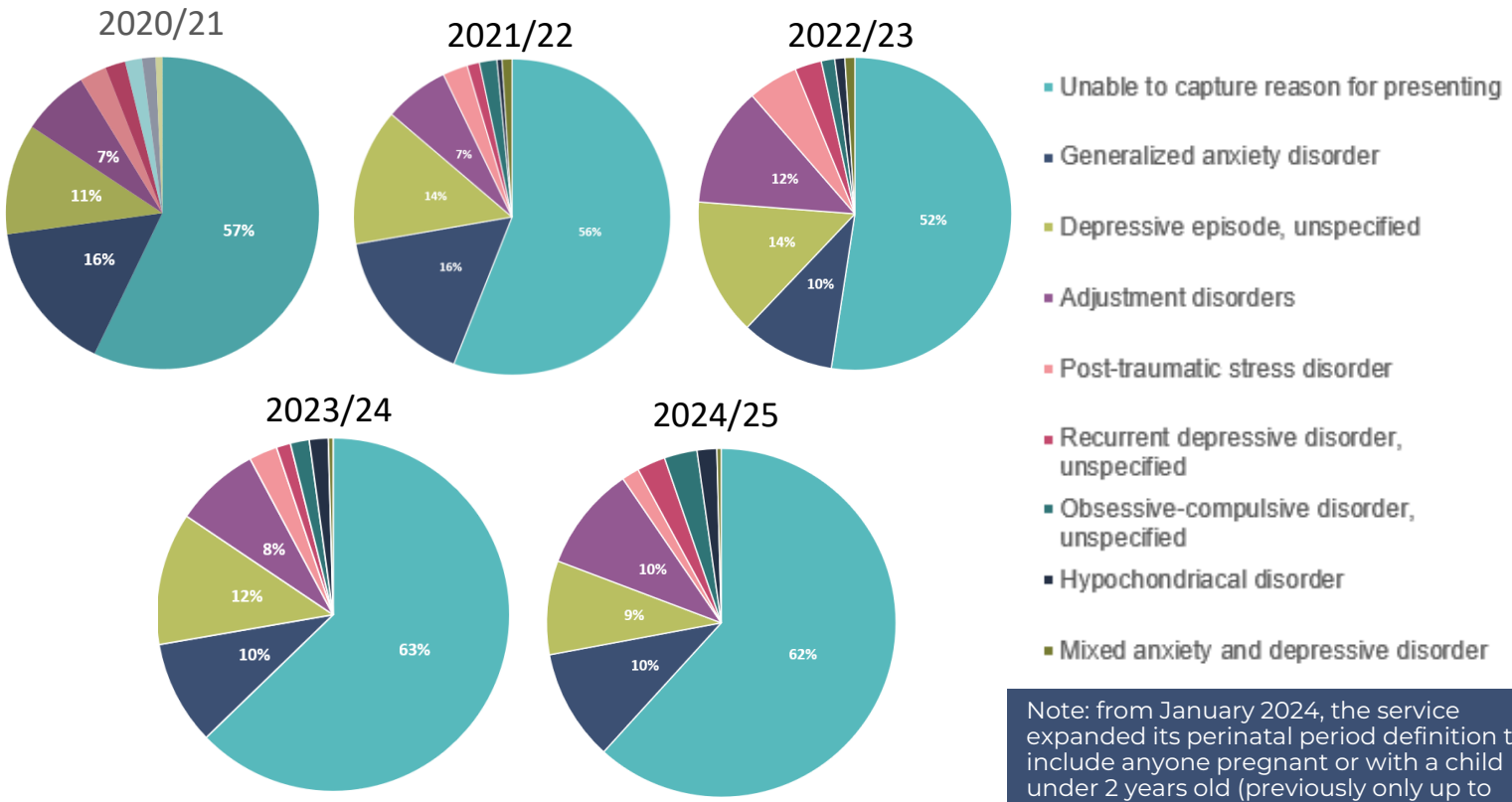


- Post COVID years, the number of referrals decreased between 2021/22 and 2023/24 to levels below that of 2020/21. The substantial increase noted in 2024/25 was due to expansion of eligibility criteria for the service to include those in the perinatal period up to 2 years post birth
- The number and proportion of people who had more than three referrals to Camden NHS Talking Therapies also doubled between 2020/21 and 2021/22 from 10 (3%) to 25 (6%).
- The proportion of self-referrals to Camden NHS Talking Therapies have reduced by 12% between 2020/21 and 2023/24. The self-referral data is confounded by how many are true self-referrals versus those prompted by a healthcare professional, like a GP, advising the patient to self-refer after discussing their mental health.
- On the contrary, referrals by other primary health care services have increased by 15% between 2020/21 and 2023/24. Other referral sources have remained relatively stable over time.
- Reasons for more than 1 referral (Service lead insight): multiple referrals often occur when an initial referral is closed due to no response or opt-in from the family. If the family later re-engages, a new referral is opened rather than reopening the old one - resulting in what appears as a repeat referral within the reporting period. These are typically due to interrupted or delayed engagement, not separate care needs.

Data source: Camden NHS Talking Therapies
Note: Data includes the number of referrals of pregnant women or women with a child under 1. Data also includes those who identify as male and are partners of women who were pregnant or have a child under 1. This data also captures those identifying as male and are partners of men who have a child under 1 (e.g. via adoption/surrogacy)

About 60% of the referrals into the service have incomplete information or deemed inappropriate for intervention

Figure 22. Proportion of pregnant people or people with a child under one year referred to Camden NHS Talking Therapies services by presenting complaint in Camden



Note: from January 2024, the service expanded its perinatal period definition to include anyone pregnant or with a child under 2 years old (previously only up to age 1).

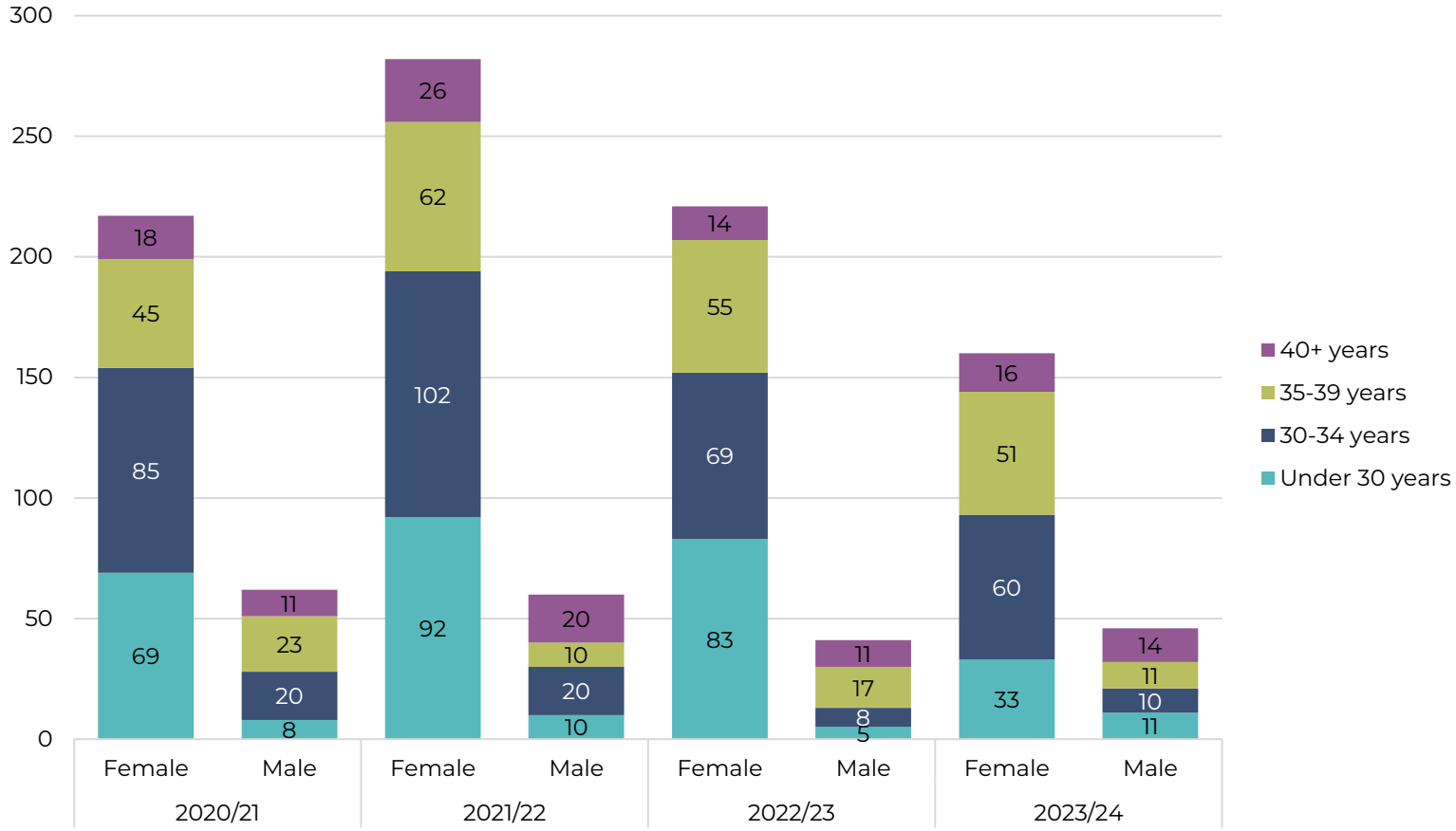
- The top three most prevalent presenting complaints were generalised anxiety disorder, depressive episode and adjustment disorder.
- About 60% of parents in the perinatal period being referred into the service lack recorded presenting complaint data. This data is only recorded after assessment, once treatment begins, as it reflects the focus of the intervention. This is in addition to the initial referral from the primary care professional which contain only brief notes about the patient's condition.
- Some reasons for why this data is not recorded:
  1. Several patients are never assessed as they are either signposted elsewhere or do not attend, so no presenting complaint is recorded.
  2. Additionally, a small percentage (~5%) is due to staff not entering the data, despite reminders.
  3. About a third of missing presenting complaint data is due to individuals being deemed unsuitable for primary care services and referred to secondary, specialist care, core teams or back to their GPs before assessment.
  4. Another significant portion includes those who were accepted for assessment but never took up the offer (did not book or attend). A smaller percentage is due to non-engagement without further action.

See appendix for further notes on inclusion/exclusion criteria.

Data source: Camden NHS Talking Therapies
Note: Data includes the number of referrals of pregnant women or women with a child under 1. Data also includes those who identify as male and are partners of women who were pregnant or have a child under 1. This data also captures those identifying as male and are partners of men who have a child under 1 (e.g. via adoption/surrogacy). The majority of the data is missing so caution needs to be taken when interpreting these results. Alcohol dependence, Agoraphobia, Social phobias, Specific phobias, Panic disorder, non-organic insomnia, and Disappearance or death of family member were excluded from this analysis.
Note: Only presenting complaints with a grand total of 10+ over the course of FY 2020/21 - 2023/24 were included. Missing data indicates that the data was not recorded. There are two reasons why this might happen: The person was never assessed or seen, so could not add a presenting complaint; or the clinician did not record the presenting complaint as they should have.

Camden NHS Talking Therapies referrals have declined for both women and men since 2021/23, with the higher proportion of referrals being made for women <34 years

Figure 23. Number of parents and expectant parents of children under 1 years referred to Camden NHS Talking Therapies by age and sex, Camden, 2020/21-2023/24

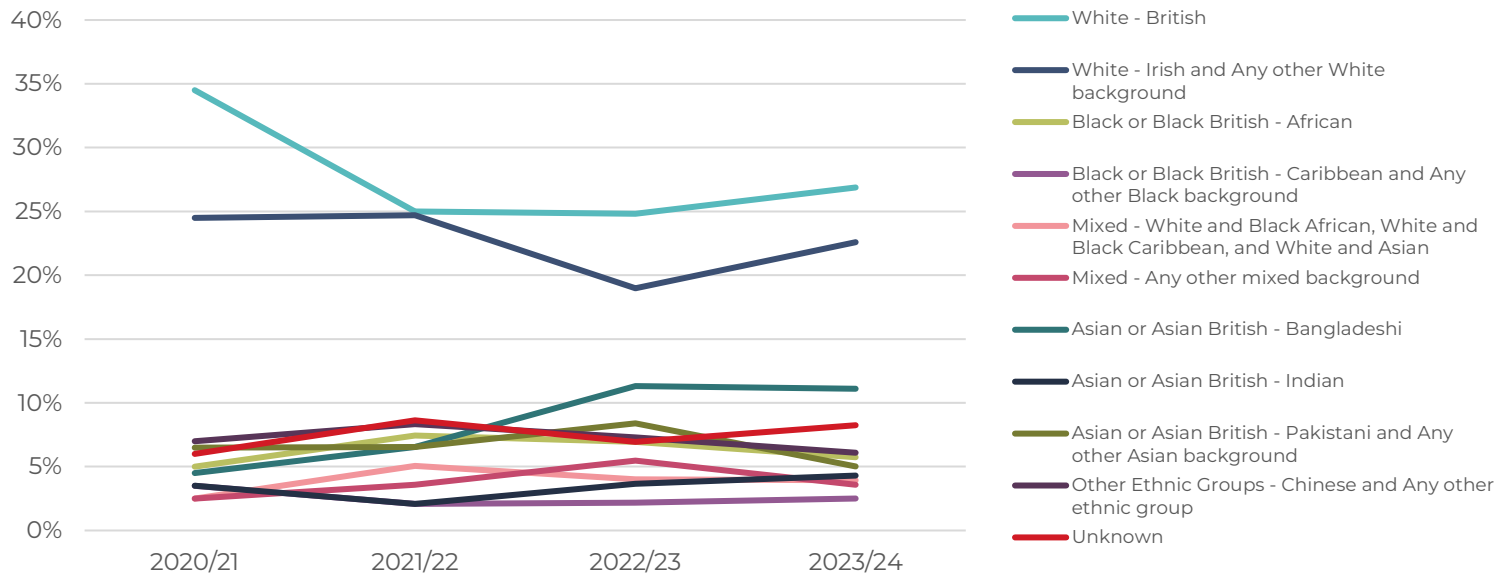


- The highest number of referrals were observed in 2021/22 (282 women and 60 men). The lowest number of referrals were observed in 2023/24 (160 women and 46 men).
- A higher proportion of women were referred to Camden NHS Talking Therapies between 2020/21 and 2023/24, the majority of which were under the age of 34 years. This is what would be expected due to the majority of live births occurring in this age group. Men are also known to be less likely to be referred for PMH.
- A substantial increase in referral numbers (see slide 73) was observed in 2024/25 as the criteria for use of the service was broadened to include those 2 years post birth.

Data source: Camden NHS Talking Therapies
Note: Data includes the number of referrals of pregnant women or women with a child under 1. Data also includes those who identify as male and are partners of women who were pregnant or have a child under 1. This data also captures those identifying as male and are partners of men who have a child under 1 (e.g. via adoption/surrogacy)

A higher proportion of women from white ethnic groups are referred into the service compared to global majority groups although referrals for Bangladeshi women have increased by 6.5% in the last 3 years

Figure 24. Proportion of parents and expectant parents of children under 1 years referred to Camden NHS Talking Therapies by ethnic group, Camden, FY 2020/21 to 2023/24

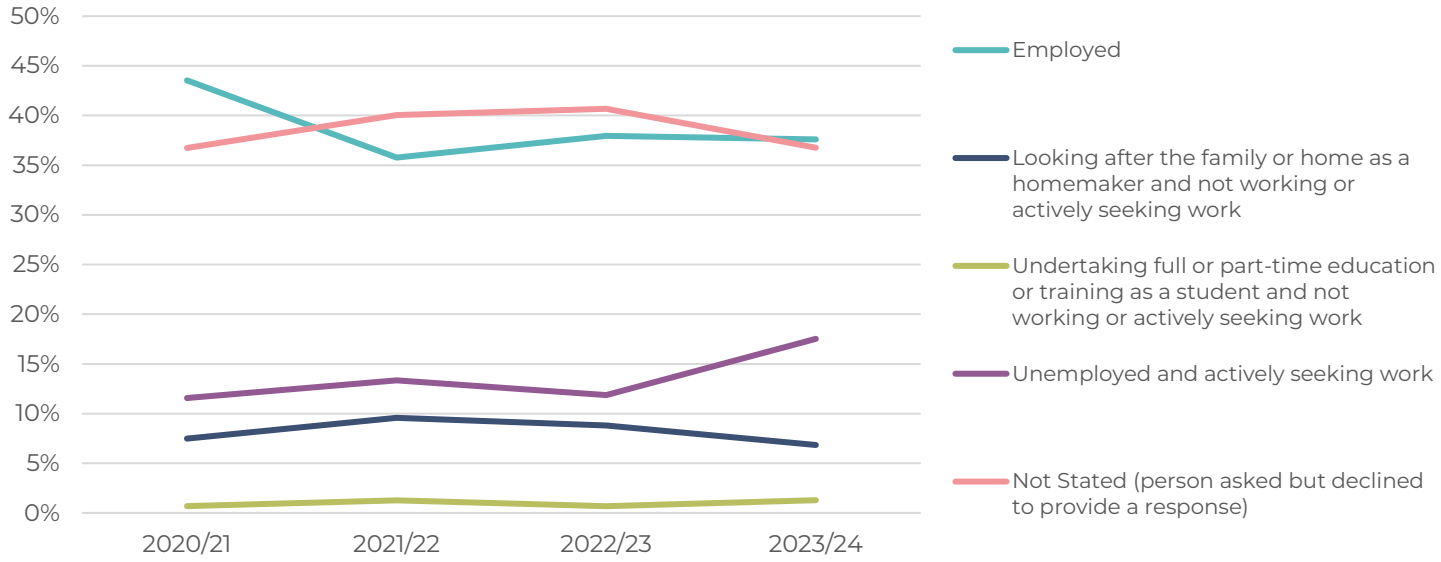


- The proportion of people referred to Camden NHS Talking Therapies from Bangladeshi ethnic group increased by 6.5% between 2020/21 and 2023/24.
- The proportion of people from White ethnic group referred to Camden NHS Talking Therapies decreased by 15% between 2020/21 and 2022/23, in contrast to Asian ethnic group which increased by 8% across this time period. The increase in proportion of people from Asian ethnic is likely driven by the increased referrals for people from the Bangladeshi population. This has been in response to outreach work done by the service with this community
- The proportion of people from all other ethnic groups referred to Camden NHS Talking Therapies remained relatively stable over time.

Data source: Camden NHS Talking Therapies
Note: Data includes the number of referrals of pregnant women or women with a child under 1. Data also includes those who identify as male and are partners of women who were pregnant or have a child under 1. This data also captures those identifying as male and are partners of men who have a child under 1 (e.g. via adoption/surrogacy)
Note: Unknown ethnic group includes "not stated", "not known" and "missing". Ethnic groups with a count of <5 for any given year have been supressed by combining them with another ethnic group.

The proportion of referrals to Camden NHS Talking Therapies for unemployed people increased by 6% in the last 3 years, even after accounting for missing employment status

Figure 25. Proportion of referrals for pregnant people or people with a child under one year referred to Camden NHS Talking Therapies services by employment status, Camden, FY 2020/21 - 2023/24

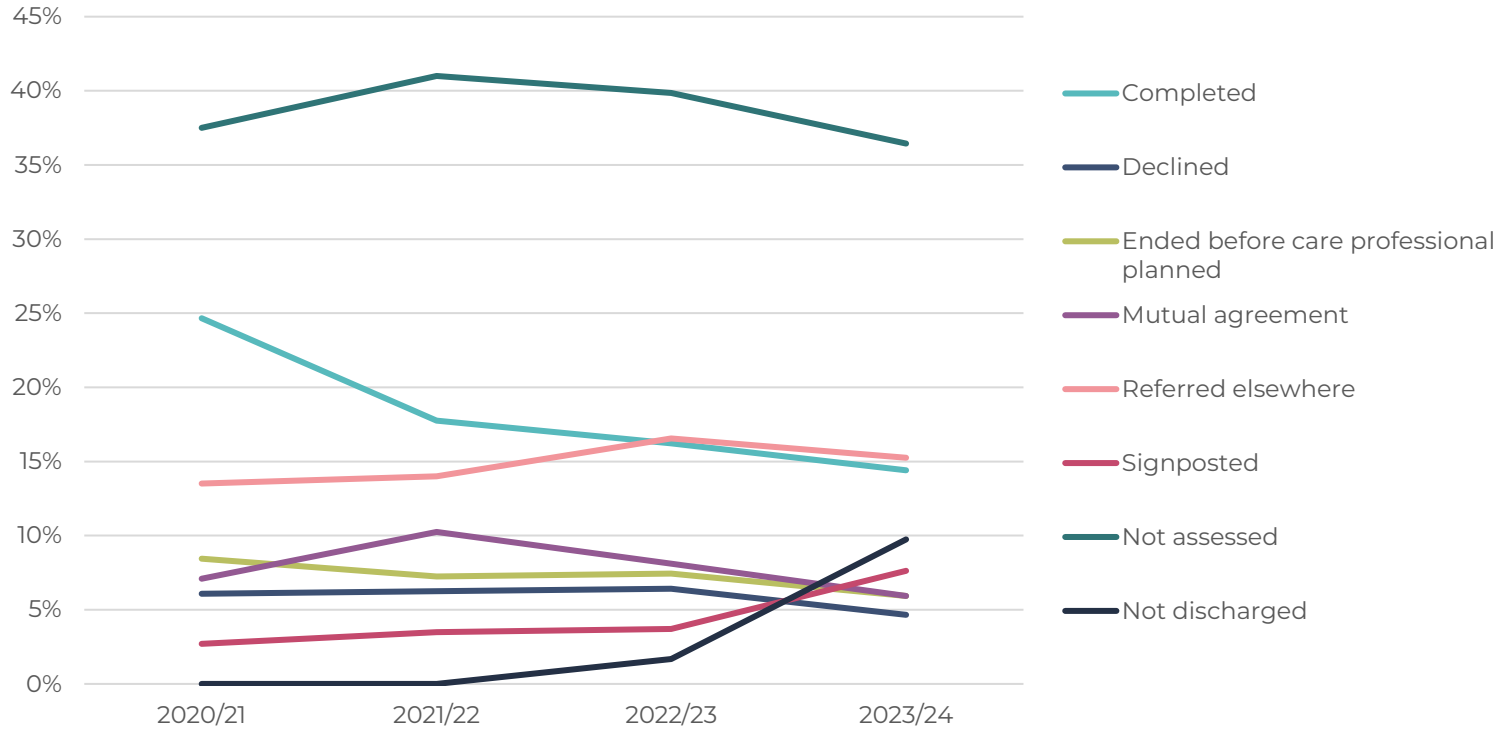


- There is a high proportion of referrals from people who did not state their employment status (approximately 37% 2020/21 and 2023/24 with highest being 41% in 2022/23).
- Approximately 13% of referrals are from those who are unemployed between 2020/21 and 2022/23 which increases to 18% in 2023/24.
- The majority of referrals received by Camden NHS Talking Therapies are from people who were employed or did not state their employment status. 38% of people were employed in 2023/24.
- The proportion of referrals received by Camden NHS Talking Therapies for people who were employed reduced by approximately 10% between 2020/21 and 2021/22. In unison, the proportion of people who were unemployed increased during that time-period.
- There appears to be a decline among those looking after family at home. This group may face barriers to accessing support such as lack of privacy or awareness of services available.

Data source: Camden NHS Talking Therapies
Note: Data includes the number of referrals of pregnant women or women with a child under 1. Data also includes those who identify as male and are partners of women who were pregnant or have a child under 1. This data also captures those identifying as male and are partners of men who have a child under 1 (e.g. via adoption/surrogacy). The majority of the data is missing so caution needs to be taken when interpreting these results. Long-term sick or disabled (those receiving government sickness and disability benefits) and those not receiving government sickness and disability benefits and not working or actively seeking work were excluded from this analysis.
Note: Only employment status' with a grand total of 10+ over the course of FY 2020/21 - 2023/24 were included. Full time is at least 16 hours per week and part-time is less than 16 hours per week.

In 2023/24, 14% of Camden NHS Talking Therapies referrals were recorded as completed, with 36% not assessed

Figure 26. Proportion of referrals to Camden NHS Talking Therapies by discharge reason, Camden, 2020/21-2023/24

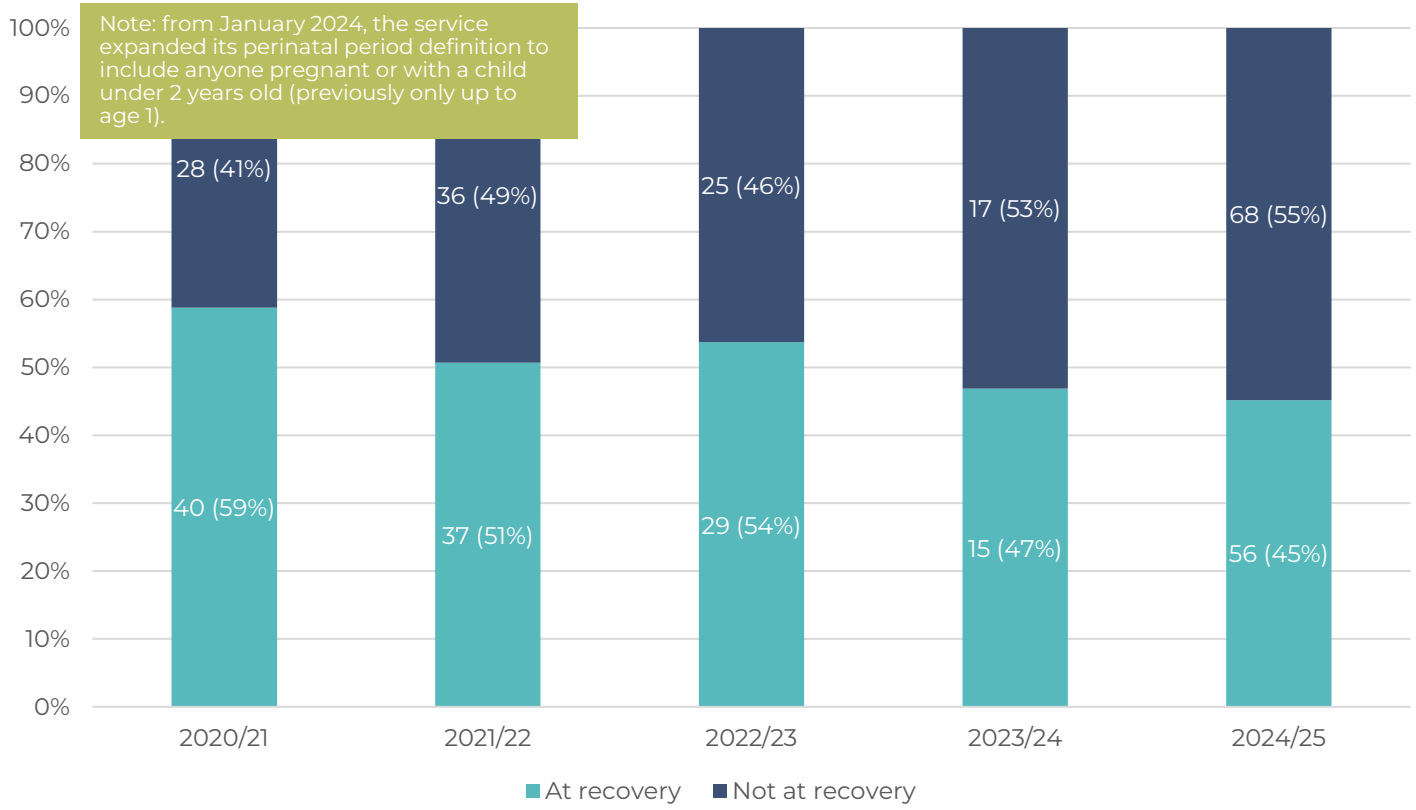


- The most prevalent reason for being discharged from Camden NHS Talking Therapies was not being assessed. This is commonly due to patients' lack of response, non-attendance or cancellations of booked assessments, or patients referred to another service based on clinical judgment at referral.
- In 2023/24, 36% of patients were referred to Camden NHS Talking Therapies services but not assessed. There was an increase in number of patients not assessed between 2020/21 and 2021/22 which coincides with the sharp 7% decrease in completed treatment and discharge over the same time period.
- The number and proportion of patients signposted elsewhere for treatment and the number of people not discharged has also increased over time.

Data source: Camden NHS Talking Therapies
Note: Some women may have had more than one referral and therefore multiple discharges/discharge reasons. "Completed" refers to patients seen and taken on for a course of treatment. "Mutual agreement" refers to patients seen but not taken on for a course of treatment by mutual agreement following advice and support provided. "Not assessed" refers to patients referred but not seen.

The target of 50% of patients reaching recovery has been met over the past few years. In 2024/25, recovery status for 76% of referrals was unable to be captured

Figure 27. Proportion of referrals to Camden NHS Talking Therapies by recovery status, Camden, FY 2020/21-2024/25



Reasons for recovery data not being recorded are:

1. Insufficient information to calculate recovery using scores from tools like PHQ-9 and GAD-7, which compare initial and final scores to determine improvement. While many people benefit from therapy, these scores may not represent all areas of improvement and therefore unable to capture progress.
2. Additionally, some patients do not respond well to therapy for many reasons - such as unsuccessful therapist-patient fit, timing of offer or disruptions from illness.

Data source: Camden NHS Talking Therapies
Note: Some women may have had more than one referral and therefore multiple recovery statuses. Only patients who were referred and treated ("completed" discharge status) and patients who ended treatment before the care professional planned were included in this analysis. All other discharge reasons were not included in this analysis. This does not include the referrals into Camden NHS Talking Therapies which were deemed inappropriate for treatment by the service due to lower/higher need, unclear referral notes, or were referred elsewhere.

The NHS Talking Therapy toolkit have been designed to encourage specific ethnic groups to engage with the service

NHS Talking Therapies is keen to reach people in north central London, including African Caribbean, Bangladeshi, Somali and Turkish communities, alongside older adults and new parents. As part of their campaign to reach and encourage individuals to access support, the North London Talking Therapies toolkit has been developed and seeks to address lack of engagement with services by:

- creating opportunities to hear from NHS Talking Therapies clinicians about their experiences of supporting patients
- encouraging people to ask their GP about the service
- working in partnership with GPs, health professionals, faith leaders, charities and community groups

Video explanations (with translations available) by Psychological Wellbeing Practitioners and Cognitive Behavioural Psychotherapists from various ethnic backgrounds, graphics, leaflets and newsletters have been created as part of this toolkit to encourage engagement with the service.

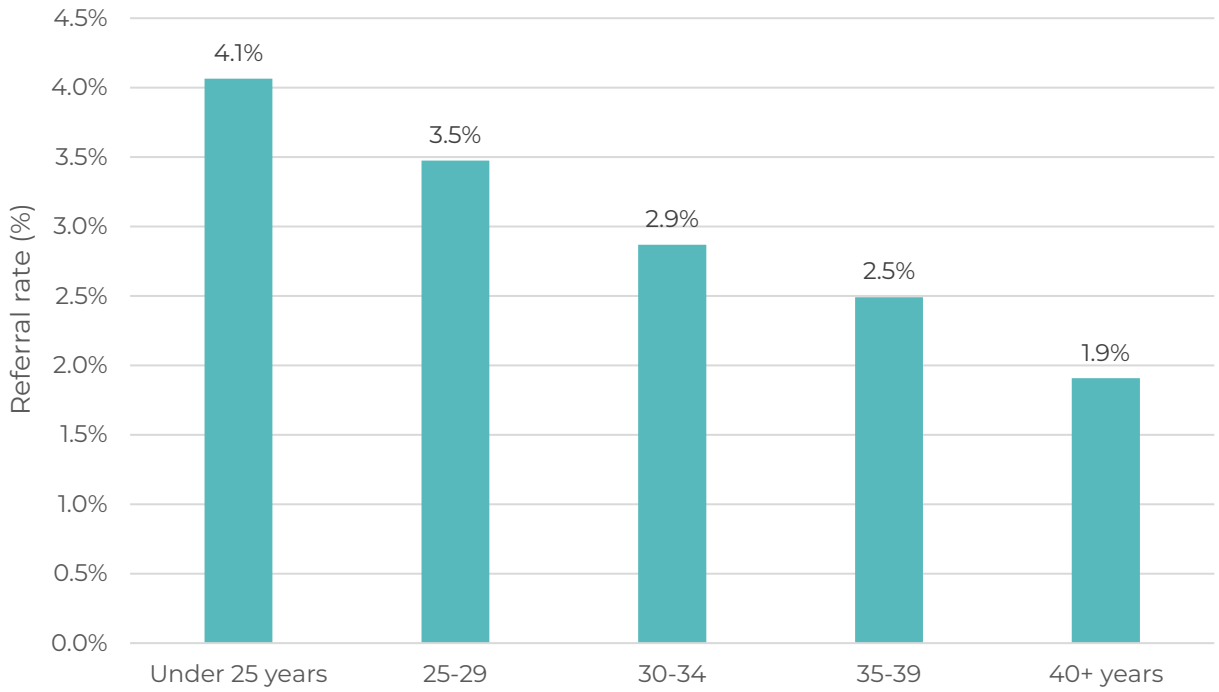
Key calls to action:

- Encouraging individuals to ask their GP about NHS Talking Therapies in Barnet, Camden, Enfield and Islington
- Encouraging individuals to refer themselves to NHS Talking Therapies

1. North Central London ICB. North London NHS Talking Therapies: Toolkit available to encourage referrals - NCL ICB General Practice Website [Internet]. NCL ICB General Practice Website. 2025 [cited 2025 Jul 8]. Available from: https://gps.northcentrallondon.icb.nhs.uk/news/north-london-nhs-talking-therapies-toolkit-available-to-encourage-referrals

GP data for the 12 weeks post birth indicates Camden NHS Talking Therapies referrals during this time decreases with increasing age

Figure 28. IAPT referral rate for postnatal women by age, FY 2020-2024



- GP/SUS data analysed in the 12 weeks post birth to determine if a referral was made to Camden NHS Talking Therapies.
- The overall Camden NHS Talking Therapies referral rate for postnatal women is 2.9% during this period.
- The Camden NHS Talking Therapies referral rate decreases with increased age. The highest proportion of referrals to IAPT is observed for women under 25 years (4.1%) and the least referrals to Camden NHS Talking Therapies is observed for women aged 40+ years., despite under 25s having a relatively lower birth rate compared to other age groups.
- Overall low rate of referral when compared to estimates of PMH problem may reflect under recognition and diagnosis of postnatal symptoms. Another possibility is unwillingness to disclose mental health concerns due to fear of stigma, social care involvement or lack of trust in the mental health care system due to previous negative experiences.

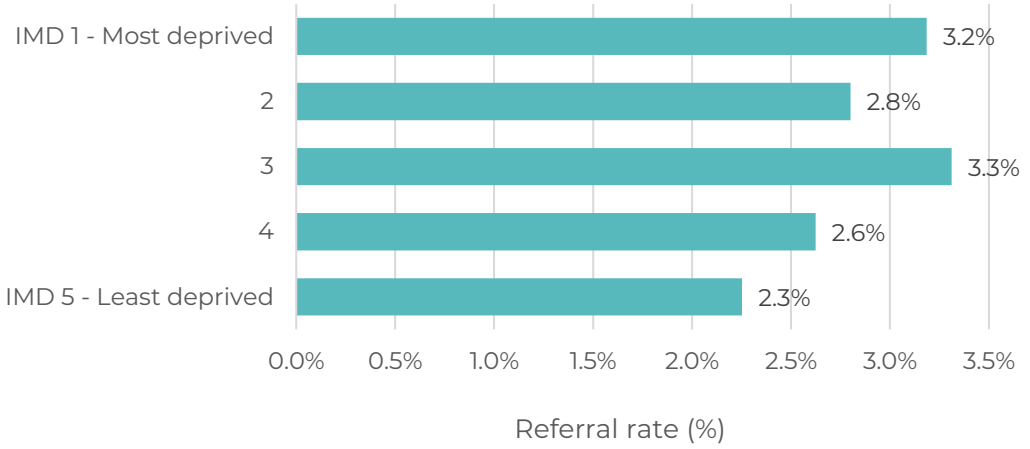
Data source: Sandpits GP/SUS
Note: One person has been excluded from this analysis due to an error pertaining age category.
Note: IAPT referrals include patients who had a referral within 12 weeks of the discharge from hospital after giving birth so the dataset could be missing a large proportion of women who may have been referred after 12 weeks.

Camden NHS Talking Therapies referral rates (by GPs) are highest in the more deprived quintiles

Table 9. Number and proportion of postnatal referrals to Camden NHS Talking Therapies by IMD, FY 2020-2024

IMD quintile	No Camden NHS Talking Therapies referral Count (%)	Camden NHS Talking Therapies referral Count (%)	Grand Total
IMD 1 - Most deprived	1,459 (96.8%)	48 (3.2%)	1,507
2	2,603 (97.2%)	75 (2.8%)	2,678
3	1,781 (96.7%)	61 (3.3%)	1,842
4	1,113 (97.4%)	30 (2.6%)	1,143
IMD 5 - Least deprived	1,128 (97.7%)	26 (2.3%)	1,154
Unknown	168 (98.2%)	<5 (1.8%)	171
Grand Total	8,252	243	8,495

Figure 29. Proportion of postnatal referrals to Camden NHS Talking Therapies by IMD, FY 2020-2024



The referral rate to talking therapies like the IAPT was highest for the more deprived quintiles compared to the least. IAPT referral rate was highest in IMD quintile 3 (3.3%), followed by IMD quintiles 1 (3.2%) and 2 (2.8%).

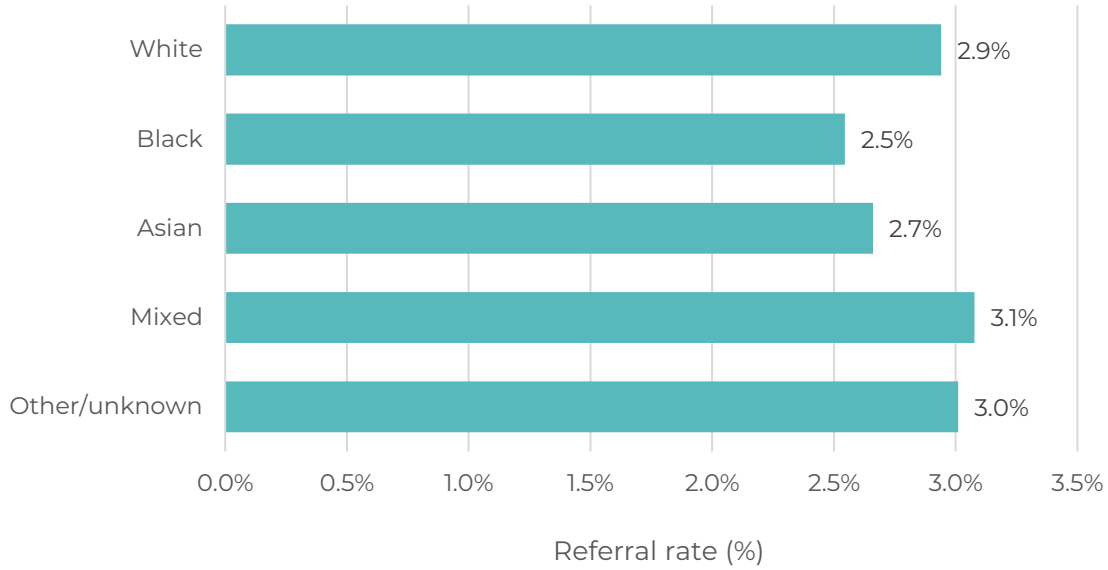
Data source: Sandpits GP/SUS.

There was no significant difference in referral pattern by ethnicity across the GP cohort

Table 10. Proportion of Camden Talking Therapies referrals by ethnicity FY 2020-2024

Ethnicity	No Camden NHS Talking Therapies referral , Referral Count (%)	Camden NHS Talking Therapies Referral Count (%)	Grand Total
White	4,324 (97.1%)	131 (2.9%)	4,455
Black	804 (97.5%)	21 (2.5%)	825
Asian	1,683 (97.3%)	46 (2.7%)	1,729
Mixed	378 (96.9%)	12 (3.1%)	390
Other/unknown	10,63 (97.0%)	33 (3.0%)	1,096
Grand Total	8,252	243	

Figure 30. Proportion of postnatal women with referrals to Camden NHS Talking Therapies by ethnicity, FY 2020-2024



Data source: Sandpits GP/SUS.

Key findings - SPMHS/ Maple

Specialist Perinatal Mental Health Services (SPMHS) focus on mental health services provided to women, babies and families (antenatal and postnatally) experiencing moderate to severe mental health issues during pregnancy or within the first year postpartum. Maple is a standalone NHS specialist therapeutic service for people living in NCL who are experiencing trauma symptoms in relation to the pregnancy-related experience e.g., birth trauma, perinatal loss, and tokophobia. Maple also works in conjunction with Camden NHS Talking Therapies.

SPMHS widened its eligibility criteria in 2023/24 to include any PMH need i.e., including mild cases, while Maple has maintained its eligibility criteria to include only moderate-severe perinatal mental health conditions.

These services sit across both the **Amber** and **Red** Camden pathways.

SPMHS

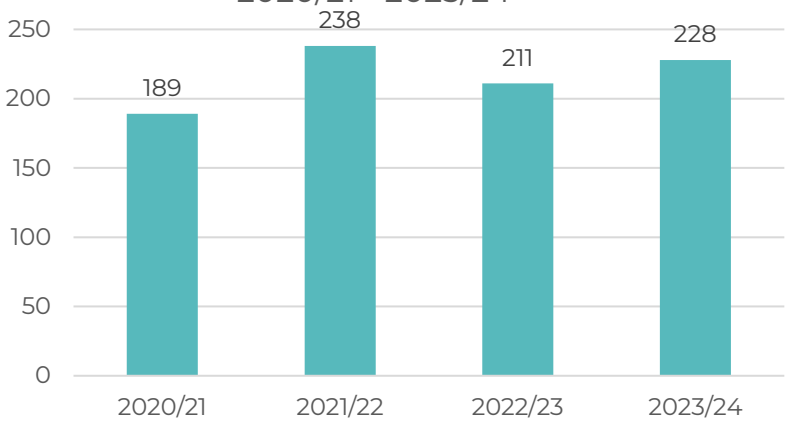
- The total number of referrals to SPMHS in **NCL** increased by 24% between 2019/20 to 2021/22; and referrals within Camden showed a similar trend: **The number of referrals to SPMHS South team increased by 25% between 2020/21 and 2021/22 within Camden**. The highest proportion of referrals were for antenatal support, for which there were double the number and proportion of referrals compared to postnatal referrals in 2023/24.
- Most of the referrals were made either from GPs or Midwives.
- Patients referred by health visitors or mental health services were most likely to be accepted for further care, and postnatal referrals show the highest proportion of declined referrals.
- Two thirds of referrals to SPMHS were accepted by the MDT. Lack of detail in referral and inappropriateness for treatment by SPMHS were the main reasons for declining referrals.

Maple (data in Appendix)

- In Camden, most referrals were for perinatal loss and child loss due to safeguarding concerns. A disproportionate caseload of loss is seen by Maple for Camden due to loss not being treated by Camden NHS Talking Therapies.

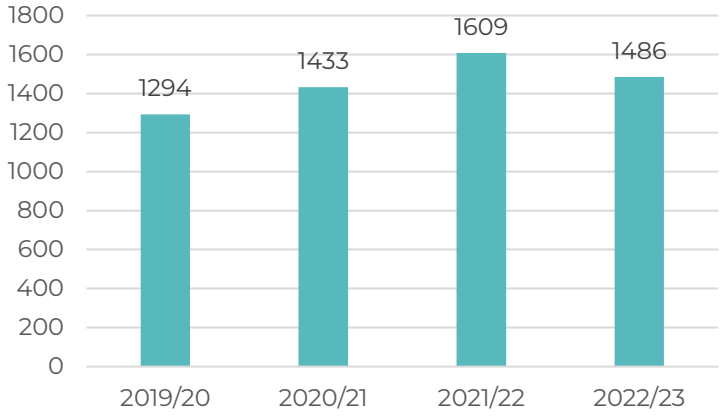
Referrals to SPMHS & Maple increased in Camden since 2020/21, during which period birth rate has declined

Figure 31. Number of referrals to SPMHS South Team, Camden, FY 2020/21 - 2023/24



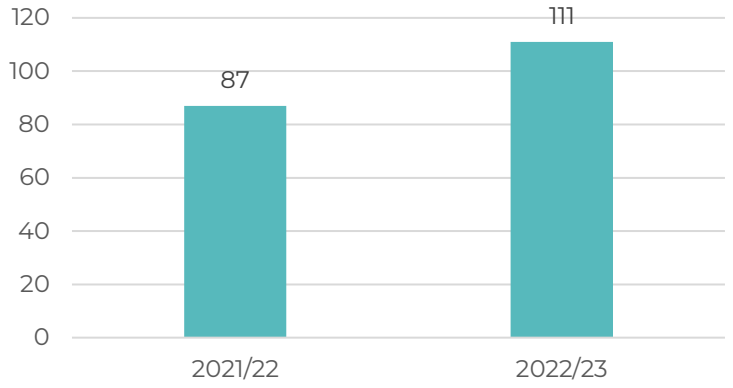
The number of referrals to SPMHS South team* increased by 25% between 2020/21 and 2021/22 and remained relatively stable between 2021/22 and 2023/24.

Figure 32. Number of referrals to SPMHS, NCL, FY 2019/20 to 2022/23



The total number of referrals to SPMHS increased by 24% between 2019/20 to 2021/22, followed by a slight decrease between 2021/22 and 2022/23.

Figure 33. Number of referrals to Maple Service, NCL, 2021/22 - 2022/23



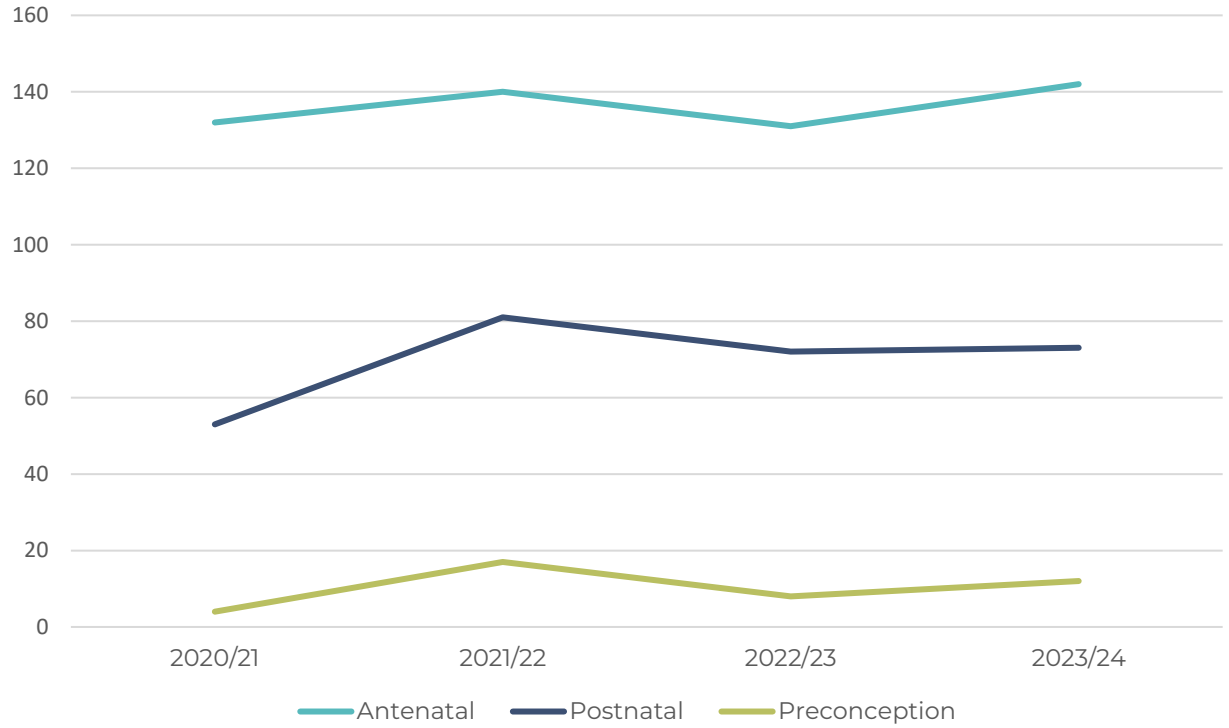
Number of referrals to Maple increased by 24 between 2021/22 and 2022/23.

- Due to low referrals into the moderate-severe services, SPMHS widened its eligibility criteria in 2023/24 to include PMH need i.e., including mild cases. Due to this change in definition, referrals have gone up from 7% to 10% in the past year, with a larger share accounting for mild conditions i.e., more opportunity for early intervention.
- Maple has maintained its strict definition for severe cases and will assess the referred patient to determine appropriateness for service.

Data source: SPMHS and Maple service
Note: Data only includes Camden residents for SPMHS South team data (South team = Camden & Islington)

The majority of referrals to SPMHS were for antenatal care, which was almost double the postnatal referrals

Figure 34. Number of referrals by type of referrals to SPMHS South Team, Camden, FY 2020/21 - 2023/24

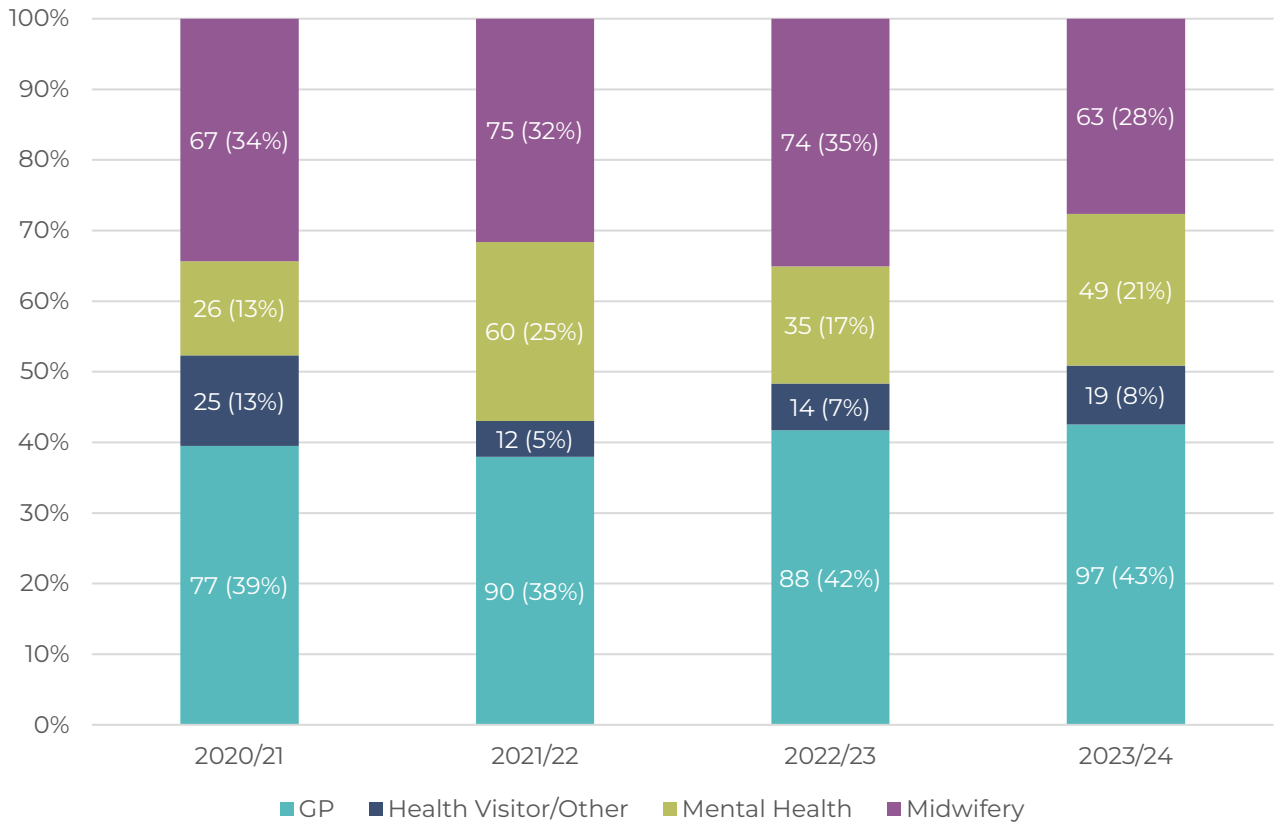


- The majority of referrals were antenatal , followed by postnatal and preconception. There were approximately double the number and proportion of antenatal referrals compared to postnatal referrals in 2023/24.
- The number of referrals for all three increased between 2020/21 and 2021/22. However, the proportion of referrals between this time period decreased for antenatal referrals due to the increased number of postnatal and preconception referrals made during this time period.
- The proportion of women referred by other mental health services increased by 12% between 2020/21 and 2021/22.

Data source: SPMHS
Note: Missing data was not included in this analysis due to low numbers. Data only includes Camden residents.

Most referrals to SPMHS came from GPs and Midwives

Figure 35. Counts and proportion of women to SPNMH by referral source, Camden, 2020/21-2023/24



- The majority of women were referred to SPMHS by GPs, followed by midwives and other mental health services.

Data source: SPMHS
Note: Missing data was not included in this analysis due to low numbers. Data only includes Camden residents.

Patients referred by health visitors or mental health services were most likely to be accepted for further care, and postnatal referrals show the highest proportion of declined referrals

Figure 36. Proportion of referrals to SPMHS by multidisciplinary team (MDT) outcome and referral source, Camden, FY 2020/21-2023/24

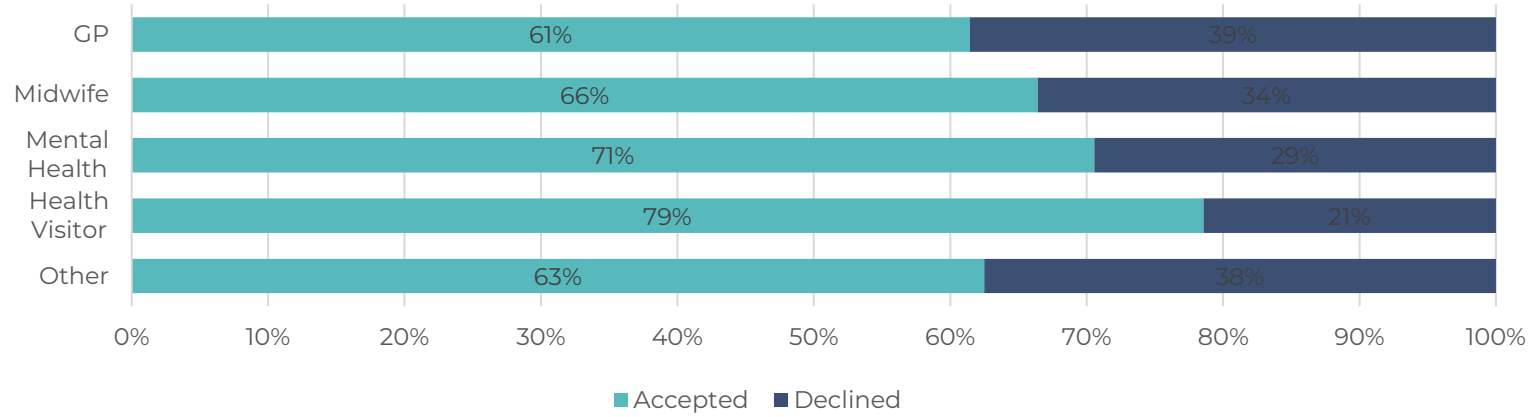
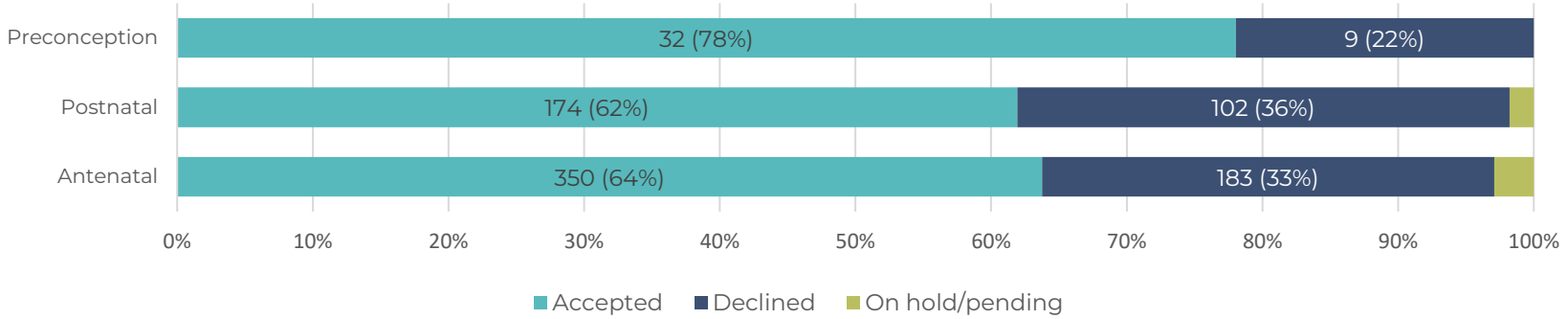


Figure 37. Proportion of referrals to SPMHS by multidisciplinary team (MDT) outcome and referral type, Camden, FY 2020/21-2023/24

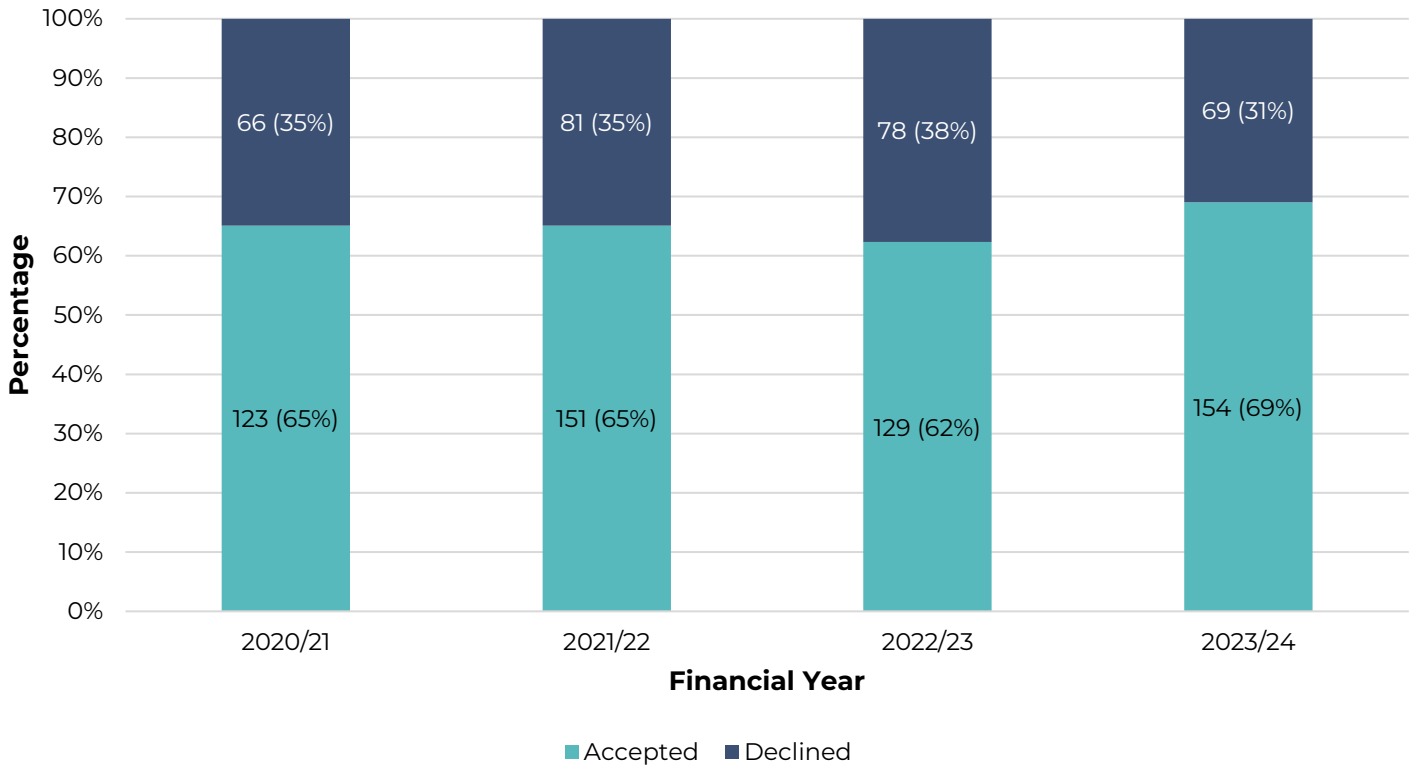


Data source: SPMHS
Note: MDT outcomes for "On hold/pending" were not included in this analysis due to low numbers and disclosure. One referral is not included in this analysis due to a missing referral source. One referral is not included in this analysis due to a missing referral source.

- Over the time period 2020/21 to 2023/24, patients who were referred by health visitors or mental health services were most likely to be accepted for further management and care (79% and 71%, respectively) compared to patients referred by GP who were least likely to be accepted (61%).
- Referral notes from GPs lacking sufficient detail has been highlighted as a reason for declined referrals.
- Over the time period 2020/21 to 2023/24, patients who were referred for pre-conception PMH were most likely to be accepted for further management and care (78% compared to patients referred for postnatal PNMH who were less likely to be accepted (62%). This should be interpreted with caution due to the low numbers of patients referred for preconception compared to postnatal and antenatal care.
- The proportion of patients accepted for further management and care were similar for postnatal and antenatal referral types.

Two thirds of referrals to SPMHS were accepted by the MDT

Figure 38. Proportion of referrals to SPMHS by multidisciplinary team (MDT) outcome, Camden, FY 2020/21-2023/24



- The proportion of referrals accepted and declined by the MDT remained consistent over time. Approximately two thirds of referrals were accepted and one third declined between FY 2020/21 and 2023/24. There was a slight increase in accepted referrals between 2022/23 and 2023/24 (7% increase).
- In addition to referrals being brief and not detailed, another reason for declining is that SPMHS may decide, on assessment, that the patient may not require secondary care and refer the patient to universal services or back to primary care.
- Being re-assessed at every referral point is not ideal for parents as it may subject them to re-traumatising, delayed care and leads to double counting in the various services' datasets.

Data source: SPMHS
Note: MDT outcomes for "On hold/pending" were not included in this analysis due to low numbers and disclosure.

Improvement in self-reported mental health between service contact and discharge was consistently recorded

Figure 39. Proportion mental health state at point of contact with service

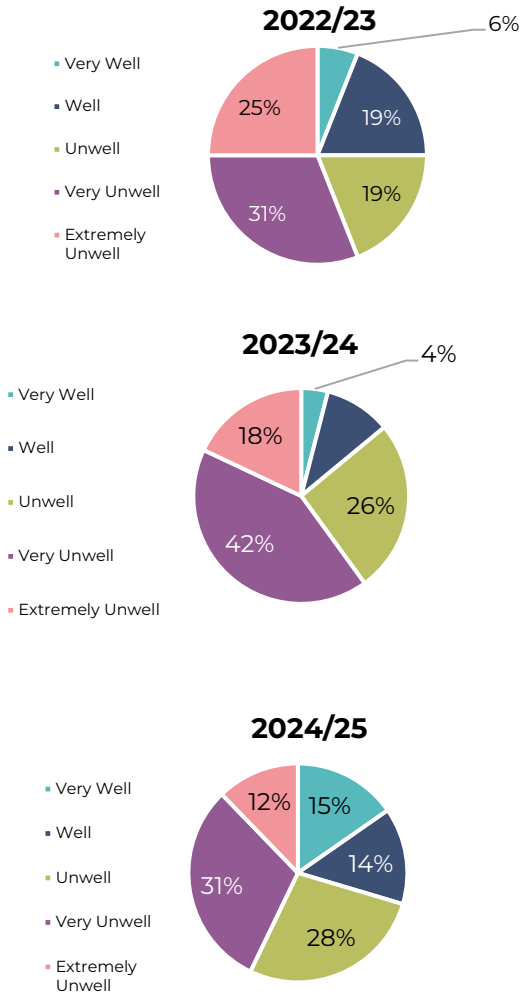
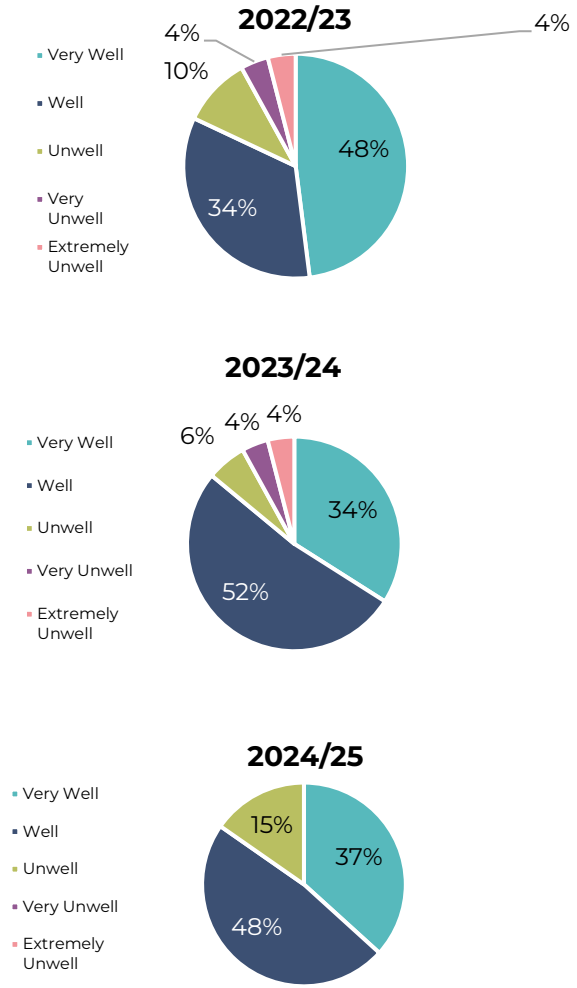


Figure 40. Proportion Mental health state when discharged from service



- Improvements in patients' mental health have been consistent over the past 3 years.
- In 2022/23 across NCL, the percentage of clients reporting their mental health as unwell dropped from 19% before accessing the SPMHS service to 4% at discharge. Those reporting their mental health as very unwell dropped from 25% to 4% at discharge.
- In 2023/24 across NCL, the percentage of clients reporting their mental health as unwell dropped from 26% before accessing the SPMHS service to 6% at discharge. Those reporting their mental health as very unwell dropped from 18% to 4% at discharge.
- In 2024/25 across NCL, the percentage of clients reporting their mental health as unwell dropped from 27% before accessing the SPMHS service to 15% at discharge.

Note: These survey results pertain to the questions: 'Please rate how your mental health has been: When I first came into contact with the service I was' and 'Please rate how your mental health has been: When I was discharged from the service I was'.
Data source: SPMHS

Stakeholder views

Qualitative insights from professional representatives

Camden

Stakeholder insights

Semi structured interviews were undertaken with perinatal midwifery leads at UCLH, and the Whittington as well as service leads from Camden NHS Talking Therapies and SPMHS. These stakeholders were asked to reflect on the findings, identify barriers and facilitators to promoting better identification and engagement with support for PMH as well as developing recommendations.

Thematic issues that arose included:

1. Continuity of Care:

- Based on experience of specialist perinatal midwives in hospitals, when mothers from global majority groups in particular, when seen by more than 2 midwives, they were less likely to have their PMH needs identified.

2. Mothers with a history of severe mental illness (SMI), learning disabilities and other health conditions are sometimes more likely to decline input from specialist PMH services and support

- Mothers with SMI were often found to be more reluctant to engage if they feel their worries are not heard or consultations are rushed. Engagement with services is very low post baby removal due to emotion distress and mistrust of the system.
- Mothers with learning disabilities, those who are uncomfortable with new faces, with special educational need and autism, or with language barriers need additional support
- Mothers who develop other conditions during pregnancy e.g. gestational diabetes, hypertension etc,. tend to get overwhelmed by the surge of appointments and scans, which leaves them with ‘little headspace’ to engage with PMH services.
- Meeting with the Specialist midwife helps encourage the vast majority of these mothers into engaging with SPMHS. This additional support and 1:1 session, during which the benefits of SPMHS are explained leads to mothers feeling heard, and seems to be a key factor in later engagement

Stakeholder insights

3. Data:

As data storing platforms used vary across NCL boroughs linkage of data on identification of need, referrals and outcomes is impossible. Across several midwifery services, paper notes are still common meaning not all notes get transcribed electronically which might be why MSDS data was often quite poorly recorded in terms of quality

4. Disproportionate severe PMH prevalence in global majority groups:

Quantitative data was limited but experientially hospital midwifes with perinatal specialism noted that white ethnic groups more commonly presented with mild to moderate mental health problems, however Black African and Caribbean populations were over-represented on acute ward admissions and in-patient settings likely indicating late identification of needs

5. Stigma around mental health:

Mental health stigma is high among global majority groups, alongside high mistrust in the diagnoses/medication prescribed by professionals in mental health settings.

6. Children's Centres and Family Hubs: asset to Camden community

Camden Children Centres and Family hubs have shown great potential in providing PIR support as well as a space where specialist support can be delivered.

Resident Voice

Qualitative insights from community representatives

Camden

Mothers/birthing parents and fathers focus group discussion

- Camden Health and Wellbeing led focus group discussions with mothers and fathers separately in Camden who were either currently experienced or have experienced the perinatal phase. Both sessions provided valuable insights into the real-life experiences and perspectives of individuals with lived experience of the perinatal period, several of whom were affected by mental health issues during the period. The discussions shed light on specific challenges, barriers to accessing services, unmet needs within the community, as well as what works well in Camden.
- The focus group aimed to elicit themes across resident on:
    - Their understanding of PMH , the PIR and what affects it
    - Their experience of screening and support for perinatal mental health in Camden
    - Their understanding of barriers for people seeking mental health support during the perinatal period
- A few semi-structured interviews were also planned with birthing parents who identified as refugee/ asylum seekers and teenage parents. However, upon initial consent, the participants declined the invite as they felt uncomfortable discussing this topic, and it is a recommendation of this work that further attempts are made in the future to seek insight from these population groups at higher risk of worse PMH outcomes.
- The focus group sessions with mothers were recruited through support from the Family Lives team. The discussions were held virtually to ensure ease of access, and all individuals were compensated for their time. The group of fathers were recruited through the father inclusion lead in Camden. Both focus groups had 6-8 participants attending.

Focus group discussions – Key findings

Table 11. Mothers/birthing parents and fathers focus group discussion key findings

Mothers focus group themes (6 mothers attended)	Fathers focus group themes (7 fathers attended)
Cultural stigma associated with accessing support from mental health services and not having caregiving support at home are factors that contribute to worse PMH.	
Sense of overwhelm and lack of support upon coming home post birth (from hospitals) especially for first time mothers	Social determinants of health: employment and housing worries during perinatal period escalate risk of mental health issues
Importance of feeling supported and heard irrespective of which health professional they encounter across the system	Fathers offering support and being there for their partners through their mental health issues increased emphasis on fatherhood
Postnatal pain and challenges with breastfeeding affect parent infant bonding	Fathers found social media groups helpful to stay socially connected with other fathers within Camden. There is appreciation for Camden services however not aware of any specialist PMH support services.
Access to mental health services and postnatal checkpoints are not consistent between families	
The additional care and support that is in place for mothers with negative past experiences and pre-existing mental health conditions are highly valued and crucial.	
Encouragement from Health visitors, Family Lives etc,. is crucial for mothers to engage in social communal groups and reduce feelings of loneliness	
Culturally competent care and resources are highly valued, and working with religious leaders/faith groups could be one way to develop this	

Key insights from mothers focus group discussion (1)

Mothers Focus Group Discussion- Key Themes

Sense of overwhelm and lack of support upon coming home post birth (from hospitals) especially for first time mothers

Mothers mentioned how much proactive support and advice was available in the hospital and the abrupt lack of it at home was associated with increased levels of loneliness and lack of support.

Importance of feeling supported and heard irrespective of which health professional they encounter across the system.

When mothers visited A&E for checkups outside of planned ones - due to concerns of not knowing how the pregnancy is progressing, questions about nutrition, care, pain etc.,- , their concerns were dismissed, especially if they were first time parents.

*"...in that hospital setting,...everyone is forthcoming with advice but **once you come home, there's no more of that encouragement to keep going**."*

*"My mental health suffered when I came home with her it all [support in hospital] sort of stopped. I could go to Camden NHS Talking Therapies but **the waiting time was nine month** forwards, a year's wait... But I had a really good health visitor"*

*"...because you're a **first time mom, they dismiss you so quickly**. It's so frustrating, because as a mum you know that something's wrong, there's a gut feeling."*

*"In the hospital, in the MFAU [emergency department for babies] **there's a different nurse all the time**. sometimes you get questioned about why I keep coming in...**if I have concerns to come in, doesn't matter if it's something silly, at least you get checked over.** And when I had a lot of scans done, my placenta was anterior..."*

Key insights from mothers focus group discussion (2)

Mothers Focus Group Discussion- Key Themes

Postnatal pain and challenges with breastfeeding affect parent infant bonding

Having services offer advice and support with regards to these issues and knowing how to access them was key. Those who found these services and support in Camden found them very useful.

Access to mental health services and postnatal checkpoints are not consistent between families

- While some mothers from the group had an excellent experience with their health visitors, GPs and were informed about useful drop-in sessions at health centres, others found that their health visitors were unreachable, and the GP/A&E staff were dismissive of their concerns.
- Camden NHS Talking Therapies was mentioned as having very long wait times to be seen by specialist perinatal mental health services.
- Mothers from the focus group discussions mentioned the positive impacts that Stay & Play sessions in Family Hubs, being approached by Family Lives, the gospel oak 1:1 health centre sessions had on their mental health, and were grateful for being encouraged by health visitors to access these communal offers

*What helped when I had concerns about baby's growth was the drop in sessions at the **Gospel Oak health centre… whatever concern you have with your child, you could just tell them**. …Specialists will give you 1:1 time and there's a duty line for health visitors. I don't know if everyone's told in Camden about these services but **these were given to me on my first visit which really helped me**… no services like that in [friends'] boroughs."*

*"They said at A&E to call my health visitor because with so many visits to A&E, she [daughter] might catch something from other people. **Now, I don't call anybody.** I don't go to the emergency or the GP, **I've become to doctor to my daughter."***

*"The physical pain from childbirth - some days it will take me 10 minutes to just get off the bed…**Before giving birth, I never took a painkiller. Now ibuprofen is like sweets to me**."*

*"…**what I found difficult was the waiting time from Camden NHS Talking Therapies** . If you're exhausted and you need help or you just need someone to talk to, …**you don't wanna wait 9 months or a year to have to talk to somebody."***

Camden

Key insights from mothers focus group discussion (3)

Mothers Focus Group Discussion- Key Themes

The additional care and support that is in place for mothers with negative past experiences and pre-existing mental health conditions are highly valued and crucial.

When there was history of pregnancy complications and trauma, (previous still birth, miscarriages) as well as pre-existing diagnosed mental health conditions (obsessive compulsive disorder), the care given for subsequent births is well planned out.

Mothers/birthing parents seek connection and relationship but struggle with getting out of the house, which leads to feeling isolated and lonely. Encouragement and reassurance from Health visitors, Family Lives etc,. is perceived as helpful.

Mothers who were pregnant during/shortly after the COVID-19 lockdown restrictions talked about how scary the outside world felt, especially now that they worried about keeping themselves safe for baby.

*"**I had a still birth before I had my daughter. So, the care I got while I was pregnant with my daughter, it was spot on**. I had more scans than you're supposed to have, I had more appointments in advance...."*

***"I didn't realise how much [COVID restrictions] affected me until I came home with [daughter]**..., it made me not want to go out. The health visitor was trying to get me to go to Stay & Play and meet other mums. But **I have to keep myself safe for her**".*

***"...Being approached by family lives really helped**.., encouraged me to take some responsibility."*

*" **[OCD] is really really bad** and I thought maybe after having a kid, it will calm down a bit, **but it's gonna get worse now**."*

*"**I struggle most with isolation**. I don't take her anywhere. I've been told that's not good for her, that I need to socialise her but **I really really struggle going outside. It's a scary world out there and everyday you see things happening to children**."*

Key insights from mothers focus group discussion (4)

Mothers Focus Group Discussion- Key Themes

Cultural stigma associated with accessing support from mental health services and having support at home

- Familial influence is a key factor in accessing support from mental health services. Especially within global majority families, there is more emphasis on turning to faith and not divulging 'secrets' with others, which also shows lack of trust in the healthcare system.
- Patriarchal systems in place expect caregiving as solely the mother's responsibility, affecting the support mothers receive at home post-birth.

Culturally competent care and resources are highly valued, and working with religious leaders/faith groups could be one way to develop this

- Having health staff who know and can advise families from a culturally sensitive perspective is sought after.
- As there tends to be more trust in religious leaders, one way to increase trust in health services is for the two to work together, perhaps though faith groups.

"I live with my mom. We are Muslims and we come from Africa and one of the ***biggest stigma*** *is that therapy is not a thing or mental health is not a thing...* ***Why would you want to go and tell people about your secrets?...*** *But I'm raised in this country where mental health is really talked about a lot."*

I had my son circumcised when he was a couple of weeks old ***...[my midwife and health visitor] were very knowledgeable on the Islamic cultures...they were very, very supportive and that was very reassuring*** *that they had actually had knowledge of my culture."*

"My husband was doing the 50-50 share... ***my dad was like oh, but why is he making the milk?...why does he have to do that? Why don't you do everything?"*** *...So I feel like* ***it's there a lot in the Asian community...but I think it's improved now and it's changing*** *but there's an odd few."*

"...There was pressure from my family to shave her head and give her a bath but after my research,... Islamically, for a girl, you actually don't need to shave the hair. ***i've been doing my own research, speaking to imams...***"

Key insights from fathers focus group discussion (1)

Fathers Focus Group Discussion- Key Themes

Impact of Social Determinants of Health

- Fathers talked about factors that contributed to their mental health during the perinatal period for instance employment and housing worries.
- The group also discussed how being young teenage parents could have lack of understanding of pregnancy related changes in birthing people and that more support is needed at that age.

Fathers being there as a supportive partner

- Most fathers saw themselves as playing a supportive role, feeling empathetic and being there for their partners though they recognise that fatherhood was a challenge with some admitting to 'struggling' through this transition.
- Those where the birthing people had pre-diagnosed SMI, fathers felt additional responsibility as they were looking after the newborn full time.

*"**Struggled a bit with the situation of finding a flat and, you know, starting a new life**; I was Uber driver, I lost my private license at the same time when my baby girl was born**. At the end of the day, I'm very happy**."*

*"...**nothing and nobody prepared me as an 18-year-old boy [for becoming a father]**; I now understand that this is part of the hormonal changes that she was going through..."*

*"**I'm always available to support. I'm constantly switching, switching, switching; I never knew I had this ability!** But it does take the toll, especially when it comes to the weekends when my partner's been looking after my daughter most of the week, and then she needs a break."*

*"**I was the one who was looking after the child full time because the mum was suffering with schizophrenia** and he found lots of difficulty during pregnancy, which was shocking."*

Key insights from fathers focus group discussion (2)

Stigma around mental health and cultural influence on seeking support

- The fathers group reflected on how women are often perceived by men to be better at dealing with emotions, while men probably are not good at talking about their mental health; they would rather opt for alternate ways of coping like going to the gym.
- In some cultures, it is not common for men to talk about mental health and as new parents, fathers in particular would feel less confident of expressing this in front of their parents or grandparents.
- It is common for people to be encouraged by family to approach faith when experiencing mental health difficulties before contacting health services.

*"My parents are from Ghana I have two other sisters and **my mom feels like an expert around how she raised us.** In a sense, she has a bit more of a fixed mindset than us."*

*"What's the point of looking out for new stuff when you know there is always going to be a conflict to have this discussion or you know, **take a back seat and let the grandma run the show**."*

*"My partner is from China, in general in China there are a lot of over- protective **parents** because of the one child policy. **They come and they criticize everything that she (partner) is doing** and don't give her any space and try to make all the decisions."*

*"**Church will pray and other people will pray** and then will be that element of **going through that before any kind of seeking help from services**."*

Key insights from fathers focus group discussion (3)

Influence of social media on seeking support

- Social media (Insta) is probably a common 'go to' platform where people would go to gather information and support. However, there is lack of awareness on specialist PMH services through such platforms.
- Social media is also helping fathers stay socially connected by means of services like Camden fathers WhatsApp Group. Fathers felt the WhatsApp group was their safe space and they really look forward to attending the session.
- COVID-19 may have exaggerated some mental health issues for those in bubbles, who were trying to keep themselves safe during pregnancy which may have impacted seeking support if necessary. The constant bombardment of negative news on social media may also have impacted fathers' mental health.
- Group suggested the council to keep up with the times, different social media appeals to different generations and to think of different ways next generation wanted to be reached out.

*"I have the WhatsApp group **(dads Group) and you know, it's kind of a bit reassuring**, there's like some form of option for me to go to."*

*"Before I knew about Camden WhatsApp group, one that we were going to was the NCT course, but we came across the Baby Academy group, it's an Instagram group. They generally consist of some midwives and quite experienced mothers. **And they give you quite a few free online courses**."*

*"I was having some mental health issues and just wanted a therapist to talk to. I haven't found anything and literally after being suggested that there might be some mental health help for fathers in Camden, **I just did a Google search and came across this Camden Council Dad's help leaflet and there's a Camden parents well-being service** apparently."*

*"When the next generation is going to start bringing in the children, in what ways do they want to be reached? For example, **I don't use Facebook so if Camden's dad group was a Facebook group, I wouldn't have any awareness about it."***

*"...I can go and meet some other fathers, meet the people in the community **and I think having that peace of mind is quite nice and I should try and use it a bit more actively**".*

Key insights from fathers focus group discussion (4)

Awareness of support services- what's good and what could be better?

- Overall, the group had great appreciation for Camden services. Some of the services which fathers were aware of were the Camden Breastfeeding team which provided bit of a personal touch to parents; fathers' WhatsApp Group was a popular one; Antenatal classes, Bump to Baby, Stay and Play and local Children's Centre services were also appreciated. However, as a group they were already somewhat engaged with services which may bias findings
- The group however, did not have any knowledge about the SPMH support services.
- One dad in particular appreciated the support from the perinatal/rehabilitation team for his schizophrenic partner.

What could be better?

- Fathers shared an example of good practice from Brent, a one stop shop website where fathers could access all the information about wellbeing support. Camden's fathers Inclusion Network is already working on this suggestion.
- The website needs to be easy to reach and to navigate.
- Early wins could be Camden's mental health webpage which has wide range of information but nothing specific for fathers, perhaps Camden Public Health/ Mental Health team can revisit the webpage and think of creating drop down style menu for different cohort including fathers.

*"**Breastfeeding is not as straightforward as it may seem,** reminded me how helpful the feeding team were and even having the drop-in sessions. I think it was quite challenging at the beginning, and **I was just really happy that my partner had a place there are experts,...**because it is a very complicated thing. "*

*"**Very thankful to the breastfeeding team and the children's centres**; anytime we needed something we called someone came to our house and helped us."*

*"**I'm not actually very aware of what mental health services are available** but I do have a sense of the **closest children's centre would let me know**."*

*"Our parents never had access to this information before; having this kind of platform, it's still incredible, because things that we might not know sometimes, **we need to share problem and speak. It's amazing."***

Summary and Recommendations

Camden

Summary of Key Findings from PMH and PIR JSNA

Population & Demographics

- Live births have increased among Black and Asian ethnic groups and in the most deprived areas. 50% of births are to non-White parents.
- 6–8 week GP postnatal reviews are not being recorded for the majority of eligible residents;
- Smoking at delivery has increased slightly.
- 90% receive a 6–8 week Health Visitor review which is significantly higher than London average

Need & Inequalities

- ~941 women and 336 men are estimated to experience PMH problems each year in Camden.
- Highest prevalence of PMH need is in women aged 30–34 years.
- Higher burden in Bangladeshi, Black African and other ethnic groups.
- Need is concentrated in the most deprived quintiles.

Screening & Detection

- Recording of antenatal MH screening in Maternity datasets increased from 40% to 50% (2019–2023) but remains low
- Women in most deprived areas more likely to be screened.
- 13% identified with MH need at 6–8 week Health Visiting review (7% low mood; 5% anxiety).

Service Use

- Talking Therapies referrals are decreasing overall; healthcare referrals rising but self-referrals falling.
- Only 14% of referrals complete treatment; 36% not assessed.
- GP referrals into Camden NHS Talking Therapies show a decreasing trend for women over 40 years, with referrals highest for those under 25 years of age
- SPMHS referrals increased by 24%; perinatal loss commonest referral reason.

Stakeholder Insights

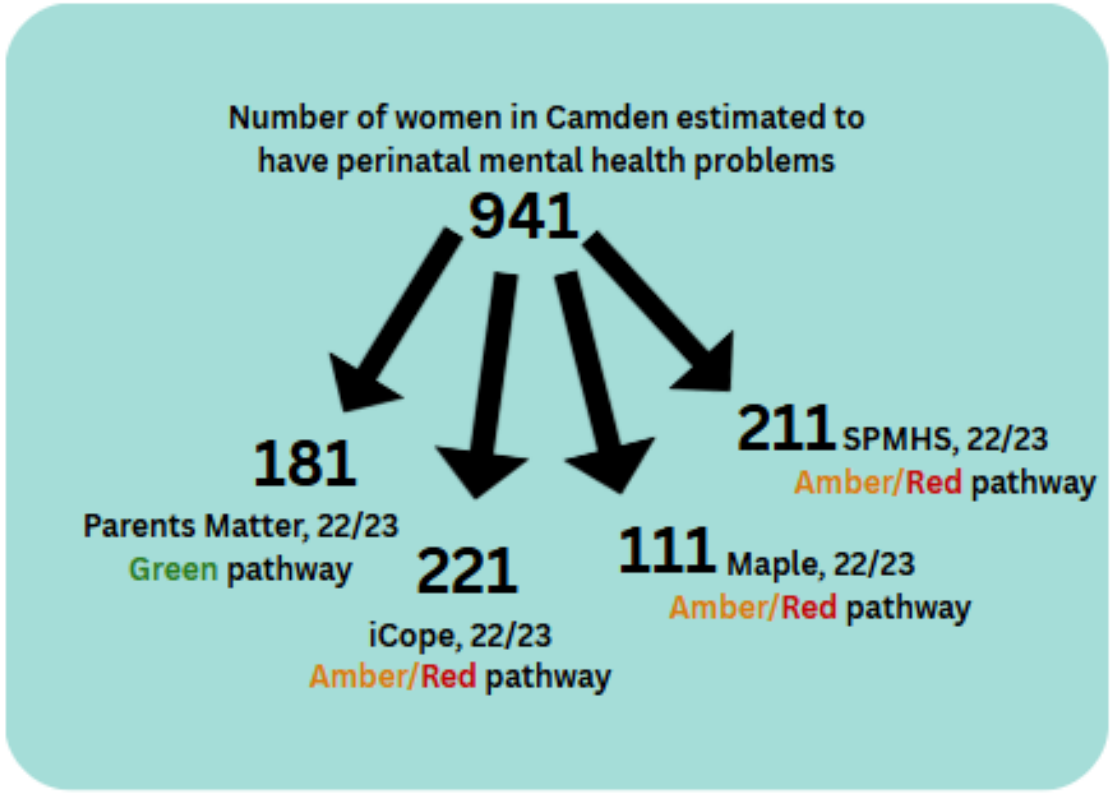
- Continuity of care improves identification of need especially for global majority families
- Poor data linkage limits tracking across services., identification of need and outcome evaluation of pilot work
- Black and Caribbean women are over-represented in acute admissions.
- Stigma, trust and inconsistent postnatal support remain barriers.

Resident Insight

- Local barriers to PMH wellbeing include stigma, sense of overwhelm and lack of support upon coming home from hospital after birth especially for first time parents, inconsistent antenatal and postnatal checkpoints,
- Local enablers to PMH wellbeing include community-based support, culturally competent healthcare staff, peer support groups for fathers, social media support services within Camden were well received too.

Diagrammatic flow of patients through some key Camden perinatal mental health support services

Figure 40. Flow of patients through some key Camden perinatal mental health support services



- These numbers are modelled estimates and must be interpreted with caution as the number of people who are using more than one service is unknown.
- These pathways also reflect only some of the main services in the perinatal and parent infant relationship support pathway

Note: iCope is the former name for NHS Camden Talking Therapies

Gaps and Limitations

Synthesis of learning across the needs assessment identified there were clear gaps as well as limitations for this work, Gaps and limitations are listed here and put forward as recommendations for action in next slides

1. **Lack of awareness of support available** – there was a lack of consistent knowledge and awareness across professionals and the residents on pathways available for support, with knowledge appearing limited to those who had lived experience of successfully navigating the system. Given high levels of estimated unmet need, there will be many who have been unable to navigate and access support or be simply unaware it exists
2. **Lack of integration of support pathway** - this work identified that the pathway for PMH and PIR support is sometimes unclear and fragmented, however the developed traffic light framework to help navigate the pathway provides an opportunity to more effectively embed it within universal services
3. **Poor data quality and consistency** – granularity of analysis possible across this needs was limited as both universal and targeted services that identify or provide direct support for PMH and PIR did not have a minimum equity dataset. Inconsistent coding also meant data demographic details such as ethnicity, referrals and outcomes were often recorded as free text, possibly limiting the analysis.
4. **Mental health stigma** – stakeholder and resident insight identified the extent to which stigma remains a barrier to engagement with mental health support for both mothers and father in the perinatal period, and in Camden in line with wider evidence this appears greater in certain global majority communities
5. **Social determinants** – where quantitative and qualitative data allowed analysis, social determinants including but not limited to poverty, housing, history of abuse and trauma, history of substance misuse came up as associated with higher levels of need. This emphasised the importance of screening and recording these risk factors and realise that these are cohort with greatest capacity to benefit
6. **Service pressures and unmet need** - modelling indicates a likely high prevalence of unmet need in Camden, which stakeholder insight indicates may be highest in those from global majority background. The exact extent of this unmet need could not be identified due to quality of data and recording available

RECOMMENDATIONS – Maternity

Recommendations	Rationale	Ownership
1. Strengthen Continuity of Care for At-Risk Mothers in the antenatal journey Ensure a named midwife provides consistent care to pregnant women identified as at risk of perinatal mental health issues—especially those from global majority backgrounds, with a history of severe mental illness (SMI), learning disabilities (hence uncomfortable around new faces), autism and those who face language barriers and/or socio-economic disadvantage.	Evidence, stakeholder and resident insight identified that mothers who see multiple midwives and practitioners are less likely to have their needs identified.	Maternity leads across acute services in Camden including UCLH, Royal Free and Whittington
2. Continuity and expansion of specialist midwifery in perinatal mental health within hospitals who can identify at-risk individual and direct them to appropriate hospital or community services for support	Strong evidence that leadership and specialism for perinatal mental health within midwifery can lead to earlier identification and support. UCLH and Whittington midwives have shown improved engagement through dedicated specialist clinics and 1:1 follow-ups.	Maternity leads across acute services in Camden including UCLH and Whittington
3. Roll out the use of evidence-based tool such as the maternity disadvantage assessment tool to enable maternity and health visiting services to identify those at greatest risk of worse perinatal mental health outcomes due to history of risk factors. In the long term identify how provision of perinatal mental health support can be more targeted in delivery towards high-risk household i.e. those on low income, history of trauma and abuse, living in social and overcrowded housing,.	All of the below factors known to increase the risk of perinatal mental health are screened for in this tool enabling earlier identification including; Poverty; History of abuse in childhood; Previous history of mental health problems; Stressful life events; being a teenage mother; maternal obesity; Alcohol or drug use; Traumatic birth; History of stillbirth or miscarriage; Relationship difficulties; Social isolation; Bereavement; Being a migrant Unplanned or unwanted pregnancy Exposure to violence or other trauma, including Domestic Violence and Abuse (DVA) and Intimate Partner Violence (IPV)	Maternity leads across acute services in Camden including UCLH and Whittington, midwives and health visitors

RECOMMENDATIONS – Maternity and Health Visiting

Recommendations	Rationale	Ownership
4. Improve continuity between midwifery and health visiting in particular around the handover and flow of information antenatally	Strong evidence that a smoother handover for high risk woman as identified through PHQ-9, GAD-7 and/or other previous medical or social history can lead to better outcomes The antenatal targeted appointment for health visitors can provide this opportunity	Maternity and Health Visiting Leadership
5. Explore opportunities for preconception care pathway development with a focus included on the importance of mental health and wellbeing in pregnancy and support available	Preconception is a time where the risk of perinatal mental health issues and importance of parent infant relationships can be communicated to parents so they are aware of potential need for support and recognize how common the prevalence is	Public Health, IEYS and Maternity Services

RECOMMENDATIONS – Integrated Early Years and Maternity

Recommendations	Rationale	Ownership
6. Integrate perinatal mental health screening tools (e.g., PHQ-9, GAD-7) in all eight Health Visitor contacts across Best Start for Baby, ensuring it is recorded and coded for in health records so it can monitored and evaluated	The enhanced health visiting offer and 3 additional contacts through Best Start for Baby service in Camden provides increased number of opportunities to identify and address perinatal mental health concerns. It is also important that training is provided to use these tools in a culturally sensitive manner with prompts coproduced with service users	Best Start for Baby leadership team and Health Visiting leads
7. Establish a Perinatal Parents Panel with diverse lived experience to guide service delivery and support work across the pathway, ensuring cultural appropriation of the offer The purpose of the group in particular would be to convene at least twice yearly and to respond to identified gaps in engagement with care-experienced, asylum seeker and refugee, and global majority mothers and fathers. They would also help guide on cultural competence training needed and explore potential for perinatal peer mentor network	Responds to gaps in engagement with care-experienced, refugee, and ethnic minority mothers and fathers	Camden Integrated Early Years & Family Hubs Manager, supported by VCS and Public Health partners
8. Integrate and promote Camden's perinatal mental health support traffic light pathway into all universal health services based in hospital, GP and community as well as social services such as Early Help that might come into contact with parents in the perinatal period	Professional awareness of the developed perinatal mental health pathways remains limited and staff across NCL as well as those operating exclusively within Camden who come into contact with potential parents in the perinatal period would benefit from training	Camden Integrated Early Years Service & Family Hubs Manager
9. Explore establishment of a joint Camden wide maternity and early years governance that can oversee these recommendations and other areas of joint work. **This may involve expansion of Camden IEYS PMH and PIR steering group to ensure secondary care and specialist perinatal mental health support service involvement**	For system wide change and greater collaborative working, it is crucial that partners are connecting on a regular basis, under appropriate governance arrangement to enable progress	Camden Integrated Early Years Service & Family Hubs Manager and Maternity leads

RECOMMENDATIONS - Integrated Early Years Service

Recommendations	Rationale	Ownership
10. Raising awareness of support for father in the perinatal period Working locally with existing and new forums with representation from father to produce campaigns to raise awareness of support available in Camden	Support is available in Camden for fathers however estimates suggest that 1 in 4 fathers may experience mental health problems during this period hence awareness of the this issue as well current levels of engagement indicate significant unmet need	Camden Fathers Inclusion Network and IEYS
11. Identifying a health visiting lead for perinatal mental health and parent infant relations as part of the best start for baby enhanced healthy child programme	Strong evidence form Durham and other Local Authorities that having a professional within the health visiting services championing this area can lead to innovation and greater importance placed on this area across the service	Commissioning of Health Visiting and Health Visiting Service Leads

RECOMMENDATIONS - Integrated Early Years, Health and Wellbeing, Maternity and VCS

Recommendations	Rationale	Ownership
12. Integrate welfare, housing and debt advice into perinatal pathways both in secondary care and in community	Strong evidence that low income, housing and debt are strong social predictors of worse perinatal mental health for both mothers and fathers. Ensure staff have adequate knowledge of how to screen for this and refer for support throughout pathways is needed.	Camden Public Health working with IEYS and Maternity leads
13. Coproduce family-focused anti-stigma activities around perinatal mental health with community and faith organisations targeting Black African and South Asian families. Consider using community location that include places of worship as well as family hubs to maximise reach. Utilise approaches that have been adopted and implemented by the motherhood group based on peer support. Social media was seen as a commonly used source of information and hence would play an important role in activities designed. Where relevant consider role of faith leaders and faith settings	Evidence both from stakeholder and resident insight in Camden as well as national literature emphasis that stigma regarding mental health issues both for father and mothers is higher in global majority families which often prohibits them form accessing support and service early. There is consistent evidence of under use of mild to moderate support, and over use of severe an inpatient mental health support	Camden Health and wellbeing working with IEYS, maternity leads and Camden VCS partners

RECOMMENDATIONS – Primary and Secondary Care

Recommendations	Rationale	Ownership
14. Address the decline in recording observed for the postnatal mother and baby review in General Practice	This GP review is an important appointment in the postnatal journey to determine need for perinatal mental health support for the mother, however local data in Camden indicates that either this appointment is not being recorded as complete in Camden or not being undertaken consistently	Camden Primary Care Federation leads and CYP Primary Care lead for Child Health Equity
15. Explore opportunities for greater involvement of peer support workers and non-professional bilingual facilitators from global majority background to co-design and where appropriate co facilitate support groups	Strong evidence of the importance of bilingual facilitators and peer support in improving outcomes and quality of life in women from south Asian and global majority background. Identified as effective in the ROSHNI-2 trial	Camden NHS Talking Therapies managers, and North London Foundation Trust Specialists Perinatal Mental Health Service leadership team and IEYS
16. Improve the rollout and sharing of training on referrals for NHS Camden Talk Therapies with a view to reducing the vast volume of inappropriate referrals the service receives	Risk of retraumatisation of residents by having to repeat their stories as well as loss of trust be referrals to services not able to support them	NHS Camden Talk therapies working with Public health, Primary Care and IEYS
17. Develop a standardised assessment tool for use by various perinatal mental health services post referral.	A high volume of repeat screening takes places across the system meaning residents are often telling their stories more than once, This process can lead to significant delays in accessing timely and appropriate care, risks re-traumatising the individual through repeated assessments, and contributes to duplication in data recording across services.	Amber and Red Perinatal Mental Health pathway services working together

RECOMMENDATIONS - All

Recommendations	Rationale	Ownership
18. Improve data quality and coding to ensure perinatal mental health screening, referrals, assessment and outcomes are captured and are available stratified by key protected characteristics in particular ethnicity, language, IMD quintile Introduce mandatory data quality standards to ensure that datasets are complete, accurate, and up-to-date. Also, regularly audit datasets to minimize missing data and identify areas for improvement, Implement a minimum equity dataset. Provide training for staff on consistent data entry	The datasets from maternity, health visiting and specialist services access and analysed in this JSNA all allowed very limited analysis due to inconsistent capture of screening, referral, and outcomes in general and by demographics.	NCL ICB lead, All service leads to include Maternity leads, Health visiting leads, Camden NHS Talking Therapies managers, and North London Foundation Trust Specialists Perinatal Mental Health Service leadership team
19. Explore potential across providers for a maternity dashboard for monitoring perinatal mental screening, referrals, engagement, and outcomes across services Utilise data from health visiting, Camden NHS Talking Therapies and SMPHS in a more integrated way to enable a timely assessment of engagement with perinatal mental health support in the borough	Enable early identification of inequalities in access and outcomes	Public Health, Maternity leads, Health visiting leads, Camden NHS Talking Therapies managers, and North London Foundation Trust Specialists Perinatal Mental Health Service leadership team