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Editorial

Specialist perinatal mental health services: future developments to meet the needs of families

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Perinatal mental health services in Ireland have been transformed with the implementation of the Specialist Perinatal Mental Health Services (SPMHS) Model of Care for Ireland (Health Service Executive 2017). Six hub sites, located in the largest maternity centres across the country supported by full multidisciplinary teams, together with 13 spoke sites, have been developed. This has increased the number of full-time staff working in perinatal mental health from five in 2017, to close to 100 to date. In addition, Specialist Perinatal Mental Health Midwives have been appointed in all 19 sites and have been pivotal in providing support for those individuals with mild to moderate mental health problems. These developments have greatly expanded and improved services available to individuals throughout Ireland during the perinatal period (Wrigley and O'Riordan, pp. 577–583). Currently, these specialist services cover the timeframe from the antenatal booking visit up until 1 year post partum. In addition to greatly enhancing the level of services provision, the SPMHS has notably raised the awareness of the importance of perinatal mental health, through education and training of staff and service users. Throughout the initial phase of service roll-out and implementation, there has been an increasing recognition that the SPMH Model of Care needs to be refined and developed to ensure that individuals, families and infants in the perinatal period, irrespective of postal address, need access to directly provided specialist perinatal mental health services. The positive financial impact of investing in specialist perinatal mental health services has been clearly demonstrated (Bauer et al. 2014), and provides very compelling support for investment in, and further development of, these services.

This issue of the Irish Journal of Psychological Medicine explores the development of specialist perinatal mental health services in both Ireland and the United Kingdom (Cantwell, pp. 543–546; Mongan et al. pp. 601–606) and showcases some examples of the important research being carried out around the country.

Unfinished business in the existing model of care

The most significant element of the Irish model of care that is currently yet to be implemented is the development of a Mother and Baby Unit (MBU). In a Scottish cohort, Langan Martin et al. (2016) demonstrated rates of psychiatric admission was significantly increased in the two years following delivery, with particularly high rates in the first six weeks post partum. In this edition of the IJPM, Moran et al. (pp. 566–570) described the high rate of suicidal ideation seen within an Irish population post natally. While only a minority of these will require admission, the article highlights, that severe mental health difficulties can be experienced in the perinatal period and with this severity comes a need for inpatient beds. Without an MBU many individuals requiring inpatient care will be admitted to general adult psychiatry wards. This almost invariably results in women being separated from their newborn, which has implications for maternal mental health, bonding, feeding and the wider family. McGuire et al. (pp. 571–576; pp. 592–600) highlighted the significant gap in policies in some general adult wards, in addressing the specific needs of those who are admitted during the perinatal period, and the lack of research to guide appropriate policy in this regard. Fortunately, some of these needs are starting to be considered with the recent publication of Gender-Sensitive Mental Health (National Women's Council, 2023) and with the awaited gender-sensitive recommendations relating to Sharing the Vision.

While teaching, training and research are vital parts of the development of SPMHS, this is currently being conducted on an informal basis, in the absence of a national coordinating body or educational forum providing oversight. O'Leary et al. (pp. 554–560) provided an excellent example of some of the training that is available. However, there is no strategic plan for how to deliver high-quality training nationally. For example, while the majority of perinatal mental health problems needs may be managed in a primary care setting, many GPs feel unprepared to address perinatal issues and formal training by the SPMHS has been sporadic and piecemeal.

The current format for national data collection from perinatal mental health services has significant limitations and does not allow for high-quality multicentre studies to be conducted. An updated data collection model is currently in development, in collaboration with the National Perinatal Epidemiology Centre in University College Cork, and is due to be piloted in several sites before the end of the current year. This will help to more accurately capture service activity, facilitate comparison across sites, and provide a platform for much-needed research in this field and an important basis for service planning and

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development. A body to oversee an integrated national plan for research, teaching and training would greatly facilitate a cohesive, coordinated approach to training and education of all healthcare staff involved in perinatal mental health care and promote much-needed research to guide evidence-based approaches to treatment.

An additional essential element of the existing model of care, that has not been fully implemented is the provision of suitable accommodation for multidisciplinary teams. Many sites, both hub and spoke, have very inadequate space for their clinical activities. Addressing this fundamental issue is and will continue to be absolutely central to the proper functioning of these services.

Factors to be considered in future iterations of the model of care

Future iterations of the SPMHS model of care will seek to bring the level of service input in the spoke sites up to the standard that is currently present in the hub sites. Spoke site services currently rely heavily on input from Liaison Psychiatry teams and, in their absence, from Adult Community Mental Health teams. Additional resources will be needed to deliver parity of specialist care nationwide. The specific value of specialist perinatal mental health care has been highlighted in a number of studies. Cooney et al. (pp. 588–591) have highlighted the improvements that are possible through more nuanced diagnosis and prescribing concordant with best practice guidelines facilitated by a functioning SPMHS on site. Mitchell et al. (pp. 584–587) highlighted the need for careful complex case management and integrated care with addiction services. McKenna et al. (pp. 561–565) and Hinds et al. (pp. 547–553) have highlighted the considerable burden of anxiety spectrum condition in the perinatal period. All of these layers of complexity cannot be met by already overstretched Liaison or Community Mental Health teams. Indeed at times some of those presenting with perinatal mental health problems and who would clearly benefit from specialist input may not meet referral thresholds for Community Mental Health teams. Updating and refreshing the 2017 model of care will be needed to focus on the further expansion of services to provide equity of access to MDT-provided specialist mental health services across all 19 maternity centres in Ireland. There are significant barriers to addressing these deficits including geographical challenges and service innovations including remote assessments will play an important role in future developments.

Infant mental health services are currently provided on a piecemeal basis in Ireland, and are not integrated into the SPMHS. These services can play an essential role in supporting bonding and helping to address risk factors for later physical and mental illness. O'Leary et al. (pp. 554–560) highlighted how valuable infant mental health training can be to general adult psychiatry teams. In the UK, many perinatal teams include maternity care workers which can provide an invaluable resource to aid bonding and support early parenting. Scotland currently has a service model which could act as a reference point for Irish services (McFadyen 2021).

Nagel et al. (2022) have recently demonstrated the extent of birth trauma in an Irish population with 18% of women in one Irish maternity centre reporting their birth as subjectively traumatic. Many of the SPMHS services have now set up birth trauma clinics and provide targeted services to address PTSD and sub threshold trauma symptoms. In the UK, services addressing trauma work in tandem with bereavement support services. They are run as a trauma and loss service that is primarily run by psychology. There is distinct overlap between a trauma and loss service and the psychological support needed in assisted fertility services. With the roll-out of national publicly funded fertility services trauma and loss supports will need to be funded both within the SPMHS and independent of it in the fertility services.

There is an increasing recognition of the mental health problems that fathers and co-parents may experience in the perinatal period (Wang et al. 2021). However, there are currently very limited supportive interventions available nationally for this group. Any future refresh of the SPMHS Model will need to assess this issue further and make recommendations about future service provision.

Conclusion

The transformation of Specialist Perinatal Mental Health care provision in Ireland in recent years cannot be overstated. These services have significantly expanded, are more proactive, have greater specific expertise and provide prompt care for individuals through their pregnancy and into the first year of parenthood. However, failing to build on this excellent foundation would do a great disservice to many women, children and families within Ireland. While we have progressed rapidly in a relatively short time, Ireland still lags behind other countries in terms of what supports are provided and the environments in which these services are delivered. Many of these challenges can be addressed and clinicians working in the field are highly motivated to do so.

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Ethical standard. The author asserts that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committee on human experimentation with the Helsinki Declaration of 1975, as revised in 2008.

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