AIMS For a better birth...

Improving Maternity Services for positive mental health outcomes: a checklist for action

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In 2007, AIMS proposed a checklist of actions[1] which we believed were necessary to improve how the maternity service worked with the issue of perinatal mental health. At that time, we said that we had to think outside the box and concentrate on a broad strategy for the future. We noted that the primary prevention of trauma was crucial.

The awareness around the topic of perinatal mental health - as it affects mums, dads, babies and the wider family, not forgetting health care professionals too - has grown tremendously since that first checklist was published. And whilst the taboo around perinatal mental health problems has not yet disappeared, it has certainly been challenged in recent years, with increasing numbers of individuals prepared to tell their story.

There was an important focus on perinatal mental health in Baroness Julia Cumberledge's Better Births report (2016) and the priority of the issue in the Maternity Transformation Programme has again been confirmed in the NHS Long Term Plan (2019). But there is a huge difference between policy intention and successful policy implementation. The AIMS campaign group have therefore updated our checklist to reflect the views of campaigners seeking to achieve positive change in this area.

As the articles in this issue demonstrate, the research into this subject is growing, and we know much more now than we did in 2007. In that context, we find that too many of the issues on the original AIMS checklist remain both relevant and outstanding. In addition, calls to the AIMS helpline suggest that improvements to the maternity services in this area are still desperately needed.

Over the next few months, AIMS volunteers, as part of the Make Birth Better collaboration, will be discussing how we can all work together to keep a focus on achieving these campaign objectives.Do get in touch if you would like to be part of this work.

IMPROVING MATERNITY SERVICES FOR POSITIVE MENTAL HEALTH OUTCOMES: A CHECKLIST FOR ACTION

1. **We call for the full implementation of a Continuity of Carer model of maternity care for all women and families, in which all maternity staff are trained to offer culturally-safe care.**Mental health issues are not limited to specific groups and we suggest that the protective care of a known

and trusted midwife throughout pregnancy, birth and the postnatal period, working as part of an effective multidisciplinary team, might play a large part in improving perinatal mental health outcomes, including by better identifying service-users most at risk of trauma and by working to both prevent and help resolve that trauma.

2. **We call for a greater emphasis to be given, both in research and in obstetric and midwifery training, to the psychological vulnerability of all those involved in the delivery of maternity services, including service-users, their family and supporters, and service providers.**
3. **We are keen to see epidemiological studies of incidence and likely causes of birth-related trauma and birth related post traumatic stress disorder (PTSD) rates (a) by birth setting and type of care and (b) by geographical area.**
4. **We are keen to see quality ratings for maternity services which include psychiatric morbidity rates as well as an appraisal of the quality of the local trauma specific treatment pathways available.**
5. **Where a woman's mental health has been negatively affected during her maternity care (either due to the nature of the birth or due to her experience of the maternity care provided, including interactions with staff), we call on each Trust to implement a system of case-specific investigations, assessing local processes as well as the actions of individual staff that may have contributed to this outcome.** These investigations should be focused on learning, and offer ongoing support for all staff involved. In the context of a no-blame learning culture we believe that mandatory reflective practice for all staff would contribute to the reduction of such incidents, but where staff are unable to meet the standards required then we call for a full range of remedial actions to be available, including retraining, suspension or dismissal.
6. **Recognising the ongoing mental health issues suffered by some women, we call for the abolition of the 12 month time limit for complaints about maternity care.** We suggest that PTSD sufferers are often incapable of making a complaint within that time-period, given the likelihood of severe flashbacks being provoked by the premature reading and writing about their experience.
7. **We call for an improvement in the quality of postnatal care, in all settings including home, to prevent the exacerbation of trauma damage by poor postnatal care and also to ensure the early identification of mothers who would benefit from additional support.** This links to our call for the implementation of a Continuity of Carer model of maternity care, which should offer midwives the opportunity to agree a personalised schedule of postnatal contacts and which should extend to a smooth transition between the midwife and health visitor.
8. **We are concerned about local variability in the availability and effectiveness of care offered to women suffering from birth-related trauma, including the availability of specialist therapy and access routes to these.** In addition to the existing referral mechanisms, there should be universal self-referral mechanisms in place. Where Trusts do not provide the required services, or where women are keen to access care from an alternative provider (for example, if further contact with their usual provider is likely to cause further harm linked to previous experiences), CCGs must ensure that care pathways are commissioned so that women are able to access suitable out-of-area or independent care.
9. **We call on the researchers working on Confidential Enquiries into Maternal Deaths to report in more detail on associations between perinatal mental health and suicide.**

In particular, where postnatal psychosis or depression has been ruled out in cases of maternal suicide, we believe that more detailed enquiries might sometimes identify traumatic birth and PTSD as a cause of suicide.

Links:
1) Post Traumatic Stress Disorder, Jean Robinson, AIMS Journal 2007, Vol 19, No 1