Perinatal Mental Health in Havering
Key Findings

The perinatal period—from pregnancy to a year after birth—is marked by major physical, emotional, and social changes. Some parents experience distress that can lead to or worsen mental health conditions.

Gaps, Growth and Opportunities for Change

Growing Need

- 22.6% increase in referrals to PPIMHS (2019/20–2023/24)
- Havering has higher access rates than both London and England

Access Limitations

- 12-month service cut-off leaves parents unsupported beyond infancy
- Discharges often due to:
  - Missed appointments
  - Childcare challenges
  - Digital exclusion

System Gaps and Fragmentation

- Poor coordination across GPs, health visitors, children's centres, and mental health services
- No centralised service directory → delays, duplication, missed care

Stakeholders report that:

- Birth trauma strongly linked to perinatal mental health (PMH) issues
- Limited access to neurodevelopmental assessments (e.g., ADHD, autism) → delayed diagnosis, worsened PMH

Who's Missing?

- No formal pathways for non-birthing partners despite real risks
- Gaps in outreach in high-deprivation areas → lower awareness & access

What's needed?

- Trauma-informed maternity care
- Neurodevelopmental support
- Support for partners
- Outreach in deprived areas
- Centralised, up-to-date directory of services

Havering
LONDON BOROUGH

Adult Mental Health Needs Assessment 2025

Perinatal Mental Health Chapter

Contents

Perinatal Mental Health in Havering

Key Findings

- Havering has a higher rate of access to specialist perinatal mental health services than London and England.
- The number of Havering resident referrals to PPIMHS, the service for moderate-to-severe perinatal mental health issues, increased by 22.6% between 2019/20 and 2023/24.
- The 12-month service cut-off for perinatal mental health services prevents parents receiving support when mental health needs emerge or persist beyond infancy.
- Parents may be discharged due to missed appointments, childcare barriers and digital exclusion.
- Service fragmentation across GPs, health visitors, children's centres and mental health services lead to duplication, delays or missed support and there is an absence of a centralised, up-to-date service directory.
- Birth trauma is a significant risk factor for development of PMH conditions. There is a need to develop a culture of trauma-informed care within maternity services.
- Access to neurodevelopmental assessments, such as for ADHD or autism, is also extremely limited, delaying appropriate diagnosis and treatment which can worsen PMH.
- Formal perinatal pathways are not all commissioned for non-birthing partners, despite them being at risk of mental health issues.
- Stakeholders highlighted that outreach and engagement are lower in areas of higher deprivation within the borough, which can limit awareness of and access to support.

Recommendations

- Develop culturally informed antenatal packages for families, including literature for family members that address common misconceptions and promote perinatal mental health awareness.
- Develop Havering Integrated Perinatal Mental Health Pathway, mapping what support is available to parents and families in Havering at appropriate levels of need.
- Explore extending support to 24 months post-birth, similar to the ELFT model, with a focus on securing funding for Havering.
- Increase peer support groups for individuals leaving structured PMH services to maintain postnatal support networks.
- Investigate opportunities for co-location, joint appointments and non-clinical settings to improve service user access to support networks
- Improve integrated working and collaboration among PMH stakeholders.
- Introduce and develop MDTs within Child Health Hubs.
- Each service to identify underrepresented groups compared to Havering's birth demographics, understanding the causes of variation between groups and reducing unwanted variation.
- Ensure use of inclusive language in all support groups, including those advertised for fathers to include non-birthing partners in its outreach.
- Provide perinatal mental health training that is trauma-informed to the Havering workforce that may work with residents in perinatal and postnatal periods.
- Ensure all PMH services have trauma-informed outlined in approach to care, whether commissioned or voluntary service.
- Develop a service pathway between CAMHS and adult perinatal mental health services for Havering residents below 18 who are in the perinatal period.

Introduction

The Perinatal Period and Mental Health

The perinatal period spans from the beginning of pregnancy through childbirth and the first year after the baby is born. It is a time of physical, emotional, hormonal, and social changes.[1] Some new parents experience emotional distress, which can develop into clinically relevant mental health issues. Additionally, pre-existing mental health conditions may worsen.

Perinatal mental health (PMH) refers to the psychological and emotional wellbeing of individuals during pregnancy and the year following birth. It includes a wide range of mental health disorders that vary in severity, duration and impact. Perinatal mental health disorders affects an estimated 10% and 20% of women during the perinatal period.[2] Perinatal mental illness can affect the infant, partner and broader family unit as well as interfere with maternal-infant bonding, child development, and family relationships.[3]

Risk Factors for Perinatal Mental Illness

A number of factors can influence perinatal mental health, including:

- **Mental Health History**
  - Personal history of mental illness
  - Family history of psychiatric conditions
- **Social and Relationship Factors**
  - Lack of emotional or practical support
  - Marital or relationship conflict
  - Intimate partner violence of domestic abuse
  - Cultural stigma around mental illness
- **Pregnancy and Birth Experience**
  - Unplanned or unwanted pregnancy
  - Obstetric complications
  - Traumatic or emergency birth
  - Neonatal complications or infant admission to NICU
  - Pregnancy loss, miscarriage, stillbirth or neonatal death
  - History of infertility or assisted reproduction
- **Socioeconomic Challenges**
  - Financial hardship
  - Housing instability
  - High stress or traumatic life events
- **Lifestyle and Health Factors**
  - Substance misuse
  - Tobacco use

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[1] Royal College of Psychiatrists, "Perinatal mental health services: Recommendations for the provision of services for childbearing women," RC Psych, 2021.

2 Bauer, A., Parsonage, M., Knapp, M., Iemmi, V., & Adelaja, B. (2014). *The costs of perinatal mental health problems*. London: Centre for Mental Health and London School of Economics. Available at https://eprints.lse.ac.uk/59885/1/__lse.ac.uk_storage_LIBRARY_Secondary_libfile_shared_repository_Content_Bauer%2C%20M_Bauer_Costs_perinatal_%20mental_2014_Bauer_Costs_perinatal_mental_2014_author.pdf

3 Centre for Mental Health. (2015). *Falling through the gaps: perinatal mental health and general practice*. London: Centre for Mental Health. Available at: https://www.centreformentalhealth.org.uk/publications/falling-through-gaps/

4 Paschetta, E., Berrisford, G., Coccia, F., Whitmore, J., Wood, A. G., Pretlove, S., & Ismail, K. M. (2014). Perinatal psychiatric disorders: an overview. American Journal of Obstetrics and Gynecology, 210(6), 501-509.

These factors often interact in complex ways, increasing vulnerability for individuals with multiple and intersecting risk factors.

Classification of Perinatal Mental Health Disorders

Perinatal mental health disorders include:

- **Perinatal and postnatal depression:** Ranges from mild depressive symptoms to major depressive episodes.
- **Perinatal anxiety disorders:** Includes generalised anxiety, panic attacks and pregnancy- or parenting-specific phobias.
- **Perinatal obsessive-compulsive disorder (OCD)**: experiencing intrusive, repetitive, and often distressing thoughts—often about the baby's safety—and compulsive behaviours.
- **Post-traumatic stress disorder (PTSD)**: May follow traumatic events, such as a negative birth experience, miscarriage, stillbirth, or neonatal loss.
- **Postpartum psychosis**: A rare but severe condition marked by hallucinations, delusions, extreme mood swings, and disorganised thinking and typically emerges within the first two weeks postpartum.

Pre-existing severe mental illness also has an impact on perinatal mental health. For example, schizophrenia is linked to adverse outcomes such as low birthweight and stillbirth, partly due to associated social and environmental factors (e.g., increasing smoking rates, limited social support networks).[4]

For the classifications of perinatal mental health disorders, please see Figure 1.

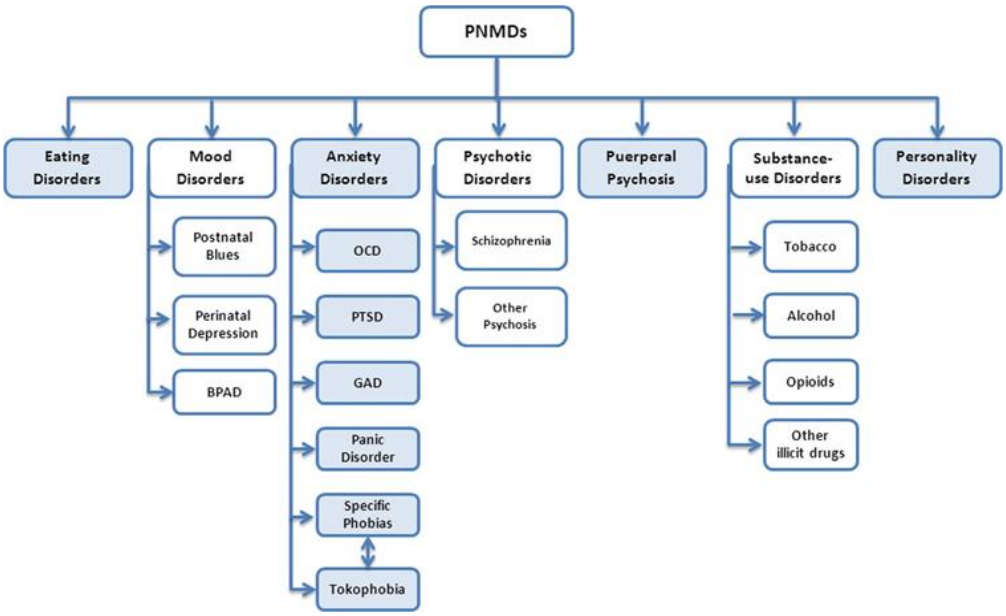

Figure 1: Classification of Perinatal Mental Disorders[5]

[4] Howard L. M. (2005). Fertility and pregnancy in women with psychotic disorders. *European journal of obstetrics, gynecology, and reproductive biology*, *119*(1), 3–10. https://doi.org/10.1016/j.ejogrb.2004.06.026

[5] Paschetta, E., Berrisford, G., Coccia, F., Whitmore, J., Wood, A.G., Pretlove, S. and Ismail, K.M., 2014. Perinatal psychiatric disorders: an overview. *American journal of obstetrics and gynecology*, *210*(6), pp.501-509.

The Early Postnatal Period: A High-Risk Window

The early postnatal period is a particularly vulnerable time for mental health deterioration. Women are more likely to require psychiatric admission during this period than at any other time in life, including those with no prior mental health history.[6]

Notably, maternal suicide is now the leading cause of direct maternal death between six weeks and one year postpartum. From 2020 to 2022, psychiatric causes accounted for 34% of maternal deaths in the UK, underscoring the need for proactive screening and multidisciplinary support.[7]

Mental Health in Non-Birthing Partners

There is growing awareness of the importance of the mental health of partners and other family members during the perinatal period.[8] Clinically diagnosed anxiety affects 1 in 20 (5.3%) non-birthing partners, while self-reported symptoms are seen in 1 in 8 (12.3%).[9] Depression affects approximately 8% of non-birthing partners.[10] Risk factors include younger age, lower educational attainment, previous mental health history, and exposure to partner's maternal depression.[11] Partners' mental health challenges are also linked to emotional and behavioural difficulties in children.[12]

The Economic Impact of Perinatal Mental Illness

A 2014 UK report estimated that perinatal depression, anxiety and psychosis cost society approximately £8.1 billion for each annual birth cohort – nearly £10,000 per birth.[13] Almost three-quarters of these costs are attributed to adverse impacts on the child. The public sector bears about £1.7 billion (or £2,100 per birth). These figures highlight the cost-effectiveness of early intervention, integrated services, and investment in perinatal mental health services.[13]

National and local context

National Context

In England, an estimated 25.8% of women—approximately 155,000 annually—are affected by PMH conditions.[14]

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[6] RCPsych (2021), Perinatal Mental Health Services: Recommendations for the provision of services for childbearing women. https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2021-college-reports/perinatal-mental-health-services-CR232

[7] MBRRACE-UK (2024). Maternal Mortality Rates and Causes: UK MBRRACE-UK Data Brief – 2021–2023. Oxford: National Perinatal Epidemiology Unit, University of Oxford. Available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-brief/maternal-mortality-2021-2023

[8] Where literature refers to paternal mental health, this has been updated to reflect the diversity of relationships shaping parenthood.

[9] Leiferman, J. A. et al. (2021) Anxiety among fathers during the prenatal and postpartum period: a meta-analysis. Journal of Psychosomatic Obstetrics and Gynecology vol. 42 152–161 https://doi.org/10.1080/0167482X.2021.1885025

[10] Cameron, E. E., Sedov, I. D. & Tomfohr-Madsen, L. M. (2016) Prevalence of paternal depression in pregnancy and the postpartum: An updated meta-analysis. Journal of Affective Disorders vol. 206 189–203 https://doi.org/10.1016/j.jad.2016.07.044

[11] Da Costa, D., Danieli, C., Abrahamowicz, M., Dasgupta, K., Sewitch, M., Lowensteyn, I. and Zelkowitz, P., 2019. A prospective study of postnatal depressive symptoms and associated risk factors in first-time fathers. *Journal of affective disorders*, *249*, pp.371-377.

[12] Gov.uk, Methodology and supporting information: children living with parents in emotional distress, March 2022 update (2024).

[13] Centre for Mental Health & London School of Economics Personal Social Services Research Unit (2014). The costs of perinatal mental health problems. https://www.centreformentalhealth.org.uk/publications/costs-perinatal-mental health-problems

[14] Office of Health Improvement and Disparities *Estimated prevalence of perinatal mental health conditions in England, 2016 to 2019*. Available at: https://www.gov.uk/government/publications/perinatal-mental-health-condition-prevalence/estimated-prevalence-of-perinatal-mental-health-conditions-in-england-2016-to-2019

Although overall PMH prevalence is slightly lower in London, significant inequalities remain. In England, Black mothers are more than twice as likely to be admitted to hospital with PMH issues compared to White mothers[15]—reflecting systemic issues such as racism, inequitable service access and a lack of culturally appropriate care.[16]

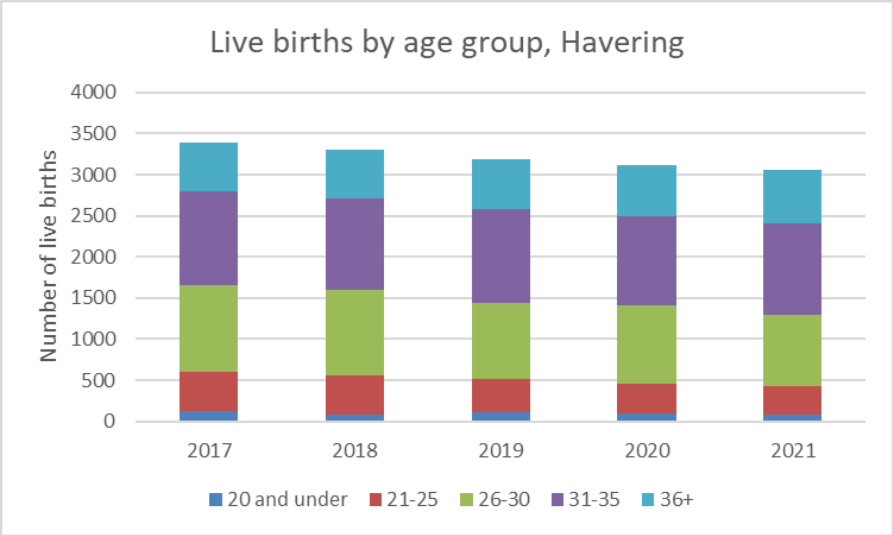
Nationally, recent investments—in line with the NHS Long Term Plan (2019)—have expanded specialist community perinatal mental health teams that support pregnant people with moderate to severe conditions.[17] These teams reduce relapse and improve outcomes, but access remains unevenly distributed. The NHS Long Term Plan set out an ambition that specialist perinatal mental health services will be available from preconception to 24 months after birth by 2023/24.[18]

Local context

Fertility and Maternal Profile in Havering

Havering's female population is approximately 138,272.[19] The greatest number of live births are to women and people aged 31-35 (Figure 2). A significant proportion are among people aged 36 and above; this older age is associated with increased risk of pregnancy complications and perinatal anxiety.[20,21]

Figure 2: Graph showing number of live births by age group of mother, Havering, 2017-2021



Source: ONS

- The number of births has slightly decreased each year from 2017 to 2021.
- The largest numbers of births are to women in the 31-35 age group.
- Births to mothers aged 25 and under made up a decreasing percentage of all births (17.5% in 2017 to 13.9% in 2021).

[15] The Guardian, Black mothers twice as likely as white mothers to be hospitalised with perinatal mental illness (2024, May). The Guardian. Available from: Black mothers twice as likely as white mothers to be hospitalised with perinatal mental illness | Race | The Guardian
[16] MBRRACE-UK (2024). Maternal Mortality Rates and Causes: UK MBRRACE-UK Data Brief – 2021–2023. Oxford: National Perinatal Epidemiology Unit, University of Oxford. Available at: https://www.npeu.ox.ac.uk/mbrrace-uk/data-brief/maternal-mortality-2021-2023
[17] Maternal Mental Health Alliance (2023) *Specialist perinatal mental health services in the UK: Maps 2023*. Available at: mmha-specialist-perinatal-mental-health-services-uk-maps-2023.pdf (Accessed: 4 May 2025).
[18] NHS Long Term Plan, 2019, https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf
[19] London Borough of Havering. *Population demographics*. Havering Data Intelligence Hub. Available at: Population - UTLA | Havering | Report Builder for ArcGIS
[20] Londero, A.P., Rossetti, E., Pittini, C., Cagnacci, A. and Driul, L., (2019) Maternal age and the risk of adverse pregnancy outcomes: a retrospective cohort study. *BMC pregnancy and childbirth*, *19*, pp.1-10.
[21] Lean, S.C., Jones, R.L., Roberts, S.A. and Heazell, A.E., (2021) A prospective cohort study providing insights for markers of adverse pregnancy outcome in older mothers. *BMC Pregnancy and Childbirth*, *21*, pp.1-17.

In 2022, Havering's crude birth rate was 11.7 births per 1,000 total population, slightly lower than the London average, but higher than England (Table 1).[22] The maternity rate was 58.1 per 1,000 women aged 15 to 44—higher than both London (49.9) and England (51.3).[22]

Havering's fertility rate at 58.7 births per 1,000 women aged 15–44 was the seventh highest rate among London boroughs, although lower than four of the other six NEL boroughs.[22]

Table 1: Table showing 2022 birth, fertility and maternity rates for Havering, London and England

Indicator	Havering		London		England	
	Count	Rate	Count	Rate	Count	Rate
Crude Birth Rate: all births per 1,000 population of all ages (2022)	3089	11.7	106,597	12.0	576,643	10.1
General fertility rate: all live births[23] per 1,000 women aged 15 to 44 (2022)	3089	58.7	106,696	50.4	577,046	51.9
Maternity rate: Maternities[23] per 1,000 women aged 15 to 44 (2022)	3,058	58.1	105,460	49.9	570,844	51.3

Source: Office for National Statistics[22]

Table 2: Summary of perinatal mental health risk in Havering compared to London and England.[24]
For a table showing borough-specific risk factors for perinatal mental health issues, comparing rates for Havering, London and England, please refer to Appendix A.

Socio-economic risk factors	• Teenage motherhood (0.8%) is low, but the under-18 conception rate (12.4 per 1,000) is higher than London's average, with the majority (73.7%) of those conceptions ending in termination of pregnancy. • Nearly half (46.6%) of births occur outside of marriage or civil partnership. • High rates of children in need (146.1 per 10,000) indicate family instability, a significant PMH risk.
Medical and obstetric factors	• Rates of low birth weight (6.8%) are lower than London (8.2%) and England (7.2%). • Multiple births (15.4%) and caesarean section rates (37.3%) are close to national averages and slightly below London rates. • Premature births are lower (67.8 per 1,000) compared to London and England. • Stillbirth, neonatal mortality, and infant mortality rates are slightly lower than national averages, but these remain important indicators of clinical risk.
Behavioural risks	• Havering's smoking rate at the time of delivery is 3.7%, which is lower than the national average and similar to the London average. • While local data is lacking for alcohol or drug use, London-wide figures suggest that around 2.3% report drinking in early pregnancy and 0.6% report drug misuse.
Service access	• Early access to maternity care in Havering (60.2%) is slightly better than London (59.2%) but lower than England (63.5%).

[22] Office for National Statistics (ONS). (n.d.). *Birth characteristics in England and Wales*. Available at: Birth characteristics - Office for National Statistics
[23] Definitions:
i. Fertility rate: The number of live births per 1,000 women of reproductive age (aged 15–44 years) in a given year.
ii. Maternity rate: The number of maternities per 1,000 women of childbearing age (aged 15 to 44 years) in a given population and time period.
[24] Fingertips (Fingertips | Department of Health and Social Care)

Prevalence of Perinatal Mental Health Conditions in Havering

- PMH conditions are estimated to affect 24.6% of women in Havering.[25]
- Adjustment disorders and other mild to moderate mental health problems affect between 15% and 30% of pregnancies.[26]
- Mild to moderate depression and anxiety are estimated to impact between 10% and 15% of pregnancies in Havering, equating to approximately 258 to 386 women per year.[27]
- Severe mental illness (SMI) is estimated to affect 5 women annually (0.2% of pregnancies).[28]
- Postpartum psychosis, a psychiatric emergency, is also estimated to occur in 5 women annually (0.2% of pregnancies).[29]
  Post-traumatic stress disorder (PTSD) related to pregnancy or childbirth affects an estimated 77 women each year, accounting for around 3% of pregnancies.[30]
- There is a clear link between area deprivation and PMH prevalence. Higher rates of perinatal mental health issues are seen in the most deprived communities, while the least deprived areas have the lowest prevalence; this lines up with local stakeholder insights.[31]

Services and Access

- In 2023/24, the proportion of women accessing maternity care early (before 10 weeks gestation) in Havering was 60.2%. This is lower than the England average of 63.5% and represents a declining trend locally.[24]
- Access to specialist perinatal mental health services is better than the national average. Between 2020/21 and 2022/23, Havering achieved a standardised access rate of 101.1 per 100,000 women, compared to 77.8 nationally.[24]

Health Inequalities

Health inequalities persist in PMH services. Underrepresented groups include:

- Women from global majority (formerly known as ethnic minority) backgrounds, particularly Black African, Asian and White Other.
- Young mothers
- Women facing multiple adversities, such as domestic abuse, deprivation, substance misuse and child removal through care proceedings.
- Neurodivergent women and families.[32]

Across north-east London (NEL), women from global majority backgrounds and deprived areas face worse maternity outcomes, such as higher rates of stillbirth, neonatal admissions, low birth weight, hypertension, diabetes and emergency caesarean deliveries.[32] Maternal mental health needs are closely linked to these physical health risks, as well as to experiences of trauma and social disadvantage. Furthermore, women from global majority

[25] Fingertips PHE, 2019. Model-based estimated prevalence of perinatal mental health conditions.

[27] BHRJSNA2022_Havering_Profile.pdf
[28] BHRJSNA2022_Havering_Profile.pdf
[29] BHRJSNA2022_Havering_Profile.pdf
[30] BHRJSNA2022_Havering_Profile.pdf
[31] The Office of Health Improvement and Disparities (OHID) *Estimated prevalence of perinatal mental health conditions in England: 2016 to 2019*. GOV.UK. Available at: Estimated prevalence of perinatal mental health conditions in England, 2016 and 2019 - GOV.UK
[32] NHS England, (2025), Perinatal Mental Health Multiple Disadvantage and Complexity Webinar.

backgrounds often access maternity care two weeks later, on average, than their White counterparts.[33]

Regional and local action

The NEL-wide approach recognises the need for more culturally competent, trauma-informed and personalised care. Relevant initiatives include:

- **Personalised Care and Support Plans (PCSPs)** to identify and address women's social, emotional, and mental health needs.
- **TULIP (Trauma, Understanding Loss and Infertility in the Perinatal Period)** specialist PMH service for women affected by birth trauma, pregnancy loss or complex emotional needs linked to reproduction.
- **Maternity Mates**, a peer support model for women with language or cultural barriers.
- **Cradling Culture**, a peer support network for those in perinatal period.
- **Digital tools** to improve access to information and services.

The NEL Maternity Equity and Equality Strategy also calls for improved ethnicity and deprivation data collection and use to enable more targeted action.[34]

For Havering, these regional priorities align with local needs: early engagement, trauma-informed pathways, culturally competent care and integrated working across maternity, mental health, social care, and voluntary sector services to address PMH inequalities.

Service provision

Wider services provision

Routine antenatal and postnatal appointments are key opportunities for health professionals to discuss emotional wellbeing and identify potential mental health concerns. Maternity, general practice, and health visiting services are well placed to offer initial early support, assess mental health needs, and make referrals to appropriate services.

General Practice

GPs play a key role in early identification of perinatal mental illness, particularly for women and people with a history of mental health issues. They can provide preconception advice and make referrals. However, fragmented information systems can hinder communication.[35] GPs also provide the 6-week postnatal check, offering an opportunity to screen for emerging mental health concerns. Training in perinatal mental health is crucial for GPs but not consistently accessible due to time and capacity constraints.[35]

Midwives

Midwives are central to PMH care. The booking appointment is a key opportunity to explore mental health history and raise awareness about symptoms and available support. However, national evidence suggests that time constraints and fear from the midwives of identifying

[33] North East London Local Maternity and Neonatal System Equity and equality strategy and action plan, 2022, https://northeastlondon.icb.nhs.uk/news/north-east-london-local-maternity-and-neonatal-system-equity-and-equality-strategy-and-action-plan/
[34] North East London Local Maternity and Neonatal System Equity and equality strategy and action plan, 2022, https://northeastlondon.icb.nhs.uk/news/north-east-london-local-maternity-and-neonatal-system-equity-and-equality-strategy-and-action-plan/
[35] Centre for Mental Health and Royal College of General Practitioners. (2019). *Falling through the gaps: perinatal mental health and general practice*. Centre for Mental Health. Available at: https://www.centreformentalhealth.org.uk/wpcontent/uploads/2018/11/falling_through_the_gaps_summary.pdf

complex issues that may be hard to resolve and could further strain already heavy workloads are barriers to routine mental health conversations.[36]

Specialist perinatal mental health midwives can strengthen pathways by:[37] [38]

- Providing direct care and advice for individuals with mental health conditions
- Acting as a link between maternity, mental health, social care, and voluntary services
- Supporting colleagues with training and case discussions.

Where continuity of midwife-led care is available, outcomes improve, including reduced risk of preterm birth and baby loss. Despite this, workforce shortages remain a challenge across the maternity system.[39]

Midwifery in Havering

The Public Health Midwifery Team at Barking, Havering and Redbridge University Trust (BHRUT)[40] includes four specialist midwives who support pregnant women and people experiencing mental health challenges or substance misuse. Service users are triaged into moderate or severe mental health pathways, with care plans developed at 31 weeks to guide delivery and early postnatal care.

Pregnant women and people can self-refer for antenatal care or be referred by GPs or other professionals. Those with moderate risk (e.g., anxiety or depression) receive care from public health midwives and mental health obstetric consultants. Those with severe risk (e.g., bipolar disorder, schizophrenia) attend joint clinics with the public health midwives, obstetricians, and consultant psychiatrists. People can be escalated between pathways if their mental health changes. In cases of acute crisis, the psychiatric liaison team is involved.

After birth, the public health midwifery team continues care on the postnatal ward to conduct wellbeing checks and alert involved professionals if required. Community midwives continue routine postnatal care after discharge.

Health Visitors

Health visitors support PMH, assessing emotional wellbeing, offering brief interventions, and signposting or referring to other services as needed. At the 6–8-week postnatal review, they screen for concerns and can offer listening visits or refer to other services. Operating within the Healthy Child Programme, they deliver five universal reviews from birth to 2.5 years.

[36] McGlone, C., Hollins Martin, C.J. and Furber, C. (2016). Midwives' experiences of asking the Whooley questions to assess current mental health: a qualitative interpretive study. *Journal of reproductive and infant psychology*, *34*(4), pp.383-393.
[37] Health Education England. (2018). *Perinatal mental health: The competency framework*. Available: https://www.hee.nhs.uk/our-work/mental-health/perinatal-mental-health/competency-framework-perinatal-mental-health
[38] Hogg, S., 2013. Prevention in mind. All babies count: Spotlight on perinatal mental health. *London: NSPCC*, pp.1-15.
[39] All-Party Parliamentary Group on Baby Loss (2022) *Safe Staffing: The impact of staffing shortages in maternity and neonatal care. APPG report*. Available at: https://www.sands.org.uk/sites/default/files/Staffing%20shortages%20-%20APPG%20report,%20Oct%2022%20(final).pdf
40 BHRUT covers both King George and Queens Hospitals; King George Hospital is only for antenatal/community appts; Queens Hospital is where the labour wards and birth centre are placed.

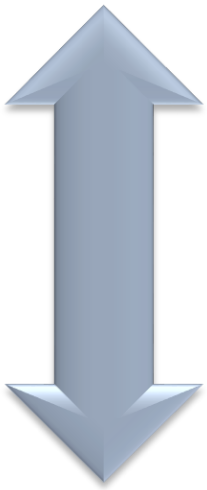
Figure 3: Universal health and wellbeing reviews and suggested contacts as part of overall support 0 to 5 years[41]

Health Visiting in Havering

NELFT provides Havering's Health Visiting service. Families in Havering are offered regular health and development reviews for their children until they are two years old. Health visitors work in various settings, including homes, children's centres, schools, and GP surgeries, to provide accessible support across the borough.

Perinatal Mental Health Support in Havering

Havering offers a range of specialist and community services to support parents experiencing mild to severe mental health difficulties during pregnancy and after birth.



Mild-to-moderate:

- Butterflies & children's centre activities
- Mums Matter (Havering Mind)
- Specialist Perinatal Health Visitor
- Feeding cafes and Infant Feeding Support
- Talking Therapies & Primary Care

Moderate-to-severe:

- Perinatal Parent Infant Mental Health Service (PPIMHS)
- TULIP
- Mental Health & Wellness Teams (MHWTs)

[41] The Office of Health Improvement and Disparities. (2021). *Health visiting and school nursing service delivery model:* GOV.UK. Available at: Health visiting and school nursing service delivery model - GOV.UK

Access to specialist perinatal mental health services

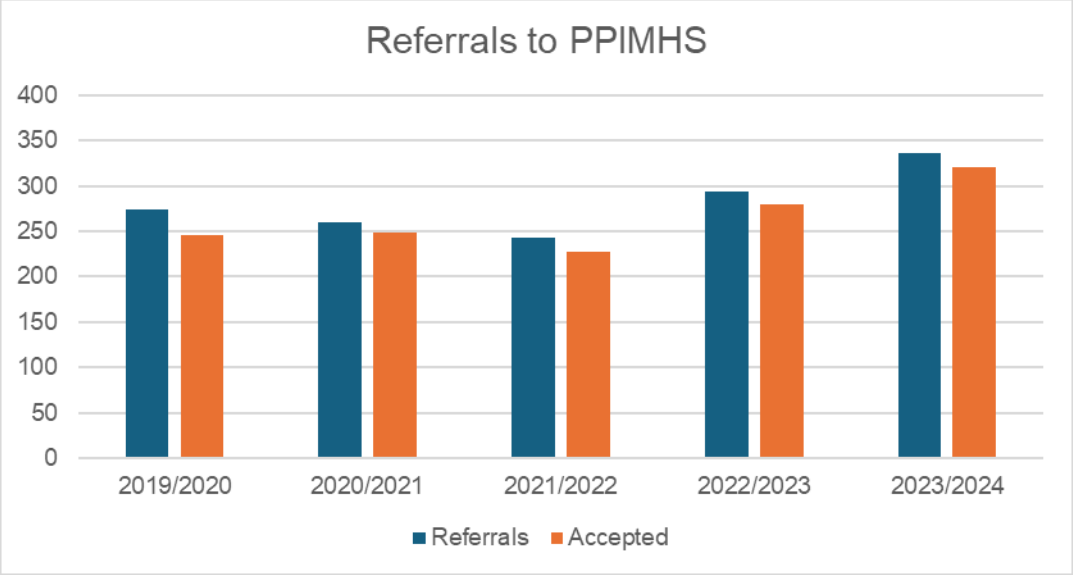
Havering has a higher rate of access (101.1 per 1,000 births) to specialist perinatal mental health services than London (74.4 per 1,000) and England (77.8 per 1,000).[42] This could reflect higher levels of need or effective referral and access processes.

Perinatal Parent Infant Mental Health Service (PPIMHS)

PPIMHS is a specialist service supporting women and people with moderate-to-severe mental health problems during pregnancy and up to 12 months postnatally. It provides perinatal psychiatry and parent-infant therapy.

Referrals data

Figure 4: Graph showing the number of Havering referrals to and accepted by PPIMHS, between 2019/20 and 2023/24



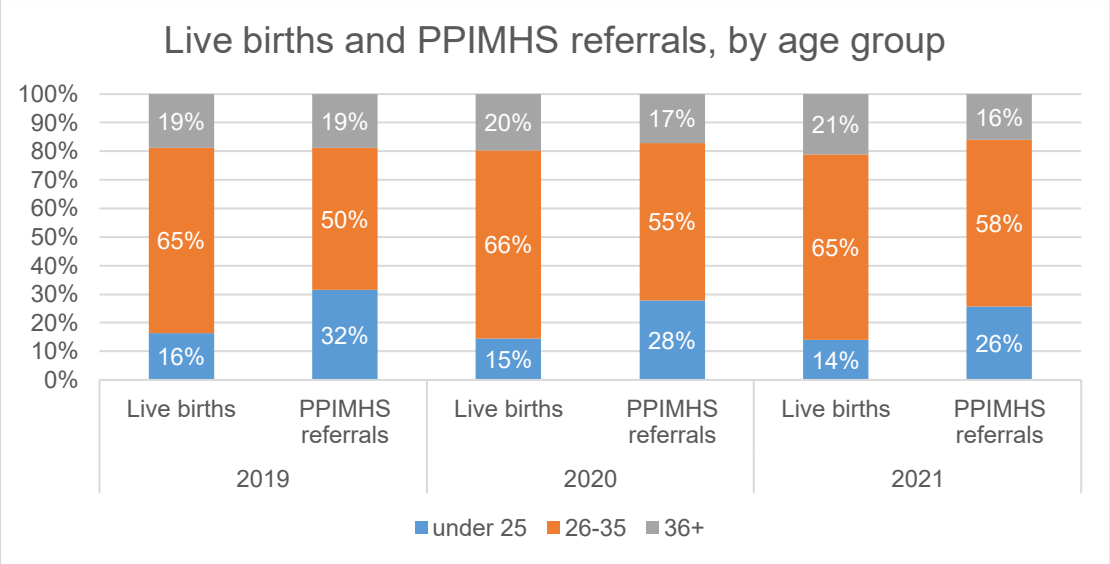
Source: NELFT

- The number of referrals to PPIMHS increased by 22.6% between 2019/20 and 2023/24. This is despite the birth rate decreasing slightly each year. This could indicate increased awareness, increased severity of conditions or perinatal mental health conditions or improved access to services.
- 99% of referrals to PPIMS have been for females. The service supports partners of referred service users as part of their provision and can refer to appropriate mental health services such as Talking Therapies if indicated.
- An average of 84% of referrals are seen within 0-6 weeks; this has been stable since 2020/21.
- The most frequent referrers are GPs, maternity services and Health Visiting teams.

Age of service users referred to parent infant perinatal mental health services

Figure 5: Graph showing the percentage of live births by age and percentage of PPIMHS referrals by age, between 2019-2021. N.B. Referrals data is by financial year, live births by calendar year.

[42] OHID Fingertips, Perinatal mental health dashboard

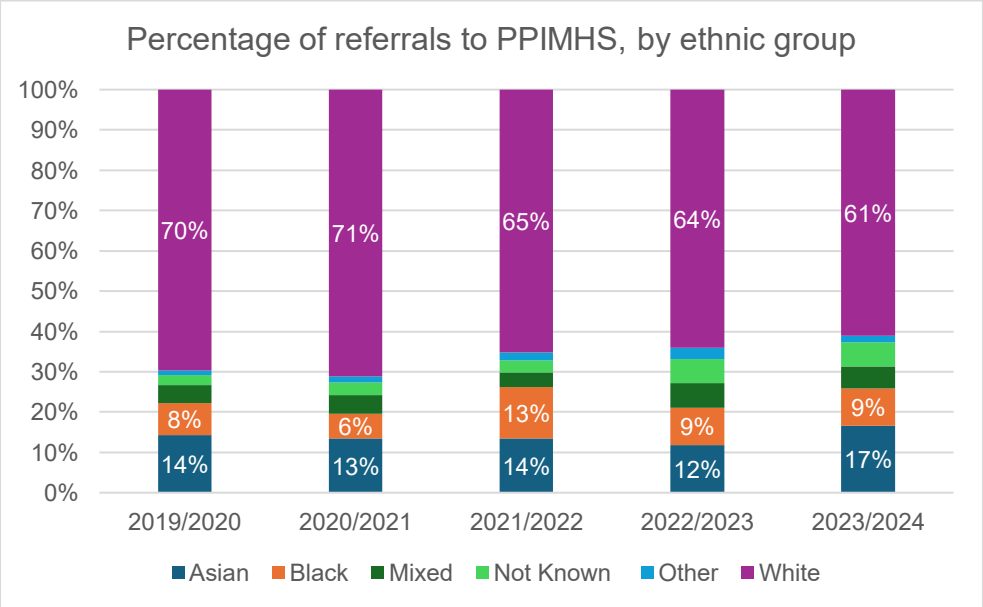


Source: ONS; NELFT

- The under 25 age group was over-represented among referrals to PPIMHS.
- Each year, the largest number of referrals were among 26-35 year olds, but the proportion of referrals from this age group was substantially lower than the proportion of births to this age group.

Ethnicity of service users referred to perinatal mental health service

Figure 6: Graph showing the percentage of Havering referrals to PPIMHS between 2019/20 and 2023/24, by ethnic group



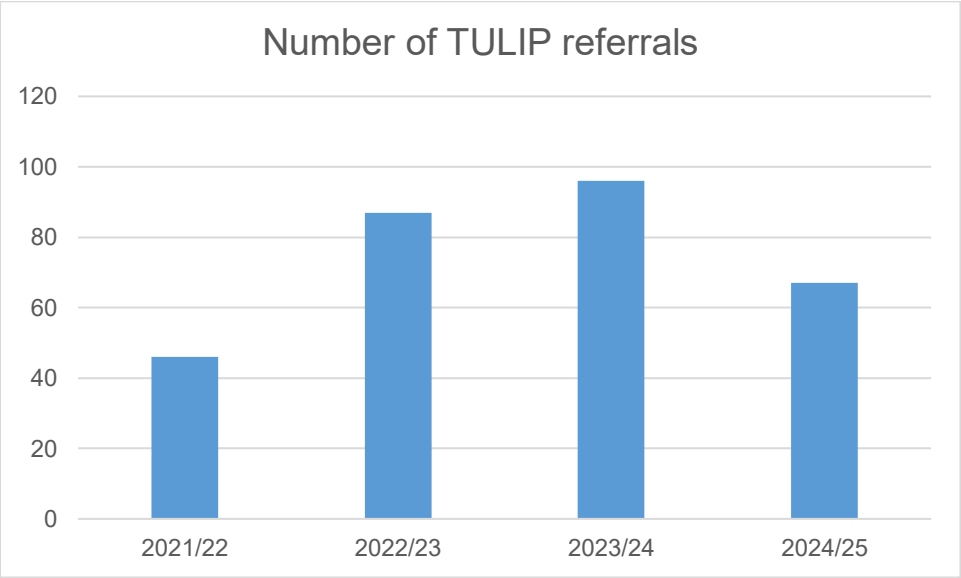
Source: NELFT

- The proportion of referrals for people from White ethnic groups decreased from 70% to 61% between 2019/20 and 2023/24.
- Overall numbers are low, but people from Asian ethnic groups made up a disproportionately large proportion of referrals to PPIMHS, compared to the 2021 Census. However, this finding is based on the overall population, not the ethnicity of birthing mothers, so should be interpreted with caution.

TULIP/Maternal Mental Health Service

TULIP is a specialist treatment service for people experiencing low to moderate psychological distress in relation to pregnancy, birth, trauma, pregnancy loss and infertility.

Figure 7: Number of referrals to TULIP, 2021/22-2024/25



Source: NEL ICB

Mums Matter

Mums Matter, run by Havering Mind, is a support service designed to empower mothers through an 8-week course, created by mums for mums experiencing perinatal mental health challenges.

Butterflies

Butterflies is a weekly drop-in support group for expecting parents and parents with babies under 12 months who live in Havering and who are experiencing feelings of low mood, anxiety or depression, with or without a diagnosis.

Havering Mental Health and Wellness Teams

The Havering Mental Health and Wellness Teams (MHWT) are multi-disciplinary teams, including psychiatrists, nurses, social workers, occupational therapists, support workers, peer workers, and employment specialists, who support Havering residents with moderate to severe mental health needs. The team includes psychiatrists, nurses, social workers, occupational therapists, support workers, peer workers and employment specialists who provide a range of support, including social support and signposting to housing and benefit help.

Havering Talking Therapies

Havering Talking Therapies offers therapy for common mental health issues during the perinatal period, including cognitive-behavioural therapy (CBT), counselling for depression, EMDR (eye movement desensitisation and reprocessing) for trauma, and online support. Referrals for people in the perinatal period should be prioritised for assessment and support.

Havering Feeding Cafes and Infant Feeding Support

Multiple services support feeding choices and emotional wellbeing:

- Infant Feeding Café – one-to-one feeding support

- LatchOn Havering – peer-led breastfeeding support sessions
- Havering Mind's Infant Feeding Peer Support Network – breastfeeding help and emotional support
- NELFT Health Visiting Service – professional guidance on feeding methods, growth and nutrition
- Havering's Breastfeeding Welcome Scheme – promotes breastfeeding-friendly public spaces
- Healthy Start Scheme – vouchers for low-income families
- Start for Life Resources/ National Breastfeeding Helpline –24/7 advice helpline

NHS Maternity Survey – Results for BHRUT

Overview

The NHS Maternity Survey is an annual survey of pregnant people and new mothers who used NHS maternity services.[43]. In 2022, for BHRUT, 548 people were invited to take part and 225 completed it (a response rate of 42%).

Individuals were invited to participate in the survey if they were aged 16 years or over at the time of delivery and had a live birth at an NHS Trust between 1 February and 28 February 2022. For further discussion on background and methodology, please refer to the report.

Results

Figure 8: Best performance relative to the trust average

[43] https://nhssurveys.org/all-files/04-maternity/05-benchmarks-reports/2022/

Figure 9: Worst performance relative to the trust average

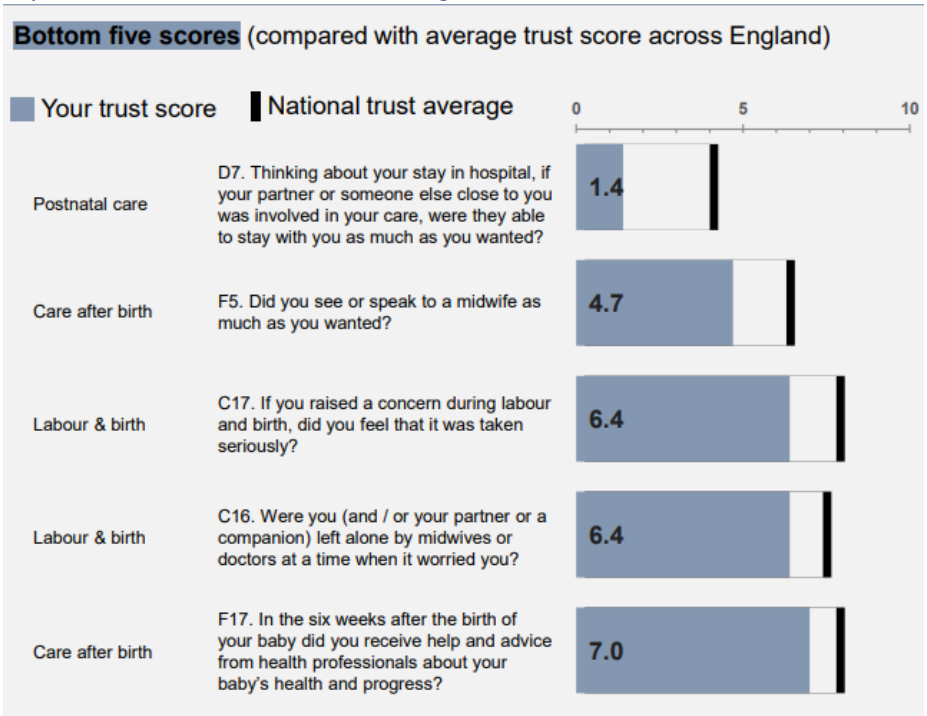


Table 3: Scoring for each evaluative question in the survey, comparing BHRUT to the national average

Over-performing	Under-performing
Antenatal Care	
• Receiving enough information to help decide where to have baby • Given enough information about coronavirus restrictions and implications for maternity care at the start of pregnancy • Midwives or doctor appearing aware of medical history • Relevant information about feeding your baby provided by midwives • Midwives listening during antenatal check-ups (in line with national average)	• Choice about where to have the baby • Allowing enough time for questions or discussions during check-ups • Midwives consistently asking about mental health • Providing enough mental health support during pregnancy • If contacted by a midwifery team, given the help needed • Spoken in a way they could understand • Involved in decisions about care • Confidence and trust in staff • Treated with respect and dignity
Labour and Birth	
• Given enough information on being inducted before it was carried out • Appropriate information on the risks associated with induced labour	• Involved in the decision to be induced • Given appropriate advice and support at the start of labour • Partner or companion involves as much as they wanted during labour and birth • Staff introducing themselves before treatment or examination • Not left alone at a time when it caused worry • Concerns raised taken seriously during labour • Immediate help from staff when needed • Spoken to in a way they could understand

	• Involvement in care decisions during labour and birth • Treatment with respect and dignity • Confidence and trust in staff • Opportunity to ask questions after the birth • Staff appearing to be aware of medical history during labour and birth • Discharge delays • Immediate help from staff when needed • Given the information or explanations needed • Treated with kindness and understanding • Partner or companion able to stay with mother as much as they wanted • Cleanliness of hospital room or ward
Postnatal Care	
• Information about changes to mental health after birth	• Decisions about feeding respected by midwives • Staff support and encouragement about feeding • Involvement in postnatal care decisions • If contacted by a midwifery team, given the help needed • Regular contact with midwives, as needed • Awareness of medical history of mother and baby • Listened to by midwifery team • Understanding of personal circumstances when given advice from midwifery team • Confidence and trust in the midwifery team after going home • Midwifery teams or health visitors' check-ins on mental health • Told they could contact if needing advice about any changes to mental health after the birth • Given information about mother's own physical recovery after the birth • Six weeks after birth, receive help and advice from a midwife or health visitor about feeding your baby • (If needing) support or advice about feeding baby during evenings, nights or weekends • Receive help and advice from health professionals about baby's health and progress

Key findings

Findings from the NHS Maternity Survey for BHRUT show that antenatal care, support during birth and labour and postnatal care are generally underperforming when compared to the national average. The emotional and physical trauma experienced during pregnancy and childbirth can have a profound impact on a mother's mental health, potentially leading to poor perinatal mental health and other long-term challenges.[44] Improving these key stages

[44] Smith, J. 2021. Understanding birth trauma and physical recovery. Journal of Pelvic, Obstetric and Gynaecological Physiotherapy, Spring 2022, 130, 22–26.

can ensure that the wellbeing of both mothers and babies improve across BHRUT, including for Havering mothers.

Where mothers' experience is best

- Midwives providing mothers with relevant information, during their pregnancy, about feeding their baby.
- At the start of their pregnancy, mothers being given enough information about coronavirus restrictions and any implications for their maternity care.
- Mothers being given enough information on induction before being induced.
- Midwives or the doctor appearing to be aware of mothers' medical history during antenatal check-ups.
- Mothers being given appropriate information and advice on the risks associated with an induced labour, before being induced.

Where mothers' experience could improve

- Partners or someone else involved in the mother's care being able to stay with them as much as the mother wanted during their stay in the hospital.
- Mothers being able to see or speak to a midwife as much as they wanted during their care after birth.
- Mothers feeling that if they raised a concern during labour and birth it was taken seriously.
- Mothers (and / or their partner or a companion) being left alone by midwives or doctors at times when it worried them during labour and birth.
- Mothers receiving help and advice from health professionals about their baby's health and progress in the six weeks after the birth.

Improvements Underway

BHRUT and the wider system have been working to address these findings. The maternity service has increased its antenatal education offerings, with support available in multiple languages. Health visitors are now conducting universal antenatal telephone calls, with in-person visits available for those with specific mental health or safeguarding needs.

TULIP provides specialised antenatal wellbeing support, including care for people with fear of childbirth and birth trauma, and is increasing collaboration with the teenage pregnancy midwife for more targeted care.

Public health midwives are working closely with perinatal mental health teams, safeguarding leads and health visitors to streamline communication and ensure integrated support across antenatal, birth and labour and postnatal care. BHRUT is also planning mandatory birth trauma training. An infant feeding coordinator is collaborating with the specialist infant feeding lead at Queen's Hospital to run antenatal workshops that will include PMH in its curriculum.

Good practice in other local authorities

To inform the strategic development of perinatal mental health (PMH) services in Havering, this needs assessment has explored models of best practice across other local authority areas in England. The rationale for this benchmarking exercise was to identify innovative responses to common challenges; to explore models that extend support beyond the

traditional 12-month postnatal period; and to strengthen the evidence base for future commissioning decisions.

Table 4: Examples of good practice in perinatal mental health from other local authorities in London and England

Area	Intervention	What was done	Impact
Blackpool	Born into Care – Recurrent Care Pathway[45]	- Co-produced a support pathway for mothers at risk of recurrent child removals. - A multidisciplinary team including psychologists, social workers, and parent advisers co-developed trauma-informed care with a problem-solving family court model.	- The initiative improved family engagement and reduced repeated removals. - It strengthened inter-agency collaboration and influenced national thinking on supporting mothers in care proceedings.
Tower Hamlets	Culturally Informed Engagement Toolkit[46]	- Developed a toolkit and training package for maternity and PMH services to engage better with minoritised communities (Bangladeshi, Somali, etc.). - Collaborated community channels like mosques and local peer networks to increase trust and referrals.	- Increased service uptake among global majority mothers. - Staff reported better cultural awareness, and services became more accessible for women with limited English or from traditional backgrounds.
Hackney, Newham and Tower Hamlets	OCEAN (Maternal Mental Health Service)[47]	- Delivered trauma-informed therapy (CBT, EMDR, group and couples' therapy) to women experiencing birth trauma, loss, or perinatal PTSD. - Integrated mental health and maternity care teams worked jointly.	- Women reported significant reduction in trauma symptoms. - Parent-infant bonding improved. - Lived experience feedback guided service development. - Success led to replication in other boroughs
Somerset	Outreach PMH Support for Asylum-Seeking Women[48]	- PMH teams embedded workers in hotel accommodation and dispersal centres. - They screened women during midwifery bookings and maintained a presence on-site to reduce stigma and build trust.	- Engagement increased dramatically. - Women accessed care earlier and avoided crisis. - Services provided trauma-informed interventions and supported transitions in housing and safeguarding.
Leeds	Perinatal Peer Support Workforce[49]	Employed peer support workers with lived experience of PMH challenges to work alongside clinicians and support mothers through group sessions, advocacy, and 1:1 support.	- Increased emotional engagement, reduced isolation, and improved therapy uptake. - Peer support workers became trusted points of contact and enhanced user voice in service design.

Abbreviations: CBT=cognitive behavioural therapy; EMDR=eye movement desensitisation and reprocessing; PMH=perinatal mental health; PTSD=post-traumatic stress disorder

[45] https://democracy.blackpool.gov.uk/documents/s98913/Appendix%205c%20-%20Born%20into%20Care%20impact%20summary%20March%2025.pdf
[46] https://democracy.towerhamlets.gov.uk/documents/s211667/Culturally%20Appropriate%20Health%20Communication%20and%20Engagement.pdf
[47] https://gps.cityandhackneyccg.nhs.uk/service/ocean-offering-compassionate-emotional-support-for-those-living-through-birth-trauma-and-loss
[48] Somerset NHS Foundation Trust. (n.d.). *Perinatal Mental Health*. Retrieved May 4, 2025, from https://www.somersetft.nhs.uk/perinatal-mental-health/
[49] https://leedsmentalwellbeingservice.co.uk/what-we-offer/talking-therapies/perinatal-support/

Stakeholder Insights

Period of Specialist Support

A key concern raised by stakeholders is the time-limited nature of PMH support, particularly the cut-off at 12 months postpartum. While services such as PPIMHS and Butterflies offer early support, many parents cease to be eligible once their baby turns one—despite ongoing or late-emerging mental health needs.[50] This issue is exacerbated by long waiting lists for psychological therapies. Although some voluntary sector organisations maintain informal contact, they lack the funding for structured follow-up.

Care Pathways

Despite the wide range of services in Havering, stakeholders pointed out unclear referral pathways and poor public awareness as challenges. Parents and professionals across NEL reported difficulties in navigating where and how to get help—worsened by digital exclusion and language barriers.

Exclusion of Non-Birthing Partners

Some stakeholders feel support for non-birthing partners is largely absent from commissioned PMH pathways. While some professionals try to include partners within the therapeutic process, there is no direct funding or structure for assessing or supporting their mental health. Non-birthing partners are eligible for the TULIP service and can be seen individually or as couples.

Voluntary sector groups, such as Mums Matter (Havering Mind) and Butterflies, welcome partners, but attendance remains low. Remote and flexible engagement formats available during the COVID-19 period reportedly helped improve partner participation, but these have since scaled back due to funding issues.

Service Fragmentation and Need for Integration

Stakeholders noted that while multiple services exist across Havering, there are communication gaps between health visitors, GPs, community groups, children's centres and mental health services which can lead to duplication, missed referrals, or delays in support.

The 2025 LBH Maternity & Neonatal Conference reinforced these needs, setting goals for:

- Improved communication and data sharing
- Increased partnership working
- Incorporation of peer support into care pathways
- Bilingual and accessible information
- Clearer service mapping and referral systems

Stigma and Lack of Mental Health Education

Stigma and unrealistic societal expectations of parenthood were cited as barriers to seeking help, with staff reporting that parents may feel that struggling makes them a "bad parent". To

[50] PPIMHS psychiatric services are commissioned for families with infants aged up to 12 months. The psychotherapeutic support is commissioned for infants up to age 24 months.

counteract this, stakeholders advocated for more antenatal education focused on emotional wellbeing, including identity shifts, emotional adjustment and signs of perinatal mental illness.

Neurodivergent and Complex Cases

Stakeholders noted that perinatal women and people who are neurodivergent or awaiting diagnosis may be at greater risk of PMH problems and may have difficulty accessing appropriate support, which can increase distress.

Similarly, NEL stakeholders report that parents with complex trauma often receive short-term interventions during pregnancy with little follow-up, despite the potential for recurring crises during future pregnancies or future trigger points (e.g. subsequent pregnancies or school transitions).

Stakeholders in NEL also noted training gaps that limit service quality, with some staff lacking expertise in trauma-informed care, cultural competence, and complex mental health needs, particularly for groups such asylum-seeking women or those involved in care proceedings.

Other Challenges

Stakeholders also identified:

- Engagement with universal services is notably lower in certain localities, particularly in the north of the borough, due to limited outreach, poor visibility, and accessibility barriers.
- Parents with social anxiety or high distress often struggle to engage, especially post-COVID.
- Staff across statutory and voluntary sectors noted that they lack capacity for intensive case-holding, leaving families without the navigation support they may require.
- Across NEL, missed appointments, childcare barriers and digital exclusion can lead to parents being discharged.
- Workforce shortages, limited capacity, lack of infrastructure, gaps in expertise, and poor data collection were all identified as key challenges in NEL.

Appendix A

Table 5: Table showing borough-specific risk factors for perinatal mental health issues, comparing rates for Havering, London and England

Indicator	Havering	London	England

	Count	Rate	Count	Rate	Count	Rate
Socio-economic risk factors						
Under 18s births rate / 1,000 (2022)	11	2.3	294	2.0	3,279	3.4
Deliveries (births) to teenage mothers, 5-year pooled data (2016/17 – 20/21)					19,417	0.7
Teenage mothers (2022/23)	15	0.8	265	0.3	3,125	0.6
Under 18s conception rate / 1,000 (2021)	57	12.4	1404	9.5	12,361	13.1
Under 16s conception rate / 1,000 (2021)	8	1.7	226	1.5	2,053	2.1
Under 18s conceptions leading to termination of pregnancy (%) (2021)	42	73.7	872	62.1	6601	53.4
Percentage of Live births within marriage or civil partnership	1,651	53.4	64,702	60.6	283,693	49.2
Percentage of Live births outside marriage or civil partnership (2022	1,438	46.6	41,994	39.4	293,353	50.8
Percentage of Live births sole registration	144	4.7	5,066	4.7	28,175	4.9
Children in need: rate per 10,000	1,574	266.7	70,960	346.6	404,310	334.3
Children in need due to family stress or dysfunction or absent parenting: rate per 10,000 children aged under 18	157	26.6	20,180	98.5	106,750	88.3
Children in need due to abuse or neglect rate per 10,000 children aged under 18 years	862	146.1	35970	175.6	230830	190.8
Medical and obstetric risk factors						
Percentage of births which are low birth weight all babies (2022)	210	6.8	8,582	8.2	40,762	7.2
Multiple births	47	15.4	1655	15.7	8,346	14.6
Premature births (less than 37 weeks gestation) (2019 - 21)	637	67.8	25,680	75.2	140,031	77.9
Deliveries by Caesarean section (2022/23)	735	37.3	37,645	39.1	195,290	37.8
Stillbirth: stillbirths per 1,000 live births and stillbirths (2021 - 23)	47	5.1	1,355	4.2	6957	4.0
Neonatal mortality rate	15	1.6	784	2.4	5,161	3.0
Post-neonatal mortality rate	13	1.4	327	1.0	1889	1.1
Infant mortality rate (2021 - 23)	28	3.0	1,111	3.5	7,050	4.1
Behavioural risk factors						

Drinking in early pregnancy			700	2.3	2600	2.4
Drug misuse in early pregnancy			335	0.6	2350	1.5
Smoking status at time of delivery (2023/24)	111	3.7	3,650	3.9	38,884	7.4
Service Access Factors						
Early access to maternity care 2023/24	2200	60.2	67,890	59.2	397,575	63.5

Source: Fingertips (Fingertips | Department of Health and Social Care)