College of Psychiatrists of Ireland

Perinatal Mental Health Services in Ireland

Position Statement

EAP/01/26

Approved by Council
February 2026

Table of Contents

SUMMARY **3**

KEY RECOMMENDATIONS **4**

EXECUTIVE SUMMARY **5**

INTRODUCTION **7**

1. CURRENT STATUS OF PERINATAL MENTAL HEALTH CARE IN IRELAND **9**

Specialist Perinatal Mental Health Services (SPMHS) 9

Adult Mental Health Services and Child and Adolescent Mental Health Services (CAMHS) 12

Primary Care provision of perinatal mental health care 13

Inpatient provision of perinatal mental health care 13

2. VISION FOR PERINATAL MENTAL HEALTH SERVICES IN IRELAND **166**

Overall SPMHS service development 166

SPMHS Spoke site service development 188

Inpatient provision of perinatal mental health services (establishing a Mother and Baby Unit) 188

Training, Education and Research centre in Perinatal Mental Health 2119

KEY RECOMMENDATIONS **232**

SPMHS service development 22

Perinatal Mental Health Training, Education, and Research 232

Mother and Baby Unit 22

CONTRIBUTORS **243**

REFERENCES **24**

APPENDICES **26**

Summary

The Perinatal Psychiatry Special Interest Group (Perinatal SIG) was established in July 2023. The group has produced this position statement to share information with the college membership and the wider healthcare community about Perinatal Mental Health Services in Ireland. The statement reviews the current state of perinatal mental health care provision in Ireland, and sets out plans for the development of services to improving the quality of perinatal mental health care within the Specialist Perinatal Mental Health Service (SPMHS) and beyond, including community and inpatient Adult Mental Health Services and Primary Care.

Key Recommendations

- Standardise national delivery of specialist perinatal mental health care across Hub and Spoke sites.
- Improve provision of support for the Mother-Infant relationship by standardising provision of Video Interaction Guidance across all SPMHS sites.
- Establish SPMHS consultant-led multidisciplinary teams (MDT) to directly provide services in the Spoke sites, and increase staffing in Hub sites to meet increasing demand, taking into consideration specific local needs.
- Develop an interface between SPMHS and Adult Mental Health Services, CAMHS and liaison psychiatry, and integrate SPMHS with the other HSE Adult Mental Health clinical programmes.
- Establish a Perinatal Mental Health Training, Education and Research Centre to facilitate improvements in the quality of perinatal mental health care provided by all services who provide healthcare to women in the peripartum period.
- Establish a Mother and Baby Unit (MBU) to provide specialist inpatient care for women with perinatal mental disorders and bring Ireland in line with international best practice.
- Improve quality of mental health inpatient care of pregnant and postnatal women through education and training while awaiting the MBU.

Executive summary

Perinatal Psychiatry is a rapidly expanding specialist area of mental health requiring treating clinicians to have specific knowledge and expertise in assessment, diagnosis and treatment of women across the perinatal period (1). The SPMHS was established in Ireland over the last 7 years based on a Hub and Spoke model. Dedicated consultant-led MDTs directly provide specialist perinatal mental health care in the 6 Hub sites [Figure 1], while perinatal psychiatry provision in the regional Spoke sites is delivered by liaison psychiatry services, and adult community mental health teams. Perinatal Mental Health Midwives are employed by the maternity services across the country to provide services to women with milder mental health problems. Demand on the SPMHS services is high and ever-increasing. A key challenge of the SPMHS services is to maintain and deliver high quality care, equitably across geographical regions, in the face of increasing demand. This report sets out plans to achieve this via service development, education and training, research, and data monitoring.

Despite the development of SPMHS in Ireland, the majority of perinatal mental healthcare is, and will continue to be, provided by Adult Mental Health Services (both inpatient and outpatient) and Primary Care. 1 in 5 women will experience perinatal mental illness (2, 3, 4). This represents significant mental healthcare need in this group. Evidence suggest antenatal depression may be particularly high in the Irish setting (5). Most mild-moderate perinatal mental illness can be recognised and managed in the Primary Care setting. Where appropriate, moderate and severe perinatal mental illness should be referred for SPMHS input. For women already under Adult Mental Health Services or CAMHS, specialist perinatal mental healthcare is offered on a shared care basis. Shared care provision and clinical pathways in this context are not clearly defined, and have been interpreted differently in different regions.

There is currently no Mother and Baby Unit in Ireland to provide specialist inpatient care. Women experiencing the most severe perinatal mental illness requiring admission are looked after by General Adult Psychiatrists. There is a need for specialist knowledge amongst the existing body of treating psychiatrists to ensure women with perinatal mental illness receive appropriate treatment. There is a particularly urgent need for specialist teaching for inpatient psychiatrists and GPs, who are on the front line providing perinatal mental healthcare, often in the absence of specialist training or education.

We propose a Perinatal Mental Health Training Education and Research Centre with the following aims: a) to improve the quality of SPMHS service provision by improving data collection and analysis to guide service development; and b) to provide education to adult psychiatrists, Primary Care clinicians and all healthcare professionals providing care to women in the peripartum period in perinatal mental health. Until this Centre is operational, there are projects in process to provide perinatal psychiatry training for various groups, including a HSEland module on Perinatal Mental Health for midwives and Primary Care clinicians, educational videos, teaching sessions, and a Perinatal Mental Health Masterclass for psychiatrists.

The Perinatal SIG advocates for the establishment of a 10-bed National MBU in Dublin, a tertiary referral unit for all of Ireland. There is also need for a further 12 MBU beds in Ireland, so other units will also need to be established outside of the capital. It is critical to the overall success of the SPMHS that there is provision of inpatient beds for women with perinatal mental illness. This will begin to bring Ireland in line with international best practice. The MBU will provide specialist inpatient care for mothers without separating them from their babies, thereby avoiding disruption to mother-infant bonding and adverse life-long effects on both baby and mother.

Introduction

Perinatal mental illness refers to new and recurrent mental illness that occurs during pregnancy and the first postnatal year. It can have a significant impact on those affected, impairing relationships, quality of life and physical health. There is a substantial body of evidence demonstrating the risks of perinatal mental illness to both mothers and their infants. Perinatal mental illness is associated with a higher risk of pre-term birth, low birth weight, impaired bonding, and long-term emotional, cognitive and psychological problems for the child (6,7,8,9,10,11,12,13). 20% of women experience mental illness during pregnancy or the first year postpartum (14). The SPMHS has faced substantial increasing demand since its inception, through increased awareness of perinatal mental illness, higher disease burden and also as the profile of the specialist services increases. The burden of disease was compounded by the global impact of the Covid pandemic. Studies in Ireland and the UK have highlighted the impact of the pandemic on women during the peripartum period with higher levels of antenatal anxiety and depression noted (15,16). However, the demand on SPMHS has sustained beyond the pandemic.

Specialist perinatal mental health services have been developed globally in the context of the recognition of the importance of prioritising women's perinatal mental health (17). It is well recognised that the perinatal period provides a unique opportunity to improve perinatal mental health by early intervention and treatment as well as promotion of perinatal mental health and prevention of illness (18,19,20). There is a clear economic argument for specialist perinatal mental health services. UK research in 2014 estimated the financial cost of perinatal mental illness at £8.1 billion, with 72% of this cost relating to adverse impact on the child rather than the parent (8).

Over the past five years, the SPMHS have been introduced to provide specialist care to women, according to the 2017 Model of Care for Ireland (21). All six multidisciplinary Hub services are now fully staffed, and offer a range of medical, psychological and other interventions to women in attending large maternity units, in metropolitan areas. These services have allowed for more varied psychological interventions to be offered, with more nuanced, individualised mental health care (22). The Spoke services are based in maternity units with lower birth rates in more rural areas. In these settings perinatal mental health midwives attached to the maternity units see women with mild-moderate illness. They are supported by the liaison psychiatry teams (where they exist) who provide the support for women with moderate to severe illness. In the outpatient setting, once the woman is discharged, community adult mental health teams provide

mental healthcare. The Model of Care proposed that Hub SPMHS psychiatrists would support the Spoke midwives, but this has not always happened in practice as Hub sites are managing the huge increase in demand for their own services (23).

Current status of perinatal mental health care in Ireland

Specialist Perinatal Mental Health Services

Structure of Services

There are 19 maternity services in Ireland with SPMHS provision. In each hospital group, the maternity service with the highest number of deliveries (>4000 births/year) is the designated Hub [Figure 1]. SPMHS MDTs have been established in the Hub sites. In the smaller Spoke maternity services, perinatal mental health midwives work with liaison mental health teams.

The Hub MDT is led by a consultant perinatal psychiatrist. In the remaining 13 spoke maternity units, the liaison psychiatry team provides input to the maternity service with the addition of a mental health midwife. The Spoke midwife should ideally be linked to the Hub teams for advice, regular meetings, training, education and clinical opinions.

There are six 12-month Perinatal Psychiatry Higher Specialist Training (HST) posts across the Hub sites, providing excellent training experiences in the specialty. There is a specific Perinatal Psychiatry competency-based curriculum, which is used as the basis for workplace continuous assessment. Perinatal Psychiatry HST posts give valuable experience for a career in adult psychiatry, and many trainees have gone on to seek Perinatal Psychiatry posts once qualified.

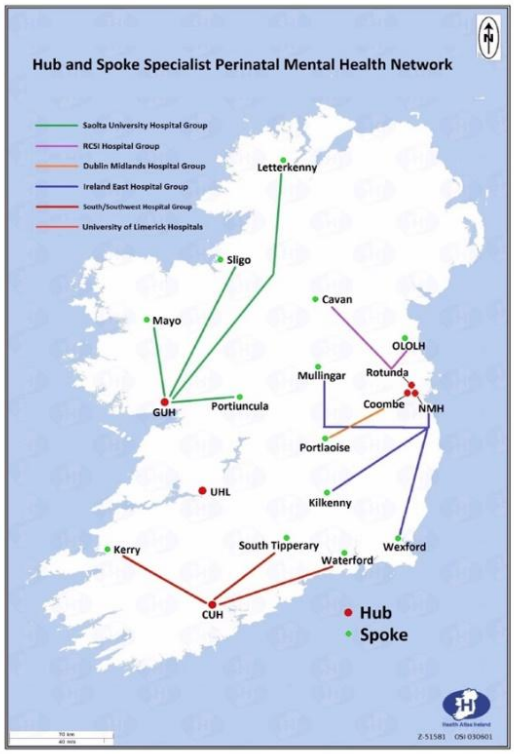


Figure 1. Hub and Spoke specialist perinatal mental health network, from the 2017 Model of Care (21).

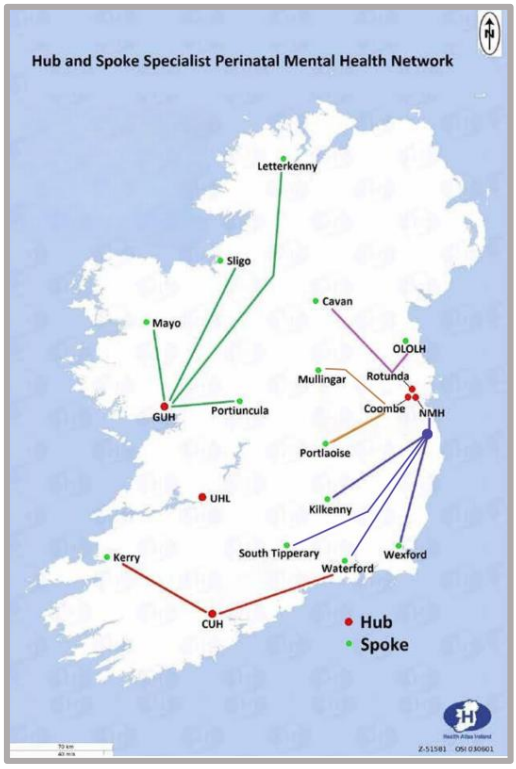


Figure 2. Adapted diagram from original Model of Care to show Spoke services distribution since the introduction of the new Regional Health Areas in March 2024.

Access to services

Women can be referred to the SPMHS by their GP, the midwife at antenatal clinics, their obstetrician or community psychiatrist. SPMHS receive a large number of referrals, averaging 30-40 per week, to the Hub services [Figure 2]. These referrals may include anything from mild to severe perinatal mental illness. The expectation from referrers is that a prompt biopsychosocial assessment and treatment will be provided to all, but referrals must be triaged and a large proportion of referrals may be redirected to Primary Care as considered appropriate.

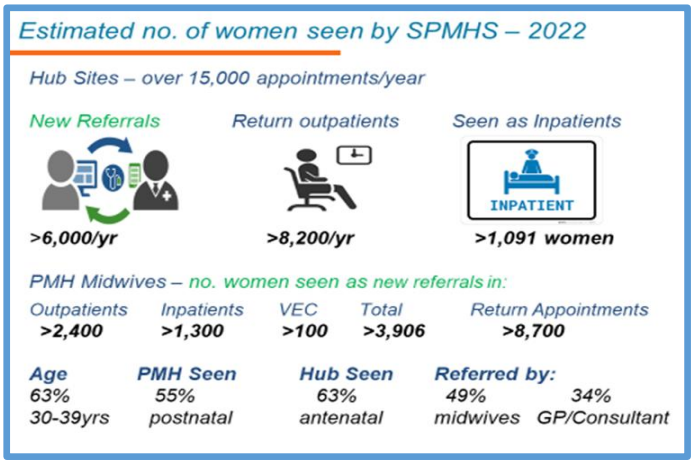


Figure 2. Estimated number of women seen by SPMHS.

Interventions offered

SPMHS Hubs offer assessment and case management of women suffering with moderate-severe perinatal mental illness. Perinatal psychiatrists also offer preconception counselling to women with severe mental illness who are planning a pregnancy.

All care is delivered with a trauma-informed approach. A range of evidence-based interventions are offered, including attachment therapy, CBT, birth trauma support, group therapy for antenatal and postnatal depression and anxiety, and other specialist interventions. Thanks to the Women's Fund, clinicians in all SPMHS were trained in Video Interactive Guidance (VIG) in March 2025, which means VIG can be offered as standard across all the sites. VIG an intensive bonding therapy, which can support women struggling to bond with their baby due to mental illness. A VIG service has been available in the Dublin hub sites for some time, and this year was expanded to

all sites. Two Hub services offer a Multidisciplinary Birth Trauma clinic, and all services offer support for women suffering after Birth Trauma.

Women with severe or complex mental illness are offered pre-birth planning meetings, where a Perinatal Mental Health Care Plan is produced with the woman, her partner or family member, and other key clinicians. The Pre-birth Planning Meeting allows a woman and her carers to discuss her early warning signs of relapse, treatment preferences, and breastfeeding preferences. It provides guidance on a mental health care framework for the pregnancy, birth and postnatal period, including the identification of relevant healthcare clinicians, the range of appropriate support services and a discussion about key family members that need to be involved.

Co morbid alcohol and substance use disorders coexist with perinatal mental illness. Drug and Alcohol Liaison midwifes are available in the Dublin Maternity Hospitals. In other centres, Medical Social Workers provide support with alcohol and substance abuse.

Accommodation

There is inadequate provision of accommodation for specialist services in the HSE sites: Cork (CUMH), Limerick (UMHL) and Galway (GUH). Appropriate accommodation is urgently needed to allow the existing teams to deliver the service safely and effectively while protecting patient's confidentiality and dignity.

Adult Mental Health Services and Child and Adolescent Mental Health Services (CAMHS)

The SPMHS adopts a shared care approach with Adult Mental Health and CAMHS, although the approach is variable across different services. There is no formalised definition of shared care in the Model of Care. This will be addressed in the upcoming Refresh of the Model of Care. The principle of the shared care approach is that pregnant or postnatal women with severe, enduring mental illness may be best cared for by both the SPMHS and the community mental health service (adult or CAMHS). The advantage of this approach is that the SPMHS can provide specialist perinatal input, such as perinatal risk assessment, medication advice and management in pregnancy and breastfeeding, pre-birth planning and liaison when the women attends the maternity hospital, specific group and individual perinatal mental health interventions, and mother-infant assessment and support. The adult community mental health

team can provide knowledge of the patient's psychiatric history, prior responses to treatment, and can offer assertive community engagement that cannot be provided by the SPMHS. The SPMHS may provide psychiatric support where women have disengaged from community services, or where there is variation in community provision of mental health services, such as lack of day hospital services and geographical challenges. However, it must be recognised that the SPMHS cannot provide a level of community support equivalent to the Community Mental Health Teams (CMHT) as they are solely clinic-based, in the maternity hospitals. In many cases, patients have excellent relationships with their CMHT/CAMHS teams and are reluctant to attend the SPMHS. In these cases, the SPMHS can provide perinatal mental health advice to community teams as requested.

There is a recognised increased risk of suicides of young women whom are care leavers, or have a history of attending CAMHS as young persons. The most disadvantaged mothers would be most at risk of suicide in the perinatal period. This highlights the need to identify young mothers at increased risk, increasing liaison with CAMHS or other adolescent services such as addiction, child sexual abuse services or children in care services, through education, both of staff and young people in relation to perinatal and infant mental health.

Young women under 18 who are referred to the SPMHS should be offered support on a shared care basis with CAMHS. Unfortunately, many young women do not meet criteria for a CAMHS assessment, and the long waiting list for many CAMHS services, makes is unhelpful for timely support in the perinatal period. Under 16s are not by SPMHS, and if not taken on by CAMHS, these vulnerable women miss out on support at this crucial period. This is an important gap in services, again that will be addressed in the new Model of Care.

Mental health midwives in the Spoke sites work with the local liaison psychiatry teams. Depending on geographical location, the level of supervision and support is variable. There is a dedicated perinatal psychiatrist (0.3WTE) working in one Spoke site (Midland Regional Hospital, Portlaoise), giving specialist perinatal mental healthcare in that area. This unique scenario is a model that works well to improve access to perinatal mental healthcare for women attending this hospital. This partial MDT model gives a working example of how spoke services could be developed in the new Model of Care.

Primary Care provision of perinatal mental health care

A large part of perinatal mental healthcare is provided in the Primary Care setting, by general practitioners, and public health nurses. There is no formal perinatal mental health training for GPs at present and as a result the level of care provided is highly variable. Some referrals to SPMHS services, which are mild-moderate in severity, are redirected to Primary Care where appropriate. SPMHS aim to provide teaching and training for GPs to allow them to provide a service to this population.

Inpatient provision of perinatal mental health care

There is currently no inpatient provision for specialist perinatal mental healthcare in the whole of Ireland. The gold standard for inpatient care for postnatal women up to the first year of the baby's life, is to be admitted to a specialist Mother and Baby Unit, staffed by specialist perinatal mental health staff, providing appropriate care to mothers and babies, and offering the full range of therapeutic services (14). Unfortunately, despite being a key recommendation in the Model of Care (21), no such unit has been built to date with plans at a very preliminary stage of development (23).

MBUs have been established in many European countries, Australia, New Zealand, Sri Lanka, India and the United States (18). Women living in countries or regions without access to an MBU have to be admitted to general psychiatric wards and separated from their babies (19). This is distressing for women, impairs bonding and attachment with their babies at a crucial stage in the baby's development, and makes it more likely that formal care arrangements will have to made for the baby where a partner is not available. When mothers and babies are not separated, and positive relationships can continue, mothers tend to retain and enhance their role as primary care-giver (25,26).

In Ireland, women with severe perinatal mental illness are currently admitted to adult mental health units and are separated from their babies. Some units make every effort to facilitate daily visits of the baby, but this is not always possible in an acute ward. Women may need several weeks in hospital to recover, and being separated from their baby is distressing and detrimental

for both mother and baby. This may cause pressure on the inpatient teams to discharge women early so they can be with their babies, before they are fully recovered.

There are significant risks of harm to mother and baby in the first 6 weeks postnatally (4), and in the first postnatal year. Women with severe illness need to be treated according to best practice principles of perinatal psychiatry (19). Inpatient teams can and should request shared care or perinatal advice from a perinatal psychiatrist to manage these complex patients. Perinatal psychiatrists can provide expert advice on treatment and risk on these issues.

An MBU service needs to be established in Ireland as a priority, but given that such a project will take time, there is an urgent need for interim training of adult inpatient psychiatrists in managing perinatal mental illness.

Vision for perinatal mental health services in Ireland

Overall SPMHS service development

The current provision of 1 WTE perinatal psychiatrist per 8,000 births is inadequate to meet the current perinatal mental needs of service users. Furthermore, it does not allow for expansion of services to address the needs of women in the Spoke sites. Additional administrative support is needed in 4 out of 6 Hub sites, to support the multidisciplinary team and be the first line of contact for women entering the service. All SPMHS services are reporting to be very busy, each referral is reviewed by a clinical team and seen within a number of weeks with urgent cases assessed by clinicians and given priority.

There is strong evidence supporting the provision of one perinatal mental health consultant led MDTs per 4,000 births (27). The appointment of additional consultant-led MDTs providing direct assessment and treatment in the Spoke sites would have enormous benefits to service users. This would provide parity of service with the Hub site and allow for proper integration of mental health services in these settings, supporting the perinatal mental health midwives in both their clinical work and education and training. The Spoke site consultants would be based in the Hub sites and visit the Spoke sites to carry out clinics on a regular scheduled rota basis. In addition, direct assessments would be complemented by remote clinics.

The Royal College of Psychiatrists recommended in 2022 that SPMHS should focus more on the mother-infant relationship (26). The mother-infant relationship is central to perinatal mental health. Bonding and attachment are related to mental illness in a bi-directional manner. More training in this area is required for and by the specialist services. Video Interaction Guidance (VIG) is an effective intervention in the perinatal period (20). The expansion of VIG to all SPMHS sites represents a significant advance in service provision in 2025.

Secure, responsive relationships are vital to babies' healthy brain development and to later mental health (28). Infant Mental Health is closely linked to that of parents' mental health (29). Parents are intuitively attuned to their infants needs and even in the most difficult and challenging circumstances deeply wish to do well by their babies. Therefore, the perinatal period and infancy is an optimal time to identify and treat parent-infant relationship difficulties sensitively and in a timely way.

Infant Mental Health is a developing movement globally and here in Ireland. There is a recognition by the government of the need to develop specific mental health services for infants and young children, as is outlined in the First Five strategy document published this year (30). Perinatal and infant mental health are closely aligned, a key focus of Perinatal Mental Healthcare is supporting the mother in providing emotional responsiveness to her baby. Understanding infant development must be a core skill in training of specialist perinatal clinicians involved.

Data collection for individuals attending SPMHS has been limited. There is a new system being established by the National Perinatal Epidemiology Centre in UCC to improve the collection process and enhance the quality of data. Accurate data is needed to demonstrate the impact of the SPMHS and identify areas that will require development.

There is ongoing work standardising triaging protocols in the SPMHS to ensure mild-moderate cases are redirected to Primary Care where appropriate, to develop internal pathways to ensure patient-centred care and streaming into group therapy. There is also ongoing work to help referrers improve the quality of referrals by providing more information so they can be triaged appropriately.

There has been an increase in focus on fathers and siblings although development here remains lacking. Fathers of young children had greater odds of depression in energy poor households, although the deleterious effect on mental health was not statistically significant for fathers of older children (31) The prevalence of paternal postnatal depression was 12%-28%. Risk factors for paternal postnatal depression included having an infant with sleep problems, a previous history of depression, a lack of social support, poor economic circumstances, not having paternity leave and not being married (32). In addition, a recent study found that partners of parents with mental illness had higher rates of depression 9 months following the birth of an infant (33). Maintaining a relationship-based developmental understanding of parental and early childhood psychopathology is essential.

Within the team, there is scope for development of an Advanced Nurse Practitioner role. Several Clinical Nurse Specialists have already trained in nurse prescribing, helping reduce pressure on the medical staff and enhancing knowledge and training of perinatal prescribing.

SPMHS Spoke site service development

Perinatal mental health midwives look after women with mental health difficulties on the milder end of the spectrum. In the absence of the dedicated MDT SPMHS teams in Spoke sites, models of supervision for perinatal mental health midwives working in Spoke sites could be developed which would incorporate an increase in regular supervision, the provision of video clinics by Hub psychiatrists for complex cases and the greater interaction of perinatal mental health midwives with Hub teams through attendance at meetings and training events.

In order to provide the equivalent quality of service in the Spoke sites, and close the service provision gap, there needs to be consultant-led MDTs established in these settings. Provision of additional mental health staffing should be mapped to numbers of births and deprivation indices. In the interim**,** Hub clinical staff time needs to be protected to offer Spoke midwife supervision, provide virtual clinic appointments and to develop links with liaison services locally.

Inpatient provision of perinatal mental health services

Ireland needs a specialist inpatient unit for women with severe perinatal mental disorders who require acute inpatient mental health care. Around 2 per 1,000 women who have a baby may need admission to hospital for their mental health problems (17,18,19,20). MBUs admit women in late pregnancy and at any point until their baby is one year old. MBUs are calm, welcoming places that are usually more homely than acute psychiatric wards. Specialist staff nurture and support the mother-infant relationship on the ward while the mother has treatment for her mental illness.

Given the overwhelming clinical and economical evidence against separating mothers and babies during the postnatal period, the National Model of Care (21) recommended that one MBU be developed in Dublin to serve as a national tertiary referral unit. The proposed MBU will be part of the HSE Area C Department of Psychiatry located on the campus of St Vincent's Hospital. A joint business case was developed and agreed in 2019 within the Ireland East Hospital Group.

By way of comparison of need, there are 20 MBUs in the UK providing inpatient services for a population of 67.3 million. It is estimated that 0.4 inpatient MBU beds are required per 1000

births (34). In Ireland, there were a total of 57,540 births in 2022, meaning there is an estimated need for 22 MBU beds nationally (35). There needs to be a concerted effort to fund, build and run this much needed part of specialist perinatal mental health care and progress to date has been slow in achieving this.

Training, Education and Research centre in Perinatal Mental Health

A key component of providing and developing specialist perinatal mental health services is the provision of a comprehensive training and education programme for all service providers. To date this has taken place on a piecemeal basis. We propose a central training base to design and provide a range of education and training programmes adapted to meet the needs of the various service providers who work with individuals with perinatal mental health problems. The programmes would be available to members of specialist perinatal mental health teams, maternity staff, mental health staff, and primary care providers such as GPS and PHNs [16].

The service would have 6 educational strands.

1. **SPMHS staff training** – including online modules/simulation training for
    a. **New staff**. Induction training courses for new SPMHS staff. A three-day training course could be developed and run on an annual basis. This would provide introductory training to all new member of SPMHS and if all places are not filled the training could be expanded to other specialists with an interest in this area.
    b. **Current staff.** Input on specific topics of interest identified by staff working in SPMHS.

2. **Patient and public awareness and education**.
    a. **Resource development**. Resource development including leaflets, apps, videos, on-line resources and educational materials could be developed by the service in close collaboration with experts by experience and clinicians.
    b. **Increasing public awareness** – For example, through social media.

3. **Training for psychiatrists** (online modules/simulation training)

a. **Psychiatry trainee** programme. To give an overview in line with the perinatal mental health curriculum.
b. **Consultant psychiatrist** programmes. To address gaps in knowledge on acute management of perinatal mental disorders, inpatient management, pre-birth planning, prescribing in pregnancy and breastfeeding, etc.

4. **Training for GPs** using online modules/simulation training with an overview of perinatal mental disorders (particularly mild/moderate) and their management in Primary Care settings.

5. **Training for multi-professionals** in Community Mental Health Teams, Liaison psychiatry teams, etc. (online modules/simulation training) with an overview of perinatal mental disorders and how to manage joint working with SPMHS.

6. **Training for public health nurses, midwives, other maternity staff** (online modules/simulation training) including an overview of perinatal mental disorders with specific advice on their clinical management.

Our experts by experience (people who have used the services and their family and organisations that support them) would ensure service user involvement in the development of these services. In addition, a centre of excellence in research would help to promote research activities to guide the development of evidence-based interventions, stimulate and foster interest in the specialty, promote recruitment across the disciplines and attract high calibre candidates to the field.

It is envisaged that this service would address five national research strands.

1. **National data analysis.** The group would be responsible for the collation and analysis of national SPMHS data including the publication of biannual reports.

2. **Irish MBRACE data.** The group would be responsible for providing data for the MBRACE report for Irish perinatal mortality cases.

3. **Clinical research.** The service would support larger scale projects and link such projects and research groups with sites that were interested in being involved in these projects, to facilitate high quality multi-site studies.

4. **Service development research.** The group would support national level research addressing basic research questions that directly relate to service provision. There is an opportunity to develop specific quality standards for SPMHS to ensure equitable access to high quality services.

5. **Patient experience research.** Research would be carried out to ensure that Irish research reflected the experiences of women and parents attending services.

Improving perinatal mental healthcare provision in Primary Care and Adult Mental Health Services

Until the Training, Education and Research Centre is functional, there is an urgent need to disseminate knowledge and expertise about perinatal mental healthcare in Primary Care and Adult Psychiatry.

An HSE Land module targeted at Primary Care and maternity staff is close to completion. This aims to improve recognition perinatal mental illness, and equip Primary Care and maternity staff with the skills to talk about mental illness, support women themselves, and refer on appropriately to the SPMHS.

GPs often prescribe psychotropic medications during pregnancy and breastfeeding. Some GPs do not feel skilled in this area, and may not be up-to-date with the latest evidence-base. There is a need for a high level of skill in prescribing in pregnancy, to ensure women are given up-to-date information about the risks and benefits of medication in pregnancy, and have robust risk-benefit discussions with the prescriber. SPMHS psychiatrists are available to give information by phone to GPs who have prescribing queries. This may avoid the need for a referral to the SPMHS.

Following on from the success of the Perinatal Mental Health Masterclass for HSTs, another Perinatal Mental Health Masterclass is proposed by the Perinatal Psychiatry Special Interest Group (SIG) for consultant psychiatrists and trainees. This will be a 1-2 day course with a focus on developing the core specialist expertise and skills needed for managing perinatal mental

illness. The Perinatal Psychiatry SIG will also continue to contribute to college conferences, and other educational events.

Key Recommendations

SPMHS service development

- Standardise delivery of SPMHS across all services, by increasing consultant staffing, and establishing MDT at Spoke sites.
- Define the shared care model with community and inpatient adult mental health services, CAMHS, and liaison psychiatry.
- Focus on infant mental health – establish VIG service in all SPMHS teams.
- Provide more input on father/partner experience.
- Provide appropriate accommodation for all SPMHS teams.

Perinatal Mental Health Training, Education, and Research

- Use SPMHS clinical activity data to monitor and improve SPMHS services efficiency and effectiveness.
- Provide access to perinatal mental health education and training to all SPMHS staff.
- Provide perinatal mental health education to all psychiatrists through Perinatal Mental Health Masterclasses, Conferences, and the Perinatal Psychiatry SIG.
- Provide perinatal mental health education to GPs, public health nurses through courses, teaching programmes, and the HSE Land module.
- Develop a research strategy for perinatal psychiatry.

Mother and Baby Unit

- Advocate and campaign for the development of this much needed inpatient service.
- Establish a 10-bed MBU in Dublin as national referral unit, as a starting point.
- Improve shared care working between inpatient mental health services and SPMHS under the current system to improve women's experience and quality of care.
- Establish a National Service Plan for the MBU.
- Raise the profile of Perinatal Psychiatry in the College via the Perinatal Psychiatry SIG, Conference input, and specialist courses.
- Encourage membership of Perinatal Psychiatry SIG amongst College members.
- Develop links with Irish College of General Practitioners and the Irish College of Obstetricians & Gynaecology.

Contributors

Dr Catherine Hinds, Chair of Perinatal Psychiatry SIG

Dr Chaitra Jairaj, Vice Chair of Perinatal Psychiatry SIG

Dr Joao Costa, Member of Perinatal Psychiatry SIG

Many thanks to the Members of the Perinatal Psychiatry SIG, and other members of the College of Psychiatrists of Ireland for their valuable comments and insight.

References

1 Galbally M, Blankley G, Power J, Snellen M. Perinatal mental health services: What are they and why do we need them? *Australas Psychiatry*. 2013;21(2):165–79.

2 Howard LM, Molyneux E, Dennis CL, Rochat T, Stein A, Milgrom J. Non-psychotic mental disorders in the perinatal period. *Lancet*. 2014;384:1775–88.

3 Howard LM, Ryan EG, Trevillion K, Anderson F, Bick D, Bye A, et al. Accuracy of the Whooley questions and the Edinburgh Postnatal Depression Scale in identifying depression and other mental disorders in early pregnancy. *Br J Psychiatry*. 2018;212:50–6.

4 Jones I, Chandra PS, Dazzan P, Howard LM. Bipolar Disorder, affective psychosis, and schizophrenia in pregnancy and the postpartum period. *Lancet*. 2014;384:1789–99.

5 Jairaj C, Fitzsimons, McAuliffe F, O'Leary N, Joyce N, McCarthy A, et al. A population survey of prevalence rates of antenatal depression in the Irish obstetric setting using the EPDS. *Arch Womens Ment Health*. 2019;22:349–55.

6 O'Leary N, Jairaj C, Molloy EJ, McAuliffe FM, Nixon E, O'Keane V. Antenatal depression and the impact on infant cognitive, language and motor development at six and twelve months postpartum. *Early Hum Dev*. 2019 Jul;134:41–6. doi:10.1016/j.earlhumdev.2019.05.021. PMID:31176100.

7 O'Leary N, Jairaj C, Nixon E, Quigley J, O'Keane V. Antenatal depression and maternal infant directed speech during the first postnatal year. *Infant Behav Dev*. 2021 Aug;64:101605. doi:10.1016/j.infbeh.2021.101605. PMID:34229207.

8 Bauer A, Parsonage M, Knapp M, Iemmi V, Adelaja B. The costs of perinatal mental health problems. *Centre for Mental Health and London School of Economics*. 2014.

9 Hendrick V, Altshuler L, Cohen L, Stowe Z. Evaluation of Mental Health and Depression During Pregnancy: Position Paper. *Psychopharmacol Bull*. 1998;34(2):297–9.

10 Macdonald E, Mohay HA, Sorensen D, Alcorn N, McDermott B, Lee E. Current delivery of infant mental health services: are infant mental health needs being met? *Australas Psychiatry*. 2005;13(4):393–8.

11 Mihalopoulos C, Vos T, Pirkis J, Carter R. The population cost-effectiveness of interventions designed to prevent childhood depression. *Pediatrics*. 2012;129(3):723–30.

12 Ontario Centre of Excellence for Child and Youth Mental Health. Supporting Ontario's youngest minds: Investing in the mental health of children under 6. *Ontario, Canada*; 2014.

13 Royal Australian and New Zealand College of Psychiatrists (RANZCP). Position Statement 63: The prevention and early intervention of mental illness in infants, children and adolescents. *RANZCP*; 2010.

14 Howard LM. Perinatal Mental Health: a review of progress and challenges. *World Psychiatry*. 2020 Oct;19(3):313–27.

15 Hinds C, Lindow SW, Abdelrahman M, Hehir M, O'Connell MP. Assessment of antenatal anxiety, depression and obsessive-compulsive disorder in pregnant women in the Covid-19 era. *Ir J Psychol Med*. 2023 Dec;40(4):547–53.

16 Ceulemans M, Foulon V, Ngo E, Panchaud A, Winterfield U, Pomar L, et al. Mental health status of pregnant and breastfeeding women during the COVID-19 pandemic – A multinational cross-sectional study. *Acta Obstet Gynecol Scand*. 2021;100(7):1219–30.

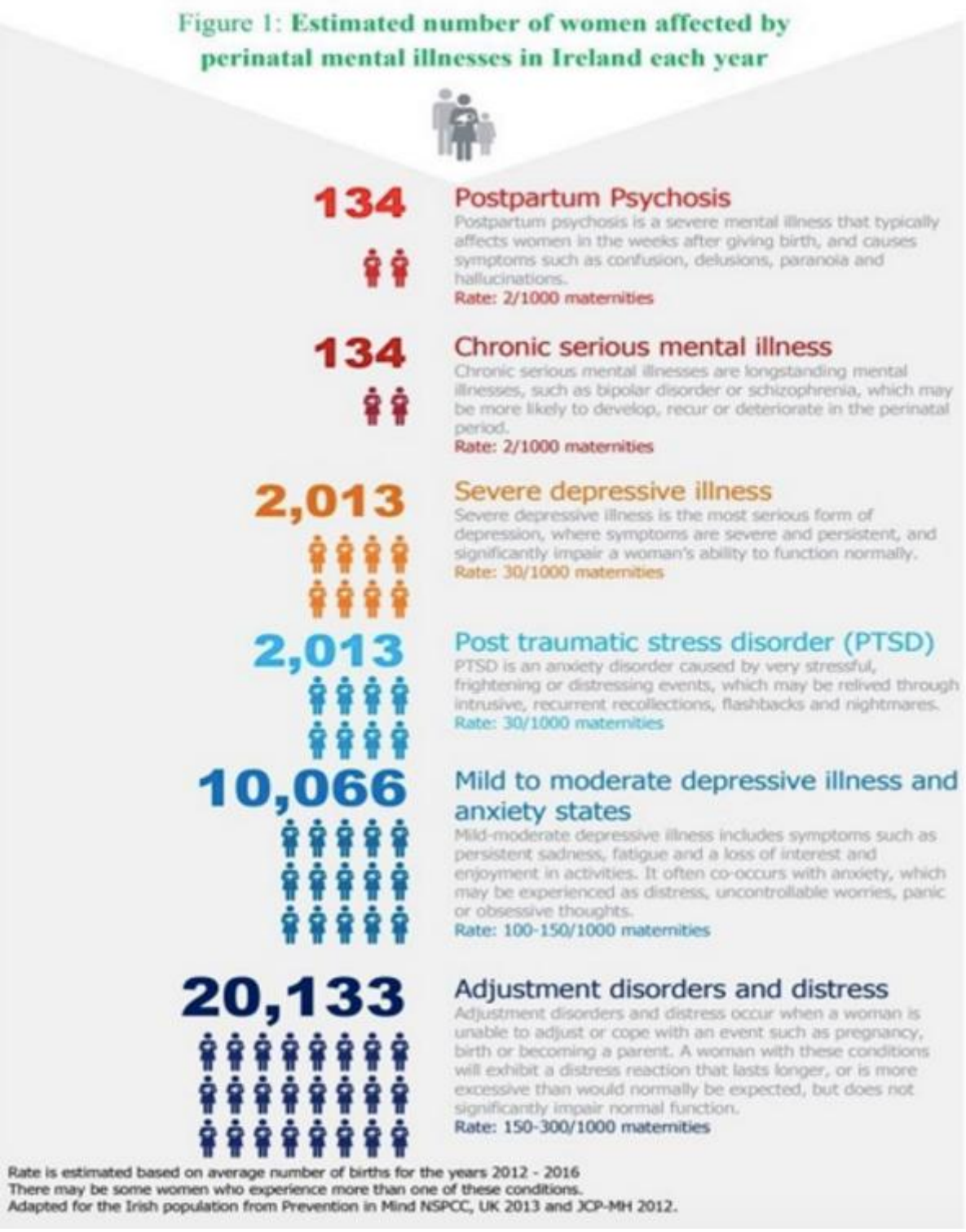
17 Powell C, et al. Engagement with perinatal mental health services: a cross-sectional questionnaire survey. *BMC Pregnancy Childbirth*. 2020;19(1):170.

18 BeyondBlue. National Action Plan for Perinatal Mental Health 2008–2010: Full Report. *BeyondBlue: The National Depression Initiative & Perinatal Mental Health Consortium*; 2008.

19 National Institute of Clinical Excellence (NICE). Antenatal and postnatal mental health: clinical management and service guidance. *NICE UK*; 2014.
20 ZERO TO THREE. Early Experiences Matter: A Guide to Improved Policies for Infants and Toddlers. *National Centre for Infants, Toddlers and Families*; 2009.
21 Wrigley M, O'Riordan F, et al. Specialist Perinatal Mental Health Services: Model of Care for Ireland. *HSE*; 2017.
22 Cooney C, Kennedy N, Doherty A, Shipsey M, Lindow SW, Hinds C. Evaluation of a new Perinatal Mental Health Service in a University Maternity Hospital. *Ir J Psychol Med*. 2023:1–4. doi:10.1017/ipm.2023.18.
23 Wrigley M, O'Riordan F. Developing Specialist Perinatal Mental Health Services: the door of opportunity. *Ir J Psychol Med*. 2023;1–7.
24 Howard LM, Khalifeh H. Perinatal Mental Health: a review of progress and challenges. *World Psychiatry*. 2020;19(3):313–27.
25 Mongan D, Lynch J, Anderson J, Robinson L, Mulholland C. Perinatal mental healthcare in Northern Ireland: Challenges and opportunities. *Ir J Psychol Med*. 2021;1–6.
26 Kumar R, Marks M, Platz C, Yoshida K. Clinical survey of a psychiatric mother and baby unit: characteristics of 100 consecutive admissions. *J Affect Disord*. 1995;33:11–22.
27 Stephenson LA, Macdonald AJD, Seneviratne G, Waites F, Pawlby S. Mother and Baby Units matter: improved outcomes for both. *BJPsych Open*. 2018;4:119–25.
28 Bowlby J. Attachment and loss. Vol. 1: Attachment. 2nd ed. *New York: Basic Books*; 1982.
29 Beebe B. Mother-infant research informs mother-infant treatment. *Psychoanal Study Child*. 2005;60(1):7–46.
30 Government of Ireland. First 5: A Whole-of-Government Strategy for Babies, Young Children and their Families 2019–2028 [Internet]. Dublin: gov.ie; [cited 2025 Jun 12]. Available from: https://www.gov.ie/en/campaigns/5d81e-about-first5/
31 Mohan G. The impact of household energy poverty on the mental health of parents of young children: Growing Up in Ireland Study. *J Public Health*. 2022;44(1):121–8.
32 Philpott LF, Corcoran P. Paternal postnatal depression in Ireland: Prevalence and associated factors. *Midwifery*. 2018 Jan;56:121–7. doi:10.1016/j.midw.2017.10.009. PMID:29096280.
33 Cruise SM, Layte R, Stevenson M, O'Reilly D. Prevalence and factors associated with depression and depression-related healthcare access in mothers of 9-month-old infants in the Republic of Ireland. *Epidemiol Psychiatr Sci*. 2018.
34 Royal College of Psychiatrists. CR232 Perinatal Mental Health Services: Recommendations for the Provision of Services for Childbearing Women. *RCPsych*; 2022.
35 Cooney C. Business case for Phase 2 Model of Care for Specialist Perinatal Mental Health Services. *HSE*; 2023.

Appendices

Figure 1: Estimated number of women affected by perinatal mental illness each year



Communications: 10 things to know about Perinatal Mental Health

Clinical Design & Innovation

Specialist Perinatal Mental Health Services

World Maternal Mental Health Day
6th May, 2020



10 THINGS TO KNOW ABOUT PERINATAL MENTAL HEALTH

1. You can still be a great mother even if you are experiencing perinatal mental illness
2. 10-15% of women can experience mild to moderate postnatal depression, fathers and partners can suffer with perinatal mental illness too
3. You won't have your baby taken away if you ask for help with your mental health
4. Suicide is one of the leading causes of maternal deaths
5. Antenatal mental illness (untreated) is a strong risk factor for postnatal illness, so it's important to seek help while you are pregnant
6. 70-100% of women experience unwanted, intrusive thoughts about their baby
7. Your GP or perinatal mental health team are there to discuss medication options if required, you can take most mental health medications while you are pregnant and breastfeeding
8. Post-traumatic Stress Disorder is estimated to occur in 6% of maternities following an emergency section
9. Women are routinely asked about their mental health at booking clinics in maternity units/hospitals
10. Mental Health Midwives and Perinatal Mental Health teams provide specialist support for women

MORE INFORMATION:

Patient information leaflets:
Search: HSE Perinatal Mental Health

Specialist Perinatal Mental Health information app for GPs and healthcare staff available at:
https://PMH.healthcarestaff.app or QR code:





HSE NATIONAL PROGRAMME
Specialist Perinatal
MENTAL HEALTH SERVICES

The Importance of developing Ireland's first MOTHER AND BABY UNIT (MBU)

A Mother and Baby Unit (MBU) is a specialist in-patient unit for women who have severe mental health problems, where the mother and baby can be admitted together. MBUs provide specialist care for mothers with an existing mental health problem that has become much worse during pregnancy or after birth and for mothers who develop severe mental health problems for the first time during pregnancy or in the first postnatal year.

"As a mother who suffers with mental health I think having an MBU will be a great thing. Being separated from your baby while there are voices in your head telling you your baby is in danger is absolutely terrifying."

Danielle, a mum who experienced a postpartum psychosis

Mental illness at this crucial time can affect a mother's relationship with her baby. It can undermine a woman's confidence and belief in her ability to be a good mother. MBUs are designed to keep mothers and their babies together. Specialist staff nurture and support the mother-infant relationship on the unit at the same time as the mother has treatment for her mental illness.

"To have to separate a mother from her baby at such a key time for both is so difficult and potentially damaging to the long term mental well-being of both. And because sometimes we have to admit women involuntarily, the forced separation is then truly inhumane."

Professor Anthony McCarthy, Perinatal Psychiatrist, National Maternity Hospital

MBUs specialise in treating severe mental illness. These include Bipolar Affective Disorder, Schizophrenia, Postpartum Psychosis and other psychotic illnesses. A mother can also be admitted for treatment of severe Depression or Anxiety Disorders, such as Obsessive-Compulsive Disorder.

"MBUs support the mother-infant relationship as well as stabilise maternal mental health. Crucially, they mean mothers and infants do not have to be separated when the mother becomes unwell, which is traumatic for women, their babies and their families. This is likely to exacerbate the woman's mental illness and potentially prolong their recovery."

Dr. Catherine Hinds, Perinatal Psychiatrist, Coombe Hospital

Currently there are no Mother and Baby Units in Ireland. This means that any woman developing a severe mental illness within a year of having a baby is invariably separated from her baby, if she requires admission for inpatient care and treatment. Covid-19 also means that the daily visits from her baby, where clinically appropriate, are not always possible.

"Knowing your baby is with you helps recovery, being separated doesn't help because a massive piece of you is missing, especially for mothers who have no support. Baby becomes confused and mothers rush recovery due to pining over their baby."

Mum, with postpartum psychosis who was admitted to a general psychiatric unit

There are no MBUs available in Ireland at present (2021). Planning for Ireland's first MBU, to be located in Dublin, is currently underway. This is in line with recommendations made in the Specialist Perinatal Mental Health Model of Care for Ireland (HSE, 2017) and the National Maternity Strategy (DOH, 2016).

"If my son was with me during my time in psychiatric care, I wouldn't have needed as long as a 6 month stay to recover, as well as 2 further years of intensive mental health support & parenting courses whilst trying to rebuild our entirely broken bond. It took 5 months after I returned for him to allow me to even physically comfort him again. This extended traumatic period of our lives as a family could have been completely prevented."

Nicola, a mum who experienced severe post-natal depression



FOR MORE INFORMATION
Search: HSE Perinatal Mental Health



Communications: HSE Perinatal Mental Health Leaflets

