Evaluability assessment of the Scottish Government's Perinatal and Infant Mental Health Programme

May 2020

March 2021

Scottish Government
Riaghaltas na h-Alba
gov.scot

Evaluability assessment of the Scottish Government's Perinatal and Infant Mental Health Programme

May 2020

Dr. Debby Wason
Dr. Jane White
Dr. Kate Woodman
Public Health Scotland

Please note:

This report was drawn up before the country was hit by the COVID-19 virus. The restrictions imposed by the necessary social control measures to limit the transmission of the virus, and the additional challenges faced by the health service at this difficult time, mean that supporting the mental health of women in the perinatal period and their babies is more important than ever. While the delivery plans of the Perinatal and Infant Mental Health Programme for transforming services which support the mental health of parents and babies may have to be adapted, delayed or even changed completely, the central concern remains the same – to support parents and very young children with their mental health. Evaluating the impact of this programme has, therefore, become even more relevant than before. As the principles of the evaluation remain the same and the same core questions need to be asked of the programme, this report is still valid and its recommendations still stand.

1 Introduction

1.1 Perinatal and Infant Mental Health in Scotland

Mental health problems in the perinatal period* affects up to 20% of women in Scotland. While perinatal mental health problems can happen to any woman, some are at increased risk of developing problems. Risk factors include having a history of mental health problems, childhood abuse and neglect and domestic violence.[1] Early identification of problems and prompt appropriate care is important to prevent long lasting effects on women and their families.[2,3]

In this report, infant mental health is understood to be the same as healthy social and emotional development in the very early years†. As such, infant mental health is fundamentally linked to the quality of the relationship between the infant and their primary care-giver. Significant adversities faced by women and their families, such as perinatal mental health problems, parental substance misuse and domestic abuse, can interfere with a parent's capacity to develop a warm and secure relationship with their infant, as well as hindering the provision of sensitive attuned parenting.[4]

The Perinatal and Infant Mental Health Programme board was established in April 2019 in order to implement the commitments to improving perinatal and infant mental health set out in the 2018/19 Programme for Government and Better Mental Health in Scotland.[5] The programme board will oversee an investment of more than £50 million to be spent on improving perinatal and infant mental health support and treatment for women and their partners in the perinatal period and infants in the very early years who are experiencing poor mental health.[6] The recommendations of the Needs Assessment for Specialist and

* The perinatal period covers from conception to the end of the first postnatal year (Perinatal Mental Health Curricular Framework: A framework for maternal and infant mental health. Edinburgh: NHS Education for Scotland, 2019; National Collaborating Centre for Mental Health. The Perinatal Mental Health Care Pathways. Full implementation guidance. London: National Collaborating Centre for Mental Health, 2018.)

† Up to three years of age

Universal Perinatal Mental Health Services carried out by the Perinatal and Infant Mental Health Managed Clinical Network will inform the vision and delivery plans of the programme board.

NHS Health Scotland (now part of Public Health Scotland) was commissioned to undertake an evaluability assessment of the Perinatal and Infant Mental Health programme to inform the development of an evaluation plan for the programme.

1.2 Evaluability assessment process

An evaluability assessment (EA) is a systematic approach to prioritising and planning evaluation projects. The process usually involves the following:

- Structured engagement with stakeholders to clarify the intervention or policy goals and how they are expected to be achieved.
- Development and appraisal of a theory of change or programme logic model, which describes how the programme contributes to change in longer-term outcomes, via change in a series of linked short- and medium-term outcomes. It can also identify:
    - the assumptions which underpin the theory/logic model
    - possible unintended consequences of implementing a programme
    - the external factors which will impact on successful implementation and achievement of the intended outcomes.
- Development of evaluation priorities and questions.
- Assessment of existing data sources and data gaps, and consideration of evaluation options.
- Provision of advice on whether an evaluation can be carried out at reasonable cost, or whether further development work on the intervention should be completed first.

A series of three workshops were held with a variety of stakeholders who work in the perinatal and infant mental health care sector including representatives from Scottish Government, health services and the Third Sector.

This paper will present:

- the programme logic model that was developed in collaboration with, and agreed by, the Scottish Government, Perinatal and Infant Mental Health programme board and other stakeholders
- the evaluation questions developed, along with a consideration of possible sources of information to answer the questions posed
- recommendations about the overall evaluation approach

2 Programme logic model and prioritisation of the outcomes

2.1 Development of the programme logic model

The programme logic models were developed and agreed in collaboration with stakeholders during the first two workshops. Between the workshops, stakeholders were given the opportunity to provide written feedback about the proposed models to the Health Scotland team. For clarity, while it was recognised that perinatal mental health and infant

mental health are closely linked, the logic models for perinatal mental health and infant mental health were developed separately. It should be noted that, due to time constraints and the fact that the programme is just beginning, only the right hand side of the logic models were developed i.e. the outcomes. Ideally the left hand side, the inputs including resources and activities of the programme will be developed as the programme develops. The task will be then to ensure that the proposed resources and activities are likely to produce the desired outcomes.

2.1.1 Perinatal mental health

The development of the perinatal mental health logic model was underpinned by the tiers of intervention that are outlined in Appendix 1. The tiers describe a spectrum of services and actions that are needed to address varying degrees of mental health concern.[7] Tiers 1-3 are taken from the Programme for Government 2018-19‡ and describe the different levels of mental health services for varying degrees of mental health illness. Tier 4-5 describe actions to identify women with perinatal health issues as early as possible, promote positive wellbeing, and prevent mental health problems. These additional tiers were agreed by the stakeholders attending the first EA workshop.

Figure 1 shows the short, medium and long term outcomes as they relate to perinatal mental health. In the each figure, the links between particular outcomes with the next level outcome are indicated by coloured arrows. All the outcomes that contribute to a particular outcome are shown by one colour of arrow. There is no significance in the choice of colour for any particular group. Each box is numbered to help discussions only and are not listed in any particular order.

2.1.2 Infant mental health

For the purposes of developing the infant mental health logic model, infant mental health was understood to be the same as healthy social and emotional development. Figure 2 shows the outcomes related to infant mental health.

2.1.3 Combined perinatal and infant mental health model

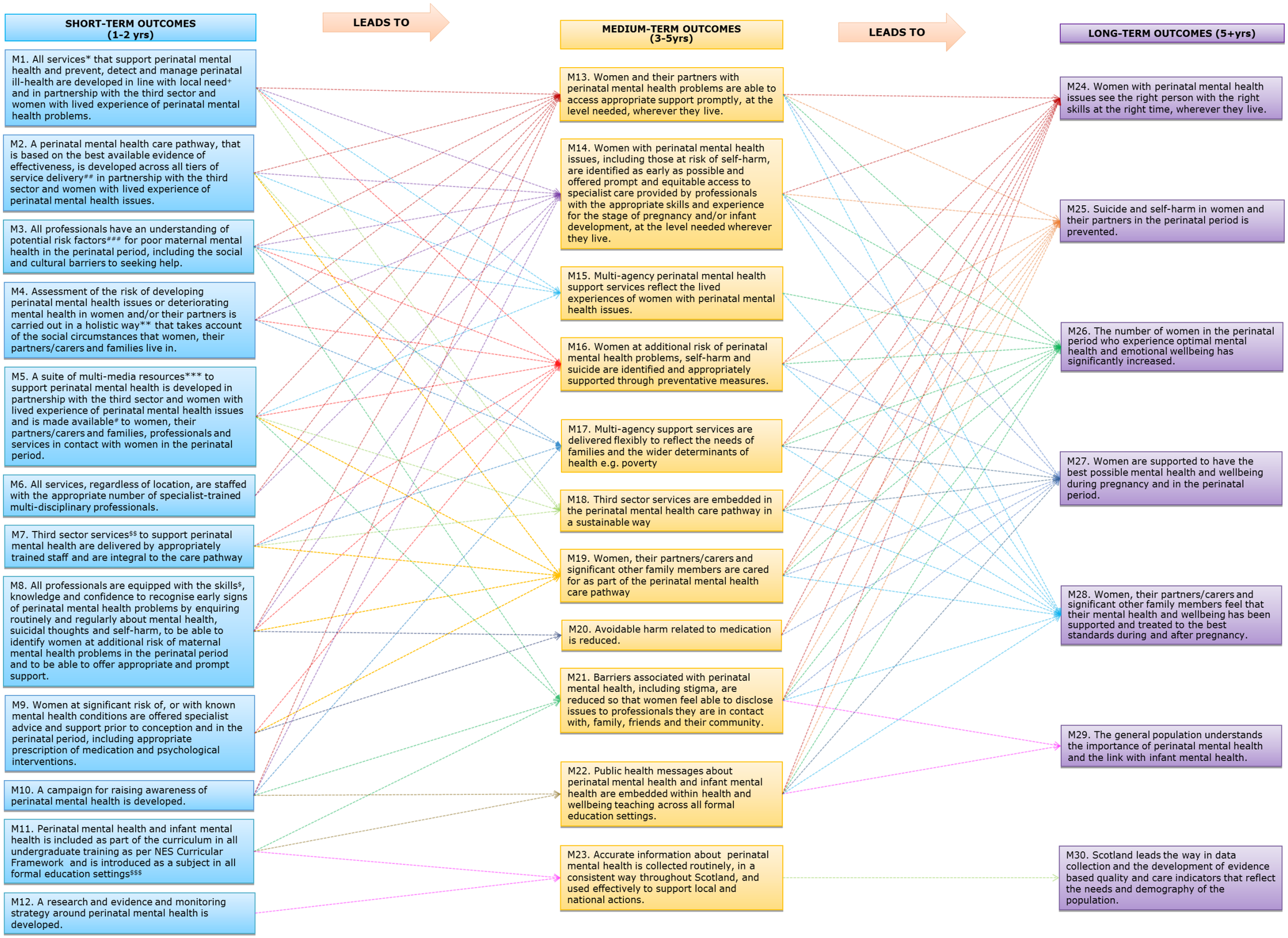
At the request of the stakeholders, the two logic models were combined. The resulting logic model is very complex – copies are available from the Perinatal and Infant Mental Health programme manager. Figure 3 brings the long term outcomes from both models together and shows their contribution to the Scottish Government's national outcomes.

2.2 Prioritisation of the outcomes

During the second EA workshop, the stakeholders were asked to prioritise the short- and medium-term outcomes for evaluation. Figure 4 brings the prioritised outcomes from both models together and shows the links between. The prioritised outcomes informed the development of the evaluation questions.

‡ P64

Figure 1: Perinatal Mental Health Logic Model *(see key)*



Key to Figure 1

[+] and reflecting the wider determinants of health e.g. poverty

[*] including specialist inpatient and community perinatal mental health services, and enhanced provision in maternity and primary care.

[**] includes consideration of biopsychosocial circumstances

[***] e.g. self-help materials, information about local peer support services such as mother and baby/toddler groups, pathways into care for women experiencing mental health difficulties

[#]including via the internet

[##] including specialist inpatient and community, maternity and primary care

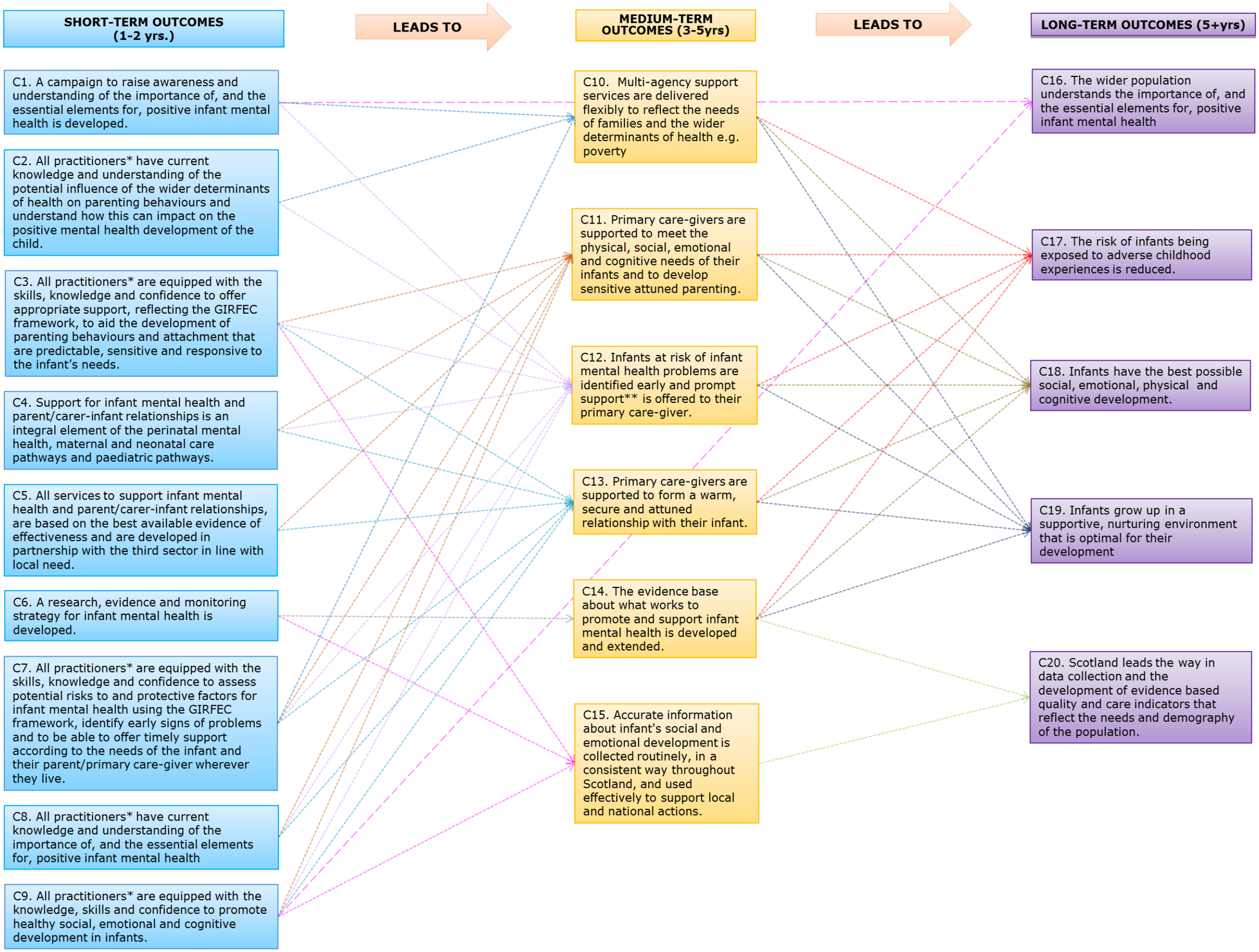
[###] including those with substance misuse, women living in poverty, those who are socially isolated, women whose first language is not English, those who have or are experiencing domestic violence, those who have experienced adverse childhood experiences, those who are care experienced, teenagers, those with a history of mental health problems, women who have experienced previous trauma or are experiencing trauma around pregnancy including loss or expected poor neonatal outcomes, and/or those who face additional complications of pregnancy and/or birth.

[$] including interpersonal and communication skills

[$$] including counselling, befriending and peer support

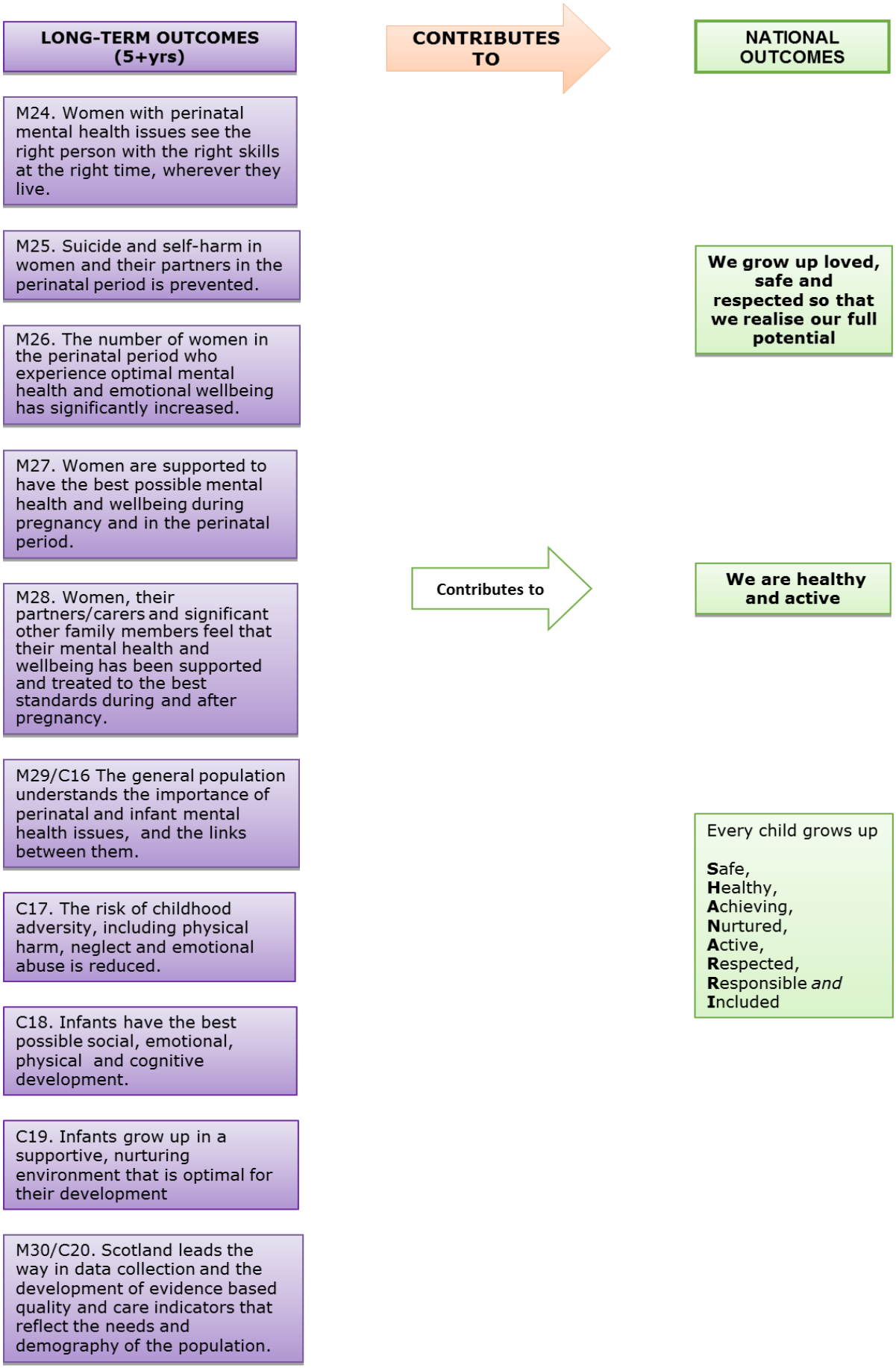
[$$$] e.g. secondary schools, Early Learning & Childcare training, child development courses.

Figure 2: Infant Mental Health Logic Model



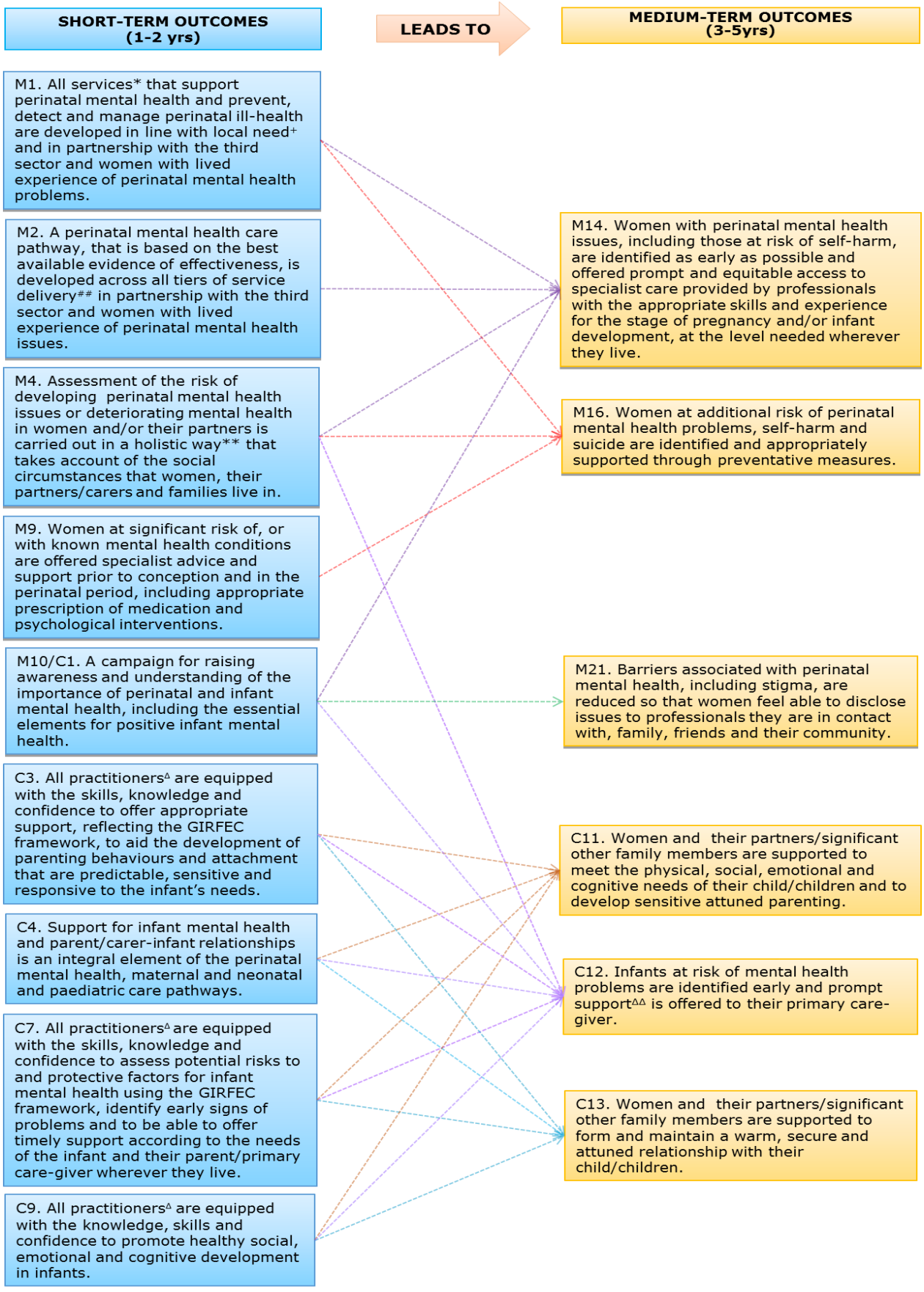
* all practitioners in contact with women, their infants and immediate families e.g. primary care health professionals, ELC staff, third sector support services etc.
** taking into account the stage of development

Figure 3: The contribution of the combined perinatal and infant mental health long-term outcomes to Scottish Government's National Outcomes



The Scottish Government's 'Getting it right for every child' (GIRFEC) approach supports children and young people so that they can grow up feeling loved, safe and respected. The eight SHANARRI wellbeing indicators describe the basic elements that all children and young people need to reach their full potential.

Figure 4: Short- and medium-term outcomes prioritised by stakeholders for evaluation *(see key)*



Key to Figure 4

[*]including specialist inpatient and community perinatal mental health services, and enhanced provision in maternity and primary care.

[**] includes consideration of biopsychosocial circumstances

[##] including specialist inpatient and community, maternity and primary care

[Δ] all practitioners in contact with women, their infants and immediate families e.g. primary care health professionals, ELC staff, third sector support services etc.

[ΔΔ] taking into account the stage of development

3 The Evaluation

3.1 Aim of the Evaluation

It was agreed that the aim of the Evaluation would be 'to find out if the mental health of women in the perinatal period and the mental health of infants, up to the age of three years, had improved as a result of changes in services and improved access to appropriate help and support'. The evaluation, therefore, has four main objectives:

1. To assess if women in the perinatal period are able to access appropriate mental health care services in a timely manner.
2. To assess if primary care givers are able to access appropriate mental health care services for their infants in a timely manner.
3. To assess if practitioners in contact with young families understand the importance of mental health in the perinatal period for both mothers and their babies and are able to appropriately identify, support and refer women and infants who may need more specialist intervention.
4. To assess if offering women and their families early intervention helps to prevent referral to more specialised mental health services.

In order to be able to respond to these objectives, the third evaluability workshop, prioritised several of the medium-term outcomes and stakeholders identified the questions for evaluation. The outcomes were then turned into the 'core' evaluation questions. The answers to the evaluation questions are the means by which the success or otherwise of the programme would be measured. Beneath each core question, several sub questions were then developed which would need to be answered to be able to fully answer the core question. The two outcomes that related to the relationship between infants and their primary care giver were considered together. Some of the sub-questions are the same for different core questions. However, the answers are likely to be slightly different depending on the context. This means that it will be possible to answer different core questions with the same sub-question.

3.2 Evaluation Questions

Core Question 1: Are women with perinatal mental health issues identified early and offered prompt appropriate care?

1.1 What understanding do professionals have about risks to mental health in perinatal period?

1.2 What understanding do women and their families about the risks to mental health in perinatal period?

1.3 Are all women regularly and appropriately assessed throughout the perinatal period? Including:

- Routinely at booking?
- Later bookers?
- Those with pre-existing mental health conditions?
- At risk groups?

1.4 Are appropriate screening tools used?

1.5 Are all professionals aware of where to refer women and are they aware of the range of appropriate interventions? Including those for women with

- Pre-existing mental health issues
- Mild to moderate mental health issues

1.6 Do all women have access to appropriate services throughout Scotland, at the most appropriate time? Including:

- Time from referral to access
- Do services respond timeously and appropriately?

1.7 Are all the staff fully and appropriately skilled and are services appropriately resources with multidisciplinary teams to meet demand?

Core Question 2: Are women at risk of perinatal mental health problems and suicide identified and appropriately supported?

2.1 What understanding do professionals have about risks to mental health in perinatal period?

2.2 What understanding do women and their families about the risks to mental health in perinatal period?

2.3 Are all women regularly and appropriately assessed throughout the perinatal period? Including:

- Routinely at booking?
- Later bookers?
- Those with pre-existing mental health conditions?
- At risk groups?

2.4 Are appropriate screening tools used?

2.5 Are all professionals aware of where to refer women and are they aware of the range of appropriate interventions? Including those for women with

- Pre-existing mental health issues
- Mild to moderate mental health issues

2.6 Do all women have access to appropriate services throughout Scotland, at the most appropriate time? Including:
  - Time from referral to access
  - Do services respond timeously and appropriately?

2.7 Are all the staff fully and appropriately skilled and are services appropriately resources with multidisciplinary teams to meet demand?

2.8 Do women feel able to be open about their thoughts for suicide and/or self-harm with relevant professionals?

2.9 What has been the impact of suicide awareness campaigns?

Core question 3: What barriers do women face in disclosing perinatal mental health difficulties?

3.1 What understanding do women and their families have about the risks to mental health in perinatal period?

3.2 What stops women talking about their mental health?
  - Stigma?
  - Certain groups?
  - Professional behaviour

3.3 Are appropriate screening tools used?

3.4 Do all women have access to appropriate services throughout Scotland, at the most appropriate time?
  - Time from referral to access

3.5 Do services respond timely and appropriately?

Core Question 4: Are infants at risk of mental health problems identified early and support offered to their care-giver?

4.1 What understanding do professionals have about risks to infant mental health?

4.2 What understanding do women and families have about risks to infant mental health?

4.3 Are women whose infant may be at risk of poor infant mental health identified in the antenatal and postnatal period?

4.4 How, by whom and at what time points are infants assessed before the age of 3 years?

4.5 Are infants at risk of poor mental health identified as soon as possible, irrespective of their social circumstances?

4.6 Is there an appropriate pathway in response to poor mental health (based on GIRFEC principles) and is this used appropriately?

4.7 Are infants at risk of poor mental health referred and offered appropriate and prompt support nationally?

4.8 What is the impact of support (i.e. services and/or intervention) in response to poor infant mental health on the long term outcomes for the child?

Core Question 5: Are primary care givers and their families supported to meet the needs of their child/children?
Core Question 6: Are primary care givers and their families supported to form and maintain a healthy relationship with their child/children?

5/6.1 What understanding, knowledge and skills do professionals have about healthy relationships between infant and care-giver?
- Including assessment

5/6.2 What understanding do women and their families have about what constitutes a healthy relationship with their infant?

5/6.3 What support is available for all parents to encourage a healthy relationship between them and their child?
- Timely?
- Who is providing it?

5/6.4 Are all professionals aware of what support is available both nationally and locally?

5/6.5 Do all women and significant care givers have access to appropriate support throughout Scotland, at the most appropriate time?
- Awareness?
- Enablers?
- Barriers?

3.3 Evaluation Approach

3.3.1 Theory Based Design

We strongly recommend that a theory based approach is taken to the evaluation. This relies on the development of a Theory of Change with clear pathways which demonstrate how a particular action should result in the desired change. As the current programme logic model (theory of change) only demonstrates the desired outcomes for the programme (the right hand side of the model), it is recommended that the rest of the model is completed when decisions about the proposed actions of the programme have been made around. This would include resource allocations, activities and outputs. The evaluation would then test whether the inputs actually produced the desired outcomes.

There are three main components that the evaluation needs to address:
- The structure and resources of the programme
- The process of implementation and how the resources are used
- The outcomes of the programme and the impact it has made on the intended beneficiaries

3.3.2 Evaluation Methodology

There are a variety of methods that can be used when evaluating an initiative like the Perinatal and Infant Mental Health programme. Randomised Control Trials (RCTs)

are often held up as the ‘gold standard’ of evaluative research but, in practice, there are significant limitations to this approach in the real world. For example, it would be ethically difficult to divide families into groups where one group received the revised programme and one did not, particularly if the revised programme included interventions that had been shown to have positive benefits for women, their families and infants. Another option is a natural experimental approach where the natural variation between groups is used to compare results. When the planned roll out of a programme is staged, the results of the early intervention group can be compared to the group who have not yet received the programme. This is a useful approach as long as that there is no reason why one area received the intervention before another, which would introduce bias into the sample.

For this evaluation, the NHS Health Boards are aiming to roll out improved services as quickly as possible and some services are already being implemented. Therefore, it is considered that a ‘before-and-after’ approach might be most appropriate, with varying baselines depending on the stage of implementation of a particular programme. This approach entails looking at outcomes for women, their families and babies, as well as the services, before the programmes are put in place and, then, assessing them again after implementation. Whilst ‘before-and-after’ designs are very common, they have limitations. It is important to ensure that any changes observed in the evaluation can be, as far as possible, directly attributed to the programme of intervention. For instance, the evaluation might detect that stigma around mental health issues in the perinatal period have reduced, but it is possible that stigma in the population had reduced for other reasons.

Using a ‘before-and-after’ approach, it is very important that Phase 1 of the evaluation produces a baseline which can be used as a comparison for the later Phase 2. Some elements of the programme have started already, so a decision might have to be made about the most appropriate time point to establish a baseline or baselines. For some elements of the programme, retrospective data may be available, while for others the work might not have fully started so a baseline could be established relatively near the beginning. For others, a certain date to act as a baseline may have to be taken, preferably based on a change in the work stream or a change in the pace of implementation. Any baseline should cover the main indicators that will be used in the evaluation. It is strongly recommended, therefore, that a survey of women, a survey of professionals and a case note review is carried out as soon as possible. Phase 2 would be methodologically the same as Phase 1 and be carried out around 3 years after the baselines have been established. In order to monitor whether the programme is on track, some form of simple process evaluation could be undertaken on an annual basis to record what activities are happening.

3.3.1 Evaluation Governance

We recommend that an Evaluation Advisory group is set up to oversee the evaluation. This should comprise mental health professionals, healthcare workers who cover maternity and early years, Scottish Government, evaluation experts and third sector and academic institutions who have an interest in this area.

We recommend the evaluation is put out to competitive tender and that this is done using a two staged approach covering the 'before' and 'after' aspects of the evaluation.

3.4 Potential sources of information

The table in Appendix 2 shows the evaluation questions in tabular form. The final two columns show the potential data sources that could be used to answer these questions and the sources of these data. They can broadly be divided into the following categories:

3.4.1 Women and/or their infant

- Routine data from Public Health Scotland, Data and Intelligence directorate (formerly Information Service Division, National Services Scotland[§])
  - Information held within the maternity record
  - Admissions to hospital and Mother and Baby Units (MBUs) for mental health issues in the perinatal period
  - Information held within the Child Health Surveillance System (CHS)
  - Information held by the Family Nurse Partnership
- Current SMR02 data return collects diagnoses at hospital admission (during and/or at end of pregnancy and this can include ICD10 codes for mental health conditions). Currently, no specific capture by national data return of this at booking.
- National Records of Scotland (NRS) for suicide patterns in women in perinatal period
- In the case of stillbirth and neonatal death, maternal history is examined by 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK' (MBRRACE-UK)
- The Maternity/Neonatal Hub (Mat/Neo Hub) is undertaking ongoing work with Perinatal Mental Health network (as part of Enhanced Mat Dataset for Scotland, EMADS) to standardise the questions asked at Booking, the tools used and the data recorded on mental health history and mental assessment at antenatal booking.
- National data only gathered on booking and delivery. Delivery data capture offers the opportunity to consider previous maternity journey and record problems identified. E.g. smoking, drugs, mental and physical health.

[§] ISD Scotland

- Clinical notes held by Health Boards. These include patient/client records from midwives, health visitors, mental health workers (including those working in the community and those in clinical settings and those working in the private and third sector), paediatricians, and consultant psychiatrists.
- Information gathered directly from women and their families by survey or qualitative interviewing.

3.4.2 Work force

- Data from NHS Education for Scotland (NES) about the content of training course for staff as well as the numbers and the professional discipline of the staff trained.
- Information directly from practitioners using survey or qualitative interviews.

3.4.3 Programme implementation

- Information from Health Boards about their implementation of perinatal and infant mental health work plans.

3.4.4 Other sources of information

There are various other sources of data, such as additional analysis which Local Intelligence Support Team (LIST) analysts have been asked to do. In addition, the Nurse Directors have set up a short term working group to look at all nursing data as it is recognised that this area needs some attention. Depending when the evaluation is conducted more data, might become available through this route. Nationally, data about Health Visiting and Community Mental Health activity is limited.

3.5 Proposed Evaluation studies

In order to answer the evaluation questions, and using, where possible, existing data, it is proposed that the following studies are undertaken. If a 'before-and-after' design is used the majority of the studies need to be take place at baseline and again, in 3 to 5 years' time, to measure the impact of the programme. However, because services are constantly changing and developing, it also needs to be recognised that the studies may reflect slightly different time points in terms of the baseline they present. It is, therefore, recommended that the Evaluation is commissioned as soon as possible so that the maximum amount of consistency in the timing of baseline measures can be achieved.

3.5.1 Analysis of existing data

Analysis of existing data would help answer evaluation questions 1.3, 1.4, 1.6, 1.7, 2.3, 2.4, 2.6, 2.7, 2.9, 3.3, 3.4, 4.3, 4.4, 4.6, 4.7, 4.8, 5/6.6

Women

This could include

- Any references to mental health or risk factors held in the maternity record

- Information collected from Psychological Therapies Services
- Data from the Maternity Care Survey, re-analysed if necessary
- Analysis of the admissions data for perinatal mental health to secondary care.
- Information from NRS about deaths of women in the perinatal period

Infants
This could include

- Known factors about infant mental health or risk factors held in the Child Health Surveillance Programme (CHSP) and the Family Nurse Partnership (FNP) records.
- Analysis of data from Early Years providers about access to their services and approaches to infants who appear to have additional support needs for mental health issues.
- There are also various ad hoc studies which could be used or reanalysed to inform on infants' mental health. These include Growing Up in Scotland (GUS) and the Scottish Study of Early Learning and Childcare (SSELC). These would give quantitative data on very young children as a baseline and elements of them could be included in any bespoke data collection after the programme has been running several years.
- It would be most useful to be able to link data for this study e.g. the maternity record could be linked to the Health Visitor (HV) record which could be linked to SMR02 data and linked to any admissions data. It would also be useful to link prescribing data to the maternity record. However, this might prove difficult to achieve. GP data would also be useful although it is unlikely this would be made available. We would recommend holding discussions with the Local Intelligence Support Teams to see what data could be accessed at a local level.
- Other data on specific groups of children, such as those who are Looked after and Accommodated or on the Child Protection register, should be monitored to see if there is any change, although this might be unlikely in the time frame of the evaluation.

Workforce

- Collection of information from NHS Education for Scotland about training

3.5.2 **Study of Clinical Notes (Clinical Note Review)**

A clinical note review would help answer evaluation questions: 1.3, 1.4, 1.5, 1.6, 2.3, 2.4, 2.5, 2.6, 3.3, 3.4, 4.3, 4.5, 4.6, 4.7.

Women
Women and their families are likely to have many encounters with a wider range of health and social care professionals throughout the perinatal period. Each encounter is an opportunity for prevention of and early intervention for mental health issues in

the perinatal period. Based on the perinatal mental health pathways developed by NHS England, the Managed Clinical Network (MCN) are developing similar pathways for the Scottish population spanning from pre-conception to urgent admission to a MBU. We suggest that it would be worthwhile to document a woman's various encounters including time points before a woman is admitted to a MBU.

A focussed study of clinical notes (Clinical Note Review) would enable the histories of a sample of women to be studied. These notes should cover midwife and Health Visitor records and also mental health worker records ranging from Community Psychiatric Nurses to consultants' clinics. If possible, it would be useful to link these notes i.e. a review is undertaken of a woman's pregnancy record, the Health Visitor record and any subsequent referral record and the notes of the agency referred into.

Infants

A similar approach can be taken for infants. The main source of data will be Health Visitor notes followed by any notes from referral agencies which may also include early years' practitioners as well as health staff. Through the Health Visitor record, it should be able to track any concerns around an infants' mental health and well-being particularly in the first three years.

3.5.3 **Survey of women and their families**

This survey would help answer evaluation questions: 1.2, 2.2, 2.9, 3.1, 3.2, 4.2, 4.5, 5/6.2, 5/6.5

A survey of women and their families should be undertaken along with qualitative interviews. The survey could cover what women and their families understand about mental health in the perinatal period and the mental health of their baby, whether women and/or their families are aware of the risk of suicide and self-harm, sources of help for women and their families as well as the barriers to accessing help both for themselves and their babies. It could also ask women about their understanding of what constitutes a healthy relationship with their baby. If desired, women could also be asked about their experience of existing services although this is not explicitly articulated in the evaluation questions. It may also be useful to target certain women e.g. those who have used services of various types.

In qualitative interviews, the experience of women with mental health issues would be explored more fully along with their experience of enablers and barriers to obtaining help. The bond/attachment between mother/primary care giver and baby could also be explored.

3.5.4 **Survey of Practitioners**

This study would help answer evaluation questions: 1.1, 1.4, 1.5, 1.7, 2.1, 2.4, 2.5, 2.8, 3.3, 4.1, 5/6.1, 5/6.4, 5/6.6.

A survey of a range of practitioners, including those in health and statutory services and the Third Sector, who are in contact with women and families in the perinatal period and/or with infants in the very early years should be undertaken along with qualitative interviews. This survey would cover practitioners' understanding of perinatal mental health both in women and infants and their knowledge of risk factors for poor mental health. The survey would cover the use of screening tools, awareness of appropriate interventions and referral pathways. It could also ask questions about the training they have received about perinatal mental health and/or infant mental health and how they have implemented that training. In addition, the perspectives of practitioners about what they believe helps or hinders women and their families accessing mental health services could be sought along with their views about the role of statutory, informal and third sector organisations in supporting the mental health of women and their families as well as infant mental health. The survey could take into account the different levels at which the practitioners intervene i.e. which of the five tiers they operate within (see Appendix 1). It would be useful also to ask practitioners to self-assess their own competencies and in this area and whether they need enhanced training.

3.5.5 ***Mapping of Existing Services***

It would be useful to map, as far as possible, existing services which support women, their families and infants in the very early years[**]. This could be a desk based exercise but should include the third sector as well as health and other statutory services.

3.5.6 **Recording and monitoring the implementation of the Programme**

The programme works to yearly work plans which aim to describe the process of implementing the recommendations set out in the Needs Assessment. We would suggest that, for every annual work plans, outputs are agreed and indicators for those outputs established in order to monitor whether the work plans are being implemented effectively. For example, if an increase in staffing is a key objective of a work plan, then an indicator would give the baseline position and, then, the expected increase in numbers for the year. Currently, the establishment of indicators has been done with some of the suggested outputs but not with others.

In addition, it might be useful at key points to have a 'taking stock' event or study. This could be done either through regular meetings with those responsible for the implementation of the programme, or a series of interviews with stakeholders

[**] Up to three years of age

conducted at key points in the roll out. This will give an idea of some of the challenges that have had to be overcome and some of the successes in terms of implementation. It addition, it will be useful information for the implementation of any adaptions the programme might need to make as the implementation is rolled out. Equally important, measures need to be taken of unintended consequences of the implementation of the programme. For instance, does raising awareness of perinatal mental health issues place more pressure on other parts of the system such as primary care? This is where hearing the experience of professionals and women and their families as the programme unfolds will be very important.

It is strongly suggested that the 'left hand side' of the logic model is now developed. Not only will this show clearly what actions and expected outputs are planned but would also demonstrate how the actions link to the outcomes. At this point, this could be a desk based exercise. It would also enable the indicators for the activities and outputs to be established and, hence, reported on as the programme progresses.

The suitability of training courses should also be measured as part of the monitoring of the implementation of the programme. Understanding the content of what frontline workers are being taught will form a necessary backdrop into evaluating the impact of that training on practice. Links should, therefore, be made with NES in order to obtain numbers accessing their courses and any assessments they have conducted as to the content and implementation of learning.

It should be stressed that monitoring the implementation of the work plans is not in itself a measure of the success of the programme. However, it will describe and assess the mechanism whereby any improvement in outcomes is achieved. The achievement of the short term outcomes as described in the programme logic model is a measure of the success of implementing the programme.

3.5.7 Literature review of women's mental health in the perinatal period and of infant mental health

A literature review about women's mental health in the perinatal period and infant mental health up to the age of three years would help ensure that the programme implementation is in line with best practice. It would also underpin the standards the evaluation would use to assess the programme. For instance, a review of the literature will help determine what appropriate pathways for infant mental health are and what would be considered appropriate interventions at what time points. Although cited last, in fact, this should be undertaken as soon as possible.

4 Summary of EA recommendations

We recommend that:

a) A Monitoring and Evaluation Advisory group is convened to oversee the development and delivery of the programme of work for the evaluation

b) The Theory of Change model (programme logic model) is developed more fully to reflect the inputs into the programme ('the left hand side of the model').

c) A Theory Based evaluation based on the Theory of Change is undertaken using a series of 'before-and–after' studies. Because implementation of parts of the workplans have been undertaken at different stages, there may be several different timepoints for the baseline of the evaluation. This will depend on the timing of the roll out of different parts of the programme. This should not have a major impact on the evaluation itself.

d) Seven studies are undertaken at baseline and at 3 to 5 years post implementation with a different cohort of perinatal women and infants. These are:

i. Analysis of existing data
ii. Clinical Note Review
iii. Survey/Interviews with women and their families in the perinatal period
iv. Survey/Interviews with practitioners who work with women and their families in the perinatal period and/or with infants in the very early years
v. Mapping of Existing Services
vi. Monitoring and recording of progress of implementing the programme
vii. Literature reviews of women's mental health in the perinatal period and of infants' mental health (if not already undertaken)

5 Appendix 1: Tiers of intervention

Tier 1.* For those 2,250 women with the most severe illness: development of more specialist community perinatal mental health services and consideration of the need for a small number of additional inpatient beds or enhanced community provision.

Tier 2.* For those 5,500 women in need of more specialist help: rapid access to psychological assessment and treatment

Tier 3.* For those 11,000 women a year who would benefit from help such as counselling: support for the third sector to provide this.

Tier 4. Women and professionals become increasingly aware of mental health issues through greater routine enquiry, leading to appropriate early intervention (early intervention).

Tier 5. The whole population and all professionals become increasingly aware of the need to promote good perinatal mental health and to prevent perinatal mental health issues developing (promotion and prevention).

* From Programme for Government 2018-19

6 Appendix 2: Outcome text, core questions and potential data sources

Outcome text	Core question	Sub-questions	Existing Data source?	Who holds this information?
1. Women with perinatal mental health issues, including those at risk of self-harm, are identified as early as possible and offered prompt and equitable access to specialist care provided by professionals with the appropriate skills and experience for the stage of pregnancy and/or infant development, at the level needed wherever they live.	1. Are women with perinatal mental health issues identified early and offered prompt appropriate care?	1.1 What understanding do professionals have about risks to mental health in perinatal period?	**None – can be gained from survey/interview**	**Professionals**
		1.2 What understanding do women and their families about the risks to mental health in perinatal period?	**Possibly Maternity Care Survey.** **Can be gained from survey/interview**	**Women and their families**
		1.3 Are all women regularly and appropriately assessed throughout the perinatal period? Including: – Routinely at booking? – Later bookers? – Pre-existing mental health conditions? – At risk groups?	**Booking data** **Clinical notes** **Routine Data collections** **Staff survey/interviews**	**Health Boards** **Mat/Neo Hub**
		1.4 Are appropriate screening tools used?	**Booking Data** **Clinical notes**	**Health Boards** **Mat/Neo Hub** **Mental Health Workers**
		1.5 Are all professionals aware of where to refer women and	**Health Visitor data** **Clinical notes**	**Professionals**

Outcome text	Core question	Sub-questions	Existing Data source?	Who holds this information?
		are they aware of the range of appropriate interventions? Including those for women with – Pre-existing mental health issues – Mild to moderate mental health issues	**Staff survey/interviews**	
		1.6 Do all women have access to appropriate services throughout Scotland, at the most appropriate time? Including: – Time from referral to access – Do services respond timeously and appropriately?	**Clinical notes** **Booking data** **Data from mental health services e.g. Psychological Therapies Service** **Maternity Care Survey**	**Health Boards** **Mat/Neo Hub** **ISD (Information Service Division Scotland[††]) for MBUs and Inpatient data**
		1.7 Are all the staff fully and appropriately skilled and are services appropriately resourced with multidisciplinary	**Training courses** **Workforce survey**	**NES** **Health Boards** **Professionals**

[††] Now Data and Intelligence Directorate, Public Health Scotland

Outcome text	Core question	Sub-questions	Existing Data source?	Who holds this information?
		teams to meet demand?		
2. Women at additional risk of perinatal mental health problems, self-harm and suicide are identified and appropriately supported through preventative measures.	2. Are women at risk of perinatal mental health problems and suicide identified and appropriately supported?	2.1 What understanding do professionals have about risks to mental health in perinatal period?	**None – can be gained from survey/interview**	**Professionals**
		2.2 What understanding do women and their families about the risks to mental health in perinatal period?	**Possibly Maternity Care Survey** **Can be gained from survey/interview**	**Women and their families**
		2.3 Are all women regularly and appropriately assessed throughout the perinatal period? Including: – Routinely at booking? – Later bookers? – Pre-existing mental health conditions? – At risk groups?	**Booking data** **Clinical notes**	**Health Boards** **Mat/Neo Hub**
		2.4 Are appropriate screening tools used?	**Booking Data** **Clinical notes**	**Health Boards** **Mat/Neo Hub** **Mental Health Workers**
		2.5 Are all professionals aware of where to	**Health Visitor data** **Clinical notes**	**Professionals**

Outcome text	Core question	Sub-questions	Existing Data source?	Who holds this information?
		refer women and are they aware of the range of appropriate interventions? Including those for women with – Pre-existing mental health issues – Mild to moderate mental health issues	**Staff survey/interviews**	
		2.6 Do all women have access to appropriate services throughout Scotland, at the most appropriate time? Including: – Time from referral to access – Do services respond timeously and appropriately?	**Clinical notes** **Booking data** **Data from mental health services e.g. Psychological Therapies Service** **Maternity Care Survey**	**Health Boards** **Mat/Neo Hub** **ISD for MBUs and Inpatient data**
		2.7 Are all the staff fully and appropriately skilled and are services appropriately resources with multidisciplinary teams to meet demand?	**Training courses** **Workforce survey**	**NES** **Health Boards** **Professionals**

Outcome text	Core question	Sub-questions	Existing Data source?	Who holds this information?
		2.8 Do women feel able to be open about their thoughts for suicide and/or self-harm with relevant professionals?	**None - can be gained from survey/interviews**	**Women**
		2.9 What has been the impact of suicide awareness campaigns?	**Suicide patterns in perinatal women** **None – women's survey/interviews**	**NRS** **Women and their families**
3. Barriers associated with perinatal mental health, including stigma, are reduced so that women feel able to disclose issues to professionals they are in contact with, family, friends and their community.	3. What barriers do women face in disclosing perinatal mental health difficulties?	3.1 What understanding do women and their families have about the risks to mental health in perinatal period?	**None – can be gained from survey/interview**	**Women and their families**
		3.2 What stops women talking about their mental health? – Stigma? – Certain groups? – Professional behaviour	**None – can be gained from survey/interview**	**Women**
		3.3 Are appropriate screening tools used?	**Booking Data** **Clinical notes**	**Health Boards** **Mat/Neo Hub** **Mental Health Workers**
		3.4 Do all women have access to appropriate services throughout Scotland, at the most appropriate time?	**Clinical notes** **Booking data** **Data from mental health services e.g. Psychological Therapies Service** **Maternity Care Survey**	**Health Boards** **Mat/Neo Hub** **ISD for MBUs and Inpatient MBRRACE-UK**

Outcome text	Core question	Sub-questions	Existing Data source?	Who holds this information?
		– Time from referral to access – Do services respond timely and appropriately?		
4. Infants at risk of mental health problems are identified early and prompt support is offered to their primary care-giver.	4. Are infants at risk of mental health problems identified early and support offered to their care-giver?	4.1 What understanding do professionals have about risks to infant mental health?	**None – can be gained from survey/interview**	**Professionals**
		4.2 What understanding do women and families have about risks to infant mental health?	**None – can be gained from survey/interview**	**Women and their families**
		4.3 Are women whose infant may be at risk of poor infant mental health identified in the perinatal period?	**Health Visitor data** **FNP Data** **Paediatrician Clinical notes**	**ISD** **Health Board**
		4.4 How, by whom and at what time points are infants assessed before the age of 3 years?	**Child Health Surveillance Programme (CHSP)**	**ISD**
		4.5 Are infants at risk of poor mental health identified as soon as possible, irrespective of their social circumstances?	**HV clinical notes** **Paediatrician Clinical Notes** **Survey of women**	**Health Boards** **Women**

Outcome text	Core question	Sub-questions	Existing Data source?	Who holds this information?
		4.6 Is there an appropriate pathway in response to poor mental health (based on GIRFEC principles) and is this used appropriately?	**HV clinical notes** **FNP data**	**ISD** **Health Boards**
		4.7 Are infants at risk of poor mental health referred and offered appropriate and prompt support nationally?	**HV notes** **FNP data** **Paediatric Clinical notes** **CHSP 'Future Actions'**	**ISD** **Health Boards**
		4.8 What is the impact of support (i.e. services and/or intervention) in response to poor infant mental health on the long term outcomes for the child?	**HV notes and CHSP** **FNP data**	**ISD** **Health Boards**
5. Women and their partners/significant other family members are supported to form and maintain a healthy (i.e., a warm, secure and attuned)	5. Are primary care givers and their families supported to form and maintain a healthy relationship with	5/6.1 What understanding, knowledge and skills do professionals have about healthy relationships between infant and care-giver?	**None – can be gained from survey/interviews**	**Professionals**

Outcome text	Core question	Sub-questions	Existing Data source?	Who holds this information?
relationship with their child/children. 6. Women and their partners/significant other family members are supported to meet the physical, social, emotional and cognitive needs of their child/children and to develop sensitive attuned parenting.	their child/children? 6. Are primary care givers and their families supported to meet the needs of their child/children?	– Including assessing		
		5/6.2 What understanding do women and their families have about what constitutes a healthy relationship with their infant?	**None – can be gained from surveys/interviews**	**Women and their families**
		5/6.3 What support is available for all parents to encourage a healthy relationship between them and their child? – Timely? – Who is providing?	**Service mapping** **"Wellbeing for Wee Ones" - Mapping of parent-infant intervention and support services in Scotland**	**Study of Local Authorities, Health Boards, Registered charities, Third sector organisations etc.** **MCN/NSPCC**
		5/6.4 Are all professionals aware of what support is available both nationally and locally?	**None – can be gained from survey/interviews**	**Professionals**
		5/6.5 Do all women and significant care givers have access to appropriate support throughout Scotland, at the most appropriate time? – Awareness? – Enablers? – Barriers?	**None – can be gained from survey/interviews**	**Women and significant care givers**

Outcome text	Core question	Sub-questions	Existing Data source?	Who holds this information?
		5/6.6 Are there pathways to guide the identification of families in need of support to develop healthy relationships with their infant?	**None – can be gained from survey/interviews Training content**	**Professionals NES**

7 References

[1] National Collaborating Centre for Mental Health. The Perinatal Mental Health Care Pathways. Full implementation guidance. London: National Collaborating Centre for Mental Health, 2018.
[2] Perinatal Mental Health Curricular Framework: A framework for maternal and infant mental health. Edinburgh: NHS Education for Scotland, 2019.
[3] National Collaborating Centre for Mental Health. The Perinatal Mental Health Care Pathways. Full implementation guidance. London: National Collaborating Centre for Mental Health, 2018.
[4] Stein A, Pearson RM, Goodman SH, Rapa E, Rahman A, McCallum M, et al Effects of perinatal mental disorders on the fetus and child. Lancet. 2014 Nov 15; 384(9956) 1800-1819
[5] Perinatal and Infant Mental Health Programme Board Delivery Plan 2019/20. Edinburgh: Scottish Government, 2019.
[6] Perinatal and Infant Mental Health Programme Board Delivery Plan 2019/20. Edinburgh: Scottish Government, 2019.
[7] Perinatal and Infant Mental Health Programme Board Delivery Plan 2019/20. Edinburgh: Scottish Government, 2019.

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-80004-803-4 (web only)

Published by The Scottish Government, March 2021

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS845546 (03/21)