Why A Whole System Approach Pathway to Perinatal Mental Health?

"Perinatal mental illness affects up to 20% of new and expectant mothers and covers a wide range of conditions, such as anxiety, depression and or postpartum psychosis. Suicide is a leading cause of maternal death in the UK up to one-year post-partum, according to reports by MBRRACE-UK (most recent information 2015-17). Untreated perinatal mental illness has been estimated to cost the NHS and social services around £1.2 billion for each annual cohort of births"

By 2024 it is expected that 100% of women who encounter maternity services will be assessed, and where necessary, receive an appropriate referral to an evidence-based intervention. (1) (2) (3) Perinatal services are also given the opportunity to extend their input to two years into the postnatal period.

As health providers and as a society, we have all become more aware of mental health issues. We have become more informed about the complexity of the mind, and the impact of mental health on overall health. We understand the vulnerability of the unborn baby, the impact on the whole family, and the fact that perinatal mental health is not just a woman's problem. We are also aware that people have an amazing ability to recover or manage their mental health successfully, given the right support.

There are many pathway's already in existence which demonstrates the good work that already underpins practice. Much of what will be in this pathway is already there in various forms. It is about joining up the services and trying to spot where the gaps are and find a solution to those gaps.

Sadly, a significant number of women are still not receiving the mental health support that would help them and their family. (4) There are stark statistics showing a racial discrimination in diagnosis and access to appropriate services. There are a number of complexities that create barriers which we need to address and start to remove. These include:- perceived stigma, a fear of what would happen to their child if mental health problems are acknowledged, huge variations across cultures as to how mental health is recognised, gaps in how assessment tools are used and skill gaps for professionals involved.

We are in the fortunate position to be seeing a variety of options becoming available for our families and staff in the form of IT progression, digital apps and online support for mental health. These systems are rapidly evolving, and this pathway will be attempting to include the potential of these options as they can have a major impact on opening-up communication, improving access to services and creating positive outcomes.

Staff are all working hard to support women and their families. However, if staff feel untrained, unsupported, isolated and under-resourced, then this can have a direct negative impact on their interaction with their patients. The pathway will, therefore, include the support of staff as an integral part of the process of identifying MH problems, minimising risk of trauma and responding accordingly.

It is not a case of one service being able to meet every woman's mental health need, but about every service doing their bit and linking up. By using the kindness, tenacity, curiosity, empathy, and professional evidence-based skills that are the embodiment of the NHS and our partner agencies, we can move towards removing the barriers to our families getting the support they need and deserve.

Who is at Risk of Perinatal Mental Health Problems?

A person with a pre-existing mental health diagnosis or a history of mental health complications, including but not exclusive to:- previous perinatal illness, experience of an eating disorder, pre-menstrual syndrome, pre-menstrual dysphoric disorder, obsessive compulsive disorder, general anxiety disorder, depression, phobias, bipolar disorder, schizophrenia and personality disorder.

A person who has experienced previous trauma (as a child or as an adult).

A woman with a direct female relative who has had perinatal illness.

A person who is experiencing addiction.

A person who is under emotional, financial, or social strain.

A person who has undergone IVF.

A person who has a multiples pregnancy

A person who feels unprepared for their baby.

A person who has, or witnesses a difficult pregnancy, labour, delivery, or postnatal recovery.

A woman who is experiencing persistent, prolonged pain.

A woman who is unable to follow through with their plan to breast feed.

A person whose baby is on NICU.

A person whose baby is ill, hard to settle or difficult to feed.

A person with a child who is chronically sick or has additional needs.

A person who is isolated within their community or with little family support.

A person in the perinatal period - vulnerability and risk factors are dynamic.

What works for Parents?

Being treated with respect and as an individual by a service that works to trauma informed practices.

Feeling safe, feeling prepared.

A service that is gender, race and culturally aware with no prejudice. (RCOG 5 Steps)

Knowing who to contact if problems arise.

Having help and support at the right time.

‘Continuity of Care’ (not necessarily of carer).

Being supported in their transition to parenthood.

Having a service that is able to offer some flexibility.

Belief, trust, and evidence that treatment is effective.

What works for Staff?

Working in environments that are safe and enable a sense of personal value.

Support systems that allow restoration, reflection, and learning.

Communication systems which enable safe collaboration between services.

Research based training (directory, e-lf online training, iHV) that is valued and protected.

Effective multiagency working.

A service that is inclusive, diverse and without prejudice.

All maternity, mental health, and community services to be using trauma informed care practices.

Pre-Conception Including, but not exclusive to: school health, senior Schools, CAMHS/CYPS/ GP/ sexual health clinics/fertility services/mental health services/A&E/Gynaecology/health visiting services and community spaces.

Pre-conception

1. Identification of a woman who has experienced trauma such as pregnancy loss, assault, ACES or is experiencing fear of pregnancy or labour should lead to offer of restorative counselling. (GP, IAPT, Online, Specialist MH Services). Consider where this information is to be recorded.
2. If a woman is experiencing vaginal pain (vaginismus, vestibulodynia or dyspareunia), offer comprehensive assessment and referral to gynaecology and where necessary - psychosexual services.
3. Clear advice such as from the Royal College of Psychiatrists given to any female of child-bearing age (and their family where possible), with a diagnosed mental health condition on pregnancy and the support available. Emphasise to not stop medication without seeking medical advice if pregnancy is suspected. Diagnosis may include previous perinatal Illness, pre-menstrual syndrome, pre-menstrual dysphoric disorder, Obsessive compulsive disorder, eating disorder, general or other anxiety disorders, depression, phobias, bipolar disorder, schizophrenia, and personality disorder.
4. Ensure prescribers have current, easily accessible information on medication related to pregnancy such as from the Royal College of General Practitioners and NICE Guidelines. If unsure, contact the Community Perinatal Mental Health Team Psychiatrist for advice.
5. Share with women self-care information and how to access support if required. Encourage to access available resources.
6. Agencies to have information available in public spaces re. mental health and pregnancy. Consider a variety of information resources so information is gender aware, accessible for non-English speakers and for those with additional learning needs.
7. Ensure robust communication in place between fertility services and their counselling services with primary care to ensure mental health can be addressed accordingly for any person or couple accessing fertility services
8. Bereavement services to ensure the woman is clear about support options prior and during pregnancy.
9. Pre-conception maternity clinic available, preferably joined with community perinatal mental health team for mothers with previous mental health illness or experience of perinatal illness.

Maternity Services including primary and secondary care, specialist maternity services (smoking cessations, healthy weight, drug and alcohol, high risk pregnancy teams, allied health professionals, breast feeding support teams and neonatal services. 0-19-year services, primary care (GP and attached services), IAPT, community perinatal mental health service, 'Sure Start', community organisations and relevant charitable organisations are also impacted and will be influenced by this process.

Pregnancy - Universal

1. All maternity-related services and agencies to be working using Trauma Informed Care Practices
2. Midwives to have Restorative Clinical Supervision embedded in practice.
3. Consider multi-agency supervision around MH (Inc. IAPT, CPMHT, HVs and Maternity Services)
4. Embed '5 Steps More' to reduce chance of cultural and race disadvantage.
5. Use of 'Women's Digital Care records' to enhance information sharing.
6. 'Early Bird' AN classes to be promoted – provide opportunity for all newly pregnant women and partners to get the appropriate advice and sign posting.
7. Booking appointment with midwife – ideally by 10 weeks. Include holistic assessment asking about past or present mental health illness and asking about mental health experience of first degree female relative. To include medical and social history.
8. Gad2 and DIQ used now and at each maternity contact. If positive progress to GAD7 and EPDS or PHQ9. During contacts explore feelings about pregnancy, plans for childbirth and feelings towards baby. Discuss previous birth experience if not first pregnancy.
9. Include the partner in the assessment for their own mental health and, also as someone who may need support to understand their partner's needs. GAD2/7 plus DIQ and EPDS are transferable to men. Men may also identify out of character anger as a symptom.
10. Midwife to share the assessment and any subsequent referral with GP and HV. Any mental health history clearly identified. Monthly CMW/HV liaison meetings.
11. At each contact, promote bonding and parenting skills. Signposting to 'Baby Buddy', or the NHS Website.
12. Mental health wellbeing apps reviewed by NHS to promote, protect and as early intervention.
13. All services to have resources available in public spaces (pictures, video, written, alternate languages) about mental health aimed at pregnant women and partners. PIMH Video, Perinatal Positivity Video
14. Promotion of antenatal classes. Consideration given to ensuring that the classes provided are current, gender and culturally aware and include emotional wellbeing element.
15. Promotion of Breast Feeding and information shared about support available.
16. Promote access to parenting classes such as 'Incredible Babies' or equivalent for both parents to increase confidence in parenting, understanding their baby and build on social support.
17. HV antenatal contact: Introduce Healthy Child Programme and role of HV. Health Needs Assessment by HV for both parents wherever possible. Facilitate 1:1 conversation with both parents to enable domestic abuse and mental health to be explore. If partner is not present, consider if alternative contact can be offered.
18. Introduce the physical or Wellbeing Plan in the Red Book
19. Support the ICON film which can be expanded to discuss parenting strategies/baby cues.
20. Bonding to be promoted through encouragement of touch, talking to baby & preparing for arrival. HV to Introduce 'Building a Happy Baby' or other bonding resources.
21. Health professional to reinforce the message that babies are not removed due to mental health illness alone.
22. At antenatal contact, HV will introduce information on parental conflict.
23. Specialist services for young Dad's may be available. Consider a 'Dad's Champion' to ensure current information is available and to promote good links with other agencies.

Pregnancy with Mental Health Risk Factors

1. Mental Health Midwife role to be considered as recommended by National Maternity Guidelines in order to support midwives meet the needs of the women.
2. Promote clear, well documented communication between agencies.
3. Care Passport to be considered if any adaption to service may be required. This may be someone who has an history of trauma, bereavement, communication need, learning need, physical or an unseen disability. A personalised care plan would reflect these additional needs. Service adaptions may be needed for parents who have additional needs (1).
4. IAPT services to prioritise perinatal parents and to have staff who have accessed additional training for this speciality. Women to be seen within 28 days of referral.
5. Referrals offered to Community Perinatal Mental Health services if the woman has a complex MH background or a history of Puerperal Psychosis. If in doubt whether to refer, ring the service. Guides and video available from 'Action on Post-Partum Psychosis'.
6. Close liaison between GP, Community Midwife (CMW) and all maternity services. Use of a 'Continuity of Care System' where possible.
7. Refer or consider access to an enhanced 0-19/25 year service.
8. Consider 'Early Help Assessment (EHA)' if likely to need a multi team approach for support. Liaise with CMW and primary care team if EHA is to be considered.
9. Consider options of IAPT run online 'drop in' sessions for staff or clients.
10. Promote c-CBT Package Silvercloud via IAPT (Online MH support for the perinatal period)
11. Where there is Post Traumatic Stress disorder or Tokophobia discuss with Perinatal Community Mental health Service to explore appropriate referral for your area.
12. Specialist Maternity Services and high-risk clinics to be aware of their clients increased risk of perinatal mental health illness. Ensure mental health monitoring, signposting and clear communication with care team is in place.
13. Monthly information sharing between community midwife, GP and health visitor to include any mother at higher risk of perinatal illness.
14. GAD7 and EPDS or PHQ9 can be used for both the mother and the partner if depression or anxiety is suspected. Do not use if already receiving effective care.
15. Promotion of breast feeding (1) and information shared about support available.
16. Consider a 'referral' to the 'Emotional and Wellbeing Visit Programme' offered by Health Visitors for low level perinatal anxiety, stress, and low mood.
17. If a parent is not accessing mental health support, explore barriers and options. Ensure that parents know how to access support if change mind. Share with primary health care team or Community Midwife
18. Antenatal Classes (A/N):- specialist A/N classes may be available but all classes to be trauma aware and accessible to all. 'Baby Steps' or similar may be available through family centres.
19. Consider links to local sports centres for specific A/N exercise classes to promote MH.
20. Ensure any psychotropic medication is reviewed by prescriber in the final trimester to reduce risk of relapse following delivery and to enable planning if to breast feed.
21. As soon as possible promote Mental Health Emergency Planning document. This can be by a key health care worker along with the family to promote early recognition of deterioration and ensure appropriate support is available to the whole family. Ensure this is shared with the care team.
22. If baby is likely to need NICU – preparation to be offered to both parents wherever possible. Introduce support services (Leo's, Tiny Lives, BLISS, Leaflet)

Labour and Delivery

1. Offer opportunity to both parents to see around the delivery suite if possible. Physical and emotional safety are paramount to supporting confidence in the environment.
2. Promote use of a birth plan and for a mother with a pre-existing condition, ask the woman whether MH Emergency Planning would be helpful. Consider how this information can be shared to make sure care is consistent.
3. Ensure staff are 'gender aware' and consider how this can be managed within the department.
4. Promote a culture of inclusion so parents understand what is happening, and why, at each stage of labour.
5. Promote skin to skin contact with the baby as soon as possible to promote bonding and attachment. If not able in delivery suite, ensure postnatal care or NICU are aware and actively encourage when able.
6. Promote breast feeding with respect given to the woman's options.
7. Ensure a clear, handover of care and check if there is anything the woman needs adding to this handover.
8. If the experience has been challenging or traumatic for staff, ensure opportunity is given for restorative supervision.

In-Patient Postnatal Care

1. Continued promotion of bonding and attachment. Ensure additional support if a mother has mobility difficulties due to intervention to promote positive experience with baby.
2. Ensure clinical assessment has taken place and is reviewed to enable adequate pain relief. Consider what other pain relief options are available if medication is not adequate. There is a direct link with poorly managed pain and PNI.
3. If breast feeding (BF), ensure staff give consistent support and follow current advice according to BF Network. Ensure rapid access to support for BF to promote a positive experience. A woman being unable to breast feed when this was planned is a pre-cursor to postnatal illness - direct to online BF support (National Breast Feeding Helpline or Breastfeeding Northumberland Website)
4. Do not advise a woman to stop breast feeding due to medication or to stop taking medication in order to breast feed without specialist advice.
5. Promote responsive feeding whatever feeding method used so conversations around baby cues, eye contact and holding baby close can be offered.
6. Provide a safe environment and opportunity to both parents to reflect on the delivery, observing for signs of post-traumatic stress disorder.
7. 'Reflections Service' information to be given to every parent where available.
8. When discharged, promote communication sharing between hospital to community reflects the physical and emotional experience for the woman.
9. For a baby of a mother who has been on psychotropic medication, ensure that the diagnosis of Poor Neonatal Adaption Syndrome (Pan London Doc.) is not made until all other likely diagnosis have been excluded.
10. For a woman whose baby is in NICU, ensure opportunities for bonding are a priority.

Community Midwife Postnatal Care

1. Community Midwife to provide a documented, individual postnatal care plan. Ensure both the woman and her partner know how to contact services.
2. Build on parenting skills and promote bonding for both parents – improving confidence will reduce anxiety. Signpost to appropriate resources:- Baby Buddy, NHS Website, NHS Child Health App, and 'Building a Happy Baby'
3. For those families whose baby is in NICU – ensure ongoing support and monitoring of emotional wellbeing of the family. Links with (Leo's, Tiny Lives, BLISS) Clarify who is monitoring maternal health and emotional wellbeing between community and hospital.
4. For mothers on psychotropic medication, ensure a clear plan with prescriber.
5. Support for breast feeding from midwife and BF support team.
6. Promote 'Wellbeing Plan' within parent-held 'Red Book'.
7. Provide opportunity to both parents to reflect on labour and delivery.
8. Post-partum psychosis is rare but when present is a medical emergency. It is most likely to occur in the first 2 weeks of delivery. The woman may appear excited or elated, severely depressed, have an altered state of mind with intense confusion or having be hallucinations. Contact CPMH team or Crisis MH team. Do not leave the woman alone. Harm to the baby is rare. Support for the family is essential.
9. On day 10/discharge visit by midwife, clear plan of action if woman is in pain. A woman who is still in pain is at greater risk of PNI at this stage.
10. Handover to health visitor using both the red book and internal handover procedure. Ensure any mental health concerns or birth trauma is clearly communicated to the HV by CMW.

0-6 weeks Postnatal

1. Continuity of HV should be aimed for throughout the perinatal period. The relationship building between HV and the family is important to build trust.
2. To remain alert to signs of post-partum psychosis or acute mental health deterioration.
3. HV to offer opportunity for both parents to reflect on labour and delivery. No pressure if the parents are wary of this discussion.
4. Continue the scaffolding of parenting skills, identifying signs of bonding and attachment, and supporting gaps. (Assessment tools such as Brazelton New-born Behavioural Assessment scale may support this work).
5. For a family whose baby is in NICU, health visitor to contact the unit to offer contact details and share information. HV to contact with the family and offer visit – this may be at home, on the unit, online or by phone. Clarify role and continue to offer emotional support as required. NICU to consider a joint discharge planning meeting. EHA may be required if multi agencies are involved on discharge.
6. Promote use of apps to help build on parenting skills. Signpost to community services – 'Sure Start' / local groups / exercise groups. BBC videos' Tiny Happy People can be helpful.
7. For a parent whose baby has been removed at birth, ensure the Child Protection Plan includes perinatal mental health and where the birth mother is receiving her postnatal care and 6-week check. Consider how the parents are receiving the information they need if not seeing a health visitor.
8. Use GAD2 and DIQ questions at each core contact from 6 weeks or as required. If positive, progress to GAD7 and EPDS or PHQ9. PIMH Resources (leaflet), (Family Lives). Promote access to GP and ensure GP is aware of additional support being offered. Remain alert to sudden changes in mental health.

6 Weeks to 2 years Postnatal

1. At each point of contact with any parent, keep mental health in mind – frequent clinic or GP attendance, A&E attendance, or frequent contact requests.
2. Offer MH assessment at each core contact to both parents.
3. If low level symptoms offer 'Emotional Wellbeing Visits' (EWV).
4. Observe for signs of Post-Traumatic Stress Disorder (BTA) and follow Trauma Pathway
5. If paternal perinatal illness is identified, offer information such as from Family Lives or iHV leaflet. Promote access to GP, IAPT and Silvercloud CBT. Specific support for men is available in some areas and access to 'Family Centre'-run groups may be possible. HV to promote bonding and attachment activities.
6. HV to support access to IAPT and access to Silvercloud online training if 6 weeks EWV support is not reducing symptoms. IAPT to prioritise parents in the perinatal period (currently up to one year but aiming for 2 years postnatal)
7. 'Red Flag Symptoms' to be acted on urgently: recent significant changes in mental state or emergence of new symptoms, new thoughts of acts of violent self-harm, new and persistent expressions of incompetency as a mother or feeling totally separate from the infant. Contact and refer to CPMHT
8. CPMHT and HV to liaise to coordinate support and contact – consider EHA.
9. Whilst a parent is unwell, consider how the partner is to be supported. Ensure they have information in an accessible form and where possible give opportunity for private discussion with regard their own mental health. Consider IAPT, carers, GP and gender or culture specific groups.
10. Whilst a parent is unwell consider the impact on older children – age-appropriate support may be helpful to reduce trauma and increase resilience.
11. Include mental health information sharing at GP/HV liaison on a monthly basis.
12. Where additional services are in place (drug and alcohol support, mental health services, paediatric support, neonatal services etc.), ensure there is robust communication in place – between professionals and including the family. Consider an Early Help Assessment.
13. HV team to work with parents to promote realistic sleep expectations and aid positive sleep pattern if needed. Consider Basis approach.
14. Responsive parenting leaflets and infant mental health resources promoted and used to support parents to minimise the impact of their own mental health to their baby and to increase parental confidence. Use appropriate tool to support parents – Mors SF Tool, Brazelton, or 'DANCE'.
15. Promote local services ('Sure Start' etc.) for further social and parenting support.
16. If a woman and her baby are within the safeguarding arena, ensure that bonding and attachment is part of the Child Protection Plan. Clarify who is to take responsibility to monitor the mother's health if child has been removed at birth. Family Action may offer support to the family or Family Rights Group
17. When working across racial and cultural diversity, remain alert to communication barriers and clarify understanding. Somatic signs may be more prevalent for PNI.
18. Ensure pre-conception advice is available to the family during or on recovery.
19. Promote access to National Maternity Voices so services can learn from women and their partner's experiences.
20. Ongoing promotion of reading cues, responsive parenting and self-awareness will promote both infant and parent mental health.
21. Offer of increased emotional support from HV service to parents of children with additional needs. Use multi-agency approach to meet parents' needs.
22. Promote access to carers services to support partners and family.
23. Consider whether eligible for benefits (carers' services may support)

Special Circumstances

Twins or Multiple pregnancy

1. Promote national or local multiples groups to enable social interaction and skill building.

Baby in NICU

2. Promote community MW contact whenever possible to enable holistic postnatal care in privacy of own home.
3. If provision of postnatal care is to be provided in hospital, ensure opportunity is given to discuss emotional wellbeing as well as physical recovery. Ensure handover to HV is complete and contact HV directly (This may be a team outside the area).
4. Health visitor to contact the unit to offer contact details and share information. HV to contact with the family and offer visit – goal would be for this to be at home but may need to be flexible if child is outside the home area. Clarify role and continue to offer emotional support as required.
5. Promote access to NICU support services such as 'Leo's', 'Bliss' or 'Tiny Lives'.
6. NICU to consider a joint discharge planning meeting. EHA may be required if multi agencies are involved on discharge. Aim to include emotional wellbeing of parents in discharge plan.
7. HV to be responsive to parental need around support. Awareness that it may take longer for depression, anxiety or PTSD symptoms to be acknowledged.

Child with Additional Needs

8. HV to ensure maternal and paternal mental health is assessed and supported.
9. Promote access to local relevant groups to reduce risks of isolation.
10. EHA to be inclusive of emotional and mental health needs.

Child in foster Care

11. For a parent whose baby has been removed at birth, ensure the Child Protection Plan includes perinatal mental health and where the birth mother is receiving her postnatal care and 6-week check.
12. Child's HV to direct parents to GP if any sign of perinatal illness. Offer can be made to liaise with GP if necessary. Continue to recognise mental health within the 'looked after plan'.
13. Promote use of IAPT services.
14. Promote use of parent support agencies. – Family Rights or Family Action.

Parents recovering from addiction or choosing to stop using substances.

15. Whilst stopping or reducing drug or alcohol use, actively promote self-help strategies.
16. Promote engagement with social group to build confidence and reduce isolation.
17. If anxiety or depression develops, encourage access to GP and IAPT services.
18. Drug and Alcohol services to liaise with primary health care team.

Bereavement

19. Follow bereavement pathway.
20. Promote other children to have access to bereavement support as required.

Professional Resources

5 Steps to reduce inequality in healthcare 2020

Better Births Review

Breastfeeding advice with PNI from BF network

Care Of next Infant (Recommended support following previous Sudden Infant Death

Case studies of Service improvement within Health Visiting 2015 DoH

Engaging with Complexity Doc. about Trauma Informed Care
Experience of Women using Mental health services 2016

Framework to work with Women with existing Mental Health Problems 2018

How to Map Patient Experience

Impact of race and culture on Maternal health 2019

Information on iHV Training

Mental Health Midwives report

MH & Wellbeing for staff supported by RCN 2020

Midwifery Supervision Model

National Bereavement Pathway – includes TOP, Still birth, miscarriage, neonatal death and SIDS

National Maternity Review

NICE Pathway and guidance 2020

Online training on Adverse Childhood Experiences

Perinatal Mental health online training by Health Education England (e-lfh training)

Perinatal Mental Health Resource kit aimed at GPs but with useful links for any professional

Perinatal OCD information for parents and professionals

Royal College of Psychiatrists Pathway and Resources

Safer Maternity Care 2017 DoH

Tokophobia and Traumatic Delivery Pathway

What our local maternity services offer

Resources for Parents

Best Beginnings support for parents who use drugs

Bipolar disorder and Pregnancy

Birth Trauma Leaflet

Bonding and Attachment Video for parents

Contact to stop unwanted baby related mail

Expecting a baby with Downs Syndrome

LGBTQ resource around mental health by MIND

Lullaby Trust app/book on recognising if a baby is seriously ill

Maternal MH Alliance Self-Help workbook

Medication in pregnancy information from Mind

Mental Health & pregnancy resources from MIND

Mental Health self-help guides produced through Northumbria Health Care

MH Booklets

Miscarriage Association

Multiple Birth Pregnancy

"My Mummy is Poorly" book for children

National support for Under 25s including mental health

Online MH information for families from Royal College of Psychiatry

Orange book on recognising childhood illness produced in Newcastle

PAC and Family Lives support for parents whose child is going into care.

Pandas PND support and awareness organisation
Parenting Resources to buy for parents with learning difficulties

Parenting with a disability advice from Best Beginnings   Disabled Parent Forum

Perinatal Positivity animation Film about Perinatal depression

Recognising illness book produced by Teesside

Relationship Resources from Unicef

Resources for Dad's:- Dad's Matter   The Book of Man   The Dad Pad   The Dad Pad Neonatal

Short films around supporting children with bereavement

Solihull Inclusive Online parenting course for all parents

Support for parents through antenatal testing and considering options

Support for partners and families of people using drugs or alcohol