



Integrated Perinatal Mental Health Care Pathway

December 2012

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Foreword

On behalf of the Regional Perinatal Mental Health Implementation Group I am pleased to present to you this Integrated Perinatal Mental Health Care Pathway.

Following recommendations by the National Institute for Health and Clinical Excellence (NICE) guidelines on antenatal and postnatal mental health (2007), a Regional Perinatal Mental Health Implementation Group was established and led by the Public Health Agency (PHA). The aim of the group was to begin discussions with key stakeholders in Health and Social Care Trusts (HSCTs), Health and Social Care Board (HSCB) and the PHA. The 5 theme areas which required action were:

1. Co-ordination of service delivery
2. The competencies of the multidisciplinary team
3. Promotion, prediction and detection
4. Effective communication
5. Appropriate use of medication

The result was to have a regional care pathway for guidance for all Health and Social Care (HSC) professionals who come into contact with pregnant women. In addition, each Trust has developed a local adaptation of this pathway for their population.

The regional group is satisfied they have responded to the 5 theme areas as set out in the NICE guidelines and, following consultation, are confident that the end result, a regional integrated care pathway for use in 'detection and treatment of perinatal mental health', will result in better outcomes for women and their babies in Northern Ireland.

This care pathway will support the local Trust guidelines now in place for staff, increase effective communication between appropriate professionals and establish effective ways of accessing information and treatment for pregnant women presenting with a previous history of and/or early signs of mental ill health.

As chair of the group I am extremely grateful to all the individuals who assisted with this work and the many experts who offered advice and guidance along the way. In particular, I wish to thank those women who have experience of using our services and took time to provide invaluable advice, guidance and directions to the groups.



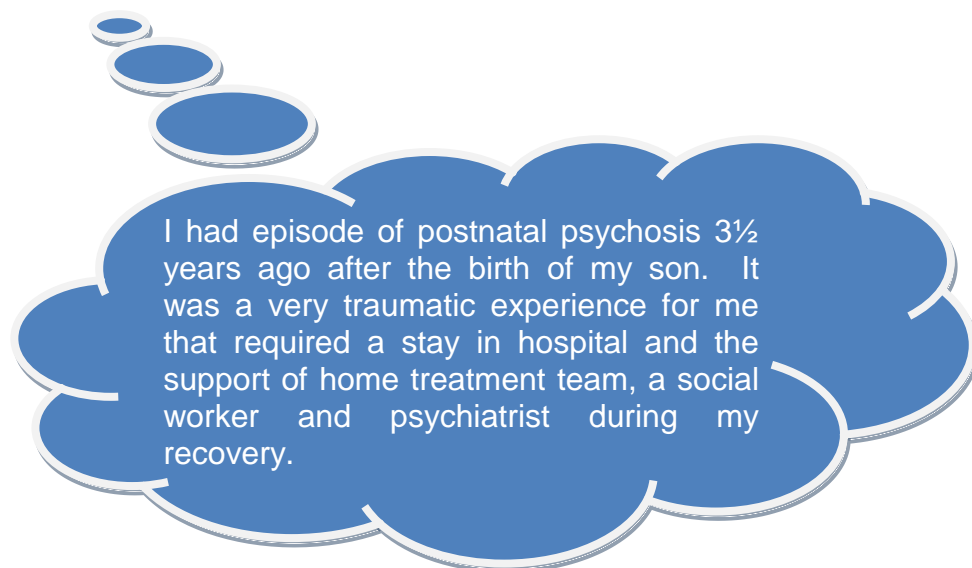
Siobhan McIntyre Regional Nurse Consultant PHA
Chair of the Regional Perinatal Mental Health Implementation Group

1.0 Care Pathway Definition

The development of this care pathway was led by the PHA supported by a wide-ranging stakeholder multidisciplinary working group for perinatal mental health (see *Appendix 1 for group membership*). The aim is to support the provision of an effective multidisciplinary service for the prediction, detection and treatment of maternal mental ill health through the antenatal and postnatal periods for all women in Northern Ireland.

Mental ill health, complicating pregnancy and the postpartum year, is relatively common. In some cases this illness may be of a serious nature and may have long lasting effects, not only on maternal health, but also on child development and family relationships. Women with pre-existing mental health illness may have a relapse or recurrence of their illness following childbirth. Women who previously have been symptom free may have an elevated risk of suffering from a mood disorder particularly the more serious mood disorders in the postnatal period. Puerperal psychosis in the UK has an overall incidence of 2:1,000 births (Jones, 2010).

The antenatal period offers health care professionals a unique opportunity to screen for risk factors associated with maternal mental ill health and thereby ensuring appropriate early interventions are provided, including referral to the best available services. Identifying and treating mental ill health is not only beneficial for the woman but also for the future health and wellbeing of her child and the family unit as a whole.



2.0 Care Pathway Scope

The care pathway for perinatal mental ill health takes account of the Stepped Care Framework referenced within The Bamford Report (2007), and other condition specific pathways applied within Mental Health Services in Northern Ireland.

The pathway takes account of the recommendations of the Department of Health, Social Services and Public Safety (DHSSPS), Maternity Strategy for Northern Ireland (2011), and the recommendations set out in Transforming Your Care, DHSSPS (2011). It is intended that the care pathway will facilitate a consistent regional approach for all pregnant and postnatal women in Northern Ireland. Local service arrangements are available in each of the HSCTs in the region and are explained in each local Trust care pathway.

It is recognised that substance misuse during pregnancy is an increasing challenge. The management of substance misuse during pregnancy and the postnatal period is not included within the remit of this care pathway.

Stepped Care Approach

A stepped care approach needs to be adopted when managing women with mental ill health during pregnancy and the postnatal period. Most women are managed within primary care, including those with mild depression, anxiety, adjustment disorders and other conditions. The majority of these women may not require medication and will respond to psychological and social interventions. Women with more significant illness may require medication and psychological and social interventions. However, for this group of women their care and treatment may continue to be provided within primary care. The individual's General Practitioner (GP) will be able to access specialist advice from psychiatric services if required, particularly with regard to prescribing medication.

Two specific groups of women will require care and treatment to be provided by mental health services. These are:

1. Women with a history of significant mental ill health who are considered to be at risk of relapse or recurrence of their illness associated with pregnancy and the postnatal period

Pre-conceptual counselling forms a significant part of care for these women, including advice on medication and risk of relapse. This group of women require their care to be provided by a consultant psychiatrist and community mental health team, who are responsible for ensuring that each woman has a personal care plan in place.

2. Women who become acutely unwell during pregnancy or the postnatal period

If there is a high level of concern or if there is evidence of a rapid deterioration in mental health, particularly within the first two weeks after childbirth, the woman requires **urgent** assessment by mental health services.

Over the last decade successive Confidential Enquiries into Maternal and Child Health (CEMACH), now Centre for Maternal and Child Enquiries (CMACE) have highlighted the consequences of failing to identify and manage maternal mental health problems. Suicide has been identified as one of the leading causes of maternal mortality and mental health disorder. There is growing evidence highlighting the long term risks for a child associated with maternal mental ill health both in the antenatal and postnatal periods.

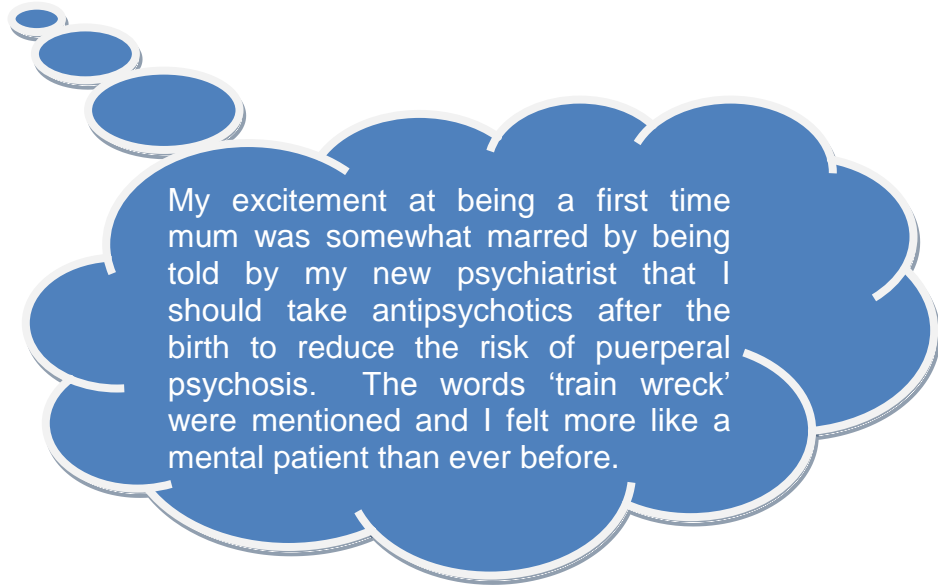
As a result of this growing evidence, CMACE enquiries, and a number of other enquiries, including the Daksha Emson Report (2003), a number of initiatives have been developed to enhance services for women with mental ill health and their children. These include the NICE guidelines (2007) on antenatal and postnatal mental health.

This care pathway has been developed taking account of the following guidance:

NICE CG 45 Antenatal and Postnatal Mental Health (2007)

NICE CG 136 (2007) Service User Experience in Adult Mental Health: Improving the Experience of Care for People using NHS Mental Health Services

SIGN Scottish Intercollegiate (SIGN) Management of Perinatal Mood Disorders. Ed SIGN, 2012



HSCTs are expected to implement and embed this care pathway in their services. Trusts are also required to provide, share and review details of their local care pathway relevant to perinatal mental health services with all relevant HSC staff who provide services for pregnant women.

3.0 Care Pathways Interconnection and Interdependencies

Professional groups, including midwives, health visitors, obstetricians, GPs, hospital and community mental health teams across HSC settings in Northern Ireland, will be involved with the implementation of this care pathway at different stages of care for women who require assessment, support and treatment. The care pathway specifies the roles and responsibilities of key staff and is intended to support staff in these roles.

3.1 The Role of the General Practitioner (GP)

The GP will, in most cases, have an established relationship with women considering pregnancy and is therefore in a unique position to provide guidance, direction and support. In most circumstances the GP will have a professional relationship with the woman's family and be aware of any relevant family history of mental ill health.

Pre-conceptual care

Any woman, who has a history of past or present severe mental ill health or mental health issues requiring ongoing mental health services, should be advised to arrange an immediate appointment with their GP following a positive pregnancy test. These women may require more intensive support in the perinatal period.

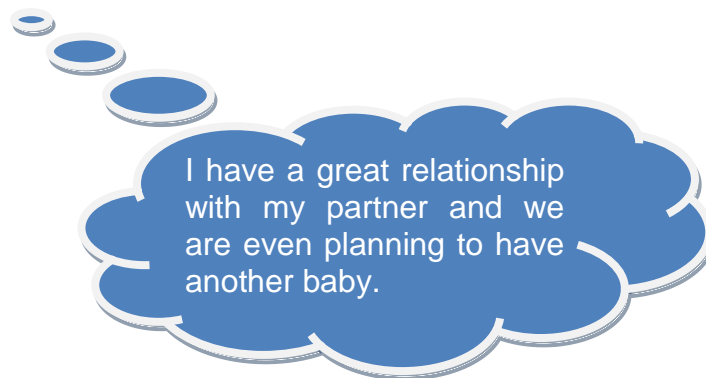
For any woman taking psychotropic medication while planning pregnancy or in the antenatal period, consideration should be given to the risks and benefits of their individual circumstances. It may be appropriate for the GP to refer to mental health services in the case of women who are not under active follow-up.

Antenatal Care

In most circumstances a woman's GP will have detailed information held within their patient care record. However, when any pregnant woman first presents to their GP they should be asked about previous or present mental ill health, including details of any care provided by mental health services. They should also be asked if there is any close family history of perinatal mental ill health. This information should be clearly identified in the referral information from GPs to antenatal services.

All other members of the primary care team, for example nurse practitioners, should be aware of the importance of including this information in antenatal referrals.

GPs should ask women the “Whooley Questions” (see *Appendix 2*) during any attendance in pregnancy. Any positive response to these questions should be followed up in line with the local Trust care pathway.



Pregnant women who have symptoms of anxiety and/or depression, severe enough to interfere with personal and social functioning but do not meet the diagnostic criteria for a formal diagnosis, should be considered for brief psychological treatment and/or individual or group based social support. These services include self-help strategies, non-directive counselling, primary care based Cognitive Based Therapy (CBT), community and voluntary sector based social interventions and Trust based services including CBT and interpersonal psychotherapy. GPs and other professionals involved in the care of pregnant woman should be aware of the importance of prioritising the social and psychological needs of pregnant women and Trust based services should prioritise these referrals (NICE 2007).

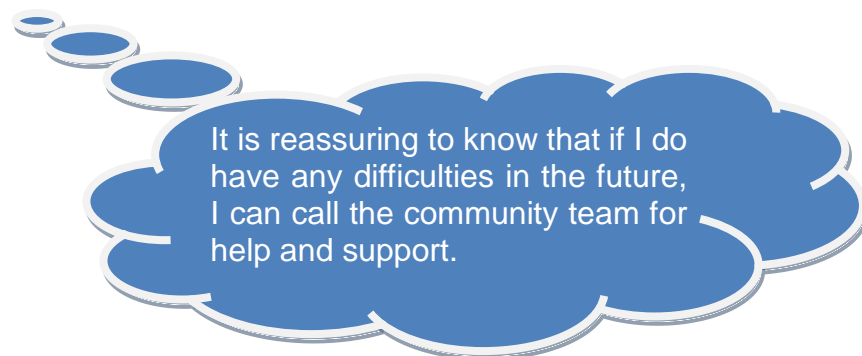
- Post-natal Care

Health visitors who have concerns about a woman’s mental health should liaise in the first place with the woman’s GP. Mild to moderate depression can be managed within primary care with a combination of psychological and social support and medication where appropriate. Referral to Trust mental health services should be made when risks are identified or a woman fails to respond to treatment.

All GPs should repeat the “Whooley questions” with all women at the routine postnatal check, usually at 6-8 weeks postnatal and follow up as appropriate.

It is important all that referrals and communication between HSC professionals are timely, documented and are appropriate to ensure a coordinated and consistent approach to the care of individual women and their children. A range of template letters are attached for consideration/use by Trusts (See Appendix 3).

All Professionals should follow their local Trust operational guidance and the local Trust care pathway.



3.2 Role of the Midwife

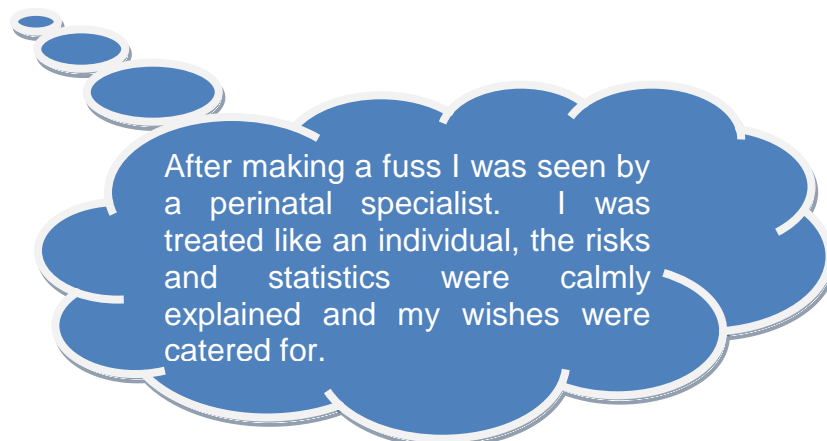
Midwives play a central role in ensuring that pregnant women with mental ill health achieve the best possible health outcomes for themselves and their babies. Midwives should work collaboratively with obstetricians, GPs, health visitors, social workers and mental health professionals when appropriate. Midwives may provide care in many locations, e.g. at home, clinics, birth centres and hospitals.

Midwives should co-ordinate the maternity care for women with mental ill health by:

- i. Asking the “Whooley Questions” for prediction and detection of mental ill health at the first booking clinic, utilising prompts, on the regional electronic Northern Ireland Maternity System (NIMATs);
- ii. Recognising and responding to identified need at all stages of pregnancy and early postnatal period;
- iii. Developing a trusting relationship with the pregnant woman, taking into account her individual needs and preferences;
- iv. Providing information and offering sensitive support and additional midwifery care as appropriate;

- v. Reviewing the woman's personal care plan and treatment at each contact;
- vi. Recording advice and information given, changes to the personal care plan and evaluation of care in the Northern Ireland Maternity Hand Held Record (MHHR);
- vii. Liaising with the GP, health visitor and the psychiatrist or community mental health team as appropriate, if the woman's mental health gives cause for concern;
- viii. If necessary, referring women at risk of serious mental ill health directly to the mental health team. The midwife should refer to the operational guidance contained within the local Trust care pathway;
- ix. Referring higher risk women for obstetric led care if not already in place;
- x. Enquiring about who lives in the home with the woman and recording the support available from partners and families;
- xi. Referring women and families who require further support to the appropriate services and referring families whose children are considered to be at risk to social services for assessment, using Understanding the Needs of Children in Northern Ireland, (UNOCINI, 2011).

Within some Trusts, midwives with specialist knowledge and/or skills in mental health are available to offer additional support to women identified as having either a previous history of mental ill health or first presentation of mental ill health developing during their pregnancy. These midwives should work alongside a consultant obstetrician and be part of the team developing multi-professional links with the other HSC providers.



Support for Midwives

Midwives are supported by their line managers and supervisor of midwives in providing safe and evidence-based maternity services. Midwives are required to have up-to-date knowledge of antenatal and postnatal mental health issues and available treatments in order to help women to achieve a satisfactory outcome for themselves and their babies. All HSCTs should ensure that midwives have access to relevant and up-to-date training on mental health ill health in the perinatal period.

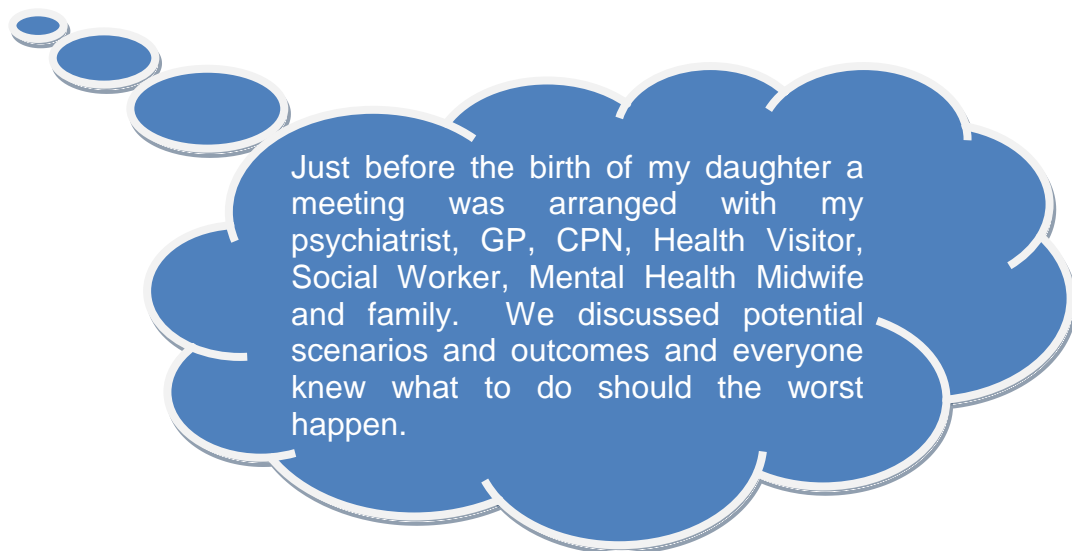
3.3 Role of the Obstetrician

Obstetricians play an important role to ensure that all women with mental ill health achieve the best possible health outcomes for themselves and their babies in the perinatal period. Obstetricians should work in collaboration with midwives, GPs, health visitors and members of mental health teams and social workers as appropriate. Obstetricians should take a lead in co-ordinating the maternity care for pregnant women with mental ill health.

Obstetricians providing private antenatal care must ensure they have processes in place to fully comply with the local Trust care pathway and operational guidance.

Women who are pregnant and have a formal diagnosis of mental ill health and have on-going support from mental health services should be seen by a consultant obstetrician. The appointment with the consultant obstetrician should be at booking or shortly thereafter to arrange a plan of care. Obstetric review will depend on other co-morbidities, current medications and liaison with mental health services. It is the responsibility of the obstetrician to liaise with other professionals in the woman's care and to ensure that the care pathway is implemented, particularly at the time of birth, for example, liaising with the GP, health visitor and the mental health team as appropriate. (NICE 2007)

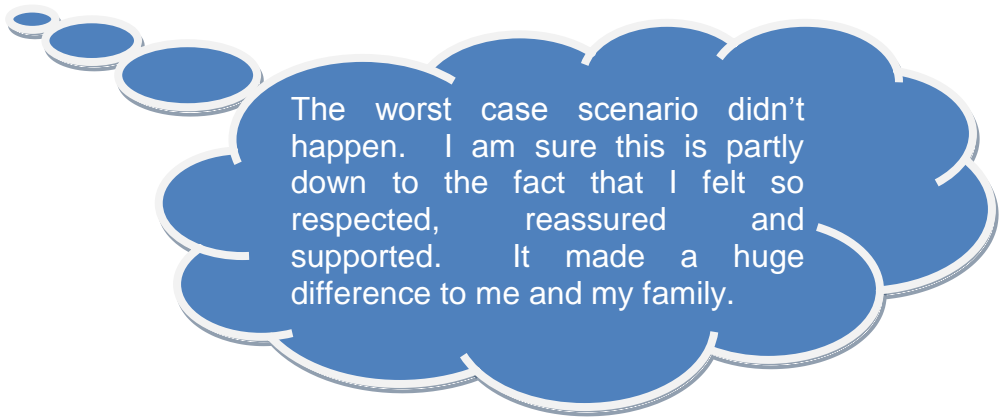
All Professionals should follow their local Trust operational guidance and the local Trust care pathway.



3.4 Role of the Health Visitor

As public health practitioners, health visitors can make a significant contribution to the early identification and effective management of mental ill health in the perinatal period. Knowledge of the possible negative impact on infant attachment, cognitive and emotional development and family functioning necessitates that it is given a high priority in health visiting practice.

The role of the health visitor within the care pathway is to identify women during the antenatal and postnatal period that may be at risk of developing mental ill health, and to assess women during the same period who are currently suffering from mental ill health. The health visitor will then need to liaise with the GP and other relevant HSC professionals regarding appropriate intervention. The health visitor will be required to document the assessment and interventions and update the Family Health Assessment (FHA) at each contact with the woman.



The worst case scenario didn't happen. I am sure this is partly down to the fact that I felt so respected, reassured and supported. It made a huge difference to me and my family.

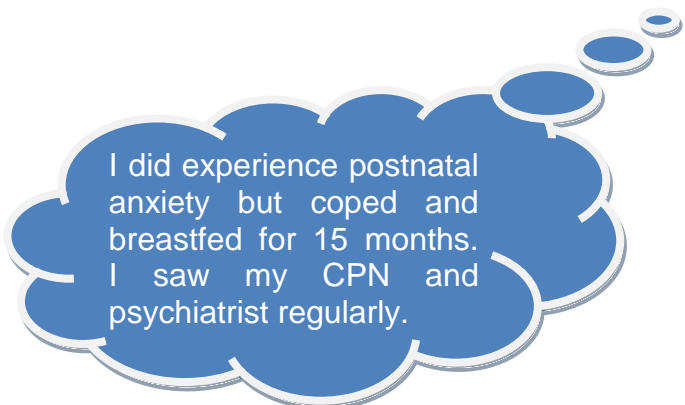
Prediction

Assessment of maternal mental health is integral to the FHA and the use of the prediction and detection questions ("Whooley Questions") which are to be included in the antenatal and postnatal period. If the woman answers "yes" to one or both of these questions, explore her options and her perceived need of help. Further assessment for women who answer "yes" should be considered using self report measures such as the Edinburgh Postnatal Depression Scale (EPDS), Hospital Anxiety and Depression Scale (HADS) or Patient Health Questionnaire (PHQ9). Women should be given relevant and up-to-date health promotion literature e.g. "The Baby Blues and Postnatal Depression."(NICE 2007)

Detection

At the postnatal reviews at 6-8 weeks and 14-16 weeks, health visitors should repeat the two "Whooley Questions" designed to detect possible depression. Again, the local Trust care pathway should be followed. As part of subsequent assessment, the health visitor should consider the (EPDS), (HADS), or (PHQ) as above and refer to the GP as appropriate (see Appendix 3 letters).

It should be noted however that the UK National Screening Committee do not recommend that EPDS is used as a screening tool in isolation. *"It may serve as a check list as part of a mood assessment for postnatal mothers but should only be used alongside professional judgement and a clinical interview".*



I did experience postnatal anxiety but coped and breastfed for 15 months. I saw my CPN and psychiatrist regularly.

All Professionals should follow their Local Trust operational guidance and the local Trust care pathway.

Health Visitor Intervention

The provision of listening visits for mild to moderate depression promotes the early support for the woman and her family during the perinatal period. Early intervention may prevent deterioration of the woman's mental ill health and referral to mental health services. Health visitor intervention offers the opportunity to assess and promote positive parent-infant attachment and to consider the impact of the illness on the infant, older children and the partner and wider family.

Listening visits should be combined with education about mental ill health and the promotion of positive mental health through social support, a healthy lifestyle and awareness of other services such as infant massage. Strategies that the health visitor should consider with the mother include:

- i. Promotion of self-help strategies (healthy diet, physical activity, practical help and support from family and friends);
- ii. Promotion of non-directive counselling;
- iii. Cognitive or solution focused therapy for parenting difficulties;
- iv. Appropriate referral to other agencies and provision of access to support groups;
- v. Signposting mother to voluntary and other groups for social contact (e.g. breastfeeding groups, Home Start, Sure Start).

Health visitors should work in partnership with families to promote emotional wellbeing and resilience. Health visitors should assess the woman's emotional health at all future contacts and agree appropriate future action with the woman and the GP. It is important that all correspondence and referral letters are included in the FHA (*Appendix 3, letters 7 and 8*).

3.5 Role of Secondary Care Mental Health Services

Secondary care mental health services include the consultant psychiatrist and psychology services and, where appropriate, the community mental health team (CMHT). These services should be involved with pregnant women with significant mental health illness, or deemed to be at significant risk of becoming acutely unwell in the postnatal period. The CMHT should liaise closely with the woman's GP, health visitor and maternity services to ensure the best possible outcomes for the woman and baby.

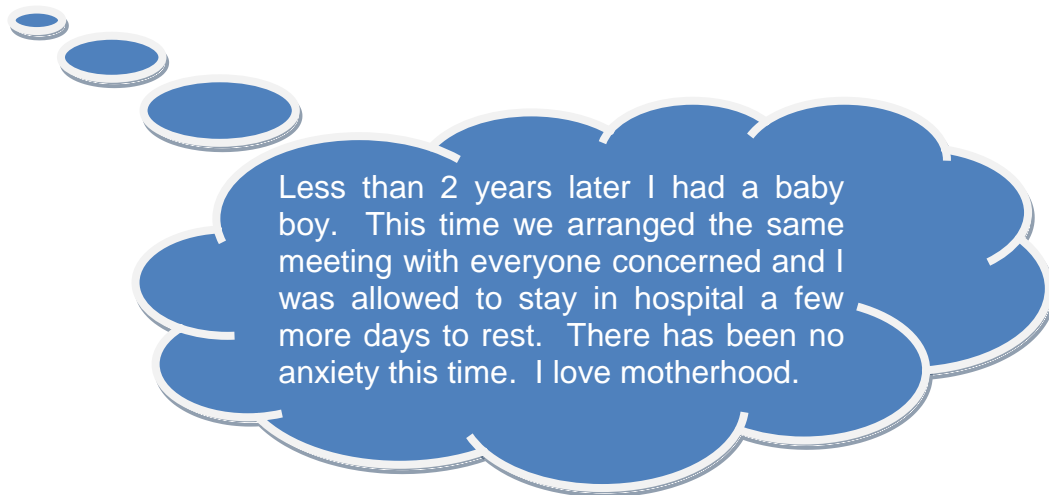
The CMHT can offer pre-conceptual counselling for those women who are, or have been, under the care of mental health services who are contemplating a pregnancy or who are at risk of an unplanned pregnancy.

The CMHT may be involved in providing telephone advice to GPs or obstetric services regarding psychotropic medication in pregnancy or breast feeding.

The CMHT may offer brief psychological interventions for pregnant women with symptoms of anxiety and/or depression which impact on social functioning, which do not meet the diagnostic criteria for a formal diagnosis with particular consideration of those with a previous history of depression. (NICE 2007)

If a woman already known to the CMHT becomes pregnant, or is referred to the CMHT during pregnancy, the team should liaise closely with primary care and maternity services. If the woman is at high risk of serious mental ill health or significant mental ill health requiring ongoing psychiatric care, the woman should be advised to make an immediate appointment with her GP. The CMHT should take a lead role in drawing up a detailed personal care plan (see *page 27-29*) for pregnancy and early post partum management. This plan should be agreed with the woman, her family/carers and shared with all services including the GP, health visitor, midwives, obstetrician and other professionals, e.g. a social worker, if involved. A copy of the personal care plan should be kept in the Maternity Hand Held Records (MHHR).

Women who develop symptoms of mental ill health should be referred to the CMHT for rapid assessment particularly if the illness arises within the first two weeks following birth. A full risk assessment should be carried out and documented, including the risk to the newborn baby and any other dependent children.



If the woman is acutely unwell, admission to hospital or referral to home treatment services should be considered.

Close liaison with the next of kin, family members and carers should be maintained following any assessments and decisions regarding care settings, treatment and follow up.

All professionals should follow their local Trust operational guidance and the local Trust care pathway.

4.0 Safeguarding Children

This section of the Care Pathway needs to be read in conjunction with:

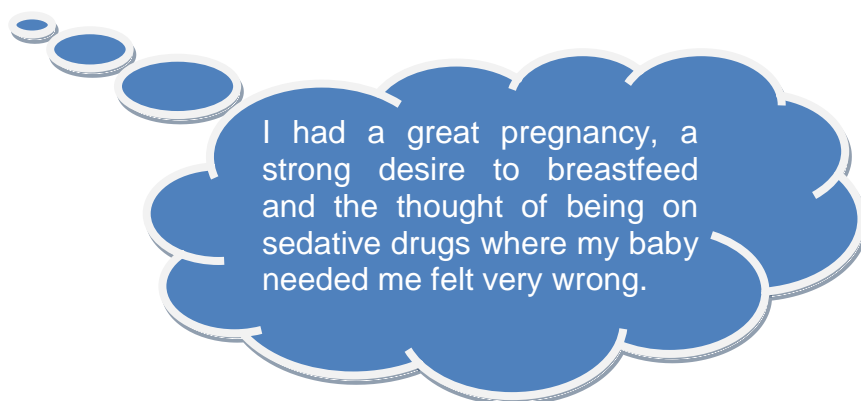
Area Child Protection Committee's Regional Policy & Procedures ACPC (2005, currently under review).

Understanding The Needs of Children in Northern Ireland (UNOCINI) (DHSSPSNI) 2011.

All Health and Social Care Professionals in NI are required to follow the Area Child Protection Committees (ACPC) Regional Policy and Procedures for Child Protection NI (2005, currently under review).

Local Trust care pathways should incorporate the application of regional and local policy and procedures for safeguarding children. All staff providing care and services for women and their families during the perinatal period should have relevant up-to-date knowledge and training in local child protection policies and procedures.

Any child protection concerns must be referred to Gateway Services and followed up with a completed (UNOCINI). In addition, advice and guidance can be sought in local Trusts from designated Child Protection professionals.



In the event of a woman's admission to hospital during the perinatal period, staff should consider whether adequate and safe arrangements are in place for the care of any dependent children. If there is any doubt an urgent telephone referral needs to be made to the Gateway Service.

5.0 Medication Issues

- i. Prescribing psychotropic medication in pregnancy and lactation involves a careful analysis of the potential risks and benefits involved. In particular, the risk posed to the unborn child or breastfeeding infant from medication crossing the placenta or passing into breast milk, has to weigh against the risks posed by the woman becoming unwell pre-conception, during pregnancy or in the postnatal period.
- ii. Contraception and the risk of pregnancy should be discussed with all women of childbearing potential who have a mental illness and/or who are taking psychotropic medication.
- iii. To minimise the risk of harm, drugs should be prescribed with caution.
- iv. Factors to be taken into consideration include the woman's diagnosis, her response to medication and her risk of relapse, as well as the potential risks posed by medications during pregnancy.
- v. The thresholds for non-drug treatments, particularly the psychological therapies, may be lower during pregnancy due to the changing risk benefit ratio.
- vi. At all times, HSC professional needs to involve the woman and, where appropriate, her partner/next of kin/family/carer in a collaborative discussion about medication issues.
- vii. Clear verbal and visual decision aids should be provided to focus on the individual woman's needs.
- viii. For information on individual drugs please refer to the NICE website www.nice.org.uk. (See *helpful contacts* on page 19).

Telephone advice can be sought from:

1. UK Teratology Information Service at 0844 892 0909
2. Breastfeeding helpline at 0116 255 5779

Web-based information can be sought from:

1. NICE website www.nice.org.uk and <http://guidance.nice.org.uk/cg45>
2. The Scottish Intercollegiate Guidelines Network website www.sign.ac.uk

6.0 Improving Outcomes for Users and Carers

At the heart of this care pathway is the need to improve the care experience and outcomes for those women and their families with antenatal or postnatal mental health needs.

The patient/carer experience is one of the most powerful levers for service and quality improvement. Consultation with user groups from local Trust Maternity Liaison Committees and community and voluntary organisations took place during the development of this care pathway.

Successful implementation of the care pathway in each HSCT should lead to the following improvements in care for women with perinatal mental ill health:

- i. A comprehensive assessment which will address each woman's needs and involve woman and their families and carers in all decisions regarding their personal care plan.
- ii. Clear information about the risks and benefits of any prescribed medication.
- iii. Clear information about how to access local care and services available.
- iv. Integrated care and referral processes where appropriate co-ordinated between the GP, health visitor, maternity services and mental health services.
- v. Flexible personalised care which addresses the needs of the woman, baby and family across the HSC system.
- vi. Where appropriate, the implementation of a written and shared Pregnancy and Early Postnatal Care Plan (PEPP), which includes clear details of care provided by all those involved in the provision of services.
- vii. Carer assessment where necessary.
- viii. Following discharge from mental health services, communication with primary care services and/or onward referral to other services as necessary, should take place.

7.0 How to use this Care Pathway

This care pathway is intended to assist professionals involved in the care of pregnant and postnatal women. The aim is to assist in the prediction and detection of those women who may experience mental ill health in association with pregnancy and the postnatal period. To enhance and support the need for consistency across HSCTs flowcharts for the antenatal and post natal period are included in this care pathway for consideration by HSCTs.

- i. **The Antenatal Screening Flowchart** is designed to accompany the recent changes in the Northern Ireland Maternity System (NIMATS). The flowchart should be followed if triggered by the NIMATS screening questions. The woman may be referred back to the primary care team for management or a referral to mental health services may be indicated (*see pages 23-26*).
- ii. **The Pregnancy and Early Postnatal Care Plan** is designed to be used for pregnant woman with a current or past history of severe mental ill health as defined by NICE guidelines (2007). The woman should be in contact with, or be referred to, mental health services and the plan should be drawn up in association with all other services and professionals involved (*see pages 27-30*).
- iii. **The Postnatal Flowchart** should be followed if the woman becomes ill during the postnatal period. The local Trust care pathway should reflect local services and referral systems (*see pages 31-32*).

A multidisciplinary approach is essential and communication between professionals must be of the highest standard to ensure that safe and effective management, care, treatment and follow-up are in place for women with perinatal mental ill health.

The implementation of a local care pathway in each HSCT will ensure that every woman known to maternity services is screened, by being asked the questions outlined in the NICE guidelines (2007) for the prediction and detection of mental ill health, at the appropriate stages in pregnancy and the postnatal period. All staff involved in the woman's care should be aware of local arrangements in each HSCT for referral into all services as deemed appropriate.

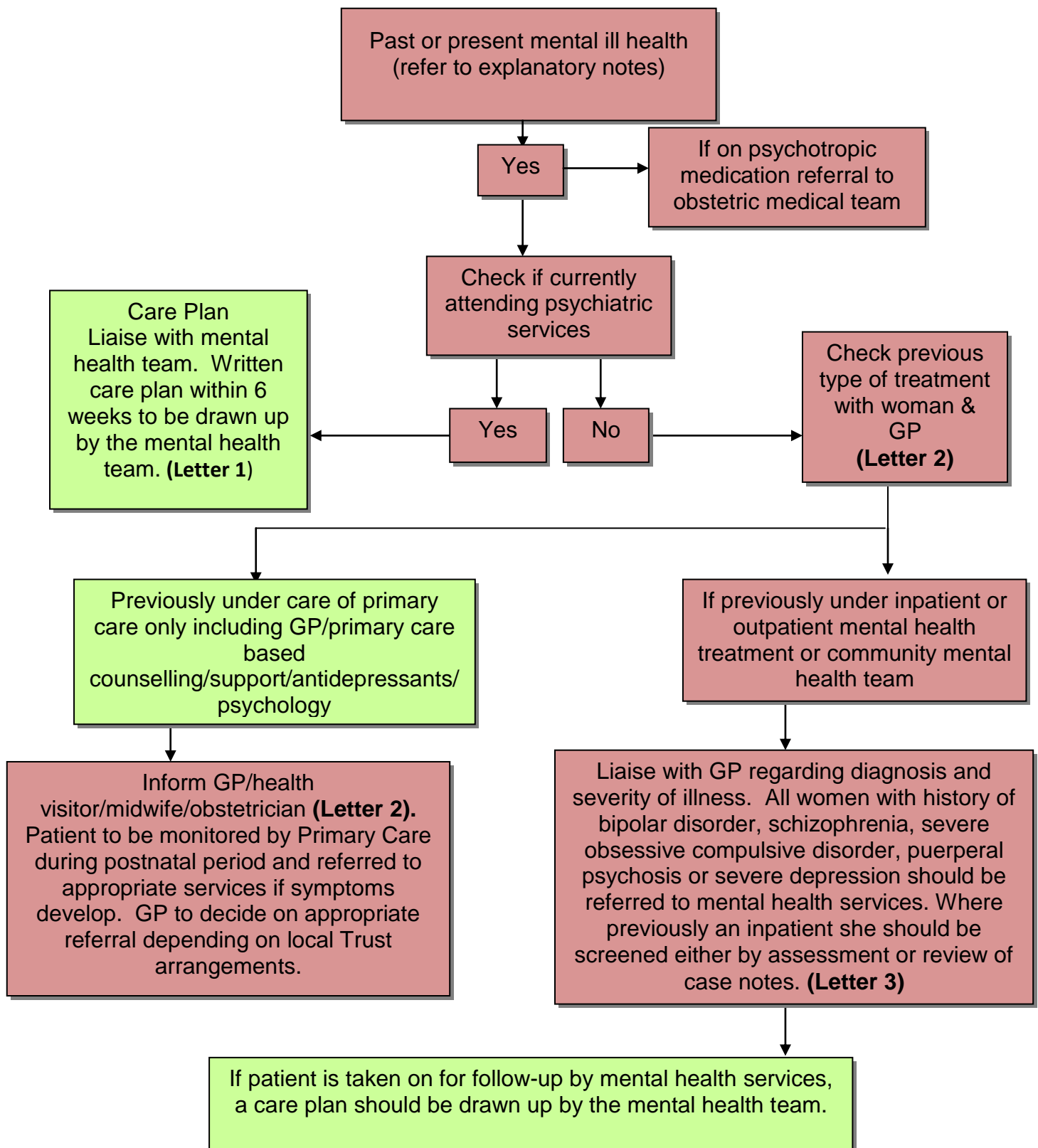
With the guidance provided in this regional care pathway, and the implementation of local Trust care pathways, women can expect to be seen by professionals who understand the risk factors for mental ill health associated with pregnancy and the post-natal period.

Women can expect to receive culturally sensitive information, including relevant information regarding the impact of mental ill health and treatment for mental ill health for themselves and on that of the unborn child or child.

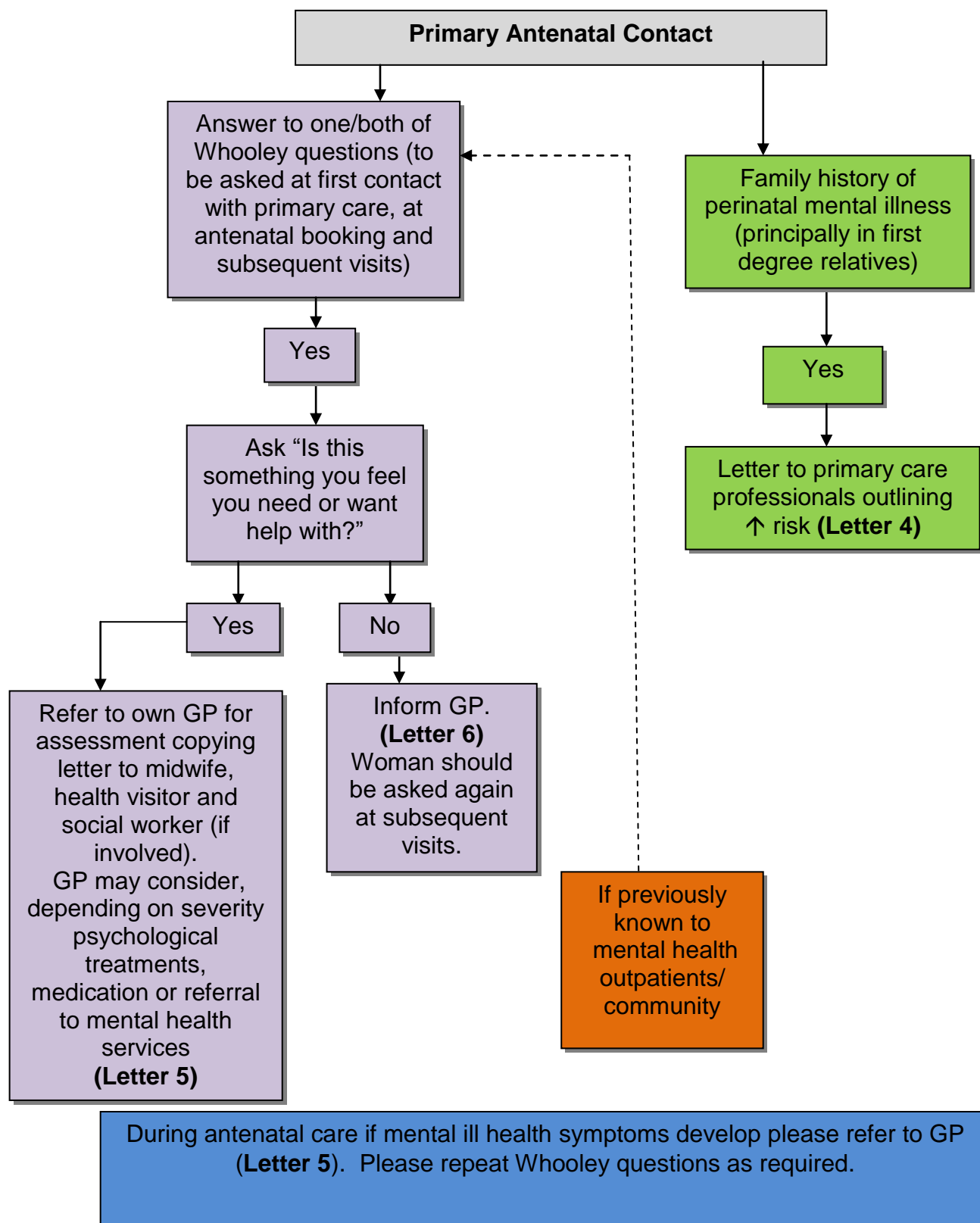
Women should expect that treatment and care will take into account their individual needs and preferences and that they and their families and carers are able to participate in informed decisions about their care supported by evidence based information.

8.0 FLOW CHART OF MANAGEMENT OF WOMEN IN ANTENATAL PERIOD WITH MENTAL HEALTH CONCERNS

ANTENATAL SCREENING FLOW CHART (Part 1)



UNIVERSAL ANTENATAL SCREENING FLOW CHART (Part 2)



8.1 Explanatory Notes Antenatal Screening Flow Chart

Personal History (Prediction)

Women with a history of severe mental ill health (e.g. bipolar disorder) may be at risk of relapse or recurrence of their illness in the postnatal period. These women should be under the care of a mental health team for the duration of their pregnancy and the postnatal period. If the woman is not already under the care of a consultant psychiatrist she should be referred, with her consent, to a perinatal psychiatrist, where available, or otherwise to the local Trust mental health team. A management plan should be drawn up by this team and shared with all professionals involved in the woman's care during the perinatal period.

Not all women who give a history of mental ill health need to be seen by a psychiatrist. The illness may have been relatively minor and not likely to recur. Previous treatment needs to be checked with the woman and her GP. If the woman was previously treated by a psychiatrist, either as an outpatient or as an inpatient, there is a higher likelihood that her illness may have been a significant one. Liaison with the woman's GP is essential to ensure correct information regarding diagnosis and severity of illness. This should be via telephone initially and followed up by a letter as per flowchart.

Family History (Prediction)

Women should be asked about any history of psychosis in the postnatal period and about a history of bipolar disorder in a parent or sibling. Studies suggest that if a woman has a family history of psychosis in the postnatal period it may be predictive for the development of mental ill health in the postnatal period.

If the woman answers yes to this question, **letter 4** (see *Appendix 3*) should be sent to all professionals involved in the woman's care highlighting the small increase in risk and advising prompt consideration to referral into mental health services if symptoms suggestive of serious mental ill health develop in the postnatal period.

Whooley Questions (Detection)

These are questions designed to detect **possible** depression during the antenatal and postnatal periods.

The two questions are:

During the past month, have you often been bothered by feeling down, depressed or hopeless?

During the past month, have you often been bothered by having little interest or pleasure in doing things?

There is also a third question if the woman answers yes to either of the initial questions:

Is this something you feel you need or want help with?

Clinical judgment should be exercised with these questions. If the professional strongly suspects the woman is depressed but she is answering “no” to the questions, the questions should be repeated at subsequent visits. If significant concerns are present these concerns should be discussed with the GP (see *Appendix 3, letters 5 and 6*).

9.0 THE PREGNANCY AND EARLY POSTNATAL CARE PLAN

To be completed by the community mental health team for those women considered at risk of severe mental illness.

Pregnancy and Early Postnatal Care Plan (PEPP)				
Name			DOB	
Address			EDD	
			Confirmed EDD	
Home No		Mobile No		
Obstetrician			Hospital/Trust	
Date PEEP		Date Reviewed		
Risk assessment	Y/N	Date completed		
Current Diagnosis/ Symptoms				
Medication at conception/ Current Medication				
Risk factors for illness in post natal period				
1. History of mental ill health/ family history				
2. Current Illness				
3. Overall risk relapse/ recurrence				
Pregnancy Plan (include medication, review dates, contingency plan)				
Delivery Plan (include changes to medication)				
Intention to breast feed? Y / N / Undecided				

Post partum instructions

1. Medication

2. Review plans – Community/ in-hospital liaison/ Home Treatment Team

3. Early warning signs

Signed by person
completing
Assessment

Date

Print Name

Position Held

Service User
Signature

Important Contacts:

[To be completed as part of care plan referral and follow up documentation]

CONTACT NAME	CONTACT DETAILS	COPY
CPN		Y / N
HEALTH VISITOR		Y / N
COMMUNITY MIDWIFE		Y / N
OBSTETRICIAN		Y / N
GENERAL PRACTITIONER		Y / N
PSYCHIATRIST		Y / N
SOCIAL WORKER (if involved)		Y / N
OTHER PROFESSIONAL		Y / N
NEXT OF KIN/ NAMED PERSON		Y / N

These 3 pages (29-31) make up the template of information to be used by community mental health teams providing assessment and care/treatment for women with perinatal mental health problems.

9.1 Explanatory Notes - Pregnancy and Early Postnatal Care Plan

This care plan is designed to be used for women with a current or past history of severe mental ill health who are pregnant.

These women should be in contact with mental health services and the care plan should be drawn up by these services in association with the woman and her next of kin/partner, other family members, if appropriate, and other relevant health professionals.

The care plan ideally will be drawn up between 26 and 30 weeks during pregnancy and shared with the all healthcare professionals involved in the woman's care. It will also be filed in the woman's handheld notes unless deemed inappropriate. It will include risk of illness, management and postnatal follow-up arrangements. A review of the care plan will be required during the pregnancy.

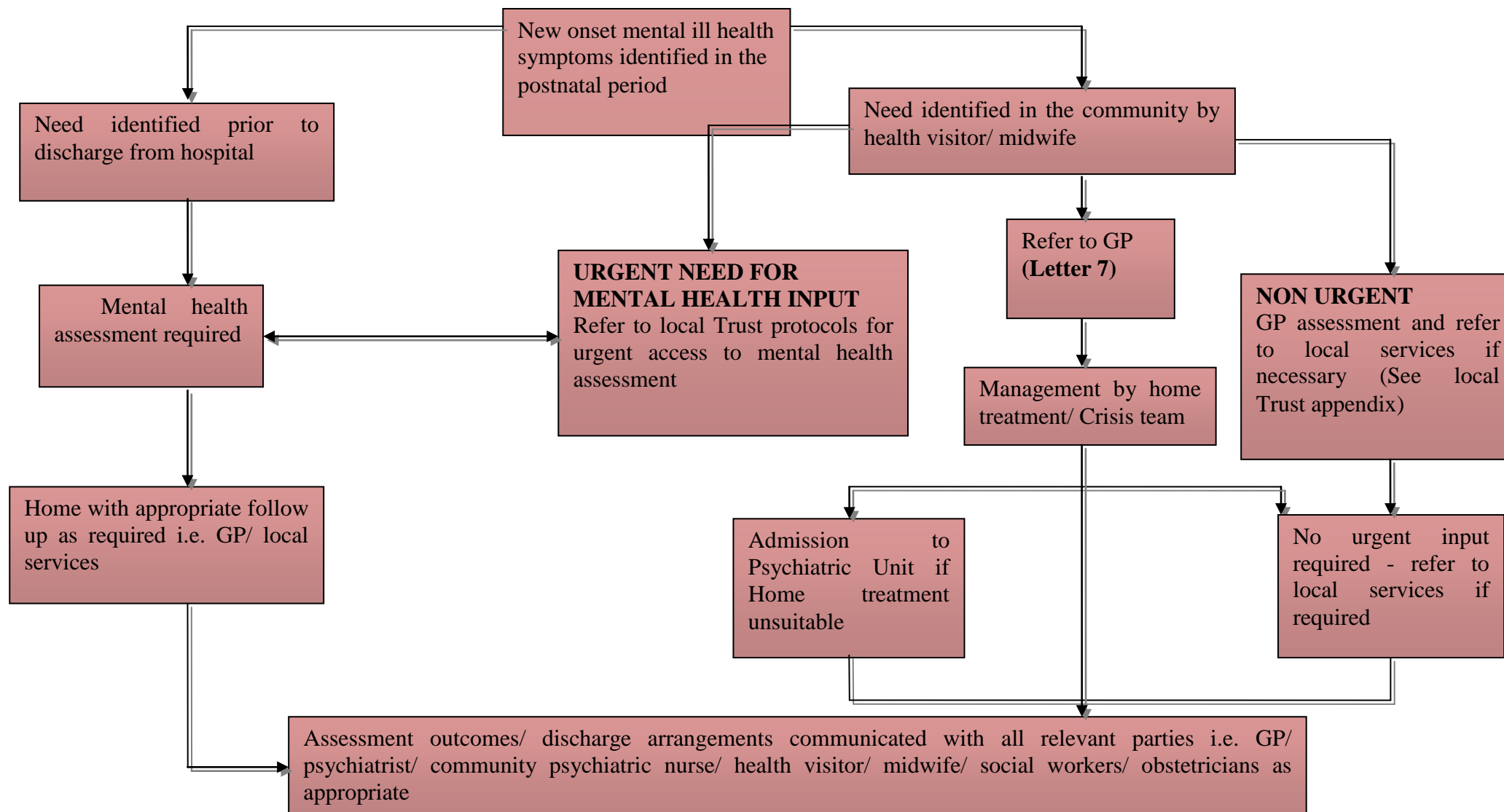
In general, the care plan will specify the level of contact with mental health services (including perinatal services where available).

The care plan is designed to promote and simplify information sharing, in order to enhance the level of care provided for women with a mental health illness in the perinatal period.

The care plan is not designed to take the place of a mental health risk assessment. A standardised risk assessment tool, including childcare issues, should be completed as part of the initial mental health assessment. Any issues of concern should be addressed as part of the risk management plan.

The care plan is not intended to take the place of correspondence involved in the care of women in the perinatal period. All professionals should follow the local Trust care pathways and consider the use of standardised letters to ensure effective communication is in place across all services involved in the woman's treatment and care.

10.0 FLOW CHART OF MANAGEMENT OF WOMEN IN THE POSTNATAL PERIOD WITH MENTAL HEALTH CONCERNS



10.1 Explanatory Notes for Postnatal Flow Chart

All women identified in the antenatal period should be followed up as planned. This chart is to be used for women presenting with newly emerging symptoms in the postnatal period.

It is recognised that at all times the safety of the newborn child will be given priority and appropriate measures taken if any concerns arise.

Identification of issues pre-discharge - Any woman felt to be exhibiting concerning symptoms on the postnatal wards should be discussed with mental health teams. Women already known to services should have a completed pregnancy care plan in their hand held notes. This should be updated, where necessary and a prompt assessment of the patient will be provided and a management plan drawn up accordingly.

Identification of issues in the community - It is recognised that care for women in the postnatal period is provided from an increasingly early stage in the community, initially by community midwives and at a later stage by health visitors.

Non-urgent - If non-urgent concerns are identified in the community it is necessary to inform the patient's GP who can assess the woman and either commence treatment in primary care or refer to local mental health services.

Urgent - In urgent situations, where it is felt a woman may need admission to hospital or immediate intervention, contact should be made with the GP or Out-of-Hours GP who should liaise with local mental health services. In addition, in very urgent situations, contact can be made with the Trust's mental health home treatment/ crisis response team directly to ensure the appropriate handover of information and allow for further assessment and management of immediate risk.

In situations where it is felt that the woman may be a risk to herself or others, consideration should be given to the level of supervision required for both the mother and her baby. Details of family support, child care arrangements and family support response times should be reviewed and considered as part of the woman's care plan.

Contact details for local Trusts teams should be detailed in each local Trust care pathway.

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Glossary of Terms

CBT- Cognitive Behavioral Therapy
CEMACH - Confidential Enquires into Maternal Health and Child Health
CMACE - Centre for Maternal and Child Enquiries
CMHT - Community Mental Health Team
DHSSPSNI - Department of Health, Social Services and Public Safety of N.I
EDD - Expected Date of Delivery
EPDS - Edinburgh Postnatal Depression Scale
FHA - Family Health Assessment
GP - General Practitioner
HAD - Hospital Anxiety and Depression Scale
HSC - Health and Social Care
HSCB - Health and Social Care Board
MHHR - Maternity Hand Held Record
NICE - National Institute for Health and Clinical Excellence
NIMATs - Northern Ireland Maternity System
OCD - Obsessive Compulsive Disorders
OPD - Out Patients Department
OT - Occupational therapy
PEPP - Pregnancy and Early Postnatal Care Plan
PHA - Public Health Agency
PHQ - Patient Health Questionnaire
SIGN - Scottish Intercollegiate Guidelines Network
UNOCNI - Understanding the Needs of Children in Northern Ireland

The “perinatal period” is the time given to the period immediately before and after birth. It is defined in diverse ways and depending on the definition; it starts at the 20th to 28th week of gestation and ends 1 to 4 weeks after birth. In the context of this document “perinatal”, however, is taken to describe psychiatric disorders that arise in association with pregnancy and the postnatal period generally up to 12 months following birth.

List of Appendices

1. Implementation Group

2. Whooley Questions

3. Template Letters

1. Obstetrician and Midwife Obstetrician and Midwife
2. Obstetrician, Midwife and Form 2 Obstetrician and Midwife
3. Obstetrician and Midwife
4. Obstetrician and Midwife
5. Obstetrician and Midwife
6. Obstetrician and Midwife
7. Health Visitor
8. Health Visitor

Appendix 1

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Appendix 2

Whooley Questions (Detection)

These are questions designed to detect ***possible*** depression in the antenatal and post natal periods.

The two questions are:

During the past month, have you often been bothered by feeling down, depressed, or hopeless?

During the past month, have you often been bothered by having little interest or pleasure in doing things?

There is also a third question if the woman answers yes to either of the initial questions:

Is this something you feel you need or want help with?

Clinical judgment should be exercised with these questions. If the professional strongly suspects the woman is depressed but she is answering “no” to the questions, the questions should be repeated at subsequent visits. If significant concerns are present these concerns should be discussed with the GP.

APPENDIX 3

TEMPLATE LETTERS

LETTER 1	Letter to mental health services from antenatal booking clinic regarding a pregnant woman who is currently a patient of mental health services.
LETTER 2 + FORM	Letter from antenatal booking clinic to GP for women who present with a history of mental ill health to ascertain level of mental health service involvement. Letter 2 has a form attached which GPs will complete and return to antenatal service.
LETTER 3	Letter from antenatal booking clinic to GP for information and update.
LETTER 4	Letter from antenatal service to GP regarding a woman with a family history of severe mental ill health.
LETTER 5	Letter from antenatal booking clinic to GP regarding a woman who has disclosed low mood and requests help and support.
LETTER 6	Letter from antenatal booking clinic to GP for a woman who has been assessed as having a low mood but declining any help at this time.
LETTER 7	Letter from health visitor to GP for a woman who has low mood.
LETTER 8	Letter from health visitor to GP for a woman who has received listening visits.

Letter 1

For Action: Consultant Psychiatrist

Date

Psychiatrist

Dear Doctor

Re:

This lady was seen in the antenatal booking clinic and identified a past history of severe mental ill health. We understand she is currently attending mental health services and we are writing to inform you that she is now pregnant with an EDD of .

We anticipate that you will forward a care plan in due course.

Yours sincerely

[Antenatal booking professional]

CC Health Visitors
 Community Midwives
 GP

Template letters: Local Trust logo and heading to be added, as required, for corresponding between different Health and Social Care professional groups.

For women who present with a past history of severe mental ill health, it is crucial to inform team of pregnancy.

Letter 2

To GP: for action

Date

GP Address

Dear Doctor

Re:

This lady recently disclosed a history of mental ill health at the antenatal clinic at booking. In order that we can ensure the best possible care for her and her baby we need to know the nature and severity of the previous illness. In particular we need to know if she has had inpatient care or has attended mental health out-patients.

We would be grateful if you would complete and return the enclosed form to us in the stamped addressed envelope provided at your earliest convenience.

Thank you.

Yours sincerely,

[Antenatal booking professional]

Enc.

Template letters: Local Trust logo and heading to be added, as required, for corresponding between different Health and Social Care professional groups.

(Form to Accompany Letter 2)

From GP detailing outcome and action

From: GP to Maternity services for information and/or action as required

Date

Address

TO WHOM IT MAY BE CONCERNED

Re:

I can confirm that this lady has a history of mental ill health. It was detailed as below:

***Option 1:** I will refer her back to mental health services so a care plan can be drawn up.

***Option 2:** I understand that you will refer her to mental health services so a care plan can be drawn up.

***Option 3:** As this illness was at the milder end of the spectrum she does not require mental health services but this will be monitored during the perinatal period and referred to services if deemed appropriate.

Yours sincerely

[General Practitioner]

CC Community Midwife
Health Visitor

*Delete as appropriate

Template letters: Local Trust logo and heading to be added, as required, for corresponding between different Health and Social Care professional groups.

Requesting information from GP

Letter 3

To GP: for Information/Action as required:

Date

Address

Re:

This lady was seen in the antenatal booking clinic and identified a past history of severe mental ill health. She is not currently attending mental health services.

***Option 1:** Following discussion with yourself we have referred her to mental health services and anticipate that in due course they will forward a care plan, a copy of which should be filed in her handheld records.

***Option 2:** Following discussion with you we understand that you are referring her to mental health services and anticipate that they will forward a care plan.

Yours sincerely

[Antenatal booking professional]

CC Health Visitor
Community Midwives
Consultant Psychiatrist

*Delete as appropriate

Template letters: Local Trust logo and heading to be added, as required, for corresponding between different Health and Social Care professional groups.

**For women who have disclosed family history of severe mental ill health to GP:
for information**

Letter 4

Date

Address

Dear Doctor

Re:

This lady was seen during the antenatal period and has disclosed a family history of severe mental ill health.

We understand that this puts her at a slightly increased risk of mental ill health in the perinatal period. If she develops symptoms suggestive of serious mental ill health in the postnatal period prompt consideration should be given to referral to mental health services. I am copying this letter to the Community Midwife and Health Visitor so all professionals are aware of this increased risk.

Yours sincerely,

[Antenatal professional]

Cc Community Midwife
 Health Visitor

Template letters: Local Trust logo and heading to be added, as required, for corresponding between different Health and Social Care professional groups.

For women who have answered yes to the “Whooley” questions, and would like to avail of help

Letter 5

To GP: for Action

Date

Address

Dear Doctor

Re:

This lady recently answered “yes” to the Whooley questions, which are asked routinely in antenatal booking to ascertain whether or not the woman is suffering from low mood. She has indicated that she would like help with this.

We have asked her to make an appointment to see the GP regarding this and possible ongoing management if appropriate.

Thank you.

Yours sincerely

[Antenatal professional]

CC Health Visitors
 Community Midwives

Template letters: Local Trust logo and heading to be added, as required, for corresponding between different Health and Social Care professional groups.

For women who require a review

Letter 6

To GP: for information purposes

Date

Address

Dear Doctor

Re:

This lady was recently seen for antenatal booking. She answered “yes” to the Whooley questions that we routinely use to screen for current low mood. She has stated that she does not wish help with this.

She will be asked again at subsequent visits and we will inform you of any further concerns.

Yours sincerely

[Antenatal professional]

Cc Health Visitor
 Community Midwife

Template letters: Local Trust logo and heading to be added, as required, for corresponding between different Health and Social Care professional groups.

Letter to GP from Health Visitor, containing information and action

Letter 7

To: GP for information/action as required

Date

Address

Dear Doctor

This lady was seen recently and answered “yes” to the Whooley questions, used to screen for low mood. I have asked her to make an appointment with the GP for further assessment and ongoing management.

*I have offered Listening Visits which will commence on_____

*I have offered Listening Visits which have been declined

Yours sincerely

Health Visitor

Template letters: Local Trust logo and heading to be added, as required, for corresponding between different Health and Social Care professional groups.

Letter 8

From Health Visitor providing information following Listening Visits

To: GP for information/action as required

Date

Address

Dear Doctor

Re

Following the delivery of Listening Visits with this lady, further assessment indicates that her mood is;

***Option 1. Improved** and my contact with her has now returned to the Universal Child Health Promotion Programme

***Option 2. Deteriorated** and I have asked her to make an appointment with the GP for a review

Yours sincerely

Health Visitor

Template letters: Local Trust logo and heading to be added, as required, for corresponding between different Health and Social Care professional groups.