Perinatal Mental Health

Resource Pack

An educational guide for professionals

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1. Introduction

Background

The aim of this educational resource pack is to support the provision of an effective multidisciplinary service for the prediction, detection and treatment of perinatal mental ill health through the antenatal and postnatal periods for all women and their families in Lanarkshire.

A core element of this resource pack is the Antenatal & Postnatal Mental Health Care Pathway (Appendix 2) which has been updated to reflect the changes to service provision within NHSL and is informed by best practice guidance derived from local and national protocols. This pathway fits within the Generic mental health Integrated Care Pathway (ICP) found on FirstPort.

The development of this resource pack and care pathway was led by the NHSL Perinatal Mental Health Steering Group (Appendix 1) and will be updated regularly online.

Lanarkshire Perinatal Mental Health Service (PMHS)

The NHS Lanarkshire Perinatal Mental Health Service is a pilot project until March 2015, supported by the Early Years Collaborative.

The primary purpose of this specialist service is to enhance existing provision in identifying and managing women with mental health problems in relation to childbearing, which we have defined as pregnancy and up to 12 months postnatal. We also offer preconception advice for those women at risk.

The core functions of the service and referral information can be found on FirstPort, http://firstport2/staff-support/mental-health/perinatal-mental-health-service/default.aspx

Who Is This Pack For?

Perinatal mental health requires close collaboration between numerous services and agencies including health, social work, education and other partner agencies. We have attempted to make this Resource Pack relevant to all professionals involved in the care of mothers across Lanarkshire.

Why Is There A Need For A Resource Pack ?

Perinatal mental health refers to the period during pregnancy and usually up to one year postnatally. Often the term includes preconception counselling.

There is considerable research evidence identifying a relationship between childbearing and mood disorders, particularly in the post natal period. In the most severe cases there can be a significant risk to the mothers and the babies which can require increased input and possibly hospitalisation.

It has been shown that untreated maternal mental illness in the perinatal period can lead to long term adverse outcomes for the whole family. Some children may go on to develop psychological, social and educational difficulties in later life.

Recent Confidential Enquiries in maternal death (see page 20) have identified that poor communication between multiple agencies is a significant risk factor in these deaths. Often numerous agencies are involved during this life changing period including mental health services; maternity services; General Practitioners; Health Visitors and Social Workers.

How to use this resource ?

As with any guidance, this pathway and resource pack should not replace clinical judgement but may help clinicians in their assessment and management of those at risk. It is intended that the Antenatal & Postnatal Mental Health Integrated Care Pathway (Appendix 2) will facilitate a consistent approach in managing all pregnant and postnatal women within Lanarkshire.

Most women are managed within primary care, including those with mild to moderate depression, anxiety, adjustment disorders and other conditions. The majority of these women may not require medication and will respond to psychological and social interventions.

Addiction and substance misuse during pregnancy and the postnatal period is not within the remit of this care pathway. Further details can be found by contacting the Specialist Addiction midwives and accessing the Substance Misuse resource pack:

http://firstport2/staff-support/maternity/Documents/Substance%20Misuse%20Resource%20Pack.pdf

2. Perinatal Mental Health information

Why is perinatal mental health important?

Background

Perinatal mental health refers to the period during pregnancy and usually up to 1 year postnatally. Often the term includes pre-conception counselling.

There is clear evidence of a relationship between childbearing and mood disorders, particularly in the postnatal period. In the most severe cases, there is a significant risk to the mother and baby which can require increased resources and hospitalisation.

It has been shown that maternal mental illness in the perinatal period can lead to long term adverse outcomes for the whole family. The child may develop psychological, social and educational difficulties in later life.

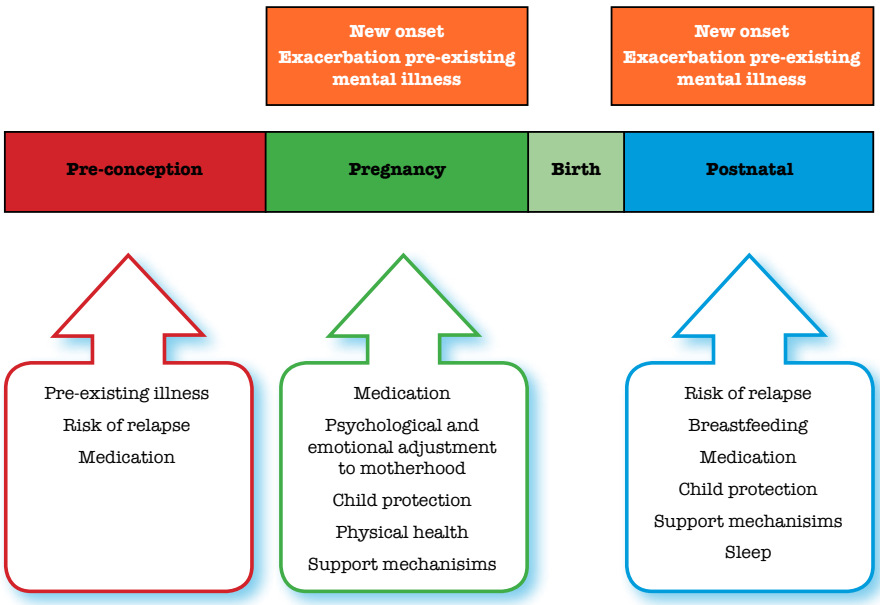
Marmot (2010) identified that in order to reduce future social and health inequalities we need to give every child the best start in life, and this reflects the view that the origins of much adult disease lie in the 'developmental and biological disruptions occurring during the early years of life' and more specifically to 'the biological embedding of adversities during sensitive developmental periods'.

Both perinatal and infant mental health are therefore major public health issues, and perinatal and infant mental health services are aimed at giving every child the best start in life by promoting the wellbeing of parents and their babies across the perinatal period, in addition to the early identification and treatment of problems that complicate pregnancy and the post-partum year.

http://www2.warwick.ac.uk/fac/med/about/centres/wifwu/research/mhpathway/about/why/

Numerous reports have identified that poor communication between multiple agencies is a significant risk factor in these deaths. Multiple agencies may be involved during this critical period including mental health services, maternity services, General Practitioners, Health Visitors and social workers.

The diagram below highlights some of the considerations during each stage of the women's journey.



13 Key facts about Perinatal Mental Health

1. Postpartum psychosis is the most severe form of perinatal mental illness. There can be significant risk to mother and baby.
   - Early Onset – often within first 3 weeks
   - Rapid deterioration
2. Be aware of **misdiagnosis**
   - Initial presentation may be of anxiety, confusion or perplexed thinking, particularly in postpartum psychosis. Be wary of minimising this
   - Actual physical illness can be mistaken for mental disorder
3. Remember preconception issues
   - Sodium valproate is **contraindicated** in childbearing women
   - Explain potential risks and effects on pregnancy when starting medication in non-pregnant women with mental illness
4. Remember 50% of pregnancies are **unplanned**
5. **Communication** is key
   - Most reports and enquiries highlight POOR communication between services, particularly between Primary care, Maternity services, Health visitors and mental health services
   - Get to know your local services
6. **Planning ahead** can save lives. There are **simple** questions that can help assess risk of illness and relapse.
   - Do **you** have a personal history of
     i. Postpartum psychosis
     ii. Any other psychotic disorder such as Bipolar disorder or Schizophrenia
     iii. Severe depressive disorder
   - Is there a **family history** (1st degree relative) of
     i. Postpartum psychosis
     ii. Bipolar disorder
   - Have you had an admission to hospital for treatment of mental illness?
7. **Do not** always stop psychotropic medication immediately if a women is pregnant/ breastfeeding, until you have assessed Risks vs. Benefits of medication
   a. Consider factors such as past history, severity of illness, vulnerability factors, alternative medication options
8. Always consider non-pharmacological options to support mothers
   - Support groups, baby massage, self-help guides, healthy reading, support from friends and family
9. Don't **forget** the **whole** family
   - Maternal mental illness affects partners, parents and other siblings. Support them as well
10. Mother-Infant relationship and attachment starts during pregnancy
    - Building a healthy attachment within the 1st year is critical.
    - Untreated maternal mental illness can have long lasting effects on mother and child many years later
11. If admission is required for the most severe cases, consider the West of Scotland Mother and Baby Unit in Glasgow
    - The mother is admitted **with** the child in most cases to facilitate healthy attachment, enhance recovery and promote infant development.
12. Use the NHSL Lanarkshire ANPN Integrated Care Pathway (ICP)
13. Use the L-PEPP (Lanarkshire Pregnancy and Early Postnatal carePlan) during the pregnancy to formulate a clear and concise management plan which is shared with **mother** and all services involved

Understanding risk of perinatal mental illness

Assessing Risk

Personal history of Postpartum Psychosis (PP)

- Risk of PP in future pregnancy is 1 in 2

Personal history of Bipolar disorder or Schizophrenia

- Bipolar: Risk of PP is 1 in 2
- Schizophrenia: Risk of PP is 15-20% over course of first year
- Risk of any mood disorder including non-psychotic depression is 1 in 2
- Risk of PP in pregnancy is 1 in 2 if first degree relative (mother or sister) had PP

Personal history of postnatal depression

- Risk of subsequent postnatal and non-postnatal relapse is 4 in 10

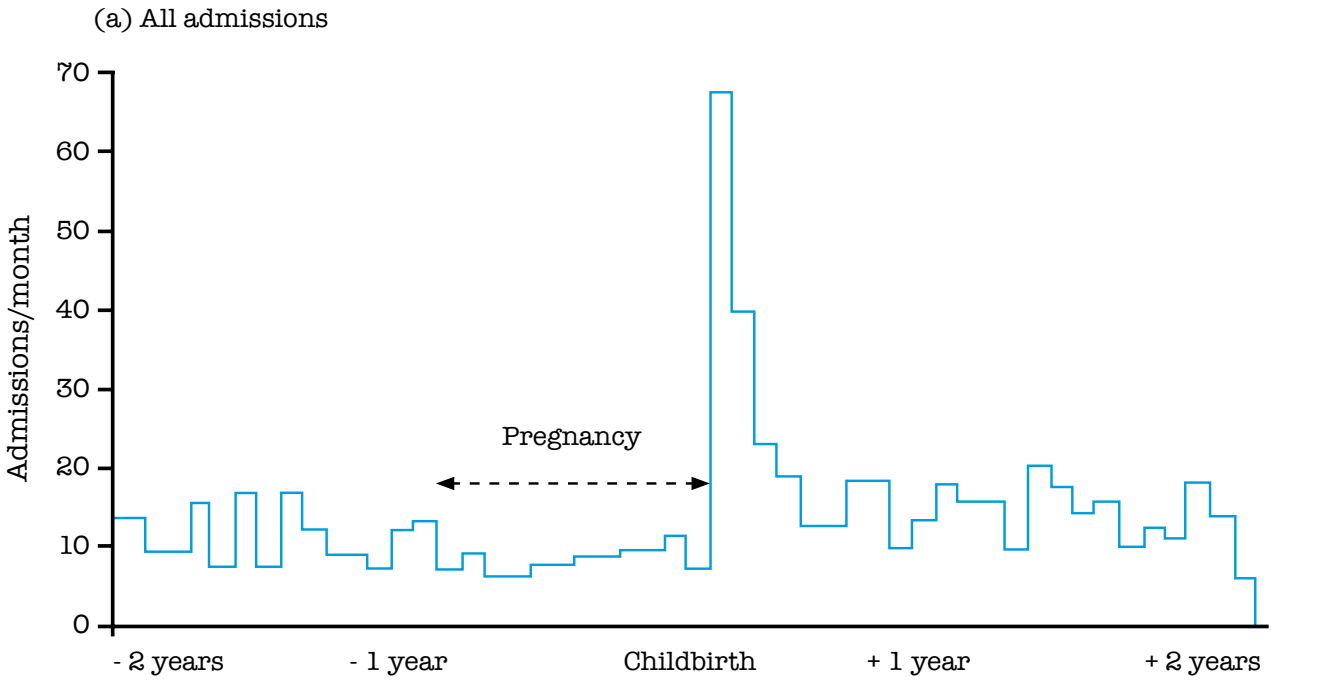
Women with a range of psychiatric disorders, particularly phobic anxiety states, panic disorder, OCD

- They may not face such an elevated risk of relapse/recurrence of their condition however their management may be complicated by pregnancy /childbirth

1 in 2 who get PP had no history to suggest increased risk

Increased rate of psychiatric admission following childbirth

- There is increased risk of relapse and admission to hospital in the immediate postnatal period
- Primigravida: Relative risk = 35 when only first deliveries were considered



R E Kendell, British Journal of Psychiatry (1987) 150:662-673

Suicide profile of perinatal women

Care needs to be taken not to equate risk of suicide with socio-economic deprivation.

Suicide is one of the leading causes of maternal death

- Age: 16-43 years (median 30 years)
- 76% married or in stable cohabitation
- 76% employed
- Of these, 41% educated to A-level.
- 28% in professional occupations
- 90% White
- Around half died during or after their first pregnancy

Suicides associated with substance misuse

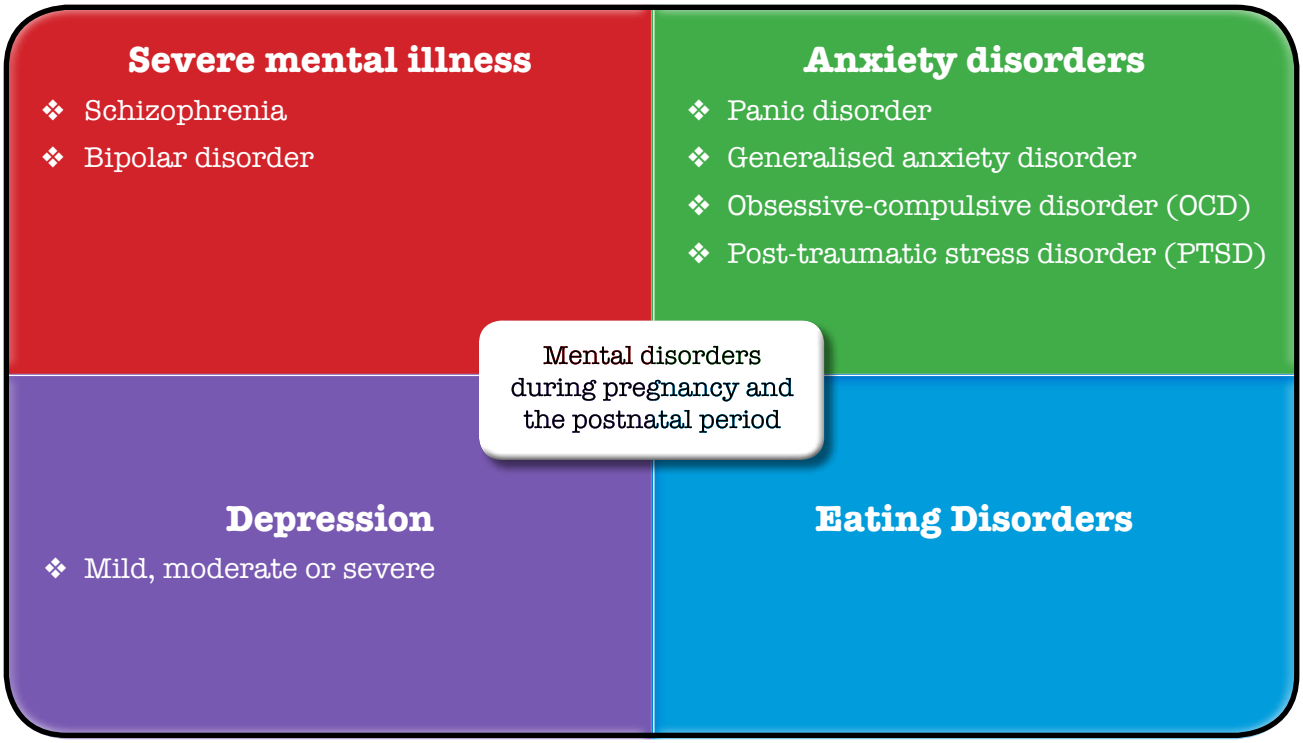
- Mostly young, single and unemployed.

Source: Confidential enquiries into maternal death

Further info: Lanarkshire Suicide Assessment and Treatment Pathway on FirstPort

Conditions

What mental disorders are you likely to see in the perinatal period?



Definitions to help assess severity of mental disorders

Assessing the severity of common mental health disorders is determined by three factors: symptom severity, duration of symptoms and associated functional impairment (for example, impairment of vocational, educational, social or other functioning).

Mild generally refers to relatively few core symptoms (although sufficient to achieve a diagnosis), a limited duration and little impact on day-to-day functioning.

Moderate refers to the presence of all core symptoms of the disorder plus several other related symptoms, duration beyond that required by minimum diagnostic criteria, and a clear impact on functioning.

Severe refers to the presence of most or all symptoms of the disorder, often of long duration and with very marked impact on functioning (for example, an inability to participate in work-related activities and withdrawal from interpersonal activities).

Source: NICE CG123 Common mental health disorders

Key conditions

Table: Distinguishing features of postnatal disorders

	Baby Blues	Postnatal Depression	Postpartum psychosis
Prevalence	50--80%	10-15%	0.2%
Onset	Day 2-5	Week 2-6	Week 1-3 50% present by day 7 90% by 3 months
Duration	3 days	Weeks / Months	Weeks / Months
Symptoms	Emotionally labile Tearful Insomnia Fatigue Irritability	Similar to Depression at other times Obsessional thinking	Rapid onset Severe Rapid fluctuations Perplexity which can appear similar to an acute confusional state Often presence of mixed affective symptoms Strong association with Bipolar disorder
Treatment	• Reassurance • Self-limiting • Support from family family and friends	Treat as depression • Medication • CBT • ECT	• Urgent assessment • Possible admission to Mother and Baby Unit

Depression

- Symptoms
  - similar whether antenatal, postnatal or non-pregnancy
  - overlap with normal emotional changes. More negative/obsessional cognitions and pervasiveness of symptoms may indicate depression
- Increased risk of depression in the early postnatal period
  - Risk is threefold in the first five weeks postnatally
- Failure to treat can have significant impact on mother, infant and family.
  - The first year is a critical period for mother-infant relationship
  - Untreated depression results in more negative responses from mother which may lead to difficulties with language skills and social/emotional development in first year. These effects can be long-term and are seen in children at age 11

Risk factors for Depression

Antenatal depression	**Postnatal Depression**
❖ maternal anxiety ❖ life stress ❖ prior depression ❖ lack of social support ❖ unintended pregnancy ❖ relationship factors	❖ past history of psychopathology and psychological disturbance during pregnancy ❖ lack of social support ❖ poor partner relationship ❖ recent life events domestic violence

Postpartum psychosis (PP)

- A wide variety of psychotic phenomena such as delusions and hallucinations, the content of which is often related to the new child
- Affective (mood) symptoms common, particularly elation and depression
- Disturbance of consciousness marked by an apparent confusion, bewilderment or perplexity
- The clinical picture often changes rapidly, with wide fluctuations in the intensity of symptoms and severe swings of mood
- Strong evidence from clinical, outcome and genetic studies for a close relationship with bipolar disorder.

Prognosis for PP

- Recovery from the initial episode is likely
- Mother is at risk of subsequent puerperal and non-puerperal episodes.
  - Recurrence rates following subsequent pregnancies >50%
  - About 50% of women have further non-puerperal episodes

Risk factors for Postpartum Psychosis

- Personal history of psychiatric illness
  - Strongest predictor of early postpartum (10-19 days) psychiatric admission
- relative risk (RR) 37.22, 95% CI 13.58-102.04
  - In the first postnatal year, 26.9% of these women required admission
- Family history of psychiatric illness
- Primigravida

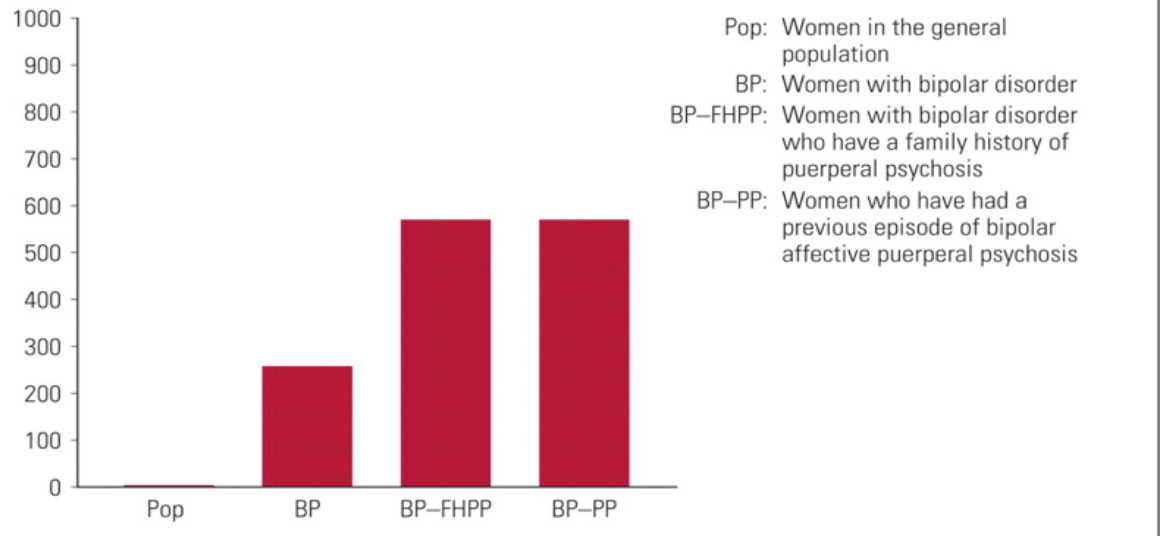
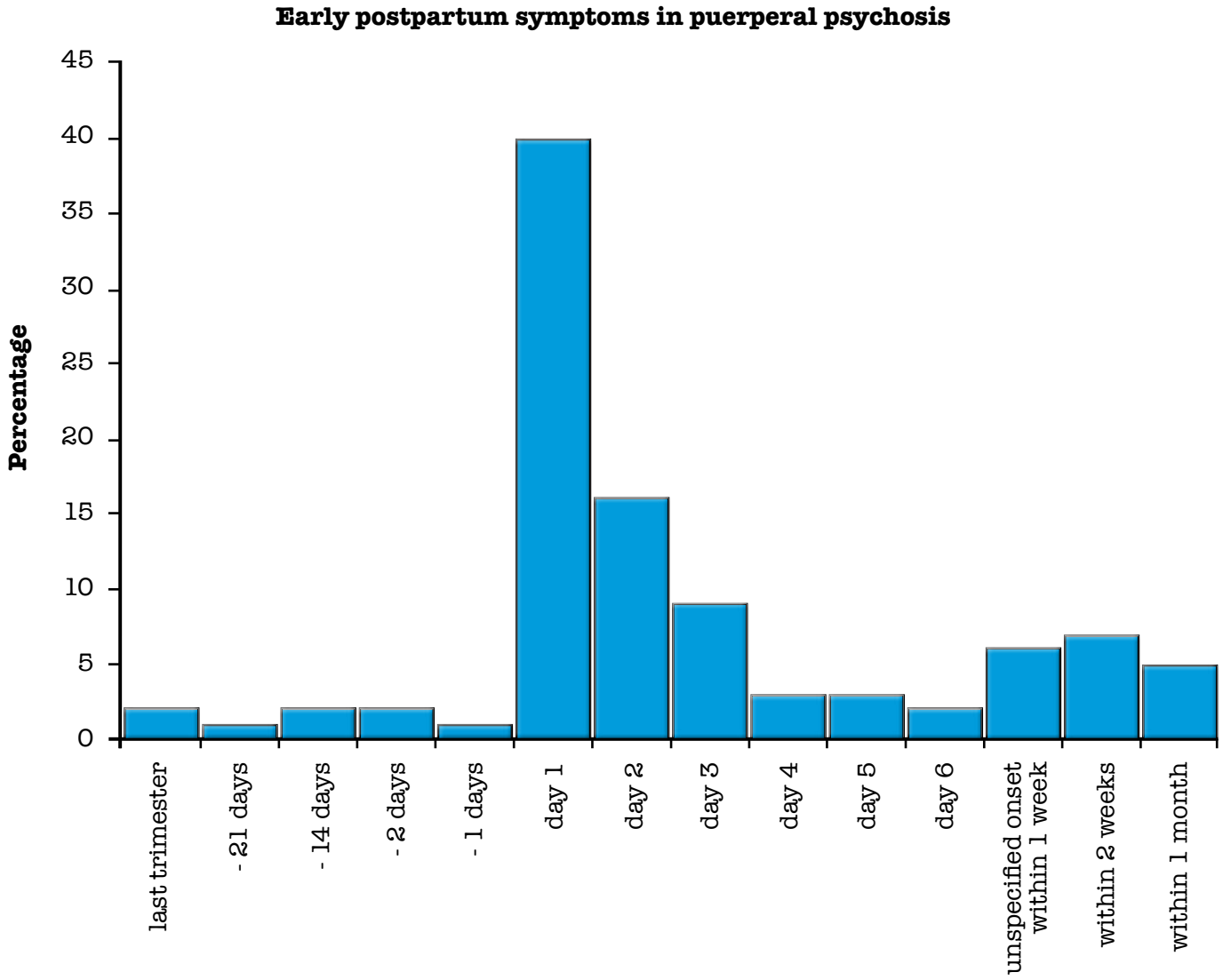


FIG 1 Rates of puerperal psychosis for every 1000 deliveries (Jones 2001a; Robertson 2005).

Jones I , Smith S APT 2009;15:411-418

Rapid onset of symptoms



Subjectively reported timing of first symptoms of PP.

Heron et al, BJOG (2008)

Effective multi-agency care

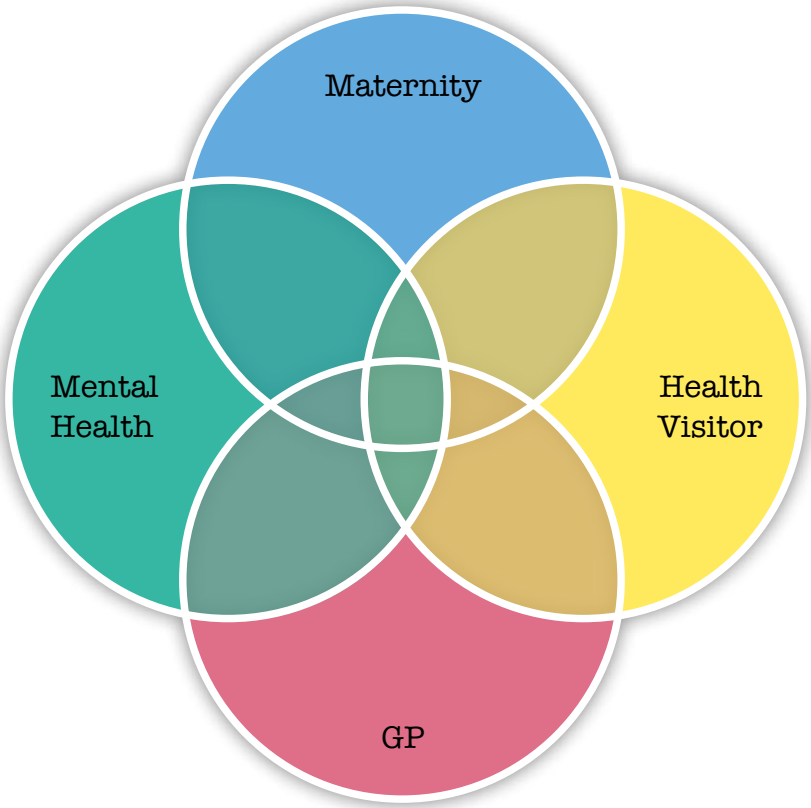
"The single biggest problem in communication is the illusion that it has taken place." - George Bernard Shaw

Themes: Substandard care

- Failure to communicate
- Failure to recognise seriousness
- Failure to recognise rapidity of change
- Failure to review past history
- Poor risk assessment
- Care by multiple teams
- Poor reviews of care

Source: Saving Mothers' Lives 2006-08

Effective communication is essential



Good practice point

All professionals should write in the woman's handheld pregnancy notes known as the SWHHMR (Scottish Women Hand Held Maternity Record)

Effective management of perinatal mental health disorders

General recommendations for women at risk

- Preconception guidance should be offered
  - Women should not be told that they should not have children
- maintain close contact and review during the perinatal period
- address avoidable factors that may increase risk
- decrease general levels of stress
- pay attention to sleep in late pregnancy and the early postpartum weeks

Screening, Prediction and Detection

See Appendix 5 for detailed information

	Disorder	When to Use	Source

History taking
- Personal history
  - Postpartum psychosis
  - psychotic disorder such as bipolar affective disorder or schizophrenia
  - severe depression
- Family history (first degree relative)
  - postpartum psychosis
  - bipolar affective disorder
	Postpartum psychosis
	Risk of relapse can be up to 50% (1 in 2)
		Antenatally and postnatally	SIGN 127
			NICE CG45

Whooley Questions (SWMHHR) 1. During the last month have you often been bothered by feeling down depressed or hopeless? 2. During the last month have you often been bothered by having little interest or pleasure in doing things? If YES to either of above ask 3. Is this something with which you would like help? Positive predictive value (PPV) for depression=32% Negative predictive value (NPV) for depression=99%	Depression	- at her first contact with primary care - at her booking visit - postnatally (usually at 4-6 weeks and 3-4 months)	NICE CG45
Self-report measures Hospital Anxiety and Depression Scale (HADS) Public Health Questionnaire-9 (PHQ-9)	Anxiety Depression	May be used as part of the subsequent assessment of mental health status or routine monitoring of outcomes	NICE CG45
EPDS (Edinburgh postnatal depression scale) - EPDS not recommended for diagnosis but can be useful as an aid for clinical monitoring and to facilitate discussion of emotional issues. - Should not replace professional judgement Cut-off value 9 or 10: PPV ranging from 9-64% for major postnatal depression Cut-off value 12 or 13: PPV ranging from 17-100% for major postnatal depression Cut-off value 14 or 15: PPV ranging from 60-80% for major antenatal depression	Postnatal depression	Postnatal at - 6-8 weeks and - 3 months	SIGN 127

Prescribing issues

Risks associated with timing of medication	
Early pregnancy	risk of teratogenesis
Late pregnancy	neonatal toxicity poor neonatal adaptation long term impact on the infant's neurodevelopment
Breast feeding	short term toxicity longer term neurodevelopment

General prescribing advice

- Make an individualised assessment of benefit versus risk
- Do not abruptly discontinue medication in pregnancy without considering risk of illness and relapse
- If medication is required,
  - choose treatments with the lowest known risk
  - aim for monotherapy
  - lowest effective dose for the shortest period necessary
  - preferable to avoid/minimise prescribing in the first trimester, if possible, due to organogenesis
  - If there is no clear evidence base that one drug is safer than another, the safest option is not to switch
  - For medications initiated in pregnancy, think ahead and consider its safety in breastfeeding
- Seek expert advice if necessary (Pharmacy or your local Psychiatrist)

What is Neonatal adaptation syndrome ?

- aka poor neonatal adaptation, neonatal withdrawal or neonatal abstinence syndrome
- A cluster of symptoms in the neonate due to psychotropic use in pregnancy
  - Irritability
  - sleep disturbance
  - persistent crying
  - tachypnoea
  - hypoglycaemia
  - poor thermal regulation
  - seizures
- Liaise with maternity services to ensure appropriate monitoring and management
- Symptoms are often self-limiting

Specific medications requiring caution

- Antenatal - Avoid Paroxetine due to risk of congenital cardiac malformations
- Antenatal -Avoid Valproate in pregnancy and women of childbearing potential due to risk of foetal abnormality and adverse neurodevelopmental outcomes
- Antenatal - Antipsychotics during pregnancy
  - Olanzapine, Clozapine - Monitor for blood glucose abnormalities
  - Close monitoring of foetal growth.

What are the medication choices available during pregnancy and when breastfeeding my baby?

Medications		
Medicine	**Can I take if I'm pregnant?**	**Can I take if I'm breast feeding?**
Antidepressants selective serotonin reuptake inhibitors (SSRI) and tricyclic antidepressants (TCA))	Yes Paroxetine should not be the first treatment choice during pregnancy. If you have already been taking this, your doctor will consider the risk and benefits to you and your baby before advising you to continue taking this or switching to another medication. It is not possible to say whether or not antidepressants increase the risk of miscarriage. It is possible that there may be a low risk or no risk at all that SSRIs cause heart defects in babies. Babies exposed to antidepressants during pregnancy may show signs such as agitation, irritability and, in rare cases, seizures. This is unusual, is not normally harmful and does not last for long.	Yes Sertraline or paroxetine are usually the first choice of antidepressants, but others may be chosen in certain situations, for example, if you need to continue the medicine you took in pregnancy or if you have depression which is difficult to treat. You should avoid doxepin.
Lithium **Lithium should not be stopped suddenly**	Yes There may be a risk of birth defects so you may have extra ultrasound scans to monitor your baby's growth and development. Babies exposed to lithium around the time of birth have increased risk of poor temperature control, floppiness, breathing problems and thyroid problems. They may need to stay in hospital longer.	Not recommended. Lithium can affect your baby's thyroid and kidney function. If you choose to breast feed, your baby will need to be closely monitored.
Anti-epileptic mood-stabilising drug (for example valproate)	No This medicine increases the risk of your baby having fetal abnormalitiesm for example, spina bifida You may have extra ultrasound scans to monitor your baby's growth and development.	Yes If you need to take anti-epileptic medicines, it may still be possible to breastfeed. The risks and benefits of taking these should be discussed with you.
Benzodiazepines (drugs like valium) **Benzodiazepines should not be stopped suddenly.**	Yes If you already take these and your doctor thinks it would be useful to continue taking them during pregnancy, you should only take them for a short time and in the lowest dose possible.	Should usually be avoided. They may make your baby sleepy and feed poorly. If they are needed a short-acting drug should be prescribed in a low dose for a short time.
Antipsychotics (medication used to treat types of mental disorder such as schizophrenia and bipolar disorder)	Yes It is not possible to say whether or not antipsychotics increase the risk of complications during your pregnancy. You may have extra ultrasound scans to monitor your baby's growth and development.	Yes It is not possible to say whether or not antipsychotics pose a risk to your baby. You should avoid clozapine.
Alternative medicines (for example St John's Wort)	No These may be harmful to your baby. There is no information that they are safe in the short or longer term	

Source: SIGN 127 Patient booklet

West of Scotland Mother & Baby Unit

Contact details

West of Scotland Mother & Baby Unit
Leverndale Hospital
510 Crookston Road, Glasgow, G53 7TU

Tel: 0141 211 6500

Webpage: http://www.nhsggc.org.uk/content/default.asp?page=s599_8_1

Virtual Tour: https://www.youtube.com/watch?v=mffgx-L_Q10

Women from Lanarkshire requiring admission to hospital with their babies should be referred to the West of Scotland Mother & Baby Unit in Glasgow

Background

Scotland's first Mother & Baby Unit was opened in September 2004 at the city's Southern General Hospital site. As part of the modernisation programme the now named West of Scotland Mother & Baby Unit relocated to Leverndale Hospital in January 2014.

Admission

The MBU admits women in later stages of pregnancy or women and their babies under 12 months old who are experiencing severe mental illness. The six bedded unit enables mothers to be supported in caring for their baby whilst having care and treatment for a range of mental illnesses, such as postnatal depression, postpartum psychosis, severe anxiety, eating disorders etc. Maintaining this contact is critical to the wellbeing of both mother and baby as it not only aids the mother's recovery but also strengthens the mother-infant relationship and infant development.

Referral

For referrals from out with NHS Greater Glasgow & Clyde, the woman should be assessed by a local psychiatrist in the first instance. The West of Scotland MBU serves the following NHS boards – Greater Glasgow and Clyde, Ayrshire and Arran, Dumfries and Galloway, Lanarkshire and the Western Isles.

3. Guidelines and Policies

NHSL integrated care pathways (ICP)

http://firstport2/staff-support/mental-health/default.aspx?RootFolder=%2fstaff%2dsupport%2fmental%2dhealth%2fDocuments%2fIntegrated%20Care%20Pathways%20%28ICP%29&FolderCTID=&View=%7b71736813%2d6526%2d4E6F%2dA2A4%2d164B94578ECC%7d

http://www.healthcareimprovementscotland.org/our_work/mental_health/icps_for_mental_health.aspx

Integrated Care Pathways (ICPs) provide guidance and outline examples of good practice which should be considered for individuals with specific Mental Health presentations.

They are for use by all professionals working in Mental Health Services and Partner Agencies for all people coming into mental health services in Lanarkshire. The guidance within the ICPs is not prescriptive and a wide range of methods in meeting individualised recovery focused care are considered.

The following ICPs have been developed and updated in 2012/13

- Generic ICP
  - For all people accessing specialist mental health services in Lanarkshire
  - Includes Appendix 5: Antenatal and Postnatal Mental Health and Wellbeing Pathway (2010). This was updated in 2015 (Appendix 2)
- Condition specific ICP
  - Bipolar disorder
  - Depression
  - Borderline personality disorder
  - Dementia
  - Schizophrenia

Scottish intercollegiate guidelines network (SIGN)

http://www.sign.ac.uk/guidelines/published/index.html#Mental
http://www.sign.ac.uk/guidelines/fulltext/127/index.html

SIGN have produced a large number of clinical guidelines based on research, evidence and best practice in order to provide a framework for professionals to deliver effective and quality health care to service users with particular health conditions or needs.

Of particular importance is SIGN guideline 127:Management of Perinatal Mood Disorders which was published in March 2012, along with a very useful Patient Booklet.

National institute for health and care excellence (NICE)

http://www.nice.org.uk/guidance/cg192

This professional body provides Health Professionals and other organisations with structured Clinical Guidelines and Pathways of Care for client groups with specific health needs or conditions.

CG192 Antenatal and postnatal mental health: Clinical management and service guidance (2014).

This guideline updates and replaces NICE guideline CG45 (published February 2007).

It offers evidence-based advice on the recognition, assessment, care and treatment of mental health problems in women during pregnancy and the postnatal period (up to 1 year after childbirth), and in women who are planning a pregnancy. New recommendations have been added in all sections except the section on the organisation of services.

Confidential enquiries into maternal death

http://www.hqip.org.uk/cmace-reports/

Confidential Enquires into Maternal Deaths (CEMD) are a national perinatal mortality surveillance programme that have highlighted perinatal psychiatric disorders as one of the leading causes of maternal death. The triennial reports have been a major factor in focusing on maternal mental illness and supporting changes in practice to influence reductions in the numbers of perinatal and neonatal deaths in the UK.

MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK) is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to continue the national programme of work investigating maternal deaths, stillbirths and infant deaths, including the Confidential Enquiry into Maternal Deaths (CEMD). The programme of work is now called the Maternal, Newborn and Infant Clinical Outcome Review Programme (MNI-CORP). The reports were previously compiled by CMACE (Centre for Maternal and Child Enquiries) and CEMACH (Confidential Enquiry into Maternal and Child Health).

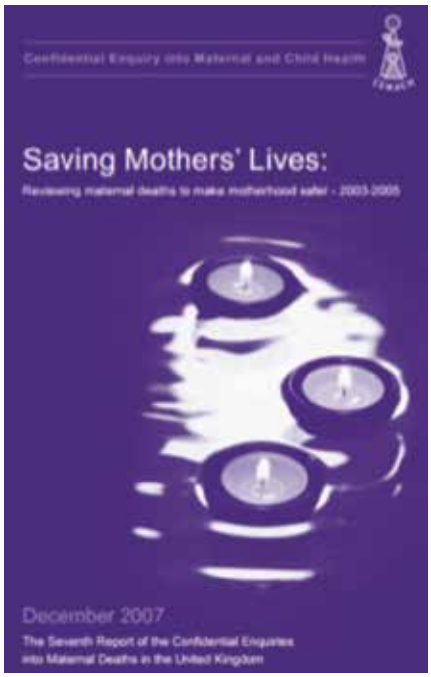
See three of the most recent reports on page 21.

Saving Mothers' Lives

Reviewing maternal deaths
to make motherhood safer: 2006–2008

8th report Confidential Enquiry
into Maternal Deaths in the UK.

Published 2011

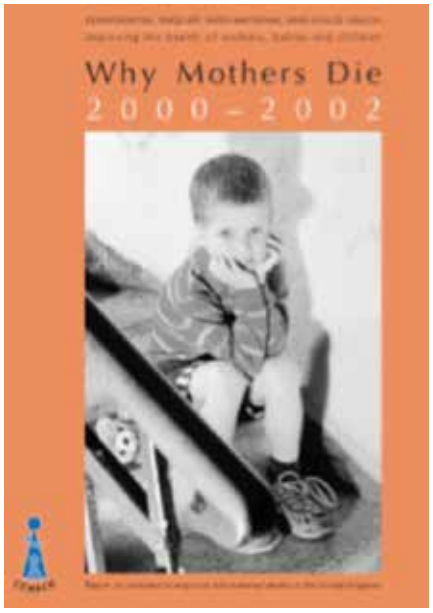


Saving Mothers' Lives

Reviewing maternal deaths
to make motherhood safer: 2003–2005

7th report Confidential Enquiry
into Maternal Deaths in the UK.

Published 2007



Why Mothers Die 2000-2002

6th report Confidential Enquiry into Maternal Deaths
in the UK.

Published 2004

Best possible start (2012-2014)

http://firstport2/resources/programmes-projects/best-possible-start/default.aspx

BPS was a two year collaboration between NHS Lanarkshire and the University of the West of Scotland responsible for co-ordinating Lanarkshire's response to implementing a suite of policy documents. The programme aimed to improve the health outcomes and reducing health inequalities of our maternal, infant and child population to provide them with the best start in life, through the development of an evidence-based universal pathway delivery of care from preconception through to the child aged 8 years.

Getting it right for every child (GIRFEC)

www.girfecinlanarkshire.co.uk

GIRFEC is a Scottish Government policy which is now implemented in Lanarkshire and embedded in all practice affecting children, young people and their families. It is an integrated approach to understanding and developing children's wellbeing and reaches across child and adult services in the public and voluntary sectors towards achieving better futures for all of our children and young people.

GIRFEC promotes key values in working with children and their families through integrated multi agency working which is based on core components with a clear focus on improving outcomes for children.

The approach calls for all workers in health centres and hospitals, nurseries, schools and leisure centres, family centres, social work services and housing offices, and in the community to work together towards changes in culture, systems and practice that will help all children and young people to grow, develop and reach their full potential.

Any child protection concerns should continue to be referred to Social Work Services through standard child protection procedures. Staff should implement the Notification of Child Protection concern process without delay if required

See appendix 3

Early years collaborative

http://www.gov.scot.uk/Topics/People/Young-People/early-years/early-years-collaborative

The Early Years Collaborative is a coalition of Community Planning Partners - including social services, health, education, police and third sector professionals - committed to ensuring that every baby, child, mother, father and family in Scotland has access to the best supports available. It's the world's first national multi-agency quality improvement programme and is led by the Scottish Government.

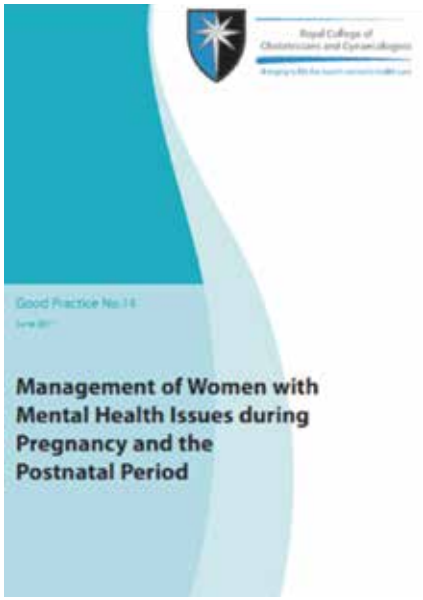
The objective is to positively translate high level policy from the GIRFEC and Early Years Framework into a tangible force to influence positive health outcomes and reduce inequalities for Scotland's children.

Lanarkshire has the North and South Early Years Collaborative which are seeking to positively influence the 3 stretch aims directed from the Scottish Government as seen below through the introduction of improvement methodology to support positive outcomes:

- To ensure that women experience positive pregnancies which results in the birth of more healthy babies as evidenced by a reduction of 15% in the rates of stillbirths and infant mortality by 2015
- To ensure that 85% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time of the child's 27-30 month child health review, by end 2016
- To ensure that 90% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time of the child starts primary school, by end 2017

Royal college of Obstetricians & Gynaecologists (Good Practice 14)

https://www.rcog.org.uk/en/guidelines-research-services/guidelines/good-practice-14/



Management of Women with Mental Health Issues during Pregnancy and the Postnatal Period (2011)

Mental illness makes a significant contribution to maternal deaths.

This document highlights the role of maternity services in the early identification of high-risk women and assessment of current illness, and describes principles of service organisation for health providers to meet these needs.

4. Roles of professionals

Adult mental health services

The mainstay of secondary care adult mental health services is provided by the 10 Community Mental Health Teams (CMHT) across Lanarkshire. Their role is to manage moderate-severe mental illness and are involved in providing care and treatment to pregnant and postnatal women with significant mental health issues.

Key Health Professionals based in CMHT

- Medical: Consultant Psychiatrist & Trainee doctors
- Nursing: Community Psychiatric Nurses (CPN)
- Occupational Therapists (OT)
- Psychological Therapies Team (PTT)

Patients requiring inpatient care are admitted to the Psychiatric wards based in the three Lanarkshire hospitals (Wishaw General, Monklands and Hairmyres). The Intensive Psychiatric Care Unit (IPCU) at Wishaw General provides intensive treatment for the most acutely disturbed patients.

Specialist Addiction, Forensic, Child & Adolescent mental health services (CAMHS) and Learning Disability services also provide care to women of childbearing age.

Adult CMHT timescales: definitions

	Response time
Routine Response time varies by profession and is defined in the CMHT operational policy.	Medical 9 weeks Nursing 3 weeks Psychology 18 weeks
Urgent Urgent referrals are those requiring a prompt assessment and may have associated risk factors	Assessment within 7 days
Crisis Referral criteria and response time as per NHSL crisis standards policy	Assessment within 4 hours

Perinatal link CPN

Each CMHT has an identified CPN who has a specialist interest in Perinatal Mental Health. The link CPN is an additional support for the locality and does not have exclusive responsibility within the CMHT's for this group of women.

Role of mental health services (CMHT/PMHS)

- Service should liaise closely with Maternity services, GP and the Health Visitor to ensure the best possible outcomes for the woman and baby.
- Mental health services should provide pre-conceptual advice for those women of child bearing age, who are under the care of mental health services.
- Take the lead role in drawing up a Lanarkshire Pregnancy and Early Postnatal Care Plan (L-PEPP) at week 28-32 gestation (Appendix XX)
  - This plan identifies the risk factors, early signs of relapse and management plan for women in late pregnancy and immediate postnatal period.
  - The L-PEPP should be discussed with the woman
  - Copies should be circulated to
    - the patient (for inclusion in the Maternity Hand Held Records SWHHMR)
    - all relevant services including GP, Health Visitor, Midwife, Obstetrician and other partner agencies, as appropriate.

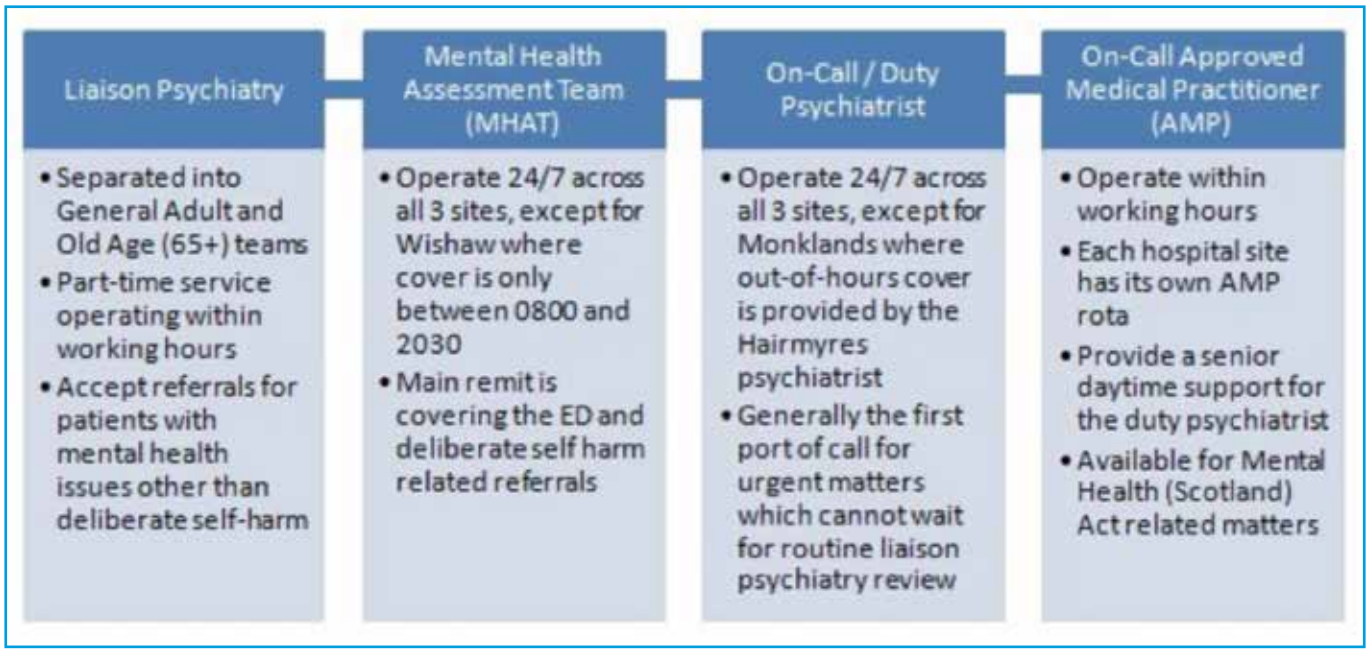
Extended CMHT service

Every locality provides a nurse-led extended hours CMHT service whose aim is to provide urgent assessment (within four hours) and management for patients who are experiencing an acute mental health crisis and/or relapse and who would otherwise be admitted to hospital. They are able to provide daily nursing contact if required.

The service is available via the GP during the following hours

- Mon – Fri (0830-1830)
- Weekends & Public Holidays (0830-1630)

MHAT and Liaison Psychiatry



In NHS Lanarkshire the Liaison Psychiatry service currently operates within a broader mental health framework providing input into the 3 acute hospitals. This framework includes

- Liaison Psychiatry
  - Liaison psychiatry services address the mental health needs of patients who have been admitted to the general hospital with physical health problems.
- Mental Health Assessment Team (MHAT)
  - Nurse-led service based across the 3 hospital sites and their aim is to assess patients presenting to Accident & Emergency and those in medical wards, particularly those with deliberate self harm. Assessments may be undertaken jointly with junior doctors on-call.
- On-call (duty) psychiatrist
- On-call Approved Medical Practitioner (AMP).

Contact above services via Hospital switchboard.

Referral information to Liaison Psychiatry
http://firstport2/staff-support/psychiatry-liaison-services/default.aspx

Good practice point

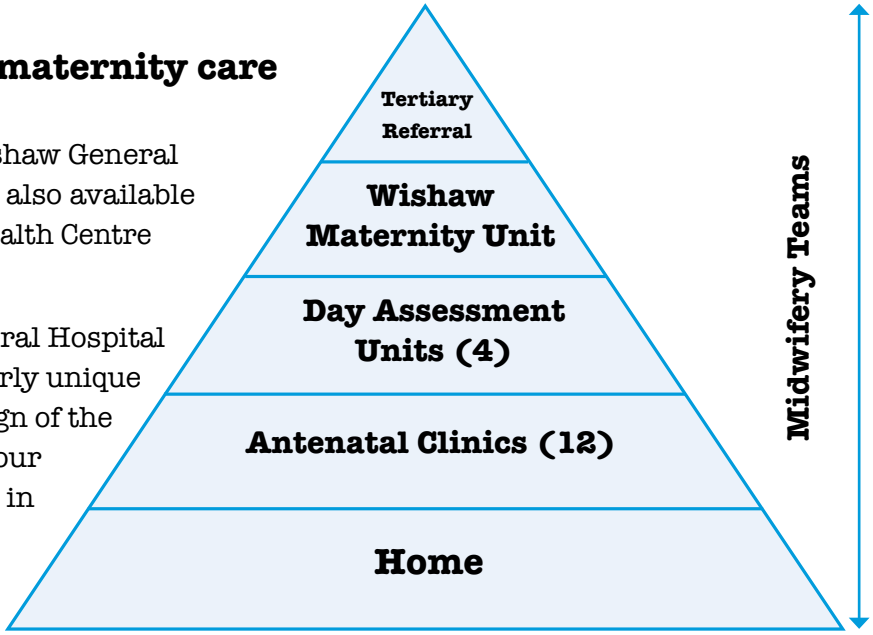
- Discharge planning
  - Discharge should be arranged following discussion with the patient, named person and those professionals/agencies involved.
- DNA (Did not attend) or Failure to engage
  - Every effort should be made to establish contact with the patient, referrer and/or relevant others to establish reason for DNA and level of risk to patient and dependant others.
  - In line with GIRFEC principles where there is a potential risk to the unborn baby and/or other children, practitioners should share information with the 'named person' (see Appendix 3)

Maternity Services

The Lanarkshire model of maternity care

Maternity services are based at Wishaw General Hospital. Day Assessment Units are also available at Airdrie Health Centre, Lanark Health Centre and Hairmyres Hospital.

The Maternity Unit at Wishaw General Hospital opened in June 2001 providing a fairly unique approach to inpatient care. The design of the unit differs from the traditional labour ward model as women are cared for in one of three geographically based wards in LDRP (Labour, Delivery, Recovery and Postnatal rooms)



This means that for the majority of women there is no need to transfer from an antenatal ward to labour ward and back to a postnatal ward. Instead, women will receive all their care from within the setting of one ward and more importantly by one team of midwives.

Role of midwife

- Asking the "Whooley Questions" for prediction and detection of mental ill health at the first booking clinic (SWMHHR).
- Recognising and responding to identified/emerging need at all stages of Pregnancy and early postnatal period;
- Developing a trusting relationship with the pregnant woman, taking into account her individual needs and preferences;
- Providing information and offering sensitive support and additional midwifery care as appropriate

The role of the midwife within the care pathway is to identify women at booking, during the antenatal or postnatal period that may be at risk of developing mental health problems. As the Lead Clinician for women with normal pregnancies the midwife plays a pivotal role in helping women experiencing mental health issues achieve the best possible outcome for themselves, their baby and their family.

Midwives work alongside Obstetricians and other professionals to ensure women receive individualised patient centred care at all times.

Clinical judgement is the best tool when assessing patients however in the SWHHMR notes the "Whooley" questions (see Appendix 5) are there to enhance clinical judgement and enable the midwife to seek advice and support for the woman and her partner from other disciplines.

Keeping Childbirth Natural And Dynamic (KCND)

http://www.maternal-and-early-years.org.uk/the-keeping-childbirth-natural-and-dynamic-kcnd-programme

KCND is a national Scottish programme established to ensure the implementation of maternity policy in practice. The programme aims to ensure all women have a robust assessment of their needs in early pregnancy; are offered the most appropriate care pathway for their need; and have care provided by the most appropriately skilled maternity professional. The programme promotes multi-professional working.
The objectives of the KCND programme are:

1) **Implementation of national multi-professional care pathways.**
   The pathways identify the most appropriate care pathway for individual need and the most appropriately skilled professional to deliver that care.

2) **Implementation of the Lead maternity professional based on risk**
   Normally a midwife has responsibility for the care of women experiencing a normal pregnancy and an obstetrician, supported by the maternity team, for those with factors that could adversely affect the outcome for mother and/or baby. A woman's general practitioner (GP) will continue to look after her general medical care and participate in antenatal care as desired.

3) **Implementation of the midwife to act as first point of professional contact in pregnancy**
   To facilitate seamless access to maternity services, all pregnant women will be offered the option of seeing a midwife as their first contact. This is in place in most NHS boards, however any women who wishes to continue to see her GP should be supported to do so.

It is important to note that women do not need to see a GP to seek confirmation of their pregnancy. If they have missed a period and a home pregnancy test has produced a positive result, no further confirmation is required. This has been standard practice for some time.

It should be recognised that for some vulnerable women self diagnosis of pregnancy using a home pregnancy kit may not be possible, therefore initial diagnosis will be required by the GP or family planning clinic.

To comply with the maternity care pathways, maternal history taking should begin with this first contact, with relevant information being documented in the Scottish Woman Held Maternity Record (SWHMR). In order to ensure the correct care pathway is identified, it is essential that accurate records are taken and there is a quality social needs assessment.

Communication between the midwife and GP is essential and therefore, where midwives undertake first contact, they will have a duty to communicate outcomes to the woman's GP and refer women to GP services as required.

Women experiencing high risk pregnancies, who would therefore benefit most from early contact with maternity services, may be in contact with other services such as drug or alcohol addiction, housing or social work. It is important that professionals working in these services signpost women to the support delivered by maternity services at the earliest possible stage.

Role of The Health Visitor

Health Visitors (formerly known as Public Health Nurses) play a pivotal role in contributing to the health and wellbeing of children (age 0-5), young people and families. They also help to identify women during the postnatal period that may be developing mental illness, in addition to providing valuable support for mother and baby.

The transition from midwife to health visitor is an important one and requires close communication.

- The named midwife will liaise as necessary with the HV of women during the antenatal and postnatal period that may be at risk of developing mental ill health. The HV will contribute to the care planning for these women and through this partnership approach will enhance the transition process and support the development of an early therapeutic relationship.
- Transition from the named midwife to the named HV will occur anytime between 10-28 days postnatally dependent on individual need. These women will have a Health Plan Indicator (HPI) – Additional, which will ensure enhanced services beyond that of the Universal Pathway (Appendix) and in keeping with 'HALL 4' (Health for All Children 4, Scottish Government) recommendations.
- Ongoing assessment of need will result in agreed patterns of visiting in partnership with the women and their support networks and will work collaboratively with the GP, CMHT and partner agencies as appropriate. HV's who have emerging concerns about a woman's mental health in the post natal period should liaise with the appropriate health professionals, whether this is the GP in the first instance and/or the CMHT to reduce any risk that may be present for the child/children.
- Mild to moderate depression can be managed within primary care with a combination of psychological and social support and medication where appropriate. Referral to secondary mental health services should be made when risks are identified or a woman fails to respond to treatment.

The Role Of The General Practitioner

It is recognised that GPs have an established relationship with women and their families and are therefore in a unique position to provide guidance, direction and support throughout the maternal journey.

The majority of mental health issues are managed in primary care. However where there is a risk of developing significant mental illness in the Perinatal period, referral to secondary mental health services should be considered, as per the ANPN Pathway (Appendix 2)

Good Practice Point

All clinicians should communicate a known mental health history to maternity services and other relevant colleagues. Confidential Enquiries into maternal deaths highlight this as a key omission.

5. Abbreviations and glossary of terms

BPAD	Bipolar affective disorder
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy aims to help you to change the way you think feel and behave. It is used as a treatment for various mental health and physical problems.
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
EPDS	Edinburgh Postnatal Depression Scale. Post partum depression is the most common complication of childbearing. The 10 question E.P.D.S is a valuable and efficient way of identifying patients at risk of "perinatal" depression. The EPDS is easy to administer and has proven an effective screening tool. The EPDS however should not override clinical judgement. A careful clinical assessment should be carried out to confirm diagnosis. EPDS is routinely undertaken postnatally at 6-8 weeks and 12-16 weeks
GIRFEC	Getting it Right for Every Child is a national policy and programme implemented in Lanarkshire
GP	General Practitioner
HV	Health Visitor, previously known as PHN
KCND	Keeping Childbirth Natural and Dynamic
LPEPP	Lanarkshire Pregnancy and Early Postnatal carePlan
MBU	Mother and Baby Unit
MHAT	Mental Health Assessment Team
PHN	Public Health Nurse, also known as Health Visitor
PMHS	Perinatal mental health service
PP	Postpartum psychosis
SHANARRI	GIRFEC wellbeing indicators – Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included.
SWHHMR	The Scottish Women Hand Held Maternity Record is an exciting and innovative NHS Scotland development. Scotland is the first of the UK countries to have a single unified hand held record for women during their maternity care. Healthcare Improvement Scotland leads this work on behalf of the Scottish Government. **GOOD PRACTICE:** Any Health Professional should document care intervention in the SWHHMR
Watchful waiting	Watchful waiting involves carefully monitoring symptoms to see whether they improve or get worse
SIGN	Scottish Intercollegiate Guidelines Network

6. Services in lanarkshire

North CHP

	Health Visitor	Tel	Mental Health	Tel	Midwifery	Area Office Number	Team Leader Mobile
Airdrie	Airdrie Health Centre 88 Graham Street Airdrie ML6 6DB	01236 772268	Airdrie Health Centre 88 Graham Street Airdrie ML6 6DB	01236 772228	Airdrie Health Centre 88 Graham Street Airdrie ML6 6DB	01236 772257 58 59 & 60	07786-251944
Bellshill	Viewpark Bellshill	01698 801501 01698 575712	Bellshill Community Clinic Greenmoss Place Bellshill ML4 1PS	01698 575700	Bellshill Community Health Clinic Greenmoss Place Bellshill ML4 1PS	01698 575737	07786-251923
Coatbridge		01236 438331	Buchanan Centre 126-130 Main Street Coatbridge ML5 3BJ	01236 703405	Coatbridge Health Centre 1 Centre Park Court Coatbridge ML5 3AP	01236 438405	07786-251939
Cumbernauld	Kildrum Condorrat Kilsyth	01236 794111 01236 723383 01236 820031 /0141 779 8191	Central Health Centre North Carbrain Cumbernauld G67 1DZ	01236 789 902	Kildrum Health Centre Afton Road Kildrum Cumbernauld G67 2ET	01236 794109 01236 794110	
Motherwell	Modyrvale Motherwell HC	01698 212626 01698 242646	Airbles Road Centre 49 Airbles Road Motherwell ML1 2TP	01698 261331	Motherwell Health Clinic 138-144 Windmill Hill Street Motherwell ML1 1TB	01698 242653	07786-251928
Wishaw	Shotts Wishaw	01501 820519 01698 354959	Wishaw Resource Network 48/54 Roberts Street Wishaw ML2 7JS	01698 359623	Wishaw Health Centre Kennelworth Avenue Wishaw ML2 7BQ	01698 354966	07786-251961

South CHP

	Health Visitor	Tel	Mental Health	Tel	Midwifery	Area Office Number	Team Leader Mobile
EAST KILBRIDE	Strathaven & Red Deer Alison Lea Hunter HC	01355 593476 01355 229861 01355 906013	CMHT Atholl House Churchill Avenue East Kilbride G74 1LU	01355 233354	Hunter Health Centre Andrews Street East Kilbride G74 1AD	01355 906600	07786-251932
HAMILTON	Team A Team B Blantyre & Bothwell	01698 723164 01698 723163 01698 855601	CMHT Regent House 9 High Patrick Street Hamilton ML3 7JA	01698 455459	Central Clinic Orchard Street Hamilton ML3 7PB	01698 201620	07786-251931
CARLUKE CLYDESDALE LANARK	Carluke Larkhall Lesmahagow & Lanark	01555 777442 01698 884731 01555 667176	Clydesdale Resource Network Lanark Health Centre Woodstock Road Lanark	01555 667159	Woodstock Medical Campus Woodstock Road Lanark ML11 7DH	01555 667155	07786-251935
CAMBUSLANG & RUTHERGLEN		0141 531 6021 0141 531 6057 0141 531 6021	Eastvale Resource Centre 130A Stonelaw Road Rutherglen Glasgow G73 2PQ	0141 531 4127	Rutherglen Maternity Care Centre 130 Stonelaw Road Rutherglen G73 2PQ	0141 531 4183	

Other Key Contacts

	Health Visitor	Tel	Mental Health	Tel	Midwifery	Area Office Number	Team Leader Mobile
Addictions			See FirstPort		Specialist midwives substance abuse Lorraine Farrow (North) Liz Walsh (South)	01698 403798 01555 777477	07827983933 07810127580
					Specialist midwife BBV	01555 777477	07557 494365
					Community/opd co-ordinator	01698 366212	07824 483307
Bereavement					Specialist midwife and counsellor Elaine Hamilton	01698 366 653	

Perinatal Link CPNs

Base	Contact No	Name	Contact Email
North CHP			
Airdie	01236 772228	Alana Burke Adele Meechan	Alana.Burke@lanarkshire.scot.nhs.uk Adele.Meechan@lanarkshire.scot.nhs.uk
Bellshill	01698 575718 01698 575719	Christine Ferguson Karen Esson	christine.ferguson@lanarkshire.scot.nhs.uk karen.esson@lanarkshire.scot.nhs.uk
Coatbridge	01236 703405	Tracy Smyth	tracy.smyth1@lanarkshire.scot.nhs.uk
Cumbernauld	01236789902	Morag Crichton	morag.crichton@lanarkshire.scot.nhs.uk
Motherwell	01698 269336	Marie Reilly	marie.reilly@lanarkshire.scot.nhs.uk
Wishaw	01698 359623	Janet Armstrong Gus MacLean	janet.armstrong@lanarkshire.scot.nhs.uk angus.mclean@lanarkshire.scot.nhs.uk
South CHP			
Camuslang & Rutherglen	0141 531 4117	Irene McConnell	irene.mcconnell@lanarkshire.scot.nhs.uk
East Kilbride	01355 233354	Margaret McGreevy Angela Kane	margaret.mcgreevy@lanarkshire.scot.nhs.uk angela.kane@lanarkshire.scot.nhs.uk
Hamilton	01698 455459 01698 880054	Bernadette Galloway Jackie Mitchell	bernadette.galloway@lanarkshire.scot.nhs.uk jacqueline.mitchell@lanarkshire.scot.nhs.uk
Clydesdale	01555 667159	Paul Thomson Julie Barr	Paul.Thomson@lanarkshire.scot.nhs.uk Julie.Barr@lanarkshire.scot.nhs.uk
Specialties			
Addictions	01698 403535	Victoria Beattie	Victoria.Beattie@lanarkshire.scot.nhs.uk
Learning Disabilities	01698 274 477	Karen Clark	karenclark4@nhs.net

7. Appendix

Appendix 1: L-PEPP

Perinatal Mental Health Service L-PEPP

Lanarkshire Pregnancy and Early Postnatal carePlan

To be completed between 28 and 32 weeks of gestation

Copies to (1) **Patient** (2) **Maternity handheld notes** (3) **All Professionals involved**
(4) Email **Perinatal Mental Health Service** PerinatalMHS@lanarkshire.scot.nhs.uk

NHS Lanarkshire

Name: _____ **CHI:** _____

EDD: _____ **Date plan agreed:** _____

CPN		Contact info	
Health visitor		Contact info	
Midwife		Contact info	
Psychiatrist		Contact info	
GP		Contact info	
Obstetrician		Contact info	
Social worker		Contact info	
Other professional		Contact info	
Family member/ named person		Contact info	

Risk of illness:

Early warning signs:

1.
2.
3.

Current management:

1.
2.
3.

Planned antenatal changes:

1.
2.
3.

Immediate postnatal plan: Intention to breastfeed? Yes ☐ No ☐ Undecided ☐

1.
2.
3.

Advance statement completed? ☐Yes ☐No

Sign/print name (NHSL worker): _____ Date: _____

Sign/print name (patient): _____ Date: _____

Adapted from the Glasgow Pregnancy and Early Postpartum Care Pathway. Good Practice No. 14 © RCOG (Rev. Nov'14)

Appendix 2: integrated care pathways (ICP) for perinatal mental health

Background

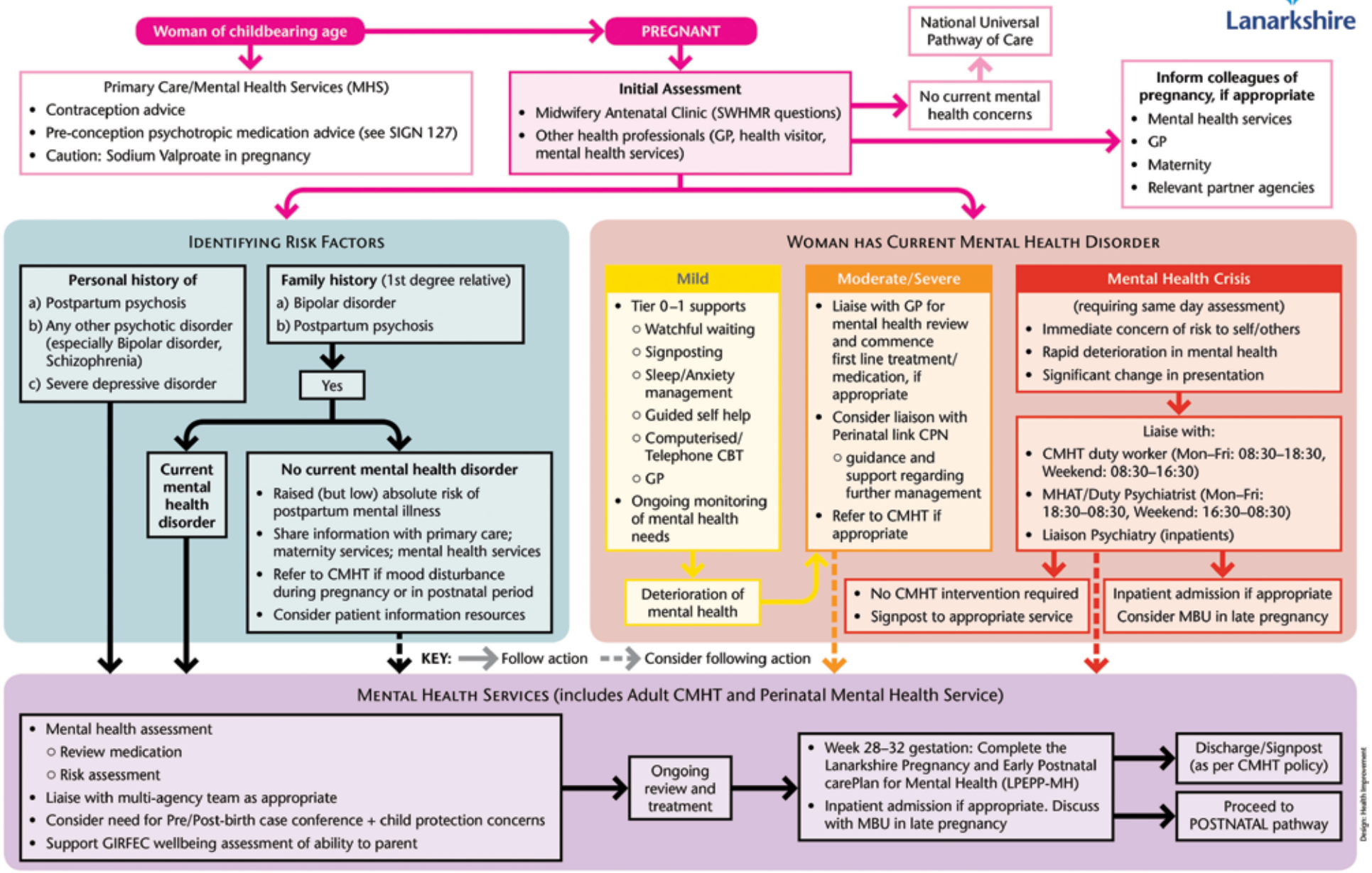
The current Antenatal and Postnatal Mental Health (ANPNMH) ICP 2015 updates the original version from August 2010. There were a number of significant considerations taken into account by the local Perinatal group,

- Updated Guidelines and Best Practice
  - SIGN 127: The Management of Perinatal Mood Disorders (2012)
  - NICE CG45: Antenatal and Postnatal Mental Health (2007)
  - RCOG GP14: Management of Women with Mental Health Issues during Pregnancy and the Postnatal Period (2011)
- Service redesign in Mental Health, Public Health and Womens' Services
- Ensure ICP is relevant to professionals from a variety of backgrounds and promotes increased multidisciplinary communication
- Impact of GIRFEC, Early Years Collaborative and Best Possible Start

It is **essential** that professionals using the ICP are clear that the Pathway is a recommendation and does not replace clinical judgement or direct communication with colleagues in situations of risk or uncertainty.

ANTENATAL
Perinatal Mental Health Pathway

NHS Lanarkshire



ABBREVIATIONS: MHAT = Mental Health Assessment Team, MBU = Mother and Baby Unit at Leverndale, SWHMR = Scottish Woman Held Maternity Record

Published: Mar 2015, Author: Perinatal Mental Health Steering Group

Design: Health Improvement

POSTNATAL (UP TO 12 MONTHS)
PERINATAL MENTAL HEALTH PATHWAY

NHS Lanarkshire

Currently on Mental Health Service caseload
- Ongoing review and treatment
- EPDS may assist assessment
- Consult Lanarkshire Pregnancy and Early Postnatal carePlan for Mental Health (LPEPP-MH) where appropriate

Initial assessment
- Health Visitor, GP, midwife, mental health services
- Use clinical judgement
- EPDS may assist assessment
- Consult Lanarkshire Pregnancy and Early Postnatal carePlan for Mental Health (LPEPP-MH) where appropriate

→ No current mental health concerns → National Universal Pathway of Care

IDENTIFYING RISK FACTORS

Personal history of
a) Postpartum psychosis
b) Any other psychotic disorder (especially Bipolar disorder, Schizophrenia)
c) Severe depressive disorder

Family history (1st degree relative)
a) Bipolar disorder
b) Postpartum psychosis

→ Yes

Current mental health disorder

No current mental health disorder
- Raised (but low) absolute risk of postpartum mental illness
- Share information with primary care; maternity services; mental health services
- Refer to CMHT if mood disturbance during pregnancy or in postnatal period
- Consider patient information resources

WOMAN HAS CURRENT MENTAL HEALTH DISORDER

Mild
- Tier 0-1 supports
  - Watchful waiting
  - Signposting
  - Sleep/Anxiety management
  - Guided self help
  - Computerised/ Telephone CBT
  - GP
- Ongoing monitoring of mental health needs.

→ Deterioration of mental health

Moderate/Severe
- Liaise with GP for mental health review and commence first line treatment/ medication, if appropriate
- Consider liaison with Perinatal link CPN
  - guidance and support regarding further management
- Refer to CMHT if appropriate

Mental Health Crisis
(requiring same day assessment)
- Immediate concern of risk to self/others
- Rapid deterioration in mental health
- Significant change in presentation

→ Liaise with:
- CMHT duty worker (Mon–Fri: 08:30–18:30, Weekend: 08:30–16:30)
- MHAT/Duty Psychiatrist (Mon–Fri: 18:30–08:30, Weekend: 16:30–08:30)
- Liaison Psychiatry (inpatients)

→ No CMHT intervention required
- Signpost to appropriate service

→ Inpatient admission if appropriate
Consider MBU

KEY: → Follow action --→ Consider following action

MENTAL HEALTH SERVICES (includes Adult CMHT and Perinatal Mental Health Service)

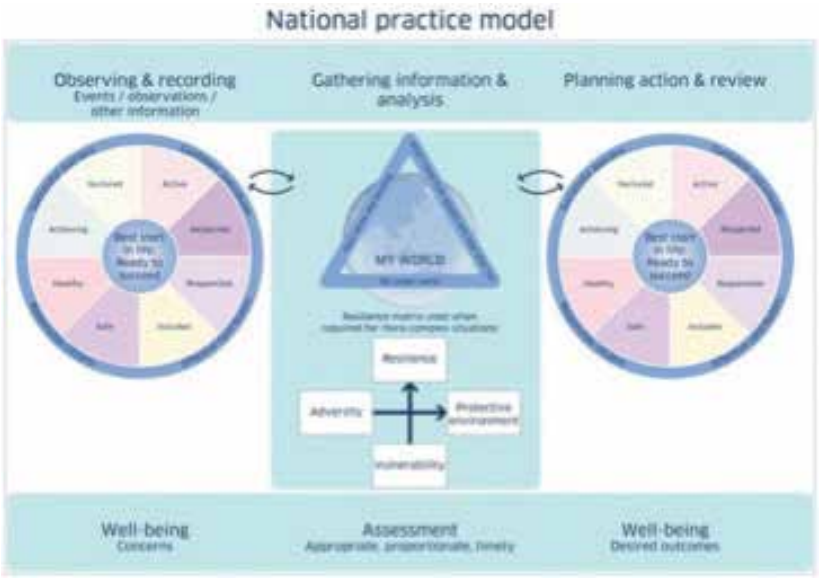
- Mental health assessment
  - Review medication
  - Risk assessment
- Liaise with multi-agency team as appropriate
- Consider need for Pre/Post-birth case conference + child protection concerns
- Support GIRFEC wellbeing assessment of ability to parent

→ Ongoing review and treatment
→ Inpatient admission to MBU, if appropriate
→ Discharge/Signpost (as per CMHT policy)

ABBREVIATIONS: MHAT = Mental Health Assessment Team, MBU = Mother and Baby Unit at Leverndale, EPDS = Edinburgh Postnatal Depression Scale

Published: Mar 2015, Author: Perinatal Mental Health Steering Group

Appendix 3: The GIRFEC practice model



http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright

GIRFEC is a framework for assessment that supports a shared understanding of the language and documentation used across disciplines and agencies and acknowledging the importance of early identification of any area of a child's life that may be impacting on their wellbeing. It also supports evidence and planning structures where there is the need for early intervention to minimise risk of harm or negative impacts on a child's future.

A child or family may experience a crisis or require additional support or service/agency provision for any number of reasons and services should be accessible, timeous, appropriate and proportionate to their needs.

Terminology

Request for Assistance (RFA)	Children's Services are accessed via RFA and they should understand the role they have to play in communicating and contributing effectively in order to keep the child at the centre of any decisions or care planning. [reword please]
Lead Professional	A lead professional should be identified when additional support is required across two or more agencies.
Named Person	The named person is the allocated professional from the most appropriate universal service dependent on the age/stage of the child. **Midwife:** Pre-birth to 10-14 days (up to in certain circumstances 28 days) **Health Visitor**: From 10-14 days until child transitions to school **Appropriate Member of Education Staff:** From school entry until leaving school The named person is the main professional who has the responsibility for assessing the child/family needs and communicating effectively with anyone who is involved with them throughout the period that they remain part of their particular universal service. It is important that any other discipline or agency keeps the named person fully informed of any deterioration/progress/intervention they may identify for the child/family. The named person will share key and relevant information with the next named person as they move through the universal pathway.

Tools

Three tools are available to support assessment, planning, intervention and monitoring of a child's needs.

Wellbeing indicators aka SHANARRI – Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included.

These are essential if a child is to go on and achieve their full potential. It supports practitioners to identify areas in which a child is progressing but equally provides a framework for the identification of concern that may be impacting on the child currently or likely to in the future.

My World Assessment Triangle is a more detailed assessment structure that supports practitioners to analyse what impacts there may be on a child from a child centred and holistic perspective.

It encourages practitioners examine more fully three key areas for a child: How I grow and develop, What I need from People who look after me and My wider world. This helps to identify what supports are in place and any gaps/risks the child may be exposed to. It is an essential framework in gathering and sharing information that can support the need for planning and action across agencies and disciplines.

The Resilience Matrix supports the assessment of evaluating exposure to risk against protective factors for a child. It strengthens the decision making progress by reflecting the degree of vulnerability the child is exposed to.

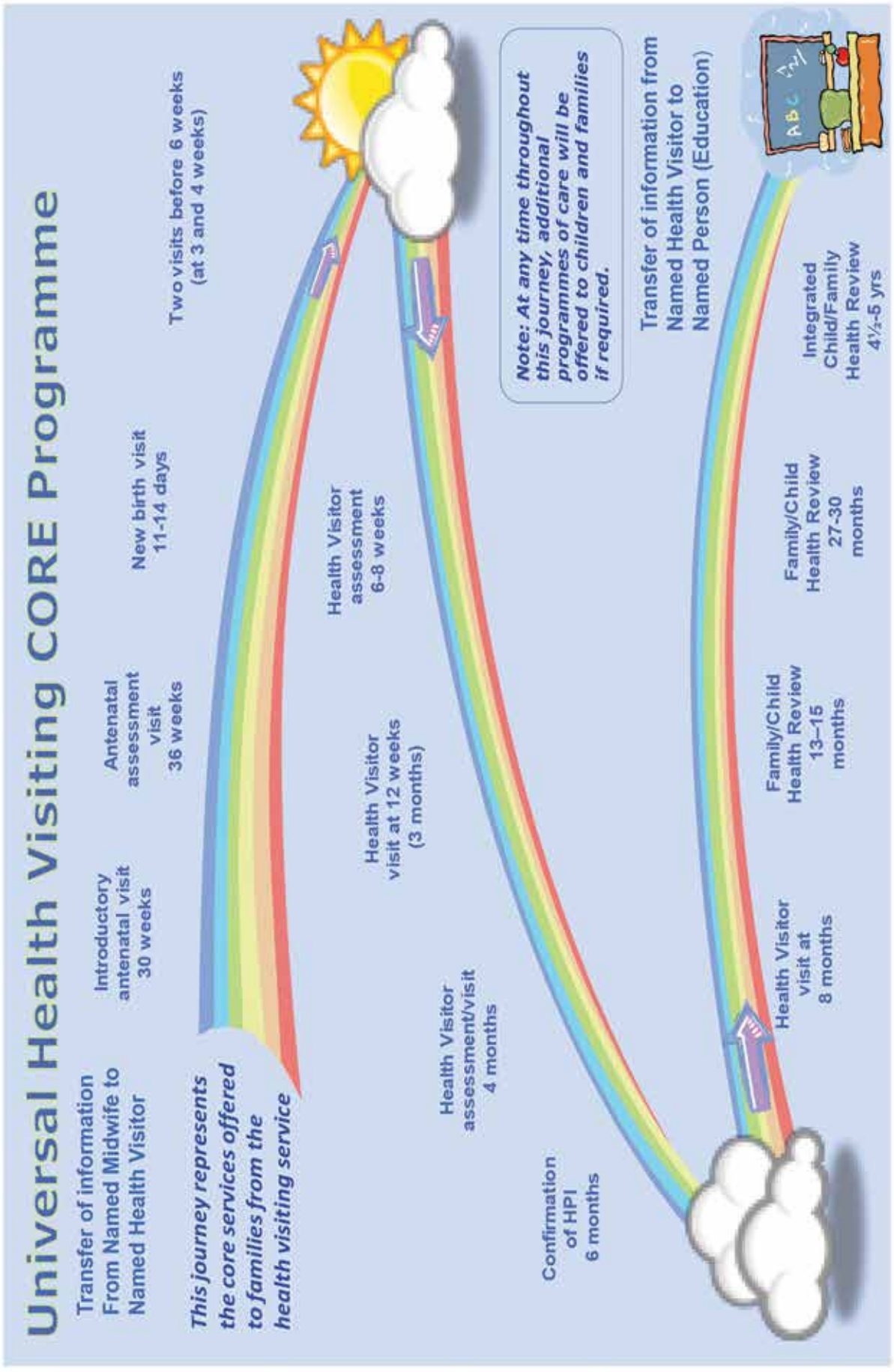
Inter-agency working

Often when it is a case of joint working, the Named Person may also be the most appropriate Lead Professional. However, on occasion it may be that a specialist service professional will take the role of Lead Professional if at any given time this is the area of their wellbeing that is most affecting the child. This should be agreed through discussion and can revert back to universal Named Person when stability is achieved.

For integrated working and where there is a network of support required for the child/family, relevant agencies and the child/carer will come together to identify actions and outcomes that will respond most effectively to meet need through an Integrated Assessment and formulation of a Child's Plan. During this a Lead Professional will be agreed by those present as being the person most appropriate at the time to co-ordinate this process.

Where there is Compulsory Intervention, the Lead Professional will automatically be the Social Worker until there is sufficient information and an agreed Child's Plan which might support another professional taking on this role at a later stage and directed through the Network of Support forum.

Appendix 4: The universal pathway



Appendix 5: Assessment tools

SIGN 127 – Detection of Antenatal and Postnatal depression

- Whilst there is expert consensus on the benefits of detecting depression, there is insufficient evidence to recommend the use of the EPDS or Whooley Questions as tools with sufficient accuracy in either the antenatal or postnatal period. However, their use is likely to have benefit in facilitating discussion of emotional issues and aiding ongoing clinical monitoring.
- Enquiry about depressive symptoms should be made, at minimum, on booking in and postnatally at four to six weeks and three to four months.
- For women regarded to be at high risk (those with previous or current depressive disorder), enquiry about depressive symptoms should be made at each contact.
- The EPDS or the Whooley Questions may be used in the antenatal and postnatal period as an aid to clinical monitoring and to facilitate discussion of emotional issues.

NICE CG45 – Whooley questions

At a woman's first contact with primary care, at her booking visit and postnatally (usually at 4 to 6 weeks and 3 to 4 months), healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask two questions to identify possible depression.

1. During the past month, have you often been bothered by feeling down, depressed or hopeless?
2. During the past month, have you often been bothered by having little interest or pleasure in doing things?

A third question should be considered if the woman answers 'yes' to either of the initial questions.

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

Edinburgh Postnatal Depression Scale (EPDS)

NHS Lanarkshire

Name: _____ CHI: _____ Baby's Date of Birth: _____

Administered by: _____ Date: _____

- *As you have recently had a baby, we would like to know how you are feeling now.*
- *Please **UNDERLINE** the answer which comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today. Here is an example already completed.*

I have felt happy: Yes, all the time Yes, some of the time No, not very often No, not at all	This would mean: *'I have felt happy some of the time during the past week'.* Please complete the other questions in the same way.

In the Past 7 Days:

	score		score
1. I have been able to laugh and see the funny side of things:		**6. Things have been getting on top of me:**	
As much as I always could	0	Yes, most of the time I haven't been able to cope at all	3
Not quite so much now	1	Yes, sometimes I haven't been coping as well as usual	2
Definitely not so much now	2	No, most of the time I have coped quite will	1
Not at all	3	No, I have been coping as well as ever	0
2. I have looked forward with enjoyment to things:		**7. I have been so unhappy that I have had difficulty sleeping:**	
As much as I ever did	0	Yes, most of the time	3
Rather less than I used to	1	Yes, sometimes	2
Definitely less than I used to	2	Not very often	1
Hardly at all	3	No, not at all	0
3. I have blamed myself unnecessarily when things went wrong:		**8. I have felt sad or miserable:**	
Yes, most of the time.	3	Yes, most of the time	3
Yes, some of the time	2	Yes, quite often	2
Not very often	1	Not very often	1
No, never	0	No, not at all	0
4. I have been anxious or worried for no good reasons:		**9. I have been so unhappy that I have been crying:**	
No, not at all.	0	Yes, most of the time	3
Hardly, ever	1	Yes, quite often	2
Yes, sometimes	2	Only occasionally	1
Yes, very often	3	No, not at all	0
5. I have felt scared or panicky for no very good reason:		**10. The thought of harming myself has occurred to me:**	
Yes, quite a lot	3	Yes, quite often	3
Yes, sometimes	2	Sometimes	2
No, not much	1	Hardly ever	1
No, not at all	0	Never	0
TOTAL /30			

Guidance notes for the Edinburgh Postnatal Depression Scale (EPDS)

The EPDS is a self-rated questionnaire that may be used in the antenatal and postnatal period as an aid to clinical monitoring and to facilitate discussion of emotional issues.

The EPDS score should not override clinical judgment.

Instructions for using the Edinburgh Postnatal Depression Scale:

- When to use the EPDS? At minimum, postnatally at 4-6 weeks and 3-4 months.
- The mother should complete the scale herself, unless she has limited English or has difficulty with reading. Many translations of the EPDS are available
- The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days.
- All the items must be completed.
- Care should be taken to avoid the possibility of the mother discussing her answers with others.

Scoring

- Maximum score is 30
- Always look at Question 10 (SUICIDAL thoughts)
- Cut-off score for postnatal depression is often suggested to be 12 or 13

Positive Predictive Value (PPV)

Cut-off value 9-10: PPV ranging from 9-64% for major postnatal depression

Cut-off value 12-13: PPV ranging from 17-100% for major postnatal depression

Cut-off value 14-15: PPV ranging from 60-80% for major antenatal depression

Appendix 6: NHS Lanarkshire Perinatal Group

NHS Lanarkshire Perinatal Mental Health Special Interest Group

Dr Amanullah Durrani	Consultant Psychiatrist
Helen Sloan	Senior Charge Nurse
Liz Troy	Community Psychiatric Nurse
Christine MacKay	Midwife
Marjorie Baxter	Secretary
Kevin O'Neill	Public Mental Health & Well-being Development Manager

NHS Lanarkshire Perinatal Mental Health: ANPN Integrated Care Pathway and Resource Pack

In addition to the above members,

Fiona Gray	Health Visitor, Best Possible Start
Jacqueline Smith	Midwife Best, Possible Start
Sandra MacInnes	Programme Manager, Best Possible Start

Perinatal Mental Health Service

Dr Amanullah Durrani	Consultant psychiatrist
Helen Sloan	Senior Charge Nurse
Liz Troy	Community Psychiatric Nurse
Kathryn Thomson	Secretary
Paula McDaid	Service Manager
Karen McIntyre	Senior Nurse

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History of Perinatal mental health activity in NHS Lanarkshire

In the mid-1990s, CPNs and Health Visitors from NHS Lanarkshire initiated a number of groups and training initiatives in the field of Perinatal Mental Health. A brief history is as follows:

1993	First 'Life after Birth' group was set up jointly by CPNs and HVs in Cumbernauld Audited in 1994, published by Clinical Resource and Audit Group (CRAG) in 1995 and presented at the national conference by CPNs Rene Rigby and Elaine Clark ❖ Isobel Caskie HV and Elaine Clark CPN presented the model at various national conferences ❖ Model rolled out by CPNs and HVs in other parts of Lanarkshire, over the next 4 years
1996	CPNs started to input to Parent Craft classes to raise awareness about Perinatal Mental Health
2000	Perinatal Mental Health Training developed with Bell College for HVs, Midwives and CPNs
2004	Perinatal Mental Health guidance was developed by NHS Lanarkshire in response to SIGN 60
2004	Perinatal Link CPNs established in all CMHTs within Lanarkshire
2005	Integrated Care Pathway (ICP) group established and links made with Mother and Baby Unit at Southern General Hospital
2006	Local Network set up for Midwives, HVs and CPNs
2007-09	ICP (Antenatal and Postnatal Mental Health) draft produced in 2007, completed 2009
2010	Formation of NHSL Perinatal Mental Health Special Interest Group
Nov 2011	First NHSL Perinatal Mental Health Conference organised at Wishaw General Hospital
Jan 2013	ICP NHSL Antenatal and Postnatal Mental Health Review group formed
Mar 2013	Second NHSL Perinatal Mental Health Conference organised at Excelsior Stadium, Airdrie
June 2013	Establishment of Perinatal Link CPN network
Nov 2013	Development of NHSL Perinatal Mental Health Resource Pack
Nov 2014	Start of pilot Lanarkshire Perinatal Mental Health Service

Appendix 7: useful resources

Information for Patients

Royal College of Psychiatrists. Click 'Postnatal Mental health'
www.rcpsych.ac.uk/healthadvice/problemsdisorders.aspx

Scottish Intercollegiate Guidelines Network (SIGN)
Patient booklet : www.sign.ac.uk/guidelines/fulltext/127/
Direct download: www.sign.ac.uk/pdf/PAT127.pdf

Maternal Mental Health Scotland
www.maternalmentalhealthscotland.org.uk

Bipolar Scotland
www.bipolarscotland.org.uk

Scottish Association for Mental Health
www.samh.org.uk

Lanarkshire Association for Mental Health
www.lamh.org.uk

NHS 24 Living Life - Cognitive Behavioural Therapy (CBT) telephone service
www.nhs24.com/UsefulResources/LivingLife

Living Life to the Full - CBT Life Skills Online course
www.llttf.com

Beyond Blue
www.beyondblue.org.au

NHS Inform: Health information you can trust
www.nhsinform.co.uk/health-library/subjects/mental-health

NHS Inform: Information about medication
www.choiceandmedication.org/nhs24

Breathing Space
www.breathingspacescotland.co.uk

Information for Professionals

Royal College of Psychiatrists
www.rcpsych.ac.uk/workinpsychiatry/faculties/perinatal/perinatallinks.aspx

Scottish Intercollegiate Guidelines Network (SIGN)
www.sign.ac.uk/guidelines/fulltext/127/

National Institute for Health and Care Excellence (NICE)
www.nice.org.uk/guidance/cg45

Action Postpartum Psychosis (APP)
http://www.app-network.org/

Information for Lanarkshire

NHS Lanarkshire Staff: Firstport Mental Health
http://firstport2/staff-support/mental-health/default.aspx

Lanarkshire Links
www.lanarkshire-links.org.uk

element: eLanarkshire Mental Health resources
www.element.org.uk

Self help: Well Connected programme
www.element.org.uk/self-help-resources/well-connected-programme.aspx

Recovery stories of women experiencing Perinatal Mental Health difficulties
(recorded for NHSL Perinatal Mental Health Conference 2013)

www.element.org.uk/lanarkshire-recovery-network/lanarkshire-recovery-stories/perinatal-mental-health-recovery-stories.aspx

GIRFEC Lanarkshire
www.girfecinlanarkshire.co.uk

GIRFEC (Getting it right for every child)
http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright

Services

West of Scotland Mother & Baby Unit
Includes Referral details and Virtual video tour of unit
www.nhsggc.org.uk/content/default.asp?page=s599_8_1

Bluebell PND Counselling
www.crossreach.org.uk/bluebell-pnd-service

Contacts

Recommended reading

Confidential Enquiries into Maternal Deaths in the UK
www.hqip.org.uk/cmace-reports/