Perinatal Mental Health Integrated Care Pathway

Printed copies must not be considered the definitive version

DOCUMENT CONTROL		
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Contents

Introduction and Background	4
Purpose and Scope	5
Objectives	5
Evidence based practice	6
Reducing Inequalities	6
Third Sector Engagement	7
Lived Experience	7
Service Evaluation	7
Referral Process Flowchart	8
Key Messages for Care for Preventing Maternal Deaths by Suicide	9
Referral Guidance	10
Care Planning and Review	13
Admission to Hospital	14
Mental Health Disorders Managed in Primary Care	16
Psychological Services	17
Infant Mental Health	19
Perinatal Occupational Therapy	21
Appendices Content List	22
Medicine Pathway	23
Preconception Advice	25
Screening Measures	29
Edinburgh Postnatal Depression Scale (EPDS)	30
Referral Guidance Notes for Midwives/Health Visitors/Family Nurses	32
Guidance for all staff with concerns for a child or adult	33
Contact Numbers	34
Identification of Perinatal Mental Illness	39
Glossary of Terms	43
Midpark Hospital Admission & Discharge Checklist	44
Pre-birth Mental Health Review	48
Links and Resources	51

INTRODUCTION

One in five women may experience mental illness or distress during their pregnancy and the first postnatal year (The Scottish Government, 2020). The perinatal period is acknowledged as a uniquely vulnerable time for development of severe mental illness for some groups of women (Jones, et al, 2014). Women with pre-existing mental health conditions can experience an exacerbation or complete relapse in symptoms during the perinatal period. Women with diagnoses such as bi-polar disorder and schizophrenia are at increased risk of developing mental illness in the post natal period (Royal College of Obstetricians and Gynaecologists, 2015).

Protection of mental health during the perinatal period is of significant importance, not only for the wellbeing of mothers, but for the parent-infant relationship (Love and McFadden, 2020). Not recognising and treating mental health in the perinatal period can impact on physical and mental health outcomes in the long term for mothers and babies (NHS Education Scotland, 2019). Maternal suicide is the leading cause of death occurring in the first year post birth (MBBRACE-UK, 2021).

For ease and clarity of writing we use the terms woman/women within these documents. Within this we acknowledge that not all birthing people identify as women.

We use the term 'Partner' throughout to be inclusive of LGBTQ+ partners, heterosexual partners and fathers.

BACKGROUND

The Perinatal Mental Health Network Scotland aims to develop and improve access to perinatal mental health care and access to treatment for women, infants and families during pregnancy and in the post birth period. This followed a mapping and gapping exercise of provision of perinatal mental health services across Scotland from 2017-2018. They aim to ensure equity of care and focus on working in partnership, developing professional expertise and delivering best outcomes (NHS Scotland, 2020). In 2019 the Perinatal and Infant Mental Health Programme Board was launched to oversee and provide strategic leadership and overall management

for improving perinatal and infant mental health services (The Scottish Government, 2020).

PURPOSE AND SCOPE

This pathway aims to ensure a standardised and quality assured approach to women who have, or are at risk of developing perinatal mental health problems. This pathway covers the patient journey from the pre-pregnancy stage to one year following birth.

The scope of this pathway is specifically for women where there are concerns about their mental health, and is not intended to cover the whole spectrum of care for pregnant and post natal women. Individual operational policies and practices for each professional group will continue to apply for women out with this pathway.

OBJECTIVES

- To promote a seamless, flexible and high quality responsive care for all women in the perinatal period.

- To improve the identification, detection and care of women who have or are at risk of developing perinatal mental health problems, whilst pregnant and up to a year after delivery.

- To ensure that women who may be vulnerable to perinatal mental health difficulties have their needs identified before becoming pregnant or at an early stage in their pregnancy, to allow appropriate supports to be put in place.

- To support women and their families to be involved in discussions about their care and treatment options.

- To support good practice by improving identification and early intervention for children and families who may be affected by perinatal mental health issues.

- To advocate that practitioners who are supporting women and their families in the perinatal period have the appropriate skills and expertise through training, consultation and development to meet the needs of women who may experience mental health issues, and also how this may impact on the welfare of the child/children.

- To ensure that information is documented and shared appropriately with all relevant practitioners providing care to the woman; this is stored within Clinical Portal and BadgerNet and enables coordinated care and inter professional communication.

- To ensure all care is trauma informed.

Evidence Based Practice

The Perinatal Mental Health Service will be guided by both SIGN 169 Perinatal Mental Health Conditions (Dec 2023) and the Matrix: A Guide to Delivering Psychological Therapies.

Reducing Inequalities:

- The Service provides comprehensive assessment and intervention appropriate to individual needs, taking into account age, culture, disability and gender.

- The service will reach out to potentially vulnerable groups. These groups include: individuals and families from all ethnic groups / LGBTQ+ families / Young parents / Older parents (over 35) / Care Leavers / Women with Neuro Diversity / Women with disabilities / Women from impoverished backgrounds / Women from the Traveller and Gypsy community.

- Women will be offered the choice of face to face and / or Near Me Video consultation depending upon their preference.

Third Sector Engagement

- The Perinatal Mental Health Service has quarterly link meetings with the main PNIMH Third Sector Organisations in Dumfries and Galloway (including Aberlour, Homestart, Action for Children, Bump, Baby and Beyond, Women's Aid, Rape Crisis, User and Carer Involvement and Sands).
- The Perinatal Mental Health Service offers training to Third Sector groups on Perinatal Infant Mental Health and the remit of the service.
- Please consider the role of Third Sector Organisations as a support for women / people accessing mental health services.

Please see Third Sector resource list in Appendix 5.

Lived Experience

- Families with lived experience are involved in the development and monitoring of the service

- Volunteers with lived experience contribute to ongoing service development

Service Evaluation

- Patient feedback is evaluated using Care Opinion and the Patient-rated Outcome and Experience Measure (POEM)

- Referrers are sent a Satisfaction Questionnaire every quarter

Perinatal Infant Mental Health Service Referral Pathway

Mental Health Nurse/Psychiatry/OT Referral
Accepted via CMHNT'S Generic Email's and Sci Gateway ***the perinatal service does not accept direct referrals for nursing/OT or medication advice***
Request can be made by NHS and Social Work staff

Request for Consultation
dg.perinatalmhs@nhs.scot

Perinatal/Maternity Neonatal Psychological Interventions :Referral Accepted via dg.perinatalmhs@nhs.scot and Sci Gateway

Request for Consultation
Most appropriate clinician responds to request.

Request for Medicines Advice from Sector Psychiatrist

Request for PNMHN Shared care assessment

NFA or Signpost to appropriate service

Assessment, formulation and intervention as appropriate. Transfer to AMH Psychology if issues not related to perinatal period

Assessment

Outcome of Assessment & Risk Assessment
Consider role of Social Work if there are Adult or Child Protection concerns

Mild difficulties

Signpost to Primary Care/ Self help materials/ Silvercloud Computerised CBT

Consider **Third Sector input**

Moderate difficulties
CMHNT/ Senior Perinatal MH Nurse shared care perinatal care plan around 30-32 weeks)

Severe/ Complex Difficulties
CMHNT/ Senior Perinatal MH Nurse Perinatal care plan (at around 30-32 weeks of pregnancy)

Consider Referral to Perinatal/ MNPI/ Adult Mental Health **Psychology**
Consider Referral to Perinatal Occupational Therapy

Significant Risk/ Red flags

Consider **Mother and Baby Unit** (Leverndale & St Johns) **Midpark** if no MBU availability. **Consider crisis team home based treatment**

Care Planning for Discharge back to CMHNT/ Senior Perinatal MH Nurse

Concerns about Parent Infant Relationship
Referrals to Infant Mental Health Service dg.infantmentalhealthservice@nhs.scot

KEY MESSAGES FOR CARE FOR PREVENTING MATERNAL DEATHS BY SUICIDE

The following are 'red flag' signs for severe mental illness and require urgent senior psychiatric assessment:

- Recent significant change in mental state or emergence of new symptoms
- New thoughts or acts of violent self harm
- New and persistent expressions of incompetency as a mother or estrangement from the infant
- Repeated reports of concern

Admission to a mother and baby unit should always be considered where a woman has any of the following:

- Rapidly changing mental state
- Suicidal ideation (particularly of a violent nature)
- Pervasive guilt or hopelessness
- Significant estrangement from the infant
- New or persistent beliefs of inadequacy as a mother
- Evidence of psychosis

Mental Health assessments should always include a review of previous history and take into account the findings of recent presentations and escalating patterns of abnormal behaviour.

Investigations into deaths from psychiatric causes at any stage during pregnancy and the first postnatal year should be carried out and should be multi-agency and include all services involved in caring for the woman.

MBRRACE-UK Perinatal Mortality Surveillance: UK Perinatal Deaths for Births from January to December 2021.
https://www.npeu.ox.ac.uk/mbrrace-uk/reports

See Identification of Perinatal Mental Illness (Appendix 6) for information around signs and symptoms of mental illness.

PERINATAL MENTAL HEALTH SERVICE

The Perinatal Mental Health service is directly involved in the care of women who have previous/current significant mental health issues and are currently pregnant or within the first year post birth, or women who have current involvement with the mental health services and are requiring preconception or antenatal advice.

Shared Care Model – Community Mental Health Nursing Team (CMHNT)

Referral guidance to CMHNT (pre birth)

- Severe or complex mental health disorders including:
    - Schizophrenia
    - Bipolar Disorder Type 1
    - Bipolar II if symptomatic
    - Moderate/severe depression with current significant impact on functioning and/or persistent suicidality and self harm
    - Severe anxiety disorder including OCD and PTSD with significant impact on functioning or persistent high levels of distress
    - EUPD with risk of destabilizing in the perinatal period and/or high levels of distress and significant impact on functioning
    - Persistent suicidal thoughts
    - New significant self harm
    - Eating disorders – moderate/high risk on ED physical risk assessment
    - Recent discharge from mental health inpatient care in current pregnancy

- Currently well but high risk of developing severe perinatal mental health disorder:
    - Previous post partum psychosis or other episodes of psychosis
    - History of severe/psychotic depression
    - History of post natal depression with significant impact on functioning and risk to woman and/or baby
    - History of severe anxiety disorder with significant impact on functioning and risk to woman and/or baby

- *Discussion with CMHNT may be helpful for perinatal women who are currently well with previous moderate illness which was prolonged and had significant impact, for planning and advice including about medication*.

- Preconception advice for women with severe mental health disorders including those currently stable on medication.

Women who are currently well with no psychiatric history but with a family history of a first degree relative with psychosis, bipolar disorder or post partum psychosis can be offered an appointment for assessment by the Senior Perinatal Mental Health Nurse where education and planning advice will be provided. Care to remain with midwife and GP unless concerns arise.

Referral guidance to CMHNT (Post birth)

- As per pre-birth criteria, and in addition:
    - Development of high levels of persistent distress, new anxiety and depression causing significant impairment in functioning or concern about risk to woman or baby.
    - Detachment from baby, poor bonding in the presence of mental health disorder
    - New persistent expressions of incompetence as a mother and estrangement from infant in addition to general concerns regarding mental health
    - Repeated referrals and/or expressions of concern regarding mental health

    - *Post partum (or puerperal) psychosis typically presents in the early post natal period usually within days or weeks of delivery however can occur at any time up to about 6 months post birth. It is characterised by fluctuating presentation/mental state including bizarre ideas/behaviour, confusion/disorientation, hallucinations/delusions, restlessness, agitation, behaviour appearing out of touch with reality, may not respond to needs of baby, irrational fearfulness, inability to sleep, elevated mood/manic behaviour.*

Referral Process to CMHNT/Senior Perinatal Mental Health Nurse (SPMHN)

Referrals should be made to the patient's local CMHNT. Referrals can be made by GP's and Medical Staff via Sci Gateway. Midwives/Health Visitors can refer by way of email to the CMHNT's

Generic email address. Colleagues within mental health services can refer using Sci Gateway or the Generic email address.

New Referrals:

- **Perinatal mental health referrals are received by the CMHNT and triaged by CMHNT**. CMHNT's to share referral information with the Perinatal Mental Health Service via their generic email – dg.perinatalmhs@nhs.scot
- The SPMHN offers joint assessments within the CMHNT joint assessment clinics alongside the CPN and medical staff and can provide Nurse Led Assessments within **6 weeks** of referral. To request this, the CMHNT should email the Perinatal Mental Health Service generic email box – dg.perinatalmhs@nhs.scot and request that the Senior Perinatal Mental Health Nurse contacts the department to liaise regarding assessment date/time.

  ASSESSMENTS SHOULD NOT BE DELAYED in the absence of the SPMHN or in a delayed response from the service.

- Following joint assessment and if further input is appropriate, a collaborative care plan will agree the level of input from both the SPMHN and CMHN with regards to key worker and co-worker roles. At a minimum the SPMHN can offer input at the pre-birth review and a post natal visit. Depending on the complexity of needs, the SPMHN can provide additional input up until one year post birth. The patient's care should remain fully with the CMHNT and Sector Psychiatrist.

Routine referrals of perinatal patients to mental health services should be assessed within 6 weeks of referral, but with capacity to be assessed within 2 weeks of referral if required. Where there is clinical urgency, the usual crisis CMHT procedures should be followed.

Existing CMHNT Patients

- CMHNT's can contact the perinatal mental health service via the generic email box – dg.perinatalmhs@nhs.scot to make a request for SPMHN involvement.
- The SPMHN can offer a joint visit with the CPN to meet with the patient. Input from the SPMHN can be offered the same as a new referral.

Unscheduled care/crisis

Referrals to unscheduled care as follows:

- Crisis Team – phone via DGRI Switchboard and discuss advice/referral with the team.
- Mental Health Liaison Team – phone via DGRI Switchboard and discuss advice/referral with the team.
- Depending on scheduled care commitments, the SPMHN may be able to offer joint assessment with unscheduled care staff. Staff can contact the Perinatal Mental Health service via the generic email box dg.perinatalmhs@nhs.scot to make a request for involvement. The email can also be followed up by directly contacting the SPMHN via telephone or via Teams.
- **CRISIS ASSESSMENTS SHOULD NOT BE DELAYED** in the absence of the SPMHN or in a delayed response from the service.

Please see referral guidance notes in appendix 6 for information around what to include in referrals.

CARE PLANNING AND REVIEW IN COLLABORATION WITH THE WOMAN, PARTNER/SUPPORT NETWORK, MDT AND MULTI-AGENCY SERVICES INVOLVED

- Identify needs, set realistic and achievable outcomes and clearly identify intervention and timescales.
- Keep named person (Midwife or HV) and GP informed.
- Between 28 and 32 weeks pregnant – develop plan for late pregnancy and early postnatal psychiatric management via pre birth review. Please see pre-birth review guidance (Appendix 10).

MEDICINE

Please see Medicine Pathway (Appendix 1)

DISCHARGE

- Follow up can be provided up to 12 months post birth by SPMHN. At the point of discharge a Multi Disciplinary Team (MDT) review including woman, partner, HV can be held if required. GP should be notified of discharge plan. If requiring ongoing input after the year post birth this would be provided by the CPN and CMHNT.

ADMISSION TO HOSPITAL

Where inpatient admission is required, consideration as to whether this should be:
Admission to the Mother and Baby Unit - Leverndale Hospital, Glasgow or St John's, Livingston, which enables mothers to stay with their babies while they undergo treatment. Maintaining this contact is critical to the wellbeing of both mother and baby, as it not only aids the recovery process but also helps strengthen future relationships.

Or

Local - with the mother being admitted to Midpark Hospital with alternative arrangements (e.g. extended family, kinship care, foster care etc. being made for the baby by the CFSW team.

Those involved in the transfer of care from one setting to another (i.e. Women and Children's DGRI to Midpark; Women and Children's DGRI to MBU; Midpark to MBU or home to MBU) must make sure all relevant information is transferred to ensure continuity of care. Transition SBAR from Midpark to MBU and CMHNT to MBU. Similarly, discharge has to be planned, ensuring all professionals and interagency colleagues involved are aware of what is happening and prepared to pick up the care provision whatever day of the week it is, ensuring that appropriate services are in place to support the mother and the family.

On-going risk assessment, risk management, care planning and sharing of information are essential.

For admissions to Midpark Hospital there is an Admission & Discharge Checklist for staff to complete – See appendix 8.

When hospital admission is required either locally or out of region, contact must be made with the CFSW team or MASH and discussion should take place about whether a Request for Assistance referral is required (p32).

Out of Hours teams should ensure patients requiring perinatal specialist care are referred the next working day.

Consultation

The SPMHN can offer advice and supervision to staff and this can be arranged by contacting the generic email address – dg.perinatalmhs@nhs.scot

Mental Health disorders managed in Primary Care - Pre/Post birth

- Currently well but previous perinatal mental illness treated by GP, Primary Care Mental Health Nurse, Maternity and/or Health Visitor and patient is making a request for planning advice.

- Mild/moderate mental health problems including:
    - Mild/moderate anxiety disorders (including Obsessional Compulsive Disorder, Post Traumatic Stress)
    - Mild/moderate depression
    - Emotionally Unstable Personality Disorder (EUPD) with no current significant impact on functioning or high levels of distress. Not on CMHNT waiting list for Structured Clinical Management. Recent sustained period of stability.

- Fleeting suicidal thoughts and minor self harm

- Eating disorders – low risk on ED physical risk assessment

- Medication advice for those with mild to moderate depressive and anxiety disorders likely to be managed by Primary care (including pharmacists who can give mental health pharmacy advice), but can be escalated to secondary care for advice if necessary.

PSYCHOLOGICAL SERVICES

The Perinatal Psychological Interventions (PPI) and Maternity and Neonatal Psychological Interventions (MNPI) service offers consultation, assessment and evidence based interventions.

This service aims to offer an assessment within 6 weeks of referral. If the referral is more appropriate for Adult Mental Health Psychology (AMH), priority on the AMH waiting list will be determined case by case.

The following guidance will help differentiate whether Perinatal Psychology, Maternity and Neonatal Psychological Interventions or Adult Mental Health Psychology/Other specialist Psychology service would be most appropriate.

Perinatal Psychology/MNPI may be appropriate for individuals where there is one or more of the following:

- Complex or severe mental health difficulties that have arisen during the perinatal period and directly relate to the experience of becoming a parent
- Complex or severe mental health difficulties that are having a significant impact on the relationship with the foetus/baby
- Long standing mental health difficulties that have been **significantly** exacerbated by the pregnancy/postpartum experience
- Women with complex needs arising from pregnancy and birth complications or loss, or previous pregnancy complications, loss or birth trauma affecting mental health in the current pregnancy
- Women with significant difficulties amenable to psychological therapies, which directly affect maternity care (e.g. needle phobia, tokophobia) or complex problems of adjustment to pregnancy and childbirth
- Birth parents whose infant's health is significantly compromised requiring neonatal care

Perinatal/MNPI Psychology will not be appropriate:

1. If the presenting issues are long-standing and unrelated to the perinatal period
2. If input required is long term and will most likely extend beyond child's first birthday
3. If a lower intensity psychological intervention would be more appropriate (see below)
4. If the issues relate more to the parent –infant relationship. If this is the case Infant Mental Health Psychology would be more appropriate

Requests for Consultation:

- Psychology can provide support to staff within Neonatal and Maternity Services working with individuals struggling to adjust to pregnancy and infant care
- Psychology can provide supervision, advice and consultation to staff in relation to low intensity psychological interventions
- Requests for consultation can be made to dg.perinatalmhs@nhs.scot

Requests for Referral:

- All cases should be discussed and accepted prior to a referral being completed
- Requests for service are accepted from: Midwives and Obstetricians/Health Visitors/Family Nurses/GP's/Neonatal Unit /Adult Mental Health (Psychology, Secondary Care, Inpatient)/ Mother and Baby Unit/others through discussion
- Completed referrals should always be sent to dg.perinatalmhs@nhs.scot or via Sci Gateway to Adult Mental Health Psychology
- Please also note that women will only be offered an assessment around suitability for a psychological therapy in the first instance. It is important to manage expectations
- Psychology within the team delivers high intensity psychological therapies. Individuals who require low intensity psychological interventions would not routinely be seen by a Psychologist
- Psychology within the team does not offer Parenting Capacity Assessments but may offer consultation if the mother is engaged in Psychological Therapy within the PMHS

INFANT MENTAL HEALTH

As part of the Perinatal and Infant Mental Health Service our Wee Mind's Matter Infant Mental Health team can provide a service as outlined below:

WEE MINDS MATTER - INFANT MENTAL HEALTH

Wee Minds Matter is an infant mental health service for infants and their primary caregivers from birth to third birthday. The service offers consultation, assessment and evidence based interventions where concerns are identified regarding the infants emotional state and/or the caregiver – infant relationship.

Wee Minds Matter works closely with the Perinatal Mental Health Service. The services work to ensure that infant's emotional and relational needs are being met in the context of their relationship with their primary carer. This is particularly important when there are maternal mental health difficulties. Weekly Multi Disciplinary meetings are held to discuss cases and initiate referrals between the two services. Joint working occurs where appropriate.

Wee Minds Matter may be appropriate where the following criteria are met:

- The infant is under the age of 3 (up to 3rd birthday)
- The infant is a resident in Dumfries and Galloway
- The infant is displaying significant emotional and/or behavioural difficulties in line with key indicators, relationship with main caregiver, emotional or cognitive functioning, sense of self and social interactions
- Difficulties are related to or impacting on the infant-parent/carer relationship.

Wee Minds Matter will not be appropriate when:

- The infant's difficulties are not related to the infant-parent/carer relationship
- The primary concerns are about the parent's mental health
- The infant's difficulties are not related to the key indicators for infant mental health: relationship with main caregiver, emotional or cognitive functioning and sense of self and social interactions

Requests for Consultation:

- Wee Minds Matter can provide consultation to staff working within Children and Adult Services within the Council, Health and Third Sector.
- Requests for consultation can be made to dg.infantmentalhealth@nhs.scot

Requests for Referral:

- All cases should be discussed and accepted prior to a referral being completed.

- Requests for input are accepted from all staff working within Children and Adult Services within the Council, Health and Third Sector.
- Completed referrals should always be sent to dg.infantmentalhealth@nhs.scot or via Sci Gateway to Child Psychology
- Wee Minds Matter does not offer Parenting Capacity Assessments

PERINATAL OCCUPATIONAL THERAPY

The journey to motherhood is associated with many significant changes in daily routines, roles, relationships and responsibilities. The Perinatal Occupational Therapist works alongside women providing practical support to help people experiencing perinatal mental health difficulties on a range of activities:

- Self-care occupations: hygiene, eating, sleeping and exercise
- Productive occupations: household management, shopping, meal preparation
- & work tasks
- Leisure occupations: hobbies and spending time with loved ones, parent and
- baby groups
- Parenting occupations: feeding, changing and playing with baby
- Help with role change
- Education and coping strategies for depression, anxiety, isolation etc
- Help establishing healthy coping habits
- Establishing occupational balance

Referral process:

Referrals to Perinatal OT are received from the Perinatal and Infant Mental Health Service.

APPENDICES CONTENT LIST

Appendix 1: Page 23
Pathway for medicines advice for psychiatric medications in the perinatal period

Appendix 2: Page 29
Screening Measures

Appendix 3: Page 32
Referral Guidance Notes for Midwives/Health Visitors/Family Nurses

Appendix 4: Page 33
Guidance for all staff (including NHS24 and NHS D&G ED staff) with concerns for a Child or Adult

Appendix 5: Page 34
Contact Numbers

Appendix 6: Page 39
Identification of Perinatal Mental Illness

Appendix 7: Page 43
Glossary of Terms

Appendix 8: Page 44
Midpark Hospital Perinatal Mental Health Admission & Discharge Checklist

Appendix 9: Page 48
Pre-birth Mental Health Review

Appendix 10: Page 51
Links and Resources

APPENDIX 1

Pathway for medicines advice for psychiatric medications in the perinatal period

We are aware that GP's are involved in helping women to make decisions about medical treatment for the above conditions, whilst they are in the perinatal period. GPs are also providing the bulk of preconception medication advice. Midwives, primary care pharmacists and primary care mental health nurses play an important role in terms of supporting women, signposting and collecting information to help treatment decisions.

The purpose of this guidance, published by the Perinatal Mental Health team, is to support primary care clinicians in their management of perinatal mental health conditions and prescribing.

General information regarding perinatal mental health prescribing, which may aid in decision making, is available through the following resources:

1. www.choiceandmedication.org/nhs24. (Provides good quality, readable, patient leaflets specifically about drugs in pregnancy. 'Handy chart' leaflets compare medicines for different conditions in pregnancy e.g. handy chart on medicines for depression. There are also specific medication leaflets with information about that medicine in different stages of pregnancy and in breastfeeding).
2. Best use of medicines in pregnancy (BUMPS) www.medicinesinpregnancy.org. Provides detailed patient leaflets with summaries of information of known risks of medication and highlights where risks are unknown. Useful for professionals to read prior to seeing patient and talking through information.
3. The UK tetralogy information service- provides information for health professionals on the safety of drugs in pregnancy.
4. LactMed the Drugs and Lactation Database of the US National Library of Medicine
5. https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/perinatal-mental-health-toolkit.aspx. A useful resource for GP's with multiple links for information in the perinatal period.

It is extremely helpful for decision making if the following information is included in an advice request:

A) Discussion Aide

- What is the current medication?
- What are they taking it for? What is the working diagnosis?
- Is it working? How is their mental health at the moment?
- Have they stopped it or reduced it before? What was the impact of that?
- Past psychiatric history i.e. information about how many episodes of illness before, and the severity. What treatment was necessary and what treatment helped in the past.
- What is the women's preference about medications? Do they want to stop it, happy to take advice, or would they prefer to continue?
- Are there any safety concerns should the woman stop medication?

Including this information will make it more likely that a reasonable and timely response can be made without the need to contact for further detail.

For women on antidepressants for mild/moderate depressive disorder or anxiety disorders who are pregnant:

For most women unless the indication for prescribing antidepressants was minor, advice to automatically stop antidepressants prior to discussion will rarely be warranted.

If antidepressants are discontinued at primary care, we would advise a plan for contact, and consideration of restarting medication if the woman's mental health deteriorates. Also consideration of whether restarting antidepressants post baby's delivery would be appropriate.

The perinatal service now includes a perinatal psychologist, and the psychology service will aim to triage women within 6 weeks if they are within the perinatal period. For some women consideration of psychological input if they want to consider an alternative to medication may be appropriate.

The discussion aide marked A above, gives questions to consider when discussing medications with women.

For patients now known to the CMHT. The local primary care (PC) pharmacist is the first point of contact if advice is sought specifically regarding medication in the perinatal period and the patient is not currently known to the CMHT. If the advice is more complex, the PC pharmacist can liaise directly with the specialist mental health pharmacy team.

For patients known to the CMHT, or if more general mental health advice is sought then an advice request should be made to your local CMHT via your usual channels. Advice requests for pregnant women should be treated as urgent and teams will aim to respond within 7 days. Once within the CMHT the member of staff doing triage should contact the mental health pharmacist or team psychiatrist to pass on the advice request. The advice request should not wait for discussion at the team meeting (due to the added delay this creates).

For patients who may need CMHT input, normal triage process is followed. If there is likely to be a delay prior to assessment, the aim should still be to give medication advice within one week.

For women with severe mood disorders, schizophrenia, bipolar, other current or past severe psychiatric disorders who are on medication who become pregnant or are seeking preconception advice:

In most cases women will remain on antipsychotic medication for schizophrenia and mood disorders during pregnancy. Lithium and clozapine will need careful consideration and management during pregnancy. Women of child bearing age should not be on Sodium Valproate for mood disorders, but if this were the case this would need urgent consideration.

If patient is already open to the CMHT or outpatient clinic. Please contact the team (via an advice request for G.P's) to let them know of pregnancy so that any medication issues can be considered.

Once within the CMHT the member of staff doing triage should contact the team psychiatrist in the first instance (or mental health pharmacist if psychiatrist is not available) to pass on the advice request. The advice request should not wait for discussion at the team meeting, and aim is for any interim advice given within one week.

If patient is not open to the CMHT or outpatient clinic: please refer to CMHT via normal process. If there is likely to be a delay prior to assessment, interim medication advice should still be given within one week. The member of staff doing triage should contact the team psychiatrist or mental health pharmacist prior to the team meeting.

Preconception Advice
GPs are providing the bulk of preconception medication advice. Midwives, primary care pharmacists and primary care mental health nurses play an important role in terms of supporting women, signposting and collecting information to help treatment decisions. General information regarding perinatal mental health prescribing, which may aid in decision making, is available through the following resources:

1. www.choiceandmedication.org/nhs24 (provides patient leaflets with decision making aids on medicines in pregnancy and concise readable information about specific medications).
2. Best use of medicines in pregnancy (BUMPS) www.medicinesinpregnancy.org- provides detailed patient leaflets with summaries of information of known and unknown risks of medication. Useful for professionals to read prior to seeing patient, and talking through information.
3. The UK tetralogy information service- provides information for health professionals on the safety of drugs in pregnancy.
4. LactMed the Drugs and Lactation Database of the US National Library of Medicine
5.https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/perinatal-mental-health-toolkit.aspx. A useful resource for G.P's with multiple links for information in the perinatal period.

It is extremely helpful for decision making if the following information is included in an advice request:

A. Discussion Aide
- What is the current medication?
- What are they taking it for? What is the working diagnosis?
- Is it working? How is their mental health at the moment?
- Have they stopped it or reduced it before? What was the impact of that?
- Past psychiatric history- i.e. information about how many episodes of illness before, and the severity. What treatment was necessary and what treatment helped in the past?
- What is the women's preference about medications? Do they want to stop it, happy to take advice, or would they prefer to continue?
- Are there any safety concerns should the woman stop medication?

Including this information will make it more likely that a reasonable and timely response can be made without the need to contact for further detail.

If antidepressants are discontinued in primary care, we would advise a plan for contact and consideration of restarting medication if the woman's mental health deteriorates. Consider whether psychological therapy would be appropriate as an alternative if symptoms recur and women do not want to restart medication in the perinatal period. Consider whether restarting antidepressants post delivery would be appropriate.

For women on antidepressants for mild/moderate depressive disorder or anxiety disorders where further advice is required:

For patients not currently known to the CMHT. If advice is sought specifically regarding preconception advice, the local primary care pharmacist is the first point of contact. If the advice is

more complex, the PC pharmacist can liaise directly with the specialist mental health pharmacy team.

For patients known to the CMHT or if more general preconception advice is sought then an advice request or referral should be made to your local CMHT via your usual channels.

Referrals should be triaged and discussed at team meeting as to whether this can be managed with remote advice or discussion, or whether an appointment with a psychiatrist is required.

For women with severe mood disorders, schizophrenia, bipolar, other current or past severe psychiatric disorders who are seeking preconception advice:

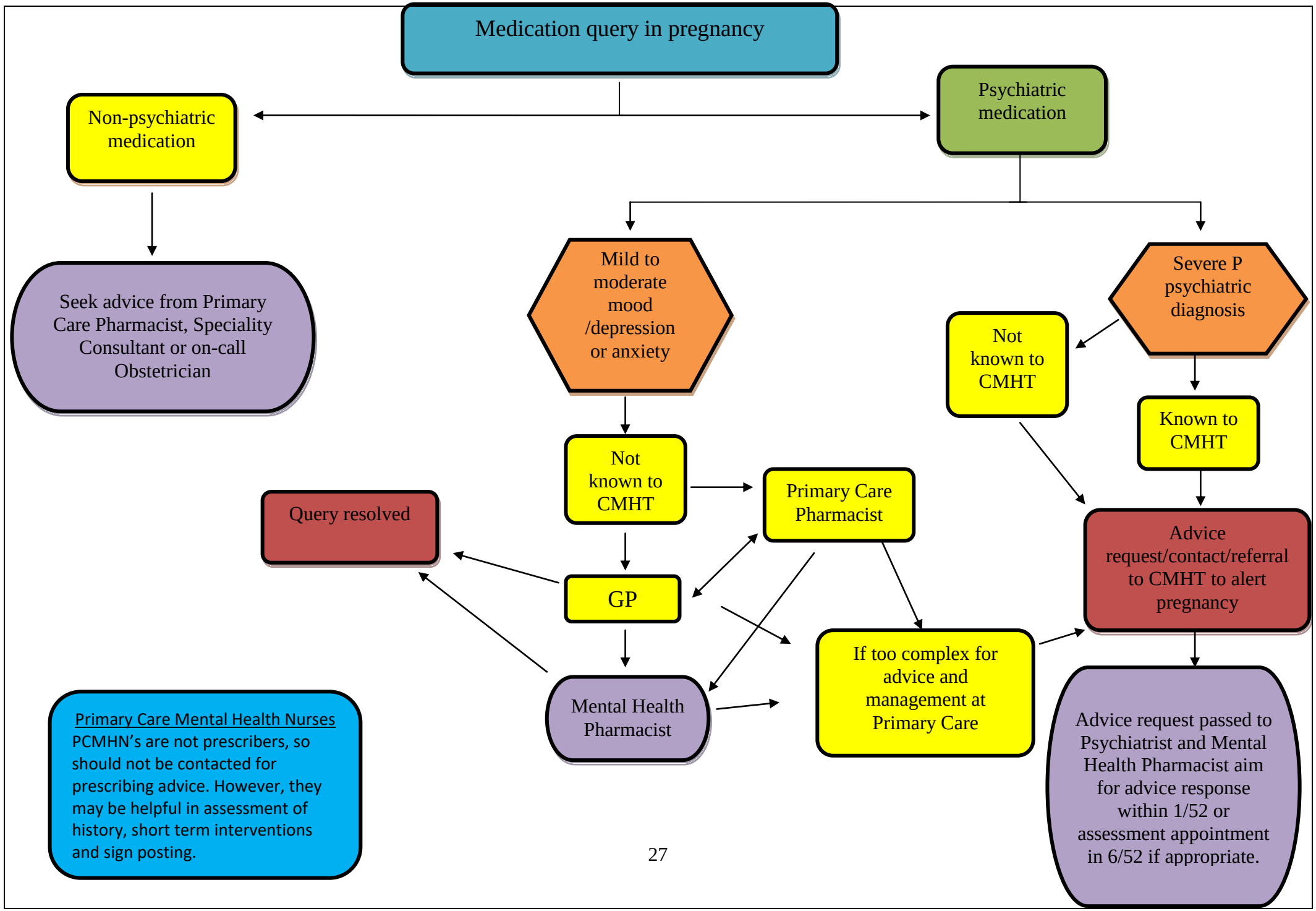
If patient is already open to the CMHT or outpatient clinic please contact the team (via an advice request for GP's) to let them know of request for preconception advice, and an appointment will be arranged.

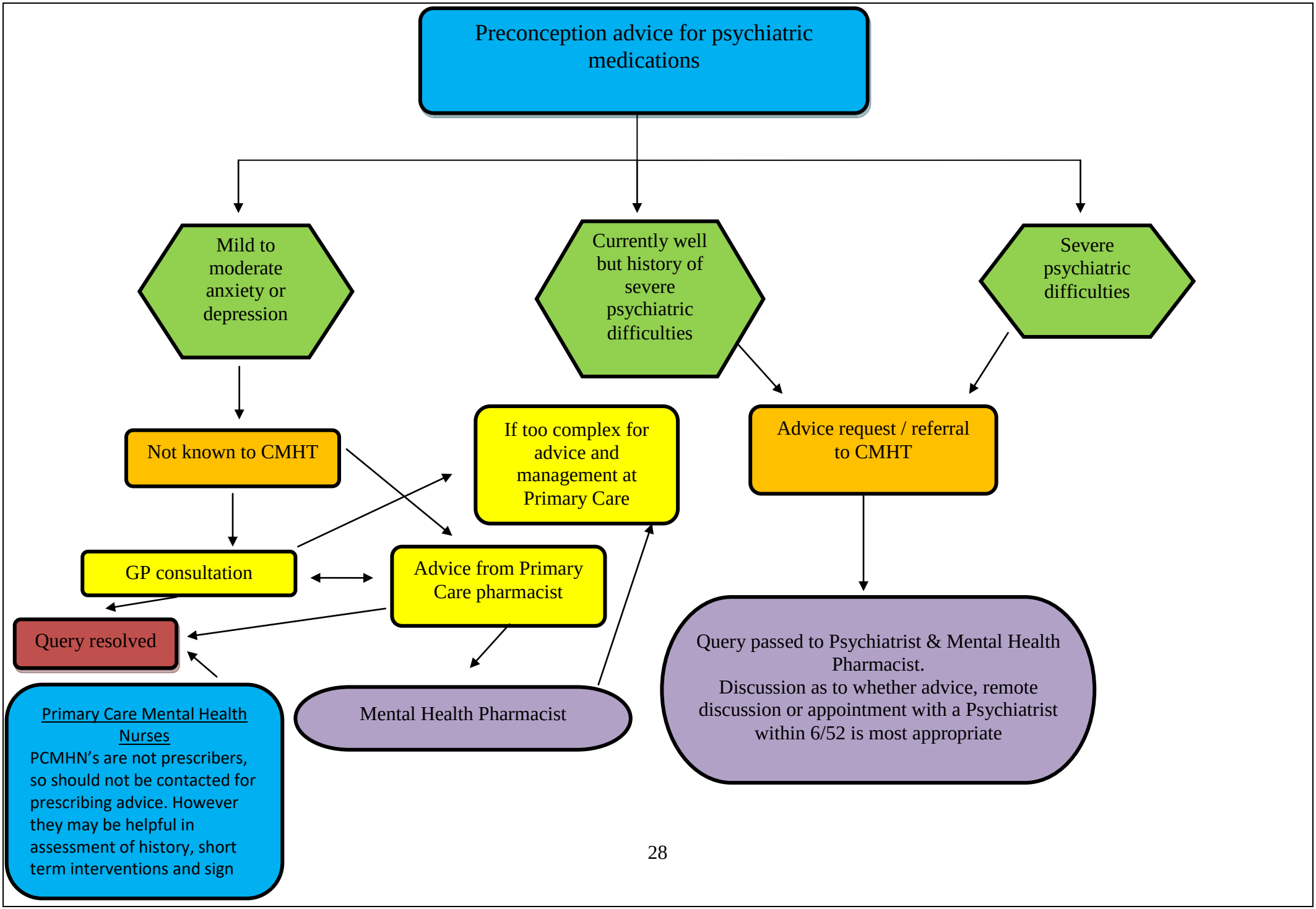
If patient is not open to the CMHT or outpatient clinic please refer to CMHT via normal process and an appointment will be arranged.

Currently this will be with the sector psychiatrist, but in future this may be offered by the perinatal psychiatrist.

For advice regarding non-psychiatric medications in pregnancy/pre-conception:
Primary Care pharmacists may be able to offer advice in the first instance. Speciality advice can be sought via advice request to the appropriate secondary care department (i.e. neurology, cardiology).

The obstetric on-call consultant is available, via DGRI switchboard, for any urgent advice for GP's, midwives or secondary care doctors. If advice is non urgent then refer to locality consultant obstetrician via the usual channels.


Medication query in pregnancy
Non-psychiatric medication
Psychiatric medication
Seek advice from Primary Care Pharmacist, Speciality Consultant or on-call Obstetrician
Mild to moderate mood /depression or anxiety
Severe P psychiatric diagnosis
Not known to CMHT
Known to CMHT
Not known to CMHT
Primary Care Pharmacist
Query resolved
GP
Advice request/contact/referral to CMHT to alert pregnancy
Mental Health Pharmacist
If too complex for advice and management at Primary Care
Advice request passed to Psychiatrist and Mental Health Pharmacist aim for advice response within 1/52 or assessment appointment in 6/52 if appropriate.
Primary Care Mental Health Nurses
PCMHN's are not prescribers, so should not be contacted for prescribing advice. However, they may be helpful in assessment of history, short term interventions and sign posting.


Preconception advice for psychiatric medications
Mild to moderate anxiety or depression
Currently well but history of severe psychiatric difficulties
Severe psychiatric difficulties
Not known to CMHT
If too complex for advice and management at Primary Care
Advice request / referral to CMHT
GP consultation
Advice from Primary Care pharmacist
Query resolved
Query passed to Psychiatrist & Mental Health Pharmacist.
Discussion as to whether advice, remote discussion or appointment with a Psychiatrist within 6/52 is most appropriate
Primary Care Mental Health Nurses
PCMHN's are not prescribers, so should not be contacted for prescribing advice. However they may be helpful in assessment of history, short term interventions and sign
Mental Health Pharmacist

APPENDIX 2: SCREENING MEASURES

Whooley/Anxiety Questions (Detection)

These are questions designed to detect ***possible*** depression in the antenatal and postnatal periods and are part of an assessment process.

The two questions relating to mental health and wellbeing 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?

The two questions relating to anxiety are:

Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious or on edge?
Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?

Clinical judgement should be exercised with these questions. If the professional strongly suspects the woman is depressed but she is answering “no” to the questions, a guided conversation may support a disclosure. If not, the questions should be repeated at subsequent visits. If significant concerns are present these concerns should be discussed with the GP.

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____ Phone: _____

As you have recently had a baby, we would like to know how you are feeling. Please tick the box to the answer which comes closest to how you have felt IN THE PAST 7 DAYS, not just how you feel today.

In the past 7 days ……..

1. I have been able to laugh & see the funny side of things
- ☐ As much as I always could
- ☐ Not quite as much now
- ☐ Definitely not as much now
- ☐ Not at all

2. I have looked forward with enjoyment to things
- ☐ As much as I ever did
- ☐ Rather less than I used to
- ☐ Definitely less than I used to
- ☐ Hardly at all

3. *I have blamed myself unnecessarily when things went wrong
- ☐ Yes, most of the time
- ☐ Yes, some of the time
- ☐ Not very often
- ☐ No, never

4. I have been anxious and worried for not good reason
- ☐ No, not at all
- ☐ Hardly ever
- ☐ Yes, sometimes
- ☐ Yes, very often

5. *I have felt scared or panicky for no good reason
- ☐ Yes, quite a lot
- ☐ Yes, sometimes
- ☐ No, not much
- ☐ No, not at all

6. * Things have been getting on top of me
- ☐ Yes, most of the time I haven't been able to cope
- ☐ Yes, sometimes I haven't been coping as well as usual
- ☐ No, most of the time I coped quite well
- ☐ No, I have been coping as well as ever

7. * I have been unhappy that I have had difficulty sleeping
- ☐ Yes, most of the time
- ☐ Yes, sometimes
- ☐ Not very often
- ☐ No, not at all

8. * I have felt sad or miserable
- ☐ Yes, most of the time
- ☐ Yes, quite often
- ☐ Not very often
- ☐ No, not at all

9. * I have been so unhappy that I have been crying
- ☐ Yes, most of the time
- ☐ Yes, quite often
- ☐ Only occasionally
- ☐ No, never

10. * The thought of harming myself has occurred to me
- ☐ Yes, quite often
- ☐ Sometimes
- ☐ Hardly ever
- ☐ Never

SCORING

QUESTIONS 1, 2, & 4 (without an *)
Are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.

QUESTIONS 3, 5 – 10 (marked with an *)
Are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.

Maximum score: 30
Possible Depression: 10 or greater

APPENDIX 3

REFERRAL GUIDANCE NOTES FOR MIDWIVES/HEALTH VISITORS/ FAMILY NURSES

- Description of main problem/difficulty and how this is impacting on the patient/baby
- How long symptoms have been present
- Any history of mental health problems
- Any family history of psychosis, bi-polar disorder, postnatal depression – these are high risk indicators.
- Any child protection involvement
- Any concerns around risk – suicidal thoughts, thoughts of harm to self or others
- Previous community health nursing team involvement
- Prescribed medications for mental health, any history of
- Does partner have current mental health problem
- Drug and alcohol use
- Social risks e.g. homelessness

Appendix 4: Guidance for all staff (including NHS24 and NHS D&G ED staff) with concerns for a Child or Adult

NHS Dumfries & Galloway

Telephone Social Work between 9-5pm on: 03033 333001
Or if Out of Hours: 01387-273660

Social Work will ask 7 questions to determine if the concern is Child/Adult Protection or a wellbeing concern:

1. What worries do you have that made you call us today?
2. How safe is the child/vulnerable adult?
3. How safe do you think they will be tonight and tomorrow if nothing changes?
4. How long have you been worried about this child/adult?
5. What are you most worried about?
6. What have you done to help?
7. What do you think given what you know about this child/adult/family that could be done to help?

For NHS D&G staff

Adult Protection Concern
Submit AP1 (Adult Protection Referral) form

On BEACON, click on the top menu bar and select 'I want to' and then 'Refer to Adult Support & Protection'. Complete referral form and press 'submit'.

Link to referral document on BEACON:
Click here

For NHS D&G staff

Child Protection/Child Welfare/ Wellbeing/GIRFEC Concern
Submit Request for Assistance Form within 48 hours of telephone call by email:

AccessTeam@dumgal.gov.uk
and it will be forwarded to the appropriate person

Copy the email to the Public Protection Team on:
dg.childprotectionteam@nhs.scot

Link to referral documents on BEACON: Click here

For NHS 24 staff

Adult or Child Concern
Submit NHS24 referral form by email to

AccessTeam@dumgal.gov.uk
and it will be forwarded to the appropriate person

Copy the email to the Public Protection Team on:
dg.childprotectionteam@nhs.scot

And any other relevant person, e.g. GP

If you have concerns for the immediate safety of an adult or child then phone the police on 999.

Health staff can contact the Public Protection Team for advice and /or support, Monday-Friday 9-5 on 01387 244300 or dg.childprotectionteam@nhs.scot or dg.asp@nhs.scot. For Out of Hours, the on call paediatrician can be contacted via the hospital switchboard on 01387 246246.

APPENDIX 5

CONTACT NUMBERS

CMHNTs

Annandale and Eskdale	01461 633291
Dumfries	01387 244428
Nithsdale	01387 244443
Stewartry	01556 505721
Wigtownshire	01776 707807

CMHT generic email address can be used for circulating relevant information, updates, etc

dg.cmhntdumfries@nhs.scot	Dumfries
dg.cmhntNithsdale@nhs.scot	Nithsdale
dg.cmhntAnnan@nhs.scot	Annandale
dg.cmhnt-Stewartry@nhs.scot	Stewartry
dg.cmhntWigtownshire@nhs.scot	Wigtownshire
dg.alt@nhs.scot	Mental Health Liaison Team

Mental Health Crisis Team

Via Hospital Switchboard	01387 246246
Mental Health Liaison	01387 246246
Psychiatry on call	01387 246246

Midpark Hospital

Ettrick Ward	01387 244156
Balcary Ward	01387 244190

Clinical Psychology

Adult Mental Health/Child/Health/ ID/Perinatal/IMH	01387 244495

Perinatal Mental Health Service

Generic Email Address	dg.perinatalmhs@nhs.scot
Advice Line – Every Thursday 9am – 10am	Via Hospital Switchboard

Public Protection Team

Link to the Public Protection page on BEACON: Click here

Public Protection Team	01387 244300 or internal 34300
Out of Hours Consultant Paediatrician on call	01387 246246

Request for Assistance – Child or Adult Concern

Access Team Social Work Monday – Friday 9am-5pm	030 33 333 001
Out of Hours Social Work	01387 273660
Send RFA by email to Access Team	AccessTeam@dumgal.gov.uk
Health Public Protection Team copy to	dg.childprotectionteam@nhs.net

CAMHS

01387 244662

Specialist Drug and Alcohol Services

01387 244555

Mother and Baby Units

Leverndale, Glasgow: 0141 2116539
St Johns. Livingstone: 01506 524175

Midwifery Teams

Red Team Community Midwives	01387 246963	dg.red-team@nhs.scot
Blue Team Community Midwives	01387 246964	dg.blue-team@nhs.scot
Yellow Team Community Midwives	01556 505711	dg.yellow-team@nhs.scot
Green Team Community Midwives	01776 707722	dg.green-team@nhs.scot
Orange Team Community Midwives	01461 202017	dg.orange-team@nhs.scot
WINGS Team	01387 241116 / 01387 244409	dg.wings@mhs.scot

Maternity

Maternity Suite	01387 241235
Birthing Suite	01387 241207/8
Neonatal	01387 241234

Health Visitors

Dumfries			
Gillbrae	07977812732	dg.gillbraehealthvisitors@nhs.scot	The Willows
Greyfriars	07977812780	dg.greyfriarshealthvisitors@nhs.scot	The Willows
Charlotte	07977812781	dg.charlottehealthvisitors@nhs.scot	Health Visitors Office
St Michaels, Lochthorn, New Abbey	07977812765	dg.stmichaelshealthvisitors@nhs.scot	Health Visitors Office
Upper Nithsdale			
Thornhill Health Centre	01848-332403	dg.uppernithsdale-hv@nhs.scot	Thornhill Health Centre
Cairn Valley	01848-332403	dg.uppernithsdale-hv@nhs.scot	Cairn Valley Practice
Sanquhar	01659-493522	dg.uppernithsdale-hv@nhs.scot	Sanquhar Health Centre
Annandale & Eskdale			
Annan Health Centre	01461-633235	dg.lowerannandale-hv@nhs.scot	Annan Health Centre
Gretna Surgery	01461 338317	dg.lowerannandale-hv@nhs.scot	Gretna Surgery
Lockerbie Health Centre	01576-205531	dg.upperannandale-hv@nhs.scot	Lockerbie Health Centre
Stewartry			
Castle Douglas Medical Group, Craignair Health Centre, The Clinic, Solway Medical Group, Glenkens Medical Practice	01556-505710	dg.stewartryhealthvisitors@nhs.scot	Garden Hill Primary Care Centre
Wigtownshire			
Newton Stewart		dg.newtonstewarthealthvisitors@nhs.scot	Creebridge
Stranraer	01776-707794	dg.stranraerhealthvisitors@nhs.scot	The Oak Tree Family Centre

Family Nurse Partnership

Family Nurses	01294-559854	dg.familynursepartnership@nhs.scot	Room 21 The Willows

Spiritual Care

Rev. Nathan Mesnikoff MA Spiritual Care Lead	01387-246246 Ext 31544	Nathan.mesnikoff@nhs.scot

Staff Support

National Wellbeing Hub	https://wellbeinghub.scot/	
NHS Dumfries and Galloway Staff Support	To access brief guided self-help **Email: dg.mhstaffsupport@nhs.scot** or **Phone: 01387 241 303**	To access psychological therapy and longer term input: **Email: dg.gp-psychology-service@nhs.scot**

Third Sector Organisations

Action for Children	01659 66135	https://www.actionforchildren.org.uk/how-we-can-help/our-local-services/find-our-services-near-you/upper-nithsdale-family-service/
Homestart Dumfries	07500631183	https://www.hsdumfries.org.uk/
Homestart Wigtonshire	07494 089436 / 07519 026578	https://home-startwigtownshire.co.uk/
Aberlour	01387 325090	https://www.aberlour.org.uk/service/family-outreach-dumfries-and-galloway
Bump Baby and Beyond		https://www.facebook.com/BumpBabyandBeyondDumfriesandGalloway/
SANDS	07864 709228	https://dg-sands.org/ https://www.sands.org.uk/support-black-communities
Perinatal Anxiety and Depression	0808 1961 776	https://pandasfoundation.org.uk/

Support		
Dad's Rock		https://www.dadsrock.org.uk/
Antenatal Choices and Results	020 7713 7486	https://www.arc-uk.org/

APPENDIX 6

IDENTIFICATION OF PERINATAL MENTAL ILLNESS

PREDISPOSING FACTORS

PHYSICAL HEALTH

Physically unwell / physical disability
Numerous pregnancies
History of infertility
Physical/sexual abuse
Substance misuse

SOCIAL FACTORS

Environmental problems
New to area
Lack of partner/family support
Single parent
Dominant partner/family
Socially isolated
Low income/financial difficulties
Number of children/age group
Ethnic group/language difficulties

PSYCHOLOGICAL FACTORS

Unplanned pregnancy/unwanted pregnancy
Previous miscarriage/termination/stillbirth/neonatal death
Fear of childbirth
Traumatic birth experience/emergency caesarean section
History of congenital anomalies/fear of abnormal baby
Psychological abuse
"Precious baby syndrome"
History of previous psychological problems/recent bereavement/postnatal depression/depression
High expectations of self
Children with health problems

FACTS, SYMPTOMS AND RISKS

BABY BLUES

THE FACTS

Baby blues is thought to affect 50-80% of new mothers and symptoms will occur and pass within the first seven days following birth.

SYMPTOMS INCLUDE

Transient state of tearfulness and emotional lability
Severe 'baby blues' is a risk factor for depression

ANTENATAL DEPRESSION

THE FACTS

Antenatal depression is thought to affect one in ten pregnant women and peaks around 32 weeks of pregnancy. The majority of women who experience antenatal depression find it ceases following the birth of the baby.

SYMPTOMS INCLUDE

Inability to concentrate
Anxiety
Extreme irritability with self and others
Sleep problems
Feeling tired all of the time
Inability to enjoy anything anymore
Constant sadness or crying more than is usual
Agoraphobia – scared to leave the home or be in social situations
Obsessive compulsive tendencies

POSTNATAL DEPRESSION

THE FACTS

Postnatal depression affects 10% to 15% of women post-natally during the first year following birth (SIGN 127, 2012).
Postnatal depression may occur immediately after the birth or many months later (NHS Health Scotland 2001).
Postnatal depression is a treatable illness. The length and type of treatment depends on the severity and how early it is detected.

SYMPTOMS INCLUDE

Constantly feeling tired with no energy
Sleep problems
Crying a lot
Appetite increased or decreased
Feeling emotionally disconnected from or even rejected by the baby or overly anxious and over protective of the baby
Lack of motivation
Constant anxiety
Difficulty with concentration
Report of strange, frightening thoughts or visions about harming self or baby
Sense of feeling overwhelmed and unable to cope
Feeling of guilt about everything including feeling a 'bad' mother
Physical aches and pains

RISKS

An assessment for the presence of risk factors for postnatal depression can facilitate targeting of interventions and support towards women at higher risk.

Risk factors may include:
Past history of psychopathology and psychological disturbance during pregnancy
Low levels of social support
Poor relationships with partner/others
Recent current or recent stressful life events
Baby blues that do not resolve
Obstetric complications or health problems with mother or baby
Domestic abuse
Social exclusion
Unplanned pregnancy
Emotional lability
Coping style

POSTPARTUM PSYCHOSIS

THE FACTS

Postpartum psychosis, affects one to two per thousand women. This rate represents a significantly increased risk for psychotic illness when compared with other times in a woman's life. Postpartum psychosis is largely affective in nature, although several studies comment on atypical features in the presentation such as mixed affective state, confusion and disturbed behaviour. It typically presents in the early postnatal period, usually within the first month. There is a close link with bipolar affective disorder; the risk of developing postpartum psychosis being substantially increased in women with bipolar disorder, particularly where there is also family history of postnatal bipolar episodes.

SYMPTOMS INCLUDE

Hallucinations or delusions
Restless, sometimes agitated behaviour, or strange movements
Irrational fearfulness and worrying often about the baby
Mood swings with inappropriate emotions. There may be manic behaviour.
Inability to sleep
Behaviour may appear out of touch with reality and mother may not respond to baby needs such as keeping him safe, healthy, nurtured

RISKS

There is significant evidence of increased risk of postpartum psychosis in women who have:
A previous episode of postpartum psychosis
A pre existing severe psychotic illness
A family history in first or second degree relatives of an affective psychosis compounds risk particularly if associated with personal history

APPENDIX 7

GLOSSARY OF TERMS

Psychosis
A mental health problem that causes people to interpret or perceive things differently from those around them.

Mixed Affective State
A state wherein features unique to both depression and mania—such as despair, fatigue, morbid or suicidal ideation; racing thoughts, pressure of activity, and heightened irritability—occur either simultaneously or in very short succession.

Hallucinations
When a person hears, sees and sometimes tastes or smells things that are not here. A common hallucination is voice hearing and can cause severe distress and a change in behaviour.

Delusions
These are fixed beliefs, based on an abnormal mental process (such as abnormal perceptions, mood, thinking processes), which is out of keeping with a patient's social, cultural and educational background. They can cause severe distress and affect behaviour.

Suicidal Ideation
Thoughts of wanting to end your own life often overwhelmed by negative feelings and feeling that you have no other option.

Bipolar Affective Disorder
Major affective disorder characterised by severe mood swings (manic or major depressive episodes) and a tendency for remission and recurrence. It is a serious mental illness.

Schizophrenia
A major psychotic disorder characterised by abnormalities in perception or expression of reality. Common signs and symptoms involve delusions, hallucinations, disorganised thinking and retreating from reality.

Psychotropic Medication
Anti-psychotic medication used for some types of mental distress or disorder mainly schizophrenia and bi-polar disorder. They can also be used to help severe anxiety and depression.

APPENDIX 8

Midpark Hospital
Perinatal Mental Health
Admission & Discharge Checklist

A. PATIENT DETAILS

Full name	
CHI	
Address	
GP name and practice	
Interpreter required?	No Yes – Details:
Accessibility required?	No Yes – Details:

B. REFERRER DETAILS

Name of referrer	
Job title	
Telephone	
Email	
Base address	
Date of most recent assessment by local psychiatrist or community perinatal MH service?	
Name and title of assessor	

C. SAFEGUARDING

Is mother the primary carer for baby?	Yes No
Baby on Child Protection Register or subject to other safeguarding measures?	Yes No
Are other children on Child Protection Register or subject to other safeguarding measures?	Yes No

Provide Details:

ADULT SUPPORT & PROTECTION concerns	Yes No
Provide Details:	

SOCIAL WORK	
Name of Social Worker	
Telephone	
Email	
Base / Office address	
Social worker updated	Yes No
Referral submitted (See 7 Questions guidance pg6)	Yes No
Reason for admission to Midpark (please tick the correct box / boxes)	No MBU bed ☐ Clinical reason ☐ Social work ☐ Patient choice ☐ Other ☐

D. ANTENATAL / POSTNATAL

ANTENATAL	
Estimated delivery date	
Maternity hospital / contact details	
Midwife	
Midwife updated	Yes No

POSTNATAL	
Baby's birth date	
Health visitor	
Health visitor updated	Yes No

E. OTHER CHILDREN

Names and ages	

Does the patient have parental responsibility for these children?	Yes No Details:
Care arrangements for dependents	
Father / parent name	
Father / parent telephone	
Has infant mental health been considered?	Yes No
Are infant mental health services involved?	Yes No

F. PSYCHIATRIC HISTORY

Is patient currently open to mental health services?	Yes No
Name of consultant psychiatrist	
Name of CPN	
Name of current mental health team	
Perinatal team updated? (dg.perinatalmhs@nhs.scot)	Yes No

Known communication needs/requirements	

G. DISCHARGE

ANTENATAL	
Midwife updated	Yes No Date:

POSTNATAL	
Health visitor updated	Yes No Date:

PSYCHIATRIC	
CPN updated	Yes No Date:
Psychiatrist updated	Yes No Date:
Perinatal mental health service updated	Yes No

	Date:
Any other professional updated Name:	Yes No Date:

SOCIAL WORK	
Social worker updated	Yes No Date:
Social worker follow up	Yes No
Outcome of any social work referral	Yes No

APPENDIX 9

PRE-BIRTH MENTAL HEALTH REVIEW

A pre-birth mental health review is a multidisciplinary team meeting, bringing together a person who is pregnant and receiving care within a Community Mental Health Team and everyone involved in their care. This review should be held between 30-32 weeks of pregnancy.

Aim of The Review

To ensure that the person has the care and treatment required for the remainder of their pregnancy and into the post birth period.

The review should be organised by the person's key worker.

People Who Require a Pre-birth Planning Meeting

A pre-birth planning meeting is essential when somebody has a current or previous serious mental illness including:

- Current or previous psychosis
- Bipolar affective disorder
- Severe depression with a significant impact on daily functioning

It may also be useful for people with other diagnoses where there are multiple risk factors or complexities involved such as:

- Physical health or obstetric complications
- Complex social difficulties
- Substance misuse
- Forensic history
- Child Protection concerns, children not in the caregivers care or planned care proceedings
- Poor engagement with services
- Personality disorder

Planning The Review

The review should be organised by the person's key worker.

Discussion should be held with the person prior to the review explaining the process and reassuring around aims of the review. A discussion about who should be invited and the venue of the review should also be discussed.

If the person does not want to attend, or declines to have a pre-birth review, explore reasons for this and consider alternatives (less people attending, what to discuss etc). Consider if a professional's meeting is required for people who are not engaging with services. Every effort should be made to involve the person in discussions around their care and treatment.

Who Should Be Invited

The person, their partner or anybody else significant that supports them and who they want to bring with them. The Key worker and co-worker, Consultant Psychiatrist, Senior Perinatal Mental Health Nurse, Midwife, Health Visitor, anybody else who may be involved such as Psychology, Occupational Therapy, Crisis Team, Children and Families Social Work/Adult Social Work, Specialist Drug and Alcohol Service, Third sector. Consider Mental Health Liaison if they are going to be part of the care plan.

There may not always be a requirement for a Consultant Psychiatrist to attend, but this should be discussed ahead of the review with the Consultant Psychiatrist. If the Psychiatrist is attending then the review should be held within their joint review clinic with discussion around length of time for review slot. If the person is an inpatient in Midpark Hospital then the Consultant Psychiatrist would attend and this should be arranged around their ward availability.

Invites to be sent out by CMHNT administration staff/Midpark Hospital Administration staff if the person is an inpatient.

Pre-birth Review Content

Mental health - history and current mental health, relapse indicators, mental health act.

Current pregnancy and obstetric history - including estimated delivery date (EDD), thoughts and feelings around pregnancy, planned mode of delivery, any obstetric complications/risks. History of birth trauma and /or past or planned neonatal admissions.

Medication - any current prescribing and review of same, administration of medicines in intra partum, considerations around breastfeeding, medication choices/plans for post birth period. Plans for contraception post birth.

Risk - current/historical. Risks around relapse or worsening in post partum, including signs/symptoms. Any increased risk/high risk of post partum psychosis – share information around this including rapid onset, symptoms and importance of urgent mental health assessment.

Discussion about care needed intra partum and post partum. Consider if the person requires mental health review prior to discharge home, informing those involved of baby's arrival, discharge planning home. Who will be involved in the initial post partum period? Family/social support, Crisis planning.

Discussion about care needed if there is a significant deterioration in mental health – Mental Health Liaison Team, Crisis Team, MBU admission.

Child safe guarding concerns - are there any and if so has a referral been made to children and families social work, if not discuss submission.

Is the unborn baby or any other children the subjection of a Child Protection Order or child plan?

Are there any concerns around inability to care for baby?

Adult Safeguarding Concerns – are there any concerns and what has been done to address these? Is the person under ASP?

Strengths Supports including Third Sector.

Additional Information

From the review is there any additional information that the patient may like/require – information around diagnosis, medicines, self help materials, contraception, mental health act, mental health services, mother and baby unit.

Everybody's roles and responsibilities should be clear and confirmed.

Post Review

Clinical notes should be input into Clinical Portal. If the review has been part of the Consultant Psychiatrist's Review Clinic, the Psychiatrist will send a letter to all involved including the patient. If the review has been nurse led without Psychiatrist attendance then all involved should be updated by the nurse leading the review.

Mental Health Care Plan – at a timely interval following the review, the key worker should meet with the person to update their mental health care plan from the contents of the review. This with consent should then be shared with the person's midwife for their information and for uploading and sharing onto Badger.Net (electronic recording system used by midwives and health visitors) so that midwifery and obstetric staff can refer to the care plan if required. A copy of the care plan should be shared with anybody else relevant/involved and whom the person consents to sharing of information.

APPENDIX 10

LINKS AND RESOURCES

Best Use of Medicine in Pregnancy (BUMPS)
https://www.medicinesinpregnancy.org/medicine--pregnancy/

Best Beginnings Baby Buddy App
https://www.babybuddyapp.co.uk/

CR 232 Recommendations for the provision of services for child bearing women (Sept 2021) Royal College of Psychiatrists
https://www.rcpsych.ac.uk/improving-care/campaigning-for-better-mental-health-policy/college-reports/2021-college-reports/perinatal-mental-health-services-CR232

Centre of Perinatal Excellence (COPE) National Perinatal Mental Health Guideline 2023
https://www.cope.org.au/health-professionals/health-professionals-3/review-of-new-perinatal-mental-health-guidelines/

MBRRACE-UK Perinatal Mortality Surveillance: UK Perinatal Deaths for Births from January to December 2021
https://www.npeu.ox.ac.uk/mbrrace-uk/reports

NES Essential Perinatal and Infant Mental Health – E Learning Modules
https://www.nes.scot.nhs.uk/nes-current/essential-perinatal-and-infant-mental-health-e-learning-modules/

NHS Scotland Perinatal Mental Health Network Scotland
https://www.pmhn.scot.nhs.uk

Sign 169 Perinatal Mental Health Mood Conditions (Dec 2023)
SIGN 169 Perinatal mental health conditions

Silvercloud Space for Perinatal Computerised Cognitive Behavioural Therapy Programme
https://www.silvercloudhealth.com/uk/programmes/family-programmes/perinatal-mental-health-and-wellbeing-programme