

Swindon Integrated Perinatal Mental Health Pathway

November 2016



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Introduction

Perinatal mental health problems are those which complicate pregnancy and the postpartum year. Perinatal mental health services are concerned with the prevention, detection and management of these problems. Promoting emotional and physical wellbeing and development of the infant is central to perinatal mental health.

This is the first perinatal mental health integrated care pathway for Swindon and it will be kept under regular review. It covers all levels of service provision and severities of disorder. It is based on evidence-based guidance and best practice particularly NICE Guidelines for antenatal and postnatal mental health (NICE December 2014) and NSPCC prevention in Mind (NSPCC 2014)

2. Aim and Scope

2.1 Aim

The aim of this pathway is to:

- specify the roles and responsibilities of service providers and their staff in the prevention, 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;
- to specify pathways between services so that all primary and secondary healthcare professionals involved in the care of women during pregnancy and the postnatal period know how to access assessment and treatment, and that women are able to access appropriate support in a timely way.

2.2 Scope

The perinatal mental health integrated care pathway covers all levels of service provision required to promote optimum perinatal maternal mental health. It sets out a framework of good practice for professionals and managers at all levels and is based on relevant national and local guidelines and policy.

The scope is therefore wide and includes all services with a role in supporting women and their families from preconception through to 12 months after the end of pregnancy. This includes universal services as well as more specialist maternity and mental health services.

- Maternity Services provided by Great Western Hospital (GWH).
- Primary Care – GP Practices in Swindon
- Primary Mental Health Care – LIFT Psychology
- Secondary Mental Health Care provided by Avon and Wiltshire Partnership Trust (AWP)
- CAMHS secondary care services provided by Oxford Health NHS Foundation Trust
- TaMHS Primary Care CAMHS service
- New Horizons Mother and Baby Unit, Bristol provided by Avon and Wiltshire Partnership Trust (AWP)
- Health Visiting and Family Nurse Partnership– provided by Swindon Borough Council (SBC)
- NSPCC
- Domestic abuse services

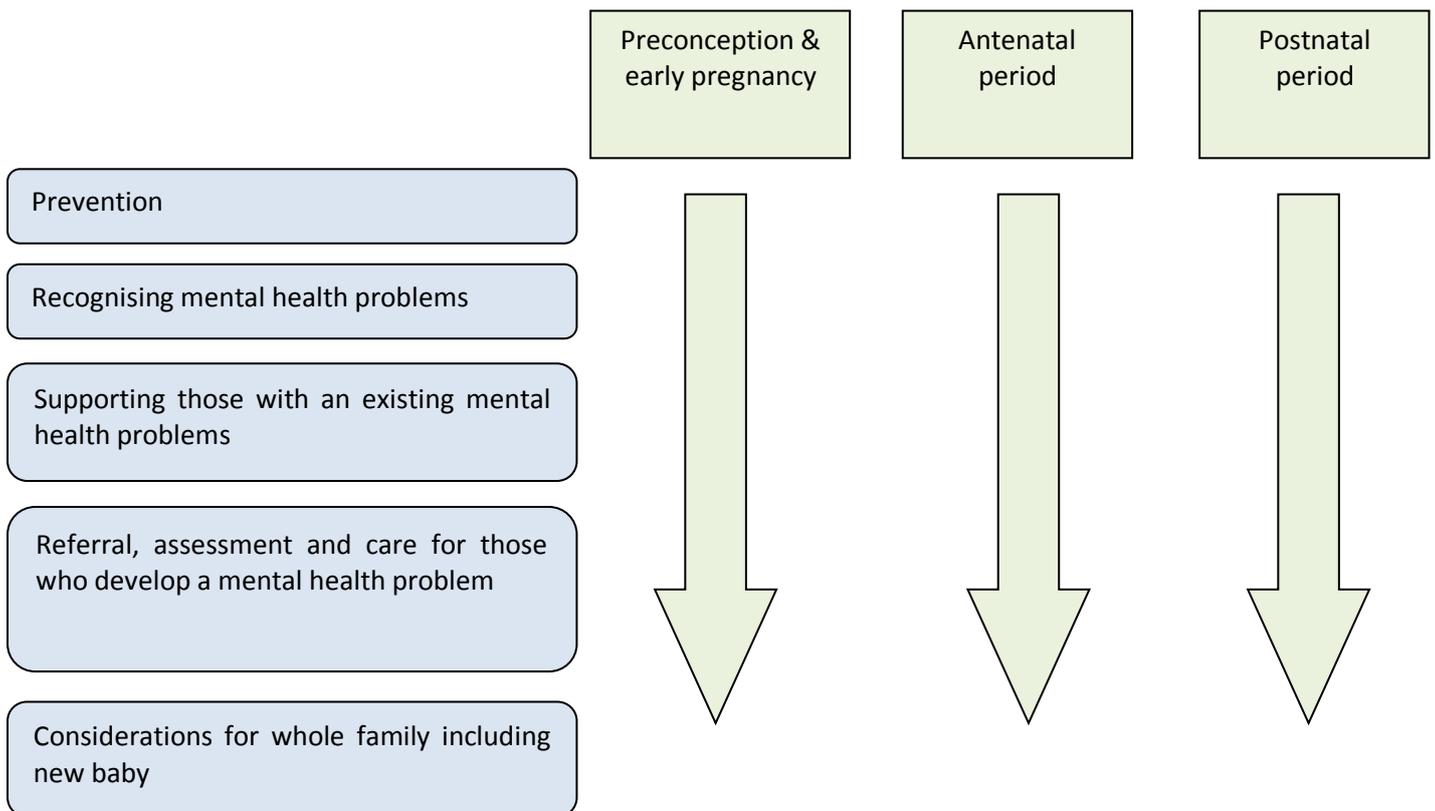
- Substance misuse services – CGL (for over 18s) and UTurn for Under 18s.

The pathway has been developed to promote effective communication and referral between maternity, child and family, and mental health services in Swindon. It aims to set out good practice for services to develop an integrated care plan for a woman with a mental health problem in pregnancy and the postnatal period that includes:

- the care and treatment for the mental health problem
- the roles of all healthcare professionals, including who is responsible for:
 - coordinating the integrated care plan
 - the schedule of monitoring
 - providing the interventions and agreeing the outcomes with the woman.
- The introduction of the Joint Perinatal Mental Health Screening Tool

The pathway includes services for women who are experiencing dual diagnosis (substance misuse and mental health) problems.

The diagram below shows the wide scope of this work.



This document also sets out guidance for commissioners for collaborative commissioning of all services with a role in the pathway of care.

2.3 Meeting the needs of Black and Minority Ethnic women and other vulnerable groups

The relationship between ethnicity/culture and mental illness is highly contested and poorly understood. However, what is known is that there is a strong correlation between social and material deprivation and onset of perinatal mental illness – particularly depression and fewer than expected black and minority women receive diagnosis and treatment despite having disproportionate exposure to risk factors. This may be for a number of reasons. BME communities fear and mistrust of mental health service might reduce the likelihood of women from minority groups either self-referring or being referred to services by their families.

The needs of BME women in relation to perinatal mental health need to be addressed not just through the provision of interpreting services but also through a sensitivity and understanding of the cultural needs and expectations of these women in relation to child bearing and mental health. This may require more joined up work with BME communities and the voluntary sector.

Other groups of women who may be marginalised or face barriers to accessing services include those:

- With previous or on-going mental health problems
- In the criminal justice system
- Who are visually impaired
- With learn disabilities
- With long-term physical health problems and/or physical disability.

REF: Perinatal Mental health of Black and Minority Ethnic Women: A review of current provision in England, Scotland and Wales. National Mental Health Development Unit 2011.

2.4 Perinatal mental health – fathers

Practitioners should not disregard the role and impact of fathers on both recognising mental health issues in the mother of their child but also in providing support. The father's functioning as a support person is key, since depressed new mothers receive more support from their partners than from any other individual, including medical staff (Holopainen, 2002).

According to the National Childbirth Trust research 38% of new fathers are concerned about their own mental health and 10% experience Post-Natal Depression most commonly 3 – 6 months after the birth of their child. The impact of perinatal mental health of either parent can be detrimental to the wellbeing of the baby. Practitioners should be aware of the role and vulnerabilities of fathers and ensure their needs are not overlooked either in providing support for their partner or in looking after their own mental health. Dad Matters UK provide a website which may offer information and support to fathers including information leaflets. www.dadmatters.uk.

2.5 Perinatal mental health needs of same sex couples

“Perinatal depression and increased stress levels may be more prevalent in same-sex female couples than heterosexually active couples. Several studies have illustrated that lesbians are at greater risk for heightened stress and anxiety around the time of pregnancy and family planning (Trettin, Moses-Kolko, & Wisner, 2005). Improved education for health care providers may lead to greater awareness of how to cater to alternative families. Simple changes like using gender-neutral pronouns such as "partner" or "significant other" instead of "father of the baby", "boyfriend", or "husband" can make a safer atmosphere for lesbian couples. Creating a comfortable environment for same-sex female couples can lead to disclosure of sexual orientation, which provides information for the health care provider on how to best serve that couple; this could ensure optimum care and decrease the risk of perinatal depression in this population.” Sigal (2009) <http://repository.upenn.edu/josnr/vol2/iss1/3>

2.6 Domestic Abuse

More than one in four women has experienced a least one incident of domestic abuse in England and Wales since age 16 (equivalent to 4.8 million women). 30 percent of domestic abuse starts during pregnancy or shortly after the birth of a child. Mental health issues during the perinatal period may be caused by or indicative of domestic violence. 30% of women first disclose incidents of domestic abuse to a health care worker.

Domestic Abuse, parental mental health and substance misuse are often cited as the 'Toxic Trio' and are viewed as indicators of increased risk of harm to children and young people.

All agencies providing support for perinatal mental health have a role and responsibility for providing support and guidance regarding domestic abuse. All practitioners should ensure they are trained to ask about domestic violence in a safe way and have information about local support services available. All women should be routinely asked about domestic abuse at booking and should be referred to the Independent Domestic Violence Advisor (see page 21).

3. Role Descriptions

All Professionals will use the Perinatal mental health screening tool included in section 4 below.

Co-ordination of care may vary depending on the severity of mental illness and the progress the woman has made through pregnancy and after birth. However, the GP will act as the data co-ordinator and all organisations and practitioners have the responsibility to inform the GP of relevant information regarding a woman's perinatal mental health. At a minimum this should be that a referral has been made or a woman has been discharged.

3.1 Midwife

Midwives play a central role in recognising mental health problems in pregnancy and the postnatal period, risk assessment, and ensuring that pregnant women with mental health problems are referred to appropriate services and supported to achieve the best possible health outcomes for themselves and their babies.

During a normal pregnancy a midwife will have contact with a pregnant woman at as a minimum:

- 8- 12 weeks: booking appointment
- 8- 14 weeks: dating scan
- 16 weeks
- 18-20 weeks: anomaly scan
- 25 weeks
- 28 weeks
- 31 weeks
- 34 weeks
- 36 weeks
- 38 weeks
- 40 weeks
- 41 weeks
- 42 Weeks

All midwives will talk to both mothers and fathers about perinatal mental illness and local support available in antenatal appointments and postnatal visits, so that they are aware of and alert to the symptoms and know what to do if they are affected.

Recognising mental health problems

Midwives are responsible for asking women about their mental health and determining which women will need additional obstetric input and/or other services during their pregnancy and in the postnatal period. It is part of their role to explicitly enquire about a woman's mental wellbeing and previous psychiatric history and to appropriately refer on those women might benefit from further support.

Mental health and wellbeing

At a woman's booking visit, and during the early postnatal period, midwives will ask the following depression identification (Whooley) questions as part of a general discussion about a woman's mental health and wellbeing:

- 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?

Midwives will also ask about anxiety using the 2-item Generalized Anxiety Disorder scale (GAD-2):

- During the past month, have you been feeling nervous, anxious or on edge?
- During the past month have you not been able to stop or control worrying?

The results of all these questions will be documented in the woman's maternity health records. Midwives will also communicate with the GP informing them of the pregnancy, asking for information about any mental health problems and alerting them if difficulties arise.

Mental health history

At a woman's first contact with services in pregnancy and the postnatal period midwives ask about:

- any past or present severe mental illness
- past or present treatment by a specialist mental health service, including inpatient care
- any severe perinatal mental illness in a family member, particularly a first-degree relative (mother, sister or daughter).

Care planning and monitoring

Midwives will assess the level of contact and support needed by women with a mental health problem (current or past) and those at risk of developing one

- agree the level of contact and support with each woman, including those who are not having treatment for a mental health problem
- monitor regularly for symptoms throughout pregnancy and the postnatal period, particularly in the first few weeks after childbirth.
- discuss and plan how symptoms will be monitored (for example, by using validated self-report questionnaires, such as the Edinburgh Postnatal Depression Scale [EPDS], Patient Health Questionnaire [PHQ-9] or the 7-item Generalized Anxiety Disorder scale [GAD-7]).

Midwives will work collaboratively with other health care professionals to co-ordinate care, liaising with the GP, health visitor and the psychiatrist or community mental health team and obstetrician as appropriate, if the woman's mental health gives cause for concern

Referral

For mild to moderate mental health problems women can be referred to LIFT Psychology or to their GP.

Midwives will refer to a secondary mental health service through the Primary Care Liaison Service (PCLS) for assessment and treatment, all women who:

- have or are suspected to have severe mental illness
- have any history of severe mental illness (during pregnancy or the postnatal period or at any other time).

Midwives will ensure that the woman's GP knows about the referral.

Management of an acute mental health crisis

If a woman is exhibiting acute psychotic behaviour or if her thoughts or behaviour give cause for concern, a medical assessment will be sought immediately. See section 3.7 for how to refer to AWP mental health service.

3.2 Specialist Mental Health Midwife

It has been recommended that every maternity service should have a Specialist Mental Health Midwife to champion the needs of women with perinatal mental illnesses (Maternal Mental Health Alliance). Specialist Mental Health Midwives are expert midwives and local champions who lead work with maternity service commissioners and providers to promote optimal care for women with perinatal mental illnesses and their families receive the specialist care and support they need during pregnancy and in the postnatal period. They support their maternity team colleagues to ensure that services deliver the best possible personalised care to these women and their families to optimise their mental health.

Swindon has a Specialist Mental Health Midwife within Maternity Services who works together with other Specialist Midwives to develop local care pathways; provide training and advice and support for other maternity staff, and provide women with additional specialist support where required (MMHA 2013).

The role of the Specialist Mental Health Midwife in Swindon is to:

- Act as a source of information and support for other midwives about women with identified mental health concerns in their care.
- Provide a single point of contact/access for other professionals working with pregnant women with identified mental health concerns.
- Support and advocate for women making choices around medication use including when feeding, and offer 1-1 supportive appointments in addition to normal antenatal care for women who may need it
- Offer information and support to family members of high risk women, including fathers, about mental health and wellbeing during the perinatal period.
- Have overall responsibility within maternity for care co-ordination, particularly around planning, safeguarding considerations and managing multi-disciplinary review meetings.
- Contribute to safeguarding assessment and child protection planning.
- Lead the development and delivery of training for midwives around mental health
- Lead the development and monitoring of maternity care pathways for perinatal mental health.

3.3 GP/Primary Care

Recognising mental health problems in pregnancy and the postnatal period is a key role for GPs and other primary care staff. All Primary Care staff will be alert to the possibility of perinatal mental health problems including postnatal depression and anxiety and, with the woman's consent, communicate with midwives and health visitors if there is a history of significant mental illness, even if the woman is well.

GPs will see women who refer themselves or who have been identified by the midwife or health visitor. They can treat uncomplicated non-psychotic depression and anxiety themselves and refer to LIFT psychology for further support, and refer to secondary mental health services for more complex or serious disorders.

Pre-conception care

GPs should ensure that patients with serious mental illness receive pre-conception counselling and are aware of the risks to their mental health of becoming pregnant. They should also take into account the possible adverse effects of psychotropic medication in pregnancy when prescribing to women of reproductive potential and provide women with this information.

Discuss with all women of childbearing potential who have a new, existing or past mental health problem:

- the use of contraception and any plans for a pregnancy
- how pregnancy and childbirth might affect a mental health problem, including the risk of relapse
- how a mental health problem and its treatment might affect the woman, the fetus and baby
- how a mental health problem and its treatment might affect parenting.

Recognising mental health problems

At a woman's first contact with primary care and during the early postnatal period, consider asking the following (Whooley) depression identification questions as part of a general discussion about a woman's mental health and wellbeing:

- 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?

Also consider asking about anxiety using the 2-item Generalized Anxiety Disorder scale (GAD-2):

- During the past month, have you been feeling nervous, anxious or on edge?
- During the past month have you not been able to stop or control worrying?

Care planning and monitoring

Every woman with an identified mental health problem will have a written integrated care plan that sets out:

- the care and treatment for the mental health problem
- the roles of all healthcare professionals, including who is responsible for:
 - coordinating the integrated care plan
 - the schedule of monitoring
 - providing the interventions and agreeing the outcomes with the woman

The care plan will be recorded in all versions of the woman's notes including Primary Care and handheld notes.

GPs will work collaboratively with other health care professionals to co-ordinate care, liaising with the midwife, health visitor and the psychiatrist or community mental health team and obstetrician as appropriate, if the woman's mental health gives cause for concern, and review the woman's personal care plan and treatment at each contact.

Co-ordination of care may vary depending on the severity of mental illness and the progress the woman has made through pregnancy and after birth. However, the GP will act as the data co-ordinator and all organisations and practitioners have the responsibility to inform the GP of relevant information regarding a woman's perinatal mental health. At a minimum this should be that a referral has been made or a woman has been discharged. The GP should ensure all information is entered into their clinical system.

Postnatal care

GPs can treat uncomplicated non-psychotic depression and anxiety themselves and refer to LIFT psychology for further support, and refer to secondary mental health services for more complex or serious disorders. In the postnatal period GPs will work collaboratively with health visitors.

For advice and guidance on prescribing please see section 4 below.

3.4 Obstetrician

An obstetrician is a doctor who specialises in the care of women during pregnancy, labour and after birth. Obstetricians deal with high risk and complex pregnancies, including women with serious mental illness. They will also see women with a range of other psychiatric disorders in pregnancy and the early postpartum period.

Women who are pregnant and have a formal diagnosis of mental ill health and have on-going support from mental health services will be seen by a consultant obstetrician.

The Sycamore Clinic is an obstetrician-led clinic for women with mental health problems provided by maternity services at the Great Western Hospital in Swindon.

The obstetrician's role is to:

- To take the lead for care of women with complex and acute mental health problems, ensuring good liaison with the mental health team.
- Draw up a care plan for a pregnant woman with high risk/complex mental health problems considering both mental health and obstetric care needs. This will be recorded in all versions of the woman's notes including Primary Care and handheld notes.
- Liaise with the Consultant Psychiatrist to review medication in pregnancy, intrapartum and postnatal periods.
- Request input to a care plan from other services as required and provide at multidisciplinary team meetings.
- Support multidisciplinary team working in the care of all women with mental health problems.
- Provide training and support to other medical teams on mental health during pregnancy and postpartum period including advice about medication use.
- Lead implementation of national guidelines for care of pregnant women and consider implications for delivery of care and data collection.
- Act as a representative at local and national clinical networks for perinatal mental health.
- Lead the development of local guidelines in the context of pregnancy mental health needs.

For prescribing information please see Section 4 below.

3.5 Health Visitor

Health visitors have an important role in identifying mothers who are at risk of, or suffering from, perinatal mental illness, and ensuring that these women get the support they need at the earliest opportunity.

Most women will see their Health Visitor:

- Antenatally
- 10 days after birth of baby
- 6 weeks after birth of baby
- 12 weeks after birth of baby
- 9-12 months after birth of baby

All health visitors will talk to both mothers and fathers about perinatal mental illness and local support available in antenatal appointments and postnatal visits, so that they are aware of and alert to the symptoms and know what to do if they are affected.

Health Visitors should have the education, training and skills to detect mental health problems in pregnancy and the postpartum period; be able to undertake basic psychological treatments such as listening visits and non-directive counselling and cognitive counselling group work and understand which women would benefit from additional visits; and support and know who to refer and to which service using the integrated care pathway.

Recognising mental health problems

At a woman's first contact with the Health Visitor will ask about:

- any past or present severe mental illness
- past or present treatment by a specialist mental health service, including inpatient care
- any severe perinatal mental illness in a family member, particularly a first-degree relative (mother, sister or daughter).

Health Visitors will refer to a secondary mental health service) for assessment and treatment, all women who:

- have or are suspected to have severe mental illness
- have any history of severe mental illness (during pregnancy or the postnatal period or at any other time).

Ensure that the woman's GP knows about the referral.

During the early postnatal period (10 days, 6 weeks, 12 weeks after birth of baby), Health Visitors will ask the following depression identification questions as part of a general discussion about a woman's mental health and wellbeing:

- 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?

Also consider asking about anxiety using the 2-item Generalized Anxiety Disorder scale (GAD-2):

- During the past month, have you been feeling nervous, anxious or on edge?
- During the past month have you not been able to stop or control worrying?

Health Visitors will communicate with the GP, asking for information about any mental health problems and alerting them if difficulties arise.

Intervention

The effectiveness of health visitor intervention in the prevention and treatment of mild to moderate postnatal depression is now well established. Health Visitors with additional training in listening visits and cognitive counselling can significantly improve the outcome of women with postnatal depression compared to standard health visitor care. Interventions by additionally trained health visitors are clinically and cost effective.

Care planning and monitoring

Every woman with an identified mental health problem will have a written integrated care plan that sets out:

- the care and treatment for the mental health problem
- the roles of all healthcare professionals, including who is responsible for:
- coordinating the integrated care plan
- the schedule of monitoring
- providing the interventions and agreeing the outcomes with the woman

The care plan will be recorded in all versions of the woman's notes including Primary Care and handheld notes.

Health Visitors will work collaboratively with other health care professionals to co-ordinate care, liaising with the GP, the psychiatrist or community mental health team as appropriate, if the woman's mental health gives cause for concern, and review the woman's personal care plan and treatment at each contact.

3.6 LIFT Psychology

LIFT Psychology offer a wide range of psychological support, from psycho-educational courses to one-to-one interventions. Usually the first point of access into LIFT is by booking an appointment at the GP surgery or by booking straight onto a psycho-education course through the LIFT website <http://www.seqol.org/lift-psychology>

Although not a medical service LIFT Practitioners have a role in providing information about mental health and wellbeing in the postnatal period. Lift psychology:

- Routinely collects data on whether the people referred are pregnant or in the postpartum year
- Ensures that additional training is given to practitioners regarding perinatal mental health and local pathways
- Ensures that pregnant and postpartum women are offered treatment within three months but more likely earlier than the 3 months

3.7 Mental Health Practitioner – Secondary Care

The Mental Health Practitioners provide information about mental health treatment in pregnancy and the postnatal period.

All mental health practitioners should regard women of reproductive age as having the potential for childbearing.

Mental health professionals will provide advice about the possible risks of mental health problems or the benefits and harms of treatment in pregnancy and the postnatal period.

This will include discussion of the following, depending on individual circumstances (NICE 2014).

- the uncertainty about the benefits, risks and harms of treatments for mental health problems in pregnancy and the postnatal period
- the likely benefits of each treatment, taking into account the severity of the mental health problem
- the woman's response to any previous treatment
- the background risk of harm to the woman and the fetus or baby associated with the mental health problem and the risk to mental health and parenting associated with no treatment
- the possibility of the sudden onset of symptoms of mental health problems in pregnancy and the postnatal period, particularly in the first few weeks after childbirth (for example, in bipolar disorder)
- the risks or harms to the woman and the fetus or baby associated with each treatment option
- the need for prompt treatment because of the potential effect of an untreated mental health problem on the fetus or baby
- the risk or harms to the woman and the fetus or baby associated with stopping or changing a treatment.

If a woman, already under the care of mental health services, becomes pregnant mental health practitioners will take the lead for and work collaboratively with maternity services to develop and monitor a care management plan that sets out:

- the care and treatment for the mental health problem
- the roles of all healthcare professionals, including who is responsible for:
 - coordinating the integrated care plan
 - the schedule of monitoring
 - providing the interventions and agreeing the outcomes with the woman

Mental health interventions

When a woman with a known or suspected mental health problem is referred to a mental health service in pregnancy or the postnatal period, she will be assessed for treatment within 2 weeks of referral.

Following the assessment the following actions may occur:

- Discharge back to care of GP
- Further assessment and possible short term interventions by PCLS
- Referred onto to the Recovery team, for allocation of a Care Coordinator.

If psychological interventions are required the following actions may occur:

- Discharged back to GP with advice to access LIFT

Referral to the Recovery Team and prioritised by the Psychological Therapy Service

Care planning and monitoring

Professionals in secondary mental health services will develop a written care plan in collaboration with a woman who has or has had a severe mental illness. If she agrees, her partner, family or carer will also be involved.

The plan will cover pregnancy, childbirth and the postnatal period (including the potential impact of the illness on the baby) and will include:

- a clear statement of jointly agreed treatment goals and how outcomes will be routinely monitored
- increased contact with and referral to specialist perinatal mental health services
- the names and contact details of key professionals

The care plan will be recorded in all versions of the woman's notes including Primary Care and handheld notes.

Management of an acute mental health crisis

If a woman is exhibiting acute psychotic behaviour or if her thoughts or behaviour give cause for concern, a medical assessment should be sought immediately. The pathway for referral depends on the location of the client and the time of day.

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) provides 24 hour rapid assessment and treatment for people experiencing a mental health crisis. The team consists of mental health nurses, social workers, doctors, occupational therapists and dedicated mental health workers that will seek to immediately reduce distress both through the use of support, advice, medication and a range of therapeutic interventions all specifically designed for those in crisis. The team can be contacted on 01793 836820

The AWP perinatal mental health pathway can be seen in Appendix 3.

For advice and guidance on prescribing please see section 4 below.

3.8 Mental Health Services for Under 18's (CAMHS)

The CAMHS Community Team in Swindon provides a Clinical Service for pregnant young women under 18 which offers:-

- Assessment and treatment of the mother's mental health difficulties
- Care co-ordination and care planning in collaboration with other professionals
- Telephone support for the mother and her family.
- Assessment and treatment of the parent infant relationship
- Outreach and/or crisis support if necessary

CAMHS provide a community service for young people throughout Swindon, which can include their own home, GP surgery, Children's Centre, clinic, or in a community setting. This will usually involve working closely with professionals already involved in their care and offering an additional service to complement existing care arrangements. CAMHS also provide an Outreach and Crisis service for young people in situations where more intense or crisis interventions may be required for a short time. CAMHS offers consultation, supervision and training to health and social care professionals to provide support in the most appropriate place for that individual.

Approximately 20% of women will experience some degree of mental health difficulties in the antenatal or postnatal period. CAMHS would offer support to women 18 and under who are experiencing, or are at risk of developing, moderate to severe mental health difficulties such as:

- Parent-infant relationship difficulties
- Depression and low mood
- Anxiety and panic attacks
- Post-traumatic stress disorder
- Psychosis
- Obsessive compulsive disorder
- Eating disorders

CAMHS should be involved with pregnant women with significant mental health illness, or deemed to be at significant risk of becoming acutely unwell in the postnatal period. The CAMHS Community team will liaise closely with the woman's GP, Family Nurse Partnership, Health visitor and maternity services to ensure the best possible outcomes for the woman and baby.

CAMHS relationship with Family Nurse Partnership and the supervision process that is integral to the work they provide ensures that a close working partnership is in place. Any concerns can be raised and detected at an early stage which means that a referral can be made quickly and a joint assessment of individual needs can take place with collaboration about a treatment package of care.

The CAMHS team may be involved in providing telephone advice to GPs or obstetric services regarding psychotropic medication in pregnancy or breast feeding. The CAMHS team may be able to offer brief psychological interventions for pregnant women with symptoms of anxiety and/or depression which impact on social functioning, which do not meet the diagnostic criteria for a formal diagnosis with particular consideration of those with a previous history of depression. (NICE 2007).

The CAMHS team will take a lead role in drawing up a detailed personal care plan for pregnancy and early post-partum management. This plan should be agreed with the woman, her family/carers and shared with all services including the GP, Family Nurse Partnership, health visitor, midwives, obstetrician and other professionals, e.g. a social worker, if involved.

Referral process

CAMHS accept referrals directly from any professional who has concerns about a mother's mental health during the antenatal period or in the postnatal period, for those who are 18 and under.

If an emergency assessment is required for a mother who has sudden onset of significant mental health difficulties (such as psychotic or actively suicidal symptoms) the Community Mental Health Team (Swindon Community CAMHS) can be contacted immediately for an urgent discussion.

If the mother is an inpatient at GWH an emergency referral to the Outreach and Crisis Team may be made directly.

● Family Nurse Partnership

For younger mothers there is specific support available in Swindon. The Family Nurse Partnership is a voluntary home visiting programme for first time young mothers, aged 19 years and under. A specially trained family nurse visit the young mum regularly, from early in pregnancy until the child is two.

The Family Nurse Partnership programme aims to enable young mums to:

- Have a healthy pregnancy
- Improve their child's health and development
- Plan their own futures and achieve their aspirations

The risk of depression is significantly higher amongst teenage mothers than older mothers.

Usually referrals are received via midwifery but anyone working with a young woman can call the Family Nurse Partnership Office on 01793 466767 with details. In order to be eligible, the woman needs to be under 20 years of age and less than 26 weeks gestation, ideally less than 16 weeks.

● U-Turn

U-turn provides a substance misuse service for those under 18 years of age and will accept referrals from all health professionals.

3.9 Substance Misuse Services

● CGL

CGL work closely with the specialist midwifery clinic at GWH for pregnant women with a substance misuse issue. These clinics are run fortnightly and are staffed by the GWH specialist midwife and the CGL maternity substance misuse worker.

All clients identified with a mental health issue as well as a substance misuse issue are referred by CGL to the AWP Primary Care Liaison Service for assessment and the midwife and GP would be informed.

CGL also visit families, which may involve clients with partners who may be pregnant. If mental health issues are raised as an issue the woman would be signposted to her GP, PCLS and midwifery. If the situation was assessed as a safeguarding concern a safeguarding alert would be raised with Children's Services.

Referrals to CGL

Referrals are accepted from all agencies concerned about a woman's substance misuse. Women can also self-refer. If an emergency assessment is required for a mother the CGL Team Leader can be contacted directly.

For women in hospital at GWH, advice on substance misuse issues can be sought from professionals through the Alcohol Liaison Workers based on site.

● U-Turn

U-turn provides a substance misuse service for those under 18 years of age and will accept referrals from all health professionals.

3.10 Domestic Abuse

- Swindon Domestic Abuse Support Service

Swindon Women's Aid

A specialist health Independent Domestic Violence Advisor (IDVA) is based in GWH and is available to support any victim of domestic abuse over the age of 16 who presents/ or is experiencing domestic abuse. The support can be on a one to one basis or as part of a joint meeting.

Referrals are accepted from all health care professionals working at GWH, who are concerned about a woman who is experiencing domestic abuse, women can also self-refer.

For women in hospital at GWH, advice on domestic abuse issues can be sought from the IDVA and arrangements can be made to meet the victim if it is safe to do so.

A specialist health outreach worker works with GPs surgeries across the Borough. Health care professionals based in GP surgeries can refer victims to one to one support or to one of the drop-in sessions available. Victims can also self-refer

If a situation is assessed as a safeguarding concern a safeguarding referral should be made to Children's Services or Adult Services as appropriate

3.11 Mother and Baby Unit

All women requiring admission for a mental health problem in late pregnancy or after delivery will be admitted with their infant to a mother and baby unit not an adult admission ward (NSPCC), where appropriate following a comprehensive assessment of risk to self, the baby and towards others.

The closest Mother and Baby Unit to Swindon is the AWP New Horizon Mother and Baby Centre. New Horizon Mother and Baby Centre offers a specialist service for women suffering from mental illness in the last trimester of pregnancy and the postnatal period (up to one year after birth); particularly when there are issues relating to attachment and when the mother's mental illness has an impact on her ability to care for her baby.

The team includes psychiatrists, psychiatric nurses and nursery nurses, health care assistants, an occupational therapist and a physiotherapist.

Antenatal out-patient appointments are available for women who have serious enduring mental illness, or have had serious mental illness related to pregnancy or birth.

The aim of this service is to give advice regarding medication, the signposting of other appropriate services and involvement in pre-birth planning meetings, if it is felt the New Horizon Mother and Baby Centre will have a role to play after the baby's birth.

The unit provides a 24/7 service and is available for emergency advice and admission.

The unit is commissioned by NHS England Specialised commissioning, and although there are only 4 beds within the unit, they are able to access units across the country, as a result of this.

The unit can admit under 18s in conjunction with input from CAMHS and oversight from the Trust safeguarding team (often social services are involved too), provided there is evidence of significant mental illness in the young mother.

3.12 Children's Services Interventions

Current evidenced-based perinatal mental health interventions in Swindon include:

The Nursery Nurse Team work with Health Visitors and are a central resource to deliver evidence based care packages for Universal Plus and Universal Partnership Plus clients.

- **Baby Massage** for targeted groups and 1:1
- **Five to Thrive** care packages working 1:1 with parents promoting healthy attachment and behaviours.
- **Baby Steps** is a targeted anti-natal and Post-natal programme. This is a manualised evidenced based, group-work based programme. It focuses on preparing for parenthood and building relationships with the baby and between the parents. This is currently a targeted, referral based programme.
- **NSPCC Pregnancy in Mind** is a new, preventative mental health service for parents-to-be that has been developed based on the latest evidence. The service is designed to support parents who are at risk of, or experiencing mild to moderate anxiety and depression during pregnancy and the first year after birth.
- Parents-to-be are able to attend between 12 and 28 weeks gestation (the middle trimester of pregnancy). This links well with our Baby Steps programme (a perinatal education group intervention), which begins at or after 28 weeks gestation, so that parents can get high quality support with their mental health as well as preparing for parenthood.
- **Working Together with Parents** courses are run on a regular basis (twice a year). These are aimed at helping parents understand the impact of their behaviour on their baby and give them strategies to cope.
- **Family Links Nurturing Parenting** courses are run by various providers across Swindon. The Nurturing Programme is designed to provide adults and children with the understanding, skills and ability to lead emotionally healthy lives, build resilience, empathy, self-esteem and support positive relationships. These are for parents with children from 9 months to 18+years.
- **Parents under Pressure.** Run by the NSPCC this course works with substance misusing parents of children under five years of age. The course aims to make families happier together by helping parents with the pressure and stress of looking after a young child and managing their drug or alcohol treatment. The 20 week programme provides advice to parents on how to deal with challenging behaviour and how to deal with their own emotions. This includes:
 - using praise and reward to encourage good behaviour
 - developing a good relationship with their child, recognising their feelings and needs (attachment theory)
 - dealing with their emotions, allowing them to keep calm and focus on being a parent.

- **Wellbeing After Baby Course** is a 4 week course which is run on demand by LIFT Psychology. It is targeted at helping people to manage depression and/ or anxiety in relation to their children. This includes, but is not restricted to, mothers with children under 2 years of age. LIFT psychology offers a wide range of psycho educational courses that people can access which are obviously not necessarily specific to mums but can be beneficial. For example, a number of women traumatised at birth attend the post-traumatic stress disorder group.

These initiatives link with the Health Visitor Child Health Programme and parent craft sessions run by Midwifery at GWH. Some initiatives use aspects of Video Interactive Guidance.

An overview of the support available to vulnerable families with children 0 - 2 years is captured diagrammatically in Appendix 2 Diagram of Support for Vulnerable Families Pre-Birth to 2 years

Appendix 2. Diagram of Support for Vulnerable Families Pre-Birth 2 years

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4. Prescribing-Perinatal Mental Health Medication Guidance (NICE 2014)

Starting, using and stopping treatment

General advice

Before starting any treatment in pregnancy and the postnatal period, discuss with the woman the higher threshold for pharmacological interventions arising from the changing risk-benefit ratio for psychotropic medication at this time and the likely benefits of a psychological intervention.

If the optimal treatment for a woman with a mental health problem is psychotropic medication combined with a psychological intervention, but she declines or stops taking psychotropic medication in pregnancy or the postnatal period, ensure that:

- she is adequately supported and
- has the opportunity to discuss the risk associated with stopping psychotropic medication and
- is offered, or can continue with, a psychological intervention.

When psychotropic medication is started in pregnancy and the postnatal period, consider seeking advice, preferably from a specialist in perinatal mental health, and:

- choose the drug with the lowest risk profile for the woman, fetus and baby, taking into account a woman's previous response to medication
- use the lowest effective dose (this is particularly important when the risks of adverse effects to the woman, fetus and baby may be dose related), but note that sub-therapeutic doses may also expose the fetus to risks and not treat the mental health problem effectively
- use a single drug, if possible, in preference to 2 or more drugs
- take into account that dosages may need to be adjusted in pregnancy

When a woman with severe mental illness decides to stop psychotropic medication in pregnancy and the postnatal period, discuss with her:

- her reasons for doing so
- the possibility of:
 - restarting the medication
 - switching to other medication
 - having a psychological intervention
 - increasing the level of monitoring and support.

Ensure she knows about any risks to herself, the fetus or baby when stopping medication.

When a woman with depression or an anxiety disorder decides to stop taking psychotropic medication in pregnancy and the postnatal period, discuss with her:

- her reasons for doing so
- the possibility of:
 - having a psychological intervention
 - restarting the medication if the depression or anxiety disorder is or has been severe and there has been a previous good response to treatment
 - switching to other medication
- increasing the level of monitoring and support while she is not taking any medication.

Ensure she knows about any risks to herself, the fetus or baby when stopping medication.

If a pregnant woman has taken psychotropic medication with known teratogenic risk at any time in the first trimester:

- confirm the pregnancy as soon as possible
- explain that stopping or switching the medication after pregnancy is confirmed may not remove the risk of fetal malformations
- offer screening for fetal abnormalities and counselling about continuing the pregnancy
- explain the need for additional monitoring and the risks to the fetus if she continues to take the medication.

Seek advice from a specialist if there is uncertainty about the risks associated with specific drugs.

Tricyclic Antidepressants (TCA), Selective Serotonin reuptake inhibitors (SSRIs) or (serotonin) noradrenaline reuptake inhibitor ((S)NRI)

When choosing a tricyclic antidepressant (TCA), selective serotonin reuptake inhibitor (SSRI) or (serotonin) noradrenaline reuptake inhibitor [(S)NRI], take into account:

- the woman's previous response to these drugs
- the stage of pregnancy
- what is known about the reproductive safety of these drugs (for example, the risk of fetal cardiac abnormalities and persistent pulmonary hypertension in the newborn baby)
- the uncertainty about whether any increased risk to the fetus and other problems for the woman or baby can be attributed directly to these drugs or may be caused by other factors
- the risk of discontinuation symptoms in the woman and neonatal adaptation syndrome in the baby with most TCAs, SSRIs and (S)NRIs, in particular paroxetine and venlafaxine. [new 2014]

When assessing the risks and benefits of TCAs, SSRIs or (S)NRIs for a woman who is considering breastfeeding, take into account:

- the benefits of breastfeeding for the woman and baby
- the uncertainty about the safety of these drugs for the breastfeeding baby
- the risks associated with switching from or stopping a previously effective medication.

Seek advice from a specialist (preferably from a specialist perinatal mental health service) if there is uncertainty about specific drugs

Benzodiazepines

Do not offer benzodiazepines to women in pregnancy and the postnatal period except for the short-term treatment of severe anxiety and agitation.

Consider gradually stopping benzodiazepines in women who are planning a pregnancy, pregnant or considering breastfeeding.

Antipsychotic medication

When assessing the risks and benefits of antipsychotic medication for a pregnant woman, take into account risk factors for gestational diabetes and excessive weight gain.

When choosing an antipsychotic, take into account that there are limited data on the safety of these drugs in pregnancy and the postnatal period.

Measure prolactin levels in women who are taking prolactin- raising antipsychotic medication and planning a pregnancy, because raised prolactin levels reduce the chances of conception. If prolactin levels are raised, consider a prolactin- sparing antipsychotic

If a pregnant woman is stable on an antipsychotic and likely to relapse without medication, advise her to continue the antipsychotic.

Advise pregnant women taking antipsychotic medication about diet and monitor for excessive weight gain, in line with the guideline on weight management before, during and after pregnancy

Monitor for gestational diabetes in pregnant women taking antipsychotic medication in line with the guideline on diabetes in pregnancy (NICE guideline CG63) and offer an oral glucose tolerance test.

Do not offer depot antipsychotics to a woman who is planning a pregnancy, pregnant or considering breastfeeding, unless she is responding well to a depot and has a previous history of non-adherence with oral medication.

Anticonvulsants for mental health problems (valproate, carbamazepine and lamotrigine)

Do not offer valproate for acute or long-term treatment of a mental health problem in women who are planning a pregnancy, pregnant or considering breastfeeding.

If a woman is already taking valproate and is planning a pregnancy, advise her to gradually stop the drug because of the risk of fetal malformations and adverse neurodevelopment outcomes after any exposure in pregnancy.

If a woman is already taking valproate and becomes pregnant, stop the drug because of the risk of fetal malformations and adverse neurodevelopmental outcomes

Do not offer carbamazepine to treat a mental health problem in women who are planning a pregnancy, pregnant or considering breastfeeding

If a woman is already taking carbamazepine and is planning a pregnancy or becomes pregnant, discuss with the woman the possibility of stopping the drug (because of the risk of adverse drug interactions and fetal malformations).

If a woman is taking lamotrigine during pregnancy, check lamotrigine levels frequently during pregnancy and into the postnatal period because they vary substantially at these times.

Lithium

Do not offer lithium to women who are planning a pregnancy or pregnant, unless antipsychotic medication has not been effective.

If antipsychotic medication has not been effective and lithium is offered to a woman who is planning a pregnancy or pregnant, ensure:

- the woman knows that there is a risk of fetal heart malformations when lithium is taken in the first trimester, but the size of the risk is uncertain
- the woman knows that lithium levels may be high in breast milk with a risk of toxicity for the baby
- lithium levels are monitored more frequently throughout pregnancy and the postnatal period.

If a woman taking lithium becomes pregnant, consider stopping the drug gradually over 4 weeks if she is well. Explain to her that:

- stopping medication may not remove the risk of fetal heart malformations
- there is a risk of relapse, particularly in the postnatal period, if she has bipolar disorder.

If a woman taking lithium becomes pregnant and is not well or is at high risk of relapse, consider:

- switching gradually to an antipsychotic or
- stopping lithium and restarting it in the second trimester (if the woman is not planning to breastfeed and her symptoms have responded better to lithium than to other drugs in the past) or
- continuing with lithium if she is at high risk of relapse and an antipsychotic is unlikely to be effective.

If a woman continues taking lithium during pregnancy:

- check plasma lithium levels every 4 weeks, then weekly from the 36th week
- adjust the dose to keep plasma lithium levels in the woman's therapeutic range
- ensure the woman maintains an adequate fluid balance
- ensure the woman gives birth in hospital

ensure monitoring by the obstetric team when labour starts, including checking plasma lithium levels and fluid balance because of the risk of dehydration and lithium toxicity

stop lithium during labour and check plasma lithium levels 12 hours after her last dose.

Rapid tranquillisation

A pregnant woman requiring rapid tranquillisation should be treated according to the NICE clinical guidelines on the short-term management of disturbed/violent behaviour, schizophrenia and bipolar disorder, except that:

- she should not be secluded after rapid tranquillisation
- restraint procedures should be adapted to avoid possible harm to the fetus
- when choosing an agent for rapid tranquillisation in a pregnant woman, an antipsychotic or a benzodiazepine with a short half-life should be considered; if an antipsychotic is used, it should be at the minimum effective dose because of neonatal extrapyramidal symptoms; if a benzodiazepine is used, the risks of floppy baby syndrome should be taken into account
- during the perinatal period, the woman's care should be managed in close collaboration with a paediatrician and an anaesthetist.

Considerations for women and their babies in the postnatal period

Monitoring babies for effects of psychotropic medication taken in pregnancy

If a woman has taken psychotropic medication during pregnancy, carry out a full neonatal assessment of the newborn baby, bearing in mind:

- the variation in the onset of adverse effects of psychotropic medication
- the need for further monitoring
- the need to inform relevant healthcare professionals and the woman and her partner, family or carer of any further monitoring, particularly if the woman has been discharged early

Psychotropic medication and breastfeeding

Encourage women with a mental health problem to breastfeed, unless they are taking carbamazepine, clozapine or lithium (valproate is not recommended to treat a mental health problem in women of childbearing potential). However, support each woman in the choice of feeding method that best suits her and her family. [new 2014]

When assessing the risks and benefits of TCAs, SSRIs or (S)NRIs for women who are breastfeeding, take into account:

- the limited data about the safety of these drugs and
- the risks associated with switching from a previously effective medication.

Seek advice from a specialist (preferably from a specialist perinatal mental health service) if needed for specific drugs.

When assessing the risks and benefits of antipsychotic medication for women who are breastfeeding, take into account:

- the limited data on the safety of these drugs and
- the level of antipsychotic medication in breast milk depends on the drug.

If a woman is taking psychotropic medication while breastfeeding, monitor the baby for adverse effects.

5. Swindon Perinatal Mental Health Screening Tool

This tool has been designed to be used by all health professionals working with women who are pregnant and in the first year after child birth. All health professionals will talk to both mothers and fathers about perinatal mental illness and local support available in antenatal appointments and postnatal visits, so that they are aware of and alert to the symptoms and know what to do if they are affected.

CLIENT DETAILS	
NAME	
DATE OF BIRTH	
(EXPECTED) DATE OF DELIVERY (EDD)	
ADDRESS	
PHONE NUMBER(S)	
GP PRACTICE	
MIDWIFE	
HEALTH VISITOR	
CHILDREN IN HOUSEHOLD (NAME/DOB)	
FORM COMPLETED BY (NAME/ROLE)	
DATE COMPLETED	
SIGNED	

The form will be completed and signed and a copy kept in the woman's notes.

Health professionals will ask the following depression identification (Whooley) questions as part of a general discussion about a woman's mental health and wellbeing at a woman's first contact with services in pregnancy and the postnatal period.

How are you feeling at the moment?

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

YES NO

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

YES NO

3. Over the past **2 weeks**, how often have you been bothered by the following problems:

	Not at all	Several days	More than half the days	Nearly every day	Not at all
a. Feeling nervous, anxious or on edge	<input type="checkbox"/>				
b. Being unable to stop or control worrying	<input type="checkbox"/>				

4. It is not uncommon for women to struggle with the thought that their life is not worth living.

Do you currently have any such thoughts?

YES NO

Additional information:

Personal history

At a woman's first contact with services in pregnancy and the postnatal period health professionals will ask about:

- any past or present severe mental illness
- past or present treatment by a specialist mental health service, including inpatient care
- any severe perinatal mental illness in the family, particularly a first-degree relative (mother, sister or daughter).

Have you ever suffered from psychological or mental health problems such as depression, bipolar affective disorder, manic episodes, schizophrenia, significant eating disorder or a debilitating anxiety disorder?

a. After delivery	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
b. At any other time	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

If yes, please provide more information

If yes to 5a or 5b:

c. Was it treated?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
d. Is treatment on-going?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

Please tell us about any treatment, medication or therapy you have received or currently using in relation to your mental health.

Family History

Has anyone in your family been diagnosed with a mental health problem?

a. Was it treated?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
b. Is treatment on-going?	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

Please say which family member and tell us about the nature of the problem

Next steps

- If no cause for concern is identified no action is required.
- Further assessment is required if the woman responds in ANY of these ways:
 - Yes to one or more of questions 1, 2, 4, 5a or 5b.
 - Total score of 3 or more to question 3
Scoring: Not at all = 0 / several days = 1 / More than half the days = 2 / nearly every day = 3
 - Question 6 identifies family history of postpartum psychosis in a first degree relative
- If serious/ acute concerns are identified (risk of harm to self or others) contact the Primary Care Liaison Service for immediate advice/assessment of mental health.
- If non acute concerns are identified (no apparent risk of harm to self or others) refer to GP and signpost to LIFT psychology for initial contact/assessment.
- If the woman is identified as having known mental health issues an integrated care plan will be developed for her care that sets out:
 - the care and treatment for the mental health problem
 - the roles of all healthcare professionals, including who is responsible for:
 - coordinating the integrated care plan
 - the schedule of monitoring
 - providing the interventions and agreeing the outcomes with the woman

The care plan will be recorded in all versions of the woman's notes including Primary Care and handheld notes.

All pregnant women identified as having cause for concern will be referred to the Sycamore Antenatal Clinic at Great Western Hospital.

Following review in Sycamore clinic the consultant obstetrician will send a management letter to the GP and relevant care providers. A referral to the Mental Health Team will be considered.

6. Safeguarding

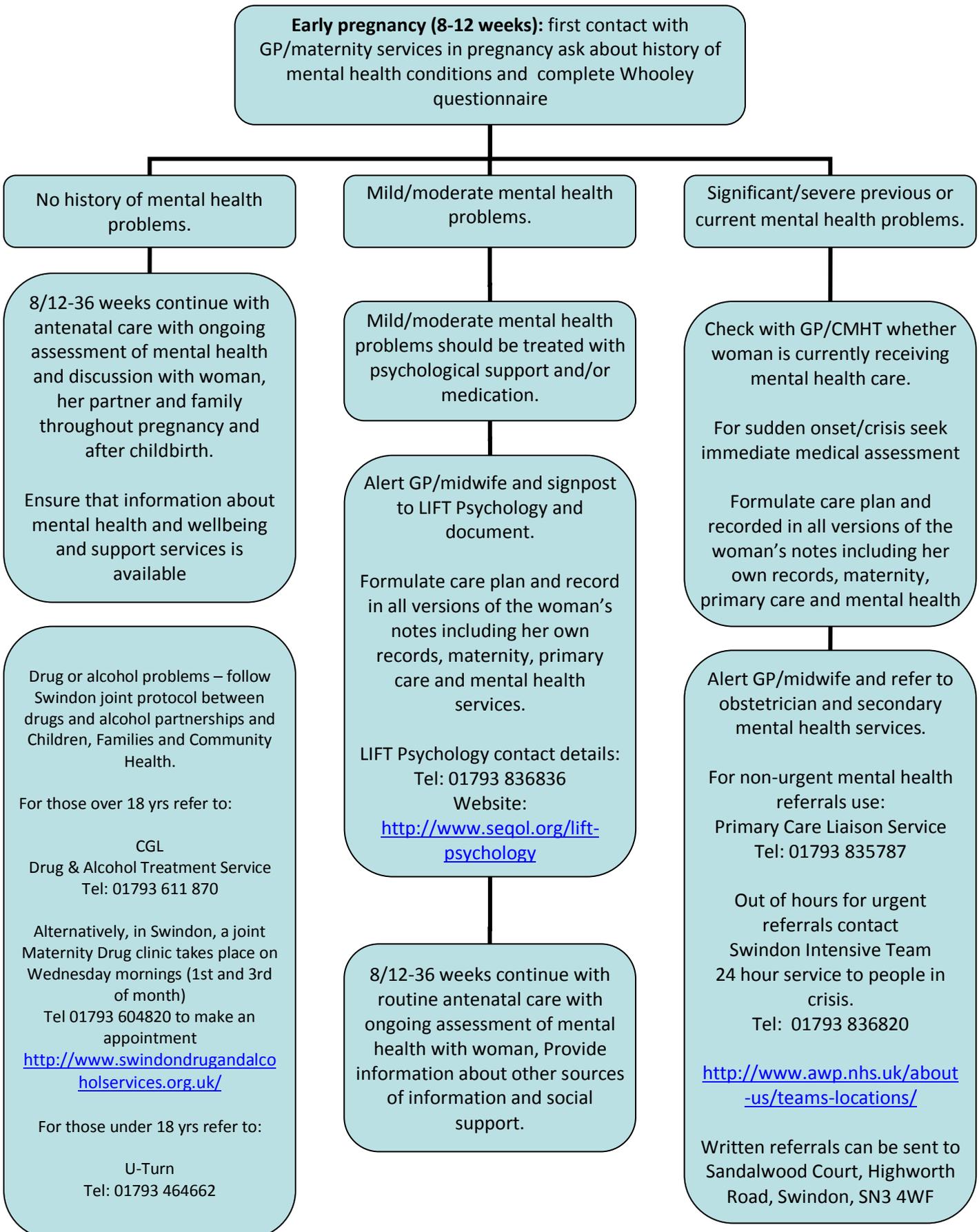
All agencies in contact with children and their families have a responsibility to act if they become worried about a child's welfare or a parent's ability to care for a child safely and adequately.

All professionals will carry out a risk assessment in conjunction with the woman and, if she agrees, her partner or family member, that focusses on areas that are likely to present possible risk such as self-neglects; self-harm; suicidal thoughts and intent; risks to others (including the baby) smoking, drug or alcohol misuse; and domestic violence and abuse.

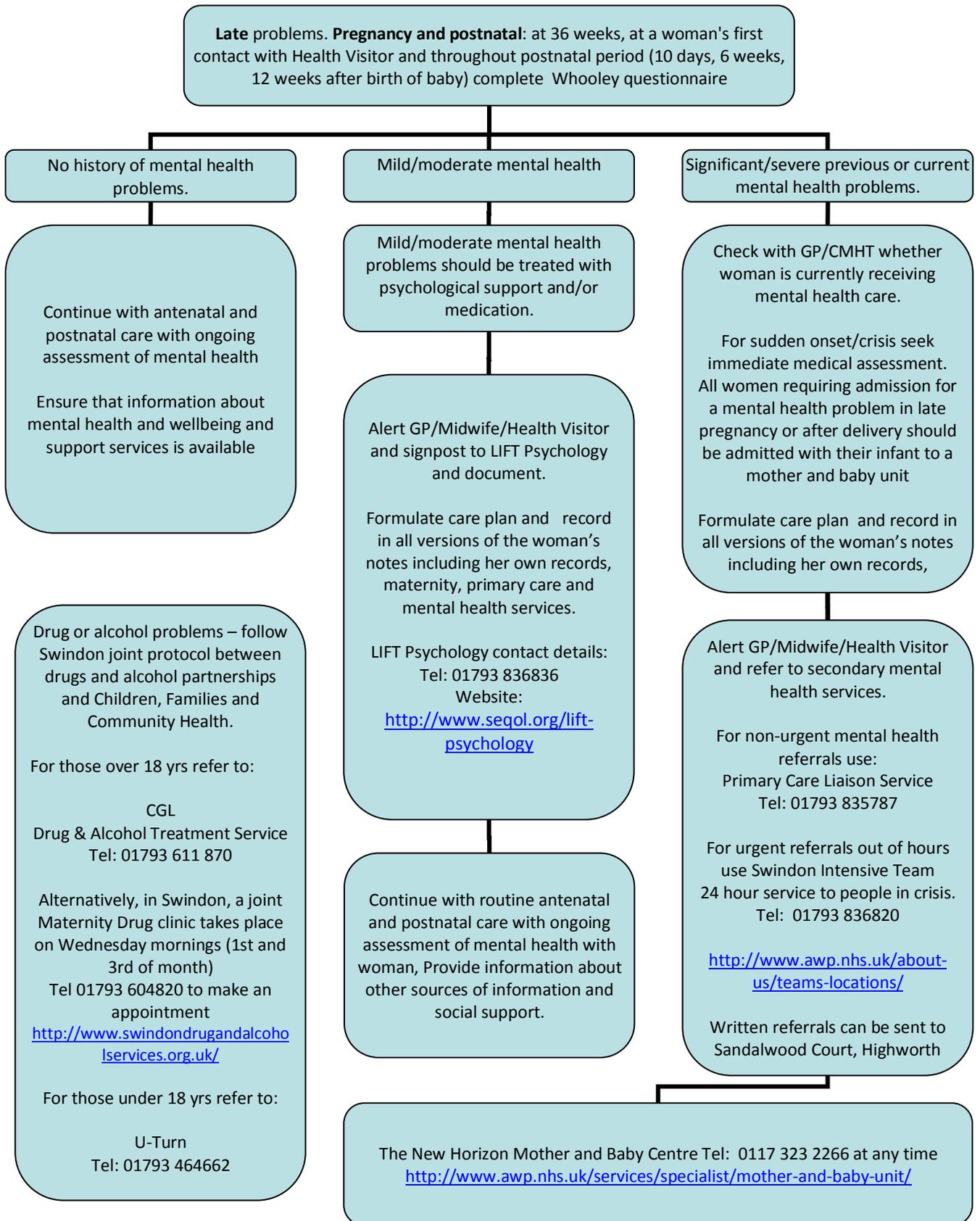
Consider safeguarding issues particularly when past or present severe mental health illness (including schizophrenia, bipolar disorder, and psychosis in the post-natal period) and severe depression is identified.

Actions will be taken in-line with Swindon See The Adult, See The Child Practice Guidelines which provide a framework for multi-agency working across children's and adult's services.

Appendix 1. Swindon Integrated Perinatal Mental Health Pathway

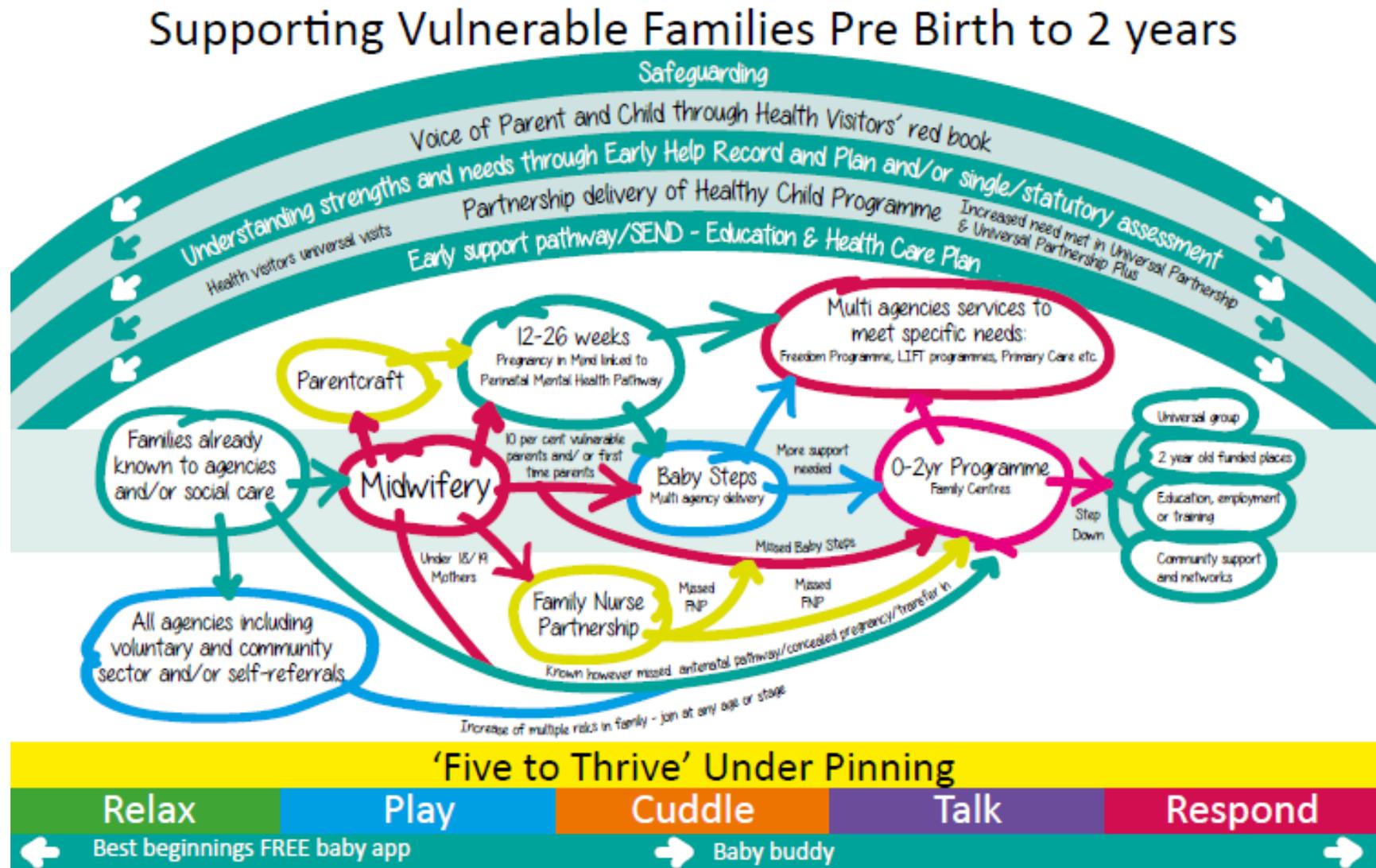


Much of the care given to pregnant women with mental health conditions will follow the care pathway for all pregnant women in accordance with NICE Guidelines and local policy. This additional pathway supplements routine pathways.



Much of the care given to pregnant women with mental health conditions will follow the care pathway for all pregnant women in accordance with NICE Guidelines and local policy. This additional pathway supplements routine pathways.

Appendix 2. Diagram of Support for Vulnerable Families Pre-Birth to 2 years



Appendix 3. AWP Perinatal Mental Health Pathway

