Perinatal Mental Health - Full Clinical Guideline

Reference No.: UHDB/07:23/M3

Contents

1. Introduction

Mental health problems during pregnancy and in the postnatal period are common, with 1 in 5 women likely to develop depression or anxiety in the year following birth, of which 2 in 1000 women will be affected by postpartum psychosis.

The MBRRACE report (2018) found that 1 in 4 maternal deaths between six weeks and 1 year after delivery died from mental health related causes and 1 in 7 women died from suicide.

Untreated mental illness can negatively impact on not only the woman but also her family/support network. It may also impact on bonding and attachment between her and her baby, leading to vulnerability and potential safeguarding issues.

2. Purpose and Outcomes

The aim of this guideline is:

- Raise awareness of perinatal mental health problems, referral pathways and local IAPT/Support services
- To increase awareness of how poor mental health can impact on parenting ability and safeguarding
- To ensure women are referred to appropriate services in a timely manner.
- To give guidance on the use of medication in pregnancy and breastfeeding.
- To ensure a robust plan of care and reduced risk.
- To reduce confusion and anxiety for women.

3. Abbreviations

ANC	-	Antenatal Clinic
CBT	-	Cognitive Behavioural Therapy
CSC	-	Children's Social Care
ECG	-	Electro-cardiograph
EHA	-	Early Help Assessment
EMDR	-	Eye Movement Desensitisation and Reprocessing
GAD	-	Generalised Anxiety Disorder
GTT	-	Glucose Tolerance Test
IAPT	-	Improving Access to Psychological Therapies
MMHS	-	Maternal Mental Health Service
NEWTT	-	Newborn Early Warning Trigger and Track
OCD	-	Obsessive Compulsive Disorder
PMH	-	Perinatal Mental Health
PTSD	-	Post-Traumatic Stress Disorder
SBAR	-	Situation, Background, Assessment and Recommendations)

4. Antenatal period

4.1 Assessment in the Antenatal Period

An initial assessment of mental health and wellbeing will be undertaken by the booking midwife.
When assessing the woman's mental health, the professional should consider the woman holistically considering possible reasons for poor emotional wellbeing including poor physical health, complex social circumstances, and family support. Consideration also needs to be given to their capacity to parent.
See safeguarding section for more information.

All women with a significant past mental health history or current severe mental health illness should be referred to the perinatal mental health team and booked into the perinatal mental health ANC **(see appendix 1 for guidance)**
Women should consequently be asked about their mental health and wellbeing at every opportunity and referrals made where appropriate.
Professionals should also be aware of the **Red Flags: -**

- 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.

Where the professional identifies any of the above an urgent referral to the perinatal mental health team is required along with booking the woman into the perinatal mental health ANC.
Consider crisis care **(See appendix 2 Staffordshire - appendix 3 Derbyshire for guidance)**

4.2 Parents with mental health issues

Practitioners involved with pregnant women, birth fathers or partners who have mental health issues, should seek clarification as to whether they are currently or previously known to mental health support services. In addition, consideration should be given to the possibility of a duel diagnosis (substance misuse and mental health issues) and/or domestic abuse.

Women already in the care of mental health services will have their care extended to include perinatal mental health team/perinatal mental health midwives. If appropriate this will usually be coordinated by the metal health team involved however the community midwife should ensure this has been completed by contacting the perinatal mental health team/perinatal mental health midwives
Consent should be sought from the woman to contact the named mental health team to ensure they are aware of the pregnancy and appropriate advice and planning can be completed.

4.3 Documentation

It is essential that there are clear communication pathways and documentation of plans to facilitate effective multidisciplinary working.
It is the responsibility of the referring practitioner to ensure that when a referral has been made to the perinatal mental health team and perinatal mental health midwives it is clearly documented within the women's handheld and electronic records (Lorenzo/V6)

Where a woman has a history of mental health difficulties a brief (as a min) comment on mental health is required within the electronic records rather than relying on "tick boxes" (MBBRACE 2018)

All future contacts where there are concerns with a woman's mental health the practitioner must clearly document their concerns within the Mental Health Communication log on Lorenzo and the Safeguarding pages on V6 as well as informing the Perinatal mental health midwives via email uhdb.pmhmidwives@nhs.net to ensure follow up.

Each contact with the perinatal mental health team and perinatal mental health midwives will be clearly documented by the perinatal mental health midwives and filed behind purple dividers within the obstetric notes and within the mental health communication log on Lorenzo and Safeguarding pages on V6.

5. Assessment of Maternal Mental Health during the Postnatal Period

5.1 Postnatal Assessment

At the earliest opportunity in the postnatal period relevant risk factors for mental health illness will be considered and enquiries made on the following: -

- Previous psychiatric history
- Previous postnatal depression
- Family history of psychological illness
- Lack of support
- Any behaviour that reflects lack of coping strategies including any current or previous substance misuse,
- Current or previous acts of self-harm or attempted suicide,
- Routine Enquiry of any Domestic Abuse of any category,

Enquiries should also be made for the following:

- Fatigue (excessive sleeping, inability to get to sleep, premature waking)
- Appetite (Overeating or lack of appetite)
- Emotions (excessive anxiety and postnatal depression)
- Parent and infant attachment problems

On-going assessment of mental health and wellbeing should be made at each postnatal visit and documented within the postnatal notes, Lorenzo/version 6 and a subsequent management plan documented therein. **(See 4.3 documentation)**

Women under mental health services will require a verbal midwife to midwife handover at discharge from the postnatal ward and again at the point of discharge from midwifery care.

6. Medication in Pregnancy

If the woman is being prescribed psychiatric medication, the health practitioner should liaise with the prescriber (GP or Psychiatrist) to discuss a medication review for appropriateness in pregnancy.

- Medication **ALWAYS** needs checking **EARLY** in pregnancy and ideally before if a planned pregnancy.
- Anti-depressants should **NOT** be automatically stopped in early pregnancy.
- If women wish to stop medication, this needs to be done slowly and monitored by the prescribing professional.

Women medicated with antipsychotic medication during pregnancy should be advised on diet and monitoring weight gain in pregnancy and must be offered Glucose Tolerance Test (GTT) between 24 - 28 weeks gestation.

A Neonatal Alert Form should be completed **(QHB only)** if the woman is on medication so that the Neonatologist can advise if there may be any adverse effect on the fetus and the planned care for the baby. Maternal medication should be documented on the baby notes form in the obstetric notes during the antenatal period. **(RDH only)**

See Neonates exposed to prescribed medications including Anti-depressants and other drugs in pregnancy guideline for guidance.

Class of Medication	Name of Medication	Assessment and Monitoring Antenatal/Postnatal
SSRI	Citalopram Sertraline Escitalopram Fluoxetine Paroxetine Fluvoxamine	No indication for increased monitoring in antenatal period, beyond psychiatric monitoring as going through pregnancy. From available data on use in pregnancy there is not enough evidence to warrant foetal monitoring; although potential for transient neonatal withdrawal symptoms. Will require 24 hour NEWTTS following delivery.
Atypical Antidepressant	Mirtazapine	No indication for increased monitoring in antenatal period. Beyond psychiatric monitoring as going through pregnancy. From available data on use in pregnancy there is not enough evidence to warrant foetal monitoring; although potential for transient neonatal withdrawal symptoms. Will require 24 hour NEWTTS following delivery
Tricyclic Antidepressants	Amitriptyline Clomipramine Dosulepin Doxepin Imipramine Lofepramine Nortriptyline	No indication for increased monitoring in antenatal period. Beyond psychiatric monitoring as going through pregnancy. From available data on use in pregnancy there is not enough evidence to warrant foetal monitoring; although potential for transient neonatal withdrawal symptoms. Will require 24 hour NEWTTS following delivery
SNRI	Venlafaxine Duloxetine	No indication for increased monitoring in antenatal period. Beyond psychiatric monitoring as going through pregnancy. From available data on use in pregnancy there is not enough evidence to warrant foetal monitoring; although potential for transient neonatal withdrawal symptoms. Will require 24 hour NEWTTS following delivery

Antipsychotic 1st generation "typical" 2nd generation "atypical"	Haloperidol Chlorpromazine Promethazine Flupenthixol Quetiapine Olanzapine Clozapine	Needs GTT between 24 – 28 weeks gestation ECG if starting any antipsychotic If taking Clozapine will require Full Blood Count Monitoring. Potential for transient neonatal withdrawal symptoms. Will require 24 hour NEWTTS following delivery
Mood stabiliser	Lithium	Serum lithium levels every 4 weeks, then weekly from 36 weeks and within 24hrs of delivery Monitor fluid balance, prevent dehydration in labour due to risk of lithium toxicity

MHRA advice on valproate: In April 2018, warnings that valproate must not be used in pregnancy, and only used in girls and women when there is no alternative, and a pregnancy prevention plan is in place. This is because of the risk of malformations and development abnormalities in the baby.

7. Perinatal Mental Health Community Teams

As perinatal mental health problems can range from mild to extremely severe, they will require different pathways, management, and care. If we can identify early the individuals prone to relapse and those who develop new illness, we can promote a timely recovery and mitigate many of the negative effects of perinatal mental health problems for women, their infants, and their wider families.

The perinatal community mental health teams provide specialist input to women experiencing significant mental health difficulties during pregnancy and the first year following a child's birth.

They also work to minimise the risk of relapse in those women who are currently well but who have a history of severe mental illness.

Preconception counselling appointments are available with the perinatal mental health service for those with a diagnosed severe mental illness.

7.1 Community Team Staffordshire

7.2 Referral criteria

- Minimum age is 16+
- Previous Puerperal Psychosis
- Bipolar Affective Disorder
- Schizo-Affective Disorder
- Previous depression resulting in hospital admission.
- Moderate/Severe depression
- Moderate/Severe Anxiety
- OCD
- Personality Disorder
- Family history of Bipolar

- RED FLAGS
- Referral forms (found on Net-i) can be emailed to: -
- Perinatal.communityteam@mpft.nhs.uk
- uhdb.pmhmidwives@nhs.net
- Telephone Number – **0300 3034132**

Referrals are discussed daily by the duty worker and an outcome letter will be sent to the referrer.
If staff wish to discuss a referral, they are able to access a member of the perinatal mental health team on **0300 3034132**

(See appendix 4 for referral form)

7.3 Community Team Derbyshire

7.4 Referral criteria

- Diagnosis of serious mental illness such as bipolar affective disorder, schizophrenia, severe depression, anxiety disorder
- Women who have developed significant mental health difficulties after the first trimester in pregnancy or following delivery that cannot be managed in primary care.
- First degree relative with bipolar disorder or serious postnatal illness
- Previously under the care of perinatal mental health services
- Previous admission to a psychiatric unit
- Referral forms (found on Net-i) can be emailed to: -
- dhcft.perinatalcmht@nhs.net
- uhdb.pmhmidwives@nhs.net
- Telephone Number – Southern Team – **01332 623911** - North Team – **01246 216523**

Referrals are discussed daily, and an outcome letter will be sent to the referrer
If staff wishes to discuss a referral, they can access a member of the Perinatal Mental Health Team via the helpline. Mon, Tues, Thurs, Fri 09.30-12 noon **03001237596**

(See appendix 5 for referral form)

8. Mother and Baby Units

The aim is to provide inpatient mental health services to women experiencing psychological and emotional difficulties related to the latter stages of pregnancy, childbirth, and early motherhood.

8.1 Brockington Mother and Baby Unit (Staffordshire)

The Brockington unit is a specialist facility which can accommodate 8 mothers and their babies (babies who are up to 12 months prior to admission). We also admit pregnant women who are 32 weeks pregnant or above.

8.2 Referral criteria

- Postpartum Psychosis
- Bipolar Affective Disorder
- Schizo-affective disorder and other psychoses
- Other serious / complex conditions
- Women in the antenatal period over 28 week's gestation who are experiencing a moderate to severe depression.
- Previous puerperal psychosis.
- Previous depression resulting in hospital admission.
- Current moderate to severe depression.
- Minimum age of mother is 16+.
- Referrals are accepted by telephoning the ward on **01785 221560**

8.3 The Beeches (Derbyshire)

The Beeches is specialist inpatient facility based at The Radbourne Unit which can accommodate 6 mothers and their babies. They also admit pregnant women from 32 weeks pregnant or above.

8.4 Referral criteria

- Symptoms of puerperal psychosis
- Severe postnatal depression
- Severe anxiety disorder
- Significant disorders of bonding
- Relapse of existing mental illness

These conditions can develop insidiously or extremely suddenly during pregnancy and in the Post-partum period. Post-partum psychosis and severe affective illnesses are particularly likely to occur close to delivery and are severe and sudden in their presentation, constituting a medical emergency.

Alternatively, NHS WebBeds is a free online bed management tool for specialist perinatal mental health mother and baby units. ... Referral details available on this site are provided to assist in locating a bed in a mother and baby unit. Referrers are responsible for making the referral.

https://nhswebbeds.co.uk/

If criteria for perinatal mental health team is not met, please consider other services.

9. Maternal Mental Health Service

The maternal mental health service (MMHS) provides specialist psychological care to people who are experiencing a range of mental health difficulties associated with perinatal loss, including miscarriage, early ending of pregnancy, stillbirth, neonatal death, as well as tokophobia and birth trauma. The MMHS covers the Derbyshire area, with the Lotus service in place for Staffordshire.

The service works in partnership with maternity services, the perinatal service, commissioners, third sector organisations including Connected (formerly Derbyshire community parenting program), Derbyshire maternity and neonatal voices, and the regional to identify the gaps in service provision and develop the service accordingly.

9.1 Referral Criteria

Women who are experiencing moderate to severe mental health difficulties because loss and / or trauma including:

- Miscarriage
- Termination / early ending of pregnancy for social or medical reasons.
- Stillbirth
- Neonatal death
- Pregnancy after loss
- Tokophobia (Severe fear of pregnancy / childbirth)
- Birth Trauma

Referrals should be made at least a month following the loss / trauma to allow for natural healing to take place. See appendices as follows for full referral pathways.

Appendix 6 Loss pathway - Derby
Appendix 7 Pregnancy after loss pathway - Derby
Appendix 8 - Lotus referral form - Burton

For full Tokophobia pathway see SOP included within antenatal guidelines.

10. NHS Talking Therapies

NHS Talking therapies services are designed to help people age 16+ with common mental health problems.

10.1 Referral Criteria

- Depression
- Social Phobia
- Generalised Anxiety Disorder (GAD)
- Panic Disorder with or without Agoraphobia
- Obsessive Compulsive Disorder
- Specific Phobia
- Post-Traumatic Stress Disorder – Single event traumas
- Health Anxiety (Hypochondriasis)
- Long term health conditions that is impacting mental health
- Loss including miscarriage, abortion and still births

Ninety percent of women diagnosed with a perinatal mental illness are cared for by primary care services. In many cases treatment is effective.
Women can self-refer,

Staffordshire Stoke on Trent and Wellbeing service – **0300 303 0923**
https://staffsandstokewellbeing.nhs.uk/pages/self-refer

Trent PTS – **01332 265659**
Talking Mental Health – **0300 123 0543**
https://www.derbyandderbyshireccg.nhs.uk/your-health-services/information-for-patients/improving-access-to-psychological-therapies-iapt

11. Management of Psychiatric and Psychological Conditions

Disorder	Symptoms	Management
Generalised Anxiety Disorder	Anxiety is a feeling people get when a situation is threatening or difficult, in generalised anxiety, these feelings are present all the time and panic attacks are unpredictable, sudden, and intense attacks of anxiety.	Referral to Perinatal Mental Health Team/ PMH ANC may not be required if being successfully managed in primary care. Please inform women of local IAPT services as CBT should be offered as first line management.
Obsessive Compulsive Disorder (OCD)	The urge to think or do certain things repeatedly that dominates their life.	Referral to the Perinatal Mental Health team/PMH ANC may be required. OCD in pregnant and postnatal; women can be a serious problem for the woman, her baby, and her family. CBT should be offered as first line management – Consider IAPT
Post-Traumatic Stress Disorder (PTSD	Is an anxiety disorder caused by very stressful, frightening, or distressing events.	If PTSD is childbirth related, referral to Maternal Mental Health Service/ PMH ANC will be required. Drug therapy is not particularly successful in PTSD (except for treatment of specific symptoms) Trauma-focused psychological therapy is preferred e.g. CBT, EMDR- Eye Movement desensitisation and reprocessing Therapy and

		Compassionate Mind Training
Bipolar Disorder	A person with bipolar disorder will have periods of depression and abnormally elevated mood lasting several weeks or months.	Pre-conceptual advice recommended to discuss continuation/change of medication. Women should be referred to the Perinatal Mental Health team/ PMH ANC and be monitored closely throughout the whole perinatal period. The risk of relapse/psychosis in the postnatal period is 50%
Schizophrenia	A disorder of the mind that affects how an individual thinks, feels and behaves.	Referral to Perinatal Mental Health team/ PMH ANC is required. Women with schizophrenia should be cared for in accordance with the NICE clinical guideline on the treatment and management of schizophrenia.
Puerperal Psychosis	A condition which brings about a rapid deterioration in a woman's mental health, characterised by bizarre and strange behaviours, hearing voices and hallucinations which pose a serious risk to herself, her baby and those around her.	The onset of puerperal psychosis is often within a week of giving birth. Psychiatric assessment and admission to the mother and baby unit will be required **(See appendix 2 Burton 3 Derby for further guidance)** Pregnant women with a history of puerperal psychosis need referral to the Perinatal Mental Health team/ PMH ANC and close monitoring in the 3rd trimester by the Multi-Disciplinary Team.

12. Management of Crisis Care in Hospital

Where staff observe potential symptoms of severe depression/anxiety or abnormal behaviour including lack of interaction with the baby an urgent mental health assessment will be required **(See appendix 2 Burton - appendix 3 Derby for guidance)**

It is not the role of the maternity services staff to identify the condition, only to identify the acute deviation from normal and refer immediately.

- Inform specialist midwife for perinatal mental health (if in working hours), the matron or senior midwife on duty (if out of hours)
- The plan of care must be clearly documented and communicated to the community midwife, the GP and health visitor should be informed of above events to ensure continuation of the care package. A phone call to the community midwife in addition to the normal postnatal discharge paperwork is required to ensure a detailed SBAR (Situation, Background, Assessment and Recommendations) is provided.
- The woman should be informed at all stages of actions taken by staff.
- If an unborn/newborn child is deemed to be at risk due to the mother's health, a referral should be made to social services following the **trust policy for safeguarding children**

12.1 Management of Crisis Care in Community

Where staff observe potential symptoms of severe depression/anxiety or abnormal behaviour including lack of interaction with the baby an urgent mental health assessment will be required **(See appendix 2 Burton, 3 Derby for guidance)**

It is not the role of the maternity services staff to identify the condition, only to identify the acute deviation from normal and refer immediately.

- Contact specialist midwife for perinatal mental health (if in working hours) the community midwife manager, on call manager to advice of the situation (If out of hours)
- Follow lone worker policy.
- Liaise with GP, colleagues and health visitor regarding outcome and treatment to ensure continuation of the care package.
- Child protection **-** follow the trust's policy for safeguarding children if required.

The local mental health services crisis team will be responsible for referral to appropriate services.

13. Specialist Midwives Perinatal Mental Health

As specialist midwives for perinatal mental health, they play a crucial role in improving the quality of maternity services and supporting the development and implementation of integrated pathways of care for women with perinatal illness. They play a critical part of multiagency perinatal mental health clinical pathways. However, they are not a substitute for specialist perinatal mental health care, nor for the mental health care delivered by all midwives. Mental health care is a core part of the role of all midwives.
They can offer advice and act as a point of contact helping to coordinate care for women and improve awareness and understanding amongst professionals. This does not replace but support the role of all midwives in caring for the mental health of women and their families they work with.

Burton
Corinne Ward – lead midwife for perinatal mental health - 07976788112
Sophie Brett – Midwife for perinatal mental health
01283 511511 Ext 4344
uhdb.pmhmidwives@nhs.net
Consultant – Dr Banerjee

Derby
Corinne ward – Lead midwife for perinatal mental health – 07976788112
Angela Harris – Midwife for perinatal mental health
Trudie Chambers – Midwife for perinatal mental health
01332 340131
07799337631
uhdb.pmhmidwives@nhs.net
Consultant – Dr Robinson

14. Safeguarding Children

Eight present of the women who died during up to a year after pregnancy in the UK in 2016-2018 were at severe and multiple disadvantages. The main elements of multiple disadvantages were a mental health diagnosis, substance misuse and domestic abuse, research has found that:

- Children whose parents have poor mental health are more likely to have a mental disorder.
- Approximately 30% of adults with mental illness have dependent children.
- At any one time approximately 10,000 children and young people are caring for a parent with mental ill health
- 25% of children subject to child protection plans have a parent with mental illness.
- 33% of children with emotional and behavioural disorder have a parent with mental health problems.
- Post-natal depression can be linked to both behavioural and emotional problems in the children of affected mothers.
- The stigma associated with mental illness can impair parenting capacity.

In extreme cases a child may be at risk of severe injury, neglect, or death. A study of 100 child deaths where abuse or neglect had been a factor showed evidence of parental mental illness in one third of cases.

The potential for adverse impact on the child's welfare increases when:

- The parent/carer becomes so pre-occupied by their own needs that they cannot empathise with the child in the usual way or prioritise the child's needs above their own.
- The child features in the adult's delusions.
- The child becomes the focus of the parent's aggression.
- Other risk factors such as substance misuse and/or domestic abuse are also present.

It is important that practitioners use a Think Family approach to ensure the needs of the children, parents and carers are considered, taking into account the woman's mental health needs as well as any mental health needs of her partner and the parent's ability to meet the needs of the children or any dependants within the household.
The voice of the child including the unborn should be the primary focus.

Professionals should have the confidence to question and challenge and should consider:

- The Pressures on family members who are living with a parent with a mental health problem,
- The impact of mental health issues on parenting capacity,
- Parental history,
- Young carers in the household. Young carers should be offered support to address impacts before they become acute.

The core aim of preventive intervention is to minimise the impact of mental illness on parents and their children. This can be achieved by clear and explicit assessment of need including stressors and protective factors and approaches involving the parents or parents to be.

The parent needs to have full access to the range of services available in the local area and information about support. Seeking help and support for parenting should be seen as a positive indicator.

If the professional feels as though the family would benefit from additional family support and consent from the woman is obtained, then an Early Help Assessment should be considered with the family.

If the assessment by the health professional at any time suggests that the Unborn/Newborn baby/existing children are considered to be at risk a referral needs to be made to Children's Social Care.
Follow the Trust policy for safeguarding children for further guidance.
Further guidance can also be found on the Derby & Derbyshire Safeguarding Children's Partnership website.
https://www.proceduresonline.com/derbyshire/scbs/user_controlled_lcms_area/uploaded_files/Derby%20and%20Derbyshire%20Pre%20Birth%20Protocol%20FINAL%20May%202020.pdf
or for referrals to Staffordshire Safeguarding Children Board at, https://www.staffsscb.org.uk/wp-content/uploads/2020/07/Responding-to-concerns-about-unborn-child-final.pdf

14.1 Potential Impact of Parental Mental Ill-Health on Children

Parenthood is generally stressful for all parents. The presence of mental illness may impose additional burdens which can alter the efficiency and effectiveness of parenting and the capacity to meet children's needs.

The majority of mentally ill parents do not abuse or ill-treat their children. However, a recent biennial analysis of serious case reviews found that parental mental ill-health had an impact in 45% of cases where children were seriously injured or killed by their parent or carer.

It must be acknowledged therefore that there are a small but significant number of families in which the presence of a mental illness in conjunction with other risks and stressors serves to outweigh parental coping capacities and this may prevent parents from meeting the needs of their children and ensuring their safety.

The presence of a mental illness can affect how parents:

- **Provide physical care**: lack of energy, poor concentration, altered belief systems and fear of going out can adversely affect tasks such as responding to a child's physical illness, shopping, cooking and other household chores.
- **Manage children's behaviour**: this requires energy, decisiveness, concentration, and emotional control. All can be impaired by excessive emotional liability, poor concentration, distorted thinking, and despair.
- **Respond emotionally** in order to support and contain children: mental illness may be associated with self-preoccupation and need for emotional support that can impair the capacity to accept and tolerate feeling of others. The parent may turn to the children for emotional support.
- **Develop self-confidence in parenting**: symptoms can lead to or be associated with a sense of failure as a parent, which generates further anxiety, guilt, and low self-esteem, all of which can further impair parenting and exacerbate symptoms.

An Early Help Assessment (EHA) should be developed as early as possible once the midwife has identified issues that would benefit from the assessment. Consent is required for an EHA; this is not a referral as such but should be seen as a request for service and support. Where there is severe and enduring mental illness a referral to CSC for a pre-birth assessment should be made as early as possible.

Psychiatric opinion on the issues below should be obtained by the specialist midwife in perinatal mental health in the first trimester in relation to women, or their partners, where they are, or have been, open to specialist mental health services to support an EHA or other assessments by health and social care staff in relation to parenting capacity.

- The nature, severity, and duration of the illness
- Child involvement and exposure to parental symptoms
- Alterations in parenting
- Alterations in family structure or functioning
- Effects of parental treatment
- Contingency plan
- The toxic trio (Domestic violence/Substance Misuse/Mental health occurring together)

(See appendix 9)

It is important that there is a liaison between all involved services and mental health services. If mental health may have an impact on their ability and capacity to parent a more detailed risk assessment must be sought from mental health services.

15. Women Requiring Translation Services

In cases where English is not the first language of the woman the midwife should facilitate the use of interpreting services to ensure that the woman's mental health needs can be adequately assessed and onward referral made as appropriate.

16. Monitoring Compliance and Effectiveness

As per Business Unit audit forward programme

17. References

BROCKINGTON, I.F. (1996) *Motherhood and mental health* Oxford University Press

CAMH (2006) *Puerperal Psychosis www.carmh.net*

MBRRACE-UK: Saving Lives, Improving Mothers' Care report for 2018, 1 Nov 2018

ELLIS, D., (2006) *Depression in Pregnancy* www.depression-in-pregnancy.org.uk, symptoms

O'HARA, MW & SWAIN AM (1996) *Rates and risk of Postpartum Depression – A meta-analysis* International Review of Psychiatry (INT REV PSYCHIATRY), 8,37-54

NICE (2014) *Antenatal and Postnatal Mental Health*: Clinical management and service guidance. BPS and RC Psych.

NONACS. R, COHEN LS (1998) *Postpartum mood disorders: diagnosis and treatment guidelines*. J Clin Psychiatry 59 Suppl 2: 34-40.

Pan London perinatal mental health care pathways, October 2015

Taylor DM et al The Maudsley prescribing guidelines in psychiatry 13th ed Chichester: Wiley-Blackwell 2018

THE ROYAL COLLEGE OF PSYCHIATRISTS (2006) *Post natal depression* www.rcpsych.ac.uk

UKTIS drug monographs on http://www.toxbase.org ; Bazire S Psychotropic drug directory 2020/21 Shaftesbury: Lloyd-Reinhold Publications 2020

WISNER, KL (1994) *Prevention of recurrent postpartum major depression*. Hospital and Community Psychiatry, 45, 1191-96

Referral criteria for perinatal mental health team and Perinatal mental health ANC

Previous Psychosis
Bipolar disorder
Schizophrenia disorder
Previous admission to a psychiatric unit
Severe depression
Severe anxiety
OCD
Personality disorder
First degree relative with bipolar disorder or serious postnatal illness

Yes

Refer to perinatal mental health team.
dhft.perinatalcmht@nhs.net (Derby)
perinatalcommunityteam@sssft.nhs.net (Staffs)
uhdb.pmhmidwives@nhs.net (Copy in email)

Book into PMH ANC
RCRMH - Tues afternoon (Derby)
BANCONS - Thurs afternoon (Burton)

No

Mild to moderate mental health difficulty
Signpost to community services
G.P - IAPT
Talking mental health and Trent PTS (Derby)
Perinatal wellbeing (Staffs)

On medication

Yes

If on antidepressant medication and well **STAY ON THEM**
Good safety profile for Citalopram, Sertraline, Duloxetine, Venlafaxine, Mirtazapine (See guideline for more information) Can be booked under any consultant and return to **MWLC** if no other reasons for CLC identified.

No

Discuss Mental health at every opportunity.
Be aware of **red flags.**

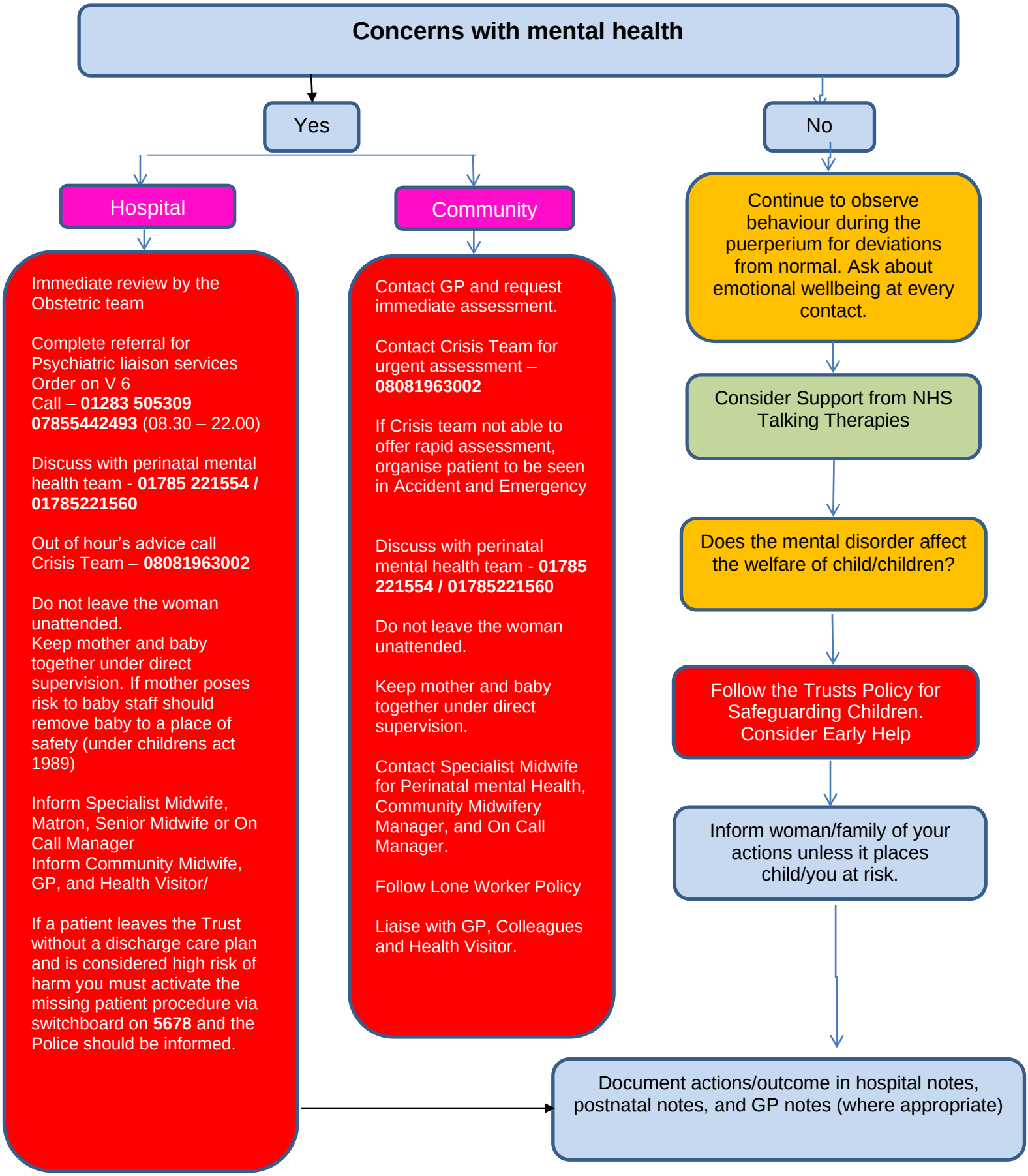
Perinatal need identified. Transfer booking to PMH ANC and refer to PMHT as above.

RED FLAGS
The mind changes as well as the body during and after pregnancy women who report.

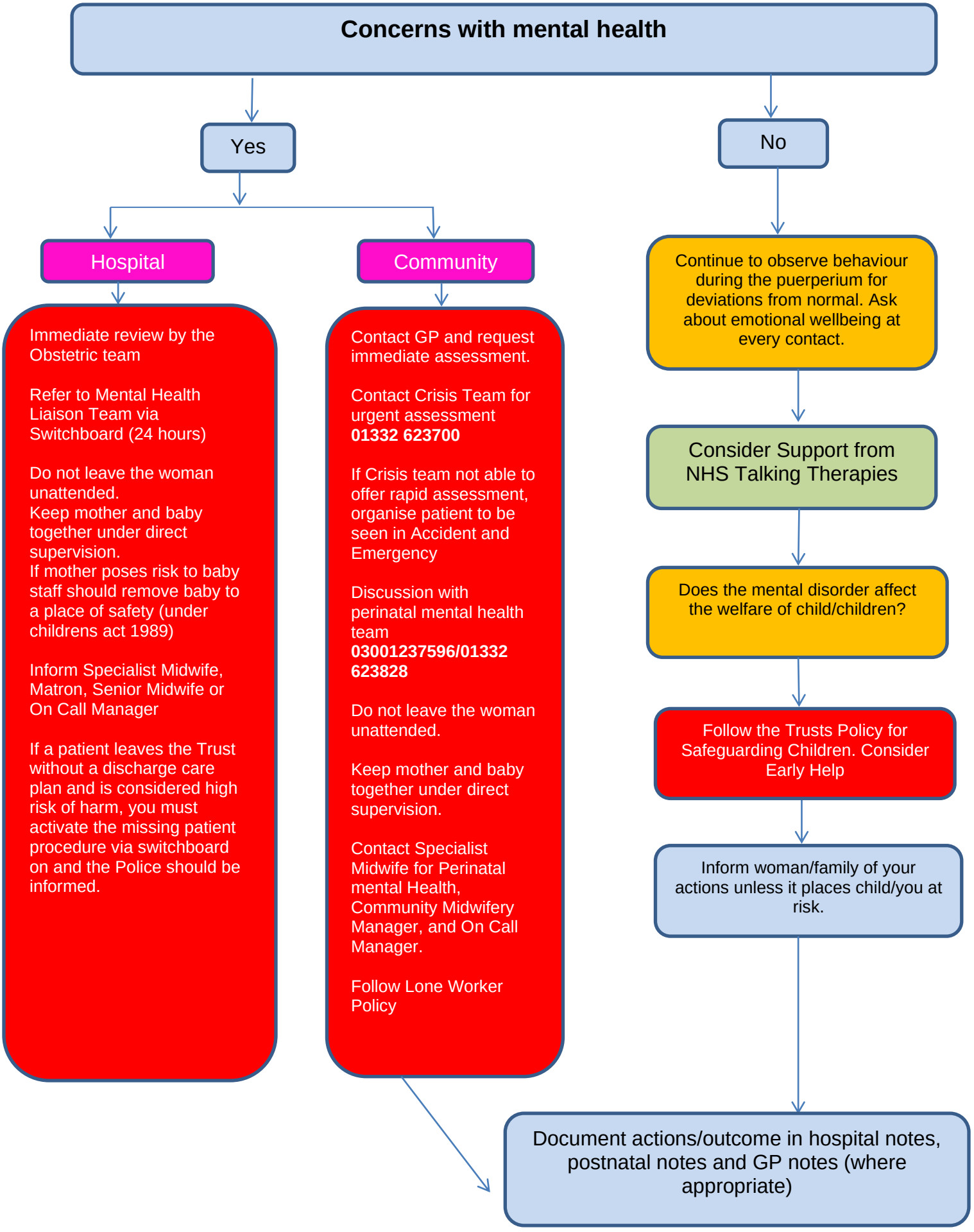
- New thoughts of violent self-harm
- Sudden onset or rapidly worsening mental symptoms.
- Persistent feelings of estrangement from their baby

Need an urgent referral to the PMHT

MANAGEMENT OF PUERPURAL PYSCHOSIS / SUICIDE RISK
Burton



MANAGEMENT OF PUERPURAL PYSCHOSIS/SUICIDE RISK
Derby



REFERRAL FOR COMMUNITY PERINATAL MENTAL HEALTH TEAM

Client Name:	Date of Referral: Name of Referrer: Job Title:
Address	DOB:
	NHS No.:
Tel No. (Home): Mobile No.: Preferred Contact No	Next of Kin:
Employment Status: U/E.	Ethnicity: White, British.
EDD (if applicable):	Baby's DOB (if applicable): Baby's Name:
Other Children: Reside with:	
Health Visitor Name: Correspondence Address: Team Email Address: Tel No.:	Community Midwife Name: Correspondence Address:
General Practitioner: Tel No:	Practice Address:

Reasons for referral: *Please include information regarding presentation, diagnosis, previous or current involvement with mental health services, contact with baby, any other appropriate information.*	
Current medication:	
Risk and Safeguarding (including current and past self-harm, suicidal ideation and safeguarding)	
Is client aware of the referral? Yes ☐ No ☐	Child Protection Plan? Yes ☐ No ☐
Child In Need? Yes ☐ No ☐	Early Help? Yes ☐ No ☐
Social Worker Details/ Early Help Lead Details (if applicable):	
Please forward referral form with attachment to: Community Perinatal Mental Health Team , St Chads House, St George's Hospital, Corporation Street, Stafford, ST16 3AG Telephone Number: 01785 221554 Fax Number: 01785 240502 Email Address: perinatal.communityteam@sssft.nhs.uk	

REFERRAL FOR DERBYSHIRE PERINATAL COMMUNITY MENTAL HEALTH SERVICE

INFORMATION FOR REFERRERS

The Perinatal Community Mental Health Service offers specialised treatment to women experiencing moderate to severe and complex mental health difficulties during pregnancy and the postnatal period. The team offers assessment and treatment of their mental illness whilst ensuring the developing relationship with the baby or processing the loss of a pregnancy / baby.

Please select the reason(s) for referral
☐ Pre-conception counselling for those with existing serious mental illness ☐ Women who have developed significant mental health difficulties after the first trimester in pregnancy or following delivery that cannot be managed in primary care ☐ Diagnosis of serious mental illness such as bipolar affective disorder, schizophrenia, severe depression, or anxiety disorder ☐ Previously under the care of perinatal mental health services ☐ Previous admission to a psychiatric unit ☐ First degree relative with bipolar disorder or serious postnatal illness ☐ Significant disorders of bonding and attachment ☐ PTSD symptoms following loss or birth trauma ☐ Loss of pregnancy due to miscarriage or medical termination ☐ Stillbirth ☐ Loss of baby within 28 days following birth or following admission to neonatal unit ☐ Primary or secondary Tokophobia

If you are unsure as to whether your referral meets the criteria please contact our advice line Monday, Tuesday, Thursday, Friday 9.30 – 12pm on 0300 123 7596 to discuss.

Please fill out all the details and once completed email to:

dhcft.perinatalcmht@nhs.net

PERINATAL COMMUNITY MENTAL HEALTH SERVICE REFERRAL FORM

(If all details are not completed it will delay the referral process)

DATE OF REFERRAL: …… **PATIENT CONSENT OBTAINED:** Yes☐ No☐
Routine ☐ **Urgent** ☐ **If urgent, please give clinical rationale below**:

PATIENT DETAILS
Title: Miss ☐ **Mrs** ☐ **Ms.** ☐ **Mx.** ☐ **Another title or none is used (please specify)** ☐
First name: **Preferred name (if applicable):**
Surname:
NHS number:
Address & Postcode:
Date of Birth:
Telephone:
Ethnicity:
Preferred language:
Interpreter needed: Yes ☐ **No** ☐

If pregnant

EDD:

Place of booking for delivery:

Date of loss if applicable:

REFERRER DETAILS	**GP'S DETAILS**
Name: **Job Title**:	**Name**:
Address and Postcode:	**Address and Postcode**:
Phone number: **Email**:	**Phone number**:

CHILDREN'S DETAILS

Name:	**Date of birth:**	**Gender:**	**Who does the child reside with:**	**Who has parental responsibility:**

Any past or current safeguarding concerns? Yes ☐ No ☐

Has a referral to Children's Services been made? Yes ☐ No ☐

(If yes, please give details of the Team referred to and the date referral was made)

Is there a Child Protection Plan/Child in Need plan in place? Yes ☐ No ☐

If there is a Child Protection Plan, Working Agreement or Court Directive please give details including what category the child(ren) is/are registered under and attach a copy of the document if possible.

CURRENT CONCERNS / REASON FOR REFERRAL

(To include relationship with infant or expected baby/level of functioning with regards to infant care or degree of distress and level of functioning following loss / trauma)

CURRENT AND PAST PSYCHIATRIC HISTORY

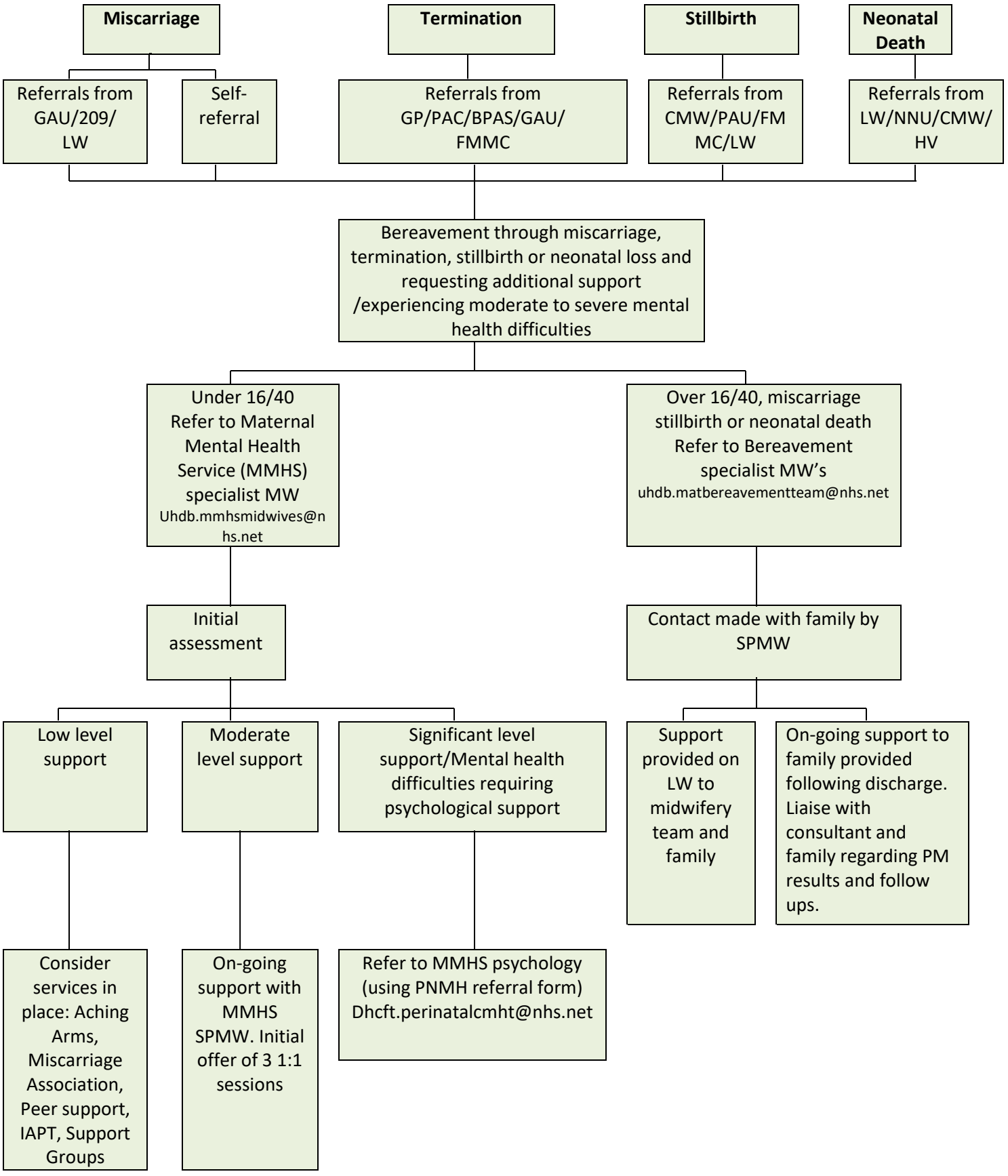
(Including risk to self/others)

OBSTETRIC HISTORY

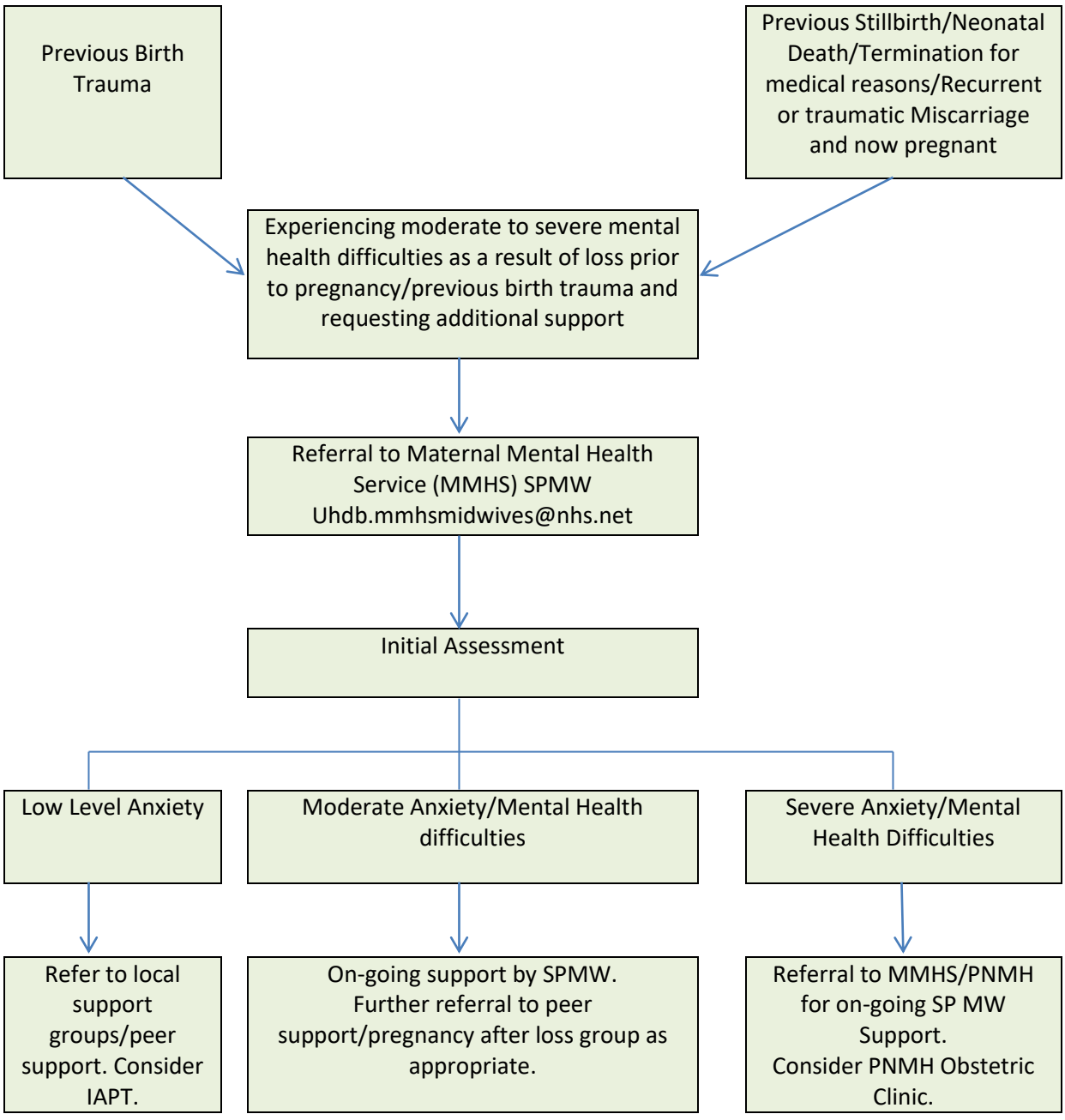
(Please include information on live births as well as previous loss: miscarriage/medical termination, stillbirth, neonatal loss, birth trauma, Tokophobia, and fertility treatment)

MEDICAL HISTORY **(Please include past and current history)**
CURRENT MEDICATION **(Please list ALL medication, including those for physical health and date commenced)**

Loss Referral Pathway



Pregnancy after loss/Trauma referral pathway



THE LOTUS SERVICE
STAFFORDSHIRE & STOKE-ON-TRENT'S
MATERNAL MENTAL HEALTH SERVICE (MMHS)

General Guidance
*****Please note*****

☐ Referrals are made by email. Referrals will be treated as routine and non-urgent. Referrals to the service are reviewed on a once weekly basis and we aim to respond back with the outcome of your referral within two weeks.

☐ If you are concerned for the physical health of this service user, please liaise with the service user's GP / primary care healthcare professional.

☐ The MMHS is not a crisis service and does not care co-ordinate. If you are concerned about a risk that the person poses to themselves or others, if they have severe or rapidly worsening mental health symptoms or they require crisis support, please contact:

- **0808 196 3002** (Mental health access line for South Staffordshire)
- **0800 032 8728** (Crisis care number for North Staffordshire)

If the person is currently pregnant or has a baby under 12 months, please contact:

- **0300 303 4132** (Specialist Perinatal Mental Health Team for South Staffordshire)
- **0300 123 1769** (Specialist Perinatal Mental Health Team for North Staffordshire and Stoke.

MBRRACE (2018) Red flags

If the person you are referring is currently pregnant or has a baby under 12 months old and is presenting with any of the below red flags please refer to the Community Specialist Perinatal Team

*****Please note*****

If the service user experiences any of the below criteria please refer to the perinatal mental health team (PNMH) not the MMHS.

- ✓ New thoughts of violent self-harm/suicide
- ✓ Sudden onset or rapidly worsening symptoms
- ✓ Persistent feelings of maternal incompetence and estrangement from baby
- ✓ Referral with mental health concerns on more than one occasion

Maternal Mental Health Referral Criteria

The person being referred **must consent** to a referral and should be **actively seeking help.**

The MMHS accepts referrals for people who are registered with a Staffordshire GP who are:

☐ **Experiencing Tokophobia (a severe fear of pregnancy or birth, in the presence or absence of any previous loss or birth trauma). And/ or a fear regarding medical procedures that is having, or would be likely to have, a severe impact on their maternity care. The patient does not have to be currently pregnant to be referred.**

☐ **Currently experiencing moderate to severe anxiety, low mood and/or post-traumatic stress symptoms associated with their maternity experience due to one or more of the following events (which has occurred in the last 12 months, or was more than 12 months ago and the person is now pregnant):**

- **Pregnancy loss (Miscarriage, Stillbirth, Termination of Pregnancy)**
- **Traumatic experience during pregnancy or birth (including a serious medical condition which might affect the woman or person and/or their unborn baby / babies; witnessed or experienced trauma)**
- **Traumatic experience and/or baby loss whilst in neonatal care setting**

****Please note***:**

Although mental health symptoms will be moderate to severe or complex, women or persons accessing the service will have low to moderate impairment in day-to day functioning and present with low risk to self or others. The Maternal Mental Health Service (MMHS) can provide access to psychological therapies, specialist midwifery care and peer support. We do not have psychiatry (medical prescribing) or care-coordination as part of our service. We are not a Crisis service.

The MMHS is designed to fill gaps between existing services as opposed to re-directing maternity related difficulties from already established services. Therefore, if a referral meets the criteria of another service (e.g. IAPT, third sector organisations) then they should continue to be offered that service instead of MMHS.

MATERNAL MENTAL HEALTH REFERRAL FORM

Please email the completed form for Newcastle and Moorlands, and the City of Stoke on Trent to: LotusService@combined.nhs.uk
Please email any referrals for South Staffordshire to: lotus@mpft.nhs.uk **and for any further queries please call us on 0300 303 4132 (Option 3)**

Which of the following has the person experienced which has directly resulted in new or worsening mental health difficulties:
☐ **Birth loss (stillbirth or bereavement after birth)** ☐ **Miscarriage** ☐ **Social or Medical Termination of Pregnancy** ☐ **Birth Trauma (post-traumatic stress; Experiencing or witnessing a difficult birth)** ☐ **Traumatic Pregnancy (including experiencing or witnessing serious medical condition which might affect the women or person, and/or baby)** ☐ **Traumatic experience whist in neonatal care setting** ☐ **Severe fear of childbirth (tokophobia)** ☐ **Fear regarding medical procedures that is having a severe impact on their maternity care.** ☐ **Other: If other please email our service so we can advise on whether a referral would be appropriate - thank you.**

Consent:	
Is the person being referred aware of this referral?	Yes ☐ No ☐
Has the person being referred consented to this referral?	Yes ☐ No ☐
If you have answered 'no' to either of the questions above we will be unable to accept the referral.	

Details of Referrer:	
Date of Referral:	
Name of Referrer:	
Role/ Profession:	
Contact Tel Number(s):	

Email:	

Details of person being referred:	
NHS Number:	
Title:	
Full Name:	
Preferred Pronouns (She/Her; They/Them; He/Him; Other)	
Address:	
Postcode:	
D.O.B:	
Ethnicity:	
Preferred contact telephone number:	
Does the patient consent to receive correspondence via text message?	**Yes** ☐ **No** ☐
Email Address:	
Does the patient consent to receive correspondence via email?	**Yes** ☐ **No** ☐
Are there any barriers to them accessing written correspondence?	**Yes** ☐ **No** ☐ **Details:**
Do they require an interpreter for appointments? :	**Yes** ☐ **No** ☐ **Details:**
Name of next of kin (preferred emergency contact):	
Next of Kin contact telephone number:	
Does the patient consent to information being shared with other NHS services or agencies (e.g. maternity, health visitors, mental health services)?	**Yes** ☐ **No** ☐
Maternity details:	
Is this person currently pregnant?	**Yes** ☐ **No** ☐
EDD (if applicable):	
Hospital booked at for delivery (if applicable):	
Has this person recently given birth?	**Yes** ☐ **No** ☐
Baby's DOB (if applicable):	
Baby's Name (if applicable):	
Has this person experienced a maternity/neonatal loss?	**Yes** ☐ **No** ☐
Date(s) maternity/neonatal loss occurred (if applicable):	
Has this person experienced a maternity related trauma?	**Yes** ☐ **No** ☐

Date(s) maternity related trauma occurred (if applicable):	

Please provide information on the person's current mental health presentation and other appropriate information.
Details of current mental health presentation: (useful prompts/questions: Thoughts? Feelings? Physical symptoms of the mental health presentation? Behavioural changes such as avoidance, withdrawal, checking, reassurance seeking? Trauma symptoms such as nightmares or flashbacks? Sleep disturbances?)
Does the person have a mental health diagnosis or previous history of mental health difficulties before this maternity/neonatal trauma or loss? Please give brief details:
Are there any identified relationship difficulties between the person and their baby/unborn? Please give brief details: (useful prompts/questions: how do they feel about the baby/unborn? Do they want to continue with the pregnancy? Do they talk to/ smile at/ play with baby (if postnatal)? Do they talk to/ touch bump/ monitor movements (if antenatal)? Are they prepared/preparing for baby/unborn?)
Is the person currently prescribed any medications? – please states below:

Other relevant mental health information:

Previous or current support:
Which support have they previously accessed for mental health issues resulting from the maternity/neonatal experience? ☐ **Birth Reflections Service / Afterthoughts / Debrief** ☐ **Staffordshire and Stoke-on-Trent Wellbeing Service (IAPT)** ☐ **Counselling through third sector/charity providers (please give details)** ☐ **Perinatal Mental Health Team** ☐ **Community Mental Health Team (CMHT)/Community Intervention Pathway (CIP)** ☐ **None of the above: Please consider referring to the above services in the first instance if appropriate.**
Are they still currently accessing support for mental health issues resulting from the maternity/neonatal experience? Please provide details (e.g. which team/service?):

Risks	Yes	No	**Details**
Risk to self	☐	☐	
Risk to others	☐	☐	
Risk from others	☐	☐	
Self-neglect	☐	☐	
Vulnerability	☐	☐	

Health and safety	☐ ☐	
Other – Please specify	☐ ☐	
Are there any know risks for home visiting – Please specify.	☐ ☐	

Safeguarding – Please indicate if open/referred to	Yes	No
POVA – Protection of Vulnerable Adults	☐	☐
MAPPA – Multi-Agency Public Protection Arrangements.	☐	☐
MARAC – Multi-Agency Risk Assessment Conference	☐	☐
Children's Social Care Services	☐	☐
Adult Social Care Services	☐	☐
Child Protection Plan	☐	☐
Child in Need Plan	☐	☐
Early Help Plan	☐	☐

Thank you for completing this form, please email your referral to the above email address as appropriate.

The information that you have provided is used by our team to determine suitability for the Lotus Service and the pathway that is offered.

All referrals are reviewed by our team on a weekly basis and we aim to provide you with an outcome within two weeks.

If you have any queries, please do not hesitate to email us.

University Hospitals of Derby and Burton NHS Foundation Trust

Perinatal Mental Health Information

DETAILS:			
Name:		**DOB:**	
NHS No:		**EDD:**	
PEOPLE INVOLVED:			
Mental Health Team		**Diagnosis**	
Partner / main support:		**Care coordinator:**	
GP:		**Consultant**	
Health visitor:		**Community midwife:**	
Psychiatrist		**CPN**	

Medication			
Medication		Safety Profile	
Dose		NAS Obs	

Mental health concerns

Should mental health deteriorate, and you have concerns about mental health and wellbeing the following services can be contacted:

Specialist Perinatal Mental Health Team Derby Advice Line: **0300 1237596** (Monday – Friday 9.30-12.00)
Specialist Perinatal Mental Health Team Staffordshire: **0300 303 4132** (Monday – Friday 9-5pm)

Perinatal Mental Health Midwife: **01332 789724/ 01283 511511** (Monday - Friday 8-6pm)

Liaison team Derby: **Ext 87780** or bleep **2638** (24 hours – 7 days a week)
Liaison team Burton: **01283 505309** (8am - 10pm - 7 days a week)

Perinatal Mental Health Focused Assessment			
Date		Location	
Seen by		EDD	

Review of other factors that may affect wellbeing
Social needs – Housing, Financial, employment:
Support networks:
Dependants:
Smoking Status:
Substance Misuse:
Past/Present Social care involvement:
Early Help offered:

Mental Health - Around Birth Care (ABC) Plan
Optimising support & communication for your wellbeing during pregnancy and after the birth

My Brief Summary	
A little about me:	
Strengths:	
Strategies that work well for me:	
Relapse signs:	***Early signs:*** ***What helps:***
Partner / carer views:	***Views / Role and any needs:***

A NTENATAL	
Current Mental Health:	
Medications prescribed:	

B irth and the first few days	
Obstetric Plans for birth:	

During delivery	For all women, the Betters Births report suggests clear communication, continuity and choice during labour helps to improve experiences.
After birth	
I plan to feed my baby:	
Feeding support / info required:	
Medication plans after birth:	
Mental health review before discharge home:	

Continuing postnatal care at home	
Maximising wellbeing at home:	
My support network:	
I will take medications:	
Safe sleep information	
Following your hospital discharge:	

Crisis & Safety
Are there any concerns or considerations at this time that require further support or referral to other agencies i.e. safeguarding? Please state brief reasons:

Crisis & Contingency Plan
If you or your family have any concerns about your mental health please contact the following services:

Information Sharing
Name made aware that professionals directly involved in her care will receive a copy of all assessments for information sharing purposes Consent to share YES NO

Maternal Mental Health Documentation

PATIENT NAME		**NHS Hospital Number**	
ADDRESS & Contact No		**D.O.B**	
EDD Date of Loss		**SUPPORT PERSON**	
Date of Assessment		**Referral From**	

PROFESSIONALS INVOLVED IN MY CARE

NAME	**ROLE**	**CONTACT DETAILS**
	Community Midwife	
	Consultant	
	MMHS Midwife	
	PNMH Contact CPN/Psychologist	
	Peer Support	

REASON FOR REFERRAL TO MMHS MIDWIFE

Obstetric History

DOB	Gestation	Gender	Name	Place of Birth/Loss	MOD	Comments

Previous Mental Health Diagnosis and Medication	*If Y - Treatment history, type of medication*

CURRENT ISSUE: **LOSS** **TRAUMA** **TOKOPHOBIA** **PREGNANCY AFTER LOSS**	*Impact on MH – Levels of functioning, daily activities, mood, sleep, appetite. Change in grieving/ Avoidance/Emotions Loss/guilt?*
CURRENT PREGNANCY	*Impact on MH - Avoidance/Anxiety/Support. Bonding with Baby/Preparations. Thoughts and Fears.*
HOW ARE THEY COPING AT PRESENT *What is working well?* *Strengths* *Worries* *How do I calm myself* *Support*	*On medication/GP/Self medicating.*
How is your support person/partner managing loss/trauma	*Supported/safe to discuss feelings/concerns/RE*
Mental State Examination *Orientated* *Mood* *Self Care* *Speech*	

RISK ASSESSMENT/SAFEGUARDING PLAN	
CURRENT INVOLVEMENT Yes/No	*If Yes - Allocated SW, Level (EH/CIN/CP), Meeting dates*
HISTORICAL	
OTHER AREAS SUPPORT IDENTIFIED	
Consider – Housing, Financial, Support, Substance use etc	

MY CARE PLAN	
MEDICATION	*Current medication and any planned changes/ escalation/ NAS observations etc*
MATERNITY CARE	**Discussion and care plan including AN/PN & IP care.**
NEONATAL CARE	*Obs, feeding plan, Neonatal Alert*
Action Following Assessment	*Refer for Peer Support/Support Group* *Refer to MMHS Psychology/PNMH* *Signpost to Sands/Third Sector/IAPT* *Refer to CRISIS for immediate intervention* *Offer on-going support from SPMW* *SG Referral/EHA/Other*

Mother's Details:

Name:		Gravida:	
Address:		Parity:	
		EDD / Baby DOB:	
DOB:		Current Gestation:	
Contact Number:		Hospital Unit Number/NHS number:	
Name of Practitioner Completing:		Date and Time:	

PHQ 9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

		Not at all	Several days	More than half the days	Nearly every day
1	Little interest or pleasure in doing things	**0**	**1**	**2**	**3**
2	Feeling down, depressed or hopeless	**0**	**1**	**2**	**3**
3	Trouble falling or staying asleep or sleeping too much	**0**	**1**	**2**	**3**
4	Feeling tired or having little energy	**0**	**1**	**2**	**3**
5	Poor appetite or overeating	**0**	**1**	**2**	**3**
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	**0**	**1**	**2**	**3**
7	Trouble concentrating on things, such as reading the newspaper or watching television	**0**	**1**	**2**	**3**
8	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	**0**	**1**	**2**	**3**
9	Thoughts that you would be better off dead or of hurting yourself in some way	**0**	**1**	**2**	**3**

GAD 7

Over the last 2 weeks, how often have you been bothered by any of the following problems?

		Not at all	Several days	More than half the days	Nearly every day
1	Feeling nervous, anxious or on edge	0	1	2	3
2	Not being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	
GAD 7 Total Score					

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ **Somewhat difficult** ☐ **Very difficult** ☐ **Extremely difficult** ☐

Interpreting the Scores and What to do

GAD-7

1 – 4	Minimal symptoms	Encourage access to support networks such as Children's Centres Discuss individual coping strategies including exercise, diet and rest.
5 - 9	Mild anxiety	Discuss, education and advice including. - Exercise, diet, rest - Encourage access to support networks such as Children's Centres - Consider self-referral for Primary mental health services.
10 -14	Moderate anxiety	Refer to GP. Antidepressant may be appropriate. Encourage woman to access psychological therapy through primary mental health services. Encourage access to support networks i.e. Children's Centres
15 -21	Severe anxiety	Refer to PMH midwife - uhdb.pmhmidwives@nhs.net Refer to GP. Antidepressant may be appropriate. Refer to Specialist perinatal mental health team.

PHQ-9

1 – 4	Minimal symptoms	Encourage access to support networks such as Children's Centres Discuss individual coping strategies including exercise, diet and rest.
5 – 9	Mild depression	Discuss, education and advice including. - Exercise, diet, rest - Encourage access to support networks such as Children's Centres - Consider self-referral for Primary mental health services.
10 -14	Moderate depression	Refer to GP. Antidepressant may be appropriate. Encourage woman to access psychological therapy through primary mental health services. Encourage access to support networks i.e. Children's Centres
15 -20	Moderate/ Severe depression	Refer to PMH midwife - uhdb.pmhmidwives@nhs.net Refer to GP. Antidepressant may be appropriate. Consider referral to Specialist perinatal mental health team.
20 -27	Severe depression	Refer to PMH midwife - uhdb.pmhmidwives@nhs.net Refer to GP. Antidepressant may be appropriate. Refer to Specialist perinatal mental health team

Important - For any patient presenting with suicidal ideation or thoughts of self-harm urgent mental health assessment will be required. **(See appendix 2 Burton –appendix 3 Derby)**

All women with history of severe mental illness must be referred to perinatal mental health team regardless of scores.

Location

The service covers the whole of Derbyshire and has two bases.

The South base is located at:

The Radbourne Unit
Royal Derby Hospital
Uttoxeter Road
Derby
DE22 3WQ
Tel: 01332 623911

The North base is located at:

Scarsdale
Newbold Road
Chesterfield
S41 7PF
Tel: 01246 216523

If you would like this information in a different language or format, including Easy Read or BSL, please contact dhcft.communications@nhs.net

Ak by ste chceli tieto informácie v inom jazyku alebo vo formáte, kontaktujte spoločnosť dhcft.communications@nhs.net

如果您想要将本信息用其他语言或格式显示，请联系 dhcft.communications@nhs.net

Si vous souhaitez recevoir ces informations en une autre langue ou un autre format, veuillez contacter dhcft.communications@nhs.net

Heke hûn dixwazin ev agahdariyê di zimanek cuda an formatê bixwazin kerema xwe ji dhcft.communications@nhs.net re têkilî bikin

Pokud budete chtít tyto informace v jiném jazyce nebo ve formátu, kontaktujte dhcft.communications@nhs.net

Jeżeli chcieliby Państwo otrzymać kopię niniejszych informacji w innej wersji językowej lub w alternatywnym formacie, prosimy o kontakt z dhcft.communications@nhs.net

ਜੇ ਤੁਸੀ ਇਸ ਜਾਣਕਾਰੀ ਨੂੰ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਫਾਰਮੇਟ ਵਚਿ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਕਰਿਪਾ ਕਰਕੇ ਸੰਪਰਕ ਕਰੋ dhcft.communications@nhs.net

اگر آپ کو یہ معلومات کسی مختلف زبان یا وضع میں مطلوب ہو تو براہ میربانی رابطہ کریں dhcft.communications@nhs.net

NHS
Derbyshire Healthcare
NHS Foundation Trust

Maternal Mental Health Service

A Guide
for Service Users

Making a positive difference

About the Service

The Maternal Mental Health Service provides specialised care to people experiencing a range of mental health difficulties associated with perinatal loss, including:

- Miscarriage
- Early ending of pregnancy
- Stillbirth
- Neonatal death
- Tokophobia (a severe fear of pregnancy and childbirth)
- Birth trauma

Support will also be provided for partners, who can be seen and signposted as appropriate.

Being Referred

People can be referred to the service by their midwife, obstetrician, GP, health visitor, or other care professional. Unfortunately, we are unable to accept self-referrals.

You will be offered an initial appointment with a member of the team. During this appointment we will talk with you about your experience and decide together the most appropriate course of action to help you.

Signposting

If this is not the most appropriate service to meet your needs, we will discuss which other services might be better placed to support you. We will write to your referrer with the care plan discussed with you during the appointment.

The Way Forward

The service provides psychological therapy and support which includes individual work, group work and peer support. Before the therapy begins, we will work with you to ensure that you feel emotionally safe and able to explore your current difficulties.

The therapy models used by the team include Eye Movement Desensitisation Reprocessing (EMDR), Compassion Focused Therapy (CFT), and Psychodynamic Psychotherapy.

The Team

The team is led by a consultant clinical psychologist and supported by three clinical psychologists, an assistant psychologist, and a peer support worker. Five specialist midwives support the service and are based at Chesterfield Royal Hospital, Queen's Hospital Burton, and Royal Derby Hospital.

Agencies We Work With

- General Practitioner
- Health Visitor
- Community Midwives
- NHS Talking Therapies (Formerly IAPT)
- Other Mental Health Services
- Social Care
- Voluntary organisations

If you need an interpreter, or any other assistance for your appointment, please contact the number on the back of this leaflet so that arrangements can be put in place.

We are committed to continually improving our service and welcome any feedback in relation to the care and treatment you receive. Should you have a concern that cannot be resolved by the team you can contact Derbyshire Healthcare Foundation Trust Patient Experience Team on 01332 623700 ext. 33751 for support.

You have the right to request a second opinion if you are not happy with your current plan of care. Please ask a member of the team who will advise you how to do this.

Documentation Control

Reference Number: UHDB/07:23/M3	**Version:** **UHDB Version 2**		**Status: FINAL**	
	Royal Derby prior to merged document:			
Version Amendment	Version	Date	Author	Reason
	4	Feb 2020	Dr R Robinson - Post CCT, Karen Anstee – Specialist Perinatal Mental Health Midwife	Review
	Burton Trust prior to merged document:			
WC/OG/42	8	Jan 2017	Specialist Midwife for Perinatal Mental Health	Review/Update
Version control for UHDB merged document:				
UHDB	1	June 2021	Karen Anstee – Specialist Perinatal Mental Health Midwife (RDH) Corrine Ward – Specialist Midwife for Vulnerable Women (QHB)	UHDB Merger review
	1.1	Feb 2023	Dr R Robinson - Consultant Obstetrician &b lead for PMH	Appendix 12 - Patient Information re MMHS added
	2	Feb 2023	Corinne Ward – Lead Midwife Perinatal Mental Health	UHDB review
Intended Recipients: All staff with responsibility for caring for AN/IP/PN women				
Training and Dissemination: Cascaded electronically through lead sisters/midwives/doctors Published on Intranet, Article in Business unit newsletter				
To be read in conjunction with:				
Consultation with:	Obstetricians, Maternity Staff			
Business unit sign off:	02/05/2023: Maternity Guideline Group Miss S Rajendran – Chair 19/06/2023: Maternity Governance Group - Mr R Deveraj			
Notification Overview sent to TIER 3 Divisional Quality Governance Operations & Performance: 20/06/2023				
Implementation date:	10/07/2023			
Review Date:	July 2026			
Key Contact:	Joanna Harrison-Engwell			