Regional Perinatal Mental Health Care Pathway

2025

HSC Health and Social Care

Perinatal mental health Service

YOU IN MIND

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Foreword

The Regional Perinatal Mental Health Care Pathway (PNMHP) was initially launched in Northern Ireland in 2012 and subsequently updated in 2014. The pathway was developed to facilitate the prediction, detection and treatment of mental health problems in women* in the antenatal and postnatal periods, but was written at a time when a specialist perinatal mental health team existed in only one of the five Health and Social Care (HSC) Trusts.

In 2021 the then Minister for Health announced funding for each of the five HSC Trusts to develop comprehensive, multi-disciplinary, community perinatal mental health teams. These teams provide specialist care both to women with mental illness and to women at risk of developing mental illness in the perinatal period.

This pathway has therefore been updated to integrate these teams into a pathway of care for women with perinatal mental health problems. It will provide guidance to all health and social care professionals who come into contact with women in the antenatal and postnatal period across all settings, inclusive of primary care.

Note: The "perinatal period" is the name given to the period immediately before and after birth. It is defined in diverse ways but in the context of this document should be taken to refer to pregnancy and the first twelve months postnatal.

Think Family

The ethos of the service is embedded in the Think Family** approach.
The three main themes of the Think Family approach are:

- improve communication and information sharing between professionals and families;
- improve access to early intervention family support for children, young people and their families;
- improve the extent to which assessment, planning and treatment is inclusive of a 'whole family' approach.

*The term 'women' used in this document is intended to be inclusive of young women under the age of 18 years.

** https://cypsp.hscni.net/regional-subgroups/think-family/

Contents

Strategic context

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

Mental Health Strategy 2021-2031

In line with commitments made as part of the New Decade, New Approach agreement, Health Minister Robin Swann launched the publication of the new *Mental Health Strategy 2021-2031* www.health-ni.gov.uk/publications/mental-health-strategy-2021-2031 on 29 June 2021.

The strategy sets out the future direction of mental health services in Northern Ireland for the next decade. This strategy has been co-produced with a broad range of stakeholders, including people with lived experience, carers, the interim Mental Health Champion, health and social care professionals, academics, the voluntary and community sector, and professional bodies. The strategy is person-centred, takes a whole life approach and has a whole system focus. The key aim is to ensure long-term improved outcomes for people's mental health.

Mental Health Strategy Action 29 - Specialist Services

Action 29 in the strategy relates directly to Specialist Services, including the continued roll out of specialist perinatal mental health teams, and aims to achieve the following outcomes:

- effective specialist interventions that meet the needs of the people, when they need it;
- a person-centred service that avoids silos and where people are treated as individuals;
- the right specialist interventions when needed, with quicker outcomes, thus reducing the time people require mental health interventions.

Demonstrating good outcomes in mental health services is always a challenge and particularly so in perinatal mental health. At least half of the women on the caseload of these teams will be well at the point of entry into the teams. They will have been taken on for management due to their psychiatric history, which places them at high risk of relapse in the postnatal period. For these women an outcome of 'no change' in a traditional psychiatric rating scale is deemed an excellent result. These dilemmas are faced UK-wide.

HSC Trusts will be expected to measure the impact of care using the regionally agreed validated measurement framework and patient experience feedback. HSC Trusts will report progress against clinically validated measurement tools via the Mental Health Outcomes Framework reporting mechanism.

The revision of the care pathway was led by the Public Health Agency (PHA) and supported by a wide ranging multidisciplinary working group.

How to read this document

This pathway should be read in conjunction with the *You in Mind Regional Mental Health Care Pathway* (online.hscni.net/wpfd_file/regional_mental_health_care_pathway), and the HSC Trust *Perinatal Mental Health Operational Policies and Supplementary*

Guidance. Other relevant documents include: *You In Mind – Talking Yourself Well Guide to Mental Health Psychological Therapies (online. hscni.net/wpfd_file/talking_yourself_well_psychological_therapies_guide), You In Mind Acute Mental Health Care Pathway*.

It is also important that practitioners read the relevant National Institute for Health and Care Excellence (NICE) Clinical Guidelines (www.nice.org.uk/guidance/published?q=mental+health) in the development of care plans.

This guidance will be subject to ongoing review and refinement in line with research and best practice and as services may be developed. Feedback on implementation of the guidance is welcome from clinicians and other practitioners and should be directed to HSC Trust Perinatal Team Managers and/or PHA Perinatal Mental Health Service planners (pha.site/perinatal-mental-health-services).

Equality statement

Mental health services have a duty to each and every individual they serve and must respect and protect their human rights. At the same time, mental health services also have a wide social duty to promote equality through the care they provide and in the way the care is provided. This includes addressing the needs of those groups or sections of society who may be experiencing inequalities in health and wellbeing.

In line with Section 75 of the Northern Ireland Act 1998, perinatal mental health services are designed and delivered to promote equality of opportunity and to address the needs of all those impacted, irrespective of gender, ethnicity, political opinion, religious belief, disability, age, sexual orientation, dependent and marital status.

Principles and values of perinatal mental health care

The pathway represents a commitment to ensuring that perinatal mental health care is delivered in a **person-centred way**, promoting **safety** and **wellbeing**. Perinatal mental health service provision should be **needs-led, responsive** and delivered in a way that **empowers** people to build on their strengths, promotes **recovery**, supports **families and carers**, and ensures **equality** for all.

Purpose and aim of the pathway

To support the provision of an effective multidisciplinary/agency service for the prediction, detection and treatment of maternal mental ill health through the antenatal and postnatal periods for all women in Northern Ireland.

Perinatal mental health issues complicating pregnancy and the first postpartum year are common with 10-20% of women developing mental ill health during this period. It is a significant public health issue and untreated, can have a devastating impact not only on the woman affected but also on her family unit. There is a spectrum of ill health, with symptoms ranging from mild to moderate low mood/ anxiety through to more serious illnesses such as psychosis. The majority of women detected will experience mild to moderate symptoms and can be helped with increased support from family, maternity services, health visitors and primary care services, including GPs.

The provision of timely support will increase protective factors that would impact on a child's life course and decrease the likelihood negative risk factors and in turn support positive infant mental health. The antenatal period offers health care professionals a unique opportunity to screen for risk factors associated with maternal mental ill health, ensuring appropriate early interventions are provided, including referral to specialist perinatal mental health teams. Identifying and treating maternal mental ill health is not only beneficial for the woman but also for the future health and wellbeing of her child and for the family unit as a whole.

Perinatal illnesses include obsessive compulsive disorder, post-traumatic stress disorder (PTSD) and postpartum psychosis (affecting 1-2 in 1000 women). Depending on the severity of the disorder, the woman may struggle to look after herself and her baby, and there may also be an impact on her ability to bond with her baby and respond sensitively to her baby's needs. There is evidence that this may impact on the emotional, cognitive and physical development of the baby.

Women with pre-existing mental health illness may have a relapse or recurrence of their illness following childbirth. This is particularly significant in women with the more serious mood disorders such as severe depression or bipolar disorder, schizophrenia or schizoaffective disorder.

Who is the pathway for?

Early identification and management of perinatal mental illness is important to prevent long-term sequelae (pathological conditions) for not only the woman, but also her baby and other family members.

This pathway is therefore aimed at primary care staff including general practitioners, health visitors and family nurses, maternity staff including obstetricians and midwives, and mental health staff including community mental health teams and crisis services.

This document can be shared with women who are experiencing perinatal mental illness and their families but a more appropriate shorter guide is also available.

Recovery principles

Recovery is centred around improving quality of life and achieving life goals, as well as a reduction in symptoms. It is highly personal, and with the right support many people recover completely or are able to manage their symptoms in a way which reduces the impact on their lives (see below).

Providing personalised, whole person-centred care

Encouraging participation and making connections

Supporting families

Focusing on personal strengths

Promoting hope and self determination

Stepped care approach

Services are organised to provide a 'stepped care approach'. This approach is used to match the needs of the service user with the right level of support and only 'stepping up' to intensive/specialist services as needs require. The level of support required is determined by personal needs of the service user and support which is known to help recovery. The stepped care approach helps ensure that service users are referred to the right service(s) and professional(s) with the right skills to meet their needs.

The stepped care approach means care can be stepped up or down.

A step up in care usually means more intensive specialist support and treatment is required.

A step down in care usually means recovery is at a stage where the service user no longer requires the same level of care and/or treatment.

A stepped care approach should be adopted when managing women with mental ill health during pregnancy and the postnatal period. The majority of these women are managed within primary care, including those with mild to moderate depression, anxiety, adjustment disorders and other conditions. They may not require medication and will often respond to psychological and/or social interventions. Women with more significant illness may require medication only or medication with the addition of psychological and social interventions.

Stepped care model: perinatal mental health

Step 1

Self-directed help

Example criteria: Positive answer to Whooley/ anxiety questions/ Edinburgh Postnatal Depression Scale.

Requires further enquiry/discussion. Information should be provided regarding available support, including community and voluntary sector services.. If support is declined professional judgement should be used. GP and universal services should be informed. Questions/ enquiries will be repeated at subsequent visits.

Step 2

Primary care talking therapies

Example criteria: Positive answer to Whooley/ anxiety questions/ Edinburgh Postnatal Depression Scale.

Requires further enquiry/discussion. Information provided regarding available support. If appropriate provide non-directive counselling (listening visits). If not appropriate refer to GP. Universal services should be informed. Support at this level usually involves responding to mental health and emotional difficulties such as anxiety and depression. GP may consider psychological treatments, medication or referral.

Step 3

Specialist community mental health services

Example criteria: Past or present mental ill health.

If currently not attending mental health services this woman should be referred to community mental health services (via GP) for assessment to assess whether there is potential risk of perinatal illness. If the woman is already known to services liaison between the mental health team and maternity services should occur. Universal services should be informed.

Step 4

Highly specialist condition specific mental health services

Example criteria: Past or present mental ill health, currently attending mental health services.

Meets criteria for specialist perinatal mental health teams.

A pregnancy and early postnatal plan (PEPP) should be developed by this service and shared with maternity services. Universal services should be informed.

Step 5

High intensity mental health services

Example criteria: Deteriorating serious mental illness.

Support at this level is usually provided in response to mental health needs. It involves the delivery of intensive recovery focused support and treatment provided at home or in hospital.

Care pathways interconnection and interdependencies

Professional groups, including midwives, GPs, health visitors, obstetricians, clinical psychologists, allied health professionals (AHPs) and hospital and community mental health teams across HSC Trust settings in Northern Ireland, will be involved with the implementation of this PNMHP. Their involvement may be at different stages of care of the women who requires assessment, support and treatment. The pathway specifies the roles and responsibilities of key professionals and is intended to support staff in these roles.

Role of the general practitioner (GP)

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

Preconceptual care - For any woman who is taking psychotropic medication, has an eating disorder or a history of substance misuse who is planning pregnancy or in the antenatal period, consideration should be given to the risks and benefits of their individual circumstances. It may be appropriate for the GP to refer to mental health services in the case of women who are not under active follow-up.

Any woman, who has a history of past or present severe mental ill health or mental health issues requiring ongoing mental health services, should be advised to consider contacting their GP practice (some have mental health practitioners within the practice) once the pregnancy is established and they have immediate mental health needs.

Antenatal care - In most circumstances a woman's GP will have detailed information held within their patient care record. However, when any pregnant woman first presents to their GP they should be asked about previous or present mental ill health, eating disorders and/or substance misuse. This will include details of any care provided by mental health services and enquiry into any close family with a history of perinatal mental ill health. This information should be clearly recorded in the referral information from the GP to antenatal services. All other members of the primary care team, for example nurse practitioners, should be aware of the importance of including this information in antenatal referrals.

GPs or mental health practitioners working in primary care should explore the mental health of these patients. A suggested tool is the Whooley/anxiety questionnaire (Appendix 6).

It is important to highlight that as soon as a woman has had a positive pregnancy test, they can self-refer directly to maternity services and detailed information about previous/present mental ill health will not be included in a self-referral.

A positive response to the Whooley/anxiety questions should be followed up in line with the local HSC Trust PNMHP. Pregnant women who have symptoms of anxiety and/or depression, severe enough to interfere with personal and social functioning, but do not meet the diagnostic criteria for a formal diagnosis, should be considered for brief psychological treatment and/or individual or group based social support. These services include self-help strategies, non-directive counselling, primary care based cognitive behavioural therapy (CBT), community

and voluntary sector based social interventions and HSC Trust based services, including CBT and interpersonal psychotherapy. GPs and other professionals involved in the care of pregnant woman should be aware of the importance of prioritising the social and psychological needs of pregnant women and HSC Trust based services should prioritise these referrals.

Postnatal care - Mild to moderate depression can often be managed within primary care with a combination of psychological and social support and medication where appropriate. Referral to the family health visitor for non-directive counselling may be considered or referral to HSC Trust mental health services when risks are identified or a woman fails to respond to treatment. Consideration will be given to the need for a referral to child care social services if risk or potential risk is identified.

GPs should repeat the Whooley/anxiety questions with all women at any postnatal contact and follow up as appropriate.

Role of the midwife

Midwives play a central role in ensuring that pregnant women with mental ill health achieve the best possible health outcomes for themselves and their babies. Midwives work collaboratively with obstetricians, GPs, health visitors, family nurses, social workers and substance misuse and mental health professionals when appropriate. Midwives provide care in many locations such as the family home, clinics, birth centres and hospitals. Midwives coordinate the maternity care for women with mental ill health by:

- asking the Whooley/anxiety questions for prediction and detection of mental ill health at the first booking clinic - a positive response to these questions should be followed up in line with the local HSC Trust PNMHP. Any woman who has a history of past or present severe mental ill health or mental health issues requiring ongoing mental health services, should be advised to consider contacting their GP practice (some have mental health practitioners within the practice) once the pregnancy is established and they have immediate mental health needs;
- recognising and responding to identified need at all stages of pregnancy and the immediate and early postnatal period;
- asking about previous or present mental ill health, eating disorders and/or substance misuse. This will include details of any care provided by mental health services - should this also include appropriate referral to GP, community mental health teams or PNMH team;
- developing a trusting relationship with the pregnant woman, considering her individual needs and preferences;
- providing information and offering sensitive support and additional midwifery care as appropriate;
- reviewing the woman's personal care plan and treatment at each contact;
- recording advice and information given, changes to the personal care plan and evaluation of care in the Maternity Record on Encompass, the Northern Ireland Electronic Health Care Record.
- liaising with the GP, health visitor, family nurse, substance misuse teams, and the community mental health team and the specialist perinatal mental health team.

In some HSC Trusts, midwifery 'champions' with additional knowledge and/or skills in mental

health are available to offer additional support to women identified as having either a previous history of mental ill health/eating disorder/ substance misuse or first presentation of mental ill health developing during their pregnancy.

Role of the obstetrician

Obstetricians play an important role to ensure that all women with mental ill health/eating disorders/substance misuse achieve the best possible health outcomes for themselves and their babies in the perinatal period. Obstetricians should work in collaboration with midwives, GPs, health visitors, family nurses, AHPs, members of mental health teams, clinical psychology and social workers as appropriate. Obstetricians should take a lead in coordinating the maternity care for pregnant women with mental ill health.

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

Women who are pregnant and have a formal diagnosis of mental ill health/eating disorder/ substance misuse and have ongoing support from mental health services should be seen by a consultant obstetrician. The appointment with the consultant obstetrician should be at booking or shortly thereafter to arrange a plan of care. Obstetric review will depend on other co-morbidities, current medications and liaison with mental health services. It is the responsibility of the obstetrician to liaise with other professionals in the woman's care and to ensure that the PNMHP is implemented, particularly at the time of birth. For example: liaising with the GP, health visitor, family nurses, AHPs, clinical psychology, social services and the mental health team as appropriate.

Role of the health visitor

Health visitors hold a qualification in specialist community public health nursing. They work with a defined population to deliver services that promote the health and wellbeing of children, young people and their families.

The health visitor works in partnership with families to promote emotional wellbeing and resilience. They will complete a holistic family health assessment and can make a significant contribution to the early identification and effective, timely management of mental ill health in the perinatal period. They will support parents to provide sensitive caregiving, in particular during the first months and years of their baby's life. Health visitors will recognise the importance of supporting the development of positive infant mental health and provide intervention or onward referral to specialist services if they identify concerns about the relationship between the parent and the child.

The role of the health visitor within the care pathway is to identify women in the ante/ postnatal period that may be at risk of developing mental ill health and provide intervention to those women experiencing low mood or other mental health issues which does not require a referral to mental health services. They may signpost and refer to appropriate services, both statutory and community and voluntary.

They will offer ongoing support to women experiencing mental ill health that requires input from mental health services, for example: community mental health teams, community addictions teams, eating disorder teams, personality disorder teams and specialist perinatal mental health teams.

Health visitors liaise closely with the GP and other relevant HSC professionals regarding

appropriate interventions and will update the family health assessment at each contact.

The health visitor uses validated tools such as the Edinburgh Postnatal Depression Scale (EPDS) and NICE screening questions. The EPDS (Appendix 7) is a self-reported questionnaire, that has been validated for use by health professionals trained in the use of sensitive guided conversations, to assist in the assessment of perinatal mental health by rating and measuring the frequency of some symptoms relating to depression and anxiety. Coupled with the use of the Whooley/anxiety questions for prediction and detection of mental ill health, a positive response to these questions should be followed up in line with the local HSC Trust PNMHP. This is in addition to the health visitor's ongoing professional assessment and observations of the woman and her interaction with her unborn baby if in the antenatal period, or her interactions and relationship with her baby/children if in the postnatal period, will strengthen their clinical assessment and support appropriate onward signposting and referral.

The health visitor will be aware of the pathways within each HSC Trust area for urgent mental health assessment and treatment as needed. They will assess the woman's emotional health at all future contacts and will agree appropriate future action in partnership with the woman and her partner/family.

Non-directive counselling (listening visits)
Non-directive counselling (listening visits) provided by health visitors are an effective intervention for mild to moderate perinatal mental ill health, as included in step 1 of the Perinatal Stepped Care Model. Non-directive counselling is concerned with helping the mother to understand her situation by exploring the possible explanations for the way she is feeling and options and strategies that might support her. It is not giving advice or information and these visits should be planned, time limited, focused support provided over four sessions followed by a reassessment, and, if required, additional listening visits and onward referral where appropriate.

These visits can be combined with psycho-education about mental ill health. The focus is on promoting hope in the woman's journey of recovery and developing her sense of self efficacy as a parent.

Strategies that the health visitor can explore with the woman may include:

- promotion of self-help strategies (healthy diet, physical activity, practical help, support from family and friends, accessing peer support groups);
- promotion of non-directive counselling;
- appropriate liaison, communication with all staff involved in a woman's care and where required referral to other agencies;
- signposting to voluntary and community groups to aid building social support networks and accessing peer support;
- signposting to online resources.

Perinatal mental health champions within core health visiting teams can offer an additional layer of guidance and advice to core teams on signposting where a woman is experiencing mild to moderate perinatal mental health illness.

Role of the family nurse partnership

Family nurse partnership (FNP) is an intensive structured early intervention programme offered to first time young mothers and fathers commencing in the early antenatal period. It aims to improve maternal health and wellbeing, to improve child health and wellbeing and to

improve the economic self-sufficiency and life course for the young family. The family nurses work closely with mental health and primary care teams to allow the young person to access appropriate help and treatment and have strong links with midwives, health visitors, child care social workers and Sure Starts.

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- to improve child health and wellbeing; and
- to improve the economic self-sufficiency and life course for the young family.

Teenage mothers are three times more likely to experience postnatal depression and relationship breakdown and have higher rates of poor mental health for up to three years after giving birth.

Family nurses use validated tools at regular intervals throughout the programme to assess mental health. The resources utilised in the programme are designed to empower young people to improve their mental health and wellbeing. The programme also equips young parents to be nurturing, engaged, positive parents when dealing with the poor mental health and emotional wellbeing.

The Family Nurses work closely with Mental Health and Primary Care Teams to support the young person to access appropriate help and treatment. They also have strong links with midwives, health visitors, child care social workers and Sure Starts.

Role of community support

There are a range of services in the community aimed at providing support to parents in the perintatal period. These include NSPCC Pregnancy in Mind Programme, which is a preventative mental health service designed to support parents to be who are at risk of, or are currently experiencing, mild to moderate anxiety and depression during their pregnancy. Aware NI deliver programmes in a range of settings, which aim to give participants knowledge and skills which can be used to maintain or regain good mental health and build resilience. Both these programmes are supported by the PHA.

Role of community mental health teams

Generic community mental health teams may be involved with perinatal women who do not meet the threshold for referral into specialist teams, but require brief psychological interventions for symptoms of anxiety and/or depression which impact on social functioning. In the event of women on the caseload of the community mental health teams becoming pregnant, the team will assess the need for specialist service input and liaise with the perinatal mental health team.

Advocacy

While in the care of mental health services a woman can have access to advocacy services. Advocacy is rights based and plays a key role in mental health recovery as having a voice for oneself and representation by others are fundamental rights of all citizens.

A key principle is that an advocate should be as independent as possible of the health and social care system. 'Independent advocacy' cannot, therefore, be delivered by a care coordinator or other member of staff employed by the services themselves. By providing independent advocacy this enables the person to question or challenge the professionals' views, while retaining

confidentiality if they need to (Voice Ability, 2015).

Role of the occupational therapist

Occupational therapists within perinatal teams offer holistic assessment and treatment, incorporating the needs of the mother, infant and other family members. The holistic approach focuses on the mother's goals and offers a wide range of interventions, taking into consideration each woman's strengths as well as her mental health, physical, learning, and cultural needs and choices.

Occupational therapists provide practical support to help people experiencing perinatal mental health problems carry out the daily activities – occupations - that are important to them, their infants and families. Occupational therapists support the activities and routines people do themselves, and those they do with their infants – 'co-occupations' - including self-care, productivity, leisure, parenting, organisation of occupations, community engagement/social inclusion work and discharge planning. Interventions are personalised and delivered individually or in groups. You might find an occupational therapist:

- supporting a woman using public transport to attend a mother and baby group;
- enabling a woman to take part in creative or physical activities that she finds personally motivating;
- running a group to help women prepare for role changes such as becoming a mother or returning to work;
- recommending equipment or task modifications to ensure a woman can carry out parenting tasks safely.

Role of psychology

Psychologists support the delivery of safe and effective perinatal psychological therapies by providing supervision, consultancy and training to HSC staff who come into contact with women in the perinatal period. They are directly involved in many mental and physical healthcare services, for both adults and children, where support of perinatal mental health may be provided. In addition to working within specialist perinatal mental health teams, they work in adult mental health, the regional maternity service, paediatrics and some neonatal units. In all these settings, high quality, psychologically informed care, can positively impact the whole family during the perinatal period.

Direct work with mothers begins with a detailed holistic assessment and a psychological formulation to inform an individually tailored care plan. In some cases, this will include consideration of the infant and the mother-infant relationship. Psychologists have knowledge and skills related to a range of psychological interventions, often known as 'talking therapies', for mothers and for couples or fathers when appropriate. When needed they may work with parent and infant together to help improve the parent-infant relationship. They draw upon evidenced-based psychological therapies such as cognitive behaviour therapy, eye movement desensitisation and reprocessing (EMDR), interpersonal therapy, behavioural couples therapy and family therapy. Communication with other involved professionals continues over time to promote consistency in approach, patient confidence and a smooth journey through the perinatal period.

Specialist perinatal mental health team

There are two groups of women who require care and treatment to be provided by perinatal mental health teams.

1. **Women with pre-existing mental illness (such as bipolar disorder or previous postpartum psychosis) who, although currently well, are considered to be at significant risk of relapse or recurrence of their illness in pregnancy or, more commonly, the postnatal period. With this group, preconceptual counselling can form a significant component of their care. They should be managed by a specialist perinatal mental health team and have individualised care plans in place.**
2. **Women who develop a significant episode of illness in association with the perinatal period. A number of these women may present with rapidly deteriorating illness, requiring urgent assessment by mental health services, particularly if they present within the first six weeks postnatal.**

This team is a multidisciplinary group of professionals including psychiatrists, lead obstetrician, psychologists, psychiatric nurses, mental health social workers, parent-infant psychotherapists, occupational therapists, midwives and health visitors. They have training and expertise in delivering care to women experiencing mental illness in the puerperal period. The team take referrals from a range of other professionals, including maternity staff, and see both those women with established illness but also those women at risk of developing serious illness due to pregnancy and childbirth. The teams offer a range of evidence based psychological, pharmacological and psychosocial interventions aimed at improving outcomes for both the women and their babies.

The specialist teams also provide a source of consultation and advice to other professionals who provide care to women with less severe illness. They provide pre-conception advice to women at high risk of early postpartum major mental illness.

Confidentiality and the use of information

Health services gather and record personal information for the purpose of providing safe and effective health and social care. Information will be stored securely and shared with others in the multi-disciplinary team for the purpose of understanding the challenges the service user is facing and to develop care and treatment programmes to meet the individual's specific needs. Consent will be sought to share information with anyone outside of the services, with an explanation about what information is to be shared, why, and what the benefits are.

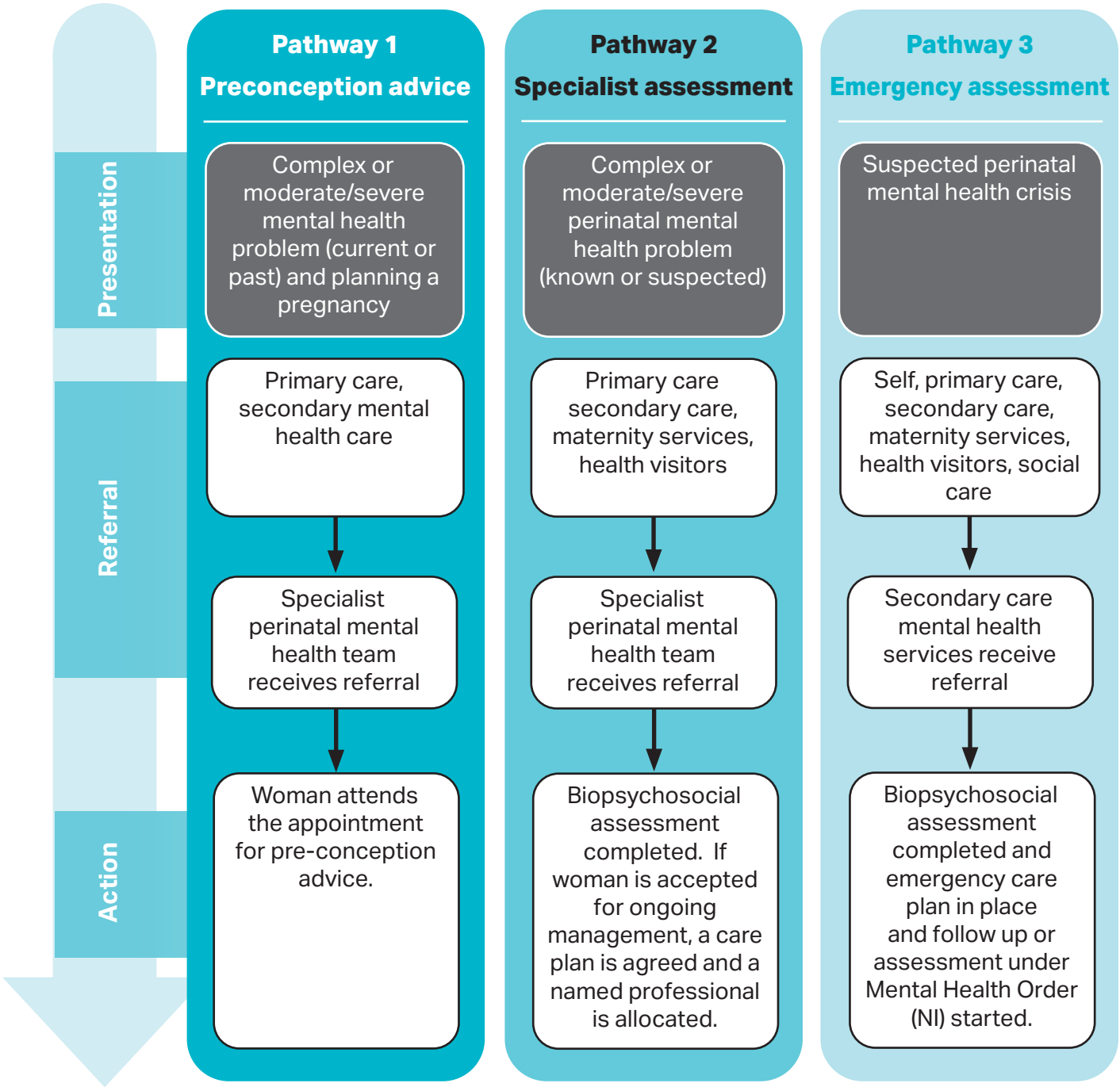
Consent will also be sought to share certain details about the service user's needs and treatment with family members or nominated friends when doing so would be beneficial to recovery.

Personal information will only be shared without consent where there is a legal obligation to do so and/or where it is considered necessary for the safety of the service user and/or others. In such circumstances agreement will be sought in the first instance and the service user will be informed about what information is being shared, with whom and why.

Perinatal mental health care pathway

Each HSC Trust has its own community-based perinatal mental health team. These teams are multidisciplinary in nature with mental health nursing, medical, social work, psychology, occupational therapy, midwifery and health visiting input. The teams are designed to provide a comprehensive service to women in the perinatal period.

Assessment pathways at a glance



(Adapted from The Perinatal Mental Health Care Pathways, Full implementation guidance. London: National Collaborating Centre for Mental Health, 2018)

Pathway 1 – Preconception advice

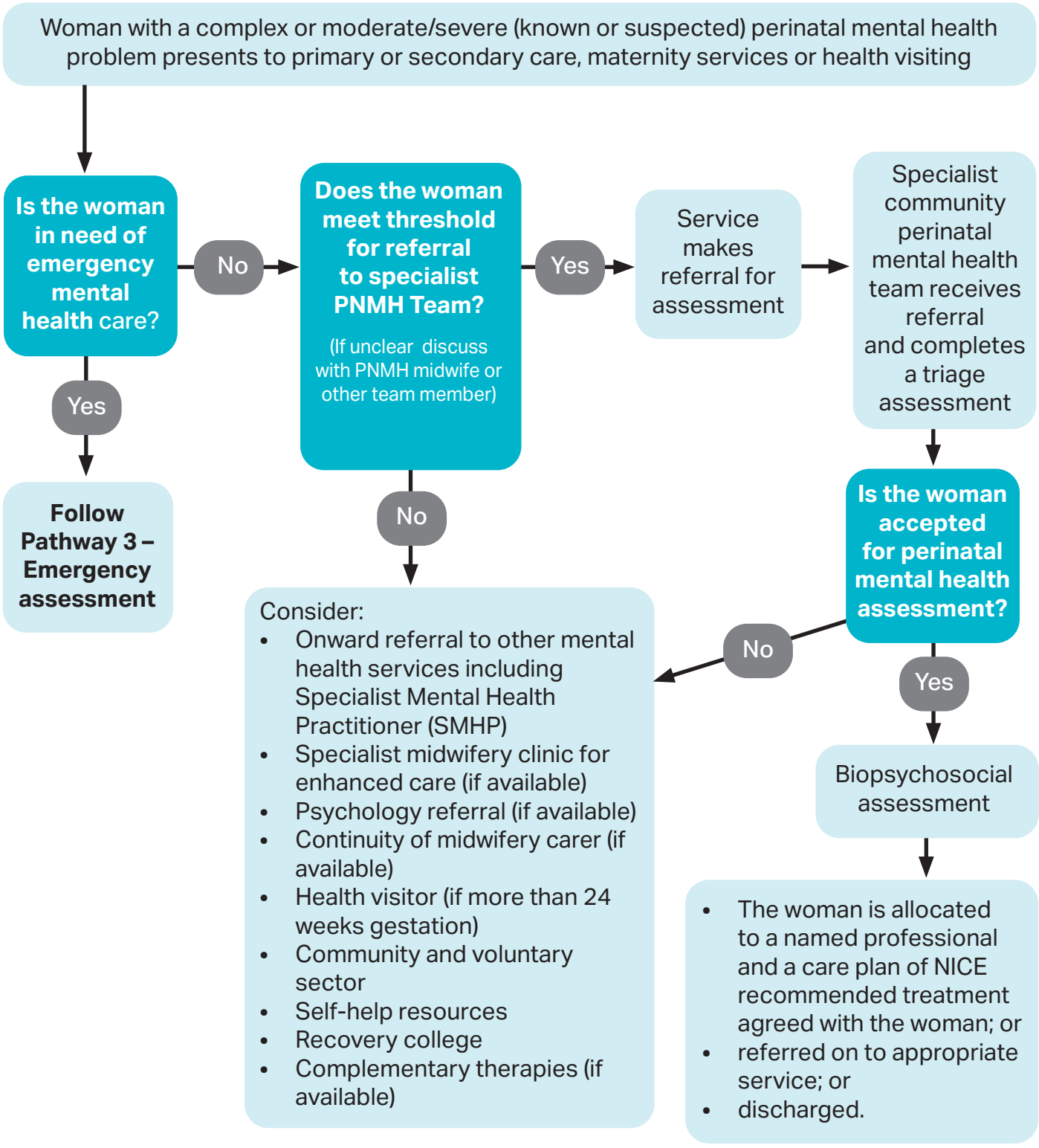
Advice and monitoring can help prevent many avoidable mental health problems and minimise the risks associated with pregnancy, particularly in women at high risk of mental illness. Up to 90% of women will stop taking medication for an existing mental health problem when they discover that they are pregnant, often without consulting a practitioner. This can have major adverse consequences, including relapse. Access to good quality advice, information and support will help women make informed decisions during their pregnancy. These decisions should be jointly planned, in advance, by the woman with the practitioner.

Preconception advice may include:

- 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 and her parenting style, and the unborn baby or baby, including the implications of medication for breastfeeding.

Women with a complex or severe mental health problem (current or past), who are planning a pregnancy, should be referred to a specialist community perinatal mental health team for preconception advice. Referrals will typically be made from primary care, or from secondary mental health care.

Pathway 2 – Specialist assessment



(Adapted from The Perinatal Mental Health Care Pathways, Full implementation guidance. London: National Collaborating Centre for Mental Health, 2018)

Appendices 1 – 4 (Antenatal screening flowcharts part 1 and part 2, guidance notes and sample letters) are intended to complement the above pathway. These should be followed by maternity services if triggered at the booking appointment.

Referrals to specialist perinatal mental health team

Referral criteria

1. Women with past or present serious mental illness, including bipolar disorder, schizophrenia, schizoaffective disorder and psychotic depression. It should be noted that this criterion includes women who are currently well but who, due to their diagnosis, are at a high risk of relapse in the postnatal period. This applies to criteria 2 and 3 below also.

2. Women with past or present psychosis in the puerperal period.

3. Women with past or present severe depression that has required acute care or involved a serious attempt on their life.

4. Women with a primary diagnosis of substance misuse and/or eating disorder, and/or an established diagnosis of personality disorder will be accepted if there is a co-existing diagnosis of mental illness as specified in 1-3 above.

   If these women are already under the care of community mental health teams or specialist teams, it may, in some instances, be appropriate that they remain with these teams to provide continuity of care. In such cases the perinatal team will provide advice/consultation, or in some cases co-working, as needed. This will be discussed on a case by case basis.

5. Other diagnoses such as moderate depression, anxiety disorder or OCD where there is:

   - a significant effect on functioning, for example parenting or ability to work;
   - a previous puerperal component to illness;
   - a significant family history particularly a history of bipolar disorder or puerperal psychosis on the maternal side (see supplementary guidance).

6. Women with a history of past/current serious mental illness who are planning a pregnancy and would benefit from preconceptual counselling.

7. Women with a high risk of relapse of serious mental illness in the postnatal period and those women with psychosis in the postnatal period can be seen, even if their baby is not in their care. However, if the woman is already receiving care from a community mental health team, advice and consultation from the perinatal team might be more appropriate. This will also apply to women with serious mental illness who experience neonatal loss, stillbirth or intrauterine death.

8. Some women with a first degree relative with a history of serious mental illness in the puerperal period may benefit from an assessment with the team for psychoeducation and to facilitate information sharing regarding risk to other involved healthcare professionals.

9. The team will accept referrals from GPs, health visitors, CMHTs, and maternity staff, including obstetricians and midwives. In general, referrals from maternity staff will have been discussed with the perinatal mental health midwife on the team and referrals from core health visiting services will be discussed with the team health visitor.

   The service provides for women of 18 and above but will provide advice and consultation to colleagues in CAMHS to ensure under 18s are not excluded from specialist services if perinatal psychiatric disorder dominates the clinical picture.

   The team accepts referrals from twelve weeks gestation up to one year postnatal, however the team is available to discuss medication issues from conception.

Factors such as clinical need or maternal choice often mean that women will give birth in a maternity hospital in a different HSC Trust area to the one they reside in. However, mental health care will be provided in the HSC Trust area they reside in.

The perinatal mental health midwives and the midwife in the HSC Trust where maternity care is being provided will be key to the delivery of care, ensuring a seamless service across HSC Trust boundaries.

Routine referrals

Routine referrals are discussed at the multidisciplinary team meeting and offered an appointment within four weeks of the time of referral. This relatively short waiting time takes into account the maternity context.

Urgent referrals

Urgent referrals will be triaged within two working days and, if deemed urgent at the point of triage, an appointment will be offered within ten working days.

Emergency referrals

Emergency referrals are those referrals where the severity of illness, or the potential for the illness to rapidly worsen, with consequent risk to self or others, means that same day assessment is required. The perinatal mental health teams may be contacted for advice regarding this but referral into acute services is necessary if the referrals are deemed an emergency and Pathway 3 should be followed.

Pathway 3 – Emergency assessment

Woman requires emergency mental health care for perinatal mental health crisis. She is referred, or presents to primary care, ED, Mental Health secondary care, maternity services, health visiting or social care.

↓

Service makes referral for emergency assessment

↓

Mental Health Assessment Centre, Primary Care Liaison Team, Crisis Response Home Treatment, Liaison Mental Health Team, receives the referral for emergency assessment

↓

Service responds to the referral

↓

Does the woman consent to accept help voluntarily?

→ No → Consideration given to assessment under the Mental Health Order (NI)

↓ Yes

↓

Biopsychosocial assessment

↓

The woman should:

- have a mental health care plan in place to include safety plan and one of the following: admission to inpatient facility or accepted and scheduled for intensive follow-up care at home by Home Treatment Team; or
- have started an assessment under the Mental Health Order (NI); or
- be referred on to appropriate service; or
- be discharged.

(Adapted from The Perinatal Mental Health Care Pathways, Full implementation guidance. London: National Collaborating Centre for Mental Health, 2018)

Care and treatment

Formulation and diagnosis

While a woman is under the care of the perinatal mental health service, the multidisciplinary team will plan care using the process of formulation. Formulation is a more in-depth process whereby all the available information is drawn together in order to identify the individual's specific needs and circumstances, and identify possible reasons why these needs have arisen. It is done collaboratively with the service user and draws on the expertise of a range of professionals (the multi-disciplinary team).

Formulation will also take into account the report of family members and the referrer, and draw upon psychological theory and research to better understand the situation and what interventions would be of most help to the individual.

Participating in the process of formulation in partnership with professionals can help the individual (and their family members) understand their needs and identify areas of their lives which may need to change.

A diagnosis is a clinical judgement that all the diagnostic criteria for perinatal mental illness met. It is usually not helpful to have a diagnosis made in isolation from the formulation process. If a diagnosis is made the clinician making it will explain it and what it may mean for the individual.

Health and wellbeing planning

A personal health and wellbeing plan will be developed by the perinatal mental health practitioner in partnership with the individual and nominated family members or friends for an adult patient. The perinatal mental health team will provide advice and consultation to Child and Adolescent Mental Health Services (CAMHS) if the woman is under 18.

The plan will outline the mental health care that is being offered; any arrangements for working closely with practitioners monitoring or treating other conditions and how family members or close friends are to be involved. The personal health and wellbeing plan will also describe any agreements about maintaining personal safety and managing crisis.

Personal safety planning

Perinatal mental health teams are required to complete screening and assessment of risk in line with regional guidelines for mental health services, and to work with individuals and their families (where appropriate) to develop plans to avoid or minimise the impact of any risk.

People using perinatal mental health teams can expect that staff will:

- openly discuss any issues which may have a significant impact on safety with the individual;
- help them think through the risks for them personally and for family and/or other relevant other people;
- assist each individual in treatment to develop their own personal safety plan.

Staff will always be mindful of the safety and wellbeing of infants, children or adults at risk of abuse, and will take appropriate action if they are concerned about the safety of a child or an adult in need of protection. (See page 25).

Personalised treatment

The specific needs of individuals experiencing mental ill health in the perinatal period can be varied and complex, therefore care and treatment interventions need to be tailored to the specific need of the individual.

Staying engaged

When an individual is referred to perinatal mental health teams it is important that they keep all appointments, and if they cannot attend to let the service know well in advance. If an individual stops attending appointments without prior discussion with the perinatal team they will not be automatically discharged. The perinatal service will:

- attempt to contact the individual directly, and if this fails, will contact the nominated person of an adult patient or parent of a patient under 18 years;
- if an individual repeatedly and/or intermittently misses or cancels appointments, the service will discuss the impact of this with them with a view to re-engaging the individual with treatment;
- jointly consider the safety of the individual with the GP or other referrer, assess the potential risks, and agree the most appropriate follow up action, which may include discharge from services.

Transitions

Transitioning from one service to another can occur when an individual's needs or circumstances change. Perinatal mental health staff will work closely with the individual, their nominated family/friends and staff from other service areas to ensure that any transition occurs smoothly and continues to support the individual's recovery.

Moving between community and inpatient services

Women who experience mental ill health in the perinatal period may on occasion require inpatient treatment, usually if there is an acute and serious risk to their health or wellbeing. In the absence of a specialised mother and baby unit in Northern Ireland, women requiring emergency mental health care will be managed by HSC Trust mental health crisis response/home treatment teams or inpatient services, depending on the situation. During any inpatient admission or period of emergency crisis care, clinical responsibility will be with the inpatient consultant and multi-disciplinary team in the hospital/crisis teams. The perinatal team will provide expert advice to the inpatient team where this is needed. On discharge from hospital clinical responsibility will normally be transferred back to the perinatal mental health team after a period of step down to the home treatment team, unless otherwise agreed between the inpatient consultant and perinatal mental health team consultant.

Moving to self-managed care

Throughout the individual's engagement with the perinatal mental health team they will be asked to monitor their personal improvement in partnership with the multi-disciplinary team. This will help determine when they are ready for discharge from specialist care.

When discharge from specialist care is agreed, staff will work with the individual to develop a relapse prevention plan and identify in what circumstances and how they can re-engage with services if they experience a setback. The service user will be encouraged to remain involved in their local community support group/advocacy service to sustain their ongoing recovery.

Safeguarding

Safeguarding children

Safeguarding is the process of:

- preventing impairment of children's health and development;
- ensuring children are growing up safely and securely and are provided with effective care;
- protecting children from abuse or neglect when it occurs, including the promotion and protection of children's rights.

Safeguarding children, including unborn babies, is everyone's responsibility. All staff working with pregnant women and families must follow the Safeguarding Board for Northern Ireland (SBNI) Core Policy and Procedures **(www.proceduresonline.com/sbni/)** when a safeguarding concern is identified.

For all staff, it is important to understand the effects that parental mental health may have upon the unborn baby. Parental mental illness can make parenting difficult but not impossible. Parental mental illness has a range of influences which may impact on child development and behaviour. Assessments therefore need to balance the rights and needs of the child and the needs and rights of the parent. They need to be holistic which necessitates collaboration and communication between children's and adult services, while incorporating professional knowledge and skills to identify needs and risk.

In the event of any professional involved with the client/family identifying a safeguarding concern a referral should be made to the appropriate children's social work team. Where possible referrals about unborn babies should be made by the 18th week of the pregnancy to allow sufficient time for a full and informed assessment and to make adequate plans for the baby's protection, where this is necessary. An 'Expectant Mother' UNOCINI (Understanding the Needs of Children in Northern Ireland) referral form should be completed for mothers over the age of 18, while the routine UNOCINI referral should be used for mothers under the age of 18.

If the concern is of a child protection nature, then a verbal referral should be made to the to the appropriate children's social work team and followed up within 24 hours with a completed UNOCINI referral form. Nurses and midwives should seek advice and guidance from their local safeguarding children nurse specialist team. This referral will initiate a pre-birth risk assessment to identify what the risks to the new born child may be, whether the parent(s) have the capacity to change so that the risk can be reduced and, if so, what supports will be required.

All staff involved with a family where there are safeguarding concerns relating to a child or family in their care have a duty to attend and share information at any safeguarding children meetings.

In the event of a woman's admission to hospital during the perinatal period, hospital staff in consultation with the perinatal team should consider whether adequate and safe arrangements are in place for the care of any dependent children. If there is any doubt an urgent telephone referral needs to be made to the local gateway service or out-of-hours regional emergency social work service.

Safeguarding knowledge and training

All staff providing care and services for women and their families during the perinatal period should understand their contribution to safeguarding and promoting the welfare of children and young people. They should be competent and confident to carry out their role. They should have relevant up-to-date knowledge and training in relation to safeguarding children and be familiar with local SBNI child protection policies and procedures. Minimum levels of learning and development are set out in the SBNI Child Safeguarding Learning and Development Strategy (www.safeguardingni.org/resources/sbni-learning-and-development-strategy).

Adult safeguarding

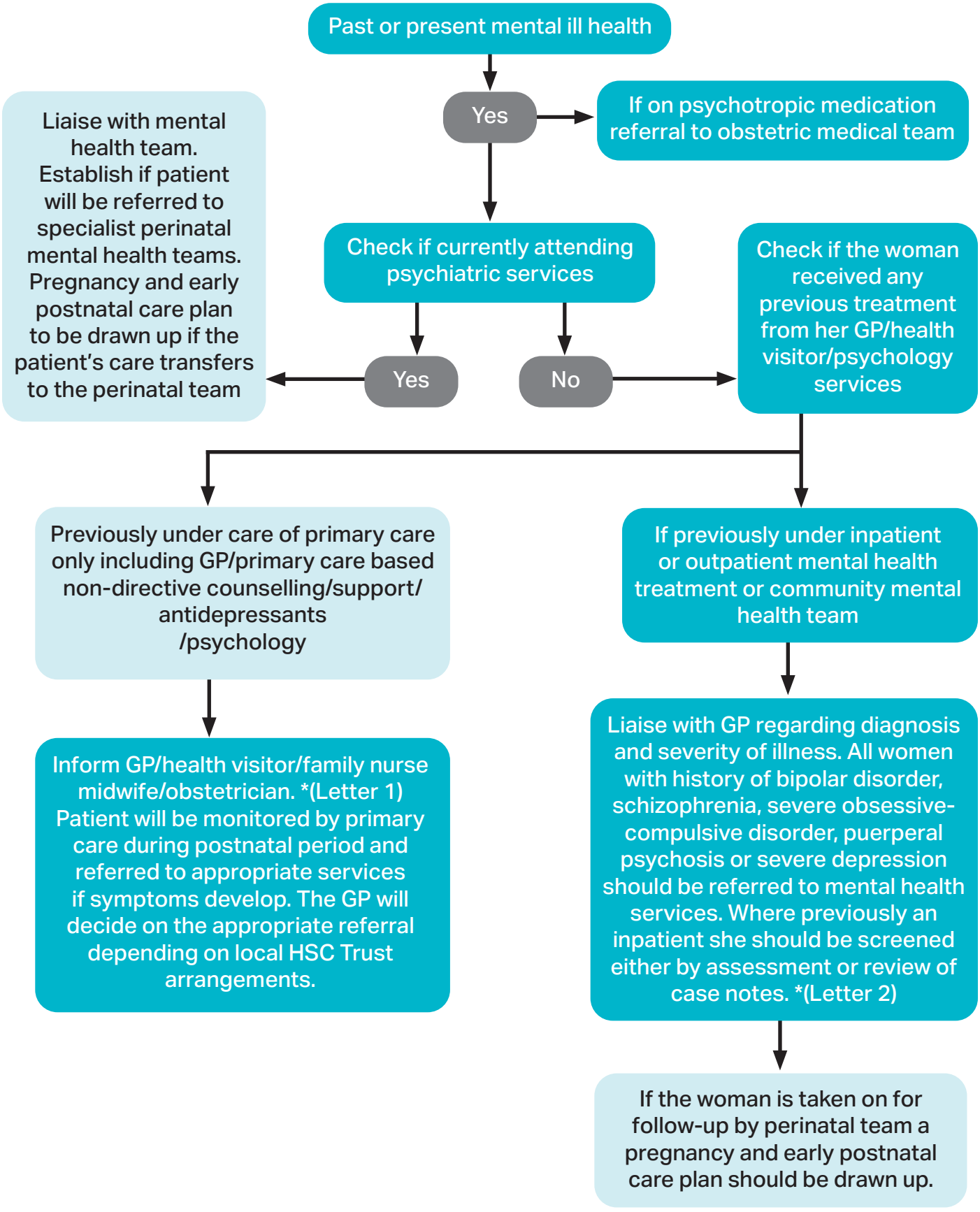
Everyone has a fundamental right to be safe. Whatever the cause, and wherever it occurs, harm caused to adults by abuse, exploitation or neglect is not acceptable. Safeguarding is everyone's business and we should all strive to prevent harm to adults from abuse, exploitation or neglect. Harm is the impact on the victim of abuse, exploitation or neglect. It is the result of any action whether by commission or omission, deliberate, or as the result of a lack of knowledge or awareness which may result in the impairment of physical, intellectual, emotional, or mental health or wellbeing. The following links aim to provide guidance and support that will improve safeguarding arrangements for adults who are at risk of harm from abuse, exploitation or neglect, for the purpose of reducing the prevalence of harm.

- **www.health-ni.gov.uk/topics/social-services**
- **www.health-ni.gov.uk/topics/social-services/safeguarding-children-young-people-and-adults-risk-harm-abuse-exploitation**

Acronyms and abbreviations

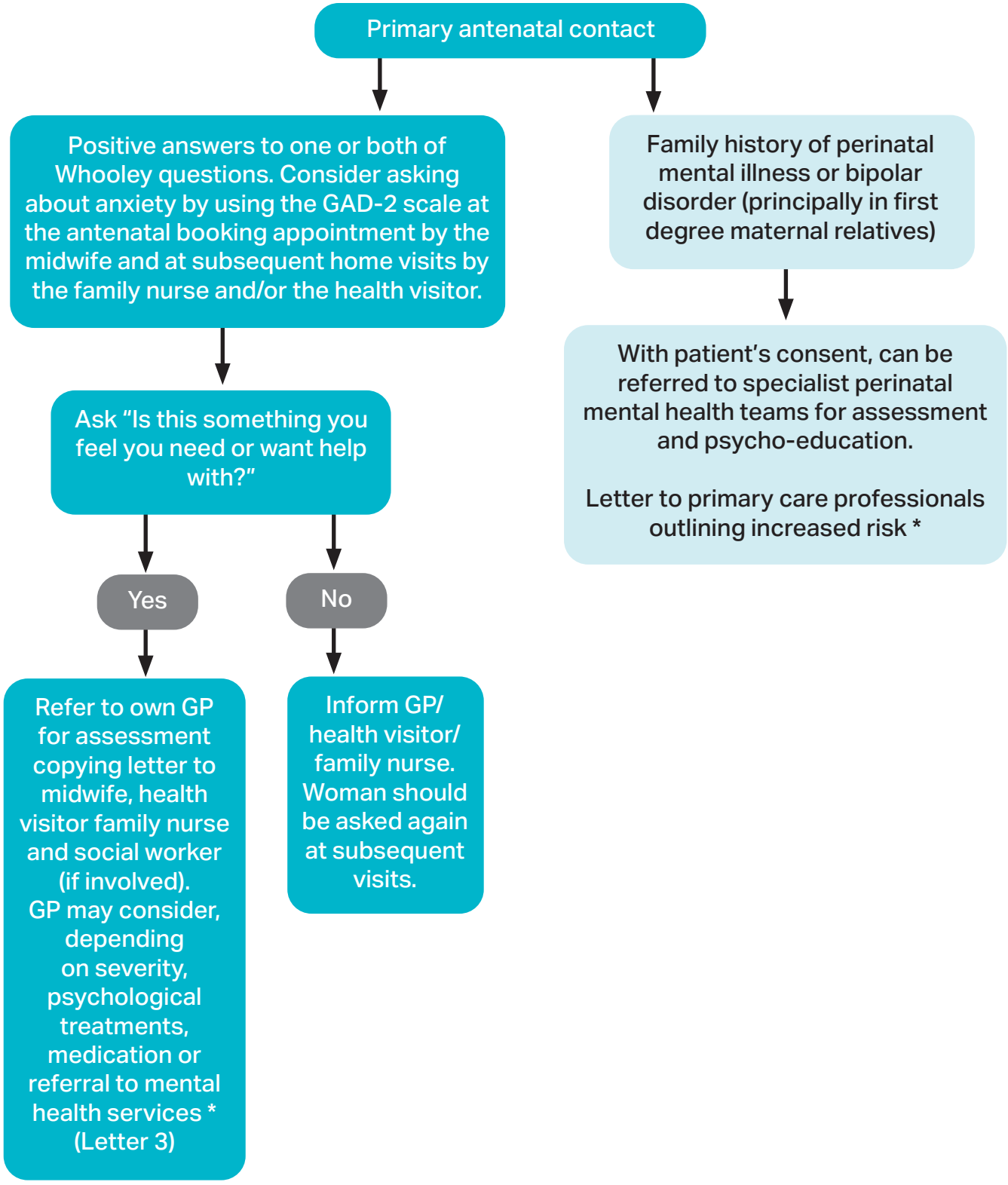
Term	Meaning
AHP	Allied Health Professionals
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CMHT	Community Mental Health Team
EDD	Expected date of delivery
EMDR	Eye Movement Desensitisation and Reprocessing
EPDS	Edinburgh Postnatal Depression Scale
FHA	Family Health Assessment
FN	Family Nurse
GAD	Generalised Anxiety Disorder
GP	General Practitioner
HSC	Health and Social Care
HSCT	Health and Social Care Trust
MDT	Multidisciplinary Team
MHHR	Maternity Handheld Record
NICE	National Institute for Health and Care Excellence
OCD	Obsessive Compulsive Disorders
PEPP	Pregnancy and Early Postnatal Care Plan
PNMHP	Perinatal Mental Health Care Pathway
PHA	Public Health Agency
PTSD	Post-Traumatic Stress Disorder
SBNI	Safeguarding Board for Northern Ireland
UNOCINI	Understanding the Needs of Children in Northern Ireland

Appendix 1: universal antenatal screening flow chart (part 1)



* Examples of standard letters – Appendix 4

Appendix 2: universal antenatal screening flow chart (part 2)



Note: During antenatal care if mental ill health symptoms develop please refer to GP. Please repeat Whooley/anxiety questions as required.

* Examples of standard letters – Appendix 4

Appendix 3: the antenatal screening flowchart – explanatory notes

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

Women with a history of severe mental ill health (refer to referral criteria) may be at risk of relapse or recurrence of their illness in the postnatal period. These women should be under the care of a mental health team for the duration of their pregnancy and the postnatal period. If the woman is not already under the care of a consultant psychiatrist she should be referred, with her consent, to the HSC Trust perinatal mental health team. A management plan should be drawn up by this team and shared with all professionals involved in the woman's care during the perinatal period and may include childcare social services if there is a potential childcare concern.

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

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

Whooley/anxiety questions (detection)
These are questions designed to detect possible depression during the antenatal and postnatal periods. Clinical judgment should be exercised with these questions. If the professional strongly suspects the woman is depressed but she is answering "no" to the questions, a guided conversation may support the woman to disclose. If not, the questions should be repeated at subsequent visits. If significant concerns are present these concerns should be discussed with the GP.

Appendix 4: Sample correspondence letters

Sample correspondence letters only. Local HSC Trust correspondence arrangements apply.

Letter 1	Letter from antenatal booking clinic to GP and health visitor and/or family nurse
Letter 2	Letter from hospital doctor/midwife to consultant psychiatrist
Letter 3	Letter from midwife/health visitor/family nurse to GP for a woman who has low mood.

Letter 1 Letter from antenatal booking clinic to GP and health visitor and/or family nurse.

From midwife or doctor to GP

Affix addressograph

Date

GP Practice address

Estimated Date of Confinement (EDC)_____

Dear Dr

Re:

This patient has booked for antenatal care in NAME OF HOSPITAL *insert as appropriate* and has identified a history of mental ill health. As this illness was at the milder end of the spectrum and as she is not attending mental health services at present, her symptoms will be monitored during the perinatal period and she will be referred to services if deemed appropriate.

If you have any concerns regarding this patient at any stage during her pregnancy, please let us know by contacting her community midwife.

Yours sincerely

_____

cc Community Midwife – NAME ☐

cc Health Visitor – NAME ☐

Letter 2 Letter from hospital doctor/ midwife to consultant psychiatrist

From hospital doctor/midwife to consultant psychiatrist

Date

GP practice address EDC_____

Dear Dr

Re:

This patient has booked for antenatal care in NAME OF HOSPITAL (insert as appropriate) and has identified a (personal) history of

- bipolar affective disorder;
- schizophrenia;
- severe obsessive compulsive disorder;
- puerperal psychosis;
- other (brief history).

We understand that she is currently attending mental health services and we are writing to inform you that she is now pregnant with an Estimated Due Date (EDD) of _____.

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

Yours sincerely

_____
Midwife

cc Community Midwife –
cc Lead Health Visitor –
cc GP

Letter 3 Letter from midwife/health visitor/family nurse to GP for a woman who has low mood.

To GP: Affix addressograph

Date

GP practice address EDC_____

Dear Doctor

RE:

This lady recently answered "yes" to the Whooley/anxiety questions, which are asked routinely in antenatal booking to ascertain whether or not the woman is suffering from low mood.

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

☐ She does not wish any help at this stage
She will be asked again at subsequent visits and we will inform you of any further concerns.

Thank you

Yours sincerely

_____
Midwife

Cc Health Visitor – NAME email sent ☐
Cc Community Team Lead – NAME

Appendix 5: guidance notes - pregnancy and early postnatal plan (PEPP)

1. Women at a high risk of severe mental illness in the postnatal period (women who have or have had a severe mental illness) should have a detailed written plan in place for their psychiatric management in late pregnancy and the early postnatal period (PEPP- pregnancy and early postnatal plan) In practice, all women under the care of perinatal mental health teams should have a PEPP completed.

2. This plan should be agreed with the woman (and, if she agrees, her partner, family or other support person) and should be shared with all relevant professionals involved in her care including maternity services, the community midwives, the health visitor, the GP and other mental health services for example liaison services or crisis response/home treatment services.

3. A copy should be in the handheld notes with the woman's permission. A copy should also be available in a shared folder in maternity, accessible to the maternity staff involve in the woman's care. The existence of the PEPP should be clearly specified in the handheld notes.

4. The plan should identify the supports in place and who to contact if problems arise.

5. Contact details should be provided for all professionals, including out-of-hours contacts.

6. The plan should clearly address any medication management issues in late pregnancy and the immediate postnatal period and should include any breastfeeding issues identified.

7. The plan should be completed between 28 and 32 weeks gestation unless there are exceptional circumstances, and updated as necessary throughout the remainder of the pregnancy.

8. A multi-professional care planning meeting should be considered to facilitate the completion of the care plan in those women with a history of psychosis or other factors, placing them at higher risk in the early postnatal period. A care planning meeting should also be considered if there are complex social circumstances, in particular the involvement of children's social services. The timing of the meeting should always be scheduled to facilitate the attendance of the woman and her partner or other support person. Attendance remotely should also be facilitated if possible.

Appendix 6: Whooley/anxiety questions (detection)

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

The two questions relating to mental health and wellbeing are:

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

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

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

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

The two questions relating to anxiety are:

Over the last two weeks, how often have you been bothered by feeling nervous, anxious or on edge?

Over the last two weeks, how often have you been bothered by not being able to stop or control worrying?

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

Appendix 7: Edinburgh Postnatal Depression Scale (EPDS)

The EPDS is a self-administered tool to assist the health visitor/family nurse in screening mothers for postnatal depression.

Scoring

- Response categories are scored 0, 1, 2, and 3 accordingly to increased severity of the symptom.
- Some items are reverse scored.
- Any score above 0 on question 10 requires further assessment.
- Validation studies have shown an EPDS cut off score of 12 or greater may be used to determine depressive symptoms among English speaking women in the postpartum period.
- The EPDS must be interpreted in combination with professional judgement to confirm postnatal mothers with depressive symptoms.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
0 As much as I always could
1 Not quite so much now
2 Definitely not so much now
3 Not at all

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

3. I have blamed myself unnecessarily when things went wrong
3 Yes, most of the time
2 Yes, some of the time
1 Not very often
0 No, never

4. I have been anxious or worried for no good reason
0 No, not at all
1 Hardly ever
2 Yes, sometimes
3 Yes, very often

5. I have felt scared or panicky for no good reason
3 Yes, quite a lot
2 Yes, sometimes
1 No, not much
0 No, not at all

6. Things have been getting on top of me
3 Yes, most of the time I haven't been able to cope at all
2 Yes, sometimes I haven't been coping as well as usual
1 No, most of the time I have coped quite well
0 No, I have been coping as well as ever

7. I have been so unhappyy that I have had difficulty sleeping
3 Yes, most of the time
2 Yes, sometimes
1 Not very often
0 No, not at all

8. I have felt sad or miserable
3 Yes, most of the time
2 Yes, quite often
1 Not very often
0 No, not at all

9. I have been so unhappy that I have been crying
3 Yes, most of the time
2 Yes, quite often
1 Only occasionally
0 No, never

10. The thought of harming myself has occurred to me
3 Yes, quite often
2 Sometimes
1 Hardly ever
0 Never

Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry 150:782-786

For information on how to contact perinatal mental health services visit pha.site/perinatal-mental-health-services

Public Health Agency

Public Health Agency
12-22 Linenhall Street, Belfast BT2 8BS.
Tel: 0300 555 0114 (local rate).
www.publichealth.hscni.net

Find us on:

03/25