NHS FORTH VALLEY

The Early Detection and Management of Perinatal Mental Health

Integrated Care Pathway

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Group Committee – Unit Clinical Governance Meeting
Final Approval

This document can, on request, be made available in alternative formats
Consultation and Change Record – for ALL documents

<table>
<thead>
<tr>
<th>Contributing Authors:</th>
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<tr>
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</table>

| Distribution: | Midwives, Obstetricians, Supervisors Of Midwives, Team Leaders, Clinical Shift Co-ordinators, Department Managers, Unit Service Manager and Head of Midwifery, Quality Improvement, Health Visitors, CPNs, Paediatric Consultants, GP’s, CHP Lead Nurse, Family Nurse Partnership |

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The Women’s Perspective

Fundamental to the successful management of perinatal mental illness is to gain a greater understanding of the woman’s perspective.
Quotes from Patients Perspective

“It just dawned on me one morning about 30 weeks pregnant that I didn’t feel bonded to the baby and that I somehow knew I wouldn’t be bonded once they were born. I am happiest when he is asleep”

“I avoided friends at all costs as I lost the ability to communicate and became very isolated” “I was terrified to admit to any health professional as I was scared they would take my son away”

“Something that I would put high up on the agenda is working with partners and family members – that’s hugely neglected....so involving partners in a meaningful and fundamental way because they’re observing their partner in a really difficult place and don’t know how to manage it”

“I couldn’t believe what was happening. Instead of being the best time of my life it had turned into some sort of nightmare and I thought I had made a huge mistake”

“I became ill about half way through my first pregnancy and was crippled by frightening thoughts, suicidal feelings and very low mood. My husband was confused and frightened, and I was terrified. I was referred to the Perinatal Mental Health Team, and with their support was able to remain an outpatient until I was discharged when my daughter was nine months old. I felt confident; I had learned many ways to help myself and knew where to look for support if I needed it.

Unfortunately I became ill again during my second pregnancy, but due to my existing relationship with the service I was able to access the help I needed very quickly. It hasn’t been easy, but the light at the end of the tunnel has come around more quickly this time”
Introduction / Exclusions / Scope / Definitions

The term postnatal depression should not be used as a generic term for all mental illness following childbirth. In Scotland the term perinatal mental health is used to cover all mental illness during the ante and postnatal period (SIGN 2012).

The enclosed document is the 2014 update of Forth Valley NHS Integrated Care Pathway for the early detection and management of Perinatal Mental Health. The document is designed to inform health professionals of Assessment Protocols and the Integrated Care Pathway. Supporting information on the provision of services and the role of professionals and voluntary groups is incorporated.

NHS Forth Valley is committed to providing services that meet the diverse needs of everyone living in the communities we serve.

We recognise that we have legal responsibilities under the Disability Discrimination Act 1995 and the Race Relations Amendment Act 2000. These responsibilities include providing a range of communication support such as interpreters, information in different formats such as various languages, large print, Braille, audiocassette, symbols and pictures. (Appendix 1)

NHS Forth Valley has systems in place which will support staff and service users in ensuring that where possible peoples communication needs will be met.

An Integrated Care Pathway (ICP) is a multidisciplinary outline of anticipated care, placed in an appropriate timeframe, to help a patient with a specific condition or set of symptoms move progressively through a clinical experience to positive outcomes (Campbell et al 1998).

Specific recommendations from the Centre for Maternal and Child Enquires (CMACE) reporting on maternal deaths from psychiatric causes highlight the need for clear referral criterion and pathways of care. A minimum requirement for women with a previous serious affective disorder or other psychosis is a referral for a psychiatric assessment in pregnancy and regular monitoring until the third postnatal month even if they are well (CMACE 2011).

In addition NHS Quality Improvement Scotland (2007) state that there is specific risk assessment and management plan for women of childbearing years that includes preconception advice

Exclusions

There is a growing body of research towards mental illnesses in the perinatal period i.e. Antenatal anxiety, schizophrenia, post traumatic stress disorder, borderline personality disorder, eating disorder and substance misuse. They are not included in this guidance please access the following link www.nice.org.uk to NICE 45 Guidelines (National Institute for Clinical Excellence 2007) for further information on those conditions.

Scope

The scope of this ICP for perinatal mental health is to identify mothers at pre-conception, the antenatal and postnatal period that have a mental illness and predict those who may be at risk of developing mental illness. Involvement of women and family and provide appropriate supportive nursing and medical services.
Definitions
Perinatal mental health considers all mental illness during pregnancy and the postnatal period therefore the focus of this ICP is the impact of affective disorders.

Neonatal Adaptation Syndrome-refers to a cluster of symptoms in the neonate including irritability, sleep disturbance, persistent crying, tachypnoea, hyperglycaemia, poor thermal regulation and occasionally seizures, which has been related to the use of psychotropic medication in pregnancy. (SIGN 2012) www.sign.ac.uk

Baby Blues'-describes the emotionally labile state experienced by the majority of women following childbirth. Commonly presenting on the second or third day it normally resolves by the fifth day with regular professional support and reassurance. Scottish Intercollegiate Guidelines Network (SIGN 2012) www.sign.ac.uk

Postnatal Depression-regarded as any non-psychotic depressive illness occurring during the first postnatal year (SIGN 2012).

Postpartum psychosis-in the majority of cases, is a severe affective psychosis of acute onset, temporally linked to the postnatal period, and typically presenting in the early postnatal period, usually within the first month of childbirth (SIGN 2012)

Postpartum Psychosis
The most acutely severe form of postnatal illness – postpartum psychosis – also has the greatest potential for prediction

Risk Factors for Postpartum Psychosis
1. A personal history of postpartum psychosis predisposes approximately 57% to experience another episode following subsequent pregnancies.
2. Approximately 25-50% with a history of Bi-Polar Disorder increasing to 74% if there is also a family history of Bi-Polar Disorder
3. Women having their first baby the relative risk during the first postnatal month is 23 
Doucet et al (2011)
4. Family history of Bi-polar is 3% rising to 6% where there have been postpartum episodes even if there is no personal history of mental illness (Munk & Olsen et al 2007)

Women with the first two risk factors must be referred to Perinatal Mental Health Team. Women with risk factor 4 should be offered referral to the Perinatal Mental Health Team for preventative management.

Symptoms commonly develop suddenly from day 2 and can deteriorate rapidly over 48 hours. While it can be a longer time period the overwhelming majority of cases present within 14 days post partum. (Brockington, 2012). Please see following link for symptoms: http://www.rcpsych.ac.uk/mentalhealthinfo/problems/postnatalmentalhealth/postpartumpsychosis.aspx
Antenatal/Postnatal Depression
Antenatal depression has not aroused the same interest as postnatal depression, however it is not less common (Brockington 2012)
Postnatal depression has a prevalence rate of 10-15%. The majority of women with a postnatal depression are treated successfully in primary care services with only 1% requiring referral and treatment by psychiatric services.

Risk Factors for Postnatal Depression

<table>
<thead>
<tr>
<th>Strong to moderate risk factors</th>
<th>Moderate risk factors</th>
<th>Small risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression or anxiety during pregnancy</td>
<td>Neuroticism</td>
<td>Obstetric factors</td>
</tr>
<tr>
<td>Past history of mental disorder</td>
<td>A difficult marital relationship during pregnancy</td>
<td>Socio-economic status</td>
</tr>
<tr>
<td>Life events</td>
<td></td>
<td>Henshaw et al 2009</td>
</tr>
<tr>
<td>Lack of or perceived lack of social support</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Symptoms of depression in the perinatal period are the same as depression at any other time. Feelings of guilt and worthlessness may focus on the maternal role. Link to http://www.rcpsych.ac.uk/healthadvice/problemsdisorders/postnataldepression.aspx for symptoms of depression.

Post-Natal Depression (PND) usually occurs between 8-12 weeks after delivery. It can present at 4-6 weeks and is normally more severe in this timeframe (Oates 2009). It can last between 6 months and a year and in some cases longer.

It is estimated 30 % of depression in the perinatal period goes undetected or untreated, and can have a serious effect on the mother’s and infants health. Research has demonstrated that unresolved PND has a negative effect on family dynamics and can cause enduring adverse effects on the social, intellectual and educational development of children (Bowlby 1989)

Role of Community Midwife in following the Integrated Care Pathway

Mental wellbeing can be assessed by using the following Whooley questions as brief focused questions:
1. “During the past month, have you often been bothered by feeling down, depressed or hopeless?”
2. “During the past month, have you often been bothered by having little interest or pleasure in doing things?”

Women may also have increased anxiety, therefore the following Generalized Anxiety Disorder (GAD) questions can also be used:
1. “During the past month, have you been feeling nervous, anxious or on edge?”
2. “During the past month, have you not been able to control or stop worrying?”

If a woman responds positively to any of the above questions, refer woman to her GP, or if a mental health problem is suspected, see referral criteria to Perinatal Mental Health Service p10 and Appendix 2

If women don’t meet the Perinatal Mental Health referral criteria, but acknowledge need for more support, Midwives can signpost to local support services

(Edinburgh Postnatal Depression Score may be used by staff in the antenatal and postnatal period as an aid to clinical monitoring to facilitate discussion of emotional issues)
Role of the Health Visitor and Family Nurse in following the Integrated Care Pathway

<table>
<thead>
<tr>
<th>Time</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification Visit</td>
<td>• Discuss emotional health</td>
</tr>
<tr>
<td></td>
<td>• If problem identified, intervention offered</td>
</tr>
<tr>
<td>6 - 8 weeks</td>
<td>• Mental wellbeing assessed (clinical judgement + Whooley/GAD questions to initiate conversation)</td>
</tr>
<tr>
<td></td>
<td>• If problem identified, intervention offered</td>
</tr>
<tr>
<td></td>
<td>• Consider allocation family within health plan indicator if appropriate</td>
</tr>
<tr>
<td>3 - 4 months</td>
<td>• Mental wellbeing assessed (clinical judgement + Whooley/GAD questions)</td>
</tr>
<tr>
<td></td>
<td>• If problem identified, intervention offered</td>
</tr>
<tr>
<td></td>
<td>• Review allocation family within health plan indicator if appropriate</td>
</tr>
<tr>
<td>8-12 months postnatally</td>
<td>If clinically well, discharge to routine GP/HV care</td>
</tr>
<tr>
<td></td>
<td>Date discharged from pathway to be documented.</td>
</tr>
<tr>
<td></td>
<td>Review profile of significant factors/allocation family within health plan indicator.</td>
</tr>
</tbody>
</table>

Role of the GP in following the Integrated Care Pathway

<table>
<thead>
<tr>
<th>Issue</th>
<th>Possible Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assess mental wellbeing</td>
<td>• Refer to health visitor – Mental Wellbeing Assessment + Whooley/GAD questions</td>
</tr>
<tr>
<td>(Acknowledgement of father/partners mental wellbeing also, and support given if and when appropriate)</td>
<td></td>
</tr>
<tr>
<td>2. Diagnosis of depression not confirmed</td>
<td>• GP care and review</td>
</tr>
<tr>
<td>3. Diagnosis of mild depression</td>
<td>• +/- no intervention</td>
</tr>
<tr>
<td></td>
<td>• Offer support and other range of psychological therapies (Mood Juice, Beating the Blues, Voluntary Sector)</td>
</tr>
<tr>
<td></td>
<td>• +/- antidepressant</td>
</tr>
<tr>
<td></td>
<td>• +/- Health Visitor</td>
</tr>
<tr>
<td></td>
<td>• +/- Social support - refer to Social Worker</td>
</tr>
<tr>
<td>4. Diagnosis of moderate depression</td>
<td>• Refer to Perinatal Mental Health Team</td>
</tr>
<tr>
<td></td>
<td>• +/- ongoing GP review</td>
</tr>
<tr>
<td></td>
<td>• +/- ongoing Perinatal Community Psychiatric Nurse review</td>
</tr>
<tr>
<td>5. Diagnosis of severe depression/psychosis</td>
<td>• Refer to the Perinatal Mental Health Team for urgent review or Community Mental Health Team – see perinatal team referral criteria</td>
</tr>
<tr>
<td></td>
<td>• If same day assessment required refer to the Psychiatric Emergency Hub who will liaise with the perinatal team to and determine need for Inpatient care/IHTT</td>
</tr>
<tr>
<td></td>
<td>• Detain under MHA if necessary</td>
</tr>
</tbody>
</table>
### Referral Criteria – Age 18yrs and above

- Pre pregnancy advice and assessment for high risk women (i.e., those on mood stabilising or antipsychotic medication, or with a history of bipolar disorder, schizophrenia or postpartum psychosis).
- Previous perinatal mental illness treated by psychiatric services.
- Pregnant or breastfeeding women who are prescribed psychotropic medication for psychiatric purposes.
- Where a pregnant or postnatal woman is already open on the caseload of mental health services in NHS Forth Valley, the perinatal mental health team offer joint management, as appropriate to the woman’s needs.
- Pregnant women with a personal or family history of bipolar affective disorder or postpartum psychosis.
- Pregnant or postnatal women who develop a severe mental illness.
- Pervious perinatal mental illness treated by GP and currently unwell with a mental illness of any severity.
- Women within 6 months of childbirth with any of the above illnesses. Anybody referred outside this timeframe will be discussed on an individual basis.
- Any woman who is referred to a regional mother or admitted to Forth Valley Royal Hospital with a perinatal illness will be seen by the perinatal team on discharge.

### Issue | Possible action
---|---
1. To help prevent or minimise severe mental illness in the perinatal period. | Provide early intervention in the antenatal period by offering a perinatal mental health assessment and if indicated ongoing review of the woman’s mental health. The development of pregnancy and early postnatal care plans that are then held in the women’s hand held notes and circulated to all relevant professionals involved in the woman’s care.
2. Pre-conception and medication advice / prescribing | Liaise with the Mental Health Clinical Pharmacy Team at Forth Valley Royal Hospital and the UK teratology information service for best choice of psychotropic medication in the perinatal period. Discuss the risk-benefit ratio with the woman and her family.
3. Interventions | Where appropriate and within sphere of competence provide brief psychological interventions
4. Consultancy, educational and liaison role | The perinatal team members will support their colleagues in generic mental health teams, provide health promotion and education to the women and their families; build up strong relationships with midwives and health visitors while becoming familiar with other systems such as children & family social workers. Liaise with third sector services building up knowledge of other supports provided by family centres etc.
5. It is suspected the woman requires admission to hospital in the perinatal period. | Liaise with the Intensive Home Treatment Team and assess the risks to the mother and unborn/born child. If a woman cannot be managed in the community during pregnancy or if for any reason the baby is not being admitted with the mother liaise with Ward 3 Forth Valley Royal Hospital. When a baby is being admitted with the mother. Liaise with the regional unit to arrange admission, review progress on the unit, facilitate home leaves and discharge planning.
Supporting role of CAMHS to Perinatal Mental Health Service

Child and Adolescent Mental Health Services (CAMHS) provides assessment and intervention for children and young people aged between 0-18 years and their families/carers.

CAMHS is organised into a tiered system to ensure that young people who are referred to the service are signposted to the most appropriate provision.

A single referral pathway meeting is used to triage cases appropriately. To support cases referred to the Perinatal Mental Health Team, both CAMHS Primary Mental Health Team (PMHT) (Tier 2) and core CAMHS team (Tier 3), will be involved.

The CAMHS PMHT Tier 2 service provision has a role and responsibility to increase awareness and understanding of emotional and psychological well-being of children and young people by offering early access for those in need of additional supports. The PMHT exist to provide interventions for those with mild to moderate difficulties and to aid in the transitions to and from Tier 3.

The PMHT has a broad remit part of which involves staff by offering training, advice and consultation as well as direct contact with young people. The PMHT is able to prioritise young pregnant women who are experiencing emotional difficulties. A range of modalities is used to enhance accessibility and inclusion. For example, interventions may be via an advice line, consultation and support to other professionals (see link to SIDS). Professional consultation can be requested with or without parental consent by contacting the Advice Line.

The Core CAMHS Tier 3 service provision exists to ensure a service for children and young people with moderate to severe difficulties and is focussed on providing treatments and interventions for young people whose clinical presentation is considered more complex - such as acute mental illness or complex trauma, and where multi-level interventions are indicated. For example, there might be co-morbid diagnoses, significant impairment as a result of past experience, child protection issues, a need to work on attachment, parenting or family systems work, etc. or cases that require a multi-disciplinary approach. Tier 3 staff can also provide staff support, consultation, training as well as direct intervention.

For further details of CAMHS criteria, please refer to our referral criteria document, which is available on the NHS Forth Valley Service Information Directory Site (SID) [http://www.sid.scot.nhs.uk](http://www.sid.scot.nhs.uk) (under Mental Health - CAMHS - Review Information - Referral Criteria).

Associated Pharmaceutical Issues
SIGN 127 Management of perinatal mood disorders www.sign.ac.uk has identified the following general principles governing prescription of new medication or the continuation of established therapy during pregnancy and in breast-feeding:

- Establish a clear indication for drug treatment i.e. the presence of significant illness in the absence of acceptable or effective alternatives
- Use treatments in the lowest effective dose for the shortest period necessary
- Medicine with a better evidence base (generally more established medicines) are preferable
Assess the benefit/risk ratio of the illness and treatment for both mother and baby/foetus

The Role of Forth Valley Community Pharmacists

Community pharmacists are a readily accessible point of information about the use of medicines in pregnancy, postnatal depression and for breastfeeding mothers. This advice includes choosing the right medicine, to be taken at the right time, for a particular person and advice about common adverse effects which may be experienced and how to manage these. All community pharmacies offer The Minor Ailment Service (MAS) which allows patients, who are exempt from prescription charges, to register with and use a community pharmacy as the first port of call for the treatment of common illnesses on the NHS. The pharmacist advises, treats or refers the patient according to their needs.

The community pharmacist is also in a good place to give advice about herbal or homeopathic medicines which people with post natal depression may want to take in addition to, or instead of, prescribed medication.

The new Medicine Information Service will be up and running by the end of January 2014. This is a joint service between Forth Valley and Lanarkshire, based at Monklands. Details still to be formalised.
# Preterm Delivery and the Impact on Perinatal Mental Health

Antenatal assessment and plans for psychological support are cut short by preterm delivery that is often precipitated by maternal illness or development of fetal complications. Consequently the information and counselling offered to women progressing through normal pregnancy are denied to those who deliver preterm.

The needs of parents whose babies are admitted to NNU or whose newborn infant is causing concern should be addressed on an individual basis as for any vulnerable group. Specifically the following steps should be followed:

- Parents mental health needs considered pre-conception where relevant
- Information regarding mental wellbeing offered as early as possible in pregnancy
- Vulnerability for perinatal mental illness identified assessed when any pregnancy complication occurs including admission to NNU or involvement of paediatric services.
- Appropriate information and links to effective support offered to all such parents
- A mother can be referred to the Perinatal Mental Health Team if she meets the referral criteria-see Appendix 2
- Early and ongoing communication among the parents and family, maternity, neonatal, Primary Care and Mental Health professionals to ensure consistent and effective health service provision.
- Effective links to Early Years Collaborative, SPSP MCQIC and GIRFEC key person to ensure longer term awareness and provision of appropriate support including the siblings of the affected infant
- Education of all health professionals in implementation of the PMHICP including care of parents rendered vulnerable by virtue of fetal or neonatal concerns
- Ongoing monitoring of all voluntary agencies identified in the local area to which families may turn for help
- Evaluation of services to facilitate continuous improvement

# Maternal Mental Health and the Effect on Pregnancy and the Infant

Anxiety or depression that is chronic may have an impact on the physiological and behavioural functioning of the fetus/baby, with consequences to their later development. Babies born to depressed mothers may have lower motor tone, be less active and more irritable. They may also display fewer facial expressions in response to happy faces, disrupted sleep patterns, increased fussiness and difficulty to soothe (Bergner, Monk and Werner, 2008)

What can health professionals do to support women in this situation:

- Create a helping relationship where the mother feels confident to talk about her feelings so that she can receive appropriate help and support
- If a mother has been prescribed antidepressants/mood stabilisers and/or anti psychotic medication during her pregnancy, the infant should be observed for 72 hours for any signs of neonatal adaption syndrome (previously neonatal abstinence syndrome)
- Bonding plays a key role in the behavioural and physiological regulation of both infant and mother, and many women may experience difficulties in bonding with their baby. A range of methods are available to support early bonding including skin-to skin care, baby carriers and infant massage

“The close body contact of the infant and his/her mother during the immediate post birth period influences the physiology and behaviour of both"
Acknowledgements

NHS FV Pathway Implementation Group would like to thank NHS Greater Glasgow for their kind permission to adapt their Perinatal Care Pathway in order to develop the Forth Valley ICP for PND.

The work of the following members of the NHS FV Pathway Implementation Group is appreciated in developing this information pack.

### Pathway Implementation Group Membership 2014

<table>
<thead>
<tr>
<th>Name</th>
<th>Designation</th>
<th>Base</th>
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<tbody>
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<td>FVRH</td>
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<td>Val Arbuckle</td>
<td>Additional Support Midwifery Sister</td>
<td>FVRH</td>
</tr>
<tr>
<td>Jo Nicholson</td>
<td>Health Psychologist</td>
<td>NHS FV Psychology Services, Stirling</td>
</tr>
<tr>
<td>Julie Whitcombe</td>
<td>Team Leader – Health Visiting</td>
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</tr>
<tr>
<td>Betty Patterson</td>
<td>Quality Improvement Facilitator</td>
<td>FVRH</td>
</tr>
<tr>
<td>Pauline Wilson</td>
<td>Health Visitor</td>
<td>NHS FV</td>
</tr>
<tr>
<td>Dr Una MacFadyen</td>
<td>Consultant Paediatrician</td>
<td>FVRH</td>
</tr>
<tr>
<td>Fiona Mitchell</td>
<td>Community Psychiatric nurse</td>
<td></td>
</tr>
<tr>
<td>Kirsty MacInnes</td>
<td>Sister Neonatal Midwife/Practice Development Midwife</td>
<td>FVRH</td>
</tr>
<tr>
<td>Jean Logan</td>
<td>Lead Pharmacist – Mental Health and Substance misuse</td>
<td>FVRH</td>
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</tbody>
</table>

The Group has also sought and acted on the opinions and views of other staff not directly involved in the Pathway Implementation group.

While the Group does not now have a service user representative attending meetings, feedback has been, and will continue to be, sought via PND groups within the community and via service user experience surveys.
References


GIRFEC http://www.nhsforthvalley.com/health-services/public-health/child-health


OATES M (2009) Perinatal Psychiatric Syndromes Psychiatry, 8 (1) 1-6


If requiring interpretation services Monday-Friday 08:30 – 16:30, please contact Barbara Logan, ext: 67156. If out of hours, contact service directly.

All wards and outpatients departments have the paperwork/instructions required for Language Line. Could all completed paperwork please be sent to Barbara Logan.
Appendix 2

Referral to Perinatal Mental Health Services
Referral Sources: General Practitioner; Health Visitor; Midwife, secondary mental health services.

Meets referral criteria (+>18yrs of age) for Perinatal Mental Health Service.

>18yrs of age, refer to CAMHS.

Routine
- Assessment within 8 weeks
  - Electronic referral - found under quick links intra net-useful forms
    - Mark Routine
    - FV-UHB.PerinatalMentalHealthService@nhs.net
  - Daily review of referrals and prioritisation of assessments within 8 weeks

Urgent
- Assessment within 5 working days
  - Electronic referral - found under quick links intra net-useful forms
    - Mark Urgent
    - FV-UHB.PerinatalMentalHealthService@nhs.net
  - Daily review of referrals with aim of prioritisation of assessments within 5 working days

Emergency
- Same day Assessment
  - Contact: 01324 567250
  - Within IHTT/Liaison hours call will be transferred to appropriate clinician
  - The clinician will determine the most appropriate location for the assessment to take place.
    - Home or FVRH
  - Outwith IHTT/Liaison hours call will be received by clinician "on call"
  - A time will be agreed for assessment to take place at FVRH
  - Daily review of referrals and prioritisation of assessments within 8 weeks

Requires Detention
- In hours: Mon-Fri 9-5
  - Contact approved medical practitioner (AMP) at FVRH 01324 566177
  - Daily review of referrals with aim of prioritisation of assessments within 5 working days

- Out of hours:
  - GP responsible for emergency detention and requirement to contact duty MHO via S/W
    - Emergency Duty Team on 01786 470500
  - Daily review of referrals and prioritisation of assessments within 8 weeks

<18yrs of age, refer to CAMHS.
Publications in Alternative Formats

NHS Forth Valley is happy to consider requests for publications in other language or formats such as large print.

To request another language for a patient, please contact 01786 434784.

For other formats contact 01324 590886,
text 07990 690605,
fax 01324 590867 or
e-mail - fv-uhb.nhsfv-alternativeformats@nhs.net