GIG CYMRU NHS WALES
Rhwydwaith Iechyd Meddwl Amenedigol
Perinatal Mental Health Network

Introduction to the Wales Perinatal Mental Health Programme

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Why a Perinatal Mental Health Programme

The Perinatal Mental Health Programme has been created following a Wales Perinatal Mental Health Network-led review of the way in which support, care and treatment was being provided for women and their families with mental health difficulties, who were planning a pregnancy, pregnant or had given birth and had a baby under one year old.

Historically there had been a lack of integrated and equitable physical and mental health care for women during pregnancy and in the weeks and months following birth, and a lack of specialist perinatal mental health services.

Although great work had already been undertaken, it was recognised that there were still opportunities for further service development, with a focus on:

- Promoting and support emotional transition to pregnancy and parenthood
- Prediction, detection, prevention and identification
- Earlier intervention - assessment and 'matching' support to individual need
- Timely provision of high quality and equitable services
- Services provided by the right people with the right skills, knowledge and support

Network members, including practitioners working across health board areas, colleagues working within third sector and voluntary organisations, women and their families who are using or have used services have worked together to review the latest evidence. An agreed all Wales approach to support service delivery was developed to improve the outcomes for all who need to access and use services across Wales.

What the Programme is for

The Wales Perinatal Mental Health Programme (WPNMHP) sets out what actions practitioners will take to ensure that the mental health and wellbeing of women and their families planning a pregnancy, pregnant and after birth up until their baby is one year old is supported.

The programme provides an overview and summary of the research and recommendations for change and pathways that are underpinned by a 'matched' care and needs-led model, which specifies the anticipated steps from universal, primary, secondary and through to tertiary care.

Five themes are highlighted:

1. Promotion, prediction and detection
2. Effective communication
3. Co-ordination of service
4. The competencies of a multidisciplinary team
5. Appropriate use of medication

Who is the Programme for

The pathways will provide guidance to all practitioners who come into contact with a woman and her family who are planning a pregnancy, pregnant or given birth and have a baby under one year old, across all settings.

In the interests of effective information sharing and communication, it is important that all referrals and communication between health care professionals are timely to ensure a co-ordinated, consistent approach to the care offered to meet the woman's unique needs.

All practitioners should also be aware of their local operational guidance for perinatal mental health services.

The "Perinatal Period"

The "Perinatal Period" is the time given to the period immediately before and after birth. In the context of this document "perinatal", however, is taken to describe mental health difficulties that arise in association with planning a pregnancy, pregnancy and the postnatal period, generally up to 12 months following birth. More recently, it has been suggested that service provision is extended to 24 months and the network will be reviewing this.

Why we need the Programme

Women and their partners and families who are planning a pregnancy, pregnant or given birth and have a baby under one year old are supported by many different services across the NHS and its partners.

These services range from the family GP, to a wide range of services including: maternity, health visiting, mental health, including primary, secondary and specialist perinatal mental health services; social services; NHS 111 Wales; A&E, third sector and voluntary organisations.

It is essential that all these services work together to ensure that women and their families who need support receive seamless care.

As part of the Wales Perinatal Mental Health Network review of current service provision, it was agreed that there would be significant benefit derived from having an all Wales approach. To support this, fully integrated care pathways, a competency framework, training plan, national data set and outcome measures framework for perinatal mental health are in the process of being developed based on the most current evidence base, as set out in a number of key influential documents.

Funding the Programme

In 2016, Welsh Government provided £1.5million to begin the development of Perinatal Mental Health (PNMH) services that were equitable across Wales.

Since 2016, health boards have been given the opportunity to bid for additional funding through the service improvement fund to further develop Specialist PNMH services and services across the pathway.

What is driving the change

Brief Introduction

Over the last few years there has been a growing momentum towards improving perinatal mental health services across the UK. This includes increased Government investment towards improving specialist perinatal mental health care for women and their families, and a growing social recognition about the impact of these conditions on those affected.

In England, developing services and improving outcomes for women with perinatal mental health problems and their families has been identified as a national priority. The UK Government ring fenced £365 million for NHS England's perinatal mental health community services development fund (between 2015/16 and 2020/21) (NHS England, 2016). As a result of this investment, the Welsh Government received additional funding as a 'Barnett Consequential' for spending in Wales and policy frameworks on perinatal mental health and new services to support women and families affected by these conditions resulted.

The Welsh Government's Together for Mental Health Delivery Plan (2019-2022) also prioritised the need to ensure that all children have the best possible start in life which is enabled by giving parents/carers the support they need (Welsh Government, 2016a). In June 2016, the Minister for Health and Social Services announced that the Welsh Government was investing £1.5 million per year to improve community specialist perinatal mental health services across Wales (BBC 2016; Welsh Government, 2016b); each health board was asked to submit a collaborative and

multidisciplinary proposal for a specialist perinatal mental health service and a Community of Practice and the All Wales Perinatal Mental Health Steering Groups were established.

In 2017, the National Assembly's Children, Young People and Education Committee launched an inquiry into perinatal mental health in Wales, as part of their work on the First 1,000 Days and the association between poor parental mental health and the impact on children's health and development. The inquiry focused on the Welsh Government's approach to perinatal mental health, patterns of inpatient care, level of specialist provision, clinical pathways, integration of perinatal mental health, bonding and attachment and health inequalities.

This inquiry has been a key driver for change in Wales, as it evidenced developments in perinatal provision and set out **27 key recommendations for improving perinatal mental health.**

In 2019, the National Clinical Lead for Perinatal Mental Health was appointed and further work to develop a Wales Clinical Network undertaken, with the network being instrumental in driving forward progress in Wales. These national developments have continued to recognise the prevalence and impact of perinatal mental health problems on women and their families across Wales.

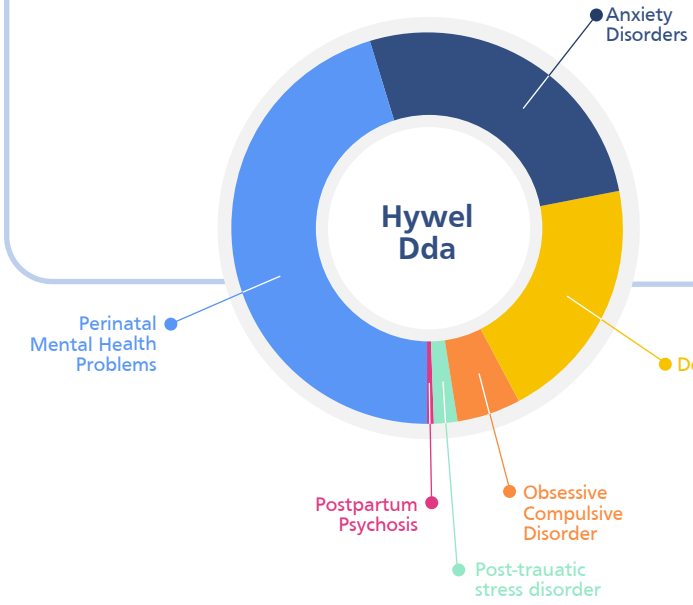
In 2013, the Maternal Mental Health Alliance launched the Everyone's Business campaign with the aim of tackling stigma surrounding maternal mental health issues and highlighting the unequal provision of specialist mental health services for women and their families across the UK. The campaign produced visually powerful maps to highlight gaps in specialist provision across the UK, which have demonstrated progress in specialist provision. In 2015, the mapping exercise by the Everyone's Business campaign revealed that specialist perinatal mental health services were unequally distributed and further maps released in 2019, noted some improvement but still a way to go to ensure all have access to the support and services that they need **(Maps | Maternal Mental Health Alliance).**

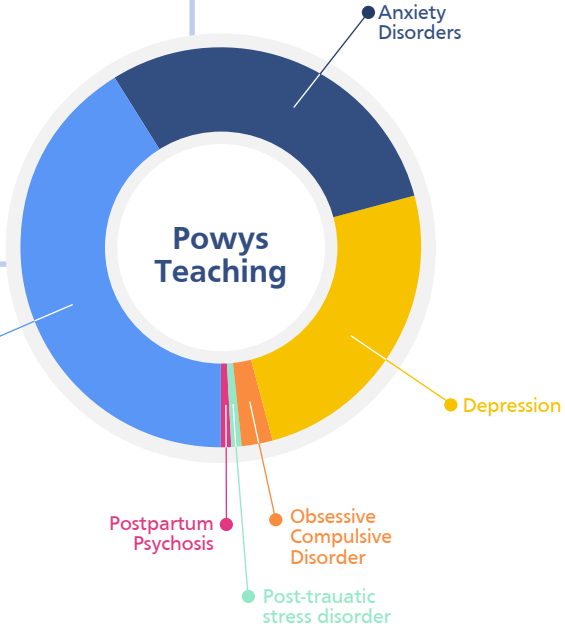
Prevalence – demand for service/demand for service by type/ disorder

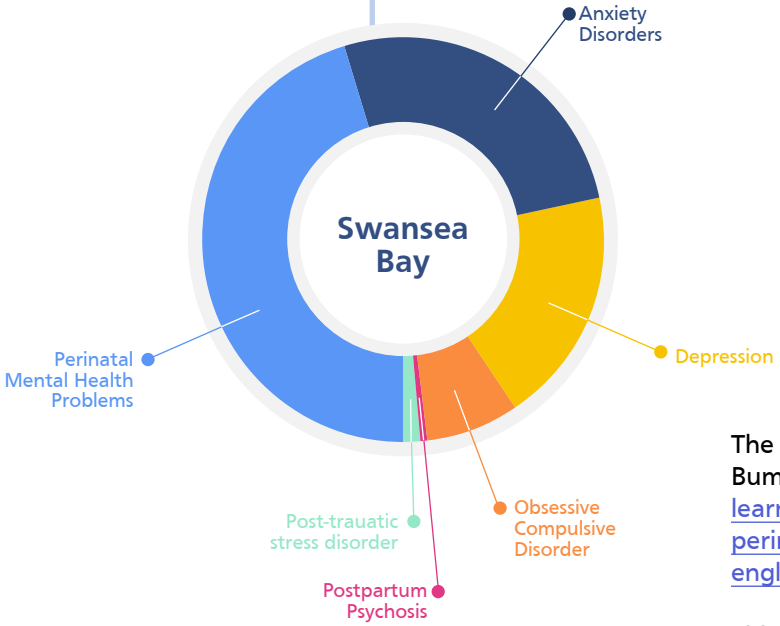
The following graphs* show estimated prevalence figures for each health board in Wales.

*All graphs out of 2000

*All graphs out of 2000







The prevalence rates use figures quoted in the 'From Bumps to Babies report (Jun 2018)'. https://learning.nspcc.org.uk/media/1049/from-bumps-to-babies-perinatal-mental-health-care-in-wales-full-report-english.pdf

This is the source of the prevalence rates cited in the Bumps to Babies report: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6457164/

Using the prevalence rates quoted, we have calculated the estimated prevalence for each Health Board in Wales, based upon 2019 live births. Live birth stats here: https://gov.wales/maternity-and-birth-statistics-2019

What the evidence tells us

During pregnancy and the year after birth, women can be affected by a number of mental health problems, from depression and anxiety; to obsessive compulsive disorder (OCD); post-traumatic distress disorder (PTSD); eating disorders and postpartum psychosis. These conditions can be mild to extremely severe (Bauer et al., 2014).

Perinatal mental difficulties are one of the most common complications that a woman can experience when having a baby (Bick & Howard, 2010), with recent UK research suggesting that one in four are affected (Howard et al., 2018). Some experiencing perinatal mental health problems for the first time in relation to pregnancy or childbirth, and others may have a pre-existing mental health condition which persists, deteriorates or reoccurs during pregnancy or after the birth of a baby.

If perinatal mental health difficulties go untreated they can have long-term implications for the well-being of women, their babies and families (Jones et al., 2014), with a number of risk factors making it more likely that an woman will experience perinatal mental health problems, including a perinatal or family history of mental illness, socio-economic factors and social adversity (Ayers & Delicate, 2016; Howard et al., 2014b; Stewart et al., 2003).

Depression and Anxiety

Depression and anxiety are the most common mental health difficulties experienced in the perinatal period (Howard et al., 2014b; O'Hara & Wisner, 2013). Depression and anxiety in pregnancy also represent two of the strongest risk factors for experiencing postpartum depression (Heron et al., 2004; Milgrom et al., 2008). A recent systematic review has also indicated that perinatal anxiety is highly prevalent in the postpartum period, with anxiety disorders affecting 10 per cent of women (Dennis et al., 2017).

Obsessive Compulsive Disorder (OCD)

The perinatal period represents a time of increased vulnerability for women to experience OCD (Forrayet al., 2010). OCD is a severe anxiety disorder, characterised by intrusive or inappropriate thoughts, obsessions and compulsions (Lord et al., 2011). Comprehensive research into perinatal OCD has traditionally been a neglected area of study until recent years (Forray et al., 2010; Uguz and Ayhan, 2011).

Prevalence rates of OCD during the perinatal period have been reported to vary in range (Lord et al., 2011; Sharma & Sommerdyk, 2015), but it is thought to affect around 1 in 100 women in pregnancy, and 2-3 in every 100 women postnatally (Royal College of Psychiatrists, 2015). A recent UK study found a rate of 2 per cent for perinatal OCD (Howard et al., 2018).

Post-traumatic Stress Disorder (PTSD)

Research suggests that the onset of PTSD can occur for the first time, reoccur or worsen during the perinatal period (Howard et al., 2014b). PTSD can present in pregnancy due to traumatic events such as accidents, interpersonal violence or natural disasters (Anniverno et al., 2013), and it can develop after having a baby, as a result of a difficult or traumatic birth (Ayers & Ford, 2012; Yildiz et al., 2017).

Postpartum Psychosis

The perinatal period is also associated with an increased risk of severe mental illness (Jones et al., 2014). Postpartum psychosis is the most severe type of mental illness which occurs suddenly after childbirth, often in the first few postpartum days (Heron, 2007). Typical symptoms include (but are not limited to) delusions and hallucinations, mood changes (both elation and depression), bizarre or disorganised behaviour, confusion, disorientation and insomnia (Jones & Smith, 2009; Monzon et al., 2014).

Although postpartum psychosis is less common than other perinatal mental heath conditions, it still affects between 1 and 2 women in 1000 maternities (Meltzer-Brody et al., 2018; Harlow et al., 2007; Munk-Olsen et al., 2006; Valdimarsdottir et al., 2009). Postpartum psychosis should always be considered a medical emergency because of its rapid onset, the severe symptoms experienced, and the potential for catastrophic consequences for women and their babies (Ayers & Delicate, 2016; Jones & Smith, 2009).

Specialist Perinatal Mental Health Inpatient Care

These disorders may require immediate intervention and in some cases inpatient psychiatric treatment (Meltzer-Brody et al., 2018), ideally within a specialist inpatient unit with their babies. These units provide specialist inpatient psychiatric care for women and their babies up to one year after childbirth (Gillham & Wittkowski, 2015).

They are designed and resourced to offer specialist treatment to women with mental health difficulties, while also supporting them to meet the physical and emotional needs of their infants and to develop healthy relationships (Joint Commissioning Panel for Mental Health, 2012).

Impact on Partners

Research has shown that partners and other family members play a critically important role in supporting women affected by perinatal mental health difficulties. Partner support has been found to protect against perinatal mental health difficulties (Lancaster et al., 2010; Pilkington et al., 2015), help them recover when they are affected (Pilkington et al., 2015), and buffer the effects of these conditions on babies and other children (Chang et al, 2007).

While partners and other family members are important sources of support, research suggests that partners and other family members may also experience perinatal mental health difficulties. This includes depression, anxiety, PTSD and OCD. Research from NCT (2015) suggests that more than one in three (38 per cent) new fathers in the UK have concerns about their mental health.

Impact on Infants and Children

Substantial evidence suggests that if perinatal mental health difficulties are not identified, treated and managed effectively, they can have adverse impacts upon infant development and child outcomes (Sweeney and MacBeth, 2016; Webb, Ayers & Rosen, 2018). Some studies have demonstrated that mothers' mental health can impact upon babies before they are born, with perinatal mental illnesses increasing the risk of early delivery and smaller size/lower weight at birth. These in turn are risk factors for impaired cognitive and social developmental outcomes in babies (Männistö, et al., 2016; Talge et al., 2007; Satyanarayana & Sirinivasan, 2011).

A growing body of evidence has also suggested that perinatal mental health difficulties adversely impact upon the interactions and care between mums and babies, which can increase the risk of children experiencing behavioural, social or cognitive difficulties (Bauer et al., 2014; Center on Developing Child, 2009; Galloway & Hogg 2016; Howard et al., 2014a; Oates, 2006; Royal College of Midwives, 2014; Stein et al., 2014; Sutter-Dally et al., 2011).

The parent-infant relationship is one of the most significant environmental factors influencing early brain development. For example, the babies of depressed mothers show atypical frontal brain activity, such as reduced joy, interest and anger (Dawson et al., 1999). If an emotional environment causes a child to feel unsafe or fearful, this will be reflected in how the brain develops to deal with stress in later life (Berens and Nelson, 2019).

In contrast, children who experience strong and secure relationships will be better able to experience, regulate and express emotions in a way that enables them to learn and participate in society in a more productive way. Learning to manage emotions and behaviour is a key developmental task in early infancy. (Parental Emotional Wellbeing and Infant Development, The royal collage of midwives, 2020)

To optimise their emotional and social development, infants need to develop a secure positive attachment to a primary caregiver during the first year of their life (Galloway & Hogg, 2015). This early attachment sets the template for later relationships and can influence physical, social, emotional and cognitive outcomes (Galloway & Hogg, 2015).

However, research shows that the symptoms that women can experience as a result of perinatal mental health conditions can make sensitive and responsive parenting difficult and can undermine a parent's ability to develop healthy and attuned relationships with their babies (Hogg, 2013). If not identified, treated and managed effectively, mental health conditions during pregnancy and the first years of a child's life can affect maternal bonding, leaving infants at risk of developing insecure attachments and experiencing poor long-term outcomes (Bauer et al., 2014; Galloway & Hogg 2015; Howard et al., 2014a; Oates, 2006; Stein et al., 2014; Sutter-Dally et al., 2011).

Further information on the evidence and case for change can be found here: https://learning.nspcc.org.uk/media/1049/from-bumps-to-babies-perinatal-mental-health-care-in-wales-full-report-english.pdf

Financial Evidence

Mental health difficulties are estimated to cost £8.1 billion per year's births in the UK, which equates to £10,000 per birth (based on 2012 birth data) with nearly three quarters (72%) of these relate to adverse impacts upon the child rather than the mother.

More than a fifth of the total costs (£1.7 billion) are borne by the public sector, with most of these falling on the NHS and social services (£1.2 billion).

The average cost to society of one case of perinatal depression is around £74,000 of which £23,000 relates to the mother and £51,000 to impacts on the child and the average costs per case; of perinatal psychosis is at least £52,000; however this is likely to be greatly underestimated due to the lack of data on the long term outcomes for the child.

Improved services would provide significant quality benefits and contribute to the longer term economic and societal benefits for

Reviews and Recommendations – Policy Guidance

The need for a review of and further development of perinatal mental health services across Wales was initially recognised in 2016, following the publication of the **Children, Young People's and Education recommendations (CYPE, 2017),** and the **Bumps to babies: perinatal mental health care in Wales Report (Witcombe-Hayes et al, 2018).**

In 2018, The All Wales Perinatal Mental Health Steering Group (AWPNMHSG), working together with colleagues from Public Health Wales, developed the **Guidance for the Delivery of Integrated Perinatal Mental Health Services in Wales (PHW July 2018).**

There was recognition that this work needed to be developed further, with pathways that reflected the most up-to-date evidence of the prediction, detection and treatment of the perinatal mental health of women and their families, to include, where appropriate, parent-infant work in the pre-conception, antenatal and post-natal period. Clarity of the expectations at each level, to ensure that the right care was being provided, at the right time by the right people with the right skills, knowledge, support and supervision, was also needed.

Healthier Wales / **Social Service and Wellbeing Act (Wales)** / **Well-being of Future Generations Act (2015)**

Updated NICE Clinical Guideline **(CG 192)** was published in December 2014 and should be used in conjunction with the guidance on service user experience in adult mental health **(CG 136)** and patient experience in adult NHS services **(CG 138)** to support the improvement in experience of women with mental health difficulties during pregnancy and the postnatal period. **In 2014, the Maternal Mental Health Alliance launched a campaign "Everyone's Business" with the aim of improving the lives of all women throughout the UK who experience perinatal mental health problems by 2020.**

This campaign identified that:

- Accountability for perinatal mental health care should be: directed nationally from ministerial level down.
- There should be Community specialist perinatal mental health teams, which meet national quality standards available in all areas of the country.
- All professional staff involved in the care of women and their families during the perinatal period access and receives training in perinatal mental health.

What do we need?
Wales PNMH Vision

Our vision for perinatal mental health in Wales is:

for Wales to lead the way in delivering high quality perinatal mental health care to women and their families.

Our priority areas include

1. **Supporting** all women and their families affected by perinatal mental health difficulties.
2. **Greater knowledge and training** for practitioners working within the perinatal period to promote prevention and early identification
3. Equitable access to **specialist services & inpatient provision** for all.
4. Delivering services that meet **excellent standards**

Commissioning and Service Delivery

The Royal College of Psychiatrists set out the general principles and core standards for specialist community perinatal mental health (CR197) This identifies the need for a strategy which sets out how local services will be delivered and how those services will work together to ensure that the most appropriate care can be accessed depending upon need. NICE guidelines also recommend that there are clearly specified care pathways so that healthcare professionals involved in the care of women during pregnancy and the postnatal period know how to access assessment and treatment link.

Practitioners within all services working with women and their families in the perinatal period should also be able to recognise, support and refer to appropriate services.

Our vision is that all women and their families across Wales who experience mental health difficulties during pregnancy or the postnatal period **have access to the right care at the right time and by the right people; and that the right people have the right skills, knowledge, support and supervision.**

How we developed the Programme

The network team facilitated opportunities for all working with women and their families to come together. The aim of the workshops were to:

Understand where we were at across Wales

Give all the opportunity to share what was working well, and what could be improved

Gather thoughts on what would make, and what we would need to do, to have high quality perinatal services across Wales.

We were also able to **engage** and **connect** with women who had used, or were using services, to understand and learn from their experiences.

The 4 'P's'

The information that was shared was collated, reviewed and themed into **four key objectives**, our '4P's' -

Partnerships
Strengthen collaborative working across services, health boards and across Wales.

Pathways
Strengthen seamless service delivery and providing care at the right time and by the right people.

Performance
Strengthen the quality of the services we deliver, and provide the best possible experience for all.

People
Strengthen our workforce, ensuring all have the right skills, knowledge, supervision and support.

What are the aims of the Programme?

To work in collaboration with service users and practitioners at all levels and in all service areas to promote excellent perinatal mental health services and identify opportunities for continued service improvement

To provide services that are able to match care to individual need - the right support at the right time by the right people

To provide high quality perinatal mental health services across all areas of Wales - including assessment, support, care and treatment – for women and their families who have been identified as having mental health difficulties and who are planning a pregnancy, pregnant and have given birth and have a baby under one year old.

To provide consultancy, advice, support, training and educational resources, based on best practice and evidence, to all who provide care to women and their families experiencing such difficulties.

Guiding Principles

Our service development and provision is underpinned by the following principles -

- **Collaboration -** strengthening mutual respect, understanding of roles and breaking down barriers across all service areas so that we are able to take a whole system approach to service delivery

- **Ensuring that mental health care is delivered in a person-centred, compassionate and supportive way -** 'matching' care to individual needs in a way that empowers women to build on their strengths, promotes recovery, supports their families and supporters and ensures equality and fairness for all

- **Getting the basics right and using every point of contact and communication as a chance to develop respectful, empowering and trusting relationships -** women need reliable, honest and dependable communication and interactions

- **Trauma Informed -** psychological trauma has been defined as "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional or spiritual wellbeing" (SAMHSA, 2012).
  Anyone can be affected by psychological trauma at any time in their life. During pregnancy and the perinatal period, women may revisit past experiences of trauma. These experiences can generate a range of responses and women benefit from staff understanding and being attuned to these. Some disclose previous abuse or trauma for the first time in maternity services (Menschner, C., & Maul, A. (2016) and Rogers, J. (2015).

Parents-to-be often reflect on their own childhood experiences and consider how they themselves were parented, this may be particularly challenging for some. The physical nature of pregnancy and birth itself may be a cause of worry or anxiety with some feeling a loss of control as their body changes and some aspects of childbirth can cause triggers or flashbacks to past trauma. Pregnancy and childbirth can also trigger a relapse of pre-existing mental health difficulties or symptoms related to past trauma.

Trauma-informed care aims to promote feelings of psychological safety, choice, and control. Every contact with a woman and her partner matters. It is important that practitioners put them at the centre of their care – this can be done by ensuring all women feel seen, heard and cared for.

With this in mind, compassion, recognition, communication, collaboration, consistency, continuity and an acknowledgement that everyone is unique is at the very heart of perinatal mental health service development across Wales.

References

Menschner, C., & Maul, A. (2016). Issue Brief: Key ingredients for successful trauma-informed care Implementation. Hamilton, NJ: Center for Health Strategies, Inc. 12 Montgomery, E., Pope, C., & Rogers, J. (2015). A feminist narrative study of the maternity care experiences of women who were sexually abused in childhood. Midwifery, 31, 54–60.
Substance Abuse and Mental Health Services Administration Trauma and Justice Strategic Initiative (SAMSHA). (2012). SAMHSA's working definition of trauma and guidance for trauma-informed approach. Rockville, MD.: Substance Abuse and Mental Health Services Administration.

- **Supporting the Parent - Infant Relationship -** Relationships influence a child's ability to manage their emotions and impulses and develop a much better understanding of themselves and others. With their experiences of positive relationships become their template, supporting them in building self-confidence and self-esteem, which in turn strengthens their relationships throughout life (Parent Infant Foundation, 2020).

- **Quality Improvement -** we will strive to take a quality improvement approach to ensure we are continually developing services that are safe, effective and provide a positive experience of care and improved outcomes for all.

Welsh Language (Wales) Measure 2011

The Welsh Language (Wales) Measure was passed by the National Assembly for Wales and given royal assent in February 2011.

The Welsh Language (Wales) Measure 2011 makes Welsh an official language in Wales and this means it must be treated no less favourably than English. More information on the Welsh Language (Wales) Measure 2011 can be found here.

As well as being a national language of Wales, the Perinatal Mental Health Programme recognises the importance of providing and developing bilingual provisions for service users if it is their choice or need, especially when this is associated with their mental health.

The programme also recognises that we all need to play a role in the ownership of the language as set out in Welsh Governments strategies such as **Cymraeg 2050; Strategic Framework for Welsh Language Services in Health, Social Services and Social Care: "More Than Just Words"** and the **Health and Care Standards.**

The recommendations from these key documents have been taking into account and will be reflected within any work undertaken by the network. In addition to the above, colleagues may also find the following useful - **The Welsh Language Standards (No. 7) Regulations 2018**

Note: some standards may not be applicable or may have specific exemptions within separate NHS organisations and Trusts.

More Than Just Words 2019-2020 Action Plan – As of July 2021 this action plan was still applicable where the objectives applied. It is likely that this will be updated in the near future.

Legislation and Guidance

The Mental Health (Wales) Measure 2010

The Mental Health (Wales) Measure 2010 is a law made by the National Assembly for Wales which helps people with mental health problems in four different ways:

Local Primary Mental Health Support Services

Making sure that more services are available from GP's and within Primary Care services. These services may include counselling, stress and anxiety management – Part 1

Care Coordination, Care and Treatment Planning

Women receiving more specialised care and support, will be overseen by a Care Coordinator with the care and treatment plan being reviewed at least once a year – Part 2

Assessment of women who have used specialist mental health services

The Measure allows easier access back into secondary mental health services for those who have been previously discharged – Part 3

Independent Mental Health Advocacy

This Part of the Measure ensures all inpatients in Wales who are receiving assessment or treatment for a mental disorder are entitled to request support from an Independent Mental Health Advocate – Part 4

Pathways

Pathway One

Pre-Conceptual Care
Specialist Team

If the woman is planning a pregnancy and has a history of complex or severe mental health problems we can support her to navigate the pathways and open the door to parenthood.

Ask. Assess. Act

Match the care to the need
Right Care. Right Time. Right People

If she is planning a pregnancy and need additional support, a **referral** can be made to a **Specialist Perinatal Mental Health professional**

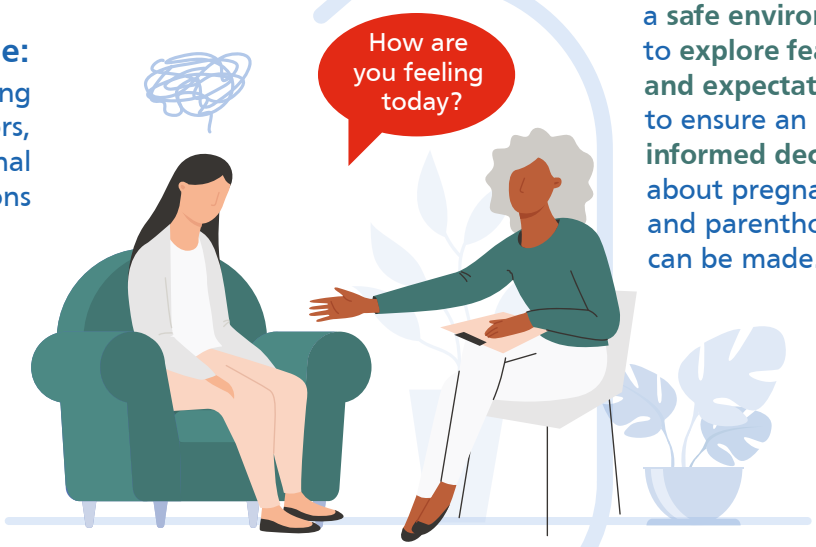
We will ensure a **family approach** and involve supportive partners, family members and others where possible and appropriate.

The review should include:

Comprehensive history including formulation, risks, protective factors, support network, intergenerational issues and wellbeing recommendations

Consideration of prescription options and medication doses during pregnancy and risk of relapse discussion

Discussion around the **risks and benefits of taking medication** during pregnancy and advice on breast feeding



We will provide a **safe environment** to **explore fears and expectations** to ensure an **informed decision** about pregnancy and parenthood can be made.

Support with the completion of a **'Having a Family' plan** which could include monitoring mental state, medication, psychological interventions, birth planning and working in partnership with maternity and health visiting.

If they go on to become pregnant, a **referral to the Specialist Perinatal Mental Health Team** will need to be offered.

Pathway Two

Pre-Conceptual Care
GP

Consultation with a woman with mild-moderate mental health difficulties and of child-bearing age.

Ask the woman about plans for **conception**

If the woman is planning to conceive, arrange an appropriate length consultation for a full assessment of her physical and mental health. Discuss, with **sensitivity:**

- How pregnancy and childbirth could affect her mental health difficulties.
- How her mental health difficulty and/or treatment might affect her or the baby, before and after birth.
- The risks of not treating her condition and the importance of controlling symptoms before conception.

Support her in making an **informed decision** about **family planning.**

With sensitivity, and starting with open questions, assess current mental health.

If indicated from her history, undertake mental state examination, including assessment of risk to self or others.

If **any risks** are identified, refer on to the appropriate agencies.

Enquire about mental health history; include any diagnoses, any previous inpatient treatment, the nature of any previous treatment, including **medication** and **psychological treatments.**

Enquire **sensitively** about any drug or alcohol misuse.

Enquire about social situation and **support network.**

If there is **no active mental health condition, and no history of a severe mental health condition,** advise that she is welcome to make contact if she feels that she is developing low mood/lack of enjoyment/worrying.

Make sure to ask about these at each contact.

If there are symptoms of a **mild to moderate mental health condition, and no history of a severe mental health condition,** discuss treatment options including psychological interventions and psychotropic medication.

For women already prescribed psychotropic medication who are planning a pregnancy, discuss continuing their current treatment, switching to a regime with a lower risk of adverse effects, or stopping treatment (avoid abrupt discontinuation of medication).[1]

Discuss thoughts about future breastfeeding, including benefits of breastfeeding, risks of medication when breastfeeding[2], and risks of stopping any medication to breastfeed. There is evidence that breastfeeding reduces the risk of postnatal depression.

Support the woman's choice.

If a woman has a **current or historic severe mental health condition,** or is on antipsychotics, mood stabilisers or is currently under secondary mental health follow up, ensure a referral to the specialist perinatal mental health services has been offered.

Advise the woman to continue effective contraception until a full assessment by a perinatal psychiatrist has been undertaken.

Advise the woman not to stop taking her medication unless otherwise directed by the perinatal psychiatrist.

Any woman with a history of previous or current mental health condition who subsequently falls pregnant **should be encouraged** to seek advice from her GP early in pregnancy.

If a pregnant woman has taken psychotropic medication with known teratogenic risk at any time in the first trimester, follow the below guidance provided by NICE:

- Confirm the pregnancy as soon as possible.
- Explain that stopping or switching the medication after pregnancy is confirmed, may not remove the risk of fetal malformations.
- Offer screening for fetal abnormalities and counselling about continuing the pregnancy.
- Explain the need for additional monitoring and the risks to the fetus if the woman continues to take the medication.
- Seek advice from a specialist if there is uncertainty about the risks associated with specific drugs.

[1] Evidence based information on fetal risk from medication is available from the UK teratology information service at www.uktis.org. Information for women about the use of medication during pregnancy is available at www.medicinesinpregnancy.org

[2] Information about the use of medication during breastfeeding is available at https://www.breastfeedingnetwork.org.uk/detailed-information/drugs-in-breastmilk/

Adapted from NICE Antenatal and Postnatal mental health: clinical management and service guidance Clinical guideline [CG192] Updated 11 February 2020

Pathway Three

Universal Midwives, Health Visitors and GP

Promotion of Mental Health & Emotional Wellbeing

ASK - How are you feeling today?

Level 1 | Level 2 | Level 3 | Level 4 | Level 5

Act – 'match' the care to the need
Right care **Right** Time **Right** People

Universal	Watchful Waiting	Active Listening	GP/PMHSS/ CMHT/CAMHS	Specialist Perinatal Mental Health Services Perinatal Mental Health Teams & Inpatient Provision

Promote and signpost to **community groups and online resources**

Bump, Baby & Beyond | Tommy's Parenting - My Pregnancy & Post-Birth Wellbeing Plan. Give it time. | GOV.WALES

Continue to re-assess by - **Asking, Assessing** and **Acting** at each contact

Pathway Four

Watchful Waiting

Ask. Assess. Act

Match the care to the need
Right Care. Right Time. Right People

ASK - How are you feeling today?

Assess – offer further screening using the EPDS and/or GAD-7, professional judgement and discussion with the woman

Level 1	Level 2	Level 3	Level 4	Level 5
Universal	Watchful Waiting	Active Listening	GP/PMHSS/ CMHT/ CAMHs	Specialist Perinatal Mental Health Services Perinatal Mental Health Teams & Inpatient Provision

Act – 'match' the care to the need
Right care **Right** Time **Right** People

Arrange to contact the woman in **two weeks**

GIG CYMRU NHS WALES
Rhwydwaith Iechyd Meddwl Amenedigol
Perinatal Mental Health Network

#OpeningDoorsToParenthood
PNMHnetwork@wales.nhs.wales

Promote and signpost to **community groups and on-line resources**

Bump, Baby & Beyond | Tommy's Parenting - My Pregnancy & Post-Birth Wellbeing Plan. Give it time. | GOV.WALES

ASK - How are you feeling today?

Level 1

Asses - offer further screening using the EPDS and/or GAD-7, professional judgement and discussion with the woman.

Level 1	Level 2	Level 3	Level 4	Level 5

Act - 'match' the care to the need
Right Care **Right** Time **Right** People

Universal	Watchful Waiting	Active Listening	GP/PMHSS/ CMHT/ CAMHs	Specialist Perinatal Mental Health Services Perinatal Mental Health Teams & Inpatient Provision

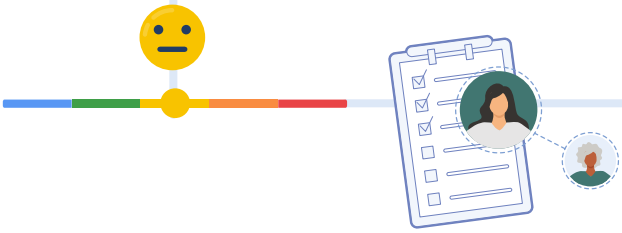
Refer to **Pathway 5** for further guidance

Continue to re-asses by **Asking, Assessing and Acting** at each contact

Pathway Five

Emotional Wellbeing Visits

ASK - How are you feeling today?



Assess - offer further screening using the EPDS and/or GAD-7, professional judgement and discussion with the woman

Level 1 | Level 2 | Level 3 | Level 4 | Level 5

Act – 'match' the care to the need
Right Care **Right** Time **Right** People

Universal | Watchful Waiting | Active Listening | GP/PMHSS CMHT/ CAMHs | Specialist Perinatal Mental Health Services Perinatal Mental Health Teams & Inpatient Provision

If the woman is experiencing **stress** or finding it **difficult to manage** or has any other symptoms indicative of psychological distress

Consider offering up to **6 emotional wellbeing visits**

Offer **weekly assessments** to **monitor progress** (level of distress, level of emotional wellbeing, sense of achievement)

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Rhwydwaith Iechyd Meddwl Amenedigol
Perinatal Mental Health Network

#OpeningDoorsToParenthood
PNMHnetwork@wales.nhs.wales

If at any time there are any **significant changes** in mental state or emergence of new symptoms, new thoughts or acts of self-harm, new and persistent expressions of maternal incompetency or rejection of the foetus or baby.

Ask Assess Act

Consider the need for a referral to GP and/or specialist perinatal mental health team

After each contact review progress - Ask Assess Act re-assess using EPDS and / or GAD7 after the 3rd contact or before as required

Improvement in mental state

Discuss and offer further contacts, **up to a maximum of 6 of required**

End of 6 contacts review – Ask Assess Act re-assess using EPDS and/ or GAD7

Improvement in mental state

Signpost to **community support and groups**

Refer to **Pathway 3** for further guidance

No improvement in mental state

Consider need for a referral to **GP and/or specialist perinatal mental health team. The safety of the baby and any other children is paramount and her/his needs must be assessed immediately prior to a referral to any perinatal mental health team/services.**

No improvement in mental state

Consider the need for a referral to **GP and/or specialist perinatal mental health team**

Pathway Six

Referral to GP/Primary Care/Primary Mental Health Support Services/ Community/Adolescent Mental Health Team

ASK - How are you feeling today?

Assess - offer further screening using the EPDS and/or GAD-7, professional judgement and discussion with the woman

Level 1 | Level 2 | Level 3 | Level 4 | Level 5

Act – 'match' the care to the need
Right Care **Right** Time **Right** People

Universal | Watchful Waiting | Active Listening | GP/PMHSS/ CMHT/CAMHS | Specialist Perinatal Mental Health Services Perinatal Mental Health Teams & Inpatient Provision

Needs assessed by GP

1. **Make time;** consider offering a double appointment. 10 minutes is unlikely to be long enough to assess the woman and provide support. Offer a separate appointment from the 6–8-week neonatal check.

2. **Acknowledge and reassure;** **acknowledge** that the antenatal, perinatal, and postnatal periods can be very difficult mentally as well as physically. **Reassure** the woman that this does not make them a bad parent.

3. **Use open questions;** Consider using open questions that allow the woman to speak freely.

4. **Assess mental health thoroughly;** Take a thorough mental health history, perform a mental state examination including assessment of risk to self (including self-neglect, as well as suicide), and risk to others (remember safeguarding at this point. Think "can this parent parent this child at this time?").

   a. The Edinburgh Postnatal Depression Scale, PHQ-9, and GAD-7 scales may be helpful if a diagnosis of depression or anxiety is suspected.

5. **Ask about feelings towards the unborn baby or baby, and observe interaction if the infant is present.**

6. **Establish a diagnosis;** Try to establish whether there is a clear mental health diagnosis, and the severity of the diagnosis. NICE guideline CG192 recommends interventions for depression, and anxiety disorders, amongst other mental health problems that may arise.

7. **Agree a management plan.**
    a. If there is evidence of a current or historic severe mental health disorder, or a history of suicide attempts or self-harm, refer the woman to specialist perinatal mental health services. The safety of the baby is paramount and his/her needs must be assessed immediately prior to a referral to any perinatal mental health team/services.
    b. **Postnatal psychosis is an emergency; this requires specialist assessment and treatment within 4 hours.**
    c. If the woman is feeling estranged, hostile, or irritable, towards her unborn or new baby, refer to specialist perinatal mental health services.
    d. If evidence of mild to moderate mental health disorder, with reference to NICE CG132, and as appropriate, consider:
        i. **Facilitated self-help**
        ii. Referral for high intensity psychological intervention e.g. CBT
        iii. Medication[1,2]
            1. If starting in pregnancy and the postnatal period, consider seeking specialist advice.
            2. Refer to NICE CG192 1.1.12 for prescribing principles.
            3. Discuss breastfeeding, including benefits of breastfeeding, risks of medication when breastfeeding, and risks of stopping any medication to breastfeed. There is evidence that breastfeeding reduces the risk of postnatal depression. Support the woman's choice.
        iv. Drug / alcohol service referral.
        v. Crisis team if concern about suicide risk.
        vi. Safeguarding referrals as needed. The safeguarding of the baby must be priority.
    e. Be aware of local sources of social support, such as parent and baby groups.

8. **Schedule follow-up;** Plan for follow-up and ongoing support. Agree a date and time to see the woman again. If the woman does not attend as planned, contact them.

9. **Provide a safety net;** make a clear plan for who the woman should contact if her mental health is deteriorating, including contact numbers, and consideration for out-of-hours.

10. **Ensure complete documentation, and timely communication with other healthcare professionals (e.g. MW and HV) involved in the woman's care.**

Local Contact Information incase of this event

[1] If a pregnant woman has taken psychotropic medication with known teratogenic risk at any time in the first trimester, follow the below guidance provided by NICE:

- **Confirm the pregnancy as soon as possible.**
- **Explain that stopping or switching the medication after pregnancy is confirmed may not remove the risk of fetal malformations.**
- **Offer referrals for screening for fetal abnormalities and counselling about continuing the pregnancy.**
- **Explain the need for additional monitoring and the risks to the fetus if the woman continues to take the medication.**
- **Seek advice from a specialist if there is uncertainty about the risks associated with specific drugs.**

[2] Evidence based information on fetal risk from medication is available from the UK teratology information service at www.uktis.org

Information for women about the use of medication during pregnancy is available www.medicinesinpregnancy.org

[3] Information about the use of medication during breastfeeding is available at https://www.breastfeedingnetwork.org.uk/detailed-information/drugs-in-breastmilk/

Pathway Seven

Specialist Perinatal Mental Health Team Assessment

ASK- How are you feeling today?

Assess - offer further screening using the EPDS and/or GAD-7, professional judgement and discussion with the woman. If a referral to the Specialist Team is required, please offer additional screening using the PHQ-9

Level 1 | Level 2 | Level 3 | Level 4 | Level 5

Act – 'match' the care to the need
Right Care **Right** Time **Right** People

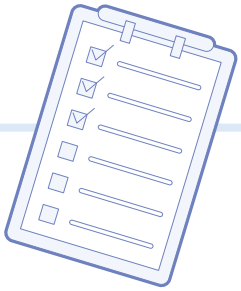
Universal | Watchful Waiting | Active Listening | GP/PMHSS/ CMHT/ CAMHs | Specialist Perinatal Mental Health Services Perinatal Mental Health Teams & Inpatient Provision

Need for **specialist perinatal mental health assessment?** The safety of the baby and any other children is paramount and his/her needs must be assessed immediately prior to a referral to any perinatal mental health team/services.

Discuss referral with specialist perinatal mental health team

Referral **accepted**

Pathway Seven



Referral form **completed** by referrer

Referral form **emailed/hard copy sent and received**

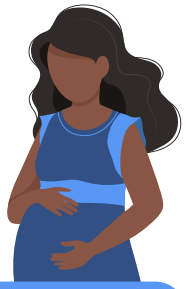
Referral form assessed by specialist perinatal mental health team and allocated to practitioner for assessment

Contact made with the woman referred and assessment arrangements agreed

Triage assessment undertaken. **Plan of care** discussed and agreed with all involved in providing care for the woman.

If appropriate, a **Perinatal Mental Health Birth Plan** meeting with the woman and community or specialist midwife will be held **between 28-32 weeks**

Letter **confirming plan** sent to the woman. Copy of triage assessment sent to referrer, GP and any practitioner involved



Significant indication of risk noted

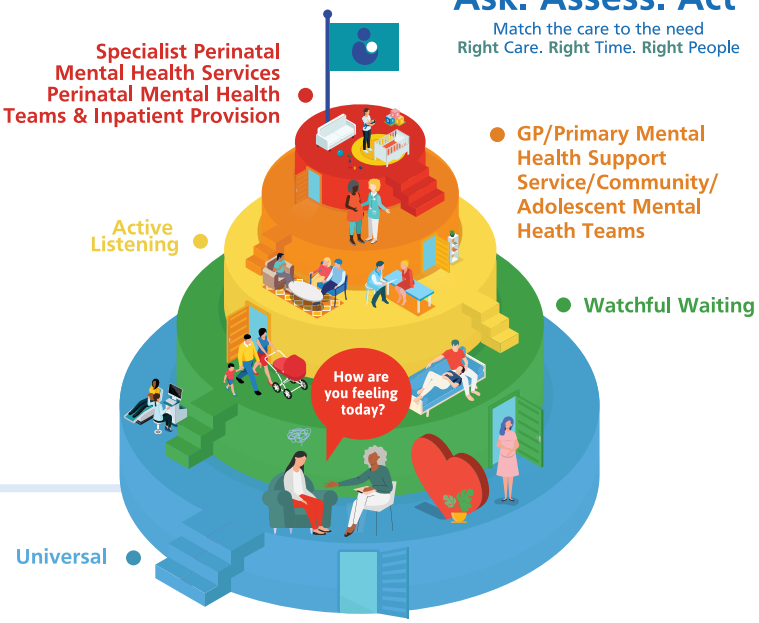
Copy of the **triage/birth plan** sent to the safeguarding midwife

Pathway Eight

Emergency Assessment

Ask. Assess. Act

Match the care to the need
Right Care. Right Time. Right People



ASK - How are you feeling today?

Assess - offer further screening using the EPDS and/or GAD-7, professional judgement and discussion with the woman. If a referral to the Specialist Team is required, please offer additional screening using the PHQ-9.

Level 1 | Level 2 | Level 3 | Level 4 | Level 5

Act – 'match' the care to the need
Right Care **Right** Time **Right** People

Universal | Watchful Waiting | Active Listening | GP/PMHSS CMHT/ CAMHs | Specialist Perinatal Mental Health Services Perinatal Mental Health Teams & Inpatient Provision

Community

Hospital or Midwifery Led Unit

Face-to-face

Not face-to-face

Remain with the woman. Update Care Co-ordinator if known

Remain with the **woman, confirm support**

Confirm support / whereabouts

Hospital or MLU

Contact liaison Psychiatry / Crisis Resolution Home Treatment Team (CRHT) Out of hours on call Psychiatry

Community

Contact GP and Sp PMHT / CMHT / CAMHs /Crisis Team, Resolution home treatment team (CRHTT)

Out of hours /weekend

Contact out of hours GP service - Refer to A&E or / if at immediate risk, call 999

If known to SP PMHT Team / CMHT / CAMHS. Inform of concerns

Update named Community Midwife / Health Visitor

Pathway Nine

Inpatient Admission

All health care professionals - e.g. midwives, health visitors and GP's to monitor mental health and to be aware of **RED FLAG SIGNS:**

Observe for:

- Sudden changes in mental state/emergence of new symptoms
- Expressions of wanting to harm self/baby or suicidal thoughts

Maternity Inpatient setting

Community setting

Emergency mental health assessment required within 4 hours:

In normal working hours: Liaise with Specialist Perinatal Mental Health Team, Liaison Service, Crisis Team (CRHT) or Care Co-ordinator in CMHT/CAMHs (if woman known to team)

OR

Out of hours: Liaison service

Emergency mental health assessment required within 4 hours:

In normal working hours: Liaise with GP, Specialist Perinatal Mental Health Team, Liaison Service, Crisis Team (CRHT) or Care Co-ordinator in CMHT/CAMHs (if woman known to team)

OR

Out of hours: On Call GP service or Liaison service via A & E

The safety of the baby and any other children is paramount and her/his needs must be assessed immediately prior to a referral to any perinatal mental health team/services.

Emergency Assessment Completed and inpatient admission required.

Contact made with Uned Gobaith colleagues and multi-disciplinary discussion completed. If no beds available within Wales, access Web beds to locate other available beds across England and liaise with WHSCC for funding.

Referral accepted, paperwork completed and admission arrangements agreed

Women with a moderate to severe mental illness who are currently stable may require a prophylatic admission. Contact to be made with colleagues at Uned Gobaith and a multi-disciplinary discussion completed

If no available beds/woman declines or other contraindication to Specialist Perinatal Mental Health inpatient admission consider:

- Referral to Crisis Resolution and Home Treatment Team (CRHTT)
- Admission to adult psychiatric unit

All women requiring admission to Specialist Perinatal Mental Health Inpatient Unit in late pregnancy or the postpartum period should be admitted together with their babies unless there are specific reasons not to.

Where beds are unavailable the woman should be transferred to a Specialist Perinatal Inpatient Unit at the earliest opportunity.

Psychological Support & Interventions

Ask - How are you feeling today?

Assess - offer further screening using the EPDS and/or GAD-7, professional judgement and discussion with the woman

Level 1	Level 2	Level 3	Level 4	Level 5
Universal	Watchful Waiting	Active Listening	GP/PMHSS/ CMHT/CAMHs	Specialist Perinatal Mental Health Services Perinatal Mental Health Teams & Inpatient Provision

Act – 'match' the care to the need
Right Care **Right** Time **Right** People

Level 1
Signposting (to community support and online resources)

- The Pregnancy and Post-Birth Wellbeing Plan
- Bump, Baby and Beyond
- Parent, Baby & Toddler Groups
- Third Sector & Voluntary Services

Links to local groups and services:

Level 2 - Watchful Waiting – (Further contact within 2 weeks)

- Consider signposting (to community support and online resources as outlined in Level 1)
- Signposting and supporting access to appropriate services- housing, Citizen's Advice Bureau, counselling, drug and alcohol services
- Online resources - Living Life to to Full (Enjoy Your Bump, Baby and Infant)
- Silver Cloud
- Reading Well

Level 3 - Emotional Health & Wellbeing Contacts (Active Listening Visits)

- Consider signposting (to community support and online resources as outlined in Levels 1 & 2)
- Local family support services
- Signposting to Stress Control, MIND Active Monitoring and/or ACTIVATE Your Life or equivalent
- Written information – Self Help Guides

Level 4 - GP/ Primary Care/ Local Primary Mental Health Support Services/ Community /Adolescent Mental Health Team

- Consider signposting (to community support and online resources as outlined in Levels 1,2 & 3)
- Written information – Self Help Guides
- Third Sector & Voluntary Services
- Referral to Local Primary Mental Health Support Services, Community/Adolescent Mental Health Team or Psychology Therapies Services

Level 5

Specialist Perinatal Mental Health Services Perinatal Mental Health Teams & Inpatient Provision

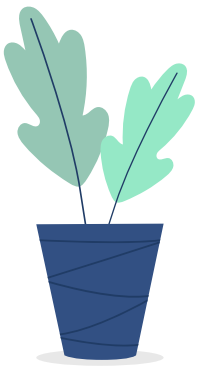
- Any services included within levels 1 – 4 should also be considered
- Parent/Infant relationships services
- Individual psychological therapy tailored to need
- Collaboration between the Specialist Community Perinatal Mental Health team and other services for example - Community Resolution Home Treatment Team, Community Mental Health Team, Community Adolescent Mental Health Team, Adult Learning Disability Team, Eating Disorder and Substance Misuse Services

NB - this list is by no means exhaustive and collaboration between services will need to reflect individual needs.

The therapies outlined below may be offered at both **levels 4 and 5**

The evidence base for psychological approaches within the perinatal-specific mental health context is less robust than other populations. Interventions at these levels will be informed by a comprehensive clinical assessment with the woman and supported by appropriate outcome measures and information from other professionals if required.

- Cognitive Behaviour Therapy (CBT)
- Compassion Focussed Therapy (CFT)
- Acceptance and Commitment Therapy (ACT)
- Dialectical Behaviour Therapy (DBT)
- Eye Movement, Desensitisation and Reprocessing (EMDR)
- Video Interactive Guidance (VIG)
- Interpersonal Therpay (IPT)
- Parent-Infant Psychotherapy
- Systemic Family Therapy
- Mindfulness Based Cognitive Therapy (MBCT)
- Mentalization Based Therapy (MBT)



Wales PNMH Network

Wales Perinatal Mental Health Network

The Wales Perinatal Mental Health Network is a national clinical network which brings together colleagues from all service areas and agencies working with women and their families who are planning a pregnancy, pregnant or have given birth to identify health service needs and to implement strategies to improve quality of care and outcomes for all.

Plans for the Network

Our aim is to work together to further develop and improve access to high quality support and care for women, their babies and their families, whether it be normal emotional transition to pregnancy and parenthood, mental health difficulties or admission to specialist perinatal mental health inpatient provision.

We would like to ensure that all who need support and care are able to access and receive it, wherever they live in Wales.

Visions for the Network

Our vision is for Wales to lead the way in delivering high quality perinatal mental health care to women and their families.

Fitting into the bigger picture

The NHS Wales Mental Health Network was established to support NHS Wales in the implementation of its national plan to improve the experiences and outcomes for all with mental health difficulties living in Wales.

The work completed in this network being guided and overseen by the NHS Wales All-Ages Mental Health Network Board and the National Programme Director for Mental Health. As part of the Network, four sub groups have been identified, one of which is the Perinatal Mental Health Network Board.

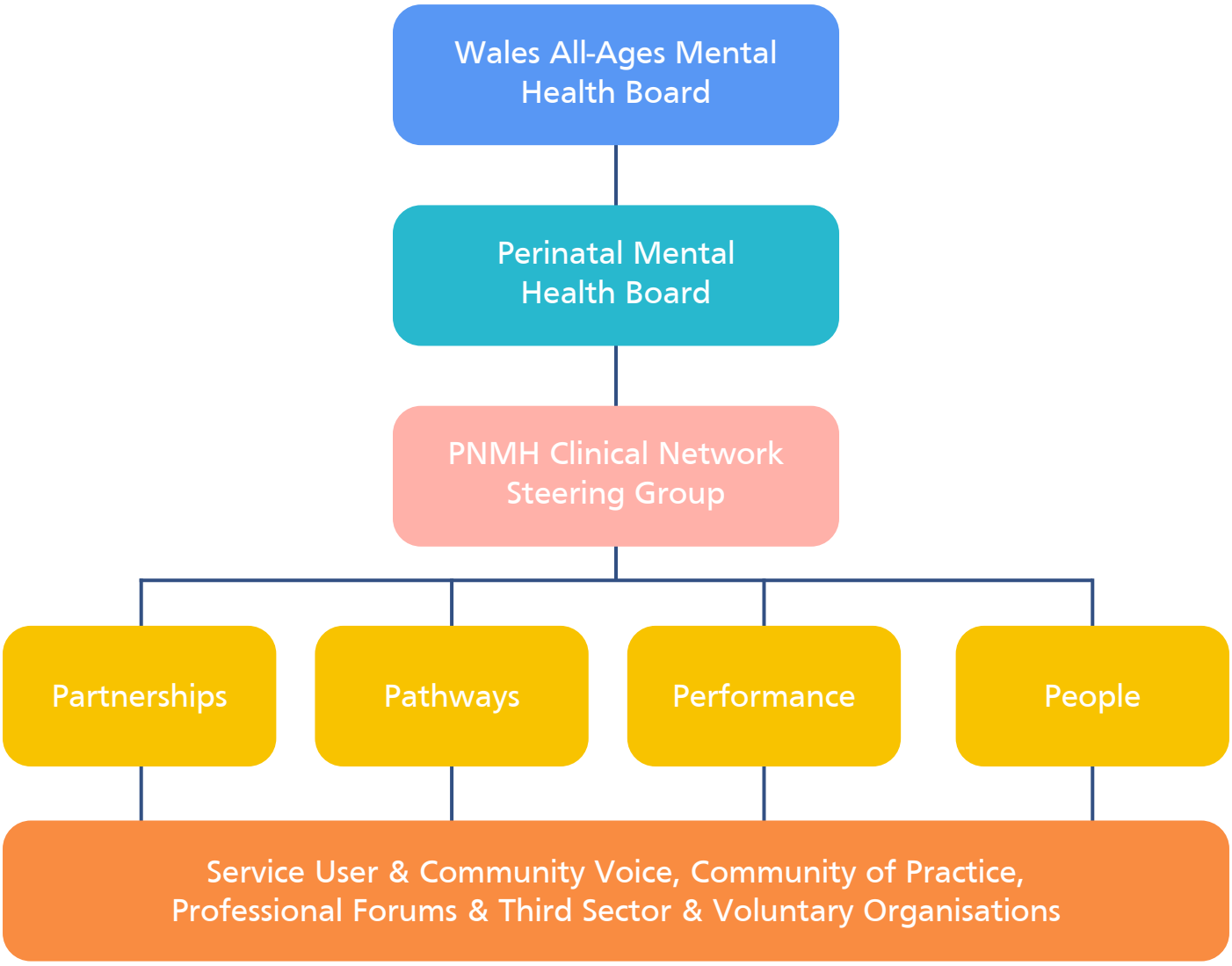
Who we report to

In order to make sure that we are doing what we say we will do and that we are going in the right direction, our governance arrangements now reflect how the PNMH Network fits into the ‘bigger picture’ across Wales.

It also recognises that all service development is shaped by those that use the services; for those that use and will need support and care from services in the future.

The importance of working together with our third sector and voluntary organisations is also key and reflected within our structure.

Perinatal Mental Health (PNMH) Governance and Reporting Structure



NHS Wales Collaborative

The NHS Wales Collaborative was established to work on behalf of NHS Wales, and in support of Welsh Government. Through collaboration, engagement, facilitation and empowerment, teams employed within the collaborative are working to improve NHS Wales's services across organisational boundaries, and improve the quality of care for women in Wales.

Working on behalf of the chief executives and chairs from the health boards, the work undertaken supports the shaping and planning of the future of NHS services across Wales. The Perinatal Mental Health Network is one of many teams employed within the collaborative whose role is to meet requests from health boards and Welsh Government.

Engagement

We recognise that service user involvement is about making sure that mental health services, organisations and policies are led and shaped by the people best placed to know what works: those who use mental health services. They are experts by experience.

Meaningful involvement of people who use - or have used - services is being recognised as an essential part of mental health service delivery. With this in mind, we have worked closely with our third sector and voluntary organisation colleagues to identify service users from across the entire pathway.

We have also identified, engaged and connected with clinicians and colleagues providing care and support to women and their partners and families during the perinatal period.

What we did

Between January and March 2019 we brought practitioners, third sector and voluntary organisations, working to provide services and support for those identified as needing additional mental health support during the perinatal period. The aim of the workshops was to:

- Understand where we were at across Wales
- Give all the opportunity to share what was working well, and what could be improved
- Gather thoughts on what would make, and what we would need to do, to have quality perinatal services across Wales.

We also met with those who had used, or were using services, to ascertain their hopes, dreams and wishes.

This information was collated, reviewed and themed into four key objectives, the '4P's'

Partnerships – strengthen collaborative working, across services, health boards and across Wales.

Pathways – strengthen seamless service delivery providing care at the right time and by the right people.

Performance – strengthen the quality of the services we deliver, and provide the best possible experience for all.

People – strengthen our workforce, ensuring all have the right skills, knowledge, supervision and support

What we did next

The '4P's', Children, Young People and Education Report (2017), Bumps to Babies recommendations (2018) and latest evidence provided the network with the steer and direction for future service development across the network.

Perinatal Mental Health Action Plan 2021-2022.

Wales Perinatal Mental Health Network Contact

National Clinical Lead
Sharon Fernandez
sharon.fernandez@wales.nhs.uk

PNMH Network
PNMHnetwork@wales.nhs.uk

Wales Perinatal Mental Health Programme

Introduction

The Children's, Young People's Education Committee review into Perinatal Mental Health Services in October 2017 made several recommendations, one of which was that Welsh Government establish and provide national funding for a clinician-led network.

The idea being that this network, should provide:

- Quality Standards
- National leadership, coordination and expertise for the further development of perinatal mental health services
- Care Pathways
- Workforce & Training
- Professional Competencies
- Training Resources

Our 4 P's

1. Partnerships

Strengthen collaborative working, across services, health boards and across Wales.

2. Pathways

Strengthen seamless service delivery and providing care at the right time and by the right people.

3. Performance

Strengthen the quality of the services we deliver, and provide the best possible experience for all.

4. People

Strengthen our workforce, ensuring all have the right skills, knowledge, supervision and support.

Section 1 - Partnerships

The recommendations suggested that the network should maintain the multi-disciplinary approach displayed by the already established Community of Practice to encourage and develop effective joint working and communication among all relevant professionals.

With this in mind, work was undertaken to develop a –

- Perinatal Mental Health Board
- National Clinical Steering Group
- Professional Forums
- Third Sector & Voluntary Organisation Group
- Health Board Steering Groups
- Community of Practice

Section 2 - Pathways

Why Pathways

The need for Fully Integrated Care Pathways (WFICP) in Wales was initially recognised in 2016, following the publication of the Children, Young People's and Education recommendations (CYPE, 2017), and the Bumps to babies: perinatal mental health care in Wales Report (Witcombe-Hayes et al, 2018). In 2018, The All Wales Perinatal Mental Health Steering Group (AWPNMHSG), working together with colleagues from Public Health Wales, developed the Guidance for the Delivery of Integrated Perinatal Mental Health Services in Wales (PHW July 2018).

There was recognition that this work needed to be developed further, with pathways that reflected the most up-to-date evidence of the prediction, detection and treatment of the perinatal mental health of women and their families. This should include, where appropriate, parent-infant work in the pre-conception, antenatal and post-natal period. Clarity was also needed regarding the expectations at each level, to ensure that the right care was being provided, at the right time by the right people with the right skills, knowledge, support and supervision.

Your Responsibility to Ask, Assess and Act

The aim of the network and the pathway is to reduce stigma, discrimination and barriers that women who are planning a pregnancy, pregnant or who have given birth and have a baby under one year old with mental health difficulties may feel; this may prevent them from admitting and seeking support.

All practitioners working with women and their families will be encouraged to take a universal approach, and all asked - **'How are you feeling today?'**

This question has been shaped following consultation with service users.

Service users also shared that they would like to be asked - 'How are you feeling today?' **more than once** during the conversation you have with them.

''If I had been asked 'how are you feeling today' rather than 'how are you feeling', I would have felt that I could have said, rather than saying that 'I was fine. By asking me more than once, this would make me feel like they care and they really wanted to know how I felt."

- Service user feedback

Step 1

Ask all women:
'How are you feeling today'

(Using the Whooley and GAD-2 and questions below to shape your conversation)

Depression Identification Questions (Whooley)	Outcome:
During the past month, have you often been bothered by feeling down, depressed or hopeless?	☐ Yes ☐ No
During the past month, have you often been bothered by little interest or pleasure in doing things?	☐ Yes ☐ No

Generalised Anxiety Disorder Scale (GAD-2)		Outcome:
During the past month, have you been feeling nervous, anxious or on edge?	'Not at all' 'Several Days' 'More than half the days' 'Nearly every day'	0 1 2 3
During the past month have you not been able to stop or control worrying?	'Not at all' 'Several Days' 'More than half the days' 'Nearly every day'	0 1 2 3

Step 2

Assess all positive responses
'by offering further screening'

Screening Tools	Yes	No
EPDS		
GAD-7		
PHQ-9 as required		

Step 3

Act now by
'signposting, supporting, referring and/or accessing specialist advice and guidance'

Levels of Need	Level 1	Level 2	Level 3	Level 4	Level 5
Outcome	Universal	Enhanced	Enhanced +	Intensive	Intensive +
GAD-7	0 Nil	0-5 Nil-Mild	6-10 Mild	11-15 Moderate	16-21 Severe
EPDS	0-9	10-12	13-15	16-19	20+
Recommended Action	Signpost to community/ online support	Review and signpost to community/ online support	Active listening and signpost to community/ online support	GP/primary care/ LPMHSS and/or CAMHS/ CMHT	Specialist PNMH Team/ admission to specialist inpatient unit

Supporting Parent-Infant Relationships

Now, more than ever before, practitioners and services understand that parental mental health may affect the social and emotional development of an unborn baby and child.

Relationships influence a child's ability to manage their emotions and impulses and develop a much better understanding of themselves and others. With their experiences of positive relationships become their template, supporting them in building self-confidence and self-esteem, which in turn strengthens their relationships throughout life (Parent Infant Foundation, 2020)

We are aware that supporting parent infant relationship is crucial, especially during the perinatal period. A child's experiences of relationships at this time, is fundamental to how they develop, within the early years and throughout their whole life.

Practitioners working in services within the perinatal period play an important role in supporting parental mental health and the parent-infant relationship, recognising when additional support maybe needed.

'Understanding infant mental health is the key to preventing and treating mental health problems of very young children and their families' (Zero to Three, 2020)

Parents need to be supported in getting to know their unborn and new baby's emotional needs and recognise their baby's cues at this critical time of development. Babies will thrive when predictable and consistent parenting is provided and need a parent to be able to keep them in mind – to think about how they may be feeling, what they may be thinking, what they would like and what they may need.

Pathway Focus and Scope

The need to focus on prevention, early identification, signposting, supporting and safeguarding was apparent, as was the recognition of a common language. With this in mind, the Welsh Levels of Care have been adopted, and adapted throughout the pathways (Fig 1).

Supporting Parent-Infant Relationships

Level of need, tiers of care and service provision

	Levels of Care for Wales Perinatal Mental Health Services			GIG CYMRU NHS WALES
Universal	**Level 1**	Tier Foundation Universal	Signpost	Signpost to universal, online self-help resources and community groups and services
Enhanced	**Level 2**		Watchful Waiting	Potential for concern and additional need identified, two week review suggested
	Level 3		Listening	Additional listening support to be offered and signpost/ refer to community groups/ services and online resources and support
	Level 4	Tier One Primary	Psychological Support and/ or medication	Referral to General Practitioner (GP) / Primary Care (PC)/ Flying Start (FS), Families First (FF), Parent and Infant Mental Health Service (PIMHS), Community Psychology. Guidance, consultation and/or referral to Specialist Perinatal Mental Health (PNMH) Team/ Community Mental Health Team CMHT or Community Adolescent Mental Health Service (CAMHs) to be considered
Intensive	**Level 5**	Tier Two Secondary	Specialist Perinatal Mental Health Services	Referral for Specialist PNMH assessment and support and possible joint assessment with specialist parent-infant team
		Tier Three Tertiary		Inpatient Provision

This pathway incorporates and is built upon the best evidence and has been shaped together with women and their families, health professionals working in the perinatal period, and third sector professionals involved in delivering perinatal mental health services in Wales.

We however recognise that there will always be new and emerging evidence and this together with feedback from women and their families or other who support them will be used, to continually improve and develop this pathway framework and improve experiences.

This document uses the term perinatal mental health problems, conditions, difficulties or illnesses to describe the range of mental health conditions that can be experienced by women during pregnancy or in the year after birth (called the perinatal period). This includes depression, anxiety, eating disorders, obsessive compulsive disorder (OCD), post traumatic stress disorder (PTSD) and psychotic disorders, such as postpartum psychosis.

Reference is also made throughout the document to women and their families – the aim being to encompass all women, men, partners and supporters who may be planning a pregnancy, pregnant or care for a baby in the perinatal period.

Care Pathway Overview, Definition and Aims

Overview

This document provides an overview and summary of the research and recommendations for change; the pathways are underpinned by a matched care, needs-led model which specifies the anticipated steps of care from universal, primary, secondary and through to tertiary care. Five themes are highlighted within;

- Co-ordination of service
- The competencies of a multidisciplinary team
- Promotion, prediction and detection
- Effective communication
- Appropriate use of medication

The pathways will provide guidance to all health and social care professionals who come into contact with women and their families in the antenatal and postnatal period, across all settings. In the interests of effective information sharing and communication, it is important that all referrals and communication between health care professionals are timely to ensure a co-ordinated consistent approach to the care of the unique needs of the individual. All professionals should also be aware of their local operational guidance.

Definition

The development of the fully integrated care pathways was led by the Wales Perinatal Mental Health Network, supported by a wide ranging stakeholder multidisciplinary working group for perinatal mental health; and was reviewed to reflect and incorporate the latest guidance, evidence and policy direction across Wales.

Aim

To support the provision of effective multidisciplinary and agency to services for the prediction, detection and treatment of mental ill health through the pre-conception, antenatal and post-natal periods for all in Wales.

- To adopt a universal approach to asking all women and their families 'How are you feeling today?'; recognising the stigma associated by some women and their families experiencing a mental health difficulty as being a significant barrier to accessing and receiving support.
- To ensure that women and their families, are enabled and empowered to make informed choices about care, support and treatment received; and are informed of all options available to them.
- To offer the right support at the right time in a non-stigmatising manner.

Matching Care to Need

Becoming pregnant and having a baby is a huge life-changing event. It can be overwhelming at times and there is no 'normal' way to feel. Some may feel happy, sad, tired or excited and it is common to experience many different feelings. It is also common to feel depressed, anxious or traumatized after the loss of a baby.

Support offered during pregnancy and the post-natal period, will reflect a 'matched care approach', in that all can be signposted to resources to support themselves, with the majority of women with mental health difficulties, being supported within primary care, including those with mild to moderate depression, anxiety, adjustment disorders and other conditions. They may not require medication and may respond to psychological and/or social intervention.

Those with more significant illness, may require medication only or medication with the addition of psychological and social interventions.
For this group their care and treatment may continue to be provided within primary care; and if required the family's midwife (MW), general practitioner (GP), health visitor (HV), nursery nurse (NN)/or equivalent and, colleagues within primary care (PC) and primary mental health support services (PMHSS) can access advice and guidance from the specialist midwife and/ or specialist perinatal mental health team, particularly with regard to prescribing medication.

Care Pathway Overview, Definition and Aims

There are, however, two specific groups of women who will require care and treatment to be provided by specialist community perinatal mental health services:

- Those with a history of a significant mental ill health that may also co-occur with an eating disorders and substance misuse, who are considered to be at risk of relapse or recurrence of their illness associated with pregnancy and the post-natal period

- Those who become acutely unwell during pregnancy or in the intrapartum or post-natal period. If there is a high level of concern or if there is evidence of a rapid deterioration in mental health, particularly in the first two weeks after childbirth, the woman requires URGENT assessment by mental health services.

Preconception counselling forms a significant part of care for these women, including advice on medication and risk of relapse.

This group requires their care to be provided by a consultant psychiatrist, working jointly with substance misuse services or community mental health/community adolescent mental health team, if appropriate. They are responsible for ensuring that individual personal care plans are in place. Where safeguarding risks are identified appropriate consideration, assessment and referral must be made.

Care Pathway Interconnections and Interdependencies

Professional groups, including midwives, GPs and primary care colleagues, health visitors, obstetricians, consultant psychiatrists, clinical psychology, allied health professionals (AHP), hospital and community mental health teams across Health Board settings and third sector and voluntary organisations in Wales, will be involved with the implementation of these pathways.

The roles and responsibilities of key professionals is outlined below, and is intended to support staff in these roles.

The importance of self-referral, peer-referral and referrals from third, voluntary sector and social services is also acknowledged. Third sector and voluntary organisations play a vital role in being a point of contact and advocate for anyone who may have concerns around accessing support and care during the perinatal period.

Identification of need - Non-urgent and Urgent

In urgent situations, where it is felt that immediate intervention or admission to specialist inpatient care may be required, contact should be made with the GP or Out of Hours GP. They must then liaise with local mental health services.

In addition, in very urgent situations, contact can be made with the Health Board's mental health home treatment/ crisis response team directly, to ensure the appropriate handover of information and allow for further assessment and management of immediate risk.

In situations where it is felt that there may be a risk to self or others, consideration must be given to the level of supervision required for both the woman and baby and the requirement for a children's services referral. Details of family support, childcare arrangements and family support response times, should be reviewed and considered as part of the care plan completed within pregnancy. Contact details for each Health Board's teams should be accessible, and all staff aware of how they can be accessed.

If significant concerns are present these concerns should be discussed with the GP, and or/ further guidance and support offered from CMHT/ CAMHT or specialist perinatal mental health team colleagues.

To ensure clarity of understanding and consistency in decision making the following definitions have been provided:

Emergency/Urgent	Non-Urgent
An emergency is an unexpected, time-critical situation that may threaten the life, long-term health or safety of an individual or others and requires an immediate response. An urgent situation is serious, and an individual may require timely advice, attention or treatment, but it is not immediately life-threatening.	A non-urgent situation is routine care, and an individual may require timely advice, attention or treatment within the time frame set out by CCQI standards, but there is no immediate life-threatening risk to themselves or others.

Pre-conceptual Care

The importance of preconception care in providing education, in the detection of potential problems and in preventing a deterioration for those with previous mental health difficulties cannot be over emphasised.

The pathway for pre-conceptual care can be separated into two areas – the general population of childbearing age and those who need to be specifically targeted due to increased risk factors.

General Population

Improved education is required for women and their families to raise awareness of perinatal mental health difficulties and its potential effects on their own lives and those of their partners and children.

For the general population, this can be achieved through the availability of leaflets, posters, website and app links in health, social care and other areas. These might include GP surgeries, hospital services (maternity, mental health), family planning clinics, schools and colleges, libraries etc. In order that this can take place there will be a need for improved education and awareness for practitioners and others who will come into contact with the public in this context.

Targeted Population

There are a number of women within the general population who are at increased risk of developing perinatal mental difficulties, this may be because they have a pre-existing or previous severe mental health condition, because of their previous obstetric or perinatal history or other risk factors, which may include:

- Drugs and alcohol misuse
- Care leavers
- Domestic violence
- Homelessness
- Previous traumatic pregnancy or birth
- Previous stillbirth / neonatal death
- Partner history of mental illness

Additional information and support is required for women who fall into these categories. This may be in terms of written information, or face to face advice and support through existing universal or specialist services (such as midwifery, health visiting, GP surgeries, postnatal services, mental health services).

The specialist perinatal mental health team should offer a preconception service so that advice on medication, psychological and psychiatric care can be provided to those most at risk.

Preconception Service - Specialist Perinatal Mental Health Team

For any woman who is taking psychotropic medication who is planning a 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 offer ongoing support to women with mild to moderate mental illness or refer to the specialist perinatal mental health services in the case of a woman who has a history of past or present severe mental ill health or mental health issues requiring ongoing mental health services.

Antenatal Care

Early Pregnancy - When a woman discovers she is pregnant she will need to make contact with the maternity service either through self-referral or GP referral. However, confirmation of a pregnancy may also be shared with colleagues from other services too. This may be acute, community or liaison psychiatry services, health visiting or gynaecology. Professionals working in these areas therefore need to have some knowledge of how and where to signpost for maternity services and ensure that women are able to access the most appropriate mental health support at the earliest opportunity.

First (booking) appointment - At this first presentation with a midwife in a hospital or community based antenatal clinic or home, women should be asked about previous or present mental ill health. This should include details of any care provided by mental health services and enquiry into any close family with a history of perinatal mental ill health. Consideration must also be given to the needs of the partner and family members. This information will need to be clearly recorded. All other members of the primary care team should be aware of the importance of including this information in antenatal referrals too.

Where a self-referral is made, the maternity service should request further information relating to past medical, including mental health and obstetric history from the GP and any pre-conceptual care provided. At the booking appointment all will need to be ask 'How are you feeling today?' using the ''Whooley/GAD-2 questions'' at each attendance in pregnancy.

If there is a positive response to these questions, further screening using the EPDS/GAD-7 should be offered and further support matched to the unique needs of each individual, in line with the national pathways.

Mental Health and Wellbeing Assessment - At this point women will be assessed and their support 'matched' to the 10 Wales Pathways. At every contact, there will be an expectation to ask, assess and act - matching care and support to the needs of the individual.

Psychological Support - Women and their partners who, have mental health difficulties, severe enough to interfere with personal and social functioning but do not meet the diagnostic criteria for a formal diagnosis, need to be considered for brief psychological treatment and/or individual or group based social support. These services include self-help strategies, nondirective counselling, primary care based Cognitive Based Therapy (CBT), community and voluntary sector based social interventions.

Midwives, GPs and other professionals involved in the care of women and their families during pregnancy must be aware of the importance of prioritising the social and psychological needs of women and their partners in line with **NICE Guidelines;** primary mental health support services need to understand why priority must be given to these referrals.

Psychological Interventions

Psychological interventions are actions performed to bring about change in how people think, feel or behave in order to achieve greater wellbeing. A wide variety of psychological interventions exist, some of which have been extensively researched and are referred to as evidence-based psychological interventions or evidence-based therapies.

Psychological interventions are usually conducted by a Perinatal Mental Health Practitioner, Perinatal Psychologist, Assistant or Trainee Psychologist and they usually occur in confidential spaces such as clinic rooms, confidential virtual spaces (Teams or Attend Anywhere) or at the woman's home.

Psychological interventions may include:

- **Psychoeducation:** the provision of information about how the brain or mind work, how emotional states affect thoughts and behaviour and how behaviour can change the way we feel and think. This information can be provided in leaflets, in a group setting or in one-to-one conversations.
- **Symptom management and skill development:** this could take the form of face-to-face or telephone conversations to support an individual in understanding how their thoughts and behaviour might impact on their feelings and vice versa and to coach them in the use of evidence-based skills to manage their symptoms. These approaches are often brief and targeted to a specific difficulty and can last between 6 and 12 sessions, and can be delivered in a one-to-one or group format. This can take the form of "Mood Management", "Anxiety management" individual or group sessions.
- **Psychological therapy or psychotherapy:** Psychological therapies are sometimes referred to as 'talking therapies'. The aim of psychological therapy is to help women better understand their feelings in the context of their past experiences. Therapy provides a supportive, non-judgemental environment where women and their families might feel more able to talk openly about their experiences. The therapist will work together with the individual to identify changes that they want to achieve to feel a greater sense of happiness, empowerment, or perhaps to feel less affected by particular experiences. Most therapies last around 12 to 20 sessions over a five month period, whilst others are longer and may last up to a year.

In perinatal mental health psychological interventions can also include understanding the impact of physical changes during and after pregnancy on mental health, or might focus on the parent-infant relationship or the couple relationship after the birth of their child.

Psychological interventions may be offered at any point during the perinatal period based on the individual and family needs.

Pregnancy up to Birth

During pregnancy all women will be seen at regular intervals according to a schedule of appointments as determined through NICE antenatal guidelines (2008). At all appointments with maternity health professionals, all should be asked and their mental health reassessed.

At any time during pregnancy, symptoms of anxiety, depression or other may develop and lead to the need for further assessment and referral. Information should be given to all women during pregnancy about the kinds of symptoms they may encounter and what support may be available for them to access. Much of this will be provided through self-help information and websites, or through community provision.

Those with more severe mental health difficulties may need to be seen much more frequently, as an outpatient (specialist midwifery, obstetric or mental health or through joint clinics) or through home visits by a midwife or mental health nurse where appropriate.

All should have a named obstetrician and may need to be seen within a joint perinatal mental health/antenatal clinic. Referrals to other services and agencies may include health visiting, safeguarding or social care. Liaison meetings between professionals should take place as needed. It may be necessary for a woman to receive inpatient care during pregnancy, either for obstetric or mental health reasons. Consideration should be given to the most appropriate place of admission, ensuring that both physical and mental health needs are taken into account.

A prophylactic referral to a Specialist Perinatal Mental Health inpatient unit may be required during this period. Wherever a woman is hospitalised, clinicians will need to be able to have an understanding of both the obstetric and mental health needs and to work together to ensure these needs are met.

From 28 weeks of pregnancy all women who have been identified as having emotional and mental health difficulties should be contacted by a health visitor for a targeted antenatal contact. Women with severe mental health difficulties will need to have a multi-professional pre-birth perinatal mental health planning meeting.

This will include the woman and her family along with relevant professionals, depending on who is or will need to be involved in the care. During pregnancy, discussions will take place between the woman and her midwife and obstetrician about both choice and suitability of place of birth, and type of birth.

Information about potential changes to mental health and wellbeing should be provided to all women and their families during this time. Psychological support may be needed to support women who have a history of complex experiences, who have lost a baby or are fearful of birth.

Labour and Birth

As outlined above, an individual plan will be in place to reflect the mental health needs during labour and birth. Where there is an identified mental health difficulty there may be a need to make a change to medication during the delivery, or to introduce a new medication immediately post-delivery. Where necessary a mental health nurse may be required to provide support, and additional input from psychiatry and paediatrics may also be required.

Postnatal Care

Initial Postnatal Care

This will be provided by the maternity team, and initially takes place on the labour ward, birth centre or at home depending on place of birth. Women in hospital may be discharged from the room where birth took place, or they may be transferred to the postnatal ward.

Mental health screening will take place alongside assessments for the physical wellbeing of both parent and baby. Inpatient care and support by the perinatal mental health team should be provided and, if required, discharge planning should take place.

Where the woman lives outside of the community catchment area of the hospital where the birth took place, communication with local maternity services are important to ensure that discharge can be facilitated smoothly and any issues discussed. Where necessary, discharge may be delayed to ensure services are in place.

It is important that maternity services understand any local variations. Postnatal information should also be offered and include details of what the family should look for and be aware of.

Community Postnatal Care

Following discharge from hospital, women will remain under midwifery care for the first 14 days and up to 28 days following the baby's birth. Where there is an existing mental health difficulty or where a new one is suspected additional support should be offered.

Consideration needs to be given to providing continuity of care through a named midwife, particularly where there is mental health or other concerns. Home visits may be required rather than those within a clinic setting depending on individual need.

Notification of birth to the GP and Health Visitor

During this time notification of birth to the GP will take place, it is important that information about emotional needs are included within this and any discharge summary sent to the GP. Liaison with the health visitor at this time should also take place. The specialist perinatal mental health service will, where necessary ensure that the most appropriate practitioner is involved in on going care.

Dependent on assessment of need, women presenting with mild to moderate depression and anxiety can often be managed within primary care. The family midwife or health visitor may offer emotional health and wellbeing contacts (listening visits), or referral to the GP, where a combination of psychological, social support and medication is required.

It is also important to be mindful of the relationship between the child and the parental

couple, with referral to parent-infant mental health services being considered if appropriate. The need to undertake a safeguarding referral if risk or potential risk is identified, will also need to be considered.

Postnatal Check

It is suggested that GPs ask 'How are you feeling today?' using the Whooley/GAD-2 questions with women at the routine postnatal check and follow up as appropriate. Again, consideration also needs to be given to taking a think-family approach and ensure that partners/supporters are asked about their mental health too.

Family Emotional Wellbeing

Emotional wellbeing visits provide an offer of up to six weekly visits to allow parents to have the opportunity to develop a trusting relationship with the practitioner. Providing a consistent, structured, strengths-based approach and a safe physical and psychological space so that parents know what to expect and have control over when they choose to disclose unsettling thoughts and worrying symptoms

It also provides the practitioner with an opportunity to assess parental mental health and any deterioration or increased risk of harm, and to explore the unique symptoms and circumstances that might be causing any form of distress. Parents will be supported to address their symptoms and to undertake work to promote their emotional wellbeing.

Fathers, Partners and Supporters

The baby's father/mother's partner will often be closely involved in the care of their partner and baby during the first days and weeks. Their role in helping to identify where anxiety, depression or more serious mental health difficulties are emerging cannot be underestimated. It is important for professionals who engage with parents to take time to listen to their concerns regarding the health of their partners. At the same time, it is important to observe for signs of difficulties in the relationship of the parents or that the father/partner is suffering from anxiety or depression themselves.

Most people are aware that anxiety and depression can affect women, but men and same sex partners are also at risk too. It is recognised that a family's makeup and support network is unique to them and this pathway is inclusive of all who may be supporting a woman with mental health difficulties – fathers, same sex partners, family members and friends, or at risk themselves.

Anxiety and depression can sometimes be hard to spot in men because of the overlap between symptoms, and the general stress and exhaustion that comes with caring for a baby.

Official statistics recognise only 10% of dads suffer from postnatal depression but a study by the National Childbirth Trust (NC) in June 2015 found many 1 in 3 dads (38%) are worried about their own health and 3 in 4 dads (73%) are worried about the health of their partner (NCT, 2015)

Men may feel worried and anxious about becoming a dad or if they are going to be good enough. However, some find it hard to control their worries. Their feelings of anxiety maybe constant and affect their daily life.

Men are more likely to recognise and describe the physical symptoms of depression (such as feeling tired or losing weight) than women. Some may also experience feeling trapped, as well as feeling incredibly alone. Men may acknowledge feeling irritable or angry, rather than saying they feel low. They may feel anger and rage towards their partners, children or other family members, leaving them feeling confused and distressed; others may feel hopeless and helpless, that their lives and sense of self might never return to normal. Consideration needs to be given to whether this is a safeguarding concern and if necessary, acted upon and clearly documented.

They may describe feeling sad, moody, angry or unable to sleep or concentrate, having an overwhelming sense of disappointment, thinking they've failed in their role and let everyone down, or feel let down themselves if fatherhood/partnership doesn't meet their expectations (Beyond Blue, 2020).

Men tend to use negative coping skills too, such as drinking, taking drugs, gambling and fighting. There has also been some recently publicised incidents of Post-Traumatic Stress Disorder associated with labour and childbirth. At the time of the crisis or trauma men often feel that they have been ignored. This may leave men feeling anxious and helpless about seeing their loved one going through the ordeal of a traumatic birth and as men tend to hide their feelings, this can be repressed for a long time before emerging much later as PTSD (NCT, 2015).

Fathers, partners and supporters should also be asked 'How are you feeling today?' at all contacts. Ways in which this is undertaken must be explored and agreed at the earliest opportunity. It is also important that they are supported to understand the woman's experience of mental health difficulties, which will enable them to support, as well as being supported themselves.

10% of Dads
suffer from postnatal depression

38% of Dads
worry about their own health

73% of Dads
worry about their partners' health

Identifying Need

Step 1

Ask

'How are you feeling today?'

(Using the Whooley & GAD-2 questions below to shape your conversation)

Depression Identification Questions (Whooley)	Outcome:
During the past month, have you often been bothered by feeling down, depressed or hopeless?	☐ Yes ☐ No
During the past month, have you often been bothered by little interest or pleasure in doing things?	☐ Yes ☐ No

Generalised Anxiety Disorder Scale (GAD-2) Over the last two weeks how often have you been bothered by the following:		Outcome:
During the past month, have you been feeling nervous, anxious or on edge?	'Not at all' 'Several days' 'More than half the days' 'Nearly every day'	0 1 2 3
During the past month have you not been able to stop or control worrying?	'Not at all' 'Several days' 'More than half the days' 'Nearly every day'	0 1 2 3

A score of more than 3 would signify clinically significant anxiety symptoms

Step 2

Assess all positive responses
'by offering further screening'

Screening Tools	Yes	No
EPDS		
GAD-7		

Levels of Need	Level 1	Level 2	Level 3	Level 4	Level 5
Outcome	Universal	Enhanced	Enhanced+	Intensive	Intensive+
GAD-7	0 Nil	0-5 Nil-Mild	6-10 Mild	11-15 Moderate	16-21 Severe
EPDS	0-9	10-12	13-15	16-19	20+
Recommended Action	Signpost to community/ online support	Review and signpost to community/ online support	Active listening and signpost to community/ online support	GP/primary care/ LPMHSS and/or CAMHS/CMHT	Specialist PNMH teams/admission to specialist inpatient unit

Prediction - Personal History

This pathway aims to ensure that a universal approach is taken when asking women and their families 'How are you feeling today?'.

It is widely recognised that some women and their families experiencing mental health difficulties may feel reluctant to share this information, or access support and services due to their perceptions around the stigma, barriers and assumptions made by others.

Guilt, previous experience, fear around pregnancy, parenthood and lack of trusting relationships, may make it too difficult for women to share exactly how they are feeling. They may feel that they are the only one that feels like this and that they should not feel like this. A very common fear is that by admitting how they feel, they will risk having their baby removed from their care. Instead, they may downplay how they are feeling and decline offers of support.

A woman's personal history should not just focus on mental health either, but should encompass a holistic history, including physical health and also wider social factors that may contribute to a mental health difficulty, in a way that is non-stigmatising; including understanding method of conception, miscarriage and loss, previous difficult pregnancy experiences and experiences of bereavement.

Not all 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. Previous treatment needs to be understood and more information obtained from the GP. If previous treatment by a psychiatrist, either as an outpatient or as an inpatient has been received, there is a higher likelihood that the illness may have been a significant one. Liaison with the GP is essential to ensure correct information regarding diagnosis and severity of illness.

A woman with a history of severe mental ill health (for example, bipolar disorder) may be at risk of relapse or recurrence of their illness in the postnatal period. They should already be under the care of a mental health team for the duration of their pregnancy and the postnatal period. Where care is already being provided by Community Mental Health Team (CMHT), or Community Adolescent Mental Health Team (CAMHS) a referral to Specialist Perinatal Mental Health Team should be made, allowing the facilitation of parallel working. A care and treatment plan may be in place, but if not, the development a pre-birth plan, and working alongside CMHT and CAMHs team colleagues, to react proactively to any relapses would be advocated.

A clear pathway of care should be available to ensure all involved fully understand their roles and responsibilities. If the woman is not already under the care of a consultant psychiatrist a referral should be made, with her consent, to a perinatal psychiatrist, within the Specialist 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 children's services if there is deemed necessary.

The network is in the process of developing pathways to reflect the collaborative work that is required between the Specialist Perinatal Mental Health Team and CAMHS/ CMHT.

Prediction - Family History

The importance of taking a holistic view when exploring a woman's family history is key to understanding whether there are factors that are underlying and contributing to how they are feeling at that point in time. It also provides an opportunity to explore what support a partner/ supporter may need in order to support the woman and their own mental health.

All women should be asked about their family history by their midwife at the first antenatal booking appointment.

There may also be a number of factors that are identified as part of this holistic assessment that may need to follow a more appropriate care pathway e.g. domestic violence, substance abuse. It is the clinician's responsibility to offer appropriate screening, advice, guidance, link or refer to additional support and information as appropriate.

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 there is a family history of psychosis in the postnatal period it may be predictive for the development of mental ill health in the postnatal period (Mind, 2016).

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

Detection - How are you feeling today?

Women will be asked 'How are you feeling today?' underpinned by the Whooley and GAD-2 questions, together with clinical judgment and further discussion which may provide an opportunity to explore factors that may be contributing to a woman having mental health difficulties.

If there is a strong suspicion that a woman may be experiencing mental health difficulties, but they are answering "no" to the questions, a guided conversation may support disclosure.

If not, the questions should be asked again at all routine contacts by the midwife and by the health visitor, at all contact points outlined within the maternity antenatal care outline Healthy Child Wales Programme. The outcome of the Whooley and GAD questions, will indicate whether further screening will be offered using the GAD-7 and Edinburgh Postnatal Depression Screening (EPDS) Tools (NICE, 2020). If referral to the Specialist Perinatal Mental Health team is deemed necessary, the PHQ-9 should be offered in addition to the GAD-7 and EPDS.

Perinatal Mental Health Care Plan

The development of care plans during the perinatal period is designed to support the holistic needs of a woman with a current or past history of severe mental ill health who are pregnant.

Care and Treatment Plan (CTP)

Where a woman is already being supported by secondary mental health services and has a CTP in place, the CTP should be reviewed by these services in association with the woman and her next of kin/ partner/other family members, if appropriate. Specialist PNMH team and other relevant health/ social care professionals should also be included in the review process. Consideration must also be given to the support that partners/other family members may need too.

Where a woman has no history of mental ill health and has required an admission to a specialist inpatient unit or inpatient care, it's the responsibility of the specialist perinatal mental health team to offer care co-ordination and completion of a CTP until such time, that care is transferred to CMHT or CAMH services.

Perinatal Mental Health Birth Management Plan

The BMP care plan will be drawn up between 28 - 32 weeks of pregnancy, its focus being on the care up to, during birth and after birth. This plan will draw upon and take into consideration the risk and early warning signs from within the CTP, if the woman has one in place.

It is to be filed in the woman's handheld notes unless deemed inappropriate and will include risk of illness, management and postnatal follow-up arrangements. Regular review of the care plan will be required during the pregnancy.

In general, the care plan will specify the level of contact with mental health services (including perinatal services where available) and is designed to promote and simplify information sharing, in order to enhance the level of care provided for women with a mental health illness during this time.

The care plan is not designed to take the place of a mental health risk assessment. A standardised risk assessment tool, including childcare issues, should be completed as part of the initial mental health assessment. Any issues of concern should be addressed as part of the risk management plan and all women identified in the antenatal period should be followed up as planned.

The Perinatal Mental Health Care Plan (PNMHCP)

All women receiving care from the specialist perinatal mental health team will have a PNMHCP following their assessment. This plan will outline the care agreed with the woman – for example, interventions, referrals, next review.

All the above plans need to consider safeguarding issues and if appropriate, developed together with colleagues from children's services, with clear links and lines of communication being made and agreed between health and social services

Some women may present with newly emerging symptoms in the postnatal period. It is recognised, that at all times the safety of the new-born child will be given priority and appropriate measures taken if any concerns arise.

Each care plan also needs to take into consideration other plans that may also be in place and reflect this within their content.

The care plan is not intended to take the place of correspondence involved in the care of a woman in the perinatal period. All professionals should follow the Wales care pathways and use the standardised letters provided, to ensure effective communication is in place across all services involved in the woman's treatment and care.

Identification of concerns pre-discharge

Any woman felt to be exhibiting concerning symptoms on the postnatal wards should be discussed with mental health teams. Women already known to services should have a completed perinatal mental health care plan in their hand held notes.

This should be updated, where necessary, a prompt assessment provided and a management plan drawn up accordingly.

Identification of need from birth and beyond

Community midwives continue to provide care for women in the postnatal period, with the health visiting service taking responsibility from 10-14 days onwards.

Detection, identification of non-urgent and urgent care and support will be undertaken as previously described above – Asking 'How are you feeling today?', further screening and a needs-led level of support depending upon the outcome of the screening, professional judgement and a conversation with the woman. Refer to Detection section.

It is also recognised that third sector and voluntary organisation colleagues are also pivotal in identifying where there may be an additional mental health need; whether they are either specifically delivering perinatal mental health programmes or working with women or their partners/families or other supporters where a mental health difficulty has been identified prior to or following birth. Where this is apparent and with the permission of the woman involved, taking a collaborative approach is key to improving outcomes.

Roles and Responsibilities

Role of the Midwife

Midwives play a central role in ensuring that all women and their families are supported to maintain their mental health and wellbeing during pregnancy. They are also uniquely positioned to identify and support women with mental ill health to achieve the best possible health outcomes for themselves, their unborn/new baby and family.

Midwives work collaboratively with obstetricians, GPs, health visitors, nursery nurses (or equivalent), social workers and mental health professionals, third sector and voluntary organisations where appropriate, and may provide care in many locations such as the family home, clinics, birth centres and hospitals. Supporting mental health and wellbeing is reflected within the **Maternity Care in Wales: a five-year vision for the future (2019-2024)**, and identifies 5 principles of maternity care - family centred care, safe and effective care, continuity of carer, skilled multi-professional teams and sustainable quality services. Continuity of carer offers women and their families, midwives and obstetricians the opportunity to build trusting relationships over the pregnancy journey and into parenthood.

It is acknowledged that women often have very individualised journeys through pregnancy from straight forward, to complex, which may require specialist inputs; the principles of continuity of carer are therefore very important when identifying women who may have mental health difficulties and require additional support (WG, 2019).

Midwives have a role in identifying, signposting, supporting, referring and co-ordinating the maternity care for women with mental ill health, who may not disclose how they are feeling until they have built a trusting relationship with them. Where mental health difficulties are disclosed or identified, it is the midwife's responsibility to liaise with the woman's GP to seek out more information on her history, family history and prescribed medication as needed.

Midwives also have a unique opportunity to identify women who are at risk of, or are suffering from, perinatal mental illness, and ensuring that they and their families get the care they need at the earliest opportunity. The wider role of all midwives in improving mental health includes:

Raising awareness

Ensuring that women and their partners know about how to maintain and enhance their psychological wellbeing, the signs of emerging mental health difficulties and illness, and what do and who to contact if further support is needed.

Tackling stigma

Reducing the stigma and discrimination associated with poor mental health through being open, confident and knowledgeable in their routine care of mental as well as physical health.

Strengthening emotional wellbeing

Providing sensitive and supportive antenatal and postnatal care that increases parents' emotional wellbeing and self-efficacy, and reduces anxiety.

Building trust

Building strong trusting relationships that support women to feel confident in speaking out if they are unwell.

Identifying risk and current wellbeing

Discussing and documenting details of an woman's past and current mental health, and being sensitive to any indicators that this may be deteriorating. Midwives can use validated tools, such as the Whooley questions, GAD-2, GAD-7 and Edinburgh Postnatal Depression Scale to strengthen their skilled clinical assessment.

Specialist Perinatal Mental Health Midwives

Specialist mental health midwives are experienced midwives and local champions who lead work with maternity service commissioners and providers to ensure that women with perinatal mental illnesses and their families receive the specialist care and support they need during pregnancy and in the postnatal period.

They support their maternity team colleagues to ensure that services deliver the best possible personalised care to these women and their families to optimise their mental health (RCM, 2018)

GPs and other Primary Care Services

GPs are ideally placed to detect perinatal mental health difficulties at an early stage, including at preconception, and thus enable early intervention.

Antenatally, the GP may be the first health care professional that a woman goes to see after she discovers that she is pregnant, despite the ability to self-refer to a midwife. However, GPs may have a very limited role in the care of pregnant women, as current midwifery practice encourages women to contact the midwife directly in the case of an urgent pregnancy-related problem.

Where a woman has mental health difficulties however, the GP may already have an established relationship with her and therefore be in a unique position to provide guidance, direction and support if she is considering pregnancy. This may not be the case in all communities however and having a knowledge of the individual and family history cannot be relied upon. Regular communication between MW, GP, HV and third sector colleagues is paramount.

It is therefore important that all involved in the provision of care, support and treatment of mental health difficulties within the perinatal period recognise that the person who knows most about their experiences and needs is the woman herself.

Within primary care, practice nurses may also routinely have contact with new parents and their babies throughout the baby's first year, if they are providing immunisations. They are therefore, ideally placed to identify mental health difficulties and link with health visiting team colleagues to ensure that parents are offered additional support if needed.

Role of the Obstetrician

Obstetricians play an important role in ensuring that all women and their families with mental health difficulties/eating disorders/substance misuse achieve the best possible health outcomes for themselves and their babies in the perinatal period. Obstetricians work closely with midwives, specialist PNMH midwives, psychiatrists, psychologists and social workers for those families who may need additional mental health support.

Women who are pregnant and have a formal diagnosis of eating disorder/substance misuse and have on-going support from mental health services will need to 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 involved in the woman's care.

Role of Neonatal Nurses

Neonatal Nurses play an important role in ensuring that women and their families with mental health difficulties receive the ongoing support that they may need at this particularly stressful time. Neonatal nurses should work in collaboration with midwives, GPs, health visitors, AHPs, members of mental health teams, clinical psychology and social workers as appropriate.

They are ideally positioned to recognise and identify where additional support might be needed. Neonatal nurses are able to ask 'How are you feeling today?' underpinned by the Whooley and GAD-2 questions; supporting the woman to seek further support from her midwife, health visitor or GP if needed.

Guidance and support can also be provided by Specialist PNMH team colleagues.

Role of the Health Visitor

Health visiting teams work in partnership with women and their families to promote and deliver key public health messages. The Healthy Child Wales Programme outlines the role of health visitors and their multi-disciplinary team members in Wales, ensuring a commitment to support the health and welfare of all children.

Health visiting teams have a particular role to play in promoting the emotional wellbeing and resilience and as public health practitioners, they can make a significant contribution to the early identification and effective management of mental health difficulties in the perinatal period.

The role of the health visitor within the care pathway is to identify and support women who may have existing mental health difficulties, be at risk of developing or present with acute mental illness where there has been no history or contributing factors, after birth. In collaboration with the woman and her family, decisions will be made as to what support and care is most appropriate for them at that point in time. Multi-disciplinary team members such as nursery nurses, are also ideally placed to support both parents and parent-infant relationships.

During this period, they will assess women who are currently suffering from mental illness and liaise with their GP and other relevant health care professionals regarding appropriate interventions.

The health visiting team can provide support to women and their families through their understanding of the illness and its impact on the infant, family and society. They are also ideally placed to enable women to access information and support from community groups, third sector and voluntary organisations.

Specialist Health Visitors in Perinatal and Infant Mental Health

Specialist Health Visitors in perinatal and infant mental health are experts within their local services. They are also able to represent the service in discussions, ensuring that women with mental health difficulties during pregnancy and the postnatal period receive an effective

pathway of universal and specialist support and that appropriate care is also provided to fathers, partners but taking a whole-family approach. This role complements the vital work that specialist perinatal mental health teams can offer in identifying and supporting women with mental health difficulties.

As well as supporting the development of services to address difficulties within the care-giving relationship between parents and infants, the Specialist Health Visitors also support their health visitor colleagues to deliver the best possible personalised care to women affected by mental health difficulties and by other difficulties that can impact on the early relationship between parents and infants.

Role of Nursery Nurses

The community nursery nurse is a health care support worker who works alongside the midwife or health visitor to deliver bespoke person centred intervention, working collaboratively with professionals and women and families who have been identified as needing additional support. The support offered by the nursery nurse will be in addition to and complement the work of the midwife and health visitor.

Support offered by the nursery nurse may include interventions that promote and enhance a positive responsive relationship with parents and their baby. This may include getting to know baby, infant massage, recognising baby's cues, responsive parenting and managing crying. The nursery nurse may also support integration into the community and self-care, thus reducing feelings of isolation and normalising the challenges of parenting by encouraging and enabling women and partners to seek out peer support.

Third Sector and Voluntary Organisations

Third sector and voluntary organisations have an important part to play in the support being offered to women and their families with mental health difficulties. A number of third sector and voluntary organisations are delivering perinatal mental health support across Wales; with locally commissioned services complementing the support being undertaken by colleagues in primary, secondary and specialist perinatal mental health services and extending the support available to women and their families.

Women who experience a mental health difficulty may already be accessing services and receiving support from voluntary and third sector services prior to them becoming pregnant or having a baby. It is therefore important that these services are taken into account and all work together to ensure continuity in care and support for the woman and her family.

Community Adolescent Mental Health (CAMH) and Community Mental Health Teams (CMHT)

CAMHs and Specialist CAMHS offer access and choice to a range of psychological therapies and psychosocial interventions for young parents; adult mental health services also offer the same to those who are known to their services or who may need continued support following discharge from specialist perinatal mental health services.

Both services would be working in collaboration with the specialist perinatal mental health teams (SPNMHT), to ensure all receive timely and appropriate care to meet their needs in accordance with the expectations of the Mental Health Measure – with emergencies being seen within 48 hours and routine referrals within 28 days.

Responsibilities of the Referrer

The care and wellbeing of the woman and her family will continue to be the responsibility of the referrer, irrespective of what service referrals are being made to, until an assessment has been undertaken; this may include offering addition support themselves and/or referring to online and community support and groups.

Home Treatment Teams (HTT)/ Crisis Resolution Home Treatment Team (CRHTT)

Colleagues within HTTs and CRHTTs will work in collaboration with the Specialist Perinatal Mental Health Teams to ensure that women experiencing an acute episode of mental health distress, are provided with a rapid assessment, intensive monitoring and management of risk, or awaiting, admission to acute mental health inpatient setting. This may include women initiating or adjusting medication in the community with identified high risk of harm to self/others during this transition or awaiting and admission to inpatient provision.

CRHTTs should work collaboratively with Specialist Perinatal Mental Health Teams and CMHTs care coordinators in delivering robust plans of care to women. This should include intensive work to reduce risk of suicide and stabilise mental state, including providing out of hours contact and access to recovery centres/day hospital if available.

It is expected that CRHTT lower their usual threshold for acceptance into their service when considering women in the perinatal period. All CRHTT colleagues will be expected to attend training on perinatal red flags and recommendations from the MBRACCE reports from perinatal specialists. This will ensure that the rational for lower thresholds is understood and decision making consistent. CRHTTs may also have a role in supporting admission and discharge to/from inpatient provision).

Children's Services

Children's services play a vital role in supporting women during pregnancy and the early years, where additional input is needed ensure that an unborn/new baby receives the care that they need. Early help and child protection services also offer targeted support to address additional social or emotional support concerns. A social worker who has extra skills and experience in perinatal mental health can complement the skills within the specialist teams.

CRHTTs should have access to consultation and advice from specialist perinatal mental health service in the assessment and management of complex risk for women during the perinatal period. However, CRHTTs would not be expected to undertake interventions/ therapeutic work during crisis episodes, the focus of CHRTT's interventions should be to support rapid stabilisation of mental state and management of immediate risk.

Specialised parent-infant relationship teams

Parent-infant relationship teams provide direct therapeutic support to families experiencing severe, complex and/or enduring difficulties in their early relationships.

Made up of a multidisciplinary team, including clinical psychologist and/or a child psychotherapist with expertise in supporting early relationships, they offer consultation, guidance, advice and supervision to practitioners across the entire pathway.

Specialist Perinatal Mental Health Team

The specialist perinatal mental health team (SPNMHT), includes colleagues from psychiatry, psychology, nursing and allied health care, with specialist perinatal mental health midwives sitting either within or working closely with the SPNMHT; where appropriate, the specialist team works alongside their community mental health service (CMHT) and community and adolescent mental health service (CAMHS) colleagues. These services are actively involved in supporting pregnant women and their families with significant mental health illnesses, or where mental illness co-occurs with disorders and/or substance misuse, are deemed to be at significant risk of becoming acutely unwell in the postnatal period (RCPsych Standards of acute inpatient services for working age adults, 2019)

The team liaise closely with a woman's GP, maternity, health visiting, clinical psychology, AHPs and children's services, where necessary, to ensure the best possible outcomes for the woman, baby and family. Specialist perinatal mental health team colleagues should communicate with the GP/maternity/health visiting, clinical psychology, AHPs and children's services via letter/ email and for midwives in the Maternity Hand Held Record.

The SPNMHT can offer pre-conceptual counselling for those women who are, or have been, under the care of mental health services who are contemplating a pregnancy or who are at risk of an unplanned pregnancy.

They will also provide telephone advice and guidance to GPs, midwives, obstetric services, health visitors, AHPs, children's services, regarding the appropriateness of referrals in to the team and around psychotropic medication in pregnancy or breastfeeding. This may also include information and details of how to access third sector and voluntary organisations within their communities.

The SPNMHT Team will offer brief psychological interventions for pregnant women with symptoms of anxiety and/ or depression which impact on social functioning, but which do not meet the diagnostic criteria for a formal diagnosis, with particular consideration of those with a previous history of depression.

All SPNMHTs have clinical psychologists and psychological therapists embedded within the team, providing interventions to meet the complex psychological needs of women that the team support. Such interventions may include trauma focused therapies such as Eye Movement Desensitization and Reprocessing (EMDR), relational based therapies such as Cognitive Analytical Therapy (CAT), interventions focused on the parent infant interaction such as Video Interactive Guidance (VIG) and third wave therapies such as Dialectical Behaviour Therapy (DBT), Acceptance and Commitment Therapy (ACT), Mindfulness-Based Cognitive Therapy (MBCT).

The wider team should be trained and supervised to deliver low intensity interventions to women with less complex psychological needs and this may include brief individual and group interventions. These interventions could include Cognitive Behavioural Therapy (CBT), skill based work (informed by Dialectical Behaviour Therapy (DBT), Acceptance and Commitment Therapy (ACT), mindfulness.

If a woman is already known to CAMHS or CMHT and becomes pregnant, or is referred to the SPNMHT during pregnancy, the team should liaise closely with primary care and maternity/ health visiting/ AHPs/ children's services (where necessary).

The SPNMHT will take a lead role in drawing up a detailed perinatal mental health care plan. This plan will be agreed with the woman and family/carers and shared with all services including the GP, midwives, obstetrician,

health visitor and other professionals, e.g. a social worker, clinical psychologist and AHPs, if involved. A copy of the care plan must be kept in the Maternity Hand Held Records.

Women who develop symptoms of mental ill health should be referred to the SPNMHT for rapid assessment, particularly if the illness arises within the first two weeks following birth. A full risk assessment must be carried out and documented, including any risk to the new-born baby and other dependent children. Consideration must be given to the need for referral to safeguarding/children's services.

If a woman is acutely unwell, referral to crisis resolution home treatment services and/or admission to inpatient provision must be considered. The team will also be actively involved in supporting admission and discharge planning, and care coordination for those presenting acutely, and are not known to mental health services.

Close liaison with the next of kin, family members and carers should be maintained following any assessments and decisions regarding care settings, treatment and follow up; all professionals must be aware of their local Health Board Specialist PNMH Team Operational Guidance.

Inpatient Provision

Some women with mental health difficulties during pregnancy, or after the birth of their baby will require specialist in-patient provision. These units are designed to keep women and their babies together. Specialist staff nurture and support the mother-infant relationship on the ward at the same time as the woman has treatment for their mental illness.

Specialist units can admit women in late pregnancy and at any point until their babies are one year old. Unit colleagues work closely with specialist perinatal mental health teams, maternity services and health visitors.

Specialist staff work closely together as a team, so they can develop a clear understanding of each woman's unique experience and circumstances. They can advise about which treatments will best help recovery and specialise in treating severe mental health illness. (RCPSYCH, 2020).

As part of the recovery process they are also key in instigating care and treatment planning as part of the discharge process and providing information and referral to third and voluntary sector services for ongoing support.

When planning for discharge, consideration must be given to the needs of other children in the family as well as that of the baby.

In April 2021, an interim six-bedded specialist inpatient unit opened in Tonna, South Wales.

Women from across the whole of Wales have access to this unit, however, it is understood that those living in north Wales may still choose to attend provision in England.

Peer Support

Peer support, delivered by NHS and third sector organisations, plays a crucial role in supporting women by offering a safe and friendly environment to share their experiences. The opportunity to talk and share new learning and challenges that they may encounter, whether that is as a first time mother or as a mother with a new baby and older children.

These opportunities provide a sense of unitedness and eases the physical isolation as well as reinforcing that they are not alone. It also provides a nurturing space for problem solving amongst themselves and increases their confidence in their role as a parent, a sense of 'I'm doing okay' and a feeling of 'good enough'.

Peer support provides an invaluable support mechanism and continued support once group work has come to an end or where 1:1 support is required. Peer support workers may also be working in collaboration with colleagues when support and treatments are being provided by them.

Wales Fully Integrated Care Pathways

Pathway Scope

The Wales Fully Integrated Perinatal Mental Health Care Pathway takes account of the 'stepped care' referenced within the Welsh Mental Health Measure (WG, 2015); it is also inclusive of the NICE Clinical Guidance 136 Service User Experiences in Adult Mental Health and Improving the Experience of Care for People using NHS Mental Health Services (NICE 2007, 2011).

The pathways will facilitate a consistent national approach for all women and their families, during pregnancy and the first year after birth, regardless of where they live in Wales.

It is expected, that Health Boards will implement and embed the pathways into antenatal/intrapartum and post-natal services and provide, share and review the details of the pathways with all relevant health and social care staff that offer and/or provide services to women and their families during the perinatal period.

A multidisciplinary and multiagency approach is essential, and communication is crucial to ensure that safe and effective management, care, treatment and follow-up are in place for all identified as needing additional support during the perinatal period.

Women and their families can expect to receive culturally sensitive information, including relevant information regarding the impact of mental ill health and treatment on themselves and their unborn/new baby.

They should also expect that treatment and care will take into account their individual needs and preferences; and that they and their families and carers are able to participate in informed decisions about their care supported by evidence-based information.

Where to begin - Asking 'How are you feeling today?'

It starts with the identification of a previous history, signs, and symptoms or a positive response to a set of questions, Whooley and Generalised Anxiety Disorder-2 (GAD-2) recommended within the Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance (NICE, 2020).

Depression Identification Questions (Whooley):	
During the past month, have you often been bothered by feeling down, depressed or hopeless?	☐ Yes ☐ No
During the past month, have you often been bothered by little interest or pleasure in doing things?	☐ Yes ☐ No

2-item GAD scale (GAD-2): Over the last two weeks have you been bothered by the following:		
During the past month, have you been feeling nervous, anxious or on edge?	'Not at all' 'Several days' 'More than half the days' 'Nearly every day'	0 1 2 3
During the past month have you not been able to stop or control worrying?	'Not at all' 'Several days' 'More than half the days' 'Nearly every day'	0 1 2 3

A score of more than 3 would signify clinically significant anxiety symptoms

Next – Need for further assessment or not

- If an individual answers 'yes' to either of the Depression Identification Questions, then further screening should be offered using the EPDS.
- If an individual scores 3 or more on the GAD-2 scale, then GAD-7 scale should be used for further screening.
- If the score is less than 3 on the GAD-2 scale, but there is still professional concern, the following question should be asked: *Do you find yourself avoiding places or activities and does this cause you problems?*
- If a positive responsive is received, consideration should be given to using the GAD-7 scale.

The outcome of further screening, together with professional judgement, and a discussion with the individual will determine next steps. Further screening using **the EPDS tool and the GAD-7 scale**, together with professional judgement, and a conversation with the individual will then determine, the right care to be provided, at the right time and by the right people. If a referral into the Specialist Perinatal Mental Health Team is deemed appropriate, please offer the PHQ-9. The outcome of this screening tool will be used by colleagues during the assessment process.

Matching care to need

The care pathways are intended to assist practitioners in deciding what care would be most suitable to meet the needs of the woman at that point in time and which practitioners would be most suitable to offer the support and treatment needed.

Pathway Guidance

Pathway 1	Pre-conceptual Care – Specialist PNMH Team
Pathway 2	Pre-conceptual Care – GP
Pathway 3	Universal – Promotion of Mental health and emotional Wellbeing
Pathway 4	Watchful Waiting
Pathway 5	Emotional Wellbeing Visits
Pathway 6	Referral to GP/ Primary Care
Pathway 7	Specialist PNMH Assessment
Pathway 8	Emergency Assessment
Pathway 9	Admission to Inpatient Provision
Pathway 10	Psychological Support & Interventions Under Development

How to use the care pathways

Pathway 1: Pre-conception advice from Specialist Perinatal Mental Health Team	Pathway 2: Pre-conception advice from General Practitioner

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 health difficulties. Up to 90% of women will stop taking medication for an existing mental health difficulty 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 (NHS England and NHS Improvement, 2018).

Pathway 1: Pre-conception advice from Specialist Perinatal Mental Health Team

Women with complex or severe mental health difficulties (current or past) who are planning a pregnancy should receive timely preconception advice from a specialist community perinatal mental health service before they become pregnant

Pathway 2: Pre-conception advice from Primary Care

Women with mild to moderate mental health difficulties (current or past) who are planning a pregnancy should receive timely preconception advice from a general practitioner before they become pregnant

Pathway 3: Universal Support - Signposting to online and community support

Midwives and Health Visitors have an important role in promoting and delivering key public health messages. Both services have a particular role to play in promoting emotional health, wellbeing and resilience; significantly contributing to supporting the emotional transition to parenthood, by providing information, signposting to online resources and encouraging and enabling parents to seek out community groups, support and information that is provided by third sector and voluntary organisations.

Pathway 3: Normalising 'normal' feelings throughout pregnancy and parenthood by providing information, signposting to online resources, community groups provided by third sector and voluntary organisations.

Pathway 4: Watchful Waiting

Midwives and Health Visitors also have an important role in offering further screening to enable them, together with the woman and using their professional judgement, to decide what care and support will be needed at that time. The screening outcome may indicate a need to take a 'watchful waiting' approach, and arrangements made to review how a woman feels in two weeks' time (or sooner, if needed). This will allow for a - 'bad day, or 'a bad night's sleep', for example - before further support, intervention, or treatment is offered. Enabling parents to seek out community groups, support and information that is provided by third sector and voluntary organisations can also 'normalise' feelings, worries and anxieties during this period.

Pathway 4: Watchful Waiting

If a need to take a 'watchful waiting' approach is decided, arrangements should be made to review in two weeks' time (or sooner, if needed). Enable parents to seek out community groups, support and information that is provided by third sector and voluntary organisations.

Pathway 5: Emotional Health & Wellbeing (Active Listening) Contacts

Emotional wellbeing (active listening) visits, provided by midwives and health visitors are an effective intervention to support emotional health and wellbeing for mild to moderate mental health difficulties. Nondirective counselling is concerned with supporting others to understand the situation by exploring the possible explanations for the way they are feeling, and options and strategies that might support them.

It is not offering advice or information; these visits should be planned, time limited, focused support, of up to six sessions followed by a re-assessment of the EPDS and/ or GAD-7 mid-way through and at the end of the series of contacts undertaken.

The benefits and progress made after each contact should be monitored closely. This together with the outcome of the repeated EPDS and/ or GAD-7 midway through, will determine the course of action to be taken – continue with listening visits up to 6 sessions maximum, or if further support is required, referral onwards to primary, secondary or specialist team colleagues for additional assessment and treatment.

Knowledge of the possible negative impact on infant attachment, cognitive and emotional development and family functioning necessitates that it is given high priority in health visiting practice.

These visits can be combined with education about promotion of positive mental health and mental ill health, through social support, a healthy lifestyle and awareness of other services and support, such as infant massage. Strategies that may need to be considered include:

- Promotion of self-help strategies (healthy diet, physical activity, practical help and support from family and friends);
- Promotion of non-directive counselling;
- Appropriate referral to other agencies and provision of access to support groups;
- Signposting to third sector, voluntary and other groups for social contact

Pathway 5: Emotional Wellbeing Visits (Active Listening)

A maximum of 6 listening visits to be offered, and if further support is required referral onwards to primary, secondary or specialist team colleagues for additional assessment and treatment must be considered.

Pathway 6: Referral to Primary Care – Primary & Secondary

Where a woman may need more than can be managed by offering emotional wellbeing/active listening visits, or where these have been undertaken with no significant improvement, a referral to the GP for a mental health assessment may be indicated.

The GP will then discuss the appropriate support to be offered, whether that be psychological support and/or medication through Primary Mental Health Support Services, or referral on to Community Adolescent Mental Health and Community Mental Health Teams, will be dependent of the level of need identified. The GP can also seek further advice and guidance from the Specialist Perinatal Mental Health Team as required.

Pathway 6: Primary and Secondary Care remove General Practice

Referral to a GP will enable further assessment and the offer or psychological support and/or medication. Onward referral to PMHSS/ CAMHs or CMHT may be also be offered. Advice and guidance can also be sought from the Specialist Midwife and/or Specialist Perinatal Mental Health Team as required.

Pathway 7: Specialist Perinatal Mental Health Team Assessment

To improve identification rates and reduce the long-term adverse outcomes of undiagnosed and untreated mental health difficulties, it is crucial that all women are asked about their mental health at each routine antenatal and postnatal contact.

If a mental health difficulty is suspected, a face-to-face assessment should be conducted during the pregnancy or the postnatal period. This helps ensure that women are offered

and are able to access timely and appropriate treatment at the earliest possible opportunity.

When a complex or severe mental health difficulty is known or suspected in a pregnant woman or new parent, a referral should be made from primary or secondary care, maternity services or a health visitor to a specialist community perinatal mental health team for a biopsychosocial assessment.

Following completion of the assessment and establishment of a care plan, developed and agreed in partnership with the woman and members of the team, a range of appropriate evidence-based interventions should be offered. This should emphasise a recovery-based approach with the woman at the centre.

Perinatal Mental Health Team Pathway 7: Specialist Perinatal Mental Health Team Assessment

Women referred to a specialist community perinatal mental health team with a complex or severe perinatal mental health difficulty (known or suspected) should have timely access to a biopsychosocial assessment. Where the need for ongoing care or intervention is identified, the woman should also

Pathway 8: Emergency Assessment

Women in the perinatal period may present with mental health difficulties that require urgent or emergency attention (for example, severe depression or the onset of postpartum psychosis, respectively) and that may put the woman and baby at risk.

Mental Health Crisis services must recognise the increased risk associated with women presenting with mental health difficulties in the perinatal period. They must prioritise their response when requests are made for assessment.

When a crisis is suspected, referral for an emergency assessment should be undertaken within 4 hours. If the woman is in a maternity inpatient setting and it is within normal working hours, contact should be made with - the Specialist PNMH team, Liaison Services, Crisis Resolution Home Treatment Team or Care Coordinator in CAMHs/ CMHT (if known to service).

If out of hours, contact should be made with Liaison Services.

If the woman is in a community setting and it is within normal working hours, contact should be made with - the GP or Specialist Perinatal Mental Health team, Liaison Service, Crisis Resolution Home Treatment Team or Care Coordinatior in CAMHS/ CMHT (if known to service).

If out of hours, contact should be made with the on call GP or Liaison Services via A & E.

If an emergency assessment is undertaken out of hours, the Specialist Perinatal Mental Health Team should be informed by the next working day.

If the need for an emergency assessment is required following birth, consideration must be given to the safeguarding needs of the baby and any other children within the family context.

An **emergency** is an unexpected, time-critical situation that may threaten the life, long-term health or safety of an individual or others and requires an immediate response.

An **urgent** situation is serious, and an individual may require timely advice, attention or treatment, but it is not immediately life-threatening.

On receiving the referral for a perinatal mental health crisis, the mental health professional should contact the most appropriate person (the woman in crisis, family member/ carer, or health or social care professional) without delay and agree the next steps to be provided in the

woman's care and support. **This should be done in line with national guidance such as the urgent and emergency liaison mental health care pathway guidance.**

Failure to provide an emergency referral and adequate assessment or start treatment immediately poses significant risk to the woman and baby.

The woman should:

- have had a biopsychosocial assessment and an urgent and emergency mental health care plan agreed, and
- as a minimum, be en-route to her next location if geographically different, or
- have started the referral process for admission to a Specialist Unit, or
- have been accepted and scheduled for intensive follow-up care at home or by the specialist community perinatal mental health team or have immediate access to care and support if waiting for an admission to an Specialist Unit or have started assessment under the Mental Health Act

Pathway 8: Emergency assessment

Undertake a biopsychosocial assessment and put an urgent and emergency mental health care plan in place and start the referral process for admission to a Specialist Perinatal Mental Health Inpatient Unit, or make arrangements for intensive follow-up care at home or by the specialist community perinatal mental health team, or have immediate access to care and support if waiting for an admission to a Specialist Perinatal Mental Health Inpatient Unit, or have started assessment under the Mental Health Act.

Pathway 9: Inpatient Care

A small number of women with complex or severe mental health difficulties will benefit from unplanned or planned inpatient care during the perinatal period. In these situations, both mother and baby should have urgent access to a Specialist Unit.

Specialist Inpatient Units provide support and care for the woman in her parenting role, and have staff with specialist expertise to manage complex or severe perinatal mental health difficulties. An emergency assessment should be undertaken as outlined in Pathway 8 (above).

If inpatient admission is required, contact should be made with Uned Gobaith colleagues and a multi-disciplinary discussion undertaken.

If there are no beds available within Wales, the woman and her family decline a bed or there are other contradictions to admission to a Specialist Inpatient Unit, consideration should be given to - referral to the Crisis Resolution Home Treatment Team Admission to a psychiatric unit. Alternative arrangements to ensure that the right support is provided should be made. This may include admission to an adult inpatient unit or support from home treatment team.

Where admission to a unit is inappropriate, the woman may leave the pathway. Appropriate follow-up steps should be taken, including an agreed NICE-recommended care (community or inpatient) package. All women requiring admission to a Specialist Inpatient Unit in late pregnancy or the early postpartum period should be admitted together with their babies unless there are specific reasons not to.

Where a bed is unavailable, the woman should be transferred to a Specialist Inpatient Unit at the earliest opportunity.

Referral Form here.

Pathway 9: Inpatient Care

Where women with complex or severe mental health difficulties require a planned or unplanned admission, a specialist unit should be prioritised.

Where this is not possible, admission to the unit should be facilitated at the earliest opportunity.

Pathway 10: Psychological interventions

Many women who develop perinatal mental health difficulties would benefit from psychological interventions (either alone or in conjunction with pharmacological treatment).

Psychological interventions should include provision for whole families' needs, including parent-infant relationships, as we know that improving the quality of this relationship can have positive outcomes for parental mental health.

Matrics Cymru is a structured guide to assist planning and delivering evidence-based psychological therapies within local authorities and health boards in Wales, including commissioned third sector and independent sector services, and it provides guidance to support greater quality and consistency in the delivery of psychological therapy across Wales.

Many women who develop a perinatal mental health problem will experience depression or anxiety disorders. Psychological interventions (either alone or in conjunction with pharmacological treatment) are extremely effective for treating depression and anxiety disorders, and many women may prefer them to taking medication.

Psychological interventions should include provision for whole families' needs, including parent-infant relationships, as we know that improving the quality of this relationship can have positive outcomes for parental mental health.

Pathway 10: Psychological interventions

Psychological interventions may be provided via primary, secondary or specialist care. Where a psychological intervention is provided by a local primary/ primary care mental health support service (LPMHSS or PCMHSS), access and waiting time standards apply.

Pathway Branches

Further consideration will also need to be given to the unique needs of each woman and family. Although mental health difficulties may be the reason why someone comes to the attention of a service, there may be many contributing factors.

The Wales Perinatal Mental Health Network will also be considering what additional pathway branches will also need to be developed in addition to the Wales Fully Integrated Care Pathways.

Wales Psychological Interventions Framework

Pregnancy and the process of childbirth and becoming a parent is a time for both physical and psychological change for women and their unborn and new baby. The need to support the mental health and wellbeing of all is therefore crucial and time critical.

Matrics Cymru and Matrics Plant provide guidance for the delivery of evidence-based psychological therapy in Wales for adults and children and young people.

The network recognised that there was a need to reflect the unique needs of the perinatal period by identifying psychological ways of facilitating the transition to parenthood, the health and well-being of parents and their babies, and supporting parent-infant relationships.

Our aims therefore were to:

- Maximise psychological well-being of women in pregnancy by identifying and agreeing specifically targeted emotional support and interventions
- Recognise this as a time where women may feel more anxious and concerned and the role of a practitioner in supporting them
- Provide opportunity in pregnancy for women to discuss and explore the process of labour and childbirth
- Ensure that the psychological impact of the birthing process is understood
- Support the emotional transition to parenthood and the parent- infant relationship during pregnancy
- Enable and empower access to and the creation of social networks during pregnancy, childbirth and the postnatal period for all (including dads/partners and supporters)
- Promote and support the parent-infant relationship
- Recognise that women with mental health difficulties may present in a variety of ways and that early recognition, identification and 'matching' of support/ interventions to need is paramount

In addition and as outlined within the **Antenatal and postnatal mental health: clinical management and service guidance we aimed to ensure that:**

- All interventions for mental health difficulties in pregnancy and the postnatal period should be delivered by competent practitioners receiving regular high quality supervision and using routine outcome measures, whilst ensuring that the woman is involved in reviewing the treatment
- When a woman with a known or suspected mental health difficulty is referred for psychological support in pregnancy or the postnatal period, **assessment for treatment takes place within two weeks of referral and psychological interventions are provided within one month of initial assessment (NICE, 2020).**

Wales Specialist Perinatal Mental Health Inpatient Provision

Uned Gobaith is an interim Specialist Perinatal Inpatient Mental Health Unit, hosted by the Mental Health and Learning Disabilities Directorate of Swansea Bay University Health Board. The Unit is a regional service serving the population of Wales and has capacity for six women, and seven babies (to enable accommodation of twins).

The Perinatal Inpatient Unit provides multi-disciplinary specialist mental health care to women from 32 weeks pregnant or those up to one year after birth. Women admitted during the postnatal period will be admitted with their baby and will require specialist assessment and/or treatment of a mental illness that is moderate to severe in nature.

The care pathway and model of service delivery for this specialist service have been developed drawing on both local and national guidance, this includes Service Specification by commissioners (WHSCC), NICE guidelines and Service Standards published by Royal College of Psychiatry for the commissioning of Mother and Baby Inpatient Psychiatric Units.

Uned Gobaith has identified pathways and communication with Specialist Community Perinatal Mental Health teams across Wales. With additional links to local antenatal, obstetric and maternity services, primary care including health visiting, liaison psychiatry, secondary mental health services, children's services and other voluntary agencies, in order to provide a comprehensive multi-agency and multidisciplinary service for women within this group during the perinatal period. To find out more about the unit and how to refer, please follow the link here.

Section 3

Performance

The Wales Perinatal Mental Health Network is focused on supporting practitioners across Wales to undertake work to ensure we are providing high quality perinatal mental health services across all areas of Wales.

By adopting a quality improvement approach the network aims to make a difference to women with mental health difficulties by improving safety, effectiveness, and experience of the care that they and their families/supporters receive. **Read more here.**

This work started with understanding where we were at and working towards the recommendations set out in the CYPE Committee Report for all health boards to –

- Become members of the Perinatal Quality Network (PQN)
- Meet and gain accreditation from the Royal College of Psychiatry Standards for Specialist Community Perinatal Mental Teams

Guidance and Standards

- Maternal Mental Health Alliance Pathway Tool
- NICE Guidance Antenatal and postnatal mental health: clinical management and service guidance
- Perinatal Specialist Community Mental Health Team Service Specification Template (CR197)
- Royal College of Psychiatry Perinatal Quality Network
- Royal College of Psychiatry Standards for Mother and Baby Units
- National Perinatal Mental Health Standards

Wales Perinatal Mental Health Data Set

Why collect data

Collecting healthcare data generated across a variety of sources increases the quality of care provided by allowing the opportunity to gain deeper insight.

Data collection tools and methods generate information about women that improves the quality of services, treatment, and care according to individual needs.

The perinatal period spans the time from conception through to a year after giving birth, it all included women with mental health difficulties who are planning a pregnancy.

The network's development of Wales Perinatal Mental Health data focuses on:

- Understanding what indicators and datasets were known to be collected and which can be drawn upon to support planning, policy, service improvement and needs assessments.
- Identify what indicators could be collected on a national level.
- Agree a dataset to be collected by all perinatal mental health service providers across the care pathway, including (but not limited to) adult mental health services, specialised services, maternity, GPs and primary care, health visitors, social care and parenting support interventions.

Work is ongoing to define a minimum required dataset for specialist perinatal MH teams that meet the needs of nationally agreed standards and pathways. Data items that are identified as being specific to perinatal MH will be added to the core dataset by via the Welsh Information Standards Board (WISB) process to ensure that data is collection is standardised and robust.

Wales Outcome Measures Framework

Improving Outcomes for All

At the heart of this care pathway is the need to improve the care experience and outcomes for women and their families with mental health difficulties who are planning a pregnancy, pregnant or have a baby under one year old.

Service user experience is one of the most powerful levers for service and quality improvement and consultation with user groups from within the Wales Perinatal Mental Health Network, local Perinatal Mental Health Steering Groups, third sector and voluntary organisations took place throughout the process of developing and shaping this care pathway.

The need to systematically capture the experiences and application of these in service design and pathway development is crucial and a key outcome measure for the pathway. To enable feedback to be used as a mechanism for continual development, the Patient-rated Outcome and Experience Measure (POEM) will be included within the Wales Outcome Measure Framework. The POEM is available to all specialist perinatal mental health team colleagues as part of their membership to the Perinatal Quality Network (PQN) and to the wider workforce via the Perinatal Mental Health pages on the NHS Wales Executive website.

There will be an expectation that all women and their families will be offered the opportunity to complete and provide feedback on the care, support and services that have been provided and accessed.

This feedback will then be used by the Wales Perinatal Mental Health Network and network members to further develop service provision across Wales.

Successful implementation of this pathway within each Health Board will lead to the following improvements in care for women and their families with perinatal mental ill health, ensuring that all, receive the right care, at the right time, by the right staff, with the right skills, knowledge, support and supervision, thus:

- Improving the experiences and providing flexible care
- A comprehensive assessment which will address individual needs and involve women, their families and carers in all decisions regarding their personal care plan
- Clear information about the risks and benefits of any prescribed medication
- Clear information about how to access local care and services
- Integrated care and referral processes where appropriate coordinated between maternity services, GP, health visitor and mental health services
- Flexible personalised care, which addresses the needs of women, their babies and familes across the health care system.
- Where appropriate, the implementation of a written and shared care plan, which includes clear details of care provided by all those involved in the provision of services, with safeguarding referrals only be completed if there are safeguarding or child in need concerns
- Carer assessment where necessary
- Following discharge from mental health services, communication with midwifery, primary care, health visiting and/or onward referral to other services as necessary, should take place.

Wales Outcome Measure Tools

Why outcome measures

When evaluating health interventions, outcomes have generally been defined as a change in health status or in the factors that influence health status as a result of a programme or intervention.

Led by Improvement Cymru the work of the Outcome Measurement in Wales project is part of the Welsh Government Mental Health Core Data Set Programme. The aim of the project being that by 2022, outcome focused practice will be embedded in teams to reflect on individual's wellbeing, goals and experiences. The model supports service users, staff and teams to work effectively together to improve service user wellbeing, experience and therapeutic relationships. An all Wales framework for the routine use of outcome tools in mental health and learning disability services has been developed.

Why is this being done?

The three main reasons for using outcome tools and gaining service user feedback are:

- It is what people, families and carers, who use services want
- To support the provision of outcome focused interventions
- To ensure we continue to have appropriate services.

It also supports:

- Practitioners to work with service users to jointly develop shared goals/outcomes
- Practitioners to reflect on whether interventions are having the desired impact and whether they need to change
- Discussions in relation to achievement of goals/outcomes.

What are the benefits?

- Helps practitioners and women build a meaningful relationship
- Clear and concise
- Facilitates change
- Women can see the changes
- Progress is documented
- Widely available
- Objective and factual
- Women can think about their own recovery
- Working together on the same goal
- Supports recovery
- Realistic goals

Agreed Outcome Tools

The agreed outcome tools have been placed into three clusters:

1. Improvement in my wellbeing
2. Being able to set my own goals and aspirations
3. My experience and satisfaction

Wales Outcome Measures Tools and Framework

Work to develop an Outcome Measure Framework and to explore and agree outcome tools to be used across the Perinatal Pathway is underway.

Section 4

People

Role of Perinatal and Infant Mental Health Champions

The Perinatal and Infant Mental Health Champion provides leadership, advocacy and cascade training for colleagues working with women and their families who are planning a pregnancy, pregnant, given birth and have a baby under one year old, and who have mental health difficulties.

The role of Champions includes:

- Being an ambassador for perinatal and infant mental health
- Involvement in developing, progressing and implementing the national integrated perinatal and infant mental health pathways locally
- Acting as a central resource and 'point of contact' for colleagues around perinatal and infant mental health concerns
- To promote evidence-based practice at all levels across the pathways
- To empower and enable colleagues to 'champion' parity for perinatal and infant mental health

Institute of Health Visiting Perinatal and Infant Mental Health Champion Training.

Wales Perinatal and Parent-Infant Mental Health Competency Framework

What is it?

The Wales Perinatal and Infant Mental Health Competency Framework identifies the competencies practitioners need to be effective in perinatal and parent-infant mental health. The framework aims to build perinatal and parent-infant mental health capability in the workforce, by identifying the skills required and supporting teams across the pathway to assess their training needs.

The competency framework will support practitioners to undertake a self–assessment of their knowledge, skills, behaviour to identify their own objectives and goals, informing their personal development plan.

National Perinatal Mental and Infant Health Competency Framework

The Wales Perinatal and Infant mental health Competency Framework is in the process of being developed.

Support, Supervision and Skills

Midwives, health visitors and AHPs are supported by their line managers, the Clinical Supervisor for Midwives, and lead or named midwife for safeguarding. Clinical, safeguarding and reflective supervision opportunities must be incorporated into service provision.

All practitioners are required to have up-to-date knowledge of antenatal, intrapartum and postnatal mental health difficulties and available support and treatments in order to enable parents to achieve a satisfactory outcome for themselves, their baby and family. There should also be an awareness and knowledge of what community support is available within their area, including types of services, eligibility, days and timings. Signposting, supporting or referring to third sector and voluntary groups and to on-line information resources where this information can be accessed should be encouraged.

Introductory and shadowing opportunities with local third sector and voluntary organisations for community midwives and health visitors should be actively encouraged. As should the use of on-line resources – InfoEngine and Dewis Cymru and community connectors or equivalent in each area.

All Health Boards will ensure that midwives, health visitors, and AHPs have access to relevant and up-to-date training, skills and knowledge on mental health, ill health, eating disorders and substance misuse in the perinatal period and have access to open door advice and support from the safeguarding team if they have any safeguarding concerns in relation to the child.

Prescribing Guidance

Prescribing Guidance

Prescribing psychotropic medication in pregnancy and lactation involves a careful analysis of the potential risks and benefits involved. In particular, weighing the risk exposing the unborn child or breastfeeding infant to medication to the risks of deterioration in the woman's mental health preconception, during pregnancy or in the postnatal period.

Each health board has pharmacists and infant feeding leads who can offer advice and guidance. Recent recommendations suggest that health professionals should not be offering valproate for acute or long-term treatment of a mental health difficulties in women with childbearing potential, planning a pregnancy, pregnant or considering breastfeeding (NICE, 2020).

For women who are already taking valproate and become pregnant, urgent advice should be sought from a consultant psychiatrist. If a woman is already taking valproate and is planning a pregnancy, advice to gradually stop the drug because of the risk of foetal malformations and adverse neurodevelopment outcomes after any exposure in pregnancy will be offered.

Contraception and the risk of pregnancy will be discussed with all women of childbearing potential who have a mental illness and/or who are taking any anticonvulsant or psychotropic medication.

Pregnant women taking antipsychotic medication will also be advised about diet and excessive weight gain, in line with the guideline on **weight management before, during and after pregnancy (NICE, 2010). Monitoring for gestational diabetes in line with the guideline on diabetes in pregnancy and oral glucose tolerance testing, will also be offered (NICE, 2008).** Additionally, prolactin levels should be monitored in women who are taking prolactin-raising antipsychotics and planning a pregnancy, as raised prolactin levels reduce the chances of conception. (NICE, 2014)

To minimise the risk of harm, drugs must always be prescribed with caution. Where possible, monotherapy should be prescribed at the lowest effective dose. Factors to be taken into consideration include the woman's diagnosis/ psychiatric history, her response to medication and her risk of relapse, as well as the potential risks posed by medications during pregnancy. The thresholds for non-drug treatments, particularly the psychological therapies, may be lower during pregnancy due to the changing risk benefit ratio. At all times, health care practitioners need to involve the woman and, where appropriate, her partner/ next of kin/ family/ carer in a collaborative discussion about medication issues.

For further information please visit **here.**

Safeguarding

Taking a Whole Family Approach

Safeguarding Children Standards for Adult Mental Health

This section of the Care Pathway needs to be read in conjunction with the All Wales and local safeguarding protocols/guidelines and policies.

Wales Safeguarding App

Statutory Function

Safeguarding and Protecting Children is a statutory function for all health services and the Children Act 2004 identifies children whose parents suffer from mental illness as one of the key groups of vulnerable children.

Wales Safeguarding Procedures

Wales Safeguarding Procedures 2019 identifies that all health professionals working with adults need to be alert to the needs of children. They should routinely enquire about any dependent children or those children with whom the adult patient has significant contact.

This highlights the importance of routinely identifying and recording if adults who use mental health services are parents or carers. Mental illness in a parent or carer does not necessarily mean that there will be an adverse impact on a child, but it is essential to assess its implications for any children involved in the family.

Being a parent with a mental health need, however, may be particularly challenging. Many parents are painfully aware that their disorder affects their children even if they do not fully understand the complexities (Falkov, 1998). Asking the right questions and recording which adults are parents is very important. Apart from the obvious consequences of not having this information for assessment and care planning, it's important that this information is easily available to facilitate service planning.

Think parent, think child, think family

As in all areas of safeguarding, good communication is vital between professions to meet the needs of the whole family. The evidence and potential impact that adverse childhood experiences may have throughout a woman's life highlights and reinforces the need for a whole family approach.

The welfare of the child must be paramount. Where professionals suspect a child has suffered or is at risk of suffering significant harm as the result of commission or omission on the part of the parent or carer, the referral process must be followed Safeguarding flow chart.

Often a barrier to joint working is the issue of confidentiality. Where an issue of child protection is involved it is valid and lawful to share any relevant information in order to protect the child. Staff should discuss information with other team members and all areas should have access to a named professional for safeguarding.

Mental Health Standards

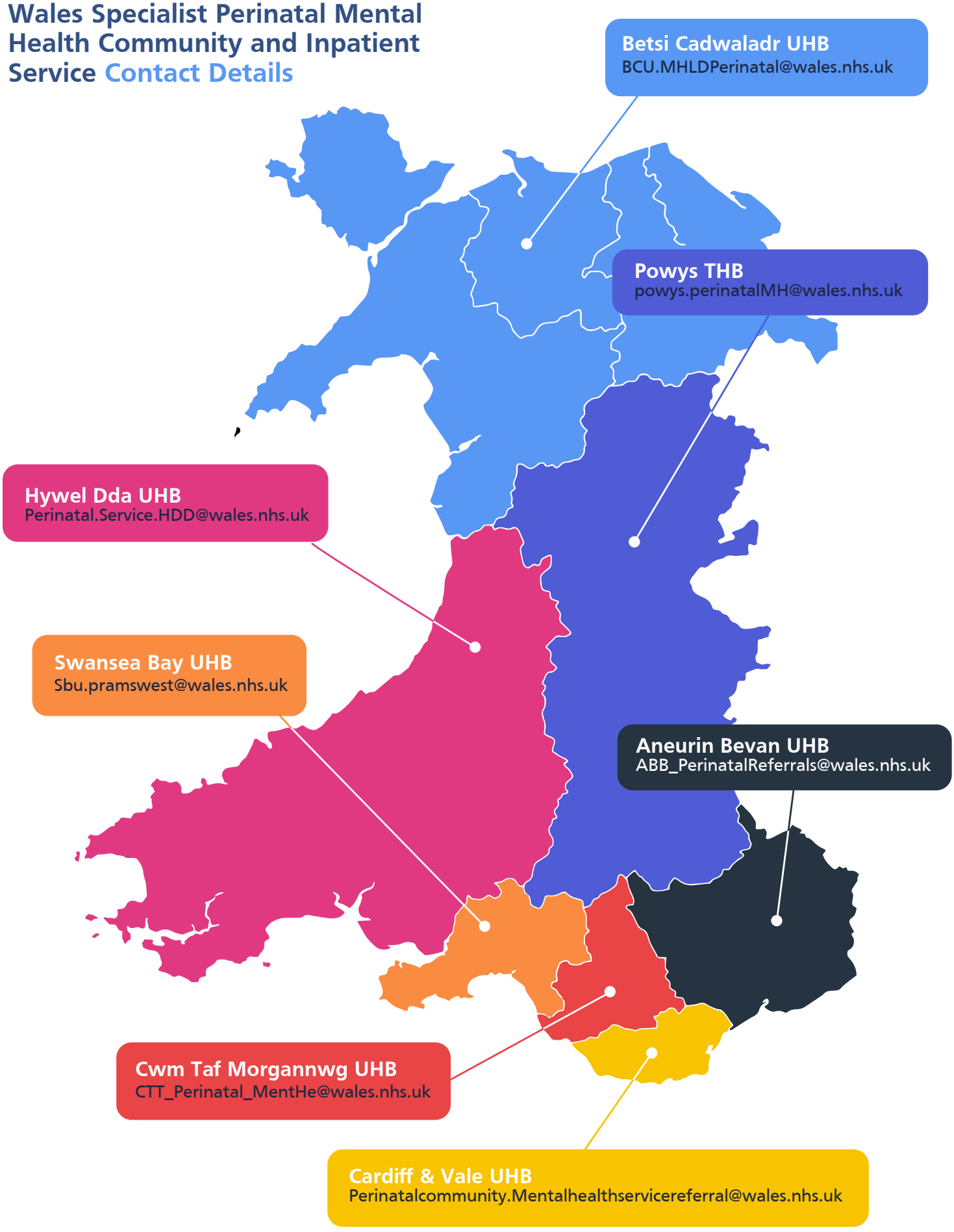
As outlined in the Safeguarding Children Standards for Adult Mental Health, the following will be asked as part of all mental health assessments, at each episode of treatment whether at an inpatient unit or in the community;

The mental health professionals will:

- Routinely record/confirm whether the adult being assessed is a parent or has a significant caring role for a child.
- Establish and record details of the children, the parenting arrangements and what agencies are currently involved.
- Following assessment, professionals should routinely inform midwifery, health visiting or school nursing service as appropriate. If the initial referral was not from the GP, primary care should be notified of any concerns which may impact upon an adults parenting or caring capacity.
- Referral process must be followed in line with the All Wales Child Protection Procedures. Where professionals suspect a child and/or unborn child has suffered or is at risk of suffering significant harm as the result of commission or omission on the part of the parent/carer, the referral process must be followed. An appropriate child protection referral should not be delayed, for example, because a diagnosis has not yet been made in relation to the adult. See the flowchart in **Appendix 1 of Safeguarding Children Standards for Adult Mental Health.**
- Professionals working within adult mental health services must ensure that their care planning includes explicit details about issues and interventions required to help their clients in their parenting roles. Consideration must be given to the adults' roles as parents and the impact of their mental ill health on their parenting capacity and subsequently on their children. This should also consider the wishes and feelings of the child regarding the parent's illness.
- Where there are issues about children's welfare, discharge plans must involve, and be agreed by all professionals working with the family. Discharge planning needs to be robust to ensure that the child's physical and emotional needs are met. Paper copies of this document should be kept to a minimum and checks made with the electronic version to ensure that the printed version is the most recent.
- The needs of children should be explicitly considered within the planning processes. Where there are concerns about service users' ability to care for their children due to their mental state, and following referral, Children's Services should be invited to attend meetings.

Contact Details

Wales Specialist Perinatal Mental Health Community and Inpatient Service Contact Details



Next Steps...

Follow the link below to find out more about the Wales Perinatal Mental Health Network objectives and workplan.

https://nhswales365.sharepoint.com/sites/NXW_PNMH/SitePages/Perinatal-Mental-Health-Objectives.aspx