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Perinatal Mental Health Community Service: Operational Policy

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1 Introduction

Around one in four women experience mental health problems in pregnancy and during the 24 months after giving birth. If left untreated, mental health issues can have significant negative and long-lasting effects on the woman, the child, and the wider family (Howard et al, 2018).

The costs of undiagnosed or untreated perinatal mental health problems include avoidable suffering, damage to families, impact on children and death and serious injury (Maternal Mental Health Alliance ((MMHA) website, 2021)). Additionally, the economic cost to society of not effectively treating perinatal mental illness far outweighs the cost of providing appropriate services.

Perinatal mental health refers to a woman or person's mental health during pregnancy and two years after birth. This includes mental illness existing before pregnancy, as well as illnesses that develop for the first time, or are greatly exacerbated in the perinatal period.

Examples of perinatal mental illness include antenatal depression, postnatal depression, anxiety, perinatal obsessive-compulsive disorder (OCD), postpartum psychosis and post-traumatic stress disorder (PTSD). These illnesses can be mild, moderate or severe, requiring different kinds of care or treatment (MMHA).

The Five Year Forward View for Mental Health (FYFVMH) (NHS, 2014) committed that by 2020/21 there will be increased access to specialist PMH support in all areas in England, in the community or in-patient mother and baby units, allowing at least an additional 30,000 women each year to receive evidence-based treatment, closer to home, when they need it.

The NHS Long Term Plan (LTP) (NHS, 2019) builds on the commitment of the FYFVMH to transform specialist PMH services across England and sets out the following ambitions:

- 'Increasing access to evidence-based care for women with moderate to severe perinatal mental health
- To expand service provision from preconception to 12 months after birth to preconception to 24 months after birth
- Expanding access to evidence-based psychological therapies within specialist perinatal mental health services so that they also include parent-infant, couple, co-parenting and family interventions
- Offering fathers/partners of women accessing specialist perinatal mental health services and maternity outreach clinics evidence-based assessment for their mental health and signposting to support as required
- Finally, a joint ambition with the Maternity Transformation Programme to implement "Maternal Mental Health Services", that will integrate maternity, reproductive health and psychological

therapy for women experiencing mental health difficulties directly arising from, or related to, the maternity experience'.

Better births supported NHS England's independent Mental Health Taskforce recommendation that there should be significant investment in perinatal mental health services in the community and specialist care, rapid referral and access when it is needed and professionals need the right training and skills to be able to identify, manage and refer to appropriate specialist support for perinatal mental health conditions.

This policy also supports the Trust's strategic goals. It does this by:

- Setting out how we will work closely with the person and/or their families, so that the experience can be as good as it possibly can be, working to ensure the person has as much choice and control in how they are supported by services
- Setting out how we will work closely with our Trust colleagues, so they feel supported in working with the person and key people that are involved in their care
- Setting out how we will work in close partnership with the other agencies involved with the person, such as their GP, to ensure seamless and compassionate care.

2 Why we need this policy

There are three Perinatal Mental Health Teams in TEWV that this policy relates to. They are:

- Teesside Perinatal Mental Health Service
- Durham and Darlington Perinatal Mental Health Service
- North Yorkshire and York Perinatal Mental Health Service

The policy outlines the clinical standards for each team so that the practice is safe and clinically appropriate.

It is important to note that this policy relates to all people of childbearing potential, which includes people who identify themselves as gender neutral or male, although a number of the key reference documents that underpin this policy still associate with the patient group as women, mothers and fathers.

2.1 Purpose

The purpose of this policy is to describe how perinatal mental health teams are to work with other TEWV staff groups involved in perinatal care and those other agencies that are involved with the same group of patients in order to describe how perinatal teams will carry out their core functions.

Understanding this policy and following the guidance within will support employees to work in a safe, effective, and productive way and assure the Trust that perinatal services are delivered in this way.

2.2 Objectives

The objective of this policy is to set out:

- The operational standards for the perinatal mental health teams
- The role of assessment and treatment of women or people who are pregnant and are currently suffering severe and enduring mental problems or who are at risk of relapse in the perinatal teams
- The role of assessment and treatment of women or people who are pregnant and are currently suffering severe and enduring mental illness or who are at risk of relapse in core community teams and IAPT (improving access to psychological therapies)
- The interventional perinatal period from conception to the end of the baby's first year or second year (if commissioned to do so).

3 Scope

3.1 Who this policy applies to

This policy applies to all healthcare professionals working within TEWV NHS Foundation Trust. Key roles and responsibilities are outlined in **Section 3.2 Roles and Responsibilities**.

Consideration has been given to those who may be affected by this policy to ensure that the document content aligns to the Trust's values, so that people who may be affected are treated with compassion, respect and responsibility.

The policy has been developed in partnership with people with lived experience and those who also contribute to the wellbeing of women and their children with perinatal mental health problems.

3.2 Roles and responsibilities

The roles and responsibilities relate to those of the perinatal mental health (PNMH) team and to those who also have core responsibility for perinatal mental health cases in the community. They include, but are not limited to:

Role	Responsibility
Consultant Psychiatrist	Provide specialist medical assessment, treatment and advice for the care of people that are referred into the team. Membership of the Leadership cell to hold joint responsibility for key quality and performance indicators. Support and supervision for Doctors-in-training, working alongside the Consultant Psychiatrist.

Role	Responsibility
	Member of the PNMH MDT.
Team Manager	To be professionally accountable and responsible for the delivery of the clinical service by the community team(s) which may be integrated, working collaboratively and in partnership with local authority services. To be responsible for the operational management of the PNMH team. Caseload supervision. Membership of the leadership cell to hold joint responsibly for key quality and performance indicators. Member of the PNMH MDT.
Psychological Professions	Psychologists, Psychological Therapists and Psychotherapists will provide specialist psychological assessment, formulation and interventions for people referred into the team. Senior Therapists will be members of leadership cell, holding joint responsibility for key quality and performance indicators. To provide training and clinical supervision to members of the team including Trainee Psychologists and Psychological Therapists. Member of the PNMH MDT.
Advanced Nurse Practitioner	Provide specialist assessment and psychological interventions to patient care, undertake formulations with patients, and provide clinical supervision for colleagues. Duty Worker, Lead Professional or care coordinate. Provides non-medical prescribing to shared caseload. Membership of the leadership cell to hold joint responsibly for key quality and performance indicators. Caseload supervision. Supports Doctors and other students in training, working alongside professionals. Member of the PNMH MDT.
Community Senior Practitioners	Provide specialist perinatal assessment and psychological treatment, co-ordinate perinatal care across all agencies. Duty Worker, Lead Professional or care coordinate.
Specialist Pharmacist	Supports people and healthcare professionals to make informed treatment decisions during the perinatal period. Provides access to specialist and evidence-based medicines information and provides specialist advice on medication in pregnancy and breastfeeding and supports preconception counselling. Offers training, develops and implements guidelines, promotes physical health monitoring and performs audits to improve quality.
Social Worker	To work within a multidisciplinary team to provide appropriate social work assessments and deliver interventions to individuals, families and carers in order to support recovery, promote self-management, and minimise risk.

Role	Responsibility
	To provide a social work service within community, mental health or hospital settings and to discharge statutory social care functions. Duty Worker, Lead Professional. Member of the PNMH MDT.
Occupational Therapist	To develop and implement occupational therapy treatment plans and provide advice to people with diverse presentations and complex needs to enable them to maintain, restore or create a balance between their abilities and the demands of their occupation and environment in the areas of self-care, productivity and leisure. In line with local agreement, contributes to duty work. Lead Professional. Member of the PNMH MDT.
Nursery Nurse	Work directly with patients in developing bond, attachment and interactions between mother/person and baby. Member of the PNMH MDT.
Community Support Worker	To assist in the delivery of patient care, as directed by Registered Practitioners and Team Manager, undertaking duties and activities with limited or indirect supervision in patients' homes and other community settings.
Peer Support Workers	People with lived experience who give practical and emotional support and instil hope. Member of the PNMH MDT
Administrator	To provide the administrative duties which are required in the team.
IAPT	IAPT is a primary care therapeutic service for those whose main presentation is a common mental health problem. IAPT adopts a uni-professional approach, with patients being offered short term psychological interventions. IAPT has an open access referral system, where patients can self-refer online, via telephone or email. Professionals can also refer to IAPT. There will be clear communication between PNMH and IAPT as IAPT can be a significant front door to perinatal referrals into mental health services.
Duty Worker	The role of the Duty Worker is, as a Registered Professional, to provide clinical advice to professionals and service users and key named individuals. Available to screen referrals into the team. The Duty Worker will have capacity to undertake joint assessments with crisis teams either following a crisis presentation or for emergency presentations of suspected puerperal psychosis.

4 Policy

4.1 Referral and access Criteria

The perinatal mental health team provides a service for those people of all ages, registered with GPs in the TEWV footprint, who are pregnant or up to one year postpartum (and up to two years' postnatal where commissioned) and will work with those with current moderate to severe mental illness, as well as those who are at risk of becoming unwell due to a history of severe mental health problems in the past.

Appendix 1, provides a standard template for referrers

Assessment by the PNMH team will be offered for those who are pregnant or up to one year postpartum (or up to 2 years' postnatal where commissioned) and:

- Are following discharge from a mental health inpatient stay
- Are currently experiencing symptoms of bipolar disorder, postpartum psychosis, schizophrenia and other psychoses which can be safely managed in the community with current symptoms of moderate to severe non-psychotic conditions (including depression, anxiety, OCD, PTSD, personality disorder)
- Initial first line treatments (e.g. medication, talking therapies) have already been trialled in primary care and have not been effective
- With historic diagnoses of bipolar disorder, postpartum psychosis, schizophrenia and other psychoses, even if currently well
- With history of severe non-psychotic conditions (including depression, anxiety, OCD, PTSD, personality disorder, eating disorder) which has required admission to mental health hospital, or long-term input from mental health service in the past
- With alcohol/substance misuse problems where there is also moderate to severe mental health problems
- Requiring pre-conception advice due to severe or complex mental illness.

Where commissioned, new referrals can be accepted by the PNMH service where the baby is 12 - 24 months postnatal if:

- Episode of perinatal mental illness identified/presented late and there is a defined perinatal need.
- A psychological intervention with a perinatal focus is needed.
- There are concerns about the person/mother-infant relationship or parenting.

4.1.1 Referrals from outside TEWV

Referrals can be made by any health or social care professional working with the person. This includes both NHS and non-NHS providers. Practitioners are encouraged to contact the team Duty Worker by telephone to discuss a case prior to making a referral into the team.

Services will also consider self-referrals, which will include consent to communicate with the person's GP, Midwife or Health Visitor.

The outcome of all referrals to PNMH will be communicated to the referrer and person's GP.

Referrals are to be electronic referrals via email:

Tees perinatal mental health service

- Referrals are to be made using electronic referral form which is to be emailed to team at teesperinatal@nhs.net

The Tees perinatal mental health team will manage all referrals from South Tees Hospitals Trust and forward them to the correct receiving PNMH team.

Durham and Darlington perinatal mental health service

- Referrals are to be made using electronic referral form which is to be emailed to team at tewv.durhamdarlingtonperinatal@nhs.net

The Durham and Darlington perinatal mental health team will manage all referrals from County Durham and Darlington Foundation Trust and forward them to the correct receiving PNMH team.

North Yorkshire and York perinatal mental health service

- Referrals are to be made using electronic referral form which is to be emailed to team at:

Scarborough Whitby Ryedale tewv.swr-amh@nhs.net
Harrogate & Rural tewv.hard-amh@nhs.net
Hambleton & Richmondshire tewv.amh-hr@nhs.net
York & Selby tewv.yorkaccesspoint@nhs.net

4.1.2 Referrals from within TEWV

Practitioners should ring the Duty Worker to discuss the case and referral may be made over the telephone. A case note is to be created summarising reasons for referral to the PNMH team, diagnosis, medication, current presentation, and details regarding baby/unborn baby should be made on the electronic patient record. An up-to-date safety summary and safety plan also needs

to be in place. If considered appropriate for PNMH, a joint appointment would then be undertaken with both current treating team and perinatal team present.

4.1.3 Exclusions

PMHT does not provide parenting assessments.

4.1.4 Declined referrals:

External referrals

The decision to decline a referral will be communicated in writing to the referrer and to the patient's GP. Good practice is for the patient to be also informed in writing.

Internal referrals

The decision to decline a referral will be communicated by telephone or email to the referrer.

A record of the decision will also be made in the patient's electronic record.

4.1.5 Improving Access to Psychological Therapy (IAPT) for perinatal patients

Within TEWV there are various local arrangements meaning each IAPT service interfaces with secondary care in different ways and so local agreements need to be in place.

IAPT services provide access into adult mental health to large numbers of people, most of whom self-refer. Therefore, it is important that there are clear links between PNMH and IAPT services to support perinatal patients and reduce patient delays to receiving treatment from the most appropriate service.

IAPT is suited to accept referrals for those with mild to moderate perinatal mental health presentations such as:

Those in the perinatal period who have less complex (mild to moderate) common mental health problems in the absence of:

- Immediate or unstable risk and/or those who are actively suicidal and unable to maintain their own safety
- Risk of self-neglect and poor functioning requiring secondary care input
- Drug or alcohol use to a level that would prevent them engaging in treatment
- A history/diagnosis of severe mental illness or personality disorders
- The cause for depression or anxiety being organic and not managed, such as a hormonal/ endocrine or thyroid problem.

Where problems are less complex (mild to moderate) and can successfully be treated via short term, uni-professional low and high psychological interventions, IAPT may be the most appropriate service.

People who are self-motivated to change and ready to engage in a therapeutic process are likely to benefit from referral to IAPT services.

IAPT is less likely to be suitable if the person has a history of MH problems during the perinatal period which have required specialist/secondary care support.

IAPT services would not be suitable to meet the needs of:

- People who are at immediate or unstable risk and/or actively suicidal and unable to maintain their own safety
- People who are at risk of self-neglect and poor functioning requiring secondary care input
- People using drugs or alcohol to a level that would prevent them engaging in treatment
- People with severe mental illness or personality disorders
- IAPT would not be suitable if the cause for depression or anxiety was organic and not managed, such as a hormonal/endocrine or thyroid problem.

IAPT assessment and risk

IAPT will carry out a full risk assessment in conjunction with the person. They will focus on areas that are likely to present possible risk such as self-neglect, self-harm, suicidal thoughts and intent, risks to others (including the baby), smoking, drug or alcohol misuse and domestic violence and abuse. If there is a risk of, or there are concerns about, suspected child maltreatment, local safeguarding protocols will be followed.

IAPT referrals that are not appropriate (risk, complexity etc.) will be considered directly via the local access routes for perinatal/core community teams for initial assessment.

IAPT will take responsibility for communicating with the patient and GP.

IAPT treatment pathway

IAPT will provide interventions for mental health problems in pregnancy and the postnatal period within the stepped-care model of service delivery, in line with recommendation of the guideline on common mental health disorders (NICE guideline CG123).

4.2 Referral to initial assessment

All referrals will be triaged, and a decision made within two working days of receipt.

All referrals will be entered onto the electronic patient record within 48 hours.

According to level of need, referrals will be triaged as Routine, Urgent and Emergency.

4.2.1 Routine referrals

People referred to a specialist community PNMH team with a complex or severe perinatal mental health problem (known or suspected) should have timely access to a biopsychosocial assessment.

- Routine referrals will be assessed within four weeks.

4.2.1.1 Referrals for pregnant person/woman prescribed Sodium Valproate or Semi-Sodium Valproate

- All referrals will be discussed with referrer within two working days of receipt.

4.2.1.2 Request for pre-conception advice

- The PNMH medic is available to provide a 'one off' appointment for pre-conception advice.

4.2.2 Urgent referrals

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

- Urgent referrals will be assessed within three working days

4.2.3 Emergency referrals & crisis/acute liaison referrals

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.

In response to physical health needs of the baby, services will seek emergency attention from ambulance services via 999.

In line with the Trust Crisis Operational Policy, crisis teams are to follow the' Red Flag' presentations for people who are pregnant.

All perinatal crisis assessments are to be undertaken by a Senior Crisis Clinician.

The Red Flags are:

1. Recent significant change in mental state or emergence of new symptoms
2. New thoughts or acts of violent self-harm
3. New and persistent expressions of incompetency as a mother/parent or estrangement from the infant.

In addition, crisis triage needs to consider:

- History of bipolar – to hold a very low threshold for taking onto caseload if there are concerns re possible relapse or very high risk of relapse predicted
- The crisis assessment is to be face to face, to enable visual assessment of mother/person with baby if possible
- **An emergency assessment within the crisis 4-hour standard or 1-hour standard if the person presents in the emergency department.**

When a person is in suspected crisis they should:

- Undergo biopsychosocial assessment and have an urgent and emergency mental health care plan in place, and

As a minimum:

- be en-route to their next location if geographically different, or
- have started the referral process for admission to an MBU, or
- have been accepted and scheduled for intensive follow-up care at home or by the specialist community PNMH team, or
- have immediate access to care and support if the person is waiting for an admission to an MBU, or
- have started assessment under the Mental Health Act.

Patients referred with **possible puerperal psychosis** require emergency comprehensive assessment.

- Emergency assessments with Emergency Departments will be undertaken by the local acute hospital liaison teams within one hour
- Crisis teams will provide emergency assessments in and out of hours within four hours of referral
- Where possible a joint assessment will be undertaken with the respective PNMH Duty Worker or designated other.

Following crisis assessment, there will be clear communication with TEWV services, Social Worker, Midwife, or Health Visitor.

Following assessment out of hours, all cases requiring specialist perinatal care will be referred to the perinatal team the next working day.

All perinatal cases assessed by Crisis Resolution and Home Treatment Teams out of hours will be discussed with the perinatal duty worker the next working day.

People who present out of hours and require a crisis assessment will have a joint appointment with the local PNMH team within three working days.

4.2.4 Emergency access to 'mother and baby' unit (MBU)

A small number of people with a complex or severe mental health problem will need unplanned inpatient care during the perinatal period. In these situations, both mother/person and baby should have urgent access to an MBU.

MBUs provide support and care for the mother/person in their parenting role and have staff with specialist expertise to manage complex or severe perinatal mental health problems.

For those that require admission to MBU with TEWV the access route is via:

NHS Web Beds - Available beds

https://nhswebbeds.co.uk

Details of MBU bed availability, universal referral form and contact details for each MBU are available on this site.

Telephone number for Morpeth MBU is 01670 501869 and for Leeds MBU is 0113 855 5509.

The outcome of the referral to PNMH and initial assessment will be communicated to the referrer and person's GP.

4.3 The role of the Duty Worker

During normal working hours (Monday to Friday 9am to 5pm) each team will have access to a named Duty Worker.

The role of the Duty Worker is, as a Registered Professional, to provide clinical advice to professionals and service users and key named individuals. They will be available to screen referrals into the team and have the capacity to undertake joint assessments with crisis teams either following a crisis presentation or for emergency presentations of suspected puerperal psychosis.

The Duty Worker will be able to support cover for the care of service users with urgent need and unplanned absence of their Care Coordinator/Lead Professional (as directed by the Team Manager).

4.4 Assessment and formulation of need

Following the triage of referrals, role of the initial assessment is to determine the level of need and associated risks to both the person who is pregnant and child/unborn child to determine if the presentation is to be managed by PNMH teams or can be safely managed within an alternative community team.

The initial assessment will support all patients undergoing a full comprehensive assessment including the development of a safety summary and safety plan and determine the initial formulation of need with the patient.

The PNMH leadership team will review the outcome of assessments and validate decision as part of an MDT discussion within two working days. Those who are identified at assessment to have mental health needs that will likely outlast the perinatal period will be referred to the appropriate core community team for care co-ordination.

The outcome of the initial assessment and formulation of need could result in:

1. PNMH will take onto caseload for treatment and intervention
2. PNMH are required to transfer case to a core community team and will co-work with them
3. A community team is suited to manage the care with advice from PNMH team, if required
4. Discharge back to the GP and signposting to services outside of secondary mental health care, which may include IAPT and non-statutory services, if appropriate.

Every person accepted onto a PNMH caseload following initial assessment, will undergo an initial formulation of need and initial treatment within 60 days of referral to treatment. The formulation of need will be completed with the person and their key named individual/carer.

4.4.1 Understanding risk

All patients will undergo a risk assessment in line with the Trust Harm Minimisation (clinical risk assessment and management) Policy.

The purpose of any risk assessment is to support the service user in their recovery and support their wellbeing through minimising the risk of harm to themselves or others. The most effective risk assessments are those that are co-produced and reviewed with service users. We do this most effectively when we have taken time to build trusting and safe relationships both with service users and within teams. This enables each person to talk about how they see the balance between potential harm and potential recovery in each situation.

All service users will have their individual identified risks formulated into co-produced safety summary, safety plans and care plans. This will be documented on the Trust's care record system in accordance with Trust procedures and practice.

The agreed safety summary and safety plans will clearly identify which practitioner or service, relative or carer (where appropriate) is responsible for which agreed intervention, including how and when the intervention will be delivered and reviewed. There are also alerts on the electronic patient record system that highlight areas of risk.

4.5 Role of PNMH team and care co-ordination

For those patients that are assessed and enter onto the PNMH primary caseload, the PNMH team will hold:

- Responsibility for Lead Professional or care co-ordination
- Responsible clinician status, including prescribing responsibility.

The PNMH team will provide specialist interventions and treatment to the person/mother, their baby, partner, and family if required, until the end of the agreed perinatal period.

For those patients that **do not** enter onto the PNMH **primary** caseload, **but sit on a community caseload**:

- The community team holds responsibility for lead professional or care co-ordination
- Responsible clinician role including prescribing responsibility
- The PNMH team member offers co-working support.

The co-working role of the PNMH team with community teams will be to:

- Provide supervision and perinatal advice to staff who have perinatal cases on their caseload
- Offer medication advice during pregnancy, but not take on prescribing responsibility
- Lead the development of the mental health birth plan required at 28 weeks' gestation
- Provide specialist interventions that support the mother/person-baby relationship
- To support the provision of increased monitoring and intervention during high-risk periods e.g. post-birth, when there is a risk of developing psychosis or deterioration in mood
- If it is known that the child is to be removed at birth the perinatal team will support with medication, advice, and care planning in the antenatal period.

Care and treatment will be provided in accordance with the Trust Care Programme Approach and Standard Care Policy.

4.5.1 Joint working arrangements

The Royal College of Psychiatrist Standards state that PNMH teams will have clear joint working protocols to support people with:

- Disordered eating (Appendix 2)
- Substance misuse problems (Appendix 3)
- A learning disability (Appendix 4)
- Severe, diagnosed personality disorders, whereby advice and guidance can be accessed from local resources to contribute to PNMH MDT discussions and care planning.

PNMH teams will co-work with CAMHS to support young people/women in the perinatal period and offer the same perinatal interventions that would be offered to working-age people/women. This could be due to having an At-Risk Mental State (ARMS) rather than established diagnosis.

The Consultant responsibility shall be retained by CAMHS.

If a young person is newly referred into mental health services a joint assessment between CAMHS and perinatal team is necessary.

4.5.2 Transfer out of PNMH teams

The PNMH team will take a supportive approach to transition people out of specialist services (in line with local commissioning arrangements) and onto the right level of onward care and treatment. This transfer of care can include transition back to the GP or a core community team.

4.6 Involvement of the father or significant other in understanding need

There is also recognition that the mental health needs of *both* parents of the baby are being addressed. As a perinatal mental health service, we are addressing the needs of the mother/person and there is also a role in ensuring that the needs of the partner/father are supported accordingly, by ensuring they can access relevant services for their needs.

Where risk and safeguarding allows, the PNMH team will involve the partner/father or significant other at key stages of the perinatal journey. As a minimum this will include:

- At the point of assessment and acceptance into service
- On changes to clinical presentation
- On crisis presentation or admission to and discharge from hospital
- When they themselves have needs, to be able to support the patient.

Following initial assessment and the person being accepted into service; PNMH will also look to actively support and engage the father or significant other in line with the Trust's 'Carers Charter.'

4.7 Role of the PNMH MDTs

The role of specialist PNMH multi-disciplinary team is to have a shared and consistent approach to care and treatment, understand, and mitigate against risk, to improve the health outcomes for those in service. The role of the MDT is also to make efficient use of resources, enhancing job satisfaction for team members.

With other services (maternity services, Health Visitors, IAPT)

The PNMH service will also attend wider MDT meetings which focus on integrated working, improving outcomes for individuals and improving communications. The primary purpose is to support the joint planning of care, including high risk cases, and to support early identification of cases that may be suited to involvement with PNMH due to changing presentation and risk.

4.8 Treatment pathways for perinatal presentations

Specialist perinatal mental health teams are commissioned to ***increase access to evidence-based specialist care for women/people experiencing moderate/complex–severe mental health problems to include parent-infant, couple, co-parenting and family interventions***. The impact of mental illness upon the infant and partner/father is of central importance in perinatal work.

Whilst PNMH teams aim to meet the Long-Term Plan ambitions, each locality will meet this ambition at a different level depending on levels of investment.

Following assessment, a coproduced formulation is agreed with the person and their team, which will be summarised in a care plan that encompasses the mother/person, infant, and partner/father's needs.

Interventions are suggested in current guidance documents from Guidelines for Antenatal and Postnatal MH (NICE, 2014), The Royal College of Psychiatry and the British Psychological Society.

There is a growing evidence base for perinatal specific interventions (for example, Video Interactive Guidance and Circle of Security) which we will continue to invest in and develop new innovations within teams and evaluate.

It is acknowledged that there are challenges/risks for some people around the 12-month transition period and expansion to 24 months enables meaningful perinatal-specific interventions for people not identified during pregnancy or in the first postnatal year.

Where commissioned, women/people are expected to be referred in the 12 to 24 month part of the perinatal period where they have a need for evidence-based specialist community perinatal care, including new presentations.

5 Safeguarding children and adults

Safeguarding children and adults in order to protect them from harm is everyone's responsibility. PNMH teams will follow the Trust's policies and procedures that relate to

- Safeguarding Children Policy

- Safeguarding Children Supervision Procedure
- Safeguarding Adults Procedure
- Domestic Abuse Procedure.

6 Definitions

Term	Definition
Inpatient mother & baby unit	Commissioned by NHS England. They provide inpatient care for people with complex or severe mental health problems during the last trimester of pregnancy and the first 12 months after childbirth. A primary function of MBUs is to enable people to receive inpatient care while remaining with their baby.
Birth care planning	For cases open to core community teams – to attend Around Birth Care Planning meeting organised by Perinatal when a person/mum is between 28 and 32 weeks.
MDT	The multidisciplinary team (MDT) involves all professionals who work within the perinatal mental health team. These individuals work collectively to assess, collaborate, and deliver high quality care, each bringing skills from their respective discipline. This group holds responsibility for patient care and clinical decision making within the team.
Daily huddle	The huddle is a structured daily discission with all members of the team to support: • Concerns about patient safety/safeguarding • Shared clinical decision making • Shared oversight of caseload • Progression of patient care • Staff wellbeing • Key communications for the team.

7 Related documents

There are a number of related documents that support this operational policy. They are:

- Harm Minimisation (clinical risk assessment and management) Policy (2021)
- Crisis Operational Policy (2021)
- The care programme approach and standard care (2020)
- Safeguarding Children Policy (2019)
- Safeguarding Children Supervision Procedure (2018)
- Safeguarding Adults Procedure (2022)
- Domestic Abuse Procedure (2021).

8 How this policy will be implemented

The policy will be implemented through the following means:

- The Policy will be available on the Trust's website and InTouch.
- Line Managers will disseminate this policy to all Trust employees through a line management briefing.
- Each Team Manager will ensure that the MDT is aware of their role and shared decision-making.
- Each Team Manager will ensure that staff members understand the implications and requirements of this policy.
- Line Managers will disseminate this policy to all Trust employees through a line management briefing.

8.1 Training needs analysis

There is no specific or additional training requirement for this policy.

9 How the implementation of this policy will be monitored

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).
1	Four-week access standard – where it applies (Tees, North Yorkshire, York and Selby)	Monthly / via contracts via IIC / trust performance team	Monitored at service level into Commissioner and Care Group Governance Group
2	Two-week access standard - where it applies (Durham and Darlington)	Monthly / via contracts via IIC / trust performance team	Monitored at service level into Commissioner and Care Group Governance Group
3	Caseload oversight via caseload supervision	Monthly/ Caseload Supervision using IIC dashboard/ Clinical leadership set of the team	Monitored at service level into Care Group Governance Group

10 References

The Perinatal Mental Health Care Pathway. NHS E, 2018

Maternal Mental Health Alliance ((MMHA) website, March 2021)

NHS Long Term Plan. NHS, 2019

Common Mental Health Problems: Identification and Pathways to Care. NICE, 2011

RCPsych CCQI Standards for Community Perinatal Mental Health Services, 4th Edition. NICE, 2014

Guideline for Antenatal and Postnatal Mental Health. NICE, 2014

Five Year Forward View. NHS, 2014

British Psychological Society Guidance

Howard, L., Ryan, E., Trevillion, K., Anderson, F., Bick, D., Bye, A., Byford, S., O'Connor, S., Sands, P., Demilew, J., Milgrom, J. & Pickles, A. (2018) 'Accuracy of the Whooley Questions and the Edinburgh Postnatal Depression Scale in Identifying Depression and Other Mental Disorders in Early Pregnancy'. The British Journal of Psychiatry, 212 (1), 50-56.

11 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval:	21 September 2022	
Next review date:	20 July 2025	
This document replaces:	Version 2 Perinatal mental health operational policy (internal)	
This document was approved by:	Name of committee/group	Date
	Trust-wide perinatal mental health steering group	17 August 2022
This document was ratified by:	Name of committee/group	Date
	Management Group	21 September 2022
An equality analysis was completed on this document on:	05 May 2022	
Document type	Public	
FOI Clause (Private documents only)	N/A	

Change record

Version	Date	Amendment details	Status
v1	July 2019	New document. Published within perinatal services only.	Internal document - withdrawn
v2	20 July 2022	Significant re-write of the policy. Added to Trustwide portfolio.	Withdrawn

v2.1	21 September 2022	Minor wording change as a result of Royal College of Psychiatry accreditation process on Teesside:- 4.1.1 page 10 The outcome of all referrals to PNMH will be communicated to the referrer and person's GP 4.2.3 page 14 Following assessment out of hours, all cases requiring specialist perinatal care will be referred to the perinatal team the next working day. All perinatal cases assessed by Crisis Resolution and Home Treatment Teams out of hours will be discussed with the perinatal duty worker the next working day. 4.2.4 page 15 The outcome of the referral to PNMH and initial assessment will be communicated to the referrer and person's GP.	Ratified

Appendix 1 - Referral Guidance & Form

Referral Guidance & Form for TEWV Perinatal Mental Health Team

Please email this completed referral form to:

Tees: enter email address

Durham and Darlington: enter email address

North Yorkshire & York: enter email addresses

If you are unsure whether to refer, please call to discuss with our Duty Worker Mon-Fri: 9am-5pm:

Tees:

Durham & Darlington:

North Yorkshire & York:

If the referral meets our criteria, we will aim to assess them within 28 days

Please note we can only accept referrals for patients who are up to 12 months postnatal and meet at least one of the criteria below. PLEASE TICK or 'fill' box to indicate and send with COMPLETED referral form.
If you are unsure whether or not to refer, please call to discuss with our Duty Worker Mon-Fri: 9am-5pm

Pre-pregnancy Planning Advice – One Off Appointment		
One off appointment for current or previous diagnosis of bipolar disorder, schizophrenia, schizoaffective disorder or severe depression previously under the care of a mental health team and planning for pregnancy		Refer to Perinatal Mental Health Team - pre-conception advice required

Pregnancy		
Mild to moderate anxiety or depression		Refer to IAPT services / GP
Family history of bipolar disorder in first degree relative		In absence of personal illness, ensure close monitoring by maternity and GP
Drug or alcohol misuse in absence of primary mental health difficulties		Refer to Substance Misuse Services
Current self-harming behaviours or thoughts of suicide		Refer to Perinatal Mental Health Team
Previously under care of a Psychiatrist or secondary mental health team, for treatment of OCD, Eating Disorder, Depression, Anxiety or a Personality Disorder		Refer to Perinatal Mental Health Team
Previous inpatient mental health care / patients discharged from Mother & Baby Unit		Refer to Perinatal Mental Health Team
Severe depression or anxiety where first line interventions in primary care have been attempted and were unsuccessful		Refer to Perinatal Mental Health Team
Require specialist prescribing advice for psychiatric medications		Refer to Perinatal Mental Health Team
Pre-existing bipolar disorder, schizophrenia, post-partum psychosis or other psychotic illness		Refer to Perinatal Mental Health Team

Postpartum		
Mild to moderate depression or anxiety		Refer to GP or IAPT Services
Severe depression or anxiety where first line interventions in primary care have been attempted and were unsuccessful		Refer to Perinatal Mental Health Team
Post-partum psychosis or other psychotic illness		Refer to Perinatal Mental Health Team
Breastfeeding mothers who require specialist prescribing advice		Refer to Perinatal Mental Health Team
Maternal mental health impacting on mother and baby bonding		Refer to Perinatal Mental Health Team
Patients discharged from Mother and Baby Unit		Refer to Perinatal Mental Health Team
Current self-harming behaviours or thoughts of suicide		Refer to Perinatal Mental Health Team
For women requiring **urgent** assessment (within 24 hours) please refer to the Crisis Team (or Liaison Psychiatric Services if in an acute hospital).		

Referral Guidance & Form for TEWV Perinatal Mental Health Team

Please email this completed referral form to:

Tees: enter email address

Durham and Darlington: enter email address

North Yorkshire & York: enter email addresses

If you are unsure whether to refer, please call to discuss with our Duty Worker Mon-Fri: 9am-5pm:

Tees:

Durham & Darlington:

North Yorkshire & York:

Patient name:	Patient address (please confirm safe to visit at home):	Contact number (confirm consent to leave a message and texts):
NHS No:	DOB:	EDD:
GP name:	GP Address:	Contact No:
Named Midwife:	Named Midwife address:	Contact No:
Health Visitor name:	Health Visitor address:	Contact No:

Patient information: please complete all sections							
Please indicate booking hospital/home							
Patient consent for referral	Yes/No	Date consent obtained		Patient consent to obtain GP record	Yes/No	Date consent obtained	

Gravida:	Parity:	Expected date of delivery:	Gestation on referral:

Current Mental Health and reason for referral:

Current medication:	**Length of time taking current dose:**	**Known allergies:**

Current medical health and relevant past medical history:

Mental Health history:

Details of other children / past pregnancies:

Known Risks	**Comments:**

Risk to self (self-harm / suicide)	Yes / No	
Risk of self-neglect	Yes / No	
Risk to others, including children	Yes / No	
Safeguarding concerns	Yes / No	
Current and historic (include names of professionals involved)		
Vulnerability Learning Disability or adolescent		
Domestic abuse:		
Is it safe to visit patient at home alone	Yes / No	

Referrer Details	
Name:	Contact Telephone:
Address:	Mobile No:
	Email Address:
Role:	Signature:

Please email this completed referral form to:

Tees: enter email address

Durham and Darlington: enter email address

North Yorkshire & York: enter email addresses

If you are unsure whether to refer, please call to discuss with our duty worker Mon-Fri: 9am-5pm:

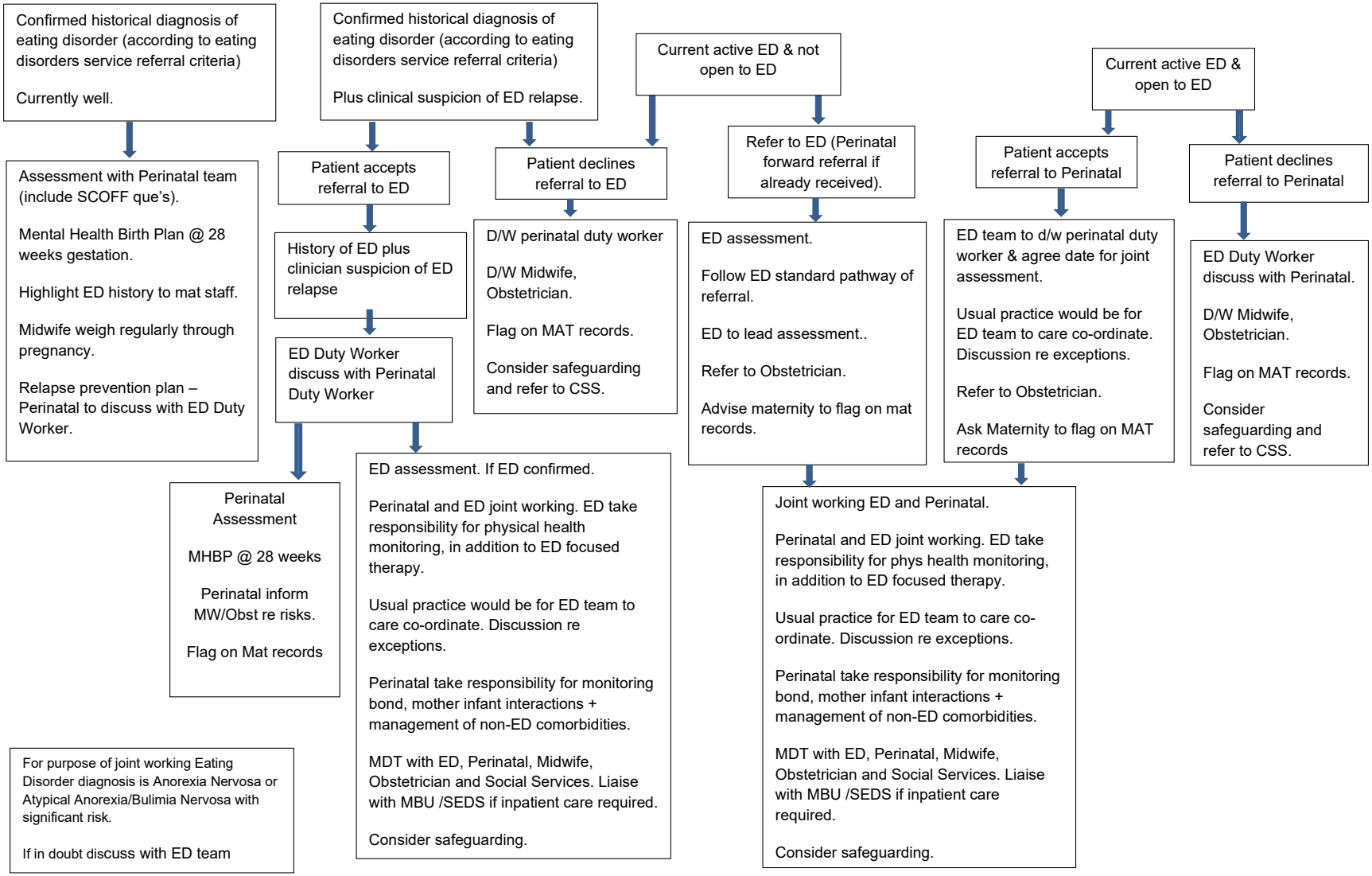
Tees:

Durham & Darlington:

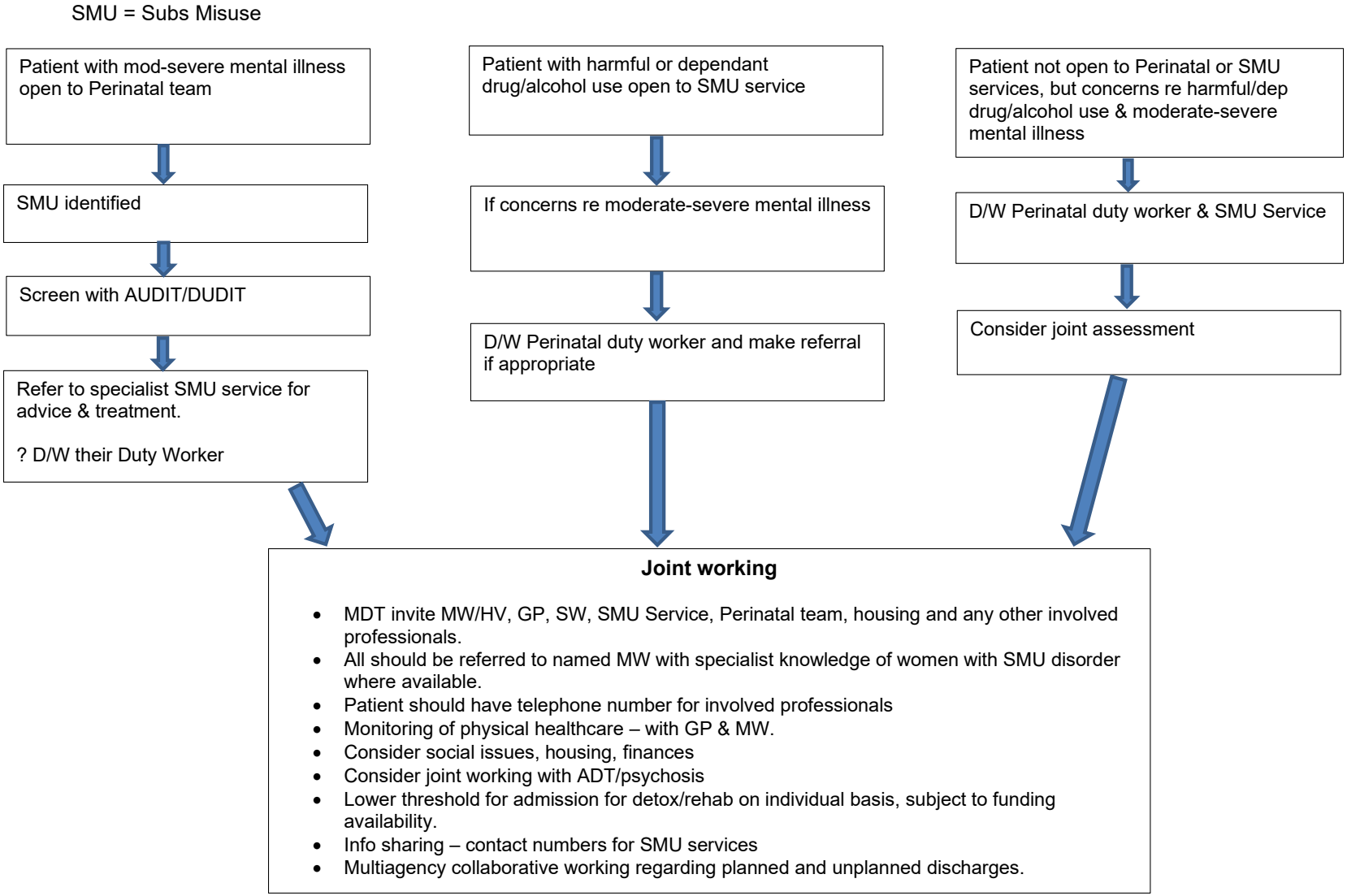
North Yorkshire & York:

If the referral meets our criteria, we will aim to assess them within 28 days.
Following assessment treatment will commence within two weeks if accepted onto caseload

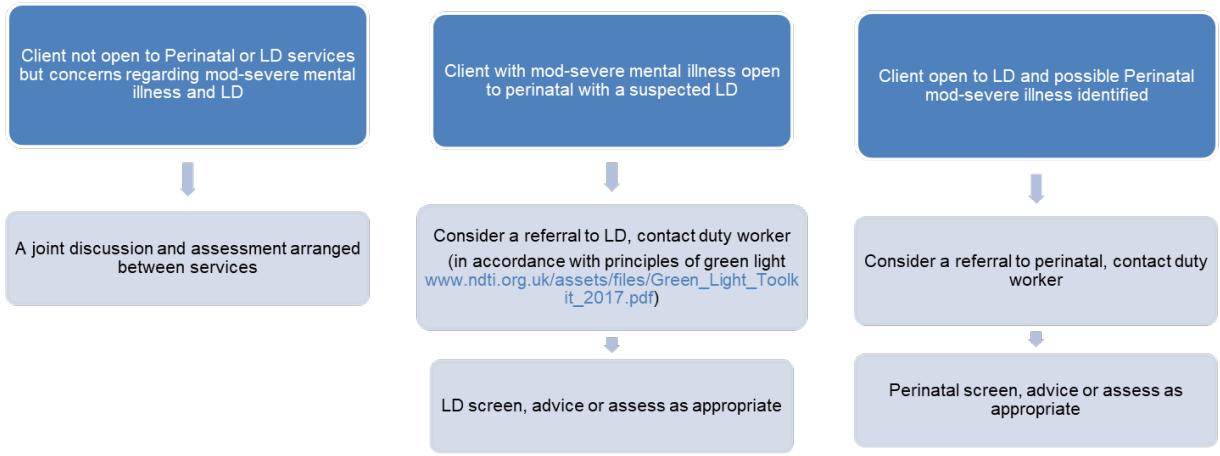
Appendix 2 - Perinatal & Eating Disorder joint working



Appendix 3 - Perinatal & Substance Misuse joint working



Appendix 4 - Perinatal & Learning Disabilities (LD) joint working



- At referral the lead professional /care coordinator must be agreed if referred to both teams with a discussion regarding the primary need and client choice.
- In all MDT meetings an invitation for all professionals involved in the care– Midwife, Health Visitor, Perinatal Team, LD, Social services, Housing and any other agencies.
- Patients should have telephone number for all involved professionals in safety plan.
- Father/ Partner /and or Carer to be involved in safety plan and care plan when we have consent to do so
- Monitoring of physical healthcare –this lies with GP and Midwife – any concerns to be directed to them.
- Consider social issues, housing and finances.
- Consider appropriate lines of communication if low literacy or accessibility barriers.
- Mental health / LD Birth Plan to be jointly developed between both services.
- PMHT and LD teams do not offer parenting assessments – refer to social services.

Appendix 5 - Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Are people involved in the development identified?	Yes	
	Has relevant expertise has been sought/used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
	Have any related documents or documents that are impacted by this change been identified and updated?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Training**		
	Have training needs been considered?	Yes	
	Are training needs included in the document?	N/A	
7.	**Implementation and monitoring**		

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
	Does the document identify how it will be implemented and monitored?	Yes	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Yes	January 2022
	Have Equality and Diversity reviewed and approved the equality analysis?	Yes	January 2022
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	Trustwide perinatal steering group
10.	**Publication**		
	Has the policy been reviewed for harm?	Yes	
	Does the document identify whether it is private or public?	Yes	Public
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	n/a	

Appendix 6 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Trust-wide perinatal mental health
Title	Perinatal mental health operational policy
Type	Policy
Geographical area covered	Trust-wide
Aims and objectives	The aim of perinatal mental health teams is to provide a service for women/people of all ages regardless of gender identity, registered with GPs in the TEWV footprint, who are pregnant or up to one year postpartum (and up to two years' postnatal where commissioned) and will work with people with current moderate to severe mental illness, as well as those who are at risk of becoming unwell due to a history of severe mental health problems in the past. The objective is to describe: • the operational standards for the perinatal mental health teams • the role of assessment and treatment of people who are pregnant and are currently suffering severe and enduring mental problems or who are at risk of relapse in the perinatal teams • the role of assessment and treatment of people who are pregnant and are currently suffering severe and enduring mental illness or who are at risk of relapse in core community teams and IAPT (improving access to psychological therapies) • The interventional perinatal period from conception to the end of the baby's first year or second year (if commissioned to do so).
Start date of Equality Analysis Screening	July 2021
End date of Equality Analysis Screening	05 May 2022

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	This policy benefits the organisation, clinical staff, service users and their carer's who present and require assessment, intervention and treatments for perinatal mental health problems.
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men, women and gender neutral etc.) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Veterans** (includes serving armed forces personnel, reservists, veterans and their families **NO**
Describe any negative impacts	n/a
Describe any positive impacts	This policy relates to all people who child-bear which includes people who identify themselves as gender-neutral or male, although a number of the key reference documents that underpin this policy still associate with the patient group as women, mothers and fathers. The positive impact that this policy brings is a consistent response regardless of where people live in the footprint of the Trust. It provides clarity regarding those who require the complete oversight by perinatal mental health teams and those that can be safely managed within community teams.

	Needs of the patient will be considered on an individual basis and adjusted to meet their needs. The policy articulates the service offer and expectations for patients.

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	Yes, see references section.
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes
If you answered Yes above, describe the engagement and involvement that has taken place	This policy has been developed in partnership with the Trust-wide Perinatal Steering Group which includes people with lived experience, our partners from maternity services, 0-19 services who connect us with Health Visitors and Safeguarding colleagues. There has also been engagement with the Trust Rainbow staff network which includes LGBTQ+ staff network, as well as seeking the views of the Trust LGBTQ+ working party, who have informed the use of language in this policy.
If you answered No above, describe future plans that you may have to engage and involve people from different groups	n/a

Section 4	**Training needs**
As part of this equality analysis have any training needs/service needs been identified?	No - No specific training required
Describe any training needs for Trust staff	No
Describe any training needs for patients	No

Describe any training needs for contractors or other outside agencies	No

Check the information you have provided and ensure additional evidence can be provided if asked