Report 2

Reducing Inequalities in Perinatal Mental Health Care

Care pathways for the identification and response to perinatal mental health concerns - a description of key similarities and differences across the West Yorkshire region

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This report is the second of five reports produced as a programme of research to understand the inequalities in identification and treatment of perinatal mental health in order to develop recommendations and adaptations to systems to address these inequalities. This research was funded by Wakefield CCGs on behalf of West Yorkshire Health and Care Partnership, in collaboration with the Perinatal Mental Health Steering Group.

Approved by:

Name	Version no.	Date
Josie Dickerson	1.0	22.04.22

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Executive Summary

Key Objectives

The aim of this report was to identify and describe the perinatal mental health (PMH) pathways within West Yorkshire Health and Care Partnership (WYHCP) NHS services. We obtained guidance documentation for five midwifery and two health visiting (HV) services in West Yorkshire and compared the PMH pathways across the region. We explored variation in structures and processes that may have resulted in or exacerbated inequalities of identification and access for women.

The PMH pathway is the process by which women move through NHS services where PMH needs are assessed and identified during points of routine contact with midwifery and health visiting services, and referrals are made as appropriate, depending on the outcome of an assessment.

Key findings

The focus of the pathways is depression, postpartum psychosis and, to a lesser extent, anxiety, which could mean poorer identification and access to PMH services by women with other PMH conditions, such as anxiety disorders, eating disorders, tokophobia, and birth-related post-traumatic stress disorder.

There are inconsistent recommendations for assessment measures. The nine item Patient Health Questionnaire (PHQ-9) and seven-item Generalized Anxiety Disorder scale (GAD-7) are the most widely recommended tools for further PMH assessment but there is some inconsistency, with some Trusts recommending use of the Edinburgh Postnatal Depression Scale (EPDS) or the Hospital Anxiety and Depression Scale (HADS) (which is not recommended by NICE). There is no mention of using translated versions of tools in any guidelines. There are inconsistent thresholds and pathways for the assessment tools. For example, the Leeds (multiagency – midwifery and health visiting; HV) guidance has a lower threshold than in the Wakefield (HV) (Bradford District Care Foundation NHS Trust) guidance, whilst Calderdale Hospitals NHS Foundation Trust (CHFT) do not provide any thresholds. This risks inequalities in access to support by postcode.

All the guidance places an importance on clinical judgement in determining the classification of women's level of PMH need, particularly in assessing mild-moderate depression and anxiety and determining the appropriate pathway (which service to refer to etc.). Where there are no or wider thresholds for assessment tools, there may be greater emphasis on clinical judgement in decision-making.

In Leeds, Bradford & Calderdale there are single point of access (SPA) referral pathways for PMH. In MYHT, there are SPA services for Wakefield and Dewsbury but not across the whole Trust. However, the organisations differ on the level of need at which the SPA referral is triggered: for CHFT, SPA is if the woman's symptoms 'significantly interfere with personal and social functioning'; in Bradford the SPA is for mild-moderate/severe; and in Leeds SPA is for moderate/severe PMH. Referrals to other services and voluntary and charitable sector (VCS) in midwifery pathways vary across areas, as do their thresholds for referrals.

There is very little mention of considering or responding to the mental health needs of fathers, other co-parents and partners. Leeds health visiting service is the only organisation to offer MH assessment and (up to three) listening visits to both parents in the year after their child's birth.

Key recommendations

Guidance and pathways for PMH care across West Yorkshire are inconsistent and may result in differences in the identification of PMH and access to support depending on where in West Yorkshire women live. A review of the guidance (and a look at consistency or differences between them and practices) could be beneficial for all organisations in the region. A shared guidance across organisations, like the West Yorkshire and Harrogate Local Maternity System guidance that is currently under development (and has been reviewed in this report with reference to our findings), would ensure consistency if it includes our recommendations for consistency in:

1. Guidance to practitioners in midwifery and HV services
2. Which tools to use and what thresholds mean (what levels of need they indicate and the corresponding referral pathways)
3. Approaches to depression and anxiety as well as to other PMH conditions (as conditions like eating disorders and post-traumatic stress disorder are often omitted from PMH guidelines)
4. Approaches to make services inclusive
5. What services are available and how they work together
6. The availability of specialist PMH professionals
7. How to identify and support MH issues in fathers, other co-parents and partners and families during the perinatal period

Abbreviations and acronyms

AFT: Airedale NHS Foundation Trust
Ax.: Assessment
BDCFT: Bradford District Care NHS Foundation Trust
BTHFT: Bradford Teaching Hospitals NHS Foundation Trust
CAMHS: Child and Adolescent Mental Health Service
CHFT: Calderdale and Huddersfield NHS Foundation Trust
DIQ: Depression Identification Questions - two questions for identifying depression, formally known as the Whooley questions.
EPDS: Edinburgh Postnatal Depression Scale (assessment of depression although contains an anxiety subscale)
ESS-MMH pathway: Early Start Services Maternal Mental Health Pathway
GAD-7: Seven item Generalized Anxiety Disorder scale (assessment of anxiety)
GAD-2+1: Two item Generalized Anxiety Disorder scale (assessment of anxiety)
HADS: Hospital Anxiety and Depression Scale (assessment of depression and anxiety)
HDFT: Harrogate and District NHS Foundation Trust
HCP: Healthcare professional
Hist.: History
HV: Health visiting service
LCHT: Leeds Community Healthcare NHS Trust
Leeds guidance: The multiagency guidance document for Leeds midwifery and health visiting services
LTHFT: Leeds Teaching Hospitals NHS Foundation Trust
LYPFT: Leeds and York Partnership NHS Foundation Trust
MH: Mental Health
MYHT: Mid Yorkshire Hospitals NHS Trust
Neg.: Negative
NICE: National Institute for Health and Care Excellence
PHQ-9: Nine item Patient Health Questionnaire (assessment of depression)
PMH: Perinatal mental health
Pos.: Positive
SMABS: Specialist Mother and Baby Mental Health Service hosted by BDCFT
SPA: single point of access
SWYPFT: South West Yorkshire Partnership NHS Foundation Trust
Urg.: Urgent
VCS: voluntary and community sector
WYH LMS: West Yorkshire and Harrogate Local Maternity System
WYHCP: West Yorkshire Health and Care Partnership

1. Background

A recent systematic review *Inequalities in identification and management of perinatal mental health problems: A review of academic and local reports* (Report 1) undertaken as part of this project identified that, nationally, most women are asked about their mental health (MH) during the perinatal period but there is variation in detection within particular groups of women, including women from minority ethnic groups, women with little or no English and women with socioeconomic disadvantage (Prady et al., 2021). This review suggested therefore that some women experience greater challenges in the identification of, and access to treatment, for perinatal mental health (PMH) concerns.

The aim of this report was to identify and describe the PMH pathways within West Yorkshire Health and Care Partnership (WYHCP) NHS services. By comparing the pathways across the region, we explored variation in structures and processes that may have resulted in or exacerbated inequalities of identification and access for women. The LMS Maternity Perinatal Services Scoping Report (Jan-Mar 2020) provided a foundation for the work in this report.

Our research was conducted in the same period that internal reviews of PMH services were being conducted in West Yorkshire. We were able to access draft versions of the West Yorkshire & Harrogate Local Maternity System (LMS) Perinatal Mental Health Guideline for Maternity Services and West Yorkshire and Harrogate LMS Maternity Perinatal Services Scoping Report (for Jan-Mar 2020). In our report, we also discuss our findings and recommendations with reference to these complementary reports.

2. Setting/location

In the West Yorkshire Health and Care Partnership (WYHCP) there are three specialist perinatal mental health (PMH) services that provide support for women in the perinatal period: the Bradford District Care NHS Foundation Trust (BDCFT) Specialist Mother and Baby Mental Health Service (SMABS), the Leeds and York Partnership NHS Foundation Trust (LYPFT) Leeds PMH Service, and the South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) PMH Team. The geographical areas covered by WYHCP and within the scope of our research are: Bradford District and Craven, Calderdale, Kirklees, Leeds and Wakefield (Figure 1 shows all the midwifery and HV organisations in this region). Harrogate is not included within the remit of the WYCHP so was not considered in this report. In this report, we explore similarities and differences in the PMH pathways for these areas.

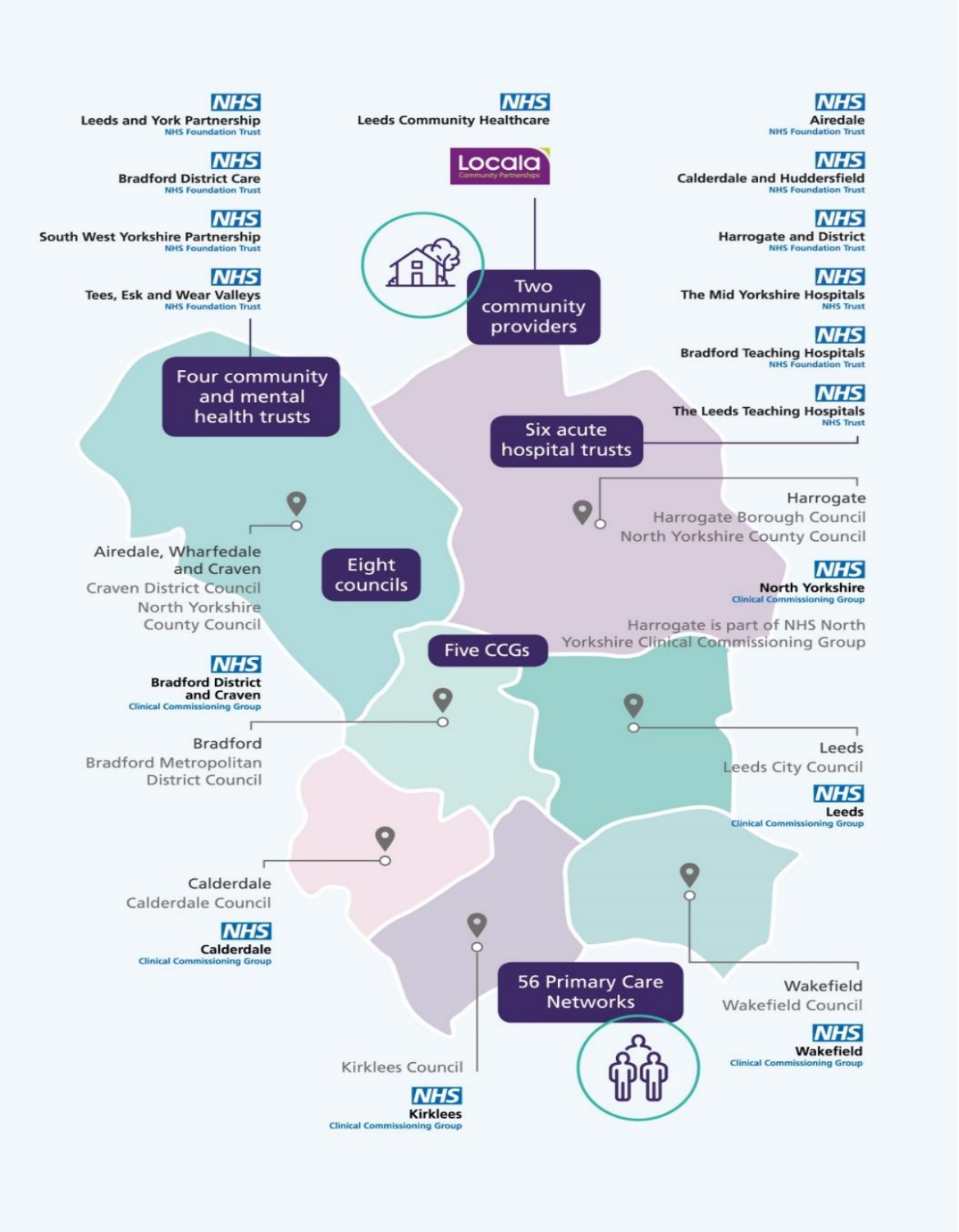

Figure 1. Map of midwifery and HV organisations in the WYHCP
Source: https://www.wypartnership.co.uk/publications/our-five-year-plan/five-year-plan-introduction

2.1 National Guidance for the PMH Pathway

'PMH pathway' is the term used to describe the prescribed process by which women move through NHS services where PMH needs are assessed and identified during points of routine contact with midwifery and health visiting (HV) services, and referrals are made as appropriate, depending on the

outcome of an assessment. Urgent care and voluntary and community sector (VCS) services are indicated, but not discussed in detail in this report.

For reference, we provide a summary of the national guidance on the PMH pathway issued by NICE (National Institute for Health and Care Excellence (NICE), 2020).

Routine care should comprise:

- Seven to ten antenatal and two postnatal appointments with a midwife or doctor planned by the midwifery service
- Four appointments should be offered by the health visiting service – one antenatally and three postnatally: 1-2 weeks; 6-8 weeks; 9-12m
- One visit with the GP at 6-8 weeks after birth

NICE guidance on the identification and assessment of PMH:

a. There is a need for the identification, assessment and treatment of specific PMH conditions and MH conditions experienced during the perinatal period, such as postnatal depression, postpartum psychosis, anxiety and eating disorders, and tokophobia.
b. Clinicians should <u>consider</u> using MH identification tools at a woman's first contact with primary care, at the midwifery booking appointment and during the early postnatal period (note we have underlined words in this report to emphasise where/how they differ).
c. Identification should include both prediction and detection elements, i.e. asking about personal and family history of MH needs and assessment using the Depression Identification Questions (DIQ; formally known as the Whooley questions) and validated anxiety and depression assessment tools.
d. Assessment: the PHQ-9, GAD-7 and Edinburgh Postnatal Depression Scale (EPDS) are recommended as tools for further assessment. The terms mild, moderate and severe depression and mental illness are used but diagnostic indicators or assessment thresholds for the different levels (i.e. mild to severe) are not defined and there is no guidance on which services should be available, to which women, and at which thresholds.
e. PMH assessment tools scoring guidance (Table 1)

Table 1. PMH assessment tools recommended in clinical guideline 192 with the thresholds specified in the tool manuals

Level of severity[1]	**PHQ-9 thresholds**	**GAD-7 thresholds**	**EPDS thresholds**
Mild	5-9	5-9	
Moderate/Major	10-14	10-14	≥13
Severe	≥15	≥15	

[1] The levels of severity identified by each measure (not in the NICE guidance – see point D above) are not all equivalent: the levels represented by the PHQ-9 and GAD-7 thresholds are: level 1, mild; level 2, moderate; level 3, severe symptoms of depression (Kroenke, Spitzer and Williams, 2001; Spitzer et al., 2006). The EPDS has a single threshold representing probable major depression, although different thresholds have been recommended for antenatal (≥15) versus postnatal (≥13) identification (Cox, Holden and Sagovsky, 1987).

3. Method

We first developed a template for visualisation of the PMH pathway, then adapted the template to produce a tailored diagram for each organisation. We aimed to provide initial insight into procedures established in midwifery and HV services, understand the levels of PMH defined in each organisation, and map out the processes for identification and response to different levels at universal contact points. To do this, we reviewed guidance documentation for each of the midwifery and HV services in West Yorkshire; we obtained documentation originally collated to inform the LMS Maternity Perinatal Services Scoping Report (For Period January to March 2020, Draft May 2020) and supplemented this where possible (Appendix 1 - details of the source documents). Publication dates varied and ranged from 2015-2020.

A number of organisations were in the process of reconsidering pathways and implementing changes, while also operating differently due to the COVID-19 pandemic. Pathways outlined here refer to services as they were before changes were implemented, and while operating in the pre-pandemic context.

Through the same process, we also aimed to create comprehensive charts of all statutory (primary and secondary care), specialist, and VCS services available to support women with PMH needs in each area. We hoped to illustrate the number and variety of services available to women, the level of need for which each service was appropriate and the relationships between services, highlighting referral pathways and joint working where multidisciplinary team or interagency collaboration is common. The guidance documents provided limited insight into eligibility for each service, and little information on the relationships between services. Accordingly, most of the information presented was gained from independent research and discussions with key stakeholders. Our findings reflect inconsistencies within and between the print guidance for midwifery and HV services in West Yorkshire. We cannot comment on the extent to which the guidance and clinical practice may differ.

3.1 Template

We constructed a template (Figure 2) for a visualised PMH pathway that was used as a foundation to build from for each midwifery and HV service. The template was informed by:

- The 'Key priorities for implementation' outlined in the NICE document *Antenatal and postnatal mental health: clinical management and service guidance* (National Institute for Health and Care Excellence (NICE), 2020);
- Tool-specific scoring guidance issued for the GAD-7 and PHQ-9 (Spitzer et al., 2006; Kroenke et al., 2001), which were found to be the most commonly used assessments in this region and are recommended for use in the NICE guidance;
- The stepped care model for the treatment of PMH needs, chiefly outlined in the *NICE Guidance on clinical management and service guidance for antenatal and postnatal mental health* ((National Institute for Health and Care Excellence, 2011; National Institute for Health and Care Excellence (NICE), 2020);
- Red flags for the identification of severe/critical PMH needs (National Institute for Health and Care Excellence, 2011).

Specifically, the inclusion of assessment tools is directly as advised in the NICE clinical guidance. The levels are derived from the guidance for the assessment tools, and the descriptive labels for each level and treatment responses are taken from the NICE stepped care model.

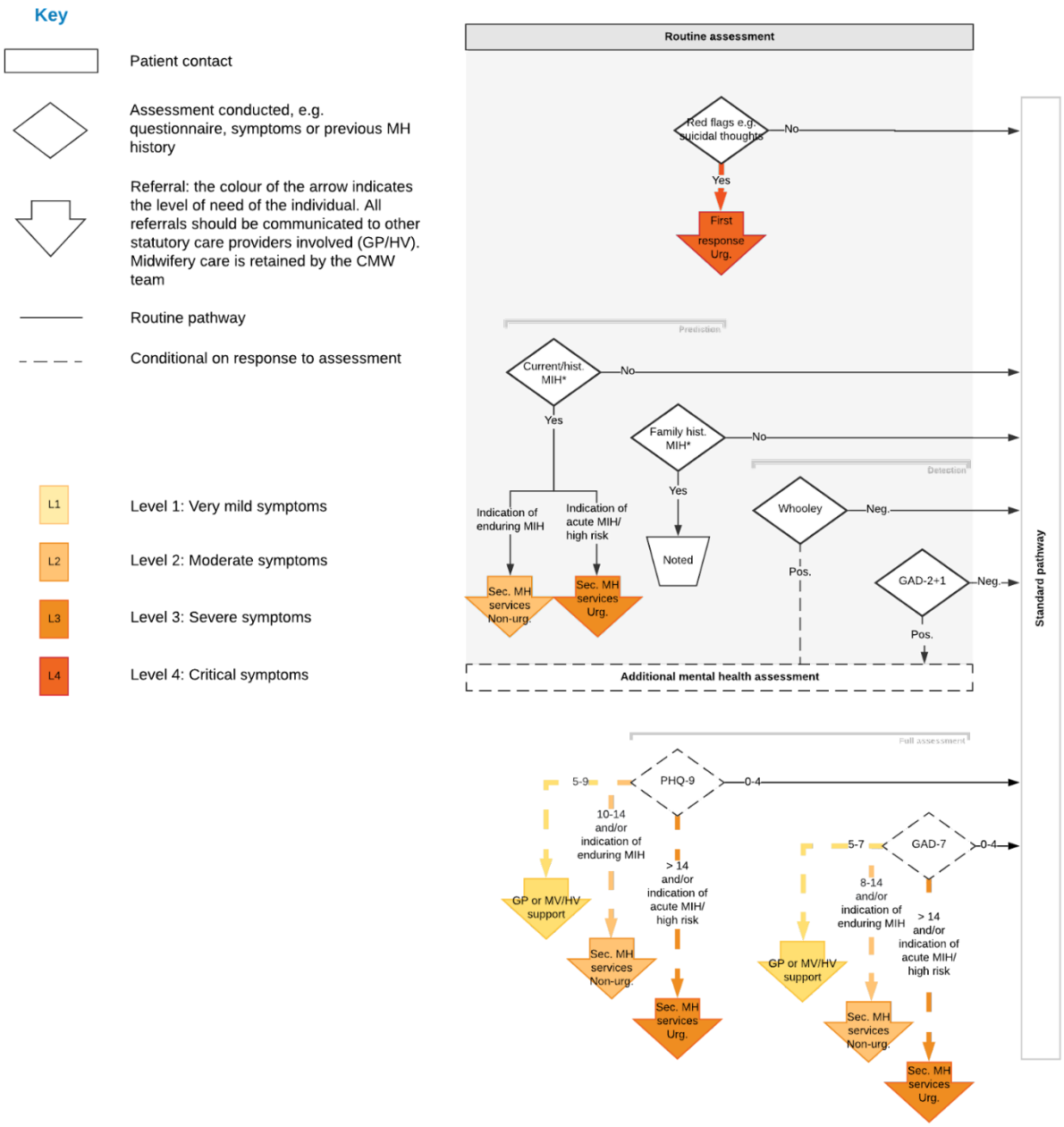

Figure 2. Template for visualisation of the pathway for identification of PMH concerns and referral to treatment and support.

The figure illustrates the key components of the NICE recommended approach for identifying a woman's level of PMH need at each contact, conducted by both midwifery and HV services during the perinatal period. These processes should be repeated multiple times by both services. It highlights when further assessment or specialist referral may be expected, for example if a woman is identified as having previous or current, known MH needs, or is identified as having emerging MH needs with use of detection tools or additional assessments.

For this report, we have attempted to categorise PMH concerns into four distinct levels of PMH symptoms with corresponding pathways for treatment and support. Levels of PMH symptoms defined in the template were based around the categories associated with PHQ-9 and GAD-7 scores (described in the manuals – see Table 1). Further to the levels in the assessment tool manuals, we

have included Level 4 - critical, as distinct from severe symptoms to reflect situations in practice where healthcare professionals (HCP) should respond urgently to MH needs, frequently described as red flag scenarios or symptoms. The corresponding treatment and support pathways map onto the NICE guidance for stepped or tiered care models for PMH treatment:

- Level 1: mild symptoms - additional monitoring required, primary care support (i.e. via GP and HVs)
- Level 2: moderate symptoms, evidence of functional impairment - non-urgent referral to support services: primary care support with additional clinical psychological support options (i.e. GP, HVs, community and non-urgent PMH services)
- Level 3: severe symptoms (including severe depression, psychosis, bipolar disorder), evidence of functional impairment - support from urgent PMH and other MH services (including crisis teams where necessary)
- Level 4: critical symptoms, marked functional impairment and/or high risk to self or others indicated by red flags (recent significant change in mental state or emergence of new symptoms; new thoughts or acts of violent self-harm; new and persistent expressions of incompetency as a mother or estrangement from the infant) and/or other (unknown) clinical decision-making) – urgent referral to support teams: crisis teams, PMH and MH inpatient care

4. Findings

4.1 Identification of poor PMH

Across almost all organisations, the service guidance is stronger than the NICE recommendation as it states that the clinician should (NICE = 'consider') use the prediction and detection measures with women at the booking appointment to determine whether there are any PMH concerns. For all subsequent contacts, there is some variation in the guidance on whether to screen using the DIQ and GAD-2 (i.e. initial assessment) or as part of a general conversation about how the woman is feeling). Verbatim guidance on when the PMH identification measures should be performed in each of the nine organisations/areas is provided in Appendix 2, in summary:

- Two say the DIQ should be asked (LTHFT HV and BDCFT HV (Wakefield));
- Three say to consider using the DIQ (AFT & BTHFT, CHFT midwifery and Locala HV (Calderdale and Kirklees));
- One seems to require identification of poor PMH via conversation rather than use of the DIQ: 'women should be asked how they are feeling at every routine appointment. This is so that they can talk to their healthcare professional about any concerns they have, and any problems can be identified' (MYHT midwifery);
- One provides the DIQ and GAD-2 under the heading 'NICE recommended screening for health professions' with no additional guidance on when it should be used (BDCFT HV, Bradford).

The NICE guidance also states that clinicians should consider using the GAD-2 both at the booking and subsequent contacts as a measure of anxiety.

Every organisation except MYHT requires use of the GAD-2 at the booking appointment, but neither Leeds (multiagency) nor BDCFT HV (Wakefield or Leeds) mention measures for identifying anxiety (e.g. GAD-7) or use of the GAD-2 thereafter.

4.2 Assessment and classification of PMH needs

The use of assessment tools was restricted to the identification of perinatal depression and anxiety, consistent with national guidance.

Every organisation recommended use of the PHQ-9 and all but MYHT recommended use of the GAD-7. MYHT and CHFT also recommended the EPDS, suggesting this or the PHQ-9 be used as part of the full assessment and ongoing monitoring. MYHT were the only organisation to recommend use of a tool not recommended in the current NICE guidance: the Hospital Anxiety and Depression Scale (HADS) as part of a full PMH assessment (Zigmond and Snaith, 1983). They did not specify when/if the HADS should be used instead of the PHQ-9, GAD-7 or EPDS. This is likely an artefact, reflecting the HADS as a recommended assessment tool in the 2007 NICE guidance: *Antenatal and postnatal mental health. Clinical management and service guidance.*

The guidance for the thresholds of symptom severity of the assessment tools (i.e. mild/moderate/severe depression) varied markedly between organisations, with some deviating from the threshold guidance specified in the assessment tool manuals, and others not specifying a threshold. For example, CHFT has no threshold guidance for the PHQ-9 or GAD-7. Both the maternity and HV guidance for Leeds and for BDCFT, use different definitions of the scoring of PHQ-9 and GAD-7 than in the assessment tool manuals. The other midwifery Trusts (AFT, BTHFT and LYPFT) and the HV guidance for Calderdale and Kirklees (Locala) provide thresholds for the PHQ-9 and GAD-7 that match the assessment manuals. Table 2 illustrates the variability in the assessment tools recommended and the thresholds specified across organisations.

Table 2. Organisation threshold guidance for levels of PMH need by assessment measure

Organisation	Level of severity[1]	Terminology for different levels indicated in guidance	PHQ-9 thresholds	GAD-7 thresholds	EPDS thresholds	HADS thresholds
Guidance issued with measure	1		5-9	5-9	N/A	8-10
	2		10-14	10-14	≥13*	≥11
	3		≥15	≥15		
AFT & BTHFT midwifery	1	Very mild	5-9	5-9	N/A[2]	N/A
	2	Mild-moderate, severe and enduring or history of severe mental illness	10-14	8-14		
	3	Acute mental illness and/or immediate/high risk of harm	≥15	≥15		
CHFT midwifery	1	Symptoms of depression and/or anxiety that do not meet the diagnostic criteria but significantly interfere with personal and social functioning	Not provided[3]	Not provided	N/A	N/A
	2	Mild/moderate/stable severe mental illness			≥11	
	3	Moderate/severe				
Leeds midwifery & Health Visiting (multiagency collaboration)	1	Adjustment and emotional health issues	0-11	0-11	N/A	N/A
	2	Risk of/or mild mental illness				
	3	Risk of/or moderate mental illness	≥12	≥12		
MYHT midwifery	1	Low/mild symptoms/risk of postnatal depression	0-9	N/A	Not provided	Not provided
	2	Mild to moderate/persistent mild/moderate depression	10-14			
	3	Severe/high risk/risk of/current severe mental illness	≥15			
BDCFT Health Visiting (Bradford)	1	Very mild	5-9	5-7	N/A	N/A
	2	Mild-moderate, severe and enduring or history of severe mental illness	Not provided	Not provided		
	3	Acute mental illness and/or immediate/high risk of harm				

Organisation	Level of severity[1]	Terminology for different levels indicated in guidance	PHQ-9 thresholds	GAD-7 thresholds	EPDS thresholds	HADS thresholds
BDCFT Health Visiting (Wakefield)	1	Mild-moderate	0-14/4-14[4]	0-10	N/A	N/A
	2	Moderate-severe and enduring or history of severe mental illness	15-27	11-21		
	3					
LCHT (Leeds) Health Visiting	1	Minimal/mild depression[5]	1-10	0-9	N/A	N/A
	2	Moderate/moderately severe	9-19	8-15[6]		
	3	Severe	20-27	15-21		
Locala Calderdale Health Visiting	1	Mild anxiety and/or depression	0-10	0-10	N/A	N/A
	2	Moderate anxiety and/or depression	11-15	11-15		
	3	Moderately severe or severe depression and/or anxiety	≥16	≥16		
Locala Kirklees Health Visiting	1	Mild anxiety and/or depression	0-10	0-10	N/A	N/A
	2	Moderate anxiety and/or depression	11-15	11-15		
	3	Moderately severe or severe depression and/or anxiety	≥16	≥16		

[1] The levels of severity identified by each measure are not equivalent. Levels represented by the PHQ-9 and GAD-7 thresholds are: level 1, mild; level 2, moderate; level 3, severe symptoms of depression. *The EPDS has a single threshold representing probable major depression (≥13) which associates most closely with levels 2 or 3 (Cox et al., 1987). The tool developers also stated that 'a threshold of 9/10 might be appropriate if the scale was considered for routine use by primary care workers' and may be why the CHFT guidance uses a ≥11 threshold score (no rationale is provided in the CHFT guidance document). It must also be noted that there is significant debate over the cut point used in the EPDS, and whether this should vary for antenatal (≥15) and postnatal (≥13) assessment, and for women with little or no English(Matthey et al., 2006). The HADS scores represent subclinical (0-7), borderline and clinical anxiety and depression, which we suggest represent levels 1 and 2. Different questions in the measure relate to anxiety or depression, thus providing a diagnosis for one or both conditions.

[2] N/A - Assessment measure not stated in the guidance

[3] Not provided means that the assessment measure has been recommended but no thresholds have been specified.

[4] Both thresholds for mild-moderate depression using the PHQ-9 are presented in the guideline.

[5] The LCHT guidance contains five levels for the PHQ-9 and four for the GAD-7, which we have collapsed in the table. The levels as presented in the guidance are: PHQ-9 scores 1-4 minimal depression, 5-9 mild depression, 10-14 moderate depression, 15-19 moderately severe depression, 20-27 severe depression; GAD-7 scores 0-5 mild, 6-10 moderate, 11-15 moderately severe, 15-21 severe anxiety. However, these thresholds do not map on the thresholds for referral (as shown in Figure 3).

[6] A GAD-7 score of 15 is presented in the guidance as the upper threshold for moderately-severe anxiety and the lower threshold for severe anxiety.

We note that none of the guidance documents specify the use of validated interpreted versions of the assessment tools for women who require an interpreter

4.2.1 Clinical judgement versus clinical assessment

A common theme in discussion with stakeholders and in review of their guidance was the importance placed on clinical judgement. CHFT states that assessment scores 'should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis.' The use of clinical judgement was considered especially important at the highest and lowest extremes of PMH need, as reflected by the inclusion of PHQ-9 zero scores as level 1 severity in the MYHT and Leeds (multiagency) pathways. Clinical judgement is also required to determine the PMH need level and referral route for women with borderline scores as there is overlap in the scores between levels (see Table 2).

CHFT elaborate on the importance of clinical judgement:

> 'it is crucial; however, that clinical judgement should also be taken into account. Even if a woman does not answer 'yes' to any of the risk factors or scores low on the chosen rating scale, the practitioner should consider her emotional state during each contact, taking into account her physical appearance, behaviour, and any thoughts or feelings expressed that may indicate mental health concerns or risk to herself or others.'

Similarly, the guidance for the AFT/BTHFT midwifery services contains a statement on justified variation in the implementation of the guidance due to clinical judgement:

> '[the Trust] fully recognises that the obligation to implement guidance should not override any individual clinician to practice in a particular way if that variation can be fully justified in accordance with Bolam Principles. Such variation in clinical practice might be both reasonable and justified at an individual patient level in line with best professional judgement.'

We note that clinical judgement is also extremely important in providing a holistic approach to the identification and assessment of PMH needs and their impact on the infant. For example, the Leeds multiagency guidance identifies that a full PMH assessment includes:

> 'exploration of severity, frequency and duration of symptoms, past history of mental health difficulties, family history of mental health difficulties, impact on functioning, responsiveness to the baby's cues/interacting with the baby and social situation, will add to the assessment, including consideration of serious suicide risk.'

Whilst not referring directly to clinical judgement, the LCFT HV guidance indicates that the assessment measures and resultant scores are intended to inform a conversation around the impact of PMH on functioning to determine the woman's level of PMH need:

> 'Conducting a clinical interview using the screening tools to put into context and determine the SEVERITY, FREQUENCY and DURATION of the symptoms (mild/moderate/severe – how often, for how long) e.g. Past History of Mental Health difficulties; Family History of Mental Health Difficulties; Impact on functioning, are they coping with everyday tasks? Are they responsive to the baby's cues/interacting with the baby? What is the impact on the baby?;

> What support have they got? How isolated are they?; Talk about risk and make particular attention to question 9 on the PHQ – 9. Notice the cut offs in the scoring system to inform a dialogue about impact and check out that it fits with their experience. It may be helpful to assess Impact on functioning by considering: Mild depression has some impact on your daily life; Moderate depression has a significant impact on your daily life; Severe depression makes it almost impossible to get through daily life.'

This guidance also advises that the duration of the current disturbance be considered and whether they are receiving any treatment for it.

4.3 Referral Pathways

We describe the identification of PMH needs and the referral pathways. We have provided the core components of the pathway for each organisation as a single instance with acknowledgment that all services indicated that these should be repeated at each contact for best practice and note that some women may be offered more contacts than others where only some services are able to provide the 3-4 month visit.

Each of the midwifery and HV services employed a stepped care approach to the treatment of PMH, typically identifying four stepped levels of PMH need with differing care pathways, with the fourth being a critical level for women experiencing a PMH crisis necessitating an emergency response. This maps onto the four steps outlined in the *NICE Guidance on clinical management and service guidance for antenatal and postnatal mental health*. However, the services available to women with different levels of need, and the referral pathways into services vary by area.

Figure 3 presents the core components of each localised pathway, original documents are provided in Appendix 3. The following section describes the similarities and differences between pathways and the implications for the identification and treatment of women with different levels of PMH needs, living in different areas in West Yorkshire.

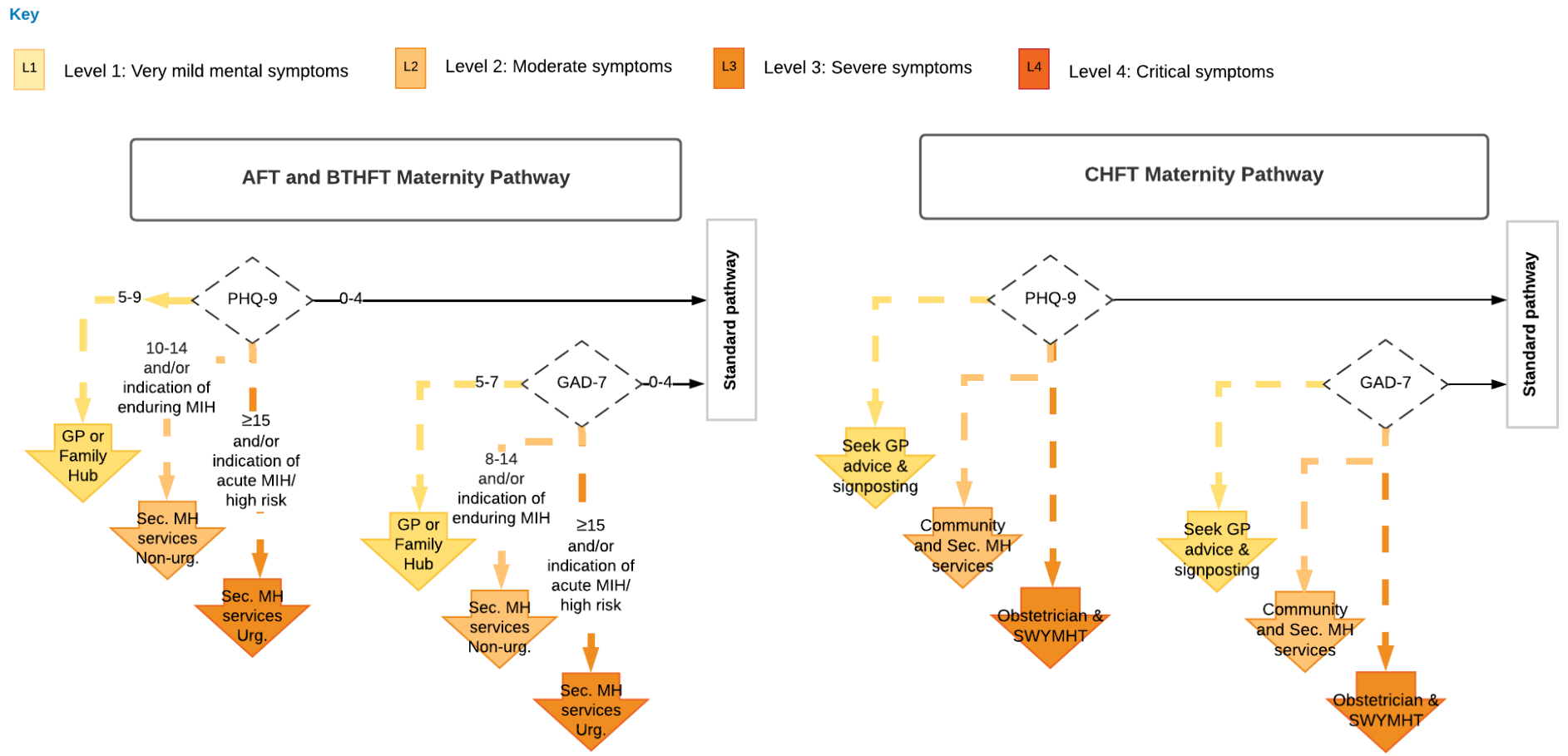

Figure 3. Pathways for the identification of PMH needs and referral to treatment and support after PMH assessment at routine perinatal appointments for maternity and HV services in West Yorkshire[1]

[1] The key presents the levels of PMH need that we have developed and not the terminology used by each organisation (see Table 1). For a key to the icons and colours used in the pathways see Figure 1. The pathways present the information provided in the guidance documents by organisation, therefore where pathways for a specific assessment tool or thresholds for different levels of mental ill health are not provided, this is because they are not specified in the document.

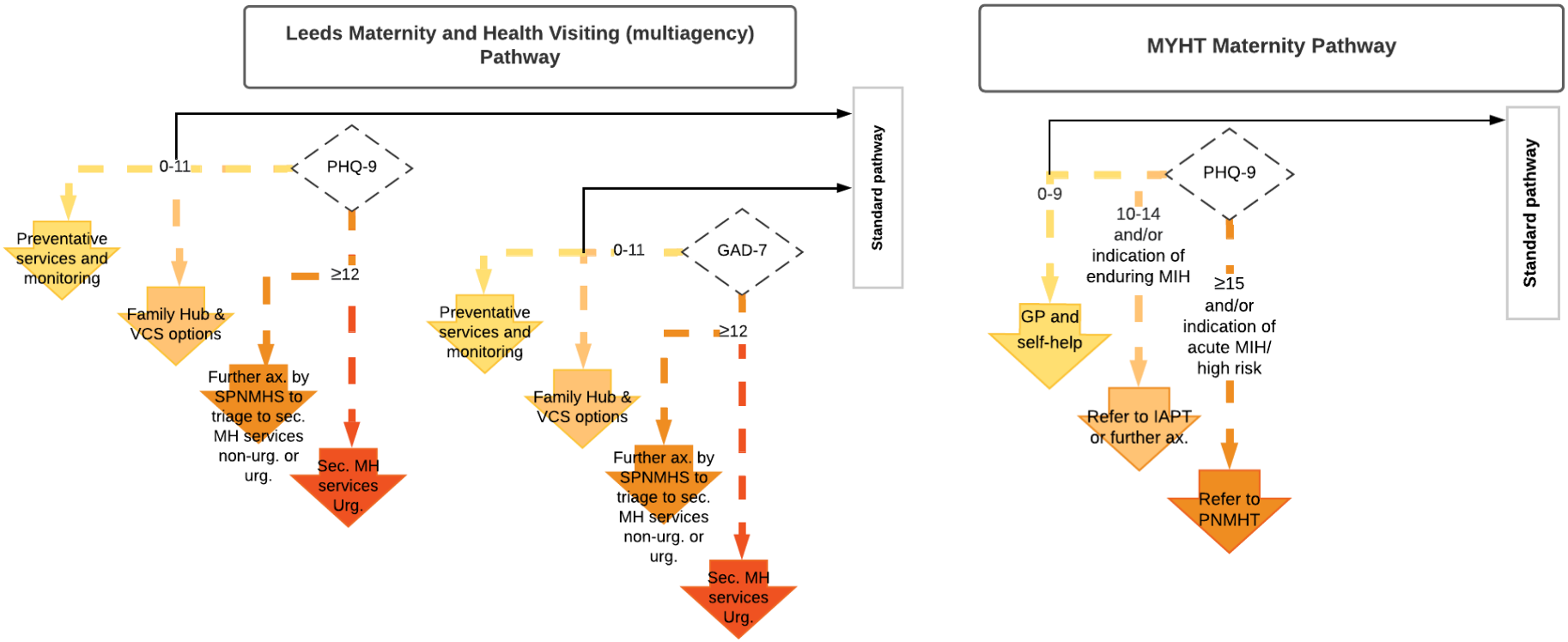

Figure 3 (continued). Pathways for the identification of PMH needs and referral to treatment and support after PMH assessment at routine perinatal appointments for maternity and HV services in West Yorkshire[2]

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[2] Multiple possible pathways (arrows) from the same outcome indicates that in the Leeds multiagency and MYHT pathways, there is potentially no minimum threshold for accessing support as professionals can employ their clinical judgement in deciding whether a woman needs PMH support; this can override the minimum threshold indicated by the outcome measure guidance (e.g. >4 for the PHQ-9).

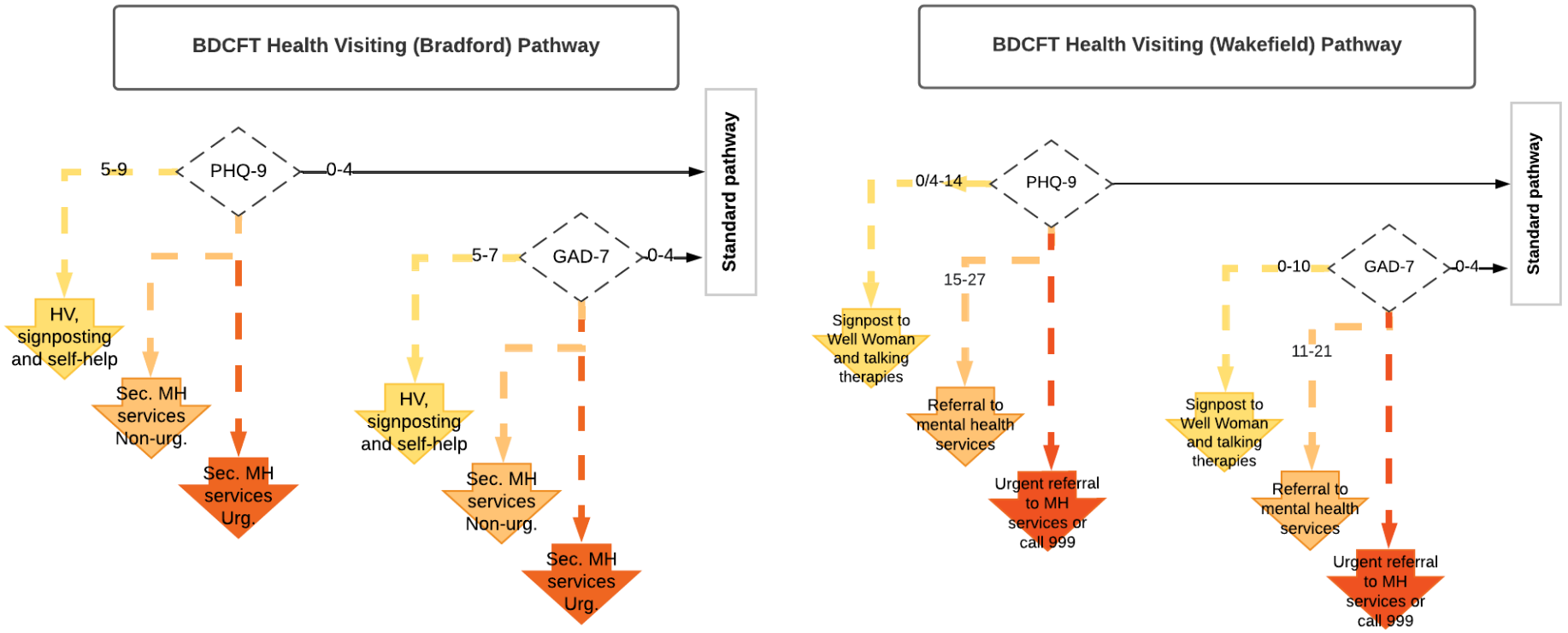

Figure 3 (continued). Pathways for the identification of PMH needs and referral to treatment and support after PMH assessment at routine perinatal appointments for maternity and HV services in West Yorkshire

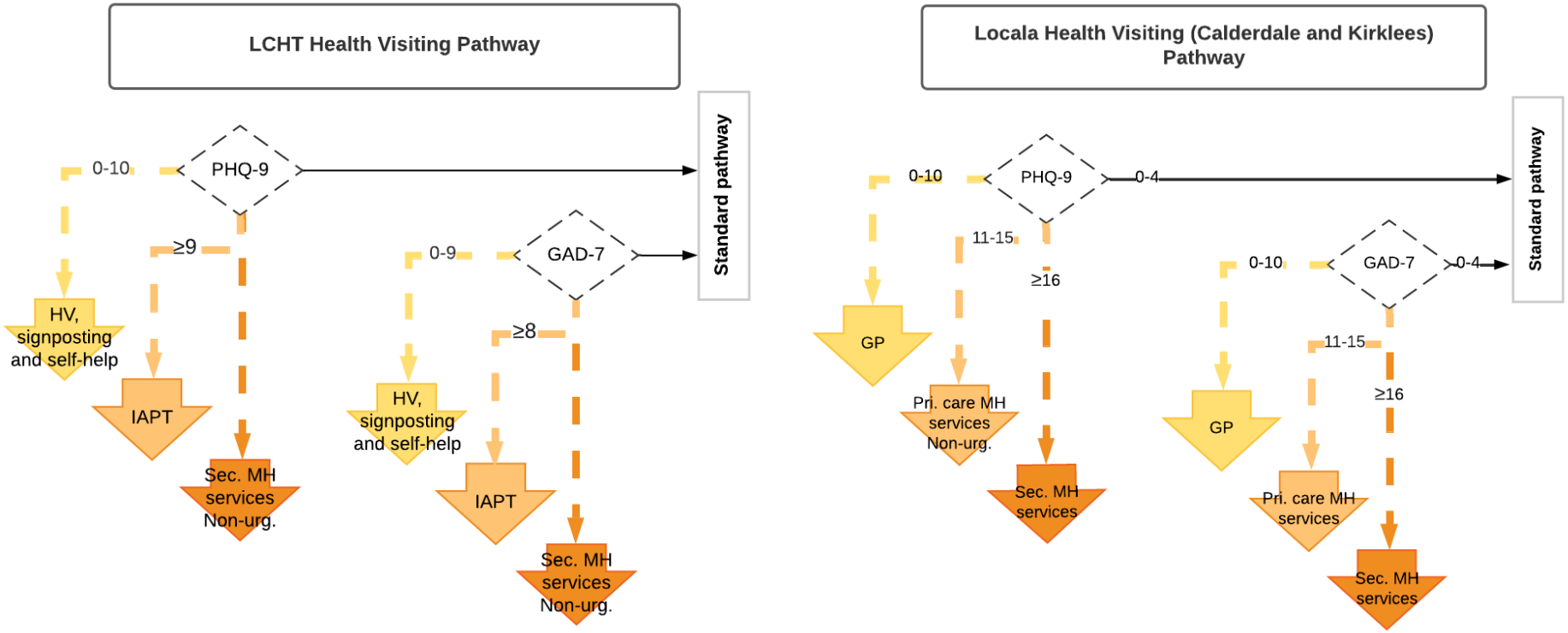

Figure 3 (continued). Pathways for the identification of PMH needs and referral to treatment and support after PMH assessment at routine perinatal appointments for maternity and HV services in West Yorkshire

Level 1-2 referral pathways

It is notable that in the four documents where no lower threshold for accessing support is specified, the description of level 1 severity PMH differs markedly, including one that specifically connects it with adjustment to pregnancy or parenthood:

- CHFT – 'risk of depression and anxiety: women who have symptoms of depression and/or anxiety that do not meet diagnostic criteria but significantly interfere with personal and social functioning'
- LCHT – 'minimal depression'
- Leeds (multiagency) – 'adjustment and emotional health issues: women who experience an inability to adjust well to pregnancy/becoming a parent, a distress reaction that lasts longer than or is more excessive than would normally be expected but does not significantly impair function'
- MYHT – 'low risk mild symptoms i.e. low level anxiety and mood'

The AFT/BTHFT care pathway is more prescriptive than others in that the thresholds for the different levels are clearly defined by PHQ-9/GAD-7 scores (e.g. level 1 is for PHQ-9 scores 5-9) (see Table 2), although the guidance does imply that a MH referral could still be made if MH needs are detected but the threshold for referral has not been reached. By contrast, in the Leeds pathway levels 1 and 2 are paired and have wide score boundaries so that clinical judgement is always used to decide what level of support the individual requires. It therefore appears to be at the clinician's discretion to decide whether the woman is referred to preventative services and monitoring or to the Family Hub and VCS services (see Figure 3). No guidance is provided in the documentation on how to make this decision, such as looking for/asking about factors that increase vulnerability to PMH needs or asking the woman if she has a preference for the type of support she receives or if she would like a referral to a specific VCS service for support.

CHFT provides no threshold guidance, thus the decision to refer and to which service is entirely the clinician's choice, unless they choose to relate the scoring system specified in the tool's own guidance to the levels of need in the Trust's guidance. For example, in the manual a PHQ-9 score of 10 indicates moderate depression, therefore the mild-moderate referral route in the Trust's guidance is followed and the woman signposted to local stay and play groups or referred to Home Start. Another diagram in this guidance, illustrates this more flexible approach to referral, indicating that the extent of the support can be graded depending on the level of need as well as referrals being made to different services (Figure 4). However, it is unknown whether this flexibility is implemented in practice.

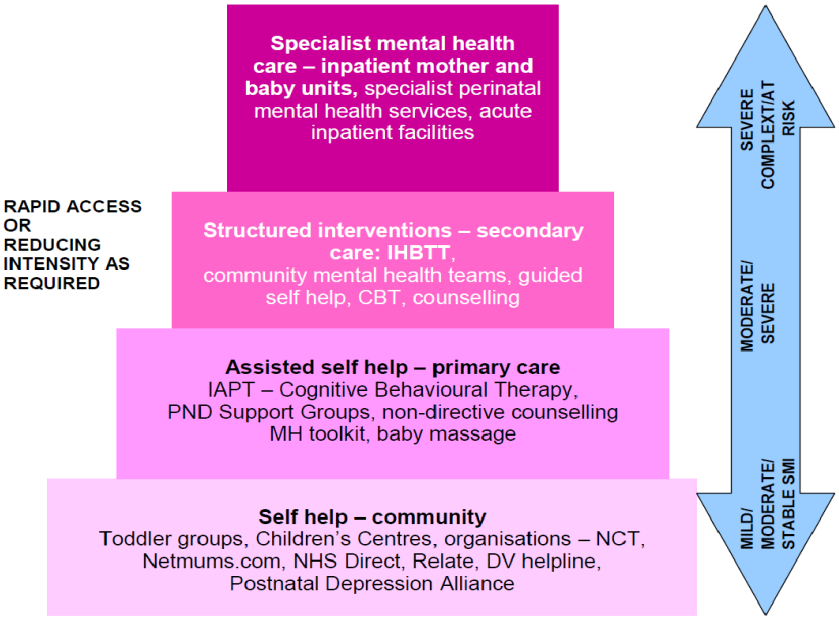

Figure 4. Stepped care approach

Image reproduced from Section 7 of the Calderdale and Huddersfield NHS Foundation Trust Maternity Service Clinical Guidance: Guideline for the Care of Pregnant Women Suffering Maternal Mental Health (2015).

Level 3-4 referral pathways

There is also a disparity between organisations in the description and approach to high level needs, with a lack of clarity as to when referral to emergency or urgent (but not emergency) PMH or MH services may be required. In the AFT/BTHFT and MYHT guidance, level 4 is characterised as crisis situations indicated by red flags:

- AFT/BTHFT - 'Red flags e.g. recent significant change in mental state or emergence of new symptoms; new thoughts or acts of violent self-harm; new and persistent expressions of incompetency as a mother or estrangement from the infant)'.
- MYHT - 'Recent significant changes in mental health or emergence of new symptoms; new thoughts or acts of violent self-harm; new and persistent expressions of incompetency as a mother or estrangement from the infant. Active psychosis or suicidal'.

There is no mention of red flags or critical PMH or clear guidance on the necessary response in either Leeds guidance documents, whereas there is very specific guidance from CHFT: where there is 'sudden onset of symptoms suggesting psychosis' the woman should be referred to secondary MH services for immediate assessment or 999 called. The response is also informed by the services available. For example, AFT/BTHFT specifies First Response, MYHT cites the Crisis Resolution Service, and the BDCFT Wakefield HV service advises contacting the SPA to make an urgent referral or dial 999.

The referral route for women with severe PMH needs but without red flags varies between the organisations' guidance and is sometimes identified as level 3 rather than level 4 PMH needs. Table 3 highlights the differences between organisations in the classification of high PMH needs and referral routes.

Table 3. Classification of high PMH needs (levels 3 and 4) and corresponding referral routes

Organisation	Level	Description of high level PMH needs	Referral route
AFT & BTHFT midwifery	Level 3	Severe and enduring mental illness, evidence of functional impairment.	Non-urgent referral to secondary MH services
	Level 4	Acute onset or crisis with marked functional impairment and/or high risk to self or others	Urgent referral to secondary MH services
CHFT midwifery	Level 3	Moderate/severe	Obstetrician and South West Yorkshire MH Team
	Level 4	Severe/complex/at risk	Secondary MH service/A&E
Leeds midwifery & Health Visiting (multiagency collaboration)	Level 3	Moderate mental illness[1]	Further assessment by Specialist PMH Service to triage to secondary MH services non-urgent or urgent
	Level 4	Severe mental illness	Urgent referral to secondary MH services
MYHT midwifery	Level 3	Severe/high risk (depression/self-harm/serious MH issues)	Perinatal Mental Health Team (SPA referral to SWYPFT)
	Level 4	Active psychosis or suicidal	Crisis Resolution Service (through SPA)
BDCFT Health Visiting (Bradford)	Level 2&3[2]	Mild-moderate, severe and enduring or history of severe mental illness	(Non-urgent) referral via SystmOne to First Response Team
	Level 4	Acute mental illness and/or immediate/high risk of harm	(Urgent) telephone referral to First Response
BDCFT Health Visiting (Wakefield)	Level 2&3[2]	Moderate-severe and enduring or history of severe mental illness	Referral to mental health services (through SPA)
	Level 4	ALL Urgent (red flags)	Urgent referral to mental health services through SPA or call 999
LCHT (Leeds) HV	Level 3	Moderately severe depression/anxiety	Not provided[3]
	Level 4	Severe depression/anxiety	Not provided
Locala Calderdale Health Visiting	Level 3	Moderate/severe	Primary care mental health services (IAPT) and the GP. Inform Clinical Lead for Perinatal Mental Health HV
	Level 4	N/A[4]	Urgent referral to Crisis Team
Locala Kirklees Health Visiting	Level 3	Moderate/severe	Primary care mental health services (IAPT) and the GP. Inform Clinical Lead for Perinatal Mental Health HV
	Level 4	N/A[4]	Urgent referral to Crisis Team

[1]Level 3 in the Leeds pathway is classified as moderate MH needs, although the referral route indicates that there may be urgent (severe) MH needs within this classification.

[2] There are only 3 levels in the BDCT HV guidelines for Bradford and Wakefield.

[3] The descriptions provided for levels 3 and 4 are the highest thresholds for the PHQ-9 and GAD-7 presented in the LCHT HV guidance but there are no referral routes mapped to these levels of need. The guidance does not mention urgent care/referral, crisis or red flag signs or responses.

[4]There is no level 4 classification in the Locala HV guidance document. The guidance says that urgent referral to the Crisis Team may be required if clinical judgement for a woman with moderate/severe PMH needs indicates it.

Leeds (multiagency & LCHT), AFT/BTHFT and CHFT identify single point of access (SPA) referral pathways for MH services whereby the SPA team triage women identified as having higher levels of PMH need (i.e. moderate-severe) to the appropriate service rather than the person who performs the assessment doing so directly. For Wakefield, there is a specific SPA service for Wakefield but not across the whole MYHT area. The organisations differ on the level of need at which the SPA referral is triggered and MYHT do not provide any guidance for the Wakefield SPA pathway (although there is in the Wakefield HV guidance - SPA for moderate-severe PMH needs and when there are red flags). For CHFT, SPA can be from level 1 upwards if the woman's symptoms 'significantly interfere with personal and social functioning' (with different numbers to call for women from Calderdale or Kirklees (for Huddersfield)). The Bradford District SPA service is required when the needs are assessed as level 2 and upwards (mild-moderate/severe), for Leeds it is level 3 and upwards (moderate/severe) whereby the SPA team determine if referral to urgent or non-urgent MH services are needed (in Leeds the Specialist PMH Service provide the SPA triage via further assessment). The Leeds guidance is the only place where self-referral to specialist services is mentioned; in other areas self-referral is only indicated for IAPT services. As far as we are aware, the impact of these differences is unknown.

4.4 A note on geographical boundaries

We have presented and compared localised pathways by organisation/area, providing clear insight into variation in guidance provided to HCPs to support their practice. However, using organisation-level guidance documents, we were not able to fully consider pathways for women who move across geographical boundaries in the care they receive. This highlights limitations in guidance, which may also have implications for workforce training. The pathways explored represent the experience for women only while under the care of each particular service (midwifery or HV). Given the number of possible combinations resulting from transition of care between services, we have not presented the entire perinatal pathway. We would, however, like to highlight some examples of where inequalities due to postcode could occur. Most notably, while referrals for specialist mental health support would be made to the SWYPFT PMH Team for women from Wakefield, Dewsbury, Calderdale and Huddersfield, women from each area receive a different approach to care both antenatally and postnatally: while Locala provide the HV service for both Calderdale and Kirklees, Calderdale offer a 3-4 month contact while Kirklees are unable to, and only Calderdale have a specialist mental health role. Further, while women from Wakefield and Dewsbury receive midwifery care from the same NHS Trust, there is disparity in the number and focus of supporting VCS services available in the two areas meaning that the opportunity for women to access support varies. Additionally, while women residing in the Craven area may choose AFT or BTHFT for midwifery care, the HV service would be provided by Harrogate and District NHS Foundation Trust (HDFT), which operates differently from BDCFT.

4.5 Fathers, other co-parents and partners' mental health

Based on the guidance documents, the LCHT HV service is the only organisation to offer direct support to fathers, co-parents and partners:

> 'any resident parent/caregiver whose mood may impact on the wellbeing of the child may be supported. This may be as part of the screening and listening support, offered as a session with either both parents or the one who is identified as being in need or signposting.

> This pathway is to be offered within the 1st year of the baby being born and is linked to the pregnancy and birth of the baby.'

The guidance includes an acknowledgement of paternal mental health needs during the child's infancy (and of the unknown scale of the issue) and indicates that the PHQ-9 and GAD-7 can also be used with fathers and other family members. Signposting to the Fatherhood Institute is provided so that HVs can find out more, although there is no signposting to support options for fathers, co-parents or partners.

In all the other organisations' guidance, there is very limited reference to fathers, other co-parents, partners and families. There are mentions in two other documents:

- AFT/BTHFT: 'midwives should take into account, and if appropriate, assess and address the needs of partners, families and carers that might be affected by a woman with a mental health problem in pregnancy and the postnatal period' (as recommended in the 2014 NICE guidance).
- Leeds (multiagency): examples include, 'HVs provide information and ongoing support and encouragement for women and their partners, to engage with universal children's centre services', and 'the CMHT will offer an assessment of support needs for carers/partners and signpost to appropriate agencies'.

This may suggest a limited holistic approach within universal services to the support of women with PMH needs and their families. There may be some unstructured (and not routine) questions asked about the fathers, other co-parents and partner's history of MH needs. The emphasis is often on history-taking rather than consideration of fathers, other co-parents and partners' current or developing MH needs during the perinatal period, and the DIQ and assessment measures are not used. To our knowledge, the LCHT HV service is the only service to explicitly offer listening visits for fathers, other co-parents and partners', although this is not also mentioned in the Leeds multiagency guidance document. Further, we do not know if this applies equally to fathers, other co-parents and partners as largely the term 'fathers' is used in the LCHT guidance.

4.6 PMH support services

We explored the PMH support services offered in each area through review of the guidance documents; where multiple documents were available per geographical area, these were combined to provide a view of the district. Discussions with HCPs from LYPFT and BTHFT supplemented guidance for the Leeds and Bradford districts. Figure 5 represents the PMH support identified as available to women in each area either in universal services (available to all/not specialist support for MH concerns) or in services designed to provide specialist MH support. Each diagram in Figure 5 also represents the services identified by service type (i.e. NHS or VCS) and by level of PMH need where this was identified in the guidance (where there is no level of need indicated, the level of need was not specified in the guidance). Overlap of services indicates explicit joint partnership working.

We note that the networks of PMH support services are likely to be larger than represented diagrammatically. Nevertheless, these illustrations highlight differences between areas in the number of services known to be available to women during the perinatal period, and the distribution/ types of services across different providers.

We recognised differences in the number of services available and the distribution of services between the NHS (or NHS partners/funded services) and the VCS. The specificity of services referenced in the guidance documents also varies, as does the detail of partnership working across services. Some of the services referenced in the guidance in CHFT (Calderdale district) and LCHT (Leeds district) are not named explicitly and little direction is provided for access, for example, signposting women with level 1 PMH needs to toddler groups and with level 2 needs to non-directed counselling. Most of these services feature in the stepped care model in the CHFT guidance rather than in the main text, therefore the type of services recommended for the different levels of need may not in fact map onto available services in CHFT). Each organisation specifies the services available for high need individuals (levels 3 and 4/women in MH crisis); typically these are a specialist PMH service with some wrap-around specialist PMH inpatient and community support and linkage to other adult mental health services.

The extent to which joint working between services, referral pathways between them and their suitability for women with different levels of PMH need was indicated varied greatly between organisations. It is not possible to know what impact this may have on when and which services women with PMH needs access and if it results in inequalities between the geographical areas. This is explored further in report four (section 2.3: *Inequalities in identification and management of perinatal mental health problems: views & experiences; what 'good' looks like*).

4.7 Women with vulnerability to poor PMH

Services available to support women with specific circumstances associated with additional vulnerability to poor PMH are identified by each organisation, although the number of services and specific circumstances that are included in the guidance varies (Table 4). We note that services and specialist HV/MWs may be available to support women with particular concerns in each area but as references are not made in documentation, availability and access pathways may be unclear to the workforce. It was outside the scope of this report to comprehensively review availability of services.

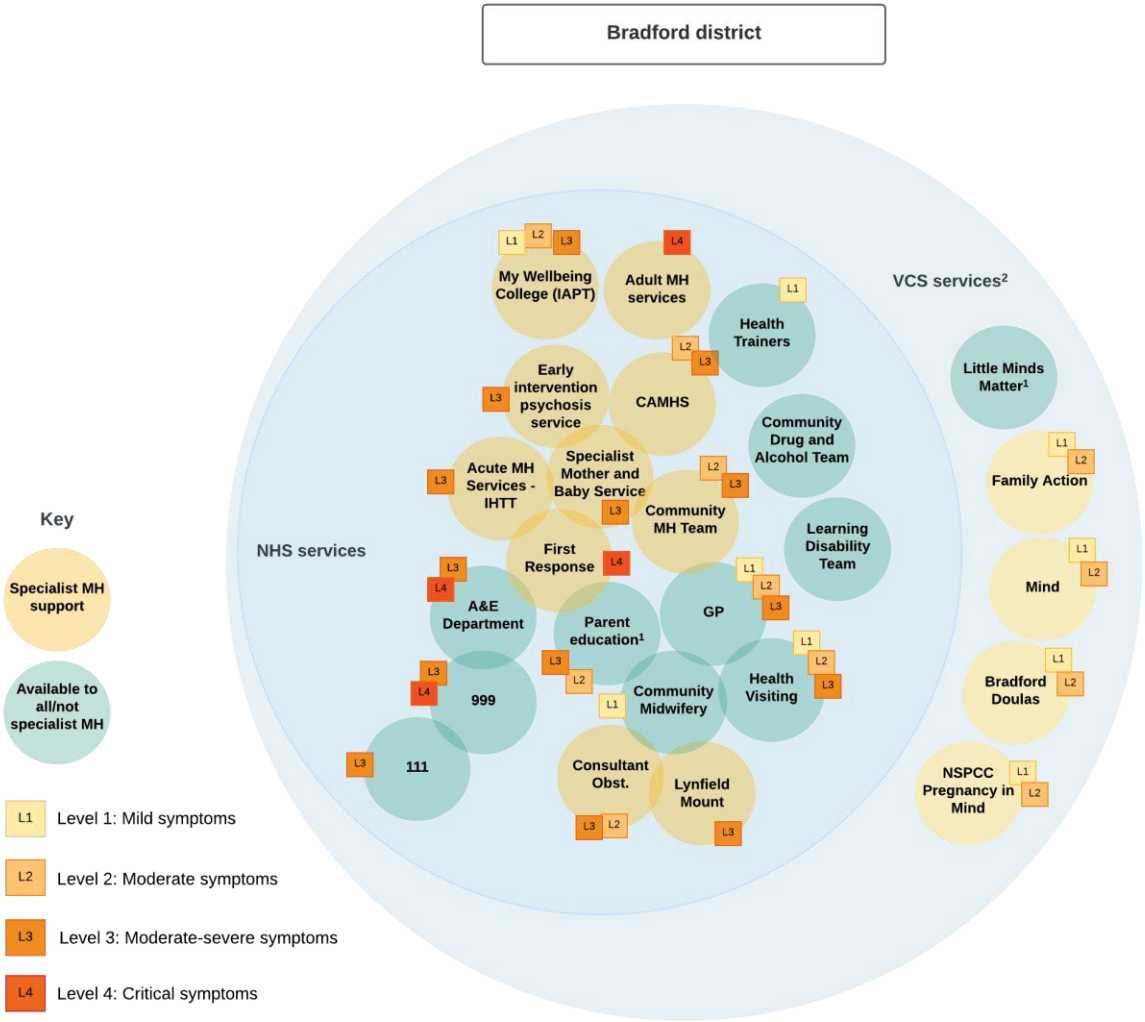

Figure 5. PMH support services

[3] Role in identification of concerns rather than support
[4] Note some joint working with NHS services not represented in this figure

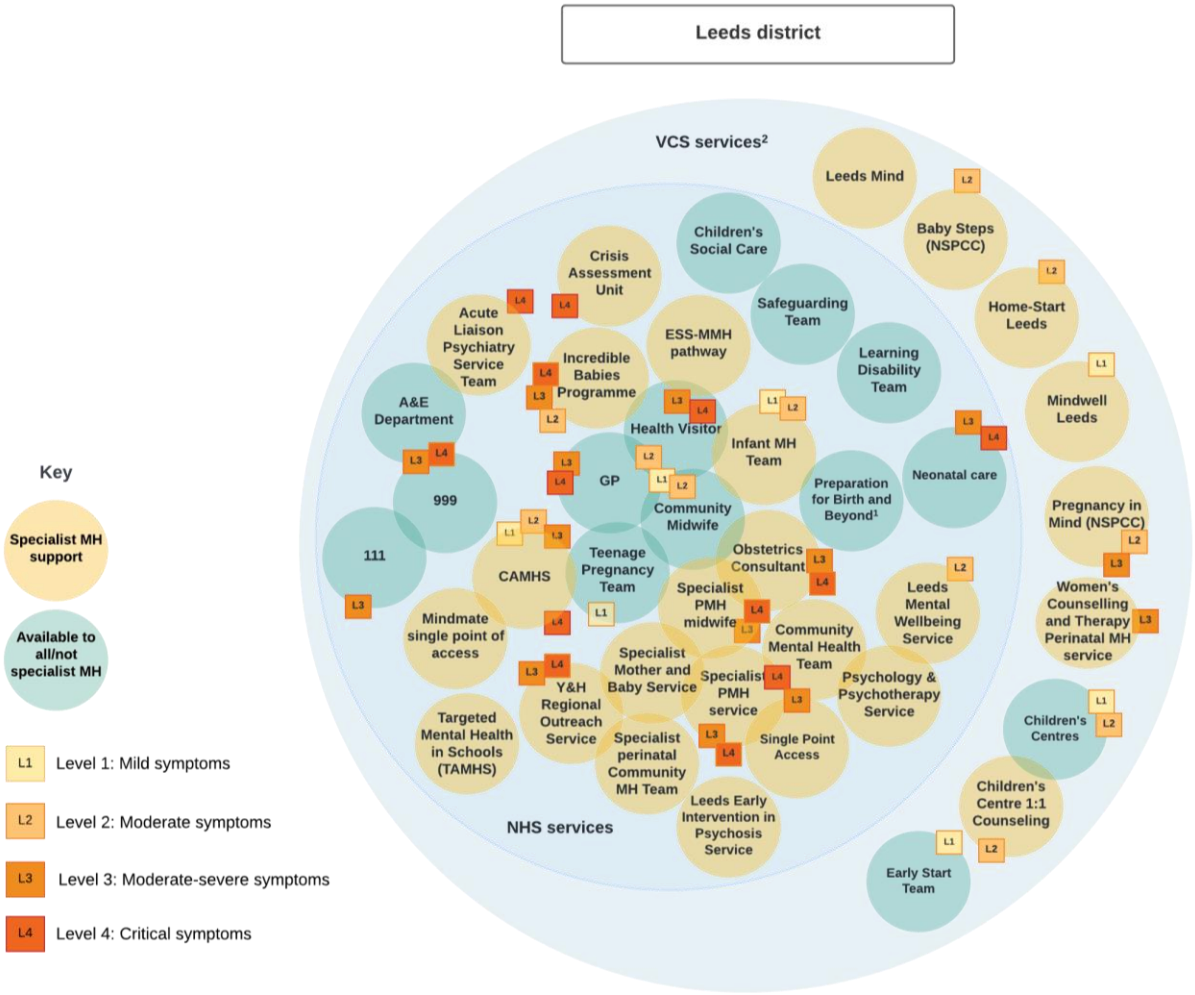

Figure 5 (continued). PMH support services

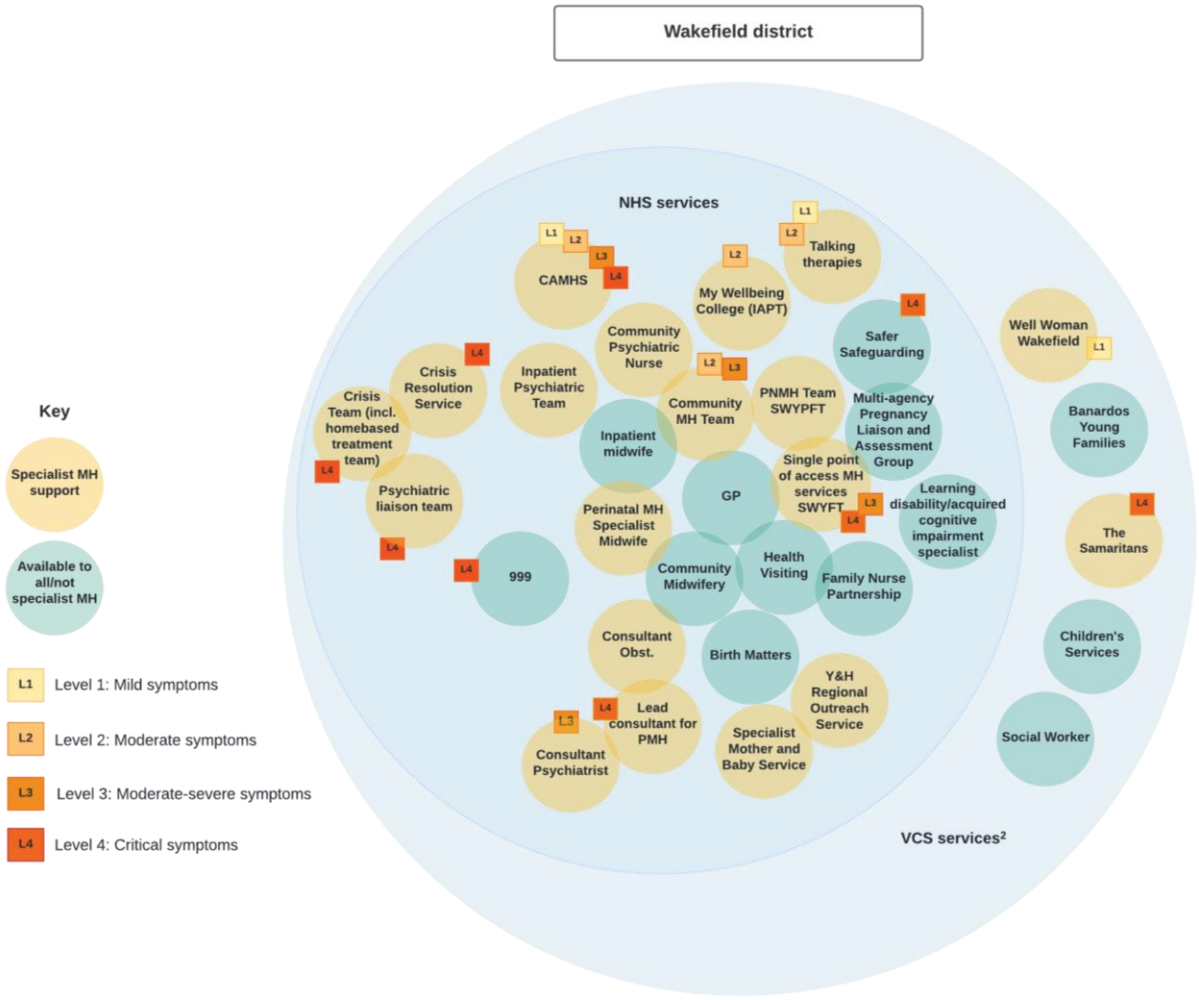

Figure 5 (continued). PMH support services

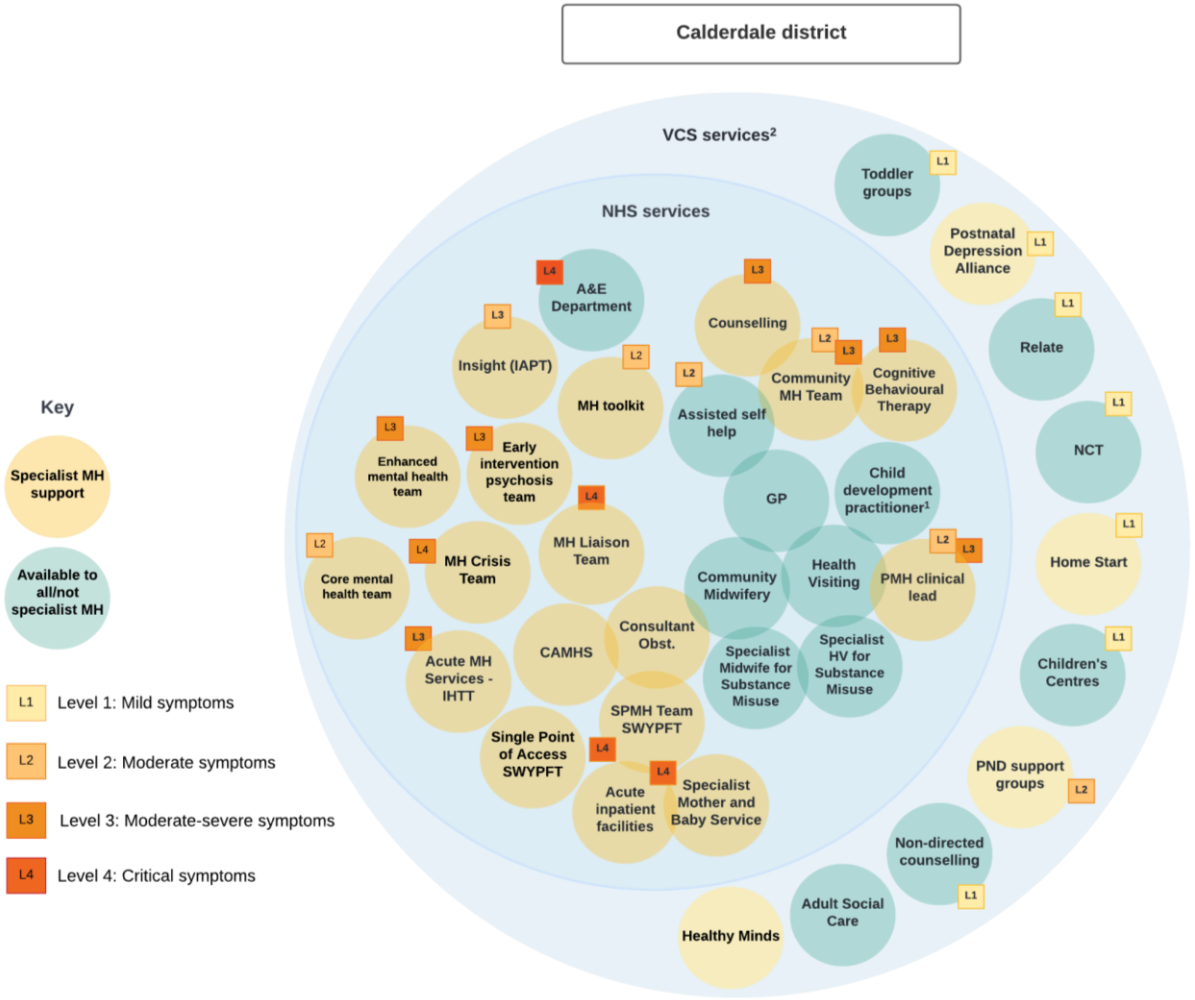

Figure 5 (continued). PMH support services

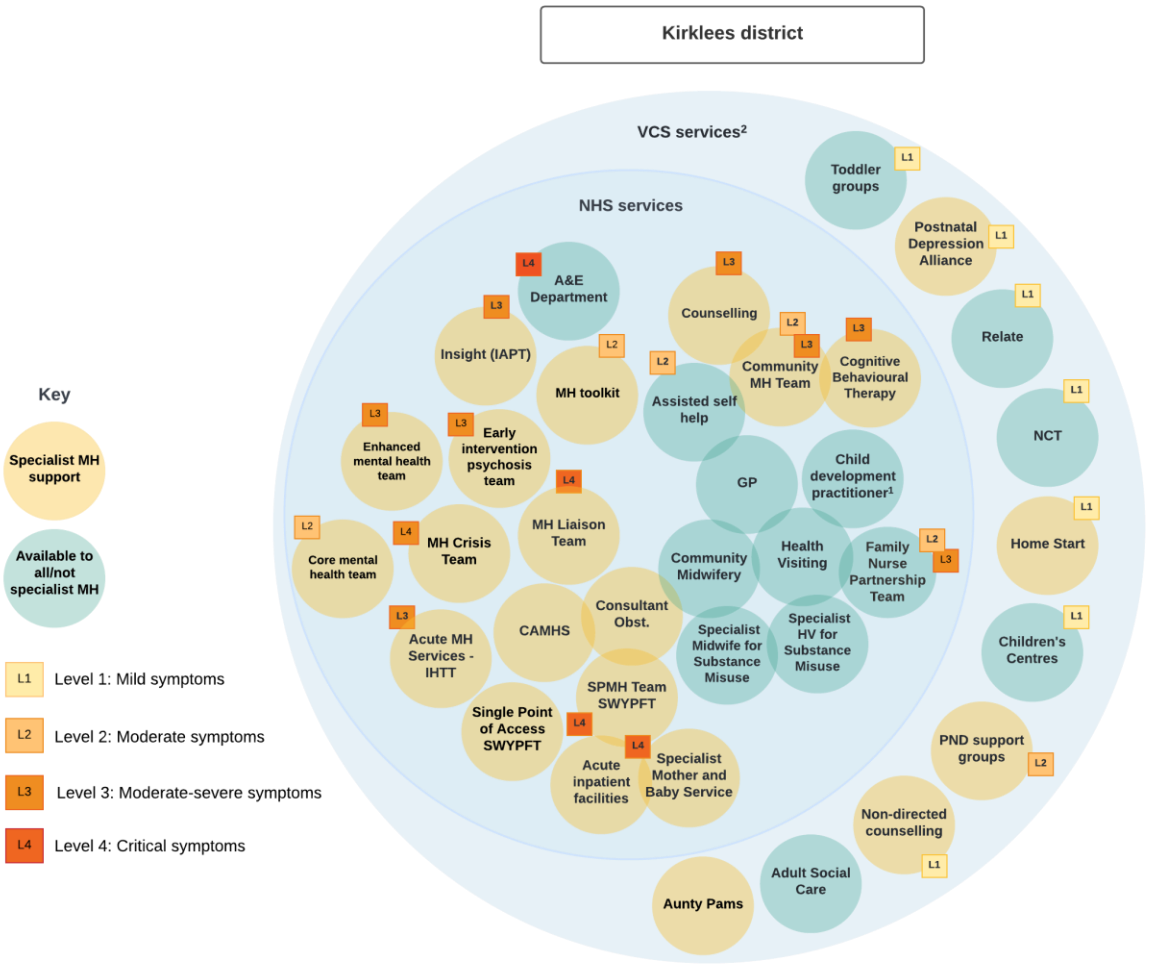

Figure 5 (continued). PMH support services

Table 4. Specific maternal characteristics for which PMH services are mentioned in the guidance document by organisation

Organisation	Teenage pregnancy / Young parents	Learning disability	Substance misuse	Domestic violence and abuse	Bereavement, PTSD and Birth Trauma	Asylum seekers and refugees	Safeguarding children and vulnerable adults	Complex social needs	Little/no English
AFT & BTHFT midwifery	NSPCC Pregnancy in Mind	Learning Disability Team	Community Drug and Alcohol Team	-	-	-	-	-	-
CHFT midwifery	-	-	Specialist midwife /HV for substance misuse	Domestic violence helpline	-	-	-	-	-
MYHT midwifery	Barnardo's Young Families	Learning disability/ acquired cognitive impairment specialist	-	-	-	-	-	-	Interpretation and independent advocate services
Leeds midwifery & Health Visiting (multiagency collaboration)	Mindmate single point of access NSPCC Pregnancy in Mind	-	Drug and Alcohol in pregnancy	N/S	N/S	N/S	N/S	Women's Counselling and Therapeutic Service – PMH case worker	-

Table 4 (continued). Specific maternal characteristics for which PMH services are mentioned in the guidance document by organisation

Organisation	Teenage pregnancy / Young parents	Learning disability	Substance misuse	Domestic violence and abuse	Bereavement, PTSD and Birth Trauma	Asylum seekers and refugees	Safeguarding children and vulnerable adults	Complex social needs	Little/no English
BDCFT Health Visiting (Bradford)	-	Waddiloves or the Oaks	N/S	-	-	-	Children's social care services	-	-
BDCFT Health Visiting (Wakefield)	Family Nurse Partnership	-	-	-	-	-	-	-	-
LCHT (Leeds) Health Visiting	-	-	-	-	-	-	-	-	-
Locala Calderdale Health Visiting	-	-	N/S	N/S	N/S	-	N/S	-	-
Locala Kirklees Health Visiting	-	-	N/S	N/S	N/S	-	N/S	-	-

N/S: Maternal characteristics identified in the guidance document, but no named services identified.
We have only included characteristics in this table for which a specified service is mentioned in one or more of the guidance documents. For example, neurodiversity and LGBT+ are not included because none of the guidance documents mentioned specific services or pathways available to women with these characteristics. The table is not an exhaustive list of characteristics that may increase women's vulnerability to poor PMH.

Most but not all of the organisations provide specific services to support pregnant teenage women and those with substance misuse issues, but they do not necessarily provide specialised PMH support. Eligibility is predominantly determined by the nature of the characteristic that increases the vulnerability (e.g. substance misuse) rather than the level of PMH need. In CHFT there is a specialist midwife and a specialist HV for substance misuse who work together and jointly with the community midwives and HVs. In Leeds (multiagency guidance), there is a dedicated SPA for child and young person's MH (Mindmate) which connects with the teenage pregnancy service and CAMHS which works collaboratively with the Mother and Baby Unit and specialist PMH service. These examples of professional and service linkage are some of the few specified in the guidance.

4.8 Services to support women from ethnic minorities and/or with English language barriers

There are no named universal NHS or statutory services specifically for women from ethnic minority backgrounds or with little/no English language ability and, overall, guidance documents make very little reference of how women with these characteristics might be disadvantaged in PMH identification and access and how these inequalities might be addressed. For example, whether different approaches to the discussion or assessment of PMH might be required.

The MYHT guidance refers to the Interpretation and Independent Advocate Service which interacts with the inpatient midwife team, whereas the CHFT guidance states:

> 'the treatment, care and information women are given about maternal mental health needs to be culturally sensitive. It should also be accessible to women with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English (NICE 2014). The Trust guidelines on the use of interpreters are already in existence as well as resources to support the needs of women from minority ethnic communities. In addition to training, the How Are You Feeling booklets will be made available to all Midwives and Health Visitors.'

However, they do not provide any direct guidance or signposting to relevant services (e.g. the interpretation service). We are aware that services, such as the Haamla service in Leeds, are available to support ethnic minority mothers during the perinatal period, but it is unclear whether there is specific PMH support for ethnic minority women in any region. The offer from NHS PMH services may not be accessible to these women if it is not culturally appropriate or available in the language they can speak or feel most comfortable speaking. Each organisation confirmed that an interpretation service would be provided to all women with language barriers, but guidance does not state how best to work with an interpreter when discussing mental health. For example, the Locala guidance (for Calderdale and Kirklees) includes the statement:

> 'When undertaking assessments, health care professionals should ensure sensitivity towards the impact of culture, language, disability and sexuality on a person's perception and understanding of mental illness'.

However, there is no indication of whether training is available to support this or why this awareness is important (e.g. due to the risk of inequalities in identification and access in ethnic minority groups).

Issues of access may also arise if women are signposted to online self-help support, or are encouraged to make a self-referral to a service, but may face digital exclusion (e.g. do not have access to a computer or smartphone, have funds for data usage, or lack confidence with use).

The themes identified in this section are explored in report four which presents the findings of our interviews with women from minority groups (ethnic minority/low socioeconomic status) and staff in VCS services that provide MH support to women during the perinatal period.

4.9 PMH professionals in universal services

Largely, the referral pathways specify a service rather than a named profession; however, we noted variability in the availability and referral pathway for a few named professions: specialist PMH staff embedded in universal services and obstetricians.

There were differences in the availability and role of specialist PMH staff in universal services. These are staff with additional training in PMH who midwives and HVs can refer to or consult on level 1 and 2 PMH cases where input from specialist PMH services is not indicated. We found mention of specialist PMH midwives, HVs and clinical leads in some but not all of the guidelines (Table 5).

Information found in guidelines was supplemented through discussion with healthcare professionals in Leeds and Bradford. At BTHFT for example, we found that a specialist perinatal mental health midwife performs an advisory role. Differences in whether specialist perinatal mental health professionals are fully caseloading, offering shared or additional visits or acting purely in an advisory role to midwifery or HV services may have implications for midwifery and HV staffing capacity, and the ability to identify and manage PMH needs in universal services. We also found that there is a potential inequality in PMH support in the Calderdale and Huddersfield area, whereby women may share the same midwifery and specialist MH services, yet only women under the care of the Calderdale HV (not Kirklees) service currently have access to a SPMH HV.

We also found differences between the guidance on when/if to refer to obstetricians during pregnancy. Largely, the referral pathways specify a service rather than a named profession; however, obstetricians are identified as a referral option in three of the pathways, although there are differences between organisations. In the CHFT care pathway, pregnant women with level 3 PMH needs are referred to an obstetrician (timeframe not indicated). In the AFT care pathway, women with level 3 needs (identified at the booking appointment) should receive a review from a consultant obstetrician at 16 weeks gestation. It is unclear from this guidance if a referral would be made/the obstetrician would be notified if level 3 PMH needs were identified at other points during the pregnancy. The Leeds (multiagency) guidance does not mention referral to obstetricians explicitly. Whereas, in the MYHT guidance referral to the Lead obstetrician is specified if there are previous serious MH needs or previous puerperal psychosis and/or female first degree relative postpartum psychosis. Thus, there is inconsistency in the guidelines concerning the role of obstetricians in PMH support.

Table 5. Specialist PMH staff embedded in universal services

Organisation	Specialist PMH staff embedded in universal services	Verbatim guidance
AFT & BTHFT midwifery	None mentioned	N/A
CHFT midwifery	PMH practitioner[1]	HVs may offer increased contact of up to 4 'listening visits' and then repeat the relevant assessment tool. If concerns remain then discussion with GP and PMH practitioner to discuss further management is required.
Leeds midwifery & Health Visiting (multiagency collaboration)	Specialist Perinatal Midwifery Service CMHT PMH lead	Following referral from the Community Midwife, the Specialist PMH MW service will provide individualised case loading midwifery care for women with severe mental health issues and liaise with obstetric and mental health services. The CMHT will provide a named perinatal mental health leads and link to each Early Start Team, to ensure close working and coordinated care.
MYHT midwifery	Perinatal Specialist Midwife (Lead for Complex Care Needs) Lead Consultant for PMH	Midwives can request support for this from the Perinatal Specialist Midwife through a joint visit and arrange a MDT meeting to share concerns. Refer for shared care with Lead Consultant for PMH if previous severe or current moderate to severe mental health concerns. Women with mild depression do not require shared care.
BDCFT Health Visiting (Bradford)	None mentioned	N/A
BDCFT Health Visiting (Wakefield)	PMH Lead HV Clinical Lead for PMH	No guidance on role or referral/consultation route
LCHT (Leeds) Health Visiting	None mentioned	N/A
Locala Calderdale Health Visiting	Clinical Lead for PMH health visiting/PMH Leads	HVs in Calderdale should liaise with the Clinical Lead for PMH and 0-19
Locala Kirklees Health Visiting	Clinical Lead for PMH health visiting/PMH Leads	Practitioners in Thriving Kirklees should seek supervision from one of the PMH Leads based in the Family Nurse Partnership team

[1] There is no indication of what is meant by this, as to whether it refers to a specialist PMH HV, midwife or other staff member in a universal setting.

4.10 Review of other recent guidance / reports against our findings

This review was conducted in the same period in which the WYHCP were developing the West Yorkshire & Harrogate Local Maternity System (LMS) Perinatal Mental Health Guideline for Maternity Services. We have also reviewed our findings against the West Yorkshire and Harrogate LMS Maternity Perinatal Services Scoping Report (for Jan-Mar 2020).

4.11 LMS PMH Guideline for Maternity Services

The new guidance attempts to address many of the potential issues and differences between areas that we have identified. Accordingly, we provide a summary of which concerns have been addressed in the new guidance, how it differs from the organisation-level guidance, if and how the potential inequalities have been mitigated. We are also aware that some organisations have also been revising their guidance, but we have not had access to these documents so cannot review whether they address any of the concerns we raise or align with the new WYHCP LMS guidance.

The LMS is comprised of midwifery and neonatal service providers, commissioners, local authorities and Maternity Voices Partnerships. The new guidance aims to provide advice to WYHCP LMS clinicians on the identification and management of women experiencing PMH conditions and covers all of the midwifery services for which we have reviewed the organisation-level guidance.

The driver for the guidance seems to be to have a regional approach to reduce maternal deaths and serious harm due to PMH needs. As such, the key messages (which touch on themes discussed in our report) are:

- For 'all healthcare professionals who have regular contact with a woman in pregnancy and the postnatal period to enquire about the emotional and general mental health of the women they see'. This should be done first using the DIQ and GAD-2+1, followed by the GAD-7 or PHQ-9 if a positive response is reported for either or both tools. The red flag questions should also be asked as part of the more detailed assessment (i.e. alongside the GAD-7 or PHQ-9).

- 'Staff should make an assessment for red flag signs at each contact. If a woman is responding positively to a red flag question then staff should contact the Crisis Team immediately'. The red flag questions are specified as:

    - Do you have new feelings and thoughts which you have never had before, which make you disturbed or anxious?
    - Are you experiencing thoughts of suicide or harming yourself in violent ways?
    - Are you feeling incompetent, as though you can't cope, or estranged from your baby? Are these feelings persistent?
    - Do you feel you are getting worse?

This is a requirement for more frequent and formal assessment of red flag signs than appears in the organisation-level guidance documents.

- The guidance identifies the need for and outlines clear responsibilities of LMS professionals and Crisis Teams in a potential or current red flag situation, including deprivation of liberty decisions.

- In midwifery services, PMH is ‘everyone’s business’: ‘it is therefore the responsibility of all WY&H LMS healthcare professionals providing care to pregnant women to be aware of the content of this guideline’.

- The necessity for clear written communication and information sharing between midwifery and primary care services, in particular to document referral and share MH history details. Prompt decisions should be made about which professional is responsible for coordinating the care of each woman with moderate to severe PMH needs, and a care plan put in place and shared with everyone involved in her care, including the woman herself.

- To put anxiety on an equal footing with depression by specifying a clear protocol for the identification of anxiety disorders both at the initial and further assessment stages (via the GAD-2 and GAD-7).

- The need to outline a clear identification and referral pathway for women with different levels of PMH need, which the guideline endeavours to do. Please note that a pathway diagram is not provided with the draft that we have seen, and there are no descriptive labels for, what we call, the different levels of need. The terms mild, moderate and severe mental illness are used but there may be a deliberate effort to move to a more holistic model which does not strictly differentiate levels of need (although this is not stated in the guidance). We have presented the pathway outlined in the guidance visually (Figure 6).The involvement of partners, carers and other family members in the woman’s PMH support: ‘if the woman agrees her partner, family or carer should also be involved in these conversations and decisions [about her care and the care of her baby]. Take into account and, if appropriate, signpost partners, other family members and carers that might affect a woman with a mental health problem in pregnancy and the postnatal period to support.’ This guidance does not, however, cover offering support for fathers, co-parents and partners with MH needs during the perinatal period.

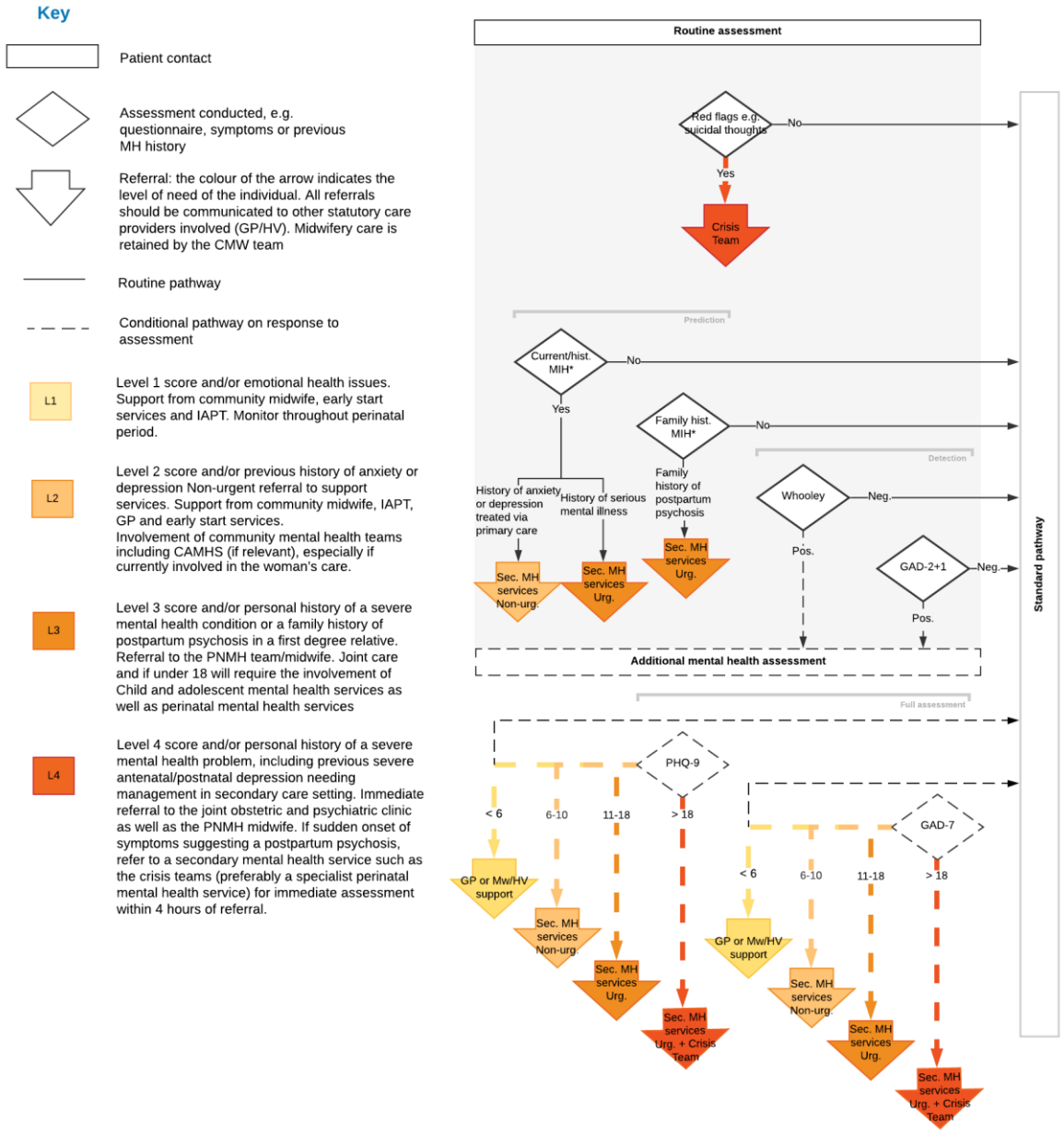

Figure 6. Pathways for the identification of PMH needs and referral to treatment and support after the initial PMH identification measures at routine perinatal appointments for West Yorkshire as outlined in the new WY&H LMS guidance

Notable elements of this pathway are:

- The absence of a minimum threshold for access to PMH support (referrals can be made for GAD-7/PHQ-9 scores equal to and above zero if the professional has concerns about the woman's mental health)
- The distinction of different pathways for women with a history of depression and anxiety who received primary care support, and women with a personal or family history of serious mental illness
- The inclusion of four levels of need with defined referral routes

The pathway outlined in the new guidance, if adopted by the West Yorkshire LMS (including Trusts and local authorities), would standardise the thresholds at which different levels of support are accessed, thus reducing the disparities in access outlined in this report. The guidance also mentions specific characteristics which may increase women's vulnerability to PMH or engagement with treatment: alcohol and drug misuse; domestic violence and abuse, sexual abuse, trauma or childhood maltreatment; housing, employment, economic and immigration status; traumatic birth, stillbirth, pregnancy loss, learning disabilities or acquired cognitive impairments (these characteristics are some of those listed in Table 4). The guidance does not acknowledge inequalities in the identification of PMH needs by the specific groups of women we highlight in this report, including women with language barriers and minority ethnic women.

4.12 LMS Maternity Perinatal Services Scoping Report

The LMS Perinatal Services Scoping Report (March 2020) chiefly used a consultation approach, whilst we largely used documentary analysis. As such, our findings highlight potential inequalities resulting from differences between or absences in the written guidance provided to professionals in midwifery and HV services, which may have important implications for consistency in responding to PMH needs and training for new staff.

There are a few notable differences between our findings and those of the LMS Maternity Perinatal Services Scoping Report, but as the Trusts are anonymised in the LMS scoping report we could not explore these further. A checklist in the LMS report indicates that partner[5] assessments (un-defined) were available in four of six Trusts, whilst we only found mention of support for partners in the guidance for two organisations (AFT/BTHFT and Leeds).

Our report and the LMS report also differ on the availability of PMH specialist midwives. We found inconsistent availability (reported in the guidance documents) whilst the LMS report found PMH specialist midwives in post in all Trusts, although both reports note differences between Trusts in whether these professionals were caseloaded (Appendix 5).

5. Recommendations

We have outlined PMH pathways which aim to identify women with poor mental health via routine perinatal appointments and signpost or refer them to appropriate NHS or VCS support in each area. In this report we have identified where there are uncertainties and differences in the guidance which may result in differences in the identification of PMH and access to support depending on where in West Yorkshire women live. It would be useful to consider the scoping review alongside our report as it has greater detail in some areas that were outside our scope, such as variation in caseloading by specialist PMH midwives by Trust.

We have identified the following themes which each Trust and HV provider could revisit to ensure that there is the opportunity for all women with poor PMH to be identified and assessed during routine appointments, and have a referral made to an appropriate service. Not all of the following are relevant

[5] The term used in all of these documents is 'partners' or 'fathers' rather than the more inclusive, and now widely accepted, language of fathers, other co-parents and partners.

for every organisation, but a review of the guidance (and a look at consistency or differences between it and practices) based on these criteria could be beneficial for all. Consistency could be ensured with shared guidance across organisations like the WY&H LMS guidance. This guidance should also include mild/moderate PMH, alignment and communication with HV partners and signposting (organisation-level information with local referral pathways for women with specific characteristics) to specific services to support women with factors that increase vulnerability to poor PMH. Across the region, we need consistency in:

1. Guidance to professionals in midwifery and HV services

a. We have found considerable differences in the guidance provided to professionals in midwifery and HV services (both within and between geographical areas in West Yorkshire), but we cannot quantify the potential impact of these inconsistencies on PMH identification and access (we have not performed close direct comparisons between the MW and HV guidance where we have both for the same area i.e. for Leeds and Bradford). The importance of communication between midwifery services and GPs is emphasised in the WY&H LMS guidance with information on developing and communicating PMH integrated care plans. Consistency in the distinction and integration between the roles and responsibilities of midwifery and HV services and the extent of communication is required.

2. Which tools to use and what thresholds mean

a. There is uncertainty in which outcome measures and thresholds should be used to identify different levels of need, or how the performance of these measures may vary for different groups.

b. It could be helpful to include a statement in any shared guidance on the role of clinical judgement together with or instead of outcome measures in the assessment of MH and decision-making about appropriate services for referral. The importance placed on clinical judgement is also a limiting factor in trying to capture existing guidance to move towards consistency in PMH identification and response across the region. There are advantages to a more subjective approach but also a risk of maintaining or increasing inequalities:

    i. Advantages – clinical judgement can help identify women who may have been missed (false negatives) and reduce unnecessary referrals (false positives). Clinicians can consider women's needs on a case-by-case basis, possibly taking a more holistic approach. It may provide the opportunity for the identification of poor MH in non-disclosing women, particularly where symptoms may be experienced differently by different groups e.g. psychosomatic symptoms or not having the awareness to be able to identify symptoms of anxiety and depression (Prady, 2013b; Prady, 2013a). However, with this there is a need for understanding, including cultural competency, by clinicians to understand why women from certain groups may be less likely to disclose poor MH and what might help these women to feel able to disclose, such as learning around emotional safety. Clinical judgement can also protect against the inappropriate referral of women with transient distress who may score high on a PMH outcome measure at one contact (e.g. due to recent circumstances) but do not require further support.

ii. Disadvantages – clinical judgement may perform differently with people from different backgrounds or with different presentations, i.e. there could be biases relating to what is identified through wider conversations and observation, whereby people with certain characteristics may be less likely to have their needs identified. This may increase the time to receiving support, possibly allowing the woman's MH to deteriorate further.

c. The adherence to descriptive rather than scoring guidance by professionals in determining the appropriate referral route and the lack of standardisation in terminology across guidance may also result in inequalities. We consider this another type of clinical judgement in action. For example, where level 1 severity in the Leeds (multiagency) guidance is described as 'adjustment and emotional issues' but 'symptoms of depression and/or anxiety that do not meet the diagnostic criteria but significantly interfere with personal and social functioning' in the CHFT guidance (and consistent with the NICE guidance), women under the care of CHFT might not be referred to services that those in Leeds may be able to access.

d. Uncertainty in the thresholds for referral comes from limited guidance around identification of women with different needs and a lack of information about which services are appropriate for those needs, or for women with specific clinical or social characteristics.

e. Different thresholds (or none) are specified in the scoring of the outcome measures to indicate eligibility for different levels of PMH support (which could be due to differences in capacity/availability of support). These thresholds typically determine to which service the woman is referred. This means that a woman scoring 4 on the PHQ-9 in the Bradford area will not receive any support other than within standard care, whilst a woman with the same score in Leeds or Wakefield (BDCFT HV guidance) could be eligible for support via the GP, Family Hub or signpost-posted to self-help options. It could result in delayed identification of vulnerability or greater deterioration of MH in Bradford than in other areas. This possibility seems most likely for women with lower level needs, given the SPA to MH services for women with more severe mental ill-health (levels 3 and 4) in almost all areas.

3. Approaches to other PMH conditions

a. Depression, postpartum psychosis and, to a lesser extent, anxiety are the focus of the pathways. Severe MH illnesses are not restricted to the perinatal period, and they are mentioned (e.g. women with bipolar disorder, schizophrenia etc.). However, there is very little guidance on assessment and referral for other MH conditions, such as anxiety disorders, eating disorders, tokophobia, and birth-related PTSD, or how to support women with comorbidities. This could result in poorer identification and access to PMH services by women with these conditions.

b. The differences between organisations' guidance documents (and sometimes absence of specific guidance) on identifying anxiety could result in differences between areas in the detection of anxiety and anxiety-related disorders.

c. There is inconsistency in the terminology used to describe different levels of need in different areas, particularly level 1 need. This may affect which services women are signposted to, especially when clinical judgement is a major factor in the assessment. The

language of adjustment and emotional health issues, used by Leeds, may be problematic as it is potentially quite a loaded or complicated description for people to engage with without relevant training.

d. Disparities between organisations in the classification of high level needs (levels 3 and 4 and whether level 4 is associated with red flag symptoms or not) could result in inequalities in access to timely and appropriate treatment. For example, following the Leeds (multiagency) guidance, a woman with severe PMH needs would receive an urgent referral to secondary MH services, following the BDCFT HV (Wakefield and Bradford) guidance the referral would be non-urgent, and following the HV guidance for Calderdale and Kirklees, a woman with severe PMH needs would receive primary care MH services and GP support.

4. Approaches to make services inclusive

a. The extent to which the services identified in the guidance are accessible to minority ethnic women or those with little or no English or socioeconomic barriers to engagement is unknown. None of the organisations' guidance identifies specific approaches or support for these groups who have a higher vulnerability to poor mental health but seemingly lower prevalence. Inclusion of processes to improve identification of poor MH, and services that support women in these vulnerable groups in the PMH pathways could ensure that these women are identified and receive appropriate support. Enhanced collaboration between VCS and NHS services could enable this.

b. We would also recommend the inclusion of information around the risk of failure to identify and support women in specific groups and opportunities for joint working, as has been included for young women and girls with a history of mental health needs in the WY&H LMS guidance (Appendix 4).

5. What services are available and how they work together

a. There appear to be differences in the number and variety of specialist services available for people with level 3 and 4 needs and for people with specific characteristics which increase their vulnerability to poor PMH, such as complex social needs, domestic violence and learning disability (which may relate to each area's knowledge of specific needs in their population). In the guidance documents, there was also limited detail of how and when different services that support women and families with PMH and related needs in any geographical area should work together. In particular, we cannot tell whether every woman with specific needs (e.g. substance misuse) accesses all of these services or how effectively these services communicate and collaborate to meet the woman's PMH needs. From the information provided, we also do not know the extent to which referral between these and PMH services is two-way, which could help us to understand whether PMH services view specific characteristics that increase vulnerability to poor PMH as requiring specialist support during the perinatal period.

b. Offer of services should not be postcode dependent

i. We identified variability in the availability of support for women with vulnerability factors and/or with PMH needs based on location. All women should have access to appropriate support.

ii. We also found variability in the availability and role of specialist perinatal mental health professionals in universal services. These roles can offer consultation services to midwifery and HV staff and provide direct clinical support to women with level 1 or 2 PMH needs. Consistency is needed in both what SPMH roles are embedded in universal services and the services they offer (i.e. caseloading and/or advisory).

6. The availability of specialist PMH professionals

a. The lack of information provided in the guideline documents on the availability and function of PMH specialists in universal services indicates a disparity in the provision of PMH specialists within universal services or that the guidelines do not reflect the provision. If the latter, then there could still be disparity in access if not all HV/MWs are aware of them, their function, and how to access support.

7. How to identify and support MH issues in fathers, other co-parents, partners, and families during the perinatal period

a. There was no reference to the role of the women's wider social support context in the identification of or support for PMH needs, and limited focus on the need to identify MH needs and support fathers, other co-parents and partners during the perinatal period. It is not known how this omission could impact differently on people with different characteristics, nor how the use of the term 'partners' and not the more inclusive 'fathers, other co-parents and partners' might impact support for families. We agree with the LMS recommendation that 'partners of women that are using midwifery services should also have access to information that addresses their own mental health needs, supporting their partner and bonding and attachment and signposting to support as required', although we suggest that the recommendation is implemented consistently for fathers, other co-parents and partners.

5.1 Further research

From a research perspective, we identified uncertainties from the guidance in the identification of poor MH that merit further investigation:

- Having no or a lower threshold than is stated in the outcome measure manuals is likely to increase the number of women identified with PMH concerns, the number of referrals and access to PMH support, but at what cost, considering the balance of false positives and false negatives?

- How does placing high value in clinical judgement in PMH assessment affect the identification of PMH needs and referral to support services? Does it exacerbate existing inequalities? For example, inequalities in the identification of PMH needs and access to treatment and support may occur when judgements based on physical appearance or behaviour are made.

Specifically, research has shown that PMH identification procedures are less likely to be used and poor PMH identified in Pakistani women, possibly because they may not present to primary care services with the same symptoms as White British women (Prady, 2016). What then happens in terms of the onward pathway – are they deemed ineligible/rejected without an assessment due to not meeting the threshold?

- Does detection via different measures (e.g. EPDS, HADS, PHQ-9) vary for different groups of women such as different ethnic groups or language abilities? How does their performance/accuracy vary with certain maternal characteristics? Should the use of red flag criteria for the identification of people in MH crises vary with people from different backgrounds?

- Given the frequent emphasis on PMH assessment at the booking appointment, to what extent is PMH need assessed at other contact points (as recommended in the guidance), and how well is the outcome of the assessment recorded? What is the role and current use of PMH monitoring in universal services (e.g. monitoring PMH whilst on the waiting list for support)?

- What is the impact of using interpreters to assist with the identification of PMH needs? What additional resources could assist other specific groups with communication needs at risk of inequalities in PMH identification and access, such as women with learning disabilities and neurodiversity?

- How can healthcare staff be supported to develop the knowledge and confidence to identify and respond to PMH needs in women at risk of inequalities in PMH identification and access?

- What, if any, inequalities result from the woman's home postcode, where this alone may result in variation of care and differing opportunities for support? Are any particular groups of women impacted more or less than others by this 'cross-boundary' route of care?

- Whilst a greater number of services does not necessarily mean better support, it would be useful to explore the interaction between services in areas where one or more services for specific characteristics exist. This could include investigation of how each service offers support to women with these characteristics during the perinatal period, pathways between services, and collaborative working.

- What is the impact of having specialist perinatal mental health professionals embedded in universal services, and how does their impact change if they are fully caseloading, advisory or both?

Acknowledgements

We would like to thank the Trust and Health Visiting service professionals who provided the documents used in this report who gave their time to review the maps and other content in this report.

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Appendices

Appendix 1 - Source documents for perinatal mental health guidance by publisher/authors

Publisher	Audience	Document title	Version	Date approved
Airedale NHS Foundation Trust and Bradford Teaching Hospitals NHS Foundation Trust	Midwives, obstetric doctors, MH Team	Bradford and Airedale Perinatal Mental Health in Maternity Care Guideline	4.1	July 2018
Bradford District Care NHS Foundation Trust	Bradford HVs	Mental Health Referral Pathway BDCFT Bradford HV	NA	Not provided
Bradford District Care NHS Foundation Trust	Wakefield HVs, Family Nurses and Nursery Nurses	Maternal (Perinatal) Mental Health Guidelines	3.07	January 2019
Calderdale and Huddersfield NHS Foundation Trust	Obstetricians, midwives, HVs, Junior obstetrics and gynaecology doctors	Guideline for the Care of Women Suffering from Perinatal Mental Health Problems	4.0	October 2015
Leeds Community Healthcare NHS Trust	Not specified	0-19 Early Start Offer Perinatal Parental Mental Health Pathway Leeds Health Visiting	NA	Not provided
Leeds: 'developed by a multiagency, multi professional group'	Not specified	Leeds Perinatal Mental Health Pathway	NA	January 2016
Locala Community Partnerships CIC	HVs, Student HVs, Child Development Practitioners, Breastfeeding peer supporters, Oral Health Practitioners, 0- 19 Practitioners, Student 0-19 Practitioners and Family Nurses	Perinatal Maternal Mental Health Policy	3.1	September 2019
The Mid Yorkshire Hospitals NHS Trust	*Midwives, support workers, medical staff*	*Perinatal Mental Health*	*9*	*Sept 2020*

Note that in some areas, midwifery and HV providers produced separate guidance; while the audience for each may overlap, the guidance produced by the particular service has been used for pathway visualisation.

Appendix 2 – Verbatim guidance on when PMH identification measures should be performed

Organisation	Booking/initial appointment[1]	Other routine appointments (including postnatal)
AFT & BTHFT midwifery	In accordance with NICE (2014) Midwife will ask the [detection] questions[2] at a woman's first contact with services in pregnancy and post-natal period contact.	At the booking appointment the midwife will ask the detection questions and should consider asking these at all subsequent contacts.
CHFT midwifery	At the woman's booking visit the midwife should ask the Whooley questions to identify possible depression. At the women's booking visit the midwife should ask the GAD-2 questions (from GAD-7 questionnaire) to identify anxiety symptoms.	It is good practice to ask about emotional wellbeing at all contacts including booking. All health care professionals who have regular contact with a woman in pregnancy and the postnatal period (first year after birth) should consider: asking the 2 Whooley questions and the GAD-2 as part of a general discussion about her mental health and wellbeing
Leeds midwifery & Health Visiting (multiagency collaboration)	Community Midwife: Mental Health screening for current and personal history of mental illness by 12 weeks of pregnancy or at first contact if later. HV screen and assessment at first postnatal visit.	Discuss emotional wellbeing with every woman at every appointment. HV & GP screen at 6-8 week check, ongoing screening at each contact.
MYHT midwifery	At a woman's booking appointment and in both the antenatal and the postnatal periods, healthcare professionals (including midwives, obstetricians, HVs and GPs) should ask the prediction questions.	At subsequent appointments women should be asked how they are feeling at every routine appointment. This is so that they can talk to their healthcare professional about any concerns they have, and any problems can be identified.
BDCFT Bradford Health Visiting	Not applicable	No guidance provided
BDCFT Wakefield Health Visiting	Not applicable	At every woman's first contact with services and at every contact thereafter, during the perinatal period, practitioners should ask the two DIQ.
LCHT Health Visiting	Not applicable	Utilise the two anxiety screening questions and two screening measures to be used at each core contact. Ask all resident parents [the DIQ], if appropriate, at the Antenatal, Birth, 6 – 8 week, 9 – 12 month and 27 month contacts. If there is a positive response to question 3 [is this something you would like help and support with] it is now recommended that the PHQ – 9 is completed. If they answer NO then what is bothering them should be explored through

Organisation	Booking/initial appointment[1]	Other routine appointments (including postnatal)
		conversation and if/how these feelings are impacting on their enjoyment of being a parent. Offer to complete the screening tool at any time.
Locala Calderdale Health Visiting	Not applicable[3]	The antenatal contact will include 'an assessment of the mother's current and previous emotional wellbeing. Assessments should always take into account the findings of recent presentations and escalating patterns of symptoms, their severity and any associated abnormal behaviour (MBRACE 2018).' At subsequent (routine) appointments the HV should 'ask the 2 depression identification questions (Whooley) and the 2-item GAD-2 questions'.
Locala Kirklees Health Visiting	Not applicable[3]	The antenatal contact will include 'an assessment of the mother's current and previous emotional wellbeing. Assessments should always take into account the findings of recent presentations and escalating patterns of symptoms, their severity and any associated abnormal behaviour (MBRACE 2018).' At subsequent (routine) appointments the HV should 'ask the 2 depression identification questions (Whooley) and the 2-item GAD-2 questions'.

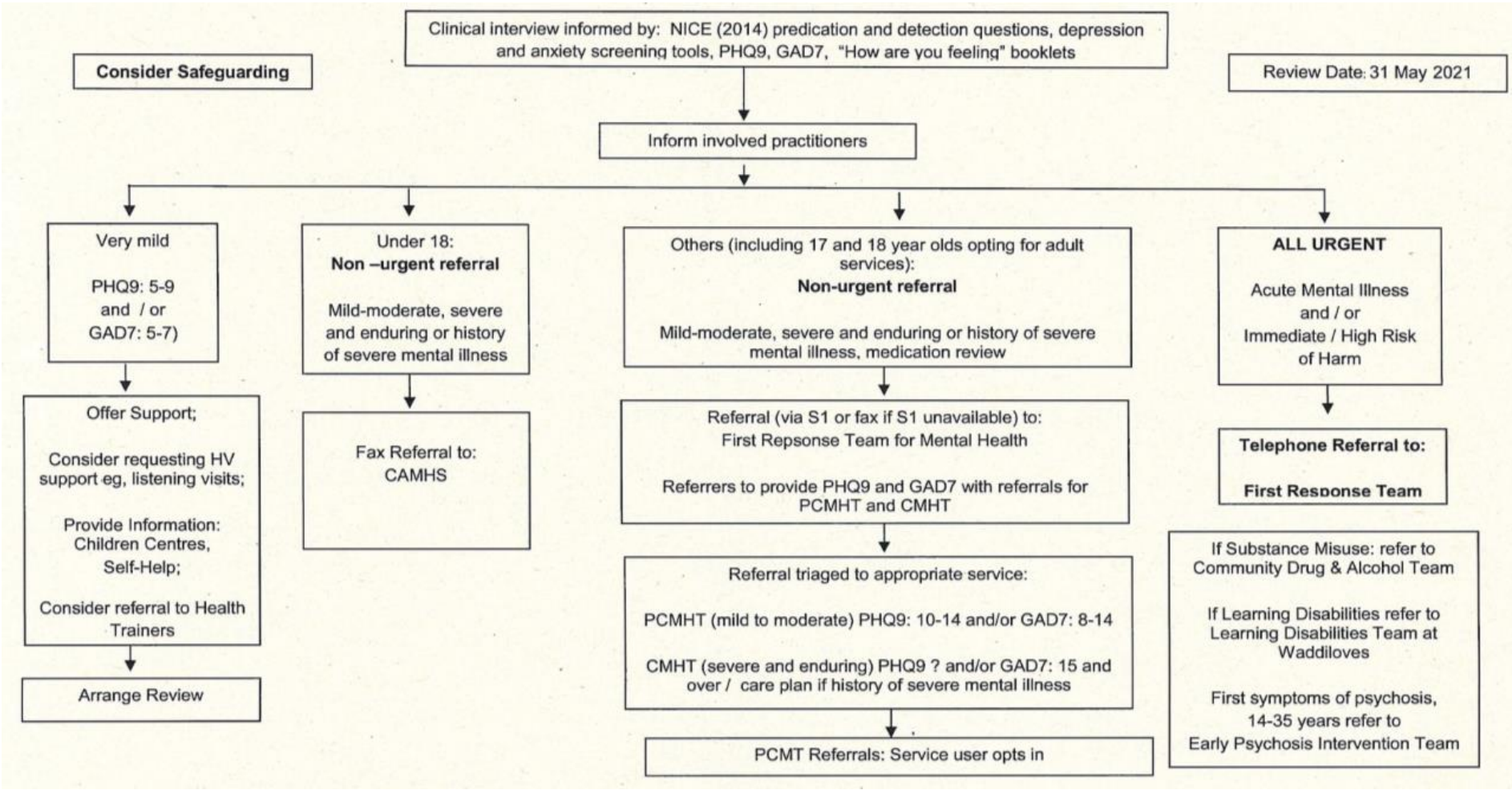
[1]In most instances, screening at the booking appointment is the only specified contact. Thereafter assessment at all pre- and post-natal contacts is recommended.

[2]The assessment tools recommended for use in each area are presented in Table 1.

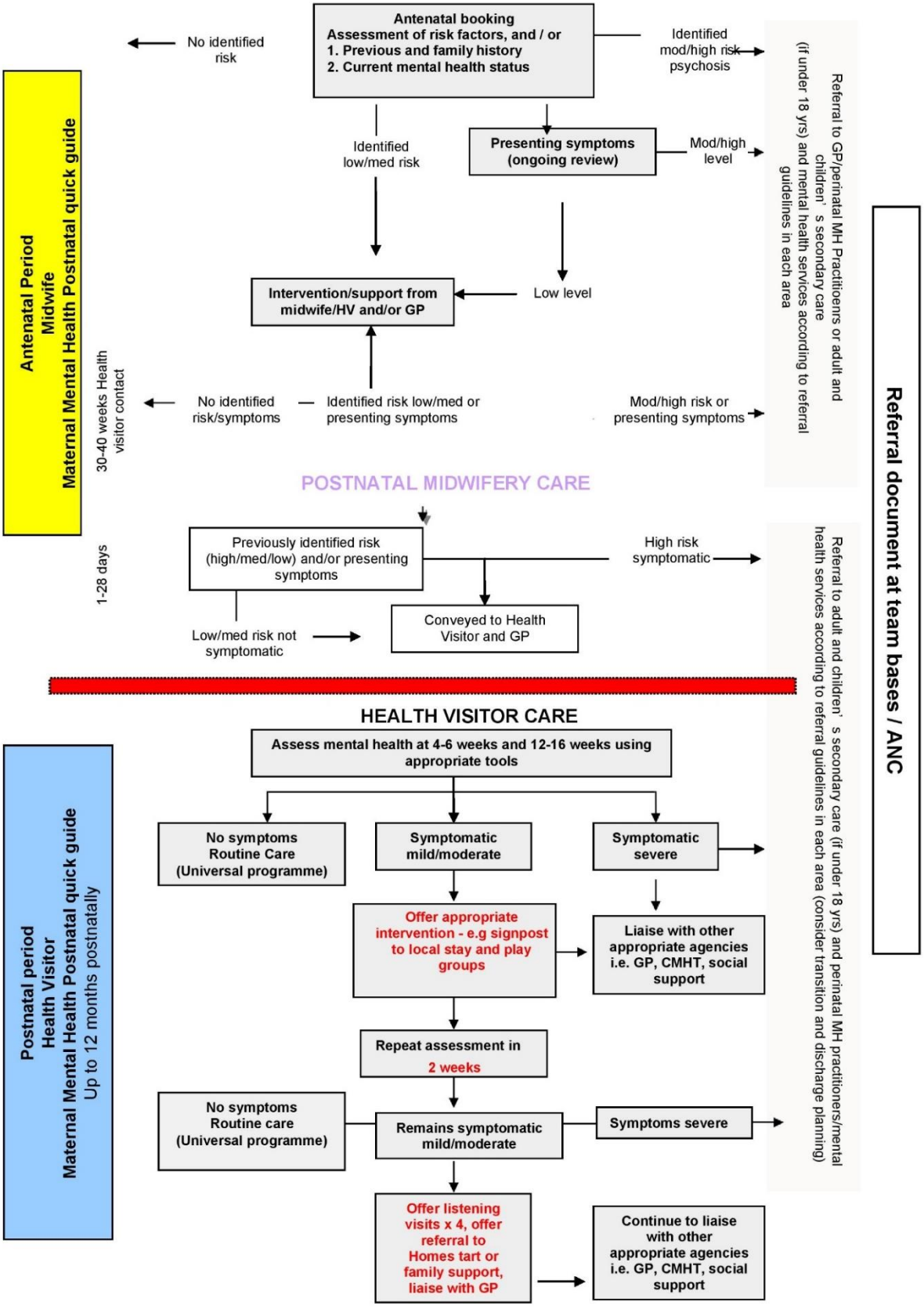
[3] Not applicable because this is guidance exclusively for HVs who do not perform the booking appointment.

Appendix 3 – Pathway and referral diagrams produced by the organisations

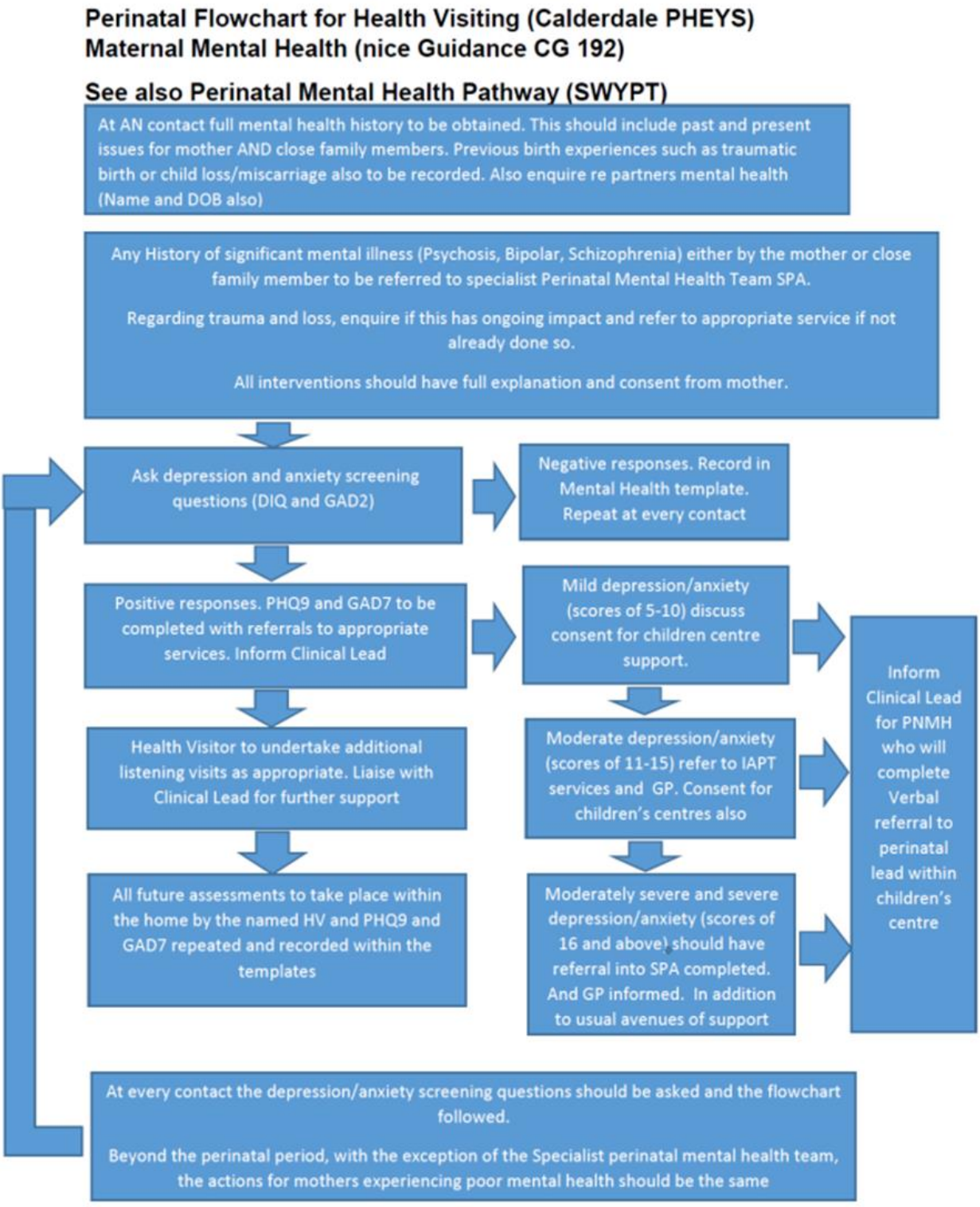
Appendix 3.1. AFT/BTHFT antenatal and postnatal PMH pathway (same pathway figure used by BDCFT Health Visiting)



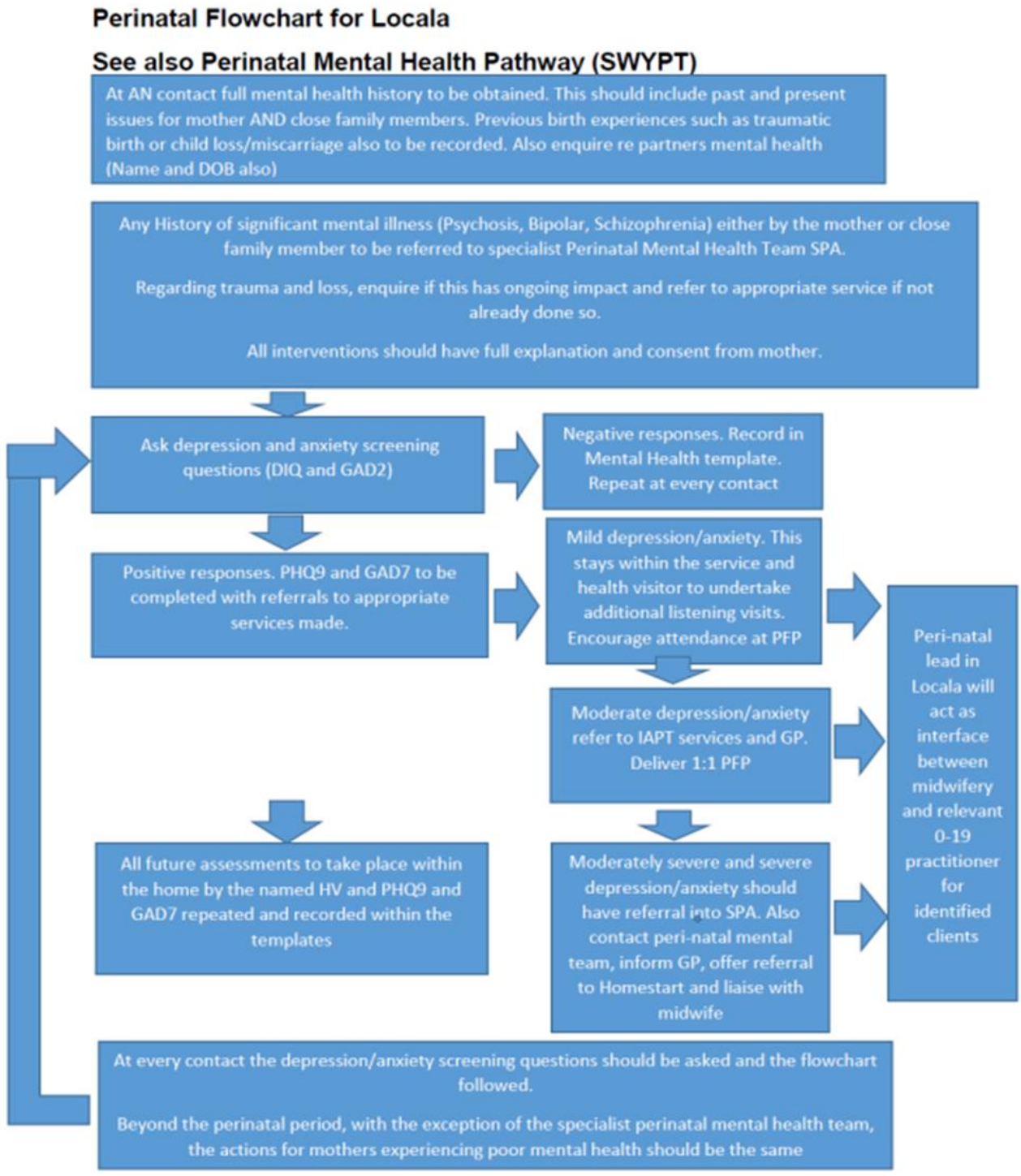
Appendix 3.2. Calderdale and Huddersfield Antenatal and Postnatal Care Pathway (CHFT)



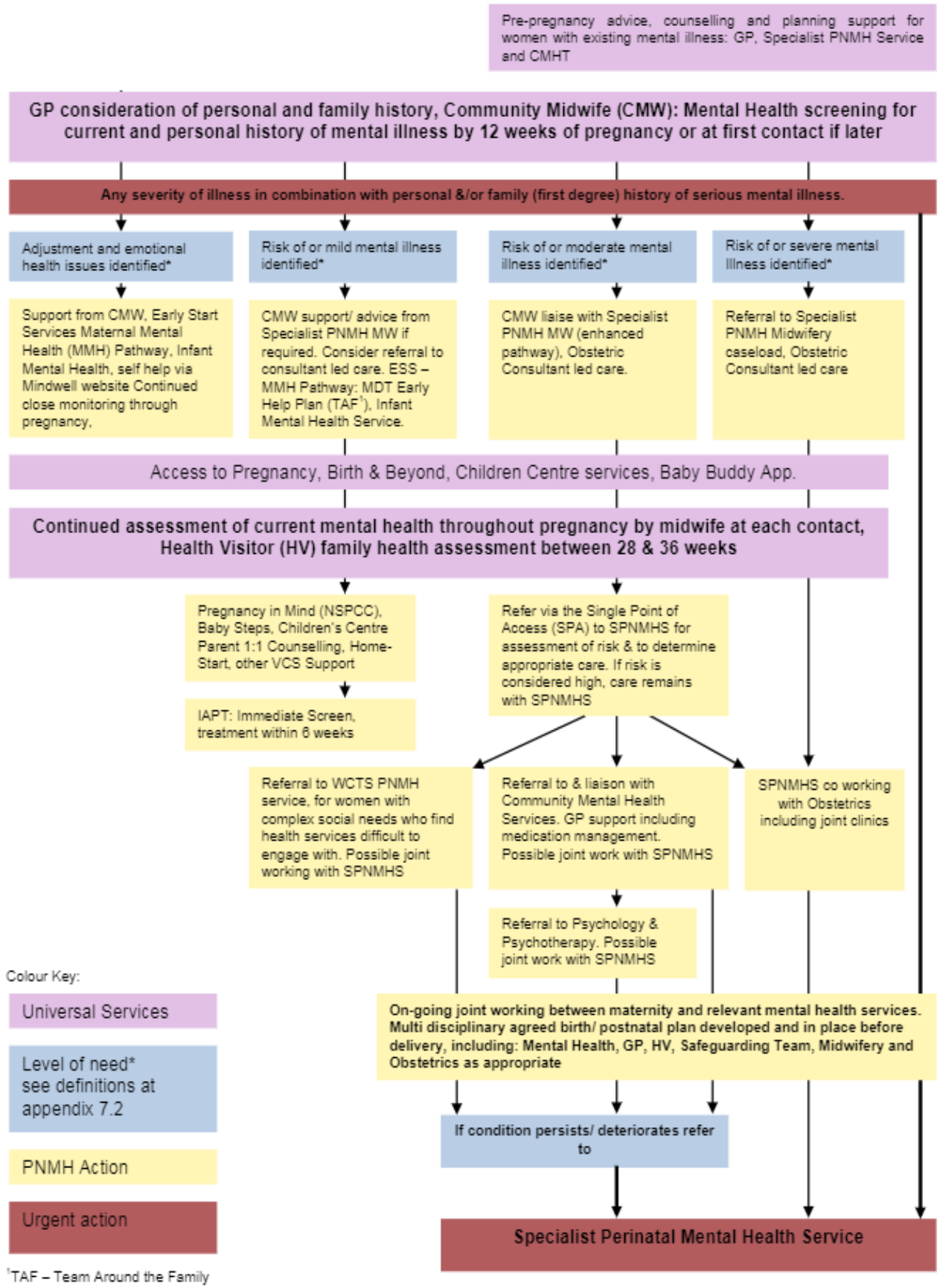
Appendix 3.3. Calderdale perinatal flowchart for HV (Locala)



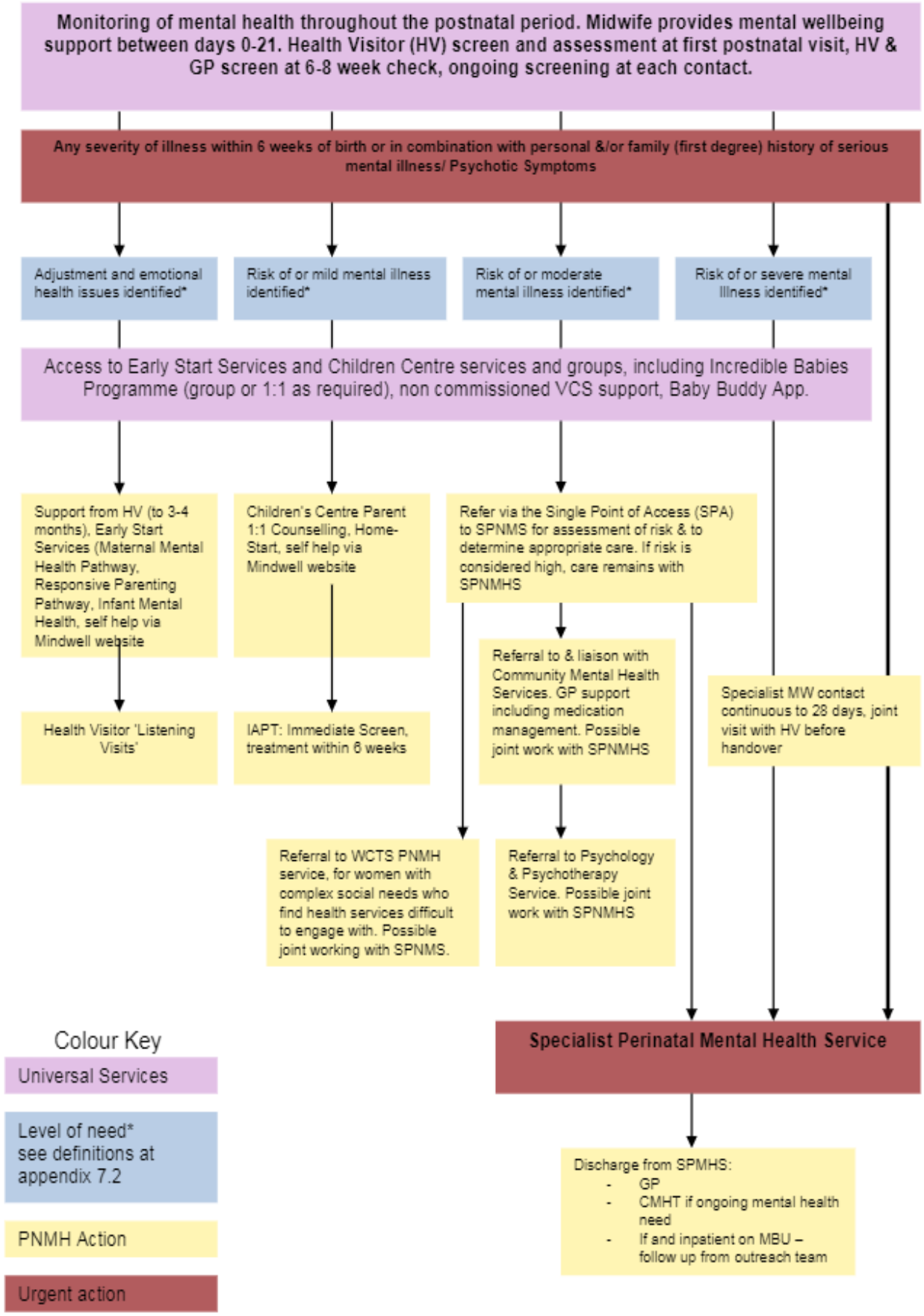
Appendix 3.4 Kirklees HV flowchart for PMH pathway (Locala)



Appendix 3.5 Leeds antenatal and postnatal PMH pathways (Leeds)

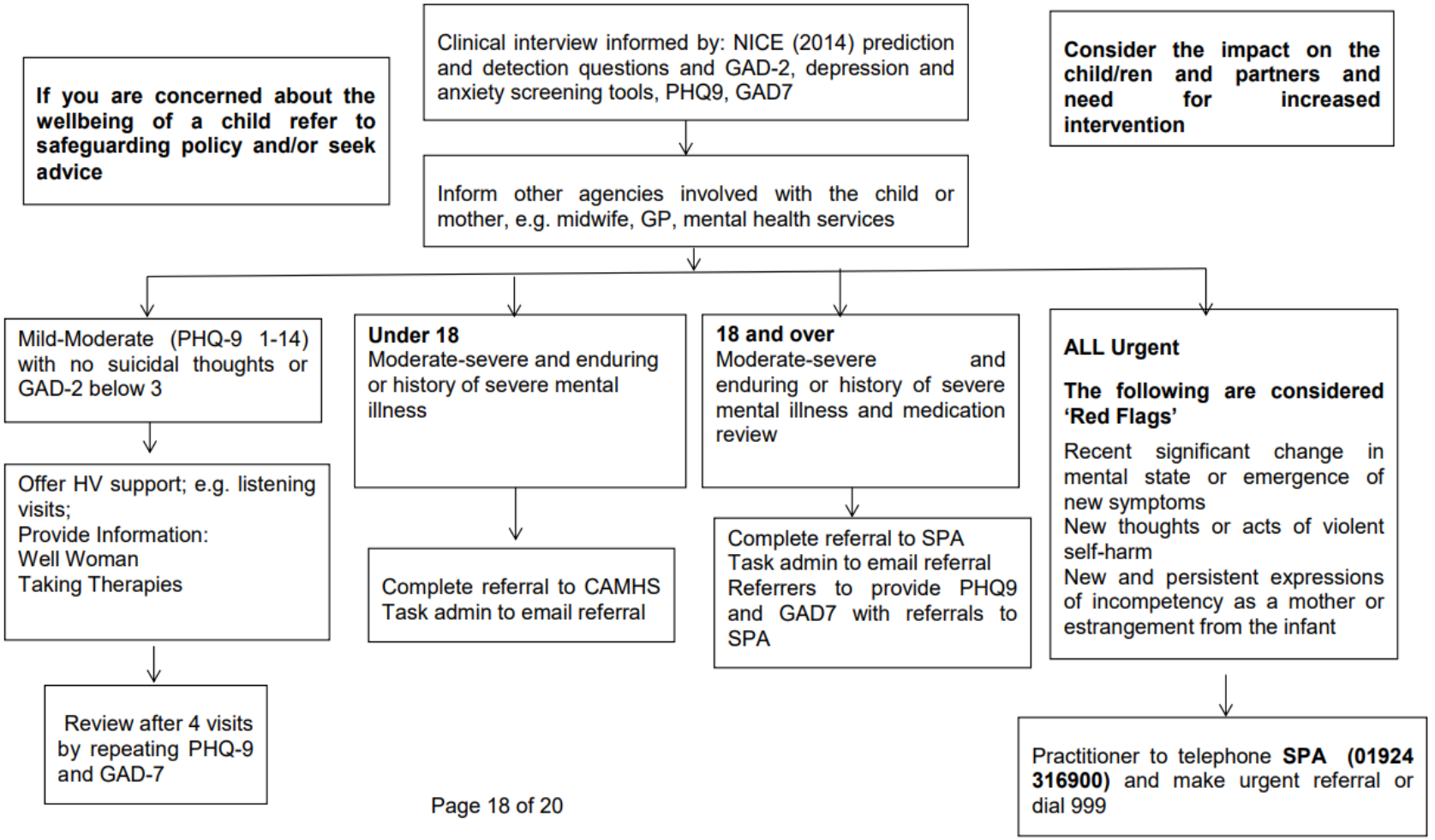


Appendix 3.5 (continued) Leeds antenatal and postnatal PMH pathways (Leeds)



Appendix 3.6 Wakefield Health Visiting PMH care pathway (BDCFT)

10 APPENDIX B: 0-19 SERVICE MATERNAL (PERINATAL) MENTAL HEALTH CARE PATHWAY PREGNANCY – 1 YEAR POSTNATAL



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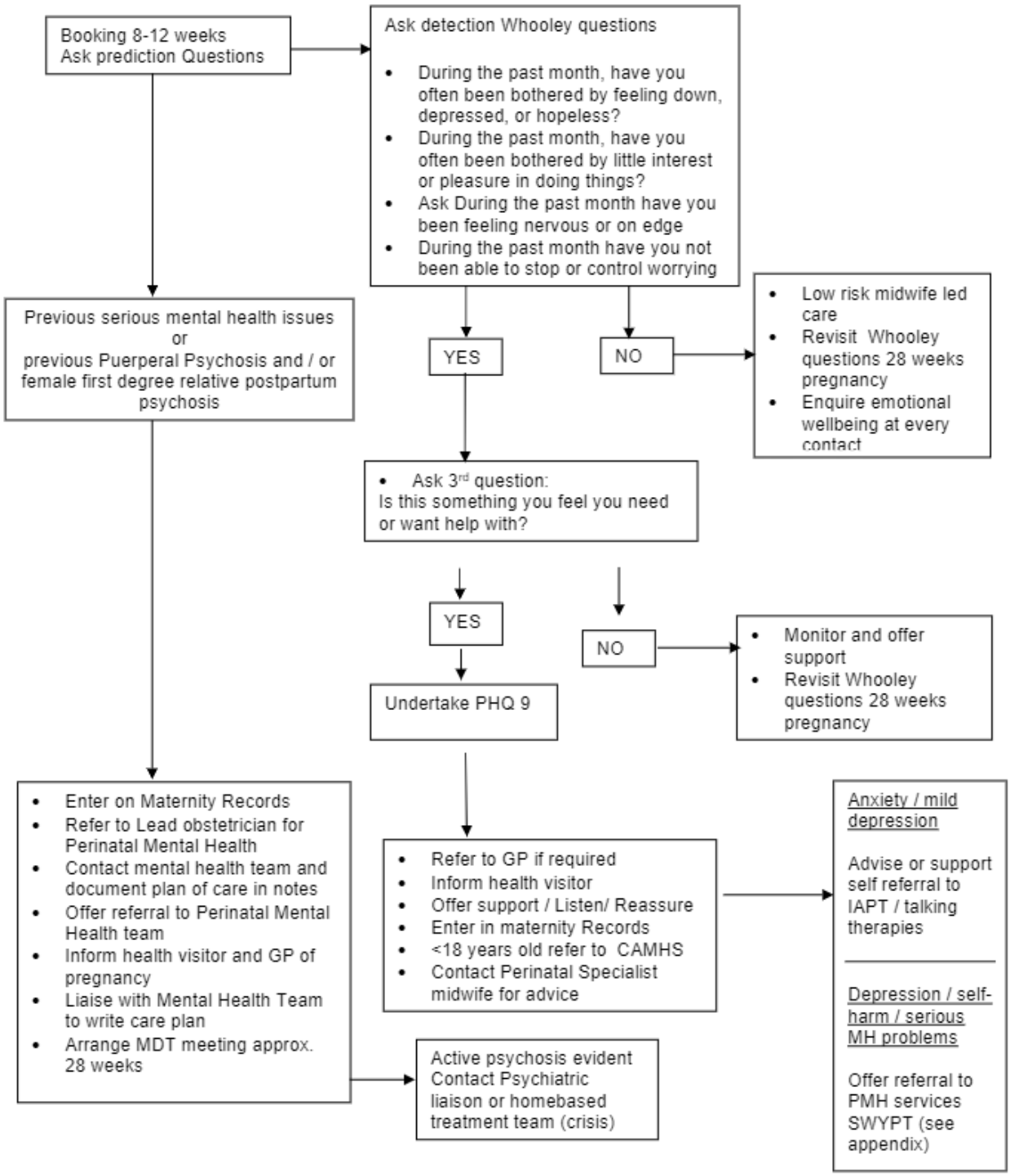
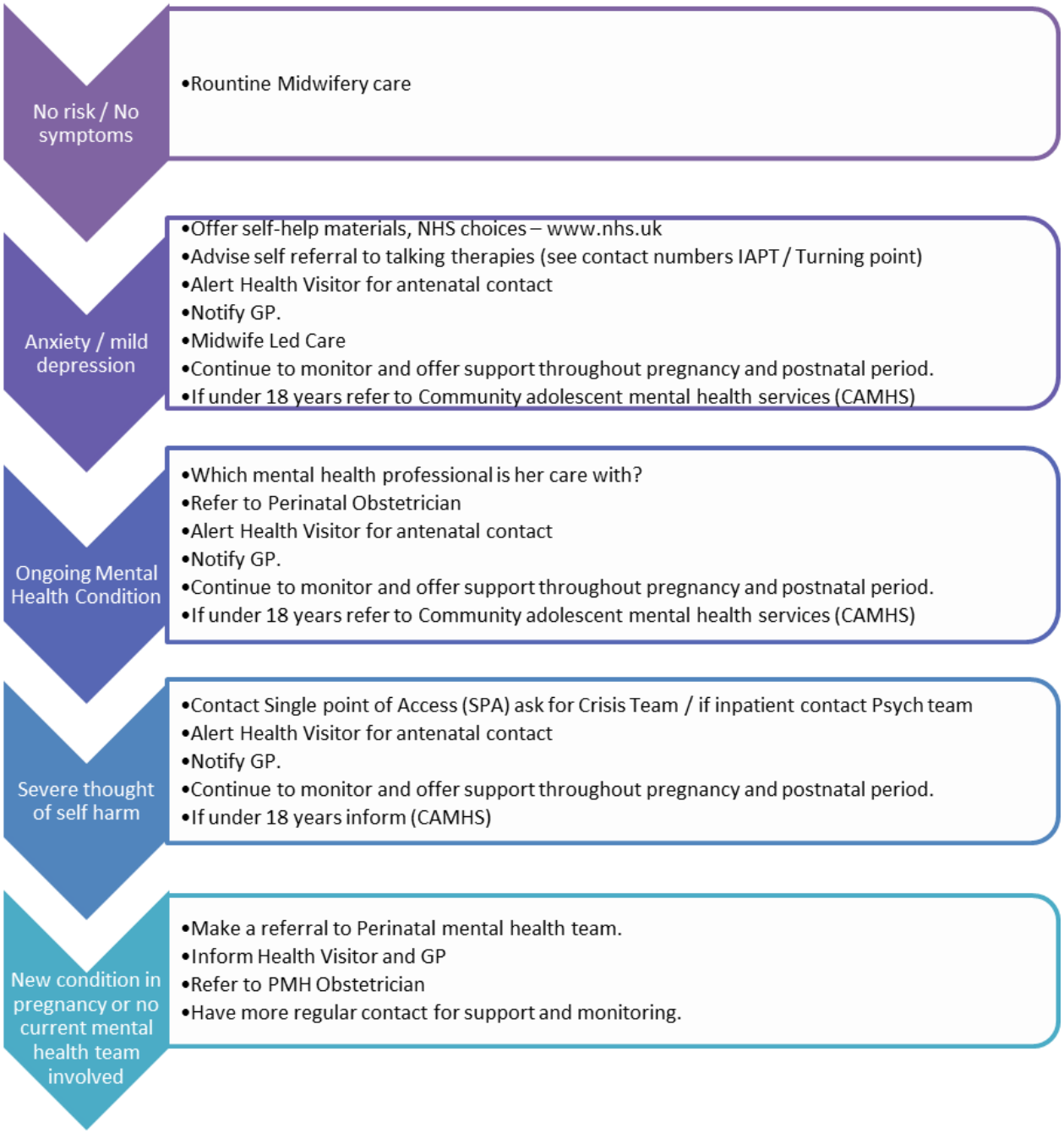
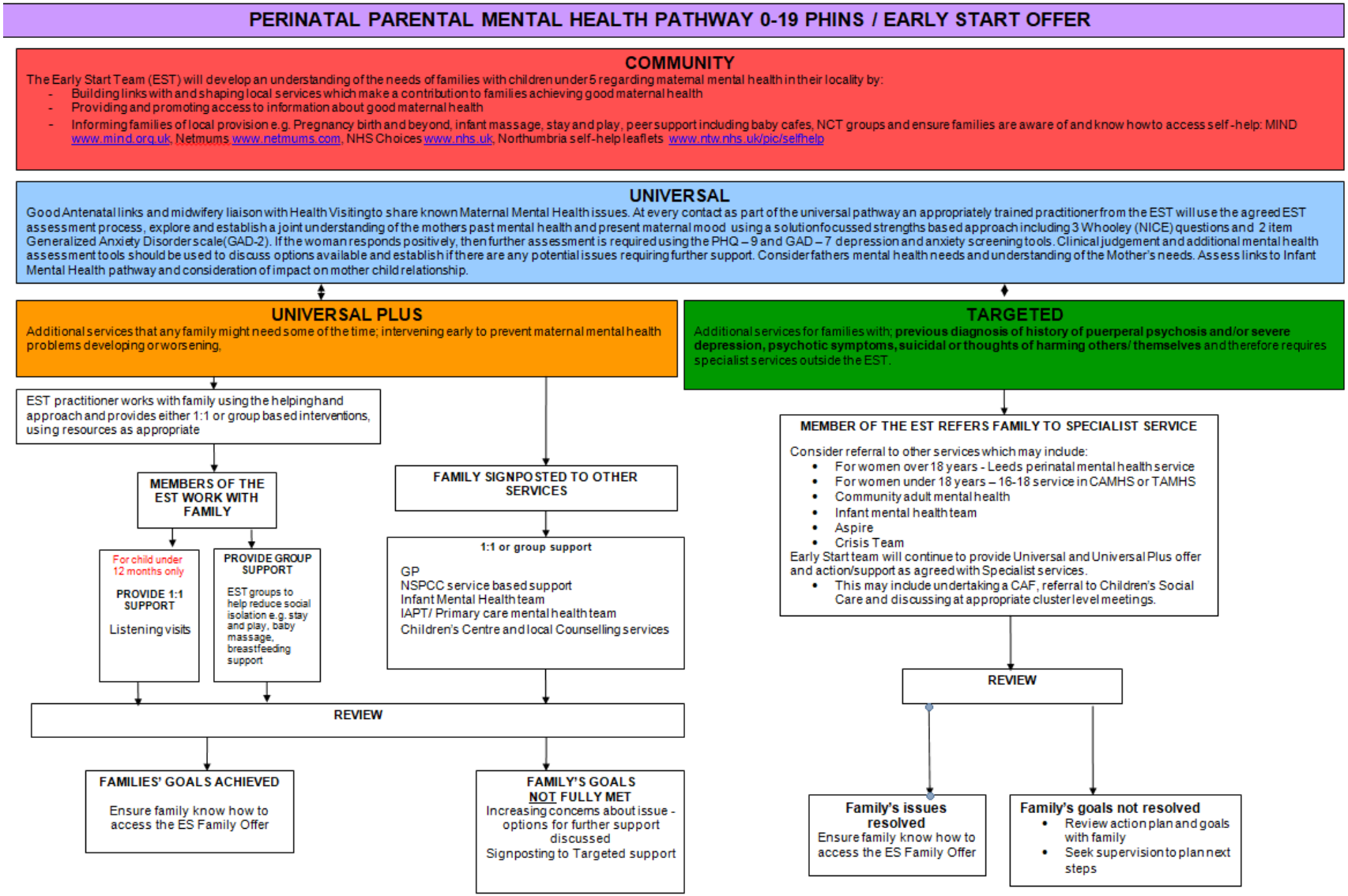
Appendix 3.7. Wakefield Antenatal and Postnatal Care Pathway (MYHT)



Appendix 3.8. MYHT PMH Referral Recommendations



Appendix 3.9. Perinatal parental MH pathway early start offer (0-19)



Appendix 4 - WY LMS guidance (document currently unpublished) on how to support young women and girls with a mental health condition in pregnancy and/or postnatal period.

When working with girls and young women (under the age 20 years old) with a mental health problem in pregnancy or the postnatal period:

- Be familiar with local and national guidelines on confidentiality and the rights of the child
- Be aware of the recommendations in section 1.4 of the guideline on pregnancy and complex social factors (NICE guideline CG110)
- Offering age appropriate services
- Acknowledge that they may be dealing with other social circumstances e.g. school work
- Offer information on help transportation to and from appointments.
- Consider the setting within which antenatal care is offered e.g. GP practices, children's centres and Schools.
- When allocating a young person to antenatal care consider this to be continuity and with direct access via telephone for the named midwife.
- Ensure information for these women is age appropriate.
- Provide antenatal age specific peer support
- Provide opportunities for the partner/father or other co-parent/s of the baby to be involved in the antenatal care, with the agreement of the woman

Health care professionals should be aware that all women under the care of child and adolescent mental health service (CAMHS) should also be under the care of perinatal mental health throughout their pregnancy and the postpartum period. It is the health care professional's responsibility to ensure that this is the case.

Appendix 5 - Clinical supervision by Trust (adapted from the LMS report)

Specialist Midwife	Trust A	Trust B	Trust C	Trust D	Trust E	Trust F
Dedicated PNMH	X	✓	X	✓	X	✓
Other	✓	X	✓	✓	✓	X
Case-loading (Continuity of Carer)	X	✓	X	✓	X	X