NHS
North West Coast Clinical Networks

Perinatal Mental Health: Resource Pack for IAPT Services

North West Coast Perinatal Mental Health Network

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Version 1.1

Contents

Introduction

It is widely recognised that the perinatal period (pregnancy and the postnatal period) causes significant emotional changes for mothers, partners and the family as a whole. Whilst some may experience these changes as a positive experience and associate them with normal changes in pregnancy, for others it can be distressing and result in the onset or exacerbation of mental health problems.

The majority of mental health problems experienced during the perinatal period will be mild to moderate (NICE, 2016) and can be appropriately managed and treated within primary care settings, such as Improving Access to Psychological Therapies (IAPT) services.

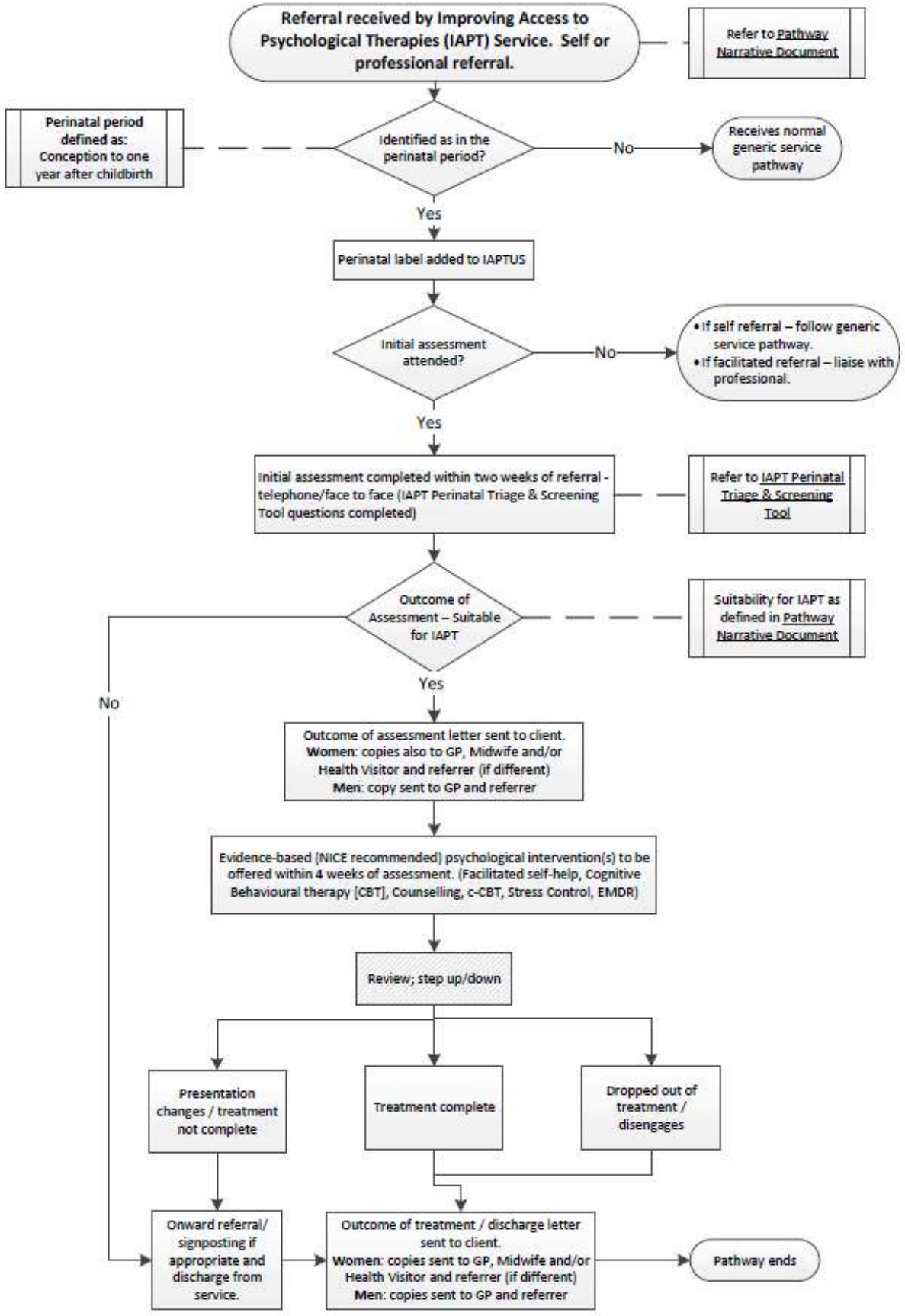
IAPT services are commissioned to deliver evidence based psychological therapies to individuals experiencing mild to moderate depression and anxiety disorders, including parents with perinatal mental health problems. IAPT acknowledges that if left untreated, mental health problems during the perinatal period could have a serious impact, and potential long-term consequences, for the mother, child, and other family members (IAPT, 2013).

Therefore, it is vital that women experiencing mental health difficulties during the perinatal period have timely access to evidence-based care and that appropriate interventions are delivered by staff that have sufficient knowledge, training and competencies to meet their needs (NICE QS115, 2016). In some cases an integrated approach to care may be required, coordinating services to ensure that a high quality provision of care is delivered to women throughout the whole of the antenatal and postnatal period.

To support the provision of perinatal mental health care within IAPT services, the North West Coast Clinical Network for Perinatal Mental Health has developed the resources within this pack/document, which aim to improve access to appropriate services within the recommended timeframe and improve integrated working with other healthcare professionals.

Special thanks are given to Lisa McCormick and the members of the Lancashire and South Cumbria IAPT and Psychological Services Sub-group of the NWC PMH Network who led the development of these resources.

Perinatal Mental Health Psychological Interventions (IAPT) Pathway



IAPT Perinatal Pathway Narrative

Referral –Both self-referral and facilitated referrals from healthcare professionals will be accepted for perinatal clients; any referring professional must have gained consent from the client to refer into IAPT services.

Identification – Identification question to be asked at point of referral; "Are you or your partner currently pregnant, or have you become a parent in the last 12 months?" Any client (male or female) that answers yes to this question should be prioritised as within the perinatal period and assessment/treatment offered within the appropriate timeframe (as per NICE guidance).

Initial Assessment – As per NICE guidance, clients identified as being within the perinatal period should be offered an initial assessment within two weeks of the referral received. Treatment (if appropriate) should commence within 4 weeks from the time of assessment (or 6 weeks from referral received).

Perinatal Triage and Screening Tool – In order for practitioners to use this tool appropriately and effectively, it would be beneficial for practitioners to have completed the iHV Perinatal and Infant Mental Health Awareness one day training. This tool should be used for all female perinatal clients at time of initial assessment, and if a person's presentation changes/there is concern about risk.

Suitability – IAPT services provide support for adults with depression and anxiety disorders that can be managed effectively in a uni-professional context. Support is provided through the delivery of evidence based interventions, using a stepped care model. Core IAPT services provide treatment for people with the following common mental health problems:

- depression
- generalised anxiety disorder
- social anxiety disorder
- panic disorder
- agoraphobia
- obsessive-compulsive disorder (OCD)
- specific phobias (such as heights or small animals)
- PTSD
- health anxiety (hypochondriasis)
- body dysmorphic disorder
- mixed depression and anxiety (the term for sub-syndromal depression and anxiety, rather than both depression and anxiety).

(IAPT Manual, 2018)

*Please see individual service SOP for further information relating to suitability.

Accessibility and Evidence based interventions – Consideration of late stage pregnancy and early postnatal period; consideration should be made as to what intervention/s could be offered to the client given their current perinatal status; this may differ slightly from the intervention that would be offered if that person were not in the perinatal period. For example it may not be appropriate to complete trauma processing work with a client in late pregnancy,

however stabilisation and anxiety management interventions could be offered to minimise impact of symptoms and reduce anxiety around the time of birth.

Services may also need to be tailored to adapt to perinatal stage. For example, sessions may need to be longer to allow time to feed or change the baby and appropriate facilities need to be available to do this. If the client has mobility issues they may prefer telephone treatment or cCBT if appropriate; there may need to be an agreed 'therapy delay' around the time of the birth etc.

Onward referrals – If risk factors are identified follow the advice on the Perinatal Triage and Screening Tool, or refer to Specialist Perinatal Services criteria guidance. If no significant risk issues, other onward referrals may be to SPA/START, back to GP, or third sector services i.e. Women's Centre.

Evidence based treatment – This should be offered to the client within 4 weeks from the time of assessment (if meets suitability criteria) and should be in accordance with NICE and IAPT guidance. Possible interventions may include: Stress Control; facilitated self-help (1:1/group); Cognitive Behavioural Therapy (CBT) computerised-CBT; Counselling; EMDR. Additional input from relevant professionals (maternity services, health visiting and Specialist Perinatal CMHT's) should also be considered and joint working facilitated where necessary and beneficial to the client.

Review – All cases should be reviewed during supervision (as per IAPT guidance) and any necessary adjustments to treatment made accordingly.

Presentation changes/treatment not complete – If a client's needs are no longer able to be met within an IAPT service, onward referral/discharge from service may be required even if treatment not complete. This should be considered when the client is unable to engage fully in psychological therapy (i.e significant deterioration in mental health, risk issues, environmental/social factors), if more complex needs are identified which require support from alternative services, or if the client is not moving towards clinical recovery/reliable improvement. In accordance with generic pathways these cases should be discussed with supervisor, and Perinatal Champion consulted for advice/guidance if required.

Drop-out/disengagement – If a client disengages from treatment, consideration should be made as to whether there have been any perinatal risk factors identified during the course of treatment, or if the client has recently entered the post-natal period; if this is the case clinical judgement and supervision should be used to determine whether any additional action is required prior to discharge from IAPT service.

IAPT Perinatal Triage and Screening Tool

The questions and prompts below are specific for perinatal clients; please obtain this information for all women identified as being in the perinatal period and take any necessary action.

- Do you consent to our service sharing information with your midwife and/or health visitor?
  (Assessment outcome and discharge letters to be communicated to these professionals)

- What is the name of your community midwife and/or health visitor? Do you have their contact details?

- Are you under the care of a Specialist/Enhanced Midwife/Specialist Health Visitor? If yes, please record name and contact details.

- **(If pregnant)** How many weeks pregnant are you?
  - What is your expected due date (EDD)?

- **(If post-birth)** Date of birth and full name of child.
  - Were there any issues with your pregnancy, or the birth?

- Have there been any issues with previous pregnancies/births?
  [Please note that loss of a child, either by miscarriage, stillbirth, and neonatal death or by the child being taken into care increases vulnerability to mental illness for a mother and she should receive additional monitoring and support (MBRRACE-UK, 2015)]

- Do you feel that you are bonding with baby/bump?

- Is there any other service involvement currently? (Consultant led care/Social services etc.)

- Do you have a partner? How are they managing at the moment?
  - Does your partner use alcohol or drugs? **(Gather details)**

RISK SECTION

When enquiring about risk indicators please be aware of the following 'red flag' signs for severe maternal illness; the presence of which requires urgent senior psychiatric assessment:

-- 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. *(MBRRACE 2015)*

- Have you ever required treatment by a specialist mental health service, including secondary care services or inpatient care?
  [Women with a history of postpartum mood destabilisation or psychotic disorder are at elevated risk]

- Have any of your first degree relatives (mother or sister) experienced severe mental health difficulties during pregnancy or following a birth?
  [*Women with a family history of bipolar disorder or postpartum psychosis should be closely monitored for any change in their mental state]*

- 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?

(MBRRACE 2018)

RISK SECTION CONTINUED….

Seek advice/consider onward referral to specialist services if risk indicators identified, particularly where a woman has any of the following:

-- rapidly changing mental state,

-- suicidal ideation (particularly of a violent nature),

-- pervasive guilt or hopelessness,

-- significant estrangement from the infant,

-- new or persistent beliefs of inadequacy as a mother,

-- evidence of psychosis.

(MBRRACE 2015)

Mon-Fri (9-5):

Specialist Perinatal Community Mental Health Teams telephone numbers:

- Lancashire and South Cumbria (LCFT)	01254 612 731
- Cheshire and Wirral Partnership NHS Foundation Trust	0151 488 8434
- Mersey Care NHS Foundation Trust	0151 702 4012
- North West Boroughs Healthcare	01925 275 303

Out of hours:

Crisis Resolution & Home Treatment Team

- Use local service number

Specialist Perinatal Community Mental Health Team websites:

- Lancashire and South Cumbria
- Cheshire and Wirral Partnership NHS Foundation Trust
- Mersey Care NHS Foundation Trust
- North West Boroughs Healthcare

** Psychotic thoughts relating to child/foetus increases risk significantly and should be stepped up immediately**

* Children and/or babies are NOT considered a protective factor in the perinatal period; therefore it must not be assumed that the presence of a child would prevent a person from acting on suicidal thoughts*

Joint working proposal – IAPT & SPCMHT

Joint working should be considered when a woman presents with a moderate-severe mental health disorder and meets criteria for input from the SPCMHT but is stable enough to engage in psychological therapy, and therapeutic input is thought to be beneficial and of value. Joint working might also be considered for women who are currently well but under SPCMHT due to high risk of perinatal mental health difficulty arising.

Possible presentations include:

- Post-Traumatic Stress Disorder
- Tokophobia (Primary/Secondary)
- Obsessive Compulsive Disorder
- Severe anxiety
- Severe depression

For joint working to be appropriate women should be considered as suitable for treatment within an IAPT service; for evidence based, brief psychological input to be deemed beneficial, and the woman likely to achieve clinical recovery within that timescale.

It would not be appropriate for women identified as having high risk factors or lack of stability*, to access psychological therapy within an IAPT setting, however mild to moderate risk issues could be managed by practitioners within the SPCMHT and regular liaison with the assigned therapist.

SPCMHT can offer wrap around approach to provide care coordination, occupational therapy, nursery nurse input for issues around bonding/attachment, medication management, risk management and review, and ongoing support where needed.

Psychological therapy within an IAPT service would not be considered suitable for women presenting with Bipolar Affective Disorder, or Personality Disorders, unless the IAPT service offered step 3.5 and had staff qualified to work with these presentations. Some areas may have Perinatal Mental Health Practitioners outside of IAPT services and joint working between SPCMHT and these services may be beneficial for these presentations.

*Consider whether any of the following factors are present when assessing level of risk and suitability for therapy:

- Thoughts of violent self-harm
- Recent suicide attempt (within 2 weeks)
- Ongoing suicidal ideation with intent
- Plans made to end life
- Patterns of reckless or dangerous behaviour
- Recent deterioration in mental state
- Persistent thoughts or plans of estrangement from infant
- Mental state significantly impacting functioning or ability to carry out activities of daily living
- Complex social needs which may prevent ability to engage in therapy
- Frequent and severe self-harm, requiring medical attention

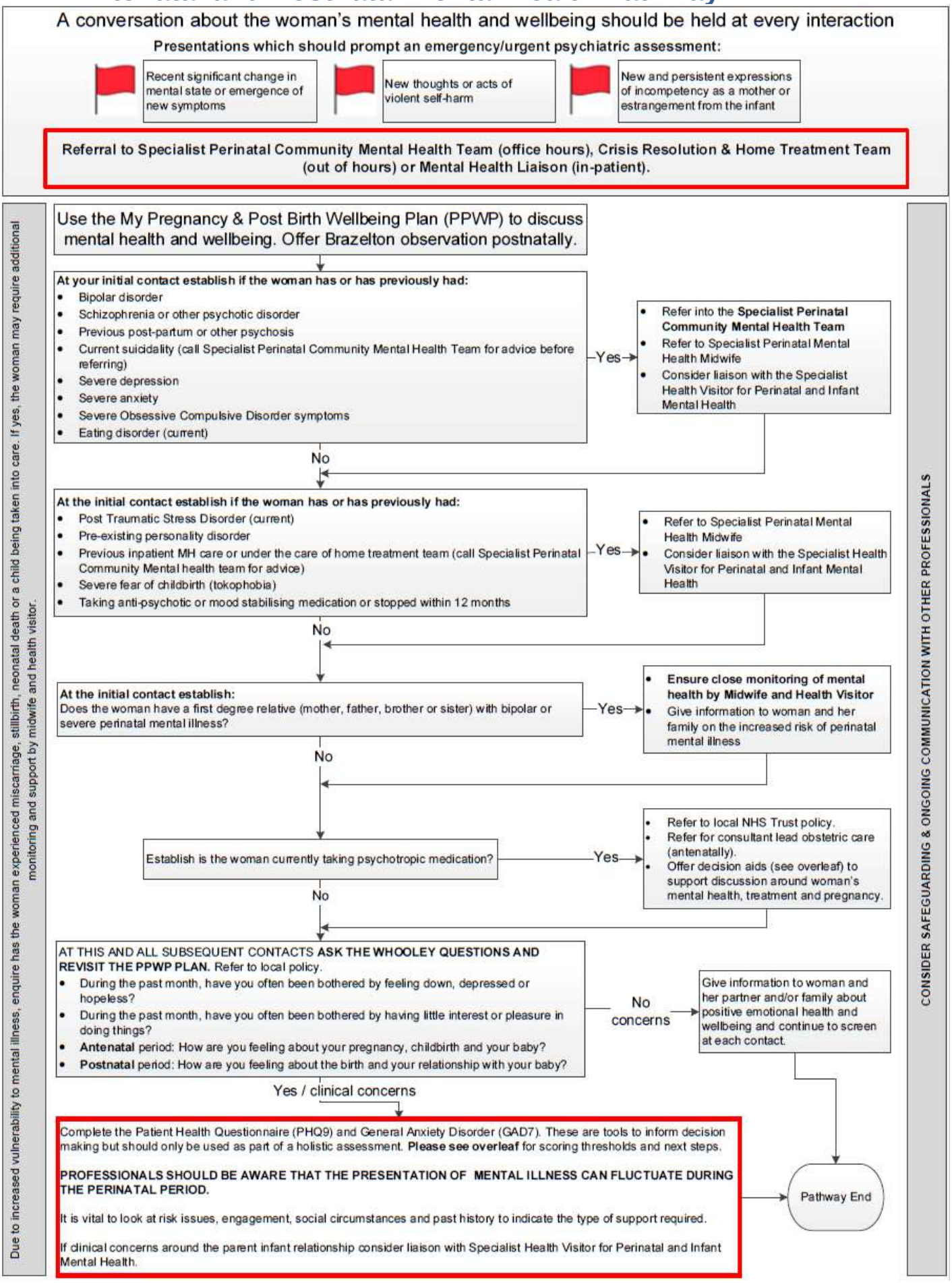
IAPT Perinatal Lead – Duties and Responsibilities

- To have, and develop, an increased knowledge and understanding of Perinatal and Infant Mental Health, and to recognise the impact of this on the wider family
- To be aware of the risk factors associated with Perinatal Mental Health, including potential safeguarding issues, and to understand the pathways and procedures in relation to these
- To have a higher proportion of Perinatal clients on caseload if possible, to further develop knowledge and skills related to working with this client group
- To joint work alongside the SPCMHT to provide psychological therapy for women with complex presentations (identified as suitable for IAPT)
- To have knowledge, and be able to advise other staff, about how to adapt treatment to meet the needs of this client group
- To assist, when possible, with the completion of perinatal initial assessments within two weeks of referral
- To give specialist supervision/advice to other staff and MDT colleagues regarding the care and treatment of perinatal clients
- To receive perinatal specific supervision from Clinical Psychologists within Specialist Perinatal Services
- To support the facilitation of perinatal referrals from other professionals
- To remain updated about local and national policies and drivers in relation to Perinatal Mental Health, as well as service pathways and procedures
- To attend Perinatal MDT meetings on occasion, if required
- To have shared responsibility with other Perinatal Leads for networking locally and nationally and disseminating/sharing information with other colleagues
- To lead on Perinatal Mental Health events/information stalls on occasion
- To regularly deliver Perinatal and Infant Mental Health Awareness training to multi-disciplinary professionals
- To attend regular training and CPD events to meet the above requirements

IAPT Perinatal Champion – Duties and Responsibilities

- To have, and develop, an increased knowledge and understanding of Perinatal and Infant Mental Health, and to recognise the impact of this on the wider family (ideally through completion of the iHV Perinatal Champion training, but to have completed the iHV One Day Perinatal and Infant Mental Health Awareness training as minimum)
- To be aware of the risk factors associated with Perinatal Mental Health, including potential safeguarding issues, and to understand the pathways and procedures in relation to these
- To have a higher proportion of Perinatal clients on caseload if possible, to further develop knowledge and skills related to working with this client group
- To have knowledge about how to adapt treatment to meet the needs of this client group
- To assist with the completion of perinatal assessments within two weeks of referral
- To offer advice to other staff regarding perinatal cases, as and when necessary
- To support the Perinatal Lead with the facilitation of perinatal referrals from other professionals, as and when needed
- To meet regularly with Perinatal Lead/s to remain updated about local and national policies and drivers in relation to Perinatal Mental Health, as well as service pathways and procedures
- To assist with Perinatal Mental Health events/information stalls on occasion
- To deliver Perinatal and Infant Mental Health Awareness training to multi-disciplinary professionals, as part of a wider training team (ONLY if completed the iHV Perinatal Champion training)
- Attend regular training and CPD events to meet the above requirements

Antenatal and Postnatal Mental Health Pathway



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GAD7 and PHQ9 scoring thresholds and next steps

Mild **GAD 5-9** **PHQ9 5-9**	**Mild Symptoms** • Give additional self-help information - e.g. RCGP Perinatal Mental Health Toolkit (see below) • Consider increasing contacts to offer support (ensure liaison with named midwife and/or health visitor) • Consider self-referral to GP • Before commencing or making any changes to mental health medication offer decision aid (see RCGP Perinatal Mental Health Toolkit – see below) • Postnatally: consider offering New-born Behavioural Observations (NBO) / Neonatal Behavioural Assessment Scale (NBAS)
Moderate **GAD 10-14** **PHQ9 10-14**	**Moderate Symptoms** • Refer to GP – facilitate appointment and communication with GP • Signpost/Facilitate referral to Psychological Therapies and/or refer to Mental Health services for comprehensive mental health assessment, highlighting perinatal status • Give additional self-help information - e.g. RCGP Perinatal Mental Health Toolkit (see below) • Consider increasing contacts to offer support (ensure liaison with named midwife and/or health visitor • Consider referral to Parent-Infant Mental Health services (if available) • Before commencing or making any changes to mental health medication offer decision aid (see RCGP Perinatal Mental Health Toolkit/ Choices and Medication resource – see below) • Enquire about engagement with services at next routine contact • Postnatally: consider offering New-born Behavioural Observations (NBO) / Neonatal Behavioural Assessment Scale (NBAS)
Moderate to Severe **PHQ9 15-19**	**Moderate/Severe Illness** • Refer to Mental Health services for comprehensive mental health assessment, highlighting perinatal status • Refer to GP – facilitate appointment and communication with GP • Give additional self-help information - e.g. RCGP Perinatal Mental Health Toolkit (see below) • Consider increasing contacts to offer support (ensure liaison with named midwife and/or health visitor • Consider referral to Parent-Infant Mental Health services (if available) • Before commencing or making any changes to mental health medication offer decision aid (see RCGP Perinatal Mental Health Toolkit/ Choices and Medication resource – see below) • Enquire about engagement with services at next routine contact • Postnatally: consider offering New-born Behavioural Observations (NBO) / Neonatal Behavioural Assessment Scale (NBAS)
Severe **GAD 15+** **PHQ9 20-27**	**Severe Illness** • Refer to Specialist Perinatal Mental Health Services, Specialist Perinatal Mental Health Midwife and Consultant Obstetrician • If Out of Hours refer to Crisis Resolution and Home Treatment Team or Mental Health Liaison – inpatient/outpatient • Liaise with Specialist Health Visitor - Perinatal & Infant Mental Health (if available) • Consider referral to Parent-Infant Mental Health services (if available) • Liaise with GP, maternity, health visiting and other services involved in care • Give additional self-help information - e.g. RCGP Perinatal Mental Health Toolkit (see below) • Consider increasing contacts to offer support (ensure liaison with named midwife and/or health visitor) • Before commencing or making any changes to mental health medication, offer decision aid (see RCGP Perinatal Mental Health Toolkit or Choices and Medication resource – see below) • Enquire about engagement with services at each contact • Postnatally: consider offering New-born Behavioural Observations (NBO) / Neonatal Behavioural Assessment Scale (NBAS)

References, resources and further information

This pathway has been written to support:
NICE CG192: www.nice.org.uk/guidance/cg192
and the findings of MBRRACE: www.npeu.ox.ac.uk/mbrrace-uk

Further information on the use of GAD in pregnancy: bmjopen.bmj.com/content/8/9/e023766

RCGP Perinatal Mental Health Toolkit – self help information, decision aids and other information:
www.rcgp.org.uk/clinical-and-research/resources/toolkits/perinatal-mental-health-toolkit.aspx

Choice and Medication website – a public facing website providing information used in a mental health setting:
www.choiceandmedication.org/lancashirecaretrust/

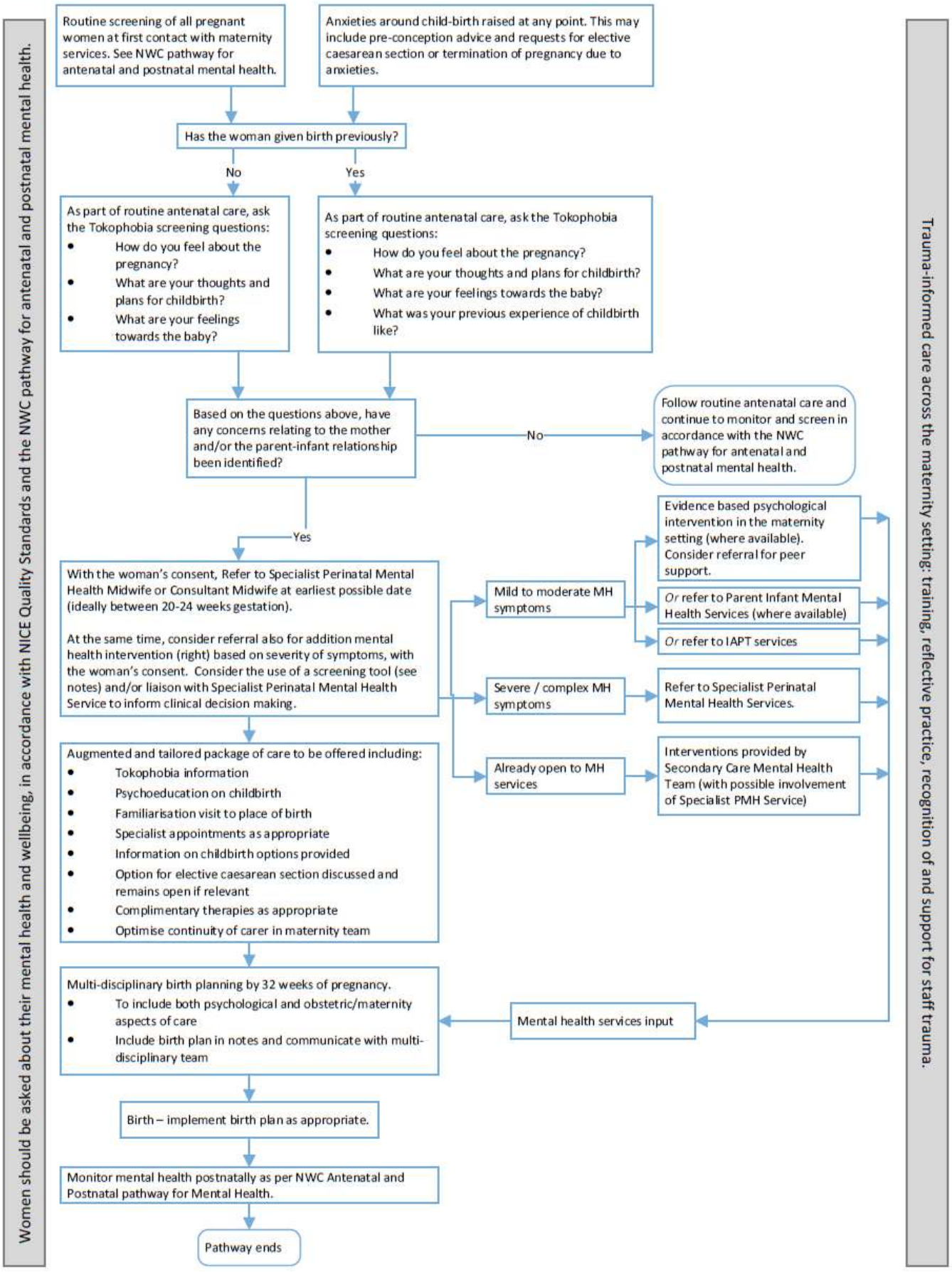
LactMed – information on medication and breastfeeding:
toxnet.nlm.nih.gov/newtoxnet/lactmed.htm

Best Uses of Medicines in Pregnancy (BUMPs):
www.medicinesinpregnancy.org/Medicine--pregnancy/

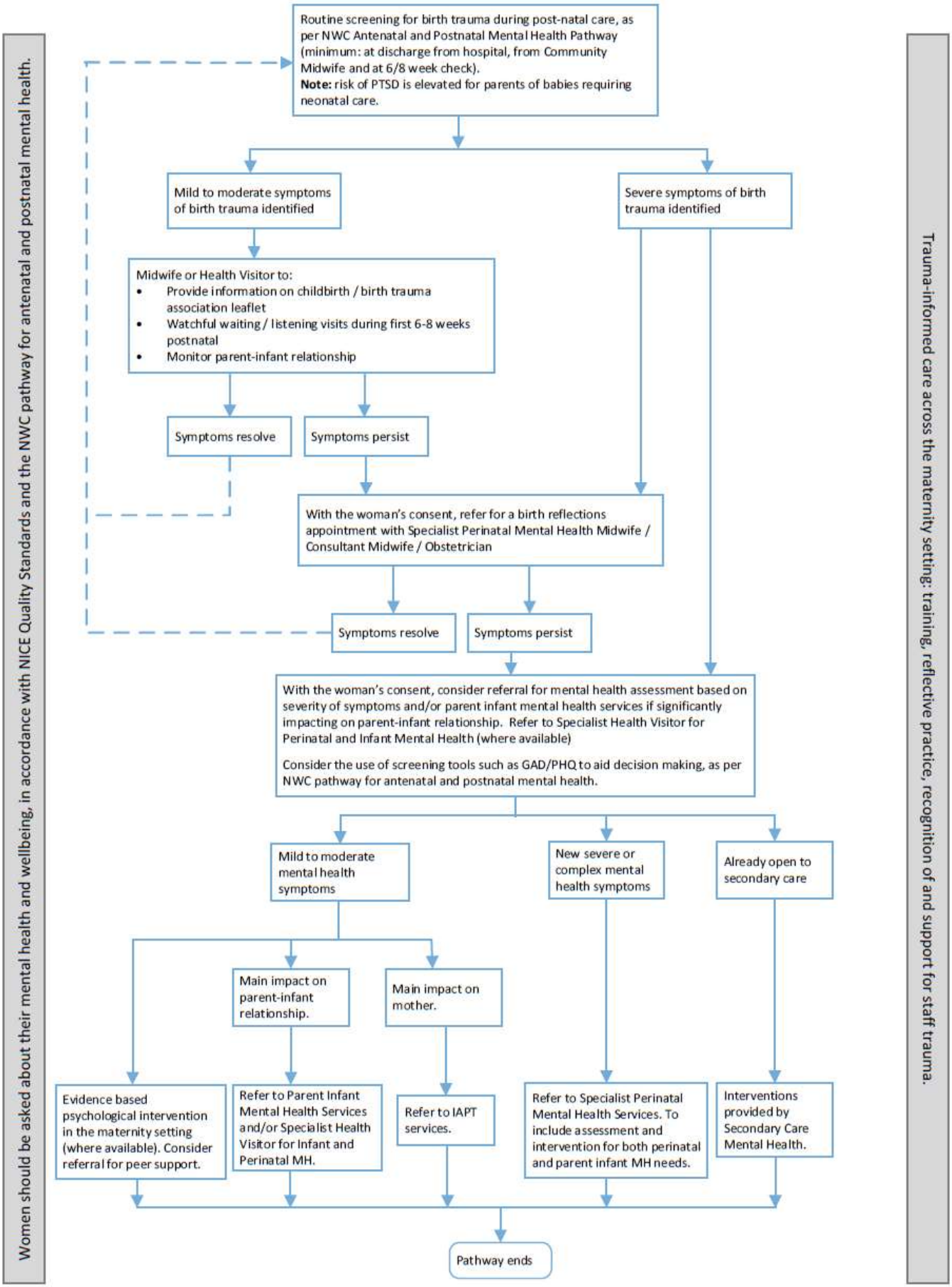
Information and leaflets from the Royal College of Psychiatrists:
www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing

Tokophobia and Birth Trauma Pathway

Antenatal



Postnatal


Women should be asked about their mental health and wellbeing, in accordance with NICE Quality Standards and the NWC pathway for antenatal and postnatal mental health.
Routine screening for birth trauma during post-natal care, as per NWC Antenatal and Postnatal Mental Health Pathway (minimum: at discharge from hospital, from Community Midwife and at 6/8 week check).
Note: risk of PTSD is elevated for parents of babies requiring neonatal care.
Mild to moderate symptoms of birth trauma identified
Severe symptoms of birth trauma identified
Midwife or Health Visitor to:
Provide information on childbirth / birth trauma association leaflet
Watchful waiting / listening visits during first 6-8 weeks postnatal
Monitor parent-infant relationship
Symptoms resolve
Symptoms persist
With the woman's consent, refer for a birth reflections appointment with Specialist Perinatal Mental Health Midwife / Consultant Midwife / Obstetrician
Symptoms resolve
Symptoms persist
With the woman's consent, consider referral for mental health assessment based on severity of symptoms and/or parent infant mental health services if significantly impacting on parent-infant relationship. Refer to Specialist Health Visitor for Perinatal and Infant Mental Health (where available)
Consider the use of screening tools such as GAD/PHQ to aid decision making, as per NWC pathway for antenatal and postnatal mental health.
Mild to moderate mental health symptoms
New severe or complex mental health symptoms
Already open to secondary care
Main impact on parent-infant relationship.
Main impact on mother.
Evidence based psychological intervention in the maternity setting (where available). Consider referral for peer support.
Refer to Parent Infant Mental Health Services and/or Specialist Health Visitor for Infant and Perinatal MH.
Refer to IAPT services.
Refer to Specialist Perinatal Mental Health Services. To include assessment and intervention for both perinatal and parent infant MH needs.
Interventions provided by Secondary Care Mental Health.
Pathway ends
Trauma-informed care across the maternity setting: training, reflective practice, recognition of and support for staff trauma.

Tokophobia and birth trauma pathway

Supporting information and references

Most women report some degree of concern, apprehension or fear about pregnancy and childbirth. However, for a minority of women the fear becomes a phobic response that affects pregnancy, childbirth choices and mental health. These guidelines are intended to help clinicians accurately screen for (primary and secondary) tokophobia, and make decisions about what is needed next. Where decisions about next steps remain unclear, services should work together with a focus on shared decision-making, collaborative treatment planning and enabling choices.

Key questions for the screening of Tokophobia (expanded):

- How do you feel about the pregnancy? (look for ambivalent or negative emotions, anxiety symptoms)
- What are your thoughts and plans for childbirth? (if she requests a caesarean section but there is no medical indication for it, explore the reasons why)
- What are your feelings towards the baby? (ask during pregnancy as well as postnatally; tokophobia and/or birth trauma are likely to make it more difficult to form a bond with the baby.
- What was your previous experience of childbirth like? (where applicable; look for symptoms of post-traumatic stress disorder such as frequent thoughts/images of the birth, flashbacks, nightmares, avoiding reminders of the birth).

Consider the following risk factors for Tokophobia:

- Previous childbirth that was experienced as traumatic: this relates to a woman's subjective experience of childbirth independently of whether or not there were any obstetric complications; it can include not only perceived risk of medical events such as maternal or infant death, but also perceived threats to integrity such as feeling violated, out of control or abandoned.
- Previous adverse medical/surgical experience.
- Previous traumatic experience of witnessing childbirth either personally (e.g. family member) or professionally (e.g. as healthcare staff).
- Pre-existing anxiety or mood disorder.
- History of sexual abuse or rape.
- History of sexual dysfunction.
- Previous miscarriage, stillbirth or neonatal death.
- Previous adverse experience of being a parent of a baby requiring neonatal care.

Screening tools

There are few validated measures of tokophobia. The following measures were found to have reasonable reliability and validity:

- Wijma Delivery Expectancy Questionnaire (WDEQ-A) by Wijma (1998) (most extensively validated, yields detailed information).
- Fear of Birth Scale (FOBS) by Haines (2011) (quick and easy to use, good for initial screening).

For secondary tokophobia, there may be symptoms of post-traumatic stress from a previous birth. Using a measure such as the Impact of Events Scale-Revised (Weiss & Marmar, 1996) in relation to this previous birth may provide a useful indication of the severity of these symptoms. The City Birth Trauma Scale (Ayers, Wright & Thornton 2018) is also a promising Birth Trauma specific measure

Key post-traumatic stress (PTSD)/birth trauma symptoms

- Re-experiencing: frequent thoughts or images of the birth, nightmares, flashbacks, high levels of distress or anxiety.
- Avoidance: avoiding reminders of childbirth e.g. hospitals, TV programmes about birth, friends who are pregnant, avoiding talking about or thinking about childbirth.
- Hyperarousal: hypervigilance, exaggerated startle response, sleep problems.

References and further information

- Fear of Childbirth (Tokophobia) and Traumatic Experience of Childbirth: Best Practice Toolkit , Pan-London Perinatal Mental Health networks https://www.healthylondon.org/resource/tokophobia-best-practice-toolkit/
- NICE CG192 Guideline for Antenatal and Postnatal Mental Health
- NICE CG132 Guideline for Caesarean Section
- NICE QS115 Quality Standard for Antenatal and Postnatal Mental Health
- NICE QS32 Quality Standard for Caesarean Section
- North West Coast Antenatal and Postnatal Mental Health Pathway, NWC Perinatal Mental Health Network
- RCOG leaflet 'Choosing to have a caesarean section': https://www.rcog.org.uk/en/patients/patient-leaflets/choosing-to-have-a-caesareansection/
- Your Rights in Childbirth http://www.birthrights.org.uk/
- Birth Trauma Association http://www.birthtraumaassociation.org.uk/
- Stillbirth and Neonatal Death (SANDS) https://www.uk-sands.org/