NHS Shetland

Perinatal and Infant Mental Health Care Pathways

Approval date:	8th December 2021
Version number:	1.0
Authors:	Kathleen Robertson, Lola Wild and Margaret Hobbs
Review date:	December 2024
Security classification:	OFFICIAL – Green: unclassified information

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Document reference number: NAPAT004

NHS Shetland Document Development Coversheet*

Name of document	Perinatal and Infant Mental Health Care Pathways		
Document reference number	NAPAT004	New or Review?	New
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Executive lead	Clare Stiles, Child Health Manager		
Review date	8/12/2024		
Security classification	OFFICIAL – Green: unclassified information		

Proposed groups to present document to:		
ANMAC	Maternity Service Management Team & Senior Clinicians	
Mental Health Service Management Team & Senior Clinicians		
Child Health Service Management Team & Senior Clinicians		

Date	Version	Group	Reason	Outcome
19/11/21	0.4	Mental Health Services Management & Senior Clinicians	PO; C/S	MR, PRO
19/11/21	0.4	Maternity Department Management and Senior Clinicians	PO; C/S	A, PRO
19/11/21	0.4	Child Health Senior Clinicians	PO; C/S	A, PRO
19/11/21	0.4	General Practice	PO; C/S	A, PRO
25/11/21	0.5	Information Governance Officer	PF	MR, PRO
8/12/21	0.5	ANMAC	FA	A, PRO

Examples of reasons for presenting to the group	**Examples of outcomes following meeting**
• Professional input required re: content (PI)	• Significant changes to content required – refer to Executive Lead for guidance (SC)
• Professional opinion on content (PO)	• To amend content & re-submit to group (AC&R)
• General comments/suggestions (C/S)	• For minor revisions (e.g. format/layout) – no need to re-submit to group (MR)
• For information only (FIO)	• Recommend proceeding to next stage (PRO)
• For proofing/formatting (PF)	• For upload to Intranet (INT)
• Final Approval (FA)	• Approved (A) or Not Approved, revisions required (NARR)

***To be attached to the document under development/review and presented to the relevant group**

Please record details of any changes made to the document in the table below

Date	Record of changes made to document
14/12/20	Consultation with Grampian NHS colleagues, information gathered on Grampian pathways. Initial document adapted from NHS Shetland Guideline for the Detection and Management of Postnatal Depression alongside additions from Grampian
25/1/21	Consultation with NHS Shetland Consultant Psychiatrist. First draft of flow charts added
22/3/21	Consultation with NHS Shetland GP, referral processes added to first draft
7/6/21	Second draft brought to Perinatal board meeting, document to be registered with information governance and adapted into official format
24/6/21	Consultation with Psychological Therapies Service, pathways added
19/08/21	Perinatal board meeting, document now registered. 3rd draft – to be formatted into template.
7/10/21	Draft Version 0.4
30/11/21	Recommendations re minor alterations from MH Service added. Formatting adjusted to meet requirements of information governance – final draft version 0.5
8/12/2021	Approved at ANMAC – Moved from Draft Version 0.5 to Version 1.0

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1. Introduction

Mental illness during the perinatal period is a significant public health concern. UK studies show that failure to address perinatal mental health issues comes at a substantial cost with over 70% of that cost being associated with the longer term impact on the future health and well-being of infants (Royal College of Psychiatrists, 2021). Research indicates that at least 1 in 10 women experience mental health problems during pregnancy and the first postnatal year, of the severity that would require psychological intervention. Common mental health problems such as depression and anxiety can quite often go undetected by health professionals in the perinatal period; stigma of mental ill health is considered to be a significant contributing factor. Professionals working with this patient group should employ strategies to overcome these barriers. More severe mental health conditions such as post-partum psychosis or bi-polar disorder are less prevalent yet can pose a significant challenge for services to provide safe and effective care. Professionals working across Maternity, Child Health and Mental Health Services need to be knowledgeable and skilled in managing the unique challenges that present in this patient group.

In 2021 Perinatal Mental Health Network Scotland published national pathways which have provided a framework for the development of care pathways in NHS Shetland. Different pathways may apply at different times in a woman's pregnancy or child bearing journey. A woman's current presentation as well as historic mental ill health need to be taken into consideration. The severity of a woman's mental health condition and impact on her overall functioning will be a good indicator of which pathway will best meet her needs.

2. Aim

To improve outcomes for patients affected by perinatal mental health problems by:

- Increasing awareness and understanding of best practice in this field
- Providing a local guideline that is helpful for all professionals working in related fields to understand processes, roles and responsibilities
- Providing a resource for clinicians for further information on this topic

3. Definitions

3.1. "Perinatal"

There is variation across the UK in how the term perinatal is applied to clinical services. Generally across Scotland, and for the purpose of this document, we use "perinatal" to refer to the period of time from pre-conception through pregnancy, childbirth and ending at 1 year post-partum.

3.2. "Infant Mental Health"

The term "Infant Mental Health" refers to healthy social and emotional development in infants, in a context of safe and rewarding relationships. During the perinatal period a baby's brain develops rapidly, and is shaped by their experiences. Research into adverse childhood experiences (ACEs) provides evidence of connections to a range of adult difficulties and future health outcomes; transgenerational patterns may be seen. Meeting an infant's mental health

needs may include support for family wellbeing, and treatment of parental perinatal mental illness, as well as direct interventions for the dyad.

3.3. "Named Person"

Within this document when we talk about the "Named Person" we refer to the term as it is used in Getting it Right for Every Child (GIRFEC) policy (Scottish Government, 2021). This is not to be confused with the term used in the Mental Health (Care and Treatment) (Scotland) Act 2003.

3.4. "Mental Health Service"

For the purpose of this document the term mental health service refers collectively to the following group of services that exists within NHS Shetland:

- Community Mental Health Team (CMHT)
    - Consultant Psychiatrists
    - Community Psychiatric Nurses (CPNs)
    - Consultant Clinical Psychologist
- Psychological Therapies Service (PTS)
- Substance Misuse and Recovery Service (SMRS)

3.5. "Psychological Therapy"

The term 'psychological therapy' can be used to refer to a broad range of approaches and practices (NHS Education for Scotland, 2014). In this document we use the terms 'psychological therapy' and 'psychological intervention' interchangeably. We use them to describe evidence based practices underpinned by psychological theory and concepts to help people understand their thinking, behaviour, and interactions with people and the world around them in order to reduce distress and improve functioning.

3.6. "Common or mild to moderate mental health conditions"

This refers to a collection of mental health conditions that are lower in severity or intensity. Generally the person is able to maintain some daily routine and functioning, and presents as being at low risk of harm to self or others. Examples include:

- Stress
- Anxiety such as phobias, panic or mild OCD
- Depression
- Sleep Disorder
- Bereavement or Adjustment Disorder
- PTSD Type I

3.7. "Moderate to severe mental health conditions"

Some of the common mental health conditions described in section 3.6 may vary in how they present in different individuals and at different times in a person's life. A moderate to severe

presentation is usually indicated by a marked reduction in functioning or increased risk of harm to self or others. Examples of these conditions are:

- Depression, Anxiety or OCD (with marked decline in functioning and increased risk)
- Personality Disorder
- Eating Disorders
- PTSD Type II (or complex trauma)

Other conditions as follows are often classed as "enduring" in nature but symptoms can be well managed through modern treatments and individuals can have periods of remission. It should also be noted however that there is a higher risk of relapse during the perinatal period in these conditions and that relapse can pose a significant risk:

- Bi-Polar Affective Disorder (BPAD)
- Psychotic Illness (such as Schizophrenia or Schizoaffective Disorder)

3.8. "Severe or complex mental health conditions"

Any acute psychotic presentation or relapse in any of the enduring illnesses described in section 3.7 would be considered the most severe or complex.

3.9. "Co-morbidities"

Co-morbidities may present alongside mental illness in some cases. Examples of co-morbidity might be someone with alcohol or drug misuse, or someone with a learning disability.

4. Principles of care

- Collaborative working across professions and agencies is key to achieving the best outcomes for this patient group.
- Maternity services should be able to provide trauma informed care and support for psychological distress occurring in the maternity context.
- Health Visitor services should be knowledgeable in the detection of mental health difficulties in parents. They should be able to provide wellbeing visits, emotional support and have skills to promote nurturing, healthy relationships between parents and infants.
- GPs and Primary Care services should be alert to the detection of mental health problems in pregnant or post-partum women. They should have knowledge of or access to advice on the risk/benefit ratio for use of psychotropic medications for more common mental health problems.
- Mental Health services should be aware of the impact of pregnancy and child bearing on the course of mental illness and adjust thresholds for treatment and intervention accordingly.
- Timely access to mental health services is crucial and prioritisation should be given to pregnant women and those up to one year post-partum.
- Fathers and partners should be considered and included in a holistic approach to working with families affected by perinatal mental ill health. Any expectant or new fathers

experiencing mental health problems should be given the same level of priority for intervention by mental health services.

5. Service Provision in Shetland and Scotland.

There is no specialist perinatal mental health service in Shetland due to our low population density and birth rate. The national recommendation is that for such a small population, Shetland should adopt a "regional model" of service delivery. This means that service is delivered locally by generic services with access to specialist clinical advice from larger boards within the North of Scotland region (PMHN Scotland Delivering Effective Services Report 2019). Specialist inpatient intervention for the whole of Scotland is provided by national Mother and Baby Units in Glasgow and Livingston.

5.1. Shetland Perinatal and Infant Mental Health Development Group

In 2020 staff representatives from NHS Shetland Maternity, Health Visitor and Mental Health services collaborated to form a project development group. One of the aims was to develop local pathways and services to meet the needs of this patient group. The project used the national pathways as a framework to build locally agreed processes. They undertook a series of consultations with key staff groups to understand a wide range of perspectives; they also gathered qualitative feedback on the lived experience of perinatal mental health issues from the public and patient groups in Shetland.

The project development group hosts a Shetland Community Network Forum for Perinatal and Infant Mental Health on a 2 monthly basis. This forum is open to services across all sectors in Shetland; it is a way to share learning, service developments and understanding of the needs of this patient group and how we can work in partnership across organisations.

Group members also regularly attend national forums and have been pivotal in the roll-out of training opportunities for local clinicians and staff working with families.

5.2. North of Scotland Specialist Perinatal Mental Health Services

Shetland's neighbouring larger board NHS Grampian is in the process of developing a Specialist Perinatal Mental Health Team and have established a steering group to take this forward. In NHS Grampian currently there is one Specialist Perinatal Mental Health Midwife who is the point of contact for advice, consultation and support. She is contactable via email: shona.mccann2@nhs.scot or telephone: 01224 559714.

The ambition is that the North of Scotland will eventually have a Regional network for Perinatal and Infant Mental Health which will include all of the north of Scotland NHS boards.

5.3. National Mother and Baby Units (MBUs)

There are two national MBUs in Scotland located in Livingston and Glasgow. These are specialist perinatal mental health inpatient facilities designed to offer admission to mothers alongside their babies when the mother is in need of inpatient psychiatric treatment and intervention. Admissions to MBUs happen fairly infrequently but if the need arises then further details of the admission process are detailed in Pathway 4 (see section 11).

6. Shared care and communication

Based on national recommendations, local pathways have been developed with the aim of streamlining care and sharing understanding around communication, roles and responsibilities. These pathways apply to a number of disciplines including Maternity, Child Health, Primary Care, and Mental Health Service. Effective communication between these professional groups is key to successful application of pathways. Professionals working in these fields should have knowledge of the pathways and be trained in the use of electronic systems of referral. Different patient record systems are in use across each of the disciplines, therefore key professionals must ensure that significant information, particularly risk assessments and care plans, are documented and shared in a way that is accessible to all professionals involved.

6.1. Screening by Midwives and Health Visitors

Midwives and Health Visitors should routinely include discussions around emotional wellbeing as part of their engagement with women and their partners throughout their pregnancy and postnatal journey. Midwives should screen for mental health problems during or soon after the first contact or booking appointment. They should ask directly about any past history and current mental health problems; in addition as part of their general discussion with the woman, they should ask the following questions (NICE, 2014):

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by having little interest or pleasure in doing things?

Clinicians should also enquire about anxiety as part of their discussions and consider using the following GAD-2 scale (NICE, 2014):

During the past 2 weeks, have you:	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
Been feeling nervous, anxious or on edge?				
Not been able to stop or control worrying?				

A positive response to either of these sets of questions may be an indicator of depression or anxiety disorder, and is an opportunity to invite further discussion around the things that may be influencing mood or anxiety levels. Other screening tools such as the “Edinburgh Postnatal Depression Scale” (EPDS) or the “Patient Health Questionnaire” (PHQ-9) may be used as a further aid to assess severity; these tools should always be used alongside clinical assessment using interpersonal skills to inspire trust and engagement.

EPDS is used routinely by Health Visitors at 6 and 12 weeks post-partum as a minimum; this is recommended as part of the Universal Health Visiting Pathway in Scotland (Scottish Government, 2015). This should always be used alongside a full clinical assessment, as detailed above. A growing body of evidence from the perspective of lived experience indicates that women often find it difficult to disclose mental health problems due to stigma. Barriers

caused by stigma can be overcome when clinicians are able to offer a consistent and open approach to discussions around mental health problems.

Health Visitors are trained in assessing parent-infant relationships and do so by engaging in open, non-judgemental and exploratory discussions with parents. Additional training in Solihull Approach, Mellow Parenting or Video Interactive Guidance (VIG) can enhance these skills further.

6.2. Referrals to mental health services

In NHS Shetland, referrals can be made to the Mental Health Service via SCI Gateway. Within the SCI Gateway referral, the referrer should mark this as "Perinatal Referral" under the tab "presenting complaint". The Mental Health Service accepts referrals from GPs, Midwives, Obstetricians, Health Visitors and ANPs.

NHS Shetland operates a "single point of referral" system for all mental health referrals meaning that referrals to Psychological Therapies Service (PTS), Community Psychiatric Nurses (CPNs), Consultant Psychiatrist, and Substance Misuse and Recovery Service (SMRS) are directed towards a central point. A Multidisciplinary Team (MDT) conducts a weekly triage process where they meet to discuss and allocate new assessments based on presenting need, identified risks and potential intervention.

Clinicians should provide a full summary in their referral where possible; this provides a good foundation from which the receiving service can make sound judgements about the most appropriate next steps in the pathway. Summaries should include:

- Current problem, clinical symptoms, and the impact on daily functioning
- Past history and treatments of mental health problems
- Social circumstances, support network
- Any risks to self or others including alcohol or substance use

All referrals received by Mental Health Service are screened and triaged by the Duty CPN on a daily basis (weekdays) and routinely put forward for discussion at the weekly MDT referral meeting. If any risks are identified within that referral the Duty CPN, using their clinical judgement, may take more proactive action.

Following a decision made at the weekly MDT referral meeting, the Mental Health Service should acknowledge receipt of the referral to the referring clinician and inform them of the proposed action or allocation that has been agreed.

For perinatal mental health referrals all sections of the Mental Health Service should endeavour to offer an assessment **within 6 weeks** of the referral having been allocated, as per national pathway standards (Perinatal Mental Health Network Scotland, 2021).

6.3. Urgent referrals

Where a case presents with a moderate to severe mental health condition and/or risk of significant harm to themselves or others, referrals to the mental health service should be made and treated as urgent. This can be done by contacting the Duty CPN on 01595 743006 to discuss the case. This should always be accompanied by a written referral through SCI Gateway system. Where there is uncertainty about whether a case is urgent or not, the

referring clinician should seek to discuss the case with the Duty CPN; they can then jointly consider the most appropriate course of action. On the acceptance of an urgent referral the Duty CPN will normally contact the person on the **same day** and make arrangements for an assessment **within 7 days**.

Urgent cases where there is immediate risk of harm may need to be directed to Accident & Emergency (A&E) at Gilbert Bain Hospital as a place of safety, and where it is warranted, emergency services may need to be contacted to assist with safe transfer. Urgent referrals can then be generated through the A&E route to Mental Health Services.

7. Prescribing in pregnancy and the post-partum period

The risks of prescribing versus the risks of not prescribing in pregnancy are difficult to quantify. However one of the fundamental principles is that decisions around prescribing should be made in a collaborative process between the woman and the prescriber. The British Association for Psychopharmacology (2017) published guidance on this, available from: https://www.bap.org.uk/pdfs/BAP_Guidelines-Perinatal.pdf

In some cases a woman may discover she is pregnant whilst receiving pharmacological treatment for a mental health condition; in these circumstances she should be referred as soon as possible to the most appropriate prescribing clinician for consultation around the risk/benefit ratio. At their booking appointment any woman who is currently prescribed medication for their mental health will be referred to the local Obstetrician and, depending on the nature and severity of the woman's condition, further advice or consultation may be sought from the Consultant Psychiatrist.

Further guidance on prescribing can be found within NICE (2014) clinical guideline 192 available from: https://www.nice.org.uk/guidance/cg192 . Prescribers should always consult the woman's preferences around breastfeeding and the potential implications when considering the options for treatment.

Some medications, particularly valproate used in the management of bi-polar disorders, are known to cause a higher risk of birth defects and developmental disorders in babies. Since 2018 there have been regulatory measures in place to ensure that any female of childbearing age who is prescribed valproate must also have a pregnancy prevention programme in place.

Other sources of information on prescribing in pregnancy and breastfeeding can be found at: https://medicinesinpregnancy.org/Medicine--pregnancy/ - this has patient friendly advice - or https://www.choiceandmedication.org/humber/printable-leaflets/drugs-in-pregnancy/ has a variety of printable fact sheets on drugs in pregnancy.

8. Pathway 1 - Preconception advice for women with pre-existing mental health problems

Women who have pre-existing mental health difficulties may be at higher risk of developing perinatal mental illness during pregnancy or the early post-partum period. It is essential that women are provided with the appropriate level of consultation during the pregnancy planning stage or at the earliest opportunity after pregnancy is known or confirmed. The level of consultation will be determined by the severity of the woman's pre-existing condition. For most women with a previous mild to moderate mental health condition, preconception advice can be

sought from their GP. In some cases women will require more specialist advice from a Psychiatrist; particularly those with a history of a moderate to severe or complex mental health condition (See **Appendix A** and refer to sections 3.6 to 3.8)

In consultation with their GP or Psychiatrist, women should have the opportunity to discuss the risk/benefit ratio of current or advised treatment and be enabled to make informed decisions regarding medication, pre-conception plans and the level of mental health support they may need during their future pregnancy. Please see **Appendix B** for a process map for this pathway. Some women will require further follow up and review by the Consultant Psychiatrist and others may be discharged back to their GP as long as their condition can be safely managed in primary care; re-referral is always an option.

9. Pathway 2 – Psychological therapy for women with common or mild to moderate mental health problems (lower risk cases)

Approximately 20% of women will experience mental health difficulties during the perinatal period and around half of those will require additional psychological support or intervention. There is a broad choice of psychological support available ranging from low-level support, self-help resources, guided self-help through to individual psychological therapy. Third sector organisations are often in the best position to offer tailored support for specific problems e.g. bereavement or relationship problems. There are many factors to consider in finding the best fit for an individual.

For every woman, pregnancy and childbearing brings a period of major life adjustment and change. A degree of anxiety is normal during periods of uncertainty and for most, low level support can help to alleviate and prevent more significant problems developing. In the early stages, a positive first step might be to direct women and/or their partners to online free self-help such as NHS Fife's "Moodcafe", available from: https://www.moodcafe.co.uk/parents-and-parents-to-be/pregnancy-and-postnatal-emotional-problems/ . Another useful online resource is Tommy's website. It covers many pregnancy topics and has a range of mental health and wellbeing resources and tools, available from: https://www.tommys.org/pregnancy-information/calculators-tools-resources/wellbeing-plan/pregnancy-and-post-birth-wellbeing-plan
It is possible for individuals to regain some emotional resilience through the use of self-help; when this is coupled with the presence of a regular and consistent support there is greater potential for anxiety to be alleviated. It is worth noting that anxiety symptoms can often be a precursor to the development of depressive illness; therefore, early intervention is key.

9.1. Midwives and Health Visitor additional wellbeing contacts

Named Midwives and Health Visitors are in a key role to offer both practical advice as well as emotional support during this period of adjustment. They can offer additional, more regular wellbeing visits to women who may be starting to show the first signs of or are already known to be experiencing mental health difficulties. For women whose difficulties arise from trauma related to pregnancy, birth or neonatal complications, Maternity can offer debrief sessions which can help the woman make sense of her experiences and relieve some of the uncertainties. Shetland Maternity Department also offer a wellbeing and relaxation clinic, which introduces relaxation and mindfulness techniques to reduce and manage anxiety.

Clinicians can enhance their ability to work in a trauma informed way by accessing further training in "Trauma Skilled Practice" available from NHS Education for Scotland; this is particularly relevant for Midwives and Health Visitors in their key role with this patient group.

9.2. Third sector organisations

Shetland has a number of third sector mental health support services. Healthy Shetland (2018) produced a directory of services available from: https://www.healthyshetland.com/site/assets/files/1949/mental_health_service_directory_list_april_20.pdf

Mind Your Head, a locally based charity, launched their Wellbeing 1000 programme in 2021. This offers a facilitated parent and infant peer support group and also a 1:1 support to parents who find themselves struggling with their mental health.

9.3. Referral to Psychological Therapies Services (PTS)

When a woman presents with psychological difficulties that are persistent and impacting on her functioning, she may benefit from more expert assessment and opinion from PTS. The National Perinatal Mental Health Network (2021) recommends that PTS should lower their threshold for perinatal referrals both for the woman and for the partner or father of the child. Perinatal cases should also be prioritised for assessment: National pathways recommend that assessment should be offered **within 6 weeks** of referral. In line with NICE (2014) guidance, NHS Shetland PTS aim to make first contact with perinatal cases, and where possible, offer assessment **within 2 weeks** of receipt of referral.

Process mapping for this pathway (see **Appendix C**) illustrates key items to consider on the route to referral. For details on how to refer to Mental Health Services please see section 6.2. When making a referral, sending a detailed summary provides a good foundation from which Mental Health Services can start to consider the most appropriate service.

Once a referral is received the person will be contacted and sent pre-assessment and opt in forms to complete. Once those are returned to the service an assessment can be arranged. Following assessment there are several options that might be considered including computerised Cognitive Behavioural Therapy (cCBT), group therapy, Behavioural Activation (BA) or individual therapy. The options should be discussed with the individual and it is important that they are ready and motivated to engage in therapeutic intervention.

A summary of recommendations will be provided to the person and the referring clinician. Within this pathway, care co-ordination is maintained by the Named Midwife or Health Visitor throughout.

10. Pathway 3 – Specialist assessment and intervention by local Community Mental Health Team for women with moderate to severe mental health problems (higher risk cases)

Around 5% of women will experience perinatal mental health problems of the severity requiring referral to a Consultant Psychiatrist or Community Psychiatric Nurse (CPN). In Shetland there is a Community Mental Health Team who provide general adult mental health services and are skilled in the treatment and management of moderate to severe mental health conditions. They have access to additional training, knowledge and skills in the treatment of perinatal mental

illness, and also can access clinical advice from Specialist Perinatal Mental Health Services in mainland Scotland.

10.1. Referral

The route to specialist psychiatric assessment is outlined in the process map in **Appendix D**. In line with national recommendations, CMHTs should reduce the threshold for accepting perinatal cases due to the additional associated risks and should also prioritise assessment of perinatal cases. When risk factors are present, referrers should be aware of how to escalate a referral to CMHT as “Urgent”. Refer to sections 6.2 and 6.3 for further information on referrals.

10.2. Assessment

Psychiatric assessment may be carried out by a CPN and/or a Psychiatrist and the majority of cases on this pathway will require Consultant Psychiatrist opinion and expertise. Following assessment, if the woman is deemed to be in need of intervention, they may be allocated to a CPN who will then act as care co-ordinator and will be expected to liaise closely with either the Named Midwife or Health Visitor.

10.3. Allocation

The allocated CPN will then implement the joint care planning process with key professionals. In some cases, for example, where there are comorbidities, the woman may be redirected towards a more appropriate service for care co-ordination e.g. Substance Misuse Nurse or Learning Disabilities Nurse. This needs to be carefully discussed and agreed between services whilst also carefully considering the woman’s wishes as to the type of intervention. The care co-ordinator takes a lead role in care planning and intervention for the mother and this needs to work neatly in tandem with the child’s plan.

10.4. Risk to child

At all stages clinicians should assess risk of potential or actual harm to the child and any such concerns should be discussed with the Named Person (Health Visitor or Named Midwife) as per GIRFEC policy. Any immediate or significant risk to the child should be escalated through Child Protection procedures.

11. Pathway 4 – Admission and transfer to a Mother and Baby Unit (MBU) (highest risk cases)

There are two national MBUs, both of which accept referrals from NHS boards across Scotland. Inpatient treatment is reserved for those whose clinical presentation cannot be safely or adequately treated and managed in a community setting. Admission must also be in both the mother’s and infant’s interests and in some circumstances admission may occur in the antenatal period if deemed appropriate.

A process map for this pathway can be found in **Appendix E.** Admission to these units can be arranged on a Consultant to Consultant basis; the NHS Shetland Consultant Psychiatrist would have the principal role in liaising with the inpatient Consultant Psychiatrist, and arranging admission. Where possible, both parents of the infant should be in agreement with the plan for admission.

11.1. Referral to Livingston MBU

Mother and Baby Unit, St. John's Hospital, Livingston, EH54 6PP

The unit has a referral form (available from: https://apps.nhslothian.scot/refhelp/guidelines/ResourcesLinks/Perinatal%20Referral%20Form%20Inpatient-updated%202020.08.docx). This should be used in making a referral after the case has been discussed with the admitting consultant. Further information about the process of referring for admission can be found via the following link: https://apps.nhslothian.scot/refhelp/MentalHealthAdult/PerinatalMentalHealth/mother-and-baby-unit-(inpatient)

Consultant Perinatal Psychiatrist: Dr Barney Coyle

Contact (via MBU nurse's station): 01506 524 175

Email referrals to: MBUInpatientsReferrals@nhslothian.scot.nhs.uk

11.2. Referral to Glasgow MBU

West of Scotland Mother and Baby Unit Leverndale Hospital, 510 Crookston Road, Glasgow, G53 7TU

There is no official referral form for this unit but a written case summary should always be provided. Further information about the service can be found via the following link: https://www.nhsggc.org.uk/your-health/health-services/mental-health-services/other-services/west-of-scotland-mother-and-baby-unit/west-of-scotland-mother-and-baby-unit/

Consultant Perinatal Psychiatrist: Dr Aman Durrani

Contact: 0141 211 6500 or, if out of hours, can direct dial to MBU (re: bed availability): 0141 211 6539

11.3. Complications and alternatives to MBU admission

There are logistical, safety and ethical issues to consider in the transfer of a mother and baby to an in-patient unit. This will involve close co-ordination between Community Mental Health Team, Gilbert Bain Hospital staff, Ambulance crew (including Air Ambulance), Social Services and the admitting MBU Team. Clinicians should refer to the Psychiatric Emergency Plan (PEP) and Standard Operating Procedures (SOP) related to admission and transfer of patients. Air Ambulance capacity can be restricted, and therefore it may not be possible to transfer mother and baby together. In that case the mother should ideally be admitted first, with arrangements for the transfer of the infant to follow shortly afterwards.

Other factors to consider are the mother's capacity to be the primary carer for her baby. In circumstances where there are risks and/or child protection issues it may not be appropriate for her to be admitted to an MBU. Lack of bed availability in an MBU may also be a factor. The Mental Welfare Commission (2016) recommend perinatal cases requiring inpatient treatment should be admitted to an MBU unless there are compelling reasons not to do so. Admission to Acute Adult Inpatients may be an alternative but women can have less favourable experiences when treated in adult acute units whilst separated from their baby for a prolonged period. In some circumstances Shetland CMHT may be able to offer a more intensive "Home Treatment" approach in the community but this can only be done when it is deemed clinically safe to do so.

12. Pathway 5 – Specialist assessment and intervention for mother-infant relationship

The case has been well made, in terms of both wellbeing and cost, for specialised input to support early relationships and to tackle adversity in the early years; the Parent-Infant Foundation (2021) provides a convincing summary of the evidence.

Where the parent-infant relationship is faltering alongside significant parental mental health difficulties, both infant and parent wellbeing should be assessed. Support should be offered to them both individually and to the dyad, and any intervention should ensure the safety and wellbeing of all involved. Parental wellbeing can be a major concern and the experiences of the child must also be taken into consideration.

12.1. Assessment

Health Visitors are trained and qualified to assess parent-infant relationships, and through close observation of the behaviours of infants and their parents, including the interactions between them, they are usually able to identify key indicators of a developing problem. Mental ill health can become overwhelming at times, which can cause difficulty for the mother attuning to the needs of her infant. When this happens repeatedly, patterns of behaviour in the infant may emerge, signifying that support or intervention may be needed. We do not have a parent-infant therapist available locally for more specialist assessment but in some cases it may be appropriate to refer the mother for Psychiatric opinion or Clinical Psychologist assessment via the Mental Health Service.

12.2. Parent-infant and family support in Shetland

For the majority of families in Shetland, parent-infant support is provided by NHS universal services (primarily Health Visiting, but also Maternity for antenatal clients). The Solihull Approach is used by Health Visitors in their work with families. Shetland Islands Council (SIC) Children's Services provide support via Family Support Workers and through the Shetland Family Centre. For infants with additional developmental needs, NHS Shetland provides support and interventions through Community Paediatrics, Physiotherapy, Occupational Therapy, and Speech and Language Therapy. Beyond the perinatal period, SIC Educational Department offers support through the Pre-School Home Visiting Team for children usually aged 2 – 5 years.

Additional resources are available through third sector organisations; both Mind Your Head and Women's Aid currently see infants with their families as part of the support offered. Health Visitors, as the Named Person and also the professional qualified to assess parent/infant difficulties, should be able to inform families on all of these sources of support, and make referrals as appropriate.

A Video Interactive Guidance (VIG) service which is used to promote parent-infant attunement is being developed in Shetland. This will be a cross-disciplinary service, and will offer specialist intervention to families where there are more moderate to severe difficulties, and possibly complex cases as part of a package of interventions.

Across Scotland there is a lack of appropriately skilled practitioners able to offer parent-infant interventions, especially for the more severe and complex difficulties. Also nationwide there is a lack of capacity in CAMHS teams to manage cases of children under 1 year old (Scottish Government, 2019) and in rural Shetland we are no different. Clinicians in Shetland can

request clinical advice, opinion or supervision via the PNIMH Managed Clinical Network (MCN). Specialist Parent-Infant Psychotherapy may be offered to mother and baby as part of inpatient treatment in one of the MBUs.

13. References

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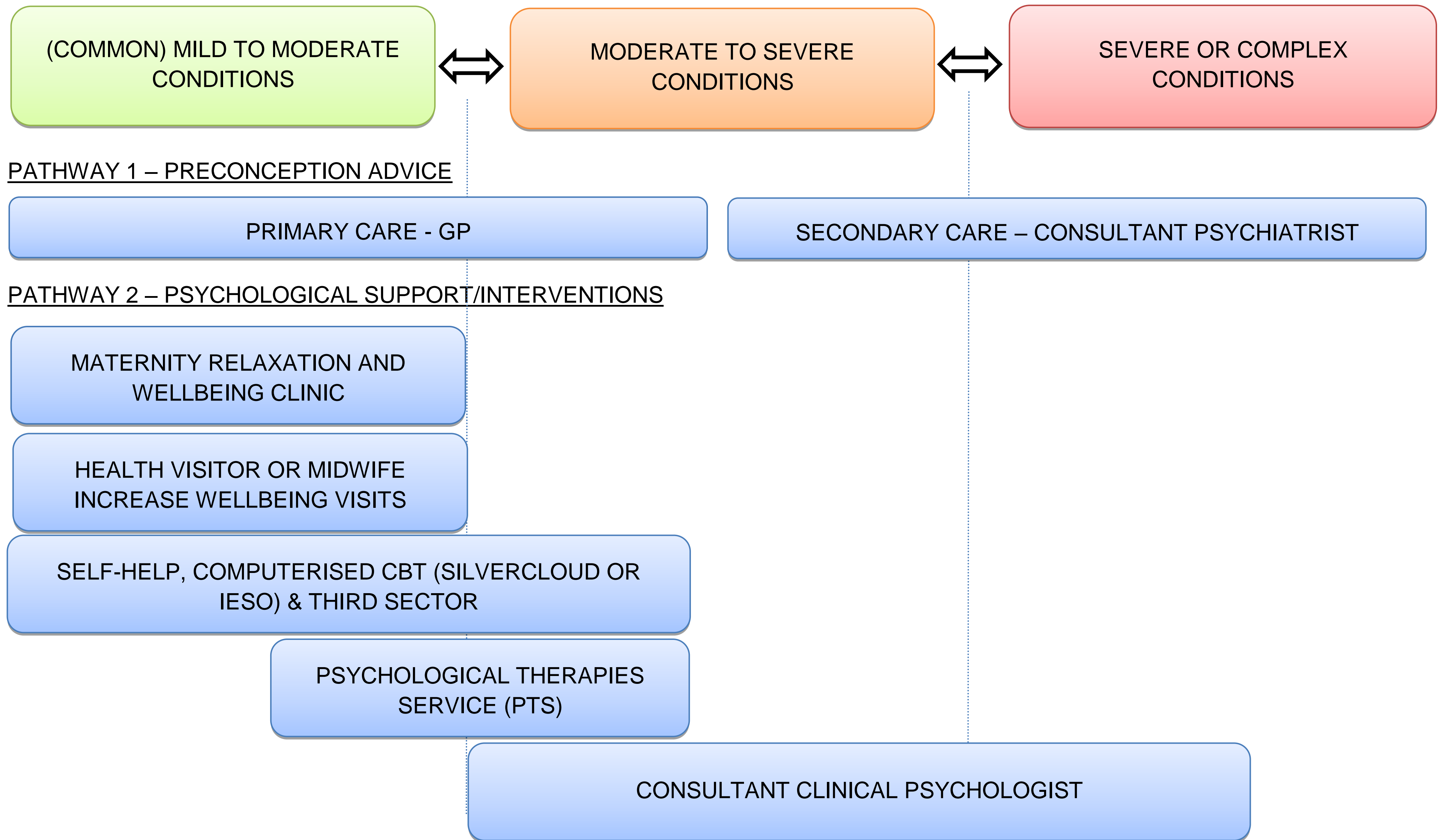
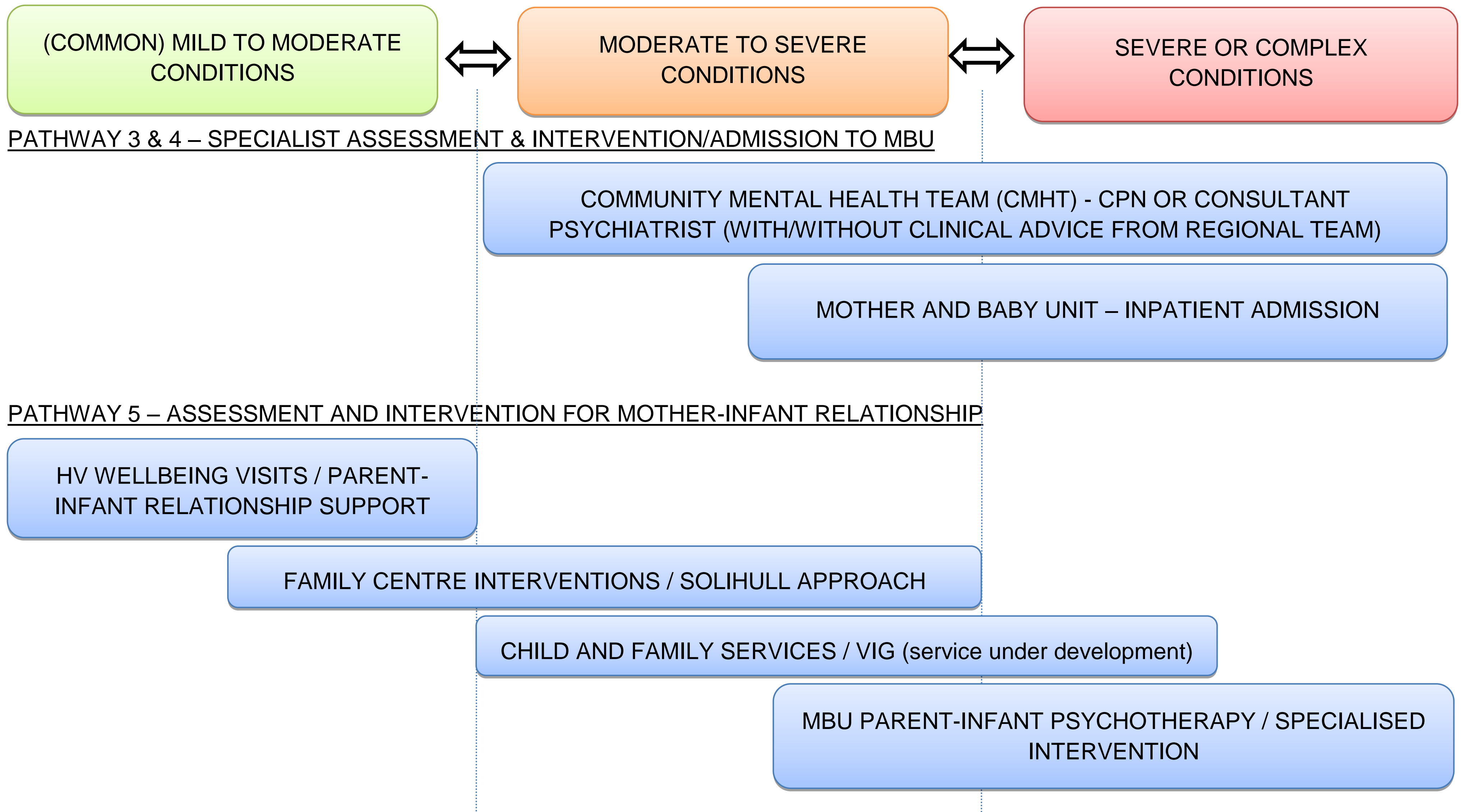
Scottish Government (2015) Universal health visiting pathway in Scotland. Accessed at https://www.gov.scot/binaries/content/documents/govscot/publications/guidance/2015/10/universal-health-visitingpathway-scotland-pre-birth-pre-school/documents/00487884-pdf/00487884-pdf/govscot%3Adocument

Royal College of Psychiatrists (2021) CR232: Perinatal mental health services: Recommendations for the provision of services for childbearing women. Accessed at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr232---perinatal-mental-heath-services.pdf?Status=Master&sfvrsn=82b10d7e_4

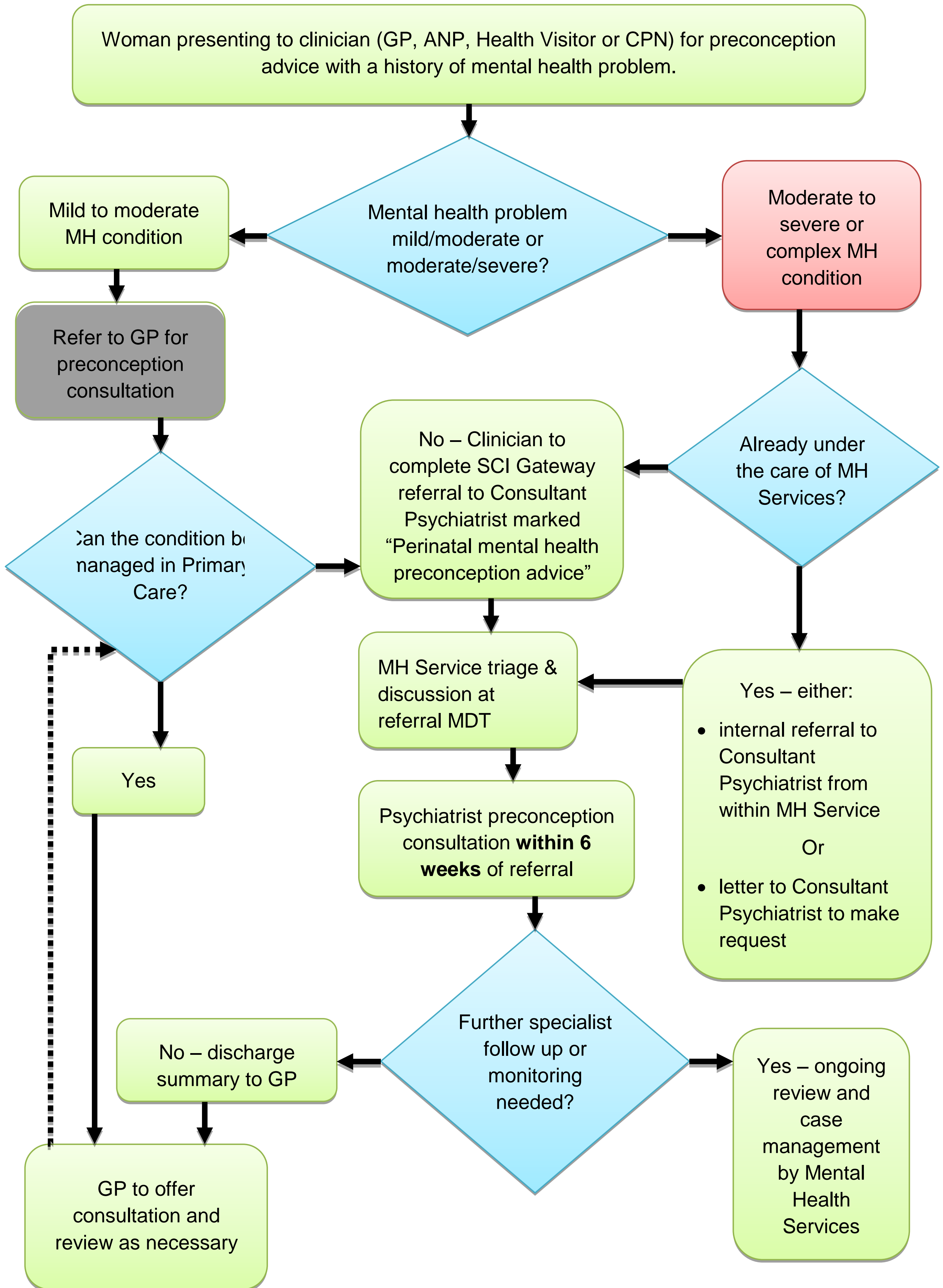
Appendix A



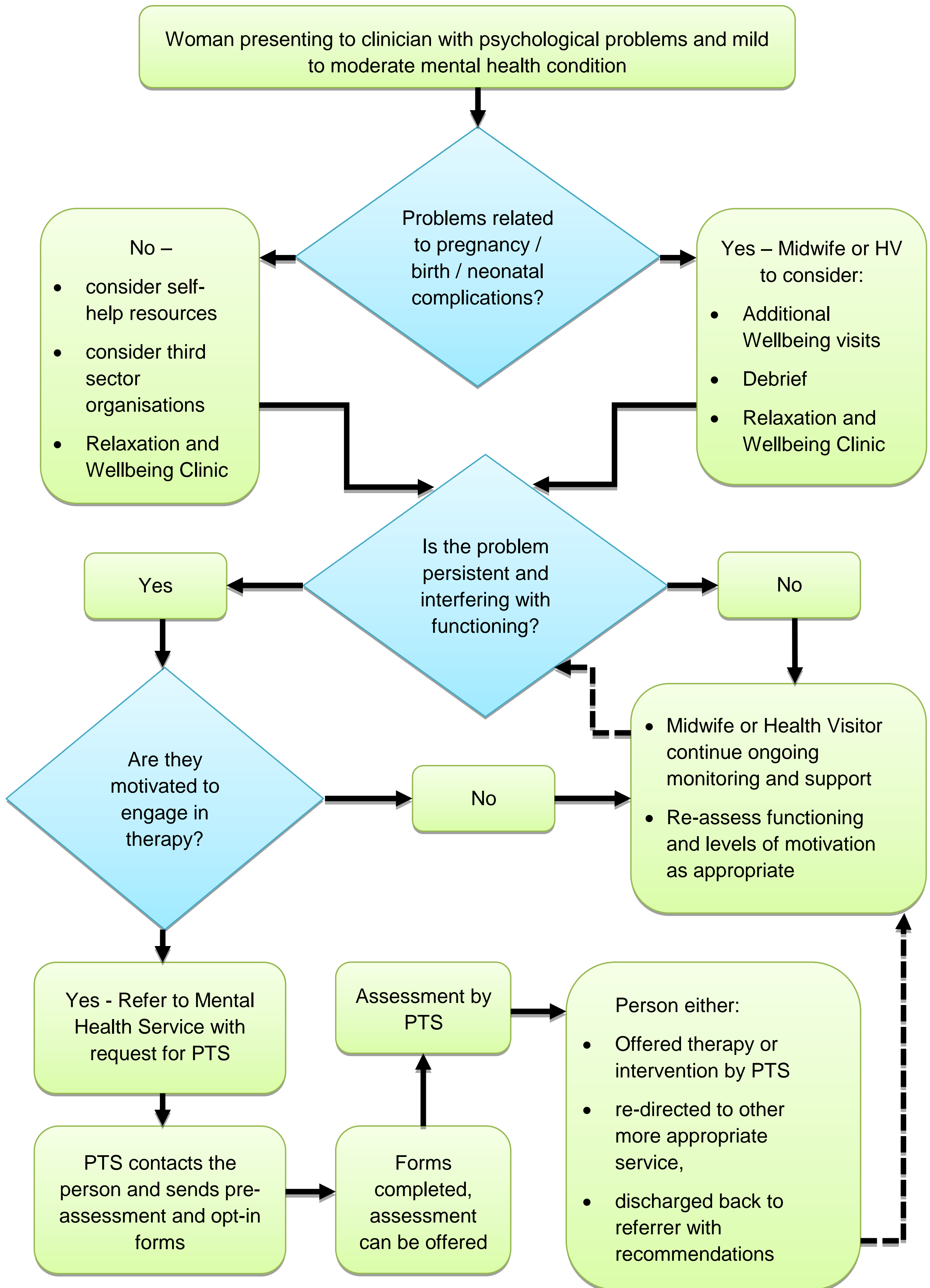
(Appendix A continued)



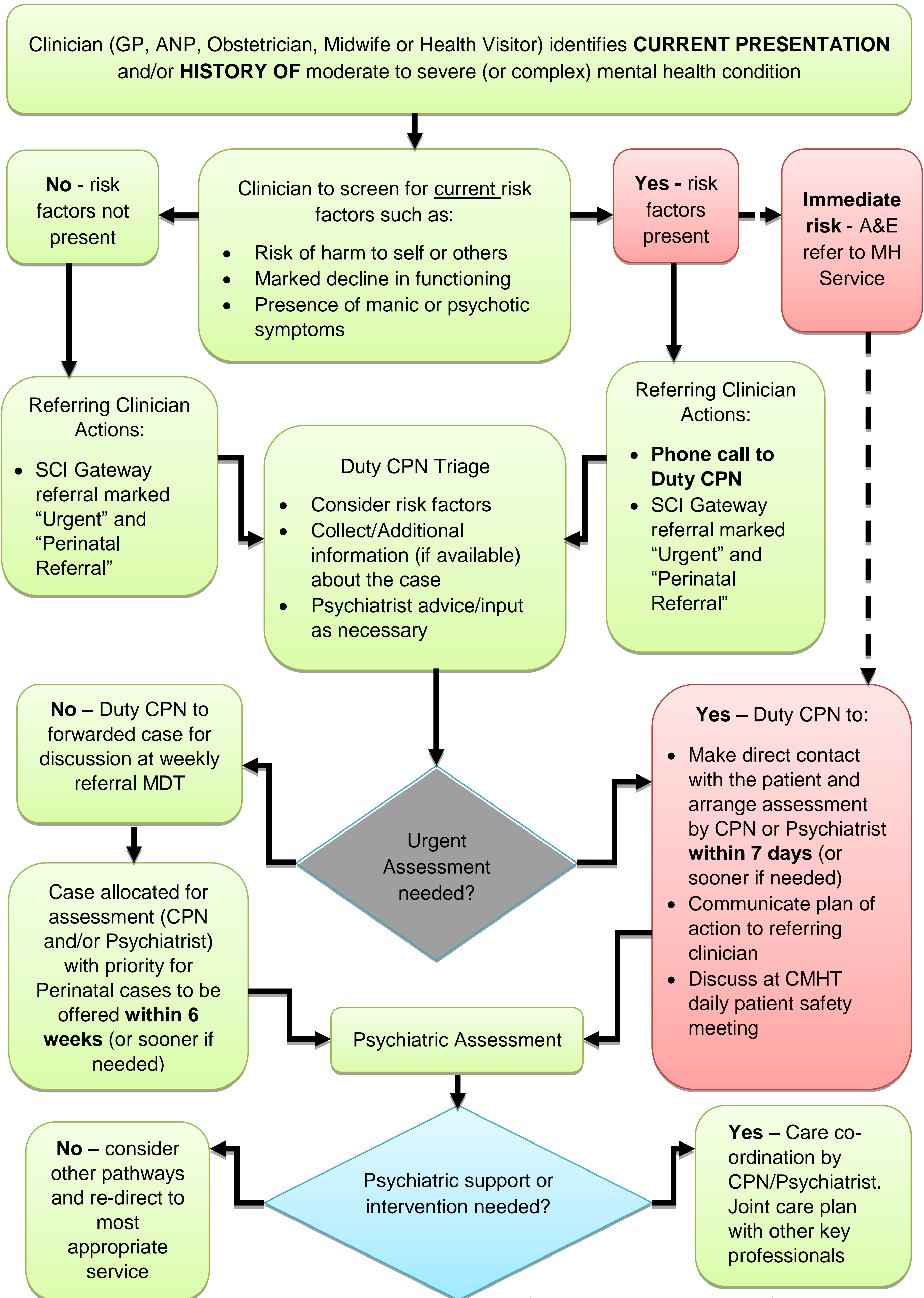
Appendix B Process map for Pathway 1



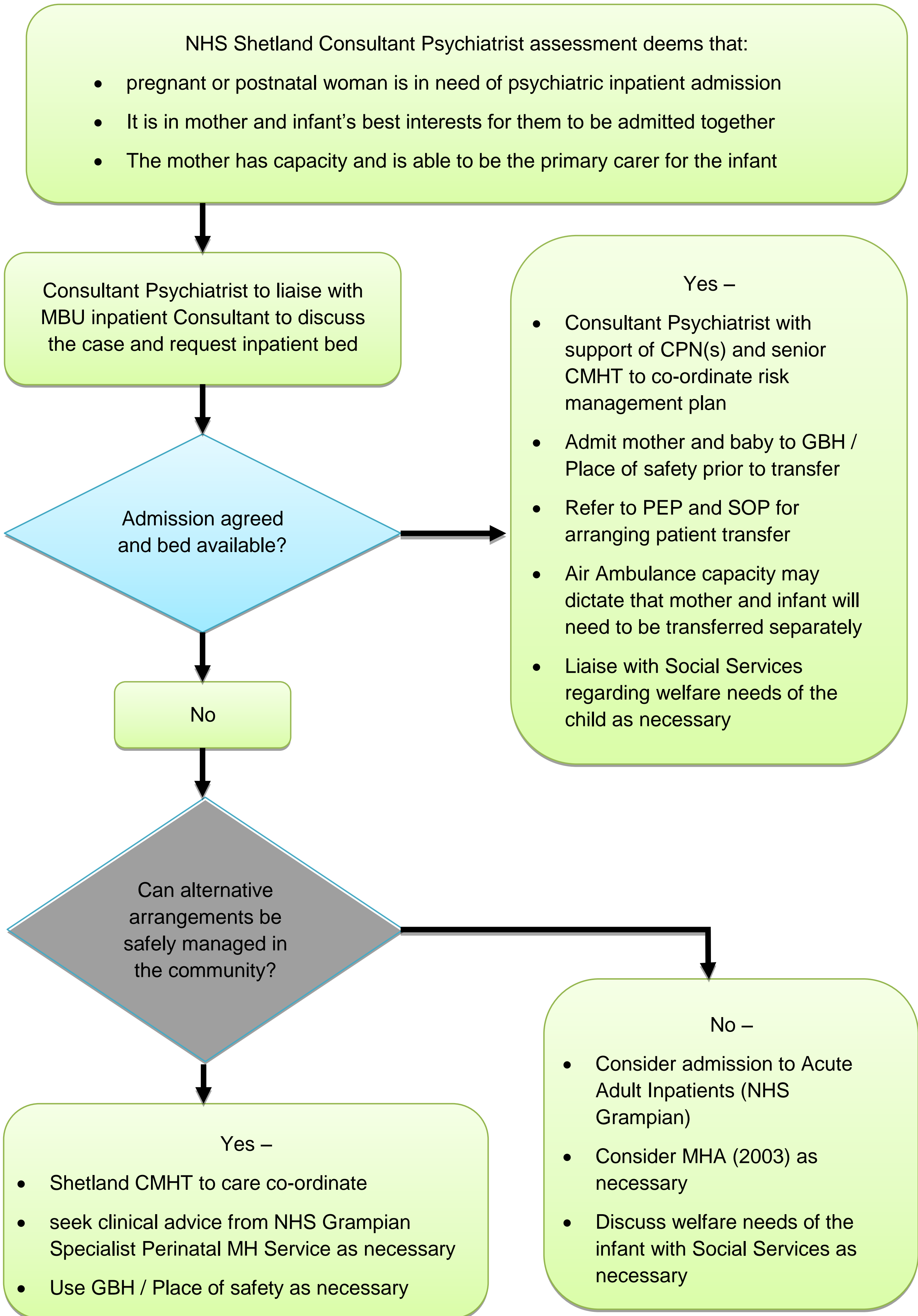
Appendix C Process map for Pathway 2



Appendix D Process Map for Pathway 3



Appendix E Process map for Pathway 4



Appendix F Process map for Pathway 5