



Regional Perinatal Mental Health Care Pathway

December 2012 Revised July 2017

Index of contents

Section	Title	Page
	Foreword	2
1.0	Care Pathway Definition	3
2.0	Care Pathway Scope	4
3.0	Stepped Care Approach	4
4.0	Care Pathway Interconnections and Interdependencies	8
5.0	Role of the General Practitioner	8
6.0	Role of the Midwife	10
7.0	Role of Family Nurse Partnership Nurse	12
8.0	Role of the Obstetrician	13
9.0	Role of the Health Visitor	14
10.0	Role of the Secondary Care Mental Health Services	16
11.0	Role of Occupational Therapist	17
12.0	Safeguarding Children	17
13.0	Medication Issues	19
14.0	Improving Outcomes for Users and Carers	21
15.0	How to use this Care Pathway	22
16.0	Antenatal Screening Flowchart	24
17.0	Explanatory Notes Antenatal Screening Flow Chart	26
18.0	Pregnancy and Early Postnatal Care Plan	28
19.0	Explanatory Notes Pregnancy and Early Postnatal Care Plan	31
20.0	Postnatal Flowchart	32
21.0	Explanatory Notes for Postnatal Flow Chart	33
	References	34
	Acronyms and Abbreviations	35
	APPENDICES	
	- 1. Pathway review group	36
	- 2. Whooley/Anxiety Questions	37
	- 3. Template Letters	38
	- 4. Edinburgh Postnatal Depression Scale	43

FOREWORD

The Regional Perinatal Mental Health Care Pathway (PNMHP) was initially launched in Northern Ireland (NI) in 2012 to facilitate the prediction, detection and treatment of the perinatal mental health of women in the antenatal and postnatal period.

A review of this pathway was required following the release of NICE Clinical Guideline 192, antenatal and postnatal mental health (Dec 2014) and the Regional Mental Health Care Pathway. Within the Regional Mental Health Pathway is a Stepped Care model which specifies the anticipated steps of care from primary care through to secondary care and the revised PNMHP has included this model to inform practice (Pages 4-8). The five themes of the 2012 Perinatal Mental Health Care Pathway remain:

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

To facilitate improved communication between all primary and secondary care services the original template letters have been revised and reduced to four (Appendix 3).

This updated Pathway will provide guidance to all health and social care professionals who come into contact with women¹ in the antenatal and postnatal period across all settings inclusive of primary care. In the interests of effective information sharing and communication, it is important that all referrals and communication between HSC professionals are timely to ensure a coordinated and consistent approach to the care of individual women and their children. All Professionals should follow their local HSCT operational guidance and their local PNMHP.

Note: The “Perinatal Period” is the name given to the period immediately before and after birth. It is defined in diverse ways and depending on the definition; it starts at the 20th to 28th week of gestation and ends 1 to 4 weeks after birth. In the context of this document “perinatal”, however, is taken to describe psychiatric disorders that arise in association with pregnancy and the postnatal period generally up to 12 months following birth.

¹ The term ‘woman’ will be used in this document and is intended to be inclusive of young women under the age of 18 years.

1.0 Care Pathway Definition

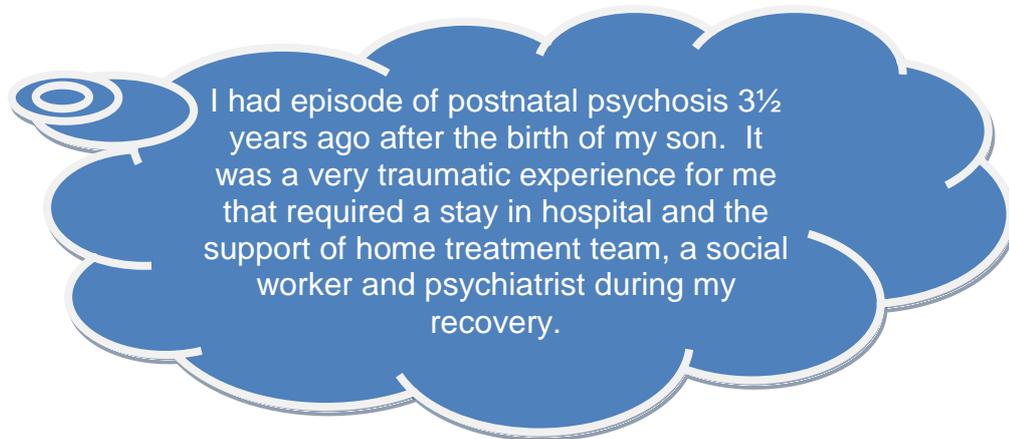
- 1.1 The development of the care pathway in 2012, was led by the Public Health Agency (PHA), supported by a wide-ranging stakeholder multidisciplinary working group for perinatal mental health and has subsequently been reviewed to reflect new national guidance (Appendix 1).

AIM

To support the provision of an effective multidisciplinary/agency service for the prediction, detection and treatment of maternal mental ill health through the antenatal and postnatal periods for all women in Northern Ireland (NI).

- 1.2 Perinatal mental health issues which may complicate pregnancy and the postpartum year are common with 10-20% of women developing mental ill health during this time. It is a major public health issue and if untreated may have a devastating impact not only on the women but on the family as a unit. The symptoms may range from mild to moderate low mood/anxiety lasting at least two weeks though to a more serious illness requiring specialist support services. The majority of women detected will experience symptoms of mild to moderate ante/postnatal depression/anxiety and can be helped by increased support from family, the midwife, family nurse and GP and health visitor.
- 1.3 Perinatal mental health illnesses also include obsessive compulsive disorder, post-traumatic stress disorder (PTSD) and postpartum psychosis which effects 1:1000 women. Eating disorders and substance misuse in pregnancy and the postnatal period are included and are collectively called perinatal mental health issues. Depending on the severity of the disorder, the mother may struggle to look after herself and her baby and may also impact on her ability to bond with her baby and be sensitive to the baby's emotions and needs. This may have an effect on the baby's ability to develop a secure attachment resulting in a significant and damaging impact on the emotional, cognitive and even physical development of the child.
- 1.4 Women with pre-existing mental health illness may have a relapse or recurrence of their illness following childbirth and women who previously have been symptom free, may have an elevated risk of suffering from a mood disorder, particularly the more serious mood disorders in the postnatal period. Puerperal psychosis in the United Kingdom (UK) has an overall incidence of 2:1,000 births.

- 1.5 The antenatal period offers health care professionals a unique opportunity to screen for risk factors associated with maternal mental ill - health and thereby ensuring appropriate early interventions are provided, including referral to the best available services. Identifying and treating mental ill health is not only beneficial for the woman but also for the future health and wellbeing of her child and the family unit as a whole.



2.0 Care Pathway Scope

- 2.1 The PNMHP takes account of the Stepped Care Framework referenced within The Regional Mental Health Care Pathway (2014) and commences with the identification of a previous history, signs and symptoms or a positive response to the “Whooley” and anxiety questions. It also takes account of the recommendations from the DHSSPS Maternity Strategy for Northern Ireland (2011), Antenatal and Postnatal Mental Health, NICE Guidance (2014), Making Life Better 2013- 2023 (PHA 2014) and the recommendations set out in Transforming Your Care, DHSSPS (2011). It is intended that the revised PNMHP will facilitate a consistent regional approach for all pregnant and postnatal women in NI and local service arrangements are available in each of the HSCTs.²

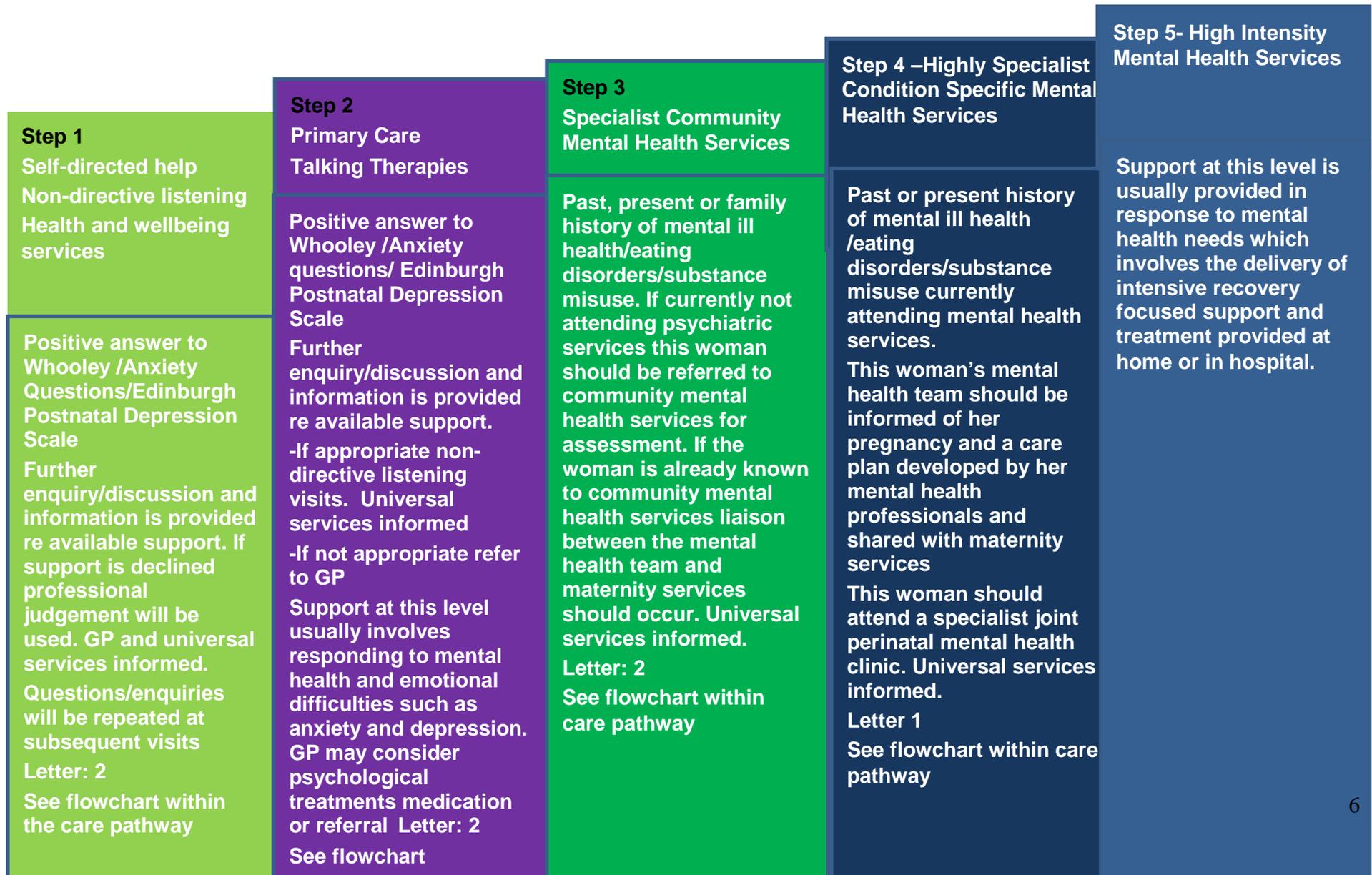
3.0 Stepped Care Approach

- 3.1 A stepped care approach should be adopted when managing women with mental ill health during pregnancy and the postnatal period. The majority of these women are managed within primary care, including those with mild to moderate depression, anxiety, adjustment disorders and other conditions. They may not require medication and will respond

² It is recognised that substance misuse during pregnancy is an increasing challenge. The management of substance misuse during pregnancy and the postnatal period is not included within the remit of this care pathway.

to psychological and/or social interventions. Women with more significant illness may require medication only or medication with the addition of psychological and social interventions. For this group of women their care and treatment may continue to be provided within primary care and if required the woman's General Practitioner (GP) can access specialist advice for psychiatric services, particularly with regard to prescribing medication.

Stepped care model: perinatal mental health



3.2 There are two specific groups of women who will require care and treatment to be provided by mental health services and these are:

- **Women with a history of significant mental ill health including eating disorders and substance misuse, who are considered to be at risk of relapse or recurrence of their illness associated with pregnancy and the postnatal period**

Pre-conceptual counselling forms a significant part of care for these women, including advice on medication and risk of relapse. This group of women require their care to be provided by a consultant psychiatrist and community mental health team, who are responsible for ensuring that each woman has a personal care plan in place. There may be a need to consider if a referral to childcare social services if risks or potential risks are identified.

- **Women who become acutely unwell during pregnancy or in the intrapartum or postnatal period**

If there is a high level of concern or if there is evidence of a rapid deterioration in mental health, particularly within the first two weeks after childbirth, the woman requires **urgent** assessment by mental health services.

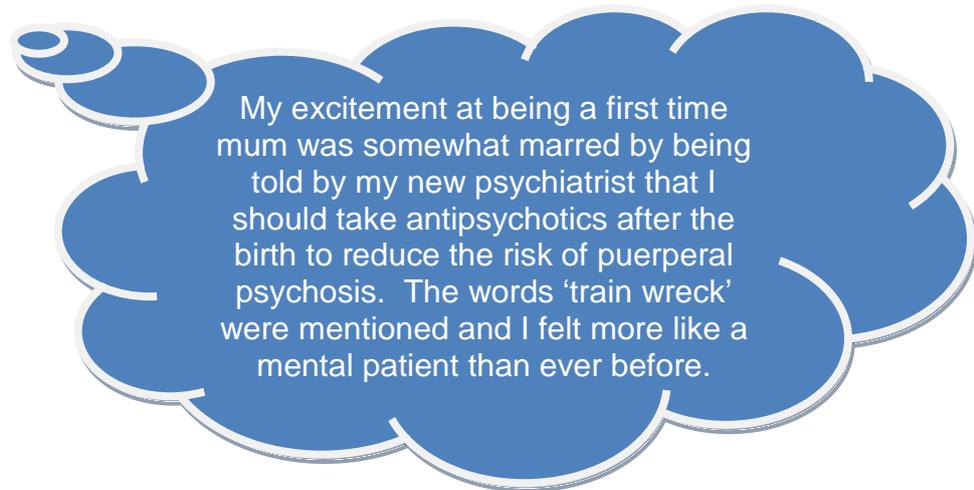
3.3 Over the last decade successive Confidential Enquiries into Maternal and Child Health (CEMACH), now Centre for Maternal and Child Enquiries (CMACE) have highlighted the consequences of failing to identify and manage maternal mental health problems. Suicide has been identified as one of the leading causes of maternal mortality and there is growing evidence highlighting the long term risks for a child associated with maternal mental ill health both in the antenatal and postnatal periods.

3.4 As a result of this growing evidence, including the Daksha Emson Report (2003), a number of initiatives have been developed to enhance services for women with mental ill health and their children. These include the NICE guidelines (2014) on antenatal and postnatal mental health.

3.5 This PNMHP has been developed taking account of:

- NICE CG 136 (2007) Service User Experience in Adult Mental Health: Improving the Experience of Care for People using NHS Mental Health Services

- SIGN Scottish Intercollegiate (SIGN) Management of Perinatal Mood Disorders. Ed SIGN, 2012



3.6 It is expected that HSCTs will implement and embed this PNMHP into ante/intrapartum/postnatal services. They are required to provide, share and review the details of their local PNMHP with all relevant health and social care staff that offer and/or provide services to women and children in the ante/intrapartum/postnatal period.

4.0 Care Pathways Interconnection and Interdependencies

4.1 Professional groups, including midwives, GPs, health visitors, family nurse partnership nurses³, Obstetricians, Clinical Psychology, Allied Health Professionals (AHP) and hospital and community mental health teams across HSCT settings in Northern Ireland, will be involved with the implementation of this PNMHP. Their involvement may be at different stages of care of the women who requires assessment, support and treatment. The pathway specifies the roles and responsibilities of key professionals and is intended to support staff in these roles.

5.0 The Role of the General Practitioner (GP)

5.1 The GP will, in most cases, have an established relationship with women considering pregnancy and is therefore in a unique position to provide guidance, direction and support. In most circumstances the GP will have a professional relationship with the woman's family and be aware of any relevant family history of mental ill health.

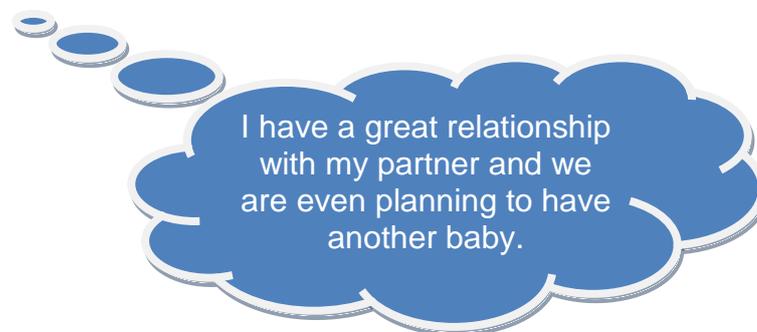
³ For the purpose of this document Family Nurse Partnership Nurses will be referred to as family nurses

Pre-conceptual care

- 5.2 For any woman who is taking psychotropic medication has an eating disorder or a history of substance misuse who is planning pregnancy or in the antenatal period, consideration should be given to the risks and benefits of their individual circumstances. It may be appropriate for the GP to refer to mental health services in the case of women who are not under active follow-up.
- 5.3 Any woman, who has a history of past or present severe mental ill health or mental health issues requiring ongoing mental health services, should be advised to arrange an immediate appointment with their GP following a positive pregnancy test. These women are more likely to require more intensive support in the perinatal period.

Antenatal Care

- 5.4 In most circumstances a woman's GP will have detailed information held within their patient care record; however, when any pregnant woman first presents to their GP they should be asked about previous or present mental ill health, eating disorders and/or substance misuse. This will include details of any care provided by mental health services and enquiry into any close family with a history of perinatal mental ill health. This information should be clearly recorded in the referral information from the GP to antenatal services. All other members of the primary care team, for example nurse practitioners, should be aware of the importance of including this information in antenatal referrals.
- 5.5 GPs should ask women the "Whooley/anxiety Questions" (Appendix 2) at each attendance in pregnancy. A positive response to these questions should be followed up in line with the local HSC Trust PNMHP.

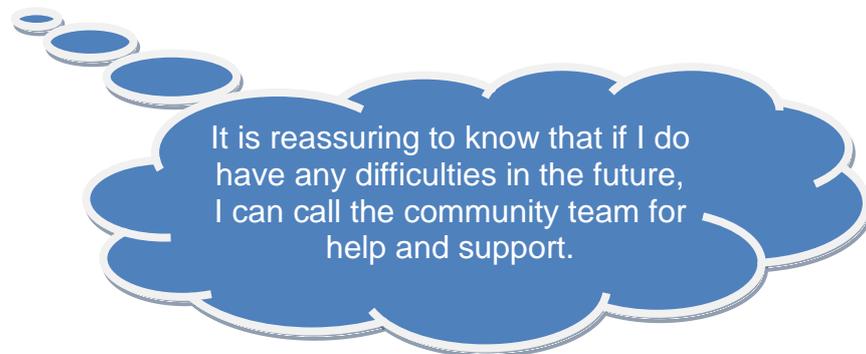


- 5.6 Pregnant women who, have symptoms of anxiety and/or depression, severe enough to interfere with personal and social functioning but do

not meet the diagnostic criteria for a formal diagnosis, should be considered for brief psychological treatment and/or individual or group based social support. These services include self-help strategies, non-directive counselling, primary care based Cognitive Based Therapy (CBT), community and voluntary sector based social interventions and HSCT based services including CBT and interpersonal psychotherapy. GPs and other professionals involved in the care of pregnant woman should be aware of the importance of prioritising the social and psychological needs of pregnant women and Trust based services should prioritise these referrals.

Postnatal Care

- 5.7 Mild to moderate depression can often be managed within primary care with a combination of psychological and social support and medication where appropriate. Referral to the family health visitor for non-directive counselling may be considered or referral to HSCT mental health services when risks are identified or a woman fails to respond to treatment. Consideration will be given to the need for a referral to child care social services if risk or potential risk is identified.
- 5.8 GPs should repeat the “Whooley/Anxiety with all women at the routine postnatal check and follow up as appropriate.



6.0 Role of the Midwife

- 6.1 Midwives play a central role in ensuring that pregnant women with mental ill health/eating disorder and or a history of substance misuse achieve the best possible health outcomes for themselves and their babies. Midwives should work collaboratively with obstetricians, GPs, health visitors, family nurses, social workers and mental health professionals when appropriate. Midwives may provide care in many locations such as the family home, clinics, birth centres and hospitals.

6.2 Midwives should co-ordinate the maternity care for women with mental ill health by:

- Asking the “Whooley Questions” for prediction and detection of mental ill health at the first booking clinic, utilising prompts, on the regional electronic Northern Ireland Maternity System (NIMATs);
- Recognising and responding to identified need at all stages of pregnancy and the immediate and early postnatal period;
- Developing a trusting relationship with the pregnant woman, taking into account her individual needs and preferences;
- Providing information and offering sensitive support and additional midwifery care as appropriate;
- Reviewing the woman’s personal care plan and treatment at each contact;
- Recording advice and information given, changes to the personal care plan and evaluation of care in the Northern Ireland Maternity Hand Held Record (MHHR);
- Liaising with the GP, health visitor, family nurse and the psychiatrist/Clinical Psychology and/or community mental health staff.
- If necessary, the midwife will refer a woman at risk of serious mental ill health directly to the mental health team. The midwife should refer to the operational guidance contained within the local Trust PNMHP. Universal services will be informed. Consideration should be given to the need for a referral to childcare social services if risk or potential risk is identified;
- The midwife will refer higher risk women for obstetric led care if this is not already in place;
- Enquiries should be made about who lives in the home with the woman and the available support from partners and families should be recorded;
- Women and families who require further support should be referred to the appropriate services and referring families whom whose children reach the threshold for referral to social services for assessment, using Understanding the Needs of Children in Northern Ireland, (UNOCINI, 2011).

6.3 In some HSCTs, midwifery ‘champions’ with additional knowledge and/or skills in mental health are available to offer additional support to women identified as having either a previous history of mental ill health/eating disorder/substance misuse or first presentation of mental ill health developing during their pregnancy. These midwives should work alongside a consultant obstetrician and be part of the team developing multi-professional links with the other HSC providers.



Support for midwives, health visitors, family nurses and AHPs

6.4 Midwives, health visitors, family nurses and AHPs are supported by their line managers, the supervisor of midwives, and safeguarding nurses when providing safe evidence-based services. They are required to have up-to-date knowledge of antenatal, intrapartum and postnatal mental health issues/eating disorders/substance misuse and available treatments in order to help women to achieve a satisfactory outcome for themselves and their babies. All HSCTs will ensure that midwives, health visitors, family nurses and AHPs have access to relevant and up-to-date training on mental health ill health/eating disorders and substance misuse in the perinatal period and have access to open door advice and support from the safeguarding nurse if they have any safeguarding concerns in relation to the child.

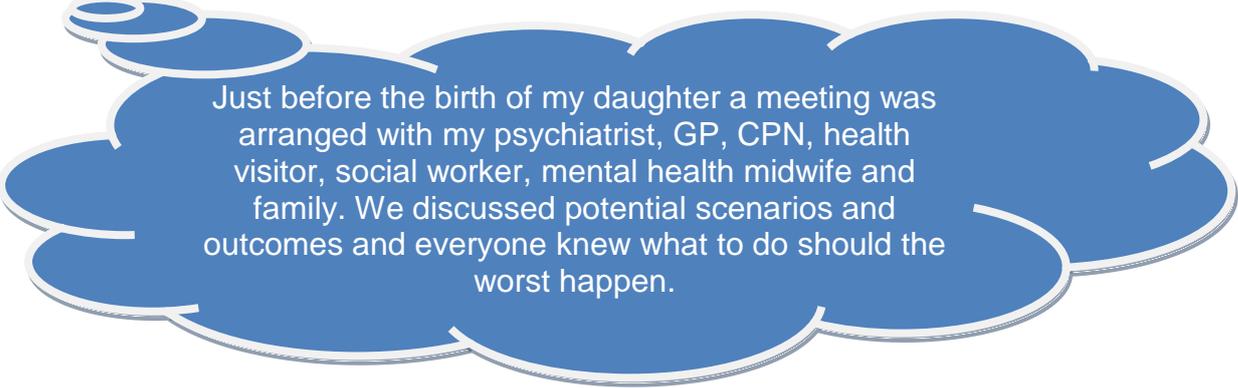
7.0 Role of the Family Nurse Partnership Nurse

- 7.1 Family Nurse Partnership (FNP) is an intensive structured early intervention programme offered to first time young mothers and fathers commencing in the early antenatal period. It aims to improve maternal health and wellbeing; to improve child health and wellbeing and to improve the economic self-sufficiency and life course for the young family.
- 7.2 Teenage mothers have higher rates of poor mental health for up to three years after birth. They are also three times more likely to experience postnatal depression. Also, two in three teenage mothers experience relationship breakdown in pregnancy or in the three years after birth.
- 7.3 Family nurses take a strengths based approach and will use the Edinburgh Postnatal Depression Screening Tool on up to 4 occasions during the programme. They will also use the General Anxiety and Depression Score GAD 7 at the same contact.

- 7.4 The resources and tools utilised in the Programme will empower young people to improve their mental health and wellbeing. The programme also equips young parents to be nurturing, engaged, positive parents when dealing with the poor mental health and emotional wellbeing.
- 7.5 The Family Nurses work closely with Mental Health and Primary Care Teams to allow the young person to access appropriate help and treatment and have strong links with midwives, health visitors, child care social workers and Sure Starts.

8.0 Role of the Obstetrician

- 8.1 Obstetricians play an important role to ensure that all women with mental ill health/eating disorders/substance misuse achieve the best possible health outcomes for themselves and their babies in the perinatal period. Obstetricians should work in collaboration with midwives, GPs, health visitors, family nurses, AHPs, members of mental health teams, Clinical Psychology and social workers as appropriate. Obstetricians should take a lead in co-ordinating the maternity care for pregnant women with mental ill health.
- 8.2 Obstetricians providing private antenatal care must ensure they have processes in place to fully comply with the local HSCT PNMHP and operational guidance.
- 8.3 Women who are pregnant and have a formal diagnosis of mental ill health/eating disorder/substance misuse and have on-going support from mental health services should be seen by a consultant obstetrician. The appointment with the consultant obstetrician should be at booking or shortly thereafter to arrange a plan of care. Obstetric review will depend on other co-morbidities, current medications and liaison with mental health services. It is the responsibility of the obstetrician to liaise with other professionals in the woman's care and to ensure that the PNMHP is implemented, particularly at the time of birth. For example: liaising with the GP, health visitor, family nurses, AHPs, Clinical Psychology, social services and the mental health team as appropriate.



Just before the birth of my daughter a meeting was arranged with my psychiatrist, GP, CPN, health visitor, social worker, mental health midwife and family. We discussed potential scenarios and outcomes and everyone knew what to do should the worst happen.

9.0 Role of the Health Visitor

- 9.1 Health visitors work in partnership with families to promote emotional wellbeing and resilience and as public health practitioners; they can make a significant contribution to the early identification and effective management of mental ill health in the perinatal period. They work with a defined population to deliver services that promote the health and wellbeing of children, young people and their families.
- 9.2 The role of the health visitor within the care pathway is to identify women in the ante/postnatal period that may be at risk of developing mental ill health. They will assess women during the same period who are currently suffering from mental ill health/eating disorder/substance misuse, liaise with the GP and other relevant HSC professionals regarding appropriate interventions and update the Family Health Assessment (FHA) at each contact. They use validated tools such as the Edinburgh Postnatal Depression Scale (EPDS), NICE screening questions and clinical interview/judgement to strengthen their clinical assessment.
- 9.3 The EPDS (Appendix 4) is a self-report questionnaire that has been validated for use by health professionals to assist in the assessment of perinatal mental health by rating and measuring the frequency of some symptoms relating to depression and anxiety. The health visitor will use the EPDS to facilitate a guided conversation which will include the Whooley and anxiety detection question at the antenatal home visit and two postnatal contacts. A holistic Family Health Assessment will be completed and a health plan developed in partnership with the family. Onward urgent referral will be progressed at any time if a woman is displaying symptoms of puerperal psychosis, bipolar disorder, eating disorder, substance misuse or depression with suicidal intent. Consideration will be given to the need for referral to childcare social services. The health visitor will assess the woman's emotional health at

all future contacts and will agree appropriate future action in partnership with the woman and her partner/family.

- 9.4 The health visitor can provide support to women, their partners and families through their understanding of the illness and its impact on the infant, family and society.

Non-directive counselling – Listening visits

- 9.5 Non-directive counselling (listening visits) provided by health visitors are an effective intervention for mild to moderate postnatal depression. Non-directive counselling is derived from the theories of Carl Rogers (1957) and is concerned with helping the mother to understand her situation by exploring the possible explanations for the way she is feeling and options and strategies that might support her. It is not giving advice or information and these visits should be planned, time limited, focused support provided over four sessions followed by a reassessment and if required, additional listening visits. Knowledge of the possible negative impact on infant attachment, cognitive and emotional development and family functioning necessitates that it is given a high priority in health visiting practice.

- 9.6 These visits should be combined with education about mental ill health and the promotion of positive mental health through social support, a healthy lifestyle and awareness of other services such as infant massage. Strategies that the health visitor should consider with the mother include:

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



10.0 Role of Secondary Care Mental Health Services

- 10.1 Secondary care mental health services include the consultant psychiatrist and psychology services and, where appropriate, the community mental health team (CMHT). These services should be involved with pregnant women with significant mental health illness/eating disorder/substance misuse, or deemed to be at significant risk of becoming acutely unwell in the postnatal period. The CMHT should liaise closely with the woman's GP, Clinical Psychology, health visitor, family nurse, AHPs, social services and maternity services to ensure the best possible outcomes for the woman and baby. Psychiatric services should communicate with the GP/maternity/health visiting/family nurse services/AHPs/social services/Clinical Psychology via letter and for midwives in the Maternity Hand Held Record.
- 10.2 The CMHT can offer pre-conceptual counselling for those women who are, or have been, under the care of mental health services who are contemplating a pregnancy or who are at risk of an unplanned pregnancy.
- 10.3 They may be involved in providing telephone advice to GPs/health visitors/family nurses/AHPs/social services or obstetric services regarding psychotropic medication in pregnancy or breastfeeding.
- 10.4 The CMHT may offer brief psychological interventions for pregnant women with symptoms of anxiety and/or depression which impact on social functioning, which do not meet the diagnostic criteria for a formal diagnosis with particular consideration of those with a previous history of depression.
- 10.5 If a woman already known to the CMHT becomes pregnant, or is referred to the CMHT during pregnancy, the team should liaise closely with primary care and maternity/health visiting/family nurse services/AHPs/social services. If the woman is at high risk of serious mental ill health or significant mental ill health requiring ongoing psychiatric care, the woman should be advised to make an immediate appointment with her GP. The CMHT should take a lead role in drawing up a detailed personal care plan (for pregnancy, intrapartum and postpartum management). This plan should be agreed with the woman, her family/carers and shared with all services including the GP, health visitor, family nurse, midwives, obstetrician and other professionals, e.g. a social worker/Clinical Psychology/AHPs, if involved. A copy of the personal care plan should be kept in the Maternity Hand Held Records.

- 10.6 Women who develop symptoms of mental ill health should be referred to the CMHT for rapid assessment particularly if the illness arises within the first two weeks following birth. A full risk assessment should be carried out and documented, including the risk to the newborn baby and any other dependent children. Consideration should be given to the need for referral to childcare social services.
- 10.7 If the woman is acutely unwell, admission to hospital or referral to home treatment services should be considered. Close liaison with the next of kin, family members and carers should be maintained following any assessments and decisions regarding care settings, treatment and follow up and all professionals should follow their local Trust operational guidance and the local Trust PNMHP.

11.0 Role of the Occupational Therapist

- 11.1 Occupational Therapists focus on 'occupation' as being intrinsic to life and wellbeing and to achieve this promotes participation in a variety of activities. Their role in the Perinatal Mother and Baby Unit (MBU) focuses on ensuring occupational balance and engagement for both the mother and the baby.
- 11.2 Babies rely on their mother/parents to create and regulate their emotional, developmental and physical wellbeing. The Occupational Therapists role is critical in enabling occupation for both, whilst supporting the mother, to develop her own role as a mother.
- 11.3 The Occupational Therapist can help mothers identify their strengths and areas of difficulty and provide opportunities to work on personal goals. Meaningful everyday activities can be used to enhance function in areas such as activities of daily living, problem-solving/decision-making, social/interpersonal skills and leisure pursuits.
- 11.4 The Occupational Therapist can initiate treatment programmes within the MBU and support the mother and baby through continued intervention post discharge.

12.0 Safeguarding Children

- 12.1 This section of the Care Pathway needs to be read in conjunction with:
- DHSSPS Co-Operating to Safeguard Children and Young People (2016)

- Regional Safeguarding Children Policy and Procedures (SBNI,2016)
- Understanding The Needs of Children in Northern Ireland (UNOCINI)
- Guidance for the Safeguarding Process Prior To and Immediately After The Birth Of A Baby Where There May Be Risks of Significant Harm (HSCB, 2016)
- Adult and Children's Services Joint Protocol. Responding to the needs of children whose parents have mental health or substance misuses issues (HSCB, 2011)
- UNOCINI: A Guide to Understanding the Effect of Parental Mental Health on Children and their Family. (DHSSPS, 2009)
- Protecting Children and Young People. The Responsibility of All Doctors. (GMC, 2012)

12.2 When a safeguarding concern is identified by any professional involved with the client/family a referral should be made to the appropriate children's social work team. Where possible referrals about unborn babies should be made by the 18th week of the pregnancy to allow sufficient time for a full and informed assessment and to make adequate plans for the baby's protection, where this is necessary. An 'Expectant Mother' UNOCINI referral form should be completed for mothers over the age of 18, whilst the routine UNOCINI referral for should be used for mothers under the age of 18.

12.3 Any child protection concerns must be referred to the appropriate children's social work team and followed up within 24 hours with a completed (UNOCINI). Nurses and midwives should seek advice and guidance from a Trust safeguarding children nurse specialist (SCNS).

12.4 In cases where it is believed the family are in need of additional support staff should discuss concerns and seek consent to make a referral to the local family support hub or to the local Emotional Health and Wellbeing Hubs. If it is deemed statutory involvement is required or preferred a referral can be made to the relevant social work team.

12.5 In the event of a woman's admission to hospital during the perinatal period, staff should consider whether adequate and safe arrangements are in place for the care of any dependent children. If there is any doubt an urgent telephone referral needs to be made to the Gateway Service or Regional Emergency Social Work Service if out of hours.

- 12.6 All staff providing care and services for women and their families during the perinatal period should have relevant up-to-date knowledge and training in relation to safeguarding children and be familiar with local child protection policies and procedures. Minimum levels of learning and development are set out in the Child Safeguarding Learning and Development strategy published by the Safeguarding Board for Northern Ireland (SBNI) 2016. Line managers are responsible for ensuring staff has access to training and learning opportunities applicable to their role and responsibility.
- 12.7 All staff involved with a family where there are safeguarding concerns relating to a child or family in their care have a duty to attend and share information at any safeguarding children meetings.



13.0 Medication Issues

- 13.1 Prescribing psychotropic medication in pregnancy and lactation involves a careful analysis of the potential risks and benefits involved. In particular, the risk posed to the unborn child or breastfeeding infant from medication crossing the placenta or passing into breast milk, has to weigh against the risks posed by the woman becoming unwell pre-conception, during pregnancy or in the postnatal period. Each trust has a Lactation Consultant and women can be referred for breastfeeding advice.
- 13.2 Recent recommendations suggest that health professionals should not offer valproate for acute or long-term treatment of a mental health problem in women who are planning a pregnancy, pregnant or considering breastfeeding.

- 13.3 If a woman is already taking valproate and is planning a pregnancy, advise her to gradually stop the drug because of the risk of fetal malformations and adverse neurodevelopment outcomes after any exposure in pregnancy. Contraception and the risk of pregnancy should be discussed with all women of childbearing potential who have a mental illness and/or who are taking any anticonvulsant or psychotropic medication.
- 13.4 Do not offer valproate for acute or long-term treatment of a mental health problem of women with childbearing potential, however if a woman is already taking valproate and becomes pregnant urgent advice should be sought from her consulting psychiatrist.
- 13.5 Advise pregnant women taking antipsychotic medication about diet and monitor for excessive weight gain, in line with the guideline on weight management before, during and after pregnancy (NICE guideline PH27).
- 13.6 Monitor for gestational diabetes in pregnant women taking antipsychotic medication in line with the guideline on diabetes in pregnancy (NICE guideline CG63) and offer an oral glucose tolerance test.
- 13.7 To minimise the risk of harm, drugs should be prescribed with caution.
- 13.8 Factors to be taken into consideration include the woman's diagnosis, her response to medication and her risk of relapse, as well as the potential risks posed by medications during pregnancy.
- 13.9 The thresholds for non-drug treatments, particularly the psychological therapies, may be lower during pregnancy due to the changing risk benefit ratio.
- 13.10 At all times, HSC professional needs to involve the woman and, where appropriate, her partner/next of kin/family/carer in a collaborative discussion about medication issues.
- 13.11 Clear verbal and visual decision aids should be provided to focus on the individual woman's needs.

For information on individual drugs please refer to the NICE website www.nice.org.uk. (See *helpful contacts* on page 19).

Telephone advice can be sought from:

- UK Teratology Information Service at 0344 892 0909

- Breastfeeding helpline at 0300 100 0212

Web-based information can be sought from:

- NICE website www.nice.org.uk and <http://guidance.nice.org.uk/cg45>
- The Scottish Intercollegiate Guidelines Network website www.sign.ac.uk

14.0 Improving Outcomes for Users and Carers

14.1 At the heart of this care pathway is the need to improve the care experience and outcomes for those women with antenatal or postnatal mental health needs/eating disorder/substance misuse, their children and families.

14.2 The patient/carer experience is one of the most powerful levers for service and quality improvement. Consultation with user groups from local Trust Maternity Liaison Committees and community and voluntary organisations took place during the development of this revision of the 2012 care pathway.

14.3 Successful implementation of the care pathway in each HSCT should lead to the following improvements in care for women with perinatal mental ill health:

1. A comprehensive assessment which will address each woman's needs and involve woman and their families and carers in all decisions regarding their personal care plan.
2. Clear information about the risks and benefits of any prescribed medication.
3. Clear information about how to access local care and services available.
4. Integrated care and referral processes where appropriate co-ordinated between the GP, health visitor, family nurse, maternity services, Clinical Psychology and mental health services.
5. Flexible personalised care which addresses the needs of the woman, baby and family across the HSC system.

6. Where appropriate, the implementation of a written and shared Pregnancy and Early Postnatal Care Plan (PEPP), which includes clear details of care provided by all those involved in the provision of services. Referral A UNOCINI referral may only be completed if there are safeguarding or child in need concerns.
7. Carer assessment where necessary.
8. Following discharge from mental health services, communication with primary care services/health visiting/family nurse partnership and/or onward referral to other services as necessary, should take place.

15.0 How to use this Care Pathway

15.1 This care pathway is intended to assist professionals involved in the care of pregnant and postnatal women. The aim is to recognise mental health problems in pregnancy and in the intrapartum and postnatal period of those women who may experience mental ill health in association with pregnancy and the postnatal period. To enhance and support the need for consistency across HSCTs flowcharts for the antenatal and postnatal period are included in this care pathway for consideration by HSCTs.

- i. **The Antenatal Screening Flowchart** is designed to accompany the recent changes in the Northern Ireland Maternity System (NIMATS). The flowchart should be followed if triggered by the NIMATS screening questions. The woman may be referred back to the primary care team for management or a referral to mental health services may be indicated (*see pages 11-13*).
- ii. **The Pregnancy and Early Postnatal Care Plan** is designed to be used for pregnant woman with a current or past history of severe mental ill health/eating disorder/substance misuse as defined by NICE guidelines (2007). The woman should be in contact with, or be referred to, mental health services and the plan should be drawn up in association with all other services and professionals involved (*see pages 9-18*).
- iii. **The Postnatal Flowchart** should be followed if the woman becomes ill during the intrapartum or postnatal period. The local Trust care pathway should reflect local services and referral systems (*see page 32*).

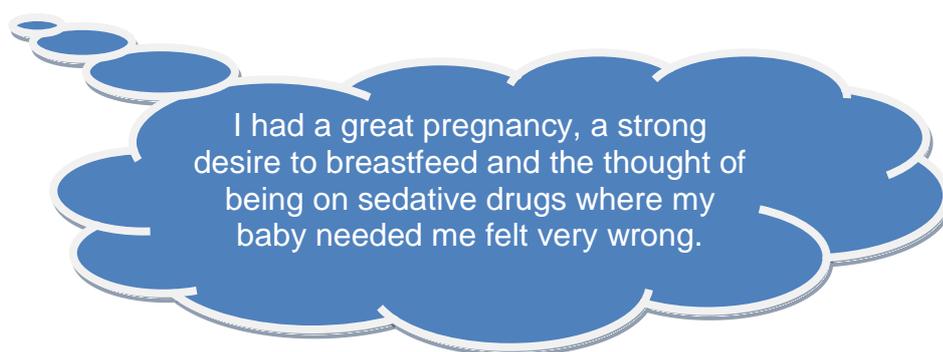
iv. A multidisciplinary approach is essential and communication between professionals must be of the highest standard to ensure that safe and effective management, care, treatment and follow-up are in place for women with perinatal mental ill health.

15.2 The implementation of a local care pathway in each HSCT will ensure that every woman known to maternity services is screened, by being asked the questions outlined in the NICE guidelines (2007, 2014) for the prediction and detection of mental ill health, at the appropriate stages in pregnancy and the postnatal period. All staff involved in the woman's care should be aware of local arrangements in each HSCT for referral into all services as deemed appropriate.

15.3 With the guidance provided in this regional care pathway, and the implementation of local Trust care pathways, women can expect to be seen by professionals who understand the risk factors for mental ill health associated with pregnancy and the postnatal period.

15.4 Women can expect to receive culturally sensitive information, including relevant information regarding the impact of mental ill health and treatment for mental ill health for themselves and on that of the unborn child or child.

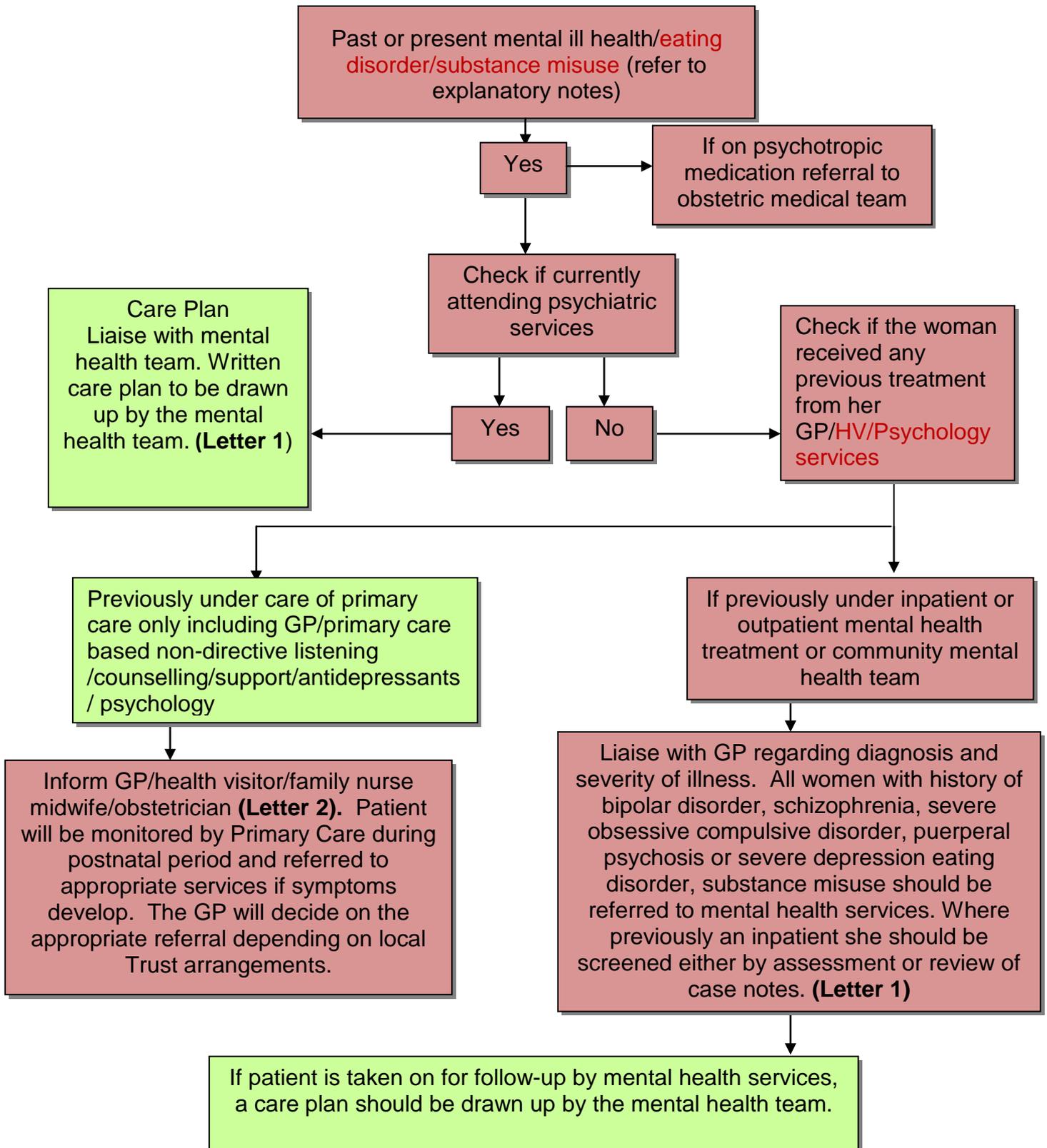
15.5 Women should expect that treatment and care will take into account their individual needs and preferences and that they and their families and carers are able to participate in informed decisions about their care supported by evidence based information.



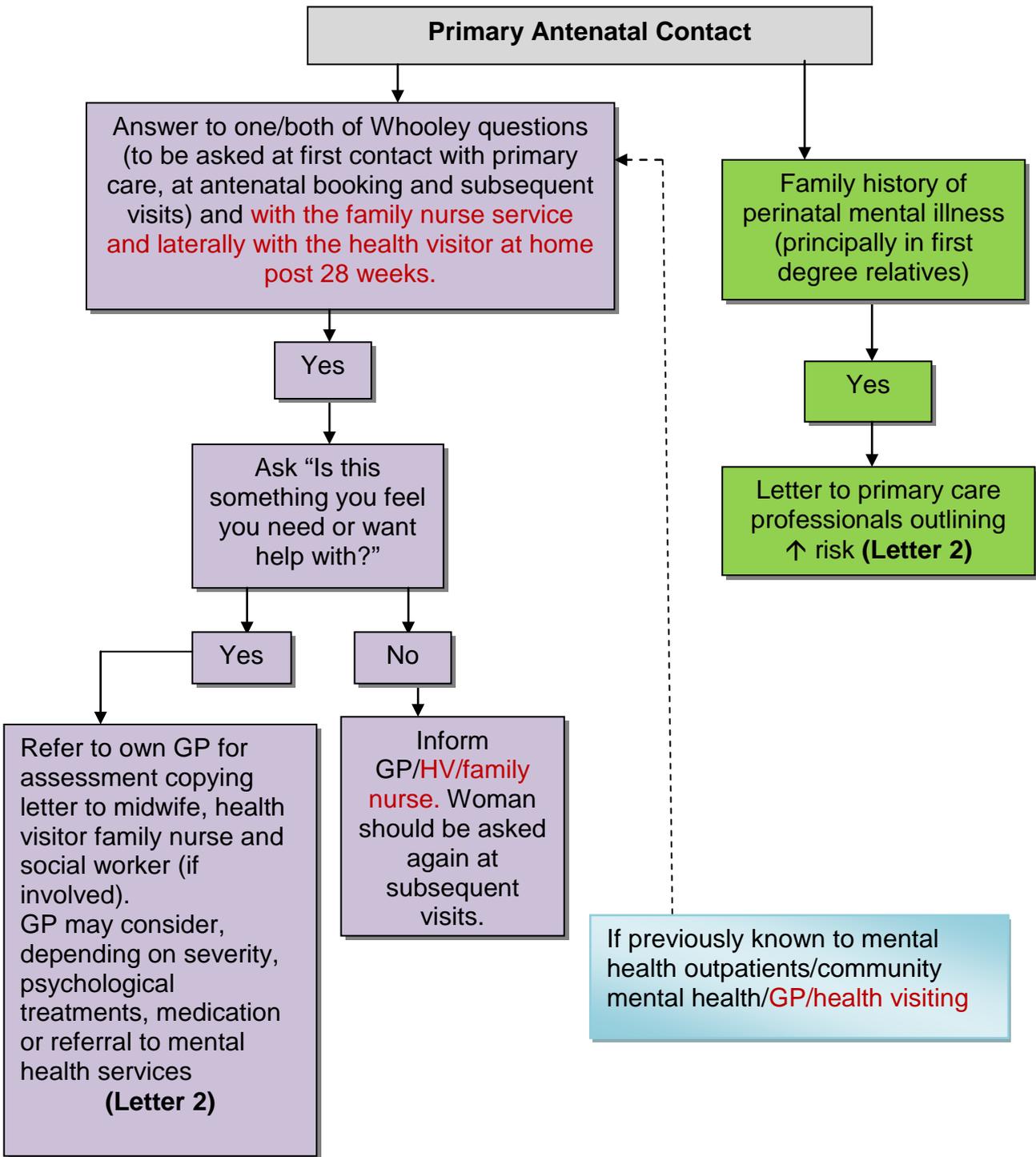
15.6 In the event of a woman's admission to hospital during the perinatal period, staff should consider whether adequate and safe arrangements are in place for the care of any dependent children. If there is any doubt an urgent telephone referral needs to be made to the childcare social work team.

16.0 Flow Chart of Management of Women in the Antenatal Period with Mental Health Concerns

UNIVERSAL ANTENATAL SCREENING FLOW CHART (Part 1)



UNIVERSAL ANTENATAL SCREENING FLOW CHART (Part 2)



During antenatal care if mental ill health symptoms develop please refer to GP (Letter 2). Please repeat Whooley questions as required.

17.0 Explanatory Notes Flow Chart

Personal History (Prediction)

- 17.1 Not all women who give a history of mental ill health need to be seen by a psychiatrist. The illness may have been relatively minor and not likely to recur. Previous treatment needs to be checked with the woman and her GP. If the woman was previously treated by a psychiatrist, either as an outpatient or as an inpatient, there is a higher likelihood that her illness may have been a significant one. Liaison with the woman's GP is essential to ensure correct information regarding diagnosis and severity of illness. This should be via telephone initially and followed up by a letter as per flowchart.
- 17.2 Women with a history of severe mental ill health (e.g. bipolar disorder) may be at risk of relapse or recurrence of their illness in the postnatal period. These women should be under the care of a mental health team for the duration of their pregnancy and the postnatal period. If the woman is not already under the care of a consultant psychiatrist she should be referred, with her consent, to a perinatal psychiatrist, where available, or if not available to the local HSCT mental health team. A management plan should be drawn up by this team and shared with all professionals involved in the woman's care during the perinatal period and may include childcare social services if there is a potential childcare concern.

Family History (Prediction)

- 17.3 Women should be asked about any history of psychosis in the postnatal period and about a history of bipolar disorder in a parent or sibling. Studies suggest that if a woman has a family history of psychosis in the postnatal period it may be predictive for the development of mental ill health in the postnatal period.

If the woman answers yes to this question, letter 2 (*see Appendix 3*) should be sent to all professionals involved in the woman's care highlighting the small increase in risk and advising prompt consideration to referral into mental health services if symptoms suggestive of serious mental ill health develop in the postnatal period.

Whooley Questions/Anxiety Questions (Detection)

- 17.4 These are questions designed to detect possible depression during the antenatal and postnatal periods. Clinical judgment should be exercised with these questions. If the professional strongly suspects the woman is

depressed but she is answering “no” to the questions, a guided conversation may support the woman to disclose. If not the questions should be repeated at subsequent visits. If significant concerns are present these concerns should be discussed with the GP (see Appendix 3, letter **2**).

18.0 THE PREGNANCY AND EARLY POSTNATAL PREGNANCY AND EARLY POSTNATAL PLAN

To be completed by the community mental health team for those women considered at risk of severe mental illness.

Pregnancy and Early Postnatal Care Plan (PEPP)

Name		DOB	
Address		EDD	
		Confirmed EDD	
Home No		Mobile No	
Obstetrician		Hospital/Trust	
Date PEEP		Date Reviewed	
Risk assessment	Y/N	Date completed	

Current Diagnosis/ Symptoms

Medication at conception/ Current Medication

Risk factors for illness in postnatal period

1. History of mental ill health/ family history

2. Current Illness

3. Overall risk relapse/ recurrence

Pregnancy Plan (include medication, review dates, contingency plan)

Delivery Plan (include changes to medication)

Intention to breast feed? Y / N / Undecided

Post partum instructions

1. Medication

2. Review plans – Community/ in-hospital liaison/ Home Treatment Team

3. Early warning signs

Signed by person completing Assessment		Date	
Print Name			
Position Held			
Service User Signature			

Important Contacts:

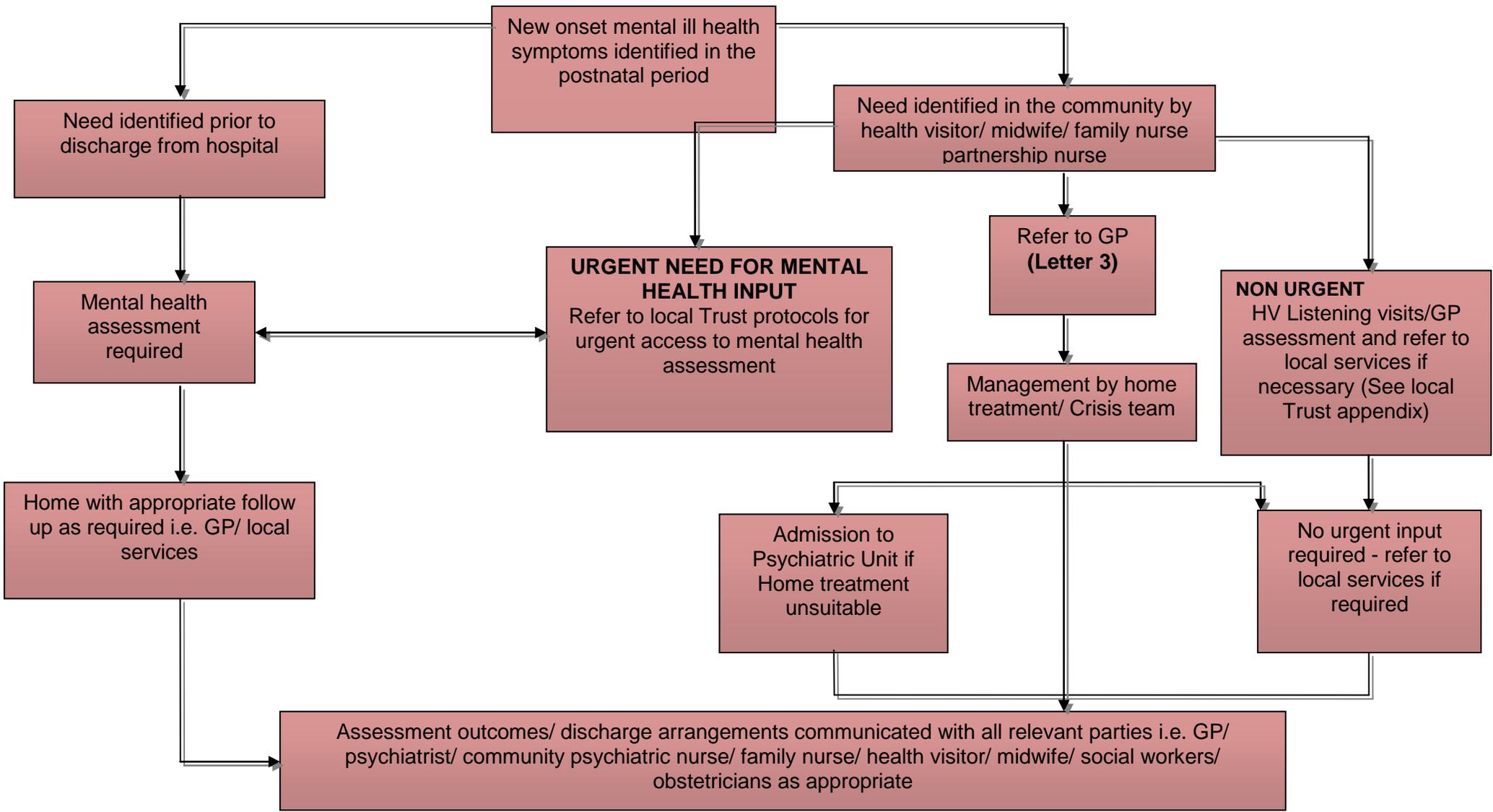
[To be completed as part of care plan referral and follow up documentation]

CONTACT NAME	CONTACT DETAILS	COPY
Community Psychiatric Nurse		Y / N
Health Visitor		Y / N
Family Nurse		Y / N
Community Midwife		Y / N
Obstetrician		Y / N
General Practitioner		Y / N
Psychiatrist		Y / N
Psychologist		Y / N
Social Worker (if involved)		Y / N
Other Professional		Y / N
Next of Kin/Named Person		Y / N

19.0 Explanatory Notes - Pregnancy and Early Postnatal Care Plan

- 19.1 This care plan is designed to be used for women with a current or past history of severe mental ill health who are pregnant.
- 19.2 These women should be in contact with mental health services and the care plan should be drawn up by these services in association with the woman and her next of kin/partner, other family members, if appropriate, and other relevant health/social care professionals.
- 19.3 The care plan ideally will be drawn up between 26 and 30 weeks during woman's care. It will also be filed in the woman's handheld notes unless deemed inappropriate. It will include risk of illness, management and postnatal follow-up arrangements. A review of the care plan will be required during the pregnancy.
- 19.4 In general, the care plan will specify the level of contact with mental health services (including perinatal services where available).
- 19.5 The care plan is designed to promote and simplify information sharing, in order to enhance the level of care provided for women with a mental health illness in the perinatal period.
- 19.6 The care plan is not designed to take the place of a mental health risk assessment. A standardised risk assessment tool, including childcare issues, should be completed as part of the initial mental health assessment. Any issues of concern should be addressed as part of the risk management plan.
- 19.7 The care plan is not intended to take the place of correspondence involved in the care of women in the perinatal period. All professionals should follow the local Trust care pathways and consider the use of standardised letters to ensure effective communication is in place across all services involved in the woman's treatment and care.

20.0 FLOW CHART OF MANAGEMENT OF WOMEN IN THE POSTNATAL PERIOD WITH MENTAL HEALTH CONCERNS



21.0 Explanatory Notes for Postnatal Flow Chart

- 21.1 All women identified in the antenatal period should be followed up as planned. This chart is to be used for women presenting with newly emerging symptoms in the postnatal period.
- 21.2 It is recognised that at all times the safety of the newborn child will be given priority and appropriate measures taken if any concerns arise.
- 21.3 **Identification of issues pre-discharge** - Any woman felt to be exhibiting concerning symptoms on the postnatal wards should be discussed with mental health teams. Women already known to services should have a completed pregnancy care plan in their hand held notes. This should be updated, where necessary and a prompt assessment of the patient will be provided and a management plan drawn up accordingly.
- 21.4 **Identification of issues in the community** - It is recognised that care for women in the postnatal period is provided from an increasingly early stage in the community, initially by community midwives/family nurse partnership nurses and post 10-14 days, health visitors.
- 21.5 **Non-urgent** - If non-urgent concerns are identified in the community it is necessary to inform the patient's GP. The HV may offer 4 non-directive listening visits in the first instance. In this circumstance the GP will be kept informed and may if necessary assess the woman and either commence treatment in primary care or refer to local mental health services.
- 22.6 **Urgent** - In urgent situations, where it is felt a woman may require admission to hospital or immediate intervention, contact should be made with the GP or Out-of-Hours GP who should liaise with local mental health services. In addition, in very urgent situations, contact can be made with the Trust's mental health home treatment/ crisis response team directly to ensure the appropriate handover of information and allow for further assessment and management of immediate risk. In situations where it is felt that the woman may be a risk to herself or others, consideration should be given to the level of supervision required for both the mother and her baby and the requirement for a child care social services referral. Details of family support, child care arrangements and family support response times should be reviewed and considered as part of the woman's care plan. Contact details for local Trusts teams should be detailed in each local Trust care pathway.

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Acronyms and Abbreviations

Term	Meaning
AHP	Allied Health Professionals
CBT	Cognitive Behavioural Therapy
CEMACH	Confidential Enquires into Maternal Health and Child Health
CMaCE	Centre for Maternal and Child Enquiries (Now MBRACE-UK: Mothers and Babies Reducing Risk through Audits and Confidential Enquiries)
CMHT	Community Mental Health Team
DHSSPS	Department of Health, Social Services and Public Safety Now Department of Health
EDD	Expected date of delivery
EPDS	Edinburgh Postnatal Depression Scale
FHA	Family Health assessment
FNPN	Family Nurse partnership Nurse
GAD7	General Anxiety and Depression Score
GP	General Practitioner
HSC	Health and Social care
HSCB	Health and Social Care Board
HSCT	Health and Social Care Trust
MBU	Mother and Baby Unit
MHHR	Maternity Hand Held Record
NICE	National Institute for Health and Care Excellence
NIMATs	Northern Ireland Maternity System
OCD	Obsessive Compulsive Disorders
OPD	Out Patients Department
OT	Occupational therapy
PEPP	Pregnancy and Early Postnatal Care Plan
PNMHP	Perinatal Mental Health Care Pathway
PHA	Public Health Agency
PTSD	Post-Traumatic Stress Disorder
SBNI	Safeguarding Board for Northern Ireland
SCNS	Safeguarding Children Nurse Specialist
SIGN	Scottish Intercollegiate Guidelines Network
UNOCINI	Understanding the Needs of Children in Northern Ireland

The “Perinatal Period” is the time given to the period immediately before and after birth. It is defined in diverse ways and depending on the definition; it starts at the 20th to 28th week of gestation and ends 1 to 4 weeks after birth. In the context of this document “perinatal”, however, is taken to describe psychiatric disorders that arise in association with pregnancy and the postnatal period generally up to 12 months following birth.

APPENDIX 1

REGIONAL PERINATAL MENTAL HEALTH PATHWAY- REVIEW GROUP (2015)

Members	
Dr Stephen Bergin	Public Health Agency
Dr Janine Lynch	Belfast HSC Trust
Shona Hamilton	Northern HSC Trust & QUB
Denise Boulter	Public Health Agency
Dr Heather Livingston	HSC Board
Mary Rafferty	Public Health Agency

APPENDIX 2: Whooley/Anxiety Questions (Detection)

These are questions designed to detect **possible** depression in the antenatal and postnatal periods and are part of an assessment process.

The two questions relating to mental health and wellbeing are:

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?

There is also a third question if the woman answers yes to either of the initial questions:

Is this something you feel you need or want help with?

The two questions relating to anxiety are:

Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious or on edge?

Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?

Clinical judgment should be exercised with these questions. If the professional strongly suspects the woman is depressed but she is answering “no” to the questions, a guided conversation may support a disclosure. If not the questions should be repeated at subsequent visits. If significant concerns are present these concerns should be discussed with the GP.

APPENDIX 3: TEMPLATE LETTERS

LETTER 1	Letter to mental health services from antenatal booking clinic regarding a pregnant woman who is currently or has previously been a patient of mental health services.
LETTER 2	Letter from antenatal booking clinic to GP and HV and/or FNP
LETTER 3	Letter from health visitor/FNP to GP for a woman who has low mood.
LETTER 4	Letter from health visitor/FNP to GP for a woman who has received listening visits.

LETTER 1

Letter to mental health services from antenatal booking clinic regarding a pregnant woman who is currently or has previously been a patient of mental health services.

For Action: Consultant Psychiatrist / Mental health Hub

Date

Psychiatrist

Dear Doctor

Re:

This lady was seen in the antenatal booking clinic and identified a past history of severe mental ill health.

- We understand she is currently attending mental health services and we are writing to inform you that she is now pregnant with an EDD of
- She is not currently attending mental health services but requires to be referred for an urgent appointment .

We anticipate that we will receive a care plan in due course.

Yours sincerely

[Antenatal booking professional]

CC Health Visitors
Family Nurse Partnership Nurse
Community Midwives
GP

Template letters: Local Trust logo and heading to be added, as required, for corresponding between different Health and Social Care professional groups.

LETTER 2	Letter from antenatal booking clinic to GP and HV and/or FNP
-----------------	---------------------------------------------------------------------

To: GP

Date:

Dear Dr.....

I have assessed..... at the antenatal clinic today

This letter is for information purposes only.

1. She has disclosed the following
 - A history of minor mental health problems
 - Mild/ moderate symptoms of anxiety
 - Family history of bipolar disorder or perinatal mood disorder

We have advised her to contact you if her symptoms deteriorate or she deems it necessary.

Please note: a family history as above should lower the threshold for referral to services if symptoms develop

- Positive response to the Whooley Questions, We have requested that she make an appointment to see yourself.

2. She has disclosed a h/o psychiatric illness requiring previous input from psychiatric services. We have advised her to contact you. If, on review of her and her notes, you have concerns please refer into psychiatric services as per your local trust guidelines. Please note that a history of bipolar affective disorder, puerperal psychosis or of previous severe depression in the postnatal period, place the woman at high risk of severe illness in the postpartum period and require proactive psychiatric management

Ms _____ has been informed that you have been sent this letter.

If you have any concerns please contact us.

Cc: Community Midwife
Health Visitor
Family Nurse Partnership Nurse

LETTER 3	Letter from health visitor/FNPN to GP for a woman who has low mood.
-----------------	----------------------------------------------------------------------------

To: GP for information/action as required

Date

Address

Dear Doctor

This lady was seen recently and answered “yes” to the Whooley/anxiety questions, used to screen for low mood/anxiety. I have asked her to make an appointment with the GP for further assessment and ongoing management.

*I have offered Listening Visits which will commence on _____

*I have offered Listening Visits which have been declined

Yours sincerely

Health Visitor/ Family Nurse Partnership Nurse

Template letters: Local Trust logo and heading to be added, as required, for corresponding between different Health and Social Care professional groups.

LETTER 4	Letter from health visitor/FNPN to GP for a woman who has received Non-directive listening visits.
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To: GP for information/action as required

Date

Address

Dear Doctor

Re

Following the delivery of Listening Visits with this lady, further assessment indicates that her mood is;

***Option 1. Improved** and my contact with her and will be reviewed at the next universal Child Health Promotion Programme contact.

***Option 2. Deteriorated** and I have asked her to make an appointment with the GP for a review

Yours sincerely

Health Visitor/Family Nurse Partnership Nurse

Template letters: Local Trust logo and heading to be added, as required, for corresponding between different Health and Social Care professional groups.

APPENDIX 4: Edinburgh Postnatal Depression Scale (EPDS)

The EPDS is a self-administered tool to assist the health visitor /family nurse in screening mothers for postnatal depression.

Scoring

- Response categories are scored 0, 1, 2, and 3 accordingly to increased severity of the symptom
- Some items are reverse scored
- Any score above 0 on question 10 requires further assessment
- Validation studies have shown an EPDS cut off score of 12 or greater may be used to determine depressive symptoms among English speaking women in the postpartum period.
- The EPDS must be interpreted in combination with professional judgement to confirm postnatal mothers with depressive symptoms.

In the past 7 days:

- 1 I have been able to laugh and see the funny side of things:
 - 0 As much as I always could
 - 1 Not quite as much now
 - 2 Definitely not as much now
 - 3 Not at all

2. I have looked forward with enjoyment to things:
 - 0 As much as I ever did
 - 1 Rather less than I used to
 - 2 Definitely less than I used to
 - 3 Hardly at all

3. I have blamed myself unnecessarily when things went wrong:
 - 0 Yes, most of the time
 - 1 Yes, some of the time
 - 2 Not very often
 - 3 No, never

4. I have been anxious or worried for no good reason
 - 0 No, not at all
 - 1 Hardly ever
 - 2 Yes, sometimes
 - 3 Yes, very often

5. I have felt scared or panicky for no good reason:
 - 0 Yes, quite a lot
 - 1 Yes, sometimes
 - 2 No, not much
 - 3 No, not at all

6. Things have been getting on top of me:
- 0 Yes, most of the time I haven't been able to cope at all
 - 1 Yes, sometimes I haven't been coping as well as usual
 - 2 No, most of the time I have coped quite well
 - 3 No, I have been coping as well as ever
- 7 I have been so unhappy that I have had difficulty sleeping:
- 0 Yes, most of the time
 - 1 Yes, sometimes
 - 2 No, very often
 - 3 No, not at all
- 8 I have felt sad or miserable:
- 0 Yes, most of the time
 - 1 Yes, quite often
 - 2 Not very often
 - 3 No, not at all
- 9 I have been so unhappy that I have been crying:
- 0 Yes, most of the time
 - 1 Yes, quite often
 - 2 Only occasionally
 - 3 No, never
- 10 The thought of harming myself has occurred to me:
- 0 Yes, quite often
 - 1 Sometimes
 - 2 Hardly ever
 - 3 Never

Total Score (Add numbers 1 to 10)



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