The Perinatal Mental Health Care Pathways

Appendices and helpful resources

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Cited as

National Collaborating Centre for Mental Health. The Perinatal Mental Health Care Pathways. Full implementation guidance. London: National Collaborating Centre for Mental Health. 2018.

Contents

APPENDICES

Appendix A: NICE-recommended interventions

Table 1, Table 2 and Table 3 summarise the recommendations from the Antenatal and Postnatal Mental Health NICE guideline. Please note that this guideline should be used in conjunction with other NICE guidelines on mental health problems.

Table 1: Specialist advice: preconception and perinatal interventions

Intervention	Summary of recommendations
Preconception advice	
Discussion	Discuss: • the use of contraception and any plans for a pregnancy • how pregnancy and childbirth might affect a mental health problem • how a mental health problem and its treatment might affect the woman, the fetus and baby, and parenting
Advice on pharmacological interventions	
Starting and monitoring medication	Taking into account a woman's previous response to medication, consider: • the drug with the lowest risk profile for the woman, fetus and baby • the lowest effective dose (dosage may need to be changed throughout pregnancy) • a single drug, if possible • the impact of treatment on breastfeeding.
Stopping medication	Discuss with the woman the risks to herself and the fetus or baby, including: • risks associated with switching from or stopping a previously effective medication (including increased monitoring and support) • discontinuation symptoms in the woman and fetus (for example, with TCAs, SSRIs and [S]NRIs) • the reasons for wishing to stop taking medication • the possibility of restarting or switching medication and/or psychological intervention.
Switching medication because of teratogenic effects	• Explain that risks of fetal malformations associated with continuing, stopping or switching the medication after pregnancy. • Offer screening, counselling and additional support; seek specialist advice if necessary.
Specific drugs	• Valproate should not be offered for acute or long-term treatment of a mental health problem in women of childbearing potential. • See the Antenatal and Postnatal Mental Health NICE guideline for specific details on the following drugs: benzodiazepines, antipsychotic medication, anticonvulsants for mental health problems lithium, TCAs, SSRIs, (S)NRIs and promethazine.

Key: NICE: National Institute for Health and Care Excellence; (S)NRI = (serotonin–)norepinephrine reuptake inhibitor; SSRI = selective serotonin reuptake inhibitor; TCA = tricyclic antidepressant.

Table 2: Assessment and monitoring interventions

Intervention	Summary of recommendations

Assessment	• This should include:
	  ○ history of any mental health problem, including in the perinatal period
	  ○ physical wellbeing (including weight, smoking, nutrition and activity level) and history of any physical health problem and alcohol and drug misuse
	  ○ the woman's attitude towards the pregnancy, including denial of pregnancy
	  ○ the woman's experience of pregnancy and any problems experienced by her, the fetus or the baby
	  ○ the mother–baby relationship
	  ○ any past or present treatment for a mental health problem and response
	  ○ social networks and quality of interpersonal relationships
	  ○ living conditions and social isolation
	  ○ family history (first-degree relative) of mental health problems
	  ○ domestic violence and abuse, sexual abuse, trauma or childhood maltreatment
	  ○ housing, employment, economic and immigration status
	  ○ responsibilities as a carer for other children and young people or other adults.
	
	• Take account of any learning disabilities or acquired cognitive impairments.
	• Carry out a risk assessment in conjunction with the woman and, if she agrees, her partner, family or carer. Focus on areas that are likely to present possible risk such as self-neglect, self-harm, suicidal thoughts and intent, risks to others (including the baby), smoking, drug or alcohol misuse and domestic violence and abuse.

Monitoring during the perinatal period	• Monitor regularly, particularly in the first few weeks after childbirth (for example, by using validated self-report questionnaires, such as the Edinburgh Postnatal Depression Scale, Patient Health Questionnaire or the 7-item Generalized Anxiety Disorder scale).

Table 3: Psychological and pharmacological interventions

Intervention	Perinatal mental health problem
Psychological interventions	
Low-intensity/brief psychological interventions (facilitated self-help)	• Subthreshold depression or anxiety symptoms • Mild to moderate depression • Initial treatment for an anxiety disorder (but not PTSD or social anxiety disorder) • Binge eating disorder • Hazardous drug or alcohol misuse
Cognitive behavioural therapy (CBT)	• Moderate or severe depression and mild to moderate depression that has not benefited from a low-intensity psychological intervention • Initial treatment for an anxiety disorder, or for a woman stopping a TCA, SSRI or (S)NRI • Psychosis and schizophrenia (CBT for psychosis) for women who are at risk of relapse • Bipolar depression • PTSD resulting from traumatic birth, miscarriage, stillbirth or neonatal death (trauma-focused CBT) • Anorexia nervosa • Bulimia nervosa and binge eating disorder (specifically adapted for the specific eating disorder)
Family intervention	• Psychosis and schizophrenia • Bipolar disorder • Anorexia nervosa
Interpersonal psychotherapy	• Bipolar depression • Moderate or severe depression and mild to moderate depression that has not benefited from a low-intensity psychological intervention • Anorexia nervosa • Bulimia nervosa • Binge eating disorder (specifically adapted for the disorder)
Behavioural couples therapy	• Bipolar depression • Moderate or severe depression and mild to moderate depression that has not benefited from a low-intensity psychological intervention
Behavioural activation	• Moderate or severe depression and mild to moderate depression that has not benefited from a low-intensity psychological intervention
Eye movement desensitisation	• PTSD resulting from traumatic birth, miscarriage, stillbirth or neonatal death
Cognitive analytic therapy	• Anorexia nervosa
Focal psychodynamic therapy	• Anorexia nervosa
Dialectical behaviour therapy	• Binge eating disorder (specifically adapted for the disorder)

Pharmacological interventions	
TCAs, SSRIs or (S)NRIs	• Moderate or severe depression • History of severe depression presenting with mild depression in the perinatal period • Anxiety disorders (if medication is preferred, or the woman declines or has not responded to psychological interventions)
Antipsychotic medication	• Psychosis and schizophrenia • Mania
Lithium (but **only** if antipsychotic medication is not effective)	• Bipolar disorder
Benzodiazepines	• Short-term treatment of severe anxiety and agitation **only**
Anticonvulsants (but **not** valproate or carbamazepine)	• Bipolar disorder
Assisted alcohol withdrawal	• Alcohol dependence
Opioid detoxification	• Opioid dependence
Promethazine	• Severe and chronic sleep problems
Combined psychological interventions	
A high-intensity psychological intervention in combination with medication	• Moderate or severe depression (if there is no response, or a limited response, to a high-intensity psychological intervention or medication alone) • Anxiety disorders (if there is no response, or a limited response, to a high-intensity psychological intervention alone).
Key: CBT = cognitive behavioural therapy; PTSD = post-traumatic stress disorder; (S)NRI = (serotonin–)norepinephrine reuptake inhibitor; SSRI = selective serotonin reuptake inhibitor; TCA = tricyclic antidepressant.	

Appendix B: SNOMED CT codes

Providers should ensure that the NICE-recommended interventions in the first column of Table 4 can be entered by clinicians into the electronic care record and submitted as SNOMED CT codes as part of Mental Health Services Dataset submissions.

SNOMED CT (Systematized Nomenclature of Medicine – Clinical Terms) consists of comprehensive scientifically validated content. SNOMED CT is available in more than 50 countries and is managed and maintained internationally by the International Health Terminology Standards Development Organisation, and in the UK by the UK Terminology Centre. SNOMED CT supports recording of clinical information in a way that allows data management and analysis to support patient care, while enabling data extraction and data exchange. SNOMED CT is specified as the single terminology to be used across the health system in Personalised Health and Care 2020: A Framework for Action.

To access the latest version of the SNOMED-CT codes, see the NHS Digital Published SNOMED CT Subset Metadata for perinatal mental health procedures.

Table 4: SNOMED CT codes

NICE recommended intervention		SNOMED CT concept description	SNOMED CT concept ID
1	Assessment	Perinatal mental health assessment	723559001
		Edinburgh postnatal depression scale	450319007
		Patient Health Questionnaire Nine Item score	715252007
		Anxiety disorder 7 item score	445598007
		Beck depression inventory	446765009
		Penn State worry questionnaire	445795008
		Clinical Outcomes in Routine Evaluation 10	718439001
2	Psychological interventions	Pre-pregnancy education	171012002
		Low-intensity/brief psychological interventions (facilitated self-help)	1026111000000108
		Brief solution focused psychotherapy	401157001
		Guided self-help cognitive behavioural therapy	444175001
		Cognitive behavioural therapy	304891004
		Family therapy	51484002
		Family intervention for psychosis	985451000000105
		Interpersonal psychotherapy	443730003
		Couple psychotherapy	440274001
		Behavioural couple's therapy	723619005
		Eye movement desensitization and reprocessing therapy	449030000
		Cognitive analytic therapy	390773006
		Focal psychodynamic therapy	718023002
		Dialectical behaviour therapy	405780009
3	Pharmacological interventions	Medication monitoring	395170001
		Medication education	967006
		Antidepressant therapy	698456001
		Anxiolytic drug therapy	723558009
		Antipsychotic drug therapy	408490001
		Lithium therapy	68852009
		Benzodiazepine therapy	1066801000000105
		Anticonvulsants	46589004
		Alcohol rehabilitation and detoxification	20093000
		Drug rehabilitation and detoxification	56876005
4	Combined psychological interventions	A high-intensity psychological intervention in combination with medication	1066811000000107

HELPFUL RESOURCES

This resource pack accompanies The Perinatal Mental Health Care Pathways full implementation guidance. It contains information and web links for commissioners and providers, to support the implementation of the perinatal mental health care pathways.

Positive practice example services

Section 1 describes some existing services that provide examples of positive practice, demonstrating how the perinatal mental health care pathways and key objectives for 2020/21 can be delivered across England. Details for each example was provided by the relevant service itself. Further information about the services can be found on the Positive Practice in Mental Health Collaborative website.

There are examples of working with system-wide partners, through the use of perinatal mental health networks and joint strategic commissioning. There are also illustrations of how one or more of the perinatal mental health care pathways can be delivered. Each example service has a focus on the delivery of at least one key statement from the Antenatal and Postnatal Mental Health NICE quality standard.

Outcome measures

Section 2 includes copies of outcome measures recommended for use in perinatal mental health services. These were suggested for consideration by the Expert Reference Group. Generic measures and measures for common mental health problems and severe mental illness are included.

Helpful web-based resources

Section 3 contains links to websites and documents, including:

- national guidance
- other NICE guidance
- perinatal mental health resources
- useful organisations.

As noted in the implementation guide, the College Centre for Quality Improvement (CCQI) is launching a quality assessment and improvement programme, which will be an ongoing source of helpful information and positive practice examples.

1 Positive practice example services and networks

1.1 Services that work with system-wide partners

London Perinatal Mental Health Network and Tameside and Glossop Early Attachment Service

Perinatal mental health network
Networks play an important role in supporting local delivery and strategic planning through encouraging innovation, service development and monitoring, and the coordination of healthcare professionals, commissioners and managers. See the *Antenatal and Postnatal Mental Health* NICE guideline for more information.

There are currently 12 perinatal mental health networks across England.

London Perinatal Mental Health Network
Since 2014, the London Perinatal Mental Health Network[1] has collaborated with the London Maternity Strategic Clinical Network[2] and the Healthy London Partnership.[3] As part of this, the partnership has:

- developed a **standardised training programme** for perinatal mental health, including a tokophobia toolkit[4] and neonatology guidance developed by the London Perinatal Neonatology Working Group[5]
- developed perinatal mental health care **pathways** for London (see the *Pan London Perinatal Mental Health Network Perinatal Mental Health Care Pathways*[6]) and supported service development by promoting the use of the care pathway as a tool in local areas. This has included an animation,[7] to raise awareness and help commissioners and providers understand the pathway and commissioning guidance.
- delivered a **London IAPT Perinatal Leads Project**, to increase the number of women being seen in London IAPT services during the perinatal period
- delivered four **annual conferences**
- developed an **Experts by Experience forum** of London women to provide input to network projects and be involved in coproduction.

Further information can be found in the Royal College of Obstetricians and Gynaecologists' report, *Joining Up Care in Maternal Mental Health: Setting Up a Perinatal Mental Health Network*.

Contact details
Contact:
Jo Maitland, London Perinatal Mental Health Network Coordinator: JMaitland@Tavi-Port.ac.uk

London 2016 maternity numbers: 127,168 (62.8 per 1000 women of childbearing age)

Tameside 2016 maternity numbers: 2,858 (68.3 per 1000 women of childbearing age)

Joint strategic commissioning: Tameside and Glossop Early Attachment Service

The Tameside and Glossop Early Attachment Service[8] (EAS) is jointly run by Pennine Care NHS Foundation Trust and Tameside and Glossop Integrated Care Foundation Trust. It is part of the larger Integrated Parent–Infant Mental Health Care Pathway. The EAS has led the borough in developing integrated perinatal and parent–infant mental health services.

Following the devolution of services to Greater Manchester, the Tameside model is in the process of being rolled out across all boroughs in that region. As a result, there will be a whole system approach to integrated perinatal and parent-infant mental health services.

This Tameside model aims to meet the whole spectrum of families' needs. This includes support for people with severe mental health problems or safeguarding issues. The model is delivered by an integration of the EAS team with other teams, including maternity, adult mental health services, IAPT, health visiting, local authority children's services and the voluntary sector. The aim is to reinforce the relationship between parent and infant, and to develop improved perinatal care services for the future. Apart from the direct clinical work, the EAS provides consultation, supervision, training of health and partner agency staff, and development of new interventions for people with universal or high levels of need. 'The focus of the EAS on improvement and monitoring quality has created a sustainable and cost effective model.

Contact details
Providers: Tameside and Glossop Integrated Care NHS Foundation Trust and Pennine Care NHS Foundation Trust
Contact: Dr Pauline Lee, GM SCN PIMH Clinical Lead, Consultant Clinical Psychologist: pauline.lee2@nhs.net
Pat McKelvey, Mental Health and Learning Disabilities Commissioning Manager: pat.mckelvey@nhs.net

[1] www.londonscn.nhs.uk/networks/mental-health-dementia-neuroscience/mental-health/perinatal-mental-health/
[2] www.londonscn.nhs.uk/networks/maternity-childrens/maternity/
[3] www.myhealth.london.nhs.uk/healthy-london-partnership
[4] https://www.healthylondon.org/resource/tokophobia-best-practice-toolkit/
[5] www.healthylondon.org/sites/default/files/Perinatal%20mental%20health%20service%20for%20London_0.pdf
[6] www.londonscn.nhs.uk/wp-content/uploads/2015/10/mh-care-pathway-231015.pdf
[7] http://maternalmentalhealthalliance.org/resources/practice/
[8] www.penninecare.nhs.uk/your-services/service-directory/tameside-and-glossop/specialist-services/healthy-young-minds-formerly-camhs/tameside-and-glossop-early-attachment-service/

1.2 Pathway 1: Preconception advice

[The Northumberland, Tyne & Wear Perinatal Community Team]

Overview

The Northumberland, Tyne Wear Perinatal Community Mental Health Team[1] provides a service for women aged 16 to 64 years who require or have had previous involvement with secondary mental health services. The women may have a range of diagnoses.

The service receives 632 referrals a year: 40% from GPs, 20% midwives, 20% health visitors and 20% other professions. The number of referrals is expected to double as the team expands its geographical footprint to Gateshead, South Tyneside and Sunderland.

2016 maternity numbers: 2,780 (56.3 per 1000 women of childbearing age)

NICE-recommended care
In line with NICE quality statements 2, 4 and 5[2]

Outcome measures used
HoNOS[3] CORE-OM[6] and POEM[4]

Delivering pathway 1: Preconception advice[5]
Local data collection and monitoring indicate that in the service all women are seen for preconception advice within 6 weeks of referral.

Appointments are usually 60 to 90 minutes and involve a face-to-face session with a consultant psychiatrist. The session covers the woman's current and past mental health problems, treatment options, the effects of pregnancy, reviews and monitoring. Each woman (and, where applicable, professional) then receives a verbal and written summary of the outcomes of the session.

Interventions
Referred women receive preconception advice and a one-to-one with a consultant psychiatrist, in the clinic or at home. A single session covers past and present mental health problems, and the woman's experience of it. Previous effective treatments and available treatment options during pregnancy are considered, as well as the impact on her mental health through the pregnancy and birth. A diagnostic review may be necessary, and women are offered monitoring from a community psychiatric nurse and admission to MBU, if required.

Workforce (whole time equivalent; WTE)

Consultant psychiatrist	(1.5)	**Team manager**, AfC band 7	(1.0)
Non-consultant doctor	(1.5)	**Clinical psychologist**	(1.0)
Community psychiatric nurse AfC band 6	(7.8)	**Administrative staff**	(5.0)

Training and supervision is offered to all staff. The service plans to introduce a preconception counselling module to psychiatrists' training.

Contact details
Provider: Northumberland, Tyne and Wear NHS Foundation Trust
Commissioner: North Tyneside CCG
Contact: Andrew Cairns, Consultant Perinatal Psychiatrist: andrew.cairns2@ntw.nhs.uk

Further information can be found on the Positive Practice in Mental Health website.

[1] www.northtyneside.gov.uk/serviceitem.shtml?p_ID=856
[2] www.nice.org.uk/guidance/qs115
[3] www.rcpsych.ac.uk/crtu/healthofthenation.aspx
[4] www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/perinatal/perinatalqualitynetwork/poem.aspx
[5] www.rcpsych.ac.uk/PerinatalCarePathways
[6] www.coreims.co.uk/About_Core_System_Outcome_Measure.html

1.3 Pathway 2: Specialist assessment

[Hampshire Mother and Baby Mental Health Service (Perinatal)]

Overview

The Hampshire Mother and Baby Mental Health Service[1] (Perinatal) provides a specialist service in the county of Hampshire, the Isle of Wight, North East Hampshire, Portsmouth and the unitary authority of Southampton for women experiencing, or who are at risk of developing, a severe mental health problem. It offers a daily triage of referrals, with a rapid call to the woman if the referral sounds high risk; this means that treatment can be started immediately and a date set for contact.

2016 maternity numbers: 14,211 (60.9 per 1000 women of childbearing age)

NICE-recommended care
In line with NICE quality statement 7[2]

Outcome measures used
POEM[3]

Delivering pathway 2: Specialist assessment[4]
Local data collection and monitoring indicate that 50% of women with a known or suspected perinatal mental health problem referred to the service are diagnosed and receive an agreed care plan within 2 weeks of referral, with all seen within 6 weeks.

Referrals are accepted from all generic and mental health care professionals and social workers, including self-referrals. Following a face-to-face assessment, each woman receives a full care package tailored to her individual needs. Interventions may include:

- work with a nursery nurse on bonding and attachment
- allocation of a specialist mental health nurse (RMN) for care coordination
- sessions with the psychologist
- group work
- medication review and monitoring.

Interventions
Telephone advice is available for healthcare professionals and women who do not need face-to-face work but would benefit from talking to specialist (for example, medication advice).

Staff training and supervision to partners
Specialist training is offered to midwives, health visitors, adult mental health workers, GPs, children's services, obstetricians and a range of third sector organisations.

Workforce (all perinatal, WTE)

Consultant psychiatrist	(1.8)	**Consultant psychologist**	(1.5)
Community team leader	(2.0)	**Nursery nurses**	(3.8)
Community mental health nurses AfC band 6 (9.0)			

Contact details
Provider: Southern Health NHS Foundation Trust
Commissioner: West Hampshire CCG
Contact: Chris Bailey, Perinatal Service Manager: chris.bailey@southernhealth.nhs.uk

Further information can be found on the Positive Practice in Mental Health website.

[1] www.southernhealth.nhs.uk/services/mental-health/adult/mother-and-baby/
[2] www.nice.org.uk/guidance/qs115
[3] www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/perinatal/perinatalqualitynetwork/poem.aspx
[4] www.rcpsych.ac.uk/PerinatalCarePathways

Devon Partnership Trust Perinatal Community Service

Overview
The Devon Partnership Trust Perinatal Community Service[1] provides community-based mental health support for women planning a pregnancy and during the perinatal period. The antenatal clinics are mainly based in Midwifery Antenatal Clinics or a range of community settings. Given the partly rural population, appointments are set to coincide with physical health care checks whenever possible.

The service offers a prediction and detection pathway. Most referrals are made by midwives and are triaged weekly, with three main outcomes: (1) standard letters containing evidence-based information are given to the woman; (2) a telephone consultation intervention; or (3) an assessment.

2016 maternity numbers: 6,878 (55.0 per 1000 women of childbearing age)

NICE-recommended care
In line with NICE quality statements 4, 5 and 7[2]

Outcome measures used
POEM,[3] Family and Friends Test[4] and HoNOS[5]

Delivering pathway 2: Specialist assessment[6]
Local data collection and monitoring indicates that this service sees 50% of women within 2 weeks of referral. The remainder of non-priority assessments are seen within 6 weeks. A biopsychosocial assessment is offered to each woman, which also looks at attachment patterns and her physical health. Women with complex prescribing needs are offered advice, on the risks and benefits of pharmacological interventions during pregnancy and breastfeeding, by a perinatal consultant psychiatrist in collaboration with a pharmacist. If a woman chooses to disengage, the service ensures that a professional-only birth plan is created.

Following assessments, the service offers a range of NICE-recommended interventions, including access to psychological therapies via IAPT and secondary mental health.

Workforce (WTE)

Perinatal psychiatrists
(1 x 1.5)
Perinatal service manager
(1 x 1.0, AfC band 8a)
Perinatal clinical team leader
(1.8 x 1.0, AfC band 7)
Perinatal clinical psychologist
(2 x 1.0)
Nursery nurses
(2 x 1.0)
Perinatal mental health practitioners
(11 x 1.0)
Admin
(5 x 1.0, AfC bands 3, and 4).

All staff receive comprehensive induction, individually-tailored training, and regular management and clinical supervision. Safeguarding and parent–infant supervision are also offered every 6 weeks. All staff in the service meet for Continuing Professional Development each month. This incorporates perinatal clinical governance, case studies and presentations relevant to the team's work.

Contact details
Provider: Devon Partnership NHS Trust
Commissioner: North East and West (NEW) Devon CCG and South Devon and Torbay CCG
Contact: Clare McAdam, Perinatal Service Manager, clare.mcadam@nhs.net

Further information can be found on the Positive Practice in Mental Health website.

[1] www.dpt.nhs.uk/our-services/pregnant-women-and-new-mothers
[2] www.nice.org.uk/guidance/qs115
[3] www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/perinatal/perinatalqualitynetwork/poem.aspx
[4] www.england.nhs.uk/ourwork/pe/fft/
[5] www.rcpsych.ac.uk/crtu/healthofthenation.aspx
[6] www.rcpsych.ac.uk/PerinatalCarePathways

1.4 Pathway 3: Emergency assessment

[Birmingham Perinatal Mental Health Service and Antenatal Liaison Clinics]

Overview
The Birmingham Perinatal Mental Health Service[1] and Antenatal Liaison Clinics, in partnership with Heart of England NHS Foundation Trust[2] (HEFT), run antenatal mental health liaison clinics for pregnant women with current or previous mental health problems. The HEFT clinics liaise with the HEFT rapid assessment interface and discharge (RAID) team[3] to identify women at high risk of mental health crisis and postpartum psychosis. The team provides assessment to women with a suspected mental health crisis within 4 hours of referral and facilitates access to specialist community perinatal mental health services and inpatient MBUs.

2016 maternity numbers: 17,252 (69.1 per 1000 women of childbearing age)

NICE-recommended care
In line with statement 6, 7 and 10[4]

Outcome measures used
Currently under review

Delivering pathway 3: Emergency assessment[5]
This service receives two streams of referrals: (1) HEFT liaison clinics receive referrals from community midwives and primary care for women during pregnancy; and (2) RAID team receives urgent and emergency referrals from the maternity units and emergency departments via single point of access.

The identification of risks during the pathway helps the team to provide adequate information and advice on medication and interventions to minimise the risks. This includes delivery of the baby in the local MBU.

Interventions
- Development of co-produced and robust care management plan
- Liaison with other healthcare professionals involved in the woman's care
- Identification and management of high risk relapse, via, for example, medication advice
- Visits to MBUs prior to delivery for the woman and the family

Workforce (WTE)
Perinatal psychiatrist (1 x 0.4) **perinatal community psychiatric nurse** (1 x 0.4)
administrative staff (2 x 0. 5) who work closely with **specialist midwives for mental health** (2.2).
HEFT antenatal mental health liaison clinics also have access to a fully-staffed RAID team.

Contact details
Provider: Birmingham and Solihull Mental Health NHS Foundation Trust
Commissioner: Heart of England NHS Foundation Trust
Contact: Dr Jelena Jankovic, Consultant Perinatal Psychiatrist: jelena.jankovic@bsmhft.nhs.uk

Further information can be found on the Positive Practice in Mental Health website.

[1] www.bsmhft.nhs.uk/our-services/specialist-services/perinatal-mental-health-service/
[2] www.heartofengland.nhs.uk/
[3] www.bsmhft.nhs.uk/our-services/urgent-care/rapid-assessment-interface-and-discharge-raid/
[4] www.nice.org.uk/guidance/qs115

1.5 Pathway 4: Psychological interventions

Torbay Depression and Anxiety Service

Overview
Torbay Depression and Anxiety Service[1] provides an IAPT[2] service to adults aged 18 years and over who may present with depression or anxiety disorders (generalised anxiety, obsessive-compulsive, social anxiety, panic and post-traumatic stress disorders, and agoraphobia). Many of the people seen by this service are women with perinatal mental health problems.

The service accepts self-referrals as well as referrals from all health professionals.

2016 maternity numbers: 1,297 (64.0 per 1000 women of childbearing age)

NICE-recommended care
In line with NICE quality statement 6[3]

Outcome measures used
IAPT minimum data set[4]

Delivering pathway 4: Psychological interventions[5]
The service meets the IAPT access and waiting time standard with 75% of women starting psychological therapies within 6 weeks of referral. This includes both low- and high-intensity interventions offered via a stepped care model.

To meet the needs of women, the service:

- has established strong links with the perinatal mental health team
- offers a new group to treat postnatal depression with free crèche facilities
- offers adapted assessment sessions, with four 45-minute sessions per week ring-fenced for perinatal mental health
- offers a flexible approach including arranging child care.

Interventions
Treatments offered in a stepped care model, include:
Step 2: Low-intensity interventions, involving up to six 30-minute sessions, including: CBT, guided self-help, behavioural activation, cognitive restructuring and graded exposure
Step 3: High-intensity interventions delivered in up to 16 30-minute sessions that include: CBT, eye movement desensitisation and reprocessing, counselling for depression and a mindfulness group.

The service also provides women with information about medication.

Workforce (WTE)

High-intensity therapists	(9.7)
Trainee psychological wellbeing practitioners	(2 x 1, 1 x 0.8)
Psychological wellbeing practitioners	(9 x 1.0)
Counsellors	(1 x 0.8, 1 x 0.6)

Training and supervision are offered to all staff. Supervision for staff delivering the postnatal depression group is provided by a clinical psychologist.

Contact details
Provider: Devon Partnership NHS Trust
Commissioner: South Devon and Torbay CCG
Contact: Nicky Haycock, High-intensity Psychological Therapist: nicola.haycock@nhs.net

Further information can be found on the Positive Practice in Mental Health website.

[1] www.devonpartnership.nhs.uk/Service-Display.60.0.html?&tx_svcdirectory_pi1%5Bmode%5D=summary&tx_svcdirectory_pi1%5Bvalue%5D=284&tx_svcdirectory_pi1%5Bback%5D=abclist%3Aabc%3AD%3A60&cHash=f57be8e1559fa4167ef5ba8dc94af98e
[2] www.england.nhs.uk/mental-health/adults/iapt/
[3] www.nice.org.uk/guidance/qs115
[4] http://ipnosis.postle.net/PDFS/iapt-outcomes-toolkit-2008-november(2).pdf
[5] www.rcpsych.ac.uk/PerinatalCarePathways

1.6 Pathway 5: Inpatient care (MBUs)

East London Mother and Baby Unit

Overview
The East London MBU[1] provides a specialist inpatient service for women in the South East of England, and receives and accepts referrals from secondary services from across England. This service is for women with moderate to severe mental health problems during pregnancy or within the first year after childbirth. Women with complex needs can be assessed in the community, and admitted in line with the recommended response time in pathway 5. However, prophylactic and planned admissions are also available for women from 32 weeks of pregnancy. The MBU works closely with local community teams to support discharge.

NICE-recommended care
In line with quality statement 7[2]

Outcome measures used
HoNOS[3] and tailored PREM informing service delivery

Delivering pathway 5: Inpatient care (MBUs)
After a referral assessment, the outcome determines each woman's need (level of urgency) for admission to the MBU, which can be arranged on the same day as the referral. Referrals can be made during the antenatal period from acute inpatient and community mental health teams, from within the trust or from external trusts. Women will be accepted from 32 weeks of pregnancy.

On admission to the MBU, the team shares information with children's social care services about the woman's care and admission plan. The facilities in the MBU rooms are suitable for a range of needs; they include large en suite family rooms, adapted for women with physical disabilities.

Interventions

Inpatient:
Interventions involve input from various professionals including nursing, medical, occupational therapist, maternity and midwifery staff, psychology and nursery nurses. Women will also receive specialist advice on the risks and benefits of medication in pregnancy and breastfeeding.

Follow-up community care:
Women will receive visits with community nurses, screening for CBT including brief therapy if needed and preconception counselling.

Workforce (WTE)

Consultant psychiatrist (1.0)
Non-consultant medical input speciality trainee 4–6 (0.5)
Core trainee 1–3 (1.2)
Clinical psychologist (1.0)
Occupational therapist (0.6)
Social worker (1.0)
Ward manager (1.0)
Modern matron (0.6)
Senior nursery nurse Band 5 (1.0)
Healthcare assistants (2.0)
Nursery nurses Band 4 (6.0)
Administration/secretarial staff (0.5)
Parent-infant psychotherapist (0.4)
Dance movement psychotherapist (0.1)
Art psychotherapist (0.1)
Life skills (1.0)
Staff nurses AfC bands 5 and 6 (13.0)

Contact details

Provider: East London NHS Foundation Trust
Commissioner: NHS England (Mother and Baby Unit)
Contact: Justine Cawley, Modern Matron: jcawley@nhs.net

Further information can be found on Positive Practice in Mental Health website.

[1] www.elft.nhs.uk/service/182/Margaret-Oates-Mother-and-Baby-Unit
[2] www.nice.org.uk/guidance/qs115/chapter/Quality-statement-7-developmental-Specialist-multidisciplinary-perinatal-mental-health-services
[3] www.rcpsych.ac.uk/crtu/healthofthenation.aspx

2 Outcome measures

Clearly defined outcomes that are collected routinely are an essential part of measuring and monitoring the effectiveness of a service. The Expert Reference Group has recommended a range of outcome measures that are relevant to one or more pathway(s) (see Table 5). The group recognises that the needs of women with perinatal mental health problems and how they will be assessed could vary in frequency and duration, depending on the areas being assessed and the purpose of the assessment. In addition to their recommendations, the decision about which outcome measure to use should be informed by the specific disorder and established sources, such as existing NICE guidance, the IAPT dataset and the International Consortium for Health Outcome Measurements.

In the evaluation of routine treatment outcomes, session-by-session measurement is to be preferred (unless recommended otherwise in Table 5). This is because sessional measurement enables more complete data collection at the beginning and end of treatment, typically 80% or more compared with 30% when only two collection points at the beginning and end of treatment are used. Using only two data points also means that service users who drop out of treatment are often not represented in summary data sets (compared with those who complete treatment) and therefore are more likely to be 'over-represented' in the data. As a consequence, this can lead to an over-estimation of the treatment effect in the overall population who started treatment.

Routine outcome measurement needs to be delivered in a way that is acceptable to both the woman and the practitioner. This can be achieved by using brief validated outcome measures that require little time to complete, and by having electronic records systems that support the collection, aggregation and feedback of outcomes at the individual and service level. Both of these should form part of any routine outcome system. Access to routine feedback has been demonstrated to improve outcomes and reviewing of individual measures can also aid clinical decisions.

Outcome measures that are free to reproduce, or that the NCCMH has permission to reproduce, are included in this section. For all others there are footnotes for references in Table 5.

Table 5: Outcome measurement

	Outcome measure	Recommended setting	Recommended use
CROMs	**Brief Psychiatric Rating Scale (BPRS):** a 24-item clinician-rated scale used as part of a clinical interview, measuring the positive, negative and affective symptoms of people with psychotic disorders, especially schizophrenia.	Specialist community perinatal mental health teams MBU	During assessment, review and discharge
	Health of the Nation Outcome Scales (HoNOS): a 12-item scale measuring behaviour, impairment, symptoms and social functioning.	Specialist community perinatal mental health teams MBU	During assessment, review and discharge
	Health of the Nation Outcome Scales Child and Adolescent Mental Health (HoNOSCA): a 15-item scale measuring behaviour, impairment, symptoms and social functioning.	Specialist community perinatal mental health teams MBU	During assessment, review and discharge as part of a minimum dataset to assess overall care
	Young Mania Rating Scale (YMRS): an 11-item scale used to assess manic symptoms based on the person's subjective report of his or her clinical condition over the previous 48 hours.	Specialist community perinatal mental health teams MBU	During assessment, review and discharge
PROMs	**Agoraphobia – Mobility Inventory (MI):** a 27-item scale used for provisional diagnosis of agoraphobia. The total score indicates the severity of the agoraphobia.	Specialist community perinatal mental health teams IAPT services MBU	During assessment, review and discharge; sessional
	Clinical Outcomes in Routine Evaluation - 10 items (CORE-10): a short, 10-item version of the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM) to be used as screening tool and outcome measure when the CORE-OM is considered too long for routine use. The tool covers anxiety, depression, trauma, physical problems, functioning, relationships and risk to self.	Specialist community perinatal mental health teams MBU	During assessment, review and discharge and sessional
	Edinburgh Postnatal Depression Scale (EPDS): for screening and measuring the severity of postnatal depression.	Primary care IAPT services	During assessment; sessional
	Generalized Anxiety Disorder scale (GAD-7): a 7-item self-rated measure for screening and measuring the severity of generalised anxiety disorder.	Primary care IAPT services	Sessional
	Health Anxiety Inventory (short version: SHAI): a 14-item inventory (main section) and a 4-item inventory (in another section). A cut-off score of 15 indicates a mixture of people who are hypochondriacal and health-anxious. A score of 18 or above identifies people fulfilling the DSM-IV diagnostic criteria for hypochondriasis.	Specialist community perinatal mental health teams IAPT services MBU	During assessment, review and discharge; sessional

	Outcome measure	Recommended setting	Recommended use
PROMs	**The Impact of Events Scale Revised (IES-R):** a 22-item scale primarily used for the provisional diagnosis of post-traumatic stress disorder.	Specialist community perinatal mental health teams IAPT services MBU	During assessment, review and discharge; sessional
	Obsessive Compulsive Inventory (OCI): a 42-item scale with a cut-off score of 40, used for the provisional diagnosis of obsessive–compulsive disorder. This tool provides a severity score from ratings of the extent to which particular experiences have distressed or bothered the person in the last month.	Specialist community perinatal mental health teams IAPT services MBU	Sessional
	Panic Disorder Severity Scale (PDSS): a 7-item scale with a cut-off score of 8 that is an indicator of panic disorder.	Specialist community perinatal mental health teams IAPT services MBU	During assessment, review and discharge
	Patient Health Questionnaire (PHQ-9): an outcome measure for screening, diagnosing, monitoring and measuring the severity of depression based on each of the nine DSM-IV-related diagnostic criteria.	Primary care IAPT services	Sessional
	Penn State Worry Questionnaire (PSWQ): a 16-item scale with a cut-off score of 45, recommended for provisional generalised anxiety disorder diagnosis. The overall score is an indicator of the severity.	IAPT services	Sessional
	Process of Recovery Questionnaire (QPR): an 11-item scale measuring key aspects of personal recovery including connectedness, hope, identity, meaning to life and empowerment.	Specialist community perinatal mental health teams MBU	During review
	The Recovery Quality of Life (ReQoL): a 10- and 20-item measure that assesses quality of life in people with common, severe and complex mental health disorders, including psychotic disorders. Suitable for primary, secondary and tertiary care settings.	Specialist community perinatal mental health teams MBU	During assessment, review and discharge
	Social Phobia Inventory[a] (SPIN): a 17-item scale with a cut-off score of 19 and above, used for the provisional diagnosis of social phobia and to indicate the severity.	Specialist community perinatal mental health teams IAPT services	Sessional

[a] Connor KM, Davidson JR, Churchill LE, Sherwood A, Foa E, Weisler RH. Psychometric properties of the Social Phobia Inventory (SPIN). New self-rating scale. The British Journal of Psychiatry. 2000;176:379–86.

	Outcome measure	Recommended setting	Recommended use
PROMs		MBU	
	Yale-Brown Obsessive Compulsive Scale (Y-BOCS): a 10-item patient-report version of the clinician-administered 89-item scale designed to assess the severity and type of symptoms in people with obsessive-compulsive disorder.	Specialist community perinatal mental health teams MBUs	Sessional
PREMs	**Patient rated Outcome and Experience Measure (POEM):** a scale measuring fluctuations within a service and patient satisfaction, with a focus on areas such as information provision, communication, the environment in which the mother and baby receive care, and baby care. There is a community version (14 items) and an inpatient version (20 items).	Specialist community perinatal mental health teams MBUs	During discharge as part of a minimum dataset to assess overall care
	Views On Inpatient CarE[b] (VOICE): a 19-item self-assessment measure with strong psychometric properties for use by service users while in hospital. It has been validated for use in inpatient perinatal mental health settings.	MBUs	During discharge

Note. CROM = clinician-reported outcome measure; PROM = patient-reported outcome measure; PREM = patient reported experience measure.

[b] Evans J, Rose D, Flach C, Csipke E, Glossop H, McCrone P, et al. VOICE: developing a new measure of service users' perceptions of inpatient care, using a participatory methodology. Journal of Mental Health. 2012;21:57-71.

2.1 Clinician-rated outcome measures (CROMs)

2.1.1 Brief Psychiatric Rating Scale (BPRS)

Brief Psychiatric Rating Scale (BPRS)
(Version 4.0)

Patient Name: _____ **Date:** _____

Rate items 1 through 14 on the basis of patient's self-report during interview. Mark "NA" for symptoms not assessed. Note items **7**, **12**, and **13** are also rated on observed behavior during the interview.

Provide examples.	**NA Not Assessed**	**1 Not Present**	**2 Very Mild**	**3 Mild**	**4 Moderate**	**5 Moderately Severe**	**6 Severe**	**7 Extremely Severe**
1. Somatic Concern								
2. Anxiety								
3. Depression								
4. Suicidality								
5. Guilt								
6. Hostility								
7. Elevated Mood								
8. Grandiosity								
9. Suspiciousness								
10. Hallucinations								
11. Unusual Thought Content								
12. Bizarre Behavior								
13. Self-neglect								
14. Disorientation								
Rate items 15 through 24 on the basis of patient's observed behavior or speech during the interview.								
15. Conceptual Disorganization								
16. Blunted Affect								
17. Emotional Withdrawal								
18. Motor Retardation								
19. Tension								
20. Uncooperativeness								
21. Excitement								
22. Distractibility								
23. Motor Hyperactivity								
24. Mannerisms and Posturing								

Sources of information (check all applicable):
_____ Patient
_____ Parents/relatives
_____ Mental health professional
_____ Chart

Confidence in assessment:
_____ **1** = not at all — **5** = very confident

Explain here if validity is questionable:
_____ Symptoms possibly drug induced
_____ Underreported due to lack of rapport
_____ Underreported due to negative symptoms
_____ Patient uncooperative
_____ Difficult to assess due to formal thought disorder
_____ Other _____

Reference: Overall JE, Gorham DR. The Brief Psychiatric Rating Scale (BPRS). Psychological Reports. 1962;10:799-812.

2.1.2 Health of the Nation Outcome Scales (HoNOS) – clinician-rated (an extract)

Rate 9 if Not Known

6. Problems associated with hallucinations and delusions

- *Include hallucinations and delusions irrespective of diagnosis.*
- *Include odd and bizarre behaviour associated with hallucinations or delusions.*
- *Do not include aggressive, destructive or overactive behaviours attributed to hallucinations or delusions, rated at Scale 1.*

0 No evidence of hallucinations or delusions during the period rated.
1 Somewhat odd or eccentric beliefs not in keeping with cultural norms.
2 Delusions or hallucinations (e.g. voices, visions) are present, but there is little distress to patient or manifestation in bizarre behaviour, i.e. clinically present but mild.
3 Marked preoccupation with delusions or hallucinations, causing much distress and/or manifested in obviously bizarre behaviour, i.e. moderately severe clinical problem.
4 Mental state and behaviour is seriously and adversely affected by delusions or hallucinations, with severe impact on patient.

Reference: Wing JK, Curtis RH, Beevor AS. HoNOS – Health of the Nation Outcome Scales: Report on Research and Development. London: Royal College of Psychiatrists; 1996.

2.1.3 Health of the Nation Outcome Scales – Child and Adolescents Mental Health (HoNOSCA)

IN THE LAST TWO WEEKS:

1. Have you been troubled by your disruptive behaviour, physical or verbal aggression?

Not at all Insignificantly Mild but definitely Moderately Severely

2. Have you suffered from lack of concentration or restlessness?

Not at all Insignificantly Mild but definitely Moderately Severely

3. Have you done anything to injure or harm yourself on purpose?

Not at all Insignificantly Mild but definitely Moderately Severely

4. Have you had problems as a result of your use of Alcohol, Drugs or solvents?

Not at all Insignificantly Mild but definitely Moderately Severely

5. Have you experienced difficulties keeping up with your usual educational abilities?

Not at all Insignificantly Mild but definitely Moderately Severely

6. Has any physical illness or disability restricted your activities?

Not at all Insignificantly Mild but definitely Moderately Severely

7. Have you been troubled by hearing voices, seeing things, suspicious or abnormal thoughts?

Not at all Insignificantly Mild but definitely Moderately Severely

8. Have you suffered from self-induced vomiting, head/stomach aches with no physical cause, bedwetting or soiling?

Not at all Insignificantly Mild but definitely Moderately Severely

9. Have you been feeling in a low or anxious mood, or troubled by fears, obsessions or rituals?

Not at all Insignificantly Mild but definitely Moderately Severely

10. Have you been troubled by a lack of satisfactory friendships or bullying?

Not at all Insignificantly Mild but definitely Moderately Severely

11. Have you found it difficult to look after yourself or take responsibility for your independence?

Not at all Insignificantly Mild but definitely Moderately Severely

12. Have you been troubled by relationships in your family or substitute home?

Not at all Insignificantly Mild but definitely Moderately Severely

13. Have you stopped attending your education sessions?

Not at all Insignificantly Mild but definitely Moderately Severely

Reference: Gowers SG, Harrington RC, Whitton A. HoNOSCA – Health of the Nation Outcome Scales for Children and Adolescents. London: Royal College of Psychiatrists' Research Unit; 1998.

2.1.4 Young Mania Rating Scale (YMRS)

1. **Elevated Mood**
   - 0 Absent
   - 1 Mildly or possibly increased on questioning
   - 2 Definite subjective elevation; optimistic; self-confident; cheerful; appropriate to content
   - 3 Elevated, inappropriate to content; humorous
   - 4 Euphoric; inappropriate laughter, singing

2. **Increased Motor Activity/Energy**
   - 0 Absent
   - 1 Subjectively increased
   - 2 Animated; gestures increased
   - 3 Excessive energy; hyperactive at times; restless (can be calmed)
   - 4 Motor excitement; continuous hyperactivity (cannot be calmed)

3. **Sexual Interest**
   - 0 Normal; not increased
   - 1 Mildly or possibly increased
   - 2 Definite subjective increase on questioning
   - 3 Spontaneous sexual content; elaborates on sexual matters; hypersexual by self-report
   - 4 Overt sexual acts (toward patients, staff, or interviewer)

4. **Sleep**
   - 0 Reports no decrease in sleep
   - 1 Sleeping less than normal amount by up to one hour
   - 2 Sleeping less than normal by more than one hour
   - 3 Reports decreased need for sleep
   - 4 Denies need for sleep

5. **Irritability**
   - 0 Absent
   - 2 Subjectively increased
   - 4 Irritable at times during interview; recent episodes of anger or annoyance on ward
   - 6 Frequently irritable during interview; short or curt throughout
   - 8 Hostile, uncooperative; interview impossible

6. **Speech (Rate and Amount)**
   - 0 No increase
   - 2 Feels talkative
   - 4 Increased rate or amount at times, verbose at times
   - 6 Push; consistently increased rate and amount; difficult to interrupt
   - 8 Pressured; uninterruptible, continuous speech

7. **Language/Thought Disorder**
   - 0 Absent
   - 1 Circumstantial; mild distractibility; quick thoughts
   - 2 Distractible; loses goal of thought; changes topics frequently; racing thoughts
   - 3 Flight of ideas; tangentiality; difficult to follow; rhyming; echolalia
   - 4 Incoherent; communication impossible

8. **Thought Content**
   - 0 Normal
   - 2 Questionable plans; new interests
   - 4 Special project(s); hyper-religious
   - 6 Grandiose or paranoid ideas; ideas of reference
   - 8 Delusions; hallucinations

9. **Disruptive/Aggressive Behavior**
   - 0 Absent, cooperative
   - 2 Sarcastic; loud at times, guarded
   - 4 Demanding; threats on ward
   - 6 Threatens interviewer; shouting; interview difficult
   - 8 Assaultive; destructive; interview impossible

10. **Appearance**
    - 0 Appropriate dress and grooming
    - 1 Minimally unkempt
    - 2 Poorly groomed; moderately disheveled; overdressed
    - 3 Disheveled; partly clothed; garish makeup
    - 4 Completely unkempt; decorated; bizarre garb

11. **Insight**
    - 0 Present; admits illness; agrees with need for treatment
    - 1 Possibly ill
    - 2 Admits behavior change, but denies illness
    - 3 Admits possible change in behavior; but denies illness
    - 4 Denies any behavior change

Reference: Young RC, Biggs JT, Ziegler VE, Meyer DA. A rating scale for mania: reliability, validity and sensitivity. British Journal of Psychiatry. 1978;133:429-35.

2.2 Patient-reported outcome measures (PROMs)

2.2.1 Agoraphobia – Mobility Inventory (MI)

Agoraphobia - Mobility Inventory

Please indicate the degree to which you avoid the following places or situations because of discomfort or anxiety. Rate your amount of avoidance when you are with a trusted companion and when you are alone. Do this by using the following scale.

1. Never avoid
2. Rarely avoid
3. Avoid about half the time
4. Avoid moist of the time
5. Always avoid

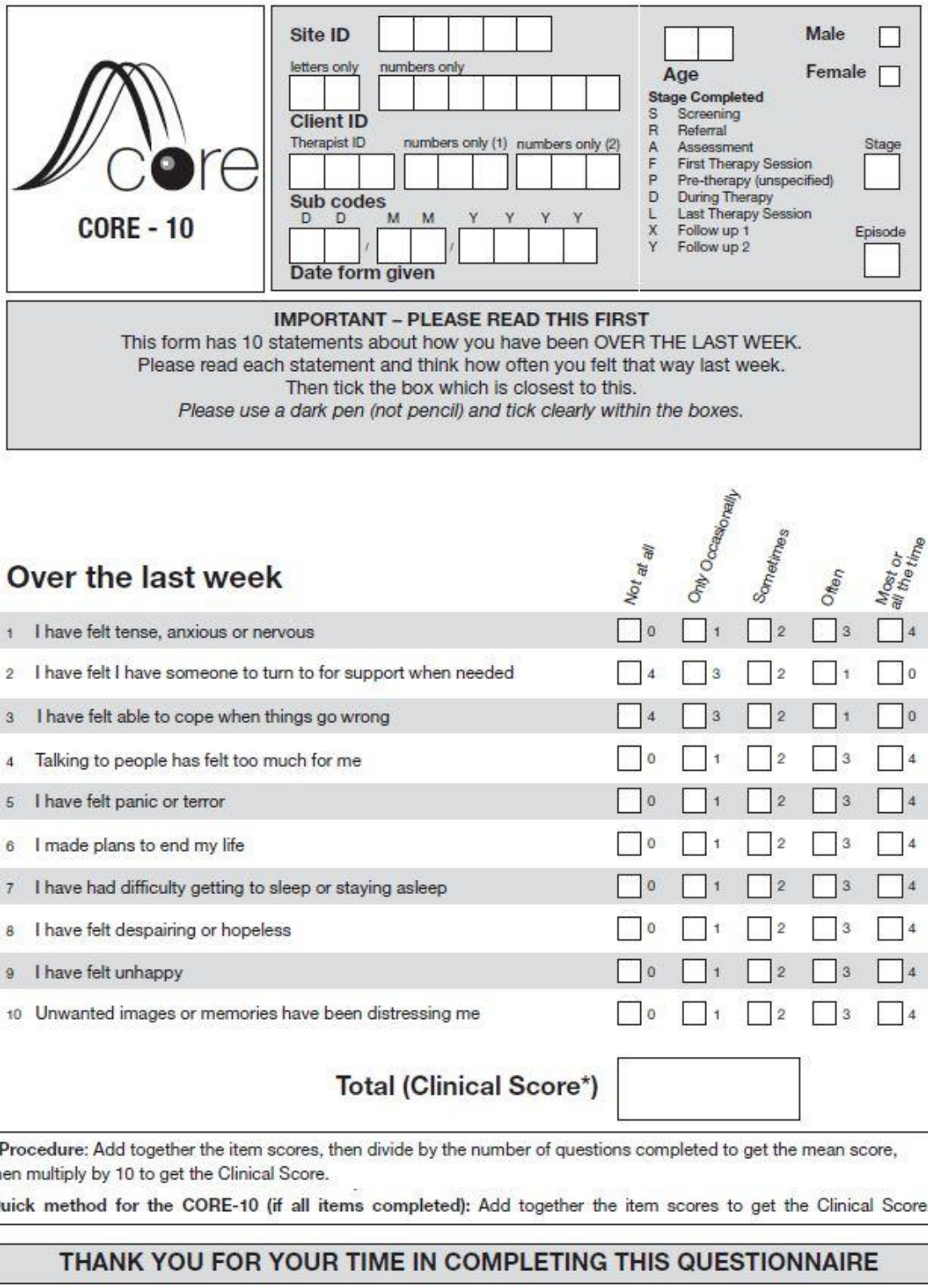
(You may use numbers half-way between those listed when you think it is appropriate. For example, 3½ or 4½). Write your score in the blanks for each situation under both conditions; when accompanied, and, when alone. Leave blank those situations that do not apply to you.

Place	When accompanied			When alone		
Theatres						
Supermarkets						
Classrooms						
Department stores						
Restaurants						
Museums						
Elevators/lifts						
Auditoriums or stadiums						
Car parks						
High Places						
Tell How High						
Enclosed spaces (e.g. tunnels)						
Open spaces						
(A) Outside (e.g. fields, wide streets, courtyards)						
(B) Inside (e.g. large rooms, lobbies)						
RIDING IN:						
Buses						
Trains						
Undergrounds/Tubes						
Airplanes						
Boats						
Driving or riding in a car:						
(A) At any time						
(B) On motorways						
SITUATIONS:						
Standing in lines						
Crossing bridges						
Parties or social gatherings						
Walking on the street						
Staying at home alone						
Being far away from home						
Other (specify): _____						
Totals: >>>>>>>>>>>>>>>>>>>>>>>>						

(Data items 40 & 41 in the IAPT Data Standard)

Reference: Chambless DL, Caputo GC, Jasin SE, Gracely EJ, Williams C. The Mobility Inventory for Agoraphobia. Behavior Research and Therapy 1985;23:35-44.

2.2.2 Clinical Outcomes in Routine Evaluation – 10 items (CORE-10)



CORE - 10

Site ID

letters only | numbers only

Client ID

Therapist ID | numbers only (1) | numbers only (2)

Sub codes

Date form given (D D / M M / Y Y Y Y)

Age

Male ☐ Female ☐

Stage Completed

S Screening
R Referral
A Assessment
F First Therapy Session
P Pre-therapy (unspecified)
D During Therapy
L Last Therapy Session
X Follow up 1
Y Follow up 2

Stage

Episode

IMPORTANT – PLEASE READ THIS FIRST

This form has 10 statements about how you have been OVER THE LAST WEEK.
Please read each statement and think how often you felt that way last week.
Then tick the box which is closest to this.
Please use a dark pen (not pencil) and tick clearly within the boxes.

Over the last week	Not at all	Only Occasionally	Sometimes	Often	Most or all the time
1 I have felt tense, anxious or nervous	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
2 I have felt I have someone to turn to for support when needed	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
3 I have felt able to cope when things go wrong	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4 Talking to people has felt too much for me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5 I have felt panic or terror	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6 I made plans to end my life	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
7 I have had difficulty getting to sleep or staying asleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8 I have felt despairing or hopeless	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9 I have felt unhappy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
10 Unwanted images or memories have been distressing me	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4

Total (Clinical Score*) ☐

* **Procedure:** Add together the item scores, then divide by the number of questions completed to get the mean score, then multiply by 10 to get the Clinical Score.

Quick method for the CORE-10 (if all items completed): Add together the item scores to get the Clinical Score.

THANK YOU FOR YOUR TIME IN COMPLETING THIS QUESTIONNAIRE

Reference: Barkham M, Bewick B, Mullin T, Gilbody S, Connell J, Cahill J, et al. The CORE-10: A short measure of psychological distress for routine use in the psychological therapies. Counselling and Psychotherapy Research. 2013;1:3–13. doi: 10.1080/14733145.2012.729069.

2.2.3 Edinburgh Postnatal Depression Scale (EPDS)

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

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

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

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

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

References: Cox J, Holden J, Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry. 1987;150:782-86.

Wisner K, Parrt B, Pintek C. Postpartum depression. The New England Journal of Medicine. 2002;347:194-99.

2.2.4 Generalized Anxiety Disorder scale – 7 items (GAD-7)

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

Reference: Spitzer R, Kroenke K, Williams J, Lowe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. Archives of Internal Medicine. 2006;166:1092-97.

2.2.5 Health Anxiety Inventory (short version: SHAI) – an extract

Each question is this section consists of a group of four statements. Please read each group of statements carefully and then select the one which best describes your feelings, OVER THE PAST WEEK. **Identify the statement by ringing the letter next to it ie. if you think that statement (a) is correct, ring statement (a); it may be that more than one statement applies, in which case, please ring any that are applicable.**

1. a. I do not worry about my health.
   b. I occasionally worry about my health.
   c. I spend much of my time worrying about my health.
   d. I spend most of my time worrying about my health.

2. a. I notice aches/pains less than most other people (of my age).
   b. I notice aches/pains as much as most other people (of my age).
   c. I notice aches/pains more than most other people (of my age).
   d. I am aware of aches/pains in my body all the time.

3. a. As a rule I am not aware of bodily sensations or changes.
   b. Sometimes I am aware of bodily sensations or changes.
   c. I am often aware of bodily sensations or changes.
   d. I am constantly aware of bodily sensations or changes.

4. a. Resisting thoughts of illness is never a problem.
   b. Most of the time I can resist thoughts of illness.
   c. I try to resist thoughts of illness but am often unable to do so.
   d. Thoughts of illness are so strong that I no longer even try to resist them.

5. a. As a rule I am not afraid that I have a serious illness.
   b. I am sometimes afraid that I have a serious illness.
   c. I am often afraid that I have a serious illness.
   d. I am always afraid that I have a serious illness.

Reference: Salkovskis PM, Rimes KA, Warwick HM, Clark DM. The Health Anxiety Inventory: development and validation of scales for the measurement of health anxiety and hypochondriasis. Psychological Medicine. 2002;32:843-53.

2.2.6 The Impact of Events Scale Revised (IES-R)

Post Traumatic Stress Disorder

Impacts of Events Scale - Revised

Name..... Date.....

Below is a list of comments made by people after stressful life events. Please check each item, indicating how frequently these comments were true for you **DURING THE PAST SEVEN DAYS**.

STATEMENTS

	Not at all	A little bit	Moder-ately	Quite a bit	Extremely
1. Any reminder brought back feelings about it.	0	1	2	3	4
2. I had trouble staying asleep.	0	1	2	3	4
3. Other things kept making me think about it.	0	1	2	3	4
4. I felt irritable and angry.	0	1	2	3	4
5. I avoided letting myself get upset when I thought about it or was reminded of it.	0	1	2	3	4
6. I thought about it when I didn't mean to.	0	1	2	3	4
7. I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8. I stayed away from reminders about it.	0	1	2	3	4
9. Pictures about it popped into my mind.	0	1	2	3	4
10. I was jumpy and easily startled.	0	1	2	3	4
11. I tried not to think about it.	0	1	2	3	4
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13. My feelings about it were kind of numb.	0	1	2	3	4
14. I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15. I had trouble falling asleep.	0	1	2	3	4
16. I had waves of strong feelings about it.	0	1	2	3	4
17. I tried to remove it from my memory.	0	1	2	3	4
18. I had trouble concentrating.	0	1	2	3	4
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	0	1	2	3	4
20. I had dreams about it.	0	1	2	3	4
21. I felt watchful and on guard.	0	1	2	3	4
22. I tried not to talk about it.	0	1	2	3	4

Total Score - sum of all 22 items. *If a client omits any items, calculate the mean of the non-missing items and then multiply by 22 to arrive at the total score, i.e. pro-rate.*	

Reference: Weiss DS. The Impact of Events Scale: Revised. In: Wilson JP, So-kum Tang C (eds). Cross-cultural Assessment of Psychological Trauma and PTSD. New York: Springer; 2007. pp. 219-38.

2.2.7 Obsessive Compulsive Inventory (OCI)

Obsessive compulsive inventory (continued)

		0	1	2	3	4
24	I get behind in my work because I repeat things over and over again.					
25	I feel I have to repeat certain numbers.					
26	After doing something carefully, I still have the impression I have not finished it.					
27	I find it difficult to touch garbage or dirty things.					
28	I find it difficult to control my own thoughts.					
29	I have to do things over and over again until it feels right.					
30	I am upset by unpleasant thoughts that come into my mind against my will.					
31	Before going to sleep I have to do certain things in a certain way					
32	I go back to places to make sure that I have not harmed anyone.					
33	I frequently get nasty thoughts and have difficulty in getting rid of them.					
34	I avoid throwing things away because I am afraid I might need them later.					
35	I get upset if others change the way I have arranged my things.					
36	I feel that I must repeat certain words or phrases in my mind in order to wipe out bad thoughts, feelings or actions.					
37	After I have done things, I have persistent doubts about whether I really did them.					
38	I sometimes have to wash or clean myself simply because I feel contaminated.					
39	I feel that there are good numbers and bad numbers.					
40	I repeatedly check anything which might cause a fire.					
41	Even when I do something very carefully I feel that it is not quite right.					
42	I wash my hands more often or longer than necessary.					
Total (add all scores together)						

Reference: Foa EB, Kozak MJ, Salkovskis PM, Coles ME, Amir, N. The validation of a new obsessive-compulsive disorder scale: The Obsessive-Compulsive Inventory. Psychological Assessment. 1998;10:206-14.

2.2.8 Panic Disorder Severity Scale (PDSS) – an extract

Panic Disorder Severity Scale

Name:_____
Date:_____

Panic Disorder Severity Scale – Self Report Form

Several of the following questions refer to panic attacks and limited symptom attacks. For this questionnaire we define a panic attack as a sudden rush of fear or discomfort accompanied by at least 4 of the symptoms listed below. In order to qualify as a sudden rush, the symptoms must peak within 10 minutes. Episodes like panic attacks but having fewer than 4 of the listed symptoms are called limited symptom attacks. Here are the symptoms to count:

- Rapid or pounding heartbeat
- Sweating
- Trembling or shaking
- Breathlessness
- Feeling of choking
- Chest pain or discomfort
- Nausea
- Dizziness or faintness
- Feelings of unreality
- Numbness or tingling
- Chills or hot flushes
- Fear of losing control or going crazy
- Fear of dying

---

1. How many panic and limited symptoms attacks did you have during the week?

   0 No panic or limited symptom episodes
   1 Mild: no full panic attacks and no more than 1 limited symptom attack/day
   2 Moderate: 1 or 2 full panic attacks and/or multiple limited symptom attacks/day
   3 Severe: more than 2 full attacks but not more than 1/day on average
   4 Extreme: full panic attacks occurred more than once a day, more days than not

2. If you had any panic attacks during the past week, how distressing (uncomfortable, frightening) were they while they were happening? (If you had more than one, give an average rating. If you didn't have any panic attacks but did have limited symptom attacks, answer for the limited symptom attacks.)

   0 Not at all distressing, or no panic or limited symptom attacks during the past week
   1 Mildly distressing (not too intense)
   2 Moderately distressing (intense, but still manageable)
   3 Severely distressing (very intense)
   4 Extremely distressing (extreme distress during all attacks)

3. During the past week, how much have you worried or felt anxious about when your next panic attack would occur or about fears related to the attacks (for example, that they could mean you have physical or mental health problems or could cause you social embarrassment)?

   0 Not at all
   1 Occasionally or only mildly
   2 Frequently or moderately
   3 Very often or to a very disturbing degree
   4 Nearly constantly and to a disabling extent

4. During the past week were there any places or situations (e.g., public transportation, movie theatres, crowds, bridges, tunnels, shopping malls, being alone) you avoided, or felt afraid of (uncomfortable in, wanted to avoid or leave), because of fear of having a panic attack? Are there any other situations that you would have avoided or been afraid of if they had come up during the week, for the same reason? If yes to either question, please rate your level of

Reference: Shear MK, Brown TA, Barlow DH, et al. Multicenter collaborative Panic Disorder Severity Scale. American Journal of Psychiatry. 1997;154:1571–75.

2.2.9 Patient Health Questionnaire (PHQ-9)

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
Column Totals	_____	+ _____	+ _____	
Add Totals Together	_____			

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Reference: Kroenke K, Spitzer R, Williams J. The PHQ-9: validity of a brief depression severity measure. Journal of General Internal Medicine. 2001;16:606-13.

2.2.10 Penn State Worry Questionnaire (PSWQ)

Penn State Worry Questionnaire

Name..... Date.....

Enter the number that best describes how typical or characteristic each item is of you:

STATEMENTS

	Not at all typical	Not very typical	Somewhat typical	Fairly typical	Very typical
1. If I don't have enough time to do everything, I don't worry about it.	1	2	3	4	5
2. My worries overwhelm me.	1	2	3	4	5
3. I don't tend to worry about things.	1	2	3	4	5
4. Many situations make me worry.	1	2	3	4	5
5. I know I should not worry about things , but I just cannot help it.	1	2	3	4	5
6. When I am under pressure I worry a lot.	1	2	3	4	5
7. I am always worrying about something.	1	2	3	4	5
8. I find it easy to dismiss worrisome thoughts.	1	2	3	4	5
9. As soon as I finish one task, I start to worry about everything else I have to do.	1	2	3	4	5
10. I never worry about anything.	1	2	3	4	5
11. When there is nothing more I can do about a concern, I do not worry about it anymore.	1	2	3	4	5
12. I have been a worrier all my life.	1	2	3	4	5
13. I notice that I have been worrying about things.	1	2	3	4	5
14. Once I start worrying, I cannot stop.	1	2	3	4	5
15. I worry all the time.	1	2	3	4	5
16. I worry about projects until they are all done.	1	2	3	4	5
Total (add all scores together, after reversing*) (Data item 43 in the IAPT Data Standard)					

*Scoring: Reverse score items 1, 3, 8, 10 and 11, then sum all 16 items:

- Very typical of me = 1 (circled 5 on the sheet)
- Circled 3 on the sheet = 2
- Circled 2 on the sheet = 3
- Circled 1 on the sheet = 4
- Not at all typical of me = 5 (circled 1 on the sheet)

Reference: Meyer TJ, Miller ML, Metzger RL, Borkovec TD: Development and Validation of the Penn State Worry Questionnaire. Behaviour Research and Therapy. 1990;28:487-95.

2.2.11 Process of Recovery Questionnaire (QPR)

		Disagree strongly	Disagree	Neither agree nor disagree	Agree	Agree strongly
1	I feel better about myself					
2	I feel able to take chances in life					
3	I am able to develop positive relationships with other people					
4	I feel part of society rather than isolated					
5	I am able to assert myself					
6	I feel that my life has a purpose					
7	My experiences have changed me for the better					
8	I have been able to come to terms with things that have happened to me in the past and move on with my life					
9	I am basically strongly motivated to get better					
10	I can recognise the positive things I have done					
11	I am able to understand myself better					
12	I can take charge of my life					
13	I can actively engage with life					
14	I can take control of aspects of my life					
15	I can find the time to do the things I enjoy					

Reference: Law H, Neil ST, Dunn G, Morrison AP. Psychometric properties of the Questionnaire about the Process of Recovery (QPR). Schizophrenia Research. 2014;153:184-89.

2.2.12 The Recovery Quality of Life (ReQoL)[c]

ReQoL™

Recovering Quality of Life

For each of the following statements, please tick one box that best describes your thoughts, feelings and activities over the last week.

Last week	None of the time	Only occasionally	Sometimes	Often	Most or all of the time
1. I found it difficult to get started with everyday tasks	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
2. I felt able to trust others	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
3. I felt unable to cope	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
4. I could do the things I wanted to do	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
5. I felt happy	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
6. I thought my life was not worth living	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
7. I enjoyed what I did	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
8. I felt hopeful about my future	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
9. I felt lonely	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0
10. I felt confident in myself	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4
	No problems	Slight problems	Moderate problems	Severe problems	Very severe problems
Please describe your **physical health** (problems with pain, mobility, difficulties caring for yourself or feeling physically unwell) over the last week.	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

*There is a longer version ReQoL-20 which contains 20 mental health questions and the same physical health question. The initial 10 questions of the ReQoL-20 are exactly the same as the ones in the ReQoL-10.

Reference: Keetharuth A, Brazier J, Connell J, Carlton J, Taylor Buck E, Ricketts T, Barkham M. Development and Validation of the Recovering Quality of Life (ReQoL) Outcome Measures. Policy Research Unit in Economic Evaluation of Health and Care Interventions. Universities of Sheffield and York. EEPRU Research Report 050; 2017

[c] A licence (free to the NHS) is required to reprint this scale. It can be accessed on the ReQoL website.

2.2.13 Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

Yale-Brown Obsessive Compulsive Scale (Y-BOCS)

PSYCHIATRIC ASSOCIATES OF ATLANTA, LLC

NAME:_____

DATE:_____

PHYSICIAN:_____

Note: Scores should reflect the composite effect of all the patient's obsessive compulsive symptoms. Rate the average occurrence of each item during the prior week up to and including the time of interview.

Obsession Rating Scale (circle appropriate score)

Item	Range of Severity				
1. Time Spent on Obsessions	0 hr/day	0–1 hr/day	1–3 hr/day	3–8 hr/day	> 8 hr/day
Score:	0	1	2	3	4
2. Interference From Obsessions	None	Mild	Definite but manageable	Substantial impairment	Incapacitating
Score:	0	1	2	3	4
3. Distress From Obsessions	None	Little	Moderate but manageable	Severe	Near constant, disabling
Score:	0	1	2	3	4
4. Resistance to Obsessions	Always resists	Much resistance	Some resistance	Often yields	Completely yields
Score:	0	1	2	3	4
5. Control Over Obsessions	Complete control	Much control	Some control	Little control	No control
Score:	0	1	2	3	4

Obsession subtotal (add items 1-5) _____

Compulsion Rating Scale (circle appropriate score)

Item	Range of Severity				
6. Time Spent on Compulsions	0 hr/day	0–1 hr/day	1–3 hr/day	3–8 hr/day	> 8 hr/day
Score:	0	1	2	3	4
7. Interference From Compulsions	None	Mild	Definite but manageable	Substantial impairment	Incapacitating
Score:	0	1	2	3	4
8. Distress From Compulsions	None	Mild	Moderate but manageable	Severe	Near constant, disabling
Score:	0	1	2	3	4
9. Resistance to Compulsions	Always resists	Much resistance	Some resistance	Often yields	Completely yields
Score:	0	1	2	3	4
10. Control Over Compulsions	Complete control	Much control	Some control	Little control	No control
Score:	0	1	2	3	4

Compulsion subtotal (add items 6–10) _____

Y-BOCS total (add items 1–10) _____

Total Y-BOCS score range of severity for patients who have both obsessions and compulsions:
0–7 Subclinical 8–15 Mild 16–23 Moderate 24–31 Severe 32–40 Extreme

COMMENTS: _____

Reference: Goodman WK, Price LH, Rasmussen SA, Mazure C, Fleischmann RL, Hill CL, et al. The Yale-Brown Obsessive-Compulsive Scale. I. Development, Use, and Reliability. Archives of General Psychiatry; 1989: 46:1006-11.

2.3 Patient-reported experience measures (PREMs)

2.3.1 Patient rated Outcome and Experience Measure (POEM)

Community version

1. Please rate how your mental health has been	*Very well*	*Well*	*Unwell*	*Very unwell*	*Extremely unwell*
When I first came into contact with the service, I was					
When I was discharged from the service, I was					

2. Please rate your view of the service based on your own experiences. Please try to tick one answer for each of the questions:	*Strongly agree*	*Agree*	*Disagree*	*Strongly disagree*
Staff **did not** communicate with others involved in my care				
Staff gave me the right amount of support				
I **did not** get help quickly enough after referral				
Staff listened to me and understood my problems				
Staff **did not** involve me enough in my care and treatment				
The service provided me with the information I needed				
Staff **were not** sensitive to my needs				
Staff helped me to understand my illness/difficulties				
Staff **were not** sensitive to the needs of my baby				
Staff helped me be more confident with caring for my baby				
The service involved other relevant people in a helpful way				
I would recommend this service to others				

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Inpatient version

1. Please rate how your mental health has been	*Very well*	*Well*	*Unwell*	*Very unwell*	*Extremely unwell*
When I first came into contact with the service, I was					
When I was discharged from the service, I was					

2. Please rate your view of the service based on your own experiences. Please try to tick one answer for each of the questions:	*Strongly agree*	*Agree*	*Disagree*	*Strongly disagree*
Staff **did not** communicate with others involved in my care				
Staff gave me the right amount of support				
I **did not** get help quickly enough after referral				
Staff listened to me and understood my problems				
Staff **did not** involve me enough in my care and treatment				
The service provided me with the information I needed				
Staff **were not** sensitive to my needs				
Staff helped me to understand my illness/difficulties				
Staff **were not** sensitive to the needs of my baby				
Staff helped me be more confident with caring for my baby				
The service involved other relevant people in a helpful way				
I would recommend this service to others				

3. ONLY answer these questions if you are being discharged from INPATIENT CARE IN A MOTHER AND BABY UNIT (MBU).	*Strongly agree*	*Agree*	*Disagree*	*Strongly disagree*
The unit was clean and hygienic				
The unit **did not** provide a good place for me to recover in				
The unit **did not** provide helpful activities and therapies				
The unit provided a good place for my baby to be with me				
The unit supported me in my contact with family and friends				
The food provided **was not** acceptable to me				

3 Helpful web-based resources

3.1 National guidance

CCG Improvement and Assessment Framework 2016/17

Closing the Gap

Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21

Implementing the Five Year Forward View for Mental Health

No Health Without Mental Health

The Government's Mandate to NHS England for 2017-2018

Stepping Forward to 2020/21: the Mental Health Workforce Plan for England

3.2 Other NICE guidance

Antenatal Care for Uncomplicated Pregnancies NICE guideline

Caesarean Section NICE guideline

Multiple Pregnancy: Antenatal Care for Twin and Triplet Pregnancies NICE guideline

Postnatal Care for Up to 8 Weeks After Birth NICE guideline

3.3 Perinatal mental health resources

Bluebell Care

Costs of Perinatal Mental Health Problems

Falling Through the Gaps: Perinatal Mental Health and General Practice

Guidance for Commissioners of Perinatal Mental Health Services

Joint Commissioning Panel for Mental Health

Maternal Mental Health Network

Maternal Mental Health Alliance: Everyone's Business

Mother and Baby Unit service specification

No Health without Perinatal Mental Health

Perinatal Mental Health: Experiences of Women and Health Professionals – Tommy's

Perinatal Mental Health Services. Recommendations for the Provision of Services for Childbearing Women (CR197)

Prevention in Mind. All Babies Count: Spotlight on Perinatal Mental Health

Royal College of General Practitioners: Perinatal Mental Health

Suffering in Silence

3.4 Useful organisations

British Psychological Society

Care Quality Commission

Child and Maternal Health Observatory (ChiMat)

Family Nurse Partnership

Health Education England

Health Visiting Programme

Home-Start

Mental Health Innovation Network

Mental Health Intelligence Network

NHS Benchmarking

NHS England

NHS Improvement

NICE

Public Health England

Quality Network for Perinatal Mental Health Service (CCQI)

Royal College of General Practitioners

Royal College of Obstetricians and Gynaecologists

Royal College of Psychiatrists

Sure Start

Abbreviations

Abbreviation	Definition
AfC	Agenda for Change
CBT	cognitive behavioural therapy
CCG	clinical commissioning group
CCQI	College Centre for Quality Improvement
CORE-OM	Centre for Outcomes Research and Effectiveness – Outcome Measure
EAS	Early Attachment Service
HEFT	Heart of England Foundation Trust
HoNOS(CA)	Health of the Nation Outcomes Scale (Child and Adolescent Mental Health)
IAPT	Improving Access to Psychological Therapies
MBU	mother and baby unit
NICE	National Institute for Health and Care Excellence
POEM	Patient rated Outcome and Experience Measure
RAID	rapid assessment interface and discharge
SNOMED CT	Systematized Nomenclature of Medicine – Clinical Terms
WTE	whole time equivalent

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