



W E S T E R N
HEALTH AND SOCIAL SERVICES BOARD

Western Area Maternal Mental Health Care Pathway for Professional Staff

(2008/09)

This Pathway was completed in conjunction with Western Health and Social Care Trust Staff
Lead Office/Department: Woman & Children's Directorate

Issue date: February 2008 • Review date: June 2009

CONTENTS

Foreword	4
Acknowledgements	5
Introduction	6
Guidance for Professionals	7
Benefits of Implementation	9
Midwifery Antenatal Referral Pathway	10
Midwifery Postnatal Referral Pathway	11
Health Visitor Referral Pathway	12
NICE Guidelines	13
Appendices	17
References	30

FOREWORD

The Western Area Maternal Mental Health Pathway is intended to support the pivotal role of all those professionals involved with Maternal Mental Health.

It is a framework which is designed to provide information and to describe the critical roles of and relationships between the different professionals who provide services during and after pregnancy.

The Pathway incorporates the NICE Clinical guideline on mental health problems during pregnancy and after childbirth (February 2007).

The Pathway presents examples of good communication practice across Secondary and Primary care settings between General Practitioners, Psychiatric Teams, Obstetricians, Midwives and Health Visitors.

These examples can be built on to ensure that communications are in place that are appropriate to local communities and to users of the service.

We are very grateful to all the professionals and users across all sectors who were involved in the development of this Pathway and also to those who provided comments during the consultation period. Their input has been invaluable.

A handwritten signature in black ink that reads "Dominic Burke". The signature is written in a cursive style with a period at the end.

Dominic Burke
Acting Chief Executive
WHSSB

ACKNOWLEDGEMENTS

This document has been endorsed by the Western Health and Social Services Board. The Board would like to acknowledge the significant contribution of the steering group who developed and edited the document and to the local users, Maternity Liaison Committees and focus groups who commented on the draft.

Steering Group Members

Mrs Siobhan McIntyre	Service Planner, WHSSB (Chair)
Mrs Marie Hutton	Community Nurse Manager, WHSCT
Mrs Lorna Moore	Community Midwifery Manager, WHSCT
Mrs Kate McDaid	Assistant Director of Health Care, Woman and Children's, WHSCT
Mrs Kate Boles	Community Nurse Manager, WHSCT.
Mrs Nuala Doherty	Assistant Programme Manager Mental Health, WHSCT.
Mrs Lee Molinger	Project Manager Strule/Erne LHSCG (up until 2006)
Miss Charlene Woods	Admin Support, WHSSB

INTRODUCTION

The Confidential Enquiry into Maternal and Child Health (CEMACH), 'Why Mothers Die' 2000 - 2002 highlighted the serious consequences of failure to address mental health adequately - suicide is now the most common cause of maternal death.

The growing awareness of the difficulties for women, their partners and their children arising from perinatal mental illness has led to several government initiatives aimed at improving available services. Thus the National Service Frameworks for Mental Health, and for Children, The Women's Mental Health Strategy 'Into the Mainstream', and the Scottish Intercollegiate Guidelines for Postnatal Depression and Puerperal Psychosis all direct that perinatal mental health be a focus for attention.

Screening for postnatal depression in primary care began in the mid 80s with the development of a questionnaire specifically designed for pregnant and postnatal women - the Edinburgh Postnatal Depression Scale (EPDS) (Appendix 5)

In recent years, doubts have arisen surrounding its uses and misuses. The National Screening Committee (NSC) was asked to advise on its suitability for use as a National Screening tool. The comprehensive review in 2001 highlighted many problems with its use, which made it unsuitable as a universal screening tool.

'Until more research is conducted into its potential for routine use for screening for postnatal depression the NSC recommends that the EPDS should not be used as a universal screening tool. It may, however, serve as a checklist as part of a mood assessment for postnatal mothers, when it should only be used alongside professional judgement and a clinical interview. The professional administering it should have training in its appropriate use and should not use it as a pass/fail-screening tool. Practitioners using it should also be mindful that, although it has been translated into many different languages, it can pose cultural difficulties for the interpretation, particularly when used with non English speaking mothers and those from non-western cultures.'

The management of postnatal depression requires a multi-disciplinary approach. This is supported by the recently published NICE guidelines on antenatal and postnatal care for women 2007, which sets out a number of key priority areas for improved service frameworks and pathways.

These guidelines have taken the recommendations into consideration in identifying key staff involved to provide support, identifying risk and referral to Mental Health Services.

GUIDANCE FOR PROFESSIONALS

This guidance is intended to support the pivotal role of the professionals involved with maternal mental health. It reflects evidence and research, with identified training for midwives, Health Visitors, community psychiatric nurses and other primary care team members to supplement their professional knowledge and skills.

The pathways in this document provide clear guidelines for staff supported by education and training which will inform professionals and enable them to:

Identify vulnerability and risk factors in a woman's life that may predict her predisposition to maternal depression using validated material.

Assess women's mental health status at identified stages during pregnancy, initiating appropriate interventions.

Increase professional knowledge, skills and confidence in this area by appropriate educational training and supervision.

Facilitate practice based on current research evidence.

Ensure consistency of approach across the Western Health and Social Services Trust area.

Support women throughout their pregnancy by providing a non-stigmatising service.

Work across all programmes of care.

The primary care intervention for maternal mental health will be offered by those primary care staff through a range of support visits using problem solving approaches, cognitive behaviour counselling skills, signposting to support networks and community resources.

The pathways comprise of directional sign-posts for Professionals defining routes for referral that facilitate early recognition of depression from the antenatal period throughout the postnatal period. Mental disorders during this period can have serious consequences for the mother, her infant and other family members. It covers all mental disorders including anxiety disorders, depression, bi-polar disorders, schizophrenia and postnatal psychotic disorders and must be read in conjunction with the NICE guidelines-Antenatal and postnatal Mental health Published February 2007.

In each locality within the Western Trust there will be named Health Care professionals who will have the responsibility for training and supporting staff and providing linkages with community organisations.

Additional support groups will be made available in a range of community settings in particular Sure Start areas throughout the Western Trust area. ***All support and interventions will be taken using a partnership approach between health professional, client and family. Clients will be encouraged to self-refer at anytime.***

BENEFITS OF IMPLEMENTATION

Implementation of the care pathways will ensure that every woman who gives birth in the Western Trust area will be offered a service to actively promote and maintain her mental health.

All women will be assessed in the antenatal period;

Timely and effective intervention will be provided through targeted services;

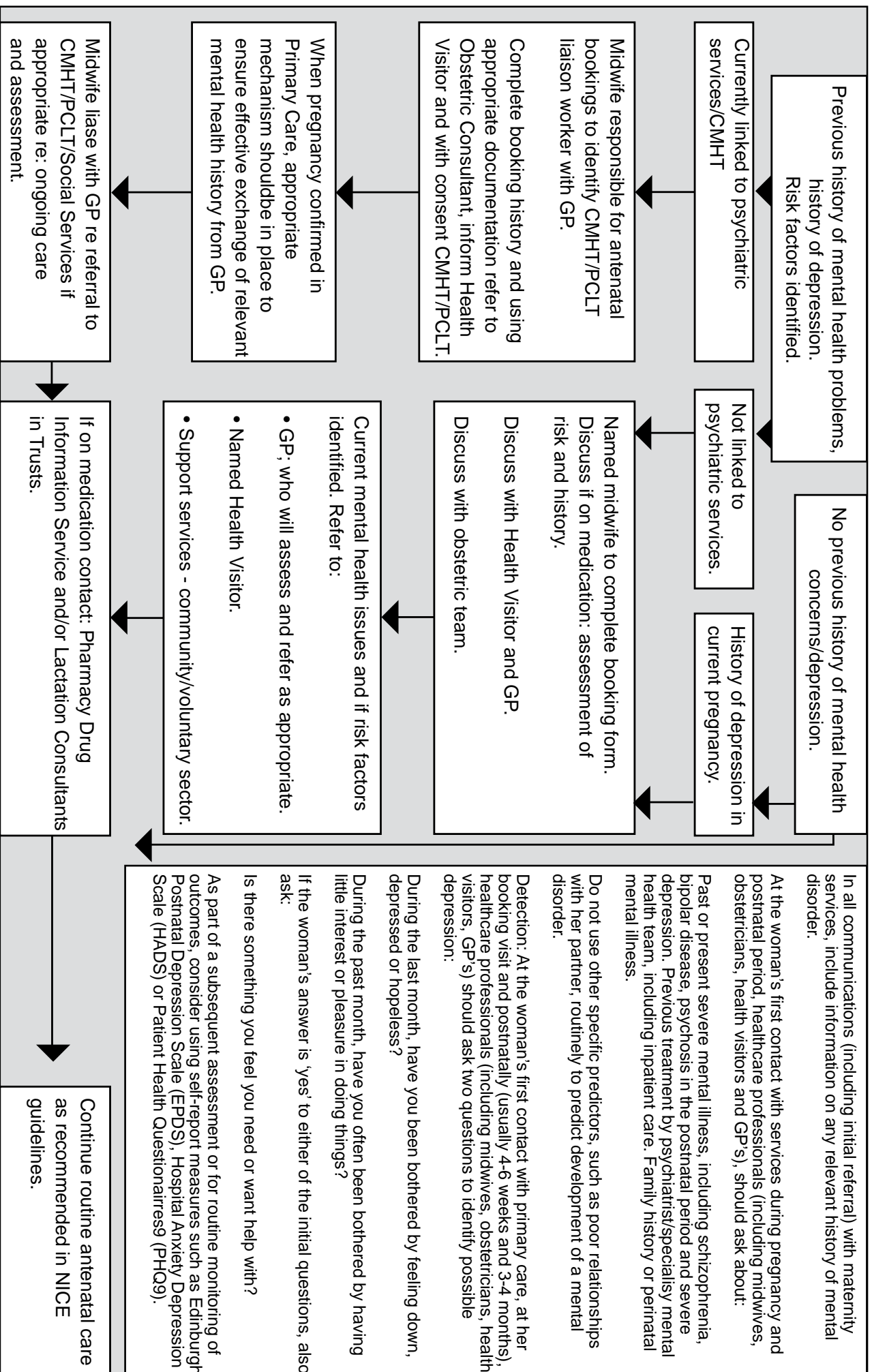
Appropriate referrals to Secondary services will be in place to ensure appropriate tracking;

Referral into Mental Health services, where appropriate, will be co-ordinated locally with Primary Care professionals in conjunction with General Practitioners who will make the referral when appropriate.

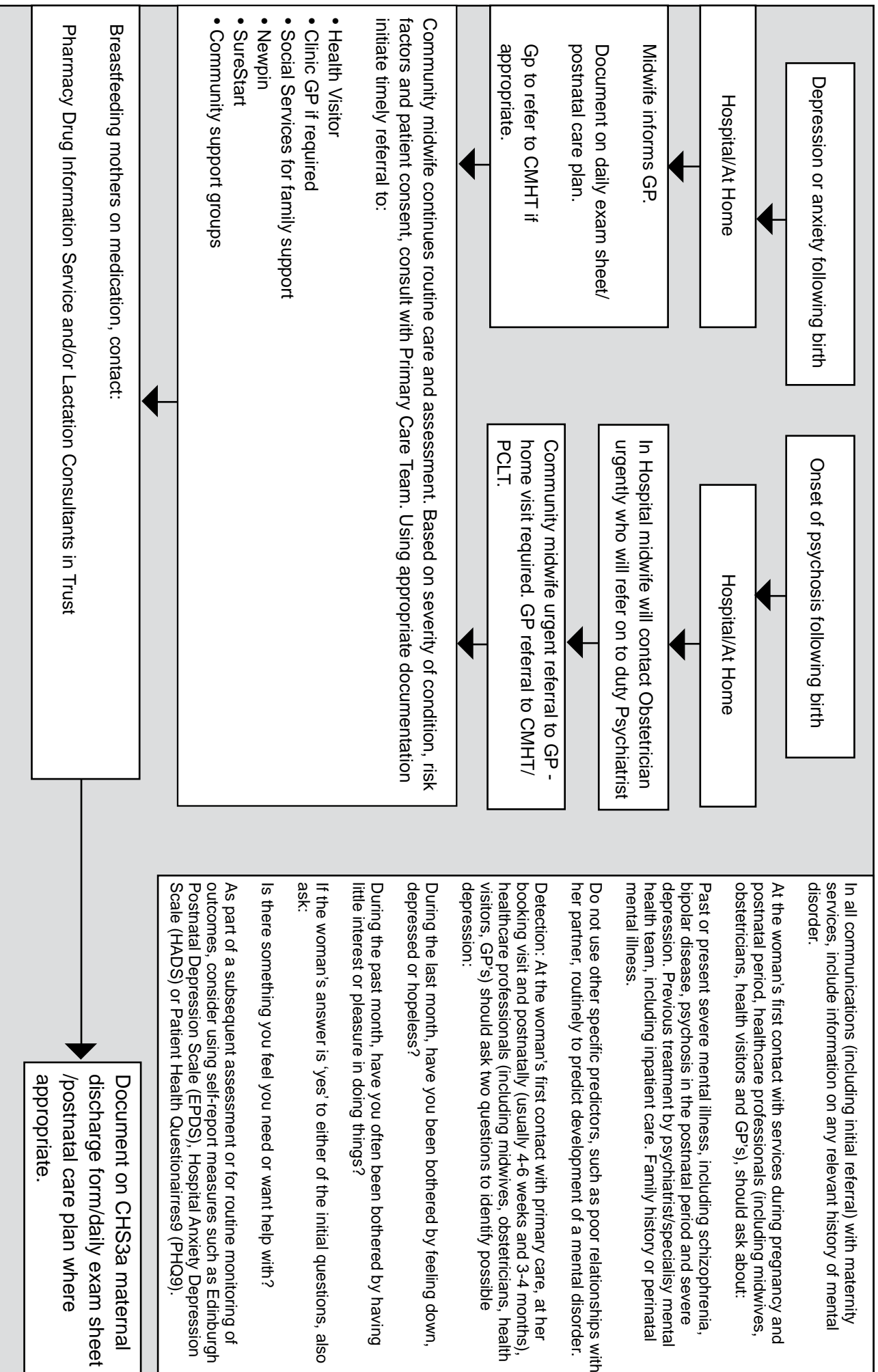
Community Support systems will be in place in each locality across the Western Trust.

Information will be made available to women and their families on the symptoms of Post Natal Depression and on how to access appropriate services.

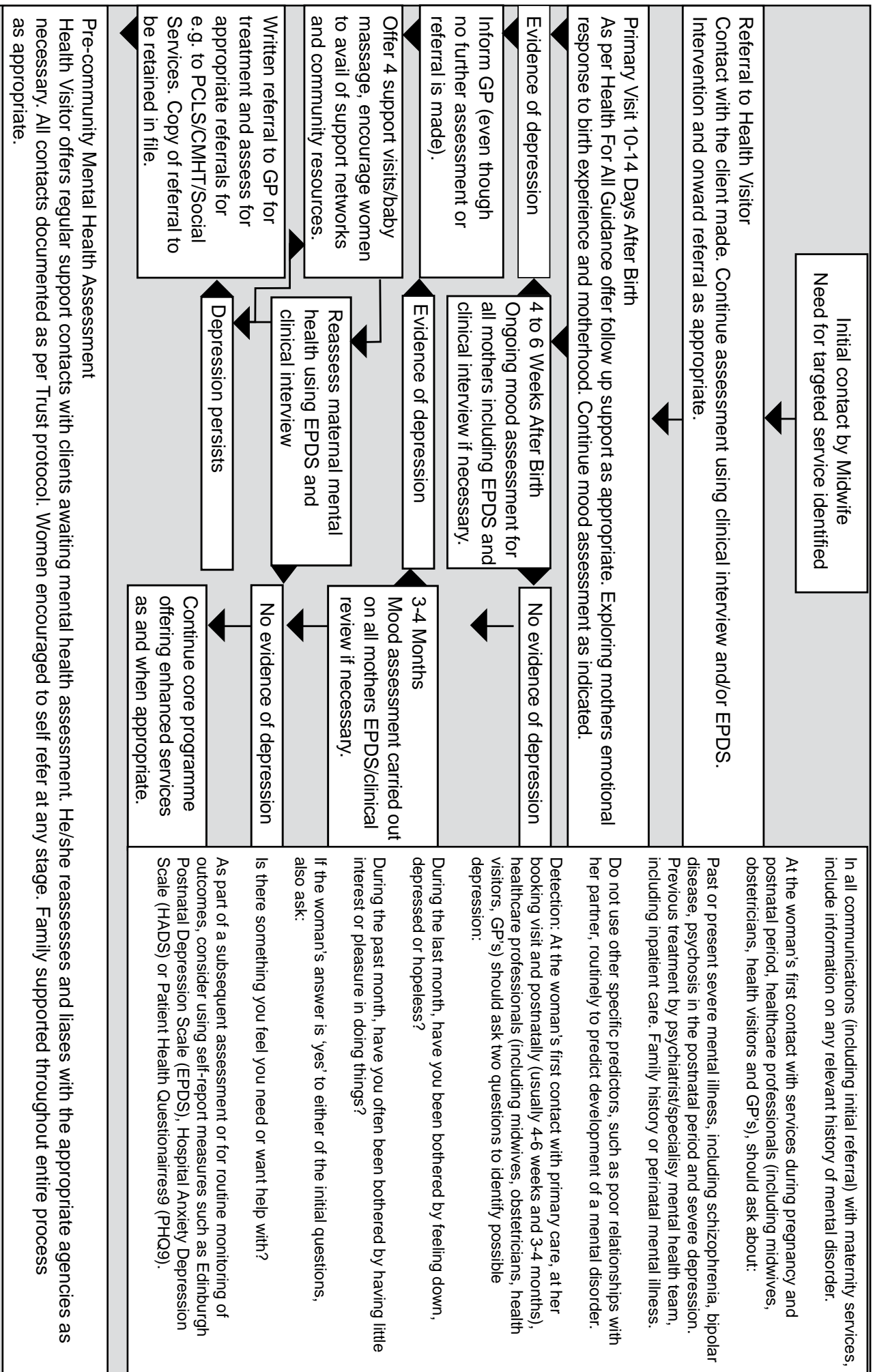
MIDWIFERY ANTENATAL REFERRAL FOR WOMEN WITH MENTAL HEALTH CONCERNS CARE PATHWAY



MIDWIFERY POSTNATAL REFERRAL FOR WOMEN WITH MENTAL HEALTH CONCERNS CARE PATHWAY



THE HEALTH VISITOR MENTAL HEALTH CARE PATHWAY



NICE GUIDELINES

Key priorities for the implementation of NICE Guidelines for antenatal and postnatal mental health 2007.

Prediction and detection

- At a woman's first contact with services in both the antenatal and the postnatal periods, health care professionals (including midwives, obstetrician, Health Visitors and GPs) should ask questions about:
 - past or present severe mental illness including schizophrenia, bipolar disorder, psychosis in the postnatal period and severe depression.
 - previous treatment by a psychiatrist/specialist Mental Health team including inpatient care.
 - a family history of perinatal mental illness.

Other specific predictors, such as poor relationships with a partner, should not be used for the routine prediction of the development of a mental disorder.

- At a woman's first contact with Primary Care, at her booking visit and postnatally (usually at 4 to 6 weeks and 3 to 4 months), healthcare professionals (including midwives, obstetricians, Health Visitors and GPs) should ask two questions to identify possible depression:
 - 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?
- A third question should be considered if the woman answers 'yes' to both of the initial questions:
 - Is this something you feel you need or want help with?

Psychological treatments

Woman requiring psychological treatment should be seen for treatment normally within 1 month of initial assessment, and no longer than 3 months afterwards. This is because of the lower threshold for access to psychological therapies during pregnancy and the postnatal period arising from the changing risk-benefit ratio for psychotropic medication at this time.

Explaining risks

- Before treatment decisions are made, healthcare professionals should discuss with the woman the absolute and relative risks associated with treating and not treating the mental disorder during pregnancy and the postnatal period. They should:
 - acknowledge the uncertainty surrounding the risks.
 - explain the background risk of fetal malformations for pregnant women without a mental disorder.
 - describe risks using natural frequencies rather than percentages (for example, 1 in 10 rather than 10%) and common denominators (for example, 1 in 100 and 25 in 100, rather than 1 in 100 and 1 in 4).
 - if possible use decision aids in a variety of verbal and visual formats that focus on an individualised view of the risks.
 - provide written material to explain the risks (preferably individualised) and, if possible audio taped records of the consultation.

Management of Depression

When choosing an antidepressant for pregnant or breastfeeding women, prescribers should, while bearing in mind that the safety of these drugs is not well understood, take into account that:

- tricyclic antidepressants, such as amitriptyline, imipramine and nortriptyline, have lowest known risks during pregnancy than other antidepressants
- most tricyclic antidepressants have a higher fatal toxicity index than selective serotonin reuptake inhibitors (SSRIs)
- fluoxetine is the SSRI with the lowest known risk during pregnancy

- imipramine, nortriptyline and sertraline are present in breast milk at relatively low levels
- citalopram and fluoxetine are present in breast milk at relatively high levels
- SSRIs taken after 20 weeks' gestation may be associated with an increased risk of persistent pulmonary hypertension in the neonate
- paroxetine taken in the first trimester may be associated with fetal heart defects
- venlafaxine may be associated with increased risk of high blood pressure at high doses, higher toxicity in overdose than SSRIs and some tricyclic antidepressants, and increased difficulty in withdrawal.
- all antidepressants carry the risk of withdrawal of toxicity in neonates; in most cases the effects are mild and self-limiting.

For a woman who develops mild or moderate depression during pregnancy or the postnatal period the following should be considered:

- self-help strategies (guided self-help, computerised cognitive behaviour therapy or exercise)
- non-directive counselling delivered at home (listening visits) e.g. by Health Visitors.
- brief cognitive behavioural therapy / interpersonal psychotherapy.

Organisation of care

Clinical networks should be established for perinatal mental health services, managed by a coordinating board of healthcare professionals, commissioners, managers and service users and carers. These networks should provide:

- a multidisciplinary perinatal service in each locality, which provides direct services, consultation and advice to maternity services, other mental health services and community services;
- access to expert advice on the risks and benefits of psychotropic medication during pregnancy and breastfeeding

- clear referral and management protocols for services across all levels of the existing stepped-care frameworks for mental disorders, to ensure effective transfer of information and continuity of care
- pathways of care for service users, with defined roles and competencies for all professional groups involved.



W E S T E R N
HEALTH AND SOCIAL SERVICES BOARD

Appendices

1. Professional Guidance for Antenatal Home Visits
2. Antenatal Referral for Women with Perinatal Mental Health Concerns
3. Postnatal Referral for Women with Mental Health Concerns
4. Maternal Mental Health Notification Form
5. EODS Screening Tool
6. Mental Health Contract Numbers. Northern and Southern Sectors
7. Abbreviations

APPENDIX ONE

PROFESSIONAL GUIDANCE FOR ANTENATAL HOME VISITS

The aim of the pathway is to provide guidance to professional staff for those women who present with a known risk factor, or belong to a group perceived as vulnerable in the antenatal and postnatal period.

The named midwife where appropriate, and on some occasions depending on need a Health Visitor, will visit the mother at least once in her home or place of residence during her pregnancy. Further antenatal home visits will be at the discretion of the midwife in discussion with health visitor based on clinical and social need.

Prediction and Detection

At a woman's first contact with services in both the antenatal and the postnatal periods, Health Care professionals (including midwives, obstetrician, Health Visitors and GPs) should ask questions about:

- past or present severe mental illness including schizophrenia, bipolar disorder, psychosis in the postnatal period and severe depression
- previous treatment by a psychiatrist/specialist mental health team including inpatient care
- a family history of perinatal mental illness

Other specific predictors, such as poor relationships with her partner, should not be used for the routine prediction of the development of a mental disorder.

At a woman's first contact with Primary Care, at her booking visit and postnatally (usually at 4 to 6 weeks and 3 to 4 months), Health Care professionals (including midwives, obstetricians, Health Visitors and GPs) should ask two questions to identify possible depression:

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

A third question should be considered if the woman answers 'yes' to both of the initial questions:

3. 'Is this something you feel you need or want help with?'
(REF NICE GUIDELINES 2007)

IF REQUIRED/FOR FURTHER REVIEW The midwife will complete the relevant documentation (see appendix 3&4).

ANTENATAL REFERRAL FOR WOMEN WITH PERINATAL MENTAL HEALTH CONCERNS

Midwife role:

At booking the midwife identifies any history of mental health problems or any predisposing factors.

Alternatively the midwife may note if patient presents with mental illness/ depression during pregnancy.

Action:

The midwife should:

- Identify any factors or problems, which may cause/exacerbate depression. Identify risk factors
- For patients with a history of/or who has ongoing mental health problems. The midwife should ascertain whether she is currently attending or liaising with **Community Mental Health Team (CMHT)/Primary Care Liaison Team (PCLT)**.

If yes

- Midwife at booking must consult with GP to identify name of CMHT/PCLT liaison worker; and complete notification form.
- Document on booking chart, complete midwife liaison form to Health Visitor.
- Refer to Obstetric Consultant; inform GP and HV and CMHT/PCLT liaison worker verbally and in writing, using forms in Appendix 4 who will, if necessary, refer to psychiatrist following discussion.
- Midwife will maintain contact with the CMHT/PCLT liaison worker who will if necessary refer to psychiatrist;
- Midwife may contact pharmacy drug information service and GP re: medication taken during pregnancy;
- Continue routine antenatal care as recommended by NICE guidelines;
- Discuss concerns with mother and obtain consent for information to be shared.

APPENDIX TWO (Continued)

Pregnant women who have a history of mental illness/depression but have no contact with CMHT/PCLT and pregnant women with no previous history of mental illness but who present with depression in current pregnancy, the midwife at booking should:

- Complete and document same on booking chart;
- Assess risk and history;
- Discuss medications with woman;
- Discuss concerns etc. with GP and HV for further follow up and if woman is admitted to hospital as in-patient inform obstetric team.
- Complete relevant notification forms for onward referral by G.P.

Midwife and Health Visitor at Antenatal Contact;

- Assess the family circumstances, discuss and identify level of risk, based on the severity of mental illness/depression.
- Refer to GP, who may refer to CMHT/PCLT
- Identify and refer local support services linking with liaison professionals in appropriate locality
- Discuss current medication - contact pharmacy drug information (if on antidepressants)
- Continue routine antenatal care as recommended in NICE guidelines.

POSTNATAL REFERRAL FOR WOMEN WITH MENTAL HEALTH CONCERNS.

Psychological Distress related to birth

This may occur in the hospital or at home. The hospital/community midwife will discuss the delivery of the baby and any related problems or concerns with the mother. Referring to Obstetrician/Paediatrician. If necessary the midwife will make an appropriate written referral to the GP and inform the health visitor in the relevant locality to discuss issues regarding further support and onward referral by the G.P. to Mental Health Team or other agencies if deemed appropriate.

Depression/Anxiety Following Delivery

In the maternity unit: The midwife will inform the Obstetrician Consultant, CMHT and Health Visitor verbally, and in writing, for assessment. The condition and treatment will be documented on the CHS 3a Maternal Discharge form and on the daily examination sheet and/or care plan.

At home: The community midwife will inform the GP verbally, and in writing, for assessment and follow up with Health Visitor or CMHT where appropriate. This will also be documented on the daily examination sheet and/or care plan.

Onset of Psychosis Following Delivery

In hospital: The midwife will contact the Consultant Obstetrician, verbally and in writing who will refer for assessment to duty Psychiatrist.

At home: The community midwife or Health Visitor will make an urgent referral to the GP requesting a home visit on that day. Professional to stay with woman until GP visits.

In all instances the Health Care Professionals will continue care and assessment as per NICE Postnatal Care Guidelines 2007 and Northern Ireland Health For All Guidance (2007). In consultation with the client and other primary care staff, based on the severity of the condition, timely referrals will be followed up in writing to appropriate services for e.g

- Primary Care Liaison Team / Community Mental Health Team (via G.P.)
- Social Services / Community Health Care (family support);

APPENDIX THREE (Continued)

- Community and voluntary support e.g. Sure Start, Healthy Living Centres, Derry Well Woman

Psychiatric disorders are the leading cause of maternal morbidity and suicide is the leading cause of maternal death in the UK. It is important that accurate information is obtained about any previous serious psychiatric illness at booking, and staff should distinguish between the various types of illness.

Details should be carefully recorded including what, if any, treatment the woman required, including medication, specialist help or inpatient treatment.

Patients with a chronic illness and already known to the Mental Health team.

It is important that the CMHT/PCLT are informed when patients under their care become pregnant. Patients with a history of schizoaffective psychosis, bipolar illness and severe unipolar depression are at significant risk of recurrence after childbirth.

Communication early in the pregnancy allows the team to review medication, and to continue appropriate care throughout the pregnancy and the postpartum period.

Patients with a history of pregnancy - related psychiatric illness

Patients who have previously had ***puerperal psychosis or severe postnatal depression requiring treatment from mental health services*** are at significant risk of recurrence in subsequent pregnancies. These patients should be referred to the CMHT/PCLT for antenatal counselling and care management plan.

Where the patient's previous care was in a different region, she should be referred to the CMHT/PCLT covering the area where she lives.

Patients who develop an acute postnatal psychiatric illness that requires emergency care and transfer.

Patients who develop acute psychosis requiring **emergency** intervention by Mental Health Services should be discussed between a Consultant Obstetrician and CMHT/PCLT.

Out of hours, referral should be made to CMHT/PCLT via the GP on call.

NB: All concerns and referrals should be documented in writing using the appropriate forms and copied to the relevant professional staff in the locality of the woman's residence. Referrals to Social Services via UNOCINI.

Referrals to Mental Health services should be coordinated via the woman's General Practitioner and copied to the liaison professionals in the appropriate locality.

Consent from clients must be obtained regarding communication of their details to other Professional groups.

Relevant information regarding past history for women with Mental Health concerns should be transferred/shared across all programmes via appropriate liaison arrangements and Trust protocol including updating information to out of hours services.

APPENDIX FOUR

MATERNAL MENTAL HEALTH NOTIFICATION FORM

Referrals to CMHT/PCLT - should be made via GP.

Referral to:

Name: _____ Contact Details: _____

Name: _____ Address: _____

Telephone no: _____ Mobile no: _____

General Practitioner: _____ Health Centre: _____

Nulliparous: _____ Gravida: _____ Parity: _____

Expected date of confinement: / / /

Baby DOB: _____ Gestational age at birth _____ wks

IDENTIFIED RISK FACTORS

Past or present severe mental illness including schizophrenia, bipolar disorder, psychosis in the postnatal period and severe depression? **Y/N**

Previous treatment by a Psychiatrist / Specialist Mental Health Team including inpatient care? **Y/N**

A family history of perinatal mental illness? **Y/N**

Edinburgh Postnatal Depression Scale (EDSP)

Score

Present mood assessment clinical interview details:

Family Support:

Comments / Action required:

Notification made by: _____

Occupation: _____ Contact Details: _____

Hospital booked for:

Altnagelvin Erne Causeway Craigavon Other

Copy to:

Midwife Health Visitor

G.P. for follow up assessment and onward referral to CMHT if necessary.

CMHT/PCLT if client has previous contact with Mental Health Services.

EPDS SCREENING TOOL

Please underline the statement for each of the following items, which best describes how you have been feeling over the past month.

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 felt worried and anxious for no very good reason:

- No, not at all
- Hardly ever
- Yes, sometimes
- Yes, very often

5. I have felt scared and 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

APPENDIX FIVE (Continued)

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

Cox J. L., Holden J.M., & Sagovsky R (1987).
Detection of postnatal depression

NORTHERN SECTOR MENTAL HEALTH SERVICES

Adult Mental Health Teams

Primary Care Liaison Team City	028 7186 5246
Primary Care Liaison Team Strabne	028 7138 2963
Primary Care Liaison Team Limavady	028 777 22123
Rehab and Recovery Team City	028 7135 0063
Rehab and Recovery Team Limavady	028 777 22123
Rehab and Recovery Team Strabane	028 7138 2963
Psychological Therapies Team	028 7137 2230

Addiction Services

Cruse Bereavement Care	028 6186 5239
Wave/Bereaved Through The Troubles	028 7126 2941
Treetops Belfast (Children)	028 7126 6655
The Compassionate Friends	028 8772 3508
	028 9265 2550

Health Centres

Waterside Health Centre	028 7131 4910
Shantallow Health Centre	028 7135 1350
Gt James St Health Centre	028 7136 5177
Bayview Medical Centre	028 7137 7027
Bridge Street	028 7126 1137
Clarendon Medical	028 7126 5391
Quayside Medical Practice	028 7126 2790
Limavady Health Centre	028 777 63131
Limavady Bovalley Health Centre	028 777 66352
Mourneside Medical	028 7138 3737
Family Practice Strabane	028 71 38 4114

Hospitals

Altnagelvin	028 7134 5171
Gransha	028 7186 0261
Waterside	028 7186 0007

Women's and Children's Directorate

SureStart Shantallow	028 7135 2552
SureStart Creevagh	028 7126 7524
SureStart Edenballymore	028 7137 1670
SureStart Waterside	028 7134 2286
SureStart Limavady	028 7774 2904
SureStart Strabane	028 7138 2658
Parent's Advice Centre	028 7126 6663
Relate	028 7137 1502
Gingerbread	028 7137 7066
N.S.P.C.C. Ireland	028 7131 2187
Childline N.I.	028 9032 7773
Child and Adolescent Mental Health Service	028 7186 5238
Leaving and Aftercare Team	028 7127 1732

Community Midwives

Altnagelvin	028 7134 5171 Ext 3196
Erne - Maternity Ward Ante & Post Natal	028 6638 2493

Health Visitors

Waterside	028 7132 1718	7132 1719
	028 7232 1717	

APPENDIX SIX (Continued)

Health Visitors (Continued)

Great James Street	028 7136 5177
Shantallow	028 7135 1350
Limavady	028 777 61100
Strabane	028 7138 4114

Community Support

Aware Defeat Depression	028 7126 0602
C.A.L.M.S.	028 7126 8698
Koran Centre Strabane	028 7188 6181
Beacon Centre N.I.A.M.H.	028 7126 9677
Derry Well Woman	028 7136 0777
Praxis	028 7130 8020
S.T.E.E.R.	028 7127 9995
National Drugs Helpline	08007 76600
Gingerbread	028 7137 7066

GP Out of Hours Services

Western Urgent Care (Out of Hours GP Service)	08706062288
---	-------------

SOUTHERN SECTOR MENTAL HEALTH SERVICES

Community Health Teams

Belmore House	028 6632 6604
Lissan House	028 8225 2202
Out of Hours	028 8224 5211

Addiction Treatment Services

Addiction Treatment Unit Tyrone & Fermanagh Hospital	028 8283 5443/5365 (Direct Lines)
---	-----------------------------------

Community Addiction Therapists

Community Addiction Teams Tyrone & Fermanagh Hospitals	028 8283 5351/5471 (Direct Lines)
---	-----------------------------------

Community Addiction Teams

Enniskillen	028 6632 5811
-------------	---------------

Community Support

Community Services Dept (Respite Services for Mental Health) Tyrone & Fermanagh Hospital	028 8283 5070
Respite Care Services	028 6632 6361
Northern Ireland Agoraphobis & Anxiety Woman's Aid, Omagh	028 9023 5170
Fermanagh Woman's Network	028 8224 5998
Victim Support Northern Ireland	028 6632 8998
Child & Adolescent Mental Health Service	028 9024 4039
Health Visitors, Fermanagh & Omagh	028 8224 0898
Omagh Health Centre	028 6638 2109
Cruise Bereavement Care	028 8283 5590
Child Bereavement Service	028 8224 4414
The Compassionate Friends, Antrim	028 8225 9139
Aisling Centre	028 9265 2550
Tara Centre	028 6623 5811
Action Mental Health, Enniskillen	028 8225 0024
NIAMH	028 6632 3830
Praxis, Lisnaskea	028 6632 2995
Samaritans, Omagh	028 6772 2778
Heads Together	028 8224 4944
The Nexus Institute, Enniskillen	028 8225 9793
	028 6632 0046

APPENDIX SEVEN

ABBREVIATIONS

CEMACH	Confidential Enquiry into Child and Maternal Health.
CEMD	The Confidential Enquiry into Maternal Deaths.
CMHT	Community Mental Health Team.
EPDS	Edinburgh Postnatal Depression Scale.
GP	General Practitioner
HV	Health Visitor
NICE	National Institute of Clinical Excellence.
NSC	National Screening Committee.
PCLT	Primary Care Liaison Team.
NULIPAROUS	Never been Pregnant
GRAVIDA	Number of Pregnancies
PARITY	Number of Children
UNOCINI	Universal Needs Assessment of Children in Northern Ireland

REFERENCES

1. Antenatal Care - Routine Care for the Healthy Pregnant Woman, Clinical Guideline October 2003, Royal College Obstetricians & Gynaecologists,
2. CPHVA (2002) Postnatal depression and maternal mental health; A public health priority OSBN: 184253 002 x.
3. Cox J. L., Holden J.M., & Sagovsky R (1987). Detection of postnatal depression
4. Domestic violence: a Resource Manual for Health professionals (Department of Health, 2000.)
5. Health for All Children, 4th Edition, David M. B. Hall & David Elliman, Oxford Medical Publications, 2003.
6. Postnatal Care - Routine Postnatal Care of Women and their Babies, July 2006 NCCPC The National Collaborating Centre for Primary Care, University of Leicester, RCOGP
7. Antenatal and postnatal mental health - Clinical management and service guidance, February 2007 National Institute for Health and Clinical Excellence (NICE)
8. NICE Guideline sites: www.nice.org.uk or www.guideline.gov.
9. Postnatal Depression and puerperal psychosis: a National Clinical Guidelines Edinburgh 2002.
10. Children's Perspectives on Domestic Violence: Audrey Mullender, Gill Hague, Umme F Imam, Liz Kelly, Ellen MalosLinda Regan, Sage Publications, 2002
11. Sheelah Seeley, Health Visitor, research Associate, Professor Lynn Murray, Professor Peter Cooper, Winnicott Research Unit, University of Reading. Postnatal Depression - Detection and Management in Primary Care.

