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Nursing & Midwifery  
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**Perinatal Mental Health Care:**  
Best Practice Principles for Midwives, Public Health Nurses and Practice Nurses

# MIND MOTHERS PROJECT



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Tús Áite do  
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## Foreword

It gives us great pleasure to present *“Perinatal Mental Health Care: Best Practice Principles for Midwives, Public Health Nurses and Practice Nurses”*. This work is underpinned by the policy CREATING A BETTER FUTURE TOGETHER: National Maternity Strategy 2016-2026 which is being implemented by the Women and Infants Programme in the Health Service Executive.

Emphasis on the emotional aspects of adjusting to parenthood is important. The national strategy states that *“Women at risk of developing or experiencing emotional or mental health difficulties in the perinatal period should be identified, and a multidisciplinary approach to assessment and support adopted”* (Department of Health 2016:62).

The Office of the Nursing and Midwifery Services Director in partnership with Directors of Midwifery and Public Health Nursing, and the Professional Development Co-ordinators for Practice Nursing commissioned a project to support midwives, practice nurses and public health nurses in relation to their perinatal mental health care.

From this *“Mind Mothers”* research, led by Professor Agnes Higgins, of the School of Nursing and Midwifery, Trinity College Dublin, recommendations in relation to policy, practice, education and research emerged. One such recommendation highlighted the need to develop Best Practice Principles to support staff work.

This document consists of 25 key principles that address collaborative practice, informed decision making, proactive planning, emotional safe care, and multidisciplinary working. As a component of the overall Mind Mothers project, they provide evidence based guidance to underpin the practice of staff when caring for women during the perinatal period. When used in conjunction with the Mind Mothers: An ELearning Programme in Perinatal Mental Health for Midwives, Public Health and Practice Nurses, they will assist nurse/midwife practitioners to assess and develop a plan of care with women in relation to their mental health support requirements, thereby improving the experience and outcomes for women during the perinatal period.

The development of these *“Best Practice Principles for Perinatal mental health care for Midwives, Public Health Nurses and Practice Nurses”* has been influenced by many individuals and we would like to express our appreciation to all involved with their development. Specific appreciation is extended to Professor Agnes Higgins and her team for their partnership working with all stakeholders to successfully complete this work.




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## Table of Contents

<b>Introduction</b>	.....	7
<b>Principle 1:</b>	Women are active participants in decision making around their mental health and their choice of mental health care .....	9
<b>Principle 2:</b>	Education on perinatal mental health is offered to all women and their significant other .....	9
<b>Principle 3:</b>	Women with pre-existing mental health problems are offered preconception advice....	9
<b>Principle 4:</b>	All women are encouraged to develop a mental health wellness plan.....	10
<b>Principle 5:</b>	Women who are taking prescribed medication for mental health issues have information on risks and benefits .....	10
<b>Principle 6:</b>	All women are asked questions about their psychosocial circumstances and about their personal and family mental health history .....	11
<b>Principle 7:</b>	A psychosocial assessment works from a strength based perspective and includes protective factors.....	11
<b>Principle 8:</b>	Screening questions and screening tools are used to support practitioners to identify women experiencing mental health problems.....	12
<b>Principle 9:</b>	Women with pre-existing mental health problems are supported to develop a perinatal mental health care or crisis plan.....	12
<b>Principle 10:</b>	Assessment of a woman’s mental health is an on-going continuous process and requires a pathway of care that reflects the woman’s need .....	13
<b>Principle 11:</b>	Women are referred urgently to specialist services if safety issues are identified.....	13
<b>Principle 12:</b>	Women who require transfer to an approved mental health centre are provided with ongoing information and support .....	13
<b>Principle 13:</b>	Partners or members of a woman’s support network are encouraged to be involved in their care, with the woman’s consent.....	14
<b>Principle 14:</b>	Women’s fears and concerns around accessing support and help are acknowledged and addressed in an on-going and supportive manner .....	14
<b>Principle 15:</b>	Women’s fears and concerns about impact of their mental distress or past history of illness on the foetus/baby are addressed in a supportive manner .....	14



**Principle 16:** Women referred to a specialist mental health service are informed and aware of the referral and the rationale ..... 15

**Principle 17:** Care offered to women is based on the principles of trauma-informed practices ..... 15

**Principle 18:** Women are provided with time to discuss their birth experience..... 15

**Principle 19:** Mental health assessment and plan of care is culturally sensitive and responsive ..... 16

**Principle 20:** Care offered to women is gender sensitive and affirmative of all sexual orientations.. 16

**Principle 21:** Care provided to support women’s mental health is documented ..... 16

**Principle 22:** Multidisciplinary communication and collaboration is central to continuity of care and integrated care..... 17

**Principle 23:** Information shared by women is confidential within the team and only disclosed when required by law or professional guidelines ..... 17

**Principle 24:** Perinatal mental health care occurs in the context of organisational and professional policies and guidelines ..... 17

**Principle 25:** Midwives and nurses pursue ongoing learning and development in perinatal mental health to ensure competent practice ..... 18

**Appendix I:** Steering committee membership ..... 19

**Appendix II:** Mental health wellness plan ..... 20

**Appendix III:** Risk and protective factors ..... 21

**Appendix IV:** Screening questions ..... 22

**Appendix V:** Guide to discussing the EPDS with women ..... 23

**Appendix VI:** Mental health crisis plan ..... 24

**Appendix VII:** Pathways of care ..... 25

**Appendix VIII:** Women’s concerns ..... 28

**References** ..... 29







## Introduction

Over the past decade, Perinatal Mental Health has gained increased attention in policy, medical and nursing literature (Paschetta *et al.* 2014). For most women, pregnancy and motherhood is a positive psychological process; however, for a minority of women this life-changing event can be overshadowed by psychological distress and mental health problems (Howard *et al.* 2014; Jones *et al.* 2014). Providing psychological and mental health support to mothers, children and families in the perinatal period (Pregnancy-1 year postpartum) is considered an important global (Beyond Blue 2008; WHO 2013) and national health issue (Department of Health and Children 2006; Department of Health 2016), as early detection and intervention can improve maternal and infant outcomes. The recently published national maternity strategy states that 'Women at risk of developing or experiencing emotional or mental health difficulties in the perinatal period should be identified, and a multi-disciplinary approach to assessment and support adopted' (Department of Health 2016: 66). In addition, the National Institute for Health Care Excellence (NICE 2014) recommends that a general discussion regarding mental health and well-being take place with all women at the first point of contact in pregnancy and in the early postnatal period, and that questions about mental health and emotional well-being are asked at each encounter. Despite the prevalence of perinatal mental health problems, international evidence suggests that they frequently go unrecognised by maternity and public healthcare practitioners (Crosland and Kai 1998; Stewart and Henshaw 2002; McConnell *et al.* 2005; Brown and Bacigalupo 2006; Ross-Davie *et al.* 2006; Skočir and Hundley 2006; Mivsek *et al.* 2008; Mollart *et al.* 2009; Almond and Lathlean 2011; McCauley *et al.* 2011; Gray *et al.* 2014; Agapidaki *et al.* 2014; Hardy 2014). Midwives, public health nurses and practice nurses, as part of the multidisciplinary healthcare team, are in an ideal position to address mental health and emotional well-being with women in the perinatal period. However, research involving midwives, public health nurses and practice nurses in Ireland indicates considerable variation in perinatal mental health assessment and care, with all three groups identifying lack of knowledge on the range of perinatal mental health problems, lack of skill in opening a discussion and developing a plan of care with women, and organisational issues, such as lack of policies, guidelines and care pathways, as barriers to addressing perinatal mental health issues (Higgins *et al.* 2017).

The aim of this document is to provide an evidence-based guidance document for midwives, public health nurses and practice nurses in the area of perinatal mental health care<sup>1</sup>. The document consists of 25 key principles that should underpin midwifery and nursing practice. The principles span the continuum of care, from preconception to the postnatal period and address the following dimensions of practice

- collaborative practice
- informed decision making
- proactive planning
- emotional safe care and
- multidisciplinary working (Figure 1).

<sup>1</sup> Some of the principles may have greater relevance and application depending on your area of work.





**Figure 1: Dimensions of practice and principles of perinatal mental health care<sup>2</sup>**

Collaborative practice	Informed decision making	Proactive planning	Emotional safe care	Multidisciplinary
Women are active participants in decision making around their mental health and their choice of mental health care (P.1)	Education on perinatal mental health is offered to all women and their significant other (P.2)	All women are encouraged to develop a mental health wellness plan (P.4)	A psychosocial assessment works from a strength based perspective and includes protective factors (P.7)	Women are referred urgently to specialist services if safety issues are identified (P.11)
Partners or members of a woman's support network are encouraged to be involved in their care, with the woman's consent (P.13)	Women with pre-existing mental health problems are offered preconception advice (P.3)	All women are asked questions about their psychosocial circumstances and about their personal and family mental health history (P.6)	Women's fears and concerns about impact of their mental distress or past history of illness on the foetus/baby are addressed in a supportive manner (P.14)	Women who require transfer to an approved mental health centre are provided with ongoing information and support (P.12)
	Women who are taking prescribed medication for mental health issues have information on risks and benefits (P.5)	Screening questions and screening tools are used to support practitioners to identify women experiencing mental health problems (P.8)	Women's fears and concerns around accessing support and help are acknowledged and addressed in an on-going and supportive manner (P.15)	Care provided to support women's mental health is documented (P.21)
	Women referred to a specialist mental health service are informed and aware of the referral and the rationale (P.16)	Women with pre-existing mental health problems are supported to develop a perinatal mental health care or crisis plan (P.9)	Care offered to women is based on the principles of trauma informed practices (P.17)	Multidisciplinary communication and collaboration is central to continuity of care and integrated care (P.22)
	Perinatal mental health care occurs in the context of organisational and professional policies and guidelines (P.24)	Assessment of a woman's mental health is an on-going continuous process and requires a pathway of care that reflects the woman's need (P.10)	Women are provided with time to discuss their birth experience (P.18)	Information shared by women is confidential within the team and only disclosed when required by law or professional guidelines (P.23)
	Midwives and nurses pursue ongoing learning and development in perinatal mental health to ensure competent practice (P.25)		Mental health assessment and plan of care is culturally sensitive and responsive (P.19)	
			Care offered to women is gender sensitive and affirmative of all sexual orientations (P.20)	

<sup>2</sup> Each principle is numbered in line with the numbering in the body of the document.

### **Principle 1: Women are active participants in decision making around their mental health and their choice of mental health care**

Women should be supported to make informed choices and decisions about their mental health and their mental health care (Department of Health 2016). The decision a woman makes about whether or not to disclose information about her mental health or accept mental health supports or interventions if required, can be influenced by her perception of the problem, her concerns, fears, beliefs and preferences regarding care, her willingness or capacity to engage with services and the availability of an appropriate health provider or practitioner (Boots Family Trust Alliance 2013). Most women, if provided with information and support, will discuss their psychological wellbeing and seek help; however, some women may decline to answer questions related to their mental health and/or make an informed choice not to avail of mental health support and/or services and these decisions need to be respected unless risk issues have been identified.

### **Principle 2: Education on perinatal mental health is offered to all women and their significant other**

Many women that develop perinatal mental health problems report that they did not receive information about the range of mental health problems that could arise in the perinatal period (Boots Family Trust Alliance 2013; Higgins *et al.* 2016). Research indicates that perinatal mental health education offered to women and their significant others varies between services in Ireland and that information about perinatal mental health problems is often limited to postnatal depression (Higgins *et al.* 2017). The provision of comprehensive evidence-based verbal and written information about the range of perinatal mental health problems is essential to assist women to prioritise their mental health during pregnancy and in the postnatal period. Information will enable the woman to recognise when her mental health is compromised beyond what one would expect in the normal course of pregnancy or early motherhood. Having information available about mental health, including information about services and supports available, enables women and their partner/significant other to access supports in a timely manner.

### **Principle 3: Women with pre-existing mental health problems are offered preconception advice**

Women with pre-existing mental health problems or those concerned about familial mental health problems should be offered the opportunity to engage in a pre-conception discussion about their mental health, so that they are informed about how pregnancy and early motherhood may impact on their mental health and how their mental health might impact on their experience of pregnancy and motherhood (Centre for Maternal and Child Enquiries (CMACE) 2011; National Institute for Health and Care Excellence (NICE) 2014). A dialogue about how mental health problems and associated treatments may affect the foetus/infant will be a critical aspect of this discussion. While midwives, public health nurses and practice nurses may not have the knowledge or skill to answer all the questions a woman may have, they should advise her to have a pre-conception discussion with her GP or mental health practitioner.



**Principle 4: All women are encouraged to develop a mental health wellness plan**

Midwives, public health nurses and practice nurses have a role in promoting positive mental health for all women throughout the perinatal period. It is important that women are supported to develop a wellness plan that best reflects their individual psychological and mental health needs (Boots Family Trust Alliance 2013). The wellness plan will include strategies that the woman has previously found helpful to manage her stress, and may also include: optimal diet and exercise planning; peer/family/partner support; strategies to obtain blocks of uninterrupted sleep; and strategies to reduce stress such as mindfulness or relaxation (Appendix II). For women with pre-existing mental health problems additional support from maternity and primary care providers is vital to minimise the potential impact of mental health problems and to address challenges, such as problems with self-care or infant care (Elliott *et al.* 2007; Gray *et al.* 2014; Glasser *et al.* 2016); thus, interventions such as regular appointments with the mental health care provider or taking prescribed medication (Sterling *et al.* 2010) may also form part of the wellness plan. Midwives, public health nurses and practice nurses should enquire if a woman has a mental health wellness plan, and if not, support her to develop one.

**Principle 5: Women who are taking prescribed medication for mental health issues have information on risks and benefits**

A woman taking psychotropic medication for mental health problems that existed prior to pregnancy or for a new mental health problem in the perinatal period is likely to have concerns regarding their use in pregnancy and breastfeeding. Whilst there are various risks to the woman, foetus and baby associated with the on-going use of psychotropic medication, there are also risks associated with untreated maternal mental health problems; therefore, it should not be assumed that discontinuing or avoiding psychotropic medication is the best course of action (NICE 2014; Taylor *et al.* 2015). To assist a woman make an informed decision about medication use, accurate, balanced and evidence-based information needs to be provided about the potential risks and benefits to the woman, foetus or baby of: i) pharmacological treatment; ii) stopping, changing or continuing medication; iii) untreated mental health problems; iv) the potential severity of relapse if pharmacological treatment is discontinued; and v) alternative treatment options (NICE 2014). The options provided to a woman will be influenced by the nature and seriousness of the problem, the potential risks associated with an ongoing mental health problem and the woman's own preference. Midwives, public health nurses and practice nurses should enquire if a woman has received information on risks and benefits, and if not, support her to access this information from her GP or mental health practitioner.



**Principle 6: All women are asked questions about their psychosocial circumstances and about their personal and family mental health history**

A number of psychosocial risk factors (Appendix III) have been identified as increasing the likelihood of women experiencing mental health problems and all health professionals caring for women need to be able to identify those most at risk (NICE 2014; Department of Health 2016). There is evidence to suggest that a woman who has a history of mental health problems prior to conception has a higher risk of developing perinatal mental health problems, particularly when combined with other risk factors (Scottish Intercollegiate Guidelines Network (SIGN) 2012; NICE 2014). Women with a previous history of depression or anxiety, as well as those that develop symptoms during pregnancy, are at higher risk of postpartum depression or anxiety than those with no history (Giardinelli *et al.* 2012; Howard *et al.* 2014). Women with a diagnosis of psychotic disorders, bipolar disorder or those that have previously experienced a postpartum psychosis are at risk of developing early postpartum symptoms (Jones *et al.* 2014). This risk increases for women with a history of mental health or perinatal mental health problems in the immediate biological family (SIGN 2012). Women experiencing multiple risk factors may be more vulnerable to developing perinatal mental health problems (Austin *et al.* 2011); therefore, midwives, public health nurses and practice nurses need to engage in a discussion with the woman about her psychosocial circumstances and her personal and family history of mental health problems, in order to be proactive about offering, organising or providing support, if required (Appendix IV for examples of screening questions). When engaging in conversations about mental health a supportive space needs to be provided. The midwife, public health nurse and practice nurse should reassure the woman that asking about mental health is part of routine care with all women.

**Principle 7: A psychosocial assessment works from a strength based perspective and includes protective factors**

It is well recognised that working with individual strengths and coping capacity promotes resilience (Haddadi & Besharat 2010; Rapp & Goscha 2012). Identifying a woman's personal, environmental and supportive protective factors and exploring how she can use or build on these to promote her mental health during pregnancy and in the postnatal period is an integral part of perinatal mental health promotion (Appendix III for a list of the risk and protective factors). The maternity strategy advocates that '*women, partners and families should be supported [to become] empowered to make positive lifestyle choices before, during and after pregnancy to promote a healthier future for baby and family*' (Department of Health 2016: 83).



### Principle 8: Screening questions and screening tools are used to support practitioners to identify women experiencing mental health problems

The identification of women with mental health problems in the perinatal period can be improved by the use of screening questions (Bosanquet *et al.* 2015) and screening tools (Austin *et al.* 2011). NICE (2014) recommends asking all women the Whooley questions (Whooley *et al.* 1997) and questions about anxiety in order to identify a woman that may be experiencing symptoms of depression and anxiety (Appendix IV for NICE (2014) recommended screening questions). If a woman responds positively to these screening questions a more extensive conversation about the woman's mental health is recommended to see if she wants or needs help with the difficulties identified (NICE 2014).

Tools such as the Edinburgh Postnatal Depression Scale (EPDS) (Cox *et al.* 1987) can also be used with pregnant and postpartum women. Although the Edinburgh Postnatal Depression Scale (EPDS) was developed to improve detection rates of postnatal depression, its use has been extended to antenatal care to identify women that may be depressed. Although not validated for screening for anxiety, a woman's response to the 3 anxiety-related questions, when combined with clinical judgement, can be sensitive to detecting symptoms of anxiety (Austin *et al.* 2011) (Appendix V for guidance on possible responses to the EPDS scores).

To help reduce a woman's fears and anxieties around disclosure, it is important to explain that the reason you are using screening questions and tools is to help identify if she could benefit from additional support or specialist assessment or intervention. While screening questions and tools are helpful, they should never be used in isolation. The context of any positive responses to questions should be clarified in discussion with the woman to inform clinical judgement.

### Principle 9: Women with pre-existing mental health problems are supported to develop a perinatal mental health care or crisis plan

It is important for a woman with pre-existing mental health problems to have a perinatal mental health care plan that describes her preferences concerning mental health treatment in a situation where her mental health deteriorates (SIGN 2012). The care plan or crisis plan<sup>3</sup> developed in collaboration and consultation with the individual woman and those involved in her care prior to delivery, facilitates the sharing of key information between all and enables the woman's preferences to be known and considered (Jankovic *et al.* 2010). It also supports the woman to be empowered to make choices about her mental health and discuss any concerns with those close to her or involved in her care. The care plan should address early warning signs of deterioration in mental health, the woman's preference for treatment and the role of personal and professional supports (Appendix VI for more details). Midwives, public health nurses and practice nurses should enquire if a woman has a mental health care plan, and be aware of the information within the plan. If a woman doesn't have a crisis plan, then she should be supported to access the support required to develop a plan, if she wishes.

<sup>3</sup> Crisis plan is sometimes called an anticipatory care plan.



### **Principle 10: Assessment of a woman's mental health is an on-going continuous process and requires a pathway of care that reflects the woman's need**

A woman's mental health, psychosocial circumstances and risk to self/baby can fluctuate over the course of the perinatal period, therefore a dialogue with a woman about her mental wellbeing should be an ongoing process rather than a once-off event (Higgins *et al.* 2015). Assessment of psychosocial and mental health risk factors together with the woman's mental wellbeing is critical to the safety of women and their infants (CMACE 2011) and these should be assessed at every maternity and primary health care encounter so that support offered matches women's fluctuating needs. Practitioner and service responses and interventions will vary according to the outcome of the assessment and the level of risk identified. Therefore, an integrated care pathway needs to be in place to ensure a woman receives the specialist support required (SIGN 2012). Pathways of care may be service specific, so it is important to follow organisational policies, protocols or guidelines (Appendix VII for information on support and pathways of care).

### **Principle 11: Women are referred urgently to specialist services if safety issues are identified**

An urgent specialist mental health assessment or emergency psychiatric care may be required for a minority of women in situations where risk to the woman, baby or others has been identified or where the woman's capacity to make decisions is compromised by her mental health (Jones *et al.* 2014). Child protection services may also need to be involved to assess issues of child safety and welfare. In these situations, it is good practice to inform the woman and her partner/significant other, if appropriate that you are concerned, that you are organising a referral (through the relevant pathway) and the reasons for your decision. In situations of risk, consent is not required; however, the woman should receive support from the midwife or nurse present until a clear response plan is identified and in-situ to ensure the safety of all concerned.

### **Principle 12: Women who require transfer to an approved mental health centre are provided with ongoing information and support**

For a small minority of women, admission to an approved in-patient mental health service may be indicated and women may be admitted voluntary or as an involuntary patient under the Mental Health Act 2001. Irrespective of the type of admission, or whether the woman is admitted from home or from a maternity service, it is critical that the woman's best interests is considered and discussed with her, and her significant other where appropriate, and that the woman's individual legal and human rights are protected. Admission is a stressful, fearful and traumatic time for both the woman and her family, and they will require emotional and practical support from all involved in their care (Higgins 2012). The woman and her family may also be concerned about the consequences of the admission on the mother-baby relationship and the impact on other children, and may require assistance to explain mental health issues in an age appropriate way to children. In addition, the woman and her family may have questions around the process of referral and admission that need to be addressed. Midwives, public health nurses and practice nurses should enquire if family members have questions and support them to access the relevant information.



**Principle 13: Partners or members of a woman's support network are encouraged to be involved in their care, with the woman's consent**

A woman's wellbeing and resilience is influenced by the availability of practical and emotional support from a partner, family member and/or significant others (Milgrom *et al.* 2008). Support from a partner or significant other is particularly important in the early stages of motherhood. Women, regardless of whether or not they have pre-existing mental health problems, should be asked about their support network and whom they would like to be involved in their care. Providing support and education to the woman's partner or significant other in a collaborative manner is essential for a good outcome (Higgins 2012; Stein *et al.* 2014; Beestin *et al.* 2014), as they may be the first person to notice a change in a woman's mental health, or may be the person who accesses help and support if required (Boots Family Trust Alliance 2013). Without information, partners or family members may misinterpret mental health problems as a normal stress or adjustment response to pregnancy or motherhood, and therefore may not recognise the need for additional support or assistance (Letourneau *et al.* 2013; Boots Family Trust Alliance 2013).

**Principle 14: Women's fears and concerns around accessing support and help are acknowledged and addressed in an on-going and supportive manner**

Women who experience mental health problems are often concerned about the consequences of disclosing their mental health issue, seeking help or discussing their experiences (Begley *et al.* 2010; Higgins *et al.* 2016). These concerns are often related to the potential impact or consequences of mental health interventions such as medication or hospitalisation. A woman may also worry that her mothering capacity will be questioned or challenged and that she could lose custody of her baby. Midwives, public health nurses and practice nurses involved in a woman's perinatal care need to acknowledge and address her fears (Appendix VIII) in order to assist her to access the support she requires. They also need to recognise and affirm the woman's mothering role and capabilities to build her confidence to deal with the challenges she may face (Aston *et al.* 2015).

**Principle 15: Women's fears and concerns about impact of their mental distress or past history of illness on the foetus/baby are addressed in a supportive manner**

Some women with mental health problems express fears about the hereditary nature of mental health problems or are concerned that their mental health problem would adversely affect the foetus, child or children (Viguera *et al.* 2002; Stein *et al.* 2014). Many women accessing maternity and primary care will not however have had the opportunity to discuss their fears, therefore it is important that midwives, public health nurses and practice nurses respond in a sensitive and supportive manner to a woman's concerns about the risks to her foetus/baby and offer her an opportunity to discuss these with a mental health specialist.





### **Principle 16: Women referred to a specialist mental health service are informed and aware of the referral and the rationale**

Specialist mental health services may be required for a small percentage of women. Any proposed new referral needs to be discussed with the woman and her partner or supportive other, if appropriate. To assist a woman in decision making she needs to know how a specialist mental health assessment or intervention might benefit her and what process to expect following referral. She also needs to be informed about the rationale for any recommended referral (Nursing and Midwifery Board of Ireland 2015).

### **Principle 17: Care offered to women is based on the principles of trauma-informed practices**

Many women who are pregnant have been exposed to traumatic events in their lives and the onus is on service providers to deliver trauma-informed care. Services that are trauma-informed understand that trauma can affect everyone and care is provided in a way that prioritises safety, choice, decision-making and control (Markoff *et al.* 2005). A woman who has experienced emotional, sexual or physical trauma may feel unsafe, which can be exacerbated by the care she receives, such as physical examinations or specific pregnancy, childbirth and postpartum trauma. Trauma-informed care promotes a culture where the woman feels comfortable to express her feelings and concerns without judgement, where information is provided in a way that she has a clear understanding about what to expect throughout the perinatal period and where her choices and decisions about her and her baby's health and wellbeing are respected (British Columbia (BC) Provincial Mental Health and Substance Use Planning Council 2013). In situations of unexpected medical intervention, midwives, public health nurses and practice nurses should communicate clearly and work collaboratively with the woman to promote a sense of personal control. As responses to trauma vary among individuals, each woman needs to be responded to sensitively and respectfully, even when the health care team does not perceive the trigger or event as traumatic (Zauderer 2014). All women who have experienced an unexpected medical intervention should be provided with the opportunity to discuss how the situation developed, why decisions were made and why specific actions were taken.

### **Principle 18: Women are provided with time to discuss their birth experience**

All women should be provided with the opportunity to discuss their birth experience and have their questions or concerns about the birth addressed. Women that perceive their labour as traumatic may be at risk of developing post-traumatic stress disorder (PTSD) or other mental health problems (Zauderer 2014). Multiple pre-pregnancy vulnerabilities, childbirth experiences and postpartum factors have been implicated in increasing the risk of PTSD (Andersen *et al.* 2012). Women have highlighted emotional support, validation and information as a significant mediating factors in minimising their distress (Borg *et al.* 2014; Grekin & O'Hara 2014; Ayers *et al.* 2016); therefore it is important that a woman's subjective experiences of childbirth is listened to by midwives, public health nurses and practice nurses.



**Principle 19: Mental health assessment and plan of care is culturally sensitive and responsive**

There are many factors to be considered when working with women from culturally diverse backgrounds. Globally there are a variety of models and theories used to describe and explain mental health and illness, which are socially and culturally located (Mental Health Reform 2016). In addition, mothering expectations and practices may also differ from culture to culture. The onus is on the midwife and nurse to understand how a woman makes sense of mental health problems, and how her social and cultural context may impact on her willingness to discuss mental health issues. Midwives, public health nurses and practice nurses need to have the opportunity to become aware of cultural differences and nuances around mental health, they need to respect a woman's beliefs and values, and offer information, supports and services that are culturally acceptable (Mental Health Reform 2016). In addition, mental health information needs to be made available in different languages and formalised interpretative services used as required (HSE 2009).

**Principle 20: Care offered to women is gender sensitive and affirmative of all sexual orientations**

Person-centred and gender sensitive services and practitioners understand the uniqueness of each woman's intimate relationships, values and world views, and create a culture that is inclusive of women of all gender identities and sexual orientations. Despite the increased acceptance and visibility of Lesbian, Gay, Bisexual and Transgender (LGBT) families, services and health care practitioners may not be LGBT affirmative or may be insensitive to the needs of all women and their families (Russell *et al.* 2012). LGBT families may experience many forms of exclusion and discrimination in health care services because of heterosexual normative assumptions and cultures that do not support diversity. Midwives, public health nurses and practice nurses need to be supported to challenge any discriminatory practices and provide information and care that is inclusive of all gender identities and sexual orientations.

**Principle 21: Care provided to support women's mental health is documented**

Documenting information about a woman's mental health history, mental wellbeing and her plan of care, as well as decisions reached in collaboration with her and her significant other, is important for communication and continuity of care (Higgins *et al.* 2015). The decision to refer a woman to other healthcare professionals or services and the outcome of the referral also needs to be documented in her health care record (Nursing and Midwifery Board of Ireland 2015). Each woman has a right to have a copy of her care plan, including her mental health care plan. In the event of a mental health crisis, documentation helps to provide clarity about interventions that were effective or non-effective for the woman prior to the crisis. It is also part of professional accountability and, in the event of a review process or adverse outcome, documentation provides information on actions and interventions to-date.



### **Principle 22: Multidisciplinary communication and collaboration is central to continuity of care and integrated care**

Inter-disciplinary and inter-agency communication and collaboration across all care settings is critical to individualised, integrated care planning and continuity of care. Midwives, public health nurses and practice nurses should work collaboratively with the woman, the woman's GP and specialist services such as mental health services, drug and alcohol services, social work services, child protection services and domestic abuse services where relevant, to ensure that adequate support is offered to address the woman's needs (Department of Health 2016). The woman, her partner and the professionals involved in the care plan need to understand the role, responsibility and the response capacity of the agencies or disciplines involved. Midwives, public health nurses and practice nurses need to communicate in a timely manner with the lead agency responsible for coordinating, monitoring and reviewing the woman's plan of care in the perinatal period. In some circumstances when the baby and the mother require separate specialist care, there may be a need for two lead professionals or agencies (Department of Health 2016).

### **Principle 23: Information shared by women is confidential within the team and only disclosed when required by law or professional guidelines**

Information shared by a woman should, in most circumstances, be kept confidential within the multidisciplinary team (MDT). Midwives, public health nurses and practice nurses are legally obliged to ensure that personal information is not disclosed to people outside the MDT involved in the woman's care without the woman's consent (Nursing and Midwifery Board of Ireland 2014). It is recognised, however, that in some situations disclosure of information may be legally or ethically required, for instance in child welfare and protection circumstances or in the interest of the woman's or other's safety. In these instances it is considered best practice to inform the woman that information is going to be shared and explain the rationale for your decision. The level of disclosure should be limited to the information required to communicate the perceived threat to personal or public safety (Higgins *et al.* 2015).

### **Principle 24: Perinatal mental health care occurs in the context of organisational and professional policies and guidelines**

Midwifery and nursing practice is governed and regulated by legislation and professional codes of practice. In addition, practice is guided by evidence that is expressed in international, national and organisational policies and guidelines. Whilst organisational/professional leadership and commitment is required to ensure quality care at a local and national level (Department of Health 2016), individual midwives, public health nurses and practice nurses have a responsibility to be knowledgeable about, and work in line with, professional and governance codes, policies and guidelines in relation to perinatal mental health care.



**Principle 25: Midwives and nurses pursue ongoing learning and development in perinatal mental health to ensure competent practice**

Research indicates that education in perinatal mental health increases practitioners' competence and confidence to open a discussion with women about their mental health, identify their unique needs and facilitate the provision of mental health support and education (Higgins *et al.* 2017). While services have a responsibility to provide structures and learning opportunities to support women-centred practice, all midwives, public health nurses and practice nurses need to engage in ongoing learning and development in the area of perinatal mental health and the nuances around cultural interpretations of mental health to maintain competence and ensure that they are working within their scope of practice (Department of Health 2016). It is also important for midwives, public health nurses and practice nurses to have the opportunity to recognise their limitations in working with women experiencing mental health problems and refer appropriately to specialist or other services as required.



## Appendix I: Steering committee membership

<b>Anne Brennan</b>	Interim Director, Nursing & Midwifery Planning and Development, HSE Dublin North (Joined 2017)
<b>Mary Brosnan</b>	Director of Midwifery and Nursing, National Maternity Hospital
<b>Susanna Byrne</b>	Director, Nursing & Midwifery Planning and Development, Dublin South, Kildare and Wicklow
<b>Margaret Carroll</b>	Associate Professor of Midwifery, School of Nursing and Midwifery, Trinity College Dublin
<b>Triona Cowman</b>	Director of the Centre of Midwifery Education (CME), Coombe Women's and Infant's University Hospital
<b>Eithne Cusack</b>	Former Interim Area Director, Nursing & Midwifery Planning & Development, HSE Dublin North East (Until July 2016)
<b>Emma Fleming</b>	NMPD Officer, Nursing & Midwifery Planning and Development, HSE Dublin North (Joined 2016)
<b>Ailish Gill</b>	E-learning project worker, School of Nursing and Midwifery, Trinity College Dublin
<b>Prof. Agnes Higgins</b>	Professor in Mental Health, School of Nursing and Midwifery, Trinity College Dublin
<b>Patricia Hughes</b>	Former Director of Midwifery and Nursing, Coombe Women's and Infant's University Hospital (Until Oct 2016)
<b>Rita Lawlor</b>	Professional Development Coordinator for Practice Nurses, HSE Dublin Mid-Leinster
<b>James Lynch</b>	Former Interim Director, Nursing & Midwifery Planning and Development, HSE Dublin North – Chair until February 2017
<b>Anne MacIntyre</b>	Director of Midwifery and Nursing, Coombe Women's and Infant's University Hospital (Joined 2016)
<b>Deirdre Madden</b>	Registered Advanced Nurse Practitioner Perinatal Mental Health, National Maternity Hospital (Joined 2016)
<b>Dr. Mark Monahan</b>	Assistant Professor Mental Health Nursing, School of Nursing and Midwifery, Trinity College Dublin
<b>Margaret Philbin</b>	Director of Midwifery and Nursing, Rotunda Hospital
<b>Virginia Pye</b>	National Lead for Public Health Nursing/Office of the Nursing and Midwifery Services Director (ONMSD)/Clinical Strategy and Programmes Division, HSE
<b>Liz Roche</b>	Area Director, Nursing and Midwifery Planning and Development, Dublin Mid-Leinster (Chair from Feb. 2017)
<b>Prof. John Sheehan</b>	UCD Associate Clinical Professor, UCD School of Medicine, Consultant in Perinatal Psychiatry, Rotunda hospital
<b>Sheila Sugrue</b>	National Lead Midwife, Office of the Nursing & Midwifery Services Director, HSE



## Appendix II: Mental health wellness plan

The focus of a wellness plan is on the strategies that the woman uses or could use to help maintain her mental health and wellbeing. It may also identify ways that people in her support network can provide emotional and practical support.

Examples of strategies that may be included in a mental wellness plan include:

- Plan for uninterrupted periods of sleep, especially in postnatal period
- Healthy eating
- Physical exercise that is safe in pregnancy and in the early postnatal period
- Time for interests, hobbies, meeting supportive friends/family
- Stress reduction strategies such as relaxation, meditation, yoga
- Reduction or avoidance of stimulants such as caffeine or alcohol

For a woman with prior mental health problems, the mental health wellness plan might also include:

- Treatment plan:
  - Enhanced Mental Health support
  - Therapeutic interventions e.g. Cognitive Behaviour Therapy, Counselling
  - Peer support/peer support groups
  - Psychotropic medication
    - Plan to stop, change or continue taking psychotropic medication during pregnancy/post delivery
    - Infant feeding plan especially if psychotropic medication recommended is contraindicated or incompatible with breastfeeding
- Maternity/Primary Health Service Support:
  - Longer stay in hospital post birth
  - Single room, if available
  - Partner or member of support network allowed to stay outside of normal visiting hours or stay overnight with the woman
  - Enhanced Public Health Nurse follow up



## Appendix III: Risk and protective factors

Risk factors	Protective Factors
<ul style="list-style-type: none"> <li>Personal past or current mental health problems</li> <li>Family history of mental health problems</li> </ul>	<ul style="list-style-type: none"> <li>Robust mental health</li> <li>No history of family mental health problems</li> </ul>
<ul style="list-style-type: none"> <li>Perceived poor partner support</li> <li>Living apart or estranged from extended family and support networks</li> </ul>	<ul style="list-style-type: none"> <li>Positive and supportive intimate partner relationship</li> <li>Available, supportive family/friends and willing/able to access support required</li> <li>Involved with others socially</li> <li>Has interests and activities</li> </ul>
<ul style="list-style-type: none"> <li>Childhood or current sexual, emotional or physical abuse or intimate partner violence</li> </ul>	<ul style="list-style-type: none"> <li>No history of childhood or current abuse</li> <li>Secure attachment with own mother</li> </ul>
<ul style="list-style-type: none"> <li>Prescribed and illicit drug use or alcohol misuse</li> </ul>	<ul style="list-style-type: none"> <li>Healthy lifestyle</li> </ul>
<ul style="list-style-type: none"> <li>Stressful or traumatic pregnancy or birth experience such as problems conceiving, unintended pregnancy, pregnancy loss, pregnancy/birth complications</li> </ul>	<ul style="list-style-type: none"> <li>Planned/wanted pregnancy</li> <li>Positive pregnancy and labour experience</li> </ul>
<ul style="list-style-type: none"> <li>Mothering related stressful events</li> <li>Unsettled infants</li> <li>Difficulty feeding infant</li> <li>Insufficient rest, sleep, diet</li> </ul>	<ul style="list-style-type: none"> <li>Adjusts well and is confident in mothering role</li> <li>Settled infants</li> <li>Obtains adequate rest, sleep and diet</li> </ul>
<ul style="list-style-type: none"> <li>Poor access to mental health or other specialist supports and services</li> <li>Negative view or experience of mental health services</li> </ul>	<ul style="list-style-type: none"> <li>Availability of diverse and flexible mental health and other specialist supports and services</li> <li>Previous positive experiences of engaging with services</li> </ul>
<ul style="list-style-type: none"> <li>Stressful life events - socio-economic disadvantage or hardship, financial problems, poor health, bereavement or relationship breakdown</li> </ul>	<ul style="list-style-type: none"> <li>Stable accommodation</li> <li>Financial security</li> <li>Good health</li> <li>Secure, positive relationships</li> </ul>
<ul style="list-style-type: none"> <li>Poor coping skills</li> <li>Afraid to discuss emotions/feelings</li> <li>Reluctant to seek help</li> <li>Pessimistic, poor self-esteem, perfectionistic or controlling traits</li> <li>Finds communication difficult</li> </ul>	<ul style="list-style-type: none"> <li>Adaptive coping mechanisms</li> <li>Open about emotions and feeling</li> <li>Capacity and willingness to seek help</li> <li>Optimistic, good self-esteem and sense of personal control</li> <li>Good communication and assertiveness skills</li> <li>Previous positive experience of managing stress or crisis</li> </ul>

(Milgrom *et al.* 2008; Haddadi & Besharat 2010; Austin *et al.* 2011; SIGN 2012; Giardinelli *et al.* 2012)



## Appendix IV: Screening questions

### Opening a discussion about mental health

- “There are a number of things I would like to discuss with you today about your physical health, your relationships and lifestyle and your emotional or mental health if that is ok?”
- “.....I would now like to ask you some questions about your mental health. We ask women these questions as it is common for women to experience mood changes during pregnancy and in the early post-natal period and we would like to support you if you find that you are affected by mood changes or any other mental health issues.”

### Questions on past personal and family mental health history

- Have you ever experienced low mood, anxiety, or other mental health problems?
- In previous pregnancies did you experience any changes in mood or behaviour during pregnancy or after the birth?
- What helped you during those times?
- Did you seek help from a health professional?
- Has anyone in your immediate biological family ever experienced a mental health problem?

### Questions on coping

- How do you normally cope with stressful situations in your life?
- What strategies do you find helpful/unhelpful?
- What things are you doing now to help maintain wellbeing?
- How are you coping with pregnancy/motherhood?
- Are there things you’re doing now that you are finding helpful?

### Questions on supports

- Who is around to support you at the moment?
- Are you currently in an intimate relationship?
- How is your relationship with your partner?
- How is your partner adjusting to the pregnancy/being a parent?

### Questions on anxiety

- Are there times when you feel worried or anxious?
- How long has the worry been a problem?
- Can you control the worry?
- Do you find yourself bothered by other symptoms, such as muscle pain?
- Do you experience any unpleasant thoughts or images that repeatedly enter your mind?
- Do you ever worry about terrible things happening?
- How often do you experience these thoughts or images?

### Questions on elevated mood

- Are there any times in the past when you have felt that you have increased energy?
- Are there any times in the past when you have felt more self-confident than usual?
- Are there any times in the past when you have felt that your thoughts were racing?

### NICE (2014) Recommended Screening Questions

- 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?
- During the past month, have you been feeling nervous, anxious or on edge?
- During the past month have you not been able to stop or control worrying?

### Help available:

- Is this something you feel you need or want help with?
- Who is around to support you right now?
- Are you aware that there is a mental health service/ sexual assault counsellor/refuge service available to assist you?





## Appendix V: Guide to discussing the EPDS with women

While it is important that you follow your organisational policies or guidelines when using the EPDS with women, it is good practice to discuss the questions with a woman when she has completed the EPDS form, regardless of the score. The responses below provide some suggestions about how to respond to women as well as recommended actions or care pathways.

Score	What you might say	Further action
Less than 10	<ul style="list-style-type: none"> <li>You seem to be coping well, would you agree?</li> <li>If this changes at any time I am happy to discuss this with you and put you in touch with any supports that you may need.</li> </ul>	<ul style="list-style-type: none"> <li>Care as usual</li> <li>EPDS at least once in pregnancy and in the early postnatal period</li> </ul>
Score of 10, 11 or 12	<ul style="list-style-type: none"> <li>I can see that some aspects of your life right now are not going as well as you would like. I know that (whatever problems the woman identified) is causing you some stress at the moment and you have told me that you have good/little support from your partner/friends/family right now.</li> <li>I would like to check in with you again in 2 weeks to see how things are going. Is that ok? It would be good if we could explore these questions again then.</li> </ul>	<ul style="list-style-type: none"> <li>Depending on clinical judgement repeat EPDS in 2-4 weeks</li> </ul>
Score of 13-15 or more	<ul style="list-style-type: none"> <li>I can see from your responses and from what you have been telling me that you are not feeling the way you would like to at the moment.</li> </ul> <p><b>Or</b></p> <ul style="list-style-type: none"> <li>I can see from your responses and from what you have been telling me the way you are feeling at the moment is getting in the way of you enjoying your pregnancy/baby.</li> <li>A lot of women that I see with similar experiences have benefitted from professional help. I would like to make a referral for you to have a mental health assessment so you can have the help and support you may need.</li> </ul>	<ul style="list-style-type: none"> <li>Depending on clinical judgement refer to the relevant person (GP, Consultant obstetrician) who will arrange for a mental health assessment</li> </ul>
Score greater than 0 on Question 10	<ul style="list-style-type: none"> <li>I see from your answer to the last question here that the thought of harming yourself has occurred to you; can you tell me a bit more about that?</li> <li>What exactly have you been thinking?</li> <li>How often do you have these thoughts?</li> <li>Can I check with you if you have had any thought of harming your baby?</li> <li>I am going to organise an appointment for you to be seen by a mental health professional so we can support you to keep you/your baby safe.</li> </ul>	<ul style="list-style-type: none"> <li>Assess safety of woman, baby and other children in the woman's care and refer to the relevant person (GP, Consultant obstetrician) who will arrange for mental health and/or child protection services to become involved based on clinical judgement</li> </ul>

(Informed by Austin *et al.* 2011)



## Appendix VI: Mental health crisis plan

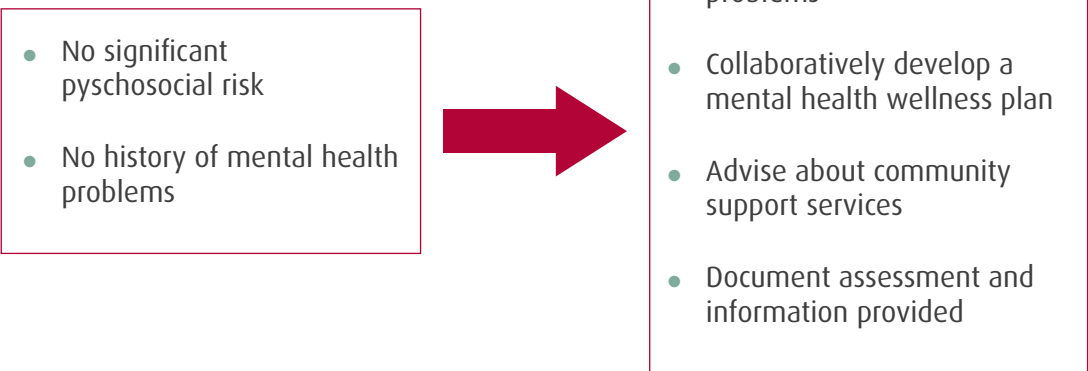
The following are some examples of the content that might be included in a mental health crisis or anticipatory care plan:

- Description of early warning signs of distress or crisis (what the woman may notice/ what others may notice)
- The woman's preferred method of support and de-escalation of the crisis (what has worked in the past/what has not worked in the past)
- Mental health care and treatments the woman would like to be provided and by who
- Mental health treatments the woman would like to avoid or decline and reasons why
- Details of trusted person to communicate with on the woman's behalf, if required
- Information on the woman's previous experience with medication, including preferred medication and any side effects experienced
- The role of any personal supports (e.g. partner, family, friends, peers/support group)
- The role and response capacity of professional supports
- The woman's preferred place of treatment or service
- Plan for the baby if the woman's mental health is compromised to the extent that she cannot look after the baby
- Who to call/who the woman doesn't want to be contacted if there is need for admission to hospital



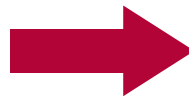
# Appendix VII: Pathways of care

## No Risk: Supported mental health care pathway



## Significant Risk: Assisted mental health care pathway

- Personal past history of mental health problems (anxiety or depression)
- First-degree relative history of bipolar disorder or psychotic disorders or perinatal mental health problems
- Multiple psychosocial risks

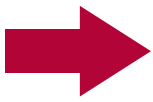


- Discuss psychosocial risks and provide information about services that can assist e.g. social work, drug alcohol services and refuge services
- Provide information about potential risks of the woman developing perinatal mental health problems
- Recommend to the woman that she avail of additional mental health support e.g. perinatal mental health service, if available; counselling in primary care
- Collaboratively develop a mental health wellness plan with the woman
- Involve partner or significant other in care with the woman's consent
- Liaise with GP and other professionals involved in the woman's care with the woman's consent
- Consider enhanced maternity (longer hospital stay) or primary health service care (Increased PHN visits)
- Document assessment, plan and actions



### High Risk: Specialised mental health care pathway

- Prior history of bipolar disorder, psychotic disorder or perinatal mental health problem
- Currently being treated for any mental health problem
- Currently taking psychotropic medication
- Currently under care of mental health service
- Suspected new onset of a perinatal mental health problem



- Talk to the woman about her mental health, her current mental health-care and identify her personal and professional supports, if any
- Ask women taking psychotropic medication if they have had a discussion with their prescriber about its suitability during pregnancy and breastfeeding, if not advise women to make an appointment to discuss
- Liaise with current mental health service provider, GP and with other professionals involved in the woman's care with the women's consent
- Encourage the woman to develop a perinatal crisis plan with her mental health team, if she has not done so
- Offer and facilitate referral to mental health service, through the GP, if the woman is not currently engaged with a service
- Refer for an urgent assessment if indicated
- Assess if there are any risks to the woman, her baby and other children and refer to appropriate services if risks are identified
- Provide an opportunity for the woman to discuss her birth experience if she has questions or issues associated with the birth
- Involve partner or significant other with the woman's consent
- Collaboratively develop a perinatal mental health wellness plan
- Consider enhanced maternity (longer hospital stay) or primary health service care (increased PHN visits)
- Document assessment, plan and actions

If the woman declines mental health service involvement



- No risk issue identified**
- Respect the woman's choice
  - Enhance supportive care
  - Re-assess mental state

- Risk issues identified**
- Support and stay with the woman
  - Involve partner or significant other if appropriate and possible
  - Facilitate referral for mental health assessment



## Appendix VIII: Women's concerns

The following are a list of women's concerns and questions that have been compiled from clinician's experience of working with women who are mothers and experience mental health issues.

<b>Mothering</b>	<p>Concerned about not feeling happy as 'supposed to'</p> <p>Questions about why mothering is hard and if other women feel this way</p> <p>Questions about coping with pregnancy weight/body changes</p> <p>Thoughts about being a 'bad', 'horrible' mother or a 'failure'</p> <p>Concerns about intergenerational repetition of mothering 'mistakes'</p>
<b>Bonding</b>	<p>Concerns over not feeling bonded to baby or loving other children more</p> <p>Not enjoying baby, dislikes or is disgusted by aspects of interaction with or care of baby (i.e. breastfeeding)</p> <p>Feeling rejected by baby – baby doesn't like me, knows I didn't want him</p> <p>Concerned that loving baby is a betrayal of previous pregnancy loss</p>
<b>Baby</b>	<p>Concerned that mental health symptoms will affect/harm baby</p> <p>Concerned baby knows (1) how mother feels (2) that mother has a mental health problem</p> <p>Concerned about hereditary nature of mental health problem</p> <p>Repetitively worried about safety of baby while feeding</p> <p>Concerns over long term future of baby</p>
<b>Normality</b>	<p>Questions whether symptoms experienced are related to a mental health problem</p> <p>Asks whether behaviour or symptoms (stressed, agitation, hyper-vigilance, excessive/compulsive cleaning) are normal</p> <p>Seeks explanation as to why she feels anxious, guilty, can't sleep</p> <p>Asks directly if practitioner thinks she/woman is 'psychotic' or 'mad'</p>
<b>The future</b>	<p>Requests for information about (1) if she will feel better (2) how long before she will feel better and (3) what to do to help feel better</p> <p>Concerns regarding future pregnancies for fear of a repeat of perinatal-associated mental health problems</p> <p>Requests information about prevention and recognition (symptoms) of mental health deterioration</p>
<b>Medication</b>	<p>Concerned medication will harm baby</p> <p>Specific questions related to breastfeeding and medication</p> <p>Asks about how long it takes for medication to work, how long she needs to take it and possibility of addiction</p>
<b>Fears</b>	<p>Concerned about referral to social worker/social services and possibility of loss of custody of the baby</p>



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