

FOI REF: 26/214

24th April 2026

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Further to your recent request for information made under the Freedom of Information Act (FOIA) 2000, I now set out our answers to your specific questions, and any clarifications sought and provided, as follows:

I would be grateful if you could confirm whether your trust holds the following information, and if so, provide copies or links where available:

1. Policies and Procedures

Does your trust have any formal policies, pathways, or standard operating procedures that reference the care of neurodivergent patients during labour and birth?

If so, please provide copies or links.

Our Perinatal Mental Health Guideline (attached) has a section that can be applied to providing individualised care to supporting Neurodiversity service users. Our Mental Health individualised management plans also address and support or reasonable adjustments during labour and birth for service users.

Please note that it is East Sussex Healthcare NHS Trust's FOI policy to only provide the names of staff that are grade 8a or above, therefore staff that are below that grade have been redacted from the attached policy.

Please also note that we have redacted the names of staff that no longer work for the Trust and are applying Section 40(2) respectively.

I can confirm that we hold this information, but it is exempt under section 40(2) of the Freedom of Information Act 2000 – Personal Information of third parties. This is because this information may allow the identification of individual staff members and disclosure would breach the principles of the Data Protection Act.

This is an absolute exemption and there is, therefore, no requirement to consider the public interest.

2. Guidelines or Protocols for Staff

Does your trust provide any guidance or protocols for staff relating to communication approaches, sensory adjustments, reasonable adjustments, or other supportive care for neurodivergent patients during the intrapartum period?

If so, please provide copies or links.

Any Neurodiversity service user who identifies as such at booking can be referred for feeding support which is then picked up by the Trust's Infant Feeding Midwife.

3. Resources, Tools, or Training Materials

Does your trust use any resources, tools, or training materials (e.g. visual aids, communication tools, sensory supports, or staff training resources) to support neurodivergent patients during labour and birth?

If so, please provide copies, links, or a brief description.

ESHT do not have any guidelines/protocols and resources/tools/training materials specifically to Maternity.

All staff have to complete the Oliver McGowen online training, along with all staff. Compliance in the maternity team with this training is currently at 96%.

I trust this information is helpful in its detail or explanation however, if you are dissatisfied with the response, then you have the right to request an internal review. If you wish to seek an internal review, please write to the Freedom of Information Team at esh-tr.foi@nhs.net quoting the above FOI reference number, within 40 working days. Please note the Trust is not obliged to accept a request for an internal review after this time period.

Yours faithfully

Freedom of Information (FOI) Team
East Sussex Healthcare NHS Trust
0300 131 4716
Core Hours of Business: Monday to Friday 9.00am to 4.00pm

Maternity Perinatal Mental Health Guideline

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Name of author and title:	Angeli Thallon Consultant Obstetrician ██████████ Perinatal Mental Health Midwife & Perinatal Mental Health Midwives(Specialist) ██████████ & ██████████
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Associated Documents:	ESHT Policy for the use of the Mental Health Act 1983 Clinical Practice Guidelines for Women, Pregnancy and Substance Misuse management https://esht.nhs.uk/wp-content/uploads/2018/08/00565

Did you print this yourself?

Please be advised the Trust discourages retention of hard copies of the procedural document and can only guarantee that the procedural document on the Trust website is the most up to date version

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1.0 2017164	May 2017	██████████ ██████████	New guideline	Replacement of <i>Care of Women with Mental Health and Perinatal Depression in Maternity Services</i>
V2	October 2020	Angeli Thallon (Consultant Obstetrician ██████████ PNMH Midwife ██████████ PNMH Midwife	Clinical Review	New pathways added to appendices, references updated, some alterations in main body of the text
V3	March 2025	██████████ – ██████████ PNMH Midwife	Clinical review and update	Updates to Neurodiversity, red flags

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Women, children's and sexual health Guideline implementation group		July 2017
Women, children's and sexual health Governance and accountability meeting		July 2017
Women and Children's Guideline Implementation group		2020
Women and Children's Governance and Accountability		Dec 2020
Women and Children's Guideline Implementation group		October 2025
Women and Children's MATNEO quality and safety meeting		November 2025

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

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1. Introduction

The aim of this guideline is to encourage early detection and management of mental health problems in women and people during the antenatal and postnatal period. Mental health problems during pregnancy and the postnatal period can have serious consequences for the mother or person, her infant and other family members. Mental health problems are becoming increasingly common and early intervention may assist in prevention.

2. Rationale

- Depression and anxiety are the most common mental health problems occurring during pregnancy, with around 12% of women experiencing depression and 13% experiencing anxiety at some point, and many women experiencing both. Depression and anxiety also affect 15–20% of women in the first year after childbirth. **During pregnancy and the postnatal period, anxiety disorders, including panic disorder, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and tokophobia (an extreme fear of childbirth), can occur on their own or can coexist with depression.** Postpartum psychosis affects between 1 and 2:1000 women who have given birth. Women with pre-existing bipolar disorder are at higher risk 10-15%, but postpartum psychosis can occur in women with no previous history of mental health illnesses (NICE 2015).
- According to MBRRACE ([2024](#)), in the period between ~~2020-2022~~, 11% of maternal deaths were due to mental health conditions and 42% of women who died were known to have pre-existing mental health illnesses or psychiatric disorders.
- Maternal suicide is the second commonest direct cause of maternal death. It is the leading cause of late maternal deaths (i.e. between 6 weeks and a year after pregnancy) (MBRRACE [2024](#)).
- Women are at higher risk of experiencing a severe (new onset) mental illness in the early days and weeks after birth than at any other time in their lives (MBRRACE 2024).

3. Scope

This guideline applies to all staff providing care to women and people and their families during the antepartum (from conception), intrapartum and postpartum.

4. Definitions

PNMHT = Perinatal Mental Health Team :-
Consultant Obstetrician
PNMH Midwife(Specialist) 2 staff currently covering this
Emotional Link Perinatal Mental Health Midwife
Emotional Wellbeing facilitators
Administrators

SPMHS= East Sussex Specialist Perinatal Mental Health Service:-
Consultant Psychiatrist
Mental Health Nurses
Psychologist
Parent/Infant Psychologist
Nursery Nurse

Perinatal Mental Health problems refers to mental illnesses that arise or are exacerbated during the antepartum, intrapartum or postpartum period.

Perinatal Period is defined as the period from conception, throughout pregnancy, labour and birth until one year postpartum. However, it is defined by World Health Organisation (WHO) as the period that commences at 22 completed weeks (154 days) of gestation and ends seven completed days after birth. This maternity policy covers the antepartum, intrapartum and postpartum up until 28 days.

Perinatal Mental Health Team – Consultant Obstetrician, Perinatal Mental Health Midwives and Emotional Wellbeing Facilitators and administrators.

Specialist Perinatal Mental Health Service (SPMHS)

Assessment & treatment team composed of mental health practitioners and consultant psychiatrist. Their community-based service supports mothers or parents who are experiencing, or who have previously experienced, severe mental health difficulties during pregnancy or up to a year after birth

Patient Health Questionnaire = PHQ-9 screening tool for depression. (see [Appendix B](#))

Generalised Anxiety Disorder = GAD-7 screening tool for anxiety. (see [Appendix C](#))

Mild Mental Health problems refers to low level anxiety or depression, managed by self-help techniques and/or therapy and can be referred to the Emotional wellbeing facilitators to signpost to services

Moderate Mental Health problems refers to anxiety, depression, personality disorders, PTSD or OCD possibly treated with medication and input from primary or secondary care and can be referred to Emotional wellbeing facilitators to signpost to self help techniques/therapy

Severe Mental Health problems refers to diagnoses of bipolar disorder, schizophrenia, past/current severe depression requiring admission to hospital, a history of psychosis or postnatal psychosis. Tokophobia which is severe and acute anxiety about giving birth for the first time.

Neurodivergence- refers to having a 'neurocognitive' experience (to do with how information is processed by the brain) that 'diverges' from (is different to) what is considered typical. Neurodivergent people experience and react to the world differently to 'neurotypical' people. There is no agreed or 'official' list of who is considered neurodivergent. People have different views about which groups of people should be included however the neurodivergences most often talked about are:

- Autism, or Autism Spectrum Conditions
- ADHD: Attention Deficit Hyperactivity Disorder, or ADD: Attention Deficit Disorder
- Dyscalculia
- Dyslexia

- Dyspraxia, or Developmental Coordination Disorder (DCD)

Studies show that there are higher rates of mental health disorders within Neurodivergent populations. Evidence shows neurodivergent people often feel unsupported and experience worse perinatal mental health compared to neurotypical people. This is partly because living in a world set-up to meet neurotypical needs has a big impact on mental wellbeing. (Babinski et al 2020, Kirsch et al 2020 and Riglin et al 2021).

5. Accountabilities

It is the registered professional's responsibility to deliver care that is based on current evidence, always acting in the woman or person's best interest. Therefore, registered professionals are expected to understand, follow and apply this guidance appropriately.

5.1 Midwives, Maternity Staff Nurses, Obstetricians and Anaesthetist

- To access, read, understand and follow this guidance
- To use their professional judgement in application of this guideline

5.2 Management

- To ensure the guideline is reviewed as required in line with the Trust and National guidelines
- To ensure the guideline is accessible to all relevant staff
- To monitor the audit process

6. Process

Identification of women or people at RISK

RED FLAGS

- Recent significant change in mental state or emergence of new symptoms
- New thoughts or acts of violent self-harm
- New and persistent expressions of incompetency as a mother/parent or estrangement from the infant (MBRRACE 2015)
- Referral with mental health concerns on more than one occasion is considered a 'red flag' which should prompt clinical review, irrespective of usual access thresholds or practice (MBRRACE 2020)

Mental health problems can be caused by a variety of contributing factors including biochemical, sociological and psychological. Please note that this is not a comprehensive list, but should be considered as predictors for perinatal mental illness.

- Bipolar disorder
- Schizophrenia.
- Severe depression.
- First degree relative with a history of bipolar disorder, postnatal psychosis or severe postnatal depression
- Personality disorder.
- Previous perinatal mental illness.
- Current depression/anxiety.

- Suicide attempts or suicidal ideation
- Self-harm.
- Eating disorders.
- Alcohol/Substance misuse.
- Domestic abuse or a history of emotional, physical or sexual abuse.
- Lack of family/social support.
- Previous psychiatric admission/assessment, including inpatient care.
- Recent stressful life events or bereavement.
- Minimal or no social support.
- Pregnancy or perinatal loss.
- Ethnic minority groups/asylum seekers and refugees.
- Post Traumatic Stress Disorder (PTSD).
- Teenage mothers/parents.
- Unplanned pregnancy.
- Adverse Childhood Experiences
- Neurodivergence

6.1 Midwifery Booking

- Please refer to the Perinatal Mental Health Pathway (**See Appendix E, F, G**).
- At the initial booking interview the midwife will obtain information from the woman or person regarding present mood, past and current mental health history as well as family history of mental health conditions and any adverse childhood experiences as well as drug and alcohol misuse. (NICE QS118)
- If neurodivergence is identified, the midwife should discuss and document how this presents to the woman or person as well as other individual need. This includes:
 - Sensory processing (this could include how the individual experiences sound, light, touch, smell and pain),
 - Communication and preferences (this could include auditory processing, information retention, eye contact, time to process and preferred method of communication such as written or the use of communication aids).
 - Executive Function (this could include support completing forms, help with remembering appointments, longer or shorter appointments, decision-making challenges, focus and attention differences_(White, V 2025).
- NICE (2015) recommend that specific questions to identify depression and anxiety should be asked:

During the past month, have you often been bothered by feeling down, depressed or hopeless?

During the past month, have you been bothered by having little interest or pleasure in doing things?

(Whooley questions)

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

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

(GAD-2)

If a woman or person answers 'yes' to the above questions, then the midwife should consider screening using the [GAD-7](#) and [PHQ-9 screening tools](#) (See [Appendix B](#) and [C](#)).

If a [GAD-7](#) and [PHQ-9](#) is completed then the midwife should action as detailed In Appendix 1 under the Care Pathway for Perinatal Mental Health. If GAD7 or PHQ9 is 15 or above then the PNMH midwives will triage (severe and enduring) and if under 15 (mild/moderate) the Emotional Wellbeing Facilitators will offer signposting/tools to self-manage.

The midwife should complete a referral to perinatal mental health team) on [Badgernet](#) computer system.

Highlighting mental health diagnosis, stating historical/current illnesses. Treatment including medication, (past/current) Date/year of last episode. Any involvement from primary/secondary care and completing GAD7/PHQ9 with a synopsis of current mental health state.

A plan of care should then be made in collaboration with the person and the Perinatal Mental Health Team **(See Appendix E).**

If a woman has any past or present severe mental illness (severe incapacitating depression, psychosis, schizophrenia, bi polar, schizoaffective disorder or postpartum psychosis) or there is a family history in first degree relative (mother, sister, daughter) of severe perinatal mental illness (postnatal psychosis or severe postnatal depression) – these need a referral to Perinatal Mental Health Midwife and Perinatal mental health Obstetric clinic via Badgernet referral. Consider a referral to the Specialist Perinatal Mental Health Service (SPMHS)

If a woman has first degree relative with severe perinatal mental health illness (postnatal psychosis or severe depression be alert for possible symptoms of [postpartum psychosis](#) in the first 2 weeks after childbirth. Sudden onset of symptoms suggesting postpartum psychosis, refer her to a secondary mental health service (preferably a specialist perinatal mental health service) for immediate assessment (within 4 hours of referral) or if in hospital refer via intranet to Mental health liaison, followed by telephone call

– these women or people will also need a referral to Perinatal Mental Health Midwife and Perinatal mental health Obstetric clinic via Badgernet referral. Consider a referral to the Specialist Perinatal Mental Health Service (SPMHS)

The midwife should communicate with the patient's GP, informing them of the pregnancy, asking for information about any mental health problems and alerting them if difficulties arise throughout the perinatal period with midwifery.

Holistic needs of the family and unborn infant or other children should also be assessed The safeguarding team should be accessed appropriately as per protocol.

Women or people should be signposted to the Trust website and directed to the Perinatal Mental Health section which has information and advice on accessing other services such as Specialist Perinatal Mental Health Team as well as a list of useful contacts.

6.2 Care Pathway

6.2.1 Mild/Moderate Mental Illness

Please refer to the Perinatal Mental Health Pathway **(See Appendix E).**

Continuity of care where possible, combined with early intervention and referrals are essential in improving care outcomes for women or people with mental illnesses.

Women/people should be advised to continue their current medication until reviewed by the GP, Consultant Obstetrician, Psychiatrist and/or Perinatal Mental Health Team. Where possible preconception advice should have taken place. (See Perinatal Mental Health: Prescribing Guidance for Trust Prescribers and GPs October 2019)

All women/people should be asked specifically about their mental wellbeing at every contact. e.g. "how are you feeling emotionally". A more general question, e.g. "how are you?" does not necessarily invite a response about a woman or person's mental wellbeing.

When women/people who have on-going depression, anxiety or disclose a new episode in this pregnancy, they should be signposted to primary care services including their GP and 'Health in Mind'(self-referral via healthinmind.org.uk) for counselling/self-help techniques/Cognitive Behavioural Therapy (CBT). Partners may also be referred for their mental health, stating their partner is pregnant or they have a child under 1 year.

Also consider referral to Early Help 0-19 Intervention Service -Perinatal and Infant Mental Health which consists of :

PCS: Perinatal Counselling Service - 10 sessions free 1:1 counselling. Virtual. Mums, dads, careers. Antenatal - 1 Year. Also supports perinatal loss, where another child < 5yrs.

EWB: Emotional Wellbeing Visits – 1-1 support in the home, up to 6 sessions by HV or PIMH. Suitable for parents who find it hard to access local groups.

TFM: Time for Me - 6-week group for mums with baby under 1 year. In person. Creche usually available.

PIR: Parent-infant Relationship – Variety of interventions carried out in the family home or virtually 1:1 focussing on building a positive relationship between infant and carer. Antenatal – 5 Years

[Contact details available on the A-Z intranet under 'Maternity' and the Perinatal Mental Health tab.](#)

Liaison with the Perinatal Mental Health Midwives is encouraged via phone or email for advice and support with providing care. [Contact details available on the A-Z intranet under 'Maternity' and the Perinatal Mental Health tab.](#)

6.2.2 Severe Mental Illness

Women/people who have severe mental illness, including psychiatric inpatient stay with their consent, should be referred to the Lead Obstetrician for Perinatal Mental Health and the Specialist Perinatal Mental Health Service as well as the Perinatal Mental Health midwife [yesfe](#) as soon as possible, even if they are currently stable.

Women/people seen in the Joint Obstetric/Specialist Perinatal Mental Health clinic, will be given information to make informed choices on medication, the effects on them and their baby, with associated risks and alternatives. Collaboration within teams and individualized care plans will be completed with women/people and if under the SPMHT a mental health practitioner will be assigned to care for the women/person throughout their perinatal period. (up to one year)

The referral form for the Perinatal Mental Health Midwives is available through badgernet computer system The role of the Perinatal Mental Health Midwife is to assist with signposting women/people with severe and enduring mental health conditions and coordinating care whilst liaising with the multidisciplinary team. The obstetrician and psychiatrist run joint clinics that the perinatal mental health midwives support.

A pre-birth plan with the women/person is collaborated with multi disciplinary teams by the Specialist Perinatal Mental Health Service around 32 week pregnant . Where indicated, the Perinatal Mental Health Midwife may complete an Individualized Management Plan if there is not a pre birth plan or it is felt that this individualized plan will support the women/person for reason of birth trauma, neurodivergent needs or Tokophobia

These should be completed and uploaded to the woman/person's Badger notes, under Perinatal Mental health – scanned documents. A copy will be given to the women/person and the intrapartum midwife should make sure they understand and work within this mental health care plan.

Minimum data to include in the pre-birth plan/Individual Management Plan:

- Contact details of professionals involved in care.
- Next of kin and nature of involvement.
- Risk assessment re: potential for self-harm, harm to unborn baby or other children (Safeguarding).
- Action Plan for a crisis, including if occurrence is out of hours.
- Medication plan and teratology.
- Paediatric plan for those unborn babies exposed to certain medication. (Neonatal Abstinence scoring 48 hrs post birth)
- Ideally a Mental Wellbeing Plan e.g. a documentation of triggers and coping strategies.
- Intrapartum plan regarding continuation of medication.
 - Neurodivergence : Sensory processing (this could include how the individual experiences sound, light, touch, smell and pain),
 - Communication and preferences (this could include auditory processing, information retention, eye contact, time to process and preferred method of communication such as written or the use of communication aids).
 - Executive Function (this could include support completing forms, help with remembering appointments, longer or shorter appointments, decision-making challenges, focus and attention differences.
 - Coping strategies.
- Side room allocation if indicated due to risk of deteriorating mental health i.e. Bipolar/psychosis/severe depression/Neurodivergence

(Individual Management Plan [available on the A-Z intranet under 'Maternity' and the Perinatal Mental Health tab.](#)).

Women/people who develop acute or severe mental illnesses as inpatients must be referred to the Mental Health Liaison Service via switchboard and referral -see Pathway for Urgent inpatient Perinatal Mental Health Services (see Appendix H) – referral form [available on the A-Z intranet under 'Maternity' and the Perinatal Mental Health tab.](#) The Consultant on call should be informed and the matron in charge. Holding power - 5(12) can be considered by Dr if deemed necessary.

For Acute assessment of women or people in community see Pathway for Community Urgent Pregnant/ has a child under 1 - Pathway (**See Appendix I**) **if under the SPMHT and a working day (Mon – Fri) contact SPMHT Duty Line on 03003040212 or for the women/person to attend A & E**

Consider any safeguarding input and close liaison with the safeguarding team including any relevant safeguarding aspects in the pre-birth plan/Individual Management Plan.

Liaison with the Perinatal Mental Health midwives via phone or email for advice and support. Contact details Mandy 07917893728 Tonia 07977749979 Sid Fry 07483452319

6.3 Interpartum Care of women or people with Mental Health

For women/people with severe mental illnesses, there should be an agreed pre-birth plan/Individual Management Plan in place – this should outline the contact details of relevant professionals, and identify the roles of different professionals – Midwives, Obstetrician, Health Visitor, Key Worker, Social Worker, SWIFT Worker, GP etc.

There should be clearly stated advice on whether women/people can continue their antipsychotic or psychotropic medication during labour and the anaesthetist and paediatrician should be made aware of this.

The perinatal mental health tab should have been regularly updated on the Badgernet computer system during the pregnancy and continue to be updated during the woman or person's admission.

6.4 Identification for women or people at RISK in the Postpartum period

Although there should be an increased awareness of women/people who have been identified as having risk factors in the antenatal period, postpartum psychosis can affect ANY postnatal woman or person.

RED FLAG: Women/people with bipolar disorder Type1 1:4 develop postnatal psychosis. Women/people who have had previous psychosis: 1 in 2 develop postnatal psychosis. A referral to the Specialist Perinatal Mental Health Service should be completed.

- Incidence: 1-2 per 1000
 - Between 600-1200 cases per year in England
 - 40% of women with Postpartum Psychosis have NO History of Mental Illness
- Distinctive features: Sudden onset, rapid deterioration, Insomnia,
- 50% symptoms within 72hrs or up to 2 weeks postnatal
 - Symptoms: Impaired attention, Perplexity or bewilderment, agitation, withdraw, elation or depression, irritability, over activity and unable to rest, unpredictability, impulsive behaviour, Hallucination and delusions – suspicious bizarre ideas, family note changes.

Women/people who need inpatient care for a mental illness during the 12 months following childbirth should be considered for admission to a mother and Baby Unit. This will be organised via the Specialist Perinatal Mental Health Service who have an updated bed status nationally..

Women/people already known to have a severe mental illness, should have their pre-birth plan/Individual Management Plan followed as well as enhanced care and close liaison with the Specialist Perinatal Mental Health Service, Perinatal Mental Health Midwives, GP and Health Visitor.

NICE (2015) recommends that the Whooley questions stated in section 6.1 should also be asked in the early postnatal period as well as use of the GAD-2. If a woman or person answers 'yes' to the above questions, then the midwife should consider screening using the [GAD-7](#) and [PHQ-9 screening tools](#) (See [Appendix B and C](#)).

Postnatal care, both inpatient and community, for all women or people, needs to include:

- Assessment of possible emerging postnatal mental illness e.g. depressed mood, poor bonding with new baby, sudden changes in mood or behaviour, irrational behaviour, reports of hallucinations or delusions.
- Reference to any Individual Management Plan as outlined in the woman or person's notes; there must be close liaison with any other agencies involved in the care of the woman or person e.g. Perinatal Mental Health Team.
- Assessment of women or people's mental wellbeing during the routine postnatal wellbeing checks.
- Liaison with Health Visiting Services and the GP.
- Consideration of provision of enhanced care for 28 days.
- Opportunities to informally discuss birth experience. If the midwife/obstetrician feels a formal debrief is required a referral should be made at a time when the woman or person feels ready to discuss the birth. See ESHT **Maternity Services Guideline for Clinical Debriefing**
- Language interpretation services where necessary.
- Discussion on normal mental wellbeing, tiredness, 'baby blues as well as postnatal depression prior to discharge.
- If indicated, signposting to mental health resources (see Perinatal Mental Health webpage on the extranet) or providing patient information leaflets relating to maternal/parental mental health - available in several languages and can be downloaded from the Royal College of Psychiatrists website <http://www.rcpsych.ac.uk/healthadvice/problemsdisorders.aspx>
- Consideration of any safeguarding input and close liaison with the safeguarding team if appropriate.

6.5 Medication, Pregnancy, Care of the Neonate & Breastfeeding/Chestfeeding

When discussing medication and treatment with women/people who are pregnant or planning to breastfeed/chestfeed the following should be covered:

- The risk of relapse or deterioration in symptoms and the woman or person's ability to be able to cope with being untreated.
- The uncertainty about the benefits and risks of treatment.
- How severe previous episodes have been and the woman or person's response to treatment.
- The risks of abruptly stopping medication.
- If a drug known to have teratogenic risk has been stopped post confirmation of pregnancy, this may not remove the risk of fetal malformations.
- Treatment options that are considered safe with breastfeeding/chestfeeding rather than those which advise against breastfeeding/chestfeeding.
- Where possible use monotherapy rather than combination therapy.

All women or people should be counselled on medication during pregnancy and breastfeeding/chestfeeding by a doctor. The prescriber should follow professional guidance and take full responsibility for the decision. Women or people should be given the opportunity to make an informed decision, and this should be documented on the patients Badgernotes.

Some antipsychotic or psychotropic medications are contraindicated in pregnancy and breastfeeding/chestfeeding. This should be assessed on an individual basis; some drugs are associated with a lower risk.

Valproate should be avoided in pregnancy and urgent consultation with a medical professional is required.

A paediatric care plan should be considered for those unborn babies who are exposed to antipsychotic/psychotropic or contraindicated medication during pregnancy.

All drugs have their own individual lactation risk category.

If the risk to the mother/parent abstaining from medication outweighs the risk to the baby, medication should continue as prescribed.

<http://www.medicinesinpregnancy.org/> has useful advice of medicines during pregnancy and breastfeeding/chestfeeding and this website should be shared with women or people to help them make an informed decision.

Breastfeeding/chestfeeding and skin to skin contact can reduce the risk of postnatal depression due to release of oxytocin so this should be encouraged where appropriate.

Please refer to the Individual Management Plan and/or Paediatric Care Plan if a neonate requires observations following birth. Please also refer to the NAS scoring guideline **Clinical Guideline for the Management of Neonatal Abstinence Syndrome** <http://eshealthcare/guideline/661.pdf>

7. Special Considerations

This is a developing pathway of care so some aspects of this guideline may be subject to change.

The development of:

- Tokophobia pathway
- Postpartum Psychosis pathway
- Lithium pathway

8. Evidence Base/References

Babinski, D.E., Neely, K.A., Ba, D.M., Liu, G.L. (2020) Depression and suicidal behaviour in young adult men and women with ADHD: Evidence from claims data. *Journal of Clinical Psychiatry*, 81 (6) 7-13.

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9. Competencies and Training Requirements.

All midwifery staff are expected:

To familiarise themselves with updated information circulated to them via email and to have an awareness of how to access referral pathways and resources available via the extranet.

To attend yearly update sessions outlining identification of mental illnesses in pregnancy and the postnatal period, including red flag signs of severe mental illness. Sessions will include: referral processes to appropriate mental health services; the role of the Perinatal Mental Health midwife in the Perinatal Mental Health Team and the Specialist Perinatal Mental Health Service; the referral pathway including tokophobia; an understanding of Individual Management Plans outlined in this guideline.

Document Monitoring Table

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/ committee for acting on recommendations/action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Via Badgernet activation of screening tools GAD-7 and PHQ-9. Assessment that timely referral has taken place.	Perinatal Mental Health Midwife	Badgernet	As required.	HoM, Service Manager, Perinatal Mental Health Midwife, MAG meeting.	HoM, Service Manager, Perinatal Mental Health Midwife, MAG meeting.	HoM, Service Manager, Perinatal Mental Health Midwife, midwifery matrons.
Via Badgernet activation of screening tools GAD-7 and PHQ-9. That referral was to appropriate healthcare professional.	Perinatal Mental Health Midwife	Badgernet	As required.	HoM, Service Manager, Perinatal Mental Health Midwife, MAG meeting.	HoM, Service Manager, Perinatal Mental Health Midwife, MAG meeting.	HoM, Service Manager, Perinatal Mental Health Midwife, midwifery matrons.
Any activated Purple flag on Badgernet states mental health concerns	Perinatal Mental Health Midwife	Badgernet PNMH database.	On-going.			

Appendix A – PHQ-9

PHQ-9

“During the last 2 weeks how often have you been bothered by.....”

1) Little interest or pleasure in doing things?

Not at all (0), several days (1), more than half the days (2), nearly every day (3) ?

2) Feeling down depressed or hopeless?

Not at all (0), several days (1), more than half the days (2), nearly every day (3)?

3) Trouble falling or staying asleep, or sleeping too much?

Not at all (0), several days (1), more than half the days (2), nearly every day (3)?

4) Feeling tired or having little energy?

Not at all (0), several days (1), more than half the days (2), nearly every day (3)?

5) Poor appetite or overeating?

Not at all (0), several days (1), more than half the days (2), nearly every day (3)?

6) Feeling bad about yourself—or that you are a failure or have let yourself for your family down?

Not at all (0), several days (1), more than half the days (2), nearly every day (3)?

7) Trouble concentrating on things, such as reading the newspaper or watching television?

Not at all (0), several days (1), more than half the days (2), nearly every day (3)?

8) Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual?

Not at all (0), several days (1), more than half the days (2), nearly every day (3)?

9) Thoughts that you would be better off dead, or of hurting yourself in some way?

Not at all (0), several days (1), more than half the days (2), nearly every day (3)?

Score:

1-4 Minimal depression

5-9 Mild depression

10-14 Moderate depression

15-19 Moderately severe depression

20-27 Severe depression

Please refer to Appendix D – Perinatal Mental Health Pathway

Appendix B – GAD-7

GAD-7

“During the last 2 weeks, how often have you been bothered by the following problems?”

1) Feeling nervous, anxious, or on edge?

Not at all (0), several days (1), more than half the days (2), nearly everyday (3)?

2) Not being able to stop or control worrying?

Not at all (0), several days (1), more than half the days (2), nearly everyday (3)?

3) Worrying too much about different things?

Not at all (0), several days (1), more than half the days (2), nearly everyday (3)?

4) Trouble relaxing?

Not at all (0), several days (1), more than half the days (2), nearly everyday (3)?

5) Being so restless that it is hard to sit still?

Not at all (0), several days (1), more than half the days (2), nearly everyday (3)?

6) Becoming easily annoyed or irritable?

Not at all (0), several days (1), more than half the days (2), nearly everyday (3)?

7) Feeling afraid as if something awful might happen?

Not at all (0), several days (1), more than half the days (2), nearly everyday (3)?

Score:

5-9 mild anxiety

10-14 moderate anxiety

15-21 severe anxiety

Please refer to Appendix D – Perinatal Mental Health Pathway



Perinatal & Infant Mental Health Referral form (external)

By completing and submitting this form you are confirming that the parent(s) are agreeing to this referral. This must be discussed with the family.

Intervention requested		PCS/ TFM/ PIR/ EWB						
Referral discussed & agreed: (date)		Yes <input type="checkbox"/> Date:						
Please tick relevant.								
Antenatal <input type="checkbox"/>								
Postnatal <input type="checkbox"/>								
Referral consent								
Name of child/children/unborn		Address		Postcode	Due Date / DOB	NHS Number	Ethnicity	
Name of parent/carer and		Contact	Address		Postcode	DOB	NHS	Ethnicity
other family members wanting intervention		Number					Number	ty
Main parent/carer email								
Reason for referral:		Please include: <ul style="list-style-type: none"> Reasons for referral to PIMH intervention Broad themes i.e. adjustment to parenthood, identity, bereavement Expectations of intervention 						

	<ul style="list-style-type: none"> Reason PIMH intervention, and not intervention within your service
Any other relevant details:	Please include (where relevant): <ul style="list-style-type: none"> Recent PHQ/ GAD scores/ clinical presentation Mental health history Current diagnosis Medication Other psychological interventions attended in past 6 months where known.
Additional professionals involved if known.	
Are they being discharged from your service?	Yes <input type="checkbox"/> No <input type="checkbox"/> Reason (if not already included):

Referrers details	
Name	
Job Title and Agency	
Email	
Contact number.	

Please note: If there is missing or incomplete information this form will not be processed and will be returned to the referrer.

Please email the form to:

EH.interventions@eastsussex.gov.uk

PIMH Intervention Guide (all mild/ moderate)

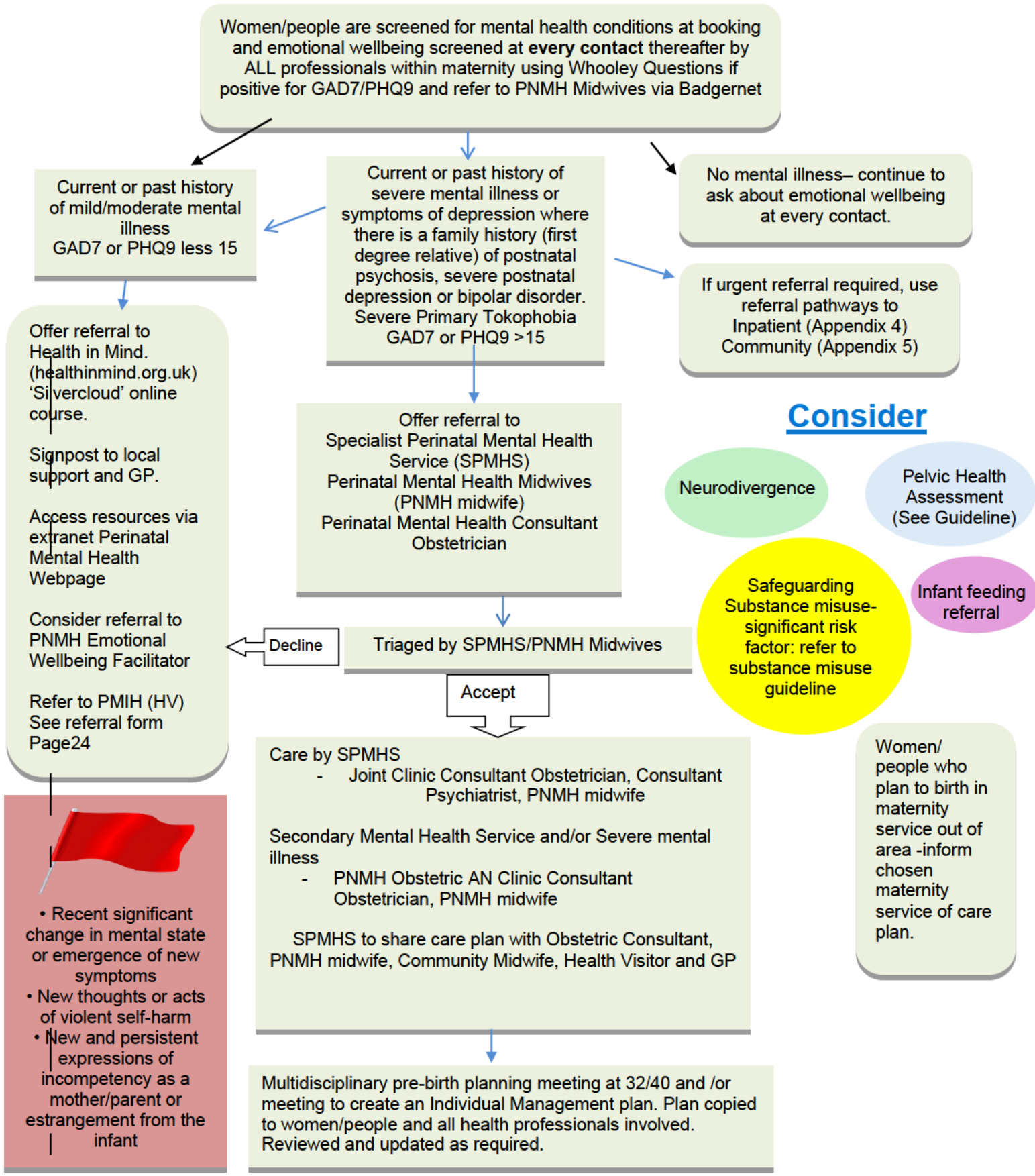
PCS: Perinatal Counselling Service - 10 sessions free 1:1 counselling. Virtual. Mums, dads, careers. Antenatal - 1 Year. Also supports perinatal loss, where another child < 5yrs.

EWB: Emotional Wellbeing Visits – 1-1 support in the home, up to 6 sessions by HV or PIMH. Suitable for parents who find it hard to access local groups.

TFM: Time for Me - 6-week group for mums with baby under 1 year. In person. Creche usually available.

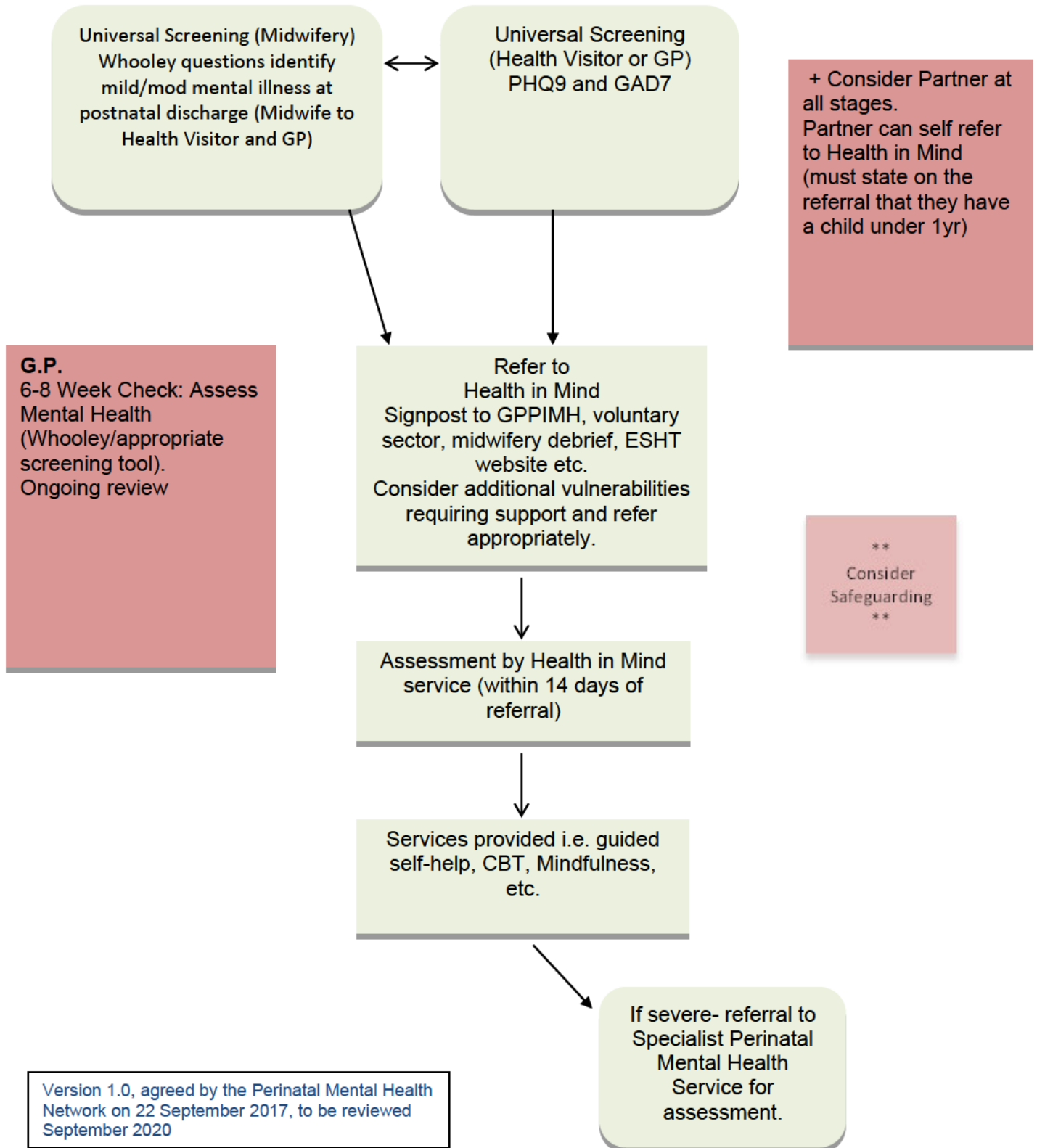
PIR: Parent-infant Relationship – Variety of interventions carried out in the family home or virtually 1:1 focussing on building a positive relationship between infant and carer. Antenatal – 5 Years.

Appendix D Pathway Perinatal Mental Health Antenatal

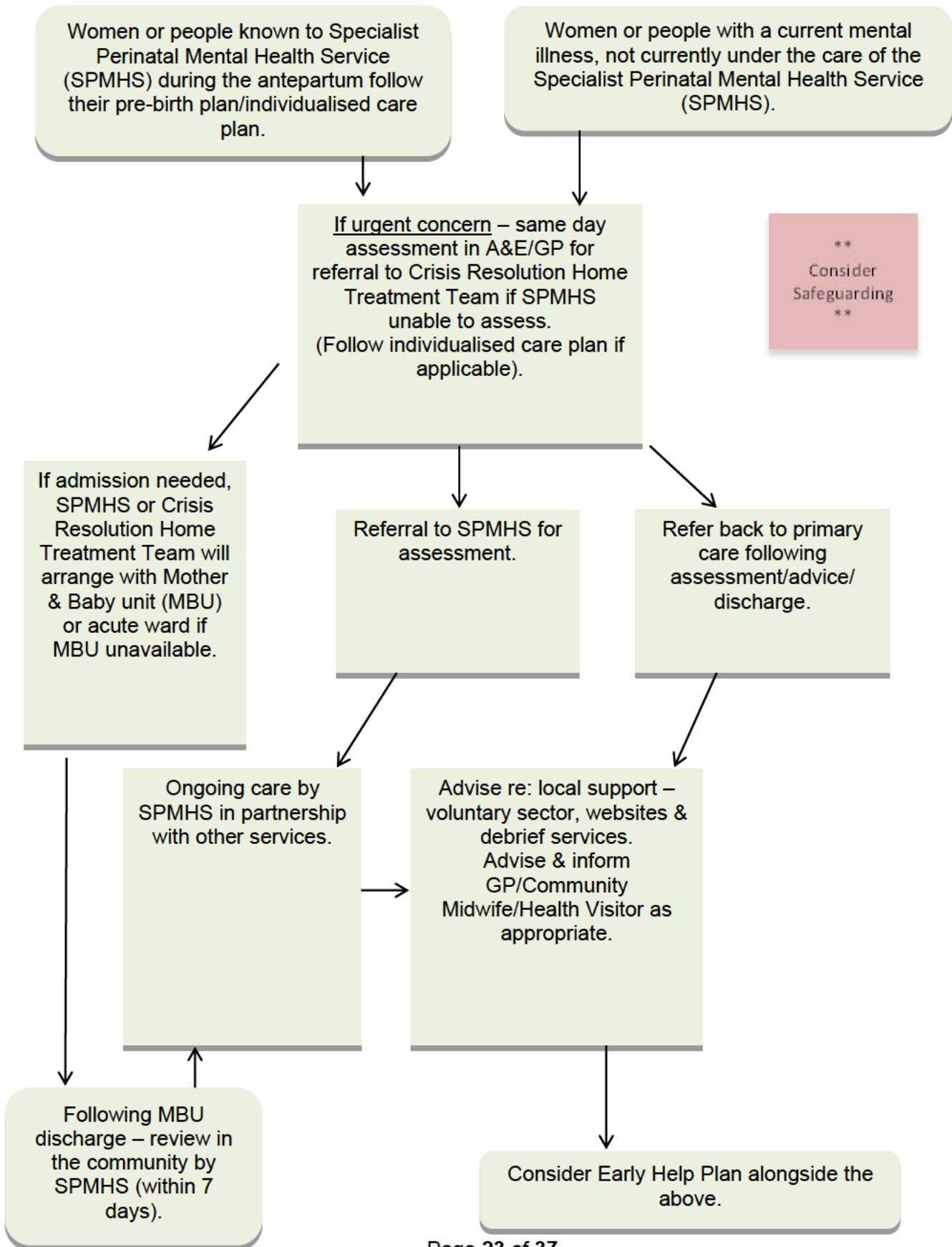


Sustainability & Transformation Partnership

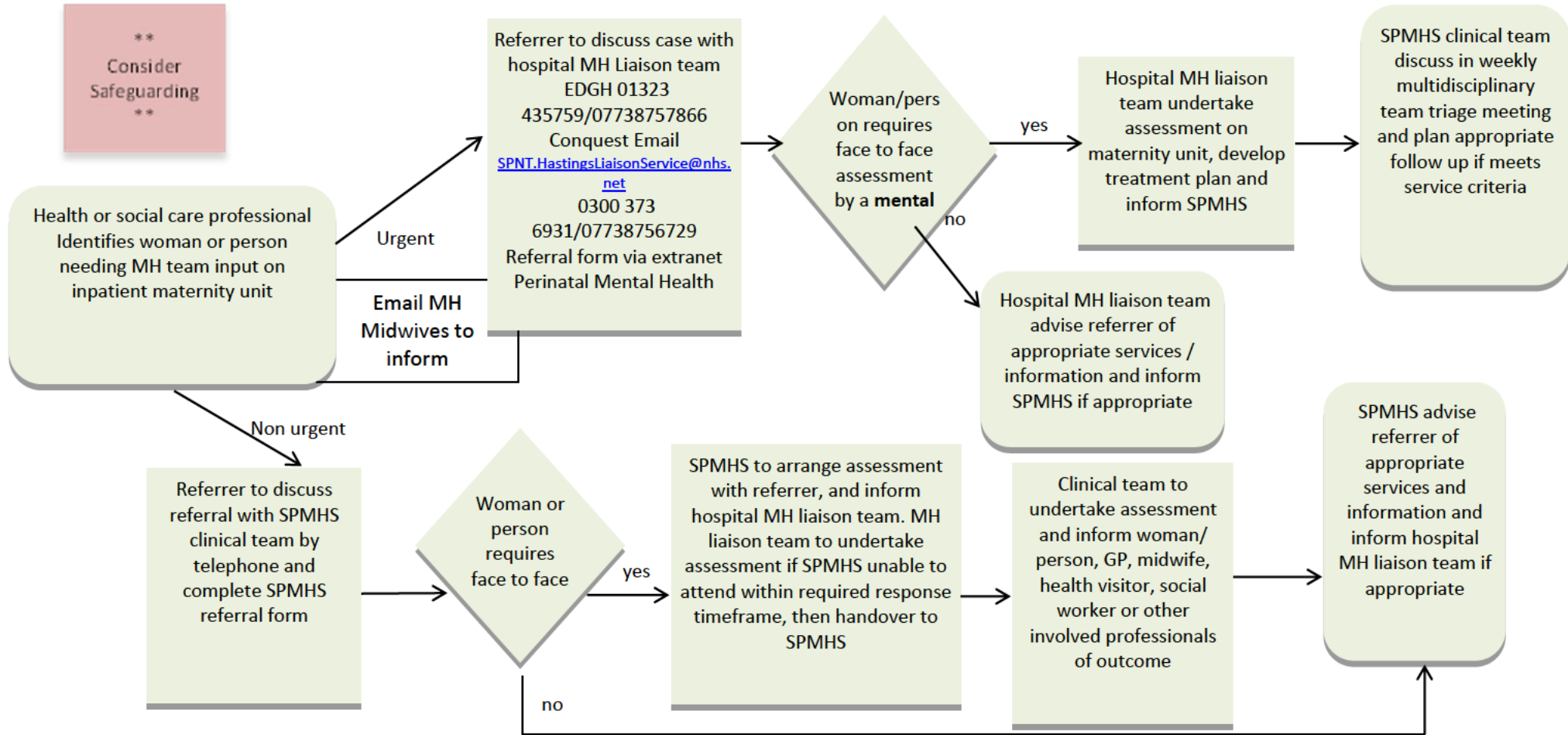
Appendix E Maternal Perinatal Mental Health Pathway for Postpartum Mild to Moderate



Appendix F - Maternal Perinatal Mental Health Pathway for Postpartum Severe Mental Illness



Appendix G Maternal Perinatal Mental Health - Pathway for urgent and non-urgent inpatient maternity services referral to Specialist Perinatal Mental Health Services (SPMHS)



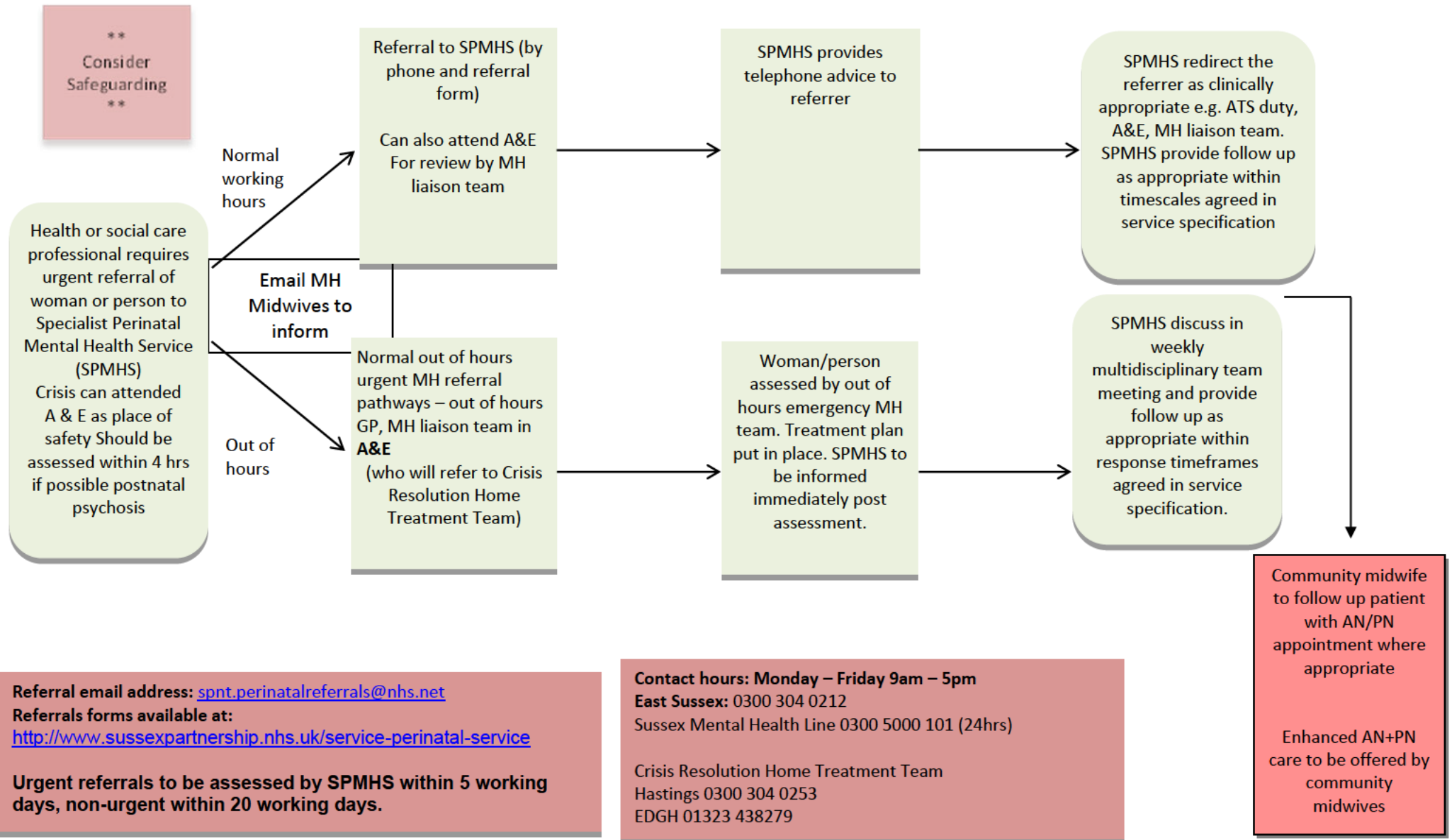
**
Consider
Safeguarding
**

Referral email address: spnt.perinatalreferrals@nhs.net
 Referrals forms available at:
<http://www.sussexpartnership.nhs.uk/service-perinatal-service>
Urgent referrals to be assessed by SPMHS within 5 working days, non-urgent within 20 working days.

Contact hours: Monday – Friday 9am – 5pm
East Sussex SPMHS:
 0300 304 0212
 07388227937

Version 1.0, agreed by the Perinatal Mental Health Network on 22 September 2017, to be reviewed September 2020.

Appendix H Community Urgent: Pregnant/ Has a child under 1 year
Refer to East Sussex Specialist Perinatal Mental Health Service (SPMHS)



Appendix I: Equality and Health Inequalities Impact Assessment (EHIA) template

Undertaking EHIA helps us to make sure that our services and policies do not inadvertently benefit some groups more than others, ensuring that we meet everyone's needs, and our legal and professional duties.

This is important because:

- Assessing the potential for services and policies to impact differently on some groups compared with others is a legal requirement.
- People who find it harder to access healthcare services are more likely to present later when their disease may be more progressed, have poorer outcomes from treatment, and need more services than other groups who have better access.

The Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. It is against the law to discriminate against anyone because of:

- age
- gender reassignment
- being married or in a civil partnership
- being pregnant or on maternity leave
- disability
- race including colour, nationality, ethnic or national origin
- religion or belief
- sex
- sexual orientation.

These are called 'protected characteristics'. The Act requires that public sector organisations meet specific equality duties in respect of these protected characteristics. This is known as the public sector equality duty.

Public Sector Equality Duty

Public bodies have to consider all individuals when carrying out their day-to-day work – in shaping policy, in delivering services and in relation to their own employees.

Public bodies must have due regard to the need to:

- eliminate discrimination
- advance equality of opportunity
- foster good relations.

Armed Forces Covenant Duty

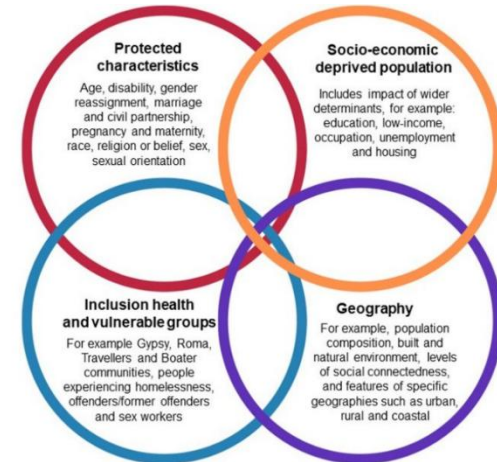
The new Covenant Duty raises awareness of how Service life can impact on the Armed Forces community, and how disadvantages can arise due to Service when members of that community seek to access key local services. The Duty requires organisations to pay due regard to the Covenant principles when exercising functions in healthcare. “Due regard” means that we need to consciously consider the unique obligations and sacrifices made by the Armed Forces; that it is desirable to remove disadvantages faced by the Armed Forces community; and that special provision may be justified in some circumstances.

Health Inequalities Duties- Equity for all

In addition to our legal duties in relation to Protected Characteristics, the Health and Social Care Act and other legislation, NHS Planning Guidance and sector specific recommendations require the NHS to have regard to the need to address health inequalities (or differences in access to or outcomes from healthcare) and take specific action to address them.

Figure 1 shows the different population groups, factors associated with where we live, or our individual circumstances, which separately, or when combined, influence access to and outcomes from health care.

Getting equal outcomes may require different inputs (or services). In completing an EHIA its important to think about whether a one size fits all approach will generate the same good outcomes for everyone, or whether we might need to make some tweaks or adjustments to enable everyone to benefit equally. The health tree diagram shows that unless we think about the needs of different people, equal services might generate unequal outcomes.

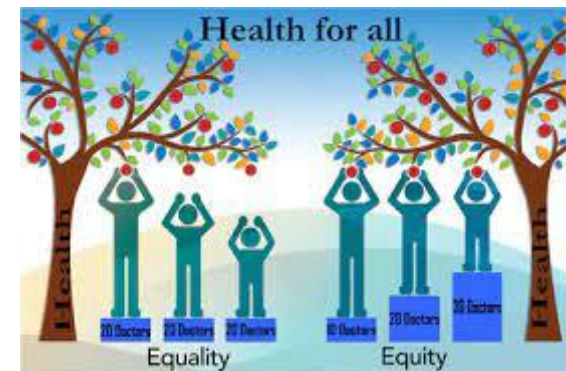


The Health Tree¹

The following principles, drawn from case law, explain what we must do to fulfil our duties under the Equality Act:

- **Knowledge:** everyone working for the Trust must be aware of our equality duties and apply them appropriately in their work.
- **Timeliness:** the duty applies at the time of considering policy options and/or before a final decision is taken – not afterwards.

¹ https://www.researchgate.net/figure/Equality-and-equity-of-medical-resources-distribution_fig2_323266914



- **Real Consideration:** the duty must be an integral and rigorous part of your decision-making and influence the process.
- **Sufficient Information:** you must assess what information you have and what is needed to give proper consideration.
- **No delegation:** the Trust is responsible for ensuring that any contracted services which provide services on our behalf can comply with the duty, are required in contracts to comply with it, and do comply in practice. It is a duty that cannot be delegated.
- **Review:** the equality duty is a continuing duty. It applies when a policy/process is developed/agreed, and when it is implemented/reviewed.
- **Proper Record Keeping:** to show that we have fulfilled our duties we must keep records of the process and the impacts identified.

NB: Filling out this EHIA in itself does not meet the requirements of the equality and health inequalities duties. All the requirements above must be fulfilled or the EHIA (and any decision based on it) may be open to challenge. Properly used, an EHIA can be a tool to help us comply with our equality and health inequalities duty and as a record that to demonstrate that we have done so. It is advised that you complete the short EHIA training session on MyLearn before completing this EHIA.

SECTION A ADMINISTRATIVE INFORMATION

This form is a central part of how the Trust makes sure and can demonstrate to others that we are meeting our legal duties; and how we can assure ourselves that all patients will get the best outcome for them from our services.

<p>A completed copy of this form must be provided to the decision-makers in relation to your proposal. The decision-makers must consider the results of this assessment when they make their decision about your proposal. Function/policy/service name and number:</p>	<h2>Maternity Perinatal Mental Health Guideline</h2>		
<p>Main aims and intended outcomes of the function/policy/service and summary of the changes you are making (if existing policy/service):</p>	<p>The aim of this guideline is to encourage early detection and management of mental health problems in women and people during the antenatal and postnatal period. Mental health problems during pregnancy and the postnatal period can have serious consequences for the mother or person, her infant and other family members. Mental health problems are becoming increasingly common and early intervention may assist in prevention.</p>		
<p>How will the function/policy/service change be put into practice?</p>	<p>Already in Practice</p>		
<p>Who will be affected/benefit from the policy?</p>	<p>Women / People receiving supportive care involving mental health while accessing maternity service at ESHT</p>		
<p>State type of policy/service</p>	<p>Policy <input type="checkbox"/></p>	<p>Service <input type="checkbox"/></p>	<p>Guideline <input checked="" type="checkbox"/></p>

	Business Case <input type="checkbox"/>	Function <input type="checkbox"/>	Existing
Is an EHIA required? NB :Most policies/functions will require an EA with few exceptions such as routine procedures	Yes <input type="checkbox"/>		
	No <input type="checkbox"/> (If no state reasons)		
Accountable Director: (Job Title)	██████████ and ██████████		
Assessment Carried out by:	Name: _____		
Contact Details:	_____		
Date Completed:	29.10.25		

SECTION B ANALYSIS AND EVIDENCE

Analysis of the potential impact – Equality and Health Inequalities Duties

For this section you will need to think about all the different groups of people who are more likely to experience poorer access or have poorer outcomes from health and care services. For each group please describe in the first column the potential impact you have identified, in the second column explain how you have arrived at this conclusion and what information you used to identify the potential impact, and in the third column say what you are going to do to prevent it from happening, or which elements of a service or policy specifically address the potential impact. Key things to remember.

- Everyone has protected characteristics but some groups who share one or more protected characteristics may be more likely to have poorer outcomes or access compared with others – and it is this potential that the EHIA process seeks to identify and address.
- The information included here should be proportionate to the type and size of the policy/service/change.
- An update to a policy should demonstrate that you have considered the potential for the policy to impact differently on different groups and taken steps to address that.
- A minor policy update is likely to need to be much less comprehensive than an EHIA for a major service change.
- You will need to know information about who uses or could use your service/policy will apply to (the population). You can use information about current patients or staff, and about the general population the Trust serves.

3. PROTECTED CHARACTERISTICS - Main potential positive or negative impact of the proposal for protected characteristic groups summarised

Please write in the box below a brief summary of the main potential impact (positive or negative) Please state **N/A if your proposal will not impact adversely or positively on the protected characteristic groups listed below, but make sure you include information on how you know there will be no impact.**

N/A

Protected characteristic groups	Summary explanation of the <i>potential</i> positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback)	Action that will be taken to address the potential for negative impact.
Age: older people; middle years; early years; children and young people.			
Disability: physical, sensory and learning impairment; mental health condition; long-term conditions.			
Gender Reassignment and/or people who identify as Transgender			
Marriage & Civil Partnership: people married or in a civil partnership.			
Pregnancy and Maternity: before and after childbirth and who are breastfeeding.			
Race:			
Religion and belief: people with different religions/faiths or beliefs, or none.			

Protected characteristic groups	Summary explanation of the <i>potential</i> positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback)	Action that will be taken to address the potential for negative impact.
Sex:			
Sexual orientation			
Veterans/Armed Forces Communities			

4. HEALTH INEQUALITIES -Potential positive or adverse impact for people who experience health inequalities summarised

Please briefly summarise the main potential impact (positive or negative) on people at particular risk of health inequalities (as listed below). **If the policy/procedure is unrelated to patients, this sections does not require completion.**

Please state none if you have assessed that there is not an impact, but please make sure you complete the 'how do you know this' column to demonstrate that you have considered the potential for impact. **If you identify the potential for impact for one or more of these groups please complete the full assessment in Appendix A**

Groups who face health inequalities²	Summary explanation of the potential positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
<p>This includes all groups of people who may have poorer access to or outcomes from healthcare services. It includes: People who have experienced the care system; carers; homeless people; people involved in the criminal justice system; people who experience substance misuse or addiction; people who experience income or other deprivation; people with poor health literacy; people living in rural areas with limited access to services; refugees or asylum seekers; people in or who have been in the armed force; other groups who you identify as potentially having poorer access and outcomes.</p>			

SECTION C ENGAGEMENT

5. Engagement and consultation

a. Talking to patients, families and local communities can be a rich source of information to inform health care services. If you are making substantial changes it's likely that you'll have to undertake specific engagement with patients. For smaller changes and policies you may have undertaken some engagement with patient groups, gained insight from routine sources e.g. patient surveys, PALS or Complaints information or information from Healthwatch, you may also have looked at relevant engagement that others have undertaken in the Trust, or locally

Have any engagement or consultative activities been undertaken that considered how to address equalities issues or reduce health inequalities? Please place an x in the appropriate box below.

Yes	No
-----	----

b. If yes, please ensure all stakeholders are listed in the consultation table at the beginning of the policy.

SECTION D SUMMARY OF FINDINGS

Reflecting on all of the information included in your review-

6. EQUALITY DUTIES: Is your assessment that your proposal will support compliance with the Public Sector Equality Duty?

Please add an x to the relevant box below.

	Tackling discrimination	Advancing equality of opportunity	Fostering good relations
The proposal will support?			
The proposal may support?			
Uncertain whether the proposal will support?	x	x	x

7. HEALTH INEQUALITIES: Is your assessment that your proposal will support reducing health inequalities faced by patients?

Please add an x to the relevant box below.

	Reducing inequalities in access to health care	Reducing inequalities in health outcomes
The proposal will support?		
The proposal may support?		
Uncertain if the proposal will support?	x	x

8. Outstanding key issues/questions that may require further consultation, research or additional evidence. Please list your top 3 in order of priority or state N/A

Key issue or question to be answered		Type of consultation, research or other evidence that would address the issue and/or answer the question
1	N/A	
2	N/A	
3	N/A	

9. EHIA sign-off: (this section must be signed)

Person completing the EHIA:	Gayle Clarke	Date:29.10.25
Line Manager of person completing:	[REDACTED]	Date:29.10.25

Breakdown of Groups who are more likely to experience health inequalities:

Groups who face health inequalities³	Summary explanation of the potential positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback)	Action that will be taken to address the potential for negative impact.
Looked after children and young people			
Carers of patients			

Groups who face health inequalities³	Summary explanation of the potential positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback	Action that will be taken to address the potential for negative impact.
Homeless people. People on the street; staying temporarily with friends /family; in hostels or B&Bs.	N/A		
People involved in the criminal justice system: offenders in prison/on probation, ex-offenders.	N/A		
People with addictions and/or substance misuse issues	N/A		
People or families on a low income	N/A		
People with poor literacy or health Literacy: (e.g. poor understanding of health services poor language skills).	N/A		
People living in deprived areas	N/A		
People living in remote, rural and island locations	N/A		
Refugees, asylum seekers or those experiencing modern slavery	N/A		
People who have served in the Armed Forces	N/A		

Groups who face health inequalities ³	Summary explanation of the potential positive or adverse impact of your proposal	How do you know this? (include here a brief explanation of what information you have used to identify potential adverse impact e.g. NICE guidance, local data, evidence reviews, stakeholder or patient feedback)	Action that will be taken to address the potential for negative impact.
Other groups experiencing health inequalities (please describe)	N/A		

EHIA Resources

Sources of Information on the East Sussex population and sources of community or patient insight.

Population Data

[State of the County 2021 Focus on East Sussex](#)

[East Sussex JSNA](#)

[Community Insight](#)

[Further Reading on Equality and Health Inequalities](#)

[Training](#)