Perinatal Mental Health Service

Lothian Perinatal Mental Health Service
Referral Form

When complete please send to: Team Administrator Mental Health Mother and Baby Unit St John's Hospital Howden Livingston EH546PW
Tel: 01506 524176 Fax 01506 523802

Name Usual Address Postcode Telephone/ Mobile	Lisa Williamson. 9 Caystane Gardens Oxgangs EH10 6TA.	Date of Birth 26/1/90.
Communication issues Y/N	Comments	Preferred Language ENGLISH.
Pregnant Y/N No weeks 16.5. EDD 23/9/10	Name and sex of baby DOB Breast feeding Y/N	No. of pregnancies 1 No of other children 0.
Referred by	Name Anne FINDLAY	Date of referral 13/4/10.
email anne.findlay@luht.scot.nhs.uk	Designation Midwife.	Telephone No 0131 536 9847
Agency /Address	community midwives Tollcross Health Centre. Dalkeith St	
General Practitioner	Name DR Alis McFarlane	Tel No 0131 455 8494.
Practice address	Craiglockhart Surgery. 161 Colinton Rd, EH14 1BG.	
Midwife	Name Anne FINDLAY Address Tollcross Health Centre.	Tel No 0131 536 9847
Health Visitor	Name 113 Allan Address Oxgangs Path & Surgery	Tel No 0131 445 3093.
Social Worker	Name Address	Tel No
Other Professional/s involved	Name Address	Tel No

15 APR 2010

Reason for Referral	(Please state degree of urgency) Referral by GP who states lady has a long history of low mood and previous self Harm.		
Give details of current or recent medication,	and any other treatment and physical health concerns was on citalopram for 2 wks but discontinued by GP. on 25/3/10		
Mental health	Current/recent mental health problems low mood		
Mental health history	Including: Previous puerperal psychosis, past/present severe psychiatric illness, Previous treatment, inpatient /specialist team care, family history severe psychiatric illness. Apparently has Hx of binge drinking and previous domestic abuse GP keen for Lisa to be seen.		
Substance misuse History/current	none.		
Risk issues e.g Violence, self harm, neglect,	past Episodes of self Harm.		
Child protection	—		
Adult protection	—		
Other agencies involved			
Social supports			
Any additional information			
If patient is unable to attend an clinic or requires a home visit please say why			
Date received		Date allocated	
Allocated to		Date to be seen	

Ethnic Group							
Asian or Asian British		**Black or Black British**			**Mixed**		
Bangladeshi	☐	Caribbean	☐	Black Other	☐	White & Asian	☐
Indian	☐	African	☐	Arab	☐	White & Black African	☐
Pakistani	☐	Arab	☐	Chinese	☐	White & Black Caribbean	☐
Other	☐	Other	☐	Other ethnic group	☐	Other	☐
White	☐	Not known	☐				
British	☑	Refused to answer	☐				
Irish	☐						
Other	☐						

Review

We welcome comments on the use of the document, these should be sent to:

Gillian Wilson
Team Leader
Perinatal Mental Health Service
St Johns Hospital
Howden
Livingston
EH546PP

Tel: 01506 524174

Mail: Gillian.Wilson@wlt.scot.nhs.uk

Mental Health Mother and Baby Unit
St John's Hospital at Howden
Howden Road West
LIVINGSTON EH54 6PP

Ms Lisa Williamson
9 Caiystane Gardens
Oxgangs
EH10 6TA

Date: 23rd April 2010
Your Ref:
Our Ref: HC/ES
CHI No:
Enquiries to: [redacted]
Extension: 54176
Direct Line: 01506 524176

Perinatal Mental Health Service

Dear Ms Williamson,

We have received a referral from your Midwife asking us to see you. I have therefore arranged to see you at home on **Thursday, 13th May 2010 at 11.00am.**

Please let me know if this appointment date or time is not convenient and I will rearrange.

Yours sincerely,

HEATHER CURRIE
Community Psychiatric Nurse
Perinatal Mental Health Team

Copy to:

Anne Findlay, Midwife, Tollcross Health Centre, Edinburgh
Dr McFarlane, Craiglockhart Surgery, 161 Colinton Road, Edinburgh, EH14 1BE

Lothian perinatal mental health service assessment

Name: Lisa Williamson

DOB: 26/1/90

Address: 9 Craigstane Grns Edw

Phone No:

Marital status: Single

Occupation: Unemployed

Ethnic Origion White

Medical Alerts: None

Date of Referral: 13/4/10

Next of kin:

Address:

Phone No:

EDD/DOB 23/9/10

Reason for referral / presenting complaint

Hx LOW MOOD. SELF HARM
CURRENT LOW MOOD

Current Medication

Medication	Dose	Frequency

Previous Psychiatric history(including treatments and compliance)

REFERRAL TO YPO - DNA'd
ON CITALOPRAM 1 WEEK STOPPED BY GP DUE TO PREGNANCY

Previous Medical History

Psychological Treatment History

NONE

Family History (histo · of mental illness, relationships)

Parents

PARENTS STILL TOGETHER. MUM DEPRESSED ? DUAL DIFFICULT RELATIONSHIP LISA IN CARE FOR MANY YEARS RELATIONSHIP IMPROVING I KEEN TO SUPPORT

siblings

SISTER LYNN 18 LIVES WITH PARENTS. TURBULENT RELATIONSHIP

Current Pregnancy (j nned/unplanned etc)

UNPLANNED - NEW RELATIONSHIP. AT SCAN DISCOVERED SHE WAS FURTHER ON THAN SHE THOUGHT FATHER IS EX BOYFRIEND - NOT INTERESTED IN PREGNANCY SOME INVOLVEMENT WITH CURRENT PARTNER

Other children(care : rangement/child protection

NONE

Social Circumstances(Housing, finances relationships etc)

WENT TO LIVE WITH GRANDPARENTS AGED 13 UNCLES FAMILY SITUATION BROKE DOWN. IN CARE SOON AFTER. THEN ST CATHERINES SECURE UNIT AGED 15 DUE TO RUNNING AWAY WENT BACK TO PARENTS AGED 16. ALSO IN CARE DUE TO ASSAULT - MOVED TO CURRENT HOME LAST MAY, SPENT MOST OF TIME AT MUMS TILL DEC. TRYING TO SPEND TIME IN OWN HOME FEELS LONELY & ISOLATED

Drugs/alchohol(histor &current use)

PREVIOUS BINGE DRINKING - ALTERNATIVE TO CUTTING. DRINKING HEAVILY IN EARLY STAGES OF PREGNANCY AS SHE PLANNED TO TERMINATE - NO ALCOHOL SINCE DECIDING TO KEEP BABY

Views of significant ot er (state who)

Mental State

Appearance and behaviour

CASUALLY DRESSED, LIMITED EYE CONTACT. INTONATION IMPAIRED

Mood

LOW - HISTORICAL & RELATED TO CIRCUMSTANCES

Suicidal thoughts

NONE EXPRESSED. NO THOUGHTS OF DEATH

Speech

NORMAL RATE & TONE

Thought content

NO THOUGHT DISORDER

Perceptions

NO PERCEPTUAL DISTURBANCE

Cognitions

REPORTS DIFFICULTIES WITH CONCENTRATION

Sleep

BROKEN - PREGNANCY RELATED

Appetite

ETC

Summary

Long history of difficult relationships. Family breakdown
Abusive boyfriend age 14. No self harm since age
17 - used alcohol instead. No current coping
strategies. Although now being more open about
how she is feeling. Aware of feeling down &
tearful. Goes to bed tends to improve.

Plan

- Family Nurse Partnership

Signature ..... **Date** 17/5/10

Referral - YPU - DNA

Self harm - cutting 13

Citalopram - 1 week
Stopped pregnancy

Moved home last May

Spending most time at Mum's [illegible]

Grandparents - 13 - [illegible] Blackburn

In care - Northfield

St Catherine's School until 15
→ evening course

Mum aged 16

Cousin Uncle - 16
- assault

Ex boyfriend no name
contact

Unplanned pregnancy

Boyfriend not known
? support

Parents supportive

Carmel House - [illegible]
now [illegible] baby born

Looking [illegible]

Tired - 2 months

Sleep broken during
pregnancy

Appetite ok

Concentration

No SH thoughts

No problems since having
baby

Age 16 - mental abuse

Died 17 - [illegible] instead of SH

Sister - Lynn 12 now with parents

Parents together Mum depressed ? [illegible]

Mental Health Mother and Baby Unit
St John's Hospital at Howden
Howden Road West
LIVINGSTON EH54 6PP

Anne Findlay
Community Midwife
Tollcross Health Centre
Ponton Street
EDINBURGH

Date: 2nd June 2010
Your Ref:
Our Ref: HC/JM
CHI No:
Enquiries to: [redacted]
Extension: 54176
Direct Line: 01506 524176

Perinatal Mental Health Service

Dear Ms Findlay

Re: **Lisa Williamson, 9 Caiystane Gardens, Oxgangs, Edinburgh, (26.1.90)**

Thank you for referring Lisa to the Perinatal Mental Health Service. I recently met with her at home. Lisa has a longstanding history of low mood and self harm. She has had referrals to the Young People's Unit as an adolescent with difficulties with her behaviour which her family found to be unmanageable. At age 13 Lisa left home to live with her grandparents. Her grandparents also found Lisa's behaviour difficult to manage and she then entered the care system. She lived in residential care and also a time in secure units. At age 16 she was in Corntonvale following charges of assault and following her release she went back to stay with her parents. Her relationship with her parents improved although she did move out into her own accommodation last May. She found it difficult being on her own and spent most of the time at her mum's up until December. She is now trying to spend more time in her own home, however, feels lonely and isolated. Her parents are still together, her mum has been depressed in the past and Lisa continues to have a difficult relationship with her father. They are both keen to support her with the new baby. She has a sister [redacted] and continues to live with her parents. Their relationship is turbulent and some of Lisa's issues stem from the feeling that her parents favoured [redacted] over her.

Lisa's pregnancy was unplanned and was very quick in a new relationship. When she went for her scan she discovered that the pregnancy was further on than she had thought and this meant the father was an ex-boyfriend. He has told her he is not interested in the pregnancy. The relationship continues with her current partner however he is unsure about what his involvement will be with herself and the baby. Lisa has used cutting herself as a coping mechanism in the past but has not harmed herself for some time. Instead of self harming she began to drink heavily. She continued heavy drinking in the early stages of her pregnancy as initially she had planned to terminate. She reports to have not used alcohol since deciding to proceed with the pregnancy.

On meeting Lisa she initially appeared slightly uncomfortable with limited eye contact, however, her interaction did improve throughout our session. She reports her mood as low and this relates to her current circumstances. She has no urge to self harm or to use alcohol to cope. She did not express any suicidal intent. She reports to have some difficulties with concentration at present. Her sleep is broken but this is pregnancy related and there are no changes to her appetite. At present Lisa does not appear to be significantly depressed, however, she is low trying to cope with difficult circumstances. She has times when she feels very lonely and feels isolated in her current home. She is hoping for a move of home when her baby is born. She anticipates that there will be some difficulties with her new baby and her abilities to manage in her new role as a mother.

Lisa is already in contact with the Family Nurse Partnership and is very enthusiastic about their input. As such I haven't arranged to see Lisa again however should there be any deterioration in her mood during her pregnancy or into the postnatal period I would be happy to see her again.

Should you require any further information please don't hesitate to get in touch.

Yours sincerely

HEATHER CURRIE
Community Psychiatric Nurse
Perinatal Mental Health Team

Copies
Dr McFarlane, Craiglockhart Surgery, 161 Colinton Road, Edinburgh
Liz Allen, Health Visitor, Path Surgery, Oxgangs
Family Nurse Partnership

700168 111

Perinatal Mental Health Service

Lothian Perinatal Mental Health Service Community Team Referral Form

Mental Health Mother and Baby Unit
St John's Hospital
Tel: 01506 524176
Lothian.PNMHS@nhs.net

We are happy to consider and review all referrals, and we will respond either with email advice or a face-to-face assessment. Our thoughts about best management for patients will be helped greatly if all the fields below are completed as fully as possible.
A separate form is available on RefHelp for inpatient referrals.

Name **Address** **Postcode** **Telephone/ Mobile**	Lisa Williamson Flat 7 9 Tytler Gardens Edinburgh EH8 8HS 07580 680 640	**Date of Birth 26/01/90** **CHI No.2601901187** UHBI: 700 168 111M
Communication issues? **No**	**Interpreter needed? No**	**Preferred Language: English**
Ante Natal **Yes/**	**Pregnant – Yes** **Gestation 12 weeks**	**EDD: 02/05/16**
Post Natal **No**	**Baby Name:** **D.O.B:** **Sex:**	**Breast Feeding – Yes/No**
Obstetric History	**Previous Pregnancies:** 1 in 2010.	**No. of Children:** **1**
Referred by	**Name: Dr S Wright** **Designation:** **GP**	**Date of referral: 20/10/25** **Telephone No: 01316573341** **E-mail:**
General Practitioner	**Name**	**Tel No01316573341**
	Address: St Triduana's Medical Practice **54 Moira Park**	
Midwife	**Name** **Address**	**Tel No**
Health Visitor	**Name Rose Ross** **Address** **St Triduana's Medical Practice** **54 Moira Park**	**Tel No** **01316573341**
Social Worker	**Name** **Address**	**Tel No**
Other Professionals/ Agencies involved	**Name** **Address**	**Tel No**

27/10/15 - Ethnic appt

21 OCT 2015

(1) ✓ Case notes requested on 22/10/15 (JMcD)

(2866)

Reason for Referral (Tick as many as apply)	(Please state degree of urgency, although we cannot see emergencies immediately) ❑ Bipolar disorder / Schizophrenia ❑ Currently in contact with psychiatric services ❑ Previously in contact with psychiatric services ❑ Current concerns about risk of harm or neglect to self or baby ❑ Current symptoms of psychosis ❑ Family history of contact with psychiatric services ❑ Other – **please specify in the space below:** Depression Concerns of risk of harm to self
Additional information eg obstetric history	Previously assessed by your service in 2010. Has been seen at PSC over last few weeks due to bleeding. Organised haematoma seen on scan as cause of bleeding. Foetus viable.
Mental health current	Depression. Feels much worse than ever remembers feeling before. Thoughts of self harm, mainly related to cutting (as has done previously). Sometimes feels existing daughter would be better off without her, but then immediately regrets these thoughts and feels guilty. Although pregnancy was planned, feels symptoms of depression have flared since becoming pregnant. Finding it difficult to cope. Has had thoughts of terminating pregnancy, but maintains she wants to continue with it.
Physical health concerns	Nil
Medication Current/Recent	Citalopram last taken 2012
Mental health history	Long history of depression, self harm and substance misuse. Previously assessed by your service during first pregnancy (2010), but not requiring follow up at that time. Has been off citalopram since 2012 and been managing well. Since becoming pregnant, with this planned pregnancy, has become very low in mood. Is having thoughts of self harm again, although at present denies she would act on it due to existing child. Struggling to cope. No motivation to look after self or existing child. Poor relationship with partner and mother. Little social support.
Substance misuse History/current	Previous history of solvent and alcohol misuse.
Risk issues e.g. Violence, self harm	Previous self harm – cuts to forearm
Known to Social Work **Child protection issues**	**No** Current/Previous: None known

Social History	Including details of other children/Family composition/Current support available/provided. Difficult relationship with parents and sister. Referred to young peoples unit as family couldn't manage behaviour. Spent time in residential care and secure units. Pregnancy was planned with current partner, but hasn't been as supportive as she was expecting.
If patient requires home visit, state reason	

Ethnic Group
White

Asian or Asian British		**Black or Black British**				**Mixed**	
Bangladeshi	☐	Caribbean	☐	Black Other	☐	White & Asian	☐
Indian	☐	African	☐	Arab	☐	White & Black African	☐
Pakistani	☐	Arab	☐	Chinese	☐	White & Black Caribbean	☐
Other	☐	Other	☐	Other ethnic group	☐	Other	☐
White	☐	Not known	☐				
British	☐	Refused to answer	☐				
Irish	☐						
Other	☐						

If a patient needs to be seen in less than a week, it may be that your local sector psychiatric services will need to be involved, as our team is very small and unlikely to be able to respond so quickly. However in emergencies an admission to the Mother and Baby Unit may be a possible alternative, for a period of up to 48 hours for a full psychiatric assessment.

If you have any queries, please contact:

- The Mother and Baby Unit: 01506 524175
- The administrator for the Perinatal Mental Health Service: 01506 524176

RCOG guidelines on indications for referral to specialised perinatal mental health services where available, otherwise general psychiatry services:

• Woman with current illness where there are symptoms of psychosis, severe anxiety, severe depression, suicidality, self-neglect, harm to others or significant interference with daily functioning. Such illnesses may include psychotic disorders, severe anxiety or depression, obsessive–compulsive disorder and eating disorders.

• Woman with a history of bipolar disorder or schizophrenia.

• Woman with previous serious postpartum mental illness (puerperal psychosis).

• Women on complex psychotropic medication regimens.

• Referral should be considered for women with illness of moderate severity if developing in late pregnancy or the early postpartum period.

• Referral should be considered for women with current illness of mild or moderate severity where there is a first-degree relative with bipolar disorder or puerperal psychosis. In the absence of current illness, such a family history indicates a raised, but low absolute, risk of early postpartum serious mental illness. Where identified, information should be shared with primary care and any evidence of mood disturbance during pregnancy or in the postpartum period should lead to referral.

• Women with previous periods of inpatient mental health care should be screened by mental health services (either by assessing case records or seeing the woman).

• Maternity services need to ensure that appropriate communication with primary care, and social services where necessary, takes place for women who decline referral to specialised mental health services.

http://www.rcog.org.uk/files/rcog-corp/ManagementWomenMentalHealthGoodPractice14.pdf

O.P. CLINICAL NOTES

(Psychiatry)

NUMBER

NAME Lisa Williamson.

DATE	SHEET No.
3/11/15	25 ♀

don't feel she'd be ... / see 3x weekend / ... 20 / 12

Partner. - [redacted] ~

Volunteer at a Youth Cafe Monday evenings

currently 14/40 pregnant. - 5 yr old daughter Mia.

EDD. 1/5/16.

pregnancy - bleeding + worry several scans.

- 3 scans.

tired + sick - morning sickness.
feels v. different to 1st pregnancy.

planned pregnancy
Relationship - Gordon (works in Greggs factory).
- he stays c his Dads.
- live in Abbeyhill - nice area.
Flat - 2 bed → live there c Mia.

(P/C).

→ feeling v. down/sad -
initially moody - then end Sept after bleed -
feels downhill - worrying constantly.
horrible thoughts /. don't want baby anymore -
don't want to be here anymore - Mia better off
without me. - Thoughts of self harm - cutting
Thoughts. - taking tablets / jumping in front of
Mia - No thought of harming Mia. trains & scares her
past month - getting worse
sleep - tired during the day - horrible dreams - frequent
waking - some difficulty getting back to sleep.
appetite - reduced / nausea a prob.

Not really enjoying things. Out enjoy outside c̄
Mia but get bored [illegible]
↓ concⁿ TV difficult
- activity ~ watch TV / play c̄ phone
or shopping
- feeling anxious - worry a lot before answering
worry about money (not got any)
something happen to Mia or boyfriend
negative ~~Harvey~~
Gordon - compares me to other people
- doesn't try to understand me
no real good days. some

Recently fell out c̄ sister 1-2/12 ago
Mum) never there for me "doesn't really bother"
Scared of giving birth - how I'm going to cope
Losing friends → person from job who rejected

- Never felt this bad before -
Before ~~do~~ saw GP 2016 - self help depression
↳ booklet -

FPH Mum mild depression also Sister ?

On and off since 17 prescribed tablets then not going back for appts.
Fluoxetine once ? other.
Last time ?~5 yrs ago . Miss my dad.

→ (FH) Parents - Father † 3/12 yrs ago Cancer 62
good man
Mum 50 not supportive.
"horrible" - played games c̄ me
unreliable
Sister Lynn - 28 - don't get on well
see grandparents - help out c̄ Mia
~~Dad~~ Georgie - lives close - support. see
Friends in Glasgow - they know how I'm feeling

drugs and alcohol
→ cannabis / drink in the past / binge drinking
→ not so recent cannabis

(PH) Born Edinburgh
childhood OK - nightshift
Mum "not much time for us"
High school "off the rails"
ended in care
Young Person's Centre - Secure 16.
[illegible] - felt happy
Anything - Not really worked
few cleaning jobs / ed

Mia doing well
good reports

Plan
citalopram
appt and [illegible]
ref CPN

Jail 8/12 - Assault Robbery / Shoplifting

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

NHS Lothian

(F)

Dr MacKay
St Triduana's Medical Practice
St Triduanas Medical Practice
54 Moira Park
Edinburgh
EH7 6RU

Date First Created	13/11/2015
Date Authorised	17/11/2015
Date/Time Printed	17/11/2015 09:10
Our Ref	700168111M
CHI	2601901187

Patient:	Ms Lisa Williamson 9/7 Tytler Gardens Edinburgh EH8 8HS	**UHPI:**	700168111M
		Date of Birth:	26/01/1990
Clinic Code:	AC/RIE	**Attendance Date:**	03/11/2015
Specialty:	Perinatal - MHT		
Consultant:	Dr Peter D LeFevre		

Outpatient Clinic Letter

Dear Dr MacKay,

I saw Ms Williamson at the Perinatal Mental Health Clinic at the Royal Infirmary of Edinburgh on 3rd November 2015. Ms Williamson is a 25 year old lady who is currently 14 weeks gestation with an estimated date of delivery of 1st May 2016. She has had one other pregnancy resulting in the birth of a healthy 5 year old daughter, [redacted] She has been with her partner, [redacted] for approximately 20 months. She currently volunteers at a youth cafe on a Monday evening.

She said her relationship with [redacted] could be better. [redacted] and the couple see each other approximately 3 times a week. Lisa, herself, lives in a well appointed flat in Abbeyhill with her daughter.

Lisa described the current pregnancy as being worrying mainly due to intermittent bleeding early in pregnancy. She has felt "*tired and sick*" with morning sickness.

Lisa described feeling "*very down and sad*". This started towards the end of September around the time of her first threatened miscarriage. She found herself worrying constantly about the pregnancy and also describing "*horrible thoughts*", including ideas that she didn't want her baby anymore and that [redacted] would be better off without her. She also described intrusive thoughts of self harm, for example, cutting, taking tablets and jumping in front of a train. She described feeling anxious at these thoughts and had no intention of carrying them out. She

likewise denied any thoughts of harming [redacted]. Over the past 4 weeks she described her general symptoms as getting worse with increasing tiredness and "*horrible dreams*". Her appetite is reduced with nausea being a particular problem. She also described not really enjoying things although enjoys contact with [redacted]. Her concentration is reduced and she finds watching TV difficult. She also described symptoms of anxiety, for example, worrying about money difficulties (even though these are absent at present) and that something bad was going to happen to either [redacted] or her boyfriend. She feels [redacted] is not particularly supportive in that he tends to "*compare me to other people and doesn't try to understand me*".

Lisa described recently falling out with her sister (approximately one to two months ago). She also feels that she has little support from her mother who "*doesn't really bother and is never there for me*". She also described negative thoughts regarding the future delivery and whether she was going to cope. She stated that she has never really felt this low in mood before although did attend her GP in 2014 for some mild depressive symptoms. Today she described her mood as generally fluctuating since the age of 17. She can remember only being prescribed antidepressants once for a brief period (Fluoxetine).

Family History

Her father unfortunately died approximately 2 to 3 years ago from cancer. He was aged 62 and described as being a "*good man*". It was clear that Lisa misses him considerably. Her mother, aged 50, was described as unsupportive with a tendency to play mind games. She does not get on well with her 23 year old sister [redacted]. She sees her grandparents regularly who are able to help out and she has a couple of supportive friends.

Personal History

Lisa was born in Edinburgh. She described a general uneventful childhood although her father used to work nightshift and her mother "*never had much time for us*". She described going off the rails in high school and ended up in care including a period of time at the age of 14 in a secure young persons home. Around this time she started self harming, predominantly by cutting. She told me that she had been sentenced for a period of 8 months due to assaults, robbery and shoplifting at the age of 16. This rather unsettled period in her life has now settled particularly subsequent to the birth of Mia.

At this assessment I did feel that Lisa was suffering from significant depressive symptoms amounting to a depressive illness of moderate severity. We discussed treatment options and I do think she would benefit from an SSRI. I have therefore suggested prescribing Citalopram at a dose of 20mg daily. I will also refer her to the

University Hospitals Division

St John's Hospital at Howden
Howden West
Livingston
West Lothian
EH54 6PP

NHS Lothian

Perinatal Mental Health Team CPNs for consideration of ongoing review and possible psychological therapy along IPT lines. I have not arranged a formal appointment for review but would be happy to see Lisa again if that was necessary.

Kind regards.

Yours sincerely

Dr P LeFEVRE
Consultant Psychiatrist

Copy to CPNs, Perinatal Mental Health Team, Mental Health Mother and Baby Unit, St John's Hospital

FACE Perinatal Risk Assessment Profile

Initial Assessment Date: 3/12/15	Repeat Date: 23/2/16	Repeat Date:	Discharge Assessment Date:
Is there any evidence of current behaviour presenting a risk to self, child or other?			
Yes (No)	Yes (No)	Yes No	Yes No
Obstetric/medical factors associated with increased risk? *e.g. infertility, prematurity*			
Yes (No)			
Children's social services involvement?			
Yes (No) Previous	Yes No	Yes No	Yes No
Partner or significant other known to pose a risk to others?			
Yes (No)			
Recent adverse incident *(past 3 months)*			
(No) Near miss SUI			
Past adverse incident? *(>3 months)*			
(No) Yes When:			
Previous psychiatric history?			
(Yes) No PP			

Current risk status

Rate all items using the scale shown (n/k = Not known, n/a = Not applicable)

0 = No apparent risk
No history/warning signs indicative of risk.

1 = Low apparent risk
No current history/warning signs indicative of risk. indication of risk, but person's history and/or warning signs indicate possible risk. Required precautions covered by standard care plan i.e. no special risk prevention measures or plan required.

2 = Significant risk
Person's history and condition indicate the presence of risk and this is considered to be a significant issue at resent. Requires a contingency risk management plan.

3 = Serious risk
Substantial current risk. Circumstances are such that a risk management plan should be / has been drawn up and implemented.

4 = Serious and imminent risk
person's history and/or warning signs indicate the presence of risk and this is considered imminent. Highest priority to be given to risk prevention.

Risk to mother	I	R	R	DC	Risk of harm to infant/fetus /children (from mother)	I	R	R	DC
Date:									
Risk of suicide	1	0			Risk of harm to fetus	0	0		
Risk of intentional self-harm	0	0			Risk of harm to infant	0	0		
Risk of significant self-neglect	0	0			Risk of non-accidental injury	0	0		
Risk of abuse/exploitation by others	0	0			Risk of neglect (infant/children)	0	0		
Risk related to physical condition	0	0			Risk of sexual abuse (infant/children)	0	0		
Risk of deterioration of mental state	1	1			Risk of emotional abuse (infant/children)	0	0		

Further actions recommended/required:

None ☐	Referral to Child Protection required? Yes ☐ No ☑
Maternal observation level:	
Mother-infant supervision level:	

Risk factors and warning signs

Time frame for all **current** warning signs = past month.
If none apply within any section check the 'NO' box at the top of the relevant column

Clinical symptoms indicative of risk	Initial Date: 3/12/15 **History** No☐	Repeat Date: 23/2/15 **Current** No☐	Repeat Date: **Current** No☐	Discharge Date: **Current** No☐	**Notes/detail:**
Ideas of harming infant	N	N			
Ideas of self-harm/suicidal ideation	N	N			THOUGHTS OF SUICIDE - NO PLAN INTENTION PROTECTIVE
Talk/mention of violent method of death	N	N			
Ideas of harming others	N	N			
Command hallucinations	N	N			
Delusions incorporating infant/children	N	N			
Fear of losing children	N	N			
Preoccupation with insomnia	N	N			
Morbid anxiety, not susceptible to reassurance	N	N			
Hopelessness	N	N			
Guilt/overvalued ideas of maternal incompetence	N	N			
Diagnostic indicators	**History** No☐	**Current** No☐	**Current** No☐	**Current** No☐	**Notes/detail:**
Behaviour indicative of risk	**History** No☐	**Current** No☐	**Current** No☐	**Current** No☐	**Notes/detail:**
Expressed hostility/irritability towards child(ren)	N	N			
Lack of warmth/concern/enjoyment of child(ren)	N	N			
Child safeguarding issues	N	N			
Difficulty in providing practical care for child(ren)	N	N			
Unable to protect child(ren) from others	N	N			
Threats/harm to others *(including child(ren))*	N	N			
Intentional self-harm	N	N			
Plans or preparations to commit suicide	N	N			
Significant self-neglect	N	N			
Not eating or drinking sufficiently	N	N			
Drug/alcohol abuse	N	N			
Impulsive/reckless behaviour *(e.g. unsafe driving)*	N	N			
Absconding *(including from home)*	N	N			

Treatment-related indicators	History No☐	Current No☐	Current No☐	Current No☐	Current No☐	Notes/detail:
Involvement with Perinatal services	W	Y				
Involvement with other psychiatric services	Y	W				
Discontinuation of medication/poor compliance	W	W				
Failure to attend appointments *(inc. obstetric)*	W	W				
Unplanned disengagement from services	W	W				
Personal factors indicative of risk	**History No☐**	**Current No☐**	**Current No☐**	**Current No☐**	**Current No☐**	**Notes/detail:**
Domestic violence/abuse	W	W				
Social isolation/absence of social support	W	W				
Social exclusion *(e.g. homeless/rootless)*	W	W				
Family history - serious affective disorder/suicide	W	W				
Concern expressed by others *(relatives, carers)*	W	W				
Recurrence of circumstances associated w. risk	W	W				
Referral to adult social services	W	W				
Other risk factor(s) *(specify):*						

Descriptive summary of main risks identified: brief details of recency, severity, frequency, pattern, ideation and intent; include details of serious untoward incidents, near misses etc

CURRENT EPISODE OF DEPRESSION. THOUGHTS OF SUICIDE BUT NO PLAN OR ATTEMPTS - DAUGHTER IS PROTECTIVE

Major life event/change in circumstance relevant to current state? (Yes) No Unclear

PREGNANCY - THINGATENED MISCARRIAGE

Does the mother belong to a high risk group? Yes (No) Unclear

If 3 or more factors from either of the following, answer Yes:
Group 1: 30+, stable circumstances/employed, educated to A level or higher; previously well 2yrs+, seriously ill now.
Group 2: <25, social services involvement, overdose/suicide attempts, substance misuse, (diagnosis irrelevant).

NO

Have actions been taken in the past to reduce risk? Yes ☐ No ✓ Unclear
(add details +effectiveness)

Mother's view of risk *(give details, including person's view of what is needed to reduce risk)*
Is the mother aware of possible risks? Yes ✓ No ☐ Unclear

Partner/family/carer's view of risk *(give details, including view of what is needed to reduce risk)*
Are partner/family/carer(s) aware of possible risks? Yes ☐ No ☐ N/A ☐ Unclear ✓

Risk management/crisis contingency plan
Date completed: 4/12/15 Review Date: 4/2/15
Areas of concern to be addressed by plan: DETERIORATING MENTAL STATE

Actions to be taken *(e.g. in the event of risk behaviour/relapse/failure to attend - in order of priority, detail below)* ☐

Telephone home	
Contact care co-ordinator	
Visit maternal home	1
Admission	3
Review with Responsible Clinician	3
Contact GP	2
Review medication	
Contact Health visitor	4
☐Send further appointment	
Contact safeguarding	
Contact social services	
Contact maternity services	
...ne	

Notes:

...formation sources available/accessed in completing risk profile *(select all sources used)*

Mother ☑	✓	
Case notes	✓	
Partner/relative ☐		
Other *(specify)*		

Completed by *(print name)*:	H. Simms
Profession:	CPN
Signature:	H. Sims
Date:	4/12/15

Copies sent to	Yes / No	Date	Copies sent to	Yes / No	Date
File			Health visitor		
Mother			Maternity services		
Partner/family			G.P.		
Social services			Other		
Child safeguarding social services / Trust safeguarding *(if involved)*					

Mother's name: L Williamson NHS No: Completed by: H. Smart

FACE Perinatal Overview Assessment OMDS V1

Confidential

Completed by:	H. Smart	Job title:	CPN
Trust:		Team or service:	Perinatal
Location of assessment:	Home	Outcomes ID:	
Date of initial assessment:	3/12/15	Date of discharge assessment:	

Demographic

Ethnicity:	White British	Relationship status:	Partner - does not live with
Obstetric status at time of referral:			
Children under 5 yrs:	1	Children 5-16 yrs:	

Mental health history

Previously known to mental health services?	Yes ☐	No ☐
Previously known to perinatal mental health services?	Yes ☐	No ☑

Episode details

Date of referral:	20/10/15	Source of referral: GP
Date of 1st contact with mental health services this episode	3/11/15	Time: 4pm
Date and time of 1st planned contact with perinatal service *(w. trained staff member)*	3/11/15	Time: 4pm
Date and time of 1st contact with perinatal services this episode *(if different)*		Time:
Date and time of admission to Mother and Baby Unit *(if different)*		Time:
Date and time of discharge from Mother and Baby Unit		Time:
Date and time of discharge from perinatal services *(if different)*		Time:

Diagnosis *(if uncertain please check ICD-10 or consult with doctor)*

Do the difficulties appear to be: Organic ☐ Psychotic ☐ Non-psychotic ☑

Main diagnosis:	Depressive episode
Additional diagnosis:	
Confirmed PbR Cluster:	

Risk *(risk scores should be derived from the Risk Profile)*

Children's social services involvement? Yes ☐ No ☑

Highest initial 'Risk to mother' score		Highest final 'Risk to mother' score	
Highest initial 'Risk to infant' score		Highest final 'Risk to infant' score	

Completed by

Signature and name of main assessor (initial):	H. Smart	Date:	4/12/15
Signature and name of main assessor (discharge):		Date:	

Psychological well-being

Depressed mood — Initial: 2 — Repeat: — Discharge: —

1 = Mild	*Variable low mood but maintains most aspects of daily activity.*
2 = Moderate	*Depressed mood is clear, present more often than not, tearful at times, causing significant interference in daily functioning. Ideas of guilt, self-blame, worthlessness.*
3 = Severe	*Depressed mood is continuous and pervasive. Perhaps very tearful. Persistent guilt, self-blame, hopelessness. Limited capacity to engage in daily activities. Marked feelings of inferiority.*
4 = V. severe	*Ordinary functioning is completely curtailed by intensity of mood disturbance/functioning dominated by intense ideas of guilt, self blame, hopelessness, self-loathing.*

Lowering of energy, drive or interest — Initial: 2 — Repeat: — Discharge: —

1 = Mild	*Clear report of variable reduction in interest or energy (e.g. lowered interest in engaging in activities or reduced enjoyment of infant), but minimal noticeable impact on level of activity.*
2 = Moderate	*Loss of interest or energy resulting in marked reduction in activity. Some enjoyment of those activities engaged in may still be present.*
3 = Severe	*Severe curtailment of everyday activities resulting from lack of energy or interest. Highly limited enjoyment of ordinarily enjoyable activities (e.g. appears to take little pleasure in children, eating, everyday interests).*
4 = V. severe	*Everyday activities/childcare reduced to a minimum. No interest in, energy to engage in, or pleasure in such activities.*

Mother's name: NHS No: Completed by:

Sleep disturbance *(excluding when woken by baby)*	**Initial**	2	**Repeat**	**Discharge**
1 = Mild	*Occasional difficulties with falling asleep, staying asleep and/or sleeping too much. Minimal impact on maternal, social or occupational functioning. Little or no distress reported.*			
2 = Moderate	*Regular sleep difficulties involving trouble falling or staying asleep and/or sleeping too much resulting in some lowering of functioning and/or distress.*			
3 = Severe	*Sleep difficulties causing persistent distress and/or disruption in maternal, social or occupational functioning.*			
4 = V. severe	*Major disruption of sleep pattern causing serious distress and seriously limiting the capacity to engage in ordinary daily activities.*			

Elevated or expansive mood	**Initial**	0	**Repeat**	**Discharge**
1 = Mild	*Elevated or expansive mood but of insufficient intensity or frequency to alter behaviour.*			
2 = Moderate	*Elevated or expansive mood noticeably unusual to others and having significant effect on maternal functioning/ pattern of daily living. Over-optimistic or exaggerated ideas/plans involving self/child.*			
3 = Severe	*Elevated or expansive mood causing major disruption in maternal, social and/or occupational functioning. Inflated excessive ideas or plans involving self/child. Grandiosity.*			
4 = V. severe	*Elevated or expansive mood dominates behaviour causing complete disruption in maternal, social and/or occupational functioning. Wildly excessive ideas/plans. Severe grandiosity.*			

Anxiety, phobias and panic *(if leads to avoidance of baby rate at least 3)*	**Initial**	0	**Repeat**	**Discharge**
1 = Mild	*Transient bouts of worrying, feelings of tension or fear. At most occasional avoidance but no consistent behavioural consequences.*			
2 = Moderate	*Persistent worrying, fear, tension of sufficient intensity to affect care of child/daily activities (e.g. regularly avoids certain situations).*			
3 = Severe	*Continuous, repetitive experiences of intense worrying, fear or tension/panic attacks. Limited ability to engage in care of child/ordinary daily activities, avoids being alone with child.*			
4 = V. severe	*Mental state dominated by intense anxiety. Behaviour dominated to the point where is unable to engage in care of child/ordinary daily activities.*			

Somatic preoccupations	**Initial**	0	**Repeat**	**Discharge**
1 = Mild	*Fleeting worries about physical state of self or child in absence of evidently justifiable physical cause, but minimal behavioural consequences (e.g. does not seek medical reassurance).*			
2 = Moderate	*Persistent worries about physical state of self or child in absence of justifiable physical cause, leading to request for investigations or medical reassurance.*			
3 = Severe	*Continuous ruminations about physical state of self or child. Consequent behaviour plays significant part in daily life (e.g. frequent requests for investigations).*			
4 = V. severe	*Disabling level of ruminations dominates daily life; conviction that has major illness unresponsive to any level of reassurance despite absence of physical evidence.*			

Obsessional ideas and compulsive behaviour	**Initial**	0	**Repeat**	**Discharge**
1 = Mild	*Presence of intrusive obsessional ideas and/or need to carry circumscribed compulsive behaviours. No appreciable impact on daily functioning. No distress caused.*			
2 = Moderate	*Obsessional ideas/compulsive behaviours have significant impact upon maternal, social or occupational functioning, by virtue of distress caused, frequency of behaviours, or both.*			
3 = Severe	*Obsessions and/or compulsions severely disrupt maternal, social or occupational functioning and/or are a frequent cause of serious distress.*			
4 = V. severe	*Daily functioning dominated by continuous obsessional ideas and/or by constant and repetitive carrying out of compulsive behaviours, and/or is a constant cause of disabling levels of distress.*			

Attention and concentration	**Initial**	2	**Repeat**	**Discharge**
1 = Mild	*Able to follow conversation/TV programmes but easily distracted. Can return to matter in hand.*			
2 = Moderate	*Difficulty following conversation/TV programme for more than a few minutes.*			
3 = Severe	*Frequent distractability. Cannot follow a conversation/TV programme. Difficulty in completing in simple tasks e.g. making up a bottle.*			
4 = V. severe	*Cannot attend to matter in hand e.g. cannot take in or respond to simple questions. Unable to complete simple tasks.*			

Strongly held unreasonable beliefs *(include only non-psychotic beliefs)*	**Initial**	0	**Repeat**	**Discharge**
1 = Mild	*Holds discreet overvalued/unfounded belief(s) but has insight and can challenge them most of the time. Minor impact on one or two aspects of role as a mother/daily life.*			
2 = Moderate	*Strongly held unfounded beliefs, with some insight. Beliefs can be challenged occasionally but are often resistant to rational argument. Has a significant negative impact on role as a mother/daily life.*			
3 = Severe	*Holds strong unfounded or irrational beliefs. Beliefs are generally resistant to rational argument. Has a negative impact on several aspects of role as a mother/daily life.*			
4 = V. severe	*Strongly held unfounded beliefs affecting beliefs in most areas of life. Beliefs are very resistant to rational argument. Has a severe and sustained impact on role as a mother/other areas of life.*			

Delusions *(if delusions involve child then rate 4)*	**Initial**	0	**Repeat**	**Discharge**
1 = Mild	*Discrete delusions not evident from daily behaviour and attitudes.*			
2 = Moderate	*Delusional beliefs evident from daily behaviour/attitudes but impact confined to circumscribed areas of activity/ attitudes and/or delusional beliefs limited to certain areas of life.*			
3 = Severe	*Delusional beliefs play major part in daily behaviour, influencing planning of activity, attitudes to and communication with others.*			
4 = V. severe	*Behaviour completely dominated by response to delusional beliefs.*			

Mother's name: NHS No: Completed by:

Hallucinations and perceptual disturbances *(if perceived as originating from child or any command hallucinations rate 4)*	**Initial**	○ **Repeat**	**Discharge**
1 = Mild	*Hallucinations present but causing at most mild distress. Limited impact on behaviour. Has a high degree of control over them.*		
2 = Moderate	*Some insight but hallucinations intrude upon daily functioning to significant degree. Hallucinations may be regular and lasting in duration. Able to exert some control.*		
3 = Severe	*Limited insight, continuous hallucinations and responses to these have major impact upon daily functioning. Limited ability to exert control over them.*		
4 = V. severe	*Hallucinations and responses to these completely dominate mental and daily life. No ability to exert control over them.*		
Thought disorganisation	**Initial**	○ **Repeat**	**Discharge**
1 = Mild	*Occasional noticeable disruption of speech pattern or reasoning but minimal impact on ability to communicate.*		
2 = Moderate	*Marked disruption of speech pattern or reasoning leading to definite interference in ability to communicate (e.g. difficulties with processing information).*		
3 = Severe	*Speech or reasoning disrupted to the point where ability to communicate is limited and ability to maintain daily living activities is affected.*		
4 = V. severe	*Incapacitated by disruption of speech and reasoning problems.*		
Memory	**Initial**	2 **Repeat**	**Discharge**
1 = Mild	*Mild but definite forgetfullness (e.g. has consistent difficulty recalling familiar names or events).*		
2 = Moderate	*Marked forgetfullness to the point that some activities are disrupted (e.g. cannot rely on finding objects or carrying out plans).*		
3 = Severe	*Consistent forgetfullness causing widespread restriction of former range of activites and independent functioning (e.g. consistently loses way, loses objects, forgets plans). Not reliably oriented in at least one of time, place or person.*		
4 = V. severe	*Pervasively forgetful. Incapacitating lack of recall of past and/or recent events/familiar others, resulting in minimal independent functioning (e.g. severe disorientation to time, place or person).*		
Aggressive behaviour *(includes damage to property, abusiveness, irritability, threatening behaviour). If in front of/towards child add 1 to score.*	**Initial**	○ **Repeat**	**Discharge**
1 = Mild	*Transient expression of excessive irritation in response to frustration; occasional abusiveness.*		
2 = Moderate	*Consistent irritability; occasional verbal threats; threat of or minor damage to property sufficient to cause concern to others.*		
3 = Severe	*Intimidating/threatening behaviour; significant damage to property; consistent concern to others.*		
4 = V. severe	*Persistent hostility; reliance on bullying or threats of physical violence; major damage to property; cause of major concern to others.*		
Overactivity *(including restlessness and agitation)*	**Initial**	○ **Repeat**	**Discharge**
1 = Mild	*Observable increase in level of activity/sense of restlessness, agitation or excitement. However, can e.g. sit reasonably still while interviewed, interactions or activities not markedly affected.*		
2 = Moderate	*Marked increase in activity, affecting everyday interactions and activities (e.g. cannot sit still for any sustained period, frequently has to get up and sit down again; doing more than is manageable).*		
3 = Severe	*Major impact on interactions and activity (e.g. frequent pacing or restlessness, unsustainable level of activity, finds it hard to complete anything). Difficult to interact with due to excitement/activity.*		
4 = V. severe	*Constant excessive level of activity. Extreme restlessness, agitation or excitement dominates interactions. Unable to engage in or complete daily activities (e.g. spends day pacing, agitated).*		
Odd, inappropriate or unacceptable behaviour *(not previously rated, exclude compulsions)*	**Initial**	○ **Repeat**	**Discharge**
1 = Mild	*Atypical or unusual behaviour, not problematic in itself but noticeable because out of the ordinary (socially unacceptable) behaviour.*		
2 = Moderate	*Problematic behaviour causing noticeable disruption/impact on maternal/daily functioning/others.*		
3 = Severe	*Frequent problem, causing major concern and having widespread impact on maternal/daily functioning/others.*		
4 = V. severe	*Constant, severe and prominent problem. Dominates everyday interactions and behaviour, including with child(ren). Social acceptance is likely to be jeopardised if persists.*		
Eating problems *(if behaviour extends to child's nutrition rate 4)*	**Initial**	○ **Repeat**	**Discharge**
1 = Mild	*Difficulty eating reasonable portions of food and excessive concern about calorie intake.*		
2 = Moderate	*Marked problems with restricting of intake. Preoccupied with calories and weight accompanied by occasional bingeing and purging by vomiting or laxative use, or excessive exercise.*		
3 = Severe	*Severe problems related to food restriction/body weight. Frequent bingeing/purging or extreme exercise routine along with severely restricted diet.*		
4 = V. severe	*Behaviours related to the body and intake of food dominate behaviour to the point that daily activities and social involvement are strictly limited.*		
Suicidal ideation and behaviour *(any thoughts involving child rate 4)*	**Initial**	2 **Repeat**	**Discharge**
1 = Mild	*Occasional thoughts that life is not worth living.*		
2 = Moderate	*Occasional thoughts of suicide with no identified methods or planning.*		
3 = Severe	*Persistent thoughts of suicide with possible methods identified but no evidence of planning.*		
4 = V. severe	*Recent attempt or persistent thoughts of suicide, evidence of planning and preparatory behaviour.*		

Mother's name: NHS No: Completed by:

Non-accidental self-harm *(any self-harm in presence of child rate minimum 3)*	**Initial**	**Repeat**	**Discharge**
1 = Mild	*Low intensity behaviour, source of concern, but at most causing minor harm (e.g. scratching).*		
2 = Moderate	*Causing significant physical harm but impermanent or inconsequential long-term damage (e.g. lacerations, bruising, cigarette burns).*		
3 = Severe	*Likely to cause permanent tissue damage or significant impairment. Medical attention necessary. Not life threatening.*		
4 = V. severe	*Episode(s) of severe physical harm with likelihood of major impairment or death.*		

For the following items, rate the worst episode ever that remains relevant to the current care plan.

Repeated self-harm *(if in presence of child score minimum of 3)*	**Initial**	**Repeat**	**Discharge**
1 = Mild	*Superficial cutting, biting, bruising etc. or small ingestions of hazardous substances unlikely to lead to significant harm even if treatment not sought.*		
2 = Moderate	*Repeat self-injury requiring hospital treatment. Possible dangers if hospital treatment not sought. Unlikely to leave lasting damage even if continues, providing medical treatment sought.*		
3 = Severe	*Repeat self-injury requiring hospital treatment and likely to leave lasting damage if behaviour continues.*		
4 = V. severe	*Repeat self-injury requiring urgent hospital treatment and likely to leave lasting severe damage or to result in death if behaviour continues.*		

Safeguarding children	**Initial**	**Repeat**	**Discharge**
1 = Mild	*Illness or behaviour causing some concerns for the safety or well-being of child but not reaching the threshold for safeguarding referral. Is aware of the potential impact but is supported and is able to make adequate arrangements.*		
2 = Moderate	*Illness or behaviour has an impact on the safety or well-being of child. Has insight and can take action to significantly reduce the impact of behaviour and is adequately supported.*		
3 = Severe	*Without action the illness or behaviour is likely to have direct or indirect severe impact on the safety or well-being of child. Limited insight, inability and/or unwillingness to take adequate precautions to protect child(ren).*		
4 = V. severe	*Without action the illness or behaviour is likely to have an extreme direct or indirect impact on the safety or well-being of child.*		

Engagement	**Initial**	**Repeat**	**Discharge**
1 = Mild	*Occasional difficulties with engagement and some understanding of own problems (e.g. some missed appointments for self and child or some inappropriate contacts between appointments).*		
2 = Moderate	*Unreliable attendance at appointments/needs prompting and/or support to attend OR regularly contacts services inappropriately.*		
3 = Severe	*Rarely attends appointments, or attendance is dependent upon considerable prompting and support, OR contacts services inappropriately frequently. Only partially complies with planned care.*		
4 = V. severe	*Does not attend appointments or refuses service input OR constantly contacts multiple agencies inappropriately (e.g. GP, A&E). Does not comply with planned care.*		

Drug and alcohol use

Current alcohol use *(include amount, type and frequency, if episodes of intoxication whilst caring for a child rate minimum 3)*	**Initial**	**Repeat**	**Discharge**
1 = Mild	*Over-indulgence beyond social norm but not causing concern to self or others.*		
2 = Moderate	*Regular excessive drinking sufficient to cause concern to others. At most, occasional loss of control.*		
3 = Severe	*Consistent heavy intake and/or loss of control, causing major concern to others and disruption to daily functioning (e.g. persistent drunkenness).*		
4 = V. severe	*Alcohol related behaviour dominates daily life.*		

Current drug use *(specify type, administration method, quantity, frequency of illicit use)*	**Initial**	**Repeat**	**Discharge**
1 = Mild	*Recreational use of minor illegal drugs. Not causing concern to self or others.*		
2 = Moderate	*Regular drug taking sufficient to cause concern to others. At most, occasional loss of control.*		
3 = Severe	*Consistent heavy intake and/or loss of control causing major concern to others and disruption to daily functioning (e.g. drug acquisition/funding significantly impacts life).*		
4 = V. severe	*Drug related behaviour (taking, acquiring, recovering from) dominates daily life.*		

Physical health and well-being

Physical health condition	**Initial**	**Repeat**	**Discharge**
1 = Mild	*Transient, self-limiting health problems, unlikely to have long-term effect or significant adjustment of lifestyle.*		
2 = Moderate	*Significant health problems requiring medical intervention/monitoring/adjustment of lifestyle to prevent deterioration.*		
3 = Severe	*In poor health. Suffering from serious condition(s) and/or physically frail. Requires medical intervention/major adaptation of lifestyle/extensive monitoring.*		
4 = V. severe	*Very poor health. Suffering from imminently life threatening condition/extreme frailty.*		

Physical impairment/disability	**Initial**	**Repeat**	**Discharge**
1 = Mild	*At most restriction on activity/mobility due to impairment/disability.*		
2 = Moderate	*Restriction in significant areas of mobility/activity due to impairment/disability.*		
3 = Severe	*Major restrictions in activity/mobility due to impairment/disability.*		
4 = V. severe	*Fully dependent. Activity/mobility severely restricted by impairment/disability.*		

Mother's name: NHS No: Completed by:

Activities of daily living *(rate over past 2 weeks)*

Personal care – self *(eating/drinking, washing/dressing, toilet needs, looking after appearance, etc.)*	**Initial**	**Repeat**	**Discharge**
1 = Mild	*Maintains most aspects of personal care of self but some difficulties or deficits in relation to appearance, personal hygiene, attention to health or food intake.*		
2 = Moderate	*Marked deficits or difficulties in maintenance of personal appearance, personal hygiene, attention to health or food/fluid intake. Insufficient to cause a health risk.*		
3 = Severe	*Major deficits or difficulties in maintenance in more than one of: appearance, personal hygiene, neglect of fluid/food intake. Difficulties cause problems with acceptability and/or detrimental to health.*		
4 = V. severe	*Does not or is not able to maintain personal care of self. Gross neglect/severe difficulties relating to appearance, diet, health or hygiene resulting in risk to health/major problem of social acceptability.*		

Day-to-day activities *(include preparing food, snacks, main meals for self and family, managing paperwork, household management tasks, shopping, etc.) A score of 2 or more indicates the need for further assessment in this area.*	**Initial**	**Repeat**	**Discharge**
1 = Mild	*Some difficulties maintaining day-to-day activities but most tasks completed adequately.*		
2 = Moderate	*Marked limitations in performance of day-to-day activities (e.g. unable to complete/neglects some aspects, performs others sporadically or inadequately).*		
3 = Severe	*Major deficits in task performance. Many tasks not performed, others only poorly. Only basic level of functioning maintained.*		
4 = V. severe	*Gross deficits in performance of day-to-day activities (e.g. necessities not attended to).*		

Interpersonal relationships *(rate over past 2 weeks)*

Care of the child(ren) – safety	**Initial**	**Repeat**	**Discharge**
1 = Mild	*Some difficulties/occasional lapses in maintaining baby in safe environment or paying attention to potential dangers e.g. safety harness, stairs, leaving baby unattended. Responds to advice and supervision. No irritability, hostility to baby.*		
2 = Moderate	*Persistent difficulties in protecting baby from potential hazards. Requires frequent advice and supervision but no irritability/hostility to baby.*		
3 = Severe	*Requires constant supervision to ensure baby is safe and/or expresses anger/hostility to baby.*		
4 = V. severe	*Unable to attend to safety of child at present, others have to undertake.*		

Care of the child(ren) – physical	**Initial**	**Repeat**	**Discharge**
1 = Mild	*Some difficulties/occasional lapses in dressing child appropriately and/or preparing feeds and/or timing of feeds and/or cleaning and changing nappy frequently. Mostly requires no more than occasional prompting, accepts advice.*		
2 = Moderate	*Frequent difficulties in initiating and completing regular and appropriate feeding/cleaning/nappy changing, dressing. Requires regular prompting but undertakes appropriate care under supervision.*		
3 = Severe	*Requires constant supervision/assistance to feed/wash/nappy change/dress infant.*		
4 = V. severe	*Unable to attend to physical care of child at present, others have to undertake.*		

Care of the child(ren) – emotional	**Initial**	**Repeat**	**Discharge**
1 = Mild	*Some difficulties/occasional lapses in making eye contact with baby/holding baby close and cuddling/smiling and talking to baby/responding to baby's cues, settling baby when tired/distressed, stimulating baby.*		
2 = Moderate	*Occasionally handles baby brusquely, talks to baby harshly at times/not responsive to baby's cues/over or under stimulates baby. Unable to respond to baby's distress.*		
3 = Severe	*Persistent difficulties in making eye contact/smiling/talking/stimulating/soothing/enjoying the baby. And/or speaks to infant harshly, expresses anger/irritability/handles baby roughly.*		
4 = V. severe	*Does not make contact with child, only does so very occasionally, or has almost exclusively negative interactions.*		

Availability of practical support *(including with childcare)*	**Initial**	**Repeat**	**Discharge**
0 = High	*Partner/family/friends provide extensive practical support as required throughout the day.*		
1 = Substantial	*Substantial practical support from partner/family/friends on a daily basis e.g. babysitting, help with housework, shopping etc.*		
2 = Moderate	*Receives some practical support on a regular but less than daily basis.*		
3 = Low	*Occasional practical assistance provided. Cannot be depended upon on a regular basis.*		
4 = None	*No or very limited practical support available from partner/family/friends.*		

Availability of emotional support from partner	**Initial**	**Repeat**	**Discharge**
0 = High	*Partner very supportive. Can confide in and rely upon partner when in need.*		
1 = Substantial	*Substantial emotional support from partner; can confide in partner who is regularly available.*		
2 = Moderate	*Receives some emotional support from partner. Can confide to limited degree OR partner not regularly available.*		
3 = Low	*Receives limited emotional support from partner. Cannot confide in and at most occasional opportunity to share difficulties.*		
4 = None	*No or very limited emotional support available from partner.*		

Mother's name:	NHS No:	Completed by:

Availability of emotional support from family/ friends	**Initial**	2 **Repeat**	**Discharge**
0 = High	*Family/friends very supportive. Has a number of people can confide in and rely upon when in need.*		
1 = Suhstantial	*Substantial emotional support from family/friends; can confide in at least one person who is regularly available.*		
2 = Moderate	*Receives some emotional support from family/friends. Can confide to limited degree OR confidant not regularly available.*		
3 = Low	*Receives limited emotional support from family/friends. Has no-one can confide in and at most occasional opportunity to share difficulties.*		
4 = None	*No or very limited emotional support available from family/friends.*		

Ability to form and maintain interpersonal relationships	**Initial**	1 **Repeat**	**Discharge**
1 = Mild	*Able to form and maintain relationships but some difficulties in maintaining relationships or in quality of relationships.*		
2 = Moderate	*Significant difficulties in forming/maintaining relationships and/or consistent involvement in dysfunctional pattern of relationships.*		
3 = Severe	*Major difficulties in forming/maintaining relationships and/or frequently involved in destructive patterns of relationship.*		
4 = V. severe	*Rarely or never forms meaningful relationships and/or highly destructive or very short-lived involvements.*		

Social activities	**Initial**	3 **Repeat**	**Discharge**
1 = Mild	*Participates in regular social activities about once a week (e.g. sees friends, family).*		
2 = Moderate	*Participates in occasional social activities only (at least once a month).*		
3 = Severe	*Social activities limited to irregular and infrequent contacts with friends or family (less than once a month).*		
4 = V. severe	*Socially isolated. Little or no social contact.*		

Social circumstances

Vulnerability (of mother)	**Initial**	1 **Repeat**	**Discharge**
1 = Mild	*Concerns about ability to protect health, safety or well-being of self requiring support or removal of existing support would increase concern.*		
2 = Moderate	*Evidence of significant vulnerability e.g. incidents providing firm indication of vulnerability. Requires significant support to protect health, safety and well-being of self.*		
3 = Severe	*Severe vulnerability. Clear evidence of abuse, exploitation or stigma and/or only able to protect health, safety or well-being of self to limited extent.*		
4 = V. severe	*Extreme vulnerability. Evidence of serious abuse causing major distress or unable to protect health, safety or well-being of self.*		

Difficulties with housing situation	**Initial**	0 **Repeat**	**Discharge**
1 = Mild	*Stable situation but problems with one or more aspects (e.g. deficiencies in decorative order or amenities).*		
2 = Moderate	*Multiple problems with accommodation causing some distress. May have limited stability.*		
3 = Severe	*Accommodation is unacceptable (e.g. urgent need of repair or at serious risk of eviction)*		
4 = V. severe	*Homeless or on the point of eviction or urgent need for repair is such that home fails to meet even basic needs or is unsanitary (e.g. no plumbed water/no useable toilet facilities).*		

Difficulties in accessing education/employment/ training	**Initial**	0 **Repeat**	**Discharge**
Not applicable	*Mother does not wish to access/engaged in childcare.*		
1 = Mild	*Some difficulties accessing appropriate resources, but has range of opportunities to engage in meaningful education, training or employment.*		
2 = Moderate	*Significant difficulties accessing appropriate resources, has some opportunity to engage in meaningful education, training or employment.*		
3 = Severe	*Major difficulties in accessing appropriate resources. Has limited opportunity to engage in meaningful education, training or employment.*		
4 = V. severe	*No opportunity to access any education, training or employment.*		

Completing the FACE Assessments: Key principles

Care Clusters

00	*Unable to assign patient to Care Cluster*
01	*Common mental health problems (low severity)*
02	*Common mental health problems (low severity with greater need)*
03	*Non-psychotic (moderate severity)*
04	*Non-psychotic (severe)*
05	*Non-psychotic disorders (very severe)*
06	*Non-psychotic disorder of over-valued ideas*
07	*Enduring non-psychotic disorders (high disability)*
08	*Non-psychotic chaotic and challenging disorders*
09	*Substance misuse*
10	*First episode psychosis*
11	*Ongoing recurrent psychosis (low symptoms)*
12	*Ongoing or recurrent psychosis (high disability)*
13	*Ongoing or recurrent psychosis (high symptom and disability)*
14	*Psychotic crisis*
15	*Severe psychotic depression*
16	*Dual diagnosis*
17	*Psychosis and affective disorder – difficult to engage*
18	*Cognitive impairment (low need)*

Lothian PNMHS Caseload Contacts Sheet Name: Chi: *

	Name:	Address:	Tel No:	E-mail:	Current involvement (detail frequency)	Date of referral
Patient	LISA WILLIAMSON	7/9 TYTLER GDNS EDINBURGH	07580 680 640			
Next of Kin						
Family contact						
GP	DR S WRIGHT	ST TIMOTHY HALLS MP	0131 657 3341			
Midwife						
Health Visitor	ROSE ROSS	ST TIMOTHYS MP	0131 657 3341			
GA Consultant						
GA CPN						
Social Work						
AHP						
MHO						
Other agencies						

Perinatal Mental Health Service- Community Mental Health Team
CARE PLAN

Name: Lisa Williamson
CHI:

Risk and Need Identified:
Depressive symptoms impacting on daily life

Plan:
Weekly review of mental state IPT

Intervention:
? IPT Commence antidepressant medication

Completed by: H. Scott Signed: H Scott Date: 4/12/15

Discussed and Agreed with patient: ☐

Patient Signature: _____

O.P. CLINICAL NOTES

(Psychiatry)

NUMBER Lisa Williamson

NAME 7/4 Tytler Gardens Edinburgh

DATE	SHEET No.
3/12/15	Seen at home following assessment by Dr Lelevre, Consultant Psychiatrist. Deteriorating mood during pregnancy. Threatened miscarriage and fears regarding safety of pregnancy. Ongoing relationship difficulties with partner. They do not live together. This is an ongoing arrangement. Feeling unsupported by him, numerous arguements. Poor eye contact, improved towards end of visit, otherwise good rapport. Spoke at length. Disturbed sleep, poor appetite, reduced interest and enjoyment. Spends most time at home alone, increased irritability. Has considered ways to end her life but no fix plan - thoughts protective.

WLT 575

14/12/15 - Visit as planned. Lisas presentation remains as previous visit. Reporting no change in symptoms. Has adressed some issues with partner, communication improved and he is providing practical and emotional support. Benefiting from reduced arguements. Support from a friend who she spends time with. Discussed maximising the support she can offer.

Only constant reliable support she has is grandparents provide practical support but not a confiding relationship. Acknowledged that there may be some benefits to having them more emotionally available, will consider discussing her depression and treatment as a last step.

Feeling more positive about pregnancy. Scan revealed baby is a girl; no feels more bond and beginning to make preparations.

Spending alot of time alone in house - avoiding company, lacking motivation and energy. Discussed planning daily - 1 hour in house, getting out house each day

O.P. CLINICAL NOTES

(Psychiatry)

NUMBER

NAME

DATE	SHEET No.
14/12/15	No current suicidal thoughts. Commenced on Citalopram 20mg daily. Minimal side effects, awaiting any positive effects on mood will take longer. H. Smart H. SMART CPN
7/1/16	Seen at home on behalf of colleague H. Smart. Daughter [redacted] at school. Lisa reporting continued improvement in mood and is trying to schedule some task to do daily. She feels motivation is still an issue, but is successfully managing to take and pick up daughter from school. She reports an improvement in her relationship with boyfriend and he is coming to house x4/wk. He may move in when the baby arrives. Has chosen a name 'Morgan' and is feeling more excited about the baby. Lisa is gaining some enjoyment from doing her volunteer work at youth cafe x1/wk. However she currently feels unable to access paid employment, so we discussed applying for alternative benefit from ESA. ? may require

medical letter.

We also discussed benefits of Citalopram. Lisa believes medication has made significant impact on mood - no suicidal thoughts or "horrible thoughts" and feels relieved by this. Discussed potential increase and advised I will liaise with Dr Lefevre re: increase.

Advised Lisa that it may be Heather who will see her on next visit and that we will contact her next week re: medication and next visit.

MOT.

20/01/16 T/C to GP/MP & e-mail re ↑ of Citalopram which was agreed by Dr Lefevre at Caseload MDT on 12/01. Heather visited Lisa at home on 15/01 at which point she commenced the 40mg dose. See e-mail for further information.

Sharon McMenemy R/N
SHARON McMENEMY

21/01/16 T/C to Lisa re: above. She will arrange to collect prescription today.

Sharon McMenemy R/N
SHARON McMENEMY

22/01/16. 4 telephone calls to Lisa to cancel todays appt. however no answer and phone unable to accept voicemail.

LHouse
Lisa Hhouse
CPN

27/01/16 Further attempts to contact Lisa have failed, the mobile number stating it is unavailable. Contacted GP practice who have no other contact number. Mhairi O'Byrne will attend Lisa's address tomorrow afternoon in hope of making contact, and leave a note to get in touch with us if not.

SMcMENEMY
SMcMenemy

LW CHI: 2601901187 - medication request

PNMHS (NHS LOTHIAN)

Sent: 20 January 2016 13:50

To: Mackay Andrew (NHS LOTHIAN); Clinical.s70785@lothian.scot.nhs.uk

Cc: Peter.Lefevre@nhslothian.scot.nhs.uk; Smart Heather (NHS LOTHIAN) [heathersmart1@nhs.net]; lothianPNMHS@nhs.net

Dear Dr MacKay

i am emailing on behalf of my colleague Heather Smart, CPN who is currently seeing a lady on your caseload, Lisa Williamson, CHI: 2601901187. Unfortunately Heather is currently off sick.
After discussion at our Caseload MDT last week with Dr LeFevre our Consultant it was agreed that as Lisa had had a patial response to Citalopram that her dose should be increased from 20mgs to 40mgs.
Heather advised Lisa of this at her visit last Friday, and Lisa doubled her dose from that point meaning her prescription will run out tomorrow.
Can we request a further prescription for her from Thursday 21/01/16 for 40mgs of Ciatalopram daily, which she can collect to have dispensed at her Pharmacy.

Many Thanks

Regards

Sharon

Sharon McMenemy
Acting Team Lead
Lothian PNMHS Community Team

Referrals for the Lothian Perinatal Mental Health Community Team are not triaged daily.
Referrers should be aware these are discussed at the weekly Triage meeting on Tuesdays, and referrals of any women causing immediate concern or requiring a more immediate assessment should be referred to local Mental Health Acute response/crisis services such as MHAS, ACAST or local IHTT services
Detailed information and handouts relating to mental health and pregnancy can be found on RefHelp; the RCGP Clinical Resources page about Perinatal Mental Health; or the Maternal Mental Health Scotland webpage.

O.P. CLINICAL NOTES
(Psychiatry)

NUMBER
NAME Lisa Williamson

DATE	SHEET No.
12/2/16	Visit as planned. Lisa not at home. H. Sut H. Smart CPN
22/2/16	Visit as planned. Lisa bright in mood, excited about having had CD scan yesterday and seeing her baby. Making preparations for baby and looking forward to baby arriving. Getting on well with [redacted], looking forward to him moving in. No reported depressive symptoms, feeling back to her usual self. Positive about the future. One further appt to complete discharge paperwork. H. Sut H. Smart CPN
14/3/16	Visit as planned. Lisa not at home. H. Sut H. Smart CPN

WLT 575

29/5/16. Phone call to Rose Ross, Health Visitor Reports Lisa is doing well with new baby. Bonding well, mood bright and appears to be well supported by partner. Agreed with GP that postnatal monitoring maybe helpful given history. Rose to advise Lisa of appt on June 6th at 12.30pm

H. Sut
H. Smart (RN)

O.P. CLINICAL NOTES (Psychiatry)	NUMBER / NAME: Lisa Williamson, 7/9 Tytler Gardens, EDINBURGH

DATE	SHEET No.
2/6/16	Phone call to Rose Ross, Health Visitor. Rose reports that Lisa remains well, bright in mood. Bonding well with new baby and adapting well to being a mother of 2. Relationship with partner continues to go well, he is providing alot of support. Agreed I would try and see Lisa given mood in pregnancy and request from GP to maintain contact postnatally. Rose will see Lisa this week and advise her I will visit on 6/6/16. H Smart CMN
6/6/16	DNA H Smart CMN

WLT 575

Smart, Heather

From: Smart, Heather
Sent: 11 April 2016 16:39
To: Mackay, Andrew; Carter, Gillian
Cc: Clinical GP St Triduanas Medical Practice
Subject: Perinatal Service patient L. Williamson CHI:2601901187

Dear Dr MacKay/Gillian

Lisa was referred to the Perinatal Mental Health Service in October 2015, this was due to Lisa suffering from significant depressive symptoms during her pregnancy. I was meeting with Lisa on a regular basis, during this time she commenced Citalopram, now 40mgs daily and worked well to improve her mood. On my last meeting with Lisa her mood had significantly improved she was feeling positive about the baby's arrival and was making appropriate preparations. Depressive symptoms were minimal. We agreed I would meet with Lisa one further time during her pregnancy , Lisa missed this appointment and I have not been able to contact her by phone since. I will sent her an opt in letter but I am aware the baby will be due soon 02/05/16. I had hoped to remain in contact with Lisa in the t natal period to monitor her mood given the difficulties she has experienced during pregnancy.

t the moment I am not sure of Lisa current mental state although she certainly was doing well. I wondered if you had had any contact with Lisa recently and if you if there were any concerns?

If I do not hear from Lisa and continue to be unable to contact her by phone I will have to the discharge her from this service.

Please let me know if you have any up-to-date information.

Thank you

Heather Smart
Community Psychiatric Nurse
Perinatal Mental Health Service
01506 524177

Patient name: Lisa Williamson **Date of birth:** 26/01/90

EDD/Date of delivery: 03/05/16 **Baby's name:**

Other children in the family: 5yr old daughter, Mia **Diagnosis:** Moderate depressive illness

PNMHS key worker: Heather Smart

Date of discussion	Risks and concerns	Current medication	Treatment plan
02/02 2016		Citalopram 40mg.	Mood improved. Engaged and committed. Managing relationship well - D/f moving in +ve about baby's arrival. Good response &
5/4/16		Continues on Citalopram	biological symptoms resolving. Baby due in next few weeks - preparing for DLC.
31/5/16			Compliant & engaged. Improved on Citalopram 20mgs. Post-natal monitoring. H/v states doing well Visit next wk.

700/89/111

NHS Lothian

Royal Edinburgh Hospital

Date: 28/06/2016

Dr MacKay
St Triduana's Medical Practice
St Triduanas Medical Practice
54 Moira Park
Edinburgh
EH7 6RU

Outpatient Clinic Letter

Patient	Lisa Williamson 9/7 Tytler Gardens Edinburgh EH8 8HS	**CHI** **Date of Birth / Age** **UHPI**	**2601901187** 26/01/1990 (26 years) 700168111M
Specialty	Perinatal - MHT	**Attendance Date**	06/06/2016
Consultant	Heather Smart		

Dear Dr MacKay

Following your referral to the Perinatal Mental Health Service during Lisa's pregnancy, she was assessed by Dr LeFevre, Consultant Psychiatrist and diagnosed with a depressive illness of moderate severity and he commenced Lisa on Citalopram 20mg daily.

I met with Lisa on a number of occasions during her pregnancy; first meeting when Lisa was 20 weeks pregnant, she was extremely low and felt at that time that she wished to terminate her pregnancy. Lisa has worked very well to improve her mood and with some persuasion did eventually begin her prescription of Citalopram and this had a positive effect on her mood. Lisa worked hard to address difficulties with her partner and improve their communication and they now appear to be working more as a team. I believe he was going to be moving in with Lisa and the children. She also began to structure her day to give her some routine and this was helpful to her. In the latter stages of her pregnancy, Lisa felt she was back to her usual self; she was bright and socially active again. She was enjoying her five year old daughter more and was looking forward to the birth of her baby. I had agreed I would see Lisa on one more occasion during her pregnancy as no further input at that point was required and review her in the postnatal period. Lisa missed this last appointment and it has proved very difficult to get in touch with Lisa to rearrange any further input. I wasn't concerned about this lack of input during her pregnancy but had hoped to see her after the baby was born. Again, establishing contact with Lisa has been difficult. Both Lisa's midwife and health visitor have reported that Lisa remains bright in mood and is coping well with her new baby with the support of her partner. I arranged to see Lisa on 6 June, an appointment which was arranged via her health visitor. However, when I went to Lisa's house, she was again not at home.

Due to the difficulties establishing contact with Lisa and reports that she is currently doing well, I will now discharge her from this service. Should there be any evidence of emerging mental illness, we can accept referrals up until her baby is six months old.

Should you require any further information, please do not hesitate to get in touch.

Yours sincerely

esigned

HEATHER SMART
CPN
Perinatal Mental Health Service

Copy: Rose Ross, Health Visitor, St Triduanas Medical Practice, 54 Moira Park, Edinburgh EH7 6RU