NHS Highland

Perinatal Mental Health

Good Practice Guidelines

Protocol Reference: 011/241008	Date of Issue: December 2008
Prepared by: Laura Patience, Sally Amor, Sandra Harrington	Date of Review: December 2010
Lead Reviewer: Sally Amor, Child Health Commisioner/Public Health Specialist	Version: 1
Authorised by: CPRG	Date: 24th October 2008
RIA undertaken: Yes	RIA: Completed Yes

Distribution:

- Midwives
- Health Visitors
- GPs & GP Sub Group
- Obstetricians
- General Managers
- Lead Nurses
- Direct Health Services Management Team
- Area Nursing & Midwifery Advisory Committee
- Clinical Governance Department
- Child Protection Advisory Groups
- University of Stirling Highland Campus,
- University of West Scotland
- University of Highlands & Islands
- CAMHs
- Psychiatrists
- Psychologists
- New Craigs Staff
- CPNs
- CPNAs
- Area Allied Health Professionals
- Area Dental Committee
- Area Medical Committee
- Women's Aid
- Northern & Strathclyde Police
- Local Authorities:
  - » Integrated Service Officers
  - » Surestart Funded Projects
  - » Children and Family Teams
  - » Fostering Service
  - » Hospital Social Work Team

Method			
CD Rom	Email ✓	Paper ✓	Intranet ✓

Contents

Perinatal Mental Health Good Practice Guidelines

Page

Foreword

Perintal mental health is a recognised area of public health concern. Health professionals, service users, researchers and policy makers have highlighted the huge impact that mental health problems can have on women and their families during pregnancy, childbirth and the postnatal year (NES 2006). The most common mental health problem is postnatal depression and many studies have documented the long term effects that untreated depression can have on families (NES 2006).

The profound cost of perinatal mental illness has been documented in the Confidential Enquiries into maternal deaths with both the 1997-1999 and the 2000-2002 triennial reports detailing that suicide and psychiatric reasons were the leading cause of maternal death (CEMD 2001, CEMACH 2004).

These guidelines have been produced to assist practitioners in their role of supporting women through this time and are a collaboration of work undertaken through the Perinatal Mental Health Reference Group, NHS Highland. The guidance represents best practice for those providing care for women through pregnancy and the postnatal period and includes maternity staff, GPs, health visitors and psychiatric staff across NHS Highland. However they may assist other agencies who support women at this time. They form part of a range of guidance to support staff working in maternity and early years services.

Reasonable Adjustment

NHS Highland has a duty to make reasonable adjustments for an individual disabled person. This applies where a provision, criterion or practice applied by or on behalf of an employer, or any physical feature of premises occupied by the employer, places the disabled person concerned at a substantial disadvantage with persons who are not disabled. In these circumstances, the employer has a duty to take reasonable steps to prevent the provision, criterion, practice or physical feature from having that effect.

1. Summary

"Mental health is an issue for us all. It is estimated that 1 in 4 people in Scotland experience mental health problems which are often associated with times of stress or change in our lives. Perinatal mental health is an area where health and social care workers can play significant roles in mental health promotion, the prevention of mental health problems and in the care, treatment and intervention for women and their families whose lives may be impacted by mental health problems." (NHS Education for Scotland 2006:2)

Summary of Guidelines

- As a routine measure, women should be asked at the first contact with services in both antenatal and postnatal periods about (NICE 2007):
  - Past or present severe mental illness including schizophrenia, bipolar disorder, psychosis in the postnatal period and severe depression.
  - Previous treatment by a psychiatrist/specialist mental health team including in-patient care.
  - Family history of perinatal mental illness.
- General Practitioners (GPs) and midwives should ensure that all relevant information concerning a woman's current or previous psychiatric history is included in referral letters to booking clinics.
- Women who have a past history of serious psychiatric disorder, whether in the postnatal period or at other times, should be assessed by a psychiatrist in the antenatal period.
- Women, who have a past history of serious psychiatric disorder, whether in the postnatal period or at other times, should have a management plan in place due to the high risk of re-occurrence following delivery. This should be agreed with the woman, her maternity team and GP and placed in her handheld record.
- Women who have suffered from serious mental health illness either following child birth or at other times, should be counselled about the possible re-occurrence of that illness following further pregnancies.

For women identified as having or at risk of mental health problems in the antenatal period:

- Discuss additional support from relatives/friends.
- Practitioners with appropriate skills and training (midwives, health visitors, GPs, obstetricians) should undertake mood assessment as required.
- Give information about support available (Appendices 5 and 6).

- If at high risk of puerperal psychosis or other serious postnatal mental illness, discuss with GP and refer women to Community Mental Health Team (CMHT) for preventative management. If the team are already involved ensure close liaison with them.
- Discuss and begin a management plan with the woman and those involved in her care. Mental health services should consider the Care Programme approach principles.
- If the woman is on psychotropic medication discuss with the GP, obstetrician the CMHT if involved, if not involved, refer to the team. Safe storage of any medication should be discussed in terms of child safety.
- Consider the wellbeing of the unborn child and other children/siblings in the home and refer to Getting it Right for Every Child (GIRFEC) principles and Child Protection Guidelines if required. Liaise with others and share in line with confidentiality and child protection guidelines appropriate information as necessary.

For women identified as having or at risk of mental health problems in the postnatal period:

- Practitioners with appropriate skills and training (midwives, health visitors, GPs, obstetricians) should assess mother/baby relationship, relationship with other children/siblings and the relationship with partner or significant other. Partner's mental health and wellbeing should be considered.
- Consider the wellbeing of other children/siblings in the home and reflect the Getting it Right for Every Child (GIRFEC) approach and Child Protection procedures if necessary.
- Ensure accurate recording in all documentation.
- Consider referral to Social Services Child and Family Team for additional or intensive support as required and discuss with child protection adviser (Appendix 5).
- Liaise and share information as appropriate with other services in line with confidentiality guidance.
- Provide information about supportive agencies including HAPIS (Appendix 6).

2. Introduction

Becoming pregnant and having a baby is a significant life changing event that for many women will be a positive and joyful process. For some though, the first days and months can be challenging in terms of their mental health and well being and for a significant minority, the consequences can be profound and life threatening.

What is known as 'perinatal mood disorder' during and after pregnancy is not unusual. This can vary from the distressing but time limited 'baby blues' which may last for a couple of days, to severe and life threatening mood disorder. We now know that one of the main causes of death for a woman within a year of having a baby is suicide (CEMD 2001, CEMACH 2004). We also know that there are a range of risk factors that as professionals we can use to identify women who may be vulnerable to perinatal mental health difficulties.

Working across agencies and services to assess the level of need and to identify the most appropriate services to support women and their families is essential. We need to be able to identify and support women experiencing perinatal mental health difficulties through a variety of interventions that are specific to her situation and circumstances.

Sharing information within secure frameworks is vital to the provision of coordinated services. Highland Data Sharing Partnerships Information Sharing Policy and the Accompanying Procedures for Practitioners provide guidance on effective, secure sharing of information between partner agencies (Highland Data Sharing Partnership 2008).

Training around perinatal mental health issues and the use of these guidelines should ensure that practitioners can be confident that they are able to gather the relevant information from women through their medical histories and records to assess the risks, and to support women, their partners and families. Standardising practice should ensure that factors that may disadvantage a woman, her infant and other siblings are identified early and appropriate support is in place.

3. Aim and Objectives

Aim

The aim of this Good Practice Guidance is to ensure a standardised and quality assured approach to women who have, or are at risk of developing perinatal mental health problems.

Objectives

1. To improve the identification, detection and care of women who have, or are at risk of developing perinatal mental health problems, whilst pregnant and up to a year after delivery.
2. To advocate that practitioners who are supporting women and their families in the perinatal period have the appropriate skills and expertise through training and development to meet the needs of women who may experience mental health issues.
3. To ensure that women who may be vulnerable to perinatal mental health difficulties have their needs identified at an early stage in their pregnancy.
4. To ensure that systems and services are put in place that support women experiencing perinatal mental health difficulties in the most appropriate way.
5. To support women and their families to be involved in discussions about their care and treatment plans and options.
6. To support good practice across statutory and voluntary services in meeting the needs of this group of women and their families.
7. To improve identification and early intervention to support children and families by virtue of parental mental health issues.

4. The Nature and Extent of the Problem

The perinatal period is described as being from conception to one year following birth and mental health issues and mood disorders associated with pregnancy and giving birth are not uncommon. For some women they may experience new feelings of anxiety or depression but for others it may be a reoccurrence of previous difficulties which may be exacerbated.

Within Highland there are over 2,000 births per year. Out of this, 34 women will be existing users of mental health services, 4 may require hospital admission due to puerperal psychosis, up to 300 will experience postnatal depression and up to 200 may experience temporary emotional distress (CRAG 1996).

The majority of women with postnatal mental health problems will experience mild depression, perhaps with related anxiety. There is little evidence to suggest that this mild depression is any more common in pregnancy or the postnatal period than at any other time.

Given the extensive range of symptoms, thorough assessment of a woman's mood is essential throughout pregnancy and the postnatal period.

4.1 Antenatal Depression

The facts

Antenatal depression is thought to affect 1 in 10 pregnant women.
Antenatal depression has been found to peak at 32 weeks of pregnancy.
The majority of women experiencing antenatal depression find it ceases following the birth of the baby.

Symptoms

Symptoms of antenatal depression, indeed all types of depression include:

- An inability to concentrate.
- Anxiety.
- Extreme irritability with others and self.
- Sleep problems - either too much or too little.
- Eating problems - lack of appetite or eating too much for the sake of it.
- Feeling tired all of the time.
- Inability to enjoy anything anymore.
- Constant sadness - crying more than is usual.
- Agoraphobia - scared to leave the house or be in social situations.
- Obsessive compulsive tendencies - e.g. washing hands repeatedly.

4.2 Baby Blues

The facts

Baby Blues is thought to affect 50 – 80% of new mothers.

Symptoms will occur and pass within the first seven days following birth.

Symptoms

- This is a transient state of tearfulness and emotional lability.
- Severe 'baby blues' is a risk factor for depression.

4.3 Postnatal Depression

The facts

Affects 10% to 15% of women postnatally during the first year following childbirth (SIGN 60 2002).

Postnatal depression is three times as common amongst teenage parents, with 4 out of 10 mothers affected. (Hall and Elliman 2003).

Postnatal depression may occur immediately after the birth or many months later; after the first baby or any subsequent baby (NHS Health Scotland 2001).

Postnatal depression is a treatable illness, the length and type of treatment depends on the severity and how early it is detected.

Symptoms

The symptoms for post natal depression may be wide ranging, generally last longer and are more severe and include the following:

- Constantly feeling tired. No energy.
- Sleep problems - can't get to sleep or waking in the early hours and not being able to get back to sleep.
- Crying a lot, often over the smallest things or for no reason at all.
- Can't eat or over-eating.
- Feeling emotionally disconnected from or even rejected by the baby or overly anxious and over protective of the baby.

Symptoms continued...

Symptoms continued...

- Lack of motivation to get up and do anything.
- A constant underlying sense of anxiety which may escalate into panic attacks. Easily upset and difficult to calm down.
- Difficulty concentrating, say on a book or film or even on a conversation.
- Putting on a front. A woman may feel that she is playing out a role rather than just living the moment.
- Reports strange, frightening thoughts or visions popping into her head about harming herself or her baby or awful things happening.
- Feeling lonely and isolated. Perhaps feeling rejected by friends, family, partner and her baby or other children.
- Sense of feeling overwhelmed and unable to cope.
- No interest in sex.
- Feeling guilty about everything - especially about being a such bad mother.
- Physical aches and pains, such as headaches, abdominal pain or blurred vision and worrying that it is something terminal.

Risk Factors for Postnatal Depression

An assessment for the presence of risk factors for postnatal depression can facilitate targeting of interventions and support towards women at higher risk.

Evidence suggests that risk factors for postnatal depression are no different to the risk factors for non-postnatal depression; these are wide ranging and may include:

- Past history of psychopathology and psychological disturbance during pregnancy.
- Low level of social support.
- Poor relationship with partner/significant other.
- Recent or current stressful life events.
- Baby Blues that do not resolve.
- Obstetric complications or health problems with the baby.
- Domestic abuse.
- Social exclusion.

Risk factors continued...

- Parents perceptions of their own upbringing.
- Unplanned pregnancy.
- Disappointment with birth experience, inability to breastfeed.
- Antenatal thyroid dysfunction.
- Coping style.
- Infertility/assisted fertility.
- Depression in fathers.
- Emotional lability.

(SIGN 60 2002)

4.4 Puerperal Psychosis

The facts

1 – 2 postnatal women per 1,000 will develop puerperal psychosis (SIGN 60 2002).

If a mother has experienced an episode of puerperal psychosis, she has a 25-57% risk of a recurrence in a subsequent pregnancy (SIGN 60 2002).

Symptoms can also begin during pregnancy especially where there has been a prior episode of psychosis or Bipolar Disorder. Onset is rapid and almost always within the first four postnatal weeks, most commonly presenting within the first 10 days postnatally.

Puerperal psychosis in almost all cases is a mood disorder accompanied by features such as loss of contact with reality, hallucinations, severe thought disturbance and abnormal behaviour (SIGN 60 2002).

Symptoms

- May experience hallucinations or delusions.
- Restless, sometimes agitated behaviour, or strange movements.
- Irrational fearfulness and worrying (often about the baby).
- Mood swings sometimes with inappropriate emotions. Mood can sometimes be elevated and energy levels heightened to an extreme degree leading to manic patterns of behaviour.
- Inability to sleep.
- Behaviour may appear out of touch with reality for example neglect of babies physical and psychological needs, inability to respond to basic needs of baby (safe, healthy, nurtured).

Risk factors for puerperal psychosis

There is significant evidence of increased risk of puerperal psychosis in women who have:

- A previous episode of puerperal psychosis –the risk of recurrence following a subsequent birth is 25-57% and the risk of non-puerperal relapse is even higher.
- A pre-existing severe psychotic illness particularly affective psychosis (bipolar affective disorder) – the risk of puerperal psychosis is again raised to between 1 in 4 to 1 in 2.
- A family history in first or second-degree relatives of an affective psychosis compounds risk particularly if associated with personal history.

(SIGN 60, 2002)

The presence of the more strongly evidenced risk factors should be specifically recorded. Any pressure of the other listed factors should be noted especially if the woman is demonstrating some stress/distress associated with them (SIGN 60, 2002).

4.5 The Consequences of Poor Perinatal Mental Health

Poor perinatal mental health has a profound effect on a mother, her infant, other siblings and the wider family/community. We know that poor mental health in the year following delivery has enormous implications for the family, siblings and society (CEMD 2001, CEMACH 2004).

It is now also recognised that the earliest minutes of life, and the subsequent days and weeks of an infant's life are a unique time for the infant's neurodevelopment. The first year of life informs the template for an individual's emotional wellbeing for life (Murray & Andrews 2000). There are very good opportunities to support infant mental health through sustaining good practice in perinatal mental health services to offset the wider consequences that can arise.

From birth babies are highly sensitive to the pitch of the mother's voice, speed of speech and eye contact. Mothers suffering from depression may be less sensitive to their babies 'cues' and maybe either too intrusive or remote in how they communicate with their babies (Murray & Andrews 2000). They might feel their babies are rejecting them if they are unable to settle them. A woman experiencing mental health problems may require considerable support to ensure a good attachment and relationship with her infant. The support of family and wider networks to promote and support both the mental health of the mother and her infant/child will also be important. Research suggests that where this support is not provided there may be long term consequences for the infant/child (Heads up Scotland 2007).

5. The Woman's Journey

When a woman discovers she is pregnant no matter her social, psychological, obstetric or general health background she may experience emotions from joy and excitement to shock and despair. Her journey through the perinatal period will be a unique life changing experience.

5.1 Preconception

Women of child bearing age who may have a history of depression or mental health issues will require support and advice about the risk factors for them if they decide to become pregnant. This is particularly important if a woman is on prescribed psychotropic medication, lithium or anti-epileptic medications where any medication change advice should be sought directly from the consultant psychiatrist responsible for her care (see Appendix 1). Safe storage of medication should be discussed in terms of child safety.

> *"Women who have suffered from serious mental illness either following childbirth or at other times should be counselled about the possible recurrence of that illness following further pregnancies."*
>
> CEMACH 2004:152

5.2 Antenatal Care

Within Highland, midwives provide antenatal care for the majority of women sharing care with a GP and obstetrician as appropriate. Once a woman has a confirmed pregnancy it is important that any support or treatment she has required or is still having in terms of her health and wellbeing is relayed to the midwife to enable booking to take place.

General Practitioners should ensure that midwives have access to the details of womens' health records to ensure thorough risk assessment takes place and allows the obstetrician to make an assessment in terms of managing her obstetric risk and liaising with appropriate others (see Appendix 1).

> *"GPs should ensure that all relevant information concerning the woman's current or previous psychiatric history is included in referral letters."*
>
> CEMACH 2004:152

If there are already older siblings to the unborn child consider the Hall 4 and GIRFEC approaches in relation to additional or intensive support needs.

5.3 Booking Appointment

The booking visit presents a unique opportunity to begin to build a relationship with a pregnant woman and an understanding of whether a woman may be vulnerable due to poor mental health and wellbeing, or significantly at risk due to previous severe mental illness in the postnatal period.

The booking process should assess the specific needs of newly pregnant women, identifying current and past medical, psychiatric or social history and assisting women to plan and make decisions over where and how they will have their baby.

Booking presents an ideal opportunity to identify current or potential problems that may require specific interventions and the following should be undertaken for each individual woman:

- A risk and needs assessment.
- A complete social history.
- Common perinatal mood disorders should be discussed.
- Any personal or family psychiatric history should be recorded, along with severity and management.

Ask about:

- Past or present severe mental illness including schizophrenia, bipolar disorder, psychosis in the postnatal period and severe depression.
- Previous treatment by a psychiatrist/specialist mental health team including in-patient care.
- Family history of perinatal mental illness.

NICE 2007

Reassess at each contact.

- If mild to moderate depression consider additional support as per Hall 4 and GIRFEC guidance and consider referral to GP for Guided Self Help Worker Service if appropriate (see Appendix 3). Give information about HAPIS (Highland Antenatal and Postnatal Illness Support) and other support available (Appendices 5 and 6).
- Healthcare professionals should ask two questions to identify possible depression.
  - » *During the past month, have you often been bothered by feeling odwn, depressed or hopeless?*
  - » *During the past month, have you often been bothered with having little interest or pleasure in doing things?*

A third question should be considered if the woman answers yes to either of these questions.

- » *Is this something you feel you need or you want help with.* NICE 2007

If any history ask:

- » *Did you receive any treatment or help for this?*
  - *What kind of help did you receive?*
  - *Support/ Counselling only*
  - *GP prescribed medication*
  - *Referred to Community Mental health team*
  - *Psychiatric in-patient*
- » *Are you still seeing someone from the psychiatric team?*

- Liaise with GP, primary care team and community mental health team. Consider consultant care.
- Consider additional/intensive support as per Hall 4 and GIRFEC. Give information about local support available (Appendices 5 and 6).

Risk factors should be explored and documented in the Scottish Woman Hand held Maternity Record (SWHMR) and the need for information sharing should be discussed as part of integrated working.

Ideally maternal history taking will be completed by 12 weeks (NHS QIS 2008) however, a complete history may take several contacts to obtain. History taking enables a risk assessment to be undertaken which will enable the correct level of care provision for each woman. Good history taking, effective communication, appropriate sharing of information and multi agency consultation, will ensure that each individual woman is offered the optimum level of care.

> *"…Maternity services should make sure that a woman's circumstances are assessed holistically and that social and psychological needs are identified and managed appropriately."*
>
> Scottish Executive Health Department 2001:11

> *"Systematic enquiries about previous psychiatric history, its severity, care received and clinical presentation should be routinely made at the antenatal booking visit."*
>
> CEMACH 2004:152

> *"Women who have a past history of serious psychiatric disorder, postpartum or non-postpartum, should be assessed by a psychiatrist in the antenatal period. A management plan regarding the high risk of recurrence following delivery should be agreed with the woman, her midwifery team and GP and placed in her hand held record."*
>
> CEMACH 2004:152

5.4 Missed Appointments

All those involved in providing support in the antenatal or postnatal period should ensure that all missed appointments are communicated between services and documented in the records, with steps taken to identify if there are any barriers to access or other reasons for non-attendance and steps taken to resolve this. For more vulnerable women, community midwives and community psychiatric nurses should offer follow-up at home and provide a vital link between services.

5.5 Assessing Mental Health and Wellbeing

An assessment of mental health and wellbeing in the perinatal period should be carried out at each contact. Good communication skills are essential to the process of developing therapeutic relationships that will facilitate discussion of information that is often sensitive and difficult for the woman to disclose.

Challenging stigma around mental health issues is important to enable and empower women to feel that they are contributing to and are supported in decisions made about their care. Health professionals are ideally placed to instigate this and should be aware of any judgments that they may make throughout their contacts with women. The use of open ended questions will help to build a broader picture of her history and contribute to the assessment. The assessor needs to be clear that the woman understands the boundaries of confidentiality and that in some circumstances certain information must be shared with others, particularly where there are concerns about either the woman's safety or wellbeing, or that of her child or other children. All staff should refer to Child Protection Policy Guidelines (Highland Child Protection Committee 2003) and the designated child protection advisor if there are any concerns around parenting capacity. Direct referral to Social Work Services should be made if any possible risk to children.

Consider Hall 4 and GIRFEC principles in relation to additional or intensive support needs.

Using a Mood Assessment Tool can assist practitioners and a useful tool has been devised which captures the symptoms of depression. It can be remembered by the by the acronym: SPACE DRAGS (Seeley 2004) (see opposite).

The Ready Steady Baby book (Health Scotland 2008) has information around emotional changes and depression in pregnancy and should be used in discussions with women. It also details information on postnatal depression and the 'Talking About Postnatal Depression' leaflet should be given to all women in the postnatal period (Highland Information Trail 2008).

SPACE - DRAGS Mood Assessment Tool

S Sleep disorder (increased or decreased).
Does she have any difficulties sleeping? If so, what is her sleep pattern – difficulty falling asleep; frequent wakening; wakening very early in the morning and not being able to get back to sleep.
Does she feel exhausted or does she have more energy than she would do normally?

P Pleasure, lack of.
How has she been feeling generally and how have things been since your last contact with her? Has there been anything in particular she has been finding difficult on a day to day basis?
Is she getting any enjoyment out of things she is doing. Is she able to enjoy and take an interest in things she previously did?
Is she able to be intimate with her partner?

A Appetite.
Have there been changes in her appetite recently?
Has she gained or lost weight out with the parameters of normal postnatal changes?

C Concentration.
Has she been able to concentrate on everyday things e.g. reading, watching a television programme?

E Energy.
Has she felt lethargic and tired no matter how much sleep she gets, or does she have boundless energy?

D Depressed mood.
How has her mood been? Has she been able to have a laugh about things recently or has she experienced any particularly “down” periods or periods when she feels “more excitable” than others? Is she laughing one minute and crying the next?

R Retardation of thoughts and behaviour.
Has she noticed that she is moving around more slowly and has her thinking and decision making been impaired?

A Agitation.
Has she felt agitated anxious or panicky, can she settle and feel relaxed?

G Guilt.
Has she had any worrying, guilty, upsetting, strange or unusual thoughts or experiences?

S Suicidal ideation.
Does she have thoughts about harming herself or thoughts of doing something that might harm the baby or older children? If so, what does she do when she has these thoughts, is she able to dismiss them or do they go around and around in her head?

5.6 Ongoing Care

The midwife will assess a woman's health and wellbeing at each contact and use of the mood assessment tool may assist this process together with clinical judgement. Although the Edinburgh Post Natal Depression Scale is not used until 6-8 weeks postnatally, along with the Mood Assessment Tool it may assist practitioners to support clinical decision making at other stages and may be used for reference (see notes Appendix 2).

Should the midwife have any concerns for the woman's mental health she should inform the obstetrician, GP and HV. Following discussion, the appropriate intervention should be provided which may include referral to the Community Mental Health Team that includes community psychiatric nurses, social workers, mental health officers, occupational therapists and in some areas support workers. The team will make a full assessment of need and work jointly with the client and other agencies involved to deliver an agreed package of care.

Assessment of any risks should be discussed with the woman (and partner or significant other if appropriate). Parenting capacity should be considered and additional or intensive support visits provided if required.

5.7 Postnatal Care

Following the birth of her baby the midwife should explore the mother's emotional response to her birth experience and motherhood.

- Observe the mother and baby relationship and document in notes.
- Offer literature and information on support networks.
- Be aware of risk factors and mental health history.
- Should there be any concerns inform GP and others involved in care.

Hall 4 and GIRFEC guidance should be considered in relation to additional or intensive support needs and when care is handed over to the community midwife on discharge from hospital, communication should take the form of written documentation with verbal and face-to-face contact as required.

The community midwife will continue to assess the woman's mental health and well being and any risk to the new born child or any other children referring and sharing information as appropriate. When care is handed over from the community midwife to the HV communication should take the form of written documentation with verbal and face-to-face contact as required (NHS Highland midwife/HV handover protocol 2006).

At each contact during the early weeks following birth a practitioner with the skills and training should assess the woman's mental health and wellbeing using the Mood Assessment Tool and clinical judgement. If the mother is assessed as being mild to moderately unwell, a needs assessment should be carried out with appropriate intervention as detailed in the Perinatal Mental Health flow chart (Appendix 1) including supportive visits.

The Guided Self Help service may be appropriate for some women and referral should be discussed with the GP who will make the referral (Appendix 3). The EPDS should be offered to women at approximately 6-8 weeks and 3-4 months following birth as part of the screening programme for postnatal depression and should be administered by a trained HV or other trained professional. EPDS is not a diagnostic tool and diagnosis of postnatal depression requires clinical evaluation (SIGN 60 2002).

EPDS Score Sheet

Q		Score		Score
1.	I have been able to laugh and see the funny side of things:			
	As much as I always could	0	Definitely not so much now	2
	Not quite so much now	1	Not at all	3
2.	I have looked forward with enjoyment to things:			
	As much as I ever did	0	Definitely less that I used to	2
	Rather less than I used to	1	Hardly at all	3
3	I have blamed myself unnecessarily when things went wrong:			
	Yes, most of the time	3	Not very often	1
	Yes, some of the time	2	No, never	0
4	I have felt worried and anxious for no very good reason:			
	No, not at all	0	Yes, sometimes	2
	Hardly ever	1	Yes, very often	3
5	I have felt scared and panicky for no very good reason:			
	Yes, quite a lot	3	No, not much	1
	Yes, sometimes	2	No, not at all	0
6	Things have been getting on top of me:			
	Yes,most of the time I haven't been able to cope at all			3
	Yes, sometimes I haven't been coping as well as usual			2
	No, most of the time I have coped quite well			1
	No, I have been coping as well as ever			0
7	I have been so unhappy that I have had difficulty sleeping:			
	Yes, most of the time	3	Not very often	1
	Yes, sometimes	2	No, not at all	0
8	I have felt sad or miserable			
	Yes, most of the time	3	Not very often	1
	Yes, sometimes	2	No, not at all	0
9	I have been so unhappy that I have been crying:			
	Yes, most of the time	3	Only occasionally	1
	Yes, quite often	2	No, never	0
10	The thought if harming myself has occurred to me:			
	Yes, quite often	3	Hardly ever	1
	Sometimes	2	Never	0

Supportive visits should be offered to women assessed as being depressed and reassessment may highlight the need to:

- Discuss additional support from relatives/friends, give information on local support available including HAPIS.
- Inform GP.
- Refer to CMHS.
- Consider referral to Social Services for additional home support in addition to health visiting service.
- Assess risk to children.

If the mother is assessed as being severely mentally unwell a referral should be made to psychiatric services for urgent specialist assessment. If any woman is considered to be psychotic:

- Immediate referral to CMHS, psychiatrist or GP who may contact Mental Health Officer if required.
- Inform obstetrician if appropriate.
- If there are concerns at any time seek advice from the Child Protection Advisor and/or Social Services.

Whilst undertaking the EPDS if any woman scores for self-harm:

- Clarify whether this refers to suicidal thoughts and if so refer to GP and Community Mental Health Service (CMHS) immediately and seek advice.
- If self harming seek advice from GP, CMHT in order to offer appropriate support and follow up.
- Inform obstetrician if appropriate.
- If there are concerns for the woman's, baby's or others safety, do not leave her alone. Further psychiatric assessment by GP, psychiatrist, CMHS is required.

5.8 In-patient Admission to Mother and Baby Unit

For mothers who are acutely and seriously unwell admission to a specialist in patient unit may be required. The Mental Health (Care and Treatment) (Scotland) Act 2003 places a specific responsibility on NHS Boards to provide specialist facilities for admitting mothers with their babies where necessary. The Scottish Executive HDL 6 (2004) 'Perinatal Mental Illness/Postnatal Depression Hospital Admission and Support Services' details the standard of care that women requiring in-patient care should have access to. Referral should be made following assessment by a consultant psychiatrist.

NHS Highland is a partner in a specialist in-patient unit in Livingston and further details of this are outlined in Appendix 4. For women and babies who live in Argyll & Bute and require in-patient admission, arrangements are in place for them to be admitted to the Mother and Baby Mental Health Unit at the Southern General Hospital, Glasgow (Appendix 4). Staff working in Argyll & Bute should follow the Glasgow Perinatal Mental Health Integrated Care Pathway which they should be familiar with.

CEMACH 2004:152 recommended that:

> *"A specialist perinatal mental health team with the knowledge, skills and experience to provide care for women at risk or, suffering from, serious post partum mental illness should be available to every women."*
>
> *"Women who require psychiatric admission following child birth should be admitted to a specialist mother and baby unit, together with their infant. In areas where this service is not available then admission to the nearest unit should take place."*

5.9 Child Protection

Everyone has a responsibility to protect children and prevent abuse. Managers must ensure that all practitioners are aware of the Guidelines produced by Highland Child Protection Committee, and must ensure that they have access to them either in hard copy or via intranet under policies.

Managers should ensure that through PDP all staff should receive regular child protection training updates, and further advice and support for staff can be sought from the local Child Protection Advisors.

If domestic or substance misuse exists in conjunction with parental mental ill health then the risks to the child increases greatly. Further information and guidance is detailed in the 'Women, Pregnancy and Substance Misuse Good Practice Guidelines' (NHS Highland 2007) and 'Domestic Abuse: Pregnancy and the Early Years Protocol' (NHS Highland 2007).

All Agencies involved with the family need to consider the welfare of children where parental mental ill health exists and consider the impact on the child. They should seek assistance in identifying children who are at risk, which aspects of the child's development are being affected and what services are needed to help the child and family in line with the GIRFEC approach. This is effectively managed by appropriate request for services such as social services or following discussion with the relevant Child Protection Advisor for your agency. The possibility of a child protection order should be discussed. In cases requiring immediate action to safeguard the child, procedures within the Child Protection Guidelines should be followed as required (Highland Child Protection Committee 2003). For further information on information sharing see Highland Data Sharing Guidelines 2008.

5.10 Equality Groups

Isolation and loneliness can be key issues for women from black and minority ethnic communities because of language or other barriers. If a woman is also part of another equality group e.g. has a disability, or is not heterosexual, she is more likely to experience some form of discrimination and therefore maybe at greater risk of depression.

The EPDS has been translated and validated in several languages and should be accessed for women who do not speak English. Practitioners should be aware of and take into account issues that may impact on a woman's mental health due to cultural differences and the use of interpreters should be sought, family members should not be used.

5.11 Accessibility and Communication Support

It is the responsibility of all NHS staff to ensure the communication support needs of their client. It is not the responsibility of the client to book or arrange for any interpretation or other support services required, these arrangements must be made in advance of any appointment within the NHS.

Telephone interpretation is provided by the National Interpreting Service. This service can be contacted on 0800 028 0073. You will also need an identification number that is related to the geographical area that is covered by the service requiring interpretation. Area identification codes can be found on the staff Intranet.

Face to face spoken language interpreting is provided by Global Language Services. They can be contacted on 01463 258839 or 0141 429 3429. Appointments requiring face to face interpreters must be booked as far in advance as possible to ensure availability of an interpreter.

British sign language/English interpreting is provided by Deaf Action Highland who can also advise about other communication support including Lipspeaking. Deaf Action can be contacted on 01463 250204. Appointments requiring face to face interpreters must be booked as far in advance as possible to ensure availability of an interpreter.

Written information in other languages can also be provided if required – this will take a maximum of 14 working days.

Further information around interpretation and translation services can be found on the NHS Highland Intranet.

9. References

Clinical Resource & Audit Group (CRAG). Working Group on Maternity Services. 1996. *Report on the Detection and Early intervention in Postnatal Depression. Edinburgh:* CRAG secretariat.

Confidential Enquiry into Maternal and Child Health (CEMACH) 2004. *Why Mothers Die 6th Report 2000-2002. London:* RCOG press.

Confidential Enquiry into Maternal Death (CEMD) 2001. *Why Mothers Die, 5th Report on the Confidential Enquiry into Maternal Deaths in the UK, 1997-1999.* London: RCOG press.

Hall, D & Elliman, D. 2003. *Health for all children.* 4th edition. Oxford: Oxford Press.

Heads up Scotland, 2007. *Infant Mental Health: A Guide for Practitioners.* A Report of the Expert Working Group on Infant Mental Health. Edinburgh: Heads Up Scotland.

Highland Child Protection Committee 2003. *Child Protection Policy Guidelines: Working Together To Protect Children in the Highlands.* Inverness: NHS Highland/Highland Council/Northern Constabulary.

Highland Data Sharing Partnership 2008. *Data Sharing Across the Highland Data sharing Partnership: Procedures for Practitioners.* Data Sharing Partnership: Inverness.

Murray, L. & Andrews L. 2000. *The Social Baby.* Surrey: CP Publishing.

National Institute for Health and Clinical Excellence (NICE) 2007. *Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance.* NICE 45. London:NICE

NHS Education for Scotland 2006. *Perinatal Mental Health Curricular Framework.* Edinburgh:NES.

NHS Health Scotland, 2001. *Talking about Postnatal Depression.* Edinburgh: Health Scotland.

NHS Highland 2006. *Procedure for the Communication and Handover of Health and Social Information between midwife and health visitor.* Inverness: NHS Highland.

NHS Highland 2007. *Domestic Abuse – Pregnancy and the Early Years: protocol for Midwives, Health Visitors, GPs and Obstetricians.* Inverness: NHS Highland.

NHS Highland 2007. Women, *Pregnancy and Substance Misuse: Good Practice Guidelines.* Inverness: NHS Highland.

NHS Highland 2008. *Highland's Information Trail.* Inverness:NHS Highland.

NHS QIS 2008. *Maternal History Taking: Best Practice Statement.* Edinburgh: The Stationery Office.

NHS QIS 2008. *Scottish Woman Hand Held Maternity Record.* Edinburgh: The Stationery Office.

Seeley, S. 20024. *Training in the Detection and Treatment of Postnatal Depression.* University of Reading.

Scottish Executive 2003. *Mental Health (Care and Treatment) (Scotland) Act 2003.* Edinburgh: SEHD

Scottish Executive, 2004. *Framework for Mental Health Services in Scotland: Perinatal Mental Illness/ Postnatal Depression, Hospital Admission and Support Services.* HDL 6 2004.

Scottish Executive, 2003. *National Programme for Improving Mental Health and Wellbeing: action plan 2003-2006.* Edinburgh: The Stationery Office.

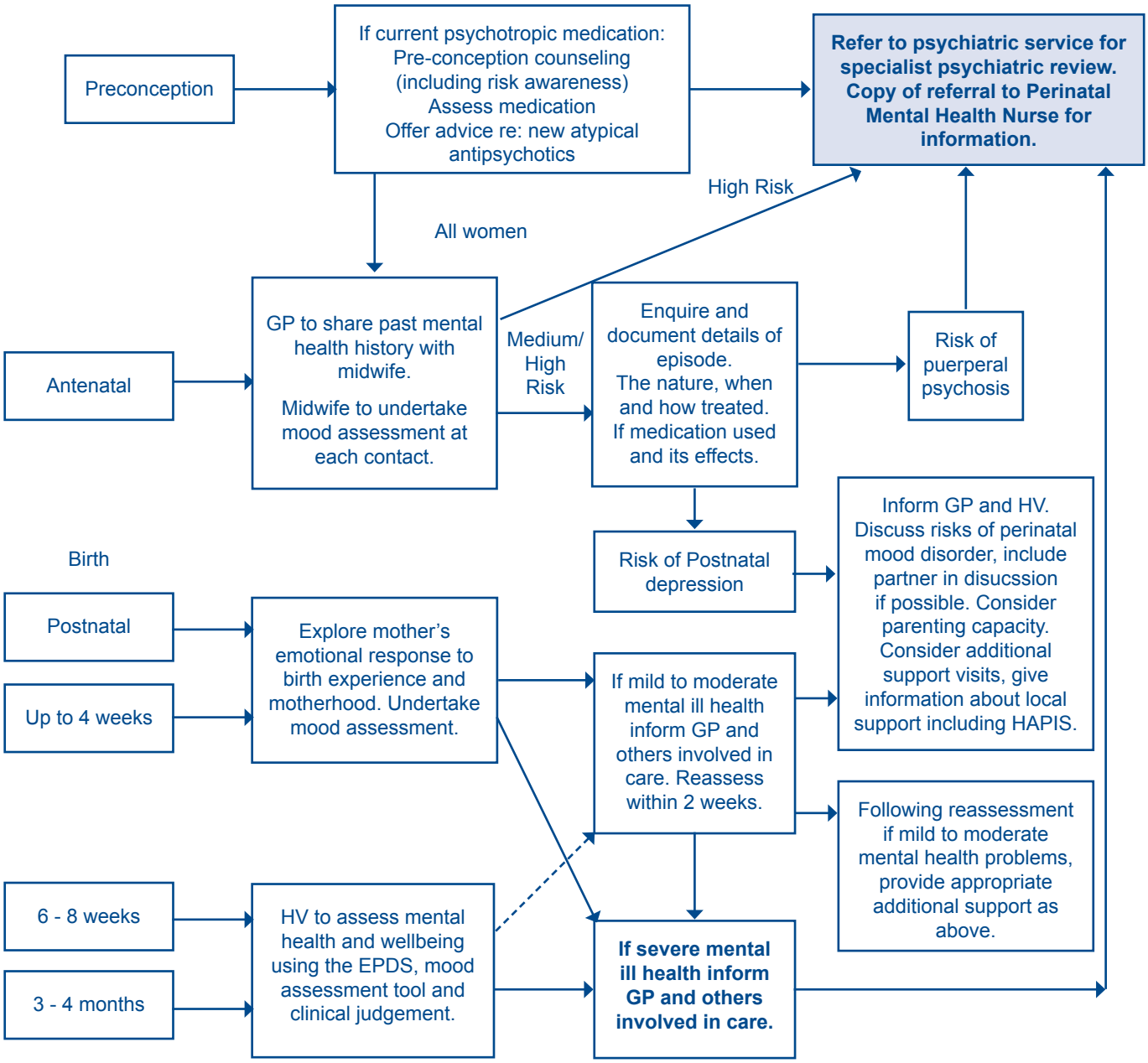
Scottish Executive, 1999. MEL 27 *Services for Women with Postnatal Depression.* Edinburgh: The Stationery Office.

Scottish Executive Health Department, 2001. A *Framework for Maternity Services in Scotland.* Edinburgh: The Stationery Office.

Scottish Intercollegiate Guidelines Network, 2002. SIGN 60 *Postnatal depression and puerperal psychosis.* Edinburgh: SIGN.

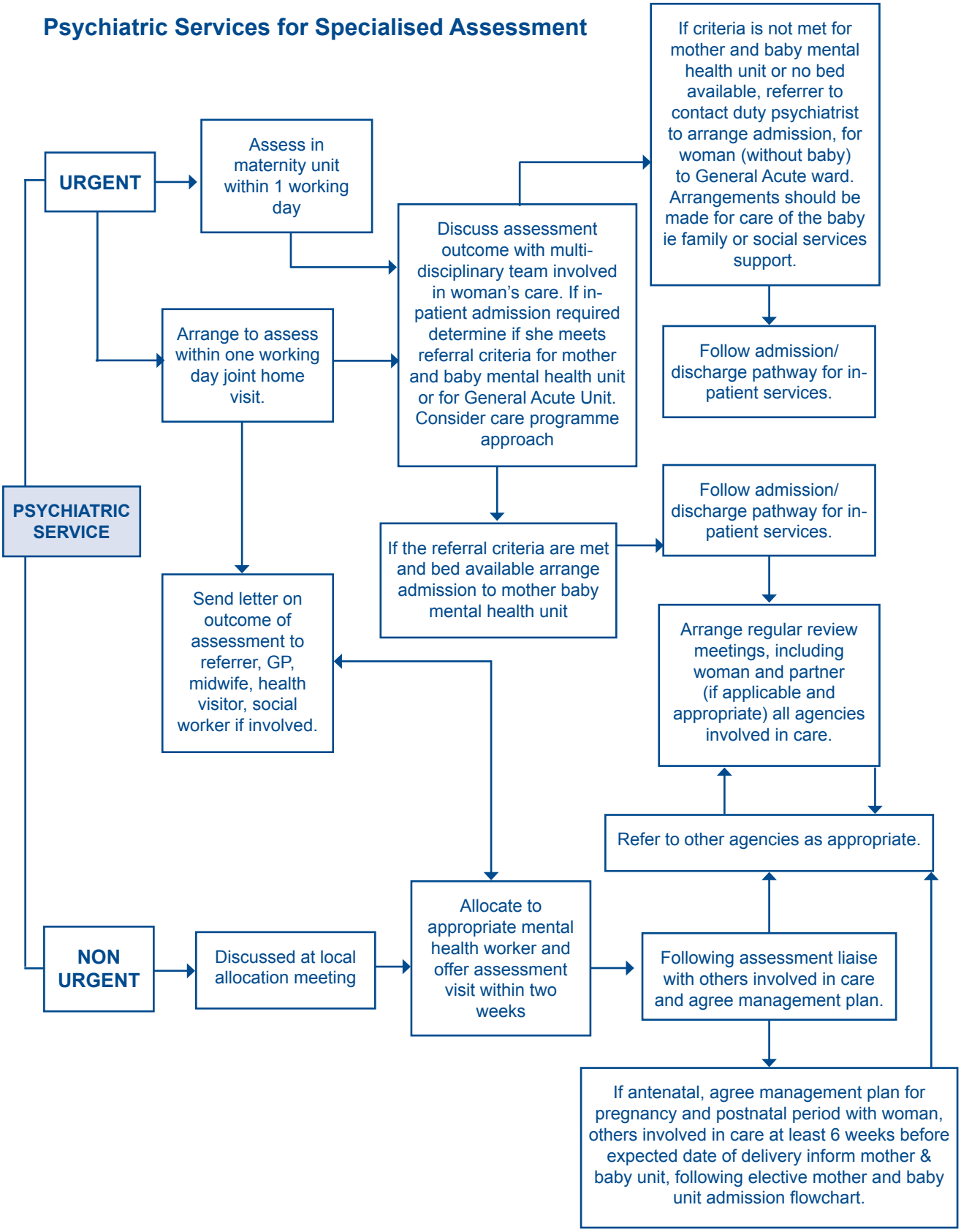
Appendix 1

Perinatal Mental Health Flowchart



Over arching principle: share information with involved colleagues.

Psychiatric Services for Specialised Assessment



Appendix 2

The Edinburgh Postnatal Depression Scale/how to use it

What it is and what it is not

- The Edinburgh Postnatal Depression Scale (EPDS) is not a diagnostic tool, but is an aid to the practitioner's clinical judgement in the detection of postnatal depression.
- It is to be administered at the 6-8 week postnatal and 3-4 month postnatal periods.
- If a depressive presentation is suspected at other times during the postnatal period, the scale can be used on additional occasions, along with clinical judgement.
- It has not been validated for use in the antenatal period.
- It is not a predictor of whether or not a woman will develop postnatal depression.

How to use it

- The woman completing the scale should some time previously have been made aware of the scale, its purpose and its content and given an opportunity to discuss any issues she may have about its use.
- The practitioner offering the scale must be trained in its use.
- It is the woman's option to decline to complete the scale.
- The practitioner offering the scale must be available to the woman during completion, can provide further instruction regarding its completion but must not (nor anyone else) influences the woman's answers.
- The scale must be completed independent of others unless literacy or language difficulties are present. The EPDS is available in other languages for mothers in whom English is not a first language.
- The scale must be completed in an environment where distractions are at a minimum and privacy available, preferably in her own home.
- The mother should be allowed as much time as she requires to complete the scale.
- All 10 questions should be answered.
- The results of the EPDS assessment must be tailed and their significance fed back immediately to the mother.
- It is imperative an opportunity is provided at the time to discuss and explore more detailed information through screening interview.

The EPDS is a tool, which is only **part** of an assessment programme. Clinical evaluation through focused discussion/clinical interview with the mother must take place to provide adequate basis for eventual diagnosis by general practitioner.

Evaluation of the Edinburgh Postnatal Depression Scale Results

The Edinburgh Postnatal Depression Scale result is the aggregate of the 10 categories, each of which are scored on a 0, 1, 2 or 3 basis according to severity of symptoms (all items are reverse scored except items 1, 2 and 4).

EPDS Score under 10 – Likely not to be depressed but use clinical judgement and beware of zero score

Total score under 10 AND if the clinician considers this a reasonable reflection of the woman's emotional state, then conclusion is no evidence of postnatal depression. The woman should be provided with care and input, which must include ongoing observation of the woman's psychological presentation and any presence of developing risk factors.

If clinical judgement raises concerns despite a score of under 10, this should be documented and the general practitioners informed. If score is 0, this is suspicious.

EPDS Score Between 10 & 12 – Possible depression but use clinical judgement

Total score of between 10 and 12 AND if the clinician considers this a reasonable reflection of the woman's emotional state, then conclusion is a possible postnatal depression. The health visitor should assess the possible need for provision of additional support and the option of follow-up EPDS and clinical assessment approximately two weeks later at the practitioner's discretion.

EPDS Score of 13 or Over – Probable depression but use clinical judgement

Total score of 13 or over AND if the clinician considers this a reasonable reflection of the woman's emotional state, then conclusion is a probable postnatal depression. **The GP must be informed, the woman encouraged to consult her GP and reassessment by EPDS and clinical judgement carried out approximately 2 weeks later, further intervention options should be considered at this point. If the midwife or health visitor is concerned at any time.**

Appendix 3

Guided Self Help Worker Service

Background
There is growing evidence that people who suffer from mild to moderate psychological problems, particularly depression, respond well to treatments involving self care and self management. This approach promotes personal responsibility for one's own health and well being and is particularly evident when self-help is guided by short-term interventions from a trained Self-help Worker.

Patients learning New Skills
The interventions are designed to provide patients with lifelong skills to detect and react appropriately to patterns of negative thinking thus lessening the likelihood of repeated episodes of distress.

Appropriate level of treatment (secondary care treatment often not required)
Not only does this service reduce the stigma associated with attending secondary mental health services (and potentially therefore reducing 'Did not attends'), the care is delivered close to the patient's home and does not over-medicalise the condition.

What is self-help?
'Guided Self-Help': This is a 'therapeutic' relationship that involves a collaborative formulation of the problem. Self-help materials are used as part of a supported, structured programme agreed by the user and the Guided Self-help Worker.
The service is delivered as close as possible to the patient's local community, usually within the GP surgery

For how long?
There are generally between 2-3 sessions over a maximum of four hours total contact. The first session is generally one hour long and gives both parties the opportunity to get to know one another, to agree some goals for recovery and for the SHW to collect some baseline data regarding the patient's condition. This is followed by one or two more face-to-face sessions of approximately half an hour. At the last session the data gathered at the first appointment will be repeated to assess the degree of recovery.

Presentation
Feelings of hopelessness, stress, no apparent medical cause, chronic health problem or chronic pain, fatigue, physical illness present, 2nd presentation within 2 weeks, person does not feel their "usual self".

High risk groups: significant physical illness, child birth in last 12 months, social isolation.

How to Refer to the Service
All referrals to the Guided Self Help Workers service are through the patient's GP.

Appendix 4

Perinatal Mental Health Mother and Baby Unit, Livingston

The Perinatal Mental Health Service is a consortium partnership service involving Borders, Fife, Highland, Lothian and Tayside NHS Board areas.

This is an in-patient service, which aims to treat women who are experiencing mental illness in the postnatal period, whilst facilitating bonding with the baby.

The Mental Health Mother and Baby Unit comprises of six beds and six cots based within St John's Hospital. The Unit has close liaison with and support from onsite maternity and paediatric services and to the full range of services available to adult mental health in-patient services:

Unit staffed by: Psychiatrists, Mental Health Nurses, Nursery Nurses, Nursing Assistants, Team Administrator, Occupational Therapist, Psychologist, Health Visitor and Social Worker.

In addition, the unit provides care for the physical needs of mothers and babies (appropriate to a psychiatric setting), facilitates the development of the mother-infant relationship and aim to reduce the impact of maternal mental illness on the developing child.

Mothers will be provided with the support, encouragement and education necessary to help them care appropriately for their infants. The service has a responsibility to provide safe and appropriate care to babies admitted to the unit with their mother and staff have an explicit duty of care to admitted babies.

Aims of the Mental Health Mother and Baby Unit.

- To provide a comprehensive multi-disciplinary assessment and treatment following admission.
- To establish, evaluate and monitor individual treatment plans that meet the ongoing changing needs of the woman.
- To provide a therapeutic programme to meet the needs of mothers and infants
- To provide timely, ongoing, planned transition ensuring cohesive arrangements between in-patient and community based care.
- To ensure that staff in the mother and baby unit have skills and knowledge relevant to the specialist nature of perinatal mental health, in order to care for mothers and babies in a safe, welcoming and therapeutic environment.
- To ensure robust links are made with health board and local authority areas in order to provide a seamless integrated service.

The Consultant Psychiatrist for the PNMHS will be medically responsible for the unit's in-patients.

Discharge Planning and Aftercare

1. Discharge planning will begin on admission. The identified local health and social work professionals will be notified of the admission and invited to attend the weekly ward review. Attendance will be expected by the key worker at least once during the admission.
2. The service will identify local area health and social care services to hand over responsibility for ongoing care as part of an agreed discharge plan.

Involvement of GP and those providing on-going care for mother and baby on return to NHS Highland should be sought with details of discharge and arrangements fully discussed. Health professionals must consider the Getting It Right for Every Child (GIRFEC) principles in respect of providing additional/intensive support and the promotion of wellbeing of mother and infant.

Mother and Baby Mental Health Unit, Glasgow

The Mother and Baby In-patient Unit comprises of 6 bed/cot mother and baby beds for joint admissions where the child is under 1 year. Usual practice is that mother and baby are admitted together unless there are good clinical reasons not to do so.

The service also offers assessment and management for pregnant women receiving antenatal care linked to Glasgow Maternity Hospitals. In particular, the team may be able to assist with the following problems:

- pregnant women with a personal or family history of bipolar affective disorder or puerperal psychosis
- pregnant women suffering from severe enduring mental illness
- pregnant women suffering from other significant mental illness

A community outreach team works closely with maternity hospitals and community mental health teams and is staffed by specially trained community psychiatric nurses, a health visitor and a social worker. The community team is able to assess patients and provide a wide range of treatments.

Southern General Hospital, 1345 Govan Road, Glasgow G51 4TF
Tel: 0141 232 7635
Fax: 0141 232 7636

Contacts

Child Protection Advisors

All NHS Highland staff should have knowledge of their local Child Protection Advisor and how to contact them.

Community Mental Health Teams

Area	Tel No
Inverness	01463 704678 / 711744
Nairn	01667 456025
Badenoch & Strathspey	01479 810957
East Ross	01349 853636
Mid Ross	01463 871901
Wester Ross	01854 612794 01445 781707
Skye	01478 613772
Lochaber	01397 709830
Caithness - Wick	01955 606915
- Thurso	01847 891224
Sutherland - Golspie	01408 633827 / 633832
- Lochinver	01571 844754
- Lairg	01549 402556
Oban, Lorn and the Isles	01631 567840
Mid Argyll and North Kintyre	01546 604956
South Kintyre	01586 555808
Isle of Islay	01496 301003
Helensburgh	01436 672158
Dunoon	01369 703244
Bute	01700 502299

Social Work Services for Family Support

Area	Tel No
Nairn	01667 453746
Aviemore	01479 810251
Wick	01955 605040
Thurso	01847 893835
Inverness - Carse	01463 724040
- Central	01463 724040
- Hilton and East Ness (Culloden)	01463 791388
- South	01463 791338 01479 810251
Raigmore Hospital	01463 701376
Dingwall	01349 865262
Ullapool	01854 613403
Fort William	01397 707025
Alness	01349 882609
Portree, Skye	01478 612943
Golspie	01408 634040
Tain	01862 893021
Oban	01631 563068
Bute	01700 501300
Cowal	01369 707300
Mull	01680 300258
Helensburgh	01436 658750
Islay	01496 810484
Kintyre	01586 552659
Tiree	01879 220765
Argyll & Bute Emergency Out of Hours	0800 811505
Highland Emergency Out of Hours	08457 697284

Appendix 6

Publications, Leaflets and Advice

HAPIS - Highland Antenatal and Postnatal Illness Support.
Information: Support group for antenatal and postnatal mothers who are feeling symptoms of ante/ postnatal illness/depression. Tel: 0775 468 7423 Web site: www.hapis.org.uk last accessed 13.3.08

Royal College of Psychiatrists - Patient Information leaflets:
Postnatal depression - Help is at Hand: Recommended standard information leaflet.
Antidepressants - Include short sections on prescribing in pregnancy and breastfeeding and non-addictive nature of antidepressants. Mental Illness after Childbirth – Covers puerperal psychosis. All downloadable from web site: www.rcpsych.ac.uk last accessed 13.3.08
17 Belgrave Square, London SW1X 8PG Tel: 020 7235 2351

Information for Professionals: Summary of postnatal depression, the effects of postnatal depression on the family and puerperal psychosis (on web site) Web site: www.mama.org.uk last accessed 13.3.08

Depression Alliance - Leading UK charity for people affected by depression. Helpline: Provision of information or support for depression associated with childbirth 0845 120 3746 (Mon-Fri 7pm-10pm) Web site: www.depressionalliance.org last accessed 13.3.08

MIND
Leading mental health charity for England and Wales - Patient information booklet: Understanding Postnatal Depression (Briefly covers 'baby blues' and puerperal psychosis) – Copies £1 from MIND, non-printable copy on web site Web site: www.mind.org.uk Last accessed 13.3.08
Mind info line 0845 766 0163

Association for Postnatal Illness (APNI)

Network of telephone and postal support from volunteers who have had postnatal illness.
Web site: www.apni.org last accessed 13.03.08 Email: info@apni.org Tel: 020 7386 0868

Meet A Mum Association (MAMA)
Offers information and support to mothers with postnatal illness. Helps mothers and mothers-to-be who are isolated and lonely by putting them in touch with others for friendship and support.
Tel: 0845 120 6162 Helpline: 0845 120 3746
Email: meet-a-mum.assoc@blueyonder.co.uk Web site: www.mama.co.uk last accessed 13.3.08

NICE guideline 45, 2007. Antenatal and Postnatal Mental Health. www.nice.org.uk
last accessed April 2008.

SIGN guideline 60, 2002. Postnatal Depression and puerperal psychosis. www.sign.ac.uk
Last accessed April 2008.

Useful Reading for Parents (to be), Carers and Practitioners

Aiken C. **Surviving Postnatal Depression: At home, No one hears you scream.** London: Jessica Kingsley Publishers; 2000. Based on 10 case accounts of women from various backgrounds covering many aspects of postnatal depression

Marce Society **Emotional Effects of Childbirth** London: Marce Society; 2002 The Marce Society is an international society for the understanding, prevention and treatment of mental illness related to childbearing. A resource pack of four units entitled: Emotions and feelings, Psychiatric illness and emotional disorders, Skills and Attitudes and In Practice. Available through Napier University Library, Melrose Campus.

Printed by:
NHS Highland
Public Health Department
Assynt House
Beechwood Park
Inverness IV2 3BW