

A Care Pathway

For Perinatal* Mental Health.



* Perinatal refers to the period from pre-conception to one year post-delivery

NB: This is designed to be a *locally relevant clinical action* pathway and should be used in conjunction with national guidance documents from NICE. It does not address the wider determinants of mental distress such as domestic violence and substance misuse and or include guidance on ethical and professional conduct issues that are integral to clinical practice.

Author: Xena Dion, Bournemouth & Poole PCT
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Statement of Intent

To provide an evidence-based, comprehensive and integrated clinical pathway for the care of women suffering mental ill-health during the perinatal period and including primary, secondary and tertiary care services.

Objectives

1. To provide a practical, evidence based Care Pathway, from primary through to tertiary care, for women suffering mental health problems in the perinatal period and so promote a 'best practice' and uniform approach amongst all health professionals involved in their care.
2. To provide a simple and 'easy-to-use' algorithm to explain the best pathway of care for women with mental health problems in the perinatal period
3. To encourage and support inter-disciplinary working and cooperation during the care of women suffering perinatal distress.
4. To promote a commitment to the implementation and evaluation of the pathway across all East Dorset health trusts.

Rationale

For every 1,000 live births, 100-150 women will suffer a depressive illness and one or two women will develop a puerperal psychosis (O'Hara and Swain 1996). Failure to treat either disorder may result in a prolonged and significantly adverse effect on the relationship between the mother and baby, between her and other family members and on the child's psychological, social and educational development (Grace et al 2003).

Mental illness is also a significant contributing factor in maternal mortality. The UK Confidential Enquiry into Maternal Deaths (CEMACH 2004) reports that psychiatric disorders contributed to 12% of all maternal deaths. Suicide is the second leading cause of maternal death in the UK after cardiovascular disease. The report also highlights some degree of inaccuracy in identification of women with mental health problems, particularly in the ante-natal period.

With evidence that early intervention and adequate, effective support and treatment can be effective for postnatal depression, puerperal psychosis and other perinatal mental health illnesses (Appleby et al 1997, Dennis 2005) there is clear justification for developing a comprehensive pathway of care to ensure that women are identified and offered immediate and effective intervention. This is not an area for one discipline or agency alone, but needs the involvement, commitment and, most importantly, the partnership working of service users, midwives, health

visitors, general practitioners, obstetricians, psychiatrists, clinical psychologists, mental health nurses, pharmacists and appropriate voluntary and statutory organisations (DoH 2003).

The Pathway

During the course of the perinatal period a woman will encounter several health professionals, if a mental health problem manifests the number of professionals involved is likely to increase. If/when that mental health problem worsens, so the intervention will be increased, as in the 'stepped care' model explained within the NICE guidance for depression (NICE 2004a)

This pathway recognises that each professional plays a unique role in the overall care of a woman during this time and that communication and joint working is essential. This means that when a woman is referred between disciplines/agencies each professional's role and the 'lead' person must be clarified. Liaison and (where appropriate) joint working must be ongoing until the situation is resolved or adequately improved.



Puerperal psychosis occurs in approximately 2 per 1000 new births with potentially tragic consequences. Up to half of all women with an existing bi-polar disorder develop puerperal psychosis immediately following childbirth (Robertson et al 2005). If there is a risk – ACT!

The evidence base

This pathway covers an extremely wide subject area. It is not possible to expand on each point or intervention option without it becoming an unmanageably large document. Where appropriate, **superscripted numbers correlate to an expanded point in 'Users Guide'** which is placed at the end of the Pathway. For more in-depth evidence and the rationale behind any points of the Pathway, practitioners are encouraged to use the references and read the underpinning documents in full, particularly the NICE guidelines for depression (2004a) and for antenatal and postnatal mental health (2007).

Terminology

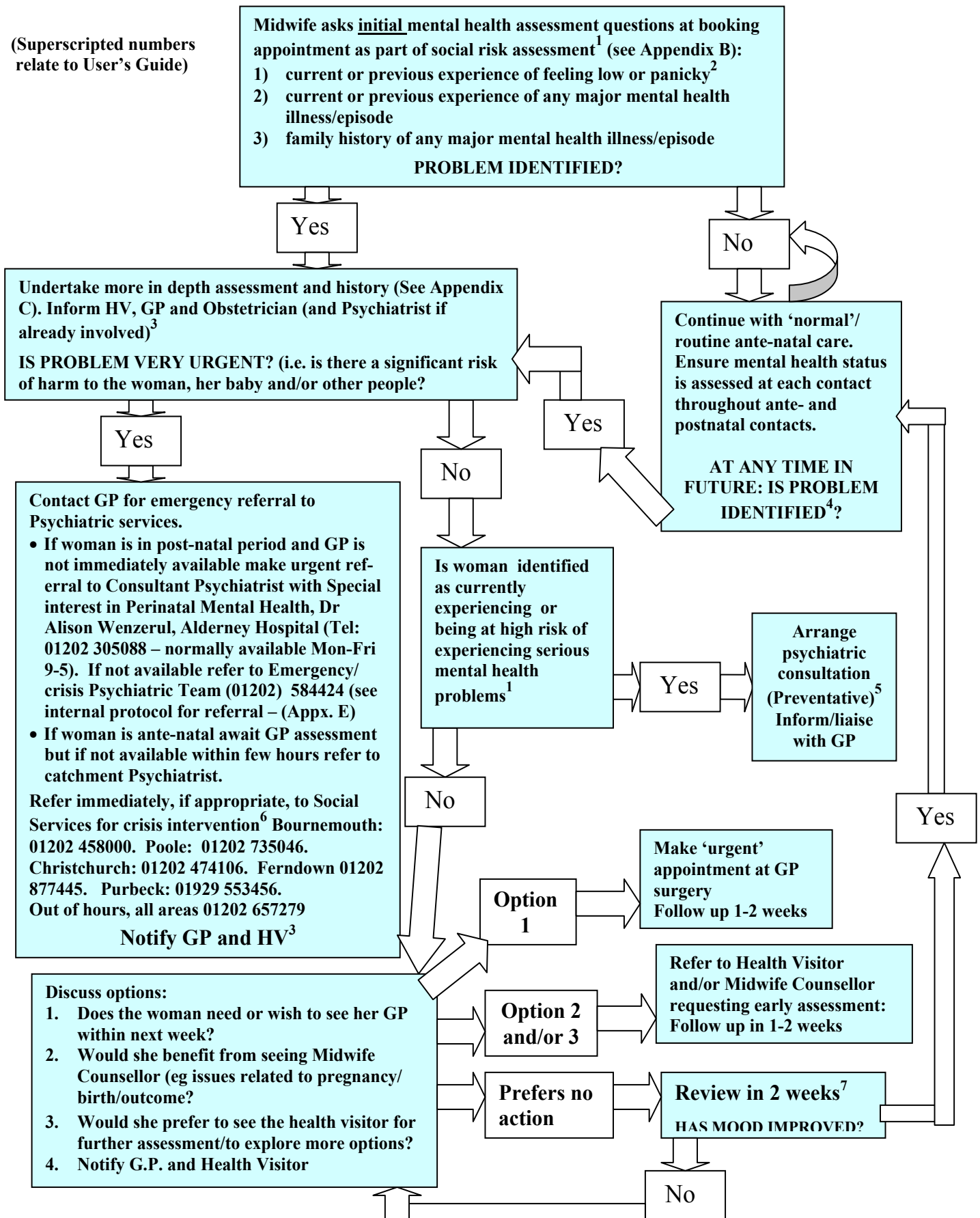
To ensure full and effective co-ordination of care between services it is pertinent to clarify frequently used terminology in conditions related to mental illness in the perinatal period. A Glossary of terms is included in the Pathway (Appendix A).



The term Post-natal Depression (PND) should not be used as a generic term for all psychiatric illness in the perinatal period. Exact details of any current and/or previous disorder must be sought and recorded to ensure the most appropriate care is offered

The Midwife's role within the multi-disciplinary approach

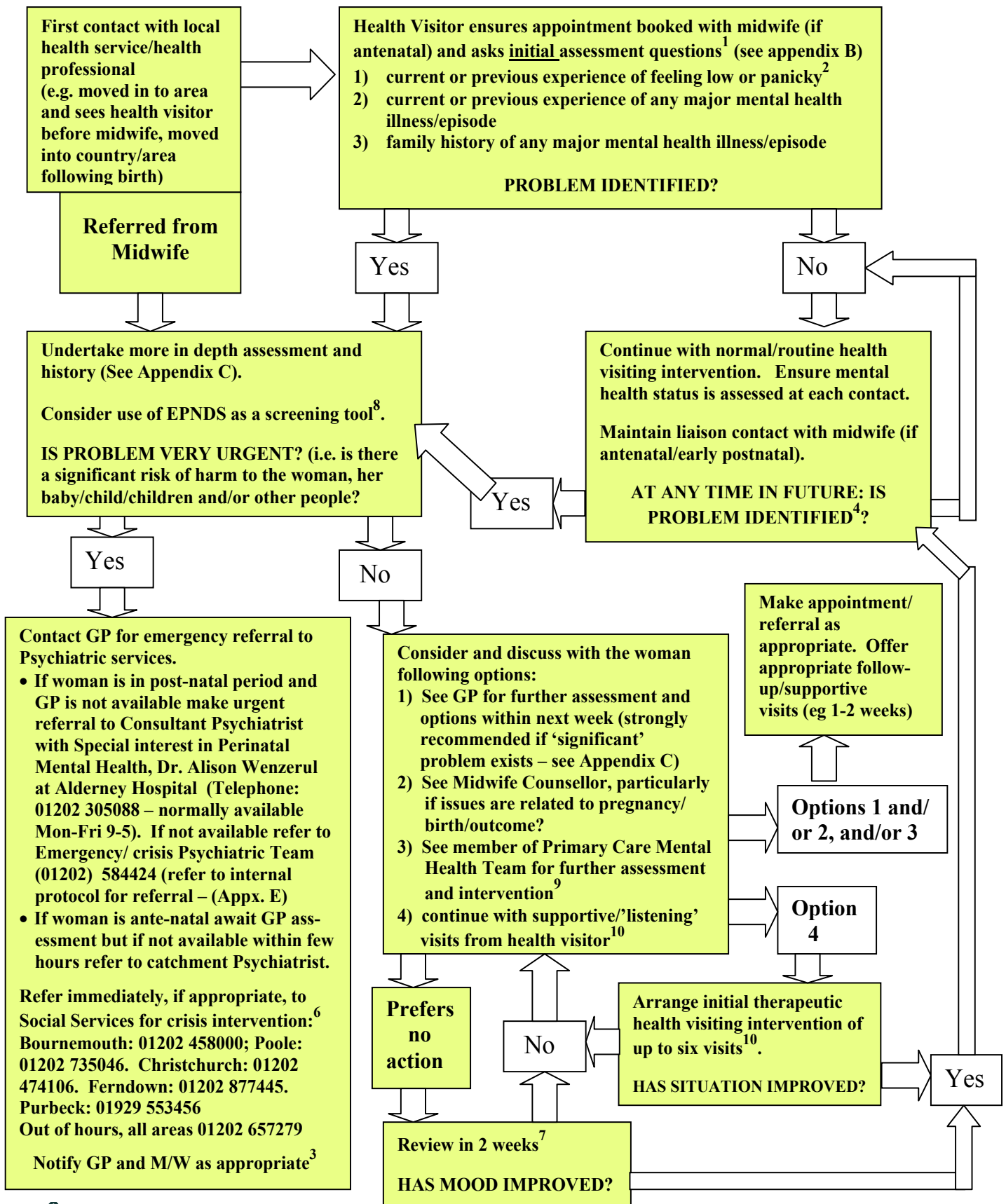
(Superscripted numbers relate to User's Guide)



Primary care teams should be aware that with decreasing duration of stay in postnatal wards, puerperal psychosis is more likely to present following a mother's discharge home

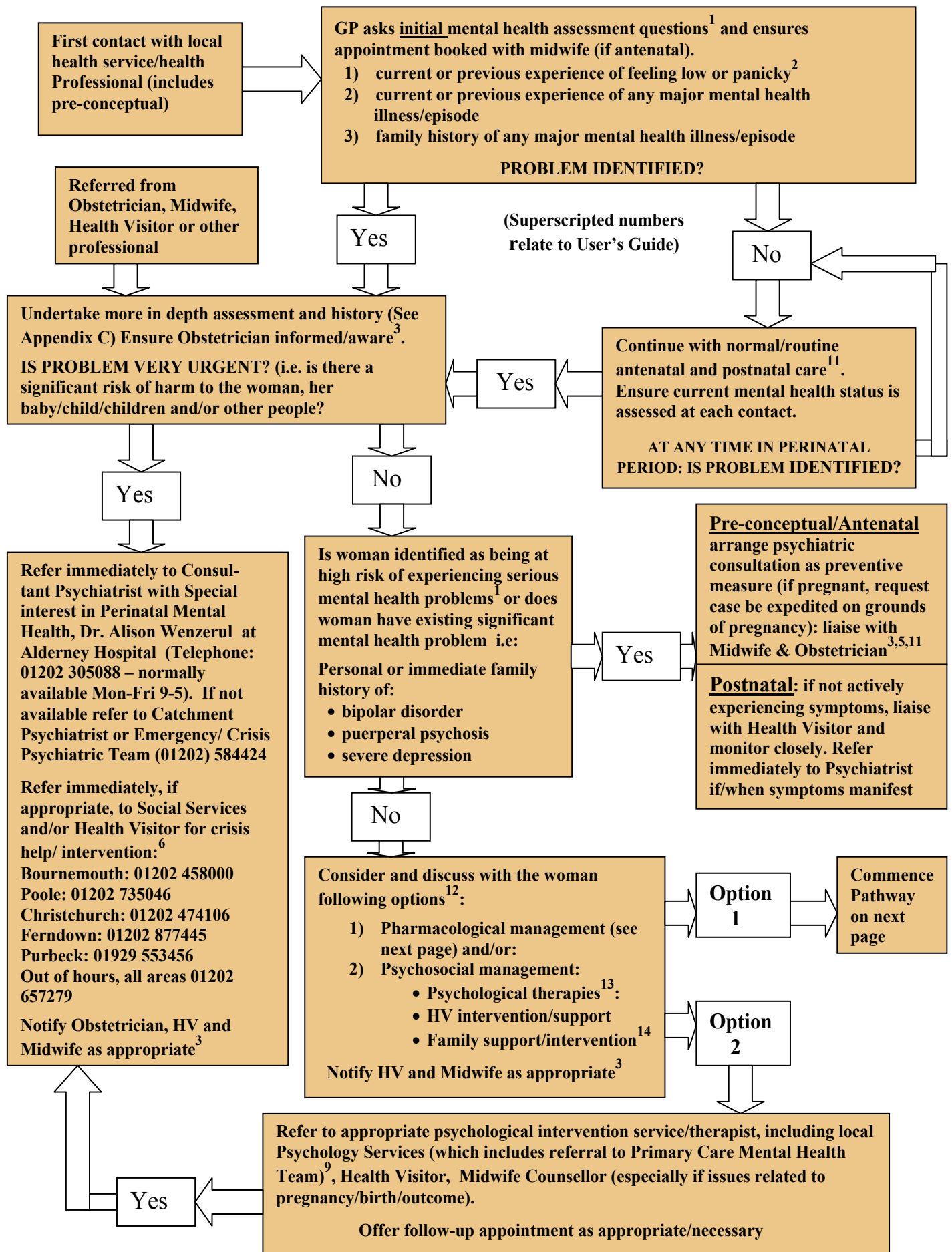
The Health Visitor's role within the multi-disciplinary approach

(Superscripted numbers relate to User's Guide)



When assessing women in the postnatal period it is important to remember that normal emotional changes may mask depressive symptoms or be misinterpreted as depression

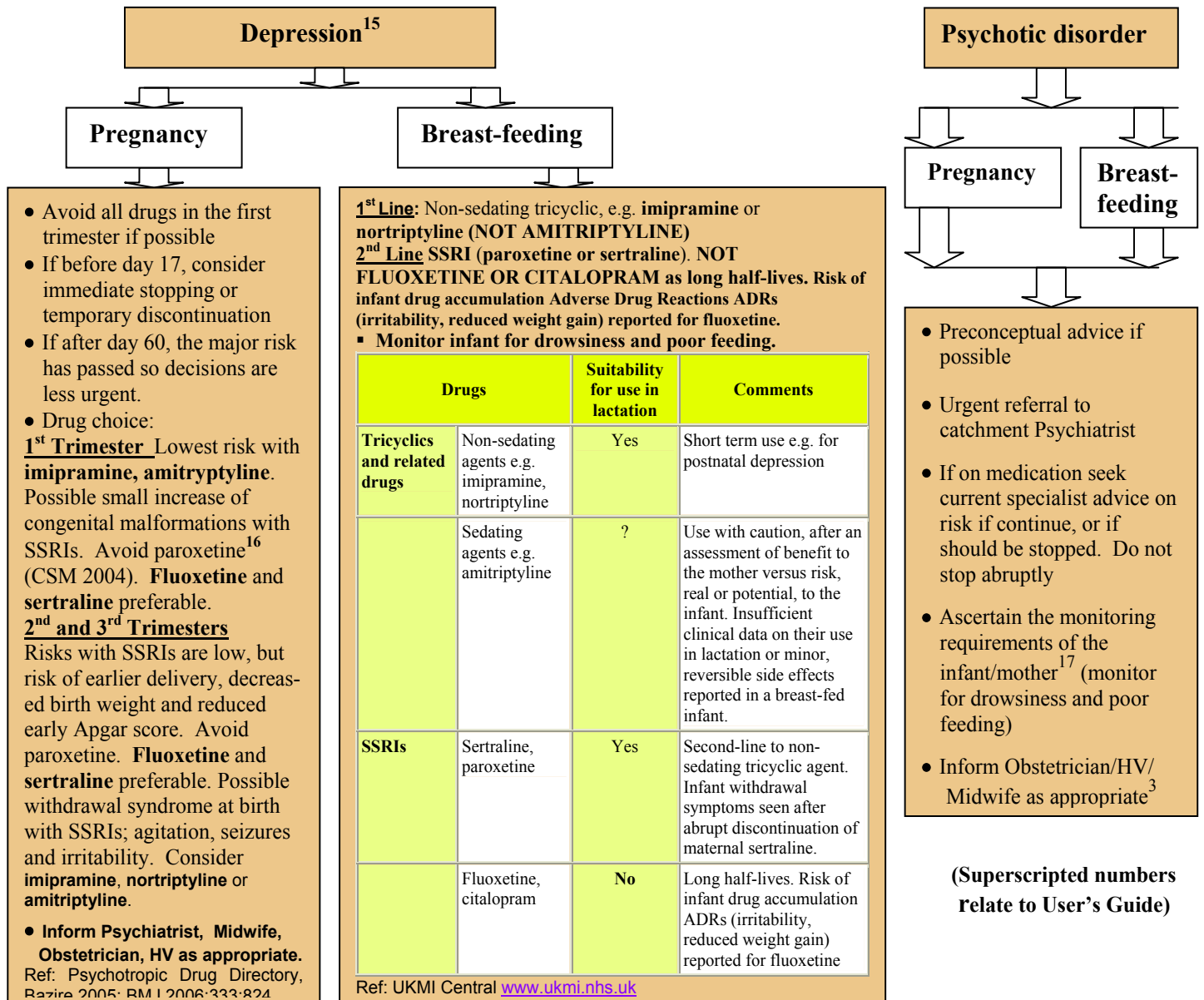
The General Practitioner's role within the multi-disciplinary approach



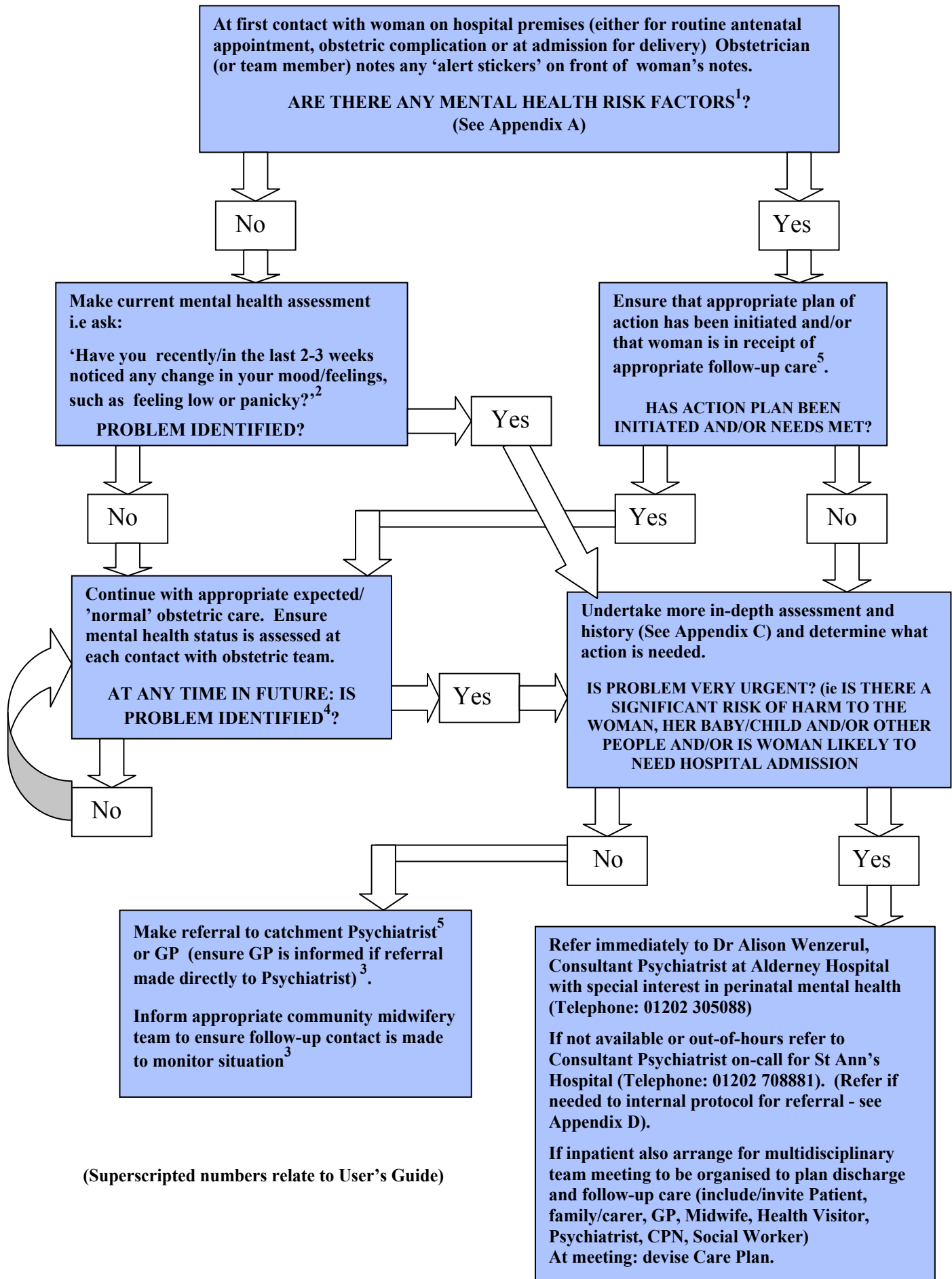
The GPs role (cont'd) Pharmacological Management

GPs are strongly recommended to read the full SIGN (2002) guidance on prescribing issues for women suffering perinatal distress. The following general principles governing prescription of new medication or the continuation of established therapy during pregnancy and in breast feeding apply to all recommendations in this guideline:

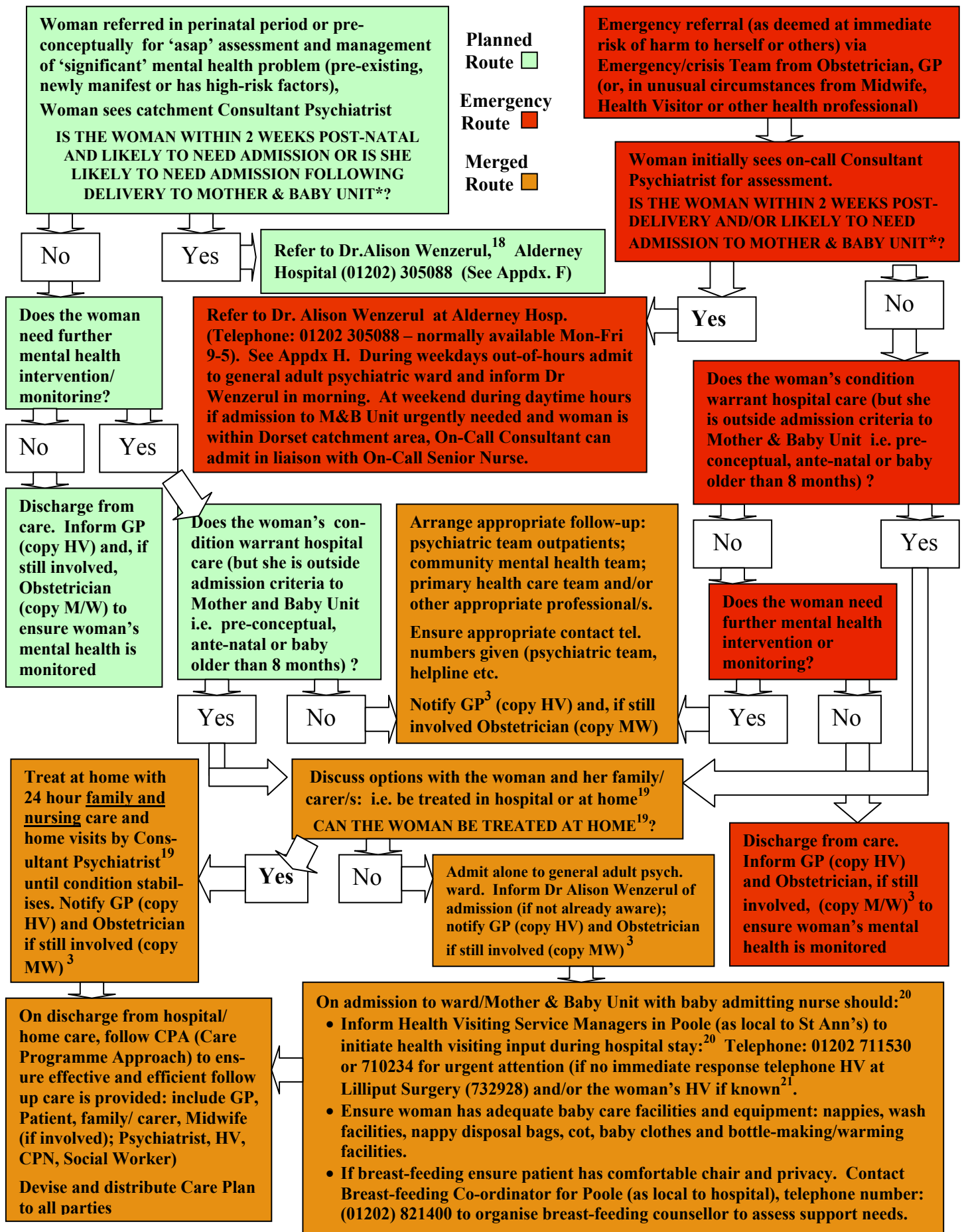
- **Establish a clear indication for drug treatment: i.e. the presence of significant illness in the absence of acceptable or effective alternatives.**
- **Assess the benefit/risk ratio of the illness and treatment for both mother and baby/foetus throughout the whole perinatal period and ensure that there is a written record that the mother is fully aware of the risks**
- **Use treatments in the lowest effective dose for the shortest period necessary. Try to avoid all drugs in the first trimester**
- **In general, all drugs should be avoided in premature or low birth weight infants, or in those who have any underlying conditions**
- **Use drugs with an evidence base (generally more established drugs)**
- **Always take into account the risk of relapse when considering discontinuing medication. Relapse may be more harmful to the mother and child**
- **Always seek up to date guidance on prescribing:**
 - ❖ Teratology Information Service: 0191 2321525 office hours. 0191 2231307 urgent enquiries 17–20.00hrs Mon-Fri:
 - ❖ UK Drugs in Lactation Advisory Service: 0121 311974 (direct) or 0121 3782211 (exts 2296/7) or 0116 2555779 or 0116 2586491
 - ❖ Dorset HealthCare NHS Trust Pharmacy Department: 01202 492042
 - ❖ East Dorset Primary Care Protocols for the Management of Depression and Anxiety (www.dorsetsomerset.nhs.uk)
 - ❖ The Maudsley 2005-2006 Prescribing Guidelines 8th Edition or current edition



The Obstetric Team's role within the multi-disciplinary approach



The Psychiatric Team's role within the multi-disciplinary approach



Superscripted numbers relate to User's Guide *Admission to Mother & Baby Unit is normally via Dr Wenzelul

User's Guide to the Pathway

1. Women should be asked questions relating to their mental health status by professionals with whom they come into contact, particularly initial contact (NICE 2007). Discussing mental health for the first time can be difficult for both practitioners and clients yet the subject can be introduced sympathetically (See Appendix B). It is important to discuss the subject as many risk factors for both postnatal depression and puerperal psychosis should be considered whilst making an overall assessment of the woman's mental health status (See Appendix C and D)
2. One of the most quick but accurate and effective methods for assessing a person's mental health status is to ask them to describe the level of their depression/anxiety etc. by choosing a number on a scale of 1 – 10, with 10 being the worst. Feelings of panic and heightened anxiety are strongly associated with depression (NICE 2004b).
3. CEMACH (2004) highlighted the lack of communication between professionals as a contributing factor to women dying from 'psychiatric causes'. GPs did not inform Obstetricians of psychiatric history and Psychiatrists were not informed when women under their care became pregnant and did not, in turn, share their management plans with Obstetricians.
4. The serious mental illnesses following childbirth tend to have an early and rapid onset, with the illness often developing very quickly over a period of 24–48 hours. Fifty percent of these illnesses have presented by day 7 and 90% by 3 months postpartum (CEMACH 2004)
5. 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 maternity team and GP and placed in her handheld records (CEMACH 2004)
6. Social services provide a 24hour duty team (**Bournemouth:** 01202 458000: **Poole:** 01202 735046: **Ferndown:** 01202 877445: **Christchurch:** 01202 474106: **Purbecks:** 01929 553456). **Out of hours for all areas: 01202 657279.** Health Visitors are normally available via the GP surgery but do not provide an emergency/24 hour service. If any child is at risk of harm/neglect due to the mother's circumstances, consider referral to Social Services for additional support using Common Assessment Framework (CAF) form.
7. For patients with mild depression who do not want any intervention or who, in the opinion of the professional may recover without intervention, a further assessment should be arranged, normally within two weeks (watchful waiting) (NICE 2004a).
8. Although there is a body of evidence that shows that the Edinburgh Postnatal Depression Scale (EPNDS) does not meet all the criteria as a screening tool, there is also a large scale agreement, however, that it does provide a useful scale for assessing common symptoms effecting depressed mothers (SIGN 2002). The original research recommended that the tool should not be used in the first five weeks of the post-natal period (Cox et al 1987) during which the woman's mood can be very variable.
9. The Primary Care Mental Health Team provides a useful service for 'common' mental health problems especially mild to moderate anxiety and depression. **NB: check with the Team the length of waiting time before making referral as this may be as long as 8-9 weeks and may not meet woman's needs.**
10. There is some evidence to suggest that supportive and effective home visiting by an appropriate health professional such as a health visitor when continued for a period of six

weeks can result in a vulnerable woman's reduction in their depression score on the EPNDS (Armstrong et al 1999)

11. General Practitioners should ensure that all relevant information concerning a woman's current or previous psychiatric history is included in referral letters to the booking clinic (CEMACH 2004)
12. A randomised controlled trial of the use of antidepressant therapy in postnatal depression carried out in a community setting in Manchester demonstrated a beneficial effect from medication combined with at least one session of modified cognitive behavioural therapy (CBT) in women with mild postnatal depression (SIGN 2002).
13. A number of studies indicate that these types of intervention, particularly psychotherapy and counselling, when provided by trained practitioners, can significantly reduce depressive symptoms (NICE 2004a, 2007). This also applies to women with postnatal depression (SIGN 2002).
14. It is clear from a number of studies (SIGN 2002) that a mother's perception of lack of support can be a risk factor in predisposing her to depression. A mother's ability to use social support (e.g. home help and childcare) may be affected by her depression. A confiding relationship and secure adult attachment are protective factors.
15. When depression is accompanied by anxiety symptoms the priority is to treat the depression and anxiety symptoms will decrease (NICE 2004b). Psychological treatments for depression often reduce anxiety and several anti-depressants also have anxiolytic effects. If there is no evidence of depression, the NICE guidance for anxiety should be followed (NICE 2004b).
16. The Committee for the Safety of Medicines raises the issue of concerns over the association of Paroxetine with increased suicidal tendencies/risks and withdrawal reactions (CSM 2004). They state that new studies have suggested a link between Paroxetine in early pregnancy and increased risk of birth defect, particularly cardiac, but there is still a need for further research
17. In view of the significant risks to the infant of a breast-feeding mother taking lithium, mothers should be encouraged to avoid breast-feeding. If a decision is made to proceed, close monitoring of the infant, including serum lithium levels, should be provided (SIGN 2002).
18. Where a woman has been referred for psychiatric assessment either pre-conceptually or antenatally as part of her planned care and she has risk factors that could result in her admission to the Mother and Baby Unit, Dr Wenzel should be notified in adequate time that she can assess the woman in the late ante-natal period. The woman should attend an Outpatients appointment and be accompanied by a member of her Community Mental Health Team to discuss her future care (See Appendix F)
19. Whilst this option may not be readily considered, the Pathway acknowledges the need to aim for best practice. In the very few cases where it would be the most effective, appropriate and preferred option for the woman to be cared for in her own home a Perinatal Distress 'team' should be identified. As it would be essential that in addition to professional input the woman has constant care, support and supervision by responsible family members, it would be an informed decision made between the Consultant Psychiatrist, the woman and her family/carers.
20. There is strong evidence to suggest that adequate good quality care and support of a woman admitted to a mother and baby unit for psychiatric disturbances in terms of helping her care for her baby contributes to her recovery (Fisher et al 2004). It is, therefore, essential that she is

provided with expert professional input to help her with the physical care of the baby and promote emotional attachment. The woman must have access to the health visiting team to guide and support her in her care of the child and to contribute to the assessment of her ability to care for her child.

21. This contact process endeavours to follow the most fail-safe route to ensure that if people are new on the ward or the usual link worker off sick/on leave etc. the system will work efficiently. The admitting nurse should ensure that the first contact is the Health Visiting Service Managers in Poole as they will know if the link health visitor at Lilliput Surgery is available/working and be able to put in place alternative arrangements if not. **If the woman is less than 11 days postnatal, the Health Visiting Service Managers in Poole must notify the midwifery managers to ensure midwifery cover is continued by local midwives until 11 days (or beyond if obstetrically necessary).** The admission must be treated by all as a matter of urgency. The link health visitor (if available) based at Lilliput Surgery will notify the woman's existing/allocated health visitor if this has not been done by the ward staff. They will then agree the most appropriate person to continue health visiting input. This would normally be the woman's own health visitor but, if not available or too far away, this is likely to be the link HV.

Health visiting input should include:

- Visits to the woman in hospital based on need following discussion with the ward staff but at least weekly
- Being available directly or by telephone to help and advise ward staff on the care of the infant
- Being involved in the discharge planning meetings and in the overall discharge process which starts from the time of admission as part of the overall care programme approach.

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Heather Thomas. Primary Care Matron and Health Visiting Advisor, Poole PCT.
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Pathway Review Date: April 2009

A larger print version of this Pathway is available from Clinical Managers, Equality and Diversity Leads or the Author.

Appendix A

Glossary of Terms*

AFFECTIVE OR MOOD DISORDERS

Disturbances in mood resulting generally in elation or depression and which are normally chronic or recurrent in nature. Usually there are also changes in activity levels, sleep and appetite. Affective disorders vary greatly in severity and include bi-polar disorder or manic depressive illness. Symptoms of anxiety may also be present.

ANXIETY

Anxiety is a common mental health problem occurring when the person's normal stress response manifests in normal everyday situations when there is no apparent need. The response becomes magnified and almost constant – interfering with sleep and coping with everyday things. In post-natal women the responsibility of caring for the baby becomes overwhelming and she may constantly seek reassurance. The condition varies in its strength and how it affects the person. Symptoms include feeling a constant sense of impending doom, muscle tension, fear of going out or to certain places, raised heart rate and feeling short of breath.

PANIC ATTACKS AND PANIC DISORDER

When anxiety increases it can escalate to a full blown panic attack. This is characterised by a very sudden, overwhelming sense of sheer terror. Physical and mental symptoms are so intense that people often think they are dying of a heart attack or not being able to breathe. Physical symptoms include breathlessness, palpitations, tingling fingers, tremor, giddiness, and sweating. Mental symptoms include feeling they are going crazy/mad, need to run away or escape the situation and further fear. These are then heightened by over-breathing/hyper-ventilation and a cycle continues for several minutes. Once the attack is over, the woman is caught in a cycle of worse anxiety as she constantly fears and tries to avoid another panic attack. The condition is known as panic disorder when several panic attacks happen over a short period of time.

'BABY BLUES'

A *brief* episode of misery and tearfulness, usually within the first 7-10 days that affects at least half of all women following delivery, especially those having their first baby.

BI-POLAR DISORDER/BIPOLAR AFFECTIVE DISORDER

Bipolar affective disorder (BPD) is a condition in which a person will have extreme changes of mood; periods of being unusually elated, 'high' or manic, and periods of being unusually 'low' or depressed. It is sometimes called **manic depressive disorder**. The mood-swings are very out of keeping with an individual's personality. Sometimes a mixture of depressive and manic symptoms are present at the same time and they can be severe enough to interfere with normal daily living

DEPRESSION

Depression is a variable condition ranging from mild to severe. Symptoms may include several of the following: feeling unhappy more often than not, losing interest in everyday things/events, finding it difficult to make decisions, difficulties concentrating, feeling irritable, loss of appetite, loss of interest in sex, feeling tired, feeling restless and agitated, loss of confidence, insomnia, feelings of not coping and thoughts of suicide. Intrusive thoughts such as self-harm and/or harming the baby are not unusual even in mild to moderate depression, and do not normally lead to actual harm. Such thoughts, though, warrant treatment. Someone is considered to be depressed if the feelings do not go away quickly (within a week or two) or interfere with their everyday life.

* Definitions are obtained from the Royal College of Psychiatrists' (2005) and the Mental Health Foundation (www.mentalhealth.org.uk) websites.

DEPRESSION/ANXIETY/OBSESSIVE COMPULSIVE TRAITS

Depression in the perinatal period is often characterised by anxiety and obsessional traits, more so than in depression at other times. Therefore if any of these symptoms are observed the woman should be offered treatment.

MANIA

A mother suffering from mania will be full of energy and confidence, even if she has never had a baby before. She will not rest, will tend to stay up all night, and will eat little, even though she is so active and talkative. She will tend to neglect her baby because she feels that she has so many other things to do - shopping, making plans, rearranging her home and her life. Though mostly cheerful and amusing, she may become very irritable if her unrealistic plans and impulses are - as is almost inevitable - thwarted. Both she and her baby are at serious risk of neglect.

PERSONALITY DISORDER

'Personality Disorder' is a controversial diagnosis which covers a wide range of different attitudes and behaviours. The term is generally used to describe behaviours that do not fit into any other obvious diagnostic category, but where the person nevertheless has difficulty coping with life and where that behaviour persistently causes distress to themselves or others. Common problems include having difficulty in sustaining relationships and interpreting social cues. The disorder affects about 10% of people. Characteristics include having a narrow range of attitude, behaviours and coping mechanisms and being inflexible in moving out of a specific 'mindset'.

POSTNATAL DEPRESSION

It is important that the term postnatal depression should not be used as a generic term for all mental illness following delivery. Postnatal depression is regarded as any non-psychotic depressive illness of mild to moderate severity occurring during the first postnatal year. However, for a significant proportion of women, the illness may have its onset in the antenatal period (Evans et al 2001). It is important to distinguish postnatal depression from 'baby blues'.

PUERPERAL

The period of six weeks following child birth

PSYCHOSIS

A serious mental illness in which a person isn't in contact with reality. This can include: sensing things that aren't really there (hallucinations); having beliefs that aren't based on reality (delusions); problems in thinking clearly; and lack of insight, or not realising that there is anything wrong with them

PUERPERAL PSYCHOSIS

Puerperal psychosis is a serious mental illness which comes on within a few weeks after childbirth. The symptoms are usually severe depression or mania, often with psychotic features (see above).

SCHIZOPHRENIA

Schizophrenia is a remote dreamy state in which a mother's thoughts and feelings are muddled. She may believe that everything that happens around her is in some special way connected with her. She may also hear voices talking to or about her and her baby, and believe that her baby is strange - a changeling, or the devil, or even a new Messiah. She may feel that she is under the influence of others who may wish her good or harm. This mixture of muddled thinking and strange ideas can make it difficult for other people to make sense of what she says. She may neglect her baby, do odd things with it, or become fiercely protective and shield it from people whom she thinks want to harm it.

These different forms of mental illness sometimes merge or replace each other - mania may be followed by depression, or schizophrenia may have manic or depressive features.

Appendix B.

Introducing 'mental health'

Introducing the concept of 'psychological wellbeing' to women engaging with the maternity services and midwives, particularly for the first time, can be daunting for midwives due to deep rooted social stigma attached to mental health issues. This guide provides some suggested approaches to introducing the subject of exploring their current mental health status and mental health history.

'We need to be thinking about the psychological wellbeing of all women who are pregnant because it is a time of such profound change and adjustment which can be challenging/difficult both emotionally as well as physically.

'We know that a first experience of depression or anxiety is much more common during pregnancy and in the year after having had a baby than at other times in a woman's life. Also women who have had a mental illness in the past are often at a higher risk of relapse during pregnancy and the first year of the baby's life than at other times in their lives. We also know that these conditions and relapses can be treated (regular support by a health visitor; talking treatments; medicine) and in many cases prevented'.

These conditions and relapses are related to pregnancy and are not a weakness or a character flaws, they have no bearing on what type of mother a woman will be.

With this knowledge in mind we encourage you to let us know if you feel low, panicky/anxious or that life is not enjoyable, and that the feeling:

- (a.) lasts longer than you would normally expect (is persistent)
- (b.) affects many areas of your life (is pervasive).

Also, if you have had a mental health problem in the past let us know so that you and I can consider the safest and most helpful way forward for you.

We discourage you from trying to cope with these feelings on your own for more than a couple of weeks because:

1. They can be treated and more quickly and effectively in the early stages.
2. If left untreated they can get worse – occasionally developing into severe mental illness.
3. We believe that women should have the healthiest and happiest experience of pregnancy and being with their young children that they can.

Appendix C:

Risk Factors for perinatal distress

Postnatal Depression

Many risk factors need to be considered whilst undertaking an assessment of a woman's mental health status. The SIGN (2002) guidance cites many risk factors for postnatal depression and states that 'evidence suggests that risk factors for postnatal depression are no different than for depression at any other time' (p3). Systematic reviews conclude that the following risk factors have been found to have a strong or moderate association:

- Past history of psychopathology and psychological disturbance during pregnancy
- Low social support
- Poor marital relationship/relationship with partner
- Recent life-changing/life events (e.g. bereavement, loss of job, moving house)
- 'baby blues'
- Some links have been found with obstetric complications; history of abuse; low income and low occupational status, but the evidence is weak.

Further risk factors identified from cohort and case control studies include:

- Parents' perception of their own upbringing
- Unplanned pregnancy
- Unemployment
- Not breastfeeding
- Antenatal parental stress
- Antenatal thyroid dysfunction
- Coping style
- Longer time to conception
- Depression in fathers
- Emotional lability in maternity blues
- Low quality social support
- Having two or more children
- Health problems of the new baby

There is no conclusive evidence that hormonal changes are a risk factor alone.

Puerperal Psychosis

Several risk factors for puerperal psychosis should be considered including:

- A personal past history of the condition
- Pre-existing psychotic illness (especially affective psychosis) severe enough to need hospital admission
- A first and/or second degree relative with a history of affective psychosis

Appendix D

History taking – questions to consider

The following list of questions is an aide for midwives and/or other health professionals to use when assessing a woman's current and previous mental health status. They are not in a sequential order, or in order of priority. They do not all have to be asked as, in some cases, problems are more readily identified. They are designed as a tool to ensure all aspects of the woman's mental health are considered.

Current Status:

NICE (2007) cite Whooley et al's (1997) recommendation of using just two questions to identify depression in primary care:

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

Although these, according to the authors have merit and are effective, the practitioner should use their professional judgement to use the most effective and appropriate questions and wording for the woman with whom they are working. Other suggestions include:

- 3) How have you been feeling in yourself this past week? Any tears? Any feelings of being overly anxious, worried or panicky for no obvious/real reason you can think of?
- 4) Have you been in any way worried about how you have been feeling lately?
- 5) Have you at any time recently felt you wanted to harm yourself or someone else?
- 6) (If post-natal) In what way do you think how you are feeling is affecting you and your baby? For instance, the way you are caring for him/her, or how you feel about him/her?

Personal History:

- 7) Have you, yourself, ever experienced a mental illness of any sort needing admission to hospital?
- 8) If so, can you explain a bit more about the illness, what you experienced? Was it a puerperal psychosis or any sort of psychotic illness (especially affective psychosis/Manias)?
- 9) (Women who have had a previous puerperal psychosis are at significant risk of future puerperal and non-puerperal episodes. The risk of a future puerperal episode lies between 25% and 57% and the risk of non-puerperal relapse is even higher. However, half the women who suffer a puerperal psychosis never become mentally ill again.)
- 10) Have you ever experienced a time when you actually have, or felt you wanted to, hurt yourself?

Family History

- 11) To your knowledge has your mother, father or other close relatives suffered from any significant or serious mental health problems?
- 12) To your knowledge has any close relative committed suicide or seriously tried to?
- 13) Do you know if your mother or any close female relatives have had any mental illness around the time of having a baby?

Appendix E

Protocol for referral to Emergency Psychiatric Services by Midwives and Health Visitors

Referral Criteria

At high or very significant risk of suicide, harm to self or harm to others in the immediate or short-term future (i.e. within 2-3 days).

Process

Telephone call to Emergency Duty Psychiatric Service (01202) 584424 specifying following information:

- 1) 'Patient'* Details:

| | |
|---------------------------|------------------------------------|
| Name | Gender |
| Date of Birth | Address |
| GP | Obstetric Consultant |
| Gestation/Weeks postnatal | Contact Details: Land/Mobile phone |
- 2) Primary concerns/current situation (*eg. the woman has become highly agitated and distressed; she has bizarre ideas about the baby and/or herself; the situation is not resolving; the woman is reporting that she is hearing or seeing things that others cannot see or hear*).
- 3) Degree and type of risk and to whom (*eg. not recognising the baby is hers; believing the baby is a danger to her or others; thoughts and/or plans of suicide/infanticide*).
- 4) Relevant (to current situation) mental health and physical health history (*eg. previous puerperal psychosis; history of depression or bi polar disorder; family history of these disorders*).
- 5) Relevant (to current situation) social history: (*e.g. substance misuse; domestic violence; family members and degree of support*).
- 6) The patient's attitude/consent to the referral (*is the woman aware that she is unwell; would she be agreeable to a transfer to St. Ann's if this was necessary?*)
- 7) Professional/referrer's name, contact details and relationship to patient.

Follow-up Administration

- Record in all appropriate patient notes
- Inform patient's GP immediately or at earliest opportunity
- If appropriate, i.e. Social Services are currently or have recently (within past 2-3 weeks) been involved, or have a need to be involved contact Duty Team (contact details in all sections of Pathway)
- Inform patient's Health Visitor at earliest opportunity. If not known or direct contact details not known, contact GP surgery and ensure *appropriate* message is left for the health visiting team. Include whether or a referral has been made to Social Services.

* NB: The term 'patient' is used during this referral protocol to avoid any confusion during the stress of an emergency/urgent situation

If there are any problems in following this Referral Protocol notify Xena Dion (01202 722746)

Appendix F

PROTOCOL

FOR THE REFERRALS TO MOTHER AND BABY UNIT

Prepared by Dr Alison Wenzerul with Approval of Dr L Mynors-Wallis

And agreed at MAC 27th March 2006

Introduction:

The Mother and Baby Unit is situated behind Twynham Ward at St Ann's Hospital. There are facilities for two mothers and their babies. They have a separate lounge / kitchen area as well as a bedroom with en suite facilities and a cot for the baby. Mothers with severe mental illness can be admitted to the Unit with a baby up to the age of 8 months old.

Urgent Referrals:

On week days should be through Dr Alison Wenzerul between the times of 9.00am to 5.00pm via her secretary on 01202 305088. Her secretary will contact Dr Wenzerul or her nominated deputy who will review the request and arrange admission if deemed appropriate.

During weekdays should an admission be needed outside of these hours the mother should be admitted to a general adult psychiatry ward until the morning. The case will then be reviewed and she and the baby, if appropriate, could then be admitted to the Mother and Baby Unit. At weekends between 9.00am and 5.00pm should a mother be considered in urgent need of admission to the Mother and Baby Unit with her baby and from the catchment area covered by Dorset NHS Trust, admission would have to be organised by the On Call Consultant in liaison with the On Call Senior Nurse.

Outside of these hours the mother if needing admission would have to be admitted to a general adult psychiatric ward without her baby.

Out of Area admissions will only be accepted on weekdays, through Dr Wenzerul.

Non Urgent Referrals:

Where possible Dr Wenzerul would like to receive a referral for the mother in the late antenatal period, the mother should attend Outpatients with a member of her CMHT to discuss possible options for the postnatal period and plan for an admission to the mother and Baby Unit if that is deemed the most appropriate.