

FRAMEWORK FOR MENTAL HEALTH SERVICES IN SCOTLAND
SECTION 3: SERVICE PROFILES

SERVICES FOR WOMEN WITH POST NATAL DEPRESSION AND PERINATAL MENTAL HEALTH PROBLEMS^{abc}

Prevalence: Annually, for every 1,000 births per year, 100 women will suffer a major depressive illness and 2 women will develop a puerperal psychosis. Patients with postnatal depression can be seriously ill, and are often undetected. Those who are known represent the tip of the iceberg - the number experiencing significant distress and difficulty in coping will be much greater. Mental health problems in the pre- and post - natal period are increased in situations of social and psychological adversity. Mothers living in situations of social deprivation are at higher risk, with illness often undiagnosed. A survey in Glasgow found a prevalence of 28%. Women whose pregnancies have ended in miscarriage or a perinatal death often do not receive the help they need.

Outcome: The prognosis for identified and adequately treated individuals is good. The majority of patients will be managed successfully in their own home. Untreated or prolonged episodes may still affect up to a third of individuals a year later. The small but definite risk of infanticide adds emphasis to the need for a well organised, integrated and effective service.

Health Gain: Apart from the personal suffering involved the importance of this disorder comes from the enduring adverse effects on the social, intellectual and educational development of the child, that it may lead to relationship breakdown, and certainly will compromise the mother's quality of life.

Domestic Violence: A Ministerial Task Force is expected to report during 1999 on Domestic Violence in Scotland, but the issue is touched on here as it is so closely related to perinatal mental health problems.

^a Report on Detection and Early Intervention in Postnatal Depression (1996)

CRAG/SCOTMED Framework for Action Working Group on Maternity Services:

^b Perinatal Psychiatry = Use and Misuse of the Edinburgh Postnatal Depression Scale (1994)

Ed. John Cox and Jeni Holden Gaskell, Royal College of Psychiatrists, London

^c Why Mothers Die - Report on Confidential Enquiries into Maternal Deaths in the UK 1994-1996 (1998) SODoH

Service Element	Description of Needs	Ways in which Services may Respond
Prevention, Advice and Information	<p><u>Primary Prevention:</u> Women with a family or personal history of mental health problems or previous post-natal depression who are in relationship difficulties, suffered childhood traumas, and are stressed and anxious are at higher risk of post-natal mental illness (40%). Awareness of the risks of post-partum illness and the means of detection may vary among midwives. The antenatal and postnatal maternity services have an important role in detecting women at risk or in distress.</p> <p><u>Secondary Prevention:</u> The high level of care normally offered to women in pregnancy and the post-partum period offers a clear opportunity to detect those at high risk, and those who have developed symptoms and signs of a mental health problem. This may be done in the course of a routine assessment interview or by using the 10-item self-report Edinburgh Post-natal Depression Scale^d. Both require all the individual clinical staff members who come into contact with the patient to be aware of the possibility of mental health problems, and in particular postnatal depression, to have the training to identify the issues sensitively, and to have the facility to provide (or refer for) treatment. (NB: the EPDS only screens for depression and would not detect a mother with another psychiatric diagnosis).</p>	<ul style="list-style-type: none"> • Screening of antenatal clinics for high risk groups followed up by focused, educational and parentcraft interventions, continuity of psychologically-trained staff, social support, individual help and anticipatory learning for the time after childbirth can reduce the risks by half. • There is increasing evidence of the benefits of community groups which links experienced parents with new parents on a one-to-one or group basis. It is helpful for the statutory services to support such groups. • For those with a previous history of mental health problems or post-natal depression, close liaison between GP, the Health Visitors, the patient and her partner, the obstetrician and midwives and the Mental Health Services should identify a package of interventions which may include psychotropic medication in the immediate post-partum period (with the implications for breast-feeding), specific psychological and/or psychiatric therapies. These may be best provided in Healthy Living Centres or where family-friendly care and childcare is offered. • Women who have experienced miscarriage, abortion or perinatal death of their child are at risk of mental health problems. <p><u>Specific actions which should be taken include:-</u></p> <ul style="list-style-type: none"> • Identification of the need for a service in a Health Board (HIP) and Joint Mental Health Strategy(ies). • Creation of an Integrated Care Pathway for pre, peri and postnatal mental health problems spanning the community (voluntary and professional), Primary Care and Secondary Care. • Clinical staff from appropriate professions involved in setting explicit and relevant standards for detection (which are audited). • Close collaboration with community groups by both Social Work departments, & voluntary groups (for support, service development, & training).

^d Detection of postnatal depression - development of the 10-item Edinburgh Postnatal Depression Scale
British Journal of Psychiatry (1987); 150: 782-786

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	<p data-bbox="517 213 913 239">(Prevention, Advice and Information)</p>	<ul data-bbox="1272 213 2051 687" style="list-style-type: none"> <li data-bbox="1272 213 2051 304">• People using the EPDS require training and regular supervision to give them the chance to discuss its use in their practice, and to develop their treatment skills. <li data-bbox="1272 312 2051 496">• General Practitioners and Health Visitors should administer the EPDS at 6-8 weeks after delivery and again 3-6 months. A screening and action strategy should be in place which advises on appropriate action on the basis of different levels of EPDS scores. They should do this within an explicit practice framework about criteria for own treatment and referral to others. <li data-bbox="1272 504 2051 560">• Clinical staff should be respectful of existing contacts and support networks and should work with them and not across them. <li data-bbox="1272 568 2051 687">• Women who are still depressed or not functioning at their usual level at 6 months post-partum should be identified to allow referral to a specialist women's mental health service which will work to back up her usual contacts.

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<p>Services in the Community</p>	<p><u>Empowerment</u>: Joint Commissioners of Mental Health Services should recognise the evidence for the beneficial effects of intervention at a population level.</p> <p><u>Integrated Care Pathway: Health (Primary and Secondary Care) and partner agencies should ensure that each locality develops a coherent approach to providing health promotion, detection and therapy services to women who are pregnant or in the first post-partum year. This should link to maternity, child health surveillance and existing mental health services at Primary and Secondary levels.</u></p>	<ul style="list-style-type: none"> • Universal actions should include: <ul style="list-style-type: none"> ➤ Education programmes in school directed at both sexes. ➤ Parent-friendly employment practices. ➤ Promoting relevant media messages. • Selective approaches: <ul style="list-style-type: none"> ➤ Education of health and social work professionals to increase awareness of the psychological dimensions of child bearing. ➤ Wide availability of parenting classes for mothers- and fathers-to-be. ➤ Support groups in the community to foster the development of supportive social networks. ➤ Attention to the mother’s experience at birth and in the immediate aftermath and the need for opportunities to reflect on the experience with the midwife or health visitor. • One senior clinician in the Primary Care Trust in each Board area should be given the responsibility for developing, co-ordinating and maintaining the ICP, and its quality assurance. • The existing services in a Board’s area should be reviewed to assess fitness for purpose against the ICP. • The needs to be served by the ICP should be identified in collaboration with Primary Care, Secondary Care and partner agencies. • A mother’s potential journey through care should be mapped out through all the services which may be required. • Each agency should co-operate with professionals in listing where it can make a contribution to the care needed. • The aims of the contribution, the standard to which it is given, and the measure of its success should be defined at each stage of the process of care. • Criteria for onward referral and the referral pathways must be explicit. • Responsibilities for both organisation and resourcing and the collection of information (about what has been done, by whom, and to what effect) must be clarified. • Any local group active in the field should be welcomed as a partner in planning and evaluation.

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<p>Secondary Care</p>	<p>The <u>specialist perinatal service</u> will contain key staff, the contribution of each being essential to maintain an intergrated service.</p> <p>The main tasks are:</p> <ul style="list-style-type: none"> - Support for mothers and families - Primary Care liaison - In Patients service - Out Patients service - Obstetric service liaison - Liaison with Child and Family Psychiatry - Training , Audit and Service development 	<p>The Community Psychiatric Nursing service:</p> <ul style="list-style-type: none"> • Supports the Primary Care Team and acts as a link with the specialist services. • Minimises admissions • Maintains liaisons with other involved agencies • Provides care at home • Supports the local creche/mother and baby group/day facilities • Delivers a range of therapeutic interventions • Works closely with an identified consultant psychiatrist and a psychologist. <p>The Out-patient service:</p> <ul style="list-style-type: none"> • Will need to provide between 20 and 40 new patient assessments and follow-ups per year for 1,000 deliveries. This will require input from an identified consultant psychiatrist with an additional multi-disciplinary input. <p>In-patient care:</p> <ul style="list-style-type: none"> • Adequate Community Services will keep admissions to a minimum. <p>Some services consider that:</p> <ul style="list-style-type: none"> • It is essential that mothers and babies are admitted together, into a safe environment. ➤ A special facility is required. ➤ A pool of nursing staff with specific skills is necessary. ➤ 4 beds (and associated cots) is the minimum size for viability. ➤ A total population of 650,000 would generate sufficient admissions to occupy it. ➤ For smaller Health Boards, a Managed Clinical Network (MCN) making joint use of a specialist In-patient facility out-of-area could be considered. <p>Obstetric Liaison:</p> <ul style="list-style-type: none"> • A liaison service to the local maternity unit should be provided on a multi-disciplinary basis, with an emphasis on collaborative care, sharing of expertise and the addition of a psychological element to the management of other issues such as infant fatality and stillbirth and the effects of domestic violence. • Links with the local child and family psychiatric service should allow attention to be drawn to the need for parenting skills development and the needs of other children in the family. • A service should be provided to couples requesting counselling on the risk of recurrence of puerperal mental health problem during and after a subsequent pregnancy and any future care which may be required.

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<p>Domestic Violence</p>	<p>Prevalence:</p> <ul style="list-style-type: none"> • 1 woman in 3 experience domestic violence at some point in her life (<i>1 in 10 in the previous year</i>) • about 30% of domestic violence starts during pregnancy • violence can often escalate during pregnancy or after birth. <p><u>Risks:</u></p> <p>Victims of domestic violence may be:</p> <ul style="list-style-type: none"> • 15 times more likely to abuse alcohol • 9 times more likely to abuse drugs • 5 times more likely to die from suicide • 3 times more likely to become more depressed <p>at high risk of developing post-traumatic stress disorder</p>	<p>Health and social work staff can help by:</p> <ul style="list-style-type: none"> • Being open to disclosures of domestic violence. • Providing support & practical advice about the available options, & liaising with community agencies. • Showing informed & understanding & providing continuing help whatever decision is reached. • Arranging specialist referral. <p>To do this staff need:</p> <ul style="list-style-type: none"> • A better understanding of the nature of domestic violence. • Compassion and the professional skills to help women address the implications and options. • The capability to provide support over a long time. • The ability to recognise the development of psychological disorders requiring specialist therapeutic input. • The availability of referral pathways to a psychological therapies service. <p><u>Warning signs:</u></p> <ul style="list-style-type: none"> • Repeated attendance at antenatal clinics, the GP or A&E for minor injuries or trivial complaints. • The constant presence of the partner. • Non-attendance at the clinic ➤ No money available for travel ➤ Not allowed out ➤ No access to a telephone • Non-compliance with treatment • Evasiveness or reluctance to speak in front of partner <p>Minimising evidence of violence from/on her body.</p>

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	<p data-bbox="515 212 739 236">(Domestic Violence)</p> <ul data-bbox="515 276 1245 435" style="list-style-type: none"> <li data-bbox="515 276 1122 300">• If violence is revealed staff need to know what to do <li data-bbox="515 308 1245 371">• If the mother does not speak English, the interpreter should not be a relation, partner or friend <li data-bbox="515 379 1218 435">• During antenatal care women should be seen at least once on their own 	<p data-bbox="1267 212 1433 236"><u>Practice Issues</u></p> <ul data-bbox="1267 276 2047 627" style="list-style-type: none"> <li data-bbox="1267 276 2047 339">• Health and Social work staff should receive training in all aspects of domestic violence <li data-bbox="1267 347 2047 499">• Primary Care Trusts, in collaboration with Obstetric Units and Social Work Departments should develop guidelines for: <ul data-bbox="1317 403 1666 499" style="list-style-type: none"> <li data-bbox="1317 403 1666 435">➤ Identification and recording <li data-bbox="1317 443 1666 475">➤ Provision of further support <li data-bbox="1317 483 1630 499">➤ Provision of information <li data-bbox="1267 507 1984 563">• Information should be widely available in antenatal clinics and female toilets <li data-bbox="1267 571 2018 627">• Enquiries about violence should be a routine part of the antenatal history and repeat examination