THE SCOTTISH OFFICE

Department of Health

NHS
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NHS Management Executive
St. Andrew's House
Edinburgh EH1 3DG

18th March 1999

Dear Colleague

SERVICES FOR WOMEN WITH POSTNATAL DEPRESSION

Summary

1. Attached to this letter is an Appendix to the Service Element section of The Framework for Mental Health Services in Scotland. The purpose is to assist commissioners of Mental Health Services, their planning and service partners, Acute and Primary Care NHS Trusts and the relevant professions to identify for their area the need for services for women, and link them in a way which is fit for the purpose, as close to the individual's home as possible. The Mental Health Reference Group has seen and approved it.

2. The Priorities and Planning Guidance for the NHS in Scotland 1999-2002 (NHS MEL (1998)63) added the needs of those suffering from postnatal depression, and the victims of domestic violence, to its reiteration of the clinical priority to be given to mental health services by the NHS in Scotland. This is in keeping with increasing emphasis on the importance of physical and mental well being of children.

3. The care needs of women with postnatal depression can only be met if a systematic approach to the prevention, detection, and successful treatment of the illness is developed through an Integrated Care Pathway, with support provided to the mother throughout. In this way lasting damage to the emotional educational, and social development of the child can be averted.

4. Domestic violence is frequently related to pregnancy and childbirth, raising the risk of mental health problems.

Addressees

For action:
General Managers, Health Boards
Chief Executives, NHS Trusts
Directors of Social Work/Chief Social Work Officers

For information:
Chief Executives, Local Authorities
Chief Executive, COSLA
Directors of Housing/Chief Housing Officers
General Manager,
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General Manager, State Hospitals Board for Scotland
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Action

5. Health Boards, NHS Trusts, and Local Authorities are asked to ensure that this letter and the Appendix, which is laid out in the same format as the Service Element section of the Framework for Mental Health Services in Scotland, are distributed to all staff involved in planning and delivery of health, social work, and home care services for mothers and families, before, during, and after delivery. These agencies should also incorporate proposals for the development of appropriate services within Health Improvement Programmes, Joint Mental Health Strategies, Community Care Plans, and Trust Implementation Plans.

Yours sincerely

for **KEVIN J WOODS**
NHS in Scotland Management Executive

GILLIAN M STEWART
Social Work Services Group

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 Taskforce 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.

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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	Primary Prevention: 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. Secondary Prevention: 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).	• Screening of ante-natal 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. Specific actions which should be taken include:- • 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.

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

Service Element	Description of Needs	Ways in which Services may Respond
	(Prevention, Advice and Information)	• 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, and voluntary groups (for support, service development, and training) • 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. • General Practitioners and Health Visitors should administer the EPDS at 6-8 weeks after delivery and again at 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. • Clinical staff should be respectful of existing contacts and support networks and should work with them and not across them. • Women who are still depressed or not functioning at their usual level at six months post partum should be identified to allow referral to a specialist woman's mental health service which will work to back up her usual contacts.

Service Element	Description of Needs	Ways in which Services may Respond
Services in the Community	Empowerment: Joint Commissioners of Mental Health Services should recognise the evidence for the beneficial effects of intervention at a population level.	• Universal actions should include: ➢ Educational programmes in schools directed at both sexes ➢ parent-friendly employment practices ➢ promoting relevant media messages • Selective approaches ➢ 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.
	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.	• 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 cooperate 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.

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	(Services in the Community)	• 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.
Secondary Care	The specialist perinatal service will contain key staff, the contribution of each being essential to maintain an integrated service. The main tasks are: - 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	The Community Psychiatric Nursing service: • 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. The Out Patients service: • 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. In Patients care: • Adequate Community Services will keep admissions to a minimum

Service Element	Description of Needs	Ways in which Services may Respond
	(Secondary Care)	Some services consider that: • 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 4 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. Obstetric Liaison: • 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 a puerperal mental health problem during and after a subsequent pregnancy and any future care which may be required.

Service Element	Description of Needs	Ways in which Services may Respond
Domestic Violence	**Prevalence:** • 1 woman in 3 experiences domestic violence at some point in her life (*1 in 10 in the previous year*) • about 30% of domestic violence starts during pregnancy • violence can often escalate during pregnancy or after birth <u>Risks</u>: Victims of domestic violence may be: • 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 • at high risk of developing post-traumatic stress disorder	Health and social work staff can help by: • Being open to disclosures of domestic violence. • Providing support and practical advice about the available options, and liaising with community agencies. • Showing informed understanding and providing continuing help whatever decision is reached. • Arranging specialist referral To do this staff need: • 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 (a core service element in "The Framework for Mental Health Services in Scotland" [1997]). <u>Warning signs</u>: • 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 her partner • Minimising evidence of violence from /on her body

Service Element	Description of Needs	Ways in which Services may Respond
	(Domestic violence) • If violence is revealed staff need to know what to do • If the mother does not speak English, the interpreter should not be a relation, partner or friend • During antenatal care women should be seen at least once on their own	Practice Issues • Health and Social Work staff should receive training in all aspects of domestic violence • Primary Care Trusts, in collaboration with Obstetric Units and Social Work Departments should develop guidelines for: ➢ Identification and recording ➢ Provision of further support ➢ Provision of information • Information should be widely available in antenatal clinics and female toilets • Enquiries about violence should be a routine part of the antenatal history and repeat examination

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