Aneurin Bevan University Health Board

Perinatal Mental Health Protocol for Health Visiting

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Status: Issue 2 | Issue date: 23 July 2014
Approved by: Healthcare Standards Meeting | Review by date: 23 July 2017
Owner: Public Health Nursing – Health Visiting | Policy Number: ABHB/Clinical/0506

Contents:

1 Executive Summary 2
2 Scope 3
3 Aim 4
4 Protocol Statement 3
5 Responsibilities 5
6 Training 6
7 Record Keeping 6
8 Monitoring and Effectiveness 6
9 References 7
10 Appendices 9
Appendix 1 10
Appendix 2 11
Appendix 3 14
Appendix 4 15
Equality Impact Assessment Guideline 16

1 Executive Summary

Health Visitors are known to make a distinctive contribution to maternal mental health and wellbeing. They deliver a model of progressive universalism ie offering preventative services to all while focussing on the vulnerable. Perinatal Maternal Mental Health can be categorized into three main categories. Baby blues, where the mother is tearful, anxious, depressed lasting for a few days in the first week after childbirth. The other end of the spectrum is Puerperal Psychosis affecting approximately one or two mothers in 1000, mothers who are likely to have a history of severe mental illness or/and a family history of perinatal illness. Mothers with such a history are identified in many cases antenatally and require specialist intervention covered in the Midwifery Perinatal Health Guidelines.

One in 10 women and up to 4 in 10 teenage mothers suffer from Postnatal Depression which is likely to occur in 2-8 weeks after child birth, but can happen up to the first year. The early years of a child's life is known to be a significant period in promoting future mental health and wellbeing, and early experiences and influences from carers affects brain development. Postnatal Depression is known to be the most frequently reported barrier to warm care giving and secure attachment, which can interfere with the social and emotional bonding process essential for an infants developmental needs. Early identification of needs and working in partnership with families using a model based on strengths and empowerment can reduce the adverse affects on the child, mother and the family.

2 Scope

The guideline is directed at Health Visiting Services and addresses the issues of mental health for women, fathers, families and infants during the antenatal, and postnatal periods. It provides evidence based guidance regarding the responsibility of Health Visitors and colleagues in the early detection, care, support and referral of women and their families during this important time of their lives to decrease the negative effect of antenatal and postnatal depression. Early communication and detection of possible depression in the antenatal and postnatal period up to the first year is based on the Mood Assessment ,ie the Whooley questions(NICE 2007),(appendix 1) and if appropriate following the use of the third mood assessment question a clinical interview is undertaken supported by the Edinburgh Post natal Depression Scale (appendix 2). The EPDS was first introduced as a screening tool to detect postnatal depression (Cox J. Holden JM 1987), however it has since been found to be more effective as a tool used as part of a maternal mood assessment (Coyle B. Adams C.(2002) The mood assessment will be recorded in the family health record with an appropriate plan of care adhering to ABUHB PND framework (appendix 3) and made in consultation and partnership with the mother and family, and in close liaison with midwifery, mental health and GP colleagues as appropriate. A Liaison letter will be used to aid communication. (appendix 4)

3 Aim

To provide a clear pathway that is evidence based providing early detection and intervention for antenatal and postnatal depressed mothers, to promote the best possible mental health to mothers and families and minimise detrimental impact on the infant. It links clearly with the Perinatal Mental Health Guidelines and relies on the Health Visitors techniques in building trusting relationships to assist early identification, and working in partnership to develop problem solving abilities within the family using promotional, motivational interviewing. It incorporates listening visits centred around active listening, reflection and provision of empathic responses, cognitive behavioural approaches, and dyadic interventions such as infant massage and postnatal interaction groups both of which focus on mother child interaction.

4 Protocol Statement

General Statistics (extracted from NICE Guidance - antenatal & postnatal mental health)

- **At least half of women** who give birth experience low mood either at some point in their pregnancy and/or in the initial days or weeks following the birth. This is commonly known as "baby blues".

  Symptoms include feeling tearful, overwhelmed and irritable, but these may pass with rest, support and reassurance.

- If low mood persists during pregnancy a diagnosis of antenatal depression may be applicable. Low mood is thought to affect up to **15% of pregnant women** and although prevalence is similar to that of postnatal depression, antenatal depression is often a neglected aspect of pregnancy.

  Diagnostic features include - a loss of interest in oneself, anxiety, loss of appetite and feeling tearful, lonely, irritable and irrational.

- If following the birth of the child, low mood persists for a prolonged period of time ie. 2 weeks or more, the mother may be diagnosed with postnatal depression **(affects 15–20%** of new mothers within 12 months of their child's birth).

  Diagnostic features include – Irritability, fatigue, sleeplessness, lack of appetite, anxiety, poor mother–infant interaction (e.g. lack of interest in the child), anxieties about the child (possibly including thoughts of harming the child), lack of motivation, panic attacks, feelings of isolation. Also a sense of being overwhelmed, physical signs of tension such as headaches or gastrointestinal symptoms and thoughts of self-harm and suicide may also be present, which may or may not lead to self-harming behaviour.

- A more severe illness, with acute onset, is puerperal psychosis; a relatively rare disorder characterised by psychotic depression, mania or atypical psychosis. This affects between **1 in 500 and 1 in 1000 women** who have given birth.

  Characteristic features in those with mania include excitability, dis-inhibition and intense over- activity. More commonly, pregnancy, childbirth and the postnatal period can be associated with the re-emergence or exacerbation of a pre-existing psychotic illness such as schizophrenia or bipolar disorder. For some women, there may be an increased risk of danger to themselves or others.

Evidence also highlights how the prolonged effects of PND can compromise the neurodevelopment of the child.

- **Emotional difficulties** - in emotional regulation (Stein 1991)

- **Security of attachment** - higher rates of insecure attachment – avoidant and disorganised. (Martins and Gaffin 2000)

- **Cognitive difficulties** - evident at 18 months and in some circumstances e.g. social adversity are still evident at 11 years(Murray1997, Hay2001)

- **Behavioural** – mothers reports of behavioural problems at 18 months, still evident at 5 years as assessed by mothers and teachers. (Murray1999)

Research also highlights other detrimental effects in relation to the child:

- Higher rates of child abuse and neglect (Scott1992, Creighton 1997)

- Sudden infant death (SIDS) (Sanderson 2002)

- Infantacide (Carpenter 2005)

The protocol requires that Health Visitors and colleagues involved have specific training to undertake evidence based approaches to enable:

- Identification as early as possible any signs and symptoms of perinatal depression.

- To offer support at the earliest opportunity.

- To enhance the mother/infant relationship and prevent any breakdown in that relationship.

- To support other members of the nuclear and extended family particularly fathers.

- To promote the social, emotional, cognitive and behavioural development of the infant.

5 Responsibilities

The responsibilities encompass the mood assessment Whooley questions used with all antenatal and postnatal mothers at booking, 4-6 weeks and 3-4 months (NICE 2007). This consists of two short verbal questions and the possible use of a third question which may indicate the need to undertake a clinical interview. The clinical interview is supported by use of the Edinburgh Postnatal Depression Scale and includes additional questioning around concentration, appetite, retardation and/or agitation and energy.
It is the responsibility of the Health Visitor:

- To inform women in the antenatal period of signs and symptoms relating to postnatal depression, the use of screening questions, tools and the support available.

- To undertake or delegate to a student Health Visitor under the guidance of a community practice teacher the clinical interview and completion of the EPDS questionnaire.

- To identify the degree of support required and develop an appropriate safe plan to include, offering predetermined/time limited Health Visiting Supportive Interventions ie active listening visits and/or Cognitive Behavioural Techniques. (active listening visits and CBT approaches are to be undertaken by a Health Visitor or appropriately trained Registered Nurse)

- To make appropriate referrals to other professionals eg GP, Mental Health Worker, counselling practitioner specific PND support groups (sunshine seekers, connect etc) based on professional judgement, clinical interview and EPDS.

- To promote other supportive services such as Flying Start/Sure Start baby groups, infant massage etc

- To evaluate outcomes of interventions of interventions using the Edinburgh Postnatal Depression Scale recording in the family health record, and communicate the result and further actions to the GP.

6 Training

The assessments should be undertaken by appropriately trained Health Visitors or Student Health Visitors under the supervision of their Community Practice Teachers.

Training in Detection and Management should be accessed from recognised evidence based training providers or ABUHB Cascade Trainers.

Focussing on:

- The Health Service context
- Depression and the impact on others
- Listening skills update
- Mood Assessment
- Clinical interview
- Use of EPDS
- Cognitive behavioural techniques
- Problem solving, coping strategies.
- Attachment and facilitation of adaptation to infant behavioural cues
- Pharmacological interventions
- Child protection, legal responsibilities and record keeping.

7 Record Keeping

- Health Visitors are required to comply with ABUHB and NMC Record Keeping Policy/Guidelines.

- A record of mood assessment and care plan should be documented in the Family health record at 6 weeks and if indicated at 3 months.

- Clinical Interview with use of EPDS and additional questions should be documented and care plans should be undertaken in partnership with the mother and family with regard to future support/ intervention, and GP letter sent. (appendix 3)

- A record of referrals should be documented

- The EPDS should be undertaken and documented again post intervention and result and future plan communicated to GP.

8 Monitoring and Effectiveness

This guideline must be audited annually.

- All family records should indicate that the mood assessment Whooley Questions were asked at 4 - 6 weeks with outcome recorded, and as appropriate re asked at 3 - 4 months with outcome recorded

- The number of women identified as having Postnatal depression written on the individual Birth Book pages for (Flying Start) or High or Medium pages for (Generic).

- Pre and post intervention EPDS recorded

- Referrals made to mental health nurse/ colleagues collated monthly.

- Audit of group questionnaires

9 References

- Confidential Enquiry into Maternal and Child Health 2007, *Saving Mothers Lives 2003- 2005: The Seventh Enquiry.* London: RCOG Press.

- Confidential Enquiry into Maternal and Child Health 2004, *Why Mothers Die 2000-2002: The Sixth Enquiry.* London: RCOG Press.

- Coyle B. Adams C. (2002)

- Cox J. Holden JM (1987)

- Martins C (2000) Effects of Early Maternal Depression on Patterns of Infant-Mother Attachment : A meta- analytic investigation. J Child Psychology and Psychiatry vol.41:6:737-746

- Hay D (2001) Intellectual Problems shown by 11 yr old children whose mothers had postnatal depression. J of Child Psychology and Psychiatry 42:871-889

- Milgrom J Treating Postnatal Depression : Wiley

- MIND 2006 "Out of the Blue? Motherhood and Depression

- Murray L., Stanley C. (1996) The role of infant factors in postnatal depression and mother-infant interactions. Developmental Medicine and Child Neurology, 38, 109-119

- Murray L., Cooper PJ (1997) Post Partum Depression and Child Development :Guilford Press

- Murray L., Sinclair D. Cooper PJ et al (1999) The socio-emotional development of five year old children of postnatally depressed mothers. JCPP, 40 (8), 1259-1272

- Murray L AndrewsL (2000) The Social Baby : CP

◦ National Institute for Clinical Excellence (NICE) *Antenatal and Postnatal Mental Health (2007), Clinical management and service guidance.*

◦ Seeley S PND Handbook.

◦ Welsh Assembly Government 2006 National Service Framework for Children, Young People and Maternity Services (final version). Cardiff: WAG

10 Appendices

Appendix 1

Mood Assessment

The Whooley Questions

At a woman's first contact with primary care, at her booking visit and postnatally (usually at 4 to 6 weeks and 3 to 4 months), healthcare professionals (including midwives, obstetricians, health visitors and GPs) should ask two questions to identify possible depression.

1. – During the past month, have you often been bothered by feeling down, depressed or hopeless?

2. – During the past month, have you often been bothered by having little interest or pleasure in doing things?

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

   – Is this something you feel you need or want help with?

NICE – Antenatal and Postnatal Mental Health (2007)

Appendix 2

Borough Specific example to be adapted for each area according to local resources

- **Sunshine Seekers**— a ten week course run by Health Visitors. Support given to Mums who are feeling low, especially after having a baby.

For more information please contact:
Flying Start Torfaen
Cwmbran Integrated Children's Centre,
Ton Road, Cwmbran NP44 7LE
Tel: 01633 647420

Teuluoedd yn Gyntaf
Families First

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

chwarae • dysgu • tyfu
play • learn • grow

Feelings and Moods in Motherhood

This questionnaire is designed to help you look at how you are feeling about yourself and your experience of motherhood.

We hope you will be able to complete it, and then it is yours to keep.

You may find it useful in the future as well as now.

Thank you

Please underline the statement for each of the following items which best describes how you have been feeling over the past 7 days.

1. I have been able to laugh and see the funny side of things:
   - As much as I always could
   - Not quite so much now
   - Definitely not so much now
   - Not at all

2. I have looked forward with enjoyment to things:
   - As much as I ever did
   - Rather less than I used to
   - Definitely less than I used to
   - Hardly at all

3. I have blamed myself unnecessarily when things went wrong:
   - Yes, most of the time
   - Yes, some of the time
   - Not very often
   - No, never

4. I have felt worried and anxious for no very good reason:
   - No, not at all
   - Hardly ever
   - Yes, sometimes
   - Yes, very often

5. I have felt scared and panicky for no very good reason:
   - Yes, quite a lot
   - Yes, sometimes
   - No, not much
   - No, not at all

6. Things have been getting on top of me:
   - Yes, most of the time I haven't been able to cope at all
   - Yes, sometimes I haven't been coping as well as usual
   - No, most of the time I have coped quite well
   - No, I have been coping as well as ever

7. I have been so unhappy that I have had difficulty sleeping:
   - Yes, most of the time
   - Yes, sometimes
   - Not very often
   - No, not all

8. I have felt sad or miserable:
   - Yes, most of the time
   - Yes, quite often
   - Not very often
   - No, not at all

9. I have been so unhappy that I have been crying:
   - Yes, most of the time
   - Yes, quite often
   - Only occasionally
   - No, never

10. The thought of harming myself has occurred to me:
    - Yes, quite often
    - Sometimes
    - Hardly ever
    - Never

EDINBURGH POSTNATAL DEPRESSION SCALE: SCORING

1		6	
As much as I always could	0	Yes, most of the time I haven't been able to cope at all	3
Not quite so much now	1	Yes, sometimes I haven't been coping as well as usual	2
Definitely not much now	2	No, most of the time I have coped quite well	1
Not at all	3	No, I have been coping as well as ever	0
2		7	
As much as I ever did	0	Yes, most of the time	3
Rather less than I used to	1	Yes, sometimes	2
Hardly at all	2	No, very often	1
I have looked forward with enjoyment of things	3	No, not at all	0
3		8	
Yes, most of the time	3	Yes, most of the time	3
Yes, some of the time	2	Yes, quite often	2
Not very often	1	Not very often	1
No, never	0	No, not at all	0
4		9	
No, not at all	0	Yes, most of the time	3
Hardly ever	1	Yes, quite often	2
Yes, sometimes	2	Only occasionally	1
Yes, very often	3	No, never	0
5		10	
Yes, quite a lot	3	Yes, quite often	3
Yes, sometimes	2	Sometimes	2
No, not much	1	Hardly ever	1
No, not at all	0	Never	0

SPACE DRAGS

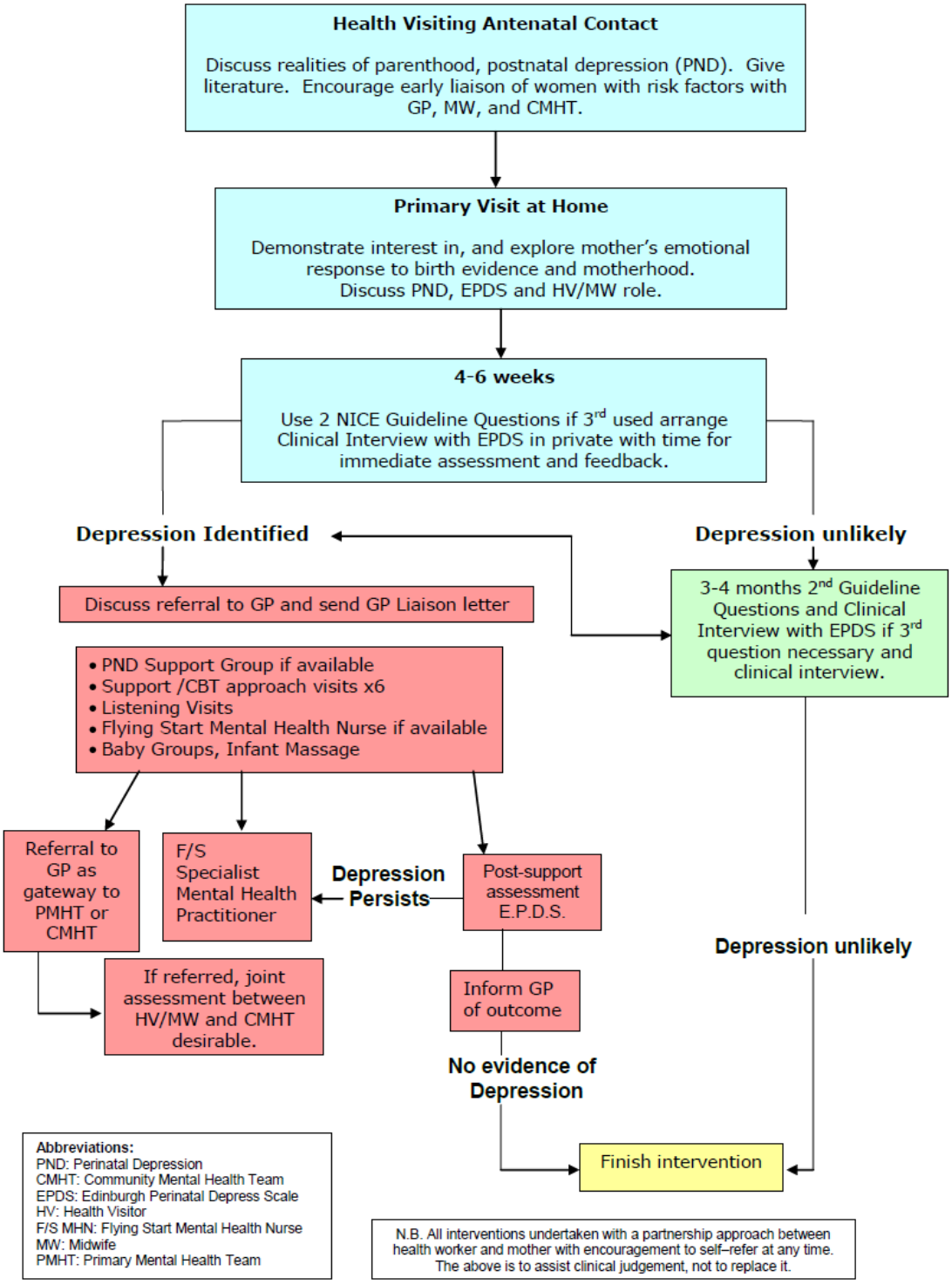
S	-	sleep disturbance	D	-	depressed mood
P	-	pleasure, lack of	R	-	retardation } Thoughts and behaviour
A	-	appetite disturbance	A	-	agitation
C	-	concentration, memory, decision making	G	-	guilt, feeling useless/worthless
E	-	energy, excessive tiredness	S	-	Suicidal ideation

CARE

C	-	concentration
A	-	appetite
R	-	retardation and/or agitation (psychomotor)
E	-	energy

Appendix 3

Postnatal Depression Flowchart



Appendix 4

chwarae • dysgu • tyfu
play • learn • grow
dechrau'n deg • flying start

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Date :

TO :

Dear Dr

Re: Name:…… DOB:……

Address:……

This patient has been assessed/reassessed following intervention for Postnatal Depression using clinical interview and the Edinburgh Postnatal Depression Scale (EPDS) and the outcome is detailed below.

Baby – Age/Gestation:

Mood assessment:

Comments/ Action taken:

Yours sincerely

Health Visitor/Community Midwife