Southern Health NHS
NHS Foundation Trust

SH CP 54

Perinatal Mental Health Guideline

Version: 3

Summary:	This guideline sets out the requirements for practitioners to provide universal support for mothers' mental health during the antenatal and postnatal period.	
Keywords (minimum of 5): *(To assist policy search engine)*	Perinatal, Mental Health, Maternal Depression / Post Natal Depression.	
Target Audience:	All members of Health Visiting Teams within Southern Health NHS Foundation Trust.	
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Version Control

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Perinatal Mental Health Guideline

1. Introduction

Health Visiting Teams will work in partnership with the family and other relevant agencies to provide a universal service which will promote and support optimum perinatal mental health in partnership with women and their families.

2. Evidence Base

Antenatal depression has been found to affect15-20% of mothers (Evans et al) with chronic maternal stress exerting a significant influence on the foetus and the infant's developmental outcomes (Talge et al, 2007). The prevalence of post natal depression is reported to be 10 – 15%. Interventions to reduce stress and anxiety during pregnancy and in the immediate post natal period have been shown to have a positive effect on the infant, improving attachment and reducing the risk of physical, cognitive, behavioural and emotional developmental problems (Talge et al). Perinatal anxiety and depression can lead to:

- Physical symptoms such as palpitations, hyperventilation, headaches, nausea aches and pains and exhaustion.
- Psychological symptoms such as poor concentration and excessive worry.
- Behavioral issues such as distress in social situations and avoidance of situations.
- Low Mood associated with guilt and loss of motivation and occasionally suicidal ideation.
- Sleep disruption.
- Personal neglect.

NICE has published clinical guidance (no 45) which lays out the priorities for evidence based service delivery for addressing maternal mental health (Clinical Guideline 45 – Ante and Postnatal Mental Health. NICE (www.nice.org/CG45).

3. Risk Factors for Perinatal Mental Health problems

- Anxiety
- Pre-existing depression and/ or low self esteem
- Pre-existing physical health problems
- Pre-existing mental health problems
- Major life events / stresses
- Poor social support / family support
- Insecure environment – housing, financial concerns, unemployment
- Domestic abuse
- Unhealthy lifestyle choices

4. Scope

- For all HV teams within the Children's Division to support the provision of interventions to promote optimum perinatal maternal mental health.
- To ensure clear and consistent evidence-based practice resulting in quality and equity of delivery of the Healthy Child Programme (DOH, 2009).
- To enable appropriate and timely information sharing to safeguard children in accordance with 'Working Together to Safeguard Children (March 2013)
- To support optimal communication links between the HV teams and their partners (GPs, Midwives and Specialist Maternal Mental Health Services) to promote integrated working.

5. Definitions

5.1 Health Visiting Team

A team of practitioners who work with a defined population to deliver services that promote the health and well-being of children, young people and their families. Team members will include all or some of the following practitioners;

- Health Visitors
- Community Staff Nurses
- Community Nursery Nurse
- Health Care Support Worker
- Clerical Support Worker /Admin
- Student Health Visitor
- Pre-registration nursing Students

5.2 The Safeguarding Team

The team will provide professional advice and training on safeguarding and child protection matters to all clinical staff. The team will ensure support and supervision is available for practitioners to discuss concerns around vulnerability. This will promote good professional practice and decision-making in order to safeguard the health and wellbeing of children and families (See Safeguarding Policy).

5.3 Perinatal Mental Health

Perinatal Mental Health describes the state of a mother's mental health in the period from conception to 1 year following the birth of their child. Perinatal mental illness is an umbrella term that refers to a group of syndromes and conditions related to pregnancy and the early postnatal period (National Perinatal Mental Health Project, 2011). These include stress and anxiety, 'the blues, ante and post natal depression and puerperal psychosis.

5.4 Promotional Guide (Centre for Parent and Child Support, 2012)

The Promotional Guide provides a structure for a guided conversation with parents. The antenatal guide is underpinned by 5 core themes which research has identified as impacting on the long term outcomes for children.

- The health, wellbeing and development of the baby, mother and father
- Family and social support
- The couple relationship
- Parent-infant care and interaction
- The developmental tasks of early parenthood and infancy.

The antenatal guide focuses on the experiences of pregnancy, preparation for labour and birth, expectations of early infancy, parenthood and family life, and the impact of current and past life experiences and circumstances. It offers parents and professionals the opportunity to identify strengths and concerns as well as priorities and effective plans for action.

5.5 The Whooley Questions

The Whooley questions are a self-report measure consisting of three questions which can be used as part of an initial assessment to identify low mood (Whooley et al, 1997).

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 little interest or pleasure in doing things?'
3. Used if the woman answers yes to either Q1 orQ2.'Is this something you feel you need or want help with?'

5.6 The Clinical Interview

A Clinical Interview allows the Health Visitor to gather information regarding how a mother may be feeling emotionally at a particular time, her physical health, her family history, employment, financial situation and any other factors that may be affecting her wellbeing. The Interview provides the Health Visitor with a comprehensive picture of the mother and family's life which helps in determining the course of action required.

5.7 The Edinburgh Postnatal Depression Scale (EPDS)

The EPDS (Appendix 1) is a self-report questionnaire that has been validated for use by health professionals to assist in the assessment of postnatal depression by rating and measuring the frequency of some symptoms relating to depression and anxiety. As such it can be used to review progress over time.

5.8 Non-directive counselling – Listening visits

Non-directive counselling (listening visits) are an effective intervention for mild to moderate postnatal depression (Turner et al, 2010 and Slade et al, 2010). Non-directive counselling is derived from the theories of Carl Rogers (1957) and is concerned with helping the mother to understand her situation by exploring the possible explanations for the way she is feeling and options and strategies that might support her. It is not giving advice or information (Hanley, 2008). Listening visits should be planned, time limited, focused support provided over four sessions followed by a reassessment.

6. Duties / Responsibilities

6.1 Southern Health NHS Foundation Trust

Southern Health NHS Foundation Trust Board has the responsibility to ensure that the health contribution to Health Visiting Services is discharged across Southern Health through commissioning processes.

6.2 Divisional Director

The Children's Divisional Director is accountable for performance within the Children's Division and has the overall strategic and operational accountability for delivery of the Health Visiting Service.

6.3 The Senior Management Team

The Senior Management team is responsible for ensuring that the staff within the Children's Division receive appropriate training and supervision in the use of this guideline. Barriers to the compliance with this guideline will be escalated to the Divisional Director.

6.4 Locality Clinical Managers (LCM)

Locality Clinical Managers have the daily operational management of the Health Visiting Service and are required to ensure all staff are suitably trained and competent to deliver the Healthy Child Programme (HCP) and are compliant with all the relevant policies. LCMs will ensure that all staff are conversant with and adhere to relevant policies and guidance. Compliance to this guideline will be audited annually and exceptions to service delivery will be raised to Area Managers.

6.5 Health Visiting Teams

Health Visiting Teams have a duty to comply with this guideline and report to their line manager if they are not able to fulfil this aspect of the HCP Service delivery.

6.6 Professional Accountability

Professionals are accountable to the Codes of Conduct of their regulatory body. The Nursing and Midwifery Council (NMC) (2008) Code of Professional Conduct states that:

- 'As a professional you are personally accountable for actions and omissions in your practice and must always be able to justify your decisions.'
- 'Provide a high standard of practice and care at all times'
- 'Work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community'.

7. Main guideline content

7.1 Identification

- Health Visitors will use the Promotional Guide at the antenatal contact and the new birth visit to assist in the identification of strengths, concerns and vulnerabilities that may impact on perinatal maternal mental health.
- At each antenatal and postnatal contact women will be asked about their emotional wellbeing.
- All mothers will be offered a mood and feelings assessment between 6 and 8 weeks post-delivery.
- Identification of low mood will be achieved through the use of the Whooley questions and/or the Clinical Interview.
- Health Visitors should at every visit be assessing for any safeguarding risk to the children present.
- The electronic patient record (EPR) should be completed as per the standard operating procedure (SOP)
- Health Visitors will follow the Perinatal Mental Health Referral Pathway (Appendix 2) to ensure all mothers receive appropriate, timely and evidence based assessments and interventions.

7.2 Assessment

- Health Visitors will assess maternal mental health using validated tools e.g. EPDS in accordance with NICE clinical guideline 45 together with the Clinical

Interview.

- Health Visitors will follow the Perinatal Mental Health Referral Pathway if a woman is identified with low mood / mild depression.
- Health Visitors should at every visit be assessing for any safeguarding risk to the children present.
- The EPR should be completed as per the SOP.

7.3 Management

- Women identified with low mood / mild depression should have a care plan opened to identify and plan any interventions. Any interventions carried out should be recorded in the progress notes as per the SOP.
- Women should be offered a series of 4 Listening Visits by the Health Visitor. A further assessment of their emotional health should be carried out at the end of this intervention and further care needs met as per the Perinatal Mental Health Referral Pathway.
- Health Visitors should liaise with GPs and Midwives as appropriate.
- Health Visitors should also signpost / refer women and families to any local interventions that may be helpful to them.
- If moderate to severe depression is identified the Health Visitor should contact with the Perinatal Mental Health Team to discuss the need for further interventions beyond Listening Visits as these are not appropriate at this stage.
- Consideration should be given to referral to the Community Mental Health Team if the baby is close to or beyond one year of age.
- Health Visitors should at every visit be assessing for any safeguarding risk to the children present.
- Urgent contact with the GP and the Perinatal Mental Health Crisis Team is required if a woman is displaying symptoms of puerperal psychosis, bipolar disorder or depression with suicidal intent. It may be necessary to contact 999 if there is immediate risk of harm to her or any children present.
- The above conditions also require a referral to be made to Children's Services and the completion of a Vulnerable Child assessment.

8. Training Requirements

- Delivery of perinatal maternal mental health training will be offered to all grades of Children's Services staff in each area by the Perinatal Mental Health trainers.
- To ensure professional competencies in this field, practitioners are required to access training from LEaD (Learning Education and Development) and external trainers as identified in their appraisals.
- Health Visitors need to demonstrate their professional accountability and competencies within this role (Appendix 3).

9. Monitoring Compliance

Compliance to this guideline will be audited every 3 years with the NICE Clinical Guidelines (45) Antenatal and Postnatal Mental Health (2007). The guideline will be monitored by quantitative and qualitative data.

10. Guideline Review

This guideline will be reviewed in 2 years.

11. Associated Documents

- The Health Visiting Overarching Policy (SHFT 2012)
- The Healthy Child Programme (2009)
- RIO Standard Operating Procedure (SOP)
- Promotional Guide (Centre for Parent and Child Support, 2012)
- Safeguarding Policy (2009)
- Clinical Record Keeping Policy (HCHC,2010)
- Working Together to safeguard Children (2013)

12. Supporting References

Evans et al (2001)Cohort study of depressed mood during pregnancy and after childbirth. BMJ 323 (7307):257-260

Department of Health (2009) Healthy Child Programme: 'Pregnancy and the first five years of life'. London: The Stationery Office

Hanley, J., (2009) Perinatal mental health: a guide for health professionals and users. Chichester: Wiley-Blackwell.

National Perinatal Mental Health Project (2011) – A Review of current service provision in England, Scotland and Wales

NHS National Institute for Health and Clinical Excellence: (2007) Antenatal and postnatal mental health: Clinical management and service guidance. NICE clinical guideline 45

Slade, P., Morrell, C., J., Rigby, A., Ricci, K., Spittlehouse, J. and Brugha, T.S. (2010) 'Postnatal women's experiences of management of depressive symptoms: a qualitative study', *British Journal of General Practice*, November 60(580) pp. 440-8.

Talge NM, Neal C, Glover V; Early stress, Transitional research and prevention science network:Fetal and Neonatal experience on child and adolescent mental health. Antenatal maternal stress and long term effects on child neurodevelopment: how and why? J Child Psychol Psychiatry.48 (34): 245-61

Turner, K., M., Chew-Graham, C., Folkes, L., and Sharp, D., (2010) 'Women's experiences of health visitor delivered listening visits as a treatment for postnatal depression: A qualitative study', *Patient Education and Counselling,* 78. pp. 234-239.

Whooley MA, Avins AL, Miranda J Browner WS. (1997) Case-finding instruments for depression. Two questions are as good as many. J Gen Intern Med 12: 439-45

Appendix 1: The Edinburgh Post natal Depression Scale

Name:

Address:

Baby's age:

As you have recently had a baby we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt in the PAST & DAYS, not just how you feel today.

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 • Not at all	**6. I have blamed myself unnecessarily when things went wrong.** • Yes, most of the time • Yes, sometimes • Not very often • No, 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	**7. I have been anxious and worried for no good reason.** • No, not at all • Hardly ever • Yes, sometimes • Yes, very often
3. I have felt scared or panicky for no very good reason • Yes, quite a lot • Yes, sometimes • No, not much • No, not at all	**8. I have felt sad or miserable** • Yes, most of the time • Yes, quite often • No. not very often • No, not at all
4. 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.	**9. I have been so unhappy that I have been crying** • Yes, most of the time • Yes, quite often • Only occasionally • No, never
5. I have been so unhappy that I have had difficulty sleeping. • Yes, most of the time • Yes, sometimes • Not very often • No, not at all	**10. The thoughts of harming myself has occurred to me** • Yes, quite often • Sometimes • Hardly ever • Never

Taken from the British Journal of Psychiatry, June 1987, Vol.150. by JL Cox, JM Holden, R Sagovsky

Appendix 2: Perinatal Mental Health Referral Pathway for Health Visitors

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AT EVERY CONTACT	**Universal/ Community**	**Universal Plus** (Care plan for mother and child)	**Universal Partnership Plus** (Care plan for mother and child and safeguarding alert)	**Acute Mental Health Crisis Management** (Care plan for mother & child and safeguarding alert)
Assess safeguarding risk Completion of relevant Electronic Patient Record (EPR) including contact forms and care plans. Communication with colleagues and partner agencies if appropriate	Routine Screening Assess safeguarding risk Mental health assessment at every contact using validated and agreed tools. Encourage to attend Child Health Clinic and engage with Children's Centres. Signpost to Community Resources according to local provision. Liaison with midwifery service and GP as needed. Referral to Perinatal Mental Health Team if history of previous severe depression, bi-polar disorder, schizophrenia or psychosis.	Women with mild to moderate depression Assess safeguarding risk Vulnerable child assessment form completed for each child. Liaison with GP and/or midwife. Assessment of impact on activities of daily living. Listening visits to be recorded using EPR care plan. Signpost and/or refer to: Local interventions and voluntary agencies as available e.g. Italk MIND	Women with moderate to severe depression and/or anxiety Assess safeguarding risk. Vulnerable child assessment form completed for each child. Liaison with GP and/or midwife. Assessment of impact on activities of daily living. Telephone contact with Perinatal Mental Health Team and referral for women with Bipolar disorder and/or psychosis, schizophrenia and poor attachment. Consider referral to Community Mental Health Team if baby is near or over one year. Signpost and/or refer to: Local interventions and voluntary agencies as available e.g. Italk, MIND	Women with puerperal psychosis or bi-polar disorder and depression or suicidal intent Assess safeguarding risk. Call 999 if significant risk of harm to self or others. Immediate contact with GP. Contact Perinatal Mental Health crisis team, for assessment possible admission to Mother and Baby Unit. Referral to children's services Vulnerable child assessment form completed for each child.

Appendix 3: Training Needs Analysis

If there are any training implications for your policy please complete the form below and contact the Learning, Education and Development department (LEaD) on 02380874091 before the policy is approved.

Training programme:	Perinatal Maternal Mental Health training
Frequency:	On induction and 3 yearly
Course length:	½ day
Delivery method:	Lecture/workshop
Trainer(s)	Perinatal Mental Health Champions within Children's Division
Recording attendance:	LMS via L&D (LMS = learning management system – electronic booking service in L&D)
Strategic and operational responsibility:	Nicky Adamson- Young / Area Managers

Division	Target audience
Adult Mental Health	
Learning Disabilities	
Older Persons Mental Health	
Specialised Services	
TQtwentyone	
Adult Physical Health	
Children's	Children's Health Visiting Team, Health Visitors Staff nurses, Nursery nurses, Support worker/ Clerical
Corporate (HR, Governance, Estates, etc.)	