Title: Good Practice Guidelines for the Management of Perinatal Mental Health Care

Policy Ref. NHSG/ PNMHG1/CTTE/0000

Across NHS Boards  Organisation Wide  Directorate  Clinical Service  Sub Department Area
Yes  Yes

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Review date: December 2007

Author: Short Life Working Group - Post Natal Depression

Policy application: NHS Grampian

Purpose: To streamline, gain consistency and improve the early detection and management of poor perinatal mental health; in particular antenatal anxiety, postnatal depression and/or puerperal psychosis; across NHS Grampian in order to reduce severity and morbidity.

Responsibilities for implementation: NHS Grampian

Organisational: - Organisational Management Team, Chief Executive
Clinical group: - Perinatal Mental Health Implementation Steering Group, Locality/CHP Perinatal Mental Health Implementation Groups, Clinical Group Co-ordinators, Lead Nurses, Maternity / Midwifery and Mental Health
Corporate: - Senior Managers
Departmental: - Heads of Service Clinical Leads
Area: - Line Managers

Review: Bi annually

Approved by: Elinor Smith  Date: 19.12.05

Signature: 

Designation: Associate Nurse Director

2
**Contents**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contents Page</td>
<td>3,4</td>
</tr>
<tr>
<td>List of Abbreviations</td>
<td>4</td>
</tr>
<tr>
<td>Features of Perinatal Mental Ill health</td>
<td>5</td>
</tr>
<tr>
<td>Introduction - National and Local Context</td>
<td>6,7</td>
</tr>
<tr>
<td>Aims and Outcomes</td>
<td>8</td>
</tr>
<tr>
<td>Guidelines</td>
<td>9</td>
</tr>
<tr>
<td>Training/ Resources</td>
<td>9</td>
</tr>
<tr>
<td>Flow Chart</td>
<td>10</td>
</tr>
<tr>
<td>Antenatal Depression</td>
<td>11</td>
</tr>
<tr>
<td>Baby Blues</td>
<td>11</td>
</tr>
<tr>
<td>Trauma of Childbirth</td>
<td>11</td>
</tr>
<tr>
<td>Postnatal Depression</td>
<td>12</td>
</tr>
<tr>
<td>Puerperal Psychosis</td>
<td>12</td>
</tr>
<tr>
<td>Postnatal Depression - Predisposing Risk Factors</td>
<td>13</td>
</tr>
<tr>
<td>Antenatal Assessment Guidance for Midwives and Health Visitors</td>
<td>14</td>
</tr>
<tr>
<td>Postnatal Assessment Guidance for Midwives and Health Visitors</td>
<td>15</td>
</tr>
<tr>
<td>Assessment Guidance for Midwives and Health Visitors for Completion of Risk factors / Antenatal Summary Sheet Checklist</td>
<td>16</td>
</tr>
<tr>
<td>Antenatal Summary Sheet Checklist</td>
<td>17</td>
</tr>
<tr>
<td>Clinical Interview</td>
<td>18, 19</td>
</tr>
<tr>
<td>Other Features that are Common in Depression but Not Required for Diagnosis</td>
<td>19</td>
</tr>
<tr>
<td>Mental Health Assessment Tool - Edinburgh Postnatal Depression Scale</td>
<td>20</td>
</tr>
<tr>
<td>Referral Guidelines for Women with Mental Health Problems</td>
<td>21</td>
</tr>
<tr>
<td>Community Mental Health Team</td>
<td>22</td>
</tr>
<tr>
<td>Substance Misuse Service</td>
<td>23</td>
</tr>
<tr>
<td>Vulnerable Children and Parental Mental Ill Health</td>
<td>24</td>
</tr>
<tr>
<td>Department of Child and Family Mental Health</td>
<td>25</td>
</tr>
<tr>
<td>Young Peoples Department</td>
<td>25</td>
</tr>
<tr>
<td>Child Protection Teams</td>
<td>26</td>
</tr>
<tr>
<td>Social Work Services</td>
<td>27</td>
</tr>
<tr>
<td>Family Centres</td>
<td>28</td>
</tr>
<tr>
<td>Sure Start</td>
<td>29</td>
</tr>
<tr>
<td>Home Start</td>
<td>30</td>
</tr>
<tr>
<td>Counselling, Cognitive Behavioural Therapy</td>
<td>31</td>
</tr>
<tr>
<td>Interactive Focused Intervention - Infant Massage</td>
<td>32</td>
</tr>
<tr>
<td>National Regional and Local Organisations</td>
<td>32</td>
</tr>
<tr>
<td>Domestic Abuse</td>
<td>33</td>
</tr>
<tr>
<td>Effects on Men and Families</td>
<td>34</td>
</tr>
<tr>
<td>Familial Support / Assistance</td>
<td>34</td>
</tr>
<tr>
<td>Physical Exercise/ Activity</td>
<td>34</td>
</tr>
<tr>
<td>Guidelines on Medication</td>
<td>35,36,37,38</td>
</tr>
<tr>
<td>Admission of Mother and Baby to Hospital due to Postnatal Depression / Puerperal Psychosis</td>
<td>39</td>
</tr>
<tr>
<td>Appendices</td>
<td>40</td>
</tr>
</tbody>
</table>

**Appendices**

- **Appendix 1: Postnatal Depression and Puerperal Psychosis 60, SIGN Quick Reference Guide** | 41,42,43 |
- **Appendix 2: UK, National, Regional and Local Organisations** | 44-56 |
Appendix 3: Integrated Flow Chart Pathway for: Management of Perinatal Mental Health Care

Appendix 4: Mental Health Assessment Tool
(a) Edinburgh Postnatal Depression Scale 58,59
(b) Edinburgh Postnatal Depression Scale Scoring Sheet 60
(c) Edinburgh Postnatal Depression Scale Scoring System - Flow Chart 61

Appendix 5: Community Mental Health Team Referral Sheet 62

Appendix 6: Dr Gray’s: Admission of Mother and Baby to Ward 4 Including Room Access / Exit and in the event of an Emergency 63-73

References 74,75,76
Members of the Working Group/ Contributors 77

List of Abbreviations

AMH Aberdeen Maternity Hospital
ARI Aberdeen Royal Infirmary
CEMD Confidential Enquiries into Maternal Deaths
CPN Community Psychiatric Nurse
CMHT Community Mental Health Team
DOB Date of Birth
EDD Estimated Date of Delivery
EPDS Edinburgh Postnatal Depression Scale
GP General Practitioner
HV Health Visitor
NHS National Health Service
OT Occupational Therapy
PMS Pre-menstrual Syndrome
PND Postnatal Depression
PTSD Post Traumatic Stress Disorder
RMO Responsible Medical Officer
RCT Randomised Controlled Trial
RCH Royal Cornhill Hospital
SIGN Scottish Intercollegiate Guidelines Network
SSRI Selective Serotonin Re-uptake Inhibitors
TCA Tricyclic Antidepressants
FEATURES OF PERINATAL MENTAL ILL HEALTH:

Women with pre existing chronic depression/ mental illness

Antenatal Mental Health Problems

Anxiety is a normal reaction to the perception of threat and depression is a normal reaction to actual or perceived loss. It is possible for both reactions to occur in response to pregnancy, for a wide range of individual reasons.

Anxiety and reactive depression can be and should be effectively treated. Antenatal anxiety may be predictive of postnatal depression. Postnatal depression can impact on the social and psychological development of the child.

Baby Blues, Postnatal Depression, Puerperal Psychosis

“Postnatal Depression (PND) is regarded as any non-psychotic depressive illness of mild to moderate severity occurring during the first postnatal year. It is important to distinguish PND from the “baby blues”, the brief episode of misery and tearfulness that affects at least half of all women following delivery, especially those having their first baby.

Puerperal psychosis is a mood disorder accompanied by features such as loss of contact with reality, hallucinations, severe thought disturbance, and abnormal behaviour. It typically presents in the early postpartum period, usually within the first month”

(The Scottish Intercollegiate Guidelines Network (SIGN), 2002, page 2)
INTRODUCTION

NATIONAL AND LOCAL CONTEXT

Postnatal Depression is a National Health Improvement priority and is highlighted in the following documents:

- A Framework for Mental Health Services in Scotland (1997)
- Our National Health: A plan for action, a plan for change (2000)
- A Framework for Maternity Services in Scotland (2001)
- Postnatal Depression and Puerperal Psychosis (60) A national clinical guideline (2002)

In June 2002 the Scottish Intercollegiate Guidelines Network (SIGN) produced a national clinical guideline, on the management of Postnatal Depression and Puerperal Psychosis (60)\(^1\) containing recommendations for effective practice based on current evidence. The implementation of the guidelines is an essential part of clinical governance aimed at establishing a standardised and consistent approach to the early detection and management of postnatal depression and puerperal psychosis. Implementation at a local level will be achieved through a series of steps, in order to secure the best possible outcome for women and their families. Perinatal mental ill health can have far reaching effects within the family, a co-ordinated approach to care and treatment in Grampian has been identified as a recommendation in the Grampian Mental Health Promotion Strategy and Action Plan 2004-2007 [Implementation Draft November 2004].

The Edinburgh Postnatal Depression Scale (EPDS) is the only recognised and validated aid, as a support to professional clinical judgement, in assessing for postnatal depression in Scotland (SIGN 2002). Currently the EPDS is used widely across NHS Grampian, but with no consistency across the region. The National Screening Committee\(^2\) supports and recommends, until more research has been conducted into the EPDS, that its potential for routine use in postnatal depression is to…

“…serve as a checklist as part of a mood assessment for postnatal mothers, when it should only be used alongside professional judgement and a clinical interview.”

(National Screening Committee Policy Position, (March 2004), National Electronic Library for Health)

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\(^1\) The recommendations for Management of Postnatal Depression and Puerperal Psychosis (60) SIGN are laid out in Appendix 1 “Quick Reference Guide”.

\(^2\) The National Screening Committee will review this position by April 2006.
NHS Grampian acknowledges that the EPDS is not an independent diagnostic tool for depression but should be used as a checklist along with clinical evaluation and judgement.

NHS Grampian also recognises that a variety of mental health assessment tools\(^3\) for measuring depression exist and it is up to teams to decide and agree locally, through their Community Health Partnership governance arrangements, the most effective mental health assessment tool to implement whilst reaching identified outcome measures to improve perinatal mental health services.

This document provides guidance on assessment, screening, diagnosis, prevention and management involving primary and secondary care. The guideline is primarily aimed at midwives, health visitors, general practitioner’s, school nurses, pharmacists, obstetricians, clinical psychologists, but may be of interest to social workers, public health physicians, community workers, users of services and all professions, voluntary and statutory, caring and providing services for women and their families.

The Good Practice Guidelines for the Management of Perinatal Mental Health Care is derived from the Postnatal Depression Redesign Project, which ran from 2000 until 2002. During this period extensive work and consultation was undertaken involving representation from health professionals engaged in antenatal and postnatal care and service users. In August 2003 a short life working group was re-established to develop an implementation plan for adopting good practice guidelines and to build on the previous work undertaken.

The Guidelines, practitioners and service users will be updated appropriately to reflect research and evidence developments.

\(^3\) Other Mental Health Assessment Tools for depression include:
Postpartum Depression Screening Scale (PDSS) (Beck,C.T and Gable,R.K)
The Hospital and Anxiety Depression Scale (Zigmond,A.S. and Snaith,R.P)
AIM AND OUTCOMES

The aim of the Guidelines:

To streamline, gain consistency and improve the early detection and management of poor perinatal mental health, in particular; antenatal mental health problems, postnatal depression and/or puerperal psychosis; across NHS Grampian in order to reduce severity and morbidity

Outcomes

- To introduce NHS Grampian Guidelines for the early detection and management of antenatal mental health problems, postnatal depression and puerperal psychosis, “Good Practice Guidelines for the Management of Perinatal Mental Health Care”
- Guidelines are clear, accessible and implemented by staff
- Appropriate training is provided to key staff
- All women will be routinely assessed during the antenatal period for past and present depression
- All women will be routinely offered screening during the antenatal period for previous puerperal psychosis, other mental illness and family history of affective psychosis
- All new mothers will have access to a postnatal depression screening programme utilising a mental health assessment tool
- Increased awareness about the input, care and treatment of antenatal mental health problems and postnatal depression among; pregnant women; their families; health professionals; and the voluntary and statutory sector
- Improved emotional wellbeing of women, their partner and family, during pregnancy and the postnatal period
- Clinical Audit Trail is developed to monitor incidence of Postnatal Depression within Grampian
- Local resources are targeted more efficiently and effectively to tackle poor perinatal mental health
- Grampian Guidelines comply with national documents and Scottish Executive policy
GUIDELINES

The Guidelines are designed to reflect continuity throughout the following areas:

Antenatal
- Assessing of all women, with consent, at booking for past and present depression in the antenatal period
- Screening of all women, with consent, at booking for previous personal or family history of puerperal psychosis/psychosis
- Assessment/discussion around antenatal mental health problems/postnatal depression/mood disorders with all pregnant women at booking and every routine antenatal visit
- Provision of information and education
- Identification of risk factors ‘Antenatal Summary Sheet Checklist’

Communication between professionals
- Discussion of mood disorders, reinforcement of information on postnatal depression and puerperal psychosis at parenting classes and on 1:1
- Identification of appropriate UK, National, Regional and Local services (Appendix 2)
- Medication/prescribing
- Child Protection
- Domestic abuse, routine enquiry
- Effects on men and families

Postnatal
- Labour/delivery debrief
- Documented handover from midwife to health visitor
- Follow up risk factors
- Mental health assessment tool offered as part of screening to all women 6-8 weeks postnatal
- Continue monitoring and support

Communication between professionals
- Appropriate follow up care initiated
- Identification of appropriate UK, National, Regional and Local services (Appendix 2)
- Medication
- Child Protection
- Domestic Abuse, routine enquiry
- Effects on men and families

TRAINING/RESOURCES – provided within Community Health Partnerships

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4 Further guidance is anticipated from the Scottish Executive on routine enquiry, it is therefore recommended by the NHS Grampian Domestic Abuse Strategy Implementation group that health care workers await this guidance before engaging in routine enquiry. As part of the NHS Grampian strategy and action plan on domestic abuse, awareness raising and training is being rolled out during 2005, also a patient policy with guidelines and resource packs will be distributed to health care settings to ensure access to appropriate information for health care workers.
FLOW CHART

The following flow chart illustrates the care components, pathway options, roles, lines of consultation and referral to all health professionals involved in the care of pregnant and postnatal women and their families. See Appendix 3 for integrated flow chart.

**Antenatal**
- Booking Visit Midwife (or GP)
  - Assess for history of past/present depression
  - Screen for previous puerperal psychosis/other psychopathology/family history of affective psychosis
  - a. Discussion around antenatal mental health problems, eg, anxiety/postnatal depression/mood disorders
  - b. Complete/update Antenatal Summary Sheet Checklist
  - c. Routine enquiry for domestic abuse
  - d. Provide written information and education
  - e. Identify risk factors + clinical judgement
  - f. If ‘high risk’ take appropriate action
  - Continue above monitoring a) to f) at routine antenatal visits

**Postnatal**
- Immediate referral of all women with serious mental health problems during pregnancy to Mental Health Services or GP to be requested to consider immediate referral
  - Offer discussion of birth with mother, either in hospital or once home
  - Awareness of antenatal risk factors
  - Discuss mood changes and assess
  - Accurate and timely information to be passed from hospital to community

**Health Visitor**
- 6-8 weeks offer mental health assessment tool
- Assess mother/baby relationship
- Take appropriate action based on, assessment, risk factors and clinical judgement

**Family Health Assessment**
- If ‘high risk’ - Monitor closely
- Refer to GP for assessment & onward CMHT referral
- Notify HV
- Follow referral guidelines

**On transfer to Health Visitor**
- Accurate and timely information passed from Midwife to Health Visitor

**Appropriate Action**
- If ‘high risk’ - Monitor closely
- Refer to GP for assessment & onward CMHT referral
- Notify HV
- Follow referral guidelines
ANTENATAL DEPRESSION

The facts:
- Antenatal Depression is thought to affect 10% of pregnant women
- The majority of cases with antenatal depression end with the birth

Symptoms
Behaviours, which may be indicative of antenatal depression, include:

- chronic anxiety, guilt, crying for no reason, lack of energy, loss of self-confidence, relationship problems, conflict with parents, isolation, afraid to seek help.

BABY BLUES

The facts:
- 50-70% of newly delivered mothers suffer from the blues

According to research there are 2 different components of “the blues”. It can be described as a temporary depression identified by weeping and emotional upset occurring between the second and tenth day after delivery.

The second more severe longer lasting form of the blues can lead onto postnatal depression. The symptoms for this second form are: weepiness, irritability, tension, confusion, anxiety, headaches, restlessness and sleeplessness.

The blues may be due to changes in the body following delivery, eg, fluctuating hormone levels or a reaction to the emotional and physical stress related to the birth.

TRAUMA OF CHILDBIRTH

For some women delivery can be a traumatic experience, especially if the wellbeing of either the mother or child is at risk. Clear and effective communication with the woman at this time and afterwards is essential.

There is some research addressing Post Traumatic Stress Disorder (PTSD) specifically in relation to childbirth (Beck 2004). However it should be acknowledged that generally PTSD is recognised to occur following the experience or witnessing of life threatening events.
POSTNATAL DEPRESSION (PND)

The facts:
- Currently 10% to 15% of women suffer from postnatal depression in the first year after giving birth (SIGN 2002).
- In Grampian this means, of 52725 births annually, 527 to 790 women will suffer from PND.
- Postnatal depression is three times as common amongst teenage parents, with four out of ten mothers affected (Hall and Elliman 2003).
- PND may occur immediately after the birth or many months later; after the first baby or any subsequent baby (HEBS 2001).
- Postnatal depression is a treatable condition; the length of treatment depends on the severity and how early it is detected.

Symptoms
Behaviours, which may be indicative of postnatal depression, include:

- uncontrollable crying or persistent sadness
- anxiety, panic attacks
- inability to sleep despite fatigue and exhaustion
- loss of appetite
- loss of energy
- restlessness
- tension and irritability
- changes of mood
- suicidal impulsions
- feelings of guilt
- feelings of being a bad mother
- inability to be interested in child
- difficulty concentrating
- loss of confidence and self esteem
- loss of interest in social life and sexual relationship

Health professionals and new parents need to be aware of the symptoms of PND and have the opportunity to talk about it prior to delivery through structured parenting classes and/or on one to one with the midwife. Support to mothers may be in the form of increased awareness through education and training; reducing the stigma associated with postnatal depression; early detection of the condition; family support - paternity leave; and greater resources for mothers, eg, childcare provision, practical help, listening and caring in the community, and medication.

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.

Women need their distress acknowledged; listened to; respected and understood.

PUERPERAL PSYCHOSIS

The facts:
- 1-2 postnatal women in a 1000 will develop puerperal psychosis (SIGN 2002).
- It usually presents within the first month following delivery.

Failure to treat postnatal depression or puerperal psychosis can have a deleterious effect on:
- The relationship between mother and baby and the child’s psychological, social and educational development in the short and long term.
- The relationship between the mother and her partner.
- Maternal Mortality

Puerperal psychosis is a psychiatric emergency with risk of maternal suicide and risk to the child’s safety if the mother is profoundly depressed.

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5 Information & Statistics Division, Edinburgh (31.03.03).
POSTNATAL DEPRESSION - Predisposing Risk Factors

The list below identifies some factors, which may increase the risk of women developing postnatal depression. NB some women may have no risk factors at all.

Moderate to Strong Associations
- Previous history of postnatal depression or puerperal psychosis
- Previous psychiatric history
- Current contact with Mental Health Services
- Family history of depression or mental health problems
- Antenatal Mental Health problems, eg, Increased Adjustment Disorder, anxiety or depression during pregnancy
- Low social support
- Poor marital relationship
- Recent life events/ changes
- Baby Blues

Weak Associations
- Obstetric complications
- History of Abuse - Domestic Abuse
- Lower occupational status
- Low family income

Other risk factors
- Antenatal thyroid dysfunction
- Not breastfeeding
- Poor parenting experienced as a child
- Unplanned pregnancy
- Unemployment
- Antenatal parental stress
- Coping style
- Longer time to conception
- Emotional lability in maternity blues
- Depression in fathers
- Two or more existing children
- Frequent GP contact throughout the pregnancy
- Early childhood trauma or a history of abuse
- History of severe pre-menstrual syndrome (PMS)

A mother’s mental health may also be affected by the health of her baby (SIGN 2002)
- Very low birth weight (less than 1500gm)
- Neonatal risk
- Stillbirth
- Sudden infant death syndrome
ANTENATAL ASSESSMENT GUIDANCE FOR MIDWIVES AND HEALTH VISITORS (HV)

Ask how she is feeling, discuss mood changes and assess mood
Provision of health education literature about mood changes/ PND
Information on postnatal depression and puerperal psychosis at parenting classes
One to one discussion with midwife
Discuss support available within family and community
Provide advice about supportive agencies as appropriate (Appendix 2)
Awareness of risk factors
Observe family dynamics

Booking Visit
1. Ask how she is feeling, discuss mood changes and assess mood
2. Discuss support available within family and community
3. Discuss mental health, antenatal and postnatal depression
4. Discuss partner’s mental health – coping ability
5. Discuss appropriate available material in Ready Steady Baby
6. Assess for past and present depression during the antenatal period
7. Screen for previous puerperal psychosis, other psychopathology and family history of affective psychosis
8. 4 Routine enquiry for domestic abuse
9. Complete Antenatal Summary Sheet Checklist – risk factors
10. For all women with a mental health problem, notify GP, Health Visitor, Obstetrician
11. Monitor closely all women considered to be “at risk”, use conversational style ‘clinical interview’ as required and refer appropriately
12. Provide advice about supportive agencies as appropriate (Appendix 2)
13. Consider thresholds for child protection

Routine Antenatal Appointments
1. Ask how she is feeling, discuss mood changes and assess mood
2. Discuss support available within family and community
3. Discuss partner’s mental health - coping ability
4. Update Antenatal Summary Sheet Checklist – risk factors
5. Monitor closely all women considered to be “at risk”, use conversational style ‘clinical interview’ as required and refer appropriately
6. Discuss findings with woman, 4 routine enquiry for domestic abuse
7. Take action based on clinical judgement, as per guidelines, if required
8. Discuss and provide appropriate literature regarding postnatal depression
9. Consider thresholds for child protection
10. Provide advice about supportive agencies as appropriate (Appendix 2)

Parenting Classes
Discuss mood disorders in pregnancy and postnatal period
Discuss partner’s mental health - coping ability
Give appropriate literature
POSTNATAL ASSESSMENT GUIDANCE FOR MIDWIVES AND HEALTH VISITORS (HV)

Postnatal Ward
1. Ask how woman is feeling, discuss mood changes/disturbances “blues” and assess
2. Use conversational style ‘clinical interview’ as required
3. Discuss support available within family and community
4. Discuss partner’s mental health - coping ability
5. Awareness of risk factors
6. Observe family dynamics
7. Assess mother/baby relationship
8. Immediate referral to mental health services for all women who have had mental health problems during pregnancy
9. Consider thresholds for child protection
10. Provide advice about supportive agencies as appropriate (Appendix 2)

First 2 weeks – Midwife, HV
1. Ask how woman is feeling, discuss behavioural and mood changes/disturbances “blues”, self perception of how others see her, and assess
2. Use conversational style ‘clinical interview’ as required
3. Discuss support available within family and community
4. Discuss partner’s mental health - coping ability
5. Documented handover with risk factors and assessment discussed - Midwife to Health Visitor
6. Awareness of risk factors
7. Monitor closely all women considered to be ‘at risk’ and refer appropriately
8. Observe family dynamics
9. Assess mother/baby relationship
10. Consider thresholds for child protection
11. Provide advice about supportive agencies as appropriate (Appendix 2)

6 weeks
1. Ask how woman is feeling, discuss behavioural and mood changes/disturbances “blues”, self perception of how others see her, and assess
2. Use conversational style ‘clinical interview’ as required
3. Discuss support available within family and community
4. Discuss partner’s mental health - coping ability
5. Offer mental health assessment tool to all women
6. Allow completion of mental health assessment tool in presence of health professional, at home/clinic visit, with time for feedback
7. Assess mother/baby relationship
8. Discuss results with woman, raising domestic abuse
9. Take appropriate action as per guidelines
10. Consider thresholds for child protection
11. Provide advice about supportive agencies as appropriate (Appendix 2)

Following the 6-8 week assessment the Family Health Needs Assessment will be used by the Health Visitor to identify ongoing postnatal depression concerns, and additional action and support required.

“The SIGN guideline on postnatal depression suggests that the EPDS should be used at approx six weeks and three months following delivery and should be administered by trained health visitors or other health professionals.” (Hall 4, 2005, p30)
ASSESSMENT GUIDANCE FOR MIDWIVES AND HEALTH VISITORS FOR COMPLETION OF RISK FACTORS/ANTENATAL SUMMARY SHEET CHECKLIST

All women should be offered the opportunity, and consent, to be routinely assessed during the antenatal period for a past and present history of depression and screened during pregnancy for previous puerperal psychosis, history of other psychopathology and family history of affective psychosis.

The client’s Antenatal Summary Sheet Checklist should be completed by the midwife/health professional at booking and referred to and updated at every routine antenatal visit6.

This checklist will assist in identifying women who may be at risk of developing mental health problems in pregnancy and/or postnatal depression.

Many women may experience a number of these risk factors and not be depressed, for others just one or two can lead to the “blues”. The professional must be aware of the presence of these risk factors and assess any changes at each visit. **Clinical judgement is necessary to determine the level of risk** in regard to development of antenatal and/or postnatal depression.

- **All women identified as being high risk should be monitored closely.**
  Direct contact should be made with the woman's GP for further assessment and potential onward referral to the Community Mental Health Team and her Health Visitor, to inform them of her status.

A previous history of postnatal depression, puerperal psychosis or previous psychiatric history is immediately considered ‘high risk’ and requires notification to the GP for GP onward referral. Details of the severity or level of the latter must be recorded, to provide clear information (RCOG 2002).

The midwife is responsible for handing over all antenatal checklists to the Health Visitor following birth; this should be documented and signed for by both professionals. A copy should also be retained in the obstetric record.

**The completed Antenatal Summary Sheet Checklist to be passed on by Midwife/HV, appropriately.**

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6 Routine Antenatal Visits:  
Primigravidae - eg, Booking 8-12 weeks, 16 wks, 20wks (ultrasound scan only), 22wks, 28wks, 32wks, 34 wks, 36wks, 38wks, 40wks, 41wks  
Multiparae - eg, Booking 8-12 weeks, 16wks, 20wks, 28wks, 34wks, 38wks, 40wks, 41wks
**ANTENATAL SUMMARY SHEET CHECKLIST**

<table>
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<th>Risk Factors</th>
<th>YES</th>
<th>NO</th>
<th>Comments</th>
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<tbody>
<tr>
<td>1. Previous history of Postnatal Depression or Puerperal Psychosis?</td>
<td></td>
<td></td>
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<td>2. Previous Psychiatric History?</td>
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<td>3. Current contact with Mental Health Services?</td>
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<td>4. Family history of depression or Mental Health problems? – <em>including her partner and partner’s family</em></td>
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<td>5. Early childhood trauma or a history of abuse?</td>
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<td>6. History of severe pre-menstrual syndrome?</td>
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<td>7. Two or more existing children? - <em>ages</em></td>
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<td>8. Previous obstetric complications? ie, <em>Problematic pregnancies, history of pregnancy losses, miscarriages, stillbirth, neonatal death</em></td>
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<td>9. Planned pregnancy?</td>
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<td>10. How are you adjusting to your pregnancy?</td>
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</tr>
<tr>
<td>11. Experience of poor parenting as a child? ie, <em>in care, fostering, looked after by …</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Lack of support? ie, <em>Spouse, partner, parents, in-laws, family</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Supportive social supports? – <em>Friends, networks, neighbours</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Employment status? – <em>employed, unemployed, full time parent, housewife</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Domestic Abuse? – <em>physical, emotional or sexual</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Marital problems? ie, <em>divorce, separation, single parent</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17. Recent Major Life changes? eg, <em>Job loss, house move</em></td>
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</tbody>
</table>

Please continue over the page with any additional comments:
CLINICAL INTERVIEW

This interview is based on the criteria for depression as stipulated in the ICD-10. To meet the criteria for mild depression the woman must confirm 2 features from section A and 2 from section B. For moderate depression 2 features from section A plus 3-4 from section B are required. Minimum duration is two weeks. For severe depression all three criteria from section A would be present with at least 4 from section B. Extreme distress may be apparent or the woman may be noticeably slowed down. She may have disturbed sleep and appetite and may feel guilty or worthless and may be at risk of harming herself. Mental health professionals will understand this classification system if the woman is referred on.

These are suggested questions to illicit postnatal depression, use appropriately in clinical situations, as far as possible, try to use a friendly conversational style approach, eg, “tell me….”

Section A

1. How have you been feeling in yourself recently?  
   Have you been feeling at all unhappy?  
   Can you remember when it started?  
   How many days would you say you’ve been feeling like this?  
   When you are miserable, does it last for most of the day? (mood may be lower in the morning)

2. Have there been times over the past few weeks when you’ve found it hard to be interested in things?  
   Have you found it hard to enjoy things, eg, things you do for the baby?  
   Have you been getting out at all or seeing friends or family?

3. Recently, have there been times when you’ve felt that you have very little energy?  
   Have you been as active as usual?  
   Do you feel drained even if you haven’t been particularly active?  
   Is this tiredness more than you would expect given that you have a new baby?  
   When you’ve had enough sleep, do you still feel drained and tired?  
   For how many days would you say you’ve been feeling like this?

Section B

a) Have you been finding it difficult to concentrate on things?  
   Do you notice that your attention wanders?  
   Have you found it difficult to make the simplest decision like what the baby should wear or what to have for lunch?

b) How have you been feeling about yourself lately? (relates to reduced self esteem)  
   Have you experienced a loss of confidence in yourself and your abilities?

c) Have you had times when you’ve felt guilty or that you weren’t useful or worth anything anymore?  
   Have these been brief feelings or have they lasted for long spells?
d) When you think about the future do you think that things will turn out OK? How do you imagine the future? Is there anything you are looking forward to?

e) Have things ever got so bad lately that you’ve thought about harming yourself? Have you ever found yourself thinking about ways to hurt yourself? Have you ever found yourself thinking that life isn’t worth living? Have you ever tried harming or even killing yourself?

f) When the baby has let you, have you been able to sleep alright? Are you waking earlier than usual? Are you having any trouble falling asleep? Do you have these difficulties most nights? Have you found you are sleeping unusually long hours?

g) How has your appetite been lately? Is it the same as usual or are you eating more or less than usual? Have you had a loss or gain of more weight than would be expected after having a baby?

Other features that are common in depression but not required for diagnosis

Anxiety/ worry/ obsessionality
Have you been feeling more anxious than usual? Have you been feeling panicky? Are you worrying about anything to a great extent? Are you worrying about your health or that of the baby?

Irritability
Are you feeling more irritable than usual, more than you would expect with the reduced amount of sleep since the baby’s birth?

Restlessness
Have you found that at times during the past few weeks you have been so restless and fidgety that you have been unable to sit still? Has anyone else commented on this? How long have you been like this?

Motor slowness
How about the opposite feeling, talking and moving about more slowly than usual?

Loss of libido
Are you less interested in sex than you used to be, even given the tiredness and any physical reasons?
MENTAL HEALTH ASSESSMENT TOOL

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS) (Appendix 4)

The EPDS was developed to assist the detection of postnatal depression. The scale consists of 10 statements, which relate to the symptoms of postnatal depression. The EPDS should be used as a checklist as part of a mood assessment and routinely offered to all women in the postnatal period at 6-8 weeks and three months postpartum (Hall 4, 2005). It should also be offered out with these times when a woman is considered to be of ‘high risk’ based on the Antenatal Summary Sheet Checklist and clinical judgement.

The EPDS should be completed in the health professional’s presence, in an environment where the woman feels comfortable and at ease, ie, her own home (however she may prefer to attend the clinic). The EPDS is designed to be a self-reporting scale, woman should complete the sheet independently, unless there are cultural or literacy difficulties; and then only should help be provided. All 10 questions should be answered, the sheet should be returned to the health professional who will calculate the overall score using the ‘EPDS scoring sheet’. The health professional will then discuss, with the woman, her response to each question using an informal ‘clinical interview’. Follow the ‘EPDS scoring system - flow chart’ for the appropriate action to be taken. The completed EPDS should be filed, to enable future comparisons to be made.

Postnatal EPDS to be filed in medical and obstetric notes
The EPDS score should be noted on the child health record

The diagnosis of PND will be a combination of:

Antenatal Summary Sheet Checklist / Risk factors + EPDS + clinical judgement + relevant information
REFERRAL GUIDELINES FOR WOMEN WITH MENTAL HEALTH PROBLEMS

1. All women identified antenatally as having a history of mental health problems:
   - Discuss with woman additional support available from relatives / friends
   - Consider and discuss GP early referral to Community Mental Health Team (CMHT)
   - Notify HV
   - Close liaison with CMHT if they are involved

2. All women assessed as depressed either antenatally or postnatally:
   - Discuss with woman additional support available from relatives/friends
   - If postnatal, assess mother / baby relationship
   - Assess relationship with other children if applicable
   - Document in records
   - Inform GP+ (and/or CMHT) / HV and Obstetrician (if antenatal)
   - Consider referral to Social Services Child and Family team for additional home support services
   - Liaise as appropriate

   a) If the midwife or HV is concerned at any time:
      - Discuss with woman additional support available from relatives/friends
      - Discuss with GP + (and/or CMHT)
      - Consider medication
      - Consider referral to CMHT via GP
      - Consider seeking advice from Child Protection Adviser or Social Services Child and Family team

   b) If any woman scores for self-harm
      - Inform GP, and GP to refer to CMHT immediately
      - Inform Obstetrician if appropriate

   c) If there are also concerns regarding mother / baby relationship
      - Discuss with woman additional support available from relatives / friends
      - Discuss with GP, for referral by GP to CMHT if appropriate
      - Consider seeking advice from Child Protection Adviser or Social Services Child and Family team

   For any woman assessed as still depressed after supportive visits completed
   - Discuss with woman additional support available from relatives / friends
   - Inform GP, for referral by GP to CMHT if appropriate
   - Consider referral to Social Services for additional home support services

   If any woman is considered to be Psychotic:
   Immediate referral to GP, for referral by GP to CMHT or Psychiatrist
   Inform Obstetrician if appropriate

   If there are concerns at any time, regarding the child or children, consider seeking advice from the Child Protection Adviser or Social Services.
COMMUNITY MENTAL HEALTH TEAM (CMHT)

Information required for Referral

When referring to any discipline, eg, GP/CPN, it is important to obtain consent. The professional should explain the purpose and benefits of such a referral to the woman and try to obtain permission. Occasionally, permission will not be given despite an explanation. When consent is not provided consideration must be given to informing the woman's GP, regarding her decision, based on clinical judgement and risk assessment.

Every General Practice in NHS Grampian is attached to a Community Mental Health Team.

GPs make referrals to CMHTs. Core members of CMHTs include psychiatrists, CPNs, Social Workers, Occupational Therapists (OTs) and Pharmacists. The Team will offer a full assessment and may refer on if necessary to, eg, community nurses – Health Visitors or psychologists.

A referral can be made verbally by telephone, followed by a written referral sheet (Appendix 5). The completed referral sheet should be distributed to other professionals as appropriate and a copy filed in the clients records.

If a woman refuses to attend the CMHT – risk to the pregnant woman and any children to be reassessed.
SUBSTANCE MISUSE SERVICE – NHS Grampian

Aberdeen City - Royal Cornhill Hospital, Substance Misuse Service, Fulton Clinic, Cornhill Road, Aberdeen, AB25 2ZH
Tel: 01224 557928

The Substance Misuse Service is a multi disciplinary team consisting of Consultant Psychiatrist, specialist doctors and trained mental health nurses who offer outpatient care for both drug and alcohol users within a community setting.

Referral into the service is by general practitioner or community mental health team.

Antenatal Clinic
This service provides a specialist service for antenatal and postnatal women attending the Antenatal clinics at Golden Square Clinic, Aberdeen (Tuesday pm) and Aberdeen Maternity Hospital (Wednesday pm/ Thursday pm). Within the multidisciplinary and multi agency Team there is also a Health Visitor for postnatal support who along with the CPNs has the opportunity to assess these women for postnatal depression and refer onwards as appropriate. This would normally include referral to the specialist substance misuse service psychiatrist and/ or general adult psychiatrist.

Aberdeenshire – There is a specialist substance misuse antenatal service run in partnership with midwives from Fraserburgh Hospital and Health Visitors at the Kessock Clinic in Fraserburgh.

Moray - Moray Drug and Alcohol Services, 252 High Street, Elgin.
Tel: 01343 552211

The service consists of a Health Service team, a Social Work team, and Moray Council on Addictions. Support can be offered through multi disciplinary assessments. The service has close links with ward 3 in Dr Gray’s hospital in Elgin. A midwife with a special interest in drug misuse acts as the link person and is based in the early pregnancy clinic in Dr Gray’s hospital.
VULNERABLE CHILDREN AND PARENTAL MENTAL ILL HEALTH

Reducing the risk

There are many factors that can reduce the risk of harm to a child. These include identifying supports available from within the family and in the wider community such as family centres, voluntary agencies, participating in school activities and engaging extended family support.

It should be recognised that many parents suffering mental illness are able to care for their children appropriately, resulting in healthy well-adjusted children. However health professionals need to consider the welfare of children where parental ill health exists and should seek assistance in identifying which children are at risk, which aspects of the child’s development are being affected and what services are needed to help both the child and the family. This is effectively managed by engaging and referring to other agencies such as social services appropriately.

Children can become vulnerable to abuse as a result of a parent's inability to provide an appropriate and safe nurturing environment for them. Recent literature and research indicates that domestic abuse, substance misuse and parental mental illness can have major effects on the well being of children who live within a household where these factors exist (The Stationary Office 1999). This can result in children becoming vulnerable to all forms of abuse including emotional and physical neglect, non organic failure to thrive, fabricated or induced illness, physical and sexual abuse. The long-term effects of abuse on children vary greatly and can include attachment disorders, psychological and emotional ill health and poor educational attainment.

In relation to parental ill health, factors that increase vulnerability to children are

- where children become involved in parental delusions
- where children are targets for parental aggression or
- where children are neglected due to the adults inability to recognise their child’s needs.

If domestic abuse or substance misuse exists in conjunction with parental mental ill health then risks to the child increase greatly.
DEPARTMENT OF CHILD AND FAMILY MENTAL HEALTH

Aberdeen - Fulton MacKay Service, Department of Child and Family Mental Health
Rosehill House, Foresterhill, Aberdeen, AB25 2ZG Tel: 01224 559919
(secretary), email: margaret.grant-beer@nhs.net

(The service is currently for Aberdeen City with telephone consultations for all of the Grampian area).

This is a service for children and young people whose parents or carers have a mental illness.
   We can help explain mental illness and what is happening to your parents or carers.
   We can listen to how it feels coping with a mental illness in the family.
   We can help your parents or carers explain what happens to them when they are ill.
   We can support other professionals and help them to find relevant materials to use.

This service can be accessed directly or through specialist referral by: Young People, Parents and Carers, Professionals - who wish to know more about the service and to discuss referrals, GP’s, inpatient and residential staff.

Moray - Department of Child & Family Psychiatry, The Rowan Centre, Maryhill, Elgin, IV30 1AT, Tel: 01343 567399

A multi disciplinary mental health team serving children and young people from 0-16 years and their families and carers (18 years if still at school or resident in Banff area).
The team offers individual and family work to help with a wide range of problems and difficulties including developmental problems, behaviour difficulties, emotional problems and major mental illness.
The team offers an eclectic approach to assessment and treatment. Referrals are taken via the team as a whole. Written and telephone communications are welcome.

YOUNG PEOPLES DEPARTMENT

Aberdeen City - Young People’s Department, Lower Garden Villa, Cornhill Road, Aberdeen, AB25 2ZH
Tel: 01224 557268
Clinics are also held in:
Peterhead and Fraserburgh

The Department helps young people between their 13th and 18th birthday with mental health difficulties such as anxiety, depression, self-harm, eating problems, disorganised thinking or developmental problems (ie, inattention, over activity, language or social relationship difficulties). The team is made up of health professionals; doctors, nurses, a clinical psychologist, an occupational therapist and a social worker. Referral is by GP, school doctor, educational psychologist or social worker. Treatment approaches include anxiety management, cognitive behavioural or interpersonal therapy, coping skills, medication, and family therapy. Input from a dietician or physiotherapist can be arranged if needed.
CHILD PROTECTION TEAMS

Children can be at risk through, Physical abuse, Emotional abuse, Sexual abuse and neglect. If you have any concerns about a child’s care, welfare or safety you must take action. Specific guidance is contained in the North East of Scotland Child Protection Committee (NESCPC) Guidelines (1997). As a minimum all staff should:

- Listen to what is said
- Observe what is happening
- Write down exactly what you see and hear
- Report exactly what you see and hear to your supervisor line manager or senior colleague.

Further advice and support can be obtained from one of the contacts below:

**NHS Grampian:**
Designated Doctor in Child Protection 01224 557723 – Ext. 57723  
Senior Nurse Child Protection 01224 559529 – Ext. 59529  
Royal Aberdeen Children’s Hospital receiving Consultant Paediatrician via Medical Registrar 01224 681818

**Moray:**
‘Named Doctor’ Consultant Paediatrician, Dr Gray’s 01343 543131 – Ext. 77511

**Grampian Police:**
Community Protection & Investigation Unit:  
Aberdeen  
Elgin                       0845 600 5700  
Fraserburgh

| Table 1 |
|---|---|---|
| **Aberdeen City Social Work** | **Aberdeenshire Social Work** | **Moray Social Work** |
| Team 1 St Nicholas House 01224 522000 | Banff 01261 818097 | Elgin 01343 552699 |
| Team 2 Kincorth 01224 874278 | Turiff 01888 562427 | Forres 01309 694000 |
| Team 3 Torry 01224 241050 | Peterhead 01779 474961 | Lossiemouth 01343 57240 |
| Team 4 Mastrick 01224 690404 | Fraserburgh 01346 516885 | Buckie 01542 837200 |
| Team 5 Quarry Centre 01224 694554 | Inverurie 01467 625555 | |
| Team 6 St Nicholas House 01224 522116 | Ellon 01358 720033 | |
| Team 7 Quarry Centre 01224 694554 | Huntly 01466 794488 | |
| | Portlethen 01224 783880 | |
| | Stonehaven 01569 763800 | |
| | Banchory 01330 824991 | |
| | Aboyne 01339 887096 | |
| | Emergency Out of Hours: 0845 840 0070 | Emergency Out of Hours: 08457 565656 |

Emergency Out of Hours: 01224 693936
SOCIAL WORK SERVICES

Duty Team - Aberdeen
The Duty Team provides the first point of contact with Social Work for members of the public and professionals. It consists of a senior social worker and 7 social workers. The team accept self referrals or referrals from any agency. The service is for anyone having problems coping with day to day living.

The Team:
• Offers an advice and counselling service, on a wide range of issues.
• Provides information about available resources, whether provided by the Social Work service or by other statutory or voluntary agencies.
• Assesses peoples needs and either provides the support or resources required or contacts the agency or agencies which can help most.
• Provides a social work service in crisis situations.

The Team’s office is located on 1st Floor St Nicholas House, Upperkirkgate, Aberdeen.

Phone line open 08.30 – 17.00
Drop in service   09.30 – 12noon Monday, Tuesday, Wednesday and Friday  
14.00 – 16.00     Every weekday

Some appointments available at the office if requested.

To contact the Duty Social Worker Tel: 01224 522939
Outside Office Hours Tel: 01224 693936

Duty Teams – Aberdeenshire, contact details as Table 1. above

Duty Teams – Moray, contact details as Table 1. above
The Duty Social Work service operates 08.30 – 17.00, Monday – Fridays.

Out of Hours Service (OOHS)

Aberdeen City - This service deals with any urgent social problem, which cannot wait until the next normal working day. Tel: 01224 693936.
The service is available:
Monday – Thursday 16.30 - midnight
Friday 16.00 - midnight,
Weekends and public holidays 08.30 - midnight

A social worker will be on call for emergencies only after midnight until 08.30.
A Mental Health Officer can be contacted through the Out of Hours Service.

Aberdeenshire - 0845 840 0070

Moray - The out of hours social work team operates from 9 North Guildry Street, Elgin, IV30 1JR. Out of hours service Tel: 08457 565656

An additional management back up rota is in operation during out of hours as well as the duty social worker.
FAMILY CENTRES

Aberdeen City

There are 9 Family Centres in Aberdeen City. The Centres work with parents to enhance children’s social and emotional development and parenting skills. There are opportunities within the centres for mothers to socialise with other members and to take part in group work. **Ashgrove, Seaton, Deeside, Quarry, Tillydrone, Williamson** are managed by the social work service and referrals can be made through health visitors/health professionals, social workers or by self referral. **Primrosehill** is run by the Aberlour Child Trust, and referrals can be made via a variety of sources including health professionals. **Fersands** and **Middlefield** are based within community projects and are open to all members of the local area and receive self-referrals.

Table 2

<table>
<thead>
<tr>
<th>Ashgrove Family Centre</th>
<th>Seaton Family Centre</th>
<th>Middlefield Mini Family Centre</th>
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</thead>
<tbody>
<tr>
<td>Gillespie Place</td>
<td>Seaton Place East</td>
<td>8 Logie Place</td>
</tr>
<tr>
<td>Aberdeen, AB25 3BE</td>
<td>Aberdeen, AB24 1XE</td>
<td>Middlefield</td>
</tr>
<tr>
<td>Tel: 01224 482293</td>
<td>Tel: 01224 494067</td>
<td>Aberdeen, AB16 7TP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tel: 01224 682335</td>
</tr>
<tr>
<td>Deeside Family Centre</td>
<td>Tillydrone Family Centre</td>
<td>Fersands Mini Family Centre</td>
</tr>
<tr>
<td>Girdleness Road</td>
<td>Pennan Road</td>
<td>22a Sandilands Drive</td>
</tr>
<tr>
<td>Torry</td>
<td>Tillydrone</td>
<td>Aberdeen, AB24 2QA</td>
</tr>
<tr>
<td>Aberdeen, AB11 8TD</td>
<td>Aberdeen, AB24 2UD</td>
<td>Tel: 01224 267487</td>
</tr>
<tr>
<td>Tel: 01224 248389</td>
<td>Tel: 01224 495683</td>
<td></td>
</tr>
<tr>
<td>Quarry Family Centre</td>
<td>Williamson Family Centre</td>
<td>Primrosehill Family Centre</td>
</tr>
<tr>
<td>Cummings Park Crescent</td>
<td>MASTRICK CLOSE</td>
<td>8 Sunnybank Road</td>
</tr>
<tr>
<td>Northfield</td>
<td>off MASTRICK DRIVE</td>
<td>Froghall</td>
</tr>
<tr>
<td>Aberdeen, AB16 7AS</td>
<td>Aberdeen, AB16 6XZ</td>
<td>Aberdeen, AB24 3NG</td>
</tr>
<tr>
<td>Tel: 01224 691800</td>
<td>Tel: 01224 692428</td>
<td>Tel: 01224 483381</td>
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Aberdeenshire

Table 3

<table>
<thead>
<tr>
<th>Banff Family Centre</th>
<th>Kemnay Family Resource Centre</th>
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<tbody>
<tr>
<td>Banff Primary School</td>
<td>Aquithie Road</td>
</tr>
<tr>
<td>Academy Drive</td>
<td>Kemnay, AB51 5SS</td>
</tr>
<tr>
<td>Banff, AB45 1BL</td>
<td>Tel: 01467 641297</td>
</tr>
<tr>
<td>Tel: 01261 813180</td>
<td></td>
</tr>
<tr>
<td>Fraserburgh Family Centre</td>
<td>Peterhead Family Centre</td>
</tr>
<tr>
<td>2/4 Berville Road</td>
<td>53a Windmill Street</td>
</tr>
<tr>
<td>Fraserburgh, AB43 9UY</td>
<td>Peterhead, AB42 1UE</td>
</tr>
<tr>
<td>Tel: 01346 515187</td>
<td>Tel: 01779 473368</td>
</tr>
</tbody>
</table>

Moray

National Children Homes Family Centres offer parenting skills and play and development opportunities for their children. The National Children’s Home is based at **Winchester House, 1 King Street, Elgin, IV30 1EU** - **Tel: 01343 549557**. This resource centre provides drop in groups, after school groups and women’s groups; available every day of the week.
SURE START

Is a government funded initiative that provides advice, help and support for families with children aged 0-3 years.

- By supporting early bonding between parents and their children, helping families to function and by enabling the early identification and support of children with emotional and behavioural difficulties
- By supporting parents in caring for their children to promote healthy development before and after birth
- By encouraging high quality environments and childcare that promote early learning, provide stimulating and enjoyable play, improve language skills and ensure early identification and support of children with special needs
- By involving families in building the community’s capacity to sustain the programme and thereby create pathways out of poverty

Table 4

<table>
<thead>
<tr>
<th>Location</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alford</td>
<td>07788 171344</td>
</tr>
<tr>
<td>Insch</td>
<td>07788 181165</td>
</tr>
<tr>
<td>Aboyne</td>
<td>07879 432975</td>
</tr>
<tr>
<td>Kemnay</td>
<td>01467 641297 07747 006292</td>
</tr>
<tr>
<td>Banchory</td>
<td>01330 825146</td>
</tr>
<tr>
<td>Laurencekirk</td>
<td>07879 486271</td>
</tr>
<tr>
<td>Banff</td>
<td>01261 813180</td>
</tr>
<tr>
<td>Oldmeldrum</td>
<td>07787 348835</td>
</tr>
<tr>
<td>Ellon</td>
<td>07879 434419</td>
</tr>
<tr>
<td>Mintlaw</td>
<td>07879 601979</td>
</tr>
<tr>
<td>Fraserburgh</td>
<td>01346 515187</td>
</tr>
<tr>
<td>Peterhead</td>
<td>01779 473368</td>
</tr>
<tr>
<td>Inverurie</td>
<td>07879 435325</td>
</tr>
<tr>
<td>Stonehaven</td>
<td>01569 768417 01569 760396 07736 866517</td>
</tr>
</tbody>
</table>
**HOME START**

Is a voluntary home-visiting scheme offering support, friendship and a practical approach to families with under-fives, helping to prevent family crisis and breakdown. Referral is by Health Visitor, General Practitioner, Social Worker, etc, or by self-referral. The only referral criteria is the client must have a child under the age of 5 years.

**Aberdeen City**

Table 5

<table>
<thead>
<tr>
<th>Homestart in Aberdeen</th>
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<tbody>
<tr>
<td>25 Greenfern Road</td>
</tr>
<tr>
<td>Mastrick</td>
</tr>
<tr>
<td>Aberdeen</td>
</tr>
<tr>
<td>AB16 6TS</td>
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<tr>
<td>01224 693545</td>
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**Aberdeenshire**

Table 6

<table>
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<th>Homestart Deveron</th>
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<tbody>
<tr>
<td>5-7 Straight Path</td>
</tr>
<tr>
<td>Banff, AB44 1TX</td>
</tr>
<tr>
<td>Tel: 01261 819 964</td>
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<table>
<thead>
<tr>
<th>Homestart Garioch</th>
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<tbody>
<tr>
<td>Lumphart Cottage</td>
</tr>
<tr>
<td>Port Road</td>
</tr>
<tr>
<td>Inverurie, AB51 3SP</td>
</tr>
<tr>
<td>Tel: 01467 624 801</td>
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<table>
<thead>
<tr>
<th>Homestart Kincardine</th>
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</thead>
<tbody>
<tr>
<td>32 David Street</td>
</tr>
<tr>
<td>Stonehaven, AB39 2AL</td>
</tr>
<tr>
<td>Tel: 01569 767 773</td>
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<table>
<thead>
<tr>
<th>Homestart UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 Salisbury Road, Leicester LE17QR</td>
</tr>
<tr>
<td>0116 233 9955</td>
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<table>
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<tr>
<th>Homestart South Scotland</th>
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<tbody>
<tr>
<td>0141 776 3042</td>
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<th>Homestart North Scotland</th>
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</thead>
<tbody>
<tr>
<td>0173 844 4020</td>
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<tr>
<th>North East Aberdeenshire Homestart</th>
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<tbody>
<tr>
<td>101 High Street</td>
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<tr>
<td>Fraserburgh, AB43 9EX</td>
</tr>
<tr>
<td>Tel: 01346 518930</td>
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</tbody>
</table>
COUNSELLING, COGNITIVE BEHAVIOURAL, INTERPERSONAL THERAPY APPROACHES, SOCIAL SUPPORT, FAMILY FOCUSED INTERVENTIONS – COUPLE INTERVENTIONS

Health Visitors, Community Psychiatric Nurses and trained practitioners can provide counselling and listening support. This may help parents outline or discuss issues, which they have been struggling with in isolation. The opportunity to “off load” to an empathic, understanding, uncritical listener in a confidential setting can be a great release for the mother and allow informal screening to take place (this applies equally to male partners). The demonstrable capacity to be empathic, understanding and uncritical is therefore a key skill for midwives and health visitors and this should be reflected in personal development plans.

The effects of PND on other family members should be considered and interventions that work with more than one family member at a time should be considered when assessing the treatment options available. The psychosocial treatment option chosen should reflect both clinical judgement and the mother’s/ family’s preference where possible. It may also help to provide information on support groups in the area, which enable mutual support.

Different types of psychological help are useful at different times:

Parenting programmes, delivered postnatally, seem to help prevent postnatal depression. Antenatal parenting programmes were not found to have this effect (Brugha et al 2000).

Antenatally, Interpersonal Psychotherapy has been shown to be an effective alternative to antidepressant medication. (Spinelli 2003) Antenatal Interpersonal Psychotherapy has been shown to be more effective than parenting programmes in preventing postnatal depression.

Antenatal anxiety is associated with growth retardation, premature delivery, epidural analgesia and increased psychological morbidity (Chung et al 2001). Several studies support the conclusion that perinatal anxiety and/or depression in either parent can have a deleterious effect on the health, behaviour and cognitive functioning of the child (Matthev 2004, O’Connor et al 2003, Leverton 2003). Condon et al (2004) in a review of five previous studies noted that the female to male ratio for developing perinatal mental health problems ranged from 2:1 to 4:1. This has two main implications:

First, perinatal anxiety and depression in either parent needs to be effectively treated. Interventions based on Cognitive Behavioural Therapy are likely to be most effective (Scott 1997). Midwives and Health Visitors should have basic counselling and listening skills and be encouraged to develop their capacity to use interpersonal and cognitive behavioural approaches in their counselling support of families. They will also need access to an effective referral route for specialists offering this approach in serious cases.

Secondly, perinatal anxiety and depression will need to be effectively detected in both parents. While the EPDS will effectively detect depression, an anxiety screening tool should also be available, eg, Hospital Anxiety and Depression scale (HAD Scale).
INTERACTIVE FOCUSED INTERVENTIONS - Infant massage

Research by Onozawa, K. et al. 2001, suggested that attending an infant massage class substantially improved the relationship between mother and infant and may also have contributed to improvements in maternal mood.

In NHS Grampian baby massage is performed by mothers on their own babies under the instruction of a qualified person; this service may be available through the family Health Visitor. Although being aware of the benefits of baby massage NHS Grampian can only endorse this procedure if it is instructed by trained NHS Grampian staff or if it is taught in NHS Grampian premises.

The facts:
Teaching infant massage to mothers with PND may be beneficial in:
- Strengthening the mother/baby bond
- Assisting the mother to tune into and meet the baby’s needs
- Contribute to confidence and self-esteem
- Meeting other mothers whose experiences are similar

UK, NATIONAL, REGIONAL AND LOCAL ORGANISATIONS

There are many organisations available in the UK to assist women, their partners and families, during pregnancy and the postnatal period, with help, advice or support. Some of these supportive agencies are listed below, a description of each and contact details are listed in Appendix 2; alternatively contact:

- www.grampiancaredata.gov.uk
- NHS Grampian healthline Tel: 0500 20 20 30
- NHS 24 Tel: 08454 24 24 24 or for text phone users 018001 08454 24 24 24

Table 7

<table>
<thead>
<tr>
<th>The Association for Post-Natal Illness (APNI)</th>
<th>Aberdeenshire Council Domestic Abuse Outreach Workers</th>
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<tr>
<td>Breathing Space</td>
<td>Aberdeen Women’s Aid</td>
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<tr>
<td>British Association for Counselling &amp; Psychotherapy</td>
<td>Couple Counselling</td>
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<tr>
<td>Depression Alliance Scotland</td>
<td>Cry-sis Helpline</td>
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<td>Depression Alliance Perinatal Depression Helpline</td>
<td>Domestic Abuse Helpline</td>
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<tr>
<td>Manic Depression Fellowship Scotland</td>
<td>Family Mediation</td>
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<td>MASH (Men as Survivors Helpline)</td>
<td>Fulton Mackay Service</td>
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<tr>
<td>Meet a Mum Association</td>
<td>Grampian Women’s Aid</td>
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<tr>
<td>MIND (National Association for Mental Health)</td>
<td>Grampian Police Domestic Abuse Liaison Officer</td>
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<tr>
<td>Miscarriage Association</td>
<td>Healthpoint</td>
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<tr>
<td>National Childbirth Trust (NCT)</td>
<td>Homemakers</td>
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<tr>
<td>Postnatal Depression Project</td>
<td>Manic Depression Fellowship Aberdeen</td>
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<tr>
<td>Samaritans</td>
<td>Moray Domestic Abuse Worker</td>
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<td>SANELINE</td>
<td>Moray Women’s Aid</td>
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<td>Scottish Women’s Aid</td>
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<td>Scottish Association for Mental Health</td>
<td>ParentLine Scotland</td>
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<td>Shakti Women’s Aid</td>
<td>Pillar Aberdeen Post Natal Depression Support Group</td>
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<td>Pillar – Kincardine</td>
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DOMESTIC ABUSE

The Confidential Enquiries into Maternal Deaths in the UK (CEMD) estimates that over a third of domestic abuse incidents start during pregnancy. Pregnancy may trigger or exacerbate male abuse in the home. Pregnancy may indeed be a consequence of abuse and an indication that the pregnant woman is in a coercive relationship. There are strong links between domestic abuse and adverse pregnancy outcomes and maternity services should be particularly alert to the possibility of abuse and proactive in its detection and management. Physical and emotional indicators such as stress, anxiety disorders such as panic attacks or depression, feelings of isolation and inability to cope, suicide attempts or gestures of deliberate self-harm may be present, which may or may not be linked to postnatal depression. However, postnatal depression is more likely to occur and it is important health care workers are alert to the indicators of domestic abuse (Scottish Executive, 2003).

There are a wide number of support agencies for victims of domestic abuse detailed in Appendix 2.

---

7 Indicators of domestic abuse are listed in the NHS Grampian Domestic Abuse Patient Policy. Health care workers may be reluctant to enquire about domestic abuse for a number of reasons, however research evidence indicates that a substantial number of women do not tell health care workers about abuse, but want the health care worker to enquire or prompt discussion (Scottish Executive, Responding to Domestic Abuse Guidelines for Health Care Workers in NHS Scotland, 2003). With training and appropriate resources health care workers will be more confident in their responsibility to give women permission to speak out about their experience.
EFFECTS ON MEN AND FAMILIES

The birth of a baby is usually a joyful event, but it can often be an exhausting, distressing, confusing or stressful time for both parents. Numerous research studies have examined the male transition to parenthood and acknowledge the potential associated depression, which men can experience both during pregnancy and the postnatal period.

It may be difficult for a man to know how to give support, especially if it is not easy for his partner to accept help. Many men may feel overwhelmed by the responsibilities of work and family, as well as increasing financial pressures. Older children may pick up on tensions and their behaviour may become more demanding, especially as the baby takes up increasing amounts of their parents’ time and attention. Generally men may also have fewer support networks, having relied primarily on their partners for support. Poor role models for parenting in childhood may put further pressures onto present day fathers. Finally men are more reluctant to seek help with emotional difficulties compared to women and consequently resort to more destructive behaviours such as alcohol abuse or other risk taking behaviours.

The facts:
- Men are more likely to suffer from depression and general health problems if their partner is diagnosed with depression.

FAMILIAL SUPPORT / ASSISTANCE

While PND can affect other members of the family in addition to the mother who has PND, there are things that immediate and extended family members can do to help, eg,
- Share responsibilities for caring for the baby whenever possible to allow the mother a nights rest.
- Provide a break for the mother, eg, grandparents could look after the baby.
- Listen to the mother about how she feels.
- Provide practical help, ie, with housework, caring for the baby, etc.

It should be noted that a mother might not want any help as she may feel that she needs to do everything to prove to herself that she is a good mother.

PHYSICAL EXERCISE / ACTIVITY

There is good evidence to support the role of exercise in promoting positive mental health, encouraging relaxation and reducing levels of depression in the general population (Sportex 2003) however there is little research into its role in alleviating postnatal depression.

The management of PND is the same as depression at any other time, except for the additional considerations regarding the use of antidepressant medication and breastfeeding. There is no reason to exclude the benefits of encouraging regular exercise, following health professional approval, in the antenatal and postnatal period. Exercise doesn’t necessarily need to be strenuous; simply going out for a walk can provide a sufficient break and relaxation from the demands of a baby (HEBS 2001).
GUIDELINES ON MEDICATION

Many women are reluctant to take medication during pregnancy and the postnatal period. However the risks of not treating postnatal depression or puerperal psychosis include harm to the mother through poor self-care, lack of obstetric care or self-harm and harm to the foetus or neonate. It is therefore important to treat postnatal depression and puerperal psychosis.

PRESCRIBING IN POSTNATAL DEPRESSION

Postnatal depression should be managed in the same way as depression at any other time with the additional consideration regarding the use of antidepressants in pregnancy and breastfeeding.

PRESCRIBING IN Puerperal PSYCHOSIS

Puerperal psychosis should be managed in the same way as psychotic disorders at any other time with the additional consideration regarding the use of drug treatments in pregnancy and breastfeeding. Prescribing is usually undertaken by a specialist service and drug treatments administered as an inpatient.

PRESCRIBING IN PREGNANCY AND LACTATION

Medication should be used cautiously in pregnancy and lactation due to the possible risks to the foetus and infant. In early pregnancy there is a risk of teratogenicity and drug use should be avoided if possible. In later pregnancy, the risks include neonatal toxicity, withdrawal syndrome following delivery and possibly long-term neurodevelopment effects in the infant. In addition many drugs are excreted into breast milk and ingested by the infant with a potential for short-term toxicity and longer-term neurodevelopment effects. Most psychotropic drugs are not licensed for use in pregnancy and lactation and the risks and benefits of treatment should be carefully considered before prescribing at this time. In all cases it is important to:
- Establish a clear indication for drug treatment
- Use the lowest effective dose for the shortest period of time necessary
- Use drugs with a better evidence base
- Assess the benefit/risk ratio of the illness and treatment for both the mother and the foetus/baby

PRESCRIBING IN THE FIRST TRIMESTER

Antidepressants

Current evidence indicates that there is no increased risk of major malformations in the new born or spontaneous abortion following exposure to Tricyclic Antidepressants (TCAs) and Selective Serotonin Reuptake Inhibitors (SSRIs) in early pregnancy. Therefore the risks of stopping TCAs or SSRIs should be carefully assessed in relation to the mother’s mental state and previous history. There is currently insufficient evidence available to recommend the use of other antidepressants.
Mood Stabilisers

- Lithium

Lithium is used as a mood stabiliser in Bipolar Affective Disorder to prevent the risk of relapse and is only prescribed on specialist recommendation. Early studies suggested that lithium exposure in early pregnancy increased the risk of major foetal malformations, including the cardiac defect, Ebstein’s anomaly. For this reason, lithium should be avoided if possible during the first trimester. However, in women with severe Bipolar Affective Disorder there may be more risk to the mother and child if lithium is withdrawn and consideration should be given to continuing lithium treatment during pregnancy if clinically indicated. In such cases, serum lithium levels should be carefully monitored and detailed foetal ultrasound scanning should be offered.

- Other Mood Stabilisers

Carbamazepine, valproate and lamotrigine are antiepileptic drugs used as mood stabilisers. Evidence from studies in women with epilepsy has revealed an increased risk of congenital malformations with these drugs, particularly Spina Bifida and their use should be avoided if possible. Valproate showed a higher relative risk than carbamazepine, especially with valproate doses > 1000mg/day and is best avoided. In addition, several antiepileptic drugs, including, carbamazepine and valproate are folate antagonists and the co-prescription of folic acid 5mg/day is recommended from pre-conception to the end of the first trimester to minimise the risk of neural tube defects. Prophylactic vitamin K should be given to both the mother and the neonate after delivery. At present there is insufficient data to recommend lamotrigine.

Benzodiazepines

Current literature suggests that there is an increased risk of major malformation and oral cleft in the foetus and their use should be avoided in the first trimester.

Other Medication

Caution should be exercised in the use of any other forms of psychotropic medication in the first trimester of pregnancy.

PRESCRIBING IN THE SECOND AND THIRD TRIMESTERS

Perinatal toxic syndromes and withdrawal syndromes have been reported in infants exposed to psychotropic medication in utero and concerns exist regarding the long term effects of such exposure on the neurological development of the infant. It is therefore important to monitor neonates, exposed to psychotropics, for signs of withdrawal syndromes following delivery. If necessary the minimum effective dose should be used with consideration given to reducing the dose and/or discontinuing 2-4 weeks before the expected date of delivery, with re-commencement after delivery.
PRESCRIBING IN LACTATION

The excretion of psychotropic medication is complex with variation in milk/maternal plasma ratios for different drugs and between foremilk and hind milk. The level of metabolic maturity of the infant will also influence any effect of drugs taken by the mother. In general medicines prescribed for breastfeeding mothers are best taken as a single dose, where possible and should be administered before the baby’s longest sleep period. Breastfeeding is best done immediately before administering the dose and should be avoided for 1-2 hours after any dose of medication when the plasma concentration will be highest.

Tricyclic Antidepressants (TCAs)

There is no clinical indication for women treated with TCAs (other than doxepin) to stop breastfeeding, provided the infant is healthy and its progress monitored. Doxepin should be avoided due to the long half-life of its active metabolite, which may accumulate in the breastfed infant.

Selective Serotonin Re-Uptake Inhibitors (SSRIs)

There is no clinical indication for women treated with paroxetine, sertraline or fluoxetine to stop breastfeeding, provided the infant is healthy and monitored. Paroxetine may be the drug of choice owing to its low milk/plasma ratio.

Mood Stabilisers

- **Lithium**
  
  Lithium is excreted in breast milk (40% of maternal serum level) and lithium toxicity has been reported in infants. In view of the risks to the infant, mothers prescribed lithium should not breastfeed.

- **Valproate**
  
  Sodium valproate is excreted into breast milk in low levels and infant serum levels are 1-2% of maternal serum level. No adverse effects have been noted in breastfed children of mothers on sodium valproate.

- **Carbamazepine**
  
  Carbamazepine is excreted into breast milk in significant quantities and infant carbamazepine levels in serum range from 6-65% of maternal serum levels. Therefore it should only be used under specialist advice.

Benzodiazepines

Benzodiazepines are excreted into breast milk with a low milk/plasma ratio. It is recommended that new prescriptions for benzodiazepines should be avoided in mothers who are breastfeeding. Note: this does not cover drug dependence, where breastfeeding may be beneficial if the infant has been exposed to benzodiazepines in utero.
Other Medication

All antipsychotic medication is excreted into breast milk. As yet there is no evidence to suggest that breastfed infants are at risk of toxicity or impaired development. In such cases the infant should be monitored and a careful assessment of the risks and benefits of prescribing made.

For further advice on the safety of specific medication contact:

- NHS Grampian Medicines Information Service: 01224 552316
- National Teratology Centre - Pregnancy: 0191 232 1525
  - Breastfeeding: 0116 255 5779
ADMISSION OF MOTHER AND BABY TO HOSPITAL DUE TO DEPRESSION / PUERPERAL PSYCHOSIS

Currently there is not a specialist Mother and Baby Unit in NHS Grampian.

- In Moray the policy document, *Admission of Mother and Baby to Ward 4 including Room Access / Exit and in the event of an Emergency* details the care management of mother and baby admitted to Dr Gray’s Hospital, Ward 4, Elgin (see Appendix 6).
POSTNATAL DEPRESSION AND PUERPERAL PSYCHOSIS 60 QUICK REFERENCE GUIDE

- KEY TO EVIDENCE STATEMENTS AND GRADES OF RECOMMENDATIONS
- LEVELS OF EVIDENCE
  1++ High quality meta-analyses, systematic reviews of RCTs, or RCTs with a very low risk of bias
  1+ Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias
  1- Meta-analyses, systematic reviews, or RCTs with a high risk of bias
  2++ High quality systematic reviews of case control or cohort studies
  2+ High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal
  2- Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal
  3 Non-analytical studies, e.g. case reports, case series
  4 Expert opinion

GRADES OF RECOMMENDATION

Note: The grade of recommendation relates to the strength of the evidence on which the recommendation is based. It does not reflect the clinical importance of the recommendation.

A
At least one meta-analysis, systematic review of RCTs, or RCT rated as 1++ and directly applicable to the target population;
or
A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B
A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results;
or
Extrapolated evidence from studies rated as 1++ or 1+

C
A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results;
or
Extrapolated evidence from studies rated as 2++

D
Evidence of level 3 or 4;
or
Extrapolated evidence from studies rated as 2+

GOOD PRACTICE POINTS

Recommended best practice based on the clinical experience of the guideline development group

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SIGN Executive
Royal College of Physicians, 9 Queen Street, Edinburgh EH2 1JQ
www.sign.ac.uk
The Scottish Intercollegiate Guidelines Network (SIGN) supports improvement in the quality of health care for patients in Scotland by developing national clinical guidelines containing recommendations for effective practice based on current evidence.

The recommendations are graded A B C D to indicate the strength of the supporting evidence

Good practice points ✔ are provided where the guideline development group wish to highlight specific aspects of accepted clinical practice.

Details supporting the evidence of these recommendations and their application in practice can be found in the full guideline, available on the SIGN website www.sign.ac.uk

This guideline was issued in June 2002 and will be updated as evidence becomes available

DIAGNOSIS, SCREENING AND PREVENTION

A. Procedures should be in place to ensure that all women are routinely assessed during the antenatal period for a history of depression.
   ✔ There is no evidence to support routine screening in the antenatal period to predict development of PND.

D All women should be screened during pregnancy for previous puerperal psychosis, history of other psychopathology (especially affective psychosis) and family history of affective psychosis.
   ✔ 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.
   ✔ 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.

C The EPDS should be offered to women in the postnatal period as part of a screening programme for PND.
   ✔ The EPDS is not a diagnostic tool. Diagnosis of PND requires clinical evaluation.
   ✔ A cut-off on the EPDS of 10 or above is suggested for whole population screening.
   ✔ The EPDS should be used at approximately six weeks and three months following delivery and should be administered by trained Health Visitors or other health professionals.
   ✔ In high risk women it may be effective to have postnatal visits, interpersonal therapy and/or antenatal preparation.
   ✔ Women identified at high risk of puerperal psychosis should receive specialist psychiatric review.

MANAGEMENT

B PND and puerperal psychosis should be treated.

D PND should be managed in the same way as depression at any other time, but with the additional considerations regarding the use of antidepressants when breastfeeding and in pregnancy.
   ✔ St John’s Wort and other alternative medicines should not be used during pregnancy and lactation until further evidence as to their safety in these situations is available.
   ✔ The use of hormonal therapies in the routine management of patients with PND is not advised.

B Psychosocial interventions should be considered when deciding on treatment options for a mother diagnosed as suffering from PND.

C The effects of a mother's PND on other family members and their subsequent needs should be considered and treatment offered to them as appropriate.

C Interventions that work with more than one family member at a time should be considered when assessing the treatment options available.
   ✔ The psychosocial treatment option chosen should reflect both clinical judgement and the mother's and family's preferences where possible.

D Puerperal psychosis should be managed in the same way as psychotic disorders at any other time, but with the additional considerations regarding the use of drug treatments when breastfeeding and in pregnancy.
MOTHER AND BABY UNITS

D The option to admit mother and baby together to a specialist unit should be available. Mothers and babies should not be admitted to general psychiatric wards routinely.

✓ A multiprofessional assessment, including social work, involving family members, should take place to review the decision to admit mother and baby to a specialist unit either before or shortly after admission.

✓ Clinical responsibility for the baby whilst the mother is an inpatient needs to be clearly determined.

PRESCRIBING

The following general principles governing prescription of new medication or the continuation of established therapy during pregnancy and in breastfeeding apply to all recommendations in this guideline.

• Establish a clear indication for drug treatment (ie, the presence of significant illness in the absence of acceptable or effective alternatives)

• Use treatments in the lowest effective dose for the shortest period necessary

• Drugs with a better evidence base (generally more established drugs) are preferable

• Assess the benefit/ risk ratio of the illness and treatment for both mother and baby/ foetus

B The risk of stopping tricyclic or SSRI antidepressant medication should be carefully assessed in relation to the mother’s mental state and previous history. There is no indication to stop tricyclic or SSRI antidepressant medication as a matter of routine in early pregnancy.

There is no clinical indication for women treated with TCAs (other than doxepin) paroxetine, sertraline, or fluoxetine to stop breastfeeding, provided the infant is healthy and its progress monitored.
<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>TELEPHONE/ website</th>
<th>CONTACT ADDRESS</th>
<th>DESCRIPTION OF ORGANISATION</th>
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<tbody>
<tr>
<td>The Association for Postnatal Illness (APNI)</td>
<td>0207 386 0868 Mon, Wed, Fri: 10.00 - 14.00 Tues, Thurs: 10.00 - 15.00 Answer machine out with office hours <a href="http://www.apni.org">www.apni.org</a></td>
<td>145 Dawes Road, Fulham, London SW6 7EB</td>
<td>To help mothers who may think they are suffering from PND. The Association is involved with information, education, research and support for sufferers. The Association can put sufferers in touch with a volunteer who has herself recovered from PND, in order to provide support.</td>
</tr>
<tr>
<td>Breathing Space</td>
<td>0800 83 85 87 Call free and confidential, 18.00 - 02.00 <a href="http://www.breathingspacescotland.co.uk">www.breathingspacescotland.co.uk</a></td>
<td></td>
<td>Breathing Space is a free, confidential phone line that anyone in Scotland can call when they are feeling low or depressed. Sometimes sharing feelings with friends or family can seem such a difficult prospect that people prefer to pretend everything is okay. However, late at night problems can seem overwhelming - for example money worries, work stress, depression, suicidal thoughts, relationship trouble or feelings of sadness for no obvious reason. Breathing Space are available to listen every evening from 18.00 - 02.00. A dedicated team of Special Phone Line Advisors can offer advice or suggest agencies that can help with more specific problems in the caller’s local area.</td>
</tr>
<tr>
<td>British Association for Counselling &amp; Psychotherapy (BACP) Private counsellors</td>
<td>0870 443 5252 <a href="mailto:bacp@bacp.co.uk">bacp@bacp.co.uk</a> <a href="http://www.counselling.co.uk">www.counselling.co.uk</a></td>
<td>1 Regent Place Rugby Warwickshire CV21 2PJ</td>
<td>Can send a list of accredited counsellors in your local area.</td>
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<tr>
<td>UK &amp; NATIONAL ORGANISATION</td>
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<tr>
<td>Depression Alliance Scotland</td>
<td>0131 467 3050 Mon, Tue, Thurs, Fri: 10.00-14.00 Closed Wednesday Answer machine out with office hours <a href="http://www.depressionalliance.org">www.depressionalliance.org</a></td>
<td>3 Grosvenor Gardens, Edinburgh EH12 5JU</td>
<td>The number one source for information on Depression in the UK. Works to relieve and to prevent the treatable condition of depression by providing information, support, and understanding, to those affected by it. Answer machine available out with opening times, leave contact details and message. For urgent enquiries ring the Samaritans 08457 909090.</td>
</tr>
<tr>
<td>Depression Alliance Perinatal Depression Helpline</td>
<td>08451203746 National helpline, Monday - Friday 19.00 - 22.00</td>
<td></td>
<td>The telephone helpline is for anyone affected by antenatal or postnatal depression and is staffed by trained volunteers.</td>
</tr>
</tbody>
</table>
| Manic Depression Fellowship Scotland | Tel / Fax 0141 560 2050 [www.mdfscotland.co.uk](http://www.mdfscotland.co.uk) | Mile End Mill Studio 1016 Abbey Mill Business Centre Seedhill Road Paisley, PA1 1TJ | The Manic Depression Fellowship Scotland has the following aims:  
- To provide information, support and advice for people with MD, their relatives, friends and carers, and all who care.  
- To promote, develop and co-ordinate a network of community-based manic depression self-help groups throughout Scotland.  
- To inform and educate members of the public, professionals and other agencies about the nature of the illness and the role and value of the Fellowship.  
- To encourage and assist in research into all aspects of Manic Depression. |
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<td>MASH (Men As Survivors Helpline)</td>
<td>0117 907 7100 Free Helpline Thurs 19.00 - 21.00</td>
<td></td>
<td>Counselling Service for men who have experienced any form of sexual abuse or sexual violence at any time in their lives. Also support for people who are close to these men.</td>
</tr>
<tr>
<td>Meet a Mum Association (MAMA)</td>
<td>01525 217064 -Information Line Answer machine <a href="http://www.mama.org.uk">www.mama.org.uk</a></td>
<td></td>
<td>The Meet A Mum Association (MAMA) was launched in 1979 by Esther Rantzen (President of MAMA) and ‘Woman’ Magazine. MAMA is now a UK registered charity which aims to provide friendship and support to all mothers and mothers-to-be, especially those feeling lonely or isolated after the birth of a baby or moving to a new area. By attending a local MAMA group, mums become part of a network of women wanting to make new friends and support each other through good times and bad. This helps alleviate the feelings of isolation and loneliness often experienced by new mothers, which can sometimes lead to, or be part of, postnatal illness. If there is not a local group in the area, we will pass on details of mums who have contacted us asking to meet other mums for friendship and support. MAMA has a network of self-help groups across the country. Personal contact details can be left on answer machine and appropriate information on local support groups will be sent out. If you wish to speak to someone about postnatal depression contact Depression Alliance Mon – Fri: 19.00 - 22.00 on 02087680123</td>
</tr>
<tr>
<td>MIND (National Association for Mental Health)</td>
<td>08457 660163 (information line) Local Call rate 09.15 - 17.15 email: <a href="mailto:info@mind.org.uk">info@mind.org.uk</a></td>
<td>Mindinfoline PO BOX 277 Manchester M60 3XN</td>
<td>Support and information for people in all forms of mental distress, and their families.</td>
</tr>
<tr>
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<tr>
<td>Miscarriage Association</td>
<td>0131 334 8883 Mon-Friday: 09.00 - 16.00 Answer machine – can leave a message 16.00 - 22.00 volunteers can be contacted: (London) 020 72775316 (Cheshire) 01244 811473</td>
<td></td>
<td>National association providing support and advice to women who have experienced pregnancy loss. Written information on a specific topic can be provided on provision of a stamped addressed envelope.</td>
</tr>
<tr>
<td>National Childbirth Trust (NCT)</td>
<td>0870 444 8707 Mon -Thurs: 09.00 - 17.00 Fri: 09.00 - 16.00 London (Local Call rate)</td>
<td>Alexandra House, Oldham Terrace, Acton, London, W3 6NH</td>
<td>The National Childbirth Trust is the largest and best known childbirth and parenting charity in Europe, and is the voice of parents on antenatal, birth and postnatal issues. They provide a range of quality educational and support services for parents at local level and promote the principle of informed choice for women and their partners. Branches and members almost everywhere. Antenatal classes, breastfeeding counselling, postnatal support. Some specialist groups, including groups for the support of mothers with postnatal depression. The NCT is a registered charity and a membership organisation with over 55,000 members across the UK. Local Contact: changes periodically and the main UK office should be contacted to ascertain the correct details of local NCT contacts.</td>
</tr>
<tr>
<td>Postnatal Depression Project</td>
<td>0131 5387288</td>
<td>Church of Scotland Board of Social Responsibility, Wallace House, 3 Boswall Road, Edinburgh EH5 3RJ</td>
<td></td>
</tr>
<tr>
<td>UK &amp; NATIONAL ORGANISATION</td>
<td>TELEPHONE/ website</td>
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<tr>
<td>Samaritans</td>
<td>08457 909090 (National Helpline) Aberdeen 01224 574488 Elgin 01343 543000 08457 90 91 92 (local rate call)</td>
<td>60 Dee Street Aberdeen AB11 6DS Open 9.00am-00.00pm for callers in person 21 Greyfriars Street Elgin, Moray, IV30 1LF</td>
<td>The Samaritans is a national organisation of charitable status. Its aim is to help unhappy, depressed and suicidal people who wish to speak about any problems, including emotional and health problems. A 24 hour telephone service seven days a week A listening ear and support whenever needed Sympathetic, caring and confidential support</td>
</tr>
<tr>
<td>SANELINE</td>
<td>0845 767 8000 Helpline 12 noon - 02.00 Local Call rate</td>
<td></td>
<td>SANELINE was established in 1992 as the first national out-of-hours telephone helpline offering practical information, crisis care and emotional support to anybody affected by mental health problems - including support to women with postnatal depression and their families. Manned by trained volunteers who:- • offer support and a listening ear during times of crisis • give information to enable you to make informed decisions • put you in touch with services in your local area • provide up to the minute details of medical, complimentary and psychological treatments • help you with current mental health legislation and the mental health system</td>
</tr>
<tr>
<td>UK &amp; NATIONAL ORGANISATION</td>
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</tr>
<tr>
<td>Scottish Women’s Aid</td>
<td>0131 221 0401</td>
<td>12 Torphichen Street Edinburgh</td>
<td>Provide support and practical help for victims of domestic violence.</td>
</tr>
<tr>
<td>Scottish Association for Mental Health</td>
<td>0141 568 7000</td>
<td>Information Centre Scottish Association for Mental Health Cumbrae House, 15 Carlton Court, Glasgow G5 9JP</td>
<td>Please contact the service by phone or email if you have a general enquiry on mental health. We are also able to offer free legal advice. You may simply be looking for a self help group in your area or have a serious complaint about your treatment. Contact our team who can help you make the right choices. We cannot provide: medical advice, counselling, financial advice, representation.</td>
</tr>
<tr>
<td>Shakti Women’s Aid</td>
<td>0131 475 2399</td>
<td>Norton Park 57 Albion Road Edinburgh EH7 5QY</td>
<td>Refuge accommodation, advice and support for black and minority ethnic women.</td>
</tr>
</tbody>
</table>
### Regional & Local Organisations

<table>
<thead>
<tr>
<th>ORGANISATION</th>
<th>TELEPHONE/ website</th>
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<th>DESCRIPTION OF ORGANISATION</th>
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<tbody>
<tr>
<td>Aberdeen Women’s Aid</td>
<td>01224 591 577</td>
<td>66 The Green Aberdeen AB11 6PE</td>
<td>Aberdeen and Aberdeenshire Women’s Aid provides advice, support and information. Refuge accommodation is available in Aberdeen. Women’s Aid counsels men as well as women.</td>
</tr>
<tr>
<td>Aberdeenshire Council Domestic Abuse Outreach Workers</td>
<td>(01779) 484 230 (01358) 720 033</td>
<td>Aberdeenshire North Aberdeen South &amp; Central</td>
<td>Two workers are available to offer support, advice and practical assistance to the victims of domestic abuse. Contact the Duty Social Worker.</td>
</tr>
<tr>
<td>Couple Counselling</td>
<td>01224 648412</td>
<td>14 Rose Street Aberdeen AB10 1UA</td>
<td>Couple Counselling Grampian is a local organisation affiliated to Couple Counselling Scotland. Couple Counselling serves the whole of the North East of Scotland including the Aberdeen City Council area and all the Aberdeenshire Council administrative Areas - Banff &amp; Buchan, Buchan, Formartine, Garioch, Kincardine &amp; Mearns and Marr - and the Moray Council area. Providing a confidential counselling and therapy service for people who have difficulties in their marriage or in other similar intimate personal relationships, including contemplating a permanent relationship, or the after effects of separation and/or divorce. There is also a Young Persons Counselling Service for 11 - 18 year olds who may be experiencing difficulties due to their parent’s separation and/or divorce, or may be having difficulties settling into a new step family. Couple Counselling also offers a psychosexual therapy service. Appointments may be made for confidential counselling, in an ongoing series of consultations, for people of all ages who are experiencing problems in relationships, whether they are married or not. Members of the public can make contact themselves or be referred by health professionals, social workers or other agencies.</td>
</tr>
</tbody>
</table>

For all appointments at the above locations contact the Aberdeen Centre on 01224 648412

For appointments in Moray Tel: 01343 556593

Mon/Thu 16.00 - 21.00

Wed: 09.30 - 12.30

www.couplecounselling.org
Cry-sis Helpline

020 7404 5011
09.00 - 22.00 (7 days per week)

info@cry-sis.org.uk

www.cry-sis.org.uk

B M Cry-sis
London
WC1N 3XX

To provide emotional support and practical help to families with babies who cry excessively and / or sleep poorly, causing disruption and concern to their parents.

Cry-sis is a registered nation wide charity, which is run by a voluntary committee.
It was set up in 1981 and is a self help support group run by parents who have experienced the problems of a crying and / or sleepless baby.
The group is a national network of volunteers who take telephone calls from parents wanting help, practical advice or reassurance about their baby or who simply want to talk to someone who understands.
In the North East of Scotland, this organisation covers the Aberdeen City Council area, all the Aberdeenshire Council administrative Areas of Banff & Buchan, Buchan, Formartine, Garioch, Kincardine & Mearns and Marr and the Moray Council area.
The Cry-sis helpline is an answering service that will redirect callers to a volunteer contact covering their area.
These volunteer contacts have been trained to assist parents, have full back-up from regional advisors, and are kept up to date with current developments in this field.
Cry-sis can provide a range of literature on the subject of crying and / or sleepless babies - please enclose a stamped addressed envelope.
Cry-sis welcome any approach from health professionals who would like information about Cry-sis or the problems faced by parents with crying or sleepless babies - please provide a stamped addressed envelope.
Cry-sis can provide speakers for meetings such as postnatal groups, and mothers and toddlers groups.
Members of the public can make contact direct.
<table>
<thead>
<tr>
<th>Regional &amp; Local ORGANISATION</th>
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<tbody>
<tr>
<td>Domestic Abuse Helpline</td>
<td>Aberdeen City: 01224 625019 Monday – Friday 09.30 - 15.30 Answerphone out with opening hours</td>
<td>47 Belmont Street Aberdeen AB10 1JS</td>
<td>The project offers a FREE, CONFIDENTIAL SERVICE to women living in the city who are experiencing domestic abuse. The project worker will offer you information, advice and support to enable you to decide what you want and then help you follow through with your choices.</td>
</tr>
<tr>
<td>Family Mediation</td>
<td>01343 540801</td>
<td>17 Institution Road, Elgin</td>
<td>Voluntary Organisation that supports families experiencing separation/ divorce, families can refer themselves or through court referrals.</td>
</tr>
<tr>
<td>Fulton MacKay Service</td>
<td>01224 559919 (secretary) email: <a href="mailto:margaret.grant-beer@nhs.net">margaret.grant-beer@nhs.net</a></td>
<td>Fulton MacKay Service Department of Child and Family Mental Health Rosehill House Cornhill Road Foresterhill Aberdeen AB25 2ZG</td>
<td>This is a service for children and young people whose parents or carers have a mental illness. Can help explain mental illness and what is happening to you parents or carers. Can listen to how it feels coping with a mental illness in the family. Can help your parents or carers explain what happens to them when they are ill. Can support other professionals and help them to find relevant materials to use. This service can be accessed by: Young People, Parents and Carers, Professionals who wish to know more about the service and to discuss referrals, GP’s, inpatient and residential staff.</td>
</tr>
<tr>
<td>Grampian Care Data</td>
<td>(0800) 136 225</td>
<td><a href="http://www.grampiancaredata.gov.uk">www.grampiancaredata.gov.uk</a></td>
<td>Provides information about local community care and health information services.</td>
</tr>
<tr>
<td>Regional &amp; Local Organisation</td>
<td>Telephone/Website</td>
<td>Contact Address</td>
<td>Description of Organisation</td>
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<tr>
<td><strong>Grampian Women's Aid</strong></td>
<td>01224 593381</td>
<td>6 Crown Terrace Aberdeen AB11 6HE</td>
<td>Grampian Women's Aid provides advice, support and refuge to women and children who have suffered domestic abuse. The abuse may be physical, sexual or emotional. We operate an office and 4 refuges which are staffed daily to offer practical and emotional support.</td>
</tr>
<tr>
<td><strong>Grampian Police Domestic Abuse Liaison Officer</strong></td>
<td>South Aberdeenshire Local Command Area 01224 387 338</td>
<td>North Aberdeenshire Local Command Area 01224 387 273</td>
<td>Domestic Abuse Liaison Officers are available to provide support and practical guidance to persons who have been abused. The assistance is confidential and can be given over the phone or by a home visit or meeting.</td>
</tr>
<tr>
<td><strong>healthpoint</strong></td>
<td>healthpoint</td>
<td>healthline free phone 0500 20 20 30 Monday - Friday 09.00 - 17.00</td>
<td>Provides a wide range of information on improving health, health conditions and procedures, healthy travel, support groups and health-related services and organisations. Any information requested is sent by post free of charge. All calls are confidential and are answered by trained health advisers</td>
</tr>
<tr>
<td><strong>Homemakers</strong></td>
<td>01343 567251</td>
<td>Pluscarden Clinic Dr. Grays Hospital Elgin</td>
<td></td>
</tr>
<tr>
<td><strong>Manic Depression Fellowship Aberdeen</strong></td>
<td>01224 590435 Fax: 01224 211721 <a href="http://www.mdf.contactbox.co.uk/">www.mdf.contactbox.co.uk/</a></td>
<td>87 Holburn Street Aberdeen AB10 6B</td>
<td>Manic Depression Fellowship Aberdeen is a self help support group for people with manic depression (bipolar disorder) and their carers, friends and family. We offer our services FREE of charge to anyone with an interest in Manic Depression. We offer the following services to our members: Helpline Service offers a listening ear, and advice in times of crisis • You can chat to our staff in a quiet and confidential setting • We have a library of books and video tapes</td>
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</table>
We can provide literature relating to Manic Depression
We have a quiet room where you can use reading material
Material on video can be viewed at the office
We have group meetings and outings for our members

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<tr>
<td>Moray Domestic Abuse Worker</td>
<td>01807 580362</td>
<td></td>
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<tr>
<td>Moray Women's Aid</td>
<td>01343 548549</td>
<td></td>
<td></td>
</tr>
<tr>
<td>National Childbirth Trust (NCT)</td>
<td>0870 444 8707</td>
<td></td>
<td>Local Contact: changes periodically and the main UK office should be contacted to ascertain the correct details of local NCT contacts</td>
</tr>
<tr>
<td>NHS 24</td>
<td>08454 24 24 24 or for text phone users 018001 08454 24 24 24 (Local rate)</td>
<td></td>
<td>Our health information service is there to answer your questions on: Illnesses Conditions NHS services Support groups and organisations Health promotion and disease prevention When you call the health information service the health information advisor will talk to you about your query and can provide you with relevant, up-to-date and quality assured information. Our staff have a substantial amount of information at their fingertips and can: Give you information over the telephone Post information to you Give you useful website addresses Do research for you</td>
</tr>
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<tr>
<td><strong>ParentLine Scotland</strong></td>
<td>0808 800 2222</td>
<td><a href="mailto:parentline@children1st.org.uk">parentline@children1st.org.uk</a>&lt;br&gt;www.children1st.org.uk/parentline</td>
<td>CHILDREN 1st believe in supporting parents so that they can provide the best possible care to their children; ParentLine Scotland is part of that commitment. In the North East of Scotland, this organisation covers Aberdeen City Council area and all the Aberdeenshire Council administrative areas - Banff &amp; Buchan, Buchan, Formartine, Garioch, Kincardine &amp; Mearns and Marr - and The Moray Council area. ParentLine Scotland is a free, confidential and anonymous service. ParentLine Scotland:&lt;br&gt;• enables parents or carers to talk through worries, problems and concerns&lt;br&gt;• listens to any problem, large or small, which concerns parents such as teenage problems, abuse, marital difficulties, children with unsuitable friends, crying babies, bullying, etc&lt;br&gt;• provides information, points parents in the right direction&lt;br&gt;Trained volunteers take the calls, listen and if a solution is required will help to find a way forward. Volunteers aim to help in any way they can.</td>
</tr>
<tr>
<td><strong>Pillar Aberdeen Postnatal Depression Support Group</strong></td>
<td>01224 621266&lt;br&gt;Answerphone out with opening hours&lt;br&gt;<a href="mailto:Pillar@aberdeen.co.uk">Pillar@aberdeen.co.uk</a>&lt;br&gt;www.pillaraberdeen.co.uk</td>
<td>20 Back Wynd, Aberdeen, AB10 1JP</td>
<td>Postnatal Depression Support Group, Tuesday 10.00 - 12.00 noon, crèche available. At the support group, Pillar Aberdeen offers opportunities for social contact to parents experiencing postnatal depression. The Group enables people to meet with others who are experiencing similar problems and enjoy a coffee and a chat. Support is available from trained staff. Although a counselling service is not provided, information and contacts are supplied regarding services and resources, which might be available. Any problems discussed with Pillar workers will be kept confidential, except in exceptional circumstances. Referrals can</td>
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be made by GP, CPN, Health Visitor, and any other professional, associated groups or by those experiencing postnatal depression.

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<tbody>
<tr>
<td>SANDS</td>
<td>Aberdeen Branch</td>
<td></td>
<td>Registered Charity, self-help. Covering Aberdeen, Aberdeenshire, Moray</td>
</tr>
<tr>
<td></td>
<td>01358 701707</td>
<td></td>
<td>Stillbirth and Neonatal Death Society (SANDS) is a national organisation which exists to support those whose baby has died at, or around the time of, birth.</td>
</tr>
<tr>
<td></td>
<td>Banff Branch</td>
<td></td>
<td>The Stillbirth and Neonatal Death Society supports parents and families through a national network of over 200 self help groups and raises awareness throughout the wider community regarding the impact of a stillbirth or neonatal death.</td>
</tr>
<tr>
<td></td>
<td>01261 812238</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Fraserburgh and Peterhead</td>
<td>01771 637692 or 01779 821238</td>
<td></td>
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<tr>
<td></td>
<td>Moray</td>
<td>01542 882587</td>
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Integrated Flow Chart Pathway for: Management of Perinatal Mental Health Care

**Identify Risk Factors – as per Antenatal Summary Sheet Checklist**

- **Low Risk**: Normal Care
- **High Risk**
  - Record
  - Monitor at visits
  - Refer to GP
  - Notify HV

NB: If positive risk factors are identified, for example, psychosis, history of depression, anxiety, etc., then a specialist psychiatric assessment is recommended.

**Raise General Awareness**
- Mental health, mood change, antenatal depression, PND, support agencies

**Provide appropriate information**

**To include**: Emotional wellbeing, mood changes, postnatal depression & perinatal psychosis

If woman did not attend antenatal classes discuss emotional wellbeing, PND, etc., at approx 34 week visit.

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**EPDS**
- **Home visit or “in private” longer clinic appointment**

**Postnatal 0-9**
- Antenatal Summary Sheet Check/ Risk Factors + EPDS score + Clinical judgement + Relevant Information
- If PND is suspected follow the appropriate linear pathway below.

- **No Action**
  - Assess client further at home or clinic
  - Reassess EPDS after 2 weeks
  - Offer extra support/contact if required.

- **Referral System**
  - CMHT
  - Other appropriate agencies
  - GP
  - GC to be achieved at all referrals
  - Other Primary Care Team

- **Continue to review support**
  - Repeat EPDS at regular intervals to monitor

- **Emergency planning**
  - Emergency planning involves removal in more severe cases
  - Review treatment if not significant improvement

---

**Midwifery Postnatal**
- Immediate referral of all women with mental health problems during pregnancy to Mental Health Services
- Offer discussion of birth with mother
- Discuss mood changes and assess
- Monitor maternal mood and infant relationship
- Take appropriate action based on assessment, risk factors and clinical judgement
- Accurate and timely information to be passed from Hospital to Community Maternity

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**Transfer to Health Visitor**
- Accurate and timely information to be passed from Community Midwife to Health Visitor
- Assess mother/baby relationship
- Take appropriate action based on assessment, risk factors and clinical judgement

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**Edinburgh Postnatal Depression Scale**
- Health Visitor to administer at 6-8 weeks postnatal
- Assess mother and baby relationship
- Take appropriate action based on assessment, risk factors, EPDS score and clinical judgement

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**Family Health Assessment**

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57
MENTAL HEALTH ASSESSMENT TOOL

Edinburgh Postnatal Depression Scale (EPDS)

Mother's Name ............................................ Phone No.----------------------
Unit No: .............................................
Address ............................................. Today's Date......................
........................................................................ Date of Delivery ...........
...................................................................
Baby's Age (in weeks) ..................... Mother's Age......................
Health Visitor/ Midwife (delete appropriately) GP .....................
Signature.......................................... GP........................................
Print Name..........................................

THE EDINBURGH POSTNATAL DEPRESSION SCALE

How are you feeling?
As you have recently had a baby, we would like to know how you are feeling now. Please underline the answer which comes closest to how you have felt in the past 7 days, not just how you feel today. Here is an example, already completed:

I have felt happy:
Yes, most of the time
Yes, some of the time
No, not very often
No, not at all

This would mean, 'I have felt happy some of the time during the past week'. Please complete the other questions in the same way.

In 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 been anxious or worried for no good reason:
   No, not at all
   Hardly ever
   Yes, sometimes
   Yes, very often

5. I have felt scared or 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 at 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

EPDS Total Score =

EDINBURGH POSTNATAL DEPRESSION SCALE SCORING SHEET
1. I have been able to laugh and see the funny side of things:
   - As much as I always could 0
   - Not quite so much now 1
   - Definitely not so much now 2
   - Not at all 3

2. I have looked forward with enjoyment to things:
   - As much as I ever did 0
   - Rather less than I used to 1
   - Definitely less than I used to 2
   - Hardly at all 3

3. I have blamed myself unnecessarily when things went wrong:
   - Yes, most of the time 3
   - Yes, some of the time 2
   - Not very often 1
   - No, never 0

4. I have been anxious or worried for no good reason:
   - No, not at all 0
   - Hardly ever 1
   - Yes, sometimes 2
   - Yes, very often 3

5. I have felt scared or panicky for not very good reason:
   - Yes, quite a lot 3
   - Yes, sometimes 2
   - No, not much 1
   - No, not at all 0

6. Things have been getting on top of me:
   - Yes, most of the time I haven't been able to cope at all 3
   - Yes, sometimes I haven't been coping as well as usual 2
   - No, most of the time I have coped quite well 1
   - No, I have been coping as well as ever 0

7. I have been so unhappy that I have had difficulty sleeping:
   - Yes, most of the time 3
   - Yes, sometimes 2
   - Not very often 1
   - No, not at all 0

8. I have felt sad or miserable:
   - Yes, most of the time 3
   - Yes, quite often 2
   - Not very often 1
   - No, not at all 0

9. I have been so unhappy that I have been crying:
   - Yes, most of the time 3
   - Yes, quite often 2
   - Only occasionally 1
   - No, never 0

10. The thought of harming myself has occurred to me:
    - Yes, quite often 3
    - Sometimes 2
    - Hardly ever 1
    - Never 0
EPDS SCORING SYSTEM – Flow Chart

Each question is scored 0-3, increasing according to the severity of symptoms experienced by the woman. The total score is calculated by adding all 10 question scores together. A total score of 0 should be approached with caution as it may be a false positive or indicate literacy difficulties. A total score of 10 or above in the postnatal period indicates possible PND and the need for further assessment, as per flow chart below. A positive answer, of any degree to Q. 10 of the EPDS Questionnaire should lead onto discussion and immediate referral to Mental Health Services.

Postnatal 0-9

- Antenatal Summary Sheet Checklist / Risk Factors + EPDS Score + Clinical judgement + Relevant Information
- If PND is suspected follow the appropriate linear pathway below.

NO ACTION

- Assess client further at home or clinic
- Repeat EPDS after 2 weeks
- Offer extra support/ contact

Postnatal 10-13

- Home visits/extra support
- Inform GP
- GP consider referral to CMHT
- Discuss treatment options in Primary Care

Postnatal 14-19

- If EPDS 10 + after 2 weeks inform GP and discuss management options in Primary Care
- Offer extra support/ contact if required.

Postnatal 20+

- Discuss with GP
- GP refer to CMHT/ psychiatrist for urgent assessment and care plan

Referral System
- CMHT
- Other Appropriate Agencies
- GP or Health Visitor
- GP to be advised of all referrals out with Primary Care Team

Ongoing liaison between services involved in care – review treatment if not significant improvement
Community Mental Health Team – Referral sheet
Send copy to GP □ HV □ Other please specify……………………………………………….
(Please ✓ all boxes appropriately)

Referral Date:…………………..    GP: ………………………………
Referred by: …………………….    Address: …………………………
Designation: ……………………..    …………………………………….
Address: …………………………    …………………………………….
Tel Contact: ……………………..    Tel: ……………………………….
Fax: ………………………………    Fax: ……………………………….

Unit No:…………………        Marital Status:…………………
Name: …………………………    Occupation: ……………………..
Address: …………………………    Parity: …………………………….
DOB: ………………Age: …………    No of live children: … Ages:…….
EDD: ……………… or Age of Baby:………..    Sex M □ F □

Edinburgh Postnatal Depression Scale Score =

<table>
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<tr>
<th>Date:</th>
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Current Medication: Yes □ No □ please provide details:

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<th>Medication</th>
<th>Dosage</th>
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Medical history: Yes □ No □
Please detail below

Psychiatric history: Yes □ No □
Please detail below including severity and relevant family psychiatric history

Other professionals / agencies involved in care: Yes □ No □
Please detail below

Family / Social Supports exist: Yes □ No □
Please provide further details, eg, concerning whether family are supportive/ nearby, close friends around, or other people who are supportive…

Reason for referral and additional Information
Including information, ie, of early wakening, changes to sleep pattern, changes to eating, socialisation, mood patterns…

Continue over the page if required
POLICY

Admission of Mother
and Baby to Ward 4
including
Room Access / Exit
and in the event of
an Emergency

Audrey Henderson
Ward Manager
21.4.03
INDEX

1 Statement

2 Risk Assessment on Ward 4

3 Risk Assessment Tool

4 Pre-setting Conditions

5 a) Contract for mother
   b) Information leaflet for mother

6 Recommendations

7 List of information used
The Scottish Intercollegiate Guidelines Network (SIGN) states that “The option to admit mother and baby together to a specialist unit should be available. Mothers and babies should not routinely be admitted to general psychiatric wards”.

It is felt that admitting mothers and babies together to a general psychiatric ward can compromise their safety. As there are limited resources for “mother and baby” specialist units it is, therefore, necessary to carry out a risk assessment on Ward 4 as an open general psychiatric ward.

The aim of this is to:

Establish an agreed plan of action from Consultant Psychiatrist, Senior Nursing Staff and Health & Safety Manager so as to minimise risk(s) to mother and baby when admission is planned.
RISK ASSESSMENT

To be carried out by Consultant Psychiatrist and Senior Nurse prior to deciding on whether admission is appropriate.

1. Will the pre-setting conditions have been adhered to?
2. Is mother well enough to adhere to contract?
3. Is it necessary that baby is admitted?
4. Is the designated mother and baby room available?
5. Is there designated medical cover for baby?
6. Are there currently any other patients on the Ward who may pose a direct risk to baby ie child abusers, etc?
7. Is there already a mother and baby admitted to Ward 4?
8. Has mother a previous history of harm to children or intending to harm baby?
9. Are there currently any infections on the Ward that would put baby at risk?

If the answer is no to any of the above, baby must not be admitted.

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐
10. Is there any other reason why baby should not be taken into Ward 4?

If the answer to questions 6 – 9 is yes, baby must not be admitted.

Additional Notes:

...........................................................
...........................................................
...........................................................
...........................................................
...........................................................
...........................................................
...........................................................

Signature(s) ........................................
on
Completion .................................

File in psychiatric notes on completion
Pre-setting Conditions for Admission

1. No mother and baby should be admitted in an emergency situation (mother only).

2. Mother and baby should only be admitted if it has been a planned admission.

3. The Consultant Psychiatrist must consult a senior nurse to discuss the necessity of admission (senior nurse being Ward Manager, Deputy Ward Manager or Senior Staff Nurse who has been Identified as a Team Leader on Ward 4).

4. The adjoining room on Ward 4 must be used (no other room is negotiable).

5. No more than one mother and baby should be admitted at any given time due to lack of resources.

6. A risk assessment must be completed by Consultant and senior nurse to ascertain whether the environment and others in it do not pose an unnecessary risk.

7. Admission of baby must be classified as essential rather than preferred and must benefit mother and no other.

8. If mother is not able mentally or physically to care for baby at all times, then alternative care should be sought until fit to do so.

9. Mother must be able to agree to the contract and understand potential risks.

10. No form of close or special observations must be used on the baby “to maintain his/her safety” or for any other reason. This puts unreasonable responsibility on to nursing staff and is not good practice.

11. A care plan should be documented in medical and nursing kardex for the baby, which should clarify the following:

   a) Who is the baby’s RMO?
   b) Who medically is contacted in the event of the baby appearing unwell in and out of hours?
   c) Who is contacted in the event of an emergency?
   d) Depending on the age of the baby, are there health checks required and if so who will do these?
   e) Do other members of the multidisciplinary team need to be advised of the circumstances?
Dr Gray’s Hospital

WARD 4

- Contract to be signed by mother
- Witness signature from Consultant Psychiatrist or Senior Nurse

I, ……………………………………………. understand that Ward 4 is an open general psychiatric ward and agree that whilst an in-patient and have baby ………………………………… present, I will be responsible for his/her care and safety.

I have read and understood the information leaflet.

Patient’s Name:…………………………………………………………

Witness Signature:……………………………………………………

Date:…………………………………………………………
Ward 4 is a general psychiatric ward which caters for people who have mental health problems. Due to this some behaviour exhibited may be observed to be unusual or difficult to understand.

It has been identified that you would benefit from admission to Ward 4 and we feel it is necessary for your own and your baby’s wellbeing that he/she is taken into hospital with you.

As a mother, we are aware that you would have many natural concerns and whilst we respect and understand these, we ask you to respect the environment you will be in and take account of this.

In order to safeguard you and your baby as far as is possible we would like to make you aware of the following:

a) You will be allocated your own bedroom and another for your baby. There is an adjoining door so you will have easy access 24 hours a day.

b) Both doors have been fitted with a lock and this means that only medical/nursing staff have access. You will be consulted if any other staff member requires entry ie domestic staff.

c) You will require to ask a member of nursing staff to get into each room and will be advised how to exit the room. You will be advised for security not to divulge this to anyone.

e) If we feel there has been security breach you will be advised.

f) We would ask that you refrain from taking your baby into the designated smoking room if this is a requirement for yourself due to Health & Safety.

Prior to your admission a risk assessment will be carried out to ensure we have minimised any potential risks and we will review this as necessary.
We ask that you take responsibility for the wellbeing of your baby so as to establish a healthy attachment to your baby and increase your confidence in your maternal role.

Nursing staff will assist you if required, but will encourage you to participate fully.

Family are encouraged to support you in your role and are welcome to visit up until 9.00 pm in the evening providing it does not interrupt your rest or treatment.

Medical/nursing staff will be aware who to contact in the event that your baby becomes unwell in any way.

If you have any other concerns, please ask medical and/or nursing staff.

Thank you.
Recommendations in order to comply

with enclosed Draft Policy

1. It has been identified that a pre-setting agreement needs to be agreed on by a Consultant(s) and senior nursing staff as part of policy.

2. Responsibility of baby care needs to be taken on by the mother as RMN’s are not qualified in this role. Therefore, a contract needs to be agreed upon perhaps accompanied by a patient information leaflet.

3. All RMN’s on Ward 4 should undergo some “core skills training” so as to be able to take full responsibility for the baby, but to be able to act reasonably in their professional capacity and do no harm ie:

   - feeding (dependent on age)
   - temperature of room
   - positioning of baby
   - prevention of cot death
   - identify when medical attention is required, etc.

4. It must be agreed that no other rooms should be used for mother and baby apart from designated rooms which have an adjoining door.

5. Changes to this area required:

   a) Both doors require to be fitted with a coded key pad so that entry is minimised to medical/nursing staff, mother and others who are invited.

   b) Essential equipment is required to be bought:

      - washable crib
      - linen for crib
      - changing facilities for baby
      - thermometer for checking room temperature.
1  SIGN guidelines on Post Natal Depression and puerperal psychosis.

2  Nursing Midwifery Council.

3  Risk Manager Ian Curphy.

4  Information from Perinatal Nurse Specialist at Gartnaval Royal Hospital.
BIBLIOGRAPHY / REFERENCES

A Framework for Mental Health Services in Scotland (1997), Scottish Executive


Beck, C ; T; Gable, R K; (Sept/ Oct 2000) Post-partum depression screening scale development of psychometric testing. Nursing Research Vol 49, No 1

Beck, C T; Gable, R K; (July /August 2001) Comparative analysis of performance of the post-partum depression screening scale with 2 other depression instruments. Nursing Research Vol 50, No 4


Health Education Board for Scotland (HEBS) Ready Steady Baby! A guide to pregnancy, birth and early parenthood Revised 2nd Ed. 2002. HEBS
BIBLIOGRAPHY / REFERENCES Continued

In Draft format *Guideline for the Management of Postnatal Depression in Grampian.* NHS Grampian, 2002. (Postnatal Depression Redesign Project materials, not previously circulated)

In Draft format *Postnatal Depression Can Affect Families Too.* NHS Grampian 2002. (Postnatal Depression Redesign Project materials, not previously circulated)

In Draft format *Tell me about Postnatal Depression!* NHS Grampian, 2002. (Postnatal Depression Redesign Project materials, not previously circulated)


National Centre for PTSD Post Traumatic Stress Disorder URL http://www.ncptsd.org/facts/general/fs/_what_is_ptsd.html 28.01.05


NHS Dumfries and Galloway. *Integrated Care Pathway Antenatal and Postnatal Depression,* 2002


NHS Health Scotland. *Our National Health: A plan for action, a plan for change 2000*

North East of Scotland Child Protection Committee (NESCPC). *Child Protection Guidelines1997*


BIBLIOGRAPHY / REFERENCES Continued


Scottish Executive. Responding to Domestic Abuse: Guidelines for Health Care Workers in NHS Scotland, 2003


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This document was widely circulated for consultation and comment during the summer of 2004 to NHS Grampian, Local Authority and voluntary sector. All feedback from the consultation process was gratefully received and alterations, reflecting feedback comments have been made to the Guidelines.