

## **PERINATAL MENTAL HEALTH SERVICES IN SCOTLAND AND THE MAIN FEATURES OF THE CURRENT MENTAL HEALTH STRATEGY IN SCOTLAND**

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### **BACKGROUND**

This briefing paper has been prepared to assist the Committee with its understanding of the approach the Scottish Government and Scottish NHS have taken to the development of Perinatal Mental Health Policy and Services, including the use of Integrated Care Pathways. In addition the main features of the current mental health strategy in Scotland, *Delivering for Mental Health*, are briefly described.

### **INTRODUCTION**

#### **Perinatal Mental Health**

The Perinatal mental health period spans conception to two years after childbirth. It is during this period that women are most likely to be admitted to a psychiatric hospital, are at increased risk of experiencing an affective mental illness, and those with a pre-existing mental illness are more prone to relapse or recurrence of the condition<sup>1</sup>.

For every 1000 live births, 100-150 women will suffer a depressive illness and one or two women will develop a puerperal psychosis<sup>2</sup>. Failing to treat either illness may result in a prolonged, detrimental effect on the relationship between the mother and baby and on the child's psychological, social and educational development. Longer term negative influences of mothers' postnatal depression, particularly in boys, on intelligence quotients have been demonstrated<sup>3</sup>.

Mental illness is also a significant factor in maternal morbidity. The report from the Confidential Enquiry into Maternal Deaths found that psychiatric disorders contributed to 12 per cent of maternal deaths and that, deaths from suicide are the leading cause of maternal death<sup>4</sup>.

It is proposed that perinatal mental health is a concern for all professionals and while much of the literature focuses on postnatal depression, there are other conditions that require further research, including the perinatal needs of women with pre-

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<sup>1</sup> Currid, T. (2004), Improving perinatal mental health care, *Nursing Standard*, 19 (3), 40-43

<sup>2</sup> A mood disorder accompanied by features such as loss of contact with reality, hallucinations, severe thought disturbance, and abnormal behaviour

<sup>3</sup> Postnatal Depression and Puerperal Psychosis, A National Clinical Guideline, Scottish Intercollegiate Guidelines Network, SIGN Executive, June 2002, Introduction, page 1

<sup>4</sup> Currid, T. (2004), Improving perinatal mental health care, *Nursing Standard*, 19 (3), 40-43

existing mental illnesses, puerperal psychoses, eating disorders and phobias, and the needs of their partners<sup>5</sup>.

### **UK Shortfall in Perinatal Services**

In 2006, the mental health charity, *Mind*, published the report *Out of the blue? Motherhood and depression*. The research around the experiences of post- and antenatal mental distress revealed that<sup>6</sup>:

- Contrary to national guidelines, 63% of women admitted to hospital were on general psychiatric wards;
- Over two-thirds of women had to wait a month or more for treatment, while 10 per cent waited over a year;
- 75 per cent of women were prescribed medication with less than 20 per cent being offered Cognitive Behavioural Therapy;
- 90% of women attributed their problems in getting care to a lack of understanding by health professionals and poor advice and information.

*Mind* propose that many health professionals caring for mothers have had insufficient training to identify mental health problems such as picking up the risk factors for the development for mental ill health e.g. the identification of risks such as history of mental health problems should be routine in early pregnancy.

*Mind* noted the shortcomings in specialist service provision as follows:

- 75 per cent of England's mental health trusts have no Mother and Baby Unit (MBU) or access to one and less than 50 per cent have any kind of specialist perinatal mental health service;
- There are only 16 MBUs in England, one in Wales, two in Scotland and none in Northern Ireland; and
- There is a lack of standards for MBUs with number of beds ranging from two to ten.

## **PERINATAL MENTAL HEALTH POLICY IN SCOTLAND**

### **Overview**

This section outlines a brief overview of policy and service developments in this area, with the sections following describing each development in further detail.

*SIGN Guideline* - The Scottish Intercollegiate Guidelines Network (SIGN) identified considerable geographic variation in Scotland in the management of perinatal mental health, including the management of postnatal depression; the coordination between primary care teams, health visitors and midwives with community psychiatric team members, in the degree of specialisation of these services; and in the access to suitable facilities to admit mother and baby together if necessary. In response, in 2002, SIGN published a Scottish national clinical guideline for *Postnatal Depression and Puerperal Psychosis*. "The guideline includes screening, diagnosis, prevention and management involving both primary and secondary care, leading to an integrated and effective multidisciplinary approach"<sup>7</sup>.

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<sup>5</sup> Currid, T. (2004), Improving perinatal mental health care, *Nursing Standard*, 19 (3), 40-43

<sup>6</sup> [www.mind.org.uk/News+policy+and+campaigns/Press/2006051MindWeek06.htm](http://www.mind.org.uk/News+policy+and+campaigns/Press/2006051MindWeek06.htm)

<sup>7</sup> Postnatal Depression and Puerperal Psychosis, A National Clinical Guideline, 60, Scottish Intercollegiate Guidelines Network, SIGN Executive, June 2002, Introduction, page 2

*Framework for Mental Health Services* - Subsequent to the SIGN guidance, the Mental Health (Care and Treatment) (Scotland) Act 2003 was passed and includes provisions<sup>8</sup> to allow mothers with postnatal depression to be admitted to hospital accompanied by their child. A working group was established to anticipate the legislation and the outcome was an additional service profile on *Perinatal Mental Illness/Postnatal Depression Hospital Admission and Support Services (March 2004)* being added to the Scottish Executive Health Department's Framework for Mental Health Services in Scotland. This framework is a living document which is kept up to date when new sections or expanded entries are required<sup>9</sup>.

*Delivering for Mental Health* - In 2006, the Scottish Executive and NHS Scotland published *Delivering for Mental Health*, a national mental health delivery plan. The plan proposes "a functional approach that focuses on the key elements of services that need to be in place at each point in a journey of care so that clinicians, service users and carers can be clear about what needs to be delivered". Part of the plan focuses on enhancing specialist services including Perinatal Mental Health Services. Work was completed in 2006 on a national and regional analysis of perinatal service needs and the implications for service redesign.

## **SIGN – Guideline 60 Postnatal Depression and Puerperal Psychosis**

### Recommendations

The guideline provides recommendations based on current evidence for best practice in the management of postnatal depression and puerperal psychosis. Some of the main recommendations found in the guideline are summarised as follows<sup>10</sup>:

- Diagnosis, screening and prevention:
  - Procedures should be in place to ensure all women are routinely assessed during the antenatal period for a history of depression – many areas in Scotland have instituted screening, often in the context of integrated care pathways for the detection and management of postnatal depression;
  - All women should be screened during pregnancy for previous puerperal psychosis, history of other psychopathology (especially affective psychosis and family history of affective psychosis); and
  - The current research base for preventative interventions in low risk women is extremely limited;
- Management;
  - Both depression and puerperal psychosis should be treated in the same way as depression at any other time with the additional considerations regarding the use of drug treatments when pregnant and breast feeding;
  - Psychosocial interventions and interventions that work with more than one family member at a time should be considered; and
  - The option to admit mother and baby to a specialist unit should be available; they should not be routinely admitted to general psychiatric wards.

### Implementation

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<sup>8</sup> These provisions came into force in April 2005

<sup>9</sup> [www.show.scot.nhs.uk/publications/mental\\_health\\_services/mhs/](http://www.show.scot.nhs.uk/publications/mental_health_services/mhs/)

<sup>10</sup> Postnatal Depression and Puerperal Psychosis, A National Clinical Guideline, 60, Scottish Intercollegiate Guidelines Network, SIGN Executive, June 2002, Introduction, pages 3-10

The implementation of the guideline is the responsibility of each NHS Trust, however the guideline proposed **Integrated Care Pathways (ICPs)** as a potential method for its implementation and noted that “*ICPs for perinatal disorders have been developed in several Health Board Areas throughout Scotland*”<sup>11</sup>. A general description of ICPs is included at Appendix 1. ICPs have been in use in NHSScotland since the mid 1990s. At the time of the guideline development five Health Board/Primary Care Trust areas had an ICP in use or being piloted and three areas were working towards an ICP. The following information on the design of the ICPs is extracted from the SIGN guideline<sup>12</sup>:

The ICPs currently in use in Scotland all have flow charts as their core, with a comprehensive and easy to follow format that illustrates the care components, options, roles, lines of consultation and referral for all health professional involved. They also include specific documentation reflecting the care pathway and, to a greater or lesser extent, have provision to detail variances from this for specific cases. The other features common to the Perinatal ICPs in use are:

- Antenatal period:
  - Explanation of the ICP to expectant mothers;
  - Screening of risk factors;
  - Available options dependent on risk factors;
  - Provision of information to and education of expectant mothers (and fathers);
- Postnatal period;
  - Details of screening through use of EPDS;
  - Available options related to clinical judgement and EPDS results;
  - Criteria for consultation with primary care;
  - Criteria for consultation with/or referral to secondary care and other support services;
- Additional features present in some ICPs;
  - Optional use of EPDS during antenatal period;
  - Use of locally developed evidence-based checklist for risk factor assessment;
  - Midwifery interventions during early postnatal stage;
  - Access to records for all professionals e.g. use of patient-held records.

### **Framework for Mental Health Services**

(Additional service profile on *Perinatal Mental Illness/Postnatal Depression Hospital Admission and Support Services* added to Framework in *March 2004*).

The service profile for Perinatal Mental Illness/Postnatal Depression Hospital Admission and Support Services sets out approaches for an admission template for the organisation of services and supports to allow mothers suffering from such conditions to be admitted to hospital accompanied by their child. The template is consistent with the Mental Health (Care and Treatment) (Scotland) Act 2003 which includes provisions designed to improve the care of mothers with perinatal mental illness, to allow mothers to be admitted to hospital accompanied by their child and the required interventions (e.g. immunisations) to be undertaken while mother and child are in hospital and to ensure continuity of care on discharge.

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<sup>11</sup> Postnatal Depression and Puerperal Psychosis, A National Clinical Guideline, 60, Scottish Intercollegiate Guidelines Network, SIGN Executive, June 2002, Introduction , pages 16-17

<sup>12</sup> Postnatal Depression and Puerperal Psychosis, A National Clinical Guideline, 60, Scottish Intercollegiate Guidelines Network, SIGN Executive, June 2002, Introduction , pages 16-17

The following is a summary of the main 'dimensions of care' and associated 'descriptions of need' from the template<sup>13</sup>:

1. Planning – The requirement to assess need for local or area Unit and interagency services required, with regard to public involvement processes from an early stage;
2. Legal Issues:
  - a. Regard to be taken of all related legislative positions, including among others the Mental Health (Care and Treatment) (Scotland) Act 2003 and Protection of Children (Scotland) Act 2003 – the needs of the child or unborn child are paramount, including the status of the child in the Unit and the duty of care to mother and child;
  - b. Admission criteria – must be clear and available to all referrers;
  - c. Parental Rights/Responsibilities – Parental rights in each case must be established, including respecting the mother's wishes as to family involvement;
3. Unit Design – minimum expectations for a Mother and Baby Unit (MBU):
  - a. Size of the unit, e.g. with day/play area large enough to accommodate toys etc.
  - b. Single bedrooms to accommodate cot and changing facilities;
  - c. Security of unit e.g. electronic baby tagging;
  - d. Baby feed preparation facilities;
  - e. Safe environment for children e.g. safety gates, temperature control;
  - f. Family accommodation; and
  - g. Disability needs;
4. Integrated Care Pathway (ICP)
  - a. As recommended by SIGN (60) should be developed to reflect local needs and conditions;
  - b. ICP should be kept under ongoing review and evaluation;
5. Assessment:
  - a. Identifying and building relationships with those at risk via screening;
  - b. Pre-admission protocol;
  - c. Admission – single point of referral; mother and baby have separate needs assessment; allocated key worker required for mother and separate for baby; and
  - d. Advocacy requirements;
  - e. Discharge planning – transition to local services;
6. Clinical Practice:
  - a. Care Plan – separate care plans for mother and child agreed by multidisciplinary team with emphasis on effects of illness on parenting abilities and effects of parenting responsibilities on mother's mental state;
7. Risk Management:
  - a. Ongoing review of potential risk of harm to (patient's ) self and baby or by others;
  - b. Infection control, including childhood illnesses;
  - c. Child Protection;
  - d. Physical health of child – continuity of child health care by health visitor;
  - e. Critical incident management;
  - f. Security of Unit;

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<sup>13</sup> Framework for Mental Health Services in Scotland, Section 3, Service Profiles, Perinatal Mental Illness/Postnatal Depression Hospital Admission and Support Services  
[www.show.scot.nhs.uk/publications/mental\\_health\\_services/mhs/](http://www.show.scot.nhs.uk/publications/mental_health_services/mhs/)

8. Human Resources – workforce planning, organisational development and professional accountabilities;
9. Awareness, information, networking and research, e.g. accessible information for mothers and others covering perinatal mental illness, the Unit and its services.

### **Delivering for Mental Health**

Part of the plan focuses on enhancing specialist services including Perinatal Mental Health Services. Work was completed in 2006 on a national and regional analysis of perinatal service needs and the implications for service redesign. The first Mother and Baby Unit opened in Glasgow and provides services for the west of Scotland and a further unit opened in Livingstone in 2007 to provide services for the east and the north. Two Health Boards, Grampian and Forth Valley have developed local solutions and Health Boards across Scotland have been developing care pathways (ICPs) for the delivery of perinatal services covering both community and inpatient services<sup>14</sup>.

As stated above, Scotland's first Mother and Baby Unit was opened by NHS Greater Glasgow in October 2004. The £1.3m six bedded unit on the Southern General Hospital site enables mothers to stay with their babies while they undergo treatment for a range of mental illnesses, including postnatal depression and puerperal psychosis. The Unit is staffed by a multidisciplinary team of 24 health professionals, including psychiatrist, mental health nurses, nursery nurses, a health visitor, social worker and nursing assistants<sup>15</sup>.

Referrals to the Unit are accepted from a wide range of health professionals including GPs, health visitors and midwives.

The development of the Unit is part of wider plans to improve services for pregnant women and new mothers who experience mental illness across Greater Glasgow. A new community team, based at the Mother and Baby Mental Health Unit has been created to support the vast majority of women who do not need inpatient care. A screening system (such as that referred to in both the SIGN Guideline and Framework for Mental Health Services outlined above) to help midwives and health visitors identify pregnant women who have, or are at risk of developing, mental health problems is also being rolled out across Glasgow.

## **CURRENT MENTAL HEALTH STRATEGY IN SCOTLAND – DELIVERING FOR MENTAL HEALTH**

### **Overview**

*Delivering for Mental Health*<sup>16</sup> is the current key strategy of the Scottish Executive. The delivery plan is supportive of innovation, so that local populations can develop and deliver local solutions that best meet their needs, in that it is “not prescriptive about the particular structure of services that need to be in place to deliver good outcomes”, instead a “functional approach” is proposed that “focuses on the key elements of services that need to be in place at each point on a journey of care so

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<sup>14</sup> <http://openscotland.gov.uk/Publications/2006/11/30164829/11>

<sup>15</sup> Information extracted from [www.nhsggc.org.uk/content/default.asp?page=s348\\_1](http://www.nhsggc.org.uk/content/default.asp?page=s348_1)

<sup>16</sup> Delivering for Mental Health, Scottish Executive (2006), [www.scotland.gov.uk/Publications/2006/11/30164829/0](http://www.scotland.gov.uk/Publications/2006/11/30164829/0)

*that clinicians, service users and carers can be clear about what needs to be delivered*<sup>17</sup>.

The expectations are described in that using this functional model for any mental health service it would be expected to see “*a description of the purpose of the service, the target population, as well as arrangements for standardised joint assessment, referral, admission and discharge, and a range of interventions and therapies which meet the need of the community*”<sup>18</sup>.

Aside from improved treatments for mental illness, it is noted that there is also now a better understanding of the importance of other interventions and supports, such as exercise, diet, better physical health and good relationships in promoting good mental health and recovery and that this evidence must be used effectively in planning service delivery.

### **Key Areas of the Strategy**

The strategy focuses on eight key areas:

1. Improving patient and career experience of mental health services;
2. Responding better to depression, anxiety and stress;
3. Improving the physical health of people with mental illness;
4. Better management of long-term mental health conditions;
5. Early detection and intervention in self-harm and suicide prevention;
6. Manage better admission to, and discharge from, hospital;
7. Child and adolescent mental health services; and
8. Enhance specialist services, including forensic services, Perinatal Mental Health services and Eating Disorders.

The strategy also identifies areas of further work: mental health and substance abuse; Improving services for older people with mental health problems; Learning disability co-morbidity; mental health and employment; and implementation of the Mental Health (Care and Treatment) (Scotland) Act 2003.

### **Commitments of the Strategy**

The strategy made 14 commitments with timescales as outlined in the ‘Commitments’ Table below, which is extracted and summarised from *Delivering for Mental Health*<sup>19</sup>. The targets support the delivery of three HEAT<sup>20</sup> targets as follows:

Targets	Timescale
<b>Target 1:</b> Reduce the annual rate of increase of defined daily dose per capita of antidepressants to zero by 2009/10.	2009/10
<b>Target 2:</b> Reduce Suicides in Scotland by 20% by 2013 (existing target).	2013
<b>Target 3:</b> Reduce the number of readmissions (within one year) for those that have had a hospital admission of over 7 days by 10% by the end of December 2009	Dec 2009

<sup>17</sup> Delivering for Mental Health, Scottish Executive (2006), page vii, [www.scotland.gov.uk/Publications/2006/11/30164829/0](http://www.scotland.gov.uk/Publications/2006/11/30164829/0)

<sup>18</sup> Delivering for Mental Health, Scottish Executive (2006), page vii, [www.scotland.gov.uk/Publications/2006/11/30164829/0](http://www.scotland.gov.uk/Publications/2006/11/30164829/0)

<sup>19</sup> Delivering for Mental Health, Scottish Executive (2006), pages 20-21, [www.scotland.gov.uk/Publications/2006/11/30164829/0](http://www.scotland.gov.uk/Publications/2006/11/30164829/0)

<sup>20</sup> HEAT Targets are a core set of Ministerial objectives, targets and measures for the NHS. They are set for a three year period and progress measured through the Local Delivery Plan process

Commitments	Timescale	Related HEAT Target
<b>Commitment 1:</b> Develop a tool to assess the degree to which organisations and programmes meet our expectations in respect of equality, social inclusion, recovery and rights.	Pilot 2007 Implemented 2010	Target 3
<b>Commitment 2:</b> Have in place a training programme for peer support workers by 2008 with peer support workers being employed in three board areas, later that year	Pilot completed by end 2008	Targets 2 & 3
<b>Commitment 3:</b> Work with GPs to ensure that new patients presenting with depression will have an assessment using a standardised tool and a matched therapy appropriate to the level of need and develop treatment models for those who have depression and anxiety and who have coronary heart disease and/or diabetes who are identified under the new QOF arrangements	2009	Target 1
<b>Commitment 4:</b> Increase the availability of evidence-based psychological therapies for all age groups in a range of settings	2010	Target 1
<b>Commitment 5:</b> Improve the physical health of those with severe and enduring mental illness by ensuring that every such patient, where possible and appropriate, has a physical health assessment at least once every 15 months	2009	Targets 2 & 3
<b>Commitment 6:</b> NHSQIS will develop the standards for ICPs for schizophrenia, bi-polar disorder, depression, dementia and personality disorder by the end of 2007. NHS Board areas will develop and implement ICPs and these will be accredited from 2008 onwards.	Standards - Summer 2007 ICP development & accreditations 2009	Targets 1, 2 & 3
<b>Commitment 7:</b> Key frontline mental health services, primary care and accident and emergency staff will be educated and trained in using suicide assessment tools/suicide prevention training programmes.	50% of target staff trained by 2010	Targets 2 & 3
<b>Commitment 8:</b> Ensure that people are managed and cared for more effectively in the community by ensuring that the crisis standards are achieved by 2009	2009	Targets 2 & 3
<b>Commitment 9:</b> Establish acute inpatient forums across all Board areas comprising service providers, service users and carers as well as other stakeholders such as Local Authority colleagues	2009	Target 3
<b>Commitment 10:</b> Improve mental health services being offered to children and young people by ensuring that by 2008 a named mental health link person is available to every school and that basic mental health training is offered to all those working with, or caring for, looked after and accommodated children and young people	2008	Target 3
<b>Commitment 11:</b> Reduce the number of admissions of children and young people to adult beds by 50% by 2009	2009	Target 3
<b>Commitment 12:</b> Implement the new Care Programme	2008	

Approach for all restricted patients by 2008		
<b>Commitment 13:</b> Translate the principles of Mind the Gaps and a Fuller Life into practical measures	2007	Targets 1, 2 & 3
<b>Commitment 14:</b> Work with the Dementia Services Development Centre at Stirling University and NHS Forth Valley to undertake a pilot programme for dementia services.	Pilot evaluated in 2008	Targets 2 & 3

### **Ensuring Delivery**

The strategy highlights that a National Improvement Programme will be established to ensure the delivery of the targets and commitments set out within the plan over the four years starting in April 2007. The emphasis on delivering is ensuring that *“Solutions must meet local need and circumstances and...engage with and actively involve staff in the change process in order to achieve sustained improvement”*.

With regard to the financing of the strategy the Scottish Executive note that NHS spend in Scotland on mental health has risen from £400m in 1999 to £670m in 2006. The Health Department is committed to funding the central support programme of the strategy and the strands of work that sit within it and *“will work with NHS Boards and other partners to ensure that clinical, as well as financial solutions are found that will help drive forward improvements in care and delivery of mental health services across Scotland”*<sup>21</sup>.

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<sup>21</sup> Delivering for Mental Health, Scottish Executive (2006), page 19,  
[www.scotland.gov.uk/Publications/2006/11/30164829/0](http://www.scotland.gov.uk/Publications/2006/11/30164829/0)

## **Appendix 1 – Integrated Care Pathways**

The following information is directly extracted from NHS Scotland, Educational Resources, Clinical Governance, What are Integrated Care Pathways?<sup>22</sup>:

Integrated Care Pathways (ICPs) provide a template for multi-disciplinary care that is evidence-based and coordinated.

**An ICP determines locally agreed multidisciplinary and multi-agency practice, based on guidelines and evidence where available for a specific patient/client group. It forms all or part of the clinical record, documents the care given, and facilitates the evaluation of outcomes for continuous quality improvement.**

Sue Overill, Journal of Integrated Care (1998) 2, 93-98

ICPs developed in the late 1990s as a basis for plotting and agreeing pathways of care for particular conditions or procedures. Pathways are designed to reduce variation in practice and allow the same quality of care to be delivered to patients across multi-disciplinary and multi-agency teams and in different care settings.

An ICP will plot the best sequence and timing of interventions by clinicians, nurses, other professionals and agencies for the best patient outcome. ICPs can be developed nationally and locally. The development of a pathway is based on:

- evidence of good practice
- patient experience
- professional experience and judgment

Once an integrated care pathway has been put in place for a procedure or condition it can act as an explicit standard for the delivery of patient care that can be monitored, streamlined and improved. Successful implementation of an ICP depends on the:

- development of ICPs as part of an organisational quality improvement process
- collaboration of patients and professionals in the development of the ICP
- support and facilitation given to staff involved
- careful selection of ICP topics
- evidence-base or professional agreement for the ICP
- agreed goals and outcomes
- collection and analysis of variations from the ICP
- completion and use of the ICP by all staff involved.

Other common names for ICPs include clinical pathways, clinical care pathways, and care pathways.

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<sup>22</sup> [www.clinicalgovernance.scot.nhs.uk/section2/pathways.asp](http://www.clinicalgovernance.scot.nhs.uk/section2/pathways.asp)