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The College

Report of the General Psychiatry Section Working Party on Post-Natal Mental Illness

The Working Party was formed under the aegis of the General Psychiatry Section of the Royal College of Psychiatrists, with the following membership: Professor John Cox – Keele University (Chairman); Dr Channi Kumar – Institute of Psychiatry, London; Dr Margaret Oates – Senior Lecturer, Consultant, University of Nottingham; Dr David Foreman – Consultant Child and Adolescent Psychiatrist, Senior Research Fellow, Keele University, Staffordshire; and Dr Helen Anderson – Consultant Psychiatrist, Bellsdyke Hospital, Larbert (Secretary).

Remit

1. To make recommendations about the optimum service provision for the prevention and treatment of mental illness associated with child-bearing.
2. To consider the quality of care provided to new parents with mental health problems.
3. To recommend guidelines for good practice.
4. To identify specific training needs and establish training programmes for medical undergraduates, general and higher training in psychiatry and continuing medical education.
5. To identify ways to allow cross-district clinical audit.

Introduction

Over the last two decades it has become more firmly established that the months following childbirth are not always characterised by emotional well-being and that one in ten recently delivered women experiences a depressive illness which in a third may last at least one year, and two per 1000 develop a psychosis. Furthermore within two weeks of delivery over a half develop marked postnatal blues especially on the fourth or fifth day, characterised by emotionalism, perplexity and irritability which, when very severe, may merge into a psychiatric disorder. Women are more likely to suffer from a major psychiatric disorder following childbirth than at other times, more likely to be referred to a psychiatrist, and to be admitted to a psychiatric hospital.

In general it is the temporal association of these mental disorders with childbearing, their occurrence at a time of maximum vulnerability for the baby when bonding with the mother occurs and new family roles are established, which explains the concern of clinicians and users for more appropriate psychiatric services and is the stimulus to research in at least seven academic departments within the United Kingdom. Brockington *et al* (1982), for example, found that perplexity, confusion and bewilderment were particular features of the puerperal psychoses and Dean & Kendell (1981) reported that such women have more florid symptoms, lesser genetic vulnerability, and a slightly better prognosis; although Platz & Kendell (1988) in their prospective studies found that most puerperal psychoses were similar in prognosis to that of manic depressive illness.

The closer the onset of a postnatal mental disorder to the birth event the less likely are other stressful life events to be implicated and the more likely biological factors should be considered, such as oestrogen sensitive abnormalities in hypo-thalamic dopaminergic systems. Thus Dowlatashi & Paykel (1990) in their study of 33 patients admitted to hospital with severe early onset puerperal psychiatric disorder found an absence of social stress compared with matched normal puerperal controls. Puerperal psychoses are more likely to follow a first birth in single mothers and are slightly more common following Caesarian section; there is usually evidence for a genetic loading.

Whatever the precise nature of the causal trigger (whether social, biological or both), the raised onset rate for puerperal psychosis is at least twelvefold, and early onset psychoses in first time mothers has a relative risk of 35. Furthermore for the later onset non-psychotic depressions an increased risk in the weeks immediately following childbirth has also been found.

The impact of these postnatal psychiatric disorders on the family, especially when severe, may increase marital difficulties, suicide, infanticide, an immediate adverse effect on the behaviour, temperament and cognitive development of the baby which may be enduring, non accidental injury, and also an effect on subsequent fertility.

It is often overlooked that most patients are parents and in particular there is a need to consider help for those children whose parents have a post-natal

mental illness. Furthermore a woman who has had a puerperal psychosis has a 1:3 chance of experiencing a further psychosis, and some parents are therefore not prepared to consider another pregnancy.

Thus although such disorders occur at a time when health professionals in primary and secondary care are usually in regular contact with the family, commonly they are not detected or adequately treated. In the prospective study of postnatal depression from Edinburgh, for example, none of the 13 depressed women were referred to a mental health professional although four were judged to require such referral.

Demand for psychiatric services

Oates (1988) in Nottingham has estimated that approximately 2% of all women will be referred to a psychiatrist following childbirth, over half being seriously mentally ill and that two per thousand recently delivered mothers will require admission – most suffering from a puerperal psychosis. Furthermore she estimated that between 15 and 20% of all patients seen by obstetricians and maternity services have problems relating to their mental health which may need to be taken into account in their obstetric management. Thus in an average large health district with 4000 births per year, 400 women will suffer from postnatal depression, and at least eight will require admission each year.

A psychiatric day hospital in a large health district with an attached nursery led by a specialist multiprofessional team can expect at least 30 referrals per month from primary care workers (general practitioners and health visitors), 15 are likely to be suffering from a depressive disorder of varying severity and require a full psychiatric assessment.

In the United Kingdom it is regarded as good practice to admit the mother when possible *with her baby* to a specially designated mother and baby facility, if a domiciliary or day hospital management is not possible. This arrangement encourages bonding, enables closer observation of disturbed mothers with their infants, provides support in the absence of other family members, and enables women to be treated who otherwise might have refused altogether.

Existing services

A survey of current facilities carried out by Prettyman & Friedman (1991) of 201 health authorities in England and Wales found that of the 194 returned questionnaires, only 38 (19%) had dedicated facilities; 94 (48%) reported that mothers and babies were admitted to acute general psychiatry wards using existing facilities – an inferior and to an extent less safe environment than a designated specific facility. Twenty-one districts (10%) reported no provisions at all for joint admission. In only 79 districts was there a consultant with any special interest in postnatal mental illness. However almost three quarters of health authorities regarded a specialised mother and baby facility as important and a resource priority.

Specialist day care facilities, which include a full-time nursery, are uncommon but are being successfully developed in a few cities (Leeds, Stoke on Trent), while established Regional Mother and Baby Units (e.g. Bethlem Hospital, Springfield Hospital, London; Manchester; Nottingham) and more recent Units (e.g. Birmingham, Derby) meet the needs of large urban populations and are an important focus for research and education. Experience of these units suggests that a close relationship between a specially designated day hospital, a mother and baby in-patient facility and a consultant-led community care team with close links to general practitioners and health visitors in primary care provides an optimum local, accessible and integrated service.

Case of need

There is a significant unmet need throughout the United Kingdom for women with postnatal mental illness; there are few comprehensive services, large deficits in in-patient provision and designated day hospital facilities, as well as lack of specific consultant led teams with specialist knowledge of the impact of mental illness on the baby and older siblings, as well as on the infant's father. Knowledge of the effect of medication during pregnancy on the mother and foetus, and on breast feeding is also expected by users. Furthermore, the ability for close liaison with child psychiatrists is particularly advantageous for collaborative management, and to increase awareness of the need to ensure that the emotional needs of the infant and older children are fully understood and met. Mothers with learning disabilities may also require specific assistance and very close collaboration between health and social services professionals. Similarly mothers of infants born with disabilities may require special assistance and there is a need for close liaison with specialists in learning disability.

These complex skills are best acquired and carried out by a specialist consultant-led team including two or three designated community psychiatric nurses with close links to primary care. This team is a resource for other local sector consultants, although is best regarded as a district, or supra-district, service.

Principles of good practice

This mental health service should therefore provide rapid, appropriate, accessible and effective care

for the mentally ill mother by health professionals who possess the appropriate skills, experience and resources. Such care should be sensitive to the emotional and physical needs of mothers and their families, and so place a high order of priority on the emotional and physical needs of the infants, as well as older children. The operation of any service for postnatal mental illness will need to take into account the rights and requirements of parents and children as defined in The Children Act (England and Wales). The care should be given in what is judged as the optimal environment for recovery, be it at home, an out-patient clinic, day hospital or in-patient unit as close to the mother's home as possible. These mental health services should also increase awareness of the patient as a parent in general psychiatric services, and so facilitate parental responsibility and the appropriate care of children.

Recommendations

1. Training

To achieve these principles the working party recommends that there should be changes in education and training, as well as service provision.

(a) *Medical undergraduate training*

There should be a greater emphasis in the paediatric and obstetric attachment on developmental psychology, normal emotional needs of parents and children, psychiatric morbidity associated with childbirth, parenting problems, emotional issues in childhood disorders, non-accidental injury and child sexual abuse. During the psychiatric attachment, there should be experience in postnatal psychiatric disorder and an emphasis on the family, the patient as parent, and the impact of parental psychiatric disorder on children.

(b) *Vocational training system*

The Working Party would recommend that similar themes are covered in vocational training schemes for general practitioners, the MRCOG course and the paediatric component of an MRCP course.

(c) *Postgraduate psychiatry*

Psychiatric disorders associated with childbirth and the impact of parental psychiatric disorder on children should be included in a 'syllabus' and, included as examination questions for the MRCPsych and examined in the clinical.

Rotational training schemes should ensure that trainees have adequate exposure to child psychiatry and to the management of psychiatric disorders associated with childbirth. The child psychiatry component of training should include exposure to, and education about normal parents, their infants, older children and in interaction between them. Psychiatric trainees should be encouraged to assess their patients as parents, to understand a patient's parental responsibilities and to be aware of the impact of psychiatric disorder on children. There should be an increased awareness of the fertility of patients for the optimum management of psychiatric illness such as the use of medication. There should be access to training in obstetrics and gynaecology liaison.

(d) *Continuing medical education*

Psychiatric disorders associated with childbirth, and the effect of parental psychiatric disorders on children, should be addressed at College meetings and in other forms of continuing medical education.

(e) *Other disciplines*

The Working Party would suggest that such topics are also included in the training of health visitors, midwives, community psychiatry nurses and social workers. All members of multidisciplinary teams should become more aware of their patients as parents.

2. Structure and function of service

As health districts vary in size of their population (approximately six-fold), social deprivation, birth rate, type of mental illness service and primary care services, it is not possible to prescribe a universal pattern of health care delivery for this group. The basic standards of care can be met in a variety of ways:

(a) All health districts should ensure that when drawing up contracts the needs for services to the post-natal population are met according to the size of the district, and its birth rate. This need could be met either by a district-based consultant or by a regional or sub-regional unit. Such a consultant should work with a full multidisciplinary team including as a minimum two community psychiatric nurses. Ideally the team should also include a social worker, occupational therapist and a clinical psychologist. A larger health district with a delivered population of 5,000 babies per annum would alone, or together with adjacent districts or regional or sub-regional units, have sufficient postnatal psychiatric morbidity to justify the appointment of a half-time consultant adult psychiatrist with supporting medical staff, and two full-time CPNs and other team members. A smaller health district could either designate one to two sessions of consultant time to this work or could use the services of a regional or sub-regional unit.

(b) This consultant and team would assess patients referred with a puerperal psychosis or severe postnatal depression, establish links with Departments of

Obstetrics and Gynaecology and with primary care assess patients with emotional problems during pregnancy or those who have experienced a termination of pregnancy, miscarriage, or a perinatal death. The team could advise about prevention of postnatal mental illness and assist other consultants with the management of their patients. Advice and support to primary health care workers, general practitioners, health visitors and social workers could be available more especially with regard to the assessment of parenting skills in patients with postnatal psychiatric illness – usually in collaboration with child psychiatrists. To establish links with self-help and other voluntary organisations, such as the Association for Postnatal Illness, New-Pin and Homestart, are particularly useful. Such a team would also provide a focus to facilitate education and research.

The future of these services is best guaranteed by a designated consultant psychiatrist with a special area of interest.

(c) Health Districts should ensure that the implementation of the White Paper *Caring for Patients* does not threaten those few services, both district based catchment area services and sub-regional inpatient facilities, that are currently running well and are a focus for service development, patient care and research. As the health care needs of a population will in future be met by contracts between purchasers and providers which involves costings, quality assurance and consumer satisfaction, the services for mentally ill mothers should be user friendly, accessible and consultant led, and so meet the standards set by the provider. Health district purchasing departments have a responsibility to meet significant health care needs, but the competitive market may threaten the viability of existing regional and district units.

(d) Health districts should ensure that facilities for data collection and cross-district clinical audit are available for a postnatal mental illness service which in smaller districts may require to be supra-district or sub-regional.

Approved by Council
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Working group on mental health information systems

The importance of information systems for clinical management, audit and resource management has been widely recognised by both the professions and management alike. While major advances in information technology have taken place in the acute hospital sector, a relative void exists within community services. Nevertheless over the last few years a number of developments have taken place which hold considerable promise for the information needs of community mental health services. In response to this void the Research Committee of the College has established a Working Group whose remit is to advise the College, and through it the Department, on the information needs of psychiatrists and the requirements of information systems that should support those needs.

Balancing the need for information is a need for communication. There is considerable risk that a myriad of unique solutions for clinicians, providers, purchasers and the Department will result in unnecessary duplication of effort and a major problem in communicating between users and management at all levels. Paradoxically the present void in information systems provides an opportunity to bring forward recommendations acceptable to clinicians and managers that will optimise communication between clinicians, within districts and across regions. The opportunities for research, audit, service evaluation and clinical