

The provision of care for women with postnatal mental disorder in the United Kingdom: an overview

KR Nicholls, JL Cox

Childbirth is a life event that is linked universally with cultural significance. It is sometimes associated with mental disorders, which need special assessment and treatment. This review describes the service provision for women with puerperal mental disorder in the United Kingdom.

HKMJ 1999;5:43-7

Key words: Community mental health services; Depression, postpartum; Health services needs and demands; Life change events; Mental disorders; Puerperal disorders

Introduction

Women are more likely to have a major psychiatric disorder, be referred to a psychiatrist, and be admitted to a psychiatric hospital following childbirth than at any other time.¹ Although puerperal mental disorder was recognised in ancient history and described in detail in the last century, its importance in terms of severity and high prevalence in contemporary populations has been rediscovered only during the past couple of decades, and the disorder is the subject of a large body of current research.

Childbirth is a unique life event which is deeply imbued with emotional, cultural, and/or religious significance; it affects not only the child-bearer, but also the father, extended family, and society.² The birth process is also deemed to have a significance that is linked to virtues such as competence, maturity, legitimacy, and the sanctity of life. On the other hand, when complications or abnormalities occur, guilt, ideas of unworthiness, or notions of divine disapproval may be invoked. These values and the fact that child-bearing and birth are profoundly stressful and exhausting (as well as joyous) mean that puerperal mental disorders demand special assessment and treatment.

China is in a key position to facilitate a better understanding of the socio-economic and cultural aspects

of postnatal disorder.^{3,4} There is an increasing interest in this field, as well as evidence that postnatal depression may be more prevalent in China than previously believed.⁵ This paper reviews the case for the development of dedicated perinatal psychiatry services and their current provision in the United Kingdom (UK), and discusses how multidisciplinary resources can be more effectively deployed.

Perinatal psychiatric services and their development

The need for perinatal psychiatric services

This topic is dealt with admirably and in detail by Oates⁶ and summarised in Box 1. At least 10% of women will suffer a significant episode of postnatal depression and in one third of these patients, the illness will last for 1 year or more.⁷ Furthermore, two in 1000 women will have a psychotic illness in the puerperium, which may be complicated by a danger of suicide or infanticide, and which usually requires admission to hospital. From these crude rates, it has been estimated that in a typical large UK health district that oversees 4000 births per year, approximately 400 women will develop postnatal depression, of whom eight will become seriously ill with puerperal psychosis and subsequently will require hospitalisation.¹ A further two in every 1000 pregnant women will need in-patient

Box 1. The need for perinatal psychiatric services⁶

- Substantial morbidity
- Seriousness of condition
- Unmet patient needs
- Effective treatment possible
- Grave consequences if untreated
- Information and education needed
- Prevention or morbidity reduction possible

Department of Psychiatry, Royal Shrewsbury Hospital (Shelton),
Bicton Heath, Shrewsbury, Shropshire, United Kingdom
KR Nicholls, MB, ChB, MRCPsych
Department of Psychiatry, Keele University, Staffordshire, United
Kingdom
JL Cox, FRCP, FRCPSych

Correspondence to: Dr KR Nicholls

treatment because of severe depression or other mental disorder, thus increasing the number of admissions due to puerperal mental disorder to 16 per year.⁶

The projected case-load represents appreciable morbidity, which may have adverse and long-term effects not only on the woman herself, but also on her family. It follows that there is a requirement for services to meet these needs, and yet it is clear that these services are not always available; when they are provided, they are of disparate structure and quality. Approximately 17 in 1000 newly delivered women are referred to general psychiatric services each year (if a special service is absent).⁶ This proportion is likely to be an underestimate; if women suffering from a pre-existing psychiatric disorder and those who are pregnant are included, the proportion will be even higher. It has been calculated that the number of referrals from 5000 deliveries is comparable to that from a general adult population of 25 000.⁶ The serious nature of puerperal morbidity is linked to the consequences of inadequate treatment. Puerperal psychoses are affective in character and may have hypomanic episodes that are associated with feckless or dangerously disinhibitory behaviour, or depressive episodes of profound hopelessness and suicidal ideas. Either type of episode may be complicated by delusions, and presentation can fluctuate very quickly. Severe postnatal depression can also present similar hazards. There is a clear potential risk of suicide, unintentionally dangerous behaviour, or infanticide; admission may be necessary to properly assess and treat affected patients.

The case that postnatal mental disorder treatment services are often inadequate is widely acknowledged. The 1992 Council Report of the Royal College of Psychiatrists pointed out the problem explicitly, stating that 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".⁴ A part of the reason for the sparseness of services is the continued training deficits, which result in the poor recognition of mental disorders in primary care. Aspects of postnatal depression are 'atypical' when compared with the conventionally recognised symptoms of depression,⁸ and the clinician needs to be aware of this differentiation. Mood is often labile with marked tearfulness and irritability and distress may be more prominent in the evenings. Anorexia, feelings of guilt, impaired concentration and anxiety may also be present, together with lethargy

or anergy. Long-standing symptoms are sometimes inappropriately dismissed as the 'baby blues' or as being 'normal', with the implication that the problem is trivial and self-limiting. Mothers may also sometimes present with difficulties apparently unconnected with psychological well-being—for example, with concerns that their infant is not feeding adequately, is vomiting, or is crying excessively. Astute evaluation by the doctor or midwife as to whether such worries may be due to underlying depression or psychosis is unfortunately not always provided, and the diagnosis or chance to refer the patient to secondary services can thus be missed. Even when postnatal depression is recognised, the ill-informed may believe it to be an understandable reaction to childbirth that does not require or would not respond to treatment; alternatively, subtherapeutic doses of antidepressant medication may be prescribed. The Edinburgh Postnatal Depression Scale has been especially designed as a screening tool to help detect postnatal depression. The screening procedure is rapidly completed and evaluated by primary care professionals, has high sensitivity and specificity, and has been validated in numerous languages and cultures.⁹

When treated rigorously, postnatal mental illness usually responds rapidly. The effectiveness of treatment has been amply demonstrated, and psychological therapies, although more costly, are as efficacious as medication. In cases of severe psychotic illness, electroconvulsive therapy may be needed and typically results in a dramatic and quick improvement. The consequences of failing to diagnose and treat these disorders are not benign, and are indeed potentially serious and long-lasting. The catastrophic but fortunately relatively rare event of suicide or infanticide has already been mentioned. These events nevertheless represent tragic and avoidable mortality in a young population, and their possibility should always form the key part of inevitably necessary risk assessment. Increasingly apparent, however, is that the average patient with a postnatal mental disorder suffers morbidity that is debilitating and that has far-reaching, long-lasting, and serious adverse effects on the mother and her family; the index infant, any siblings, and the father are all potentially affected. It is known that inability on the part of the mother to interact normally with her infant due to her depression may impair their long-term relationship.¹⁰ This disruption in turn leads to abnormal cognitive,¹¹ and emotional development in the child, and a poor maternal relationship may even predispose to having a depressive disorder as an adult. The woman's husband or partner may also become clinically depressed¹² and their relationship may become strained to the point of family breakup.

Collectively, these consequences illustrate the strong but poorly recognised need to better address postnatal mental disorder and its treatment.

Information and prevention are crucial functions of perinatal mental health services and are indispensable tools for lobbying for better resources. Improving awareness in primary care (general practices in the UK) may involve doctors and their teams, especially midwives and health visitors. As a consequence, improvements in diagnosis will put indirect pressure on purchasers and commissioning bodies to provide better resources. Another important aspect of perinatal mental health services should be to provide education to patients and their families. This service may vary from providing basic support and information (and reassurance if appropriate) to organising in-patient care and appropriate physical treatment. Very occasionally, formal admission to hospital under the Mental Health Act (1983) may be necessary to ensure adequate, safe, and legal treatment.

Support and advice during subsequent pregnancies may be a valuable source of reassurance to a woman who has suffered a previous episode of illness in the puerperium. The knowledge that contact with a service has been restored is often all that is needed to put the woman's mind at rest, safe in the knowledge that if a relapse does occur it will be diagnosed and treated at an early stage. Those who have suffered from bipolar affective disorder or previous puerperal psychosis will need very careful monitoring, reassurance and advice. The whole obstetric and primary health team will be required—together with family members if appropriate—to maintain the support and vigilance necessary to detect early signs of deterioration, especially in the first few weeks after delivery. Special advice and liaison regarding psychotropic medication will usually be crucial—for example, the recommencement of post-partum lithium treatment and monitoring of its serum level, and the appropriate use of antidepressants as prophylaxis¹³

Women with chronic psychotic illnesses should not be forgotten, and a good perinatal psychiatry service will develop outreach services to advise and assist them. Practical help (eg with transport) often greatly improves compliance with antenatal clinic attendance. Neuroleptics may be indicated, especially after the first trimester and require careful discussion and informed consent; there is evidence that their use helps prevent relapse of psychotic illness post partum.¹⁴

The need for special (designated) services

Much of the justification for specialised and designated

Box 2. Justification for special services⁶

- Large group/shared characteristics
- Distinctive needs
- Different organisation of service
- General service not meeting needs
- Sufficient workload to make designated service viable

perinatal psychiatric services is interrelated with previous points. The definitive list of factors is again credited to Oates (Box 2).⁶ The physical and psychological aspects of postnatal psychiatric disorder are unique and demand specialised staff expertise. The dedicated unit can provide 'critical mass' care whereby sufficient numbers of patients warrant a team of multidisciplinary professionals. Such units are also viable in terms of facilitating a research and teaching base to assist others in academic work and service development.¹⁵ Organisational considerations also indicate a need for separate perinatal psychiatric services. Approximately one third of referrals to a perinatal service can be regarded as psychiatric emergencies demanding a specialised assessment and rapid response either to an obstetric ward or to the patient's home.⁶ In-patient beds must be able to safely accommodate relatives and infants, and provide special facilities such as a changing area and separate milk kitchen. The multidisciplinary team also requires access to certain resources such as adequate interview and therapy rooms and an equipped play area. Legal considerations may also contribute to the safe accommodation of women and their children. These considerations include the provision of safe doors and gates, electrical appliances, and pram access, as well as an awareness of professional obligations, relevant statute law, and responsibilities according to child protection procedures or the UK Children's Act. In addition, confidential assessment and meeting places and secretarial support would be required.

Service provision and models of care in the United Kingdom

The postnatal care of mentally ill women and their babies in the UK is variable and services are not uniform. Innovative organisations of very different structure may provide excellent care and treatment, for example. The variation reflects to a large extent the individual qualities and flair of the senior clinicians of each service, and their diversity should be viewed as a strength that enables comparisons to be made between different models of care. Three disparate modes of care delivery will be described in brief outline to illustrate the scope of developments that have been made.

Community-based care

Community-based care has been pioneered in the UK by Dr Margaret Oates in Nottingham.⁶ Patients accepted for care in the scheme must live within 20 minutes of the hospital and have a responsible adult living with them. The duration of care varies between 8 hours daily, to visits on alternate days by community-based nurses. Even severely ill women have been successfully cared for in this system, which is especially useful when the mother is reluctant to go to hospital because of the need to care for her older children. However, the backup of a mother and baby unit is deemed essential.¹⁶

Parent and baby day-units

Day facilities can be a valuable resource, and the lead in this area is being given by the team at the Charles Street Parent and Baby Day Unit, Stoke-on-Trent, led by Prof JL Cox. The day unit places special emphasis on the development of links with primary care, and health visitors in particular have been recruited to routinely screen for postnatal depression using the Edinburgh Postnatal Depression Scale. In addition to referrals from the day unit, there are close connections with general practitioners, obstetricians, and midwives. Women can also present without referral, and their husbands or partners are encouraged to attend. Approximately two thirds of the women attending have major or minor depression, as defined by the Research Diagnostic Criteria (RDC) instrument. At the assessment interview, women are allocated to a key worker and, where appropriate, further assessment by a psychiatrist is arranged. Antidepressants and other medications are prescribed, if indicated. Selective serotonin re-uptake inhibitors are useful postnatally when the mother is not breast-feeding; these drugs may have a more rapid effect than the traditionally used tricyclic antidepressants. Citalopram seems to be especially useful (more easily tolerated) if nausea or other gastro-intestinal problems are present. Prenatal depression or depression when the mother is breast-feeding, is treated most safely with tricyclic antidepressants,¹³ of which lofepramine has theoretical advantages for lactating mothers or when there is a risk of overdose.¹⁷ It is crucial to ensure that an effective therapeutic dose is prescribed (lofepramine 210 mg/d in divided doses or equivalent).

A care programme is individually tailored and includes counselling as well as group activities. The Charles Street Parent and Baby Day Unit operates 5 days a week during normal working hours only. This means that admission arrangements may have to be coordinated through the local psychiatric ward, or on occasions with the nearest mother and baby units. Day

units logistically rely on a densely populated catchment area that is served by good communications, especially public transport; thus, day units are unlikely to be feasible in rural areas.¹⁸

Mother and baby units

Joint admission of psychiatrically ill women and their baby was first advocated and practised by Dr Tom Main at the Cassel Hospital in the 1940s.¹⁶ During the post-war period, the concept of joint admission gained ground in the light of work on attachment theory by Bowlby¹⁹ and Ainsworth et al.²⁰ Unfortunately, not all areas in the UK are able to benefit from high standards of provision and many hospitals do not have dedicated mother and baby facilities; if designated services are in place, they are not always served by a consultant with a special interest in perinatal psychiatry.

The most extensively quoted study of provision for puerperally ill mothers in psychiatric facilities was published in 1991.²¹ It was a questionnaire survey of 201 health authorities, 194 of which responded and 38 (19%) of which had dedicated facilities for women with postnatal mental disorders. A further 94 (48%) admitted such women to acute psychiatric wards and 50 (27%) used the facilities of other districts. No facilities for joint admission were available in 21 (10%) authorities (categories were not mutually exclusive). Nearly half (18) of those with a dedicated mother and baby unit were found to have only one or two joint admission beds. The total number of joint beds identified in England and Wales at that time was 133.²¹

It is widely believed that joint admission is desirable for psychotic mothers; a salient reason is the need for the mother-baby bonding, which may include the need to continue breast-feeding. Another reason is the belief that women are more likely to agree to informal admission if they can be with their baby.²² However, research on the subject is lacking. For example, it has not been proven that mother-only admission is detrimental to bonding and attachment when intensive infant contact is arranged. Likewise, the need for breast-feeding to bond has not been substantiated; not all mothers choose to breast-feed and of those who do, a proportion are unable to lactate or unable to feed due to medication. Our own research has shown that differences between admission to an acute psychiatric ward and designated mother and baby unit are not as substantial as may be commonly thought.²³ It is important to distinguish between substantive mother and baby units and 'mother and baby beds' in acute psychiatric wards. Some units have six or more beds and tend to be regional facilities that accept referrals

from several districts. It is likely that the function of these larger units is slightly different in that they sometimes provide assessment and management of complex cases; to this extent, they are serving as tertiary referral centres. Substantive mother and baby units are highly specialised and use the expertise of professional staff such as clinical psychologists, social workers, occupational therapists, and specialist nurses (including nursery nurses). Such an involvement of personnel can only be organised and deployed for units with sufficient referrals ('critical mass') to occupy a minimum number of beds. It is unclear what threshold number of beds can be cited, although Prettyman and Friedman²¹ showed that nearly half of the dedicated facilities surveyed (18 of 38) consisted of only one or two beds. It is difficult to imagine how these minimal provisions can lead to adequate standards and numbers of staff, or warrant the label of a specialist service, especially if a psychiatrist with a proven interest and dedicated sessions is absent. It is probable that an increase in the provision of mother and baby units since the Prettyman and Friedman study of 1991²¹ has involved increasing the number of beds in acute wards, so that anxious managers can be seen to be progressive providers of joint facilities, while also avoiding costly referrals for care elsewhere. The real value of these beds as a resource is questionable. It is possible that many such facilities are no better than mother-only admissions as long as sustained efforts are made to ensure daily contact between the mother and infant. Yet, our clinical experience suggests that the presence of an infant on an acute psychiatric ward might be a source of considerable anxiety to the ward nurses, whose misgivings could easily be transferred to the already disturbed mother. In such circumstances, it may be more desirable for competent relatives to care for the infant.

Conclusion

The provision of facilities for puerperally ill mothers and their infants is complex and currently inadequate in the UK. Quality care can be delivered through diverse modes, but there is probably much variation within each service model. The value of joint admission is poorly defined and established assumptions may not be valid. There is clearly an identified need to divert increased effort into providing services in this area, but further research is necessary to determine how this can be best achieved.

References

1. The Royal College of Psychiatrists. Postnatal mental illness—report of a Working Party of the General Psychiatry Section. London: The Royal College of Psychiatrists; 1992. Council report No.: CR28.
2. Cox JL. Perinatal mental disorder—a cultural approach. *Int Rev Psychiatry* 1996;8:9-16.
3. Kleinman A. China: the epidemiology of mental illness. *Br J Psychiatry* 1996;169:129-30.
4. Lee S, Kleinman A. Mental illness and social change in China. *Harv Rev Psychiatry* 1997;5:43-6.
5. Lee DT, Yip SK, Chiu HF, et al. Detecting postnatal depression in Chinese women. Validation of the Chinese version of the Edinburgh Postnatal Depression Scale. *Br J Psychiatry* 1998;172:433-7.
6. Oates M. Psychiatric services for women following childbirth. *Int Rev Psychiatry* 1996;8:87-98.
7. Cox JL, Connor YM, Kendell RE. Prospective study of the psychiatric disorders of childbirth. *Br J Psychiatry* 1982;140:111-7.
8. Pitt B. "Atypical" depression following childbirth. *Br J Psychiatry* 1968;114:1325-35.
9. Cox JL, Holden JM, Sagovsky R. Detection of postnatal depression. Development of the 10-item Edinburgh Postnatal Depression Scale. *Br J Psychiatry* 1987;150:782-6.
10. Murray L, Fiori-Cowley A, Hooper R, et al. The impact of postnatal depression and associated adversity on early mother-infant interactions and later infant outcomes. *Child Development* 1996;67:2512-26.
11. Cogill R, Kaplan HL, Alexandra H, Robson KM, Kumar R. Impact of maternal postnatal depression on cognitive development of young children. *Br Med J (Clin Res Ed)* 1986;292:1165-7.
12. Ballard CG, Davis R, Cullen DC, Mohan RN, Dean C. Prevalence of postnatal depression in mothers and fathers. *Br J Psychiatry* 1994;164:782-8.
13. Cox JL, Nicholls KR. Prescribing psychotropic drugs for pregnant patients. *Prescr J* 1996;36:192-7.
14. Kendell RE, Chalmers JC, Platz C. Epidemiology of puerperal psychoses. *Br J Psychiatry* 1987;150:662-73.
15. Margison F, Brockington IF. Psychiatric mother and baby units. In: *Motherhood and mental illness*. London: Academic Press; 1992.
16. Riley D. *Perinatal mental health*. Oxford: Radcliffe Medical Press; 1995.
17. Nicholls KR, Cox JL. Antidepressants and breastfeeding [letter]. *Psychiatr Bull* 1996;20:309
18. Cox JL, Gerrard J, Cookson D, Jones JM. Development and audit of Charles Street Parent and Baby Day Unit, Stoke-on-Trent. *Psychiatr Bull* 1993;17:711-3.
19. Bowlby J. *Attachment and loss*. Volume 2. Separation: anxiety and anger. London: Penguin; 1975.
20. Ainsworth MD, Bell SM, Stayton DJ. Individual differences in the strange situation behaviour of one-year-olds. In: Shaffer ED, editor. *The origins of human social behaviours*. London: Academic Press; 1971.
21. Prettyman RJ, Friedman T. Care of women with puerperal psychiatric disorders in England and Wales. *BMJ* 1991;302:1245-6.
22. Sneddon J. The mother and baby unit—an important approach to treatment. In: Hamilton JA, Harberger PN, editors. *Postpartum psychiatric illness—a picture puzzle*. Philadelphia: University of Pennsylvania Press; 1992.
23. Nicholls KR. Comparison of an acute psychiatric ward and mother and baby units for the treatment of puerperal mental disorder [dissertation]. Staffordshire: Keele University; 1998.