Standby CPD

by Aimee Yarrington and Ursula Rolfe

Postpartum depression – more than the ‘baby blues’

This case study has been adapted for Standby CPD using information from *Mental Health Care in Paramedic Practice*.[1] To learn more about this condition, as well as other mental health presentations, please refer to the full text.

It’s a bright spring day, there is finally a break in the rain and the birds are singing for once. You are just pulling up at a local fast-food restaurant thinking about treating yourself to a late lunch, as it is a Saturday, when the data terminal flashes up a message: “Please can you respond to the following job.” You are sent the details of an address about 15 minutes away, where there is a 32-year-old female patient. There is little more information about the case except that the caller, who is her husband, is concerned about her mental state having found her crying uncontrollably in the bathroom.

On arrival at the property, you are greeted by a tired-looking man still in his bathrobe, who takes you to the upstairs bathroom where you are met by your patient, who is crying. She is still in her nightwear and has not showered or brushed her hair. She is pale and has dark circles below her eyes, as if she has not slept at all. Her husband informs you that she gave birth 3 weeks ago, but it was a long labour and a forceps birth. She had originally planned on having a home birth but had been transferred to hospital in the first stage of labour, as meconium liquor was present and there were concerns about the fetal heart rate. The baby is very unsettled due to reflux, and neither parent has slept well since the birth.

You undertake a quick assessment of the patient’s vital signs, which are all within normal parameters.

> What do you do next: Explain there is nothing more you can do for the patient at home and take her to A&E (read on) ***OR*** Question her further (skip the next paragraph)?

Take her to A&E

You consider the situation and conclude that you are not qualified to deal with this, as it is clearly a case of postpartum depression, so you choose to take the patient to A&E. It takes almost an hour for her to get herself dressed and organised, and this makes her even more distressed. By the time she and the baby are packed up and ready to go, control have asked for several updates from scene, which has distressed her further, and she is now worrying about everything else you could have been doing instead of attending her. She then changes her mind and refuses to leave the house. Her husband says he will wait and call their GP on Monday.

Question her further

By questioning the patient further you find out where her mental state is at the present time and establish if there is any risk to her or the baby. You ask some questions about her past medical history and pre-natal history before using the Mental State Examination as a guide to your assessment:

Pre-natal history – full term pregnancy with no complications; attended all appointments and scans; initially booked for a low-risk home birth.
Birth history – forceps birth after transfer in labour for meconium-stained liquor.
Past medical history – nil of note; no medication taken apart from over-the-counter pain medications.
Professional contacts – she was seen for the full 10-day postnatal period by the community midwifery team, and has since been handed over to the health visiting team; they have conducted 2 visits at 7 and 14 days, and had agreed to see her next week as she has reported feelings of low mood for longer than the initial baby blues period.
Appearance – she is still in her nightwear and has not showered or brushed her hair; she is pale and has dark circles below her eyes as if she has not slept all night.
Behaviour – she is curled up on the bathroom floor crying; however, she responds to you and answers all questions appropriately.
Speech – normal between the crying.
Mood – appears low; she says that she has been showing little interest in doing anything around the house, but doesn't want to leave it.
Thought – no formal thought disorders are identified; form, content and possession appear normal.
Perception – appears normal; she is aware of the care she must provide for the baby, and there is no perception that she may cause harm to herself or the baby.
Cognition – appears intact; she is aware of the needs of the baby.
Insight and judgement – she accepts that it is not right to feel this way in what should be a time of excitement with a new baby; her husband is asking if she is suffering from postpartum depression, as the health visitor had given him an information leaflet with signs to look out for.
Risk – she does not state any suicidal thoughts or thoughts of harming the baby.

After looking at all of these factors, you get the impression that the patient is suffering from postpartum depression (PPD).

> What do you do next: Leave the patient till Monday to contact her own GP (read on) ***OR*** Contact the out of hours GP (skip the next paragraph)?

Leave her until Monday

You are not completely sure if waiting until Monday is the right thing, but the patient assures you she is no threat to herself or her baby. You agree together that the patient will call the GP on Monday to ask for some help. Instructions are given to the husband to call back if there are any changes or the patient deteriorates. Unfortunately, the patient's condition does worsen, and you see the husband in the A&E department the following day, without the baby as they have had to be separated, which has unfortunately made the patient's mental state worse.

Contact the out of hours GP

As it is Saturday, and the patient's regular GP practice is not open until Monday, you do not think it is suitable for her to be left until then without being seen by a doctor. You call the OOH service and speak directly to a GP. They are in agreement with you about the impression of postpartum depression, and they believe specialist input from a perinatal mental health service should be sought as soon as they are able to make the referral. Unfortunately, at present services offered around the country will differ, and individuals will need to check their local service availability.

The GP thinks that commencement of an antidepressant should be considered along with referral and self-care advice, so agrees to come and visit the patient later in the day to make the assessment for the correct type of medication. This worries the patient, as she is breastfeeding, but the doctor assures her that they follow the NICE guidance and can offer medications that are suitable for breastfeeding women.

You are able to leave the patient in the comfort of her own home with the reassurance that she will be followed up by multidisciplinary team support. There is no set time frame given for the arrival of the GP, so you ensure the husband knows to call back on 999 if there is any deterioration in the patient's condition before the GP sees her.

Recognition of the condition

Postpartum depression (PPD) is defined by the Royal College of Psychiatrists as a depressive illness, which affects between 10 to 15% of women having a baby.[2] Symptoms are similar to depression and can include low mood, and other symptoms, lasting at least two weeks.[2] Depression-related disorders are often hard to distinguish in the postpartum period and can co-occur with any other previously diagnosed mental health conditions. History-taking to enquire about symptoms of excessive worry, panic, obsessional thoughts and compulsive behaviours, as well as remote or recent traumatic events, may be helpful here if possible. Family history of depression, bipolar disorder or postpartum psychosis (PPP) should also be enquired about, as this increases the woman's risk of these conditions developing.[3]

<Exclamation Box>
According the NHS, postpartum psychosis is characterised by hallucinations, delusions, a manic mood, a low mood, loss of inhibitions, feeling suspicious or fearful, restlessness, feeling very confused, and/or behaving in a way that is out of character.[4] This is a serious mental illness and should be treated as a medical emergency.
</Exclamation Box>

Patients with PPD may struggle to look after themselves and their baby; this is an important factor to consider when it comes to safety-netting. For some women, bonding with the baby can be difficult, which can be linked to the birthing experience, so it's important to enquire about history. It is important to observe how the mother reacts to and interacts with her baby.

Timing with postpartum depression varies. Often it can present within the first or second month of giving birth, sometimes it can start several months after birth. About a third of women with postpartum depression have symptoms which actually started in pregnancy and continued on after birth.[5]

PPD should not be confused with the 'baby blues', which is a recognised condition that can affect up to 80% of new mothers in the first few days after birth.[6] This is mainly due to the regulation of hormones after birth. Symptoms include heightened emotions, tearfulness without reason, anxiety and feelings of being overwhelmed.[6] When these symptoms present after the first few days and last more than 10–14 days, the diagnosis of PPD is more likely.[7]

PPD is not exclusive to women, as it can affect partners too.[7] The transition into parenthood often affects both partners and, although the cases of female PPD are discussed and the main content of this article, it should not be forgotten that partners can also suffer from PPD and should be treated and managed accordingly. There is evidence

to suggest that untreated partner depression can cause emotional and behavioural problems in their children and is more prevalent in male infants.[8]

Understanding the condition

MIND say that there are different theories about the causes of postpartum depression.[9] However, some patients will be more at risk of developing postpartum depression if they have had:

- previous mental health problems
- biological causes (for example, hormonal changes)
- lack of support
- difficult childhood experiences
- previous or current abuse (for example, domestic violence, verbal and/or emotional abuse, sexual assault or financial abuse)
- low self-esteem
- stressful living conditions (for example poverty, poor housing, insecure employment)
- major life events (for example, major illness or death, relationship break up, moving house or losing their job)

A link has also been found between women who suffer a negative birth experience and PPD. Several studies have found that a significant association between the woman's birthing experiences and what is viewed as a negative experience can also be a contributing factor in the woman developing PPD.[10]

There are several misconceptions regarding PPD, such as the belief that it will go away by itself, it is less severe than other types of depression, it is entirely due to hormonal changes, it is different from depression that is present before childbirth, and there is no risk of its recurrence in the non-postpartum period.[11]

Treatment and management

The treatment of PPD is extremely important because not only does this impact on the woman's quality of life, but on the family life also. A very large study of almost 10,000 women with various levels of PPD found that the children of the women whose PPD persisted beyond the postpartum period were more likely to develop behavioural problems as well as lower grades.[12]

There are several options with regard to treatment, but these would need to be made depending on the clinician’s level of training and referral pathway availability. Even in general practice, treatment discussions should ideally take place in conjunction with a perinatal mental health specialist. All treatment options should be on an individualised basis; there are, as with all mental health conditions, no blanket care options. Treatment options should be made in conjunction with the woman and with her past mental health history taken into consideration. There are three main options.

Talking therapies

These include cognitive behavioural therapy (CBT) and interpersonal psychotherapy (IPT). Both are therapy options for all cases.

Medication
Medication choices are dependent on the woman's method of feeding the baby, and the ability of the attending clinician to be able to prescribe. For a woman with a history of severe depression, who initially presents with mild depression in the postpartum period, NICE recommends considering a tricyclic antidepressant (TCA), selective serotonin reuptake inhibitor (SSRI), or (serotonin-) noradrenaline reuptake inhibitor [(S)NRI].[13] Women who are breastfeeding may find reassuring information from breastfeedingnetwork.org.uk; their recommendation is that sertraline is the antidepressant of choice due to its short half-life and low likelihood of accumulation in the infant. Many women will want to avoid TCAs due to sleepiness as a side effect.[14] TCAs are also often not prescribed due to the risk of overdose.

Women who decline treatment must also be counselled about the potential consequences of not having treatment for PPD. According to NICE there is some evidence to suggest there is a risk of harm to both mother and baby, including an increase in sudden infant death syndrome (SIDS) and self-harm in the mother.[13]

Combination of both
The most common treatments encompass a combination of all treatment options, along with the self-help suggestions discussed below.

Self-care suggestions for the patient[9, 13]
Look after herself
When the patient is busy looking after a new baby, she may often forget or neglect basic personal hygiene. Encourage her that little things like getting washed and dressed can make a big difference to her mood.

Local baby and parent groups
Enquire if she is attending any activities with the baby; local mother and baby groups are often a source of support for mothers who may be in a similar situation.

Access online support
There are also several online forums that provide support and enable access to other mums not in the direct vicinity, such as Mumsnet or Netmums. Pandas (http://www.pandasfoundation.org.uk) also provide support on the phone or in groups specifically for antenatal and postnatal support. It's good to be aware, however, that there are also some negative aspects to accessing social media; many portray a rosy glow to parenthood and only recognised support groups should be recommended.

Sleep
Is she able to get some sleep? Poor sleep has a direct relationship with mental health. The phrase "sleep when your baby sleeps" is always advised; however, for babies that don't sleep well, this is often difficult. There is a certain expectation of sleep deprivation, as a baby's sleep pattern is often erratic, and this is normal. If it is possible, finding a friend to mind the baby or taking it in turns with a partner overnight can often help with sleep. This, of course, is not a helpful suggestion to those who are isolated or solo parenting.

Exercise
Is she able to get out of the house for a walk or just a change of scenery? Even if it's just 10 minutes, encourage her to keep active, as gentle activity is not only good for her physically, it can also enhance her mood. Does she have any family or friends she could

trust to help out for a few minutes a day while she has a shower, drinks a cup of tea, or has an adult conversation, as these may help to lift her mood also?

Healthy diet

Keeping diet as healthy as possible is important because a poor diet can lead to low mood. Planning in advance and choosing meals that are easy to prepare by batch cooking when she feels well means that there is access to quick and nutritious food.

Relaxation

Life with a newborn may feel very overwhelming and difficult, with little time for anything else, so suggest she takes a small amount of time – even if it's only 5 minutes – to herself to recharge and unwind. A little relaxation can go a long way.

When should you refer or seek specialist advice?

According to NICE (2018a), women who require admission for a mental health problem within 12 months of childbirth should ideally be admitted to a specialist mother and baby unit, unless there are specific reasons for not doing so. Admission of babies to general psychiatric wards is not advised. Work closely with the patient's GP to discuss a referral to a secondary mental health service, ideally a specialist perinatal mental health service, for immediate assessment (within 4 hours of referral) if she has a sudden onset of symptoms suggestive of postpartum psychosis.

Working in conjunction with either the local mental health crisis team or an advanced mental health practitioner, consider an urgent referral to a secondary mental health team (ideally with a special interest in perinatal mental health) if the patient:

- is severely depressed and presents a considerable immediate risk of harm to herself or other people – admission may be required if clinically indicated
- shows evidence of severe self-neglect or is unable to care for her infant
- has a possible diagnosis of bipolar disorder
- has a history of severe mental illness, including postnatal depression, puerperal psychosis, or bipolar disorder (during pregnancy or the postnatal period or at any other time).

With the guidance of the woman's GP or an advanced mental health practitioner, consider referring the woman to a specialist substance misuse service if, in addition to depression, the woman has harmful or dependent drug or alcohol misuse in pregnancy or the postnatal period. Refer or seek specialist advice if the woman is considering starting, stopping or switching antidepressant treatment and if she is not responding to treatment appropriate to the severity of her depression. NICE (2018a) adds that specialist advice may be sought ideally from a specialist perinatal mental health team where available, or from a secondary mental health service.

Lastly NICE advise you to consider the following additional factors when deciding whether to refer or seek specialist advice:

- the woman's preference
- the woman's past history and response to treatment
- the degree of functional impairment
- the presence of significant co-morbidities or specific symptoms.[13]

Do not do!

- Do not assume she cannot take care of her baby.
- Do not assume it's only women who suffer PPD.
- Do not tell her to give up breastfeeding for antidepressant treatments, but discuss the evidence in regard that no medication is licensed for use with breastfeeding; however, there should be discussions regarding the benefits of breastfeeding over the small amount of medication that is excreted into the milk.

Aimee has been a qualified midwife since 2003. She left full-time midwifery practice to join the ambulance service, starting as an emergency care assistant and working her way up to paramedic, while always keeping her midwifery practice up to date. She has worked in several areas within the ambulance service including the emergency operations centre and the education and training department.

Ursula is a principal academic and deputy head of Midwifery and Health Sciences Department at Bournemouth University. Ursula has a PhD with the focus on how paramedics manage patients experiencing mental health from University of Southampton and has presented her work at various national and international conferences. Her book Mental Health Care in Paramedic Practice, which she authored with David Partlow, was the next step in terms of identifying means to support her fellow paramedics in managing mental health patients.

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Assessment

To get your CPD certificate, complete the quiz via the ParaPass app: **parapassweb.co.uk** or turn over for answers.

1. When does postpartum depression present?
    a. First month
    b. Second month
    c. In pregnancy
    d. It varies
2. In every 100 women having a baby, how many will experience PPD?
    a. 50–60
    b. 1–2
    c. 10–15
    d. 0
3. A risk factor for developing PPD is:
    a. Low self-esteem
    b. Lack of support
    c. Abuse
    d. All of the above
4. An example of a talking therapy to help treat PPD is:
    a. TCA
    b. CBT
    c. SSRI
    d. SIDS
5. Self-care advice includes:
    a. Sleep
    b. Gentle exercise
    c. Healthy foods
    d. All of the above
6. Before assessing treatment options, you should ideally:
    a. Make a cup of tea
    b. Transport to A&E
    c. Discuss with a perinatal health specialist
    d. Assess the father
7. The most common treatment option for PPD is:
    a. Talking therapy
    b. Medication
    c. Self-care
    d. A combination of all of the above
8. If a mother is experiencing hallucinations postpartum, she may be suffering with:

    a. PPD
    b. Postpartum psychosis
    c. Depression
    d. Bipolar
9. The ‘baby blues’:
    a. Is another term for PPD
    b. Can affect men
    c. Affects up to 80% of new mothers
    d. Is untreatable
10. If a mother presents a considerable risk to herself or others:
    a. Refer immediately to mental health services in accordance with local policy
    b. She has postpartum psychosis
    c. Call the out of hours GP
    d. Suggest she looks after herself

Answers: 1: D, 2: C, 3: D, 4: B, 5: D, 6: C, 7: D, 8: B, 9: C, 10: A