The Royal HOSPITAL FOR WOMEN

LOCAL OPERATING PROCEDURE

Approved by Quality & Patient Care Committee
21 June 2018

MENTAL HEALTH ESCALATION – MATERNITY OUTPATIENT

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

Appropriate assessment, diagnosis and treatment to ensure the safe care of a pregnant or postpartum woman experiencing **acute mental health symptoms**

2. PATIENT

Pregnant or postpartum woman who is an outpatient and may be displaying **any of the following symptoms**:

- Disorganised behaviour
- Incoherence
- Suicidal and/or infanticidal ideation or intention
- Paranoia
- Mania
- Confusion
- Severe depression
- Psychosis
- Severe panic attack

3. STAFF

- Medical, midwifery and nursing staff
- Allied health staff
- Access and Demand Manager (ADM)
- After Hours Nurse Manager (AHNM)

4. EQUIPMENT

- Nil

5. CLINICAL PRACTICE

- Identify the unwell woman according to the criteria above
- Assess risk of suicide/infanticide as per Appendix 1
- Assess the immediate safety of the woman and neonate and provide safe care of the neonate, if postpartum
- Inform ward manager and ADM/AHNM
- **NOTIFY SECURITY IF WOMAN'S BEHAVIOUR IS THREATENING TO SELF OR OTHERS (EXT 22847) OR INITIATE CODE BLACK (777)**
- Organise mental health review as per Appendix 2

ADDITIONAL INFORMATION FOR ASSESSMENTS PERFORMED BY MIDWIVES IN THE HOME SETTING

- Ensure personal safety
- Ensure safety of other minors in the household
- Contact services according to level of concern
- Request family member return home (if not present) to provide supervision and secure woman's safety until services arrive

MODERATE TO LOW RISK

- Refer to General Practitioner
- Advise PMH CMC to coordinate follow up

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HIGH RISK

- Call ambulance or Police on 000 to transport woman to the nearest Emergency Department for psychiatric assessment if there is an **immediate safety concern**
- Call Mental Health Line 1800 511 011, provide details and request same day review if **safety is secure**

6. DOCUMENTATION

- Medical record
- Schedule 1 Mental Health Act (2007)
- Schedule 3 Statement of Rights (Involuntary patient)
- Schedule 3A Statement of Rights (Voluntary patient)

7. EDUCATIONAL NOTES

- There is growing literature and evidence that perinatal experiences can influence later psychological and developmental outcomes for the baby. This evidence underpins the practice of early identification and intervention with women in mental health distress during the perinatal period.
- It is now well recognised that vulnerability to psychological distress and disorder is accentuated in the perinatal period not only for the mother, but also her infant, partner and family. Poor maternal mental health can significantly affect the emotional, social, physical and cognitive development of her child and is associated with increased incidence of chronic disease. The perinatal phase is critical, both in terms of the attainment of parenting skills and secure parent infant attachment.
- The Edinburgh Depression Scale (EDS) is a screening tool for depression. High scores do not themselves confirm a depressive illness and, similarly, some women who score below a set threshold might have depression. Thus, the EDS does not provide a clinical diagnosis of depression and it should not be used as a substitute for full psychiatric assessment or clinical judgement.
- Behavioural strategies can be suggested as part of a safety plan. These strategies include practicing guided muscle relaxation, breathing exercises and using mindfulness Apps e.g.; Mind the Bump, Headspace and Smiling Mind. Other strategies could include creating a healthy sleeping plan, exercise and introducing an increase in pleasurable activities.

8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP

- Mental Health Escalation Policy – Maternity Inpatient
- Care Coordination; Planning from Admission to Transfer of Care in NSW Public Hospitals Procedures.
- Inter-facility Transfer Process for Adults Requiring Specialist Care.
- RHW Business Rule. Admissions.
- RHW Business Rule. Inter hospital Transfer
- SESLHDPR/230 WHS - Working Off Site Risk Management Procedure

9. RISK RATING

- Low

10. NATIONAL STANDARD

- CC – Comprehensive Care

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MENTAL HEALTH ESCALATION – MATERNITY OUTPATIENT cont'd

11. **REFERENCES**

1. NSW Department of Health, 2009, NSW Health/Families NSW Supporting Families Early Package – SAFE START Guidelines: Improving mental health outcomes for parents and infants, NSW Department of Health
2. Baradon, T. (2010) Relational trauma in infancy: psychoanalytic, attachment and neuropsychological contributions to parent infant psychotherapy.
3. Perinatal Mental Health National Action Plan 2008-2010 Full report Beyond blue: the national depression initiative
4. Centre for Perinatal Excellence (COPE). Mental Health Care in the Perinatal Period, Australian Clinical Practice Guideline October 2017 http://cope.org.au/wp-content/uploads/2018/05/COPE-Perinatal-MH-Guideline_Final-2018.pdf
5. Mental Health Act (2007) Guide Book 5th addition incorporating the 2015 Mental Health Act Amendments http://www.mha.nswiop.nsw.edu.au/images/Mental-Health-Act_Guide-Book_2016.pdf
6. Mental Health Act (2007) http://www.legislation.nsw.gov.au/viewtop/inforce/act+8+2007+FIRST+0+N/

REVISION & APPROVAL HISTORY
Reviewed and endorsed Maternity Services LOPs 19/6/18
Approved Quality & Patient Safety Committee 20/2/14
Appendix 2 updated March 2014
Endorsed Obstetrics LOPs 28/1/14

FOR REVIEW : JUNE 2023

……/ Appendices

APPENDIX 1

ASSESSMENT OF SUICIDE/INFANTICIDE RISK

Developed form the recommendations in SESLHD PD 2006/5 Clinical Risk Assessment and Management Policy

TO BE USED IN CONJUNCTION WITH THE EDINGBURGH DEPRESSION SCALE (EDS)

If risk is suspected, please explore the woman's current situation and if possible complete the EDS. If QUESTION 10 SCORE IS 1, 2 OR 3, PLEASE DO THE FOLLOWING:

1) **PRELIMINARY EXPLORATION**
   a) **LANGUAGE AND COMPREHENSION**
      i) Did she read and correctly understand the question?
      ii) Culturally and Linguistically Diverse (CALD) women may misunderstand "self-harm"
      iii) Fear of an accident during pregnancy may be thought of as self-harm e.g. hurting yourself if you have a fall
      iv) Distinguish between thoughts present now and within the past week vs. some time ago

   b) **SELF HARM OR SUICIDAL**
      i) Some women are recurrent self-harmers without suicidal intent e.g. those who inflict superficial lacerations but are not likely to come to serious harm

   c) **AREAS TO DISCUSS AND DOCUMENT**
      i) What exactly is the thought?
      ii) How often is it present and how severe?
      iii) Has she made any attempt to harm herself? When? How?
      iv) Has she got a plan? How likely is it to be effective?
      v) What would stop her from acting on her thoughts (e.g. child, husband)?
      vi) How hopeless is she feeling?
      vii) What supports does she have (e.g. family, General Practitioner or family doctor, friends)?
      viii) If she has a partner, has she told him/her and how did he/she react?
      ix) Does she have thoughts of harming the baby?
      x) How does she interact with the baby at interview?
      xi) Your confidence in the assessment?

2) **SPECTRUM OF RISK**
   Use the tables below to identify the score associated with the level of risk

SUICIDE RISK SPECTRUM		
RISK LEVEL	**EXPRESSED THOUGHTS**	**SCORE**
LOW	Wants to escape situation e.g. "run away" but no thoughts of harm to self or baby	**1**
LOW	Would rather not wake up. Wants to go to sleep to shut things out of mind. No other thoughts	**2**
LOW	Passive suicidal thoughts. Wouldn't mind if had serious accident or illness (e.g. got run over or told she had cancer) but no active thoughts	**3**
MODERATE	Suicidal thoughts - "I wish I was dead etc." But NO plan	**4**
MODERATE	Fleeting suicidal plans BUT wouldn't do it because of baby /husband/ religion etc	**5**
HIGH	Repeated thoughts of suicidal plan AND "no reason to live" or hopelessness is prominent	**6**
EXTREME	Current specific plans with past attempts	**7**
EXTREME	Previous diagnosis of a mental health disorder such as schizophrenia, bipolar etc.	**8**

3) TIMING OF MENTAL HEALTH CLINIC REVIEW

Use the table below to clarify the urgency of the mental health review in relation to the risk spectrum score

Timing of mental health review		
SCORE	**Situation**	**Review**
1-3	Situation contained at home	Next available Clinic appointment and Multidisciplinary Case Discussion (MCD)
	Situation not contained at home	Clinic appointment within 1-2 weeks and MCD
4-5	Situation contained at home	Clinic appointment within 1-2 weeks and MCD
	Situation not contained at home	Same day (RHW psychiatrist/POWH Emergency Department (ED))
6-8	Urgent	Immediate (RHW psychiatrist/POWH ED)

APPENDIX 2

FLOW CHART – Mental health escalation – Outpatient