

Service Development Guidelines

*for facilities providing
maternal mental health care*



Perinatal Mental Health Project

Caring for mothers. Caring for the future.



Centre for
Public Mental Health

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Acknowledgements

Cover art by Lesley Charnock.
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Forward

Integrating maternal mental health: service development guidelines for facilities

In South Africa, at least one in three women will experience postnatal depression. In most cases this can be detected early, during pregnancy when women attend facilities for antenatal care. Mental illness can be managed at primary level.

Since 2002, the Perinatal Mental Health Project has been operating an integrated mental health service in a primary level maternity facility. We offer mental health screening, counselling and psychiatry services to pregnant and post-natal woman *on site* at the facility where they receive their antenatal care.

We have been asked by other facilities to describe how our service runs. We have drawn from our experience and tried to develop some guidelines about how an integrated mental health service could be adapted for other facilities. Each management team would need to assess their own needs and adapt these guidelines to ensure that the maternal mental health service works well within the specific environment.

We anticipate that this document could be used by those planning mental health services or facility managers wanting to implement integrated services.

Where there are competing health priorities, low staffing levels and a lack of resources, it may seem like an unrealistic task to develop new services for mental health. However, the PMHP team has been inspired and learnt from the creativity, drive and resourcefulness of health workers operating in very difficult circumstances.

From village health workers in rural Eastern Cape to nurses in gangland in Cape Town, we have seen health workers develop mental health services for mothers. They have gained new skills, maximised existing resources and made working plans. We have learnt from each other in drawing up these guidelines.

We hope these guidelines help you with your service development.

The PMHP team.

October 2010.

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1 INTRODUCTION

1.1 What is mental health?

The World Health Organisation says “health is a state of complete physical, mental and social well-being and not merely the absence of disease”.

- Mental health is an important part of health.
- Mental health is more than the absence of illness.
- Mental health is connected to physical health and behaviour.

Mental illness affects people’s feelings, thoughts and behaviour. Mental illness can have negative effects on people's lives or the lives of their families. Symptoms of illness can include

- changes in mood
- changes in a person’s perception of reality
- changes in a person’s ability to organise or focus their thoughts.

These changes can interfere with how people are able to function.

But, mental illness is treatable.

People who have a mental illness may not know about it, or may be ashamed to talk about it. This makes it difficult for them to ask for help and get treatment.

1.2 Mental health and culture

Illness cannot be separated from social background and the language used to describe it. As a result, mental illness can be described in different ways. Some people may complain about a physical pain or problem, e.g. stomach-ache, being very tired, headaches, or other general physical symptoms. To address these symptoms, health workers will need to address a person’s physical **and** mental health.

A woman may use physical problems as a way of getting care. By getting attention for her physical problem, a woman may hope that health workers will treat her “real” underlying emotional problem.

1.3 Mental health and poverty

Research shows that people who live in violent and difficult conditions are more likely to suffer from mental health problems. In poor and low-income countries, people are focused on survival. In this setting, health care is focused on the most severe physical problems and emotional well-being is not considered a priority.

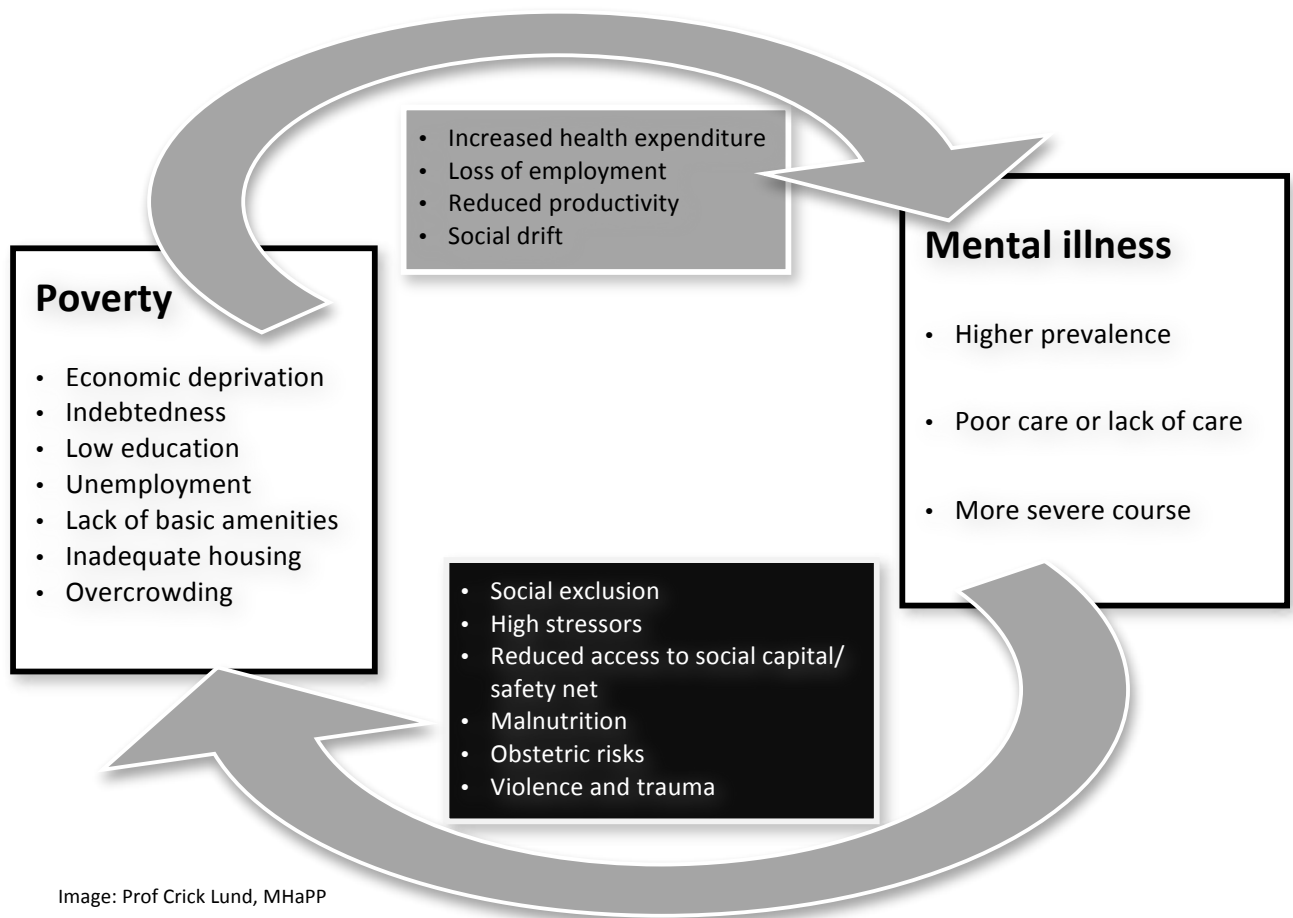
However, mental health affects physical health. For example, someone who feels depressed:

- may not be able to access the medical care that they need.
- may be more likely to get sick because the immune system is weaker.
- may impact on a person's ability to take the medication that they need.

People suffering with mental illness may be

- less productive at work
- less able to cope with problems
- more likely to lose contact with their social networks and support systems.

These factors all add to the vicious **cycle of poverty and mental illness**.



1.4 Mental health is everybody's business

Mental health care is often seen as a specialist field that only highly trained health workers can deal with, e.g. psychiatrists or psychiatric nurses.

Mental illnesses are far more common than both health workers and clients often realise. Poor mental health can affect clients in many ways. That is why it is important that all levels of medical staff are able to recognise mental illness.

Why don't health workers ask about how a client is feeling?

- Perhaps the answer will require too much time and effort.
- It may be easier to deal with a physical problem.
- Perhaps the question reminds health workers about their own personal issues.
- It is often difficult for health workers to hear about clients' feelings because they may feel unable to offer help to clients.

1.5 Staff mental health

Health professionals who work with women during pregnancy and after birth should be aware that their personal feelings could affect the care they give their clients.

Health workers

- have had their own parenting experiences (e.g. having parents and being parents)
- have their own cultural or religious beliefs about pregnancy, childbirth and parenting, and
- have their own emotions about these experiences.

Many health workers are also stressed in their personal and professional lives. It is important that health workers' own emotional health be addressed to ensure the best care for their clients.

Health workers also need support, compassion and appreciation.

1.6 Stigma

People often do not get the care they need because of stigma around mental illness. **Stigma** is when someone holds a negative opinion about another person because that person seems to be 'different'. It can cause people to be thought of as 'bad' or 'unacceptable' and to be rejected or treated poorly.

Mental illness is often a cause of stigma. People with a mental illness are often labelled in a negative way and judged, e.g. they are seen as bad, mad, dirty or difficult. Therefore, people are often not willing to admit that they have mental health problems because they are afraid of being labelled and judged.

Health workers and health facilities can help to reduce stigma by:

- training staff to be more sensitive to the mental health needs of their clients
- acknowledging and addressing the mental health needs of staff
- making mental health screening a routine part of ordinary services

1.7 Mental illness

1.7.1 What is Normal?

It is **normal** for people to have changes in mood. Everyone experiences different events that can cause stress. For example, one may feel very happy on one's birthday, but feel depressed and sad when one's cell phone gets stolen.

When trying to decide whether or not a person is experiencing clinical depression or an anxiety disorder, health workers need to ask how long the symptoms have been present and how the symptoms affect the person in various ways. This gives some idea about how significant the complaints are, and whether they will need help to get better.

1.7.2 What is Depression?

Depression is a type of mental illness. It is also called 'depressive disorder', 'clinical depression' or a 'mood disorder'. Symptoms can include:

- extreme sadness
- an inability to experience pleasure
- difficulty in concentrating
- a significant increase or decrease in appetite and weight
- tiredness, or a significant increase or decrease in time spent sleeping
- extreme feelings of guilt and worthlessness
- feeling hopeless and helpless

In more serious cases the above symptoms could be accompanied by suicidal thoughts or an attempt to commit suicide.

With depression, a person's mood **stays low for days to weeks**. This low mood **affects** the person's ability to do his/her **day-to-day activities**.

1.7.3 What is Anxiety?

Anxiety is a normal human emotion. Anxiety is usually a useful emotion. It helps us deal with fear or other extreme situations. When we are confronted by a 'threat', anxiety helps us to decide whether we should stay and 'fight' the threat, or if we should get away from the threat (flight).

Sometimes people feel anxiety when there is no threat. When this happens often and interferes with a person's ability to function, it is called an **anxiety disorder**. Symptoms can include

- sweating e.g. sweaty palms
- an increased heart-beat, chest pain or shortness of breath
- choking
- nausea
- an abnormal and overwhelming sense of uneasiness, worry or fear about a possible threat
- doubt concerning the reality and nature of the threat
- self-doubt about one's ability to cope with the threat

Often, people with mental illness experience symptoms of anxiety and depression **at the same time**.

1.7.4 What is Psychosis?

Psychosis is a state of mind in which a person is said to be "out of touch with reality". It can be frightening.

There are certain types of illnesses, like schizophrenia, where a person experiences psychotic states. These come and go, and usually continue to do so throughout the person's life.

Some drugs like TIK can also cause psychotic states. In addition, illnesses, such as AIDS, can cause psychosis. It is for this reason that when an HIV+ person is psychotic, he or she needs to be examined carefully by a doctor.

Symptoms of psychosis may include some or any combination of:

- speech problems
- behaviour problems e.g. irrational behaviour, homicidal or suicidal thoughts
- delusions or distorted thinking
- beliefs or perceptions which are wrong or 'out of touch'
- violent behaviour
- obsessive compulsive behaviour
- extreme panic
- feeling very agitated or 'trapped'
- severely clouded emotions
- hallucinations e.g. hearing voices, seeing things which are not there
- paranoid thoughts e.g. someone is planning to harm them or their baby, someone or something is controlling their thoughts

- Some people with severe depression may show psychotic symptoms. It is important to remember that just because someone is depressed **does not mean that they are psychotic.**
- At most, 2 mothers out of 1,000 may experience psychosis. If you do think that a woman in your care is psychotic **contact a doctor and arrange IMMEDIATE psychiatric care.**

1.8 Why maternal mental health?

Change can be very stressful. When entering into something new, such as parenthood, one may feel anxious, stressed or uncertain. When a person feels too much stress, he or she may become emotionally unstable.

Pregnancy is a time of change – both physically and emotionally. It is understandable that a woman may feel depressed or anxious during and after pregnancy. However, if these feelings become so severe that they interfere with a woman's daily life, it is possible that she is suffering from a mental illness.

It is important that caregivers recognise that this a highly vulnerable time for women.

It is also common for a new mother to feel emotional after childbirth. She may experience sudden mood swings, feel very happy one moment, then very sad the next, she may cry for no apparent reason, feel impatient, very irritable, restless, anxious, lonely or sad. This is usually a common but temporary psychological state called the 'baby blues'. The 'baby blues' may last a few hours or as long as 2 weeks after delivery.

But, it is important not to confuse the 'baby blues' with postnatal depression. 'Baby blues' may not always require treatment, but more serious conditions like depression or anxiety do.

1.8.1 Opportunity

During pregnancy, many women return to the same clinic several times. This provides an opportunity for maternity staff to find out about mental health problems and to arrange mental health care for the mother.

1.8.2 Prevention

By screening for mental health problems early, and providing help, health workers can:

- identify women who are most likely to become depressed and anxious and provide them with support.
- treat women who already have a mental illness and prevent it from getting worse.
- treat and/or manage mental illness before the baby is born so that the mother is better able to cope and care for herself and her baby.

1.8.3 Health promotion

Treating mental health problems has the benefit of promoting general health.

Women who are mentally well have better physical health and are more likely to use health services in the best possible way.

1.8.4 Staff capacity

Health workers may feel overwhelmed by their workload. However, they are aware that mental illness is a problem.

Training in mental health and skills development may help them cope with problems they previously felt unable to deal with.

Health workers have expressed feelings of relief when because they are better equipped to provide basic mental health for the women in their care.

Building staff capacity through maternal mental health training can empower and improve staff morale.

1.8.5 Better Birth Initiative

Good maternal care affects the emotional and physical health of the baby and the mother, in the years to come. This has been studied and the evidence drawn together into the Better Birth Initiative (BBI).

The BBI has identified practices in low-resource settings which can

- improve the health of women and infants
- reduce harm to the mother and infant
- prevent maternal and infant deaths

The role of the health worker is very important. By caring for the mother's overall wellbeing, you can have a positive impact on the infant's development and the mother's ability to care for her child. A mother who feels safe, understood and well cared for will be better able to bond with, breastfeed, and care for her baby.

The mother's mental state may be linked to birth complications, a traumatic birth experience and postnatal depression. These complications may be avoided if the mother receives gentle and **compassionate care**.

The Better Birth Initiative makes the following recommendations for compassionate care:

- Allow mothers to move during labour
- Allow mothers to be in different positions for delivery
- Provide fluids and food during labour for energy and hydration
- Encourage and ensure that mothers have a companion during labour
- Only use enemas when they are necessary.
- Do **not** shaving pubic hair – this is degrading and has no medical benefit
- Perform an episiotomy **only** when clinically required – episiotomy has been linked to poor healing and longer-hospital stays
- Ensure that HIV positive mothers can prevent mother-to-child transmission
- Provide magnesium sulphate for treating eclampsia
- Provide oxytocin in the third stage of labour to prevent postnatal complications
- Reduce early amniotomy (rupturing of membranes) – this has no clinical benefit **unless** progress in labour is abnormal
- Use suction **only** for babies when meconium is present

The BBI has 4 guiding principles:

- **Humanity** Women are to be treated with respect
- **Benefit** Provide care that is based on the best available evidence
- **Commitment** Health professionals are committed to improving care
- **Action** Develop effective strategies to change practices which may be harmful to mothers and infants

These principles are useful guidelines when thinking about a maternal mental health service in your facility.

Notes

2 WHAT KIND OF MENTAL HEALTH INTERVENTION CAN BE DEVELOPED?

Even with limited resources, it may be possible to develop a mental health intervention at your facility. It is important to understand your facility, clients and community to be able to set up a service that suits the local situation.

Appendix A is a basic plan to help you think about setting up an intervention. Those designing a mental health service need to assess local resources in terms of:

- What time is available?
- Which personnel are available?
- Who has the necessary skills? Who is already trained? Who can be trained?
- Is there a private space available where the counselling sessions can take place?
- Who can help set up an intervention?
- What referral services or resources are available in your community?

2.1 Principles for mental health integration

Before looking at what and how you can set up a service, it is useful to take the following principles into account.

- Integration is a **process** – not an event. Integration takes time. Services change and may need to be adapted to develop best practice for the local setting.
- **Policies and plans** need to incorporate mental health into the primary care setting. Although the South African Mental Health Act (2002) states that mental health care should be integrated into routine primary care, such services are not yet available in the maternal care environment.
- Advocacy is needed to **shift attitudes** and behaviour. Information needs to be shared to inform staff and clients about mental health and create change.
- Adequate **training** needs to be given to staff. They need to be equipped with the skills to feel confident to carry out their tasks.
- **Tasks** need to be manageable for staff. Support needs to be on-going and supervised so that primary care workers are not overwhelmed by new responsibilities.
- **Specialist mental health professionals** and facilities need to be available for support. These could be psychiatric nurses, psychiatrists or social workers. They can supplement the service to provide assistance with referrals, support and supervision.
- **Collaboration with partners** in other sectors – these include non-health government sectors, NGOs and social groups. In sharing resources and providing support, partner organisations can provide holistic help for clients with mental health problems.
- A **service co-ordinator** is important to oversee the process. They 'champion' service development and help to problem-solve challenges and difficulties.
- Establish the **financial and human resources** that are needed for successful mental health integration.

2.2 Situational analysis

A **situational analysis** means finding out about the maternal mental health needs and resources in your local area. In order to set up a suitable service, it is important to know how big the demand for mental health services is, and what resources may already exist to help meet this demand.

The PMHP experience

Health workers do not always respond positively about setting up mental health services. Some reasons could be:

- People may feel intimidated or threatened because they do not know much about mental health.
- Health workers may feel guilty about not dealing with mental health problems before.
- Fear of having more work to do, when health workers are already over-loaded, could cause feelings of anger and resentment.
- People may feel uncomfortable about dealing with mental health issues if they have personal mental health problems.

These concerns need to be addressed when setting up a service.

The following sections outline useful steps to follow when doing a situational analysis.

2.2.1 Your local area

This exercise will help you identify the services already available in your area.

a) Describe your local community.

- Population size?
- Urban to rural?
- Old or young?
- Men or women?
- Permanent or temporary communities?
- Levels of poverty?
- Immigrants / refugees?
- Health factors e.g. HIV prevalence, rate of teenage pregnancy, substance or alcohol use?

- b) Describe health facilities in the area.
- How easy is it for the community to access services?
 - What types of health services are available for pregnant women and mothers?
 - Can women access continued services before and after birth?
- c) Describe existing support services for mothers and pregnant women.
- Family support?
 - Church services e.g. soup kitchens / support groups?
 - Social support e.g. support groups?
 - Traditional carers?
 - Government agencies, e.g. social services office?
 - NGOs (non-governmental organisations) e.g. Mothers2Mothers.

The following questions can help to find out what services are available:

- What services do they provide e.g. Counselling? Food parcels? HIV counselling? TB treatment support (DOTS)? Day care? Home care?
- Is there a fee for the service?
- When is the service available – on what days, at what times?
- How many women do they see?
- How are women referred to the service? What is the referral procedure?
- Does the service provider need training in maternal mental health?
- Will the service provider be able to see your referrals?

2.2.2 For your health facility

These are important questions to think about before starting a service at your facility.

2.2.2.1 Staff

- How many staff work with antenatal and postnatal women?
- Do the same staff see women before and after birth?
- What are the different ranks of the staff working with antenatal and postnatal women?
- How many obstetric staff have mental health experience or qualifications in mental health care?
- Do existing staff members have the capacity to be trained in maternal mental health? And would they have the capacity to provide mental health services?

2.2.2.2 Structures

- What mental health services already exist in your area? (You would have identified these organisations in your 'situational analysis'.)
- Do these services deal with **maternal** mental health issues? Are there lines of referral between your facility and these services?
- Have relationships been established between mental health professionals and obstetric services at your facility?
- Is there space at your facility to provide private screening and counselling? If not, can a space be created? (The PMHP has seen staff convert linen rooms, storage cupboards and waiting areas into cosy, private counselling spaces.)

2.2.2.3 Clients

- How many women are seen at each site per day?
- Why do women attend your facility? e.g. Antenatal care or postnatal care?
- How many new clients are seen at your facility per week? Per month?
- What is the average number of antenatal and postnatal visits per woman?
- How many of the women seen are HIV positive?
- How many of the women are under 20 years?
- How many women have a companion with them when they give birth?
- If you have noticed non-physical presenting problems, what kind of problems are these? e.g. Anxiety? Depression? Trauma? Substance abuse?

Notes

3 THE PMHP SERVICE MODEL

The PMHP model has **7** basic steps. This model can be adapted to your setting. **Appendix B** (the strategic planning table) may help with your planning for each step. The 7 steps are:

1. Prepare and train general health workers
2. Screen clients
3. Refer clients
4. Counselling
5. Psychiatry
6. Monitoring and evaluation
7. Supervision and management

3.1 Prepare and train general health workers

Health workers may not have had training in mental health care. Many health workers also have their own mental health needs. Providing mental health training and addressing the mental health needs of staff can create positive attitudes toward taking on mental health care.

Different types of training are outlined on the next page.

The PMHP experience

Many staff within the health system have experienced mental illness themselves or within their families.

The PMHP recognises that it is important to address staff's own mental health needs and provide support where necessary.

Caring for staff helps to create sensitive and quality care for pregnant women and mothers. Caring for staff is important for the success of mental health services.

How to support staff:

- Acknowledge and validate their mental health issues.
- Inform all staff of existing support systems, e.g. ICAS.
- Help to set up simple support systems for staff e.g. team building, support groups, positive feedback for good work.

Do you know about ICAS?

ICAS is the Independent Counselling and Advisory Service for health workers in South Africa. By calling their toll free number **0800 611 057** health workers (and their dependents) can access psychological counselling services in all of South Africa's official languages, free of charge.

Short-term face-to-face counselling can also be arranged.

3.1.1 Interactive dynamic training

The "Secret History" training is a 2-hour session and is facilitated by 2 trainers. The ideal group size is between 10 to 20 participants of similar professional rank. The method is interactive and very dynamic, using group role-play.

The PMHP experience

Training method: The "Secret History" training

Aim: This method encourages health workers to understand their own emotions while, **at the same time**, learning to understand the emotions of the client. This helps to develop more sensitive and empathetic care for clients while validating the experiences of staff.

Trainees are divided into 2 groups. One group role-play a client and the other group role-play a health worker. As a group, each role embarks on a journey through a pregnancy, following the relationship between the "health worker" and the "client". See **Appendix C** for a typical story used to facilitate the role-play.

Each group gets a chance to express the feelings and needs that they have as they move through this “journey”. **Appendix C** gives examples of the types of feelings and needs that may come up. Facilitators encourage the teams to respond negatively each other, and to even be aggressive about how they feel. Halfway through the role-play, the participants switch roles: the “nurse” becomes the “client”, and the “client” becomes the “nurse”.

At the end of the role-play the facilitators encourage a debriefing discussion of the process. Humour is used extensively in the debriefing period because aggression and other strong emotions may have been expressed during the role-play. Participants draw their own conclusions and reflect about intrapersonal and interpersonal issues within the staff-client relationship. This reflection shows that the “health worker” and the “client” share the same feelings and needs, e.g. feeling overwhelmed, feeling stressed, needing someone caring to talk to.

By swapping roles in this way, we experience what it is like to be the “other” person. This is an important part of the training and gives trainees the opportunity to learn about their own and their clients’ distress. At the end of the training, trainees develop their own plans for being more aware, responsive and supportive of the needs of clients, and each other.

3.1.2 Maternal Mental health education (didactic training)

The key issues to address when providing maternal mental health education are:

- Why is maternal mental health important?
- Why is early diagnosis important?
- What makes it more likely for women to feel stressed/depressed?
- What are the syndromes?
- How may the foetus or child be affected?
- How can mental illness be treated?

The PMHP Experience

In South Africa, there is a history of physical and emotional abuse of women by health care workers during pregnancy and childbirth.

Maternal mental health training should develop ways of addressing the attitude and practice of health workers. This should be done by consulting with health workers in a therapeutic manner.

3.1.3 Basic counselling skills

It is possible to equip all staff useful counselling tools, such as the ability to:

- listen: let the woman tell her whole story
- allow her to give her own understanding of her distress
- not being judgemental or blaming the client for her distress
- respect
- empower: assist the client to find her own solutions and explore practical options with her
- be supportive
- maintain confidentiality

Refresher training in basic counselling skills is often needed. The PMHP has developed 'Basic Counselling Guidelines' that could be a useful resource.

3.1.4 Need for ongoing training and supervision

Staff dealing with mental health issues need ongoing training, supervision and support to:

- prevent burnout
- maintain motivation
- ensure quality of care and professional standards
- build capacity of staff

Notes

3.2 Screening

Before setting up an intervention, staff need to have a way of deciding which women may be supported. What is realistic for your facility? It is not useful to set up expectations that cannot be met.

Making mental health screening part of standard booking procedures has many advantages:

- It **reduces stigma** as it is seen as part of the normal care offered to the public.
- It **maximises coverage** as everybody completes the screening, which means we can identify and treat women who are in distress.
- There is an increase in **staff efficiency**: the more frequently screening takes place, the quicker and easier the task will become for staff.

Screening women for mental health problems allows large numbers of women to be triaged* into the best care.

Screening is used to **supplement clinical judgement**.

* *Triage means to:*

- *Sort out clients according to their immediate mental health needs*
- *Sort out clients according to the seriousness of their condition.*
- *Sort out clients according to who will benefit most from mental health care. This is often important in facilities with limited resources.*

The following questions can help to decide how to develop the screening process:

- Who will be screened?
 - Can everybody be screened?
 - Can only the most vulnerable women be screened? e.g. teenagers, HIV positive women?
 - How best will busy health workers be able to identify the most vulnerable women?

- When will women be screened?
 - Is there likely to be only one visit to the facility?
 - Will there be more visits allowing for more screening opportunities?

- How to screen?
 - How much time do staff have to administer the screening questionnaire?
 - How many staff have been trained or can be trained to administer the screening tool?
 - What staff rank is best suited to do the screening?
 - What questionnaire would be best suited to the clients at your facility?
 - Are there high levels of literacy? Or will women need staff to assist them in filling in the questionnaire?
 - Are there many language needs? Will you need to have questionnaires in isiXhosa, Afrikaans, French or another language?

- What will be the coverage of your screening process?
 - How many of the women you want to screen will actually get to be screened?
 - What is your target? What are your reasons for this target?
 - It is important to know how many women your facility serves before deciding on the number of women to screen. This will impact the size of the service you will have to provide.

The PMHP experience: 1/3 (one third) of women who are screened qualify for referral.

Notes

3.2.1 How to screen?

Several stages should be followed when screening.

3.2.1.1 Explain why screening is being done

A useful thing to say is: “At this health facility, we are not only interested in your physical health. We are also interested in how you feel inside.”

This shows that mental health care is part of the normal health care that your client gets. Inform her that the questionnaire may help to find out if she needs extra support that can be provided in your facility. You could also say:

- “These questionnaires help us to know how you are feeling inside.”
- “They help us decide whether we can offer some extra support in the form of counselling.”

3.2.1.2 Explain that screening is voluntary

Make it clear that being screened is a choice. Your client is not under any obligation to be screened. It is important to let her know that her overall care at the facility will not be affected if she chooses not to be screened.

3.2.1.3 Take informed consent

Some facilities prefer to give their clients an “informed consent form” before screening. This form helps to make sure that the client understands the screening process. **Appendix D** shows a copy of the PMHP consent form.

3.2.1.4 Discuss confidentiality

Health workers are in a privileged and unique position – someone is telling them personal, private information. This trust must be respected. That means not sharing the information with anyone. It is only acceptable to share your client’s private information with another health worker when this is needed for the management of the case.

Confidentially requires that you as the health worker ensure the client’s privacy. Questionnaires should be answered with no partners or family members present.

Explain the following information to the client:

- Who will be responsible for assessing her questionnaires?
- The forms will be kept in a locked cabinet and not the in the general medical folders, if possible.
- All personal information is kept strictly confidential.

3.2.1.5 If the woman chooses to fill in the questionnaires by herself:

- Ask in which **language** she would prefer her questionnaires (English, Afrikaans, Xhosa and French, if available).
- Check **literacy**. Many women may not be able to read and write well. Say, “please call me to help you if you have any problem completing the questionnaires”. Help her to complete the forms if necessary.
- Check forms have been filled in **correctly**.

3.2.1.6 Scoring

- Try to **score** the questionnaires while the client is still in the clinic or waiting to see the health care worker. If you have questions about how she filled in the forms or need to make a referral, you may not get another chance to talk to her.
- Explain the **result** of the score to the client.
- If you offer a **referral**, explain what she might expect and where you are referring her. Also be sure to explain that this is voluntary. The client does not have to take your referral - unless it is an emergency. Give some details regarding what may happen at the referral agency. Having more information helps the client feel more at ease and makes it more likely that she will attend your referral.

3.2.2 Screening Tools

There are several screening questionnaires to choose from. Three questionnaires are explained here:

- The Edinburgh Depression Scale
- The Risk Factor Assessment
- The Self-Reporting Questionnaire

3.2.2.1 The Edinburgh Depression Scale (EDS)



This is one of the most commonly used screening questionnaires in the world. It helps to check for depression and anxiety during or after pregnancy. The tool has been tested in a wide range of cultural settings and in different languages.

The PMHP version of this questionnaire – which has been adapted slightly to make it easier to use – is included in **Appendix E** (In English with scores).

Appendix F can be used as the client version. It is available in Afrikaans (**Appendix I**), isiXhosa (**Appendix K**), and French (**Appendix M**).

- There are 10 multiple-choice questions assessing mood symptoms experienced for at least the past 7 days.
- The worse the symptom, the higher the score.
- Usually, a score of 13 or more may indicate a mental health disorder. The client may require a referral.

3.2.2.2 The Risk Factor Assessment (RFA)

The Risk Factor Assessment was developed by the PMHP by studying international research on the most common risk factors for maternal distress.

A risk factor is a characteristic, condition or behaviour that increases a person's chances of developing a disorder or disease. For example, high blood pressure, high cholesterol and smoking are risk factors for heart disease. Or, lack of support at home, an HIV-positive diagnosis and unemployment are risk factors for depression.

The RFA may be useful for:

- Finding out about a woman’s social circumstances.
- Identifying if a woman has a mental health problem, or if she may develop a mental health problem in the future.

The RFA has 11 questions. These are answered with either a “yes” or a “no”. You can get an idea about a client’s risk by looking at which questions she answered “yes” or “no” to.

The RFA, with explanations, is included as **Appendix G**, the English client version as **Appendix H**. Afrikaans (**Appendix J**), isiXhosa (**Appendix L**) and French (**Appendix N**) versions are also provided.

It is important to note that the RFA has not been formally tested. But, many health care workers have found it to be a useful mental health screening tool.

The PMHP experience

- The PMHP uses both the EDS and the RFA together. These take between 5 and 15 minutes to administer.
- Multiple-choice questionnaires are hard for staff to score accurately. Staff need frequent updates, support and training to make sure that screening remains consistent and that scoring is accurate.

3.2.2.3 The Self-Reporting Questionnaire (SRQ-20)

This questionnaire lets women describe their own feelings and physical problems. Many of the physical complaints could be normal for pregnant women, like poor sleep or change in appetite.

It is very common for people to explain emotional problems as physical problems. Therefore it is important to find out if physical symptoms have emotional causes. The SRQ-20, with scoring explanation, is included as **Appendix O**. The client version appears as **Appendix P**.

Remember, some physical symptoms are indicators for other diseases, like HIV.

The SRQ-20 has 20 questions. These are also “yes” or “no” questions. This is a useful questionnaire because:

- it has been used successfully in facilities which have little or no resources.
- it is easy for staff to ask the questions – clients either **do** or **do not** have the symptom.
- Questions ask about feelings **and** physical problems.
- A score of 6 or more indicates that the client may have depression.

See **Appendix Q** for an example of the PMHP screening and management protocol, and **Appendix R** for an example of a screening log.

Notes

3.3 Referral

This is an important part of any mental health service. It is often not given enough attention. It is important to have a proper referral system set up before starting to screen women for mental health problems. If this is not done, expectations for help may not be met, which can have a negative effect on clients' health.

3.3.1 Why do women with mental health problems default?

The PMHP experience

1/3 (one third) of appointments may be defaulted!!!

There are many reasons why women do not attend mental health appointments. Women may feel:



- Worried they will be seen as “mad” or be afraid that they will be judged as an unfit mother and that their baby will be taken away.
- Scared to think and talk about their problems.
- Fear that the counsellor will tell other people about what they have shared.
- Unable to make the necessary arrangements to get to the appointment, because of their depression.
- Feel that they are not worthy of getting help.
- Want to attend, but have problems with transport, childcare or finding the time to make the appointment.

The difficulties with referrals may be due to:

- An appointment not being properly set up by health workers.
- The women who is referred having real practical or emotional obstacles in keeping the appointments.



3.3.2 Tips for referral

These tips may maximise the chances of having a successful referral, where time is well spent and the woman receives good quality assistance.

3.3.2.1 Explain why she is being referred

It may be useful to express concern for her well-being and the possible outcomes of her situation for her and her family.

3.3.2.2 Prepare for the referral

- Choose the organisation or service well.
- Make a personal contact with a staff member there. This will make things much easier for the person who makes the referral and for the client.
- Write a detailed referral letter **and** ask for a reply from the service provider.

An example of a letter of referral is attached as **Appendix S**.

3.3.2.3 Explore whether the client will go

- The time and place must suit the client.
- Be non-judgmental when making arrangements with her.
- Explore practical or emotional challenges that may prevent the client from keeping her referral appointment. For example:
 - is she able to take time off work?
 - does she have taxi or bus fare?
 - can she make childcare arrangements?
 - can an appointment be made at the same time as her next appointment at your facility?

3.3.2.4 Follow-up

- Arrange for follow-up with the same person who refers the client, at the same unit, if possible.
- Try to find out if the client went to the appointment and if the appointment was helpful for her.
- A referral evaluation form can help you keep track of useful services and whether or not your client accepted the referral. An example is included as **Appendix T**.

3.3.2.5 Open-door policy

Many women may refuse to be referred. Many may also default on the referral appointment. Even though they really need mental health care, women may be afraid. They may also have work or home problems that the person who makes the referral does not know about.

Depressed or anxious women may find it very difficult to use services. Practical and emotional tasks may make them feel overwhelmed.

It is very important not to get angry with them if they do not go to their appointment. Be careful to not judge or “punish” a woman for this.

By letting her know that you are someone who cares about her wellbeing, she will be able to feel “safe” with you. At a later stage, perhaps in a crisis, she may change her mind and want the referral. This is OK. It is important that she can access the care she needs at any time.

3.3.3 Possible resources for referral

When a health worker screens a woman for mental distress or is able to pick up social or emotional problems in the consultation, it may be necessary to refer the woman to a service specialising in her particular problem.

It is useful to learn about non-governmental organisations (NGOs) in the local area. However, there may be governmental or community-based services that can be used as well.

3.3.3.1 Community Mental Health Nurses

- They are linked to psychologists and psychiatrists on a Community Mental Health Team. They may also be called Community Psychiatric Nurses.
- The referring health worker should show that the woman has symptoms of mental illness (more than 2 or 3 weeks) and that her distress is not simply part of a short-term adjustment to social problems.

3.3.3.2 Social Workers

Refer to a social worker if the woman has problems related to housing or grants.

3.3.3.3 Directory of Resources

- Contact the Mental Health Sub-directorate for a list of services in your area.
- If possible, contact local Department of Health services for directories.
- NGOs and other social networks in your area may have their own directory of resources. It could be useful to link up with these organisations and share information.

3.3.3.4 Local resources

There may be a range of service in your specific area, such as:

- Religious organisations
- Income-generating projects
- Micro-finance lending schemes
- Local support groups

3.3.3.5 Emergencies

If the woman is suicidal, has thoughts of harming others, or seems to be psychotic, then admit or refer her on the same day to a:

- psychiatry ward in a general hospital.
- psychiatric hospital, if the client is known to them.
- community mental health nurse.
- doctor at the midwife unit, the community health centre or general hospital.

Notes

3.4 Counselling

Counselling is an important intervention in addressing maternal mental illness.

3.4.1 What is counselling?

Counselling involves listening to your client. Counselling is about supporting your client and empowering her to find her own solutions.

Counselling is **not** about giving advice!

3.4.2 What can counselling provide?

- A safe space to be heard – the woman tells her whole story
- A way to understand her own distress
- Someone who will listen without blaming or judging
- Respect
- Validation of feelings
- An opportunity to explore practical options with her
- An opportunity to look for solutions to her problems
- Support

The PMHP experience

- 42% of women who qualify for counselling decline the referral to see a counsellor.
- One third (1/3) of counselling appointments are defaulted.
- 12% of women referred to counselling are lost to follow up – they never attend any counselling appointments.
- 46% of those that qualify for counselling will see a counsellor.

When a dedicated Mental Health officer (nurse, counsellor or other type of health worker) takes responsibility for managing the service, the service works more efficiently and effectively.

3.4.3 Staff

On-site

Staff who provide counselling need to be **at the same place** where women get antenatal care.

Dedicated staff

It helps to have one or two people responsible and accountable for the clinical management of the mental health service.

If possible, this should not be an additional duty that they have to perform on top of their regular job.



Human resources

Which group of staff will be responsible for the service? Will these be lay or professional health workers? What skills and finances are available at your facility?

Selection of staff

How will the person be chosen? Are there staff who show an interest in providing maternal mental health care? Do they have any qualifications?

Training

Will staff need training to provide the service? Are there already qualified staff available? Staff who provide the mental health service will need ongoing training to update skills and to build capacity.

Supervision

Who is going to provide clinical supervision to the counsellor? All those involved in psychological counselling need regular clinical supervision.

Prevent burnout

This is a stressful and emotional job. Staff who provide counselling also need to “de-brief”. They will not be able to keep listening to and helping other people if they are not being cared for themselves!

Management

Who is responsible for overseeing the management of the service?



3.4.4 What kind of counselling?

3.4.4.1 Flexibility

Keeping an “open door policy” and making sure that women can have access to services when they need them may need some flexibility from health workers. Clients may attend more or less sessions than you plan for, or you may need to use different types of counselling in different situations.

- Most clients only manage **1 to 2 sessions**. This may seem like very little time to spend with a client, but even a few counselling sessions can have a positive impact.
- Different **types of counselling** could be used to respond to different needs, examples are:
 - Cognitive Behavioural therapy (CBT)
 - Interpersonal therapy (IPT)
 - Motivational Interviewing (MI)

These types of counselling have all been shown to be helpful, even in poor and rural settings. Lay people can also be trained in these techniques.

3.4.4.2 Different counselling arrangements

- A counsellor could work with an individual, or with a group. Which arrangement would work best in your facility?
- Counsellors could link with other available services and resources in the area. Could your facility develop systems to address the different needs of women in your area? For example, a counsellor could work with
 - social services and social workers
 - legal support organisations
- Where possible, counsellors could develop relationships with specialist organisations which may support the ongoing recovery of the client, for example
 - income-generating projects
 - women’s shelters in cases of domestic violence and abuse
 - support groups
 - home-based care organisations

3.4.4.3 Follow-up to the counselling sessions

It is important that counselling for vulnerable women continue from the antenatal period through to the postnatal period. Even if women attend baby clinics at a different site, they should be allowed to return to the maternity counselling service after the baby is born.



In some cases, counselling may need to continue for many months after the birth. It is important that counselling services at the maternity facility remain available to women after birth.

- Open-door policy for women who have declined or defaulted on counselling
 - Women may only feel able or ready to take up counselling at a later stage. It is important that they feel free to return to ask for help.
- Targeted follow-up after the birth
 - Vulnerable women should get a phone call from the counsellor 6 weeks after the birth.
- Tracing defaulters
 - Phone the client to find out why she was unable to attend.
 - Ask her if she would still like to have an appointment.
 - What made it difficult for her to attend? What would make it possible for her to attend counselling?
 - It is important to remain non-judgmental of defaulters.
- After the birth, the counsellor may link the client with additional support for specific problems from social services, legal support, women's organisations other health workers.

Keeping track of your clients

It is useful to keep a log of your clients. This way you can monitor your clients' progress. It is also important for other health workers to know this information to provide the best care for the client. Basic details and presenting problems can be categorised. See **Appendix U** for a counselling log form and **Appendix V** for a list of presenting problem categories.

A log is also useful to monitor and evaluate the service, and to write a summary report when "closing" a case with a client. See **Appendix W** for an example of a counselling summary report.

Suggestions from PMHP counsellors

- It is useful to remember that the counsellor may only see the client once. Be supportive and listen to what the client says.
- Before meeting a client for the first time, it is helpful to check through the screening questionnaires. Note which items have the highest scores and which risk factors have been marked.
- If there is a referral form that outlines the problem, it is useful to use the information when you start speaking to the client – this approach helps you get straight to the issue:

“I see that the health worker was concerned about you because you seemed very sad when she was speaking to you.”

“The health worker mentioned that you are experiencing trouble at home.”

“The health worker said that you lost your mother recently.”

- Another approach to starting the session is to ask what the client thought about the questions on the form. Find out how she understood the questions in a non-threatening and non-judgemental way.
- If the client’s scores are high, remember that the client probably feels that it is a struggle just to keep going.
- It is important to try and listen carefully and understand the client’s feelings and thoughts. Do not try to interpret them. How the counsellor responds to the client is very important.
- Sensitive discussion is recommended rather than getting the client to “open up”. This could leave the client feeling exposed and vulnerable.
- It is important to be sensitive to your client’s culture, religion and social background. Be respectful and flexible in your approach to counselling.



- Your counselling style should adapt to the client's situation, for example:
 - Trauma counselling: if your client has experienced a traumatic life event.
 - Bereavement counselling: if your client has experienced the loss of a loved one.
 - Interpersonal psychotherapy: if there is evidence of "role conflict".
 - Cognitive-behaviour therapy: for depression or anxiety.
 - Progressive relaxation and visualisation: for tension or fear of childbirth.
- Some of the women who are referred for counselling may have enough social support and personal resources to cope with the difficulties they may be facing. The client has clearly developed healthy coping strategies in the past. It is important not to undermine these coping strategies and problem-solving abilities. It is useful to identify these strategies with the client as a reminder of her ability to cope.

- The initial stage of counselling is client-centred. The main idea is to try to create a safe space in which the client can talk about her feelings and problems. This may help her to think of her own solutions on an emotional and practical level.
- It is important to respond to the needs of the individual client. This means being sensitive to the timing of interventions, and the way in which you approach the intervention.

Interventions that are too early may overwhelm the client. A counsellor who tries to interpret the client's feelings could break down healthy behaviour (such as adaptive defences). This prevents the client from developing her own coping strategies.

- Sometimes, however, counselling may have to be more directive.

This means that the counsellor may have to offer supportive suggestions, sensitive advice, encouragement or referral to another agency. This could also mean that the counsellor should respond in a supportive way to the client's painful experience, or help the client think about more ways to respond to certain situations (this is called "reframing").

- During pregnancy, the client's problems could include maternal issues.

For example, she may have lost a baby or miscarried. She may have had a difficult or traumatic pregnancy. She may have other social issues, such as family conflict, domestic violence or financial problems. Some young women may have been told scary stories about childbirth. The client may need to hear some facts from you to reassure her.

- Ideally, clients should "take something away" from each counselling session. As the counsellor, you are providing a bridge of support at an important and difficult time in a person's life.
- Most important of all, "do no harm".

Be gentle with your client. Reaffirm her dignity and worth through being empathetic. Do not let labels or the need to "diagnose" stop you from seeing the client as a unique individual.

3.5 Psychiatry

Most women with mental health problems can be managed with simple counselling and basic social support. However, some women may need psychiatric services to help them recover.

3.5.1 What is psychiatry?

Psychiatry is the medical specialty which focuses on the study and treatment of mental disorders. It means the “medical treatment of the mind”.

In areas with little or no resources, there may be no access to a psychiatrist. However, there may be other psychiatric services available in your facility, like psychiatric nurses.

The PMHP experience

- 10% of women who are seen by a counsellor are also seen by a psychiatrist.
- The number of women referred to a psychiatrist depends on a counsellor’s level of skill. More experienced counsellors may be able to support women who may otherwise need psychiatric intervention.

Consider the following steps when setting up psychiatric services.

- If possible, psychiatric services need to be offered **on-site**. Women who have to go to another site may be less likely to attend appointments.
- In most cases, psychiatric services should **add to, not replace** counselling.
- The counsellor should set up a **communication system** with psychiatric services to prevent duplication of services and ensure complete care for the client.
- At psychiatric **in-patient** facilities, mothers and babies should be together if possible.
- Psychiatrists may wish to keep a log of their clients. An example of a log form (**Appendix X**) and psychiatric assessment guidelines (**Appendix Y**) are provided.

3.5.2 Psychiatric medication

Sometimes, psychotropic medication (e.g. antidepressants) may be a useful part of managing a client's mental illness. The following points should be considered before providing medication as part of your service.

- Are there clients at your facility who would benefit from using medication?
- Which medications would be most useful for these clients?
- It is important to be aware of the national and local policies governing the prescribing, distribution and storage of psychotropic medication.
- Are there qualified staff who can prescribe and dispense the medication?
- Is there a safe and appropriate storage facility for the drugs?
- What will it cost to get and keep supplies of the medication?

3.5.2.1 Effects of medication

Each client responds differently to medication. Some will have side effects that they do not like. When prescribing medication, it is important to explain what side effects may occur. It is important to outline ways to minimise side effects, where possible. Explain to your client that it is natural for a body to respond to something new in the system. Some side effects may disappear as the body gets used to the medication.

Important!

- It may take many weeks for some medications to work, especially antidepressants.
- Explain to your client that it is not likely that she will feel better right away. Psychotropic medications take some time to show that they are working.
- It is very important that the client does not stop the medication during this time. The full benefit of the medication will only be visible over time.
- Once your client starts feeling better, she should NOT stop taking her medication. It is very important to continue taking the medication for the time prescribed by the doctor or psychiatrist.

Stopping and starting medicines can be harmful.

3.5.2.2 Safety issues

Pregnant and breastfeeding women may transmit some of the medication to the foetus or newborn. However, only 10% of the drug is passed through the placenta and 1-2% through breast milk. She may be able to time the taking of medication to fit in after the biggest breast-feeding session of the day and minimise how much medication is passed to the baby.

The benefits of medication to the mother should be carefully balanced with possible side effects on the infant. **But**, a mother's mental illness is usually a greater risk to the baby's development than the medication.

In most cases, a mother who is well will be better able to care for her baby.

3.5.2.3 Basic drugs

The World Health Organisation (WHO) list of essential medications for mental illness is summarised below:

<i>Medication for depressive disorders</i>	<ul style="list-style-type: none">• Amitriptyline (antidepressant)• Fluoxetine (antidepressant)
<i>Medication for substance dependence</i>	<ul style="list-style-type: none">• Methadone• Buprenorphine
<i>Medication for psychotic conditions</i>	<ul style="list-style-type: none">• Chlorpromazine• Fluphenazine• Haloperidol
<i>Medication for obsessive-compulsive disorder</i>	<ul style="list-style-type: none">• Cloripramine
<i>Medication for generalised anxiety and insomnia</i>	<ul style="list-style-type: none">• Antidepressants• Diazepam
<i>Medication for bipolar disorder</i>	<ul style="list-style-type: none">• Carbamazepine• Lithium carbonate• Valproic acid

3.6 Monitor and Evaluate

When designing a service, it needs to take into consideration the local environment. Information that is gathered about the service helps one to understand what is going well, and what needs to be improved.

Routine checking about how the service is running feeds back to role-players so that they can make changes to make their service work better. If problems are identified early, staff can be resourceful and creative about finding solutions.

This section brings together information about monitoring and evaluation discussed in the previous sections of this document.

The PMHP experience

If possible, all screening, counselling and psychiatry information should be entered into an electronic database on a monthly basis. Individual client information (e.g. names) must be removed for confidentiality. Overall monthly data may be organised together on a general data collection table. See **Appendix AA** for an example.

Excel is a useful computer programme that can sort and analyse data. It can also convert the information into graphs that show trends from month-to-month or year-to-year.

Notes

3.6.1 Why monitor and evaluate?

The PMHP experience

Regular monitoring and evaluation allows the service to develop and improve. It boosts staff morale when they can learn about the impact of their efforts.

3.6.1.1 Monitoring and evaluation allows for:

- Collection of the best information (data).
- Continual assessment.
- Improvement of services.
- Best practice and quality of care.

3.6.1.2 The following data may be collected:

- Number of women booking at a facility.
- Number of women screened.
- Number of women referred. (What proportion is this of those screened?)
- Number of appointments attended. (What is the defaulting rate?)
- Women who need follow-up. (Where have they been referred? What happened?)
- Log sheets help data collection and allow for data checking. Examples of these are provided in the in the Appendix.

3.6.1.3 Feedback

It is important to give feedback of the service trends to **all** staff involved in service delivery – clerical, nursing, counselling, doctors etc.



3.6.2 Service monitoring

Examples of the forms that the PMHP uses to collect information and monitor its service are attached as **Appendix Z** (Counselling Data Collection table) and **Appendix AA** (General Data Collection table). These may be adapted to suit your needs.

3.6.2.1 Counselling appointment diary records

Information includes:

- Number of appointments per counsellor.
- Appointments attended.
- Appointments defaulted.
- Appointments rescheduled.
- Follow-up for appointments missed.

3.6.2.2 Psychiatry diary records

Information includes:

- Appointments attended.
- Appointments defaulted.
- Appointments rescheduled.
- Follow-up for appointments missed.

3.6.2.3 Suggested daily monitoring

- Screening forms should be checked against the screening log by the counsellor.
- Missing data should be filled in and incorrect data amended.
- Appointment diaries to be reviewed by the counsellor.
- Daily service activities are reported to and discussed with the Sister-in-Charge at the health facility.
- It is best to appoint someone to be responsible for these daily duties.

3.6.2.4 Screening

Review screening logs daily, clean data and produce monthly trends for:

- Number of clients booking at the facility during the month.
- Number of clients offered screening.
- Screening coverage rate.
- Number of clients who decline screening.
- Number of clients who qualify for referral, and decline referral.
- Number of clients referred for counselling.

3.6.2.5 Counselling

Counselling logs should be reviewed and data should be cleaned. Counselling appointment diary records should be reviewed and checked against the counselling log.

Monthly trends may be recorded for:

- Number of new clients seen.
- Number of sessions attended.
- Number of sessions defaulted.
- Number of clients lost to follow-up.
- Average number of sessions per client.
- Total categories of presenting problems.
- Number of referrals to psychiatrist.
- Number of referrals to other organisations.



Counsellors may choose to use a table to collect their data. See **Appendix U** for an example of a counselling log form.

3.6.2.6 Psychiatry

Psychiatry logs should be reviewed and data cleaned. Psychiatry appointment diary records must be reviewed and checked against the psychiatry log. Monthly trends may be recorded for:

- Number of new clients seen.
- Number of sessions attended.
- Number of sessions defaulted.
- Average number of sessions per client.
- Total categories of presenting problems.
- Number of clients prescribed medication.

3.7 Supervision and Management

Supervision and management helps members of staff to take responsibility for the work that they are doing, being accountable for their activities, but with support, guidance and input from others. This ensures best practice models of service and quality of care for clients.

3.7.1 Clinical supervision

There should be supervision for all clinical workers involved: screeners, counsellors and psychiatrists. Supervision can be done individually or in a group with peers. An example of a supervision process monitoring log is attached as **Appendix BB**. Clinical supervision provides:

- clinical workers an opportunity to share the emotional stress of the work.
- an opportunity to discuss difficult cases.
- an opportunity to share ideas of how to do things differently or better.

3.7.2 Mental health service supervision

Service supervision is necessary for:

- Monitoring and evaluation.
- Improving team cohesiveness and morale.
- Ensuring quality of care.

3.7.3 Management

Dedicated management ensures that somebody takes responsibility and is accountable for the service. The service manager should:

- be able to monitor and evaluate how the service is operating.
- be a champion for maternal mental health.



A final thought from the PMHP team

Congratulations on taking the first steps towards developing a mental health service for mothers. Although there is a huge need for this service, and you may feel passionate about caring for mothers, please know you will face many challenges.

However, when maternity services take into account the mental health needs of mothers and babies, everyone benefits. The culture of the work environment changes. Staff are motivated by new skills and insights learnt. Benefits for mothers are noticeable.

If you can be flexible, adapt to change and keep a sense of humour, your innovation is bound to succeed!

Good luck and good (mental) health.
The PMHP team

4 APPENDICES

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Appendix A: Basic planning framework for maternal mental health services

Your Ideal Vision	Obstacles	Opportunities	Realistic Objectives	Action – who – when

Appendix B: Strategic planning table

Component	Objectives	Activities	Resources	Who responsible	Time line	Indicators
Training						
Screening						
Referral						
Counselling						
Psychiatry						
M&E						
Supervision & Management						

Appendix C: “Secret History” training – A story about a maternity facility

You are Thumi, a 26 year old. This is your second pregnancy. You miscarried the first pregnancy. You are now 18 weeks pregnant. Your boyfriend is working in Johannesburg and you are staying in the house with his mother and 3 sisters. This is your third visit during this pregnancy as you have ongoing vaginal discharge.

Feelings	Needs
loneliness/fear/uncertainty	reassurance/friends

You are Nurse Jacobs, a 36 year old, divorced mother of 2. You have been up all night as one of your children has asthma. This is the 3rd visit from this patient. You have spoken to the doctor who says you need to pass a speculum and do a swab for culture. The patient refuses to undress.

Feelings	Needs
angry/un-supported/worried/tired	co-operation from patient

(Thumi) The reason that you did not want to undress is that 2 years ago you were raped. You have not told anybody your story.

Feelings	Needs
disapproval from community & family/lack of trust/isolation	a safe place to tell my story/acceptance/gentleness

(Nurse Jacobs) There are only 2 of you in a very busy clinic. The other sister who is meant to be here is off sick again with a migraine. This is the 4th time this month that she has been off.

Feelings	Needs
tired/unsupported/resentful	support from colleagues and management/ a break/vent frustration at someone

----- SWAP ROLES -----

(Thumi) You are coming to the clinic because the baby has not moved much in the last 4 days. You are now 24 weeks pregnant and have not gained any weight.

Feelings	Needs
no interest/worried/self-blame/low energy	reassurance that baby is fine/a kind welcome

(Nurse Jacobs) The patient arrives at the clinic at 3pm. You have an appointment with your divorce lawyer in half an hour as you need to get your ex-husband to start paying maintenance. You feel the baby and it moves well when you palpate. You can hear a strong reactive heartbeat with the fetascope.

Feelings	Needs
undermined by ex-husband/ aggressive	support/get rid of patient/teach patient a lesson

Appendix D: PMHP service consent form

Maternal Support Questionnaire

The staff at _____ are concerned about their clients' **emotional** well-being, as well as their **physical** health. They have developed a service, which may assist women to be mentally healthy around the time of their pregnancies.

If you agree to participate you will be asked to fill in two written tick-form **questionnaires**, by yourself, **in private**. The questionnaires are designed to help staff recognise those women who are in **emotional difficulties**.

If you are identified as needing further care, you will be offered the **option** of seeing a **counsellor**.

This service is **free** of charge and you do not have to accept the offer, unless it is an emergency. All notes and records regarding screening and management for possible mental health problems will be kept **confidential** and **secure**.

You may be contacted **after the birth** of your baby and offered follow-up counselling or requested to participate in a follow-up assessment of the Project. You **may refuse** these offers. Your confidential information will not be divulged to any members of your household.

You have the **freedom to choose not to participate** in the service. Non-participation will **not** affect the quality of the routine care received at this facility.

Any **queries** may be directed to the sister in charge during working hours.

I, (name in full) _____ ,
folder number _____ , have read this consent form (or had it explained to me) and all my questions have been answered. I agree to participate in the Maternal Support questionnaire.

Signed _____

Date _____

Witness

Signed _____

Date _____

Appendix E: The Edinburgh Depression Scale (EDS): PMHP version

Please give the client a copy that does not show the scoring system – see Appendix F.

My feelings now that I am pregnant/have had a baby...

As you are pregnant/ have had a baby, we would like to know how you are feeling. It may assist us in choosing the best care for your needs. The information you provide us will be kept private and confidential.

There is a choice of four answers for each question. Please mark the one that comes closest to how you have felt *in the past seven days*, not just how you feel today.

In the past seven days:

1. I have been able to laugh and see the funny side of things:

- As much as I always could (0)
- Not quite so much now (1)
- Definitely not so much now (2)
- Not at all (3)

2. I have looked forward with enjoyment to things:

- As much as I ever did (0)
- A little less than I used to (1)
- Much less than I used to (2)
- Hardly at all (3)

3. I have blamed myself when things went wrong, and it wasn't my fault:

- Yes, most of the time (3)
- Yes, some of the time (2)
- Not very much (1)
- No, never (0)

4. I have been worried and I don't know why:

- No, not at all (0)
- Hardly ever (1)
- Yes, sometimes (2)
- Yes, very much (3)

- 5. I have felt scared or panicky and I don't know why:**
- Yes, quite a lot (3)
 - Yes, sometimes (2)
 - No, not much. (1)
 - No, not at all (0)
- 6. I have had difficulty in coping with things:**
- Yes, most of the times I haven't been managing at all (3)
 - Yes, sometimes I haven't been managing as well as usual (2)
 - No, most of the time I have managed quite well (1)
 - No, I have been managing as well as ever (0)
- 7. I have been so unhappy I have had difficulty sleeping:**
- Yes, most of the time (3)
 - Yes, sometimes (2)
 - Not very much (1)
 - No, not at all (0)
- 8. I have felt sad and miserable:**
- Yes, most of the time (3)
 - Yes, quite a lot (2)
 - Not very much (1)
 - No, not at all (0)
- 9. I have been so unhappy that I have been crying:**
- Yes, most of the time (3)
 - Yes, quite a lot (2)
 - Only sometimes (1)
 - No, never (0)
- 10. I have thought of harming myself or ending my life:**
- Yes, quite a lot (3)
 - Sometimes. (2)
 - Hardly ever (1)
 - Never (0)

Thank you

Scores for EDS are shown in brackets next to the questions. These need to be added together for a total score. **A score of 13 or more is an indicator for referral.**

Appendix F: The Edinburgh Depression Scale (EDS): PMHP version

My feelings now that I am pregnant/have had a baby...

As you are pregnant/ have had a baby, we would like to know how you are feeling. It may assist us in choosing the best care for your needs. The information you provide us will be kept private and confidential.

There is a choice of four answers for each question. Please mark the one that comes closest to how you have felt *in the past seven days*, not just how you feel today.

In the past seven days:

1. I have been able to laugh and see the funny side of things:

- As much as I always could
- Not quite so much now
- Definitely not so much now
- Not at all

2. I have looked forward with enjoyment to things:

- As much as I ever did
- A little less than I used to
- Much less than I used to
- Hardly at all

3. I have blamed myself when things went wrong, and it wasn't my fault:

- Yes, most of the time
- Yes, some of the time
- Not very much
- No, never

4. I have been worried and I don't know why:

- No, not at all
- Hardly ever
- Yes, sometimes
- Yes, very much

5. I have felt scared or panicky and I don't know why:

Yes, quite a lot

Yes, sometimes

No, not much.

No, not at all

6. I have had difficulty in coping with things:

Yes, most of the times I haven't been managing at all

Yes, sometimes I haven't been managing as well as usual

No, most of the time I have managed quite well

No, I have been managing as well as ever

7. I have been so unhappy I have had difficulty sleeping:

Yes, most of the time

Yes, sometimes

Not very much

No, not at all

8. I have felt sad and miserable:

Yes, most of the time

Yes, quite a lot

Not very much

No, not at all

9. I have been so unhappy that I have been crying:

Yes, most of the time

Yes, quite a lot

Only sometimes

No, never

10. I have thought of harming myself or ending my life:

Yes, quite a lot

Sometimes.

Hardly ever

Never

Thank you

Appendix G: The PMHP Risk Factor Assessment

Please give the client a copy that does not show the scoring system – see Appendix H.

My situation now that I am pregnant/have had my baby:

We are interested to find out how your situation is in your pregnancy/now that you have had your baby. This questionnaire may help us suggest extra care for you if necessary. Your answers will be kept confidential. Please answer either **yes** or **no** to the following questions. Tick the box.

	YES	NO
I feel pleased about being pregnant/now that I have had my baby.		*
I have had some very difficult things happen to me in the last year (e.g. losing someone close to me, losing my job, moving home etc.)	*	
My husband/boyfriend and I are still together.		*
I feel my husband/boyfriend cares about me (say no if you are not with him anymore).		*
My husband/boyfriend or someone else in the household is sometimes violent towards me.	*	
My family and friends care about how I feel.		*
I have experienced some kind of abuse in the past (e.g. physical, emotional, sexual, rape).	*	
My family and friends help me in practical ways.		*
On the whole, I have a good relationship with my own mother (indicate “no” if your mother has passed away).		*
I have experienced one of the following in the past: miscarriage, abortion, stillbirth, or the death of a child any time after birth.	*	
I have had serious depression, panic attacks or problems with anxiety before.	*	

Thank you

NAME: _____

FOLDER NUMBER: _____

GESTATION: _____

DATE: _____

AGE: _____

GRAV: _____

PARA: _____

EDS: _____

RFA: _____

In the RFA, there are blocks that have a “*”. These indicate a risk for maternal distress. If the client ticks the block with a “*”, then this counts for a score of 1. All the blocks with an “*” need to be added together for a total score. **A score of 3 or more is an indicator for referral.**

Appendix H: The PMHP Risk Factor Assessment

My situation now that I am pregnant/have had my baby:

We are interested to find out how your situation is in your pregnancy/now that you have had your baby. This questionnaire may help us suggest extra care for you if necessary. Your answers will be kept confidential. Please answer either **yes** or **no** to the following questions. Tick the box.

	YES	NO
I feel pleased about being pregnant/now that I have had my baby.		
I have had some very difficult things happen to me in the last year (e.g. losing someone close to me, losing my job, moving home etc.)		
My husband/boyfriend and I are still together.		
I feel my husband/boyfriend cares about me (say no if you are not with him anymore).		
My husband/boyfriend or someone else in the household is sometimes violent towards me.		
My family and friends care about how I feel.		
I have experienced some kind of abuse in the past (e.g. physical, emotional, sexual, rape).		
My family and friends help me in practical ways.		
On the whole, I have a good relationship with my own mother (indicate "no" if your mother has passed away).		
I have experienced one of the following in the past: miscarriage, abortion, stillbirth, or the death of a child any time after birth.		
I have had serious depression, panic attacks or problems with anxiety before.		

Thank you

NAME: _____

FOLDER NUMBER: _____

GESTATION: _____

DATE: _____

AGE: _____

GRAV: _____

PARA: _____

EDS: _____

RFA: _____

Appendix I: The Edinburgh Depression Scale - Afrikaans translation

My gevoelens nou dat ek swanger is/my baba gekry het

Nou dat jy swanger is/die baba het, wil ons graag weet hoe jy voel. Dit mag ons help om die beste sorg vir jou behoeftes te beplan. Die inligting wat jy aan ons verskaf sal privaat en vertroulik hanteer word.

Daar is 'n keuse van vier antwoorde vir elke vraag. Omsirkel asseblief die antwoord wat die beste beskryf hoe jy gedurende die afgelope sewe dae gevoel het, nie net hoe jy nou vandag voel nie.

Gedurende die afgelope sewe dae:

1. Kon ek die snaakse kant van dinge sien:

- So maklik soos ek altyd kon
- Nie heeltemal so maklik nie
- Defnitief nie so maklik nie
- Glad nie

2. Kon ek met genot na dinge uitsien:

- So baie soos ek altyd het
- 'n Bietjie minder as wat ek altyd het
- Baie minder as wat ek gewoonlik het
- Amper glad nie

3. Het ek myself blameer wanneer dinge verkeerd gaan, al was dit nie my skuld nie:

- Ja, meeste van die tyd
- Ja, soms
- Nee, nie dikwels nie
- Nee, nooit nie

4. Was ek bekommerd en ek weet nie hoekom nie:

- Nee, glad nie
- Omtrent nooit
- Ja, soms
- Ja, dikwels

5. Het ek bang en paniekerig gevoel en ek weet nie hoekom nie:

Ja, nogal baie

Ja, soms

Nee, nie so baie nie

Nee, glad nie

6. Het ek gesukkel om dinge te hanteer:

Ja, meeste van die tyd sukkel ek om dinge te hanteer

Ja, soms hanteer ek dinge nie so maklik soos gewoonlik nie

Nee, meesal hanteer ek dinge redelik goed

Nee, ek hanteer dinge so goed as wat ek altyd kon

7. Was ek so ongelukkig dat ek sleg geslaap het:

Ja, meeste van die tyd

Ja, soms

Nie dikwels nie

Nee, glad nie

8. Het ek hartseer en ongelukkig gevoel:

Ja, meeste van die tyd

Ja, nogal dikwels

Nie dikwels nie

Nee, nooit nie

9. Was ek so hartseer dat ek gehuil het:

Ja, meeste van die tyd

Ja, dikwels

Net soms

Nee, nooit

10. Die idee om myself leed aan te doen het al by my opgekom:

Ja, nogal dikwels

Soms

Amper nooit

Nooit

Baie dankie

Appendix J: Risk Factor Assessment - Afrikaans translation

My situasie nou dat ek swanger is/my baba gekry het

Ons stel daarin belang om uit te vind wat jou situasie is in jou swangerskap. Hierdie vrae kan ons help om moontlik extra hulp vir jou aan te bied indien nodig. Jou antwoorde sal vertroulik hanteer word.

Antwoord asseblief Ja of Nee op die volgende vrae. Maak 'n kruisie.

	JA	NEE
1. Ek voel gelukkig nou dat ek swanger is/my baba het.		
2. Baie moeilike dinge het in die afgelope jaar met my gebeur (bv. iemand na aan my is dood, ek het my werk verloor, ek het getrek).		
3. My man/vriend en ek is nog bymekaar		
4. Ek voel dat my man/vriend gee om vir my (merk Nee as julle nie meer bymekaar is nie).		
5. My man/vriend of iemand anders in die huis tree soms agressief teenoor my op.		
6. My familie en vriende gee om hoe ek voel.		
7. Ek was al in die verlede mishandel (bv. fisies, emosioneel, seksueel, verkrag).		
8. My familie en vriende help my op praktiese maniere		
9. Oor die algemeen het ek 'n goeie verhouding met my eie ma (merk Nee as jou ma reeds oorlede is).		
10. Ek het een van die volgende in die verlede ervaar: miskraam, aborsie, stilgeboorte, dood van my kind enige tyd na geboorte.		
11. Ek het van te vore aan ernstige depressie gelei, paniek aanvalle of probleme met angs gehad.		

Dankie

NAAM: _____

LEER NOMMER: _____

GESTATION: _____

DATUM: _____

OUDERDOM: _____

GRAV: _____

PARA: _____

EDS: _____

RFA: _____

Appendix K: The Edinburgh Depression Scale - isiXhosa translation

Indlela endiziva ngayo ngexa ndikhulelweyo naxa disasandula ukufumana umntwana

Njengokuba ukhulelewe okanye usandula ukufumana usana sifuna ukwazi ukuba uziva njani. Oko kungasanceda ukukhetha eyona ndlela esingathi sancedisane nemfuno zakho. Yonke inkcazelo oyakuthi usinike yona izakugcinwa iyimfihlo.

Kunentlobo ezine zempendulo kumbuzo ngamnye, Nceda yenza isangqa kwenye ethe yasondela kwindlela ubuziva *ngayo kwintsuku ezisixhenxe ezidlulileyo*, hayi ngendlela oziva ngayo ngoku.

Kwintsuku ezisixhenxe ezidlulileyo:

1. Ndibenakho ukubona icala lezinto ezingalunganga:

Kangangoko bendisenza
Hayi kangako
Ngokuqinesekileyo akukho kangako ngoku
Akukho kwaphela

2. Izinto ndizijonga ndinolonwabo:

Njengoko bendihlala ndisenza
Kancinane kunokuba ndisenza
Kancinci kakhulu kunokuba bendisenza
Hayi konke konke

3. Bendibeka ityala kum xa izinto zingandihambeli kakhule, ibe ingeyompazamo yam:

Ewe amaxesha amaninzi
Ewe ngelinye ixesha
Hayi kangako
Hayi kwaphela

4. Bendikhathazekile kwaye ndingamazi unobangela:

Hayi konke konke
Kunqabile ukuba kwenzeka
Ewe ngamanye amaxesha
Ewe kakhulu

5. Bendiziva ndisoyika okanye ndinexhala kwaye ndingamazi unobangela:

Ewe kakhulu
Ewe ngamanye amaxesha
Hayi kangako
Hayi konke konke

6. Ndifumene ubunzima kakhulu ukumelana nezinto:

Ewe ixesha elininzi bendikwazi ukumelana nezinto
Ewe ngelinye ixesha bendingakwazi ukumelana nezinto ngendlela ebendimelana nazo ngayo
Hayi ixesha elininzi bendiphumelela kakhulu
Hayi bendingafumani bunzima kwaphela

7. Bendingonwabanga kakhulu kwaye bendifumana ubunzima xa kufuneka ndilele:

Ewe ixesha elininzi
Ewe ngalinye ixesha
Hayi kangako
Hayi konke konke

8. Bendizive ndibuhlungu kwaye ndixhalisekile:

Ewe amaxesha amaninzi
Ewe ngolonahlobo
Hayi kangako
Hayi konke konke

9. Bendingonwabanga kakhulu ndisoloko ndilila:

Ewe ixesha elininzi
Ewe ngolonahlobo
Ngamanye amaxesha
Hayi azange

10. Inginga yokuzenzakalisa ike yandifikela:

Ewe ngolonahlobo
Ngamanye amaxesha
Ayizange kwaphela
Ayizange

Appendix L: Risk Factor Assessment - isiXhosa translation

Imeko endikuyo njengokuba ndikhulelwe/naxa ndifumene umntwana

Sinomdla wokwazi injani imeko okuyo njengokuba ukhulelewe okanye ufumene umntwana. Lemibuzo ingasanceda ukuthi sikwazi ukukubonelela ngoncedo xa kuyimfuneko. Impendulo yakho iyakugcinwa iyimfihlo.

Nceda phendula apha Ewe okanye Hayi kulemibuzo ilandelayo. Hlaba kwibhokisi.

	EWE	HAYI
Ndiziva ndixolile njengokuba ndinzima/njengokuba ndifumene umntwana.		
Ndibenezinto ezibuhlugu kakhulu ezindehleleyo kulonyaka uphelileyo (umzekelo ndaye ndaphulukana nomsebenzi, ndaphulukana nomntu owayesondele kakhulu kum, ndafuna indawo yokuhlala ngokutsha).		
Umyeni/isoka lam sisekanye kunye (uthi hayi ukuba anisahlali kunye).		
Ndicinga ukuba umyeni/isoka lam lindikhathalele kakhulu.		
Umyeni/isoka lam okanye omnye umntu endlini ngamanye amaxesha babanobundlongondlongo kum.		
Izazalwane kunye nezihlobo zam ziyikhathalele indlela endiziva ngayo.		
Ndifumene ingxaki yokuphatheka kakubi kwixesha elidlulileyo (umzekelo ngokwasemzimbeni, ngokwasemphefumulweni, ngokwesondo nangokudlwengulwa).		
Izizalwane nezihlobo zam bezindinceda kwizinto ezenziwayo.		
Ngokupheleleyo ubuhlolo phakathi kwam nomama buhle kakhulu.		
Ndifumene ezingxaki kwixesha elidlulileyo: ukuphuma isisu, ukuqhomfa, ukuzala umntwana sele etshabile, okanye ukuswelekelwa ngumntwana sendimfumene.		
Ndike ndaba nokudakumba okuxhalabisayo komphefumlo, ndaziva ngathi. Ndivaleka umphefumlo, intliziyo ibetha ngamandla, ndinokudinwa okugqithileyo kwixesha elidlulileyo.		

Enkosi

NAME: _____

FOLDER NUMBER: _____

GESTATION: _____

DATE: _____

AGE: _____

GRAV: _____

PARA: _____

EDS: _____

RFA: _____

Appendix M: The Edinburgh Depression Scale - French translation

Mes sentiments, maintenant que je suis enceinte/que j'ai un bébé ...

Comme vous êtes enceinte/vous avez un bébé, nous aimerions savoir comment vous vous sentez. Cela nous aidera à choisir les meilleurs soins dont vous avez besoin. Les renseignements que vous nous fournirez demeureront privés et confidentiels.

Il y a un choix de quatre réponses pour chaque question. Encerclez celle qui se rapproche le plus de la manière dont vous vous êtes sentie **les sept derniers jours**, et pas seulement la manière dont vous vous sentez aujourd'hui.

Les sept derniers jours:

1. J'ai été capable de voir le côté amusant des choses:

- Autant que je l'ai toujours pu
- Pas autant maintenant
- Certainement pas autant
- Pas du tout

2. J'ai attendu les événements avec impatience et plaisir:

- Autant que je l'ai toujours fait
- Un peu moins qu'auparavant
- Bien moins que d'habitude
- Presque pas

3. Je me suis blâmée quand les choses n'allaient pas bien et que ce n'était pas ma faute:

- Oui, la plupart du temps
- Oui, quelquefois
- Pas beaucoup
- Non jamais

4. J'étais inquiète, et je ne savais pas pourquoi:

- Non, pas du tout
- Presque jamais
- Oui, quelquefois
- Oui, beaucoup

5. Je me suis sentie effrayée et pleine de panique et je ne savais pas pourquoi:

- Oui, beaucoup
- Oui, quelquefois
- Non, pas beaucoup
- Non pas du tout

6. J'ai eu des difficultés à faire face aux événements:

- Oui, la plupart du temps, je n'ai pas pu me débrouiller
- Oui, quelquefois, je n'ai pas pu me débrouiller comme d'habitude
- Non, la plupart du temps, je me suis assez bien débrouillée
- Non, je me suis pas débrouillée aussi bien qu'avant

7. J'ai été si malheureuse, que j'ai eu des difficultés à dormir:

- Oui, la plupart du temps
- Oui, quelquefois
- Pas beaucoup
- Non, pas du tout

8. Je me suis sentie triste et misérable:

- Oui, la plupart du temps
- Oui, beaucoup
- Non, pas beaucoup
- Non, pas du tout

9. J'ai été si malheureuse que j'ai pleuré:

- Oui, la plupart du temps
- Oui, beaucoup
- Quelquefois seulement
- Non, jamais

10. La pensée de me faire du mal m'est venue:

- Oui, souvent
- Quelquefois
- Presque jamais
- Jamais

Merci

Appendix N: Risk Factor Assessment - French translation

Ma situation, maintenant que je suis enceinte.

Nous aimerions connaître votre situation durant votre grossesse. Ce questionnaire nous aidera à suggérer des soins supplémentaires pour vous, si c'est nécessaire. Vos réponses seront confidentielles.

	OUI	NON
Je suis heureuse d'être enceinte.		
J'ai connu des difficultés au cours de l'année dernière (par exemple: perte de quelqu'un de cher, perte de mon emploi, déménagement, etc.).		
Mon mari/compagnon et moi sommes toujours ensemble.		
Je sens que mon mari/compagnon m'aime toujours (dites Non, si vous n'êtes plus avec lui).		
Mon mari/compagnon, ou quelqu'un d'autre à la maison est quelquefois violent avec moi.		
Ma famille et mes amis se soucient de la manière dont je Me sens.		
J'ai souffert quelque forme de mauvais traitement dans le passé (ex. physique, émotionnel, sexuel, viol).		
Ma famille et mes amis m'aident dans les choses pratiques.		
Dans l'ensemble, je jouis d'une bonne relation avec ma propre mère (écrivez « non », si votre mère est morte).		
J'ai subi l'un des chocs suivants dans le passé: fausse-couche, avortement, enfant mort-né ou la mort d'un enfant quelque temps après la naissance).		
J'ai souffert de dépression sérieuse, panique ou des problèmes d'anxiété au passé.		

Merci

NOM: _____

NUMÉRO DE DOSSIER: _____

GESTATION: _____

DATE: _____

AGE: _____

GRAV: _____

PARA: _____

EDS: _____

RFA: _____

Appendix O: Self-Reporting Questionnaire (SRQ-20)

Please give the client a copy that does not show the scoring system – see Appendix P.

This following is an example of the SRQ-20 questionnaire. Scoring is indicated below. All Yes answers score 1, these need to be counted up and given as a total score. **6 or more is an indicator for referral.**

In the past month:

- | | |
|--------------------------------------------------------------|----------|
| 1. Do you often have headaches? | Yes / No |
| 2. Is your appetite poor? | Yes / No |
| 3. Do you sleep badly? | Yes / No |
| 4. Are you easily frightened? | Yes / No |
| 5. Do your hands shake? | Yes / No |
| 6. Do you feel nervous, tense or worried? | Yes / No |
| 7. Is your digestion poor? | Yes / No |
| 8. Do you have trouble thinking clearly? | Yes / No |
| 9. Do you feel unhappy? | Yes / No |
| 10. Do you cry more than usual? | Yes / No |
| 11. Do you find it difficult to enjoy your daily activities? | Yes / No |
| 12. Do you find it difficult to make decisions? | Yes / No |
| 13. Is your daily work suffering? | Yes / No |
| 14. Are you unable to play a useful part in life? | Yes / No |
| 15. Have you lost interest in things? | Yes / No |
| 16. Do you feel that you are a worthless person? | Yes / No |
| 17. Has the thought of ending your life been on your mind? | Yes / No |
| 18. Do you feel tired all the time? | Yes / No |
| 19. Do you have uncomfortable feelings in your stomach? | Yes / No |
| 20. Are you easily tired? | Yes / No |

Score: 0 = no symptoms, 1 – 5 = low symptoms
6 + = high symptoms/case for common mental disorder

NAME: _____
FOLDER NUMBER: _____
GESTATION: _____
DATE: _____

AGE: _____
GRAV: _____
PARA: _____
SRQ-20: _____

Appendix P: Self-Reporting Questionnaire (SRQ-20)

In the past month:

- | | |
|--------------------------------------------------------------|----------|
| 1. Do you often have headaches? | Yes / No |
| 2. Is your appetite poor? | Yes / No |
| 3. Do you sleep badly? | Yes / No |
| 4. Are you easily frightened? | Yes / No |
| 5. Do your hands shake? | Yes / No |
| 6. Do you feel nervous, tense or worried? | Yes / No |
| 7. Is your digestion poor? | Yes / No |
| 8. Do you have trouble thinking clearly? | Yes / No |
| 9. Do you feel unhappy? | Yes / No |
| 10. Do you cry more than usual? | Yes / No |
| 11. Do you find it difficult to enjoy your daily activities? | Yes / No |
| 12. Do you find it difficult to make decisions? | Yes / No |
| 13. Is your daily work suffering? | Yes / No |
| 14. Are you unable to play a useful part in life? | Yes / No |
| 15. Have you lost interest in things? | Yes / No |
| 16. Do you feel that you are a worthless person? | Yes / No |
| 17. Has the thought of ending your life been on your mind? | Yes / No |
| 18. Do you feel tired all the time? | Yes / No |
| 19. Do you have uncomfortable feelings in your stomach? | Yes / No |
| 20. Are you easily tired? | Yes / No |

NAME: _____

FOLDER NUMBER: _____

GESTATION: _____

DATE: _____

AGE: _____

GRAV: _____

PARA: _____

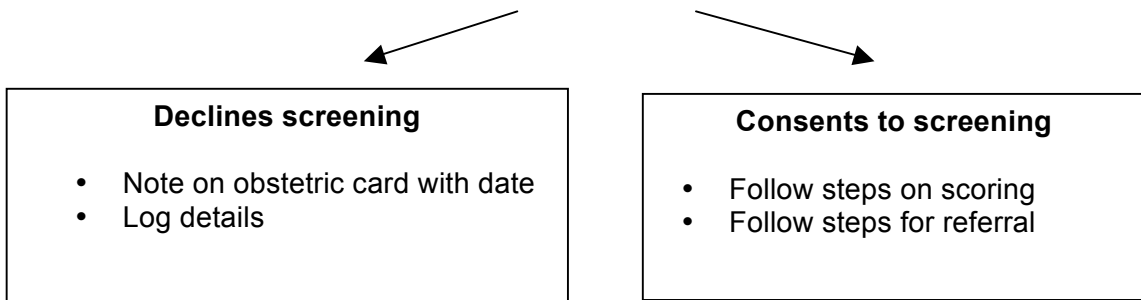
SRQ-20: _____

Appendix Q: The PMHP Screening and Management protocol

Screening

- Screen all women at booking visit (or later if missed before).
- Offer language of choice.
- Ensure complete privacy for questionnaires (ask partners, family members etc. to wait in waiting room).

Clients have a choice



Scoring

- Score questionnaires immediately.
- For EPDS, see copy with scores attached (Refer if 13 or more).
- Check EPDS question on sleep if does not "fit" with rest of answers.
- **Always** have discussion if any suicidality (Q. 10) and refer if doubtful.
- For RFA, note that sometimes "YES" is a risk factor and sometimes "NO" is a risk factor (ask yourself, is this a good thing or a bad thing, a bad thing = risk).
- Count up the blocks that are ticked that have a * in them. (Refer if 3 or more).

Put score in 3 places

- On last page of questionnaire.
- On obstetric card (with date of screening).
- On log in PMHP file – with NB demographic details.

Filling in Log

All patient information can be found in the patient's hospital folder.

Scoring questionnaires - possible outcomes

EPDS score less than 13,
RFA score less than 3

No action required

- Note score on obstetric card with date.
- Log details on log.
- Completed questionnaire put in PMHS file.

EPDS score 13 or more,
RFA score 3 or more

Qualifies for referral

- Offer referral to women with qualifying scores **OR** those you are concerned about (i.e. teens, HIV +).
- Explain that the service is **free** and **confidential**.
- Explore any practical or psychological barriers she may have to attending counselling. Demystify counselling – “just a space to talk about your stresses, to feel heard by a caring, experienced woman counsellor”.

Referral

- Find counselling appointment that suits woman – if possible on same day as follow-up antenatal visit, similar time.
- **Put patient name, folder number and all telephone numbers in counselling appointment book – NB for defaulters and follow-up.**
- Note appointment on client's white clinic card.
- Fill in details (including contact numbers) on referral form, including counsellor name and appointment time.
- STAPLE referral form to screening questionnaires and put in relevant place for counsellor.
- Note score on obstetric card with date.
- Write referral details in log.
- Suicidal patients **NEED URGENT** referral.

Declines referral

- Explain “open door” policy – if they change their minds they can request an appointment at another time.
- Completed questionnaires to be filed away in secure place.
- Note score on obstetric card.
- Log details – note **DECLINED** under action column.

Appendix R: The PMHP screening log form

Date	Name	Age	Folder no.	Address	Gestation	EPDS	Risk Factors	Noted in folder? (yes/no, date)	Action	Gravidity Parity

Appendix S: Example of a referral letter

Address of health unit
Town
District
Telephone number

Contact at referral organisation
Name of referral organisation
Address of referral organisation
Town
District
Telephone number

Date

Dear _____
include name of contact person here

Re: _____
include name of client here

Thank you for considering _____
include name of client here .

She is _____ years old.

I am concerned about this patient because

I hope that you will be able to assist her with her difficulties.

Please contact me for further information and to let me know that this referral has been successful. My telephone number is _____.

Yours sincerely
Your name
Job Title

Appendix T: Referral evaluation form

Date referral made _____

Who made referral? _____

If referred, where? _____

When was appointment? _____

Did you go? Yes / No

If **No**, what stopped you? _____

If **Yes**, did you get help for your problem? Yes / No

What help was given? _____

What do you think about the help that was offered? _____

Would you recommend that place to a friend? Yes / No

Why? _____

Appendix V: Presenting problems categories

Category A: Problems with primary support group

- Death in the family
- Health problems in family
- Disruption by separation, divorce, estrangement
- Sexual /physical abuse
- Inadequate social support
- Parental or spousal conflict

Category B: Problems relating to social environment

- Occupational problems
- Housing problems
- Economic problems
- Educational problems

Category C: Health/medical problems

- HIV
- Birth complications/ obstetric interventions (previous/current)
- Other illnesses/ physical conditions

Category D: problems adjusting to lifecycle transitions

- Unplanned pregnancy
- Teenage pregnancy
- Infant temperamentality difficulties
- Childcare stresses

Category E: Previous/present psychiatric condition

- Pre/postnatal depression or anxiety
- Eating disorder
- Bipolar disorder
- Sleep disorder
- Obsessive compulsive disorder
- Schizophrenia or other psychotic disorder
- Substance related disorder
- Personality disorder (e.g. Borderline personality)

One patient may present with problems in more than one category. For example a pregnant teenager may no longer have her families support – and could have presenting problems in category A (parental conflict), category B (housing problems) and category D (teenage pregnancy).

The relevant presenting problem categories are noted on the counsellor log for each patient.

Appendix W: Counselling summary report

Client's name	
Counsellor's name	
Folder No.	
Date of screening	
Date of first session	
Date of baby's birth	
Date of telephone interview	

Presenting problems (Clients view)

Assessed problems

Problem	Specify problem				
Primary support					
Primary/Secondary	Worse	No change	Some improvement	Much improvement	Resolved
Social environment					
Primary/Secondary	Worse	No change	Some improvement	Much improvement	Resolved
Health/medical					
Primary/Secondary	Worse	No change	Some improvement	Much improvement	Resolved
Lifecycle transition					
Primary/Secondary	Worse	No change	Some improvement	Much improvement	Resolved
Previous/present psychiatric condition					
Primary/Secondary	Worse	No change	Some improvement	Much improvement	Resolved

If referred on, referral resources:

Psychiatrist		Legal aid	
Medical specialist		HIV support	
Social worker		NGO	
Refugee support		Other	

General outcomes:

	Positive / yes	Negative / no
Birth experience		
Breastfeeding		
Bonding established		
Sleep		
Support/help with the baby		
Current mood		
Current coping		
View of experience before counselling		
View of experience after counselling		
View of counselling		

Is this client scheduled to continue counselling? Yes / No

Closing data:

Case closed		Date	
Total no. of sessions attended		Total no. of sessions defaulted / cancelled	
Referral on accepted		Referral on refused	
Referral helpful		Referral unhelpful	

Comments: _____

Did this client present any special problem to you? (If yes, specify)

Appendix Y: Psychiatric assessment guidelines

General

- Date of visit
- Name of patient
- Age
- Gestational age at visit
- Contact details
- Referred by
- Reason for referral
- Gestational age at referral

History

- **Main complaint:** Why the patient is referred and/or what they see as their main problem.
- **History of main complaint:** Onset, progression, course, relieving and exacerbating factors, associated stressors, associated symptoms, first episode, recurrence, history of all previous episodes, etc.
- **Systemic enquiry:** All other current psych symptoms. Check for suicidal or homicidal thoughts.

Family History

- **Genogram (Family tree)**
 - Family history – psych/medical illness
 - Patient’s relationship with family members
- **Personal History**
 - Antenatal – any problems/complications during patient’s mothers pregnancy
 - Birth and delivery – any problems/complications
 - Early childhood development and milestones
 - School history
 - Level of education
 - Any problems at school
 - Occupational history
 - Jobs done, course of work, problems
 - Religion
 - Social support

- **Sexual and relationship history**
 - Age of menarche (first period), feelings about this
 - Sexual education
 - First and subsequent sexual experiences
 - Relationship history
 - Children? Feelings and relationships with children
 - Abuse: childhood? Current? By whom?

Current pregnancy

- Planned or not
- Wanted or not
- Feelings about pregnancy
- Feelings about delivery
- Feeling about unborn child

Past psychiatric history

All episodes, treatment etc. in detail

Past medical history

Alcohol/substance use

- In this pregnancy?
- Previous pregnancies?
- Smoking?

Forensic History

Mental State Examination

- General appearance and contact
- Orientation and cognitive function
- Mood symptoms
- Suicidal/homicidal ideation/intent/plan. If so can contract or not.
- Thought – form and content
- Perceptual disturbances – hallucinations and illusions
- Anxiety symptoms
- PTSD symptoms
- Insight and judgement
- Assessment of personality

Summary of problem

- **Diagnosis**

Axis	I	Psychiatric diagnosis
	II	Developmental disorder/ personality disorder traits
	III	Medical problems
	IV	Social problems/stressors
	V	Global Assessment of Functioning ¹

- **Management plan**

- **Date of follow-up**

- **Referral to others**

¹ This is a pre-set numeric scale. Rather, assess social and occupational (school) functioning and rate no, mild, moderate, severe impairment

Appendix Z: Counselling data collection table

Month: _____

								Total
Counsellors names:								
No. new clients								
No. sessions attended								
Ave. no. sessions/client								
Ave. age								
Ave. EPDS								
Ave. RFA								
Ave. gestation at screening								
Ave. Grav								
Ave. Para								
Presenting problems categories								
A - Primary support								
B - Social environment								
C - Health/medical								
D - Lifestyle transition								
E – Psychiatric								
Included in 2 or more								
No. postnatal sessions								
No. referrals to psychiatrist								
No. referrals to other orgs.								

