

**Stockport Integrated Care
Pathways for Antenatal and
Postnatal Mental Health**

2008

Stockport Integrated Care Pathways for Antenatal and Postnatal Mental Health

Foreword

Up to one in six women experience a mental health disorder at some point in pregnancy or after the birth. Many women reading this document have been that 'one in six' and have found that they have not been able to function as they would like. They have not enjoyed their pregnancy and have little delight with their baby. Indeed, for some, those early months following the birth of their child are lost in a fog of depression.

Not only women suffer but we know that their partners and the baby are affected by maternal mental ill health which can have far reaching consequences for the relationship with the child and her partner.

Therefore it is with great pleasure that I introduce Stockport Integrated Care Pathways for Antenatal and Postnatal Mental Health. The focus of the pathways is to promote mental health and well being, keeping pregnant women happy and full of expectancy. Following the birth, we want women to have a sense of contentment because we know that contented mothers produce contented and thriving babies and young children.

But when illness does occur the services should rally to support each woman. When these pathways are followed we can be sure that despite mental ill health families will receive the best care at the right time and in the most appropriate place tailored to individual women. These pathways build on the excellent work that is carried out by midwives, doctors and specialists, health visitors, mental health workers and psychologists and give pregnant women, babies and their partners the support they need at a major point in the life cycle.

I would like to thank the many people who have been engaged in the development of these pathways and, in particular, recognise the invaluable contribution of the members of the Multi-Disciplinary Task Group which was chaired by Eileen Maloney and Rose Tyldesley.



Associate Director – Children and Families
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Endorsement

Mental Health disorders during pregnancy and the postnatal period can have serious consequences for the health and wellbeing of a mother and her baby, as well as for her partner and other family members.

Our aim is to provide high quality, accessible and responsive services by putting the woman at the heart of everything we do.

Integrated Care Pathways provide a framework which enables the woman to be central to her care, ensuring a co-ordinated approach with effective communication links across all disciplines.

We fully endorse the care pathway approach as a way of providing best evidenced practice.



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Section 1: Document Development

1.1 Introduction

The first Stockport Post Natal Depression Strategy was published in 1997 and led to joint training for professionals and a clear set of guidelines for staff working with families where a mother had postnatal depression.

The NSF for Children, Young People and Maternity Services (2004) outlined a 10 year vision to improve and update services and meant that there was a need to review the Strategy and update the guidelines. In order to do this a multi-agency group was formed in 2005.

In early 2007, NICE (National Institute for Clinical Excellence) published guidelines for antenatal and postnatal mental health and incorporated into the new Integrated Care Pathways.

1.2 Vision

To promote positive mental health for the families of Stockport by offering non-stigmatising and timely support to women antenatally and postnatally through coordinated multi-agency working.

1.3 Objectives

- To update the existing Strategy and provide evidence based guidelines for practitioners involved in the care of women and their families.
- To broaden the document to include the promotion of positive mental health in the antenatal and postnatal period.
- To outline specific care pathways for identified women.
- To make recommendations for communication of the Integrated Care Pathways and update the training programme for all key workers.
- To provide a framework for monitoring and evaluation that links to clinical governance requirements.

1.4 Background

According to Oates and Rothera (2006) who were commissioned by MIND to undertake a survey of women and summarise recent evidence.

- One in six women is affected by mental distress during pregnancy or following childbirth.
- 25 per cent of all maternal deaths are linked to mental health problems.
- Mental health problems around childbirth, if not dealt with can affect the relationship between mother and baby and the child's development over the longer term.

Moreover, certain groups are particularly vulnerable including teenage mothers, who have three times the rate of postnatal depression of older mothers and higher rates of poor mental health for up to 3 years after the birth of a baby. (DCSF and DH 2007)

There is a significant cost to health, education and social care services due to needs resulting from perinatal mental health problems and its associated outcomes for children. Research by Murray and Cooper (2003) found that children of women with untreated postnatal depression show signs of reduced social, emotional and cognitive development.

Recent research has also found that health professionals working in primary care, maternity and psychiatric services were unclear about their roles and responsibilities in the management of mental health problems around childbirth (Oates and Rothera 2006).

Historically, postnatal depression was not always clearly defined and the one term was used to define a range of problems.

Four main categories of problems have been identified (MIND, 2006)

1. antenatal depression
2. postnatal depression
3. puerperal psychosis
4. pre-existing conditions including bi-polar disorder and major depression.

The promotion of mental health and wellbeing around pregnancy and childbirth needs to be managed by primary, secondary and tertiary health services in close partnership with local authority, non-statutory and voluntary sector services.

1.5 National Policy

The National Service Framework for Children, Young People and Maternity Services (2004) Standard 11 clearly identifies the importance of identifying and addressing mental health problems for women during or after pregnancy and ensuring local perinatal psychiatric services are available to women who need them.

The impact of maternal mental health on outcomes for children is also now widely recognised and has influenced documents such as Every Child Matters (2004), Every Parent Matters (2007) and Reaching Out: the Action Plan for Social Exclusion (2006).

Confidential Enquiry into Maternal and Child Health (CEMACH 2004) report has also highlighted the lessons to be learned from tragedies of maternal and infant deaths related to mental health problems and influenced the recently published NICE guidelines accordingly. The learning from these documents has been applied to the care pathways developed through the work of the Task Group. A specific care pathway for women at high risk of mental illness has been developed.

1.6 Local Context

The Stockport Integrated Care Pathways for Antenatal and Postnatal Mental Health links with other key strategic documents:

- The Children and Young Peoples Plan 2006-2009
- The Multi-agency Parenting Strategy 2004-2006
- The Multi-agency Family Support Strategy 2005-2008
- The Teenage Pregnancy Strategy and Pathway revised 2007

1.7 Principles of Care for all Women with Mental Disorders During Pregnancy and the Postnatal Period (NICE 2007)

- **Providing and Using Information Effectively**- providing information about the nature, course and treatment of a mental disorder during pregnancy and the postnatal period facilitates access to services and improves understanding and collaboration between the woman, her partner, family members, carers and healthcare professionals.
- **Supporting partners, families and carers** -The needs of the partner, family members and carers of a woman with a mental disorder during pregnancy and the postnatal period should be assessed including the welfare of her infant and other dependant children and adults.
- **Considerations for Adolescents** - Healthcare professionals working with adolescents experiencing a mental disorder should be familiar with local and national guidelines on confidentiality and the rights of the child.
- **Importance of Mental Health Promotion**- Professionals should include promotion of mental health and wellbeing in their care of women in the antenatal and postnatal period.

Section 2: Care Pathways for Promotion of Mental Health in the Antenatal and Postnatal Period

2.1 The multi-disciplinary task working group has developed and agreed a pathway for assessment and four pathways for care of women in the antenatal and postnatal period:

- Perinatal Mental Health and Wellbeing Assessment.
- Pathway 1 Promoting Universal Mental Health and Wellbeing.
- Pathway 2 Care Pathway for Perinatal women with Mild to moderate risk of mental illness.
- Pathway 3 Care Pathway for Pregnant women with or at high risk of mental illness.
- Pathway 4 Care Pathway for Postnatal women with or at high risk of mental illness.

Perinatal Mental Health & Wellbeing Assessment

Ascertain whether woman needs interpreter or advocate present

Ask the following questions to assess each woman's risk of Mental Illness at woman's first contact with primary care, antenatal booking visit and postnatal at 4-6 weeks and 3-4 months.

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month have you often been bothered by having little interest or pleasure in doing things?

A third question should be considered if the woman answers YES to both of the initial questions.

- Is there something you feel you need or want help with?

Yes

Refer to pathway 1 & 2

NO

Follow pathway 1

Trigger factors

- Difficult birth
- Previous History or antenatal history of depression/anxiety
- High risk pregnancy
- Family stress/environmental factors – financial difficulties

YES

Refer to pathway 1 & 2

No

Follow pathway 1

At the woman's first contact with services in both the antenatal and postnatal periods, professionals should ask questions about:

- Past or present severe mental illness including schizophrenia, bi-polar disorder, psychosis in the postnatal period and severe depression
- Previous treatment by a psychiatrist/specialist mental health team including inpatient care.
- A family history of perinatal illness

YES

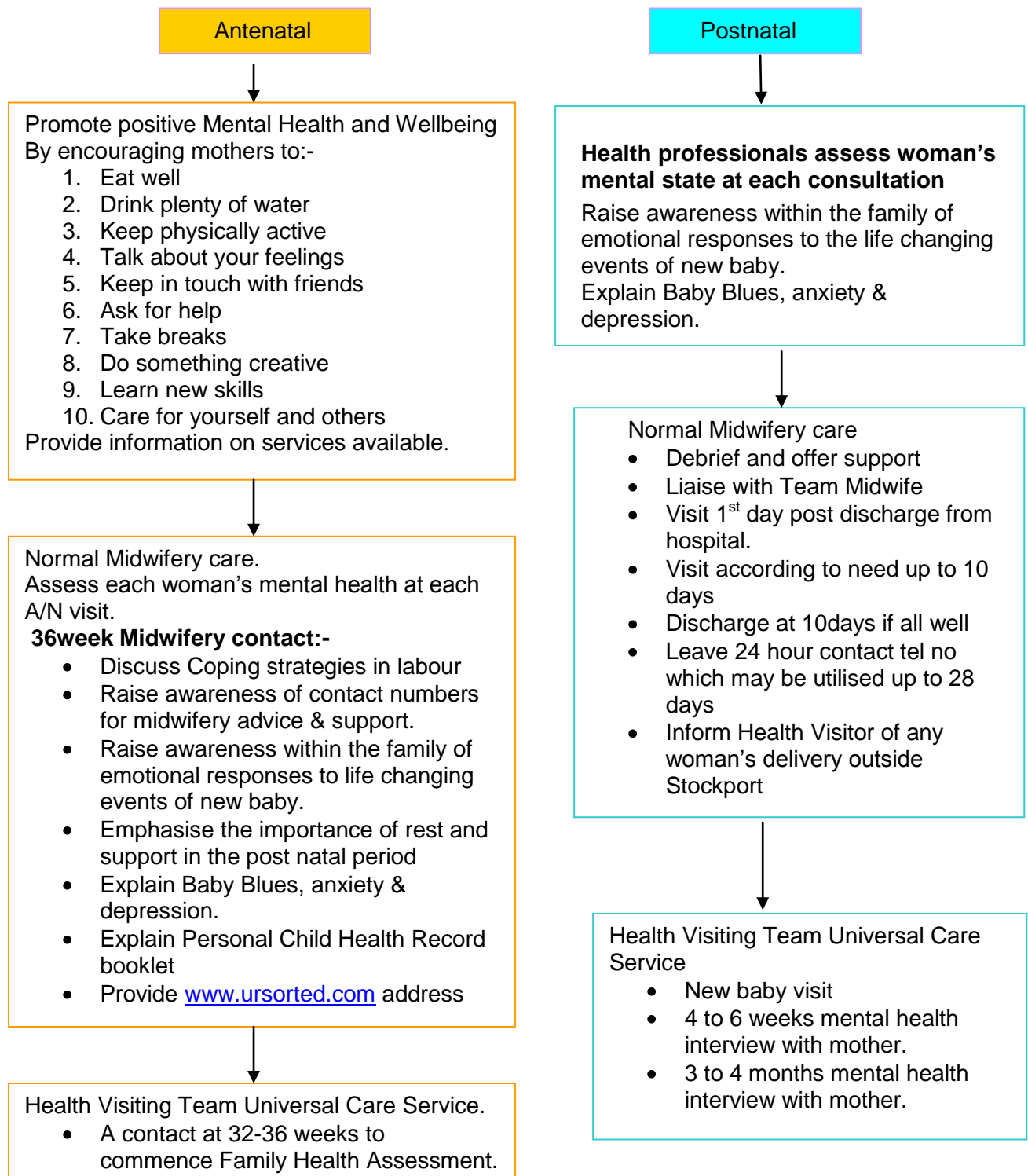
Refer to pathway 1, 3 4

NO

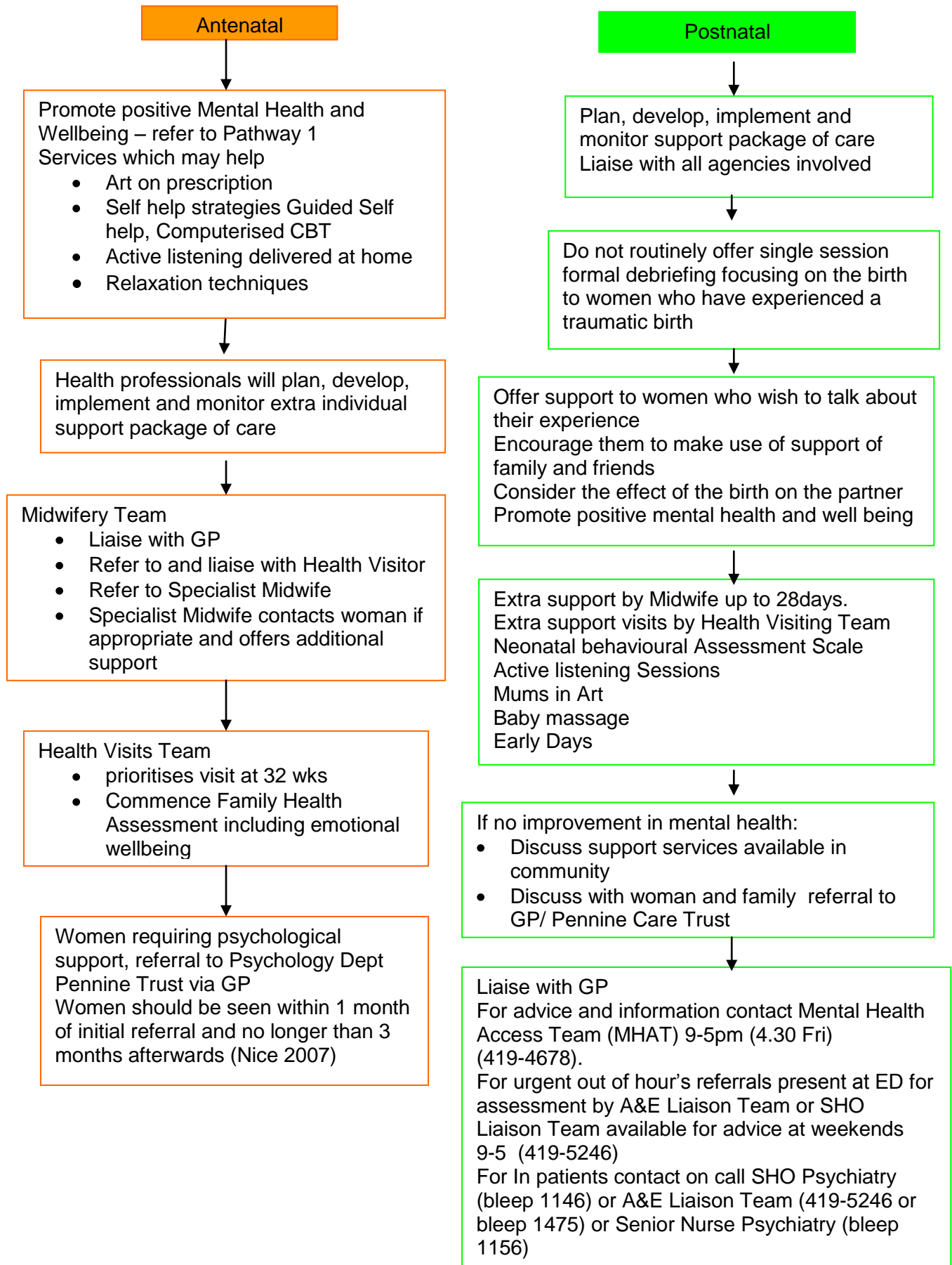
Follow pathway 1

Record discussion, information provided and outcome of discussion in woman's notes

Promoting Universal Perinatal Positive Mental Health & Wellbeing

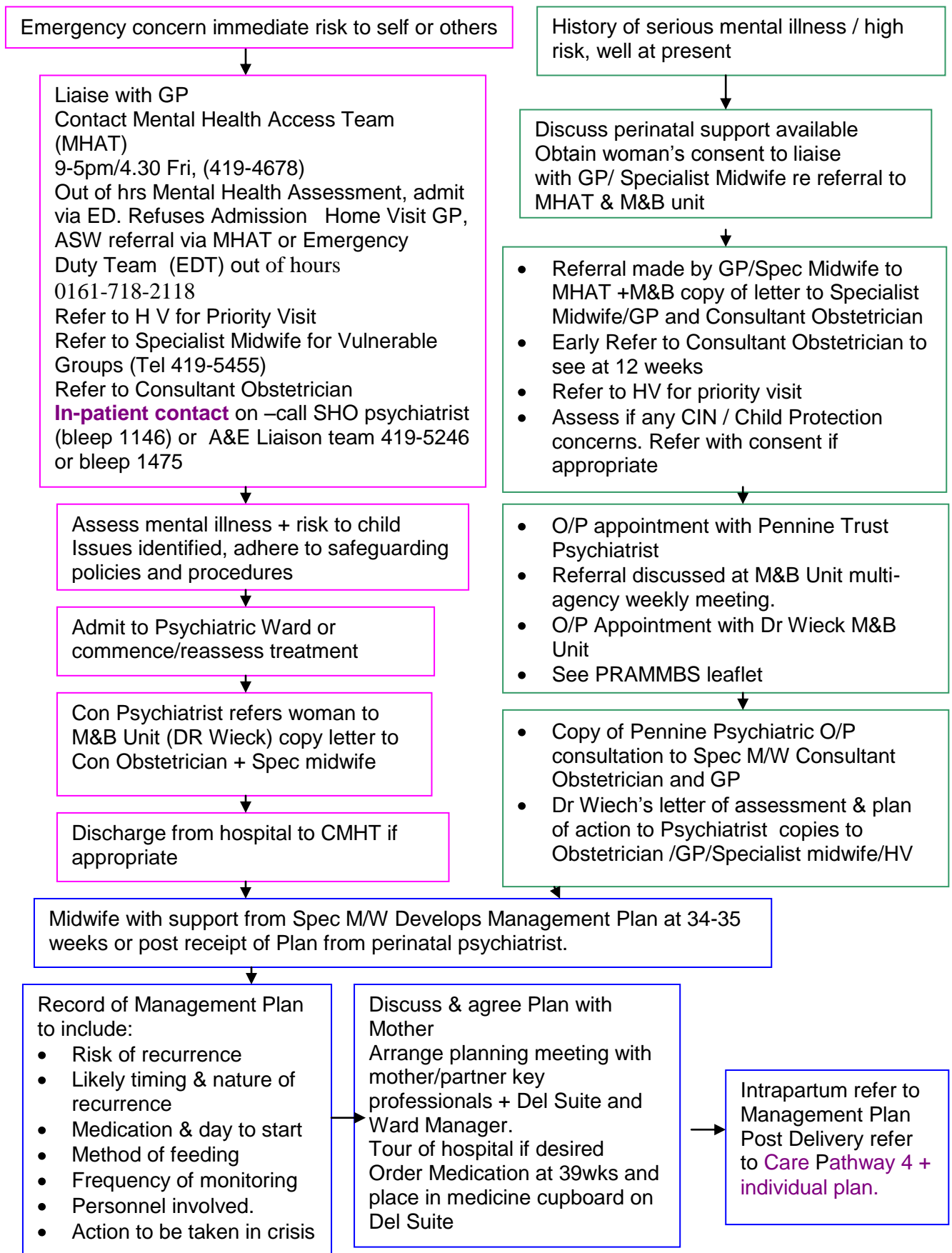


Care Pathway for Perinatal Women with Mild to Moderate Risk of Mental illness



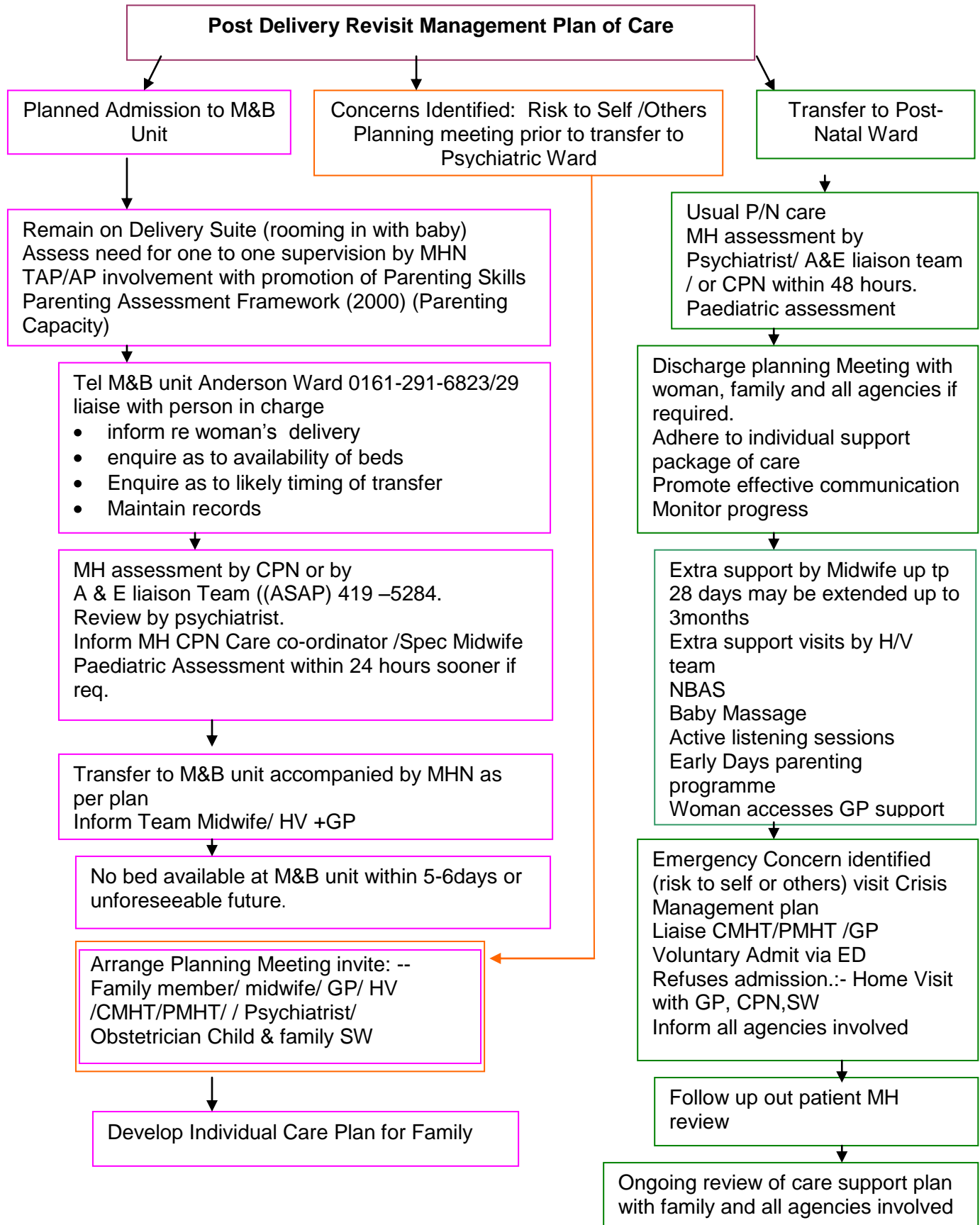
Care Pathway for Pregnant Women with or at High Risk of Mental Illness

At each contact ensure all women are aware of treatment options



Pathway 4

Care Pathway for Post Natal Women with or at High Risk of Mental Illness



Glossary of Terms

ED: Emergency Department

CPN: Community Psychiatric Nurse

CP: Child Protection

CIN: Children in Need

CMHT: Community Mental Health Team

GP: General Practitioner

HV: Health Visitor

MHAT: Mental Health Access Team

SW: Social worker

M&B: Mother and Baby

PRAMMBS: Psychiatric Referral Assessment and Management Mother and Baby Service

PMHT: Primary Mental Health Team

2.2 The clinical services of midwifery and health visiting have developed specific guidelines for staff working with antenatal and postnatal women. These are the clinical guidelines available to each staff group.

The guidelines and the pathways for midwives and professionals are on the intranet obstetrics and gynaecology menu under documents.

The guidelines for health visitor teams are available on the SPCT corporate drive/policies and in the Child Health Promotion guidelines file in each community clinic.

2.3 Evidence-Base and Rationale

The care pathways and evidence-based guidelines have been produced following a review of the recent research and key documents such as the CEMACH Reports (2000-2002) and the NICE Guidelines (2007).

The use of care pathways as a tool is encouraged by NICE for professional groups and service users to facilitate the introduction of guidelines.

The care pathways incorporate the key recommendations of NICE (2007). As part of the clinical interview, NICE recommend the use of 2 key questions as part of the screening. The questions are stated in the care pathways. Evidence shows that a combination of using EPNDS (Edinburgh Postnatal Depression Scale) and clinical assessment produced the highest sensitivity in assessment (Elliot and Leverton 2000).

The use of EPNDS has been widely discussed in recent years leading to the National Screening Committee (NSC) being asked to advise on its suitability. The NSC reporting in 2001 found no evidence to stop its use. It recommended that EPNDS not be used as a pass or fail screen and advised that a mood assessment is made prior to its use. NICE (2007) found the EPNDS to be a useful tool as an aid to improve detection of postnatal depression. It allows women to think about their feelings and facilitates open discussion. The EPNDS is not diagnostic; it is intended to assist in the screening process. The largest study of its use showed two thirds of women scoring over 12/13 were correctly identified as depressed (Murray and Carrothers 1990). The Community Practitioners and Health Visitor Association (CPHVA) have also produced booklets to support the assessment of women from BME groups.

NICE (2007) report in some detail on the medical treatment of mental health problems in the antenatal and postnatal period that is not within the remit of this document. The professional guidelines for midwives and health visitors provide guidance on when to refer to a medical practitioner for further assessment which may lead to drug treatment.

The approaches which are recommended for use by health visitor teams and midwifery teams to support women are active listening, cognitive behavioural approaches and helping women to access social support groups such as Mums in Art, Beat the Blues and the family support services offered via Children's Centres.

Studies have shown that 6 or 8 sessions of weekly non-directive counselling was more effective than routine care (Holden and Cox 1989 and Wickberg and Husang 1996). Cognitive behavioural approaches with problem solving have also been shown to be helpful for women with postnatal depression (Appleby et al 1997).

2.4 The Parent-Infant Dyad

The support and care of women with antenatal and perinatal mental health problems is important for the mother herself, her partner, wider family and crucially in order to promote the healthy development of a positive relationship and attachment between mother and infant. The increasing body of research on infant brain development and the importance of early nurturing relationships in this process have led to policy makers focusing to a greater extent on early intervention to promote attachment (Cabinet Office 2006). In order to improve outcomes for children, it is important to support the developing mother-infant relationship (NSF2004).

Infant massage, as an early intervention strategy, can have a positive impact on the mother – infant relationship by facilitating the mothers and the infant's responsiveness to interaction and positive touch (Onozawa et al 2001). The neonatal behavioural assessment scale (NBAS) is another tool which can enhance the parents understanding of their infant's behaviour and capacities in a positive way in the first two months of life (Brazelton and Nugent 1995). Both infant massage and the NBAS have been highlighted as ways of promoting sensitive parenting in The Child Health Promotion Programme (DCSF and DOH 2008).

Section 3 Governance Arrangements

3.1 Data Collection

Health visiting services undertake annual data collection of numbers of women identified with postnatal depression using caseload profiles and caseload dependency tool. The following information will be collated to help evaluate the service:

- Number of women identified with a perinatal health need.
- Number of women who received additional health visiting interventions to promote mental health needs.
- Number of women referred to other services for support with mental health needs.

The Specialist midwife for Vulnerable Women monitors perinatal mental health in relation to the number of women referred to her by midwives and other professionals with history of:

- previous postnatal depression
- depression in pregnancy
- past history of depression
- self-harm
- panic & anxiety
- Personality disorder
- Eating disorder
- serious mental illness classified as bi-polar, schizophrenia, puerperal psychosis and Obsessive Compulsive Disorder
- dual diagnosis - drug misuse and mental illness, domestic abuse and mental illness

In addition, the specialist midwife audits the number of women referred to:

- Psychology Unit Pennine Care Trust
- Mental Health Access Team Psychiatric department Pennine Care Trust
- Psychiatric Referral Assessment Management Mother and Baby Services and
- The number of individualised management plans created as a result of multi agency input.

3.2 Evaluation

The audit will provide quantitative data which will help to evaluate the effectiveness of the use of the pathways in identification of women with mental health needs. This can be compared to national data.

The Task Group will explore ways of undertaking a survey of service users when the Integrated Care Pathways has been implemented for a defined period of time.

3.3 Training

The training provided by the SPCT will be:

1. One day training for all health visitors and staff nurses in the detection and management of postnatal depression in primary care.
2. All staff should attend a half day supervision session annually to promote good practice.
3. Half day training for nursery nurses and health care assistants in the awareness of postnatal depression.

Training within the Stockport Foundation Trust will be ongoing. The training includes:

- Use of assessment tool to enable a systematic enquiry re. mental illness at booking (CEMACH 2000-2002)
- Practical sessions linked to the care pathways
- Empowering women by discussing care pathway 1 with all pregnant women in order to promote positive mental health and wellbeing. Care pathways 2, 3 and 4 are discussed and issued to women identified as having a mental illness.

Further training modules in cognitive behavioural approaches and counselling are available for continuing professional development through the University of Manchester.

Training provision will be evaluated and reviewed in response to the changing needs of the workforce, particularly in the light of the modernisation of roles within teams.

3.4 Standards for Better Health (2004)

The Standards for Better Health document provides a governance framework which has been used to review the integrated care pathways for antenatal and postnatal mental health document. The domains have been considered as follows:

Safety:

The updated Care pathways document emphasise the importance of adequate assessment of women antenatally and postnatally in order to identify those at high risk of mental health problems.

Clinical Cost Effectiveness:

The Assessment tool and care pathways aim to assist practitioners in early identification of need in order to support and treat women effectively in a community setting with multi-agency resources and avoid hospital admission.

Governance:

The most recent NICE guidelines and research evidence have been applied in the development of the Stockport Care Pathways for Antenatal and Postnatal Mental Health. The implementation of the document ensures that Stockport is working towards reaching the targets set out by the NSF for Children, Young People and Maternity Services.

Patient Focus:

The Task group will undertake a survey of service users to evaluate the service and take these views into account in further development of the service. Members of the Task group also link with patient led support groups to include their views in service development.

Accessible and Responsive Care:

The Integrated Care Pathways document has included the clinical and community based services available and prioritised the promotion of positive mental health as well as care for those in greater need.

Care Environment and Amenities:

Strong links are being made between midwifery, health visiting, local mental health professionals and the development of Children's Centre services to offer more services in new, community based settings with crèche facilities where possible.

Public Health:

The promotion of maternal mental health is recognised by policy makers as a public health priority due to the impact it has on family function, risk of social exclusion and negative outcomes for children in both the short and long term if not addressed.

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Task Group Membership

Multi-Disciplinary Task Group Membership

Name	Job Title
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Annette Holt	Manager, Access and Crisis Team, Pennine Care Trust
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Dil Januffur	Manager, Pennine Care Trust
Eileen Maloney (Chair)	Specialist Midwife for Vulnerable Women, Stockport Foundation Trust
Fiona Clear	Manager , Family Info Link
Fran Russell	Coordinator, Home-Start
Gail Spray	Team Leader, Family Support Team, SMBC CYPD
Helen O'Rourke	Counsellor, Pennine Care Trust
Jayne Crookes	Ward Manager, Pennine Care Trust
Linden Woods	Health visitor, Great Moor Clinic
Maura Appleby	Professional Development Nurse, Parenting Team
Mona Kamran	Consultant Obstetrician, Stockport Foundation Trust
Nancy Neehan	Social Worker, SMBC CYPD, Mount Tabor
Rose Tyldesley (Chair)	Professional Development Nurse/Community Development worker (Mental Health)
S. Kaligotla	Consultant Psychiatrist, Pennine Care Trust
Stephen Melman	Manager Psychological Therapies, Pennine Care Trust
Sue Holden	Manager, Pennine Care Trust
Tracey Bushell	Health Visitor, Brinnington Health Centre

Equality Impact Assessment

		Yes/No	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability – learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	Is there any evidence that some groups are affected differently?	Yes	Culture differences will be addressed in the training which supports the pathways.
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4.	Is the impact of the policy/guidance likely to be negative?	No	
5.	If so, can the impact be avoided?	N/A	
6.	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7.	Can we reduce the impact by taking different action?	N/A	