Kirklees NHS
Primary Care Trust

MATERNAL MENTAL HEALTH POLICY

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Contents

Section		Page
1.	Introduction	4
2.	Associated Policies & Procedures	5
3.	Aims & Objectives	5
4.	Scope of the policy/procedure	6
5.	Accountabilities & Responsibilities	6
	5.1 Pathway Use	6
	5.2 Training Requirements	6
	5.3 Communication	7
	5.4 Supervision	7
6.	Equality Impact Assessment	7
7.	Training Needs Analysis	8
8.	Monitoring Compliance with this Policy/Procedure	8
9.	References	9
Appendices		
A	Maternal Mental Health Care Pathway Flowchart	10
B	Survey of Current Health Visiting Practice in Kirklees with Regards to Antenatal and Postnatal Mental Health – May 2007	11
C	Definitions; Key Stakeholders	14

Policy Statement

Kirklees PCT supports the mandatory use of the maternal mental health care pathway by health visitors at Kirklees PCT during contacts with all women from first contact and during their postnatal period.

Health visiting staff will receive training around use of the pathway, information recording, communication and supervision, to ensure its effectiveness.

1. Introduction.

Maternal mental well-being is of significance to healthy functioning of both mother and child with around 35% of mothers reporting mood changes that are sufficient to impact negatively upon the maternal-child relationship (Hayes et al, 2001).

Postnatal depression is a common condition that according to official figures affects between 10 – 15 per cent of mothers with new babies and for between one third and one half of these women their symptoms will be severe. (Cooper et al 1988) Postnatal depression usually emerges between four to six weeks after the birth but can develop at any time during the following one to two years. Postnatal depression has negative implications for:

- The persistence of breast feeding (Cooper & Stein, 1993),
- Infant behaviour and secure attachment (Murray, 1992; Murray & Cooper, 2003).
- Infants of mothers with maternal depression may also show neurological delays, sleep/wake disturbances, and limited responsiveness, which can begin as early as the neonatal period (Field, 1998).

Puerperal psychosis (post partum psychosis) on the other hand affects clinically only about two mothers out of every thousand deliveries (Cooper et al 1988). It is frequently characterised by severe affective symptoms, either manic or depressive in nature, or both. The onset of symptoms is usually rapid, frequently occurring within 3 – 14 days of giving birth. When these symptoms occur, there is an urgent need for help and usually hospitalisation, preferably in a mother and baby unit.

Economic costs of postnatal depression

Although difficult to estimate, there are also economic and social costs associated with the cognitive and behavioural impact of postnatal depression.

The national economic burden of this condition to public services is estimated at £35.7 million per annum. The mean estimated cost for maternal care in the community for those with postnatal depression is 55% higher than for those without. These costs are reflected in the greater number of contacts with GPs, social workers and other community care services, yet with no similar increase in HV contact (Petrou et al, 2002). Although anti-depressant treatments are less costly than psychological therapies, the cost-benefit ratio for such drug treatment is poor, and cognitive-behavioural interventions are recommended for mild to moderate depression generally (NICE, 2004).

The maternal mental health pathway and its supporting guidance follow the evidence-based recommendations of NICE clinical guideline 45 – Antenatal and Postnatal Mental Health (February 2007).
It also enables primary and secondary prevention of mental health problems, as recommended in NSF for Mental Health (1999), and relates to Every Child Matters outcomes – being healthy and staying safe.

2. Associated Policies and Procedures.

This Policy / procedure should be read in accordance with the following policies, procedures and guidance.

- KPCT Child Protection Procedures
- KPCT Supervision Policy
- KPCT Child Protection Supervision Policy
- KPCT Records Management
- Policy/Guidance for Implementation of the Mental Capacity Act
- Kirklees Adult Protection Policy and Procedures 2006/07
- West Yorkshire Consortium Safeguarding Children Procedures 2007

3. Aims and Objectives.

This policy outlines the responsibilities of health visiting staff using the pathway and recording appropriate data. By supporting this policy and the recommendations within it, Kirklees PCT aims to:

- Prevent mental health problems in mothers during the antenatal or postnatal period
- Reduce severity, duration and impact of any mental health problems that do occur.

Related outcomes should be to:

- Attenuate the impact of any mental health problem upon the woman and her family
- Support effective and positive parenting, including bonding and attachment
- Improve the general health and overall quality of life of parents and families in receipt of universal or targeted support for mental health.

These will be achieved by providing:

1) A care pathway that will guide health visitors in assessment, support and referral of women in their care;
2) Training in order to use the pathway, carry out the necessary assessments effectively and record patient care – and training for those in related roles who can signpost and support;
3) Evidence-based resources to promote discussion and aid clinical judgment.

4. Scope of the Policy / Procedure

This policy / procedure must be followed by all relevant PCT employees and staff on temporary or honorary contracts as well as pool staff and students.

5. Accountabilities & Responsibilities

5.1 Pathway use

(see appendices for flowchart)
Use of the postnatal guide for maternal mental health, and where indicated the pathway flowchart, is mandatory for health visitors at Kirklees PCT in contact with women in the postnatal period from the birth visit or first contact, whichever is sooner. Review of mental health need and support should be offered where indicated until discharge from the pathway, in agreement with the mother. Mood/mental health assessments using tools e.g. Edinburgh Postnatal Depression Scale or 'How are you feeling?' (see postnatal quick guide) should be offered at the time intervals indicated by the pathway and guidance, as part of an ongoing dialogue and holistic assessment. These should only be carried out by health visitors or equivalent.

Further mental health/mood assessment may be necessary where life events or situations indicate a need for maternal mental health support after discharge from the maternal mental health pathway.

Mental health/mood assessments using either tool are not diagnostic, but may indicate a need for further support and/or referral. Clinical mental health assessment may be required if results of such assessments combined with clinical judgement highlight risk or presence of symptoms. Further discussion by the health visitor with community mental health teams may be necessary for further information and advice. Agreement should be reached with the mother about any proposed support or referral.

Informal avenues of support may still be offered or recommended where symptoms are mild in order to prevent any worsening of symptoms and their negative impact upon mother and family.

Where there is any cause for concern about a child's welfare, child protection procedures should be followed as usual.

Responsibilities around confidentiality and information sharing apply in the usual way, and appropriate procedures should be followed where there are concerns. In such cases, a discussion with one of the Safeguarding Team is advisable.

5.2 Training requirements

It is essential for all health visiting staff to attend relevant training as provided by Kirklees PCT prior to using the pathway and conducting any mood assessments.

Supporting Maternal Mental Health two-day training sessions give detail about effective use of assessment tools, referral processes and evidence-based treatment options. Health visiting staff members have a responsibility to update and refresh their skills where necessary.

Health visitors or equivalent should attend the two day course once initially, and following that, any refresher courses offered annually.

Health visitors should also attend pathway training sessions to use the Maternal Mental Health Care Pathway and know where and how to record information.
They should attend this session once, and again, should attend any annual refresher courses.

Staff members in a secondary supportive role e.g. nursery nurses, may flag up initial concerns about a mother to the appropriate health visitor, and should attend training in order to be able to do this effectively. A briefer one-day training session is available.

Nursery nurses, link workers, children's centre staff as appropriate, and anyone else in regular contact with mothers who works alongside the health visitor should attend the one day training every 2 years.

Postnatal mental health/mood assessment, review and structured listening visits are the responsibility of the health visitor/case manager rather than staff members in a secondary supportive role.

5.3 Communication

At first contact with a mother, the health visitor should ensure that they have received handover information from the appropriate midwife. Where relevant, this should detail any risk factors for postnatal depression or puerperal psychosis, previous history or current diagnosis, and any care plan information if necessary.

Where the mother is in contact with mental health services or receiving GP treatment, the health visitor should maintain communication with that service to ensure that appropriate support can be offered where needed.

Following mental health/mood assessments, any concerns or referral requests should be communicated appropriately and with the agreement of the mother. Adult or child mental health services (as appropriate) should be contacted for information and advice by the health visitor if needed. To ensure continuity of communication and support, the health visitor should ensure that the patient's GP is aware of any referrals or other action taken where mental health symptoms are present. The health visitor should also seek information from the GP about ongoing treatment for any mental health difficulty.

The health visitor should seek informed consent from the woman before sharing information with others, unless there is significant risk to herself or her family. Procedures for obtaining consent apply.

5.4 Supervision

Health visitors are responsible for obtaining formal supervision following the procedures as for other areas of expertise, as detailed in the PCT's Supervision Policy.

6. Equality Impact Assessment.

All public bodies have a statutory duty under the Race Relation (Amendment) Act 2000 to "set out arrangements to assess and consult on how their policies and functions impact on race equality." This obligation has been increased to include equality and human rights with regard to disability age and gender. The PCT aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

In order to meet these requirements, a single equality impact assessment is used to assess all its policies/guidelines and practices. This Policy / procedure / guidance was found to be compliant with this philosophy.

7. Training Needs Analysis.

The last health visitor training needs analysis was completed in 2003/2004. This demonstrated that 73% identified training needs around depression, and although frequently involved in this issue, confidence around providing support was average. A survey in May 2007 to assess competency of health visitors around the requirements of NICE guideline CG45 showed that 42.7% of respondents had last received training around detection and management of postnatal depression more than 3 years ago. Two thirds felt that they still had training needs and would welcome an update. The last survey is included in the appendices.

8. Monitoring Compliance with this Policy / Procedure.

Prior to implementation, baseline data should be collected where possible relating to performance indicator (1) specified on page 2 of this policy. This will provide some data to demonstrate impact when the all requirements around training and pathway use are fulfilled. It may not be possible to demonstrate severity and duration of episodes of maternal mental illness until the pathway is implemented and systems for monitoring performance are in place.

Indicator (2) will be informed by data from performance monitoring (health visitor outputs via SytmOne or equivalent).

Additional data will inform impact evaluation at the end of the first year of implementation. Responsibilities around data collection, monitoring and evaluation are as follows:

- Training uptake data will be provided by the training department and the training facilitators, and also provider services where necessary;
- Collection of data around performance monitoring (i.e. quantitative output data via SystmOne or equivalent) and communication (qualitative audit) will be carried out by provider services;
- SystmOne will be used to inform data relating to tier of intervention, and this will be combined with data from health informatics and commissioning as appropriate;
- Analysis of audit data and technical support for evaluation of impact will be provided by public health;
- Information regarding uptake of support services outside health visiting provision will be followed up through children’s centres and health informatics as appropriate;
- Data relating to patient satisfaction should be collected through provider services and/or children’s centres as appropriate;
- Ownership for audit process overall and any actions that arise from it rests with commissioning (adult mental health).

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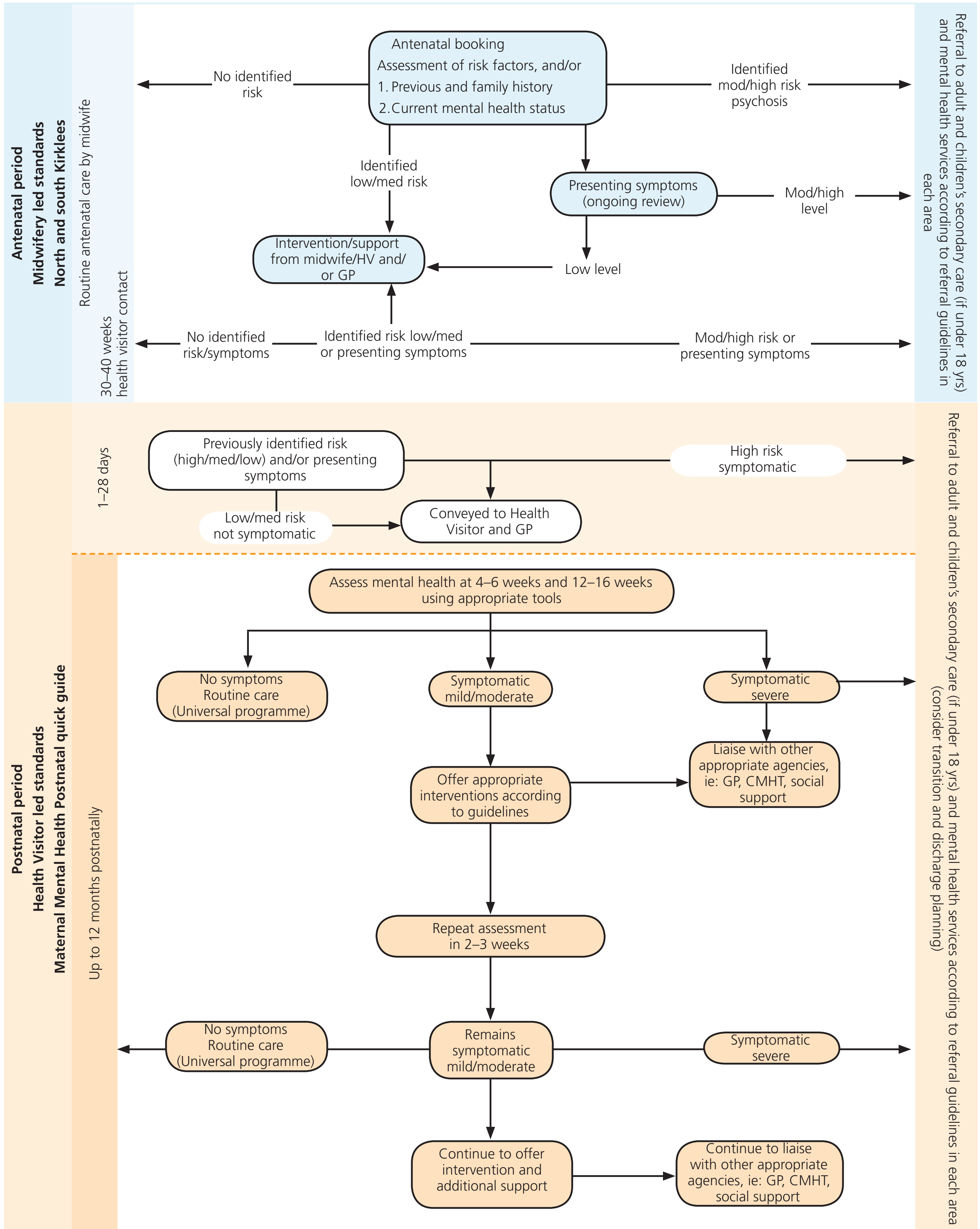
Maternal Mental Health Care Pathway

N.B. To be used in conjunction with Maternal Mental Health Quick Guide.



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APPENDIX B

Survey of Current Health Visiting Practice in Kirklees with Regards to Antenatal and Postnatal Mental Health

Target:
All health visitors

Date:
May 2007

Response:
21 out of 75 health visitors - 28%

Results:

Q1 Do you routinely carry out antenatal visits?

	Number of respondents	Percentage
Yes	15	71.4%
No	0	0%
Mostly	4	19%
Rarely	1	4.7%
Only targeted	1	4.7%

Q2 Do you assess for risk of postnatal depression, antenatally?

	Number of respondents	Percentage
Yes	18	86%
No	1	4.7%
Sometimes	1	4.7%

Q3 If yes, how do you do this?

14 of 18 respondents answering yes stated that they looked for risk factors. The remainder used clinical judgements and / or tools such as EPND, 'How are you feeling?' booklets and the Emotional Needs Score.

Q4 How do you assess a woman's mood and current mental health status?

16 (76%) of respondents assessed a woman's mood through discussion, questioning and using clinical judgement rather than using a particular tool. For those who use a tool, 5 (23.8%) use EPND, the others use the HNA or 'How are you feeling?' booklets.

Q5 On a scale of 0- 5, how confident do you feel identifying individuals with depression and other mental health problems (0= not at all, 5= very)?

Score	Number of respondents	Percentage
0	0	0%
1	0	0%
2	3	14.2%
3	7	33.3%
4	8	38%
5	3	14.2%

Q6 On a scale of 0- 5, how confident do you feel supporting individuals with depression and other mental health problems (0= not at all, 5= very)?

Score	Number of respondents	Percentage
0	0	0%
1	1	4.7%
2	4	19%
3	9	42.8%
4	7	33.3%
5	1	4.7%

Q7 When did you last receive training around the detection and management of postnatal depression?

	Number of respondents	Percentage
Within the last year	7	33.3%
1-3 years ago	5	23.8%
3-5 years ago	3	14.2%
5+ years ago	4	19%
Never had any training	2	9.5%

Q8 Please describe what that was

8 of the respondents who had had training stated they had done EPND training specifically, the rest stated Maternal Mental Health Training or Postnatal Depression Training – but this may well have been the same thing. 2 respondents had also done Managing Depression and 1 the Brief Encounters Training.

Q9 Do you feel you have training needs in relation to antenatal and postnatal mental health problems?

	Number of respondents	Percentage
Yes	14	66.6%
No	7	33.3%

Q10 If yes, please describe what they are

10 of the 14 respondents who stated they had training needs said that they would like an update. 1 wanted full training on assessment, referral and treatment, 1 on supporting women in special categories for example those with learning disabilities or those from BME groups, 1 on antenatal assessment, and 1 on use of the 'How are you feeling?' tools.

Q11 Is there a system in place whereby health visitors are informed of women who are at risk of developing postnatal depression?

	Number of respondents	**Percentage**
Yes	14	66.6%
No	7	33.3%

Q12 If yes, please describe what that is

All of the 14 respondents who stated they had a system in place, said they would be informed via the midwifery service. There are several ways of doing this: via phone call, via booking or antenatal form or through meetings with midwifery colleagues whereby women at risk are discussed. 2 respondents stated that they also get information via the woman's GP.

Catherine Smyth
5.6.07

APPENDIX C

A. Definitions

Postnatal depression: non-psychotic depression with onset during the first 3-6 months postnatally.

Puerperal/postpartum psychosis: a severe mental disorder with rapid onset usually within the first 3 months postnatally, characterised by extreme moods, delusions and psychotic symptoms. It may be a continuation of an existing severe mental disorder.

Postnatal quick guide: The guidance produced by Kirklees PCT for use by health visitors to interpret the flowchart, and to inform and guide practice.

Maternal mental health care pathway flowchart: The flowchart (see appendices) used to guide communication, timing of assessments, and referrals to other agencies.
EPDS: The Edinburgh Postnatal Depression Scale (Cox, Holden & Sagovsky, 1987) is a 10-item scale for detection of symptoms of postnatal depression. Recommendations for use are given in training content and quick guide.

How are you feeling?: Booklets developed by Adams and Sobowale (2004) to aid discussion of feelings during pregnancy and after childbirth, using culturally appropriate illustrations. Recommendations for use are given in training content and quick guide.

B. Key Stakeholders consulted / involved in the development of the policy / procedure.

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