



An exploration of the range of approaches a children's centre
can adopt to maximise collaboration with professional
stakeholders in responding to postnatal depression

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Jane Powl

Childrens Workforce Development Council (CWDC)'s Practitioner-Led Research projects are small scale research projects carried out by practitioners who deliver and receive services in the children's workforce. These reports are based in a range of settings across the workforce and can be used to support local workforce development.

The reports were completed between September 2009 and February 2010 and apply a wide range of research methodologies. They are not intended to be longitudinal research reports but they provide a snapshot of the views and opinions of the groups consulted as part of the studies. As these projects were time limited, the evidence base can be used to inform planning but should not be generalised across the wider population.

These reports reflect the views of the practitioners that undertook the research. The views and opinions of the authors should not be taken as representative of CWDC.

A new UK Government took office on 11 May. As a result the content in this report may not reflect current Government policy.

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Abstract

INTRODUCTION

The current national and local policy frameworks emphasise the importance of improved maternity and child outcomes. They require the development of services which meet local needs and are evidence based.

This project was, therefore, designed to explore the advantages and challenges of delivering such services in the specific context of PND, with a view to understanding how a multi-agency group working with children's centres can maximise both service needs and quality.

METHODOLOGY

Within a short time frame (from September 2009 to February 2010), we carried out a literature search around multi-agency working and the importance of safeguarding children. We administered a questionnaire which was supplemented by semi-structured one-to-one interviews to explore the views of a small sample of practitioners which included: five GPs, two health visitors, a childcare advisor, and a primary mental health worker. Using a reflective practice approach, scheduled group meetings were held, the learning documented, and experience shared.

FINDINGS

- High GP awareness of children's centre and family support team provision. Shift from previous first choice in low level PND referral.
- High use of health visitors and children's centres as the most popular intervention referral route for low level PND.
- Participating in research with multi-agency practitioners has increased awareness of services and laid strong foundations for working together – face-to-face contact appears to have had a dramatic effect on this process.
- Providing a supportive sharing environment for practitioners with children's centres, and family support team linking with GP and health visitor practice.

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Introduction

The project stemmed from the need of a local children's centre team and multidisciplinary practitioners to further address maternity and child outcomes as part of key national and local targets, together with addressing approaches a children's centre could adopt. We decided to set up a pilot group to look at how we could better address the needs of mothers experiencing low level postnatal depression (PND), as well as supporting the ongoing development of integrated working within a children's centre.

A group of managers, practitioners, a GP practice, a link health visitor (HV) and commissioner, who are already working together with children's centres, agreed to dedicate time to meet regularly to support the project.

Anecdotal evidence from practitioners was that mothers experiencing low level PND had increased. It was agreed by the group to focus on this as a priority.

Aims

The key aim of this project was to facilitate the development of a multi-agency response which is considered high quality and has a consistent approach to the needs of mothers with low level PND. The project also aimed to:

- explore the way practitioners currently categorise different levels of PND;
- identify good practice examples of local practitioners' engagement with children's centres;
- explore the perceptions of contributions made by different models of working together, specifically defining link HV roles to children's centre cluster, and model of GP engagement with children's centres; and
- identify the training and learning needs of children's centre staff.

Background

The key drivers for this project were the national and local strategies designed to improve maternity and child outcomes through integrated working and more co-ordinated approaches to service provision.

The *Every Child Matters, Change for Children (ECM)* programme (DCSF, 2004) provides the overarching strategy for children, with the aim of improving outcomes and life chances for all children and young people, especially those most in need. *The National Service Framework for Children and Maternity (NSF)* (DH and DfES, 2004) is closely aligned to ECM and, through a set of standards, provides a benchmark and good practice guidance for all children and maternity health services.

The recent national child health strategy *Healthy Lives, Brighter Futures (DH, 2009)* brings together the best elements of ECM and the NSF, and builds on new evidence from recent research. This strategy and the 0-5 Healthy Child Programme (DH, 2009) are based on principle of 'progressive universalism', to ensure that services meet the needs of the most disadvantaged children, an approach that is also embedded in children's centres. The Think Family strategy is designed to provide intensive and more co-ordinated support for the most vulnerable families. Speaking at the launch of the Family Pathfinder programme, Ed Miliband, Cabinet Office Minister stated:

“To ensure children get a fair start in life, we must support the needs of the whole family” (May, 2009).

At a local level, Local Area Agreements and Local Delivery Plans (2009) have prioritised the following:

- improving early access to maternity services;
- reducing teenage conception rate; and
- access to comprehensive Child and Adolescent Mental Health Services (CAMHS).

Improving maternity and early years services are also priorities in the Primary Care Trust's (PCT) commissioning and operating plans, including a review of perinatal mental health services.

The importance of early intervention and prevention is now seen as an imperative for all public policy. New information about neurological development, the impact of stress in pregnancy and further recognition of the importance of attachment and its effects into adulthood have placed a new emphasis on improving pregnancy and infancy outcomes.

Based on these national and local priorities the project group decided to focus on PND to contribute to improving both maternal and infant health and family well being.

The Value of Inter-Agency & Collaborative Working

The Children Act 1989 stressed the importance of interagency working and The Children Act 2004 sets out the duty of local authorities to develop common working practices between professionals and staff in children's services.

Children's centres are at the heart of government strategy to provide seamless, holistic and integrated services which deliver better outcomes for children and families, building on existing good practice. Addressing targets to reach vulnerable and hard to reach families experiencing a wide range of family health issues, mental health problems, domestic violence, and substance misuse will now be part of statutory provision.

The Victoria Climbié Enquiry report (Laming, 2003) identified failure of communication and a lack of a co-ordinated approach as factors which contributed to Victoria's death. The report re-emphasised the need for joined up working in early years and children's services. The report's recommendations led to the Every Child Matters (ECM) Green Paper (DfES, 2003) and ECM: Next Steps programme (DCSF, 2004), setting out five outcomes for all children: being healthy; staying safe; enjoying and achieving; making a positive contribution; and achieving economic well being.

The background in which this project takes place is very relevant. In addition to local and national strategies and programmes, there is high profile debate taking place around professional uncertainties and safeguarding issues.

The research demonstrated that families need to have trust in services, and professionals are secure in their own identity. Key to the development of good practice service provision included: having clarity around PND agreed referral routes; awareness of a range of services available and of individual professional process; agreed information sharing standards; and use of the

Common Assessment Framework (CAF) to allow families to have a route to contribute to the family plan.

What is PND?

Depression, anxiety and other mental health problems are reported by a significant percentage of pregnant and postnatal women. The birth of a child is known to place additional stress on a couple's relationship. It is estimated that about one in ten women will experience PND, although in areas of deprivation and for single parents this appears to be higher (O'Hara et al., 1990).

In the Community Practitioners' and Health Visitors' Association (CPHVA) response to the Marmot Review on Health Visiting (Cowley, 2009), the importance of maternal mental health on the long-term health of the child is emphasised:

'Maternal mental health is particularly important in setting up positive parent-infant relationships, a precursor to later positive parenting styles and protection against vulnerability. Although PND responds well to early intervention, where it remains untreated or unresolved and persists over one year, it is shown to have long term impact on recurrent depression in the mother and behavioural emotional and cognitive development of children.'

PND is not a separate condition from depression, occurring at any other time, but it can have a serious effect on the baby as well as the mother and the wider family.

Anti-depressant therapy is one option for the treatment of more severe PND, but other evidence-based treatments are recommended for mild to moderate PND that do not involve drugs, these include:

- non-directive counselling – talking about feelings and problems with a trained listener;
- inter-personal psychotherapy – looks at how current and past relationships play part in depression; and
- cognitive behaviour therapy – aims to change negative thoughts.

Baby massage to promote bonding and peer support from other mothers is also considered valuable, but further research and evidence is needed to support these claims.

The NICE clinical guideline on antenatal and postnatal mental health (NICE, 2007) recommends asking screening questions (Whooley questions) at a woman's first contact with primary care, at her booking visit, and postnatal visits (usually at four to six weeks and three to four months).

Practitioners were asked about their knowledge and use of NICE guidelines during the research interviews, however, it is not known if the guidelines are consistently used across the borough.

Services and support for women with PND

Locally, a number of services provide information, support and advice to new mothers and their families, but there does not appear to be a clear borough-wide strategy to address PND.

Universal midwifery and health visiting support are provided for all families, as well as a range of third sector services, community groups, drop-ins, and counselling services. Additionally, several new services and care pathways have been developed to meet the needs of children and families with higher levels of risk, including women with PND. These include:

- A borough-wide Family Support Team (FST) is a multidisciplinary service and provides counselling and a range of support for referred and self referred families around PND.
- The Family Nurse Partnership Programme is working intensively with vulnerable teenage mothers and young families from pregnancy until their child is two years old.
- A new psychological therapy service, Back on Track, is about to be launched and includes a remit to provide cognitive behaviour therapy for women with mild to moderate PND and couples counselling. This is a useful additional service, and the PCT will be evaluating how well it is used by mothers.

Much research has been carried out on the role of HVs working with mothers with PND to achieve positive outcomes (Holden et al, 1988). Locally, HVs provide listening visits, general family support and baby massage sessions at several children's centres, however, provision is variable across the borough.

There is a clear role for children's centres to be part of a co-ordinated support package for women with PND and their families. Children's centres are welcoming, non-clinical settings and can provide resources and activities such as baby café, peer support, baby massage and non-stigmatising access to other professionals from the FST and HV. Children's centres need to work alongside agencies, and by being aware of the implications of PND for families and children, highlights an ongoing professional training need. Raising awareness of NICE guidelines; ongoing use of CAF; and knowledge of services available to support families could be part of an approach to focus on low level PND support. It would also contribute to the review and development of a more comprehensive and joined up care pathway for perinatal mental health.

Having HV, FST and GP participation in this project, together with children's centres, it is hoped a good practice model of working together will be developed and translated.

Introduction to the Methodology

Before setting up the research project, the group had already begun meeting and had identified possible areas to focus on. Specifically, it was thought to be helpful to obtain a baseline of parents' and carers' existing awareness of the children's centre and other local services in order to identify gaps in provision.

Unfortunately, an attempt to identify service users' knowledge of services by using a children centre in-house questionnaire with newly registered families achieved a very poor response rate. As a result, it was felt that it would be better to defer further on research on why this was unsuccessful, and the group decided to identify more appropriate methodology at later date.

Based on the increasing number of referrals for women with depression and anxiety and also NHS Hammersmith and Fulham's Maternity and Child Health Commissioner's interest in using learning from the project to inform the PCT's review of perinatal mental health care pathways, the group agreed to focus on PND.

Methodology

The methodology included:

- A literature search on multi-agency, team working, PND, national and local legislation, and relevant guidance, articles and research reports;
- Group meetings to reflect on practice, multi-agency working, and address issues of PND, with the learning documented;
- Questionnaires were administered and supplemented by semi-structured one-to-one interviews to explore the views of five GPs, two HVs, one childcare advisor and one primary mental health worker.

These research methods were thought to be practical and achievable within the given timescale. A draft questionnaire and interview schedule was agreed by the group with specific input from a GP trainee who then joined the project. Protocols were agreed and approval was obtained from senior managers for staff to take part in the research. Guarantees of anonymity were made to participants who gave informed consent to be interviewed.

The link HV then conducted interviews with practitioners based at a GP practice.

Responses to questionnaire

Each of the eight questions had tick box responses but the interview process provided opportunities for further probing (see Appendix).

- It was interesting to note that over half of the respondents rated their knowledge as comprehensive, three rated their knowledge as reasonable, and two responded that they were keen to extend their knowledge base.
- The majority used NICE guidelines to identify different levels of PND and, in addition, three sought other professional advice. Listening to clients was felt to be very important.
- Referral routes for low level PND showed high preference for HV (six) and links with children's centres (five) which indicated positive awareness of these and other similar services. Children's services (social services) had a nil response in terms of access to support families and it was perceived as being 'hard to access social services' and 'given hard time', although it was not clear if this is the family or practitioner.
- Language was also felt to be a barrier as referrals to some services were not always accepted if the women spoke English as a second language.

Open ended questions around collaboration and joint working received positive feedback. Some comments from interviewees included:

'Good local support for PND most picked up by HV'

'Children's centre invaluable in giving support'

'If everyone works together the family gets best support'

It is acknowledged that this is a very small sample but the findings provided useful messages which could help inform evidence based practice.

Key Findings

- There was a surprisingly high GP awareness of children's centres and FST provision.

- There was a shift to less medical referral routes for low level PND, following closer joint working, with HV and children's centre as the most popular intervention in low level PND cases.
- Positive feedback was received on the advantages of collaborative interagency working, which were identified as a priority in working to support women with low level PND.
- Existing barriers to providing support for women with PND were identified and included: different systems, difficulty sharing information and different service approaches.
- Questionnaire and interview responses indicate that practitioners appeared well informed and aware of NICE guidelines.
- Information about available services was variable, indicating that it would be helpful for a clear care pathway and referral route to be developed.
- It was felt that learning for children's centre staff on services which were continually changing, CAF and NICE guideline, needed to be an ongoing process.

Group Meetings

In addition to carrying out the interviews, the group had dedicated time to reflect on existing practice and share information regarding services. Analysis of the questionnaires took place during these meetings as well as reflection on the barriers and challenges and how these could be addressed. Identification of learning needs and an action plan for the future was also a planned outcome. Confidentiality protocols for sharing information and group guidelines were agreed which helped to build group confidence and trust.

Anderson (1987) in the Reflecting Team discusses how no two people have the same picture of the world, and conversations on differences enrich each others pictures. Bogdan (1984) supports the importance of meeting face to face to better understand differences.

Implications for current systems within children's services

Children's centres work with a range of agencies and services and need to be aware of the different protocols.

- It was acknowledged that having multiple information sharing policies and data collection systems could be a barrier in working more closely and required innovative solutions. The importance of clear information sharing protocols was also considered key.
- Each service has different systems and there has been historic reluctance to share information concerning vulnerable families with children's centres.
- There are different medical and social models of care and support – each with their own professional systems which may be unfamiliar.
- Practitioner may have variable knowledge about local strategies, priorities, needs assessment, and how best to help inform and shape practice.
- There is a need for a central information point to collate different services and information streams.
- Lack of dedicated time to reflect and research.
- Evidence base about what works? Not easy to access and understand some services which are based on custom, practice and individual practice.
- Lack of knowledge about available services, so possible gaps and duplication.
- Varying levels of communication and information sharing between children's centres, social workers, and GPs, etc.

- Varied perceptions regarding remit of children's centres and referral boundaries. New children's centres in process of getting established, new relationships to be made, standards set for process, data sharing, record keeping, etc.
- Sporadic use of CAF, no e-CAF to facilitate better information sharing, with limitations of hard copies only.

Future implications for improved joint working with children's centres

Partnership working can be seen as a hierarchical continuum and it is important to identify which level of partnership is being employed – *'cooperation, collaboration, co-ordination, or integration – to enable effective joint working to take place'* (Frost, 2005: 13).

Time for reflection is also central to development to allow team trust and identity to develop: *"There is rarely time built in to the contracts of newly appointed multi-agency team members for sharing of and reflection on their beliefs, values, associated working practices."* (Anning, 2005)

A key success of the research was the use of meeting time for reflective discussion and learning; to address barriers; identify a range of approaches which could be adopted to maximise collaboration; and to identify what works best.

Common Assessment Framework (CAF)

The research team felt that the use of CAF would be a positive way forward as the process had already been introduced and was working well in the borough. The Family Information Service coordinates the database, and support from the borough-wide Family Support Team (FST) manager was available for advice.

CAF would provide a consistent assessment tool and could be used with families experiencing PND, as a tool for documenting impact on child/children.

'The common assessment framework (CAF) can provide a bridge for communication between members of the children's workforce in respect of individual children and underpin the provision of seamless service tiers 2, 3.' (Tunstall et al, 2007)

The tier system is way of categorising need. Tier 1 services are universal, Tier 2 targeted services for additional need, while choice remains with the family, Tier 3 services targeted or referral based with needs threshold, and Tier 4 services are classed as rehabilitative, and may involve legal processes.

Evaluation

Standard evaluation process and feedback from clients and service users could also encompass the requirement from health providers to measure outcomes, patient reported outcome measure (PROM) and patient reported experience measure (PREM). Further planning is needed to explore how outputs can be measured, and how services are evaluated, and what criteria are considered essential, for example, is the service user-friendly, accessible and meeting the needs of the family.

Referral Pathway

The development of a diagram to demonstrate clear referral pathway using a vignette of a mother with low level PND was designed, using CAF as the assessment process where

appropriate. This was accompanied by linking circle diagrams to demonstrate service provision and networks of children's centres (see Appendix).

The referral pathway is not a replacement of existing health services, and it is well understood by children's centre staff that referral to GP and HV is the first route to follow when diagnosing and determining a package of support. The pathway signposts referrers to HV, children's centres, Baby Café provision, providing baby massage, mentor support, peer support, access to HV, FST, and use of CAF as needed to identify other needs, wider support and referral routes to GP, perinatal mental health, and IAPT services.

Clear diagram of children's centre service provision and links to accompany referral pathway will address the lack of information identified as need in the questionnaire.

Example of one approach which is practiced with children's centres and HV link role in one children's centre:

- The HV role is vital in facilitating links with services and families. This link role has developed as identified service needs have emerged. HV within the local PCT are now linking to individual children's centres. Families are identified as needing support PND by GP, HV or self referral and linked to children's centre and Baby Café weekly programme support group for antenatal and postnatal mothers. The children's centre worker provides baby massage/baby yoga promoting bonding, in friendly atmosphere, healthy snacks provided, as backdrop to informal peer support.
- Counsellor from borough-wide FST and HV attends Baby Café on alternate weeks and are available both in sessions, for one-to-ones and can follow up with home visiting.
- Professional meetings are held to share and plan interventions and families are included in this process through referral assessment CAF.
- Children's centre family support meetings are held regularly and HV attends, in addition to local maternity hospital meetings and will advise children's centres of families in area needing support.
- The development of children's centre pack of policies and safe practice in home visiting traffic light risk assessment and supervision protocols, together with guidance on record keeping as standards for children's centre, has supported good practice and consistency.
- Children's centre and FST managers attended GP practice meeting to share information on services and referral routes. GP practice has now started process of GP trainees attending children's centres as part of induction plan to raise awareness of children's centre services. GP commitment to children's centre development has also led to information sharing sessions, plans to attend children's centre team meetings and provide specific identified training to staff, childminding network, and children's centre cluster.
- Midwifery team visit children's centre weekly to provide antenatal and postnatal sessions. These sessions are supported by family mentors who link families to children's centre services, Baby Café and build relationships with both families and with team of visiting midwives to raise awareness of children's centre services.
- Child and Adolescent Mental Health Services (CAMHS) worker has provided training sessions to children's centre FST on PND and provided consultation around specific vulnerable families, which it is hoped to continue and could extend to children's centre cluster.

It is conceivable that this format of the working group could develop into virtual team to support children's centre cluster. Feedback from service users is an ongoing process and will be used to inform service provision.

Other approaches children's centres can adopt involve looking at group dynamics. This was considered briefly but would require further research as to which teams are working together if the concept of a virtual team to support cluster of children's centre were to be adopted, smart working and organisational change will have an impact on this practice.

Key approaches which underpin effective partnership working have been well researched and evidenced and include:

- clear leadership
- commitment
- clear focus with common aims
- cultural understanding
- need for consistency
- importance of regular meetings
- spending time on the ground work of professionals learning to communicate and understand each others working activities (Anning et al, 2006).

Views, Learning & Feedback of Participating Team Practitioners

Views from the Commissioner

The PCT's maternity and child health commissioner provided invaluable support in setting up the project, providing a strategic overview and advising the group about research evidence and information about local services.

'Being part of the research group has provided me with a better understanding of local needs and workforce issues and contributes to meeting the PCT's World Class Commissioning Competencies (DH, 2007). The valuable learning from the research project is being used to inform the development of the integrated Healthy Child Programme locally (DH, March 2008, super ceded Nov 2009) and a review of local perinatal mental health services. Through joint working, professional barriers have been broken down and we have developed effective collaborative working relationships.

We now have a far better joint understanding of how practitioners can contribute to commissioning and how strategic plans can be implemented in practice. It has helped demystify the commissioning process and re-confirmed that we are all working to achieve the same outcome – improve health and life chances for children and families. The children's centre has been essential in facilitating the group, and has provided an ideal venue and supportive environment to enable the development of these relationships of trust.

Views from the Family Support Team

The Manager has supported the research project and children's centre development in advising on standards, policies and procedures for safe practice around record keeping, information sharing and the CAF process, enabling the children's centre teams to access ongoing training and the peer supervision process.

Views from GP

Involvement in this project has helped us understand the knowledge and attitudes of professionals both in our organisation and locally, to the detection and management of PND. It has helped us to build links with the children's centre, establishing deeper and more supportive relationships between us than we would all usually manage. The shared project has produced shared understanding that has spread far wider than the original remit. We are all planning more networking between us and the already established links will hopefully become more extensive.

Service Manager GP Practice

"The collaboration between the children's centre and GP medical centre has resulted in a number of benefits. We have become much more aware of the range of services provided at the children's centre, including those that assist in treating PND. The doctors are more likely to promote the services to mothers and fathers. Particularly useful have been the exchanges organised early in the registrars (GP speciality trainees) placements. As a result, the trainees have gained confidence in their knowledge and understanding of the services provided."

Having a service manager from the GP practice being very proactive in initiating links and participating in the research group meetings helped the building of good collaborative practice.

Health Visitor

"Health visiting and children's centres are the two main services providing support for all families in the community. It is essential for joint working to take place in order to provide holistic support for these families. By linking a named HV to each children's centre it is hoped this will be facilitated. In my experience, increased presence at the children's centre has been invaluable in improving these links and has had a positive effect in the support provided for parents, in particular those suffering PND. There has been a dramatic change in awareness of roles across all services and an increased inclination to refer to children's centres before medical treatment or therapy."

The group has benefited from this research project process and agreed the following action plan.

Action plan to progress after research project completed

- To build on existing foundations and continue to work together as a group of practitioners.
- To consult with families as to the outcomes and evaluation of service provided.
- To increase knowledge base around PND with more joint training.

Learning from the Research Project, as Lead Practitioner

Working with a group emphasised the need to plan ahead and schedule time to meet but if this was not possible because of other professional demands, it was important not to delay actions and work creatively around other people's availability. It is important to acknowledge that not all the group will be able to meet all the time, given the nature of the various professional roles within group, for example: jury service; GP on call; dealing with acute swine flu issues; attending case conferences, etc.

The group is dynamic and flexible and composed of mix of skills and knowledge, with each member fulfilling a function. What is the ideal configuration? Could this also inform a virtual team combination? What became clear was that each member provided significant valuable input at various times. As a practitioner, this process has been invaluable in working with a group of people with a common aim, committed to the project to improve service provision and outcomes for families experiencing PND.

Conclusion

This process of joint meetings, reflecting as practitioners, and having time to better understand each others roles, has increased awareness of services and laid strong foundations for working together. This process can be taken for granted but does require a commitment and willingness to develop. Different levels of management of PND were explored within meetings but this requires a wider arena. A clear referral pathway for low level PND, accessing children's centres and working with other agencies is just the beginning. Clearer understanding as to the services provided by children's centres has also developed, and it is planned to continue this information sharing process. Examples of how one children's centre has developed a model of joint working could be taken forward, and with the development of services working in clusters, the concept of a virtual team to support each cluster could work, encompassing shared training and building links which, should lead to families receiving the best possible support.

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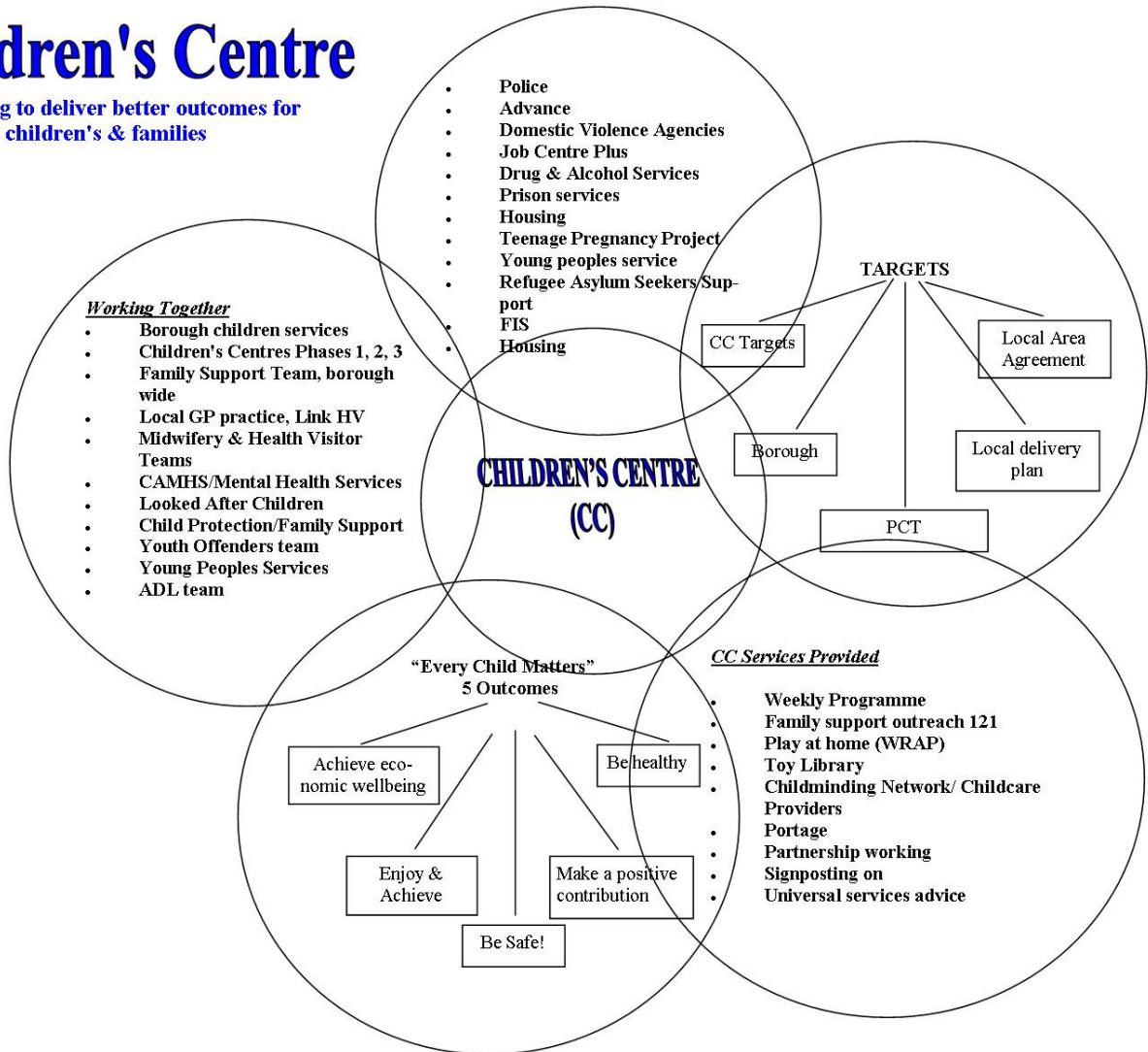
Appendices

- Appendix A Children's centre circles
- Appendix B Flowchart, Use of CAF with low level PND in CC
- Appendix C Virtual team to support children's centre cluster
- Appendix D Stakeholders questionnaire related to PND
(With responses)
- Appendix E NICE questions
- Appendix F Presentation

Appendix A

Children's Centre

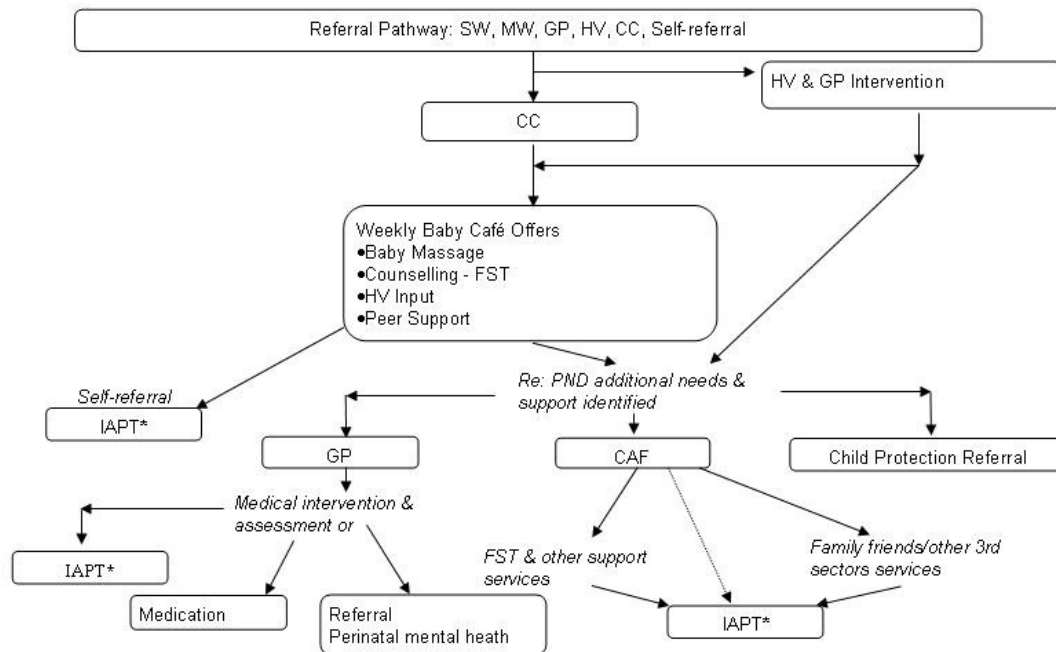
Working to deliver better outcomes for children's & families



Appendix B

USE OF CAF (Common Assessment Framework) Tool

Use of CAF as the shared & appropriate process for referral & assessment, when women & families with low level PND & isolation identified needing additional support & services.



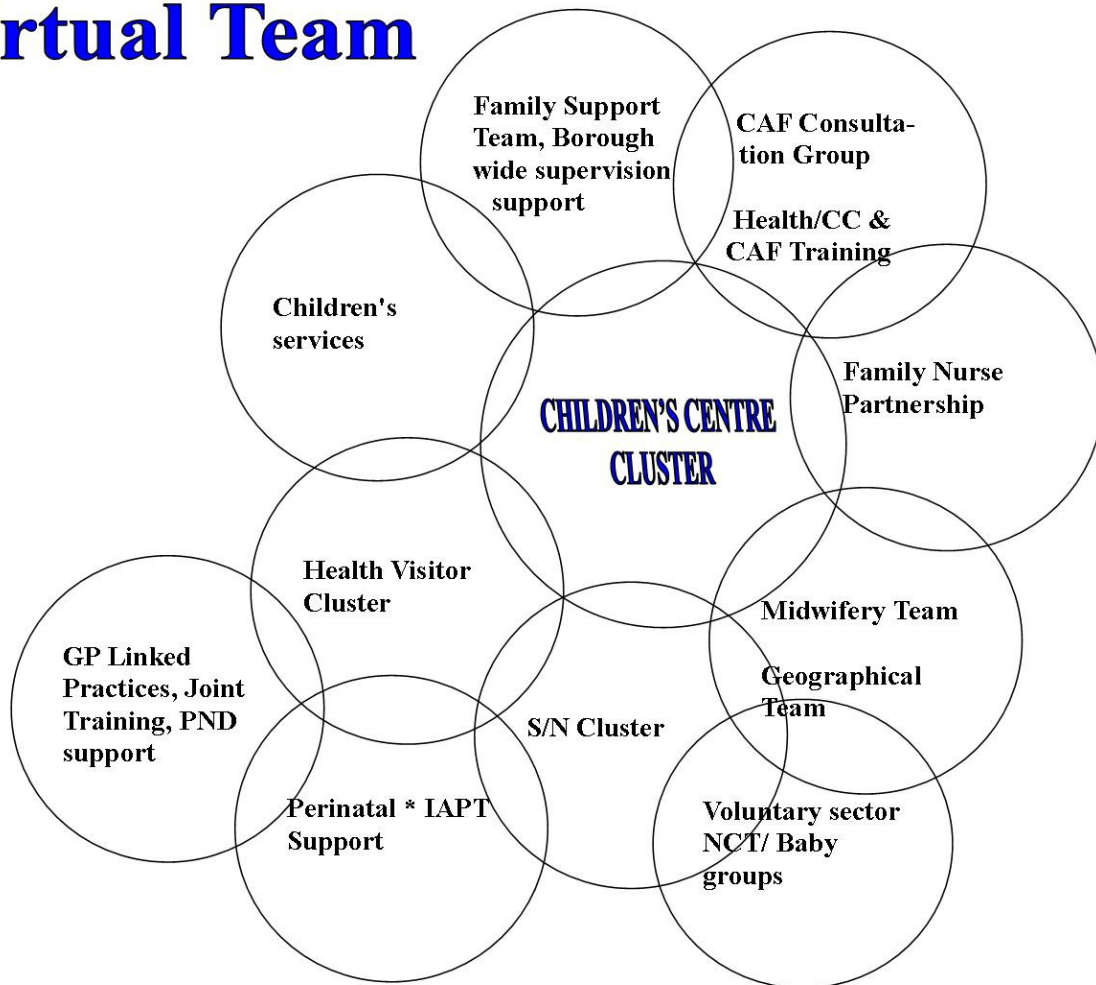
Questions arising from research

Key issues - What are thresholds for referral to different services, is CAF suitable for referrals to all services
 Raised issues about referral & assessment & use of CAF

***IAPT, Improving Access to Psychological Therapies**

Appendix C

Virtual Team



Representatives from each circle provide advisory & support services

Appendix D

CWDC research project CPCC October 2009-10-27

These responses were collated from a varied panel of GP's, Health visitors, Childcare advisors & Primary MH workers.

“To explore the range of approaches a Children’s Centre can adopt to maximize collaboration with Professional Stakeholders, in responding to Post Natal Depression (PND)”

1. How would you rate your knowledge of issues around PND?

- √√√√√ Comprehensive/Detailed
- √√√ Reasonable
- √√ I'd like to know a bit more than I do
- *Aware of nice guidelines*

2. How would you identify different levels?

- √√√√√ Nice Guidelines/Other Guidelines
 - *PHQ/OHD*
 - *Eight week check*
 - *HAD*
- √√√ Other professionals Opinions
- √√√√ Patients own report

3. When you meet someone who you would identify as suffering with PND what would you consider doing?

- √√√ Medication
- √√√ Psychology/Counselling
 - *Psychiatrist*
- √√√√√ Health visitor referral
 - *1st*
 - *1st*
- √√√√√ Children’s centre referral
- † Other
 - *Family support team, GP*
 - *Refer to GP (immediate)*
 - *GP, Baby Massage*
 - *GP referral, Adult mental health*
 - *Baby Massage, self help sites*

- *Perinatal Team*
- *Asks if patient wants anything*
- *OCC Psych referral, Patient choice, Self help colleague*

4. What, if any, additional support do you require to undertake this work e.g. psychology supervision?

- †√√√ Training
 - *In order to identify*
- † Referral processes
- †√√ Leaflets / written materials
 - *Health visitors onsite*
 - *Referral*

5. How do you evaluate the outcomes or impact of your intervention? E.g. how do you obtain user feedback about the value of the intervention?

- †√√√ √√√ Face to face patient review
- †√√ Professional feedback
- †√√√ Using guidelines
- †√ Telephone follow up

6. Do you undertake any joint work with other professionals when working with PND?

- †√√√ Always
- †√√ Sometimes
- †√√ Never
 - *Not yet but would*
 - *Would but haven't yet*
 - *Haven't seen anyone*

7. What services are available to support families in your area who are experiencing PND?

- †√√√√√√√ GP
- †√√√√√√√√ HV
- †√√√√√√√ Children's Centre
- †√√ Family support team
- † Social Services

7/√√√√
7/√√√√
7/√√√
7/√√

Baby Massage
Psychology
Psychiatry
Voluntary

- *Mother & Baby Groups*
- *Perinatal Team Chelsea*
- *National Telephone Support*
- *NCT, Drop-in play groups*
- *Counselling*
- *Psychotherapy, Counselling*
- *Perinatal at Chelsea & West/Imperial*

8. Have you had any experience of barriers/problems in accessing services to support PND?

7/√√√

Yes

- *Hard to access social services "give hard time"*
- *Biggest barrier around vulnerable families "some are better than others"*
- *No perinatal service, focused service for postnatal. Good local support for PND most picked up by Health visiting.*

7/√√√√√

No

- *Not recent, was in the past*
- *Ask Health Visitor*
- *No perinatal service, Language – psychology don't always accept referral if English is not first language*

Any other issues raised?

- *If everyone works together family will get the "best" support!*
- *Evidence CBT not good for PND*
- *Some HV's better than others at identifying PND and referring on*
- *Children's centres invaluable in giving support*
- *Dave needs to upload NICE on desktop, need Mary's form on system*

Appendix E

WHOOLEY Questions

Healthcare professionals (including midwives, obstetricians, HVs and GPs should ask 2 questions to identify possible depression.

- 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 asked/considered if woman answers yes to either of the initial questions

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

Appendix F



Practitioner-Led Research Project

To explore the range of approaches a children's centre can adopt to maximize collaboration with professional stakeholders in responding to postnatal depression (PND)

Lead Practitioner: Jane Powl Jane.Powl@lbhf.gov.uk

INTRODUCTION

- How can we better address low level post natal depression in children's centres?
- "Post natal depression feels a lot like depression you get at other times of life. The only difference is how it affects your feelings about being a mother & your ability to care for your child"
- Featuring a multi agency group who set up a series of regular meetings to address this as a locally identified priority.



Objectives

- To explore the way practitioners currently categorize different levels of PND
- To identify examples of good practice of the engagement of CC by local practitioners
- To explore effective collaborative working
- To identify training and learning needs of CC staff

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AIMS

- Key aim: To facilitate the development of a multi agency responsive, high quality & consistent approach to the needs of mothers with low level postnatal depression (PND)

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Post natal depression (PND)

- What is PND?
 - A depressive illness in the post natal period
- Levels of PND
 - Mild
 - Moderate
 - Severe
 - Chronic

There are varying interpretations of the levels of PND, for this study we have taken mild/moderate as meaning low level, without the need of medical intervention.

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METHODOLOGY

- Literature search around
 - (i) PND
 - (ii) Multiagency / team working
 - (iii) safeguarding children
- Semi structured interviews with 5 GP's, 2HVs, 1Childcare advisor, 1Primary mental health worker
- Using reflective practice approach with series of scheduled group meetings where learning & experiences shared were documented to inform practice



FINDINGS

- Surprisingly high awareness of CC & FST provision plus referral rate. Shift from previous first choice in low level PND following joint working
- High use of HV and cc most popular intervention/referral
- Positive feedback on interagency /joint working was identified as priority in working to support low level PND
- Evidence base through small sample interviews/PND questionnaire



GROUP REFLECTIONS

Barriers

- Identified barriers emerged through PND questionnaire & group reflections
- Different services, different systems
- High service demands, needs, less time
- “always busy”



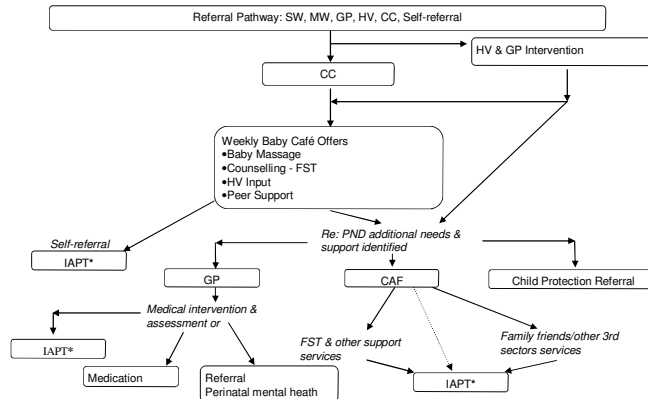
GROUP ACTIONS

- 'Make time' to meet, identify needs and plan approaches
- Developed referral pathway for management low level PND ,using CAF
- Developed outline based on working practice on model for HV and GP links with CC
- Provided clarity around CC provision and explored possibility of virtual team to support CC cluster



USE OF CAF (Common Assessment Framework) Tool

Use of CAF as the shared & appropriate process for referral & assessment, when women & families with low level PND & isolation identified needing additional support & services.



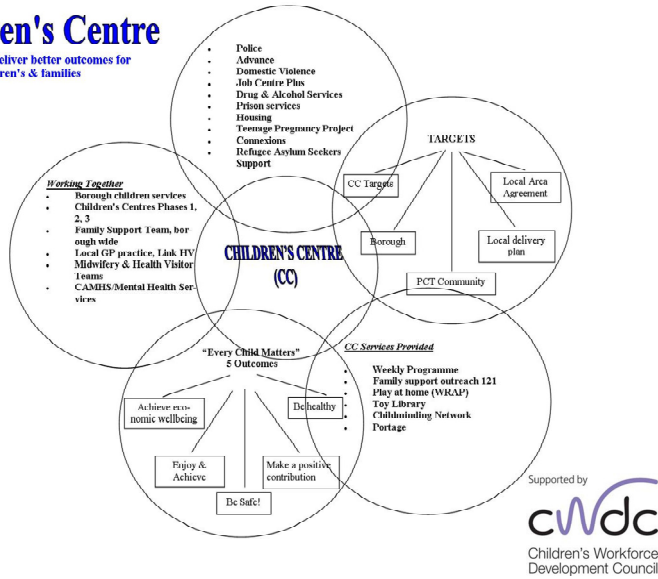
Questions arising from research

Key issues - What are thresholds for referral to different services, is CAF suitable for referrals to all services
 Raised issues about referral & assessment & use of CAF

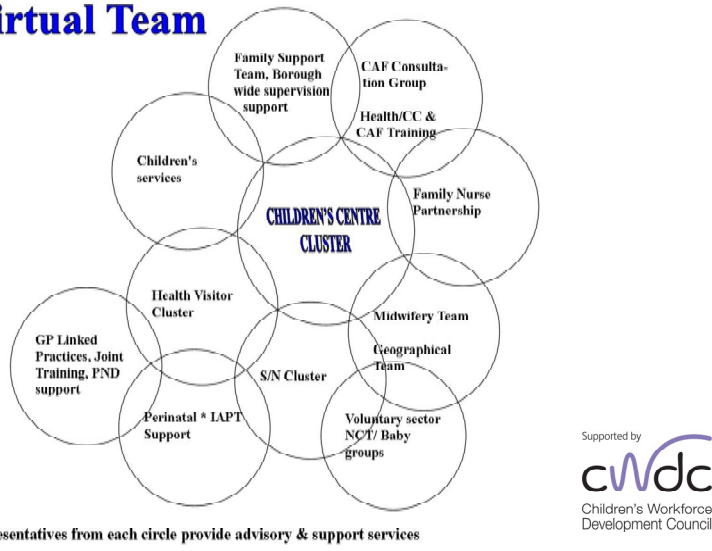
*IAPT, Improving Access to Psychological Therapies

Children's Centre

Working to deliver better outcomes for children's & families



Virtual Team



Representatives from each circle provide advisory & support services

PND QUESTIONNAIRE contd.

What, if any, additional support do you require to undertake this work e.g. psychology supervision?

- √√√ Training
 - In order to identify
- Referral processes
- √ Leaflets / written materials
 - Health visitors onsite
 - Referral

How do you evaluate the outcomes or impact of your intervention? E.g. how do you obtain user feedback about the value of the intervention?

- √√√√ Face to face patient review
- √√ Professional feedback
- √√√ Using guidelines
- √ Telephone follow up

Do you undertake any joint work with other professionals when working with PND?

- √√√ Always
- √√ Sometimes
- √ Never
 - Not yet but would
 - Would but haven't yet
 - Haven't seen anyone

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PND QUESTIONNAIRE contd.

What services are available to support families in your area who are experiencing PND?

- √√√√√ GP
- √√√√√ HV
- √√√√√ Children's Centre
- √ Family support team
- Social Services
- √√√ Baby Massage
- √√√ Psychology
- √√√ Psychiatry
- √ Voluntary
 - Mother & Baby Groups
 - Perinatal Team Chelsea
 - National Telephone Support
 - NCT, Drop-in play groups
 - Counselling
 - Psychotherapy, Counselling
 - Perinatal at Chelsea & West/Imperial

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PND QUESTIONNAIRE contd.

Have you had any experience of barriers/problems in accessing services to support PND?

- √√√ Yes
 - Hard to access social services "give hard time"
 - Biggest barrier around vulnerable families "some are better than others"
 - No perinatal service, focused service for postnatal. Good local support for PND most picked up by Health visiting.
- √√√√ No
 - Not recent, was in the past
 - Ask Health Visitor
 - No perinatal service, Language – psychology don't always accept referral if English is not first language

Any other issues raised?

- If everyone works together family will get the "best" support!
- Evidence CBT not good for PND
- Some HV's better than others at identifying PND and referring on
- Children's centres invaluable in giving support
- Dave needs to upload NICE on desktop, need Mary's form on system

CONCLUSION

- Developing approach of joint working with virtual team to support CC (clusters?) encompassing shared training & information sharing protocols can help improve provision for families experiencing low level post natal depression
- Face to face contact has a dramatic effect on raising the awareness of practitioners of services
- “If everyone works together the family will get best support”



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