Can Health Visitors succeed in delivering a maternal mental health service in the absence of fidelity to a model/pathway?

Introduction

The coalition government has clearly set out its intention and commitment to supporting families, and recognises the crucial role that Health Visitors have in taking the lead in communities to deliver services in partnership with midwives, GPs, Sure Start Childrens’ centres and others. The recently published Health Visitor Implementation Plan 2011-2015: A Call To Action and its associated work programmes, underlined and emphasised the value of taking a “stepped approach” to delivering services; targeting and supporting families early with a range of interventions. It supports recommendations in the Healthy Child Programme (2009), which focus on a wide range of health and wellbeing issues, including offering supportive, targeted, services to families where one or both parents have a mental health need. Research evidence has emerged for the need to change the way midwives, health visitors ’ and specialist mental health services work with pregnant and postnatal women in relation to their mental as well as their physical health. This recognition is based on compelling evidence from research, National Institute for Clinical Excellence (NICE) guidance C45, Cross Government Mental Health Reports (2009, 2011) and reports from the Royal College of Psychiatrists.

The purpose of this article is to promote national implementation of the Maternal Mental Health Pathway by demonstrating, the notion that fidelity to a pathway/model is seen (by the author) as being a crucial factor which influences service development and enhances clinical practice. Bond et al (2000) define fidelity as being the degree to which a program model is implemented as intended. The more generic understanding of the word “fidelity” suggests that the term refers to qualities of faithfulness and loyalty (Oxford English Dictionary 1991). Scanlan (2005) suggests that this more common usage of the word has useful connotations for the successful
development of robust models or care pathways, which deliver a sense of faithfulness to philosophies of care and loyalty to patient/clients needs. The current national experience has exposed the issue that there is no firm health visiting model or pathway for maternal mental health with defined fidelity criteria that other practitioners can utilise. There are, however, guidelines and recommendations for individuals or groups to follow, the danger is, that without developing these guidelines and organising them into a bona fide service, the current situation is reliant on

- Workers remaining in place
- Workers continually searching for innovative approaches to impact on capacity issues.

It is acknowledged that pathways are already established and used to deliver quality in maternal mental health. This pathway and the health visiting work programme intend to build on existing work and to draw on evidence and good practice to develop a Guidance document which supports the new health visiting service offer. The new pathway will begin in the antenatal period and continue until the end of the first postnatal year. An integrated approach to developing this pathway will ensure a seamless journey which includes health visiting contributions regarding support, care and advice for families.

The article will look at the issue of using the concept of fidelity to develop an evidence based, sustainable and measurable care pathway, along with an analysis of the benefits and potential pitfalls of an over emphasis on developing strict criteria models. The process of developing the maternal mental health pathway will not be discussed in detail, rather the notion that one needs to exist as part of a credible fidelity model.

Academics, politicians and clinicians have responded to the overwhelming evidence of the links between serious mental health disorders such as severe depression, puerperal psychosis and post traumatic stress disorder and high maternal mortality (CMACE 2006 - 2008). Researchers have also demonstrated increased emotional and physical health risks to the unborn
child, infants and the wider family as well as identifying interventions which ameliorate these conditions (Meta-analysis Beck 1996, Milgrom et al 1999, Barlow et al 2010). Depression and anxiety are common in the postnatal period but are also prevalent antenatally (Evans et al 2001), and some but not all of these women go on to have postnatal depression (Green, Murray, Cox & Holden 2001). Postnatal depression is defined as a non-psychotic depressive episode that begins in or extends into the post-partum (Cox, Murray & Chapman, 1993; O'Hara 1995). It affects 12% to 15% of child bearing women (Beck, 1998; Cox, Holden & Sagovsky, 1987; O'Hara & Swain, 1996). The condition usually is unreported and frequently undetected by health care professionals, making the early detection of maternal depression an important issue for all midwives, health visitors and other professionals working with women in the antenatal and postnatal period. The Social Exclusion Task Force (2007) identified a number of risk factors for children’s health and wellbeing, including having one or both parents with a mental health diagnosis. The National service Framework (1999) for mental health recommends that within Primary Care teams, Health Visitors, with training, use their skills and routine contact with new mothers to identify postnatal mental health. O’ Hara (1996) and Webster (2000) suggest that identified postnatal risk factors could be used antenatally and any integrated Care Pathway should include antenatal assessment to positively influence the impact maternal mental health has on families. In addition, NHS 2010 – 2015 : Good to Great: Preventative, people centred and productive, endorses New Horizons (2009) which sets out plans for improving mental health services and promoting public mental health. It emphasises the role of prevention, early intervention and innovation giving the example of maternal mental health including those with postnatal depression, as an area of clinical priority. The Maternal Mental Health Pathway demonstrates a journey through which every pregnant and post-natal woman should travel (although it is acknowledged that not every woman has easy access to the universal care offered by Midwives and Health Visitors for example, travellers, and asylum seekers: NICE Pregnancy and complex social factors CG110 September 2010). During her journey, she would be screened in a culturally sensitive
way, for potential and actual mental health problems with a robust system of support and treatment built in as part of the care pathway.

The development of the MMHP introduces changes into the working practices of Health Visitors and Midwives. These changes are both innovative and challenging. Previous and current Confidential Enquiries into Maternal and Child Health CEMCAH - Why mothers die 1997-1999 & 2000- 2002 & CMACE 2006-2008, strongly advises that midwives should focus less on the task orientated method of collecting information relating to obstetric history, and spend more time in discussion and conversation exploring the womans’ domestic situation to gain more information in a less “automated” way. During a two year local process of consultation and collaboration of key stakeholders the author found, a common theme of “positive resistance” emerged from the main practitioner participants. This resistance stemmed from the fear of taking on “extra” work when they felt that they were already “over-worked”, as well as taking the view that by asking “difficult questions” they would uncover issues which would be difficult to resolve without a significant increase in resources. Clinicians were also fearful that the “extra” work would take more time. At the same time though, practitioners saw the necessity for changing practice to improve outcomes for clients. Research carried out by Hanna & Jarman et al (2004) evaluated the use of a checklist in the early detection of postpartum depression. Although the research was flawed in its premise that it could predict postnatal depression by screening in the antenatal period; it gathered valuable data regarding participant perception of the process. Streubert & Carpenter pg 3 (1995) comment that perception is not objective, that it is a way of processing and observing events perceived as reality. A reality, which has been developed and constructed over a lifetime of receiving, processing, and interpreting information.

Change is disruptive, messy, and complicated. Even with the best laid plans, events rarely occur exactly as they were predicted. "Real change in real organisations is intensely personal and enormously political," (Nadler & Nadler, 1998). Change processes entail not only structures and ways of doing tasks, but also the performance, expectations and perceptions of all involved.
parties. Change has become widespread and unpredictable, but is still manageable (Bainbridge, 1996).

It could be argued that the successful management of this change has yet to be fully evaluated. However, there are key criteria that can be demonstrated as being essential factors for the success of future models. These criteria are centred around the strong evidence base for embracing the notion of asking women difficult questions about their mental health while they are pregnant, (CEMD 2004, DoH NSF for Children and Young People 2004, Oates 2003) and equipping Health Visiting and Midwifery staff with the knowledge, skills, confidence and support to do this in an inclusive client centred way (DoH NSF for Children & Young People 2004).

In some regions, training programmes to support the implementation of Maternal Mental Health Pathways have been designed for midwives, health visitors and Sure Start children's centre staff. It is crucial that all staff are given the opportunity and encouraged to attend the training. It is recommended that organisations assess and respond to the mental health training needs of staff who work with mothers experiencing mental distress and their families by:

- Increasing the involvement of service users and carers in mental health training
- Linking training needs with care pathways
- Linking training needs to service developments in maternal mental health
- Linking training needs to national workforce developments
- Working with all stakeholders in a whole systems way to ensure that flexible and responsive services are available for mothers experiencing mental distress.

The whole process of developing models or pathways that adhere to fidelity criteria causes some practitioners concern. The concern usually arises around the issue of rigidity that may exclude innovation and experimentation. Koop et
al (2004) suggests that contrary to this sceptical view, the development and measurement of well-defined models will lead to model rigidity, they can in fact, facilitate useful innovation around those component criteria known to be effective. This article does not intend to advocate the development of strict fidelity criteria for health visiting teams, but suggests that it is worth developing increased understanding that seem to enhance the ability of Health Visiting teams to provide a high quality service.

By developing a core of fidelity components for Health Visiting focussed Maternal Mental health services, these components may help to prevent the practice of copying successful innovations that have “worked” in a particular area. It is the case that some innovations work because of a “magic ingredient” that may be associated with expertise and charisma of individual “champion practitioners”; or perhaps success is due to an organisations’ readiness to change. Either way, there are good examples of interventions working in some places but not in others (Creed et al 1991).

**Suggested Criteria for fidelity model for perinatal mental health**

Department of Health publications, NICE Guidance Antenatal & Postnatal Mental health (2007) and reports from CMACE 2006-2008, The Healthy Child Programme (2009) and “The Call to Action” 2011 have influenced the fidelity criteria for the Maternal Mental Health Pathway and Health Visiting. Along with the recommendations directly associated with Maternal Mental Health, NICE have produced guidelines for common mental health disorders which show a stepped care approach and the need for access to psychological services. This guidance reassuringly matches aspects of existing services and is integral to the fidelity criteria model. These criteria are based on the successful implementation of pathways already in place (e.g.Wakefield, Northampton, Doncaster). At the inception of these care pathways, the absence of a strict criteria and the presence of good practice guidance was unsettling, but because of strong leadership and a shared commitment from
partner organisations, an innovative model for maternal mental health has been created. There are however, improvements that can be made, and these will be discussed in the next section.

**Suggested Fidelity Criteria for a Maternal Mental health Pathway**

- Appointment of a Health Visitor to take a strategic lead to facilitate, coordinate, and drive the model forward.
- Implementation of the maternal mental health pathway, which initiates in the antenatal period with special attention given to the interface between primary and secondary care.
- Development of training to support clinicians in the implementation of the care pathway and on-going support and clinical supervision in practice.
- Positive inclusion of all stakeholders including service users in the development of the care pathway and training package.
- Establish links with local higher education establishments to embed training in pre & post registration nurse, midwifery and health visitor training.
- The ability to evaluate process and effectiveness of interventions.

**The Way Forward**

Antenatal and Postnatal NICE guidance (2007) recommends that regions develop managed clinical networks which will support development of strong pathways of care. A MCN, “links groups of health professionals and organisations from primary, secondary and tertiary care, in a co-ordinated manner, unconstrained by existing professional and existing boundaries to ensure equitable provision of high quality, clinically effective services,” (Scottish Office DoH 1998). Whilst this kind of coordinated network can focus on specialist mental health provision for mothers with severe mental health issues; it lacks the ability to drive forward local practice and wholesale implementation of a universal pathway for mothers.
which takes into account the whole spectrum of mental health & wellbeing needs and the effect this has on families and communities. Therefore, strong health visiting leadership from within provider services and strategic health authorities is necessary to drive this pathway and others forward to make a positive difference to families and achieve the population and targeted outcomes set out in the pathway rationale.

References and Bibliography


*New Horizons: A shared vision for mental health*, Department of Health, December 2009,


