

# Supporting families early SAFE START strategic policy



**NSW DEPARTMENT OF HEALTH**

73 Miller Street

NORTH SYDNEY NSW 2060

Tel. (02) 9391 9000

Fax. (02) 9391 9101

TTY. (02) 9391 9900

**[www.health.nsw.gov.au](http://www.health.nsw.gov.au)**

This work is copyright. It may be reproduced in whole or in part for study training purposes subject to the inclusion of an acknowledgement of the source. It may not be reproduced for commercial usage or sale. Reproduction for purposes other than those indicated above requires written permission from the NSW Department of Health.

Suggested reference: NSW Department of Health, 2009, *NSW Health/Families NSW Supporting Families Early Package – SAFE START Strategic Policy*, NSW Department of Health

© NSW Department of Health 2009

SHPN (PHCP) 080164

ISBN 9781 74187 285 9

Further copies of this document can be downloaded from the  
NSW Health website [www.health.nsw.gov.au](http://www.health.nsw.gov.au)

June 2009

# NSW Health / Families NSW

## Supporting Families Early package

The *NSW Health / Families NSW Supporting Families Early package* brings together initiatives from NSW Health's Primary Health and Community Partnerships Branch and Mental Health and Drug & Alcohol Office. It promotes an integrated approach to the care of women, their infants and families in the perinatal period. Three companion documents form the *Families NSW Supporting Families Early* package.

### Supporting families early maternal and child health primary health care policy

The first part of the package is the *Supporting Families Early Maternal and Child Health Primary Health Care Policy*. It identifies a model for the provision of universal assessment, coordinated care, and home visiting, by NSW Health's maternity and community health services, for all parents expecting or caring for a new baby. This model is described within the context of current maternity and child and family health service systems.

### SAFE START strategic policy

The second part of the package, the *SAFE START Strategic Policy*, provides direction for the provision of coordinated and planned mental health responses to primary health workers involved in the identification of families at risk of developing, or with, mental health problems, during the critical perinatal period. It outlines the core structure and components required by NSW mental health services to develop and implement the SAFE START model.

### SAFE START guidelines: improving mental health outcomes for parents and infants

The third part of the package, the *SAFE START Guidelines: Improving Mental Health Outcomes for Parents and Infants*, outlines the rationale for psychosocial assessment, risk prevention and early intervention. It proposes a spectrum of coordinated clinical responses to the various configurations of risk factors and mental health issues identified through psychosocial assessment and depression screening in the perinatal period. It also outlines the importance of the broader specialist role of mental health services in addressing the needs of parents at risk of developing, or with, mental health problems.



# Message from the Director-General

Pregnancy and becoming a parent is usually an exciting time, full of anticipation, joy and hope. It can also be a time of uncertainty or anxiety for parents and families. To support families fully during what can be a stressful period, it is important to address the range of physical, psychological and social issues affecting the infant and family. This range of issues and parents' understanding of the tasks and roles of parenthood are recognised as significant influences on the capacity of parents to provide a positive environment that encourages optimum development of the infant.

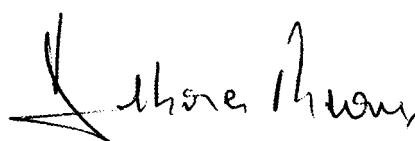
Providing support for infants, children and parents, beginning in pregnancy, including their physical and mental health, is a key priority of the NSW Government. This is clearly articulated in the NSW Action Plan for Early Childhood and Child Care which is part of the Council of Australian Government's National Reform Agenda, the NSW State Plan, and the NSW State Health Plan.

The NSW whole-of-government *Families NSW* initiative is an overarching strategy to enhance the health and wellbeing of children up to 8 years and their families. One way it does this is by improving the way agencies work together, so that parents get the services, support and information they need.

NSW Health is a key partner with other human service agencies in developing prevention and early intervention services that assist parents and communities to sustain children's health and wellbeing in the long term. Health services are the universal point of contact for these families entering the *Families NSW* service system.

NSW Health's vision is for a comprehensive and integrated health response for families. This response will encompass all stages of pregnancy and early childhood development and link hospital, community and specialist health services. The aim is to assist families in the transition to parenthood, build on their strengths, and ameliorate any identified risks that can contribute to the development of problems in infants and later on in life.

The *NSW Health / Families NSW Supporting Families Early* package integrates three NSW Health initiatives that are underpinned by a common understanding of the challenges that parenthood can involve, the importance of the early years of a child's development, and the benefits of appropriate early intervention programs. The initiatives contained within *Supporting Families Early* are an important contribution to the provision of services that enhance the health of parents and their infants, help to protect against child abuse and neglect, and enhance the wellbeing of the whole community.



Professor Debora Picone AM  
Director-General  
NSW Health

# Contents

<i>Families NSW Supporting Families Early package</i> .....	i
Message from the Director-General .....	ii
Section 1. Rationale – Why a focus on SAFE START?.....	2
1.2 Overview of the SAFE START model.....	4
1.3 The policy and planning context .....	5
Section 2. Core principles of SAFE START .....	7
Section 3. SAFE START strategic action plan .....	8
Strategy 1: Planning and partnerships .....	8
Strategy 2: Implementation of the SAFE START model .....	9
Strategy 3: A supported and skilled workforce.....	10
Strategy 4: Mental health care for pregnant women and families with an infant up to two years .....	11
Strategy 5: Sustainable, effective SAFE START .....	12
 <b>APPENDICES</b>	
1A Edinburgh post natal depression scale (EPDS).....	13
1B Edinburgh depression scale (antenatal) (EDS).....	14
1C Edinburgh depression scale (EPDS/EDS) scoring guide .....	15
2 Psychosocial risk variables I-VII .....	16
3 Strengths and issues - models of SAFE START implementation .....	17
 References .....	 18

# Rationale – Why a focus on SAFE START?

Infancy is a crucial developmental phase with implications for later mental health. Providing infants with opportunities for healthy development is a key strategy in building resilience and reducing mental health problems across the life span.

From birth, infants are very sensitive to the emotional states of their caregivers. Parenting style, the quality of attachment relationships and family context during the first few years of life have long-lasting effects on neurobiological and socio-emotional development. Infant development occurs in the context of care-giving relationships and infants learn to regulate their emotions and understand relationship experiences through the profound early relationship with their parent or care giver. That is, their attachment figure.

Healthy attachment relationships promote optimal infant development. Parents who are experiencing adverse relationships (current or unresolved memories of past difficult relationships) and emotional distress or anxiety states, will understandably find it challenging to remain attuned and sensitively responsive to their infant's needs. The impact of poor parental mental health on childhood emotional, cognitive and social development and its trajectory into adulthood has been identified as a key focus area for NSW Health.

The SAFE START model aims to enhance the mental and physical health of parents and their infants by providing a consistent model for psychosocial assessment and depression screening for women expecting or caring for an infant, and by supporting the development of local networks of services, which will work collaboratively to support families. The SAFE START model also aims at early identification of parental mental health problems, reduction of relapse rate and lowering of the impact of parental mental illness on the infant, whilst preserving the family unit.

Increased levels of depression and anxiety symptoms during pregnancy contribute independently of other biomedical risk factors to adverse obstetric, fetal and neonatal outcome (Alder et al., 2007).

Parenting behaviour critically shapes human infants' current and future behavior. The parent-infant relationship provides infants with their first social experiences, forming templates of what they can expect from others and how to best meet others' expectations throughout childhood and adult life (Swain et al., 2007).

## Perinatal mental health statistics

- Common mental health problems during the antenatal and postnatal period include depression and anxiety disorders, such as panic disorder, obsessive compulsive disorder (OCD) and post traumatic stress disorder (PTSD). An estimated 10% to 15% of women suffer from depression after the birth of an infant. For the vast majority of these women, professional help will be provided solely by primary health care services in community settings (National Collaborating Centre for Mental Health, 2007).
- Around 3% to 5% of women giving birth have moderate or severe depression, with about 1.7% of these women being referred to specialist mental health services (Cox, Murray & Chapman, 1993).
- First presentations of severe mental illness, primarily schizophrenia and bipolar disorder, in the perinatal period are rare, with a rate in the region of two per thousand resulting in hospital admissions (Kendell, Chalmers & Platz, 1987).
- More common, particularly with bipolar disorder, is the exacerbation of an existing disorder, with some studies reporting relapse rates for bipolar disorder approaching 50% in the antenatal period and 70% in the postnatal period (Viguera, Nonacs, Cohen, et al., 2000).
- These women, along with others suffering from severe depression and other severe disorders such as severe anxiety disorders or personality disorders will benefit from integrated specialist mental health care (National Collaborating Centre for Mental Health, 2007).
- In Australia it has been estimated that between 25-50% of children and young people with parents with mental illness experience psychological disorder (Barnett, Schaafsma, Guzman & Parker, 1991).



The terms “perinatal and infancy period” and “pregnancy and postnatal period” in the SAFE START documents describe the period from conception to two years after delivery. They are used to emphasise the significance of problems that can arise in the pregnancy and early parenting periods. These terms also recognise the importance of infant brain development in the context of the primary care-giving relationship during the first two years, and the critical manner in which this early infant development influences outcomes across the lifespan.

This approach regards pregnancy as a crucial period for early intervention, and recognises the need for extended or sustained support for some mothers, infants and their families in the first two years of the infant’s development.

The term “caregiver(s)” is frequently used in the SAFE START documents instead of “mothers” or “parents” in recognition of the fact that the infant needs the consistent nurturing of a caring adult who may not necessarily be the biological mother. The important role of fathers/partners, relatives or foster carers who share the immediate care of the child is recognised as essential.

SAFE START provides a framework using a population health model for mothers, infants and their families. SAFE START involves universal psychosocial risk assessment and depression screening for all women as part of a comprehensive health assessment during both pregnancy and the postnatal periods. This is linked to a network of supports and health-related services for those mothers, infants and families at risk of adverse physical and mental health outcomes (Appendix 1).

A range of bio-psychosocial factors may impact on parenting capacity and the provision of a safe, physical and emotional environment for the infant.

Identification of parental risk factors is the first step in prevention of risk for infants development. Evidence from neuroscience, epidemiology, sociology and developmental psychology has highlighted the vital nature of brain development during gestation and the first years of life on learning and behaviour, and the complex, intricate interplay between brain development in the infant and appropriate stimulation delivered to the child through nurturing and positive parenting. This exchange can be influenced by various psychological and social factors such as poverty, domestic violence, anxiety, depression and other mental health problems and disorders. These factors may affect the nurturing

process and the growth of the infant.

The *SAFE START Strategic Policy* defines the core principles underpinning the initiative. It identifies five strategies to guide Mental Health Service managers, policy makers and clinicians to effectively and comprehensively implement the SAFE START model.

Forming strong relationships and attachments involves understanding the needs of the other, providing care and protection, and a preoccupation with the interests and wants of the other. The human transition to parenthood involves a set of highly conserved behaviours and mental states, reflecting both genetic endowment and early life experience – including the intrauterine environment. Apart from parenting, there are many other forms of interpersonal relationship – adoption, foster care, step-parenting, teaching, mentoring, grandparenting as well as friendship and romantic love – each involving similar genetic, neurobiological and experiential systems that have the potential to inform clinical practice, particularly early intervention programs for high-risk expectant parents (Swain et al., 2007).

To paraphrase Winnicott (1960), ‘good enough’ genes combined with good enough parental care ensure positive outcomes in childhood and beyond. Unfortunately, ‘good enough’ circumstances are often not available. (Cited in Swain et al., 2007). Each year, many children become victims of abuse or neglect, with a biological parent identified as the perpetrator in the majority of cases. Abuse and neglect perpetrated by a child’s biological parent represents a fundamental breakdown in this important attachment relationship, resulting in serious long-term consequences for the offspring (Swain et al., 2007).



## 1.2 Overview of the SAFE START model

*Families NSW*, which is coordinated through the Communities Division in the NSW Department of Community Services (DoCS), aims to improve the effectiveness of prevention and early intervention services for families with children aged 0–8 years. SAFE START is one of the core strategies to link prevention and early intervention services and programs.

Pregnancy and infancy are ideal times for families to be engaged in a range of professional support services. Antenatal Clinics and Early Childhood Health Centres provide high-quality assessment of health and support needs for mothers and their babies during this crucial developmental period. The SAFE START model incorporates psychosocial factors and depression screening into the assessment process to identify psychosocial difficulties and/or current depression in all pregnant and postnatal women. Psychosocial difficulties and depression during pregnancy and after the birth of a baby may impact on parenting. The SAFE START model provides a framework to access appropriate support and care provided by maternity staff, child & family health nurses, secondary-level services (e.g. allied health) and specialist health services including mental health and drug & alcohol services.

It is anticipated that all Area Health Services (AHSs) in NSW will implement, or further implement, the SAFE START model so that psychosocial assessment and depression screening are provided for all women at the time of the antenatal booking-in assessment and again in the community setting, after the birth of the baby.

The universality of the psychosocial assessment and depression screening is important because risk factors for poor mental health outcomes span the spectrum of socio-economic and cultural groups. Because the people who are most at risk are sometimes reluctant to engage with services, assertive and sensitive relationship building approaches during the assessment process are essential to avoid being stigmatising for families.

The purpose of psychosocial risk assessment and depression screening for all women that are expecting or caring for a baby is to embed mental health promotion, prevention and early intervention practice throughout the perinatal period, for all families. Psychosocial assessment and depression screening must be implemented and maintained in conjunction with a spectrum of support and intervention options according to number of risk factors, levels of adversity, strengths and resources within each individual family.

Equitable and timely access to family-focused assessment and supportive interventions for families with complex problems including substance abuse, mental health problems and/or domestic violence is crucial. Multidimensional assessment undertaken collectively and collaboratively by relevant health professionals should focus on the parents (as individuals and parenting couple), the child and entire family system. Inter-service and inter-team collaboration to periodically deploy relevant health professionals to participate in multidimensional parent-infant-family assessment processes may optimise infant and family health outcomes through correctly identifying parent-infant relationship risks (and strengths, and targeting interventions accordingly).

The SAFE START psychosocial assessment format will be standardised throughout NSW Health Services to promote universality throughout the health workforce.

## 1.3 The policy and planning context

The *SAFE START Strategic Policy* is informed by national policy documents including the National Mental Health Policy (Australian Health Ministers, 1992), Mental Health Statement of Rights and Responsibilities (Australian Health Ministers, 1992), National Mental Health Plan (Australian Health Ministers, 2003), National Action Plan on Mental Health (Council of Australian Governments, 2006) and the National Action Plan for Promotion, Prevention and Early Intervention for Mental Health (Commonwealth Department of Health and Aged Care, 2000).



## NSW: A New Direction for Mental Health

Released in July 2006, this Plan outlines significant investment by the NSW Government over five years to reform mental health services to ensure the right care can be provided at the right time. It aims to balance hospital focussed care with community care, by building stronger links between the public, private and community services, between hospitals and GPs and between the State and Federal Governments. The Plan aims to achieve change through four areas of effort:

- Promotion, prevention and early intervention across the lifespan
- Improving and integrating the care system
- Participation in the community and employment including accommodation
- Better workforce capacity.

The NSW Government recognises the importance of activities to promote better mental health for everyone, prevent and minimise risk factors and intervene early to improve treatment outcomes. This commitment to promotion, prevention and early intervention encourages working in partnership with stakeholders to increase community awareness and knowledge of ways to promote good mental health and reduce stigma. NSW Mental Health is committed to implementing programs that build resilience in young people, reduce the risk factors associated with drug use, and intervening early with high-risk families.

A strategic approach to mental health policy in NSW encapsulates a whole-of-government commitment to improving the mental health and wellbeing of the NSW community. This has been achieved through the development of two companion plans:

**NSW Interagency Action Plan** recognises that a number of government agencies have a role to play in responding to the needs of people affected by mental illness and sets out a coordinated approach for agencies to work better together.

## NSW Community Mental Health Strategy

The NSW Community Mental Health Strategy 2007–2012 describes the model for community Mental Health Services in NSW. It covers services delivered across the age range, across diverse communities and in collaboration with service partners. The purpose of the Strategy is to guide NSW Health, NSW Aboriginal Mental Health Services, and NGOs in the implementation of this model. It aims to achieve improved outcomes in mental health by delivering comprehensive recovery oriented community mental health services across NSW that will:

- Promote mental health and wellbeing
- Embed a recovery approach to service delivery
- Prevent and/or intervene early in the onset or recurrence of mental illness
- Improve evidence based practice in community supports and services
- Enhance community responses to mental health emergencies and acute care needs.



## **A Secure Base For The Future: NSW Mental Health Service Plan For Children, Adolescents And The People Who Care For Them**

The development of *Building A Secure Base For The Future: NSW Mental Health Service Plan For Children, Adolescents And The People Who Care For Them* has involved an extensive consultation process. The Plan aims to improve the mental health of children and adolescents, to help them, their families and others caring for them to optimise their development and build a secure base for their futures. It outlines the principles for service development over a ten year period.

The Plan adopts the term Child and Adolescent Mental Health Services (CAMHS). This terminology is consistent with National Mental Health reporting frameworks in reference to services for the population aged 0–17 years inclusive. Under this convention, an infant is included in the term “child”. Development has also reflected the context of increasing attention to collaborative interagency and cross-service partnerships to foster the mental health of children and adolescents and to protect children and young people. Perinatal and infant mental health are areas specifically identified in the plan as especially suited to integration across CAMHS and adult mental health services, linked to health more broadly.

**SAFE START** embraces a population health model (Mrazek & Haggerty, 1994), which outlines the range of services and interventions required to ensure good mental health care for individuals, their families and communities. The spectrum of care encompasses health promotion and prevention, early intervention, treatment, recovery and continuing care. The strategies developed in this SAFE START Policy address aspects of the population health model, from prevention to specialist intervention, with an emphasis on the specific needs of families during pregnancy and the postnatal period.



## Core principles of SAFE START

- SAFE START promotes continuity of family care throughout pregnancy, postnatal and early childhood periods.
- SAFE START recognises the significance of risk and protective factors in health. The complex interaction between risk and resilience is acknowledged as well as the strengths and diversity of local communities in the determinants of health.
- SAFE START acknowledges the role of parents and family systems in providing sound foundations for the healthy development of children. The vital role of support systems, especially fathers or partners, is identified and opportunities to include them and participate in care.
- SAFE START interventions are undertaken as early as possible and are flexible enough to respond to variations in individual and family circumstances.
- A comprehensive network of local resources and services is required. These include hospital and community health services, General Practitioners, primary health and specialist health services, including mental health and drug & alcohol services, and includes government and non-government community agencies.
- The formation of partnerships for service delivery is essential. This involves active partnerships based on communication, collaboration and cooperation between the mother, her family and various professionals across the spectrum of care.



## SECTION 3

# SAFE START strategic action plan

## Strategy 1: Planning and partnerships

**Expected outcomes:** Develop a multidisciplinary and multi-agency system of family-focused health care for pregnant women and families with infants up to two years age.

Actions	Performance indicators	Agency
1.1 Identify existing <i>Families NSW</i> , Health Home Visiting and Perinatal networks and structures within the AHS; and identify lead SAFE START position within the AHS.	<ul style="list-style-type: none"> <li>Relevant existing structures, and positions identified.</li> </ul>	AHS <sup>1</sup>
1.2 Establish Area SAFE START implementation committee that includes representatives from Senior Management and frontline staff from Divisions, Sectors and Agencies providing health care for families through pregnancy and early parenting.	<ul style="list-style-type: none"> <li>SAFE START implementation committee linked with <i>Families NSW</i>; reflected in the <i>Families NSW</i> regional implementation plan.</li> <li>Membership of committee: Senior Health Managers from Divisions, Sectors or Clusters (particularly from Maternity, Child and Family Health, Mental Health and Drug &amp; Alcohol services) are matched in terms of level of seniority.</li> </ul>	AHS
1.3 Develop an Area SAFE START plan that localises implementation of the <i>SAFE START Strategic Policy</i> .	<ul style="list-style-type: none"> <li>Area SAFE START plan complete and endorsed.</li> </ul>	AHS
1.4 Implementation and evaluation of Area SAFE START plan in collaboration with <i>Families NSW</i> Coordinators, Child and Family Health Managers and Maternity Service Managers, Mental Health and Drug & Alcohol Managers.	<ul style="list-style-type: none"> <li>Formal communication pathways established for implementation of the Area SAFE START plan through relevant governance and reporting.</li> </ul>	AHS
1.5 Identify strategies to engage the primary health and private sector (GPs, private obstetricians, private psychiatrists and therapists) in collaborative care for families with complex needs who are pregnant or have an infant(s) up to two years age.	<ul style="list-style-type: none"> <li>Formal links with General Practitioner (GP) Shared-Care programs including referral pathways.</li> <li>Strategies that inform the private sector and that support the development of working partnerships.</li> </ul>	DOH <sup>2</sup> AHS
1.6 Link SAFE START and Children of Parents with Mental Illness (COPMI) strategic plans to support consistent service planning and delivery of care to all children of parents with a mental illness and their families, from the time of conception.	<ul style="list-style-type: none"> <li>Formal links between SAFE START and Children of Parents with a Mental Illness – (COPMI) NSW (State) and Area Strategic Plans to deliver seamless modes of intervention throughout developmental stages.</li> </ul>	MHDAO <sup>3</sup> MH-Kids <sup>4</sup> AHS

<sup>1</sup> Area Health Service (AHS)

<sup>2</sup> NSW Department of Health (DOH)

<sup>3</sup> Mental Health and Drug & Alcohol Office (MHDAO)

<sup>4</sup> MH-Kids (an Area hosted unit of MHDAO)

## Strategy 2: Implementation of the SAFE START model

**Expected outcomes:** Early identification of psychosocial risk and depressive symptoms and timely access to appropriate interventions for pregnant women and families with infants up to two years of age.

Actions	Performance indicators	Agency
2.1 Ensure that universal psychosocial assessment and depression screening are implemented in maternity and early childhood health services throughout each AHS; including formal adoption by Area of validated tools and domains of psychosocial risk assessment.	<ul style="list-style-type: none"> <li>■ Psychosocial assessment tool includes the 7 identified key variables (domains of risk to be assessed – Appendix 2).</li> <li>■ Edinburgh Depression Scale (EDS/EPDS) routinely used as recommended by <i>SAFE START Guidelines</i> document.</li> <li>■ Proportion of women attending public Maternity and Child and Family Health services who are offered psychosocial assessment and depression screening, and number of clients who receive intervention when indicated. Annual reports to DOH.</li> </ul>	AHS
2.2 Develop and implement multidisciplinary, inter-sectoral (multi-agency) intake procedures in Maternity and Child and Family Health settings for the allocation of vulnerable families to appropriate care pathway; including collaborative care when required.	<ul style="list-style-type: none"> <li>■ Area/Sector Cluster intake policy developed and endorsed for families with complex needs and who are expecting or caring for an infant.</li> <li>■ Regular clinical planning meetings in all Maternity and Child and Family Health settings with representation from: Mental Health; Drug and Alcohol; Aboriginal Health; Multicultural Health, and; other relevant Services.</li> <li>■ Triage, Intake and Assessment protocols in Adult and Child and Adolescent Mental Health, and Drug &amp; alcohol services focusing on pregnant women and parents with children up to two years of age.</li> </ul>	AHS  AHS & MHDAO
2.3 Identification of perinatal and infant clients in mental health services.	<ul style="list-style-type: none"> <li>■ Include identification of 'perinatal' client in Child and Adolescent and Adult Mental Health client registration and data collection (adolescent or adult women who are pregnant or have an infant up to two years age.)</li> <li>■ Include identification of 'parent of an infant' in Child and Adolescent and Adult Mental Health client registration and data collection (any person who lives with or provides regular care for an infant up to two years age – or lives with a pregnant woman).</li> <li>■ Development of Mental Health client registration, standardised assessment format, and data collection for children 0–2 years.</li> </ul>	MHDAO MH-Kids InforMH
2.4 Assess specialist services' capacity to intervene effectively when women who are pregnant or caring for an infant up to two years age are identified with risk factors requiring early intervention.  Develop solutions to remedy service integration gaps.	<ul style="list-style-type: none"> <li>■ Local scoping document of existing resources, services roles and service responsibilities in regard to SAFE START to be undertaken by Area Mental Health and Drug &amp; Alcohol services.</li> <li>■ Evidence of strategies undertaken at Area and State level to reduce gaps in integrated service delivery for women who are pregnant and families with an infant up to two years age (eg collaborative, cross-boundary assessment; prioritisation strategies; formulation of links to specialist perinatal psychiatry consultation through supra-regional teleconferencing; forging of partnerships within and outside health and with specialist early parenting services such as Karitane and Tresillian).</li> </ul>	AHS & MHDAO MH-Kids

## Strategy 3: A supported and skilled workforce

**Expected outcomes:** Enhanced knowledge and skills of health and related workers to deliver psychosocial assessment and depression screening; and in the provision of early mental health interventions for mothers, infants and their families.

Actions	Performance indicators	Agency
3.1 Sustainable SAFE START training and education strategy implemented in each AHS.	<ul style="list-style-type: none"> <li>■ Online SAFE START Education and Training available to each AHS in 2009.</li> <li>■ Area SAFE START training and education plan endorsed and Coordinator identified.</li> <li>■ Proportion (benchmark) of midwives and child and family health nurses completing SAFE START Training.</li> <li>■ SAFE START training embedded in orientation process for all relevant service sectors.</li> </ul>	MHDAO  AHS  AHS  AHS
3.2 Identify Mental Health and Drug & Alcohol workers to attend SAFE START specialist Training; and other relevant, specialised perinatal and infant mental health, attachment and early parenting training as available.	<ul style="list-style-type: none"> <li>■ SAFE START Specialist Education and Training available to each AHS in 2009-2010.</li> <li>■ Proportion of Mental Health and Drug and Alcohol educators and clinicians attending SAFE START Specialist Education and Training session.</li> </ul>	MHDAO MH-Kids AHS
3.3 Foster collaborative partnerships between Mental Health, Maternity and Child and Family Services, GPs, DoCS and other relevant service providers to improve development of and access to individual, group or peer supervision, or reflective case discussion groups relevant to families with complex needs – conception to two years age.	<ul style="list-style-type: none"> <li>■ Local formal partnerships (eg Memorandum of Understanding, Service agreement, or policy/protocol) outlining cross-boundary staff attendance at reflective case discussion or supervision networks.</li> <li>■ Senior Clinical and Management leaders identified to oversee cross-boundary supervision or reflective case discussion groups.</li> </ul>	AHS
3.4 Foster collaborative partnership with the GP Alliance to support access to SAFE START training for GPs.	<ul style="list-style-type: none"> <li>■ Liaise with the Divisions of General Practice.</li> <li>■ GP participation in local SAFE START education and training.</li> </ul>	AHS
3.5 Link SAFE START, COPMI and Parenting for Mental Health training initiatives to enhance assessment and early intervention skills and advanced knowledge in the workforce caring for mentally ill parents.	<ul style="list-style-type: none"> <li>■ SAFE START, COPMI and Parenting for Mental Health training initiatives integrated at State and Area level.</li> </ul>	MHDAO MH-Kids AHS
3.6 Work with universities, other tertiary education facilities and professional associations to incorporate training specific to: <ul style="list-style-type: none"> <li>■ perinatal and infant mental health</li> <li>■ psychosocial assessment and depression screening during pregnancy and the postnatal period</li> <li>■ social and emotional development.</li> </ul>	<ul style="list-style-type: none"> <li>■ Links with universities and professional associations established.</li> <li>■ Joint appointment (academic-clinical positions) in Midwifery, Child and Family and Psychiatry based in AHS/University to be kept abreast with SAFE START and related education and training needs of undergraduate medical, nursing and allied health students.</li> </ul>	MHDAO MH-Kids



## Strategy 4: Mental health care for pregnant women and families with an infant up to two years age

**Expected outcomes:** Improved access to timely and appropriate integrated care systems for vulnerable families with infants up to two years age.

Actions	Performance indicators	Agency
<p>4.1 Improve mental health service integration with other health care providers to improve appropriate mental health assessment for pregnant women and parents who care for an infant up to two years age.</p> <p>4.1.1 Review current mental health service intake policy and assess service capacity to: include specific responses to pregnant women and parents who care for an infant up to two years age; direct joint assessments with Maternity or Child and Family Health referrers; include protocol for comprehensive parent-infant mental health assessment.</p>	<ul style="list-style-type: none"> <li>■ Area Mental Health Director involvement in development and implementation of SAFE START locally – particularly in relation to local Maternity and Child and Family Health Service policy related to administering depression screening and care pathways for response to risk identified.</li> <li>■ Area mental health service policy developed for family-focused perinatal intake and assessment process.</li> </ul>	AHS
<p>4.2 Identify roles and functions of adult and child and adolescent Mental Health Services in the implementation of SAFE START.</p>	<ul style="list-style-type: none"> <li>■ Defined lines of responsibility for: <ul style="list-style-type: none"> <li>– assessment of parenting capacity, and care of the mentally ill parent with an infant up to two years age</li> <li>– monitoring and management of identified problems within the parent-infant relationship that warrant a secondary or tertiary level mental health assessment and collaborative care (eg with DoCS)</li> <li>– care-coordination, liaison and collaborative care for parent-infant mental health clients.</li> </ul> </li> </ul>	AHS
<p>4.3 Develop Area Mental Health Action Plans for perinatal and infant mental health service in line with <i>Building a Secure Base for the Future: NSW Mental Health Services Plan for Children, Adolescents and the People who Care for them</i>.</p>	<ul style="list-style-type: none"> <li>■ Area Mental Health document in line with 'Building a Secure Base for the Future' developed and endorsed that: defines target population as per Mental Health Clinical Care and Prevention Model (MH-CCP) and local service delivery framework with a focus on cross-setting emergency response, mother-baby mental health hospital care and community care.</li> </ul>	AHS/MH CAMHS MH-Kids
<p>4.4 Identify strategies and protocols that promote and support active partnerships and collaborative practice between adult and child and adolescent Mental Health Services.</p>	<ul style="list-style-type: none"> <li>■ Regular integrated care planning meetings to support parallel interventions by adult, child and adolescent mental health clinicians and child and family clinicians working with mentally ill parents.</li> </ul>	AHS/MH CAMHS MH-Kids
<p>4.5 Support the development and implementation of service agreements and policies that foster active collaboration between Mental Health services and DoCS during pregnancy and for families with infants up to two years age to promote early intervention and prevention activities prior to parental relapse or infant mental health problems occurring.</p>	<ul style="list-style-type: none"> <li>■ Local Service Agreement or Memorandum of Understanding (MOU) clarifying role of MH Services and DoCS in working with parents and infants who are experiencing mental health problems.</li> <li>■ Practice guidelines in place to ensure effective prenatal reporting and collaborative DoCS – MH Early Intervention.</li> </ul>	AHS MH-Kids MHDAO
<p>4.6 Advocacy for fathers who have a mental illness and are parenting an infant; adequate support to ameliorate the impact of the illness on the family during the perinatal period.</p>	<ul style="list-style-type: none"> <li>■ Joint planning and care agreement developed between Mental Health Services and Primary Health Care Services including GPs and NGOs.</li> <li>■ Assertive relapse prevention approach to support fathers with mental illness during the perinatal period.</li> </ul>	AHS

# Strategy 5: Sustainable, effective SAFE START

**Expected outcomes:** Ongoing performance monitoring demonstrates that pregnant women and families with infants up to two years age identified as vulnerable are engaged with appropriate specialist assessment and integrated care.

Actions	Performance indicators	Agency
5.1 Regularly evaluate the effectiveness of implementation of SAFE START.	■ SAFE START monitoring and feedback systems developed and in place.	AHS MHDAO MH-Kids



# Edinburgh post natal depression scale

(Cox J, Holden J, Sagovsky R. 1987)

Date\_\_\_\_\_ Mother's name\_\_\_\_\_ Age\_\_\_\_\_

Baby's name\_\_\_\_\_ Date of birth\_\_\_\_\_ Sex\_\_\_\_\_

As you have recently had a baby we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today. Here is an example, already completed.

I have felt happy:

Yes, all the time

Yes, most of the time

No, not very often

No, not at all

This would mean: "I have felt happy most of the time" during the past week. Complete the other questions in the same way.

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

As much as I always could

Not quite so much now

Definitely not so much now

Not at all

2. I have looked forward with enjoyment to things:

As much as I ever did

Rather less than I used to

Definitely less than I used to

Hardly at all

3. I have blamed myself unnecessarily when things went wrong:

Yes, most of the time

Yes, some of the time

Not very often

No, never

4. I have been anxious or worried for no good reason:

No, not at all

Hardly ever

Yes, sometimes

Yes, very often

5. I have felt scared or panicky for no very good reason:

Yes, quite a lot

Yes, sometimes

No, not much

No, not at all

6. Things have been getting on top of me:

Yes, most of the time I haven't been able to cope at all

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

No, most of the time I have coped quite well

No, I have been coping as well as ever

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

Yes, most of the time

Yes, sometimes

Not very often

No, not at all

8. I have felt sad or miserable:

Yes, most of the time

Yes, quite often

Not very often

No, not at all

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

Yes, most of the time

Yes, quite often

Only occasionally

No, never

10. The thought of harming myself has occurred to me:

Yes, quite often

Sometimes

Hardly ever

Never

# Edinburgh post natal depression scale (antenatal)

(Cox J, Holden J. 2003)

Date\_\_\_\_\_

Mother's name\_\_\_\_\_

Age \_\_\_\_\_Baby's name\_\_\_\_\_

Date of birth\_\_\_\_\_Sex\_\_\_\_\_

As you have recently had a baby we would like to know how you are feeling. Please UNDERLINE the answer which comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today. Here is an example, already completed.

**I have felt happy:**

- Yes, all the time
- Yes, most of the time
- No, not very often
- No, not at all

This would mean: "I have felt happy most of the time" during the past week. Complete the other questions in the same way.

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

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

**2. I have looked forward with enjoyment to things:**

- As much as I ever did
- Rather less than I used to
- Definitely less than I used to
- Hardly at all

**3. I have blamed myself unnecessarily when things went wrong:**

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

**4. I have been anxious or worried for no good reason:**

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

**5. I have felt scared or panicky for no very good reason:**

- Yes, quite a lot
- Yes, sometimes
- No, not much
- No, not at all

**6. Things have been getting on top of me:**

- Yes, most of the time I haven't been able to cope at all
- Yes, sometimes I haven't been coping as well as usual
- No, most of the time I have coped quite well
- No, I have been coping as well as ever

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

- Yes, most of the time
- Yes, sometimes
- Not very often
- No, not at all

**8. I have felt sad or miserable:**

- Yes, most of the time
- Yes, quite often
- Not very often
- No, not at all

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

- Yes, most of the time
- Yes, quite often
- Only occasionally
- No, never

**10. The thought of harming myself has occurred to me:**

- Yes, quite often
- Sometimes
- Hardly ever
- Never

# Edinburgh Postnatal Depression Scale

## scoring guide

Score for each question has been inserted on the left-hand side of each possible response.  
Add the scores for each question to calculate a total score out of a possible 30.

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

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

**2. I have looked forward with enjoyment to things:**

- 0 As much as I ever did
- 1 Rather less than I used to
- 2 Definitely less than I used to
- 3 Hardly at all

**3. I have blamed myself unnecessarily when things went wrong:**

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

**4. I have been anxious or worried for no good reason:**

- 0 No, not at all
- 1 Hardly ever
- 2 Yes, sometimes
- 3 Yes, very often

**5. I have felt scared or panicky for no very good reason:**

- 3 Yes, quite a lot
- 2 Yes, sometimes
- 1 No, not much
- 0 No, not at all

**6. Things have been getting on top of me:**

- 3 Yes, most of the time I haven't been able to cope at all
- 2 Yes, sometimes I haven't been coping as well as usual
- 1 No, most of the time I have coped quite well
- 0 No, I have been coping as well as ever

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

- 3 Yes, most of the time
- 2 Yes, sometimes
- 1 Not very often
- 0 No, not at all

**8. I have felt sad or miserable:**

- 3 Yes, most of the time
- 2 Yes, quite often
- 1 Not very often
- 0 No, not at all

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

- 3 Yes, most of the time
- 2 Yes, quite often
- 1 Only occasionally
- 0 No, never

**10. The thought of harming myself has occurred to me:**

- 3 Yes, quite often
- 2 Sometimes
- 1 Hardly ever
- 0 Never

# Psychosocial risk variables I–VII

Variables (Risk Factors)	Suggested format for psychosocial assessment questions
I. Lack of support	1. Will you be able to get practical support with your baby? 2. Do you have someone you are able to talk to about your feelings or worries?
II. Recent major stressors in the last 12 months.	3. Have you had any major stressors, changes or losses recently (ie in the last 12 months) such as, financial problems, someone close to you dying, or any other serious worries?
III. Low self-esteem (including lack of self-confidence, high anxiety and perfectionistic traits)	4. Generally, do you consider yourself a confident person? 5. Does it worry you a lot if things get messy or out of place?
IV. History of anxiety, depression or other mental health problems	6a. Have you ever felt anxious, miserable, worried or depressed for more than a couple of weeks? 6b. If so, did it seriously interfere with your work and your relationships with friends and family? 7. Are you currently receiving, or have you in the past received, treatment for any emotional problems?
V. Couple's relationship problems or dysfunction (if applicable)	8. How would you describe your relationship with your partner? 9. a). <b>Antenatal:</b> What do you think your relationship will be like after the birth OR 9. b). <b>Postnatal (in Community Health Setting):</b> Has your relationship changed since having the baby?
VI. Adverse childhood experiences	10. Now that you are having a child of your own, you may think more about your own childhood and what it was like. As a child were you hurt or abused in any way (physically, emotionally, sexually)?
VII. Domestic violence. Questions must be asked only when the woman can be interviewed away from partner or family member over the age of three years. Staff must undergo training in screening for domestic violence before administering questions	11. Within the last year have you been hit, slapped, or hurt in other ways by your partner or ex-partner? 12. Are you frightened of your partner or ex-partner? <b>(If the response to questions 11 &amp; 12 is "No" then offer the DV information card and omit questions 13-18)</b> 13. Are you safe here at home? /to go home when you leave here? 14. Has your child/children been hurt or witnessed violence? 15. Who is/are your children with now? 16. Are they safe? 17. Are you worried about your child/children's safety? 18. Would you like assistance with this?
Opportunity to disclose further	19. Are there any other issues or worries you would like to mention?



# Strengths and issues - models of SAFE START implementation

SAFE START models	Strengths	Potential issues
<b>Specialist SAFE START team</b> Dedicated team. <i>Main role is to effect sustainable change in service in short period of time.</i>	<ul style="list-style-type: none"> <li>■ Useful when service providers identify a need for urgent changes in service delivery.</li> <li>■ Identified resources and process for education, service development, evaluation and research activities.</li> </ul>	<ul style="list-style-type: none"> <li>■ SAFE START not perceived by mainstream services as within their core practice.</li> <li>■ Dialogue with SAFE START team rather than between services.</li> <li>■ Substantial ongoing funding required.</li> </ul>
<b>SAFE START Coordinator</b> Dedicated position <i>Main roles are to:</i> <ul style="list-style-type: none"> <li>■ <i>put into effect sustainable changes in clinical practice</i></li> <li>■ <i>develop and monitor organisational change.</i></li> </ul>	<ul style="list-style-type: none"> <li>■ Promotes the identification of pathways to care and recognition of gaps in service delivery.</li> <li>■ Conducive to clinical action research.</li> <li>■ Favourable to the building of links between services.</li> <li>■ Most useful at AHS level as it promotes sustainable change and standardisation of practice.</li> </ul>	<ul style="list-style-type: none"> <li>■ Complexity of the role is highly challenging and may be difficult to sustain.</li> <li>■ Recruitment of a multi-skilled mental health specialist able to meet the complexity of the role may be difficult.</li> <li>■ Challenge of working across health sectors especially when the service configuration is varied and some population groups have high needs.</li> </ul>
<b>Whole of AHS responsibility</b> Duties associated with SAFE START are incorporated into current roles.	<ul style="list-style-type: none"> <li>■ Capacity building model.</li> <li>■ Shared sector ownership.</li> <li>■ Potential to improve motivation of all staff, in regard to SAFE START activity.</li> <li>■ Enhance partnerships between services, organisations, and relevant agencies.</li> <li>■ SAFE START becomes core business.</li> <li>■ Increased sustainability.</li> <li>■ Involves limited expenses.</li> </ul>	<ul style="list-style-type: none"> <li>■ Potentially slower organisational change.</li> <li>■ Dependent on leaders sustaining focus on SAFE START.</li> <li>■ Strong senior management support and sponsorship required.</li> </ul>

# References

- Alder, J., Fink, N., Bitzer, J., Hosli, R., Holzgreve, W. 2007, Depression and anxiety during pregnancy: A risk factor for obstetric, fetal and neonatal outcome? A critical review of the literature. *The Journal of Maternal-Fetal and Neonatal Medicine*, March 20(3), pp. 189–209.
- Barnett, B., Schaafsma, M.F., Guzman, A.M. & Parker, G. 1991, Maternal anxiety: A 5-year review of an intervention study. *Journal of Child Psychology and Psychiatry*, Vol. 33, pp. 423–438.
- Australian Health Ministers, 1992, *National Mental Health Policy*. Canberra: Australian Government.
- Australian Health Ministers, 1992, *Mental Health Statement of Rights and Responsibilities*, Canberra: Australian Government.
- Australian Health Ministers, 2003, *National Mental Health Plan 2003–2008*. Australian Government, Canberra.
- Commonwealth Department of Health and Aged Care 2000, *National Action Plan for Promotion, Prevention and Early Intervention for Mental Health*. Mental Health and Special Programs Branch, Commonwealth Department of Health and Aged Care, Canberra.
- Council of Australian Governments (COAG), 2006, *National Action Plan on Mental Health 2006 – 2011*. Commonwealth Government, Canberra.
- Cox, J., Holden, J., Sagovsky, R. 1987, Detection of postnatal depression: development of the 10-item Edinburgh postnatal depression scale. *British Journal of Psychiatry*, Vol. 150, pp. 782–786.
- Cox, J. and Holden, J., 2003, *Perinatal Mental Health: A Guide to the Edinburgh Postnatal Depression Scale (EPDS)*. Gaskell, London.
- Cox, J., Murray, D and Chapman, G., 1993, A controlled study of the onset, duration and prevalence of postnatal depression, *The British Journal of Psychiatry*, Vol. 163, pp. 27 – 31.
- Gotlib, L., Whiffen, V., Mount, K., Cordy, N. 1989, Prevalence rates and demographic characteristics associated with depression in pregnancy and the postpartum. *Journal of Consulting and Clinical Psychology*, Vol. 57(2), pp. 269–274.
- Kendell, R., Chalmers, J., Platz, C. 1987, Epidemiology of puerperal psychosis. *British Journal of Psychiatry*, 150, pp. 662–673.
- Llewellyn, A., Stowe, Z., Nemeroff, C. 1997, Depression during pregnancy and the puerperium. *Journal of Clinical Psychiatry*, Vol. 58, pp. 26–32.
- Mrazek, P.J. and Haggerty, R.J. (eds) 1994, *Reducing risks for mental disorders: Frontiers for preventive intervention research*. Institute of Medicine, National Academy Press, Washington DC.
- Murray, L. 1992, The impact of postpartum depression on infant development. *Journal of Child Psychiatry*, Vol. 33, pp. 543–561.
- National Collaborating Centre for Mental Health, 2007, Antenatal and Postnatal Mental Health: The NICE Guideline on clinical management and service guidance. *National Clinical Practice Guideline Number 45*, The British Psychological Society and Gaskell.
- O'Hara, M. Swain, A. 1996, Rates or risks of postpartum depression – a meta-analysis. *International Journal of Psychiatry*, Vol. 8, pp. 37–54.
- Puckering, C., 2004, Parenting in social and economic adversity, In: Hoghugh M., Long, N., (Eds) *Handbook of parenting: theory and research for practice*, Sage Publications, London, pp. 38–54.
- Seeman, M. 2000, Women and schizophrenia. *Medscape Women's Health*, Vol. 5, No 2.
- Smatmari, P., Nagy, J. 1990, Children of schizophrenic parents; a critical review of issues in prevention. *Journal of Preventive Psychiatry and Allied Disciplines*, Vol. 4, pp. 311–327.
- Swain, J.E., Lorberbaum, J.P., Kose, S., Strathearn, L., 2007, Brain basis of early parent-infant interactions: psychology, physiology, and in vivo functional neuroimaging studies. *Journal of Child Psychology and Psychiatry*, 48:3/4, pp. 262–287.
- Viguera, A., Nonacs, R., Cohen, L. et al., 2000, Risk of recurrence of bipolar disorder in pregnant and non-pregnant women after discontinuing lithium maintenance. *The American Journal of Psychiatry*, Vol. 157, pp. 179–184.



