

# GLOUCESTERSHIRE'S STRATEGY FOR MATERNAL DEPRESSION 2005 – 2010

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Version 1.2

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Abbreviations:

BME: Black & Minority Ethnic groups

CEMD: Confidential Enquiry into Maternal Deaths

CEMACH: Confidential Enquiry into Maternal and Child Health

CMHT: Community Mental Health Team

CNST: Clinical Negligence Scheme for Trusts

DV: domestic violence

EOC: Essence of Care

EPDS: Edinburgh Postnatal Depression Scale

GPT: Gloucestershire Partnership Trust

IM&T: Information Management & Technology

NICE: National Institute of Clinical Excellence

NSC: National Screening Committee

PCCAG: Primary & Community Care Audit Group

PMHS: Primary Mental Health Service

SIGN: Scottish Intercollegiate Guideline Network

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## EXECUTIVE SUMMARY

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The purpose of the countywide strategy is to outline the provision of a service across Gloucestershire's Partnership Trust and three Primary Care Trusts and describe how it can be achieved.

The strategy will lead towards the provision of an equitable and effective, multi-disciplinary service for the prevention, detection and treatment of maternal depression during pregnancy and up to one year following childbirth. It will ensure that every woman known to the maternity, health visiting, primary care and mental health services is assessed and managed appropriately and according to evidence based best practice. Appropriate and effective management will contribute towards lessening the impact of maternal depression for women, their babies, other children and partners, both in the short and long term.

The aims and objectives of the strategy are laid out against a background of current service provision and drivers for change, for example the National Service Framework for Mental Health, the Confidential Enquiry into Maternal Deaths and the National Suicide Prevention Strategy. This is followed by recommendations and a priority focused action plan for implementation based on short and long term goals over the next 5 years.

This strategy will contribute directly to an overarching countywide Strategy for Maternal Mental Health which is currently being developed by the Gloucestershire Maternal Mental Health Steering Group. The Strategy for Maternal Mental Health will cover other maternal mental health conditions, such as puerperal psychosis, phobic anxiety states and panic disorder, obsessive-compulsive disorder, substance misuse, manic-depressive/bipolar disorder and schizophrenia. These strategies will compliment each other and clearly justify the high level of priority now being afforded to perinatal maternal depression. This document will also demonstrate the need to embed this strategy in local service level agreements.

The strategy has involved wide consultation and concentrates on building on services already available in recognition of existing expertise and resources in order to avoid duplication and make the best possible use of scarce resources.

As Oates reminds us, 'Pregnancy is the only known trigger for mental illness that comes with nine month's warning'<sup>1</sup>. This strategy offers evidence based recommendations for these nine months to be used to prevent mortality and reduce morbidity in women who will experience perinatal depression and who have predictable mental health risks factors.

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<sup>1</sup> Oates (2002) *Suicide leading cause of deaths among new mothers* RCOP Annual Meeting June 2002

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## 1. INTRODUCTION

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Maternal mental health is a major health issue for individual and public health. In the recently published Confidential Enquiry into Maternal Deaths<sup>2</sup> it is highlighted that death due to psychiatric illness was not only the most common cause of *Indirect* death (i.e. death due to pre-existing maternal disease aggravated by pregnancy) but it was also the largest cause of maternal deaths overall. The majority of these deaths were due to suicide and were by violent means such as hanging, jumping off bridges, drowning, cutting their throats or throwing themselves in front of fast moving vehicles - and most of them were severely depressed or suffering from puerperal psychosis<sup>3</sup>. It is also important to remember that these maternal suicides are the tip of the iceberg – these were women who were so desperately ill that they meant to kill themselves, these were not cries for help – and that there is a significant amount of morbidity and suffering below this threshold.

The time of childbirth is expected to be a time of personal fulfilment and enjoyment. However, for those women who experience postnatal illness it can be a time of untold suffering for women which can also have a major negative impact on infant's cognitive, emotional, social and behavioural development. It is also recognised as a key contributory factor in family breakdown. Maternal mental health now appears in key government White Papers thus recognising its importance for individuals, families and public health as well as health and social care organisations. In addition, the Royal College of Psychiatrists has developed core standards for the requirements and provision of a perinatal maternal mental health service<sup>4</sup> (See *Core Standards of a Perinatal Maternal Mental Health Service* at Appendix A).

This strategy brings together all the agendas that underpin service development, build on what already exists and works well (including services provided by non-profit organisations), and proposes new ways of working with families. It makes recommendations that will influence the provision of a high quality specialist perinatal mental health service that meets the mental health needs of all women who are mothers across the county. Not only will it seek to benefit women and their families but it will also address benefits to professionals and organisations. Lastly, it makes recommendations on how the strategy will be implemented and evaluated.

Details of those included in the initial consultation process are contained at Appendix B.

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<sup>2</sup> CEMACH (2004) *Sixth Report of the Confidential Enquiry into Maternal Deaths 2000-02* RCOG London

<sup>3</sup> Oates M (2002) *Suicide leading cause of deaths among new mothers* RCOP Annual Meeting June 2002

<sup>4</sup> RCOP (2002) *Perinatal Maternal Mental Health Services* Royal College of Psychiatrist London

## 1.1 DEFINITION

Maternal depression is maternal anxiety and depression occurring during pregnancy and/or up to a year following childbirth with clinical depression as defined by the Diagnostic and Statistical Manual of Mental Disorders: DSM IV<sup>5</sup> and International Classification of Diseases: ICD-10<sup>6</sup>. It can occur in mild, moderate and severe forms and is not to be confused with the ‘baby blues’, a transitory episode of low mood and tearfulness between 3 and 5 days that affects 50 to 80% of women following childbirth. The term ‘postnatal depression’ suggests that maternal depression occurs solely after childbirth. Research shows that the incidence of depression in the antenatal period, however, is similar to that in the postnatal period (see section 1.2 below). This strategy encompasses both the antenatal and postnatal episodes; therefore although the term ‘perinatal depression’ is used throughout the document it includes management and local service developments up to one year postnatally.

A more severe illness, with acute onset, is puerperal psychosis. This is a relatively rare disorder characterised by psychotic depression, mania or atypical psychosis and affects 1 to 2 per 1000 women following childbirth. It carries a significant risk of danger to the woman herself, others and the baby. The strategy focuses on perinatal maternal depression but as the identification of maternal depression encompasses the identification of other mental health risk factors it is mentioned here and in the following section on incidence. The management of psychiatric illnesses other than depression, however, will be dealt with in depth in Gloucestershire’s Strategy for Maternal Mental Health which is currently under development (due for publication in 2005/06).

## 1.2 INCIDENCE (NATIONAL AND LOCAL)

The epidemiology of postnatal mental illnesses is well established with an incidence of about 10% of all recently delivered women meeting Research Diagnostic Criteria for major depressive illness and 3-5% of delivered women meeting the criteria for moderate to severe depressive illness<sup>7</sup>. However, other studies report a higher incidence of 15-20%<sup>8</sup>. In addition, the rate of recurrence of PND after a subsequent birth is 30%. Up to 15% of pregnant women are affected by antenatal depression and although the prevalence is similar to that of postnatal depression it is often a neglected aspect of pregnancy. The incidence of postnatal depression and referrals to psychiatric services can be estimated from local data

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<sup>5</sup> American Psychiatric Association 1997 DSM IV

<sup>6</sup> WHO 1992 International Classification of Diseases: ICD-10

<sup>7</sup> RCOP (2002) Perinatal Maternal Mental Health Services Royal College of Psychiatrist London

<sup>8</sup> NICE (2004) **Guideline for antenatal and postnatal mental health Scope Document** DOH London

sets using well established epidemiology<sup>9</sup>. In Gloucestershire there are approximately 6107 births a year<sup>10</sup>. It can therefore be estimated that there will be 611 cases of maternal depression, 183 to 305 cases of severe maternal depression, 104 referrals to psychiatric services and 36 admissions (12 women admitted with psychosis, 12 with non-psychotic depression and 12 with relapse of a severe and enduring mental illness). (See *Applied epidemiological data* at Appendix C). There are also women who do not fall into these categories who nevertheless require admission to specialist mental health services. When interpreting these statistics it has to be acknowledged that figures involving small numbers are prone to significant % variation in year on year. Local health data that is available, however, does not reflect the incidence suggested above. Figures from the Information Department and Health Records tells us that few women are admitted to specialist mental health services in Gloucestershire or to specialist mother & baby units out of area. In fact, in the last 5 years there are two recorded cases of puerperal psychosis and one recorded case of postpartum depression. This raises a number of questions such as -

- Does the incidence of perinatal maternal depression in Gloucestershire reflect the national incidence demonstrated in the research?
- Are women not receiving the type of care that is recommended by the evidence base<sup>11</sup>?
- Are women being provided for in other levels of healthcare e.g. maternity services or GP services?
- Are cases not being identified?
- Is data not being recorded/coded in a way that reflects cases?

There is probably no simple answer to this but there is no reason to suggest that Gloucestershire's incidence of maternal depression should be different to that identified and replicated in many studies. On the other hand, anecdotal evidence about frustrations, difficulties and problems around identification, referrals and accessing appropriate services is backed up by specific incidents discussed by professionals both in primary care and specialist mental health services.

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<sup>9</sup> Oates M (2000) **Perinatal Maternal Mental Health Services** RCOP London

<sup>10</sup> Gloucestershire datasets 2003

<sup>11</sup> Royal College of Psychiatrists (2000) Perinatal Maternal Mental Health Services Royal College of Psychiatrists, London

### 1.3 THE IMPORTANCE OF MATERNAL DEPRESSION

Perinatal maternal depression is of importance not only to those concerned with maternal well-being but also those concerned with infant and child mental health. In severe cases of postnatal depression the mother is at increased risk of self-harm and suicide. The mother may also have anxieties about the baby including thoughts of harming the child.

Where the mother has depressive symptoms there is a risk of poor mother-infant interaction e.g. lack of interest in the baby. The mother-infant relationship and secure attachment are dependent on the mother being emotionally available to the infant and being able to read the baby's cues. Adverse effects on infant development are most likely when the mother finds it difficult to maintain sensitive and active engagement with the infant. These adverse effects are well-documented, particularly the long-term effects on the later social attachments and cognitive development of the child. These effects have been noted in particular in boys, and are detectable after the resolution of the maternal depression<sup>12</sup>.

Paternal depression is also a factor as fathers are significantly more likely to suffer from depression and general health problems if their partners are diagnosed with postnatal depression<sup>13</sup>. This is significant not only in terms of individual suffering, possible suicide risk and potential breakdown in the parental relationship but also in terms of two depressed parents being unable to meet the infant's emotional and physical needs.

As parental mental illness can adversely affect the safety, as well as the development, of the infant or child it follows that child protection procedures must be followed where it is apparent that the risks outweigh parental coping capacities and social supports.

### 1.4 RISK FACTORS AND IDENTIFICATION

The evidence base provides a list of risk factors with moderate to strong associations with postnatal depression, as well as other factors with a recognised but weaker association<sup>14</sup>. A history of depression at any time increases risk, and a history of postnatal depression carries a risk of >30% recurrence.

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<sup>12</sup> Cooper PJ, Murray L, (1995) Course and recurrence of postnatal depression. Evidence for the specificity of the diagnostic concept. *British Journal of Psychiatry*, 166, 191-195

<sup>13</sup> Ballard CG, Davis R, Cullen PC, Mohan RN, Dean C, (1994) Prevalence of postnatal psychiatric morbidity in mothers and fathers. *British Journal of Psychiatry* 164, 782-788

<sup>14</sup> SIGN (2002) Guideline for Postnatal Depression and Perinatal Psychosis SIGN Executive Edinburgh

Screening for postnatal depression has gained in popularity since the original studies on the effectiveness of screening by health visitors in primary care were published<sup>15</sup>. However, screening can have negative consequences, particularly in mental health so it is important that health professionals administering the screening programme are adequately trained. Until the National Screening Committee (NSC) undertook a review of the use of the Edinburgh Postnatal Depression Scale (EPDS) as a screening tool, health visitors who had been trained to use it were screening women postnally. However, the NSC reported that the limitations of the EPDS meant that it should not be used as a screening tool and issued a statement that it should be used instead as a checklist alongside a clinical interview and clinical judgement<sup>16</sup>. This requirement has training implications as health visitors do not routinely receive training on conducting clinical interviews.

Some of the limitations of the EPDS relate to its use with non-English populations despite the fact that it has been translated into several different languages. However, there are now validated tools that can be used in some non-English populations as an alternative assessment tool e.g. the 'How are you feeling?' booklets<sup>17</sup> and the Dhoop Chaon Scales<sup>18</sup>.

Domestic violence, of which 30% of cases commence during pregnancy, has a major impact on women's mental health. In addition, where there is a history of domestic violence it often intensifies. Enquiring about existing mental health issues and risk factors for mental health problems provides an opportunity to enquire about domestic violence and plan appropriate interventions to reduce risk to the woman and baby.

## 1.5 MANAGEMENT OF MATERNAL DEPRESSION

The response to both pharmacological and psychosocial interventions is good and up-to-date evidence-based guidance on the management of maternal depression is available in the SIGN Guideline for Postnatal Depression and Puerperal Psychosis. The mother and infant should be treated by a specialist perinatal mental health team and mother and baby should be treated together and not separated. Where admission is required this should be to a specialist mother and

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<sup>15</sup> Cox J, Holden J (1994) Perinatal Psychiatry: use and misuse of the Edinburgh Postnatal Depression Scale Gaskell, London

<sup>16</sup> NSC (2002) NSC (2002) [www.nchl.nhs.uk/screening](http://www.nchl.nhs.uk/screening)

<sup>17</sup> CPHVA (2003) 'How Are You Feeling?' Booklets CPHVA, London

<sup>18</sup> Oswald J, Akhtar N (2004) Transcultural aspects of Postnatal Depression. Developing a care pathway in Rochdale SureStart Mental Health Project (available from The Pennine Acute Hospitals NHS Trust Clinical Audit Department).

baby unit<sup>19</sup>. South Gloucestershire NHS PCT has published clinical guidelines on the pharmacological management of postnatal depression<sup>20</sup> and this could serve as a useful local resource.

## 1.6 EQUITY AND ACCESSIBILITY

Services should be designed to be approachable and flexible enough to meet the needs of all women, including the vulnerable and hard to reach, those who are socially disadvantaged and those from Black and Minority Ethnic groups.

It is known that depression is diagnosed relatively less frequently in the Asian population than in the white population, despite the fact that the incidence of suicide is increased among young Asian women<sup>21</sup>. It is also known that people from Black and Minority Ethnic communities are much less likely to be referred to psychological therapies<sup>22</sup>. In Gloucestershire, Gloucester district has the largest population of black and minority ethnic (BME) groups, accounting for 7.5% (8193) of the population<sup>23</sup>.

There are identified pockets of deprivation across the county and a number of Sure Start areas have developed ways of working to meet the mental health needs of mothers and families in these areas. One of the key elements in providing an appropriate and responsive service is to ensure that the relevant user groups are involved in the development process. Public and patient involvement of Sure Start women and Black and Minority Ethnic Group women is crucial if developing services in Gloucestershire are to meet the needs of women. Sure Start area services are due to become mainstreamed with the advent of Children's Centres in 2006. This will facilitate developing services and meeting the needs of vulnerable women who currently do not live within Sure Start areas. These issues require further attention in the strategy.

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<sup>19</sup> Royal College of Psychiatrists (2000) Perinatal Maternal Mental Health Services Royal College of Psychiatrists, London and SIGN (2002) The SIGN Guideline for Postnatal Depression and Puerperal Psychosis SIGN Executive, Edinburgh

<sup>20</sup> South Gloucestershire NHS PCT (2004) CLINICAL GUIDELINES Postnatal Depression & Puerperal Psychosis: Detection, management & referral in Primary Care

<sup>21</sup> DH (2002) Women's Mental Health: Into the Mainstream DH Publications, London

<sup>22</sup> DH (1999) National Service Framework for Mental Health Stationary Office London

<sup>23</sup> ONS 2001 Census

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## **2. AIM OF THE STRATEGY**

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To provide the PCTs and the Partnership Trust in Gloucestershire with a strategic framework to ensure the development and delivery of equitable and effective, multi-disciplinary district-wide services for the identification and management of maternal depression antenatally and postnatally up to one year following childbirth.

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## **3. DRIVERS FOR CHANGE**

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### **3.1 GOVERNMENT POLICY**

- 3.1.1 Confidential Enquiry into Maternal Deaths: Why Mothers Die 2000-02 (2004)
- 3.1.2 National Service Framework for Children (2004)
- 3.1.3 NICE Guideline for Depression: Management of depression in primary and secondary care (2004)
- 3.1.4 NICE Guideline for Antenatal Care (2003)
- 3.1.5 Laming Report (2003)
- 3.1.6 Women's Mental Health: Into the mainstream (2002)
- 3.1.7 National Suicide Prevention Strategy (2002)
- 3.1.8 Social Inclusion Policy
- 3.1.9 SIGN Guideline for Postnatal Depression and Puerperal Psychosis (2002)
- 3.1.10 National Plan for Mental Health (2000/1)
- 3.1.11 National Service Framework for Mental Health (1999)
- 3.1.12 Sure Start Agenda

This wide range of government policy underpins the specific development of services to address perinatal maternal depression as well as the broader development of services to

address women's mental health issues. The policies range from suicide prevention to the most up to date evidence regarding the management of postnatal depression. This is contained within the SIGN Guideline for Postnatal Depression and Puerperal Psychosis and provides the evidence base to inform practice and service developments.

The NICE Guideline for Antenatal and Postnatal Mental Health is due for publication in February 2007 and its implementation will form the basis of a future review of Gloucestershire's strategy. The review will also consider the NICE Guideline for Postnatal Care (due to be published in June 2006) which will provide guidance on the management of women who experience transient low mood ('Baby blues') in the early days following the birth of their baby.

The National Suicide Prevention Strategy is relevant to this strategy both for women who are mothers and men who are fathers. Local data tells us that mortality rates for suicide in Cheltenham are well above County, Regional and National averages (although rates are based on small numbers of cases, so may be affected by small annual fluctuations)<sup>24</sup>. Suicide is also the most common cause of death in men under 35 years of age and whilst people with mental health problems are at high risk, around 75% of people who commit suicide are not in contact with mental health services. Men under 35 are likely to be fathers and if their partner is receiving antenatal/postnatal care this provides health professionals with an opportunity of reaching men who may not be in contact with mental health services. This should be seen as a way of PCTs responding to the National Suicide Prevention Strategy and ensuring the early identification and management of depression in primary care.

### **3.2 PROFESSIONAL GUIDANCE**

- 3.2.1 The Fourth Hall Report (2003)
- 3.2.2 Perinatal Maternal Mental Health Services (RCPsych 2000)
- 3.2.3 Recommendations on the use of the EPDS (CPHVA 2002)
- 3.2.3 National Screening Committee recommendations on the use of the EPDS (NSC 2002)

### **3.3 LOCAL GUIDANCE**

- 3.3.1 Gloucestershire Mental Health Toolkit

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<sup>24</sup> C&T PCT (2002) Local Delivery Plan 2003-2006

- 3.3.2 PCT Local Delivery Plans
- 3.3.3 Health Visitor Best Practice Benchmarks
- 3.3.4 Essence of Care: Maternal Mental Health

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## **4. CURRENT SERVICE PROVISION IN GLOUCESTERSHIRE**

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The majority of services for women with perinatal depression are currently provided in primary care. (See *Mapping of Service Provision for Perinatal Maternal Depression in Gloucestershire* at Appendix D). There are pockets of activity that demonstrate evidence of good practice in Gloucestershire's three Primary Care Trusts, but there are notable variations in practice and services across the county which would benefit from a more coordinated approach; both to improve use of resources and to improve the women's experiences in relation to perinatal depression. A comparison of current service provision with national policy, guidelines and recommendations demonstrates that further developments are necessary to ensure that women and families receive equitable, effective, evidence based services for the identification and management of perinatal depression.

### **4.1 Primary/Community Care**

#### **4.1.1 Midwifery Practice**

Identification of existing mental health problems and risk factors for perinatal depression are currently based on the self-completion National Maternity Record. This document has recognised limitations in the brief nature of its enquiry into maternal mental health and it does not fulfil the evidence based recommendations for a systematic enquiry about family history/previous psychiatric history, its severity and management. This is an area for development as is the assessment of partners' mental health needs. Both have implications for training and staff costs.

#### **4.1.2 General Practice**

When pregnant women first make contact with the primary care health service they often see a community midwife and women with uncomplicated pregnancies generally receive midwifery-led care. Many women still have an expectation, however, to see a GP and in some cases the initial booking appointment will be with the doctor. In cases where the GP sends a referral letter to the community midwife there is anecdotal evidence suggesting that there is variation in the level of relevant information regarding psychiatric, social and family history that is

passed onto the antenatal care team (e.g. midwives, health visitors). Whilst acknowledging that communication systems can and do work well, there is a need for a standardised approach and the NSF for Children has highlighted the need for the development of a standard national 'booking referral letter'. Clarification is required on whether the 'booking referral letter' refers to the GP letter, the community midwifery letter or whether it is a letter that should be generated by whichever professional first sees the woman.

When referral to the Community Mental Health Team is required it currently takes place via a woman's GP rather than by direct referral through a woman's midwife. Community midwives, however, have voiced a need for a countywide agreement for direct referral and this could serve to avoid delays for women requiring referral.

#### 4.1.3 Health Visiting Practice

Up until recently there has been a notable variation in practice and service provision across Gloucestershire's three PCTs. However, two years ago the Gloucestershire PND Trainer Group formed and the group has been working towards increasing, improving and standardising training for health visitors in the identification and management of postnatal depression. The training includes the use of the EPDS. Much of the background work of this group has led directly to this strategy. (See *The Gloucestershire PND Trainer Group: background to the strategy* at Appendix E).

Despite the ongoing work of the PND Trainer Group, there continues to be a variation across the three PCTs both in the number of specialist PND Trainer Health Visitors and in the number of health visitors who are trained (See *Variation in PND Trainer and Training Across the County* at Appendix F). This variation needs addressing.

Health visitors who have been trained can offer non-directive counselling and some health visitors have also been trained in the use of Solution Focused Brief Therapy. This is another valuable resource that can be used to manage perinatal maternal depression in primary care. By December 2004 the SIGN Guideline for Postnatal Depression had been incorporated into cross-county health visitor training. The success of the training programme and providing an early intervention service in primary care, however, is dependent both on joint training and supervision being provided by a specialist role health visitor and a CPN. Historically, health visitor and CPN trainers are individuals with a special interest in the field of maternal mental health who have sought managerial support to train as trainers. Varying levels of managerial support have been secured, particularly from the Specialist Mental Health Service, which explains in part the variation across the county. It is vital, however, that CPN contribution to the provision of supervision for trained health visitors is secured within Specialist Mental Health Service policy/service level agreements in order to support the development of a

countywide perinatal mental health service and meet the needs of women and families.

The EPDS is used as an identification tool for postnatal depression, but there is currently no alternative tool in use in the county for non-English speaking women or those from different cultures. This needs to be addressed in order to deliver an equitable and effective service to all women.

There is variation across the county in access to Postnatal Depression Support Groups for women, despite evidence of their effectiveness in the treatment of postnatal depression. (See *Map of Countywide Perinatal Maternal Mental Health Services* at Appendix G).

A Care Pathway for Postnatal Depression is currently under development in C&T PCT with the aim of improving identification and outcomes by ensuring that care and management of women at risk of, or suffering, postnatal depression is based on up to date, evidence based best practice. The care pathway document will incorporate the unique variance tracking tool to compare planned care with actual care given. In other words, audit care at the point of delivery. The care pathway development is a multi-disciplinary approach and ensures continuous improvements in practice, care and outcomes. The care pathway document will also meet all the legal requirements for record keeping.

#### 4.1.4 The Primary Mental Health Service (PMHS)

This relatively new service has been growing since it was established in the Summer of 2004. Its aim is to support professionals to meet the mental health needs of service users in the community and in Primary Care. A range of activities based on the Stepped Care Approach, including assessment, joint assessment, brief intervention and sign-posting in GP surgeries, supervision, telephone Guided Self-Help (for Depression/Anxiety/Anger Management) and Stress Management Workshops is undertaken by Gateway/Triage Nurses and Graduate Workers. The service is being rolled out across the county in phases and is currently at different stages in the three PCTs. The PMHS has developed a comprehensive Mental Health Toolkit for use in Primary Care and provides information via leaflets and a website. Women who have perinatal depression can be referred to Gateway/Triage Nurses in GP surgeries where the service is available, and the feasibility of a dedicated telephone Guided Self-Help for Perinatal Maternal Depression is currently being assessed.

#### 4.1.5 Sure Start Infant Mental Health Team

In Cheltenham, the Sure Start midwives assess and explore women's mental health needs in the antenatal period and where appropriate refer to the Infant

Mental Health Service. Women living in Sure Start areas, therefore, have access to a valuable service. However, depression related mother-infant relationship problems are not confined to these small Sure Start geographical areas – on the contrary, perinatal maternal depression shows no social class distinction. Therefore, developing a needs-led service could mean taking an approach where the Infant Mental Health Service would be accessible to the 3-5% of women with severe perinatal depression and/or complex histories. The current situation provides women across the county with an inequitable service. There is potential to change this approach as Sure Start services become mainstreamed.

#### 4.1.6 Sources of Information and Support/Signposting

There is a variety of sources of information for women on postnatal depression but published leaflets are costly and there is no standardised agreement across the county about the most appropriate/evidence-based source of information that should be made available to women. Information is also available in the Gloucestershire Mental Health Toolkit and from the Gloucestershire information service, GUIDE. Access to evidence-based information for cross-county use needs addressing, including information on sign-posting to other resources when other mental health problems are identified.

## 4.2 Specialist Care / Tertiary Care

Specialist Mental Health Services focus service provision on Severe and Enduring Mental Illnesses. From a historical point of view maternal mental health, and in particular postnatal depression, has not been given a high priority in primary or specialist mental health care. Gloucestershire does not have a local specialist perinatal mental health team or a specialist mother and baby unit. If referral is indicated, it is to a General ‘Adult’ Psychiatrist and, as highlighted in Section 1.2, there is a lack of comprehensive data on what services women who need admission to specialist mental health/tertiary care services (as defined by the Royal College of Psychiatrists recommendations) currently receive.

Anecdotally, it proves both challenging and costly to arrange out of county care for women needing in-patient services. An in-patient episode to a mother and baby unit costs £15-25,000. The process of arranging admission needs addressing in order to minimise delays and improve women’s experiences during an acute episode of care.

## 4.3 Substance misuse services for pregnant women

Women with alcohol and substance misuse problems are managed during the antenatal period using countywide guidelines and involving a multi-disciplinary approach. The service is run by a consultant with a special interest and two

specialist midwives. There are currently no guidelines for the management of this client group in the postnatal period.

#### **4.4 Liaison across primary, specialist and tertiary care**

Women presenting with perinatal depression require a multi-disciplinary approach, and in some cases this will be an integrated care plan or the Care Programme Approach. Liaison between all levels of service provision is vital to ensure that communication systems are effective. Poor communication systems can result in dispersed responsibility and this can be a recipe for disaster.

#### **4.5 Audit/health information**

There are currently no systems in place in the Primary, Community or Specialist Mental Health Services that provide robust data on incidence of antenatal and postnatal depression, referrals and admissions. Such information is vital for service planning and providing evidence on meeting local and national targets e.g. for CHAI inspections. The care pathway for postnatal depression will generate data that has not been available to date. A small pilot is also currently underway at one C&T PCT GP Practice incorporating current read codes with risk factors for postnatal depression within the antenatal booking/routine antenatal examination/new patient booking templates to improve identification and early, appropriate referral. Further developments to enhance data collection need to be addressed.

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## **5. A STRATEGY FOR CHANGE: A VISION FOR GLOUCESTERSHIRE**

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The strategy is laid out as a five year plan in line with Gloucestershire's Mental Health Strategy. It provides a strategic framework with an action plan that builds on existing services and addresses gaps in services. It acknowledges that full implementation will take time and that local organisations and the individuals within them are at different starting points. For this reason it is divided into short and long term goals. Implementation of the objectives in the action plan are required in order to meet the recommendations set out in the NSFs and other government policies/recommendations highlighted in Section 3 of this document, as well as to reap the benefits for women, their families, staff and the organisations in which they work.

Implementing the strategy will be achieved through several routes:

1. A care pathway for maternal depression
2. Primary Mental Health Service developments
3. A specialist perinatal mental health service

## **5.1 A CARE PATHWAY FOR MATERNAL DEPRESSION**

This has already been described in Section 4.1.3. It is being funded and sponsored by Cheltenham & Tewkesbury PCT. Once the care pathway is fully implemented at the end of a year long project the aim will be to implement it across Cotswold & Vale PCT and West Gloucestershire PCT.

## **5.2 PRIMARY MENTAL HEALTH SERVICE DEVELOPMENTS**

Developments within the PMHS will be based on the Stepped Care Approach (See *Stepped Care Approach to Perinatal Depression* at Appendix H), as follows:

- 5.2.1 Graduate Mental Health Workers – extended work to cover Guided Self-Help for Maternal Depression following referral via the Gateway/Triage Nurses.
- 5.2.2 Create a permanent specialist Maternal Mental Health Lead post to lead implementation of strategy, develop literature and website, review and incorporate NICE Guideline for Antenatal and Postnatal Mental Health when published, to be a resource and link with community/primary/specialist mental health services and voluntary/charitable organisations, training resource for student nurses/midwives/health visitors and Graduate Mental Health Workers, to link with Maternal Mental Health Strategy development.
- 5.2.3 The PMHS Website will have a dedicated section on maternal depression with links to existing local and national resources for mild to moderate maternal depression and other relevant resources.
- 5.2.4 PMHS series of leaflets -
  - Postnatal depression and how to deal with it
  - Postnatal depression and how to deal with it: for partners and family
  - Postnatal depression and how to deal with it: medication

### 5.3 A SPECIALIST PERINATAL MENTAL HEALTH SERVICE

The Royal College of Psychiatrists has issued recommendations on the development of specialist perinatal maternal mental health services which can serve as a basis for service development in Gloucestershire<sup>25</sup>. The RCPsych recommendations outline the functions of a specialist perinatal mental health service (See *Functions of a Specialist Perinatal Mental Health Service* at Appendix I) and give details on how the material and human resources required for a specialist service can be estimated from the local annual birth rate and knowledge of the epidemiology of perinatal psychiatric disorders. The RCPsych also details the functions of a Perinatal Mental Health Strategy (See *Requirements of a Perinatal Mental Health Strategy* at Appendix J). The needs of all women with serious mental health needs, including perinatal depression, must obviously be considered as a whole when developing such a service, despite the fact that this strategy focuses on maternal depression.

The RCPsych guidelines on developing services include calculations that cover the provision of an in-patient mother and baby unit (or access to one), out-patient clinics, alternatives to admission (intensive home nursing and/or day hospital) and community treatment. Whilst day hospitals are traditionally not suitable for mothers and babies, day service provision in Gloucestershire is currently being redeveloped and new day services available from April 2006 will provide appropriate resources for managing women with maternal depression. There needs to be a discussion among key stakeholders about how perinatal mental health service provision will be developed in Gloucestershire. Should this be service redesign or the development of a separate specialist service requiring new resources and funding?

An admission to a mother and baby unit costs between £15,000 - £25,000. Based on the figures in Appendix C there would be approximately 36 admissions per year (with a probably few extra admissions of women with other mental health problems not covered in the categories given). This would require a 6-bedded unit with an annual cost to the county of £540,000 - £900,000. If such a service were not viable, could a 12-bedded unit be developed at Strategic Health Authority level to provide services for the region and with service level agreements with PCTs in other regions to buy the service when required? Another consideration is that although Gloucestershire's nearest Mother & Baby Unit in Barrow is currently unable to accept women requiring admission to a specialist perinatal mental health unit, this is a temporary situation that is anticipated will be resolved in 2007 following the Unit's relocation.

Other areas to consider are the role of the Early Intervention Service, the Crisis Resolution and Home Treatment Team and the development of specialist liaison health visitors, specialist liaison midwives, specialist liaison CPNs and social workers etc.

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<sup>25</sup> Royal College of Psychiatrists (2000) Perinatal Maternal Mental Health Services Royal College of Psychiatrists, London

The organisation of specialist mental health services is currently undergoing a period of change and there needs to be consideration and discussion about how the needs of women with depression and other mental health problems will be met as these services evolve. A key requirement will be a Consultant Perinatal Psychiatrist/General 'Adult' Psychiatrist with an interest in Maternal Mental Health.

Discussions also need to take place among key stakeholders regarding the provision of a specialist infant mental health service, also based on the Stepped Care Model.

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## 6. CLINICAL GOVERNANCE

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Evidence from all the following areas of clinical governance will contribute towards the evidence required by CHAI.

### 6.1 Risk Management (**Suicide prevention and child protection**)

- Reduced risk of maternal suicide/infanticide
- Reduced risk of paternal suicide
- Reduced CNST and litigation payments: Maternal depression, in its most severe form, and puerperal psychosis present an episode of increased risk for maternal and infant mortality and morbidity. There is a requirement for local implementation of national guidelines for the management of women who are at risk of a relapse or recurrence of a serious mental illness following delivery. This will not only improve care and outcomes for women and families but also benefit Trusts by reducing CNST and litigation payments.
- Reduced long term negative outcomes for children's cognitive, emotional, behavioural and social development with reduced demand/referral to CAMHS.
- Links with the National Patient Safety Agency Maternal Mental Lead and the CEMACH (Confidential Enquiry into Maternal and Child Health) supplementary report on maternal deaths due to psychiatric causes 2003-2005, which will examine morbidity/near misses as well as morbidity.

### 6.2 Research and effectiveness (**Evidence based best practice**)

- Delivery of evidence-based best practice for all ante/postnatal women.

### 6.3 Clinical audit (**Variance Tracking and evidence for CHAI**)

- Variance tracking or ‘live’ audit embedded in patient care record to deliver continuous improvements in care.

### 6.4 Patient and public involvement (**Planning around service users needs**)

- Women will be involved in ‘mapping the patient journey’ and there will be a women service user questionnaire as part of the care pathway development, ensuring that services are developed around women’s needs.

### 6.5 Education and training (**Professional development**)

- Staff training/continuing professional development in evidence-based best practice around perinatal maternal depression will contribute to evidence required by the Strategic Health Authority and Workforce Development Confederation.

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## 7. IMPLICATIONS

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There are a number of implications in the following areas that need to be addressed.

- Staffing
- Training
- Resources
- MDT working
- Clinical supervision

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## 8. CONCLUSION

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Perinatal Maternal Depression is the most common major complication in the postnatal period. It affects all aspects of a woman’s functioning and can result in both short and long term negative outcomes. A number of drivers for

change now provide a climate that underpins service developments that can make a major impact in planning and provision of care and services for this group of women. It is clear that the infrastructure to manage women with maternal depression within current services already exists in Gloucestershire. This strategy now presents a plan to drive the development and delivery of equitable, effective, evidence-based, multi-disciplinary, countywide services in Gloucestershire.

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## 9. RECOMMENDATIONS

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The following recommendations aim to ensure that the strategy will be implemented across the county.

- Approval by Gloucestershire Partnership Trust and PCTs with support at Board level.
- Specialist skills, standards and roles required to deliver the required level of service agreed by stakeholders.
- Key stakeholders engaged and ready to implement strategy (April 2005).
- Funding for service developments/commissioning new services to be presented to PECs (April 2006).
- Review dates to evaluate strategy in place (April 2006 and 2010).
- Evaluation of the strategy and its implementation / evaluate against NICE Guideline for Antenatal and Postnatal Mental Health when published (April 2007).
- Permanent specialist PMHS Maternal Mental Health Lead post to implement strategy.

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## 10. APPENDICES

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### **APPENDIX A: *CORE STANDARDS OF A PERINATAL MATERNAL MENTAL HEALTH SERVICE***

- 1 All health authorities should have in place a perinatal mental health strategy covering the care of women with perinatal mental health problems at all levels of health care provision.
- 2 All women who experience perinatal mental health problems should have access to suitable treatment at the level of health care provision appropriate to their needs.
- 3 All women with perinatal mental health problems should, if necessary, have access to a consultant psychiatrist with a special interest in perinatal psychiatry, supported by professionals with experience and skills in this area.
- 4 All women who require admission to a psychiatric unit following childbirth should be admitted to a specialist mother and baby unit.

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## **APPENDIX B: CONSULTATION PROCESS**

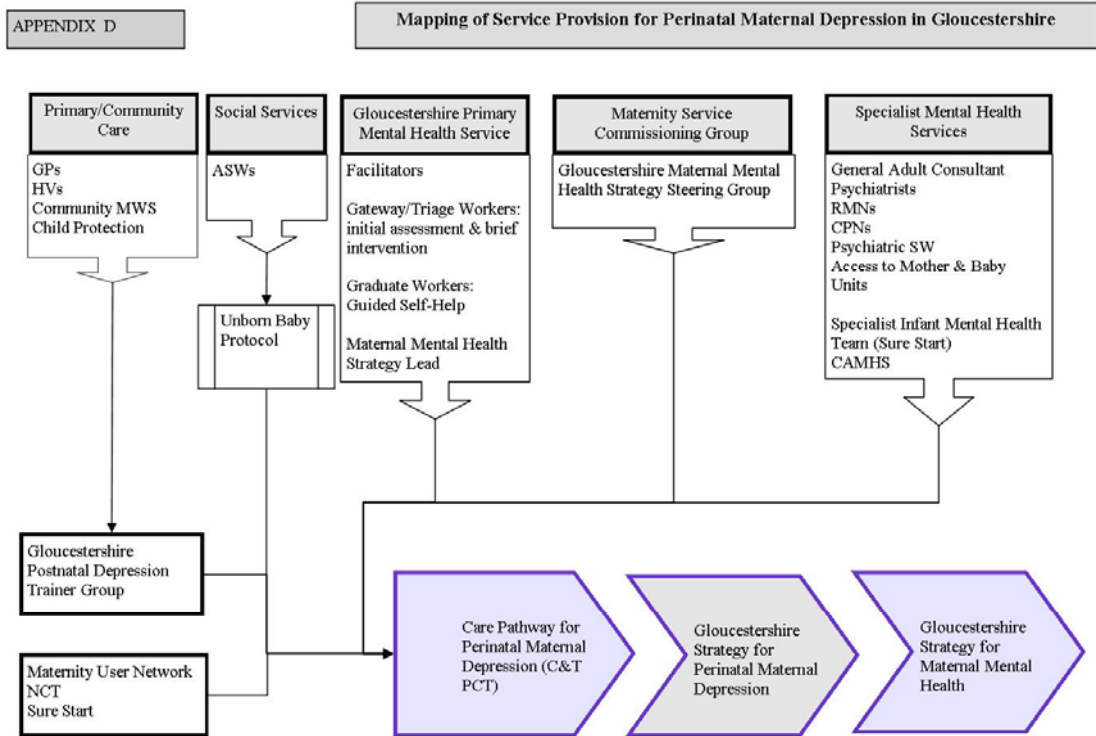
Mental Health Lead, C&T PCT: Jackie Prosser  
Mental Health Lead, WG PCT: Roger Haynes  
Mental Health Lead, C&V PCT: Dr Martin Freeman  
Lead Commissioner for Mental Health Services, C&T PCT: Andy Moore  
Lead Commissioner for Mental Health Services, WG PCT: Nicki Millin  
Lead Commissioner for Mental Health Services, C&V PCT: Nick Breakwell  
Midwifery Services Commissioner: Michelle Poole  
Consultant Obstetrician, Acute Hospitals Trust: Mark James  
Specialist Midwife, County Substance Misuse Service: Sally Unwin  
Lead Consultant Psychiatrist/Assistant Medical Director WAACG, GPT: Dr Chris Fear  
Consultant Psychiatrist, WAACG, GPT, Charlton Lane: Dr Beverley Arredondo  
Consultant Psychiatrist, WAACG, GPT, Wotton Lawn: Dr Jim Laidlaw  
Consultant Psychiatrist, County Substance Misuse Service, GPT: Dr Karen Williams  
Consultant Psychiatrist, Charlton Lane: Chandni Metha  
Women's Services Lead, GPT: Vicky Macdougall  
Children's Services Commissioner: Alison Melton  
Gloucestershire Postnatal Depression Trainer Group: Caroline Andrews, Pippa Howse, Rachel Webster, Pauline Pearson, Louise Page, Helen Thomas, Fiona Ritchie, Kerry Garbutt, Ellie Moore, Trish Butler.  
Integrated Care Pathway Project Coordinator, GPT: Jonathan Hill  
Child Psychologist, Sure Start/CAMHS: Robin Balbernie  
Lead Nurse Child Protection, Gloucestershire: Nuala Livesey  
Child Protection Lead CPN, GPT: Sally Forlong  
Patch Manager, Lead for Children & Family Services, C&T PCT: Cate Carrington-Green  
Health Visitor Development Group Lead, WG PCT: Susan Harvey  
Health Visitor Lead, C&V PCT: Sally Snowden  
PEC Nurses, C&T PCT: Theresa Cuthbert, Judy Richards  
PEC Nurses, WG PCT: Helen Moss, Susanne Noblett  
PEC Nurses, C&V PCT: Jan Jepps, Jane Smith  
Assistant Director, Public Health, C&T PCT: Steve Hams  
PCCAG IM&T Clinical Lead: Dr Robin Hollands  
Assistant Director, Public Health, WG PCT: Pat Diskett  
Deputy Director, Public Health, C&V PCT: Ruth Wain  
Sure Start Health Visitor, C&T PCT: Gill Newell  
Team Leader, Brownhill Centre, GPT: Helen Maplestone  
Facilitators, PMHS: Pete Carter, Rob Newman, Karl Gluck  
GP, Overton Park Surgery: Dr Sarah Moliver

## APPENDIX C: APPLIED EPIDEMIOLOGICAL DATA

Predicted number of cases per year in Gloucestershire.

Diagnosis	%age of deliveries	Total number of live and stillbirths: 2003			Total number of live and stillbirths: Gloucestershire maternity hospitals 2003 (6107)
		C&T PCT (1662)	C&V PCT (1871)	WG PCT (2574)	
<b>Postnatal depression</b> (of all women delivered)	10%	166	187	258	611
<b>Moderate – severe depression</b> (of all women delivered)	3-5%	50-83	56-93	77-129	183-305
<b>Referred to psychiatric service</b> (1.7% of all women delivered are referred to psychiatric services)	1.7%	28	32	44	104
<b>Admitted with psychosis</b> (2 per 1000 women delivered)	0.002%	3	4	5	12
<b>Admitted with non-psychotic depression</b> (2 per 1000 women delivered)	0.002%	3	4	5	12
<b>Relapse of severe/ chronic / enduring mental illness (predominantly chronic schizophrenia)</b> (2 per 1000 women delivered)	0.002%	3	4	5	12

## APPENDIX D: MAPPING OF SERVICE PROVISION FOR PERINATAL MATERNAL DEPRESSION



GloucestershirePerinatalMaternalDepressionServiceProvision/v1/strategydoc/Mar05

## ***APPENDIX E: THE GLOUCESTERSHIRE PND TRAINER GROUP: INFORMATION ON THE BACKGROUND OF THE STRATEGY***

In September 2002, eleven healthcare professionals (a PMHT Facilitator and postnatal depression trainers comprising health visitors/CPNs/RMN) from the three PCTs and the Partnership Trust formed the Gloucestershire Maternal Mental Health Group. The group realised that access to, and content of, training for health visitors across the Gloucestershire varied and that not all women at risk of, or suffering, postnatal depression had access to the same level of services. The aim of the group, therefore, was to standardise training in postnatal depression and the use of the Edinburgh Postnatal Depression Scale and ensure the provision of an equitable cross-county service for women at risk of, or suffering, postnatal depression. To date they have developed an electronic based training package and training is available cross-county, thereby making best use of scarce resources. The group has renamed itself the Postnatal Depression Training Group – a change that reflects the group’s focus on postnatal depression rather than the broader maternal mental health issues that the previous title suggested. The group continues to meet monthly to further develop the training related issues such as skill mix. Progress has been slow because of the low priority and lack of resources attributed to this specialty at an organisational level. Sharing knowledge, expertise and resources has been hindered because of geographical and organisational barriers to communication and simply not knowing ‘what else is happening out there’. Whilst this situation perpetuates gaps in service provision, and creates challenges in meeting women’s mental health needs and protecting infant mental health, there continues to be a strong will and keen enthusiasm to maintain and further develop this area of mental health promotion. Much has already been achieved and there is a solid foundation for future development.

**APPENDIX F: VARIATION IN PND TRAINER AND TRAINING ACROSS  
THE COUNTY**

	C&T PCT	C&V PCT	WG PCT
No. of specialist role health visitor PND Trainers	4	1	1
No. of specialist role CPN PND Trainers	1	2 contributing to training and supervision but not attended training to be a PND Trainer	0
%age of HVs trained in the use of the EPDS and non-directive counselling	100%		61%
Dedicated time or backfill for specialist role (specialist health visitor PND Trainers)	Yes	Yes	No
Dedicated time or backfill for specialist role (specialist CPN PND Trainers)			

## **APPENDIX G: MAP OF COUNTYWIDE PERINATAL MATERNAL MENTAL HEALTH SERVICES**

### **Countywide Perinatal Maternal Mental Health Services**

National Childbirth Trust  
Association for Postnatal Mental Illness telephone helpline  
Birth Trauma Association helpline  
Primary Mental Health Service Mental Health Toolkit & Resource Directory  
Primary Mental Health Service Self-Guided Help for Postnatal Depression (from April 2005)  
Primary Mental Health Service web page for Perinatal/Postnatal Depression  
NHS Direct  
Family Centres/Sure Start initiatives  
GDAS  
Domestic violence helpline  
Samaritans

#### **Cheltenham & Tewkesbury PCT Perinatal Mental Health Services**

- Postnatal Depression Support Group (from May 2005)
- Direct GP referral to Samaritans (from April 2005)
- Referral to Primary Mental Health Service Gateway/Triage Nurses (Phase Two from April 2005)
- Sure Start Infant Mental Health Service

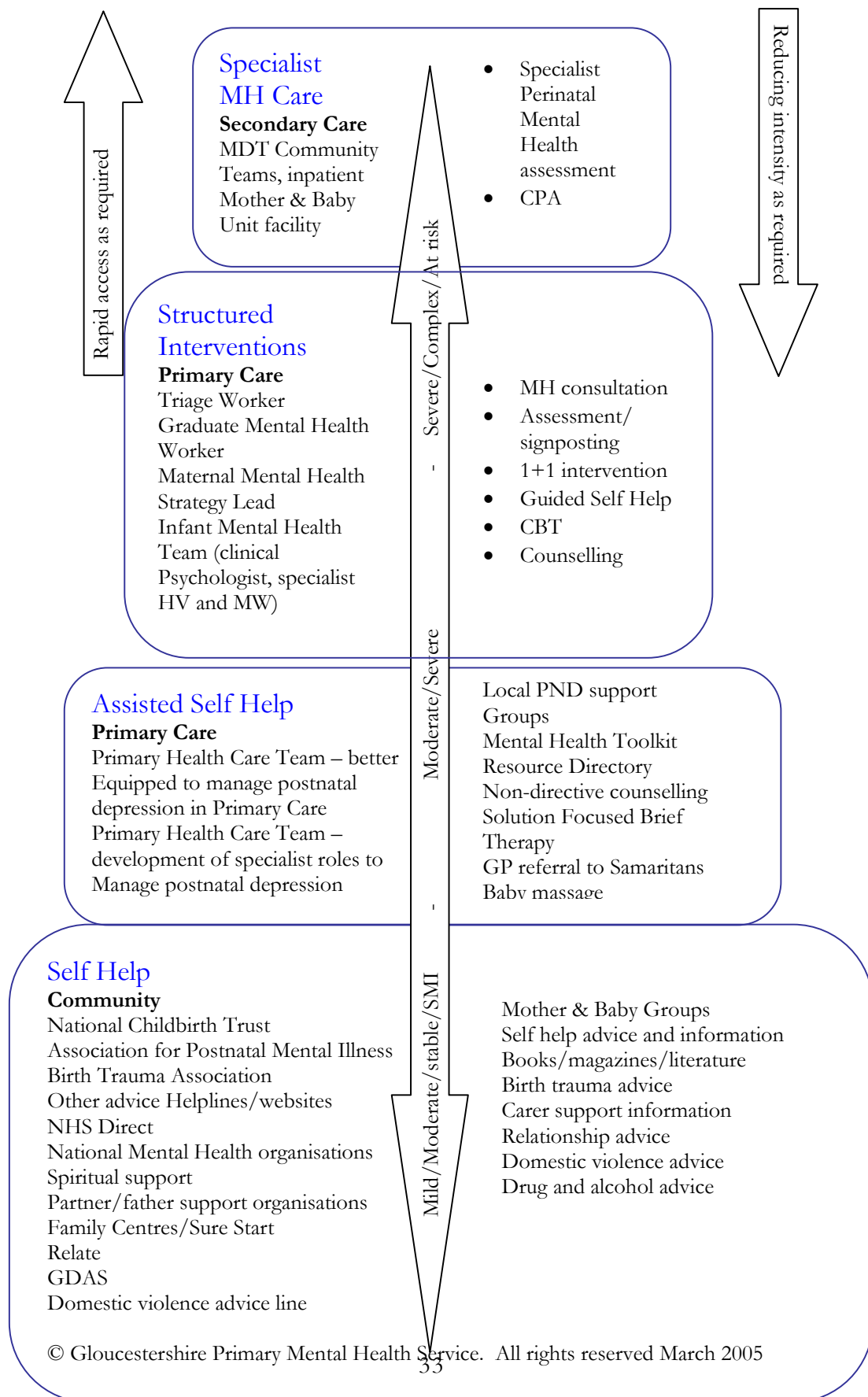
#### **Cotswold & Vale PCT Perinatal Mental Health Services**

- Referral to Primary Mental Health Service Gateway/Triage Nurses (Phases Two, Three and Four from April 2005)
- Homestart
- Postnatal Depression Support Group (NCT, from April 2005)

#### **West Gloucestershire PCT Perinatal Mental Health Services**

- Russet House
- Referral to Primary Mental Health Service Gateway/Triage Nurses (Phase Two from April 2005)
- Forest of Dean Group for women with severe and enduring mental illness
- Postnatal Depression Support Group

**APPENDIX H: *STEPPED CARE APPROACH TO PERINATAL DEPRESSION***



## **APPENDIX I: *FUNCTIONS OF A SPECIALIST PERINATAL MENTAL HEALTH SERVICE***

- 1 It will assess and manage those suffering from puerperal psychosis and other severe postnatal mental illnesses.
- 2 It will provide a range of facilities for their management, including an in-patient mother and baby unit (or access to one), out-patient clinics, alternatives to admission (intensive home nursing and/or day hospital) and community treatment.
- 3 It will advise on and, if necessary, manage patients with continuing psychiatric disorder who become pregnant while under the care of other adult psychiatrists.
- 4 It will liaise with primary health care professionals to assist in the management of less serious psychiatric conditions.
- 5 It will provide an obstetric liaison service, assessing mental health problems associated with pregnancy and the post-partum period and dealing with emergencies.
- 6 It will provide prenatal counselling and high-risk management for women at risk of developing an illness post-partum owing to previous major mental illness.
- 7 It may undertake the assessment of women with severe chronic mental illness in respect of the ability to parent their child.

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## **APPENDIX J: *REQUIREMENTS OF A PERINATAL MENTAL HEALTH STRATEGY***

Requirements of a perinatal mental health strategy:

1. A comprehensive overview of all services and facilities involved in perinatal mental health. This is needed to establish a framework for cooperation and efficient management of disorder to avoid duplication of services and for the commissioning of new resources.
2. The identification of a lead consultant psychiatrist with a special interest in perinatal psychiatry. This individual will not only take forward the development of specialist psychiatric provision to this group of patients but also contribute to the management of perinatal mental health problems at other levels of health care provision.
3. Care that is informed by research and the best current clinical practice. This evidence should inform general principles of care, from which will be developed core standards of care. These in turn inform the way in which services are delivered to the local population. The specific design of services and the way in which they are delivered will depend on not only the core standards of care but also local considerations such as size of the population and the birth rate, the sociogeographic and socioeconomic profile of the catchment area, existing service provision and the style of mental health service delivery in the area.

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## 11. ACTION PLAN

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**SHORT TERM PLAN:** One year (Target April 2006)

**LONG TERM PLAN:** Five year (Target April 2010)