Embedding PIMH care and research into primary care obstetric service

A ‘ONE STOP SHOP’ FOR FAMILIES IN WA

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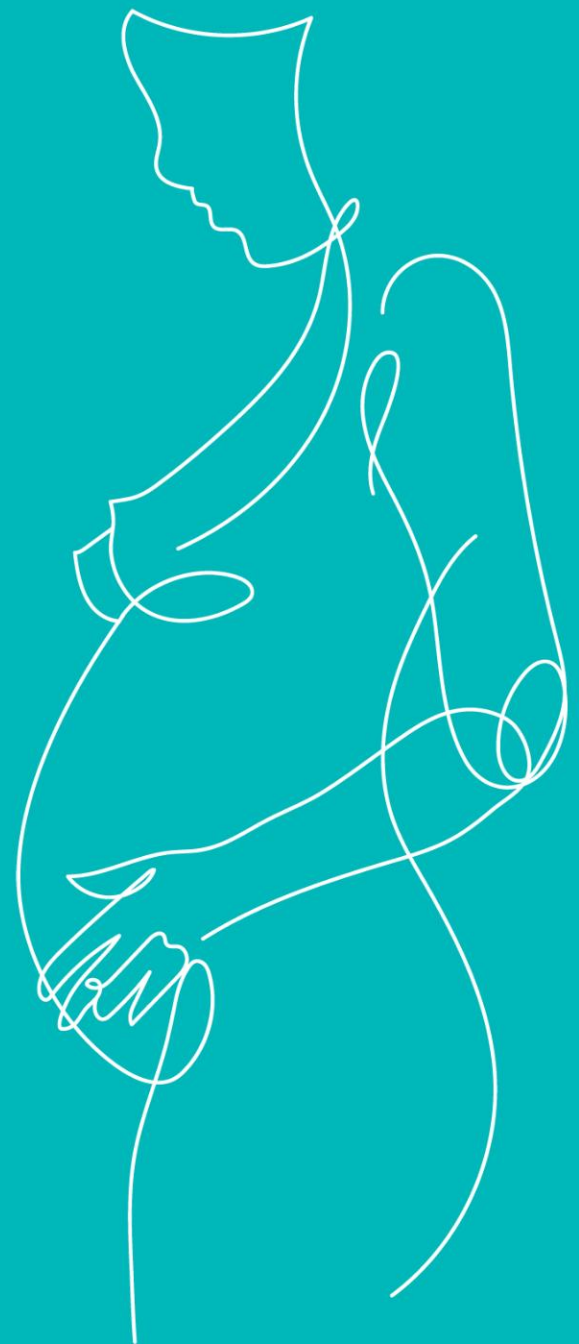


BACKGROUND

- Depression has a prevalence of 9% in pre-natal women and increases to 16% of postnatal women
- In 50% of the cases of postnatal depression, symptoms were present in the antenatal period, in may cases undetected and not acted upon
- We know that perinatal mental health issues have a significant effect on the ‘family’- with depression impacting on the development of the attachment between the mother and her infant. The first few months are critical for the future health and wellbeing of children
- There is recognition that early identification and intervention leads to significantly improved outcomes in perinatal mental health
- Only 50% of women with PIMH issues have treatment

THE BIRTH OF ONE FOR WOMEN

- One for Women is a multidisciplinary clinic that commenced in Feb 2019.
- The clinic has introduced a team based approach to care, with a focus on education, screening and early intervention.
- The antenatal and postnatal care is provided by a team of midwives, GP obstetricians and Specialist Obstetricians
- They are supported by Perinatal Mental Health providers (Elizabeth Clinic), Lactation providers (GP lactation expert and lactation consultants), women’s health physiotherapists, dietitian and diabetic educators.

WHAT WE DO DIFFERENTLY - ANTENATALLY

- CONTINUITY OF CARE. The same providers care for the patient throughout the perinatal period (from antenatal, to intrapartum and through to the postnatal period).
- ONE LOCATION- recognising that many presentations are complex and have elements of different specialties that need to be addressed in unison- ie the unsettled infant may be due to feeding issues and underlying perinatal mental health concerns
- EDUCATION AND EARLY INTERVENTION-emphasis on education and early intervention- each of our antenatal appointments are 20-40 minutes in length
- PATIENT CENTRED-actively involve the patient in their care

WHAT WE DO DIFFERENTLY - INTRAPARTUM

- LOWER INTERVENTION-continuity of care and rostering of our specialist leads to lower intervention
- MEDICALLY INDICATED IOL-We discourage induction of labour, unless medically indicated, prior to 39 weeks- recognising the importance of the whole nine months on development outcomes and breastfeeding outcomes
- LOWER CAESAREAN RATE-We believe that lower intervention rates and the rostering of specialists will lead to lower caesarean section rates
- BIRTH PLANNING-We actively embrace birth planning and work with patients to set realistic expectations
- BIRTH EXPERIENCE-Our objective is to improve the birth experience- recognising the importance of perception of birth experience on perinatal mental health

WHAT WE DO DIFFERENTLY - POSTNATALLY

- CONTINUOUS INVOLVEMENT-We believe in the importance of continuous involvement in the postnatal period, rather than a solitary appointment at 6-8 weeks.
- HOME BASED CARE- Patients are followed up at home within the first week of birth by one of the OFW Visiting Midwives - this is to assess adjustment post delivery, to check on feeding and importantly to check on the mother-baby attachment and maternal mental health
- EARLY INTERVETION-We believe in early intervention - both mother and baby have an early intervention two week check, in which mental health assessment is a key component of the assessment

WHAT ARE THE KEY PARTS OF THE OFW APPROACH TO PIMH?

- Education
- Screening
- A comprehensive mental health assessment schedule
- Streamlined referral pathway with the Elizabeth Clinic
- Psychologist and visiting psychiatrist at the OFW clinic

EDUCATION

- We believe in the importance of education and early intervention.
- As such there is an emphasis on education, including:
  - PREVALENCE: Discussion of the prevalence of mental health issues in pregnancy- including discussion around symptom recognition and
  - SETTING EXPECTATIONS: As part of preparation of parenthood education session there is discussion around expectation and the impact of parenthood on relationships. As part of this workshop we talk about resilience and the importance of establishing a support network
  - POSTNATAL PLANNING: In the later part of pregnancy we undertake postnatal planning and develop a mental health toolkit- this includes mindfulness, support network, emergency plan and a reflection on existing strategies for dealing with mental health challenges.

SCREENING

- We utilise both the Elizabeth Clinic Screening Tools - Growing Together, Maternal Experience and Coming Together Questionnaires - and the EPNDS
- We also undertake brief intervention at each appointment. The brief intervention questions that are utilised are:
  - ‘Since your last visit how have you felt about your pregnancy’.
  - ‘Is there anything that is making you feel upset, tense or panicky’
  - ‘Since your last visit, have you been as happy as you were at your last visit’.
- Importantly, as we are delivering care with the same providers - subtle changes can be detected and acted upon.

OUR MENTAL HEALTH ASSESSMENT OUTLINED

- Initial visit: assessment of risk of mental health issues- this is loosely based on the ANRQ and includes assessment of previous mental health issue, recurrent pregnancy loss, significant life events, low income or financial stressors, lack of support, low self esteem, negative cognitive style and previous sexual abuse (if disclosed). An initial EPNDS is completed
- At 24 weeks the EC Growing together questionnaire is completed
- At 28 weeks the EPNDS is repeated
- At 32 weeks the EC Growing together questionnaire is repeated
- At 36 weeks the EPNDS is repeated
- In between, brief intervention is undertaken

IN THE POSTNATAL PERIOD

We recognise the importance of early intervention. As such we undertake an early intervention two week appointment in which we assesses:

- A - Adjustment. With a particular focus on fatigue. A key question is whether they can settle quickly when their baby is asleep
- B - Breasts and feeding
- C - Coping. Both the EPNDS and EC-Mother Experience questionnaire completed. The questionnaire is undertaken as a conversation style rather than being given to patient to complete
- D - Down there. Physical recovery after birth

STREAMLINED REFERRAL PROCESS

- All patients who have risk factors on initial assessment or who develop mental health issues through the perinatal period are referred to the Elizabeth Clinic via a streamlined referral process
- Once a referral is received by the Elizabeth Clinic, patients are offered a comprehensive perinatal and infant mental health assessment and an initial management plan
- The initial assessment is undertaken by the assessment team at the Elizabeth Clinic.
- If psychologist input is required, either the patients General Practitioner or OFW can complete a mental health care plan

WHAT ARE THE INITIAL FINDINGS?

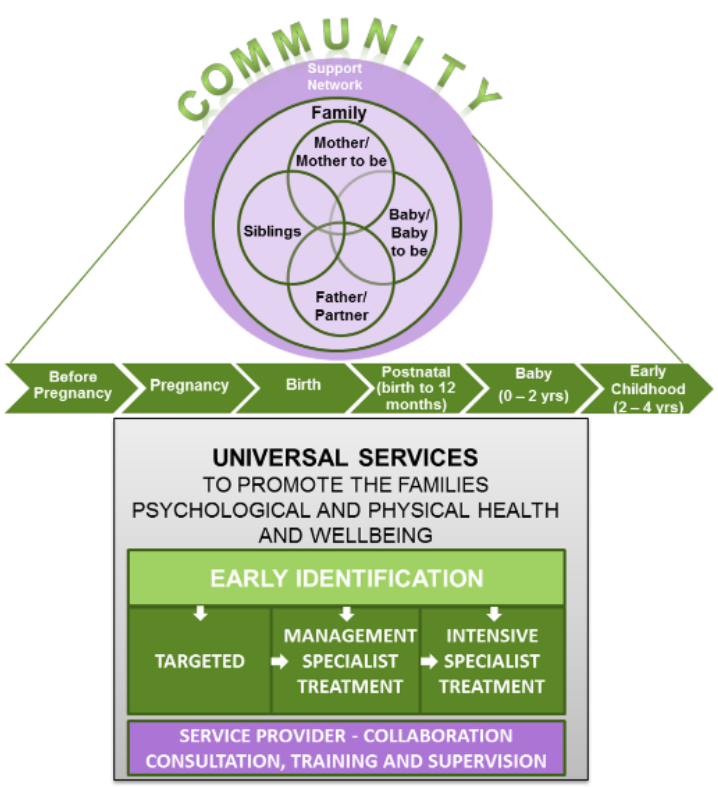
- The Elizabeth Clinic Questionnaires are very effective at identifying those patients that require referral.
- The GP Obstetricians and GP lactation providers at OFW are very experienced in managing perinatal mental health issues - early intervention has led to the resolution of issues prior to them becoming problematic
- The education and support in the antenatal period has been very effective in preventing postnatal mental health issues
- The continuous involvement (and support) in the postnatal period has led to lower incidence of postnatal mental health
- There has been a high level of referral for psychologist input in the antenatal period- the commonest cause being a previous history of postnatal depression but only two referrals in the postnatal period (both patients attended OFW for postnatal care only, neither delivered via OFW)

WHAT ARE THE FUTURE RESEARCH PLANS?

- We are looking at the postnatal outcomes of patients who are managed through One for Women. We are looking at breastfeeding rates, perinatal mental health outcomes, birth outcomes and overall patient satisfaction
- We are looking at validating the Elizabeth Clinic Questionnaires as a screening tool for perinatal mental health

PERINATAL AND INFANT MENTAL HEALTH

Figure 1: Perinatal and Infant Mental Health Conceptual Model



THE ELIZABETH CLINIC

CARING FOR YOUNG FAMILIES

Embedding PIMH Care & Research into a Primary Care Obstetric Service - a one-stop shop for families in WA

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Australasian Marce Society Conference 12th October 2019, Perth WA

Origins of the Elizabeth Clinic Questionnaires

- Clinically driven
- WA PIMH MOC, ACOG, NICE, & Australian Perinatal Guidelines support a woman-centred approach
- Concerns about maternal reticence to seek help
- Stigma
- Very low take up of services
- Preliminary research

Elizabeth Clinic PIMH Questionnaires

In pregnancy:

GROWING TOGETHER QUESTIONNAIRE (GTQ)

1-14 days postpartum:

MOTHERS' EXPERIENCE SURVEY (ME)

2 weeks to 15 months postpartum:

COMING TOGETHER QUESTIONNAIRE (CTQ)

Elizabeth Clinic PIMH Questionnaires

Purpose:

1. To examine risk for perinatal depression and anxiety
2. To examine risk for a parent-infant relationship problem (disturbance to the developing attachment relationship)
3. To provide a non-stigmatising way of engaging mothers (and fathers) in early identification of problems, and in early help-seeking
4. To prevent the development, or worsening of perinatal depression and anxiety, and problems in the parent-infant attachment relationship

Elizabeth Clinic PIMH Questionnaires

Questionnaire content:

- Anxiety/Depression: Recent feelings of being tense, panicky, or having low mood, birth-related trauma
- Caring for, being with, and comforting baby
- Perceived support: professional, social, self-efficacy, and worries about partner's well-being
- Specific questions and phrasing included about worries related to pregnancy, peri-partum period, and first postpartum year
- Questionnaires can be adapted for multiple birth, and to gauge fathers' feelings about the pregnancy and baby

Elizabeth Clinic PIMH Questionnaires

Using the questionnaires:

1. Self-report questionnaire
2. Aimed for use in primary health, as well as specialist settings
3. Uncomplicated and quick to score
4. Best used within 12-24 hours of completion
5. Allow for targeted discussion of issues that mean a lot to mothers in the transition to parenthood with a new baby (throughout the perinatal period), while avoiding stigmatising labels around mother's mental health
6. Require knowledge of local resources for appropriate referral

Preliminary research

- Perinatal Experience Study (PES) 2011

  Trial of first questionnaire – 6mths longitudinal study

- Week One Study

  Retrospective case-note audit 2010 – 2014 (n=340)

- Take Up of Postnatal Services (TUPS) Pilot study

  Retrospective anonymous online study

- Development of the PES (PES-D) Study

  Development and validation of the ME & CTQ

Scoring the Questionnaires

- 12 Questions
- Scored 0 to 3, like the EPDS
- Does not show a score, but problem areas can be seen at a glance
- A score of 2 or 3 on any item should prompt further discussion with patient
- No reversals
- Designed to be woman-friendly and personal
- Questions about partner wellbeing & holding baby can be left unanswered, but if so, each automatically scores 3
- No obvious place for a total score on the form

Scoring

Example from MOTHERS' EXPERIENCE SURVEY (ME)

I would describe my birth experience as:

- ☐ Quite easy
- ☐ Difficult at times
- ☑ Traumatic at times
- ☐ Traumatic overall

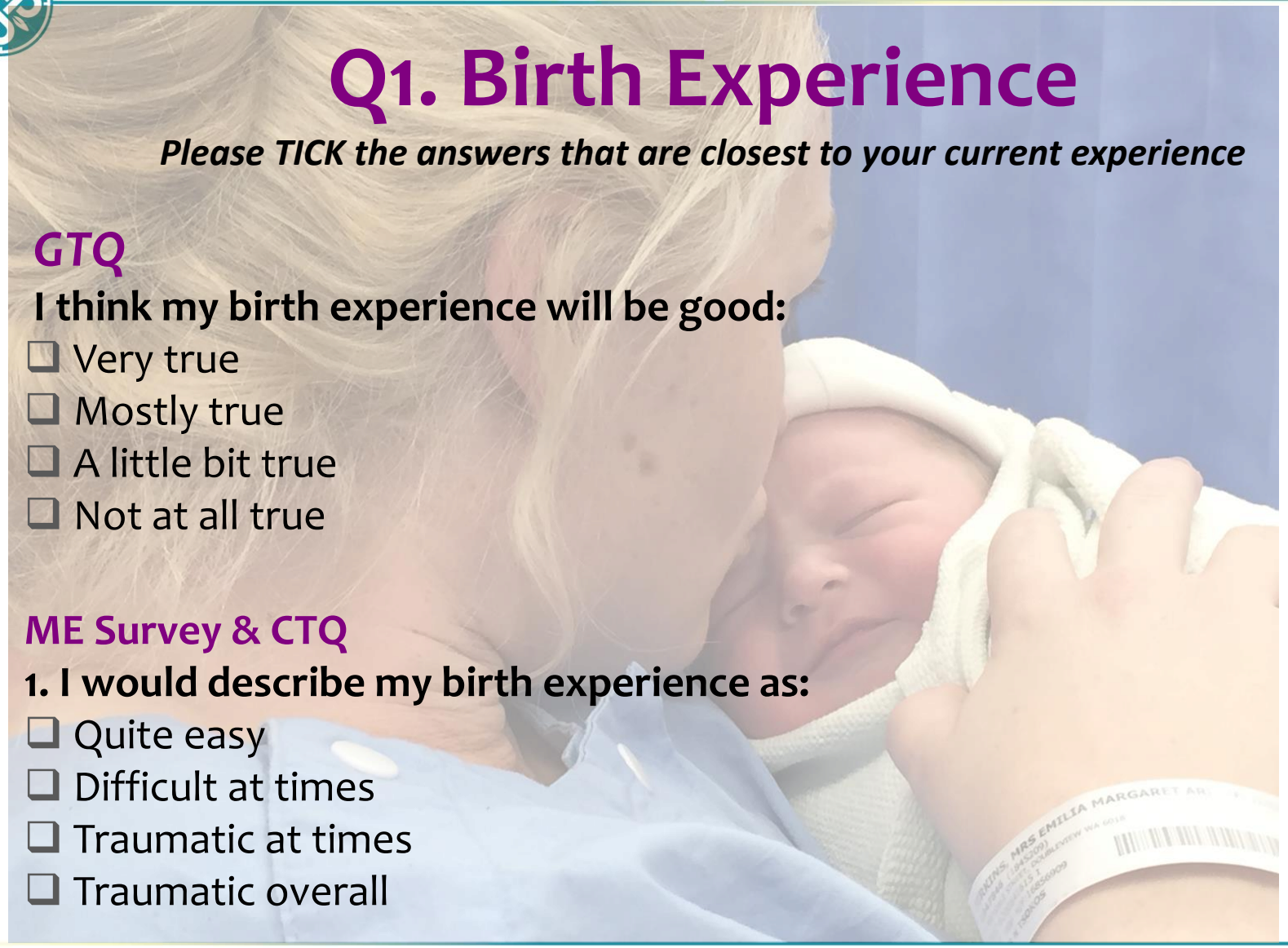
CLINICIAN: _____

(Potential highest score = 36 e.g. 6/36)

☐

Q1. Birth Experience

Please TICK the answers that are closest to your current experience



GTQ

I think my birth experience will be good:

- ❑ Very true
- ❑ Mostly true
- ❑ A little bit true
- ❑ Not at all true

ME Survey & CTQ

1. I would describe my birth experience as:

- ❑ Quite easy
- ❑ Difficult at times
- ❑ Traumatic at times
- ❑ Traumatic overall

Q2. Feeding Baby

GTQ:

When I think about feeding my baby, I feel worried:

- ❑ Never
- ❑ Sometimes
- ❑ Quite often
- ❑ Always

ME:

2. Feeding my baby has been:

- ❑ Going really well
- ❑ Going well with a few challenges
- ❑ Not going well a lot of the time
- ❑ Not going well at all

CTQ:

Feeding my baby has been:

- ❑ Not stressful
- ❑ Mildly stressful
- ❑ Stressful, but getting better
- ❑ Very stressful

What comes next?

FURTHER RESEARCH PLANNED:

- Trial of ME Survey with postpartum mothers in Doha
- Trial of questionnaires in community settings
- Focus groups and Key Informant Interviews to refine wording of GTQ
- RCT using ME and GTQ in hospital settings

- And more in the planning ….

What comes next?

SURVEYS AVAILABLE FOR USE WITH PIMH POPULATIONS:

- Surveys freely available, but not to be shared without permission
- Further more detailed training available for clinicians
- Written guides for using questionnaires available with further training
- Services need to develop (and maintain) a local resource list
- Services using the questionnaires must be prepared to participate in research to assist with validation:
  - Use HREC-approved protocols
  - Share de-identified data