PRE-BIRTH PLANNING MEETINGS:

SERVICE INTEGRATIONS FOR WOMEN WITH MODERATE/SEVERE MENTAL HEALTH ISSUES; IMPROVING OUTCOMES FOR WOMEN AND THEIR BABIES.

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ANP Perinatal Mental Health

- Mental Health Nurse for over 20 years
- Worked in a variety of settings in Ireland and Australia
- Trigger for interest in perinatal mental health
- CNS in perinatal mental health for 2 years
- Candidate then registered ANP in past 16 months
- Caseload: women with a previously diagnosed MMI (BPAD, Schizophrenia, schizoaffective, major dep disorder, in patient adm, significant suicide attempt). Ideal caseload ~25, current caseload ~45.

Presentation Overview

- Perinatal Mental Health Services
- Perinatal Mental Health Issues
- Profile of women, profile of our communities changing
- What is a pre birth planning meeting
- Who/what services attend and why
- Format of meeting
- Why prioritise this cohort of women?
- Example of integrated care; Pre Birth Planning Meeting for a woman with diagnosis of BPAD
- How integrated care improves services for healthcare staff
- How integrated care improves services for the women who access our service
- How do we support the woman going through this process
- What women tell us
- Next steps

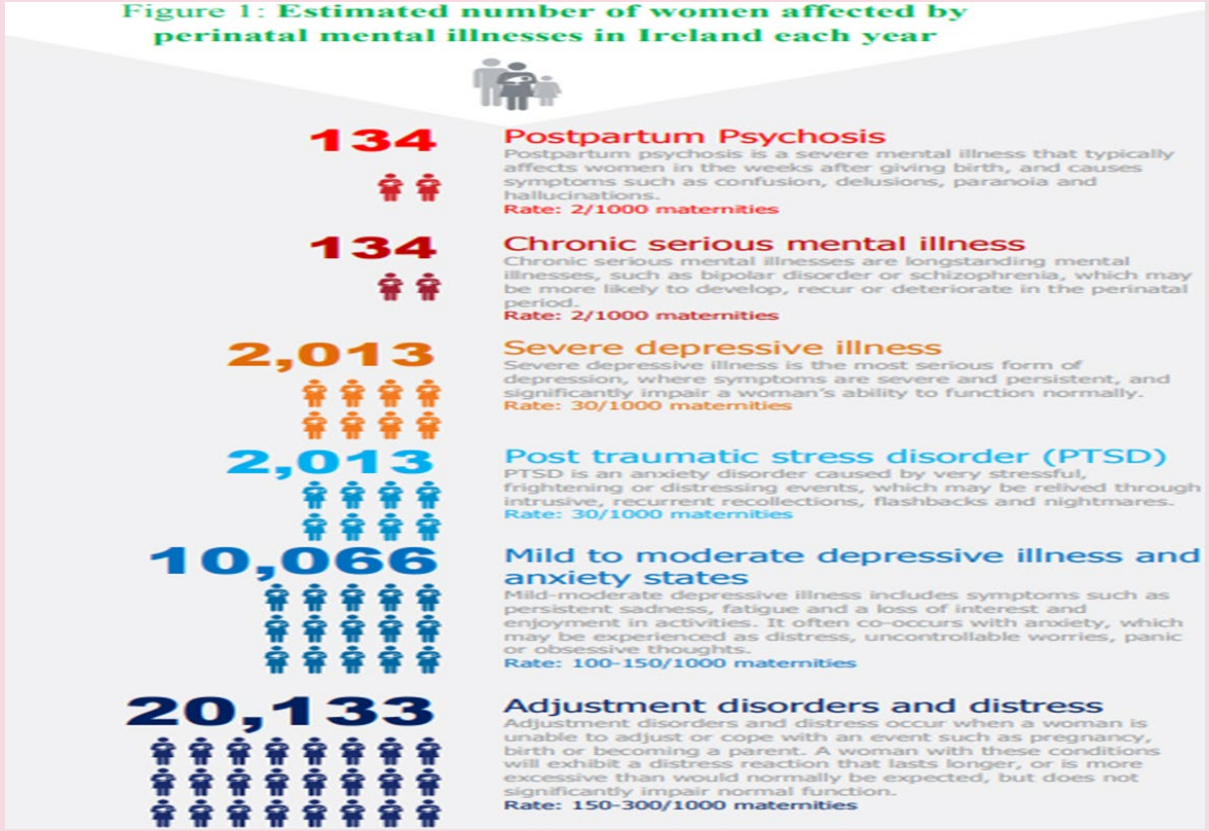
Perinatal Mental Health Services

- Set up from Model of Care in 2017, Limerick was first team outside of Dublin in 2018
- Services set up as hub and spoke model with 7 hubs in the hospitals with highest birth rates.
- Work in an MDT format, with bot community and liaison responsibilities.
- Catchment: Limerick city and county, Clare, Tipperary. Women on the borders of Cork, Kerry, Offaly, Port Laois and Galway who choose to have their obstetric care in UMHL also have access to our service.
- Referrals from ANC, GP, CMHT, in patient wards; pregnant or up to 6/12 postpartum.
- Average around 1000 referrals per year.
- Open caseload 265
- Can be referred for pre conception advice

What are Perinatal Mental Health Issues?

- Perinatal mental health disorders are those which complicate pregnancy (antenatal) and the first postnatal year.
- Approx. 1 in 4 women will experience a perinatal mental health issue with the most common ones being anxiety and/or depression.
- They include both new onset and a relapse or reoccurrence of pre existing disorders.
- Longitudinal research demonstrates the potential of perinatal mental health issues to affect the relationship between mother, child and family unit with consequent later development of significant emotional and behavioural difficulties in the child.

Incidence of Perinatal Mental Health Issues



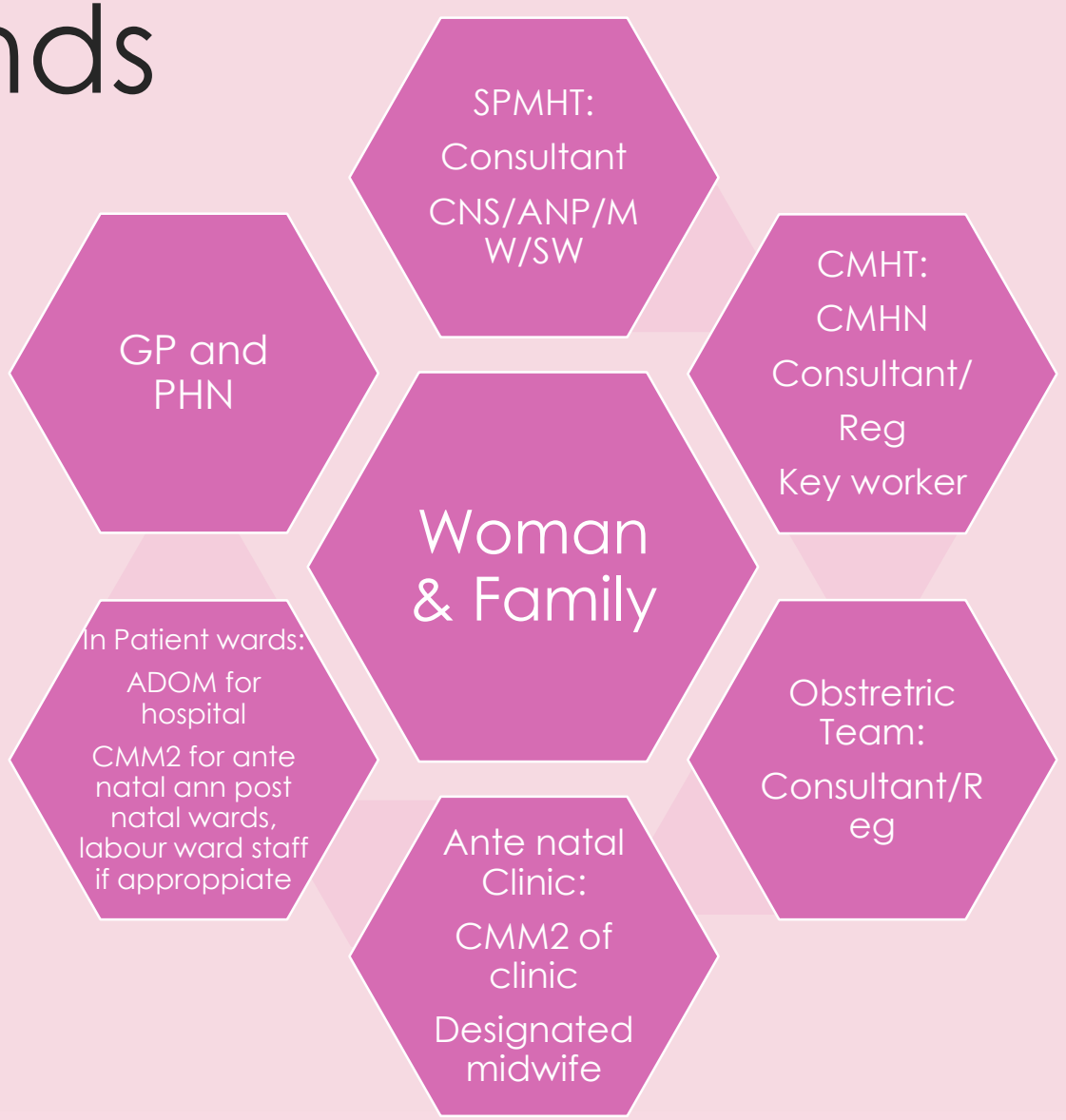
Profile of Women & Profile of our Communities Changing

- Traditionally women with these mental health issues were advised not to become pregnant due to risks of relapse and medications causing issues for baby.
- Medications and interventions have improved so women with these conditions have better quality of life, are more likely to have job, relationships etc……this is true across spectrum of conditions such as CF, diabetes, auto immune conditions.
- Traditionally GP, PHN, CMHN all familiar with each other, all familiar with the woman and her family.
- Our communities are different, HCP less familiar with the community, moved around a lot etc.
- This means we need to formalise many of the supports that were previously there but on a less formal basis.

What is a Pre Birth Planning Meeting?

- Pre-birth planning meetings are an essential means of bringing services together to form a strong safety net for vulnerable women
- As we are a relatively new service we look to our UK and Australian counterparts, and we draw from initiatives that have worked well for them
- Resource intensive
- Offered to women with more severe mental illness.
- Empowering the woman in her own care
- Sharing information so each person understands the risks, responsibilities and action plans
- **16 meetings, 14 women over the past 4 years. 1 relapse and hospital admission for 3 week duration.**

Who Attends


SPMHT:
Consultant
CNS/ANP/MW/SW
GP and PHN
CMHT:
CMHN
Consultant/ Reg
Key worker
Woman & Family
In Patient wards:
ADOM for hospital
CMM2 for ante natal ann post natal wards, labour ward staff if approppiate
Obstretric Team:
Consultant/Reg
Ante natal Clinic:
CMM2 of clinic
Designated midwife

- Other services as required; e.g. Family Resource Centre, Tusla, Barnardos

- Coming together to collaborate between services, assign keys responsibilities, gain commitments for ante natal, in patient and postpartum care
- Ideally in person but more practical for some to ring in e.g. GP/PHN.

Format of Pre Birth Planning Meeting

- Specific format; **woman's history** (presented by the woman or her key worker on her behalf), outline of risks and times of increased vulnerability (day 3-4 postpartum)
- **In pt. setting:** how to best meet her needs in clinic, plan for admission to have baby, plan for ante natal care, labour care and postnatal ward care. Accommodations that can be made.
- **Out pt. setting;** PHN, GP, SPMHT, CMHT assigning responsibilities
- Establishing **clear pathways** for services should there be a change or concern
- Everyone gets copy of minutes, woman holds her own copy, inserted into notes.
- Assigns key roles, responsibilities
- **Establish relationships** between HCP, and with woman and her family, for common goal
- Clear **contact details.**

Why Prioritise this Cohort of Women?

- Women with MMI such as BPAD have:
- 1 in 3 chance of relapse, more recent studies suggest 1 in 2 due to the way data is reported/collected.
- **Consequences of relapse;** hospital admission, often involuntary, no M&B unit, separated from baby. Consequences for family in terms of caring for baby. Bonding with baby impacted.
- If they relapse; exceptionally high risk of postpartum psychosis
- **Almost 100% of women who develop PP are adm to APU**
- **5% of women end their life by suicide**
- **4% of women commit infanticide**

Case example: Kathleen

- Kathleen is 32 years old with a long term diagnosis of BPAD since age of 19 years.
- 7 admissions to acute mental health units, 1 of these were involuntary, mean duration was 12 weeks.
- Last 8 years is mentally stable with no acute episodes; treated with Lithium 800mgs per day.
- Full time employment, responsible job. Married. Carer for her mother. Active in her own community.
- Pregnant and very happy to be pregnant
- At significant risk of relapse of BPAD

How integrated care improves services for healthcare services & staff

- *Huge cost savings for services; specifically in respect of future needs of baby*
- *Reduced hospital bed days (longer obstetric admission by 3 days versus 84 day acute psychiatric admission)*
- *Staff involved feel they have increased understanding and knowledge which increases their confidence when working with these women*
- *Staff feel they are part of something positive and meaningful, remind us why we came into healthcare; to do good*

How integrated care improves services for the women who access our service

- *Prevent avoidable relapses (BPAD has relapse risk of 1:2 to 1:3 in PP period)*
- *Prevent avoidable admissions, no MBU in Ireland, acute admission, separates mother from baby (7 previous admissions, one invol)*
- *Decrease impact for woman, family and baby (baby cared for by its mother, reduced trauma to all)*

How do we support the woman going through this process?

- Key worker from SPMHT
- History prepared well in advance
- Woman can decide to be there or not for this section
- Women can decide to present their own history or key worker can present it.
- Walk in and out with key worker to reduce intimidation.

What women tell us

- *"The support I received for my mental health was phenomenal, especially after the pre-birth planning meeting, I felt really safe from that point on. My baby is 10 weeks old and thriving, I am well and I get to enjoy being a mother, like every woman hopes for."*

Next Steps

- Kathleen consented for her case to be written up as a case study for publication in a journal. ANP collaborated with a lecturer from UL and Consultant Perinatal Psychiatrist. Recently accepted for publication with the British Journal of Midwifery.
- Identified a need for future research in this area and is part of the 2024/2025 plan. Very achievable given the numbers of women involved. Study likely to focus on the woman's experience of the pre birth planning meetings. We aim to use this research to inform future practice.

Questions/Comments

References

- Health Services Executive (2017) Best Practice Guidance for Mental Health Services; Supporting you to meet Regulatory Requirements and Towards Continuous Quality Improvement, Dublin: Health Services Executive.
- Moore L. The development of Health Services Executive Best Practice Guidance for Mental Health Services in Ireland. International Journal of Integrated Care. 2017;17(5):A14. DOI: http://doi.org/10.5334/ijic.3315
- National Mental Health Division (2017) 'Specialist Perinatal Mental Health Services; A Model of Care for Ireland', Health Service Executive, available:https://www.hse.ie/eng/services/list/4/mental-health-services/specialist-perinatal-mental-health
- O'Hare, M.F., Manning, E., O'Herlihy, C. on behalf of MDE Ireland (2015) Confidential Maternal Death Enquiry in Ireland: Report for 2009-2012, Cork: Hackett Retrographics.

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