**Appendix 2**



**‘Empowering primary care practitioners to effectively predict, detect and manage PMI to ensure pregnant and postnatal women’s optimum mental health’**

**Final Report 8 June 2015**

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**‘Empowering primary care practitioners to effectively predict, detect and manage PMI to ensure pregnant and postnatal women’s optimum mental health’**

**Final report**

**Background**

Perinatal Mental Illness (PMI) is acknowledged as a significant global problem and an important public health issue. There is now a firm policy remit for PMI in its broadest sense and across the maternity spectrum.

Identifying and treating PMI in primary care settings is an important part of women’s health care; however this is often complex and challenging. The negative impact of maternal depression on both the mother and baby highlight the importance of managing maternal depression accurately and effectively in primary care (Leiferman et al 2008). It is therefore important that General Practitioners (GPs) and other front line primary care staff, who come into contact with pregnant women and new mothers, are familiar with the risk factors, diagnostic criteria, and management of mental health issues that may arise in the ante- and postnatal period. Accurate and timely diagnosis of PMI by primary care staff is essential in determining appropriate treatment and preventing future episodes. Evidence, however, suggests that current practice falls short of this goal (McCauley & Casson 2013).

GPs and other primary care practitioners will see women who refer themselves for PMI or who have been identified by the midwife or health visitor (HV). They may treat uncomplicated non-psychotic depression and anxiety themselves or refer to IAPT (Improved Access to Psychological Therapies). For complex or serious disorders, they may refer to perinatal mental health (PMH) services, or in their absence, adult services (Joint Commissioning Panel of Mental Health [JCPMH] 2012). GPs have been working with women with PMI for years, but there is little published work on the role played by GPs in the management of PMI; of the few published studies available it is noteworthy that the focus of this research is PND only and not PMI more broadly.

Lack of training and the need for further training in PND is a key theme and a recommendation across a number of studies (Chew-Graham et al. 2008, McCauley & Casson 2013, Stanley et al. 2006, Milgrom et al. 2011, Leiferman et al. 2008, Leddy et al. 2012). Chew-Graham et al. (2008) explored GPs’ and HVs’ attitudes towards women with PND and management in primary care, and findings demonstrate that specialised services can improve care through the introduction of protocols, care pathways, educational initiatives and training for primary care teams.

**Aims and objectives**

The main aim of this study was to empower primary care practitioners to effectively predict, detect and manage PMI to ensure pregnant and postnatal women’s optimum mental health. The specific research outcomes were:

* to identify practitioners’ illness perceptions in relation to PMI
* to determine the impact of training on the components of knowledge and illness perceptions in relation to PMI
* to determine whether training assists practitioners to deal with PMI more effectively in clinical practice
* to establish the usefulness of an adapted IPQ-R (Illness Perception Questionnaire – Revised) to identify illness perceptions of PMI amongst practitioners
* to make recommendations to support and underpin the development of effective training packages for PMI for practitioners
* to work with the Hull CCG to develop links to ‘Map of Medicine’ to provide practitioner’s with access to advice and prescribing information for women with PMI

**The study**

***Intervention***

Primary care practitioners (GPs and Practice Nurses) were invited to attend three training sessions provided by the Hull and East Yorkshire Specialist Perinatal Mental Health (PMH) team. The training sessions were standardised and co-delivered by a Consultant Psychiatrist in PMH and a senior PMH nurse. The training covered a broad range of issues in line with the study objectives. The first training session was attended by eleven GPs; only eight of them completed questionnaires. The third event was attended by five practitioners, including one practice nurse. The second session was cancelled as only three practitioners had booked on it. Attendance at the training sessions was much lower than anticipated.

***Study Design: Quantitative***

Primary care practitioners attending the training sessions provided a convenience sample for the study. A questionnaire was administered immediately before and after the training sessions, to determine the impact of the training on practitioners’ knowledge, illness perceptions and confidence. The questionnaire comprised the Illness Perception Questionnaire (Revised): IPQ-R to measure knowledge and illness perceptions, and visual analogue rating scales to assess self-rated knowledge of PMI and confidence in relation to the identification/management of women with PMI. Practitioners were also asked about their gender, age and professional role. As a potential confounder, information about length of time qualified was collected as well as information on any previous training in relation to PMI. The IPQ-R tool was initially developed for individuals with illness, but has more recently been used to explore practitioner perspectives of patient’s illness (Fleming et al 2009, Grankvist & Brink 2009, Worsley et al 2011).

***Study Design: Qualitative***

Practitioners were asked on the pre-training questionnaire to record what they perceived to be key issues in perinatal mental health and what they would like training to include.

Documentary analysis was going to be used to with these comments to help determine the content and consistency of knowledge gaps and requirements. However, due to the low numbers of attendees the comments were simply grouped into categories and presented in tables.

A focus group of practitioners who had attended the training had been planned in order to further explore practitioners’ experience of the training. However, due to the lack of interest this has not taken place.

**Results**

Due to the low numbers of participants only descriptive results are presented. Data from both training events is presented together.

***Participants’ characteristics***

Thirteen practitioners took place in the two training events, twelve GPs and one practice nurse. Three of these only completed the pre-training questionnaire. Practitioners’ ages ranged from 29 to 65 years, with an average of 50.9 years. Eight women and 5 men took part. The time they had been in their current role ranged from two to 30 years.

***Key issues***

The key issues and training needs identified by practitioners were grouped into categories and are shown in Tables 1 and 2.

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| **Table 1 Key issues identified by practitioners** |
| **Mental health issues**Perinatal mental health issues - anxiety, depression, phobia, postnatal/antenatal depressionAnorexia PNDRelationship issues Mum’s mental health |
| **Safety**SafetyMaking sure mother and baby are safe SafeguardingSafety of the child |
| **Diagnosis**Recognising perinatal depression and risk factors Not missing somethingIdentifying women with anxiety and depression in the perinatal period |

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| **Treatment**Non-medical / medical treatment available Pharmacological managementPrescribing |

|  |
| --- |
| Being able to offer support / ask the right questionsManaging women with anxiety and depression in the perinatal period |
| **Referral**Accessing appropriate & timely support for patients Accessing servicesReferral pathways |

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| **Table 2 Training needs identified by practitioners** |
| **Mental health issues** Anxiety/depression AnorexiaOverview |
| **Diagnosis**Recognising perinatal depression and risk factors Identify issuesidentifying |
| **Treatment**Non-medical / medical treatment available Pharmacological managementKnowing which medications are preferred, especially for breastfeeding women Assessment, managementManagement What to do |
| **Referral**Clear pathway guidance; easy referral accessHow to access mental health support & counselling PathwaysWhat is available |
| **Confidence**Increase my confidence |

***Previous training and experience***

Four practitioners reported having had previous training in perinatal mental health problems while eight said they had not received training; one practitioner did not answer this question. The helpfulness of previous training was rated as 0, 1, 2 and 4 on a scale from 0 to 5, with 0 ‘not helpful at all’ and 5 ‘extremely helpful’.

All except one had previous experience of working with women with perinatal anxiety and/or depression, while six of the thirteen practitioners had experience of working with women with severe mental health problems.

***Knowledge and confidence***

Practitioners were asked to rate how knowledgeable and confident in identifying and managing women with perinatal anxiety and/or depression and women with severe mental health problems they felt they were on a scale from 0 to 5, with 0 being ‘not at all confident/knowledgeable’ and 5 ‘extremely knowledgeable/confident’. The results for pre- and post-training scores are presented in Figures 1 and 2. These are based on data from the 10 participants who completed both pre- and post-training questionnaires.

**Figure 1: Participants scores for how knowledgeable and confident they felt with respect to perinatal anxiety and depression**

4.50

4.00

3.50

3.00

2.50

2.00

1.50

1.00

0.50

0.00

**Anxiety & Depression** before after

knowledgeable confident in identifying confident in managing

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**Figure 2: Participants scores for how knowledgeable and confident they felt with respect to severe mental health problems**

4

3.5

3

2.5

2

1.5

1

0.5

0

**Severe PMI**

knowledgeable confident in identifying confident in managing

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***Effect of how long practitioners had been in their current role***

The length of time a practitioner had been in their current role did not appear to have an effect on whether they had received training previously. While the GP who had been in the

role for the shortest time was the only one who had no experience of caring for a woman with perinatal anxiety and/or depression, the length practitioners had been in their role appears to have had no effect on whether they had experience of caring for a woman with severe PMH problems. Overall, practitioners who had been in their role for a shorter time felt least knowledgeable and confident in identifying and managing mental health problems.

***Contributing factors and consequences of perinatal mental health problems***

Due to the small sample size, a meaningful analysis of what practitioners thought were the contributing factors and consequences of PMH problems is difficult. It is notable that for the contributing factors most scores increased (including for hormonal imbalances), apart from those for age, substance misuse, low social support and domestic violence. Mean scores for what practitioners considered the consequences of PMH problems increased for all items after training, with the exception of an increased rate of assisted deliveries.

***Multidimensional health locus of control***

Complete data for the multidimensional locus of control scale (MHLC) was only available for 6 participants; a meaningful interpretation of such a small sample is not possible. Overall there was little change in the subscales, though both the internal and chance subscale were reduced after training (Table 3).

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|  **Table 3 Mean MHLC scores**  |
|  |  **Internal**  | **Chance**  | **Doctors**  | **Others**  |
| **Pre-****training** | 16.3 | 15 | 11 | 13.8 |
| **Post-** **training**  | 13.4  | 12  | 12  | 12.2  |

**Challenges**

The biggest challenge was engaging a sufficient number of GPs and practice nurses. One training event had to be cancelled due to a lack of interest and numbers at the other two events were far lower than anticipated. The first event was held as part of protected time for learning but interest was still low, partly because another training event relevant for GPs was running at the same time. A further challenge was that not all who attended the training event completed the questionnaires; some only completed a pre-training questionnaire, others none at all. Furthermore, some of the questions and measures in some of the questionnaires were not completed. The planned focus group has not (yet) taken place; it is unlikely that we will complete this due to insufficient interest from practitioners.

**Lessons learned**

The small sample and lack of some data has made analysis and interpretation of the results very difficult. While it was not possible to fully meet the original aims and objectives of the study, it is possible to draw some conclusion and the study has provided some insight into the training needs and effects of practitioners.

Practitioners identified a range of key issues and training needs which overlap to a large extent, mostly focusing on mental health conditions, diagnosis, treatment and referral. The importance of clear referral paths and available services was emphasized by several participants. The study also identified a clear need for further training: only a third of the participants had received previous training and most of those rated this training as poor.

While almost all practitioners had experience of working with women with perinatal anxiety and/or depression, fewer than half had experience of working with those with severe PMH problems. Overall, practitioners felt less knowledgeable and confident in the management and treatment of severe mental health problems than of perinatal anxiety and depression. Average scores for how knowledgeable and confident practitioners felt in managing and treating both perinatal anxiety and/or depression and severe perinatal mental illness increased after training, suggesting that the training has been successful in empowering practitioners in working with women with PMH problems.

The small sample size makes it difficult to interpret the results for the measures of contributing factors, causes and health locus of control. However, data suggests that the training may be effective in altering practitioners’ perceptions of PMH problems. Mean scores for most contributing factors (including hormonal imbalances) increased, except for age, substance misuse, low social support and domestic violence. Mean scores for the consequences of perinatal mental health problems also increased, except for the score for an increased rate for assisted deliveries, i.e. after the training practitioners had a reduced belief that perinatal mental health problems would lead to an increase in assisted deliveries. Interpretation of the MHLC scores is difficult. However, the data may suggest that the belief in internal locus of control and chance were reduced after training. These results indicate that a study with a larger sample size could provide new insights into practitioners’ perceptions of PMH problems and how these perceptions may be affected by training.

The initial results of the study were disseminated to GPs and practice nurses at a Hull CCG funded learning event aimed at bridging primary and maternity care. Some discussion was encouraged at this event regarding the best way of delivering PMH training. GPs identified that training events, including the PMH event, are difficult to attend due to work commitments. Furthermore, a number of GPs identified that consultation times with women are limited (10 minutes); consequently, they see their role as one which is merely ‘signposting’ rather than ‘digging deeper’ to uncover more about women’s mental health. There was a sense that GPs struggle to prioritise PMH training, when their consultation times do not permit, or in some cases, require them to utilise what they have learned from the training. In short, they felt they just needed to know who to sign post these women to.

If further research with GPs and practice nurses is to be undertaken, it is important that this takes place during protected learning time which does not clash with other events. However, this may not be sufficient and it may be necessary to look at different ways of delivering the training, for example by making use of online resources. While the training program and its evaluation were the main focus of this study, it also aimed to explore practitioners’ perceptions of PMH problems through the use of the questionnaire assessing contributing factors, causes and health locus of control. The small sample size did not enable us to make use of this data sufficiently. A potential option would be to conduct a larger survey of local

practitioners which will not only provide insight into practitioners’ perceptions and locus of control, but also facilitate the construction of a new measure of health professionals’ perceptions of perinatal mental health problems. A limitation of this study, is the potential for a lack of engagement from practitioners with respect to completion of the survey, however, this data may enable us to meet the objectives of the study.

Finally, it is important to highlight that this project was designed in January 2014, at a time when lack of training and the need for further training in PMH was a key theme and a recommendation across a number of research studies (Stanley et al 2006, Leiferman et al 2008, Chew-Graham et al 2008, Milgrom et al 2011, Leddy et al 2012, McCauley & Casson 2013). As a result of a number of recent reports and campaigns throughout 2014/2015, including ‘Falling through the gaps: perinatal mental health and general practice’, which makes recommendations for Health Education England to work with RCGP clinical champions to support PMH training provision of qualified GPs, strategies for the development of national training for PMH are now underway, which will lead to improved consistency and accountability in the provision of PMH care and services for women and their families. In the meantime, we consider this study as an important step in providing some learning and support to a small number of engaging practitioners to help them to provide the best possible care to patients.

**References**

Chew-Graham, C. (2008) GPs' and health visitors' views on the diagnosis and management of postnatal depression: a qualitative study. *The British Journal of General Practice* 58 (548):169–176

Fleming, M.P., Martin, C.R., Miles, J. and Atkinson, J. (2009) The utility of the Illness Perception Questionnaire in the evaluation of mental health practitioners’ perspectives on patients with schizophrenia. *Journal of Evaluation in Clinical Practice.* 15(5):826–831

Grankvist, G. and Brink, E. (2009) Illness perception of nursing students regarding myocardial infarction. *Nursing Education Perspectives* 30(4):234–238

Joint Commissioning Panel of Mental Health (JCPMH) (2012) *Guidance for commissioners of perinatal mental health services.* Volume 2, available from [www.jcpmh.info](http://www.jcpmh.info/)

Leddy, M.A., Farrow, V.A., Joseph, G.F. and Schulkin, J. (2012) Obstetrician/gynecologists and postpartum mental health: differences between CME course takers and nontakers. J*ournal of Continuing Education in the health professions* 32 (1):39–47

Leiferman, J.A., Dauber, S.E., Heisler, K. and Paulson, J.F. (2008) Primary Care Physicians’ Beliefs and Practices toward Maternal Depression. *Journal of Women Health* 17 (7):1143–1153

McCauley, C.O. and Casson, K. (2013) A qualitative study into how guidelines facilitate general practitioners to empower women to make decisions regarding antidepressant use in pregnancy. *International Journal of Mental Health Promotion* 15 (1):3–28

Milgrom, J., Holt, C.J., Gemmill, A.W., Ericksen, J., Bronwyn, L., Buist, A. and Schembri, C. (2011) Treating postnatal depressive symptoms in primary care: a randomised controlled trial of GP management, with and without adjunctive counselling. *BMC Psychiatry* 11:95

Stanley, N., Borthwick, R. and McLeod, A. (2006) Antenatal depression: mothers' awareness and professional responses. *Primary Health Care Research and Development* 7:257–268

Worsley, C.*,* Whitehead, K.*,* Kandler, R. and Reuber, M*. (*2011*)* Illness perceptions of health care workers in relation to epileptic and psychogenic nonepileptic seizures*. Epilepsy & Behavior* 20*:*668*–*673.