Psychological Interventions in Perinatal Community Mental Health Teams in the United Kingdom

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Abstract: The promotion of perinatal mental health and the provision of effective, evidence-based psychological interventions has become a priority within the UK. Increased awareness of the impact of poor maternal mental health and improved financial investment has led to the rapid expansion of perinatal community mental health services. This evaluation was undertaken to learn more about the psychological provision within UK Perinatal Community Mental Health Teams (PCMHTs) at the end of 2017. All PCMHTs with Royal College of Psychiatrists (RCPsych) Perinatal Centre for Continuous Quality Improvement (CCQI) membership in September 2017 (23 teams) were contacted and asked to complete a six-item online questionnaire developed for the purpose of this investigation about the psychological interventions currently being offered in their service. Seventy-four percent of teams contacted completed the survey. The findings suggest that, while there was considerable variability within the psychological provision in the PCMHTs, there were also important commonalities. The variation in psychological provision in the PCMHTs may reflect differences in service user needs, in local mental health and statutory services provision, in staff skills and training, and in the developmental stage and staffing provision of the team. Commonalities suggest that teams are striving to work within the "perinatal frame of mind" (Tavistock and Portman, 2016), tailoring interventions to their interpretations of the specific needs of this client group.

Keywords: perinatal, research, community mental health

The perinatal period is commonly portrayed as a time of great joy and emotional stability (Cree, 2015). However, the significant hormonal, physical, psychological, social, relational, and quality of life changes women experience makes this period a time of transition, characterized by worry and uncertainty, in which women are more vulnerable to experiencing mental health difficulties (Wenzel, 2016). In the UK, around 20% of women develop a mental health problem during pregnancy or within one year of giving birth (Bauer, Parsonage, Knapp, Lemmi, & Adelaja, 2014). While the majority of these women experience mild to moderate difficulties, there are a significant number who will experience more severe illness. Of every 1,000 women who give birth, two are

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estimated to experience postpartum psychosis, two experience chronic serious mental illness, 30 experience severe depressive illness and another 30 experience post-traumatic stress disorder (Oates, 2014).

The costs of not treating perinatal mental health problems in the UK has been estimated at £8.1 billion per year's birth cohort (Bauer et al., 2014). The needs of perinatal women with moderate to severe mental health difficulties, and those who may be currently well but have previously experienced severe mental illnesses, cannot be managed within universal services (National Institute for Health and Care Excellence [NICE], 2014) and require services with specialist expertise that are resourced to respond within limited time-frames (Oates, 2014). Despite this, in 2014 the large majority (85%) of localities in the UK were estimated to either have no existing specialist perinatal services at all, or services that failed to meet NICE guidelines (National Health Service England, 2016). In order to address this gap, a budget of £365 million over five years was directed to perinatal mental health so that by 2020/21 an additional 30,000 women will receive specialist perinatal mental health care (NHS England, 2016). This has led to a rapid increase in and expansion of PCMHTs within the UK, with the professionals staffing these teams coming from a number of professional backgrounds (in line with guidance from the RCPsych around PMCHT staffing).

Psychological interventions are often the treatment of choice in the perinatal period, as pregnant and breastfeeding women want to limit their baby's exposure to medication (NICE, 2014; Wenzel, Scott, & Koleva, 2016). Beyond interventions directly with service users, specialist perinatal psychologists have a significant role to play in developing psychologically informed team approaches to the perinatal period and in training and supporting staff (McKenzie-McHarg et al, 2016; Tavistock et al, 2016). New and extended perinatal mental health services have been commissioned in line with current guidelines and service standards to include dedicated provision to enable specialist perinatal psychological assessment and formulations, interventions and psychologically informed multidisciplinary team management of perinatal cases (Joint Commissioning Panel for Mental Health, 2014; McKenzie-McHarg et al., 2016; NICE, 2014; Oates, 2014; Thompson & Rodell, 2014). However, the specification around psychological interventions for perinatal populations is limited and guidance around psychological approaches to the perinatal period broad. Within empirical research, the focus of the majority of studies has been on psychotherapy for perinatal depression, with increasing attention being paid to perinatal anxiety (Wenzel et al., 2016). Furthermore, despite studies highlighting the prevalence of comorbid maternal mental health disorders (Dennis, Falah-Hassani, & Shiri, 2017), particularly maternal anxiety and depression (Farlah-Hassani, Shiri, &

Dennis, 2016; Farr, Dietz, O'Hara, Burley, & Ko, 2014) the majority of studies of psychological interventions have used pure populations (Wenzel et al., 2016). Nearly three-quarters (72%) of the costs of not treating perinatal mental health difficulties have been estimated as being associated with the child (Bauer et al., 2014). While effective, evidence-based parent-infant psychological and psychosocial interventions exist, there is a lack of evidence on whether these interventions are effective in women diagnosed with mental health problems, of which interventions are most effective, or of the adaptations that are needed (NICE, 2014). These limitations within the research base and within guidelines have left new and expanding community perinatal mental health services facing uncertainty regarding the most appropriate and effective ways to provide psychological interventions and approaches within their teams.

Inpatient mother and baby units (MBUs) face similar challenges to PCMHTs in designing and delivering psychological interventions. Researchers have sought to address these difficulties by investigating the current provision of psychological interventions in UK MBUs. Two investigations used surveys to evaluate psychological and psychosocial interventions in MBUs (Elkin et al., 2009; Wittkowski, & Santos, 2017.). Similar research within PCMHTs could be useful, but despite being an area of rapid investment and innovation in the UK, the current provision of psychological interventions in PCMHTs in the UK has yet to be evaluated. This survey therefore aimed to identify:

a) What type of interventions were offered by PCMHTs across the UK,
b) Who these interventions were offered to,
c) Who they were offered by,
d) What psychological frameworks were used to inform teams' approaches and how these were supported, and
e) What adaptations were offered to increase accessibility.

Method

NHS professionals, including perinatal clinical psychologists and members of a PCMHT designed the survey in line with findings from previous literature and in response to the needs of a newly commissioned service. Having been granted approval from the local NHS research and evaluation department, quantitative and qualitative data was collected via an electronic survey, between September 2017 and November 2017.

Participants

Participants included UK PCMHTs with RCPsych Perinatal CCQI membership in September 2017, as these teams were likely to be well-established and/or funded to commissioning guidelines. Twenty-three teams were identified and contacted via electronic survey. Although the job title of respondents was not requested, the majority of surveys were directed to psychological leads, clinical team leaders and perinatal service leads. Responses to the survey were gathered and tabulated; only descriptive statistics were calculated.

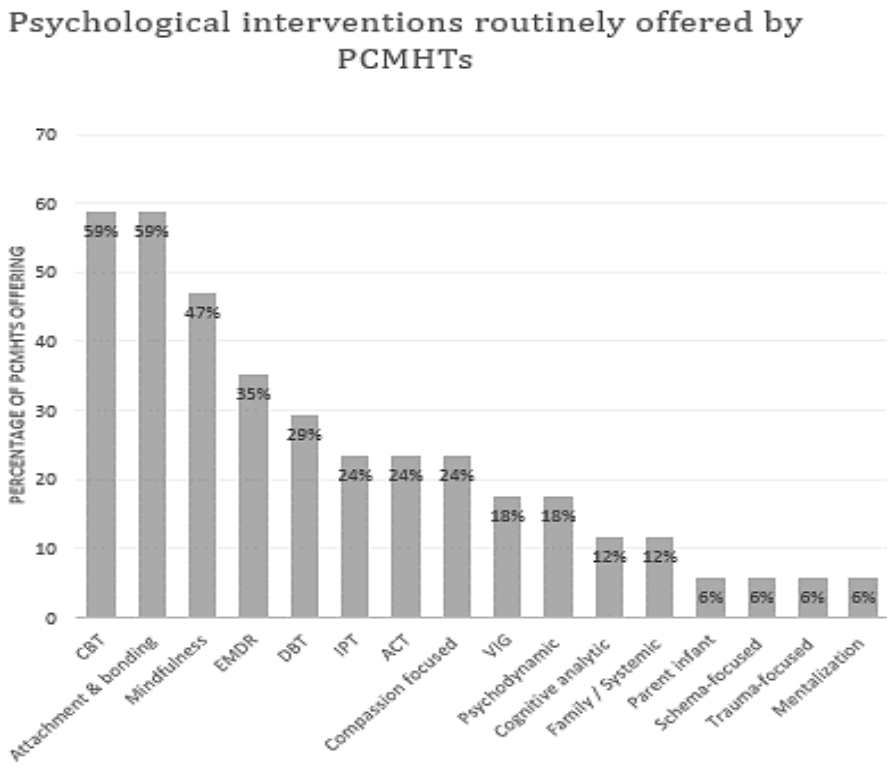
Results

Of the 23 PCMHTs contacted, 17 (74%) replied.

Types of psychological interventions offered

The number of different psychological interventions each team routinely offered varied between one and eight, with the mean being four. The psychological interventions offered most frequently were cognitive behavioral therapy (CBT), attachment and bonding, and mindfulness (see Figure 1). CBT was offered by 59% of the teams, and a further 18% of the teams offered interventions that include significant elements of CBT (compassion focused therapy (CFT); acceptance and commitment therapy (ACT)). Parent-Infant Attachment and Bonding interventions, including Video Interactive Guidance (VIG) and Parent-Infant Psychotherapy (PIP), were also offered by 59% of teams. Mindfulness interventions were offered by 52% of PCMHTs and an additional 18% offered interventions with significant elements of mindfulness (dialectical behavior therapy (DBT); CFT). While only 24% of PCMHTs offered interpersonal therapy (IPT), an additional 24% offered interventions with a strong interpersonal/relational focus (cognitive analytic therapy (CAT); psychodynamic; family/systemic). It was notable that 18% of PCMHTs specified that they were able to refer to other services for psychological interventions: this number is likely to be higher as it was additional information rather than being directly requested.

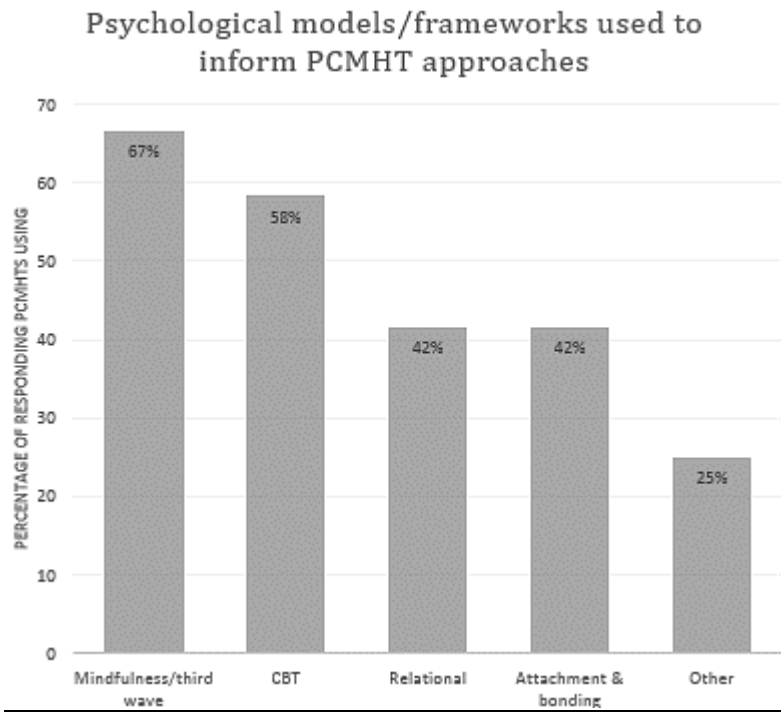
Just over half of teams (53%) offered group interventions, although a further 18% had groups planned or due to start. Teams offered up to three groups of 1-12 sessions in length. Regarding group content, attachment and bonding interventions were used in over half the groups (56%). Mindfulness and third wave approaches were equally prevalent (56%).



The Psychological Frameworks Used to Inform Teams' Approaches and How These Were Supported

The majority of teams (71%) described the psychological models that inform their team approach (see Figure 2). These included mindfulness/third-wave models (67% total: including CFT 33%; DBT 25%; ACT 17%), CBT (58%), attachment and bonding (42% total: including PIP 8%; Watch, Wait, Wonder 8%), and relational approaches (42% total: including Psychodynamic 17%; IPT 8%; CAT 8%; Family/Systemic 8%) Other approaches used were Eye Movement Desensitization Reprogramming (EMDR) (8%), Mentalization Based Therapy (MBT) (8%) and Psychoanalytic (8%).

Over half of respondents (59%) detailed the training and support given to team members on psychological models. While the majority of teams (80%) provided regular specialist supervision, there was considerable variation, from ad hoc supervision (10%) or non-specialist supervision (10%) through to comprehensive training packages supported by regular specialist supervision (30%).



Delivery of Interventions and Recipients

All teams offered psychological interventions to mothers, although for some teams the scope of these interventions was limited. Over half of PCMHTs (59%) offered interventions to both mothers and to mother-infant dyads, the same percentage that offered attachment and bonding interventions. Nearly a quarter of PCMHTs (24%) offered interventions to mothers' wider support network, with 18% of teams offering interventions to mothers, mothers and babies, partners/fathers, mother and partners/fathers, caretakers and family members and 6% of PCMHTs offering to the same groups but not partners/fathers.

Clinical psychologists and psychiatric nurses were the professional groups most frequently delivering interventions, with each being represented in 76% of teams. Nursery nurses provided interventions in 42% of teams, occupational therapists in 35% and psychology assistants in 29%.

Adaptations to Increase Accessibility

Over half (59%) of PCMHTs offered home visits in order to facilitate access to psychological interventions. GP surgeries/other local facilities (41%), outpatient setting (24%) and hospital sites (18%) were also used. Only 12% of PCMHTs were able to offer crèche (a nursery where babies and young children are cared for during the working day) facilities. Phone/Skype interventions were used by 18% of PCMHTs, while only 6% used online therapy packages.

Discussion

This study gathered responses on the psychological interventions offered by PCMHTs in the UK with RCPsych CCQI registration. Whilst similar studies have been conducted on UK MBUs, to our knowledge no studies have addressed this knowledge gap for PCMHTs.

While the range of interventions routinely offered by PCHMTs was diverse, four broad approaches were most frequently used: cognitive behavioral therapy based approaches; mindfulness (or third wave) approaches; attachment and bonding approaches; and relational-focused approaches. Most teams routinely offered interventions from two or more of these broad approaches, suggesting that each approach has unique relevance to the perinatal period. One of the most interesting findings was on the prevalence with which mindfulness/third wave interventions were used, with over two-thirds of teams offering these interventions. Mindfulness and third wave cognitive approaches are not described within NICE guidelines (NICE, 2014) for use with perinatal populations, and there is little research evidence around use and effectiveness in the perinatal period (Wenzel et al., 2016). The use of these interventions may reflect the importance of acceptance and distress tolerance in the perinatal population, where physical and behavioral health changes and the experience of uncertainty are large contributors to mental distress (Bonacquisti, Cohen, & Edler Shiller, 2017). It may also reflect some of the particular characteristics of the perinatal population, which has higher levels of anxiety than the general population (Dennis et al., 2017) and high co-morbidity between anxiety and depression (Farlah-Hassani et al., 2016, Farr et al., 2014). Research with non-perinatal populations has shown that where depression and anxiety are comorbid, symptoms are more severe, outcomes are poorer and resistance to treatment (both pharmacological and psychological) is higher (Dennis et al., 2017). Adaptations of existing protocols are often required to optimize treatment efficacy (Rivas-Vazques, Saffa-Biller, Ruiz, Blais, & Rivas-Vasquez, 2004). The diversity of interventions, the prevalence of third wave/mindfulness

interventions and the flexibility with which interventions were offered may well reflect adaptations that incorporate specific strategies for the symptomology of multiple disorders.

Nearly three-quarters of the costs associated with perinatal mental health difficulties relate to the child (Bauer et al., 2014). Parent-infant attachment and bonding interventions have been shown to lead to improved child outcomes and be effective in alleviating the symptoms of maternal psychopathology (Wenzel et al., 2016). It was therefore an unexpected finding that attachment and bonding interventions were not offered by more PCMHTs: only just over half of the teams offered attachment and bonding interventions and mother-infant dyadic therapy. Among other factors, this may reflect the specific skill mixes available in teams. For example, not all teams were able to offer interventions from nursery nurses. It may also reflect that attachment and bonding interventions were offered within other services in the same locality, for example by local children's centers or by Parent-Infant Mental Health Attachment Teams (PIMHATs). There is significant variability nationally, both in the provision of PIMHATs and in the ways in which these teams are linked to PCMHTs. The lack of specification around recommended delivery models within BPS, NICE and RCPsych CCQI guidelines—i.e. what should be delivered by PCMHTs and what by PIMHATs—may also be contributing to the existing levels of attachment and bonding interventions that are being offered. Finally, lack of evidence about which are the most effective interventions to improve mother-infant relationships in the first year of birth where the mother has a recognized mental health difficulty may also be a factor. The research recommendations in NICE 2014 guideline include a request for randomized controlled trials comparing psychological interventions aimed at improving the quality of mother–baby interactions (that are known to be effective in populations without mental health problems) against standard care.

While mother-infant dyad and attachment and bonding interventions may be provided by other local services, the use of attachment and bonding frameworks to inform the whole team's approach within PCMHTs is seen by many as essential (Joint Commissioning Panel for Mental Health, 2014; McKenzie-McHarg et al., 2016; NICE, 2014; Oates, 2014; Tavistock & Portman, 2016; Thompson & Rodell, 2014). Despite the importance of working within the perinatal frame of mind, in which the needs of the mother, the baby and the mother-baby dyad are balanced and equal (Tavistock & Portman, 2016), just a third of respondents reported using attachment and bonding models to inform their team approach. In attempting to elucidate this finding, a specific area for consideration is whether adequate training programs for dyadic interventions and

attachment models are available within the UK. Given the rapid expansion of perinatal community mental health teams, staff members will have had to be drawn from many different backgrounds, and will not necessarily have experience of attachment and bonding interventions/frameworks and models, or of applying these in mental health settings. Training programs will have the crucial task providing training that meets the needs of disparate groups of professionals and is neither too long and in depth (and thereby too expensive) nor too brief and general to be useful.

The lack of attachment and bonding frameworks in informing PCMHTs' approaches is reflected in a wider issue. Nearly a third of PCMHTs did not give information about the frameworks they use to inform their team approach and the responses themselves were varied, with some teams reflecting very clear approaches and structures to support them, while others had not considered these areas at all. This may reflect that historically teams have developed piecemeal, with a minimum of a psychiatric nurse and dedicated medical time (Oates, 2014), resulting in the adoption of a broadly medical model across perinatal services. As PCMHTs develop, and have increased psychological resource, it may be that increasing attention is paid to the psychological frameworks that underlie team approaches and how team members can be trained and supported in them.

This study was intended to capture a snapshot of the range and formats of psychological interventions offered by the UK during a time of change due to increased investment. Emphasis was placed on not overburdening respondents. This meant that background information that may have elucidated respondents' answers, such as the range of disorders treated, the staffing of teams and local provision for psychological interventions within other teams, was not collected. Participation was also limited to teams with current RCPsych CCQI registration. Mapping data from the Maternal Mental Health Alliance Everyone's Business (2015) campaign (Maternal Mental Health Alliance, 2018) suggests that there may be many more PCMHTs working with this population. Future studies could seek to investigate in more details the reasoning behind the psychological interventions being offered by PCMHTs, to determine the extent to which these are active choices based on best-practice and elucidate the mechanisms of change that may be at work. Similarly, studies expanding the understanding of psychologically informed team approaches to the perinatal population, looking at the challenges of implementation, reasoning behind approaches used and change processes involved, by researching teams' practice could be useful. Studies such as these would offer the potential to generate practice-based evidence to complement evidence-based practice.

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