Perinatal Mental Health

Sally Tribe
Approximately 700,000 women give birth every year in UK

1/10 women suffer from a perinatal mental illness
Postnatal depression affects more than 1 in every 10 women within a year of giving birth.

Health professionals should be alert to the increased risk of experiencing mental health problems among teenage mothers and women who have experienced:

- previous history of mental illness
- a traumatic birth
- a history of stillbirth or miscarriage
- relationship difficulties
- social isolation
Estimated numbers of women affected by perinatal mental illnesses in England each year

1,380
Postpartum psychosis
Postpartum psychosis is a severe mental illness that typically affects women in the weeks after giving birth, and causes symptoms such as confusion, delusions, paranoia and hallucinations.
Rate: 2/1000 maternities

1,380
Chronic serious mental illness
Chronic serious mental illnesses are longstanding mental illnesses, such as schizophrenia or bipolar disorder, which may be more likely to develop, recur or deteriorate in the perinatal period.
Rate: 2/1000 maternities

20,640
Severe depressive illness
Severe depressive illness is the most serious form of depression, where symptoms are severe and persistent, and significantly impair a woman’s ability to function normally.
Rate: 30/1000 maternities

20,640
Post traumatic stress disorder (PTSD)
PTSD is an anxiety disorder caused by very stressful, frightening or distressing events, which may be relived through intrusive, recurrent recollections, flashbacks and nightmares.
Rate: 30/1000 maternities

86,020
Mild to moderate depressive illness and anxiety states
Mild-moderate depressive illness includes symptoms such as persistent sadness, fatigue and a loss of interest and enjoyment in activities. It often co-occurs with anxiety, which may be experienced as distress, uncontrollable worries, panic or obsessive thoughts.
Rate: 100-150/1000 maternities

154,830
Adjustment disorders and distress
Adjustment disorders and distress occur when a woman is unable to adjust or cope with an event such as pregnancy, birth or becoming a parent. A woman with these conditions will exhibit a distress reaction that lasts longer, or is more excessive than would normally be expected, but does not significantly impair normal function.
Rate: 150-300/1000 maternities

* There may be some women who experience more than one of these conditions.
Source: Estimated using prevalence figures in guidance produced by the Joint Commissioning Panel for Mental Health in 2012 and ONS data on live births in England in 2011.
Why is perinatal mental health important?

- It is common

- Major cause of maternal death (from suicide).

- Most women will have mild to moderate illness, including depression, anxiety and PTSD, but some will have severe depression, PTSD, schizophrenia or bipolar disorder or they may develop postpartum psychosis / OCD.

- Distress for women and their families. The first two years of a baby’s life are the building blocks of their long-term social and emotional development.

- 90% of women diagnosed with perinatal mental health illness are cared for in primary care.

- Intervening early reduces the impact of the disorders on the mother, her child and family.

*Royal College of General Practitioners, 2015*
Maternal factors for poor detection

- Stigma
- Putting on a brave face
- Fear of being thought a ‘bad mother’
- Fear the baby may be taken away
- Not knowing what is ‘normal’
- Not knowing if treatment will help

GP factors for poor detection

- Not asking
- Time constraints
- Lack of training or confidence
- Lack of access to specialist service
- Normalising or dismissing symptoms
Effects of PND on child development

• Postnatal depression (PND) confers risk for a range of negative child developmental outcomes, at least in part through its impact on parenting behaviour.

• Behavioural effects of depression on parenting.

• Cognitive mechanisms that may mediate parental depression
Depression

- Increasingly despondent
- Hopeless soon after the baby is born.
- Feel terribly miserable and sad for no particular reason.
- Spend a large part of each day in tears.
- May feel rejected by her partner, family, friends, or even by the new baby.
- Usually feeling permanently tired and lethargic, unable to cope with household chores.
- May give up bathing, dressing properly or making-up.
- Caring for baby may be too much.
Anxiety

• Feel extremely anxious about a variety of subjects and situations.

• May experience severe pain for which the doctor can find no satisfactory explanation. Pain can be in the head or neck.

• Or suffer backache, and chest pains which they fear are due to heart trouble.

• The mother may have a number of minor medical complaints which can cause undue distress.

• Anxiety may take the form of unjustified worries about the health and well-being of other members of the family, especially the baby.
OBSESSONAL AND INAPPROPRIATE THOUGHTS

• Obsessional thoughts are common.

• These may be about a person, a situation or about a certain activity. (*tv drama)

• Some mothers become very frightened and believe that they may harm a member of their family or baby.

• These fears are very common symptoms of depression and may or may not be accompanied by feelings of guilt.

• Such fears are almost entirely unjustified, and can develop into OCD.

Other problems...

CONCENTRATION

SLEEPING

SEX
Don’t forget the men!
Barriers to accessing treatment

- Stigma – this ‘should’ be a happy time
- Social pressures – seeing other mums doing well
- Pressures from healthcare professionals e.g. breastfeeding
- Putting needs of child/family first
- Worried about the child being taken away or ‘child at risk’
- Difficulty accessing appointments with a young child
- Waiting times
- Limited time
- Possible physical health problems associated with pregnancy/childbirth
Why?

The guiding principles of IAPT include:

- Increasing access to services
- Improving clinical outcomes and recovery
- Improved socio-economic participation
- Increased patient choice and satisfaction
- High quality training leading to better performance

Our focus is on improving access to evidence-based mental health therapy

By enabling others to use our knowledge and platform, many more people will be able to access therapy.
Internet-enabled CBT

- Therapy via written (typed) conversation in a secure online environment developed specifically for the purpose
- Live one-to-one scheduled appointments
- Strict clinical and information governance
- NICE approved patient pathway and recovery metrics
- Evidence-based
Live 1-1 therapy chat sessions augmented by out-of-session activity & engagement

- Live one-to-one CBT
- Clinically validated
- Quality controlled

- Increase access
- Improve outcomes
- Enhance quality
It's well known that people say and do things in cyberspace that they ordinarily would not in the face-to-face world.
Theoretical context

CBT has a strong empirical evidence base that demonstrates efficacy for a wide number of psychological disorders (Roth & Fonagy 2005)

CBT places emphasis on the patient learning theoretical principles and practical skills (Abramowitz and Arch 2014)

Consolidating learning is essential if recovery is to be achieved and maintained (Lieberman 2007, Bjork 1988)

Visual learning (reading and writing) has been demonstrated to be more efficacious than aural learning (Klinger et al., 2011, Marton et al, 1984, Laurillard 2002)
Ieso Digital Health – an IAPT provider

15 years of therapy provision

IAPT provider since 2012 – Assessment, Step 2 and 3 CBT

Any Qualified Provider – NHS Surrey, NHS West Kent, NHS Camden, NHS East Riding of Yorkshire

Subcontracted by other IAPT providers

Over 300 Clinical Affiliates based across the country

Mandatory regular supervision and CPD events

Increases access & completion rates

Improves choice for patients

Extends capacity, especially for out-of-hours appointments
IAPT Service Outcomes

2015 Data

56% 51% 21/24
Completed Treatment Recovery Mean PEQ Score (60% return)

Step Distribution

83% 17% 17%
Step 2 Step 3

“I had been wanting to seek therapy for a long time now but could not get up the courage to see and speak to a stranger in person.” *Ieso Patient*

These data have been collated from monthly IAPT Reports published on the HSCIC website [http://hscic.gov.uk/iaptreports](http://hscic.gov.uk/iaptreports) (April-September 2015)
User experience

Many people prefer the idea of online therapy to traditional methods:

Relative anonymity
Reduced pressure
Discreet
Anytime, anywhere

Text communication supports therapy:

Forces order and logic
Documents a narrative
Embedded & reinforced learning
Transcripts available

“It’s unusual not having to look the therapist in the eye but it makes me feel like I can open up a lot more.”
Ieso Patient
Perinatal Data
Perinatal data

• From January 2014 to end of February 2017 there were 320 perinatal patients discharged from treatment

• Distribution of disorders:

![Perinatal disorder distribution chart]

- Depression: 22%
- Agoraphobia (with or without panic disorder): 3%
- Anxiety disorder, unspecified: 1%
- Generalised anxiety disorder: 3%
- Obsessive-compulsive disorder: 13%
- Panic disorder (episodic paroxysmal anxiety): 15%
- Mixed anxiety and depressive disorder: 6%
Outcomes for Ieso perinatal patients vs IAPT outcomes as per annual IAPT report 2015/2016:

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Ieso Perinatal</th>
<th>IAPT All</th>
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<tbody>
<tr>
<td>Referral to assessment wait</td>
<td>14.6 days</td>
<td>29.4 days*</td>
</tr>
<tr>
<td>Referral to first treatment wait</td>
<td>23.3 days</td>
<td></td>
</tr>
<tr>
<td>First to second treatment wait</td>
<td>9.7 days</td>
<td>34.2 days</td>
</tr>
<tr>
<td>Mean treatment duration</td>
<td>5.7 sessions</td>
<td>6.4 sessions</td>
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<tr>
<td>% entering treatment</td>
<td>87%</td>
<td>68%</td>
</tr>
<tr>
<td>% completing treatment</td>
<td>74%</td>
<td>38%</td>
</tr>
<tr>
<td>% drop-out</td>
<td>14%</td>
<td>44%</td>
</tr>
<tr>
<td>% improvement</td>
<td>62%</td>
<td>62%</td>
</tr>
<tr>
<td>% recovery</td>
<td>48%</td>
<td>46%</td>
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</tbody>
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* IAPT publishes time from referral to first treatment
Benefits

Flexibility and accessibility

- Reduce waiting lists
- Anytime, anywhere
- Evenings and weekends
  (Need unusual appointment times)

Discreet

- Speed of disclosure leading to faster recovery
  (Embarrassed or stigmatised)

Specialisms
- No travel
  (Unable to travel)

Social anxiety

Remote location

Too busy
Improving access to evidence-based mental health therapy

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