Perinatal Infant Mental Health Service

Perinatal and Infant Mental Health Services are a state wide inpatient, outpatient and community outreach service with three key and interconnected elements:

- Inpatient service for 6 parent-infant dyads, (inpatient services, and associated outpatient appointments and groups) are located on Glenside Health Services
- Community appointments, education & consultation services also based at Glenside
- Perinatal and Infant Mental Health Consultation and Liaison service to the Women’s and Children’s Hospital.

Service Description

Who do we see?

- Women in the perinatal period, with significant or severe mental health and wellbeing distress or disorders, which impact on their ability to care for and parent their infants and young children.
- The primary care giver (including that person’s partner, children and family) who has a severe mental health problem such as puerperal psychosis, bipolar mood disorder, schizophrenia, schizo-affective disorder, major depressive disorder, or severe anxiety disorders co-morbid personality disorders such that there is a major impact on their level of functioning and/or ability to parent

What do we do?

Inpatient and outpatient services at Helen Mayo House:

- Provide acute inpatient treatment of women with significant emotional or mental health and wellbeing issues in the perinatal period
- Promotion and preservation of the mother-infant relationship
- Delivery of seamless, therapeutic, recovery and independent skills focused care for mothers, infants and families that is holistic and community oriented
- Provide short-term assessment and treatment by a multidisciplinary team for women with severe mental illness and their infants, children and partner/family members
- Promote seamless delivery of care, building capacity within local communities to provide quality mental health and psychosocial support services to perinatal women and their families
- Provide referral pathways and clinical back up to existing secondary and primary care services
- Access to other health services such as a dietician or speech pathologist
- Comprehensive medical assessment screening where appropriate (CT scans,
bloods, electroencephalograms (EEG) etc.

Community appointments, groups and consultation through Helen Mayo Community Program

> Originated in 2007 through the General Practice initiative of Mental Health Shared Care created to support GPs with their Mental Health Clients and to support ongoing ‘FeelingAttached and Connecting Mums’ training, as well as linking community support for perinatal clients and Helen Mayo House. As of 2015, it is an established part of the overall PIMHS and positions in geographic areas where need has been identified as greatest.

> Trains workers with perinatal mental health clients and families through the 'Feeling Attached' and 'Connecting Mums' training program and manual.

> Provides consultation and liaison in the field of perinatal and infant mental health to General Practice, Mental Health Professionals, and others involved with perinatal clients.

> Supports discharge planning when required for identified clients of Helen Mayo House including home visiting follow-up for selected clients as short term support to bridge the gap to community service uptake as well as limited long term follow-up for perinatal clients with chronic illness.

> Supports General Practice and antenatal classes in the Northern and Southern outer metropolitan regions (Gawler, Mount Barker, & Smithfield Plains) for perinatal clients with referral from GPs, CaFHS, PIMHS & Community Mental Health.

> Provides co-facilitation of the Helen Mayo House Dialectical Behaviour Therapy program for mothers and young children.

> Group facilitation at Children’s Centres for attachment based Acorn Groups

> Support to clients awaiting inpatient services through Helen Mayo House

> Support assessment & pathways to care for women at CaFHS Torrens House

Perinatal and Infant Mental Health Consultation and Liaison Services at the Women’s and Children’s Hospital

> Specialist perinatal and infant mental health consultation and liaison services to mothers, fathers/partners and infants of the Women’s and Children’s Hospital both in the obstetric ante and postnatal wards, ante-natal outpatient clinic, special baby care nurseries and paediatric impatient and outpatients 0-3 years), Pre-pregnancy counselling for women with severe mental health disorders.

> Specialised feeding assessment and treatment including involvement with a Play Picnic a program for tube dependent/or artificially fed infants and those with feeding disorders. This is an infant led food exploration to regain autonomy in feeding.

> An antenatal Mindfulness Based Cognitive Therapy group as an early intervention and prevention program for women at risk of perinatal anxiety and depression

> “Mindful Moments” a self-care group program incorporating mindfulness skills
for parents of children with severe and complex medical needs and where there is a significant burden of care on the parent (usually the mother) in conjunction with the complex care social worker.

> Education and training for midwives, trainee medical staff and consultants

**Who does it?**

**Governance**

The Clinical Director of CAMHS has overall clinical responsibility for the treatment and care provided to consumers of Perinatal Infant Mental Health Services, with the Medical Unit Head and Clinical Services Coordinator ensuring day to day responsibility. This includes entry to and discharge from Perinatal Infant Mental Health Services.

Perinatal Infant Mental Health Services has an Operational Management Group, which meets monthly. This includes Perinatal Infant Mental Health Services Medical Unit Head, Director Strategic Mental Health Operations, CAMHS Nursing Director, Clinical Services Consultant, and Psychiatry Consultant from the WCH Perinatal and Infant Mental Health Services team. In addition members of CAMHS Executive and hospital based services are also in attendance.

Perinatal Infant Mental Health Services operates in a manner consistent with the principles of the Mental Health Act 2009 and with state-wide and regional policies and procedures.

**Service Profile**

> Medical Unit Head
> Consultant Psychiatrists
> Registrars
> Nursing (CSC, CPCs, RN2s, RN1s, ENs and student nurses)
> Administration staff
> Psychology, Occupational Therapy, Social Work
> Infant Parent Therapists
> Personal Service Assistants
> Volunteers

The service is supported by:

> Senior Pharmacist Glenside Health Services (Mental Health)
> Paediatric Registrar from WCHN, 0.2

**Service Process**

**Clinical Pathways – entry, interventions, transfer of care**

1) **Entry to Helen Mayo House**

Women are referred by a doctor, hospital unit or adult community mental health team with disorders that have a major impact on their level of functioning and/or ability to parent. These may include:

> severe mental health problems such as puerperal psychosis, bipolar mood
disorder, schizophrenia, schizo-affective disorder, major depressive disorder, or severe anxiety disorders

> dual diagnoses where a woman has a primary severe mental health problem and a current substance abuse (illicit drugs or alcohol) problem
> severe mental health problems and for whom there is a request by Families SA for a parenting assessment.

Assessment

On referral consumers are assessed by a medical practitioner or Adult Mental Health Triage to confirm suitability for admission.

> Assessments are carried out at the time of admission and treatment programs are tailored according to need
> Parent-Infant attachment issues are a focus of the therapeutic work in the unit.
> Consumers meet with a social worker, who often also meets other family members to assess the extent to which family issues are impacting on the woman’s mental state, and the level of family and community support that is available
> Developmental assessments may be carried out by staff in the unit

Where need for inpatient admission is confirmed but cannot be offered immediately women and their infants may be referred to PIMHEC for initial care planning and support in the community.

Care Planning

Review of inpatient care / treatment occurs regularly with a focus on risk assessment of both parent and infant(s)

> Includes strategies for recovery and parenting capacity building
> Incorporates the development of consumer social networks to assist transition following discharge
> Case management responsibilities after discharge are primarily undertaken by general practitioners or other identified services

Interventions and Treatment Modalities include

**Infant mental health services**

> Identification of, and intervention for, the emotional and mental health needs of the infant and young children
> Address therapeutically the psychosocial, emotional and mental health needs of the mother and the impact on the mother-child relationship
> Play based therapy

**Group programs**

> Therapeutic groups using a range of modalities including cognitive behaviour therapy, ACT, Circle of Security, music, art, educational, practical parenting, skills development and journaling

**Individual and family counselling**

> Therapeutic counselling routinely offered to all inpatients
> Perinatal and infant mental health staff provide training, education, capacity building and consultation / liaison to the general practice. adult mental health
sectors and other community agencies working with young families

**Outpatient programs**

- Short term individual follow up in transition to community care
- Mother Infant-DBT group program
- Peek-a Boo Clinic- parent infant therapy sessions

**Transfer of Care to other services**

- Discharge planning commences upon a woman’s arrival and is reflected in comprehensive, multidisciplinary treatment plans that are regularly reviewed
- Assistance for consumers with comorbid issues is readily accessible due to the co-location of mental health and drug and alcohol services.

2) **Entry to Helen Mayo Community Program**

- Referrals accepted from GPs, Midwives, CaFHS (including Torrens House), PIMH, and Community Mental Health for perinatal women who have mental health disorders that impact on their functioning or ability to parent in these areas: Gawler, Mt Barker, Strathalbyn and Smithfield Plains.
- Weekly clinics at Gawler Women’s Health centre and Mount Barker Hospital for perinatal clients and fortnightly clinics at John Hartley Children’s Centre, Smithfield Plains and Strathalbyn CaFHS
- Home visits, on a selected basis, to clients identified as short term support to bridge between service implementation, [eg., HMH to Staying Attached Service]. Also Home visits to clients in Gawler and Mount Barker who are presently unable to attend clinic [eg., LCSC immediate postnatal]

**Intervention**

- Long Term Support [limited basis] for clients with long term chronic Axis 1 and Axis 2 mental health clients – generally having been HMH clients with significant need for support and mental health monitoring.
- Introducing co-facilitation of DBT group at HMH
- Support of Wait List Clients of HMH that are identified of not having other supports in place.
- General Consultation with HMH, GPs, Psychiatrists, and other health professionals of community supports and services that are appropriate to their perinatal clients.

3) **Entry to Perinatal and Infant Mental Health Consultation and Liaison Service at WCH**

- Women are referred through antenatal screening in the maternity service, Women’s Social Work High Risk planning process (Strengthening Links), and parents and infants via Neonatal and Special baby care nurseries, Paediatric outpatients, Dieticians and Speech pathologists and HENS, Paediatric inpatients.
- Referrals are also received from General Practitioners, Adult Community Mental Health Services, DASSA, and directly from the client or her family.

**Assessment/Consultation**

- Inpatient process
Written Referrals are collected each morning from the Ante and Postnatal Wards in WCH. These are discussed at morning handover and allocated to team members for review.

Referrals are also received via Fax to the Department of Psychological Medicine or via on call person on perinatal triage. This includes infant referrals.

Outpatient process

Comprehensive assessments are provided including a focus on the emotional, psychosocial and mental health needs of both the parent and/or infant. Ongoing treatment includes regular reviews, and liaison with other agencies (both in the community and hospital based services) and family counselling.

Infant Mental Health Assessments are comprehensive and involve a focus on the emotional, psychosocial and developmental needs of the infant within the context of their relationships. There may be developmental task specific assessments used, eg feeding or specific interactional elements. Ongoing contact is reviewed regularly with liaison of progress given to other agencies involved both within the WCH and to other community agencies when indicated.

Care Planning

PIMHS will contribute to the overall care planning of a client and their infant through

- making recommendations to the treating team (WABS, Paediatric)
- offering follow up consultations/assessment and/or specific programs as part of an overall plan

Intervention and Treatment Modalities may include

- Specialised feeding assessment and treatment including involvement with a Play Picnic a program for tube dependent/or artificially fed infants and those with feeding disorders. This is an infant led food exploration to regain autonomy in feeding.
- Antenatal Mindfulness Based Cognitive Therapy group as an early intervention and prevention program for women at risk of perinatal anxiety and depression
- "Mindful Moments" a self-care group program incorporating mindfulness skills for parents of children with severe and complex medical needs and where there is a significant burden of care on the parent (usually the mother) in conjunction with the complex care social worker.
- Education and training for midwives, trainee medical staff and consultants as an ongoing component of the Liaison role within the WCH.

Transfer of Care

At the conclusion of an episode of care, PIMHS ensure that parents, infants and their families are referred to the most appropriate community services. This includes returning care to the clients General Practitioner.

Length of contact

Women can be seen up to 12 months post-partum with linkage to community services, during or after this time.
For infants up to 3 years old if further treatment is needed infants and their families will be referred to the appropriate services in the community or within the hospital.

Links with other parts of the Service or Partners

- CaFHS
- Women’s and paediatric services at the Women’s and Children’s Hospital
- CAMHS Community Teams
- Adult Mental Health Services
- Non Government services
- DECD Children’s Centres
- Various Church groups.
References