The first 12 months of a perinatal outreach service

Meena Patel, Jona Lewin and Ann Stevens

Aims and method This paper describes and evaluates a new community treatment service for women suffering from mental illness during the perinatal period. Data about referrals, treatment methods and outcome were analysed for the first year of its service.
Results The service was acceptable to patients and effective in improving the mental health and parenting skills of mothers but less successful in improving relationship problems.
Clinical implications A specialised perinatal outreach service is likely to be more acceptable to new mothers than the traditional psychiatric service and may also be able to reduce the need for hospital admission and length of admission.

The psychiatric care of patients who suffer mental illness shortly before or following childbirth requires specialised expertise due to the complex social and psychological needs of the patient, her baby and the partner. A working party of the Royal College of Psychiatrists (Royal College of Psychiatrists, 1992) therefore postulated that comprehensive services for this patient group should be established. This paper describes a perinatal outreach service, which is attached on an in-patient mother and baby unit.

The study

A perinatal outreach service, linked to an in-patient mother and baby unit was established for the Borough of Brent and Harrow in North London in April 1997. This service provides community psychiatric care to women suffering from moderate to severe degree of mental health problems, either in the last trimester of their pregnancy or in the first year after the baby's birth. Members of the team are also involved in liaison, consultation, information and education regarding perinatal mental health problems to other professionals working within this field including health visitors, midwives, general practitioners, obstetricians, social services and community psychiatric nurses.

The staff consists of a half-time general adult psychiatrist (associate specialist), a full-time senior clinical nurse specialist in family therapy and a full-time community psychiatric nurse. A consultant general adult psychiatrist acts as the responsible medical officer. During its first year data were collected to evaluate the acceptability and effectiveness of this service.

Findings

During its first year of operation (1 April 1997–31 March 1998) 116 referrals were made to the perinatal outreach service. Table 1 shows the source of referrals. The majority of referrals (53.4%) came from primary care. Less than 15% of referrals were made at the antenatal stage. About 21% of referrals were dealt with over the telephone alone, and nearly 64% of patients were offered ongoing treatment (see Table 1). Over a third (36%) of the referred patients had no partners, and many who stated that they had a partner did not always live with him. Ethnic minority groups were over-represented in the referral group compared with the catchment area population.

Most patients suffered from a mood disorder (69%) while the remainder suffered from a schizophrenic or schizoaffective disorder. Considering the seriousness of the diagnoses it was surprising that 25% of patients were treated without psychotropic medication; individual counselling and parental skill assessment/treatment were most commonly applied (80% of cases). Couple therapy was applied in 50% of cases and extended family therapy in 28% of cases. A significant group of patients (27%) required daily contacts for a period of time. The majority of these patients (19 of 27) spent some of the treatment period as in-patients at the mother and baby unit. In addition to home visits, with the frequency and duration tailored to the patients' needs, the service also offered regular and at times intensive contact over the telephone.

At the end of the treatment period patients were asked to complete a patient satisfaction questionnaire and were also asked to comment about the treatment they received. Staff completed an additional clinical assessment of outcome. There were significant improvements in mental health of the patients (in 92% of cases)

https://doi.org/10.1192/pb.23.11.665 Published online by Cambridge University Press

Table 1. Source of referrals, outcome of referrals and outcome at end of intervention of a perinatal outreach service

	n	%
Source of referrals (n=116)		
General practitioner	41	35.3
Health visitor	21	18.1
Psychiatrists	23	19.8
Community psychiatric nurses	14	12.1
Obstetricians	6	5.2
Paediatricians	4	3.4
Social workers	4	3.4
Others	3	2.5
Outcome of referrals (n=116)		
No action needed (consultation over the phone)	24	20.7
Assessed once, referred back or elsewhere (community+admissions)	18	15.5
Assessed and ongoing treatment offered (total, community+admissions)	74	63.8
Assessed and admission to mother and baby unit arranged	19	16.4
Outcome of interventions (n=93)		
Discharged with no further interventions	52	56.5
Referred to voluntary agencies	30	32.6
Referred to community mental health team (sector team)	22	23.9
Referred to children's social services	12	13.1
Referred to children and family psychiatric services	3	3.2

and in their parenting skills (in 84% of cases). However, improvements in the relationships with significant others were only evident in 32% of cases. This may reflect the level of disturbed social relationships, which would need more intensive attention. Slightly over 40% of the patient group were referred to other agencies for further help while nearly 60% of the patient group required no further interventions at the end of the treatment period (Table 1).

Comments

To our knowledge there are only two other community perinatal psychiatric services in the UK. Oates established such a service in Nottingham in 1982 (Oates, 1988). During the year from March 1983 they treated 11 mothers throughout their illness and 20 mothers following their discharge (Brockington, 1996). In 1988 a similar service was established in Birmingham. They had 174 referrals in their first year and 400 referrals in 1994 (Brockington, 1996). Both services comprise medical and nursing staff with varying numbers. The philosophy and working practice of both services are similar. Our service described above is different to both services as we offer a wider range of treatment options, including parental skills training and family and couple therapy. The large increase of referrals observed by the Nottingham service within a few years represents both the needs in the community and the popularity of this service.

Domiciliary assessments and treatment in the community were more acceptable to the patients with young babies than attending hospital out-patient clinics or being admitted to hospital. With the appropriate and varied expertise, intense frequency of visiting and with emphasis on involving family and community, the team was able to provide an effective and safe community treatment programme. It is very likely that this specialist community service also resulted in referrals of patients who would not have been referred to a psychiatric service otherwise and therefore catered for a previously unmet need. Though the team treated a significant proportion of patients who may not have required hospital admissions anyway, nearly half the patients treated suffered from or had a history of a severe mental illness. Nearly 20% of patients treated by the outreach team required admission to the in-patient unit at some stage during their treatment. The main reason for admission was concern over the safety of the patient and/or the baby. However, while patients were on the ward the outreach team continued to be involved in the care of these patients in order to facilitate earlier discharge and to ease the transition into the community.

Acknowledgement

We would like to thank Professor R. Kumar for helpful comments on an earlier draft of this article.

https://doi.org/10.1192/pb.23.11.665 Published online by Cambridge University Press

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Perceived role of psychiatrists in the management of substance misuse

A questionnaire survey

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Aims and methods A postal questionnaire sent to all psychiatrists working in four NHS trusts in and around Birmingham was used to survey the number of new cases of drug and alcohol misuse identified in the previous month and the degree of postgraduate training in the management of such cases. Attitudes and beliefs about substance misuse problems were also elicited.

Results A response rate of 70% was achieved across six sub-specialities in psychiatry and four levels of training. Of the 143 respondents, over half had identified at least one new case of alcohol (61%) or drug misuse (55%) in the previous month. Approximately half of the sample admitted to having received no training in management of substance misuse cases in the previous five years (45% alcohol, 50% drugs). There was general agreement about the potential management role of the doctor in the field, but less consensus on whether the clinician had a responsibility to intervene in such cases. A clear discrepancy was demonstrated between psychiatrists' perceptions of the evidence supporting various treatments and the actual evidence base.

Clinical implications The study highlights the pressing need for training psychiatrists at all levels and in all sub-specialities in the management of substance misuse.

The management of substance misuse is currently very topical, and the 'Drug Czar's' report has raised the profile of addiction on the political agenda (President of the Council, 1998). Although doctors, and psychiatrists in particular, have a role in the detection of addictive behaviours and their management, this may present a number of problems. As Unnithan *et al* (1994) suggest, there may be three particular areas of anxiety among general psychiatrists that lead to reluctance to provide care for those who misuse substances:

(a) 'role adequacy' – having the necessary information and skills in order to identify and respond appropriately;
(b) 'role legitimacy' – the extent to which management of such problems is felt to fall within their responsibility;
(c) 'role support' – the confidence in the existence and adequacy of help and advice when it might be needed.

The anxiety in the area of 'role adequacy' is underpinned by evidence to suggest that both undergraduate and postgraduate training oppor-

https://doi.org/10.1192/pb.23.11.665 Published online by Cambridge University Press