Building Perinatal and Infant Mental Health Workforce Capacity in Rural and Remote Queensland: e-PIMH Pilot Project

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Website: www.childrens.health.qld.gov.au/qcpimh
Overview

• Who are we
• What is perinatal and infant mental health?
• What did e-PIMH look like?
• How did we know if it was effective in building local capacity?
• Lessons learned and recommendations
Who are we?

The Queensland Centre for Perinatal and Infant Mental Health (QCPIMH) was established in 2008 as a state-wide hub of expertise in perinatal and infant mental health. QCPIMH has both a state-wide strategy and service development unit and a clinical infant mental health unit which provides specialist infant mental health services in Brisbane. This is supported by the Family Support Program.

Key Directions:
1. Service development and implementation
2. Workforce development
3. Mental health promotion and prevention
4. Research and evaluation
5. Advocacy
What is perinatal mental health?

Perinatal mental health refers to parents’ mental health from preconception until 24 months after the end of pregnancy.
Why do we focus on the parents’ mental health during the perinatal period?

Adjusting to the changes that occur during the perinatal period can be stressful, particularly if combined with other bio-psycho-social issues such as:

- Limited support
- Previous history of mental health issues
- Substance misuse
- Chronic disease
- Difficult birth, etc.

- Ongoing stress and untreated mental health conditions affect the person’s mood, ability to cope, relationships, and overall quality of life.
- For some parents, these issues affect their ability to bond with their baby.

In Queensland, in 2015 suicide was the leading cause of death for women during pregnancy and in the first year post pregnancy.
What is infant mental health?

- Refers to the capacity of the infant to form close and secure relationships
- Is the ability for the infant to express, experience and regulate their emotions

“Feeling lovingly protected is the cornerstone of early mental health”
(Lieberman & Van Horn, 2008)
The importance of an attuned relationship
Still Face Experiment: Dr Edward Tronick
http://www.youtube.com/watch?v=apzXGEbZht0
The "Still Face" Experiment
Why a workforce development pilot?

Significant and challenging perinatal and infant mental health service gap in rural and remote areas of Queensland

Common workforce challenges:
- Funding
- Isolation and distance
- Difficult to recruit to and retain
- Lack of trust with external service providers
- High turnover of staff
- May be a sole practitioner with limited support dealing with complex issues, covering large geographic areas
### Addressing identified workforce development challenges

<table>
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<th>Enablers</th>
<th>Barriers</th>
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<td>Training and education</td>
<td>Turnover of staff</td>
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<td>Lack of networking opportunities</td>
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<td>Online resources</td>
<td>Lack of Professional Development opportunities</td>
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<td>Face-to-face meetings</td>
<td>Isolation</td>
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<td>Video/Teleconference</td>
<td>Poor infrastructure</td>
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<td>Provision of resources</td>
<td>Lack of appropriate training</td>
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<td>Building up local relationships</td>
<td>Varied workforce structure</td>
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<td>Identifying local champions</td>
<td>Undeal referral pathways</td>
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<td>Minimal clinical support</td>
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**Enablers included:**

- Video conferencing capacity
- Research supports the importance of intervening early
- Having Indigenous specific resources

**Barriers included:**

- Degree of diversity across different regional areas
- High demand on staff who may cover a few roles
- Experience of transient nature of services due to funding changes
What did e-PIMH do?

e-PIMH was based in Brisbane and provided:
Non-clinical advice and support via telephone, email and video conferencing
Training and education via video conferencing or, on site when possible
Visits to rural and remote sites when appropriate

The aim of the e-PIMH was to:
• provide non-clinical advice and support to health professionals in the area of perinatal and infant mental health
• work in collaboration with Rural and Remote Hospital and Health Services, specifically South West, Central West, North West and Torres and Cape
• collaborate with key local stakeholders who acknowledge the importance of supporting pregnant and parenting families with infants and toddlers
• raise awareness of perinatal and infant mental health
• increase capacity of local workforce through tailored training and education to respond to perinatal and infant mental health needs
• facilitate linking of local referral pathways
A Snapshot of e-PIMH

- Had **74** meetings and met with **159** people – distributed resources
- **197** people attended **14** training sessions in an eight month period
  - This includes two Indigenous led services and a group of Indigenous Health Workers
  - Two sessions delivered via video conference
- Monthly emails sent with resources on identified topics (antenatal educational resources, dads and fatherhood, newborns and baby cues, sleep settling and challenging behaviours)
- Limited ad hoc support via phone and email
Distribution of respondents’ service delivery areas across Queensland
Respondents by Organisation Type (n=53)

- 56% Government
- 38% Non-Government Service
- 6% Private Organisation

Respondents by Occupation (n=53)

- Manager 21%
- Allied Health 15%
- Community Worker 23%
- Education 8%
- Medical Officer 2%
- Nursing 23%
- ATSI Specific 8%
Respondents’ Engagement with Different Aspects of e-PIMH
Results from Online Survey

41 participants completed this section with the following results:

- 80 to 88% of respondents agreed that their engagement with e-PIMH **improved their awareness of infant and perinatal mental health respectively**
- 66% agreed that it **improved their skills in detecting problems**
- 85% agreed that it **provided resources which helped them in their work with their clients**
- 66% agreed it **improved local connections and referral pathways**
- 73% agreed their increased understanding of perinatal and infant mental health **assisted them in their work with clients**
Implementation Results

• 94% (n=36) agreed that there is a strong need for a model of support like e-PIMH.

• 87% (n=31) agreed that the e-PIMH model fit with their current service.

• 94% (n=32) said their service is open to accessing and using the support.

• 66% (n=32) did not find that their organisation’s infrastructure posed a barrier to engaging with e-PIMH.

• 57% (n= 33) did not identify any difficulties with accessing the e-PIMH project.

Feedback

“Numerous clinicians have made use of elements of the project, however, as a whole HHS, implementation and driving uptake on this has been mostly passive from the educational perspective. This is due to demand/supply imbalance where we do not have enough human resources to cover all of our demands contemporaneously”
Why Did Services Request Training?

- Identified need for professional development in the area
- Important to improve skills and knowledge base in this area due to limited psychological and psychiatric services due to remoteness of areas
- Staff work with Indigenous families with a range of complex issues
- Important for staff to have some ‘foundational knowledge’ in this area to inform the work they do with families
- Increase understanding of brain development and how to assist parents
Training Evaluations

Indigenous Health Workers, Apunipima, and RAATSICC Training Combined Evaluation (n = 46)

Mt. Isa Combined Evaluation (n = 19)
Some learnings...

• Important to engage services at level that is appropriate and they are ready for
• Could view online training when convenient, choose which information to print out
• Need for clinical support as well as non-clinical
• Emailing of resources is highly valued – targeted and not too frequent
• Regular training and education due to staff turnover
• Site visits to meet service providers in person and build trust
• Connection
• Responsive and relevant
• Flexible and adaptive
• “One stop shop”
• Appreciate site visits – makes significant difference to level of engagement and trust
• Need for mentoring opportunities
• Workload and lack of resources impeded ability to engage with the pilot
• Staff experiencing ‘online learning fatigue’
Some feedback...

“We were not swamped with information and calls. We could access the service for help, and information was sent to us but we were not bombarded by emails”

“Very well, they are responsive to the challenges we face in a rural and remote area and work hard to find us alternative (or "out of the box") solutions to those challenges”
Recommendations

Recommendation One
Develop a model of clinical tele-psychiatry support for perinatal and infant mental health

Recommendation Two
Support ongoing training, education and awareness-raising

Recommendation Three
Continue building relationships and trust, and ensure ongoing consultation around changing needs

Recommendation Four
Continue the current communication strategy with regional, rural and remote stakeholders

Recommendation Five
Promote and participate in consistent collection of relevant data
Where to from here?

• Continue to build connections and relationships via email, telephone and site visits

• Develop a flexible model of perinatal and infant mental health tele-psychiatry
  • Clearly define what a tele-psychiatry service will do and how it will value add
  • Establish baseline measures and evaluation processes
  • Determine how and why roll out sites will be chosen
  • Identify who the key players will be in implementing such a service
Some useful websites

For parents:

www.panda.org.au
www.beyondblue.org.au
www.blackdoginstitute.org.au
http://mothersmatter.co.nz/

For children:

• www.zerotothree.org
• www.raisingchildren.net.au
• www.whatwerewethinking.org.au
• www.circleofsecurity.net
• www.aaimhi.org.au
Contact details

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