POSTER ABSTRACT

Amending integrated perinatal care policy to respond to women in distress in pregnancy using a risk stratification model

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Introduction: We have previously presented on the design and implementation of an integrated care initiative for vulnerable families in central and inner-west Sydney, Australia. That design was based on earlier mixed-method emergent theory building research in relation to family stress in the perinatal period. A focus for integrated care programs has been on the identification and support of families experiencing stress, anxiety and depression during the perinatal period. A program of research has been undertaken to better inform both risk stratification and evidence-based interventions.

The Edinburgh Perinatal Depression Scale (EPDS) is the most widely used depression screening measure in the perinatal period with a score of 13 or more used as the threshold for further assessment and intervention. However, an increasing body of literature suggests subthreshold scores of 10 to 12 indicate clinically relevant distress. Many women go on to develop postnatal mental health disorders without any formal recognition of antenatal precursors, despite common risk factors such as subclinical symptoms, being identifiable.

Description of policy context and objective: The New South Wales (NSW) perinatal integrated care guidelines (Safe Start) are intended to facilitate psychosocial assessment (including depression screening). Owing to the misguided concern that all levels of identified risk would require specialised assessment, it was decided that clinical interventions would be restricted antenatal and postpartum EPDS thresholds of 13 or more. Despite increasing advocacy for more attention to be paid to women who were distressed, though subthreshold for intervention, new clinical practice guidelines endorsed by the National Health and Medical Research Council, in 2017, upheld an EPDS threshold of 13 or more.

Targeted population: Preliminary research of a diverse population cohort of pregnant and postpartum women in NSW has demonstrated that women scoring 10 to 12 on the EPDS have similar psychosocial and obstetric vulnerability when compared to women scoring 13 or more, and have a much higher risk of developing postnatal depression. Without policy recommendations for targeted and proportionate interventions for this population, there is a missed opportunity to integrate care effectively at a preventative, service and clinical level. It also risks dismissing an identified stratum of women who are signalling distress.
Highlights: We propose an amendment to the current NSW SafeStart policy, underpinned by a proportionate universalism philosophy. We conceptualise the EPDS as a risk stratification tool. Women currently scoring 13 or more on EPDS screening are offered further assessment and intervention which may include intensive support with sustained nurse home visitation. For women scoring 10 to 12, we recommend offering a suite of evidence-based interventions with a focus on therapeutic interaction and prevention, such as locally delivered mothers groups, couples-based interventions or peer telephone-based support. Finally, women scoring 9 or less are targeted by broad health promotion strategies.

Comments on transferability: The EPDS is used widely for depression screening in community and inpatient contexts. The suggested interventions are population-derived, offered according to stratification, and are low-resource. Potential policy instruments such as existing mental health access funding models could be utilised.

Keywords: integrated perinatal care; risk stratification; policy reform; epds screening; proportionate universalism