Women’s views and experiences of having their mental health needs considered in the perinatal period.

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What is perinatal mental health?

Refers to the mental health of women during pregnancy and up to 1 year postpartum (Austin, 2003; Austin et al. 2008; Galbally et al. 2010; Howard et al. 2014b).

Perinatal mental health problems (PMHPs) include range of mental health difficulties from psychological distress to serious mental health problems (Austin et al., 2008).

PMHPs are associated with adverse outcomes including recurrent depression, increased risk of psychosis, less-responsive care-giving and increased risk of suicide (Knight et al. 2014).
Perinatal mental health is a major public health issue. 20% of women will experience a PMHP (RCOG, 2017).

PMHPs are often undetected (Bauer et al., 2014). Need to improve detection, to improve outcomes (RCOG, 2017).

Affects woman/baby/partner/whole family (NICE, 2014). Early detection can improve outcomes (Yawn et al., 2012).
Screening

*Should include enquiry about any mental health condition and open the conversation around emotional health and wellbeing.*

‘...a complex process that includes detection, evaluation, engagement, intervention, reduction of symptoms or risk, an achievement of functional improvements” Wisner et al. (2015, p194).

Midwives play an important role in the continuum of care in screening and assessment to identify women experiencing PMHPs (Sanger et al., 2015).

Identification of women with mental health problems in the perinatal period can be improved by the use of screening questions (Bosanquet et al. 2015) and screening tools (Austin et al. 2011).
Current practice - screening

- No national guidelines
- Local practice varies
- UK recommendations vary (NICE/SIGN/RCOG)
- Internationally US/Australia recommends routine screening
- Conflicting!
Screening: All health care professionals involved in antenatal and postnatal care, should be trained to identify women at risk of developing or experiencing emotional or mental health difficulties, including an exacerbation of previous mental health issues, in the perinatal period.

Principle 6: All women are asked questions about their psychosocial circumstances and about their personal and family mental health history.

Principle 8: Screening questions and screening tools are used to support practitioners to identify women experiencing mental health problems.
Research focus

1. Critically examine how women *feel* about screening for PMHPs in pregnancy and the postnatal period?

2. What are the barriers and drivers women perceive in disclosing or discussing mental health issues?

3. What are women’s views and experiences of having their mental health needs considered in the perinatal period?
Context

Dublin maternity hospital with access to established perinatal mental health team.

Circa 9000 deliveries per year.

Combined AN care, Midwife led, Private/Semi Private Care.

Postnatal women were invited to participate in the study.
Methodology

Qualitative design using semi-structured interviews.

Eight participants were recruited and interviewed in the early postpartum period.

Data was analysed using Thematic Analysis (Braun & Clarke, 2006).
Findings

See thematic map (Nagle, U. 2017).
Theme One
The experience of mental distress

- An emotional time
- You’re supposed to be happy

Confidence in managing mental health

Theme Two
Telling and disclosing

- Talking to healthcare professionals
- Screening tools – ticking the box

Stigma/shame

Theme Three
The experience of obtaining help

- Attitudes of healthcare professionals
- Baby as a motivator

Getting help
T1 An emotional time

P5: I worried that something was going to happen to my partner, that I might be left by myself, the fear that something was going to happen to the child.

P2: I'd have intrusive thoughts even that I was gonna harm the baby and that used to freak me out so much. It's really distressing, and to actually verbalise what I was thinking would help me.

P6: Half way through the pregnancy the fear of becoming a new Mam kicked in and I was pretty anxious. I thought that if I took a panic attack it would have an effect on the baby.
T1 You’re supposed to be happy

P4: I don’t enjoy being pregnant, I’ve never been the happiest pregnant person to be honest, but I wouldn’t really say that out loud.

P5: Everybody just assumes that you're delighted to be pregnant...well maybe I'm not but you can’t say that.
T1 Confidence in managing mental health

P8: I like going to access a service if I want to, but I don’t like being pushed into a service. I prefer to go and get the service when I want it… as opposed to being referred. But I like to know it’s there if I need it.

P2: I have a toolbox in my head, I know where to go if I’m not well.
T2 Talking to healthcare professionals

P1: It makes women feel like someone is taking care of them, looking after you.

P2: It’s all about the baby, not about your headspace.

P5: The midwives are all so busy, I would feel like a burden talking to them because they’re so busy on the wards.

P1: It makes women feel like someone is taking care of them, looking after you.
T2 Screening tools – ticking the box

P2: If it’s written down, I know they’re gonna look after me because I’ve disclosed it.

P4: You just fill it out and tick the boxes.
T2 Stigma and shame

P8: There is a stigma with mental health and you don't want that stigma because sick patients take on a patient role, I didn't want to take on that role - this ‘mental health patient’ role. I don't like to feel like I'm being boxed off in that ‘tragic’ box.

P7: I think that's people’s fear, they're afraid if they tell you there's something wrong that social workers will get involved.
T3 Attitudes of healthcare professionals

P5: The midwives on the ward are absolutely lovely but you can tell which ones are listening and which ones aren't.

P2: Sometimes it needs to be done for you, I needed someone to really like hold me, you know to be proactive.
T3 Baby as a motivator

P6: If I’m struggling I will say, I have to. I have to be the best I can be for the baby.

P8: I stopped meds because I didn't want to potentially give the baby problems, I didn't mind.
T3 Getting help

P3: I would prefer to know someone before I asked them for help.

P5: If there was 5 minutes to ask women how they’re feeling before they go home, it would be an opportunity to say ‘I need help’.
Conclusions

Women appreciate enquiry about their mental health in the perinatal period and time to discuss concerns with HCPs.

Barriers to disclosure included perceived busy staff workloads, stigma and shame, fear of referral to social workers.

Drivers included the baby as a motivator, continuity of care, knowing a point of contact who provides support.

Women with significant histories chose not to engage with available PMH services unless they needed to, fitting with the concept of ‘precovery’.

Screening tools were viewed as a ‘tick box’ exercise, but also as an opportunity to disclose negative thoughts and open the conversation around emotional wellbeing.
Recommendations

Women should be regularly asked about their mental health throughout the pregnancy and postpartum continuum.

Enquiry about mental health should include broad focus of mental health disorders, not just anxiety and depression.

Screening tools can assist in the detection of women at risk of or experiencing PMHPs, useful where time/privacy is restricted.

Antenatal education should include emotional wellbeing and the full spectrum of perinatal mental health problems for women and partners.

Regular education and training for staff involved in antenatal and postnatal care.

Specialist mental health midwife to review women with significant mental health histories at the antenatal booking visit to be a visible point of contact and facilitate early referral to PMH team/early intervention.
References


