PERINATAL MENTAL HEALTH

EXPERIENCES OF WOMEN AND HEALTH PROFESSIONALS

October 2013

Boots Family Trust
netmums.com
IHV Institute of Health Visiting Excellence In Practice
Tommy's
The Royal College of Midwives

Perinatal Mental Health
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October 2013 | Introduction from the Boots Family Trust

Boots Family Trust Alliance

The Boots Family Trust was established in June 2012 after a particularly severe episode of postnatal depression resulted in tragic consequences. The aim of the Trust is to promote awareness of the illness and to provide support to those dealing with actual or potential incidents of postnatal depression.

There tends to be a natural flare up of compassion when postnatal depression results in tragedy. But the real truth – as made clear in this report – is that many new mothers experience some level of emotional distress and all deserve systematic and compassionate support.

Our hope is that this report is the first step in the evolution of a comprehensive network of professional tools, public policy, and general awareness that provides that much needed support.

To that end, the Boots Family Trust Alliance is a collaboration amongst those who have a particular interest and role to play in addressing maternal mental health issues, and includes Netmums, the Institute for Health Visiting, Tommy's, and the Royal College of Midwives.

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Acknowledgements

Our thanks go to Rita Newland who prepared the mothers' survey, Cathy Lowenhoff who reported on the health professionals' survey and to all the national experts who commented on questions and drafts. We are most grateful to those women and professionals who shared their experiences with us and allowed us to produce this report and create the resources that will support families in years to come.

This report was compiled by Sally Russell and Dr Beckie Lang, with help from Jacqui Clinton, Dr Cheryll Adams and Julia Lamb.

Netmums

Netmums is an online community which supports women through pregnancy and parenthood. It provides a range of services for free:

- information on local support available
- expert information on treatment and self-help options
- safe, peer support through a moderated online forum
- direct advice by online Health Visitors and experts from Relate, CAB and Women's Aid
- a free online Cognitive Behaviour Therapy course for those with postnatal depression.

Tommy's

Tommy's is a national charity which funds research into the causes and prevention of miscarriage, premature birth and stillbirth and provides free pregnancy health information for parents-to-be and supporting information for health professionals. In addition to the three specialist pregnancy clinics attached to the Tommy's research centres in London, Edinburgh and Manchester, Tommy's provides a freephone PregnancyLine staffed by expert midwives to answer calls on pregnancy health and pregnancy loss.

Institute of Health Visiting

The Institute of Health Visiting (iHV) was launched as a UK-wide charity at the end of 2012. Its purpose is to become a centre of excellence for health visitors thereby strengthening the quality and consistency of the services they can provide for children, families and communities. It has recently trained 300 health visitors as perinatal mental health champions in every region of England.

Royal College of Midwives

The Royal College of Midwives (RCM) is the trade union and professional organisation that represents the vast majority of practising midwives in the UK. The RCM is the voice of midwifery, providing excellence in representation, professional leadership, education and influence for and on behalf of midwives. The RCM actively supports and campaigns for improvements to maternity services and provide professional leadership for one of the most established clinical disciplines.

Executive summary

Perinatal mental illness is relatively common amongst women and occurs in the period from conception to the baby's first birthday. Research has shown that depression alone can affect one in seven women. This report describes the key findings from two surveys: of around 1,500 women; and of more than 2,000 health professionals. In both surveys, although respondents were self-selected, their number enables trends to be identified with confidence.

Survey of women who suffered with perinatal mental illness

In the survey of women, all had experienced some form of mental health problem during the perinatal period. Almost half said they had suffered with either depression or anxiety while they were pregnant, and two thirds said they had suffered with postnatal depression. Two per cent had suffered with puerperal psychosis.

The most common symptoms were low mood and tearfulness, experienced by eight out of ten women. In all, more than eighteen symptoms were described, with some being notable because it is less likely that they would be picked up by health professionals. For example, half experienced feelings of anger, while more than four out of ten felt it was hard to leave the house. Over half experienced a change in their appetite with over-eating more common than a loss of appetite. Bonding with their baby was difficult for just over a quarter of those surveyed and a fifth reported having suicidal thoughts.

Survey of professionals

The survey of health professionals included the experiences of hospital and community midwives (365), health visitors (1330), Family Nurse Practitioners (106) and others. Almost all the midwives reported that they ask women about their emotional wellbeing when they are booked in for maternity care, but only one in ten of women recalled or recognised that they were being asked. It was suggested by some professionals that there is an over-reliance on the use of the Whooley questions alone, which are currently recommended for use as a first step in case finding by NICE.[1]

Women with a previous history of mental health problems are at increased risk of developing mental health problems during pregnancy and the postnatal period, but only half of professionals said that they were confident that they knew about the previous history of the women in their care. They acknowledged a lack of confidence due to poor or insufficient training, availability of information from other professionals, undocumented history in maternity notes, poor continuity of care, lack of support services and the reluctance of women to discuss their mental health issues.

Causes of ill-health

Women put their mental health problems down to trying to live up to unrealistic expectations, and a lack of support in the main. One in seven also said they felt they were prone to having mental health problems – it was a feature of their personality. A high proportion said they'd also experienced additional pressures such as a traumatic birth (more than 4 in 10), financial or relationship problems or an unsettled baby.

Seeking help

The results indicated that the first step for getting better was for women to recognise they were unwell, and then to be prepared to talk about how they feel. More than half of the professionals surveyed agreed that written materials would support their discussions with mothers.

Women's resistance to talking about their feelings was the biggest barrier to being able to access help, with less than a fifth saying that they had been completely honest. Indeed, almost a third of those surveyed had never told a health professional that they felt unwell.

Over a quarter of those surveyed admitted that they were concerned about revealing their true feelings as they thought their baby might be taken away.

However, for those who decided to seek help, a quarter confided in a health professional before telling anyone else, while just under half spoke to their partner or husband first. Knowing that a quarter of sufferers are likely to tell a health visitor, midwife or GP as the first person they confide in is empowering for professionals, as it is a significant opportunity for them to support women who are starting to explore what their symptoms may mean.

Role of partners

Four out of ten women who are in a relationship said their partner had experienced anxiety or depression and in addition, of those surveyed, seven out of ten said their relationship with their partner had been affected by their illness. Professionals agreed that partners are likely to pick up the signs of mental health problems before the woman is able to recognise that she is unwell. This is why it is important that the partner

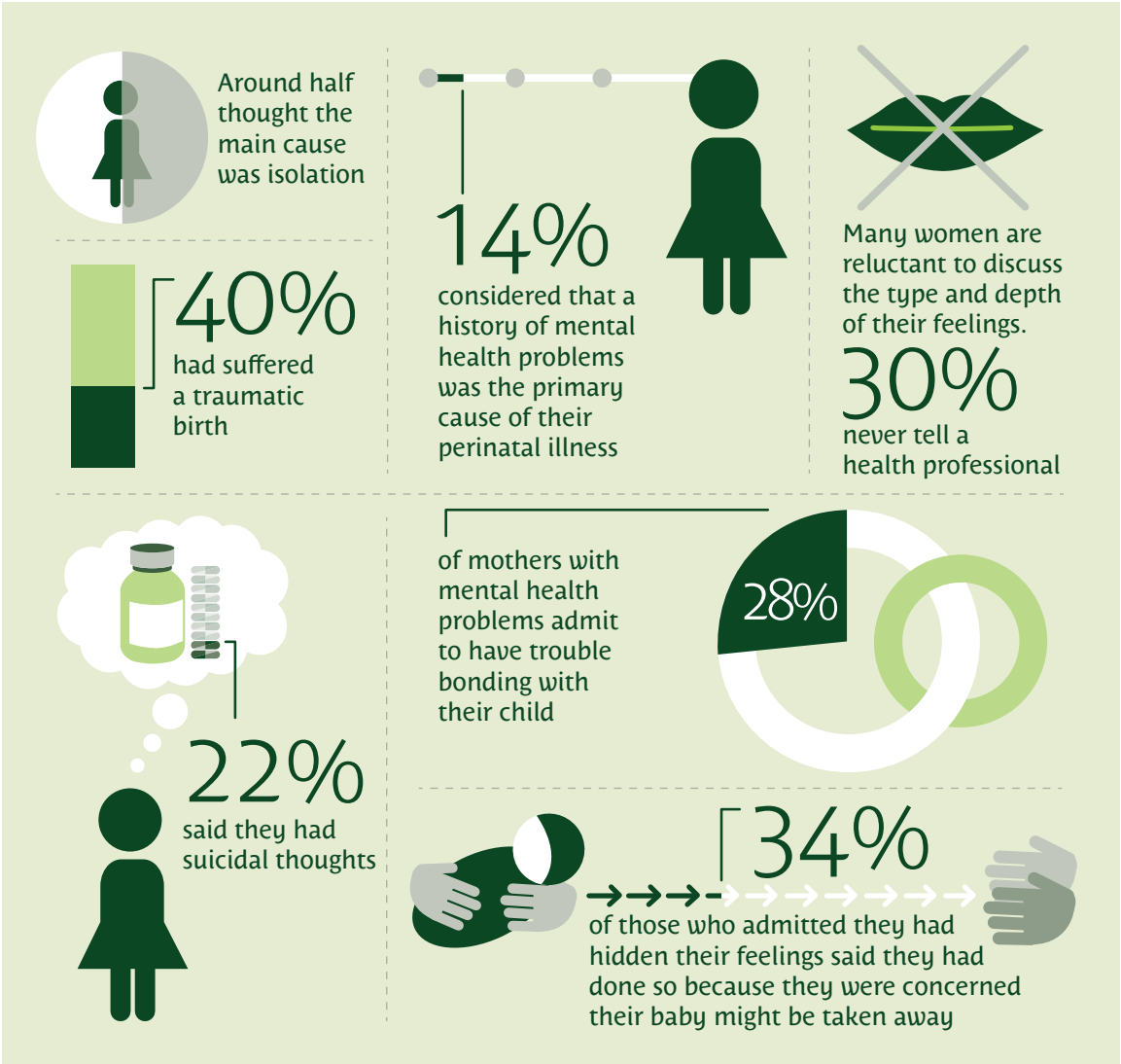
is encouraged, where appropriate, to have a significant role and should routinely be involved and so well-informed and prepared. Resources to support partners and other family members were requested.

Getting better

Women reported that they had recovered or improved through a variety of support and treatment. Half of them had used medication such as antidepressants and around four in ten had tried counselling, but the support of loved ones and friends, reducing stresses, talking with experts, self-help strategies and exercise were all identified as important.

The two biggest healers were considered to be time and the recognition and acceptance that they had mental health problems.

> Mental illness includes a wide range of symptoms which means women can struggle to understand that they are ill. Health professionals should be alert to a wide array of symptoms.

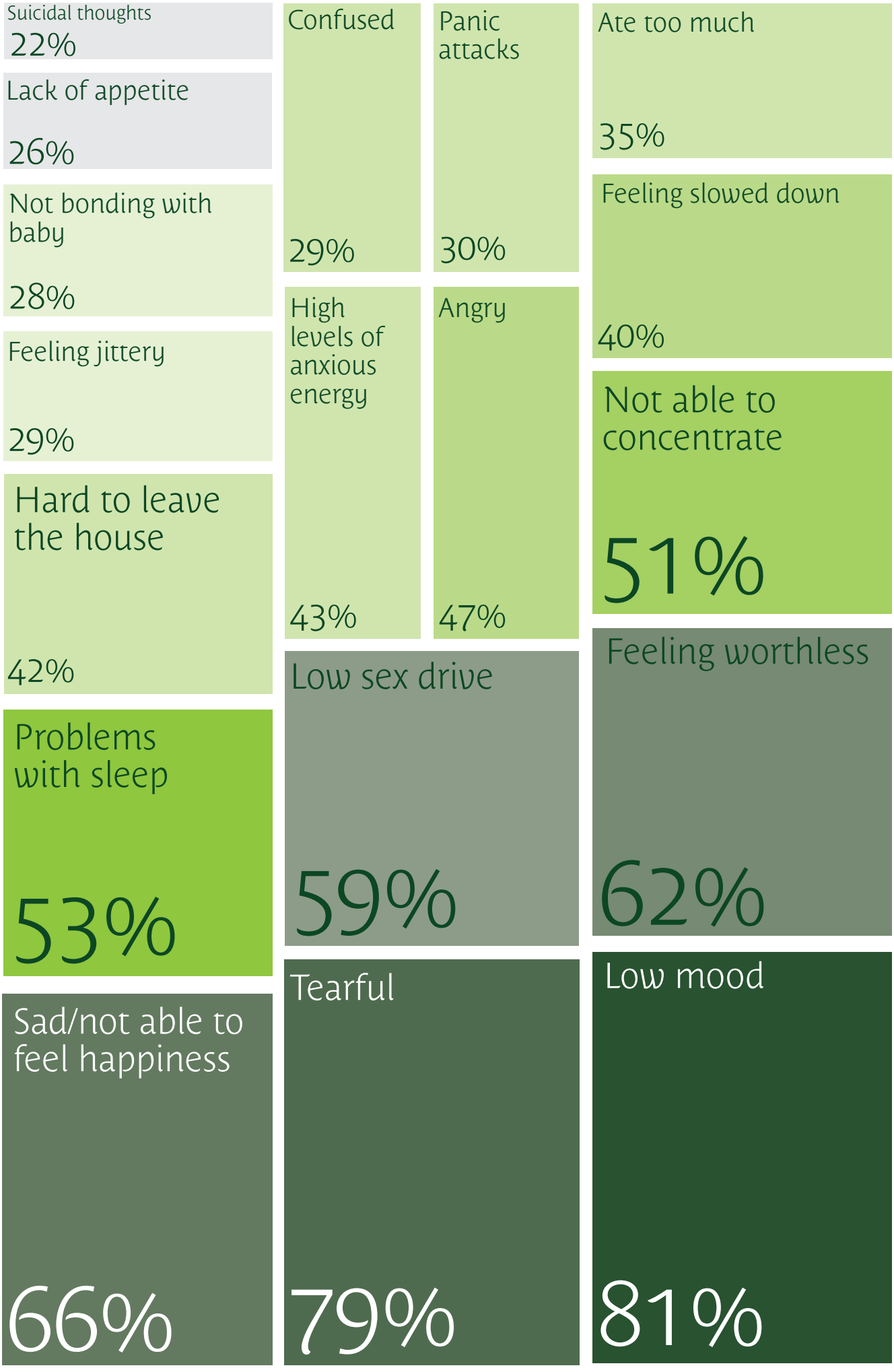


Next steps

The results suggest the following will help professionals to work with women more effectively and help women and their families to be more open and better supported if they become unwell:

- Use of a *Wellbeing Plan* in a similar way to a *Birth Plan* to provide information and open up discussions.
- Clearer and appropriate discussions with parents about emotional wellbeing throughout pregnancy and the post-natal period.
- Identification of mental health problems may include use of the Whooley questions, but there should not be a reliance on them alone, especially given that so many women are inclined to hide their feelings.
- Accurate documentation and better information sharing between professionals and better communication with mothers with respect to any previous history of mental health problems.
- Professionals must dispel the myth that babies are taken away from mothers with depression or anxiety, while also explaining to mothers that it is common for them to have this concern.
- Partners must be routinely involved, where appropriate, so they are in a position to help identify difficulties and provide early support.
- Explore issues that may have affected the mother-to-be or mother, such as worries and expectations, a traumatic birth or wider family issues including financial concerns, relationships and coping with other children.
- When women reveal they feel unwell to a professional it may be the first time they have spoken to anyone and so a significant opportunity to provide help and support.
- Women should be helped to talk with family and friends where appropriate and signposted to sources of information about their condition.
- There should be explicit consideration of both infant-mother attachment and thoughts of suicide and professionals should be trained to both ask and then consider the most appropriate support for women who are struggling with these.
- Be mindful that referrals to secondary services are not the only support available. Professionals should be aware of and familiarise themselves with the wide range of advice, support and other interventions that are available and may be helpful for the woman.
- There should be a minimum standard of training for midwives, health visitors and other professionals, such as GPs, in identifying women with mental health problems and an availability of a package of measures for support and referral as appropriate.
- Maternity and postnatal services should be configured around the woman, to both increase continuity of care, promoting the woman's willingness to talk, and to allow for sufficient time and famliarity for mental health issues to be addressed.
- Public and professional education campaigns will help to normalise, reduce the stigma of, and promote early recognition and treatment of perinatal mental illness.

Mothers, mothers-to-be, their partners and wider family are able to find out more about non-statutory services that are able to help them at Netmums at www.netmums.com/pnd or by using Tommy's free PregnancyLine on 0800 0147 800.


Suicidal thoughts
22%
Lack of appetite
26%
Not bonding with baby
28%
Feeling jittery
29%
Hard to leave the house
42%
Problems with sleep
53%
Sad/not able to feel happiness
66%
Confused
29%
Panic attacks
30%
High levels of anxious energy
43%
Angry
47%
Low sex drive
59%
Tearful
79%
Ate too much
35%
Feeling slowed down
40%
Not able to concentrate
51%
Feeling worthless
62%
Low mood
81%

Introduction

The perinatal period, as defined in relation to mental illness, spans the time of conception to when the infant reaches the age of one. This is a time of both physical and mental change for women as their baby grows in the womb, they deliver their baby and adapt to parenthood.

The physical impacts of pregnancy are widely discussed and recounted by both women and health professionals. In comparison, the emotional changes during this time attract less attention and are less well publicised.

Around one in seven experience depression during pregnancy and a further one in seven women experience postnatal depression[2–4] but in snapshot surveys, as many as one in three report having experienced some level of depression or anxiety during the perinatal period.[5,6]

While the severity varies from person to person, mental health problems during pregnancy and post birth may have serious consequences for both mother and baby. For mothers, effects can include failure to bond with their baby, a broken relationship with the father and suicide attempts.[7–9] There is emerging evidence of the impact of maternal stress and anxiety on the fetus which could lead to premature birth or a low birth weight. The impacts of stress on the fetus and poor interaction post birth can both increase the risk that a child may experience a range of difficulties affecting every stage of their future life. These include depression, cognitive impairment, a greater risk of needing long term mental health services and a greater likelihood of entering the criminal justice system.[10–17] It is increasingly accepted that services to support the emotional wellbeing of mothers and their partners at this very vulnerable time must be strengthened;[18, 19] firstly to help them avoid illness where possible, and secondly to provide suitable and timely support or treatment. It is important that those services are provided both efficiently and effectively, to maximise the outcomes for the whole family.

This report describes the findings from survey work conducted with approximately 1,500 women and 2,000 health professionals on the topic of perinatal mental health. The aspects of illness that impact women's access of care, what women find helpful and relationships with health professionals are discussed. It further reviews the work of professionals and makes recommendations for the improved support of women.

About the research

Two surveys were conducted, the first to delve deeper into the lived experience of women experiencing perinatal mental health problems, and the second to identify the experiences and needs of professionals working with women in the perinatal period.

Survey of women

The survey of women was conducted online by Netmums during August and September 2012. Netmums is an online parenting community where mothers can find both local information and support. As the biggest parenting community in the UK it attracts women from all backgrounds but there is a slight over-representation of those in lower socio-economic groups. Those responding self-selected to do so and all respondents had experienced perinatal mental health problems (either diagnosed by a health professional or self-diagnosed). The survey received responses from 1,547 women.

The survey explored the experiences of mothers including symptoms, disclosure, the impact on family relationships and how front-line health services were helping these mothers or not.

Survey of professionals

The survey of professionals was also conducted online. It was distributed during March and April 2013 by a number of organisations supporting health professionals including the Institute of Health Visiting and the Royal College of Midwives.

The survey was developed by Tommy's, the leading UK charity who fund research into miscarriage, premature birth and stillbirth and provision of pregnancy health information for parents-to-be.

It looked at the confidence of health professionals in raising mental wellbeing with patients and the resources that they felt would benefit them in working with women and their families. The survey was completed by 2,093 self-selected health professionals, predominantly health visitors (1,330), but also midwives, family nurse practitioners and others.

As with all questionnaire research of this kind, both surveys are likely to have attracted those with an interest in the topic, however the survey remains helpful in suggesting some clear trends and opportunities for service improvement.

SECTION 1
EXPERIENCES OF ILLNESS

Experiences of illness

Describing illness

While the term 'postnatal depression' is very well known, antenatal depression, anxiety and other perinatal mental health problems, such as maternal Obsessional Compulsive Disorder (OCD) and Post-Traumatic Stress Disorder (PTSD), are relatively unknown by the general public.

This lack of awareness around mental health can make it more difficult for those affected and their families to spot the symptoms and recognise when they are unwell.

How women are able to describe their feelings to health professionals can have an impact on whether their mental health problems are detected, the timeliness of the support they receive and the nature of the help offered.

"I'm currently into my second pregnancy and think I am suffering from depression.... I feel scared and feel like I have trouble bonding with this pregnancy... I don't know what is wrong with me this time."

In the survey of mothers, women were asked about their experience of anxiety, depression, puerperal psychosis and when they felt they became unwell. The survey did not investigate problems of those with longer term or chronic mental health problems but focussed on perinatal problems specifically.

As shown in Figure 1, almost a quarter of respondents said they had suffered with antenatal depression and just over two thirds had suffered with postnatal depression. Anxiety in pregnancy was reported by almost one in three, and half of respondents reported anxiety postnatally. Two per cent had experienced puerperal psychosis.

However, two in five of those surveyed lacked a formal diagnosis for their illness and it was generally found that reported symptomology was similar whether they experienced anxiety or depression. The terms seem to be used interchangeably and may reflect a misuse of terminology given the greater knowledge of depression post pregnancy and the lack of awareness of its manifestation during pregnancy.

Health professionals should provide practical advice, with a focus on those symptoms that the woman says she finds most disruptive, and to pay close attention to attachment and suicidal thoughts for the sake of both mother and child.

What is it like being unwell?

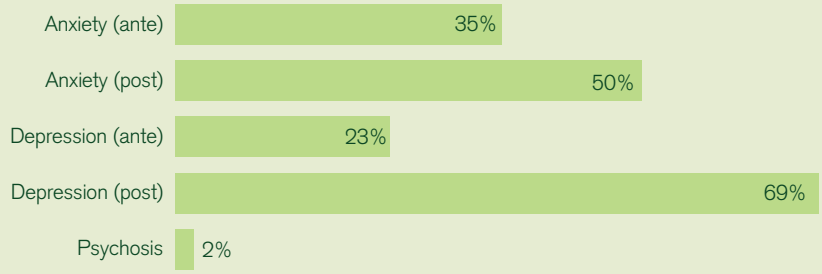
Mothers described a wide range of symptoms they experienced when they felt unwell, with four in ten having suffered for more than a year.

The most common feeling expressed by women was **low mood** experienced by 81% of women.

Tearfulness was also extremely common (81%) and could be a good proxy by health professionals when exploring a mother's wellbeing.

Appetite changes were reported by 57%, with over-eating being more of a problem than under-eating.

Figure 1 – Condition Experienced



Anger affected half of women (49%) and although not identified as a common characteristic within formal diagnostic criteria such as the International Classification of Disorders, ICD-10[20] professionals should be alert to it.

Difficulty leaving the house affected just under half of women (43%) and may present an area for exploration by health professionals as agoraphobia often isn't disclosed. In addition, this symptom may prevent access to social support, attendance at health appointments, or even seeking help in the first instance.

"I think I'm suffering from anxiety. I'm not depressed, I love my little boy to bits and I do not want to harm myself... but I'm scared to go out the house because a freak lightening bolt may hit me (it could happen – I live in a flat area)."

More than a quarter (28%) reported that they had trouble **bonding with their baby** and more than one in five (22%) reported having **suicidal thoughts**. Intrusive thoughts and self-harm were also identified.

"It just dawned on me one morning about 30 weeks pregnant that i didn't feel bonded to the baby and that I somehow knew I wouldn't be bonded once they were born. I am happiest when he is asleep..."

Discussion of symptoms

The survey of health professionals revealed a variety of approaches for identifying if a patient had symptoms of a perinatal mental health problem.

Current guidelines[1] suggest that the Whooley questions are used, in the first instance, to identify those who may be unwell during pregnancy and the postnatal period. These are two simple questions that determine whether a woman has felt sad or lost an interest in things. Unfortunately, they do not address anxiety or some of the more serious symptoms described, and in this survey, professionals suggested if used on their own, they don't encourage an open or extensive discussion.

It appeared that not all midwives and health visitors are using the Whooley questions routinely.

Two thirds of professionals reported that they use the Whooley questions, but just as many used the Edinburgh Postnatal Depression Scale (including 80% of the health visitors surveyed) and 12% of professionals (primarily Family Nurse Practitioners) use the Hospital Anxiety and Depression Scale (HADS) to assess an individual's current state.

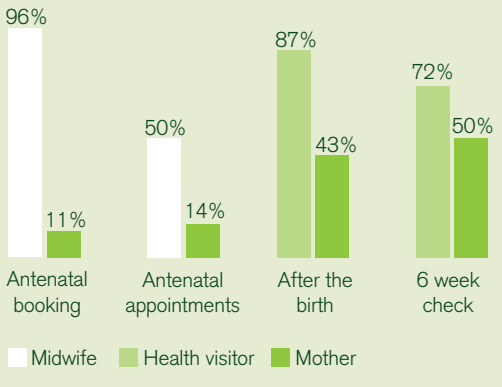
Some health professionals expressed their concerns that too many vulnerable mothers were 'missed' when using the Whooley questions as the first part of a mental health assessment, especially those that had mental health problems other than depression.

"I think the introduction of the Whooley questions have had a detrimental effect on the screening and treatment for PND. Many mothers in my experience have no idea that they are being 'screened'..."
Community Practitioner, South East

Most women either didn't recall or didn't recognise that they were being asked about their emotional wellbeing in pregnancy or after the birth, in stark contrast to the numbers of midwives and health visitors who reported they were asking at various time points.

Figure 2 illustrates these significant differences. For example, most midwives confirmed that they ask about mental wellbeing at booking (96%) but only 11% of mothers reported that they had been asked about their feelings at this stage.

Figure 2 – Comparison of Midwives & Health Visitors asking about wellbeing and mothers' recollections



Causes of illness

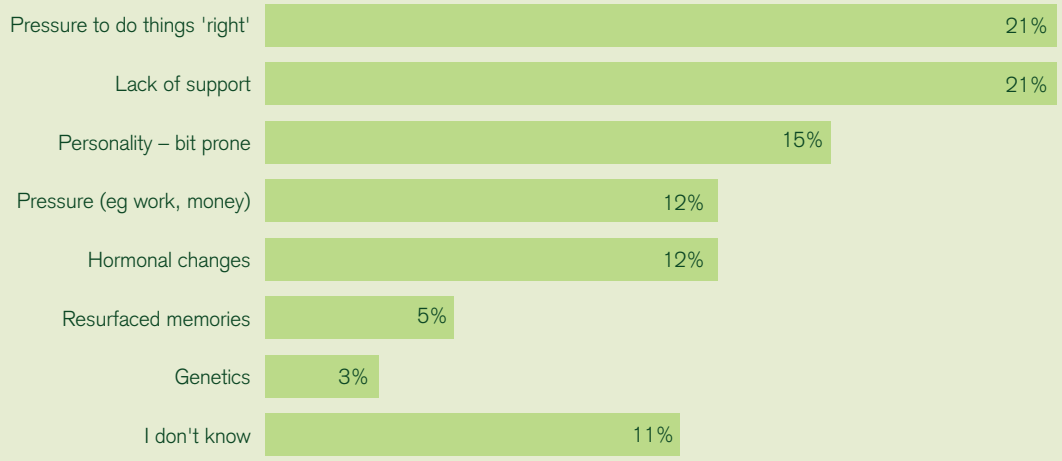
A previous history of mental health problems is the only factor used to identify women at increased risk of perinatal illness[1]. In the survey of health professionals only half were confident that they would know if a woman had an existing or previous history of mental illness. Explanations for the lack of confidence include lack of training, lack of available information from other professionals, lack of documented history in maternity notes, lack of continuity of care, lack of

support services and the reluctance of women to talk about their mental health.

It cannot help that mothers don't necessarily appear to recognise that a previous history of mental ill-health is important. In the survey of mothers, only one in seven identified their 'personality – I am a bit prone to this' as the cause of their illness. More common was struggling with 'pressure to do things 'right'' or a 'lack of support'.

Factors that exacerbated their ill-health were a traumatic birth, identified by four out of ten women, and relationship difficulties, financial problems or an unsettled baby, each affecting around a third.

Figure 3 – Reported causes of illness



SECTION 2
STEPS TO ACCESSING HELP

Steps to accessing help

The survey results suggest that for women to ask for help they need to go through three stages.

1. Recognise the symptoms they have as being unusual.
2. Accept the possibility of illness.
3. Have trust in the individuals or service that they would approach for support.

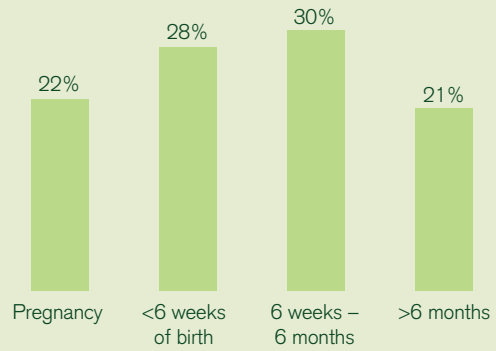
Recognition of illness

The first step to getting better is to recognise you are ill in the first place. Indeed, a quarter of women said it was the most important contribution to their recovery.

Women were asked when they realised that they were unwell, and to think about the first time if they had suffered more than once. Just over a fifth of women recognised they were unwell during their pregnancy. (A further one in ten said they didn't recognise symptoms at the time, but realised in hindsight that they had been ill during pregnancy).

More than a quarter recognised that they felt unwell within six weeks of the birth, and a further three in ten within six months.

Figure 4 – Recognition of feeling unwell



It has already been shown that women often don't recall that they've been asked about their mental wellbeing, especially during pregnancy. Almost half also reported they weren't told about the possibility of mental health problems. Having better information in advance of the onset of symptoms, so women and their families can be alert to potential problems could help.

More than half of the professionals surveyed agreed that written materials would support their discussions with mothers and better information about available support services would be helpful. Other suggestions included access to a colleague with specialist knowledge, trust in the quality of referral services, clinical supervision and examples of how others talk about the subject.

> The use of tools, such as a Wellbeing Plan, that help parents think through the possibility of illness may enable professionals to normalise mental health problems and help mothers and fathers take the messages on board.

Acceptance and Trust

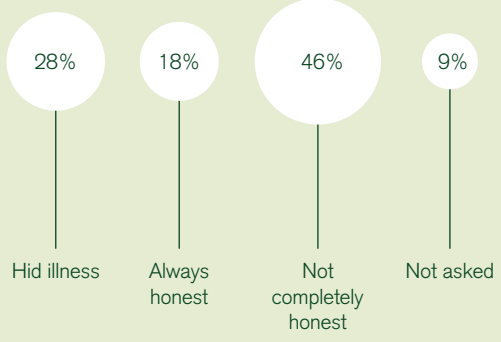
Many women surveyed felt that experiencing mental health problems was a sign of failure, which made disclosure more difficult.

The survey looked at who women disclosed to, and how honest mothers were when talking about their feelings with a health professional.

Of those surveyed, almost a third (30%) had never told a health professional that they were unwell. When asked about their honesty around feelings more generally, more than a quarter reported that they had hidden their feelings and just under one in ten reported that they had not been asked.

For women who did discuss their wellbeing with their health professional, there were varying degrees of disclosure with few being completely honest and the majority choosing a middle ground where they disclosed some of their feelings.

Figure 5 – Acceptance and Trust



When asked about the reasons for hiding their feelings, those that had done so reported that they felt embarrassed, or that the timing was wrong and they weren't ready to admit it (Figure 6).

It was significant that 34% of those who admitted they had hidden their feelings said they had done so because they were concerned their baby might be taken away. This is a myth that has to be addressed up front by health professionals if women are going to trust that they can talk openly.

"I avoided friends at all costs as I lost the ability to communicate and became very isolated…"

"I was terrified to admit to any health professional as I was scared they would take my son away…"

Some also reported that they thought the professional wouldn't be able to help.

Interestingly, health professionals are aware of the lack of confidence on the part of women. Although almost all of the health professionals were 'quite comfortable' or 'very comfortable' raising the issue of mental health and wellbeing, almost a third felt that women did not feel able to talk enough about their mental health compared to their physical health.

Women who are unwell may believe that they are not the best person to be looking after their baby, or worry that others might think it. The common and very real fear that a baby might be taken away should be addressed at the start of discussions when mental health problems are identified.

Time and relationships

Women reported that in addition to their own insecurities there were other specific barriers when talking to midwives and health visitors:

- they didn't always see the same person,
- they always seemed busy, or
- they just didn't ask about the issue.

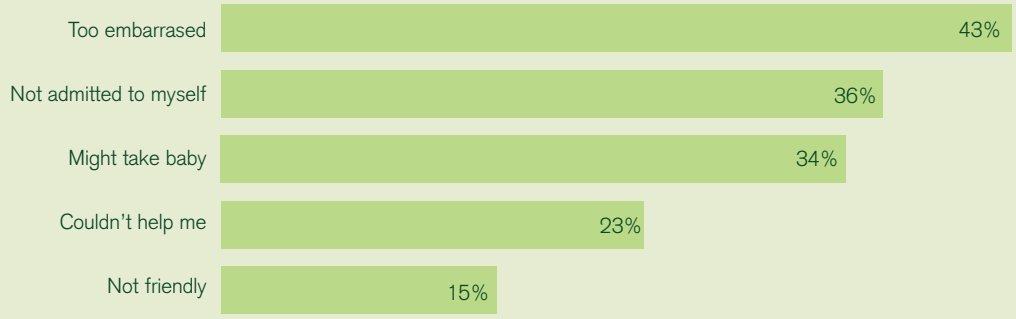
This was also reflected in the responses from health professionals which showed that fewer than half of community midwives and health visitors see the same women throughout her care. More often, health professionals work as part of a team to support women in their locality and so may not see the same woman more than once during her pregnancy or postnatal check-ups.

Many also made comments about constraints of time with respect to duration and frequency of contacts and highlighted it as a significant barrier to the quality of the care health professionals can provide.

"I feel that although we do ask about mental health unless the women feels that she has trust in talking to me, it's very difficult to bring the problem out in the open…"

"I feel continuity of care is very important in order to pick up on these issues and more time needs to be given at appointments with women in order to cover these issues."
Community Midwife, North West

Figure 6 – Reasons for lack of honesty



"People need to be in a trusting relationship with their health professional before they may feel confident to confide difficult thoughts and feelings. There needs to be continuity and sufficient contacts with one person before that trust is earned."
Health Visitor, South East

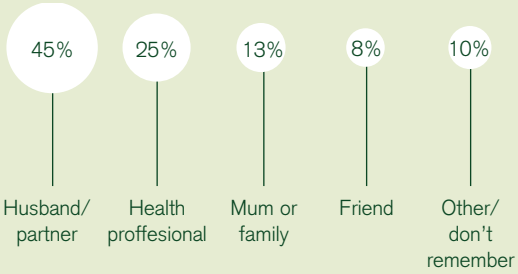
Health professionals reported further barriers to discussing mental health with their patients; almost half also felt that cultural/ translational difficulties constituted a significant barrier to raising the issue; one in seven health professionals felt they had not received enough training in the topic; and just over one in ten felt that they couldn't raise the issue as they did not have further services they could refer women to.

Being the first person

Despite the difficulties of getting past the stigma of being unwell, the concerns women have with being open, and the lack of time available in appointments, a quarter of women talk to a health professional before telling anyone else about their concerns (Figure 7).

This is encouraging and empowering for those on the frontline of perinatal mental health care.

Figure 7 – Who did you tell first?



It is always worth asking a woman whether she has told anyone else, and if not, helping her explore how she might do so.

SECTION 3
PARTNERS

Partners

Partners are usually the first to know if there is a problem; of the women surveyed, 45% said they told their partner they felt unwell before anyone else.

Beyond the direct statement, though, changes in the relationship between a woman and her partner can be telling markers of deteriorating mental health:

- Over 36% of women said that relationship worries had an impact on the way they felt;
- In addition, of those surveyed, seven out of ten women said that their relationship with their partner had been affected by their illness;
- And 59% cited low sex drive as one of the key ways they were affected.

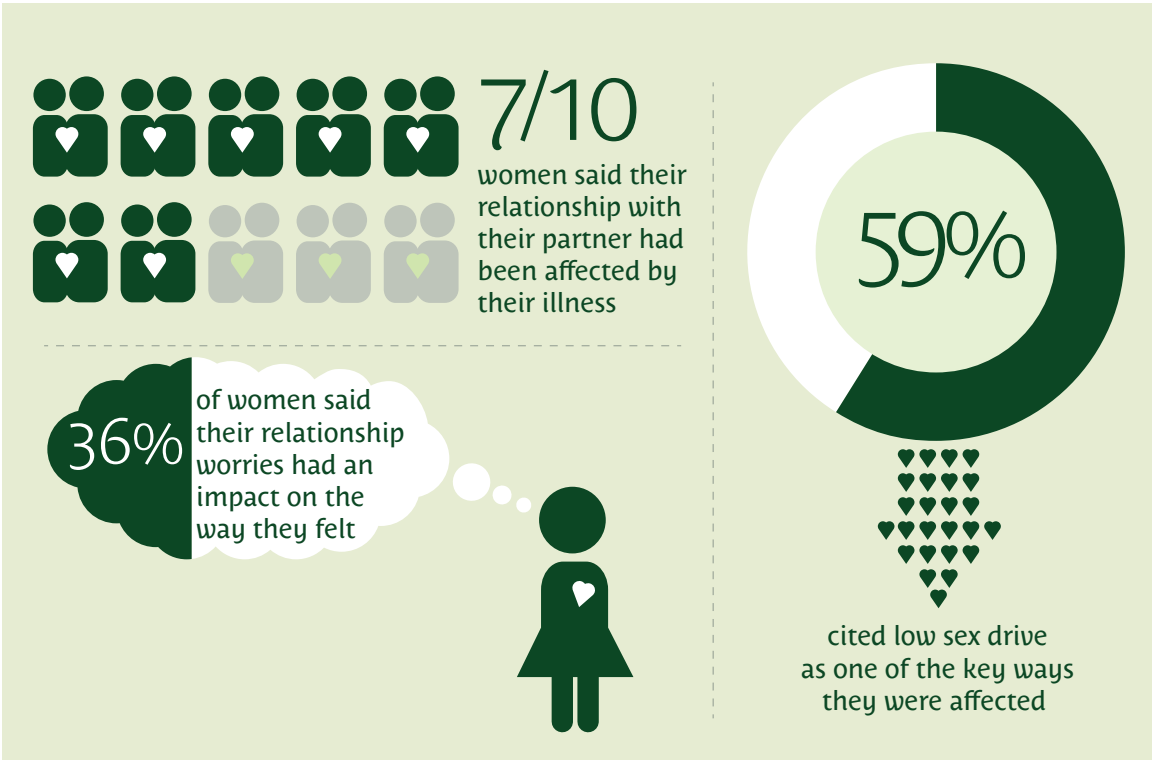
As recognition of illness is such a key contributor to getting better, partners could have a significant role to play if they were routinely involved, well-informed and prepared.

Professionals don't always meet with the partner or husband, with fewer than one in five having it as a key part of their work. Nevertheless all reported that they felt it was good for partners to be aware of possible illness in women and when and how to raise the possibility.

> 90% of health professionals thought that partners would spot signs of deteriorating health before the woman herself.

Resources to raise the issue of mental illness with them were requested.

This study has looked at the experiences of women, but husbands and partners not only play an important role in the women's response to mental health problems, they can also suffer themselves. Of those women in a relationship, four out of ten said their partner had experienced anxiety or depression before or after the birth of their child.



SECTION 4
TREATMENT OPTIONS

Treatment options

Women reported the variety of treatments they had tried including taking antidepressants, reading books, getting expert advice online, and having visits from a health visitor or midwife.

Half of women took antidepressants and of those around half found them helpful.

Just under three in ten received counselling, with almost half reporting it was helpful. Talking with experts, both online and through listening visits was also reported to play an important role.

For many though, recovery was a gradual process with time and the support of loved ones amongst the most important healers.

"Recovered with time and a lot of support from hv and then midwife in second pregnancy when suffering with antenatal depression, just about avoided PND second time."

Some health professionals were concerned that they didn't have good referral services or in some cases the skills to advise women if they were found to be unwell.

"I believe it is because midwives are not really confident in discussing the mental health issues. The services are not there to support women and why open a can of worms that you can do nothing about."
Community Midwife, Scotland

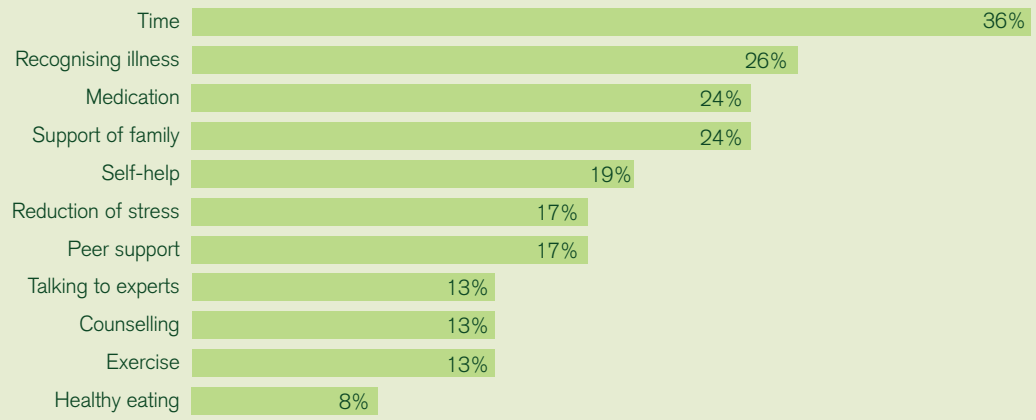
In fact, the range of options available to women is wide, and professionals shouldn't rely only on specific referral services.

Professionals have the opportunity to be creative; assisting women to identify guided self-help options as suggested in the NICE guidance[1] and 'being there' to impart other ideas if things don't progress.

Women surveyed had tried regular exercise, attending local support groups (including such things as baby massage, or mindfulness), reading books or online information, talking to experts online, talking to friends, and good nutrition. Many benefitted from having a helpful and understanding partner or family and appreciated visits from health visitors or midwives.

The type of help or treatment needed will depend on the severity of illness, but it is likely that a combination of activities will eventually make a difference. Managing expectations over the time it might take is important as well as being clear about what options are available locally too.

Figure 8 – What was *most* helpful for recovery



SECTION 5
IN SUMMARY

In summary

Women tell us:

- There can be difficulty in recognising when symptoms are illness and not just a temporary failure to cope.
- Partners are not only a source of support, but can also be the first to recognise illness in a loved one. Relationship difficulties can also arise through poor mental health, or indeed be the cause of it. It is important to remember partners and husbands can develop mental health problems during this time too.
- Many women are reluctant to discuss the type and depth of their feelings. Almost a third (30%) never tell a health professional.
- Hiding the extent of symptoms is common, one key reason is the fear that a baby might be taken away.
- Few women (14%) considered that a history of mental health problems was the primary cause of their perinatal illness. Around half thought the main cause was isolation or unachievable expectations of motherhood.
- Women also identified isolation, financial pressures and relationship problems as exacerbating their symptoms. 40% had suffered a traumatic birth.
- Around a quarter (28%) of mothers with mental health problems admit to have trouble bonding with their child.
- Over one in five (22%) said they had suicidal thoughts.
- When they are ready to talk, a quarter of women turn to their health professional first, although it is most likely that a woman will talk to her husband or partner first.
- Women reported that a wide range of support acts as treatment, from talking with family and friends through to local support groups or advice provided via the internet.

Health professionals tell us:

- Even where they are adequately trained and confident in their skills, they do not have the time provision to explore mental wellbeing properly with women.
- Many work within teams and so a trusting relationship is more difficult to nurture and this may limit an open and honest discussion by the woman.
- That perinatal mental health services are not always available for referral for women in their care.
- They would like resources to support them raising the issue and discussing emotional wellbeing with women and to allow women to have information about symptoms, risks and possible support.
- They would like to involve partners/family/friends more in the discussions where appropriate and having access to resources to help them would also be welcomed.

SECTION 6
NEXT STEPS

Next steps

The Boots Family Trust Alliance

- Have created a 'Wellbeing Plan' for use by parents and midwives during pregnancy, which can be later passed to health visitors, to help normalise and explore some of the barriers discussed in this report. It is downloadable for printing from all partner websites.

- Are continuing to produce new resources based on these findings, including a comprehensive guide and printable topic sheets tailored to the needs of different health professionals, including GPs, Midwives, Health Visitors and Family Nurse Practitioners.

- Are also promoting messages to women to encourage dialogue and openness on perinatal mental health.

- Are continuing work on the development of maternal mental health information for partners, and on tools for health professionals to use when raising the issue with them.

Women

- We need to achieve **much greater awareness** about mental health issues amongst women. Women should be able to share their feelings confidently and safely with the expectation of receiving appropriate support.

- If they are able to **share their experiences** openly with other women it would help to normalise mental health problems at this time.

- **All women who suffer a traumatic birth** should have the opportunity to talk through the experience with health professionals and should also be alerted to the possibility that they might need further support.

- Women should be encouraged to **manage their expectations** as to what they can realistically achieve while pregnant or with a young baby, and find ways from pregnancy onwards to reduce potential isolation and seek support.

- **All women should be encouraged** to interact with their babies from pregnancy onwards in a way that helps develop their attachment. Where such bonding is difficult, women should be encouraged to raise this with their health professional.

- **Partners** and close family members have an important role to play in identifying illness and supporting women to access support and in their treatment. Their involvement should be encouraged and facilitated where appropriate, and information provided for them about spotting the signs of mental health problems.

- **All health professionals** should be aware of the difficulties women face in discussing their feelings and make the most of opportunities to normalise emotional ill-health, provide suitable information and open up discussions.

- **There shouldn't be an over-reliance on the Whooley questions** to identify those who are unwell, but other tools and professional expertise and experience can be used to aid discussion. Further research is needed to develop the optimal approach that is suitable for pregnancy.

- Some women will suffer in silence, so **advice on maintaining mental wellbeing** should be provided to all women as routine.

- **Health professionals** should have the skills to recognise and respond to attachment difficulties and to ask about suicidal ideation and know what action to take if a mother is at risk.

- An understanding of the woman's relationships with her **partner, family and friends** is central to tailoring her care.

- **Midwives** should be provided with further training and resources to overcome specific barriers to addressing mental ill health in pregnancy. This could include how best to communicate with a pregnant woman on this topic and how to spot signs of mental health problems. The Wellbeing Plan should be made available to all women during the third trimester.

- **Midwives** should be focussing on prevention as well as identification of problems and mental wellbeing during pregnancy should be a routine discussion as per physical health.

Midwives and Health Visitors

- **Midwives and health visitors** should be made aware of the risks for the fetus if the mother is suffering with anxiety and prioritise ensuring the mother has support to address as far as possible the sources of her anxiety.

- **Midwives and health visitors** should have an available expert colleague who specialises in perinatal mental health to refer to for advice and referral options.

- There should be **information**, compiled by local midwives and health visitors and available to all their colleagues on local perinatal mental health services and local activities.

- **New resources, sufficient time, and being able to build a relationship with an individual** (at the Universal level) are all important to removing barriers.

- **Health visitors** should be measured on the work they do on supporting women's mental health, with a focus on emotional wellbeing outcomes in the commissioning of health visiting services.

- **The Department of Health** has recently funded the training of a network of around 300 Perinatal Mental health Visitor Champions, and this training now needs to be cascaded down through the profession.

- **Commissioners** of front line health professionals need information on best practice in perinatal mental health in order to commission effective services.

- They should **consider the structuring of services** to maximise continuity of care in order to increase the support that women are able to receive.

- **Commissioning** should take notice of outcomes and review staffing levels to ensure community midwifery and health visiting services have sufficient staff with the time and skills to provide appropriate care.

- There needs to be increased movement towards **parity of investment** in care for physical and mental illness.

- They should look to **ensure appropriate perinatal mental health care pathways** are in place within their region to ensure a clear referral route where appropriate. Of help to commissioners will be the Joint Commissioning panel guidance.[21]

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