Perinatal mental health: The midwife’s role and current developments in maternity services.

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With thanks to MBBRACE for recent 2018 slide presentations

Perinatal Mental Health

- Pregnancy and the period after childbirth can bring a range of emotional changes influenced by numerous factors

- Normal anxieties, concerns and adjustments

- Changes can be a positive experience, but can also result in the onset or exacerbation of mental health problems

Public Health England aim:
- To reduce the burden of perinatal mental illness
Risks associated with poorer perinatal mental health

- Preterm birth and low birth weight risks (Field 2004)
- Impact of stress or lack of support on neuroendocrine, immune and vascular mechanisms and impact of coping behaviours (Glover)
- Increased risk of complicated birth (Andersson et al 2004)
- Impaired attachment (negative effects on the emotional, social and cognitive development of the child) (Lindgren 2001, Deave et al 2008)
- Long term impact on mother’s well being (Stein et al 2014)
- Suicide – Confidential Enquiries’ Reports

Since 1952, maternal deaths have been reviewed regularly in the UK

Latest report published 1st November 2018
2015 MBBRACE-UK

Key messages from the report 2015

9 women per 100,000 died up to six weeks after giving birth or the end of pregnancy in 2011 – 13

Mental health matters

Almost a quarter of women who died between six weeks and one year after pregnancy died from mental-health related causes

1 in 7 women died by Suicide

Specialist perinatal mental health care matters*

It’s OK to tell

For more information, please contact the experts:

Women who report:

• New thoughts of violent or self-harmous behaviour
• Sudden onset of anxiety or panic

It’s OK to talk

Women who report:

• Feelings of severe depression
• Feelings of extreme sadness

It’s OK to ask

Women who report:

• Feelings of estrangement
• Feelings of guilt

Causes of maternal death 2014-16
One woman died violently a few months after the birth of her child. She developed a significant depressive disorder, including suicide ideation, a few months after the loss of her first pregnancy. This was managed in primary care but her history was not passed on to the maternity services at the booking of the next pregnancy.

After the birth of baby, she did not attend the postnatal review and her health visitor was not made aware of this.

She died in close proximity to the anniversary of her previous pregnancy loss.
Repeated recommendations

1. Communication of previous history
2. Red flags
3. Amber flags
4. Forward planning for future risk
5. Crisis, liaison and home treatment team training
6. MBU consideration
7. Experience of loss
8. Partner and family involvement
9. Grade of assessor
10. Care by multiple teams
11. Extended suicide

Pre-existing mental health problems

Current difficulties, risk of re-occurrence, exacerbation and hope
Perinatal Illness

- Antenatal anxiety / depression (7-20%)
- Baby Blues’ (15 – 70% deliveries) 3 – 7 days postpartum
- Postnatal Depression (15%) < 6 months (peak 2 – 4 weeks)
- Puerperal Psychosis (0.2%) ~2 weeks postpartum

Gavin et al 2005; Fairbrother et al 2015

NHS England, NHS Improvement, National Collaborating Centre for Mental Health 2018 – 5 perinatal mental health care pathways

Pathway 1 Preconception care

Women with a complex or severe mental health problem (current or past) who are planning a pregnancy should receive timely preconception advice from a specialist community perinatal mental health service before they become pregnant.

Risk that women who are already taking medication may stop when they become pregnant.

Targeted preconception advice to include medication, contraception and care planning
Pathway 2: Specialist assessment
Identification and assessment

All women should be asked about their mental health at each antenatal and postnatal contact.

When a complex or severe mental health problem is known, or suspected, a referral should be made from primary or secondary care, maternity services or health visitor to a specialist community perinatal mental health team for a biopsychosocial assessment.

Where ongoing care is needed, an agreed care plan using a range of evidence-based interventions should start with a named professional.

A recovery-based approach should be emphasised.

Pregnancy notes
Perinatal Institute
2018
Whooley questions for depression

NICE (2014;17) recommend using these questions to assess depression:

1. During the past month, have you often been bothered by feeling down, depressed or hopeless? □ Yes □ No
2. During the past month, have you often been bothered by little interest or pleasure in doing things? □ Yes □ No

“Yes” to one (or both) questions = positive test (requires further evaluation)
“No” to both questions = negative test (not depressed)

If yes to either of these questions, consider offering self-reporting tools such as PH9.

Questions about anxiety

These questions use the 2-item Generalized Anxiety Disorder scale (GAD-2):

Over the last 2 weeks, have you been feeling nervous, anxious or on edge?

Over the last 2 weeks, have you not been able to stop or control worrying?

Do you find yourself avoiding places or activities and does this cause you problems?

If yes to any of these questions, consider offering a self-reporting tool such as GAD 7
Consideration of psychosocial factors contributing to perinatal mental health

- **Housing and the environment** - 1 in 5 dwellings fail to meet decent living standards.
- **Education and skills** - key to accessing work, feeling empowered and having supportive social connections.
- **Financial security** - 1 in 5 people living in poverty, greater financial security supports reducing stress, adopting and maintaining healthy behaviours and providing sufficient resources to fulfil needs.
- **Work** - Having supportive, fulfilling work could enable us to have sufficient resources as well as widening our social networks.
- **Family and relationships** - Positive relationships could reduce conflict, increase social capital and provide a supportive environment from which to enter pregnancy.
- **Domestic abuse** – important to ask about this during antenatal care, see women alone.
- **Drug and alcohol misuse** - be alert, over prescription of opiates post surgery.

Public Health England 2018, MBRRACE – UK 2018

Pathway 3
Emergency assessment

Women with mental health needs that require urgent or emergency attention – severe depression, or the onset of postpartum psychosis, that put mother and baby at risk should be referred for emergency assessment immediately.

Emergency assessments should be with secondary care mental health services such as crisis resolution or home treatment teams or liaison mental health teams. Ideally a specialist mental health team should lead this.

The woman’s needs:
Biopsychosocial assessment and urgent emergency mental health care plan AND
- be either admitted to a Mother Baby unit or other hospital admission (or be referred) OR
- Have been accepted for intensive follow-up community perinatal mental health team support

OR
- Have started assessment under the Mental Health Act.
Pathway 4
Psychological Interventions

Many women may develop depression and anxiety disorders.

Psychological interventions (either alone or with pharmacological treatment) are effective.

Many women prefer these to taking medication.

They are also recommended for eating disorders and severe mental health disorders.

Psychological interventions may be provided by primary, secondary and tertiary care including IAPT services.

Women with a known or suspected mental health problem who are referred in pregnancy or the postnatal period should receive timely access to evidence-based (NICE recommended) psychological interventions.

Pathway 5
Inpatient care (MBUs)

Women who need unplanned urgent care should have urgent access to mother and baby units (MBUs).

MBUs are equipped to provide support and care to support mothers in their parenting roles and have appropriately trained staff to manage complex or severe mental health problems.

Challenges: availability – travel for family
New messages for care

1. Multiple adversities
2. Judgements based on diagnosis or social circumstances
3. Avoidance of care
4. Self-harm
5. Gatekeeping, silo-working and co-ordination of care
6. Psychiatric co-morbidities
7. Care of women in prison
8. Prescribing issues – de-prescribing
9. Prescribing issues – propranolol
10. Adequacy of mental health records returns

Messages for care

- Continue trying to engage these complicated and sometimes challenging women
- You can make a difference and we know that pregnancy is a strong intrinsic motivator for drug abuse cessation
- Ask about domestic violence and see the woman on her own
- When you hand them over make sure as far as you can that there is someone taking overall responsibility- the system is less clear
- And make sure that there is a clear discharge plan and follow up appointments are booked
Midwives' role

Challenges for midwives

Wadephul et al (2018):
- Midwives knowledge about PND good but lacking around severe mental health problems.
- Assessment skills were good, especially for depression.
- Lacking in confidence and knowledge around treatments.
- Poor attitudes at times – many positive attitudes but stereotyping, stigma, and taboo topic.
- Time pressures in practice - initial appointments
- Lack of referral facilities
  Continuity of carer important for effective care- relationships etc
  Emotional impact on midwives was noted – support needed here

Pre-registration midwifery education:
DoH Mandate 2015 to include a module on perinatal mental health in all programmes

UoM BMidwif (Hons); 150 hours distributed in a spiral curriculum
(includes tier 1 dementia education and 12 hours of Inter - Professional Learning).

Generally reported that education needs to be developed for the current workforce.
Women’s voices on maternal mental health

RCOG (2017) survey:
- Concern over stigma of disclosure.
- Fear of information written on pregnancy records.
- Embarrassment
- Not asked by health professionals
- Find health professionals unapproachable
- Did not realise that health professionals can help / did not want to waste their time
- Not sure what was wrong

Messages for our communication styles and consideration on responses to disclosure.

Father’s voices on mental health

Under researched but evidence emerging ……

Prevalence rates:
- Anxiety during partner’s pregnancy = 16%
- Anxiety during postnatal period = 18%
- Depression affects around 10% during perinatal period

Three areas identified in a qualitative systematic review:
1. Forming a fatherhood identity.
2. Competing challenges of a fatherhood role.
3. Negative feelings and fears.

Precipitated behaviours such as denial, escape activities (working longer hours), smoking as coping strategies. (Baldwin et al 2018)

Implications for parent education and support in the postnatal period.
Changing maternity practices and implications for maternal mental health

NHS Maternity Statistics 2018

Increasing inductions rates:
- 20.4 per cent in 2007-08 to **32.6 per cent** in 2017-18
- Caesarean birth rates = **28%**
- Perineal lacerations the most common complication of birth (**42% of total complications**)  
- **31% of women under 20 years** smoking at booking

- Almost 80% of women 1st contact by 12 weeks gestation
- 81% babies have skin to skin contact at birth within 1 hour
- 74% of babies had breastmilk as first feed

*We can do better!*

*Borra et al (2015) – breastfeeding intentions have implications of incidence of PND – breastfeeding as planned decreased PND, not being able to breastfeed as planned increases PND*


References / Further reading

References / Further reading


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