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

- *Ursula Nagle, RNP, MSc (Mental Health), BSc RM, BSc RN.*
- *CMSp Perinatal Mental Health, Rotunda Hospital, Dublin.*

- *Dr Mary Farrelly, PhD, MMedSc, BNS, RGN, RPN, Assistant Professor, DCU.*

- *NMBI National Midwifery Conference 22/11/2018*

Background

Perinatal mental health is a major public health issue.

20% of women will experience a PMHP (RCOG, 2017).

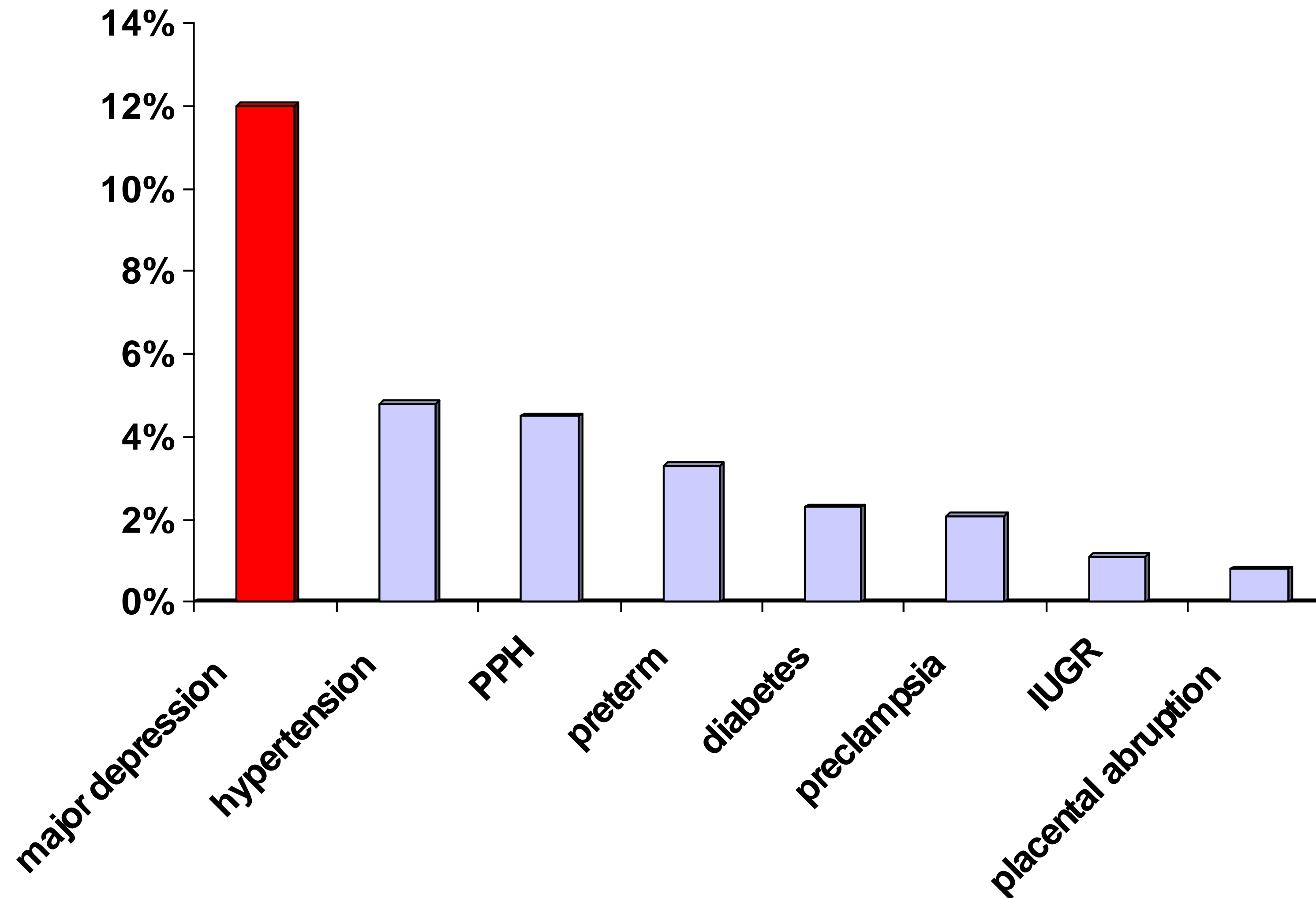
Affects woman/baby/ partner/whole family (NICE, 2014).

PMHPs are often undetected (Bauer et al., 2014).

Need to improve detection, to improve outcomes (RCOG, 2017).

Early detection can improve outcomes (Yawn et al., 2012).

Depressive illness: the most common major complication of maternity



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

01

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

02

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

03

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

Study setting

- Dublin maternity hospital.
- Established perinatal mental health team.
- >9000 deliveries per year.
- Combined AN care, Midwife led care, Consultant led Private/Semi Private Care.

Methodology

Qualitative design using semi-structured interviews.

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

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

Findings

- See thematic map (Nagle, U. 2018).

Theme One

The experience of mental distress

- Confidence in managing mental health
- You're supposed to be happy
- An emotional time

Theme Two

Telling and disclosing

- Talking to healthcare professionals
- Screening tools – ticking the box
- Stigma/shame

Theme Three

The experience of obtaining help

- Getting help
- Baby as a motivator
- Attitudes of healthcare professionals

T1 The Experience of Mental Distress

- ***Sub-theme 1: An emotional time***
- P5: *"I worried that something was going to happen to my partner, or something was going to happen to the child."*
- P2: *"I'd have intrusive thoughts that I would harm the baby and that used to freak me out so much…it's really distressing."*

T1 The Experience of Mental Distress

- ***Sub-theme 2: You're supposed to be happ***y
- P4: *"I never enjoyed being pregnant, but I wouldn't say that out loud."*
- P5: *"Everyone assumes that you're delighted to be pregnant, well maybe I wasn't…but you can't say that."*

T1 The Experience of Mental Distress

- ***Sub-theme 3: Confidence in managing mental health***
- P8: *"I like going to access a (mental health) service if I want to, but I don't like being pushed in to it. I prefer to get help when I want it, but I like to know it's there if I need it."*
- P2: *"At this stage I have a toolbox in my head, I know where to go if I'm not well."*

T2 Telling and Disclosing

- ***Sub-theme 1: Talking to healthcare professionals***
- P1: *"It makes you feel like someone is taking care of you, looking after you."*
- P2: *"It's all about the baby…not about your headspace."*
- P5: *"The midwives are all so busy…I'd feel like a burden talking to them because they're so busy on the wards."*

T2 Telling and Disclosing

- ***Sub-theme 2: Screening tools – ticking the box***
- P1: *“I could write down thoughts about self-harm…nobody asked me about this.”*
- 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 Telling and Disclosing

- ***Sub-theme 3: Stigma and shame***

- P8: *"There's a stigma with mental health and you don't want that stigma because sick patients take on a sick patient role. I don't want to take on the 'mental health patient' role. I don't want to feel like I'm being boxed off in that 'tragic box'."*

- P7: *"I think people are afraid that if they tell you there's something wrong that social workers will get involved, or that people might think you can't cope."*

T3 The Experience of Obtaining Help

- ***Sub-theme 1: Attitudes of healthcare professionals***
- P5: *"The midwives on the ward are absolutely lovely…but you can tell which ones are listening…"*
- P2: *"Sometimes (if you're feeling low)…you need someone to really hold you, to be proactive."*
- P6: *"I said to (the midwife) last night, 'I feel so anxious'…she was so helpful, trying to reassure me."*

T3 The Experience of Obtaining Help

- ***Sub-theme 2: Baby as a motivator***
- P6: *"If I am struggling, I will say it…I have to. I have to be the best I can be for my baby."*
- P8: *"I stopped my (antidepressant) medication because I didn't want to potentially cause the baby any problems, but I will restart them when I've finished breastfeeding."*

T3 The Experience of Obtaining Help

- ***Sub-theme 3: Getting help***
- P3: *"I prefer to know someone before I can ask them for help."*
- P5: *"If there was just five minutes (on the postnatal ward) to ask women how they're feeling (emotionally) before they go home, it would give you an opportunity to say 'I need help'."*

Conclusions

Women experience challenges to their mental health in perinatal period.

Women open to all methods of enquiry about mental health.

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.

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 visible point of contact who provides mental health support.

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

Recommendations

- Ask about mental health/emotional wellbeing at each perinatal contact.
- Continuity of care.
- Enquiry should include broad spectrum of mental health disorders.
- Screening questions/tools can assist in the detection of women at risk of or experiencing PMHPs, useful where time/privacy is restricted.
- Promote awareness perinatal/infant mental health in antenatal education.
- Education/training for HCPs involved in antenatal and postnatal care.
- Specialist/advanced mental health midwife to be a visible point of contact.
- National guidelines/pathways.

Midwifery 66 (2018) 79-87

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/locate/midw

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Ursula Nagle, MSc, BSc RM, BSc RN[a,*], Mary Farrelly, PhD, MMedSc, BNS, RGN, RPN[b]

ARTICLE INFO

Keywords:
Women's experiences
Screening
Perinatal mental health
Qualitative research

ABSTRACT

Objective: To explore women's views and experiences of having their mental health needs considered in the perinatal period in an Irish maternity hospital setting.
Design: A qualitative design using semi-structured interviews was used to explore women's views and experiences. Data were analysed using Thematic Analysis (Braun and Clarke, 2006).
Setting: A voluntary maternity hospital in Dublin, Ireland which had access to a perinatal mental health team.
Participants: In total 8 women who met the inclusion criteria were recruited and participated in this study. The women were interviewed in the early postpartum period.
Findings: The study offers important insights into how women feel about having their mental health needs considered in the perinatal period. Women reported pregnancy was an emotional time, feeling expected to be happy, and women with significant mental health histories preferred not to be referred to available services unless they asked for help. Women reported barriers to disclosure including stigma/shame, lack of time. Screening tools were viewed with mixed opinions. In getting help, the baby was a motivator for some women, attitudes of healthcare professionals and lack of time affected this.
Key Conclusions: Women appreciated all methods of enquiry about their mental health and being given time to discuss concerns with healthcare professionals. Perceived busy staff workloads was a barrier in asking for help, as was lack of continuity of care. Screening tools were viewed as a tick box exercise, but also as a 'modality' to assist detection of women at risk. Mental health enquiry focused on depression and anxiety, with little or no enquiry about less common disorders. Women with significant histories were less likely to engage or accept referral to perinatal mental health services, preferring to access help if they felt they needed to.
Implications for practice: HCPs should enquire regularly about women's emotional wellbeing at every antenatal and postnatal contact, offering support where required. Detailed enquiry about mental health should encompass the broad spectrum of perinatal mental health problems, including but not limited to depression and anxiety. Screening tools can assist in the identification of women at risk of developing perinatal mental health problems. A specialist mental health midwife should link with high-risk women at the first antenatal booking visit and provide information on early intervention and access to services.

Introduction

The experience of pregnancy, birth and becoming a mother is a positive life event for most women. However up to 20% of women will experience a perinatal mental health problem (PMHP) (Royal College of Obstetricians and Gynaecologists (RCOG), 2017; Bauer et al., 2014), defined as a mental health issue presenting from conception up to one year after childbirth. PMHPs can range from mild depression and anxiety to mania and psychosis (O' Hara et al., 2014). The effects of PMHPs in pregnancy have been associated with substandard antenatal care, early delivery and low birthweight in babies (Stewart, 2011), and are recognised as a significant cause of distress to women, children and families (Martin, 2012). The long-term outcomes of children exposed to maternal depression, anxiety and stress in the perinatal period has been widely researched (Van den Bergh et al., 2005; Talge et al., 2007; Glover, 2011) and clearly affects the social, cognitive and neurodevelopmental health of babies and children and the wider family (NICE, 2014). PMH is a major public health issue (MBRRACE-UK, 2017) and suicide continues to be a leading cause of maternal deaths during pregnancy and up to one year after delivery (MBRRACE-UK, 2017 p.6). The NHS Mental Health Task Force (2016) highlighted as a public health priority the need to improve the identification, assessment and treatment of

* Corresponding author.

https://doi.org/10.1016/j.midw.2018.07.015
Received 22 February 2018; Received in revised form 14 July 2018; Accepted 25 July 2018

Thank you

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