Perinatal mental health: research report

June 2019

Contents

Executive summary

An in-depth qualitative research study conducted between September 2018 and May 2019 explored the experience of 18 mothers from Lambeth with mild to moderate mental health problems at perinatal stage. The views of 12 health and social care professionals on their confidence to support mothers and their knowledge on the relevant services mothers can access were also sought. The perinatal stage spans from pregnancy into the first year after birth.

The research found:

- The identification of mental health problems does not happen in a timely manner and it varies considerably due to several factors associated with the mother and with the professionals. This includes a lack of confidence of both the mother and the professional to discuss mental health conditions. The findings showed that in some cases, the mother's condition is being dismissed as hormonal and normal which hinders early identification.
- There is a propensity for mothers to develop mental health problems after the birth of their child. Apart from four with pre-existing mental health problems, 14 mothers had this experience. They reported feeling overwhelmed and unsure of what to do.
- Having a trusting relationship and access to informal social support play an important role in coping with mental health conditions. Mothers associate their ability to cope with being a part of social groups, both in person and online, where they could share their experience with other mothers. Social groups, for three mothers, paved the way for them to build confidence in talking to their family about what they feel and having the courage to ask for help.
- It appears that there are very few relevant services that are known to professionals and mothers, because either there are gaps in services or there is lack of information about services, or both. It also appears that there is also no proactive approach to share information with mothers and amongst professionals.

We propose four recommendations to be addressed by the following: King's College Hospital NHS Foundation Trust, Guy's and St Thomas' NHS Foundation Trust, St. George's University Hospitals NHS Foundation Trust, the Lambeth Clinical Commissioning Group, primary care services, maternity services, midwifery and health visiting services, Improving Access to Psychological Therapies (IAPT), service commissioners in both adults and children, social care teams, Early Help service, Lambeth Early Action Partnership (LEAP), Living Well Alliance, and voluntary sector organisations.

- To provide training to professionals in order to gain knowledge and build confidence in identifying signs and symptoms of mental health conditions. Training courses on communication skills, how to ask sensitive questions, and how to show empathy should also be provided.
- There should be a proactive approach to information sharing, for example though a database of services that is easily updated and accessible to all professionals, and second, creating opportunities for networking and sharing of good practices.
- To raise public awareness on mental health which may help de-stigmatise mental health.
- For health and social care professionals to proactively engage with the relevant people in the mother's life as a source of support for them.

Introduction

Healthwatch Lambeth was established in 2013 as a requirement of the government's Health and Social Care Act 2012 and is part of national network of local Healthwatch supported by Healthwatch England. It has a statutory role to be the consumer champion and ensures that local people's voices count when it comes to shaping and improving local health and care services. Our current priorities are mental health, older people, children and young people, and people with learning disabilities. We aim to address inequalities and ensure services meet people's needs.

We hold information and consultation events; conduct research studies and service assessments; influence services and policies in health and social care; signpost people to services; and undertake Enter & View visits to commissioned health and care services. We work collaboratively with partners from health and social care services including the NHS and the voluntary sector, and some education settings.

We have carried out this research in order to inform and influence service provision for parents with mental health problems. Our interest in this area is primarily drawn from anecdotal accounts and women's experience which came to our attention via our signposting service. Some Lambeth residents shared their experience of unsatisfactory perinatal support.

For this study, we have used the NHS England's definition of perinatal mental health problems: "those which occur during pregnancy or in the first year following the birth of a child."

For the purpose of this research, we chose to focus on perinatal mental health and use the definition of the National Institute for Health and Care Excellence (NICE), as follows: "A mild mental health problem is when a person has a small number of symptoms that have a limited effect on their daily life. A moderate mental health problem is when a person has more symptoms that can make their daily life much more difficult than usual" (NICE, 2011).

It is our intention for this study to be shared with Lambeth service commissioners, service providers, and policy makers with a view to learn from it and be considered in future planning and service development.

This research is partly funded by Healthwatch England and will be included in their national research on perinatal mental health.

Literature review

The Five Year Forward View for Mental Health is aimed at providing specialist perinatal mental health services for all women and their families who need them. The programme which lasts until 2020/21 requires a significant increase in access in most areas of England as only 15% of localities are thought to have services which fully meet NICE guidelines. In addition, it was also identified as a core issue in the national maternity review Better Births that is aimed at making services safer, more professional, kinder and accessible to mothers and their families (Better Births, 2016).

Data shows that perinatal mental health problems affect 10%-20% of women during pregnancy and the first year after having a baby. In addition, it was found that in the UK, suicide is the main cause of death for women during pregnancy and in the year after giving birth (Bauer, 2014). Two in 1000 women who have given birth are affected by postpartum psychosis and 12-13 % of pregnant women experience depression and anxiety, respectively. More recent studies also found that one in four pregnant women have mental health problems (Howard, 2018). In the UK, it is estimated that between 7-15% of women will experience antenatal and postnatal depression (NICE, 2014), and of those, women with a prior history of depression or antenatal depression have an increased risk of depression in the postnatal period (Glasser et al. 2016).

In a survey with 2,300 women in 2016, mothers said that they were not given information about mental health and professionals are dismissive of their symptoms. In addition, it was found that that another reason for not seeking help is the normalisation of 'baby blues' to mental illness that puts onus on women, the condition is stigmatised, and there is a wide-held belief that professionals would not be able to help them. Fifty-five per cent (55%, N=2,300) of the respondents said they were not referred to specialists, and only 7% of those who were referred, had their assessment after waiting for a year. This caused them to seek private treatment (The Lancet, 2017).

It was also found that half of all cases of perinatal depression and anxiety go undetected, or if they are detected, they fail to receive evidence-based forms of treatment. For example, a recent survey by the National Society for the Prevention of Cruelty to Children (NSPCC) said that 41% of new mothers hadn't been asked about depression in their most recent pregnancy by their midwives (Bauer, 2014).

Some mothers keep their mental health problems to themselves. For example, 30% of respondents in the Boots Family Trust 2013 survey admitted that they didn't tell a professional about their mental health problems, usually because they thought

their baby might be taken away (Bauer, 2014). In another study in Scotland, only 13.6% of 656 women with a perinatal depression sought help for their emotional problems. The majority of women who had not sought professional assistance identified several barriers to help-seeking, particularly knowledge barriers (Fonseca et al., 2016). Similarly, in a survey with 43 GPs, it was found that the biggest barrier to providing better support to women experiencing poor mental health in the perinatal period is low identification of need. This pointed out to several factors such as lack of contact with patients, knowledge, awareness and confidence in discussing mental health problems; and time pressures on GPs (Khan, 2015).

While midwives identified that they have an integral role in perinatal mental health care provision, their willingness to offer emotional care to them is compromised by a perceived lack of confidence, competence, and lack of practical and emotional support systems (Jones et al., 2012a).

In the North of England, a study with 42 health professionals showed that they lack confidence in identifying needs of Black women with mental health condition both for identifying the specific needs of Black women and for managing perinatal depression more generally, particularly in women with mild/moderate and 'subthreshold' depression. Health professionals enumerated several factors including failure to routinely check on women and confusion about professional roles and boundaries (Edge, 2010).

Local context

In Lambeth, the recorded prevalence of depression among mothers is 7.5% which is lower than England as a whole (9.1%). However, severe mental illness prevalence is 1.28% which is higher than the national figure of 0.90% (ChiMat's Data Atlas, 2017).

Unpublished data from the Maternity Service Review Data Profile (King's College Hospital Foundation Trust, 2014) showed that 165 women have serious mental illness meeting the threshold of Perinatal Mental Health teams, while an additional 629 have mental health problems and were being looked after by their GP, midwife, or health visitor. King's College Hospital (KCH) offers a Caseload Model of midwifery care for women who meet the threshold for care by its Specialist Perinatal Mental Health team. This provides relational continuity between midwife and a woman and her family throughout all her pregnancy, labour and up until baby is one month old. More time is available for planning health and social care with mothers at the initial maternity booking and at all consultations and visits. They are contactable 24 hours, seven days a week.

Data provided by Guy's and St Thomas' NHS Foundation Trust (GSTT) indicate that in 2018/19, there were 1119 (13%) women (out of 8412) who upon meeting their midwife for the first time indicated having mild to severe mental health concerns in their medical history form. 22% of 6,420 answered 'yes' to the GAD-2 questions. Generalised Anxiety Disorder (GAD-2) is a two-question initial screening tool for generalised anxiety disorder (Howard et al., 2017). Six caseload teams offered continuity of care to 589 women in 2018 with moderate mental illness. Continuity of care involves having a named midwife throughout antenatal, intrapartum, and postnatal period. For those living with moderate mental illness who live outside GSTT's catchment area, a clinic run by the specialist perinatal mental health midwife commenced in Feb 2019. As of June, 32 women have been supported.

Methodology

2.1 Aims of the research

The previous studies that had been included in the literature review showed a number of things: the mental health conditions of mothers tend to be detected late; some professionals don't feel confident in having conversations with and supporting mothers; and there is either lack of information about relevant services or there are gaps in services for them. It was also found that there is no published research conducted in the last 10 years with mothers from Lambeth. The sources of quantitative data are mainly KCH and GSTT. KCH data showed that over 75% (600) of women with perinatal mental health problems don't meet the criteria for severe mental illness and therefore rely on services in the community. GSTT data showed that 1,119 of 8412 mothers experienced certain mental health problems in 2018/19 although the number is not segregated into types of mental health conditions.

This study is aimed at understanding the experience of mothers in Lambeth with a mild to moderate mental health condition at the perinatal stage, in accessing relevant services and support, and how they view the timeliness of support in meeting their needs. We also looked into the perception of health and social care professionals on their knowledge and confidence to support mothers with mental health problems.

We explored the perception and experiences of mothers and those of health and social care professionals on mental health service provision. Specifically, we sought to understand mothers' views on the following:

- Timeliness of identifying women at risk of or with perinatal mental health problems.
- Referral routes and waiting time.

- The range and type of information and services accessed by mothers, including their views of their quality, accessibility, and timeliness.
- Knowledge and skills of professionals in supporting mothers with a mental health condition, including awareness of relevant services in Lambeth.
- Informal or formal support in the community.

2.2 Design

This is qualitative research using the case study approach. The aim of case study research is to develop an in-depth understanding of a single case or to explore an issue or problem using the case as a specific illustration. The case might be an individual, a small group, an organisation or an entity, and has to be defined within certain parameters such as a specific place and time (Yin, 2009).
In this research, the case explored is a group of women from Lambeth with mild to moderate mental health problems during the perinatal stage.

2.3 Sampling technique and access to respondent and gatekeepers

Due to the sensitive topic, it was deemed that access to respondents (mothers) would be challenging as they might not put themselves forward to take part. Therefore, we used a snowball sampling technique.

Snowball sampling technique is when the researcher accesses informants through contact information that is provided by other informants (or respondents). This process is, by necessity, repetitive: informants refer the researcher to other informants, who are contacted by the researcher and then refer her or him to yet other informants, and so on. Hence the evolving 'snowball' effect (Noy 2008). This technique is often used in qualitative research when accessing respondents who may not traditionally engage due to the sensitive nature of the topic being explored, such as mental health.

We also wanted to give potential respondents the opportunity to know about the research. We promoted it through the Healthwatch Lambeth newsletter and local GP newsletters, and distributed flyers in libraries, GP surgeries, children's centres, leisure centres, and churches. Healthwatch representatives attended networking events and meetings.

To access health professionals, the research was promoted by attending Clinical Commissioning Group (CCG) meetings, through the voluntary sector forum, and at different events. The Healthwatch researcher also emailed some key contacts who were then able to signpost or refer her to some respondents.

2.4 Data gathering and data analysis

We used semi-structured interviews as the main data gathering technique. Five mothers were interviewed in person and 13 were interviewed over the phone. The interviews with 12 professionals were conducted over the phone. Interviews lasted for 30 to 45 minutes and were not recorded though written notes were taken which were later typed up and saved securely.

Data were analysed using a thematic approach. This involved identification of emerging themes and grouping those themes. Quotations from the transcripts were used to highlight major themes and possible contradictions in respondents' answers.

Analysis was done by the Healthwatch staff member and then discussed with the volunteer co-researcher. As a quality control measure and to ensure rigour in the research process, this research report was also sent to Healthwatch England's Informatic and Intelligence Research Group (IIRG), a network of different local Healthwatch composed of trained researchers and officers.

2.5 Research ethics

We adhere to certain research ethical standards which are stated in the Healthwatch Research Governance Framework including seeking informed consent and maintaining confidentiality. We ensure that we promote voluntary participation and that it is clear with potential respondents that they can choose not to take part.

We sought their informed consent by first explaining the research aims and how their data will be used. Respondents were told that we would keep their private data safe and they would not be shared without their written consent. We also gave respondents the opportunity to ask questions which we responded to. Only after those steps did we ask for their consent. They gave verbal consent, and this was noted in the interview notes. From experience, respondents are usually hesitant to give written consent where sensitive topics are being researched, such as mental health.

We acknowledge that ethics is also about avoiding and reducing harm to the respondents and the researcher. We made sure that the interviews are conducted privately and at their most convenient time. We were mindful that they could feel anxious and affected by the interview, considering their lived experience of mental health problems. We made it clear that should the interview affect them, we would stop it.

Healthwatch Lambeth ensured that the volunteer researcher was trained and received weekly supervision to ensure that any difficult situation could be handled professionally with due regard to the respondents' and their own safety.

We were also mindful that using a snowball sampling method in accessing respondents has potential to breach confidentiality when respondents refer someone they know. To remedy this, we explained that it is important to keep private information confidential and for the respondent to respect this. We emphasised that the report would not bear any identifiable information about any of the respondents.

Findings

3.1 Respondents profile

We interviewed 30 respondents: 18 mothers and 12 health and social care professionals. Fourteen mothers came from eight areas in Lambeth [Brixton, Herne Hill, Clapham, Kennington, Oval, Stockwell, and Vauxhall]. Four did not wish to identify their place of residence.

Four of the 18 mothers said that they had accessed mental health services before their pregnancy. One of them had been diagnosed with post-traumatic stress disorder (PTSD). Seven mothers including the four with previous mental health problems said that they developed what they referred to as 'post-natal depression' while one said that her depression came back when she gave birth.

Mothers' age

Of the 18 mothers, 50% (9) were 18 to 25; 39% (7) were 26 to 35; and 11% (2) were 40-45 years old. Half of the mothers were aged between 18 to 25, with only two mothers aged over 40.

Figure one: showing the percentage of respondents by age

11% (2)

50% (9)

39% (7)

■ 40-45 ■ 26-35 ■ 18-25
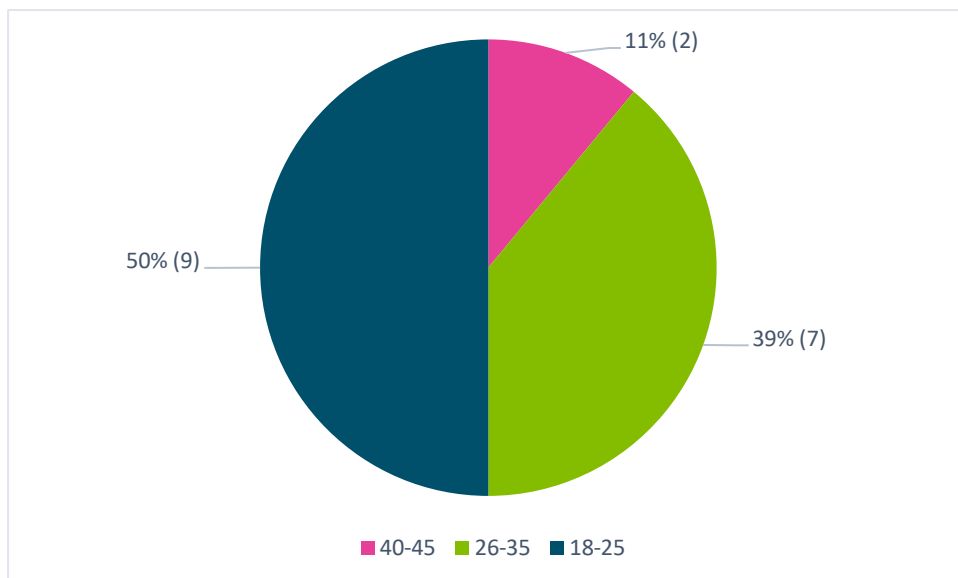
Professional respondents

We interviewed 12 professionals (eight health professionals and four social workers) as follows:

Professional	Number (N=12)
GPs	4
Nurses	2
Midwives	2
Social workers	4

3.2 Emerging themes

We have identified six themes:

1) varying referral pathways and identification of mental health problems
2) presenting issues/problems when mothers access services
3) mothers' access to services
4) mothers and professionals' knowledge of relevant services
5) professionals' knowledge about perinatal mental health
6) presence of informal support.

3.2.1 Varying referral pathways and identification of mental health problems

Five (28%) mothers had satisfactory experience of support from their health visitors while seven praised their midwife. Two young mums talked highly of the Young Mums Midwife. Four (22%) of the 18 mothers did not receive any support from the midwife or the health visitor and said that they found services on their own by searching the internet and asking their friends. Of the seven (39%) mothers who were supported by midwives and health visitors, two were referred to Improving Access to Psychological Therapies (IAPT) and the rest were signposted to other services including children's centres, voluntary sector groups, milk spots, and baby massage centres.

One mother came to her doctor upon unsuccessful contact with her health visitor, saying:

"After the first week of giving birth, I suffered post-natal depression. I contacted my health visitor who never got back to me. I told my doctor and he told me what I was feeling was normal."

All mothers said that they could have benefitted from early identification of their needs or timely provision of therapies. The two mothers who were referred to IAPT waited for several months before they were seen. However, they also said that the IAPT service provided them with useful strategies to deal with their condition. The long waiting time to be seen by IAPT therapies was also mentioned by the two doctors and two social workers who said that they have supported mothers who had to pay for their own private therapy session because they could not access IAPT when they needed it.

Some mothers had good experiences of their doctors saying that they knew about services and referred them to the relevant ones. For example, one 18-year old mother said:

"I accepted my doctor's referral who referred me to an organisation called Family First Partnership who will be visiting me and my baby for two years."

All mothers, except for one, expressed their feelings to health professionals. However, they were told that what they were feeling was normal and was only due to hormonal changes. For example, one mother said:

"I informed both the midwife and the doctor. The doctor was not much help, everything I asked he just said it is normal without referring me to anything."

Interestingly, one mother had the opposite experience with her doctor who explained to her that many women experience post-natal depression in the first two months. He also gave her a list of classes to attend for free, saying that it was good for her to socialise with other mothers and get out of the house with the baby.

According to the four GPs, they see between 5 and 14 new mothers in a month, and 15 to 20% experience mental health problems. They said the majority of referrals were self-referrals and that this is mainly through the 6-8 week post-natal check-up, which they consider to be an opportunity to ask mothers how they are feeling and how they are coping with other issues in the family. They can ask questions because they are familiar with the history of the mothers and would understand what they went through and are confident that trust has been built. Midwives and nurses also said that mothers either self-refer themselves or are referred by other professionals such as GP, midwife, and health visitor, or their relatives.

The four social workers had different experience of referral to their service. They said that mothers do not self-refer themselves. Instead referrals come from many routes including the police, health professionals, and schools. Some mothers are being referred by the Early Help Service, Housing, GAIA Centre, NSPCC and Community Mental Health teams. Social workers said that the reason mothers do not self-refer is because of 'stigma'.

Stigma has been defined as "society attaching a label on someone as tainted or less desirable. It involves three elements; a lack of knowledge, negative attitudes, and people behaving in ways that disadvantage the stigmatised person" (Thornicroft 2017). It can be noted that the word stigma had been mentioned by health and social care professionals but not by mothers although they use words that might indicate stigma such as 'fear', 'red flag', and 'felt embarrassed'.

3.2.2 Issues presented by mothers

When asked how they presented their issues to health professionals, 15 mothers said that they talked of feeling low and overwhelmed, but that they did not know at that time what they were feeling. Three mothers said that they were hesitant to share their feelings and emotions due to fear of being judged as an unfit parent. One of them was a child in care and did not want her own history to cause her child to be labelled as a 'red flag'.

Two social workers said that they have assisted mothers who were in care and subsequently had their children placed into social care. They also added that while mental health is a presenting issue for some, they had to consider the other areas of the family life. They said that some mothers they have supported were in

situations of domestic violence, and some had alcohol and substance misuse problems. They said that some of the mothers with mental health conditions that they have supported had suicidal tendencies and could have benefitted from earlier intervention.

Two first-time mothers said they did not know what to expect from parenthood and while they felt happy, they also felt overwhelmed with becoming first-time parents. For example, one said:

"I was happy to see my baby and it felt good, but I felt down and did not know why."

Another mother said:

"My mental health was up and down. I was breaking into tears over little things and was frustrated with myself as I am normally a very strong person. I experienced 'cabin fever', the feeling of wanting to stay indoors. I believe this made my mental state worse."

However, not only first-time mothers feel overwhelmed. One second time mother felt overwhelmed by the experience. She said:

"After giving birth, I felt mentally fragile, struggling to breastfeed the twins. I had low confidence even though my birth went opposite to what was predicted, I still felt unsure about my ability. At the beginning of my pregnancy, I was fed negativity by the doctor who made it clear I was a high risk. Hearing this really affected me throughout my pregnancy."

Some of the responses from the mothers resonated with the responses from all professionals who said that mothers present a wide range of issues such as housing (poor and/or lack of), finances and benefits, and relationship issues including domestic violence and unsupportive partners. Some relied on family/relatives for help but they were not always available, and some mothers had relatives who were helping them but had to go back to their countries.

The GPs who were interviewed said that mothers, especially first-time mothers and single parents, feel overwhelmed and expressed fear over coping with parenting. They said that some mothers felt that they have additional responsibilities which are difficult to juggle, such as having other children and/or elderly parents. In addition to the social issues outlined above, the professionals said that some mothers present pre-existing mental health problems and memories of abuse, and some had substance misuse/abuse. They said that they have supported a few mothers who had difficulty in communication with English not

being their first language. In addition, they reported that some mothers also present problems with baby crying and sleep deprivation.

Interestingly, all health professionals said that hormonal changes also trigger mental health problems but none of the social workers or the mothers talked of it as a reason why they were feeling low.

All the GPs said that where trust has been established between the health professional/s and the mother, the professional felt confident asking about sensitive issues including relationships and finances and could then signpost them to the relevant services. They see the value of building the relationship with women even before the pregnancy. This was echoed by the social workers who said that establishing a trusting relationship is important for the mother to feel safe in sharing their problems

One social worker said:

"There are mums who are struggling but are not engaging. They fear that it [what they share] will be kept in the record and they worry about the children. So, they hide it and deal with it alone. They also don't want to be seen as failures or bad parents."

3.2.3 Mothers' access to services

It appears that accessing services varies and is not often easy. This is due to number of factors including health professionals' knowledge of services; mothers' knowledge of services; and the presence of friends and relatives who know about services.

For example, all mothers said that they relied heavily on their health visitor, doctor and midwife to signpost them to services. However, 13 mothers said that they were not often told of the services they could access and had to search for them themselves. Where midwives and health visitors lack knowledge of what services are available, mothers rely on their personal social network of friends and family. When asked how they came to know which services were available, the mothers said that they searched online and joined online mums' forums where they can talk freely about their issues and receive advice from parents who have gone through or are going through the same issues. Some also said that they went for a walk and socialised with friends and family which helped them think more positively.

Their experience of different services also varied. For example, half the mothers had satisfactory experience of health visitors and/or midwives, saying that their

midwives continued advising them while they were waiting for other services and signposted them to alternative services they could access. However, the other half had very unsatisfactory experiences with their midwife or health visitor. They said that health visitors had unannounced visits and were in a rush. Three said that they called their health visitors, but it took up to three weeks before they returned their call and one did not call at all. It was during that time that they felt most vulnerable and had to look for services on their own.

One mother said:

"I received no support from my health visitor. She came unannounced and was in a rush. She could not assist with an injection of heparin."

Mothers said that they accessed milk spots, services provided by the voluntary sector such as Family Action and St. Michael's Fellowship, and services by GSTT and Lambeth Early Action Partnership (LEAP), and IAPT. The two mothers who accessed IAPT said that they waited for two and six months respectively, before they received the therapy. They said that the strategies helped them but waiting to be seen had been unhelpful, and further impacted on their mental health condition and affected them negatively. Two doctors and one social worker also said that some mothers they have commented on long waiting times for IAPT.

3.2.4 Mothers and professionals' knowledge about relevant services

Timely access to services is important in early identification of the mental health condition and provision of support to mothers. However, professionals' and mothers' understanding of services varies. Most of the mothers did not know about services available to them, apart from two mothers who knew about the baby and mum yoga class in Streatham, Atkins School and postnatal classes.

Twelve mothers received information from doctors, midwives and health visitors and were able to locate some services. However, six said that their health professionals did not inform them of services and that they had no other option but to search the internet or ask their friends. Those who were able to find their local children's centres were able to understand more and able to attend milk spots and talk to other mothers. Five mothers said that they were signposted to children's centres and some voluntary sector groups and were able to get some support.

The above pattern also resonated in the responses of professionals, some of whom were new to their post and still learning what is available in the community. However, those who had been practitioners in the field for many years felt confident to signpost mothers to different services. For example, one social worker said that:

"We have service days every month where different services come together to talk to us, give us brochures and tell us the referral process."

However, knowledge about services also varied even within the same profession. One social worker admitted that while she is confident in establishing a trusting relationship with the mother, she does not know much about the different mental health services in Lambeth, particularly therapies.

All respondents, mothers and professionals, agreed that information about services should be made available to mothers during and after pregnancy.

3.2.5 Professionals' knowledge about perinatal mental health and how to support mothers

Most professionals (10) said that they are confident with their knowledge of perinatal mental health. However, two health professionals admitted not having enough knowledge on the topic and suggested that training should be provided to all practitioners who support mothers. They said that 15% of service users they see present mental health problems and they should be equipped with skills — not to do the therapy themselves, but to be able to explain to mothers what each service is about.

It is not only knowledge about perinatal mental health that professionals find important. They said that it would be helpful to understand the threshold for different services so they can signpost correctly. One social worker and one nurse said that they do not know the threshold for IAPT.

In addition to knowledge on perinatal mental health and thresholds for services, the value of listening and asking difficult questions was also mentioned.

One mother said:

"Professionals should be good listeners and be more supportive."

Another mother said that professionals should not make assumptions:

"I am a mum with kids and they assumed I know all the services."

Only a few of the professionals interviewed were aware of the GSTT perinatal training. One of the two nurses said that as they are a small team, a full day or even half day training would be challenging because of capacity issues. He suggested short in-house training sessions.

Most of the mothers we interviewed said that their experience of accessing mental health advice from professionals after giving birth was unsatisfactory. Seven of them reported that they developed post-natal depression but also said that their GP, midwife, and/or health visitor told them that what they were feeling is hormonal and normal. The experience was shared by both first-time mothers and those who had children before.

One mother trusted her doctor and was able to confide in her, saying that talking to her doctor was the first step in dealing with her post-natal depression and she was fortunate that her doctor knew about the symptoms.

Two social workers said that they supported mothers who shared their unsatisfactory experience of health professionals. One of them said that a mother who was referred to her remembered being questioned by her GP about her ability as a parent, and they had been told by the GP that she was a risk to her children.

Another social worker said that one mother was told by her health visitor told her to 'shut up' and 'don't let people know [you have a mental health need]'. The mother went on to say that this was because of the culture in the country where they both came from, where people with mental health conditions are seen as 'mad'.

3.2.6 Mothers' access to informal support

Fourteen mothers had support from either their friends or family, which according to them provided great help when they felt low and depressed. Those who had supportive parents and partners found their support invaluable. They said that they offered emotional support as well as practical support, such as looking after their other children and doing household tasks.

One mother who struggled to find formal support relied heavily on her family. She said:

"If it were not because of my family, I would not have coped at all. They helped me with my other two children and my mother helped me a lot."

Some of them also found chatting with other mothers though online forums helpful because they could relate to their experience. They were able to share similar feelings and received tips on how to deal with emotions.

One mother said:

 "Speaking to others online helped me as I felt no one understood what I was going through emotionally."

Speaking with other mothers had a positive impact on one mother particularly who was not open about her condition with her family. She said that after attending breastfeeding class and talking to other mothers, she found the courage to talk to her sister and her friend who ensured that she got out of the house weekly.

Other interviewees also spoke of the benefits of coming out of the home environment. One mother said:

"Getting out of the house and attending services where I could communicate with other mums was helpful. I found that many felt the same way I did. After two weeks, my negative thought process had stopped".

A young mother with three children said that talking to other mothers helped her to develop more positive thoughts on parenting.

3.3 What can be improved?

Towards the end of the interview, we asked the respondents to suggest things that they think could be improved so that mothers can be supported better.

3.3.1 Improved waiting time for IAPT

As previously noted, although some of our interviewees had good experiences of IAPT, they were dissatisfied with the waiting time, something that the professionals also highlighted. Two mothers who accessed IAPT had good things to say of the strategies they learned to cope with depression. One social worker also said that the mother she worked with had shared about the long waiting time for IAPT. Some professionals also mentioned that some mothers they work with talked of the long waiting time.

3.3.2 Better health visiting service

GPs said that the reduced health visiting service had tremendous effect on support to mothers. This echoed the lived experiences of mothers who did not get support from their health visitors or had only one visit from them. There are parents who received excellent support from their health visitors, but it appears there is inconsistency in the service. Mothers said that they would like health visitors to take time to visit them more than once, especially those who had a difficult childbirth.

3.3.3 Improved professional knowledge on perinatal mental health

While the majority of professionals are confident about their knowledge of services, mothers felt that this is an area to improve. Their reported experiences of health visitors, GPs and midwives was varied and did depend heavily on each professional's knowledge of services. One doctor said that:

"Mothers fall through the gap when they don't receive the services early enough. Mothers should be offered information right after they give birth and a reliable contact person in case they need help later."

3.3.4 Increased time with the mother

Two of the four GPs feel that the 10-minute allocated time for each mother is not enough to cover all issues they face. This, in addition to reduced health visiting service and the new system to correspond with them, that is only via email, makes it difficult to signpost and follow though actions for certain mothers.

In addition, professionals said that they don't receive updates from Community Mental Health teams about mothers they have referred to them. This makes it difficult to follow up mothers for additional support they might need.

3.3.5 Accessible information on perinatal mental health services and timely access to services

All professionals said that there is not enough information on community-based support to mothers suffering from perinatal mental health whose condition is not severe to merit referral to secondary care. They suggested that there should be more community-based support such as informal support groups. As mothers referred to IAPT also struggle with the long waiting time, the professionals felt this client group could benefit from other services. One doctor said that existing support groups should offer a more relaxed environment for mothers to freely express their emotions and share with others who have the same experience. The GP felt that support groups are also useful for mothers who are hesitant to seek formal health support for fear of being labelled as unfit parents. For others, it could also be a good way to find the courage to talk about their issues with family members.

Two GPs and one social worker said that mothers had no other option but to seek private support and pay up to £60 per hour to enable them to cope as they wait for other services.

In addition to more post-natal check-ups, one mother said that care should be given to women immediately after giving birth because this is the stage where they

feel most vulnerable. It would also help if health visitors and midwifes would follow up and talk to them about their feelings.

Mothers said that that there is not enough information about post-natal depression and this should be given during ante-natal appointments. They also said that doctors should be aware of how they advise women at the start of their interaction with them, considering that some advice might have long lasting effects and actually be a cause of post-natal depression. All professionals said that there must be a source of information about signs and symptoms of perinatal mental health problems so that they can advise parents early on.

3.3.6 Provision of training to professionals

Ten professional respondents appreciated the value of training and networking. One suggested that there should be short training sessions that can be done in the work setting, considering their already-stretched capacity.

One social worker also said that some mothers struggle with their relationship with their GPs as some GPs don't explain services that they are signposted to. She said that mothers had told her that they have gone to the service only so as not to let the GP down.

Mothers said that health professionals should be knowledgeable and able to inform mothers of mental health symptoms.

3.3.7 De-stigmatising mental health

One social worker suggested that mental health should be freely discussed in children's centres, so parents will not fear seeking help. She said that more and more mothers are presenting mental health conditions and they should feel free to talk about it.

Discussion

This study explored the views of mothers and professionals on the experience of mothers in accessing support for their mental health conditions in the first year after birth. We have seen from the presentation of findings in that there are some factors contributing to and hindering support to mothers.

While we do not claim that the experience of 18 mothers and 12 professionals who took part in this research represents the experience of the whole local population of mothers with mental health, it can be noted that the findings have highlighted

some aspects that are common amongst respondents and reflect what had been found from previous studies conducted on the same topic in different places in England.

This study found that access to services by mothers with mental health conditions varies considerably depending on several factors, but mainly due to health and social care professionals' knowledge about services and perinatal mental health itself. It has also found that, for most interviewees, the mother's condition was not identified early on and there were missed opportunities to help them in a timely manner.

4.1 The identification of mental health problems does not happen in a timely manner and it varies considerably due to several factors associated with the mother and with the professionals with whom she was in contact.

It was found that the mental health conditions of mothers who took part in this study were not identified early enough. This resonates in the findings of previous research studies that mental health conditions of mothers go undetected (Bauer 2014, Alder et al. 2011). This is not due to a single factor but a combination of many factors.

First, mothers were fearful and felt stigmatised, resulting in their hesitancy to share their feelings with health professionals. Instead, they kept it to themselves as they did not want to be seen as bad parents. Again, this reflects the experience of mothers in Bauer's research (2014) on stigma.

Second, there appears to be a knowledge and confidence barrier where both mothers and professionals feel that they don't know much about existing services. In addition, some professionals feel that they don't have confidence to identify perinatal mental health. This was also highlighted in a similar study where it was found that professionals lack confidence to detect mental health problems (Higgins et al. 2017, Jones et al. 2012, Downes 2016, Khan 2015).

The third factor that prevents early detection is the quality of relationship built between the professional and the mother. Where mothers and professionals built a trusting relationship, mothers were less scared to share their feelings. Some mothers admitted that they were hesitant to share their emotions due to fear of being seen as an unfit parent, or that the child would be taken away from them. This can be due to two things: the stigma that is still attached to mental health and the trust that has been established between the mother and the professional. It appears that the very few mothers who received timely support had an interaction with professionals who had the appropriate knowledge about mental health and therefore were confident to provide advice and to signpost them to the relevant services.

Those who were in contact with professionals who dismissed their condition as 'normal and hormonal' did not receive the support early enough. They had to look for the services themselves and relied heavily on informal support provided by their respective families and social networks.

4.2 Mental health problems manifest during the early perinatal stage

There was a propensity noticeable from our research for mothers to develop mental health problems during the early perinatal stage. Apart from four interviewees with pre-existing mental health conditions, mental health problems developed for all the other mothers we spoke to within 2-4 weeks after the birth of the child.

Mothers told us they felt overwhelmed and unsure of what to do, and it was during that time that they could have benefitted from useful advice and support. Some mothers reported that health professionals dismiss their feeling as normal and hormonal but did not offer any explanation or support. This then results in differing experience of support.

As the condition develops in the first few weeks, it could be suggested that the 6-8 week post-natal consultation might be too late to offer support. In this context, the role of the midwife and health visitors is potentially crucial in early detection of perinatal mental health needs. However, as our study found variances in the level of support provided by those professionals, this suggests an inconsistency in the level of knowledge and confidence amongst professionals. Further, some health professionals tend to view mental health from a biological perspective, with some dismissing it as hormonal and normal, as opposed to a condition that is potentially sociological and can improve with the right intervention.

4.3 Having a trusting relationship and access to informal social support plays an important role in coping with the mental health condition.

The stigma attached to mental health and the lack of confidence by professionals to ascertain the mental health needs of the mother can be considered as two of the most important reasons that hinder mothers' access to relevant support. Mothers who do not trust professionals don't share their emotions with them and equally, professionals who are not confident in perinatal mental health are also hesitant to ask questions of a sensitive nature. It is during this point that the relationships with the mother and her family and friends, and access to other social support play a big part in the mother's ability to cope.

The mothers we interviewed associated their ability to cope with their mental health condition with being a part of social groups, both in person and online,

where they could share their experience with other mothers. Social groups, for some, also paved the way for them to build confidence in talking to their family about what they feel and having the courage to ask for help. Those who have relatives and friends could share their feelings with them and also receive advice on which services to access.

Respondents with trusted networks were able to cope with the mental health condition even in the absence of formal support – eg therapies and counselling. This was true with the experience of two mothers who waited several weeks before they were seen by IAPT clinicians and had to rely on the support of their respective friends and families.

4.4 There are gaps in services as well as information about services that mothers can access

It appears that there are only very few services that are known to professionals and mothers and this could be attributed to two things: there are changes or gaps in services and/or there is a lack of information about services. It also appears that there is no systematic and proactive way of sharing information with and amongst professionals. This then results in the varied experiences of mothers getting information about services.

Doctors said that they look for services themselves, take leaflets from different places they visit, and ask colleagues. However, all respondents said that they could benefit from being given a list of services or access to a database. All mothers also said that information could have been given to them even during early pregnancy so that they could access them if the needs arises.

It was also reiterated that information on services should also include the criteria for referrals. It was found that some professionals need to understand what the different services provide to be able to make the appropriate referrals and to also explain to mothers what can be expected from certain services.

Conclusion and recommendations

This research found that there were issues on the identification of the perinatal mental health condition of mothers, lack of information and timely access to the relevant services, and varying knowledge and confidence amongst professionals to support mothers with mental health conditions. We also found that stigma on mental health including fear of being seen as a bad parent hinders mothers to access the support they need. Mental health is still viewed as a sensitive subject and this prevents mothers with mental health conditions to seek help and equally, some professionals are hesitant to have open discussion about it.

However, we have found that some services accessed by mothers are helpful in alleviating their conditions and that there is the intention amongst professionals to support mothers. We have identified that informal support groups — both online and in person — are able to provide mothers the cushion in order to cope with their conditions.

That said, we are recommending the following to address the identified needs to support mothers with mental health problems in a timely manner.

5.1 Training and networking for professionals

Professionals can benefit from further training on mental health, different types of mental health problems, and their signs and symptoms. They need to have basic understanding not to diagnose the patient but to identify any problem early and open up conversations with the mother so that the support is provided in a timely manner. Understanding mental health in biopsychosocial perspectives will also address the issue of dismissing the mother's feelings as merely hormonal or normal.

Training should also include how to communicate effectively by showing empathy and discussing sensitive topics with the patient. It can be appreciated that confidence is built over time, and so there should also be networking opportunities for professionals to share good practices and learn from each other.

5.2 Proactive approach to information sharing and opportunities for networking

There could be a library of resources that is accessible to all professionals and mothers, online as well as in paper format, which can be given to mothers whilst they are pregnant, as the 6-8 week post-natal check-up seems to be too late.

There should also be a way by which different professionals share information about the services they come to know and add to the existing list. An initial audit of relevant services should be conducted to inform the resource list.

5.3 Raise public awareness on mental health to break down the stigma

It appears that there is still stigma associated with mental health. One way to break this down is to make mental health a part of regular conversation so that the person with the condition will not be afraid to ask for help. There could be more awareness raising activities for pregnant women and post-birth in different formats and at different places. Some activities may include campaigns on mental health through community groups and the general public; inclusion of mental health topic

in health promotion activities; and encouragement of discussions on mental health in public.

5.4 Engage with the relevant people in the mother's life as a source of support for them

It was evident from the experience of the majority of the respondents that the presence of informal help from family and social networks was the default place for gaining support. This can be considered as positive and professionals could use it in a more conscious way when working with clients. For example, they could start to involve some members of the mother's family and friends who could potentially offer support to the mother when/if she needs it. This could be done by the health or social care professionals who come in contact with the mother and who may know the support she needs. Family and relatives can be given information on relevant services and tips on how to talk about wellbeing with the mother.

Healthwatch Lambeth

Reference list

Agapidaki, E., Souliotis, K., Jackson, S. F., Benetou, V., Christogiorgos, S., Dimitrakaki, C., & Tountas, Y. (2014). *Pediatricians' and health visitors' views towards detection and management of maternal depression in the context of a weak primary health care system: A qualitative study*. BMC Psychiatry, 14, 108.

Alder, J., Fink, N., Urech, C., Hosli, I., and Bitzer, J. (2011). *Identification of antenatal depression in obstetric care*. Archives of Gynaecology and Obstetrics, Volume 284, No.6 pp. 1403–1409.

Barber, C. C. (2009). Perinatal mental health care in New Zealand: The promise of beginnings. New Zealand Journal of Psychology, 38(1), 32–38.

Bauer, A. (2014). *The costs of perinatal mental health problems*. London: Centre for Mental Health. https://www.nwcscnsenate.nhs.uk/files/3914/7030/1256/Costs_of_perinatal_mh.pdf (accessed 15/6/2019)

Baby Buddy (2018). *Best Beginnings*. Retrieved from web.bestbeginnings.org.uk: https://web.bestbeginnings.org.uk/web/lets-get-started (accessed 15/6/2019)

Better Births, Improving outcomes of maternity services in England - A Five Year Forward View for maternity care. National Maternity Review. NHS England. https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf (accessed 15/6/2019)

Downes, C., Carroll, M., Gill, A., Monahan, M., and Higgins, A. *Practice nurses' knowledge and competence in relation to perinatal mental health care*. Published Online: 30 Nov 2017. https://doi.org/10.12968/pnur.2017.28.12.542 (accessed 15/6/2019)

Edge, D. (2010). *Falling through the net — Black and minority ethnic women and perinatal mental healthcare: health professionals' views*. General Hospital Psychiatry. Volume 32, Issue 1, January–February 2010, pp. 17-25

Five Year Forward View for Mental Health: One year on. NHS England. https://www.england.nhs.uk/wp-content/uploads/2017/03/fyfv-mh-one-year-on.pdf (accessed 15/6/2019).

Fonseca, A., Gorayeb, R., and Canavarro, M.C. (2015). *Women's help-seeking behaviours for depressive symptoms during the perinatal period: socio-demographic and clinical correlates and perceived barriers to seeking professional help*. Midwifery, 31, 12 (2015), pp. 1177-1185.

Getting help and support for common mental health problems Information for the public Published: 1 May 2011. National Institute for Health and Care Excellence. https://www.nice.org.uk/guidance/cg123/resources/getting-help-and-support-for-common-mental-health-problems-pdf-235529147077 (accessed 15/6/2019)

Glasser, S., Hadad, L., Bina, R., Boyko, V., and Magnezi, R. (2016). *Rate, risk factors and assessment of a counselling intervention for antenatal depression by public health nurses in an Israeli ultra-orthodox community*. Journal of Advanced Nursing, 72(7), pp. 1602–1615.

Higgins, A. et al. (2018). *Barriers to midwives and nurses addressing mental health issues with women during the perinatal period: The Mind Mothers study*. Journal of Clinical Nursing, Volume27, Issue9-10.

Howard L.M. et al. (2017). *Accuracy of the Whooley questions and the Edinburgh Postnatal Depression Scale in identifying depression and other mental disorders in early pregnancy*. British Journal of Psychiatry.

Howard, R. T. (2018). *1 in 4 Pregnant Women Have Mental Health Problems. British Journal of Psychiatry*. Retrieved from King's College London: https://www.kcl.ac.uk/ioppn/news/records/2018/january/1-in-4-pregnant-women-have-mental-health-problems.aspx (accessed 15/6/2019)

Khan, L. (2015). *Falling through the gaps: perinatal mental health and general practice*. Centre for Mental Health. https://maternalmentalhealthalliance.org/wp-content/uploads/RCGP-Report-Falling-through-the-gaps-PMH-and-general-practice-March-2015.pdf (accessed 15/6/2019)

Kendall, C. M. (2016). *Implementing the five year forward view for mental health*. Retrieved from www.england.nhs.uk: https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf (accessed 15/6/2019)

King's College Hospital Trust Data Review, March 2014.

NICE Guidance (2014). *Antenatal and postnatal mental health: clinical management and service guidance*. Retrieved from https://www.nice.org.uk/guidance/cg192/chapter/Introduction (accessed 15/6/2019)

Mental health in pregnancy, the postnatal period and babies and toddlers Report for Lambeth local authority (2017). Perinatal Mental Health, England. ChiMat's Data Atlas. https://fingertips.phe.org.uk/reports/ssrs/?reportName=chimat%2FMental_health_in_pregnancy_and_infants&areaCode=E38000092&areaTypeId=153&parentCode=E39000018&groupId=1938132960&format=pdf (accessed 15/6/2019).

NICE Guidance (2014). *Antenatal and postnatal mental health: clinical management and service guidance*. Retrieved from https://www.nice.org.uk/guidance/cg192/chapter/Introduction (accessed 15/6/2019)

Noy, C. (2008). *Sampling knowledge: the hermeneutics of snowball sampling in qualitative research*. International Journal of Social Research Methodology, 11(4), pp. 327-344. https://nbn-resolving.org/urn:nbn:de:0168-ssoar-53861 (accessed 15/6/2019)

Paschetta, E. et al. (2014). *Perinatal psychiatric disorders: an overview*. American Journal of Obstetrics and Gynecology. Volume 210, Issue 6, June 2014, pp. 501-509.

Perinatal Mental Health Care Pathways (May 2018). National Institute for Health and Care Excellence https://www.rcpsych.ac.uk/pdf/The_Perinatal_Mental_Health_Care_Pathways_Short_Guide.pdf (accessed 15/6/2019)

Thornicroft, G. et al. (2007). *Stigma: Ignorance, prejudice or discrimination*. British Journal of Psychiatry 2007; 190: 192-3.

Yin R. (2003). *Case Study Research: Design and Methods*, 3rd ed. Sage Publications, Thousand Oaks.

Healthwatch Lambeth

This research is partly-funded by Healthwatch England.

Report written in June 2019.

Healthwatch Lambeth
336 Brixton Road
London, SW9 7AA
Tel 020 7274 8522
Text 07545 211 283
info@healthwatchlambeth.org.uk
www.healthwatchlambeth.org.uk/enterandview

Registered charity no: 1153444
Registered company in England and Wales no: 8430436