The statistics on perinatal mental health are alarming. In almost half of the UK, pregnant women and new mothers have no access to specialist mental health services; and only 3% of Clinical Commissioning Groups have a maternal mental health service strategy, putting a huge number of women and babies at risk. And those risks may result in death. The figures provided by the MBRACE-UK report on maternal deaths 2011-13 show that a quarter of the women who died between six weeks and one year after pregnancy died from mental health-related causes – one in seven were suicide.

One in five women will develop a mental illness during pregnancy or in the year after birth – that’s 160,000 women in the UK alone. The cost to the public sector is £8.1bn in direct and indirect costs, which is five times what it would cost to improve services. O&G magazine examines maternal mental health and what the future holds.
The MBRRACE-UK report calls for seamless care across the different professions, disciplines and agencies, and stresses that all the services need to work together to share information about relevant mental health history. There is an urgent need to improve perinatal mental health training in all the relevant professional groups.

In the UK, we are seeing increasing recognition of the importance of maternal mental health. The 2014 Annual Report of the Chief Medical Officer (CMO) devotes an entire chapter to perinatal mental health, stressing the need for all professionals in contact with pregnant women to be able to identify possible mental illness and
Maria Viner’s first pregnancy had a tragic outcome: her son William died within 24 hours of a difficult birth. She went through a period of intense grief and was referred to a psychologist. After six months, she and her husband decided to try for another child. Maria explains, “I was anxious throughout the pregnancy. I couldn’t believe that I would be bringing a live baby home.”

Joel was born by elective caesarean at 38 weeks, but had reflux and lost weight quickly. He fed well, but was sick constantly. Maria says, “I was sure there was something wrong with him. I became depressed and didn’t want visitors, yet none of the hospital staff recognised my condition.” When Maria returned home, her anxiety grew and she feared Joel would be taken away. Fortunately, Maria chanced upon Mothers for Mothers, a Bristol-based charity supporting women and their families through perinatal mental illness, which provided her with a lifeline. She eventually recognised that she was suffering from postnatal depression and agreed to attend counselling. When Joel was six months old, the couple decided to try for another baby. Maria was scared of being pregnant again, but did conceive after some difficulty. The relationship she had built with the consultant at the birth of Joel was so vital to her that she changed hospitals to stay with him. Sadly, she again faced a traumatic birth: Trinity was born by elective caesarean at 39 weeks, but the epidural did not work properly. Then it was discovered that Trinity had a patent foramen ovale (PFO).

Maria says, “I felt that if I looked at Trinity, I would love her, and if I loved her, she would die. We did not bond and I had terrible trouble feeding her.”

During Trinity’s first year, Maria lost interest in everything. She became tearful, anxious, irritable, angry, helpless and hopeless. She lacked energy and was troubled by obsessive thoughts. Again, peer support from Mothers for Mothers was essential. A holiday was the turning point and she finally felt able to appreciate being a mum. With the group’s support, Maria returned to counselling and began to get back into control, returning to work after five years of illness.

Maria is now a director and trustee of Mothers for Mothers. mothersformothers.co.uk

What goes wrong?
There is a lot of pressure on mothers-to-be: personal pressure to be ‘a good mum’, and societal pressures through constant exposure to images and ideals of motherhood. Mothers can also feel great fear: of failing, of social services being called or of having their baby taken away from them.

Above all, there remains a stigma surrounding mental illness that prevents women from being open. Judy Shakespeare, Clinical Champion for Perinatal Mental Health, Royal College of General Practitioners (RCGP), explained that many women are concerned that having a mental illness is incompatible with being a good mother. As the personal stories

refer appropriately for assessment and treatment. It also calls for improvements in coordination and communication between healthcare professionals.

In January 2016, Prime Minister David Cameron pledged £290m to help expectant and new mothers who develop mental health problems around the time of birth – meaning that around 30,000 more women each year will have access to specialist mental healthcare. Clearly, it has never been more important to break down the barriers to high-quality maternal healthcare, but how can we achieve this?

What is the situation?
Earlier this year, the RCOG organised a one-day meeting, ‘Joining up care in maternal mental health’, to mark International Women’s Day.

David Richmond, RCOG President, told delegates, “Now is the time to make changes because there is money in the pot to try to make a difference.” He explained that the issues of gender equality and parity of esteem are at the core of perinatal mental health. Lesley Regan, RCOG President-Elect, said that with the recent flood of reports, the numbers are now clear and the challenge is to turn statistics into action.

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Maria’s Story

Maria Viner suffered from two bouts of postnatal depression, after the births of her son Joel and daughter Trinity.

Maria Viner’s first pregnancy had a tragic outcome: her son William died within 24 hours of a difficult birth. She went through a period of intense grief and was referred to a psychologist. After six months, she and her husband decided to try for another child. Maria explains, “I was anxious throughout the pregnancy. I couldn’t believe that I would be bringing a live baby home.”

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Expecting Help
There is a lack of joined-up services for expectant and new mothers
£8.1 billion
The direct and indirect costs of maternal mental illness to the UK public sector

on these pages show, women with mental illness struggle with feelings of shame, compounded by the fear that their babies may be taken away. As a consequence, many choose not to disclose their feelings or may not recognise that they are ill. And once inside the system, parents with mental illness find that their pathology is emphasised rather than their parenting.

It is important that everyone involved in the clinical pathway of an expectant or new mother is alert to the red flags. But symptoms can easily be missed, buried in the anxiety, elation, apprehension and joy faced by pregnant women. The familiar Whooley questions commonly used at GP and booking appointments seem to be of limited use.

In fact, as Judy Shakespeare explained, sometimes healthcare professionals contribute to the issue. Women are deterred from disclosing their fears because they feel that their concerns are being dismissed or the responses they receive aren’t consistent. Sometimes they feel rushed, judged or ‘processed’.

Why does it go wrong?
There is a lack of a joined-up service for expectant and new mothers. Judy Shakespeare pointed out that GPs drop out of the picture once a pregnant woman has been passed to the midwife, and that the primary care services are fragmented and located in different places, making it difficult to maintain traditional patient management.

Kathryn Grant, who was diagnosed with bipolar disorder (see panel, right), said she never saw the same midwife twice, while Maria Viner, who was diagnosed with postnatal depression (see panel, facing page), actually changed hospitals to be able to stay with the same consultant.

Matthew Jolly, National Clinical Director for Maternity Review and Women’s Health for NHS England, agreed that there are gaps in provision and that better pathways are needed to more easily recognise the opportunities. He also recognised that there is probably already enough guidance in this area.

“In order to make progress towards pathways that work, we need great commissioning,” he told delegates.

The extent of inequality of services and clinical provision across the UK is much clearer now, thanks to the NHS 2015 benchmarking mapping, said Geraldine Strathdee, National Clinical Director for Mental Health at NHS England. She reminded delegates that there is a £4bn investment in digital and innovation that should begin to involve patients in self-entry of data, helping to identify pockets of high risk.

What can the RCOG do?
The RCOG is a great example of how to influence government policy and was specifically mentioned in Cameron’s speech on 11 January. Geraldine Strathdee was clear that constant lobbying is the only way to influence policy. The RCOG is already responding to recommendations made in the CMO’s report and will be strengthening training and CPD courses to ensure members can hone their skills in screening and assessment in maternal mental health.

KATHRYN’S STORY
Kathryn Grant had experienced periods of depression in her twenties, but was delighted when she became pregnant and didn’t want to think about her depression. She expected that pregnancy and motherhood would protect her against mental illness.

She never saw the same midwife more than once during her pregnancy and was unable to build a relationship with any healthcare professional. She never confided in anyone that she was “a little worried” and didn’t want to discuss her mental health issues. However, she was able to honestly answer “no” to the Whooley questions at her booking appointment: she was the happiest she had ever been to be pregnant.

Her pregnancy was without health worries, but problems mounted as the birth approached. Kathryn had trouble sleeping and suffered from increasing anxiety. When her baby was almost two weeks overdue, labour was induced and, after slow and difficult progress, it was decided that a caesarean was the best solution. Following a long and tense operation, Kathryn gave birth to James, a healthy baby boy.

Although Kathryn was determined to breastfeed and bond, that night she suffered a full-blown psychotic episode. Her family persuaded the hospital staff to let her go home, as they thought she would be able to get more rest there. However, she had built up so much anxiety about her son that she soon asked to be taken back to the hospital. She had started to distrust her family and couldn’t be persuaded that there was nothing wrong with James.

The extent of Kathryn’s condition was missed by midwives who visited while she was at home. They noted her anxiety, but were not alarmed. “I think they saw the things around me, but not me,” says Kathryn.

As a result of the psychotic episode, her mental health history was examined and she was diagnosed with bipolar disorder. “I wish I had known that some behaviour in my twenties, such as leaving jobs abruptly, buying horses, and racking up credit card debts, was down to bipolar episodes,” she says.

A further sign of the stigma associated with mental illness emerged when Kathryn and her family persuaded that her own grandmother suffered from postpartum psychosis in 1949. Kathryn is now a trustee of Cocoon Family Support, which provides mental health support services to families across London. cocoonfamilysupport.org